Public Health Intervention Guidance

School- based interventions to prevent smoking - Consultation on the Draft Scope: Stakeholder Comments and Response Table

Monday 22nd September – Monday 20th October 2008

Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	**Response** **Please respond to each comment**
Action on Smoking and Health (ASH)		General	Given that there is currently little evidence to show that schools-based interventions are effective in preventing the uptake of smoking by children, it is important that the guidance recognises that the best way of preventing children from smoking is by having a comprehensive tobacco control programme in place to reduce smoking across the whole population.	Thank you for your comments. We recognise the point you make, and all NICE guidance on tobacco use issued to date acknowledges the need for a comprehensive and evidence based tobacco control programme..
Action on Smoking and Health (ASH)		4.3 Questions & outcomes	Although the proposed questions should reveal the effectiveness or otherwise of conventional smoking education interventions the current scope risks excluding other innovative ways of incorporating information about smoking into the curriculum. For example, statistics on smoking – such as the risk of contracting a smoking related disease – could be used in maths lessons while the marketing of tobacco might be a component of classes on citizenship. Will there be any way of ensuring that non-standard methods of imparting information about smoking and health are covered by the literature search that will form the basis for this guidance?	Thank you for your comment. This guidance will consider evidence about any interventions or approaches delivered to the target populations where some or all of the intervention or approach is delivered in a school. We anticipate that this will include a range of different types of intervention including, for example, education-based approaches, peer-support, wider school smokefree policies, , etc). We will clarify the scope .
Action on Smoking and Health (ASH)		2.d – Target audience	We recommend that examination boards and other curriculum authorities should be included in the list of target groups for this guidance.	Thank you; we have clarified this in the scope.
ARCADE(Amethyst Centre for Alcohol & Drug Education)		general	New research: Beyond Smoking Kills; ASH October 2008	Thank you for passing this reference on.
ARCADE(Amethyst Centre for Alcohol & Drug Education)		general	The scope should identify and include reference to wider health education programmes which include an element of smoking prevention	NICE is also involved currently in writing guidance on personal, social and health education, and we will endeavour to ensure consistency between the two pieces of guidance. See: http://www.nice.org.uk/guidance/index.jsp?action=byID&o=11673

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ARCADE(Amethyst Centre for Alcohol & Drug Education)		3c	The 11-15 year old figures tend to hide the fact that 15% of 15 year olds are still smoking. Research into these key transition years should fall within the scope.	Thank you for your comments. This point has been clarified in the scope.
ARCADE(Amethyst Centre for Alcohol & Drug Education)		3d 3e	"The more deprived your circumstances, the more likely you are to smoke"(Deborah Arnott, President ASH). In addition to the risk factors listed, poor families, being more likely to smoke, are more likely to produce future smokers. This factor should be addressed by the scope.	Thank you. Although not explicitly stated in the scope, we expected the review of literature that we commission to uncover any differences in effectiveness and cost-effectiveness according to the socio-economic status of the target audience.
Association of School and College Leaders (ASCL)		General	I am responding on behalf of ASCL – an organisation of some 14000 school and college leaders.	Thank you for your comments
Association of School and College Leaders (ASCL)		General	The Association of School and College Leaders (ASCL) represents 14,000 members of the leadership teams of maintained and independent schools and colleges throughout the UK.	Thank you for your comments
Association of School and College Leaders (ASCL)		General	I hope that this is of value to your consultation, ASCL is willing to be further consulted and to assist in any way that it can.	Thank you for your comments
Association of School and College Leaders (ASCL)			We welcome all attempts to discourage young people from consuming tobacco or tobacco-related products.	Thank you for your comments
Association of School and College Leaders (ASCL)			We welcome the decline in the incidence of smoking by young people – the decline being at a faster rate than the target set in 1996	Thank you for your comments
Association of School and College Leaders (ASCL)			We welcome any support for strategies already put in place by schools to discourage smoking,	Thank you for your comments
Association of School and College Leaders (ASCL)			We welcome any effective strategies outside of school, especially those aspects of the media which have such a powerful influence over young people's patterns of behaviour.	Thank you for your comments

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Association of School and College Leaders (ASCL)		3c-3d	We regret that the incidence of smoking in girls has not declined as rapidly as that for boys. We need to investigate why this should be the case. Is it related to a perception that smoking acts as a depressant to diet?	Thank you. Although not explicitly stated in the scope, we expected the review of literature that we commission to uncover any differences in effectiveness and cost-effectiveness according to the gender of the target audience.
Association of School and College Leaders (ASCL)		3d	Since smoking is much more prevalent in groups who also drink, we need to make such links apparent in PSHE lessons in schools.	NICE is also involved currently in writing guidance on personal, social and health education, and we will endeavour to ensure consistency between the two pieces of guidance. See: http://www.nice.org.uk/guidance/index.jsp?action=byID&o=11673
Association of School and College Leaders (ASCL)		3d	Schools already have in place mechanisms to identify truants. We need to be careful not to confuse cause and effect here. It is unlikely that truancy causes smoking, but rather that the complex collection of factors and behaviours which lead a person to truant are likely to have much in common with those that lead them to smoke.	Noted, thank you.
Association of School and College Leaders (ASCL)		3d	Raising educational aspiration is a key driver for most schools seeking to improve in so many ways.	Thank you for your comments
Association of School and College Leaders (ASCL)		4.3	The most effective school-based interventions are those that seek to inform and educate, not 'tell' children how to behave.	Thank you for your comments
Association of School and College Leaders (ASCL)			Most youngsters already view smokers with disdain and would not dream of starting. We must not lose sight of the sensible approach of most young people.	Thank you for your comments
Association of School and College Leaders (ASCL)			We need to explain the health impact – not in an emotional and 'frighten them' way, but calmly and rationally.	Thank you for your comments

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Association of School and College Leaders (ASCL)			We need to emphasise the social undesirability of smoking – the economic effects, the risk of exclusion from social circles.	Thank you for your comments
Association of School and College Leaders (ASCL)			The children themselves mainly see those who smoke as 'losers' in some way.	Thank you for your comments
Association of School and College Leaders (ASCL)			We need to find ways to encourage those who smoke to stop.	Thank you for your comments. Although helping children to quit smoking is a crucial factor in their future health, this guidance does not address smoking cessation in children and young people. However, we would encourage you to suggest other topics for future NICE public health guidance, and you may do so at: http://www.nice.org.uk/getinvolved/suggestatopic/suggest_a_topic.jsp.
Association of School and College Leaders (ASCL)			We should supply FREE 'stop smoking' strategies, be they nicotine patches or whatever.	Although helping children to quit smoking is a crucial factor in their future health, the referral for the guidance relates specifically to prevention and so the scope and does not address smoking cessation for children and young people. You may wish to see the guidance on cessation advice to young peopole and the use of pharmacotherapy at: http://www.nice.org.uk/Guidance/PH10. We would also encourage you to suggest other topics for future NICE public health guidance, and you may do so at: http://www.nice.org.uk/getinvolved/suggestatopic/suggest_a_topic.jsp
Association of School and College Leaders (ASCL)			We should encourage youngsters to see this as THEM making a CHOICE to adopt a HEALTHY LIFESTYLE as a package of activities – sensible eating, exercise etc.	Thank you for your comments

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Association of School and College Leaders (ASCL)		3	ASCL agrees that this is an important issue, and that guidance is needed, not least because school leaders are uncertain about what are the most effective approaches for discouraging uptake and continuation of smoking.	Thank you for your comments
Association of School and College Leaders (ASCL)		4.1	The two sections are not exhaustive. In particular, less than half of 16-19 year olds are in schools. It seems likely that this is not the key age to be targeted, but if 16-19 year olds are covered at all then those in colleges, apprenticeships and work-based training should not be overlooked.	Thank you for your comment This has been clarified in the scope; young people aged 16 -19 who are still in education – including schools and colleges of further education - are included in the scope for this guidance.
Association of School and College Leaders (ASCL)		4.2	Agreed.	Thank you.
Association of School and College Leaders (ASCL)		4.3	When considering cost-effectiveness it is imperative to include the opportunity cost of each intervention as well as its direct cost. Any measure which takes curricular time, involves teachers, or requires the attention of hard-pressed school and college leaders will automatically have considerable hidden costs. Such approaches, even when they have preformed well I pilots, often do not translate well to more general use.	Thank you. We aim to consider all relevant factors when assessing the cost-effectiveness of interventions, this includes giving consideration to opportunity costs. We note though that because schools are expected to cover smoking anyway, opportunity costs may not arise if the NICE recommended interventions take as much time as what is being done currently.

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Barnsley PCT			4.1.1. Children and young people in educational institutions including, but not limited to: I do not understand the rationale for this limitation of scope. I would have: 4.1.1. School-age Children and young people including, but not limited to: If a school-age child is not in an educational institution, but instead is in Care Home, Prison, Home Schooling, Illegal immigrant, etc etc, then they are liable to be much more vulnerable. So the scope of this guidance is inequitable at one level and might fail on a health equity impact assessment.	Thank you for your comment. We appreciate that prevention of smoking for young people not attending school an important issue, and that those children may be particularly vulnerable. However, the referral for this guidance focuses exclusively on school-based smoking prevention. However, we would encourage you to suggest other topics for future NICE public health guidance, and you may do so at: http://www.nice.org.uk/getinvolved/suggestatopic/suggest_a_topic.jsp

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Barnsley PCT			4.2.2 Activities/measures that will not be covered I am concerned that so many key areas are being left out of the NICE guidance. I would be reassured if further NICE guidance was being planned which addressed the areas not currently within the scope of this guidance, but I would be concerned if key areas were out of scope with no further plans. Commissioners inevitably respond to issued guidance sometimes at the expense of investing in areas which are out of scope. My perception is that many of the areas currently out of scope have great promise and it would be most unwise to make it harder to fund these areas by excluding them from the scope of planned NICE guidance.	The guidance process requires NICE to base its scope and guidance on the referrel from the Departmern of Health. The current referral requires that we develop guidance on school-based smoking prevention. However, we would encourage you to suggest other topics for future NICE public health guidance, and you may do so at: http://www.nice.org.uk/getinvolved/suggestatopic/suggest_a_topic.jsp

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British Association for Stop Smoking Practitioners (BASSP)		General	BASSP welcomes evidence based guidance which is intended to educate and support those addressing smoke education in schools. BASSP feels that this guidance will structure the depth of smoking education in schools and provide a framework for initiatives such as "healthy schools".	Thank you for your comments
British Association for Stop Smoking Practitioners (BASSP)		4.3	Personal, Social and Health Education (PSHE) coordinators in primary and secondary schools and school nurses should have Level 1 Intervention as part of their core training	Thanks for your comments. Where it is available, we will consider suitable evidence on the effectiveness of different professionals delivering interventions in a school setting
British Association for Stop Smoking Practitioners (BASSP)			School nurses, Healthy School leads and PSHE staff should work in partnership with their LSSS to develop a local map of the areas where there is a high prevalence of smoking and specific awareness/education programmes should be developed in partnership and implemented throughout the schools located in those areas	Thank you, noted.
British Association for Stop Smoking Practitioners (BASSP)			Education programmes should contain separate projects dealing with (a) the risks to health and physical performance caused by smoking (b) the social cost of becoming a smoker (c) the financial costs of smoking (d) the legal constraints on smoking and why they exist	Thank you for your comments
British Association for Stop Smoking Practitioners (BASSP)			Increase awareness of how the media, advertisements, point-of-sale displays and activities impact on choice and explore positive and negative role modelling	Thank you for your comments
British Association for Stop Smoking Practitioners (BASSP)			Reinforce a 'whole school' approach to the denormalisation of smoking by good communications between the LSSS and appropriate public health / health promotion staff and school governors of every school in any area	Thank you for your comments
British Association for Stop Smoking Practitioners (BASSP)			Support Smokefree lifestyle message by easy access to on-line resources which are easily adaptable to local circumstances	Thank you for your comments

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British Association for Stop Smoking Practitioners (BASSP)			Wherever possible incorporate the Smokefree message into school age sporting activity at all levels (school, county, regional etc)	Thank you for your comment. This guidance will consider evidence about any interventions or approaches delivered to the target populations where some or all of the intervention or approach is delivered in a school. We anticipate that this will include a range of different types of intervention including, for example, education-based approaches, peer-support, wider school smokefree policies, sporting-based activities, etc). We will clarify the scope to make this clear.
Coventry Teaching Primary Care Trust		4.3 What factors aid the delivery …	A centrally produced National Curriculum document, that is written into core curriculum, delivered on by schools in partnership with Local Stop Smoking Services	Thank you for your comments
Coventry Teaching Primary Care Trust		4.3 Expected outcomes …	For smoking and its effects to be taught in the same way as sex education is taught. Not as an 'add on talk' at the end of term. Ground smoking cessation in the curriculum delivery plans	Thank you. We appreciate that smoking cessation is an important issue for practitioners working with some children and young people, however the referral for this guidance focuses exclusively on prevention of smoking uptake. You may wish to see the published guidance on cessation advice to young people and the use of pharmacotherapy at: http://www.nice.org.uk/Guidance/PH10 . Additionally, we would encourage you to suggest other topics for future NICE public health guidance, and you may do so at: http://www.nice.org.uk/getinvolved/suggestatopic/suggest_a_topic.jsp
Coventry Teaching Primary Care Trust		4.3 Secondary outcomes: Improved social skills	The use of positive role models and champions.	Thank you for your comments

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Department of Health (DH)		General	In our view, the scope of this proposed guidance aligns with current DH policy, including commitments under the children's plan, PSA 12, 14	Thank you for your comments
Department of Health (DH)		General	There are references to several old research papers (for example, Owen & Bolling 1995) which may no longer be relevant, given the fall in smoking prevalence (which is now only 6% in 11-15 year olds). Papers that we believe should be referenced include: BMA's *"breaking the cycle of children's exposure to tobacco control"* (2007), BMA's *"cool forever: the influence of smoking imagery on young people"* (2008) and ASH's *"Beyond Smoking Kills"* (2008).	Thank you for these suggestions. The 2007 BMA report was referenced in the draft scope. The 2008 BMA report has been referenced in the revised scope, however, the studies that it cites on these points were not conducted in England or the UK. Therefore, we have maintained the UK papers cited in the draft scope.
Department of Health (DH)		General	The scope appears to be very limited. There may be more helpful ways to limit the scope that would nevertheless produce more meaningful results, for example, interventions to prevent uptake of smoking among school-aged children (that is, not just in school); or changing education to school-based (that is, could include non-formal peer-based programmes). Sole consideration of education would, in our opinion, make the guidance very limited; we feel that it could be much more useful if a more integrated approach was taken.	Thank you for this comment. The referral from DH is for 'school based prevention ' of the uptake of smoking. It was the intention of the draft scope to include all school-based interventions including those delivered outside formal lessons. This has been clarified in the final scope.
Department of Health (DH)		Evidence to be considered	We would recommend that the guidance takes into account the outcomes of the drug, alcohol and tobacco review	Thank you for your comments

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Department of Health (DH)		Policy political implications	There is currently a lot of guidance that is available to schools. We consider that it would help schools to make good use of NICE findings if the guidance was closely aligned, to support appropriate strands arising from the government review of drug, alcohol and tobacco. In our view, it would then be seen as part of a coherent strategy to reduce smoking in young people, as opposed to 'stand alone' advice.	Thank you for this helpful information and references
Department of Health (DH)		2(c)	We believe that there should be a reference to another policy document, that is, *"Excellence in tobacco control: 10 high impact changes to achieve tobacco control"*.	Thank you for this reference. This seems reasonable.
Department of Health (DH)		2(e)	In our view, there should be a reference to the upcoming *tobacco control strategy*, which is expected in 2009.	Thank you. This has been added as a reference.
Department of Health (DH)		3(d)	We believe that there should be reference to two of the biggest external factors in determining smoking status, namely the influence of parental smoking, and peer smoking.	Noted, thank you.
Department of Health (DH)		4.2.1	We feel that the scope could be expanded to ensure that non-formal education programmes (which, nevertheless, take place in schools [e.g. peer to peer programmes like ASSISST]) are covered.	Thank you . This has been clarified in the final scope. (see above).
Department of Health (DH)		4.3	Could you please consider amending the first question to read: *"Which school-based intervention, or combination of school-based interventions, are effective and cost-effective. ",* to ensure that it is not an 'either/or' question. We feel that some programmes may be more effective in combination.	This has been changed, thank you.

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East Sussex County Council - PSHE & Healthy Schools Team, School Improvement Service		3	*Pathways to Problems* (Advisory Council on the Misuse of Drugs, 2006), identifies tobacco smoking as the single best predictor of future drug misuse. "……..if any drug should have a "just say never" tag attached to it, it is tobacco**".**	Thank you for this information
East Sussex County Council - PSHE & Healthy Schools Team, School Improvement Service		4.1.1	• Given that many young people take up smoking as a 'rite of passage' to adulthood, it is important to target sixth form colleges and Further Education providers, and whilst the scope includes these implicitly, I think it would be better to make their importance explicit. • Transitions, especially Y6/7 and Y11/12 are very vulnerable times for children and young people to experiment with tobacco, and perhaps should be explicitly addressed. • Young Offenders Institutions also provide education for a particularly vulnerable cohort of young people, and should be included.	Thank you for your comments. We have highlighted these issues in the final scope.

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East Sussex County Council - PSHE & Healthy Schools Team, School Improvement Service		4.2.1 and 4.2.2	• We need to take into account the extended schools agenda, which is targeted to be fully in place by the time the Guidance is due to be published. Many community projects e.g. sports projects are currently funded from drug prevention 'pots' and directly or indirectly address smoking prevention. It is likely that the extended schools agenda will draw these within the remit of the school as community broker of services to children and young people. Thus many smoking prevention activities apparently now in the community arena may shortly be covered by extended schools. • Smoking prevention activities provided by the Youth Service and voluntary sector organizations e.g. Scouts etc may also be drawn into the extended schools provision, and become relevant to the guidance. This may go some way to address concerns about poor attenders raised at the scope meeting. • Family interventions may also come under extended schools.	Thank you for these comments. The revised scope has been changed to take the extended schools agenda into account.

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East Sussex County Council - PSHE & Healthy Schools Team, School Improvement Service		4.3	Given the new secondary school curriculum framework, which prescribes a more cross-curricular approach to subjects across the secondary curriculum, but particularly in relation to PSHE education, it may be difficult – and indeed unhelpful - to separate specific 'interventions' from a 'drip, drip' approach to smoking prevention across the curriculum and based on a whole-school anti-smoking ethos. Experience which suggests a multi-pronged attack on the issue is the most successful – including e.g. parental disapproval, making access difficult, and advertising campaigns (c.f. Blueprint drugs education pilot) – would suggest that the smoking prevention message could well be organised across many if not all areas of school life.	Noted, thank you. The guidance will consider evidence about both interventions that are delivered as 'stand alone' approaches, and those that are delivered as part of broader health and lifestyle programmes, where evidence is available, where some (although not necessarily all) of the intervention or approach is delivered in a school setting. This means that if there is evidence available for some of the identified interventions about broader, non-school factors (such as parental disapproval), it will be considered.
East Sussex County Council - PSHE & Healthy Schools Team, School Improvement Service		5, General	Particularly vulnerable groups who need to be brought into the consultation process include Looked After Children, Gypsy, Roma and Traveller population, poor attenders and the Youth Offending lobby.	Noted, thank you.
Educari		General	We are glad that this Guidance is being developed. We understand that referrals from the DH are very specific. However, we worry about Guidance being too topic-specific – good educational practice is to address topics such as smoking not in isolation but in the context of healthy lifestyles. We hope that the Guidance will reflect this broader context, and that the development process takes account of this.	Thank you for your comments

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Educari		General	We are concerned that any cost effectiveness analyses take proper account of the fact that many programmes showing promise are multi-dimensional – i.e. they address smoking as a part of a broader intervention. Therefore, the cost of such programmes as they relate to smoking should be separated out from the total programme cost when comparing them with 'single issue' programmes (that, in this case, focus exclusively on smoking). Otherwise, large programmes that may have relatively small effects on smoking (as part of possible effects across a broad range) will not be treated comparably with focused programmes. (We know that this is something that you take account of, but we wanted to reiterate its importance.)	Thank you for this comment. We agree it is very important to be clear about the different costs attached to single issue and multi-component/multi issue programmes. The review process will consider whether it is possible to disaggregate the data in studies with mixed approaches and should modelling be required, sensitivity analyses will be undertaken to test the assumptions around key variables such as effectiveness.
Educari		3b	Of course nicotine is very addictive, but we think it is worth saying here that not only do young people become 'addicted' but that they become 'accustomed to the habit' – in other words, acknowledge the social aspects of smoking, as well as the biochemical aspects.	Thank you for your comments.
Educari		3d	for clarity, insert 'illegal' before the words 'drug use'	Thank you for this comment, however the term commonly used across NICE public health guidance in this and other areas is 'drug use' rather than 'illegal drug use', therefore for consistency we will continute to use the original term .

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Educari		4.2.1	We strongly oppose the use of the word 'delivery' to describe professional interventions. 'Delivery' implies that someone takes a 'package' and passes it on to someone else, unchanged. Professional work is not like this. The role of the person implementing a programme is recognised as a crucial factor in effectiveness – and is a major reason why programmes that 'work' under controlled conditions do not work so well when 'rolled out' (another horrible term). It is also disrespectful for dedicated professionals not to have their contribution to implementation properly acknowledged.	Thank you for your comment, which we note. However, as with the previous response, the term 'delivery' (whilst it may not always adequately capture the skilled professionalism involved in health and education practice) is nonetheless the commonly used term across the public health literature.
Educari		4.2.1	We think it important not just to look at interventions that prevent uptake, but ones that *delay* it, as well	Thank you for this comment. We anticipate that if the evaluation of interventions include delaying onset of smoking as an outcome measure, then this will considered in developing the guidance.
Educari		4.3	(the word 'delivery' is used *twice* in the second question)	Please see our previous response: Whilst we recognise and understand this point, it is the commonly used term**.**
Educari		4.3	'Expected outcomes': surely, the self-reported or biochemical validation is not so much an outcome as a *measure* of the prevalence reduction?	The outcome is non-smoking status, whether validated biochemically or self-reported by the individual.
Educari		4.3	'Expected outcomes' fourth bullet point should say '*positive* changes'	Thank you. There is always a chance that a public health intervention could produce negative, as well as positive, outcomes, or unintended outcomes, and it is very important to identify where this is the case so that appropriate steps may be taken. Therefore, 'changes' is a more appropriate term than 'positive changes' , since if an intervention had the unanticipated outcome of increasing smoking rates it would be very important to identify it.
Educari		4.3	'Expected outcomes': As mentioned above, we would include 'delaying onset' as a Primary Outcome (or at least as a Secondary one)	See above.

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Educari		4.3	'Expected outcomes': improved skills should be a Primary Outcome – they are probably more important than knowledge in achieving behaviour change	Noted, thank you.
East Lancs PCT – Stop Smoking Service		4.3	East Lancashire Stop Smoking Service is working in partnership with healthy schools teams and schools to provide smoking interventions for young people, in the form of an assembly package to 3 to 8 years followed by Educational Packages.	Thank you for this information.
East Lancs PCT – Stop Smoking Service			Healthy schools co-ordinator or PHSE to be trained by qualified smoking advisors providing full training and resource packs to be given to each school. Engaging health professionals, and school nurses with brief intervention training.	Thanks for your comments. Where it is available, we will consider suitable evidence on the effectiveness of different professionals delivering interventions in a school setting.
East Lancs PCT – Stop Smoking Service			Monitoring and updating of resources will be carried out on an ongoing process.	Thank you for your comments
East Lancs PCT – Stop Smoking Service			An external holistic approach will be used to engage extended family and friends to prevent the uptake of smoking. Additional education to extended family to provide support and encouragement for the younger person to achieve their goal and to provide ongoing support for parents/carers.	Thank you for your comments

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Fresh- Smoke Free North East		General	Overall pleased with range to be covered. Would ask that stakeholders with in depth experience of this area are part of the expert panel.	Thank you for this suggestion. We are keen to ensure that stakeholders are engaged in the development of this guidance, and our Public Health Interventions Advisory Committee includes researchers and practitioners with a wide range of expertise, including the area of smoking (see http://www.nice.org.uk/aboutnice/howwework/developingnicepublichealthguidance/publichealthinterventionsadvisorycommittee/public_health_interventions_advisory_committee.jsp for more information on the committee). We will also be considering bringing additional co-optees with expertise in the area onto the committee for this guidance. .
Gateshead, South Tyneside and Sunderland Stop Smoking Service		General	Feel that interventions should be targeted at Primary age to help prevent the uptake of smoking. Once they have moved to secondary, pressures of new school, new environment new peer group all contributory factors	Thank you for your comments
Gateshead, South Tyneside and Sunderland Stop Smoking Service		General and 4.2.2b	In many cases, promoting educational and intervention – based programmes to secondary school pupils is too late. Cessation support cannot be separated from this! I know it wasn't included in the scope but feel that one can't exist without the other.	Thanks for your comments. We acknowledge that smoking cessation is relevant for some children and young people, and the guidance on smoking cessation services (http://www.nice.org.uk/Guidance/PH10) did make recommendations for these groups. The current referral relates specifically to school-based prevention, hence the focus of the scope. However, we would encourage you to suggest other topics for future NICE public health guidance, and you may do so at: http://www.nice.org.uk/getinvolved/suggestatopic/suggest_a_topic.jsp

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Gateshead, South Tyneside and Sunderland Stop Smoking Service		General	Effectiveness – one size doesn't fit all so multi-faceted approach is required	Thank you for your comments
Gateshead, South Tyneside and Sunderland Stop Smoking Service		General	In terms of who should deliver, once again it is varied and it may well be down to who is in the best place at the right time. Some young people look upon School Nurses as 'medical' and may have suspicion about disclosure of smoking habits and disciplinary measures. External partners such as drug or alcohol workers or Stop Smoking Advisors may be more easily accepted	Thank you for your comments.
Gateshead, South Tyneside and Sunderland Stop Smoking Service		General	Barriers to delivery – Depends on the ethos of the educational establishment, some schools colleges are very receptive whilst others may oppose such interventions. Also organisational skills and time allocated to interventions are a major factor. If all are on board then there is a better chance the intervention will be successful.	Thank you for your comments
Hampshire and IOW PCT - Smoke Free Hampshire and Isle of Wight		4.2.2 (a)	It would be useful if the guidance could include interventions to promote smokefree homes and cars. As they aim at social unacceptability, they seek to encourage young people not to start. There is therefore some justification in their inclusion.	Thank you for your comments The guidance process requires NICE to base its scope and guidance on the referral from the Department of Health. The current referral requires that we develop guidance on school-based smoking prevention. However, we would encourage you to suggest other topics for future NICE public health guidance, and you may do so at: http://www.nice.org.uk/getinvolved/suggestatopic/suggest_a_topic.jsp

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Hampshire and IOW PCT - Smoke Free Hampshire and Isle of Wight		4.2.2 (c)	The use of chewing tobacco is particularly prevalent in some ethnic groups, as opposed to cigarette smoking. It is just as important to review evidence on preventing the uptake of chewing and smokeless tobacco as it is cigarettes.	Thank you. The current referral relates specifically to smoking tobacco, hence the focus of the scope. However, we would encourage you to suggest other topics for future NICE public health guidance, and you may do so at: http://www.nice.org.uk/getinvolved/suggestatopic/suggest_a_topic.jsp
Hertfordshire County Council		Section 2 (Background)	Will the document take into consideration the following evidence: *Martine Stead et al., (2007) Delivery of the Blueprint Programme, London: Home Office* *Mentor UK Youth Involvement Project (2008), Mentor UK*	Thank you for this helpful information and references.
Hertfordshire County Council		Section 4.3 (key questions)	Your first question mentions schools-based interventions but this does not take include the groups stated in 4.1.1. The guidance should explore how different groups and settings may require different approaches.	Thank you. Although not explicitly stated in the scope, we expected the review of literature that we commission to uncover any differences in effectiveness and cost-effectiveness according different groups and settings.
Hope UK		General (introduction)	Hope UK is an alcohol and drug education charity which includes tobacco within its remit. Our aim is to encourage young people to make drug-free choices (which include tobacco-free choices).	Thank you for this information.
Hope UK		General	Our first general point is therefore one that argues for seeing tobacco use in the context of all substance use so that guidance takes account of this.	Thank you for your comments

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Hope UK		General	Our second point relates to the need to consider the prevention of smoking in a holistic whole-community context. We appreciate that the brief to NICE is limited but would argue strongly that school-based interventions to prevent smoking must take account of the community within which the school is situated; the role of parents; and the need to help students who are already smoking to quit because of the importance of peer influence and role modelling.	Thank you for your comments The guidance process requires NICE to base its scope and guidance on the referral from the Department of Health. The current referral requires that we develop guidance on school-based smoking prevention. However, we would encourage you to suggest other topics for future NICE public health guidance, and you may do so at: http://www.nice.org.uk/getinvolved/suggestatopic/suggest_a_topic.jsp
Hope UK		4.2.2	We would argue that schools are part of their local community and therefore 'community-based interventions' should be devised which take account of what takes place within formal education settings such as lessons and what can be done informally. Paragraph 3 (e) highlights the key influence that families have on whether or not children take up smoking. We see this as an extremely strong argument for including family interventions within guidance.	The scope has been revised to make it clear that interventions that come under an extended schools programme will be included. If an intervention taking place in the home or community has a schools component focused on prevention, it is included in the scope for this guidance.

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Hope UK		4.2.2 (b) and (c)	We see it as totally artificial to exclude interventions which encourage students to quit smoking (or chew tobacco/use smokeless tobacco) because these young people are the peers of those for whom the prevention advice is being targeted. They will be receiving the same lesson and therefore need to be taken account of in the production of curriculum materials.	Thanks for your comments. We acknowledge that smoking cessation is relevant for some children and young people, and the guidance on smoking cessation services (http://www.nice.org.uk/Guidance/PH10) did make recommendations for these groups. The current referral relates specifically to school-based prevention, hence the focus of the scope. However, we would encourage you to suggest other topics for future NICE public health guidance, and you may do so at: http://www.nice.org.uk/getinvolved/suggestatopic/suggest_a_topic.jsp Similarly, the current referral relates specifically to smoking, hence the focus of the scope. Again, we would encourage you to suggest other topics for future NICE public health guidance at the link above.
Hope UK		Appendix A	Schools have varying degrees of independence and therefore we are surprised to see that the Department of Health brief does not include school governors (including private education) alongside local authorities and primary care. Furthermore, as local authorities have responsibilities for the entire community (as do primary care teams), then we would hope that consideration could be given to change this referral so as to include a community context because both local authorities and PCTs can initiate action for the whole community.	The Department of Health refer topics to the Centre for Public Health Excellence at NICE on which to develop guidance, and NICE then develop each referral into a draft scope which sets out the planned parameters of the work and guidance. School governors, local authorities and anyone working on smoking prevention with children and young people in a schools setting will be audiences for this guidance.

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Kent County Council	KCA Young Person's Services (2006) Smoking Cessation for Vulnerable Young People in East Kent	**4.3 Question 1:** Which school-based interventions are effective and cost-effective in preventing children and young people from taking up smoking?	• Many school based interventions have been evaluated as to their effectiveness - mostly in America. Little UK evidence of effectiveness of school-based interventions. • Bruvold (WH Bruvold "A meta analysis of adolescent smoking prevention programmes" American journal of public health, 1993) carried out a meta analysis of evaluations of school programmes published in the 1970's and 1980's. School interventions were divided into 4 types: **Rational Approaches** - focus on information about cigarettes - effects, consequences. Based on lectures, demonstration materials (such as tar coated lungs, pictures/videos). Worksheets and question and answer sessions often back up such approaches. **Developmental approaches** - offer affective education aimed at increasing self esteem and self reliance - reducing alienation and developing interpersonal skills and decision making skills. May use didactic methods but may also use more active teaching and learning methods. **Social Norms approach** - seek to provide alternatives to smoking, aim to increase self esteem and reduce boredom. Aim to promote normative information to YP. Cont'd	Thank you for this helpful information

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Kent County Council			**Social Reinforcement approach** - focuses on pressures to smoke with the aim of enabling the resistance to such pressures. In practice, schools have employed more than one approach, Bruvold concluded that: • All 4 approaches had a sizeable effect upon knowledge • Changes in attitudes were not as consistent as changes in knowledge. The social reinforcement approach was most successful in changing attitudes. • Both the social reinforcement and social norms approaches produced consistently positive and more significant changes in behaviour.	Thank you for this helpful information

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Kent County Council		**4.3 Question 2:** What factors aid the delivery of effective school-based interventions to prevent the uptake of smoking?	Schools need to take a whole school approach to smoking education. This includes: staff training and support, consultation and involvement of children/YP, Support for children/YP who experience problems with smoking, smoking education programme, procedures for managing smoking related incidents, policy, involvement and education of parents/carers and governors, involvement and support of outside agencies. Schools need to develop smoking education rather than propaganda. Smoking education should: • provide accurate information and combat ignorance, stereotypes and prejudice • Develop understanding of, mutual respect and care for others - smokers and non smokers • Enable children to become aware of a range of views about smoking issues and reach their own informed opinions • Enable children to express their own feelings and opinions • Develop skills relevant to decision making about smoking • Enhance self esteem • Be integrated into a programme of PSHE • Be taught as a spiral curriculum - differentiated to meet the needs of ages and learning abilities • Be conducted in a sensitive manner • Help prepare children for the future • Actively involve parents/carers.	Thank you for your comments. NICE is also involved currently in writing guidance on personal, social and health education, and we will endeavour to ensure consistency between the two pieces of guidance. See: http://www.nice.org.uk/guidance/index.jsp?action=byID&o=11673

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Kent County Council		**4.3** **Question 3:** What are the barriers to successful delivery?	• Lack of time to sufficiently develop and deliver a curriculum • Lack of training for teachers (which may be available - but may not be taken up) • Lack of coordination of PSHE/Science Learning objectives- thus resulting in repetition i.e. continuity and progression. • Insistence on "shock/scare" tactics rather than on what works • Lack of evaluation or proper needs assessment – it is essential to teach according to level of need, and well before first indicators of interest in smoking i.e. early primary. • Lack of management support - it is vital that school managers promote smoking education at the highest level. • Inconsistency of messages. Education verses incidents (i.e. promoting a supportive, caring approach through education and then demonstrating a punitive approach through incident management.) • Policy development in school is often weakest in this area. • Family attitudes towards smoking can weaken the influence of school-based interventions therefore it is essential to include transference of learning (taking learning into the home via for example homework) techniques.	Thank you for your comments – please see our previous response.

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Kent County Council		**4.3** Expected Outcomes	• This section could also include "delaying onset" i.e. reducing overall harm/later affects/damage. • Making "improved social skills, etc" a secondary outcome could lead to misinterpretation – it is the development of such skill including resilience, which need to be emphasised as pre-requisite to prevention of uptake.	Although the delaying issue is not discussed in detail in the scope, where interventions and programmes have included delating smoking onset as an outcome measure then this evidence will be taken into consideration in developing the guidance. Improved social skills are now listed as a key outcome in the amended scope.
Kent County Council		**4.2.2**	It was mentioned by several of the stakeholders that future guidelines will be needed on the development of young people's smoking cessation interventions (please see attached document which refers to the research and scoping exercise which has been carried out in East Kent). Schools are already attempting to develop these for themselves despite the little evidence available to them of "what works" in this field.	Thanks for your comments. We acknowledge that smoking cessation is relevant for some children and young people, and the guidance on smoking cessation services (http://www.nice.org.uk/Guidance/PH10) did make recommendations for these groups. The current referral relates specifically to school-based prevention, hence the focus of the scope. However, we would encourage you to suggest other topics for future NICE public health guidance, and you may do so at: http://www.nice.org.uk/getinvolved/suggestatopic/suggest_a_topic.jsp
Kirklees PCT		General	Stopping young people smoking is a widely endorsed public goal with schools providing a route for communicating with a large percentage of children and young people. However there has always been a lack of high quality evidence to support the effectiveness of using school based projects alone in reducing the prevalence of smoking.	Thank you for your comments.

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Kirklees PCT		General	**I would like consideration of the following points**: You cannot approach the delivery of smoking/health education in the same information-giving curricula way as for example history and expect a change in behaviour, as information alone does little or nothing to address the factors associate with the uptake of smoking which is a complex process. Multiple approaches do seem to be the way forward and should start with all schools being encouraged to achieve The Healthy School Standard. Early intervention is key as many children start smoking before reaching high school. The Healthy School Standard makes it possible to promote a coherent health promotion curriculum and an environment conducive to supporting and valuing health from a child's entry into the school system, this may eventually have an effect on a Childs decision to smoke Involve health professionals i.e. The school Nurse in the delivery of high quality health education programmes through Schools PHSCE curriculum, as they can facilitate the acquisition of health related skills such as communication, decision making and coping with peer pressure Consider inviting qualified youth workers into the classroom setting as quite often they can provide a different perspective. Consult with and involve children and young people in any intervention, as they can provide valuable insight into their experiences and opinions if asked! Cont'd	Thank you for your comments, which we have noted. The evidence to be considered by the guidance will not be limited to education-only approaches but will include all interventions delivered in a school setting, encompassing a broad range of styles and formats such as peer support and education, environmental changes, and so on. The guidance will consider evidence about both interventions that are delivered as 'stand alone' approaches, and those that are delivered as part of broader health and lifestyle programmes, where evidence is available, where some (although not necessarily all) of the intervention or approach is delivered in a school setting. This also means that if there is evidence available for some of the identified interventions about broader, non-school factors (such as parental disapproval), it will be considered. Where evidence is available, the guidance will also consider the role and impact of different professionals (and the skills required) in delivering interventions, and the potential benefits of involving children and young people in intervention planning and delivery.

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			Explore the reasons why most young people remain non-smokers, is it a single distinct decision or a complex process similar to the decision to start.	Thank you for your comments.
Life Education		General	I would agree with the person in the consultation meeting for Stakeholders who pointed out that single-issue and multi-component programmes and their effectiveness and cost-effectiveness need to be assessed accurately and fairly, and representing each model/type of programme.	Thank you for this comment. We agree it is very important to be clear about the different costs attached to single issue and multi-component/multi issue programmes. The review process will consider whether it is possible to disaggregate the data in studies with mixed approaches and should modelling be required, sensitivity analyses will be undertaken to test the assumptions around key variables such as effectiveness.
Life Education		General	Also mentioned was differentiating children/young people who are most at-risk and/or hard to reach (early identification of vulnerable children). I would agree with this and suggest that effective work/interventions with this group be assessed since it is a sizeable group and often more prone to smoking/affected by risk factors. This has an impact on prevalence as well in terms of the social demographic being most likely to smoke.	Thank you for this comment. The search strategy will include these groups. Whether effectiveness differs for different groups, including those you mention, is a key question the review seeks to address.
Life Education		Section 3 – page 3, d)	It is important to look at the factors that can increase the risk of becoming a regular smoker, as listed in this section; but also important to differentiate between "causative" factors and those factors that are correlated/linked with or are the effects of regular smoking. In general, risk and protective factors from research [NIDA; DfES - Drugs: Guidance for schools, 2004; and Home Office Online Report 04/07] are important to cite and use in work/interventions aimed at preventing substance use, including smoking.	Thank you for this reference; it has been added to the revised scope.

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Life Education		Section 3 – page 4, e)	Clearly stating that the family is a key influence is excellent. Although the focus of the guidance is school-based interventions, often perceived solely as work with pupils, it is essential that schools provide programmes/work with parents/carers to reinforce messages being given to children at school. This area of work can sometimes be overlooked in terms of importance, and it would be helpful to be highlighted in the guidance.	Thank you for your comment. The evidence review will be looking for evidence of effectiveness and cost effectiveness in combined programmes as you suggest.
Life Education		Section 4 – page 4, 4.1.1	The specific age range could be inserted here to clarify it at the start of the section (it is referred to more generally on page 5 in 4.1.2). Different interventions/ approaches/methods are needed for different age groups in the target age range in order to be appropriate and thus effective (this could be noted and examples for age groups could be given). Also, I agree with a Stakeholder in the consultation meeting on the 3rd of October who mentioned that the transition from primary to secondary school is a key period affecting children and needs to be addressed specifically.	Thank you for your suggestions. This has been clarified in the scope.

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Life Education		Section 4 – page 6, 4.3	Re Expected (primary) outcomes for children/young people: • Reduction in smoking prevalence: it will be important to be realistic about what can be achieved through the types of programmes that would be conducted in schools and a specified time frame (short-term vs long-term). It would be helpful if an appropriate time period was listed when prevalence data would be examined. Also, detailing causative factors is important as each may have different effects. • Self-reported or biochemical validation of non-smoking status: as mentioned in the consultation meeting for Stakeholders, "biochemical validation" with young people could be problematic and there are ethical issues. It is better to develop a method for getting high quality self-reported information – e.g. ensuring anonymity/confidentiality and separating this measure from the school (an external person/organisation gets the data). Cont'd	Thank you. The literature review conducted on NICE's behalf will address these methodological issues. .

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Life Education			• A reduction in the prevalence of experimentation with smoking: The concept of "experimentation" can be problematic – some studies classify this as "use" (one time use, 2-3 times use, etc.). If "experimentation" will be assessed, the methods for measuring this need to be very detailed, "experimentation" needs to be defined (how many times of use is "experimental" use?) and able to be differentiated from short-term use or extension into longer term use. • Changes in knowledge and attitudes related to smoking tobacco: these are easiest to measure and most appropriate outcomes for school-based interventions. Also, knowledge and attitudes would be relevant factors affecting the three primary outcomes listed above (prevalence, non-smoking status and experimentation). Thus, knowledge and attitudes could be given greater importance and be seen as foundations for use or non-use).	Thank you for these comments. We expect that the literature review conducted on NICE's behalf will address these methodological issues.

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Middlesbrough PCT		4.2.2	If preventing uptake is the main goal, the exclusion of schemes such as Smoke Free Families may miss out an initiative with potential impact. What influenced the decision to make this choice?	The guidance will consider evidence about any intervention that includes a school-based component. The referral for this guidance requires a focus on school based prevention, which means that the potential audience for the guidance will be all those professionals and commissioners working on smoking prevention with children and young people in a school setting. Of couse, the overall issue is broader than smoking prevention in schools alone, and time and resource limitations mean that no one piece of guidance could address *all* of the relevant factors adequately. For example, smoking cessation in a range of settings relevant to children and young people is also important, as is smoking prevention for children in settings outside of schools, and for those excluded from school. The current guidance does not stand alone: It sits alongside other guidance in the area already developed (or currently in development: see http://www.nice.org.uk/Guidance/Type) by NICE. We also encourage you to suggest other topics for future NICE public health guidance, and you may do so at: http://www.nice.org.uk/getinvolved/suggestatopic/suggest_a_topic.jsp

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Middlesbrough PCT		4.2.1	Community based interventions – not included but mentioned in 4.2.1	The guidance will consider evidence about both interventions that are delivered as 'stand alone' approaches, and those that are delivered as part of broader health and lifestyle programmes, where evidence is available, where some (although not necessarily all) of the intervention or approach is delivered in a school setting. This also means that if there is evidence available for some of the identified interventions about broader, non-school factors, and from community-based parts of interventions, it may be considered.
Middlesbrough PCT		4.3	Are baselines for the expected outcomes already set? Will the outcomes be measured using a self reporting tool or will other methods be adopted i.e. focus groups, youth led events.	The guidance will be informed by a thorough review of the best available evidence, which will look for evidence from good-quality evaluated interventions. It is likely that good-quality studies will include both baseline ('before') and 'after' assessments of smoking levels in the groups that they include, however we cannot anticipate what those baseline measures will be as they will be specific to each piece of research. Equally, we cannot anticipate what other outcomes will be present in the research literature until we begin to identify and assess it but previous experience teaches us that self report is likely to be a reported outcome in some studies – but other studies may use different outcomes, such as biochemical validation. We will not be carrying out primary research as part of the development of this guidance.

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Middlesbrough PCT			In particular how will values and attitudes be measured, peer influence has a major impact on uptake, and will this be given special focus/consideration?	See above
NASUWT - The Teachers' Union		General	The NASUWT supports all activity which is designed to persuade children and young people not to smoke as being wholly consistent with the aims of Every Child Matters. The Union urges the National Institute for Clinical Excellence (NICE) also to take account of the Well Being guidance currently in production by the Department of Children Schools and Families.	Thank you for this helpful information and references.
NASUWT - The Teachers' Union		General	The NASUWT is also keen to emphasise that NICE guidance, when it is drawn up, takes account of the Personal Health and Social Education and Citizenship programmes which form a part of the National Curriculum in maintained and other schools. It is very important that any NICE guidance should work in harmony with the curriculum.	NICE is also involved currently in writing guidance on personal, social and health education, and we will endeavour to ensure consistency and a seamless interface between the two pieces of guidance. See: http://www.nice.org.uk/guidance/index.jsp?action=byID&o=11673

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NASUWT - The Teachers' Union		General	The NASUWT believes it is essential that in writing the NICE guidance, account is taken of the changes to the structure and roles and responsibilities of staff, both teachers and education support staff, which have taken place as a result of the reform and remodelling of the school workforce. In 2003 the Department for Children Schools and Families, as it is now, reached an agreement with NEOST representing the employers of teachers along with ASCL, ATL, NAHT, NASUWT, VOICE, UNISON, GMB and T&G unions called Raising standards and tackling workload. The agreement has two overarching aims described by its title. In order to achieve these aims it has been necessary to engage in a significant remodelling of the workforce in schools. This remodelling has two purposes. Firstly to re-focus the work of teachers and head teachers to teaching and leading teaching and learning, and secondly to introduce into the school workforce additional professionals able to carry out a range of educational, clerical and administrative and technical work which teachers are no longer required to carry out. It is very important therefore that in framing the guidance the roles and responsibilities of head teachers, teachers and a wide range of school support staff are taken into account. Clearly it will not fall to teachers alone to have regard to the NICE guidance. Where the guidance addresses concerns which fall beyond teaching, learning and assessment there will be an important role for support staff to fulfil.	Thanks for your comments. Where it is available, we will consider suitable evidence on the effectiveness of different professionals delivering interventions in a school setting.

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NASUWT - The Teachers' Union		General	Finally the NASUWT believes it to be important for NICE to take into account in its guidance that an increasing number of schools are providing a platform for the provision of extended services such as health and social support which is not led by teachers. Extra curricular activity such as this would clearly have an important part to play in preventing the uptake of smoking among children. It is important that NICE recognises that local level implementation of interventions will be in the context of the Children and Young People's Plan which will be executed through the Children's Trust.	Thank you for your comments.
NASUWT - The Teachers' Union		Section 3	The NASUWT is surprised to see, in this section, the estimate that by 2007 6% of 11 – 15 year old children were smoking one cigarette or more per week. Whilst the Union recognises that this figure is for the whole of England, it seems to be rather a low estimate. Many of the Union's members would suggest that he real figure is higher than this, and in some areas of the country significantly higher. The NASUWT recognises the difficulties inherent in collecting accurate information around such behaviours but would nevertheless suggest that more work is done to ensure that as accurate a picture as possible of the number of young people taking up smoking is created.	We agree that these estimates have inherent difficulties, and would welcome any competing estimates and references.
NASUWT - The Teachers' Union		Section 4.1.1	The NASUWT agrees with the classification of the groups to be covered and suggests, in addition, that the guidance also covers the children of service personnel who receive their education overseas in establishments run by the Service Children Education (SCE).	This guidance will focus on school-based prevention of smoking in England, and will – where possible – prioritise evidence from a UK setting.

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NASUWT - The Teachers' Union		Section 4.1.2	The NASUWT believes that further thought should be given to the category of children within the draft scope currently described as pre-school children. The changes currently being made to early years education provision will require a rather tighter definition than pre-school. The NASUWT would suggest something along the lines of "below the compulsory age for education and still in the full time care of their parents. There are now, and are likely to be in the future, increasingly large numbers of young children receiving non-school education and care, outside of the influence of their parents, and in a variety of settings. The scope of the guidance should take this into account.	Thank you. The current referral relates specifically to school age children, hence the focus of the scope. However, we would encourage you to suggest other topics for future NICE public health guidance, and you may do so at: http://www.nice.org.uk/getinvolved/suggestatopic/suggest_a_topic.jsp
NASUWT - The Teachers' Union		Section 4 General	The NASUWT believes that the draft scope document, in respect of activities that will and will not be covered, is satisfactory.	Thank you for your comments.
National Health Education Group		General	Whilst we welcome this future guidance we agree with the document when it mentions the influence of the family. Is it true that the mother has a much stronger influence on children taking up smoking>	Parental and sibling rates of smoking influence children's smoking prevalence (in fact, presence of an older sibling who smokes has greater influence on children than parental smoking) , as do a wide range of other family issues such as single parent status, and family income. References for these are provided in the scope.
National Health Education Group		General	We think that the barriers to successful delivery are: adult smoke; it is not illegal to smoke – just to purchase; cigarettes are easily available everywhere for legitimate purchase (for those old enough); smoking in some groups is socially acceptable indeed in the wider society it is accepted when it is i.e. in private, in the open air.	Thank you for your comments.

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National Health Education Group		General	If the intervention is designed to change the behaviour of some young people i.e. those who smoke, then it could fail. The young people themselves have **to want to make** a change and no amount of external pressure (especially from adults who appear to want to stop them for smoking) will force the issue – often reinforce their determination to continue.	Thank you for your comments.
National Health Education Group		General	Some young people will want to smoke and we have to accept that this is so. Some will experiment or be casual smokers. Need to know why these young people are making the decision – is it to do with their background, family experiences, social class, culture	Noted, thank you. The evidence review that will inform this guidance will also consider the qualitative research literature on the barriers and opportunities to smoking prevention, and if there is appropriate evidence available on the issue that you raise then we will consider it here.
National Health Education Group		General	Young people perceive the dangers from smoking as long term i.e. will not affect them until they are old (and they think over 25 is old!) so they will cope with it when they reach that age.	Thank you for your comments.

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National Health Education Group		General	Trying to stop young people from smoking with messages within a PSHE education programme in schools may be in direct conflict with the aims of such a programme which is to help young people develop the ability to make decisions and choices of their own and to prepare them to take responsibility for their actions. It can be perceived as a programme which develops knowledge and understanding so that the young people can make (healthy) choices. Those who choose to smoke could do so based on a very good programme that has pointed out all the down sides, medical and social issues, yet they still exercise their choice and make a decision. Only the adults might perceive it as being the 'wrong' decision. If young people are making choices and are aware of the risks and consequences of their decisions it does put them in charge of their behaviour.	NICE is also involved currently in writing guidance on personal, social and health education, and we will endeavour to ensure consistency and a seamless interface between the two pieces of guidance. See: http://www.nice.org.uk/guidance/index.jsp?action=byID&o=11673
National Health Education Group		General	The need for a good programme of learning for all young people focusing on smoking is essential is they are all to get clear messages about the risks and consequences. May also be useful for young people to talk with people who smoke (could be interviews with their parents) to ascertain when they started smoking, what made them start, have they ever tried to stop, how hard was it, what have they had to give up as a result of this habit etc.	Thank you for your comments.
National Health Education Group		General	Work done by peers has been found to be particularly helpful. This can be seen as 'cool' and can offer a support network to help give up.	Thank you for your comments.
National Health Education Group		General	It is often quoted as the strongest influence of a young girl to give up smoking is when she has a new boyfriend who is a non-smoker.	Thank you for your comments.

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National Health Education Group		General	Difficult to give anti-smoking messages which are in direct conflict with what the young person experiences at home. In areas where many parents smoke this could be seen as insensitive.	Thank you for your comments.
National Health Education Group		General	As some young people are motivated by being able to purchase clothes and/or engage in social activities with other young people – spending all their money on cigarettes may not allow them to do so. Pointing this out i.e. what it costs, especially in today's economic terms. What will 10 a day mean over the year and what could be bought might appeal to some young people.	Thank you for your comments.
National Health Education Group		General	Need to acknowledge that many young people do **not** smoke. Why is that? Pat on the back for these young people. Also need to check if it is more boys than girls who have forsaken smoking. What are the false messages the girls believe about smoking i.e. helps them stay thin?	Thank you for your comments.
National Health Education Group		General	We are concerned with the seeming increase in the number of young Asian men who are smoking.	Thank you. Although not explicitly stated in the scope, we expected the review of literature that we commission to uncover any differences in effectiveness and cost-effectiveness according to the ethnicity of the target audience.
National Health Education Group		General	Our comments are very general but we hope that you have a flavour of our thoughts. Many of our members have been engaged in this work for over 20 years. If it was that easy maybe we would have succeeded before now.	Thank you for your comments.

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Newcastle PCT		General	Newcastle PCT welcomes the production of NICE guidance on school based interventions to prevent the uptake of smoking among children. This provides an opportunity to re-visit the evidence this issue and provide a comprehensive guide for schools and other agencies about what should be delivered and how this should be done to ensure that interventions are undertaken which are effective and cost effective.	Thank you for your comments.
Newcastle PCT		General	Newcastle PCT would welcome NICE consulting with young people themselves on this guidance to ensure it best meets with their expressed needs. The responses of young people to the Department of Health's recent consultation on a national tobacco strategy drew responses from a number of young people's groups and Newcastle PCT would welcome NICE liaising with the DH to identify if the views of young people can be considered here. Further, we would welcome the guidance expressly considering whether a proactive approach of consulting and involving young people in tobacco prevention programmes in the school setting is effective and how this should be done.	Noted, thank you. We are actively exploring ways of incorporating the views and experiences of children and young people into this guidance, and will also consider the qualitative research literature on barriers and opportunities to smoking prevention with children and young people.

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Newcastle PCT		2d	Newcastle PCT feels it is imperative that a sound mechanism is established for disseminating the guidance to schools in particular, to ensure that it is effectively implemented. It recommends therefore that this guidance be disseminated via QCA and the DCSF and through the National Healthy Schools Programme. There is a danger that without a robust dissemination procedure one of the key target groups for the guidance; teachers, will not be aware of it and its use will be limited.	Thank you for your comments. We anticipate that the dissemination strategy developed by NICE's implementation directorate closer to guidance release will address these issues
Newcastle PCT		2d	It is important that this guidance is also aimed at regional and local healthy school coordinators, voluntary organisations who are currently involved in the delivery of smoking prevention such as QUIT, and Higher Level Teaching Assistants who often deliver elements of the smoking education curriculum, especially primary schools.	Thanks for your comments. Where it is available, we will consider suitable evidence on the effectiveness of different professionals delivering interventions in a school setting.
Newcastle PCT		4.1.1	Whilst Newcastle PCT agrees with the proposed main target audiences, it also feels that links with further education colleges need to be established as secondary school pupils can access courses within such settings as part of their statutory schooling for the new diplomas. There needs to be consistent messages about tobacco in every education setting which young people aged 5-18 years access during their schooling.	Thank you for your comment. We appreciate that prevention of smoking for young people not attending school an important issue. The current referral requires that we develop guidance on school-based smoking prevention. However, we would encourage you to suggest other topics for future NICE public health guidance, and you may do so at: http://www.nice.org.uk/getinvolved/suggestatopic/suggest_a_topic.jsp

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Newcastle PCT		4.2.2	Newcastle PCT feels that it is essential that the guidance looks at the holistic context for effective smoking prevention interventions to take place. Evidence does demonstrate that a holistic whole school approach is the most effective approach to smoking education and prevention. We would urge therefore that the guidance highlights the need for the school site (internal and external area) to be totally smoke free to all people at all times. We recognise that this goes further than current smoke free legislation requirements, however we feel that this extension to cover the outside areas of the school site, is important in reinforcing social norms that tobacco use is not the norm for the majority of society. It also helps to reinforce and strengthen the National Healthy School Programme criteria related to smoking, particularly in relation to Pupil Referral Units where, smoking prevalence among young people is often considerably above the norm in the secondary age group. The whole school approach also needs to promote stop smoking support services for young people to further reinforce the de-normalisation message.	Noted, thank you. The guidance will consider evidence about both interventions that are delivered as 'stand alone' approaches, and those that are delivered as part of broader health and lifestyle programmes, where evidence is available.
Newcastle PCT		4.2.1	Newcastle PCT would welcome the guidance addressing whether gender specific interventions for smoking prevention in the school setting are most effective or not and what interventions work most effectively with each Key Stage group. Training requirements for teachers and Higher Level Teaching Assistants need to be identified in the guidance to ensure that they can then be fully equipped to deliver it. Recommended resource materials for these groups for use with young people in the school setting would be welcomed.	Thank you. Although not explicitly stated in the scope, we expected the review of literature that we commission to uncover any differences in effectiveness and cost-effectiveness according to the gender of the target audience.

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Newcastle PCT		4.3	Newcastle PCT feels that the guidance should provide recommendations on how schools can measure the effectiveness of their tobacco education and prevention activities, in line with National Healthy School Programme requirements to identify impact outcomes of the interventions used. This will also assist schools to address the need to assess pupil progress in relation to the forthcoming Ofsted pupil well- being indicators.	We anticipate that the tools developed by NICE's implementation directorate closer to guidance release will address these issues. Thank you also for the reference to the Osted project
NHS East Lancashire		4.2 /4.3	To effectively determine the impact of interventions on smoking uptake, not only do I think we need to look at effective methods for the provision of interventions but also who is providing them and the most appropriate settings. Different settings, geographical issues and complex communities may have large implications and result in different approaches to successful educational interventions.	Thank you. Although not explicitly stated in the scope, we expected the review of literature that we commission to uncover any differences in effectiveness and cost-effectiveness according to setting
NHS East Lancashire		4.2.2 (a)	Fully engaging with the harder to reach communities and their young people may only be achievable through accessing and providing community –based interventions e.g. BME community and socially isolated communities.	Thank you for your comments.
NHS East Lancashire		4.2.2 (c)	Within East Lancashire we have a high BME community with limited awareness around effects of specific smokeless tobacco products, especially amongst children. There is a need to determine and provide evidence based education activities within the BME communities, especial to children.	Thank you. The current referral relates specifically to smoking tobacco, hence the focus of the scope. However, we would encourage you to suggest other topics for future NICE public health guidance, and you may do so at: http://www.nice.org.uk/getinvolved/suggestatopic/suggest_a_topic.jsp

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NHS Manchester - Manchester Stop Smoking Service		4.2.1	Manchester Stop Smoking Service funds a programme that is delivered by City in the Community (Manchester City Football Club) to primary schools across the city. The programme is offered to all primary schools (140) and is delivered by City in the Community coaches to year 5. If you would like any further details please contact me or the project directly:	Thank you for your comments.
Nottinghamshire County tPCT – Public Health		4.1.1 Q4.3	Does the guidance include state-sector nursery/early years settings e.g. Surestart, Children's Centres? Should it also include pre-school children in private nurseries/other settings? Preventative messages need to start in Early Years settings to begin 'spiral curriculum' and link to parents/carers, environmental smoking, wider community, as this is when they are more likely to succeed in preventing C&YP from taking up smoking (see below). NB. PRU's now known as learning centres.	Thank you. The current referral relates specifically to school age children, hence the focus of the scope. However, we would encourage you to suggest other topics for future NICE public health guidance, and you may do so at: http://www.nice.org.uk/getinvolved/suggestatopic/suggest_a_topic.jsp

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Nottinghamshire County tPCT – Public Health	Ashfield & Mansfield District PCT (2006) Leaves and Buds. Synthesising Primary Prevention and Smoking Cessation Provision for Children and Young People	General & 4.2.2a Q.4.3	Tobacco control agenda is inter-related. P4 Talks about family as being a key influence therefore needs whole family/community approach. Can we assume therefore that although it says (4.2.2a) community-based and family interventions will not be covered, this only infers those with **no** school component? Evidence suggests that interventions are most effective when combined as part of wider community interventions (ref. Leaves & Buds attached – local scoping exercise).	Thank you for this helpful information and references. You are correct; family and community-based interventions that have no schools component will not fall within the scope of this guidance. Those that may combine school-based with community or family components will be included.
Nottinghamshire County tPCT – Public Health	Nottinghamshire Health Schools (2006) Scheme of Work	General & 4.2.2c,d	As above – whilst not at the level of 'policy change', prevention/smoking education must include other tobacco control measures such as tobacco pricing policies, smuggling etc as children and young people need to be aware of the illicit side of tobacco sales i.e. where cigarettes are coming from and where they are going to, links to organised crime etc.(4.2.2d). In Nottinghamshire the Healthy Schools programme has developed a Scheme Of Work (SOW) for smoking education for schools to include elements of the wider tobacco control agenda (attached).	Thank you for this helpful information and references.

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Nottinghamshire County tPCT – Public Health		General & 4.2.2b, 4.3	Cessation and prevention are inextricably linked (4.2.2b). Within any group children/young people will inevitably come into contact with smokers, whether or not they smoke themselves. There must be some element of signposting within any preventative session. In Nottinghamshire the Healthy Schools programme has developed a SOW for schools to include Brief Interventions (BI's) - attached. One of the expected outcomes (4.3) of the draft guidance is self-reported or biochemical validation of non-smoking status, itself most widely used within cessation.	Thank you for this helpful information and references.
Nottinghamshire County tPCT – Public Health		4.3	Resources are limited within schools for PSHEE where smoking is usually addressed as part of drug education, also Science. They are also few and far between, which is why we developed SOW for smoking education (attached) for Nottinghamshire schools, so that teachers could just pick it off the shelf and deliver sessions about smoking with few/little resources. Who is going to do it needs careful consideration. Will it be teachers? Do they have the knowledge/skills? In some schools there are specialist PSHEE teams, in other secondary schools the form tutor delivers PSHEE.	Where it is available, we will consider suitable evidence on the effectiveness of different professionals delivering interventions in a school setting.. Additionally, NICE is currently developing guidance on Personal, social and health education, and we will endeavour to ensure consistency and a seamless interface between the two pieces of guidance. See: http://www.nice.org.uk/guidance/index.jsp?action=byID&o=11673
Portsmouth City Council		4.2.2 a)	Social acceptability and social norms need to be challenged especially with young people	Thank you for your comments.

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Portsmouth City Council		4.2.2 b)	If in delivering smoking education the opportunities and difficulties attached to a young persons quit attempts are not discussed a golden opportunity is being missed. Surely this is the time to encourage this when a young person has fresh information that may well inform and convince them to quit.	Thanks for your comments. We acknowledge that smoking cessation is relevant for some children and young people, and the guidance on smoking cessation services (http://www.nice.org.uk/Guidance/PH10) did make recommendations for these groups. The current referral relates specifically to school-based prevention, hence the focus of the scope. However, we would encourage you to suggest other topics for future NICE public health guidance, and you may do so at: http://www.nice.org.uk/getinvolved/suggestatopic/suggest_a_topic.jsp
Portsmouth City Council		4.2.2 c)	This can be quite common in some communities and with a public smoking ban can be seen as a safe alternative to smoking. This may not need mass coverage but it would be a wasted opportunity not to mention at all the dangers.	Thank you for your comments.
Portsmouth City Council		4.3	The use of statistics to challenge the social norms and show the increasing decrease in smoking prevalence has a positive impact with young people as does anything that impacts in the here and now rather than when they are 72 or even 32 or 22.	Thank you for your comments.
QUIT		General	QUIT would like to thank NICE for producing this guidance on school based prevention of the uptake of smoking in children.	Thank you for your comments.
QUIT		General	QUIT has been delivering smoking prevention services since 1994	Thank you for your comments.

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QUIT		General	QUIT recommends that NICE include: Michaelidou, N. Dibb, S. & Ali, H., *The effect of health, cosmetic and social antismoking information themes on adolescents' beliefs about smoking*, International Journal of Advertising The Quarterly Review of Marketing Communications, Vol 27, Number 2, 2008; within the evidence review.	Thank you for this helpful information and reference
QUIT		4.1.2	Children are aware of cigarettes by the age of 5, whether or not their parents smoke. Therefore evidence on pre-school children should be included in the guidance.	The referral for this guidance requires a focus on school-based smoking prevention. However, because of the extended schools agenda, children attending pre-school within the 'extended schools' programme are included in the revised scope.
QUIT	QUIT Because School-Based Youth Smoking Interventions Feedback. Available from QUIT.	4.3 – Questions	Particular attention should be made on interventions that occur during the transition years from primary to secondary school, when young people are most likely to try smoking for the first time. QUIT has attached documents with qualitative feedback on our own school-based interventions to be included in the evidence review on effectiveness.	Thank you for t your comment and information
QUIT		4.3 – Expected outcomes/Appendix B	Improved social skills, coping with stress and improved self-esteem and self-efficacy should be a primary outcome, not secondary. Delaying onset of smoking should also be listed at least as a secondary outcome, as this relates to the long term outcome of reduction in morbidity and mortality caused by smoking.	This has been amended in the final scope. Although the delaying issue is not discussed in detail in the scope, we anticipate that we will find useful literature on delaying smoking uptake. If so, these will feed into the guidance.
Royal College of Nursing		General	The brief is clear and the scope seems comprehensive for schools.	Thank you for your comments.

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Royal College of Nursing		General	Regarding the title and ethos of the guidance... Schools have a huge remit around health, but Children and Young People are only there for part of their lives. We consider that this guidance should scope school aged children and young people wherever they may be, not just school based.	Thank you for your comment. We appreciate that prevention of smoking for young people not attending school an important issue. The current referral requires that we develop guidance on school-based smoking prevention. However, we would encourage you to suggest other topics for future NICE public health guidance, and you may do so at: http://www.nice.org.uk/getinvolved/suggestatopic/suggest_a_topic.jsp
Royal College of Nursing		General	We would like to see some consideration of how this links with other initiatives aimed at preventing children from undertaking potentially harmful activities but not sure how to express within the scope or if it is already implicit in public health guidance.	We acknowledge that the links between high-risk behaviours are relevant to the issue of smoking prevention in children and young people, and this guidance will consider smoking prevention interventions that are part of broader health and lifestyle approaches: however, the main outcomes of relevance to this guidance are all focused around smoking prevention. If you would like to suggest a further topic for future NICE public health guidance, you may do so at: http://www.nice.org.uk/getinvolved/suggestatopic/suggest_a_topic.jsp
Royal College of Nursing		General	Young Peoples groups or retailers were not represented at the stakeholders meeting. Would be useful to involve them at this early stage.	Thank you. We are keen to involve young people in the development of the guidance and are now exploring ways that this may be done.

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Royal College of Nursing		General	Interventions by school nurses should include: • Drop ins • Health days • Health fairs • Parents evenings – display for stopping smoking • Work with teaching staff to get them on board to promote services for school aged children • Clinics in school prescribing patches etc • Assemblies based on Stop Smoking campaigns/information	Thank you, any intervention in these categories that yields useful research will be reported.
Royal College of Paediatrics and Child Health		General	The College believes that the fact that girls are taking up smoking at a higher rate than boys is particularly concerning because of the impact on the next generation. Pregnancy smoking has impacts on foetal growth, lung and immune function with enormous increases in post-natal morbidity and even an effect on mortality rates. This suggests there should be a specific focus on girls and more stringent targets. It is very likely that interventions will need to be gender specific.	Thank you, noted. We recognise the gender differences in smoking uptake, and the evidence review will consider gender differences in interventions and effectiveness, where evidence is available.
Royal College of Paediatrics and Child Health		3d-f	Peer influence has one of the most potent effects on up-take of smoking and equally may be the best target for intervention.	Thank you for your comments.

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Royal College of Paediatrics and Child Health		4.2.1	Facilitated peer lead educational strategies have proved effective for sex education. Given the potent effect of peer influence this should be a focus of investigation. It will be necessary for NICE to extend its review of interventions beyond smoking alone. Study of strategies which have worked for other problems such as teenage pregnancy may provide clues to the best approaches which can then be recommended for research programmes.	Thank you for your comments. We acknowledge that the links between high-risk behaviours are relevant to the issue of smoking prevention in children and young people, and this guidance will consider smoking prevention interventions that are part of broader health and lifestyle approaches: however, the main outcomes of relevance to this guidance are all focused around smoking prevention. If you would like to suggest a further topic for future NICE public health guidance, you may do so at: http://www.nice.org.uk/getinvolved/suggestatopic/suggest_a_topic.jsp
Royal College of Physicians		General	Thus we would suggest that if covering prevention of smoking in schools, the guidance should at least attempt to be as comprehensive as possible in covering primary and secondary prevention, for the entire school population – including those who should be there, as well as those who are.	Thank you. Thank you for your comment. We appreciate that prevention of smoking for young people not attending school an important issue. The current referral requires that we develop guidance on school-based smoking prevention. We would also encourage you to suggest a further topic for future NICE public health guidance, and you may do so at: http://www.nice.org.uk/getinvolved/suggestatopic/suggest_a_topic.jsp
Royal College of Physicians		4.1.1	The groups covered do not include those who have been excluded from school, those who do not attend at all, or the many who attend sufficiently to remain on the school roll but spend most of the day outside school. These are the groups among whom smoking is most prevalent. The guidance should at least acknowledge the existence of this population and if nothing more, identify the need to address the problem they present.	Thank you for your comment, which we have noted. The evidence review for this guidance will also consider the barriers and opportunities to smoking prevention with children and young people, and if there is appropriate evidence on the topics that you raise then it will be considered here.

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Royal College of Physicians		4.2.1	We appreciate the objective to define this guidance in terms of interventions that take place in school, and to distinguish these from more general population interventions, but are concerned that the focus on 'educational interventions' is too narrow. Other non-educational school-based interventions, such as strong smoke-free policy leadership and implementation, are also school-based and are effective. The guidance, if limited to what goes on in schools, should at least then include everything that can be done in schools.	Thank you for your comment. This guidance will consider evidence about any interventions or approaches delivered to the target populations where some or all of the intervention is delivered in a school. We anticipate that this will include a range of different types of intervention including, for example, education-based approaches, peer-support, wider school smokefree policies, , etc). We have attempted to clarify this in the revised scope.
Royal College of Physicians		4.2.2.(b)	On the same argument, effective preventive policies are only part of a comprehensive approach to school-based interventions on smoking. Prevention messages are likely to be diluted if a school has a significant number of pupils who smoke: these people also probably need help to quit, and most will want to. There is good evidence that the prevalence of smoking in a school (or specifically within a tutor group) is an important determinant of incident smoking. Provision of support for people who want to quit is therefore an important part of prevention. Previous NICE guidance has dealt with the effectiveness of pharmacotherapy in young people, but not the design and implementation of services. This guidance should cover those omissions.	Thanks for your comments. We acknowledge that smoking cessation is relevant for some children and young peoplehowever current referral relates specifically to school-based prevention, hence the focus of the scope. However, we would encourage you to suggest other topics for future NICE public health guidance, and you may do so at: http://www.nice.org.uk/getinvolved/suggestatopic/suggest_a_topic.jsp
Sandwell PCT		3e	Information on smoking in children in two parent families could also include some reference to percentages or ratios of children who smoke where only one parent is a smoker	Thank you for your comments.
Sandwell PCT		3e	Children ……are also more likely to smoke if they live with one parent. Does this apply to all one parent families or is it specific to situations where the single parent is a smoker??	This applies to one parent families regardless of whether the parent is a smoker or not (Goddard 1992).

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Smoke Free Norfolk Alliance		General	Tobacco (and alcohol) education as part of a planned PSHE programme should give age appropriate knowledge, develop skills and question attitudes. In primary schools the statutory science curriculum addresses knowledge only however, PSHE curriculum which would enable children to develop life skills is non-statutory and therefore the provision in schools varies considerably. Therefore to provide a comprehensive programme which looks beyond the knowledge the aim must be to make PSHE statutory in schools. This would enable schools to develop life skills in order to equip children to make healthy choices and also time and space in a safe forum to express and question attitudes towards tobacco.	Thank you for this comment. NICE is also involved currently in writing guidance on personal, social and health education, and we will endeavour to ensure consistency between the two pieces of guidance. See: http://www.nice.org.uk/guidance/index.jsp?action=byID&o=11673
Smoke Free Norfolk Alliance		Section 4.1.1 Groups that will be covered	1. We strongly support the proposal to research and use the views of children and teachers as well as of health professionals. 2. Given smoking prevention is seeking an attitudinal change; we feel prevention work should begin in infant schools before children's attitudes harden.	Thank you. We are keen to involve young people in the development of the guidance and are now exploring ways that this may be done. The scope covers pupils in infant schools and those who are at pre-school in an extended schools setting.

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Smoke Free Norfolk Alliance		Section 4.2.2 Activities that will not be covered	1. The public health guidance should also cover interventions involving quit advice to children. This is because implicit, or explicit within such schemes is a strong message not to start smoking. Failing the success of this comment, please treat it as a suggestion for a future topic to be considered by NICE.	Thanks for your comments. We acknowledge that smoking cessation is relevant for some children and young people, and the guidance on smoking cessation services (http://www.nice.org.uk/Guidance/PH10) did make recommendations for these groups. The current referral relates specifically to school-based prevention, hence the focus of the scope. However, we would encourage you to suggest other topics for future NICE public health guidance, and you may do so at: http://www.nice.org.uk/getinvolved/suggestatopic/suggest_a_topic.jsp
Smoke Free Norfolk Alliance			2. Another point – litter control and street clearing are important. If children see cigarette stubs on the pavements and in gutters, especially near schools, it suggests smoking is both normal and acceptable.	Thank you for your comments.

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Smoke Free Norfolk Alliance		Section 4.3 Key questions and outcomes	**Key question** – What factors aid the delivery of effective school based interventions and what are the barriers? 1. Teachers' time is crucial for success. Anecdotally, where there is any time in the syllabus for such subjects, there seems pressure on schools to concentrate on alcohol and drugs rather that on smoking. **Key question** – Which school-based interventions are effective and cost-effective? 1. The ASSIST project now has a large sample size and has demonstrated some success. We recommend it be greatly expanded as, at present, it is limited to a few parts of the country. This requires: • Funding • Freeing up teacher and support staff time • Contractual work at the school to ensure children do not later lapse. • Additional monitoring and evaluation This is mentioned separately because it is expensive. We recommend NICE speaks to the people who are currently implementing ASSIST. **Expected outcomes** 1. Even if no smoking advice doesn't stop children from smoking, it may delay the uptake. This is helpful as any such delay may influence the strength of future addiction.	Thank you for your comments, which we have noted. The evidence review that will inform this guidance will search for appropriate evidence on both the topics that you raise. Thank you for this suggestion. Although delaying smoking is not discussed in detail in the scope, the evidence review will include this as an outcome of interest when we search the literature and if appropriate evidence is identified then it will inform the guidance.

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South Asian Health Foundation		General	It should be remembered that the south Asian group is different. Recent surveys in the United Kingdom have shown that smoking is much more common among Bangladeshi men (49%) than among white (29%), Pakistani (28%) or Indian men (19%). In South Asian women, smoking rates are reportedly low (Bangladeshi women 4%, Indian women 1%, Pakistani women 2%). Smoking in young south Asians tends to be hidden from older members of the community. National smoking prevalence is strongly associated with socioeconomic status in Bangladeshi people living in the United Kingdom, and the majority of them are socially deprived. Pakistanis and Bangladeshis typically have higher levels of socioeconomic deprivation than white residents Recent national surveys have also shown Bangladeshis to be the poorest and least well educated, and further disadvantaged with respect to their health. This disparity is a portent of the future, of higher disease prevalence and earlier disease incidence. Substantial effort and investment is needed in culturally sensitive smoking cessation interventions for South Asians, and this should involve both adults and children, involving the government and national and local health agencies (in particular, primary care trusts). The Race Relations (Amendment) Act 2000, which obliges public authorities, including the NHS, to promote racial equality in access to services will underline and add urgency to this requirement. Cont'd	Thank you for your comments. We regcognise that smoking prevalence varies by ethnicity, and this is one of the factors that the evidence review will consider. If we identify appropriate evidence on culturally sensitive intervention, then it will inform the guidance.

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South Asian Health Foundation			Any programme needs to be also co-ordinated with others e.g. those on diet and physical activity. South Asian children are less likely to walk to school for instance. Given that smoking uptake amongst children (11-15 year olds) is concentrated amongst 14 and 15 year olds we would suggest concentrating on these specific age groups.	Noted, thank you. This has been made more specific in the revised scope.
South Asian Health Foundation		3 c	'Girls are more likely than boys to smoke on a regular basis' – we should be aware that the converse is likely to be true in South Asians, replicating the pattern seen in adults. Smoking in men is viewed with a strong sense of social acceptance, social bonding, and tradition and is seen as a "normal" part of "being a man." This view is particularly strong among Bangladeshi participants. It is intimately bound up with notions of male identity. Macho and fashionable images were associated with smoking and reinforced by Indian films and popular media. Smoking in Bangladeshi and Pakistani women is viewed with taboo, stigma, and non-acceptance. Smoking is also perceived to affect the chances of a woman marrying. Women were regarded as having fewer opportunities to smoke, both culturally and economically.	Thank you for your comments.

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South Asian Health Foundation		4.1.1.	Alternative centres of education could include religious institutions e.g. mosque schools. This could simply be in the form of information supplied, rather than intensive counselling. The dominant religion is Islam among both Bangladeshis and Pakistanis Islamic scholars have historically had mixed views about tobacco, because cigarettes are a more recent invention and did not exist at the time of the revelation of the Qur'an in the 7th century A.D. In more recent times, as these dangers of tobacco use have come to be proven beyond any doubt, scholars have become more unanimous in pronouncing tobacco use clearly forbidden to believers. For example: "In view of the harm caused by tobacco, growing, trading in and smoking of tobacco are judged to be haram (forbidden). The Prophet, peace be upon him, is reported to have said, 'Do not harm yourselves or others.' E.g. most Muslims would say that it was religiously unacceptable to smoke in a mosque and that the potential for women to smoke was reduced as they have a protected status in the Muslim religion. Many Muslim schoolchildren attend religious schools outside school, so this may represent an opportunity to educate.	**T**hank you for these comments. If there is evidence of effective interventions in faith schools, this should be found in the evidence review. The revised scope has been made more specific about the inclusion of extended schools and less formal educational use of schools settings. We hope that this reflects our intention to look broadly at smoking prevention in schools.

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South Asian Health Foundation		4.2.2.a	The family is an important medium though which cultural norms and values associated with smoking are shaped and negotiated in south Asians. Young boys often learn to smoke by observing male elders smoking, whereas opportunities for women are limited owing to the cultural restrictions imposed on a Muslim woman by her parents. We should not look at school-based interventions in isolation.	Thank you. Any intervention that has a schools component can be considered.
South Asian Health Foundation		4.2.2.c	NICE should not completely ignore smokeless tobacco use in schoolchildren - resonates with smoking cessation guideline from NICE and pertinent to minority ethnic groups, especially girls. A lack of parity in the portrayed harm of oral tobacco with smoked tobacco, will make the drive to tackle inequalities in health driven by cardiovascular disease more challenging.	The evidence review will consider any available evidence on school-based prevention of uptake of smoking, including sheesha smoking, but will not consider smokeless tobacco. The current referral relates specifically to school-based prevention of uptake of smoking, hence the focus of the scope. However, we would encourage you to suggest other topics for future NICE public health guidance, and you may do so at: http://www.nice.org.uk/getinvolved/suggestatopic/suggest_a_topic.jsp

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South Asian Health Foundation		4.3	Falk Müller-Riemenschneider et al showed [in one of the few reviews on this subject] that among 14 randomized studies investigating school-based interventions, only 9 were of good to high methodological quality and of these, only 2 reported clearly positive intervention effects. One of these took a culturally adapted approach [a multicultural curriculum] and targeted a very specific population group [Hispanic]. The results of the 7 remaining studies were inconclusive or even indicated that the intervention effects had been unfavorable. The results of their meta-analysis provide no evidence for the long-term effectiveness of school-based interventions. Contrasting with this, estimated pooled effects provided more evidence for the long-term effectiveness of community-based interventions and multisectorial interventions to prevent smoking among children, in both of whom family interventions were frequently used [such as informing parents, improving parent-child communication, or strengthening the parent-school partnership]. Activities targeted at parents who smoke were found to be especially effective. The findings of this review thus confirm the conclusions drawn in a Cochrane Review by Thomas et al. which did not find convincing evidence for the long-term effectiveness of school-based interventions. This thus adds to our feelings expressed under 4.2.2.a that school-based interventions on their own are not likely to be successful. Cont'd	Thank you for this helpful information and for the references.

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South Asian Health Foundation			There is good evidence to show that a comprehensive tobacco control strategy aimed at the whole population is the best way to reduce demand for tobacco products among young people. There is widespread and growing support for measures to reduce tobacco marketing such as removing tobacco from view at the point of sale and plain packaging and the reasons behind this could be explored in teaching in schools [e.g. in media/English]. There is strong evidence to show that tobacco advertising and promotion encourages children to smoke and this evidence underpinned the UK law which banned most forms of tobacco advertising. Tobacco packaging is now the principal means by which tobacco companies promote their brands and point of sale displays are a form of tobacco advertising. Removing tobacco products from public view will not affect adult smokers' ability to buy them but it will remove the temptation of children to try to purchase them. It is noteworthy that in Iceland, where point of sale displays were made unlawful in 2001, the proportion of 16 and 17 year olds who reported that they had ever smoked fell from 61% in 1995 to 46% in 2003. We appreciate that this has been covered in other NICE guidance but wish to emphasise its importance and that school-based interventions may not be successful on their own.	Thank you for your thoughtful comments and the points you raise. We agree about the necessity of a comprehensive approach. All NICE guidance on tobacco use issued to date recognizes the necessity of a comprehensive and evidence based tobacco control programme.

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South Asian Health Foundation		References	Understanding influences on smoking in Bangladeshi and Pakistani adults: community based, qualitative study Judith Bush, Martin White, Joe Kai, Judith Rankin, Raj Bhopal. bmj.com 2003;326:962 Physical activity and sedentary behaviours of South Asian and white European children in inner city secondary schools in the UK Kamlesh Khunti, Margaret A Stone, John Bankart, Paul K Sinfield, Diane Talbot, Azhar Farooqi and Melanie J Davies. Family Practice 2007 24(3):237-244; doi:10.1093/fampra/cmm013 Long-term effectiveness of behavioural interventions to prevent smoking among children and Youth. Falk Müller-Riemenschneider, Angelina Bockelbrink, Thomas Reinhold, Andrej Rasch, Wolfgang Greiner, Stefan N. Willich. Tob Control. Published Online First: 3 June 2008. doi:10.1136/tc.2007.024281 Thomas R, Perera R. School-based programmes for preventing smoking. Cochrane Database Syst Rev 2006;3:CD001293. The European School Survey Project on Alcohol and Other Drugs (ESPAD). www.espad.org/sa/node.asp?node=730	Thank you for this helpful information. The references you have supplied will be shared with the team conducting the evidence review for this guidance.

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The British Lung Foundation		General	Smoking during childhood increases the short and long-term risks of respiratory disease. In order to minimise the future burden of respiratory diseases it is therefore vital that the overall prevalence of smoking in the UK is reduced and that less children take up smoking. The majority of people take up smoking during their teenage years and most smokers once they reach adulthood say that they wish that they could quit. Schools are therefore in a key position to reduce the future burden of lung disease by ensuring that people do not become addicted to tobacco in the first place. The BLF supports efforts to promote lung health and to raise awareness amongst children of the dangers of smoking, particularly within the school environment. We are therefore delighted to respond to this consultation.	Thank you for your comments.
The British Lung Foundation		4.1.1 Groups that will be covered	It is important that education about the danger of smoking is focused on children of all social backgrounds and on children of all ages. The BLF therefore supports the wide range of educational institutions that the draft scope will apply to.	Thank you for your comments.
The British Lung Foundation		4.2.1 Activities/ measures that will be covered	The BLF believes that more can be done to educate children within schools on the danger of smoking. We therefore support the proposals to focus these campaigns within educational institutions.	Thank you for your comments.

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The British Lung Foundation		4.2.2 Activities/ measures that will not be covered	It is disappointing to see that the draft scope will not consider interventions to encourage children who already smoke to help them give up their habit. The BLF believes that in order to reduce the number of minors who smoke, initiatives to prevent the uptake of smoking must be accompanied by efforts to help children who are already addicted to tobacco. We support previous NICE guidance on smoking cessation (February 2008) which recommends people between 12 and 17 years old be offered support to stop smoking as well as nicotine replacement therapy (NRT) as part of a supervised regime for those who show clear evidence of nicotine dependence. It is important that attention is drawn to the wider responses that are needed to ensure that fewer children smoke. We therefore urge NICE to incorporate their previous recommendations on smoking cessation services within their guidance on school-based interventions to prevent smoking.	Thanks for your comments.. While it is not possible to incorporate recommendations from previous NICE guidance directly, we will ensure that the Public Health Interventions Advisory Committee will be made aware of the recommendations on smoking cessation form young people so it can be considered in their deliberations. However, if you think more should be done about guidance on smoking cessation for children and young people, we would encourage you to suggest other topics for future NICE public health guidance, and you may do so at: http://www.nice.org.uk/getinvolved/suggestatopic/suggest_a_topic.jsp

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The British Lung Foundation		4.2.2 Activities/ measures that will not be covered	The BLF believes that all children have the right to a smoke free environment and that educational campaigns about the dangers of second hand smoke should be aimed at both parents and children. It is therefore disappointing that the scope document does not include plans to educate children about the damage caused by second hand smoke in the home and in cars. We have been publicly approached by a member of one of our Breathe Easy groups who, despite never smoking in her life, has COPD as a result of her parents smoking. It is important that both children and parents are aware of the dangers of second hand smoke and to stop people from suffering in this way. Children should be aware of the dangers of second-hand smoke, not only so they can raise this issue with their parents, but also because they themselves are likely to be parents at some point in the future.	Thank you for this comment. If interventions to prevent the uptake of smoking among children and young people include elements of education about the dangers of second hand smoke, we would expect this to be identified in the literature search. Again, we would encourage you to suggest other topics for future NICE public health guidance, and you may do so at: http://www.nice.org.uk/getinvolved/suggestatopic/suggest_a_topic.jsp
The British Lung Foundation		4.2.2 Activities/ measures that will not be covered	The BLF believes that the scope should include plans to discourage chewing tobacco. It is not a safe alternative to smoking cigarettes and school based education programmes should include efforts to discourage children from chewing tobacco.	Thank you. The current referral relates specifically to smoking tobacco, hence the focus of the scope. However, we would encourage you to suggest other topics for future NICE public health guidance, and you may do so at: http://www.nice.org.uk/getinvolved/suggestatopic/suggest_a_topic.jsp

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The British Lung Foundation		4.3 Key questions and outcomes: Which school-based interventions are cost-effective in preventing children and young people from taking up smoking?	The BLF supports a wide ranging approach that provides children with consistent measures, formal smoking education, support to those who want to quit and also the provision of smoking messages to parents.	Thanks for your comments. We acknowledge that smoking cessation is relevant for some children and young people, and the guidance on smoking cessation services (http://www.nice.org.uk/Guidance/PH10) did make recommendations for these groups. The current referral relates specifically to school-based prevention, hence the focus of the scope. However, we would encourage you to suggest other topics for future NICE public health guidance, and you may do so at: http://www.nice.org.uk/getinvolved/suggestatopic/suggest_a_topic.jsp
The British Lung Foundation		4.3 Key questions and outcomes: expected outcomes	As explained in our previous answer, we believe that it is important to raise awareness of the dangers of second hand smoke amongst children and that this should be added to the list of expected outcomes. The BLF supports the list of expected primary outcomes. We fully support the long-term outcome of reducing morbidity and mortality by smoking.	Thank you for this comment. If interventions to prevent the uptake of smoking among children and young people include elements of education about the dangers of second hand smoke, we would expect this to be identified in the literature search.
The British Lung Foundation		Page 4	e) to take out 'has a' and insert 'is the'	Thank you for your comment.
The British Lung Foundation		Page 5	b) to take out 'or' and insert 'and'	Neither interventions to encourage nor support children and young people to quit smoking will be considered by this guidance.

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The British Lung Foundation		General	The third remark is something near to my heart. That patients could or should be used as examples in the presentations to show what can and probably will happen to smokers. What the youngsters see in the 'flesh' cannot be so easily 'brushed under the carpet'. I know that this is not everyone's cup of tea, but I for one would be quite willing to offer my services.	Thank you for your comments.
The British Psychological Society		General	Research has shown (America cancer society, 1999; Meier, 1991) that the younger the age of initiation of smoking, the less likely that a person will ever quit. In order to address this public health concern effective health intervention strategies must take into account psychosocial and psychological parameters. This can be partly achieved through anti-smoking awareness and health education school based programmes for children and young people by considering theoretical models/ framework, which include components of the Ajzen & Fishbeins's (1980) Theory of reason action and or social influence models (i.e. Bandura's (1977,1986) Social Cognitive Theory). Ajzen & Fishbeins's theory takes into account the underlying expectations of individual's beliefs and also, the perception of these expectations that influence behaviour (Strecher, DeVillis, Becker and Rosenstock, 1986). What this means in terms of prevention it will help to identify rigid core beliefs, which in the aforementioned group can lead to copying/ mimicking the behaviour of others, therefore potentially resulting in the reinforcement of the learnt behaviour of smoking cigarettes.	Noted, thank you. The evidence review that will inform this guidance will consider research identified via a systematic search of the relevant literature.

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The British Psychological Society		General	School Based Programmes The implementation of school-based interventions could be delivered by stop smoking specialist psychologist/counsellors which would not require further investment in teacher training and divert from other academic use of class room time. Interventions could take several forms: ❑ Social influence versus information-giving (peer, teacher, role model versus, psycho-education through lectures, quiz, collages, puppet plays, debates, role plays, making videos) ❑ Tobacco focused interventions (Bangert-Drowns, 1988) ❑ Tobacco interventions with alcohol or dugs ❑ Refusal skills techniques Bandura (1977) postulates that problem solving and refusal skill techniques are positive coping strategies, which should be encouraged and reinforced. The processes of refusal skills are also addressed by Epps & Manley (1993) who also maintain that refusal techniques will counter act negative peer pressure. The above interventions do not have to be used in isolation and activity educational sessions to include cultural practices around perceptions of what is not harmful. This should include Shisha smoking and roll-up cigarettes. Interventions could also include parents, as expressions of parental disapproval have been effective deterrents to children smoking (Sargent, J.D., & Dalton, M. 2001). A study review conducted by Petrie et al (2007) has demonstrated that parenting programmes for preventing tobacco misuse in children < 18 years has an effect when used along side class room interventions. Cont'd	Thank you for your comments. The revised scope has been changed to make it clear that all school-based interventions, including those delivered outside of regular lessons will be covered by the guidance. Please see our previous response: The evidence review will consider any available evidence on school-based prevention of uptake of smoking, including sheesha smoking.

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The British Psychological Society			These programmes would have to be structured and may be best carried out over a period of six sessions tailored to the age groups attention span (i.e. 20-30 minutes slots) and added into the learning curriculum. The Hutchinson smoking prevention project, (HSPP) (Peterson, 2000) has assessed the outcome of what social influence approach can achieve when working towards implementing a school based intervention. Thomas & Perera's (2006) review on school based interventions suggests also that social influence approaches can play a role in the setting up school based prevention programmes in smoking.	Thank you for this information: Please see our previous response.
The British Psychological Society		Section 3	Further to comments made towards the December 2007 consultation on public health intervention guidance – 'preventing children smoking' – this school-based intervention is clear and concise – identifying the future health concerns of adults who begin smoking in childhood and contributing factors such as gender, (the prevalence higher in girls), age (prevalence increasing with age), school-related issues and the influence of the family.	Thank you for your comments.

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The British Psychological Society		Section 4	The institutions (and groups) to be measured in this guidance are clear and targets the relevant age groups at risk – but there is no mention of how 'hard to reach' children will be targeted – and as truancy is listed as one of the predicting factors to smoking uptake (page 3) – this may need to be addressed in this or future guidance. In addition, the types of interventions expected to be delivered are not explored. The term 'education interventions' is used – but what does this mean? Does this encompass the full model of New Public Health – which considers not just health education – but also health promotion? There may be a risk that one institution will focus merely on health education, specifically drawing on communication and attitude theories where the concepts of threat and fear are used.	Thank you for your comment. We appreciate that prevention of smoking for young people not attending school an important issue. The current referral requires that we develop guidance on school-based smoking prevention. However, we would encourage you to suggest other topics for future NICE public health guidance, and you may do so at: http://www.nice.org.uk/getinvolved/suggestatopic/suggest_a_topic.jsp Thank you for this comment. The revised scope has been changed to make it clear that all school-based interventions, including those delivered outside of regular lesson, and combiniations of intitatives, s will be covered by the guidance.

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The British Psychological Society		Section 4	The underlying principle of these campaigns is the belief that the fear they induce will motivate prevention from the behaviour in the case of smoking. However, empirical evidence available on the efficacy of this approach is mixed. Individuals do not necessarily respond rationally to avoid the threat linked to so called 'fear-appeals', and will often disassociate themselves from the message (often coined as 'unrealistic optimism'). To simply expect children to avoid smoking behaviour when presented with information or a threat of disease or illness is naïve. The assumption that the recipients of fear arousing messages are rational thinkers when it comes to their health is an obvious limitation of theoretical constructs incorporating the emotional element of fear (such as Protection Motivation Theory or the Health Belief Model). Under conditions of low levels of perceived vulnerability and high self-efficacy individuals may be motivated to avoid health behaviour. Therefore, interventions aiming to produce these two cognitive states may be recommended. However, fear is associated with the prediction of a negative outcome (Walker, 2001). This has lead to resistance towards messages targeting adolescent risk taking behaviours (Franzkowak, 1987) and denial of the threat (Soames-Job, 1988). The use of such strategies in intervention packages aimed at enhancing health-promoting and disease-preventing behaviours should be used with caution as they may, in turn, be counter-productive. Cont'd	Thank you for this information.

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The British Psychological Society			The key questions from this guidance may essentially answer the questions and issues identified above. And more research is needed in this area as recent unpublished doctoral studies has uncovered (Chater, Worrell and Vögele, *in preparation*). However, the expected outcomes, both primary and secondary also draw on interesting cognitive areas that are not stated as predictors of smoking behaviour, although there is a body of evidence which suggests they are (see Conner & Higgins, 2003; McMillan, Higgins & Conner, 2005). These are more internal factors, rather than the external factors focused on in section 3. Changes in attitudes and self-efficacy are mentioned as expected outcomes – however, up until this point there is no reference to their significance in preventing smoking behaviour or their theoretical basis.	Thank you for thisl information

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The British Psychological Society		Section 4.3	As there is increasing interest in intervention mapping (Kok et al, 2004; Bartholomew et al, 2001) in the fields of behavioural medicine and public health, it may be useful to include in the guidance a recommendation that interventions that aim to prevent children from smoking, should be either evidence-based or based on appropriate theory. Two obvious theories that incorporate the cognitive elements mentioned in the expected outcomes are Social Cognitive Theory (Bandura, 1986) and the Theory of Planned Behaviour (Ajzen, 1985). Further to this, research presented at the XXIX International Congress of Psychology in Berlin (Chater, Worrell and Vögele, July 2008) found that, like differences in age for prevalence of cigarette smoking, there are also age differences in cognitive beliefs, such as the ones included in the theories above, relating to the avoidance of smoking behaviour, with younger children holding more favourable outcome expectancy beliefs. Therefore, school-based interventions may benefit from age-specific tailored programmes, that are mapped to relevant and evidenced-based theoretical approaches, to prevent the uptake of smoking among school-children.	Thank you for this information. We are aware of Bartholomew et al and the idea of intervention mapping. We will be incorporating this in our thinking about the development of logic models and conceptual frameworks. As previously stated, the guidance will be developed according to established processes (please see http://www.nice.org.uk/aboutnice/howwework/developingnicepublichealthguidance/publichealthguidanceprocessandmethodguides/public_health_guidance_process_and_method_guides.jsp for more information on our methods) employed by NICE. The recommendations will largely be based on systematically identified research evidence (that has been assessed on quality and other criteria). If appropriate evidence is identified in any of the areas you mention, then it will be considered in the course of developing the guidance.

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The British Psychological Society			References: *Ajzen, I. (1985).* From Intentions to Action: A Theory of Planned Behaviour*. In J. Kuhl & J. Beckham (Eds.)* Action Control: From Cognitions to Behaviour*. New York: Springer-Verlag, 11-39.* *Ajzen, I., & Fishbein, M. (1980) Understanding attitudes and predicting social behaviour. Englewood Cliffs, NJ: Prentice-Hall, Inc.* *American Cancer Society (1999) Cancer facts & figures 1999. Atlanta: Author* *Bandura, A. (1977) A social learning theory. Englewood Cliffs, NJ: Prentice-Hall.* *Bandura, A. (1986).* Social Foundations of Thought and Action: A Social Cognitive Theory. *Englewood Cliffs, NJ: Prentice Hall.* *Bangert-Drowns, R.L.(1988) The effects of school based substance abuse education. A meta-analysis. Journal of drug education. 18:243-64* *Bartholomew, K. et al (2001).* Intervention mapping: Developing theory and evidenced-based health education programmes. *Mountain View, CA: Mayfield.* *Chater, A., Worrell, M., & Vögele, C.* Age and gender differences in children's health perceptions and health behaviours. *Included in a symposium on Gender and Health at XXIX International Congress of Psychology (Berlin, July 2008).* *Cont'd*	Thank you for all the references below. They will be shared with the reviewers to be checked against the studies that emerge from their searches.

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The British Psychological Society			*Chater, A., Worrell, M., & Vögele, C.* In preparation. *Predicting children's health behaviour intentions.* *Epps, B.R., & Manley, M.W. (1993) Prevention of tobacco use during childhood and adolescence. Cancer, 72(3), 10002-1004* Franzkowiak, P. (1987). Risk taking and adolescent development. *Health Promotion, 2,* 51-60. Higgins, A. & Conner, M. (2003). Understanding adolescent smoking: the role of the Theory of Planned Behaviour and Implementation Intentions. *Psychology, Health & Medicine, 8, (2),* 173-186. Kok, G. et al, (2004). Intervention mapping: Protocol for applying health psychology theory to prevention programmes. *Journal of Health Psychology, 9, (1),* 85-98. McMillan, B., Higgins, A. R. & Conner, M. (2005). Using an extended Theory of Planned Behaviour to understand smoking amongst schoolchildren. *Addiction Research and Theory, 13, (3),* 293-306. Peterson, A.V.Jr., Mann, S.L., Kealey, K.A., & Marek, P.M.(2000) Experimental design and methods for school-based randomised trials: Experience from the Hutchinson smoking prevention project (HSSP) Controlled clinical trials. 21: 144-65 Soames-Job, R. F. (1988). Effective and ineffective use of fear in health promotion campaigns. *American Journal of Public Health, 78,* 163-167. Strecher, V.J., DeVillis, B.M., Becker, M.H., & Rosenstock, I.M. (1986) The role of self-efficacy in achieving health behaviour change. Health Education Quarterley, 13(1), 73-91. Cont'd	See the section above

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The British Psychological Society			Thomas, R.E., Perera, R. School-based programmes for preventing smoking. Cochrane Database of Systematic Reviews 2006, (3) Art.No. CD001293.DOI:10.1002/14651858.CD001293.pub2 . Walker, J. (2001). *Control and the Psychology of Health.* Buckingham: Open University Press.	See the section above.
Tower Hamlets Council Youth and Community Service (LA)		4.1.1	Work with Faith schools and Faith Groups who deliver Extra Curricular Activities	The revised scope has been changed to make it clear that all school-based interventions, including those delivered outside of regular lessons will be covered by the guidance.
Tower Hamlets Council Youth and Community Service (LA)		4.2.2	Explicit mention of Sheesha (AKA Hooka, Nargila, Water pipe etc)	The evidence review will consider any available evidence on school-based prevention of uptake of smoking, including sheesha smoking.
Wiltshire PCT		General	An identified Key worker should be in each school to promote the negative messages of smoking tobacco. At the present time school nurses are often given this task to work into their every day duties and unfortunately due to the volume of work expected in other areas this often does not prove to be high priority.	Thanks for your comments. Where it is available, we will consider suitable evidence on the effectiveness of different professionals delivering interventions in a school setting.
Wiltshire PCT		General	Ideally school children should be consulted when developing marketing resources. The leaflets should be designed to have maximum impact across all social levels.	We recognise the important of consultation with children and young people, and are currently investigating ways that this might be done for this guidance.
Wiltshire PCT		General	The NHS stop Smoking Service should be included in the development of any process in educating school children in the harm those results from smoking cigarettes. Perhaps regular assessments in each school as to numbers who smoke would reinforce the educational programme.	Thank you for your comments.

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WRS Group UK			• Youth Clubs/Centres… As discussed even though the title states School-Based Interventions to Prevent Smoking, I'm concerned that this will mean a two tier approach to the Prevention education that would occur. In my background as a Smoking Prevention & Cessation Specialist in Manchester I realised quite quickly that Youth Clubs and Youth Leaders do impart a lot of Health Education, albeit in a rather more relaxed and shorter 'lesson' structure. I found that in many cases the Young People most 'likely' (*due to the various evidenced based reasons*) to become smokers were the ones more likely to receive/gather their health education information in the more informal settings such as Youth Clubs. I have noticed that sales of Tobacco Education materials sell approximately 2 to 1 in terms of secondary schools and youth centre's. This leads me to believe that although 'structured' lessons are occurring in schools, the Youth Clubs are also providing these as well. It would therefore in my mind, be better to make the scope of this Consultation to be more in regard the *"Interventions that can be used with School Aged Young People to Prevent Smoking"* than just School Based.	Thank you for your comments. The guidance process requires NICE to base its scope and guidance on the referrel from the Departmern of Health. The current referral requires that we develop guidance on school-based smoking prevention. However, we would encourage you to suggest other topics for future NICE public health guidance, and you may do so at: http://www.nice.org.uk/getinvolved/suggestatopic/suggest_a_topic.jsp

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WRS Group UK			• I would ask if Leading School Nurses had been consulted… many school nurses have a role to play in Smoking Prevention initiatives.	School nurses are among the school staff mentioned in the draft scope, and representative organisations have been invited to register as stakeholders – this opportunity is open throughout the process. A number of registered stakeholders will include school nurses in their associates or employees – for a full list please see http://www.nice.org.uk/guidance/index.jsp?action=download&o=42137 .

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WRS Group UK			• I have a problem with the scope 'only' focusing on ***Prevention…*** if by 15 there are already 20% of the young people smoking, how possibly can we use only prevention lessons to 'stop' them from starting to smoke, when they have already started to smoke… bit of an Oxymoron really… essentially if the 'whole point' of the exercise is to prevent young people 'ever' becoming smokers in adulthood, then we have to realise that prevention only lessons will not be relevant on those people most likely to be smokers in adulthood***, i.e. those young people who smoke in their teenage years***. So… therefore even though the Scope title states *Prevention*, then the guidance completed would need some of the lessons to focus on an understanding of ***Cessation*** in order to *'Prevent the young people who do smoke'* becoming adult smokers. There is of course a famous old saying, no use telling someone to lock the stable door, after the horse has already bolted… what has to be remembered is that a cessation lesson, can be as good at informing young people who don't smoke, not to smoke, as a 'normal prevention based lesson'. For instance I have written a lesson plan that is designed to show all pupils in a class how to quit smoking, it is though focused also on how very hard this can be, and so it helps to reinforce the fact that smoking is very dangerous as a habit to those that don't smoke. It is therefore both a Prevention & a Cessation Lesson. Cont'd	Thanks for your comments. We acknowledge that smoking cessation is relevant for some children and young people, and the guidance on smoking cessation services (http://www.nice.org.uk/Guidance/PH10) did make recommendations for these groups. The current referral relates specifically to school-based prevention, hence the focus of the scope. However, we would encourage you to suggest other topics for future NICE public health guidance, and you may do so at: http://www.nice.org.uk/getinvolved/suggestatopic/suggest_a_topic.jsp

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WRS Group UK			Through the Secondary School the lessons must be tailored to meet both those who could become smokers, and those that are already smokers… and because we can't segregate them, and so we shouldn't, then the lessons written (*and general guidance*) must enable the lessons to equally focus on both groups. If you are to state that NICE may look at Cessation and Young People (or has already), then why have two elements that should be one…? After all have we even as a group determined yet the 'time that schools provide for Tobacco Prevention & Cessation lessons'… I have looked at this in some detail and can tell you that if you can succeed in introducing 7 lessons in Primary Schools and 7-10 in Secondary schools that build up together, then you will have done very well indeed in the current tight scheduling of schools… In other words I'd hate to see us as a group produce 24 lessons that work in a structured fashion from KS1 to KS 4, when we haven't realised only about 15 lessons would ever be allocated through schools currently…	See comment above