Public Health Intervention Guidance

School-based interventions to prevent smoking - Consultation on the evidence – Stakeholder Response Table

1st May – 3rd June 2009

Stakeholder Organisation	Evidence submitted	Document Name/No.	Section	Page Number	Comments Please insert each new comment in a new row.	*Response* *Please respond to each comment*
Advisory Council on the misuse of drugs	Advisory Council on the Misuse of Drugs (2006) Pathways to Problems				Please see attached evidence	Thank you for this report.
ASCL		Systematic review of qualitative research	Delivery context of the interventions	1	Schools in the UK are predominantly, probably wholly, no-smoking environments and it is likely that socio-political changes have removed or lessened this barrier	Thank you for this comment. We recognise that the UK context has changed in very recent times, and that schools must now comply with legislation banning smoking in the workplace. Furthermore, the majority of schools are either working towards – or have achieved – the Healthy Schools Standard. However, expert testimony presented to the Public Health Interventions Advisory Committee (as well as some of the evidence presented in the reviews) suggests that there is variation in how thoroughly schools are able to implement smoke-free policies, and in the activities undertaken and implemented as part of the Healthy Schools Standard. We are pleased, therefore, to be able to include some evidence on how best to enhance the delivery and context of school-based smoking prevention programmes as part of the evidence considered in developing this guidance.
ASCL		Systematic	Programme	2	It is difficult not to include “fear based approaches”	PHIAC recognise that the issue is

Public Health Intervention Guidance

School-based interventions to prevent smoking - Consultation on the evidence – Stakeholder Response Table

1st May – 3rd June 2009

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		review of qualitative research	content		alongside others when facts and statistics made available through science/PSHE or citizenship lessons inevitably focus at times on mortality rates and smoking related illnesses.	not straightforward. The study that this finding refers to was examining the effectiveness of a wider drug, alcohol and tobacco intervention, and the authors of the review note that it was difficult to extrapolate information specific to tobacco prevention and use. We will ask the reviewers to look at this issue again. Other guidance has found that use of 'fear-arousing communications' can be effective if given with appropriate support. See guidance on preventing the uptake of smoking through mass media and point-of-sale measures http://guidance.nice.org.uk/PH14
ASCL		Effectiveness review Executive summary	Summary of findings	2	It was surprising that the school based interventions described didn't include joint school/PCT approaches (such as *Help 2 Quit*) which are more available. Some schools report success in referral and self referral to such schemes and they rightly feel that they are part of the school based strategy for reducing and preventing the uptake of smoking. The peer group interactions of students who attend such programmes would also merit investigation.	This guidance will consider effective school-based interventions aimed at preventing smoking uptake, and projects aimed at helping children and young people to quit smoking are outside of the current scope. You may, however, suggest a topic for future NICE public health guidance (subject to due process) at this link: http://www.nice.org.uk/getinvolved/suggestatopic/suggest_a_topic.jsp Limitations on time meant that The effectiveness review included only randomised controlled studies (RCTs) that had been published in

Public Health Intervention Guidance

School-based interventions to prevent smoking - Consultation on the evidence – Stakeholder Response Table

1st May – 3rd June 2009

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						peer reviewed journals. We are aware that this is only a portion of the available evidence, and PHIAC will also consider findings from a number of other sources , including the review of qualitative research, expert testimony and consultations on the draft guidance with professionals, practitioners, stakeholders and children and young people themselves in forming their recommendations.
ASCL		Effectiveness review	Evidence statement 1b	7	The ECM agenda – and specifically the "be healthy" component form a significant part of PSHE curricula. Much of the success of these programmes comes about from flexibility of delivery methods and diversity of approaches. "Healthy Schools" initiatives complement this work. It is encouraging to see that the review finds evidence to support this flexible approach.	Thank you for these comments.
ASCL		Effectiveness review	Evidence statement 1c	9	There seems to be evidence that booster sessions enhance main programmes. It would seem disingenuous not to support such school-based programmes with flexible funding to allow schools to tailor extended school's work to the particular needs of the population of students.	Thank you. We have noted this finding, and we will also pass it on to colleagues working on the implementation of the final guidance.
ASCL		All reviews	General		It is hard to escape the view, having read all the documentation in the consultation, that there are relatively few areas where there is clear agreement in the literature. It is concerning, given the volume of research that has been undertaken in recent years, that the overwhelming body of evidence seems to be inconclusive about the effectiveness/cost effectiveness of school based interventions.	Several factors may contribute to the findings, including the wide range of intervention types that were assessed by the included studies, variations in length of follow-up, and variations in measures used. Despite these factors, though, there is an overall trend towards effectiveness in the

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						studies considered. Furthermore, PHIAC will also consider information from other sources of evidence when developing the guidance.
ASH		Cost Effectiveness review	General		The tentative conclusion that the reviewed studies "may" be an efficient use of resources appears to be outweighed by the uncertainty as to whether the reviewed studies are applicable to the UK. In addition, the fact that most studies failed to take into account the deterioration of the effect of interventions in the long term also casts doubt on the viability of such interventions.	Thank you for your comments. Due to the limited evidence available bespoke modelling was undertaken to determine the cost effectiveness of schools' based prevention programmes. Several models were tested representing assumptions about whether smoking actually decreases onset of smoking in the long term or simply delays the onset of smoking. Most of the analyses suggest these programmes are cost-effective. The draft report is available at; http://www.nice.org.uk/guidance/index.jsp?action=download&o=44031. The final report, which will include additional analyses will be available when the guidance is published in 2010.
ASH		Effectiveness review	Evidence statement	11	Given that the observed effect of the 46 RCTs did not achieve statistical significance in most cases and the conclusion that the interventions had no more than a "modest" effect in preventing the uptake of smoking, there does not appear to be sufficient evidence to justify expenditure on special school-based anti-smoking interventions, beyond standard health education on smoking.	Thank you for your comments.
ASH		Effectiveness	General		In the light of the paucity of evidence in favour of	We look forward to receiving your

Public Health Intervention Guidance

School-based interventions to prevent smoking - Consultation on the evidence – Stakeholder Response Table

1st May – 3rd June 2009

Stakeholder Organisation	Evidence submitted	Document Name/No.	Section	Page Number	Comments Please insert each new comment in a new row.	*Response* *Please respond to each comment*
		review			school-based interventions to prevent youth smoking, ASH recommends that the resulting guidance should be extremely cautious in advocating such measures. Instead, the guidance should stress that other approaches, particularly measures that apply to the whole population, are a more effective and cost-effective means of preventing smoking uptake among children.	comments on the draft guidance.
Cardiff University		**Effectiveness review**	General	General	Within the effectiveness review, and across the effectiveness and qualitative reviews, there is inconsistent reporting of the ASSIST trial results (Campbell et al 2008). The qualitative review generally highlights ASSIST as a 'particularly promising approach'. The effectiveness review varies substantially in which effect estimates it uses and in general elects to adopt a highly conservative approach in its selection and interpretation of findings to report. The ASSIST evaluation found statistically significant effects of the intervention at 1-year follow-up (OR: 0·77; CI: 0·59, 0·99) and a clinically significant but statistically non-significant (p>0.05) effect at 2-year follow-up (OR: 0·85; CI 0·72, 1·01) amongst all students. These are the figures reported in the evidence table (Table 5-15). The corresponding odds ratios for the high-risk group (a priori identified as a key target group for the intervention, and the group amongst which uptake of regular smoking is most common) were 0·75 (CI: 0·56, 0·99), and 0·85 (CI: 0·70, 1·02), respectively are also included in Table 5-15. In the pre-planned primary analysis of the trial, a multilevel model with data from all three follow-ups, the odds of being a smoker in intervention compared with control schools was 0·78 (0·64, 0·96). There was no statistically significant attenuation effect over time. This is not reported in	Thank you for your comments. To clarify, the referral for this guidance asked NICE to develop public health guidance on effective school-based interventions for preventing the uptake of smoking. Given this focus, the effectiveness review placed greater emphasis on studies in which outcomes related to children who are non-smokers at baseline were reported'. In accordance with this, when the smoking prevalence is greater than 0% at baseline the reviewers used sub-group results from baseline non-smokers in the forest plots and the main text. This applies not only to the ASSIST trial but also to other studies (e.g. Aveyard 2001).

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					Table 5-15 or anywhere in the text. Nevertheless, in this multilevel model, a sub-group analysis for those who had never smoked at baseline found an odds ratio of 0.81 (0.62, 1.06). For some unknown reason, it is this estimate of effect that is included in the forest plots and text of sections 3.2 and 3.3 of the effectiveness report. This is highly misleading. There appears to be no rationale for selecting this statistic; only a small minority of smokers at two-year follow-up come from the sub-group who were never smokers at baseline.	
Cardiff University		**Effectiveness review**	Exec summary 1b	14	The question "Are the intervention effects delaying rather than preventing the onset of smoking?" is not directly answered by the statement "Results from Campbell et al. 2008 (+, UK) and Bond et al. 2004 (+, Australia) RCTs suggested an attenuation of programme effect over time." The intervention may be delaying onset in some young people, hence the attenuated effect over time, but it may also be preventing many young people from ever starting to smoke. While on the one hand the review sticks rigidly to p-vales of 0.05 to recognise or rule out effects as being present, it appears that a suggestion of attenuation of effect can be reported, even though there is no statistically significant attenuation of effect over time. This question also does not reflect the analysis reported in the economic modelling report that delayed onset is associated with earlier cessation, and thus a valuable outcome in its own right.	Thank you for your comment. PHIAC will consider the findings of all of the reviews (and the economic modelling report) in drafting their recommendations, as well as other sources of evidence (testimony from experts working in policy, research and practice; consultation with stakeholders, and fieldwork with practitioners, children and policy makers). They also take into account methodological and quality issues in the evidence, We have taken your comment back to the review team, who explain your observation by noting that, when looking at whether the effect of an intervention attenuates over time, data needed to adequately address the issue using a meta-analysis (such as survival curves, log rank tests and hazard ratios, preferably in students who were not

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						smoking at the start of the RCT) were generally not reported by studies. . In the absence of this data, the reviewers instead plotted RCTs , and looking at those with multiple follow-ups it was possible to see the trend you describe (although the RCTs were not powered for this outcome).
Cardiff University		**Effectiveness review**	Exec summary 1c	15	The statement "One RCT (Campbell et al. 2008 +, UK) showed that effectiveness of peer-led school-based smoking prevention programme was the same as non-peer led programme" is completely misleading and makes no sense whatsoever. It suggests that there was a comparison of the effectiveness of the ASSIST peer-led programme was with a non-peer led version of the programme, which was not the case. This stems from a misunderstanding of the statement reported on *page 101* about the potential differential effect in a sub-group analysis of the ASSIST Programme over and above normal smoking education among those students who acted as peer supporters compared to among those who were not peer supporters (the rest of the year group).	Thank you for bringing this to our attention. The review team will remove the statement on ASSIST peer-led status from this section
Cardiff University		**Effectiveness review**	Exec summary 1d	16	There is an inaccuracy in the reporting of effectiveness according to location. Insert "valleys" after "South Wales" in statement "Evidence from one RCT (Campbell et al. 2008; +, UK) indicated that students from schools located in the South Wales were less likely to be regular smokers." This is important as this differential effect is thought not to be associated with the location per se but to the types of well-defined	The review team will amend their report in line with your suggestion. We cannot, however, see evidence from the study itself that the effect was due to the type of community rather than the non-urban location.

Public Health Intervention Guidance

School-based interventions to prevent smoking - Consultation on the evidence – Stakeholder Response Table

1st May – 3rd June 2009

Stakeholder Organisation	Evidence submitted	Document Name/No.	Section	Page Number	Comments Please insert each new comment in a new row.	*Response* *Please respond to each comment*
					close-knit communities and social networks found in the valleys	
Cardiff University		**Effectiveness review**	Forest plots	General	For Campbell et al, in Table 5-15 the statistic used is from a multilevel model sub-group analysis for those who had never smoked at baseline. This is highly misleading. There appears to be no rationale for selecting this statistic; only a small minority of smokers at two-year follow-up come from the sub-group who were never smokers at baseline. The upper bound of this OR is 1.06, which is higher than for any other statistic that might have been chosen for these forest plots.	Thank you for your comment – please see our earlier response.
Cardiff University		**Effectiveness review**	Table 3-1	63	For Campbell et al, table states that seven schools withdrew after randomisation. This is not true. 59 schools were randomised, of which two withdrew and were replaced with two schools prior to any baseline data collection, and randomised.	This will be amended by the review team.
Cardiff University		**Effectiveness review**	3.3.1	80	States "For children who had never smoked becoming a regular smoker, two RCTs (Campbell 2008, Aveyard 2001) found no difference between intervention and control groups." This is correct. However, the primary target group of the intervention was those students who were at high risk of uptake of regular smoking. Should the effect on this group not be reported here? It is from this sub-group that the vast majority of new regular smokers emerge. That is why the intervention was designed to target them and is the group amongst which it was most effective. Only a small minority of regular smokers at age 14/15 come from the population of students who have never smoked or experimented with cigarettes by age 12.	Please see our earlier response.
Cardiff University		**Effectiveness review**	3.4.1	91	See response in relation to page 14	See above
Cardiff		**Effectiveness**	3.4.1	93	See response in relation to page 14	See above

Public Health Intervention Guidance

School-based interventions to prevent smoking - Consultation on the evidence – Stakeholder Response Table

1st May – 3rd June 2009

Stakeholder Organisation	Evidence submitted	Document Name/No.	Section	Page Number	Comments Please insert each new comment in a new row.	*Response* *Please respond to each comment*
University		**review**				
Cardiff University		**Effectiveness review**	3.5	100	See response in relation to page 15	See above
Cardiff University		**Effectiveness review**	3.5	101	The reporting of the potential differential effect of the ASSIST Programme on those students who acted as peer supporters, and those who did not as peer supporters is correct here. There is an inaccuracy in the translation of this statement into the summaries on pages 100 and 15.	Thank you for bringing this to our attention. The summaries will be corrected in line with the text
Cardiff University		**Effectiveness review**	3.6	106	See response in relation to page 16	See above
Cardiff University		**Effectiveness review**	3.6	107	Re-word “For example, one recent RCT (Campbell et al. 2008 +, UK) found statistically significant differences between schools located in town or city and those located in a South Wales valley.” To read “For example, one recent RCT (Campbell et al. 2008 +, UK) found statistically significant differences between schools located in towns and cities and those located in the South Wales valleys” for clarity. And the odds-ratios 0.52 and 0.89 do not relate to odds of being a smoker in these areas but to the odds of being a regular smoker in the intervention group compared to control in the fully adjusted model. Therefore, the statement after this paragraph (“Contrary to this finding; Sussman et al. 1993; (-, USA) demonstrated that smoking prevalence was higher in the rural schools than in the urban schools”) is a different point and does not follow on from it.	Thank you for bringing this to our attention. The review team will amend their report in line with this comment.
Cardiff University		**Effectiveness review**	3.8.3	129	For Campbell at al, the results from random effects logistic regression at one and two years are presented here (not the trial’s primary planned analysis, but the	Thank you for pointing out this inconsistency. The review team will amend their report in line with this

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					same as some of the data in Table 5-15, but not the figure used in the forest plots!), and the intervention is said to be 'effective in reducing smoking uptake'. This is in contrast to the repeated assertion earlier in the report and in all references to the various forest plots, in which it is stated that the ASSIST intervention was not effective.	comment.
Cardiff University		**Effectiveness review**	3.8.6	140	The ASSIST Programme is not considered in the section titled "Baseline risk factors (high risk groups)" which states that "There is no conclusive evidence about the variability of programme effectiveness in high risk individuals." A major identifiable risk factor for regular smoking at age 14/15 is early experimentation at age 12/13. The majority of regular smokers at age 14/15 come from those who are occasional or ex-smokers at age 12/13.	Thank you for your comment. The review team will amend their report to include evidence from the ASSIST trial in this section (baseline risk factors).
Cardiff University		**Effectiveness review**	Discussion	151	See response in relation to page 14	See above
Cardiff University		**Effectiveness review**	Discussion	152	See response in relation to page 15	See above
Cardiff University		**Effectiveness review**	Discussion	153	See response in relation to page 16	See above
Cardiff University		**Effectiveness review**	Table 5-15	202	For Campbell et al 1998: Individual-level socioeconomic status measures using FAS, AND family vehicle ownership. Primary outcome 1) weekly smoking amongst all students Primary outcome 2) weekly smoking in those students classed at 'high-risk' of smoking. Results included are those from random effects logistic	Thank you for your comments, and for the information you provide about our interpretation of this study. The review team will amend their table in line with your suggestion. We have queried the rating ascribed to this study with the review team, who point out that rating of internal validity of included studies was conducted using the methodology checklist (randomised

Public Health Intervention Guidance

School-based interventions to prevent smoking - Consultation on the evidence – Stakeholder Response Table

1st May – 3rd June 2009

Stakeholder Organisation	Evidence submitted	Document Name/No.	Section	Page Number	Comments Please insert each new comment in a new row.	*Response* *Please respond to each comment*
					regression models and not those from primary planned analysis. There was a single intervention category – this has been queried in the table. It is unclear what the ambiguity is here. The internal validity score is +, yet there are no limitations of substance, so why not a score of ++?	controlled trials) from the Methods for development of NICE public health guidance (2006). Studies were downgraded if groups were not similar at baseline (especially baseline smoking status). Campbell et al. 2008 was rated as (+), because more students in control schools reported smoking every week than did those in intervention schools at base (this difference was statistically significant).

Public Health Intervention Guidance

School-based interventions to prevent smoking - Consultation on the evidence – Stakeholder Response Table

1st May – 3rd June 2009

Stakeholder Organisation	Evidence submitted	Document Name/No.	Section	Page Number	Comments Please insert each new comment in a new row.	*Response* *Please respond to each comment*
Cardiff University		**Qualitative review**	General	General	For the ASSIST programme, there is a further paper now published. It's particularly relevant to the section on how aspects of the delivery context of school-based interventions act as barriers and facilitators to effective delivery. Holliday J, Audrey S, Moore L, Parry-Langdon N, Campbell R. High fidelity? How should we consider variations in the delivery of school-based health promotion interventions? Health Education Journal 2009;68(1):44-62. DOI: http://dx.doi.org/10.1177/0017896908100448.	Thank you for bringing this paper to our attention. Although efforts were made by the review team to identify relevant forthcoming publications, this study was not identified in the search process, and its publication date falls outside of our search parameters. However, PHIAC I consider the findings of all of the reviews - and the economic modelling report – taking into account any quality or methodological issues, in drafting their recommendations. They also consider other sources of evidence, including testimony from experts working in policy, research and practice; consultation with stakeholders, and fieldwork with practitioners, children and policy makers. As this paper has been bought to our attention during the consultation on the evidence, it will be summarised and reported along with the other consultation responses.
Cardiff University		**Qualitative review**	Peer interventions	18-19	ASSIST: Suggest that two references to pupils being allowed to 'choose' peer supporters (from within their class) should be rephrased to ensure clarity of the method used. Students nominated individuals from	Thank you for your comment – the review team will amend their report in line with your suggestion.

Public Health Intervention Guidance

School-based interventions to prevent smoking - Consultation on the evidence – Stakeholder Response Table

1st May – 3rd June 2009

Stakeholder Organisation	Evidence submitted	Document Name/No.	Section	Page Number	Comments Please insert each new comment in a new row.	*Response* *Please respond to each comment*
					within their school year using a questionnaire which asked them to name individuals they respected, considered to be good leaders, and who they looked up to. They did not know the purpose of the questionnaire and therefore did not choose peer supporters for this task.	
Cardiff University		**Qualitative review**	Evidence tables	29	There is an inaccuracy in the reporting of the data used the Audrey et al, 2006 study. In addition to the participants reported here, questionnaire data were also gathered from all year 8 students in 30 intervention schools (Baseline = 5213; post-intervention =5086) and from peer supporters in 30 intervention schools (1st follow-up session = 759' 4th follow-up session=733)	Thank you for your comment – the review team will amend their report in line with your suggestion
Cardiff University		**Qualitative review**	Evidence tables	30	There is an inaccuracy in the reporting of the data used the Audrey et al, 2008 study. Data were collected from the following participants: Questionnaires completed by teachers in 30 intervention schools; Baseline semi-structured interviews conducted with 8 teachers in four intervention schools; Post-intervention semi-structured interviews conducted with 10 teachers in four intervention schools.	Thank you for your comment – the review team will amend their report in line with your suggestion
CfBT Educational Trust	KINN (2008) Smoke Alarm 08 Feedback Forms and Results. Available from www.kinn.org.uk				Please see attached evidence	Thank you for this information, which will be summarised and fed back to PHIAC in our report on the consultation on the evidence..

Public Health Intervention Guidance

School-based interventions to prevent smoking - Consultation on the evidence – Stakeholder Response Table

1st May – 3rd June 2009

Stakeholder Organisation	Evidence submitted	Document Name/No.	Section	Page Number	Comments Please insert each new comment in a new row.	*Response* *Please respond to each comment*
Hampshire PCT			4.3	6	We see guidance on these two questions as central and within this feel it important that we segment children and young people into some recognisable groupings so that we have clarity on what is most effective with different aged children. This appears particularly important when considering ownership of smoking prevention education by schools and their teachers, as there is anecdotal evidence/ comment from teachers that more work should be conducted on smoking education and awareness in primary education, as smoking uptake is getting increasingly more juvenile. This suggests that we need to bracket "what works" against either specific or universal groupings as appropriate.	Thank you for your comments.
Hampshire PCT	**Sex, Alcohol and Drugs Cheap Entertainment & Self-Medication**		4.3	6	Providing clear information and evidence regarding young people's attitudes to smoking and tobacco is important to demonstrate what it likely to be effective at reducing smoking uptake prevalence. Professor Mark	Thank you for these points, and for the reference.

Public Health Intervention Guidance

School-based interventions to prevent smoking - Consultation on the evidence – Stakeholder Response Table

1st May – 3rd June 2009

Stakeholder Organisation	Evidence submitted	Document Name/No.	Section	Page Number	Comments Please insert each new comment in a new row.	*Response* *Please respond to each comment*
	for Youths. Bellis et al, 2007, Downing & Bellis, m.a.bellis@ljmu.ac.uk Centre for Public Health Liverpool John Moores University				Bellis suggests that puberty onset is changing with modern higher-fat diets and these induce earlier risk-taking behaviours e.g. patterns of alcohol consumption and sexual activity are lowering accordingly.	
Hampshire PCT			General		We would like clear guidance and evidence that doesn't look at school-based smoking interventions in isolation, outside of other and related risk-taking behaviours? We would be interested to understand how effective innovative 'compelling learning' approaches to teaching and education can unite a series of behaviours/youth perspectives and effectively influence youth decision-making in ways that support healthier lives and positive outcomes etc.	Thank you for this interesting observation. Whilst we recognise that integrated – and innovative – approaches to health in schools may have great potential, the points you raise are outside the scope of this particular guidance. NICE welcomes suggestions for future guidance. Information on making a suggestion can be found at http://www.nice.org.uk/getinvolved/suggestatopic/suggest_a_topic.jsp
Hartlepool PCT			General		It is disappointing, but not surprising, that there is little in the way of conclusive evidence to guide practice. However, it is felt in Hartlepool that we should keep in line with the DFES guidance and within school continue to support the training of teachers as the main deliverer of tobacco/drug education with additional support from other professionals. The issue of effective practice coming from those who know what and how to deliver is clear in the NICE guidance and has implications for CPD which needs to be addressed. Using the DFES guidance it is clear that the training	Thank you .for your views on these important issues. We look forward to receiving your comments on the draft guidance.

Public Health Intervention Guidance

School-based interventions to prevent smoking - Consultation on the evidence – Stakeholder Response Table

1st May – 3rd June 2009

Stakeholder Organisation	Evidence submitted	Document Name/No.	Section	Page Number	Comments Please insert each new comment in a new row.	*Response* *Please respond to each comment*
					and lesson plan delivery needs to be based around interactive teaching and learning approaches and should form part of a spiral curriculum both within primary and secondary school. This could be more successful when PSHE becomes statutory across all key stages in the near future. There should also be awareness of the importance of linking any work undertaken to other strategies in the curriculum such as SEAL, SRE and personal safety but that specific content driven lessons are still delivered. The issue of parental influence, behaviour and engagement was highlighted – but getting parents 'through the door' to attend sessions is an ongoing challenge.	
Hartlepool PCT			General		Bearing in mind all of the above, it is felt that we should be continuing to seek an evidence base through a wide variety of approaches and interventions and sharing the results with others. There is much good work going on to find examples of good practice, particularly in the North East. As the results of this study confirm there is as yet, no conclusive evidence of practice to follow.	Thank you for your comments
Liverpool PCT (Smokefree Liverpool)		Qualitative review	General		Comprehensive review of available relevant evidence; identified themes would provide a useful framework for guidelines.	Thank you for your comments
Liverpool PCT (Smokefree Liverpool)		Qualitative review	General		Would welcome inclusion of further high quality UK based research prior to development of definitive guidance.	Unfortunately there is a lack of high quality UK-based studies, and the reviews have attempted to locate and use all those contemporary studies that do exist.
Liverpool PCT		Effectiveness Review	General		Appears to be a thorough investigation of current available evidence. Would welcome inclusion of further	See comment above

Public Health Intervention Guidance

School-based interventions to prevent smoking - Consultation on the evidence – Stakeholder Response Table

1st May – 3rd June 2009

Stakeholder Organisation	Evidence submitted	Document Name/No.	Section	Page Number	Comments Please insert each new comment in a new row.	*Response* *Please respond to each comment*
(Smokefree Liverpool)					high quality UK based research prior to development of definitive guidance.	
NHS Great Yarmouth and Waveney		Cost-effectiveness review	General		It is encouraging that people are looking at interventions aimed at working effectively with young people. We believe that a whole community approach combined with peer interventions have a positive effect, but would be interested in seeing a systematic model developed in the UK, and in looking at long-term effects.	Thank you for your comments and for raising the issue of 'whole community ' approaches. You may be interested to know that in addition to the cost-effectiveness review a bespoke model was developed to investigate the long term impact of school based prevention programmes. The draft report is available at http://www.nice.org.uk/guidance/index.jsp?action=download&o=44031. The final report, which will include additional analyses will be available when the guidance is published in 2010.
QUIT	QUIT Because (2009) Overall Feedback	General	General		QUIT would like to thank NICE for producing this guidance on school based prevention of the uptake of smoking in children.	Thank you..
QUIT		Qualitative research review	5. Findings	20	'Qualitative studies suggest that delivery by external professionals rather than teacher can be effective.' QUIT agrees with the above statement, as young people (and teachers) have consistently informed us that QUIT's own youth advisers deliver informative and effective prevention messages. (see attached feedback from young people gathered from 2006 – 2009)	Thank you for your comments, and the attached material.
QUIT		Qualitative research review	6. Discussion	24, 26	QUIT believes that young people should be involved in the design and planning of prevention interventions, whether or not the interventions are being delivered by	We look forward to receiving your comments on the draft guidance.

Stakeholder Organisation	Evidence submitted	Document Name/No.	Section	Page Number	Comments Please insert each new comment in a new row.	*Response* *Please respond to each comment*
					the young people. Including young people in the planning of the initiatives will be empowering for them and provide ownership and authenticity to the messages.	
QUIT		Qualitative research review	6. Discussion	25	'When pupils are from ethnic minority communities, the meaning, type and level of tobacco use in those communities should be considered and interventions should be culturally sensitive.' QUIT prevention messages often include discussion on shisha, as there is very little knowledge on the risks of its use among young people. However, we have found that the use of shisha is no longer restricted to ethnic minorities and it is worth discussing with most groups of young people, at least those based in urban areas. QUIT also feels that there is a weakness in health surveys when discussing smoking habits and that shisha must be addressed explicitly – young people to not see smoking shisha as a problem or think of it as 'smoking.'	Thank you for your comment. We recognise the need to ensure that all variations in smoking uptake (and practice) are considered, and in particular that we adequately address issues for black, minority and ethnic communities. Shisha is an important issue, but no studies including shisha use or prevention were identified. However, the review does include studies that emphasise the importance of developing culturally sensitive interventions and this is highlighted again in the discussion section.
QUIT		Qualitative research review	6. Discussion	25	QUIT agrees with the discussion that smoking amongst teachers acts as a barrier to delivery of school-based interventions. QUIT's own efforts to deliver school interventions have been hampered by smoking teachers. In addition, non-smoking teachers have informed QUIT that their efforts to achieve 'Healthy School' status have been blocked by smoking teachers. Comprehensive smokefree school policies need to be implemented for school-based interventions to be effective.	Thank you. Your comment supports the findings of the qualitative review.

Public Health Intervention Guidance

School-based interventions to prevent smoking - Consultation on the evidence – Stakeholder Response Table

1st May – 3rd June 2009

Stakeholder Organisation	Evidence submitted	Document Name/No.	Section	Page Number	Comments Please insert each new comment in a new row.	*Response* *Please respond to each comment*
QUIT		Effectiveness review	General		Since there is no clear evidence as to who should deliver prevention messages (peers, teachers, outside experts, etc.) or as to which type of intervention is most effective, the Department of Health should conduct its own trials of existing prevention programmes in the UK to determine their efficacy. QUIT's youth prevention programme has been running since 1994, using our own advisors to deliver prevention messages to young people. Given the opportunity, QUIT would welcome an external, independent evaluation of our services.	The guidance will be making a number of research recommendations, and we hope that these will help spur research in the UK, and address some of the issues that you raise.
QUIT		Cost-effectiveness review	General		Since it is not clear if the cost-effectiveness demonstrated by the studies reviewed would be applicable in the UK, the Department of Health should conduct its own trials of existing prevention programmes in the UK to determine their cost-effectiveness. QUIT's youth prevention programme has been running since 1994. Given the opportunity, QUIT would welcome an external, independent evaluation of our services.	Thank you for your comments. Due to the limited evidence available, bespoke modelling was undertaken to determine the cost effectiveness of schools' based prevention programmes. Several models were tested and most of the analyses suggest these programmes are cost-effective. The draft report is available at; http://www.nice.org.uk/guidance/index.jsp?action=download&o=44031. The final report, which will include additional analyses will be available when the guidance is published in 2010.
QUIT		Cost-effectiveness model	Chapter 2 Discussion	21	'Our analysis suggests that smoking prevention initiatives among children and teenagers could have substantial benefit even if their effect is simply to delay the onset of smoking without achieving an overall reduction in the number of participants initiating smoking.' Acknowledging that delaying smoking (in lieu of initiation) is also beneficial is incredibly useful to	Thank you for your comments. The modelling report referred to above included several models to test different assumptions about whether smoking actually decreases onset of smoking in the long term or simply delays the onset of smoking. Most of the analyses suggest these programmes are cost-effective.

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					delivering prevention programmes. QUIT has asserted through our work with young people that delay in smoking uptake is a viable outcome of prevention work.	
Royal College of Nursing			General		The RCN welcomes this document it is comprehensive. The RCN supports proposals to develop this public health intervention guidance. The proposed guidance should include strategies for making resources available to commissioners to make this a priority so they can commission sufficient school nurses to undertake this work and give them a stronger rationale for becoming more involved.	Thank you for your comments. We recognise that resources are an issue for implementing guidance, and NICE routinely publishes sets of implementation tools (including a costing tools) to support public health guidance.
Royal College of Physicians		All	General		These are thorough and definitive reviews, and we commend the authors for synthesising and summarising such disparate evidence. That the reports are unable to reach definitive conclusions on many of the questions posed simply reflects the difficulty of research in this area, and consequent quality of the evidence. The size, cost and time involved in researching this area are all substantial, so progress is inevitably slow and expensive. It is therefore important the research agenda is now carefully targeted towards the needs arising from these reviews.	Thank you for making these observations. The final guidance will include a section that identifies gaps in the evidence. Moreover, PHIAC will make research recommendations to address some of the more glaring gaps in published literature.
Royal College of Physicians		Evidence review (and all)	General		The review demonstrates that evidence in this area is extensive but inconclusive. However there are areas in which conclusions of effectiveness can be made, sufficient to permit the development of some guidance on what school-based interventions should contain. Given the resource implications of research in this area, and the consequence that research progress is slow and very expensive, we would argue that it is now important to define a basic framework for UK	Thank you for this. PHIAC will consider other sources of information, such as expert testimony, when it develops the guidance. We look forward to receiving your comments on the draft guidance.

Public Health Intervention Guidance

School-based interventions to prevent smoking - Consultation on the evidence – Stakeholder Response Table

1st May – 3rd June 2009

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					interventions based on the available evidence summarised herein, and implement this in conjunction with appropriate evaluation and to build in opportunities to research individual refinements or alternative components in the process of this implementation.	
Teenage Cancer Trust		Effectiveness data	General		Teenage Cancer Trust shares the concern that available effectiveness data dates back to the 1980s and 1990s. More recent research reflecting any shifts in attitudes since the 2007 smoking ban would be welcome.	We anticipate that it may take a little longer for post-2007 evidence to be published in the research literature. NICE public health guidance is routinely reviewed three years after publication. If there have been significant studies published that may alter the guidance, then it may be updated.
Teenage Cancer Trust			General		Teenage Cancer Trust would like to see any schools related activity considered within the context of an integrated campaign that also targets adults and communities, so the message is reinforced outside of the classroom.	We look forward to receiving your comments on the draft guidance.
Teenage Cancer Trust		Review of research		27	Teenage Cancer Trust is concerned about a lack of data from the UK and a reliance on information from US studies. Although attention to cultural sensitivities is recognised as a requirement, Teenage Cancer Trust would like to highlight the need to consider: - Inner city schools versus rural and town based schools. - North and South divide - Social and cultural variances.	We agree – the lack of UK based studies means that the literature must be interpreted cautiously. In addition, PHIAC will consider other information, such as expert testimony and consultation on the draft guidance with stakeholder, professionals and practitioners.
West Midlands Public Health Group		Cost effectiveness review	4. Discussion	76	I believe it is a spelling error: “Only medical costs...expenses covered by private insurance **than** are not considered...” Should be that (?)	Thank you for bringing this to our attention, the review team will amend their report.

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West Midlands Public Health Group		Qualitative review	1.f	20	Grammatical error: "There is moderate evidence that **the**(delete THE) race ..."	Thank you for bringing this to our attention, the review team will amend their report.
West Midlands Public Health Group		General	General		As the lead for the West Midlands regional youth and tobacco group I am very pleased to see this guidance being produced. Experienced with US based youth prevention strategies as well as youth advocacy I understand that they vary in effectiveness and may not translate well to the UK. Once this guidance is publicly available then it will provide a wonderful starting point from which our regional group and others as well, may help to ensure another spoke to an effective and cost effective comprehensive tobacco control plan.	Thank you for your comments.