Working Paper 73

Evaluation of European Adolescent Smoking Cessation Pilot Programme Report for the Welsh Assembly Government

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This report presents evaluation findings from the first year of the European programme in 2004.
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Mae CISHE yn gwneud ymchwil rhyngddisgyblaethol sy'n arloesol o ran ei methodoleg. Mae hefyd yn cydlynu'r ymchwil honno, gyda chyfraniad cryf o'r gwyddorau cymdeithasol ac ym meysydd perthynol biofeddygaeth, gwasanaethau iechyd, iechyd cyhoeddus a biofoeseg. Rydym yn gwneud ymchwil o'r radd flaenaf yn rhyngwladol ac yn ei hyrwyddo, gan roi pwyslais ar fynd i'r afael ag anghydraddoldebau iechyd a sicrhau bod ein hymchwil yn cael effaith ar bolisi ac ymarfer yng Nghymru a thu hwnt.

Abstract: Smoking cessation is well documented to be a clinically effective and cost effective health care intervention for adults. However, there has been limited research about whether the provision of smoking cessation services would be as appropriate for the adolescent age group, given the differences in their smoking behaviour and attitude.

Following pilot adolescent smoking cessation schemes in Denmark, the Netherlands and Wales, the Welsh Assembly Government led the development of further pilot projects in: Belgium; Denmark; Greece; the Netherlands; Portugal; the Slovak Republic; Spain and Wales. Most projects delivered school-based weekly cessation sessions over a six to eight week period focussing on 16 to 18 year olds. However, there was variation in the approach adopted and in the contexts in which projects operated.

Researchers from the Cardiff Institute of Society, Health and Ethics (CISHE) were appointed to evaluate the EU funded pilot programme focussing on a process evaluation of how the programme was implemented, delivered and supported in three case study countries. This report includes key lessons about what works in terms of setting up and implementing projects with a particular focus on adapting smoking cessation activities for adults to the different and changing needs of adolescents.

Keywords: smoking; cessation; adolescents; process evaluation.

Contents

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Executive summary

Introduction

1. Following the results of literature reviews from the Netherlands and Wales, and pilot schemes in Denmark, Netherlands and Wales, the Welsh Assembly Government led the development of a proposal to implement further adolescent smoking cessation pilot projects in the following countries: Belgium; Denmark; Greece; Netherlands; Portugal; Slovak Republic; Spain and Wales. The target age group for these interventions was 12-20 year olds and project activities needed to be complete by November 2004. In 2004 the EC agreed to fund the programme for another 12 months until December 2005. Two other countries, Italy and Romania, will also participate in the second year of the programme.

2. The programme is being co-ordinated by the Health Promotion Division, Welsh Assembly Government and they appointed researchers at the Cardiff Institute of Society, Health and Ethics (CISHE), at Cardiff University, to evaluate the pilot programme. This includes a process evaluation drawing on case studies in the Netherlands, Portugal and Wales (the Cardiff project) to provide an in-depth insight into project set up and implementation. In addition, a minimum data set has been designed to collect comparable outcome data across the pilot programme.

Setting up the programme

3. Generally, project managers cited benefits of being part of the wider European programme especially in terms of learning points which they could apply to their own project. There was scope for new insights for projects at the early stage of their development and for those that were more established. However, partners recognised that countries had different designs, materials and approaches and valued the flexibility to develop their own approach in the context of their own countries.

4. Regarding the accessibility of EC funding, projects noted that it was not helpful to delay the receipt of funds until after project completion. This was coupled with concerns about the overall short timescale for setting up and delivering projects especially given the time needed to forge networks and engage partners and adolescents.

5. Projects were working in a variety of contexts including variation in: tobacco control policy; the culture of smoking amongst adolescents and the availability of pharmacological support. Available support structures also varied between countries and within countries with different levels of enthusiasm from central and local governments.

6. Building up networks within schools and other delivery settings was seen as time well invested with partnerships being crucial for successful implementation. As part of setting up the projects, partners also considered plans for monitoring and evaluation and a number of projects were planning longer term follow-up surveys with participants.

Project activities

7. Most projects were targeting 16 to 18 year olds although some focussed on younger and/or older age groups. Smoking status also varied across the programme with some projects targeting regular and occasional smokers while others had a narrower focus selecting only those smokers who were at the 'right' stage of motivation to quit. Typically projects were based on a model of six cessation sessions, usually in school settings during lesson time or outside school hours. Projects adopted a range of intervention strategies including providing an experience of a quit attempt, preparing to quit, and dealing with withdrawal symptoms.

8. In addition to cessation sessions, projects also facilitated a range of other support activities including: information meetings for teachers about school smoking policies; cessation courses for teachers; information meetings for students and up-dates on teaching materials available. Also, two projects (Spain and Denmark) devised self-help computer programmes and internet based resources to supplement face-to-face cessation support.

9. Throughout the process evaluation project partners emphasised the importance of the facilitators in initial recruitment and running the course. A combination of smoking cessation expertise, an ability to work with adolescents in a group setting together with an empathy with the adolescents' social environments were seen as key prerequisites of a successful facilitator.

10. Most projects reported that recruitment was a challenging issue and several experienced problems recruiting the numbers anticipated. Projects were creative about recruitment strategies, which included initial information sessions and incentives to try and encourage attendance. Overall, project managers stressed the importance of the recruitment phase of the programme and advocated investing time in this.

Outputs and outcomes

11. Output and outcome data are based on the minimum data sets received from six of the eight countries by mid-January, 2005. The minimum data sets provide a useful indicator of the key trends in the outcome data. However, limitations of the minimum data sets mean that findings should be interpreted with caution. Overall enrolment numbers were not as high as anticipated, mainly because not all settings participated and in some cases there was considerable change in the approach adopted. A range of other project outputs were reported including training for facilitators, the development of materials and other cessation support such as internet based services.

12. In terms of smoking behaviour outcomes, in three countries at least 50% of participants made a quit attempt at some point during the project and the majority said that the project was an important factor in doing so. Projects reported positive results relating to participants' awareness of smoking and cessation, with a slightly less positive result in terms of awareness about where to go for help about quitting, reflecting the limited availability of support for adolescents outside this programme. Motivation levels were also assessed and overall, the majority of respondents said that the project had made them more determined to quit, cut down or stay smoke free. Most respondents who were still smoking at the end of the project reported that they were looking to quit at some point in the future.

13. Feedback from project managers, partners and adolescents suggests that something else is needed to sustain these outcomes beyond the end of the cessation course. Further consideration needs to be given to the nature of the follow-up support and how this can be tailored to the needs of adolescents.

Conclusions

14. The pilot programme has tested out different approaches for adolescents and to date the evaluation has highlighted learning points in relation to setting up and delivering cessation interventions for this group. The context for adolescent smoking and the challenges faced in cessation varies between and within countries but there are generic learning points which the evaluation has highlighted.

15. By January 2005, all eight countries had attempted to establish adolescent smoking cessation provision although some countries had progressed further than others. The infancy of adolescent smoking cessation contributed to the difficulties that some

countries encountered, and the pilot projects were not strongly embedded within broader tobacco control strategies.

16. Smoking behaviour outcomes were encouraging and awareness and motivation outcomes were positive. Building capacity in adolescent smoking cessation amongst practitioners was also an important outcome.

17. Establishing successful smoking cessation interventions for adolescents requires the establishment of multi-layered networks of support at the strategic level and within delivery settings. Addressing wider school smoking issues and involving staff, parents and students in a network of support was seen as crucial.

18. The pilot programme provided useful insights into what works in delivering adolescent smoking cessation and there is a growing recognition that approaches that may work well with adults need to be adapted to take account of the fluctuating needs of this groups – in terms of cigarette consumption, motivation and wider social needs. This has implications at the front-end of cessation interventions in terms of spending time recruiting those at the right stage of motivation, and also at the back-end in terms of providing more structured follow-up support over a longer period.

19. Gaining support from partner organisations, investing time in recruitment and providing longer-term support all appear to be important in maximising the effectiveness of adolescent smoking cessation services. However, it may prove difficult to address these issues without increasing resources available for these services.

Crynodeb Gweithredol

Cyflwyniad

1. Yn dilyn canlyniadau ystyried llenyddiaeth o'r Iseldiroedd a Chymru, a chynlluniau peilot yn Nenmarc, yr Iseldiroedd a Chymru, arweiniodd Llywodraeth Cynulliad Cymru waith i ddatblygu cynnig i roi prosiectau peilot pellach ar waith ar helpu'r glasoed i roi'r gorau i ysmygu yn y gwledydd canlynol: Gwlad Belg; Denmarc; Groeg; yr Iseldiroedd; Portiwgal; Gweriniaeth Slovacia; Sbaen a Chymru. Y grŵp oedran a dargedwyd ar gyfer yr ymyriadau hyn oedd pobl 12-20 oed ac roedd angen i weithgareddau'r prosiect fod wedi'u cwblhau erbyn Tachwedd 2004. Yn 2004 cytunodd y GE i gyllido'r rhaglen am 12 mis arall tan fis Rhagfyr 2005. Bydd dwy wlad arall, yr Eidal a Rwmania, hefyd yn cymryd rhan yn ail flwyddyn y rhaglen.

2. Mae'r rhaglen yn cael ei chydgysylltu gan Is-adran Hybu Iechyd Llywodraeth Cynulliad Cymru a phenodwyd ymchwilwyr ganddynt yn Sefydliad Cymdeithas, Iechyd a Moeseg Caerdydd (CISHE), ym Mhrifysgol Caerdydd, i gloriannu'r rhaglen beilot. Mae hyn yn cynnwys gwerthusiad proses yn tynnu ar astudiaethau achos yn yr Iseldiroedd, Portiwgal a Chymru (prosiect Caerdydd) er mwyn cael dealltwriaeth fanwl o sefydlu prosiect a'i roi ar waith. At hynny, lluniwyd set ddata sylfaenol i gasglu data canlyniadau cymaradwy ar draws y rhaglen beilot.

Sefydlu'r rhaglen

3. At ei gilydd, roedd rheolwyr prosiectau'n sôn am fanteision bod yn rhan o'r rhaglen Ewropeaidd ehangach, yn enwedig o ran y pwyntiau dysgu y gallent eu cymhwyso i'w prosiectau eu hunain. Roedd cyfle i ennill dealltwriaeth newydd yn achos prosiectau yng ngham cynnar eu datblygiad a phrosiectau a oedd wedi eu sefydlu ers mwy o amser. Ond roedd partneriaid yn sylweddoli bod gan wledydd wahanol ddyluniadau, deunyddiau a dulliau ac roeddent yn gwerthfawrogi'r hyblygrwydd i ddatblygu eu dull eu hunain yng nghyd-destun eu gwledydd eu hunain.

4. O ran pa mor hawdd oedd cael at gyllid y GE, nododd prosiectau nad oedd oedi cyn derbyn cyllid hyd nes byddai prosiect wedi ei gwblhau o gymorth. Ynghyd â hyn roedd pryderon ynghylch yr amserlen fer gyffredinol ar gyfer sefydlu a chyflwyno prosiectau, yn enwedig o gofio'r amser yr oedd ei angen i ffurfio rhwydweithiau a chael partneriaid a phobl ifanc i gymryd rhan.

5. Roedd prosiectau'n gweithio mewn amryfal gyd-destunau gan gynnwys amrywiaeth mewn: polisïau rheoli tybaco; diwylliant ysmygu ymhlith y glasoed a'r cymorth ffarmacolegol a oedd ar gael. Roedd y strwythurau cymorth a oedd ar gael hefyd yn amrywio rhwng gwledydd ac o fewn gwledydd gyda lefelau gwahanol o frwdfrydedd gan lywodraethau canolog a lleol.

6. Roedd meithrin rhwydweithiau o fewn ysgolion a mannau cyflwyno eraill yn cael ei ystyried yn fuddsoddiad da o ran amser gyda phartneriaethau'n hanfodol er mwyn gweithredu'n llwyddiannus. Fel rhan o sefydlu'r prosiectau, bu partneriaid hefyd yn ystyried cynlluniau ar gyfer monitro a gwerthuso ac roedd nifer o brosiectau'n cynllunio arolygon dilynol mwy hirdymor gyda chyfranogwyr.

Gweithgareddau'r Prosiect

7. Roedd y rhan fwyaf o brosiectau'n targedu pobl ifanc 16 i 18 oed er bod rhai'n canolbwyntio ar grwpiau oedran iau a/neu hŷn. Roedd statws ysmygu hefyd yn amrywio ar draws y rhaglen gyda rhai prosiectau'n targedu ysmygwyr rheolaidd ac achlysurol tra bod eraill yn fwy penodol ac yn dethol dim ond yr ysmygwyr hynny a oedd yn y cam cymhelliant 'cywir' o ran rhoi'r gorau iddi. Roedd prosiectau at ei gilydd wedi eu seilio ar fodel o chwe sesiwn rhoi'r gorau i ysmygu, fel rheol mewn sefyllfa ysgol yn ystod amser gwersi neu y tu allan i oriau ysgol. Mabwysiadodd y prosiectau amryfal strategaethau ymyrryd, gan gynnwys darparu profiad o ymgais i roi'r gorau iddi, paratoi i roi'r gorau iddi, ac ymdrin â symptomau diddyfnu.

8. Yn ogystal â sesiynau rhoi'r gorau i ysmygu, bu prosiectau hefyd yn hwyluso amrywiaeth o weithgareddau cefnogi eraill gan gynnwys: cyfarfodydd gwybodaeth i athrawon ynghylch polisïau ysmygu ysgolion; cyrsiau rhoi'r gorau i ysmygu ar gyfer athrawon; cyfarfodydd gwybodaeth i fyfyrwyr a gwybodaeth ddiweddar am ddeunyddiau addysgu a oedd ar gael. Yn ogystal â hynny, dyfeisiodd dau brosiect (Sbaen a Denmarc) raglenni hunangymorth cyfrifiadurol ac adnoddau rhyngrwyd i ategu'r cymorth wyneb-yn-wyneb i roi'r gorau i ysmygu.

9. Gydol y prosiect gwerthuso proses, roedd y partneriaid yn tanlinellu pwysigrwydd yr hwyluswyr yn y gwaith recriwtio cychwynnol a'r gwaith o redeg y cwrs. Roedd cyfuniad o arbenigedd ar roi'r gorau i ysmygu, gallu i weithio gyda'r glasoed mewn sefyllfa grŵp ynghyd ag empathi ag amgylcheddau cymdeithasol y glasoed yn cael eu hystyried yn hanfodol i hwylusydd llwyddiannus.

10. Adroddodd y rhan fwyaf o brosiectau fod recriwtio yn her a chafodd sawl prosiect anhawster i recriwtio'r niferoedd a ragwelwyd. Roedd prosiectau'n greadigol ynghylch strategaethau recriwtio, a oedd yn cynnwys sesiynau gwybodaeth cychwynnol ac anogaethau i geisio sicrhau presenoldeb. At ei gilydd, tanlinellodd rheolwyr

prosiectau bwysigrwydd cam recriwtio'r rhaglen ac roeddent yn argymell buddsoddi amser yn hynny.

Cynnyrch a chanlyniadau

11. Seilir data cynnyrch a chanlyniadau ar y setiau data sylfaenol a dderbyniwyd oddi wrth chwech o'r wyth gwlad erbyn canol Ionawr, 2005. Mae'r setiau data sylfaenol yn ddangosyddion defnyddiol o ran y tueddiadau allweddol yn y data canlyniadau. Ond mae cyfyngiadau i'r setiau data sylfaenol sy'n golygu y dylid bod yn ofalus wrth ddehongli eu canfyddiadau. Nid oedd y rhifau ymrestru cyffredinol cyn uched ag y rhagwelwyd, yn bennaf gan na chymerodd pob lleoliad ran, ac mewn rhai achosion bu cryn newid yn y dull a ddefnyddiwyd. Nodwyd amrywiaeth o ganlyniadau eraill i'r prosiectau gan gynnwys hyfforddiant i hwyluswyr, datblygu deunyddiau a chymorth arall i roi'r gorau iddi, fel gwasanaethau rhyngrwyd.

12. O ran canlyniadau yn ymwneud ag ymddygiad ysmygu, mewn tair gwlad ceisiodd o leiaf 50% o'r cyfranogwyr roi'r gorau iddi ar ryw adeg yn ystod y prosiect a dywedodd y mwyafrif ohonynt fod y prosiect yn ffactor pwysig yn hynny o beth. Rhoddodd prosiectau wybod am ganlyniadau cadarnhaol yn ymwneud ag ymwybyddiaeth cyfranogwyr o ysmygu a rhoi'r gorau iddi, gyda chanlyniad ychydig yn llai cadarnhaol o ran gwybod ble i fynd am help i roi'r gorau iddi, sy'n adlewyrchu prinder y cymorth sydd ar gael i'r glasoed y tu allan i'r rhaglen hon. Aseswyd lefelau cymhelliant hefyd, ac at ei gilydd dywedodd y mwyafrif o'r ymatebwyr fod y prosiect wedi eu gwneud yn fwy penderfynol o roi'r gorau i ysmygu, ysmygu llai neu aros yn ddi-fwg. Dywedodd y rhan fwyaf o'r ymatebwyr a oedd yn dal i ysmygu ar ddiwedd y prosiect eu bod yn bwriadu rhoi'r gorau iddi ar ryw adeg yn y dyfodol.

13. Mae adborth gan reolwyr prosiectau, partneriaid a'r glasoed yn awgrymu bod angen rhywbeth arall i gynnal y canlyniadau hyn y tu hwnt i ddiwedd y cwrs rhoi'r gorau i ysmygu. Mae angen ystyriaeth bellach i natur y cymorth dilynol a sut y gellir teilwrio hyn i weddu i anghenion y glasoed.

Casgliadau

14. Mae'r rhaglen beilot wedi profi gwahanol ddulliau ar gyfer y glasoed a hyd yma mae'r gwerthusiad wedi tanlinellu pwyntiau dysgu mewn perthynas â sefydlu a chyflwyno ymyriadau rhoi'r gorau i ysmygu ar gyfer y grŵp hwn. Mae cyd-destun ysmygu gan y glasoed a'r heriau a wynebir wrth roi'r gorau iddi yn amrywio o wlad i wlad ac o fewn gwledydd ond mae'r gwerthusiad wedi tanlinellu pwyntiau dysgu generig.

15. Erbyn Ionawr 2005, roedd pob un o'r wyth gwlad wedi ceisio sefydlu darpariaeth i helpu'r glasoed i roi'r gorau i ysmygu er bod rhai gwledydd wedi mynd ymhellach nag eraill. Roedd y ffaith bod rhoi'r gorau i ysmygu yn ei fabandod yn cyfrannu at yr anawsterau a gafodd rhai gwledydd, ac nid oedd y prosiectau peilot wedi gwreiddio'n gadarn o fewn strategaethau rheoli tybaco ehangach.

16. Roedd canlyniadau o ran ymddygiad ysmygu yn galonogol a chanlyniadau o ran ymwybyddiaeth a chymhelliant yn gadarnhaol. Roedd meithrin gallu ymarferwyr i helpu'r glasoed i roi'r gorau i ysmygu hefyd yn ganlyniad pwysig.

17. Mae sefydlu ymyriadau llwyddiannus i helpu'r glasoed i roi'r gorau i ysmygu yn galw am sefydlu rhwydweithiau cymorth aml-haen ar y lefel strategol ac yn y mannau cyflwyno. Roedd mynd i'r afael â materion ehangach yn ymwneud ag ysmygu mewn ysgolion, a chynnwys staff, rhieni a myfyrwyr mewn rhwydwaith o gefnogaeth, yn cael eu hystyried yn allweddol.

18. Bu'r rhaglen beilot yn ffordd ddefnyddiol o weld beth sy'n gweithio o ran helpu'r glasoed i roi'r gorau i ysmygu, ac mae pobl yn sylweddoli fwyfwy bod angen addasu dulliau a all fod yn gweithio'n dda gydag oedolion er mwyn ystyried anghenion newidiol y grŵp hwn – o ran nifer y sigaréts a ysmygir, cymhelliant ac anghenion cymdeithasol ehangach. Mae goblygiadau i hyn ym mhen blaen ymyriadau rhoi'r gorau i ysmygu o ran treulio amser yn recriwtio'r bobl sy'n aeddfed eu cymhelliant, a hefyd yn y pen arall o ran darparu cymorth dilynol mwy strwythuredig dros gyfnod hwy.

19. Ymddengys fod cael cymorth gan sefydliadau sy'n bartneriaid, buddsoddi amser mewn recriwtio a rhoi cymorth mwy hirdymor i gyd yn bwysig er mwyn cynyddu effeithiolrwydd gwasanaethau sy'n helpu'r glasoed i roi'r gorau i ysmygu. Gall, fodd bynnag, fod yn anodd mynd i'r afael â'r materion hyn heb gynyddu'r adnoddau sydd ar gael ar gyfer y gwasanaethau hyn.

Cyfieithwyd gan Glenys Roberts/Araul ar ran Llywodraeth Cynulliad Cymru.

1   Introduction

Background to the adolescent smoking cessation programme

1.1   Following the results of literature reviews from the Netherlands and Wales, and pilot schemes in Denmark, the Netherlands and Wales, the Welsh Assembly Government led the development of a proposal to implement a series of pilot projects in the following countries: Belgium; Denmark; Greece; the Netherlands; Portugal; the Slovak Republic; Spain and Wales. The programme was supported by ENYPAT (European Network on Young People and Tobacco).

1.2   The pilot programme was awarded funding by the European Commission (EC) for one year in the first instance. The broad aim of the programme was to develop smoking cessation projects in eight European countries based on best available evidence and, following evaluation, produce a report providing key findings and recommendations for effective practice. The programme also aimed to promote a co-ordinated way of developing cessation projects, building on the experiences of participating countries, which have to date predominantly worked in an ad hoc and isolated manner.

1.3   The EC proposal set out four key work activities:

- To review and disseminate good practice in relation to adolescent smoking cessation in a number of countries

- To establish a set of common objectives, methods and evaluation frameworks for use in each participating country

- To implement pilot projects in each country

- To provide evaluation support for pilot projects and an overarching evaluation across the participating countries, with the final report outlining key findings and recommendations for future practice.

1.4   Following an initial planning workshop each of the participating countries developed a pilot programme of cessation activities. The programme in Wales incorporated seven individual cessation projects across Wales, co-ordinated by the Welsh Assembly Government. The target age group for these interventions was 12-20 year olds and project activities aimed to be completed by November 2004.

1.5   In 2004 the EC agreed to fund the programme for another 12 months until December 2005. All eight countries were asked to produce outline proposals of work to be undertaken over the additional 12 months. Two other countries, Italy and Romania, will also participate in the second year of the programme.

The evaluation

1.6   Researchers at the Cardiff Institute of Society, Health and Ethics, (CISHE), were appointed to evaluate the pilot projects, co-ordinated by the Health Promotion Division of the Welsh Assembly Government. The evaluation was commissioned in May 2004 and will continue until the end of 2005, in line with the programme extension. The evaluation was jointly funded by the EC and the Welsh Assembly Government.

1.7   The broad aim of this study was to 'assist in the development of an evaluation framework to be used by each of the eight participating countries in the project, including advice on data to be collected, to provide limited ongoing evaluation support to each of the eight partners and to undertake an overarching evaluation of the projects' success. Given that the projects are pilots, the evaluation will be required to examine how they operate in each country and to identify common themes to emerge, with a view to improving the potential effectiveness of such projects across Europe.'

1.8   The specific objectives of the evaluation were as follows:

- To identify a minimum set of data that projects should use to conduct their country level evaluations

- To review the proposed country level evaluation plans and to offer limited remote support

- To undertake more detailed process evaluation in a small number of countries

- To provide a critique of the approaches undertaken by projects, identifying strengths and weaknesses

- To explore the potential for incorporating economic evaluation techniques into the overarching evaluation.

1.9   In response to the invitation to tender the evaluation work programme incorporated a combination of outcome data (collected by projects through self-evaluation) together with process data (collected through the overall evaluation). Given the pilot nature of the projects and the diversity of approaches and contexts across the eight participating countries it was important to emphasise the value of the process evaluation. Key elements of the evaluation are presented below.

Initial planning workshop

1.10   The initial planning workshop was hosted by the Welsh Assembly Government in Cardiff, Wales, in May 2004. This was an important first step in the evaluation as it was the first chance for the evaluation team to have face-to-face contact with the project partners from the participating countries. The workshop included dedicated time for guidance on monitoring and evaluation and this was used by the evaluation team to introduce the concept of the minimum data set (see below) and scope feasibility of outcome measures with the European partners. At the end of the workshop all partners were asked to complete a task sheet detailing the context in which they were working, their aims and objectives, their anticipated activities, outputs, outcomes, impacts and their plans for monitoring and evaluation. Task sheets were reviewed by the evaluation team to gain an insight into project plans and evaluation plans, and to help decide how best to take the evaluation forward.

Minimum data set (MDS)

1.11   In order to ensure that comparable data were collected across the pilot programme the evaluation team was asked to design a minimum set of data to be used by all countries. These were very much the *minimum* data that countries were expected to collect and did not restrict other evaluation measures they intended to put in place. A revised version of the minimum data set was produced following initial comments from project managers.

1.12   The minimum data set included a set of questionnaires to be used with young people, facilitators and project managers involved in the intervention. The intention was for project managers to collate the responses into one minimum data set document which would be

submitted electronically to the evaluation team. Six countries submitted minimum data sets by the mid-January deadline and these have been incorporated into this report. It should be noted that the minimum data set from Wales included data from five out of seven projects across the country. The two remaining countries were not in a position to submit data by the deadline as their cessation activities were still continuing and country-wide data had not been collated. The six minimum data sets received by the deadline had data limitations. In some cases only baseline data were included as follow-up data had not been collected or collated. Other data limitations included slight variations in question wording between those set out in the minimum data set and those used by the partner countries. This was due to translation issues as well as some questionnaires being developed before the minimum data set was issued. Minimum data sets that were not available for this report, will feed into the final report for the EC.

Process evaluation

1.13   A review of all project implementation plans and task sheets completed at the initial planning workshop was used to select three case study countries, to include Wales, as requested by the Welsh Assembly Government. The aim of the selection was to include a range of countries in terms of their approaches to adolescent smoking cessation, the age of the target group, and also to try and identify countries where the evaluation would successfully demonstrate good practice and generate learning points which could be applied elsewhere. Weighing up the selection criteria it was agreed that projects in the Netherlands, Portugal and Wales (the Cardiff project) would be the focus of the case study work.

1.14   The case study countries were contacted regarding their involvement, with the emphasis on keeping disruption to projects at a minimum. Initially a telephone interview was conducted with the project manager before they embarked on project implementation. This provided a chance to investigate project plans and expectations at an early stage. This initial telephone interview was followed up with a visit to the case study projects during the implementation phase (September to November 2004). During the visits face to face interviews were conducted with the project manager and implementation team plus a number of key partners. In addition, one-to-one or small group discussions with participants were organised wherever possible. This provided a good opportunity to gain an insight into the young people's perspective first hand.

1.15   In the remaining five countries not selected for the detailed process evaluation, baseline and follow-up telephone interview were conducted with the main country lead. This provided an overview of the activities being undertaken in these five countries, a description of the

settings and types of cessation activities adopted as well as an insight into key lessons learnt so far.

Feedback workshop

1.16   The Welsh Assembly Government hosted a feedback workshop in Cowbridge, Wales, in December 2004. The aim of this conference was to feed back progress to date and all participating countries presented activities undertaken so far. This also provided an opportunity for the evaluation team to present initial findings and outline plans for the remaining evaluation tasks. Small breakout groups facilitated discussion about key issues arising and the additional data gathered through this exercise have been drawn on throughout this report.

Outline of this report

1.17   This report documents progress by the projects and charts the key evaluation findings. This includes data from all four sources described above. Throughout the report, examples have been drawn from projects to highlight key points. Chapter two focuses on issues arising with the setting up of the pilot programme and chapter three provides a more in-depth discussion of the range of interventions being undertaken to date. Outputs and outcomes are presented and discussed in chapter four and the final chapter draws some preliminary conclusions.

2   Setting up the programme

Being part of the European programme

2.1   One key area covered by the baseline interviews with all project managers was their experiences of being part of the wider European programme. Did they feel that their project benefited from being part of this wider network, and was there any scope for making more of the network with other partners? Generally, project managers cited benefits of their involvement in this wider programme, especially in terms of learning points which they could apply to their own project. There was scope for new insights for projects at the early stage of their development (those that were experimenting with adolescent smoking cessation for the first time) and for those that were more established (those that had undertaken some formative work on adolescent smoking cessation including previous pilots). This was endorsed by feedback from the minimum data set where project managers were asked about European support as one factor affecting delivery. The responses indicate that countries trying out adolescent smoking cessation for the first time welcomed the support while for other countries, especially those that were further established in terms of adolescent smoking cessation work, it was less important.

• One project partner noted the benefits of receiving a fresh perspective on a more established project: *"It's also useful to have feedback from other people on what you are doing because they look at it cold or with fresh eyes so they can often come up with something that maybe you probably hadn't thought of. So one of the comments we had about our scheme was that it seems to be targeting youngsters from areas of high levels of socio-economic deprivation and youngsters that had low levels of educational achievement. Now, to my mind that seems a very obvious place to target this kind of intervention because we know that smoking prevalence is higher amongst those groups but obviously from their perspective they thought that this was quite an interesting take on it, that we targeted in that way. So some of that was useful, to have that feedback, to take a step back and say ok, there is another way of looking at this."*

• A project partner from a less established project also commented on the benefits of sharing experiences through the wider programme: *"I was also working on another project which was not EU wide and this gives you a lot of benefit because when you go to the conference you can meet other countries, other partners and they can tell you their experiences and you can take that into account for your own project in your own country, and that's very important."*

2.2   There was evidence that some of the networking initiated at the planning workshop in Cardiff had been continued, with some countries looking to others for particular resources or expertise. For example, in Belgium links had been made with Denmark and also the Belgian co-ordinator visited a project facilitator in the Netherlands in order to find out more about their approach and materials.

2.3   The issue of building networks across the programme was debated at the feedback workshop and the main feeling was that although the face-to-face opportunities created by the workshops were helpful, especially in relation to debates about the theory and approach to adolescent smoking cessation, it was recognised that countries had different designs, materials and approaches and valued the flexibility to develop their own approach in the context of their own countries. Less established projects, which had limited previous experience in delivering adolescent smoking cessation would benefit from greater support and guidance from across the programme, especially on issues such as recruitment strategies and adolescent-friendly materials. One suggestion was that this forum could be incorporated into the existing ENYPAT network and the Globalink[1] email forum was highlighted as a good model for sharing experiences.

2.4   The accessibility of European funding was another problem which partners highlighted, with the main problem relating to the timing of receipt of funds. Projects noted that it was not helpful to delay the receipt of funds until after project completion. Indeed, in some cases this hindered project implementation. For example, in one country, additional capacity could not be called upon due to limited funds available from the lead organisation. Pre-financing also posed problems in other countries, especially where the lead organisation was small and working with limited structural funding (e.g. some NGOs). This issue has caused some concern about future involvement in EC funded programmes.

2.5   In addition, the timescale for project completion set out by the EC, was not always seen as helpful, especially where timescales were not coterminous with school calendars. This meant that the timing of the intervention was generally limited to a very short window, often in an already busy period for schools. This was coupled with concerns about the overall short timescale for setting up and delivering projects which some partners found frustrating, especially given the time needed to forge networks and engage partners and young people. It should be noted that project managers originally submitted applications based on a three year timescale which was later reduced to one year, with the possibility of an extension year, (which has now been agreed). Discrepancies between the timescale for projects in Wales (based on the financial year, March to April) and the timescale for other EU countries (based

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[1] http://member.globalink.org/gt-uk

on the calendar year, January to December) also posed problems in terms of co-ordinating data submission dates. However, the alignment of timescales in 2005 should overcome this.

2.6   One final issue about being part of the European programme relates to how the international status of the project was conveyed to project participants. Some project managers felt it was important for young people to recognise that they were taking part in a large scale programme and that the completion of questionnaires and involvement in interviews or focus groups was contributing to an evaluation which could help other young people across Europe. The production of materials for young people to inform them about their role in such a programme was suggested as a way of encouraging young people to take part in the evaluative elements of the programme, especially those involved as part of a control group.

Setting up the projects

2.7   The setting up of projects brought a number of key issues to light. A better understanding of the different *contexts* that partners were working in, the opportunities and challenges of *partnership working* and an insight into anticipated plans for *monitoring and evaluation* provides a useful starting point from which to evaluate the programme. It is essential to consider activities and project outcomes in the wider context of how the projects were set up.

Working in different contexts

2.8   Asking questions about the history and culture of addressing adolescent smoking cessation, and finding out about the opportunities and challenges facing previous initiatives was an appropriate method of gaining insights into the contexts of projects. The intention here is not to chronicle the contexts within each partner country but rather to highlight the variations that exist and to recognise this as one of the challenges of drawing pan-European recommendations on what works with adolescent smoking cessation.

2.9   At one level the evaluation aimed to find out about the political will for encouraging adolescents to quit, while at another inter-related level, questions were asked about the existing support structures available. For example, had there been a history of working with young people on smoking issues, and had there previously been any cessation support? In some countries smoking prevention programmes may have been part of tobacco control strategies, but incorporating cessation activities into that strategy was seen as breaking new ground. This is an important point as it acknowledges that in some countries adolescent smoking cessation was not a service that adolescents or those working with adolescents expected to be available. One of the key generalisations that can be made about the partner countries is that most are working within a context where cessation for adolescents is a new

and developing area of health promotion. In most cases it is a novel approach and even those that have developed pilot projects previously still have far to go in terms of finding out what works.

2.10   Discussions with project managers raised a number of issues including the culture of being a smoker or a non-smoker and legal measures or regulations such as government restrictions on sales to minors. Drawing on secondary data sources, Table 2.1 summarises the position of the partner countries in terms of youth smoking, tobacco restrictions and cigarette prices. This is useful as an overview of the macro-environment in which projects were operating, although these factors need to be seen within each country's economic context (represented by GDP per capita). The differences between these contextual factors and how they affect project delivery, is important to grasp. For example, is project delivery affected by the difference between higher levels of teenage smoking in Denmark compared with Belgium, and cheaply available cigarettes in the Slovak Republic compared with Denmark? Although the economic context varies between these countries, (e.g., $10,702 GDP per capita in the Slovak Republic compared with $26,541 in Denmark), it does help us understand the different challenges projects are facing. It is also interesting to understand how these different factors interact within countries. For example, what is the implication of higher levels of adolescent smoking and banned sales to minors in Spain compared with lower levels of adolescent smoking and unregulated sales to minors in Greece? The process evaluation provides a useful tool for investigating the interaction between these contextual factors and their impact at ground level.

Table 2.1: Country level contextual factors				
Country	*Key factors*			
	15 year olds reporting ever having smoked (%) [1]	*Tobacco advertising & sales to minors (sales to persons under a predetermined age)[2]*	*Retail price of 20 cigarettes with tax (domestic brand US $)[2]*	*Real GDP per capita (PPP) US Dollars (2000)[2]*
Belgium	(Flemish)	advertising restricted; sales to minors not regulated	$2.92	$25,877

Table 2.1: Country level contextual factors

Country	*Key factors*			
	15 year olds reporting ever having smoked (%) [1]	*Tobacco advertising & sales to minors (sales to persons under a predetermined age)*[2]	*Retail price of 20 cigarettes with tax (domestic brand US $)*[2]	*Real GDP per capita (PPP) US Dollars (2000)*[2]
	55.4% females; 52.0% males			
Denmark	60.5% females; 54.7% males	advertising banned; sales to minors not regulated	$4.48	$26,541
Greece	38.8% females; 42.6% Greece	advertising restricted; sales to minors not regulated	$1.98	$15,557
Netherlands	57.4% females; 56.6% males	advertising restricted; sales to minors not regulated	$3.17	$24,731
Portugal	58.6% females; 57.6% males	advertising restricted; sales to minors not regulated	$2.13	$16,225
Slovak Republic	No data available	advertising banned; sales to minors banned	$0.66	$10,702
Spain	69.2% females; 59.5% males	advertising restricted; sales to minors banned	$1.39	$18,087
Wales	64.5% females; 51.3% males	(UK data): advertising restricted; sales to minors banned	(UK data): $6.93	(UK data): $22,461

[1]*Young People's Health in Context. Health Behaviour in School-aged Children (HBSC) study: international report from the 2001/2002 survey.* http://www.euro.who.int/Document/e82923.pdf
[2] *Tobacco Control Country Profiles, Second Edition (2003). WHO.*

2.11   The use of pharmacological support, including nicotine replacement therapy (NRT), was another contextual factor discussed with project managers. Although the age of licensing for NRT varies across the EU, none of the countries offered NRT as a core part of their intervention. In some cases the decision was made on the basis of lack of robust evidence of effectiveness with adolescents and in most cases, project managers instructed facilitators to refer participants to health services if they wanted further advice about its use. In the Slovak Republic the organisation running the smoking cessation project is supported by Pfizer, one of the major manufacturers of NRT gums and patches, and information is provided online about the use of these therapies. But the general view is that NRT does not have a large effect on adolescent smokers, as the number of cigarettes smoked and level of nicotine dependence is limited.

2.12   Subtleties of the macro-environments in which projects are operating, which are not always apparent from government statistics or reports, were revealed during discussions with project managers. Intra-country variations in levels of support were a key feature of the environments in which projects were operating with some settings being more supportive than others. The influence of working in an unsupportive environment has implications for project implementation, with projects facing difficulties engaging partners, securing budgets and subsequently engaging young people. For example, Greece has a high prevalence of smokers, in particular amongst school teachers, which is not believed to be beneficial for gaining support from schools.

2.13   Variations in the cultural contexts had implications for the potential variety of settings that could be used for smoking cessation activities. For example, in Wales, projects were looking to forge links with youth services and develop cessation activities in youth club settings. However, in Portugal, project managers considered faith groups as a possible alternative to school settings as these were a greater magnet for adolescents in some areas compared with youth and community settings. The level of support within settings varied according to whether they regarded smoking issues as part of their responsibility and in some cases this was low on the list of priorities. The smoking cessation projects offered the lead organisations a way into these 'more difficult' schools but there is still a long way to go in terms of changing attitudes

Partnership working

2.14   All project managers reported undertaking some element of partnership working in their project activities. Indeed, for some, a significant amount of time was invested in building up networks of partners, with facilitators and those within the delivery settings. On reflection, project managers recognised the importance of engaging in multi-layered networks to facilitate setting up effective smoking cessation projects.

Support at a strategic level

2.15   Follow-up interviews highlighted that governmental support for adolescent smoking cessation would have been helpful to encourage schools and other involvement. A top-down as well as a bottom-up approach to encouraging schools to become involved was seen as a more robust approach which might save time and lead to more sustainable partnerships in the longer term. One project manager reflected on the problems caused by not having specific strategic approval for a project within a partner organisation. This meant that other demands were made of the partner's time and the smoking cessation project became sidelined. Raising awareness about the project as a specific aspect of the organisation's approach to tobacco control, even at the pilot stage, is vital.

"If someone applies for funding you assume they've gone through a mechanism to do that. But in some cases, it seems that things have been put forward and then the structure doesn't know that's happening. So what you've got is that suddenly the structure will make demands on the person's time and they'll say well I've got projects running that the structure knew nothing about."

Support within settings

2.16   Most projects invested a great amount of time in establishing links with delivery settings and this was seen as crucial for successful implementation of the projects. For example, the following project facilitator highlighted the importance of links with key teachers in schools:

"We couldn't do the project without the link teachers. I mean, they're absolutely crucial in terms of me going into the schools and having a group there to sort of go and speak to when I first go, so they make the initial contact with the young people and so they get that initial interest started. Also, it's really positive if they do get involved in working in partnership with me because it means that they're putting health as a priority on their agenda and that means that they're making some positive steps towards incorporating and working on health within schools. So that's a positive thing, and you know hopefully it will be a relationship, a partnership that can be built on and maintained for future programmes to run in schools."

2.17   Other projects also stressed the importance of building multi-layered networks in the hope that these would lead to more effective and sustainable projects. For example, in Greece the board of parents at schools played an important role in selection and recruitment by convincing the school management of the need for smoking cessation sessions for young people. In Portugal, an institutional approach was aimed for, whereby teachers, other school staff and young people were offered smoking cessation services. The Portuguese partners said that in the future, they might consider using a peer support training model to involve young people more directly in the intervention.

2.18   Learning from the experience of projects that had made effective links with partners, a number of key points were highlighted. Clarifying the role of the link teacher/link person was important as an initial task, making sure that the aims and objectives of the programme and different roles and responsibilities within the project were clear. The Welsh case study project for example, has now devised a guidance sheet for the link teacher outlining the respective roles and responsibilities of the Health Promotion facilitator and the link teacher at the start of the project. Identifying benefits for the whole school also seemed to be an effective strategy to encourage initial involvement and engagement. Payment to schools was seen as a consideration in future but other incentives such as building a more positive image for the school and contributing to its status as a 'healthy school' were also seen to be important.

2.19   Project managers also commented on the importance of setting an appropriate tone for links with schools and getting the right balance between a formal and informal relationship. One project manager initially commented on the need, on the one hand, to create an informal

relationship in order to encourage school involvement, but in contrast, the subsequent need for perhaps a more formalised relationship in order to clarify roles and responsibilities.

"I think it has been at a more informal level. They had a small discussion and then a talk with the school principal and then the principal tells the teacher what to do and already that communication is difficult. I think one partner had the attitude that in order to make it nice for the schools to participate it has to be in an informal way but it gives them some problems later on because if you keep it too informal no-one really knows what to do."

2.20   Gauging an appropriate tone for the links with partner organisation is an important first step in trying to set up adolescent smoking cessation provision and these examples illustrate that the approach needs to be tailored to the individual setting and individuals concerned.

2.21   Another opportunity which could be developed is the link with partners who have wider interests in the health and well-being of adolescents. This might dove-tail with the adoption of a wider, more holistic approach to tackling the health and well-being of young people. It was suggested that this is starting to happen in Wales, with the development of the 'healthy schools'[2] scheme and a number of health professionals are approaching schools to help with nutrition, addictions and sexual health. However, perhaps more could be made of this in other countries, especially where the lead partner is already based within a public health organisation encompassing other public health expertise. Not only would this offer young people a more holistic approach to their health and well-being but it may also provide further opportunities for successful partnership working with schools and other youth settings.

Monitoring and evaluation

2.22   As part of setting up the projects, partners also considered plans for monitoring and evaluation. Although all projects were asked to complete the minimum data set, it was stressed that this was the *minimum* requirement in terms of evaluation. Projects were encouraged to embark on their own, local level self-evaluations including longer term follow-up surveys with participants, as the following examples illustrate.

- *Denmark* undertook a baseline survey in all experimental and control schools during August, 2004. This was followed up with an immediate post-test in December 2004 and they also planned a follow-up in all schools in April/May, 2005.

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[2] http://www.cmo.wales.gov.uk/content/work/schools/wnhss-e.htm

- *Belgium* conducted face to face interviews with facilitators post-intervention. This included questions about how they felt the course had been delivered, and the obstacles and opportunities encountered. The project co-ordinator also conducted informal focus groups and interviews with participants and those that had dropped out from the project. They will be using this to review their materials and approach to cessation. Belgium is also conducting a six-month follow-up in all intervention and control schools.

- *The Netherlands* organised small group interviews with young people to gain a better understanding of the low response and limited participation in the intervention. Also, a qualitative analysis as part of the general project evaluation is planned.

2.23   In any future programme it will be important that this sort of longer term outcome evaluation and formative, process evaluation is encouraged and resourced at a local level. Given that one of the limitations of the overarching evaluation is that longer term outcome data are not being collected in all countries, it will be important that the longer term evaluation put in place at a local level is more widely disseminated to other partner countries. In this way the programme will contribute to the fairly limited existing empirical base around adolescent smoking cessation.

3 Project activities

Introduction

3.1 This chapter presents some of the basic data and elements of project activities across the programme. This includes characteristics of the target group, the settings in which interventions were delivered and the types of intervention adopted. The purpose of this chapter is to provide an overview of the parameters examined as part of the process evaluation. The evaluation is concerned with how these parameters vary across the programme and how they result in different outcomes in different contexts. An overview of the characteristics of the pilot projects is tabulated at the start of each of the following sub-sections. This information is taken from the minimum data sets where available.

Characteristics of participants

Table 3.1: Characteristics of participants					
Country	*Characteristics of participants*				
	Age group	*Sex*	*Smoking status at start*	*Number of cigarettes smoked each day*	*When did they start smoking*
Belgium	16 to 18, mostly 16 and 17	50% male, 50% female	Regular and occasional smokers. MDS incomplete.	MDS incomplete.	MDS incomplete.
Denmark	14 to 18, mostly 15 and 16	41% male, 59% female	95% were daily smokers	50% smoked between 11 and 20 a day	All started smoking more than one year ago.
Greece	13-18	Not available	Not available	Not available	Not available
Portugal	15-18 for secondary schools, 18-24 for universities	Not available	Not available	Not available	Not available
Netherlands	15 to 20, mostly 15 to 17	38% male, 63% female	All daily smokers	Mostly smoking between 6 and 20 a day.	All started more than one year ago.
Slovak Republic	14 to 16, mostly 15	48% male, 52% female	One third used to smoke but stopped, another third never smoked. 5% daily smokers and 17% weekly smokers. 12% less than once a week.	Most daily smokers smoked between 1 and 5 a day	Most had started smoking between six months and more than a year ago.
Spain	16 to over 20, mostly 17 to 19	35% male, 65% female	All daily smokers (this was part of their inclusion criteria).	Majority smoked between 6 and 20 a day.	All started smoking more the one year ago.
Wales	Under 12 to 19, mostly 13 to 16	43% male, 57% female	88% were daily smokers	Most smoked between 1 and 20 a day	Over two thirds (68%) started smoking at least one cigarette per week more than one year ago.
NB – Data for Greece and Portugal are based on follow-up interviews.					

3.2 Most projects targeted 16 to 18 year olds, although some focussed on older age groups. For example, Portugal ran a programme at universities, targeting an age group of approximately 24 years. Most projects attracted mixed sex groups but there was a bias towards the involvement of girls, reflecting the higher rates of smoking amongst females in these

countries, together with a range of other factors. For example, in the Netherlands, two thirds of participants were female, although this reflected the particular school type (vocational training) in which the intervention took place rather than distribution of smoking levels.

3.3   Most of those recruited to the project were daily smokers. Two thirds of 724 young people across five countries, for which data were available, reported being daily smokers at the start of the project. Of these daily smokers, a third said they smoked between 6 and 10 cigarettes a day and a similar proportion smoked between 11 and 20. Of the weekly smokers, 35% said they smoked between 1 and 10 cigarettes per week and 29% smoked between 11 and 20 per week. More than four fifths (86%) said that they started smoking more than one year ago. One country, which stands out in Table 3.1 in terms of the smoking status of participants, is the Slovak Republic. Two thirds of recruits did not smoke and 5% were daily smokers. This could reflect the fact that in the Slovak Republic, both smokers and non-smokers were addressed in a large group setting.

Characteristics of settings

Table 3.2: Characteristics of settings		
Country	*Characteristics of settings*	
	Type of setting	Number of settings
Belgium	Schools – general, technical and vocational education.	9 schools
Denmark	Residential schools in rural area (control schools in urban area).	21 schools
Greece	Secondary schools, general higher level of education, all in Athens	4 schools
Netherlands	Vocational secondary schools, lower level of education, major cities in country	2 schools
Portugal	Secondary school in capital city, general higher education	1 school
Slovak Republic	Secondary schools in the capital city (plans for sessions in more rural areas)	4 schools
Spain	Schools in five Spanish zones	9 schools
Wales	Schools, colleges, community venues, leisure centres, youth clubs, Youth Offending Teams	19 settings including schools, colleges and community venues (based on data for 5 areas in Wales).
NB – Data for Greece and Portugal are based on follow-up interviews.		

3.4   Smoking cessation activities were delivered in 69 settings across the eight countries representing an average of nine settings per country. This ranged from one setting in Portugal to 21 settings in Denmark. This may be a reflection of the existing networks with partners and settings that pre-dated this programme; in Denmark the intervention county had already piloted this project with schools in previous years, whereas in Portugal they were building up new links with settings.

3.5   All projects planned to deliver at least some element of their project in a school setting but the barriers to delivering projects in schools have been highlighted by project partners, some of which have already been noted in chapter two (for example, the difficulties of fitting a European project into the school calendar). There were other logistical issues such as obtaining initial access and finding an appropriate window for these sessions. Some projects were looking for an appropriate time to run the sessions within the school curriculum but where this was not possible, finding a free window during or after the school day also proved difficult. Several projects stressed the need for support from a wide range of stakeholders, including teachers, the school board and parents, both for initial selection and longer-term sustainability of the project.

3.6   Some projects targeted a range of schools and therefore covered a range of education levels allowing useful intra-country comparisons to be made. For example, one project manager reflected on the variation in implementation across vocational and general education schools:

"I can see that pupils who are studying in a vocational education are more open to it than pupils form general education, because I think students from general education, they see themselves as already grown up, and they see themselves as educated enough to decide for themselves if they can or cannot stop smoking. And if you see students in...vocational education, they really want help and they are very happy to take part in it. I can see it already in control schools, if I go to a general school, if they have to fill in a questionnaire, they are not happy. They don't like it, it's too long. And if you go to a vocational school, they are very happy because it seems that you are interested in them, they have a lot of questions because they don't know everything, they are more open."

3.7   Continuing to monitor these intra-country variations will be an important part of the ongoing process evaluation. The analysis of minimum data sets from all countries coupled with further process evaluation will enable more in-depth reflections on 'how the success of the intervention varied across the different settings?' and 'what level of differentiation in approach and materials is needed for these different groups of adolescents?'

3.8   A further area of reflection that the evaluation will focus on during the next phase of work is around the opportunities and challenges of running cessation activities in non-school settings. Feedback from interviews with project managers so far suggests that they are beginning to give further thought to other settings which could overcome some of the difficulties faced in schools. One project co-ordinator commented on the potential benefits of running cessation work in youth settings compared with cessation courses in schools:

"They're there in their free time and it's like a different view. A school is a setting that wants to educate and the community youth club they are a setting that provides youngsters with

having a nice free time. So if their leaders are giving a course it will feel different from when

it will happen in the school."

Characteristics of intervention

Table 3.3: Characteristics of intervention				
Country	*Characteristics of intervention*			
	Number of sessions	*Timing of sessions*	*Number per group*	*Facilitators*
Belgium	6 sessions, 1 per week, 55 minutes each	During and after school (school to decide).	Average of 4 participants	A teacher or administrative worker at the school (trained by external health promotion specialist). 19 facilitators overall.
Denmark	6 sessions, 1 per week, 90 minutes each	During and after school	Average of 7 participants	External health educators already networked with schools. 12 facilitators overall.
Greece	4-6 sessions	Within school time during lesson on health education	Aim for 15 participants	External, with help from teacher introducing the course
Netherlands	5 sessions, 1 per week, one class hour each	During school time (class hours)	Average of 5 participants	External health professionals with special training in adolescent smoking cessation. 3 facilitators overall
Portugal	1 general awareness session and 2 small group sessions.	During school time (class hours)	17.5 participants (35 over two groups)	3 external health promotion specialists.
Slovak Republic	2 sessions, 90 minutes each	Within school time	Average of 60 participants	Teachers trained by specialist health workers. 4 facilitators overall.
Spain	7 sessions between December and June, 90 minutes each	After school	Average of 10 participants	External health professionals, trained in adolescent smoking cessation. 9 cessation group facilitators and 7 self-help programme facilitators.
Wales	Average of 7 sessions, 75 minutes each	Some during school (personal and social education lessons) some after school (especially those in youth or community settings)	Average of 7 participants	External, mostly health promotion specialists. 13 facilitators.
NB – Data for Greece and Portugal are based on follow-up interviews.				

Number of sessions

3.9   As Table 3.3 indicates, most projects were based on a model of about six cessation sessions, based on one session per week. The exceptions to this model were the Slovak Republic and Spain. The Slovak Republic held two 90 minute sessions for both smokers and non-smokers to raise awareness and give general information about smoking and how to quit. In Spain seven sessions were facilitated but these were spread over a six month period with a more gradual withdrawal of cessation support. Feedback from follow-up interviews suggests that project managers would have liked to have extended courses up to about ten sessions in order for further work to be undertaken. Given the time needed to build up relationships between

the young people and the facilitator, there was a limit to what could be achieved in just six sessions.

3.10   The timing of these sessions varied with a combination of in-school and after school sessions and in some cases the timing was left to the discretion of the individual setting or facilitator. Some issues relating to different timings have emerged. For example, sessions held during school hours conflicted with lessons, although in the case of one project in Wales, holding the sessions during Personal and Social Education (PSE) lessons worked well, as the sessions fitted with the remit of this area of the curriculum. Hosting sessions at lunchtimes or after school proved difficult in some cases due to the logistics of finding a suitable venue and in terms of motivating the young people to attend in their own time. Interestingly, some young people themselves indicated that they believed it was justified if the intervention had to take place outside class hours. For example, young people in the Netherlands said that it didn't really matter if courses were available in their own time or in lesson time and that it would be fairer if sessions were held when they didn't have classes (that is, during breaks or after school). However, they did admit that one of the initial reasons to start the cessation project was to skip classes, which they were able to do to attend the course.

Length of sessions

3.11   The length of individual sessions ranged from 55 minutes to 90 minutes. Overall contact time with young people varied between three hours in the Slovak Republic and ten and a half hours in Spain. Thus a young person's commitment to attending a three hour intervention is different to what they are expected to commit to and can potentially achieve from a ten and a half hour intervention and these variations need to be considered when interpreting project outcomes.

Number per group

3.12   Group size might also be important in determining successful outcomes. Projects aimed for groups sizes of up to 15 participants. In practice most projects worked with group sizes of about six participants, with the Slovak Republic working with up to 60 participants, although this was not considered ideal given the limited attention that could be given to individual participants. Project managers developed their thinking about optimum group size over the course of the programme. Initially most anticipated working with groups of about 10 or 12 participants but post-intervention some acknowledged that smaller group sizes worked best. One project co-ordinator reflected on feedback from the project facilitators and their comments about group size:

"At first we said teachers in one session can have six to ten pupils but now I can say that one session can have a maximum six pupils and some of them tell me that three, four pupils that's very good. And then they can go and talk really privately, in-depth with pupils and if you have six that's too much...in our course a lot of attention is paid to the talking part. Lets talk about your feelings, how did you stop, why did you stop, how do you feel now and these things. And if you have six pupils it's not time enough."

Role of the facilitators

3.13   Throughout the process evaluation, project partners emphasised the importance of the facilitators in determining the success of the project. This includes both the status and background of the facilitator. The minimum data set asked project managers about factors influencing the delivery of the project. One clear finding was the importance of the facilitator. All five project managers (from whom we have responses) strongly agreed that the motivation and enthusiasm of staff involved was important in improving delivery, as was the combination of smoking cessation knowledge and skills in working with young people. However, there was less consensus about whether there should be an existing relationship between the facilitator and young people. This was probably influenced by the approach adopted. For example, Belgium drew on teaching staff to facilitate sessions and strongly agreed that an existing relationship was important, but for others, where external facilitators were used, it was thought to be of less importance.

3.14   In the majority of projects, external facilitators such as health promotion specialists, youth workers and health professionals were used and, on the whole this was seen as preferable to using facilitators from within the setting (such as teachers). External facilitators were seen to be more neutral and credible and able to offer a confidential service allaying participants' fears about parents finding out about their smoking behaviour. It was suggested that teachers may not be as approachable for young people and their expertise in smoking cessation would not be as well developed as that of a health professional, even if training was provided. One project partner described the key elements of this 'different relationship' between the external facilitator and the adolescent:

"Some of the things are quite personal and they do quite like the idea of someone from outside listening and providing advice and support on that because it's not somebody that had prior knowledge or any judgements on them or who they have a history with...It's a different relationship. The youth health development worker isn't somebody that's got to get them through their exams or...keep control over them; it's a very different relationship."

3.15   Participants also seemed to favour the external facilitator over a teacher:

"Teachers know about you and what you're like and it's telling them stuff in it. And when you don't know someone you can tell them stuff cos they ain't gonna know who you are."

3.16   Another young person underlined the need for a facilitator 'who has lots of expertise that the teacher can't have' and added how he felt privileged to have an external health professional coming into the school. In addition teachers acknowledged that the project achieved a different response because it was not facilitated by a member of staff:

"…the teacher changes the complexion anyway. Sometimes they need somebody who isn't a teacher. But they do respond differently to the way they would a youth worker or a health worker."

3.17   In the Netherlands teachers were used to support the first information session in order to get access to the students. However, they brought in external health professionals, with a background in adult smoking cessation, to run the cessation course.

3.18   The follow-up interviews highlighted that in some contexts internal facilitators could also work well. In Belgium, school teaching staff were recruited for the project and attended a one-day training programme facilitated by the project co-ordinator. The teachers delivered cessation sessions within their own schools, with ongoing support from the project co-ordinator via telephone and email. For example, despite some initial concerns that numbers attending sessions were low, re-assurance from the project co-ordinator helped them continue and see the bigger picture of what they were trying to do in a pilot context. Overall, all parties involved in the project found that this approach worked well. There was one example of where a student stopped attending the sessions because the facilitator, who was also their teacher, gave them poor results in a test, but on the whole, teachers were pleased that they could help students in different ways outside their normal 'teaching role' and the students saw benefits in having a teacher take on a smoking cessation role. For example, the project co-ordinator commented on how the young people felt that they always had someone to turn to, particularly during break times when some of their peers were smoking.

"In one school I had a facilitator, she told the pupils whenever you have problems you can always come and talk with me. And they did that so they always had someone to go to and when they were standing in the playground, when it was lunch time or in the afternoon and maybe some friends were smoking they could see the teacher and say I'm doing my best, I'm doing my best."

3.19   One of the over-riding factors determining the successful role of the facilitator is the combination of smoking cessation expertise and the ability to work with young people in a group setting, as was previously highlighted in the evaluation of pilot projects in Wales.[3] The findings from this European evaluation endorse this view and in addition suggest that the initial rapport that young people establish with the facilitator is key to how the rest of the project develops. This includes developing an empathy with the background of the young people involved and encouraging a sense of trust. In one project the manager talked about the relationship between the facilitator and adolescents, a key turning point being when one of the role model students became an ally of the facilitator, encouraging others to give greater commitment.

"There was one facilitator where there was this role model student among one of the groups and after one or two sessions, this person was very positive to the programme and that had a great impact on how to run the sessions because most of the pupils were disruptive but if you have this role model who is positive to the programme he is an ally. And that gives a very positive and enthusiastic atmosphere…"

3.20   The importance of the sex and age of the facilitator is still an area for debate. Some evidence from the pilot programme suggests that it helps if the facilitator is of the same sex and close to the age of the participants. For example, in one project it was noted that the fact that the facilitator was young and female meant that the girls on the project connected with her as a 'role model':

"The last lot of young people that came through the programme were girls and there is something there about them wanting almost someone who appears as if they care for the groups of girls and can support them. There's some quite emotional stuff going on there I think. They're almost looking for that, they're looking for a role model and for someone to support them a bit, motivate them really, motivate them about quitting smoking, but also about other things within their lives."

Recruitment and retention

3.21   Most projects reported that recruitment and retention were important issues, and several had experienced problems recruiting the numbers they anticipated at the outset. However, it should be recognised that some cessation activities might be better delivered to a select,

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[3] Stead M, MacAskill S & MacFadyen L. Evaluation of an adolescent smoking cessation pilot scheme in Wales. Summary prepared for 'A Review of Adolescent Smoking Cessation Seminar'. Cardiff, 23 July 2002.

highly motivated group where higher numbers may prove counter-productive, especially if some members of the group are not fully motivated. Striking a balance between recruiting higher numbers and recruiting those at an appropriate motivational level is important and will depend on the chosen objectives of the project.

3.22   Some projects had a broad remit to target regular and occasional smokers while others had a narrower focus selecting only daily smokers. For example, in Spain the selection procedure was an informative and evaluative session to select adolescents who were interested in quitting. Students filled in a smoker profile questionnaire and those who met the five selection criteria (voluntary attendance, possibility of extra time to quit, to feel the need to give up smoking, positive dependence and motivation tests) were accepted for the intervention.

3.23   Further information from local self-evaluations and interviews undertaken with participants who left the project at an early stage, point towards low motivation levels as the main factor influencing their lack of commitment. One project co-ordinator interviewed young people who had dropped out of the project and commented on their lack of readiness to quit. Personal factors together with the wider social environment seem to be the root cause of poor motivation levels in this case:

"They were just not motivated enough. They said 'yeah I tried, but it just didn't work and it's too difficult. I mean I don't see the point to stop'. They were not motivated enough. I think also the policy in the school is very important because I talked to some pupils who dropped out and some of them said okay, the first session was fine and the second session and then you had to stop smoking but in the breaks in that school pupils can smoke."

3.24   Other studies[4,56] have explored the readiness to quit of the adolescent smoking population and suggest that at any given time a relatively small group (about 15-19%) are seriously considering quitting, with a further 30% ready for 'priming' for future interventions. This suggests a diversity of approaches is needed for tackling adolescent smoking which takes into account motivation and readiness to quit.

3.25   Projects were creative about the recruitment and retention of young people, using a range of strategies to try and engage adolescents in the programme. These include initial information sessions incorporating activities such as carbon monoxide readings. These events provided an

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[4] Engels, R.C., Knibbe, R.A., De Vries, H., et al. (1998) 'Antecedents of smoking cessation among adolescents: who is motivated to change' in Preventative Medicine, 27 pp.348-57

[5] Pallonen, U.E., Prochaska, J.O., Velicer, W.F., et al. (1998) 'Stages of acquisition and cessation for adolescent smoking: an empirical integration' in Addictive Behaviour, 23 pp.303-24

[6] Mermelstein, R. (2003) 'Teen smoking cessation' in Tobacco Control, 12 pp.25-34

opportunity for young people to meet facilitators for the first time and to ask questions about the subsequent cessation sessions. It also allowed important issues such as confidentiality to be clarified. Some projects experimented with the use of incentives as a recruitment and retention tool. For example, in the Netherlands, participants were offered a CD voucher of 10 euros for participation in the course and for being part of the research project. However, the young people participating claimed that this did not affect their motivation for taking part and staying in the programme. An earlier evaluation of pilot work in Wales[7] identified that incentives and rewards can play various roles including 'generating initial interest', 'encouraging attendance' and 'enhancing cessation motivation'. However, there was debate about the actual role of incentives and rewards in determining cessation group success as it proved 'difficult to disentangle their influence.' It is important that project information about the use of incentives is drawn on to aid the interpretation of enrolment and completion rates.

3.26   The pilot programme also enabled projects to test out other recruitment and retention strategies such as the use of participant contracts in Belgium. Participants were told that they could drop out after the first session but not after the second session, as they would be making buddies in the project and it would affect the group dynamics if young people did not continue the course. They were asked to sign a contract to stay in the project after the first session. In practice this approach was not as successful as planned as the contract did not have much currency with this particular age group.

3.27   Discussions at the December feedback workshop moved the recruitment and retention debate forward and there appeared to be general agreement about some of the key ingredients needed for success. Partners stressed the importance of the recruitment phase of the programme and advocated investing time in this. This has implications for the overall timescale in which projects are expected to set up and deliver. The role of the facilitator in *delivering an effective project* has already been highlighted in the discussion above but the facilitator also plays a key role in *effective recruitment.* The most successful recruitment, in terms of engaging smokers who want to quit, appeared to occur where expert, experienced facilitators were able to make the first point of contact with adolescents and gain their trust at an early stage.

3.28   Post intervention feedback from project managers endorsed these points and in addition a number of other issues were raised. There seemed to be key moments in the project when retention was a particular problem. For example, in Belgium the highest rates of drop-out were experienced after the first session and after the third session. As the project co-ordinator noted, participants dropped out of the course after the first session when they soon realised the group was not right for them, or after the third session which was when they really had to

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[7] Stead, M., MacAskill, S. & MacFadyen, L. 'Evaluation of an adolescent smoking cessation pilot scheme in Wales' summary prepared for 'A Review of Adolescent Smoking Cessation Seminar' Cardiff, 23 July, 2002.

stop smoking. The timing of the course and the fact that there was a week of holiday after the third session also did not help:

'Those pupils that wouldn't succeed in this stopped the course…that was actually the most important session and then they were left alone for a week.'

3.29   There were other cases of projects ending at difficult times such as just before Christmas holidays and just before examination periods. Greater thought and planning about the project's timescale and co-ordinating key points in projects activities (such as the quit day) is likely to alleviate some of the retention problems experienced thus far.

3.30   Future phases of the programme should build on these key lessons about recruitment and retention and also consider trying out other approaches. Underlying many of the recruitment and retention problems was the wider issue of building a multi-layered network between project partners, including those at a strategic level and within settings, as outlined in the previous chapter. For example, working to ensure the commitment of partners was often seen as the crucial first step to effective recruitment. A related issue was the importance of finding dedicated time within the curriculum for cessation activities and working towards embedding the concept within organisations.

Nature of the interventions

3.31   Throughout the pilot programme there has been an emerging understanding of what seems to work well in adolescent smoking cessation and importantly, how this needs to be adapted from cessation approaches used with adults. This includes recognition of adolescents enduring a phase of physical, emotional and social change, and the fact that their self-regulation skills including self-monitoring behaviour and developing plans for handling difficult situations may not be well developed.[8] Hence, projects have developed techniques to nurture these sorts of skills including the use of carbon monoxide monitors as a way of encouraging adolescents to keep track of their own progress. There is also an emerging recognition of the fact that a 'one size fits all'[9,10] strategy is likely to be inappropriate – as might be expected given the volatile nature of the teenage years. This emerging expertise was reflected in the range of core ingredients that fed into project interventions:

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[8] Mermelstein, R. (2003) 'Teen Smoking Cessation' in Tobacco Control, 12 pp.25-34

[9] Reid, D.J., McNeill, A.D. & Glynn, T.J. (1995) 'Reducing The Prevalence Of Smoking In Youth In Western Countries: An International Review' in Tobacco Control, 4,3 pp.266-277

[10] Yach, D. & Ferguson, B.J. (1999) 'Can we stop children and adolescents from smoking?' in Social Science and Medicine, 48, supplement 1 pp.757-758

- *Awareness raising* - including information on the effects of smoking, the benefits of quitting and where to go for additional support. Projects were imaginative about how they facilitated awareness raising, including a number of self-discovery based exercises which included the analysis of the contents of cigarettes and discussions around their personal health related experiences of smoking.

- *Skill development* – including how to deal with withdrawal symptoms, dealing with stress and relaxation techniques, dealing with difficult situations (emotional, physical and social). Also encouraging self-regulation skills through the regular use of carbon monoxide monitors.

- *Strategy planning* – in some cases this involved setting a quit date at some point during the project. Action plans were then developed to facilitate working towards this quit date and dealing with post-quit issues. In other cases, strategies were planned for meeting weekly targets such as cutting down or avoiding situations that could lead to smoking.

3.32 Box 3.1 provides examples of how these key elements translated into practice, with some projects placing greater emphasis on different aspects. For example, in the Welsh case study project the focus was on providing adolescents with a quit experience during the project. This was in contrast to the project in the Netherlands where the focus was on preparing participants to quit, although it was not anticipated that they would necessarily reach that stage before the end of the project. This was one of the main elements that distinguished the adolescent model from the adult smoking cessation course, where a collective quit-moment is incorporated in the sessions. The line of thought here was that the chaotic nature of the teenage years would mean that it would be difficult for all young people in the group to agree a collective quit moment.

Box 3.1: Intervention approaches

Providing a quit experience - Wales
The structured six week project included understanding smoking behaviour, the effects of smoking and withdrawal, quit strategies and skills development, especially refusal skills, assertiveness and communication. Participants were encouraged to set a quit date after the first two workshops and carbon monoxide monitors provided feedback to the young people on their progress. A self-help cessation pack was produced to supplement the cessation sessions. This included contact details for other forms of cessation support. Key principles underlying the approach included: running the sessions in a fun, non-judgemental environment; encouraging active participation by young people; differentiating sessions and materials according to educational and ability levels; and building up a relationship of trust between the facilitator and the participants. Student engagement was an integral part of the project. At the pilot stage students were involved in determining: the content of the sessions; the approach and methods adopted (including an end of project incentive); the name/branding of the project; and how to evaluate the project.

Focus on preparing to quit – Netherlands
The approach in the Netherlands was targeted at preparing young people to quit smoking at some point in the near future, though not as a strict point within the cessation course. So in contrast to the adult smoking cessation model, no collective quit moment was built into the sessions. There was a moment though, during the third meeting of the intervention, where all participants signed a contract in which they declare their intention to quit

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smoking by a certain to be specified date. Although stopping smoking altogether during the course was not the main aim, the facilitator did ask participants to 'cut out crucial smoking moments', so for example not have a cigarette after dinner when participants were used to that, as a means of cutting down. During the next session withdrawal symptoms would be discussed alongside other issues to do with giving up smoking.

General information and awareness meetings
In several countries, including the Netherlands, Portugal and the Slovak Republic, general information and awareness sessions formed a substantial part of the intervention. These sessions were usually targeted at smokers and non-smokers, the main aim being to inform all young people of the effects of smoking and how to stop smoking, usually within a framework where the role of the tobacco industry was also discussed. While in Portugal and the Netherlands these general information sessions had a function in recruitment of smokers for smaller group sessions, in the Slovak Republic the intervention consisted of two successive meetings for both smokers and non-smokers. In this way, anonymity of the young people (e.g. smokers who did not wish to admit to their addiction in public) was safeguarded.

3.33   Taking account of the social context within which adolescents find themselves was seen as being important for an effective intervention, in particular the way in which the facilitator and the intervention took account of the home, community and school environments. As one project manager described, it was important to be aware of young people's circumstances and try to provide skills to deal with difficult situations that might arise:

"I think making sure the sessions are as relevant as possible to their everyday life. And having enough awareness of the barriers they face outside of the workshop in terms of quitting smoking…But you have to say to the young people that those things aren't going to change overnight. What can change is your reaction to those things and how you manage those situations and that's where you're trying to build the skill, to be able to negotiate those settings and that's difficult."

3.34   Adopting a flexible approach to take these factors on board also extended to allowing participants to discuss other health issues if thought to be important. When asked to comment on aspects of the sessions that worked well, one facilitator noted that it was important for participants to:

"Feel free to mention other health issues that they thought were related to smoking…and giving them the freedom to be able to talk about what's on their minds and bring things up in a supportive, non-judgemental atmosphere."

3.35   Underpinning this flexible approach to adolescent smoking cessation is the recognition that the approach needs to respond to individual needs. This implies going a step further than recognising the wider contextual factors such as smoking regulations and school smoking policies, acknowledging the teenage years as a time of change which requires an approach to

cessation that is flexible enough to respond to ongoing and changing needs. Other studies[11] have suggested 'subgroup interventions' for different stages of the teenage years but perhaps there is a need for more sophisticated subgroup interventions which take into account variables other than age group, such as social demographics and motivation levels.

Non-course based support

3.36   In addition to cessation sessions, projects also provided a range of other support activities for the young people and the staff at the school. For example, Denmark adopted a holistic approach to addressing smoking cessation in schools by offering a programme of support which included: information meetings for teachers about school smoking policies; cessation courses for teachers; information meetings for students; and up-dates on teaching materials available. In some cases these other activities were also used as a mechanism for recruiting young people onto the project. For example, in Portugal a pro-active awareness raising day was used to introduce the young people to the project workers and to recruit for the cessation sessions.

3.37   To supplement face-to-face support for adolescent smoking cessation, some projects also set up other support mechanisms. Spain and Denmark established computer programmes as additional means of support. In Spain, the self-help computer programme 'I quit now' was originally designed for over-25 year olds but the Spanish team adapted this for use with adolescents. The programme focuses its content on the short term quit process and includes a six-month follow-up. The aim is to set up a network of all 150 users of the computer programme so that they can support each other. Also, the intervention will include one or two personal contacts with facilitators. They will be using a combination of media (telephone and email) to track participants through to June, six months after the intervention started. In Denmark, the 'Xhale.dk' internet smoking cessation programme is designed to be promoted nationally through vocational schools (the cessation sessions are being facilitated in residential schools). The on-line support includes SMS text messaging and email to motivate young people in the run up to their quit date[12]. The cessation courses are the priority for programme partners, with these other support mechanisms being secondary and complimentary. However, the potential of European funding and interest in electronic support mechanisms might suggest there is mileage in this area of work in years to come. The potential reach of internet support programmes, together with the creation of virtual social

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[11] Mermelstein, R. (2003) 'Teen Smoking Cessation' in Tobacco Control, 12 pp.25-34

[12] It should be noted that Denmark's internet smoking cessation programme is not a core activity from the EC funding stream. The internet site received some funding from the European adolescent smoking cessation programme but the bulk of the funding came from national partners.

support networks, is an interesting field to explore and to date there have not been evaluations of such interventions for adolescents.[13]

3.38   Some projects situated their adolescent smoking cessation intervention in a broader context of smoking prevention. School-based initiatives for example could build on the network of the Smokefree Class Competition, via which links were already developed or about to be set up, although this mostly concerns younger age categories, (usually 11-15 years of age). In some cases participation in the Smokefree Class Competition did facilitate communication with a network of schools.

4   Outputs and outcomes

Outputs

4.1   As noted in chapter one, six countries submitted minimum data sets by the mid-January deadline and these have been drawn on in this chapter. Some of these data sets included baseline data only as follow-up data had not been collected or collated. Two countries were not in a position to submit data by the deadline as their cessation activities were still continuing. Project partners listed a range of anticipated outputs in their original project plans. This included numbers of participants, training for facilitators and the development of materials and other forms of cessation support, such as internet based services. Table 4.1 presents these anticipated outputs alongside the actual outputs as of mid-January 2005. Data from the minimum data set are presented where available and for other countries data collected through follow-up interviews have been used. General trends indicate that numbers of participants were not as high as expected (see recruitment and retention issues in previous chapter) but in the majority of cases the expected outputs have been reached in terms of materials produced and other support mechanisms set up. These are important programme outputs, particularly given the relative infancy of support for adolescent cessation and these

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[13] Mermeistein, R. (2003) 'Teen Smoking Cessation' in Tobacco Control, 12 pp.25-34

resources can be seen as a step towards developing greater capacity. These resources have been influenced by other materials used for cessation work with adults, as well as building on the lessons learnt from earlier pilot projects and initial literature reviews. Examples of materials produced include the following:

- In the *Netherlands* a course book has been developed for young people and a training manual for facilitators. The course book has a modern layout with chapters corresponding with the sessions, including short written assignments to do during the course and at home, quiz-like tests, cartoons, illustrations and a smoking diary. Also, audiovisual material (video) forms part of the course.

- *Greece* developed a cessation diary with everyday tips on how to quit smoking, and a telephone directory with useful numbers to support young people in their quit attempt.

- *Spain* utilised a self-help computer programme called 'I already quit'. This was adapted from a programme for 25-34 year olds. Online support was supplemented with telephone support from public health experts.

- In *Denmark* they developed an internet smoking cessation programme called 'xhale' which is designed to offer young people an easily accessible method of smoking cessation. This was mainly supported through national funds.

Table 4.1: Expected and actual outputs to date		
Country	*Expected outputs (Source: baseline interviews with project managers)*	*Outputs as of mid-January 2005 (Source: MDS where available. Data for Greece and Portugal are based on follow-up interviews).*
Belgium	Young people: Up to 144 students in 12 schools Number per group: 10-12 Other outputs: Training for facilitators – 1 or 2 per school.	Young people: 52 enrolled and completed at least one session. 54% completed entire course Number per group: Average of 4 per group Other outputs: Training for facilitators – 1 or 2 teachers per school.
Denmark	Young people: Between 120 -200 students across 12-20 schools. Number per group: About 10 Other outputs: Other support in schools e.g., information meetings for staff and students.	Young people: 144 enrolled. 18% completed entire course. Number per group: Average of 7 per group Other outputs: Other support in schools e.g., information meetings, cessation events, smoking policy meetings with the staff (teachers and the principal). Approximately 1500 students have taken part in these.
Greece	Young people: 100 young people (4 schools) for smoking cessation sessions at schools Number per group: 15 Other outputs: Quitline already running, IT intervention tool planned.	Intervention still has to be completed, and no data are available on current outputs.
Netherlands	Young people: 4 schools to run sessions, at least 24 participants Number per group: 6-12 Other outputs: Training courses for facilitators; development of course material; brochure for young people; IT intervention to support sessions.	Young people: 10 participants enrolled and completed the entire project. Number per group: Average of 5 per group Other outputs: Course materials for participants and facilitators; training of facilitators.

Table 4.1: Expected and actual outputs to date		
Country	*Expected outputs (Source: baseline interviews with project managers)*	*Outputs as of mid-January 2005 (Source: MDS where available. Data for Greece and Portugal are based on follow-up interviews).*
Portugal	Young people: Awareness activities, information sessions – 4 sessions of 10 participants so 40 young people in total Number per group: about 10 Other outputs: Leaflets; poster campaigns in schools; meetings at schools (school board, parents, young people).	Young people: Total of 35 attended 2 sessions. 2 other sessions did not go ahead due to low turn out. Two more sessions are planned for April 2005 for the 10th grade students. Number per group: Average of 17.5 per group
Slovak Republic	Young people: 6 smoking cessation courses in 3 different settings: schools, army and youth clubs. Number per group: 8-12 Other outputs: Courses for facilitators.	Young people: 233 young people enrolled. 85% completed the entire course. Number per group: Average of 60 per group Other outputs: Smoker cessation courses for facilitators (35 participants), information campaign and established contacts with new settings (army and youth centres). Plans for textbook for teachers
Spain	Young people: 2 cessation groups with 12-15 participants in 5 Spanish zones, so approx 125 Number per group: 12-15 Other outputs: Self-help computer programme – 25 students in each of the 5 zones so 125.	Young people: No data on actual enrolments but 205 students attended the selection sessions. Other outputs: Self-help computer programme – now only 50 young people involved in this.
Wales	Young people: Across 10 projects estimate 629 young people Number per group: 5-15 Other outputs: Some projects running courses for facilitators.	Young people: 189 young people enrolled. 47% completed the entire course Number per group: Average of 7 per group Other outputs: Two groups ran outdoor activity incentive days. *NB – this is based on data from 5 projects.*

4.2   In the five countries that returned minimum data set information on enrolments, 628 young people enrolled on the programme, ranging from ten in the Netherlands to 233 in the Slovak Republic. Overall enrolment numbers were not as high as anticipated, mainly because not all settings participated. For example, in Belgium nine out of the twelve original schools went ahead with the project and in Wales, seven areas (of which we have data for five) delivered a project by January 2005, instead of the 10 areas anticipated at the start. In Belgium, Denmark and the Netherlands, average numbers per groups were slightly below what was expected and in Wales group sizes were as expected. In Portugal the first two sessions attracted higher numbers than expected (17.5 participants compared with an estimated 10), but none attended the subsequent sessions. In the Slovak Republic smaller groups were anticipated (8-12 participants) but in practice sessions were held with two or more classes taking their actual group size up to 60 participants. This was a practical consideration, as personnel changes meant it proved difficult to organise smaller group sessions. Instead, a number of classes were brought together for general information sessions.

4.3   Overall 57% of participants attended the entire course, ranging from 100% in the Netherlands to 18% in Denmark. However, these figures do not provide a complete picture of the process. Some project managers commented that actual participation rates were higher than these figures suggest. For example, in Denmark 80% of participants attended at least 50% of the

sessions, although only 18% completed the entire course. Project managers suggested there needs to be an agreed definition of course completion as it is not always appropriate to just focus on those who completed the entire course, as non-attendance at one or two sessions could be unavoidable (and often was in schools, for example during exam time). Perhaps a more appropriate definition would be to include those who attended 50% or more of the course and completed both a baseline and follow-up questionnaire. Furthermore, the rates do not take into account the variation in contact time and differences between six 90 minute sessions (Denmark) and two 90 minute sessions (the Slovak Republic). Outcomes can only be judged on the project being evaluated, therefore expectations will differ.

4.4   In the original project plans, partners outlined their expected outcomes from the project; that is, their expectations about the changes in the skills, knowledge and behaviour of participants. All projects cited smoking behaviour outcomes in their original plans, including quit attempts and cutting down. However, projects did not just narrowly focus their expectations on smoking behaviour outcomes, including a range of other outcomes in their project plans. Self-efficacy was a key outcome with projects looking to equip adolescents with the skills they needed and the belief that they would be able to quit or remain smoke-free. Developing knowledge about the harmful effects of smoking, the benefits of quitting and the support available for quitting were also listed by project co-ordinators. As the following project partner describes, the aim of the project was about far more then quit rates and cutting down:

"In terms of what we're aiming for in relation to young people it's about reducing the smoking rates amongst young people within that 13 to 19 category. It's certainly about giving them all an experience of quitting, so setting a quit date and having a range of strategies to help them quit. But it's also about those particular groups of young people, which I feel quite often are very vulnerable, when I go out and meet them I think they've got very difficult, complicated lives, and for them to take control in any one area of their lives seems almost an insurmountable task, but its about starting to develop some of the skills and strategies for taking control of their own behaviours and for looking at health issues and of having a positive experience of doing that. What we want ultimately is for these young people to have coping skills and strategies for dealing with life and being able to change their behaviour and being able to come through difficult circumstances."

4.5   Diverting the focus away from the individual, other outcomes related to the wider environment for adolescent smoking cessation. Creating more supportive environments and putting healthy behaviour on the agenda in schools featured in some initial plans. For example, the following outcome measures are taken from the task sheets completed at the initial planning workshop and the baseline interviews with project partners:

- *"the school should regard students' health as a matter for the school"*

- *"the school will stand up as a supportive environment (non-smoking is the norm in the school); schools will support pupils to stop smoking"*

- *"we have in our minds that cessation is for adults and prevention is for adolescents. And also that adolescents that start to smoke do not want to quit. This is what is in the health professionals' and politicians' minds, but it is not in my mind. I did some research and I know that from the beginning adolescents think that they should stop."*

- *"we need to know if this project could actually work, because it's never been tried before. I see this project as a means of improving our knowledge about giving up smoking, so getting insight and accumulating knowledge in this field, in what works and what doesn't work in supporting young people to quit smoking. And what's important too: young people themselves indicate they want to quit, as we found from research. But they don't know how. Fifty per cent of the young people that smoke, from 16 years and older want to quit smoking. That's a lot. So for me that's enough reason to develop something to support them."*

- *"hopefully the outcome of the project is to create a new fashion, a new attitude towards smoking."*

Outcomes to date

4.6   The minimum data sets provide a broad indication of project outcomes. However, there are a number of limitations of the minimum data sets which mean that caution needs to be exercised in drawing conclusions from these data alone.

4.7   Within the minimum data sets, data were presented in aggregate form that did not allow individual participants to be tracked throughout the programme. Some respondents were lost to the intervention between baseline and follow-up and there was also the problem of item non-response with some participants choosing not to answer particular questions or failing to follow the correct questioning route. Therefore, the data from the baseline and follow-up questions are not directly comparable and as a result, the tables below include discrepancies between the numbers providing responses (n values). A further limitation of the minimum data set is that in most cases projects relied on self-reported outcome measures. Comparisons between countries also need to be handled cautiously due to the variation between interventions together with variations in data collection methods. Interpretation of country level data needs to be set within the context of the individual country's aims and objectives.

4.8   In the future, utilisation of minimum data sets should be supported by resources to ensure the data collected can be used to draw more robust conclusions. This includes providing centralised support at a programme level to provide guidance on data collection together with resources at a project level to ensure data collection is complete and rigorous. It is also important to allocate sufficient time at the start of the evaluation to ensure that minimum data set tools are well developed and piloted. Ideally, the minimum data set needs to be integrated into the overall programme management and should be in place before project work commences.

Smoking behaviour outcomes

4.9   Table 4.2 presents the key data related to changes in smoking behaviour throughout the programme. This includes quit attempts made during the project as well as cutting down on levels of smoking. Participants' pre- and post-project smoking status is presented along with

Table 4.2: Key outcomes						
Country	Key outcomes					
	Made a quit attempt during project	Average longest period stayed stopped	Project completely influenced or had a big influence on helping them quit	Didn't quit but cut down during project	Project completely influenced or had a big influence on helping them cut down	Smoking status at end of project classified as 'used to smoke but stopped during the project'
Denmark	88%(n=56)	6 days (n=51)	82% (n=52)	77% (n=13)	89% (n=34)	14% (n=72)
Netherlands	0% (n=8)	N/A	N/A	38% (n=8)	100% (n=3)	0% (n=8)
Slovak Republic	57% (n=75)	6 days (n=45)	60% (n=46)	44% (n=32)	72% (n=14)	9% (n=172)
Wales	69% (n=104)	7 days (n=45)	77% (n=44)	63% (n=32)	86% (n=21)	35% (n=69)
n = number providing data						
No data for Belgium, Greece, Portugal or Spain.						

the role of the project in influencing changes in behaviour.

4.10   In three countries at least 50% of participants made a quit attempt at some point during the project. This ranged from 88% in Denmark to 57% in the Slovak Republic. The lower rate in the Slovak Republic is a reflection of the higher proportion of non-smokers involved in the project. No quit attempts were made in the Dutch project as this was not seen as a main aim of the intervention. Most of these participants made either one or two quit attempts and the average longest period they stayed stopped was around six or seven days across the three countries. In Wales and Denmark the largest groups of participants who quit stayed stopped for up to four days (58% and 75%, respectively) while in the Slovak Republic the largest group stayed stopped for between four and seven days (76%). Overall 74% (n=142) said the

project had a big influence or completely influenced their decision to quit. The lowest rates were reported in the Slovak Republic where just under two thirds of those who quit said the project played an important part. At the end of the project, all three countries where quitting was a key aim of the project were able to report participants whose status was 'used to smoke but stopped' ranging from 35% in Wales to 9% in the Slovak Republic.

4.11 The proportions reporting that they had cut down during the project ranged between 77% (in Denmark) and 38% (in the Netherlands) and the majority said that the project was an important factor in doing so.

Awareness of smoking and cessation

4.12 Table 4.3 presents summary data for responses to statements about smoking and cessation. These were used to identify participants' awareness of the effects of smoking and how and why it is important to quit. This links to the aims and objectives of the overall cessation programme which was to provide adolescents with information about smoking and quitting in addition to providing the skills and confidence to quit.

Table 4.3: Smoking and cessation awareness				
Country	*Strongly agree or agree with the following statements*			
	I now have a better understanding of how to quit smoking	*I now have a better understanding about where to go for help about quitting*	*I now have a better understanding of why it is important to quit*	*I now have a better understanding of the effects of smoking*
Denmark	88% (n=58)	67% (n=57)	88% (n=57)	86% (n=58)
Netherlands	85% (n=7)	63% (n=8)	88% (n=8)	100% (n=5)
Slovak Republic	63% (n=198)	46% (n=197)	62% (n=177)	64% (n=203)
Wales	82% (n=67)	85% (n=68)	89% (n=68)	90% (n=58)
n = number providing data				
No data for Belgium, Greece, Portugal or Spain.				

4.13 Overall, the results look positive with at least 60% agreeing with most of the statements. Responses were less positive in relation to knowing where to go for help about quitting, which highlights the limited availability of support for adolescents outside this programme. It is noticeable that responses to this question were most positive in Wales (85%) where there is an established framework of support outside the cessation sessions in the form of website materials and a telephone helpline. Overall, proportions in Denmark, the Netherlands and Wales were very similar with the exception of the help item, as noted above.

4.14 Another element of awareness about smoking and cessation relates to changing participants' perceptions about smoking. Participants were asked to agree or disagree with a series of ten statements in the baseline and follow-up questionnaires. These statements related to the health

risks associated with smoking (e.g. 'smoking increases your risk of a heart attack') as well as the social aspects of smoking (e.g. 'most young people smoke'). Responses have been scored and an average score for all participants calculated for each country with the expectation that scores should increase as perceptions become more positive by the end of the project. The results are presented in Table 4.4.

Table 4.4: Perceptions of smoking		
Country	*Average scores – baseline and follow-up (from 0 to 50 where 0 = negative perceptions, 50 = positive perceptions).*	
	Baseline	*Follow-up*
Denmark	No data	35.0 (mean n=57.1))
Netherlands	34.9 (mean n=8)	34.5 (mean n=7.9)
Slovak Republic	35.6 (mean n=232.6)	37.3 (mean n=203.3)
Wales	34.6 (mean n=80.9)	37.8 (mean n=50.6)
n = mean number providing data		
No data for Belgium, Greece, Portugal or Spain.		

4.15 The results were fairly consistent across the two points in time but it is important to remember that the data at baseline and follow-up are not directly comparable with the absence of matched data at the individual level. Generally scores were positive, reflecting a well developed understanding about the effects of smoking, even at the start of the programme. Respondents scored less well on the statements relating to the social aspects of smoking. For example, over half of respondents in each country agreed that 'most young people smoke' at the start of the programme and at least two fifths continued to agree with this by the end of the programme. Similar perceptions about adults smoking were also observed with at least two fifths agreeing that 'most adults smoke' both before and after the programme. This adds to our understanding of the social barriers that young people perceive they face in terms of quitting smoking. Incorporating these findings into course materials and approaches to cessation will help to address these misconceptions in future years.

Motivation levels

4.16 As noted earlier, some projects assessed motivation levels at the recruitment stage of the project, trying to select those motivated enough to quit smoking. The follow-up evaluation questionnaires also included a number of measures designed to assess levels of motivation to attempt to quit or stay smoke free.

Table 4.5: Motivation levels				
Country	*Measures of motivation*			
	Very or fairly confident they'd still be quit this time next year *(those who had attempted to quit and were still stopped at the end of the project)*	*Seriously thinking of quitting in the next 30 days* *(those who were still smoking at follow-up)*	*Seriously thinking of quitting in the next 6 months* *(those who were still smoking at follow-up)*	*Taking part in the project made them more determined to quit/cut down/stay smoke free* *(all at follow-up)*

Denmark	72% (23 respondents) n=32	44% (18 respondents) n=41	32% (13 respondents) n=41	84% (49 respondents) n=58
Netherlands	No data	38% (3 respondents) n=8	0% n=8	75% (6 respondents) n=8
Slovak Republic	87% (13 respondents) n=15	3% (2 respondents) n=61	10% (6 respondents) n=61	71% (143 respondents) n=202
Wales	100% (6 respondents) n=6	23% (13 respondents) n=57	25% (14 respondents) n=57	87% (73 respondents) n=84
n = number providing data				
No data for Belgium, Greece, Portugal or Spain.				

4.17 Focussing on those respondents who had quit by the end of the project, between 23 (in Denmark) and 6 (in Wales) said that they were either fairly or very confident that they would still be quit this time next year. Looking at future readiness to quit amongst those who were still smoking at the end of the project, between 3 (the Netherlands) and 31 (Denmark) were seriously thinking of quitting in the next 30 days or within the next six months. Most other participants who continued to smoke at the end of the project reported that they were looking to quit at some point in the future with just 1 participant in Denmark and 12 in the Slovak Republic 'not thinking of quitting.' Overall, the majority of respondents said that taking part in the project made them more determined to quit, cut down or stay smoke free. These findings suggest that the future bodes well for those that had quit by the end of the project. For some of those that had not quit the data suggest that they will look towards quitting in the future. However, once the intervention is over, is it more likely that the desire to quit will diminish rather than a quit attempt being made hence the need for longer term follow-up. The small group that were not planning to quit might need a different type of intervention focussed on raising their motivation levels before launching into cessation itself.

Sustaining outcomes with young people

4.18 The discussion has highlighted some promising immediate post-project outcomes and tracking these in the longer term will be important. Feedback from project managers, project partners and young people themselves suggest that something else is needed to sustain these positive outcomes beyond the end of the cessation course. While in the adult cessation literature[14] there is evidence that support over extended periods leads to improved long term cessation success, most adolescent cessation activities have been short term. Although projects are at a relatively early stage, this evaluation has identified evidence that partners and

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[14] Fiore, M.C., Bailey, W.C., Cohen, S.J., et al, (2000) 'A clinical practice guideline for treating tobacco use and dependence – A US Public Health Service Report' in Journal of the American Medical Association, 283 pp.3244-54.

young people regarded follow-up support as a key issue. For example, the young people who were interviewed as part of the case study work stressed their ongoing needs for cessation support after the six week course. They found the course helpful but needed something additional after the course had finished. This view was also endorsed by teachers at the school. One teacher had given thought to the format of follow-up work which they regarded as an important element of approach to tackling adolescent smoking cessation:

"Not necessarily sessions, but follow-up visits, either by somebody who was not the deliverer…Then maybe if it was initially one month later, then three months later, then six months later, that's the end of it now and it comes to a more gradual end and there's a follow-up to it. Because they're only probably getting started on it and then they haven't really got the maturity to think well we had that and I'll do it myself next time. It's asking a lot of them to remember what it is they think they learnt and putting that into practice. Three months in the life of a 15 or 14 year old is a huge length of time, you know so much happens for them."

4.19   One project co-ordinator commented on the need for something to come after the intervention rather than just an abrupt halt. When asked why they thought some young people would relapse, even if they had made a quit attempt, they said:

"I think because there is nothing anymore. First they were doing the six sessions in a very high level and then after six weeks they have the Christmas holiday and there is nothing anymore so there is nothing happening anymore to help them. I think it's because of that."

4.20   Overall, project managers regarded follow-up support being aided by greater links with partner organisations. Future considerations need to be given to the sort of follow-up support provided, such as ongoing sessions on a less frequent basis, drop in by facilitators, an off-site facility for a number of settings, or something which the partner organisation (school, youth club etc) facilitates itself. Some projects suggest that they are providing ongoing provision in the form of telephone helplines and internet support, but the extent to which these match the ongoing needs of young people needs further consideration. Once again this is something that needs to be tailored to the needs of adolescents and not just a replication of what is available in the adult service. The cost implication of undertaking follow-up support should also be incorporated into initial project planning and budgeting.

5   Conclusions

Conclusions

5.1   This report has provided an overview of the programme so far, including the mechanisms involved in setting up projects, the main intervention activities that have taken place and the outcomes that have arisen. Underlying the variations in set up mechanisms, project activities and reported outcomes are the different contexts in which projects have operated, including country-wide smoking regulations and cultures as well as more local contextual factors such as varying degrees of support from partners and settings. The programme has provided a useful opportunity to compare and contrast various approaches and there have been some general findings and trends that will be helpful in contributing to the wider research base on adolescent smoking cessation. However, this is not an evaluation of a homogenous programme where the outcomes are generalisable and the lessons replicable. Instead, findings should be interpreted with caution bearing in mind the context in which the project is operating and the aims and objectives of that project. In particular, caution should be noted when drawing conclusions from the outcome data, taking into account the limitations of the minimum data set as discussed in chapter four.

Progress to date

5.2   By January 2005, all eight countries had attempted to establish adolescent smoking cessation provision although some countries had progressed further than others. While some managed to establish interventions close to those that had been planned, others struggled to reach the scale or intensity envisaged. Cultural and environmental factors played a key role in determining progress to date, including support for adolescent smoking cessation at a national and local level, as well as background expertise in delivering this kind of tobacco control. The infancy of adolescent smoking cessation has also contributed to the difficulties that some countries encountered. It is still not widely accepted as a service that should be available for this age group and greater reach and impact is to be expected as the projects and adolescent smoking cessation in general becomes more established. As they were new projects, they were still undergoing development during the evaluation period, and were not strongly embedded within broader tobacco control strategies. All countries were developing ideas about what worked well in adolescent smoking cessation but some were in the initial formative stages of experimenting with methods and approaches. One of the advantages of having a network of countries should be the sharing of good practice between partners and there is scope for further programme wide

support and guidance, particularly for those countries facing difficulties with certain aspects of smoking cessation.

5.3   The smoking behaviour outcomes are encouraging but require more robust validation through longer term follow-up. At the start of the programme, project managers stressed the importance of other individual level outcomes including self-efficacy and providing adolescents with the skills to be able to stay smoke free, cut down or quit smoking. The evidence presented in this report is encouraging with projects focussing on skill development and awareness raising as part of their overall interventions and positive outcomes related to awareness of the harmful effects of smoking and the benefits of cessation.

5.4   Anticipated outcomes also related to the wider environment for adolescent smoking cessation, including the creation of more supportive environments and putting smoking cessation on the agenda for schools and other youth settings. The pilot projects have initiated the first step towards addressing these issues and in some cases the project offered a way into these settings. However, changes in the culture and attitude at school and national level will take much longer to achieve. Reflecting on project outcomes for individual project managers and cessation teams this programme has taken them forward in their accumulation of knowledge in the field of adolescent smoking cessation and for some this marks the beginning of adolescent smoking cessation within their country.

What was learnt about establishing adolescent smoking interventions?

5.5   Discovering how different countries prepared and set up adolescent smoking cessation projects provided useful lessons about the practical realities of doing this sort of health promotion work. Establishing multi-layered networks of support is fundamental to effective project delivery and includes gaining support at a strategic level and support within delivery settings. However, there is an acknowledgement that the organisation-wide approach is difficult and takes time to set up. Addressing wider school smoking issues and involving staff, parents and students in a network of support was seen as one way of enhancing the effectiveness and sustainability of cessation projects.

5.6   The cost implications of setting up adolescent smoking cessation interventions need to be more closely scrutinised. At this pilot stage developmental costs will be high but the increased costs associated with intervention enhancements (such as longer lead in times to build up networks, smaller group work sessions and longer term support) need to be examined, alongside outcomes and longer term impacts. The ongoing requirements for relapse prevention, which are likely to be substantial for this age group, also need to be factored in.

What was learnt about delivering adolescent smoking cessation interventions?

5.7   The pilot programme has also provided insights into what works in delivering adolescent smoking cessation. There is a growing recognition amongst cessation practitioners that approaches that may work well with adults need to be adapted to take into account the different (sometimes very different and changing) needs of adolescents. Issues such as ensuring confidentiality and encouraging commitment are key for adolescents and whereas an adult-based approach is primarily influenced by individual addiction, peer influences play a greater role amongst adolescents. This has implications at the front-end of cessation interventions in terms of spending time identifying those at the right stage of motivation, and also at the back-end in terms of providing more structured support over a longer period than might be the case with adults. The role of the facilitator is also perhaps more prominent in adolescent cessation with their attitude and approach playing a key role in how well young people respond, both in terms of initially signing up for the project and in terms of their ongoing commitment to cessation.

5.8   Adolescent smoking cessation practitioners also need to recognise the teenage years as a phase of change which needs a correspondingly flexible, sub-group approach. Interventions must take account of where young people are at in terms of their social, emotional and environmental needs. Cessation activities, incorporating quit attempts and support, should be pitched at those smokers who are at the right stage of motivation in terms of their readiness to quit. However, there is a tension here between the need to respond to individual needs (social, emotional, environmental and motivational) and a recognition that these individual needs are constantly changing. For example, it is hard to identify a young person's stage of readiness because they constantly shift. Targeting by stage of change or readiness to quit will be a difficult task to undertake and is one of the key challenges for adolescent smoking cessation practitioners. At the same time, greater thought needs to be given to interventions targeted at the 'harder to reach groups' who have not yet reached the ready to quit stage.

What was learnt about undertaking an evaluation of a European adolescent smoking cessation project?

5.9   Interpreting outcomes and findings in light of the various contexts in which projects are operating is fundamental to an evaluation of this kind. As a result the evaluation has relied heavily on the process elements of the work programme using the case studies and interviews with project managers to unpack the challenges and opportunities facing each project. The minimum data set was a useful tool to collect standardised outcome data across the programme but the limitations of this tool should be highlighted. Loss to the intervention and item non-response meant the baseline and follow-up data were not directly comparable and in most cases

self-reported data are presented. Also, there were some difficulties with the data collection process as facilitators were not always familiar with the structure and format of the questions, particularly with the filtering format of some questions. In the future, facilitators should receive guidance on this at the start of projects and it will be important for the minimum data set to be in place before individual projects develop their own measures and self-evaluation tools. Allocating sufficient time and resources both centrally and at a local level is paramount if this sort of evaluation tool is to be used effectively.

Next steps for the programme

5.10 Looking to the next phase of the programme between March and December 2005, there are a number of key steps to be taken at a programme-wide level to ensure maximum gain for projects and learning across all partner countries. With two new projects coming on board and recognition that some projects still need guidance and support for the next phase of project activities, it will be important that the programme co-ordinators facilitate cross-programme information dissemination of evaluation findings. This includes lessons from the overall evaluation as well as project level evaluations, some of which are tracking longer-term outcomes.