SILNE-R

Enhancing the Effectiveness of Programs and Strategies to Prevent Youth Smoking: A Comparative Realist Evaluation of Seven European Cities

GA Number AMD 0635056-18

Recommendations to prevent youth smoking in Ireland (national, local and school)

Joan Hanafin and Luke Clancy

Work Package 3 (WP3)

DELIVERABLE REPORT D3.2

APPENDIX G

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Fine-grained (evidence-based, context specific) recommendations at national, local and school levels to prevent youth smoking in Ireland

Ireland: Context

Ireland, the capital of which is Dublin, has a population of 5.0 million. Dublin has a population of 1.3 million and a physical area of 115 km^2. Ireland had a national tobacco policy score of 70 in 2013 and in 2016, the only SILNE-R country not to record an increase in national tobacco score in that time period. Smoking prevalence for 2013 is not noted as Ireland did not participate in SILNE. In 2016, for students participating in SILNE-R, weekly smoking prevalence was 5.1%, ever-tried smoking was 25.86%, and ever-tried e-cigarettes was 28.37%.

Data sources for findings and recommendations in this report

The fine-grained policy recommendations to prevent youth smoking in Ireland that are contained in this report are based on findings and recommendations from many quantitative and qualitative data sources collected for the SILNE-R project (2015-2018). The fine-grained recommendations for Ireland in this report should be read in conjunction with the reports containing cross-national, national, local, and school-level findings and recommendations (D3.2 Appendices A, B, C and D).

Overseen by WP8, surveys of more than 13,000 school students in 7 cities were carried out (2016/17) to examine student health, social networks, smoking (prevalence, access to cigarettes, attitudes to smoking, parental smoking, location of smoking, smoking in the home, e-cigarettes, *etc.*), perceptions of school tobacco policies, *etc.*. The general participation rate for student surveys was 89.6 % (all countries). In Ireland, 2117 students participated (99.72% participation rate).

From late 2016-2017, overseen by WP9, 56 single-sex focus group interviews took place, 8 in each of the 7 cities, involving 319 participants. The focus groups paid particular regard to school smoke-free policies and age-of-sale laws. Participants were recruited by teachers, who identified students they believed to be smokers or at risk of

becoming smokers. Half the focus groups were conducted with girls and half with boys. Overall, 168 girls and 151 boys participated, with 3-9 participants per group. Half of all groups were conducted with students attending schools that served a predominantly high socioeconomic status (SES) population, and half in schools serving a low SES population. Adolescents were aged 14-19 (average age of participants was 15.2 years) with most focus groups having participants under the legal age limit. In Dublin, 4 focus group interviews were held with girls and 4 with boys, in 2 participating schools.

Staff questionnaires regarding school characteristics, school tobacco policies, health promotion and prevention, *etc.* were also completed for WP8 and interview data with staff was collected for WP7. Consultations and focus group interviews (initial and follow-up) were held with policymakers and stakeholders from the 7 SILNE-R countries and also from other EU and non-EU countries, overseen by WP5 at the national level and by WP6 at the local level.

Data relating to enforcement and implementation costs of certain tobacco control measures (ban on sale to minors; point-of-sale advertising; ban on smoking in public places) was overseen by WP10. In some cases, school staff were interviewed regarding the cost of school bans and educational programmes for WP10 (cost questionnaires/interviews).

National-level findings and recommendations to prevent adolescent smoking

Ireland is a progressive country in relation to tobacco control and there is strong support for tobacco control policies in Ireland among policy makers and the general public. Ireland was an early adopter of progressive policies to reduce smoking prevalence and to denormalise tobacco use. It continues to be at the forefront of tobacco control initiatives, with a stated government policy of a smoke-free (< 5% smoking prevalence) Ireland by 2025[1]. Ireland has good laws and policies regarding high taxation on tobacco products, smoke-free legislation, standardised packaging, and bans on point-of-sale displays.

WP5's[2] analysis of policy monopolies of pro and anti-tobacco interest groups across six European SILNE-R countries found that one of the main factors influencing variation in tobacco control policies across European countries is the relative policy dominance of pro and anti-tobacco control interest groups. WP5 examined whether there are patterns and similarities with regard to framing of tobacco and institutional arrangements across countries that have a relative dominance by either one of the two groups. In doing so, they conducted 32 semi-structured interviews with relevant stakeholders in Belgium, Finland, Germany, Ireland, Italy, and the Netherlands.

They found that, in countries like Ireland where health non-governmental organizations (NGOs) have a policy dominance in tobacco control, NGO communities are well developed and have tight links to government while the industry is largely economically absent. In addition, the health ministry plays a central role in the policymaking process, FCTC Article 5.3. is strictly interpreted and the framing of tobacco focuses on the health aspects of smoking. In contrast, in countries where the tobacco industry and associated businesses have a policy dominance, the industry is more strongly embedded in the domestic economy while NGO communities are weak or absent in the field of tobacco control. They concluded that the way tobacco is framed in a country and the way institutions are arranged correspond to the policy monopoly in place, with strong similarities across countries with the same policy monopoly.

Certain structural and institutional conditions at national level in Ireland assist in advancing progressive tobacco control initiatives. The Department of Health takes an active role in the creation, adoption, and implementation of policies. The department has close ties to health and community NGO organisations to formulate and to deliver policies. Structural factors such as the small size of Ireland may also facilitate policymaking processes. Recently, the focus has developed to refine the current policies in order to target specific populations and certain settings (*e.g.*, tackling socio-economic inequalities around smoking; expanding smoke-free spaces, especially where children are present, such as playgrounds *etc*.).

Smoke-free legislation was introduced in Ireland in 2004 banning smoking in all indoor work areas. Since then, there have been efforts to extend and refine this policy

to outdoor settings (*e.g.*, playgrounds; health campuses; higher education campuses, *etc*.), with mixed results. Many of the more recent smoke-free initiatives have been introduced from the 'bottom-up' from sub-national authorities (*e.g.*, bye-laws from city and county councils for smoke-free playgrounds) and have been focused on continuing denornmalisation efforts and minimising young people's exposure to second-hand smoke. Ireland relevant national-level observations and recommendations follow.

1. Adolescent smoking remains a problem

The problem of adolescent smoking has not disappeared in Ireland, and must be kept high on policy agendas. SILNE-R WP8[3] (2016-2017) data from Dublin showed weekly smoking among students to be 5.1%, ever-tried smoking 25.86%, and ever users of e-cigarettes 28.37%. Health initiatives in Ireland are beginning to focus elsewhere and, in the context of decreasing smoking prevalence, there is a sense from stakeholders that the "tobacco problem" has been dealt with.

Recommendations:

- **There is no safe level of smoking and smoking prevalence among adolescents continues to be a problem. tobacco control is in competition with, and in danger of being swamped by, priorities on other adolescent health problems. We recommend keeping tobacco at the top of policy agendas, with constant reminders of the death and disability uniquely caused by smoking.**

2. Cognisance needs to be taken of dominant frames influencing policy

SILNE-R data[4] show the importance of policy change processes in shaping tobacco control policies within individual countries. In order to enact effective tobacco control policy, cognisance must be taken of these processes by tobacco control advocates and stakeholders. The strength of the dominant frame (health side versus tobacco industry) influences the policy environment and the receptiveness to change within the policy system[5]. In Ireland the health-side of the framework is dominant, and there is an intersectoral approach to population health that engages with multiple sectors and actors[6]. Specifically, within this frame, the Department of Health is responsible for creating and introducing new policies. There is cross-party almost unanimous

political support for tobacco control measures. There is co-ordination between government health departments and health advocacy organisations to drive and develop policies. Ireland's progressive tobacco control environment is further assisted by having a broader framework in place that focuses on health, *viz.*, the *Healthy Ireland* strategy[7]. Ireland also has a specified end-game goal, to be smoke-free by 2025.

Recommendations:

- **It is recommended that, when developing tobacco control policy and advocating in Ireland, cognisance is always taken of the particularised complexity of the national policy context, and that uptodate data are maintained regarding dominant frames that shape tobacco control within each country.**
- **Education in the complexities of policy change processes is recommended for tobacco control advocates, NGOs and health experts in Ireland whose professional substantive areas of expertise cannot be expected to include policy change processes. This is particularly important in Ireland where strides made by active and effective health NGOs could be further amplified by knowledge of the elements of a taken-for-granted *tobacco control policy paradigm*.**
- **Further research is required to "fill out" the understandings gained by WP4 and WP5 regarding policy monopolies in SILNE-R countries and to keep them up-to-date. Such research would develop the concept of a *tobacco control policy paradigm* and explicate its particularised operation across Europe countries and (regional and other - demographic *etc.*) contexts.**

3. Gather data on dominant frames in Ireland to support continued progressiveness in tobacco control and use this in tobacco control advocacy

As described above, dominant values and beliefs that underpin tobacco control policy in Ireland are supportive of a progress tobacco control environment. Positive tobacco control dominant frames notwithstanding, such frames may be under-exposed, taken-for-granted, and unchallenged. Regular data collection about values and beliefs that

are known to have an impact on tobacco control policies in Ireland, extending the work of WP4 and WP5, would be a valuable tool for tobacco control advocates, supporting them in maintaining and expanding tobacco progressive control efforts.

In Ireland, the role of robust and effective health advocacy organisations exist is central to its progressive tobacco control environment. In exposing these dominant frames, tobacco control experts and advocates can direct their efforts to ensure that dominant policy frames in Ireland continue to be supportive of progressive tobacco control policy environments. This latter could be done through the further development of intersubjective discourses (*e.g.*, focussed on evidence bases, health, child frame).

- **We recommend regular data collection about values and beliefs that are known to have an impact on tobacco control policies in Ireland so that those supportive of Ireland's progressive tobacco control environment may be protected and negative changes noted and challenged.**
- **In terms of a dominant governmental frame in Ireland: Further develop public discourses that highlight tobacco harms, are protective of citizens, and emphasise child health.**
- **In terms of civil and business institutions in Ireland: Make even stronger networks of health NGOs and provide example to countries where health advocacy groups are weak and/or non-existent.**
- **We recommend an audit of current TC-related organisations, and interventions (resources, development) in order to be able to support them individually and draw on their good practices in countries with less progressive tobacco control environments. We further recommend that existing international networks of tobacco control organisations (ENSP/ SFP/ FCA) establish sub-groups charged with advocating for national-level transferability of knowledge that is based on the complex policy monopoly environment within which each country operates.**
- **Support the NGO community in Ireland to create even stronger networks at national and international levels so that they can actively try to influence policymakers and politicians to progress the endgame goal.**
- **Overall, strengthen further health monopolies and weaken further tobacco industry monopolies.**

- **Pay attention to moments of potential change when stable policy-making processes are disrupted by moments of crisis. At these times, policy change may be more likely to occur. Note Punctuated Equilibrium Theory Framework (D3.2 Appendix A).**

4. Tobacco control efforts showing success but must be continued, expanded and translated

Current tobacco control policies are taking effect, evident in reduced adolescent smoking prevalence in Ireland but gains are not homogeneous, with tobacco-related health inequalities evident in some population sub-groups. This is the time for continued, expanded and translated/ transferred tobacco control efforts.

Recommendations:

- **In Ireland where prevalence is relatively lower, and tobacco control environments more progressive, two broad approaches are required.**
    - **1. Continue with existing policies and interventions, ensuring strict enforcement.**
    - **2. Expand tobacco control efforts by adding new interventions where they are lacking to support the endgame vision.**

5. Specific measures to increase TCP progressiveness

Progressive tobacco control policy environments are characterised by systematic transposition of, strong compliance with, and strict enforcement of the Framework Convention on Tobacco Control (FCTC) treaty; the "Big Six" MPOWER[8] policies; the EU Tax Directive and the EU Tobacco Products Directive (TPD). SILNE-R cities like Dublin that have lower youth smoking prevalence are characterised by such progressive tobacco control policies. We recommend continued strong enforcement of tobacco control policies at national level in Ireland.

Recommendations:

- **Continue Ireland's progressive tobacco control approach with strict implementation, enforcement and oversight of FCTC policies recommendations.**
- **Meaningful enforcement is the most important measure for smoke-free**

legislation is required. Continue strict enforcement of existing smoke-free areas, and expand smoke-free areas especially in areas where "child health" discourses more easily justify it.

- **As a more progressive tobacco control country, Ireland has ambitious 'endgame' aspirations. Further efforts are recommended to support this vision, such as improvements in smoking cessation services and more consistent mass media campaigns.**

6. Access: enforcement and other measures needed

The vast majority of SILNE-R adolescents were unable to legitimately purchase cigarettes from retailers in Ireland because they were under the legal age of purchase, *i.e.*, 18 years, as specified by National Minimum Age of Sale Laws (NMASLs). National Minimum Age of Sale Laws (NMASLs) are designed to prevent young people from accessing cigarettes, with the aim of reducing youth smoking uptake and prevalence. WP9's analysis [9] of focus group research exploring adolescents' perceptions and experiences of accessing cigarettes across 7 cities found that access was largely in contravention of national minimum age of sale laws (NMASL). Participants across SILNE-R cities including Dublin accessed cigarettes with ease, using a variety of methods to obtain cigarettes from: 'legitimate' retailers or vending machines; people above the legal age of purchase; friends; 'proxies' (known or stranger adults who purchased cigarettes on their behalf); stealing from family members; buying from other young people; and purchasing cigarettes abroad. Methods to access cigarettes differ across cities, reflecting variation in the implementation or enforcement of NMASLs at a national or local level. Adolescents in Ireland generally reported being able to obtain cigarettes with ease, by utilising a variety of methods. Participants in Ireland reported being able to access cigarettes via certain legitimate retailers – particularly small, local shops located in socio-economically deprived areas. A small number of participants suggested that community shops would sell cigarettes to minors, if they believed those cigarettes were for an of-age family member. Participants reported using both acquaintance and stranger proxies. Stranger proxies were targeted primarily by reference to age (young adults) and by cultural markers. Most Irish participants had never seen a cigarette vending machine. Policy recommendations are based on WP9[10] and other SILNE-R findings.

Dublin relevant recommendations:

- **Meaningful enforcement is the most important measure. Enforce national minimum age of sale laws. Despite Ireland's progressive tobacco control policy environment, access to cigarettes is not adequately restricted for under-age adolescents.**
- **Ireland should consider following the example of 6 states (California, New Jersey, Massachusetts, Oregon, Hawaii and Maine) and at least 350 localities in the U.S. that, as of 19th September 2018, have raised the minimum age of sale to 21 years[11]. As the vast majority of smokers start smoking before the age of 20, enforcement of such a law would likely result in further decreases in youth smoking prevalence.**
- **Strengthen supply side-restrictions. Consider the introduction of a licencing levy or penalty to discourage smaller retailers from supplying cigarettes to underage purchasers. This may be particularly effective in Ireland because of adolescent patterns of accessing cigarettes.**
- **Take action on proxies via awareness raising. This is an area where Ireland could make headway. We recommend, among others, an intervention to be included in tobacco-related health education. This could include making smokers aware of their responsibilities in promoting smoking, especially as older students generally do not want younger students to start smoking**
- **A trans-national European approach - the fluid borders of Europe and the mobility of its citizens - means that successful policy-making should be seen as a supra-national/international endeavour.**
- **Specific education and media campaigns on the health harms of tobacco are required in the context of stranger proxies and older (known) persons buying cigarettes for young students in breach of the NMASLs.**
- **Further context-specific recommendations are detailed in Appendix D.**

7. Costs and cost effectiveness of various tobacco control policies

As regards the current landscape of tobacco control policies and their costs in 7 European cities / countries, the findings of WP10[12] provided a snapshot of costs for the implementation of various policies to prevent adolescent smoking. In

Dublin/Ireland:

- A year of implementation of non-school bans (bans on smoking in public places, bans on sales to minors, bans on advertising at point-of-sale) cost €0.20 per person covered (PPP).
- A year of implementation of school bans cost, in mean, €34.76 per student covered (PPP), if considering a conservative perspective. Considering a realistic perspective, the implementation of this ban cost €0.10 per student.
- The implementation of a school smoking prevention programme cost, in mean, €0.65 per student covered (PPP).
- Long-term effectiveness estimates ranged from 31,700 to 1,587,000 healthy years gained after the implementation of a strategy with a short-term effectiveness of 1 to 50% relative reduction of smoking prevalence, respectively.
- For these cost and effectiveness estimates, the implementation of non-school bans, school bans (realistic and conservative perspectives), and school programmes was highly cost effective (according to the WHO threshold of 1 times the GDP per capita) for the reduction of at least 1% of the prevalence of smoking among adolescents.

Recommendations:

- **Data on cost and cost effectiveness are scarce but it is clear from WP10 that school tobacco control policies (STPs) are highly cost-effective.**
- **To maximise the potential for use of financial data to support a demand for appropriate STPs, it is important that cost and cost-effectiveness data collection be made a component of STP monitoring and be available to support policy makers.**
- **It is important that the cost effectiveness of smoke-free laws is emphasised and kept prominent when public health, and particularly disease prevention, is being considered.**
- **Cost-effectiveness is a valuable tool when advising policy-makers and may be particularly important when tobacco control policies are in competition with, and possibly getting a lower priority than, other prevention areas for resources and public (electoral) support.**
- **Cost-effectiveness should be included in intersubjective discourses being**

developed by tobacco control advocates.

- **Collection of cost data for use in cost-effectiveness analysis should be part of monitoring of smoke-free laws.**

Local-level findings and recommendations to prevent adolescent smoking

WP3 synthesised and translated evidence from SILNE-R WP4-10 in order to make local-level recommendations for the prevention of youth smoking in Ireland. Using the prism of WP4 policy models and briefs, and drawing on WP6's qualitative assessment of expert interviews (n=56) with European decision makers and stakeholders, and a consultation group, we make some observations. These observations and resulting recommendations are described in detail in D3.2 Appendix C.

Local context

Separate from a national policy and legislative context, schools exist within local contexts that must be taken into account in order to reduce and prevent adolescent smoking. Local primary prevention in schools in Ireland must be framed with adequate national tobacco control policies, such as effective tobacco taxation and advertising bans, but features of the local context may support or hinder reductions in smoking prevalence among young people. In particular, local factors can create environments that, rather than discouraging young people from smoking, serve to facilitate youth tobacco use. This occurs despite national legislative frameworks, as a consequence of poor local enforcement, or lack of specific policy or legislation at the local level.

A critical realist qualitative study of the implementation of smoking bans at the local level of 7 SILNE-R cities based on semi-structured expert interviews (n=56) with local decision makers[13] showed that existing implementation processes at the local level in Dublin may be categorised as "progressive-hungry" (rather than "upper-saturated", "moderate-rational", or "lower saturated"), particularly with regard to engagement in enhancing smoke-free environments as well as the level of perceived

de-normalisation and public smoking visibility. In Ireland, local tobacco control policies are framed within ambitious national policy environments such as effective tobacco taxation, comprehensive smoke-free laws, banned vending machines, plain packaging, point-of-sale and advertising bans. Smoke-free laws have been adapted and modernised specifically for outdoor places (such as playgrounds) and private contexts (*e.g.,* cars) that are frequented by children. Regular and active smoke-free monitoring enhances effective long-term enforcement of smoke-free environments.

Barriers at the local level

Barriers identified across the 7 cities to successful local-level implementation of tobacco control activities to prevent youth smoking are: lack of a unified structure that deals with implementation, monitoring and enforcement of national-level policy and legislation; lack of an 'implementation plan' or strategy or endgame vision for prevention of youth smoking; lack of resources for tobacco control at local level; uneven efforts regarding denormalisation and specifically, advertising bans; inadequate expansion of smoke-free spaces, especially those where children may be (all indoor and outdoor areas in schools, health facilities, crèches, recreational facilities, sports stadia); and need for increased efforts for population sub-groups suffering specific disadvantage regarding smoking prevalence (low SES groups; some school types and tracks).

Suggested solutions at the local level

Suggested solutions to mitigate these barriers at the local level include tobacco taxation, institutional structures, expansion of smoke-free spaces, and community involvement. The use of intersubjective discourses - especially regarding evidence bases and child frames - is necessary and health advocates must employ intersubjectivity as a way of building support and achieving policy consensus around smoke-free (and other policy) initiatives at the local level as much as at (inter-)national and school levels. These suggestions and derived recommendations are detailed in D3.2 Appendix C.

Dublin relevant local-level recommendations

A summary of Dublin relevant local-level recommendations to support the prevention of youth smoking is listed here.

Recommendations:

- **Emphasise the continuing need to improve national-level tobacco control policies to avoid the emergence of complacency and achieve the tobacco control 'endgame'.**
- **Institute a national-level office of an ombudsman/woman charged with national, local and school level oversight of tobacco control and particularly the prevention of youth smoking.**
- **Prioritise low SES groups as they have higher smoking prevalence than everyone else and pool limited resources for socially disadvantaged contexts.**
- **Expand further child-related smoke-free contexts, such as all playgrounds and public parks. Continue the expansion of smoke-free local legislation by encouraging more city and county councils to enact bye-laws banning smoking in areas such as playgrounds under their control, as many have already done.**
- **Consider localised community-group interventions for tobacco control, e.g. in the arts arena.**
- **Use intersubjective discourses at the local level and ensure that there is continuing health education concerning tobacco and nicotine addiction.**

School-level findings and recommendations to prevent adolescent smoking

School-level findings and recommendations to prevent adolescent smoking focus on smoke-free schools, school tobacco policies (STPs), and tobacco-related health education.

Smoke-free schools

Smoking is banned in all indoor areas, but no legislation currently exists banning smoking in the outdoor areas of school grounds in Ireland. However, all schools impose their own bans, which apply to both indoor and outdoor settings, prohibiting students from smoking in school buildings or on school grounds. Smoking prevalence is low in the Dublin schools reflecting the overall level of denormalisation in Ireland. Challenges within Irish schools relate to the 'small number of students' who continue to smoke and who are addicted to the habit.

Recommendations:

For a number of years prior to 2004, Ireland had in place a complete ban on smoking in schools. At a minimum, extend the current ban on smoking in indoor areas to include a ban also on smoking in outdoor areas in schools.

Implementation of school smoking ban in Dublin

In its report to WP3[14], WP7 provided a brief overview of the implementation of a school smoking ban in each of the 7 SILNE-R countries. Its report was based on topics that were discussed in the school staff interviews and did not aim to provide a comprehensive understanding on policies in each country/schools. In Ireland, legislation on smoke-free workplaces had significant impact on smoking bans and smoking in schools. However, in Ireland there is no legislation prohibiting smoking outdoors on school premises. Regardless, some schools had banned smoking outdoors on the premises. Smoking was rather de-normalised in the society and also in schools (low prevalence), so most often the lack of smoking ban on the school premises did not cause problems. Smoking addiction was considered to cause challenges in the enforcement of tobacco-free school policy. Staff smoking was not considered a problem in general, even though some staff members smoked in some schools and at least one school provided a smoking place for staff outdoors on the premises and out of sight.

Adolescent adherence to smoke-free school policies

Focus group research carried out with 319 students in 17 schools across 7 cities to explore adolescents' reports of variations in adherence to smoke-free schools policies was analysed by WP9 and synthesised for WP3[15]. Participants were recruited from two schools (one low SES and one high SES) in Dublin.

- Participants from the Low SES School reported no on-site smoking but reported overt off-site smoking, which was not challenged by teachers.
- Participants from the High SES School reported limited on-site smoking, conducted in secret. This breach of the smoke-free school policy apparently followed the strict policing of off-site smoking, as well as restrictions on movement during school hours, *e.g.*, students were prevented from leaving the school site.

Recommendations:

- **School policies on smoke-free schools need to be clear about what is expected of students, and about the extent of smoke-free areas on school campuses (school boundaries) as well as about off-site smoking at the periphery of school campuses.**
- **Consideration should be given to teacher and student perceptions of the school jurisdiction (*i.e.*, the space and time over which school rules are enforceable) and how they have an impact on willingness to enforce/ observe a school-site peripheral smoking ban; and on teachers' "right" to influence student behaviours both on and off the school site. Teacher and student "buy-in" is essential to successful implementation of smoke-free school policies. Such consideration could occur in the context of whole-school policy development that seeks to include all stakeholders in committing to policy.**
- **Students from low SES groups are more likely to smoke, and also report being more likely to smoke outside the school premises without school or teacher sanction. Care should be taken not to increase further socio-economic inequalities arising from management of smoke-free school policies.**

School tobacco policies

Tobacco control policies at schools (STPs) were examined by WP8 and each school given a STP score [16]. The STP score comprises three dimensions, namely comprehensiveness (who, where and when the policy applies to, whether they have smoking rooms installed and whether students perceive that there is a policy), enforcement (whether students perceive the policy as strict and the different types of consequences applied if a student is caught smoking) and communication (whether the policy is formal and how it is communicated to others). Each dimension ranges from 0 to 10 and the STP score is an average of all three dimensions. As no data were available for Dublin in 2013, no improvement (or otherwise) in STP score could be recorded. Overall the total score of the policy for Dublin is significantly higher than the average across the sample (respectively, 6.2, and 6.0). The comprehensiveness of the policy in 2016 is significantly higher than the average across the sample (respectively, 8.2, and 7.97). The enforcement of the policy in 2016 is significantly

higher than the average across the sample (respectively, 4.2, and 3.0). However, the communication of the policy in 2016 is significantly lower than the average across the sample (respectively, 6.2, and 7.1).

Tobacco-related health education

From an analysis of interview data with school staff members, WP7 provided for WP3 an account of the current landscape of tobacco-related health education within the seven SILNE-R cities[17]. Ireland, like Finland, is a forerunner in tobacco-related health education, having comprehensive and curriculum based health education. In Ireland, the Social, Personal and Health Education (SPHE) programme is almost universally implemented and was in place in all three schools examined by WP7. SPHE is integrated in the curriculum, delivered at both the Junior and Senior cycles of post-primary schooling, and consists of modules on a variety of health and wellbeing matters, among them tobacco. Within the contents of the SPHE curriculum, time allocated to tobacco or smoking related issues is minimal.

Teachers were not aware of any evidence evaluating the effectiveness of SPHE in relation to tobacco control or smoking prevalence. Variation was noted in schools' pedagogical approaches to tobacco-related health education, ranging from information giving to positive health approaches. For example, in one of the schools selected by WP7, tobacco-related health education covered basic information and awareness raising about the health harms of tobacco and addiction. This traditional mode of delivery of health education was considered questionable as simple information delivery on long-term consequences of smoking was seen to be ineffective. In the other two schools, the focus was more on emphasising positive aspects of health as the guiding principle in (health) education. Staff suggested that the overall pedagogical approach should be supportive (for example based on counselling) rather than punitive. Preaching was to be avoided. Staff suggested that anti-smoking education strategies should emphasise health and fitness, rather than "preaching" tobacco avoidance or risk avoidance.

Recommendations:

- **School staff involved in the delivery of tobacco-related health education should be supported in understanding the efficacy of various approaches**

to tobacco-related health education and, in particular, the importance of supportive rather than punitive measures for students addicted to nicotine in order to help them to stop smoking.

Smoking prevalence among Irish adolescents has fallen steeply and there was some evidence of a creeping complacency regarding the need for tobacco-related health education. For example, staff reported that because smoking was no longer considered a problem among staff and students, extra resources or efforts were not invested in smoking prevention.

Recommendations:

- **Despite decreasing prevalence of smoking among Irish adolescents, attention should be focused on those adolescents who smoke, and on ways of supporting them to stop smoking. Creeping complacency is a real threat in countries with progressive tobacco control policies and education policy and decision makers should avoid contributing to this by highlighting current prevalence and the government's goal of a tobacco free Ireland by 2025 (less than 5% of population smoking).**

A lack of external experts - for example, from local NGOs - who could come to the school and give lessons on smoking related themes was noted, especially for the junior cycle programme of post-primary schooling. Better resources were available for other topics, such as alcohol. Overall, these external partners were considered very useful.

Recommendations:

- **Compile a panel of experts on tobacco harms, tobacco-related health education, and smoking cessation for adolescents, these personnel to be available to schools for junior and senior cycle tobacco-related health education.**

Continuous professional development courses are available for SPHE teachers who do participate in them, giving some continuity in schools. However, not all teachers feel comfortable teaching health-related issues even when they have good relationships with their students. This leads to challenges in finding the right teacher to teach SPHE.

Recommendations:

- **Consideration could be given to the development of a more advanced qualification than currently exists for SPHE teachers in Ireland. For example, in Finland, health education teachers have a M.Sc. degree level qualification that includes specialisation in health education and pedagogical competence in this area. A similar initiative in Ireland would serve to increase the status of a marginal subject and improve the confidence and interest of teachers in teaching this subject. Given the falling prevalence of smoking among adolescents in Ireland and the threat of creeping complacency identified elsewhere, it would be important that such a qualification would contain sufficient focus on tobacco-related health education.**
- **Waterford Institute of Technology offers a part-time Higher Diploma in SPHE and a MA in Advanced Facilitation Skills for Promoting Health and Wellbeing. Evaluate extent of tobacco-related health education and consider negotiating inclusion of same if it does not exist.**
  https://www.wit.ie/courses/type/undergraduate/education/higher_diploma_in_social_personal_and_health_education_sphe_part_time

  https://www.wit.ie/courses/type/health_sciences/department_of_health_sport_exercise_studies/ma-in-advanced-facilitation-skills-for-promoting-health-and-well-being
- **Provide substantive support for teachers to attend these programmes, for example using the model for Guidance Counselling teacher education.**

Schools in Ireland are characterised by a collaborative working culture, with teachers conferring when planning topics they should cover in health education in the following year. When new health promotion programmes are adopted, all staff members are involved in discussions about it, even though they may not have practical involvement in the initiative. This type of involvement is seen as a way to build a common value system and to bring about change in the school culture. The school principal was identified as having a key role in building the school culture. School culture, values and practices were identified as key factors in strengthening

staff members' readiness for tobacco education/health promotion. However, the responsibility for what was termed "pushing" new initiatives and informing colleagues was seen to rest with SPHE and life-skills teachers.

Recommendations:

- **School principals are key in tobacco-related health education and should receive regular updates about smoking prevalence in adolescents and information about ways of supporting SPHE and other teachers involved in delivering tobacco-related health education.**

Staff identified a lack of resources in terms of relevant materials for tobacco-related health education. They noted that having good materials available is one way to support teachers' confidence in teaching these topics. No mention was made of available websites, or e-learning teaching and learning materials. Staff also identified a need for continuing education to update teachers on understanding the addictive nature of nicotine, and the social aspects of smoking initiation.

Recommendations:

- **Compile a list of available resources for tobacco-related health education and develop new resources to meet emerging need, *e.g.*, e cigarettes/ ENDS/ *etc.*.**

A major challenge identified for schools was how to deal with addicted students. Staff mentioned the desirability of counselling and support for students who are caught smoking and suggested that this might be offered by local health services.

Recommendations:

- **Develop a suite of smoking cessation supports for adolescents addicted to nicotine.**

Parental involvement in new health related initiatives was perceived as essential and two schools mentioned that they had active collaboration with the Parent Teacher Association (PTA).

Recommendations:

- **Consider ways to involve parents using Parent Teacher Associations, as well as parent representatives on Boards of Management.**
- **Provide school-organised talks for parents on tobacco harms and**

supports for children to stop smoking.

- **Develop materials for parents to recognise warning signs of tobacco addiction and to suggest ways of supporting their children in stopping smoking.**

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[1] Department of Health, 2013. Tobacco-Free Ireland. Dublin: Department of Health. Available at https://health.gov.ie/wp-content/uploads/2014/03/TobaccoFreeIreland.pdf. Accessed 1 October 2018

[2] WP5 (UNIMASS), D5.3, Article 3: Who calls the shots in tobacco control policy? policy monopolies of pro and anti-tobacco interest groups across six European countries. Paper submitted to 'Social Science and Medicine'. Final SILNE-R Report, September 2018.

[3] WP8 (UCL). D8.2. Report on cross-national differences. Final SILNE-R report, 2017.

WP8 (UCL). D8.3, Appendix 9.b. paper 2, Vincent Lorant, Adeline Gerard, Nora Melard, Pierre-Oliver Robert, [SILNE-R- Coauthors], Anton Kunst. Trends in adolescents smoking in 6 countries. Final SILNE-R report, September 2018.

[4] WP5 (UNIMASS). Deliverable D5.2. National-level analysis of the implementation of tobacco control strategies. (2016).

WP5 (UNIMASS). Deliverable D5.3. Final report on integrated evidence. Final SILNE-R report. September 2018.

[5] The full findings from WP5 are to be found in D5.3.

[6] WP5 (UNIMASS). Deliverable D5.2. National-level analysis of the implementation of tobacco control strategies. (2016).

[7] Department of Health (2014). *Healthy Ireland. A Framework for Improved Health and Well-Being 2013-2025*. Dublin: Department of Health. Available at https://health.gov.ie/wp-content/uploads/2014/03/HealthyIrelandBrochureWA2.pdf. Accessed 2 October 2018.

[8] MPOWER: Monitor tobacco use and prevention policies, • Protect people from tobacco smoke, • Offer help to quit tobacco use, • Warn about the dangers of tobacco, • Enforce bans on tobacco advertising, promotion and sponsorship, and • Raise taxes on tobacco.

[9] WP9 (UEDIN), 2018. Adolescent Tobacco Control Policy Recommendations: WP9 Recommendations to WP3. Internal SILNE-R report from WP9 to WP3, 26 March 2018.

[10] WP9 (UEDIN), 2018. Adolescent Tobacco Control Policy Recommendations: WP9 Recommendations to WP3. Internal SILNE-R report from WP9 to WP3, 26 March 2018.

[11] Campaign for Tobacco-Free Kids (2018). States and localities that have raised the minimum legal sale age for tobacco products to 21. https://www.tobaccofreekids.org/assets/content/what_we_do/state_local_issues/sales_21/states_localities_MLSA_21.pdf Accessed 29 September 2018.

[12] WP10 (NSPH) Policy Recommendations Template for WPs 8 & 10, Feeding back findings to WP3. Internal SILNE-R report from WP10 to WP3, 3 April 2018.

[13] WP6 (MLU). Appendix 3 Martin Mlinarić, Laura Hoffmann, SILNE-R study group, Matthias Richter, Enhancing smoke-free environments at the local level: a comparative realist study and qualitative type construction across 7 European cities. SILNE-R Draft paper, September 2018, Final SILNE-R report and Presentation to SILNE-R: Sixth Consortium Meeting, Madrid, June 12-13, 2018, Hospital Clínico Universitario San Carlos.

[14] WP7 (UTA). Smoking Ban. Final report on school smoking ban implementation in seven European countries. Internal SILNE-R report from WP7 to WP3, May 2018.

[15] WP9 (UEDIN), 2018. Adolescent Tobacco Control Policy Recommendations: WP9 Recommendations to WP3. Internal SILNE-R report from WP9 to WP3, 26 March 2018.

[16] WP8 (UCL). The current landscape of tobacco control policies within seven European countries / cities. Internal SILNE-R report from WP8 to WP3, April 2018. WP8 (UCL). D8.3. Report with general overview. Final SILNE-R report, September 2018.

WP8 (UCL). D8.3, Appendix 9.a. paper 1, Nora Mélard, Adeline Grard, Pierre-Olivier Robert, Mirte Kuipers, Michael Schreuders, Teresa Leão, Laura Hoffmann, Matthias Richter, Arja Rimpela, Anton Kunst and Vincent Lorant. School tobacco policies and adolescent smoking in 6 European countries. Final SILNE-R report, September 2018.

[17] WP7 (UTA). Education. Final report on tobacco related health education. Internal SILNE-R report from WP7 to WP3, May 2018.