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ACCESS REPORT

Access Strategies for Teen Smoking Cessation:

Guiding Principles, Strategies and Activities

The purpose of the ACCESS REPORT is to support providers, developers, funding bodies and policy makers in the development of effective recruitment strategies to increase the impact of youth smoking cessation interventions.

Final Version July 2010

The ACCESS Consortium

ACCESS is an EU project that aims at increasing the impact of adolescent smoking cessation interventions through supporting providers, developers, funding bodies and policy makers in the development of effective recruitment strategies.

In more detail, the objective of the project is to gain knowledge on how to motivate young smokers to take part in smoking cessation interventions and to transform this knowledge into concrete recommendations for cessation practice. Therefore, national networks in 10 European countries were established fostering the collaboration between various stakeholders in teen (health) development. In order to display promising access ways, the project output consists of a report with guiding principles and recruitment strategies as well as a practice catalogue of motivational activities reported by providers of adolescent cessation interventions in the ACCESS countries.

The project started in September 2009, runs until October 2010 and has received co-funding from the European Union in the framework of the Health Programme. It consists of 11 partners across Europe and is coordinated by the IFT Institut für Therapieforschung, Dr. Anneke Bühler. The partners are:

Kommentar [KB1]: geändert

- IFT - Institut für Therapieforschung München, Germany
- Danish Cancer Society, Denmark
- Maastricht University, The Netherlands
- General University Hospital in Prague, Czech Republic
- Stop smoking NGO, Slovak Republic
- Agencia Formacion Investigacion y Estudos Sanitarios, Spain
- Slovenian Coalition for Tobacco Control, Slovenia
- Riga City Council Department of Welfare, Latvia
- Foundation Against Respiratory Diseases, Belgium
- Institut für Sozial und Gesundheitspsychologie, Austria
- GABO:mi, Gesellschaft für Ablauforganisation, Germany (project management)

More information is available online: www.access-europe.com

Introduction

Youth generally start smoking around the age of 13 with highest smoking rates at the age of 18. According to the ESPAD[1] study, 58% of 15-16 year old students had tried smoking a cigarette at least once, 29% had used cigarettes during the last 30 days. Of these 12% had smoked 1-10 cigarettes a day, 4% had smoked 11-20 cigarettes a day and 2% at least 1 pack per day.

Tobacco dependence develops rapidly among youth smokers. Half of teen smokers who loose autonomy over tobacco do so by the time they are smoking seven cigarettes per month, half of those who meet the criteria for ICD-10-defined dependence do so by the time they are smoking one to two cigarettes a month.[2] The mean time interval between regular smoking and a nicotine dependence diagnosis among young smokers is estimated to be one and a half years[3]. One in three adolescent tobacco users develops a clinically relevant dependence until the age of 35 and thus is exposed to all well known health hazards related to tobacco use.

It has also been found that the desire and attempts of youth smokers to quit develop soon after smoking onset[4]. Already within three months of starting to smoke, young people start to seriously think about quitting. Over the next two years, smokers gradually lose confidence in their quitting ability. After a smoking career of two and a half years youth become gradually aware of smoking as an addiction and how difficult it is to quit. International data shows that about 60% of adolescent smokers tried to quit during the last six months but that 90% of those who initially quit turned back to this risk behavior within a six months period[5].

The development of effective youth smoking cessation interventions is therefore not only necessary from a public health point of view but also corresponds to a need experienced by adolescent smokers themselves. However, international experience has shown that adolescent smokers are generally not interested to participate in smoking cessation interventions[6]. Still more than 80% believe that they can stop on their own. They expect interventions to be patronizing and think that seeking external support, except with their friends, is not necessary.

On European as well as on international level this attitude is mirrored in low participation rates reported by intervention providers. Besides effective interventions,

[1] ESPAD, 2009 The 2007 Espad Report, Substance among students in 35European countries. www.espad.org
[2] Di Franza et al (2007). Symptoms of tobacco dependence after brief intermittent use. Arch Pediatr Adolesc Med, 161, 704-710.
[3] Wittchen et al (2008). What are the high risk periods for incident substance use and transitions to abuse and dependance? Implications for earlc intervention and prevention. Int J Methods Psychiatr Res, 17 (S1), S16-S29
[4] O'Loughlin et al (2009). Milestones in the Process of Cessation Among Novice Adolescent Smokers, American Journal of Public Health, 99, 499-504
[5] Bancej et al (2007). Smoking cessation attempts among adolescent smokers: a systematic review of prevalence studies. Tobcacco Control, 16, e8
[6] P.Dalum, Events for Adolescent smoking cessation- the Development, Implementation and Evaluation of a Danish Adolescent Smoking Cessation Intervention. Danish Cancer Society, 2009

successful recruitment is the major determinant for public health impact of youth smoking cessation interventions (Effect x Reach = Public Health Impact)[7].

The ACCESS project aims at increasing the impact of adolescent smoking cessation interventions through supporting providers, developers, funding bodies and policy makers in the development of effective recruitment strategies. This report is the result of our work and presents identified principles, strategies and activities related to the question of how to motivate young tobacco users to participate in cessation aids.

What this report offers

The major objective of the report is to support stakeholders in adolescent smoking cessation who want to increase participation in their intervention. *Guiding Principles* refer to what should generally be considered when trying to motivate young smokers. *Strategies* report on what kind of recruitment methods are currently being used. A list of *activities* shows examples of real world implementation of these methods.

Method

Content of the report is based on three sources of information that were generated within the ACCESS project. First, a systematic literature review was conducted by the Danish Cancer Society on what is known about the recruitment of young people to smoking cessation interventions and in particular what individual, social and structural factors are important in this regard. Conclusions of the literature review are based on a systematic search of relevant studies. Secondly, national meetings of stakeholders were held in each ACCESS partner country. The aim of these meetings was to discuss current practice experience. From these meetings conclusions about what to consider in motivating teen smokers to use cessation aids were drawn. Finally, a survey among cessation intervention providers revealed what kind of motivational activities are implemented in the ACCESS countries. Each partner sent out a minimum of five questionnaires collecting information on practise recruitment activities in a standardised format. Altogether recruitment practice from 36 cessation interventions was described in the national reports of the European countries. Information from these reports and from two additional US-American studies resulted in 36 identified activities. From the pool of specific activities 24 more abstract strategies were derived. The list of strategies and activities is not intended to be exhaustive.

The ACCESS project leader merged the available information from these three sources into recruitment principles, strategies and activities. Principles were mainly generated from national network meeting discussion results and the literature review. Strategies and activities mainly stem from the survey. The outcome is a policy document combining (scarce) scientific evidence and practical experience.

Validation of report content proceeded in two steps. The ACCESS consortium reviewed the first draft version which then was revised according to received comments. The conference version of the report was discussed during the consultation conference and amended to the final version accordingly.

[7] De Vries & Brug (1999). Computer-tailored interventions motivating people to adopt health promoting behaviours: Introduction to a new approach. Pat Edu Couns, 36, 99-105.

1. Guiding principles to increase participation in youth smoking cessation interventions

Marketing and recruitment campaigns for smoking cessation interventions should be an independent but integrated part of any budget set aside for the development of smoking cessation interventions in general and for young persons in particular.

Networks among health professionals and youth smoking cessation providers should be established to pool resources, to create transfer of knowledge and increase cost effectiveness of interventions.

The most elaborate, scientifically correct and well developed smoking cessation intervention is not a cost-effective means to reduce smoking prevalence if no young person uses this service. So recruitment goes beyond motivating to quit tobacco use, i.e. the aim is to enhance willingness to participate in cessation aids.

Nine principles have been identified to guide providers and policy makers in the development of comprehensive recruitment strategies.

Principle 1

Establishment of non-smoking as a social norm

In order to motivate young people to stop smoking, *a social environment conducive to quitting has to be established*. One of the most important measures to change the social environment and denormalize tobacco consumption is to adopt a comprehensive tobacco control policy on national and local level and especially in the settings where adolescents live. Legislative measures should be in place and effectively enforced to reduce the demand for and availability of tobacco products.

A comprehensive list of legal measures has been laid down in the Framework Convention on Tobacco Control (FTCT)[8] Together with 168 countries world wide, all EU Member States except the Czech Republic have ratified and signed the FCTC and engaged themselves to implement these measures on national level in order to establish non-smoking as the social norm. Following measures relating to the reduction of demand and supply of tobacco products have shown to contribute particularly to the decrease in smoking prevalence among youth:

Kommentar [KB2]: change of order

- a total ban on smoking in places open to the public and in workplaces decreases the social acceptability of smoking, limits the opportunities of youth to smoke alone or in groups and to exchange cigarettes. It limits the progression to smoking, undermines consolidation and increases quitting[9]

[8] Framework Converntion on Tobacco Control (FCTC) , www.who.int/fctc/en/
[9] Forster et al (2007). Strategies to Prevent Tobacco Use in Adolescents and Young Adults. Am J. Prev Med, 33 (6S), S335-339

- a comprehensive ban on advertising, sponsorship and promotion of tobacco products significantly and negatively influences aggregate tobacco consumption [10]
- a regular increase of tobacco prices: a 10% increase in tobacco prices may increase the probability of smoking cessation by 11-12% for 18 year olds and an estimated 6-7% for teens.[11]

Through the establishment of effective legislation and the public discussion accompanying its introduction as well as the implementation of effective smoking prevention measures, non-smoking can be established as the social norm and pro-smoking recruitment strategies of the tobacco industry can be successfully counteracted. In a country without these conditions effective recruitment into cessation interventions is much more difficult.

Principle 2

Availability of effective youth specific smoking cessation interventions

Effective smoking cessation interventions must be available free of charge at all times for all young people who desire to quit.

Evidence based smoking cessation interventions tailored to the need and expectations of young people should be available at all times and easily accessible in places where youth is spending time. This may include schools, out of school settings, health care facilities, social service institutions and the internet.

Smoking cessation interventions can have different formats such as group courses, brief interventions or individual counseling sessions, e-learning via the internet etc. Interventions should be developed on basis of cognitive-behavioral and motivational enhancement theory[8]. They should be carefully tailored taking into account age, gender, educational level, socio-economic background, specific youth culture and life circumstances. Adequate timing of cessation interventions is necessary so as to not collude with other youth activities.

Kommentar [KB3]: suppose "collide" is meant?

Smoking cessation treatment for young people should be an integral part of the national health care and welfare system. Sufficient funding needs to be made available to develop cost effective interventions and to ensure large scale and long term implementation.

Part of taxes collected on tobacco sales should be redirected to finance comprehensive cessation strategies for adolescents.

[10] Quentin et al (2007). Advertising bans as a means of tobacco control policy: a systematic literature review of time-series analyses, Int J Public Health, 52, 295-307
[11] Sussman &, Sun (2009) Youth tobacco use cessation: 2008 update. Tobacco Induced Diseases, 5, 3

Principle 3

Evidence oriented recruitment

Extensive knowledge of teen behavior in relation to tobacco use and their attitude towards use of smoking cessation interventions is needed to be in a position to develop and implement effective recruitment strategies. This implies the implementation of the following methods.

First, systematic monitoring on population level of smoking prevalence, intention to quit, cessation and relapse rates according to age, gender and socio-economic status should be in place in order to be able to document the severity of the smoking epidemic in adolescents correctly and to estimate the need and demand for cessation interventions more precisely. Positive or negative attitudes to smoking and smoking cessation should be assessed as well as beliefs and values. As youth subgroups nowadays are more heterogeneous than can be described by age, gender and socio-economic status, a combination of smoking relevant life-style indicators should also be collected to facilitate effective tailoring of communication with different target groups. These should include a.o. preference in music, entertainment, fashion, sports, etc.

Second, a clear access point analysis is needed to be able to document where smoking adolescents can be reached most effectively to motivate them to participate in smoking cessation interventions.

Third, clear documentation at the EU level is needed concerning the number and type of smoking cessation interventions available per region/country and setting as well as on awareness, demand and use of interventions by young tobacco users. This should be systematically monitored. Need assessments within providing settings should guide recruitment on local level.

Fourth, recruitment strategies should be theory-based and empirically documented and tested to assess their effectiveness in reaching adolescents. As there is no theoretical background up to date to be referred to[12], research has to develop models explaining why certain strategies work and with whom, which factors facilitate recruitment and under what conditions motivation strategies fail.

Principle 4

Positive branding of cessation interventions

A negative attitude to participation in youth smoking cessation interventions generally prevails among adolescents. Although the majority of young smokers want to stop, they do not believe that there is a need for them to enroll in smoking cessation

[12] Backinger et al (2008). Factors asscociated eith recruitment and retention of youth into smoking cessation intervention studies – a review on the literature. Health Edu Res, 23, 359-368

interventions. They generally believe that they are not addicted but able to stop on their own whenever they decide to do so.

As young people expect smoking cessation interventions to be patronizing, dull and ineffective, there is an urgent need to *promote smoking cessation interventions as a desirable and useful* consumer product[13]. Social marketing campaigns should be conducted to "brand" smoking cessation interventions as a successful means for youth to stop smoking. It should be communicated that they are helpful, interesting and fun and accepted within the youth culture. The added value to the individual's quality of life should be pronounced rather than focusing on health-related messages only.

Principle 5

Choosing the right language

Communication on smoking cessation works best if it is respectful of the individual and uses comprehensive messages.

Information sent out by the smoking cessation provider should be authentic and avoid patronizing[13]. The aim should be not to tell young people what to do, but to let them take their own decisions. From this perspective it may be more appropriate to offer support for young people who wish to reflect upon their tobacco use and to set up changes in their smoking behavior rather than to talk specifically about "cessation" interventions.

Youth want to be treated as adults. Yet, young people live in their own world, with their own codes, their own language. Words have to be chosen carefully so as to ensure that the target group interpret and understands messages correctly. Adolescents may not perceive themselves as smokers although they might meet such criteria from the scientific and health community perspective[13]. In addition, adolescent smokers are more than just smokers. They need to be addressed as a holistic person with all facets of his or her personality, resources and problems.

Communication channels should be carefully chosen and adapted to the different habits and life styles of the target population. Young people form heterogeneous groups beyond age, gender and social economic status and will best respond to specifically tailored messages. Although one general message should be chosen as the leading motto, different messages could be developed according to different style groups. A style group may for instance be girls living in an urban environment with a large group of friends (clique) and having a preference for HipHop music.

Youths themselves know their own culture best. Participation of young people in the development of communication strategies and effective targeting is essential.

[13]Dalum et al (2010). Recruitment to Adolescent Smoking Cessation Interventions – A literature review. ACCESS Project

Principle 6

Dissemination of information about cessation aids

The availability of local smoking cessation interventions is often not known to young tobacco consumers and to their social environment (parents, schools, teachers, sports clubs, health care providers and the wider community)[13]. Therefore *information on smoking cessation interventions must be communicated regularly and extensively* to the target population by all available communication channels including traditional and new media.

Principle 7

Pro-activity and personal touch

The principle of pro-activity requires that the *provider actively reaches out to young tobacco users* instead of only reacting to young people's initial request for a cessation intervention[13]. Outreach should be based on interpersonal communication addressed at specific target groups in chosen settings or in one-to-one situations. Effective communication means talking and listening and should be realized in two directions: provider-smoker and smoker-provider. Respected persons having no direct authority on the young smokers such as peer group leaders, youth workers or school nurses/psychologists are generally well accepted to guide them into cessation interventions. Pro-active recruitment strategies should be used as an *opportunity for the young smoker to get acquainted with the type of smoking cessation intervention, to meet the facilitator conducting the intervention, to find out what he or she can expect*. The aim is to build up a *trustful relationship*.

As young people may smoke without their parents or others knowing about it, confidentiality is a very important issue[13]. Nevertheless, leading authorities which play an important part in young peoples' lives should also be actively involved in the recruitment process and support smoking cessation interventions i.e. school authorities, parents' and teachers' associations, sports clubs and community leaders etc.

Principle 8

Using Incentives

Smoking cessation interventions are competing for the attention of young people with other products on the market. Competition to persuade young people to adopt a certain behavior or to buy a certain product is fierce. This is true for the tobacco industry but also for other youth-related lifestyle products. Young people are an

important consumer group and can freely decide which item or service to purchase/use or which behavior to adopt.

In order to catch young tobacco users' attention and increase their willingness to participate in smoking cessation interventions, the use of incentives such as vouchers to buy magazines or cinema tickets may be an option for those providers who have the financial resources[13].

Principle 9

Creating partnership with stakeholders in youth (health) matters

Collaboration of cessation aids providers with health professionals (pediatricians, midwives, health care centers, dentists, psychological counselors), social and youth workers as well as prevention workers is indispensible as they have lots of opportunities to address youngsters and speak about cessation.

To promote smoking cessation interventions for young people, networking opportunities with entities that are part of young peoples' lives should be organised[13]. Collaboration with sports clubs, culture clubs, night life locations as well as with parents' and teachers' associations should be explored. Cosmetic or fashion retailers have valuable arguments to persuade young people to participate in smoking cessation interventions.

Networking with youth media is important to promote the use of smoking cessation interventions as an accepted behavior, to identify role models among peer groups and to support free media coverage.

Policy makers, public health professionals and communities should be involved to support recruitment strategies and creation of multi-level and multidisciplinary approaches. Their commitment facilitates institutionalization of cessation interventions and might ensure sustainable funding.

2. Recruitment Strategies and Activities

Within the scope of the ACCES project different recruitment strategies were identified which are applied to variable extent in participating countries.

These recruitment strategies were derived from the pool of practice based activities (see Methods box for further details on how we arrived at these strategies) .They are intended to be complementary to the general principles presented in the previous chapter. From the question what should be done, which is discussed in the general principles, this chapter moves one step further describing strategies and activities to introduce ways and means to recruit young people into smoking cessation.

2.1 Identified strategies

Strategies were grouped into five categories:

1. Interpersonal communication
2. Marketing
3. Tailoring
4. Behavioral learning techniques
5. Structural change

1. Interpersonal communication

Interpersonal communication is a feature of recruitment which can be realised in almost all settings and is considered to be a very important factor in persuading young people to enrol in smoking cessation interventions. Interpersonal communication can take following forms:

a) Face to face/one to one provider-tobacco user

Through personal contact with the provider, tobacco users have the chance to get to know who will work with them during the cessation intervention and therefore reduce their negative expectations or uncertainties with regard to participation. The trainer or facilitator of the cessation aid may pro-actively approach the tobacco user in a face-to-face situation and ask him or her personally to participate in the intervention. In addition, the trainer has the opportunity to listen to the smokers' opinion before giving information or propose assistance. E.g. information session, personal introduction etc.

b) Peer to peer

Any kind of involvement of peers or friends in the recruitment process is based on the intention to motivate adolescents more easily because of higher relevance and credibility of interpersonal communication among same-age persons. E.g. initiated word-to mouth, information of the student board, peer-led interventions etc.

c) Adult person of trust

A respected adult person whom the adolescent trusts talks to the smoker about the intervention and tries to motivate him or her to participate in the cessation aid. The relationship is characterized by confidence rather than dependence/inequality of power. E.g. social school worker or youth centre personnel.

d) Authority

An authority person whom the adolescent has to respect due to his or her superior position in a specific setting encourages tobacco users to take part in a cessation aid. The relationship is characterized by an inequality of power but does not have to be "negative". E.g. parent, teacher, head of the school, mentor at work place etc.

2. Marketing

Marketing is a category of recruitment strategies that are used to inform adolescent tobacco users about the availability of cessation interventions. This category comprises strategies with a view to enlarge the decisional basis of young tobacco users providing them with facts about the cessation process.

e) Media campaigns

Advertisements in national and local TV and newspapers, youth magazines, sports magazines, banners on websites, posters, leaflets, postcards etc. are used to promote smoking cessation as an acceptable and desirable behaviour among youth. This is a passive but far reaching recruitment strategy, however indispensable to inform adolescents about cessation interventions across all settings using a cognitively less elaborated route of persuasion rather than a logically reasoning approach. Linkages within new technologies and between new and conventional media enhance pervasion of messages.

f) Specific information about the intervention

The target group is informed about the specificities of an intervention: What are the aims? What kind of approach is it? What happens during the intervention? Who provides it? How long does it take? Where does it take place? Are there costs? Are there rewards? How effective is it? E.g. information session, description on website, information material, leaflets etc.

g) Education about the cessation process

Education about the nature of nicotine dependence, the process of cessation and the difficulties smokers experience on their way to a tobacco-free life intends to persuade classes/groups to use a cessation aid by providing them with information and reasoning, i.e. using a cognitively elaborated route of persuasion. This strategy emphasizes the relevance of cessation aids for smokers who want to quit. E.g. information session, website element, information material

h) Tobacco industry manipulation

Adolescents can be motivated to quit tobacco use and use cessation aids through educating them about marketing strategies of tobacco companies and how they try to manipulate adolescents' behaviour. E.g. explaining PR activities of the tobacco industry, information on how much money is made on tobacco vs. death and disease caused etc.

i) Media advocacy

The topic of adolescent smoking cessation taken up by the media intends to influence young smokers' decision to join a cessation intervention through making them and their social networks aware of cessation offers and increase the social acceptability thereof. E.g. articles in youth magazines, interviews in radio shows, TV-documentary etc.

j) Testimonials

Adolescents who already participated in or completed a cessation intervention and can tell about their positive experiences in order to motivate other young smokers to do the same. E.g. testimonials' video clips, initiated word to mouth, tweeting or blogging etc.

k) Ambassadors

Public persons that are role models for adolescents are won to support smoking cessation and the use of cessation aid. E.g. fashion models, athletes, pop stars etc.

l) Fun

Obviously it is easier to catch people's attention if you make them smile or laugh about your idea of motivating them for the cessation intervention. E.g. use of surprising location of information, funny flyer format, nonsense activity, cool non-smoking events/parties etc.

3. Tailoring

The right message format is important to reach a specific target group (adolescents using tobacco) as a whole and/or specific subgroups among them.

m) Non-stigma

Adolescent smokers are approached in a non-stigmatizing way so that their status as a tobacco user is not pronounced. Fears of social disapproval for being a tobacco user are minimized and thus inhibition to get involved in smoking cessation activities is attenuated. E.g. common activity for light, heavy smokers and non-smokers, life-style workshops, positive naming of intervention etc.

n) Holistic personality

Young tobacco users are addressed in a holistic way. This means acknowledging and emphasizing that they are more than just "smokers" and that their personality consists of more than their smoking habit and with many positive facets and

resources. E.g. talking to the sports person, the youth leader, the fashion idol, the music lover, a great friend etc.

o) Broader intervention approach

Offering more than cessation support in your intervention and including non-tobacco issues that are important for teenagers makes your offer more relevant to young people. E.g. coping with stress, gaining self esteem, targeting other problem behaviour etc.

p) Gender specific

Girls or boys are motivated to participate in a cessation aid by relating the issue of cessation to their particular life style, priorities and needs. E.g. issues of beauty, physical condition etc.

4. Behavioural learning techniques

q) Reflecting own behaviour

Young smokers often do not perceive themselves as smokers and therefore feel not addressed by smoking cessation appeals or aids. Reflecting the own behaviour leads to adequate self-perception and problem awareness, the first stadium in the process of change. Tobacco users already motivated to quit are characterized by ambivalence towards cessation and participation in cessation interventions. Here reflecting on their own behaviour combined with the offer of cessation support can emphasize the negative side of tobacco use and move the user closer to the decision to stop and to use professional tools for it. Adolescent smokers who already tried to quit on their own but relapsed benefit from reflecting on their quit behaviour in the sense that professional support might become more relevant to them. E.g. smoking behaviour and history assessment, dependence screening, CO-measurement etc.

r) Repeating

Repeating motivational activities again and again is a technique by itself. Motivation to use cessation interventions is a process not a status which has to be favourably influenced at repeated time points. E.g. face-to-face contacts every day, repeated Emails or SMS with slightly different content, individual session to bridge the time until cessation group intervention starts etc.

s) Incentive for participation

The motivation of the tobacco user to participate in an intervention is increased because he or she is rewarded for participation. E.g. vouchers, events, consumables, non-monetary kinds of incentives like class credits etc.

t) Emotional arousal combined with self-efficacy enhancing elements

Emotional arousal aims to motivate the use of quitting support by combining fear-evoking messages with elements that enhance self-efficacy in quitting. E.g. pictures

of lung cancer combined with quit line telephone number, interviews of patients with lethal tobacco-related disease combined with the offer of a cessation intervention etc.

u) Visualisation

In order to illustrate negative health consequences of smoking, visualising tools can be used to attract the tobacco user's attention and enhance motivation to quit and participate in cessation interventions. E.g. smoking and decreased capillary blood circulation, analysing tobacco ingredients by experimenting with cigarettes, morphing/ageing software, CO-measurement etc.

v) SMART goal setting

In order to support young tobacco users in achieving their goal of quitting smoking it helps to consider the acronym SMART which says that goals should be *S*pecific, *M*easurable, *A*ttainable, *R*elevant and *T*ime-bound. Walking adolescents through this goal setting process or parts of it is a recruitment strategy if the relevance of using cessation aids is pointed out: Participating in professional interventions increases attainability of the cessation goal, helps to measure progress, provides a timeframe etc. E.g. giving reasons for quitting today, reflecting on specific personal cessation "goal", reflecting on relevant personal reasons for quitting

w) Norm-setting

The norm-setting technique intends to "normalise" cessation and non-tobacco use behaviour so that adolescent smokers feel "mainstream" to participate in cessation interventions. E.g. feedback about school survey on smoking behaviour, information about societal trends towards non-smoking etc.

5. Structural change

Structural activities to promote participation in cessation interventions do not directly address young smokers but the settings in which they are motivated to use cessation aids.

x) Policy and infrastructure

Infrastructure and policies influence important factors in the motivational process: availability of interventions and providers, implementation conditions, cost of interventions, tobacco policy in a given setting, cooperation agreements with other health professionals, mobile cessation providers for rural areas etc.

y) Mandatory/Obligation to participate

Due to e.g. the tobacco policy of the setting, adolescents are committed to participate in a cessation intervention. E.g. after violating a smoking ban, based on medical indication etc.

z) Tailoring to organisational needs

Interventions should be tailored to youth-specific needs. The implementation of the intervention should be tailored to the organisational needs of young people. E.g. flexibility of schedule, flexibility of location etc.

Identified recruitment activities in ACCESS partner countries

Young people can be recruited in different settings where they spend their time. Six general access points have been identified.

- Health care services, social services/institutions
- Schools and work places
- Internet
- Traditional media
- Out of school/leisure settings
- Specific access points for tobacco users

The activities listed were reported in a survey by the ACCESS national network members in each partner country where cessation interventions for adolescents exist (see Methods box for further details). They are implemented by providers to motivate adolescent tobacco users to participate in offered cessation aids. With regard to effectiveness of each activity it was not possible to generate scientifically valid estimations within the ACCESS project. Thus labels like “evidence-based” or “best practise” cannot be applied. However, benefit of activities was validated by providers and stakeholders in a two-step consultation process (see Methods box for further details).

Please note that

- activities were mostly reported as a combination of several approaches at the same time.
- some activities reported in the section of one access point may be easily transferred to another access point (e.g. CO-measurement can be done in schools, leisure or health care settings)
- in the following tables single activities are described and strategies realised through the given activity are indicated.
- on our web site there will be a data base of activities with additional referrals to the countries in which the activity was reported and the intervention format for which they were used (www.access-europe.com)

Health care services, social services and institutions

This category comprises clinics, counselling centres, medical offices, dentists, psychotherapists' offices, midwives and nurses resp. social workers, youth workers, family counselling centres, youth centres, centres for juvenile delinquents and prisons etc. and thus refers to situations in which the adolescent seeks help or receives support for health or social reasons.

Activity		Strategies
Prevention workshop	During a smoking prevention workshop for non-smokers and smokers the topic of cessation and an available cessation aid is introduced (by the provider)	• g) Education • f) Information about intervention • a) face to face • m) Non-stigma • q) Reflecting own behaviour
Preliminary sessions	Smokers receive individual intervention sessions in order to bridge the time gap and maintain their motivation between the time they decide to participate in an intervention and the actual start of the intervention	• a) Face to Face • r) Repeating
Cooperation with other youth (health) care organisations	Medical staff, counselling staff, youth welfare staff and other providers are informed about the intervention during a workshop or meeting. Cooperation agreement with regard to recruitment of smokers into intervention with pediatricians or youth psychiatric clinics or youth welfare centres	• x) policy and infrastructure
Initial information	Smokers are informed about the intervention by doctors and nurses.	• f) Information about intervention • c) Adult person of trust • d) Authority
Questionnaire and tailored feedback	Adolescent patients are asked to fill out questionnaire and receive tailored feedback by provider	• q) Reflecting own behaviour • y) Mandatory
Significant others	Parents, other relatives and friends who want to support the smoker and seek help are informed about the intervention.	• b) Peer to peer • c) Adult person of trust
Tobacco policy	Tobacco policy at clinic including smoking bans for staff, no smoking zones, information about policy and cessation offers at introductory meeting, consequences for violation of smoking ban, establishment of a tobacco control quality circle etc..	• x) Policy and infrastructure
Medical Indication	Patients under the age of 18 or with pulmonary symptoms are obliged to participate in a cessation intervention due to medical indication enforced by doctor	• x) Policy and infrastructure • y) mandatory • d) Authority

Early information	Personal letters and phone calls before scheduled doctors appointment followed by meeting with providing staff at the clinic	• f) Information about intervention • a) Face to face
Adaptation to clinic life	Prior assessment of conditions relevant to implementation of the cessation aid: practice behaviours, knowledge, attitudes and self-efficacy towards cessation with adolescents; establishing strong working relationships between provider and medical office staff in order not to create additional work load	• x) Policy and infrastructure
Oximobil	Mobile cessation station travelling between remote villages	• x) Policy and infrastructure • z) Tailoring to organisational needs

Schools and work places

Depending on the age of the tobacco user, he or she can be reached in school or at the work place. Recruitment can take place during school/working time or extra-curricular. Strategies may be implemented for classes or for the whole school.

Activity		Strategies
Information session plus provider meeting with interested smokers	Prior to the cessation aid an information session given by the provider is held for the target group of the intervention. Motivation to stop smoking and to participate in the intervention is enhanced through discussing pros and cons of smoking and cessation, pronouncing and visualising the norm of non-smoking, investigating tobacco industry youth marketing and informing about the how and when of the intervention. The session is mandatory for non-smoking and smoking students of the targeted age group and held during school hours. It is followed by a meeting hosted by the provider for interested smokers to clarify further questions and tailor the intervention time schedule to the needs of participants.	• g) Education • f) Information about intervention • a) Face to face • h) Tobacco industry • w) Norm-setting • n) Non-stigma • y) Mandatory
Feedback after school survey	Results of a school survey on non-smoking, smoking and cessation behaviour are presented to the target group as a whole Personalised feedback from a mandatory questionnaire assessment through letters from provider.	• w) Norm-setting • q) Reflecting own behaviour
In-school social workers	In-school social workers who know the target group well approach potential participants and ask them to join the intervention repeatedly using a motivational interviewing style of discussion. The provider is introduced by the social worker.	• c) Adult person of trust • f) Information about intervention • a) Face to face • r) Repeating

Pro-active phone call	The provider approaches the adolescent through a pro-active telephone call after he or she was identified as a smoker in a school-based survey.	• a) Face to face • f) Information about intervention
Project stand	Exhibition stand placed centrally at the school attracting students to get information about tobacco use and cessation.	• g) Education • f) Information about intervention • a) Face to face
Cessation contest	Cessation contest with money prizes is organized for the whole school	• t) Incentive • w) Norm-setting
Vouchers, T-Shirts	Participants receive vouchers (media store, movies) or T-Shirts for attendance	• f) Incentive
Piss point/toilet paper	Advertisements for the intervention are placed in pissoirs or on toilet paper.	• e) Campaign • l) Fun
Informational event for stakeholders	Peers in the students' board which might be opinion leader for other students are informed about the cessation aid and asked to support the implementation. Likewise the teachers as well as the school board are involved in the recruitment process.	• d) Authority • c) Adult person of trust • f) Information about intervention
Cooperation with local stakeholders	Local representatives of health/non-smoking/child protection organisations are asked actively support recruitment and intervention	• x) Policy and infrastructure

The internet

The internet is an important means for very different and still evolving access points (web sites, interactive e-learning systems, social communities, chat rooms, blogging etc.).

Activity		Strategies
Intervention website	A website or community profile about the intervention is created not only informing about the cessation aid and its' provider but also including a discussion forum in which adolescents can exchange quit experiences, a self-test, information about smoking etc	• f) Information about intervention • g) Education • e) Campaign • q) Reflecting own behaviour • b) Peer to peer
Youth web sites	Non-tobacco-related youth websites are hyper-linked to the cessation intervention website or Paid advertising banners on the cessation intervention	• e) Campaign
Personalized contact provider-smoker	Personalized communication from provider to smoker through e-newsletters. e-mails and SMS	• f) Information about intervention • a) Face to face

Invite a friend	Within a web-based social community adolescent smokers are invited to become a fan, friend, follower etc. of the intervention provider/ profile or of peer testimonials.	• c) Peer to peer • e) Campaign • j) Testimonials
Search engines	Money is invested so that the intervention is on top of list of search results in web search engines.	• e) Campaign

Traditional media

In comparison to web-based applications, TV, radio and print media are traditional or old media channels.

Activity		Strategies
TV and radio spots	Public announcements about smoking cessation and the intervention are aired.	• e) Campaign • f) Information about intervention
Information material	Fancy, nonstandard information material is used to inform the target group about the cessation intervention (flip book flyer, postcards, boomerang cards, own newspaper) Traditional information material like posters, flyers, cd-roms, folders, leaflets are distributed in various settings.	• e) Campaign • f) Information about intervention • l) (Fun)
Press contact	Press releases are texted for the local newspaper During every contact with the press, the provider mentions the intervention. Information in youth magazines Advertising in local newspapers	• e) Campaign • f) Information about intervention • i) Media advocacy
TV and radio shows	The provider participates in (local) TV or radio shows (at cessation-relevant times like New Years Eve) to promote the intervention.	• e) Campaign • f) Information about intervention • i) Media advocacy

Out of school/Leisure settings

Leisure settings are places and systems where adolescents primarily go to have fun or where they spend their time out of school and family. This includes youth clubs, cinemas, sports clubs, shopping malls, discotheques, night life accommodations, restaurants/bars, fairs, holiday resorts, etc.

Activity		Strategies
Life-style workshop plus ambassador	Female smokers and non-smokers are attracted by offer of a life-style workshop focussing on beauty, romantic relationships and cessation. Popular fashion model co-leads the lifestyle workshop.	• o) Broader approach • m) Non-stigma • p) Gender-specific • k) Ambassador
Fruit or carrot	Young people ask young smokers in the streets to exchange cigarette for carrot or flower or fruit and thus involve them in a discussion about cessation.	• b) Peer to peer • l)Fun
Initial information	Same-age youth organisation leaders inform smokers about the intervention. The informants themselves participate in the intervention or completed it already.	• b) Peer to peer • f) Information about the intervention • j) Testimonials
Morphing	Using "ageing" software, smokers can see how they will look like at older ages if they keep on smoking and if they stop.	• u) Visualisation
CO-measurement	The breath of interested adolescents is analysed and CO is measured.	• q) Reflecting own behaviour • u) Visualisation

Specific access points for tobacco users

Smoking adolescents may also be reached in tobacco use related places and through tobacco-related channels. E.g. tobacco products, tobacco retail points, smoking zones etc.

Activity		Strategies
Warning label	The number of the quit line is placed on cigarette package with fear-evoking picture	• t) Emotional arousal • f) Information about intervention

3. Conclusions

Although 60% of young tobacco users in Europe have tried to quit, only very few succeed and fewer still make use of already available cessation interventions. The reasons for this are multiple including ambivalent feelings in relation to quitting, the wish to stop on their own or at best with help of their friends, the feeling that cessation interventions are patronizing and dull or a lack of information about available cessation interventions.

The ACCESS project has brought together available evidence and practice-based experience in order to generate guiding principles and recruitment strategies to help health professionals and policymakers to increase participation of young tobacco users in cessation interventions in Europe. These guiding principles and recruitment strategies have been elaborated based on evidence, documentation and observations collected in 10 partner countries. To gather the available scientific evidence an international literature search was performed. To collect European practice a survey of recruitment strategies and youth cessation interventions on national level was conducted. This knowledge generating process was supported by national networks of experts in youth smoking cessation including communication experts working in the living environment of young people. This wide consultation process culminated in a stakeholder conference drawing together health professionals, tobacco control experts, smoking cessation providers, educators, experts in youth communication and policy makers.

The main finding from all sources of the project is that successful recruitment activities to motivate young tobacco users to participate in cessation interventions will increase the cost-effectiveness of any cessation intervention, because even the most promising cessation intervention will not be cost-effective if there are no participants to use it. It is therefore of utmost importance that recruitment strategies are an integral part of any cessation intervention, that no cessation intervention will be allocated public funding without providing for effective recruitment strategies and that a separate budget is allocated to the development and implementation of such strategies.

Recruitment measures have the aim to reach young people both mentally and physically in order to trigger a positive attitude towards using cessation aids. To promote this change it has been consented in all partner countries that certain preconditions have to prevail on society level to succeed in this endeavor. A comprehensive tobacco control framework has to be in place to support non-smoking as the social norm. Effective monitoring systems must be in place to lay the basis for sound scientific evidence concerning youth' attitude towards tobacco, tobacco use, cessation and effectiveness of interventions and finally quality-driven cessation interventions tailored to the needs and life circumstances of young people have to be freely and widely available. In the course of the project, it became evident that in most partner countries all pre-conditions to make youth tobacco cessation the norm are not united.

To become an accepted part of youth culture, smoking cessation interventions must be branded as a desirable and useful consumer product. Youth specific communication channels should be used to disseminate information on smoking cessation interventions.

Innovative, youth specific marketing techniques need to find their way into the public health community.

Providers need to reach out pro-actively to young smokers using interpersonal communication instead of waiting passively until an interest in smoking cessation interventions manifests itself. Messages must be authentic, non-patronizing and offer factual information. Communication should be targeted using simple language to ensure correct understanding and avoid misinterpretation. Young people should be respected in their own rights. They need to be addressed as a holistic person rather than just as a “smoker”.

Gaps in research have been identified on several levels: first of all there is a need to empirically determine which recruitment strategy works in motivating young smokers to use cessation aids and to find out what kind of adolescents are reached through which kind of strategy. To date there is no theoretical framework which could lead this kind of research program. Although randomized controlled trials have highest strength of evidence, evaluation of strategies can take many forms that are less resource consuming. Evaluation starts with systematic observation and collection of data which should be the minimum within any implementation process.

The ACCESS project identified nine guiding principles and a number of recruitment strategies which were grouped into five categories: interpersonal communication, marketing, tailoring of messages, behavioral learning techniques and structural change. Young people can be recruited in different settings where they spend their time. Six general access points have been identified in which specific activities were conducted: health care services, social services/institutions, schools and work places, the Internet, traditional media, out of school/ leisure settings and specific access points for tobacco users. As far as recruitment strategies are concerned, only few activities are known which use families and youth workers for recruitment purposes. A lack of recruitment has also been identified in points of sale of tobacco products, on cigarette packages and in locations where smoking is still allowed. Here it may be useful to adapt recruitment strategies from other settings. Multidisciplinary networking among health professionals, providers of cessation interventions, educators, communication specialists and policy makers is a key issue.

Stakeholders and partners of the ACCESS project alike have agreed that to achieve economy of scale, exchange of experience should be continued and intensified beyond the current ACCESS project funding. Maintaining a good practice database is essential. Through coordinated research projects current practice-based expertise should be gradually transposed into scientific evidence.

It is consensus among the European ACCESS network that recruitment campaigns are an effective instrument to improve participation rates in smoking cessation interventions with the final aim to reduce youth smoking rates in Europe. However, this instrument is under-used and has not been implemented sufficiently so far. Recruitment strategies for smoking cessation interventions should be fully integrated into Art. 12 and Art. 14 of the Framework Convention on Tobacco Control (FCTC) and systematically implemented on national and regional level. It is urgent that recruitment is recognized by society as a self standing element of any tobacco cessation strategy and a priority task for educators, health professionals and policy makers alike.

Every effort has to be made so that more young tobacco users choose to participate in smoking cessation interventions in view of increasing cost-effectiveness and reducing future tobacco related death and disease.