



Public Health  
England

Protecting and improving the nation's health

## **Tobacco control: JSNA support pack**

Good practice prompts for planning  
comprehensive interventions in 2015-16

## About Public Health England

Public Health England exists to protect and improve the nation's health and wellbeing, and reduce health inequalities. It does this through advocacy, partnerships, world-class science, knowledge and intelligence, and the delivery of specialist public health services. PHE is an operationally autonomous executive agency of the Department of Health.

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For queries relating to this document, contact your local PHE centre tobacco control lead.

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# Introduction

Smoking is still the single largest cause of health inequalities and responsible for around half the difference in life expectancy between the richest and poorest.<sup>1</sup>

Comprehensive tobacco control interventions, implemented at local level and part of a strategic partnership approach, reduces smoking prevalence and the use of tobacco.

## Cut costs to local public services

In England each year it is estimated that smoking costs the public £13.1bn in terms of the output lost from early deaths, smoking breaks, NHS care, sick days, the impact of passive smoking, household fires, and smoking litter.<sup>2</sup>

## Protect children from harm

Two thirds of smokers say they began smoking before the legal smoking age of 18 and nine out of ten before the age of 19.<sup>3</sup> Children exposed to tobacco smoke are at much greater risk of cot death, meningitis, lung infections and ear disease.<sup>4</sup>

## Boost the disposable income of the poorest people in your local area

Two adult smokers with a 20-a-day habit are likely to spend more than £5000 per year on cigarettes. Workers in routine and manual jobs are twice as likely to smoke as those in managerial and professional roles. Poorer smokers spend five times as much of their weekly household budget on smoking than richer smokers.<sup>5</sup>

## Drive improvement across key measures of population health

Reducing smoking rates will impact on core indicators included in three out of the four public health domains identified in 'Improving outcomes and supporting transparency: a public health outcomes framework for England'.<sup>6</sup> Examples of indicators which would be positively affected include:

- sickness absence
- the number of children in poverty
- numbers of low-birth-weight babies
- pregnant women smoking at time of delivery
- smoking prevalence rates in adults and children
- infant mortality and all cause
- preventable mortality
- mortality from cardiovascular disease
- mortality from cancer
- mortality from respiratory disease
- preventable sight loss

## Joint strategic needs assessments

Joint strategic needs assessments (JSNAs) analyse the current and future health and social care needs of communities to inform and guide the commissioning of health, wellbeing and social care services within local authority areas. The joint health and wellbeing strategy (JHWS) sets out the strategy for meeting the needs identified in the JSNA.

## Purpose of this support pack

Public Health England (PHE) supports local authorities to deliver locally appropriate interventions and services by providing data, interpretation and evidence to enable local teams to improve the public's health. This support pack supports the JSNA process and to help local authorities to commission comprehensive tobacco control interventions.

## Feedback

This is PHE's first version of a JSNA resource pack focused on tobacco control. It is hoped that it will not only provide a valuable resource for reference, but that it will generate feedback from commissioners and other local stakeholders regarding its usefulness and suitability to support the case for local tobacco control action.

# 1. Commissioning principles for comprehensive local tobacco control

Local authority public health commissioners work closely with all relevant partners to commission high-quality, evidence-led 'comprehensive tobacco control' interventions.

## What will you see locally if you are meeting the principle?

Effective integrated commissioning of services that achieve positive outcomes for individuals, families and communities by:

- effective partnership working between local authority-led public health, the NHS (clinical commissioning groups and NHS England local area teams), mental health services and adult social care, regulatory services, children's services and criminal justice agencies
- operating transparently according to assessed need
- bringing partner agencies and services providers together into cost-effective delivery systems
- fully involving service users and local communities, including through Healthwatch

All people who smoke tobacco can be offered a cessation intervention suitable for their needs.

Tobacco control is a prominent action within strategies aimed at addressing health and social inequalities.

## What questions should you ask to check you are following the evidence and best practice that supports the principle?

### 1.1. Embedding local systems

- 1.1.1. Do tobacco control needs assessments, the local commissioning strategy, clinical commissioning group strategy and joint health and wellbeing strategy (JHWS) demonstrate an explicit link between evidence of need and service planning?
- 1.1.2. Does the local public health structure have mechanisms in place for reporting on the impact of tobacco to the health and wellbeing board?
- 1.1.3. Has the local authority public health team responsible for commissioning tobacco control and stop smoking services established partnership arrangements with clinical commissioning groups, local clinical networks, NHS England local area teams, regulatory services and criminal justice agencies?

- 1.1.4. Is there a formal strategic partnership in place for tobacco control involving key stakeholders and agencies (acute health, mental health, public health, regulatory services, employment, social care, children's services, fire and rescue service and criminal justice), the aim of which is to develop a fully integrated and comprehensive system aimed at preventing smoking uptake, supporting smokers to stop, reducing the harm and inequalities caused smoking, and advocating for a smokefree generation?
- 1.1.5. Have such strategic partnerships undertaken a self-assessment<sup>7</sup> to enable you to:
  - evaluate your local action on tobacco
  - ensure that local activity follows the latest evidence-based practice
  - identify priority areas for development?
- 1.1.6. Have strategic partner organisations acknowledged their responsibilities under article 5.3 of the WHO framework convention on tobacco control (FCTC) by signing the local government declaration on tobacco control?<sup>8</sup>
- 1.1.7. Do the general public, health care professionals and staff in partner agencies (including the voluntary sector) have ready access to information that enables them to understand the stop smoking services available, the pathways between them and methods of referral?

## 1.2. Needs assessment

- 1.2.1. Does the local JSNA include a comprehensive section on tobacco control that reflects need across the whole spectrum of reducing smoking-related harm and health inequalities, and readily acknowledges the impact of tobacco control activity across the public health outcomes framework and the NHS outcomes framework, resulting in partnership, collaboration and support?
- 1.2.2. Is there a shared understanding of the local level of demand and need, based on a range of local and national data across a range of public services?
- 1.2.3. Is local data on tobacco control interventions provided in hospitals, primary health care and other settings collected to inform needs assessment?
- 1.2.4. Do commissioners analyse the local levels of tobacco-related admissions to hospital in order to target interventions?
- 1.2.5. Do commissioners analyse and monitor local stop smoking service treatment data, including specific breakdown by gender, age, postcode, condition, route of referral, treatment outcome, etc, in order to compare current treatment provision with need?

1.2.6. Does the needs assessment take into account the availability and potential development of existing community support networks and other local assets, using a methodology such as asset-based community development?

1.2.7. Are the following fully identified:

- gaps in the delivery of brief interventions across all partner agencies?
- equality of access to stop smoking services for key populations with a higher prevalence of smoking (eg, routine and manual workforce, teenage pregnant women, mental health, prison populations, LGBT communities, etc)
- the impact of tobacco control and stop smoking interventions on hospital admissions, length of stay, and social care activity?

### 1.3. Finance

1.3.1. Is investment sufficient for a range of prevention, harm reduction and stop smoking services commensurate with the level of identified need?

1.3.2. Can commissioners identify the total level of local investment by all partners who contribute to delivery?

1.3.3. Have the partners identified the potential 'return on investment' for funding tobacco control interventions, including the economies to be achieved by commissioning supra-local/sub-national activity?<sup>9</sup>

### 1.4. Effective commissioning

1.4.1. Is commissioning based on the evidence base, such as NICE guidance, for effective interventions in tobacco control and tackling smoking-related harm?

1.4.2. Is there a tobacco control strategy that describes how best to meet local need, which clearly identifies:

- the level of local demand
- existing strengths and ways in which services can be commissioned
- finance and resources made available?

1.4.3. Are reliable cost-effectiveness data tools used when making commissioning decisions to ensure that investment in tobacco control is based on an understanding of expenditure, performance and effectiveness?

1.4.4. Are there contracts in place for commissioned services that specify the outcomes to be achieved and that are regularly monitored and reviewed?



- 1.4.5. Are interventions and services geographically and socio-culturally appropriate to those for whom they are designed?
- 1.4.6. Are commissioning functions fit for purpose? Is there sufficient tobacco control commissioning capacity and expertise?
- 1.4.7. Are arrangements in place to facilitate supra-local/sub-national commissioning with regional partners?
- 1.4.8. Do commissioners include formal evaluation of the range of tobacco control interventions within the commissioning strategy?

## 2. Supporting people to stop smoking successfully

Stop smoking services are highly cost-effective and form a key part of tobacco control and health inequalities policies at local and national level. The provision of high-quality stop smoking services is essential to the reduction of health inequalities and in improving health for local populations. All health and social care services can play a key role in identifying smokers and referring people to stop smoking services. For those people who are unwilling or unable to stop smoking in one step there are a range of harm reduction strategies available.

### **Statement of principle**

Targeted stop smoking services, as an integral part of any comprehensive tobacco control strategy, provide high-quality evidence-based support to those people who require it the most.

### **What will you see locally if you are meeting the principle?**

In line with NICE guidance recommendations, service providers treat at least 5% of their local smoking population.<sup>10</sup>

Your stop smoking service achieves success rates, carbon monoxide validation rates and lost to follow-up rates that are comparable to areas with similar smoker profiles and within the nationally prescribed range.

Successful stop smoking interventions are delivered to vulnerable populations and those identified as at risk in the JSNA.

Services receive a high satisfaction rating from service users.

Services are independently audited and improvement plans are implemented where required.

### **What should you ask to test whether you are doing what the available evidence and best practice suggests will help you meet the principle?**

- 2.1. Is service design and delivery informed by the latest evidence base, summarised in the local stop smoking service delivery and monitoring guidance 2014-15<sup>11</sup> and in NICE guidance?
- 2.2. Has an equality impact and gap analysis been carried out (or planned) and do our commissioning priorities reflect this?
- 2.3. Have all stop smoking practitioners achieved certification through the National Centre for Smoking Cessation and Training (NCSCT)?

- 2.4. Are all licensed stop smoking medicines offered as first-line interventions, including nicotine replacement therapy in combination and varenicline, to maximise success?
- 2.5. Can services provide behavioural support to clients wishing to use unlicensed nicotine- containing products, such as e-cigarettes?
- 2.6. Are those who have most to gain from the service (ie, smokers with mental health problems, pregnant smokers, those from routine and manual groups, etc) being targeted?
- 2.7. Are local stop smoking service providers monitored to ensure equitable success rates?
- 2.8. Are four-week quit outcomes collected and is this data submitted quarterly to the Health and Social Care Information Centre?
- 2.9. Do service specifications require providers to reduce the number of clients that are lost to follow-up?

### 3. Tobacco harm reduction

Stop smoking services provide highly cost-effective interventions to help people stop smoking and any investment in harm-reduction should not detract from their provision. Rather, harm-reduction interventions are intended to support and extend the reach and impact of existing services.

Although existing evidence is not clear about the health benefits of smoking reduction, those who reduce the amount they smoke are more likely to stop smoking eventually, particularly if they are using licensed nicotine-containing products (NICE PH45).<sup>12</sup>

The NICE guidance defines harm reduction approaches as follows:

- stopping smoking, but using one or more licensed nicotine-containing products as long as needed to prevent relapse
- cutting down prior to stopping smoking with or without the help of licensed nicotine-containing products
- smoking reduction with or without the help of licensed nicotine-containing products
- temporary abstinence from smoking with or without the help of licensed nicotine-containing products

#### **Statement of principle**

The best thing a smoker can do is to stop immediately, completely and permanently. However, not all smokers are able or wish to stop in one step, therefore harm-reduction interventions can move them closer to becoming smokefree.

#### **What will you see locally if you are meeting the principle?**

Public awareness of the harm caused by smoking and second-hand smoke is linked to information on how people who smoke can reduce the risk of illness and death (to themselves and others) by using one or more licensed nicotine-containing products.

Provision of harm-reduction interventions do not detract from the provision of local stop smoking service interventions.

People who are not ready or are unwilling or unable to stop smoking in one step are offered a harm-reduction approach with use of licensed nicotine-containing products recommended.

People continue to use licensed nicotine-containing products in the long term rather than risk relapsing after they have stopped or reduced their smoking.

**What should you ask to test whether you are doing what the available evidence and best practice suggests will help you meet the principle?**

- 3.10. Is advice on quitting completely and in one step offered to all smokers in the first instance?
- 3.11. Is referral to stop smoking services made where support is required?
- 3.12. Are all types of licensed nicotine-containing products offered to people who smoke, as part of a harm-reduction strategy (either singly or in combination)?
- 3.13. Are licensed nicotine-containing products offered to help prevent relapse among people who have stopped smoking or reduced the amount they smoke?
- 3.14. Are people who want (or need) to abstain temporarily on a short, medium or long-term basis advised on how to do this?
- 3.15. Is behavioural support offered to people who want (or need) to abstain temporarily?
- 3.16. Are harm-reduction interventions incorporated into the management of smoking in the care plan for people in closed institutions who smoke?
- 3.17. Can it be demonstrated that investment in harm-reduction approaches will not (or does not) detract from existing stop smoking services?
- 3.18. Do providers of stop smoking and other behaviour-change services offer people who smoke the harm-reduction approaches if they are not ready, willing or able to quit?
- 3.19. Are these harm-reduction approaches available in the community, as part of primary and secondary healthcare and on offer from local authorities?
- 3.20. Have activity and outcome measures been developed to assess the performance of service providers involved in the provision of harm-reduction approaches?

## 4. Supporting pregnant smokers and those with infants to stop smoking

Addressing the issue of smoking in pregnancy should be a focus for all local areas as this has an impact on a range of issues related to health, inequalities and child development. NICE has produced guidance on how best to support women to stop smoking in pregnancy.<sup>13</sup>

Smoking during pregnancy causes up to 2,200 premature births, 5,000 miscarriages and 300 perinatal deaths every year in the UK. It also increases the risk of developing a number of respiratory conditions; attention and hyperactivity difficulties; learning difficulties; problems of the ear, nose and throat; obesity; and diabetes.<sup>14,15,16</sup>

Although rates are lower than in the past, 12% of women in England are recorded as smoking at the time of delivery, which translates into over 83,000 infants born to smoking mothers each year.<sup>17</sup>

There are significant demographic differences and factors associated with inequalities related to this issue. For instance, pregnant mothers under the age of 20 are more than three times as likely to smoke as mothers aged 35 or over. Those in routine and manual occupations are more than four times as likely to smoke throughout pregnancy as those in managerial and professional occupations (29% and 7% respectively). Infants born to smokers are much more likely to become smokers themselves, which further perpetuates health inequalities.<sup>18</sup>

Treating mothers and their babies (0-12 months) with problems caused by smoking during pregnancy is estimated to cost the NHS between £20m and £87.5m each year.<sup>19</sup>

### **Statement of principle**

All pregnant women who smoke and all those who are planning a pregnancy or who have an infant aged less than 12 months should be referred for help to stop smoking.

### **What will you see locally if you are meeting the principle?**

The issue of smoking will be addressed by all healthcare professionals working with pregnant women at appropriate moments throughout their pregnancy.

All pregnant women will have a carbon monoxide test at the booking appointment. If this indicates smoking, a referral will be made to a specialist smoking cessation advisor for further discussion and/or support to stop.

Robust (opt-out) referral pathways are in place between the healthcare professional who raises the issue of smoking with the pregnant women and the stop smoking

service or relevant (trained) person providing the intervention. This includes feedback mechanisms to ensure the referring healthcare professional is aware of the outcome.

Partners and family members who smoke are also offered support to quit and information is provided on the risks associated with secondhand smoke.

**What should you ask to test whether you are doing what the available evidence and best practice suggests will help you meet the principle?**

- 4.10. Is NICE Guidance (PH26) appropriately implemented across systems in your local area?
- 4.11. Do service specifications for local midwifery services include requirements for the issue of smoking to be addressed?
- 4.12. Do these specifications include routine carbon monoxide testing at booking appointment (and other appointments if possible)?
- 4.13. Are there appropriate key performance indicators in place to monitor this activity? Are these monitored regularly? What systems are in place to address poor performance?
- 4.14. Are individuals identified as smokers provided with appropriate and consistent messages around smoking, the risks of continuation and importance of cessation (and/or second-hand smoke)?
- 4.15. Are there referral pathways in place for access to the stop smoking service or specialist midwife? Is this an opt-out system? Are there functioning feedback mechanisms to the referrer (for future follow up)?
- 4.16. Are all healthcare professionals who meet with pregnant women trained to raise the issue of smoking and refer to specialist services?
- 4.17. Are those providing stop smoking interventions appropriately trained? Does the training meet NCSCT standards?<sup>20</sup>
- 4.18. Do the stop smoking interventions adhere to the evidence base? Are they provided on an ongoing basis, with information on and access to stop smoking medications?
- 4.19. Is smoking status at booking collected? Is this a mandatory requirement? Does this include carbon monoxide reading?
- 4.20. Does the system include the option of 'not known'? If so are there plans to remove this to ensure more accurate and informative data collection?
- 4.21. Are rates of smoking at time of delivery (and booking) monitored regularly within and across the locality?
- 4.22. Is there a local multi-agency partnership in place with appropriate local leadership to address the issue of smoking in pregnancy? Is there a strategy?

- 4.23. Are contract specifications reviewed regularly? Is there a process monitoring delivery and outcomes?

## 5. Smoke-free homes and cars

Millions of children in the UK are exposed to second-hand smoke that puts them at increased risk of lung disease, meningitis and cot death. Each year it results in over 300,000 GP visits, 9,500 hospital visits in the UK and costs the NHS more than £23.6 million.<sup>21,22</sup>

A survey undertaken of 1,000 young people aged 8-13, on behalf of the Department of Health in October 2011, demonstrated that children want smokefree lives. This found:

- 98% of children wish their parents would stop smoking
- 82% of children wish their parents wouldn't smoke in front of them at home
- 78% of the children wished their parents wouldn't smoke in front of them in the car
- 41% of children said cigarette smoke made them feel ill
- 42% of children said cigarette smoke made them cough

Exposure to second-hand smoke in confined spaces such as a car is particularly hazardous. As there is no safe level of exposure to tobacco smoke, it is important that other vulnerable groups such as older adults are also protected.

### **Statement of principle**

Smokefree environments are healthier places for infants, children and young people to grow and older adults to live.

### **What will you see locally if you are meeting the principle?**

Frontline health and social care workers routinely ask service users if they are ever exposed to tobacco smoke in an enclosed environment.

Frontline health and social care workers advise about the benefits of a smokefree home or car.

Local policies and plans are in place to increase smokefree spaces, including enclosed environments, supporting smokers to create and maintain smokefree homes and cars.

### **What should you ask to test whether you are doing what the available evidence and best practice suggests will help you meet the principle?**

- 5.1. Have early year's partners assessed their capacity to deliver brief interventions and advice regarding smoking cessation and second-hand smoke interventions?
- 5.2. Do frontline health and social care workers monitor and record smoking status?



- 5.3. Are there measures of exposure to second-hand smoke for vulnerable groups, especially children?
- 5.4. Is there access to a freely available and evidence-based stop smoking service for everyone who smokes or uses tobacco in any other form? (See section 2 'Supporting people to stop smoking successfully' for more prompts.)
- 5.5. Have smoking cessation advisors and frontline health and social care workers completed the NCSCCT module for very brief advice on second-hand smoke?<sup>23</sup>
- 5.6. Does advice on second-hand smoke extend to cars, with and without children present, and other enclosed environments?
- 5.7. Do you have evidence that brief interventions on second-hand smoke are being implemented?
- 5.8. Do you have evidence that commitments to smoke-free homes and cars are being adopted and maintained?

## 6. Preventing young people from taking up smoking

Smoking is a childhood addiction, not an adult choice. The majority of smokers start while in their teenage years with very few starting after the age of 20. It is estimated that approximately 207,000 children aged between 11 and 15 start smoking each year in the UK, with 18% of 15-year olds classified as current smokers.<sup>24</sup>

There are many risk factors associated with increased likelihood of youth smoking including whether a parent, carer or sibling smokes. Risk factors also include the level of exposure to tobacco industry marketing, tobacco imagery in the media, and the availability of cheap tobacco. Lower socio economic status, higher levels of truancy and substance misuse are all associated with higher rates of youth smoking.

Young people who smoke can be particularly susceptible to negative effects of smoking on their health, both in the short and the long-term, including respiratory illness and poorer lung function. Smoking can also impair lung growth in children and young people.

### **Statement of principle**

Positive influences in the school, home and local community prevent young people from taking up smoking.

### **What will you see locally if you are meeting the principle?**

There are tobacco policies in learning environments that are widely understood and aim to prevent smoking uptake and increase cessation in young people.

Education content implemented in learning environments informs young people about short and long term health, economic and societal consequences of tobacco.

Targeted peer mentoring programmes implemented in areas of greater need.

A reduction in the number of young people exposed to smoking role models and instances of smoking.

A reduction in the availability and affordability of tobacco for young people.

### **What should you ask to test whether you are doing what the available evidence and best practice suggests will help you meet the principle?**

6.10. Is tobacco prevention work in schools evidence-based?<sup>25</sup>

6.11. Do schools have a tobacco policy that is understood and implemented?

6.12. Do schools include tobacco education as part of the curriculum?

6.13. Are adult-led interventions adopted and maintained?

- 6.14. If peer-led interventions are rationed, do you prioritise in areas of greatest need?
- 6.15. If you commission tobacco prevention work for young people that is not evidence-based, is it evaluated and are the results published?
- 6.16. Are frontline workers in schools and youth settings trained to discuss smoking with young people?
- 6.17. Are young people who smoke offered very brief advice by frontline workers in school and youth settings?
- 6.18. Is there access to a freely available and evidence-based stop smoking service for everyone who smokes or uses tobacco in any other form?<sup>26</sup>
- 6.19. Is the stop smoking service accessible for young people?
- 6.20. Are harm-reduction approaches offered for those who smoke but do not want to quit?<sup>27</sup>
- 6.21. Are there evidence-based programmes in place to protect young people from the harms of second-hand smoke<sup>28</sup> (See section 5 'Smokefree homes and cars' for more prompts.)
- 6.22. Do you monitor compliance with point of sale legislation for tobacco?<sup>29</sup>
- 6.23. Is training and information offered to retailers to maintain or strengthen compliance with point of sales legislation?
- 6.24. Is your monitoring and enforcement of point-of-sale legislation intelligence led?
- 6.25. Are systems in place to identify and report sales of illicit tobacco locally? (See section 11 'Cheap and illicit tobacco' for more prompts.)

## 7. Workplace interventions

Reducing levels of smoking among employees will help reduce some illnesses and conditions (such as cardiovascular disease and respiratory problems) that are key causes of sickness absence. This will result in improved productivity and less costs for employers.

The workplace has several advantages as a setting for smoking cessation interventions:

- large numbers of people can be reached (including groups who may not normally consult health professionals, such as young men)
- there is the potential to provide peer group support
- a non-smoking working environment encourages smokers to quit (NICE PH5)<sup>30</sup>

### Statement of principle

Interventions delivered in the workplace will encourage more people to access support to stop smoking, will reduce absenteeism and increase productivity.

### What will you see locally if you are meeting the principle?

A widely accessible stop smoking service available to all employees.

Employers supporting employees through quit attempts by enabling access to stop smoking services.

Where demand is identified, stop smoking clinics delivered on site in workplaces.

Smoke-free working environments and comprehensive no-smoking policies are consistently enforced.

### What should you ask to test whether you are doing what the available evidence and best practice suggests will help you meet the principle?

- 7.10. Is support for smoking cessation established in local workplace wellbeing initiatives?<sup>31</sup>
- 7.11. Are their established channels of communication between the stop smoking service and local employers?
- 7.12. Have barriers to accessing stop smoking support from the workplace been scoped?
- 7.13. Do we routinely provide employees with information on local stop smoking support services. Are staff allowed time off to attend stop smoking services?
- 7.14. Do larger employers in the area allow the local stop smoking services to attend events to offer very brief advice?

- 7.15. Are public-sector smoking policies an exemplar to other local employers?
- 7.16. Does our policy facilitate the use of licensed nicotine replacement therapy in the workplace?
- 7.17. Does our policy make allowances for the use of nicotine vapourisers (e-cigarettes) and distinguish between them and smoked tobacco?
- 7.18. Are all employees protected from second-hand smoke in their workplace (including those who do home visits).
- 7.19. Is our smoke-free policy regularly reviewed and updated if necessary.

## 8. Mental health

Smoking is around twice as common among people with mental disorders and even higher among those with more severe disease.<sup>32</sup> With up to three million smokers in the UK, 30% of all smokers have evidence of a mental disorder and up to one million have long-standing disease. In contrast to the marked decline in smoking prevalence in the general population, smoking among those with mental disorders has changed little, if at all, over the past 20 years. Smokers with mental disorders are just as likely to want to quit as those without, but are more likely to be heavily addicted to smoking and to anticipate difficulty quitting smoking, and historically much less likely to succeed in any attempt to quit.<sup>33</sup>

### **Statement of principle**

Comprehensive tobacco control strategy provides high-quality evidence-based interventions to those people who require it the most.

### **What will you see locally if you are meeting the principle?**

NICE guidance specifically related to smoking cessation and tobacco control is implemented fully in all aspects of care for individuals with mental health problems.<sup>34</sup>

People with poor mental health are provided with the same, or better, opportunities to access support services as the general population.

These services provide outcomes that are comparable to those experienced by the general population.

Effective links between primary and secondary care provision, resulting in seamless care that is fundamentally linked to other health outcomes.

Providers of mental health services have an excellent understanding of what they are required to deliver in relation to smoking cessation and smokefree environments.<sup>35</sup>

Smoke-free signage and application of policy is clear and consistent throughout the estate, with high levels of compliance.

Those people who do not want, or are unable, to stop smoking in one step are offered other strategies to reduce the harm of tobacco, as outlined in NICE public health guidance PH45: tobacco harm reduction.<sup>36</sup>

**What should you ask to test whether you are doing what the available evidence and best practice suggests will help you meet the principle?**

- 8.10. Has NICE public health guidance (PH48), which supports mental health trusts' implementation of smokefree policies, been followed and have staff and patients had an opportunity to voice and overcome their concerns?
- 8.11. Has consultation with appropriate stakeholders, including service user groups, influenced the design of services?
- 8.12. Are the needs of people with a mental disorder who smoke sufficiently well understood to ensure that services are appropriately commissioned?
- 8.13. Do senior clinicians support and champion the process (eg, identification, referral, intervention, follow-up)?
- 8.14. Do all staff in mental health settings receive training on brief interventions for smoking cessation, with medical and nursing staff receiving more extensive training in smoking cessation?
- 8.15. Are smoke-free mental health units an integral part of a more health promoting culture, providing alternative, meaningful activity during the day?
- 8.16. Do specialist cessation services for those with mental illness achieve results comparable with the best services nationally?
- 8.17. Are mental health service users able to access stop smoking medications?
- 8.18. Are policies in place to monitor levels of other relevant medication as a result of smoking cessation?
- 8.19. Are outcomes monitored in such a way as to ensure that they reduce health inequalities?
- 8.20. Do services achieve the desired outcomes?
- 8.21. Has demand for services increased?
- 8.22. Are those people who do not want, or are unable to stop smoking in one step, offered other strategies to reduce the harm of tobacco, as outlined in NICE public health guidance PH45: tobacco harm reduction?
- 8.23. Are policies in place regarding use of unlicensed nicotine containing products within the mental health estate?

## 9. Offender health

Nationally around 80% of prisoners smoke compared with just under 20% in the general population, with similar levels recorded across the offender journey in police custody and probation where data are available.<sup>37,38</sup>

This high rate of smoking causes health problems to the smokers themselves and to non-smokers who are exposed to their tobacco smoke. The offender population has a high prevalence of poor mental health, other substance misuse and are predominantly from disadvantaged backgrounds,<sup>39,40</sup> all of which are associated with elevated smoking prevalence. Offenders who smoke and those exposed to this smoke experience a marked increase in health inequalities.

A strong case for addressing smoking among offenders is endorsed in 'Improving health, supporting justice',<sup>41</sup> which recognised high levels of health needs among offenders, whether in police custody or under community supervision and included key objectives such as working in partnership, equity of access to services, improving pathways and continuity of care.

### **Statement of principle**

Comprehensive tobacco control strategy provides high quality evidence based support to those people who require it the most.

### **What will you see locally if you are meeting the principle?**

NICE guidance, related to smoking cessation and tobacco control, is implemented fully in all aspects of care for those within the justice system

People in custody and on probation are provided with the same, or better, opportunities to access stop smoking support services as the general population.

These services provide outcomes that are comparable to those experienced by the general population.

People in custody and on probation report that the services provided are accessible, suitable and address their specific needs.

There are links throughout the offender pathway, resulting in seamless care that is fundamentally linked to other health outcomes.

Licensed nicotine containing products are available (and offered) to those entering a custodial situation for the first time (eg, police custody).

Staff working within the criminal justice system have a full understanding of what they are required to deliver.



Those people who do not want, or are unable, to stop smoking in one step should be offered other strategies to reduce the harm of tobacco, as outlined in NICE public health guidance PH45: tobacco harm reduction.<sup>42</sup>

**What should you ask to test whether you are doing what the available evidence and best practice suggests will help you meet the principle?**

- 9.10. Has NICE public health guidance been followed and have staff and offenders had an opportunity to voice and overcome their concerns?
- 9.11. Has consultation with appropriate stakeholders, including groups who represent offenders, influenced the design of services?
- 9.12. Are the needs of people in custody or on probation sufficiently well understood to ensure that services are appropriately commissioned?
- 9.13. Do governors, senior management and senior clinicians support and champion the process?
- 9.14. Do all staff in custodial and probation settings receive training on brief interventions for smoking cessation, with medical and nursing staff receiving more extensive training in smoking cessation? This should also include training staff in prison settings, in particular health providers, listeners and peer supporters. Such training would advise on best practice for assisting those with mental health problems to successfully give up smoking.
- 9.15. Is smokefree accommodation an integral part of a more health-promoting culture within custodial settings, providing alternative, meaningful activity during the day?
- 9.16. Do specialist cessation services for those in custody or on probation achieve results comparable with the best services nationally?
- 9.17. Are outcomes monitored in such a way as to ensure that they reduce health inequalities?
- 9.18. Do services achieve the desired outcomes?
- 9.19. Has demand for services increased?
- 9.20. Are those people who do not want, or are unable, to stop smoking in one step offered other strategies to reduce the harm of tobacco, as outlined in NICE public health guidance PH45: tobacco harm reduction?

## 10. Secondary care

Stopping smoking at any time has considerable health benefits for people who smoke and for those around them. For people using secondary care services, there are additional advantages, including shorter hospital stays, lower drug doses, fewer complications, higher survival rates, better wound healing, decreased infections, and fewer re-admissions after surgery.<sup>43</sup>

Secondary care providers have a duty of care to protect the health of, and promote healthy behaviour among, people who use or work in their services. This duty of care includes providing effective support to stop or abstain from smoking while using or working in secondary care services. (NICE PH 48)<sup>44</sup>

### **Statement of principle**

Secondary care settings present an excellent opportunity to engage with people who smoke and this engagement will have positive outcomes for the recipient and the provider.

### **What will you see locally if you are meeting the principle?**

People who attend secondary care settings and who smoke are offered advice and support to stop.

All hospitals have an on-site stop smoking service that provides intensive behavioural support and pharmacotherapy as an integral component of secondary care.

Integrated care pathways exist that allow for a seamless transition of care between primary and secondary settings.

Stop smoking medications are available on hospital formularies and available to support people experience nicotine withdrawal when in hospital.

There are no designated smoking areas or staff-facilitated smoking breaks for anyone using secondary care services.

Strong leadership and management that ensure premises remain smokefree.

All secondary care estates are designated completely smokefree and it is clear to all patients, staff and visitors that this is the case.

Local tobacco control strategies include secondary care as a main point of contact for smokers.

### **What should you ask to test whether you are doing what the available evidence and best practice suggests will help you meet the principle?**

**10.10.** Do all secondary care settings have a policy on smoking cessation and smokefree for both staff and patients?

- 10.11. Do local tobacco control strategies include secondary care?
- 10.12. Is information on the stop smoking policies and services available provided for planned or anticipated use of secondary care?
- 10.13. Is there a mandatory training programme for all frontline healthcare staff to know and use very brief stop smoking advice and, where possible, train in motivational interviewing for behavioural change, in order to 'make every contact count'?
- 10.14. Do health and social care practitioners in all acute, maternity and mental health services – including community services, drug and alcohol services, outpatient and pre-admission clinics – identify people who smoke and offer help to stop?
- 10.15. Is anyone who is not willing or able to stop completely provided access to harm-reduction strategies and pharmacotherapies to support them?
- 10.16. Do hospital staff routinely provide information and advice for carers, family, other household members and hospital visitors on the services available to help them stop smoking?
- 10.17. Are all stop smoking pharmacotherapies available as first line treatment for people who are in hospital?
- 10.18. Are robust referral systems in place that provide a prompt for action (including the referral of people to stop smoking support), ensure smoking status is consistent in all patient records, and are stored in a way that facilitates easy access and audit?
- 10.19. Do directors, senior managers and clinical leads provide leadership on stop smoking support?
- 10.20. Do all secondary care sites have smokefree grounds or do they have a plan to achieve this status within the next six months?
- 10.21. Do secondary care providers act as exemplars of best practice as is befitting of their position as the flagships of health care?
- 10.22. Are staff provided with support to stop smoking?

## 11. Tackling cheap and illicit tobacco

The illicit tobacco market is in long-term decline but still remains a problem in some communities. It undermines tobacco control measures, including taxation and age of sale regulations, enabling children to get hooked on a lethal addiction and encouraging smokers to smoke more than if they were paying full price. Criminal activity in the illicit trade tends to target smokers in deprived areas, increasing health inequalities further.<sup>45</sup>

Effective approaches are co-ordinated across large geographical areas where health and enforcement partners collaborate to reduce the demand for and supply of illicit tobacco. Evidence-based social marketing and public relations campaigns have raised awareness of the issue, helped to generate intelligence and have provided the facts on illicit tobacco by countering the misinformation circulated by the tobacco industry.

### **Statement of principle**

There are established supra-local partnership arrangements in place focused on reducing the demand for and supply of illicit tobacco.

### **What will you see locally if you are meeting the principle?**

Full engagement between public health, police regional intelligence units, trading standards and HMRC to improve the intelligence base.

A greater awareness and understanding of the impact of illicit tobacco among partner organisations and the general public.

Clear data and intelligence on the levels of demand for illicit tobacco, enabling priority communities to be targeted.

Increased reporting of illicit tobacco from the general public.

### **What should you ask to test whether you are doing what the available evidence and best practice suggests will help you meet the principle?**

- 11.1. Have local measures been established to measure the impact of activity, including levels of information received from the public, seizures and enforcement activity, and increased partnership working between agencies?<sup>46</sup>
- 11.2. Have regional evaluation surveys been conducted to measure the impact of activity (including the establishment of a baseline)?

- 11.3. Is there a safe, anonymous intelligence-sharing resource available for the public and partner agencies to use?
- 11.4. Is there a dedicated budget for illicit tobacco enforcement activity/social marketing activity?
- 11.5. Is there collaboration on illicit tobacco between local areas within the region?
- 11.6. Has a public opinion and stakeholder survey been carried out on illicit tobacco?
- 11.7. Does the regional trading standards organisation recognise tackling illicit tobacco as a strategic priority within broader tobacco control work?<sup>47</sup>
- 11.8. Is there a regional policy in place on the WHO framework convention on tobacco control article 5.3: protecting policies from the interests of the tobacco industry?

## Next steps

### Feedback requested

It is hoped that this JSNA resource will prove valuable in supporting local tobacco control commissioning programmes. Comments on its content and examples of its use in the supporting the JSNA process are welcome. It is envisaged that future versions will include local case studies and examples of innovative and noteworthy practice.

### Supporting strategic partnerships

Effective partnerships are central to moving the tobacco control agenda forward. It is therefore vital to ensure that partner agencies involved in local tobacco control activity have an opportunity to contribute to the process of assessing need and assessing further additional action that can be undertaken.

Formal strategic partnership in place for tobacco control should involve key stakeholders and agencies (acute health, mental health, public health, regulatory services, employment, social care, children's services, fire and rescue service and criminal justice), the aim of which is to develop a fully integrated and comprehensive system aimed at prevention of smoking uptake, supporting smokers to stop, reducing the harm and inequalities caused smoking and advocating for a tobacco-free generation.

### Self-assessment: CLear model

Have local strategic partnerships undertaken a self-assessment to enable:

- an evaluation of your local action on tobacco
- to ensure that local activity follows the latest evidence-based practice
- to identify priority areas for development

CLear is an evidence-based improvement model which helps you to develop local action to reduce smoking prevalence and the use of tobacco.<sup>48</sup> The model is designed for use by local authorities, tobacco alliances and health and wellbeing boards. The CLear model offers:

- a free-to-access self-assessment tool that can assist in evaluating the effectiveness of local action addressing harm from tobacco – a major aspect of any health and wellbeing strategy

- a voluntary peer assessment process, which provides independent challenge to your self-assessment and access to a recognised quality mark
- a chance to benchmark your work on tobacco over time and against others
- membership of Smoke Free Action Coalition and a growing professional network which shares your goals

A guide to the CLeaR process can be found at:

[www.gov.uk/government/publications/clear-local-tobacco-control-assessment](http://www.gov.uk/government/publications/clear-local-tobacco-control-assessment)

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- <sup>7</sup> CLear Tobacco Control Self-Assessment <https://www.gov.uk/government/publications/clear-local-tobacco-control-assessment>
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