Response from the UK Faculty of Public Health to the Department of Health's consultation on *The Future of Tobacco Control*

The UK Faculty of Public Health

The Faculty of Public Health (FPH) is the leading professional body for public health specialists in the UK. It aims to advance the health of the population through three key areas of work: health promotion, health protection and healthcare improvement. In addition to maintaining professional and educational standards for specialists in public health, FPH advocates on key public health issues and provides practical information and guidance for public health professionals.

FPH is a member of the Smokefree Action Coalition and has recently published, in association with ASH, a position statement on the health effects of secondhand smoke on children. It has also published a statement on mental health and smoking (endorsed by ASH, the Chartered Institute of Environmental Health, the Mental Health Network of the NHS Confederation, the Royal College of General Practitioners, the Royal College of Nursing, the Royal College of Psychiatrists and the UK Public Health Association). Both statements are available from: www.fph.org.uk

We welcome the government's commitment to a new national tobacco control strategy, in particular, its focus on protecting children and young people from tobacco use.

Part A: Reducing smoking rates and health inequalities

1. What smoking prevalence rates for all groups (children, pregnant women, routine and manual workers and all adults) could we aspire to reach in England by 2015, 2020, and 2030, and on what basis do you make these suggestions? What else should the government and public services do to deliver these rates?

Targets for the prevalence of all forms of tobacco use should be included in the final document.

FPH congratulates the government on its commitment to developing a new national tobacco control strategy. On the basis of a comprehensive new strategy, which is monitored, evaluated and regularly updated and includes a harm reduction approach, ambitious new targets should be achievable. The aim should be to reduce smoking prevalence rates for England by 2015 to 11% for the general population and 17% amongst routine and manual workers. Such stringent targets are supported by the significant decline in smoking prevalence in England following implementation of smokefree legislation,[i] recent rates of decline in the proportion of children smoking in England[ii] and evidence of rates of decline achieved over a number of years in

[i] Smoking ban triggered the biggest fall in smoking ever seen in England. Cancer Research UK press release, 30 June 2008. Research presented by Prof Robert West at the UK National Smoking Cessation Conference (30 June–1 July 2008).
[ii] Drug use, smoking and drinking among young people in England in 2007. The Information Centre for Health and Social Care, 2008.

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other jurisdictions with comprehensive tobacco control strategies [iii] (eg. Canada, Norway and California). Progress should be reviewed in 2012 to determine whether any revision of the tobacco control strategy is required in order to achieve these targets and again in 2015 to set new targets for 2020 and 2025.

Eroding the differential in smoking between the classes will be slow but achievable in the longer-term. By 2020 it should be possible to reduce smoking prevalence to around 1 in 20 in the general population, and around 1 in 10 in routine and manual groups. It is too soon to set targets for 2030 but by then smoking should be uncommon right across the classes.

Given that smoking uptake amongst children (11-15 year olds) is concentrated amongst 14 and 15 year olds we would suggest setting targets for these specific age groups for 2015 of 5% for 14 year olds and 10% for 15 year olds (compared to 9% and 15% in 2007 respectively). This would give a smoking prevalence rate amongst 11-15 year olds of 4% by 2015, compared to 6% in 2007.

These suggestions are made on the following basis:

- Countries and other jurisdictions that have already begun putting in place key strategies have experienced dramatic declines in tobacco use eg. California, Canada, New Zealand and Australia. We especially refer to the document by the Center for Disease and Prevention Control: *Sustaining State Funding for Tobacco Control* [iv] which succinctly reviews the overwhelming evidence for a comprehensive approach with relevant references.

- Professor Robert West, Cancer Research UK's director of tobacco studies at the Health Behaviour Research Centre based at UCL, who carried out the Smoking Toolkit Study which showed a decline in smoking prevalence of 5.5% post 1/7/07, said: "If the Department of Health can keep up the momentum this has created, there is a realistic prospect of achieving a target of less than 15 per cent of the population smoking within the next 10 years."[v]

- The 2004 Health Survey for England[vi] survey clearly demonstrated the need to include measures to reduce the use and prevalence of chewing tobacco. In particular the use amongst Bangladeshi men (9%) and women (16%) but it is also widely acknowledged that other black and minority ethnic groups chew tobacco as a cultural and social activity.

Other measures to help government deliver these rates:

- Establish and fund a Nicotine Regulatory Authority. At the moment there exists an anachronistic situation in that the least damaging form of nicotine delivery (in relative terms) is the most tightly regulated. Nicotine replacement therapy is also expensive, difficult to obtain in daily-dose packs at affordable prices, and only available at a very limited number of outlets. By contrast, the most health-damaging delivery mechanisms for nicotine (ie. cigarettes and roll-your-own tobacco) are the *least* regulated, easily available in daily-dose packets, and available at a very wide range of outlets. This situation urgently needs reversing.

[iii] Health Canada. Long-term trends in the prevalence of current smokers. Available from: http://www.hc-sc.gc.ca/hl-vs/tobac-tabac/research-recherche/stat/_ctums-esutc_prevalence/chart_image_2005-eng.php
http://www.hc-sc.gc.ca/hl-vs/tobac-tabac/research-recherche/stat/index-eng.php
Statistics Norway: Smoking prevalence and social surveys. Available from: http://www.ssb.no/royk_en/main.html
CDC Behavioural Risk Factor Surveillance System http://www.cdc.gov/brfss/
[iv] Center for Disease and Prevention Control: *Sustaining State Funding for Tobacco Control (2004)* available from: www.cdc.gov/tobacco/tobacco_control_programs/stateandcommunity/sustaingingstates/00_pdfs/FactsFInal.pdf
[v] Smoking ban triggered the biggest fall in smoking ever seen in England. Cancer Research UK press release, 30 June 2008. Research presented by Prof Robert West at the UK National Smoking Cessation Conference (30 June-1 July 2008).
[vi] Sproston K, Mindell J (eds.) *Health Survey for England 2004: The health of minority ethnic groups.* London: Information Centre, 2006.

- Ensure that tobacco control continues to be a high priority for the public, NHS and public services and the government. A comprehensive, effective, fully-funded tobacco control strategy should become a central element of government health policy and should cut across government departments, in particular health, education, business and enterprise, and revenue and customs.

- Work with European Commission to increase tobacco taxation levels so that all countries raise the minimum tobacco tax to at least 64% of the retail price. This should help reduce the incentives for tobacco smuggling and importation.

- The phasing out of subsidies to farmers for growing tobacco, due to end in 2010, will help as these gave a confused message to consumers and was an inappropriate use of public money, an order of magnitude greater than spend on tobacco control

- Implement the World Health Organization's MPOWER package[vii] (including a full ban on international and internet advertising) as well as support take up for this programme across the European Community.

- Provide additional post-graduate training to enable suitably qualified health professionals, such as dentists, pharmacists and practice nurses, to prescribe nicotine replacement products in addition to GPs.

- Work with training providers of healthcare workers to ensure that tobacco control is a mandatory element of core training, with the end result that all healthcare professionals are adequately trained to offer brief interventions on smoking cessation.

- It is also crucial that primary care trusts (PCTs) and local authorities are required to set appropriate local targets for smoking prevalence reduction and that these targets are adopted by Local Strategic Partnerships. The Department of Health (DH) should ensure that monitoring of smoking prevalence at PCT and local authority level is carried out consistently and comprehensively to enable PCTs and local authorities to measure their effectiveness in meeting their targets.

- Targets should also be set for exposure to secondhand smoke, by asking smokers whether they smoke in the home or in private vehicles, backed up by measurement of cotinine levels amongst both children and adults.

- Ensure that tobacco use, in all its forms, and its associated health risks are widely understood by everyone involved in 'Stop Smoking' services, healthcare and any other aspect of tobacco control.

2. What more do you think could be done to reduce inequalities caused by tobacco use?

Further measures to reduce inequalities include:

- Local NHS 'Stop Smoking' services should focus their efforts on disadvantaged populations. They should ensure that health promotion materials are culturally appropriate and that special outreach efforts target high risk populations, such as more disadvantaged smokers, pregnant women.

- Wider tobacco control policies that encourage smoking cessation and/or discourage smoking initiation should be targeted where possible at more disadvantaged populations

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[vii] WHO Report on the Global Tobacco Epidemic, 2008 - The MPOWER package - set of six key tobacco control measures that reflect and build on the WHO Framework Convention on Tobacco Control - http://www.who.int/tobacco/mpower/en/

or be implemented in such a way that they are not differentially more effective in more affluent areas. Tobacco control polices should be evaluated to ensure they do not increase inequalities.

- Undertake further research and analysis of the needs and barriers faced by smokers in disadvantaged groups accessing support.

- Actively involve disadvantaged smokers and those at risk of taking up smoking in the development and implementation of continued/new interventions on smoking cessation.

- Where appropriate aim for a reduction in harm where a full quit attempt is not currently possible (see Section D)

- Re-orientate services to meet the needs of harder to reach smokers.

- FPH welcomes the inclusion of mental health premises in smokefree legislation. People with mental illness experience high levels of poor physical health, and the highest premature morbidity and mortality in the country, due in significant part to tobacco use. Protecting them and staff from tobacco smoke exposure is crucial. It is also important to ensure that adequate support is available to help people with mental illness to stop smoking, and stay stopped. For an in-depth discussion on mental health and smoking see the FPH statement: *Mental health and smoking*.[viii]

- The prison population includes some of the most deprived and marginalised groups in society. Tobacco has long been used as a currency and incentive within prison life, further damaging the health of many prisoners. Government should review the existing situation where prison governors have discretion over what protection, if any, prisoners and prison staff have from tobacco smoke exposure, including the ability to allow where smoking can take place, such as in cells even if they are shared by non-smokers.

- There is now much greater understanding of the harmful effects of tobacco smoke on children. However, greater awareness is now required among parents/carers and people who work with parents/carers and with children regarding which strategies are effective in protecting children (such as, stopping smoking, never smoking in any room inside the home or outside with the door open) and which strategies are not effective (such as, smoking by an open window, in other rooms in the house, by an open door). For a more indepth discussion see the FPH/ASH *Children and Secondhand Smoke* statement[ix] and the FPH/ASH information leaflet for parents and carers.[x]

- Current services should also include support for people who regularly chew tobacco.

- In the longer term, reducing the income and education inequalities that lead to unequal prevalence of smoking initiation and cessation are also very important in tackling the inequalities consequent with tobacco use.

- Social marketing campaigns targeted more effectively at poorer smokers could also help reduce health inequalities.

[viii] *Mental health and smoking*, endorsed by ASH, Royal College of Psychiatrists, Royal College of Nursing, Royal College of General Practitioners, the Mental Health Network (of the NHS Confederation), UK Public Health Association and the Chartered Institute of Environmental Heath is available from: www.fph.org.uk.
[ix] *Children and Secondhand Smoke*, produced by FPH and ASH, is available from: www.fph.org.uk.
[x] *Children and Secondhand Smoke: Information leaflet for parents and carers*, produced by FPH and ASH, is available from: www.fph.org.uk.

3. Do you think the six-strand strategy should continue to form the basis of the government's approach to tobacco control into the future? Are there other areas that you believe should be added?

- There is good evidence that each of the six strands of tobacco control is effective in reducing smoking rates. The UK has made great strides in helping people to quit, banning tobacco advertising and promotion and reducing exposure to secondhand smoke, Although the six strands are still relevant, activities to take each one forward should be based on the latest evidence on effectiveness, and a standard model should be formulated to assist regional and local partnerships to take actions forward to avoid limited resources being spent on duplicating efforts.

- The six strands compare reasonably to the WHO MPOWER strands[xi] but lack a clear strand on monitoring tobacco usage and prevention policies. Current moves for improved prevalence data and a revised strategy are to be welcomed.

Key outcome indicators for all tobacco control actions should be developed and could be based on the document by the USA Centre for Disease Control (CDC).[xii] The document rates the strength of the evidence of each tobacco control action, providing information on the most effective use of limited resources.

- The strategy should be expanded to also cover all forms of tobacco use (rather than focusing only on smoking).

- Greater investment should be made in effective, targeted, mass media education campaigns and investment in social marketing of stop smoking services.

- Promotional opportunities for the tobacco industry should be further reduced.

Other areas to be considered:

- The document, *Ending the Tobacco Problem: a Blueprint for the Nation*[xiii], highlighted the fact that changing the regulatory environment is a necessary condition for ensuring a more substantial long term impact on tobacco use. In the section, 'Changing the Regulatory Landscape', 17 recommendations are given. We would urge government to consider the recommendations and identify those which have potential for adaptation to regulatory landscape in England.

4. How can collaboration between agencies be enhanced to contribute to the inland enforcement against illicit tobacco?

- An improved strategy to tackle smuggling at national, regional and local level is needed to stop the flow of tobacco smuggled by criminal gangs, with new tougher targets for a continued reduction in the market share of smuggled cigarettes and hand-rolled tobacco. The new Borders Agency must work closely with HM Revenue & Customs and the

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[xi] The six strands of MPOWER are:
- **M**onitor tobacco use and prevention policies
- **P**rotect people from tobacco smoke
- **O**ffer help to quit tobacco use
- **W**arn about the dangers of tobacco
- **E**nforce bans on tobacco advertising, promotion and sponsorship
- **R**aise taxes on tobacco

[xii] *Key Outcome Indicators for Evaluating Comprehensive Tobacco Control Programs.* CDC, 2005. Available from: http://www.cdc.gov/tobacco/tobacco_control_programs/surveillance_evaluation/key_outcome/

[xiii] *Ending the Tobacco Problem: a Blueprint for the Nation,* Richard J. Bonnie, Kathleen Stratton, and Robert B. Wallace, *Editors*, Committee on Reducing Tobacco Use: Strategies, Barriers, and Consequences. Board on Population Health and Public Health Practice, 2007. The document can be found at http://www.nap.edu/catalog.php?record_id=11795

Treasury to develop a new and improved anti-smuggling strategy and ensure that cracking down on smuggling remains a priority for the UK government.

- FPH supports the proposals as set out in the consultation. However, the UK government should also lobby for, and sign up to, a strong illicit trade protocol as part of the international treaty on tobacco – the Framework Convention on Tobacco Control (FCTC). The UK should also sign the EU anti-smuggling agreements, in line with all other EU Member States.

5. What more can the government do to increase understanding about the wider risks to our communities from smuggled tobacco products?

- The government should encourage the European Community and other member states to develop and sign up to a comprehensive international protocol on illicit tobacco as agreed in the Framework Convention on Tobacco Control.

- Government should aim to increase understanding and raise awareness about the wider risks to our communities from smuggled tobacco, including providing information about the scale of smuggling and campaigns to encourage the public to report illegal tobacco sales.

Other measures include:
- increasing the investment in staff and equipment needed to control the influx of smuggled tobacco;
- reviewing the appropriateness of the current level for the importation of cigarettes for personal use;
- encouraging HM Revenue & Customs and the police to put a high priority on activities reducing the supply of smuggled goods;
- requiring Trading Standards to prioritise activities for identifying counterfeit cigarettes.

Part B: Protecting children and young people

6. What more could the Government do to:

a. reduce demand for tobacco among young people?

- The most important factors affecting young people's use of tobacco are:
  - price, relative to income;
  - advertising, sponsorship, and brand image;
  - availability;
  - perceptions of smoking as a 'normal' adult activity;
  - attitudes of adults who have a significant role in young people's lives;
  - the 'cool' image they think it portrays to their peers.

- It is therefore important that:
  - price continues to rise by more than inflation;
  - counterfeit and contraband sales are vigorously restricted;
  - generic packaging is introduced;
  - positive licensing is introduced, to restrict the sale of tobacco products to licensed outlets;
  - legislation preventing underage sales is pro-actively enforced, with forfeit of licences by offenders.
  - vending machines are better controlled or removed;
  - adults are encouraged and supported to quit smoking;
  - adults are encouraged not to smoke where children may breathe that smoke or see adults smoking; and
  - parents, especially those who smoke, are encouraged to discourage smoking by their children.

- There is good evidence to show that a comprehensive tobacco control strategy aimed at the whole population is the best way to reduce demand for tobacco products among young people (rather than targeting programmes at children, such as the young smoking programmes run by the tobacco industry which are shown to have an adverse effect on smoking prevalence in children[xiv]). In addition to the 'six strands' identified above, there is widespread and growing support for measures to reduce tobacco marketing such as removing tobacco from view at the point of sale and plain packaging.

- Take further action to reduce 'positive' images of smoking in the media. This should include examining the impact of film classification, and the scope for making well researched and well produced anti-smoking adverts mandatory prior to the screening of any film which contains smoking imagery.

- Encourage the use of positive, non-smoking role models for young people.

- The Healthy School Programme should encourage school boards to require middle schools and high schools to adopt evidence-based smoking prevention programmes and implement them with fidelity. Schools and colleges should be encouraged to have smokefree campuses and school grounds.

- Young people should be consulted on how to implement the recommendations of any new National Tobacco Strategy.

- Clinicians, dentists and other healthcare providers should screen and educate (including through brief interventions) young people about tobacco use during healthcare visits. They should also encourage parents/carers to have a smokefree home and vehicle policy, to discuss smoking with their children, to convey that they expect their children to not use tobacco and to monitor their children's tobacco use. Professional societies should encourage clinicians and healthcare providers to adopt these practices.

- Undertake meaningful education campaigns eg. the visible effects associated with oral cancer treatment may prove a greater deterrent than showing a diseased lung. Likewise, bad breath/tooth staining in the short-term associated with smoking may be more meaningful to young people than the risk of systemic disease later.

b. reduce the availability of tobacco products to young people?

- Evidence indicates that when all retailers in an area observe the laws, it does reduce smoking initiation.[xv]

- Retailers should be licensed to sell tobacco in line with alcohol sales and England should follow Ireland's lead: from 1 July 2009, if a retailer is convicted of an offence under the legislation, eg. selling tobacco products to anyone under 18 years, they are automatically removed from a register of tobacco retailers for 3 months and hence are unable to sell tobacco products to anyone for that period. As well as reducing access to tobacco products to underage smokers, licensing of tobacco sales should also help to control sales of smuggled and counterfeit tobacco.

- Require trading standards to vigorously enforce the age of sales legislation.

[xiv] Landman A, Ling P, Glantz S. 2002. Tobacco industry youth smoking prevention programs: Protecting the industry and hurting tobacco control. *Am J Public Health*; 92 (6): 917-930.
[xv] Gemson DH, Moats HL, Watkins BX *et al*. 1998. Laying down the law: reducing illegal tobacco sales to minors in central Harlem. *American Journal of Public Health*. 88, 6:936-939.

- The sale of all tobacco products, including chewing tobacco, should be subjected to the same law enforcement as cigarettes, hand rolled tobacco and cigars.

- Develop legal sanctions that prosecute people purchasing tobacco on behalf of/for children (in line with alcohol laws).

- The sale and shipment of tobacco products directly to consumers through mail-order or the Internet or other electronic system is open to abuse and should be restricted. If practicable, the shipment of tobacco products should be permitted only to licensed wholesale or retail outlets.

- Banning sales of tobacco from vending machines, increasing price through taxation and stronger measures to curb smuggling will reduce the availability of tobacco products to young people.

7. Do you believe that there should be restrictions on the advertising and promotion of tobacco accessories, such as cigarette papers?

- Yes, this is a 'concealed' form of tobacco advertising and can act as a 'prompt' or reminder about smoking. FPH also believes that these products should be included in restrictions around sponsorship of sports events. We would also like to see the same tobacco purchasing age restrictions applied to the purchasing of tobacco accessories.

8. Do you believe there should be further controls on the display of tobacco product in retail environments?

- Yes. There is strong evidence to show that tobacco advertising and promotion encourages children to smoke, and this evidence underpinned the UK law banning most forms of tobacco advertising.[xvi, xvii] FPH therefore believes that tobacco products should not be on display within retail stores and we therefore support option number three which requires retailers to remove tobacco products from display.

- There is a growing international trend to remove tobacco products from sight in retail outlets, including legislation in Iceland and a number of Canadian provinces, and proposed legislation in four Australian states, Norway and New Zealand. Point of sale displays are a form of advertising. Since tobacco products are both lethal and addictive, advertising should not be permitted and the exemption for point of sale displays from the Tobacco Advertising and Promotion Act 2003 cannot be justified. Tobacco advertising is a major factor in young people starting to smoke, and point of sale displays also tempt adult quitters to relapse and non-daily smokers to smoke more frequently. It is noteworthy that in Iceland, where point of sale displays were made unlawful in 2001, smoking rates among 16 and 17 years olds fell from 61% in 1995 to 46% in 2003.[xviii]

- Research needs to also be undertaken in relation to the concerns expressed by retailers about loss of sales. If sales of tobacco products fall, it adds weight to the evidence that display stimulates purchase. Retailers should probably be less concerned than the tobacco industry would lead them to believe, as the evidence shows that ex-smokers generally spend the same amount of money but on other goods, rather than saving

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[xvi] Pierce J *et al*. 1991. Does tobacco advertising target young people to start smoking? Evidence from California. *JAMA*. 266(2): 3154-3158.

[xvii] Mindell JS. 1992. Direct tobacco advertising and its impact on children. (Commissioned review) *J Smoking-Related Disorders* .3:275-84.

[xviii] The European School Survey Project on Alcohol and Other Drugs (ESPAD). Available from: www.espad.org/sa/node.asp?node=730

money when they stop smoking.[xix] The tobacco industry should be required to support retailers in managing the transition.

9. Do you believe that there should be further controls on the sale of tobacco from vending machines to restrict access by young people? If so, what is your preferred option?

- Yes. FPH would support option number three and would like to see the removal of tobacco products from vending machines.

- The consultation reports research showing that vending machines account for 17% of cigarette sales to smokers aged between 11 and 15 years. It is therefore highly desirable that children do not have access to vending machines containing tobacco products. The simplest means of achieving this would be to make it unlawful to sell cigarettes through such machines. Age verification systems, whether by token, ID card or other means, are inherently insecure; ID can be borrowed, or proof of age not requested. Since the consultation reports that shops account for 78% of tobacco sales to 11 to 15 year old smokers it would appear that existing legal requirements for age verification are routinely ignored.

- Banning the sale of tobacco products from vending machines would make it harder for children to purchase cigarettes. Many countries already prohibit the sale of tobacco from vending machines (or have never allowed it) and a total ban on tobacco sales from vending machines has been recommended by the World Health Organization.

10. Do you believe that plain packaging of tobacco products has merit as an initiative to reduce smoking uptake by young people?

- Yes. FPH strongly supports the introduction of plain packaging for tobacco products. Package design is part of the advertising process, and cigarette packets effectively function as advertisements for different brands. There is extensive evidence to show that tobacco promotions increase the chances of young people beginning to smoke. A major review published in the Official Journal of the American Academy of Paediatrics' in 2006 concluded that *"exposure to tobacco promotions increases the risk for initiation or progression toward regular tobacco use".*[xx] The tobacco industry will be vehemently opposed to this proposal, indicating that it is a vital strand in recruiting and maintaining their target audience. Industry analysts also believe that plain packaging would have a significant negative impact on cigarette sales.[xxi] A review by Freeman, Chapman and Rimmer[xxii] suggests that from what is already known (mainly Canadian research), plain packaging would be likely to depress the incidence of smoking uptake by non-smoking teenagers, and increase the incidence of smoking cessation by teenagers.

11. Do you believe that increasing the minimum size of cigarette packs has merit as an initiative to reduce smoking uptake by young people?

- We support banning the sale of packs of less than 20 cigarettes. Packets of 10 cigarettes are more easily affordable for young people. Making such packs illegal could help to reduce the number of young people purchasing cigarettes. In Northern Ireland, the Public

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[xix] Buck D, Godfrey C, Raw M, Sutton M. 1995. *Tobacco and Jobs. The impact of reducing consumption on employment in the UK.* York: Centre for Health Economics, University of York.
[xx] DiFranza JR, Wellman RJ, Sargent JD, Weitzman M, Hipple BJ, 2006. Tobacco Consortium, Center for Child Health Research of the American Academy of Pediatrics. Tobacco promotion and the initiation of tobacco use: assessing the evidence for causality. *Pediatrics.* 117:e1237-48.
[xxi] Material new risk appears: UK government suggests plain packaging. Citigroup, 2 June 2008.
[xxii] Freeman B, Chapman S, Rimmer M. The case for the plain packaging of tobacco products. *Addiction.* 2008;103:580-90.

Health (Tobacco) (Amendment) Act 2004 has already made it illegal to sell packets of cigarettes of less than 20. We encourage the government to investigate the impact of this initiative in Northern Ireland or evaluate it here if effectiveness is still unclear.

12. Do you believe that more should be done by the government to reduce exposure to secondhand smoke within private dwellings or in vehicles used primarily for private purposes?

- The DH should invest in a sustained, effective, targeted mass media campaign which not only highlights the dangers of second-hand smoke to children but also gives practical advice on how to make homes and vehicles smokefree. FPH have produced, with ASH, information on the damaging health effects of secondhand smoke on children.[xxiii]

- All health professionals should make a commitment to encouraging parents and carers to make their homes and vehicles smokefree to protect children's health, and help parents and carers to give up/reduce their smoking. FPH and ASH have produced an information leaflet for parents / carers and professionals who work with them.[xxiv]

- Consider extending smokefree legislation to cover private cars, as a minimum when children are present.

- Consideration should be given to banning smoking while driving a vehicle on safety grounds (as per mobile telephones). This would be in addition to its inclusion in the highway code.

- Commission research into effective ways of helping parents to stop smoking and to prevent children's exposure to smoke if parents do not stop smoking.

Part C: supporting smokers to quit

13. What do you believe the government's priorities for research into smoking should be?

- Research should be undertaken on how to 'industrialise' brief interventions as studies show that if all health professionals offered a brief intervention to smokers the impact would be greater than raising the price of cigarettes or any other tobacco control activity.[xxv, xxvi]

- Exploration of how many health professionals believe that undertaking smoking cessation advice compromises their relationship with their patients/clients.

- Research to ascertain the extent of use of smuggled, counterfeit, and personally imported tobacco by young people and people living in disadvantaged communities.

- Further research is also needed in
  - relapse prevention, given that 80% of smokers who quit restart after 4 weeks;
  - alternative methods of stopping smoking such as cognitive behavioural therapy;
  - why more young women than men start smoking;
  - the social, societal and psychological behaviours that trigger initiation, maintenance and the decision to quit;
  - the barriers that hard to reach 'high risk' groups face when attempting to quit;

[xxiii] *Children and secondhand smoke* is available to download from: www.fph.org.uk
[xxiv] *Children and Secondhand Smoke: Information leaflet for parents and carers*, produced by FPH and ASH, is available from: www.fph.org.uk.
[xxv] Russell MAH, Wilson C, Taylor C, Baker CD. Effect of general practitioners' advice against smoking. *BMJ* 1979; 2: 231-235.
[xxvi] Eddy D. *David Eddy ranks the tests.* Harvard Health Letter, 1992; 17:10-11.

- understanding and overcoming the barriers to using medicinal nicotine or other pharmacotherapies;
- improving the identification, referral and retention in treatment of pregnant smokers;

- studies to examine the impact of interventions and policies on different social groups;
- the use of tobacco amongst ethnic minority groups;
- studies to examine the efficacy of different prevention approaches including mass media interventions on young people;
- studies to assess the impact of pack size on sales to young people.

14. What can be done to provide more effective services NHS Stop Smoking Services for:

- ***smokers who try to quite but do not access NHS support;***
- ***routine and manual workers, young people and pregnant women – all groups that required tailored quitting support in appropriate settings?***

- 'Stop Smoking' services are very cost effective and combined with the use of pharmacotherapies can increase a smoker's chances of quitting four-fold compared to using willpower alone. However, take up by smokers wanting to quit is still low with only 3% to 6% of smokers making use of the services per year. If attendance was raised to 10% of smokers, it is estimated that the population long-term quit rate could be increased by 0.5%.[xxvii] Therefore, there is huge scope for improving the services and making them more attractive to people seeking help in stopping smoking.

- Government should increase financial support for NHS 'Stop Smoking' services, making them more widely available and easy to access particularly for disadvantaged and pregnant smokers.

- The cost of purchasing stop smoking aids can be a barrier to use, as can the limited availability of these products. Although some versions of nicotine replacement therapy are now on general sale, availability is still largely limited to pharmacies and supermarkets. However, tobacco products are widely available from many outlets such as corner shops, garage forecourts, supermarkets, pubs and vending machines in licensed premises. To help smokers who want to quit without NHS support, stop smoking aids should be accessible in all the places where tobacco products are currently sold.

- A health equity audit could be required to ensure stop smoking services are likely to decrease rather than increase inequalities.

- Free nicotine replacement therapy and other stop smoking medications should be provided for all smokers who are trying to stop smoking through the NHS. This will increase cessation rates, ensuring smokers are less likely to stop using the products prematurely, and will save the NHS money in the longer term by reducing the number of smokers who require treatment for smoking-related disease.

- We would like to see innovative ways for smokers to stop on their own with an incentive attached for data to be passed on to local stop smoking services.

- Brief interventions by all frontline staff need to be 'industrialised' with the development of resources and a systems approach to empower health professionals to provide preventive interventions to the following high risk groups:

  - Routine & manual workers
  - Other disadvantaged groups (eg unemployed and those on benefits)
  - Young people and children

[xxvii] West R. *The Smokers Toolkit Study.* www.smokinginengland.info

    - Pregnant women

- Increased referral rates from primary and secondary care to the stop smoking services.

- Pregnant women and those undergoing operations, including oral surgery, should have to opt out of smoking cessation support rather than opt in. Referral to stop smoking services needs to be immediate.

- Data on maintenance of quitting should be collected at say 12 weeks, 26 and 52 weeks as quitters are particularly vulnerable to relapse during the first 2-3 months of cessation, rather than relying solely on the current indicator of success, 'four week quits'

15. How can communication and referral be improved between nationally provided quit support (such as the website and helplines) and local services?

- Identify ways in which communications between national support and local services can be made more immediate (eg. email referral).

- Develop a national 'choose and book system' that allows direct booking of an appointment with a local smoking cessation team. This can then integrate text or telephone support.

- Development of self-help resources eg. interactive CD/DVD, online, text or telephone services.

- Ensure that ALL NHS staff are aware of the referral procedure to local smoking cessation services.

16. How else can the government support smoking cessation among high prevalence, hard-to-reach groups?

- More funding should be spent on sustained social marketing campaigns on how and why smokers should stop, aimed at key target groups. Greater awareness is needed on the positive benefits of cessation, not just on the harm from smoking. These campaigns should include promoting local NHS stop smoking services in ways which make them appealing, attractive and affordable to the target audience.

- More emphasis should be put on the 'psychology' of identified 'high risk' groups, and on the reasons why they smoke. This should then inform the development of targeted approaches. Many Stop Smoking campaigns focus on the health risks of smoking but these issues do not influence all groups or individuals to give up smoking.

- Ensure that (future) interventions and government strategies are developed and informed by the views of the specific target group (such as heavily addicted smokers, young people) to better understand the reasons why they smoke, the barriers they face to stopping smoking, and what support they feel the need to stop smoking, and stay stopped.

- Ensure (future) interventions are rigorously evaluated and add to an evidence base to enable the sharing of best practice nationally.

- Services should be aware of and be orientated to overcome the many barriers faced by tobacco users.

- All appropriately trained health professionals with prescribing powers should be able to prescribe or dispense nicotine replacement therapies (NRT) eg. dentists; 76% of adult smokers think NRT should be easier to get hold of.

- Services should adopt positive approaches to motivate individuals to stop tobacco use in addition to the several punitive measures outlined in this document eg. reward schemes.

- VAT should be removed from NRT products to encourage their use (in place of smoking) and not disadvantage those on lower incomes.

- Over the counter NRT products should be more widely available eg. wherever tobacco is currently sold.

- All health professionals should be trained to offer opportunistic stop smoking advice and referral to the stop smoking services, particularly to disadvantaged smokers who are likely to be in most need of help and ongoing support.

- Smoking cessation should be included as part of the clinical training for all healthcare professionals.

- There should be more outreach with services being set up in places where people are likely to see and use them, such as in workplaces, shopping centres, pubs and schools.

- Better use could be made of existing social networks, including faith groups, to reduce smoking prevalence.

- The NHS smoking quitline should appear on all tobacco packaging.

Part D: Helping those who cannot quit

17. Do you support a harm reduction approach and, if so, can you suggest how it should be developed and implemented?

- FPH supports the development of a comprehensive harm reduction strategy.

- Government should take a lead in encouraging the development and promotion of pure nicotine products (which like the current medicinal products on the market only contain nicotine and not any other tobacco products) as an alternative to smoking. This should include educational campaigns to raise awareness of the relative safety of nicotine, as currently a significant proportion of smokers and health professionals believe that nicotine can cause smoking-related diseases such as cancer. [xxviii] Such an approach will be particularly attractive to more deprived smokers who tend to be more heavily addicted to nicotine and so find it harder to quit, thereby helping to reduce health inequalities.

- It should be clear that smoking cessation is the safest (and cheapest) option but for those unable to quit that nicotine replacement is safer than continuing to smoke.

- We recommend that the Government should set up a Nicotine Regulatory Authority, as outlined above.

[xxviii] Siahpush M, McNeill A, Hammond D, and Fong GT. 2006. Socioeconomic and country variations in knowledge of health risks of tobacco smoking and toxic constituents of smoke: results from the 2002 International Tobacco Control (ITC) Four Country Survey. *Tobacco Control*. 15: iii65 - iii70.