

SMOKEFREE WILTSHIRE CONSULTATION RESPONSE Sept. 4, 2008

Part A: Reducing smoking rates and health inequalities caused by smoking.

Question 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?

Adult smoking prevalence is falling 0.4% per annum in the UK; a conservative estimate of prevalence in 2015 would therefore be 18%. However the drop may well increase markedly now that the smokefree law is in place, other policies on the horizon and social norms around smoking changing. Looking at other countries we can see prevalence drops over 10 years of: 4.1% in California (1997-2006, www.tobaccofreeca.com/ca_success.html); 10% in Canada (1996-2005, www.hc-sc.gc.ca/hl-vs/tobac-tabac/research-recherche/stat/ctums-esutc_prevalence/chart_image_2005-eng.php) and 11.3% in Norway (www.ssb.no/royk_en/main.html).

We think that England could aspire to at least emulate the success of Canada – that is **we could aim for a general adult prevalence of 12% by 2015**. Longer term targets would be dependant on achieving the 12%; we therefore think that 2020 and 2030 targets would need to be extrapolated from progress observed over the next few years. Processes for accurate tracking of smoking prevalence at PCT level need to be put into place. Because all PCTs are involved it would be sensible if these processes were developed at national level for local implementation.

Prevalence of smoking in routine & manual workers is currently 7% higher than in the general population. We think this gap should be reduced through changes in social norms and specific targeting (social marketing). We think a gap of 5% is possible by 2015 – a prevalence of **17% in routine & manual workers by 2015**.

In 2007, 6% of 11-15 year old pupils said they smoked regularly (at least once a week). This is down from 9% in 2006, and at the lowest level ever measured by the survey (www.ic.nhs.uk/webfiles/publications/sdd07/SDD%20Summary%2007%20%2808%29-Standard.pdf). This large drop may be a statistical anomaly and it would be unwise to expect such large drops to be replicated. A reasonable target for **2015 prevalence (11-15 year old) might be 3-4%**.

During pregnancy, 17% of women smoked throughout their term in 2005. Among teenage pregnancies this figure rose to 45% (Infant Feeding Survey 2005). We should aim for a decrease in this prevalence at least equal to the drop mentioned for adults (10%) – **smoking throughout pregnancy - prevalence of 7% or less by 2015**.

Moreover, what else should the government and public services do to deliver these rates?

The government should continue with and probably increase its social marketing based targeting of groups with higher levels of smoking. Financial support of NHS stop smoking services, tobacco alliances and regional tobacco control offices should be increased to reflect new prevalence targets put into place. Funding should be consistent to ensure that services can be sustained year on year.

The government should also continuously reinforce the knowledge that secondhand smoke is dangerous – especially in homes with children and in cars. **We think the provisions of the 2007 smokefree law should be extended to include cars with children [Q 12]**.

Take up of smoking by young people should be targeted strongly by implementing suggestions detailed in other sections of this consultation response (viz. removal of point of display advertising, cigarette paper advertising and introduction of plain packaging).

A new national campaign should target smoking in pregnancy.

Question 2

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

The health inequalities link to smoking is complex as pointed out in the consultation document (sect.2.11 to 2.22). The cumulative effect on smokers of different elements such as: *environment, tobacco supply, addiction, poverty, psychological makeup, life-goals, self-efficacy, meaning of smoking, social norms* and *personal relationships* is not fully understood but some of these elements are controllable and targeting them in appropriate ways may reduce health inequalities:

- **Tobacco supply:** it is known that increasing price reduces tobacco usage - a 10% rise in price leads to a 4% decline in consumption (World Bank, 1999). Price increases should therefore continue, but this is a double-edged sword - poorer smokers may get poorer or be swayed into buying cheaper smuggled tobacco. A Feb 2008 YouGov poll commissioned by ASH found that 1 in 5 poorer smokers buy smuggled tobacco compared to only 1 in 20 of the most affluent smokers. More concerted action is needed to stop smuggling [see Qs 4 & 5].
- **Environment:** smokefree homes campaigns and legally enforced smokefree cars with children.
- **Addiction:** as pointed out in sect. 2.15 of the consultation document more disadvantaged smokers tend to be more heavily addicted. Improved stop smoking support and improved usage of NRT products (including for harm reduction purposes) is needed [See Qs 13-17].
- **Social norms:** Social marketing targeted astutely could reduce health inequalities by targeting more disadvantaged smokers with meaningful and motivating smokefree messages.

Question 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?

It should continue as it is evident it has been successful. Success could be enhanced by doing more along the existing six strands. The social marketing segmentation approach to guide appropriate messaging is imperative to alter social norms, increase take-up of the NHS stop smoking services and reduce exposure to secondhand smoke even further.

In the current climate of green global concerns we see media messages focusing on the tobacco industry and the ecological detriments of tobacco production as a potential profitable route to modify public perception of tobacco in general. We think this is especially relevant for reducing youth take-up of smoking, where changing the focus from smoking and smokers towards the tobacco industry (as in the Florida Truth Campaign) may prove fruitful.

Other strands: further reduce tobacco promotion; more regulation of tobacco products; further reduce the availability and supply of tobacco products to young people [see also Qs 6-12].

Question 4

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

The Borders Agency must work closely with HMRC and the Treasury to prioritise and implement an improved anti-smuggling strategy. The Government should also help formulate and sign up to EU and international anti-smuggling agreements.

At local level in Wiltshire there exists already a degree of co-operation between enforcement agencies but it is often ad hoc, on an informal basis and such co-operation will vary from one area to another. Information is often not shared between the parties for fear of transgressing the Data Protection Act etc. Such co-operation needs to be set out on a more formal basis with all parties

able to share information freely with one another, e.g. data on smuggling could assist health services and local authorities in targeting approaches to high risk communities.

Question 5

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

The Government needs to invest in educational campaigns to advise smokers of the wider risks – again using social marketing segmentation approaches to tailor messages in order to make them meaningful and motivating to different smoking communities. One of the messages could well be the potential health risks - e.g. counterfeit cigarettes may have greater heavy metal and dioxin content (but guarding against implying that duty paid cigarettes are safe by comparison). We should also be aiming for a situation in which people feel it is acceptable to report illegal tobacco suppliers. This would need publicity to ensure the general public know how to report illegal tobacco supplies (and what kind of tobacco is illegal).

Part B: Protecting children and young people from smoking.

Question 6

What more do you think the Government could do to:

- a. reduce demand for tobacco products among young people?***
- b. reduce the availability of tobacco products to young people?***

- a) 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 [see Qs 7-11]. In schools, programs to de-normalise smoking and to turn young people against the tobacco industry (as in Florida Truth campaign) should be developed and made available nationally, backed up with mass media social marketing support messages.
- b) Test tobacco purchases in Wiltshire (Feb 2008) by 15 and 16 year old secret shoppers found that 16% of premises in North and West Wiltshire sold to the underage customers; 32% of vendors sold in Kennet and Salisbury Districts (total number of premises visited: 65). Penalties should be increased for such illegal sales to under-18s and the Court's should be advised of the need to impose severe penalties. The law should also allow for prohibition of sales of tobacco products where repeated offences are proven. We welcome support for enforcement by additional funding this year but it needs to continue on a year by year basis and not be just a one-off initiative.

Question 7

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

Yes, all advertising for roll-up tobacco products and other tobacco accessories should be prohibited as they can act as prompts and reminders to smoke. This is especially important for cigarette paper advertising which can currently be used at tobacco points of sale with no restriction or health warning. In recent years there has been a rise in the proportion of smokers using hand-rolled tobacco: from 12% in 1996 to 22% in 2006 (Smoking-related Behaviour and Attitudes, 2006. Office for National Statistics, 2007). Imperial Tobacco has used the Rizla brand to sponsor motor racing, thereby maintaining a link between sport and smoking, despite UK and European law which has outlawed tobacco sponsorship of sport (Good, G. Presentation at UBS Tobacco conference. 1 December 2006). Rizla also produces clothing and other goods and sponsors music festivals, all of which are designed to appeal to young people.

Question 8

Do you believe that there should be further controls on the display of tobacco products in retail environments? If so, what is your preferred option?

[We are particularly interested in hearing from small retailers and in receiving information on the potential cost impact of further restrictions on display. What impact would further controls on the display of tobacco have on your business and what might the cost be of implementing such changes?]

We support **Option 2**: Regulate point of sale display more strictly by further restricting permitted advertising space and/or restricting display space or ways in which tobacco products are displayed.

The tobacco industry has spent large amounts of money on point of sale displays. Imperial Tobacco have stated that because of advertising restrictions, cigarette packs and their display in retail outlets are now a major marketing tool and that new additions to brand families have increased their share of the market (Imperial Tobacco, UBS Tobacco Conference, 01 December 2006, London). As noted in paragraph 3.21 of the consultation document, a report from LACORS in 2006 found a high level of compliance with existing point of sale regulations, but there is a growing tendency to use counter-top devices such as counter mats to complement increasingly large and designed displays of cigarette packs.

There is strong evidence to show that tobacco advertising and promotion encourages children to smoke (see e.g. Forever cool: the influence of smoking imagery on young people, BMA July 2008; Big Tobacco's Guinea Pigs: how an unregulated industry experiments on America's kids and consumers, www.tobaccofreekids.org). Point of sale displays were made unlawful in Iceland in 2001. The proportion of 16 and 17 year olds who reported that they had ever smoked fell to 46% by 2003 (from 56% in 1999). (<http://www.espad.org/sa/node.asp?node=730>).

We recognise the need for tobacco products to be stored securely and the use of a kiosk is one way of achieving this. To require retailers to remove tobacco products from display completely as in option three would be ideal but would cause considerable operational difficulties for larger supermarkets who stock a wide range and large quantity of cigarettes. Our preferred option is therefore option two - a total restriction on all advertising at the point of sale. If plain packaging is introduced [Q 10], option 2 becomes more equivalent to option 3.

Question 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?

We support **Option 3**: A total ban on the sale of tobacco products from vending machines.

We recognise that although vending machines only account for a small proportion of overall cigarette sales, a disproportionate number of young people under the legal minimum age for the sale of tobacco obtain cigarettes from this source. Fig. 10 in the consultation document shows that 17% of 11-15 year old smokers in 2006 reported that vending machines were their usual source of cigarettes.

In Wiltshire there appear to be fewer vending machines in operation these days, usually in public houses or in hotels where it is difficult to control their use. Whilst there may be ways to limit access to a vending machine these tend to be dependant upon a physical action by a member of staff. This places the onus on that member of staff to make checks on the age of the intending purchaser, something that may not happen at busy times (and vending machines are often out of sight of staff e.g. on stairwells). Trading standards checks on underage sales reveal that the majority of sales are due to inattention by staff or poor training. We have little confidence that the limiting devices on vending machines always have the desired effect and so we would prefer option 3 to prohibit the use of vending machines altogether.

Question 10

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

Yes. Efforts by the tobacco industry to design products, packaging and associated imagery to attract young people is well documented (see e.g. Forever cool: the influence of smoking imagery on young people, BMA July 2008; Big Tobacco's Guinea Pigs: how an unregulated industry experiments on America's kids and consumers, www.tobaccofreekids.org). Industry analysts believe that plain packaging would have a significant negative impact on cigarette sales (Material new risk appears: UK government suggests plain packaging. Citigroup, 2 June 2008).

Plain packaging may reduce the effect of certain brands being purchased as a status symbol. In Wiltshire we have noticed teenagers using certain brands almost as 'bling' and plain packs could help to eradicate this.

Plain packs would also allow the existing statutory warnings and graphic images coming in October to stand out even more. On an ecological point, a change to plain packaging may reduce the carbon footprint of tobacco manufacturers.

Question 11

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

Yes. Increasing the minimum size of a pack of cigarettes may help to take cigarettes out of the price range that younger children can afford which could prevent youngsters from taking up smoking at an early age. However it is unlikely to deter a 16 year old who is working and earning enough to buy a pack of twenty.

Limiting the minimum size of packs may cause problems for the vending machine industry who have traditionally sold packs in machines containing only 17 or 18 cigarettes. This would be obviated however if we prohibit vending machines [Q 9].

We would like to suggest limiting the number of cigarettes that can be purchased at any one time, similar to the requirements in place for retail sales of certain drugs. The purchase of 200 cigarettes at a supermarket is not uncommon. This currently means that smoking households can have a ready supply of cigarettes and a pack could be given to a younger member of the family or indeed stolen (or sold/given to other youngsters). Limiting sales would contribute towards limiting access to cigarettes by young people in the home. Having limited stocks at home could also help adults cut down on smoking if they know they have to make a journey to purchase more.

We also think the Government should prohibit 'special offers' on the price of cigarettes. The manufacturers use money-off packs as introductory offers. Young people tempted by smoking are likely to purchase the cheapest pack and the prohibition of special offers may help to deter them.

Question 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? If so, what do you think could be done? Where possible, please provide reference to any relevant information or evidence to accompany your response.

Yes, we support the recommendations of the Faculty of Public Health and ASH (Children & Secondhand Smoke: A position statement – Faculty of Public Health and ASH 2008 http://www.fph.org.uk/resources/AtoZ/ps`secondhand_smoke.pdf):

- Run further mass media campaigns targeted at parents/carers about the health effects of secondhand smoke, particularly in enclosed places such as the home and motor vehicles.

- 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. (This links to the harm reduction approach outlined in question 17.)
- Ensure that the stop smoking services and tobacco alliances are adequately funded and continue to target disadvantaged smokers and other groups such as parents.
- Consider extending the smokefree regulations to cover private cars*.

* We think that smoking in cars with children should definitely be prohibited by law.

We estimate that in Wiltshire there may be over 20,000 homes where children are being exposed to secondhand smoke. Furthermore, it is likely that 84% of these households have cars which are probably also a source of secondhand smoke exposure to children. The latter would be adequately dealt with by a smokefree car law. Smoking in the home is being targeted by most PCTs through smokefree homes initiatives; the Government can support these schemes through continuing media campaigns on the dangers of secondhand smoke in homes and cars.

Part C: Supporting smokers to quit

Question 13

What do you believe the Government's priorities for research into smoking should be?

- Research how best to modify the *meaning* of smoking within community groups with high prevalence of smoking
- Research into how best to help pregnant smokers stop
- Research into how to best help strongly *psychologically* addicted smokers
- Explore efficient harm reduction techniques for those smokers unable to stop
- Determine the most effective approaches to influence young people's smoking behaviour

Question 14

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

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

Research should be conducted to examine the effectiveness and cost-effectiveness of strategies to increase the uptake of the smoking cessation services. Computer based training in brief intervention for all frontline health staff should be made mandatory. Smoking cessation should be included in the Standards for Better Health set by the Healthcare Commission.

Smokers referred for hospital operations should be routinely advised to stop at least 6 weeks before the operation. Ideally there should be routine monitoring of the smoking status of patients entering hospitals, brief intervention advice to all smokers, easy access to stop smoking medicines and a seamless referral to stop smoking services. Smoking rates of people leaving hospital should also be monitored.

In areas such as pregnancy the services should work closely with acute trusts to deliver a flawless pathway of consultation and monitoring beginning with women thinking of conceiving through to delivery and motherhood. Women who do stop smoking during pregnancy should be followed up in order to try and reduce the high numbers who return to smoking after the baby is born.

It should be a priority to identify local areas with high prevalence of smoking and to introduce social marketing campaigns targeted at these social groups. Stop smoking support should be very flexible; clinic times and appointments should be available at weekends and evenings. Telephone consultations, emails and text messages should also be considered for busy individuals who cannot commit to clinic times.

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 NRT are now on general sale, availability is still largely limited to pharmacies and supermarkets. Meanwhile tobacco products are widely available from many outlets such as corner shops, garage forecourts, supermarkets, pubs, vending machines in licensed premises, and specialist tobacconists. In order 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. There is widespread public support for such as policy. According to a YouGov poll, 76% of adult smokers in England said they supported making NRT easier to access. Many smokers complain of the high cost of NRT products (equivalent to perhaps smoking 20 a day) – the Government should consider subsidising the cost of NRT to make it more affordable (certainly less than the cost of smoking).

In areas with prisons (Wiltshire being one), smoking interventions within the prison population (including staff) is important because of the high prevalence of smoking among the prison community. A higher than average lower socio-economic group representation and high incidence of mental health problems make these interventions challenging. The South West Public Health Group has already done a lot of work in this area including discussions with Prison / PCT partnership boards to boost support for stop smoking/smokefree policies and interventions.

For supporting young people to stop, PCT stop smoking services should seek the views and ideas of young people when planning smoking prevention or intervention strategies for that particular age group.

Question 15

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

Clients consent should be sought on first contact to allow details not only to be passed to the local stop smoking service so the interest in quitting can be followed up quickly and details entered on data base for future consultations. The essence in maintaining motivation is often timing so if an individual has the desire to quit the information needs to be transferred quickly to the relevant service.

Details of clients wishing to access the service could be emailed immediately to each PCT within minutes of the request.

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Question 16

How else can we support smoking cessation, particularly among high-prevalence or hard-to-reach groups?

Research into best practice [see Q 13].

Train more community workers (statutory and non-statutory) in brief opportunistic stop smoking interventions.

Fund stop smoking drop-in clinics in community areas of higher smoking prevalence. Increase advertising of the NHS smoking quitline in these community areas.

Part D: Helping those who cannot quit.

Question 17

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

Yes. However we do not support 'lower harm cigarettes' or 'smokeless tobacco' (e.g. snus).

We do support the introduction of new products containing medicinal grade nicotine for use by smokers who can't quit. We do not support the view that such an approach promulgates nicotine addiction. Nicotine addiction is a fact of life for many people across the world. A harm reduction approach using safe nicotine can be likened to methadone treatment for heroin addiction – an approach which is not viewed as condoning heroin use. Successful substitution of smoking by a safer source of nicotine could lead to a reduction in health inequalities.

Importantly, such nicotine products would need to be developed and promoted in ways that make them *attractive* substitutes for smoking – particularly to the more deprived / addicted smoker.

We think that the pharmaceutical industry may not be best placed to produce attractive safe nicotine products for *younger* smokers. Research underlying the Florida Truth Campaign uncovered certain attitudes among young people to the effect that messages from 'the establishment' (or any controlling 'power') were not well received. For that reason 'Truth' posters for example were not displayed in medical establishments. The pharmaceutical industry may well be viewed as part of the medical establishment by younger people and any safe nicotine product treated with suspicion.

Paradoxically, the tobacco industry itself may be best placed to produce such products. Regulations on any such product produced by a tobacco company would need to be very strict in order to avoid the possibility that the product itself became a gateway to smoking for young people. In our view if the tobacco industry was making sufficient profit from safe nicotine products there would be no incentive for them to push cigarettes on to clients using safe nicotine. Whether the tobacco industry would want to go down this 'safe nicotine' route is another matter. If they did there would need to be adequate access to their data on product make-up, marketing strategies, usage / sales etc.

Increasing the number of smokefree homes and cars [Q 12] would constitute a harm reduction approach for children re. secondhand smoke.

We support the removal of misleading tar, nicotine and carbon monoxide test results from packs. We support switching to a statement along the lines of: "In smoking this material you will inhale the following health affecting chemicals -" [*list of major damaging chemicals*]

We support the introduction of fire-safer cigarettes.

The following response could not have been put together without the input of many individuals; local contributors included:

Mary-Ann McKibben (consultant in public health)
Mike Jones (health promotion specialist)
Maggie Thornton (stop smoking service lead) and her team
Andrew Tilley (principal trading standards officer)

My personal thanks to everyone who helped produce this document.

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