Supplement to the Strategic Directions For Tobacco Control in NSW 2011-2016 Discussion Paper

Evidence and Achievements

NSW GOVERNMENT | Health

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PART A

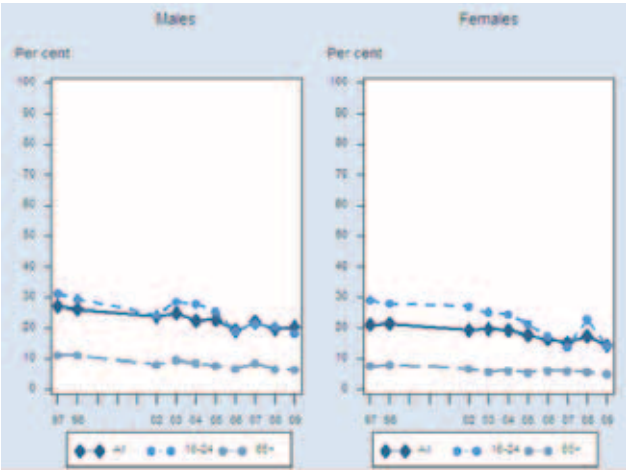
Smoking Prevalence, Quitting Trends and Smoke-free Settings

Smoking Prevalence

Results from the 2009 NSW Population Health Survey [1] showed that:

- The prevalence of current smoking (daily or occasional) among adults was 17.2 per cent.
- More males were current smokers than females (20.3 per cent compared to 14.2 per cent).
- Since 2008, there has been a significant increase in current smoking among males aged 45-54 years and a significant decrease in current smoking among females aged 16-24 years.
- Since 1997, there has been a significant decrease in the proportion of adults who were current smokers (24.0 per cent to 17.2 per cent).

Figure 1: Current smoking by age, persons aged 16 years and over, NSW, 1997-2009



Source: New South Wales Population Health Survey 2009 (HOIST).
Centre for Epidemiology and Research, NSW Department of Health.

Smoking is more prevalent among the disadvantaged groups in our society. Current smoking is higher among adults in the fifth or most disadvantaged quintile (21.6 per cent) compared to those in the least disadvantaged quintile (11.2 per cent) [2] and this disparity has widened over the past decade. Smoking among other disadvantaged groups such as people in correctional facilities, those with mental illness and drug and alcohol problems is also higher than the general population.

Smoking prevalence among Aboriginal people in NSW in 2002-05 was estimated to be 44.7 per cent for Aboriginal males and 41.8 per cent for Aboriginal females aged 16 years and over [3]. Recent results from the Australian Bureau of Statistics 2008 National Aboriginal and Torres Strait Islander Social Survey found that between 2002 and 2008, the proportion of Aboriginal and Torres Strait Islander current daily smokers aged 15 years and over nationally fell from 49% to 45%. This represents the first significant decline in national smoking rates since 1994.

While these results are encouraging, there is much more that needs to be done, as Aboriginal people remain twice as likely as non-Aboriginal people to be current daily smokers. In 2007, over half (51.8 per cent), of Aboriginal pregnant women smoked compared to 14.8 per cent in the general population [4].

Current smoking by secondary school students was 8.6 per cent in 2008 [5].

Quitting Trends

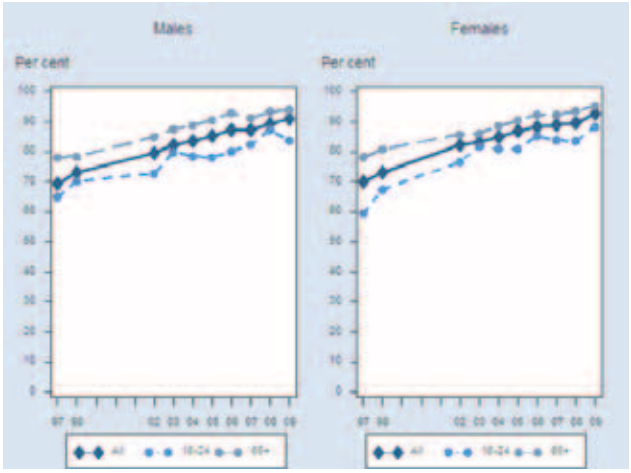
In 2008, 61.8 per cent of adults who were current smokers intended to quit smoking in the next 6 months [6]. There was no significant difference between males and females. There was no significant difference among quintiles of disadvantage, or between rural and urban health areas, or among health areas. These data confirm the results of other surveys with smokers showing that the vast majority want to quit smoking.

Since 2002, there has been a significant increase in the proportion of adults who were current smokers who intend to quit smoking in the next 6 months (50.7 per cent to 61.8 per cent in 2008) [7].

Figure 2: Intend to quit smoking by year, adults aged 16 years and over who are current smokers, NSW, 1998-2008

Source: New South Wales Population Health Survey 2008 (HOIST).
Centre for Epidemiology and Research, NSW Department of Health

Figure 3: Live in smoke-free households by age, adults aged 16 years and over, NSW, 1997-2009



Source: New South Wales Population Health Survey 2009 (HOIST).
Centre for Epidemiology and Research, NSW Department of Health

Smoke-free Households

In 2009, just over 9 in 10 adults (91.9 per cent) lived in smoke-free homes [8]. A significantly higher proportion of adults in the first or least disadvantaged quintile (94.6 per cent), and a significantly lower proportion of adults in the fifth or most disadvantaged quintile (88.4 per cent), lived in smoke-free homes in 2009, compared with the overall adult population [9].

Since 1997, there has been a significant increase in the proportion of adults who lived in smoke-free homes (69.7 per cent to 91.9 per cent in 2009). The increase has been significant in all age groups, in all quintiles of disadvantage, and in urban and rural health areas [10].

PART B

Policy Context

International Policy Context

Framework Convention on Tobacco Control

The World Health Organization's Framework Convention on Tobacco Control (FCTC) is an international treaty (legal instrument) to address the health, social, environmental and economic consequences of tobacco consumption throughout the world. The FCTC is the first global health treaty entered into force on 27 February 2005 making the provisions of the treaty legally binding for the first 40 contracting parties to the convention. Australia ratified the FCTC on 27 October 2004.

The FCTC aims to enhance international efforts to protect present and future generations from the preventable devastating consequences of tobacco use. The treaty commits nations to implement policies on tobacco price and tax increases, banning or restricting tobacco advertising and sponsorship, labelling with more prominent health warnings, reducing exposure to second-hand smoke, smoking cessation treatments and illicit trade. Australia has played a leading role in the development and implementation of the FCTC. As a signatory to the WHO Framework Convention on Tobacco Control (FCTC), Australia is required to submit a five year report to the WHO FCTC.

National Policy Context

National Tobacco Strategy 2004-09

The National Tobacco Strategy was endorsed by the Ministerial Council on Drug Strategy in March 2005. The goal of this strategy is to 'significantly improve health and reduce the social costs caused by, and the inequity exacerbated by, tobacco in all its forms'. The Strategy has eight areas for action including regulation of tobacco, promotion of quit and smoke-free messages, cessation services and treatment, community support and education, addressing social, economic and cultural determinants of health, tailoring initiatives for disadvantaged groups, research evaluation and monitoring and surveillance and workforce development.

The development of the next National Tobacco Strategy is expected to be finalised in 2010.

National Partnership Agreement on Preventive Health

In December 2008, the NSW Premier agreed to the National Partnership Agreement on Preventive Health (Agreement). The Agreement between the Federal Government, states and territories focuses on mechanisms to address the rising prevalence of lifestyle related chronic diseases. This Agreement sets an overall target for daily smoking of no more than 10 per cent of adults by 2020. The Agreement also sets interim targets with significant reward payments provided to states and territories which meet these performance indicators. The interim targets specify the following performance indicators:

- Reduction in state baseline for proportion of adults smoking daily commensurate with a two percentage point reduction in smoking from 2007 national baseline by 2011; and
- 3.5 percentage point reduction from 2007 national baseline by 2013.

National Preventative Health Strategy

The National Preventative Health Strategy, prepared by the National Preventative Health Taskforce, follows on from the discussion paper *Australia: the healthiest country by 2020* and was released in September 2009 by the Federal Health Minister. The Strategy outlines an approach to addressing the burden of chronic disease caused by obesity, tobacco and excessive consumption of alcohol.

The Strategy adopts the targets from the National Preventative Health Partnership Agreement, setting a target of no more than 10 per cent of adults smoking by 2020.

The Strategy sets out 11 key actions for achieving the targets, to be implemented by the Federal Government, states, territories, non-government organisations and other groups. The Preventative Health Strategy is accompanied by a comprehensive literature review completed in 2009,

outlining the evidence base for these recommendations. The discussion paper for the NSW Tobacco Strategy 2011-2016 draws on both the literature review and the strategy recommendations.

In May 2010, the Federal Government released its formal response to the National Preventative Health Strategy. The Federal Government announced that it would adopt many of the recommendations made by the National Preventative Health Taskforce in relation to tobacco, including increasing the cost of cigarettes; introducing mandatory plain packaging for cigarettes; and increased funding for social marketing to reinforce the benefits of quitting for those who smoke, and to discourage non-smokers from taking it up. Other initiatives are aimed at particular sub-population groups among whom smoking rates remain high, such as Indigenous communities, in line with Taskforce recommendations.

National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes

In December 2007, the Council of Federal Governments (COAG) agreed to close the gap on Indigenous disadvantage, including closing the life expectancy gap within a generation. This commitment recognises the extent and urgency of the levels of health and social disadvantage faced by Aboriginal people. The Federal Government is contributing $805.5 million to COAG's $1.6 billion investment over four years to support the National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes. Approximately $161 million of this money will be used to tackle the key risk factors for chronic disease, including smoking.

In NSW, the Government has committed to spend $180.38 million over four years to 2012/13 in five key priority areas including: tackling smoking; healthy transition to adulthood; making Indigenous health everyone's business; primary health care services that can deliver; and fixing the gaps and improving the patient journey through the health system. The NSW Department of Health will administer $4.14 million over four years to support the Tackling Smoking initiative of the National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes. This funding will be used for the development, implementation and evaluation of two specific projects, including smoking cessation support for pregnant Aboriginal women and support for the Aboriginal Health and Medical Research Council to work with their member organisations to expand and roll out existing tobacco control efforts across NSW.

NSW Policy Context

The NSW State Plan

The NSW State Plan: *Investing in a Better Future* sets priorities for government action, reflecting community views for the future of NSW. Of specific relevance is the priority, under Healthy Communities, to improve health in the community. The Plan sets the following target for smoking:

Continue to reduce smoking rates by 1 per cent per year from 2006 to 2010, then by 0.5 per cent per annum to 2016.

The NSW Cancer Plan

The NSW Cancer Plan 2007-2010 prepared by the Cancer Institute NSW, built on the achievements of the first Cancer Plan. It provided a comprehensive approach to the prevention, detection and control of cancer in NSW. The Plan focused on the five priorities most likely to improve cancer results with priority 1 focusing on *Preventing Cancer.*

The Plan acknowledges that the most successful cancer prevention programs are the tobacco control programs. Around 30 per cent of cancer deaths in men and 13 per cent in women are due to tobacco smoking. The NSW Cancer Plan set a target to reduce tobacco smoking by 1 per cent per year. The Cancer Institute NSW's tobacco control program is primarily focused on the design, development and delivery of social marketing campaigns. The Cancer Institute NSW is responsible for the funding, policy and management of the NSW Quitline service and undertakes population based research on tobacco, evaluation and monitoring of tobacco programs and provision of tobacco policy advice.

NSW Tobacco Action Plan 2005-09

The NSW Tobacco Action Plan 2005-09 set a target of 1 per cent reduction per annum in adult smoking prevalence between 2005 and 2009. The Plan included the following priority areas:

- Smoking cessation
- Environmental tobacco smoke
- Marketing and the promotion of tobacco products
- Availability and supply of tobacco products
- Capacity building
- Research, monitoring and evaluation

The Tobacco Action Plan was a comprehensive and detailed document providing information on the evidence base, context for tobacco control, actions to be implemented and the evaluation framework.

PART C

Achievements of the Tobacco Action Plan 2005-09

Achievements of the NSW Tobacco Action Plan 2005-09 included the following (by priority areas):

Smoking Cessation

- Less than one in five adults are current smokers in 2009 (17.2 per cent) a fall of more than 5 percentage points since 2003.
- Current smoking by secondary school students fell by 6 percentage points since 2002 to 8.6 per cent in 2008.
- The number of secondary school students who smoked in the last 7 days fell by 6 percentage points since 2002 to 7.3 per cent in 2008.
- The proportion of smokers who have never tried to quit decreased from 24 percent in 2005 to 18 per cent in 2009.
- Tobacco campaigns are keeping quitting "top of mind" for smokers with more smokers intending to quit. A 2009 survey by Cancer Institute NSW showed that 2 in 5 smokers reported having thought about quitting at least once a day over the past two weeks, and almost three quarters had thought about quitting at least once in the last fortnight.

Environmental Tobacco Smoke

- From July 2007, all enclosed public places in NSW pubs, clubs, nightclubs and the casino became smoke-free (with the exception of the private gaming area in the casino).
- From July 2009, smoking in a car with a child under the age of 16 years present became an offence.
- 9 out of 10 adults (91.9 per cent) now live in smoke-free homes - an increase of almost 8 percentage points from 2004.
- Local councils are increasingly implementing smoke-free outdoor spaces, particularly where children spend significant amounts of time such as playgrounds and beaches.
- In 2009 the Guidance for Implementing Smoke-free Mental Health Facilities in NSW was released.
- Landmark court decision in 2009 further clarified the *Smoke-free Environment Act 2000*, enhancing compliance by NSW clubs and pubs.

Marketing and Promotion of tobacco products

- From 1 January 2010 the display of tobacco was prohibited with small retailers needing to comply by 1 July 2010.
- In 2007 amendments to the *Public Health Act 1991* banned the sale of sweet, fruit and confectionary cigarettes and mobile sales of tobacco often used to target youth focused events.
- Tobacco and smoking products are now prohibited as part of shopper loyalty schemes.

Availability and supply of tobacco products

- In 2009 a tobacco retailer notification scheme was introduced and penalties for selling tobacco to minors were significantly increased.
- In July 2009 it became an offence to sell tobacco from more than one point in a retail outlet.
- In 2007 it became an offence to sell tobacco from mobile or temporary premises, including music festivals popular with young people.

Capacity Building

- 81 training workshops in brief interventions for smoking cessation were held across NSW as part of the SmokeCheck Project which commenced in 2007. Around 44 per cent of the total Aboriginal Health Worker workforce in NSW has received training under this program.
- Policies, guidelines and training programs were developed and implemented across NSW Health to improve the management of nicotine dependent inpatients and enhance brief interventions for smoking cessation.
- The NSW Tobacco Control Network (TobNet) provides a mechanism for development and enhancement of partnerships and advocacy in NSW. Annual TobNet meetings provide opportunities to members to enhance professional skills in tobacco control through training and development.

Research, monitoring and evaluation

- The Social Costs of Tobacco Project was commenced in 2009 to estimate updated social costs resulting from tobacco use within NSW.

PART D

Priority Areas Evidence and Progress to Date

Priority Area 1: Continue social marketing campaigns to motivate smokers to quit

Evidence

The promotion of *Quit and Smoke-free* messages to adult smokers is a central component of tobacco control strategies across Australia [11]. The importance of social marketing campaigns within a comprehensive tobacco control framework has also been recognised through the World Health Organization's Framework Convention on Tobacco Control.

Both the National Tobacco Strategy 2004–2009 and the National Preventative Health Strategy have noted that to 'discourage initiation to smoking and to promote quitting, as well as smoking around children, requires sustained and commercially realistic funding for campaigns. This is necessary to keep quitting on people's agenda to reach people as they cycle in and out of 'readiness to quit' at many times each year and to reach people at times in their life when they are receptive to messages about smoking, and times when they are more likely than usual to be responsive to encouragement to change [12].

In 2008, the National Cancer Institute released their monograph on *The Role of the Media in Promoting and Reducing Tobacco Use* providing the most up to date and comprehensive summary of the scientific literature on media communications in tobacco control. This expert report concluded that *"mass media campaigns are effective in reducing smoking and have an even greater impact when conducted as part of a comprehensive tobacco control program"* [13]. The review found that adult-targeted social marketing campaigns can encourage adult cessation as well as change young people's attitudes about tobacco use and curb smoking initiation. The review also recognised the effectiveness of campaigns that arouse strong negative emotions and recommended that these types of campaigns should form a key component of tobacco control programs [14].

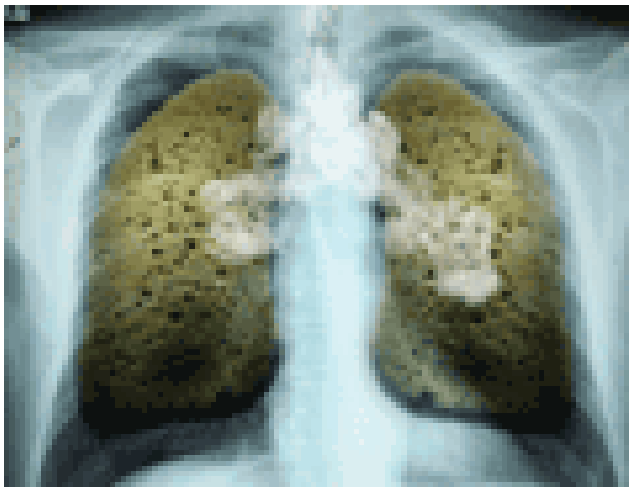
To be effective, social marketing campaigns must be underpinned by behavioural research and funded at levels that ensure adequate reach and impact across the target group. The National Preventative Health Strategy also remarked on the need for campaigns to be bold and take some risks in order to challenge the strongly held opinions and self exempting beliefs of smokers [15].

Progress to date

The Cancer Institute NSW has lead responsibility for the design, delivery and evaluation of anti-tobacco social marketing campaigns in NSW. Since 2004, over 40 anti-tobacco campaigns have been implemented using a variety of styles of advertisements, from graphic to emotive executions, to maximise personal relevance and believability among smokers to motivate quitting. Examples of these high performing campaigns include *What's Worse, Sponge and Everybody Knows*.

What's Worse

Sponge



Everybody Knows

Priority Area 2: Continue to provide evidence based cessation services to support smokers to quit

Evidence

Complementing anti-tobacco social marketing campaign strategies are cessation support services to help smokers to quit. These cessation services include a range of programs such as the NSW Quitline, on line services, specialised cessation services, brief interventions provided by health professionals and workplace programmes.

Surveys of smokers consistently show that most smokers want to quit smoking and the majority regrets ever starting [16]. A survey conducted in 2009 by the Cancer Institute NSW [17] also shows that:

- Two thirds of smokers were considering quitting in the next 6 months.
- Two in five smokers think about quitting at least once a day.
- Most quitters had made multiple attempts to quit.
- Health reasons are the most common motivators for quit attempts.
- The vast majority of smokers who quit manage to quit successfully on their own.

Quitting smoking at any age results in immediate health benefits, irrespective of how long a person has been smoking. Even people who have already developed smoking-related health problems, like heart disease, can still benefit from quitting. For example, compared to continuing smokers, people who quit smoking after having a heart attack reduce their chances of having another heart attack by 50 per cent [18]. If smokers quit before the age of 35, their life expectancy is similar to someone who has never smoked.

Quitline

The Quitline is a confidential telephone based service designed to help smokers quit. Quitline advisors are specialists who have been trained in health, education, psychology and smoking cessation. Quitline provides an assessment of callers' smoking status, level of nicotine dependence, readiness to quit, co-morbidity including relevant medications and confidence in quitting. It provides an individually tailored service suitable for the caller's stage in the quitting process and can provide a callback service

for those callers seeking additional follow up. Quitline services in NSW adhere to a set of national minimum standards for such things as the range of services provided, response times for calls, data collection, and the training and qualifications of counsellors.

Quitline provides an important route of access to support for smokers offering high quality and accessible services for the price of a local landline call. From an equity perspective, there are significant benefits providing equity of access regardless of location and income.

A Cochrane review of the effectiveness of telephone helplines such as Quitline services concluded that proactive telephone counselling does help smokers interested in quitting. The review found evidence of a dose response and that multiple calls were more effective than a single call. Three or more calls increase the chances of quitting compared to a minimal intervention such as providing standard self-help materials, brief advice, or compared to pharmacotherapy alone [19].

A US study examined the real-world effectiveness of the California Smokers' Helpline, a state-wide quitline based on a successful clinical trial [20]. The review found high rates of relapse among smokers at 12 months. However, telephone counselling approximately doubled abstinence rates compared to a control group.

The effectiveness of Quitline service across Australia was comprehensively evaluated as part of the National Tobacco Campaign. The review found that callers rated the Quitline positively and at a 12 month follow up, Quit rates were highest when NRT or other approved pharmacotherapy is combined with more intensive behavioural support, such as the Quitline callback program, group courses or counselling with other trained health professionals [21, 22, 23].

The research suggests that, the more intensive the intervention, the better the outcomes, with long-term quit rates reaching as high as 15 per cent to 20 per cent compared to the 3 per cent to 5 per cent success rates for unassisted quitting [24, 25, 26].

Advice by health professionals

There is a substantial body of evidence that clear advice from a health professional can motivate a smoker to quit, whether the advice comes from a doctor, dentist, nurse or other health professional and whether it occurs in practice rooms, in a community health centre of in a hospital [27, 28, 29].

While spending more time (longer than 10 minutes) advising smokers to quit yields higher abstinence rates than minimal advice, offering brief advice (even as little as three minutes) has been shown to have clear benefits [31, 32, 33].

Because health services, GPs and other primary health care services see a large proportion of smokers each year, even small effects of treatments can contribute to reducing population prevalence. Ensuring that health professionals in all settings routinely ask patients if they smoke and advise them to quit can promote quit attempts by smokers.

Products

The development and introduction of drug therapies has provided important assistance for smokers trying to quit, particularly for more dependent smokers [34, 35].

A report on the effectiveness of pharmacotherapies prepared by the Cancer Institute NSW [36] demonstrated in clinical trials that products such as nicotine replacement therapy (NRT) and other drugs such as varenicline, can increase the chances of a successful quit attempt by two to three times. The report showed that the use of these agents are also cost-effective, with around five life years gained for a smoker quitting up to the age of 40 years. Most cessation drugs will deliver benefits at a cost of less than $30,000 per life year gained for a 40 year old smoker. Such successful quit attempts have large potential savings for the community [37].

It should be noted that price can provide a significant barrier for some low income groups to access these medications. Currently NRT patches are subsidised for aboriginal smokers and veterans but some other highly disadvantaged groups face considerable difficulties in accessing NRT and other products, for example people with mental illness.

Clinical Guidelines produced by the US Agency for Health Care and Quality *:Treating Tobacco Use and Dependence: 2008 Update* [38] and recommended by the US Surgeon General points to the need to offer these products in combination with other forms of support stating the combination of counselling and medication is more effective for smoking cessation than either medication or counselling alone. Therefore, whenever feasible and appropriate, both counselling and medication should be provided to patients trying to quit smoking.

Progress to Date

Awareness of the Quitline among smokers and ex smokers is high. Just over one in ten current smokers had called the Quitline at some stage. While the demand for Quitline services has varied over the past five years around 3,000 to 3,500 calls were made to the Quitline each month in 2009.

The 13QUIT website was developed in May 2007 to provide quit smoking information on the Internet, in line with the contents of the quit kit. It is currently an informational website and provides a limited experience for the user. Despite no promotion of the website address, the website attracts approximately 2,700 visits per month and use of the website increased by an average of 43 per cent per month between 2007 and 2008. This suggests that more people are searching for quit smoking information online. A key advantage of online support is that it is available 24 hours seven days a week.

In 2010 a new Quit website was launched to deliver a comprehensive interactive quit smoking program online to engage more effectively with smokers. The website will:

- Provide information for smokers for smokers and health professionals;
- Provide tailored information for individual smokers (e.g. tracking tools, information relevant to their age or withdrawal symptoms); and
- Draw on the support of a community of quitters to share their stories, inspire and emphasise that they are not alone in their journey to quit.

A survey by the Cancer Institute NSW in 2009 [39] found that smokers and ex smokers showed high levels of confidence in GPs or other health professionals, with two thirds believing their advice would increase one's chance of quitting compared with quitting on your own. However data from the 2008 Population Health Survey suggest that in 2008, only 40.0 per cent of adults who smoked were advised to quit smoking the last time they visited their general practitioner, a decrease from 50.3 per cent in 2007. This decrease was significant among women and men and urban and rural areas. This shift suggests there is a need to enhance brief interventions by GPs, health services and a range of other health professionals.

The survey by the Cancer Institute NSW also suggests that smokers appear to have mixed opinions in relation to Nicotine Replacement Therapy (NRT) and prescribed medications. There were high levels of uncertainty regarding their efficacy. Over two thirds agreed that, if you really want to quit, you'll succeed just as well on your own as with help, yet agreement was lower for the notion that willpower alone is sufficient.

In the Cancer Institute survey, most smokers felt they knew where to get help to quit smoking (89 per cent agreement). When asked to name any particular support services, assistance or methods available to help smokers quit, 59 per cent showed unprompted awareness of Quitline. Compared with a previous survey in 2005, significantly fewer smokers (40 per cent) showed unprompted awareness of NRT, whereas more smokers mentioned GPs/ health professionals or prescription medication (both 16 per cent). 'Cold turkey' remains the most common strategy used on any quit attempt (76 per cent), followed by cutting down the amount smoked (66 per cent), then NRT (44 per cent), and changing to low tar tobacco (36 per cent).

These data suggest there are opportunities to increase smokers self efficacy in quitting and to increase awareness of pharmacotherapies, particularly for highly dependent smokers. Actions to enhance call back services and improve integration of referral networks between Quitline and health services would also be beneficial.

There is also a need to ensure that population-wide approaches are accompanied by more targeted efforts for disadvantaged groups with high rates of smoking. A number of smoking cessation projects currently funded by the Department of Health are relevant, for example: 'Providing 'smoking care' training for staff who work with disadvantaged populations with high smoking rates' focuses on the development and implementation of training for staff from health and community services organisations who routinely work with disadvantaged populations with high smoking rates. Another project 'Building the capacity of community organisations in Blacktown to provide sustainable quit smoking support for disadvantaged populations' will build the capacity of community service organisations in Blacktown to more actively address tobacco smoking and provide quit smoking support for disadvantaged population groups.

Priority Area 3: Work in partnership with Aboriginal communities and peak bodies to reduce smoking and exposure to environmental tobacco smoke among Aboriginal people

Evidence

The level of poor health and disadvantage experienced by Aboriginal people is significant. Aboriginal people experience poorer health, greater levels of chronic disease and injury, and have shorter life expectancies than the general population. In the context of high rates of chronic disease, the contribution of tobacco is significant. The burden of disease and injury study for the Aboriginal and Torres Strait Islander population of Australia published in 2007 shows that the Aboriginal health gap accounted for 59 per cent of the total burden of disease for Aboriginal people in Australia in 2003. Tobacco was the largest risk factor responsible for 17 per cent of the health gap and 12 per cent of the total burden of disease [41].

Generally, more Aboriginal people take up smoking, do so at an earlier age, smoke for longer and make fewer quit attempts than the broader Australian population.[42] Aboriginal children have high exposure to environmental tobacco smoke and over half (51.8 per cent) of pregnant Aboriginal women smoke compared to 14.8 per cent in the general population.[43] While smoking prevalence in the general population in NSW has declined over the past ten years, there has been little change in smoking rates for the Aboriginal population in this period. Smoking rates remain close to 50 per cent (44.7 per cent of Aboriginal men and 41.8 per cent of Aboriginal women in NSW smoked in 2002-05). [44, 45, 46]

Recent results from the Australian Bureau of Statistics' 2008 National Aboriginal and Torres Strait Islander Social Survey found that between 2002 and 2008, the proportion of Aboriginal and Torres Strait Islander current daily smokers aged 15 years and over nationally fell from 49% to 45%. This represents the first significant decline in national smoking rates since 1994. [47] However, while these results are encouraging, there is much more that needs to be done, as Indigenous people remain twice as likely as non-Indigenous people to be current daily smokers.

The drivers of the high rate of smoking among Aboriginal peoples are complex and include both historical and contemporary processes. Evidence suggests that smoking is highly normalised in Aboriginal communities and that strong social factors drive early initiation and act as barriers to smoking cessation among Aboriginal peoples. Smoking is both common and accepted amongst Aboriginal people. Strong social ties combined with the high level of stress and disadvantage faced by many Aboriginal people reinforce smoking. Many Aboriginal people view the onset of smoking related disease as almost inevitable. Smoking is also prevalent among Aboriginal health workers and community leaders. [48, 49]

"When you don't smoke you stand out a bit, you feel a bit odd....Cause everyone around you smokes. Everyone that I know smokes. There is not one person that I know in [town] who doesn't smoke. So like, it is a bit hard." 24 year old Aboriginal smoker [50]

All Australian Governments have committed to 'Closing the Gap' to improve health outcomes for Aboriginal people and reduce the gap in life expectancy. Achieving these targets requires a major focus on decreasing Aboriginal smoking. Over the next four years a major national program will be rolled out to tackle this problem complemented by the state based actions described in this Strategy.

Progress to Date

Capacity Building

There is an urgent need to enhance the skills of Aboriginal health organisations and health workers in smoking cessation and tobacco control more broadly. The NSW SmokeCheck project was developed to train Aboriginal health workers and other relevant health workers in the delivery of evidence-based best practice brief interventions for smoking cessation. Between 2007 and July 2009, 81 workshops had been held across the state involving 718 health professionals. Evaluation of Phase 1 of the Project found significant increases in the level of confidence of Aboriginal health workers talking to clients about smoking and its health effects, advising and offering advice to support clients to quit and assessing client's stage of change for smoking cessation.

As part of the national commitment to Closing the Gap - Indigenous Health National Partnership Agreement, funding will be provided to support the Aboriginal Health and Medical Research Council (AHMRC) to implement a project to build tobacco control capacity amongst Aboriginal Community Controlled Health Services (ACCHS). This project will build on existing projects such as the BREATHE project described below. The AHMRC will work with their member organisations to expand and roll out existing tobacco control efforts across NSW. Key components of the project will include:

- Training and workforce development,
- Development of a state wide social marketing campaign targeting Aboriginal people,
- Monitoring of smoking cessation and tobacco control activities undertaken by ACCHS; and
- The dissemination of models of best practice smoking cessation policy and procedures relevant to ACCHS.

The BREATHE project (Building Research Evidence to address Aboriginal Tobacco Habits Effectively) is also currently being implemented by the AHMRC. This project is a large scale, action orientated, community-based research project that aims to evaluate the impact of funding and supporting specialist tobacco control workers in Aboriginal community controlled health services. It will generate evidence that will inform future programs at the local, state and national level. The project receives support from key partners including the National Heart Foundation, NSW Cancer Council, Sax Institute and NSW Health and is funded by the Australian Respiratory Council. It is expected to report in 2010/11.[51]

Social marketing

The evaluation of the National Tobacco Campaign and more recent qualitative research conducted on behalf of the Cancer Council WA [52] and Cancer Institute NSW [53] has confirmed that mainstream tobacco social marketing campaigns are effective in increasing awareness and understanding of the health effects of smoking among Aboriginal people and that many of these advertisements were considered personally relevant to Aboriginal smokers. However the research also identified a need to place more emphasis on representation of Aboriginal people and relevant themes in campaigns where possible.

The research also suggests that a targeted approach complementing mainstream campaign activity would be effective. Targeted campaigns would allow for the specific development of messages challenging the acceptability of smoking and the inevitability of smoking related diseases for Aboriginal people.

Campaigns that more accurately reflect the life of an Aboriginal smoker, in terms of the high prevalence of smoking, experience of smoking related health effects, effects of environmental tobacco smoke (ETS) exposure and cross-generational smoking behaviour, are likely to be powerful in moving Aboriginal smokers further along the continuum towards quitting. This offers the ability to develop communications that are culturally relevant, which is likely to enhance awareness and recall of the advertising. It is likely that radio presents the best opportunity for the development of these tailored messages providing an effective and complementary medium that can be geographically targeted in particular areas of NSW. [54, 55]

The research and experience in Western Australia and NSW suggests that the optimum way forward involves a "twin track" approach of utilising existing effective tobacco campaigns and adding a complementary Aboriginal specific campaign element, an approach also recommended in the National Preventative Health Strategy.

As previously stated, the Federal Government will provide $27.8 million over four years to fund anti-tobacco social marketing campaigns targeted to groups within the community that have been harder to reach by traditional methods, such as Indigenous Australians. The campaign will comprise a multi-tiered social marketing approach including: targeted media strategy; extending the mainstream campaign; community toolkits; partnerships programs; cross-coordination initiatives; and direct mail campaigns.

Supporting Quitting

As part of the commitment to Closing the Gap, smoking cessation support for pregnant Aboriginal women will be strengthened. NSW Health in partnership with the Aboriginal Maternal and Infant Health Service (AMIHS) will deliver the program 'Quit for new life' which will include the employment of dedicated smoking cessation coordinators, provision of smoking cessation training for health workers who are in contact with pregnant Aboriginal clients, resource development and provision of free nicotine replacement therapy (NRT) for pregnant women where appropriate. Included within this program will be messages about the health risks of exposure to ETS, especially for children and babies.

The experiences and evaluation of existing programs such as the "Stop Smoking in its Tracks" program will inform the development and roll out of future strategies. Stop Smoking in its Tracks, also funded from the National Indigenous Tobacco Control Initiative is trialling a cessation program with pregnant Aboriginal women in collaboration with NSW Health and four rural AMIHS teams across NSW. The program involves the development of resources, training of AMIHS staff, individual support to women and households, provision of free NRT, quitting support groups and rewards for women who successfully quit.

Phase 2 of SmokeCheck will focus on ensuring best practice brief interventions in smoking cessation are delivered as part of routine care to Aboriginal people.

Increasing awareness of NRT, its correct use and uptake among Aboriginal people also provides an opportunity to support quit attempts among Aboriginal people. Since 1 December 2008, Nicotine Replacement Therapy (NRT) has been available to Aboriginal and Torres Strait Islanders through the Pharmaceutical Benefit Scheme (PBS). Individuals are able to obtain 2 courses of NRT (Nicorette,15 mg per 16 hours) of up to 12 weeks duration per year on a prescription provided by their doctor.

Strengthening the evidence base

The current evidence base to guide action in reducing Aboriginal smoking is not well developed, although it will be strengthened by some of the recent national and state initiatives. There is a need to develop the evidence base for future interventions through systematic data collection and rigorous research, evaluation and monitoring. Strategies to disseminate the key findings to policy makers and workers in the field will also be important. Key areas of focus could include the effectiveness of specialist tobacco control workers, the impact of social marketing campaigns, the effectiveness of programs supporting pregnant women to quit, and developing a better understanding of the drivers of the high rates of smoking initiation among Aboriginal children.

Leadership and coordination

There is an urgent need to strengthen leadership and coordination of strategies and programs to reduce Aboriginal smoking in NSW. Partnerships between government and non-government organisations, coordinated planning, additional resources and sustained effort to address Aboriginal smoking can deliver results and reduce Aboriginal smoking rates over time.

Priority Area 4: Strengthen efforts to discourage smoking among people in low socioeconomic and other groups with high smoking prevalence

Evidence

Over the past forty years, smoking prevalence has declined significantly in the general population. However, the decline has been less evident amongst the most disadvantaged. Smoking rates are high among people from low socioeconomic groups, Aboriginal people, those who are unemployed, homeless or imprisoned, and those with a mental illness or other drug or alcohol dependency. For example:

- Smoking rates among people in NSW correctional facilities are around 72 per cent and the prevalence is higher among inmates of psychiatric wards. [56]
- People who self-reported mental or behaviour problems have smoking rates of 32 per cent compared to 20 per cent of those who do not report these problems. [57]
- People in drug treatment have smoking rates ranging from 74-100 per cent. [58]

Current smoking prevalence among the least disadvantaged (Quintile 1) was estimated to be 11.2 per cent compared to 21.6 per cent among the most disadvantaged (Quintile 5).[59] The health disparity between these groups has been widening over the past 10 years.

Studies have also found that some culturally and linguistically diverse groups in the community have a higher prevalence of smoking. In 2002-2005, 21.6 per cent of NSW adults were current smokers. However, a significantly higher proportion of people born in Lebanon (35.3 per cent) were current smokers.[60]

The health and financial costs of smoking for these groups is enormous and many of these groups face significant barriers to quitting smoking.[61] The poorest smoking households in NSW spend nearly 20 per cent of their income on tobacco exacerbating existing financial hardship and also suffer the greatest health burden associated with smoking. [62] It is estimated that smoking may contribute a third of the excess mortality that arises from socioeconomic disadvantage.[63]

Despite these factors, research consistently shows that very disadvantaged smokers are motivated to stop smoking. For example, studies have shown nearly 75 per cent of prisoners want to quit, between 50 per cent and 80 per cent of people in drug treatment are motivated to stop [64] smoking and 48 per cent of people with a mental illness are worried about their smoking and want to stop.smoking can also be seen as a social justice issue – because tobacco ultimately undermines wellbeing and personal autonomy. [65]

Within this priority area, disadvantaged populations include people from low socioeconomic groups, people with mental illness, people with drug and alcohol dependency, people in correctional facilities, and other population groups with high smoking prevalence such as some culturally and linguistically diverse groups. Aboriginal people are covered under priority area 3 and are not included in this section.

It should be noted that there is crossover between these groups with significant numbers of people having both drug and alcohol and mental health problems and an overrepresentation of people with mental illness and drug and alcohol problems in prison.

Working in these settings is complex and poses many challenges for tobacco control.

Mental health facilities, drug and alcohol treatment facilities and prisons pose some unique issues in that they are workplaces for some and for others, a place of residence, perhaps against their will. Physical health in general, and smoking in particular, are not their central role and there may be historical and cultural factors related to smoking which pose challenges. Nevertheless, these are important settings from which a comprehensive approach can radiate. NSW Cancer Institute "Literature Review: Smoking and mental illness, other drug and alcohol addictions and prisons"

People from low socioeconomic groups

One of the most effective strategies to address smoking by low socioeconomic and other disadvantaged groups is to increase the price of tobacco. There is substantial evidence that increasing the price of tobacco is a key strategy for reducing consumption. Price is particularly effective at reducing smoking by children and disadvantaged groups as they are more price sensitive. Analysis of smoking prevalence in several Australian states has found that the price of cigarettes had the most powerful impact of all the policies studied and that the effect of price was greatest among those on the lowest incomes. [66]

On 29 April 2010, the Federal Government announced an increase in the tobacco excise of 25 per in a bid to reduce smoking rates to below 10% by 2018. According to the Federal Government, the move will increase the price of a pack of 30 cigarettes by around $2.16 and is expected to cut total tobacco consumption by around six per cent and the number of smokers by two to three per cent, representing around 87,000 Australians.

It is important to ensure that tobacco tax increases are accompanied by measures to provide assistance for smokers from socially disadvantaged groups. Introducing tax increases in a staged process will maximise quitting opportunities and give remaining smokers time to reduce the amount they smoke and adjust their expenditure. [67]

Research also shows that while most quit attempts are motivated by health concerns, cost of cigarettes is a factor in prompting quit attempts among low socioeconomic smokers. Analysis of price increases resulting from increases in tobacco tax in Australia and overseas showed reductions in smoking were greater among low socioeconomic groups compared to higher socioeconomic groups. [68]

People with mental health and drug and alcohol problems

People living with mental illness have significantly higher rates of smoking than the general population. Adults who report having high/very high levels of psychological distress were more likely to be current daily smokers than those who reported a moderate or low level of distress. As noted previously, those undergoing treatment for drug and alcohol problems also have high smoking rates and there is evidence to suggest that alcohol-dependent people are more likely to die of tobacco related disease than they are of alcohol-related disease. [69]

A literature review undertaken by the Cancer Institute NSW [70] reported that "hospitalisation for mental illness can impact on smoking prevalence and may lead non-smokers to become smokers, reflecting the established norms and the considerable role played by historical and cultural practices related to smoking within psychiatric inpatient facilities, as well as the impact of hospitalisation on an individual's usual routines."

Correctional facilities

Addressing smoking in the custodial setting is a complex issue requiring a comprehensive response across both the custodial setting and the community to achieve a reduction in exposure to ETS and reduced smoking rates among prisoners.

A literature review conducted by the Cancer Institute in 2008 reported that 78 per cent of men and 83 per cent of women in NSW prisons smoked in 2001. Almost all (95 per cent) smoked hand-rolled cigarettes with men smoking an average of 50g of pouch tobacco a week. Imprisonment itself influences smoking behaviour; 47 per cent of women and 41 per cent of men said they smoked more in prison than in the community while 26 per cent of women and 30 per cent of men said they smoked less and 4 per cent of female smokers and 8 per cent of male smokers said they had not smoked in the 12 months before entering prison. Of non smokers, 30 per cent were sharing a cell with a smoker. [71]

Surveys in 1991 of 225 prison staff and 135 prisoners from a medium security setting in Western Australia revealed the following attitudes: [72]

- 77 per cent favoured separate zones for smokers and non-smokers at work.
- 79 per cent said they found tobacco smoke annoying at work.
- 47 per cent said they suffered ill-effects from environmental tobacco smoke.
- More than half said they would like to give up smoking, would try if a quit program was offered and would smoke less if workplace bans existed.
- Non-smokers favoured more restrictive policies than smokers, and employees favoured more restrictive policies than prisoners.

Progress to date

People from low socioeconomic groups

Continuing to advocate for incremental tobacco tax increases by the Federal Government is a key strategy to address smoking by low socioeconomic and other disadvantaged groups. The NSW Government submission to the National Preventative Health Taskforce discussion paper *"Australia: the Healthiest Country by 2020"* supported tobacco pricing and taxation issues as part of a comprehensive approach to reducing smoking. The submission argued that the introduction of price increases must not be made over a long period of time, but over a short period of time of two to five years in incremental steps to manage the expected increase in cessation support needs of different price-sensitive populations.

A second key strategy is implementing anti-tobacco social marketing campaigns. Over the coming years the Cancer Institute NSW will continue to refine campaign strategies to reach and impact on low socioeconomic smokers and other disadvantaged groups.

The NSW Government will also be working in partnership with non-government organisations, including social service organisations, to address smoking in these groups. For example the NSW Department of Health will be providing funding to the Cancer Council NSW for the implementation of two projects over the next two years as part of the Tackling Tobacco Program. The first project focuses on the development and implementation of training for staff from health and community services organisations who routinely work with disadvantaged populations with high smoking rates. The second project will build the capacity of community service organisations in Blacktown to more actively address tobacco smoking and provide quit smoking support for disadvantaged population groups. Sydney West Area Health Service will provide assistance and support the implementation of the project in Blacktown.

People with mental health and drug and alcohol problems

In 2009, the NSW Department of Health developed new guidelines to facilitate the implementation of the 'NSW Health Smoke Free Workplace Policy' in public hospital and residential mental health care facilities. The Guidelines draw on the current evidence base around implementing smoke-free policies for mental health care facilities and promotes the active engagement of consumers, their families and carers and all staff of mental health care facilities and services in the implementation process. Area Health Services will be required to report on progress in implementing the NSW Health Smoke Free Workplace Policy, including progress in implementing the policy in mental health services.

However most people with mental illness live in the community and are managed by community based mental health services and general practitioners with the support of specialised psychiatric services. While myths and misconceptions abound in relation to smoking and mental illness, evidence shows that interventions that assist people in the general population to quit including strategies to

manage nicotine withdrawal are also effective for people with mental illness.

It is important that health professionals encourage and support people with mental illness and drug and alcohol problems to quit smoking. Treatment for nicotine dependence should be part of routine care for all people in contact with health services. Providing access to information and a range of cessation support options such as the Quitline, on line services, pharmacotherapies and support from GPs and other health professionals are important strategies to reduce smoking in this group.

Correctional facilities

In NSW in 2000, a survey of staff and inmates in prisons did not support a total ban on smoking by staff and inmates, suggesting that further restricting smoking could increase tension between staff and inmates although further restricting smoking would be acceptable if help (counselling and pharmacotherapy) were offered to those who wanted to quit.

There is a need for health agencies to continue to work collaboratively with Corrective Services NSW to develop and implement policies to reduce exposure of staff and inmates to ETS and encourage quitting. Justice Health has played an important leadership role in establishing tobacco control programs within this setting and their role will be critical to future policy development and capacity building approaches within this setting. It will be important to ensure that both staff and inmates are aware of the risks of smoking and exposure to ETS and appropriate cessation support is provided for inmates in both the custodial setting and post release from prison. [74]

There is a need to build the evidence base in this area, particularly in relation to effective policies and interventions.

Priority Area 5: Eliminate the advertising and promotion of tobacco products and restrict the availability and supply of tobacco, especially to children

Evidence

The Framework Convention on Tobacco Control defines tobacco advertising and promotion as 'any form of commercial communication, recommendation or action with the aim, effect or likely effect of promoting a tobacco product or tobacco use either directly or indirectly' and requires that each country shall 'undertake a comprehensive ban on all tobacco advertising, promotion and sponsorship'. Australia as a signatory to the FCTC is bound by this agreement.

The 2000 US Surgeon General's report on Reducing Tobacco Use highlights the influential nature of industry advertising and promotion:

- Despite the overwhelming evidence of the adverse health effects from tobacco use, efforts to prevent the onset or continuance of tobacco use face the pervasive challenge of promotional activity by the tobacco industry.
- The tobacco industry uses a variety of marketing tools and strategies to influence consumer preference, thereby increasing market share and attracting new consumers.
- Advertising increases consumption of tobacco products by encouraging children or young adults to experiment with tobacco products and initiate regular use, reducing current smokers' motivation to quit and prompting former smokers to resume smoking.
- Among all US manufacturers, the tobacco industry is one of the most intense in marketing its products.
- Children and teenagers constitute the majority of all new smokers, and the industry's advertising and promotion campaigns often have special appeal to these young people.
- One tobacco company, the Liggett Group, Inc., admitted that the entire tobacco industry conspired to market cigarettes to children.
- Tobacco documents obtained in litigation indicate that tobacco companies purposefully marketed to children for many years. [75, 76]

Over the past twenty years, NSW has progressively

introduced measures to restrict tobacco advertising in retail outlets and public places and prevent the sale of tobacco to children. As sponsorship, point of sale advertising and other marketing approaches have been restricted and progressively phased out, the visual presence of the cigarette packet in the retail outlet became a major focus for tobacco marketing activities. While the advertising of tobacco was significantly restricted by legislation, these displays of tobacco products remained a highly visible tobacco advertisement featured in many supermarkets, service stations, convenience stores, newsagents and other retail outlets.

A survey by the Cancer Institute NSW in 2009 demonstrated that smokers, as a group, were the most likely to always notice cigarette displays at cash registers (39 per cent). Ex-smokers (rather than non-smokers) were most likely to report never noticing the display, and the authors suggest this may the result of 'wilful inattention'. Almost one in four smokers reported sometimes, often or always buying cigarettes on impulse when they were shopping for something else, which is likely to be an underestimate of this effect. Younger smokers (18–39 years) were more likely than older smokers to notice the displays and, where noticed, to buy cigarettes on impulse.

In response to research that suggested that tobacco displays can influence children's perceptions about the availability and accessibility of cigarettes in their community, while also making it harder for smokers to quit the NSW Government introduced legislative reforms in 2009 to prohibit the display of tobacco products in retail outlets. [77, 78]

NSW has developed a comprehensive program to restrict sale of tobacco to children under the age of 18 years. Strategies to restrict the availability of supply to children have included heavy penalties for retailers caught selling to minors, stringent proof of age requirements, publicity of successful prosecutions, restrictions on vending machines and a comprehensive compliance monitoring program involving test purchases by young people.

Progress to date

In 2008 the NSW Government introduced a comprehensive package of legislative reforms designed to protect children from tobacco and prevent uptake of smoking by young people. These reforms followed a comprehensive public consultation process involving over 12,000 submissions and a consultation forum held at Parliament House. *The Public Health (Tobacco) Bill 2008* was passed by Parliament in November 2008 and *the Public Health (Tobacco) Act 2008* came into effect from 1July 2009.

These reforms have positioned NSW at the forefront of tobacco control legislative efforts in Australia and virtually eliminated tobacco advertising at point of sale. Internationally, the English, Welsh and Scottish Governments are in the process of introducing similar bans.

The key elements of the reforms introduced in the *Public Health (Tobacco) Act 2008* and *Public Health (Tobacco) Regulation 2009* include:

- A ban on displaying tobacco and smoking products from 1 January 2010 with smaller retailers needing to comply by 1 July 2010;
- A single point of sale for tobacco products;
- Restrictions on the number and location of tobacco vending machines in licensed premises;
- A ban on smoking in cars when children under the age of 16 years are present;
- Significantly increased penalties for selling tobacco to minors;
- Introduction of a notification scheme for tobacco retailers to support improved compliance monitoring and enforcement of the legislation; and
- A prohibition on tobacco and smoking products in shopper loyalty programs.

The NSW Government has a strong commitment to enforcing tobacco legislation and will continue to allocate substantial resources to the monitoring and enforcement of these measures.

It should also be noted that the Federal Government has significant responsibilities in this area. These include

- the regulation of tobacco products through trade practices legislation;
- the prohibition of sponsorship and advertising of tobacco products; and
- the regulation of tobacco packaging, including cigarette contents and graphic health warnings on cigarette packs.

On 29 April 2010, the Federal Government announced its intention to introduce legislation requiring all cigarettes to be sold in plain packaging by 1 July 2012 and will provide $2.6 million over four years from 2010-11 to implement

plain packaging for tobacco products. This will remove one of the last remaining frontiers for cigarette advertising, and was a key recommendation of the National Preventative Health Taskforce. Tobacco companies will only be allowed to print their brand and product name in a standard colour, position, font, size and style on the packet and will be required to remove all coloured logos and brand imagery from 2012. These changes are designed to reduce the attractiveness and appeal of tobacco products to consumers and increase the prominence of health warnings.

The Federal Government has also committed to enacting legislation to restrict Australian internet advertising of tobacco products through amendments to the *Tobacco Advertising Prohibition Act 1992*, bringing the internet into line with restrictions already in place in other media.

To enhance efforts to ban the display of tobacco products in retail outlets in this state, NSW supports the elimination of the promotion of tobacco products through design of packaging and supports amendments to Commonwealth legislation to close other loopholes permitting tobacco advertising.

Priority Area 6: Reduce exposure to environmental tobacco smoke in workplaces, public places and other settings

Evidence

Evidence regarding the dangers associated with environmental tobacco smoke (ETS) began to emerge in the 1970s and 1980s. It is now well-established that there is no safe level of exposure to ETS and that it causes a range of serious health problems including coronary heart disease and lung cancer in non-smoking adults. [79] Children are particularly susceptible to health damage caused by ETS due to their immature immune systems and their smaller airways, suffering a range of health problems including, increased risk of asthma and increased risk of sudden infant death syndrome.[80]

The US Surgeon General released a landmark report on ETS in 2006, *The Health Consequences of Involuntary Exposure to Tobacco Smoke: A Report of the Surgeon General*, concluding that: [81]

1. Second hand smoke exposure causes disease and premature death in children and adults who do not smoke.

2. Children exposed to second hand smoke are at an increased risk for sudden infant death syndrome (SIDS), acute respiratory infections, ear problems, and more severe asthma. Smoking by parents causes respiratory symptoms and slows lung growth in their children.

    - Children who are exposed to second hand smoke are inhaling many of the same cancer-causing substances and poisons as smokers. Because their bodies are developing, infants and young children are especially vulnerable to the poisons in second hand smoke.

3. Exposure of adults to second hand smoke has immediate adverse effects on the cardiovascular system and causes coronary heart disease and lung cancer.
    - Concentrations of many cancer-causing and toxic chemicals are higher in second hand smoke than in the smoke inhaled by smokers.
    - Breathing second hand smoke for even a short time can have immediate adverse effects on the cardiovascular system and interferes with the normal functioning of the heart, blood, and vascular systems in ways that increase the risk of a heart attack.
    - Non smokers who are exposed to second hand smoke at home or at work increase their risk of developing heart disease by 25 - 30 percent.
    - Non smokers who are exposed to second hand smoke at home or at work increase their risk of developing lung cancer by 20 - 30 percent.
4. The scientific evidence indicates that there is no risk-free level of exposure to second hand smoke.
    - Short exposures to second hand smoke can cause blood platelets to become stickier, damage the lining of blood vessels, decrease coronary flow velocity reserves, and reduce heart rate variability, potentially increasing the risk of a heart attack.
    - Second hand smoke contains many chemicals that can quickly irritate and damage the lining of the airways. Even brief exposure can result in upper airway changes in healthy persons and can lead to more frequent and more asthma attacks in children who already have asthma.

5. Eliminating smoking in indoor spaces fully protects non smokers from exposure to second hand smoke. Separating smokers from non smokers, cleaning the air, and ventilating buildings cannot eliminate exposures of non smokers to second hand smoke.
    - Conventional air cleaning systems can remove large particles, but not the smaller particles or the gases found in second hand smoke.

Exposure to ETS is an Occupational Health and Safety issue, negatively impacting of the health of workers as well as a public health issue. This factor has driven the establishment of smoke-free workplaces across Australia. By the mid 1990s, smoke-free policies had been introduced extensively across most public and private sector workplaces. In response to increasing health concerns and strong public support, the *Smoke-free Environment Act 2000* was enacted in NSW requiring smoke-free restaurants and other enclosed public places such as shopping centres. On 2 July 2007, amendments to the Act ensured that all enclosed public places in NSW pubs, clubs, nightclubs and the casino (with the exception of the private gaming area) also became smoke-free.

Smoke-free environments are effective in reducing non-smokers exposure to ETS. They are also beneficial for smokers by supporting their efforts to quit and reducing consumption of cigarettes because they have fewer opportunities to smoke. A 1999 study of Australian smoke-free workplaces legislation found that a smoking ban was responsible for an annual reduction in consumption of some 602 million cigarettes.[83, 84]

Progress to date

NSW Health has a strong commitment to enforcing smoke-free legislation and this will remain a priority over the next five years.

Substantial progress has also been made in ensuring the community is aware of the dangers of exposure to ETS. In 2009 nine out of ten adults (91.9 percent) live in smoke-free homes - an increase of 22 percentage points since 1997 (69.7 per cent). [85] However, exposure to ETS is also linked to social disadvantage, with Aboriginal children and children in low socioeconomic groups having greater exposure to ETS than the general population (refer to Figure 4 below). Legislative reforms introduced in 2008 have provided additional protection for children, prohibiting smoking in a car when child under the age of 16 years is present.

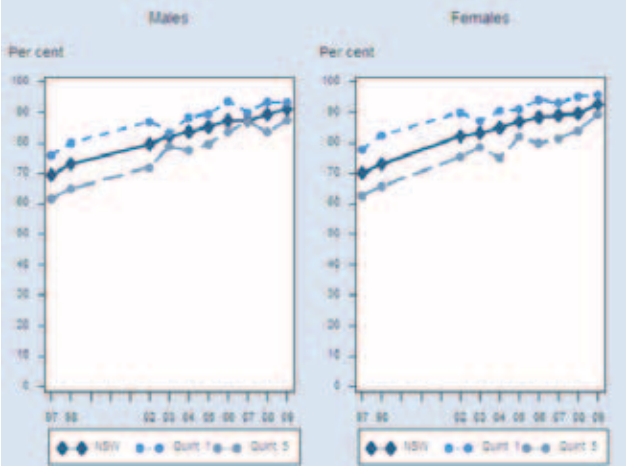
There is good community support for smoke-free legislation in NSW. The 2008 NSW Population Health Survey asked respondents about their expected frequency of visiting hotel and licensed premises and also outdoor dining areas if there was a total ban on smoking at these venues. In 2008, 39.5% of adults reported that they would be more likely to frequent hotels and licensed premises if there was a total ban on smoking, and 4.3% would be less likely to frequent hotels and licensed premises if there was a total ban on smoking. In 2008, 40.6% of adults reported that they would be more likely to frequent outdoor dining areas if there was a total ban on smoking, and 5.4% would be less likely to frequent outdoor dining areas if there was a total ban on smoking. The *Cancer Institute NSW's 2007 Smoking and Health Survey* found an even higher level of community support for pubs and clubs going smoke-free, with 88% of respondents to the survey agreeing that this would make them more pleasant to attend.

Across NSW, a number of local councils have also acted to introduce by-laws under the *Local Government Act 1993* to create smoke-free playgrounds and outdoor spaces, particularly those where children spend considerable amounts of time. A 2010 survey of local governments in NSW by the Heart Foundation found that as of 31 July 2010, 50% of all NSW councils had implemented some form of smoke-free outdoor area policy. Of the 76 councils with a smoke-free policy, 75 (99%) covered children's playgrounds, making this the most common smoke-free area. The second most common category was sports fields with 61 councils (80%) having smoke-free policy in this area. 35 councils (46%) had introduced a policy at pools and 32 councils (42%) have made areas within a certain distance of council buildings smoke-free. 22 councils had a policy covering alfresco dining areas, representing a 144% increase on 2009. [86]

Building on these population-wide reforms, other more targeted approaches to reduce exposure to ETS have been developed. These include the development and continued implementation of the Smoke Free Workplace Policy for NSW Health facilities and the development of new guidelines to facilitate the implementation of this policy in public hospital and residential mental health care facilities and drug and alcohol facilities (including step-down units) utilised by mental health consumers. A number of Area Health Services have already moved to implement phase 4 of the Smoke Free Workplace Policy, where smoking is prohibited in all health care facilities, campuses and vehicles under the control of NSW Health. Over the coming years,

all Area Health Services will be required to report on progress in implementing the NSW Health Smoke Free Workplace Policy, including progress in implementing the Guidelines to facilitate the implementation of the Smoke Free Workplace Policy in mental health care facilities.

Figure 4 Live in smoke-free households by socioeconomic disadvantage, adults aged 16 years and over, NSW, 1997-2009



Source: New South Wales Population Health Survey 2009 (HOIST). Centre for Epidemiology and Research, NSW Department of Health.

Priority Area 7: Strengthen efforts to prevent uptake of smoking by young people

Evidence

The teenage years are the most common time for taking up smoking, with 80 per cent of current smokers saying they began before the age of 20 years. [87,88] The earlier a person takes up smoking, the harder it is to quit. Already by the age of 20, more than 80 per cent of smokers wish they had never started, having underestimated the addictive power of nicotine.[89] The younger a person is when they start to smoke, the less likely it is that they will ever cease.[90, 91]

A range of socio-demographic, environmental, behavioural and personal indicators predict the likelihood of adopting or rejecting smoking, particularly in early adolescence. Detailed literature reviews have been published in the US Surgeon General's Reports of 1994 and Tobacco in Australia: Facts and Issues 2009.

As in all aspects of tobacco control, reviews of the literature indicate that effective youth smoking prevention requires a comprehensive approach sustained over time. A range of evidence based, coordinated and complementary strategies act synergistically and reinforce each other, thereby increasing overall effectiveness. Sustained and integrated effort is required – short-term and one-off or limited focus interventions targeting young people are unlikely to have lasting results. [92]

Critical to efforts are population health measures to denormalise smoking and social marketing campaigns to encourage adult smokers to quit. One of the most significant predictors of the likelihood of young people smoking is whether their parents smoke. Young people, whose parents smoke, are significantly more likely to experiment with smoking than those whose parents do not smoke. Other research shows that children of non smokers are also more likely to remain non smokers in the long term.

A recent article examining the denormalisation of smoking in Australia by Chapman and Freeman notes that that smoking by Australian teenagers has also fallen to unprecedented levels. They argue that this fall has occurred in the absence of any significant mass reach anti-smoking program targeted at youth, suggesting that the movement away from smoking by youth has been stimulated by factors far wider than specific "youth" oriented interventions. The authors note that "increasingly from the early 1980s onwards, mass reach health campaign advertising in Australia has influenced public perceptions of smoking by showing graphic images of blackened lungs, amputated limbs and regretful smokers surrounded by grieving families... Today, it is rare to find a magazine item or television program dealing with health improvement that does not condemn smoking." The authors argue that this relentless tide of bad news about smoking has contributed to the denormalising of smoking. [93]

Others argue that advocacy addressing portrayal of smoking in movies, bans on advertising and bans on smoking in enclosed public places may also have a substantial effect on adolescent smoking behaviour influencing young people's perceptions of both the social acceptability and the frequency of smoking.[94]

The review by the National Cancer Institute in 2008 on the role of media in promoting and reducing tobacco use confirmed NSW research that shows that adult-targeted

social marketing campaigns can change young people's attitudes about tobacco use and curb smoking initiation as well as promote quitting among adult smokers. [95] This is consistent with research undertaken by the Cancer Institute NSW. Continuing to encourage parents to quit is one of the most important things we can do to create a generation of non smokers in NSW. Therefore NSW will continue to build on the success of campaign efforts so far, continuing to develop, implement and evaluate anti-tobacco social marketing campaigns to encourage and motivate adult smokers to quit.

Flay and others suggest there are three interconnected steams influencing youth uptake of smoking: [96, 97, 98, 99]

- **Biology and personality (intrinsic factors),** these include individual demographic, physiological and psychological factors. These influences lead to self-efficacy, which may be broadly defined as individual's sense of self, social competence, and self-determination.
- **Social context (extrinsic factors),** relating to the influence of family and friends through their behaviour and attitudes, resulting in the development of a perception of what is normative behaviour.
- **Broader environment,** taking in cultural contexts, the information environment, and legislative and policy issues that affect pricing and availability of tobacco. The broader environment influences knowledge, expectancies, values and evaluations, leading to attitudes.

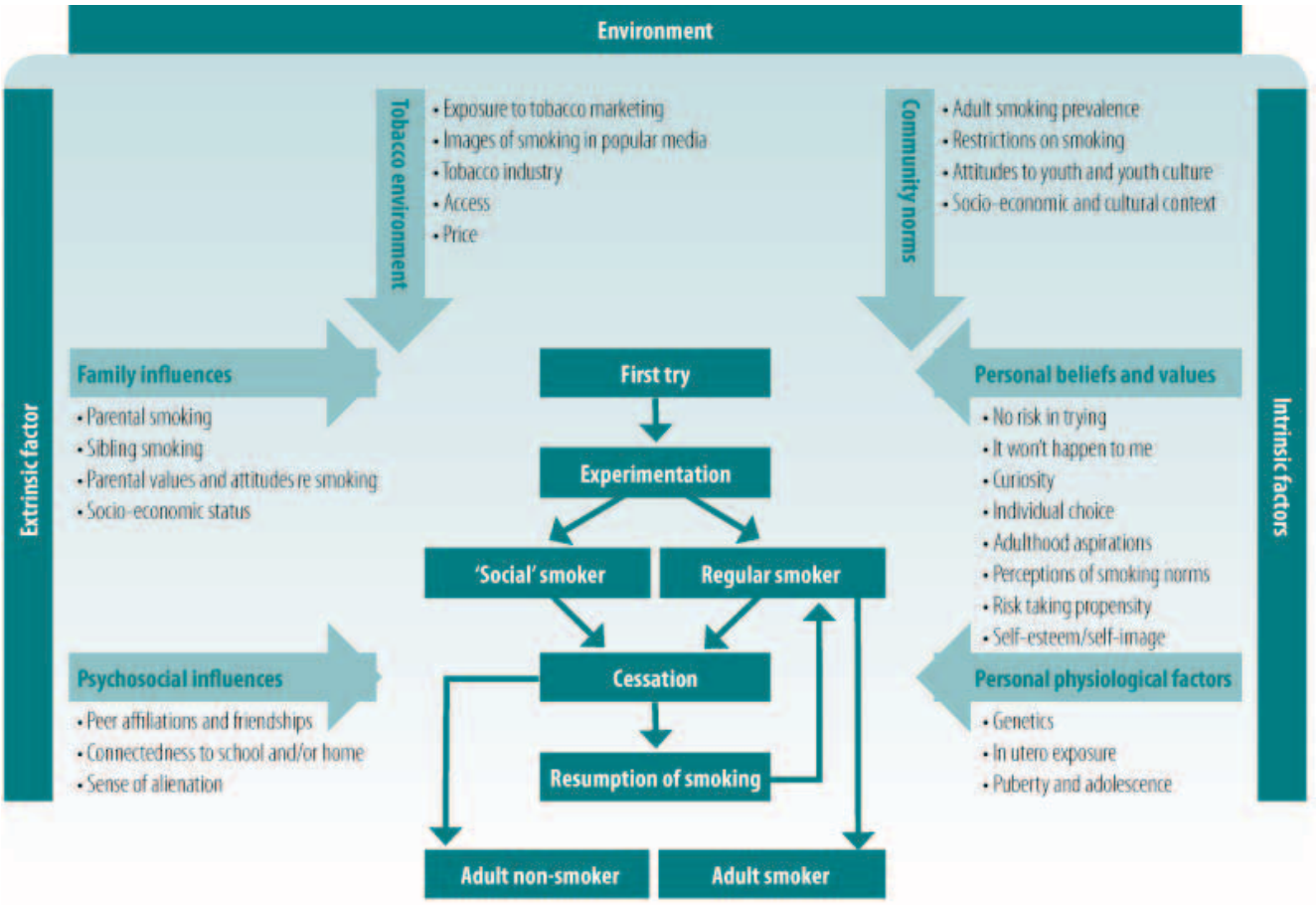
The authors argue that the combined effect of these factors leads to an individual's intentions and ultimate decision about whether or not to smoke and the relative importance of each of these factors will vary throughout a person's life. A decision to smoke leads to experimentation and the resulting process is influenced by these factors. This is illustrated in Figure 5 on the next page.

Scollo and Winstanley in "Tobacco in Australia Facts and Issues" note that the evidence base for youth smoking prevention in Australia is hindered by the lack of evaluation of many projects. However, they provide a useful overview of some of the key uptake factors identified in the literature that can be modified.

Figure 6: Core components of comprehensive youth smoking prevention programs

Influences to smoke	Intervention approaches that can address this
Family environment	Adult campaigns and cessation interventions Parent/home components of school-based interventions Information and resources directed at parents regarding youth smoking

Figure 5: Influences on uptake of smoking [100]



Source: Wood as reported in Tobacco in Australia Facts and Issues 2009.note

Smoking behaviour of peers, and peer attitudes and norms	Mass media campaigns targeted at young people (and flow on effect of adult campaigns) Peer influence strategies incorporated into school interventions, youth resources Peer education approaches
Intentions, attitudes and beliefs	Youth directed mass media campaigns School-based programs Targeted resources, internet and technology strategies Interactive technology strategies Strategies to denormalise smoking (including smoke-free public places)
Educational environment	School curriculum and programs School smoke-free policy Complementary initiatives that are protective against smoking (e.g. physical activity, school connectedness)
Accessibility to and availability of tobacco products	Sales to minors interventions Point of sale stock regulations Removing display at point of sale in retail outlets Licensing
Affordability	Pricing and taxation
Tobacco advertising and promotion targeted at young people	Advertising and promotion bans Health warnings on packaging and advertising Plain packaging of tobacco products/packets Monitoring and advocacy around new tobacco industry tactics to target young people
The portrayal of smoking in the popular media	Advocacy and publicity Exposing young people to deceptive tobacco industry marketing approaches (including smoking in movies)
Tobacco products created to appeal to new users	Advocacy and regulation to curb packaging, flavourings that appeal to young people

Source: Scollo and Winstanley Tobacco In Australia; Facts and Issues 2009

Progress to Date

In 2008 less than ten percent of NSW students were current smokers (8.6 per cent) – a fall of six percentage points from 2002. [101] This significant decline in smoking among secondary school students demonstrates the success of an integrated population approach to tobacco control.

The approach to preventing uptake of smoking by young people in NSW has been very successful, but more needs to be done to maintain and improve on these results. Successful approaches to youth smoking in NSW have included a strong focus on legislative measures to prohibit tobacco advertising and prevent the sale of tobacco to children. These legislative measures have been consistently monitored and enforced for a sustained period over many years and non-compliance publicised to ensure high retailer compliance with the laws. Other programs implemented have influenced young people's perceptions about the relative normality of smoking, educated young people about the health consequences of smoking and supported parents and teachers to discourage the use of tobacco.

The *Public Health (Tobacco) Act 2008* introduced from 1 July 2009 a strong and responsible package of reforms designed to reduce young people's exposure and access to tobacco products through restrictions on the display of tobacco products across all retail settings. In particular, the display ban is part of a 'denormalisation' approach, which seeks to address the perception of tobacco as an everyday product like milk or bread. Other reforms aim to reduce young people's take up of smoking through restrictions on the placement, number and operation of tobacco vending machines.

Reducing the exposure of children to ETS has also been a priority for NSW, given the significant health risks associated with this exposure and their contribution to denormalising smoking. Key strategies have included enforcing existing legislation and encouraging the creation of smoke-free homes particularly among low socioeconomic groups, Aboriginal people and other disadvantaged populations through education campaigns.

A key aim of all of these strategies is to 'denormalise' smoking – to make it more and more the exception, rather than just simply accepted as a part of daily life.

One of the most important national strategies to reduce uptake of smoking by children and young people is to increase the price of tobacco through tobacco tax increases because evidence shows children are particularly sensitive to price increases. NSW will continue to advocate for incremental tobacco tax increases by the Federal Government as a key strategy to address smoking by young people. The Federal Government's commitment to introduce plain packaging of tobacco by 2012 will contribute to NSW's efforts in enforcing the tobacco display ban to reduce the appeal of smoking by young people.

Complementing these population-wide measures have been more targeted strategies delivered in the school setting. They include the implementation of smoke-free policies for all school grounds and the inclusion of tobacco information in the curriculum. In addition, a secondary school-based smoking prevention program is being implemented by the NSW Department of Education and Training in partnership with the NSW Department of Health. The program aims to prevent and reduce tobacco use amongst young people and focuses on improving learning outcomes for secondary school students through the development and promotion of innovative approaches to classroom-based smoking prevention education. Teachers and students are able to access a range of interactive online resources to support the smoking prevention program learning.

Priority Area 8: Strengthen research, monitoring, evaluation and reporting of programs for tobacco control

Evidence

Tobacco control is based on a strong body of Australian and international research that has amassed since the 1950s and continues to develop.

Policies and interventions in tobacco control in NSW are underpinned by a strong research, monitoring and evaluation capacity. NSW has developed a comprehensive monitoring and surveillance system for population health measures including tobacco. These include the NSW Population Health Survey, the Secondary School Health Behaviours Survey (formerly ASSAD), the NSW Smoking and Health Survey and the Tobacco Continuous Information Tracking program. The results of these surveys are published and widely available on the internet. They allow us to monitor population trends over time and evaluate our success in achieving our targets.

Progress to Date

The NSW Population Health Survey is the primary source by which NSW smoking prevalence trends are measured and reported. Reports are released annually providing information on adult current (daily and occasional) smoking prevalence, smoking status and intention to quit smoking.

The NSW School Students Health Behaviours (SSHB) Survey collects information about the health behaviours and attitudes of secondary school students in NSW. The survey includes questions on tobacco, alcohol, illicit drug use, and sun protection from the Australian Secondary School Alcohol and Drug (ASSAD) Survey. Reports are released every three years providing information on smoking status, intention to quit or smoke, source of cigarettes, information on purchase behaviour and a range of other relevant indicators.

The NSW Department of Health also conducts regular surveys of community attitudes to smoke-free laws in NSW pubs and clubs. More recently, the survey has included questions on community attitudes to the new reforms introduced under the *Public Health (Tobacco) Act 2008*, such as the ban on smoking in cars with children present. Results from these surveys will be released as they are completed and used to inform future strategies.

The Cancer Institute NSW conducts the Smoking and Health Survey every three years to measure knowledge, attitudes and behaviours toward smoking. The Smoking and Health Survey aims to understand: (a) patterns of tobacco use, quit attempts, motivations and barriers to quitting, (b) knowledge about the health consequences of smoking (c) community attitudes towards tobacco control policy priorities.

The Tobacco Continuous Information Tracking (CIT) aims to monitor the efficiency and effectiveness of tobacco related paid and unpaid social marketing in NSW. Since 2005, the Cancer Institute NSW has conducted CIT as part of the evaluation of the effectiveness of its anti-tobacco campaigns. Data are collected on a range of indicators: demographics and media consumption; smoking status and behaviour; quitting behaviour and intention; attitudes towards smoking and quitting; awareness of and attitudes towards graphic warnings on tobacco products; awareness of the health benefits of quitting and the performance of paid and unpaid media.

National smoking data are collected as part of the Strategy National Drug Household Survey conducted every three years by the Australian Institute of Health and Welfare. This survey will be used as the primary source to benchmark progress in reducing smoking prevalence nationally and by individual states under the National Preventative Health Partnership Agreement. The survey reports on the use of tobacco by persons 14 years and older, and includes type of tobacco smoked, smoking behaviour, motivators for behaviour change and average number of cigarettes smoked per week.

Comprehensive and robust monitoring and surveillance systems are fundamental to an effective approach to tobacco control. Collecting and managing population-level data systems allows us to monitor our progress in achieving our specified targets over time.

It is also important to have the capacity to analyse and identify the implications of research findings, disseminate key messages and translate them into effective practices and interventions. [102] Better linkages between researchers, policy makers and those implementing programs at the local level will have enormous potential benefits for tobacco control.

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