

The Future of Tobacco Control Consultation – Response from Derbyshire Action on Smoking

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

It should be possible to cut smoking prevalence in the general population to 15% by 2015 and to 19% amongst routine and manual workers. By 2020, fewer than one in ten of the population should still be smoking, and by 2030 the figure should fall to fewer than one in 20.

Most smokers in England express a desire to quit and many will make a serious attempt to do so in the next twelve months. However, only between 3% and 6% of these smokers will try to stop smoking using the evidence based methods provided by the local NHS Stop Smoking Services. A realistic goal would be for this percentage to increase to around 10% of smokers quitting through the NHS service. Obviously this will require many more smokers to be familiar with the NHS service, be attracted to it and be aware of the advantages of stopping smoking this way.

Local evidence suggests that many people access the local service as a result of a referral or recommendation from their GP and that a brief intervention by a GP or hospital doctor is often a significant factor in seeking support to quit smoking. All GPs and other health professionals should be routinely expected to ask patients about their smoking and to make timely and appropriate referral to the local stop smoking service. There should be greater financial, moral and other incentives to ensure that this happens.

We believe that these challenging targets are possible on the basis of recent trends which have shown an annual decline in smoking

prevalence of around 0.4% of the population per annum, and on the evidence from other jurisdictions when comprehensive tobacco control strategies have been implemented such as California.¹ However, we believe that it is only possible to achieve these more challenging targets of a 0.8% smoking prevalence decline in the general population and 1% decline amongst routine and manual workers, if the measures outlined below are implemented.

- Stop smoking services should be sited in places where people are likely to engage with them such as job centres, schools, supermarkets and workplaces. Typically, workplace stop smoking services do not have a great deal of support from senior management in the business community and this could be addressed through the partnership approach used by local tobacco control alliances.

DAS are currently piloting a motivational session to be delivered in workplaces. This presentation is aimed not only at smokers but also at their non-smoking colleagues. It is hoped that by targeting all employees rather than only those who smoke, smokers will not feel marginalised and non-smokers will not feel that their smoking colleagues are getting extra time away from work etc. Non-smokers can be useful advocates for tobacco control. They are able to encourage and support colleagues to stop smoking in the workplace and are able to take the messages home to friends and family.

The presentations focus on a wide range of tobacco control issues such as addiction, the financial costs of smoking, the marketing of tobacco, the immediate effects of living with smoking, the issues around smoking and how it accelerates the ageing process, secondhand smoke etc.

The motivational sessions are delivered in a fun, non judgmental way but the serious message around the harmful effects of tobacco use are effectively delivered.

The sessions are delivered by a Tobacco Control Worker and a Specialist Stop Smoking Service Adviser. At the end of the session participants are invited to sign up to Stop Smoking Support in the workplace.

These sessions are still being evaluated but initial take up of the service after delivery of a session was excellent.

¹ California Tobacco Survey (CTS) Reports. <http://ssdc.ucsd.edu/tobacco/reports/>

Young people in particular may not be attracted to existing services so new methods of delivery to these groups should be explored.

Since the introduction of the rise in the age of sale legislation DAS has been undertaking a project working with young people between the ages of 14 and 18 which consists of targeted presentations, quizzes, games etc. The presentations are particularly suited to colleges, E to E groups, and excluded students. The information given to young people does not focus on the fact that 50% of smokers will die from their addiction but looks at what it is like living with the effects of smoking. Topics covered include addiction, fertility, impotence, financial costs of smoking, effects of secondhand smoke, how smoking ages the skin (used in conjunction with the age progression software) and how the tobacco industry uses clever marketing to recruit and retain smokers.

The presentations have been very well received by staff and students and evaluation of how the sessions have been delivered has been excellent. Further evaluation is now taking place to discover if the presentations have resulted in any change of behaviour or beliefs around tobacco and smoking.

- Increased and sustained effort and resources must be directed towards reaching hard to engage with groups. If health inequalities caused by smoking are to be effectively addressed then the local services can no longer concentrate efforts on the 'easy wins' gained from targeting more affluent groups.
- Smoking prevalence amongst people with mental health problems is far higher than in the general population. It is estimated that around 70% of mental health inpatients smoke, 50% of people with bipolar disorder smoke more than 20 cigarettes a day², significantly more than in the general population. With the introduction of a smoking ban in mental health units in July this year further resources should be invested in ensuring that specialist and appropriate support is available from Stop Smoking Specialists for both patients and staff.

² www.mind.org.uk/factsheets/smoking+giving+up+mental+health

The Government needs to ensure that resources are maintained to sustain and, where appropriate, expand local tobacco control alliances to allow the full range of effective tobacco control measures to be put in place. No one intervention can be successful on its own in reducing smoking prevalence. In order to meet these challenging targets in the longer term a comprehensive approach to tobacco control, driven forward by local alliances, will be vital.

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

Smoking is the greatest cause of premature death in this country and is a major contributor to health inequalities. It is possible to reduce the massive burdens that tobacco use inflicts on our communities by introducing and sustaining comprehensive tobacco control strategies implemented at national, regional and local levels.

Smoking creates major health, economic and social burdens within our communities, making it vitally important that tobacco control is elevated to a high level within the statutory and voluntary sectors and in other organisations that can play a role in reducing smoking rates by facilitating engagement with communities and hard to engage with groups. Effective tobacco control needs to be informed by national policy and driven by local priorities, local action and local leadership. If significant steps are to be taken to reduce health inequalities it is important that tobacco control is not seen only as the responsibility of the health sector. To maximise the effect of any stop smoking initiatives a fully integrated approach is needed. The concept that stopping smoking is both achievable and desirable needs to be supported by and embedded into every organisation's business planning. If we are to achieve the tobacco control aim of denormalising smoking as a desirable, everyday activity, then it is important to ensure that supporting smokers to stop is the business of every organisation.

As the most evidence based support system available, local NHS stop smoking services are a vital part of this process. However, all too often the Stop Smoking Services are seen as the sole agency that can deliver tobacco control at a local level. While these services should be fully involved in an overall strategic and comprehensive tobacco control programme they are not able to deliver this in isolation. All the major international guidance on tobacco control

strategies consider supporting smokers to stop as a key part of a multi strand approach, together with fiscal measures, health promotion and legislative reform. To reduce health inequalities, denormalise smoking and change the culture around smoking behaviour within our more deprived and targeted communities will need a range of tobacco control initiatives, delivered by a number of agencies and lead by a strong local tobacco control alliance

Local tobacco control alliances have a very important role to play in addressing these health inequalities and in ensuring that all key people and organisations are actively involved in the tobacco control agenda. There is a very real danger that if this multi sectoral involvement diminishes, previous achievements will be diluted and smoking prevalence rates will stabilise and then rise rather than fall. Government should recognise the important role that tobacco control alliances fulfil in ensuring community engagement and in building capacity and should ensure that alliances are adequately recognised and resourced.

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?

There is good evidence that each of the six strands of tobacco control is effective in reducing smoking rates. The United Kingdom has achieved a great deal, particularly with respect to helping people who want to quit, banning tobacco advertising and promotion, and reducing exposure to secondhand smoke. However, it is important that the six strands are reviewed, updated and a new strand around harm reduction is added which will help those smokers who are not ready to quit or who are struggling to do so to reduce their tobacco intake and to protect others from the harmful effects of their smoke. This could have a significant effect on health and on health inequalities (see answer to question 17).

Any new tobacco control strategy must ensure that each of these strands is adequately funded. It is particularly important that funding is in place to allow local enforcement agencies to plan, implement and sustain robust, informed and successful enforcement campaigns for both new and existing legislation.

A crucial factor in embedding this six strand approach into local communities and polices is the existence of an effective multi agency, cross sectional partnership approach. Fully engaged partnership working is an essential requirement for successful local tobacco control action. This requires sustained commitment from a wide range of partner agencies across a local area; all of whom are active in making their own contribution to reducing smoking prevalence, the impact of smoking on the health of local people and in reducing health inequalities. Such partnerships can have huge operational benefits by avoiding duplication of effort, allowing for pooling of resources and in some cases can even avoid the competition between agencies for limited funds.

Over the last twenty years the promotion of health through local alliances has become a keystone of public health policy and the importance of mobilising communities to promote health was reinforced by the White Paper on tobacco, Smoking Kills 1998³. This document proposed a nation-wide campaign bringing together schools, parents, professional bodies and local authorities to create a smokefree environment. The involvement of communities is consistent with best practice in smoking interventions internationally. Government recognises that smoking prevalence is higher in the more deprived communities and that there is a need to target smokers in those areas and in the more routine and manual occupations. In order to do this effectively it will be necessary to engage with these communities through local community groups. Good partnership working between, the health sector, statutory organisations and the voluntary sector, will be vital to our success in helping these people to stop smoking.

Derbyshire Action on Smoking (DAS) has been in existence for nearly twenty years and has undertaken many successful campaigns which have supported the six strands at local level. DAS members, Chair and Coordinators have worked consistently to keep a high profile for the Alliance ensuring that the membership and work of the partnership reflects the current priority areas of tobacco control. For instance DAS was actively involved in lobbying MPs for comprehensive smokefree legislation. Once the legislation had been agreed DAS set up a sub-group which included Environmental Health Officers from all the local Councils across Derbyshire and Derby city. This group developed action plans, communications plans and targeted and themed information for local businesses on the smokefree legislation ensuring a unified and consistent approach to enforcement across the county.

Effective, inclusive local partnerships are integral to local tobacco control measures. Any new tobacco control strategy should recognise that partnerships are an asset in moving the tobacco control agenda forward. This should result in realistic amounts of ongoing, sustainable funding specifically available to alliances which are able to demonstrate their effectiveness and commitment to reducing ill health and health inequalities caused by tobacco use.

DAS also believes that any new tobacco control strategy should continue to develop the work already undertaken on compliance with the smokefree legislation. Government should ensure that Local Authorities are given adequate funding to build on the excellent compliance rates with smokefree premises. It must be remembered that while the majority of premises are compliant with the law there are a small but significant number who continue to flout the restrictions. These cases need to be pursued by enforcement action through the courts. Such action is costly in both officer time, in the actual process of writing prosecution reports, gathering witness statement and legal advice and input. Another aspect of the Smokefree laws that is proving problematic is the enforcement of smokefree vehicles. Local Authorities need to be properly resourced and funded to ensure that the necessary action can be taken to ensure that the legislation continues to be effective. While the funding given by the Department of Health to help with the introduction of the legislation was welcome and certainly helped to ensure a smooth introduction to the legislation such funding needs to be ongoing, adequate and ring fenced.

DAS has recently been made aware that an increasing number of complaints are being received about the amount of smoking related litter left on our streets much, of the increase in which is being attributed to the introduction of the smokefree laws. Once a cigarette has been smoked, the cigarette butt will be disposed of. If there is no safe convenient place to dispose of the butt it will simply be dropped on the floor and crushed underfoot. Cigarette butts are the biggest component of smoking related litter. While most people are aware that the dropping of litter is considered to be anti social and may incur sanctions, many do not consider that cigarette butts are litter and are unaware that the careless disposal of them can have an adverse effect on the environment. It is important to develop campaigns to highlight these facts to the public and to ensure that local authority enforcement officers are adequately trained and resourced to deal with this problem. The six strand

strategy should take this nuisance into account and develop a campaign to address this issue.

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

An improved strategy to tackle smuggling at national, regional and local level is needed to stop the flow of tobacco smuggled into this country by criminal gangs. This will need the introduction of new tougher targets for a continued reduction in the market share of smuggled cigarettes and hand-rolled tobacco. The new Borders Agency must work closely with HMRC and the Treasury to develop a new and improved anti-smuggling strategy and ensure that cracking down on smuggling remains a priority for the Government. A strong consistent message supported by good quality, appropriately targeted media interventions and printed material will be needed to support any campaign.

We support the proposals as set out in paragraphs 2.38 – 2.39. However, the UK Government should also lobby for, and sign up to, a strong illicit trade protocol as part of the international treaty on tobacco – the Framework Convention on Tobacco Control. The UK should also sign the EU anti-smuggling agreements, in line with all other EU Member States.

78 % of respondents in a survey carried out in Derbyshire in August 2008 agreed that the penalties for smuggling or selling on smuggled or bootleg tobacco should be increased.

Good quality intelligence is important in the fight against illegal tobacco. Locally many people and communities have information which could contribute to the enforcement of existing laws. However, it is often difficult for local agencies, alliances or members of the public to ensure that this information is passed to the relevant enforcement agency. Most people do not have the knowledge of which agency has responsibility for which area of law.

Additionally if people report suspected infringements of the law to one agency there is no guaranteed, robust system for ensuring that

this information is passed to the relevant enforcement agency, thus a considerable amount of valuable information is lost.

A survey carried out in Derbyshire in August 2008 showed that very few people knew to which agency breaches of the law around illicit tobacco should be reported .

When asked to which organisation would you report someone selling counterfeit or fake cigarettes; 49% answered that they did not know. 27% said they would report such sales to the police, 14% said Trading Standards and 8% stated they would report such sellers to HMRC.

When asked to which organisation would you report someone selling smuggled cigarettes or tobacco; 52% answered that they did not know, 25% stated the police, 16% said HMRC and 7% stated they would report sellers to Trading Standards.

Although 90% of respondents said they were aware of legislation to prevent tobacco being sold to children; when asked to which organisation they would report someone selling cigarettes to children, 50% said they did not know, 32% stated the police, 17% stated Trading Standards and 1% and they would report such sales to the council.

Clearly there is considerable confusion about the correct agency to report breaches of the law around the illicit sale of tobacco products and it is likely that due to this lack of clarity around reporting that a considerable amount of local, national and regional intelligence is lost.

Consideration should be given to providing and widely publicising a national reporting line which will facilitate information received to be passed directly to the relevant enforcement agency. Introducing a new separate reporting number and line would not be necessary and could be counter productive as the public will have yet another number to remember. Additionally setting up, staffing and staff training is likely to be prohibitively expensive. It is suggested that the existing Consumer Direct number 0854 040506 could be used as a reporting line. Consumer Direct advisers are already fully trained in obtaining and accurately recording information and intelligence from members of the public and have highly sophisticated procedures for ensuring that this information is passed to the relevant agency in accordance with agreed service level agreements.

Question 5: What more can the Government do to increase understanding about the wider risks to our communities from smuggled tobacco products?

Price is a major factor in encouraging people to stop smoking. The current situation with the smuggling of cheap illicit tobacco is an international problem. Tackling this problem effectively will require a range of actions to be taken at all levels, locally, regionally, nationally and on an international scale. It is clear that unless this supply of cheap tobacco is controlled the impact of other tobacco control measures will continue to be seriously undermined. Illicit tobacco negatively impacts on the high tobacco tax policies that are designed to reduce tobacco consumption, erodes attempts to stop people smoking and encourages relapse.

Criminal activity around illicit tobacco tends to be concentrated on targeting smokers in the more deprived areas, so increasing health inequalities even further.⁴

Nationally there should be more investment in mass media campaigns to encourage the public to report illegal tobacco sales (see answer to question 4) and to show how the availability of cheap smuggled tobacco undermines other tobacco control measures. There should also be greater transparency of information about the scale of smuggling to allow the monitoring of the anti-smuggling strategy and to allow lobbying for change where necessary.

Unfortunately there is little research evidence detailing what interventions actually work in tackling illicit tobacco locally, because work is generally targeted at global, international and national supply issues. Although tackling supply is important, and there have been considerable successes by HMRC in removing large stashes of illegal tobacco from the supply chain, it is equally important to tackle the demand for these illegal products. While supply and the criminal activity associated with it can only be effectively tackled by enforcement agencies, local tobacco control alliances are well placed to begin to tackle local demand. This can be done in a number of ways such as disseminating national messages locally, sharing good practice, facilitating the sharing of intelligence and encouraging a full range of agencies such as local authorities and

⁴ Excellence in tobacco control – 10 high impact changes. DOH Tobacco Control National Support Team 2008

trading standards departments to join forces on this essential activity. Any new tobacco control strategy should reflect the importance of tobacco control alliances in facilitating a partnership approach to tackling this demand for illicit tobacco.

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. Around 80% of all smokers start smoking as teenagers and these young people are at the greatest risk of becoming highly addicted long-term smokers and are at most risk of dying as a result of their addiction.

Tackling youth smoking as a stand alone intervention can only have a limited impact. Such interventions must be part of a comprehensive tobacco control strategy aimed at the whole population and aimed at denormalising smoking in the adult population. Once smoking ceases to be seen as a normal activity it will become less appealing to young people.

However, there is wide support amongst DAS partners for piloting new measures to reduce youth smoking and to prevent young people from ever starting to smoke. It is recognised that traditional educational approaches have had a limited impact and young people continue to smoke and to become smokers. This suggests that traditional approaches may educate young people but they do not influence their decision to start smoking. DAS believes that it is necessary to trial and evaluate new approaches on influencing the smoking behaviour of young people. In addition to the work that is already being undertaken in Derbyshire we are aware of many other initiatives taking place across the country. Government should initiate a research scheme for consistently evaluating this work and for sharing best practice

on new interventions which actually work with young people.
(see page 2 of this response for work undertaken by DAS)

Two major surveys of teenagers in Western Australia reveal a dramatic re-think in attitudes towards smoking between 1999 and 2005. Results showed a substantial increase over time in the number of teenagers who thought smoking was costly, unattractive and affected fitness levels. Dr Michael Rosenberg, a population health expert at the University of Western Australia, said the results showed the short-term effects of smoking were now a powerful deterrent. Dr Rosenberg said, "The good news is that there is evidence that the view of smoking has changed in youth culture. It's important to keep continually reinforcing those messages on the short-term effects, because they obviously work."

The study, published in the Health Promotion Journal of Australia, found that the number of teenagers who are put off by smoker's breath increased from 61 per cent in 1999 to 90 per cent in 2005. The number who thought smoking made you less fit increased from 86 to 94 per cent, and there was a similar increase in those who thought smoking wastes money.

- b. Tobacco is a uniquely dangerous product. When used according to the manufacturers instructions it kills half of its users. Most long term smokers do not choose to continue to smoke but are controlled by their addiction. Children who start to smoke at a young age do not have the knowledge and life experience to make informed choices about smoking and by the time they are able to make those choices they are often too far into the cycle of addiction to stop smoking without considerable help and support.

In October 2007 the age at which tobacco products could be sold to young people was increased from 16 to 18. This age increase was welcomed by DAS and by local Trading Standards Officers as it brought this age restricted product in line with other restricted products. However, it is disappointing to note that it is not a mandatory requirement for local Trading Standards Departments to actively enforce this legislation. The Children and Young Persons (protection from tobacco) Regulations 1991 only imposes a duty on regulatory authorities to consider the legislation at least once in every twelve months. There is no mandatory minimum level of

enforcement specified in the legislation. This means that a number of authorities across the country do not actively take any enforcement action against retailers who sell tobacco products to children.

In a recent survey undertaken in Derbyshire when asked should more be done to prevent young people from starting to smoke 93% of respondents said yes. Of these 67% thought that the existing services should be used to educate young people on how to resist the pressure to start to smoke, 44% thought that licensing of tobacco sellers would have an impact on the uptake of smoking, 55% welcomed laws that allowed tobacco to be confiscated from children and 76% wanted the penalties for selling tobacco to young people to be increased.

Before the Government considers further legislation on protecting young people from smoking and tobacco products it should review the current regulatory requirements around the age at which tobacco products are sold. The current legislation should be upgraded to impose a mandatory duty on each local enforcement authority to enforce at a meaningful level. Audits of test purchasing processes and of local targets should become part of regulatory assessments of enforcing authorities to ensure that test purchasing activity takes place within good practice guidelines and to a high standard. Steps should also be taken to ensure that Trading Standards departments receive sufficient targeted funding to enable them to ensure that existing legislation is effectively enforced and implemented.

Consideration should be given to ensuring that local magistrates are trained in tobacco control and are fully aware of the serious health impacts that smoking can have on young children. A full understanding of the effects on health of smoking and inequalities is likely to affect the seriousness with which the offence of selling to children is viewed and may result in higher levels of fines.

Additionally section 7(3) of the Children and Young Person's Act 1933 gives powers to a police constable or uniformed park keeper to seize tobacco or cigarette papers from any person who appears to be under 16 years of age who is found

to be smoking in any street or public place. The seized material can then be disposed of in an appropriate manner as determined by the relevant police authority. Paragraph 7 of the Part 1 of Schedule 4 to the Police Reform Act 2002 extends these powers to police community support officers. This legislation should be updated and amended to include any person who is apparently under the age of 18 to bring it line with the age of sale restrictions. The powers conferred by this legislation should be widely publicised and all local police authorities should be encouraged to actively seize tobacco products from young people who appear too young to have been sold them legally. A central government campaign should be implemented to inform the public of these powers and to encourage public support of these measures. Consideration should also be given to extending these powers to teachers, youth workers etc.

Reducing the accessibility of tobacco products would indirectly limit tobacco marketing opportunities. Currently retailers do not need a licence to sell tobacco, as is the case for alcohol. This makes it difficult to identify and control the number of locations where young people can buy tobacco and reduces the ability to enforce age of sale legislation. The introduction of a positive licensing scheme requiring retailers to obtain a licence from their local authority to enable them to sell tobacco products would go some way to addressing the problem. Positive licensing has been used to control the sale of alcohol for many years in the UK and is being used to control the sale of tobacco in a number of other jurisdictions. Both positive and negative licensing controls on the sale of tobacco have been introduced in the majority of states in the USA, in several Canadian provinces, in New Zealand and in all Australian states and territories. A licensing system would make it easier to target illicit tobacco sales by providing a new offence of selling tobacco without a licence. However, as with any legislation increased resources and adequate funding must be made available to Trading Standards departments to accommodate increased enforcement activity.

From April 2009 Part 11, section 143 of the Criminal Justice and Immigration Act 2008 will come into force. This new legislation will introduce penalties for those retailers who persistently sell tobacco to children. The legislation will allow a magistrate to grant a restricted premises order in respect of

the premises from where the tobacco was sold more than twice in any two year period. In effect this order will mean that tobacco and tobacco products will no longer be able to be sold from those premises for a period that does not exceed one year. In effect this legislation introduces a system of negative licensing. While DAS welcomes the introduction of this legislation and believes that this is a good starting point for a licensing system it is felt that Government should be considering the introduction of a positive licensing system for the sale of tobacco products, and believes that the introduction of a system similar to that required for the sale of alcohol is desirable. Additionally in order to obtain a licence retailers should be required to attend a training session on tobacco control, the law relating to the sale of tobacco products and the wider effects of smoking on health, inequalities etc. The requirement to attend this training should be mandatory i.e. no verified attendance at training no licence to sell tobacco products.

As stated previously tobacco is a uniquely dangerous consumer product. Currently there are estimated to be in excess of 200,000 retail outlets in England that sell tobacco products yet only around 22 % of the population are smokers. Access to cigarettes and other tobacco products by children has not been as difficult as it should be.

In a recent test purchasing exercise undertaken by Derbyshire Trading Standards 41 attempted purchases were made from local retailers. 13 sales were made.

In the same exercise 12 attempted purchases were made from tobacco vending machines and a total of eight of these test purchases resulted in a sale.

Additionally 156 attempted test purchases from retailers were made across a range of age restricted products. 44 sales were made. Many of these retailers also stocked tobacco products.

Derbyshire Trading Standards also carry out risk assessment/advice visits to retailers across Derbyshire which includes giving advice on underage sales and on point of sale advertising.

It is not unreasonable for retailers to accept that selling such a product will impose certain duties upon them to ensure that the public and young people in particular are protected. Those who repeatedly flout the law and sell tobacco to children should not be allowed to continue to sell a harmful and addictive product such as tobacco. In addition to strengthening control of underage sales such a positive licensing system would also help reputable retailers by enabling unlicensed sales of tobacco to be tackled more effectively (for example in street markets or car boot sales) and by ensuring disreputable retailers are stopped from selling tobacco.

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

DAS believes that the advertising restrictions on other tobacco products should be extended to cover the advertising of tobacco accessories.

The advertising of tobacco accessories such as cigarette papers or lighters can act as a prompt and reminder about smoking. In recent years there has been a rise in the proportion of smokers using hand-rolled tobacco: from 12% in 1996 to 22% in 2006.⁵ It is noteworthy that when the Tobacco Advertising and Promotion Act was implemented Imperial Tobacco chose to place advertisements for Rizla cigarette-rolling papers at the point of sale since they did not require health warnings. Imperial has also used the Rizla brand to sponsor motor racing, thereby maintaining a link between sport and smoking, despite UK and European legislation outlawing tobacco sponsorship of sport.⁶

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?

DAS favours Option 3 requiring retailers to remove tobacco products from display.

⁵ Smoking-related Behaviour and Attitudes, 2006. Office for National Statistics, 2007

⁶ Good, G. Presentation at UBS Tobacco conference. 1 December 2006 http://www.imperial-tobacco.com/files/financial/presentation/011206/ubs_transcript.pdf

Cigarette displays are a powerful marketing tool for tobacco companies. In order to support the tobacco advertising ban that was introduced in the UK in 2003 the advertisement of tobacco products at the point of sale – the ‘powerwall’, where large quantities of cigarettes form a backdrop at the cash point should be prohibited. Such displays at the point of sale normalise tobacco use particularly when they are placed next to every day items⁷.

There is a growing international trend to remove tobacco products from sight in retail outlets. Legislation has been introduced in Iceland and a number of Canadian Provinces. Legislation is currently being proposed for four Australian States, Norway and New Zealand. There is strong evidence to show that tobacco advertising and promotion encourages children to smoke and this evidence underpinned the UK law which banned most forms of tobacco advertising.⁸ Point of sale displays are a form of advertising and tobacco packaging is now the principal means by which tobacco companies promote their brands in the UK. Since tobacco products are both lethal and highly addictive, the advertising of tobacco in any form should not be permitted and the exemption for point of sale displays from the Tobacco Advertising and Promotion Act 2003 can no longer be justified and should be removed.

Removing tobacco products from public view will not affect adult smokers’ ability to buy them but it will remove the temptation of children to try to purchase them. Tobacco Advertising is a major factor in young people starting to smoke. Research has shown that young people become more aware of tobacco brands when cigarettes are on display and they are more likely to express an interest in trying named brands. School children who were shown a cigarette display at point of sale were more likely to perceive that it would be easy for them to buy cigarettes than those who were shown a till point with no cigarette display⁹. It is therefore, noteworthy that in Iceland, where point of sale displays were made unlawful in 2001, the proportion of 16 and 17 year olds who

⁷ Department of Health (2006) Consultation on under-age sale of tobacco changing the age of sale and strengthening sanctions against retailers for underage sale of tobacco. London: DOH

⁸ Pierce J et al. Does tobacco advertising target young people to start smoking? Evidence from California. JAMA 1991; 266(2): 3154-3158

⁹ Wakefield M, Germain D and Durkin S et al (2006) An experimental study of effects on schoolchildren of exposure to point of sale cigarette advertising and pack displays. Health Education Research 21: 338-47

reported that they had ever smoked fell from 61% in 1995 to 46% in 2003.¹⁰

Point of sale advertising displays are often cited as a factor tempting adult quitters to relapse and non-daily smokers to smoke more frequently. A ban on the display of tobacco products is also likely to remove the temptation for adults who are trying to quit to make an impulse purchase.¹¹

69% of people surveyed in Derbyshire in August this year were in favour of the removal of counter displays from the prominent display positions in retailers. Only 10% said no. The remaining respondents were unsure whether or not this would have an impact on people taking up smoking.

Eliminating point of sale promotion and cigarette displays will help to remove temptation from underage children and would be quitters.

There has been considerable speculation in the retail trade press about the cost to the retail trade of this measure. However, evidence from Canada shows that the tobacco industry paid for cigarette displays and, once they were banned, the companies continued to pay retailers for the tobacco storage units.¹² The tobacco industry has the means and resources to assist tobacco retailers in managing similar changes in the UK. Moreover, we believe that the tobacco industry should be required to disclose to the Government the amount of money it spends on marketing its products, as is the case in Canada.

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?

¹⁰ The European School Survey Project on Alcohol and Other Drugs (ESPAD).

www.espad.org/sa/node.asp?node=730

¹¹ Wakefield, M. The effect of retail cigarette pack displays on impulse purchase. *Addiction* Nov 2007

<http://www.addictionjournal.org/viewpressrelease.asp?pr=69>

¹² Anti-tobacco troopers won't butt in - *The Gazette* (Montreal), 19 May 2008

DAS favours Option 3 and supports a total ban on the sale of tobacco products from vending machines.

In a recent Derbyshire survey 79% of respondents were in favour of the phasing out of tobacco vending machines.

No reasonable society would agree to other age restricted products such as knives, fireworks, solvents and alcohol being available from vending machines. Of all the age restricted products only tobacco is sold through vending machines, and this is a product that kills over 50% of its lifelong users.

Although vending machines account for a small proportion (1% of the UK market) 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. This is because the machines are not properly supervised, are incorrectly sited and children can access them relatively easily. A voluntary code agreed with the National Association of Cigarette Machine Operators is supposed to ensure that vending machines are only sited in easily supervised areas so that underage smokers cannot buy cigarettes. The latest survey conducted when the legal age for purchasing tobacco was 16, found that 17% of 11-15 year old smokers reported that vending machines are their usual source of cigarettes because they found it easier to buy cigarettes from vending machines rather than shops¹³. [See Derbyshire trading Standards figures for sales resulting from a recent test purchasing exercise at question 6.](#)

Following the rise in age of sale to 18, it is possible that unsupervised vending machines could become a more significant source of under age sales because there are very few age checks in place. The prohibiting of tobacco sales from vending machines would reduce the number of outlets available to young people and may restrict their access to cigarettes.

Banning the sale of tobacco products from vending machines would make it harder for some children to purchase cigarettes. Many countries already prohibit the sale of tobacco from vending machines (or have never allowed it) and a total ban on tobacco

¹³ Fuller, E. Smoking, drinking and drug use among young people in England 2006. NHS Information Centre, Leeds, 2007.

sales from vending machines has been recommended by the World Health Organisation.

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

The world Framework Convention on Tobacco Control (FCTC) which has now been ratified by the UK, requires nations to ban all tobacco advertising and promotion. In the face of these restrictions, tobacco packaging has become the key promotional vehicle for the tobacco industry to interest smokers and potential smokers in its products. Although no jurisdiction has yet implemented a law requiring plain packaging, research suggests that it would help deter young people from taking up smoking because smoking would lose its appeal.¹⁴

Plain packaging is packaging that is devoid of brand logos, brand colours and information other than the brand name and messages required by law. Packaging would be required to be identical in size, colour, shape, font size and style and would leave only the name to identify the brand. The aim of plain packaging is to remove the function of cigarette packaging as an attractive advertisement.

There is evidence from around the world to show that the tobacco industry uses branding in general and pack design in particular to:

- Target young people
- Maximise display space (some members of brand families are virtually indistinguishable on taste alone yet the number of variants has increased dramatically in recent years).
- Communicate misleading messages (it would be illegal for manufacturers to claim products were “low tar” “light” or less harmful yet all these are communicated by the colour of sub-brand packaging)

Tobacco companies invest considerable resources in making tobacco packaging alluring and eye-catching, as this is now one of the few methods currently available to the industry to market its

¹⁴ Cunnigham, R. & Kyle K. The case for plain packaging. Tobacco Control 1995; 4: 80-86

products to new and existing smokers.¹⁵ Industry analysts believe that plain packaging would have a significant negative impact on cigarette sales.¹⁶ As well as removing the allure of the tobacco packaging, Plain packaging offers a number of additional benefits to tobacco control:

- It decreases the effectiveness of other tobacco marketing strategies such as point of sale displays.
- It can increase the prominence and impact of health warnings on packets and leaves more space for picture and other health warnings
- It can lead to denormalisation of tobacco products
- 44% of Derbyshire residents who were surveyed were in favour of plain packaging

Studies of youth, tobacco company spokespersons, and marketing experts confirm the importance of packaging in the marketing of tobacco. DAS believes that plain packaging is a necessary measure in addressing the smoking epidemic, and that it would be an effective tool in reducing uptake of smoking amongst young people. The Government should consider the introduction of legislation to require plain packaging as an essential component of any future tobacco control strategy.

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?

Article 16 of the framework Convention on Tobacco Control calls for bans on the sales of 'small packs' of cigarettes and DAS would strongly support such a move.

Recent research has shown that many underage smokers buy their cigarettes in packs of ten. Over half (55%) of all underage smokers claimed that the last cigarettes purchased had been a pack of ten¹⁷.

¹⁵ Wakefield, M. The cigarette pack as image: new evidence from tobacco industry documents. Tobacco Control 2002; 11:i73-i80 http://tobaccocontrol.bmj.com/cgi/content/full/11/suppl_1/i73

¹⁶ Material new risk appears: UK government suggests plain packaging. Citigroup, 2 June 2008

¹⁷ National statistics and NHS Information Centre (2006) Smoking, drinking and drug use among young people in England 2004, London: the Stationary Office

Smaller packs are cheaper and tend to be more appealing to young people. Prohibiting the sale of packs of ten cigarettes is a necessary step in reducing access to tobacco by young people.

At a focus group carried out at a local Children's Centre in Derbyshire participants suggested making the minimum pack size 25 plus. It was felt that this would increase the cost of purchasing cigarettes. For a period of time it would be easy to spot potentially illegal products and larger packs would be less convenient to carry around in handbags or pockets. A Derbyshire Environmental Health Officer suggested that minimum pack sizes should be increased to 50.

In a recent survey undertaken in Derbyshire 52% of respondents felt that the production of packs of 10 cigarettes should be stopped and 80% felt that stopping the production of packs of 10 would have an effect on youth smoking. Of the 52% who wanted packs of ten outlawed 64% felt that they contributed to children starting to smoke and 36% felt that pack of ten contributed to ex smokers starting to smoke again.

Packs of ten cigarettes have been successfully outlawed in a number of other jurisdictions including Australia, New Zealand, Canada, France and 14 State in the USA.

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.

More could be done by both Government and individuals to reduce children's exposure to secondhand smoke. It is estimated that almost half of children in the UK are exposed to secondhand smoke in the home. Children exposed to secondhand smoke face a greater risk of respiratory diseases, asthma and sudden infant death syndrome as well as a three fold greater risk of lung cancer.

For example, the Government should

- 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.
- Educate parents, carers and health professionals about what does and what does not protect children from secondhand smoke exposure. This should include targeted education to ensure that there is a wide awareness that there are no safe levels of exposure to secondhand smoke and that the only way to protect children is by not smoking in the home, car or other enclosed space and by making homes and cars totally smokefree. Simply opening windows or smoking in another room does not offer sufficient protection.¹⁸
- Fund and 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 with particular focus on helping people in disadvantaged groups. (This links to the harm reduction approach outlined in question 17.)
- Ensure that the stop smoking services are adequately funded and continue to be targeted towards disadvantaged smokers and other groups such as parents.
- Consider extending the smokefree regulations to cover smoking in private cars.
- Run specific advertising campaigns to publicise the health hazards of smoking in cars. Adults should be discouraged from smoking in cars when children are present. Some places (eg California, South Australia and Cyprus) have already banned smoking in cars in order to protect children from the dangers of breathing in other people's smoke, which is particularly concentrated in the confined space of a car¹⁹

¹⁸ Royal College of Physicians. 2005. Going smoke-free. The medical case for clean air in the home, at work and in public places. London: RCP

¹⁹ Rees V, Connelly G. 2006. Measuring Air Quality to protect children from secondhand smoke in cars. Am J Prev Med. 31: 363-8

- Actively support local tobacco control alliances to implement Smoke free homes and motor vehicle campaigns.

Derbyshire Action on Smoking (DAS) are piloting a Smoke Free Homes and Cars project in two of the more deprived areas of Derbyshire. This project has three distinct strands:

- Training health and other professionals to understand the damaging effects of secondhand smoke and to deliver the smokefree homes and cars project.
- Encouraging everyone in every community to have a smokefree home by using a range of different messages around how secondhand smoke affects, children, the elderly, those with respiratory and other health
- Empowering children to be able to ask for their space to be smokefree.

This project is being developed by a range of partners lead by DAS. It is due to be launched in the two pilot areas in December and will be rigorously monitored and evaluated before being rolled out across Derbyshire.

Part C: Supporting smokers to quit

Question 13: What do you believe the Government's priorities for research into smoking should be?

- Research to further understand and overcome the barriers to using medicinal nicotine or other pharmacotherapies.
- Research should be conducted to examine the effectiveness and cost-effectiveness of strategies to increase the uptake of the smoking cessation services.

- Research to improve the identification, referral and retention in treatment of pregnant smokers.
- Research is needed to establish if the approach taken in Sweden to target all women with stop smoking support rather than only pregnant women is the most effective method for reducing smoking in pregnancy.
- Studies to examine the impact of interventions and policies on different social groups.
- The use of tobacco amongst ethnic minority groups
- Studies to examine the efficacy of different prevention approaches including mass media interventions on young people

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?***

Stop smoking services are very cost effective and combined with the use of pharmacotherapies can increase a smoker's chance of quitting four-fold compared to using willpower alone. However, take up by smokers wanting to quit is still low with only 3% to 6% of smokers making use of the services per year. If attendance was raised to 10% of smokers, it is estimated that the population long-term quit rate could be increased by 0.5%.²⁰ Therefore, there is huge scope for improving the services and making them more attractive to people seeking help in stopping smoking.

Hospitals should be required to monitor smoking status of patients and to give all smokers brief advice to quit, encourage access to stop smoking medicines and referral to stop smoking services. Smoking status of people leaving hospital should also be monitored and appropriate information passed to local NHS Stop Smoking Services.

²⁰ West, R. The Smokers Toolkit Study. www.smokinginengland.info

In addition, smoking cessation should be included in the Standards for Better Health set by the Healthcare Commission.

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. According to a You Gov poll, 76% of adult smokers in England said they supported making NRT easier to access. [In a recent Derbyshire survey nearly 100% of respondents thought that NRT should be free or cheaper.](#)

Research should be conducted to examine the effectiveness and cost-effectiveness of strategies to increase the uptake of the local NHS Stop Smoking Services.

Social marketing campaigns targeted at particular social groups should be used to assist those who find it most difficult to quit.

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

Clearly much more needs to be done to make the local stop smoking services attractive to people who want to stop smoking. This could be achieved by improving the selection, training, assessment and supervision of specialists; the implementation of treatment protocols, and high quality administrative support for services.

Mass media health campaigns should be complemented by community-based initiatives to promote local services.

Question 16: How else can we support smoking cessation, particularly among high-prevalence or hard-to-reach groups?

All health professionals should be trained to offer opportunistic stop smoking advice and referral to the stop smoking services, particularly to disadvantaged smokers who are likely to be in most need of help and ongoing support. This training should be extended to local authority workers who should be actively encouraged and supported to make brief interventions with their clients and to signpost or refer to local stop smoking services.

Tobacco Control and smoking cessation should be incorporated into the medical training for all healthcare professionals.

Stop Smoking Services should be encouraged and resourced to provide more outreach opportunities, with services being set up in places where people are likely to see them, such as in workplaces, shopping centres, supermarkets and schools. Good quality, structured local telephone support should be available outside normal office hours.

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

Details of the NHS smoking quit-line should appear on all tobacco packaging and appropriate enforcement action should be taken to enforce the requirement that the National Stop Smoking Services contact number be displayed prominently at point of sale.

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?

To date, tobacco control has focussed on encouraging quitting, with support and on preventing people from ever starting to smoke.

People are free to smoke but smoking causes serious harm to both smokers and non-smokers. It is important to find ways of reducing the harm caused by smoking whilst allowing people to use nicotine in a way that will not endanger their health. Nicotine is relatively safe but little has been done to promote longer term use of nicotine replacement therapy (NRT) as an alternative to smoking for those who are unable to quit. Although the Medicines and Healthcare Regulatory Agency (MRHA) has taken steps to increase the

accessibility of NRT DAS considers that much more needs to be done. Existing nicotine replacement products are expensive and designed to be used as aids to quitting. As discussed previously tobacco is widely available at a large number and variety of retail outlets but nicotine replacement products and other smoking cessation aids are sold mainly through pharmacies.

The Government should take a lead in encouraging the development and promotion of pure nicotine products (which like the current medicinal products on the market only contain nicotine and not any other tobacco products) as an alternative to smoking. This should include educational campaigns to raise awareness of the relative safety of nicotine. Currently a significant proportion of smokers and health professionals believe that nicotine can cause smoking-related diseases such as cancer.²¹

There is significant scope for making these products more attractive and available to smokers. This could be done by:

- Requiring nicotine replacement products to be placed on sale alongside tobacco products. If tobacco products were required to be moved to under the counter there would be plenty of available space for the prominent display of NRT.
- Encourage the commercial promotion of these products as an alternative to smoking. This may be temporary, permanent or as an aid to cessation.
- Provide these products free through the NHS in a similar way that free contraception is provided.
- Introduce single day packs, starter packs and free samples.
- Promote these products as being more healthy than smoking tobacco. Cigarettes are highly addictive and very dangerous. NRT products are relatively low risk.

Such an approach will be particularly attractive to more deprived smokers who tend to be more heavily addicted to nicotine and so find it harder to quit, thereby helping to reduce health inequalities.

²¹ Siahpush M, McNeill A, Hammond D, and Fong GT. Socioeconomic and country variations in knowledge of health risks of tobacco smoking and toxic constituents of smoke: results from the 2002 International Tobacco Control (ITC) Four Country Survey. *Tobacco Control* 2006; 15: iii65 - iii70.

DAS does not support the legalisation of oral tobacco such as snus.
