CONSULTATION VERSION

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TEN YEAR TOBACCO CONTROL STRATEGY FOR NORTHERN IRELAND

CONSULTATION VERSION

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EXECUTIVE SUMMARY

Chapter 1: Why we need this Strategy

Smoking is the single greatest cause of preventable illness and premature death in Northern Ireland, killing around 2,300 people each year. Of these deaths, approximately 800 are as a result of lung cancer, which is now the most common cause of cancer death for both men and women. Further illnesses for which smoking is a major risk factor include coronary heart disease, strokes and other diseases of the circulatory system.

The cost of smoking to our society is high. In economic terms, the hospital cost of treating smoking related illnesses in Northern Ireland is in the region of £119m each year. Harder to quantify is the human cost relating to the large numbers of people dying or suffering from debilitating illnesses directly caused by smoking. The harm caused by tobacco smoke also extends to non-smokers through exposure to secondhand smoke, with children and unborn babies being particularly vulnerable.

Chapter 2: Aim of the Strategy

The overall aim of the Strategy is to create a tobacco-free society.

The key objectives, which have been carried forward from the Tobacco Action Plan 2003-2008, are: -

- fewer people starting to smoke;
- more smokers quitting; and
- greater protection from tobacco-related harm.

The Strategy is aimed at the entire population of Northern Ireland as smoking and its harmful effects cuts across all barriers of class, race and gender. However, a strong relationship exists between smoking and inequalities, with more people dying of smoking related illnesses in disadvantaged areas of Northern Ireland than in more affluent areas. In order to ensure that more

focused action is directed to where it is needed the most, three priority groups have been identified. They are:

- children and young people;
- disadvantaged people who smoke; and
- pregnant women who smoke.

Chapter 3: Fewer people starting to smoke

Every year in Northern Ireland, thousands of young people take up smoking despite being aware of evidence proving it is harmful to their health. Critical to reducing prevalence levels in the long term is preventing the uptake of smoking by young people in the first place. The Strategy identifies the following measures as key to being successful in reducing the uptake of smoking amongst children and young people:

- reducing the impact of tobacco promotion;
- raising awareness - about the effects of tobacco smoke on smokers' and non-smokers' health – through public information and education; and
- reducing availability of tobacco to children and young people.

Chapter 4: More smokers quitting

In a recent survey carried out in Northern Ireland, more than three-fifths of current smokers said they wanted to quit. However, as nicotine is a highly addictive substance, the desire to quit is very often not enough, and the majority of smokers will attempt to give up the habit several times before achieving their aim.

Supporting smokers to quit is a key priority for the Department and funds have been invested accordingly. There are now almost 650 specialist smoking cessation services available throughout Northern Ireland, provided in a range of settings including community pharmacies, GP surgeries, hospitals and community settings. The number of smokers accessing these services and

setting quit dates has been increasing year on year from the introduction of smoke-free legislation in 2007 and during 2009/10, 23,383 people set a quit date.

The two main forms of effective interventions available to support people to quit are:

- brief opportunistic advice; and
- specialist cessation interventions.

These interventions are supported by public information campaigns which stimulate interest and signpost people to services. Online advice also has a valuable role to play.

Cessation services need to be properly targeted. For the priority groups which have been identified – children and young people; disadvantaged people who smoke; and pregnant women who smoke - a range of services tailored to meet their specific requirements is necessary in order to reduce smoking prevalence.

The particular requirements of other groups such as those from an ethnic minority background, those with a disability, and those from the rural community, also need to be addressed by smoking cessation service providers.

Chapter 5: Protecting people from tobacco smoke

Until the overall aim of the Strategy – a tobacco-free society – is achieved, it is important that appropriate measures are in place to protect people from the harm caused by exposure to environmental tobacco smoke (ETS). Children, including unborn babies in the womb, are particularly vulnerable to the effects of ETS, as are adults with certain pre-existing medical conditions such as asthma.

The introduction of smoke-free legislation in April 2007 was a major step forward in protecting people at work, and the general public, from secondhand exposure to the numerous harmful chemicals in tobacco smoke. Compliance levels with the legislation in Northern Ireland have been high, with concerns only expressed in relation to smoke-free work vehicles.

Further work is required in order to reduce levels of smoking in areas not covered by smoke-free legislation, such as private homes and vehicles, and entrances and exits to public buildings. It is unlikely that additional legislation will be developed to achieve this, rather, the focus will be on awareness raising and education.

Key smoking facts

- Smoking is the single greatest cause of preventable illness and premature death
- It is a major risk factor for cancers, coronary heart disease, strokes and other diseases of the circulatory system
- More than 2,300 people die in Northern Ireland each year from smoking related illnesses (this equates to more than 6 people a day, 44 individuals every week)
- Latest research puts smoking prevalence at 24% amongst people aged 16 years and over.
- 77% of adult smokers started smoking in their teens or younger.
- In 2007, almost 9% of children aged 11 to 16 in Northern Ireland were current smokers

CHAPTER 1 Why do we need a tobacco control strategy?

1.1 Smoking remains the single greatest cause of preventable illness and death and is one of the primary causes of health inequality in Northern Ireland, causing over 2,300 deaths a year (almost one third of which are from lung cancer). Half of all long-term smokers will die prematurely from smoking-related disease, a quarter of these in middle age[1]. On average each person killed by a smoking-related illness loses between 10 and 15 years of their natural lifespan.

1.2 Over the past ten years we have made many inroads into reducing the harm caused by smoking, with latest figures showing that adult smoking prevalence is down from 29% in 1998/99 to 24% in 2009/10. However, smoking levels, especially amongst manual workers, remain very high.

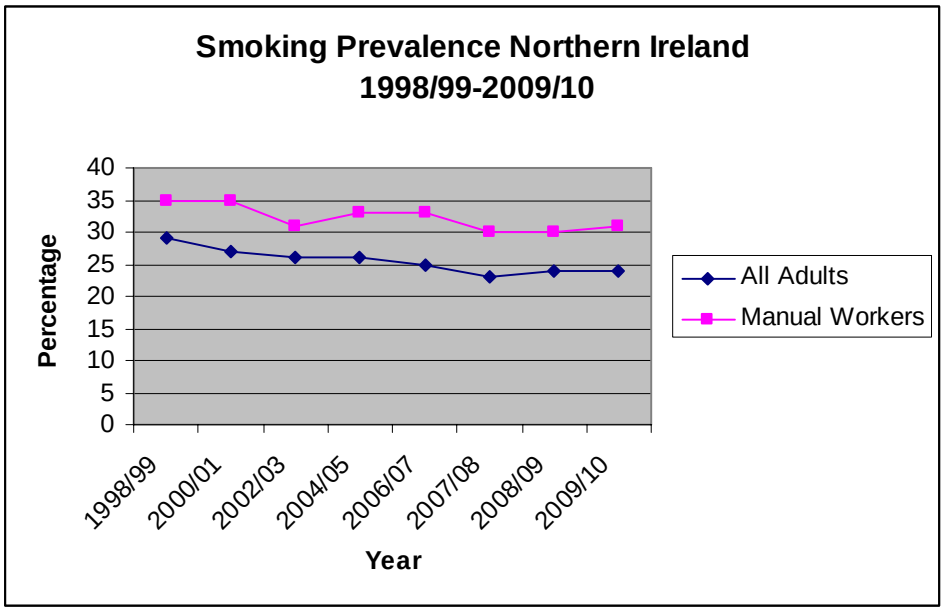


Figure 1: Smoking prevalence for all adults and for manual workers in Northern Ireland from 1998/99 to 2009/10[2]

1.3 The uptake of smoking by children and young people is also of major concern. Statistics reveal that almost 9% of 11 to 16 year olds in Northern Ireland are current smokers[3] and over three quarters of adult smokers in Northern Ireland started while in their teens, or younger[4].

1.4 It has been estimated that children who start smoking at age 15 are three times more likely to die of cancer due to smoking than the already high rate for a young person who takes up the habit in their mid twenties. Further measures must be introduced if we are to successfully tackle smoking by children and young people under 18 years of age. A key objective of the new Strategy is, therefore, to prevent people from starting to smoke.

Tobacco Action Plan 2003-2008

1.5 In 2003 the Department of Health, Social Services and Public Safety (DHSSPS) published the Tobacco Action Plan 2003-2008. The overall aim of the Plan was to create a tobacco-free society. The Plan had the following three main objectives:

- preventing people from starting to smoke;
- helping smokers to quit; and
- protecting non-smokers from tobacco smoke.

While aimed at the whole population, three target groups were identified – children and young people; disadvantaged adults who smoke; and pregnant women who smoke.

Table 1: Progress made on smoking prevalence rates from 2003

	Previous Strategy (2003)	Latest Figures (2010)
Adult prevalence	**27%**	**24%**
Manual Workers*	**35%**	**31%**
Pregnant Women	**22%**	**18%**
11-16 year olds	**14.5%**	**9%**

* The term *manual workers* covers the following socio-economic groups – skilled manual, semi-skilled manual, and unskilled manual – and is used to gauge smoking prevalence rates amongst people living in areas of social or economic disadvantage.

1.6 A multi-sectoral working group was established in 2009 to review the 2003-2008 Plan and to develop a new 10-year strategy for tobacco control in Northern Ireland. This draft Strategy reflects the working group's consideration of relevant research and evidence related to tobacco control, and its examination

of policy and practice at international level. The purpose of the document is to highlight the Department's current and emerging priorities and to set out the direction for the future of tobacco control. An action plan to accompany the Strategy will be developed by the Public Health Agency (PHA). A PHA tobacco workshop held in February 2010 will help to inform this. An evaluation framework will also be developed, against which the effectiveness of the action plan will be measured.

Recent developments

1.7 Since the publication of the Tobacco Action Plan 2003-2008, the DHSSPS, working in partnership with a number of organisations, has delivered a broad programme of tobacco control measures. These include:

- the introduction in Northern Ireland of smoke-free legislation from 30 April 2007, ensuring the population is protected from the harm caused by exposure to secondhand smoke in enclosed public and work places;
- raising the age of sale for tobacco products from 16 to 18 years;
- investing in the development of specialist smoking cessation services to make them available to greater numbers of smokers wishing to quit – almost 650 services are now available in a range of settings, helping over 66,000 people set a quit date between 2007/08 and 2009/10;
- making pharmaceutical smoking cessation interventions, including Nicotine Replacement Therapy (NRT), more widely available, including on prescription;
- continuing to provide comprehensive public information which reaches thousands of smokers on a regular basis; and
- the inclusion of smoking-related standards in three of the Department's Service Frameworks.

1.8 Tobacco control legislation is enforced by District Councils in Northern Ireland. Since the introduction of smoke-free legislation, increased funding has been provided by the Department to District Councils for an additional 12

Tobacco Control Officer (TCO) posts. The TCOs are based within the Environmental Health service and are tasked with a range of tobacco control duties including ensuring compliance with smoke-free legislation and coordinating enforcement action in relation to underage sales of tobacco products.

Smoking and inequalities

1.9 Addressing health inequalities is a high priority for the Northern Ireland Executive. Reducing smoking rates in our more disadvantaged communities represents one of the greatest challenges in public health but is vital if we are to make progress on closing the inequalities gap in health. Smoking rates are highest among people who earn the least and lowest amongst those on higher incomes.

1.10 However, this represents only part of the link between tobacco use and social and economic disadvantage. Studies have shown that smokers are more likely to live in rented accommodation, receive state benefits, have no access to a car, be unemployed or live in overcrowded accommodation. In addition, there is emerging evidence that those from disadvantaged backgrounds experience higher nicotine dependency than those from areas which do not experience economic or social deprivation.[5]

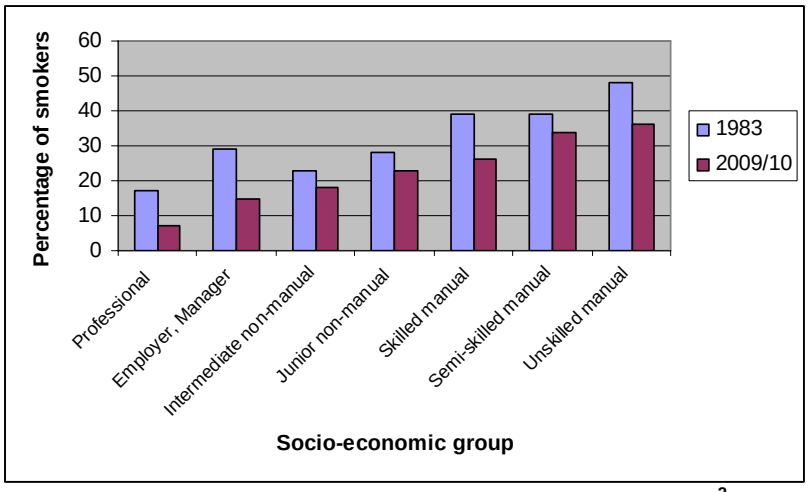
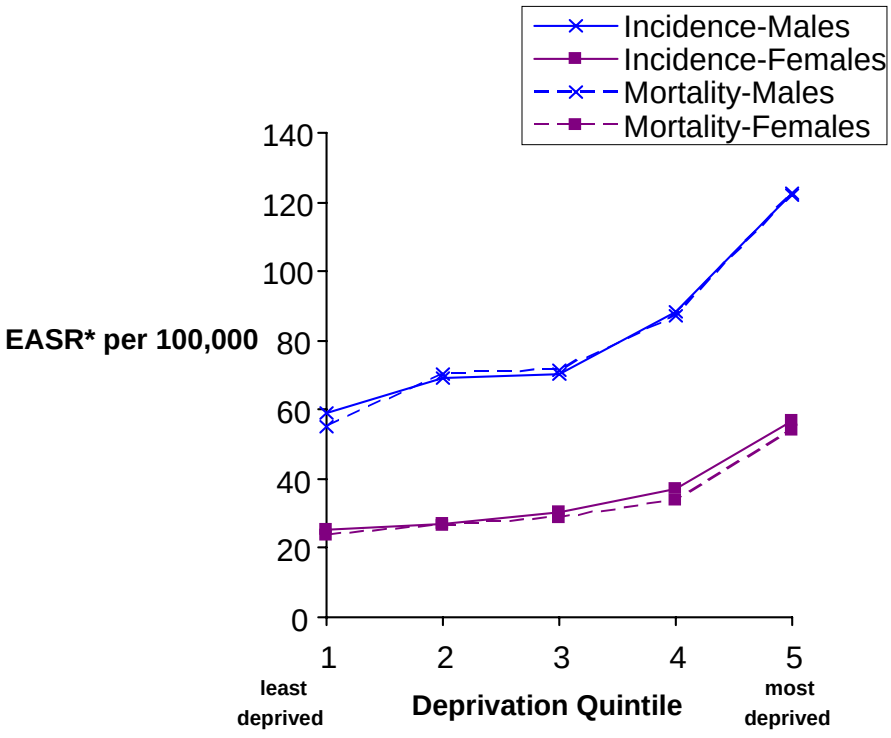


Figure 2: Smoking prevalence in Northern Ireland by socio-economic group[2]

1.11 Lower socio-economic status has also been linked to less successful quit attempts and having no intention to quit.[6] Societal factors influence quit attempts; a smoker living in an environment where several friends and family members smoke will have less motivation to give up, and receive less support in their efforts to stop. All these factors make it more difficult for those from deprived areas to stop smoking, and therefore contribute to the gap in health inequalities.

1.12 Although smoking rates have fallen in the last number of years, this has not occurred to the same extent in lower socio-economic groups (see Figure 2). In addition, children in lower socio-economic groups are more likely to be born to a mother who smokes, and suffer greater exposure to secondhand tobacco smoke and its harmful consequences during their childhood.

Figure 3: Lung cancer incidence and mortality by deprivation quintile[7]



***European age standardised rate**

Smoking in pregnancy

1.13 The Infant Feeding Survey 2005 shows that 32% of mothers in Northern Ireland smoked before pregnancy while 18% continued to smoke during pregnancy, indicating that 14% managed to quit. Those working in managerial or professional occupations were less likely to have smoked during pregnancy than those in routine or manual occupations. Even in cases where mothers didn't smoke, many were still exposed (and their unborn babies also) to secondhand smoke, with 37% of mothers in Northern Ireland living in a household where at least one person smoked during their pregnancy[8].

1.14 Smoking in pregnancy increases infant mortality by about 40%[9]. It is also associated with a number of complications for mother and baby including:-[10]

- Ectopic pregnancy
- Premature detachment of the placenta and premature rupture of the membranes
- Spontaneous abortion
- Premature delivery
- Low birth weight babies (on average 200 to 250g lighter than those of non-smokers) – a leading cause of infant death
- Foetal growth restriction
- Sudden Infant Death Syndrome (SIDS)
- Oral clefts

Smoking and mental health

1.15 There is a strong link between smoking and mental health disorders, with smoking being responsible for a large proportion of the excess mortality of people with mental illness[11]. Smoking occurs at much higher rates in this population group, with almost half of total tobacco consumption and smoking-related deaths occurring in those who suffer from a mental disorder[12]. Studies carried out in the UK have shown smoking prevalence amongst inpatients in

mental health units to be up to 70%, with around half of inpatients recorded as being heavy smokers[13]. Despite the very high smoking prevalence levels, large numbers of people with mental health conditions report that they would like to quit smoking.[14] Consideration should therefore be given as to how cessation programmes can be further developed to meet the specific needs of this group of people.

Death and illness from smoking

1.16 Smoking is the single greatest cause of preventable illness and premature death in Northern Ireland and it is estimated that it causes approximately 2,300 deaths each year. It is a major risk factor for a range of cancers, coronary heart disease, strokes and other diseases of the circulatory system. Smoking has also been attributed to being a major cause of health inequalities and is the principal reason for the gap in life expectancy between the most affluent and the poorest in our society.

Table 2: Estimated Number of Hospital [1]Admissions Attributable to Smoking in Northern Ireland - 2008/09

	Male	Female
Lung Cancer	1,823	1,187
Other Cancers	2,191	567
Chronic Obstructive Lung Disease	2,106	2,293
Pneumonia	508	440
Ischaemic Heart Disease	3,015	984
Cerebrovascular Disease	719	538
Aortic Aneurysm	240	83
Other Circulatory Diseases	18	10
Stomach / Duodenal Ulcer	302	342
Total Admissions	**10,921**	**6,445**

Attributable percentages for NI have been calculated by the Health Development Agency in England

[1] Deaths and discharges are used to approximate admissions; these figures should not be used to denote individuals, as a person may be admitted to hospital more than once in a year or across a number of years

1.17 Tobacco smoke contains over 4,000 chemicals, of which more than 50 are known to cause cancer in humans. A number of illnesses can be directly attributed to smoking, with lung cancer being the biggest killer. In 2008, there were 927 deaths from lung cancer in Northern Ireland, and the disease has now overtaken breast cancer in causing the largest number of cancer deaths amongst women in Northern Ireland.

1.18 Smoking is also a major factor in the development of a number of other types of cancer including cancer of the mouth, larynx, oesophagus, bladder, kidney, stomach, cervix and pancreas. It is linked both to chronic obstructive disease (e.g. bronchitis, emphysema) which caused almost 600 deaths in 2008/09, and Ischaemic Heart Disease, which killed almost 400 people during the same period[15].

1.19 The results of a review of 130 articles, carried out by the International Association for Research on Cancer (IARC) in 2009, have indicated that parental smoking has been found to be causally associated with childhood cancers - hepatoblastoma and childhood leukaemia. The results also identified that smoking is linked with breast cancer, having shown tobacco chemicals in mammary tissue in animal studies[16].

1.20 Smokeless tobacco, while not as harmful as the smoked form, is still a factor in a number of cancers including mouth, oesophageal, pancreatic, and liver cancer. It comes in a number of forms, the most common being chewing tobacco, and due to the high levels of nicotine contained within smokeless tobacco products, is as addictive as smoked tobacco. Prevalence of smokeless tobacco use in Northern Ireland is not known, however, as it is most commonly used by the South Asian population, it is thought that the extent of the problem here is relatively small.

Smoking and surgery

1.21 Any surgery carries risk, but for smokers who continue to smoke right up to the day of their surgery, the likelihood of suffering from complications both during and after the operation is increased[17]. Possible complications include:

- lung and heart problems;
- higher risk of post-operative infection;
- impaired wound healing; and
- longer hospital stay possibly with time spent in an Intensive Care Unit.

By stopping smoking some weeks prior to elective surgery, patients will be reducing post-operative risks, and will also be gaining a range of long-term health benefits from quitting. Due to the considerable costs involved in paying for additional hospital bed days, the Health and Social Care services would also benefit financially from investing in pre-operative smoking cessation services.

Why do people continue to smoke

1.22 Given all that we know now about the dangers of smoking, why do people continue to smoke? The highly addictive nature of the drug nicotine, which is found in tobacco, is the main reason. Psychological and habitual dependence also develop with the use of tobacco. The majority of smokers have their first cigarette as a teenager, and while they are aware of the dangers, they are at an age where any consequences of smoking appear to be a far distant threat.

1.23 Nicotine is a stimulant that increases a person's heart rate and affects many different parts of the brain and body. Addiction explains why giving up smoking can cause nicotine withdrawal symptoms, which include cravings, irritability, anxiety, difficulty concentrating, restlessness and disturbed sleep. Although most of these symptoms, which are related to the absence of nicotine in the body, will disappear within a few weeks of quitting, the behavioural dependence can take much longer to conquer.

Secondhand tobacco smoke

1.24 Secondhand tobacco smoke (also known as Environmental Tobacco Smoke or passive smoking) is a mixture of side stream smoke from the burning tip of a cigarette and mainstream smoke exhaled by a smoker. Secondhand smoke kills, and scientific evidence shows that there is no safe level of exposure. In 2004, the independent Scientific Committee on Tobacco and Health reported that exposure to secondhand smoke can cause a number of serious medical conditions including; lung cancer, heart disease, asthma attacks, childhood respiratory disease and sudden infant death syndrome. The World Health Organisation (WHO) has classified secondhand smoke as a known carcinogen[18].

1.25 Young children are especially vulnerable to secondhand smoke as they have a higher relative ventilation rate, which in turn leads to higher internal exposure. The greatest exposure to secondhand smoke is likely to occur in the child's own home from the smoking habits of parents and older siblings, or in family cars. Smoking in the presence of infants and children puts them at increased risk of sudden infant death syndrome, ear problems and more severe asthma. It can also cause acute respiratory infections and slows lung growth in children.

Economic costs of smoking

1.26 There are a number of diseases of which smoking is recognised as being a contributable factor and treating these diseases costs the Health and Social Care in Northern Ireland millions of pounds each year. Latest available figures for 2008/09 show that the annual hospital cost for treating active smokers for the three main smoking related diseases - Lung Cancer, Ischaemic Heart Disease and Cerebrovascular Disease - is approximately £50m.

1.27 Whilst these three diseases are the ones most closely linked with smoking, there is evidence that smoking is a contributory factor in a range of

other circulatory and respiratory diseases. The estimated hospital costs associated with these additional smoking-related diseases is approximately £69m. The total Northern Ireland hospital costs of treating smoking related diseases is therefore in the region of £119m per annum[19].

1.28 A study which looked at the hospital costs (2005 figures) of lung cancer patients, found them to be around £5,900 per patient over a 12 month period[20]. Other unknown costs to the economy, comprising sickness and invalidity benefits, accidents/damage caused by house fires, and the costs to industry of lost productivity must also be taken into account.

National and international developments

1.29 In May 2003, the WHO Framework Convention on Tobacco Control became the first treaty to be adopted under article 19 of the WHO constitution. The treaty came into force on February 27, 2005 and was signed by 168 countries. The Framework Convention on Tobacco Control is a supranational agreement that seeks "to protect present and future generations from the devastating health, social, environmental and economic consequences of tobacco consumption and exposure to tobacco smoke"[21] by enacting a set of universal standards stating the dangers of tobacco and limiting its use in all forms worldwide. The Treaty addresses tobacco industry marketing campaigns executed simultaneously throughout different countries, and cigarette smuggling that is often co-ordinated by the tobacco industry in many countries.[22]

1.30 WHO developed the MPOWER package to help countries to implement the FCTC. The MPOWER package contains six tobacco control measures of proven cost-effectiveness and ability to save lives. To implement the MPOWER package, Northern Ireland needs to:

- **M**onitor tobacco use
- **P**rotect people from tobacco smoke
- **O**ffer to help quit tobacco use

- **W**arn about the dangers of tobacco
- **E**nforce bans on tobacco advertising and promotion
- **R**aise taxes on tobacco products

1.31 While raising taxes on tobacco products is outside of the remit of the Northern Ireland Assembly, the Department can support the UK government in any efforts to achieve this. The other five measures listed as part of the MPOWER package all currently form part of the Department's tobacco control policy.

1.32 In the Republic of Ireland, further provisions of the Public Health (Tobacco) Acts 2002 and 2004 were commenced on 1 July 2009. They included a ban on the display of tobacco products in retail outlets, further restrictions on the sale of tobacco from vending machines, and an order for all retailers selling tobacco to register with the Office of Tobacco Control. Other countries to introduce a ban on the display of tobacco products include Iceland, Norway and Canada, with a number of states in Australia planning to introduce bans between 2010 and 2013.

Health Act 2009

1.33 The Westminster Health Act, which was granted Royal Assent on 12 November 2009, contains a number of tobacco related provisions which also extend to Northern Ireland. The Act bans the display of tobacco products at point of sale and provides UK Departments (excluding Scotland) with powers to make regulations banning the sale of tobacco from vending machines.

Illicit cigarette trade

1.34 The UK has a large illicit cigarette trade with the tobacco industry often stating the cause for this being the government's high tax policy, however smuggled cigarettes typically sell for half the price of duty paid products and appear to be readily available, particularly in areas of social deprivation. The

illicit cigarette trade includes both large scale commercial smuggling and smaller quantities of cigarettes brought into the country for non-personal use. Products can either be genuine or counterfeit. From the most recent figures published (2007/08), it is estimated that in the UK illicit cigarettes accounted for 10% of the market share of all cigarettes smoked.

1.35 HM Revenue & Customs (HMRC) are working in partnership with the UK Border Agency to improve the detection of illicit tobacco at the UK border and beyond. Their joint strategy, *Tackling Tobacco Smuggling Together,* was published in November 2008. Some success has been achieved to date with a total of 1.8 billion illicit cigarettes destined for the UK market seized in 2008/09. In one instance in Northern Ireland in July 2009, HMRC seized 8.5 million cigarettes, worth an estimated £5m at Belfast docks which were smuggled in a shipping container from China.

1.36 Since publication of the 2003-2008 Tobacco Action Plan, the illicit cigarette market has actually declined. However the purchasing of smuggled and counterfeit cigarettes remains a significant problem in many areas/communities. While this is primarily a matter for HM Revenue & Customs, the Department cannot ignore the fact that the availability of contraband tobacco invalidates significantly the positive impact, in terms of reduction in smoking prevalence, which may have been made by tax increases on tobacco. The availability of illicit tobacco helps to support people in a smoking habit which they may otherwise not have been able to afford.

CHAPTER 2 Aim of the Strategy

Overall aim: To create a tobacco-free society.

2.1 Because nicotine is highly addictive, it will take considerable time to achieve the ultimate goal of a tobacco-free society. It is therefore recognised that this 10-year Strategy represents another major step in a longer-term drive to tackle the harm caused by tobacco. Significant progress has been made in Northern Ireland since the Tobacco Action Plan 2003-2008 was published in June 2003. Smoking prevalence amongst adults has decreased from 27% to 24% thanks to a range of measures developed by the Department and its partner organisations. There is still much we can learn from best practice in other countries in order to reduce prevalence rates further, particularly amongst people who experience economic and social disadvantage.

Objectives

2.2 The key objectives are: -

- fewer people starting to smoke;
- more smokers quitting; and
- greater protection from tobacco-related harm.

2.3 These objectives will only be achieved if a co-ordinated, multi-disciplinary approach is adopted across Northern Ireland. Focus will remain on –

- Further development of legislative controls focusing on the advertising, marketing and sale of tobacco products.
- The provision of comprehensive public information, aimed at preventing and discouraging tobacco use, backed up by educational programmes targeting children and young people in particular.
- Increasing the range of smoke-free locations not currently covered by the Smoking (Northern Ireland) Order 2006.
- Motivating and assisting smokers who wish to quit.

Values and principles

2.4 The values and principles adopted by this Strategy are as set out in "*Investing for Health*". They include:

- health as a fundamental human right;
- actively pursuing equality of opportunity and the promotion of social inclusion;
- reducing social inequalities;
- maximising opportunities for individuals to protect and improve their own health;
- focusing public policies towards improving health and well-being;
- encouraging community involvement in improving health; and
- partnership working.

Priority groups

2.5 This Strategy is aimed at the entire population of Northern Ireland. Smoking, and its harmful effects, cut across all barriers of class, race and gender. However, three priority groups have been identified as requiring more focused action. They are:

Children and young people

2.6 We know from recent surveys[4] that over three-quarters of our smoking population took up the habit regularly whilst in their teens or younger. Therefore, a main priority for the Strategy must centre around preventing children and young people from making the life altering decision to take up smoking.

2.7 Children and young people are more vulnerable, not only to efforts by the tobacco industry to recruit them as the new generation of smokers, but also to the harmful effects of secondhand smoke. "Looked after" children and young people appear to have particularly high smoking prevalence rates with a study

carried out in England revealing that 7 out of 10 children in residential care homes are regular smokers[23].

2.8 Surveys which look at smoking behaviours in relation to 11-16 year olds reveal that young girls are more likely to be current smokers than boys the same age[3]. This situation changes during adulthood, when smoking prevalence between the two sexes is recorded as being more or less equal.[2]

2.9 Consideration must also be given as to how to protect children from being exposed to secondhand smoke in their homes and in cars. This is considered in more detail in chapter 5 of the strategy.

Disadvantaged people who smoke

2.10 Among certain social groups, high smoking prevalence is endemic. Smoking remains a particular problem for people living in areas of social or economic deprivation. Almost one in four adults smoke in Northern Ireland but this figure is closer to one in three for those working in manual occupations. Death rates from tobacco are two to three times higher in disadvantaged social groups[24]. Smoking, more than any other factor, is responsible for the gap in life expectancy between those most in need and those with the most advantages.

2.11 As well as people living in areas of social or economic deprivation, the term “disadvantaged adults” includes other social groups such as:

- people suffering from mental illness;
- people serving custodial sentences in prisons or in young offenders’ institutions; and
- immigrants to Northern Ireland from countries where tobacco control policy is less advanced.

2.12 In order to ensure that the special needs of this priority group are met, smoking cessation services will need to be tailored to make them more accessible and to encourage greater uptake.

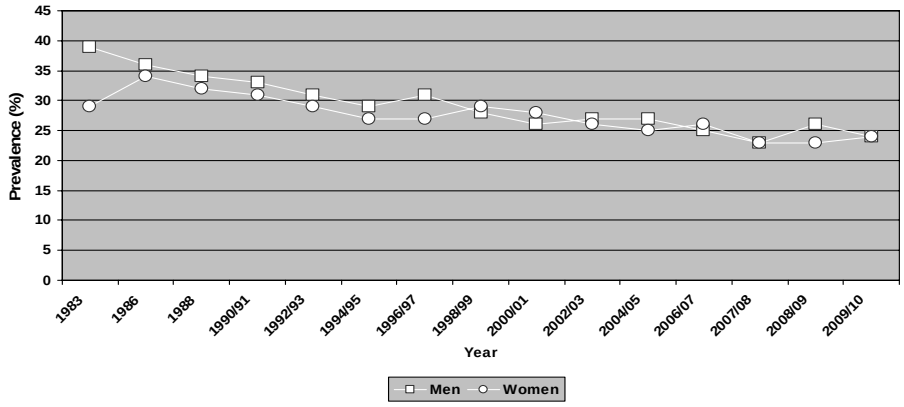
Pregnant women who smoke

2.13 The 2003-2008 Tobacco Action Plan included a target to reduce the percentage of pregnant women who smoke from 22% to 18%. While the Infant Feeding Survey 2005 confirmed that this had been achieved in Northern Ireland, the current level of smoking prevalence amongst pregnant women remains too high. There were almost 25,000 live births in Northern Ireland in 2009 (provisional figures)[25]. If we consider that approximately 18% of pregnant women continue to smoke during pregnancy, that equates to approximately 4,500 women.

Future Aspirations

2.14 The Northern Ireland Statistics and Research Agency has been gathering information on smoking prevalence rates since 1983 through the Continuous Household Survey. In that period, adult smoking prevalence has dropped from 33% to 24% (2009/10). This decline has been relatively slow and without further robust tobacco control and smoking cessation measures, further decline will continue to be slow. However, given certain conditions, significantly greater inroads could be made into reducing smoking prevalence in Northern Ireland.

Figure 4: Prevalence of smoking 1983 – 2009/10



2.15 These conditions include the full commitment of relevant partners from the public, private and voluntary sector, and the availability of the necessary resources required to implement new policies. If we accept that these conditions will be met, then the Department aspires **by 2020** to:

- reduce the proportion of 11-16 year old children who smoke to 3%;
- reduce the proportion of adults who smoke to 15%;
- reduce the proportion of pregnant women who smoke to 9%;
- reduce the proportion of smokers in manual groups to 20%; and
- to ensure that a minimum of 5% of the smoking population in Northern Ireland, accesses smoking cessation services annually.

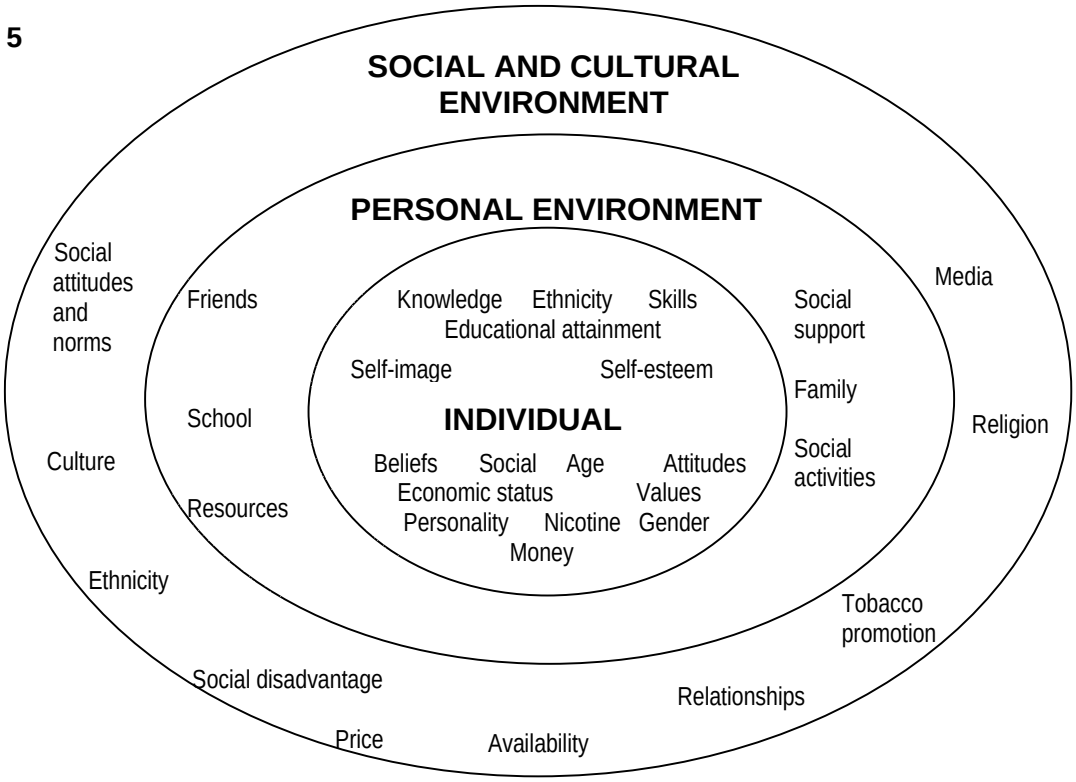
CHAPTER 3 Fewer People Starting to Smoke

Introduction

3.1 Every year in Northern Ireland, thousands of young people take up smoking despite being aware of evidence that proves it is harmful to their health. These young people are taking the place of the thousands of smokers who die due to smoking each year, and unless serious inroads are made into youth smoking prevalence, the aim of a tobacco-free society will never be realised.

3.2 Considerable research has been carried out into the reasons behind youth smoking. Many studies have shown that young people are more likely to smoke if one or both of their parents smoke[26], or if they share a house with someone who smokes[27]. A review carried out into youth smoking in England in 2009[28] identified three levels of influence around young people starting and continuing to smoke. These levels - individual, social and community, and societal - are further explained in figure 5 below.

Figure 5



3.3 In order to have an effective tobacco control strategy, a number of key elements must work together to achieve a society where smoking is no longer perceived to be the norm. Only through the denormalisation of smoking as an activity, will attitudes and consequently behaviours change, resulting in fewer people taking up the habit. This process has already started, with many smokers now making a conscious decision not to smoke in certain private areas or in front of children. This must now be built on, to put tobacco even more firmly out of sight.

3.4 Preventing people, particularly children and young people, from starting to use tobacco will require co-ordinated activity involving a partnership approach with the statutory, voluntary, community and private sectors. It requires a range of measures in the following key areas:

- reducing the impact of tobacco promotion;
- raising awareness - about the effects of tobacco smoke on smokers' and non-smokers' health – through public information and education; and
- reducing availability of tobacco to children and young people.

Tobacco promotion

Advertising

3.5 The tobacco industry is huge and like all industries, in order to attract new clients, it relies heavily on product promotion. The BMA Board of Science 2008 study which looked at the influence of smoking imagery on young people stated that *tobacco marketing in all its forms is a central influence on the initiation and continuance of youth smoking*[29].

3.6 Avenues open to tobacco companies to advertise their existing and new brands have been shrinking from 1965, when the government first moved to ban the advertising of cigarettes on television. The ban was extended to cover loose tobacco and cigars from 1991.

3.7 Since then, various pieces of tobacco control legislation have been introduced which have resulted in the following forms of advertising being banned in the UK:

- Billboards, newspapers and magazines (2003)
- All tobacco related sponsorship agreements (2005)
- Advertising of tobacco products at point of sale and brandsharing (2005)

3.8 Children are particularly influenced by advertising and promotion of tobacco products. A recent Cancer UK funded report[30] found that in 2006, almost half of UK teens were aware of tobacco marketing at point of sale. The hard truth is that tobacco companies need children to respond favourably to their promotional efforts in order to replace smokers who have either quit or died. The Department would be supportive of further measures introduced to reduce the influence of tobacco advertising and promotion upon children.

Point of sale displays

3.9 Point of sale displays of tobacco products in retail outlets remain one of the few advertising options left open to tobacco companies. Following the ban on advertising and promotion of tobacco, retail displays have become larger - so much so that they are now a source of promotion of smoking to children and adults alike. Research shows that children and young people are particularly susceptible to advertising and those exposed to tobacco advertising and promotion are more likely to take up smoking[24].

3.10 In order to protect children and young people from the ubiquitous influence of tobacco promotion, the Department has plans to introduce legislation in 2011 which will see point of sale displays removed from shops. While retailers will still be able to sell tobacco products, they will not be permitted to have them on general view, ensuring that large brightly lit cigarette gantries will become a thing of the past. The new measures will also support ex-smokers as point of sale displays can prompt impulse buys and undermine efforts to quit.

Smoking in the media

3.11 The way that smoking is portrayed by the media in films and on television, is often more advantageous to tobacco manufacturers than it is to anti-tobacco campaigners. Smoking onscreen is rarely portrayed in an unattractive manner, or associated with negative consequences. While guidelines in relation to smoking have been established by the communications regulator, Ofcom[31], these are often not rigorously applied. The UK government and Ofcom have committed to working with the British Board of Film Classification in order to ensure a consistent approach across the board.

Raising awareness

3.12 Few people in Northern Ireland today could claim to be unaware of the harm caused by smoking. However, despite widespread public knowledge, it is important to continue to develop sustained public information and education campaigns to raise awareness of issues relating to tobacco use, such as the health risks to smokers and non-smokers. Another important aspect is to counter promotional activities carried out by the tobacco industry, which despite considerable legislative restrictions, are still successful at recruiting thousands of new smokers in our country every year.

New media

3.13 Developments in technology mean that there are many new approaches to targeting potential audiences. These should be exploited to the full when addressing ways of getting the "no smoking" message across. An example is the US anti-smoking campaign "TheTruth.com" which features hard-hitting advertisements aimed mostly at young people. The 2009 campaign used reality television stars who would be easily recognizable by young viewers and featured an interactive website which would also appeal to this generation. The use of

social networking sites such as Facebook and Twitter should also be exploited to target young people.

Public information

3.14 The Public Health Agency has responsibility for developing public information campaigns for tobacco control in Northern Ireland. In the past ten years, several successful campaigns were launched by the former Health Promotion Agency, including the "Every cigarette is doing you damage" campaign and the "Passive smoking – there's nothing passive about it" campaign which was launched in advance of the introduction of smoke-free legislation. Evaluations of both campaigns, which included advertisements on television, radio and the printed media, as well as being covered on the HPA website, revealed high levels of awareness by the target audience.

3.15 The campaigns were supported by three websites, which are regularly updated. The first www.up-2-you.net is aimed at children and young people and provides information and advice on a range of issues affecting the target age group including smoking, drinking and drug abuse. The second – http://www.spacetobreathe.org.uk/ was developed in the lead up to smoke-free legislation in Northern Ireland. This website provides guidance on the legislation, the dangers of secondhand smoke, and advice for people wanting to quit smoking. The third site www.want2stop.info concentrates on providing support and help in relation to smoking cessation. In 2009/10, the website aimed at children and young people received over 10,000 hits, with the other sites receiving over 5,000 hits each.

3.16 Meaningful engagement with children and young people is essential in order to influence future decisions around smoking. An initiative aimed at 9-11 year olds, - *Smokebusters* - has been rolled out by the Ulster Cancer Foundation since 1988. The initiative has three main aims:

- To encourage young people to reject the smoking habit by increasing their defences against pressures to experiment with cigarettes.
- To provide information to children about the harmful consequences of smoking.
- To encourage young people to get involved in enjoyable activities to promote a smoke-free environment in their school, home and community.

3.17 An evaluation of the project by the University of Ulster in 1997 showed its effectiveness in delivering important information on many of the consequences of smoking to Key Stage Two pupils as well as influencing their future smoking knowledge, attitudes and behaviour. This project is being developed with increased emphasis on schools listed within areas of social and economic deprivation.

3.18 New and innovative approaches to public information need to be considered to ensure that the intended health messages are being filtered through. The emphasis and resources should be directed at preventing children and young people from starting to smoke. As high profile information campaigns are expensive, and often only run during certain months of the year, it is important to build partnerships with interested organisations – such as relevant charities, health and fitness centres, schools and district councils - and exploit unpaid media opportunities at other times. Young people are heavily influenced by role models, therefore, the involvement of local television and sporting personalities could be explored further.

Education

3.19 In order to make an impact on young people's attitudes to smoking, it is important to educate and inform children on the harm caused by tobacco from a very early age. By including health information right through from primary school to undergraduate courses, we can help to prepare children to develop some

resistance to the influential messages which the tobacco industry's marketing divisions produce on a daily basis.

3.20 Educational establishments, from primary to tertiary, are ideally suited for the delivery of health promotion messages - either formally, through the curriculum or on a more ad-hoc basis, using extra-curricular activities. The Department of Education (DE) had issued two circulars on smoking, one to schools and the second targeted at youth organisations, encouraging them to adopt smoke-free environments. As these circulars were issued before the introduction of smoke-free legislation in 2007, they are due to be reviewed by DE.

SUMMARY OF EDUCATIONAL RESOURCES AVAILABLE TO TEACHERS AROUND SMOKING (DN - This will show up as a greyed out table in the Strategy)

Primary

Living.Learning.Together. is a resource which provides primary teachers with support in planning, teaching and assessing Personal Development and Mutual Understanding (PDMU).

Year 1 to Year 4

The focus is on general health and well-being.

Year 5 Unit 3: Stay Safe and Healthy

Activity 4: Smoking - Making responsible and informed decisions based on accurate information.

Year 6 Unit 3: Healthy Habits

Activity 2: Smoking: What do you think? - Children explore the effects of smoking through the use of a questionnaire.

Activity 3: Don't make it a habit - The options and consequences of choices are explored.

Year 7 Unit 3: Fit for the Future

Activity 3: Secondhand smoke - Positive, healthy attitudes towards a smoke-free environment are developed.

Activity 4: What is a drug? - Accurate knowledge about drugs is provided to ensure clearer decision-making.

Activity 6: Let's do something -Children examine the implications of peer pressure.

Post-primary - Key Stage 3

InSync is a resource for exploring Personal Development issues at Years 8, 9 and 10. In general, aspects of drugs education (including tobacco) are covered in InSync under Theme 10 'Drugs Awareness'. Activities that specifically focus on aspects of smoking and the drug nicotine include:

Year 9 Unit 10

Activity 2: 'What do you know about smoking?'

Year 10 Unit 10

Activity 2: 'Counting the cost'.

Education and Library Boards' Drugs and Alcohol Education Officers also provide training and support for teachers in providing drugs education.

Outside of the curriculum, the Extended Schools (ES) programme provides resources for almost 500 schools serving areas of the greatest social disadvantage to provide a wide range of extracurricular services and activities. These include numerous health promotion events and tobacco awareness programmes which highlight the dangers of smoking, offer advice and support on stopping and measures aimed at preventing the uptake of smoking for pupils, their families and the local community. A number of schools also offer specific smoking cessation classes.

Restricting sales to children

3.21 Research carried out in 2007 showed that almost 9% of children aged between 11-16 years old in Northern Ireland are current smokers. This is in spite of the fact that the minimum age of sale for tobacco products was 16 until new legislation increased it to 18 in September 2008. While friends and family continue to be a regular source of tobacco for children, a survey carried out in England in 2008 revealed that for 55% of regular child smokers, shops are a usual source of cigarettes, while 12% access the product through tobacco vending machines[27].

3.22 In recent years, councils have stepped up their efforts in relation to underage sales. In 2009/10, test purchasing exercises were carried out in a total

of 457 premises, with further action taken in 88 cases. While the majority of tobacco retailers in Northern Ireland are aware of the legislation with regards to underage sales of tobacco products and act responsibly to ensure that they do not breach this law, test purchasing exercises carried out by councils have shown this is not always the case

3.23 Early in 2010, the Department consulted on plans to introduce stronger sanctions against retailers who regularly flout the law with regards to underage sales. The consultation paper included proposals for a negative licensing scheme which would see repeat offenders losing their legal right to sell tobacco products for a period to be determined by the Northern Ireland Courts Service. The proposed measures will bring Northern Ireland into line with England, Wales and the Republic of Ireland, all of whom introduced similar laws from 2009. Scotland is also planning similar action under the Tobacco and Primary Medical Services (Scotland) Act 2010.

3.24 Legislation which will see an end to tobacco vending machines in Northern Ireland is also being progressed. While only 1% of adults regularly use such machines in Northern Ireland, the British Heart Foundation estimates that approximately 850 11-15 year olds use them on a regular basis. These machines, which have already been removed from all council owned properties, are still widely available in pubs and hotels and are often to be found in areas largely unsupervised by staff. The complete removal of tobacco vending machines will make it more difficult for children and young people to access cigarettes.

Increasing taxes on cigarettes

3.25 Increasing taxes on cigarettes would present another opportunity for restricting sales to children. Smoking is already an expensive habit, particularly for young people and those from lower socio-economic groups, and there is evidence linking a reduction in smoking prevalence with an increase in the

product price[32]. While tax increases are not within this Department's discretion, we would support proposals by the UK government to introduce above inflation increases in duty on all tobacco containing products.

Illicit cigarette market

3.26 There may be potential for further awareness raising which will alert smokers who purchase illegal cigarettes to certain key facts about this activity. Awareness campaigns could focus on the fact that illegal cigarettes are often counterfeit and therefore are manufactured in uncontrolled and unregulated conditions. Another perspective which may deter potential purchasers is the fact that very often sales of illegal cigarettes fund other forms of organised crime. Awareness raising to influence public attitudes towards illicit cigarettes would need to be considered by DHSSPS in conjunction with HM Revenue and Customs, and other government departments.

CHAPTER 4 MORE SMOKERS QUITTING

Introduction

4.1 Helping smokers to quit is a key priority for the Department. By successfully quitting, a person not only reduces their personal risk of harm, but also contributes to the protection of others from secondhand smoke and promotes good role modeling behaviour, which in turn encourages prevention. In a recent survey carried out in Northern Ireland, more than three-fifths of current smokers said they wanted to quit[33]. However, as nicotine is a highly addictive substance, the desire to quit is very often not enough, and the majority of smokers will attempt to quit several times before achieving their aim.

Service development

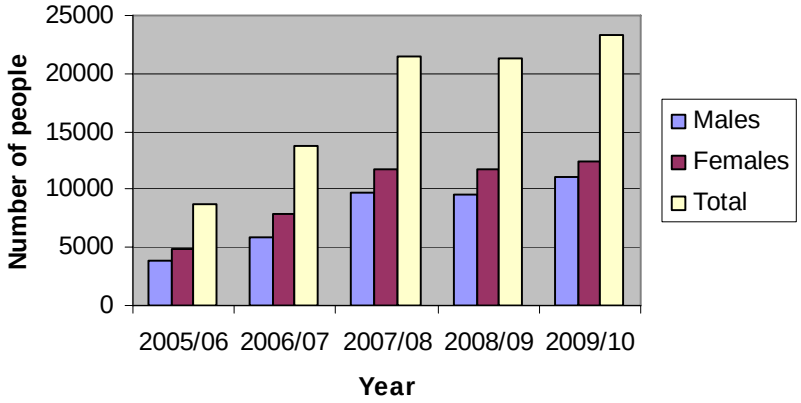
4.2 Considerable funding has been invested in recent years towards the development of smoking cessation services. There are currently almost 650 specialist smoking cessation service providers registered with HSC Trusts. Around half of these are community pharmacies. Other settings include hospitals, GP surgeries, community centres, voluntary agencies, schools and workplaces.

4.3 This increase in service provision has been justified by substantial increases in the number of smokers setting a quit date - up from 8,702 in 2005/06 to 23,383 in 2009/10 (figure 6). Another initiative, the annual No Smoking Day, also provides the incentive required for thousands of people each year to make the move towards quitting smoking.

4.4 If an impact is to be made on reducing prevalence amongst the hardcore group of smokers, this level of activity on smoking cessation must at the very least be sustained. Smoking prevalence amongst the manual workers subset remains very high. In response to this, the Public Health Agency has developed an Action Plan aimed at improving access to smoking cessation support for

manual workers which is being rolled out over a two year period ending in March 2011. This work will need to be continued beyond that date.

Figure 6: The number of people setting quit dates in Northern Ireland from 2005/06 to 2009/10



4.5 The provision of a range of accessible smoking cessation services will only be effective if these services are widely promoted. A number of well received public information campaigns have been run in recent years which have included television, radio, online and poster advertising as well as a text service that provides smokers with help and advice.

4.6 In order to reduce smoking prevalence rates further, the public must continue to receive targeted and accurate information about the dangers of smoking. This must be supported by information on how to access accredited cessation services for help and support to quit. Further consideration should also be given to the development of a single "brand" to be adopted by all HSC cessation service providers.

Referrals by Health and Social Care (HSC) Services

4.7 For those smokers who suffer from a life-limiting or life-threatening illness, such as Chronic Obstructive Pulmonary Disorder or cancer, it is important that they are given every help to quit. The Department has recently developed a number of service delivery frameworks for the HSC sector in order to improve the way that health and social care is planned, commissioned and delivered in

Northern Ireland. A number of these service delivery frameworks include standards which are related to smoking. The standards state that:

- the HSC should work in co-operation with voluntary, education, youth and community organisations to prevent recruitment of young people to smoking; and
- all HSC professionals should identify people who smoke, make them aware of the dangers of smoking, advise them to stop and provide information, and then to signpost to the well-developed specialist cessation services available.

They can be found in the following three frameworks: Cardiovascular Health and Wellbeing; Respiratory Health and Wellbeing; and Cancer Treatment and Care.

Support to quit

4.8 There are a number of effective interventions available to support and encourage people to quit smoking. The two main forms are:

- brief opportunistic advice; and
- specialist cessation interventions.

Public information campaigns also play a part, both by stimulating interest in quitting and by signposting smokers to help and support.

4.9 Normal healthcare contact with patients/clients provides an excellent opportunity for healthcare professionals to offer **brief opportunistic advice** on giving up smoking. **Specialist cessation interventions** are usually in the form of clinics, or one-to-one sessions and are delivered by trained specialists who have received recognised training that meets the Regional Training Framework standard for this role.

4.10 Brief intervention training has been comprehensively rolled out across many disciplines, not only in the health service, but also among other groups involved in working with young people. Professions now routinely offered training include doctors, nurses, pharmacists, dentists, youth workers, and teachers. However, further work is required in terms of ensuring that the training is

effectively applied and that the relevant professionals are taking advantage of opportunities when they are presented to them. Consideration should also be given to extending brief intervention training to include health visitors and midwives.

4.11 New quit kits which were piloted by NHS Stop Smoking services in England, have also been made available in Northern Ireland. Other developments being rolled out in different parts of the UK such as "stop shops" will be monitored with a view to similar schemes being adopted locally.

Smoking cessation medicines

4.12 There are currently three stop smoking medicines approved by the National Institute for Health and Clinical Excellence. They are: Nicotine Replacement Therapy (NRT); bupropion (Zyban) and varenicline (Champix). Following a review in 2005[34], NRT was declared as safe for use by adolescents aged 12+, pregnant women and people with cardiovascular disease. The non-nicotine containing products, bupropion and varenicline, both help to reduce the craving for nicotine and are only available on prescription.

Table 3: The relative impact of a variety of evidence-based stop smoking interventions and pharmacotherapies upon four-week quit rates

Four-week quit rates	No medication	NRT	Bupropion	Varenicline
No support	16%	25%	28%	37%
Individual behaviour support	22%	37%	39%	52%
Group behavioural support	32%	50%	55%	74%

(Table source: Cochrane Database of Systematic Reviews[35])

Other support systems

4.13 A pilot for a new smokers' helpline commenced in January 2011. The helpline provides a confidential service tailored primarily to the needs of adult smokers seeking help and advice to stop smoking. Services provided range from

dealing with requests for quit kits, to information on local cessation services. Callers with more complex needs can be offered more specialised counselling. This service will be monitored and reviewed by the Public Health Agency in order to evaluate the type of service required by an effective smokers' helpline. Another option for people seeking advice on giving up smoking, is to refer to the PHA website for tips on quitting. A wide range of printed materials on quitting smoking is also produced by the PHA, and these are available in a number of healthcare and community settings.

NRT and harm reduction

4.14 Levels of tobacco addiction vary and some smokers, in spite of frequent and determined efforts to quit smoking, find it impossible to completely stop the habit. In such cases, harm reduction schemes can reduce the risks to health through the regular substitution of tobacco with NRT products. Recent licensing changes have seen the indication for an NRT Inhalator product being extended to include harm reduction. This development will inevitably lead to other companies seeking to have the status of their licensed NRT products similarly extended.

4.15 There are a number of products currently on the market which claim to contain nicotine including some electronic cigarettes and topical gels. These products are widely available but are not licensed medicines and have therefore not been tested for safety, quality and efficacy. It is the intention of the Medicines and Healthcare Regulatory Authority (MHRA) to bring all such nicotine containing products – with the exception of tobacco and tobacco products - within the medicines licensing regime. This would require all currently unlicensed nicotine containing products on the market to apply to the Medicines and Healthcare products Regulatory Agency (MHRA) for a medicines marketing authorisation.

Current guidance on smoking cessation services

4.16 NICE has produced a number of public health guidance documents for professionals on smoking cessation services including guidance on:

- brief intervention training[36];
- workplace interventions to promote smoking cessation[37];
- smoking cessation services covering a range of settings and aimed at priority groups[38];
- quitting smoking in pregnancy and following childbirth[39]; and
- school-based interventions to prevent smoking[40].

4.17 In addition, the National Health Service (NHS) produced its own service and monitoring guidance for 2010/11[41]. While this document offers best practice guidance relevant to the provision of all NHS stop smoking interventions, it is also a useful tool for all service providers in Northern Ireland.

4.18 The *Training Framework for Smoking Cessation Services in Northern Ireland 2003* sets standards for Health and Social Care services in relation to service provision. The framework is also promoted as best practice among all individuals involved in developing and running smoking cessation services. While still a very relevant document, given new developments and guidance issued in this area in recent years, an updated framework is now required. Only services which comply with the standards in the Framework may be commissioned by the HSC and these services should be formally accredited.

Self Quitters

4.19 While smoking cessation services are crucial, and evidence has shown that smoking cessation treatment is one of the most cost-effective interventions in modern medicine[42], research shows that two-thirds to three-quarters of ex-smokers stop unaided[43]. The most common methods used by successful ex-smokers are “cold turkey”, and reducing-then-quitting. Whilst recognising that for

many people assistance to quit will be vital, it would also be useful to deliver the message that the majority of quitters go it alone.

Table 4: Outcome after 8 months of 1 million smokers quit attempts[44] (California)

	Quit	Still smoking	
Professional help +/- NRT	**33,014 (19.7%)**	**134,986 (80.3%)**	**168,000 (100%)**
Self-help only, no NRT	**60,999 (7.3%)**	**771,001 (92.7%)**	**832,000 (100%)**
Total	**94,013**	**905,987**	**1,000,000**

Priority Groups

4.20 It is important that cessation services, provided to advise and support smokers in their quit attempts, are properly targeted. For the priority groups identified in this Strategy, a range of services tailored to meet their specific requirements is necessary in order to reduce smoking prevalence.

4.21 The particular requirements of other groups such as those from an ethnic minority background, those with a disability, and those from the rural community, also need to be addressed by smoking cessation service providers.

Children and young people

4.22 The percentage of 11-16 year olds in Northern Ireland who smoke has decreased significantly from 14.5% in 2000 to 8.8% in 2007. This is a positive indication that efforts invested in prevention have been effective to a degree. However, despite being fully aware of the dangers of smoking, 24% of children in 2007[3] reported having smoked at least once, with the highest percentage of children reporting that they smoked their first cigarette at the age of 13 years old (figure 7).

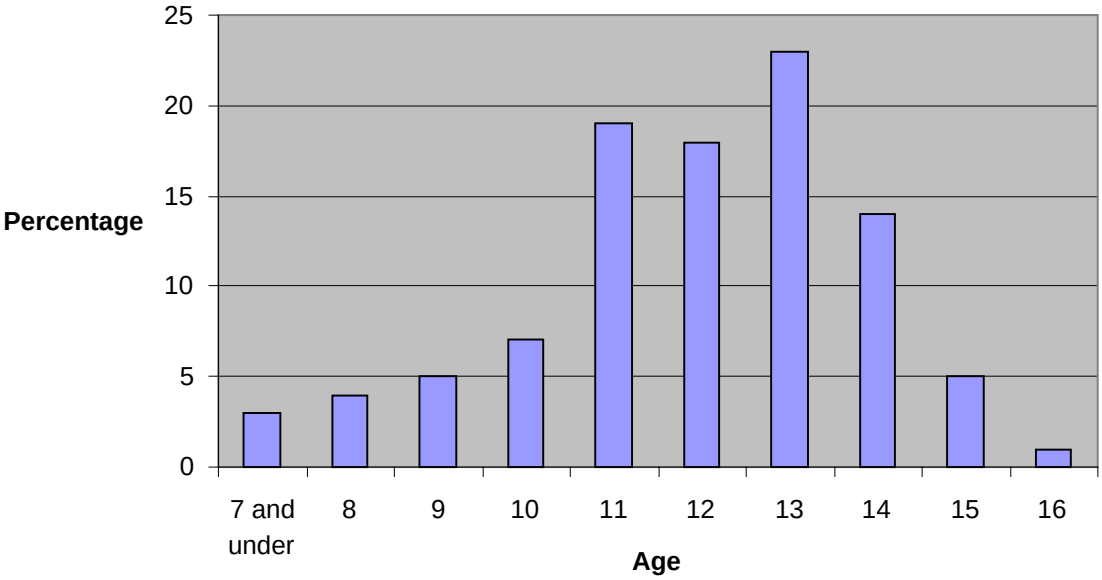
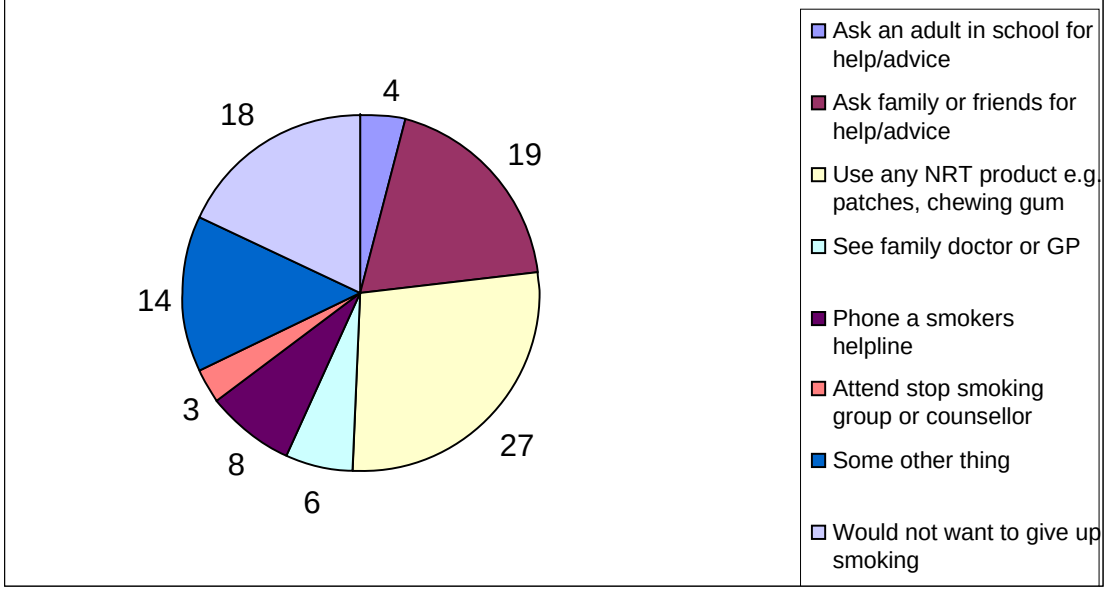


Figure 7: Age first cigarette smoked

4.23 Smoking cessation training has been rolled out to teachers, youth workers and other professionals involved in working with young people, however, uptake of cessation services by under 18s has been low. Children and young people represent the smallest proportion of people setting a quit date through smoking cessation services (only 2% of under eighteens in 2009/10). This is in spite of the fact that 80% of 11-16 year old current smokers surveyed in 2007, stated that they would like to give up smoking cigarettes altogether[3].

4.24 There is further potential for increasing awareness of specialist cessation services amongst those working with children and young people in order to improve signposting to, and potential uptake of, these services. NRT was the first choice amongst 11-16 year olds when asked what they would be most likely to try to give up smoking (figure 8), therefore it would be helpful if young people were made aware of services in their area where they could find this type of support.

Figure 8: Response to question "Which of these would you be most likely to try for help giving up smoking?" asked to 11-16 year olds (YPBAS 2007)



4.25 Further consideration needs to be given to increasing the uptake of cessation services by young people. In order to do this, more research may be required in order to explore the apparent disparity between the high percentage of young people who say they would like to quit, and the very small numbers who are presenting to cessation services.

4.26 Within this particular priority group, two sections of the population – children in care and young offenders - need to be given special consideration. High smoking prevalence rates and lack of direct parental support for both groups places them in a vulnerable situation, and highlights the need for tailored cessation services.

Disadvantaged adults

4.27 Rather than being a source of enjoyment, smoking is viewed by many adults as essential to help them cope with stress. This view of tobacco as a necessary crutch only serves to create an additional barrier to quitting. It is widely accepted that reducing adult smoking prevalence through cessation will also result in reductions in smoking prevalence in young people[28]. In areas of social and economic deprivation, where higher levels of smoking prevalence are

common, it is vitally important that every effort is made to promote access and uptake of cessation services.

4.28 Disadvantaged adults who smoke face a number of barriers to accessing services including fear of failure, fear of being judged and lack of knowledge[45]. In spite of increased funding and the extensive development of smoking cessation services in recent years, there are still problems concerning this group in taking advantage of the services available.

Pregnant women who smoke

4.29 Pregnant women who smoke not only have additional health incentives to quit, but they also have regular access to health professionals who should be well placed to offer advice, support, and signposting to local specialist cessation services. A number of services aimed specifically at pregnant women are available throughout the country, some of which are provided in their own home.

4.30 In 2009/10, 616 pregnant women set quit dates through cessation services, 53% of whom self-reported to have quit four weeks later[46]. Many pregnant women manage to stop smoking during the pregnancy but take up the habit again once the baby has been born, therefore consideration should be given to follow-up post-natal support services.

General population

4.31 The ultimate aim of this Strategy is the creation of a tobacco-free society. While we have identified three priority groups to be targeted specifically, it is important that smoking cessation services are not restricted or promoted to attract people from these three groups only. Members of the general population who smoke must also be targeted for cessation services which should be resourced in such a way as to provide for at least 5 percent of the smoking population each year.

CHAPTER 5 PROTECTING PEOPLE FROM TOBACCO SMOKE

Introduction

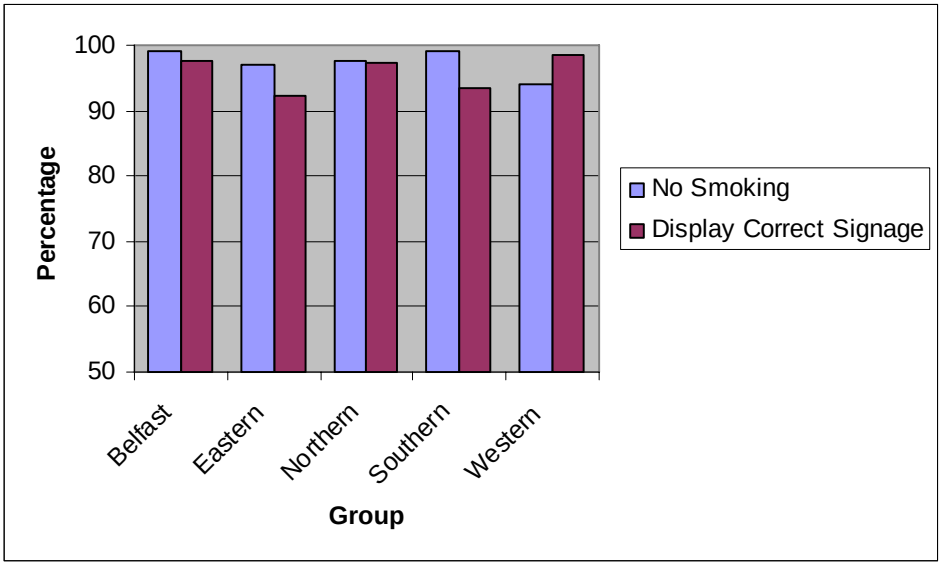
5.1 Nicotine is a highly addictive substance and, while it has been available in Europe in the form of tobacco from the end of the sixteenth century, the twentieth century saw its use gain unprecedented popularity among the general population. It seems likely then, that in spite of significant inroads made into reducing smoking prevalence in recent years, tobacco will still be around for some years to come. In the meantime, we need to work to protect people as much as possible from the harmful effects of secondhand smoke.

5.2 Smoking remains a legal activity, however, legislation is now in place around protecting those who don't smoke from the harmful effects of Environmental Tobacco Smoke (ETS). As set out in more detail in Chapter 1, children are more vulnerable to the effects of ETS than adults, but for adults with certain pre-existing medical conditions, such as asthma, tobacco smoke can be particularly harmful.

Smoking in public places

5.3 The introduction of smoke-free legislation in April 2007 was a major step forward in protecting people at work, and the general public, from secondhand exposure to the numerous harmful chemicals in tobacco smoke. Compliance levels in Northern Ireland have been, and continue to be, reassuringly high. The latest available figures for April 2009 to March 2010 show that across Northern Ireland, 98% of premises have been found to comply with the no smoking law and 95% were displaying the correct signage.

Figure 9: Compliance with smokefree legislation across the Northern Ireland between 1 April 2009 and 31 March 2010



5.4 Environmental Health Officers have been proactive in carrying out regular visits in order to assess compliance levels with the new legislation. Between the period of 30 April 2007, when the legislation was first introduced, to 31 March 2010, 4,451 written warnings were issued, 1,613 Fixed Penalty Notices handed out and 95 prosecutions sought.

Smoking in work vehicles

5.5 The smoke-free legislation which came into force on 30 April 2007, also included regulations which made smoking in work vehicles, either used by the public, or more than one person, illegal. While, as stated above, compliance levels have been high with regards to the smoke-free legislation, the one area in which Environmental Health Officers are experiencing some difficulties around non-compliance is with work vehicles. During the period 1 April 2009 to 31 March 2010, from a total of 885 Fixed Penalty Notices issued, 823 were for smoking in a smoke-free vehicle.

What more needs to be done?

5.6 While we have come far in terms of protecting people in public and work places, consideration must be given as to how non-smokers can be protected in private settings which are not covered by smoke-free legislation. Adults can often protect themselves in this situation, however, thousands of children in Northern Ireland are being exposed on a daily basis to secondhand smoke from their parents' cigarettes either at home or in cars or both.

5.7 Further work is required in order to raise awareness and reinforce existing messages to smokers about the adverse health implications for non-smokers of smoking in enclosed or substantially enclosed places which are not required to be smoke-free under the legislation e.g. the home, designated hotel rooms and private vehicles. It is unlikely that this will be addressed through further legislation in the immediate future. Rather, the emphasis will be on educating people through public information campaigns, and other, more formal channels where appropriate.

5.8 The issue of smoking in work vehicles will need to be considered again in order to determine if a specific public information campaign is required to clarify the law in this area. A programme of work, involving organisations and District Councils, could also be considered to set out clearly for employers their responsibilities with regards to employees smoking in shared work vehicles.

5.9 Since the introduction of smoke-free legislation, there have been concerns raised about smokers congregating at the entrance to buildings, in particular, hospitals. Other users, wanting to enter or exit the buildings, are finding they have to walk through clouds of tobacco smoke, often with access restricted. There are also those who argue that by forcing smokers outside, they, and consequently, the smoking habit, becomes more visible and appealing to young people.

5.10 An initiative introduced by the Western Health and Social Care Trust in March 2009, in response to issues around smoking at hospital entrances, could be more widely applied. The Trust extended its smoke-free policy to state that staff are not permitted to smoke anywhere on Trust grounds with the exception of their own personal vehicles. Patients and visitors may only smoke in designated areas, and not freely in Trust grounds. While no formal evaluation has been carried out, views from the Trust's health improvement unit are that the new policy has been successful in reducing the numbers of people to be found smoking directly outside of hospital entrances.

5.11 A similar initiative was introduced in St Vincent's University Hospital outside Dublin, when it was announced that the existing indoor smoking ban would be extended to the whole of the campus, including the grounds, from 1 January 2009. Connolly Hospital in Blanchardstown, Co. Dublin, followed St. Vincent's example from 31 May 2009. Other key organisations in Northern Ireland, e.g. health trusts, university campuses, Civil Service Departments etc will be encouraged to adopt more comprehensive smoke-free policies, such as that introduced by the Western Trust.

5.12 The Department has commenced work on a three year review of smokefree legislation in Northern Ireland which it intends to publish in 2011. Following this, further consideration will be given to appropriate measures aimed at protecting people from being exposed to secondhand tobacco smoke.

CHAPTER 6 MAKING IT HAPPEN

6.1 The aim and objectives of this Strategy will not be achieved unless a co-ordinated approach ensures effective partnership working between Government departments, statutory, private, voluntary and community sectors. However, if the three objectives identified in **Chapter 2**, are comprehensively realised, the ultimate goal of a tobacco-free society will be within reach.

Action Plan

6.2 An Action Plan to accompany the Strategy will be developed by the Public Health Agency. If the objectives are to be met, it is essential that structures are in place to oversee the programme of action. The Plan's success will also require sufficient resources and systematic arrangements for monitoring and accountability.

Managing the Plan

6.3 The Public Health Agency will be responsible for implementation, with the assistance of a multi-agency Implementation Group to oversee and drive forward the actions outlined in the Plan. The Group will be asked to set intermediate targets in areas such as behavioural change following public information campaigns and uptake of smoking cessation services. It will report progress to the Department on an annual basis.

Research

6.4 The Implementation Group will wish to consider the need for additional research to help monitor and evaluate progress taking account of the need to draw comparisons with other countries. This could include research to increase our knowledge of the social and cultural factors that influence tobacco use, particularly among young girls, and those living in areas of social or economic deprivation. Research examining the effectiveness of various specialist smoking cessation services would also be important to ensure that investments made in this area are being returned. A number of existing surveys regularly monitor

adult and young people's smoking activity. These include: the Health Survey Northern Ireland; the Infant Feeding Survey; and the Young Persons' Behaviour and Attitudes Survey.

Resources

6.5 The Department of Health, Social Services and Public Safety allocated over £5m between the 2009/10 and 2010/11 financial years towards tobacco control measures. This funding is primarily for the development of public information campaigns, smoking cessation services and NRT, and enforcement of tobacco legislation subject to the impact of broader public health sector funding constraints. The Department will continue to support these services through funding allocated to the Public Health Agency.

Review

6.6 The Plan will undergo a formal review after a three year period in order to assess progress against objectives and targets, and to inform the development of a new action plan to run in tandem with the 2014/17 Programme for Government/Comprehensive Spending Review.

Tobacco Control: Roles and Responsibilities

6.7 The implementation of an Action Plan requires input from a variety of organisations, agencies and individuals ranging from Government Departments, Health and Social Services and local councils, to employers, trades unions, the voluntary sector and local communities.

6.8 **The Department of Health, Social Services & Public Safety (DHSSPS)** – is responsible for the health and well-being of the population and therefore has a key role to play in delivering the aims of the Action Plan. It has specific responsibility for legislative provisions to introduce future tobacco control measures. Through the Chief Environmental Health Officer, the Department has a role in promoting consistent and effective implementation of the legislation, protocols and codes by local councils. In the longer term, DHSSPS will monitor

the impact of the Strategy and the Action Plan on smoking levels among adults and young people.

6.9 **The Public Health Agency** – has overall responsibility for implementing the Department's policy on tobacco control. As budget holder for the tobacco strategy implementation plan, the Agency will commission public information campaigns, fund and monitor enforcement of tobacco control legislation carried out by local District Councils, and commission smoking cessation services jointly with the Health and Social Care Board.

6.10 **The Health and Social Care Services** – have a key role in developing smoking prevention and support programmes. This involves collaboration between the Health and Social Care Board, Trusts and primary care, as well as the voluntary and community sectors.

6.11 **The Department of Education** – is responsible for securing the place of health education in schools and in the Youth Service. Personal Health is a statutory component within Personal Development and Mutual Understanding (PDMU) at Primary level and within the Personal Development strand of Learning for Life and Work at Key Stages 3 and 4. It is matter for teachers, using their professional skills, to determine what they teach and the resources to be used in delivering any given element of the curriculum. The Council for Curriculum, Examinations and Assessment (CCEA) has produced a number of resources which address issues of smoking, either directly or indirectly to assist teachers in their delivery of the curriculum.

6.12 **Education and Skills Authority** – will be responsible for ensuring the delivery of health education across all sectors from early years to post-16s and in the youth service from age 8 to age 25. This function currently resides with the five Education and Library Boards.

6.13 **The Department for Employment and Learning** - is responsible for promoting learning and skills and preparing people for work. Regarding health

education, it can encourage further and higher education institutions to communicate appropriate messages to the students.

6.14 **The Health and Safety Executive** - is an Executive Non-Departmental Public Body, sponsored by the Department of Enterprise, Trade and Investment. It is the lead body responsible for the promotion and enforcement of health and safety at work standards.

6.15 **District Councils** - are responsible for enforcement and education in respect of the illegal sale of tobacco products to those under 18. This involves investigating complaints, educating retailers about their responsibilities, bringing the role of councils to the attention of the general public and, where appropriate, instituting legal proceedings. Councils also have responsibility for ensuring compliance under the Smoking (NI) Order 2006, and will be responsible for enforcement of tobacco related regulations under the Health Act 2009.

6.16 **HM Revenue & Customs** - is responsible for the investigation of organisations and individuals engaged in tobacco smuggling and related activities, and their prosecution. The **UK Border Agency** is responsible for preventing and detecting the illegal import of tobacco products into the UK.

6.17 **Employers** – have an important role to play in protecting their employees from the dangers of tobacco smoke through the development of clearly defined smoking policies in the workplace.

6.18 **Trades' Unions** - have a responsibility to safeguard their members' interests through collaboration with employers regarding exposure to environmental tobacco smoke.

6.19 **The Voluntary Sector** - can do much to promote a change in the social climate towards smoking by, for example, highlighting the benefits to health and the financial implications of quitting. They can also help promote and provide cessation services. Organisations such as the Chest, Heart and Stroke

Association, the Ulster Cancer Foundation and the British Heart Foundation have many years experience in this area and can offer practical help to those trying to quit, as well as delivery awareness raising programmes.

6.20 **Communities** - Local communities have an important role to play in reducing health inequalities by providing services, support, information and advice within their own localities. This work needs to be built upon and arrangements put in place to maximise their support for those who wish to quit smoking. Family and friends can play an important role in supporting and encouraging individuals trying to quit, particularly through the difficult early days.

6.21 **Universities** – Health Care Professionals including Doctors, Dentists, Pharmacists, Nurses, Professions Allied to Medicine e.g. Physiotherapists and Occupational Therapists, have a role in promoting the smoke free and quit smoking messages. It is important this is included in a formal way in the undergraduate curriculum. It is equally important to continue to promote the inclusion of training on illegal tobacco activity and enforcement in undergraduate and postgraduate education for Environmental Health Officers. Universities also have an important role in terms of research, including the evaluation of measures and programmes.

TECHNICAL ANNEX

Estimates of the prevalence of cigarette smoking in Northern Ireland are obtained through the Continuous Household Survey (CHS) which is one of the largest ongoing surveys carried out here. The survey is funded by a range of government departments including DHSSPS and is designed, conducted and analysed by the Northern Ireland Statistics and Research Agency (NISRA). Since 1991 the CHS has included a module on smoking every two years but following the introduction of the Smoking (Northern Ireland) Order 2006, the smoking module has been included annually.

ANNEX 1

Tobacco Action Plan Working Group Membership

Dr Elizabeth Mitchell (Chair)	DHSSPS (Acting Chief Medical Officer)
Dr Naresh Chada	DHSSPS (Senior Medical Officer)
Mr Nigel McMahon	DHSSPS (Chief Environmental Health Officer)
Mr Gerard Collins	DHSSPS (Health Improvement Policy Branch)
Mrs Jenny McAlarney	DHSSPS (Health Improvement Policy Branch)
Mrs Cathy Harrison	DHSSPS (Pharmacy Branch)
Mr Kieron Moore	DHSSPS (Public Health Information & Research Branch)
Mr Gerry McElwee	Ulster Cancer Foundation
Mr Owen Metcalfe	Institute of Public Health
Mrs Gerry Bleakney	Public Health Agency Eastern area
Ms Madeline Heaney	Public Health Agency Northern area
Ms Cathy Mullan	Public Health Agency Western area
Ms Breda Teahan **to September 2009**	Public Health Agency Southern area
Ms Marion Magill	DEL (Strategy & Equality Unit)
Mr Sean Martin	Chief Environmental Health Officers Group
Ms Anne Madden	NI Chest Heart & Stroke
Mr Kieran Coll	HM Revenue & Customs
Professor Bernie Hannigan	Research & Development Office (HSC)
Ms Barbary Cook **to 17 August 2009** Joanne Morgan	Community Development & Health Network
Dr Anna Gavin	Centre for Public Health
Dr Paul Coulter	Patient Client Council
Ms Jayne Murray	British Heart Foundation (BHF) Northern Ireland
Ms Bridie Mullan	Western Education and Library Board

ANNEX 2

GLOSSARY

National Institute for Health and Clinical Excellence (NICE)	NICE is an independent organisation responsible for providing national guidance on promoting good health and preventing and treating ill health.
Brief opportunistic advice	Can come from any healthcare professional and its purpose is to encourage the patient either in a quit attempt, or at least to motivate them to giving quitting some consideration. Typically takes between 5 and 10 minutes and may include: advice to stop; a brief assessment of the patient's commitment to quitting; and going a step further to support the patient to quit e.g. by referring them to specialist services; offering support in the form of NRT or pharmacotherapy; or simply providing further information in the form of literature.
Specialist cessation interventions	Usually in the form of clinics and are delivered by specialists who have received accredited training for this role. The HSC commission specialist services which are evidence based and offer intensive treatment usually in the form of one-to-one or group support, over the course of up to 12 weeks. Clients attending the sessions can be offered additional support in the form of Nicotine Replacement Therapy and/or pharmacotherapy.
Nicotine Replacement Therapy	NRT is a way of getting nicotine into the bloodstream without smoking, and stops, or reduces, the symptoms of nicotine

	withdrawal. It presents in many forms including gums, patches, inhalers, tablets, lozenges and sprays, and is available on prescription, or to buy in Northern Ireland over the counter, in pharmacies or retail outlets.
Quit Kits	Contain materials designed to help people stop smoking and support, advice and details on all the support options available.
Stop Shops	Usually located in areas which have a high level of client "footfall", e.g. high streets and shopping centres, stop shops offer smokers a range of support measures seven days a week.

ANNEX 3

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