Tobacco Smoking

Edited by Justin Healey
**Tobacco Smoking** is Volume 329 in the ‘Issues in Society’ series of educational resource books. The aim of this series is to offer current, diverse information about important issues in our world, from an Australian perspective.

**KEY ISSUES IN THIS TOPIC**

Tobacco smoking kills up to half of its users and has a global annual death toll of more than five million people. It is the largest cause of preventable death in the western world. Around 3 million Australians are daily smokers, many of whom are socially disadvantaged.

This title reveals the toxic contents of tobacco and the health effects of smoking (including passive smoking) on the body. The book also addresses a number of commonly held myths and misconceptions about the risks and impacts of smoking. A range of different quitting methods and products for overcoming nicotine addiction is also explored in detail.

Another focus of this book is the role of government and legislation in controlling tobacco use and its marketing. Why do so many people continue to let their health go up in smoke?

This book presents the topic in three chapters: Tobacco use and health; Quitting smoking; and Tobacco control and marketing.

**SOURCES OF INFORMATION**

Titles in the ‘Issues in Society’ series are individual resource books which provide an overview on a specific subject comprised of facts and opinions.

The information in this resource book is not from any single author, publication or organisation. The unique value of the ‘Issues in Society’ series lies in its diversity of content and perspectives.

The content comes from a wide variety of sources and includes:

- Newspaper reports and opinion pieces
- Website fact sheets
- Magazine and journal articles
- Statistics and surveys
- Government reports
- Literature from special interest groups

**CRITICAL EVALUATION**

As the information reproduced in this book is from a number of different sources, readers should always be aware of the origin of the text and whether or not the source is likely to be expressing a particular bias or agenda.

It is hoped that, as you read about the many aspects of the issues explored in this book, you will critically evaluate the information presented. In some cases, it is important that you decide whether you are being presented with facts or opinions. Does the writer give a biased or an unbiased report? If an opinion is being expressed, do you agree with the writer?

**EXPLORING ISSUES**

The ‘Exploring issues’ section at the back of this book features a range of ready-to-use worksheets relating to the articles and issues raised in this book. The activities and exercises in these worksheets are suitable for use by students at middle secondary school level and beyond.

**FURTHER RESEARCH**

This title offers a useful starting point for those who need convenient access to information about the issues involved. However, it is only a starting point. The ‘Web links’ section at the back of this book contains a list of useful websites which you can access for more reading on the topic.
Chapter 1

Tobacco use and health

TOBACCO
A FACT SHEET FROM THE NATIONAL DRUG AND ALCOHOL RESEARCH CENTRE

WHAT IS TOBACCO?

Tobacco is made from the dried leaves of the tobacco plant. Tobacco smoke is a mixture of almost 4,000 different chemical compounds, including nicotine, tar, carbon monoxide, acetone, ammonia and hydrogen cyanide. Forty-three of these chemicals have been proven to be carcinogenic (causing cancer).

Tobacco is ingested through smoking cigarettes, pipes and cigars. In the form of a fine powder, it may also be sniffed as snuff, or it is sometimes sold in blocks to be chewed. It can also be ingested through passive smoking. Cigarettes account for approximately 98 per cent of tobacco consumed in Australia.

Nicotine

Nicotine is a poison. Swallowing a small amount of pure nicotine can kill an adult. Nicotine is the stimulant drug in tobacco smoke that causes dependency, as it is highly addictive, both physically and mentally. A key brain chemical involved in mediating the desire to consume drugs is the neurotransmitter dopamine, and research has shown that nicotine increases the levels of dopamine in the part of the brain that regulates feelings of pleasure. This is an important reason why nicotine is so addictive.

The nicotine hit is extremely quick. In cigarette smoke it is absorbed directly from the mouth and because it is alkaline, dissolves instantly in saliva. It is then carried through the mouth’s lining into the bloodstream and straight to the brain. It only takes a few seconds for the smoker to feel somewhat light-headed and dizzy.

Nicotine makes the smoker feel stimulated and alert, it makes the heart beat faster, so more blood circulates around the body per minute. However, it also causes the small blood vessels in the body to narrow, restricting the flow of blood and causing blood pressure to rise. Nicotine reduces tension in muscles, which can make the smoker feel relaxed. It seems to help some people work by improving concentration, relieving boredom and fatigue.

Many smokers believe smoking calms their nerves. However, smoking releases epinephrine, a hormone that creates physiological stress in the smoker, rather than relaxation. The addictive quality of the nicotine contained in the cigarette makes the user smoke more to calm down, when in fact the smoking itself is causing the agitation.

Nicotine is also strongly linked with the development of cancers.

Tar

Tar is released when a cigarette burns. It is the main cause of lung and throat cancer in smokers, and it also aggravates bronchial and respiratory disease. A smoker who smokes one packet a day, inhales more than half a cup of tar from cigarettes each year.

Carbon monoxide

Carbon monoxide is a colourless, odourless and very toxic gas, which is taken up more readily by the lungs than oxygen. High levels of carbon monoxide in the blood is typical of
smokers and, together with nicotine, increases the risk of heart disease, hardening of the arteries and other circulatory problems.

**How many people use tobacco?**

The most recent figures available in the 2001 National Drug Strategy Household Survey showed that:

➤ The average age at which Australian smokers took up tobacco smoking was at 15 years of age
➤ It was estimated that in 2001 approximately 3.6 million Australians aged 14 years or older were smokers
➤ One in five (19.5 per cent) Australians aged 14 years or older smoked daily in 2001
➤ One in two (49.4 per cent) Australians aged 14 years or older had smoked at least 100 cigarettes or the equivalent amount of tobacco at some time in their lives.

Tobacco smoking is the single largest preventable cause of death and illness in Australia, responsible for over 19,000 deaths each year, and many more disabilities.

In 1998, the National Drug Strategy Household Survey showed that tobacco smoking remained the leading cause of drug-related hospital episodes, with 142,525 (71 per cent) episodes in 1997-98.

The main tobacco-related illnesses requiring hospitalisation were cancer, chronic obstructive pulmonary disease, and ischaemic heart disease.

Half of all teenagers who are currently smokers will die from diseases caused by smoking if they continue to smoke over the long-term. Half of these premature deaths will occur in middle age, with an average loss of 23 years of life.

**Nicotine is strongly linked with the development of cancers.**

**Other names for tobacco**

Tobacco is also known as cigs, fags, gaspers, rollies and smokes.

**What are the short-term effects of tobacco?**

The short-term effects produced by tobacco include:

➤ Rise in blood pressure and heart rate
➤ Brain and central nervous system activity stimulated then reduced
➤ Decreased blood flow to body extremities; particularly noticeable in fingers and toes
➤ Increased carbon monoxide levels in the bloodstream, reducing the amount of oxygen available to body organs and tissue
➤ Acid in the stomach
➤ Dizziness, nausea and watery eyes
➤ Appetite, taste and smell are weakened.

**What are the long-term effects of tobacco?**

The long-term effects of tobacco include:

➤ Diminished or extinguished sense of smell and taste
➤ Shortness of breath
➤ Persistent cough
➤ Increased risk of colds and chronic bronchitis
➤ Increased risk of emphysema
➤ Increased risk of heart disease
➤ Increased risk of stroke
➤ Premature and more abundant face wrinkles
➤ Increased risk of cancer of the mouth, larynx, pharynx, oesophagus, lungs, pancreas, cervix, uterus and bladder
➤ Increased risk of stomach ulcers
➤ Increased risk of peripheral vascular disease due to decreased blood flow to the legs
➤ Reduced fertility in both men and women.

**What are the effects of smoking during pregnancy?**

Smoking during pregnancy can affect the unborn child. Babies are more likely to miscarry, be of low birth weight, premature or stillborn.

**What is passive smoking?**

Passive smoking occurs when one breathes in the tobacco smoke of others. Passive smoking has been shown to contribute to lung damage including cancer, and heart disease. Children exposed to passive smoke are especially susceptible, having more respiratory and ear infections, and suffering from higher levels, and more severe asthma.
Despite the social acceptance of tobacco smoking, its many negative effects, most notably its relation to various cancers, have been known for many years. Tobacco contains the powerfully addictive stimulant nicotine, which can make smoking a regular and long-term habit that isn’t easy to quit. In recent years the negative effects of passive smoking have also been highlighted, demonstrating that the risks to health of smoking affect more than just the smoker.5

over time

As awareness of the negative impacts of tobacco smoke has increased, the proportion of people who smoke has declined steadily, as reported by the National Health Survey (NHS), since tobacco consumption was first included in the survey in 1989-90. Decreasing by 24% over the 18 year period, this represents an annual average decline of around 1.5%.

The NHS reported around 3 million daily smokers in 2007-08. There were 716,000 people who had been a daily smoker 12 months prior, but who either now smoked less than daily (112,000 people) or were no longer smokers at all (604,000).

age and sex

In 2007-08, around 8 million Australian adults aged 15 years and over had smoked at some time in their lives. Around 3.3 million were current smokers, with the vast majority (91%) of these people smoking daily. Males were more likely to be current smokers than females (22% compared with 18%).

Around 9% of young men aged 15-17 years were current smokers, with the rate peaking at 33% for those aged 25-34 years before declining to around 5% for men aged 75 years or over.

The smoking rate for young women aged 15-17 years was slightly lower than for men of the same age (4.5%). For women aged 18-54 years, the smoking rate plateaued at 22% before declining in the older age groups.

A large decrease in smoking rates from 1989-90 to 2007-08 occurred in the 18-24 year age bracket (dropping by a third for men and 39% for women). This was accompanied by a rise in the number of 18-24 year olds who had never smoked (from 55% to 64% for men and 52% to 65% for women).

... as a health risk

Research shows that smoking is associated with increased risk of coronary heart disease, stroke, peripheral vascular disease and cancer. While the 2007-08 NHS collected information on long-term health conditions, it is not possible to infer causality. Nevertheless, smokers were more likely to have certain conditions. Current smokers were 3.9 times as likely to have emphysema than were non-smokers although there was not much difference in relation to other chronic conditions.

However, those who had ever smoked were more likely than those who had never smoked to have particular illnesses, suggesting that certain health conditions may be associated with a history of smoking rather than just a person’s current smoking status. People who had ever smoked were 6.3 times more likely to have emphysema, twice as likely to have a heart disease and 1.6 times as likely to have bronchitis, than those who had never smoked.

... passive smokers

Around 459,000 (or 3.5% of) adults aged 15 years or over who were not current smokers and 291,000 (or 7.2% of) children aged under 15 years lived in a household where a daily smoker was reported to have smoked indoors. These people may be exposed to environmental tobacco smoke and the associated health risks of tobacco consumption.

... age first started

People in their teens may take up smoking as part of a social activity that is perceived to be well suited to their youth culture and allows them to better fit in with or rebel
against friends or family. People who started smoking daily at a younger age were less likely than others to have reduced their frequency of smoking or to have kicked the habit altogether at the time of interview.

Of people who had ever smoked daily, 61% first took up the habit on a daily basis when aged 15-19 years. About one in five (18%) of those who had ever smoked daily had first started doing so under the age of 15 years.

Of people aged 25-54, those who first started smoking daily as a child aged under 15 years were more likely to have also been a daily smoker at the time of interview (55%) than those who first started at an older age (46%).

Burden of disease and injury
Exposure to tobacco or alcohol and high body mass have been identified as three of the main risk factors contributing to the burden of disease and injury within Australia. This burden was calculated using Disability-Adjusted Life Years (DALYs), which include years of life lost due to premature death as well as ‘healthy’ years lost due to disability.

Exposure to tobacco, accounting for 7.8% of the total burden, was strongly linked with lung cancer, chronic obstructive pulmonary disease and ischaemic heart disease.

High body mass (a little more inclusive than the traditional overweight and obesity categories) accounted for 7.5% of the total burden, with Type 2 diabetes and ischaemic heart disease major contributors to this.

Alcohol harm was responsible for 3.2% of the total burden of disease and injury and accounted for the greatest amount of burden specifically for males under the age of 45 years. Alcohol abuse, road traffic accidents and suicide made up two-thirds of the harm attributed to alcohol.

For more information see The burden of disease and injury in Australia 2003 (Australian Institute of Health and Welfare, cat. no. PHE 82).

ENDNOTES

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Australian Social Trends 4102.0, December 2009
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A BRIEF HISTORY OF SMOKING

Some questions and answers from the Cancer Council NSW

How long has tobacco been around?
➤ Tobacco has been growing wild in the Americas for nearly 8,000 years
➤ Around 2,000 years ago tobacco began to be chewed and smoked during cultural or religious ceremonies and events.

Who discovered tobacco and where?
➤ The first European to discover smoking was Christopher Columbus
➤ In 1531 tobacco was cultivated for the first time in Europe (at Santo Domingo). By 1600 tobacco use had spread across Europe and England and was being used as a monetary standard, a practice that continued throughout the following century
➤ By the 1700s smoking had become more widespread and a tobacco industry had developed.

When was tobacco first considered to be dangerous to health?
➤ In 1602 an anonymous English author published an essay titled Worke of Chimney Sweepers (sic) which stated that illnesses often seen in chimney sweepers were caused by soot and that tobacco may have similar effects. This was one of the earliest known instances of smoking being linked to ill health
➤ In 1795 Sammuel Thomas von Soemmering of Maine (Germany) reported that he was becoming more aware of cancers of the lip in pipe smokers
➤ In 1798 the US physician Benjamin Rush wrote on the medical dangers of tobacco
➤ During the 1920s the first medical reports linking smoking to lung cancer began to appear. Many newspaper editors refused to report these findings as they did not want to offend tobacco companies who advertised heavily in the media
➤ A series of major medical reports in the 1950s and 1960s confirmed that tobacco caused a range of serious diseases.

When were cigarettes developed?
➤ Cigarette making machines were developed in the latter half of the 1800s. The first such machines produced about 200 cigarettes per minute (today’s machines produce about 9,000 per minute). Cheap mass production and the use of cigarette advertising allowed tobacco companies to expand their markets during this period.

What caused the growth and later decline of smoking in traditional markets?
➤ The prevalence of smoking increased dramatically during the world wars, mainly due to the policy of providing free cigarettes to allied troops as a ‘morale boosting’ exercise
➤ Later in the twentieth century smoking became less popular due to a rapid increase in knowledge of the health effects of both active and passive smoking
➤ People also became aware of the tobacco industry’s efforts to mislead the public about the health effects of smoking and to manipulate public policy for the short-term interests of the industry
➤ The first successful lawsuits against tobacco companies over smoking-related illness happened in the latter part of the 20th Century.

What are current global smoking trends?
➤ As smoking prevalence rates have declined in the traditional markets of North America and western Europe the tobacco-related burden of disease has shifted to the nations of Africa, Asia, the former Soviet Union and Latin America
➤ If current patterns continue, tobacco use will kill approximately 10 million people every year by 2020; 70 per cent of these deaths will occur in emerging nations.

USEFUL LINKS
➤ Breed’s collection of tobacco history sites: http://smokingsides.com/docs/hist.html
➤ Tobacco Control Resource Centre (for legal history) http://tobacco.neu.edu

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Tobacco is grown and sold by many different countries. The largest producers of tobacco are China, USA, the former Soviet states, Brazil and India.

Cigarettes are made from the dried leaves of the tobacco plant. The leaves of the tobacco plant are dried by burning trees in ovens. One hectare of trees is needed to dry every hectare of tobacco. That is nearly 5 million hectares of forest each year. When a person smokes they contribute to damaging the environment and they are also damaging their health.

After the leaves of the tobacco plant have been dried they are treated with many different chemicals. Cigarette smoke contains over 4,000 chemicals and many of them cause cancer. One hectare of trees is needed to dry every hectare of tobacco. That is nearly 5 million hectares of forest each year.

When someone smokes a cigarette, they breathe in:

**Tar** – a black, sticky substance that contains many poisonous chemicals such as: ammonia (found in floor and window cleaner), toluene (found in industrial solvents) and acetone (found in paint stripper and nail polish remover). Tar is the main cause of throat and lung cancer. Tar also causes the yellowish brown stains on smokers’ fingers, teeth and lung tissue and on the ceilings in rooms where people smoke heavily.

**Nicotine** – the drug in tobacco which contributes to addiction to cigarette smoking. Nicotine is poisonous and has a number of effects on the body. These include: stimulating the nervous system, increasing heart rate, raising blood pressure and making the small blood vessels under the skin shrink, which can cause wrinkles.

**Carbon monoxide** – a poisonous gas that reduces the amount of oxygen taken up by a person’s red blood cells. This means less oxygen goes to organs of the body and the heart has to work harder.

**Hydrogen cyanide** – the poison used in gas chambers during World War II. It damages the tiny hairs which act as natural ‘lung cleaners’ in our bodies. As a result, toxic substances can build up in the lungs.

**Metals** – lead, nickel, arsenic (white ant poison) and cadmium (used in car batteries) are among the many metals found in tobacco smoke.

**Radioactive compounds** – are found in cigarettes and cause cancer.

Smoking is the largest cause of preventable death in the western world. The more cigarettes a person smokes, the greater the risk of harm to their body.

**Pesticides** – such as DDT, methoprene (found in flea powder) are used in growing tobacco. Other chemicals such as benzene (found in petrol) and naphthalene (found in mothballs) are added when the cigarettes are being made.

Smoking is the largest cause of preventable death in the western world. The more cigarettes a person smokes, the greater the risk of harm to their body. Even if you don’t smoke you can still be harmed by these poisonous chemicals just by being around people who are smoking.

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http://oxygen.org.au
Nicotine is the addictive substance in tobacco that causes smokers to continue their smoking habit. Along with nicotine, smokers also inhale about 4,000 other chemicals. These chemicals harm nearly every organ in the body.

Nicotine is the addictive drug in tobacco smoke that causes smokers to continue to smoke. Addicted smokers need enough nicotine over a day to ‘feel normal’ – to satisfy cravings or control their mood. How much nicotine a smoker needs determines how much smoke they are likely to inhale, no matter what type of cigarette they smoke.

Along with nicotine, smokers also inhale about 4,000 other chemicals in cigarette smoke. Many of these chemicals come from burning tobacco leaf. Some of these compounds are chemically active and trigger profound and damaging changes in the body.

There are over 60 known cancer-causing chemicals in tobacco smoke. Smoking harms nearly every organ in the body, causing many diseases and reducing health in general.

In Victoria, from 1 January 2010, it is illegal to smoke in cars carrying children under 18 years of age.

There are over 60 known cancer-causing chemicals in tobacco smoke. Smoking harms nearly every organ in the body, causing many diseases and reducing health in general.

Tobacco smoke contains dangerous chemicals

The most damaging compounds in tobacco smoke include:

- **Tar** – this is the collective term for all the various particles suspended in tobacco smoke. The particles contain chemicals including several cancer-causing substances. Tar is sticky and brown and stains teeth, fingernails and lung tissue. Tar contains the carcinogen benzo(a)pyrene that is known to trigger tumour development (cancer).

- **Carbon monoxide** – this odourless gas is fatal in large doses because it takes the place of oxygen in the blood. Each red blood cell contains a protein called haemoglobin – oxygen molecules are transported around the body by binding to, or hanging onto, this protein. However, carbon monoxide binds to haemoglobin better than oxygen. This means that less oxygen reaches the brain, heart, muscles and other organs.

- **Hydrogen cyanide** – the lungs contain tiny hairs (cilia) that help to clean the lungs by moving foreign substances out. Hydrogen cyanide stops this lung clearance system from working properly, which means the poisonous chemicals in tobacco smoke can build up inside the lungs. Other chemicals in smoke that damage the lungs include hydrocarbons, nitrous oxides, organic acids, phenols and oxidising agents.

- **Free radicals** – these highly reactive chemicals can damage the heart muscles and blood vessels. They react with cholesterol, leading to the build-up of fatty material on artery walls. Their actions lead to heart disease, stroke and blood vessel disease.

- **Metals** – tobacco smoke contains dangerous metals including arsenic, cadmium and lead. Several of these metals are carcinogenic.

- **Radioactive compounds** – tobacco smoke contains radioactive compounds, which are known to be carcinogenic.

Respiratory system

The effects of tobacco smoke on the respiratory system include:

- Irritation of the trachea (windpipe) and larynx (voice box)

- Reduced lung function and breathlessness due to swelling and narrowing of the lung airways and excess mucus in the lung passages

- Impairment of the lungs’ clearance system, leading to the build-up of poisonous substances, which results in lung irritation and damage

- Increased risk of lung infection and symptoms such as coughing and wheezing

- Permanent damage to the air sacs of the lungs.

Circulatory system

The effects of tobacco smoke on the circulatory system include:

- Raised blood pressure and heart rate

- Constriction (tightening) of blood vessels in the skin, resulting in a drop in skin temperature
Less oxygen carried by the blood
Stickier blood, which is more prone to clotting
Damage to the lining of the arteries, which is thought to be a contributing factor to atherosclerosis (the build-up of fatty deposits on the artery walls)
Reduced blood flow to extremities like fingers and toes
Increased risk of stroke and heart attack due to blockages of the blood supply.

Immune system
The effects of tobacco smoke on the immune system include:
- The immune system doesn’t work as well
- The person is more prone to infections such as pneumonia and influenza
- Illnesses are more severe and it takes longer to get over them
- Lower levels of protective antioxidants, for example Vitamin C, in the blood.

Musculoskeletal system
The effects of tobacco smoke on the musculoskeletal system include:
- Tightening of certain muscles
- Reduced bone density.

Other effects on the body
Other effects of tobacco smoke on the body include:
- Irritation and inflammation of the stomach and intestines
- Increased risk of painful ulcers along the digestive tract
- Reduced ability to smell and taste
- Premature wrinkling of the skin
- Higher risk of blindness
- Gum disease (periodontitis).

The male body
The specific effects of tobacco smoke on the male body include:
- Lower sperm count
- Higher percentage of deformed sperm
- Reduced sperm mobility
- Changed levels of male sex hormones
- Impotence, which may be due to the effects of smoking on blood flow and damage to the blood vessels of the penis.

The female body
The specific effects of tobacco smoke on the female body include:
- Reduced fertility
- Menstrual cycle irregularities or absence of menstruation
- Menopause reached one or two years earlier
- Increased risk of cancer of the cervix

Greatly increased risk of stroke and heart attack if the smoker is aged over 35 years and taking the oral contraceptive pill.

The unborn baby
The effects of maternal smoking on an unborn baby include:
- Increased risk of miscarriage, stillbirth and premature birth
- Low birth weight, which may have a lasting effect on the growth and development of children. Low birth weight is associated with an increased risk for early puberty and, in adulthood, is an increased risk for heart disease, stroke, high blood pressure, being overweight and diabetes
- Increased risk of cleft palate and cleft lip
- Paternal smoking can also harm the foetus if the non-smoking mother is exposed to second-hand smoke
- If the mother or father continues to smoke during their baby’s first year of life, the child has an increased risk of ear infections, respiratory illnesses such as pneumonia and bronchitis, sudden infant death syndrome (SIDS) and meningococcal disease.

Diseases caused by long-term smoking
A lifetime smoker is at high risk of developing a range of potentially lethal diseases, including:
- Cancer of the lung, mouth, nose, voice box, tongue, nasal sinuses, oesophagus, throat, pancreas, bone marrow (myeloid leukaemia), kidney, cervix, ureter, liver, bladder and stomach
- Lung diseases such as chronic obstructive pulmonary disease, which includes chronic bronchitis and emphysema
- Coronary artery disease, heart disease, heart attack and stroke
- Ulcers of the digestive system
- Osteoporosis and hip fracture
- Poor blood circulation in feet and hands, which can lead to pain and, in severe cases, gangrene and amputation.

WHERE TO GET HELP
- Your doctor
- Your pharmacist
- Quitline Tel. 13 7848 (13 QUIT).

THINGS TO REMEMBER
- Many of the 4,000 chemicals in tobacco smoke are chemically active and trigger profound and potentially fatal changes in the body
- Smoking harms nearly every organ in the body.

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You can greatly reduce the risks of these effects by choosing to be smoke free.

Some of the benefits of being smoke free are:

- Healthier skin
- Fresh-smelling clothes and hair
- Fresher breath
- Whiter teeth
- Better sense of taste and smell
- Improved fitness
- Less sickness
- Saving money
- Helping save the environment
- Most people are smoke free.

Many people who start smoking think they will be able to stop whenever they want. Unfortunately, the younger people start smoking the harder it can be to quit. Most adult smokers wish they had never started in the first place.
Myths and misconceptions about smoking

CANCER COUNCIL AUSTRALIA ANSWERS SOME COMMON QUESTIONS

Are low-tar cigarettes safe to smoke?

There is no safe cigarette; a low-tar cigarette is just as harmful as other cigarettes. Although low-tar cigarettes can be slightly less damaging to your lungs over a long period of time, people who smoke these have been shown to take deeper puffs, puff more frequently and smoke the cigarettes to a shorter butt length. Switching to low-tar cigarettes has few health benefits compared with the benefits of quitting.

Are ‘rollies’ safe to smoke?

Roll-your-own tobacco contains many of the same chemicals as manufactured cigarettes. Research suggests that roll your own (RYO) tobacco is at least as harmful, or possibly more harmful than smoking factory-made cigarettes. Studies show that RYO smokers tend to make cigarettes that can yield high levels of tar and nicotine. They may also not use a filter. Both RYO only and mixed smokers report inhaling more deeply than factory-made cigarette smokers. More research is required to determine the levels of chemicals inhaled by RYO smokers.

Will cutting down the number of cigarettes I smoke reduce my health risks?

There is no safe level of cigarette consumption. Some people try to make their smoking habit safer by smoking fewer cigarettes, but most find this hard to do and quickly return to their old pattern. Although reducing your cigarette consumption will slightly reduce your risk, quitting is the only way to long-term health benefits. Just three cigarettes a day can trigger potentially fatal heart disease, with women particularly at risk.

Is it OK to smoke socially?

Anyone who smokes is at a risk of becoming addicted to nicotine. The more you smoke, the more your body learns to depend on nicotine – this is what makes quitting so hard. People often think they are in control of social smoking habits when they are not; even low levels of cigarette consumption are damaging to you and the people around you.

Only old people get ill from smoking don’t they?

Anyone who smokes tobacco increases their risk of ill health. All age groups suffer short-term consequences of smoking that include decreased lung function, shortness of breath, cough and rapid tiring during exercise. Smoking also diminishes the ability to smell and taste and causes premature ageing of skin.

Anyone who smokes is at a risk of becoming addicted to nicotine. The more you smoke, the more your body learns to depend on nicotine – this is what makes quitting so hard.

Smoking-related diseases often develop over a number of years before a diagnosis is made. The longer you smoke, the greater your risk of developing cancer, heart, lung and other preventable diseases. However, people in their 20s and 30s have died from strokes caused by smoking.

Are men or women more at risk from smoking?

Men and women are equally susceptible to the damage caused by chemicals in cigarettes.

For women, cigarette smoking increases the risk of a number of specific health problems. Women who smoke can experience irregular periods and secondary amenorrhoea (absence of menstruation); and those on the pill have a greater risk of heart attack, stroke and other cardiovascular disease.

Women smokers also have a higher risk of developing cervical cancer, vulval cancer and heart disease.

Will smoking affect pregnancy?

Women who smoke can experience difficulties during pregnancy and childbirth, including complications, miscarriage and premature birth. Smoking is also associated with a higher risk of having stillborn and low birth-weight babies, and losing children early in life.

Does everyone who quits smoking put on weight?

When you stop smoking you are likely to find you have a larger appetite and be tempted to replace cigarettes with food. You can avoid weight gain after quitting by being aware of this and doing extra exercise and adopting healthy eating habits.

Is there a proven link between passive/second-hand smoke and disease?

Every credible medical and scientific organisation in the world agrees that second-hand smoke exposure causes serious illness and death in non-smokers. The only group that denies a link between passive smoking and illness in adults and children is the tobacco industry.

Don’t I have the right to smoke if I want to?

Very few adults ‘choose’ to smoke. Most smokers start as children or adolescents, before they know the risks of tobacco use and the addictive qualities of nicotine. Of course you have the right to smoke, but not the right to harm others with that smoke.

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www.cancer.org.au
The smoking rate of the Australian population is just less than 17 per cent\textsuperscript{1} but for people with a mental health problem the rate is about 32 per cent\textsuperscript{2} and in some cases, such as for people with schizophrenia, the rate is up to 62 per cent.\textsuperscript{*} The relationship between smoking and mental health problems is at times complex, and quitting smoking can be hard, but the evidence shows that people with a mental health problem can quit smoking and can do so safely.

This information sheet looks at important questions about smoking and your mental health, examines some beliefs about smoking and mental health problems and provides information for people with a mental health problem who are thinking about giving up smoking.

**EFFECTS, BENEFITS AND HARMS OF SMOKING ON MENTAL HEALTH**

Most people are now aware of the effect of smoking on a person’s health, such as the increased risk of cancer and heart disease. But smoking also affects your life and your mental health – your overall health and wellbeing – in a number of different ways.

**Mental health symptoms:** It is commonly believed that smoking improves some people’s ability to focus and perform tasks and can help correct some symptoms of schizophrenia, however the evidence for this is not strong and these ‘benefits’ may simply be due to relieving nicotine withdrawal.\textsuperscript{3} Smoking has also been linked with first-ever incidence of a mental health problem such as anxiety and alcohol abuse.\textsuperscript{4}

**Medication:** Smoking interferes with a number of medications such as those taken for schizophrenia and depression. It affects the dosage of medications; some medications may need to be increased, some may need to be decreased and for others there is a variable or unknown effect.\textsuperscript{3}

**Physical health:** Smoking will cause a person to have more coughs and colds, tooth decay, be short of breath and makes being active in general, such as just going for a walk, a lot harder.

**Stress:** Many people say that smoking helps with stress relief and that they feel less stressed after a cigarette. But there is a lot of evidence that shows smoking might actually cause stress and that people who give up smoking are, after a while, less stressed, anxious and depressed. Smoking will help you deal with the stress from withdrawal symptoms, like sadness, anxiety, stress, depression and poor concentration, but the relief is only short term because the stress will return until you have your next cigarette.\textsuperscript{3}

**Social stigma:** More and more places are becoming smoke-free, so there are less and less places where a smoker feels comfortable. Smoking also affects a person’s physical appearance, such as yellowing of fingers and teeth, and how their clothes and hair smell. This in turn affects how others respond to them and how they feel about themselves.

**Financial hardship:** In general people who smoke will have more financial stress. A person who is on a pension and smokes 40 cigarettes a day may be spending almost a third of their income on cigarettes.\textsuperscript{3}

**ADDRESSING YOUR SMOKING**

If you smoke and you have a mental health problem you can give up smoking. Giving up smoking is hard for anybody because smoking is addictive and for many people is a longstanding habit. On average it can take anyone seven to eight attempts to finally give up smoking. It is possible for people with a mental health problem to do something about their smoking and the following provides some information on how and what to think about.

**How to give up smoking:** The strategies to give up smoking are the same as for anybody else, in the end, how you give up smoking is up to you to decide. People give up smoking in many ways – some people ‘go cold...
turkey’ and some people reduce their smoking until they quit (see next page). Making an attempt to quit smoking requires planning.

Individual or group counselling can help some people with managing a quit attempt, and for other people pharmacotherapies, or quit smoking medications, can help with withdrawals and cravings.

There are three types of these medications:
- Nicotine Replacement Therapy (NRT)
- Bupropion (Zyban)
- Varenicline (Champix).

It is important to remember that these medications are not a substitute for counselling or other support and they need to be used as directed to be effective, and close monitoring is recommended when using Zyban or Champix.

There is evidence that combining these medications with individual or group support is one of the best ways to give up smoking.

PHARMACOTHERAPIES FOR PEOPLE WITH A MENTAL HEALTH PROBLEM

NRT: NRT is safe for people with a mental health problem to use. It supplies nicotine to your body in smaller doses to reduce nicotine withdrawal symptoms and comes in the form of patches, inhalers, gum and tablets.

Bupropion: It is important to consult your doctor before taking this product so they can help with monitoring if there are any problems. It is an antidepressant medication only available on prescription that helps to ease withdrawal symptoms and cravings. It may not be suitable for people with a history of seizures, people with a history of anorexia or bulimia and people using other antidepressants.

Varenicline: It is important to consult your doctor before taking this product to monitor if there are any problems. It is a new medication only available on prescription. It helps with withdrawal symptoms and takes away the pleasure of smoking. There have been some reports of depressed mood, suicidal ideation and changes in emotion and behaviour using this product.

IMPORTANT THINGS TO CONSIDER ABOUT ADDRESSING YOUR SMOKING

Medication: Giving up smoking may have on the amount of any medications you take for a mental health problem. If you decide to stop smoking, your medication should be monitored by a clinician to monitor if the dose needs to be changed. But any effect is less risky than smoking and should not be an obstacle to quitting.

Mental illness relapse: There is little evidence that people with schizophrenia who give up smoking are at risk of psychosis. The evidence about the effect of quitting on depression is more mixed: some studies show that quitting reduces the incidence of depression, others show that quitting may increase the incidence of depression. Therefore it is important for clinicians to monitor anybody with schizophrenia or a history of depression who plan to quit.

Withdrawal symptoms: When you give up smoking you may experience some withdrawal symptoms like sadness, anger, anxiety, depression, irritability, restlessness and poor concentration. You can expect these symptoms to decrease after about two weeks. It is important to remember this is normal for anybody giving up smoking and is not necessarily a symptom of mental illness. If you have any concerns you should speak to your doctor.

Get support: Ask a friend or relative to support you in giving up smoking. Talk to your doctor so they can give you extra support and advice in giving up smoking. Call the Quitline on 13 7848 (13 QUIT). They can give you helpful advice and information to give up smoking.
### COMMON CONCERNS ABOUT SMOKING AND MENTAL HEALTH

<table>
<thead>
<tr>
<th>MYTHS/BELIEFS</th>
<th>EVIDENCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Smoking helps people deal with their mental health problems</td>
<td>There is weak evidence that smoking improves the neurological functioning of people with schizophrenia. Smoking is strongly related with first-ever incidence of a mental health problem such as anxiety and alcohol abuse.</td>
</tr>
<tr>
<td>Smoking helps to ease stress</td>
<td>Smoking may actually cause stress. Smoking only helps to ease the stress of withdrawal symptoms like sadness, anxiety, stress, depression and poor concentration in the short term. People who stop smoking report less stress and anxiety than they had before.</td>
</tr>
<tr>
<td>People with a mental health problem have a right to smoke</td>
<td>People with a mental health problem also have a right to the opportunity to do something about their smoking if they want to. Smoking has not only been ignored, it has been encouraged and reinforced in the mental health sector.</td>
</tr>
<tr>
<td>People with a mental health problem are not interested in giving up smoking</td>
<td>This is an assumption. Research and anecdotal evidence show that many people with a mental health problem are interested in giving up smoking.</td>
</tr>
<tr>
<td>It is too hard for people with a mental illness to give up smoking</td>
<td>Giving up smoking can be hard for anybody to do and it can take on average 7-8 take of attempts before successfully stopping. It can take a longer amount of time for some people with a mental health problem to give up smoking and they may need more intensive support but it is not impossible.</td>
</tr>
<tr>
<td>Quitting smoking will cause a relapse in mental illness</td>
<td>There is very little evidence that people with schizophrenia are at risk of psychosis if they give up smoking. Some people with a history of depression will not experience a relapse and some people will experience a relapse.</td>
</tr>
<tr>
<td>Pharmacotherapies are not suitable for people with a mental health problem</td>
<td>It is safe for people with a mental health problem to use NRT. It is also generally safe to use Bupropion or Varenicline for most people, but it is important to speak to your doctor first. All of these products should be used in conjunction with individual or group counselling.</td>
</tr>
</tbody>
</table>

**FOR MORE INFORMATION**


**ENDNOTES**


This information sheet was developed by Cancer Council NSW and the Mental Health Coordinating Council as part of the Tackling Tobacco Program, 2008.

Second-hand smoking and your health

Second-hand smoking affects people who don’t smoke, as well as people who do.
A fact sheet from the National Heart Foundation of Australia

What is second-hand smoking?
Second-hand smoking is breathing in other people’s tobacco smoke, either from the burning end of a cigarette or from the smoke breathed out by a smoker. There are over 4,000 chemicals present in cigarette smoke, and many are known carcinogens (substances that are known to cause cancer).

Second-hand smoking is sometimes referred to as ‘exposure to environmental tobacco smoke’ or ‘passive smoking’. It affects people who don’t smoke, as well as people who do.

The amount of smoke that you breathe in from passive smoking depends on:
➤ How many people are smoking and how near they are to you
➤ The size, shape and ventilation of the area that you are in
➤ How long you are exposed to the tobacco smoke.

What are the risks of second-hand smoking?
Smokers aren’t the only people who are at risk from their smoking. There is evidence that second-hand smoking at home, at work and in enclosed public places can harm adults and children.1

➤ A non-smoker’s risk of heart disease can increase by up to 25-30% if they are exposed to second-hand smoke2-3
British research suggests that the effect may be even greater, with one study reporting the increased risk of heart disease as high as 50-60%.4
➤ The risk of heart disease for men and women increases with the amount5 of second-hand smoke that they are exposed to and/or number of years that they are exposed to it6
➤ There is growing evidence that non-smokers who are exposed to second-hand smoke have an increased risk of stroke7,8

Tobacco smoke is absorbed quickly from your lungs into your bloodstream. The damage caused by second-hand smoking is similar to that caused by actually smoking.

➤ Even very short-term exposure to second-hand smoke (as little as 30 minutes) can harm your body’s cardiovascular system9,10
➤ People who already have heart disease or have a higher risk of heart disease should take particular care to avoid being exposed to second-hand smoke because it can cause more immediate risks to their health.10

How does second-hand smoking affect my health?
Tobacco smoke is absorbed quickly from your lungs into your bloodstream. The damage caused by second-hand smoking is similar to that caused by actually smoking.
Tobacco smoke:
➤ Makes your blood ‘stickier’ and causes blood cells to clump together – this slows the blood flow and makes blockages in the bloodstream more likely
➤ Slows the blood flow, making blockages more common
➤ Helps to start (and speed up) the artery clogging process
➤ Damages the lining of the arteries where clots can form – this starts happening even in healthy young adults.11

Other health problems caused by second-hand smoking
Tobacco smoke can irritate the eyes, nose and throat of non-smokers. Second-hand smoke can also cause respiratory tract irritation, an increased risk of bronchitis and pneumonia, and increase the frequency and severity of asthma symptoms.12

Second-hand smoke is especially risky for children and babies.1,12 It is associated with:
➤ Low birth weight babies
➤ Sudden infant death syndrome (SIDS) – where babies suddenly stop breathing during sleep
➤ Bronchitis and pneumonia
➤ Middle ear infections
➤ The onset of asthma or increased frequency and severity of asthma attacks.

Everyone in Australia should be able to go about their daily lives without exposure to other people’s cigarette smoke.

What can I do to protect myself, my family and friends?
As noted by the US Surgeon General, exposure to second-hand smoke is a common public health hazard that is completely preventable.9

Everyone in Australia should be able to go about their daily lives without exposure to other people’s cigarette smoke. Therefore, all workplaces, homes, cars, enclosed indoor public places and outdoor restricted public places, such as sporting venues, should be smoke-free.

In your home and car
➤ If you smoke, smoke your cigarettes outside. Blowing smoke away from people, going into another room to smoke or opening a window will not protect family and friends from the dangers of second-hand smoking.
➤ If you don’t smoke but family members do, be sympathetic and understanding but encourage them to quit. If they must smoke, ask them to smoke outside.
➤ If visitors to your home want to smoke, politely remind them not to smoke inside. Most smokers respect this and are happy to smoke outside. Display a smoke-free sticker on your front door if you feel uncomfortable asking a visitor to smoke outside.
➤ Don’t smoke in your car or allow others to do so. Children and babies have no choice about exposure to second-hand smoke in confined spaces and it damages their health.
➤ If you need to smoke on a long car trip, make regular stops to smoke outside the car.
➤ Be a good role model for your children: don’t smoke. Children whose parents don’t smoke are much less likely to take up smoking.14,15,16

In public places
➤ Know the law. Food preparation areas, public transport, elevators, airports and aircraft, theatres, schools, childcare centres and cinemas in Australia are all smoke-free. All states and one territory have introduced legislation for smoke-free workplaces and public places, including restaurants, hotels and nightclubs.
➤ Research shows that the health risks of second-hand smoking cannot be adequately reduced by ventilation or air cleaning, or by providing separate smoking and non-smoking areas.17,18 Recent studies in the USA report that hospital admissions for heart attack decreased after comprehensive smoke-free policies were introduced in workplaces and public places.19
➤ If you go to a public venue that is not smoke-free or where smoke-free policies are ignored, contact the manager. Remember that the majority of Australians do not smoke. You are entitled to breathe clean air and avoid exposure to health risks in a public place.

At work
➤ If your workplace is not smoke-free, talk with your employer about it. Occupational health and safety legislation requires employers in Australia to take all practicable measures to protect the health, safety and welfare of employees and others in the workplace. This applies to passive smoking. Smoke-free workplaces not
Australia is highly regarded internationally for its progress in reducing exposure to second-hand smoke, but more can be done.

**Keep up the good work**

Australia has been successful in reducing the prevalence of smoking in recent years, but much more needs to be done. We encourage you to be active in further reducing your exposure to second-hand smoke, and in supporting everyone's right to breathe smoke-free air.

Australia is highly regarded internationally for its progress in reducing exposure to second-hand smoke, but more can be done. With your help, a smoke-free Australia is an achievable goal.

**REFERENCES**


For heart health information – Tel: 1300 36 27 87
www.heartfoundation.org.au

Second-hand Smoking and Your Health fact sheet
© 2008 National Heart Foundation of Australia
www.heartfoundation.org.au

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Chapter 2

Quitting smoking

STOPPING SMOKING

A POSITION STATEMENT FROM CANCER COUNCIL AUSTRALIA

The toxins in cigarette smoke cause disease in nearly every organ of the body. Stopping smoking at any age has immediate and long-term health benefits. There are effective support services to help you quit.

KEY MESSAGES

The toxins in cigarette smoke go everywhere the blood flows, causing disease in nearly every organ of the body, at every stage of life.1

If you smoke – you put at risk your own health and the health of others around you.1,2

Stopping smoking has immediate as well as long-term benefits, reducing your risk of disease and improving your health in general – regardless of age and even if you have already developed an illness through smoking.1,3

The good news is that there is support for those who need it – you don’t have to go it alone. And help is only a phone call away – 137 848.

Cancer Council Australia recommends:

➤ Choose a method that is safe, effective and suits you
➤ Be sceptical of methods that seem too good to be true – they usually are
➤ Nicotine is highly addictive and, while various products can assist a person to quit smoking, there is no easy fix
➤ If you are taking medications, are pregnant, or have suffered from depression, anxiety or other mental illness, speak to your doctor before quitting
➤ Don’t be shy about getting help with quitting – it can improve your chance of quitting successfully
➤ If you are a heavily addicted smoker*, your chances of quitting successfully may be greater if you combine counselling support and stop-smoking medications
➤ Quitting takes practice – those who succeed are those who keep trying.

* ’Heavily addicted smoker’ is generally defined as someone who smokes more than 15 cigarettes a day, smokes within 30 minutes of waking and/or suffered withdrawals during previous quit attempts.

APPROACHES TO QUITTING

There are different methods for quitting smoking and products you can use to help you cope with cravings for a cigarette. Choose something that is safe and suits you.

The Quitline: 137 848

The Quitline provides access to self-help resources, advice, support, and confidential telephone counselling for smokers who want to quit. Quitline staff can help you to understand why you smoke, assist you in making a plan to quit, and provide you with encouragement and information to help you stick with quitting. You can also ask to use the Quitline call-back counselling service: meaning you can ask staff to make follow-up calls, at convenient times, to see how you are going with quitting.

The Quitline is answered 24 hours a day. Counselling is provided by trained and experienced professional telephone counsellors/advisors. Research has found that
using this kind of service can increase the chances of quitting successfully.\(^4\)

**Do-it-yourself**

Making an attempt to quit by yourself is a good way to start and there are resources, such as the national Quit booklet, available to increase your chances of success. Self-help materials are available to help people to understand why they smoke and offer advice and practical strategies on stopping smoking and staying stopped.

**Gradual approaches**

Gradual approaches are not recommended unless they are part of a well-structured program.\(^5\)

Some people think that switching to low tar cigarettes will reduce their health risks from smoking and make it easier for them to give up. There is no evidence that this is the case. It has been shown that lung cancer risk is similar for people who smoke medium-tar cigarettes, low-tar cigarettes or very low-tar cigarettes.\(^6\)

**Courses**

If you have tried to quit a number of times before without success, you may find it useful to attend a course. Courses offer extra support for those who need help in getting ready to quit and staying stopped.

Research on properly evaluated courses show that:\(^7\)

- Around 70 per cent of people who complete the course will be non-smokers at the end of the course
- At least 15 per cent of people who complete the course will still be non-smokers after 12 months.

**Effective, quality courses generally:**

- Provide details of the course when asked, such as number and length of sessions, or type of information provided and costs
- Have trained experienced staff conducting the courses.

**Gradual approaches**

Gradual approaches are not recommended unless they are part of a well-structured program.\(^5\)

Some people think that switching to low tar cigarettes will reduce their health risks from smoking and make it easier for them to give up. There is no evidence that this is the case.

**Alternative methods**

You may be interested in acupuncture, hypnotherapy, herbal and homeopathic preparations. While there is currently insufficient evidence of the effectiveness of such methods to recommend their use as an aid to quitting, the counselling that may accompany them can be helpful.\(^8\)

**Nicotine replacement therapy (NRT)**

Nicotine replacement therapy (NRT) products can assist highly dependent smokers who are motivated to quit. They are designed to reduce nicotine withdrawal symptoms while the person quitting concentrates on breaking the habit.

It is important if you choose to use NRT that you read and follow the instructions on how to use these products in order to maximise their effectiveness.

There are several different forms of NRT, including patches, gum, inhalers, lozenges and tablets. A doctor or pharmacist can help determine the best NRT for you and explain how to use the products. Research shows that nicotine replacement products are most helpful for people who smoke more than 15 cigarettes per day.\(^9\)

**Other drug therapies**

The drug bupropion, sold under the brand name Zyban, is available only on prescription, and is approved by the PBS. Its active ingredient is bupropion hydrochloride, which is also present in certain antidepressant medicines. The tablets do not contain nicotine. This drug must be prescribed by a doctor, as it is not suitable for all people. Using bupropion can reduce some nicotine withdrawal symptoms and, together with counselling, can increase your chances of quitting successfully.\(^10,11,12\)

If you are taking medications, are pregnant, or have suffered from depression, anxiety or other mental illness, speak to your doctor before commencing any drug therapy for quitting smoking.
TALKING TO YOUR LOCAL HEALTH PROFESSIONALS

Doctors, pharmacists, nurses, and other health professionals can be a good source of advice and information to help smokers to quit. Your GP or pharmacist is best-placed to advise on whether NRT or other drug therapies are suitable for you.

FURTHER HELP OR INFORMATION ON QUITTING SMOKING

Call the Quitline – 137 848 (available 24 hours a day, 7 days a week).

Contact your State Quit Campaign or Cancer Council, and ask about resources or courses they may offer for smokers wanting help to quit, or training for health professionals on supporting their clients to quit.

Quit SA – www.quitsa.org.au
Quit Tas – www.quittas.org.au
Quit Victoria – www.quit.org.au
Cancer Council WA – www.cancerwa.asn.au

Cancer Council Australia gratefully acknowledges the assistance of Quit Victoria in the development of this statement, which is based on Quit Victoria publications.

The criteria for selecting smoking cessation courses are adapted from guidelines developed jointly by the Australian Medical Association (WA) and the Australian Council on Smoking and Health.

REFERENCES


2004;328:72-5.

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Reviewed September 2008
www.cancer.org.au
Addiction

What keeps people smoking? Nicotine addiction is as strong or even stronger than heroin or cocaine addiction. A fact sheet from Quit Victoria

When so many people want to quit, what keeps them smoking?
- Cigarettes and other forms of tobacco are addictive
- Nicotine is the drug in tobacco that causes addiction.

How do people get addicted?
Nicotine occurs naturally in the tobacco plant. Nicotine causes changes in the brain. The effect of nicotine is less dramatic than that of many other drugs. Despite this, nicotine addiction is as strong or even stronger than heroin or cocaine addiction.

In large amounts nicotine is poisonous and first-time smokers often feel sick and dizzy as a result. After a while the body gets used to nicotine, reducing its effect, so the smoker may smoke more.

New smokers start to associate situations or moods with smoking. They may become used to having a cigarette when they are at a party or feeling depressed. Before too long they organise their day around smoking and feel anxious if they can't smoke. Nicotine reinforces and strengthens the desire to smoke and causes users to keep on smoking.

What is nicotine addiction like?
Unlike other legal drugs, such as alcohol, most users of tobacco are addicted to nicotine.

Smokers are physically dependent on nicotine. Most smokers will only go an hour or two without smoking. A highly dependant smoker is one who smokes within half an hour of waking up, ranks the first cigarette as the most important of the day and smokes more than 25 a day.

Even after long periods of not smoking, most smokers who want to have an occasional cigarette quickly return to the previous levels of smoking. It is used despite harmful effects. For example, only half of smokers who suffer a heart attack manage to quit, despite advice from their doctor. One in two of all regular smokers will die as a result of their habit.

REFERENCES
Smoking harms nearly every organ in your body. It weakens your health throughout your life and can cause fatal diseases.

As soon as you stop smoking, your body begins to repair itself. In the first days after quitting your body is already working better (even if you don’t necessarily feel it).

The earlier you quit, the better for your health. The benefits of stopping smoking apply to men and women, young and old, and people with and without smoking-related diseases. So it is worth having a go.

The benefits of stopping smoking apply to men and women, young and old, and people with and without smoking-related diseases. So it is worth having a go.

Depending on the number of cigarettes you smoke, typical benefits of stopping are:

**WITHIN A DAY**
- Almost all of the nicotine is out of your bloodstream
- The level of carbon monoxide in your blood has dropped and more oxygen can reach your heart and muscles.

**WITHIN A WEEK**
- Your lung’s natural cleaning system will start to recover and become better at removing mucus, tar and dust from your lungs
- You will have higher blood levels of protective antioxidants, such as Vitamin C.

**WITHIN TWO MONTHS**
- Your lungs will no longer be producing extra phlegm caused by smoking
- You’ll cough and wheeze less
- Your immune system will have begun to recover
- Your blood is less thick and sticky, and blood flow to your hands and feet improves
- Your body is better at healing cuts and wounds.

**WITHIN SIX MONTHS**
- Your lungs are working much better. Exercising will be easier, as more air is getting into your lungs.

**AFTER ONE YEAR**
- Your blood pressure returns to normal.

**WITHIN TWO TO FIVE YEARS**
- There is a large drop in your risk of heart attack and stroke. Your risk then continues to gradually decrease
- For women, within five years your risk of cervical cancer is the same as someone who has never smoked.

**AFTER TEN YEARS**
- Your risk of lung cancer is markedly lower than that of a continuing smoker and continues to decline (provided the disease is not already present).

**AFTER FIFTEEN YEARS**
- Your risk of heart attack and stroke is close to that of a person who has never smoked.

Stopping smoking reduces your risk of developing, or the worsening, of lung disease including chronic bronchitis and emphysema. Over time, your sense of taste and smell will slowly improve.
Nicotine dependence and withdrawal

Tobacco contains more than 4,000 harmful chemicals. Nicotine is the chemical that causes addiction to smoking. Knowing how dependent you are on nicotine can help you decide about the best way to quit, according to this tobacco and health fact sheet from the NSW Department of Health.

LOW OR HIGH LEVEL OF NICOTINE DEPENDENCE?

The six questions below will show how dependent you are on the nicotine in tobacco.

<table>
<thead>
<tr>
<th>QUESTION</th>
<th>ANSWER</th>
<th>SCORE (CIRCLE ONE)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. How soon after waking up do you smoke your first cigarette?</td>
<td>Within 5 minutes</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>6-30 minutes</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>31-60 minutes</td>
<td>1</td>
</tr>
<tr>
<td>2. Do you find it difficult to abstain from smoking in places where it is forbidden?</td>
<td>Yes</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>0</td>
</tr>
<tr>
<td>3. Which cigarette would you hate to give up?</td>
<td>The first one in the morning</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Any other</td>
<td>0</td>
</tr>
<tr>
<td>4. How many cigarettes a day do you smoke?</td>
<td>10 or less</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>11-20</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>21-30</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>31 or more</td>
<td>3</td>
</tr>
<tr>
<td>5. Do you smoke more frequently in the morning than in the rest of the day?</td>
<td>Yes</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>0</td>
</tr>
<tr>
<td>6. Do you smoke even though you are sick in bed for most of the day?</td>
<td>Yes</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>0</td>
</tr>
</tbody>
</table>

Score:
1-2 = very low dependence
3-4 = low dependence
5 = medium dependence
6-7 = high dependence
8+ = very high dependence

Total: Your score: Add the numbers you have circled

WHAT YOUR SCORE MEANS

The higher your score on the test, the more likely you are to benefit from using nicotine replacement therapy (NRT) or Zyban to assist with withdrawal symptoms and to quit. Those with a score above five should consider using a higher dose of NRT. Those with a score of four or less may benefit from a lower dose of NRT.

If you have had a health problem, such as a heart attack or stroke see your doctor before you quit. If you’re pregnant or planning to start a family it is very important to discuss your quit plan with your doctor.

So what’s the good news?

Within 20 minutes of quitting, your body begins a series of changes that continue for years. For example, four hours after quitting smoking, the nicotine level in your blood is reduced by half. Within hours carbon monoxide in the blood decreases and the oxygen level in blood increases. Within days the ability to smell and taste has improved and physical activity becomes easier. Within three months, coughing, sinus congestion and shortness of breath decrease.

NICOTINE WITHDRAWAL

Nicotine withdrawal is usually worst in the first 24-48 hours of quitting. Few people experience all the symptoms and they don’t all happen at once. The symptoms you might experience are a normal and expected part of quitting smoking. The symptoms will gradually decline in intensity and the worst is usually over after a couple of weeks.

Withdrawal is your body’s response to ridding itself of dependence on nicotine. Some people think of the withdrawal as ‘recovery symptoms’. After about two weeks ‘recovery symptoms’ should be less severe. If you have a moderate or high level of nicotine dependence...
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and expect withdrawals, using nicotine replacement therapy (NRT) is a smart move.

It’s a good idea to let members of your family, friends and workmates know what you’re going through.

Some of the symptoms of nicotine withdrawal you may experience include:

**Irritability and anxiety**
Feelings of irritability or anxiety may be experienced as your body adjusts to being without nicotine.1

It’s common to feel anxious when you make a big change in your life. To counter this effect, reduce the amount of stress in your life in the first two weeks of your quit attempt. Do things that relax you while you’re quitting. If you only have time for a short break, then a brief walk and change of environment may help.

**Difficulty concentrating**
The physical changes that are happening in your body and the cravings for a cigarette may make it more difficult to concentrate.2

Your body is now receiving more oxygen and will adjust to this in a few days. Complete your tasks or activities in small ‘bite-size’ chunks. You can do this by taking regular breaks and doing something active during those breaks. Your concentration levels will return to normal in a few weeks time.

**Restlessness**
Some people feel as though they can’t sit still and that they need to move about or do something with their hands. Use this restlessness in a positive way by doing some physical activity that you enjoy. As your body is removing nicotine it is able to absorb more caffeine. It may be helpful to reduce your intake of tea, coffee and cola drinks by half.

Read the labels on chocolate bars and energy drinks as some of these items also contain caffeine. An increase in caffeine levels may add to your feelings of restlessness or insomnia.

**Problems falling asleep or frequent waking**
Your sleep patterns may be affected as your body withdraws from nicotine.3 This should ease after about a week. Some people report having unusual or strong dreams, others find that they sleep better. Do something that you find relaxing before you go to bed.

**Craving for tobacco**
Some people think of cravings as ‘desires’ for a cigarette. Cravings are normal and expected. They last only a few minutes and have a beginning, middle and an end. As time passes your cravings will be less intense, shorter and happen less often. You may like to think of cravings as ‘time limited desires’. Some people keep a diary to document how they feel, including the frequency and intensity of their cravings. This can help to demonstrate that things are improving.

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**Tingling sensations and dizziness**
Tingling in your fingers and toes and dizziness show that the blood circulating through your body has more oxygen in it. Some of the aches and pains you experience are signs that your circulation is improving. This is because more of your smaller blood vessels are opening up and your body is adapting to having more oxygen.

**Coughing**
Coughing means that your lungs are getting rid of tar and mucus. Try to think of coughing as your lungs now working better to clean themselves.

**Appetite changes**
Some people start to feel more hungry once they have quit smoking. This is because nicotine reduces the appetite. You may find that you develop a ‘sweet tooth’. It may be helpful to take glucose, which is low in kilojoules and may help to satisfy the desire for sweet foods, without eating foods like chocolate cake or ice-cream that can add to your body weight. Glucose is available in liquid or tablet form from pharmacies. People with diabetes should consult their doctor before using any product containing sugars.

A final note
Coping with nicotine withdrawal is a challenge, especially in the first few days. Most withdrawal symptoms gradually reduce over the first couple of weeks. The long-term benefits of quitting will definitely outweigh the short-term difficulties. Stay positive and be kind to yourself while you’re experiencing ‘recovery symptoms’.

And remember, nicotine replacement therapy (NRT) can reduce your body’s addiction to nicotine and reduce the symptoms of withdrawal, while you think about changing your habits and triggers for smoking.

**REFERENCES**

If you would like to quit smoking contact the Quitline 13 7848 or speak with your doctor or pharmacist.

Visit the website: www.quitnow.info.au

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www.health.nsw.gov.au

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QUIT SMOKING: 10 TIPS

It’s never too late to quit smoking and there are many benefits to be gained no matter what age you are when you give up. Here are some quick tips from myDr.com.au to help you kick the habit.

TIP 1
Quitting is different for everyone, so find an approach that will work for you. This may be either the cold turkey approach (stopping suddenly and totally) or a more gradual reduction in the number of cigarettes you smoke each day. Set a date to quit – and stick to it. Make it sooner rather than later. If you are quitting by yourself, it is recommended that you stop smoking completely on your quit date.

TIP 2
Get as much support as you can from family, friends and work colleagues. Let them know you are planning to quit, and ask smokers not to smoke around you or offer you cigarettes. Quitting with a friend can also be an excellent idea – you can share your feelings and encourage each other.

TIP 3
Throw out all cigarettes, ashtrays and lighters and anything else that might remind you of smoking. Wash your clothes and clean your car to remove the smell of smoke.

TIP 4
Nicotine replacement therapy, such as nicotine patches or chewing gum, could be a good idea for those who smoke heavily or who feel they may need the extra help. There are also medicines available on prescription, such as varenicline (brand name Champix) and bupropion (brand name Zyban) that can help you quit by reducing withdrawal symptoms and the urge to smoke. Talk to your doctor about what would be best for you.

TIP 5
Write down all the reasons that made you decide to quit smoking, and carry them with you in case you need reminding.

TIP 6
Plan ahead for situations in which you are likely to be tempted to smoke, such as parties, drinking or going out for coffee. Try to avoid these situations in the early stages of your quitting programme, or try sitting in the non-smoking section at restaurants, drinking your coffee standing up or with the other hand, or keeping something in your hand when you’re talking on the phone.

TIP 7
Keep the following four Ds in mind when you have a craving.
➤ Delay: remember that the worst cravings last for only a few minutes and will become even less frequent the longer you have quit
➤ Deep breathe: this should help you relax and focus your mind on something else

TIP 8
If you drink a lot of coffee, you may also want to cut down on your coffee intake as you will retain more caffeine when there is no nicotine in your system. Feeling jittery will not help your plan to quit. It may also be best to avoid alcohol as many people find it hard to resist smoking when they drink.

TIP 9
If you find you are losing motivation to quit, remind yourself of the many medical and financial benefits of quitting! For example, did you know that 12 months after quitting, your risk of heart disease is reduced to nearly half that of a smoker’s?

TIP 10
Telephone the National Tobacco Campaign’s Quitline on 131 848 for more advice and assistance to quit smoking.

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Quitting services and products

Different people have success with different quitting strategies. It is important to choose a way to quit that is safe, effective and suits you. Some tips from Quit Victoria

This guide to quitting services and products can help you decide how to quit. Different people have success with different quitting strategies. It is important to choose a way to quit that is safe, effective and suits you. Be sceptical of any services or products that promise success without you needing to do anything.

Choosing the best way to quit

Research shows that people who have the best chance of quitting are those who get some coaching and use quitting medications. The more contact you have with a coach or advice and support service, the better your chances of quitting. If you smoke at least 10 cigarettes per day, using a nicotine replacement product or a prescription medicine can help you quit.

Before quitting

Chemicals in cigarettes change the way some medications work. See your doctor before quitting if you are taking medication. We know that stopping smoking can be stressful. So if you have suffered from depression, anxiety or other mental illness, speak to your doctor before quitting.

Research shows that people who have the best chance of quitting are those who get some coaching and use quitting medications.

Do-it-yourself

Making an attempt to quit by yourself is the way most people choose to start and there are resources available to increase your chance of success. However using an advice and support service has been shown to produce better results. Quit Victoria provides booklets and videos/DVDs, such as Quit’s Ten Steps to Quit for Good, to help people understand why they smoke. They offer advice and practical strategies on stopping smoking and staying stopped. They are low cost, often no more than the cost of a phone call.

You can order Quit resources via our website www.quit.org.au under ‘Downloads and orders’ or call the Quitline.

The Quitline 13 7848

The Quitline telephone service provides access to self-help resources, advice, support, and confidential telephone counselling for people who want to quit smoking. Quitline advisors help you to understand why you smoke, they assist you in making a plan to quit and provide you with encouragement and information during your attempt to quit. If you decide to use the Quitline callback counselling service, Quitline advisors will arrange to call you before and after your quit date at times convenient to you.

The Quitline is answered 24 hours a day. Counselling is available Monday to Friday from 8am to 8pm and is provided by trained and experienced professional telephone advisors. Research has found that using this kind of service can increase your chance of quitting successfully.

One-on-one advice

Discussing quitting with your doctor, health educator, psychologist, psychiatrist, or other health professional who has been trained in assisting quitting can increase the likelihood of your success.

Courses

Some people find attending a quit course helpful. Courses offer you extra support when trying to quit. They are usually conducted in a group. Research shows that on average, group courses can increase your chance of quitting successfully, compared to quitting without any help. However, the success rates of programs vary widely.

More effective programs are run by a trained leader, who provides information to help you understand your smoking, and can help you develop coping or problem solving skills. Skills may include identifying and avoiding situations where you are tempted to smoke, controlling or managing ‘triggers’ for smoking, changing your lifestyle to reduce stress, ways of lessening negative moods, and overcoming slip-ups. The leader should provide you with support and encouragement to quit. You should feel welcome to discuss any problems or worries you have about quitting with them.
Some quit courses promise very high success rates. It is very difficult to make comparisons due to the differences in the ways they are evaluated. Some results are based simply on those who complete treatments or only those who respond to later contact. Ideally results should be based on all participants with full details of how the course is evaluated. A survey showing the percentage of participants who remain quit after six months is necessary for meaningful quitting rates. A 12-month survey is needed to determine long-term success rates.

Typical rates of successful quitting for group courses in the long-term are around 14 per cent. Be wary of claims that far exceed this. Ask to see evidence of how figures were obtained. Check the experience and training of those running the course and whether a reputable organisation is responsible for the program.

You should not feel under pressure to attend. One way to deal with this is to delay signing up, get some do-it-yourself materials and think about it.

Quit Victoria runs the Quit Fresh Start course and the Quit Short Course. Both courses have been evaluated, and have 12 month quitting rates (after course completion) between 16 per cent and 21 per cent. The Quit Fresh Start course is an eight session program. It has run for more than 15 years and has helped thousands of people to quit smoking. The Quit Short Course is a two session program that combines features of the Fresh Start course with support from the Quitline telephone callback service. Trained and accredited leaders run the courses at centres throughout Melbourne and country Victoria. Ring 13 7848 for more information about the courses and your nearest centre.

The Quit Coach – www.quitcoach.org.au

The QuitCoach is a free interactive website, offering advice designed specifically for you. It can help you decide whether you want to quit, help you to quit and help you stay stopped. The QuitCoach asks questions and uses your answers to give you advice tailored to your situation. Each time you visit, your latest answers are used, together with the answers from your previous visits, to give you advice that takes into account any changes you have made.

Research shows that people who use nicotine replacement products are more likely to quit and stayed stopped.

Nicotine replacement therapy

All nicotine replacement products – the gum, patches, lozenges, inhaler and tablet (Microtab) – are sold at pharmacies without prescription. Some are also sold in supermarkets and at some service stations. Research shows that people who use nicotine replacement products are more likely to quit and stayed stopped. Nicotine replacement products work best for people who smoke at least 10 cigarettes per day and who want to quit. They are intended to reduce nicotine withdrawal symptoms while you focus on breaking your smoking habits and learn to live without cigarettes. You can discuss with your pharmacist, doctor or Quitline advisor which product would best suit you.

Nicotine replacement products are much safer than cigarettes, as they do not contain cancer-causing substances, carbon monoxide or other dangerous chemicals found in tobacco smoke. Nicotine products are designed to be less addictive than cigarettes: you absorb less nicotine, at a slower rate than smoking. Within seconds of puffing on a cigarette, high levels of nicotine reach your brain. In contrast, it takes over 30 minutes for the level of nicotine in your blood to peak after starting use of the gum, inhaler, lozenge and tablet, and between two to 10 hours for the patch (depending on the brand of patch). It is important to carefully follow the instructions on how to use these products to gain the most benefit from them. The nicotine gum, inhaler, lozenge and tablet work best when taken every one to two hours throughout the day.

Using a nicotine product will still increase your chances of quitting even if it does not completely control cravings. Your pharmacist or doctor may recommend using combination therapy (using the patch with the nicotine gum or lozenge) if your cravings are bad or you have not been able to quit using one product alone.

If you feel unready or unable to quit, the ‘cut down to stop’ method allows you to use the nicotine inhaler, gum or lozenge while cutting down the number of cigarettes you smoke over six months before stopping completely.

If you have any medical conditions, are taking any medicines (including non-prescription ones), or are pregnant or breastfeeding, you should talk to your pharmacist or doctor before using nicotine replacement.
If you are aged 12 to 17 years, you may use nicotine replacement products to quit, with support from your doctor or counselling service.

**Nicotine chewing gum**

Nicotine gum comes as 2 mg and 4 mg pellets. After chewing the gum to get a peppery taste, you rest it in the side of your mouth. You absorb nicotine from the gum through the lining of your mouth. You may ‘chew and rest’ the gum several times before discarding it. The 4 mg gum is used by people who smoke more than 20 cigarettes per day or who cannot quit using the 2 mg gum.

**Nicotine patches**

Sets of nicotine patches come in three sizes, and you usually start with the strongest patch (either a 15 mg 16-hour patch or a 21 mg 24-hour patch). The patch is worn on the skin, and you absorb nicotine from it continuously. Some people may find patches easier to use than other nicotine products. You may also use a type of patch (brand name ‘Pre-Quit’ patch) for two weeks leading up to your quit day. This product increases your chance of success over starting use of the patch after you stop smoking.

**Nicotine inhalers**

A nicotine inhaler consists of a plastic tube with a plug loaded with nicotine, which is inserted into a mouth-piece. When you draw air through the inhaler, nicotine is vapourised and absorbed through the lining of your mouth. The nicotine dose from the inhaler is similar to the 2 mg gum.

**Nicotine lozenges**

Nicotine lozenges are tablets which dissolve in your mouth. They slowly release nicotine, which is absorbed through the lining of your mouth over a period of about 30 minutes. They come in two strengths: 4 mg for people who normally smoke within 30 minutes of waking and 2 mg for people who normally smoke more than 30 minutes after waking.

**Nicotine sublingual tablets**

Nicotine tablets (sold under the brand name Microtab) are small tablets, which dissolve under your tongue. They come in the 2 mg strength only. Most people use between eight to 12 tablets per day. However, people who usually smoke within 30 minutes of waking and smoke over 20 cigarettes per day can increase their dose by taking two tablets at once or by taking one tablet more often.

**Prescription medications**

In Australia, there are two prescription only medications used for quitting smoking: bupropion and varenicline. These medications do not contain nicotine. They must be prescribed by a doctor, as they are not suitable for all people. Both are subsidised by the Pharmaceutical Benefits Scheme (PBS). To get the PBS subsidy you must also be receiving counselling for quitting smoking from your doctor or a support service such as the Quitline.

Bupropion is sold under the brand names Zyban SR, Clorpax, Prexaton and Bupropion-RL. Its active ingredient is bupropion hydrochloride, which is also present in certain anti-depressant medicines. Using bupropion can reduce some nicotine withdrawal symptoms and, together with counselling, can increase your chances of quitting successfully.

Varenicline, sold under the brand name Champix, works by reducing cravings and negative moods, and by reducing the rewarding effects of smoking (if you slip-up while quitting using this medication). Research shows that people who use varenicline are more than twice as likely to quit and stayed stopped.

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**UNPROVEN METHODS AND PRODUCTS**

**Herbal preparations**

These can be available as drops, mouth spray and herbal cigarettes. There is no evidence that these have any benefit other than a placebo effect (no physical effect but may improve some people's confidence at quitting).

Some herbal cigarettes are blended with tobacco. Even herbal cigarettes which contain no tobacco or nicotine have levels of tar and other substances similar to cigarettes and may be harmful to your health.

**Acupuncture**

This involves treatment by applying needles or surgical staples to the skin of the ear or other parts of the body. Related treatments include acupressure, laser therapy, and electrostimulation. To date, there is no clear evidence to support the use of acupuncture or related treatments in their own right as a quitting aid. More research is needed to determine if daily or sustained acupuncture has a benefit.
Acupuncture may be more effective when combined with counselling or skills training.

**Hypnosis**

The aim of hypnotherapy for supporting quitting is to put suggestions in people's non-conscious mind to weaken the desire to smoke, or strengthen their will to stop, or improve their ability to carry through a treatment program. The success of hypnosis has been poorly studied, with studies producing conflicting results. It has not been shown that hypnotherapy itself increases long term quitting rates, although counselling or other treatments that accompany it can be helpful to some smokers.

Research shows that smokers who choose to switch to weaker tasting or less harsh cigarettes...inhale just as much disease causing chemicals from each cigarette as they did from their previous brand.

**Switching to weaker tasting cigarettes**

Research shows that smokers who choose to switch to weaker tasting or less harsh cigarettes (previously branded 'low tar') inhale just as much disease causing chemicals from each cigarette as they did from their previous brand. These cigarettes are designed to make it easy for smokers to get the amount of nicotine that they are used to. There is no evidence that switching to a weaker tasting cigarette reduces addiction or helps smokers to quit. Smokers of these cigarettes do not have less risk of smoking related diseases such as lung cancer, heart disease and emphysema, than smokers of regular cigarettes. To read more about 'low' tar/nicotine cigarettes, refer to Quit's Background Brief: 'Light' or 'low tar' cigarettes.

**Filters and filter blockers**

Filters and filter blocking products (such as drops) are used to help people gradually reduce the amount of smoke they inhale from each cigarette. However, some smokers may compensate for the drop in nicotine by inhaling the smoke more deeply or smoking more cigarettes. There is not enough evidence to recommend these products as quitting aids.

**Aversion methods**

Aversion methods include rapid smoking, covert sensitisation (smoking while imagining unpleasant associations), smoke-holding, electric shocks, silver acetate or pairing smoking or urges to smoke with other unpleasant methods or products. More research is needed to determine if rapid smoking has a benefit, although it can have serious side effects. There is no evidence to support the other methods.

**Exercise**

There is some evidence that exercise may help reduce withdrawal symptoms and cravings. It is also recommended as one way of reducing weight gain that occurs when quitting. However, more research is needed to show if exercise can increase the chance of quitting.

**Other products and methods**

Other methods and products are often marketed as quitting aids, such as homeopathic cures, potions, lobeline, glucose tablets, magnets, lasers, and motivational secrets. Some have not been found to help quitting and many have not been studied. Be sceptical of unsupported claims.

**More information**

You can receive more detailed Stopping Smoking Information sheets on each nicotine replacement product and bupropion by calling the Quitline 13 7848, or by visiting the Quit website www.quit.org.au under ‘Background on Tobacco’ – ‘Topics in Depth’. Also available from the Quitline is the easy-to-read brochure Choosing the best way to quit.
NICOTINE REPLACEMENT THERAPY

Quit SA explains how nicotine replacement therapy (NRT) can assist smokers to quit

What is NRT?
The aim of nicotine replacement therapy (NRT) is to replace some of the nicotine obtained from cigarettes without the harmful constituents found in tobacco smoke.

NRT reduces withdrawal symptoms associated with nicotine addiction, allowing people who smoke to focus on the other aspects of quitting. These aspects include the habit or behaviour of smoking and the emotional dependency that people learn to associate with smoking over time such as stress and boredom.

Quitting involves finding ways to manage the significant change from someone who smokes to someone who used to smoke. For many people this is a major life change that usually involves making several quit attempts over time before quitting for good.

Nicotine replacement therapy (NRT) assists with the physical addiction to nicotine while quitting smoking counselling from a service such as the Quitline helps with the behavioural and emotional aspects.

Research has shown that the best outcomes are achieved when NRT or other medications such as Champix are combined with ongoing counselling and support.

Which NRT product should I use?
There are a number of different brands of NRT available from chemists or the supermarket such as Nicorette, Nicobate and QuitX. Each brand has a range of different products available such as patches, gums, inhalers, lozenges, and sublingual tablets.

There are no significant differences in the effectiveness of these different forms of NRT and therefore the choice of product depends on practical and personal considerations.

People who smoke are advised to discuss with a Quitline counsellor, a pharmacist or their GP which product or brand might be best for them.

Will I still experience cravings when using NRT?
Blood nicotine levels are lower in people using NRT compared to people who smoke. This means that for those who are heavy smokers the standard doses of NRT may not be sufficient to manage nicotine cravings and withdrawal symptoms. Cigarettes provide significantly more nicotine than any form of NRT so heavy smokers may still experience nicotine cravings.

In these situations, the use of more than one form of NRT such as patches and gum (combination therapy) may be necessary. People who smoke tend to be very knowledgeable about the amount of nicotine they need to satisfy their addiction and are usually best able to determine what level of NRT is right for them.

The following graph illustrates the differences in blood plasma levels of nicotine over 24 hours for an ‘average’ smoker i.e. 25 cigarettes/day (the red line) – compared to different forms of NRT used at recommended levels. It is clear from the graph that NRT provides a level of nicotine in the blood, but less than that provided by cigarettes.

What are the recent changes approved for the use of NRT in Australia?
Previously NRT was not recommended for people still smoking, pregnant women and young people.

Following the evidence on the safety of NRT these and other restrictions have been relaxed.

The key changes are:
➤ Combination Therapy: patches can be used in combination with gum or other intermittent forms of NRT to reduce cravings for those who are more nicotine dependent
➤ Cut Down To Stop (CDTS): patches or other forms of NRT can be used to help reduce the number of cigarettes smoked prior to quitting
➤ Young people (12 and older), pregnant women and some people with cardiovascular disease can safely use some forms of NRT
➤ ‘Stepping down’ or ‘weaning’ from higher to lower strength patches is no longer considered necessary, using the 21 mg patch and then stopping abruptly is just as effective
➤ Using NRT to quit is always safer than continuing to smoke.

What NRT products are there?
All NRT products are sold with a Consumer Medicine Information (CMI) leaflet. If this leaflet is not in the packet when NRT is purchased then ask the pharmacist for one. It is

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recommended to read this information before using any NRT product. A summary of NRT products is provided here but it is not a replacement for the CMI provided by the pharmaceutical company.

NRT products can be divided into two groups: patches and oral forms (gum, inhaler, lozenge, sublingual tablet). All oral forms of NRT essentially work in the same way. They all provide nicotine by absorption through the lining of the mouth. Oral forms of NRT can be used as a cigarette substitute and are very effective if you want to cut down the number of cigarettes you smoke prior to quitting.

The choice of an oral form of NRT will depend on personal preferences and many people use different forms of NRT to work out what suits them best.

Obtaining nicotine from NRT is very safe compared to smoking. If nausea or any other adverse effects from NRT are experienced, then you should reduce the amount you are using or stop using it, and speak to your pharmacist or GP. The experience of nausea may occur, but nicotine toxicity is unlikely to occur from the levels of nicotine contained in NRT products. While NRT is a safe form of medication for adults who smoke, it is a poison and therefore caution needs to be exercised around small children. Caution is particularly needed with products such as the gum and mini lozenges that could be mistaken for lollies.

Patches

The nicotine patch is designed to continuously deliver nicotine into the bloodstream through the skin throughout the day. Blood plasma levels of nicotine slowly rise during the first few hours after application with the maximum level being reached after 6-10 hours. The 21 mg/24-hour patch is recommended for those smoking more than 15 cigarettes per day and smoking within 30 minutes of waking. Using this patch for 24 hours, however, may lead to vivid dreams and/or disturbed sleep. If this is experienced then it is advisable to remove the patch overnight. After patch removal, nicotine already in the skin continues to be absorbed for up to two hours.

If vivid dreams and/or disturbed sleep are experienced, then the 15 mg/16-hour patch may be a better alternative. However, when the patch is not worn overnight strong nicotine cravings may be experienced in the mornings after waking. This is more likely in the early stages of quitting or cutting down when nicotine dependence is higher. Intermittent forms of NRT such as lozenges, inhalers, gum and tablets can be used to provide a more immediate dosage of nicotine while waiting for the nicotine from the patch to be delivered.

The rate of delivery is similar for both the 21 mg/24-hour patch and the 15 mg/16-hour patch. However, the 21 mg patch does deliver a higher overall dose of nicotine than the 15 mg patch. The amount of nicotine delivered by the 21 mg patch is approximately half that obtained from smoking a 25 pack cigarettes/day.

Cut Down Then Stop (CDTS).

The patches marketed as ‘Pre-quit’ patches (Nicabate) are actually 21 mg patches that can be used to cut down the number of cigarettes smoked prior to quitting. Recent research has found that using patches or intermittent forms of NRT to cut down the number of cigarettes smoked prior to quitting doubles the success rate compared to using patches for abrupt quitting.

Clear patches provide the same therapeutic benefits as flesh-coloured patches and may be preferred as they are less obvious when the skin area is visible. The patch should be applied to a clean, dry, hairless area of the skin above the waist such as the upper arm with the location changed daily to avoid skin irritation. Adverse effects of the patch include itching and tingling of the skin at the application site, redness of the skin and sleep disturbances such as insomnia.

Gum

Nicotine gum can be used to actively control nicotine cravings when they are felt. The gum contains nicotine which is absorbed through the lining of the mouth and then enters the bloodstream. Maximum blood levels are reached within 5-10 minutes.

Chew Park Chew: Gum is available in two strengths, 2 mg and 4 mg, and needs to be chewed in a particular way to achieve maximum benefit. The gum should be chewed slowly until a peppery taste becomes strong and/or a tingling sensation is noticed. It then needs to be ‘parked’ between the gums/ teeth and cheek until the taste has faded and then chewing is repeated.

The blood levels of nicotine reached using gum are approximately one-third (2 mg) or two-thirds (4 mg) of that reached from cigarettes. The gum is available in a variety of flavours such as mint, fruit, and the ‘classic’ nicotine flavour. Adverse effects of gum usage include nausea and vomiting, indigestion, hiccups, and occasionally headaches if the gum is chewed too rapidly. These unpleasant effects can be minimised by using the products as recommended.

Inhaler

The nicotine inhaler can be used to control cravings by copying the hand to mouth action of smoking. The inhaler consists of a plastic...
mouth-piece and cartridge containing 10 mg of nicotine. The cartridge is placed in the mouth-piece and when closed the foil ends are punctured to allow the release of nicotine as a vapour. Each cartridge contains enough nicotine for about 20 minutes of ‘puffing’.

Although the device is called an inhaler, nicotine is absorbed through the lining of the mouth, not the lungs or airways. The inhaler produces nicotine concentrations that are about one-third of those achieved with smoking. Unpleasant side effects include coughing, headache, heartburn, nausea, hiccups, and throat irritation.

**Lozenge**

The nicotine lozenge can be used to actively control nicotine cravings when they are felt. The lozenge is available in two strengths, 2 mg and 4 mg. The stronger lozenge is recommended for more nicotine dependent smokers.

The lozenge is placed in the mouth and occasionally moved from side to side until completely dissolved, usually within 30 minutes. The nicotine from the lozenge is absorbed through the lining of the mouth. The lozenge should not be chewed or swallowed whole. People should not eat or drink while the lozenge is in the mouth.

This form of NRT is suitable for people who have problems with gum but prefer an oral form of NRT. Adverse effects are similar to the gum.

Nicabate has introduced the Mini lozenge, available in two strengths, 1.5 mg and 4 mg. The Mini lozenge is used in a similar way as the lozenge but may be preferred because of its smaller size. Company trials of the Mini lozenge found that nicotine was absorbed more rapidly from the lozenge than the equivalent or similar strength of gum.

**Sublingual tablet**

The sublingual tablet has been designed to enable a more discrete way to control cravings when they are felt. The tablet is placed under the tongue where it dissolves slowly within 30 minutes, releasing nicotine which is absorbed through the lining of the mouth. It should not be chewed or swallowed. Adverse effects are similar to the lozenge.

**How do I know if I need to use NRT?**

NRT is only recommended for those people who are assessed as nicotine dependent. You can work out your level of nicotine dependence by answering the following two questions:

Knowing your nicotine dependence can help you decide which products would be most beneficial to help you quit. The following table can help with product selection.

The recommended treatment period for all products is 8-12 weeks. Regular use beyond 12 months is not generally recommended although long-term use of some forms of NRT has been reported with no ill health effects.

<table>
<thead>
<tr>
<th>PRODUCT</th>
<th>DOSAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Combination therapy</strong></td>
<td>For people with a Heavy dependence on nicotine and who experience cravings using only one form of NRT</td>
</tr>
<tr>
<td></td>
<td>✧ 15 mg/16-hour patch in combination with 2 mg gum or</td>
</tr>
<tr>
<td></td>
<td>✧ 21 mg/24-hour patch in combination with 2 mg gum or 1.5 mg Mini lozenge or</td>
</tr>
<tr>
<td></td>
<td>✧ Patch in combination with any intermittent form of NRT</td>
</tr>
<tr>
<td><strong>Patch</strong></td>
<td>Heavy to Moderate dependence: 21 mg/24-hour patch or 15 mg/16-hour patch</td>
</tr>
<tr>
<td></td>
<td>Moderate to Low dependence: 15 mg/16-hour patch</td>
</tr>
<tr>
<td></td>
<td>Use 1 patch daily</td>
</tr>
<tr>
<td><strong>Gum</strong></td>
<td>Heavy to Moderate dependence: 4 mg (after the first 2 weeks you may prefer to use the 2 mg gum)</td>
</tr>
<tr>
<td></td>
<td>Moderate to Low dependence: 2 mg</td>
</tr>
<tr>
<td></td>
<td>Use 1 piece per hour or 10-15 pieces per day</td>
</tr>
<tr>
<td><strong>Lozenge</strong></td>
<td>Heavy to Moderate dependence: 4 mg lozenge or Mini lozenge</td>
</tr>
<tr>
<td></td>
<td>Moderate to Low dependence: 2 mg lozenge or 1.5 mg Mini lozenge</td>
</tr>
<tr>
<td></td>
<td>Use 1-2 lozenges per hour (8-12 per day)</td>
</tr>
<tr>
<td></td>
<td>Use 1 Mini lozenge every 1-2 hours</td>
</tr>
<tr>
<td><strong>Inhaler</strong></td>
<td>Use 6-12 cartridges per day depending on level of dependence</td>
</tr>
<tr>
<td><strong>Sublingual tablet 2 mg</strong></td>
<td>Heavy dependence: 2 tablets per hour or 24 per day</td>
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<tr>
<td></td>
<td>Moderate dependence: 1-2 tablets per hour or 12-24 per day</td>
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<tr>
<td></td>
<td>Low dependence: 1 tablet every 1-2 hours or 8-12 per day</td>
</tr>
</tbody>
</table>

1. How soon after waking do you smoke your first cigarette?
   - a. Less than 5 minutes (3 points)
   - b. 5 to 30 minutes (2 points)
   - c. 31 to 60 minutes (1 point)

2. How many cigarettes do you smoke each day?
   - a. More than 30 cigarettes (3 points)
   - b. 21 to 30 cigarettes (2 points)
   - c. 11 to 20 cigarettes (1 point)

**References**


Quit SA, February 2010
www.quitsa.org.au
Smoking racket

In 2006, the global nicotine replacement therapy (NRT) market was estimated at $1.7 billion. The pharmaceutical industry places more messages about quitting in front of smokers than any other source: in the USA, smokers see 10.37 pharmaceutical cessation advertisements per month compared with 3.25 from health agency messages. The constant megaphoning of the idea that quitting requires drugs is causing a rather spurious tail to wag a large banished dog carrying an important message. Simon Chapman explains his views.

Twenty years after the launch of NRT, studies repeatedly show two thirds to three quarters of permanent ex-smokers stop unaided and about half find it easier than anticipated – a phenomenon that also occurs with problem drinking, gambling and narcotics use. But when was the last time you heard that good news? Instead, the increasing medicalisation of cessation emphasizes the opposite and that serious attempts at quitting should be pharmacologically mediated.

The good news on cessation is treated almost like a state secret. There are no campaigns highlighting that most ex-smokers quit unaided despite globally hundreds of millions having done so. Among my colleagues, unassisted cessation is rarely researched, instead framed in studies often funded by the pharmaceutical industry as a challenge to be eroded by persuading more to use drugs. Yet if a smoker asked “how do most smokers quit?”, failure to emphasise that most have always stopped unaided would be like explaining that most cyclists have professional tuition rather than being self-taught or that most domestic cooks attend cooking classes. Quitting has become increasingly pathologised, risking distortion of public awareness of its natural history, to the obvious benefit of the drug industry. Research on cessation is dominated by ever-finely tuned accounts of how smokers can be encouraged to do anything but go it alone when trying to quit – exactly opposite of how a very large majority of ex-smokers succeeded.

A large body of evidence from clinical trials shows unequivocally that those who use NRT in trials have 50-70 per cent greater success than those using placebo. But clinical trial conditions overstate real world efficacy because of factors such as trialists getting free drugs, effects caused by the research attention paid to them and subjects’ desire to please the researchers with whom they interact. A 2005 review concluded “sales of NRT were associated with a modest decrease in cigarette consumption immediately following the introduction of the prescription nicotine patch in 1992. However, no statistically significant effect was observed after 1996, when the patch and gum became available OTC.” Moreover, one review found only 23 per cent of NRT placebo-controlled trials assessed blindness integrity and 71 per cent of these trials found that subjects could detect if they had been assigned to the active agent.

Another review of all NRT randomised controlled trials found 51 per cent of industry-funded trials reported statistically significant cessation effects, against 22 per cent of non-industry trials. Many assume that we are now down to a ‘hard core’ of smokers. Ex-smokers are assumed to be dominated by those who were not heavily addicted and so who were better able to quit unaided and that a greater proportion of today’s smokers need help. But recent data comparing smoking in 50 US states provides compelling evidence against this idea: the average cigarettes smoked daily and the percentage who smoke daily are all much lower in US states with low smoking prevalence, exactly the opposite of what would follow.

When citizens have common, self-limiting ailments, traits and behaviours like smoking regularly redefined as needing treatment, avoidable iatrogenic consequences and burgeoning health care expenditure can follow. But the steady erosion of human agency as populations lose confidence in changing unhealthy practices is of greater concern. There are serious negative consequences arising from smokers being increasingly imbued with messages that serious efforts at cessation require treatment.

When unassisted cessation and willpower are dismissed in pharmaceutical industry supported propaganda, smokers might understandably feel that it would be foolish of them to attempt to stop unaided. Because most assisted cessation attempts end in relapse, such ‘failure’ risks being interpreted by smokers as “I tried and failed using a method that my doctor said had the obvious benefit of the drug industry. Research on cessation is dominated by ever-finely tuned accounts of how smokers can be encouraged to do anything but go it alone when trying to quit – exactly opposite of how a very large majority of ex-smokers succeeded.

Pharmacotherapy is also irrelevant in today’s largest tobacco markets, which are nations with massive populations on low incomes, making the drugs prohibitively expensive. In Indonesia, three months NRT costs as much seven year’s supply of cigarettes. It would be a disaster for tobacco control progress if such nations were to be influenced to proliferate labor-intensive and expensive approaches based on assisted cessation before they implemented comprehensive and sustained population-focused cessation policies and programs like tax rises, advertising bans and graphic pack warnings.

The persistence of unassisted cessation as the most common way that most smokers have always succeeded in quitting is an unequivocally positive message which should be openly embraced by health authorities as the front-line, primary ‘how’ message in all clinical encounters and public communication about cessation. Along with motivational ‘why’ messages designed to stimulate cessation attempts, smokers should be repeatedly told that cold turkey and reducing then quitting are the methods most commonly used by successful ex-smokers; that more smokers find it unexpectedly easy or moderately difficult than find it very difficult to quit; and that ‘failures’ are a normal part of the natural history of cessation – rehearsals for eventual success.

Simon Chapman is Professor in Public Health at the University of Sydney.

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The Drum Unleashed | www.abc.net.au/unleashed
First published by ABC Online, 10 February 2010.
GLOBAL TOBACCO CONTROL
The World Health Organization provides some key facts

KEY FACTS

➤ Tobacco kills up to half of its users
➤ The annual death toll of more than five million could rise to more than eight million by 2030 unless urgent action is taken to control the tobacco epidemic
➤ More than 80 per cent of the world’s one billion smokers live in low- and middle-income countries
➤ Total consumption of tobacco products is increasing globally, though it is decreasing in some high-income and upper middle-income countries.

Gradual killer
Because there is a lag of several years between when people start using tobacco and when their health suffers, the epidemic of tobacco-related disease and death has just begun.
➤ Tobacco caused 100 million deaths in the 20th century. If current trends continue, it will cause up to one billion deaths in the 21st century
➤ Unchecked, tobacco-related deaths will increase to more than 8 million per year by 2030. More than 80 per cent of those deaths will be in low- and middle-income countries.

Leading cause of death, illness and impoverishment
Tobacco use is one of the biggest public health threats the world has ever faced. It kills more than 5 million people a year – an average of one person every six seconds – and accounts for one in 10 adult deaths. Up to half of current users will eventually die of a tobacco-related disease.

More than 80 per cent of the one billion smokers worldwide live in low- and middle-income countries, where the burden of tobacco-related illness and death is heaviest.

Tobacco users who die prematurely deprive their families of income, raise the cost of health care and hinder economic development. In some countries, children from poor households are frequently employed in tobacco farming to provide family income. These children are especially vulnerable to ‘green tobacco sickness’, which is caused by the nicotine that is absorbed through the skin from the handling of wet tobacco leaves.

Surveillance is key
Good monitoring tracks the size and character of the epidemic and indicates how best to tailor policies. Two-thirds of countries – more than four in five of them low- and middle-income – do not have even minimal information about tobacco use.

Second-hand smoke kills
Second-hand smoke is the smoke that fills restaurants, offices or other enclosed spaces when people burn tobacco products such as cigarettes, bidis and water pipes. There is no safe level of second-hand tobacco smoke.

Every person should be able to breathe smoke-free air. Smoke-free laws protect the health of non-smokers, are popular, do not harm business and encourage smokers to quit.1
➤ Only 5.4 per cent of people are protected by comprehensive national smoke-free laws
➤ In 2008, the number of people protected from second-hand smoke increased by 74 per cent to 362 million from 208 million in 2007
➤ Of the 100 most populous cities, 22 are smoke free
➤ Almost half of children regularly breathe air polluted by tobacco smoke
➤ Over 40 per cent of children have at least one smoking parent
➤ Second-hand smoke causes 600,000 premature deaths per year
➤ In 2004, children accounted for 28 per cent of the deaths attributable to second-hand smoke
➤ There are more than 4,000 chemicals in tobacco smoke, of which at least 250 are known to be harmful and more than 50 are known to cause cancer
➤ In adults, second-hand smoke causes serious cardiovascular and respiratory diseases, including coronary heart disease and lung
Tobacco Smoking

Tobacco users need help to quit

Studies show that few people understand the specific health risks of tobacco use. For example, a 2009 survey in China revealed that only 37 per cent of smokers knew that smoking causes coronary heart disease and only 17 per cent knew that it causes stroke. Among smokers who are aware of the dangers of tobacco, most want to quit. Counselling and medication can more than double the chance that a smoker who tries to quit will succeed.

National comprehensive health-care services supporting cessation are available only in 17 countries, representing 8.2 per cent of the world’s population. There is no cessation assistance in 29 per cent of low-income countries and 8 per cent of middle-income countries.

Picture warnings work

Hard-hitting anti-tobacco advertisements and graphic pack warnings – especially those that include pictures – reduce the number of children who begin smoking and increase the number of smokers who quit. Studies carried out after the implementation of pictorial package warnings in Brazil, Canada, Singapore and Thailand consistently show that pictorial warnings significantly increase people’s awareness of the harms of tobacco use. Although pictures are more powerful deterrents than words on tobacco packaging warnings, only 19 countries, representing 24 per cent of the world’s population, mandate pictorial warnings.

Just 15 countries, representing 7.6 per cent of the world’s population, meet the highest standards for pictorial warnings, which include that they be in colour and cover at least half of both the front and back of cigarette packs.

Ad bans lower consumption

Bans on tobacco advertising, promotion and sponsorship can reduce tobacco consumption. Only 26 countries, representing 8.8 per cent of the world’s population, have comprehensive national bans on tobacco advertising, promotion and sponsorship.

27 per cent of the world’s population live in countries that do not ban free distribution of tobacco products.

The six MPOWER measures are:

➤ Monitor tobacco use and prevention policies
➤ Protect people from tobacco use
➤ Offer help to quit tobacco use
➤ Warn about the dangers of tobacco
➤ Enforce bans on tobacco advertising, promotion and sponsorship
➤ Raise taxes on tobacco.

WHO response

WHO is committed to fight the global tobacco epidemic. The WHO Framework Convention on Tobacco Control entered into force in February 2005. Since then, it has become one of the most widely embraced treaties in the history of the United Nations with nearly 170 Parties covering 86 per cent of the world’s population. The WHO Framework Convention is WHO’s most important tobacco control tool and a milestone in the promotion of public health. It is an evidence-based treaty that reaffirms the right of people to the highest standard of health, provides legal dimensions for international health cooperation and sets high standards for compliance.

In 2008, WHO introduced the MPOWER package of tobacco control measures to further counter the epidemic and to help countries to implement the WHO Framework Convention.

Endnotes


Action on tobacco: a role for all Australians

Currently about 32 per cent of Australians’ illnesses stem from chronic disease associated with obesity, tobacco and excessive consumption of alcohol, according to the National Preventative Health Taskforce.

In its National Preventative Health Strategy, *Australia: the Healthiest Country by 2020*, the National Preventative Health Taskforce has recommended strategies to reduce the number of smokers from ‘one in six to one in 10 adults or fewer’.

These strategies include:
- Raising the price of cigarettes to $20 a pack
- Investigating legal action against tobacco companies to recover health costs
- Adopting plain cigarette packaging (aside from health warnings)
- Restricting outlets that can sell tobacco products and making smoking a classifiable factor in films.

### TARGETS: REDUCE DAILY SMOKING TO UNDER 10% BY 2020

- Reduce the prevalence of daily smoking among adult Australians from 17.4% in 2007 to 10% or lower by 2020
- Eliminate exposure to other people’s tobacco smoke, especially for children, and ensure smoking during pregnancy is minimal
- Substantially reduce smoking and exposure to tobacco smoke among Indigenous Australians.

### MAKE TOBACCO PRODUCTS SIGNIFICANTLY MORE EXPENSIVE

- Ensure that the average price of a packet of 30 cigarettes is at least $20 (in 2008 $ terms) within three years, with equivalent increases in the price of roll-your-own and other tobacco products
- Contribute to the development and implementation of international agreements and a national strategy to combat the illicit trade of tobacco
- End duty free tobacco sales in Australia and abolish concessions for all travellers entering Australia.

### INCREASE THE FREQUENCY, REACH AND INTENSITY OF SOCIAL MARKETING CAMPAIGNS

- Allocate long-term funding at federal and state levels for sustained media campaigns
- Run effective social marketing campaigns at levels of reach demonstrated to reduce smoking, choosing messages which ensure reach to young smokers and socially disadvantaged groups.

### INDIVIDUALS AND FAMILIES

#### AUSTRALIAN GOVERNMENT
- End all remaining forms of advertising and promotion of tobacco products
- Amend Tobacco Advertising Prohibition Act 1992 to require that no tobacco product may be sold except in packaging of a shape, size, material and colour prescribed by government
- Amend legislation nationally and in all states to ensure tobacco is out-of-sight in retail outlets
- Improve consumer product information related to tobacco products; mandate plain packaging, review health warnings content regularly and establish a system for Chief Medical Officer to issue early warning of new and emerging health concerns.
- Ensure nicotine replacement therapy is affordable for those that need it
- Give government power to regulate design, contents and maximum emissions for tobacco and related products, and establish a regulatory body with responsibility for specifying required disclosure to government, labelling and any other communication to consumers
- Make smoking a classifiable element in movies and video games.

#### MENTAL HEALTH SERVICES
- Educate mental health professionals about the importance of quitting and not discouraging quit attempts by clients
- Educate GPs and other health professionals about quit smoking benefits and successes for people with mental health problems
- Ensure all child, adolescent and adult mental health facilities:
  - Are smoke free
  - Routinely identify smokers
  - Include smoking cessation advice and treatment of nicotine dependence in all patient treatment plans
  - Offer support to patients at transition points

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**ACTION ON TOBACCO: A ROLE FOR ALL AUSTRALIANS**

<table>
<thead>
<tr>
<th>SCHOOLS</th>
<th>STATES AND TERRITORIES</th>
<th>PRIMARY HEALTH CARE</th>
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<tbody>
<tr>
<td>✴ Assist parents and educators to discourage tobacco use and protect young people from second-hand smoke</td>
<td>✴ Eliminate exposure to second-hand smoke in public places</td>
<td>✴ Ensure that all patients are routinely asked about their smoking status and supported to quit</td>
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<tr>
<td>✴ Cover the medical, social, environmental and economic aspects of tobacco in the school curriculum</td>
<td>✴ Amend current legislation to:</td>
<td>✴ Train heath professionals in smoking cessation counselling.</td>
</tr>
<tr>
<td>✴ Enforce smoke-free policies for students, staff and visitors consistently, both indoors and on school grounds.</td>
<td>✴ Ensure smoking is prohibited in any public places where the public, particularly children, are likely to be exposed</td>
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<td></td>
<td>✴ Protect against exposure to second-hand smoke when travelling in cars</td>
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<td>✴ Protect against exposure to second-hand smoke in workplaces, including outdoor areas</td>
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<td></td>
<td>✴ Further regulate supply of tobacco products</td>
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<td>✴ Amend current legislation to:</td>
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<td>✴ Preclude sales through vending machines, the internet, and at hospitality and other social venues</td>
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<td>✴ Require all tobacco retailers be licensed</td>
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<td>✴ Ensure all smokers in contact with health services are encouraged and supported to quit</td>
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<td>✴ Ensure all state and territory funded healthcare services are smoke-free indoors and on facility grounds</td>
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<td>✴ Ensure all state and territory funded human services agencies and correctional facilities are smoke-free and provide appropriate cessation supports</td>
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<td>✴ Increase availability of Quitline services</td>
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<th>MATERNAL AND CHILD HEALTH SERVICES</th>
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<tr>
<td>✴ Extend smoke-free workplace policies to apply to building entrances and ban the retail sale of cigarettes in canteens and on-site shops</td>
<td>✴ Ensure all pregnant women and those planning pregnancy are routinely asked about their smoking status and supported to quit.</td>
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<td>✴ Provide support and incentives for employees to quit and stay smoke-free.</td>
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<td>✴ Work with state and local governments and community organisations to discourage smoking in highly disadvantaged neighbourhoods</td>
<td>✴ Boost efforts to reduce smoking among Indigenous Australians</td>
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<tr>
<td>✴ Implement community-based tobacco control projects, especially in highly disadvantaged communities.</td>
<td>✴ Place the majority of any outdoor or mobile advertising campaign in highly disadvantaged areas.</td>
<td>✴ Establish multi-component community-based tobacco control projects that are locally developed and delivered</td>
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**MEASURE PROGRESS AGAINST AND TOWARDS TARGETS**

✴ Address the current gaps in the developed surveillance system on tobacco to enable governments to assess progress and ensure targets will be met.

**ENSURE THE PUBLIC, MEDIA, POLITICIANS AND OTHER LEADERS REMAIN AWARE OF THE NEED FOR SUSTAINED AND VIGOROUS ACTION TO DISCOURAGE TOBACCO USE**

Source: *Australia: the healthiest country by 2020*

National Preventative Health Strategy

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Timeline of Australian tobacco regulation

THE REGULATORY HISTORY OF TOBACCO IN AUSTRALIA OVER THE PAST 40 YEARS

- First health warnings appear on cigarette packaging (1972)
- Advertising on television and radio banned, except accidental or incidental (1976)
- State and Territory Governments amend their legislation to include four new health warnings for tobacco product packaging (1985)
- Smoking banned on Australian domestic flights (1987)
- Advertising at sporting events (with exemptions) banned in SA (1988)
- Advertising is banned in Australian print media (magazines and newspapers) (1989)
- Tobacco Advertising Prohibition Act 1992 passed by Federal Parliament, eventually bans all forms of tobacco advertising, except point of sale advertising which is state/territory jurisdiction (1992)
- Federal Government makes major changes to excise and customs duty on tobacco products causing prices to increase (1992)
- Legal age for purchasing tobacco products is increased in SA to 18 years (1994)
- Smoking on public transport is banned in SA (1994)
- Smoking banned on international flights (1996)
- Tobacco Products Regulation Act 1997 is passed in SA (1997)
- Smoke-free dining is introduced in SA (1999)
- Tobacco industry banned from distributing free giveaways when cigarettes sold (2002)
- Smoking restrictions applied to Victorian licensed premises with gaming rooms and machines (2002)
- Point of sale advertising restricted in Vic except for product display and price (2002)
- Smoking banned in NT enclosured workplaces, restaurants, cafes, shopping centres and the dining areas of licensed venues, licensed premises required to provide smoking and non-smoking areas of equal amenity (2003)
- NT introduces licence requirements for tobacco retailers, advertising prohibited and product display and point of sale restrictions (2003)
- Smoking banned in SA enclosured public places, workplaces, and shared areas (2004)
- All enclosed workplaces and public places (except licensed hospitality venues) became smoke-free (2004)
- Restrictions on the number of points of sale of tobacco products and requirement for separate retail tobacco licences (2004)
- Advertising at point of sale banned (2005)
- Tobacco industry required to stop using ‘mild’ and ‘light’ terms to promote their products as being ‘safer’ (2005)
- Smoking banned in Qld workplaces, enclosured public places and other public areas (2005)
- SA places restrictions on number of points of sale of tobacco products and requires separate retail tobacco licences (2005)
- Tobacco advertising in SA at point of sale banned (2005)
- SA limits cigarette vending machines to one per venue and restrictions applied to placement or operation (2005)
- SA bans all forms of tobacco advertising in retail outlets (2005)
- WA introduces restrictions on indirect forms of the sale of tobacco products by mail order or the internet (2005)
- Federal: pictorial graphic health warnings required on cigarette packaging (2006)
- Federal: all tobacco sponsorship for international sporting events held in Australia phased out (2006)
- Qld reduces retail display of tobacco to 1m² (2006)
- SA bans sale of overt fruit-flavoured cigarettes (2006)
- ACT bans sale of overt fruit-flavoured cigarettes (2006)
- ACT bans tobacco vending machines distributing smoking products (2006)
- SA and Tas ban split packs (2006)
- Smoking banned in Tas pubs and clubs enclosured areas and all enclosed public places and workplaces (2006)
- Smoking banned in Qld pubs and clubs enclosured areas (2006)
- Smoking banned in WA pubs and clubs enclosured areas and all enclosed public places (2006)
- Smoking banned in ACT pubs and clubs enclosured areas and all enclosed public places and workplaces (2006)
- Smoking banned in Vic and NSW enclosured workplaces and public areas (2006)
- WA restricts advertising of price discounting and display of tobacco advertisements at point of sale (2006)
- WA restricts vending machines to licensed premises and amenity areas of mine sites (2006)
- Nationally, graphic health warning labels for tobacco products introduced (2006)
- All tobacco-related sports sponsorships in Australia banned (2006)
- Tobacco sponsorship in nightclubs banned (2006)
- SA ban retailer rewards, vending requires lock out system (2007)
- SA ban retail sales via the internet (2007)
- NSW ban mobile sales and fruit flavours (2007)
- WA reduces retail display of tobacco to 1m² (2007)
- WA introduces retailer licensing for selling tobacco products (2007)
- Tas bans display of retail display of tobacco products (2007)
- Tas bans sale of fruit or confectionary flavoured cigarettes (2007)
- SA reduces retail display of tobacco to 1m² (2007)
- Smoking banned in Vic pubs and clubs enclosured areas (2007)
- Smoking banned in NSW pubs and clubs enclosured areas (2007)
- Smoking banned in SA pubs and clubs enclosured areas (2007)
- Smoking banned in cars with children in SA (2007)
- Indoor smoking bans begin to be introduced (2007)
- Restrictions on the display of tobacco products, including the need to display a graphic health warning poster where products are on display and limiting the size of tobacco product displays (2007)
- Ban on including tobacco sales in customer loyalty schemes (2008)
- Ban on retail sale of tobacco via mail, telephone, facsimile transmission or internet or other electronic communication (2008)
- Federal: national move to ban sale of overt fruit flavours across Australia (2008)
- Smoking banned in cars with children in Tas, NSW, Qld (2008)
- Regulations for Reduced Fire Risk cigarettes in Australia passed (2008)
- NSW and ACT pass laws for total retail display ban of tobacco products (2008)
- SA vending machines to have appropriate staff intervention mechanism to operate (2008)
- Victoria announces retail display bans and banning smoking in cars carrying children (2008)
- All tobacco vending machines must have staff intervention (2008)
- Local councils move to make alfresco areas smoke-free (2009)
- Ban on display of tobacco products at temporary stalls (2009)
- Retail display bans introduced in NSW and ACT, with similar bans to follow in WA, Vic and Tas (2010)
- Smoking inside pubs and clubs banned in every Australian state (2010)
- Tobacco excise increased by 25% (2010).

Sources:
Quit Victoria and Tobacco in Australia: Facts and Issues, compiled by Cancer Council Victoria
British American Tobacco Australia Submission to the Senate Inquiry into Plain Tobacco Packaging (Removing Branding from Cigarette Packs) Bill 2009, 6 May 2010.

Compiled By The Spinney Press
Resistance to tobacco control activities is usually based on assertions that are unsupported by evidence, yet are often cited by social commentators and policymakers. Cancer Council Australia addresses some inaccuracies.

An important part of ‘de-normalising’ a habit that causes such an enormous amount of preventable death and disease is to counter, using evidence, these inaccuracies.

Some of the salient catchphrases used to argue against an increased commitment to tobacco control can be readily debunked by the evidence.

➤ We have done everything possible to control tobacco, apart from banning tobacco altogether
➤ Australia is going OK already or Australia is doing better than anyone else
➤ It is a legal product
➤ Smoking provides economic benefits to government and society in general
➤ Smoking is an adult choice
➤ Tobacco control is part of a nanny state.

It is a legal product

Tobacco is a commercial and regulatory anomaly. Smoking causes a higher disease burden than the combined use or misuse of all other ‘legal products’ that are rigorously regulated for safety reasons, including over-the-counter drugs, prescription medicines, pesticides, alcohol and motor vehicles. On the basis of demonstrated harm, tobacco products are also under-regulated in comparison with other environmental carcinogens and hazardous consumer products.

Smoking provides economic benefits to government and society in general

Major tobacco companies have cited the tax-raising and business benefits associated with smoking in their submissions to government reviews of tobacco marketing; these alleged benefits of tobacco use have also been cited in newspaper opinion pages. A leaked internal memo from one tobacco company even suggested that the premature death caused by smoking was beneficial to the economy. However, independent economic analyses clearly demonstrate that smoking has a high net social and economic cost to the community. Similar analysis has also shown that reduction in smoking rates would not harm the economy.

Objective evidence also shows the strong return on investment in tobacco control. The most recent Commonwealth Department of Health and Ageing analysis on this issue found that every $1 spent on tobacco control yields $2 in savings; and the consultancy firm Applied Economics concludes that tobacco control yields better gains than any other public health program expenditure, with a benefit to cost ratio of 50:1.1

Smoking is an adult choice

Research shows that the major risk period for...
people to take up smoking is in mid to late adolescence. Studies also show that around 60 per cent of smokers would prefer to quit, but struggle with an addiction developed before they were mature enough to make an adult decision and fully understand the consequences of nicotine addiction and the harms of smoking.2,3

Most adult smokers are not fully aware of the dangers of smoking, with a recent survey finding that while two-thirds identified lung cancer as smoking-related, only one-quarter knew smoking caused heart disease and fewer than 10% understood the risk of emphysema, stroke and vascular problems.4

Evidence also shows that most adult smokers are not fully aware of the dangers of smoking, with a recent survey finding that while two-thirds identified lung cancer as smoking-related, only one-quarter knew smoking caused heart disease and fewer than 10 per cent understood the risk of emphysema, stroke and vascular problems.4

**Tobacco control is part of a nanny state**

The myth that proactively reducing smoking rates is the mark of a ‘nanny state’ – i.e. a government that restricts personal freedoms with risk-averse, patronising public policy – is debunked by the evidence outlined against the five myths discussed above. In addition, a number of tobacco control measures are recommended as a way of supporting decisions that people are already making. Every year, 30-40 per cent of smokers attempt to quit, but only one in 10 quit attempts is successful. Tobacco control measures reduce relapse rates and help intending quitters to break their addiction. Governments also have a responsibility to protect non-smokers from the increasingly evident harms of environmental tobacco smoke and to reduce the economic burden, borne by the wider community.5

**REFERENCES**

Plain packaging of tobacco products

A Tobacco Facts information sheet from the Action on Smoking and Health (ASH)

In April 2010 the Australian Government announced that all tobacco products must be sold in plain packaging in Australia by 1 July 2012 – the first country in the world to make this commitment.

Plain packaging of tobacco products is likely to:
➤ Stop use of packs as promotion and advertising
➤ Increase effectiveness of health warnings
➤ Prevent use of misleading and deceptive packaging to create false beliefs of different strength and quality
➤ Reduce youth smoking and decrease youth uptake
➤ Remove positive association with cigarette brands/image.

WHAT IS PLAIN PACKAGING?
It requires all tobacco products to be sold in packaging with plain-font brand name only – no colour, decorative or design that could add appeal; no trademarks, logos, descriptors, inserts/onserts or promotional information.

Prescribed pack
Exact dimensions, shape, colour, material and style of package opening would be prescribed by type of product and include colour, gloss level, ink colour and font style that can be used on the outside and inside of any packaging and any wrapping papers, foils and any other lining material.

Prescribed product
Prohibition against promotional elements should apply both to exterior and interior of package, including the cigarette etc itself. This would prohibit use of unique or coloured filters or printing or embossing of logos. Shape and size of the actual product should also be specified.

Recent studies show a majority of the Australian population would support plain tobacco packaging.

Regulation of pack design and descriptors in Australia is limited. Tobacco Advertising Prohibition Act 1992 and various State and Territory laws on tobacco advertising do not extend to the pack itself.

By using colours, novelty packaging, logos and other imagery, manufacturers are able to engineer the pack to appeal to their intended market segment and convey certain brand characteristics and quality.

“... it’s because not everything is illegal. And they employ advertising agencies to help them sell their products within the legal framework that they’ve been given.”
Todd Sampson: The Gruen Transfer – ABC

THE PACK AND BRAND IMAGE
The pack communicates much about brand character and quality, and stylishness and sophistication of the smoker.

Tobacco packs are seen as "badge products" that "remain with the user once opened and are repeatedly displayed in social situations," becoming "direct ... mobile advertising for the brand". Packs aim to target market segments, attract new smokers and encourage brand switching.

The primary job of the package is to create the desire to purchase and try. To do this, it must look new and different enough to attract the attention of the consumer.
Miller, A Arthur D Little Inc report to Liggett and Myers

THE PACK AND ITS TARGET AUDIENCE
Tobacco companies also use new and innovative pack designs to target particular market segments and promote brand characteristics. Cigarettes are often packaged in slim long packs, with pastel colours or extensive white space used to appear sophisticated or feminine.

“Some women admit that they buy Virginia Slims, Benson & Hedges etc when they go out at night to complement a desire to look more feminine and stylish. ... more fashionable feminine packaging can enhance the relevance of some of our brands.”
Philip Morris (1992)

HEALTH WARNINGS: PACK IMPACT
Brand imagery alongside health warnings on packs sends a mixed message about the product and can undermine impact of warnings, particularly on young people. Some brands incorporate colours of health warnings into pack design so they ‘blend in’ and become less striking.
THE PACK AND PERCEPTIONS OF QUALITY AND STRENGTH

Studies on effects of pack design, including by the tobacco industry, have found packaging materials and imagery influence consumer perceptions of quality and sensory attributes of different brands. Light colours and pastel shades are universally used to suggest that a particular brand is less harmful than its ‘stronger’ counterpart. Green shades, often used for menthol variants, convey concepts of freshness and mint flavour.

However, there appear to be no international or domestic barriers to plain packaging laws in Australia.

Philip Morris website, www.plain-packaging.com promotes their objections to plain packaging. They say:

- It will violate trademark and constitutional rights ...
- Legal experts respond that international agreements and trademark laws protect trademarks and prevent third parties using them – but don’t guarantee a right to use them. Tobacco industry documents show they know this. Plain packaging is justifiable and proportionate on public health grounds, so is consistent with international trade agreements. Plain pack laws do not amount to property ‘acquisition’ under Constitution s.51(xxxi), so government will not need to compensate tobacco companies.

- It will increase illicit tobacco trade ...
- There is no hard evidence available either way. But if prevalence falls, illicit trade is unlikely to rise. Global experts recommend controlling the tobacco supply chain as the main strategy to reduce smuggling. The tobacco industry exaggerates the extent of Australia’s illicit trade.

- It will cause confusion, inconvenience, security risks ...
- Packs will still carry clearly printed names of manufacturer and product variant, easily readable by retail staff and normally stored in labelled rows as before.

- “No evidence” it will reduce smoking ...
- No country has yet mandated plain packaging (under review in Canada and UK). While direct impact can’t yet be measured, studies point strongly to likely impact, especially on youth. Industry documents show they regard the packet as their ‘silent salesman’.

If this policy was not a threat to tobacco sales, would the industry be working so hard to oppose it?

© Action on Smoking and Health (ASH), October 2010
www.ashaust.org.au

Light colours and pastel shades are universally used to suggest that a particular brand is less harmful than its ‘stronger’ counterpart. Green shades, often used for menthol variants, convey concepts of freshness and mint flavour.
BIG TOBACCO’S COUGHING FIT
A BIG TICK FOR PLAIN PACKAGING

We are killing people by not acting on smoking, writes Fiona Sharkie

I

n the world of tobacco reform, we use the scream test to determine if a particular set of actions will help reduce the number of people smoking.

Quite simply: if the tobacco industry screams loudly enough about a proposed change or reform, we know we are on to a good thing.

Yesterday, the screams from the tobacco industry were deafening.

The Rudd government’s decision to introduce plain packaging for cigarettes by 2012, increase tobacco tax and provide extra funding for anti-smoking campaigns was a huge feat. It is possibly the biggest raft of tobacco reform measures we have seen introduced by an Australian government, and could save hundreds of thousands of lives.

Plain packaging is the showstopper. It has been recommended as a key tobacco control measure by the World Health Organisation. Australia will be the first country in the world to introduce it, and will pave the way for other countries to follow suit.

Cigarette packets will no longer feature a colourful, flashy mini-billboard, communicating images of desirability and glamour. Instead, as the name implies, the pack will be plain, dull and unattractive. The brand name will be featured in a mandated size and font, alongside an enlarged graphic health warning. This will help communicate what cigarettes actually are: poisons that kill 15,000 people in Australia each year.

Cries about a ‘nanny state’ are irrelevant when we consider that cigarettes are not normal consumer products; they kill half of all long-term users. And there is nothing desirable or glamorous about dying of a smoking-related illness.

Cancer Council Victoria research shows that plain packaging will especially affect adolescents, reducing the appeal of cigarette packs and the taste expectations of cigarettes among young people. Quit believes it will lead to a reduction in the number of teens taking up the habit.

Most adult smokers have been addicted since they were teenagers. By driving down youth smoking rates even further, we will have an overall effect on lessening the prevalence of smoking in the wider community.

Quite simply: if the tobacco industry screams loudly enough about a proposed change or reform, we know we are on to a good thing.

Morgan Stanley research has found that after taxation, one of the biggest regulatory changes concerning the tobacco industry is homogeneous packaging.

The cigarette companies are well aware of the potential loss of sales and profits and have set up websites and lobby groups aimed at preventing decisions like this – more evidence of an industry running scared of the domino effect plain packaging legislation in Australia could have across the world.

Reduced sales and profits translate to reduced smoking and fewer people dying from smoking-caused illnesses, which should be celebrated.

The hard evidence about tax increases on cigarettes shows that it is the single biggest intervention a government can make to drive down smoking rates.

Australia hasn’t had a real tax increase on tobacco in 10 years, so it is long overdue. We estimate that the 25 per cent excise increase will lead to 100,000 Australian smokers quitting the habit almost immediately.

Price rises have the biggest impact on smoking rates among low-income smokers. Yesterday’s tax increase will reduce social disparities in smoking and, in turn, should reduce socio-economic disparities in life expectancy and incidence of disease. All Australians are entitled to a long and healthy life, and in the words of Health Minister Nicola Roxon, “we’re killing people by not acting”.

Now that smokers have been given the extra motivation to quit, we’d like to see them get some more support on their quitting journey.

Cancer Council Victoria research shows that about seven out of 10 smokers are in favour of a cigarette tax increase provided some of the money goes towards providing them with more affordable nicotine replacement therapy; and the Pharmaceutical Benefits Advisory Committee has recommended nicotine patches be listed on the PBS, which would reduce the cost barriers to smokers needing to manage their cravings while quitting.

The price rise will be especially effective when coupled with more money for anti-smoking advertising campaigns. Recent quitters report that the cost of cigarettes and anti-smoking television commercials are the two most useful aids in helping them give up.

All in all, yesterday was a lifesaver for tens of thousands of Australians.

Fiona Sharkie is the executive director of Quit.
Increasing tobacco excise to reduce smoking rates

Fact sheet information on the initiatives being implemented under the government’s National Health and Hospitals Network

Tobacco smoking is the single largest cause of premature death and disease in Australia. Smoking kills over 15,000 Australians each year and is estimated to cost the economy $31.5 billion per year in social costs, including $5.7 billion per annum attributed to absenteeism and a reduction in the workforce.

The Australian Government is taking action under its National Health and Hospitals Network.

The Australian Government has decided to implement a 25 per cent increase in tobacco excise to reduce smoking rates.

**HOW WILL THIS INITIATIVE WORK?**

The Government increased the excise and excise-equivalent customs duty rate applying to tobacco products by 25 per cent from 12.01 am on 30 April 2010.

The excise on cigarettes increased from $0.2622 to $0.32775 per stick and loose leaf tobacco from $327.77 to $409.71 per kilogram of tobacco. This is expected to increase the price of a pack of 30 cigarettes by $2.16.

This measure alone is expected to cut total tobacco consumption by around six per cent and the number of smokers by two to three per cent, or around 87,000 Australians.

It is estimated that this measure will provide an extra $5 billion over four years that, together with existing revenues collected from tobacco, will be directly invested in better health and hospitals through the National Health and Hospitals Network Fund.

Prior to the increase, tax as a proportion of the retail price of tobacco was just 62 per cent in Australia, compared to 80 per cent in France and 77.5 per cent in the United Kingdom. This increase will bring Australia’s tax treatment of tobacco closer to comparable countries.

**WHAT HAS THE GOVERNMENT DONE SO FAR TO TACKLE SMOKING?**

Since 2007, the Government has:

➤ Invested $872 million with states and territories over six years from 2009-10 under the COAG National Partnership Agreement on Preventive Health, including $61 million for tobacco social marketing
➤ Invested $15 million over four years from 2008-09 to reinvigorate the National Tobacco Strategy
➤ Invested $14.5 million over four years from 2008-09 in the Indigenous Tobacco Control Initiative and more than $100 million over four years from 2009-10 to tackle indigenous smoking through the COAG Closing the Gap Indigenous Health National Partnership
➤ Continued to subsidise ‘stop smoking’ supports through the Pharmaceutical Benefits Scheme at a cost of around $62 million annually.

Source: National Health and Hospitals Network
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www.yourhealth.gov.au
A new report commissioned by the Cancer Council Western Australia debunks tobacco industry arguments that higher tobacco taxes will be detrimental to the Australian economy.

Weighing the evidence: evaluating the social benefits and costs of the Australian tobacco industry is the first independent analysis of economic arguments the tobacco industry has put forward in its defence over many decades.

Director of the Cancer Council Western Australia’s Tobacco Program, Denise Sullivan said the report assessed the economic impact of both the tobacco industry and public health measures aimed at reducing tobacco use.

“The tobacco industry frequently employs economic scare tactics when policymakers are considering measures for reducing demand for tobacco, such as increases in taxes on the sale of tobacco,” Ms Sullivan said.

“This report provides the evidence that there would be few, if any negative economic consequences in further measures to curb tobacco consumption in Australia.”

The report was produced by internationally renowned health economists, Professors David Collins and Helen Lapsley.

“Overall, the study found that the tobacco industry provides no net gains to the Australian economy, and that tobacco control measures do not cause economic harm,” Professor Lapsley said.

“A fall in demand for tobacco, while significantly affecting the tobacco industry, will have very little, if any, negative economic impact. Indeed, it is possible that the overall impact would be mildly positive.”

Professor Collins said the tobacco industry analyses of their contribution to the Australian economy were flawed.

“Overall, the study found that the tobacco industry provides no net gains to the Australian economy, and that tobacco control measures do not cause economic harm.”

Professor Helen Lapsley

“The industry fails to take into account healthcare costs imposed on the community for the treatment of illnesses caused by tobacco,” he said.

The report has shown that the economic contribution of the tobacco industry is around $1 billion a year, substantially less than the estimated social costs of smoking which is a staggering $31 billion a year.

“Clearly tobacco tax revenue paid by the tobacco industry itself does not cover the social costs of tobacco consumption,” Professor Collins said.

Professor Lapsley said the number of jobs dependent on the tobacco industry was also overstated.

“The figures put forward by the tobacco producers include jobs of those who sell materials to the industry as well as those at the retail level for whom only a fraction of their business depends on tobacco,” Professor Lapsley said.

“It also ignores the fact that money saved by quitting or reducing smoking will be spent on other goods and services, themselves generating employment and tax revenues.”

President of the Public Health Association of Australia (PHAA), Professor Mike Daube, said the report ended the last vestiges of credibility for the industry’s arguments about the economic contribution it made to Australia.

“Big tobacco has opposed increased taxes on its products on the basis of the economic harm this would cause. This report shows that the industry’s arguments, as so often, are misleading and based on self-interest.

“It’s time for taxes on tobacco to be increased. We have not had a significant tax increase on tobacco for at least 10 years and are one of the lowest tobacco-taxing countries in the OECD.”

Professor Daube said that tax increases would have an important impact in reducing smoking among disadvantaged groups.

“Tax increases are the single most effective means of reducing smoking. When the price of tobacco goes up, we know that smokers from lower socio-economic groups are more likely to quit, improving both their health and their financial circumstances.

“We also know that there is strong public support for such increases.”

“This report gives the Federal Government a strong mandate for a significant tobacco tax increase, which will also enable them to spend more money on public health, including further action to reduce smoking, which still kills one in two regular smokers,” Professor Daube said.

“The only people with anything to lose with this strategy are the tobacco companies themselves.”
TOBACCO FUNDING: TIME TO QUIT

It is time for all political parties to refuse tobacco funding, argues Mike Daube

Tobacco companies are not philanthropic institutions. As long ago as 1967 the late Senator Robert Kennedy said, “the cigarette industry is peddling a deadly weapon. It is dealing in people’s lives for financial gain”.

The Australian tobacco industry is dominated by three big companies (or in modern political parlance, three “great big” companies), British American Tobacco, Philip Morris and Imperial Tobacco – all overseas-owned, with decisions made not in Sydney or Melbourne but in London and New York.

These are tough and ruthless multinational corporations, promoting and selling a product that kills one in two of its regular users. They have known for sixty years that their product is lethal. During this time almost one million Australians have died because they smoked – while the tobacco companies have denied and downplayed the evidence, doing their utmost to oppose and delay any action that might be effective in reducing smoking. Around the world their products cause five million deaths a year – a figure which will only increase as their drive into developing countries bears lethal fruit.

The new Chief Executive of Imperial Tobacco, Alison Cooper, was recently reported in the UK media as still refusing to accept that smoking causes cancer. Small wonder that only last week a survey of the reputations of the UK’s largest 150 companies had Imperial Tobacco at 147 and British American Tobacco at a rock bottom 150.

There is massive evidence from once-confidential industry documents now available following litigation in the US that for decades tobacco companies have acted more cynically than even tobacco campaigners might have thought – summarised by a quote from an industry executive – “We don’t smoke this shit, we just sell it. We reserve the right to smoke for the young, the poor, the black and the stupid.”

And as if all this were not enough, the industry has been found guilty of racketeering in the US. Tobacco companies have only one aim, in London, New York or Canberra. In line with their responsibility to their shareholders, they spend money with the sole purpose of benefiting their interests.

So why would anybody want to take money from this pariah industry?

The Australian Electoral Commission website reports that in recent years both the Philip Morris company and British American Tobacco have been generous donors to the Liberal Party and the National Party. During the year 2008/9 Philip Morris contributed $158,000 to the Liberal and National parties around Australia. No doubt in addition to direct contributions there is also much indirect funding from groups supporting and representing tobacco companies, but this is much harder to pin down.

The only reason for these contributions is to further the interests of tobacco companies. The website of the British American Tobacco company is quite explicit about political donations: “Such payments can only be made for the purpose of influencing the debate on issues affecting the company or Group ...”

A review of tobacco industry political donations in the US, published in the American Journal of Preventive Medicine, concluded that, “tobacco industry monetary contributions are closely related to the way a legislator votes on tobacco issues”, and “The more campaign contributions received by a Congress member, the more likely he/she votes pro-tobacco on tobacco-related bills”.

Political donations are not simply about an intention to buy direct support: they are also about much less tangible benefits gained through indirect support, influence, contacts, access and credibility.

The Greens and Democrats took the lead in refusing tobacco industry funding, followed by the ALP. The other major parties understand the dangers of smoking; they know exactly why tobacco companies want to give them money; it is hard to imagine that they would knowingly take money from drug dealers – and yet they seem content to accept contributions from an industry whose products cause more than 80 per cent of Australia’s drug deaths. Surely there is something awry with the moral radar of anyone who accepts this kind of blood money.

The argument we sometimes hear that this is a “legitimate industry” is old and tired. If cigarettes were a new product they would not be allowed on the market. Our parliaments have decreed that the product is so harmful that it should not be sold to children and adolescents, should not be advertised, and that its sales should be subject to ever-increasing controls. This is no ordinary product, no ordinary industry.

The Australian government now leads the world in action to reduce smoking, complementing strong action in most jurisdictions (other than the Northern Territory, whose lack of interest in tobacco remains a mystery).

It is time for all political parties to refuse tobacco funding, or for legislation that forbids such contributions from companies that still seek to oppose the work and recommendations of governments and health authorities, and whose products cause 15,000 Australian deaths each year when used precisely as intended. Then we can be assured that all parties are making policy on this vital public health issue free of the taint of association with tobacco companies, and free of any suspicion that their policies might be influenced by these disreputable, lethal donors.

Mike Daube is Professor of Health Policy at Curtin University.

The Drum Unleashed | www.abc.net.au/unleashed
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Promoting tobacco to young people

Recruitment of under 18s has been critical to the viability of the tobacco industry, observes Cancer Council NSW

young adults to smoke your cigarette brand is perhaps the best way to try to communicate that your brand is the in-brand.3

The young have therefore been the target of extensive tobacco product marketing.4, 5, 6

When traditional forms of tobacco advertising were banned in Australia in the early 1990s, tobacco companies responded by cynically developing non-traditional ‘under the radar’ methods of marketing cigarettes to youth.7 This fact sheet briefly describes these methods.

THE NEW TOBACCO MARKETING

Non-traditional tobacco marketing methods aimed at reaching the youth market include:

➤ ‘Stealth marketing’. Typical stealth marketing activities include the presence of temporary cigarette sales promotions at youth-oriented events and venues including:
   - music festivals such as Homebake, Livid and Big Day Out
   - fashion shows and dance parties
   - pubs and nightclubs.8 In 2008 the NSW Government prohibited this kind of marketing.

➤ ‘Guerrilla marketing’. Typical guerrilla marketing techniques include commissioning graffiti, paying teenagers to talk to their friends about a product and creating an event or website that is clearly identifiable with a particular brand without using specific brand imagery. Guerrilla marketing by tobacco companies is well developed and documented in Australia.9

➤ ‘Trade parties’ – a loophole in 1992 Commonwealth legislation allows for advertising or promoting to those involved in manufacture, distribution or sales of tobacco products. A recent local example was British American Tobacco’s funding of a series of trade parties for hospitality industry personnel at Sydney’s fashionable Home nightclub.10

➤ ‘Point of sale’ displays of tobacco product can serve many of the functions of traditional advertising, and there is ‘strong evidence’ that point of sale displays, may entice children and young adults to experiment with and continue tobacco use.11 New laws in NSW now prohibit tobacco product displays at most retail outlets. Specialist tobacconists have until 1 July 2013 to remove their tobacco product displays.

TOBACCO INDUSTRY ‘SMOKING PREVENTION’ PROGRAMS

The tobacco industry’s ‘Youth Smoking Prevention’ programs comprise mainly of media campaigns that are designed, according to the industry, to convince underage consumers that smoking is for adults only. These programs have been found to be ineffective as youth smoking prevention strategies.12

The real intentions of the programs, it would appear, are to improve the industry’s public image and to create a political environment that is more favourable to the industry.

As one tobacco company document entitled ‘Youth and Smoking Plan’ stated:

Efforts such as these significantly enhance our relationships with legislators ... It also puts the antis (anti-smoking groups) on the defensive and forces them to expend their resources fighting our agenda, rather than pursuing their own. Furthermore, the goodwill gained in these efforts will help us in other legislative battles.13

SMOKING IN MOVIES

The tobacco industry has a long history of product placement in...
youth-appealing movies. Product placement in this context is the provision of product or money by tobacco companies to film producers or actors in exchange for favourable portrayals of the product or its use. Some tobacco companies have stated that they no longer engage in this practice however cigarette branding continues to appear in movies.

There is a substantial and still growing body of evidence that smoking in film has become a significant factor influencing youth smoking uptake.

**REFERENCES**

2. Carter SM. ‘From legitimate consumers to public relations pawns: The tobacco industry and young Australians’. *Tobacco Control*;12:i71.

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**HISTORY OF TOBACCO MARKETING**

Below are some advertising strategies used by the tobacco industry in the past that have since been banned in Australia. A fact sheet from the *OxyGen* website

In short, (the) defendants have marketed and sold their products with zeal, with deception, with a single minded focus on their financial success, and without regard for the human tragedy or social costs that success exacted.” US District Judge Gladys Kessler in her final opinion in the court case: *US Government vs. the Tobacco Industry*, 2004.

**The advertisements** – Prior to 1976, the tobacco industry advertised their deadly products on television and radio. The video clips below show TV characters and attractive models being used to sell cigarettes to young people in the 1940s, 50s and 60s.

**The billboards** – Billboard tobacco advertising was banned across Australia in 1993. BUGA UP (Billboard Utilising Graffitists Against Unhealthy Promotions) was a movement of people from Australia who defaced billboard advertisements – particularly those for alcohol and tobacco. Check out the BUGA UP website).

**The ‘light’ and ‘mild’ sham** – Prior to 2005, the tobacco industry used these terms to promote some of their products as being ‘safer’ than regular cigarettes. In 2005, the Australian Competition and Consumer Commission reached an agreement with the tobacco industry to stop using these misleading terms.

**The sport sponsorships** – Banned in 2006, the purpose of this marketing strategy was to link cigarette brands with an exciting, popular and highly skilled sport to improve the image and appeal of the cigarette brand. This sponsorship also undermined the health warnings on tobacco products by linking smoking with physical fitness and excellence.

This is what R.J. Reynolds Tobacco Company said about using sporting events to advertise its cigarettes: “We’re in the cigarette business. We’re not in the sports business. We use sports as an avenue for advertising our products …We can go into an area where we’re marketing an event, measure sales during the event and measure sales after the event, and see an increase in sales.”

**The free gifts** – The industry promoted and distributed free giveaways when you purchased a packet of cigarettes. Giveaways such as watches, CD cases and make-up cases were promoted to entice people to buy their cigarettes. The tobacco industry was banned from using this advertising strategy in 2002.

**The nightclub events** – The tobacco industry use to promote their products in nightclubs by holding themed events. Attractive models dressed in glittery clothes that complemented the colourings of the cigarette brands would mingle with patrons and invite them to purchase their products. This form of tobacco sponsorship was banned in 2006.
EXPLORING ISSUES

ABOUT THIS SECTION

‘Exploring issues’ features a range of ready-to-use worksheets relating to the articles and issues raised in this book.

The activities and exercises in these worksheets are suitable for use by students at middle secondary school level and beyond.

As the information in this book is gathered from a number of different sources, readers are prompted to consider the origin of the text and to critically evaluate the questions presented.

Does the source have a particular bias or agenda? Are you being presented with facts or opinions? Do you agree with the writer?

The types of ‘Exploring issues’ questions posed in each Issues in Society title differ according to their relevance to the topic at hand.

‘Exploring issues’ sections in each Issues in Society title may include any combination of the following worksheets: Brainstorm, Research activities, Written activities, Discussion activities, Quotes of note, Ethical dilemmas, Cartoon comments, Pros and cons, Case studies, Design activities, Statistics and spin, and Multiple choice.

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WORKSHEETS AND ACTIVITIES

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Brainstorm, individually or as a group, to find out what you know about tobacco use and health.

1. Describe the following contents of cigarettes and their impacts on human health:
   - Tar:
   - Nicotine:
   - Carbon monoxide:
   - Hydrogen cyanide:
   - Metals:
   - Radioactive compounds:
   - Pesticides:

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BRAINSTORM

2. What are the short-term effects of tobacco?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

3. What are the long-term effects of tobacco?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

4. Smoking is the largest cause of preventable death in the western world. Describe the health impacts of tobacco smoke on the following:
   - Respiratory system:
     ______________________________________________________________________
     ______________________________________________________________________
   - Circulatory system:
     ______________________________________________________________________
     ______________________________________________________________________
   - Immune system:
     ______________________________________________________________________
     ______________________________________________________________________
   - Musculoskeletal system:
     ______________________________________________________________________
     ______________________________________________________________________
   - Unborn babies:
     ______________________________________________________________________
     ______________________________________________________________________
1. Explain how these National Preventative Health Taskforce tobacco control strategies may contribute to reducing tobacco use in Australia.
   - Raising the price of cigarettes to $20 a pack:

   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________

   - Investigating legal action against tobacco companies to recover health costs:

   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________

   - Adopting plain cigarette packaging (aside from health warnings):

   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________

   - Restricting outlets that can sell tobacco products:

   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________

   - Making smoking a classifiable factor in films:

   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________
Complete the following activities on a separate sheet of paper if more space is required.

1. What diseases are caused by long-term smoking?

2. What is second-hand smoking, and what are its risks?
1. As awareness of the negative impacts of tobacco smoke has increased, the reported proportion of people who smoke has declined steadily since tobacco consumption was first included in the *National Health Survey* in 1989-90. Decreasing by 24% over the 18-year period, this represents an annual average decline of around 1.5%. The *National Health Survey* reported around 3 million daily smokers in 2007-08. There were 716,000 people who had been a daily smoker 12 months prior, but who either now smoked less than daily (112,000 people) or were no longer smokers at all (604,000).

2. As smoking prevalence rates have declined in the traditional markets of North America and western Europe the tobacco-related burden of disease has shifted to the nations of Africa, Asia, the former Soviet Union and Latin America. If current patterns continue, tobacco use will kill approximately 10 million people every year by 2020; 70 per cent of these deaths will occur in emerging nations.

3. Tobacco smoking is the single largest cause of premature death and disease in Australia. Smoking kills over 15,000 Australians each year and is estimated to cost the economy $31.5 billion per year in social costs, including $5.7 billion per annum attributed to absenteeism and a reduction in the workforce.

4. Every year, 30-40 per cent of smokers attempt to quit, but only one in 10 quit attempts is successful.
QUOTES OF NOTE

Read the following quotations and express your own position on the facts and/or opinions expressed. You may wish to discuss the statements in pairs, or use them as starting points for group debates.

1. Along with motivational ‘why’ messages designed to stimulate cessation attempts, smokers should be repeatedly told that cold turkey and reducing then quitting are the methods most commonly used by successful ex-smokers; that more smokers find it unexpectedly easy or moderately difficult than find it very difficult to quit; and that ‘failures’ are a normal part of the natural history of cessation – rehearsals for eventual success. (Simon Chapman, Professor in Public Health, University of Sydney)

2. Cries about a ‘nanny state’ (regarding the Australian government’s plans to introduce plain packaging for cigarettes) are irrelevant when we consider that cigarettes are not normal consumer products; they kill half of all long-term users. And there is nothing desirable or glamorous about dying of a smoking-related illness. (Fiona Sharkie, Quit)

3. These are tough and ruthless multinational corporations, promoting and selling a product that kills one in two of its regular users. They have known for sixty years that their product is lethal. During this time almost one million Australians have died because they smoked – while the tobacco companies have denied and downplayed the evidence, doing their utmost to oppose and delay any action that might be effective in reducing smoking. Around the world their products cause five million deaths a year – a figure which will only increase as their drive into developing countries bears lethal fruit. (Mike Daube, Professor of Health Policy, Curtin University)

4. There is a substantial and still growing body of evidence that smoking in film has become a significant factor influencing youth smoking uptake. (Cancer Council NSW)
Complete the following multiple choice questionnaire by circling or matching your preferred responses. The answers are at the end of the next page.

1. The National Health Survey (2007-08) reported the following number of daily smokers:
   a. 2 million
   b. 3 million
   c. 5 million
   d. 8 million

2. The National Health Survey (2007-08) reported the following number of Australian adults aged 15 years and over had smoked at some time in their lives:
   a. 4 million
   b. 6 million
   c. 8 million
   d. 9 million

3. Respond to the following statements by circling either ‘true’ or ‘false’:
   a. There are over 60 known cancer-causing chemicals in tobacco smoke. true / false
   b. Smoking harms nearly every organ in the body true / false
   c. Nicotine addiction is as strong or even stronger than heroin or cocaine addiction true / false
   d. Smoking calms smokers’ nerves and relieves stress true / false
   e. Cigarette smoke contains over 4,000 chemicals true / false
   f. Low-tar cigarettes are less harmful than other cigarettes true / false
   g. Just 3 cigarettes a day can trigger potentially fatal heart disease true / false
   h. The health damage caused by second-hand smoking is similar to actually smoking true / false
   i. Over 80% of the world’s one billion smokers live in low- and middle-income countries true / false
   j. Total consumption of tobacco products is increasing globally true / false
   k. Tobacco caused 100 million deaths in the 20th century true / false
   l. Women are more susceptible than men to health damage caused by cigarette smoking true / false
   m. If current trends continue, tobacco use will cause up to one billion deaths in the 21st century true / false
   n. Up to half of current users will eventually die of a tobacco-related disease true / false
   o. Tobacco use kills more than five million people a year – an average of one person every six seconds – and accounts for one in 10 adult deaths true / false

4. Select the correct symptoms of nicotine withdrawal:
   a. Irritability/anxiety
   b. Difficulty concentrating
   c. Restlessness
   d. Lethargy
   e. Problems falling asleep or frequent waking
   f. Craving for tobacco
   g. Craving for caffeine
   h. Tingling sensations/dizziness
   i. Coughing
   j. Appetite changes

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MULTIPLE CHOICE

Complete the following multiple choice questionnaire by circling or matching your preferred responses. The answers are at the end of this page.

5. Which of the following are not proven nicotine replacement therapy (NRT) methods and products:
   a. Nicotine chewing gum
   b. Hypnosis
   c. Nicotine patches
   d. Aversion methods
   e. Nicotine inhalers
   f. Nicotine lozenges
   g. Switching to weaker tasting cigarettes
   h. Nicotine sublingual tablets
   i. Exercise
   j. Prescription medications
   k. Herbal preparations
   l. Acupuncture
   m. Filters and filter blockers

   a. Proven / Unproven
   b. Proven / Unproven
   c. Proven / Unproven
   d. Proven / Unproven
   e. Proven / Unproven
   f. Proven / Unproven
   g. Proven / Unproven
   h. Proven / Unproven
   i. Proven / Unproven
   j. Proven / Unproven
   k. Proven / Unproven
   l. Proven / Unproven
   m. Proven / Unproven

6. Match the following terms to their correct definitions:
   a. Second-hand smoking
   b. Quiting
   c. Tobacco control
   d. Environmental tobacco smoke

   1. Purposefully direct, suppress or change the prevalence of tobacco use and limit the morbidity and mortality it causes.
   2. Smoke in the atmosphere formed by a mix of sidestream smoke and gases which leak from cigarettes during smoking.
   3. Cessation of smoking, through a range of possible methods. Many smokers may make several attempts before they are successful.
   4. Breathing in other people's tobacco smoke, either from the burning end of a cigarette or from the smoke breathed out by a smoker.

   a. 2
   b. 3
   c. 1
   d. 4

MULTIPLE CHOICE ANSWERS

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In 2007-08, around 8 million Australian adults aged 15 years and over had smoked at some time in their lives. Around 3.3 million were current smokers, with the vast majority (91%) of these people smoking daily. Males were more likely to be current smokers than females (22% compared with 18%). (p.3)

In 2007-08, around 9% of young men aged 15-17 years were current smokers, with the rate peaking at 33% for those aged 25-34 years before declining to around 5% for men aged 75 years or over. (p.3)

In 2007-08, the smoking rate for young women aged 15-17 years was slightly lower than for men of the same age (4.5%). For women aged 18-54 years, the smoking rate plateaued at 22% before declining in the older age groups. (p.3)

A large decrease in smoking rates from 1989-90 to 2007-08 occurred in the 18-24 year age bracket (dropping by a third for men and 39% for women). This was accompanied by a rise in the number of 18-24 year olds who had never smoked (from 55% to 64% for men and 52% to 65% for women). (p.3)

Research shows that smoking is associated with increased risk of coronary heart disease, stroke, peripheral vascular disease and cancer. (p.3)

According to the National Health Survey 2007-08, people who had ever smoked were 6.3 times more likely to have emphysema, twice as likely to have a heart disease and 1.6 times as likely to have bronchitis, than those who had never smoked. (p.3)

Around 459,000 (or 3.5% of) adults aged 15 years or over who were not current smokers and 291,000 (or 7.2% of) children aged under 15 years lived in a household where a daily smoker was reported to have smoked indoors. These people may be exposed to environmental tobacco smoke and the associated health risks of tobacco consumption. (National Health Survey 2007-08) (p.3)

Of people who had ever smoked daily, 61% first took up the habit on a daily basis when aged 15-19 years. About one in five (18%) of those who had ever smoked had daily started doing so under the age of 15 years. (National Health Survey 2007-08) (p.4)

Of people aged 25-54, those who first started smoking daily as a child aged under 15 years were more likely to have also been a daily smoker at the time of interview (55%) than those who first started at an older age (46%). (National Health Survey 2007-08) (p.4)

Tobacco has been growing wild in the Americas for nearly 8,000 years. Around 2,000 years ago tobacco began to be chewed and smoked during cultural or religious ceremonies and events. (p.5)

The prevalence of smoking increased dramatically during the world wars, mainly due to the policy of providing free cigarettes to allied troops as a ‘morale boosting exercise’. (p.5)

As smoking prevalence rates have declined in the traditional markets of North America and western Europe the tobacco-related burden of disease has shifted to the nations of Africa, Asia, the former Soviet Union and Latin America. (p.5)

If current patterns continue, tobacco use will kill approximately 10 million people every year by 2020; 70% of these deaths will occur in emerging nations. (p.5)

Cigarettes are made from the dried leaves of the tobacco plant. The leaves of the tobacco plant are dried by burning trees in ovens. One hectare of trees is needed to dry every hectare of tobacco. That is nearly 5 million hectares of forest each year. When a person smokes they contribute to damaging the environment and they are also damaging their health. (p.6)

Nicotine is the addictive substance in tobacco that causes smokers to continue their smoking habit. Along with nicotine, smokers also inhale about 4,000 other chemicals. These chemicals harm nearly every organ in the body. (p.7)

There are over 60 known cancer-causing chemicals in tobacco smoke. Smoking harms nearly every organ in the body, causing many diseases and reducing health in general. (p.7)

There is no safe cigarette; a low-tar cigarette is just as harmful as other cigarettes. (p.10)

Although reducing your cigarette consumption will slightly reduce your risk, quitting is the only way to long-term health benefits. Just three cigarettes a day can trigger potentially fatal heart disease, with women particularly at risk. (p.10)

The smoking rate of the Australian population is just less than 17% but for people with a mental health problem the rate is about 32% and in some cases, such as for people with schizophrenia, the rate is up to 62%. (p.11)

Second-hand smoking is sometimes referred to as ‘exposure to environmental tobacco smoke’ or ‘passive smoking’. It affects people who don’t smoke, as well as people who do. (p.14)

The toxins in cigarette smoke go everywhere the blood flows, causing disease in nearly every organ of the body, at every stage of life. (p.17)

As soon as you stop smoking, your body begins to repair itself. In the first days after quitting your body is already working better (even if you don’t necessarily feel it). (p.21)

Quitting is different for everyone, so find an approach that will work for you. (p.24)

Tobacco kills up to half of its users. (p.33)

The annual death toll of more than five million could rise to more than eight million by 2030 unless urgent action is taken to control the tobacco epidemic. (p.33)

More than 80% of the world’s one billion smokers live in low- and middle-income countries. (p.33)

Total consumption of tobacco products is increasing globally, though it is decreasing in some high-income and upper middle-income countries. (p.33)

In April 2010 the Australian Government announced that all tobacco products must be sold in plain packaging in Australia by 1 July 2012 – the first country in the world to make this commitment. (p.40)
Nicotine replacement therapy (NRT) can assist highly dependent smokers who are motivated to quit. They are designed to reduce nicotine withdrawal symptoms while the person quitting concentrates on breaking the habit. There are several different forms of NRT, including patches, gum, inhalers, lozenges and tablets. A doctor or pharmacist can help determine the best NRT for you and explain how to use the products. Research shows that nicotine replacement products are most helpful for people who smoke more than 15 cigarettes per day.

Nicotine withdrawal
Nicotine withdrawal is usually worst in the first 24-48 hours of quitting. Few people experience all the symptoms and they don't all happen at once. The symptoms you might experience are a normal and expected part of quitting smoking. The symptoms will gradually decline in intensity and the worst is usually over after a couple of weeks. Withdrawal symptoms can include: irritability and anxiety; difficulty concentrating; restlessness; problems falling asleep; frequent waking; tobacco craving; tingling sensations; dizziness; coughing; appetite changes; and stomach problems.

Quitting
Most smokers prefer to quit on their own, with 90% of smokers successfully quitting without the use of pharmacological aids or courses. However, many may make several attempts before they are successful. The key is to keep trying and to learn from previous attempts. Quitting methods include: cold turkey; gradual approaches (cutting down, postponing); courses; and using quitting products such as nicotine replacement therapy (patches, gum, inhalers, lozenges and tablets); alternative therapies; and the prescription drug Zyban.

Second-hand smoking
Second-hand smoking is breathing in other people's tobacco smoke, either from the burning end of a cigarette or from the smoke breathed out by a smoker. There are over 4,000 chemicals present in cigarette smoke, and many are known carcinogens (substances that are known to cause cancer). Second-hand smoking is sometimes referred to as 'exposure to environmental tobacco smoke' or 'passive smoking'. It affects people who don't smoke, as well as people who do.

Tar
Tar is a black substance that comes from burning tobacco. It is released in tobacco smoke in the form of tiny particles. Tar is the main cause of lung and throat cancers and also makes asthma and other lung diseases worse. It also causes yellow stains on teeth and fingers.

Tobacco
Tobacco is made from the dried leaves of the tobacco plant. It is smoked in cigarettes, cigars or pipes, or less commonly chewed. Many smokers become ill or die from the effects of tobacco.

Tobacco control
A part of public health science dedicated to controlling the prevalence of tobacco use and limiting the morbidity and mortality it causes.

Dependence
Dependence on tobacco means that smoking takes up much of your thoughts, emotions and activities. Not all people who smoke are dependent.

Environmental tobacco smoke
ETS is the smoke in the atmosphere and is a mix of sidestream smoke and gases which leak from cigarettes during smoking. There is twice as much sidestream smoke released during smoking as there is mainstream smoke.

Plain packaging
In April 2010 the Australian Government announced that all tobacco products must be sold in plain packaging in Australia by 1 July 2012 – the first country in the world to make this commitment. It requires all tobacco products to be sold in packaging with plain-font brand name only – no colour, decorative or design that could add appeal; no trademarks, logos, descriptors, inserts/onserts or promotional information.

Nicotine
A chemical that acts on the brain and causes people to become dependent on tobacco. The immediate effect of nicotine on the brain is to make you feel alert, active, and/or relaxed. Nicotine causes the blood vessels to narrow, which then affects blood pressure and also makes the heart beat faster. These effects only happen when you smoke tobacco, and not with nicotine replacement therapy, as smoking delivers nicotine to the body very quickly. Nicotine is a poison – swallowing one drop of pure nicotine is enough to kill an adult.

Nicotine addiction
Nicotine is a psychoactive drug, causing chemical or biological changes in the brain, and producing a mood altering effect. It is reinforcing, which means that smokers will keep using the drug. Even after long periods of abstinence, most smokers who want to have an occasional cigarette quickly return to previous levels of smoking. It is used despite its obvious harmful effects. Smokers develop a tolerance to nicotine, so the body gets used to the drug and its effect is reduced. Regular smokers are therefore able to take in far greater amounts of tobacco smoke and associated poisons than if they had not become tolerant. Smokers are physically dependent on nicotine. Most smokers suffer from withdrawal which affects their behaviour and is a major reason for taking up smoking again.

Nicotine replacement therapy (NRT)
Nicotine replacement therapy (NRT) products can assist highly dependent smokers who are motivated to quit. They are designed to reduce nicotine withdrawal symptoms while...
Websites with further information on the topic

Action on Smoking and Health (ASH) Australia  www.ashaust.org.au
Australian Bureau of Statistics  www.abs.gov.au
Better Health Channel  www.betterhealth.vic.gov.au
Cancer Council New South Wales  www.cancercouncil.com.au
Cancer Council Western Australia  www.cancerwa.asn.au
Department of Health and Ageing  www.health.gov.au
National Heart Foundation of Australia  www.heartfoundation.org.au
National Tobacco Campaign  www.quitnow.info.au
OxyGen  www.oxygen.org.au
Quit SA  www.quitsa.org.au
Quit Victoria  www.quit.org.au
Smarter than Smoking  www.smarterthansmoking.org.au
Tobacco in Australia  www.tobaccoinaustralia.org.au

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