Review of Tobacco Control Services

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Executive Summary

**Background**

In 2011 the New Zealand Government adopted an aspirational goal of reducing smoking prevalence and tobacco availability to minimal levels by 2025. Achieving this Smokefree 2025 goal would mean New Zealand becoming essentially a smokefree nation.

Researchers from SHORE & Whariki Research Centre, College of Health, Massey University, were selected to undertake a review of tobacco control services funded by the Ministry of Health to inform the Ministry on how its portfolio of funded tobacco control services might best be developed and delivered over the next 10 years in order to support the achievement of the Government’s Smokefree 2025 goal.

This review focused on the operational components and services delivered by the Ministry of Health’s tobacco control programme. Macro public policies (e.g. pricing or taxation policies, plain packaging, duty free sales) were not a key focus. Tobacco services funded by other agencies, such as the social marketing and health promotion funded by the Health Promotion Agency (HPA) were also not in scope.

**Research overview**

The review consisted of four phases: evidence review, map of tobacco control services, consultation with tobacco control sector, and identification of gaps and opportunities.

* Evidence review: A review and summary of published evidence relevant to tobacco control service delivery models and approaches was undertaken. The focus of the review was on services that address high rates of smoking in priority populations and interventions that achieve value for money.
* Map of tobacco control services: A map of current tobacco control services was developed using multiple sources.
* Consultation with tobacco control sector: An online consultation process was undertaken and three face to face consultation meetings were held. Three consultation meetings were held with Ministry of Health personnel responsible for tobacco control policy and operations.
* Identification of gaps and opportunities: This analysis was informed by the three earlier phases of the research and additional relevant data and research.

A summary of findings from the evidence review, map of tobacco control services, and gaps and opportunities follows. (Points arising from the consultation are provided in Appendix 1)

**Evidence review**

The review considered published research evidence on service delivery models and approaches and programme structure as it relates to tobacco control. There is a particular emphasis on approaches effective in New Zealand priority populations of young people, Maori, Pacific, lower SES and pregnant women. The publications covered are mainly but not exclusively reviews of published evidence and are often meta-analyses. Many are published by the Cochrane collaboration. This means that the evidence taken into account is quantitative and is mainly the result of randomised controlled trials. It is acknowledged this evidence base does not take into account approaches not easily susceptible to such evaluation. Some complementary research and experiential knowledge informs later sections of the Review.

The focus is on programmes and approaches that are funded or can be potentially funded, by the Ministry of Health. Tobacco excise taxation is therefore not covered in detail. Smokefree legislation is considered because enforcement and compliance services are funded by the Ministry of Health.

The review first discusses the content of smoking cessation interventions and then service delivery models for prevention followed by service delivery models for cessation. It then goes on to cover cost effectiveness and interventions that operate at a population level. Within each section there is discussion of results in different settings, implemented in different ways and targeted at specific groups.

In many cases there is insufficient evidence to conclude that a given intervention is either effective or ineffective in a given context. It is important to stress that insufficient evidence for an effect is not the same as evidence of no effect.

**Types of intervention**

Individual counselling is effective at increasing smoking cessation. Brief advice is effective and other approaches taking a more theory-based view, such as motivational interviewing, cognitive behaviour therapy or behavioural therapy based on the stage the potential quitter is at in the quitting process have shown beneficial effects but there is evidence only of a small additional effect of more intensive counselling when compared with brief advice.

Counselling is effective whether provided face to face or by telephone.

Group counselling is more effective than quitting without help but it is not more effective than individual behavioural support. There is no evidence that group counselling has an additional impact on successful quitting when combined with Nicotine Replacement Therapy (NRT) or advice from a health professional.

A number of pharmacotherapies have been shown as effective in aiding cessation. Nicotine Replacement Therapy (NRT) in a number of forms is the most widely currently used but bupropion, varenicline, nortriptyline and cytisine are alternative or supplementary therapies for smokers trying to quit. E-cigarettes have not yet been demonstrated to be effective. Varenicline has been shown to be more effective at aiding quitting than either single form NRT or bupropion and is as effective as combination NRT (where two types of NRT are used e.g. a patch and an inhaler).

There is insufficient evidence to show effectiveness for aversion therapy, hypnotherapy, acupuncture or laser therapy.

Financial incentives (sometimes referred to in the literature as contingency management) have not been demonstrated as effective in general populations but have increased short term quitting by adolescents and those on opioid management. They have also been shown to be effective for pregnant women and have some favourable effect in workplace settings.

There is moderate evidence that smokefree legislation has reduced prevalence rates of smoking.

Reflecting the above findings, the consensus in the literature is that good cessation services include a primary focus on brief advice and some behavioural support with pharmacotherapy where necessary. Financial incentives may also be appropriate.

**Service delivery models for prevention**

With regard to settings:

Studies evaluating the effect of programmes to promote non-smoking in families have found no evidence of an effect. There was some evidence that programmes based in the community reduced the uptake of smoking by young people but this was not strong.

With regard to priority groups:

There is no evidence for an effect of interventions specifically aimed at preventing smoking in indigenous youth on overall prevalence. Only two evaluative studies exist of such interventions.

For adolescents in the general population mass media campaigns are effective when implemented as part of a comprehensive tobacco control programme aimed at denormalising smoking.

Certain types of programmes based in schools have been shown to be effective at preventing uptake and the evidence is better than for interventions based in the family.

There is some evidence that multi-component interventions based in the community have an effect on reducing uptake in young persons but the evidence is not strong.

Young adults (18-24) are a somewhat neglected group in tobacco control research based on the belief that most smokers start before the age of 18. However there is evidence of later uptake of smoking in New Zealand and that transitioning to a dependent smoker may occur in this age range.

**Service delivery models for cessation**

Brief advice given by GPs aids cessation as does brief advice given by nurses, health visitors or dentists. There is limited evidence that community pharmacy-based smoking cessation interventions can signiﬁcantly impact abstinence rates. There is no research evidence for brief advice given by other health professionals such as physiotherapists or dieticians. No research was found evaluating delivery of brief advice by sectors beyond health professionals.

Cessation interventions that begin in hospital and continue for at least one month after discharge are effective and more effective if intensive counselling is combined with NRT.

Specialist clinics, where multifaceted treatments can be designed and implemented, are not currently part of the New Zealand cessation services.

Interventions based in the community (i.e. outside the health sector) are usually aimed at changing the social environment in which smoking takes place and thereby intended to influence sustained quitting or long term reduced uptake. This type of intervention is difficult to evaluate using the Cochrane Review methodology but no evidence of effect has been found in the studies considered by the reviewers the most rigorous.

Interventions aimed at increasing partner support for quitting have not been found to be effective but it was not clear that the interventions considered had in fact enhanced partner support so it is not known whether partner support is an aid to cessation.

A number of interventions have been based in the workplace. The results were that approaches to cessation worked as well, but not better, in the workplace as other settings.

**Comprehensive and integrated services**

The England and Wales Stop Smoking service is a rare example of a comprehensive smoking service delivered since 2013 by local authoriries. It has been shown to be effective at reaching large numbers of smokers, particularly in low-SES groups and has achieved a quit rate four times that common for unaided quit attempts. This corresponds to a system where smokers are monitored through the health system and referred onwards and between various services according to their needs. The actual service received by a potential quitter in the UK depends on their local authority and this means some smokers may receive too little support as services available vary across location.

**Ways of reaching smokers**

Telephone quitlines have been shown to be effective whether the counselling is initiated by the smoker or the quitline and whether or not pharmacotherapy is involved. Quitlines have been shown to be effective at aiding cessation even when smokers are ‘cold called’ i.e. the first contact was initiated by the quitline.

The widespread use of internet-enabled phones mean that the demarcation between internet based and mobile phone based interventions has become blurred. Trials that took place when the two were more distinguishable found evidence of effectiveness only for internet based interventions when the content of the intervention was tailored to the smoker. Generic messages were not effective. Mobile phone text messaging has been found to be effective at aiding cessation. This effectiveness depends on the timeliness and pertinence of the message.

Self-help materials have also been found to aid cessation particularly if tailored to the client and when the alternative was to receive no help

**Harm reduction** divides public health specialists in the tobacco as in other fields. Smokers find it difficult to quit because of nicotine addiction which may be lifelong. The harm caused by smoking however, is caused by the toxins in tobacco smoke. Switching from tobacco smoking to an alternative nicotine delivery device (such as NRT or e-cigarettes) reduces the harm from smoking (although e-cigarettes themselves may have other harmful effects that have yet to become apparent). However, many tobacco control advocates do not favour harm reduction approaches, particularly in the case of e-cigarettes and the way these are being marketed. The opinion of some in the field is that the promotion of e-cigarettes as an alternative to tobacco smoking rather than as an aid to quitting may undermine the whole approach of denormalising smoking and encourage an addiction to nicotine. The evidence base for e-cigarettes is still too weak to draw conclusions about effects at the population level.

**Cessation services for priority populations**

Indigenous populations: the evidence for effective cessation interventions is weak as there are too few quality studies. The results suggest that interventions that are effective in the general population are also effective in smoking cessation for indigenous groups.

For adolescents and young adults behavioural interventions are judged effective but pharmacotherapies less so. Interventions shown to be effective in the general smoking population are as effective for young adult smokers but the latter tend to have little contact with the systems that provide such services.

Counselling and incentives have been shown as effective in aiding cessation in pregnant women. No effect was found for NRT. While not generally considered a priority population all smoking women of child bearing age are potentially pregnant smokers and might be considered worth additional focus given the impact of smoking on offspring.

The high rates of smoking in low-SES populations are a major cause of persistent health inequalities. A review of most of the interventions considered in this report found very few that were more effective in low-SES than in high-SES populations. Therefore most interventions either increased or did not decrease health inequality. An effective intervention found to reduce health inequality was to raise the price of cigarettes. There is also evidence that social marketing with a focus on the negative health impacts of smoking are effective with low SES smokers.

All stop smoking services struggle with high rates of relapse between short term abstinence and sustained quitting. For this reason ‘recent quitters’ are also considered a priority population. There is limited evidence but a 12-week course of varenicline had a significant effect on 12 month quit rates when compared with a placebo.

Those diagnosed with mental illness have very high rates of smoking and these rates have not fallen along with those of the general population. For those with mental illness bupropion was found to be effective for those with severe mental disorders such as schizophrenia. For those with common mental disorders such as depression, mood management techniques were more effective.

There is a lack of evidence on aiding cessation among prison populations. Although smokefree prisons reduce consumption whilst the smoker is inside, most inmates revert to smoking soon after release. There have been few interventions specifically aimed at recently released prisoners and we were unable to find any research evaluating interventions for this group.

**Restrictions of supply and enforcement models**

Although many countries have a minimum purchase age for cigarettes in New Zealand this is not entirely effective at restricting supply. Approximately one in three Year 10 students were given tobacco by an older sibling or parent. Others in the adolescent age group received cigarettes from a peer or took without permission. The HPA survey of Year 10 students in 2012 showed one-half (50%) of current smokers bought cigarettes from a dairy at least once in the past month; one-in-five (21%) bought cigarettes from a service station and one-in-five (19%) current smokers bought cigarettes from a supermarket. Maori (60%) were more likely than non-Maori (39%) to have purchased cigarettes from a dairy at least once in the past month. Also Maori and Asian children were less likely to be refused. This suggests poor compliance with the regulations on selling to underage customers. Successful enforcement requires at least an element of controlled purchase operations (CPO) and compliance may be improved by licensing or registering tobacco retailers. Smuggling or illicit tobacco is not a problem in New Zealand though a serious problem globally.

**Cost effectiveness**

With respect to cost effectiveness virtually all treatments that are effective are also cost effective because the health benefits from cessation are so large. All estimates of cost expressed in terms of life years saved, DALYs or QALYs, are well below the levels of other health interventions. Brief advice is the most cost effective because of the limited time involvement.

Comparing the cost effectiveness of interventions is complex because of the different assumptions made and the different methods used but the consensus appears to be that brief advice is the most cost effective behavioural intervention. For pharmacotherapies varenicline is more cost effective than bupropion which in turn is more cost effective than NRT.

Mass media campaigns and smokefree policies have also been found to be cost effective probably because of their universal coverage but estimates of cost per life year saved or per QALY vary widely. There is a gap in the evidence for the effectiveness and cost effectiveness of mass media campaigns in New Zealand.

**Second hand smoke and denormalisation**

Smokefree legislation has had significant effects on rates of heart attacks and lung cancer. This is through protection of individuals from second-hand smoke. Current smokefree legislation mainly covers public indoor spaces but there are examples overseas of legislative bans on smoking in public outdoor areas and a debate about restricting smoking in private indoor spaces such as cars and multi-unit housing.

Part of the effect of smokefree legislation is to denormalise the use of tobacco. Removing smoking from all public spaces is intended to change the context in which smoking takes place and remove positive associations of smoking and smokers as role-models for children. Interventions employing such techniques are difficult to evaluate because their effects, if any, are long term.

In some jurisdictions legislation has been enacted to ban portrayals of smoking in TV and films. This is as a result of a perceived increase in such images since explicit tobacco advertising was stopped and evidence young people exposed to images of smoking in films and on TV are more likely to start smoking.

There are also ethical issues involved in balancing denormalisation with any stigmatisation of smokers.

**Social marketing and mass media campaigns**

Advocacy differs from mass media campaigns which encourage quitting or prevent uptake in that it is intended to change the social, legal or economic environment in which decisions about smoking take place. The media is used to disseminate messages and research about smoking, the activities of the tobacco industry and to advocate for effective policy. We were unable to find any evaluations of advocacy campaigns for this review.

Mass media campaigns have been shown to be effective and cost effective but the active ingredient of an effective campaign is often difficult to isolate because of the many different approaches followed. Findings are that effective campaigns have a high level of reach, duration and exposure and that negative messages about smoking have a greater effect on low-SES populations.

**Social media**

The use of social media interventions in tobacco control is relatively new and social media is thought to be underutilised for public health. Analyses of social media postings find that a majority are supportive of tobacco use.

Tobacco industry denormalisation is an approach taken to make smokers, or potential smokers, more aware of the tobacco industry’s strategies and thereby better able to resist its messages. This has been shown to be effective at increasing quit attempts.

**Gaps in the evidence**

There are a number of gaps in the evidence necessary to design a comprehensive and integrated programme. In particular evaluations of the ways of organising, funding and monitoring a scaled up and joined up stop smoking service. The interventions evaluated are quite piecemeal and delivered by different parts of the health, welfare and research sectors with little recognition of the overlaps between the target populations. Specific gaps also include ways of turning short term quits into sustainable non-smokers and means to reduce smoking in indigenous populations. Further studies to test whether interventions effective in the general population are as effective in specific sub-populations would also be helpful.

**Map of Existing Services**

**Methods**

Information on activities relating to smoking cessation, health promotion and advocacy, leadership and coordination and research taking place in all DHB areas was obtained from:

* Reports to the MoH from DHBs on smokefree DHB and tobacco control contracts
* MoH contracts database
* Datapeople database on directly contracted providers
* Information on services in local area requested from each DHB’s smokefree coordinator
* Online consultation
* Other sources including websites, annual reports, MoH documents and material gathered during consultation meetings

**Smoking Cessation Services**

The MoH funds smoking cessation services directly through Quitline, Aukati Kaipaipa (AKP), pregnancy services and Pacific providers of services. It also funds all DHBs for a range of smokefree activities.

**Quitline**

The MoH has a contract with Quitline to provide cessation services worth $9.4 million. In 2012/13 Quitline supported 50,297 quit attempts as compared to 62,580 the previous financial year.

A cost effectiveness study of Quitline calculated that it cost $187 per supported quit attempt and $743 per 4-week quit.

There is wide variation in the numbers contacting quitline both by region and by ethnicity. For example, overall 8 % of Maori smokers and 6 % of Pacific smokers registered compared with 8–10% overall. There was variation in accessing Quitline across DHB areas: general population –13%; Maori 4–12%; Pacific 2–12%. For example, only 5% of Pacific smokers in Counties Manukau DHB area and only 4% of Maori smokers in Tairawhiti DHB area registered with Quitline in 2012/13. Areas with a high degree of contact and/or registration include Auckland, Capital and Coast and Hutt Valley.

Quitline achieves a 24.2% self-reported quit rate (intention-to-treat seven-day point prevalence) at three months and 20.9% at 12-months. On the same basis the quit rates for Maori using quitline at 12 months are lower at 16.4% and for Pacific, 18.9%.

**Aukati Kaipaipa (AKP)**

The MoH funds 32 service providers to deliver cessation services in each region. These services are aimed mainly at Maori smokers although they can be accessed by anyone. The total cost of the AKP services in 2013/14 is $5.8 million.

AKP is a kaupapa Maori smoking cessation services primarily delivered face to face. AKP offers evidence based counselling and provision of NRT to clients. AKP clients are also encouraged to involve their whanau to support their quit attempt.

AKP service providers vary in size and resourcing. Enrolments in the financial year 2012/13 varied between 90 and 560. For each FTE quit counsellor financed by the AKP contract there are expected to be at least 120 enrolments. Some DHB areas share AKP providers with other DHBs whereas Waikato DHB area (for example) has 6 small AKP providers.

A number of consistent performance indicators are collected for AKP providers that allow close monitoring of their work. These data are not made available in reports from DHBs for DHB funded cessation service providers thus making it difficult to compare across services.

There is variation in effectiveness of AKP providers with validated abstinence rates at three months ranging from 4% to 71%.

**Pacific Services**

There are four providers specifically contracted to offer cessation services to Pacific People who smoke. Their contracts total around $1.3 million. These providers operate in the DHB areas with the highest numbers of Pacific smokers, Counties Manukau, Canterbury, Waitemata, Waikato, Auckland and Capital and Coast/Hutt Valley. All the contracted Pacific providers are relatively large with annual enrolments in the 2012/13 financial year between 200 and 400. Similar to AKP, detailed information on performance is available

Validated abstinence rates at four weeks vary between 7% and 32%.

These services are supplemented by those funded by a number of DHBs, for example the South Seas Health Care Trust in Counties Manukau.

**Services for pregnant women who smoke**

There are six providers contracted with the MoH to provide smoking cessation services to pregnant women with a total contract worth $1.5 million.

These services are provided in Auckland, Counties Manukau, Canterbury, Hawke’s Bay, Southern and Waitemata DHB areas. Annual enrolments in the financial year 2012/13 varied between providers from 154 to 325. Validated four-week abstinence rates varied from 0% to 33% (self reported rates were between 30% and 77%).

**District Health Board services**

The MoH funds all DHBs for a range of smokefree activities including provision of ABC (Ask about smoking, give Brief Advice to stop smoking, and offer Cessation support) by primary and secondary health services. For primary health this is through DHB contracts with Primary Health Organisations. Some DHBs also directly fund cessation services.

DHBs provide six-monthly reports on these contracts. The DHBs report against a number of targets including that 95% of patients in secondary care receive ABC and that 90% of patients who smoke, are enrolled, and are seen by a primary care physician, receive ABC.

All DHBs have achieved the secondary care target for the past six quarters. No DHBs reported having achieved the Primary Health Target in their six-monthly report (2012/13) However, there is an increased focus on the primary health care targets and collaborations with PHOs.

Training of health workers to achieve ABC targets: eighteen DHBs reported providing training to Health workers, there was variation between DHBs in how extensive this was with Canterbury and Southern reporting extensive training, Tairawhiti and Hawke’s Bay reporting little and Mid Central and Northland reporting none.

Referrals can provide the cessation part of the ABC: nine DHBs reported numbers of referrals made in their six-monthly report, ranging from 37-582; three DHBs (Auckland, Bay of Plenty & Mid Central) made more than 500 referrals, others were below 300. Counties Manukau and Mid-Central DHBs developed a triage/referrals management system, and Southern DHB developed single referral format.

Group-based cessation: six DHBs ran group based cessation programmes and/ or WERO.

DHBs do not routinely report quit rates or other performance indicators for the cessation services they fund or support. Reported three-month validated quit rates ranged from 9-40%, however, for most DHBs, there is no information given on quit rates.

**Priority Groups:**

Maori: four DHBs provided/funded specific cessation services for Maori smokers (in addition to services provided by AKP) – Counties Manukau, Southern, MidCentral and Northern.

Pacific: three DHBs provided specific cessation services for Pacific peoples (in addition to services directly funded by MoH) – Canterbury, Counties Manukau, MidCentral.

Pregnant Women: four DHBs provided specific services to pregnant women (other than those funded directly by the MoH) – Counties Manukau, MidCentral, Taranaki and Hutt.

Youth: two DHBs provided specific services to youth – Whanganui, Tairawhiti.

Low SES: no DHB provided specific services to low income people.

Mental illness: no DHB provided specific services to those with mental health illness.

Nelson Marlborough DHB trained mental health staff in ABC. MidCentral DHB supported the Acute Mental Health Inpatient Unit becoming smokefree. The four northern DHBs are part of a project led by the Northern Regional Alliance raising awareness of the benefits of quitting smoking for those in the mental health sector.

Ex/current Prisoner: no DHB provides specific services to ex or current prisoners.

Hospital follow up services: two DHBs reported provision of follow up services for hospital patients. Waitemata DHB provided face to face or groups counselling from professional psychologists and NRT to hospital outpatients. Nelson Marlborough DHB offered four-eight phone follow up services (unless patient able to travel to hospital for follow up appointments) for three months.

**Brief summary of cessation services by DHB region**

The services provided by each DHB and those provided by other services (national and local) in the DHB area are summarised below. They are presented in descending order of the number of smokers usually resident in the DHB catchment area based on 2013 Census.

**Canterbury DHB** directly provides little cessation support although its public health arm, Community and Public Health is the AKP provider for Canterbury, South Canterbury and West Coast DHB areas. There are also services provided for Pacific smokers by the Pacific Trust and for pregnant women by Smokechange. Cessation services are funded by three local PHOs: Pegasus, Rural Canterbury and Christchurch.

**Counties Manukau DHB** has relatively few residents contacting Quitline but has a number of smokefree services in place initially set up to support cessation and referrals for secondary care patients but being used more widely. There is also a quit smoking programme run by the East Health PHO. CMDHB funds additional Maori services to those provided by AKP and funds the South Seas Healthcare Trust for Pacific services. Counties Manukau also has a pilot project giving financial incentives to pregnant women to encourage them to quit along with Mangere Community Health Trust providing cessation support to pregnant women.

**Waitemata** DHB has a service supporting quit attempts for hospital in-patients or outpatients who smoke. It also supports a PHO project to support cessation for adults who live in households with children under 16. In the Waitemata area 17 pharmacies are able to both provide counselling and NRT in a project implemented by Procare PHO. Pacific cessation services in Waitemata are provided by the Auckland Regional Health Service, pregnancy services by Waitemata PHO and AKP by Ngati Whatua O Orakei, a provider shared with Auckland, a smaller provider, Te Rununga o Ngati Whatua, and an innovations fund project. Waitemata is the only DHB with an Asian specific smokefree service with counselling and NRT.

**Waikato DHB** funds no cessation other than the ABC. There are also limited referrals to Quitline. Waikato DHB area has six AKP providers listed, although all except the largest, the **Te Runanga o Kirikiriroa Trust, have enrolments below 200. K’aute Pasifika provide Pacific services.**

**Auckland DHB provides no cessation services directly other than to pregnant women. However it refers smokers to Quitline, to the AKP provider (shared with Waitemata), to the Pacific Quit services (through Auckland Regional Public Health) or the online service Smokestop. Auckland DHB also has run four Community Quit Groups. Procare PHO is also piloting a project to contact and offer advice to enrolled patients who haven’t presented at a GP. Auckland DHB has a contract with MoH for providing cessation support for pregnant women who smoke.**

**Southern DHB does not provide any direct cessation support except on a small scale. There are four providers of services to Maori smokers; two are financed through AKP and two by the DHB.**

**Capital and Coast DHB funds no direct cessation services. Pacific services are provided for the three DHB areas of Capital and Coast, Hutt Valley and Wairarapa by Pacific Health Trust Porirua. This is the largest Pacific provider with 410 enrolments in 2012/13 although many of the clients enrolled with Pacific Health Trust are Maori. There is also a large AKP provider, the Kokiri Marae Keriana Olsen Trust working across the region.**

**Bay of Plenty DHB funds a small group therapy program for general population quitters and a support service for individuals implemented by the Eastern Bay Primary Health Alliance PHO. Referrals are made to Quitline or AKP. The DHB also funds a small cessation service for pregnant women. There are two AKP providers Nga Kakano and Ngati Awa Social and Health Services.**

**MidCentral DHB funds no cessation services directly. All local resources for smoking cessation are directed to** Te Ohu Auahi Mutunga – Smoking Cessation Services which is aimed at Maori, Pacific or pregnant women. Those not eligible for its programmes are referred on to Quitline. The AKP provider is Te Runanga O Raukawa.

**Northland DHB** has a cessation service run through the Manaia and Te Tai Tokerau PHOs. Clinical staff provide cessation support in hospitals. The DHB contracts two Maori NGOs and two community trust providers to implement cessation services to Maori. Only one, Ngati Hine Health Trust is an AKP provider the other three are funded by the DHB.

**Hawke’s Bay DHB** does not fund cessation services directly. There are two AKP providers who between them enrolled 509 clients in 2012/13. Choices – Kahungunu health services provide services to pregnant women and their families. Hawke’s Bay DHB is also implementing a project trialling an NRT mouth spray.

**Hutt Valley DHB** receives AKP and Pacific services from the same providers as for Capital and Coast the large Kokiri Marae Keriana Olsen Trust and Pacific Health Trust Porirua.

**Nelson Marlborough DHB** funds cessation services implemented by the PHO and delivered at GP surgeries. Hospitalised patients have the services of a quit coach. There are three AKP providers, all quite small, who operate only in parts of the DHB area. The AKP provider in Nelson City has a majority of Tongan clients. There is an innovation fund project trialling approaches to cessation to Pacific smokers in Blenheim.

**Taranaki DHB** funds cessation support through counselling and NRT at local GP surgeries. There are two AKP providers, one in the north and one in the south of the DHB area. The majority of clients for the northern provider are NZ European. The DHB has recently started funding a service for pregnant women who smoke; this is provided by the Te Kawau Maro Alliance.

**Lakes DHB** has three or four AKP providers geographically dispersed across the DHB area. All have contracts corresponding to roughly one FTE post.

**Whanganui DHB** funds a drop in quit clinic implemented by the Whanganui Regional Health Network. This had 458 new patients in the last 12 months, 312 stayed on the programme for at least three months. GPs are funded by the DHB to provide cessation support to priority populations and 231 claims were made by GPs in the last 12 months. Te Ha Ora – Te Oranganui Iwi Health Authority is the AKP provider. Whanganui has also recently set up a youth quit clinic for 12-19 year olds.

**Tairawhiti DHB** area has the highest smoking prevalence in New Zealand. Ngati Porou Hauora is one of the two AKP providers the other is Te Hauora O Turanganui a Kiwa. The Te Aka Ora Charitable Trust is funded by the DHB to provide services to teenagers, teenage parents and pregnant teenagers.

**South Canterbury DHB** funds a smokefree service which provides group or individual therapy in community, workplace or clinic settings. This is in addition to the ABC provided in primary care. The AKP provider is Community and Public Health Canterbury, one of the larger AKP agencies covering Canterbury, South Canterbury and West Cost DHB areas.

**Wairarapa DHB** funds two FTE quit coaches and the PHO recruits to this service through newspaper advertisements. The AKP provider is the Whaiora Whanui Trust which also has two FTE coaches.

**West Coast DHB** funds the Coast Quit programme provided by GPs. This programme provided about half the smokers with varenicline to aid their quit attempts and found a significantly higher abstinence rate after three months with this group. The number of counselling sessions is limited to seven although the DHB also funds 1.5 FTE quit coaches for those that require more sessions. The AKP provider for the West Coast DHB area is Community and Public Health Canterbury.

**Training and Capacity Building**

Three organisations are contracted by the MoH to provide training and capacity building services at a national level.

Inspiring Limited train cessation practitioners in evidence based cessation treatment. They have run training workshops for generalist cessation providers and for those concentrating on group based therapies.

Stop smoking practitioner training is provided by the Heart Foundation to healthcare workers. The Heart Foundation also implement Pacific Heartbeat which provides training specifically to cessation practitioners working with the Pacific community.

National Training for Midwives to Support Pregnant Women to Stop Smoking is provided by Smokechange.

The Ministry of Health has developed an NZQA qualification in smoking cessation. This will be available in 2014 and will be a formal industry standard qualification for cessation practitioners; it will set the core competency for smoking cessation treatment and practice.

**Health promotion and advocacy**

**National level**

ASH and the Smokefree Coalition are funded to provide smokefree and information and advocacy services at a national level.

There are a number of other organisations that promote smokefree that are not funded by the MoH to do so. These include the Cancer Society, the HPA and the Heart Foundation.

**Regional level**

All DHBs reported undertaking health promotion and smokefree to the general public through a variety of activities.

**Enforcement**

Tobacco enforcement within DHB catchment areas is mainly concerned with ensuring the retail sector does not sell tobacco to minors and is the responsibility of the public health units. Low rates of sales are reported by PHUs carrying out controlled purchase operations but CPOs were not carried out in some areas. Other tobacco enforcement activities reported included visiting retailers to check compliance, investigating complaints about workplace smoking, and checking licenced premises in relation to the Smokefree Environments Act.

**Leadership and coordination**

**National Level**

Four NGOs receive MoH funding to provide leadership and coordination of the tobacco control sector.

ASH provides services to engage communities in the democratic process around tobacco policy and undertakes intensive community work around local and settings-based Smokefree policies. It also is involved in regional strategic forums for local Smokefree policies and works with several DHB’s on regional Smokefree 2025 strategies.

The National Maori Tobacco Control Leadership Service is provided by Hapai Te Hauora Tapui jointly with ASH. This service is recently established.

The Smokefree Coalition leadership role includes developing, maintaining and strengthening strategic alliances and collaboration between agencies involved in promoting tobacco control in New Zealand.

The Heart Foundation is contracted to provide training services to health professionals as well as other sector support activities to help achieve the health target and to provide Pacific leadership and health promotion in relation to tobacco control and awareness.

The Cancer Society and the National Smokefree Working Group are other organisations, not funded by the MoH that are active in the field of leadership and coordination.

**Regional Level**

All the DHBs reported undertaking leadership and coordination activities. Activities include the development, review and implementation of smokefree policies as well as supporting other organisations through activities such as training and assistance with policy making.

**Research and knowledge**

**National Level**

The Ministry of Health directly funds research into tobacco control carried out in New Zealand.

The New Zealand Tobacco Control Research Turanga was established in 2011 (by MoH and HRC) as a national programme of research to inform rapid smoking prevalence reduction.

The ASH Year 10 (14-15 year olds) survey is funded by the Ministry of Health as part of the New Zealand Youth Tobacco Monitor. The survey has monitored student smoking annually since 1999. The survey results are freely available online.

Additional tobacco control research activity is undertaken by ASPIRE2025, HPA and others.

Four projects with a national focus have been supported by the MoH Pathway to Smokefree 2025 Innovation funding: National Quit Month, WERO group stop smoking competition, Campaign to enhance smoking cessation interventions in general practice, and Smokefree movement.

**Regional Level**

There is little research activity at regional level. MoH Pathway to Smokefree 2025 Innovation Fund is supporting ten projects with a regional focus.

**Gaps and opportunities**

**Current situation**

The 2013 census records 463,000 smokers in New Zealand. The overall prevalence is 13.7%.

There is variation in the rates of prevalence across DHB catchment area with the lowest rates in Auckland and Waitemata and the highest in Tairawhiti and West Coast.

The highest absolute numbers of smokers are in Canterbury and Counties Manukau.

The national prevalence rate for 15-19 year olds is 9.3% and for 20-14 year olds is 19%. The four DHBs with the highest numbers of smokers in these groups are Canterbury, Counties Manukau, Waitemata and Waikato.

There are 318,000 NZ European smokers in New Zealand with a prevalence of 13.4%.

There are 122,000 Maori smokers in New Zealand with a prevalence of 31%. The DHBs with the highest numbers of Maori smokers are Waikato, Counties Manukau, Bay of Plenty and Northland.

There are 41,000 Pacific smokers in New Zealand with an overall prevalence of 21.6%. The DHBs with the highest numbers of Pacific smokers are Counties Manukau, Auckland, Waitemata, Capital and Coast and Hutt Valley. 78% of all Pacific smokers live in these areas.

There are 27,000 Asian smokers in New Zealand with an overall prevalence of 7%. 65% of all Asian smokers live in Auckland, Waitemata and Counties Manukau.

There are 50% more ex-smokers than current smokers in New Zealand. This varies across DHBs. In Nelson-Marlborough DHB area there are twice as many whereas in Counties Manukau only 10% more.

Current rates of cessation are too slow to reach the goal Smokefree 2025. Simulation studies suggest that annual rates of cessation need to increase to 10% from about 4% for non-Maori and to 20% from about 3% for Maori.

Assessing the level of quitting from Quitline and from AKP providers and under certain assumptions it is estimated that New Zealand is achieving around 12,500 successful quits a year. This is less than the estimated 46,000 per annum necessary to reach a negligible prevalence in 2025.

On a regional basis, given certain assumptions including there will be no reduction of effort in these regions, Auckland, Capital and Coast and Waitemata will be the only DHB catchment areas where the overall prevalence will be at or below 5% by 2025.

The success rate of unassisted quitting is low (<4%) but more smokers make quit attempts without any support than are assisted. Reaching a goal of low prevalence in 2025 requires a level of mass quitting of which the majority of attempts will be unassisted.

Pharmac currently funds the provision of three types of NRT and three types of pharmaceuticals for smoking cessation; bupropion, nortriptyline and varenicline. The cost to Pharmac of NRT was $6.97 million in financial year 2012/12 and of other drugs $17.6 million. $11.4 million was for varenicline which is subsidised for three months and requires a special dispensation to be funded.

**Smokefree Environment in New Zealand**

Expanding Smokefree environments and providing strong messaging will encourage cessation and prevent uptake. Such population interventions have been shown to affect priority groups.

**Leveraging quit attempts off policy change**

Annual excise tax increases of 10% are mandated until 2016. The continuation of these will maintain an environment for reduced uptake and enhanced cessation and offer opportunities for leveraging increased quit attempts via relevant messaging which appears to be a current gap.

**Access to tobacco**

Data in New Zealand suggests minors are able to purchase cigarettes relatively easily. Tobacco retailers are not licensed in New Zealand and licensing could assist efforts to reduce access to underage smokers, reduce uptake and increase cessation. There is also a failure to carry out CPOs in some areas. Social supply is also a common way for minors to access tobacco.The equivalent of social supply legislation enacted for alcohol ([Sale and Supply of Alcohol Act, 2012](#_ENREF_4) [[1](#_ENREF_1)]) is not in place to address social supply of tobacco to minors.

**Smokefree Environments**

The Smokefree Environments Act has reduced smoking in many public places. There is current lack of clarity regarding outside areas associated with bars and this was raised as an issue by stakeholders.

Smokefree legislation currently provides for 100% smokefree indoor workplaces. Some organisations have developed more comprehensive policies to reinforce and extend smokefree places and include surrounding environments but this is not yet universal.

Not all organisations contracting for government services are required to have comprehensive smokefree policies.

**Messaging about preventing uptake and encouraging quitting**

Evidence suggests messaging can be effective, especially if part of a comprehensive programme.

**Exposure to Smokefree messaging**

The total expenditure on anti-smoking advertising by Quitline and the Health Sponsorship Council (HSC) fell by almost 50% between 2008 and 2013. Because there is a dose response relationship between exposure to social marketing and smoking cessation this reduction in expenditure is a constraint on efforts to reach Smokefree 2025.

**Regional and priority population needs**

Quitline quit attempts and registrations vary between DHB areas and by ethnicity. This suggests need for more focus in some areas and may require enhanced collaboration with local agencies, including the health promotion activity of DHBs to ensure messages are appropriately framed and variation in uptake is reduced as far as possible.

**Target populations for messaging**

Maori, Pacific and children are priority populations for messaging. Young adults (18-24 years) should also be a priority as they have high prevalence, some evidence of increased uptake and are the age group with the least contact with the health sector. Women of childbearing age are another potential priority group.

**Messaging content**

Smokefree 2025 could be a strong message to encourage community wide conversations about quitting. This is a gap in messaging.

In the consultation meetings stakeholders identified denormalisation of the tobacco industry as another gap in messaging in New Zealand. There is evidence of the effectiveness associated with this approach in other countries.

Given the importance of policy drivers for quit attempts, messaging will benefit from being linked to policy initiatives, such as the regular excise tax increases and increased implementation of smokefree environments.

**Social Media**

Social media is now an integral part of communication and needs to be fully exploited in communicating the Smokefree messaging but is currently underutilised.

**Engagement beyond the health sector**

Reaching the Smokefree 2025 goal requires a cross-government approach which is currently lacking. Many influences on health come from outside the health sector and issues of health impact on the workings of other sectors. Government agencies need to consider health outcomes when formulating all policy. The role of the MoH in providing leadership at the highest levels to assist this was emphasised.

To encourage the expansion of Smokefree policies the benefits to the core business of non-health sectors of such an approach must be highlighted.

**Enhancing incentives and structures to encourage collaboration across the health sector**

Referrals within the health sector are an area of considerable current effort. Referrals need to be straightforward and technology is a key variable. The use of Medtech to allow primary health providers to refer to Quitline is a good example of low cost referral systems. Evidence suggests providing on-going support for discharged hospital patients is effective and may be warranted in contexts with high prevalence and priority groups.

**Assisted smoking cessation services**

**Priority Populations**

Maori and Pacific peoples are priority populations because of high prevalence rates and inequalities in health status and pregnant women a priority because of the significant harm caused to the foetus.

**Maori**

Maori still have very high rates of prevalence but the trajectory of use is going down. Maori use of Quitline, while high in some areas is slightly lower overall than New Zealanders of European origin and in some of the DHB areas with high numbers of Maori smokers registration with Quitline is low. There are also lower rates of successful quits. Specific cessation services (also available to other ethnicities) are provided through AKP and five additional DHB services. Some AKP services provide support beyond smoking cessation and are more holistic, wrap around and whanau focused than some other smoking cessation services. There is variation between providers in outcomes, both in meeting targeted enrolments and validated quit rates. There is no evidence of services designed for indigenous people being more effective than mainstream but there may be issues with strength of studies and NZ AKP services are achieving very high quit rates in some cases.

**Pacific**

Pacific smoking rates are also higher than European origin but smoking trajectories are also downwards. Pacific smokers are concentrated in four DHB catchment areas and have relatively low use of Quitline. Pacific specific cessation services provided through MoH contracts are well targeted. Additional services are provided by DHBs and Heart Foundation.

**Pregnant Women**

The harm to the unborn child caused by smoking during pregnancy is extensive and cessation before 15 weeks of pregnancy returns risk to the foetus to that of a non-smoker. There are six providers of specific services with direct contracts with MoH, supplemented by services provided by four DHBs. In general these services are characterised by low numbers of enrolments and, in some cases, low rates of quitting (where data is provided).

Targets for ABC for midwives have been achieved but many pregnant smokers do not have contact with midwifery services until well into pregnancy. The evidence review found evidence of effectiveness for counselling and financial incentives on quitting but there was no evidence that NRT was effective for this group.

Given the importance of this priority group expanding effective approaches and finding new innovative ways to achieve change is needed.

**People with mental health illness**

No specific services for those with mental health illness were reported. Some DHBs are providing brief advice for smokers who are patients in mental health services.

**Prison populations**

Approximately 4,500 people leave NZ prisons every year and the experience of Smokefree prisons provides an opportunity for change if the inmates were previously smokers. No New Zealand services were identified and there is no published literature on effectiveness but overseas studies are underway.

**Group quitting**

Smoking behaviour is strongly linked to the social networks in which people are embedded and social structures shape an individual’s ability to successfully quit smoking. There is no evidence of additional effectiveness of group quitting in the research literature. However, approaches to assisted cessation, such as WERO which utilise social influences, if evaluation supports its effectiveness, may provide a valuable innovative opportunity for a new direction in assisted quitting in New Zealand.

**Improving access to effective services**

The variation in use of Quitline is one example of service variation. On a regional basis this ranges from 5% of smokers in a DHB catchment area to 13% and the variation is larger than between ethnicities and among young adults. As stated earlier there is a need for collaboration with local health sector and/or via messaging to increase use in some areas.

The evidence suggests brief intervention by health professionals is both effective and cost effective. There is considerable effort going on in this area with PHOs funding activity as well as DHBs and the Ministry directly. The reported level of achievement of the target varies and some DHBs focus on all enrolled clients rather than presenting clients.

**Leveraging the current government target**

The current government target is that 95% of hospitalised patients who smoke and are seen by a health practitioner in public hospitals and 90% of enrolled patients who smoke and are seen by a health practitioner in general practice are offered brief advice and support to quit smoking. The evidence supports health professionals giving brief advice.

**Reporting on assisted quitting**

There is more data available on the performance of providers directly funded by the Ministry of Health than for indirectly funded cessation services, such as those implemented or funded by DHBs or PHOs. For these latter services there is no or little information available on the numbers enrolled or their characteristics, the methods used to assist their quitting or the numbers of quits judged successful. There are also variations in measures used. The Quitline reports on un-validated intention-to-treat seven-day point prevalence at three and 12 months and AKP providers report validated and self-reported four-week and three month abstinence. The literature is not clear on the best indicator of successful quits and this requires consultation but to allow comparison of approaches to assisted quitting it would be necessary for all cessation services to make available a core set of indicators.

**Supply and distribution of pharmacological interventions**

The evidence suggests that Nicotine Replacement Therapy is not effective when used without any other support. NRT is often dispensed in large amounts such that the smoker does not have to frequently return to a health professional. Switching to smaller pack amounts could maintain contact with the supplier and aid effective use of the product. There is also evidence use of two delivery modes for NRT is more effective than one.

There are also innovative and useful pharmacotherapies being developed and discovered and these may be valuable to assisted cessation once the evidence base on effectiveness and side effects provides support for their use.

**Building the capacity and capability of the sector (organisational, infrastructure, workforce)**

Issues about the capacity and capability of the sector raised in consultations included minimum staffing levels, split positions and shared roles creating inefficiencies and sometimes isolation. Competency and the need to ensure the workforce maintains its motivation were discussed. There were reports of some workers being unable to access training and professional development.

Sector leadership was also raised as an issue in the consultation. The main view expressed was that the non-government sector was providing leadership and coordination. It was observed the Ministry had not provided the sector with a strategy or a logic model and these had instead been developed from within the sector. However, the opportunity to develop a plan was also valued. The co-ordination and collaboration provided by the National Smokefree Working Group (NSWG) was generally acknowledged.

**Pathway to Smokefree New Zealand 2025 Innovation Fund and Research**

The Pathway to Smokefree New Zealand 2025 Innovation Fund supports the implementation and evaluation of innovative approaches to reduce the smoking prevalence among Maori, Pacific people, pregnant women and young people across New Zealand. There is no clear mechanism in place to ensure timely roll out and scale up of the innovations shown to be effective.

**Allocation of cessation resources by region**

Analysis of the MoH resources going into each DHB region primarily for smoking cessation *per smoker* shows wide variation (between $124 and $25 per smoker). The origin of the resource (e.g., Quitline, AKP or DHB) also varies widely. These data may inform consideration of future resource allocation once economies of scale, demographic make up of DHB catchment area and provision of non-MoH funded resource is taken into account.

**Recommendations**

The following recommendations reflect analysis of data collected in the evidence review, consultation and mapping exercise.

In general the MoH funded services in the tobacco control area were assessed as in line with evidence. Important initiatives are being funded and evaluated allowing for innovative developments where evidence is lacking and to further develop tobacco control efforts. The Review identified some areas for further development and it is recommended the MoH consider the following recommendations:

**Revitalise Smokefree 2025 goal**

**MoH leadership**

*The data shows declining rates of smoking in New Zealand and both cessation and reduced initiation are playing an important part. The evidence review suggests much of what MoH is funding is effective. However, there remains inequality in smoking prevalence with high rates among Maori (one in three in some DHBs), the prevalence in the 20-24 year old age group is higher than total prevalence for every DHB, and the current rate of decline in national prevalence levels will not result in achievement of the goal of Smokefree 2025.*

*In the consultation carried out as part of this project many positive activities and positive structural aspects of the tobacco control sector were reported, however, there was also an expressed need to avoid a ‘business as usual’ mentality in the sector and concern was expressed that the Smokefree goal had fallen off the national radar. Increased expenditure and effort to enhance public awareness of Smokefree 2025 and a collaborative process to translate recommendations from this review into accountabilities within the sector could re-invigorate the tobacco control sector*.

* **Expand awareness of and positive support for Smokefree 2025 among all relevant sectors and communities to increase widespread engagement in achieving the goal by:**
* **Clarifying with contracted NGO providers the need to increase media advocacy specifically around the Smokefree 2025 goal**
* **Working with HPA to ensure adequate promotion of the Smokefree 2025 goal**
* **Developing an action plan including a logic model(s) in consultation with the tobacco control sector and informed by the recommendations from this Review; to include key interventions, expected outcomes and detail the accountabilities, including reporting responsibilities, of those in receipt of government tobacco control funding.**

**Government cross sector activity**

*The focus on joined up government and on Health in All Policies (HiAP) internationally and in New Zealand provides a platform to increase cross-sectoral activity to achieve Smokefree 2025. HiAP aims to support intersectoral collaboration by bringing together partners from many sectors to recognize the links between health and other issue and policy areas, break down silos, and build new partnerships to promote health and equity and increase government efficiency .The aim is to benefit multiple partners and**the process must therefore advance the core business of other sectors. There are a number of models operating in New Zealand, for example, the cross agency initiative ‘Safer Journeys’. The MoH Interagency Committee on Drugs established in 2007 is another example.*

*The consultation suggested there is wide variation in government departments in extent to which they embrace Smokefree 2025 goal. One example of a lack of co-ordination is the failure to assist those leaving smokefree prisons to remain smokefree. A survey of released inmates in 2001 in the United States found that 66% had had a cigarette within a day of release and 97% within a week and the consultation suggested similar outcomes in New Zealand.*

* **MoH seek to establish an Inter-agency committee to engage all relevant government ministries/agencies in a joined up government focus on achieving Smokefree 2025 goal by:**
* **Encouraging participation in local level initiatives with DHB and other sectors (see below)**
* **Increasing commitment of senior management in relevant government departments to enhance smokefree status among their employees and, where possible, clients. This will include Ministry of Social Development, Housing New Zealand, Department of Corrections/Probation.**

**Mass Media/Social Marketing**

**Expenditure on mass media/social marketing**

*There is a dose response relationship between levels of exposure to social marketing and smoking cessation. A recent analysis of expenditure on mass media advertising aimed to reduce smoking undertaken by Quitline and Health Sponsorship Council (HSC) from 2008-2013 showed total expenditure reduced by 44% (78 % for HSC expenditure) over this period.*

* **Collaborate with HPA and Quitline to achieve increased expenditure on messaging aimed to reduce smoking**

**Design of mass media/social marketing**

*Evidence in New Zealand showed tax increase****s*** *stimulated quit attempts (these amounted to considerably more than assisted quit attempts in the same time period). Messaging can build on such events to further encourage quit attempts.*

* **Encourage media messaging which builds on policy drivers (e.g., a campaign emphasising price increases and benefits of quitting).**
* **Ensure no messaging discourages unassisted quit attempts**

While there is little evidence of interventions which work with disadvantaged populations some evidence suggests negative health messages are effective

* **Encourage media messaging which resonates with disadvantaged groups**

There are considerable difficulties in reaching disadvantaged pregnant women early in pregnancy and many do not quit suggesting the need for efforts to be focussed earlier.

* **Design messages to resonate with women of childbearing age**

**Telehealth Systems**

*Telehealth systems are a cost effective way of delivering cessation services to the population and the current service, Quitline, is responsible for the largest numbers of assisted quits in New Zealand and has a relatively high reach compared with overseas telehealth systems. New technologies such as web based, quitting and Interactive Voice Response technology will be an essential part of telehealth systems. Evidence to date shows telehealth systems are less effective with more disadvantaged people and there are slightly lower levels of uptake in New Zealand among Maori and Pacific peoples. There is the need for increase in reach to disadvantaged populations (particularly in rural areas).*

* **Maintain focus on telehealth system (phone and newer technologies) as the major source of assisted quitting (and onward referrals) in New Zealand**
* **Increase and design messaging to increase uptake of telehealth cessation service, particularly in rural and predominantly Maori areas and among Pacific peoples.**

**Pharmacology**

*Evidence suggests NRT is not effective outside of counselling situation and indiscriminate distribution is likely to be a waste of resource. There is evidence of relative effectiveness of concurrent use of two different delivery modes of NRT and of pharmacological alternatives to NRT.*

* **Maintain requirement of engagement with cessation service before receiving subsidised NRT and increase use of two different delivery modes**
* **Work with PHARMAC to investigate increased availability (eligibility and course of treatment) of varenicline.**

**Local cross sector initiatives**

*There is limited evidence for the success of local cross-sector initiatives reflecting lack of evaluated examples. One model is provided by the New York City Department of Health and Mental Hygiene tobacco control programme which included increased taxation, smokefree work areas, cessation services including NRT and advertising in broadcast and print media. The programme was evaluated and a reduction in smoking in young adults (mainly women) was found and was larger in low income areas. Along with price and advertising focusing on negative health outcomes, the only other approach known to address inequities in smoking is to increase access to cessation services in low SES areas.*

*The DHBs are funded to provide local smokefree initiatives, leadership and co-ordination. Examples of cross sector activities from 2011– 2013 focused on implementation of Smokefree policy and some promotion and provision of cessation support beyond the health sector. This included work with TAs, a government department (WINZ), wananga, university, marae, workplaces and sports and welfare organisations Other key sectors identified in the consultation included: budgeting services, department of Corrections (working with paroled prisoners); the Ministries of Education and Justice, the New Zealand Defence Force, Iwi (as kaitiaki of the environment) and Whanau Ora.*

*However the reports did not reflect a widespread focus on co-ordinated cross-sector activity at locality level. Many DHBs’ activities seemed to be focussed within the health sector. A lack of evaluation does not allow for accurate assessment of activities in those DHBs reporting cross sectoral activities.*

* **Encourage enhanced focus by DHBs on collaboration with TAs, government departments, NGOs, relevant employers and cessation service providers; including**:
* **health promotion and cessation (especially innovative ways of expanding ABC in settings not currently used and which might reach disadvantaged groups, e.g., workplace context, WINZ offices) and encouraging uptake of telehealth system (Quitline).**
* **smokefree environments (eg developing and implementing local policies on smokefree outdoor public places)**

**Brief Advice**

*Brief advice (which can take as little as 30 seconds and simply advises those who smoke to stop) has been shown to be effective when delivered by doctors, nurses or health visitors and dentists. The health targets set for DHBs to ensure brief advice to be given to all patients in hospital, and those receiving care from midwives are largely being met. Brief advice given to those who attend primary health care settings is less complete but significant progress is being made. There is limited evidence regarding the effectiveness of pharmacists.*

* **Maintain support at current levels of DHB efforts to achieve and sustain brief advice targets for secondary and primary health care providers including midwives. This will include a primary focus on A (ask) and B (brief advice).**
* **Monitor the international research literature and the Waitemata DHB programme funding pharmacists to give Brief Advice (and NRT) to inform future policy**
* **Investigate and encourage trials of non-health sector provision of Brief Advice (eg sports organisations; budgeting advice service)**

**Referrals in context of Brief Advice**

*C (cessation) is addressed by enabling referrals to cessation services including the telehealth system (Quitline) and referrals are being increased by technological advancement (e.g. the Medtech referral form) in primary health care. Quitline data on incoming referrals show some DHBs with high prevalence do not refer to Quitline. Referrals to specialist cessation services (e.g. AKP, Pasifika, DHB funded cessation services) require awareness of and confidence in the services. Not all DHBs are reporting data on referrals making it difficult to assess the overall picture.*

* **MoH to ensure complete reporting from all DHBs of referrals made and data on to which cessation service the referral was made.**

**AKP and Pasifika Providers**

*AKP and Pacific providers which are directly contracted by the Ministry of Health are largely appropriately located. They contribute small numbers of quits relative to Quitline but these are from hard to reach, disadvantaged populations. These services provide data on validated quits and these show marked differences between providers*

* **Review different rates of enrolments and successful quit rates achieved by different AKP and Pasifika providers operating in similar contexts and provide additional support/training or reallocate resource to new provider as appropriate.**

**Protecting the foetus from tobacco**

*Pregnant women are a priority for all cessation services in New Zealand and Midwives are providing ABC at the target level set by the MoH. In addition MoH currently directly funds six cessation services specific for pregnant women and these are supplemented by four DHB funded programmes. Referrals and enrolments are below target and quit rates variable. There is evidence that NRT is not effective with pregnant women. Financial incentives have been found in two published trials to be effective in increasing quitting by pregnant women. A Pathway to Innovations funded project being carried out by CMDHB has reported good preliminary results.*

* **Monitor outcome of CMDHB financial incentives pilot project with a view to disestablishing specialist pregnancy smoking cessation services and reallocating money to the provision of financial incentives to increase quitting among pregnant women living in disadvantaged areas**

**People with Mental Health Issues**

*The prevalence of smoking is around twice as high for those with mental illness as in the general population; around a third of all cigarettes in New Zealand are smoked by those with poor mental health and, unlike most other groups, there has been no decline in prevalence in the last 20 years. Evidence suggests adding a psychosocial mood management component (where participants learn techniques to manage depressive symptoms) to a standard smoking cessation package is effective in increasing abstinence rates in those both currently depressed and those with a history of depression. For people with schizophrenia bupropion has been found to be effective. For those hospitalised with mental health issues there is anecdotal evidence that addressing smoking is seen as too hard given other issues. However reports of DHB activities showed a number of initiatives being taken to promote Smokefree policies in mental health treatment settings and increase focus on cessation.*

**Increase focus on smoking cessation for people with mental health issues by:**

* **Encourage funders and providers of mental health services to prioritise smoking cessation for clients of mental health services**

**Allocation of Resource to DHB regions**

*Prevalence of smoking in New Zealand DHB catchment areas reflects ethnic makeup, rural settings, and socio-economic status. Uptake of Quitline is influenced by media spend and referrals but is also self-determined and is inversely related to prevalence, disadvantage and rural settings. The evidence for approaches to reduce smoking among most disadvantaged groups is very limited and, other than tax and messaging with negative health messages, increasing access to services is one way to do this.*

*Resource allocation for smoking cessation per smoker across DHB regions suggests an appropriate level given rates of prevalence and these predictive variables. (Estimates of prevalence may change when estimates of resident population become available from Statistics New Zealand.) If resource became available the DHBs with high levels of disadvantaged smokers and effective ways to provide cessation services to these groups would have priority.*

* **Monitor developments in DHBs with highest prevalence and low utilisation of telehealth services to assess future funding needs**

**Capacity Development / Professional Development**

*MoH has funded training for those providing Cessation Services via several contracts and there was positive comment about these opportunities in the consultation. MoH also funds workforce development opportunities for Smokefree Regulatory Officers. However, in the consultation it was argued that more support from the MoH was required. One example was lack of clarity and therefore regulatory action regarding outside licensed premise areas. There is also evidence from New Zealand surveys of young people successfully purchasing tobacco, with Maori more likely to do so. However, the mapping showed high smoking prevalence catchment areas where no CPOs were conducted.*

**Increase support (training, co-ordination and guidance) for Smokefree Regulatory Officers**

* **to increase their ability to enforce the Smokefree Environments Act particularly in relation to outside licensed premises**
* **to enforce prohibition of sale to minors.**

**Innovation in quitting Interventions**

*MoH funding is enabling exploration of innovative ways to assist quitting through the Pathway to Smokefree New Zealand 2025 Innovation Funding and initiatives developed in the Turanga project. If these (and other evaluated initiatives) demonstrate evidence of effectiveness it will be appropriate to ensure they are scaled up and rolled out. Since new funding is unlikely DHBs may have to reprioritise spending away from poorly performing cessation services or health promotion activities in order to do so.*

* **MoH to develop a mechanism to ensure new initiatives are critically evaluated for relative cost effectiveness against each other and against existing services in order to promote awareness among DHBs and, where results justify, ensure tobacco control resources are reallocated to ensure scaling up and rolling out.**

**Reporting, evaluation and utilisation of data**

*Cessation services in New Zealand vary in the data provided on enrolments, quit attempts and success rates. Data on enrolments and outcomes for DHB funded cessation services are not included in reports to MoH. To make useful comparisons and estimate future trends it would be valuable for all services to report comparable variables.*

* **MoH to ensure data on the number of enrolments, therapies used, four week and three month self-reported and validated quit rates are reported for all services, including cessation services funded by DHBs, and projects funded under Pathway to 2025 Innovation Fund.**

Introduction

## Background

Tobacco is a significant public health issue with tobacco use having extremely negative health impacts for individuals. Smoking of tobacco products has been “causally linked to diseases of nearly all organs of the body, to diminished health status, and to harm to the foetus” (p.7) ([1](#_ENREF_1)). Costs to the economy are incurred because of lost production due to early death of smokers, lost production due to smoking-caused illness, and smoking-related health-care costs.

In Aotearoa New Zealand 463,194 people identified as smokers in the 2013 census. This is a smoking prevalence of 13.7%. However, smoking prevalence among Maori across all groups is much higher than for non-Maori. Currently 122,533 Maori report smoking, which is a prevalence of 30.9%. Smoking prevalence is also higher for Pacific peoples at 21.6%. Higher smoking prevalence contributes to on-going health disparities for Maori and Pacific relative to the non-Maori/non-Pacific.

In 2011 the New Zealand Government adopted an aspirational goal of reducing smoking prevalence and tobacco availability to minimal levels by 2025. Achieving this Smokefree 2025 goal would mean New Zealand would essentially be a smokefree nation.

New Zealand has a multi-pronged approach to tobacco control. Key objectives in the tobacco control programme are: (a) reducing smoking initiation, (b) increasing the number of successful quit attempts made each year and (c) reducing exposure to second-hand smoke. Successful tobacco control requires recognising both that smoking is a modifiable behaviour and the important role social and environmental factors play in becoming smokefree.

In order to assist the Ministry of Health in taking the necessary steps to leading the sector to achieving the Smokefree 2025 goal, a review was commissioned to gather information and data and undertake robust analysis. Researchers from SHORE & Whariki Research Centre, College of Health, Massey University, were selected to undertake a review of tobacco control services and activities funded by the Ministry of Health.

The scope of the review was determined by the Ministry of Health. The review was focused on the operational components of the Ministry of Health tobacco control activities and the macro public policies (e.g., pricing or taxation policies, plain packaging, duty free sales) were not a key focus. Other funding for control tobacco services such as the social marketing and health promotion activities of the Health Promotion Agency (HPA) were also not a primary focus.

## Research team

A core group of researchers from SHORE & Whariki Research Centre undertook this review and were responsible for producing this report. They were:

* Professor Sally Casswell, Co-director, SHORE & Whariki Research Centre
* Dr Martin Wall, Senior Researcher
* Dr Judy Lin, Postdoctoral Fellow
* Dr Jeffery Adams, Senior Researcher

Other Massey University researchers and others from the tobacco control and public health sectors were advisers to the project. These advisers were:

Massey University advisors

* Professor Paul McDonald, Pro Vice Chancellor, College of Health
* Professor Helen Moewaka Barnes, Co-director, SHORE & Whariki Research Centre
* Dr Lanuola Asiasiga, Researcher, SHORE & Whariki Research Centre
* Dr Angela Moewaka Barnes, Researcher, SHORE & Whariki Research Centre

Advisory Group members

* Professor Richard Edwards, Head of Department of Public Health, University of Otago/Director ASPIRE 2025
* Anaru Waa, Research Fellow, Health Promotion & Policy Research Unit, University of Otago
* Dr Heather Gifford, Research Director, Whakauae Research Services/ASPIRE 2025
* Dr Jan Pearson, National Health Promotion Manager, Cancer Society of New Zealand
* Warren Lindberg, Chief Executive Officer, Public Health Association of New Zealand
* Dr Hayden McRobbie, Clinical Consultant, McRobbie, Chee and Associates Limited

The advisory group meet three times by audio conference and provided advice on all phases of the research.

## Review approach overview

The review consisted of four phases.

**Evidence review**

A review and summary of published evidence relevant to tobacco control service delivery models and approaches was undertaken. The focus of the review was on services that address high rates of smoking in priority populations and interventions that are high value for money.

**Mapping of tobacco control services**

A map of current tobacco control services was developed using multiple sources: data provided by the Ministry of Health (including contract reports from service providers), information and data on websites, data provided from district health boards and other agencies, and information provided by participants in the sector consultation processes.

**Consultation with tobacco control sector**

Consultation was held with the wider tobacco control sector. An online consultation process was made available and advertised widely within the sector and 105 submissions were received. Following this three face to face consultation meetings were held (Auckland, Wellington and Christchurch) involving 35 participants and seven SHORE & Whariki and Massey researchers. The main issues identified through the consultation activities are presented in Appendix 1.

In addition, two consultation meetings were held with Ministry of Health personnel responsible for tobacco control policy and operations.

**Identification of gaps and opportunities**

The identification of gaps and opportunities was informed by the three earlier phases of the research.

Evidence of effective approaches to tobacco control

# Introduction

This review reports on evidence relating to service delivery models and approaches, programme structures and hierarchies of impact as related to tobacco control programmes.

The review should guide optimal tobacco control methods.

The scope of the review included services that are, or potentially can be, funded by the Ministry of Health either directly or indirectly. Policies such as raising the tobacco excise tax are not under the control of the MoH and are not considered. Smokefree legislation is considered as enforcement and implementation of smokefree areas falls under the DHB tobacco control contracts with the Ministry of Health.

Specific focus is given to strategies that:

1. address high rates of smoking in priority populations
2. have the highest cost effectiveness

The priority populations are:

1. Young (adolescent)
2. Maori
3. Pacific
4. Low Income
5. Suffering from poor mental health, and/or
6. prisoners and recently released from prison

These populations are regarded as being a priority for tobacco control because, except for the first group, they have high smoking prevalence and rates of smoking have not fallen in line with the general population rates. The majority of smokers took up smoking and became dependent either as teenagers or young adults. Efforts to prevent young smokers becoming habitual or addicted smokers can therefore generate large benefits in terms of lifetime health.

## Methods

Published works on the effectiveness and cost effectiveness of the content and context of interventions were identified and reviewed.

Published and unpublished works on the settings and modes in which these interventions are delivered were located. These are the main focus of this document. For each setting and mode we examined:

* + The scope of the project (pilot or scaled up)
  + The target group or groups
  + The type or types of intervention offered
  + The number of people participating, both smokers and non-smokers
  + The cost of the project
  + The quality of the evidence

Evaluation of many of these interventions is not straightforward as they take the form of what the UK Medical Research Council calls ‘complex interventions’ where the active ingredient is not clear ([2](#_ENREF_2)). There is also a considerable overlap between the interventions as they refer to a setting, a method or combination of methods, a type of combination and a target group.

Many of the evaluations considered are produced by the Cochrane collaboration and are referred to here as Cochrane reviews. Such reviews follow a standard methodology in analysing published research and therefore can be compared. Most other reviews that report meta-analyses of other studies follow Cochrane guidelines.

The results are reported in a standard form either as an odds ratio (OR) or relative risk ratio (RR). Both represent the effect of the intervention.

The odds ratio is the odds of a successful outcome on the intervention (e.g. quitting smoking) divided by the odds of a successful outcome in the control group. If is the proportion of those receiving the intervention that quit smoking and is the proportion of those in the control group who quit smoking then the OR is defined as . To be considered effective a stop smoking intervention must have an odds ratio significantly greater than one, i.e. the reported 95% confidence interval of the statistic must not include unity.

The relative risk ratio is defined as . It also takes the value 1 when there is no effect. The OR and RR take similar values when and are small.

When relative risk ratios or odds ratios are reported in the tables and text below they follow the Cochrane Review methodology when pooling results on the rate of abstinence from smoking at the longest follow up as the measure of success for each intervention.

## What is covered by this review

This review is mainly based on completed meta-analyses that have examined the context in which interventions to prevent the initiation or encourage the cessation of smoking have taken place. Many are published by the Cochrane collaboration. This means that the evidence taken into account is quantitative and is mainly the result of randomised controlled trials.

In areas where there are few reviews individual studies were consulted. In many of the cases the interventions being considered are combinations of techniques such as pharmacotherapy and behavioural therapy and it is the appropriateness of the setting or target group that is being evaluated.

It is typical in reviews based on the Cochrane methodology to regard the randomised controlled trial as the strongest test of the effectiveness of the intervention. In such a trial participants are randomly assigned to either a group receiving the intervention or a control group - receiving no intervention or an alternative intervention. This design, when carried out correctly, allows the effect of the intervention to be clearly isolated from other confounding effects. However RCTs only measure the effect in a certain time and place and in a certain set of circumstances and inferring that this effect is applicable in all situations is not always possible (see Cartwright ([3](#_ENREF_3))). In addition there is much evidence that, although not based on an RCT, shows such a regular or frequently observed relationship between the intervention and the effect or illuminates such a plausible pathway between the intervention and effect as to be considered equally strong.

## What is not covered by this review

In the first section we summarise the components or contents of what the literature has found to be effective interventions. This is because even the best designed programme in terms of context or reach will not achieve its desired outcome if it does not contain a mix of effective components. However, other than in this first section the contents of interventions are not the main focus of the study.

In general programmes or policies that are not under the remit of the Ministry of Health will not be covered. This includes pricing or taxation policies, plain packaging and some aspects of health promotion. However we will not exclude areas towards where the MoH could potentially shift resources

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# Summary of results

The table below contains a summary of the results found in the text

Table 1: Summary of results

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Content of Intervention | | Effect on main outcome measure | Comparison/control | Source | Date of Review |
| Individual (face to face) counselling | | OR=1.56\*(smoking cessation at 6 months or longer) | No intervention | Cochrane Review([4](#_ENREF_4)) based on 18 trials | 2005 |
| Of which: | Cognitive Behavioural Therapy | No strong evidence, few evaluations of CBT alone  May be helpful where there are comorbidities of anxiety or depression | Other psychosocial interventions | 2 published articles, one grey literature, one Cochrane review ([5-8](#_ENREF_5)) | 2001-2013 |
|  | Motivational Interviewing | RR=1.27\*\*(smoking cessation at 6 months or longer) | Brief advice or usual care | Cochrane Review([9](#_ENREF_9)) (14 studies) | 2010 |
|  | Stage Based Behavioural Therapy | No effect | Non-stage based therapies | Systematic Review([10](#_ENREF_10)) (23 trials) | 2003 |
|  | Brief advice | Shown to be effective when given by doctors (RR=1.66 CI: 1.42-1.94), nurses, health visitors and dentists. | Minimal intervention or usual care | See references under ‘settings’ below |  |
|  | Intensive counselling | Intensive counselling has small additional effect when compared to brief advice RR=1.37 CI:1.2-1.56 | Brief advice | Cochrane Review ([11](#_ENREF_11)) (15 trials) | 2013 |
| Group Counselling |  | RR=1.98\* (smoking cessation at 6 months or longer) | Self-help | Cochrane Review ([12](#_ENREF_12))(13 trials compared group counselling with self-help. 5 trials compared group counselling with individual counselling. 11 studies compared group counselling with advice from a GP or nurse. 3 trials compared group therapy with NRT with NRT alone) | 2005 |
|  |  | No effect | Individual counselling of same intensity |
|  |  | Limited evidence of effect when added to another intervention | Advice from health professional or NRT |  |
| Pharmacotherapy | |  |  |  |  |
| Of which | Nicotine Replacement Therapy | 1.6\*(smoking cessation at 6 months or longer) | Placebo or any non NRT | Cochrane Review([13](#_ENREF_13)) (117 trials) | 2012 |
|  | Combination NRT (use of two types of NRTs) | RR=1.34\* | Single type of NRT | Cochrane Review ([13](#_ENREF_13)) (9 trials) | 2012 |
| Other pharmacotherapies | |  |  |  |  |
|  | Bupropion | OR=1.82\*  No effect | Placebo  NRT | Cochrane Review ([14](#_ENREF_14))(36 comparisons, Bayesian meta-analysis) | 2013 |
|  | Varenicline | OR=2.88\*  OR=1.57\*  OR=1.59\*  No effect | Placebo  Single forms of NRT  Bupropion  Combination NRT | Cochrane Review([14](#_ENREF_14)) (15 comparisons of varenicline with placebo, 3 direct trials of varenicline with bupropion, no direct comparisons of varenicline with NRT – results are from a network meta-analysis) | 2013 |
|  | Cytisine | RR=3.98\* | Placebo | Cochrane Review ([14](#_ENREF_14)) (2 trials) | 2013 |
|  | Nortriptyline | RR=2.03\* | Placebo | Cochrane Review ([14](#_ENREF_14)) (6 trials) | 2013 |
|  | e-cigarettes | No sig. effect  No sig. effect | Nicotine patches  Placebo e-cigarettes | RCT([15](#_ENREF_15)) (n=637) | 2013 |
| Other Therapies | |  |  |  |  |
| Of which | Aversion Therapy | Insufficient evidence |  | Cochrane Review ([16](#_ENREF_16)) (25 trials) | 2004 |
|  | Contingency Management | No effect in general populations but effective in subgroups:   * + 1. Adolescents (short term only)([17](#_ENREF_17))     2. Those on opioid management programmes (short term only)([18](#_ENREF_18))     3. In workplace settings ([19](#_ENREF_19))(26 studies)     4. Pregnant women([20](#_ENREF_20)) | | Cochrane Reviews([20](#_ENREF_20), [21](#_ENREF_21))  Published articles  Systematic review | 2011  2006-2010 |
|  | Acupuncture | Insufficient Evidence | | Cochrane Review ([22](#_ENREF_22)) (33 studies) | 2011 |
|  | Acupressure | Insufficient Evidence | | Cochrane Review([22](#_ENREF_22)) | 2011 |
|  | Hypnotherapy | Insufficient Evidence | | Cochrane Review([23](#_ENREF_23)) (11 studies) | 2010 |
| Combination therapy | Pharmacotherapy and behavioural interventions | RR=1.82\* (abstinence from smoking after at least 6 months) | Minimal intervention or usual care | Cochrane Review([24](#_ENREF_24)) (40 studies) | 2012 |
|  | Adding behavioural support to pharmacotherapy | RR=1.16\* (abstinence from smoking at 6 months or more) | Pharmacotherapy only | Cochrane Review([25](#_ENREF_25)) (38 studies) | 2012 |
| Smokefree legislation |  | Moderate evidence of effect on effectiveness after one to 3.5 years |  | Systematic Review ([26](#_ENREF_26)) (20 studies) | 2012 |
| Service Delivery Models for Prevention | |  |  |  |  |
| Community Based | Young people  Multi-component | There is some evidence to support the effectiveness of community interventions in reducing the uptake of smoking in young people, but the evidence is not strong and contains a number of methodological flaws. | No intervention or single intervention or school-based | Cochrane Review([27](#_ENREF_27)) (25 studies) | 2011 |
| Priority populations | |  | |  |  |
| School Based | Reduced rate of smoking | OR=0.88\* (outcome is not taking up smoking) only when effect is measured at longest follow up (>1 year). Effects were in programmes based on social competence or a combination of social competence and social influence. No effect were found for programmes providing information only, social influence training only or multimodal programmes (see text) | | Cochrane Review([28](#_ENREF_28)) (134 studies) | 2013 |
| Maori or Pacific youth | Reduced rate of smoking | Too few studies of specifically tailored interventions for conclusions | | Cochrane Review([29](#_ENREF_29)) (2 studies) | 2012 |
| Adolescents (general population) | |  |  |  |  |
| Of which | Incentives | Outcome measure: smoking status of adolescents who had been non-smokers at baseline. No evidence of effect at 6 months, some evidence at shorter time period | | Cochrane Review([30](#_ENREF_30)) (5 trials 11-14 year olds  Published article([17](#_ENREF_17)) | 2012 |
|  | Family Based | Outcome measure smoking status of children who reported not smoking at baseline.  Family interventions had no extra effect when added to school based interventions. | No intervention  School based intervention | Cochrane Review([31](#_ENREF_31)) (9 trials compared family intervention to control group, 7 compared family plus school programme to school programme alone) | 2007 |
|  | Mass Media | Same outcome measure as above but target group all young people under 25. Some evidence of positive effect (i.e. reducing uptake).  Mass media campaigns successful when part of comprehensive tobacco control programme to denormalise smoking | | Cochrane Review([32](#_ENREF_32)) (7 studies)  CDC Report ([33](#_ENREF_33)) | 2010  2006 |
|  | Multi component programmes to reduce availability and denormalise tobacco | Considered effective – no single active ingredient |  | Published report ([34](#_ENREF_34)) | 2013 |
| Young adults (18-24 | | Little evidence of effective interventions |  |  |  |
| Service Delivery Models for Cessation | |  |  |  |  |
| GP based | Brief Advice | RR=1.66\* CI: 1.42-1.94 (abstinence from smoking at 6 months or more) | No intervention or usual care | Cochrane Review([11](#_ENREF_11)) (17 trials) | 2013 |
| Hospital based | Intensive counselling that began in hospital and followed up after discharge for at least 1 month | RR=1.34\*(abstinence from smoking at 6 months or more) | Usual care | Cochrane Review([35](#_ENREF_35)) (25 trials) | 2012 |
|  | NRT + intensive counselling (as above) | RR=1.54\*(abstinence from smoking at 6 months or more) | Intensive counselling only | Cochrane Review([35](#_ENREF_35)) (6 trials) | 2012 |
| Specialist Clinics |  | Thought to be effective but no RCT | | Evaluation reports([36](#_ENREF_36))  Published article([37](#_ENREF_37)) | 2013 |
| Based in other part of health sector | |  |  |  |  |
|  | Dentist based  Brief advice | OR= 1.71\* (abstinence at longest follow up) | Usual care | Cochrane Review([38](#_ENREF_38)) (14 studies) | 2012 |
|  | Nurse based (or health visitor) Brief advice | RR=1.29\*(abstinence from smoking at 6 months or more) | Usual care | Cochrane Review([39](#_ENREF_39)) (35 trials) | 2013 |
|  | Midwives | Significant increase in abstinence in one trial | Usual care | Published article([40](#_ENREF_40)) | 2006 |
|  | Community Pharmacy Based  Counselling or health promotion | Can have positive effect, limited evidence | Usual pharmacy care | Cochrane Review([41](#_ENREF_41))(2 trials, could not be combined)  Meta analysis ([42](#_ENREF_42)) | 2004 (assessed as up to date 2007) |
| Community Based | |  |  |  |  |
|  | Adults  Multi-Component | The largest and best conducted studies showed no significant effects on quitting. | No intervention | Cochrane Review([43](#_ENREF_43)) (US COMMIT trial and Australian CART main studies) | 2002 |
|  | Family Based  Partner support | No evidence was found that the interventions had increased partner support so its effect on quit rates was not tested | Intervention without partner support | Cochrane Review([44](#_ENREF_44)) (13 studies) | 2012 |
| Workplace Based | Behavioural, NRT | Individual interventions as effective in workplace setting as elsewhere  Collective interventions at workplace level not effective | | Cochrane Review (57 studies (61 comparisons) 31 studies of workplace interventions aimed at individual  workers, covering group therapy, individual counselling, self-help materials, nicotine replacement therapy, and social support, and 30  studies testing interventions applied to the workplace as a whole, i.e. environmental cues, incentives, and comprehensive programmes.  The trials were generally of moderate to high quality, with results that were consistent with those found in other settings. | 2008 |
| Comprehensive & integrated Services | Referral to specialist services, quitting advice given at all stages, smoking status monitored | The UK NHS stop smoking services have been evaluated as effective at 4-week quitting though relapse rates to 1-year quitting are not better than other schemes. Good at contacting low SES | | Published evaluations([37](#_ENREF_37), [45](#_ENREF_45)) | 2005, 2013 |
| Ways of Reaching Smokers | |  |  |  |  |
| Telephone | Telephone Counselling Effect of additional proactive calls | RR=1.38\*(cessation at longest follow up | Brief telephone counselling initiated by smoker | Cochrane Review([46](#_ENREF_46)) (12 studies) | 2013 |
|  | Telephone counselling | RR=1.34\* (cessation at longest follow up | Self-help or minimum intervention | Cochrane Review([46](#_ENREF_46)) (30 studies) | 2013 |
|  | Telephone counselling + pharmacotherapy | RR=1.14\* (cessation at longest follow up) | Pharmacotherapy alone | Cochrane Review([46](#_ENREF_46)) (11 studies) | 2013 |
|  | Proactive recruitment | At 4 months significantly more in intervention (3.4%) than control (1.8%) had been abstinent for prolonged period. Those in intervention arm significantly more likely to make quit attempt | Mailed self help | Published evaluation([47](#_ENREF_47)) (1569 smokers recruited into trial. 769 offered proactive counselling & 793 received mailed self-help) | 2011 |
| Internet | Tailored to user & interactive | Some evidence (RR=1.48\* 3 trials) Studies were very heterogeneous and could not be pooled | Usual care or Self –help materials | Cochrane Review([48](#_ENREF_48)) | 2013 |
|  | Non tailored or interactive | No effect | Usual care | Cochrane Review([48](#_ENREF_48)) | 2013 |
|  | Internet interventions (any type) | No effect | F2F or phone counselling | Cochrane Review([48](#_ENREF_48)) | 2013 |
| Mobile phone | Text/video messaging of motivational support or quitting advice | RR=1.71\* (abstinence at 6 months or more but allowing lapses) | Variety of controls | Cochrane Review([49](#_ENREF_49)) (5 studies) | 2012 |
| Self-help materials | Non-tailored | OR=1.24\* (abstinence at 6 months or more) | No intervention | Cochrane Review ([50](#_ENREF_50))(11 trials) | 2005 |
|  | Tailored | OR=1.42\* (abstinence at 6 months or more) | No intervention or non-tailored materials | Cochrane Review([50](#_ENREF_50)) (17 trials) | 2005 |
| Harm Reduction | Reduction in smoking | Substantial reduction in smoking is necessary for small health benefits | | Systematic review([51](#_ENREF_51)) | 2007 |
|  | Switch to non-tobacco nicotine products | No adverse impacts found for long term NRT use. E-cigarettes not proven safe |  | NICE Public health guidance([52](#_ENREF_52)) |  |
| Cessation services for Priority Populations | |  |  |  |  |
| Indigenous people | Interventions appropriate for indigenous people | Limited research but no evidence that intervention effect differs from general population. | | Review([53](#_ENREF_53)) (5 trials)  Published articles on New Zealand trials([54-56](#_ENREF_54))  Cochrane Review([57](#_ENREF_57)) (4 studies) | 2013  2005-11  2012 |
| Young People | Adolescents behavioural intervention | RR=1.56\* (outcome: abstinence at one year – this result drawn from studies using trans theoretical model of behaviour change) | Usual care | Cochrane Review([8](#_ENREF_8)) (2 studies) | 2013 |
|  | Adolescents pharmacotherapy intervention | Limited evidence of effectiveness |  | Cochrane Review([8](#_ENREF_8)) | 2013 |
|  | Young (post school) Adults – all interventions | As effective as with adult populations but problem with underutilisation of services | | Meta-analysis([58](#_ENREF_58)) (14 studies) | 2012 |
| Pregnant Women | Counselling | RR=1.44\* (smoking cessation in late pregnancy) | Usual care | Cochrane Review([59](#_ENREF_59)) (27 studies) | 2013 |
|  | NRT | No evidence of effectiveness or safety (outcome: smoking cessation in late pregnancy) | Placebo | Cochrane review ([60](#_ENREF_60)) (6 studies) | 2012 |
|  | Incentives | RR=3.64\* | Alternative intervention | Cochrane Review ([59](#_ENREF_59)) (1 study) |  |
| Low -SES | A review of a range of policy options and interventions showed the only effective way of reducing smoking in low SES smokers with regard to high SES smokers and thereby reduce socioeconomic health inequalities was to raise the price of cigarettes | | | Review([61](#_ENREF_61)) (77 primary studies and 7 reviews) | 2013 |
| Recent quitters |  |  |  |  |  |
|  | Varenicline | RR=1.18\*(outcome: abstainers at baseline remaining abstinent at 6 month or more follow up) | placebo | Cochrane Review([62](#_ENREF_62)) (1 trial) | 2013 |
|  | Behavioural interventions | No significant effect |  | Cochrane Review([62](#_ENREF_62)) | 2013 |
|  | Bupropion + NRT | No Significant effect |  | Cochrane Review (6 trials)([62](#_ENREF_62)) | 2013 |
|  | NRT | More evidence needed |  | Cochrane Review ([62](#_ENREF_62)) | 2013 |
| Mental Health |  |  |  |  |  |
| Severe mental disorders | Schizophrenia: Bupropion | RR=2.78\* (abstinence or reduction after at least 6 months) | placebo | Cochrane review ([63](#_ENREF_63)) (5 trials) | 2013 |
| Common mental disorders | Depression:  Mood management + standard cessation treatment | RR=1.47\*(outcome: abstinence from smoking at 6 months or longer) | Standard cessation treatment | Cochrane review([64](#_ENREF_64)) (11 trials) | 2013 |
| Prisoners | No evidence | Strong overlap between prison population and other priority populations. Smoke free prisons unlikely to have sustained effect unless followed up after release | | Published article([65](#_ENREF_65))  Report ([66](#_ENREF_66)) | 2013  2011 |
| Supply side restrictions | |  |  |  |  |
| Enforcement |  |  |  |  |  |
|  | Controlled Purchase | Effective enforcement of minimum purchase age requires some test purchase operation | | Published Articles([67](#_ENREF_67), [68](#_ENREF_68)) | 2005, 2012 |
|  | Anti-Smuggling | Major problem in some countries but not in NZ | |  |  |
| Cost Effectiveness | |  |  |  |  |
|  | All treatments | Cost effective | No treatment | Guidelines([69](#_ENREF_69)) | 2006-10 |
|  | Brief advice | £745-£829(2006)/QALY | No treatment | Published article([70](#_ENREF_70)) | 2006 |
|  | NRT | £1000-£2400 (2002)/LYS | Brief advice only | Published article([71](#_ENREF_71)) | 2002 |
|  | Bupropion | £640-£1500 (2002)/LYS | Brief advice only | Published article([71](#_ENREF_71)) | 2002 |
|  | Varenicline | More cost effective than NRT or bupropion | | Published Articles ([72](#_ENREF_72), [73](#_ENREF_73)) | 2010,2012 |
|  | Telephone quitline | €137-€213(2013)/LYS | No treatment | Published Article([74](#_ENREF_74)) | 2013 |
|  | Mass media campaigns | Wide variety in CE estimates. Unclear why this is | | Review([75](#_ENREF_75)) | 2011 |
| Population Level |  |  |  |  |  |
| Second-hand smoke | Smokefree bans | Marked reduction in SHS exposure in workplace (and also possibly in home and other settings). Significant falls in acute myocardial infarction following introduction of bans. Lower incidence of lung cancer, better air quality. Unclear what the effect is on cessation or initiation | | Published articles([76](#_ENREF_76), [77](#_ENREF_77)) | 2010,2013 |
|  | Denormalising | Reducing visibility of smoking, increasing stigma associated with smoking, censoring images of smoking. Little evidence but difficult to evaluate. However, there is evidence in favour of Tobacco Industry Denormalisation TID which improves awareness of tobacco industry behaviour. This has been shown to be effective at reducing initiation and prevalence and increasing intentions to quit. | | Review of TID ([78](#_ENREF_78)) |  |
| Social marketing |  |  | |  |  |
|  | Advocacy | Using the media to changes the social environment within which decisions to smoke are made – no evaluations found | | Framework for evaluation ([79](#_ENREF_79)) |  |
|  | Mass media | Outcome was any change in smoking behaviour. 8/11 studies showed positive impact of mass media campaigns on smoking but only 3 significant. Heterogeneity in evaluation | | Cochrane review ([80](#_ENREF_80)) (11 studies) | 2013 |
|  | Social media | New approach, limited evidence |  | Published Article([81](#_ENREF_81)) | 2013 |

Note: \* indicates the statistic is significant at 5%

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# Types of intervention

This section discusses the content of interventions that have been used to prevent an individual from taking up or increasing smoking or to aid them in quitting.

## Individual (face to face) counselling

Individual counselling is where a smoker receives cessation advice from a healthcare worker not involved in their clinical care. A Cochrane review found 18 trials with over 7000 participants where individual counselling was given to one group whereas the control group received a minimal intervention. The pooled odds ratio was 1.56 (95% CI 1.32 to 1.84) where a successful outcome was smoking cessation 6 months or longer after the quit attempt. No significant effect was found when individual counselling was added to an intervention using nicotine replacement therapy and intensive counselling was found to have only a small additional effect when compared to brief advice alone ([11](#_ENREF_11)).

### Cognitive Behavioural Therapy

There have been few evaluations of the effectiveness of CBT in itself, although it has been shown to be effective in assisting quitting in smokers with anxiety or depression ([5](#_ENREF_5)) and when part of a self-help programme ([6](#_ENREF_6)). However, its effectiveness for longer term abstinence is not clear ([7](#_ENREF_7)). A Cochrane review of cessation interventions for young smokers found that interventions containing CBT ‘showed promise’ at increasing abstinence but again reiterated the lack of strong evidence and found no statistically significant effect ([8](#_ENREF_8)).

### Motivational Interviewing

Motivational interviewing was developed by Miller and Rollnick and is described by them as being a ‘‘directive, client-centred counselling style for eliciting behaviour change by helping clients to explore and resolve ambivalence’([82](#_ENREF_82)). “It is viewed as being particularly useful for clients who are reluctant to change or who are ambivalent about changing their behaviour” ([83](#_ENREF_83)). The conclusions of a Cochrane Review are that “(m)otivational interviewing appears to be modestly successful in promoting smoking cessation, compared with usual care or brief advice. ([9, p12](#_ENREF_9))”. The authors found a Relative Risk ratio (RR) of 1.27 (95% CI 1.14 to 1.42) with an RR of 3.49 when the intervention was by a primary care physician. An older review also found motivational interviewing to outperform traditional advice in 80% of the 72 RCTs it covered although only a minority of these were specifically aimed at smoking. The authors of this study argue that, because of its focus on the intrinsic motivation for change even a small change could be interpreted as positive as it is intended to be a catalyst for change ([83](#_ENREF_83)).

### Staged based behavioural therapy

In this approach, closely related to motivational interviewing and largely based on the transtheoretical model ([84](#_ENREF_84)), current smokers are classed according to their readiness for change (i.e. readiness to quit). These stages include precontemplation, contemplation, preparedness, action and maintenance. The choice of therapy for each smoker then depends on what stage of the quit process they are at. A systematic review of studies employing this approach however, showed no advantage in effectiveness over non staged-based behavioural therapy ([10](#_ENREF_10)).

### Brief advice

Brief advice can be given in as little as 30 seconds and consists of simply advising all those who smoke to stop. It has been shown to be effective when given by doctors ([11](#_ENREF_11)) (RR=1.66 17 trials), nurses or health visitors([39](#_ENREF_39)) (RR=1.29 35 trials) or dentists ([38](#_ENREF_38)) (RR=1.71 14 studies). Although the New Zealand Smoking Cessation Guidelines states ([85, p8](#_ENREF_85)), citing a Cochrane review, that brief advice is more successful with less dependent smokers, the most up to date version of this Cochrane review no longer contains this result ([11](#_ENREF_11)).

## Group Counselling

There have been a large number of evaluations of therapies given to a group of smokers rather than an individuals although the last Cochrane review was in 2005 ([12](#_ENREF_12)) (assessed as being up to date in 2008). The reasoning behind using this type of therapy is both that smokers can be mutually supportive and that such interventions can reach more smokers for the same cost as individual counselling. Evaluating these using RCTs is complex because such interventions differ markedly in the intensity of the therapy, the therapeutic element that is the active ingredient of the approach and whether the group is rolling (open to all those trying to quit no matter their stage of the process) or closed (a cohort of those at the same stage of the quit process). Comparing group therapy with the provision of self-help materials gave a RR of 1.98 (95% CI 1.60-2.46)([12](#_ENREF_12)). There was no evidence of a positive effect of group therapy over individual counselling of the same intensity (RR=1.01, 95% CI 0.77-1.32) although the effect may have been confounded by participants also being offered NRT. There was no significant impact of group therapy over controls in which the alterative interventions included physician or practice nurse advice, health education or NRT alone. The author’s conclusions from the Cochrane review are therefore guarded: “There is reasonable evidence that groups are better than self-help, and other less intensive interventions, in helping people stop smoking, although they may be no better than advice from a healthcare provider. There is not enough evidence to determine how effective they are in comparison to intensive individual counselling. From the point of view of the consumer who is motivated to make a quit attempt it is probably worth joining a group if one is available – it will increase the likelihood of quitting. Group therapy may also be valuable as part of a comprehensive intervention which includes nicotine replacement therapy (NRT)” ([12, p13](#_ENREF_12)).

## Pharmacotherapy

### Nicotine Replacement Therapy

(NRT) aids quitting by supplying nicotine to the smoker to reduce the withdrawal effects. NRT comes in a number of forms; patches, chewing gum or sprays and the multiple formulations of NRT may assist smokers in choosing the form which most addresses their type of addiction([86](#_ENREF_86)).Patches are the slowest way in which the nicotine enters the system. All the methods are slower ways of taking in nicotine than smoking and all deliver less nicotine than a cigarette ([13](#_ENREF_13)). NRT has been shown to be effective in assisting quitting independent of setting and method and is the only non-prescription medication shown to be effective at aiding cessation. A comparison of NRT with any non-NRT intervention had an RR of 1.60 [95% CI 1.53-1.68]. A combination two types of NRT taken in unison was found to be more effective than single NRT (RR=1.34 [95% CI 1.18-1.51 9 trials])([13](#_ENREF_13)). Combining with the antidepressant, bupropion may lead to a greater effect ([13](#_ENREF_13)). The use of NRT increases the rate of quitting by between 50% and 70%. However more recent studies and findings than those covered by the Cochrane review are finding that using NRT without any other cessation support, is not effective in aiding quitting([87](#_ENREF_87)).

### Other pharmacotherapies

A number of other medications have been used to aid cessation. There are two first-line medications available: Bupropion (Zyban) and varenicline (Champix (Chantix in the US)). Other medicines such as cytisine, clonidine and nortriptyline also have been shown to be effective in aiding cessation ([88-90](#_ENREF_88)). In a systematic review of studies bupropion had an OR of 1.82 [95% Credible Interval 1.60-2.06] and varenicline an OR of 2.88 [95% Credible Interval 2.40-3.47] when compared with placebos. Bupropion is as effective as NRT and varenicline is more effective than either bupropion or single NRT. The two most effective pharmacotherapies are either a combination of fast acting and slow acting NRT or varenicline. Other pharmacotherapies that had a significant effect on quitting without adverse effects included cytisine RR=3.98 [95% CI 2.01 - 7.87] and nortriptyline RR=2.03 [95% CI 1.48 - 2.78]. One obstacle to the widespread prescription of varenicline as a first line medication for smoking cessation is possible side effects such as nausea or insomnia. These are outlined in the prescribing guidelines published by the US Food and Drug Administration([91](#_ENREF_91)). Recent studies have shown no increased risk of neuropsychiatric adverse events with varenicline over NRT and no significant increased risk of cardiovascular events ([92](#_ENREF_92)).

There are a number of other medications that have been tried for smoking cessation but there is currently no evidence of their effectiveness.

### E-cigarettes

Electronic cigarettes (e-cigarettes or electronic nicotine delivery systems [ENDS]) are electrically powered devices generally similar in appearance to a cigarette that deliver a propylene glycol and/or glycerol mist to the airway of users when drawing on the mouthpiece. Nicotine and other substances such as flavourings may be included in the fluid vaporised by the device ([93](#_ENREF_93)). A trial of e-cigarettes in New Zealand was unable to demonstrate a statistically significant effect of nicotine e-cigarettes on cessation over nicotine patches or placebo e-cigarettes (without nicotine)([15](#_ENREF_15)). The proponents of e-cigarettes argue that by preserving the addictive substance and some of the culture around smoking they make it far easier for smokers to quit tobacco, the harmful substance. Opponents of e-cigarettes argue that, as they resemble cigarettes they undermine efforts at denormalising smoking. E-cigarettes are also currently unregulated in many countries and are being heavily advertised. This means that instead of being used exclusively as cessation devices to wean nicotine addicts off tobacco they are being marketed as desirable consumable products in their own right. This might lead to them becoming gateways into a lifetime of nicotine addiction for non-smokers – who will eventually take up tobacco ([94](#_ENREF_94)). The European Union recently rejected calls to classify e-cigarettes as medicine, which would have brought their supply under more control.

## Other therapies

There are a number of therapies not falling into the main classes that have been tried. These include:

### Aversion therapy

Aversive therapy pairs the act of smoking a cigarette with some unpleasant stimulus thereby creating or strengthening an association of smoking with unpleasant feelings such as nausea. The last review of this intervention in 2004, updated in 2009, found insufficient evidence of effectiveness ([16](#_ENREF_16))

### Financial incentives (contingency management)

Contingent management interventions reinforce positive behaviour by using rewards. These have been considered as a cost effective way of increasing healthy behaviour such as exercising more or eating more healthily ([95](#_ENREF_95), [96](#_ENREF_96)). Traditionally economists have argued that people modify their behaviour as a result of incentives. Modern behavioural economics questions this by arguing that paying rewards in this way is inefficient as it may outweigh the intrinsic motives for undertaking such behaviour ([97](#_ENREF_97)).

In general populations of smokers incentive schemes that reward abstinence have not been found to be effective on long term quitting with early advances tending to dissipate when the rewards cease ([21](#_ENREF_21)). However, such schemes have been shown to be effective, at least in the short term, on aiding smoking cessation in adolescents ([17](#_ENREF_17)) (although later reviews found no long term effect in this group ([30](#_ENREF_30))) and those on opioid maintenance programmes ([18](#_ENREF_18)). Another possible effect of financial incentives is in increasing recruitment to quitting programmes. A systematic review has also shown that there is strong evidence that workplace based incentives and competitions in combination with additional interventions are effective in increasing the number of workers who quit.. There was insufficient evidence for the effectiveness of such incentives or competitions when not in combination with additional interventions ([19](#_ENREF_19)).

Incentives have been recently used in interventions intended to reduce smoking in pregnant women and indigenous women who are pregnant ([98](#_ENREF_98)). For pregnant women Cochrane reviews have found that, out of all interventions, contingent incentives had the strongest effect on reducing smoking during pregnancy although this was only when the incentives were provided intensively and was based only on three studies all in the US ([20](#_ENREF_20), [59](#_ENREF_59)). For indigenous populations the Australian ‘stop smoking in its tracks’ programme provided incentives with a median value of AU$294 and a potential maximum value of AU$970 for abstinence among indigenous women. In New Zealand the AWHI study provided a NZ$25 voucher for each smokefree week for Maori pregnant women. In both cases the results are unclear because the programmes are continuing and recruitment is low so it is not known whether this is more or less successful in this group.

### Acupuncture, Acupressure, Electrical Stimulation, Laser Therapy, Hypnotherapy

A Cochrane review of these therapies concluded that “There is no consistent, bias-free evidence that acupuncture, acupressure, laser therapy or electro stimulation are effective for smoking cessation, but lack of evidence and methodological problems mean that no firm conclusions can be drawn.”([22](#_ENREF_22)). Two reviews of studies investigating the effectiveness of hypnotherapy on smoking cessation also had inconclusive results ([23](#_ENREF_23), [99](#_ENREF_99)).

## Combination of interventions

The recommended approach to cessation involves multi-session behavioural support with medication (NRT, bupropion, varenicline) for those who are nicotine dependent ([24](#_ENREF_24), [85](#_ENREF_85), [100](#_ENREF_100), [101](#_ENREF_101)). A Cochrane review of the evidence found 40 trials where a combination of pharmacotherapy and behavioural interventions were offered and found a relative risk (RR) of 1.82, [95% CI 1.66 to 2.00]. This was when these were compared with usual care, brief advice or less intensive behavioural support. There was no increasing effect with greater intensity of the behavioural intervention([24](#_ENREF_24)). Adding behavioural support to a pharmacotherapy intervention had a small but significant impact (RR 1.16, 95% CI 1.09 to 1.24). This was slightly higher for interventions where all the cessation counselling was done by telephone (six trials, RR 1.28, 95% CI 1.17 to 1.41)([25](#_ENREF_25)). Research continues into the most effective combinations of medical and behavioural support for successful quitting ([102](#_ENREF_102))

## Smokefree legislation

The widespread adoption of legislation to ban smoking in public places was motivated by the evidence of the harms caused to non-smokers by second hand smoke. However, the main public health impact may be through reducing the prevalence of smoking or the consumption of tobacco by smokers. A workplace ban in the Netherlands was shown to reduce prevalence significantly with an OR of 0.91 whereas a ban in all hospitality venues increased quit attempts but had no significant impact on prevalence ([103](#_ENREF_103)). A qualitative study in the UK of the effect of legislation in 2007 concluded that the ban had reduced consumption through constraining opportunities to smoke but had not led to successful quitting. The authors concluded that the social network in which the smoker was embedded was the most important factor determining smoking behaviour ([104](#_ENREF_104)). A later, unpublished, review found strong evidence that smokefree policies can be effective at reducing tobacco consumption ([105](#_ENREF_105)). Smokefree areas also play a role in the denormalisation of tobacco use (see below). A Cochrane review found insufficient evidence to show that smoking bans reduced either the prevalence of smoking or tobacco consumption ([106](#_ENREF_106)). However another systematic review by Wilson et al based on more studies (20 as opposed to the Cochrane Review’s 15) found moderate evidence of an effect of smokefree areas on prevalence ([26](#_ENREF_26)). The explanation for the difference in the findings may be a result of the Wilson review looking at prevalence rates over a longer time period (1-3.5 years). The Wilson review found reductions in prevalence of between 7.4% and 31.9% as a result of smoking bans.

# Service delivery models for prevention

Taking up smoking is a process rather than an event with researchers identifying stages including preparation, trying, experimentation, regular and dependent ([107](#_ENREF_107)). The factors that move a smoker from one stage to the next may not be constant over this process and hence prevention initiatives may be more effective by targeting the key factors at each stage.

## Settings

### Family/Whanau based

Children and adolescents are influenced by their family and friends in the decision to start smoking. Programmes to promote non-smoking behaviour and strengthen non-smoking attitudes in the family may be effective at preventing children or adolescents from starting. A Cochrane review found little evidence to support family based interventions with only three of six trials finding positive effects of interventions (reduced uptake of smoking) and none of seven interventions finding a family based programme had any effect when added to a school based programme. The intensity of the intervention did not have a significant effect on outcomes. However the authors noted the lack of good quality RCTs necessary to truly test interventions of this type ([31](#_ENREF_31)).

A review of literature on family based interventions for the Health Sponsorship Council identified a number of interventions relevant to the New Zealand context. The He Arorangi Whakamua tobacco control programme included an intervention to improve parenting skills to reduce smoking uptake. The intervention based on the TIPS approach (Tips and Ideas on Parenting Skills) was (among other things) intended to address the powerlessness that parents felt when challenging children’s smoking in a situation where smoking was extremely common. Although evaluators found an increase in parental confidence, no impact on adolescent smoking was seen within the time frame of the project([108](#_ENREF_108), [109](#_ENREF_109)).

### Community Based

Community based interventions as described in the literature tend to be interventions that are a) not in a healthcare, educational or workplace setting, b) attempt to change the social environment of smokers to influence behaviour in a sustained way, and c) multi-component and coordinated ([110](#_ENREF_110), [111](#_ENREF_111)). They may also involve community members in deciding upon or delivering some of the intervention. A Cochrane review of community interventions to reduce the prevalence of smoking in young people found “some evidence to support the effectiveness of community interventions in reducing the uptake of smoking in young people”, but the evidence is not strong and contains a number of methodological flaws ([27, p2](#_ENREF_27)).

## Priority populations

The following populations are considered a priority for prevention. It is still the case that the majority of smokers begin smoking in adolescence and may be regularly smoking by the time they are young adults. Young Indigenous populations are an even higher priority as they are in situations where cigarette use is more normalised as a result of the higher rates of adult smoking. It is also the case that adolescents become nicotine dependent at about half the dose as adults ([112](#_ENREF_112)) so the opportunity for prevention between the experimentation and dependent stages of smoking is limited.

### School based

Smokers who begin smoking in adolescence tend to smoke for more years and find it more difficult to quit and both of these are associated with being younger at first cigarette. Smoking rates for adolescents are falling in developed, but increasing in developing countries. Basing an intervention in a school is typically thought to be an effective way of reaching those at risk of becoming smokers, as virtually all children attend school. The interventions aimed at preventing current non-smoking schoolchildren from becoming smokers have been based on a number of theoretical models

1. *information only curricula*: challenging the normative status of smoking, relies on information alone to change behaviour
2. *social competence:* to improve the life skills and self-esteem of studentssothey are not pressured into smoking, decreases their susceptibility to all substance abuse
3. *social influence:* This curricula aims to increase the “adolescents’ awareness of the various social influences that support substance use.” Students are more able to resist influences on them to smoke,
4. *a combination of social competence and social influence* and
5. *multimodal programmes:* these are wider than the school curricula and may involve parents and the community to improve policies and activities.

A Cochrane review compared programmes based on these five theoretical approaches with control groups receiving no or limited interventions ([113](#_ENREF_113)). The review used only randomised control trials where students were followed for at least 6 months. When data at longest follow-up was pooled the interventions had a significant effect on preventing smoking with an OR of 0.88 (95% CI 0.82-0.96) (i.e. the odds of a student in the intervention group taking up smoking were 88% of the odds of a student in the control group taking up smoking). The effect was only found when the outcome was measured at longer than one year. The significant impacts were in the interventions that introduced curricula based on social competence or social competence combined with social influence. No effect was found for interventions based on information only, social influence only or the multimodal interventions. These effects were also found only in what the review authors call the pure prevention cohorts. This is where a group of never smokers are followed over the course of the study. There was no overall effect detected for studies that had changes in smoking behaviour as their outcome measure or for those where the outcome measure was point prevalence (i.e. where this is measured by repeated cross-section).

### Interventions aimed at preventing smoking in Maori or Pacific youth populations

Maori and Pacific populations in New Zealand have higher smoking rates than the general population. A number of presenters at the Oceania Smokefree conference in Auckland in October 2013 suggested that high prevalence of smoking is common in indigenous populations globally and that this may be because smoking is more normalised in these communities, for example, for adolescents tobacco is supplied by family and friends rather than being something done surreptitiously and this might lead to higher initiation at younger ages. For New Zealand Maori the disparity with non-Maori is greatest between females aged 15-19 who are 3.5 times as likely to smoke as their contemporaries. Best practice guidelines for New Zealand suggest that encouraging the parents to quit smoking or involving the child in more extra-curricular activity can prevent smoking initiation. Also it is important to carry out a HEEADSSS assessment covering smoking as this is often an indicator of mental health problems or of substance abuse and cessation is easier before the smoker becomes nicotine dependent. Once the adolescent becomes nicotine dependent quitting is more difficult and NRT, or other pharmacotherapies have not been shown to be effective in young people ([114](#_ENREF_114)). A Cochrane review found few studies evaluating programmes specifically tailored for indigenous youth and, of the two studies located, both were for Native Americans. The authors argued the need for further specific research ([29](#_ENREF_29)).

The He Arorangi Whakamua project referred to above specifically addressed the need for improved parenting skills to address uptake of smoking in Maori children or adolescents. Although favourably evaluated, no results of the effect on smoking initiation have been produced.

### Interventions aimed at preventing smoking in adolescents

It has been estimated that 88% of all smokers start before the age of 18 ([34](#_ENREF_34)). Therefore adolescent age groups are important in preventing smoking initiation. Non-smokers have also not become addicted to nicotine so it should be easier to keep a non-smoker as a non-smoker than to turn a smoker into a non-smoker.

*Incentives:* A Cochrane review found seven studies evaluating programmes that offered adolescents incentives for not starting to smoke. All of the studies were of the Smokefree Class Competition where, if a whole school class refrains from competition they go into a draw to win prizes. The review found no significant effect ([30](#_ENREF_30)).

*Based in the family:* A number of interventions have been aimed at preventing adolescents from taking up smoking by encouraging or strengthening anti-smoking attitudes in their families and promoting non-smoking for the whole family. The Cochrane Review cited in the section on family settings found the number of approaches too diverse for a formal meta-analysis. However it concluded that some high quality trials had demonstrated a positive effect of family-based intervention on adolescent smoking prevention ([31](#_ENREF_31)).

*Mass Media Campaigns:* The 2012 Surgeon General’s report *Preventing Tobacco Use among Youth and Young Adults* stated that “Evidence indicates that mass media campaigns can be one of the most effective strategies in changing social norms and preventing youth smoking. Influential and successful campaigns contain a number of essential elements including optimized themes, appro­priate emotional tone, appealing format, clear messages, intensity, and adequate repetition” ([34](#_ENREF_34)). A Cochrane review found seven studies of mass media campaigns that met their inclusion criteria. The authors concluded that there was some evidence that mass media can prevent the uptake of smoking in young people although the evidence was not strong ([32](#_ENREF_32)). Evidence from Australia suggests that the most effective mass media campaigns stress the negative health effects of smoking and that sustained campaigns at a level of 400 TARPs (a ‘TARP’ is a target audience ratings point or the percentage of the target audience that views the message or advert) may be more effective than shorter campaigns at 800 TARPs ([115](#_ENREF_115)). A 2006 CDC review of mass-media smoking prevention campaigns found that they were effective when they i) were part of a comprehensive tobacco control initiative, ii) contained a strong and negative emotional appeal triggering sadness or anger (although the ads have to be wary of emotional burnout), iii) presented information on the health effects of tobacco in an innovative way, iv) used personal testimony to engage youth, v) used multiple media channels to reach youth with different susceptibilities to smoking and vi) had a strong and consistent broadcast presence. The campaign must be amenable to evaluation so that the strategy can be optimised over time ([33](#_ENREF_33)).

*Social Marketing:* A number of social marketing campaigns have been used to address the initiation of smoking. The American Legacy Foundation’s ‘Truth’ campaign has been judged effective in reducing smoking rates in 12-17 year olds ([116](#_ENREF_116)) leading to an estimated 300,000 fewer smokers in the United States. Although the campaign was estimated to have cost US$324 million over the first three years of operation (including US$17 million in litigation costs against a tobacco company that sued over the campaign) it saved an estimated US$1.9 billion in medical costs. Even under pessimistic assumptions it cost US$4,300 per QALY saved which is cost effective when compared with many public health interventions ([117](#_ENREF_117)).

The literature therefore suggests that there is no ‘silver bullet’ for adolescent smoking, that is, comprehensive and coordinated programmes need to be followed involving mass media, smokefree environments, setting and enforcing a minimum purchase age, restricting tobacco marketing and increasing prices. The overall aim of the comprehensive tobacco control programmes undertaken in California and Australia is the denormalisation of smoking ([118](#_ENREF_118)).

### Interventions aimed at preventing smoking in young adults

Young adults (18-24 years of age) have tended to receive less attention in the tobacco control literature which has focused on prevention in the under 18 group. This is probably because 88% of adult smokers say they began smoking before the age of 18 ([34](#_ENREF_34)). However young adults now have the highest rate of smoking amongst all age groups in the US and Canada and this is inconsistent with declining initiation in adolescents unless significant numbers are starting to smoke after the age of 18. Indeed evidence from the National Survey on Drug Use and Health showed almost a 50% increase in the number of young adults who were starting to smoke when comparing the surveys of 2002 and 2008 ([119](#_ENREF_119)). This trend is also apparent in New Zealand data ([120](#_ENREF_120)). Factors that seem to be associated with initiating smoking as a young adult include impulsivity, poor academic performance and alcohol use ([119](#_ENREF_119)). We could not find reviews of evidence for this group however, as one example, the New York City multi-faceted programme was judged to have reduced prevalence in young adult smokers, more so in low SES groups ([61](#_ENREF_61)).

# Service Delivery Models for Cessation

## GP/Primary Care Based

A systematic review ([11](#_ENREF_11)) has shown that brief advice given by a GP significantly impacts quit rates (by 1-3%) (RR=1.66 [95% CI 1.42-1.94]) as compared to no advice. Very intensive interventions by GPs had only a small or no additional effect when compared with very brief advice

## Hospital based

Smoking is linked to many diseases that might lead to hospitalisation and smoking is a risk factor for adverse surgical outcomes. For these reasons, entering a hospital makes many smokers more receptive to anti-smoking messages. A Cochrane review found that intensive counselling interventions that started during the patient’s spell in hospital and continued for at least a month after the patient was discharged promoted quitting with an RR of 1.37, [95% CI 1.27 - 1.48; 25 trials]. Adding NRT to the intensive counselling intervention increased the chances of quitting (RR=1.54 [95% CI 1.34-1.79; 6 trials]). No effect was found for less intensive counselling or for interventions that used the pharmacotherapies bupropion or varenicline. The effect did not vary according to the patient’s diagnosis (for example, if they had been admitted for a smoking related disease or not) or by whether the hospital was acute or rehabilitation ([35](#_ENREF_35)).

## Specialist clinics

Although many of the interventions discussed in this document are effective in helping smokers to quit the current set of interventions in New Zealand mean that 18% of those who receive some form of cessation assistance remain abstinent after 12 months. This rate of success although comparable both to other countries cessation rates and other medical interventions cure rates, is not enough for the 2025 goal to be reached. Addiction to nicotine addiction, like other addictions is complex and individual and needs to be treated like other chronic conditions in specialist clinics where multi-component cessation treatments can be designed, delivered and monitored. Such clinics would provide a concentration of experts in smoking cessation allowing patients to receive combinations of treatments appropriate to their needs ([121](#_ENREF_121)). The UK NHS stop smoking services (referred to below) include clinic treatment as a key component and it is estimated that smokers are four times as likely to quit successfully after contact with this service than without ([121](#_ENREF_121)). The odds of smokers quitting in the UK are also significantly higher if they are treated in specialist clinics rather than in primary care (the outcome measure is CO-verified abstinence at 4 weeks) ([122](#_ENREF_122)).

In New Zealand the Aukati Kaipaipa (AKP) programme provides a specialist service of this type delivered through over 30 Maori health service providers and which focuses on face to face cessation support (although most of the clients also receive NRT or other pharmacotherapy). This programme has had success in reaching Maori populations and those who live in deprived areas but evidence regarding its effect on sustained abstinence is not clear ([36](#_ENREF_36)).

## Based in other part of health sector

### Dentist

Smoking is a risk factor for oral diseases including oral cancer. Smokeless tobacco use is also associated with poor oral health. A Cochrane review located 14 studies assessing the impacts of dental interventions. All of them involved brief advice to quit given by the oral health professional. The overall finding was that “when dental interventions were compared to usual care, no contact, or less treatment intensive controls, the pooled odds ratio (OR) for abstinence at a follow-up of between six and 24 months was 1.71 (95%CI 1.44 to 2.03)” ([38, p8](#_ENREF_38)). This suggests individuals may be as responsive to brief advice from their dentist as from their GP.

### Practice nurse based

Nurses work throughout health services and potentially provide a means of communicating messages to patients when doctors have little time. The International Council of Nurses has encouraged nurses to “...integrate tobacco use prevention and cessation ... as part of their regular nursing practice” ([123](#_ENREF_123)). A Cochrane review identified 49 trials of nurse interventions across a number of countries and found that brief advice given by nurses was effective at aiding cessation with an RR of 1.29 [95% CI 1.2-1.4]. There was some evidence that the effect was higher when the patients were in hospital for a cardiovascular disease. There was also evidence that the effect was less when given as part of a routine health check ([39](#_ENREF_39)).

### Pharmacy based

Community pharmacists or pharmacists who do not work in hospitals have a role to play in smoking cessation as in many countries NRT can be dispensed without prescription. Therefore the pharmacist is the point of contact with the health sector and may be able to offer other aids to quitting such as advice or health promotion. A Cochrane review found just two trials of this type of intervention, both in the UK. Although the pharmacists valued the training they received and were more likely to talk with patients about their smoking no effect was found on abstinence rates. This may possibly be because of the paucity of trials ([41](#_ENREF_41)). A later review using the Cochrane methodology drew a more positive conclusion that “implementation of community pharmacy-based smoking cessation interventions can signiﬁcantly impact abstinence rates” ([42](#_ENREF_42)) although this finding was based on just one extra RCT than considered in the earlier Cochrane Review.

A number of Australian hospitals are trialling programmes where the hospital-based pharmacist leads the intervention and manages nicotine dependent patients. No results based on outcomes have yet been made available ([124](#_ENREF_124)).

### Allied health professionals

Other health professionals may also have a role to play insofar as they interact with patients whose condition is caused or exacerbated by smoking. As an example physiotherapists working with patients suffering from COPD can give patients anti-smoking advice ([125](#_ENREF_125)). This requires that allied health professionals all receive training in smoking cessation and appropriate referrals. This might not be the case currently ([126](#_ENREF_126)).

### Midwives

Midwives provide routine health care for pregnant women and therefore can be ideally placed to offer stop smoking support. Midwives have been advised to talk to the woman about their smoking at the first opportunity([127](#_ENREF_127)). A number of trials have taken place of using midwives in this way. Moore ([128](#_ENREF_128)) involved midwives in providing self-help materials but this did not effect smoking rates. DeVries ([40](#_ENREF_40)) reported on a trial in the Netherlands that trained midwives to provide brief advice and self help materials. For the intervention group 19% had been abstinent for 7 days at 6 weeks post intervention compared with 7% in the control group. However there have been problems with implementation with midwives not regarding this as part of their role or not having time to carry out the intervention ([59](#_ENREF_59)).

## Community based

A Cochrane review of community interventions for adult smokers showed no effect on quit rates between the intervention and control arms. Although 37 studies were included altogether the two most rigorously conducted evaluations (the US COMMIT study ([129](#_ENREF_129)) and the Australian CART study ([130](#_ENREF_130))) did not demonstrate significant effects. Although the intervention communities had more quit attempts, greater knowledge of health risks, better social and environmental support for quitting and a change in attitude towards smoking there was little evidence of reduced prevalence for smoking when compared with control communities ([43](#_ENREF_43)).

In the US the ‘full court press’ intervention post-dated the Cochrane Review. It was targeted at reducing smoking in young persons (13-14 years old) and consisted of the components: (i) media advocacy designed to promote community norms for the non-use of tobacco by youth; (ii) youth mobilisation and leadership to build a network of youth committed to reducing tobacco use and to advocate for stronger private and public policy; (iii) an effective youth access enforcement mechanism to reduce ease of youth access to tobacco; (iv) mobilisation of the community to promote reduced youth tobacco use; and (v) development of effective youth cessation services. The programme ran from 1996 to 2000 and saw a 27% reduction in the prevalence of young persons’ smoking. The lack of a control group makes the attribution of the intervention to this change difficult but the intervention has been found to be both effective and cost effective ([131](#_ENREF_131), [132](#_ENREF_132)).

## Workplace based

Those in full time employment spend a considerable proportion of their lives at work and contacting them in their workplaces is potentially a cost effective means of providing support for smoking cessation. In addition quit smoking attempts by groups of workers can be reinforced by peer pressure. Workplace based interventions can also provide a means of contacting and recruiting groups such as young men who have little contact with their doctors. Workplace bans on smoking, although having an effect on cessation in their own right ironically weaken the utility of the workplace as a location for basing quit attempts as those that continue to smoke now do so away from the workplace.

Evaluating interventions based at workplaces is also problematic because of the variety of programmes offered. A Cochrane review found that group and individual counselling and nicotine replacement therapy were effective in aiding cessation in workplace settings but no more so than when offered elsewhere. Self-help materials were as ineffective as when offered elsewhere. In some cases interventions were applied to the whole workplace with incentives to quit and other comprehensive type approaches followed. No evidence of an effect was found for these interventions ([133](#_ENREF_133)).

An American review specifically looking at incentives or competitions in workplaces found an insignificant effect – this became significant when the competitive element was augmented with other cessation interventions. Given the role of the employer in paying health insurance costs in the US the authors concluded that such interventions were cost saving ([19](#_ENREF_19)).

Workplace smoking bans have been legislated in a number of countries with the main objective being to reduce exposure of non-smokers to second hand smoke. A review of the effect of these bans ([106](#_ENREF_106)) found that few measured the impact on active smoking behaviour and therefore the effect of workplace bans on smoking prevalence was inconclusive.

## Family based

In terms of smoking cessation partner support may be important; smokers tend to marry or become partners to smokers, to smoke similar amounts as their partner and to quit at the same time. Smokers married to ex-smokers or never-smokers are more likely to successfully quit. Married smokers are more likely to quit than those who are divorced, widowed or never married. Spousal/partner support has been shown to be highly predictive of successful cessation (see references on page 2 of ([44](#_ENREF_44))). Given these results a number of interventions have tried to use partner support to measure its impact on smoking cessation or its additional benefit when added incrementally to other cessation approaches. A 2012 Cochrane review looked at all these interventions. The partner was defined more widely as spouse, friend, child, parent or ‘buddy’. Surprisingly perhaps given the previous research this review found no significant effect for these interventions. This might be because the effect is too small to be detectable given the power of the studies, that the interventions themselves failed to actually increase partner support in a way that would reduce smoking, or perhaps the inclusion of studies that included as partners not only spouses but also work colleagues and friends diluted the response ([44](#_ENREF_44)).

## Comprehensive and integrated services

Since 1999 the UK NHS has offered stop smoking services that include behavioural support and appropriate pharmacotherapy and are freely available to all smokers. Currently this is the only country that does this ([134](#_ENREF_134)) although other countries are adopting this approach ([100](#_ENREF_100)). Until April 2013 these were run in England by the 151 Primary Care Trusts and since then responsibility has passed to the local authorities. The service configuration is therefore at a local level although there are national guidelines ([37](#_ENREF_37)). Outcomes are measured as the number of smokers who remain abstinent at four weeks even though it is known that 70% of those who stop smoking at four weeks are smoking again after a year. The number of users who were CO verified as quitters at 52 weeks was 14.6% which makes the successful quit rate about four times higher than for those who receive no support ([45](#_ENREF_45)). There were 9 million smokers in England in 2010/11 and 8% of those set quit dates with the stop smoking services in that year. Under standard assumptions about relapse the services generated 24,413 life years saved at a cost of £3,441 per discounted life year. This is 20% of the cost effectiveness threshold set by the National Institute for Health and Care Excellence (NICE). One of the problems in evaluating the service is that, because the services offered are determined at a local level there is high degree of heterogeneity. This heterogeneity is in terms of throughput (the number of quit dates set per 100,000 population which varied across the 151 local stop smoking services between a high of 5,500 and a low of 800) and four week quit rates (reaching 50% in the most successful stop smoking services but not exceeding the baseline quit rate in the least successful). This variation in outcomes is not explained by the characteristics of the populations that each stop smoking service works with, but is linked to variations in the services offered. The service has been effective at reaching low SES smokers as over half those in contact with the service are eligible for free prescriptions ([37](#_ENREF_37)).

Many who smoke are in contact with, or under the care of health systems and there is a recognition that, as currently organised health systems do not consistently identify smokers, provide support for smoking cessation or refer smokers to cessation services across all levels of care or all points of contact ([135](#_ENREF_135), [136](#_ENREF_136)). There is limited evidence as to what the best form of health system could be. Recommendations from NICE issued in 2006 emphasise the need for all who work in the healthcare sector to i) advise all smokers to quit, ii) refer them to smoking cessation services. If unwilling to accept referral they should be prescribed a course of pharmacotherapy. The NICE recommendations also were that smoking cessation services should be available in community, primary and secondary care settings and that those designing policy should ensure these services are concentrated on deprived areas or disadvantaged populations. NICE also recommended that monitoring services should enable health professionals to know the smoking status of each patient, the last time they were offered advice and their response to that advice ([101](#_ENREF_101)).

## Cross sectoral integration: Actions across and beyond the health sector

The National Smokefree Working Group in New Zealand has advocated a ‘layered’ approach to smoking cessation ([137](#_ENREF_137)) whereby an individual smoker receives the interventions that are mostly suitably tailored to maximise the likelihood of quitting. This means that smokers are encouraged to quit, offered a full range of cessation services from which they can choose or be advised of the best options and routinely referred to other cessation service providers. This addresses the issue that cessation services often act in single silos where the services received by the smoker depend on his or her entry point to the system rather than what is most likely to stop them smoking. Smoking cessation services also suffer from being delivered at local and national levels by a mixture of dedicated and general providers, funded through different and more or less observable budgets and with different levels of priorities and positions on the agenda. To move to a more comprehensive and integrated approach requires a cross-sectoral coordination and joined-up approach across the health, social and welfare sectors. There is also the role of the research and innovation sector in developing and evaluating interventions that are successful in the variety of contexts. Smoking cessation services have also to be based on the best evidence available. There is a need for research and literature on the problems of translating the large number of pilot studies and trials into a scaled up programme that can make a change in population health. In particular there is a shortage of literature on the optimal systems for delivering smoking cessation or how sub-optimal the system can be and still be beneficial. The only guidelines seem to be drawn from the NHS stop smoking services in the UK. Here the benefits of setting priorities at a local level have been given precedence over the need to provide the best services to all, resulting in a situation where the quality of services received by a potential quitter depend on where he or she lives.

The working group also identifies the necessity of building support for further regulation in order to encourage compliance where enforcement might be difficult, for example banning smoking in cars containing children. Similarly housing departments could restrict or ban smoking in multi-unit social housing because of the smoke drifting between units. Councils can implement smokefree policies in all outdoor spaces (as, for example in Auckland). In general there is a mixture of local and national policies implemented across a number of sectors.

## Ways of reaching smokers

### Telephone based counselling

Telephone counselling (quitlines) are an intervention where the active ingredient (in the MRC sense ([2](#_ENREF_2))) is not clear, as the only apparent difference between telephone and other counselling is the telephone itself (although the anonymity may be an attraction). It has the possibility of being cheaper to reach smokers and can reach them in their own homes or workplaces. Quitlines are proactive (where the counsellor initiates a number of calls to the smoker to provide support) or reactive (where the contact is always initiated by the smoker). Although a review identified 77 studies evaluating quitlines there was heterogeneity in the working methods of the quitlines (e.g., the intensity of the intervention) and of the studies (e.g., recruitment of participants, intervention chosen as control) ([46](#_ENREF_46)). Studies of telephone quitlines have produced a range of effect sizes with wide confidence intervals. When compared with minimal intervention the RR was 1.34 [95% CI 1.22-1.46], this was similar to the effect when the control was brief face to face counselling (RR=1.46 [95% CI 1.2-1.66]). There was little evidence that more or longer sessions had a greater impact on quit rates though below 2-3 calls there was no impact. The interaction of quitlines with pharmacotherapy such as NRT was complex. Adding telephone counselling to pharmacotherapy had a small effect that was barely significant however in many cases the provision of free NRT has encouraged quitline calls and telephone counselling may lead to more effective use of pharmacotherapy ([46, p24](#_ENREF_46)).

Although quitlines have been shown to be effective at smoking cessation they are only used by between 1% and 7% of smokers each year. Some studies have looked at the effectiveness of quitlines that actively recruit smokers through cold calling. Such smokers will be less motivated to quit than those who initiate contact with the service. They are also more likely to be male, less educated, older, employed, less addicted and less likely to have a previous quit attempt than those who ring the quitlines. Active quitline recruiting would therefore be a possible way of reaching this group of smokers and increasing the proportion of smokers in contact with the quitline from the small percentage above to between 41% and 52% ([138](#_ENREF_138), [139](#_ENREF_139)). Evaluating this strategy is complex, quitlines usually do not support those who are not ready to set quit dates and that will be the case with most cold-called smokers. This will require a different quitline approach. Those who do not contact quitlines tend to be the lighter non-addicted smokers and these may be more likely to succeed in quitting with or without quitline support. A randomised controlled trial in New South Wales recruited 1,562 smokers through cold calling and randomly assigned them to a group receiving proactive telephone counselling and a control group receiving self-help materials. Those in the intervention arm were significantly more likely to be abstinent at four months and seven months but not 13 months. They were also significantly more likely to have made a quit attempt and to have reduced their cigarette consumption ([47](#_ENREF_47)).

### Internet based

The advantages of using the internet to access and provide materials to smokers is its cheapness, the ability of the smoker to interact at any time they wish and the capability to tailor the materials provided to the individual smoker depending on their status and interactions. A Cochrane review of the studies undertaken to evaluate internet based approaches failed to find any strong evidence of an effect. Tailored and interactive interventions seemed to have the most promising results when compared to minimal interventions but the studies that evaluated them were judged to have a high risk of bias. Non tailored or interactive internet interventions were not found to be effective as were internet interventions when compared to face to face or telephone counselling ([48](#_ENREF_48)). The US Community Preventative Services Task Force made a similar inference stating that there was insufficient evidence to make any conclusions about the effectiveness of such studies as the content differs and those receiving the intervention are often receiving other therapies ([75](#_ENREF_75)).

### Mobile phone based

A key issue in smoking cessation is reaching smokers in the community who are not in education or any contact with the healthcare system. These are usually young adults who have high rates of smoking. Given the ubiquity of mobile phone use in this group, the use of mobile phones as a way of changing their smoking behaviour may be promising. A Cochrane review of this approach however was restricted to studies where the smoker was seeking to quit. Evaluating interventions in this area is also complicated by the pace of technological change – mobile phone and internet interventions that were distinct only a few years ago are now very similar given the widespread adoption of internet-enabled phones. The review found that interventions based on text messaging alone had an effect on long term abstinence with a RR of 1.71 [95% CI 1.47-1.99: 5 studies]. The text messages contained a variety of motivational support, quit advice and reminders when urges to smoke are encountered. The five studies considered were heterogeneous in timeliness and message content so no recommendations were made on the optimal frequency or content of the messaging.

## Self help

Self-help methods are defined in the Cochrane review ([50](#_ENREF_50)) as the provision of materials to aid cessation where there is no contact with a therapist. The review showed that any effect of providing self-help materials was likely to be small and did not add to the effectiveness of other interventions. However they did find that provision of self-help materials led to higher cessation rates with an OR of 1.24 [95% CI 1.07-1.45; 11 trials] when compared to smokers receiving no such materials. This effect increased when the self-help materials were individually tailored to the smoker with an OR=1.42 [95% CI 1.26-1.61] though the authors caution that this might be due to the extra contact between the therapist and smoker required to tailor the materials.

## Harm reduction

Harm reduction is the mitigation of the impacts of tobacco smoking short of abstinence. It is not clear whether New Zealand’ s 2025 goal refers to abstinence or harm and this suggests that harm reduction approaches may have a role. The harm associated with cigarette smoking is almost entirely caused by the toxins and carcinogens found in tobacco smoke – not the nicotine ([140](#_ENREF_140)). The nicotine is however the addictive substance that sustains the smoking habit. Nicotine addiction may cause changes in brain structure that affect the ability to sustain abstinence and these changes may be irreversible. A Royal College of Physicians report states that “it appears increasingly probable that some smokers may experience very long-term, perhaps lifelong, disruption of brain function, mood and/or cognitive ability following smoking cessation. Such individuals may require similarly long-term treatment support or nicotine maintenance, and this may account for the sustained use of nicotine medications by some ex-smokers, many of whom report that their use is to enable them to maintain abstinence” ([141, p78](#_ENREF_141)). The degree of harm caused by tobacco could be considerably reduced if those who find it hard to quit because of nicotine dependency switch to a non-tobacco nicotine source. Harm reduction for tobacco is then the use of non-tobacco nicotine sources. These may include e-cigarettes, nicotine replacement therapy, smokeless tobacco, topical gels or any other alternative nicotine delivery system. These may also be suitable for those who do not wish to quit. Note that under harm reduction NRT is not an aid to quitting but a substitute for smoking tobacco and that it may be used for a lifetime. Long term use of NRT has not been associated with adverse effects ([52](#_ENREF_52)). However the safety of e-cigarettes for long term use has not yet been proven. There is evidence that users of Swedish snus have higher rates of certain types of cancers but that there is a significant health benefit from getting cigarette smokers to switch to snus ([52](#_ENREF_52)).

Harm reduction in tobacco use is as controversial as it is for other substances. The use of products such as e-cigarettes that look like cigarettes and maintain some of the culture around smoking goes against the strategy of denormalising smoking ([142](#_ENREF_142)). The standard argument against harm reduction also is true here; if you make the activity less harmful you will increase its prevalence. Currently the evidence for either a positive or negative effect of e-cigarettes at a population level is too weak to draw conclusions.

Harm reduction is however a possible solution to the problem of achieving the necessary quit rates to reach the 2025 goal. There are smokers who don’t want to, or find it very difficult to quit outright and many smokers are not contacting the cessation services.

There is a possibility that the previously united front of tobacco control advocates may be split as discord arises between those who are in favour of harm reduction and those who are concerned to ensure complete abstinence and no addiction to nicotine([143](#_ENREF_143)). However several New Zealand academics have made the point that, “the failure to separate tobacco from nicotine is a major barrier to further progress in preventing tobacco related disease” ([144, p3](#_ENREF_144)).

Harm reduction may also relate to reducing smoking to a safe level. However, the evidence as to whether reducing cigarette consumption has any health benefits is inconclusive or suggests that substantial reductions in consumption are required for any significant benefits ([51](#_ENREF_51)) ([145](#_ENREF_145)). It is possible that smokers adopt ‘compensatory smoking’ whereby they cut down the number of cigarettes they smoke but smoke each of them more intently.

## Cessation Services for priority populations

### Interventions aimed at smoking cessation in indigenous populations

Rates of smoking in Maori in New Zealand and in Indigenous Australians are higher, sometimes much higher than in the general population. Also rates of smoking have not fallen in indigenous populations as they have in the general population. Limited research has been undertaken to examine whether and what types of interventions are effective in indigenous populations and if effects differ between indigenous and non-indigenous populations. A Cochrane review, published in 2012 found little evidence based on four studies. Although they reported a relative risk of 1.43 [95% CI 1.03-1.98] in favour of interventions over control they rated the quality of evidence as very low ([57](#_ENREF_57)).

A more recently published review ([53](#_ENREF_53)) found only five studies (all but one of them not included in the Cochrane review) all of which had taken place in New Zealand. In one, two weeks of NRT plus Quitline usual care was added to Quitline usual care to examine the effect on 6 months abstinence ([146](#_ENREF_146)). Little effect was found and there was no difference between Maori and non-Maori. Two other studies also trialled enhancements to Quitline usual care but found no difference between ethnic groups in the effect ([54](#_ENREF_54), [55](#_ENREF_55)). Another study looked at the effect of using mobile phone text messaging to increase the success of quit attempts. Maori participants received text messages in Maori and messages more relevant to Maori. The intervention showed no difference in results between Maori and non-Maori although a significantly higher proportion of the Maori group was lost to follow-up ([56](#_ENREF_56)).

A study whose results were published too late to be included in the Cochrane Review evaluated a community based intervention in eight indigenous communities in Northern Queensland. The intervention included education about the health risks of smoking, greater delivery of brief advice by health workers, support for quit attempts, monitoring of retailers’ compliance with sales restrictions and more smokefree workplaces. The intervention effects were evaluated by surveys with individuals resident in the communities at baseline and follow up. There were significant declines in the number of daily smokers and the number of cigarettes smoked weekly in the interventions as compared to the control communities despite the fact that the components of the intervention were evaluated as having been poorly implemented ([147](#_ENREF_147)).

The lack of studies means that the results are not as robust as they should be. The question remains, if interventions are effective, as suggested by the Cochrane review, and there are no differences in the results of interventions, as suggested by Johnston ([53](#_ENREF_53)), why have rates of smoking remained stubbornly high in indigenous populations. This seems an important issue for research.

### Interventions aimed at smoking cessation in young people

Although the majority of smokers start smoking before the age of 18 there is also evidence that suggests smokers becomes confirmed in their habit, or nicotine dependent, at a later age, perhaps at 20-21 years old. This implies that the group of late-teens/young adults are important for cessation interventions and yet this is also the post-school cohort that has the least contact with the healthcare system.

A Cochrane review looked at cessation interventions aimed at regular smokers under the age of 20. They found 28 studies most of which used a combination of behavioural therapies. Three trials based on the transtheoretical model achieved an RR of 1.56 at one year [95% CI 1.21-2.01] and 12 based on motivational enhancement had an RR of 1.6 [95% CI 1.28-2.01]. Thirteen trials of interventions including Cognitive Behavioural Therapy found no effect. No interventions including either NRT or bupropion had any significant effects ([8](#_ENREF_8)).

Around 22% of Americans between the ages of 18 and 24 years smoke tobacco. A meta-analysis looked at interventions in this age group. The meta-analysis showed that interventions that were effective in reducing smoking in the general adult population also worked for young adults. The authors concluded that the high prevalence of smoking for young adults is more a factor of their underutilisation of cessation services ([58](#_ENREF_58)).

Evidence from the US suggests that subpopulations of young Blacks, females, Hispanics and low SES populations had a higher price response in terms of prevalence than youth smokers as a whole. Smoke free laws had a higher impact on higher SES and male smokers in terms of prevalence ([148](#_ENREF_148)).

Evidence from the UK suggests that, contrary to what has been assumed, the highest incidence of quitting (where quitting here is defined as remaining abstinent for more than a year) is in the 21 to 30 year old age group. This is particularly marked in women and the higher social grades ([149](#_ENREF_149)). There seems to be a need for further research into the smoking behaviour of young adult populations to understand these seemingly disparate results.

### Interventions aimed at smoking cessation in pregnant women.

Smoking during pregnancy is a risk factor for complications, for low birthweight and for preterm birth. It may also retard the foetus’s development causing long term health problems for the child. Although smoking during pregnancy is reducing in high-income countries the trend is towards an increase in middle and low-income countries. Women of lower socioeconomic status also have a higher prevalence of smoking and this is a cause of persistent health inequalities.

NRT for pregnant women is more complex as nicotine is metabolised faster so that a higher dose is needed to obtain the same effect. A Cochrane review found six studies of NRT in pregnant women and none that considered bupropion or varenicline. The authors of the review concluded that there was insufficient evidence to show that NRT was either effective or safe for pregnant women ([60](#_ENREF_60)).

A far larger literature covers psychosocial interventions to encourage cessation in pregnant women. A separate Cochrane review based on 88 studies found a significant effect for counselling when compared to usual care (RR=1.44 [95% CI 1.19-1.75] 27 studies)([59](#_ENREF_59)). This effect persists after delivery and is strongest in the interval 12-17 months postpartum.

The intervention type with the largest effect was based on incentives (RR=3.64 [95% CI 1.84-7.23], 1 study ([150](#_ENREF_150)) but with an even higher effect in another study([151](#_ENREF_151))).

Interventions where the mother receives feedback about foetal health or about by-products of smoking were only effective when provided along with other ingredients and only when compared with usual care. This was true also of interventions based on health education and social support; the number of studies was low and the evidence weak.

In general the effect size was larger when the comparison was usual care rather than a less intensive version of the intervention.

The effect size was the same when interventions targeted at lower SES women were considered however there was no effect found in the two studies looking at smoking in indigenous pregnant women.

Those receiving psychosocial interventions had a lower incidence of low birthweight babies or preterm births([59](#_ENREF_59)).

### Interventions aimed at smoking cessation in lower SES populations

Smoking prevalence tends to be higher in lower SES populations and hence this group is a priority. Men between the ages of 35 and 69 in lower SES groups are roughly twice as likely to die as those in the high SES groups. About half of this difference is due to smoking ([152](#_ENREF_152)). This implies that little progress can be made on reducing health inequalities without reducing the disparity in smoking rates. Recent analysis of UK data has also shown that quit rates are much lower in low-SES groups than high-SES ([149](#_ENREF_149)).

The evidence regarding the differential impact of tobacco control policies on low-SES groups has recently been reviewed ([61](#_ENREF_61)). The authors reviewed the evidence under the following headings:

**Price increases**: these are judged to have the greatest effect with nine studies showing that price increase have a higher impact on low-SES smokers than high-SES smokers.

**Smokefree environments**: There is some evidence that, before comprehensive smoking bans were implemented, voluntary adoption of smokefree workplaces was more likely for high-SES occupations. Thus, low-SES smokers may have benefited from the legislative bans. The evidence is weak on this measure.

**Educational and media campaigns**: There is no evidence that mass media campaigns or health messages are more effective on low-SES smokers than any other group of smokers. Campaigns targeting low-SES smokers were not found to have any impact.

**Multiple media**: There was no differential impact found by SES

**Television**: Some studies have shown TV ads using personal testimony have equal impact across the SES gradient. Information based anti-smoking messages on TV tend to have a higher impact on high-SES groups

**Internet**: No evidence of effectiveness among low-SES groups

**Health warnings**: No evidence of differential impacts of health warnings on packs.

**Advertising bans**: No study has evaluated the impact of advertising bans

**Behavioural and pharmacotherapy**: The UK NHS stop smoking services have tried to address the problem of smoking in low-SES groups by concentrating services in deprived areas. This has led to higher uptake of those services by low-SES but the quit rates are still lower than in more advantaged communities.

Most studies have shown that despite targeting disadvantaged groups, and using the recommended combinations of behavioural and pharmacotherapy, quit rates in low-SES groups are worse than for high-SES groups. The higher uptake of services by low-SES smokers partially compensates for this.

**Behavioural Therapy alone**: The evidence is weak, but such as it is, it points towards behavioural therapy being more effective in high-SES groups.

**Pharmacotherapy alone**: One study reported greater relapsing among low-SES participants.

**Telephone support (quitlines**): The results are mixed. There is evidence that high-SES smokers are more likely to contact quitlines and more likely to succeed in quitting using a quitline. Others have found equal rates of quitting by SES but still low recruitment of low-SES.

**Internet Support**: High-SES smokers are more likely to engage with and quit using internet based support so such programmes have a negative equity impact.

**Brief interventions**: Low-SES smokers are less likely to receive brief interventions as they are less likely to visit a health professional for preventative reasons. Other studies have shown that brief interventions have lower rates of success for low-SES smokers.

**Community based programmes**: New York City’s Department of Health and Mental Hygiene implemented a 5-point tobacco control programme in 2002. This involved taxation, which raised the price of a packet of cigarettes by 32%, legislation to make all indoor work areas smokefree, cessation services including provision of NRT in the form of patches and counselling, education including advertising in broadcast and print media emphasising the benefits of quitting and the danger of environmental smoke. The fifth component was the evaluation. This programme reduced smoking in young adults in the three years following the project’s start from 23.8% to 18.8% and the impact was greater in low- income areas. This is the only such programme judged to have a positive equity impact. Further analysis of this result showed that the fall in smoking prevalence was entirely due to young women stopping smoking. Prevalence in young males remained the same([153](#_ENREF_153)). For adult smokers the prevalence fell from 21.6% to 19.2% with higher falls for women and low-income women ([154](#_ENREF_154)). Although this programme was demonstrated as effective in reducing smoking more for low-income smokers it included a large rise in pack prices so it could be argued that this re-iterates the result that a price rise is the most effective way to get low income smokers to quit.

A summary of this and other evidence is that:

Tax and price policies have a higher impact on low-SES populations and these are the only effective means to reduce inequality in smoking. Smokefree legislation has not reduced inequalities in smoking although partial or voluntary workplace bans increased inequity. The UK has a comprehensive anti-smoking service and it was felt that the wide reach of this service compensated for the low quit rates in low-SES smokers ([134](#_ENREF_134))(and compare youth results ([148](#_ENREF_148))).

### Interventions specifically aimed at recent quitters

Although a number of interventions have been shown to help people to quit smoking, a high percentage (70-75%) of those who have remained abstinent for a short time have started smoking again a year after their quit attempt. A number of interventions have been proposed to turn recent quitters into sustained non-smokers. These include those that utilise the skills approach whereby quitters learn to identify situations that are high-risk for relapse and behavioural or cognitive techniques for dealing with these situations. Other approaches include extending sessions with the therapist who provided cessation support and other psychological techniques. A few studies have been of pharmacotherapies for maintaining abstinence. A Cochrane review found no evidence of an effect for any behavioural intervention on sustained quitting. The authors noted however, the low statistical power of the evaluation studies considered and the generally low quality of the evidence. The pharmacotherapies had better results, an extension of varenicline treatment by 12 weeks had a RR of 1.18 [95% CI 1.03-1.36] when the outcome was based on abstinence at 12 months from quit date and the control group received a placebo. The authors noted a need for further studies of the effect of extended treatment with forms of NRT ([62](#_ENREF_62)).

### Interventions aimed at smoking cessation for those with poor mental health

One priority population receiving increasing attention is of those with mental health illness ranging from those with common mental disorders treated within the community, such as anxiety or depression, to those with rarer but more severe mental health problems requiring inpatient treatment. The prevalence of smoking is around twice as high for those with mental illness as in the general population; around a third of all cigarettes in New Zealand are smoked by those with poor mental health and, unlike most other groups, there has been no decline in prevalence in the last 20 years ([155](#_ENREF_155)). Although those with mental disorders tend to be in more frequent contact with health services this has not lead to them receiving better support for cessation. Smoking is also part of the culture of the settings and institutions that exist to care for people with poor mental health. This suggests that smoking is still seen as normal in this population and that healthcare professionals do not see smoking cessation as important as they do for those in the general population ([155](#_ENREF_155)). In New Zealand there has been resistance to mental health facilities becoming smoke free with some arguing that it will discourage people from seeking help. As an example, two former psychiatric patients took Waitemata DHB to court arguing that being prevented from smoking in a secure mental ward violated their human rights and some specialist psychiatric care hospitals, such as Hillmorton have rescinded blanket smoking bans on the premises following resistance from patients ([156](#_ENREF_156), [157](#_ENREF_157)).

Interventions for those with severe mental illness may be different from those with common mental disorders as smoking cessation treatments may interact with their medication and symptoms of nicotine withdrawal may be similar to those of their illness. A Cochrane review concluded that only bupropion was effective as an aid to smoking cessation in patients diagnosed with schizophrenia with a relative risk ratio for increased abstention compared with a control group of 3.03 [95% CI 1.69 to 5.42] based on seven trials during the intervention phase and 2.78 [95% CI 1.02 to 7.58] after six months. Varenicline was also effective but there were too few trials for conclusive results and it was linked with several adverse episodes ([63](#_ENREF_63)).

Smokers with current or past depression are more nicotine dependent, more likely to suffer negative mood changes after stopping smoking and more likely to relapse after a quit attempt. A Cochrane review found that adding a psychosocial mood management component (where participants learn techniques to manage depressive symptoms) to a standard smoking cessation package is effective in increasing abstinence rates in those both currently depressed and those with a history of depression (RR=1.47 [95% CI 1.13 - 1.92] 11 trials). Bupropion was found to be effective for those with past but not current, depression. There was insufficient evidence for other anti-depressants ([64](#_ENREF_64)).

### Interventions aimed at those in, or recently released from, prison

Rates of smoking in prison are very high, around 80% ([158](#_ENREF_158)). A number of countries have implemented smoking bans in prison, in the United States 60% of prisons have a tobacco ban and in Australia the Northern Territory has a full smoking ban. However, in the UK there is not, or likely to be, a full smoking ban in the near future and New Zealand is the first country to make prisons completely smoke free ([159](#_ENREF_159)).

Those with poor mental health or those who have problems with illegal drugs tend to be over represented in prisons meaning there is an overlap with other priority populations. However, when asked, prisoners have expressed desires to quit to the same degree as the general population ([160](#_ENREF_160)). Authorities have used prohibition of tobacco in the past as a punitive measure against prisoners although such bans are difficult to enforce and in some cases there has been strong resistance from prisoners. They have not made the decision to quit themselves and the quit date has been forced upon them. In most jurisdictions there is limited cessation support within prison. Whatever the impact of the bans has been inside the prison a survey of released inmates found that 66% had had a cigarette within a day of release and 97% within a week ([65](#_ENREF_65), [161](#_ENREF_161)). This has health risks for the prisoner and their families. This suggests that stopping prisoners smoking does not make them non-smokers. Research in this area suggest that cessation support should be provided both in prison and importantly continue after release ([66](#_ENREF_66), [162](#_ENREF_162)). The denormalisation of smoking in prison has not been matched by a denormalisation in the environment into which the inmate is released. Without cessation services that extend beyond the prison it is likely that such bans will still be considered punitive. In the Northern Territory of Australia a pilot project is underway to maintain contact with recently released inmates (84% of whom are indigenous) to encourage them to remain non-smokers. This project is still in its early stages so there are no results as yet ([163](#_ENREF_163)). In New Zealand cessation support services were in place before the ban was implemented but on release prisoners only have access to the standard cessation services such as Quitline ([164](#_ENREF_164)). Given the high risk of relapse immediately following release there may be a case for some special services for prisoners at this stage.

## Restrictions of supply and enforcement models

**Supply side interventions**

These include controlling the availability of tobacco and thereby preventing access particularly by young people. This is usually done by setting a minimum age for cigarette purchase, educating merchants about the law and enforcing the law (see below). Evidence shows that these programmes can be effective in restricting illegal tobacco sales to minors but do not seem to affect rates of smoking as young people in early stages of smoking can get cigarettes from social sources([165](#_ENREF_165)). Research in New Zealand has shown that in 2008 92% of young smokers obtained cigarettes from non-commercial sources including friends or people they had asked to purchase for them. Still 34% bought cigarettes in shops. The proportion of young people who had been refused cigarettes had reduced between 2002 and 2008 from 45% to 28%. Maori and Asian youth were less likely to be refused tobacco. Two thirds or respondents had never been asked proof of age but other evidence suggests that retailers only check ID in a cursory fashion and will sell to those with an ID showing them to be under the legal age or who present someone else’s ID ([166](#_ENREF_166)). Currently no license or registration is required to sell tobacco and the introduction of such a scheme has been recommended by the national smokefree working group as this would enable a much closer monitoring and control of supply ([167](#_ENREF_167)). In California tobacco retailers pay a nominal state-wide fee for a license. However local authorities can put in place a higher license fee at the local level with the proceeds being used to fund enforcement of restrictions on sales to minors ([168](#_ENREF_168)).

### Controlled Purchase Operations to enforce minimum purchase age

The 168 signatories of the WHO Framework Convention on tobacco control have committed themselves to preventing the sale of tobacco to minors. Such laws are only effective in reducing tobacco consumption by minors if enforced and only methods that have been shown to disrupt the supply are effective in enforcing sales laws. Effective enforcement measures involve inspections and the use of test purchasing by a minor ([67](#_ENREF_67), [68](#_ENREF_68)).

### Anti-smuggling

Smuggling of tobacco across borders is a threat to public health both because there is a supply of cheap cigarettes to encourage smoking but also because the tobacco industry uses the existence of smuggling to argue against the imposition of higher taxes. It is estimated that 12% of cigarettes globally are contraband ([169](#_ENREF_169)). Contrary to tobacco industry arguments the degree of smuggling does not seem to be correlated with the price of legal cigarettes ([170](#_ENREF_170)). In New Zealand it is estimated that less than 2% of tobacco is illicit. Even though a study of discarded cigarette packets in a number of New Zealand towns showed a significant percentage were purchased from abroad the most common source country was Australia. It is unlikely there is any deliberate smuggling to avoid duty from Australia as cigarettes are more expensive there ([171](#_ENREF_171)).

# Cost effectiveness

The cost effectiveness of an intervention is the amount of health benefit, measured in terms of some health-related metric such as quality adjusted life years (QALYs) or life years saved (LYs), divided by the cost of the intervention. Cost effectiveness is usually expressed in relative terms (that is an intervention is cost effective relative to an alternative intervention). Public health authorities typically set a hurdle at which an intervention is considered cost effective; for the UK the National Institute for Health and Care Excellence sets this at about £20,000 per QALY. However such thresholds have the potential to be controversial and PHARMAC has explicitly denied the existence of such a threshold in New Zealand ([172](#_ENREF_172)).

There is also a difference between the efficacy of an intervention and its effectiveness. Its efficacy is the measured impact of the intervention when implemented by an expert team of researchers in a group of patients or in settings that are usually highly motivated and prepared for change. Its effectiveness is how it works when implemented by ordinary, usually overworked, employees of the healthcare, educational or other systems on patients or individuals who may have more or less interest in complying with the treatment. Most of the results presented in this document are from reviews of other studies evaluating the efficacy of interventions. The emphasis is on the randomised controlled trial as the gold standard means to assess whether the intervention can be said to cause the outcome. That is not the same as showing that it will improve outcomes in a real world situation and is equivalent to the problems involved in moving from a pilot study to a scaled up project. There is no guarantee that the most efficacious interventions will turn out to be the most effective and some authors have argued that it may be better to choose programmes that are less efficacious but, because they are easier to implement, more effective ([173](#_ENREF_173)).

Accurately assessing cost effectiveness for smoking cessation interventions in any case may not be as important as the harms from smoking are so high that “findings from economic analyses from the UK and elsewhere confirm that smoking cessation interventions, including pharmacotherapy, are among the most cost-effective health care interventions available” and that “cost-effectiveness analysis, even with its inherent methodological problems, consistently shows that when smoking cessation interventions are effective they are invariably also cost-effective.”([69, p1](#_ENREF_69)). Even under the most pessimistic set of assumptions (poor take up and compliance with the treatment, efficacy judged at the low end of the confidence interval) smoking cessation interventions are always under the cost effectiveness threshold and in many cases cost saving for the health services as they reduce future smoking related morbidity.

A 2002 review of the cost effectiveness of smoking cessation assumed that for each successful quitter 1-3 life years were saved. It showed that adding NRT to a behavioural intervention had an incremental cost of £1,000-£2,400 per life year saved. Adding bupropion to a behavioural intervention had an incremental cost of £640-£1,500 per life year saved and adding both NRT and bupropion had an incremental cost of £900-£2,000 per life year saved ([71](#_ENREF_71)).

A number of studies have found varenicline to be more cost effective than either NRT or bupropion across a variety of models ([72](#_ENREF_72), [73](#_ENREF_73)).

There are fewer studies that assess the cost effectiveness of behavioural therapy to stop smoking. The most highly cited is from 1989 and estimates that brief advice given during a routine GP visit costs between US$705-US$988 per life year saved for men and US$1204-US$2058 per life year saved for women ([174](#_ENREF_174)).

A study done for the National Institutes for Health and Clinical Excellence (NICE) and from the perspective of the UK health service estimated the costs per QALY of a number of interventions ([70](#_ENREF_70)). The results are summarised below (Table 3). This takes into account the benefits of quitting at a younger age and the savings to the health sector of reduced morbidity among smokers. They also assume that not all NRT prescribed is used. This table shows the relative cost of the interventions and concluded that “even in the most pessimistic scenarios cost-effectiveness did not reach the NICE £20,000 benchmark.”([70, p22](#_ENREF_70)).

Table 2: Summary of cost-effectiveness of brief interventions

|  |  |  |
| --- | --- | --- |
| **Summary of cost-effectiveness of brief interventions: Cost per QALY based on 50 year old cohort (treatment cost perspective) Incremental cost/QALY over and above control** | | |
| **Intervention** | **Male** | **Female** |
| Brief opportunistic advice from a GP (5 minutes) | £829 | £745 |
| Brief opportunistic advice from a GP (10 minutes) | £1659 | £1690 |
| Brief opportunistic advice from a GP + advice to use NRT | £2390 | £2435 |
| Brief opportunistic advice from a GP + telephone helpline (2% - 3% above control) | £318 - £434 | £324 - £443 |
| Brief opportunistic advice from a GP + self-help material | £419 | £727 |
| Brief advice from a practice nurse in a primary care setting (0.5% - 3% above control) | £575-£3448 | £586-£3514 |
| Brief advice from a staff nurse in a hospital setting (0.5% - 3% above control) | £258-£1548 | £263-£1578 |

A Danish study showed that telephone counselling was estimated at costing between €137 and €213 per life year saved with a worst case cost of €1199. Even in the worst case this was considerably below the average cost of €1592/LYS in other Danish settings for other interventions ([74](#_ENREF_74)). In 2004 an economic evaluation assessed the cost effectiveness of NRT when added to Quitline in New Zealand and showed that the cost per QALY ranged from $2,449 to $6,794 depending on assumptions about the quit rate. Again, under the worst case this intervention is very cost effective when compared to other health care interventions([175](#_ENREF_175)).

A Community Preventative Task Force review ([176](#_ENREF_176)) found that in 2011 US Dollars the median cost of a QALY using mass media interventions was $577 and per Life Year Saved was $213. Even though there was a wide range of estimates all were well below any threshold value and the cost-benefit ratio varied from 7:1 to 74:1. This differed markedly from other cost effectiveness evaluations such as that of the American EX campaign (see §73) which had costs of $37,000-$81,000 per QALY. There needs to be some review of why such differences in cost effectiveness estimates exist for these interventions.

Study that compared across different types of interventions showed that a state-wide workplace smoking ban was considerably more cost effective (US$726 per QALY) than NRT (US$6,367 per QALY)([177](#_ENREF_177)). However this must be compared with the weak evidence of smoking bans on cessation.

# Second hand smoke and denormalisation

Second-hand smoke is the harm caused to non-smokers by the tobacco fumes emitted by smokers. The burden of disease suffered by second-hand smokers is mainly in the form of cardiovascular disease, lung cancer and respiratory disease and developmental impairment in children ([76](#_ENREF_76)). Article 8 of the Framework Convention on Tobacco Control mandates all signatory countries to "protect citizens from exposure to tobacco smoke in workplaces, public transport and indoor public places."([178, p8](#_ENREF_178)). This population group therefore does not smoke and they cannot modify their own behaviour to reduce this health risk other than by removing themselves from the environment where they are exposed to smoke (paradoxically a group that suffers significant harm from second hand smoke is smokers themselves – they are often in smoky environments and some of the tobacco smoke they inhale is not generated by their own cigarettes. This is often ignored in estimates of the harm caused by second hand smoke). If this is their workplace or home this is not easy to do. The international evidence is that smokefree legislation has improved the air quality of the areas where it has been implemented, usually workplaces, restaurants and other enclosed public spaces. Other possible solutions, including increased ventilation or better segregation for smokers, have not been as effective in maintaining air quality.

Hospital admissions for acute myocardial infarction drop by 10% a year after smokefree legislation, and have fallen a further 20% after three years ([76](#_ENREF_76)). Lung cancer has a longer latency period but US states with smoking bans have faster declines in the incidence of cancer than those without. Contrary to the views of the tobacco industry smoking bans have not had significant effects on revenues in the hospitality industry ([76](#_ENREF_76), [77](#_ENREF_77)).

Although smokefree policies are now common in indoor public areas there are concerns about the exposure of younger children to tobacco smoke in private areas such as homes or cars because of smoking by their parent or guardian. A Cochrane review of interventions intended to reduce a child’s exposure to tobacco smoke found four successful studies all of which involved intense parental counselling ([179](#_ENREF_179)). Smoke free homes have been shown as being effective at encouraging adult smokers to quit although it may be that homes with smokers who do not want to quit are less likely to become smokefree ([180](#_ENREF_180))

Smokefree policies have yet to be implemented in multiunit housing ([181](#_ENREF_181)), private enclosed spaces or public outdoor spaces. There is insufficient evidence to either confirm or refute the tobacco industry’s contention that smoking bans in public places will shift smoking to the home where children are more at risk of exposure. The evidence on the impact of second-hand smoke in outdoor areas is still at an early stage ([182](#_ENREF_182)).

In most areas of public health, practitioners have tried to reduce the stigma associated with certain conditions. In the case of tobacco a contrary position has been taken with some suspecting that there are policies in place that deliberately increase the stigma associated with smoking as a means of encouraging quitting ([183](#_ENREF_183), [184](#_ENREF_184)). This has been done through the denormalisation of tobacco; for example, its exclusion from public spaces. This process has been criticised as non-transparent as, although this is usually justified as preventing second hand smoke or exposing children to images of smoking, there are no reviews of evidence of how denormalisation could reduce smoking harm. By adopting policies for which there is little or no evidence public health advocates of this approach could risk losing credibility ([185](#_ENREF_185)). There are also ethical issues around whether the health benefit of the stigmatisation outweighs the dehumanizing aspects ([186](#_ENREF_186)).

On the other hand there is evidence for the contrary argument that having smoking as part of the milieu does encourage tobacco use, especially in young people. For example UK youths are exposed to 28% more instances of smoking in movies than youths in the US because of the ratings system ([187](#_ENREF_187)) and because having main characters smoke is not a factor in classifying movies in the UK.

Countries that have tried to legislate against portrayals of cigarette smoking in TV and films include Turkey, China and India. Information from the United States suggests there was a significant increase in depictions of smoking in films since direct advertising was banned and that exposure to cigarette smoking in films and on TV has had a significant impact on youth and adolescent smoking([34, p565 et seq.](#_ENREF_34)). This increase has been more marked in films aimed at younger age groups. Since 2007 depictions of smoking can lead to a film being rated ‘R’ so that no one under 17 can view the film without a parent or guardian.

# Social Marketing and mass media campaigns

## Advocacy

Public health research is mainly published in academic journals or reports with few readers or presented to specialist conferences with comparatively few spectators. Some have argued that this lack of interest in disseminating results much more to the public or to policy makers is weakening efforts to reduce smoking. Unlike mass media campaigns “media advocacy doesn’t try to persuade individuals to make specific behaviour changes, but instead seeks to use the media to change the *social environment* in which individuals make personal behaviour decisions” ([188, p245](#_ENREF_188)). Evaluating advocacy is complex as many of the indicators of a successful campaign – such as ensuring messages were carried in the media – are difficult to translate into indicators of increased quitting. A framework for evaluation is presented in ([79](#_ENREF_79)).

## Mass media

Apart from the ‘Truth’ campaign aimed at adolescents to prevent smoking the American Legacy Foundation ran the EX campaign between 2004-9 to encourage smoking cessation in 18-49 year olds. An evaluation carried out on the project ([189](#_ENREF_189)) assessed its societal cost at US$314 million but that it generated 53,000 quit attempts and 4,238 extra quitters. The cost per QALY saved was between US$37,355 and US$81,301, in either case below the US$109,000 cost effectiveness threshold. This was true for both the 18-49 year old group and the 18-24 year old sub-group.

An evaluation of the Australian National Tobacco Campaign, which reached its maximum intensity in 1997, estimated that the programme, which cost AU$9 million, would generate 190,000 quitters and save 407,000 QALYs. The difference in the results of this study and the EX study above are not explained ([190](#_ENREF_190)).

A Cochrane review of mass media campaigns found it difficult to meta-analyse the results of the existing studies due to differences in methods. Of the eleven studies identified most (8/11) showed some beneficial impact on smoking behaviour but in only three cases was this significant ([80](#_ENREF_80)). Another review found some evidence that mass media campaigns that aimed at educating people about the dangers of smoking had an effect on reducing prevalence ([26](#_ENREF_26)). A further review of 26 studies of mass media campaigns reiterated that they could be both effective and cost effective but stressed the need for the campaign to have adequate exposure and reach, intensity and duration. Negative messages tended to be associated with more favourable smoking outcomes particularly for low income groups ([191](#_ENREF_191)).

The Community Preventative Service Task Force review ([176](#_ENREF_176)) on the contrary found strong evidence for its findings that:

* Increased exposure to anti-tobacco media messages was significantly associated with decreased tobacco use prevalence (four studies).
* Increased exposure to anti-tobacco media messages correlated with a decrease in adolescent tobacco users (one study).
* Increased exposure to and appeal of anti-tobacco media messages were associated with an increased sense of tobacco independence and positive social imagery of not smoking, both of which strongly correlated with not smoking (one study).
* Increased intervention intensity was associated with increased odds of quitting (two studies).
* Exposure to anti-tobacco media did not significantly increase cessation in three studies.
* Number of calls to quitlines: median relative increase of 132% (IQI: 39% to 378%; 11 studies)
* Interventions were effective in increasing use of cessation services, especially quitlines (17 studies).
* Initiation among young people (11-24 years of age): decrease of 6.7 percentage points (95% confidence interval: -13.0 to -0.4 percentage points, one study)
* Higher intervention exposure or higher intervention recall or appeal was associated with reduced tobacco use initiation (five studies).
* Awareness of anti-tobacco advertising was associated with reduced smoking initiation among high-sensation-seeking young people (one study).

The CDC study on tobacco use prevention campaigns for youth has already been discussed (section 0). Although this covers the preventative effects of such campaigns there seems nothing about the content of the featured campaigns that would not make them relevant to cessation([33](#_ENREF_33)).

## Social Media

Tobacco companies are adept at using social media to promote smoking but there has been relatively little use of this means to promulgate anti-smoking messages. An example of some recent social media campaigns have been to use twitter, Facebook and change.org to put pressure on musicians not to play at events in Indonesia sponsored by tobacco companies ([81](#_ENREF_81)). The bands themselves were from Europe, the US or Australia. The authors recommended such strategies such as coordinating tweets at a certain target at the same time to create a trend or momentum. Change.org currently has many ongoing petitions regarding smoking. Most are for extending the current legislation by extending smoking bans to named areas but many push at legislation in new areas, for example banning smoking in cars carrying a minor or banning smoking in multi-unit apartments where there are a majority of non-smokers. Several of the petitions are informative as they emphasise the gap between the environment in developed and developing countries; for example, there is a petition to British American Tobacco in Nigeria to ask them to stop holding smoking parties for young people and to Fitness First in Indonesia to get them to enforce a smoking ban in the gym. The potential for social media is large and is underutilised for health promotion. This may be reflected in the fact that, in a study of 7,362 twitter posts researchers found that there was a clear majority that were interpreted as being positive about tobacco (46% of 7,362 posts) ([187](#_ENREF_187)).

Another approach taken has been ‘tobacco industry denormalisation’ where interventions aim a making smokers or potential smokers more aware of the activities of the tobacco industry and therefore more informed and able to make better decisions. A review of 56 studies of interventions containing some element of tobacco industry denormalisation showed it to be an effective strategy to reduce prevalence and initiation and increase the number of quit attempts([78](#_ENREF_78)).

# Gaps in the Evidence

There is a lack of evidence on what, if anything is added to the effectiveness of tobacco cessation services if they are to become comprehensive and integrated. The UK NHS stop smoking services are often quoted as an example of such a joined up service and the evidence seems favourable but it is not clear what the effective ingredient of this approach is.

A large number of interventions are successful at turning smokers into quitters but most short term quitters relapse into smoking again within six months of receiving the intervention. There seems relatively little attention given to relapsing and the one review of techniques for preventing relapse seems to show markedly different results from those relating to cessation. Cessation specialists seem to regard the ratio of long term to short term quitters as fixed and therefore see their role as increasing short term quitting.

Lack of evidence around effective interventions for indigenous populations- and also the question whether this group is relevant for smoking cessation – e.g., does an intervention shown to be successful for Inuit have pertinence for indigenous Australians?

There seems a lack of evidence on how to get priority populations to access cessation services. Although many smokers want to quit and there is evidence on how to help them there are still too many who do not want to quit, are too addicted to quit, are unable to quit and cannot get the help they need to quit. Explaining why low SES smokers for example have lower quit rates seems crucial to understanding the gaps in the effective stop smoking services.

There is a lack of attention to young adult age groups. It is not clear if the high rates of smoking in this group are because of high uptake in adolescence or whether there is a trend towards taking up smoking after the age of 18. This group also has low contact with the healthcare system and so reaching them is not straightforward.

# Conclusions

The effective and cost effective interventions to reduce smoking are well known and supported by a large amount of literature and summarised in the table starting on page 38. There is less evidence on the effectiveness of these interventions when used in real and specific populations. In particular in indigenous populations, people with poor mental health or lower SES groups all of whom have seen little fall in smoking prevalence in the last 20 years. If this continues smoking will become concentrated in communities already marginalised by their health, their ethnicity or their economic status and health inequalities will become more entrenched.

Map of Tobacco Control Services

# Introduction

The Ministry of Health funds tobacco control by contracting a number of different agencies and bodies at both national and local levels to provide services to smokers, to train the staff who provide such services, to develop the tobacco control sector, to promote anti-smoking and prevent uptake of smoking by non-smokers.

District Health Boards are required to improve, promote and protect health in their areas and each has a number of contracts from the Ministry for both tobacco control and public health.

The total amount DHBs receive through the tobacco control budget in the 2013/14 Financial Year is $16.7 million divided into $8.2 million for smokefree DHB and tobacco control, $5.8 million for public health, $0.5 for cessation services and $1.3 million for miscellaneous other services. The total also includes $0.9 million for AKP or Pacific cessation services where the provider is the DHB.

The following table contains information on all MOH funded cessation services in each DHB area whether through tobacco control or AKP or Pacific services provided in that area.

Table 3: MOH DHB contracts 2013/14

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| DHB | Smokefree DHB+tobacco Control | Cessation Services (Not AKP or Pacific) | AKP | Pacific Cessation Services | Pregnancy cessation | Total | Per smoker |
| Auckland | $492,920 |  | $183,772 | $250,314 | $338,698 | $1,265,704 | $35 |
| Bay of Plenty | $317,500 |  | $450,000 |  |  | $767,500 | $32 |
| Canterbury | $497,827 |  | $273,749 | $170,000 | $357,491 | $1,299,067 | $25 |
| Capital and Coast | $287,000 | $158,066 | $348,101 | $266,805 |  | $1,059,972 | $42 |
| Counties Manukau | $679,920 | $135,374 | $270,000 | $202,190 | $301,396 | $1,588,880 | $31 |
| Hawke's Bay | $393,000 |  | $359,907 |  | $144,310 | $897,217 | $46 |
| Hutt Valley | $281,632 |  | $227,249 | $137,995 |  | $646,876 | $39 |
| Lakes | $535,000 |  | $270,000 |  |  | $805,000 | $59 |
| MidCentral | $290,000 | $109,717 | $244,691 |  |  | $644,408 | $32 |
| Nelson/Marlborough | $325,000 |  | $225,000 |  |  | $550,000 | $39 |
| Northland | $400,000 |  | $869,430 |  |  | $1,269,430 | $64 |
| South Canterbury | $182,120 |  | $35,737 |  |  | $217,857 | $32 |
| Southern | $559,000 | $149,856 | $203,076 |  | $85,000 | $996,932 | $29 |
| Tairawhiti | $495,000 |  | $360,000 |  |  | $855,000 | $124 |
| Taranaki | $370,000 |  | $318,000 |  |  | $688,000 | $49 |
| Waikato | $370,000 |  | $760,743 | $207,670 |  | $1,338,413 | $31 |
| Wairarapa | $169,750 |  | $241,849 |  |  | $411,599 | $74 |
| Waitemata | $588,770 |  | $366,228 | $79,541 | $316,700 | $1,351,239 | $30 |
| West Coast | $234,500 |  | $25,135 |  |  | $259,635 | $54 |
| Whanganui | $435,000 |  | $225,000 |  |  | $660,000 | $77 |
| Total | $7,903,939 | $553,013 | $6,257,667 | $1,314,515 | $1,543,595 | $17,572,729 | $942 |

Quitline is the main national provider of cessation services and received $9.4 million from the Ministry of Health for the 2013/14 Financial Year. There are 32 providers of Aukati Kaipaipa (AKP) services who together received $5.8 million. There are four providers of Pacific Cessation services who together receive $1.3 million and 6 providers of pregnancy stop smoking services ($1.1 million).

The Ministry in addition funded the following organisations for 2013/14

Action on Smoking and Health (ASH) received $578,000 for Smokefree Information Services and $468,000 for an Innovations Fund project.

The National Heart Foundation received $248,000 for an Innovations Fund project and $577,000 for a contract ‘Pacific Heartbeat=Tobacco’ and a tobacco control project under the heading of nutrition, physical activity, tobacco and Pacific Island Heartbeat services.

The Smokefree Coalition Trust was funded $167,000 for tobacco control.

Hapai Te Hauora Tapui Ltd was funded $587,000 for National Maori Tobacco control and Public health leadership.

There are a number of other contracts in the Financial Year 2013/14 for providing training or sectoral development also funded by the Ministry. These include:

* Auckland University of Technology have a contract ‘smokefree nurses’ worth $60,000 and an Innovations Fund project worth $228,000;
* Massey University have an Innovations Fund project for $73,000;
* The University of Otago have an Innovations Fund project for $243,000;
* Auckland UniServices have a $20,000 for stop smoking innovations for hard to reach pregnant women and a $1.9 million Innovation Funds project;
* The NZ College of Midwives have a $30,000 contract but we have no information on the purpose;
* McRobbie, Chee and associates have a $394,000 contract ‘National Tobacco Cessation Training Service’ (this might be the same as the Inspiring contract). They also have a $136,000 contract ‘Health sector target support’ and a $15,000 contract for travel expenses related to the target support contract;
* Te Whanau O Waipareira Trust has a $94,000 Innovations Fund project;
* Datapeople have a $100,000 for providing software and database services. This includes collecting performance data for AKP, Pacific Cessation and Pregnancy cessation providers contracted to the MoH
* The Midlands Regional Health network Charitable Trust has a $34,500 for a Midland Health Network
* LMC services and Midwifery and Maternity Providers Organisations have a $60,000 contract for ‘Data to Support the 'Better Help for Smokers to Quit' Maternity Health Target’;
* Healthshare have a $150,000 project for Midlands DHB governance;
* Smokechange have a $285,000 contract for training midwives to support pregnant women to stop smoking.

# Methods

Data for mapping these services was obtained from a variety of sources (some of these are not available publicly and so should be treated as confidential):

* Six monthly reports from DHBs covering their tobacco control or smokefree DHB contracts provided to the Ministry of Health covering either 2012 or 2013 activities.
* Information Supporting the Estimates (ISE) reports detailing Public Health Unit activity.
* The listed smokefree coordinators for all 20 DHBs were approached and asked to complete a template to provide data on all cessation activities they were aware of in their region funded by the health system. Sixteen responses were received.
* For each DHB a summary page was prepared with all information we had drawn from their submitted reports, their responses to our data requests and any other information we had obtained, these were then sent to the contact person at the DHB and they were asked to comment.
* Data was also drawn from the MoH contracts database provided by the Ministry of Health.
* Information on AKP, Pacific Cessation and Pregnancy stop smoking services was taken from the monitoring dataset compiled by Datapeople for the Ministry of Health.
* Information on Quitline was from their annual reports and reviews and data provided on their website.
* Other information was drawn from the websites and published annual reports of DHBs and Public Health Units, the website of the smokefree coalition and ASH.
* A number of unpublished Ministry of Health documents were also consulted during this study.

The 2013 census data has been used to measure the need for cessation services for the total, Maori and Pacific populations. The numbers we have received are total responses so that someone identifying with more than one ethnicity will be counted in both sub-populations. The sum of sub populations therefore exceeds the total population. In addition some DHBs also make estimates of the population for which they provide services that differ from census figures due to individuals being non-present on census night or for other reasons. These estimated resident population figures are not yet available for the 2013. We have therefore used 2013 total responses rather than estimated residents based on 2006 Census figures.

We report first on mapping Smoking Cessation Services, then Health Promotion/Advocacy, Enforcement and Research.

# Smoking Cessation Services funded by the Ministry of Health

Quitline is the only provider of cessation services at a national level. The MoH funds services at a local level through its direct contracts with AKP providers, Pacific providers and providers of services to pregnant women who smoke. Local services are also provided by DHBs through contracts with the MoH.

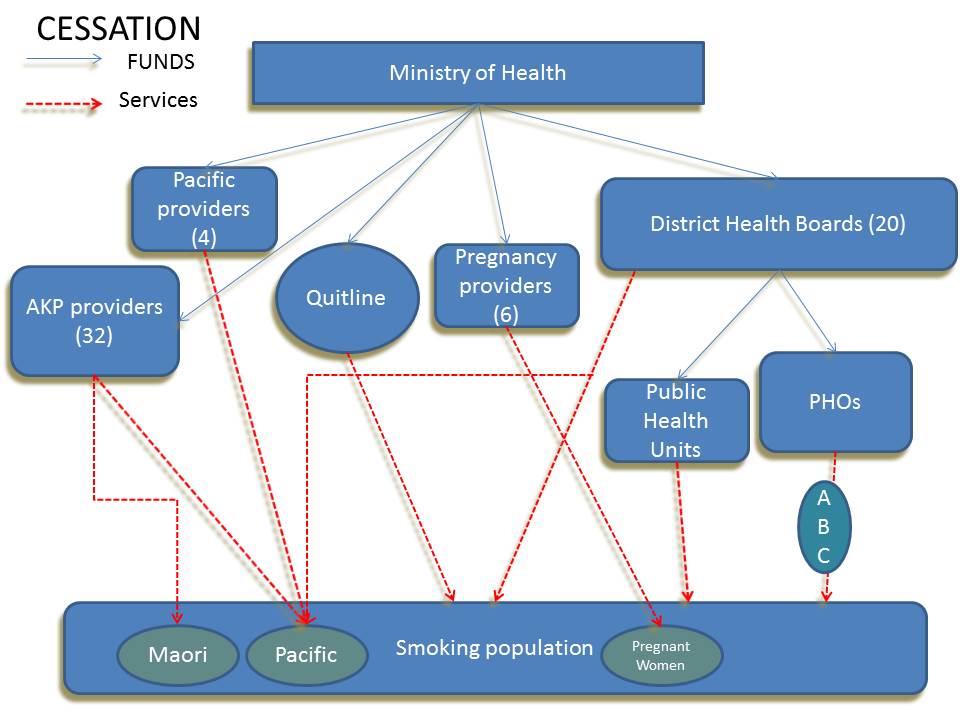


Figure 1: Structure of cessation services

**Quitline:**

Quitline’s current contract with the MoH for the financial year beginning 1/7/2013 is for $9.4 million.

Unlike the previous financial year where there were 5 contracts covering Quitline activity in the 2013/14 financial year there is only one. The contract has the same overall value and the tobacco control purchase code.

Table 4: Quitline contracts with the MoH

|  |  |  |  |
| --- | --- | --- | --- |
| Contract number | Contract purpose | FY | Value |
| 335831 | Tobacco Control Core Service | 2012/13 | $6.4 |
| 335831 | Text Service – tobacco control | 2012/13 | $0.5 |
| 335831 | Quitline capability and capacity | 2012/13 | $1.6 |
| 335831 | Mass media campaigns | 2012/13 | $0.8 |
| 335831 | Quitline capacity extra hours | 2012/13 | $0.15 |
| 335831 | Smoking Cessation | 2013/14 | $9.4 |

**Costing**

A costing report for the Quitline service suggested it cost $187 per supported quit attempt and $743 per four week self-reported quitter.

**Reach**

The annual review for 2012/13 stated that Quitline supported 50,297 quit attempts as opposed to 62,580 the previous financial year. There appears to be quite high variation in the number of people who contact the Quitline between various years. Given 463,194 smokers in New Zealand this suggests that Quitline has contact with between 8-10% of them over the year which is a high penetration rate (e.g. compared with 3.6% in Australia ([192](#_ENREF_192))). 10,748 of those supported quit attempt were for Maori (about 8% of Maori smokers), 2,716 were Pacific (or 6% of Pacific smokers).

The following table shows the quit attempts registered with Quitline compared with the number of Maori or Pacific smokers. Noticeably low levels are for Pacific Peoples in Counties Manukau, Auckland and Waitemata. The number registering as compared to the number of smokers is well below that in the general population.

According to the Gravitas report on Quitline ([193](#_ENREF_193)) the intention to treat seven day point prevalence for all smokers after 12 months was 20.9%. For non-Maori/non-Pacific this was 21.6%, for Pacific 18.9% and for Maori 16.4%. Therefore Maori do not quit after receiving Quitline services to the same degree as non-Maori. However, younger people and those who only accessed Quitline by phone had much lower quit rates and greater representation of Maori in those groups may partially account for their lower quit rates.

Table 5: Quitline Registrations by priority groups: July 2012-June 2013

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Maori | % of smokers in that DHB | Pacific | % of smokers in that DHB |
| Auckland | 693 | 12% | 477 | 7% |
| Bay of Plenty | 586 | 6% | 51 | 8% |
| Canterbury | 595 | 8% | 96 | 5% |
| Capital and Coast | 561 | 11% | 201 | 6% |
| Counties Manukau | 1031 | 7% | 661 | 5% |
| Hawke's Bay | 468 | 6% | 43 | 5% |
| Hutt Valley | 352 | 8% | 116 | 6% |
| Lakes | 472 | 7% | 38 | 7% |
| MidCentral | 534 | 9% | 62 | 7% |
| Nelson/Marlborough | 175 | 7% | 16 | 5% |
| Northland | 663 | 7% | 45 | 7% |
| South Canterbury | 46 | 6% | 8 | 12% |
| Southern | 420 | 9% | 72 | 9% |
| Tairawhiti | 174 | 4% | 4 | 2% |
| Taranaki | 317 | 8% | 16 | 7% |
| Waikato | 1005 | 6% | 103 | 6% |
| Wairarapa | 57 | 4% | 10 | 7% |
| Waitemata | 711 | 9% | 297 | 6% |
| West Coast | 26 | 4% | 1 | 2% |
| Whanganui | 165 | 5% | 13 | 5% |

|  |
| --- |
| Summary points for Quitline |
| There were approximately 40,000 – 60,000 quit attempts supported by Quitline per year Quitline was utilised by 8 – 10% smokers nationally (8% Maori; 6% Pacific)There was variation in accessing Quitline across DHB areas:  * + General population 5 - 13%   + Maori 4 - 12%   + Pacific 2 - 12%  Cost $187 per supported quit attempt and $743 per 4 week quitter (self-report) Quit rate ( self reported 7-day point prevalence measured using intention to treat) of 20.9, lower for Maori and Pacific smokers |

## Aukati Kaipaipa (AKP)

### Introduction

Aukati Kaipaipa (AKP) is a by Māori for Māori smoking cessation programme funded by the Ministry of Health. In the current AKP contracts list there are 32 providers and total funding for the 2013-14 financial year was $5.8 million.

Detailed data on AKP including the number of referrals, enrolments, achieved outcomes and therapies used are provided by Datapeople.

AKP services do not fit geographically within the DHB structure, sometimes one DHB catchment area has more than one AKP provider and sometimes (for example with Canterbury, South Canterbury and West Coast) a single AKP provider covers more than one DHB. This will be discussed further in the DHB sections below.

The structure of AKP has evolved rather than been designed to meet gaps in or to complement other cessation services. The services vary in their funding and the number of clients they are expected to enrol. A few providers are sufficiently large and based in urban areas and can provide consistent cessation services. Smaller providers, often with one or less FTE quit support counsellor, and based in rural areas are vulnerable to the loss of, or difficulty of recruiting, key staff.

Table 6: AKP providers

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Name | Region | Resources funded by MoH | F/Y 2013/14 | Number of people enrolled 2012/13 | Cost per Enrolment | Validated (self reported) Abstinence Rate at 4 weeks |
| Te Kupenga Hauora-Ahuriri | Hawke’s Bay, Napier | Two full time workers group or individual cessation advice | $179,906 | 269 | $668 | 21% (35%) |
| Whaiora Whanui Trust | Wairarapa | (1 FTE quit coache 0.5 FTE health promoter now seems to be one)  Group sessions | $180,000 | 200 | $900.00 | 27% (41%) |
| Te Awhina Marae O Motueka Society Incorporated | Nelson- Marlborough DHB Motueka only | (0.5 FTE Smoking cessation coach (2009) | $45,000 | 36 | $1250 | 58% (67%) |
| Te Runanga O Raukawa | Mid-Central | 2 FTE quit coaches (2009) | $180,000 | 150 | $1200 | 14% (24%) |
| Te Roopu Tautoko Ki Te Tonga Incorporated | Southern (Dunedin) | 1 FTE Quit coach, 0.2 admin (2009) | $101,538 | 125 | $812 | 44% (79%) |
| Te Ha O te Oranga o Ngati Whatua | Kaipara district of Waitemata DHB | 1.5 FTE quit coach, 0.25 admin, 0.2 coordinator (2009) – no current info | $135,000 | 149 | $906 | 11% (17%) |
| Kokiri Marae Keriana Olsen Trust | Capital & Coast/Hutt Valley | 5.5 FTE quit coaches, 0.7 admin, 1 quit coordinator | $575,350 | 496 | $1160 | 14% (21%) |
| Tipu Ora Charitable Trust | Lakes (Rotorua) | 1 FTE quit coach, 0.1 admin | $90,000 | 91 | $989 | 17% (94%) |
| Te Oranganui Trust Incorporated | Whanganui | 2.5 FTE quit coaches (2009) | $225,000 | 301 | $748 | 27% (32%) |
| Nga Kete Matauranga Pounamu Charitable Trust | Southland | 1 FTE quit coach, 0.5 admin (2009) | $101,538 | 133 | $763 | 39% (47%) |
| Te Kohao Health Limited | Hamilton/ Cambridge/ Te Awamatu | 1 quit coach, 0.5 admin (2009) | $90,000 | 116 | $775 | 28% (32%) |
| Te Korowai Hauora o Hauraki Incorporated | Hauraki/ Coromandel | 1.3 FTE quit coaches (2009) | $112,768 | 193 | $584 | 14% (36%) |
| Te Hauora O Turanganui A Kiwa Limited | Tairawhiti | 2 FTE quit coaches (2009)  4 quit coaches (2013) | $180,000 | 242 | $744 | 54% (56%) |
| Te Hauora O Ngati Rarua Ltd | Malborough/ Wairau | 1 FTE quit coach (2009) | $90,000 | 90 | $1000 | 8% (13%) |
| Taumarunui Community Kokiri Trust | Ruepehu District - Waikato | 1 FTE quit coach (2009) | $90,000 | 143 | $629 | 8% (18%) |
| Raukura Hauora O Tainui Trust | Counties Manukau | 3 FTE quit coaches 0.5 admin (2009) | $270,000 | 362 | $746 | 33% (44%) |
| Ngati Ruanui Tahua Trust | South Taranaki/ New Plymouth | 1 quit coach, 0.1 admin (2009) | $90,000 | 125 | $720 | 30% (40%) |
| Ngati Whatua O Orakei Health Clinic Limited | Auckland | 3.5 FTE Quit coaches 0.5 admin (2009) – no current info | $415,000 | 514 | $807 | 24% (30%) |
| Nga Miro Charitable Trust | Waikato (North) | 1 quit coach 0.3 Health promoter | $90,000.00, | 138 | $652 | 39% (45%) |
| Ngati Porou Hauora Charitable Trust | Tairawhiti | 2 FTE quit coaches, 0.2 admin | $180,000 | 363 | $496 | 10% (19%) |
| Korowai Aroha Trust | Lakes (Rotorua) | 1 quit coach, 0.2 admin (2009)  Now 2 quit coaches? | $90,000 | 220 | $409 | 33% (59%) |
| Nga Kakano Foundation | Western Bay of Plenty | 3 FTE quit coaches | $270,000 | 409 | $660 | 34% (37%) |
| Canterbury DHB/Community and Public Health | Canterbury/ South Canterbury and West Coast | 3.6 FTE quit coaches, 0.3 admin (2009) | $334,621 | 559 | $599 | 33% (42%) |
| The Ngati Maniapoto Marae Pact Trust Incorporated | Waitomo/ Otorohanga | 1 FTE Quit coach, 0.5 admin (2009) | $90,000 | 98 | $918 | 36% (50%) |
| Whakatu Marae Committee Inc | Nelson | 1 FTE quit coach (2009) | $90,000 | 161 | $559 | 11% (17%) |
| Tuwharetoa Health Charitable Trust | Lakes (Taupo) | 1 FTE quit coach, 0.1 admin (2009) | 90,000 | 121 | $743 | 13% (15%) |
| Tui Ora Limited | New Plymouth | 2 FTE quit coaches, 0.5 admin (2009) | $228,000 | 182 | $1253 | 13% (35%) |
| Te Runanga O Kirikiriroa Charitable Trust | Waikato | 2.7 FTE quit coaches, 0.3 quit coordinator (2009) | $244,000 | 290 | $841 | 14% (29%) |
| Ngati Awa Social and Health Services Trust | Eastern Bay of Plenty | 2 FTE quit coaches (2009) | $180,000 | 250 | $720 | 81% (83%) |
| Te Taiwhenua o Heretaunga | Central Hawke’s Bay | 2 FTE quit coaches, 0.2 admin (2009) | $180,000 | 240 | $750 | 32% (52%) |
| Te Hauora O Te Hiku O Te Ika | Northland | 3FTE quit coaches (2009) | $274,000 | 436 | $628 | 39% (42%) |
| Ngati Hine Health Trust Board | Northland | 3FTE Quit coaches (2009) | $274,000 | 301 | $910 | 35% (38%) |

The following table maps AKP providers onto DHB regions. Columns c to j are all from data. In columns k and l we have attempted to calculate an indicator of the capacity of the AKP service in relation to the number of Maori smokers in that DHB

Some AKP providers cover more than one DHB region. These providers are italicized. For those we have assigned (in column k) attributable quitting clients to each DHB by the proportion of Maori smokers in each DHB. Some DHBs have more than one AKP provider. Here we have assigned total quit attempts as the sum of the AKP providers clients setting Target Quit Dates (TQDs). We have then expressed this (in column l) as a percentage of the total number of Maori smokers in each DHB. This is one indicator of the extent of the service provision in an area relative to its need.

On this indicator Auckland DHB is not well served with a provider with quite a low capacity compared to the number of Maori smokers. Counties Manukau has an even lower figure (but they have the Mangopare Maori service which is not an AKP provider but is partly funded by the MoH). Tairawhiti and Wairarapa seem relatively well served both with large capacity AKP providers relative to their populations of Maori who smoke. Nelson Marlborough also seems relatively well served but its main AKP provider, Whakatu Marae, has far more Pacific clients (Tongans) than Maori.

We also calculate another indicator based on the attributable Target Quit Date (TQD) figures (column k), the percentage of Maori in the clients who have set a TQD (column g) and the three months abstinence rate (column d) to generate a figure as to the number of Maori who have quit (column m). So for example, for Auckland we have 211 clients setting TQD with the Ngati Whatua o Orakei Health Clinic. Of these 45% are Maori (=95) and the abstinence rate at three months is 21% given 19 quits. This is clearly a small percentage of the total number of Maori smokers in Auckland, 5,637. In only Bay of Plenty, Northland and Tairawhiti are quits more than 2% of the smoking population. Those areas that are relatively successful have a combination of high numbers of clients setting TQDs as a percentage of the target population, good quit rates and high percentage of Maori clientele. Note that this is not quit rates by AKP provider but quit rates averaged over the AKP providers associated with each DHB area.

The table also includes for completeness providers of cessation services primarily for Maori who are not funded through AKP contracts with the Ministry of Health. These include a Te Whare Hauora O Ngongotaha in Lakes and Uruuruwhenua Health in Southern. As they are not AKP providers we have no data on quit rates for them.

Table 7: AKP Providers by Region

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | AKP provider | Enrolments 2012/13 | Validated Abstinence rate 3 months | Pregnant women | Clients with TQD | % Maori | % receiving NRT | % more than 4 sessions | Maori Smokers | Attrib. | Attr % of Maori Smokers | Maori quits |
| a | b | c | d | e | f | g | h | i | j | k | l | M |
| Auckland | *Ngati Whatua o Orakei Health Clinic* | 514 | 21% | 12 | 503 | 45% | 87% | 88% | 5,697 | 211 | 4% | 19 |
| Bay of Plenty (1) | Nga Kakano Foundation | 409 | 47% | 40 | 409 | 67% | 95% | 88% | 10,062 | 661 | 7% | 281 |
| Bay of Plenty (2) | Ngati Awa Social & Health Services | 250 | 71% | 11 | 252 | 90% | 85% | 18% |  |  |  |  |
| Canterbury | *Community and Public Health Canterbury* | 559 | 28% | 28 | 570 | 55% | 89% | 69% | 7,395 | 477 | 6% | 75 |
| Capital and Coast | *Kokiri Marae Keriana Olsen Trust* | 496 | 12% | 14 | 528 | 63% | 86% | 97% | 4,974 | 275 | 6% | 20 |
| Counties Manukau | Raukura Hauora O Tainui | 362 | 25% | 16 | 361 | 88% | 87% | 50% | 14,751 | 361 | 2% | 80 |
| Hawke's Bay (1) | Te Kupenga Hauora Ahuriri | 269 | 20% | 10 | 261 | 83% | 98% | 96% | 7,695 | 492 | 6% | 90 |
| Hawke's Bay (2) | Te Taiwhenua o Heretaunga | 240 | 26% | 3 | 231 | 78% | 84% | 80% |  |  |  |  |
| Hutt Valley | *Kokiri Marae Keriana Olsen Trust* | 496 | 12% | 14 | 528 | 63% | 86% | 97% | 4,587 | 253 | 6% | 19 |
| Lakes (1) | Korowai Aroha Health Centre | 220 | 27% | 4 | 221 | 79% | 80% | 91% | 6,876 | 437 | 6% | 90 |
| Lakes (2) | Te Whare Hauora O Ngongotaha |  |  |  |  |  |  |  |  |  |  |  |
| Lakes (3) | Tipu Ora | 91 | 49% | 14 | 103 | 82% | 44% | 93% |  |  |  |  |
| Lakes (4) | Tuwharetoa Health Services Limited | 121 | 6% | 3 | 113 | 71% | 93% | 80% |  |  |  |  |
| MidCentral | Te Runanga O Raukawa | 150 | 5% | 3 | 162 | 56% | 72% | 54% | 5,667 | 162 | 3% | 5 |
| Nelson/Marlborough (1) | Whakatu Marae Committee Ltd | 161 | 11% | 0 | 162 | 19% | 97% | 26% | 2,337 | 285 | 12% | 14 |
| Nelson/Marlborough (2) | Te Awhina Marae O Motueka Society | 36 | 44% | 2 | 34 | 41% | 82% | 78% |  |  |  |  |
| Nelson/Marlborough (3) | Te Hauora O Ngati Rarua | 90 | 12% | 5 | 89 | 54% | 95% | 92% |  |  |  |  |
| Northland (1) | Te Hauora O Te Hiku O Te Ika | 436 | 36% | 16 | 437 | 72% | 85% | 83% | 9,474 | 710 | 7% | 213 |
| Northland (2) | Ngati Hine Trust | 301 | 47% | 10 | 273 | 80% | 76% | 85% |  |  |  |  |
| South Canterbury | *Community and Public Health Canterbury* | 559 | 28% | 28 | 570 | 55% | 89% | 69% | 753 | 49 | 6% | 8 |
| Southern (1) | Uruuruwhenua Health |  |  |  |  |  |  |  | 4,908 | 247 | 5% | 46 |
| Southern (2) | Te Roopu Tautoko ki te Tonga | 125 | 27% | 0 | 112 | 66% | 100% | 69% |  |  |  |  |
| Southern (3) | Nga Kete Matauranga Pounamu Trust | 133 | 36% | 3 | 135 | 50% | 90% | 93% |  |  |  |  |
| Southern (4) | Tokomairiro Waiora |  |  |  |  |  |  |  |  |  |  |  |
| Tairawhiti (1) | Ngati Porou Hauora | 363 | 14% | 14 | 377 | 74% | 74% | 21% | 4,488 | 621 | 14% | 133 |
| Tairawhiti (2) | Te Hauora O Turanganui A Kiwa | 242 | 52% | 11 | 244 | 74% | 87% | 85% |  |  |  |  |
| Taranaki (1) | Tui Ora Limited | 182 | 4% | 6 | 198 | 41% | 87% | 60% | 3,843 | 345 | 9% | 25 |
| Taranaki (2) | Ruanui Health Centre | 125 | 31% | 2 | 147 | 54% | 97% | 25% |  |  |  |  |
| Waikato (1) | Te Runanga O Kirikiriroa Trust | 290 | 17% | 9 | 253 | 65% | 81% | 66% | 15,870 | 960 | 6% | 140 |
| Waikato (2) | Nga Miro Charitable Trust | 138 | 39% | 4 | 146 | 81% | 83% | 100% |  |  |  |  |
| Waikato (3) | Te Korowai Hauora O Hauraki | 193 | 15% | 2 | 192 | 41% | 69% | 24% |  |  |  |  |
| Waikato (4) | The Ngati Maniapoto Marae Pact Trust Inc | 98 | 41% | 2 | 99 | 62% | 90% | 75% |  |  |  |  |
| Waikato (5) | Te Kohao Health Limited | 116 | 28% | 1 | 116 | 72% | 97% | 74% |  |  |  |  |
| Waikato (6) | Taumarunui Community Kokiri Trust | 143 | 12% | 15 | 154 | 68% | 85% | 62% |  |  |  |  |
| Wairarapa | Whaiora Whanui Trust | 200 | 28% | 4 | 202 | 32% | 72% | 65% | 1,410 | 202 | 14% | 18 |
| Waitemata (1) | Te Ha O Te Oranga O Ngati Whatua | 149 | 10% | 2 | 153 | 63% | 90% | 93% | 7,863 | 445 | 6% | 40 |
| Waitemata (2) | *Ngati Whatua o Orakei Health Clinic* | 514 | 21% | 12 | 503 | 45% | 87% | 88% |  |  |  |  |
| West Coast | *Community and Public Health Canterbury* | 559 | 28% | 28 | 570 | 55% | 89% | 69% | 687 | 44 | 6% | 7 |
| Whanganui | Te Oranganui Iwi Health Authority | 301 | 28% | 8 | 271 | 77% | 77% | 67% | 3,204 | 271 | 8% | 58 |

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| Summary points for AKP |
| 32 providers, primarily but not exclusively for Maori Total number of referals 2012-13 10,342.Total number of people enrolling into the programme 2012- 13; 7,503 Variation across DHB areas  * + - Validated quit rates at three months vary from 4% to 71% with an average of 27%  Costed $410-$1,250 per enrolment and $1,400 -$9,500 per 4 week quitter (validated) |

### Pacific Stop Smoking Services

There are four providers listed as being funded directly by MoH contracts. The table also includes DHBs that receive funding for Pacific cessation services but do not provide them directly.

The average 3-month validated quit rate for Pacific cessation providers is 27%, the same as for the AKP providers. However this masks the fact that Pacific Health Trust Porirua has a low validated rate. The costs per enrolment is within the range of AKP providers if slightly more expensive. Costs per 4-week validated quitter vary widely because of the variation in quit rate ranging between almost $14,000 for the Pacific Trust Porirua and $2,800 for K’aute Pasifika in Waikato.

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Provider | Area | Contracted service | Funded | Enrolments | 3-month Self report (validated) Abstinence | Contract value | Cost/Enrolment | Cost/4-week validated quitter |
| K’aute Pasifika | Hamilton, Tokoroa |  |  | 282 | 48% (46%) | $ 207,670 | $ 736 | $2,806 |
| Auckland Regional Public Health Service | Auckland/Waitemata | Pacific Smoking Cessation service | Funded by ADHB and WDHB $116,420 (ARPHS report gives a budget of $402,000 and 4.11 FTE – for 2013/14 this is 4.46 FTE but still $402,000) | 354 | 56% (32%) | $ 402,000 | $ 1,136 | $7,444 |
| Pacific Health Service Porirua Incorporated | Capital and Coast DHB Porirua |  |  | 401 | 29% (6%) | $ 404,800 | $ 1,009 | $13,959 |
| South Seas Health Service | South Auckland |  |  | No information |  |  |  |  |
| Waitemata DHB |  | Pacific Cessation Services |  | No Information |  |  |  |  |
| Counties Manukau DHB |  | Pacific Cessation Services |  | No information |  |  |  |  |
| Auckland DHB |  | Pacific Cessation Services |  | No Information |  |  |  |  |
| Pacific Trust Canterbury |  | Pacifika Smoking Cessation and Health Promotion |  | 199 | 40% (36%) | $ 170,000.00 | $ 854 | $3,269 |

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| --- |
| Summary points for Pacific stop smoking services |
| 10 regional providers, 4 with MoH contracts; areas covered include: Auckland, Waitemata, Waikato, Capital and Coast, Hutt Valley, Counties Manukau, and CanterburyEnrolments range between 200-400 in 2012/13. The average quit rate (abstinence at three months validated) is 27% but varies between 9% and 46% (cost per enrolment varies between $730 and $1136 and per validated 4-week quitter between $2,800 and $13,900 |

### Pregnancy Stop smoking Services

There are six providers contracted by the MoH to provide services to pregnant women who smoke. These services have quite a high level of resources when compared with many AKP providers and the cost per enrolment when we look at the contract cost divided by the number of clients is, in most cases, high relative to AKP. This is exacerbated further when we look at the cost per four week validated quitter or abstainer. Smokechange for example only had five validated quitters in 2012/13 whereas Mangere Communiy Health Trust had none. (MoH suggested this could be a result of validation not being used for these providers until late in the year as self reported abstinence is high but we have no further information.)

Table 8: Services for pregnant women who smoke

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Provider | Area | Contract | MoH contract 2013/14 | Enrolments 2012/13 | SR (validated) 4-week abstinence | Cost/enrolment | Cost/4-week quitter |
| Waitemata PHO (as Comprehensive Care) | Waitakere, North Shore, Rodney |  | $317,000 | 208 | 40% (22%) | $1,524.04 | $14,409.09 |
| Auckland DHB | Auckland DHB area |  | $338,698 | 205 | 30% (20%) | $1,652.19 | $9,154.00 |
| Mangere Community Health Trust | Counties Manukau |  | $301,395 | 208 | 39% (0%) | $1,449.01 | na |
| Kahungunu Health Services | Hastings area |  | $144,310 | 154 | 32% (14%) | $937.08 | $2,886.20 |
| Nga Kete Matauranga Pounamu Charitable Trust | Southland | AKP service with pregnancy cessation (see above) | $85,000 | 160 | 47% (33%) | $531.25 | $1,370.97 |
| Smokechange | Canterbury, |  | $357,491 | 325 | 77% (5%) | $1,099.97 | $71,498.20 |

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| --- |
| Summary points for pregnancy stop smoking services |
| Six local providers, areas covered include: Auckland, Waitemata, Counties Manukau, Hawke’s Bay, Southern, and Canterbury Quit rates (validated abstinence rate at three months) vary between 2% and 36% Enrolments range: 154 and 325 a year. All but one of the pregnancy providers were well short of their target enrolments. (Referrals 1841, Enrollments 1260). Cost per enrolment varied between $531 and $1652 |

## Cessation Service provided at DHB Level

### DHB six monthly report to MoH

Six monthly reports against DHB contracts were provided by Ministry of Health for 19 DHBs. Table 11 provides a summary of these data.

Table 9: Cessation services and support provided by DHB (from reports)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| DHB | Reporting Period | % Given Brief Advice[[1]](#footnote-1) | Training of Health workers | Smokefree and/or Cessation Services |
| Canterbury | Jan –Jun 2013 | * Increased from 91% in Q3 to 93% in Q4. * All CDHB PHOs consistently achieving above the 70% threshold for the PPP indicator of smoking status ever recorded. | * 33 CDHB staff were supported to make a quit attempt. * 44 pharmacy staff have completed the ABC E-learning training. * 483 Quitcards have been issued in the January – June period. * Provided additional on-site ABC training to 20 pharmacy staff member. * A full day cessation training course has been delivered to 22 PNs, and one two-hour update sessions around ABC and Cessation to a further 11 PNs. * 523 people in the CDHB area have done the E-learning / cessation training in the period, of which 286 were from CDHB Secondary care locations. * 668 people (CDHB secondary care staff, General Practice staff, pharmacy staff, dentists, and other primary care provider staff) attended 42 formal ABC training sessions during this period. * Eight Smokefree ABC sessions were provided to 40 4th year medical students. * 11 training sessions have been provided to the Southern Cross (private hospital) staff . * Cessation and ABC training (full day) was provided to 22 nurses across the three PHOs. * A poster targeting staff outlining constraints and requirements, has been widely distributed within the hospitals. | * 267 Hospitals to Quitline calls. * 37 referrals from the CDHB to AKP. * 69 referrals from the CDHB to Smokechange. * An average of 500 Quitpacks are given to inpatient and outpatients who smoke per month. * A total of 2645 callers to Quitline were from people in the CDHB area. * 2003 enrolments to PEGS (Pegasus GP delivered cessation programme). * A total of 3824 Quitcards were issued to providers in the CDHB area. |
| Counties Manukau |  | No report received |  |  |
| Waitemata | Jan –Jun 2012 |  | * Hosted and facilitated an ABC training sessions for health care workers in aged residential care. * Hosted and facilitated an ABC education session for dentists in the Auckland region. * Secondary Care staff including both inpatient and outpatient services have trained all staff in the ABC approach. * More than 85% of health professional staff at PHOs has completed ABC training. * About 50% of the mental health professionals have completed ABC or Heart Foundation training. * The Smokefree Team provides the mandated ABC training for all New Grads, Orientation Training, Return to Nursing staff, RMOs, and recently, updates for the hospital and community based Midwives. Specialty Smokefree training has been also developed and delivered for those working in Surgical and Child Services. Secondary Care also has 31 out of 34 services with a smokefree lead trained using the STEPS programme across both hospital sites. They are supported and resourced by the Smokefree Team. Smokefree training is also delivered to 3rd Year Nursing Students in collaboration with Massey University before the students commence their placements. * To support inhouse Smokefree training, Waitemata DHB has also created an NRT e-learning module for its staff alongside the development of supportive paper based resources |  |
| Waikato | Jan –Jun 2013 | * Achieved target in Quarter 4 2013 | * ABC training for all Waikato DHB was delivered by Smokefree Coordinator * Provided training in ABC smoking cessation, tobacco control and pharmacotherapy to undergraduate student nurses at Wintec. | * 402 clients enrolled at “Wrap Around” service with 148 successfully quit for 6 months |
| Auckland | Jul – Dec 2012 | * PHO: ranging from 30% to 50.4% * ADHB: rising from 93.9% in July to 97.1% in December | * Provided ABC training to a total of 627 attendees (note: staff can attend several training sessions) * 154 staff completed ABC of Smoking Cessation e-learning programmes * 64 staff registered as Quit Card Providers * Supported 6 staff to quit * Constantly updating ADHB Intranet Smokefree site   Jul – Dec 2013   * Provided ABC training to a total of 385 attendees (note: staff can attend several training sessions) * 77 staff completed ABC of Smoking Cessation e-learning programmes * 64 staff registered as Quit Card Providers * Supported 6 staff to quit * The PHOs have also provided training to their GPs and nurses and some health care assistants. The PHOs have a target of 85% of health professional staff trained in the ABC approach (including how to document). It is unknown how many have been trained to date. The PHOs provide training updates when their Practice Liaison Teams visit GPs and through Cell Group education. * The DHB has facilitated training for dentists and mental health staff employed by NGOs | * 582 referrals to ADHB Smokefree services (203 referrals contacted) * 184 pregnant women referred to ADHB Smokefree Pregnancy Service, 90 enrolled |
| Southern | Jul - Dec 2013 | * The Secondary Care Health Target has been achieved for Quarter 1 (95.9%) and 2 (95.8%). * The Primary Care Health Target improved steadily over the last six months, reaching 60% in Q1. | * Educated 326 staff in Secondary care on Smokefree best practices. * ABC sessions were provided through mandatory training to nursing and allied health staff, and regular updates to ward staff as required about ABC. * 62 people have accessed the online education module from August 2013 to December 2013. * Quitcard training delivered to 86 allied health staff. 11 staff in Secondary care and 82 staff in other Primary care registered as Quit Card Providers in this reporting period (in total there are 3,338 Quitcard providers across the district). * Smokefree education sessions, including the 2025 goal was delivered to 27 practice nurses, 16 practice managers and 70 allied health workers. * Group smokefree education sessions were delivered to 27 nurses on the health target, Smokefree 2025, respiratory conditions and asthma management. * A one-day Quitcard training was delivered to 6 Probation Officers from the Central Otago, Southland region. | * Established group based cessation sessions with DHB staff based at the PHO. * The AKP provider contracted by the DHB has seen a total of 39 Maori clients for Central and South Otago over the last 6 months. |
| Capital & Coast | Jan –Jun 2013 | * Health Target achieved | * Worked with the Learning Development and Research Team at CCDHB to upgrade the resources, including the powerpoint and handout for the Smokefree and Nicotine Replacement Therapy Competency E-Learning ward training. * The Capital & Coast DHB (CCDHB) ABC Facilitator provided training, education and ABC champion role focused on workforce development service for health professionals throughout primary and secondary care to up skill them in the ABC approach to smoking cessation in their practice, and to ensure that evidence based smokefree advice is provided to the community. This ABC Facilitator is managed through Ora Toa PHO, and is proactive in providing ABC training to eligible services throughout the CCDHB. |  |
| Bay of Plenty | Jan –Jun 2012 | * Brief Advice/Cessation Support/Referral:   - Eastern BOP PHA = 21.1% (Q1) & 27.0% (Q2)  - Nga Mataapuna Oranga Ltd = 32.1% (Q1) & 36.8% (Q2)  - Western BOP PHO = 39.1% (Q1) & 41.8% (Q2)   * Tobacco Health Target of 91% was reached | * Te Hotu Manawa Maori in collaboration with Nga Kakano Foundation have trained 15 smokefree champions * The THMM District Smoking Cessation Trainer programme have trained 40 people * Opotiki Hospital at 100% trained * Whakatane Hospital at 90% trained * Tauranga Hospital at 90% trained | * Made 536 referrals to local cessation providers and the Quitline |
| Mid central | Jan –Jun 2013 | * Targets have not yet been met but the proportion of primary care patients who smoke being provided with brief advice has increased to 67%. |  | * 555referrals were received by Te Ohu Auahi Mutunga (TOAM). The Mātanga situated at the Public Health Unit on the MidCentral site received **458** referrals triaging 176 to TOAM and the rest to Quitline, AKP or their home address service. TOAM ensured all referrals are contacted within 48 hours of receipt of referral. |
| Northland | Jan –Jun 2013 | * Has been exceeding the 95% target since Oct 2012 |  | * 150 smokers took part in the WERO Group Stop Smoking Competition. Preliminary results showed a 40% quit rate at the end of the competition. |
| Hawke’s Bay | Jan –Jun 2013 | * Average of 98.7% per month | * Completed staff development plan and delivery of smokefree education with Te Kupenga Hauora Ahuriri. | * 7 teams of 10 smokers took part in the WERO Group Stop Smoking Competition (i.e., N=70). At 2 weeks, 18 (out of 66 valid responses) indicated total abstinence in the previous 2 weeks. At 4 weeks, 30 (out of 61 valid responses) indicated 24 hour abstinence. |
| Hutt Valley | Jul –Dec 2012 | * Quarter 1 was 28.9%, Quarter 2 increased to 30.2% | * 4 practice nurses, 1 primary health nurse and 4 pharmacist received ABC training. * Provided a continuing medical education (CME) to 30 Hutt Valley GPs (staff from Aukati Kaipaipa and Pfizer were invited to support the session). * A presentation to raise awareness of the importance of smoking cessation in primary care was provided to an all-of-staff meeting at Kowhai Health. |  |
| Nelson Marlborough | Jan –Jun 2013 | * Target has been reached in all quarters except Q3 when it was 92.9% | * Several MHS staff members are trained to provide quit support * All MHS staff have completed the E-learning module and NMDHB Smokefree education | * Hospital-based cessation programme: abstinence rate at 4 weeks = 55%; abstinence rate at three months = 30.5% * Primary care based cessation programme: quit rate was between 33 and 40% |
| Taranaki | Jul –Dec 2012  Jul – Dec 2013 | * Reached 93.18% at December 2012 (it was 89.78% for the 6 months period ) * Base Maternity unit achieved 78.72% and Hawera Maternity unit achieved 83.33% for the 6 months period. * Between Jul – Dec 2013, 96% smokers received advice to quit * Between Jul – Dec 2013, Base Maternity unit achieved 95.30% and Hawera Maternity unit achieved 97.30% for the 6 months period. * The Primary Care Health Target improved steadily reaching 67% in Jul-Sep 2013. | * Provided training at Taranaki DHB weekly induction training and information day and the First year House Surgeons Training. * Smokefree/Auahi Kore Coordinator presented at the Western Institute of Technology for first year nursing students.   To date, approximately 88% of nurses and 50% of GPs have completed smoking cessation training (24 completed STEPS training, 53 completed ABC online module, and 75 completed National Heart Foundation modules/courses). | * 178referrals have been made; 49 resulted in uptake of quit support services * 793 Quit Card Products Issued |
| Lakes | Jan-Jun 2013 | * 100% smokers at Lakes DHB Mental Health Inpatient Unit received advice to quit and cessation support. * 95.8% smokers (in Q1) and 96.9% smokers (in Q2) received brief advice. * Women Child and Family Services reached 100% coverage of hospitalised smokers. | * Lakes Auahi Kore/Smokefree Coalition facilitated Smokefree Training and Workshops within Lakes region. * Smokefree coordinator continued to facilitate all training of ABC in the Lakes region. |  |
| Whanganui | Jul – Dec 2011 | * Secondary services has made the target of 95% (Jul- Sept was 96.2%, Oct- Dec was 95.5%) * PHO: 434 new quit attempts were made in the quarter (103 occurred with the Quit Clinic and 331 in General Practice); the 4 week quit rate with the Quit Clinic was 49% for the quarter | * 462 Staff completed training, 139 still to complete * Continued to provide ‘ask the elephant’ and STEPS face to face training to all staff across the hospital. * Provided following resources to clinical staff: NRT Workbook, NRT Quick Reference Guide, Quitcard Writing Guide, and Case studies x 10. * Presented at: Breastfeeding Study Day, Maternity ward Scheduled Tutorials, Tikanga Hauora, Health Care Assistants Study Day, and Marton Health Centre Update Session.   Quit Clinic   * By Dec 2013, Quit Clinic had trained over 50 health professionals including Nurses, YMCA staff, UCOL nursing students, hospital staff, WRHN staff, Registrar’s, and other smoking cessation workers. | * 73 referrals from the hospital to Quitline (38 contacted with 16 registered to quit) * Te Runanga o Ngati Apa: 6 staff registered Quit smoking programme, 9 clients registered on Aukati Kaipaipa programme * Ngati Rangi Community Health Centre: provided 24 people with cessation support   Quit Clinic   * Between Oct-Dec 2013, there were 92 new clients at Quit clinic * By the end of 2013, Quit Clinic established a referral youth clinic for young smokers aged between 12-19 |
| Tairawhiti | Jan –Jun 2013 | * Dropped to 83.3% over the summer period, targeted education was delivered to all staff and the rate was above 95% by June * Maternity unit achieved 100% since April. | * 2 STEP’s one-hour roadshows were held with 20 attendees |  |
| South Canterbury | Jan –Jun 2013 | * Target achieved for all quarters with June 2013 being 98.8% | * All newSCDHB staff have received ABC training at orientation * E-learning completed by 5 Secondary services staff, 5 students and 4 primary care staff during this period * STEP training was held with 6 new practice nurses attending * ABC e-learning was completed by 2 Private Hospital staff, 8 Mental Health NGO staff and 2 Corrections/Police staff * Provided support and advice at monthly GP forums. | * 168 referrals have been processed * 91 clients enrolled at AKP cessation service |
| Wairarapa | Jan –Jun 2013 | * Q3 was 96.4% and Q4 was 97.0% (was 96.7% for the 6 months period) | * Smokefree Coordinator (SFC) presented at: bi-monthly orientation days for new staff at Wairarapa DHB; Resident Medical Officers’ orientation; WDHB respiratory training days; the annual NEPT programme for new nurses; Orthopedic education day; and Practitioners Training. | * 45 people enrolled in the quit groups. Overall quit rate was 70%. * Whaiora received 125 referrals and 121 people joined the programme. |
| West Coast | Jan –Jun 2013 | * Secondary Care achieved 90.5% in Q1, 88.6% in Q2, 91.0% in Q3 and 94.5% in Q4 * Primary Care brief advice provided = 39.9% in Q1, 44.1% in Q2 and 53.6% in Q3. Cessation Support provided = 16.0% in Q1, 14.4% in Q2 and 13.2% in Q3. * Maternity ward consistently achieved 100% | * 4 DHB staff attended Quit Card Update session * 12 people attended Smoking cessation Practitioner training * All staff in WCDHB Mental Health services attended the mandatory smokefree training * Activities ran by the Smokefree Services Coordinator during this period included: PHO’s monthly orientation sessions on tobacco health target and smoking cessation services/programmes; a staff training session on the use of CO monitor at Maternity ward; an ABC Update session and a presentation on nicotine dependence for Rata Te Awhina staff. | * Cessation referrals: AKP (74), Coast Quit (265), WCDHB cessation services (255) and Quitline (144) |

The following individual sections are in order of the usually resident number of smokers within each DHB area from the 2013 census. This is likely to be less than the estimated resident population for some DHB areas (e.g. Counties Manukau, Auckland and Waitamata).

### Canterbury

|  |  |
| --- | --- |
| Population | 391,908 |
| Smokers | 52,212 |
| Maori Smokers | 7,395 |
| Pacific Smokers | 1,761 |

**General Cessation**

1. Quitline report 1,084 quit attempts by smokers in the Canterbury DHB area between July and September 2013, this is the highest number for all DHB areas.
2. In the Canterbury DHB area the general population receives cessation services provided by primary care physicians. Three PHOs fund this; Pegasus ($160,000 2013/14), Rural Canterbury ($55,000 2013/14) and Christchurch (no figure given). The Pegasus funded service has 804 patients (3% Asian, 77% European, 13% Maori, 2% Pacific, 4% other). The Rural PHO service has 55 patients Christchurch PHO has carried out 98 assessment sessions (last three months) and this is assumed to be different patients. Data is not provided on quit rates.

Canterbury DHB funds and provides some cessation support to staff and some people recruited from the community if they are unsuitable for other services.

**Cessation services for priority populations**

1. AKP provide face to face counselling and NRT funded by the MoH and provided by Community and Public Health Canterbury (CPHC) and Canterbury DHB. Overall CPHC received 728 referrals and enrolled 559 onto programmes, in excess of its yearly enrolment target of 396. The validated abstinence rate at three months was 28% and self reported was 42%. Of the 570 clients who set a target quit date during the year 373 were women and 28 were pregnant. 316/570 were Maori and 217/570 European, 89% received NRT. 30% of clients received less than four sessions, 36% received four to eight sessions and 32% nine to sixteen sessions. Canterbury DHB has a contract with an annual value of $334,000 to provide AKP services to Canterbury, West Coast and South Canterbury DHB areas.
2. Pacific Trust Canterbury provides cessation services to Pacific Peoples including counselling and NRT. It had 245 referrals during 2012-13 and enrolled 199 below its Minimum Expected Enrolment target of 240 per annum. The validated abstinence rate at three months was 36% and the self reported rate was 40%. Of the 207 clients who set a TQD during this year 113 were women and five were pregnant, 22/207 were Maori, 63/207 were Samoan and 32/207 NZ European. 60% did not receive any NRT or other pharmacology and 50% of those who set a TQD received between four to eight sessions of counselling. The MoH provides $170,000 a year to Pacific Trust for cessation services.
3. Services for pregnant women who smoke are provided by Smokechange. Patients are recruited from primary care and lead maternity carers. Smokechange received 442 referrals in 2012/13 and enrolled 325, below their minimum expected enrolment target of 420. The validated abstinence rate at three months was 6% well below the self reported figure of 73%. It is not clear why there is such a discrepancy between these figures (MoH suggested may be due to validated data being collected only part way through the reporting period). Of the 97 clients who set a TQD in this period 22 were men and 64 were pregnant women. 63/97 were NZ European and 19/97 Maori. Only 31/95 received any pharmacology and 56/95 received between four to eight sessions of counselling. Smokechange’s annual contract for 2013/14 is for $357,491.

### Counties Manukau

|  |  |
| --- | --- |
| Population | 391,908 |
| Smokers | 52,212 |
| Maori Smokers | 14,751 |

|  |  |
| --- | --- |
| **Pacific Smokers** | 14,736 |

**General Cessation**

1. Quitline supported 778 quit attempts from CMDHB in July to September 2013 and 630 from October to December. This is below the national proportion of smokers contacting Quitline. Between July to September 2212 Maori and 564 Pacific smokers and between October and December 2013 1898 Maori and 447 Pacific registered with Quitline. There is a big discrepancy between Maori and Pacific smokers contacting Quitline as there are about equal numbers of smokers in each ethnic group in Counties Manukau.
2. CMDHB Smokefree Service: This is a service that is mainly for patients referred from secondary care but is increasingly receiving referrals from other sources. The service provides two key functions:
   1. Specialist cessation service: intensive cessation support for clients requiring specialist support including inpatients, pregnancy, postnatal, mental health and other high needs, as well as non-Maori, non-Pacific clients that are less well catered for by external cessation services which prioritise Maori, Pacific and pregnancy. This support is delivered by experienced, trained Smoking Cessation Practitioners.
   2. Triage/Referrals Management: the service has a role in providing a first point of contact for all referrals received through secondary care, and increasingly from other sources. The service actively manages all referrals, providing feedback to referrers and monitoring client outcomes. All referred clients receive an initial phone assessment and are triaged according to their needs. They could receive a one-off conversation or NRT (or support to access other pharmacotherapies such as Champix), be referred to an in-house specialist for cessation support, or referred to a community-based cessation provider or to Quitline for cessation support.

A significant proportion of referrals received by some of the community-based services listed below come through this process.

For October to December 2013 there were 495 referrals to the service

Table 10: Counties Manukau DHB smokefree service

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | Maori | Pacific | European | Other | Unknown | Total |
| Referrals to service | 237 | 113 | 103 | 34 | 8 | 495 |
| Intensive in-house support | 29 | 3 | 25 | 1 |  | 58 |
| One-off intervention | 20 | 6 | 9 | 6 |  | 41 |

The majority of the 495 referrals are referred to a community-based cessation provider, followed by referrals to Quitline. The remainder are either uncontactable or declined

Included in the 495 were 142 referrals of in-patients of which 105 received a first assessment and were referred to a community-based cessation provider, 23received a one-off assessment only and 14 declined any support.

This service is funded from the main tobacco control contract for Counties Manukau. This contract has an annual value of $679,920 for the current financial year although this funds all tobacco control activity not just cessation.

1. The East Health Trust PHO also provides cessation support though a seven week quit smoking programme. The programme is group based and has been run eight times since May 2012. Since that time 168 people have registered for the programme and 90 completed. This programme receives no special funding from the MoH or DHB.
2. CMDHB (together with Waitemata PHO) received funding from the MoH Pathway to 2025 Innovation Fund to operate a mobile Quit Bus to provide smoking cessation support and advice and to distribute Nicotine Replacement products in hard to access areas. This project runs for three years with a budget of $1,881,766.

**Cessation Services for priority populations**

1. Smoking cessation services for Maori are provided by two programmes; the Aukati Kaipaipa and Mangopare Maori services. These programmes work in the same way and are both provided by Raukura Hauora O Tainui. Raukura Hauora o Tainui has a contract with the MoH for the Aukati Kaipaipa service with an annual value of $135,000. Raukura received 362 referrals and enrolled 362 on their programme in 2012/13 just above their minimum expected enrolment target of 360 for the year. The validated abstinence rate at three months was 25% and the self-reported rate was 68%. Of the 361 clients who set a TQD in this period 243 were women and 16 were pregnant. 318/361 were Maori. 316/361 received NRT as part of the programme and 203/361 had 4 or fewer counselling sessions, a further 168 had between four to eight sessions.

The Mangopare Maori service is funded by CMDHB via MOH funding for Maori cessation and additional CMDHB funding, at an annual value of $220,000. This service has an annual target of 400 enrolments. Abstinence rates are not provided for this service. In addition to intensive cessation support the service is contracted for coordination activity to support a minimum of 10 smokefree organisations and maximum of 20 smokefree champions per annum.

1. Pacific people: Pacific smoking cessation services are provided in Counties Manukau by the South Seas Healthcare Trust. This is part of the Alliance Healthcare Plus Trust. The contract for these services in 2013/14 is $200,000. This contract is funded by CMDHB via MOH funding for Pacific cessation. The quarterly target for enrolments is 125. Abstinence rates are not provided for this service.

The National Heart Foundation (Tala Pasifika) obtained Ministry of Health’s Innovation Fund for the project “Back to the Future: Preserving our people through performance” ($1.3 million for up to three years). This project utilised traditional methods of communication for Pacific people such as storytelling, dance, humour, live theatre, song and more modern forms such as blogging and Facebook to encourage Pacific people to stop smoking. This project is mainly carried out in Manukau area.

1. Pregnant women who smoke:
   1. Pregnancy incentives pilot: This is a one-year pilot being implemented by the CMDHB Smokefree Service and funded by the MoH Pathway to 2025 Innovation Fund. 54 Pregnant women (45 Maori, 8 Pacific and 1 unknown; 20 between 14 and 20 years old, 17 between 21 and30 years old and 17 between 31 and 40 years old) and 14 Whanau were enrolled between October and December 2013. The programme provides intensive support and NRT alongside vouchers to act as an incentive for quitting. This has a one year funding of $138,330. This also can be considered a research activity.
   2. Mangere Community Health Trust provides smoking cessation services for pregnant women including individual or group support and NRT. In 2012/13 the trust received 405 referrals and enrolled 208, less than 50% of its target minimum enrolment of 420 (MoH advises performance has improved during 2013/14). The validated abstinence rate at three months for 2012/13 was 2% and was only 9% when self-report was used. 208 clients set a TQD during this period of which 16 were male and 39 pregnant. 103/208 were Maori and 34/208 were Cook Island Maori. 174 or 178 cleints whose therapy was recorded received NRT and a large number of counselling sessions were also provided with 68/93 receiving more than nine sessions. The trust has a contract worth $301,396. This programme has also included running group based support in mental health settings.

### Waitemata

|  |  |
| --- | --- |
| Population | 417,567 |
| Smokers | 45,474 |
| Maori Smokers | 7,683 |
| Pacific Smokers | 4,974 |

**General Cessation**

* 1. Quitline: There were 810 quit attempts from Waitemata in the period October to December 2013 and 1,018 in the July – September period.
  2. Elective service: All smokers referred for elective surgery are offered this service which is provided by Waitemata DHB secondary care. The service is telephone or face to face and also can include NRT. During October to December 2013there were 58 enrolments on this scheme. This is funded by the DHB from its tobacco control contract with MoH. This contract is $588,770 in the current financial year though the elective service has a budget of $50,000.
  3. Hospital Outpatient services: These are offered to inpatients or outpatients that require support to quit smoking. Patients receive face to face or groups counselling from professional psychologists and NRT. This is funded by the DHB and has a budget of $170,000. It enrolled 80 patients in the last three months.
  4. Whanau smokefree communities: This consists of face to face, text, phone or email contact plus NRT where necessary and is directed at adults who live in households with children under 16 years old. The service is provided by Waitemata PHO and funded by Waitemata DHB through its MoH contract. In the last quarter 73 patients were enrolled. The annual budget is $180,000.
  5. Pharmacy services. Waitemata DHB has a service operated by Procare PHO who have contracted 17 pharmacies to provide NRT. The pharmacy recruits the patient and provides face to face counselling or advice and NRT. Waitemata pays Procare $10,000 for administration and $100 per patient up to a maximum of 550 patients. Currently the service is underutilised with 47 enrolments. The DHB will be administering this service directly with community pharmacies from 1 July 2014 and expects utilisation to improve over the 2014-15 year.
  6. Waitemata PHO (together with CMDHB) received funding from the MoH Pathway to 2025 Innovation Fund to operate a mobile Quit Bus to provide smoking cessation support and advice and to distribute Nicotine Replacement products in hard to access areas. This project runs for three years with a budget of $1,881,766.

**Cessation Services for priority populations**

1. Aukati Kaipaipa: The Waitemata DHB report two AKP providers in the Waitemata area. Ngati Whatua O Orakei and Te Ha O Te Oranga O Ngtai Whatua. The former also works in Auckland DHB area and separate figures are not provided.

Table 12: Waitemata DHB AKP providers 2012-13 year

|  |  |  |
| --- | --- | --- |
|  | Ngati Whatua O Orakei | Te Ha O Te Oranga O Ngati Whatua |
| Referrals | 749 | 151 |
| enrolments (target) | 514 (480) | 149(156) |
| Three Month abstinence self reported (validated) | 25% (21%) | 18% (10%) |
| TQD | 503 | 153 |
| o/w female | 277 | 88 |
| o/w pregnant | 12 | 2 |
| Maori | 225 | 97 |
| NRT | 451/516 | 137/153 |
| 4-8 sessions | 109/528 | 106/135 |
| 9-16 sessions | 317/528 | 19/135 |

1. Te Whanau O Waipareira Trust: Te Whanau O Waipareira Trust was funded by MoH Pathway to 2025 Innovation Fund to provide culturally tailored smoking cessation programme for whanau smokers in the Waitemata DHB region. This includes a quit coach, wrap around care plans and referrals to existing services. This programme cost $306,000 for three years.
2. Pacific Quit Services are funded by Waitemata DHB and Auckland DHB and are provided by the Auckland Regional Public Health Service (ARPHS). The service contains face to face, telephone, text or email support plus NRT where necessary. The Waitemata DHB contract is for $180,000 (funded via two separate MOH contracts).. The MoH does not have a direct contract with ARPHS for provision of this service. The programme is monitored as a Pacific service by Datapeople. In 2012/13 the service received 526 referrals and enrolled 324, just below its target of 360. It had a self-reported three month abstinence rate of 56% and 32% when validated. The majority of its recruits during the April – June 2013 came from self-referrals (36/85) although 21/85 were referred by GP and 19/85 by hospitals. In the 2012-13 financial year 358 clients set a TQD of which 148 were female and none were pregnant. 21/375 were Maori, 36/375 were European but 179/375 were Samoan. Virtually everyone (351/358) received NRT as part of their therapy. The clients also received considerable counselling with 130 receiving between 4 and 8 sessions and 171 between 9 and 16.
3. Pregnancy smokefree communities: This service is provided by Waitemata PHO (Comprehensive Care) through a direct contract with the MoH. The service is for both pregnant women and their partners. Support through face to face, phone text or email and NRT is available. The annual budget is $317,000. From the monitoring data this service received 225 referrals and enrolled 208, well below its minimum annual target of 420. The self-reported abstinence rate at three months was 34% and 16% when validated. Although 184 clients set a TQD with Comprehensive Care this period there is demographic information on only 76 of them and there is no reason given for this lack of data, 61 were pregnant women and 15 men. 29/76 were Maori and 54/72 received NRT. There is also considerable counselling by this service 59/64 received more than 9 sessions and 27/64 more than 17.
4. Asian smokefree communities: This is a service provided by Asian language speakers and consists of face to face, text, phone or email contact and, where necessary, NRT. Waitemata DHB region has 5,379 Asian smokers, the highest number for any DHB region after Auckland. Patients are recruited from primary care and through community networking. This is funded by the DHB with an annual budget of $182,000 and provided by Waitemata PHO. In the last quarter there were 84 new enrolments.
5. NRT Survival Packs: Waitemata DHB was funded by MoH Pathway to 2025 Innovation Fund to distribute survival packs to people that smoke and who are visiting the hospital. The survival packs will contain Nicotine Replacement lozenges and the design of the pack will provide supportive messaging and information on smoking cessation. This 18-months project is for $133,748.
6. Community Mental Health services have developed smokefree policies, guidelines and resources for use in their services. They have also developed a smokefree assessment form and plan that is utilized throughout a client’s journey. They have held a number of forums over the last few years to identify and address the barriers to quitting smoking in mental health services and promote culture change.

### Waikato

|  |  |
| --- | --- |
| Population | 281,724 |
| Smokers | 43,785 |
| Maori Smokers | 15,870 |
| Pacific Smokers | 1,758 |

**General cessation**

* 1. Quitline. There were 3,242 quita attempts from the Waikato DHB area between July 2012 and June 2013. This suggests that 7% of the area’s smokers may have been supported in their quit attempts by Quitline. During October –December 2013 159 Maori and 14 Pacific smokers registered with Quitline (207 Maori and 16 Pacific smokers in the previous 3 month period). Waikato DHB referred 0 to Quitline in July-September 2013 and 48 in October to December 2013 of which 30 were successfully contacted.
  2. Waikato DHB Planning and Funding department reported that no other general cessation services were being funded by the DHB. Their staff concentrate on the A(sk) and B(rief advice) of tobacco control but not the C(essation support).

**Cessation Services for priority populations**

1. Aukati Kaipaipa: There are 6 AKP providers listed for Waikato on the AKP website

Table 13: AKP providers Waikato DHB

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | Te Runanga o Kirikiriroa Trust | Ngā Miro Health | Te Korowai Hauora o Hauraki | Ngāti Maniapoto Marae Pact Trust | Te Kohao | Taumarunui Community Kokiri Trust |
| Referrals | 451 | 186 | 486 | 173 | 228 | 210 |
| enrolments (target) | 290(288) | 138(120) | 193(120) | 98 (120) | 116(120) | 143(120) |
| Three Month abstinence self reported (validated) | 26% (17%) | 44% (39%) | 33% (15%) | 44% (41%) | 29% (28%) | 17% (12%) |
| TQD | 253 | 146 | 192 | 99 | 116 | 154 |
| o/w female | 160 | 88 | 134 | 72 | 73 | 101 |
| o/w pregnant | 9 | 4 | 2 | 2 | 1 | 15 |
| Maori | 164 | 116 | 79 | 61 | 84 | 104 |
| NRT | 224/275 | 123/148 | 149/216 | 91/101 | 113/116 | 132/156 |
| 4-8 sessions | 156/251 | 131/145 | 40/170 | 66/96 | 85/116 | 80/141 |
| 9-16 sessions | 9/251 | 14/145 | 0 | 6/96 | 1/116 | 6/141 |

These providers have similar characteristics in that they all have NRT as part of the programme for virtually all clients and most clients receive fewer than 8 sessions of counselling.

1. Pacific stop smoking services are provided by K’aute Pasifika in Hamilton. In the 2012/13 financial year they received 293 referrals and enrolled 282, above their target of 276. The 3-month self-reported quit rate was 48% (46% validated). Of the 261 clients who set a TQD with them this year 116 were women of which 2 were pregnant. There were 55 Europeans, 38 Maori, 42 Samoan and 35 Tongan in that 261. 172/277 received NRT as part of their programme although 85 received no pharmacotherapy. 186/228 received less than 4 seesions of counselling. Their annual MoH contract is for $207,670.

### Auckland

|  |  |
| --- | --- |
| Population | 357,342 |
| Smokers | 36,141 |
| Maori Smokers | 5,697 |
| Pacific Smokers | 7,173 |

From the report on the tobacco control contract with the MoH *“ADHB does not fund a generalist smoking cessation service since the original contracts, for 2001 – 2004 and 2004 – 2007, changed to a contract focussing on implementing the ABC approach by the nursing, allied, and medical staff.”*

**General cessation**

* 1. Quitline: 4,840 quit attempts from residents of the Auckland DHB were supported by Quitline during July 2012 until June 2013. In October – December 2013 112 Maori and 77 Pacific smokers from Auckland registered with Quitline, in July September the figures were 129 Maori and 91 Pacific.
  2. General cessation services for the ADHB population are provided by Quitline, Ngati Whatua o Orakei, Pacific Quit, SmokeStop (online), ADHB Community Quit Groups initiative, and individual Medical Centres within the 4 PHOs – ProCare, Auckland PHO, National Hauora Coalition, and Alliance Health Plus.

Although ADHB does not have a hospital based quit service, ADHB Smokefree has a central referrals function. In the period 1/7/13 to 31/12/13, 913 referrals were sent on from inpatient services. Ngati Whatua O Orakei services received 277 referrals, Pacific Quit 180, and Quitline 45. Other referrals went to Counties Manukau Smokefree and Waitemata Smokefree Communities. ADHB Smokefree runs Community Quit groups: 4 groups have been run since August 22/8/13 and resulted in 33 people quitting at 4 weeks and 20 at 12 weeks (no denominator provided).

ADHB has targets around the provision of brief advice to patients who attend hospital or seek primary care. By end December 2013 the 12 monthly target for 95% of hospitalised current smokers to have been given brief advice to quit patients stood at 96%, and 60% of current smokers enrolled with the 4 PHOs had received advice and offered support to quit. The ADHB is working with PHOs to proactively contact enrolled smokers on GP lists to offer advice and support to quit via telephone or text. Procare is running a 12 month project called ‘mission smokefree’ to increase the amount of brief advice being offered.

* 1. Auckland Regional Public Health Service (ARPHS)

Auckland DHB along with Counties Manukau and Waitemata DHBs funds the ARPHS. This provide Smoking cessation and tobacco control services.

ARPHS also has a Pacific cessation service although this is classed as a non-core contract under its annual report. This contract is funded by Auckland DHB and Waitemata DHB. The ARPHS gives the annual funding for this as $402,000 Between July 2012 and June 2013 this had 526 referrals, over half from hospital services. Details of this service are given under the section on Waitemata DHB as the monitoring data does not allow the activities of the ARPHS to be split among the DHBs.

**Cessation Services for priority populations**

1. Aukati Kaipaipa. Ngati Whatua O Orakei is the AKP provider serving the Auckland DHB area for cessation services. The information about this service is given in the section on Waitemata DHB area as it also provides services there and the data does not allow services to be disaggregated for the two DHB areas.

The MoH has a contract with Auckland DHB for smoking cessation services for pregnant women. This employs 3.5 FTE staff (3 quit coaches plus administrative support) and has an annual budget of $338,698. In 2012/13 this service received 353 referrals and enrolled 205, below its annual target of 360. The 3-month abstinence rate for this service was 16% sel-reported and 11% validated. Of the 212 who set a TQD with this service during 2012/13 there were 184 women of which 126 were pregnant. 69/212 were Maori and 46 European. 99/109 received NRT as a part of the programme and 98/188 received less than 4 sessions of counselling.

1. Pacific Quit: This service is funded by Auckland Regional Public Health Services and provides face to face, and group, quitting. It has a 2.5FTE structure. There is a manager plus a team of 3 smokefree facilitators. The service is classed as a non-core contract under its annual report. This contract is funded by Auckland DHB and Waitemata DHB. The annual funding for this service via ARPHS is $402,000. During the period July 2012 June 2013 the total of referrals was 303 (this includes hospital, GP, and Self referrals). In this period the breakdown of referrals was ADHB 205, WDHB 91, Out of zone 6, unknown DHB 1. In the July 2012 to June 2013 period there were 526 referrals and 354 enrolments. The self-reported quit rate at three months was 56% and the validated rate 32%. Of the 358 clients who had a TQD in the 2013/13 financial year 148 were women and none were pregnant. 179/375 of these clients were Samoan. Virtually everyone (351/358) received NRT as part of their therapy. The clients also received considerable counselling with 130/348 receiving between 4 and 8 sessions and 171/348 between 9 and 16.

Auckland Region NGO Mental Health project: NGOs in the ADHB area are included in this project lead by the Northern Regional Alliance (NRA, formerly known as NDSA). The project is raising awareness in the mental health sector of the benefits of promoting quitting smoking to mental health service users and addressing the barriers to quit attempts. It includes training of mental health workforce in ABC approach, developing smokefree environment policies and systems to ensure that smokers are given advice and support to quit. The 4 Northern DHBs have added clauses to all mental health contracts requiring them to develop comprehensive smokefree policies for their facilities, grounds, staff, cars etc.

### Southern

|  |  |
| --- | --- |
| Population | 243,024 |
| Smokers | 34,668 |
| Maori Smokers | 4,908 |
| Pacific Smokers | 840 |

**General cessation**

* 1. Quitline: From July to September 2013 732 quit attempts from Southern DHB area were supported by Quitline. This fell to 659 in the October- December period. 92 Maori and 14 Pacific smokers registered with Quitline between July and September compared with 70 Maori and 7 Pacific smokers in October to December. Southern DHB made 83 referrals to Quitline in June to September 2013 and 93 between October and December.
  2. SDHB is working with Nga Kete in Southland to deliver hospital-based group cessation. In Dunedin, the DHB is working with the PHO to deliver group-based cessation. This is a small programme provided by DHB staff with a budget in the last financial year of $700. It consisted of a 7-week group based counselling plus NRT. Eleven people enrolled and 4 completed
  3. Southern DHB contracted Inspiring Ltd to provide group-based cessation training in April 2013. All local providers were invited and primary care, midwives and DHB staff were encouraged to attend. Part of this contract was to provide mentoring support and two lots of group cessation were supported via email/skype/phone. We are awaiting the final report from Inspiring.
  4. SDHB has developed a single district –wide referral form that prompts smokers to be referred to local cessation providers and/or the Quitline. The referral form has been rolled out in secondary care and is being tailored for use in primary care.

**Cessation Services for priority populations**

1. Cessation services for Maori smokers are provided by Uruuruwhenua Health Inc. in North Otago, South Otago and Central Otago (Tokomariro Waiora are subcontracted to provide the service in South Otago), Te Roopu Tautoko Ki Te Tonga Incorporated in greater Dunedin, **Nga Kete Matauranga Pounamu Charitable Trust in Southland.**
2. **Uruuruwhenua (and Tokomairiro) are funded by Southern DHB. There are two contracts, one worth $153,000 a year covering Central and South Otago and one worth $44,000 a year for North Otago. The Southern DHB funded programme follows the AKP approach with face to face, telephone and group sessions and pharmacotherapy.**

Table 14: Southern DHB: Maori Health providers

|  |  |  |  |
| --- | --- | --- | --- |
|  | Uruuruwhenua Health & Tokomariro Waiora\* | Te Roopu Tautoko Ki Te Tonga | Nga Kete Matauranga Pounamu |
| Funder | Southern DHB | AKP | AKP |
| Referrals | 127 (jan-dec 2013) | 125 | 242 |
| enrolments (target) | 104 (jan-dec 2013) | 125(120) | 133(120) |
| Three Month abstinence self reported (validated) | (35%) | 52% (27%) | 46% (36%) |
| TQD |  | 112 | 135 |
| o/w female |  | 68 | 76 |
| o/w pregnant | 2 | 0 | 3 |
| Maori | 41 | 74 | 67 |
| NRT |  | 112/112 | 129/144 |
| 4-8 sessions |  | 93/135 | 92/138 |
| 9-16 sessions |  | 0 | 36/138 |

\*Contract with Uruuruwhenua - reporting combined

Pacific smokers and pregnant women who smoke are treated as priority by the AKP providers. There were 135 enrolled by Nga Kete Matauranga Pounamu, above their target of 120. Of the 135 who set a TQD 67 were Maori, 55 were European and one was Cook Island Maori. There were 76 women enrolled of whom three were pregnant. For the other MoH AKP provider Te Roopu Tautoko Ki Te Tonga in Dunedin, TQD clients were 74 Maori, 25 Europeans, 8 Samoans, two Cook Island Maori and one Tongan. 68 women were enrolled and none were pregnant.

For Uruuruwhenua, from Jan – Dec 2013 of the 104 enrolments, two were pregnant women, four were Pacific, 41 were Maori and 65 were NZ European.

There is a programme run by the Asthma Foundation in Dunedin to get patients with COPD to stop smoking. This is a small programme and we were unable to get further information.

Oamaru hospital also has funded and implemented a nurse led programme to get smokers to cut down their smoking. This is in the form of a weekly clinic at the hospital.

Nga Kete is funded for a 0.8 FTE pregnancy smoking cessation service. There are no separate figures for this service although as noted above the service enrolled 3 pregnant women during 2012/13.

### Capital and Coast

|  |  |
| --- | --- |
| Population | 230,571 |
| Smokers | 25,362 |
| Maori Smokers | 4,974 |
| Pacific Smokers | 3,573 |

**General Cessation**

* 1. Quitline: There were 716 quit attempts supported by Quitline from Capital and Coast DHB between July and September 2013 and 648 between October and December. 111 Maori and 52 Pacific smokers registered with the service between July and September and 120 Maori and 41 pacific between October and December. Capital and Coast DHB referred 18 clients to Quitline between July and September and 25 between October and December.

**Cessation Services for priority populations**

1. Pacific Health Trust Porirua. In the last financial year this service had 534 referrals mainly self-referral or ‘other referred source’[[2]](#footnote-2). Of these 401 enrolled below the target enrolment of 480 a year. The self-reported (validated) 3-month quit rate for this service was 32% (9%) for the 2012/13 financial year. Clients who set TQDs during this period (447) were predominantly Pacific with a majority of Samoan (155/447). There is a significant number of NZ Maori who also receive this service (105/447), 206 were female of whom seven were pregnant. About half the clients (214/447) did not receive any pharmacotherapy. The emphasis was on counselling with 348/400 receiving more than nine sessions and 143 receiving more than 17. PHT Porirua has an annual contract with the MoH worth $404,800
2. The AKP provider for the Capital & Coast DHB area is Kokiri Marae Keriana Olsen Trust. They were referred 823 clients in the financial year 2012/13, the vast majority (591) were self referral. 496 enrolled on the programme, below the target enrolment of 660 for the year (this is the largest target enrolment for any AKP or Pacific provider). Self-reported and validated abstinence rates for three months were 19% and 12% respectively for this period; 528 clients set a TQD in this period; 335/528 clients were Maori and 115/528 were NZ European. There were 340 women of whom 14 were pregnant; 456/531 received NRT; 402/577 received more than nine sessions of counselling and 161/577 received more than 17. The MoH contract with Kokiri Marae is for $575,350 in the 2013/14 financial year.

### Bay of Plenty

|  |  |
| --- | --- |
| Population | **162,474** |
| Smokers | 24,315 |
| Maori Smokers | 10,062 |
| Pacific Smokers | 675 |

**General Cessation**

1. Quitline: Quitline supported 438 quit attempts from Bay of Plenty smokers between July and September 2013 and 404 between October and December. Maori smokers and 13 Pacific smokers registered with Quitline between July and September and 99 Maori and 12 Pacific between October and December. 10 clients were referred from BOP DHB to Quitline between July and September and eight between October and December.
2. The BOP DHB funds a group therapy programme, including NRT, which is implemented by the Western Bay of Plenty PHO. Clients self-refer or are referred by their GPs. The programme received 75 referrals in the last three months of whom 17 were Maori. There are no data on enrolments or quit rates. In 2012/13 this had a budget of $40,000 and in 2013/14 this has increased to $57,500. The BoP DHB also funds a service implemented by the Eastern Bay Primary Health Alliance. This provides support through phone or face to face contact. Clients are referred to Quitline or the AKP provider if appropriate. In the last three months there were 206 referrals of which 127 were Maori. In 2012/13 this had a budget of $40,000 and in the current financial year the budget is $57,500.

**Cessation services for priority populations**

1. Aukati Kaipaipa: The AKP provider for Bay of Plenty is Nga Kakano Foundation. They received 589 referrals in the 2012/13 financial year of which the largest source was community services (151) followed by self-referral (123) and hospital services (120). 409 were enrolled on the programme which meant the foundation exceeded its enrolment target of 360 per year. The validated abstinence rate at three months was 47% (which is among the highest reported). The self reported rate was 53%. 409 clients set a TQD during this period of which 257 were women and 40 of them were pregnant. Also 273/409 were Maori; 425/428 received some form of pharmacotherapy; the majority NRT although 20 received varenicline; 324/377 received between four and eight sessions of counselling. Nga Kakano has a contract with the MoH worth $270,000 in the current financial year.
2. Ngati Awa Social and Health Services Trust (Te Tohu o te Ora o Ngāti Awa) also have a tobacco control contract with the MoH worth $180,000 in the current financial year. However, this is wider than smoking and covers health promotion, nutrition and physical activity. This service was referred 242 clients in the 2012/13 year. The number enrolled was higher, 250 and this exceeded the enrolment target of 240 for the year. The three month validated abstinence rate is 71% (the highest among all AKP providers). Of the 252 clients who set a TQD during this period 227 were Maori, 162 were women and 11 of them were pregnant; 216/253 received NRT; 184/224 received less than four sessions of counselling.
3. There are no specific providers for Pacific smokers as there are few in the BoP DHB area. They are covered by AKP and the general cessation services.
4. Up until the end of 2013 there were no specific services for pregnant women who smoke but in October 2013 BOP DHP funded a $54,000 per year project to be implemented by the maternity services of its provider arm. This will include both face to face and NRT.
5. Hospitalised patients, including those on mental wards, receive ABC and NRT implemented by the BoP DHB hospital services. This has a budget of $109,000. We do not have information on the numbers receiving this service
6. DHB employees receive one on one counselling and NRT through the BoP DHB employee health and safety service. This has a budget of $26,000

### Mid-Central

|  |  |
| --- | --- |
| Population | **129,729** |
| Smokers | 19,989 |
| Maori Smokers | 5,667 |
| Pacific Smokers | 846 |

**General Cessation**

1. Quitline: Between July and September 2013 Quitline supported 496 quit attempts from MidCentral DHB. Between October and December this fell to 431; 105 Maori and 20 Pacific registered with Quitline between July and September and 85 Maori and 10 Pacific between October and December. There were 15 referrals from the DHB to Quitline between July and September and 0 between October and December

**Cessation Services for priority populations**

1. Te Ohu Auahi Mutunga - Smoking Cessation Services. This is a service provided by Whakapai Hauora Charitable Trust. This in turn is part of Tanenuiarangi Manawatu Incorporated. MidCentral DHB directs all local smoking cessation resources to this provider. The service is mainly for Maori, Pacific People and pregnant women who smoke. The service is provided in partnership with the Central PHO. All DHB referrals are firstly to this service with those who do not meet the criteria for the programme being referred onto Quitline. We currently have no information on the numbers receiving this service or its success rate. The overall funding for this is $1.8 million but this covers a range of health services offered by this trust.
2. Te Runanga O Raukawa. This is an AKP provider. It received 199 referrals in the 2012/13 financial year and 150 enrolled on smoking cessation programmes below its yearly target of 240 enrolments. The abstinence rates achieved by this programme were relatively low, 10% self-reported abstinence at three months and 5% validated. The enrolments are majority Maori (90/162) but with a substantial number of NZ European (60/162); 100/162 of those with a TQD were women of which three were pregnant; 122/169 received NRT and a further 36/169 received varenicline. The majority of clients received less than 8 sessions of counselling. This service has an annual contract worth $180,000.

### Northland

|  |  |
| --- | --- |
| Population | **118,941** |
| Smokers | 19,986 |
| Maori Smokers | 9,474 |
| Pacific Smokers | 642 |

**General Cessation**

1. Quitline: In the period July to September 2013 297 quit attempts were supported by Quitline. In the October to December period 295 quit attempts from Northland residents were supported by Quitline. 135 Maori and seven Pacific registered with Quitline between July and September and 136 Maori and two Pacific registered with Quitline between October and December. Northland DHB referred five patients to Quitline between July and September and three patients to Quitline between October and December.
2. Northland DHB has an ABC service run through the Manaia and Te Tai Tokerau PHOs. In the October to December 2013 period 372 patients were enrolled onto a cessation service. This led to 276 quit attempts of which 51% were by Maori smokers and 1.3 % by pregnant women who smoke. The service is funded through the DHB’s tobacco control contract with a budget of $133,333 per financial year.
3. Hospitalised patients receive AB and cessation support provided by the DHB clinical staff in the hospitals. In October to December 2013 1335 in-patients were given brief advice (688 Maori, 16 Pacific, 631 Other; 143 women in Maternity Services and 52 Mental Health Service users). The current funding for this is $150,000.

Hospital stop smoking services were provided and funded by the Northland DHB public health unit until January this year. Now they are funded through the Smoke Free facilitator as the cessation support – the 1 FTE person delivering this service – is now community rather than hospital based. The funding is 1 FTE cost or $62,000 a year. The service is face to face in the ward or by phone following discharge. Clients are often referred to community based services such as AKP. The service has received 64 referrals of which 43 were Maori, 19 NZ Euro, 1 Pacific and 1 unknown. There were 38 females. Twenty-four were referred on: 23 to Aukati Kaipaipa services and one to Quitline. Nine were followed up by DHB Quit Coach. Twenty-six declined the service or could not be contacted.

**Cessation services for priority populations**

1. Maori: The DHB contracts two Maori NGOs and 2 Community Trust providers to implement the AKP service. The organisations are
   1. Te Hauora o te Hiku o te Ika – a health services trust. In the 2012/13 financial year this service received 591 referrals and enrolled 436. At three months the self-reported abstinence rate was 39% and the validated rate 36%. 437 clients set a TQD during this period which 314 were Maori and 103 European; 251/437 clients were women and 16 of these were pregnant; 374/438 received NRT and a further 35/438 received varenicline. 355/437 received between four and eight sessions of counselling.
   2. Ngati Hine Health Trust is an AKP provider. In the financial year 2012/13 336 clients were referred to this service and 301 enrolled. This was below the yearly target of 360. The validated abstinence rate at three months was a high 47% and the self-reported rate was 53%. The majority of clients (218/273) who set a TQD with the service in that year were Maori; 205 were women of which 10 were pregnant; 220/288 received NRT as part of their programme and a further 58/288 received varenicline. 225/276 had between four and eight sessions of counselling. This service has an MoH contract worth $549,000 a year.
   3. Hokianga Health Enterprise Trust. Most of the activities related to smoking cessation (as outlined in their report) are to do with health promotion and advocacy. However as a provider of primary and secondary care they also report providing support (beyond brief advice) to 223 smokers recruited via primary care and 21 recruited through hospital. There are also programmes intended to reduce smoking amongst pregnant women. The Northland DHB provided no data for this service.
   4. Whangaroa Health Services Trust: The Trust has a contract with Northland DHB to provide smoking cessation services. According to DHB figures the service had 39 clients in the last three months of 2013 but no quits at 12 weeks.

The total funding by the DHB for these services is $316,000 although it is not clear if this is additional to the MoH direct funding.

### Hawke’s Bay

|  |  |
| --- | --- |
| Population | **118,689** |
| Smokers | 19,602 |
| Maori Smokers | 7,695 |
| Pacific Smokers | 843 |

**General Cessation**

1. Quitline: Quitline supported 335 quit attempts from Hawke’s Bay between July and September 2013 and 310 between October and December. Ninety-three Maori and eight Pacific smokers registered with Quitline between July and September and 94 Maori and nine Pacific between October and December. Hawkes Bay DHB referred 38 patients to Quitline between July and September and 46 between October and December.

**Cessation Services for priority populations**

1. AKP services are provided by Te Kupenga Hauora Ahuriri in Napier. In the 2012/13 financial year this had 321 referrals and 269 enrolments. This exceeded its annual target of 240. The validated (self-reported) abstinence rate at three months was 20% (33%). The clients of this service who had set a TQD in this period were overwhelmingly Maori (218/261) and almost all (257/263) received some form of NRT. There were 146/261 women who set a TQD, 10 of whom were pregnant. 193/254 clients received between four and eight weeks of counselling. The total value of this contract is $179,906.
2. Te Taiwhenua o Heretaunga are an AKP provider based in Hastings. In the 2012/2013 financial year they received 227 referrals and enrolled 240 clients, exactly at their target; 231 clients seta TQD; 181/231 of these clients were Maori, 150/231 were women of whom three were pregnant; 209/250 received NRT and 16/250 received varenicline; 80% (201/252) more than four sessions of counselling. The three month validated quit rate was 26% the self reported rate 36%. Their annual contract was for $180,000.
3. Pregnant women who smoke: Choices – Kahungunu health services provides a service to reduce smoking in pregnancy, including home visits, one-on-one counselling and NRT. It has a quarterly target of 45 enrolments. In the last financial year it had 245 referrals and enrolled 154, below its target of 180. The self-reported quit rate for this service was 30% at three months although the validated rate 16%. The service is not just for the pregnant women themselves but also for their families and 24 men and 48 non-pregnant women were listed among the 155 who set a TQD in this period. There were 78/155 Maori enrolments and 53/155 NZ European enrolments. 121/156 received NRT and 161/173 received four or more and 16 or less sessions. Choices has a contract with MoH worth $144,310 a year for pregnancy stop smoking services.
4. Highly tobacco dependent people: Hawke’s Bay DHB was funded by MoH Pathway to 2025 Innovation fund to work directly with local stakeholders in Wairoa to deliver free NRT mouth spray to highly tobacco dependent people. This is a two year project worth $204,136 and it ran as an adjunct to the current subsidised NRT quitting aids (patches and behavioural support) already available.

### Hutt

|  |  |
| --- | --- |
| Population | **109,230** |
| Smokers | 16,557 |
| Maori Smokers | 4,587 |
| Pacific Smokers | 1,848 |

Hutt has a high prevalence of smoking among its Pacific population. No information has been received from Hutt Valley DHB.

Hutt Valley DHB has two contracts with MoH. The first has a value of $281,600 and is for ‘tobacco control’. The second, for $541,300 is for ‘tobacco control – general’ and is further described as ‘public health services – core contract’.

**General Cessation**

1. Quitline: Quitline supported 438 quit attempts from Hutt Valley in the July to September period and 362 in the October to December period. Ninety-two Maori and 31 Pacific smokers registered with Quitline from Hutt Valley in July to September and 75 Maori and 20 Pacific between October and December. Hutt Valley referred no patients to Quitline between July and December 2013.

**Cessation Services for priority populations**

1. The AKP provider covering the Hutt Valley DHB area is the Kokiri Marae Keriana Olsen Trust. This service has already been discussed in the section on the Capital and Coast DHB
2. The Pacific provider covering the Hutt Valley is the Pacific Health Trust Porirua. This has already been discussed in the section on Capital and Coast DHB.
3. Pregnant women who smoke: The Hutt Valley Maori Health Action Plan July 2013 – June 2014 states that pregnant women who smoke will be offered advice and support to quit and that this will be provided by clinicians.

### Nelson Marlborough

|  |  |
| --- | --- |
| Population | **111,072** |
| Smokers | 14,271 |
| Maori Smokers | 2,337 |
| Pacific Smokers | 312 |

**General cessation**

1. Quitline supported 256 quit attempts from Nelson Marlborough DHB region in July to September of 2013 and 250 between October and December. Thirty-four Maori and two Pacific smokers registered with Quitline during July to September and 37 Maori and three Pacific during October to December. Nelson and Marlborough DHB referred 101 patients to Quitline during July to September and 104 between October and December.
2. The general cessation service run in the Nelson-Marlborough DHB region is based in GP surgeries. Following ABC, those smokers wanting quit support have an intensive consultation where they develop a quit plan. They have access to three follow-up consults offered in line with service specification; these can be phone, face to face or other as agreed. The service is implemented in GP surgeries and funded by the DHB through a contract with the PHO. About 430 people are enrolled on the service each quarter. There is no information on quit rates. The cost of the service is $81,000 although additional resources are provided by ABC facilitators.
3. Hospitalised patients: They are offered a consultation on the ward to discuss their smoking and external referral options at Nelson Hospital. Otherwise they receive one to one support usually first contact face to face on ward and phone follow up, (unless patient able to travel to hospital for follow up appointments). Offer four to eright sessions over three months and extended support to pregnant or breastfeeding women. In October-December 2013 there were 54 general referrals of which 30 had two or more sessions. There were 17 ward consultations in Nelson hospital. When quit coach in hospital is not available DHB staff refer smokers to Quitline and NMDHB referred 97 to Quitline (104 in total from all DHB schemes).

**Cessation Services for priority populations**

1. The general practice based cessation service is available to high priority patients: Maori, Pacific, Asian; Quintiles 4&5; pregnant or breastfeeding woman or household/whanau member; parents of children with chronic respiratory disease; pre-operative; people with long-term conditions; people with a community services card or beneficiaries or those recently discharged from hospital.
2. There are three AKP providers in this district:
   1. Whakatu Marae: During the financial year 2012/13 Whakatu Marae in Nelson had 112 referrals, only one from GP or primary care, and enrolled 161. This was above its annual target of 120. The validated abstinence rate at three months was 11% and the self reported rate 15%. There were 162 clients who set a TQD during this period. Of these 24 were female. There were 31 Maori and 14 European but the majority (112) were Tongan. All but five received NRT as part of their cessation support. 120/162 received less than four sessions of counselling support. Whakatu Marae have a contract worth $90,000 a year.
   2. Te Awhina Marae O Motueka Society: This small provider works in the Motueka and Tasman Bay region. It received 48 referrals and enrolled 36 on its programmes in Financial Year 2012/13 – below its target of 60. The validated abstinence rate at three months was 44%, the self-reported rate 53%. 34 clients set TQDs during this period of which 18 were women and two were pregnant. There were 15 Europeans and 14 Maori on the scheme and all but four received NRT as part of their cessation effort; 28/36 received between four and eight sessions of counselling support. Te Awhina’s AKP contract is worth $45,000
   3. Te Hauora O Ngati Rarua are based in Blenheim. They received 212 referrals in financial year 2012/13 and enrolled 90, below their target of 120. The validated abstinence rate was 12% at three months, the self-reported rate was 18%. Of the 89 clients who set a TQD in this period 55 were women and five were pregnant, 48 were Maori and 37 European. All but five received NRT as part of their support and of those five, four received varenicline; 71/86 received between four and eight sessions of counselling. Te Hauora O Ngati Rarua have a $90,000 AKP contract with MoH.
3. Pacific people: Kimi Hauora Wairau (Marlborough PHO Trust) was funded by MoH Pathway to 2025 Innovation fund to help Pacific smokers in Blenheim to stop smoking through providing smoking cessation information and products at community group meetings. This has a one year funding of $88,200.
4. Pregnant women receive support through the DHB smokefree service once they have been referred by LMCs. Some support is offered after the birth. In the last three months of 2013 no one was referred or enrolled on this service due to some concerns about service availability.
5. Young persons: Paediatric admissions are screened for smoking or exposure to second hand smoke and can be referred appropriately. This is part of normal healthcare procedure not a special scheme.
6. Mental Health: Mental health staff have been trained in ABC and can offer cessation support or refer onwards.

### Taranaki

|  |  |
| --- | --- |
| Population | **86,586** |
| Smokers | 13,998 |
| Maori Smokers | 3,843 |
| Pacific Smokers | 225 |

**General cessation**

1. Quitline supported 259 quit attempts from Taranaki DHB region in July to September of 2013 and 254 between October and December. Sixty five Maori and two Pacific smokers registered with Quitline during July to September and 53 Maori and two Pacific during October to December. Taranaki DHB referred 44 patients to Quitline during July to September and 25 between October and December. Taranaki DHB report the number of people that use Quitline as 254 – this is the same figure as Quitline give for supported quit attempts for October to December. The DHB has more demographic information, the median age is in the 24-44 age group, 143 are female, 53 Maori, 192 European, two Pacific, four Asian and 17 Other.
2. Primary Care (Midland Health Network Taranaki): Taranaki DHB receives funding to commission and provide smoking cessation and tobacco control services for Primary Care. This covers: 1) implementation of ABC approach in Primary Care and 2) dedicated Cessation Support in a primary care setting. In the last three months 51 patients/clients have been on this scheme. There were 28 female and 23 male with the median age bracket 45-54 years. Of these 10 were Maori and 41 European.
3. Eight Taranaki General Practices provided face to face free cessation support. The funding was $120,000 per annum. Secondary Care (Hospital Setting): Taranaki DHB has no internal smoking cessation service, all staff are responsible for the ABC model to provide hospitalised patients with brief advice and offer Nicotine Replacement Therapy and referral to specialist smoking cessation services. Between October and December 2013, Brief Advice has been offered to 922 patients of which 242 were Maori, and 9 Pacific. Funding for July 2013-June 2014 is $95,000.

**Cessation Services for priority populations**

1. The AKP providers for this area are:
   1. Tui Ora (Piku Te Ora Nursing Services): This service is based in New Plymouth and delivered out of Tui Ora Limited. This provider delivers the service in North Taranaki. In the last financial year it had 319 referrals (109 self-referrals) and enrolled 182 on the scheme. This is below the yearly target of 240 enrolments. The validated three-month abstinence rate was 4% which is the lowest across all providers that reported this figure. The self reported rate was 28%. There were 198 clients who had a TQD during this period. 116 were female and 6 were pregnant. There were 81 Maori and 109 NZ Europeans who set a TQD. The majority (87% or 191/219) of those on the scheme received NRT and a further 14/219 received varenicline. 181/195 received eight or fewer sessions of counselling support. Funding is $128,000 per year.
   2. Ngati Ruanui Health Clinic: This service is based in Hawera and delivered out of Ngati Ruanui Health Centre. This service received 111 referrals during financial year 2012/13. Most of these were self-referrals although there were some from schools. Enrolments for the year were 125 which were higher than the target of 120. The validated abstinence rate at three months was 31% and the self reported rate 37%. There were 147 clients who had a TQD during this period of which 93 were females of whom two were pregnant; 79/147 were Maori and all but 10 of the rest were NZ European; 96% or 144/149 of clients received NRT and 74% or 110/147 had fewer than four counselling sessions. Funding is $90,000 per year.
2. Pregnant women (Mana Wahine Hapu): This contract is with Te Kawau Maro (Taranaki Strategic Alliance between Tui Ora Ltd and the National Hauora Coalition). This service recognises and responds to specific needs of pregnant women who smoke, and will ensure that the service is safe and effective in helping them to quit smoking. The service will be accessed by self-referral and referrals from health and other services such as LMCs, Midwives, General Practices, hospitals and the community. Taranaki DHB receives funding to commission and provide smoking cessation support for pregnant women who smoke to the total value of $320,000 for a period of two years through a DHB contract with the Ministry of Health.
3. Pacific smokers. There are very few Pacific smokers in Taranaki and there are no specific services.

### Lakes

|  |  |
| --- | --- |
| Population | **76,008** |
| Smokers | 13,554 |
| Maori Smokers | 6,876 |
| Pacific Smokers | 582 |

**General cessation**

1. Quitline supported 219 quit attempts from Lakes DHB region in July to September of 2013 and 192 between October and December. Ninety-two Maori and thirteen Pacific smokers registered with Quitline during July to September and 85 Maori and six Pacific during October to December. Lakes DHB referred 80 patients to Quitline during July to September and 56 between October and December.

**Cessation Services for priority populations**

1. Maori. There are four AKP providers listed for the Lakes DHB, situated in the north of the DHB region in Rotorua and Ngongotaha and in Taupo.
   1. Korowai Aroha Health Centre: This centre received 396 referrals in the 2012/2013 financial year and enrolled 220 clients on cessation programmes. This was higher than its yearly target of 120. The validated abstinence rate is 27% at three months and the self-reported rate was 58%. Of the 221 clients with TQD in this period 162 were women and 4 were pregnant. There were 174 Maori and 28 Europeans; 80% or 184/230 received NRT and 18% or 42/230 varenicline; 174/251 received between four and eight sessions of counselling. Korowai Aroha has a $90,000 contract with MoH in the 2013/14 financial year.
   2. Te Whare Hauora O Ngongotaha: Although on the AKP website as a Lakes DHB provider this organization does not appear to have a MoH contract and is not listed as an AKP provider elsewhere under this name.
   3. Tipu Ora: This service is to provide health promotion and well child services and AKP may be a part of that. The service was referred 105 and enrolled 91 people in the 2012/13 financial year and achieved a three-month abstinence rate of 49% (validated, 83% self-reported); 103 persons set a TQD with this service in 2012/13 of which 82% (84/103) were Maori. Of the 103 who set a TQD there were 74 women of which 14 were pregnant. A low proportion (45/105) of those receiving support were treated with NRT but 48/103 received varenicline. 53/94 got between four and eight sessions of counselling. Tipu Ora has a $90,000 contract with MoH.
   4. Tuwharetoa Health Services Limited: This is to provide AKP services. In the last financial year they had 121 enrolments and 113 clients set a TQD. The three-monthly validated abstinence rate was, however, only 6% (the self reported rate was 8%). Of their clients that set a TQD in this period 80/113 were Maori. 85/113 were women of whom three were pregnant; 106/114 received NRT as part of their cessation support and 75/123 had had between four and eight sessions of counselling. Tuwharetoa Health Services Limited have a $90,000 contract with MoH.

### Whanganui

|  |  |
| --- | --- |
| Population | **47,694** |
| Smokers | 8,610 |
| Maori Smokers | 3,204 |
| Pacific Smokers | 261 |

Some information has been provided by the Whanganui DHB. At present there is no smokefree coordinator in Whanganui DHB.

**General cessation**

1. Quitline supported 131 quit attempts from Whanganui DHB region in July to September of 2013 and 93 between October and December. Thirty-one Maori and one Pacific smokers registered with Quitline during July to September and 28 Maori and one Pacific during October to December. Whanganui DHB referred 13 patients to Quitline during July to September and five between October and December.
2. Whanganui has a drop in quit clinic provided by the Whanganui Regional Health Network. The WHRN GPs also provide subsidised cessation services funded by the DHB.

The table below was provided by Whanganui DHB.

Table 15: Whanganui DHB: Quit clinic

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | New Patients | Consult 2 | Consult 3 | Consult 4 + 5 | Total no appts. |
| Jan – March 2013 | 100 | 61 | 36 | 50 | **247** |
| April – June 2013 | 135 | 97 | 70 | 92 | **394** |
| July  - Sept 2013 | 131 | 69 | 58 | 81 | **339** |
| Oct – Dec 13 | 92 | 54 | 53 | 42 | **241** |
| Total for last 12 m | **458** | **281** | **217** | **265** | **1221** |

Twenty-three percent of new patients whose ethnicity was recorded identified as Maori and 52% were female. Referrals to this service come from many sources. The most popular is by word of mouth and from a GP or nurse.

Over 2013, 312 clients remained on the programme for three months and 149 were smoke free (although not clear if this is validated or a self-report); 280 persons reached six months on the programme during 2013 and of these 115 or 41% were abstinent.

By Dec 2013, Quit Clinic has established a referral youth clinic (for young smokers between the ages of 12-19), and had put together a seven-day NRT trial pack with “The Quit Book”, stickers and car/house advice leaflets and local services details to be given out to every smoker on every ward at the hospital.

1. General practitioners presented 231 claims for funded cessation support, provided subsidised for priority populations. These are Pacific Islanders, Maori; those from Decile 5 and pregnant women. Of these claims 58% were female and 60% Maori.
2. The WHRN has improved its achievement levels of the targets. On average across the practices 92% of patients have their smoking status recorded, 89% is the average for the percentage of smokers given brief advice or cessation support and 22% is the average percentage of smokers given, or referred to, cessation support.

**Cessation Services for priority populations**

1. Maori: Te Ha Ora – Te Oranganui Iwi Health Authority. This service was referred 337 clients in the last financial year. Most of these (262) were self-referrals. Total enrolments on the programme were 301 - equal to the annual target. The validated abstinence rate was 28%; 271 clients set a target quit date in this financial year of which 160 were women and eight of which were pregnant; 209 of those who set a target quit date were Maori and 50 were European. NRT was given to 76% of those trying to quit, Varenicline to 8% and 14% received no pharmacology. Te Oranganui has an annual contract with the MoH worth $225,000.
2. Te Oranganui Iwi Health Authority also operates three health centres in Whanganui that can provide cessation support.

### Tairawhiti

|  |  |
| --- | --- |
| Population | **32,925** |
| Smokers | 6,906 |
| Maori Smokers | 4,488 |
| Pacific Smokers | 201 |

Tairawhiti has a high prevalence of smoking and most smokers are Maori. For that reason the cessation services in Tairawhiti don’t separate the Maori from the general population

**Cessation services**

1. Quitline supported 60 quit attempts from Tairawhiti DHB region in July to September of 2013 and 49 between October and December. Twenty-nine Maori registered with Quitline during July to September and 19 Maori during October to December. No Pacific smokers registered from Tairawhiti during this 6 month period. Tairawhiti DHB referred no patients to Quitline between July and December 2013.

**Cessation Services for priority populations**

1. Ngati Porou Hauora (NPH) holds the AKP contract for Tairawhiti. Individuals are offered three months of support or seven weeks group therapy plus NRT where necessary. Referrals are from GPs, LMCs, police, WINZ, Wellchild and word of mouth. NPH received 729 referrals in the last financial year, about equal numbers from hospitals and other health services and 160 from GPs. It enrolled 363 people on the scheme which is above its yearly target of 240. The validated abstinence rate at three months is 14%. There were 377 clients with a TQD during this period of which 252 were women and 14 were pregnant; 279/377 clients were Maori and 49 European; 74% of the clients received NRT and 15% no pharmacological product; 285/362 clients received less than four sessions of therapy. The AKP contract with NPH is for $180,000 in the current financial year.
2. Te Hauora O Turanganui A Kiwa is an AKP provider in Gisborne. It provides the same service as NPH. It was referred 237 clients in the 2012/13 financial year and 242 enrolled on the programme, exactly meeting its enrolment target of 240. The validated rate of abstinence for this programme at three months was 52%. There were 244 clients setting a TQD in this period of which 176 were women and 11 of them were pregnant; 181/244 were Maori and 48/244 NZ European; 87% received NRT and 9% no pharmacotherapy. Unlike the NPH service which gives most of its clients less than four sessions, the majority of clients 185/241 received four to eight sessions of counselling. Te Hauora O Turanganui A Kiwa is funded by an AKP contract worth $180,000 and receives some funding through the Midlands health PHO.
3. High school students (11-17 years), pregnant teenagers and teenage parents receive one-on –one smoking cessations advice from Te Aka Ora Charitable Trust. This is funded by the DHB with a 12 month contract worth $45,000. In the last three months 17 persons were on this scheme.

### South Canterbury

|  |  |
| --- | --- |
| Population | 45,492 |
| Smokers | 6,816 |
| Maori Smokers | 753 |
| Pacific Smokers | 66 |

**General cessation**

1. Quitline supported 144 quit attempts from South Canterbury DHB region in July to September of 2013 and 91 between October and December. Sixteen Maori and one Pacific smoker registered with Quitline during July to September and 10 Maori and two Pacific during October to December. South Canterbury DHB referred 60 patients to Quitline during July to September and 59 between October and December.
2. The smokefree team at SCDHB provides a general population cessation service which consists of individual or group based therapy in the community, workplace or in clinics. One hundred and five clients took part in this scheme in the last three months, 99 European and six Maori. This is in addition to the cessation advice and support provided at primary care level by GPs and practice nurses. The MoH funds this at $160,000 a year and the DHB also provides some funding.
3. Hospitalised patients receive cessation support including in many cases a one to one session with an adviser and NRT whilst they are in-patients. This is funded by the DHB. There is no information on numbers on this programme or the rate of success.

**Cessation Services for priority populations**

1. The AKP provider for South Canterbury is Community and Public Health Canterbury (CPHC) The CPHC is part of Canterbury DHB and also works in the Canterbury DHB and other DHB regions. It is not clear which figures for CPHC are relevant to the South Canterbury DHB region. Overall CPHC received 728 referrals and enrolled 559 onto programmes, in excess of its yearly enrolment target of 396. The validated abstinence rate at three months was 28%. Of the 570 clients who set a target quit date during the year 373 were women and 28 were pregnant. 316/570 were Maori and 217/570 European, 89% received NRT. 30% of clients received less than four sessions, 36% received 4-8 sessions and 32% 9-16 sessions. Canterbury DHB has a contract with an annual value of $334,000 to provide AKP services. South Canterbury reports 15 people enrolling on the programme in the last three months from their area and that the funding is $60,000 for their area.

### Wairarapa

|  |  |
| --- | --- |
| Population | 32,961 |
| Smokers | 5,550 |
| Maori Smokers | 1,410 |
| Pacific Smokers | 138 |

**General cessation**

1. Quitline supported 78 quit attempts from Wairarapa DHB region in July to September of 2013 and 56 between October and December. Seventeen Maori registered with Quitline during July to September and there were 12 Maori registrations during October to December. There were no registrations from Pacific smokers. Wairarapa DHB referred no patients to Quitline during the last six months of 2013.
2. Wairarapa DHB has two FTE smoking cessation coaches. PHO pays for newspaper ads to recruit smokers to the service. There is no information on the number of people receiving cessation services provided by the DHB.
3. There is a WERO challenge in operation (three-month group stop smoking service) with 20 persons enrolled.

**Cessation Services for priority populations**

1. Maori: The AKP provider for Wairarapa is the Whaiora Whanui Trust. They also have two FTE smoking cessation coaches. They received 144 referrals in the last financial year most of which were self-referrals. They enrolled 200, below their yearly target of 240. The validated quit rate at three months was 28%. There were 202 clients that set a TQD in this period of which 134 were women and four pregnant; 118/202 were NZ European and 64/202 were Maori; 72% received NRT, 20% Varenicline and 6% no pharmacology. The AKP contract is for $180,000.

There are no services specifically for pregnant women who smoke, young smokers, low income groups, Pacific smokers or those in or recently released from prison.

### West Coast

|  |  |
| --- | --- |
| Population | 26,001 |
| Smokers | 4,794 |
| Maori Smokers | 687 |
| Pacific Smokers | 48 |

**General cessation**

1. Quitline supported 48 quit attempts from West Coast DHB region in July to September of 2013 and 42 between October and December. There were eight Maori smokers registered with Quitline during July to September and seven Maori during October to December. There were no registrations by Pacific smokers. West Coast DHB referred no patients to Quitline in the last 6 months of 2013.
2. Coast Quit programme. This is provided by GP practices and includes up to seven sessions of one-on-one counselling, phone advice and support and NRT or other pharmacotherapies. Special dispensation was obtained to provide varenicline. The service if funded by the PHO and in 2012/13 cost $43,756 for 569 enrolments. The budget for 2013/14 has increased to $50,000. The service followed up 295 of those who received the service after three-four months 140 of whom had received NRT, 140 varenicline and 15 bupropion. One hundred and twenty three had remained quit at that date. There was a much higher success rate for those who had received varenicline than the other pharmacotherapies – however this was not a randomised trial so the results may not be applicable.
3. The DHB also has smoking cessation providers who supply the same service as the Coast Quit Programme but the number of sessions is not limited to seven. There is one FTE quit coach in Greymouth and 0.5 FTE in Westport.

**Cessation Services for priority populations**

1. Maori: The AKP provider for West Coast is Community and Public Health Canterbury (CPHC) based in Greymouth. The CPHC is part of Canterbury DHB and also works in the Canterbury DHB and other DHB regions. It is not clear which figures for CPHC are relevant to the West Coast DHB region. Overall CPHC received 728 referrals and enrolled 559 onto programmes, in excess of its yearly enrolment target of 396. The validated abstinence rate at three months was 28%. Of the 570 clients who set a target quit date during the year 373 were women and 28 were pregnant; 316/570 were Maori and 217/570 European, 89% received NRT; 30% of clients received less than four sessions; 36% received 4-8 sessions and 32% 9-16 sessions. Canterbury DHB has a contract with an annual value of $334,000 to provide AKP services. It is not clear how much of this is for services provided in the West Coast DHB region.

|  |
| --- |
| Summary points for cessation services within DHB Catchment Area |
| **Health Target:**  * 13 DHBs reported achieved Secondary Health Target in their 6-monthly report   + Waikato, Auckland, Southern, Capital and Coast, Northland, Hawke’s Bay, Nelson Marlborough, Taranaki, Lakes, Whanganui, Tairawhiti, South Canterbury, Wairarapa * No DHBs reported achieved Primary Health Target in their 6-monthly report   + Canterbury achieved above 70%, MidCentral and Taranaki 67%, Southern 60%   + Auckland, Bay of Plenty and West Coast achieved between 20-55%   + Other DHBs gave no information   Training to health workers:   * 18 DHBs reported providing training to Health workers, there is variation between DHBs * extensive (e.g., Canterbury, Southern) * little (e.g., Tairawhiti, Hawke’s Bay) * none (e.g., MidCentral, Northland)   Referrals:   * 9 DHBs reported number of referrals in their 6-monthly report   + Number ranging from 37-582   + 3 DHBs (Auckland, Bay of Plenty & MidCentral) made more than 500 referrals, others were below 300 * Counties Manukau and Mid-Central DHBs had a triage/referrals management system * Southern DHB developed single referral format * AKP providers in Auckland, Bay of Plenty, Nelson Marlborough, Taranaki and Tairawhiti DHBs received referrals from agencies other than health providers (e.g., police, WINZ, wellchild, schools)   Group-based cessation:   * 6 DHBs ran group based cessation programmes and/ or WERO * Counties Manukau, Southern, Bay of Plenty, Northland, Hawke’s Bay, Wairarapa * Wairarapa reported a quit rate of 70% * Not enough information is available to calculate cost per quit   Priority Groups:   * Maori: 5 DHBs provided/funded specific cessation services for Maori smokers (in addition to services provided by AKP) * Counties Manukau, Waitemata, Southern, MidCentral, Northern * Pacific: 7 DHBs provided specific cessation services for Pacific peoples * Canterbury, Counties Manukau, Waitemata, Waikato, Capital and Coast, MidCentral, Hutt * Pregnant Women: 8 DHBs provided specific services to pregnant women * Canterbury, Counties Manukau, Waitemata, Auckland, Bay of Plenty, MidCentral, Hawke’s Bay, Taranaki * Youth: 2 DHBs provided specific services to youth * Whanganui, Tairawhiti * Low SES: no DHB provided specific services to low income people * Mental illness: no DHB provided specific services to mental illness patient, however, Nelson Marlborough DHB mentioned they trained mental health staff in ABC, MidCentral DHB had supported the Acute Mental Health Inpatient Unit became smokefree, and the 4 Northern DHBs have added clauses to all mental health contracts requiring them to develop comprehensive smokefree policies for their facilities, grounds, staff, cars etc. * Ex/current Prisoner: no DHB provided specific services to ex or current prisoners   Hospital follow up services:   * Waitemata DHB provided face to face or groups counselling from professional psychologists and NRT to hospital outpatients * Nelson Marlborough DHB offered 4-8 phone follow up services (unless patient able to travel to hospital for follow up appointments) for three months   PHO:   * Canterbury: 3 PHOs funded general cessation services in the Canterbury DHB area (i.e., Pegasus, Rural Canterbury and Christchurch) * Waitemata: Waitemata PHOs were funded (by DHB or directly by MoH) to provide specific services to Whanau, Asian and pregnant women. Procare PHO have contracted 17 pharmacies to provide NRT (funded by DHB). * Auckland: DHB worked with PHOs to proactively contact enrolled smokers on GP lists to offer advice and support to quit * Southern: DHB worked with the PHO to deliver group-based cessation in Dunedin * Bay of Plenty: Western BOP PHO received funding from DHB to provide group therapy programme including NRT to clients * Mid-Central: PHO partnered with Te Ohu Auahi Mutunga to provide specific service for Maori, Pacific People and pregnant women * Northland: Manaia and Te Tai Tokerau PHOs provided ABC service (funded by DHB) * Nelson Marlborough: GP surgeries provided general cessation services in Nelson Marlborough DHB area (funded by the DHB through a contract with the PHO) * Tairawhiti: Midlands health PHO provided some funding to Te Hauora O Turanganui A Kiwa (AKP provider) * Taranaki: local GP practices provided face to face support and NRT (funded by DHB) * Whanganui: GPs provided subsidised cessation services funded by the DHB * Wairarapa: PHO pays for newspaper ads to recruit smokers to the cessation service * West Coast: PHO funded Coast Quit programme   Quit rate   * Reported 3-month validated quit rate for AKP, Pacific and pregnancy cessation services providers ranged from 2-71% the average for AKP and Pacific was 27% and for pregnancy services 14%. For most DHBs, there is no information on quit rates. |

# Cessation sector development and collaboration

1. National
   1. National Heart Foundation
   2. Innovation Fund
2. Regional level development through Innovation funding from the Ministry of Health

**National Heart Foundation**

The contracts for the National Heart Foundation included a monthly innovations fund project worth $248,256 a year and a project on “Nutrition, Physical Activity, Tobacco and Pacific Island Heartbeat Services” worth $863,081 a year.

With the funding of $863,081 for 2013/14, the Heart Foundation proposed to:

* Support general practice ‘buy-in’ to the Health Target together with change in practice, focusing on GPs, Practice Managers and Practice Nurses
* Increase those confident to deliver cessation support through more accessible training, particularly for those in general practice and working with Pacific populations e.g. online options, one day and 1-2 hour refresher options, follow up newsletters and mentoring (particularly Pacific)
* Help improve data capture and feedback to GPs by promotion data tips e.g. the Quitline referral form in MedTech 32 and use of audit tools such as Dr Info and Health Stat
* Help improve referrals to cessation providers
* Transition our health promotion activities to make greater use of multiple media e.g. radio, social media, as well as our traditional face to face activities
* Continue to provide Tobacco Control leadership for Pacific peoples (i.e., increase Pacific people awareness and knowledge of harm of tobacco use, provision of strong and effective leadership for the Pacific tobacco control sector, strengthen knowledge and skill base of Pacific communities to empower community leadership to adopt Smokefree practices and be agents of change, and be the conduit for bringing a Pacific voice to the development of related public policy and practice)
* Greater integration of smoking cessation and CVD activities to support both Health Targets
* Put day one of our CPT flagship course online and do more mentoring

During the period July-December 2013, the following activities have been taken:

* PHO and General Practice Support: CVD Risk and smoking cessation health targets. All 35 PHOs contacted; over 20 sessions on CVD and 11 smoking cessation specific sessions.
* Smoking Cessation training: 57 sessions and participants have completed 1,059 courses.
* Training Alumni e-Newsletter: A new e-newsletter to 4,860 smoking cessation training alumni (from 2005)
* Promotion: Four key Primary Care conferences to promote CVD Risk assessment and smoking cessation support services.
* Pacific Health Promotion: New Pacific Smoking Cessation Specialist and Pacific Smokefree Health Promoter recruited. Focus on developing a Smokefree promotion, marketing and media plan.

**Innovation Fund: National level**

**ASH**

For the “National Quit Smoking Month” project ($2,257,000 for three years), ASH received $46,875 per month from September 2013 to June 2014. This project absorbed the previous No Smoking Day and has the aim to achieve 65,000 quit attempts through a multi high-level profile promotion.

During the period July – December 2013, the following activities have been taken:

* Regular meetings with Health Promotion Agency and Inspiring Ltd have been held at ASH
* Drafted the success criteria for the project
* Successful recruited National Quit Month Campaign coordinator, technical advisory group and stakeholder group

**Auckland UniServices**

The “WERO-Group stop smoking competition” project ($3,875,078 for three years) aimed at triggering mass quitting through group competition (with each team having its own coach and smoking cessation provider).

**Auckland University of Technology**

The “Campaign to enhance smoking cessation interventions in general practice” project ($334,650 for one year) is a media campaign for the primary care sector. This project will include a video of smokers and ex-smokers talking about the smoking cessation care they expect from staff in general practices and will contribute to the Ministry’s primary care health target ‘Better Help for Smokers to Quit’.

**Innovation Fund: Regional level**

**Counties Manukau DHB**

CMDHB’s “Supporting Smokefree Intersectorally” project ($1,342,050 for three years) aims to provide a total package of smokefree support for agencies across a range of sectors outside of health that service populations in the Counties Manukau area.

**Hawke’s Bay DHB**

HBDHB’s “**Shifting the Culture in Mental Health Services” project ($208,449 for two years)** aims to effect a culture change within mental health services regarding the current acceptance and encouragement of tobacco use. It includes developing practice guidelines and implementing these within a pilot site. There is scope in this project for a national roll-out.

**University of Otago**

**The “Taking NRT Direct to Smokers” project ($757,466 for 13 months)** gives smokers the opportunity to sample Medsafe-approved nicotine replacement therapy products to inspire them to make a quit attempt. A competition will run from at least four community-based project sites in the greater Wellington area.

# Health Promotion and Advocacy

## National Level

### ASH

One of the contracts ASH had with the Ministry of Health is for the ‘Smokefree Information Services’ running from 1 July 2013 to 1 July 2014 with a budget of $578,000. 31% (2.2 FTE) of this funding is allocated to the Knowledge and Information output and 26% of this funding (1.2 FTE) is allocated to the Raising Awareness output.

During the period July – December 2013, the following awareness-raising activities have been taken:

* Regularly updated ASH website with summaries of NZ smoking data, latest news in research and international trends and developments. This site had 10,000 visits since July 2013 and the website platform is currently being reviewed.
* Daily updated ASH Twitter feed and Facebook page with the latest news and information.
* Produced monthly media summary reports of key stories, and reviewed media trends, journalist support and the reach of key messages to different audiences.
* Administered an email network for people working in New Zealand tobacco control (this work is not funded by MoH but by donors).
* Monitored and published information on tobacco pricing.
* Continued to make use of tobacco industry documentation to help inform the public how the industry operates.
* Responded inquiries and requests for information on tobacco issues.
* Presented to young alternative education settings with predominantly high Maori and Pacific enrolments to stimulate and encourage conversation and debate around smoking.
* Provided advice and support to high needs communities.
* Published a quit smoking options brochure.
* Worked on raising awareness among community groups of the Ministry of Health consolation on plain packaging of cigarettes.
* Commented on TVNZ news bulletins and 3 News, Radio NZ, National Radio, Prime News, Mike Hoskings Show, Planet FM, NiuFM, Radio 531PI, Te Karere, Māori TV, and Radio Waatea, and there were over 200 stories featured ASH comments in printed media.
* Supported the delivery of World Smokefree Day activities in the Auckland region.

#### Smokefree Coalition

The Smokefree Coalition Trust had a contract for $167,213 in the financial year 2012/13. The Smokefree Coalition currently has 56 organisational members, its priority is to achieve tobacco free Aotearoa, mainly through awareness raising and advocacy.

In the financial year 2012/13, the following activities have been taken:

* Calls to action sent to members or to the Smokefree2025 listserv whenever new democratic processes needed support or when risks to the Smokefree 2025 goal were identified. These were concentrated on: 1) public consultation of Plain Packaging of Tobacco products; 2) greater taxation and reduction of duty-free allowances; 3) Smokefree cars; and 4) the Trans Pacific Partnership Agreement negotiations.
* Provided fortnightly e-newsletter “Tobacco Control Update” to keep the sector updated on progress throughout the country and around the world. The subscription rate is currently 1023.
* Reviewed all past Tobacco Control Updates back to 2010 and archived it according to the objectives of the Smokefree National Action Plan.
* Regularly updated SFC website and Twitter (@[Smokefreeby2020](https://twitter.com/Smokefreeby2020)) with the latest documentation, publications and media releases.
* Developed and maintained an online national database “Smokefree Contacts Online Datamap”

**HPA**

The Health Promotion Agency (HPA) was formed on 1 July 2012 through the merger of the Alcohol Advisory Council (ALAC) and Health Sponsorship Council (HSC) and some health promotion functions previously delivered by the Ministry of Health. HPA is the main health promotion organisation in New Zealand, with tobacco control as one of its key areas. HPA has a particular focus on youth, with its “Smoking Not Our Future” social media campaign, the “Smokefreerockquest” and “Smokefree Pacifica Beats” musical events, and the “Smokefree Schools” project.

Although HPA is not under the scope of this review, it is important to note its activities in this area.

### Local Level

#### DHB health promotional activities

The six monthly DHB reports provided by the Ministry of Health indicated that most DHBs carried out some sort of health promotional activities during the six month reporting period. Table 18 provides a summary of those activities. (Please note that some of the activities listed in the “Leadership and Coordination” section may also have some health promotion component (e.g., developing and implementing smokefree policies) which are not listed again here).

Table 16: Health promotion and advocacy undertaken by DHB

|  |  |  |  |
| --- | --- | --- | --- |
| DHB | Reporting Period | Health promotion to the general public | Advocacy |
| Canterbury | Jan –Jun 2013 | * World Smokefree Day 2013 :   + Smokefree displays were set up at various organizations and workplaces. Some places had staff to provide Quitcards, cessation support, information, and motivational advice.   + Letters were sent to all Secondary Schools which included a couple of SFD resources. Some schools accessed further resources and mounted displays, ran SF activities, and provided SF information.   + Letters were sent out to all GPs reminding them of WSD and included some resources for making a basic display.   + Displays were set up in all the five major hospital foyers and in two units in the Specialist Mental Health Services. Gift baskets containing coffee tea and biscuits and WSD resources were made up for the 48 wards on the Christchurch site (funded by the Director of Nursing). WSD coffee cup sleeves were provided in all cafes on the Christchurch Hospital site.   + Extensive media coverage through radio (Mai FM, Tahu FM, Plains FM), TV (Newstalk ZB, Canterbury TV), feature articles in newsletters and CEO Update, Facebook and Smokefree Canterbury website. * Presentations have been carried out at The Press (for Heart Week), Pullins Shearing Health Day (three sessions), the Pulmonary Rehab group, The Refugee and New Migrant Centre, Nova Trust and Phillipstown Kohanga Reo. * A presentation on the social service community ABC work was presented at a Healthy Christchurch hui (200 member organizations). * Work has been done with a number of rest-homes and a Smokefree / ABC presentation was made at the residential care forum. * Developed several resources: table top conversation starters; Quitpacks; two pull-up banners advertising Smokefree 2025 and the CDHB Smokefree policy; Smokefree lanyards; Posters outlining the new constraints around staff smoking; Swingcards outlining the ABC and NRT information; and Smokefree noticeboards. |  |
| Counties Manukau |  | No report received |  |
| Waitemata | Jan –Jun 2012 | * Co-facilitated with Pacific Heartbeat smokefree education sessions for Pacific churches. * Sent a pack of information and supportive resources about quitting in pregnancy to all LMCs in the district. * Supported organizations that undertook World Smokefree Day activities. * Co-facilitate with ADHB, the Auckland Regional Smoking Cessation Network educational meetings for the smoking cessation and tobacco control workforce across the region (bi-monthly). | * Championed a submission to PHARMAC regarding opening access to NRT – supported and signed by DHBs representing 2.3 million New Zealanders. |
| Waikato | Jan –Jun 2013 | No activities reported |  |
| Auckland | Jul – Dec 2013 | * Quit Now Display/Stand ran twice a month on Level 5 of Auckland Central Hospital (ACH). * Displayed ‘Stop smoking’ banner at entry to ACH and had ‘Please take a brochure’ desk below the banner. * World Smokefree Day: one display stands at ACH, one at National Women’s Health, and one at Greenlane Clinical Centre were set up to discuss quitting options and sample some product. * Smokefree posters used at ADHB external events. * Regularly featured in the weekly electronic ADHB publication ‘Nova Notice board’ * Constantly updated the ADHB Intranet Smokefree site * Health promotion activity done by PHOs: * Procare used its Health Promoting Practice framework to promote quitting smoking in its member Practices. They also ran a competition amongst practices for the best smokefree display / promotion. * The Auckland PHO CEO chairs the CVD risk and diabetes working group within ADHB |  |
| Southern | Jul - Dec 2013 | * Supported the development and implementation of the Little Lungs – Pūkahukahu Iti project (16 centres have taken part; a six month evaluation report has been drafted for the 9 Otago centres). * Developed the Pacific version of Smoking Affects Lives poster series (which will be launched in 2014). * The Otago Smoking Affects Lives was displayed at five workplace settings and in two community events. The Southland Smoking Affects Lives Pasifika was displayed at 4 settings in the community and at two community events. * Smokefree was featured in a Better Health TV episode aired on the local Dunedin station. * A Christmas promotion “Quit Now and Give Yourself a Pay Rise for Christmas” was held, with copies of the promotion posters sent to all primary health services. * Produced and sent out the first of a quarterly newsletter “Smokefree Southern News” to all hospitals and practices. | * Wrote to Invercargill City Council on behalf of Smokefree Murihiku requesting cemeteries to be designated as smokefree. * Smokefree submissions were approved and processed by the Submissions Committee, including comments on the: Greater Taylor Park Reserve Management Plan: Clutha District Council and the Roxburgh Reserve Management Plan: Central Otago District Council. |
| Capital & Coast | Jan –Jun 2013 | * Provided more Smokefree signs to CCDHB hospital and health clinic grounds and buildings particularly around hospital entrances. * Personnel from various tobacco oriented services including those funded By CCDHB regularly participated in community events such as Creekfest and carried out health promotion activities on World Tobacco Free Day and similar opportunities. |  |
| Bay of Plenty | Jan –Jun 2012 | * Toi Te Ora Public Health Unit:   + Promoted smokefree through a variety of communication channels including: feature articles in newsletters, E-updates and web news, media coverage for WorkWell smokefree.   + Provided ‘Health Promoting Schools’ programme to 76 schools.   + Uploaded the latest Smokefree resources on the Toi Te Ora - Public Health Service health promoting schools website to support schools to become Smokefree. * World Smokefree Day:   + Eastern Bay: events held in Whakatane and Opotiki.   + Western Bay: events held in BOP Polytech and Tauranga Hospital and the Tauranga Moana Wahakura Pepi-Pod Wananga. |  |
| Mid central | Jan –Jun 2013 | * Tobacco Free Central (TFC) collaborated in the following activities: Relay for Life, Shannon School Gala, Hato Paora College Gala, Pasifika Celebration Day (Horowhenua), Workshops with UCOL first year nursing students, Whanau Triathlon, Summer Packs (smoking cessation support), Midwife packs (smoking cessation support), He Ara Hou Quitcards (“One Card”), Te Wananga o Raukawa (policy development), Te Wananga o Aotearoa (policy development), Palmerston North City Council Smokefree Outdoor Areas policy development. * World Smokefree Day: close to 75% of those who attended were rangatahi Maori and their whanau. * Sponsored the Manawatu Turbos (NPC Rugby) and displayed Smokefree messages on screens at Turbos games, at the showground’s grandstand, and on Turbos rugby jerseys. |  |
| Northland | Jan –Jun 2013 | * World Smokefree Day:   NHHT   * + Uploaded 30 video testimonials on You Tube.   + Held ‘Quit and Win’ weekly competition.   + NDHB showed ‘My People, My Place, My Identity’ on ED TV and provided to Channel North.   + Held Quit Kiosk in Cameron Street Mall.   Te Hiku   * + Created Waiata.   + Held Quit Kiosk at old Pak’n’Save car park.   + Rangi Awhia Kura walked down street promoting SF cars.   Te Ha Oranga   * + Introduced quit services to clients and staff in DRG and offered cessation support.   Hospital Team   * + Promoted staff who have successfully quit “roll of honour”.   + Held Quit Kiosk at staff café.   Hauora Hokianga   * + Held Women’s Health golf tournament.   + Photo booth SF Hokianga Tangata, Hokianga Korero.   + WSFD/Quit presence at Kohewhata Hauora Day, Kaikohe. |  |
| Hawke’s Bay | Jan –Jun 2013 | No activities reported |  |
| Hutt Valley | Jul –Dec 2012 | No activities reported |  |
| Nelson Marlborough | Jan –Jun 2013 | No activities reported |  |
| Taranaki | Jul –Dec 2012 | * Supported initiatives driven by the Smokefree Coalition which included: Taranaki A & P Show, Smokefree High Schools Project, and Christmas Parades held in Manaia and Eltham. | * Smokefree/Auahi Kore Coordinator wrote a submission ‘To Introduce Plain Packaging of Tobacco Products in New Zealand’. |
| Lakes | Jan-Jun 2013 | * Lakes Auahi Kore/Smokefree Coalition distributed resources for WSFD. * Implemented Smokefree communications plan which included: * distributed Smokefree resources to the community and primary care * used Smokefree gazebo, flags and balloons at community events * provided Media releases * carried out Clean air for baby campaign * carried out Pepi pod campaign |  |
| Whanganui | Jul – Dec 2011 | * No Smoking Day 2011: Gave out ‘Helper Pack’, ‘Quit Pack’, and NRT patches/ gum/ lozenges at 8 different locations, used local media (newsletters and radio) and flyers to promote No Smoking Day. * Developed ‘Summer Pack’ to support quit attempts over the Public Holidays of Christmas and New Year.   Quit Clinic   * Between Oct-Dec 2013, Quit Clinic put together a seven day NRT trial pack with “The Quit Book” , stickers and car/house advice leaflets and local services details to be given out to every smoker in the hospital | * Submitted information and evidence for the DHB submission on the Green Paper of Vulnerable Children.   Quit Clinic   * Between Oct-Dec 2013, Quit Clinic worked with the Wanganui quit smoking network and the city council in writing the policy for a “smokefree city centre” |
| Tairawhiti | Jan –Jun 2013 | * Supported Te Wananga o Aotearoa with smokefree promotions at their Mana Tauira Student Open Day. * World Smokefree Day 2013: distributed WSFD resources across TDH, Ngati Porou Hauora and Turanga Health. A range of activities were carried out by different providers throughout the month of May culminating to a community march along the main street in Gisborne on World Smokefree Day. Turanga Health had a cook-off at Three Rivers Medical Centre while Ngati Porou Hauora focused on food vs. tobacco price comparisons and had information on display within their communities. |  |
| South Canterbury | Jan –Jun 2013 | * AKP presentations at four health related hui held in conjunction with Arowhenua Whanau services. * Mailed out to 68 retailers regarding Smokefree Law Change in general, 4 letters separately targeting ‘tobacconists’. * Three workshops have been held with ECE personnel. * Signage and Quit information has been provided to 200 shearing contractors. * World Smokefree Day: surveyed the public on smoking in cars and provided media coverage including newspaper, radio and newsletters. * Promoted Smokefree 2025 to committee member’s management teams, Local Cancer Network Committee, Community & Public Health, Heart Foundation Volunteers. * Letter to the editor re Plain Packs published. | * Letters sent to John Key, Tariana Turia and Jo Goodhew regarding Plain Packs. Letter to Mackenzie District Council regarding “Butt Bins”. |
| Wairarapa | Jan –Jun 2013 | * Smokefree Coordinator (SFC) provided Smokefree training for Baby Friendly Community Initiative, The Heart Foundation, and Two Hearts. * Provided extensive media coverage (in local newspapers and on the radio) on a variety of activities carried out by the Wairarapa Smokefree Network, including World Smokefree Day, smokefree champions and the success of the All Together Quit Groups. * Provided Smokefree signage to playgrounds. * Completed 34 education visits. * Distributed a pamphlet developed by the Police about psychoactive substances to retailers. * Wairarapa Smokefree Network provided smokefree banners and resources at the following events: Waitangi Day, Ngati Hamua Kohanga Reo 30 year celebration, the Heart Foundation’s Mother’s Day Walk, Families Day, Youth Week, and Children’s Day. * World Smokefree Day: a celebratory morning tea was held for smokefree pregnant mums; a lunch was held to promote smokefree Whanau; photographs were taken of junior rugby, soccer and Ngati Hamua Kohanga Reo for the “Turn Your Back on Tobacco Campaign”; displays were provided at pharmacies, libraries and the hospital; held Wairarapa Smokefree Awards ceremony. |  |
| West Coast | Jan –Jun 2013 | * Activities ran by the West Coast Tobacco Free Coalition during this period included: Smoke free tent at Relay for Life in Greymouth and at the Waitangi Day picnic; TXT2QUIT posters delivered to over 25 agencies; ‘Quit Now’ support packs mailed-out to over 20 employers; made submissions to all 3 District Councils; and developed ‘Smokefree Guidelines’ for smokefree events. * Smokefree May 2013: Smokefree display on the theme of ‘Quit Now. It’s about Whanau’ and had a brochure display stand containing smokefree and cessation brochures at various locations; distributed at least 50 Text2Quit posters; prepared weekly media releases; and promoted participation in the ASH Year 10 survey. * Activities ran by the Buller Smokefree Youth Co-ordinator during this period included: circulated youth-focused information and resources to schools; provided cessation support to students and tutors; promoted the smokefree message at events such as the Waitangi Day picnic and Reefton Skate Park Event; spoke about cessation and smokefree message at the Fishing School. * Media activities included: various media articles have been published in local newspapers; Smokefree messages at the Greymouth fundraising Boxing event; Smokefree messages have been included in primary school notices; notices regarding the Smokefree Youth Coordinator have been included in the daily notices at Buller High School. |  |

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| --- |
| Summary points |
| SH provided Smokefree information and advocacy at the national level, including  * updating website/twitter/Facebook * media monitoring and producing summaries of media items * media appearances  Smokefree Coalition provided Smokefree information and advocacy at the national level, including  * Calls to action sent to members/sector * Fortnightly e-newsletter * updating website/twitter  15 DHBs promoted Smokefree to general public in their area through  * World Smokefree Day promotions * Displaying SF signs/posters/displays * Distributing SF resources * Supporting SF events run by other organisations * Producing Media releases * Presenting SF messages to community groups/schools  5 DHBs advocated for tobacco control through  * Submissions * Letters |

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# Enforcement

### DHB enforcement

Tobacco enforcement within DHB’s is largely the responsibility of the public health units. There are 12 PHU’s that often work across DHB regions.

For example Auckland, Counties Manukau and Waitemata DHBs, enforcement activities were carried out by Auckland Regional Public Health Service who ensured compliance with the smokefree legislation and also carried out Controlled Purchase Operations (CPO) to confirm retailers are not selling to those under the purchase age. For Capital and Coast, tobacco control enforcement activities were coordinated by Regional Public Health.

CPOs are being carried out and reported in the ISE report. PHUs report carrying out 36 such operations between July 1 and December 31 of 2013 visiting 506 premises and reporting 36 positive sales. Tairawhiti and Northland DHBs reported no CPOs during this period.

Table 17: Controlled Purchase Operations (CPOs) carried out by Public health Units: Jul-Dec 2013

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Tobacco retailer education visits | Number of CPOs carried out | Number of retailers visited during CPOs | Number of positive sales during CPOs |
| Auckland Regional Public Health Service | 0 | 2 | 27 | 0 |
| Bay of Plenty (Toi te Ora) | 42 | 4 | 35 | 4 |
| Community and Public Health, Canterbury | 177 | 10 | 146 | 7 |
| Health Care Hawke's Bay | 110 | 1 | 66 | 0 |
| Health Waikato | 42 | 3 | 29 | 6 |
| MidCentral Health | 109 | 6 | 67 | 3 |
| Nelson Marlborough Health | 124 | 2 | 21 | 5 |
| Northland PHU | 0 | 0 | 0 | 0 |
| Public Health South | 155 | 3 | 22 | 1 |
| Regional Public Health (Wellington) | 36 | 3 | 61 | 5 |
| Tairawhiti PHU | 0 | 0 | 0 | 0 |
| Taranaki Healthcare | 26 | 2 | 32 | 5 |
| Aggregate | 821 | 36 | 506 | 36 |

DHBs also reported other enforcement activity carried out in their regions (Table 20).

Table 18: Enforcement reported by DHB

|  |  |  |
| --- | --- | --- |
| DHB | Reporting Period | Enforcement |
| Canterbury | Jan –Jun 2013 | * 63 visits were made checking compliance and providing supporting education. * 5 CPOs were carried out testing 40 retailers – nine were selling to minors. |
| Counties Manukau |  | * ARPHS carried out enforcement activities |
| Waitemata | Jan –Jun 2012 | * ARPHS carried out enforcement activities * WDHB – enforcing Smokefree Buildings and Grounds at both hospital sites |
| Waikato | Jan –Jun 2013 | * No enforcement activities reported |
| Auckland | Jul – Dec 2012 | * ARPHS carried out enforcement activities |
| Southern | Jul - Dec 2013 | * + - * Retailer education visits: * Otago – 104 * Southland - 30 * Central Otago & Queenstown Lakes – 28   + - * Control Purchase Operations: * Southland – CPOs for herbal smoking products – no sales * Clutha – CPO for tobacco products – one retailer sold * Reactive CPO of premise suspected of selling to minors – no sale.   + - * Complaints and Enquiries: * A total of 13 complaints were received * A total of 19 enquiries were received * A total of 853 licensed premises were reviewed for tobacco compliance with the Smokefree Environments Act as part of liquor license applications. |
| Capital and Coast | Jan- Jun 2013 | * No enforcement activities reported |
| Bay of Plenty | Jan –Jun 2012 | * Toi Te Ora Public Health Unit:   The Environmental Health Team continued to carry out regulatory work in relation to tobacco control (e.g., CPO, night visits to licensed premises, investigating complaints, and visiting retailers re tobacco products displays).   * Security regularly patrolled DHB grounds/roof garden for smoking on site; Smokefree grounds being monitored regularly. |
| Mid central | Jan –Jun 2013 | * 37 CPOs were carried out - there were 3 sales to the underaged volunteers. Mid-central’s provider organisation, Mid Central Health, is also responsible for enforcement and regulatory oversight in Whanganui DHB region |
| Northland | Jan –Jun 2013 | * No enforcement activities reported |
| Hawke’s Bay | Jan –Jun 2013 | * No enforcement activities reported |
| Hutt Valley | Jul –Dec 2012 | * No enforcement activities reported |
| Nelson Marlborough | Jan –Jun 2013 | * No enforcement activities reported |
| Taranaki | Jul –Dec 2013 | * Taranaki DHB Public Health Unit carried out enforcement activities |
| Lakes | Jan-Jun 2013 | * No enforcement activities reported |
| Whanganui | Jul – Dec 2011 | * No enforcement activities reported |
| Tairawhiti | Jan –Jun 2013 | * No enforcement activities reported |
| South Canterbury | Jan –Jun 2013 | * 1 CPO was carried out – no sales recorded. * 3 Workplace smoking complaints investigated. |
| Wairarapa | Jan –Jun 2013 | * 1 CPO was carried out, 13 premises were visited – no sales recorded. * Continued to monitor compliance of On Licensed premises around the Smokefree Environments Act. |
| West Coast | Jan –Jun 2013 | * 2 CPOs were carried out, 15 tobacco retailers were visited – no sales recorded. * Community & Public Health staff visited retailers to discuss retail displays (removal of tobacco displays) and other related issues. |

|  |
| --- |
| Summary points |
| * 11 DHBs reported on enforcement  CPOsVisited retailer to check complianceInvestigated complaints  * The 12 PHUs carried out 36 controlled purchase operations in the 6 months prior to 31 December 2013, visiting 506 premises and recording 36 sales.  Northland and Tairawhiti PHUs did not carry out any CPOs |

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# Leadership and coordination

### National Level

#### ASH

The main contract ASH had with the Ministry of Health is the ‘Smokefree Information Services’ running from 1 July 2013 to 1 July 2014 with a budget of $578,000. 40% (2.3 FTE) of this funding is allocated to the ASH community work. This covers the work ASH does on engaging communities in the democratic process around tobacco policy, intensive community work around local and settings-based Smokefree policies, involvement in a number of regional strategic forums for local Smokefree policies and work with several DHB’s on regional Smokefree 2025 strategies.

During the period July – December 2013, the following leadership and coordination activities have been taken:

* Attended and contributed to all National Smokefree Working Group meetings
* Attended and assisted in Smokefree Conferences and symposium
* Strengthened relationships with Hapai Te Haoura Tapui in Auckland following a successful bid for a joint venture to deliver the National Maori Tobacco Control Leadership Service – Te Ara Ha Ora
* Supported Maori and non-Maori quit support services (Aukati Kai Paipa and others) in Northland, Auckland, Whanganui, Taranaki and other areas to increase opportunities to solicit quit attempts from their communities
* Offered support, feedback and advice to other non-Māori Health organisations in their approach to Māori and pacific communities
* Worked with settings who have high Māori and Pacific enrolment to support them to support their students to live Smokefree
* Participated in the International Human Rights and Tobacco Control Network, and the International Tobacco and Trade Network
* Involved in a number of national and regional boards of trustees, advisory groups and committees
* Supported Cessation Promotion with the Framework Trust Touch Tournaments played throughout the year to promote Smokefree and quitting at their Auckland regional mental health consumer touch rugby tournament
* Collaborated with and supported the Heart Foundation on several tobacco-related issues
* Collaborated with Auckland Cancer Society to provide feedback to Auckland Council
* Collaborated with the Cancer Society National Office on advocacy and promotion of urgent tax increases on tobacco

#### National Maori Tobacco Control Leadership Service (Hapai Te Haoura Tapui)

Hapai Te Haoura Tapui had two contracts with the Ministry of Health. The “National Maori Tobacco Control Leadership Service” is $300,000 a year (from 2013 to 2015). Its goal was to reduce tobacco related mortality and morbidity amongst Māori in New Zealand, and to reduce health inequalities caused by tobacco. Hapai proposed to achieve these through: 1) Te Whāinga Tuatahi: Whakawhanaungatanga – Build relationships; 2) Te Whāinga Tuarua: Nga Whakamarama o te tino kaupapa – Promote key messages; and 3) Te Whāinga Tuatoru: Te Puna Rangahau – Use of evidence. For this contract, Hapai formed a Memorandum of Understanding with ASH for the delivery of the service (Note: there has been no separate contract with ASH for this service).

During the period July-December 2013, the following activities have been taken:

* Identified and recruited a King Tuheitia appointed patron (June Mariu) as well as Māori champions
* National Media coverage for services
* Launched and promoted Te Ara Hā Ora through face to face meetings and IT innovations
* Connected and built relationships with Māori cessation providers, Māori health promoters and iwi leaders across NZ
* Secured tupeka kore champions
* Built relationship with researchers and policy developers in tobacco
* Forged new relationships and partnerships that will benefit Māori tobacco control
* MOU with ASH and built a positive working relationship

The other contract, “Maori Public Health Leadership” is $287,182 for the financial year 2013/14.

#### Smokefree Coalition

The Smokefree Coalition Trust had a contract for $167,213 in the financial year 2012/13 and one for $167,300 in the FY 2013/14. Besides awareness raising and advocacy, the Smokefree Coalition is also active in:

* Developing, maintaining and strengthening strategic alliances
* Developing communication and collaboration between agencies involved in promoting tobacco freedom for Aotearoa
* Coordinating and strengthening the efforts of agencies involved in tobacco control with the objective of facilitating and presenting a unified voice on tobacco control
* Providing leadership in national advocacy campaigns and the National Smokefree Working Group
* Liaising with regional Smokefree Coordinators and coalitions

In the financial year 2012/13, the Smokefree Coalition continued to develop and maintain collaborations between agencies. Prudence Stone was assigned "lead agent" on dissemination and monitoring of Effective Legislation & Regulation of the National Smokefree Working Group's Action Plan for 2013-2015.

#### National Heart Foundation

The National Heart Foundation is contracted to provide Pacific leadership and health promotion in relation to tobacco control and awareness. For more information please refer to “Cessation sector development and collaboration” section.

#### Other unfunded organisations

Other organisations are involved in tobacco control leadership. For example, the Cancer Society of New Zealand is a key contributor to the National Smokefree Working Group. It is not funded for this involvement.

### Local Level

#### DHB leadership activities

Besides undertaking health promotional activities and carrying out enforcement in relation to tobacco control (these were covered in other chapters), DHBs also provided leadership via participating/holding meetings and reviewing policies.

Table 19: Leadership activities provided by DHB

|  |  |  |
| --- | --- | --- |
| DHB | Reporting Period | Leadership activities |
| Canterbury | Jan –Jun 2013 | * Approved ‘The combined South Island DHB Tobacco Control Position Statement’ and ‘The CDHB Strategic Tobacco Control Plan 2012 – 2015’. * Provided administrative support to Smokefree Canterbury, and leadership via participation on the Executive team. * Provided support and training to: Salvation Army, City Mission, Presbyterian Support services, and Kingdom Resources. * Preliminary work (meetings, presentations, motivational support, quitting support, other activities) has been carried out with various organizations, aiming to build relationships and make contacts to enable more groups to be trained in providing or promoting cessation support. These include the Wananga, The Arthritis Society and Kimihia Young Parents College. * Provided support to Christchurch Polytech which has now a fully smokefree site policy in place. |
| Counties Manukau |  | * CMDHB Smokefree 2025 plan: aims to achieve a Smokefree district by 2025. Two key workstreams: improving cessation, reducing initiation. * National health target activity: secondary, primary and maternity. * Coordination of Counties Manukau Smokefree Provider Network: forum for all involved with smokefree activity, with a focus on cessation * Participation in ARPHS/DHB Regional Forum * Participation in regionally coordinated activities including World Smokefree Day * Submissions on national and regional tobacco control and smokefree policy issues including Tobacco Plain Packaging, Auckland Council Smokefree policy development |
| Waitemata | Jan –Jun 2012 | * Representation on Waitemata PHOs community Based Mental Health Smoking Cessation pilot project. * Held WDHB Smokefree Advisory Group meeting. * Reviewed the DHB smokefree environments policy and associated signage and methods of managing breaches of the policy. * Participated in the Regional Smokefree working group consisting of DHB/ARPHS membership. * Funded and managed contracts for the following cessation services: Asian Smokefree Service; Pacific Quit Smoking Service; Whanau Smokefree Service; A quit smoking service for Elective Surgery patients; An intensive quit smoking service for those at high risk of re-admission due to their smoking; A quit smoking service for DHB staff. * Smokefree Environments Policy – standardized requirement for all Waitemata DHB funded contracts to have a comprehensive and implemented policy. * Held a Regional Mental Health and Addictions Forum to identify the core principles and successful strategies for issues related to on-going tobacco use for mental health services. * The DHB distributes MOH tobacco control funding to coordinators / educators across the DHB, including Secondary Care (including Maternity) 2.5 FTE, PHOs 2 FTE and Community Mental Health 1 FTE. Each of these positions is responsible for coordinating training, and developing systems in their sector to promote smoking cessation. For the past two years the DHB has also provided additional funding to the PHOs to undertake catch-up texts and phone calls for those people that have missed receiving advice and support to quit when they visited their GP. |
| Waikato | Jan –Jun 2013 | * Updated the Waikato DHB Tobacco free Smokefree policy for staff, patients, visitors and contractors. * Utilized smokefree DHB funding for primary care through the flexible funding programme to support their achievements of ‘Better Help for Smokers to Quit’ target. * Funded a “wrap around’ service for clients who are trying to quit, delivered by Pharmacists for the DHB area. * Waikato DHB has representatives on the Midland Smokefree Leadership group who have participated in a regional workshop and ongoing planning work. * Currently working with the Ministry of Health and primary care partners to develop a plan for transition of Smokefree DHB resources to primary care to assist with achieving the target. * Attended monthly teleconference with Ministry staff and other smokefree coordinators. |
| Auckland | Jul – Dec 2012 | * Held/attended the following meetings: ADHB planning and funding meetings, Regional DHB Smokefree Coordinators and ARPHS meeting, ADHB Smokefree Steering Committee meetings, ADHB Mental Health Smokefree Steering Committee meetings, ADHB Smokefree and Local PHO Coordinators meeting, and World Smokefree Day planning. * Discussed with the acting service manager and the Starship paediatric community physician about follow up in the community (re protecting children from second hand smoke). * Identified activities required (over the next 2 quarters) to further the work in tobacco control. |
| Southern | Jul - Dec 2013 | * Obtained sign-off and approval of the Action Plan. * Implemented smokefree clauses into NGO DHB contracts. * Supported Mental Health services on the Wakari (Dunedin site) to become totally smokefree in November. * Met with local aged care residential providers around raising awareness of Smokefree. * Continued to work with the Dunedin City Council to develop a draft Smokefree outdoor public places policy. * Supported local Smokefree Otago and Smokefree Murihiku to develop a pre-election survey for prospective Councillors standing for election within their local authority area (88 surveys completed - 84 candidates were aware of the 2025 goal and 84 supported the goal; 69 candidates supported smokefree public spaces). * Supported the development of Smokefree marae. * Supported The University of Otago to become Smokefree from 1 January 2014. |
| Capital & Coast | Jan –Jun 2013 | * The C&C DHB Smokefree Teams met regularly with HHS, PHO, Regional Public Health and University of Otago Wellington School of Medicine personnel with tobacco control related roles. * The Service Integration and Development Unit was established in December 2012 and incorporates the planning and funding functions of Capital & Coast, Hutt Valley, and Wairarapa DHBs. The Population Health Advisor role includes coordinating the Tobacco Control contract portfolio including reporting requirements across the 3 DHBs. Contracts related to CCDHB include: * CCDHB Hospital Health Services: Tobacco control, ABC training provision, inpatient smoking cessation support and referrals, Health Target; Better Help for Smokers to Quit in hospital settings. * Ora Toa PHO – ABC facilitator: provision of ABC training in primary care services and hospital health services * Ora Toa PHO – Quit Smoking Service : provision of smoking cessation support and promotion in the community across all PHOs in the CCDHB including, schools, health and social services, workplaces, prisons, and shopping malls by way of face to face, telephone, texting, and email. |
| Bay of Plenty | Jan –Jun 2012 | * Reformed and renamed the BOPDHB Steering Group to the Tobacco Control Advisory Group (TCAG), new terms of references have being developed. * Held/attended the following meetings: fortnightly meetings between SFHC and Smokefree Leaders; monthly meetings of the Smokefree Organisational Group. * SFHC visited Lakes Smokefree MH service and team to review implementation of smokefree environment policy and strategies. * Reviewed early (April 2012) SF Policy to remove Mental Health exclusion for designated outdoor smoking area. |
| Mid central | Jan –Jun 2013 | * Developed and implemented the Central Region Tobacco Control Plan. * Introduced standard Smokefree clause specific to health provider contracts as part of the 2013/14 contract review and renewal process. * Established a working group to develop an action plan to move Ward 21 the Acute Mental Health Inpatient Unit, towards becoming smokefree. |
| Northland | Jan –Jun 2013 | * Completed the development of Hapunga Auahi Kore Alliance (Stop Smoking in Pregnant Women), the Alliance membership included NDHB, Midwives, LMCs, PHOs, Quitline, and AKP providers. |
| Hawke’s Bay | Jan –Jun 2013 | * Obtained commitment from Wairoa council, HBDHB Board, Napier Mayor, HBDHB Director of Maori Health and Ngati Kahungunu Iwi to the Smokefree 2025 HB Strategy. * Developed appropriate smokefree sub clauses to be included in all HBDHB contracts. * DHB representation on Ngati Kahungunu Iwi with Tupeka Kore strategy and action group. * Provided support to Smokefree Schools interagency project. |
| Hutt Valley | Jul –Dec 2012 | * Established Hutt Valley DHB Primary Care Tobacco Target Steering group, which included representatives from Te Awakairangi PHO, Hutt Valley DHB Planning and Funding, Cosine PHO and Regional Public Health. * RPH continued to meet monthly with CCDHB to share information and resources for ABC in primary care. |
| Nelson Marlborough | Jan –Jun 2013 | * Coordinated the Smokefree Coalition groups (Nelson and Marlborough) to work together in the community on activities such as World Smokefree Day. * Participated in the Smokefree Coordinators teleconferences and Primary Care teleconferences. |
| Taranaki | Jul –Dec 2012  Jul-Dec 2013 | * Smokefree/Auahi Kore Group:   + Implemented a range of activities to prepare staff and the community for the removal of all designated smoking areas from DHB sites.   + Distributed Smokefree/Auahi Kore Newsletters.   + Smokefree/Auahi Kore Coordinator: participate in the monthly teleconference on Better Help for Smokers To Quit Target for Primary Care and Secondary Care facilitated by Ministry of Health; attended monthly meetings with the Public Health Unit, Regulatory & Environment Team; attended quarterly meetings and participated in the planning for a ‘Workplace Quit Campaign’ during National Heart Week; attended Kawa Whakaruruhau – Cultural safety for people working in Mental Health & Additions; attended the Ministry of Health pre-conference workshop; attended the Tobacco-free Aotearoa Conference 2012; chaired a meeting involving Aukati Kai Paipa services from Tui Ora Limited and Ruanui Health, Primary Care Smoking Cessation Coordinator and TDHB Smokefree team; provided updates on the development of the Smokefree site project. * Developed (and completed) a number of new policy and strategic plans. * Contributed to the Smokefree Midland Network. * Actively participated in the Taranaki Smokefree Coalition and Smokefree Midlands Project. * Reviewed the Taranaki Tobacco Action Plan in December 2013 and currently implementing the 1 June 2013 – 30 June 2014 Plan. * The interim review of Tautoko I Rerenga a Tupeka Kore Taranaki Supporting the Journey to a Tobacco Free Taranaki plan has been completed.   On 1February 2013 Taranaki DHB removed ‘Designated Smoking Areas’ making all buildings and grounds smokefree |
| Lakes | Jan-Jun 2013 | * Held/attended the following meetings: Smokefree project team meetings, Lakes Auahi Kore/Smokefree Coalition group meetings * Made an addition to the Smokefree Policy to ban the use of electronic cigarettes among staff, inpatients and visitors. * Obtained support from Iwi Governance for the new signage “Absolutely No Smoking on Lakes DHB grounds” * Participated and contributed to the regional smokefree activity. |
| Whanganui | Jul – Dec 2011 | * Contracted four Iwi providers to provide cessation support. * WRPHO continued to provide cessation services across their 17 practices. * Continued to facilitate the Whanganui DHB Tobacco Control Steering Group. * A subgroup has been formed to support Wanganui District Council with the implementation of their smokefree parks and reserves bylaw. * Held/attended the following meetings: WDHB Smokefree Coordinator meeting, WRPHO tobacco control Champion meeting, Executive management team meeting. * Collaborated with the WINZ office to consider a smokefree workforce and to encourage clients to use local cessation services. * Identified council spoke person for smokefree in the three councils in WDHB region and brought to their attention the end game vision of a smokefree New Zealand by 2025 and how that affects their public places policies and bylaws. |
| Tairawhiti | Jan –Jun 2013 | * Funded several community projects to deliver community level activities and programmes: Gisborne Netball Centre have developed a project focusing on Maori hapu women and young Maori women that smoke as well as promoting smokefree netball grounds and smoke free vehicles. Te Aka Ora Charitable Trust will deliver smoking cessation support services to their service users. Ngati Porou Hauora has received funding to support the continued promotion of wahakura as a safe sleeping space for babies through their Mama and Pepi Service. * Contracted Te Aka Ora Charitable Trust to provide smoking cessation support and services to their client population (i.e., several rural and town schools, a teen parent education centre, teen parent housing facility and an alternative education centre). * Supported the Smokefree and Alcohol Free Sidelines project and actively participated on the steering group. * Approved funding for a gap analysis to take place from July looking at appropriate key messages and information that would encourage and support young Maori women (13-19yrs) to quit smoking. * Provided support to Alzheimers Support Group to assist with the implementation of a Smokefree Workplace and Staff Policy. * Explored with Sport Gisborne Tairawhiti the opportunities to integrate TDH Smokefree Policy with the current Wellness @ Work programme. * Held/attended the following meetings: Tobacco control steering group meetings; bi-monthly meetings of the Taki Tahi Toa Mano Smokefree Coalition; Midland Smokefree Programme meetings; DHB Smoking Cessation coordinator monthly teleconferences. |
| South Canterbury | Jan –Jun 2013 | * Liaised with Smokefree coalition, ASH and HPA, to run a survey regarding attitudes to smoking in cars (946 surveys completed, with 904 indicating support for smoking in vehicles where children are present). * Supported district councils with Smokefree signage. * Liaised with Healthy Workplace coordinator with regard to resources, websites and smokefree messages. This has included the combined health work place expo’s run in conjunction with ACC and other stakeholders. Every presentation has a Smokefree component. * Advised 2 primary school regarding smoking at the front gate and during sporting events. |
| Wairarapa | Jan –Jun 2013 | * Smokefree Coordinator participated inthe following meetings/workshops: bi-monthly meetings of the Wairarapa Smokefree Network; monthly teleconferences with DHB smokefree coordinators and the Ministry of Health (MoH) Tobacco Team; monthly teleconferences with the Primary Health sector and MoH Tobacco Team; weekly meetings at Compass Health Wairarapa; Wellington Smokefree Network meetings; fortnightly meetings/ teleconference with the Regional Public Health (RPH) Group Manager Preventive Health and Chronic Disease; a community meeting in South Wairarapa around a community response to psychoactive substances; SUDI Workshop; Central Region Smokefree Plan Workshop; Ministry of Health 101; Aspire 2025. * WDHB worked alongside the PHO to draft an action plan to utilise the funding (from MoH) allocated to the implementation of ABC into Primary Care. |
| West Coast | Jan –Jun 2013 | * Held/attended the following meetings: The West Coast Tobacco Free Coalition meetings, regional Smokefree meeting. * Developed the Prevention services section of the SCDHB 2013/14 Annual Plan (with feedback and endorsement from HWCGG and ALT). * Smokefree Development Manager provided quarterly reports to HWCGG and the Alliance Leadership Team (ALT), regular reports regarding smokefree to Tatau Pounamu Manawhenua Advisory Group. |

|  |
| --- |
| Summary points |
| * National Level * ASH, National Maori Tobacco Control Leadership Service (Hapai Te Haoura Tapui) and Smokefree Coalition all actively contribute to the leadership and coordination of the tobacco control sector  Regional Level: DHBsAll DHBs reported leadership and coordination activities. These included:Developed, reviewed and/or implemented Smokefree policiesHeld/Attended meetingsSupported other organisations (e.g., training, policy making, awareness raising, and the establishment of Smokefree area)Funded/managed contracts for local smokefree / cessation activities |

# 

# Research and building knowledge

### National Level

The Ministry of Health directly funds some tobacco control research in New Zealand.

#### Tobacco Control Research Turanga

In 2010, the Ministry of Health and Health Research Council of New Zealand formed the Reducing Tobacco-related Harm Research Partnership and in 2011, they awarded $5 million to the University of Auckland to establish the New Zealand Tobacco Control Research Turanga. It is a national programme of research to inform rapid smoking prevalence reduction.

The current Turanga projects are:

* Introducing E-cigarettes in clinical practice for smokers with multiple addictions
* Every smoker, once a year: Increasing the prevalence of quitting and use of support: The Quit Booth Pilot
* Incentives to stop smoking among pregnant Maori women: The AWHI-Incentives trial
* Talanoa Samoa: Cessation on Pacific Radio
* Smokefree Rohe Tamaki

Over the two months period from October to December 2013, the following activities have been reported by Turanga:

|  |  |  |
| --- | --- | --- |
| **Area** | **Project Title** | **Progress** |
| Tobacco Control Policy | Quota Management Policy for New Zealand Tobacco Supply | A journal article has been submitted. |
|  | Smokefree Rohe: Tamaki | Approached Auckland retailers (about half the retailers approached have agreed to sell nicotine replacement therapy as an alternative to tobacco). Presented project update at the *Smokefree Oceania* Conference. |
|  | Harnessing New Zealand’s Radiation Protection Law for Tobacco Control | A systematic review of the literature is underway to draw together evidence to support a case that a component of the tobacco leaf is a radioactive material. |
| Nicotine Studies | Nicotine Reduction Study (ENRIQ) | Results were presented at the *Oceania Tobacco Control Conference.* A journal article has been prepared. |
|  | Monoamine Oxidase Inhibitors – are there more there than have yet been found? | This project is now completed with a journal article in preparation. |
|  | Biochemical and Behavioural Causes of Addiction to Tobacco Smoking (Tūranga Masters Scholarship) | A journal article has been accepted to *Current Psychopharmacology.* A second article has been published in *Addiction Biology*. |
|  | Cost of Smoking: Cigarette Price Breakpoint Study | Results were presented at the *Oceania Tobacco Control Conference.* |
|  | Introducing E-cigarettes in clinical practice for smokers with multiple addictions | Provisional ethics approval has been granted for the project and data collection is now underway. |
| Māori Tobacco Control | WERO: Whānau End Smoking Regional Whānau Ora challenge – a group stop smoking competition | A main outcomes paper has been submitted to *BMC Public Health*. |
|  | Effects of social network structures on adolescent Māori female tobacco use (Tūranga PhD Scholarship) | Data collection is now complete and analysis of the data is underway. |
|  | Every smoker, once a year: Increasing the prevalence of quitting and use of support: The Quit Booth Pilot (Smokefree Rohe sub-study) | Ethics has been granted and development of the App is now underway. |
| Pacific Tobacco Control | TALANOA Samoa | Ethics has been granted. Development of the project materials is progressing with the cessation programme expected to go to air early 2014. |
|  | Finding ways around tobacco tax: Pacific people and duty free cigarettes | Results were presented at the *Smokefree Oceania Conference* |
| Reducing Smoking in Pregnancy | Incentives to stop smoking among pregnant Māori women: A feasibility trial | Data analysis is underway and corporate stakeholder interviews will commence shortly. Preliminary results were presented at the *Smokefree Oceania Conference.* |
|  | Motivational Interviewing for Smoking Cessation among Pregnant Youth and Young Mothers (Tūranga Masters Scholarship 2013) | Ethics approval has been granted and data collection is now underway. |
| Mental Health | Smokefree Mental Health and Addictions in Non-Government Organisations | A journal article is now ready for submission. |

#### ASH Year 10 Survey

The ASH Year 10 Snapshot Survey has been used to monitor student smoking and risk factors for smoking since 1999. This annual survey samples around half of the schools in New Zealand with Year 10 students and is the largest survey of youth smoking in New Zealand.

The Ministry of Health provide the funding for this project as part of the New Zealand Youth Tobacco Monitor.

Students who consented to take part completed a questionnaire (in class time under the supervision of teaching staff) that asked about demographic data (age, gender and ethnicity) and about their smoking behaviour (Have you ever smoked a cigarette, even just a few puffs? How often do you smoke now?) The survey also included questions about the smoking status of family and friends, exposure to second hand smoke and attitudinal beliefs about tobacco control issues.

Results of those aged 14-15 years were presented in a series of factsheets that cover all students, ethnicity, gender, SES, DHB, Maori and Pacific smoking. <http://www.ash.org.nz/research-and-information/ash-research/latest-ash-year-10-survey/>

#### MOH Pathway to Smokefree 2025 Innovation Fund

The following national projects have received MOH Pathway to Smokefree 2025 Innovation funding commencing July 2013:

|  |  |
| --- | --- |
| Cessation sector development and collaboration | * ASH – National Quit Month $2.3m * Auckland UniServcies – WERO group stop smoking competition $3.9m * AUT – Campaign to enhance smoking cessation interventions in general practice $335k |
| Smokefree movement | * Massey University – Smokefree movement $115k |

#### Other National Level Research Activities

It is important to note that other organisations, in particularly, ASPIRE2025 and HPA, also undertake a wide range of research activities related to tobacco control. However, as they are not funded by the Ministry of Health, they are not within the scope of this review.

ASPIRE 2025 is a partnership between major New Zealand research groups carrying out research to help achieve the Government’s goal of a tobacco-free Aotearoa by 2025. It was launched in 2011 and brings together leading tobacco-free researchers and health service groups in New Zealand and strengthens existing collaborations.

The research activities of the HPA are for both internal and external audiences and inform policy, practice and future research. Key research activities include: The Health and Lifestyles Survey (HLS) provides information about the health behaviour and attitudes (including tobacco) of New Zealanders; The New Zealand Smoking Monitor (NZSM) provides information on smokers’ and recent quitters’ knowledge, attitude and behaviour; and the New Zealand Youth Tobacco Monitor which provides information about adolescents’ smoking related knowledge, attitudes and behaviour.

### Local level pilot projects

#### MOH Pathway to Smokefree 2025 Innovation Fund

The following regional projects received MOH Pathway to Smokefree 2025 Innovation funding commencing July 2013:

|  |  |
| --- | --- |
| Smoking Cessation | * CMDHB – Incentives for pregnant women to stop smoking $138k * CMDHB, Waitemata PHO & Transitioning Out Aotearoa – Quit bus $1.9m * Hawke’s Bay DHB – Using nicotine spray for highly tobacco dependent people in a high risk community $204k * Kimi Hauora Wairau (Marlborough PHO) – A journey to smokefree wairau using Talanoa Mo’ui Model $88k * National Heart Foundation (Tala Pasifika) – back to the Future: Preserving our people through performance $1.3m * Te Whanau o Waipareira Trust – Pae o Te Haa $306k * Waitemata DHB – NRT survival packs $134k |
| Cessation sector development and collaboration | * CMDHB – Supporting smokefree intersectorally $1.3m * Hawke’s Bay DHB – Shifting the culture in mental health services $208k * University of Otago – Taking NRT direct to smokers $758K |

#### DHB research and innovation

Eight DHBs reported having funded or participating in research activities during the six month period.

Table 20: Research and innovation undertaken by DHB

|  |  |  |
| --- | --- | --- |
| DHB | Reporting Period | Research and knowledge building activities |
| Canterbury | Jan –Jun 2013 | * No research/knowledge building activities reported |
| Counties Manukau |  | * No research/knowledge building activities reported |
| Waitemata | Jan –Jun 2013 | * Te Whanau O Waipareira Trust was funded by MoH Pathway to 2025 Innovation Fund to provide culturally tailored smoking cessation programme for whānau smokers in the Waitemata DHB region. * Waitemata DHB was funded by MoH Pathway to 2025 Innovation fund to distribute NRT “survival packs” to people that smoke and who are visiting the hospital. * Waitemata PHO (together with CMDHB) received funding from the MoH Pathway to 2025 Innovation Fund to operate a mobile Quit Bus to provide smoking cessation support and advice and to distribute Nicotine Replacement products in hard to access areas. * Incentives for Pregnant Women to stop smoking |
| Waikato | Jan –Jun 2013 | * No research/knowledge building activities reported |
| Auckland | Jul – Dec 2012 | * No research/knowledge building activities reported |
| Southern | Jul - Dec 2013 | * Supported local Smokefree Otago and Smokefree Murihiku to develop a pre-election survey for prospective Councillors standing for election within their local authority area. The results of these surveys were analysed by PHS staff and provided to members of the local coalitions. * Continued to support the development and implementation of the Little Lungs – Pūkahukahu Iti project which provided Smokefree trainings/workshops to 16 Early Childhood centres. * SDHB worked with a local Maori Provider to: (1) support Marae-based Tupeka Kore Leadership and reduce Whanau and Tamariki exposure to second hand smoke. (2) Undertake a scoping exercise using qualitative interviewing to identify why people choose to stop smoking and what the barriers are for those who chose not to quit. |
| Capital and Coast | Jan- Jun 2013 | * CCDHB smokefree personnel work in partnership with researchers at the University of Otago Medical School. A current example is training quit card providers to work in a six month study offering an assortment of NRT products including a newly developed inhaler to smokers being carried out in the Porirua shopping mall |
| Bay of Plenty | Jan –Jun 2012 | * Toi Te Ora Public Health Unit piloted ‘Hapu Hauora Toolkit’ in the Eastern Bay of Plenty. Its aim was to develop five Public Health Toolkits, including tobacco, for use by iwi and hapu to create healthy and supportive environments for whanau attending Marae. |
| Mid central | Jan –Jun 2013 | * No research/knowledge building activities reported |
| Northland | Jan –Jun 2013 | * No research/knowledge building activities reported |
| Hawke’s Bay | Jan –Jun 2013 | * There were 2 successful applicants of RFP from innovation funding during the reporting period. One specifically targeted at isolated populations in Wairoa (providing Nicorette spray as an additional cessation aid). The second was to develop National Mental Health Services Smokefree Guidelines. * HBDHB continued to support Smokefree Schools interagency project which was at its final stages with Public Health Nurse acquiring Smokefree schools toolkit. |
| Hutt Valley | Jul –Dec 2012 | * No research/knowledge building activities reported |
| Nelson Marlborough | Jan –Jun 2013 | * No research/knowledge building activities reported |
| Taranaki | Jul –Dec 2012 | * During September 2012 an online survey with clinical staff was completed to review the current ABC systems, resources and training to reflect the reality of staff delivering the ABC Approach. One of the main outcomes from the survey was that staff wanted to gain more general knowledge and as a result regular in-services are now being held covering the ABC Approach, standing orders, and the Health Target. |
| Lakes | Jan-Jun 2013 | * No research/knowledge building activities reported |
| Whanganui | Jul – Dec 2011 | * No research/knowledge building activities reported |
| Tairawhiti | Jan –Jun 2013 | * Approved funding for a gap analysis to take place from July 2013 to look at appropriate key messages and information that would encourage and support young Maori women (13-19yrs) to quit smoking. A series of focus groups will be conducted across rural, urban and coastal high schools / teen parent centres / alternative education centres. |
| South Canterbury | Jan –Jun 2013 | * Liaised with Smokefree coalition, ASH and HPA, to run a survey regarding attitudes to smoking in cars (946 surveys completed, with 904 indicating support for smoking in vehicles where children are present). |
| Wairarapa | Jan –Jun 2013 | * No research/knowledge building activities reported |
| West Coast | Jan –Jun 2013 | * No research/knowledge building activities reported |

|  |
| --- |
| Summary points |
| National Level  * Tobacco Control Research Turanga had 5 funded research projects * ASH Year 10 Survey has been completed and fact sheets from the 2012 surveys are available online * 4 projects funded by MOH Pathway to Smokefree 2025 Innovation funding * Other organisations (e.g., ASPIRE) carry out non-MoH funded research activities  Regional Level10 projects funded by MoH Pathway to Smokefree 2025 Innovation funding8 DHBs funded or participated in local research initiatives |

Gaps and Opportunities

This section of the report draws on information provided by the 2013 census to describe the smoking population in New Zealand. It also synthesises data from the evidence review, the mapping of Ministry of Health funded services, the consultation processes and other relevant New Zealand and international published information and research to identify and comment on gaps and opportunities. The section concludes with a list of recommendations for Ministry of Health consideration.

# The current situation in New Zealand: data from the 2013 Census

## Smokers in New Zealand

The 2013 census data shows that, in order to reach Smokefree New Zealand by 2025, about 460,000 smokers have to quit (about 46,000 per year).

## Smokers by DHB area

The 2013 census provides current data on the prevalence of smoking broken down into demographic types and geographical regions. The following tables provide some summary data by District Health Board. The data is for over 15 years olds only.

The analysis using 2013 Census data are based on Usually Resident (UR) data not Estimated Resident (ER). The ER figures takes into account net census undercount as measured by the 2006 Post-enumeration Survey. It is not yet available for 2013 data. Analysis by Counties Manukau DHB show the difference between ER and UR differs across ethnicities for their DHB area – the Pacific population was 13.5% higher in the ER number than the UR. Maori ER were 10.4% higher, Asian 14.1% higher whilst 'E/O' was only 0.6% higher (Doone Winnard, personal communication). It is estimated there will be about 77,000 more people who smoke at a national level (11,500 for the CMDHB area) who would need to be considered in relation to tobacco control services.

We have retained analysis based on UR for this analysis but the additional needs for the areas most affected by this issue; CMDHB, Auckland, Waikato and Waitemata should be borne in mind.

### Overall prevalence

Table 21: Overall smoking prevalence

|  |  |  |
| --- | --- | --- |
| DHB | Smokers | Prevalence |
| Canterbury | 52,212 | 13.3% |
| Counties Manukau | 50,571 | 14.2% |
| Waitemata | 45,474 | 10.9% |
| Waikato | 43,785 | 15.5% |
| Auckland | 36,141 | 10.1% |
| Southern | 34,668 | 14.3% |
| Capital and Coast | 25,362 | 11.0% |
| Bay of Plenty | 24,315 | 15.0% |
| Mid central | 19,989 | 15.4% |
| Northland | 19,986 | 16.8% |
| Hawke's Bay | 19,602 | 16.5% |
| Hutt | 16,557 | 15.2% |
| Nelson Marlborough | 14,271 | 12.8% |
| Taranaki | 13,998 | 16.2% |
| Lakes | 13,554 | 17.8% |
| Whanganui | 8,610 | 18.1% |
| Tairawhiti | 6,906 | 21.0% |
| South Canterbury | 6,816 | 15.0% |
| Wairarapa | 5,550 | 16.8% |
| West Coast | 4,794 | 18.4% |
| Total New Zealand | 463,194 | 13.7% |

The overall average prevalence is 13.7%. Areas with high prevalence include: i) Tairawhiti, ii) West Coast, iii) Whanganui, iv) Lakes, and v) Wairarapa.

The lowest prevalence is in Auckland DHB area, followed by Waitemata DHB area.

Fifty percent of all smokers in New Zealand are in the populous but relatively low prevalence areas of Canterbury, Counties Manukau, Waitemata, Waikato and Auckland. The high prevalence areas have few smokers because they have small populations.

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### Prevalence by age

The prevalence for the 15-19 year olds is less than the total prevalence for all DHBs. The DHBs with the highest number of 15 to 19 year old smokers are: Canterbury, Counties Manukau, Waikato, Waitemata and Southern.

Table 22: Numbers and prevalence: 15-19 year olds

|  |  |  |
| --- | --- | --- |
| DHB | Smokers (15-19yrs) | Prevalence (15-19yrs) |
| Canterbury | 3,180 | 9.8% |
| Counties Manukau | 3,084 | 8.3% |
| Waikato | 2,856 | 11.1% |
| Waitemata | 2,358 | 6.4% |
| Southern | 2,133 | 9.4% |
| Auckland | 1,629 | 5.4% |
| Capital and Coast | 1,548 | 7.6% |
| Bay of Plenty | 1,548 | 11.9% |
| Hawke's Bay | 1,401 | 13.9% |
| MidCentral | 1,191 | 10.0% |
| Northland | 1,161 | 12.1% |
| Hutt | 951 | 10.2% |
| Lakes | 885 | 13.4% |
| Taranaki | 807 | 11.8% |
| Nelson Marlborough | 771 | 9.7% |
| Whanganui | 558 | 14.0% |
| Tairawhiti | 447 | 14.7% |
| Wairarapa | 396 | 15.2% |
| South Canterbury | 363 | 10.8% |
| West Coast | 225 | 12.3% |
| Total New Zealand | 27,495 | 9.3% |

The next age group, 20-24 year olds is also important as this age group typically has the highest prevalence but is often that has the least contact with the health sector.

Table 23: Numbers and prevalence: 20-24 year olds

|  |  |  |
| --- | --- | --- |
| DHB | Smokers (20-24yrs) | Prevalence (20-24yrs) |
| Counties Manukau | 6,591 | 19% |
| Canterbury | 6,405 | 19% |
| Waikato | 5,259 | 21% |
| Waitemata | 5,145 | 15% |
| Auckland | 4,941 | 12% |
| Southern | 4,242 | 19% |
| Capital and Coast | 3,639 | 15% |
| Bay of Plenty | 2,634 | 25% |
| MidCentral | 2,412 | 21% |
| Hawke's Bay | 2,247 | 28% |
| Hutt | 2,010 | 23% |
| Northland | 1,878 | 27% |
| Lakes | 1,605 | 28% |
| Taranaki | 1,488 | 24% |
| Nelson Marlborough | 1,431 | 24% |
| Whanganui | 924 | 28% |
| Tairawhiti | 837 | 33% |
| South Canterbury | 693 | 26% |
| Wairarapa | 576 | 30% |
| West Coast | 456 | 27% |
| Total New Zealand | 55,401 | 19% |

The prevalence in the 20-24 year old age group is higher than total prevalence for every DHB. The biggest percentage difference is in Nelson-Marlborough although there is also a big difference in Wairarapa. Between 10% and 14% of all smokers in each DHB are in this age group.

### Number and Prevalence by ethnicity

Table 24: Smoking number and prevalence (ordered by number of European smokers)

|  |  |  |
| --- | --- | --- |
| DHB | European Smokers | Prevalence |
| Canterbury | 43,788 | 13.5% |
| Waitemata | 31,527 | 11.2% |
| Southern | 30,171 | 14.6% |
| Waikato | 30,078 | 14.4% |
| Counties Manukau | 22,632 | 13.7% |
| Auckland | 19,356 | 10.0% |
| Capital and Coast | 17,511 | 10.4% |
| Bay of Plenty | 15,840 | 13.0% |
| MidCentral | 15,330 | 15.1% |
| Hawke's Bay | 12,954 | 14.6% |
| Northland | 12,447 | 14.8% |
| Nelson Marlborough | 12,243 | 12.7% |
| Hutt | 11,478 | 14.7% |
| Taranaki | 11,130 | 15.6% |
| Lakes | 7,905 | 15.6% |
| South Canterbury | 6,153 | 15.2% |
| Whanganui | 6,114 | 16.6% |
| Wairarapa | 4,584 | 16.3% |
| West Coast | 4,248 | 19.2% |
| Tairawhiti | 3,093 | 16.2% |
| Total New Zealand | 318,612 | 13.4% |

The following table shows the number of Maori smokers from the Usually Resident total response counts in the 2013 Census (as previously mentioned, the number of Maori and the number of Maori smokers may be undercounted in these figures). The number of Pacific smokers usually resident in each DHB area is also reported (again these figures may be subject to under reporting).

Table 25: Smoking number and prevalence (ordered by number of Maori smokers)

|  |  |  |
| --- | --- | --- |
| DHB | Maori Smokers | Prevalence |
| Waikato | 15,870 | 32.6% |
| Counties Manukau | 14,751 | 33.9% |
| Bay of Plenty | 10,062 | 32.2% |
| Northland | 9,474 | 31.8% |
| Waitemata | 7,863 | 25.9% |
| Hawke's Bay | 7,695 | 33.7% |
| Canterbury | 7,395 | 29.3% |
| Lakes | 6,876 | 32.8% |
| Auckland | 5,697 | 25.1% |
| MidCentral | 5,667 | 30.7% |
| Capital and Coast | 4,974 | 25.1% |
| Southern | 4,908 | 28.5% |
| Hutt | 4,587 | 32.6% |
| Tairawhiti | 4,488 | 33.9% |
| Taranaki | 3,843 | 32.8% |
| Whanganui | 3,204 | 33.7% |
| Nelson Marlborough | 2,337 | 28.8% |
| Wairarapa | 1,410 | 34.1% |
| South Canterbury | 753 | 31.0% |
| West Coast | 687 | 32.4% |
| Total New Zealand | 122,553 | 30.9% |

Table 26: Smoking number and prevalence (ordered by number of Pacific smokers)

|  |  |  |
| --- | --- | --- |
| DHB | Pacific smokers | Prevalence |
| Counties Manukau | 14,376 | 21.5% |
| Auckland | 7,173 | 20.4% |
| Waitemata | 4,974 | 19.4% |
| Capital and Coast | 3,573 | 23.2% |
| Hutt | 1,848 | 23.4% |
| Canterbury | 1,761 | 22.2% |
| Waikato | 1,758 | 21.8% |
| MidCentral | 846 | 24.8% |
| Hawke's Bay | 843 | 22.6% |
| Southern | 840 | 22.3% |
| Bay of Plenty | 675 | 25.1% |
| Northland | 642 | 27.0% |
| Lakes | 582 | 25.9% |
| Nelson Marlborough | 312 | 22.9% |
| Whanganui | 261 | 25.1% |
| Taranaki | 225 | 23.7% |
| Tairawhiti | 201 | 23.5% |
| Wairarapa | 138 | 22.7% |
| South Canterbury | 66 | 18.6% |
| West Coast | 48 | 24.2% |
| Total New Zealand | 41,139 | 21.6% |

Table 27: Smoking numbers and prevalence (ordered by number of Asian smokers)

|  |  |  |
| --- | --- | --- |
| DHB | Asian smokers | Prevalence |
| Auckland | 6,867 | 7% |
| Waitemata | 5,379 | 8% |
| Counties Manukau | 5,295 | 7% |
| Canterbury | 2,271 | 8% |
| Capital and Coast | 1,770 | 7% |
| Waikato | 1,269 | 7% |
| Southern | 771 | 7% |
| Hutt | 717 | 7% |
| Mid central | 507 | 7% |
| Bay of Plenty | 426 | 6% |
| Lakes | 318 | 8% |
| Hawke's Bay | 288 | 8% |
| Nelson Marlborough | 267 | 9% |
| Northland | 258 | 9% |
| Taranaki | 228 | 8% |
| Whanganui | 108 | 10% |
| South Canterbury | 78 | 7% |
| Tairawhiti | 75 | 11% |
| West Coast | 51 | 10% |
| Wairarapa | 45 | 7% |
| Total New Zealand | 26,988 | 7% |

Prevalence among Maori is very high everywhere, usually double the European prevalence. The biggest difference between the prevalence rates of smoking in the European and Maori populations is in the Auckland and Capital and Coast DHB regions.

Rates of smoking in the Pacific population are higher than those in the European populations and lower than prevalence in the Maori population in every DHB region.

The five DHBs with the highest numbers of smokers by ethnicity are as follows:

Table 28: Numbers of smokers: DHB ranking

|  |  |  |  |
| --- | --- | --- | --- |
|  | European | Maori | Pacific |
| 1 | Canterbury (1) | Waikato (1) | Counties Manukau (1) |
| 2 | Waitemata (2) | Counties Manukau (2) | Auckland (2) |
| 3 | Southern (4) | Bay of Plenty (3) | Waitemata (3) |
| 4 | Waikato (3) | Northland (5) | Capital and Coast (4) |
| 5 | Counties Manukau (7) | Waitemata (4) | Hutt (7) |
|  | 50% | 47% | 78% |

The bottom row shows the percentage of all smokers in this class who are in these DHBs. Most Pacific smokers live in just five DHBs.

The numbers in brackets are the rankings in terms of total populations so Southern DHB and Counties Manukau DHB rank more highly in terms of the numbers of European smokers who live in their areas than the total numbers of Europeans.

The rates of smoking in the Asian population are much lower than for the other populations and 65% of Asians who smoke live in the Auckland, Waitemata and Counties Manukau DHB areas.

For Pacific Peoples; the ranking is exactly the same as the total population until we come to Hutt which ranks 7th in population but 5th in number of smokers.

## Ex-smokers

According to the 2013 census there are many more ex-smokers than current smokers in New Zealand (702,012 vs 463,194).

The following table shows the number of ex-smokers in the DHB region compared to the current smokers. (The higher the ratio the more ex-smokers in relation to smokers). This is a possible indicator of the success of current programmes and may therefore indicate gaps, although it will also relate to broader structural issues of ethnicity and educational level. .

Table 29: Ex-smokers compared to smokers

|  |  |  |  |
| --- | --- | --- | --- |
| DHB | Smokers | Ex-Smokers | Ratio |
| Nelson Marlborough | 14271 | 28356 | 1.99 |
| Capital and Coast | 25362 | 47370 | 1.87 |
| Waitemata | 45474 | 83661 | 1.84 |
| South Canterbury | 6816 | 11034 | 1.63 |
| Bay of Plenty | 24315 | 39324 | 1.62 |
| Canterbury | 52212 | 83634 | 1.60 |
| Auckland | 36141 | 57453 | 1.59 |
| Southern | 34668 | 54822 | 1.58 |
| Wairarapa | 5550 | 8688 | 1.57 |
| Northland | 19986 | 29400 | 1.47 |
| Hawke's Bay | 19602 | 28557 | 1.46 |
| Hutt | 16557 | 23991 | 1.45 |
| MidCentral | 19989 | 28413 | 1.42 |
| Taranaki | 13998 | 19560 | 1.40 |
| Waikato | 43785 | 59853 | 1.37 |
| Whanganui | 8610 | 11382 | 1.32 |
| West Coast | 4794 | 6159 | 1.28 |
| Lakes | 13554 | 17388 | 1.28 |
| Counties Manukau | 50571 | 55650 | 1.10 |
| Tairawhiti | 6906 | 7233 | 1.05 |
| Total New Zealand | 463194 | 702012 | 1.52 |

In every DHB there are more people who are ex-smokers than there are current smokers. However in Nelson-Marlborough there are almost twice as many whereas in Tairawhiti there are only 4% more. Counties Manukau DHB region also does poorly on this indicator and the Auckland DHB region does not look as impressive on this as it does on other indicators as it suggests that the current low rates of prevalence might be due to there being fewer people who have ever smoked and who live in this region.

Rates for ex-smokers in the 15-19 year old population were also examined. These are more difficult to interpret as anyone who has answered that they were an ex-smoker in this age group either started very early or may not have been a regular smoker for long enough to become addicted. For every 15-19 year old smoker there is .27 ex-smokers in the same age group nationally. There is limited variation across the DHBs although Auckland has the highest rate.

The above tables are one-way cross-tabulations of indicators by DHB area. For that reason the results on the gaps or needs of a particular area are provisional. One missing dimension is socioeconomic. Higher rates of smoking among those with lower socioeconomic status are an important factor in persistent health inequalities. Auckland might have low rates of smoking because of the higher socioeconomic status of its residents. There is also a case for two-, or more-way tables where DHB, ethnicity, age and smoking status are examined. Data from the census of this type might be available from the second quarter of 2014.

# Projected impact of assisted quits

In this section we discuss the amount of assisted quitting currently taking place compared to the need expressed in the above tables.

This has already been considered by researchers at the University of Otago ([194](#_ENREF_194)) using a more detailed model but without access to the 2013 census data and without regional breakdowns. Their conclusion was that to reach the 5% prevalence goal by 2025 in each ethnic group requires annual net cessation rates to increase to 10% for non-Maori and 20% for Maori with a halving or quartering of initiation. For the period 2002-11 they estimated that annual cessation rates were between 3.2% and 6.1% for non-Maori and 0.6% and 5.8% for Maori depending on age and sex.

In this section we look at the likely impact of Quitline and AKP, (which the mapping exercise suggested are the two major sources of assisted quitting), in the next 10 years, nationally and shown for DHB regions.

### Limitations

Data on the quit rates of the cessation services provided by DHBs, Pacific providers and cessation services for pregnant smoker are not included in these projections. This was because we had insufficient data on quit rates from DHBs and the numbers of quitters from the Pacific and pregnancy cessation service providers was small. Nor is there any allowance for the effect of brief advice being given in secondary and primary health care settings. Evidence suggest brief advice is effective and adds 1–2% to unassisted quitting rates, giving a quit rate of 3–4% ([11](#_ENREF_11)), but we do not have figures on the number of brief advices given in New Zealand. These projections do not allow for deaths of smokers, any increase in quit rates or better contacts with Quitline or AKP in the future. However, they also assume no new smokers, that is, the increased population from migration and young people reaching adulthood will all be non-smokers. In fact 6.8% of those in the Year 10 survey were regular smokers in 2013 ([195](#_ENREF_195)) and an unknown proportion of migrants will be smokers. Despite these shortcomings the projections illustrate the limited impact of the primary forms of assisted quitting in the DHB regions of New Zealand.

### National Projections

Nationally, Quitline lists 50,268 quit attempts in 2012/13. A follow up study of those who attempted quits using quitline services found an intention-to-treat seven-day point prevalence of 24.2% at three months and 20.9% at 12 months. This study did not contact all those that had attempted to quit using Quitline so the assumption that all those who were not contacted had resumed smoking may affect the reported quit rate. Applying the latter percentage to the annual number of quit attempts suggests that around 10,500 people had quit using Quitline.

AKP is a national service with 32 providers around the country and good data on successful quits. If we apply the three month validated quit rate for the AKP providers to the numbers of these setting a TQD with them in 2012/13 there were 2,035 quitters through AKP.

The data from the two main sources of assisted quits in New Zealand therefore suggest approximately 12,500 successful assisted quits per annum of the 46,000 quits required to reach zero or the 30,000 or so quits necessary to reach a 5% prevalence goal. While there are limitations to these projections (see above) the addition of other funded assisted quits is unlikely to make a big difference to the gap illustrated here. This highlights the necessity of large numbers of quits that occur without any assistance from health services as well as increasing access to the most effective interventions.

### Regional Projections

In the following table we take the number of quit attempts from Quitline from each DHB. Then assuming that the rate of contact from smokers in each DHB with Quitline remains constant and that the 12 month quit rate from Quitline also remains constant at 20.9% we show the number of smokers in 2025 as a percentage of the projected 2025 population for each DHB. The key factor is the contact rate. Auckland and Capital and Coast have high contact rates and Tairawhiti and Waikato have low rates and, if this situation remains steady, this implies that Auckland and Capital and Coast will have low prevalence in 2025 and Tairawhiti and Waikato will have high prevalence.

Table 30: Projected prevalence assuming quitline quits

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| DHB | Quit Attempts 2012/13 | 12-Month Quits | Attempts/Smokers | Prev in 2025 assuming constant QR & constant rate of contact |
| Auckland | 4840 | 1012 | 13% | 5% |
| Bay of Plenty | 1977 | 413 | 8% | 8% |
| Canterbury | 4982 | 1041 | 10% | 7% |
| Capital and Coast | 3316 | 693 | 13% | 5% |
| Counties Manukau | 3787 | 791 | 7% | 7% |
| Hawke's Bay | 1519 | 317 | 8% | 10% |
| Hutt Valley | 1818 | 380 | 11% | 8% |
| Lakes | 1056 | 221 | 8% | 10% |
| MidCentral | 2450 | 512 | 12% | 8% |
| Nelson/Marlborough | 1216 | 254 | 9% | 7% |
| Northland | 1438 | 301 | 7% | 10% |
| South Canterbury | 484 | 101 | 7% | 10% |
| Southern | 3380 | 706 | 10% | 8% |
| Tairawhiti | 332 | 69 | 5% | 13% |
| Taranaki | 1290 | 270 | 9% | 10% |
| Waikato | 3242 | 678 | 7% | 9% |
| Wairarapa | 334 | 70 | 6% | 12% |
| Waitemata | 4534 | 948 | 10% | 5% |
| West Coast | 269 | 56 | 6% | 12% |
| Whanganui | 561 | 117 | 7% | 12% |

### AKP quits

The table below shows the numbers who quit through AKP services during 2012/13. This is calculated by using the number of clients who set a TQD during this period multiplied by the validated three month abstinence rate. (This is not the same as the Quitline rate which is a self-reported seven-day point prevalence at 12 months.)

Apart from the wide variation between the DHBs these data demonstrate that AKP is not a means for producing mass quitting on the scale necessary for reaching the 2025 goal. Even a doubling of the numbers of quitters by AKP would not substantially impact on the numbers of smokers in New Zealand within a ten year period.

Table 31: AKP quits by DHB 2012/13

|  |  |
| --- | --- |
| DHB | AKP 3 month quits |
| Auckland | 46 |
| Bay of Plenty | 372 |
| Canterbury | 132 |
| Capital and Coast | 37 |
| Counties Manukau | 91 |
| Hawke's Bay | 112 |
| Hutt Valley | 24 |
| Lakes | 116 |
| MidCentral | 8 |
| Nelson/Marlborough | 44 |
| Northland | 284 |
| South Canterbury | 17 |
| Southern | 80 |
| Tairawhiti | 180 |
| Taranaki | 54 |
| Waikato | 220 |
| Wairarapa | 57 |
| Waitemata | 73 |
| West Coast | 12 |
| Whanganui | 75 |
|  | 2035 |

### Unassisted Quitting

The majority of quit attempts are unassisted that is, without the use of behavioural or pharmacological support. However studies have shown that the prevalence of unassisted quit attempts (as a proportion of all quit attempts) has fallen over time. This downward trend is apparent in data from the USA, the UK and Australia and may be as a result of the availability and publicity regarding aids to cessation ([196](#_ENREF_196)).

Results from the International Alcohol Control Survey in New Zealand found that, in the nine months following the excise tax increase of January 1 2011, 70% of smokers reported a quit attempt, 50% of which were reported to have been influenced by the excise tax increase. With 463,194 smokers then we could expect this to be equivalent to 324,000 quit attempts (at 70% or 230,000 at 50% – this is an underestimate since there were probably more than 463,000 people smoking before the tax change of January 2011) ([197](#_ENREF_197)).

Similar proportions of Maori and Pacific respondents reported quit attempts in the same period and 60% of Maori and 45% of Pacific reported an influence of excise tax increases 72% of current smokers made some form of quit attempt following the increase in taxes in January 2011.

If the 2025 goal is to be achieved a sizable number of successful quit attempts will need to be unsupported. Policy change as a driver for unassisted and assisted quitting is likely to be very important. The impact of tax increases in driving quit attempts should be closely monitored and supported as required with other actions to ensure calls to Quitline (and other quit attempts) remain high.

# Smokefree Environment in New Zealand

Population level interventions such as expanding Smokefree environments and providing strong messaging will both assist cessation and prevent uptake. Such population interventions have been shown to affect priority groups.

## Increases in Price

The government has put in place four annual excise tax increases of 10% until 2016 ([198](#_ENREF_198)). It will be important for these to continue to provide an appropriate environment for reduced uptake and enhanced cessation efforts. With regard to lower SES groups the only interventions where there is evidence of greater effect is excise tax (and messaging focused on negative health effects of smoking). In a survey carried out after the January 2011 excise tax increase Maori were as strongly influenced by excise task to attempt a quit as were European origin New Zealanders with Pacific slightly less so ([199](#_ENREF_199))).

## Access to tobacco

The Maori Affairs Select Committee (MASC) recommended that the penalty for selling cigarettes to minors be increased and that greater enforcement measures are implemented ([200](#_ENREF_200)). The HPA Youth Insights Survey of Year 10 students in 2012 showed one-half (50%) of current smokers bought cigarettes from a dairy at least once in the past month; one-in-five (21%) bought cigarettes from a service station and one-in-five (19%) current smokers bought cigarettes from a supermarket. Maori (60%) were more likely than non-Maori (39%) to have purchased cigarettes from a dairy at least once in the past month ([201](#_ENREF_201)). The Controlled Purchase Operations (CPO) data provided in the reports from the PHU indicates monitoring of tobacco supply to individuals is being carried out. PHUs report low levels of supply in some areas but not all. Overall in the six months to 31 December 2013, 506 premises were visited in CPO and 36 positive sales were recorded (7.1%). Relatively high rates of supply are reported by a few PHUs: Nelson Marlborough (24%), Health Waikato (21%), and Bay of Plenty (Toi Te Ora) (11%).  Two DHB areas (Tairawhiti and Northland) reported no CPOs happening in this period.

There is no licensing or registration of tobacco retailers in New Zealand and this could assist efforts to reduce access to underage smokers, reduce uptake and increase cessation. In California the introduction of licenses reduced supply. Local authorities in California can adopt local tobacco retail licensing policies where the fees raised by the license scheme are used to finance the enforcement of restrictions on sales to minors ([168](#_ENREF_168)).

Community engagement around supply can also affect sales (in one of the Turanga projects, Smokefree Rohe Tamaki has approached Auckland retailers about half of whom agreed to sell NRT as an alternative to tobacco ([202](#_ENREF_202)) and recent media reports have referred to retailers making decisions not to sell tobacco ([203](#_ENREF_203)). It appears, however, there is a relative lack of community engagement in relation to the Smokefree 2025 Goal.

## Social Supply

**A**pproximately one in three Year 10 students were given tobacco by an older sibling or parent. Other common forms of social supply were taking without permission and supply by a peer ([201](#_ENREF_201)). The model of social supply legislation enacted for alcohol ([204](#_ENREF_204)) could provide a useful model.

## Smoking in Public

The Smokefree Environments Act has reduced smoking in many public places. A key current issue is smoking in outside areas associated with bars. The litigation which invalidated the use of the ‘calculator’ and the apparent difficulty of finding an alternative led participants in the consultations to suggest an amendment to the Smokefree Act is required to make such areas completely smokefree. The issue was considered urgent in all areas and in Christchurch, given the rebuild underway, was especially fraught.

Some territorial authorities have adopted Smokefree policies applying to parks, playgrounds and sports fields which, when implemented, reduce public smoking. Lack of implementation remains an issue and MoH funded services have been engaged in encouraging action.

Local authorities in New Zealand have both opportunities and difficulties under current legislation to restrict the sale and use of tobacco. Local authorities can make bylaws that impact on public health under the Health Act of 1956. In the case of tobacco the main areas in which bylaws could be made include:

1. Licensing or otherwise restricting the sale of tobacco
2. Extending the areas in which smoking is not allowed

Bylaws of this type could be challenged on the grounds that they are ‘unreasonable’ in that they overly restrict public rights without a sufficiently clear public benefit. However, in most of the cases that are likely to occur in New Zealand where the extension of restrictions is limited or clearly backed by public health evidence existing case law suggests that the bylaws will stand ([205](#_ENREF_205)).

There are no bylaws prohibiting smoking in open areas such as parks or beaches and the current local authority approach is purely educational. There are gaps in the provision of signage and in some areas DHBs have assisted with signage. This is a potential area for MoH to encourage greater collaboration.

Issues of access and public smoking go beyond those of passive smoking and are relevant to the denormalisation of smoking and are likely to have broader impacts ([206](#_ENREF_206)). The Maori Affairs Select Committee recommended steps be taken to denormalise tobacco use and carry out counter marketing against the tobacco industry’s messages ([200](#_ENREF_200)).

## Workplaces Smokefree Policies

Smokefree legislation currently provides for 100% smokefree indoor workplaces. However some organisations have developed more comprehensive policies to reinforce and extend smokefree places and include surrounding environments (e.g., grounds, cars). An example of this is Massey University which has a policy to provide a healthy environment for everyone who works, studies, visits, or has business on University campuses, sites and farmlands. To achieve this all University workplaces, grounds and vehicles are totally smoke free, with the exception of designated smoking areas.

A useful addition to workplace policies would be the introduction of policies and systems to ensure smokers are given advice and support to quit. The evidence suggests interventions in the context of workplaces are as effective as elsewhere. At present we are not aware of any employer providing or facilitating such opportunities

## Smokefree environment clauses in government contracts

In the consultation phase a suggestion was made that all organisations/people contracting for government services be required to have comprehensive smokefree policies for facilities, grounds, cars etc. One example provided of this was the four Northern DHBs (Northland, Waitemata, Auckland and Counties Manukau) which have clauses in the contracts for mental health services requiring such smokefree policies. It was noted that there was a variation across government departments with respect to the smokefree policies for the department.

# Messaging about preventing uptake and encouraging quitting

Messaging about tobacco use comes in New Zealand from a variety of sources. Evidence suggests messaging can be effective, especially if part of a comprehensive programme.

## Exposure to Smokefree messaging

The two major sources of mass media advertising to reduce smoking in New Zealand are the HPA, the work of which is largely outside scope of this review, and Quitline.

The Health Promotion Agency (HPA) has had a particular focus on youth, with its “Smoking Not Our Future” social media campaign, the “Smokefreerockquest” and “Smokefree Pacifica Beats” musical events, and the “Smokefree Schools” project. Currently a new campaign with a focus on smoking denormalisation is under development.

Quitline plays an important role in messaging. Quitline uses mass media campaigns to encourage use of its service. This has positive effects on Quitline enrolments ([116](#_ENREF_116), [207-209](#_ENREF_207)).

A recent analysis of expenditure on mass media advertising aimed to reduce smoking (with forecast figures for 2012-13) undertaken by Quitline and Health Sponsorship Council (HSC) from 2008-2013 showed total expenditure reduced by 44% (78 % for HSC expenditure) over this period. Inflation adjusted figures would show a greater reduction ([210](#_ENREF_210))). There is a dose response relationship between levels of exposure to social marketing and smoking cessation ([191](#_ENREF_191)). Given this the reduction in expenditure is a major limitation in efforts to reach Smokefree 2025.

## Regional and priority population needs

There is considerable variation in Quitline supported quit attempts from one DHB area to another (e.g. 13.4% of smokers in Auckland DHB area versus 4.8% of smokers in Tairawhiti DHB area) and the variation in Quitline registrations by ethnicity (e.g. 12% of Maori smokers in Auckland versus 4% in Tairawhiti). While these may reflect differences in the population of potential quitters, differences in the referral methods adopted by local healthcare services or the existence of local stop smoking services and different Smokefree policies there may also be different response to current Quitline media. To increase access to Quitline services may require enhanced collaboration with local agencies to ensure messages are appropriately framed.

The MoH funds health promotion activity by the DHBs. A proportion of this is focused on awareness-raising. It is difficult to see a strategic direction in the disparate and largely small scale activities reported on. The variable rates of uptake of Quitline services by DHB suggests a need for additional and novel messaging in some regions and DHBs may have a collaborative role to play. Participants in the consultation supported a national focus on messaging but felt the presence of local faces and voices was also important.

Given the importance of a telehealth service such as Quitline in delivering cost effective services and exploring new technologies collaboration with local agencies to encourage uptake in Quitline services is likely to be a good investment.

## Target populations for messaging

Young adults are a significant group within the smoking population with high prevalence, some evidence of increased uptake and the age group with the least contact with the health sector. This may suggest they should join Maori, Pacific and children as priority populations for messaging. Given the importance of cessation in the early weeks of pregnancy and the fact that many pregnant women do not have contact with the health sector until later in pregnancy, it might be appropriate to focus on smoking women of childbearing age as an additional target group.

## Messaging content

In the consultations it was suggested that Smokefree 2025 should be a rallying cry to encourage community wide conversations about quitting and to support and promote local activities and policies to help achieve the SF 2025 goal. There was some lack of clarity among participants in the consultation about whether this would be acceptable to government and the MoH could therefore take a role in ensuring wider understanding of the potential value of promoting this message.

Denormalisation of the tobacco industry was also identified as a gap in messaging in New Zealand in the consultation meetings and there is evidence of effectiveness associated with this approach in other countries ([78](#_ENREF_78)) (and it was recommended by Maori Affairs Select Committee).

Unassisted quitting will play an essential role in achieving Smokefree 2025 and needs to be encouraged and supported by all messaging in New Zealand. Given the importance of policy drivers for quit attempts, messaging needs to be linked to policy initiatives, such as the regular excise tax increases and increased implementation of Smokefree environments.

A previously used Quitline message comparing success rates of Quitline supported quitting with unassisted quitting may have unintended consequences of reinforcing perceptions of the difficulties of unaided quitting. This issue is complex because although unassisted quitting is not as successful as any form of assistance ([211](#_ENREF_211)) the majority of successful quit attempts are unassisted, simply because many more people attempt to quit this way. Achieving the 2025 goal requires population level or public health interventions that will encourage the large number of unaided quit attempts necessary. It is important all messaging be considered in the light of encouraging these, at least alongside messaging about availability of support for quitting. Chapman and MacKenzie ([192](#_ENREF_192)) suggest messages for smoking should include that:

* There is good news about cessation: in a growing number of countries, there are more ex-smokers than smokers. (This is true in New Zealand: 702,012 ex-smokers compared with 463,194 current smokers)
* Up to three-quarters of ex-smokers have quit without assistance (“cold turkey” or cut down then quit), and unaided cessation is by far the most common method used by most successful ex-smokers.
* A serious attempt at stopping need not involve using NRT or other drugs or getting professional support.
* Early “failure” is a normal part of trying to stop. Many initial efforts are not serious attempts.
* NRT, other prescribed pharmaceuticals, and professional counselling or support also help many smokers, but are certainly not necessary for quitting.

The consultation participants also suggested the importance of targeted messages on how to quit.

## Social media

Social media is now an integral part of communication and needs to be fully exploited in communicating the Smokefree messaging. These methods are being incorporated into Quitline activity and work carried out by the national NGOs funded by MoH. The Maori Affairs Select Committee recommended new forms of social media were used to promote anti-smoking.

# Engagement beyond the health sector

A strong view expressed in the consultations was reaching the Smokefree 2025 goal needs a cross government and cross-sector approach. The role of the MoH in providing leadership at the highest levels to assist this was emphasised. There is a growing research literature on, and examples of the health in all policies (HiAP) approach. This starts with the recognition that many influences on health and healthy behaviour come from outside the health sector and that issues of health impact on the workings of other sectors. This means that all government agencies need to put health outcomes on the agenda when all polices are being formulated.

South Australia, among other jurisdictions, has explicitly adopted this approach ([212](#_ENREF_212)). A current evaluation on South Australian’s intersectoral approach has found that, HiAP (through the Health Len Analysis), has successfully increased understanding by policy-makers of the impact of their work on health outcomes; changes in policy direction; development and dissemination of policy-relevant research; greater understanding and stronger partnerships between health and other government departments; and a positive disposition toward employing a health lens analysis in future work (Lawless, Williams, Hurley et al., 2013). The authors concluded that HiAP through health lens analysis “is a promising means of moving the agenda from policy rhetoric to policy action”.

Sweden, Finland, Norway and Netherlands also have addressed health inequalities through HiAP with a whole of government approach. Although the success of the HiAP approach in improving public health is naturally difficult to assess, Finnish analysis has suggest that HiAP approach has dramatically reduced their cardiovascular disease rates and also the rate of mortality due to coronary heart disease (Melkas, 2013; Puska, 2007). Another successful example of HiAP was road safety in the Netherlands, which has shown the number of road casualties dropped from approximately 3000 in the mid 1970 to 720 in 2009, while the number of travelled kilometers nearly doubled (van der Heiden, 2010). Merkel (2010) in his discussion on the European Union experience of HiAP emphasized that a legal commitment to HiAP, while very valuable, is not of itself sufficient. He pointed to the need for shared vision and goals between sectors, the necessity for a specific focus for the work and clear shared objectives and deliverables.

Learning from other countries’ experiences, evidence of how facilitating Smokefree assists the core business of the non-health sector needs to be understood and communicated clearly in order to get other sectors involved. Positive examples were given in the consultations such as local government providing social housing introducing Smokefree policy once health sector staff highlighted the costs involved in remediating housing from the effects of tobacco smoke. DHB staff are working with budgeting services. Other sectors identified as relevant included: Department of Corrections (working with paroled prisoners); the Ministries of Education and Justice, Work and Income, the New Zealand Defence Force and Iwi (as kaitiaki of the environment); Whanau Ora.

Government (and NGO sector) agencies were identified as potentially able to deliver ABC as part of their work programme. This was seen as particularly appropriate for agencies with face to face public contact including people from priority populations (e.g., WINZ, Corrections). Training a wider workforce to deliver ABC would enable a greater range of clients to be accessed and more referred for appropriate cessation support. Currently there is no evidence for effectiveness of brief advice given by other than health professionals, however, so such an intervention would need to be piloted and evaluated.

Referrals can also be encouraged from outside of the health sector. AKP providers in Auckland, Bay of Plenty, Nelson Marlborough, Taranaki and Tairawhiti DHBs have received referrals from agencies other than health providers (e.g., police, WINZ, Wellchild, schools). It may be possible to encourage greater engagement from other sectors.

A number of small scale attempts to work cross sector are happening in New Zealand. This is one example of many where bringing together evaluation data and sharing experiences to allow roll out and scaling up could be valuable (see below).

An increased emphasis on this approach would involve Ministry of Health in engagement at the highest levels. It could also facilitate (and require via service specifications) training in communication about Smokefree framed in relation to cross agency core business.

An opportunity exists in tobacco control policy to address the reduction of smoking by engaging with Maori understandings of hauora; for example Te Pae Mahutonga: A model for Maori health promotion ([213](#_ENREF_213)). These models and concepts acknowledge that hauora is broader than health services and includes health cultures, healthy environments, and healthy participation in all aspects of society. Te Pae Mahutonga is a model that is currently being used and provides a strong foundation for further development. Hapai Te Haoura Tapui (National Maori Tobacco Control Leadership Service) could support developments and provide leadership in this area. In the consultation it was suggested that collaborations were developed with iwi to investigate synergies between protecting the environment (kaitiakitanga) and strategies to encourage smokefree environments.

# Enhancing incentives and structures to encourage collaboration across the health sector

Considerable effort is occurring to encourage referrals across the health system. For example, the CMDHB Triage/Referrals Management which provides ongoing support for hospital patients after they leave hospital. There is evidence of effectiveness of ongoing support for hospital patients after they leave hospital (see ‘Review of Evidence’). However, roll out and scaling up has to take into account costs involved in intensive health system approaches It may be, where these intensive interventions may facilitate quitting in priority groups and reduce health inequalities (as in CMDHB context), they are a valuable addition to the ABC approach.

Referrals need to be easy to make and technology is a key variable. The recent innovation to allow the use of Medtech to allow primary health providers to refer to Quitline is a good example of low cost referral systems. In addition Quitline’s should continue to refer clients to face to face or other specialist cessation services as appropriate

Referrals within the health sector are an area of considerable current effort. In the consultations reporting was cited as an issue with perverse consequences for collaboration across the sector. When services have enrolments targets to meet they are less willing to make referrals, even if potentially helpful. Setting reporting measures in terms of referrals also has some associated issues (Quitline reports less readiness to quit among referrals from PHOs) but is considered worth examining; as a participant in the consultations commented, every referral leads to a conversation about quitting which may have an impact longer term.

# Assisted smoking cessation services

## Priority Populations

Maori and Pacific peoples are priority populations because of high prevalence rates and inequities in health status and pregnant women because of harm to the development of the foetus. It should also be noted given population size there were in excess of 318,000 European smokers in New Zealand at the time of the 2013 Census and it will also be necessary for these smokers to quit to reach the 2025 goal.

## Maori

Maori still have very high rates of prevalence (32%) but the trajectory of use, according to the ASH year 10 survey is down (as is the case among all ethnic groups).

Maori use of Quitline, while high in some areas (e.g., Auckland), is lower than European and in some of the DHB areas with high numbers of Maori smokers, e.g. Waikato, CMDHB, Bay of Plenty and Northland registration rates are relatively low (6 – 7%). There are also lower rates of successful quits. Twelve month intention to treat seven-day point prevalence rates for Maori who use Quitline services are 16.4% as compared to 21.4% for non-Maori/non- Pacific.

Specific cessation services (also available to other ethnicities) are provided through AKP and five additional DHB services. The AKP services provide support beyond smoking cessation and are more holistic, wrap around and whanau focused than some other smoking cessation services. There is variation between providers in outcomes, both in meeting targeted enrolments and validated quit rates and there is a need to understand what lies behind this variation (NB: AKP, Pacific Services and Pregnant Women services all have better data collection on validated quits than cessation services provided by DHBs and others so variation in these services may not be higher than in others). In the consultations some of the AKP providers were described as not well connected with the smoking cessation sector. The recent contract with Hapai Te Haoura Tapui to work with ASH on a National Maori Tobacco Control Leadership Service may help this situation.

There is no evidence of services designed for indigenous people being more effective than mainstream but may be issues with strength of studies and AKP services are achieving very high quit rates in some cases.

## Pacific

Pacific smoking rates are also higher than European (22% vs 13%) but smoking trajectories are also downwards.

Pacific smokers are concentrated in Counties Manukau, Auckland, Waitemata and Capital and Coast DHB areas. About 5 – 6% of Pacific smokers in those DHB areas are registered with Quitline although this figure is a slightly higher 7% in Auckland.

Four Pacific specific cessation services are provided through MoH contracts and DHBs provide a further seven. The MoH funded providers are all large (relative to many of the AKP providers) and have the same validated three month abstinence rate as the AKP providers.

As with Maori, there are lower rates of accessing Quitline and this is a gap needing further attention.

## Pregnant Women

The risks associated with smoking during pregnancy are high and cessation before 15 weeks of pregnancy returns risk to the foetus to that of a non-smoker ([214](#_ENREF_214)). There are six providers of specific services with direct contracts with MoH and these are supplemented by services provided by six DHBs. In general these services are characterised by low numbers of enrolments (for example, the service delivered by Auckland DHB was under enrolled) and, in some cases, low rates of quitting (where data is provided).

While there is a focus on midwifery services many pregnant smokers do not have contact with midwifery services until well into pregnancy. It was recommended during the consultation that New Zealand amend the maternity service notice pursuant to Section 88 of the Public Health and Disability Act (2000) to require the LMC to refer a pregnant smoker to cessation services. However, the MoH informed us that the target for ABC for midwives had been achieved. It may be, given the late contact for many pregnant smokers, further focus on midwifery services beyond the current Target will not be of great value.

The evidence review found evidence of effectiveness for counselling and financial incentives on quitting but there was no evidence that NRT was effective for this group. CMDHB is trialling a service offering financial incentives to pregnant women and early results are seen to be promising. This is another approach where looking at rolling out and scaling up may be appropriate.

Given the importance of cessation in the early weeks of pregnancy and the fact that many pregnant women do not have contact with the health sector until later in pregnancy it might be appropriate to refocus on smoking women of childbearing age as the target and design messaging which resonates with this demographic sector.

## People with mental health issues

There is some evidence of positive effects of pharmacological intervention with people experiencing schizophrenia and of behavioural counselling for people with depression. This latter is a significant proportion of the population (the Dunedin cohort study reported 41% of the sample had at least one diagnosed episode of depression between the ages of 18 and 32 ([215](#_ENREF_215))). No specific services for those with mental health illness are reported on in New Zealand and the DHBs who reported on this issue are providing brief advice for smokers who are patients in mental health services. There is a strong association between poor mental health and smoking and there needs to be more focus on developing and evaluating interventions to support cessation among this group, and there may be a need to change cultures within some mental health care services about the priority of smoking cessation for this group.

## Prison populations

Approximately 4,500 people leave NZ prisons every year and the experience of Smokefree prisons provides an opportunity for change if the inmates were previously smokers. No NZ services were identified and there is no published literature on effectiveness. A programme is underway in the Northern Territories of Australia to support released prisoners to remain smokefree. This is a collaboration between the corrections service and health ([163](#_ENREF_163)). A RCT study has also been developed to prevent discharged prisoners from returning to smoking after release from a smoke free prison but study results are not yet published ([162](#_ENREF_162)). A service to provide support to released prisoners in New Zealand could utilise collaboration between the Ministry of Health and the Department of Corrections to allow contact prior to release, possibly by the telehealth system (Quitline). Evaluation would be essential.

## Group quitting

Smoking behaviour is strongly linked to the social networks in which people are embedded and social structures shape an individual’s ability to successfully quit smoking. Tobacco control policy must engage with this phenomenon. Research in the U.S. has suggested whole clusters of people quit smoking together, and, for example, in small firms, smoking cessation by a co-worker decreased the chances of smoking by 34% ([216](#_ENREF_216)). However, the Cochrane Review discussed in the Evidence Review chapter was unable to find evidence of a group effect over and above the effects on individuals([12](#_ENREF_12)). Approaches to assisted cessation such as WERO which utilise these influences, may provide a valuable opportunity for a new direction in assisted quitting in New Zealand and the evaluation data needs to be carefully reviewed and taken into account in decisions to roll out and scale up activities.

## Improving access to effective services

The variation in use of Quitline is one example of service variation. On a regional basis this ranges from 5% of smokers to 13% and the variation is larger than between ethnicities. (It is noticeable that there are few contacts from the high prevalence DHB areas of Tairawhiti, West Coast, Lakes, Wairarapa and Whanganui).

The situation is repeated for 15-24 year old smokers. Only eight smokers in this age group in Tairawhiti contacted Quitline over the whole July-September period and only seven in the West Coast. In every DHB the contact rate for 15-24 year olds was below the overall contact rate.

As stated earlier there is a need for collaboration with local health sector and/or via messaging to increase use in some areas.

One of the issues raised in consultation was a perceived lack of awareness in the smoking population of the availability of support to quit. It was suggested messaging could increase this (see above). A large number of small scale awareness raising activities are reported under the health promotion activities of the DHBs. The extent to which these are effective in increasing awareness (if that is the problem) is unknown.

The evidence suggests brief intervention by health professionals is both effective and cost effective. This is the focus of one of the health targets "Better Help for Smokers to Quit" (and has been since 2009). There is considerable effort going on in this area with PHOs funding activity as well as DHBs and the Ministry directly. The reported level of achievement of the target varies. There is a lack of clarity in the sector regarding the implementation of the primary health target with some DHBs interpreting a need to contact all enrolled clients (i.e. not waiting for presentation) to provide ABC.

Once this primary health target has been met there are other considerations affecting access about the extent to which presenting/enrolled patients include some of the hard to reach priority populations such as the young adults.

## Leveraging the current government target

The current government target is 95 percent of hospitalised patients who smoke and are seen by a health practitioner in public hospitals and 90 percent of enrolled patients who smoke and are seen by a health practitioner in general practice are offered brief advice and support to quit smoking. This is an input target and data on the relationship between these targets and the numbers who make a quit attempt or who succeed in quitting is unknown. In consultations the targets were raised a number of times with a general sense being they had been very useful in getting the conversation going but were too tight a focus and somewhat beside the point. It was felt, as currently implemented, the targets encourage DHBs and PHOs to focus on the ‘A’ & ‘B’ part of the approach (‘**Ask** about and document every person’s smoking status’ and ‘give **Brief** advice to stop to every person who smokes’) and give less attention to the ‘C’ (‘strongly encourage every person who smokes to use **cessation support (**a combination of behavioural support and stop-smoking medicine works best) and offer to help them access it. Refer to, or provide, cessation supportto everyone who accepts your offer’). The ‘C’ is worded to prompt referral to specialist cessation service providers. However, the evidence does support the use of brief advice by health professionals. There is no reporting on the outcomes for these smokers.

# Reporting on assisted quitting

Providers with direct contracts with the Ministry of Health such as those providing services for Maori or Pacific smokers are required to meet stringent reporting standards. They must regularly report on a wide set of indicators that allow close monitoring of their performance. These are set out in the tier 1 service specifications. For indirectly funded cessation services, such as those implemented or funded by DHBs or PHOs the data is less available. For these services there is no or little information on the numbers enrolled or their characteristics, the methods used to assist their quitting or the numbers of quits judged successful. Quitline, like AKP and the other directly contracted providers, reports on the intention to treat seven-day point prevalence at four weeks and three months. The difference with the AKP providers is that Quitline rates are necessarily unvalidated and for all the directly contracted providers the self-reported rate was (at three months) 11 percentage points higher (37% versus 26%). For DHB and other services indirectly funded by the MoH there is limited information.

# Supply and distribution of pharmacological interventions

NRT is a significant cost to the tobacco control sector ($6.9 million in financial year 2012/13) and the belief that access to it should be easier is widespread. However, the evidence suggests that Nicotine Replacement Therapy is not effective when used without any other support. Most of the NRT that is being offered for use as a smoking cessation aid has been available for many years and many current smokers may have already tried and failed to quit with it.

There are also issues of supply of NRT. It is often dispensed in amounts that mean that the smoker does not have return to get resupplied for some time. However, simply distributing NRT without any support, contact or advice is ineffective and a waste of resources. Switching to smaller amounts could maintain contact with the supplier and could aid effective use of the product.

There were different perspectives expressed in the consultations with some suggesting NRT should be as widely and easily available as possible (while tobacco became harder to get) while a different view, that the sector had become too dependent on the use of NRT, was also expressed.

There are also innovative and useful pharmacotherapies being developed and discovered and there is more research demonstrating that these medicines are not commonly associated with harmful side effects and therefore might be considered as first line medications rather than as being supplied only after a smoker has failed to quit using NRT.

These include varenicline (Champix), bupropion (Zyban), nortriptyline and cytisine (the latter not currently licensed for this use in NZ). These are more expensive than NRT but may be more cost effective. Currently varenicline is only subsidised in New Zealand for three months (and can only be accessed after NRT has been tried) whereas in Australia smokers can receive a 6-month subsidised supply. Expenditure on varenicline was $11.4 million and on bupropion and nortriptyline $6.2 million (though these latter two drugs are not used exclusively for smoking cessation)

Evidence on these newer pharmacotherapies is sparser for their use in special groups such as those with mental health illness.

# Building the capacity and capability of the sector (organisational, infrastructure, workforce)

Issues about the capacity and capability of the sector were raised in the consultations a number of times. It was reported some organisations are staffed at minimum levels and that there are spilt positions and shared roles, which were seen to be inefficient. Workers were sometimes isolated. It was suggested the model used in Community Action on Youth and Drugs (CAYAD) in which service specifications require a minimum of 2FTE working together could be useful.

In addition concerns were raised about the capability of the workforce. There were reports of varying competency among workers and the need to ensure workforce remains motivated. The NZQA training modules are a new development which should ensure a minimum standard of expertise in the smoking cessation sector. Other related training opportunities, e.g., a Certificate in Public Health, have also been developed. There were reports of some workers being unable to access training and professional development, including examples given regarding attendance at recent HPA tobacco seminars. It would be appropriate for all MoH to specify a minimum level of training and personal development for all sector workers in contracts.

Sector leadership was also raised as an issue in the consultation. The main view expressed was that the non-government sector was providing leadership and coordination. It was observed the MoH had not provided the sector with a strategy or logic model and this had instead been developed from within the sector. However, this was also valued by many participants in the consultation who felt the Ministry had done well to provide the opportunity for the sector to develop its own plan and co-ordination. The value in the co-ordination and collaboration provided by the National Smokefree Working Group (NSWG) was generally acknowledged.

# Pathway to Smokefree New Zealand 2025 Innovation Fund and Research

The Pathway to Smokefree New Zealand 2025 Innovation Fund was established in 2012 to advance progress towards the Government’s aspirational goal of Smokefree 2025. Its purpose is to support innovative approaches to reduce the smoking prevalence among Māori, Pacific people, pregnant women and young people across New Zealand. It is a contestable fund and in Round One (2013) 14 projects were funded. Four of these projects have a national focus and 10 are more regionally focused.

This fund provides an opportunity to invest in new ideas to improve smoking cessation and tobacco prevention. The funded projects include an evaluation component. Identifying successful interventions is crucial as it will add to local evidence base of works in tobacco control and offers the opportunity to roll out and scale up these programmes. At the present time it is not clear what mechanism will be used to ensure fast roll out and scaling up of effective interventions.

The Ministry of Health contributes funding to the tobacco related research in New Zealand through funding to the New Zealand Tobacco Control Research Turanga and direct to other organisations such as ASH (e.g., Year 10 Survey). Other non-Ministry of Health funded research is also undertaken.

The results of the evaluations of the work supported by the Innovation Fund and relevant research results should be disseminated to ensure best practice is adopted across the sector.

# Allocation of funds and accountabilities

## Cessation resources by region

The following table shows the resources going into each DHB for smoking cessation (and DHB health promotion, leadership and co-ordination as these cannot be separated out) through all MoH funded sources. The table shows the resources *per smoker* through various channels. Tairawhiti and Northland DHB areas receive the most MoH resources but for Northland the main contribution is the AKP services whereas for Tairawhiti the smokefree DHB contract is also very large (the largest across all DHBs). On the other hand Tairawhiti is receiving the lowest amount of Quitline resources. This comparison is not correcting for the greater cost of providing services in rural areas as compared to urban one, or demographic differences. While there may be some economies of scale it may suggest DHB regions with large numbers of smokers, including priority populations, such as Counties Manukau, Waitamata and Waikato, may be under-resourced. This could be addressed by increased use of Quitline resource, increased access to AKP and Pacific services, or increased funding of Smokefree DHB. Any adjustment should also take into account funding of cessation services provided from other sources and prioritise most cost effective services.

Table 32: DHB Smoking Cessation Resources

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Smokefree DHB & Tobacco control | Public health | Cessation Services (Not AKP or Pacific) | AKP | Pacific Cessation Services | Quitline resources | Pregnancy cessation | Total |
| Auckland | $13.64 | $28.99 |  | $5.08 | $6.93 | $25.04 | $9.37 | $89.06 |
| Bay of Plenty | $13.06 | $12.08 |  | $18.51 |  | $15.20 |  | $58.85 |
| Canterbury | $9.53 | $13.83 |  | $5.24 | $3.26 | $17.84 | $6.85 | $56.55 |
| Capital and Coast | $11.32 |  | $6.23 | $13.73 | $10.52 | $24.45 |  | $66.24 |
| Counties Manukau | $13.44 |  | $2.68 | $5.34 | $4.00 | $14.00 | $5.96 | $45.42 |
| Hawke's Bay | $20.05 | $13.06 |  | $18.36 |  | $14.49 | $7.36 | $73.32 |
| Hutt Valley | $17.01 | $32.70 |  | $13.73 | $8.33 | $20.53 |  | $92.30 |
| Lakes | $39.47 |  |  | $19.92 |  | $14.57 |  | $73.96 |
| MidCentral | $14.51 | $18.73 | $5.49 | $9.00 |  | $22.92 |  | $70.66 |
| Nelson/Marlborough | $22.77 | $12.45 |  | $15.77 |  | $15.93 |  | $66.92 |
| Northland | $20.01 | $27.15 |  | $27.45 |  | $13.45 |  | $88.07 |
| South Canterbury | $26.72 |  |  | $5.24 |  | $13.28 |  | $45.24 |
| Southern | $16.12 | $11.89 | $4.32 | $5.86 |  | $18.23 | $2.45 | $58.88 |
| Tairawhiti | $71.68 | $23.59 |  | $52.13 |  | $8.99 |  | $156.39 |
| Taranaki | $26.43 | $22.92 |  | $22.72 |  | $17.23 |  | $89.30 |
| Waikato | $8.45 | $19.02 |  | $17.37 | $4.74 | $13.85 |  | $63.44 |
| Wairarapa | $30.59 |  |  | $32.43 |  | $11.25 |  | $74.27 |
| Waitemata | $12.95 |  |  | $8.05 | $1.75 | $18.64 | $6.96 | $48.36 |
| West Coast | $48.92 |  |  | $5.24 |  | $10.49 |  | $64.65 |
| Whanganui | $50.52 | $9.67 |  | $26.13 |  | $12.18 |  | $98.51 |

Recommendations

The following recommendations reflect analysis of data collected in the evidence review, consultation and mapping exercise.

In general the MoH funded services in the tobacco control area were assessed as in line with evidence. Important initiatives are being funded and evaluated allowing for innovative developments where evidence is lacking and to further develop tobacco control efforts. The Review identified some areas for further development and it is recommended the MoH consider the following recommendations:

**Revitalise Smokefree 2025 goal**

**MoH leadership**

*The data shows declining rates of smoking in New Zealand and both cessation and reduced initiation are playing an important part. The evidence review suggests much of what MoH is funding is effective. However, there remains inequality in smoking prevalence with high rates among Maori (one in three in some DHBs), the prevalence in the 20-24 year old age group is higher than total prevalence for every DHB, and the current rate of decline in national prevalence levels will not result in achievement of the goal of Smokefree 2025.*

*In the consultation carried out as part of this project many positive activities and positive structural aspects of the tobacco control sector were reported, however, there was also an expressed need to avoid a ‘business as usual’ mentality in the sector and concern was expressed that the Smokefree goal had fallen off the national radar. Increased expenditure and effort to enhance public awareness of Smokefree 2025 and a collaborative process to translate recommendations from this review into accountabilities within the sector could re-invigorate the tobacco control sector*.

* **Expand awareness of and positive support for Smokefree 2025 among all relevant sectors and communities to increase widespread engagement in achieving the goal by:**
* **Clarifying with contracted NGO providers the need to increase media advocacy specifically around the Smokefree 2025 goal**
* **Working with HPA to ensure adequate promotion of the Smokefree 2025 goal**
* **Developing an action plan including a logic model(s) in consultation with the tobacco control sector and informed by the recommendations from this Review; to include key interventions, expected outcomes and detail the accountabilities, including reporting responsibilities, of those in receipt of government tobacco control funding.**

**Government cross sector activity**

*The focus on joined up government and on Health in All Policies (HiAP) internationally and in New Zealand provides a platform to increase cross-sectoral activity to achieve Smokefree 2025. HiAP aims to support intersectoral collaboration by bringing together partners from many sectors to recognize the links between health and other issue and policy areas, break down silos, and build new partnerships to promote health and equity and increase government efficiency .The aim is to benefit multiple partners and**the process must therefore advance the core business of other sectors. There are a number of models operating in New Zealand, for example, the cross agency initiative ‘Safer Journeys’. The MoH Interagency Committee on Drugs established in 2007 is another example.*

*The consultation suggested there is wide variation in government departments in extent to which they embrace Smokefree 2025 goal. One example of a lack of co-ordination is the failure to assist those leaving smokefree prisons to remain smokefree. A survey of released inmates in 2001 in the United States found that 66% had had a cigarette within a day of release and 97% within a week and the consultation suggested similar outcomes in New Zealand.*

* **MoH seek to establish an Inter-agency committee to engage all relevant government ministries/agencies in a joined up government focus on achieving Smokefree 2025 goal by:**
* **Encouraging participation in local level initiatives with DHB and other sectors (see below)**
* **Increasing commitment of senior management in relevant government departments to enhance smokefree status among their employees and, where possible, clients. This will include Ministry of Social Development, Housing New Zealand, Department of Corrections/Probation.**

**Mass Media/Social Marketing**

**Expenditure on mass media/social marketing**

*There is a dose response relationship between levels of exposure to social marketing and smoking cessation. A recent analysis of expenditure on mass media advertising aimed to reduce smoking undertaken by Quitline and Health Sponsorship Council (HSC) from 2008-2013 showed total expenditure reduced by 44% (78 % for HSC expenditure) over this period.*

* **Collaborate with HPA and Quitline to achieve increased expenditure on messaging aimed to reduce smoking**

**Design of mass media/social marketing**

*Evidence in New Zealand showed tax increase****s*** *stimulated quit attempts (these amounted to considerably more than assisted quit attempts in the same time period). Messaging can build on such events to further encourage quit attempts.*

* **Encourage media messaging which builds on policy drivers (e.g., a campaign emphasising price increases and benefits of quitting).**
* **Ensure no messaging discourages unassisted quit attempts**

While there is little evidence of interventions which work with disadvantaged populations some evidence suggests negative health messages are effective

* **Encourage media messaging which resonates with disadvantaged groups**

There are considerable difficulties in reaching disadvantaged pregnant women early in pregnancy and many do not quit suggesting the need for efforts to be focussed earlier.

* **Design messages to resonate with women of childbearing age**

**Telehealth Systems**

*Telehealth systems are a cost effective way of delivering cessation services to the population and the current service, Quitline, is responsible for the largest numbers of assisted quits in New Zealand and has a relatively high reach compared with overseas telehealth systems. New technologies such as web based, quitting and Interactive Voice Response technology will be an essential part of telehealth systems. Evidence to date shows telehealth systems are less effective with more disadvantaged people and there are slightly lower levels of uptake in New Zealand among Maori and Pacific peoples. There is the need for increase in reach to disadvantaged populations (particularly in rural areas).*

* **Maintain focus on telehealth system (phone and newer technologies) as the major source of assisted quitting (and onward referrals) in New Zealand**
* **Increase and design messaging to increase uptake of telehealth cessation service, particularly in rural and predominantly Maori areas and among Pacific peoples.**

**Pharmacology**

*Evidence suggests NRT is not effective outside of counselling situation and indiscriminate distribution is likely to be a waste of resource. There is evidence of relative effectiveness of concurrent use of two different delivery modes of NRT and of pharmacological alternatives to NRT.*

* **Maintain requirement of engagement with cessation service before receiving subsidised NRT and increase use of two different delivery modes**
* **Work with PHARMAC to investigate increased availability (eligibility and course of treatment) of varenicline.**

**Local cross sector initiatives**

*There is limited evidence for the success of local cross-sector initiatives reflecting lack of evaluated examples. One model is provided by the New York City Department of Health and Mental Hygiene tobacco control programme which included increased taxation, smokefree work areas, cessation services including NRT and advertising in broadcast and print media. The programme was evaluated and a reduction in smoking in young adults (mainly women) was found and was larger in low income areas. Along with price and advertising focusing on negative health outcomes, the only other approach known to address inequities in smoking is to increase access to cessation services in low SES areas.*

*The DHBs are funded to provide local smokefree initiatives, leadership and co-ordination. Examples of cross sector activities from 2011– 2013 focused on implementation of Smokefree policy and some promotion and provision of cessation support beyond the health sector. This included work with TAs, a government department (WINZ), wananga, university, marae, workplaces and sports and welfare organisations Other key sectors identified in the consultation included: budgeting services, department of Corrections (working with paroled prisoners); the Ministries of Education and Justice, the New Zealand Defence Force, Iwi (as kaitiaki of the environment) and Whanau Ora.*

*However the reports did not reflect a widespread focus on co-ordinated cross-sector activity at locality level. Many DHBs’ activities seemed to be focussed within the health sector. A lack of evaluation does not allow for accurate assessment of activities in those DHBs reporting cross sectoral activities.*

* **Encourage enhanced focus by DHBs on collaboration with TAs, government departments, NGOs, relevant employers and cessation service providers; including**:
* **health promotion and cessation (especially innovative ways of expanding ABC in settings not currently used and which might reach disadvantaged groups, e.g., workplace context, WINZ offices) and encouraging uptake of telehealth system (Quitline).**
* **smokefree environments (eg developing and implementing local policies on smokefree outdoor public places)**

**Brief Advice**

*Brief advice (which can take as little as 30 seconds and simply advises those who smoke to stop) has been shown to be effective when delivered by doctors, nurses or health visitors and dentists. The health targets set for DHBs to ensure brief advice to be given to all patients in hospital, and those receiving care from midwives are largely being met. Brief advice given to those who attend primary health care settings is less complete but significant progress is being made. There is limited evidence regarding the effectiveness of pharmacists.*

* **Maintain support at current levels of DHB efforts to achieve and sustain brief advice targets for secondary and primary health care providers including midwives. This will include a primary focus on A (ask) and B (brief advice).**
* **Monitor the international research literature and the Waitemata DHB programme funding pharmacists to give Brief Advice (and NRT) to inform future policy**
* **Investigate and encourage trials of non-health sector provision of Brief Advice (eg sports organisations; budgeting advice service)**

**Referrals in context of Brief Advice**

*C (cessation) is addressed by enabling referrals to cessation services including the telehealth system (Quitline) and referrals are being increased by technological advancement (e.g. the Medtech referral form) in primary health care. Quitline data on incoming referrals show some DHBs with high prevalence do not refer to Quitline. Referrals to specialist cessation services (e.g. AKP, Pasifika, DHB funded cessation services) require awareness of and confidence in the services. Not all DHBs are reporting data on referrals making it difficult to assess the overall picture.*

* **MoH to ensure complete reporting from all DHBs of referrals made and data on to which cessation service the referral was made.**

**AKP and Pasifika Providers**

*AKP and Pacific providers which are directly contracted by the Ministry of Health are largely appropriately located. They contribute small numbers of quits relative to Quitline but these are from hard to reach, disadvantaged populations. These services provide data on validated quits and these show marked differences between providers*

* **Review different rates of enrolments and successful quit rates achieved by different AKP and Pasifika providers operating in similar contexts and provide additional support/training or reallocate resource to new provider as appropriate.**

**Protecting the foetus from tobacco**

*Pregnant women are a priority for all cessation services in New Zealand and Midwives are providing ABC at the target level set by the MoH. In addition MoH currently directly funds six cessation services specific for pregnant women and these are supplemented by four DHB funded programmes. Referrals and enrolments are below target and quit rates variable. There is evidence that NRT is not effective with pregnant women. Financial incentives have been found in two published trials to be effective in increasing quitting by pregnant women. A Pathway to Innovations funded project being carried out by CMDHB has reported good preliminary results.*

* **Monitor outcome of CMDHB financial incentives pilot project with a view to disestablishing specialist pregnancy smoking cessation services and reallocating money to the provision of financial incentives to increase quitting among pregnant women living in disadvantaged areas**

**People with Mental Health Issues**

*The prevalence of smoking is around twice as high for those with mental illness as in the general population; around a third of all cigarettes in New Zealand are smoked by those with poor mental health and, unlike most other groups, there has been no decline in prevalence in the last 20 years. Evidence suggests adding a psychosocial mood management component (where participants learn techniques to manage depressive symptoms) to a standard smoking cessation package is effective in increasing abstinence rates in those both currently depressed and those with a history of depression. For people with schizophrenia bupropion has been found to be effective. For those hospitalised with mental health issues there is anecdotal evidence that addressing smoking is seen as too hard given other issues. However reports of DHB activities showed a number of initiatives being taken to promote Smokefree policies in mental health treatment settings and increase focus on cessation.*

**Increase focus on smoking cessation for people with mental health issues by:**

* **Encourage funders and providers of mental health services to prioritise smoking cessation for clients of mental health services**

**Allocation of Resource to DHB regions**

*Prevalence of smoking in New Zealand DHB catchment areas reflects ethnic makeup, rural settings, and socio-economic status. Uptake of Quitline is influenced by media spend and referrals but is also self-determined and is inversely related to prevalence, disadvantage and rural settings. The evidence for approaches to reduce smoking among most disadvantaged groups is very limited and, other than tax and messaging with negative health messages, increasing access to services is one way to do this.*

*Resource allocation for smoking cessation per smoker across DHB regions suggests an appropriate level given rates of prevalence and these predictive variables. (Estimates of prevalence may change when estimates of resident population become available from Statistics New Zealand.) If resource became available the DHBs with high levels of disadvantaged smokers and effective ways to provide cessation services to these groups would have priority.*

* **Monitor developments in DHBs with highest prevalence and low utilisation of telehealth services to assess future funding needs**

**Capacity Development / Professional Development**

*MoH has funded training for those providing Cessation Services via several contracts and there was positive comment about these opportunities in the consultation. MoH also funds workforce development opportunities for Smokefree Regulatory Officers. However, in the consultation it was argued that more support from the MoH was required. One example was lack of clarity and therefore regulatory action regarding outside licensed premise areas. There is also evidence from New Zealand surveys of young people successfully purchasing tobacco, with Maori more likely to do so. However, the mapping showed high smoking prevalence catchment areas where no CPOs were conducted.*

**Increase support (training, co-ordination and guidance) for Smokefree Regulatory Officers**

* **to increase their ability to enforce the Smokefree Environments Act particularly in relation to outside licensed premises**
* **to enforce prohibition of sale to minors.**

**Innovation in quitting Interventions**

*MoH funding is enabling exploration of innovative ways to assist quitting through the Pathway to Smokefree New Zealand 2025 Innovation Funding and initiatives developed in the Turanga project. If these (and other evaluated initiatives) demonstrate evidence of effectiveness it will be appropriate to ensure they are scaled up and rolled out. Since new funding is unlikely DHBs may have to reprioritise spending away from poorly performing cessation services or health promotion activities in order to do so.*

* **MoH to develop a mechanism to ensure new initiatives are critically evaluated for relative cost effectiveness against each other and against existing services in order to promote awareness among DHBs and, where results justify, ensure tobacco control resources are reallocated to ensure scaling up and rolling out.**

**Reporting, evaluation and utilisation of data**

*Cessation services in New Zealand vary in the data provided on enrolments, quit attempts and success rates. Data on enrolments and outcomes for DHB funded cessation services are not included in reports to MoH. To make useful comparisons and estimate future trends it would be valuable for all services to report comparable variables.*

* **MoH to ensure data on the number of enrolments, therapies used, four week and three month self-reported and validated quit rates are reported for all services, including cessation services funded by DHBs, and projects funded under Pathway to 2025 Innovation Fund.**

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Appendix: Consultation with tobacco control sector

# Online consultation – overview and key issues

**Purpose**

The purpose of the online consultation was to “address themes arising from the literature and the mapping of existing services, to obtain views on approaches used, best practice strategies, barriers to success and experiences of tobacco control delivery and programme structure” (from contract service specifications).

The online consultation provided the research team with a snapshot of the views of individuals working in the sector or with an interest in tobacco control. These views informed the face to face consultation.

**Methods**

Views of the sector were obtained via an online consultation form using a SNAP survey. The consultation was promoted widely and information about the project and a link to the survey was distributed to potential participants in several ways:

* Email directly to 250 (approx.) on an email list supplied by MoH
* Flyer distributed to attendees at the HPA Tobacco control seminar series in Auckland and Rotorua
* Announcements via three email lists (Tobacco Control Update – Smokefree Coalition, ontheground2025, Public Health Association Bulletin)

Qualitative data from the online survey were analysed using a general inductive approach. This is a useful method to condense textual data and establish links between research objectives and the summary findings ([217](#_ENREF_217)). These data presented are the key ideas expressed by participants who completed the online consultation and therefore not necessarily representative of all the sector.

**Participants**

Online submissions were received from 105 people. The sectors/job roles of submitters and the DHB region were the submitter is located are outlined below. Several participants provided feedback from a national perspective.

#### Participant Detail

**Sector**

|  |  |
| --- | --- |
| Primary Care | 23 |
| Secondary Care | 16 |
| Both Primary and Secondary care | 2 |
| DHB administration, management | 17 |
| Central Government | 2 |
| Aukati Kaipaipa | 6 |
| Maori Health provider | 1 |
| Community service | 2 |
| Health promotion | 5 |
| Local government | 1 |
| NGO | 10 |
| Public Health | 8 |
| Research and Policy | 4 |
| Smokechange Ltd | 1 |
| Smoking Cessation Practitioner | 1 |
| Training and Advocacy | 2 |
| Quitline | 1 |
| Smokefree officer / enforcement | 2 |
| Did not specify | 1 |
| Total | 105 |

**Region**

|  |  |
| --- | --- |
| Auckland | 8 |
| Bay of Plenty | 2 |
| Canterbury | 4 |
| Capital & Coast | 5 |
| Counties Manukau | 4 |
| Hawke’s Bay | 8 |
| Hutt | 4 |
| Lakes | 8 |
| Mid Central | 4 |
| National | 14 |
| Nelson & Marlborough | 13 |
| Northland | 3 |
| South Canterbury | 3 |
| Southern | 8 |
| Tairawhiti | 3 |
| Taranaki | 1 |
| Waikato | 4 |
| Wairarapa | 2 |
| Waitemata | 4 |
| West Coast | 1 |
| Whanganui | 2 |
| Total | 105 |

**Results**

The results presented are a summary of the views of the sector in relation to: (a) smoking cessation, (b) health promotion and advocacy, (c) enforcement, and (d) research.

**Smoking cessation**

*What is working well*

* There were several comments from those who thought cessation services were working well, or as well as expected given the resources.
* Tier Level One has been useful in bringing consistency to services.
* The sector is highly engaged including in the development of key objectives (e.g., as reflected in the Smokefree National Action Plan)

*Gaps and opportunities*

The consultation feedback around gaps and opportunities was largely about improving what is already offered/incremental change.

Awareness

* Lack of knowledge about cessation and other services among general population
* Poor knowledge of services about cessation services among providers/health services particularly in relation to AKP

Referrals

* Patch protection (targets/retaining clients too dominant, limited cross referrals)
* Brief advice and meeting targets at expense of client needs
* GPs reluctance to refer (but some doing good job)
* Hospitals were identified as doing OK with referrals

Quality focus

* Focus should be on quality and client needs, rather than meeting targets
* Better monitoring of services required – consistent reporting standards, better contract management

Ways of working

* Face to face cessation and support was often preferred by providers to meet client needs/expectations, home visiting often essential; but more groups could be offered (WERO is resource intensive)
* In Auckland – DHB boundaries restrict service provision (e.g., people may live and work in different DHB areas)
* Investigate and provide new options (e-cigs?, specialist smoking cessation clinics, incentivised quitting, mobile clinics, walk in clinics, more/free NRT options)
* Smoking cessation services should be provided in every DHB, not just referral to Quitline

Training/skills of staff

* Training does not include sufficient cultural content
* National AKP conference would be a mechanism to provide Kaupapa Maori training
* Skills/appropriateness of staff varies
* Fragmentation in roles – competing responsibilities (e.g., cessation and health promotion are quite different/competing)
* AB done well, not so sure about C

Resources/capacity

* Limited, insufficient capacity to meet demand
* The available resources affects the capacity of the sector (i.e. services that can be provided and innovation)
* Capacity does not meet contract expectations
* 2025 goal is not backed up by sufficient policy and funding
* Agencies such as Quitline need long term stable funding streams to facilitate planning

Gaps in coverage

* Across all areas more can be done; but especially mental health consumers, pregnant women, youth

Monitoring /evaluation and information

* MoH could more intensely monitor and manage contracts; services should be reviewed to ensure continuous improvement
* MoH needs to understand better what is being done well among existing services – instead of being so strongly committed to innovation
* All cessation services should have consistent expectations about outcomes

Policy

* MoH does not work within its own inequities framework – and others in sector are not held to addressing inequities

***Health promotion and advocacy***

*Gaps and opportunities*

Whole of government approach

* Integrate 2025 across all programmes of government
* Some examples of other departments being involved, e.g. WINZ; but more opportunities available in Ministry of Social Development, Ministry of Education, Ministry of Youth Development, Housing, etc.

Awareness raising

* More focus on preventing uptake
* In community (including business, schools, community groups, etc.)
* Mass media important (HPA needs to do more; there is less mass media activity when compared with HSC activity)
* More visible, in your face messages needed
* Denormalising smoking is required and it is important to commence this in schools
* World Smoke Free Day seen as important and well received; but some view it as becoming under-resourced and one comment was made that this general promotion of smokefree at should not be done over specific targeting of messages to priority groups
* Promote cessation services especially AKP
* Culture change among health professionals required to ensure smokefree message is pushed and cessation services consistently offered
* All tobacco health promotion should contain an explicit quit messages (e.g., could do more during pregnancy)

Advocacy

* There is limited advocacy from within the sector
* Need to focus on raising understanding of practices of tobacco companies
* Sector has played important role around some issues (e.g., plain packaging; decreasing duty free limits)
* Government funded organisations limited as to what they can advocate for

Coordination

* Coordination and working across services varies
* Examples of areas with good coordination provided, e.g., Smokefree Canterbury, Taki Tahi To Mano (Tairawhiti)
* Need to work across whole region and pool resources.
* Stronger links with other areas of health promotion needed
* More coordinated approach needed (only activities that match the logic model should be supported)

Policy

* Smokefree policies implemented by local authorities are considered to be important. Some local authorities are considered to be lagging in policy development/implementation.

Resources

* Limited resources impact on health promotion that can be provided
* Exciting (i.e., engaging and innovative) tobacco health promotion resources are scarce
* Dedicated health promotion roles needed (not shared with other health promotion activities)
* Health promotion often seen as additional to other tobacco control duties (e.g., cessation)

Monitoring /evaluation and information

* Lack of clarity about benefit being provided by PHU (60% funding is supposed to be for health promotion)

Other comments

* Innovation stifled by need to be evidence-based and evaluated

***Enforcement***

* Limited submissions provided in this section
* A range of enforcement options identified as being undertaken (CPOs, visiting retailers, smokefree parks etc.)

*Gaps and opportunities*

Capacity

* Enforcement is time consuming – often required to cover big geographic areas or in areas with high populations
* Limited time allocated to enforcement (e.g., in one DHB 8 hours per week).
* Enforcement training is inadequate. Using 9 trainers to train other EO via peer support and networking questioned.

Enforcement service levels

* Some comments that insufficient enforcement is undertaken
* Enforcement services reactive, not proactive. Proactive services can be used as way of providing health promotion and encouraging change (e.g., enhancing smokefree policy in workplaces)
* Smokefree environments (e.g., hospital grounds) need to have an enforcement element

Outdoor area calculator

* Ineffective MoH leadership on ensuring there is a reliable outdoor calculator is available was noted
* Poor guidance for using outdoor calculator and enforcing non-smoking in bars and cafes
* Vague rules means venues deliberately flouting rules

Other gaps/issues

* Need to make it hard to be a smoker – and move people towards quitting
* “Social enforcement” observable – more negative community feeling towards smoking, means some people only smoke at home
* Sale of medicines containing nicotine not enforced (but issue is that if it was it would drive people back to combustible cigarettes)
* Enforcement does not deal with social supply issues
* CPOs seem to put too much ‘blame’ on individuals selling the tobacco, not enough ‘blame’ is on retailing business for illegal sales
* Rights of non-smokers to enjoy outside spaces e.g., at cafes
* Areas of concern for enforcement included: Minors/youth access to purchasing tobacco, smoking in smokefree places

***Research***

* Limited submissions provided in this section
* Limited knowledge of research activity; submitters from national organisations more likely to have knowledge.
* Two national organisations were identified as being involved with research (Quitline undertake research, Smokefree Coalition providing Tobacco Control Update).
* ASPIRE2025, Turanga, University of Otago noted as key research groups.

*Gaps and opportunities*

Funding

* A lack of funding for research was noted; transactions costs to receiving funding are high

Areas of research

* A range of topics/areas of research were identified. Research needed in two areas most commonly noted:
  + Maori and smoking
  + emerging cessation products including e-cigs.
* Several other topics/questions noted, e.g.,
  + why health professionals continue to smoke?
  + what’s working in cessation and prevention for young adults?

Links to tobacco control sector

* Research not always viewed as well linked to the sector

**Face to face consultation – overview and key issues**

**Purpose**

The purpose of these meetings was to “address themes arising from the literature and the mapping of existing services, to obtain views on approaches used, best practice strategies, barriers to success and experiences of tobacco control delivery and programme structure” (from contract service specifications). The face to face meetings were also informed by the results of the online consultation.

The face to face consultation provided the research team with a snapshot of the views of individuals working in the sector or with an interest in tobacco control. These data presented are the key ideas expressed by participants during the consultation meetings.

**Meeting locations**

Three face to face meetings were held:

* Auckland, at Sorrento in the Park, One Tree Hill (11am-3pm, 24 March)
* Christchurch, at The Meeting Rooms, Christchurch Airport (1pm-5pm, 25 March)
* Wellington, at Massey University (11am-3pm, 28 March)

**Participants**

Seventy-seven potential participants for the face to face consultation were identified by the MoH. They largely comprised senior/key people within the sector who were expected by the Ministry to have something valuable to contribute to the consultation based on their knowledge of and experience within the sector. These potential participants were invited by email to attend any one of the scheduled meetings. Some potential participants identified other people within their organisation to attend the consultation with them, or in place of them.

A total of 35 participants and seven SHORE & Whariki/Massey researchers attended the meetings.

**Auckland 24 March 2014**

|  |  |
| --- | --- |
| Name | Organisation |
| Stephanie Erick | Director ASH |
| Warren Lindberg | PHA |
| Kim Arcus | Heart Foundation |
| Louisa Ryan | Heart Foundation |
| Nigel Chee | Inspiring Limited |
| Sally Wong | Inspiring Limited |
| Marewa Glover | Director, Tobacco Control Research Centre, University of Auckland |
| Fili Tupu | Funding & Planning, Waitemata DHB |
| Leanne Catchpole | Funding & Planning, Waitemata DHB |
| Vicki Evans | Programme Manager, Counties Manukau DHB |
| Hector Kaiwai | National Māori Tobacco Control Leadership Service |
| Maude Takarua | Manager, Ngati Awa Social and Health Services (Whakatane) |
| Johanna Wilson | Ngati Awa Social and Health Services (Whakatane) |
| Hayden McRobbie | McRobbie, Chee and Associates |
| Doone Winnard | Clinical Director Population Health, Counties Manukau DHB |
| Stewart Ngatai | Smokefree Project Manager BOP DHB |
| Jan Pearson | Manager, Health Promotion, Cancer Society |
| Dwayne Tamatea | Manager, Turanga Health |
| Paula Snowden | CEO, Quit Group |
| Paul McDonald | Pro Vice Chancellor College of Health, Massey University |
| Helen Moewaka Barnes | SHORE & Whariki Research Centre |
| Lanuola Asiasiga | SHORE & Whariki Research Centre |
| Sally Casswell | SHORE & Whariki Research Centre |
| Martin Wall | SHORE & Whariki Research Centre |
| Jeff Adams | SHORE & Whariki Research Centre |
| Paul Duignan | Honorary Research Fellow, Massey University |

**Christchurch 25 March 2014**

|  |  |
| --- | --- |
| Name | Organisation |
| Joanna Houston | Smokechange |
| Vivien Daly | Canterbury DHB |
| John Caygill | Smokefree Services Co-ordinator, West Coast PHO |
| Christine Leleifenika | Quit Coach, Pacific Trust Canterbury (ChCh) |
| Kerry Marshall | Manager, Community and Public Health |
| Greg Hamilton | Planning and Funding, Canterbury DHB |
| Geraldine McGettigan | Smokefree Enforcement Officer |
| Bruce Bassett | Quitline |
| Sally Casswell | SHORE & Whariki Research Centre |
| Martin Wall | SHORE & Whariki Research Centre |
| Jeff Adams | SHORE & Whariki Research Centre |

**Wellington 28 March**

|  |  |
| --- | --- |
| Name | Organisation |
| Eleni Mason | Manager, Pacific Health Services Porirua |
| Prudence Stone | Director, Smokefree Coalition |
| Kath Blair | Smokefree Programme Manager, Health Promotion Agency |
| Fay Selby-Law | Manager, Te WakaHuia Manawatu (Palmerston North) |
| Steven Vega | Smokefree Coordinator |
| Kristen Foley | Team Leader, Tobacco, Alcohol and Other Drugs Team, Regional Public Health, Hutt Valley DHB |
| Gevana Dean | Regional Public Health, Hutt Valley DHB |
| Karen Larsen | Datapeople, Wellington |
| Sally Casswell | SHORE & Whariki Research Centre |
| Martin Wall | SHORE & Whariki Research Centre |
| Jeff Adams | SHORE & Whariki Research Centre |
| Paul Duignan | Honorary Research Fellow, Massey University |

|  |  |
| --- | --- |
| **Auckland participants** | **Wellington participants** |
| cid:A57C623A-BC8F-45F8-97F0-69D4FC3F8662 | \\alb-file2\shoredb\Projects\Review of Tobacco Control Services\consultation\Photos from consultation mtgs\20140328_150835.jpg |
| **Christchurch participants** | |
| \\alb-file2\shoredb\Projects\Review of Tobacco Control Services\consultation\Photos from consultation mtgs\20140325_153537.jpg | |

**Consultation meeting process**

The Auckland and Wellington meetings were facilitated by Dr Paul Duignan (Parker Duignan Consulting and Honorary Research Fellow, SHORE) and in Christchurch by Dr Jeffery Adams (SHORE & Whariki research team). Seven questions/topics were developed by the research team to guide the consultation. An opportunity was provided at each meeting to suggest alternative and additional questions/topics. Two questions/topics were added at the Auckland meeting and participants in Christchurch and Wellington also discussed these and did not add additional questions/topics.

The questions/topics used for discussion were:

1. How can it be made harder to smoke in public and to access tobacco?
2. Is the messaging about preventing uptake and encouraging quitting right?
3. How to engage beyond the health sector – WINZ, Housing NZ, other government agencies?
4. Are there sufficient incentives and structures to encourage collaboration cross the health sector?
5. What are we doing / what can we do better to assist cessation and prevent uptake among priority populations?
6. Can we better understand variation and improve access to services?
7. Issues in the supply and distribution of pharmacological interventions.
8. Building the capacity and capability of the sector (organisational, infrastructure, workforce).
9. Leveraging the current government target.

Participants were divided into small groups and systematically worked through the list of questions/topics. After three questions/topics had been discussed, brief feedback to the whole group was made. A member of the research team was present in each discussion group, but largely played an observer role. In the Christchurch and Wellington meetings participants recorded the key discussion points and in Auckland a member of the research team recorded the discussion points.

Subsequent to the face to face meetings all notes made by the participants and the researchers during the sessions were compiled. Data were then analysed using a general inductive approach. This is a useful method to condense textual data and establish links between research objectives and the summary findings ([217](#_ENREF_217)).

**Results**

The results presented are an analysis of the views of participants attending the face to face consultation in relation to the nine questions/topics.

**How can it be made harder to smoke in public and to access tobacco?**

Non-smokefree environments / policies

* Expansion of smokefree environments was widely discussed and supported
* Many opportunities for expansion were noted, including: sports grounds, bus stops, entrances to malls, parks, churches, tertiary institutions (especially PTEs, universities are quite good)
* One important area noted were environments where children are likely to be
* Christchurch is in a unique position to introduce smokefree environments (opportunities exist with the health precinct, outdoor spaces etc.)
* Support was expressed for local government to be active in developing smokefree environments
* Enforcement needs to be resourced and could be backed up by social enforcement (one suggestion was this could be supported with a HPA campaign)
* Some concern raised as to how far smokefree environments should be pursued (i.e. 100% of environments being smokefree might not be necessary to achieve the desired impact) and that ‘evidence’ about the effectiveness of smokefree environments is required
* Iwi could take a lead in smokefree environments in places like national parks.

Outdoor smoking calculator

* Clear guidelines on open / internal areas needed to be provided by the MoH
* One suggestion was to remove smoking anywhere on licensed premises – it is too easy to smoke literally inside bars

Licensing/regulation

* Licencing/regulation is a key way to reduce access though making it harder to access products
* Support for licencing of retailers
* Psychoactive substance licensing model might be appropriate
* Some support for moving selling of tobacco products out of dairies
* Other options for selling – chemists. By 2025 smokers could be required to obtain a doctor’s script to access tobacco.
* One caution noted was that licensing may be counterproductive and needs a solid rationale underpinning it
* More enforcement. Many local authorities have no resources to enforce regulations. However, noted that only MoH can prosecute and not clear if instant fine regime has improved the situation.
* Controlled Purchase Operations tend to suggest small number of retailers selling illegally (more likely to sell illegally to people they know)
* It was noted that in Ireland tobacco is licensed and infringements can result in the suspension of license.
* MoH needs to make clear the role/expectations of smokefree enforcement officers

Social supply

* Could be addressed through legislation like social supply of alcohol
* Needs to be done in a non-punitive way

**Is the messaging about preventing uptake and encouraging quitting right?**

Content of messages

* Different people affected by positive and negative messages
* Statement negative messages are effective in low SES is queried
* National messages should be customised/tailored to local/target audiences
* One size does not fit all – tailored messages to target/priority audiences
* Focus on social norms and denormalising smoking (i.e. smokefree is the norm currently and most people do not smoke, and historically Aotearoa New Zealand is a tobacco free nation), not harms. Also noted that most young people (82%) wish they had not started smoking.
* 2025 goal needs to prominent, let smokers and public know the goal
* Need to challenge, expose and pre-empt the tobacco industry (e.g., framing the industry as responsible for poor health outcomes)
* Micro targeting could be driven by census data
* New Zealand messages are weaker than those in Australia

Gaps in messages

* Messages need to be tailored e.g., young people do not care about health but will care that smoking makes them smell.
* Does current messaging reflect the age of smoking initiation is increasing?
* No prevention messages for those just out of school (and able to access bars with smoking areas).
* Pacific people need to see themselves reflected in social marketing (and using range of Pacific languages)
* Pregnant women (especially Maori and pacific).
* Social and occasional smokers – there is no focus on this group.
* Messaging is part of prevention – but ignores social issues including poverty, education

Messenger

* Who is giving the message matters (unclear if this is related to a credibility issue of the messenger). This is as important as the message.
* Having HPA as single message provider is not good as it is tied politically as to what can be done
* Centralising health promotion not supported (one group only discussed)

Delivery of messages

* Mobile internet becoming more common especially for youth
* Social media important – but public health might be behind in social media use
* Public champions re under utilised
* Movies should be smokefree.

Social networks

* Smoking could be understood as a ‘communicable’ disease because of ubiquitous social networks

Evaluation

Messaging needs to be evaluated

* Need to know who sees messaging (i.e. is it reaching the priority populations?), not just numbers seeing it

**How to engage beyond the health sector – WINZ, Housing NZ, other government agencies?**

Whole of government

* There was strong support for tobacco control to be ‘whole of government’ and cross-sectoral
* The need to have an explicit government commitment to this approach was discussed
* To successfully engage central government agencies departmental approval/mandate to get people onto cessation programme’s is required. While there has been some success at working at a local level (e.g., enrolment/referral desk at a WINZ office), the ability to offer this type of service varies across offices.
* Particular agencies identified included: military, education providers, prisons
* Two people raised the issue of being smokefree and immigration (one suggested all people immigrating to New Zealand must be smokefree – this was particularly related to Pacific migrants; and one noted additional ‘points’ could be awarded for smokefree status).

Other sectors

* Potentially many organisations that can be partnered with, e.g., budgeting services, churches
* Need to explore options in the commercial sector. One example provided were beauty therapists raising issues relating to skin care with clients who smoke.
* Industries with potentially high rates of smoking among staff were also identified as targets to work with, e.g., fisheries, bus/transport providers
* It is essential to make tobacco issues relevant to other sectors and demonstrate how people quitting is relevant to their core business and has positive financial outcomes for them. One example of this is housing providers who would have less cleaning/maintenance/painting costs with smokefree homes. Canterbury City Council social housing has a smokefree policy.
* Champions within business/government to promote smokefree required (e.g., head of large companies like Fonterra, John Key as head of the military, etc.).

Broaden cessation workforce

* Staff in other agencies could be trained in cessation and be quit card providers

**Are there sufficient incentives and structures to encourage collaboration cross the health sector?**

Health sector wide

* Strong view that smokefree/tobacco control needs to be promoted and enforced across whole health sector. This will require cross government leadership.

Problems with targets

* There was some discussion that people want to work together and that collaboration was desirable
* A major issue noted was that competitive funding environment/contracts obstruct collaboration
* One outcome of this is fighting over clients as the funding model does not encourage referrals
* Competition for ideas, protecting ideas and not wanting to support others is fostered in a competitive model
* “Hitting the target means missing the point” of providing quality services appropriate for client. Need to focus on the people, not the organisation’s need to make a referral. It is a waste of time to talk to people who do not want to be referred. The quality of a referral is very important.

Referral practices

* Referral systems/practices must be made easier
* Paper-based systems within DHBs make referral difficult
* Feedback loops are needed – to know if person was previously referred. There needs to be better feedback between ABC and support to know what is actually happening.
* Systems are needed to encourage continuous care and a register of smokers could be established at the DHB level
* GP referral is not about collaboration, it is about good clinical practice
* Medtec allows easy referral to Quitline; but not to Aukati Kaipaipa (AKP). In some instances additional referral options have been added to Medtec (e.g., Palmerston North). The ability to make referrals through Medtec has resulted in 170% increase in referrals.
* Other systems do not necessary allow for referrals. Some work around solutions to referrals has been done, e.g., Pacific service in Porirua is able to make referrals from clinical setting to cessation because of co-location of services

Opportunities for referrals

* There is not necessarily enough local capacity and limited capacity in organisations sometimes restricts the option of making referrals
* Make more use of group, buddy and mentoring cessation approaches (make best use of scarce resources and people enjoy group approaches)
* Referring to Quit Line if no local or specialist providers
* Opportunities for a joint enrolment/referral service across several organisations could be investigated and this may bring some efficiencies

Encouraging collaboration

* More flexibility around contacts needed
* Collaboration should be a requirement in all contracts
* Focus on quality service for people, rather than organisation’s need for getting a referral

Measuring success

* There is limited information about cessation outcomes
* Need to have standardised ‘counting’ and all reporting to MoH in the same manner to allow meaningful comparisons across cessation settings.
* Validated quit rates are only a snapshot. It is likely that some interventions that lead to sustained quitting are losing out to less effective approaches that produce better ‘spot rates’.

**What are we doing / what can we do better to assist cessation and prevent uptake among priority populations?**

Health sector wide

* Smokefree needs to be promoted and enforced across whole health sector
* Mental health sector needs to take issue seriously and have dedicated care and services to quit

Challenges

* A common theme across all the population groups is that they are heard to reach. Many of these hard to reach might still be smoking at 2025 – need to still focus on the ‘low hanging fruit’.
* A key challenge is getting people to think about quitting – move from ‘wanting to quit’ to ‘need to quit’. All other needs have to be subsidiary to need to stop smoking. One way to do this is to make the harm more urgent. If hard to reach continue to receive messages eventually some factor will change and they will be ready to quit.
* Tax impact is losing effect for some populations (these populations not identified)
* Funding policy/structure must incentivise the most effective practice
* More people need to be engaged with cessation services. At present only 11% smokers seen in cessation. More needs to be done with current resources – the 150 target per FTE may need revision.
* Mass quitting is required. Need to ensure every smoker in Aotearoa New Zealand makes one quit attempts a year (Robert West quoted). Current estimate is only 15% smokers make an attempt (Marewa Glover estimate).
* Innovation fund provides very little money, and local organisations need assistance in applying for it. Noted that there were no funded projects in the South Island.

Design of interventions

* Co-design of interventions with the priority populations will strengthen the intervention.
* Need to ensure engagement identifies what is important to that group, e.g., it could be about tax increases and effects on income
* Build in recognition that that motivation waxes and wanes and be prepared to let smokers go and bring them back when they are ready. Long term support is not beneficial
* Cultural appropriateness is essential
* Social marketing for these populations (and more generally) needs to incorporate myth-busting about tobacco and tobacco companies for specific populations
* Address the intermediate step between wanting to quit and being in a cessation programme
* Undertake modelling to look at return on investment – do the (potential) outcomes justify the investment. Investment should be prioritised according to evidence.

Capacity and capability

* Ensure a widely trained ABC workforce.
* Capacity issues need to be addressed so priority areas can be focused on
* Better understanding of medication/pharmacotherapy required by health workers/medical people. Side effects of medications can largely be managed effectively.
* Services need to be culturally appropriate
* Improve capacity/skills re cessation and ensure adequate behavioural support is available.

Specific priority populations

* Need to focus on areas of most need – identified as Maori and Pacific populations.
* Pacific populations need to build on what is already working and ensure contracts are direct with organisations and not through a third party (e.g., a DHB) to ensure accountability and less dilution of funding.
* Prisons – need to harness the smokefree status of prisoners on release and encourage Corrections Service, Probation and Prisoner’s Aid Rehabilitation Society to engage.
* Mental health – is a priority area that is generally not well served with some exceptions, for example in Waitemata there is a focus on this area. Recognition that one of the innovation projects in the Hawke’s Bay is looking at ways of working with this population. Much more focus is required on this priority population group.
* Pregnant women – as these women are often late to engage with maternity services there is a need to find ways to have earlier engagement. Need to acknowledge pregnant women who smoke often feel “weight of disapproval” on them if they smoke, but are often not ready to give up. Midwife will not promote not smoking if there are other issues to address. More emphasis needed on this group. One suggestion is to look at UK model which requires referrals for pregnant smokers instead of it being at midwife’s discretion. Could target women before they get pregnant, as there are issues with midwives.
* Restrict supply via duty free (this as especially discussed in relation to Pacific peoples). There is a need to price it out of these communities.

**Can we better understand variation and improve access to services?**

Explanations for variation

* MoH is concentrating on A&B, not C – access is seen is key issue, rather then quitting.
* Variation in AKP services might be due to different ways of working. Reports of staff being side-tracked into other areas, and not 100% focused on supporting quitting. While there is variation, overall the service is working.
* Some variation might be explained by leadership and management
* Could be due to local approaches or to local populations
* Reflects readiness of different groups
* Difficult to target populations when not geographically clustered
* In DHB areas with high smoking rates/poor engagement with services etc need to look at them individually to understand why
* Examine capacity in relation to ‘problem’ areas and services
* Ensure appropriate service specifications and adequate contract accountability

Improving access to services

* Funding could be allocated in proportion to need
* Provide transport to access services
* Working more closely with providers, e.g., Maori providers
* Encourage new approaches (e.g., Mana wahine Hapu-Taranaki, community champs, whanau champs, group support, personalised phone/text support, drop in centres)
* Ensure targeted marketing occurs
* Right services, right place, right time
* Look at service mix and improvements (service specifications, networking of services, referral pathways, shared care, triage people to most appropriate service)
* Build into service mix expectation that smokers will try a range (or even all) the services available to them
* GPs are not promoting cessation

Other comments related to the question

* Smoking is a social issue, quitting is a clinical issue
* Using a public health funding approach for treatment services
* Public health funding is appropriate for health promotion

**Issues in the supply and distribution of pharmacological interventions.**

General issues

* Too much emphasis on pharmacological interventions, that is a clinical answer to quitting
* Poor compliance with treatment among priority groups

Nicotine replacement therapy (NRT)

* Restricting supply (providing in small amounts) would be preferable as coming back for supply maintains contact
* Supply NRT through local outlets, e.g., train up dairy owners
* PHARMAC rules around NRT supply make supply inefficient
* NRT sample packs need to be available
* Issues noted around wastage of products
* Often a delay in accessing NRT
* Working group to review NRT was suggested
* NRT Should only be supplied along with counselling/other support
* More choice required in NRT products – products are now very old. Most smokers have failed at least once to quit with it. Other options should be investigated. What are the best products? What are the innovative and new products/technologies?
* What is the cost of NRT –is it effective?
* NRT is a useful way to engage with quitters.
* Options for pregnant women are limited – need to be careful about saying it is ineffective as this might lead to disengagement with quitting (this issue applies to other populations as well).
* Social marketing needed for NRT – especially for pregnant women.

Other approaches/technologies

* Investigated feasibility of De-nic cigarettes (this is possible within government regulations). RCT proven successful way to encourage quitting.
* Champix is more effective than NRT and it should be used more widely. Relapse strategies, behavioural support needed. The course of Champix is too short (need longer timeframe as in Australia). GPs need to actively engage and proactively manage patients.

Other comments related to the question

* A better understanding of pharmacotherapy required. MoH could provide training around understanding – about products and how and why they help quit.
* Primary care not a good place for ABC for Pacific people, as they only attend when really sick (this notion was questioned)

**Building the capacity and capability of the sector (organisational, infrastructure, workforce).**

General issues

* Capacity/capability needs to be matched with population needs
* More effective treatment options need to have priority.
* How can service be planned to meet increased demand?
* What is the role for Maori leadership? (Question was not answered)
* Mixed (e.g., health promotion and cessation) and split roles (e.g., part-time positions) are not necessarily effective

Workforce issues

* Lack of energy, resources and capacity (especially strongly reported in Auckland). Reports of burnout.
* Initiative stifled in politically risk adverse environment
* Managers/leadership feel embattled, subject to political pressures and insecurity (e.g., recent issues with Problem Gambling Foundation)
* Insecurity feeds competition and collaboration suffers
* CAYAD model of a minimum of 2FTE might be appropriate model to use in cessation services
* Innovations can place demands on the sector, e.g., Stoptober is going to stretch capacity within the sector

Training

* Many reports of staff not having access to appropriate training, personal development (e.g., some DHB staff are not allowed to travel for any training and pay for any training/professional development)
* Training not centralised and there is overlap, and training is done to varying standards
* Make training mandatory and in contracts
* Mandatory training impacting on providers’ capacity (unclear about this point)
* Little training / professional development for smokefree coordinators
* Training needs to be ring fenced
* Specifications about the minimum level of training are needed
* Workforce needs to walk the walk – not just be non-smokers, but have healthy lifestyles and offer broad holistic support

Ministry leadership/national planning

* Sector has a developed a plan including logic model, but the MoH does not have a strategy or logic model
* Public health approach
* Alignment, collaboration and integration of goals should underpin plans (this is currently not evident)
* Targets have been useful in getting the conversation going, but a suggested change in focus from ABC to focus on getting from B to C
* Short sighted moving resources from secondary to primary care
* Not always alignment between the work of organisations and their contracts
* Higher quality of monitoring of contracts needed as there is a suggestion tobacco control is not always getting the money that is allocated to it
* DHB contracts need to be less vague and directed to what is known to work. MoH, in general, is getting better at giving direction and this needs to be applied to tobacco contracts.

Sector leadership

* Advocacy has been written out of all contracts – and replaced with new words like support and inform. This has created confusion in the sector.
* Sector organisation is clear and groups feed into the National Smokefree Working Group (NSWG)
* One area where the sector might feel overwhelmed is the provision of information
* NSWG has developed logic model to guide the sector. One contrary view expressed that this ‘model’ was imposed on the sector.

**Leveraging the current government target**

Targets

* Targets have been useful in getting the conversation going, but as noted in (Question 4) targets do not foster collaboration and are not about the quality of the service.
* Targets can miss the point – e.g., hospital targets are largely relevant to older people (who are not a priority population)
* Much discussion about how the targets could be improved, and several suggestions made:
  + focus from ABC to focus on getting from B to C
  + uptake of referrals
  + % of smokers accessing a stop smoking service
  + Consistency in data collection recommended: 4 weeks, three months, 12 months

Other comments about targets

* Current targets are also quite short (e.g., 4 weeks, 12 weeks).
* Because follow up is difficult, focus is on throughput and not on the quality of the service
* Needs to be consistent data collection
* Target for cessation could be support people in your area to be smokefree

1. In 2012/13, the target was that 95% of hospitalised patients who smoke and are seen by a health practitioner in public hospitals and 90% of enrolled patients who smoke and are seen by a health practitioner in general practice are offered brief advice and support to quit smoking. [↑](#footnote-ref-1)
2. It is not clear what ‘other referred source’ can be given that referrals from GPs, hospitals, community services, Quitline, workplace or schools are already covered. [↑](#footnote-ref-2)