

**Submission**

**No 36**

**INQUIRY INTO TOBACCO SMOKING IN  
NEW SOUTH WALES**

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**Theme:**

**Summary**

Please find attached a submission from The Children's Hospital at Westmead for your Inquiry into Tobacco Smoking. I am not sure whether this has already been sent to you by our Director of Corporate Services but as he is away today I am resubmitting it in case you haven't received it.

The submission was prepared by Dr Bronwyn Milne with the help of Dr Sue Towns and myself. Dr Milne & Dr Towns were involved in a project at this hospital which developed a training program for clinicians in brief interventions targeting parents and adolescents who smoke, which is described in the submission. The submission also highlights the detrimental effects that environmental tobacco smoke exposure, particularly in pregnancy and early childhood, can have on children's long term health as well as recognising the importance of early intervention in childhood and adolescence to prevent the initiation of smoking.

I hope this submission is helpful in your deliberations.

Yours sincerely, Peter van Asperen

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## INQUIRY INTO TOBACCO SMOKING IN NEW SOUTH WALES

### RESPONSE TO THE TERMS OF REFERENCE: SPECIFIC TO THE PAEDIATRIC HEALTH CARE SETTING.

#### **A) The Cost and Other Impact of Smoking:**

Tobacco smoking is a major public health issue, the cost and impact on children and adolescents often being overlooked. Within a Paediatric health care setting, there are two separate populations of interest; first - parents who smoke increasing the risk of environmental tobacco smoke for infants and children, secondly, young people who are at risk of transition from experimental smoking to regular smoking during their adolescent years.

Exposure to Environmental Tobacco Smoke (ETS) particularly in infancy and early childhood is a clearly established risk factor for many health issues that have a high cost to our society<sup>1</sup>. They are listed below;

- Asthma: more frequent exacerbations, more severe disease, greater number of hospitalisations and life-threatening attacks.
- Lower respiratory tract infections including pneumonia, croup, bronchitis and bronchiolitis.
- Middle ear disease including acute and chronic otitis media and surgery for middle ear effusions.
- Impaired lung function secondary to parental smoking during pregnancy and exposure to ETS.
- Sudden Infant Death Syndrome: higher rates of SIDS in babies of mothers who smoked during pregnancy and of babies who live with a smoker.
- Parental smoking is associated with learning difficulties, behavioural problems, and language impairment.

- ETS exposure is associated with physiological changes in children that may increase their risk of cardiovascular disease.

Children are particularly vulnerable to ETS because of their smaller airways and immature immune systems. ETS exposure to children predominantly occurs via proximity of children to smoking parents, particularly in the home and car. Despite campaigns to improve children's risk to ETS, smoking rates in homes continue to be high, with the highest in NSW (34%), compared to a low of 20% in South Australia. (Car and Home smoke free campaign) Children whose parents smoke also have a greater risk of smoking themselves.

Smoking is also a major health concern for teenagers. It is estimated that 42,800 Australian school students make the transition from experimental smoking to an established smoker each year.<sup>2,3</sup> More than 90% of individuals who have ever smoked and 70% of established smokers initiated smoking before 18 years of age.<sup>4</sup> In 2002, a study of Australian secondary school students showed that 6% of 12 year old students were established smokers, increasing to 35% of 17year old students.<sup>2,3</sup> The most significant period for transition to established smoking appears to occur around the age of 14 years.<sup>3</sup>

Cigarette smoking is also reported to be a gateway drug for adolescents. Tobacco is generally the first drug used by young people who subsequently use other illicit substances. Adolescents who smoke are 3 times more likely to use alcohol, 8 times more likely to use marijuana and 22 times more likely to use cocaine than are their nonsmoking peers.<sup>4</sup> Nicotine addiction can develop rapidly in adolescents. Adolescent smokers are interested in quitting and usually make frequent attempts to quit. Despite this however not enough is being done to prevent smoking onset and aid in smoking cessation in this age group or to train clinicians working in a paediatric health care setting to facilitate smoking cessation in both parents who smoke and adolescents who smoke.

**B) The effectiveness of strategies to reduce Tobacco Use**

There are a number of strategies which should be implemented to help reduce the costs of tobacco smoking in a paediatric setting.

- i) Strategy to reduce ETS for children of parents who smoke.
- ii) Training hospital and community based clinicians in brief interventions for parents who smoke and teenagers who smoke.
- iii) Supporting organisational change within the hospital and community to assist clinicians in offering brief interventions.
- iv) Specific strategies to prevent initiation of smoking in Adolescents and assist smoking cessation in this age group.

i) Strategy to reduce ETS for children and parents who smoke: Increasing awareness and education about the risks of ETS has lead to a reduction in the number of people who smoke in enclosed areas in the presence of children ([www.smokefreezone.org.au](http://www.smokefreezone.org.au)), however further resources are required to sustain and expand such campaigns. Target groups include antenatal clinics and delivery units, paediatric services, community health services assisted by mass media campaigns. Smoking cessation programs in pregnancy have been shown to reduce the proportion of women who continue to smoke, and reduce low birth weight and preterm birth.<sup>5</sup> Expectant parents and parents of unwell children are often more open to receiving new information about tobacco cessation and have increased likelihood and motivation regarding quit attempts.

ii) Training hospital based clinicians in brief interventions – International evidence suggests that brief interventions for smoking cessation are effective in increasing quit rates.<sup>6,7</sup> Results of the meta-analysis for the US Clinical Practice Guideline show brief intervention counseling of up to 3 minutes is effective in increasing abstinence rates.<sup>8-10</sup> The “5As approach” encapsulates the evidence-based model for effective brief advice determined by the US clinical guidelines for smoking cessation: Clinical Practice

Guidelines for Australian General Practitioners also use the 5A's approach,<sup>11</sup> that is; (i) **Ask** about smoking at every opportunity, (ii) **Assess** willingness to quit, (iii) **Advise** all patients to quit smoking, (iv) **Assist** in quitting and (v) **Arrange** follow up.

The clinician's primary role with the parent and adolescent smoker is to motivate a quit attempt. Over all, only 3-5% of all smokers who quit each year remain abstinent for a year or longer.<sup>4</sup> Smoking cessation interventions are likely to bring population health gains for relatively modest expenditure and in the long term they will reduce smoking related health care costs.<sup>12</sup> Brief smoking cessation advice from doctors delivered opportunistically during routine consultations has a modest effect, but sizable public health benefit. The addition of pharmacotherapy with nicotine replacement therapy (NRT) or sustained release bupropion is an effective aid proven to double quit attempts.<sup>6,7,9,13</sup> The use of NRT in nicotine dependent adolescents is known also to be safe and effective.<sup>12,14,15</sup>

The hospital setting provides a 'teachable moment', in which the health risks of smoking and the benefits of quitting can be highlighted for parents and young people who smoke, in particular provide an opportunity for cessation counseling. Clinicians can play a powerful role in assisting patients to quit smoking and thereby reduce the high morbidity and mortality associated with tobacco related diseases. Health care professionals working in both the hospital and community setting cannot be excluded from this responsibility. They may also be of influence in preventing initiation of smoking in young people or prevent transition from experimental to established smoking. The hospital should provide guidance to effective interventions for clinicians working in the community setting. Studies have shown however, paediatricians are reluctant to discuss smoking routinely.<sup>15</sup>

Australian and international studies show that at any one time 37% of smokers are not ready to quit, 42% are unsure and 21% are ready to quit.<sup>16,17,18</sup> Training clinicians in brief interventions should therefore aim to target the 20% of smokers who at any one time are ready to quit, in order to motivate a quit

attempt. Brief interventions targeted to teenagers may also prevent transition from experimental smoking to established smokers in this age group. Previous studies have shown that training health professionals in smoking cessation intervention is effective in increasing the number of patients who receive counselling, set a quit date, and receive a follow up appointment.<sup>6,19,20</sup>

- iii) Supporting organisational change within the hospital. Lancaster et al state that training alone is unlikely to represent a useful investment of resources unless it is linked to organisational changes which facilitate the intervention.<sup>21</sup> A recent study performed at the Children's Hospital at Westmead showed that training clinicians in brief intervention for smoking cessation increased clinicians knowledge and confidence in NRT, motivational interviewing and brief intervention – however further change in practice would be supported by additional changes within the organisation to assist ongoing clinical practice improvement in this area.<sup>22</sup>

Community based health care settings including community health services and youth health services should also focus on creating an environment that aids smoking cessation interventions in their clients.

- iv) Specific strategies to prevent initiation of smoking in Adolescents and assist smoking cessation in this age group. Helping young people to avoid starting smoking is a widely endorsed goal of public health, but there is uncertainty as to how to do this. There is lack of high quality evidence about the effectiveness of interventions for teenagers, combining social influences, social competence interventions and multimodal programs, including community interventions.<sup>23</sup> More research is needed for evidence based interventions for the prevention of smoking in adolescents.

Similarly, there is little research into evidence based approaches for smoking cessation interventions for adolescents who smoke. More research is needed to determine the most effective intervention to assist smoking cessation in this vulnerable age group.

Although evidence is being gathered to develop clinical practice guidelines for the treatment of tobacco dependence in youths, tobacco treatment currently recommended by experts and professional organizations needs to be made available to youths through the health care system. Coordinated efforts are needed at several levels of the health care system to maximize the likelihood that cessation interventions will be routinely delivered to young people. Important points of intervention include the clinician (eg, best practices for clinicians, clinician training, tools), organizational systems (eg, health care system changes, office systems), and policy (eg, reimbursement, incentives, performance measures). A number of actions taken by the clinicians and their practices, professional organizations, and the health care system and policy makers will facilitate this goal of integrating tobacco treatment intervention into routine practice.<sup>24</sup>

- C) **The effects of smoke-free indoor venues on the initiation and maintenance of the smoking habit.** The NSW Health smoke free workplace guidelines are active within the Paediatric health care setting. Parents and adolescents who smoke have few places in which they can smoke around the hospital setting. This is endorsed via the Smoke free workplace working party. We should be aiming towards a totally smoke free hospital environment to further enhance the benefits of smoke-free venues. This not only decreases the exposure to environmental tobacco smoke for children and adults, but also promotes attempts to reduce smoking.
- D) **Factors affecting initiatives for smoke-free indoor areas.** NSW Health recently had a campaign promoting “Car and Home a smoke free zone” This promotes the reduction of childhood exposure to ETS and subsequently decreasing the associated adverse health effects. Ongoing support for these campaigns is needed to continually educate the



community on the harmful effects of ETS as outlined earlier, particularly on children. It is extremely important to consider the effects of tobacco smoking on children when considering the development of legislation to achieve smoke-free environments.

E) **The effectiveness of media, educative, community and medically-based Quit**

**Initiatives.** The impact of tobacco advertising and promotion on adolescents was reviewed in a Cochrane study by Lovato et al. The longitudinal studies reviewed consistently suggest that exposure to tobacco advertising and promotion is associated with the likelihood that adolescents will start to smoke.<sup>25</sup> Tobacco advertising specifically targets young people, quit-smoking media campaigns however target adults.

There is little evidence on medically based quit initiatives including the use of nicotine replacement therapy in adolescents, evidence based guidelines for adults are currently being translated for the adolescent smoker. This again highlights the need for further research and specific interventions targeting young people in order to decrease smoking rates in this age group.

F) **The adequacy of the budget for smoking control initiatives**

At present there are few resources allocated to smoking cessation specific to the paediatric health care setting. The budget for smoking control initiatives should include a two pronged approach, addressing the different needs of the specific populations targeted, i.e parents who smoke and adolescents who smoke. Resources must be invested into education and prevention of smoking, particularly for the adolescent patient, as well as intervention or smoking cessation in order to increase quit attempts, subsequently reducing the burden of disease from tobacco smoking.

A suggested approach to improving resources for tobacco cessation within a Paediatric Health care setting includes the following;

- i) Support clinical staff to deliver training to hospital based medical and nursing staff in brief interventions for both parents who smoke and teenagers who smoke.

- ii) Provide organisational change for the hospital to provide educational resources about smoking cessation and brief interventions for both parents and young people who smoke.
- iii) Provide NRT particularly for adolescents who smoke when admitted to a paediatric or inpatient mental health ward.
- iv) Continue educational strategies including mass media campaigns highlighting the effects of ETS on children in attempt to reduce the exposure and subsequent risk to the paediatric population.

The current hospital budget does not allow for the above strategies, particularly staffing support for tobacco cessation initiatives within the paediatric setting. Each year a \$5,000 grant is offered to the area health service for initiatives for World No Tobacco Day. This however is insufficient to sustain staff for ongoing training and counselling for smoking cessation. A pilot study was performed at the Children's Hospital at Westmead, developing a training program for clinicians in brief interventions targeting parents and adolescents who smoke. Continued funding for such a project, including funding for clinical staff to deliver training and support organisational change could be developed further and be used as a guide for further work in other paediatric settings.

**G) The Smoke-free Environment Amendment (Motor Vehicle Prohibition) Bill 2005  
introduced by Revd Mr Nile in the Legislative Council**

Despite campaigns to improve children's risk to ETS, smoking rates in cars and homes continue to be high subsequently having harmful health effects on children. It is also well known that children whose parents smoke, have a greater risk of smoking themselves. Increased emphasis, education and legislation to support the importance of a smoke-free environment will have long term health benefits for children and young people.

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