population, the use of NRT in quit attempts, or the success of quit attempts overall. The authors argued that there are barriers to NRT use, other than having to visit a doctor to obtain a prescription. They suggested that the cost of NRT was a likely barrier. The impact of over-the-counter sales on effectiveness of NRT for smoking cessation is further called into question in a recent study of the Californian population.[5] The study observed an increase in reported use of NRT after over-the-counter sales were introduced, but not the long term population cessation outcomes that might have been anticipated. The authors identified levels of motivation and compliance with manufacturers guidelines for use (including duration of use and use of adjuvant counselling), as important potential differences between the general population of California and trial participants.

NRT is not subsidised under the Australian Pharmaceutical Benefits Scheme (PBS) and a 10 week course of patches costs the consumer A$310 (recommended retail price (RRP); approximately US$170). Anecdotally, the cost of NRT is often cited by smokers using South Australian cessation services as a major impediment to accessing NRT and to quitting. In response to these concerns, as part of a South Australian workplace based smoking cessation programme conducted in 2000-01, employees of participating organisations were offered free Quit Smoking courses and subsidised (half RRP; approximately US$85) 10 week courses of nicotine patches (the manufacturer's recommended period for successful cessation). Interested employees had to enrol in and attend a Quit Smoking course, conducted at their own or a nearby workplace, and complete the Fagerstrom test for nicotine dependence.[6] Vouchers were distributed within a week of attending a course, by mail or via the workplace, to individuals indicated to be addicted to nicotine. The vouchers could be redeemed for discounted NRT patches at any store of a widespread participating pharmacy chain.

Interest in subsidised NRT was very high among programme participants, with 93% of the 301 course participants completing the Fagerstrom test in order to be assessed for eligibility, and 83% of those (232 participants) found to be eligible. Hence, 232 books of 10 vouchers were distributed to smokers, giving a total of 2320 vouchers. Vouchers indicated an expiry date of 31 March 2001, giving smokers a period of 3–7 months to redeem their vouchers. Tracking of the numbered vouchers revealed that a total of 355 individual vouchers were redeemed, representing 15% of all vouchers distributed. Overall, 39% of the 232 smokers redeemed one voucher or more, leaving 61% of voucher recipients who did not redeem any vouchers at all. Among smokers who did redeem at least one voucher, the total number redeemed by an individual ranged from 1–10, with a mean of 4 vouchers. When a random sample of 33 voucher recipients (response rate 66%) were followed up nine months after the courses began, they were asked why they had not redeemed all or any of their vouchers. Responses indicated that many recipients (54%) had decided to make a quit attempt without using all or any of the patches, but almost half (46%) had changed their mind about making a quit attempt and continued to smoke. It is noteworthy that although bupropion (Zyban) became available under PBS subsidy during this period (February 2001), only one respondent surveyed said that they had not used their patches because they decided to use bupropion instead.

These findings suggest that cost may not be the barrier to accessing NRT that it is often claimed to be. Rather, individual readiness to quit may be a very important factor in determining use, and should be taken into consideration when planning programmes involving free/subsidised NRT.

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Impact of the new EU health warnings on the Dutch quit line

On 1 May 2002, four months sooner than required by the European Union (EU), the new EU health warnings on cigarette packaging came into effect in The Netherlands. The warnings included the telephone number of the Dutch quit line. There are reports in the literature about the general impact of health messages,[1] but very little about what this means for quit lines.

The front of the pack is required to have one of two health warnings, covering 30% of the surface. The back of the pack has one of 14 different health warnings. The cigarettes are distributed in such a way that all 14 messages are evenly mixed. One of these (translated from Dutch) states: "Ask for help with smoking cessation: DEFACTO 0900-9390 (0,10 Euro cent/min) or www.stoppen-met-roken.nl or consult your physician or chemist". DEFACTO's 0900 number is the national quit line. Following the introduction of the new packages, both the quality and quantity of the calls to the quit line changed dramatically. This increase is most likely due to the introduction of the packages, since there were no campaigns or policy changes in The Netherlands during the period of investigation that could have provided for an alternative explanation.

Figure 1 shows the increase in the number of callers starting in week 20 (second week of May). The increase started gradually, because it took several weeks before the supply of old packages was replaced. Also, manufacturers varied in their stock supplies. Whereas Marlboro cigarettes showed the new warnings very soon, after four months most Camel packages still had the old warnings. After a peak in week 24, the number of callers gradually stabilised around 700 per week, which is still 3.5 times higher than before.

We found that because of the telephone number on the packages, more callers phone during the evening or night. Consequently, we now have advisers working in the evening. Before the introduction, most callers were motivated smokers typically from middle socioeconomic groups in the preparation or action stage of quitting. After the introduction, we now receive a much broader group of smokers. Our impression is that we now get many more callers from lower socioeconomic groups who are still uncertain about whether they really want to quit smoking and whether they are able to quit smoking. Moreover, many contact us with questions about the truthfulness of the new health warnings. We also get callers who are not so serious or who are aggressive. Because our phone number is on the package, many think that our organisation is responsible for the health warnings.

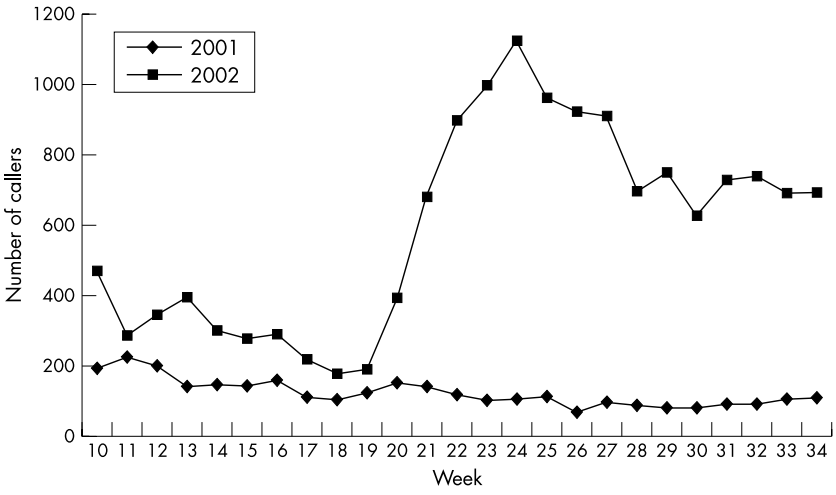

Figure 1 Increase in the number of callers to the Dutch quit line, following the introduction of health warnings on cigarette packages bearing the quit line telephone number.

They call us for an explanation or just want to tell us that they are angry. Our counsellors have received additional training to be able to better cope with this and we have made a new archive with factual information pertaining to the various health warnings on the packages.

Despite the fact that we now have less serious callers, we find that about 90% can be persuaded to have an informative conversation about smoking cessation. Our experience is that even aggressive callers have an interest in hearing about how they can quit smoking. Overall, we are very pleased that our quit line is on the cigarette packages, because a much larger and broader group of smokers is now being reached.

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Intervention effects on youth tobacco use in the community intervention trial (COMMIT)

The Community Intervention Trial for Smoking Cessation (COMMIT) was an intervention trial funded by the National Cancer Institute to evaluate the effects of a multi-component, community based smoking control intervention on cessation in adult smokers.[1 2] The primary (adult) outcomes of this trial have been published elsewhere.[3 4] In this letter we test the hypothesis that a comprehensive, community based intervention aimed at adult smokers would have an ancillary impact on the prevalence of youth smoking.

The COMMIT intervention[5] included youth oriented activities directed toward four principle areas: school based education programmes, smoking policies in schools, legislative activities related to youth smoking, and participation by students and teachers in other COMMIT activities. The evaluation involved a two group, pre-test/post-test, quasi-experimental design with community as the unit of assignment and ninth grade classroom (ages 14–15 years) as the unit of assessment. Overall classroom participation rates were 90% (8235) at time 1 and 86% (8945) at time 2.

Table 1 shows percentages and change scores (increases or decreases) in mean per cents comparing time 1 to time 2 for each study condition. None of these differences were significant.

Rank correlations were calculated contrasting pair wise differences in adolescent seven day smoking prevalence with pair wise (that is, same pair) differences in adult cohort quit rates from the 1993 COMMIT Endpoint survey.[6] These adult rate differences for each community pair were correlated with youth smoking differences in the same community pair using current weekly smoking rates from the 1992 Youth Survey. The correlation was 0.2 ($p < 0.001$), indicating that higher quit rates are associated with higher youth smoking.

The data reported here do not support the hypothesis that the adult focused COMMIT intervention was efficacious in reducing the prevalence of regular youth smoking. Among ninth graders living in treatment communities as well as among their counterparts living in comparison communities, the general trend was toward little or no difference over the time interval assessed (1990 to 1992)—a levelling off in tobacco use rates that is consistent with national trends reported in other surveys conducted during this time period.

It is important to underscore that the COMMIT approach was without question and by design an adult focused intervention, and the design of the study was not set up to evaluate youth smoking changes. Other concerns that are relevant to the interpretation of these results include: implementation fidelity; the possibility that these activities may have been delivered inconsistently, or, at least, more effectively in some communities than in others; the age group selected for the evaluation (it is possible that the intervention had a greater effect on adolescents who were either older or younger than the ninth graders selected for our sample); and the time frame for the evaluation (that is, it is possible that the interim between 1990 and 1992 was not long enough for an intervention effect to have been demonstrated, especially given secular trends during that period).

It appears that the COMMIT intervention, which did target adult smokers, was not a cause of change in adolescent smoking behaviour. Changes in adolescent smoking rates are likely to come from other sources, such as exposure to tobacco product marketing, and broad based policies and programmes intended to discourage smoking such as cigarette taxes, limits on public smoking behaviour, and community based anti-tobacco education, and mass media messages about smoking. Targeting these influences certainly forms part of the national tobacco use reduction agenda for youth.[7–10]

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Table 1 Percentage students by smoking status condition totals

	Current smoker*	Ex-smoker	Never smoker/ intender	Never smoker/ non-intender
Treatment: time 1	18.6	18.1	13.6	55.2
Treatment: time 2	21.3	18.8	15.8	44.0
Difference: T1 *v* T2	+2.7	+0.7	+2.2	−11.2
Comparison: time 1	19.6	18.2	13.7	48.5
Comparison: time 2	20.6	18.9	14.7	45.7
Difference: C1 *v* C2	+1.0	+0.7	+1.0	−2.8
Difference: C1 *v* T1	+1.0	+0.1	+0.1	−6.7
Difference: C2 *v* T2	−0.7	+0.1	−1.1	+1.7

No significant differences.

NOTICE

2nd Australian Tobacco Control Conference, Melbourne, Australia
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Hosted by The Cancer Council Victoria, in conjunction with the Commonwealth Department of Health and Ageing, the Victorian Department of Human Services, the Heart Foundation and the Victorian Health Promotion Foundation (VicHealth), the conference theme is Tobacco Control: A Blue Chip Investment: Smokefree: a healthy future. For more information visit http://tobaccocontrol03.conference.net.au