

2008. A significant overall reduction in heavy smoking was observed with a corresponding increase in the proportion of light smoking.

This is an interesting epidemiological observation but it should not be misinterpreted as a public health achievement or as a desirable goal in itself. As Thomas rightly points out, reducing daily cigarette intake is not an effective harm reduction strategy.

Smokers who reduce their daily cigarette intake by more than 50% compensate by having deeper and more frequent puffs to maintain their nicotine levels, thereby neutralising any potential health benefit.² Even reducing smoking intensity to very low levels (1–4 cigarettes per day) carries substantial risks. Furthermore, there is no evidence to indicate that smoking reduction is associated with a subsequent increase in abstinence rates, unless medication is used.³

The most likely explanations for the reduction in smoking intensity in Indigenous communities are the rising cost of smoking and public health measures, although there are evidence gaps in the research.⁴ Smoking is still regarded as normal in Indigenous communities and there is scant evidence of a shift in attitudes to smoking.⁵ Under these circumstances, there is unlikely to be any benefit from reduced daily cigarette consumption in terms of health or abstinence rates.

The goal for clinicians, smokers and communities should always be complete smoking cessation, which has proven, sustained and substantial health benefits.

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Changes in smoking intensity among Aboriginal and Torres Strait Islander people, 1994–2008

TO THE EDITOR: The recent study by Thomas¹ documents the change in smoking intensity of Australian Indigenous people between 1994 and

self-regulation is failing to prevent exposure of children and young people to alcohol advertising

Pierce et al



The goal for clinicians, smokers and communities should always be complete smoking cessation

Mendelsohn et al

¹ Thomas DP. Changes in smoking intensity among Aboriginal and Torres Strait Islander people, 1994–2008. *Med J Aust* 2012; 197: 503–506.

² Tverdal A, Bjartveit K. Health consequences of reduced daily cigarette consumption. *Tob Control* 2006; 15: 472–480.

³ Asfar T, Ebbert JO, Klesges RC, Relyea GE. Do smoking reduction interventions promote cessation in smokers not ready to quit? *Addict Behav* 2011; 36: 764–768.

⁴ Ivers R. Anti-tobacco programs for Aboriginal and Torres Strait Islander people. Canberra: Australian Government, 2011. (AIHW Cat. No. IHW 37.)

⁵ Gould G, Munn J, Watters T, et al. Knowledge and views about maternal tobacco smoking and barriers for cessation in Aboriginal and Torres Strait Islanders: a systematic review and meta-ethnography. *Nicotine Tob Res* 2013; 15: 863–874. □

IN REPLY: Nowhere in my article do I promote reducing the number of cigarettes patients smoke, rather than smoking cessation, as a goal for clinicians. Mendelsohn and Gould have created their own straw man with which to argue.

I explain in the third paragraph of the Discussion that the population changes in smoking intensity may have been caused by previously heavy smokers cutting down (with only modest health benefits) or by younger cohorts never becoming heavy smokers (which will lead to greater health benefits).¹ There are early signs of the more important latter change occurring, as has been shown in the United States with more detailed datasets.²

Mendelsohn and Gould are wrong to dismiss these changes as mere epidemiological curiosity. They are a public health achievement, probably caused by the public health measures that I described and which they acknowledge. Together with previously reported trends in smoking behaviour, these changes should lead to lower rates of sickness and early death due to smoking in Aboriginal and Torres Strait Islander people.

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¹ Thomas DP. Changes in smoking intensity among Aboriginal and Torres Strait Islander people, 1994–2008. *Med J Aust* 2012; 197: 503–506.

² Pierce JP, Messer K, White MM, et al. Prevalence of heavy smoking in California and the United States, 1965–2007. *JAMA* 2011; 305: 1106–1112. □