



A joint submission to the National Preventative Health Taskforce by the Council of Social Service of New South Wales and the Cancer Council NSW

Reducing tobacco related harm among highly disadvantaged groups

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Introduction

Cancer Council NSW (CCNSW) and the Council of Social Service of New South Wales (NCOSS) welcomes this opportunity to provide comment to the National Preventative Health Taskforce (NPHT). Our focus in this submission is on the proposals the Taskforce has outlined in the Technical Report No 2 *Tobacco Control in Australia*¹ particularly those relating to reducing smoking among disadvantaged population groups.

About Cancer Council NSW and NCOSS

Cancer Council NSW

CCNSW is the leading cancer charity in NSW. Its mission is to defeat cancer and it works toward this goal through research, information and support services, and health promotion initiatives to prevent cancer and other chronic disease. CCNSW has a particular and longstanding interest in tobacco control and supports the need for broad reaching and comprehensive activity to reduce smoking related harm. We recognise the need for legislative and regulatory action to create an environment which supports an individuals' decision to quit or resist smoking. Our active involvement in campaigns for smoke free pubs and clubs and to protect children from tobacco promotion through retail outlets are examples of this commitment.

NCOSS

The Council of Social Service of NSW (NCOSS) is an independent non-government organisation (NGO) and is the peak body for the non-government human services sector in NSW.

NCOSS has as its vision a society where there is social and economic equity, based on cooperation, participation, sustainability and respect. NCOSS works with its members on behalf of disadvantaged people and communities towards achieving social justice in New South Wales.

It was established in 1935 and is part of a national network of Councils of Social Service, which operate in each State and Territory and at Commonwealth level.

NCOSS membership is composed of community organisations and interested individuals. Affiliate members include local government councils, business organisations and Government agencies. Through current membership forums, NCOSS represents more than 7,000 community organisations and over 100,000 consumers and individuals.

Member organisations are diverse; including unfunded self-help groups, children's services, youth services, emergency relief agencies, chronic illness and community care organisations, family support agencies, housing and

homeless services, mental health, alcohol and other drug organisations, local indigenous community organisations, church groups, peak organisations and a range of population-specific consumer advocacy agencies.

Our interest in smoking and disadvantage

In recent years CCNSW has become more aware of the relationship between smoking and disadvantage and has resolved to direct more energy and resources to reducing the impacts of smoking on our most disadvantaged groups. This resolve led CCNSW to develop the Tackling Tobacco Program, previously called the Tobacco Control and Social Equity Strategy.² The Tackling Tobacco Program aims to reduce tobacco harm among vulnerable people groups in NSW through partnership with community service organisations. NCOSS fully endorses the Program and was a key contributor to its development and has remained actively involved in its implementation. An important feature of Tackling Tobacco is that it seeks to reframe smoking as an important equity issue given that our most vulnerable groups bear a disproportionate share of the harms imposed by tobacco. The Tackling Tobacco Program encourages community service organisations to better address tobacco through shaping service environments, developing policy and providing active case work support to help clients quit. Important elements of the Program include: awareness raising and education; development of policy and case work resources; development of smoking care training for the community sector; research into effective smoking care and its integration into services and; support for tobacco control and smoking cessation projects within organisations. To date over 40 such projects have been completed or are currently operating within community organisations in NSW.

How this submission is organised

This submission is divided into two main parts. The first part comprises overall comments regarding the NHPT paper on tobacco control, its approach and our views on what is required to see the proposals for action come to fruition. The second part provides more specific comment on some of the proposed actions contained in the technical report, focussing mostly on the sections relating to smoking and disadvantage, particularly sections 3.5, and 3.6.

Part 1: Overall comments

NCOSS and CCNSW strongly support the inclusion of tobacco as a priority area in *Australia: The Healthiest Country by 2020*.³ Both the discussion paper and accompanying technical report on tobacco control illustrate the case for

decisive and sustained action to prevent tobacco related harm. In response to the documents NCOSS and CCNSW would like to draw attention to the following points.

1. The need for sustained emphasis on priority population groups

NCOSS and CCNSW are pleased to note and strongly support the emphasis within the technical report on actions directed to reduce smoking among groups that experience severe socio-economic disadvantage.

Whilst smoking rates across the community have declined in the last decade, smoking rates for low income and disadvantaged population groups have remained high. In NSW amongst males, 15.4% of the least disadvantaged quintile smoke compared to 22.6% of the most disadvantaged.⁴ Among females the gap is even greater, with only 10.2% of the least disadvantaged smoking compared to 26.0% of women in the most disadvantaged quintile.⁴ Smoking rates are even higher amongst groups who experience more severe disadvantage or are otherwise vulnerable:

- Around 50% of Aboriginal people smoke.⁵ 51% of Aboriginal women report smoking during pregnancy⁶
- Smoking rates among people with mental illness vary with the condition. Adults with any mental health or behaviour problem report a smoking prevalence of 32%.⁷ Smoking rates of 73% (males) and 56% (females) have been found among people with psychotic illness in Australia⁸
- 46% of single parents smoke with higher rates for low-income single parents⁹
- Rates of 65% have been recorded among vulnerable young people¹⁰
- People in drug treatment have smoking rates between 74% - 100%¹¹
- Smoking rates of 70%, 78% and 90% among homeless people have been reported in studies in the US, Canada and the UK respectively^{12, 13, 14}
- 82% of Aboriginal people and 77.2% of non-Aboriginal people in custody are current smokers.¹⁵ The majority of the population in custody surveyed were male (82%).

These very disadvantaged groups bear a disproportionate burden of smoking related harm in Australia. Giving more attention to addressing smoking among these groups is warranted on at least two grounds.

Smoking is a social equity and justice issue. Disadvantage in its various forms is associated with higher smoking rates and smoking acts to maintain and

deepen disadvantage.¹⁶ We should be as concerned about smoking among our most vulnerable citizens as we have been about smoking among the general population. Also, as Baker et al (2005) observe, we are unlikely to see further strong reductions in smoking rates across the board unless we pay more attention to reducing smoking among high prevalence groups.¹¹ The fact that the lessening of the gap in smoking rates between our least and most advantaged groups seems to have stalled, if not starting to reverse, provides even more reason to act decisively.¹⁷ We support the view that a strong focus on reducing smoking among very disadvantaged population groups is complimentary to whole of population strategies to reduce smoking rates.¹⁸

2. The need for a detailed implementation plan and an authoritative body to drive it

NCOSS and CCNSW see great value in the intention and proposed actions contained in the technical report. Stating the proposed actions is an important first step. Seeing them through to implementation will require other steps, the details of which are yet to be determined. We consider these should include:

- The establishment of an authoritative body to drive implementation and monitor progress of the agreed initiatives
- A detailed implementation plan that fleshes out the main strategies and who will carry them out
- A realistic and adequate budget for the resources that will be required

Without this sort of commitment we are concerned that the many positive proposals the NHPT has outlined will remain unrealised. The National Tobacco Strategy 2004-2009 is a case in point.¹⁹ It contained many excellent policy intentions but only some of these have been translated into concrete action. NCOSS and CCNSW would be in support of a reinvigoration of the National Tobacco Strategy but it must meet the criteria noted above.

Any plan to implement the NPHT's proposals must provide for national integration in the context of complex Federal and State relationships and differing responsibilities. New initiatives need to take account of State and Territory tobacco strategies and activities (in NSW a number of initiatives flow from the NSW State Plan commitment to reduce rates of smoking). The States and Territories are responsible for the bulk of service delivery through health and other social service systems, and as such they play an essential role in the implementation of the strategy. These relationships, roles and responsibilities need to be made explicit in the plan.

We also consider that any plan should include clear and specific measures to assess prevalence and smoking related harm in the most disadvantaged groups. Whilst population-wide measures are necessary, such measures should be complimented by specific targets for priority population groups to

ensure an ongoing motivation to reduce the gaps in health status resulting from tobacco use. Such targets would focus on identified priority population groups, and could include commitments related to people in low socioeconomic groups; single parents; people with a mental illness; Culturally and Linguistically Diverse (CALD) groups; young people and any other identified priority population group.

One way to achieve the above requirements and ensure that the NPHT's proposals are appropriately implemented would be to establish a national prevention agency as suggested by the NPHT and the National Health and Hospitals Reform Commission.²⁰ A national agency would provide an administrative framework to facilitate implementation of strategies across Federal/State and Territory jurisdictions and across departments and sectors. It would also help quarantine preventative health strategies from erosion due to increasing demand for acute care services.

To be effective we believe that a national prevention agency should recognise and support all levels of government, including local councils, in improving health and creating healthy environments. At the same time it should have regulatory authority bestowed by an act of parliament and power to implement, monitor and, where necessary, ensure compliance with its strategies.

The national prevention agency must have appropriate long term funding which is commensurate with the seriousness of the impact of chronic disease in this country. It should have a clear strategic plan and its contribution to achieving set goals should be assessed against clear performance indicators and outcome measures. To enhance the authority of the agency we suggest that it report directly to the Prime Minister or its own preventative health minister. The agency should also report periodically to Parliament on progress against its goals.

3. The role of the community sector in contributing to reduced smoking related harm among disadvantaged groups

NCOSS and CCNSW welcome the recognition, expressed in many of the NPHT's proposed actions, of the role that government-funded human services and the non government community sector could play in reducing smoking and the harm it causes. We believe that community-based organisations (as well as communities themselves) should be actively engaged in the development and implementation of tobacco control and smoking care initiatives. There are several factors which suggest community services provide promising settings to address tobacco issues²¹:

- Established links with the population groups with high smoking rates: Community services provide support to the main target groups mentioned in section 3.5 - Aboriginal people, people with mental illness, the homeless, disadvantaged pregnant women, vulnerable young people. They are also present in disadvantaged communities. While

the community sector does not deal exclusively with the most disadvantaged and vulnerable and not all people in these groups are in contact with community services, the sector has considerable reach into these groups. NCOSS estimates that in NSW alone there are around 7000 community service organisations.

- The nature of their contact with disadvantaged people: Many services provide ongoing support which means they have regular, stable and sometimes long term contact with their clients.^{22, 23} Importantly clients tend to trust services and their staff and expect help with life issues.²⁴ This provides a platform for provision of active support to stop smoking and multiple quit opportunities; both of which are factors in quit success.^{25, 26}
- Addressing the needs of the whole person: While services target specific issues e.g. housing, drug and alcohol issues, mental health concerns etc they recognize that clients are whole people and face multiple issues; thus they seek to meet a range of needs. There is some evidence that smoking within disadvantaged groups is best addressed alongside other issues within existing programs to improve client's lives.²⁷ Qualitative research supports this. Clients are open to quit smoking support as part of a mix of supports delivered by services they already know and trust.^{28, 29, 21, 24}
- Work from a strengths perspective: Some community services adopt a strengths perspective that emphasizes client's capabilities and strengths rather than deficits. This approach focuses on solutions more than problems and celebrates improvements. This helps build a sense of self confidence and achievement among clients, something which is important among people who may have had all too little experience of success in life. A sense of self efficacy is correlated with success in quitting smoking and low self efficacy is a barrier to quitting.³⁰ Studies on quit smoking support for vulnerable groups have called for strategies to boost self efficacy to be incorporated into interventions.^{23, 31}

Potential barriers

Engaging the community sector around tobacco may require a change in culture and understanding in some organisations. Clients of community-organisations can have a range of complex needs and their contact with community-organisations can be in their context of current or precipitating crisis situations. As such, support and assistance in relation to smoking can be minimised in the context of other more immediate concerns. This can be accompanied by arguments that smoking is one of clients' 'few pleasures in life'³²; a lack of knowledge about smoking and effective interventions and; beliefs that clients are not able to quit, are not interested in quitting or that its unfair to ask when they are dealing with other issues.^{33, 34}

Our experience in the Tackling Tobacco Program suggests that in many organisations these views are shifting, and appropriate mechanisms for building smoking related support into work with clients can be established within a variety of different service environments. It is also clear that time and resources to support the changes will be needed. The potential of community

services to make a telling contribution to reducing smoking among their clients, given their reach into vulnerable groups, their skills, and their concern for client wellbeing, make the effort worthwhile.

What the Tackling Tobacco Program is aiming to achieve with the community sector

The overall aim of the Tackling Tobacco Program is to engage the community sector as allies in smoking cessation²² and to make smoking care part of the routine care that services provide. We see two areas of action all community services could consider taking:

- Creating a supportive environment
- Addressing smoking through casework

Creating a supportive service environment

Research tells us that a person's environment has an impact on their smoking behaviour.³⁵ This includes service environments. It is important then to create a service environment that reduces exposure to tobacco smoke and encourages quitting. Most states and territories have legislation that requires the enclosed areas of workplaces to be smoke-free. Beyond this requirement, we would encourage community services to develop their policy on smoking that provides a clear statement of their position on smoking and tobacco and the practical actions they will take to reduce smoking related harm. There is no one 'right' way to do this. While some organisations may choose to implement a complete smoking ban covering all parts of their premises, others may decide to establish or maintain a separate designated smoking area. The important thing is for organisations to be thinking about tobacco and to take the next step in reducing tobacco related harm in their service. For further ideas on developing smoking policy see the Cancer Council NSW resource: *Addressing Smoking in Community Service Organisations: a policy toolkit*³⁶

Addressing smoking through casework

Community organisations wanting to help clients quit smoking can take some simple steps that don't take a lot of time or resources:

- Ask people about their smoking and if they are interested in quitting. Include agreed actions in casework goals
- Refer people to appropriate services (like Quitlines), their GP or local quit programs
- Encourage and provide emotional support to clients who are trying to quit or change their smoking.

Some organisations will be able and want to provide more such as: providing NRT, training staff in brief intervention for smoking or offering a quit group or individual counselling.

NCOSS and CCNSW believe that actively engaging the community sector can extend the reach and benefit of the NHPT's proposals and help reduce smoking related harm among our most disadvantaged groups.

Maximising involvement of the community sector in the NHPT's proposed actions

Currently the NHPT's proposed actions regarding the community sector are expressed in fairly general terms. It is not always clear who the prospective partners in the proposed actions are: whether government departments providing human services or government funded community services provided by the community sector. There also needs to be greater detail on what specific strategies are envisaged and how they would be resourced and implemented. It is vital that an adequate budget and other resources are made available to assist organisations to address tobacco issues with the groups they serve.

In order to strengthen the potential for community sector involvement in actions proposed by the Taskforce we recommend that any national prevention agency establish a steering or advisory committee made up of representatives of peak community sector organisations and major charitable organisations to provide a mechanism for connecting the activities of the taskforce to community organisations, with a view towards supporting these organisations to build their capacity in supporting the activities of the Taskforce.

Part 2: Discussion of specific issues and proposals

The following comments relate to specific issues, proposals for action or ideas for consideration that are raised in the technical report.

Increasing tobacco excise (See Section 3.1.1 Price through tax)

The price of tobacco products is a major determinant of consumption.³⁷ Other than indexation, excise and customs duty on cigarettes in Australia has not increased since 1999. The price of cigarettes in Australia is less than in Ireland, the United Kingdom and Hong Kong. There is ongoing accumulation of research evidence demonstrating the effectiveness of high levels of tobacco taxation in reducing consumption and smoking prevalence, especially amongst youth.^{38, 39, 40}

People of lower socio-economic status in Australia are more likely to smoke than people of higher socio-economic status.⁴¹ A United Kingdom study investigated the triggers for a recent quit attempt by surveying 2,441 smokers and ex-smokers aged 16 or over. This study found that those of lower socio-economic status were more likely to cite cost as a trigger to making a quit attempt than people in higher social grades.⁴² Thus the cost of tobacco products is a significant influencing factor in the decision by smokers of lower socio-economic status to quit.⁴²

Higher rates of smoking amongst socially and economically disadvantaged groups gives rise to concerns that cost increases and regulating the supply of tobacco products will have a disproportionate impact on socio-economically disadvantaged groups, who will not have the same capacity to either absorb these cost-increases or seek, access or afford smoking cessation suitable supports. An increase in the price of cigarettes has the potential to have a (possibly short term) negative impact on the financial wellbeing of severely disadvantaged people. As such, a greater balance between punitive measures and incentives is required in order to avoid an unintended exacerbation of smoking-related inequalities.

NCOSS and CCNSW support a staged increase in the cost of tobacco products *only if* they are accompanied by the implementation of targeted smoking cessation support services to help disadvantaged people to quit smoking. A necessary component of this is increasing the availability of heavily subsidised nicotine replacement therapy to severely disadvantaged groups.

NCOSS and CCNSW support calls for a staged approach to tobacco excise increases as follows:

Phase A: An immediate increase of 21% (up 7.5 cents per stick) on current prices (this would restore cigarettes to the prices consistent with the recommendations of the World Bank³⁷ and World Health Organisation⁴³). This must be accompanied by the increased availability of subsidised nicotine replacement therapy.

Phase B: Following adequate investment in community-based smoking cessation support measures and in the control of illicit tobacco trade, a staged 50% price increase (up 17.5c per stick) on current prices (this would ensure the price of an average packet of 30 cigarettes is not lower than \$20).

The Cancer Council Victoria has modelled the impacts of the above increases in excise and customs duty on tobacco, as summarised in Table 1.⁴⁴ The recommended retail price of a packet of 30 cigarettes in Australia was \$13.50 in September 2008. The model shows that a 21% increase in price through excise (a retail price of \$16.35) would prompt 130,000 adults across Australia to quit smoking and prevent 35,000 children from taking up smoking. For those whose smoking habits did not change, this would lead to an increased amount spent on tobacco products of \$9.20 per week on average. Once the

price of tobacco products were raised by 50%; this would increase the pack price to over \$20. For those whose consumption did not change, this would increase their weekly spending on tobacco by \$21.55 on average. (see table below).

Table 1. Predicted consequences of increases in excise and customs duty on tobacco.

Price increases	Current prices, spending, consumption	Phase A. 21% increase in price	Phase B. 50% increase in price
Cents per stick	25.45c	32.95c	42.95c
Recommended retail price of typical pack of 30 cigarettes	\$13.50	\$16.35	\$20.15
Increase in price per pack	-	\$2.85	\$6.65
Impact on behaviour of smokers			
Predicted total reduction in consumption of cigarettes	25 billion cigarettes [ref]	8%	20%
Predicted fewer children taking up smoking	140,000 teenagers currently smoker per week [ref]	35,500	83,000
Predicted number of adults quitting	3 million current smokers [ref]	131,000	306,000
Impact on spending per week			
Average extra amount spent per smoker per week if consumption was not decreased	-	\$9.20	\$21.55

Subsidised Nicotine Replacement Therapy (see Section 3.3.2 Subsidy of treatments and Section 3.5.6 The Homeless)

There is growing evidence that many people in severely disadvantaged groups want to quit smoking. A literature review commissioned by Cancer Council NSW concluded that there is strong evidence that people with a

mental illness want to quit.⁴⁵ Other studies found significant interest in quitting among people in drug treatment programs¹¹ and amongst homeless smokers.²¹ These studies indicated that many disadvantaged people want to quit but face obstacles associated with their disadvantage which prevent them from doing so.

One strategy that we believe would constitute practical action to reduce smoking among people who experience extreme socio-economic disadvantage would be to provide access to free or reduced-cost nicotine replacement therapy (NRT). Reasons for supporting the provision of free or subsidised NRT to severely disadvantaged smokers include:

- Smokers who experience socio-economic disadvantage are by definition much less able to afford the up-front costs of NRT
- Clinical trials show that NRT can roughly double the chance of successful quitting^{46, 47}
- Research findings suggest that NRT may play a role in increasing smoking cessation rates among severely disadvantaged groups⁴⁸
- New evidence that NRT-assisted gradual reductions in smoking by individuals can increase the likelihood of cessation⁴⁹
- New evidence that most people who quit smoking do so only after numerous attempts. NRT use by severely disadvantaged smokers may increase the number of times they attempt to quit²⁶
- There appears to be widespread support for subsidised or free NRT by socio-economically disadvantaged smokers and social welfare agencies who see the cost of NRT as a barrier to smoking cessation.^{28, 32, 50}

The Tackling Tobacco Program has found that the cost of NRT is frequently cited as a barrier to use for low income and socially disadvantaged groups.³² Provision of free or heavily subsidised NRT is the most commonly identified strategy by staff of community service agencies to assist their clients to quit smoking.^{32, 36}

NCOSS and CCNSW support measures to make the provision of subsidised NRT more widely available, for example through vouchers provided to the Quitline as outlined in the NPHT inquiry papers. However, services such as Quitlines reach only a relatively small proportion of smokers overall and may be under-utilised by the most disadvantaged smokers in particular.¹ We think the NPHT should consider other mechanisms for distribution of affordable NRT, including making vouchers available through community service organisations. We support the NPHT proposal to investigate the feasibility of various options for maximise the use of NRT by low-income smokers. We encourage the NPHT to consult with the community sector as part of this investigation. A feasibility study needs to be backed up by subsequent action on any recommendations. We note that the National Tobacco Strategy 2004-2009 included a recommendation for subsidised NRT to be introduced by December 2008, but this has not yet occurred.

Regardless of the precise distribution mechanism we believe the benefits of NRT will be maximised for disadvantaged groups when it is provided in

association with other types of support. One reason for this is to ensure that the NRT is used most effectively and appropriately. Anecdotal evidence suggest people don't always know how best to use NRT, for example, the need to chew briefly and then 'park' NRT gum, and its benefit is therefore compromised.⁵¹ The other reason is to provide the emotional support and encouragement that may be especially important for disadvantaged smokers to quit. UK research reveals that the smokers in the lowest socio-economic groups are more likely to try to quit, but less likely to succeed.⁵² This implies the need for more intense support for the most disadvantaged smokers. We know that both one-to-one counselling and group counselling approximately double the chances of quitting, compared to no treatment. It is also more effective than brief advice alone.⁵³ These supports are best provided within an environment that provides sustained, trusted and on-going support for disadvantaged people.

Utilisation of Quitline by disadvantaged groups (see Sections 3.3.2; 3.5.2; 3.5.3; 3.5.4; 3.5.6)

The technical report contains proposals to increase use of Quitline by low-income smokers; pregnant disadvantaged women; CALD groups; people with mental health problems and; the homeless.

While we support these proposals in principle we believe that they must be adopted thoughtfully, recognising the implications of decisions, and supported by adequate resources.

Strategies to make subsidised NRT available, increase tobacco excise and increase referrals to Quitline by the health and community sectors can all be expected to increase call volume. Funding and infrastructure development for Quitlines will be essential if they are to respond adequately and not be overwhelmed.

Where Quitline services need to be upgraded, appropriate resources also need to be made available to support this process. This applies, for example, to development of specialised treatment protocols for particular groups, or to recruit and retain people with specialist skills such as counselling pregnant women or people with mental health problems.

Continued funding needs to be made available for translation of tobacco resources in different languages to responded to changes over time.

Encouraging very disadvantaged smokers to call Quitline may have implications for the time taken for calls and training of Quitline counsellors. Very vulnerable smokers often face multiple complex issues. They may also lack confidence in quitting and require more intensive support.^{27, 31, 52} It is important that Quitline counsellors express some understanding of the sorts of obstacles and concerns that very disadvantaged groups face. Having skills in strengths based counselling would be beneficial and where counsellors lack these skills training should be supplied.

Due to the issues noted above calls with very disadvantaged smokers are likely to take longer than with other smokers. This was the experience in the South Australian trial using low cost NRT to attract low income smokers to Quitline.⁵⁴ The total minutes of counselling in the intervention and control groups were 62 and 44 minutes respectively. This compares with an average of 12.2 minutes for a sample of routine callers to the South Australian Quitline.⁵⁴ The longer duration may be due partly to the research design and methodology requiring a more intense service but it also suggests that more disadvantaged smokers will need more time to engage with and benefit from a Quitline service.

Notwithstanding the above caveats we believe that the proposals to increase use of Quitlines by disadvantaged groups could be supported by:

- Promotion of Quitlines and what they offer to staff of the community sector. Community sector leaders could be consulted as to the best methods to raise awareness about Quitlines. The aim would be to encourage sector staff to be more active referrers of their smoking clients to Quitlines
- Development of a community sector specific referral form and development of sector friendly referral pathways

Indigenous Australians (Section 3.5.1)

We recognise and applaud the Commonwealth Government's pledge to tackle smoking in Indigenous communities, including research plans to build the evidence base around what works in supporting people in these communities to quit smoking. Tobacco use in Indigenous communities would be expected to benefit from broader tobacco control measures as proposed by the NPHT, such as improved regulation, increased cost of tobacco and reduced availability of tobacco products. However, mass media campaigns to address smoking in the wider community have apparently had no effect on smoking rates in the Indigenous community, which have remained constant over the past 15 years. Strategies to reduce tobacco use which specifically target Indigenous people are only just beginning to be explored in Australia. However, there is sufficient basic research already available to indicate a productive direction for future effort.

For example, the Aboriginal Health and Medical Research Council is currently undertaking a two-year randomised controlled trial of a cessation strategy in Indigenous communities. It is funded primarily by the Australian Respiratory Council with some additional funding contributed by the National Heart Foundation and Cancer Council NSW. The BREATHE project (Building Research Evidence to address Aboriginal Tobacco Habits Effectively) involves work with 12 Aboriginal Community Controlled Health Services (ACCHS) in NSW. Tobacco Control Workers will be placed in six of the

ACCHS sites. Their major roles will be to undertake local capacity building and advocacy, particularly through training of staff. They will also be involved in influencing workplace smoking policy and supporting local quit groups. Baseline data collection for the project has already commenced. The Tobacco Control Workers will be supported and linked together using a similar model AHMRC has employed over several years for Aboriginal Drug and Alcohol Workers.

Within NSW NCOSS and CCNSW support the AHMRC call, in their submission to the Taskforce, to build on the infrastructure and experience that has, and will be developed through the implementation of the BREATHE project rather than establish a whole new trial. The BREATHE project will generate evidence regarding a range of tobacco control interventions within Aboriginal community settings. This evidence should inform similar activities in other locations.

As the NPHT papers point out, tobacco control strategies which target Maori groups in New Zealand have been more effective than those targeting Indigenous Australians. In New Zealand, the National Maori Tobacco Control Strategy: 2003-2007 was developed and coordinated by the Aparangi Tautoko Auahi Kore (ATAK) - the Maori Smokefree Coalition. This strategy comprises tobacco control activities that are designed by Maori for Maori people, such as the Aukati Kai Paipa, (a smoking cessation pilot programme for Maori women and their extended families) as well as those designed for the general community, such as the Quitline.⁵⁵

Consultation, community ownership and involvement have been recognised as major contributors to the success of the Maori Tobacco Control Strategy. Tobacco control has also been positioned in the wider context of the right to good health for all Maori people, including the physical, spiritual and cultural well-being of Maori, as individuals and as a collective.⁵⁵

New Zealand also implemented the world's first indigenous mass media cessation television campaign in 2001, which was designed by representatives from Maori organisations and Maori experts in public health. The consultation process for designing this campaign highlighted the central role of the traditional Maori family unit, the importance of recognising traditional and contemporary perspectives on being Maori, and the importance of not creating negative stereotypes of Maori as smokers. Evaluation of the campaign found that more than half of the Maori smokers surveyed stated that the targeted television commercial had made them more likely to quit.⁵⁶

Cancer Council Victoria has emphasised the need for a comprehensive approach to Indigenous tobacco control, which would include targeted social marketing campaigns, and also access to pharmacological aids to cessation, and a supportive structure for cessation to occur.⁵⁷ The importance of community leaders, culturally appropriate support material and structures, the role of remote community shops and the role of health workers also need to be included in a comprehensive tobacco control strategy to ensure real health and social gains are made in the Indigenous community.

Because of the comprehensive approach needed, while we support the proposed initiatives outlined in the NPHT technical paper, Tobacco Control in Australia, we strongly encourage consideration be given to the development of a separate and complimentary Indigenous Tobacco Strategy, guided by an Indigenous Tobacco Control Reference Group. We recommend that specific funding is allocated for the Indigenous Tobacco Control Strategy and its activities. The level of this funding should reflect the disproportionate impact of tobacco in Indigenous communities and a commitment to closing the gap regarding Indigenous life-spans.

The Indigenous Tobacco Control Reference Group would have a strong Indigenous representation and should include extensive community consultation, engagement and ownership. The reference group would be responsible for advising on the development of culturally appropriate social marketing methods and messages; culturally appropriate smoking cessation support programs and activities; and the development of performance measures (e.g. What would a successful intervention into smoking rates amongst pregnant Aboriginal women look like?). The ultimate aim of the strategy would be that Indigenous communities are able to lead tobacco control initiatives in their own communities.

Pregnant women from Indigenous and other disadvantaged groups (Section 3.5.2)

We support the proposed actions in principle but suggest other strategies could also be employed.

Access to health services, including hospital-based ante-natal services, varies across different population groups, with some not accessing these services until later stages in their pregnancy.

Community service organisations who work with women who may become pregnant should be equipped with targeted information concerning the impacts of smoking on the unborn child and their subsequent development. Training in brief intervention could also be made available to staff as well as encouraging them to refer clients to Quitlines.

We also suggest that smoking during pregnancy be featured as part of a more extensive media campaign, outlined in Section 3.2 Public Education.

We support the investigation of the use of financial incentives to pregnant women to quit. In our experience pregnancy can provide an additional motivation for young disadvantaged women to quit even when they are not ready to quit for their own sake. Providing an additional financial incentive may give additional impetus to make a quit attempt.

Non-English speaking people (Section 3.5.3)

We support the proposed action with the following additional comments:

We suggest that community service organisations which serve particular language and ethnic groups be utilised as vehicles for the distribution of targeted information in community languages, referral to Quitlines and provision of brief support and encouragement to quit smoking. Representatives of major CALD peaks should be included in discussion of strategies most suited to reduce smoking among their target populations.

The mentally ill (Section 3.5.4)

Cancer Council NSW and NCOSS strongly support a greater focus on creating environments and practices which support people with mental illness to quit smoking.

Cancer Council NSW recently published a literature review on smoking and mental illness.⁴⁵ The review found that some of the common beliefs around smoking and mental illness- that smoking is the norm for people with mental illness; that smoking helps relieve stress; that people with a history of depression find it harder to quit smoking; that smoking provides real benefits to people with schizophrenia; that people with mental illness are uninterested in quitting- are not supported by the evidence. The authors found that the factors underlying smoking for people with mental illness were largely the same as the factors underlying smoking for people without mental illness. However, they also found a culture within mental health circles that was either neutral or at times condoned or even actively encouraged smoking. Most significantly, the report concluded that the risks of smoking among people with a mental illness far outweigh any possible benefits and that the benefits of quitting for people with a mental illness far outweigh any risks. Two clear implications of the report are that:

- no person with a mental illness should be deliberately or inadvertently encouraged to smoke and;
- every person with a mental illness who smokes should be offered (and provided) help to quit smoking.

Cancer Council NSW, through its Tackling Tobacco Program, has funded a number of community organisations to conduct quit smoking support for clients with serious mental illness. One organisation reflected on some of the main lessons it had gleaned at the conclusion of a six month project:⁵⁰

- People with mental illness are just as aware as the general population of the dangers of smoking and the benefits of quitting and are just as interested in giving up
- When working with clients with mental illness attempting to quit smoking its important to have support from a mental health

professional or committed GP to monitor symptoms, affect on medications etc

- Its important to provide community sector staff with training to build the knowledge, skills and confidence to provide smoking care as part of usual case management
- The underwriting or at least subsidising of Nicotine Replacement Therapy is a major factor in the success of any quit smoking program for this population group.

People with a mental illness, including severe mental illness, spend more time in the community than they do in hospital. Nor do they necessarily see doctors or other health professionals very regularly. According to a 1998 study⁵⁸ of people with mental illness in Australia, 43% of people with severe mental disorders had not seen a health professional about their condition in the preceding year. Nearly two thirds of people with any mental disorder had not seen a health professional or service about their condition in the previous year. One implication is that we cannot rely on the health system alone to assist people with a mental illness to quit smoking. It's important that people with a mental illness find encouragement and support to quit smoking in the course of their everyday lives and in the settings in which they live, work, learn and play. This includes the community services that they may connect with on an occasional or regular basis.⁵⁹

We urge that resources be set aside for non-government community services working with people with mental illness to provide service environments that help reduce smoking related harm, provide active support and encouragement for quitting, train staff in smoking care and affordable NRT. As hospitals in-patient psychiatric facilities become smoke free it is important that community services are also able to support those people with a mental illness who would like to continue with a smoke-free lifestyle.

The homeless (Section 2.5.6)

As stated in the overall comments section there is evidence that homeless people have an interest in quitting smoking, but express low levels of confidence in their ability to quit.^{31, 60} Research suggests that services that provide regular contact with homeless people, such as drop in centres, soup kitchens, drug and alcohol services may provide ideal locations to reach homeless smokers with support to quit smoking.²¹ Organisations that provide services to homeless people can be supported, and funded, to provide smoking care as part of a holistic service provision. Again this should involve: policy support and resources to make service environments as smoke-free and quit-friendly as possible; education for staff around impacts of smoking and provision of brief smoking care and; access to affordable NRT. Services to homeless people are aware of the need to provide a comprehensive suite of supports to assist people with the transition from homelessness to a more stable and healthy life in the longer term. Given the health, social and financial

impacts of smoking on homeless people it is vital that we find ways to integrate ways of addressing smoking into our response to homelessness.

Highly disadvantaged neighbourhoods (Section 3.5.7)

CCNSW and NCOSS support the suggestion of the Taskforce, for localized campaigns to boost the use of cessation products and services in disadvantaged areas.

There is evidence that smoking is not just correlated with individual disadvantage but that there is a relationship between neighbourhood disadvantage and smoking prevalence that goes beyond the individual characteristics of residents.⁶¹ Qualitative research conducted in very disadvantaged communities in Scotland, found that a poorly resourced and stressful environment, strong community norms for smoking, isolation from wider social norms and limited opportunities for recreation and respite encouraged tobacco use and discouraged quitting.⁶² Other research found smokers in deprived areas of Nottingham (UK) had a lack of knowledge about existing services and misconceptions about pharmacotherapies.⁶³

An overview of research on community level interventions indicates benefits in knowledge about health risks, changes in attitudes to smoking, increased quit attempts and better environmental and social support for quitting but cautions that these have not translated into reductions in community smoking levels.⁶⁴ Nevertheless there seems to be sufficient evidence to warrant the trial of community advertising and awareness approaches in very disadvantaged communities. The details of this idea remain to be determined but CCNSW and NCOSS suggest that inclusion of the following elements may enhance the concept:

- Form a local coalition to coordinate local advertising and awareness campaigns. Local council through its community services or health division could provide drive and overall organisational support. Coalition members should include area health service health promotion staff, representatives from community service organisations, sporting clubs, schools, local business, GP's, churches, services clubs and resident's organisations.
- Some of the strategies employed should be low or no cost options that do not require much additional resources and can be performed by existing staff or volunteers.
- Engagement of local media such as local newspapers and radio in support of the campaign
- Awareness and advertising should be complimented by local quit support initiatives where possible and access to affordable NRT or other pharmacotherapies as well as referral to Quitlines.
- Targeting specific local neighbourhoods in a larger area sequentially may be a way of maintaining precise targeting but maintaining heightened awareness of the issues over a longer period. For example,

a local campaign could maintain focus on one Council ward at a time over a set timeframe.

- Utilize existing social networks to support quitting. Currently in very disadvantaged communities smoking provides a means of social participation and sense of belonging.⁶² This can act as a barrier to quitting. One way to harness this influence in a positive direction is to encourage pairs, threes or small groups of people to quit at the same time

The Taskforce suggestion of quit and win and other incentive schemes could be integrated within the above concept.

MacAskill et al (2002) suggest the notion of meaningful exchange as a way of thinking about the issue of smoking in very disadvantaged communities. They argue that it is essential to consider what smoking provides people in marginalized communities.⁶⁵ From their research smoking is perceived as providing a means of coping with and compensation for the stress, exclusion, boredom, poverty and unemployment people in marginalised communities face on a daily basis. Smoking also supplies a way to interact, share and support one another- it is a form of solidarity. They pose a question for all wanting to encourage quitting within very disadvantaged communities- What can be offered that represents an adequate exchange for these benefits? This may be question that is useful for local initiatives to consider.

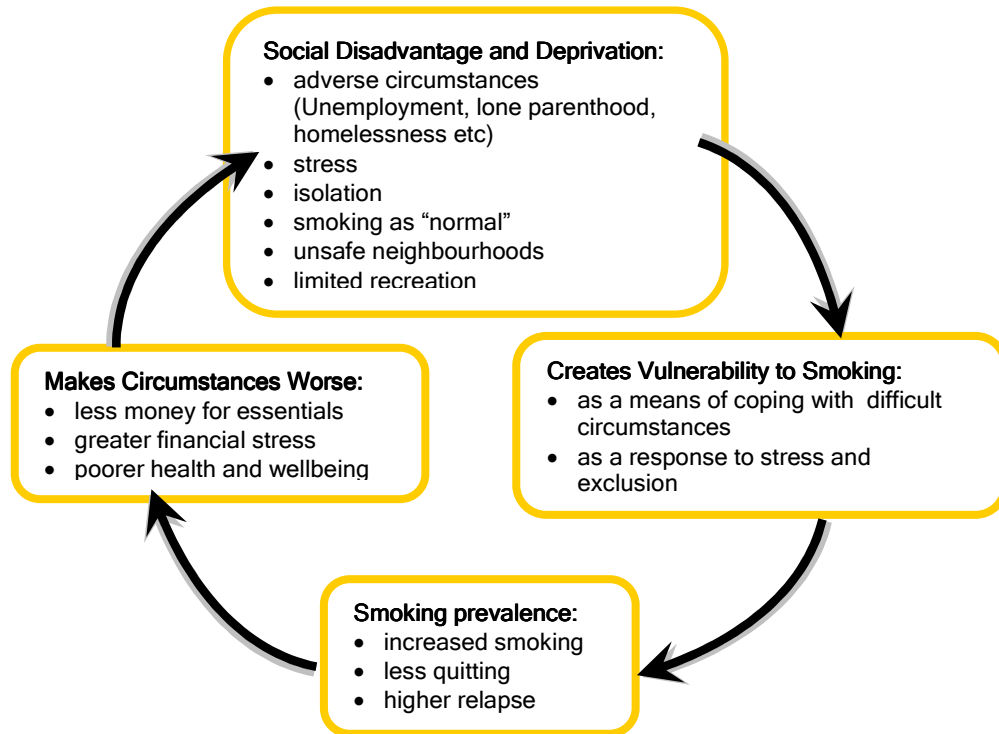
Address causes of disadvantage (Section 3.6)

Social Inclusion (Section 3.6.1)

CCNSW and NCOSS strongly support the Taskforce's emphasis on addressing the causes of social disadvantage.

The relationship between smoking and disadvantage is well established. Disadvantage in its various forms is associated with higher rates of smoking and lower rates of quitting. We agree with Marmot and Wilkinson that the casual pathway runs both ways.¹⁶ People turn to alcohol and other drugs, including smoking, as a way of dealing with adversity and the chronic stress that it induces; and dependence on substances, including tobacco, maintains and deepens people's disadvantage. The following diagram presents this cyclic relationship:⁶⁶

THE VICIOUS CYCLE OF SMOKING AND DISADVANTAGE



The response to this situation must embrace more than a focus on changing individual behaviours. We must also address the patterns of social deprivation from which problems originate. Strategies that focus on smoking behaviour without addressing the social and structural drivers of disadvantage run the risk of blaming the victim, are inadequate, and will ultimately be ineffective. MacAskill et al call for strategies to address smoking at the macro, community and micro (individual levels).⁶⁵ They argue that macro level initiatives are needed to reduce the hardship for which smoking is a coping mechanism and means of relief and respite. Strategies to improve employment, education, income, housing and community safety are required.

We also agree with the Taskforce that having strong bonds with parents and families and with school are protective for children and young people exposed to multiple risks.¹ Strategies to strengthen vulnerable families and to improve disadvantaged children’s learning and schooling, especially early learning, are critical. Such programs, alongside their other benefits, have the capacity to contribute to reduce smoking rates even when smoking reduction is not an explicit program goal. For example, the Elmira Prenatal/Early Infancy project⁶⁷ provided nurse home visits to mostly high risk new mothers over a two year period. The primary goal was to improve birth weight and reduce child protection risk in the families. Longitudinal follow up revealed significant short term benefits for mothers such as better nutrition, improved childbirth class attendance and reduced cigarette use. The Carolina Abecedarian Early Childhood Intervention⁶⁷ provided intensive, high quality preschool services to children up to five years of age from low-income families. Child medical

support and parental support and education programs were also offered. The aim of the programs was to improve academic performance and special functioning at school entry. Results from a youth risk behaviour survey⁶⁸ calculated smoking rates for program participant and non-participants as 39% and 55% respectively. It was estimated that the total cost benefit of the program was \$222 817 per participant (against a cost of \$58, 955) of which reduced smoking prevalence contributed \$29 229 per participant (13.1% of total economic benefit).

In addition to the ideas for consideration the Taskforce has outlined CCNSW and NCOSS suggest that all Commonwealth and State funded programs designed to strengthen families and improve early childhood education and care include a more explicit focus on addressing smoking. The approach would be to offer information and support in response to those who express an interest in quitting, not to impose or require any restrictions on smoking. Steps programs could take include:

- Ask clients if they smoke and record smoking status
- Include information on impacts of smoking and benefits of quitting to all clients, particularly those with young children
- Provide education to staff on the relationship between smoking and disadvantage and the health, financial and social impacts of smoking, including impacts on child development
- Provide training to staff on offering smoking care (brief intervention) to clients
- Ask all clients if they are interested in quitting
- Provide active support and referral and ongoing encouragement to all clients interested in quitting
- Provide affordable NRT to all clients interested in quitting
- Collect data on smoking related outcomes (readiness to quit, quit attempts, confidence in quitting, smoking prevalence).

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