Submission

No 65

INQUIRY INTO TOBACCO SMOKING IN NEW SOUTH WALES

Organisation: Department of Aboriginal Affairs

Name: Ms Jody Broun

Position: Director General

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Date Received: 1/05/2006

Theme:

Summary

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Aboriginal Affairs

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Our Ref:06/PR/0440

Director
Joint Select Committee on
Tobacco Smoking in NSW
Legislative Council,
Parliament House,
Macquarie Street
Sydney NSW 2000

Dear Director

I refer to your letter, forwarded on the 14 March 2006, inviting my Department to submit to the *Inquiry on Tobacco Smoking in New South Wales*.

The rate of tobacco smoking among Aboriginal people is more than twice the rate of that of the broader Australian community and is having a devastating impact on the health and well being of Aboriginal people.

There is compelling evidence that tobacco is the leading cause of preventable deaths in Aboriginal communities. The top four causes of death for Aboriginal people are circulatory diseases, external causes, neoplasms (cancers) and respiratory disease. Tobacco use is directly related to three out of four of these causes of death.

However tobacco smoking in Aboriginal communities has previously received a relatively low priority by health agencies and Aboriginal health service providers.

Given the serious impact of tobacco on Aboriginal health the Department of Aboriginal Affairs is pleased to have an opportunity to forward a submission to the inquiry that deals with the particular needs of the Aboriginal community and the urgent need for Aboriginal targeted, culturally appropriate, tobacco cessation programs to be instigated in NSW.

Please find attached a considered response to this inquiry's terms of reference. If you have any further queries regarding this submission please contact Cathy Eatock, Senior Policy Officer, Policy and Regulation Division, at the Department of Aboriginal Affairs on 9219 0764 or email cathy.eatock@daa.gov.au.

Yours sincerely

Jody Broun
Director General
28 April 2006

Department of Aboriginal Affairs
Submission to the
NSW Parliament's Joint Select Committee on
Tobacco Smoking

April 2006

Terms of Reference:

That a joint Select Committee be appointed to inquire into and report on tobacco smoking in New South Wales, and in particular:

a) the costs and other impacts of smoking,

b) the effectiveness of strategies to reduce tobacco use,

c) the effects of smoke free indoor venues on the initiation and maintenance of the smoking habit,

d) factors affecting initiatives for smoke free indoors areas,

e) the effectiveness of media, educative, community and medically-based Quit initiatives,

f) the adequacy of the budget for smoking control initiatives, and

g) the smoke free Environment Amendment (Motor Vehicle Prohibition) Bill 2005 introduced by the Revd Mr Nile in the Legislative Council.

CONTENTS

INTRODUCTION

Tobacco use has a devastating impact on the lives and well being of Aboriginal people. It is the most preventable cause of premature death and ill health for Aboriginal people.

Studies on rates of Aboriginal smoking in Wilcannia NSW in the late 1980's established that 71% of Aboriginal men and 76% of Aboriginal women reported smoking. Nationally smoking rates in Aboriginal communities are at least at 54% of the population which is more than twice the 22% smoking rate of the non-Aboriginal population.

While Aboriginal people experience addiction and share some similar reasons for smoking with the general population, there are also significant additional factors which have contributed to both a higher rate of tobacco use and a significantly higher impact on Aboriginal mortality and morbidity levels.

The rate of smoking and the associated health outcomes for Aboriginal people has a high correlation with other socio-economic factors such as income, educational background, employment and access to infrastructure and appropriate services. On all these social indicators Aboriginal people experience substantial disadvantage compared to non Aboriginal people and their health status and rates of smoking reflects this.

Tobacco use in Aboriginal communities is continuing to have a devastating impact on the lives and health of Aboriginal people. Tobacco cessation programs in Aboriginal communities have not however, received the funding or priority that the associated health risks warrant by either health funding agencies. The more immediate health concerns associated with alcohol and drug use compared against the relatively slow progression of smoking related diseases has resulted in Aboriginal-specific cessation strategies and programs often being given a lower priority.

Aboriginal health workers at the forum *Smoking in Indigenous Communities: What can we do to address the issue,* in February 2002, determined that it was imperative that smoking cessation programs targeted at Aboriginal communities be implemented as a priority. The forum also confirmed that Aboriginal smokers require targeted culturally appropriate tobacco control and cessation programs that consider the social and historical context of Aboriginal smoking and are developed, run and owned by the Aboriginal community.

RECOMMENDATIONS

- Tobacco cessation programs in Aboriginal communities in NSW are made a priority
- Cessation programs are adequately funded and that funding reflect the impact of tobacco on Aboriginal peoples health and lives
- Tobacco cessation programs and strategies maximise community control
- Tobacco cessation initiatives are long term and holistic
- Tobacco programs are long term
- Tobacco cessation programs and strategies recognise and respond to the social and historical context of smoking in Aboriginal communities
- Tobacco control and cessation programs address levels of stress in Aboriginal communities
- That tobacco cessation programs and strategies incorporate adequate evaluation and monitoring of their effectiveness

NSW GOVERNMENT POLICY CONTEXT

The New South Wales Government's Aboriginal Affairs Plan 2003-2012, *'Two Ways Together'* establishes a framework that is the basis for coordinating whole of Government action across key strategic areas. *Two Ways Together* is a ten year plan that brings Aboriginal people to the table as equal partners to develop Government policy and service delivery models that work with Aboriginal people to effectively improve the lives of Aboriginal people in NSW. *Two Ways Together* works to streamline planning, to cut out duplication of services and target service provision to areas that Aboriginal people identify as priorities.

Two Ways Together is aligned with the Council of Australian Governments (COAG) Productivities Commission's *'Overcoming Indigenous Disadvantage Key Indicators 2005 Report'.* The four priority cluster areas of Economic Development, Justice, Families and Communities and Culture and Heritage have high level strategic targets and action plans to address key indicators.

Two Ways Together establishes biennial reporting of Government performance to the Premier on key indicators and the progress of Cluster Action Plan initiatives to the Aboriginal Affairs Plan Coordinating Committee (AAPCC) and the CEO Group on Aboriginal Affairs. Regular reporting on indicators and action plans enabling the monitoring of success and allows agencies and clusters to modify strategies where necessary.

The Two Ways Together Report, June 2005, outlines key indicators NSW agencies are to report on. These include the following areas that are risks factors associated with tobacco use: life expectancy for Aboriginal people, infant mortality, birth weight, rates of disability including hospital separations for cardiovascular disease and diabetes, otitis media and conductive hearing loss, acute respiratory infection and drug and other substance use. The *Two Ways Together* 'Families and Communities Cluster' has also identified reduced rates of Aboriginal children with otitis media as a multi agency indicator in its Action Plan.

The Aboriginal Affairs Plan *Two Ways Together* provides a strong basis to drive action where it is most needed to reduce, and ultimately eliminate the gaps which currently exist between Aboriginal people and the wider population. Reducing the rate and impact of tobacco smoking in Aboriginal communities will require a co-ordinated and targeted approach across Government.

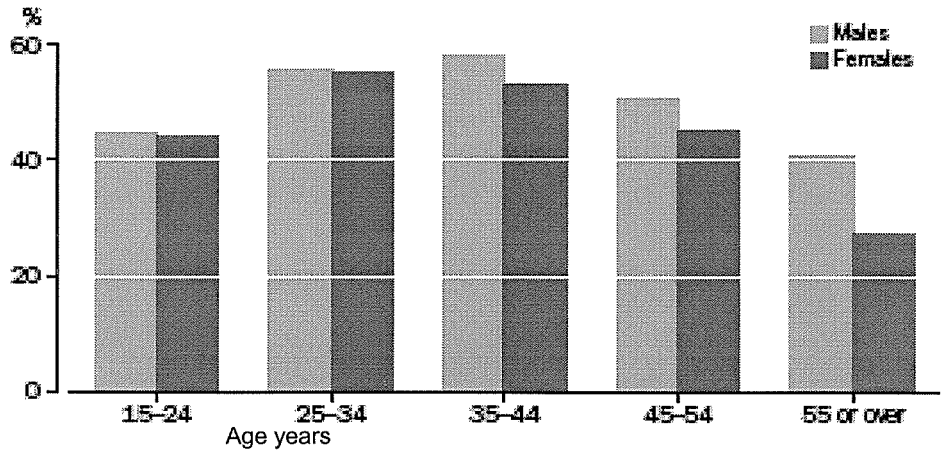
THE COST AND OTHER IMPACTS OF SMOKING

Prevalence of Tobacco Smoking in Aboriginal Communities

The Australian Bureau of Statistics National Aboriginal and Torres Strait Islander Health Survey (NATSIS) in 2004-5 found that 52.9% of Aboriginal people over the age of 15 years were current smokers, with 51.8% of men and 53.9% of women current smokers. In NSW Aboriginal smoking was 47.6% compared to a non Aboriginal rate of 20.8% that is smoking is 2.5 times more prevalent amongst Aboriginal people in NSW. The NATSIS survey also found that Aboriginal people underestimated the risk of tobacco smoking.

Graph 1:

Current Daily Smokers - Indigenous persons aged 15 and over



Health Impact in the Aboriginal Community

There is compelling evidence of the detrimental impact of tobacco on Aboriginal health. Tobacco is the leading cause of preventable deaths in Aboriginal communities.[1] Aboriginal people continue to suffer high mortality and morbidity rates from conditions associated with tobacco smoking. Aboriginal people experience 2-8 times the death rate of non-Aboriginal people in all age groups.[2] The top four causes of death for Aboriginal people are circulatory diseases, external causes, neoplasms (cancers) and respiratory disease. Tobacco use is directly related to three out of four of these causes of death.

The life expectancy for Aboriginal people in 1997-99 was 56.8 years of age for men and 63.6 years for women, that is around 20 years less than that of other Australians, at 76.9 years for men and 82.4 years for women.[3]

Aboriginal people also die at a younger age than non-Aboriginal people from tobacco related illness. Of those who died before the age of 55 years, 49% of Aboriginal men's and 48% of Aboriginal women's deaths were related to tobacco use, compared to 11% for non-Aboriginal men and 10% for non-Aboriginal women. [4]

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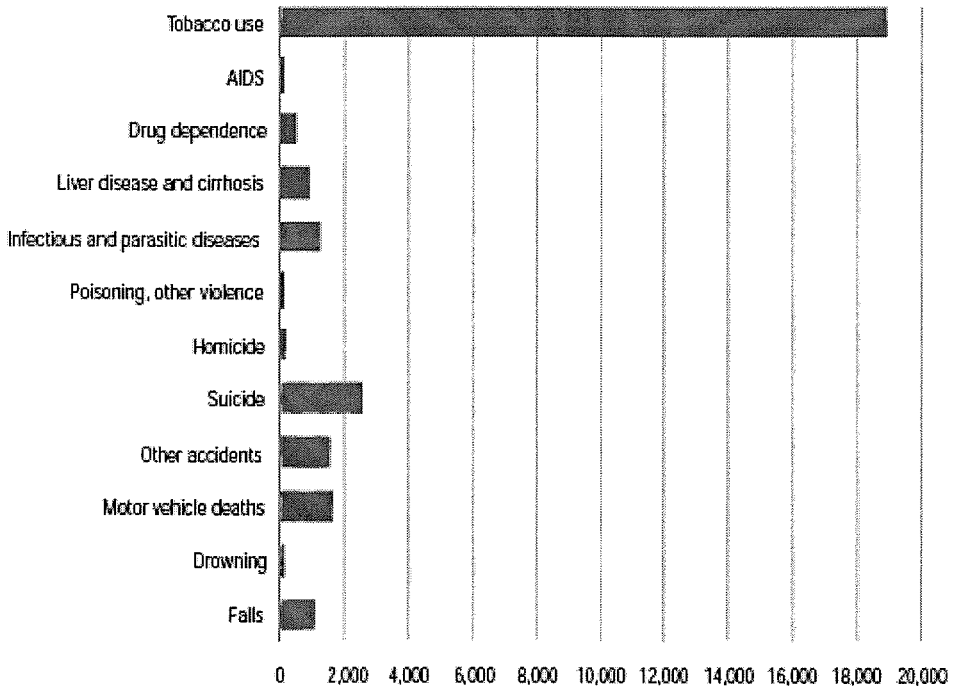
[1] Dr Rowena Ivers, *Indigenous Australians and Tobacco: A Literature Review* 2001 p5
[2] ibid p32
[3] Two Ways Together Report 2005 p20
[4] Ivers ibid, p31.

Graph 2: Number of Australians who died in 1998 due to smoking compared with other causes of death[5]



The high number of deaths associated with tobacco use (see Graph 2) in the Aboriginal community is due to the proportionally greater use of tobacco in Aboriginal communities. The rate of smoking-related deaths was significantly higher for Aboriginal people than for non-Aboriginal people, 2.4 times higher for men and 3.7 times higher for women.[6] Aboriginal people suffer a markedly lower rate of health across a range of tobacco related health indicators.

Cardiovascular disease is the major cause of death for Aboriginal people and accounted for 27% of deaths among men and 30% of deaths among women.[7] The National Aboriginal and Torres Strait Islander Health Survey 2004-5 of Aboriginal people in NSW found that 22.1% of persons aged 15 years and over suffered heart or circulatory problems/disease compared to 16.4% for non-Aboriginal people. Aboriginal women are also 6.8 times more likely than the general population to die from ischaemic heart disease while Aboriginal men are 3.2 times more likely to die from the same disease.[8]

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[5] Lindorff p42
[6] *Australian Indigenous Health Infonet* p 5.
[7] Ivers ibid p34.
[8] Ibid p35

Nationally lung cancer caused 10% of all deaths in Aboriginal men and 13% of all deaths in Aboriginal women.[9] Aboriginal women are 3.1 times more likely to die of lung cancer than the rest of the Australian population while Aboriginal men are 2.2 times more likely to suffer lung cancer.[10] Aboriginal people also present later with lung cancer than non-Aboriginal people and their disease progression is often exacerbated by concurrent inflammatory lung disease.

The risk of other cancers is also attributable to smoking. Aboriginal women have a mortality rate for cervical cancer which is 13.3 times higher than for the broader community.[11]

Aboriginal men were 4.6 times more likely to die of chronic obstructive airways disease (COAD) and Aboriginal women were up to 10.7 times more likely to die of COAD than other people.[12] The rate of asthma among Aboriginal people over the age of 15 years in NSW is 17.6% compared to 9.2% for non-Aboriginal people.[13]

The incidence of death from pneumonia is alarmingly high with Aboriginal women 19.2 times and Aboriginal men 15.1 times the rate of death in the general population. Hospitalisations as a result of pneumonia were 40.8 times the rate for the general population. [14]

A study of Aboriginal women and antenatal care and birth found that 60% of mothers smoked compared to 16% for the non-Aboriginal mothers.[15] Mothers who smoke have a significantly increased risk of low birth weight, still births and Sudden Infant Death Syndrome (SIDS). Aboriginal women are 2.8 times more likely to deliver an infant with low birth weight and the perinatal mortality rate is 2-3 times higher than that of non-Aboriginal babies. National data reveal that Indigenous deaths account for 31 percent of total infant deaths from respiratory and cardiovascular disorders specific to the perinatal period (with 28 days of birth)[16]. The rate of Sudden Infant Death Syndrome (SIDS) is 3.9 times higher for Aboriginal babies than that of non-Aboriginal babies.

Aboriginal people also have significantly higher rates of blindness, cataracts and deafness and diabetes often associated with smoking.

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[9] Ibid p33
[10] Ibid
[11] Ibid p35
[12] Ibid p33
[13] Australian Bureau of Statistics, *National Indigenous Health Survey* 2004-5
[14] Ibid p34
[15] Ibid p36
[16] *Two Ways Together* Report 2005 p 21

Impact of Passive Smoking

Aboriginal children are much more likely to be exposed to passive smoking in their environment than non-Aboriginal children. In a NSW study of Aboriginal children in 1995 87% lived in a house with at least one smoker and 23% lived in a house with three or more smokers.[17]

Aboriginal children are 10 times more likely to be hospitalised for respiratory infections than children generally.[18] Parental smoking also increased the risk of developing otitis media by 1.7 times and middle ear effusion by 1.4 times.[19]

Financial Cost of Smoking

The financial cost of tobacco smoking has serious consequences for individuals, families and communities. Aboriginal people on low incomes spend a greater proportion of their income on cigarettes than the general population. A survey in the Northern Territory in 1997 of sales through a community store found Aboriginal families spent 22% of all income on tobacco.[20] The prioritising of tobacco for low income families over essentials items such as food and utility bills has broader health implications for family members, adding significantly to the level of poverty experienced. An average Aboriginal smoker may smoke one packet of 25 cigarettes a day at an average cost of $12 a day or $60 a week. This is a significant financial outlay for low income families. The cost for heavy smokers can be up to double this, as it is when both parents smoke. The financial cost of smoking directly impacts on the nutrition, education, safety and emotional well being of smokers and their families.

Social Cost of Smoking

The addictive ingredients in tobacco can increase levels of stress experienced by smokers during withdrawal. Tobacco dependency-induced stress can not only impact on the individual but also the family and community. Like other drugs, nicotine dependency can lead to crime and violence. Community surveys undertaken by Kylie Lindorff reported that intimidating behaviour, aggression and threats of violence to secure tobacco were common. Participants also reported that a significant number of burglaries and theft from clubs and stores by Aboriginal people was related to the theft of tobacco and not cash also kept on the premises.[21]

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[17] Ibid p38
[18] Ivers p38 Ibid
[19] ibid p38Ibid
[20] Ibid p26
[21] Lindorff p53

REASONS FOR SMOKING

Physical Addiction

The early age of commencing smoking amongst Aboriginal people means that addiction to nicotine is well established by adolescence. A study of the physical health of Aboriginal People in Bourke considered the age at which Aboriginal people commenced smoking and found that 49% of Aboriginal men and 11% of Aboriginal women who smoked were regular smokers by the age of 12 years of age, and the percentage of smokers who regularly smoked by the age of 16 years of age was 94% of men and 53% of women.[22]

History

Aboriginal people in NSW (and elsewhere in Australia) traditionally smoked Pituri, a local tobacco, which was dried and the leaves roasted, although its use was strictly controlled. After colonisation, when Aboriginal communities were confined on missions and reserves, Aboriginal people were repeatedly exposed to tobacco smoking through government rations which included regular tobacco rations. It has been suggested that tobacco was used as a means of social control encouraging Aboriginal people to stay on the reserves and missions that were established.[23]

Aboriginal people as with other colonised Indigenous peoples have a high prevalence of tobacco smoking (see Graph 2). The historical abrogation of Aboriginal rights to their traditional lands and cultural practices, confinement on reserves and missions with strict social controls together with government polices that could forcibly remove children and wages, contributed to a history fraught with trauma. The National Aboriginal and Torres Strait Islander Survey (NATSIS) in 1994 found that those who had been taken away from their family as children were far more likely to smoke. Smoking rates for those that were taken away as children were 70% for men and 60% for women, compared to 55% for men and 47% for women for the average Aboriginal person.[24]

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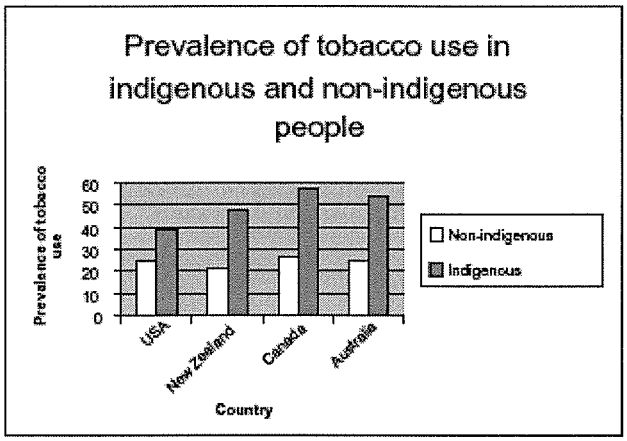
[22] Ivers ibid p15
[23] Ibid idem p10 (cited Briggs 1996)
[24] Lindorff ibid p5

Graph 1: Prevalence of tobacco use in indigenous and non-indigenous people



Graph 3: Prevenance of smoking among indigenous peoples in US, New Zealand Canada and Australia

Socio-economic

Economic disadvantage is an acknowledged risk factor associated with an increased rate of smoking. R. S Hogg reported that from a sample of 273 Aboriginal people in NSW in 1998, the rate of smoking amongst those employed was 27% and increased to 54% for those who were unemployed. The 2004-05 National Aboriginal and Torres Strait Islander Survey (NATSIS) found that smoking rates were at 70% for those employed through the Community Development Employment Program (CDEP) and 66% for those unemployed. This rate dropped to 48% for those employed. [25]

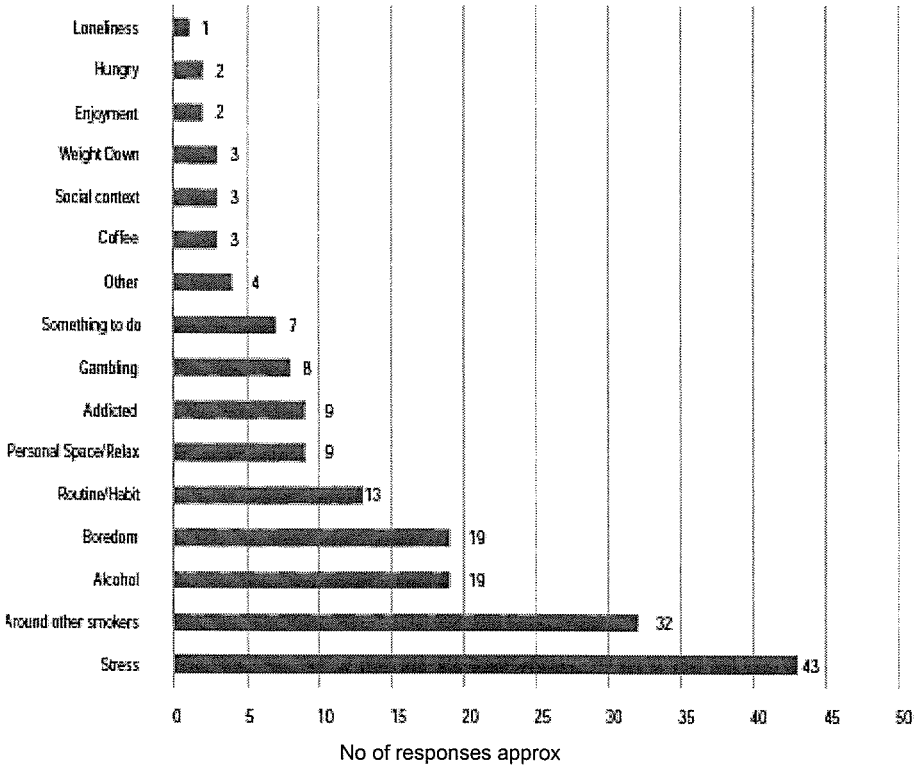
Those who reported that they lived in their own house or who were purchasing their home were also less likely to smoke as were those who had completed year 12 and beyond. A correlation between those that drank alcohol or not also reflected a higher rate of smoking for those that drank than for those that abstained. [26]

Aboriginal people often experience life-long poverty and suffer high levels of stress associated with lower weekly income and unemployment. Social and economical disadvantaged, higher rates of domestic violence and assault, high rates of drug and alcohol use and high incarceration rates contribute to greater levels of stress for Aboriginal people.

[25] Ivers ibid p16
[26] Lindorff ibid p5

Stress is a major contributor to high levels of smoking in Aboriginal communities. The 'Way's Forward' on mental health within Aboriginal and Torres Strait Islander communities reported high levels of depression, stress, trauma, grief, self harm and suicide in Aboriginal communities compared to the broader community. Tobacco use in Aboriginal communities is often seen as a coping strategy and was seen by many smokers as having a calming effect. Gilchrist's 1998 survey on 'Smoking Prevalence Among Aboriginal Women' found 68% of Aboriginal smokers believed smoking relieved boredom and 86% believed that smoking calms the nerves.[27] Lindorff quoted a focus group participant "a lot of people in our community that smoke, say they smoke because they don't have anything else to do." [28] The other reasons identified in Lindorff's survey are given in Graph 4. [29]

Graph 4: Reasons for Aboriginal Smoking



[27] Ivers ibid p25
[28] Lindorff p80
[29] Lindorff p79

Cultural

Tobacco use in Aboriginal communities has been normalised and accepted as a coping mechanism but it has also developed as an important social component of community life. Smoking and sharing cigarettes has become a central part of kinship and social relations. The sharing of cigarettes has filled traditional social obligations and acts to reinforce social cohesion and feelings of belonging and solidarity among friends and family members.

Social cohesion through smoking plays a greater role in Aboriginal communities than the broader community given the cultural importance of reinforcing friendships and family connections for Aboriginal people.

THE EFFECTIVENESS OF STRATEGIES TO REDUCE TOBACCO USE,

Tobacco smoking is not widely recognised and responded to as the leading cause of drug related deaths in Aboriginal communities. Though most Aboriginal people interviewed in the 1997-98 National Tobacco Campaign were aware that smoking caused respiratory disease. However, Aboriginal people generally did not identify the cessation of smoking as a priority. In the National Drug Strategy Household Survey in 1994 66% of Aboriginal respondents identified alcohol as a major health problem in their community while only 3% nominated tobacco.[30]

Perceptions that smoking is less harmful than alcohol and other drugs by the Aboriginal communities and health service providers will need to be addressed in strategies to reduce rates of smoking.

In Aboriginal health programs tobacco is often addressed within broader drug programs, but competing with the more immediate impact of alcohol and illicit drugs tobacco receives a lesser priority.

Effective smoking cessation and harm minimisation programs for Aboriginal people need to inform Aboriginal people and address the range of motivations, perceptions and the cultural context of Aboriginal smoking.

Attitudes to Quitting

Comparatively few Aboriginal people are ex smokers. The early uptake of smoking for many Aboriginal people compared to non Aboriginal smokers means that nicotine addition is often established by adolescence.

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[30] Ivers ibid p27

Aboriginal people often experienced difficulty ceasing smoking because of a high rate of environmental tobacco in homes and overcrowding which makes it difficult to separate away from other smokers. Aboriginal female non-smokers attending a Perth medical service reported that 35% of them experienced environmental tobacco smoke in their homes. While a study of Aboriginal infants in Western Australia by Eades and Read in 1999 noted that 80% of babies were exposed to tobacco smoke. [31]

However, despite overwhelming evidence of the health implications of smoking for Aboriginal people there are very few tobacco cessation programs or resources specifically targeted to Aboriginal people.

Lindorff's focus groups indicated that 55% of community members and 68% of health staff were either trying to quit or were thinking of quitting. Most Aboriginal people also support policies aimed at preventing children and adolescents from smoking.

Key predictors of successfully quitting smoking are a strong desire to quit, lower stress levels, and social support.[32] Any cessation program for Aboriginal people must be holistic and have strategies to deal with stress. The program must also explain how nicotine addiction contributes to feelings of stress and that quitting may actually decrease the levels of stress experienced.[33]

Cessation programs for Aboriginal people

As with other smokers, Aboriginal smokers believe they would quit if given external support, through the provision of Nicotine Replacement Therapy (NRT) and other means.

The delivery of tobacco cessation and harm minimisation programs for Aboriginal people differs significantly to that required by the general population. Aboriginal smokers require specific programs and resources that consider the different historical context and social and economic environments in which Aboriginal people live.

Successful strategies need to be culturally appropriate, developed and directed by Aboriginal people and delivered by Aboriginal health workers, through an Aboriginal service provider, to maximise the effectiveness of the program and resources.

Effective cessation programs for Aboriginal people require individual and group support that work closely with other organisations in the community. Substance

[31] ibid p18
[32] ibid p46
[33] Lindorff pp 63 & 80

misuse programs and strategies for Aboriginal people need to be holistic and recognise that the removal of one substance often leads to an increase of reliance on another substance.

However all of these approaches need to be culturally appropriate and for smokers, incorporate non-coercive methods of counselling and support strategies.

Health care Interventions

A study considering addiction of nicotine in Aboriginal communities, undertaken by Watson, Fleming and Alexander in 1988, confirmed that habit, addiction to tobacco or wanting to prevent withdrawal symptoms were important reasons for smoking. [34]

There is strong evidence that Nicotine Replacement Therapy (NRT) increases the cessation rate in other communities. According to tobacco researcher Ivers, Aboriginal people believed that they would benefit from access to NRT. The current cost of NRT, however, remains a disincentive for many Aboriginal people.

The rate of smoking amongst Aboriginal health workers reflects the overall high rate of smoking in the Aboriginal community and needs to be actively addressed before tobacco cessation strategies that are implemented can be optimally effective.

Regular health assessments should include checks on the smoking status of patients/clients in all consultations by health services. These regular checks would raise the issue of smoking with patients and permit inquiries about smoking habits and support cessation strategies to be raised with individuals.

Resource kits and replacement therapies such as nicotine patches (a form of NRT), and anti-depressant therapies have proved to be an effective cessation aid in the broader community. There have been several small unpublished trials of nicotine replacement therapy indicating that nicotine patches may be of some use to Aboriginal communities.[35] There is evidence that the anti-depressant, bupropion, may also assist smokers to quit especially when combined with nicotine patches.[36]

Given that up to 60% of pregnant Aboriginal Women in NSW smoke[37], programs need to target pregnant women about the dangers of smoking and the effects of passive smoking on children. *The Strong Women, Strong Babies, Strong Culture*

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[34] Ibid p24
[35] Lindorff ibid p115
[36] Ivers ibid p60
[37] Ibid p64

Program, an intervention pilot in three communities in the Northern Territory aimed at reducing the rate of tobacco smoking among pregnant women found the prevalence of Aboriginal low birth weight declined from 20% to 11% during the program. [38]

Community interventions

Successful community cessation campaigns need to be designed by and for Aboriginal communities, be locally based with local content and involve elders and significant community members and foster a sense of community ownership and control.[39]

Aboriginal people are also likely to respond more effectively to Aboriginal-specific educational material that is easy to read, uses visual images and incorporates local or well-known Aboriginal identities as role models.

Tobacco cessation programs directed at the Aboriginal community should not only highlight the high death rate and lower life expectancy of smokers but needs to highlight the correlation between smoking and other health conditions such as diabetes and all forms of cancers. The impact of passive smoking, particularly on children, targeting of pregnant women and young mothers demands particular attention in community intervention programs. In addition consideration of the economic and social costs to Aboriginal communities may also assist to motivate smokers to quit.

The Aboriginal Medical Service in Redfern has run a limited tobacco cessation program for the last five years offering nicotine patches at half the retail price. The program has received no funding, nor does it have the resources to evaluate its effectiveness or to run counselling sessions for tobacco cessation. Anecdotal feedback from participants have commented that after commencing with nicotine patches, continuing to afford patches is problematic and has contributed to the reverting of smoking.

Cessation programs should also address the use of cannabis in Aboriginal communities, given that many marijuana users mix tobacco with cannabis. Cannabis use is becoming increasingly prevalent in Aboriginal communities. In 2001, 1994, the Australian Institute of Health and Welfare Household Drug Survey revealed that 27.3% of Aboriginal respondents reported they recently used cannabis, a significant rise from the 22% found in the 1994 Survey. The comparable figure for non-Indigenous respondents was steady at 13% and 12.7%, respectively.

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[38] Ibid idem p64

[39] Lindorff ibid p130

There is evidence that community education campaigns that reinforce and compliment strategies throughout school life are likely to be effective in reducing the uptake smoking in the young. However the effectiveness of this approach has not been evaluated in Aboriginal communities.

'Quit' courses for the general population are unlikely to attract Aboriginal participants, however 'Quit' groups or support groups specifically for Aboriginal people may have improved outcomes for Aboriginal people. No specific studies have been undertaken on the effectiveness of 'Quit' support groups for Aboriginal people.

Interventions aimed at reducing the rate of passive smoking is a key area for community intervention. Only a few Aboriginal targeted interventions on reducing environmental exposure have been instigated and none undertaken in Aboriginal communities have been evaluated.

Legislative Interventions
Control of advertising and promotion of tobacco has reduced consumption in the wider community and is likely to have benefited Aboriginal communities though no specific studies have been under taken. Health warnings on packaging may be less effective because of lower literacy rates.

Government Strategies

Australian Government

Ministerial Council on Drug Strategy

The Ministerial Council on Drug Strategy (MCDS) is the peak policy and decision-making body in relation to legal and illegal drugs in Australia. The Council is represented by Ministers of Health, Law Enforcement and Education from both the federal and State Governments. The role of the Council is to determine national policies and programs intended to reduce drug related harm within the Australian community. The Council enables regular consultation between Governments and promotes a coordinated national approach to policy development and implementation in relation to all drugs issues and also considers matters submitted to the Council through its members and through the Intergovernmental Committee on Drugs.

Intergovernmental Committee on Drugs

The Ministerial Council is supported by the Intergovernmental Committee on Drugs (IGCD). The IGCD provides policy advice to the Ministers on drug-related matters and is responsible for implementing the National Drug Strategic Framework. This Committee consists of senior officers representing health and law enforcement from Federal and State Governments and people with expertise in identified priority areas including the Ministerial Council on Aboriginal and Torres Strait Islander Affairs and the Department of Education, Science and Training. The NSW members of the IGCD include Ms Jody Broun, Ministerial Council on Aboriginal and Torres Strait Islander Affairs, Mr David McGrath, NSW Health Department and Superintendent Frank Hansen, NSW Police.

The National Drug Strategy 2004-2009

The National Drug Strategy 2004-2009 is a policy framework that provides a coordinated, integrated approach to prevent and reduce the harms caused by drugs in the Australian community. The Strategy guides governments and non-government organisations in the development and delivery of drug strategies and programs that aim to prevent and reduce the harmful effects of drug use.

National Drug Strategy Aboriginal and Torres Strait Islander Peoples Complementary Action Plan 2003-2006.

The Ministerial Council on Drug Strategy has developed the National Drug Strategy Aboriginal and Torres Strait Islander Peoples Complementary Action Plan 2003-2006. This plan was developed to more appropriately complement the National Drug Strategy Framework. The six key result areas include:

1. Enhanced capacity for individuals, families and communities to address current and future issues in the use of alcohol, tobacco and other drugs and promote their own health and well being.

2. Whole of Government effort in collaboration with non-government organisations to implement, evaluate and improve comprehensive approaches to reduce drug related harm

3. Substantially improved access to the appropriate range of health and wellbeing services that play a role in addressing alcohol, tobacco and other drug issues.

4. A range of holistic approaches from preventative through to treatment and continuing care that is locally available and accessible.

5. Workforce initiatives to enhance capacity of community controlled and mainstream organisations to provide quality services.

The National Aboriginal and Torres Strait Islander Tobacco Control Project

The National Health Promotion and Protection Branch, Department of Health and Aged Care and the Ministerial Tobacco Advisory Group (MTAG) collaborated with the Office of Aboriginal and Torres Strait Islander Health to develop a strategic approach to Indigenous smoking. An Aboriginal and Torres Strait Islander Tobacco Strategy Sub-Committee was established to provide advice to MTAG and develop an Aboriginal and Torres Strait Islander National Strategy.

The National Aboriginal and Torres Strait Islander Tobacco Control Project was funded under the National Tobacco Strategy and sponsored the Lindorff report '*Tobacco Time For Action*'. This report identified the following issues:

- A lack of national coordination
- Community Control should be maximised
- Respecting the social context of Aboriginal and Torres Strait Islander Tobacco use
- The need for tobacco control to become a national Aboriginal and Torres Strait islander health priority.
- The need to high light that funding for tobacco controls is grossly inadequate
- A lack of progress and action.
- The importance of combining expertise for greatest effect
- Recognition that many people want to quit smoking.
- The consequences of monetary expenditure on tobacco
- Issues around health staff and tobacco use.

NSW Strategies

There are at least 3 Aboriginal tobacco cessation programs in NSW that are on-going or are about to commence:

The Partnership for Aboriginal Care Quality Improvement-Smoking Cessation Plan Trial

This Smoking Cessation Plan, on the north coast of NSW, has been instigated by the Aboriginal Medical Service in Port Macquarie. This strategy has trained staff and is using NRT. The trial has been operating for 18 months now and is currently in the process of reviewing the initial stages. There have been 380 people who have participated in the trial to date. Initial findings suggest a success rate of 5% for abstaining from smoking for 6 months or more. The last three months have also seen an extension of the program to include one to one counselling with smokers to provide further support in abstaining from tobacco use.

The National Aboriginal and Torres Strait Islander Tobacco Control Project was funded under the National Tobacco Strategy and sponsored the report 'Tobacco Time For Action' by Kylie Lindorff. This report identified the following issues:

- A lack of national coordination
- Community Control should be maximised
- Respecting the social context of Aboriginal and Torres Strait Islander Tobacco use
- The need for tobacco control to become a national Aboriginal and Torres Strait islander health priority.
- The need to high light that funding for tobacco controls is grossly inadequate
- A lack of progress and action.
- The importance of combining expertise for greatest effect
- Recognition that many people want to quit smoking.
- The consequences of monetary expenditure on tobacco
- Issues around health staff and tobacco use.

Marri Ma Health Promotion Trial in Broken Hill

Marri Ma Health Aboriginal Corporation in Broken Hill is in the process of receiving a grant of $300,000 Health Promotion Demonstration Grant, over three years to target smoking in seven surrounding Aboriginal communities. These towns have been targeted because of their high Aboriginal populations and their isolation. The program involves a health check and follow up for the community to identify potential participants. A six week 'Quit' plan with counselling and NRT will be available to those people attempting to quit. Research and an evaluation of the projects outcomes will be undertaken.

The Koori Tobacco Cessation Project

The Koori Tobacco Cessation Project is based in the Illawarra and Shoalhaven regions of NSW. The project involved one hundred and fifty people who participated in quit smoking programs. It involved subsidised nicotine replacement therapy, information and counselling. The project achieved 6% cessation rates among Aboriginal participants.

The NSW Aboriginal and Torres Strait Islander Tobacco Prevention Project

This project is a component of the NSW Tobacco Action Plan 2005-2009. An advisory committee was established in 2002. The focus of the project is to train Aboriginal health workers and health workers who predominately work with

Aboriginal people in NSW in delivering better smoking cessation programs. This approach was established in response to recommendation of the Aboriginal Health Workers Conference *'Smoking in Indigenous communities: what can we do to address the issue.'*

The Conference recommended that highest priority in addressing smoking in Aboriginal communities is to increase the skills and capacity of health workers in smoking cessation programs. The administration and implementation of the two-year $495,000 per annum project has gone to tender. This project will commence in July 2006.

A sustained effort is required by the NSW Government to address tobacco cessation in Aboriginal communities. Implementation of effective programs requires coordination with the Federal Government, Aboriginal health service providers and the Aboriginal community.

THE EFFECTS OF SMOKE FREE INDOOR VENUES ON THE INITIATION AND MAINTENANCE OF THE SMOKING HABIT

Environmental tobacco smoke in public venues is a significant contributor to health complaints associated with passive smoking. Literature on the topic suggests allowing smoking in public areas leads to a perception that the community condones smoking. Environmental smoke also increases the difficulty of abstaining from smoking for those attempting to quit.

As more indoor venues become smoke-free, the number of cigarettes smoked decreases. Interventions aimed at smoke-free public places have proven to be effective in reducing exposure to environmental tobacco smoke. However the affects of smoke-free areas legislation has not been assessed in Aboriginal communities.

FACTORS AFFECTING INITIATIVES FOR SMOKE FREE INDOORS AREAS,

Over 70% of Aboriginal people support bans on smoking in the workplace and shopping centres.[40] Initiatives that establish smoke-free indoor venues are likely

[40] Ivers ibid

to assist in lowering the rate of passive tobacco smoking. Given the prevalence of health conditions associated with passive smoking, controls on environmental tobacco smoke are likely to be beneficial for Aboriginal people.

The success of smoke free indoor areas, like other initiatives and programs for Aboriginal people, is reliant on Aboriginal communities directing, controlling and policing smoke free areas. Smoke-free venues need to be an important part of broader community smoking cessation strategies and programs. Community ownership and responsibility for passive smoking is required to lower rates of passive smoking in Aboriginal communities.

Passive smoking among children and pregnant women in Aboriginal communities is an area that needs to be specifically addressed. Aboriginal community educational campaigns will need to also target rates of passive smoking in homes, vehicles and other private areas.

THE EFFECTIVENESS OF MEDIA, EDUCATIVE, COMMUNITY AND MEDICALLY-BASED QUIT INITIATIVES

Given the lack of Aboriginal-specific campaigns to address the high rate of smoking in Aboriginal communities there is potential for media, educative and community-based 'Quit' programs and strategies to significantly impact on Aboriginal attitudes to smoking and increase the rate of quitting.

Aboriginal people, though generally aware that smoking has negative effects on smoker's health, are often unaware of the level of impact, the rate of impact or the associated health consequences. The link between tobacco and diabetes, most forms of cancers, not just lung cancer, and the effect of passive smoking and smoking during pregnancy were not clearly understood. [41]

The effects of tobacco smoking are invisible and relatively slow acting compared to the more immediate concerns such as alcohol related violence for Aboriginal people. The National Drug Strategy survey in 1995 found that only 5% of Aboriginal participants believed that smoking could damage their health and 31% believed that "a pack a day" could be smoked safely. Most Aboriginal participants (59%) also believed that regular smoking was 'ok' compared to 36% of the general population.[42]

[41] Lindorff ibid p111
[42] Ivers ibid p22

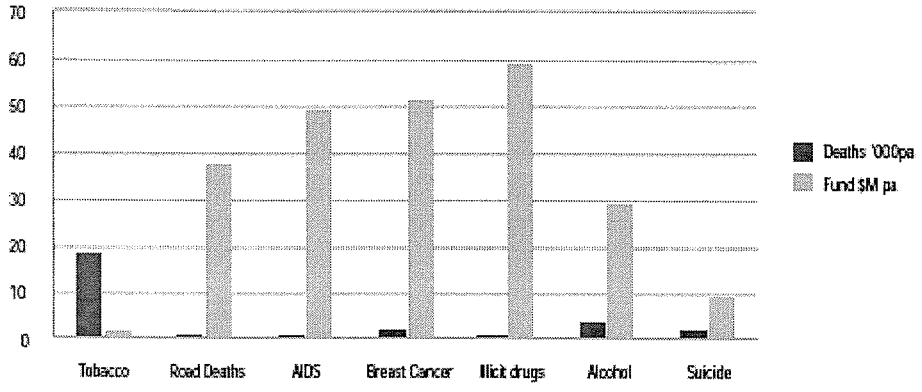
Informing Aboriginal people is the most critical step to countering misconceptions about tobacco and the impact smoking has on their and their family's health and well being.

THE ADEQUACY OF THE BUDGET FOR SMOKING CONTROL INITIATIVES

Health agencies need to prioritise funding for tobacco cessation strategies for Aboriginal people. The current lack of culturally-appropriate tobacco cessation and programs means Aboriginal people are still smoking.

An analysis of funding to health areas that cause the greatest harm to Aboriginal people demands that tobacco cessation programs received adequate financial resources as a priority (Graph 5).[43]

Graph 5: Federal Budget measures: commitment to public health programs compared with deaths



[43] Lindorff p 45

Nationally, tobacco cessation program delivery have previously lacked coordination and sustained funding; many projects received funding for only 12 months.

Previous report on tobacco smoking in the Aboriginal community recommends that a set percentage of tax revenue from tobacco sales be allocated by the Federal Government to tobacco cessation programs and that Aboriginal specific programs are prioritised.[44]

Tobacco cessation and control strategies and programs need to be established as a priority with funding that is commensurate with the impact on Aboriginal health and the level of tobacco use. To be effective the funding of programs needs to be on an ongoing basis and not short term in duration.

THE SMOKE FREE ENVIRONMENT AMENDMENT (MOTOR VEHICLE PROHIBITION) BILL 2005 INTRODUCED BY THE REVD MR NILE IN THE LEGISLATIVE COUNCIL.

Though tobacco smoking and environmental smoke clearly have a devastating impact on the health of Aboriginal people legislation to prevent smoking in motor vehicles with high penalty fines is likely to detrimentally and unfairly impact Aboriginal people as low income earners.

Coercive or punitive approaches to prevent smoking or lower the incidence of environmental smoke are likely to be unsuccessful in Aboriginal communities. Like similar offences (for example consumption of alcohol in an alcohol-free zone) the enforcement will likely unfairly target Aboriginal drivers and families.

The hefty fine of $550 is a substantial amount for low income earners and is likely to cause hardship for low income families and their children. The fine may also indirectly lead to participating in a criminal activity, for example, unlicensed driving if their licence is cancelled for defaulting on the fine.

Smoking in a confined space such as a car can significantly increase the density and resulting damage of environmental smoke. However more effective results are likely through targeted educational campaigns that warn parents of the dangers of passive smoking and highlight the increased risk of smoking in the

[44] Lindorff ibid p46

confined space of a motor vehicle. Indeed the broader community would benefit from such a campaign.

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