Addressing Smoking in Community Service Organisations

A Policy Toolkit
What we need is for community service organisations to adopt a new mindset on this issue and to put it up higher on the list of priorities with their clients … It is an issue of social justice, and when we start to think and act in those terms, much can be done.

Rev. Harry Herbert, Executive Director, UnitingCare NSW.ACT at the launch of the Tackling Tobacco Program (then called the Tobacco Control and Social Equity Strategy), October 2006
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Addressing smoking in community service organisations: a policy toolkit was produced as a resource for the Tackling Tobacco Program, a project of Cancer Council NSW. The Program aims to reduce the harm caused by tobacco use among disadvantaged population groups by supporting community service organisations to assist their staff and clients to stop smoking and adopt harm reduction behaviours. The target groups for the Program include:

- People living with a mental illness
- Vulnerable young people
- Aboriginal and Torres Strait Islanders
- Low-income single-parent families
- People with drug and alcohol problems
- Homeless people
- People in the NSW prison system.

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Foreword
– Tobacco as a social justice issue

The harm caused by tobacco use in Australia costs individuals and the community more than $31 billion each year. But this statistic, staggering though it is, is still no measure of the heartbreak of a life cut short or compromised in its quality due to tobacco-related illness.

In the past 30 years, smoking rates for the population as a whole have declined significantly, and for this we should be thankful. However, when we examine the smoking rates for specific population groups, there is still cause for concern. Smoking rates are highest among the least well-off groups. Most worryingly, persons who experience multiple forms of social disadvantage continue to smoke at very high rates in many instances. It is now low-income and socially disadvantaged groups who bear the greatest burden of tobacco-related illness in Australia. Tobacco use maintains and exacerbates material hardship as well as health inequalities.

We know that the environments in which people live have a major influence on smoking. Community service organisations are expressing interest in finding out how they can tackle the issue of tobacco and create service environments that are more supportive of people quitting smoking.

In July 2006, the Cancer Council NSW commenced a new initiative, the Tackling Tobacco Program: Action on Smoking and Disadvantage. This program, viewing tobacco as an important social justice issue, aims to reduce rates of tobacco use among socially disadvantaged population groups. A primary focus of the Tackling Tobacco Program is on collaboration with the community service organisations that work with disadvantaged groups with very high rates of smoking. Together we want to influence social and service environments to make it easier for socially disadvantaged people to resist or cease smoking.

This policy toolkit provides background information on the links between smoking and disadvantage and the burden that smoking imposes on the already vulnerable. It also contains practical guidelines and ideas for how community service organisations can make a commitment to dealing with tobacco through their organisational policy, their service environment and their practice.

I commend this resource to you.

Andrew Penman
Chief Executive Officer
Cancer Council NSW
1. The facts about smoking and disadvantage

While smoking rates in Australia have declined in recent years to below 20% of the population, men and women in the lowest socioeconomic group continue to have significantly higher rates of smoking than the rest of the community. Nearly a quarter (24.3%) of the most socioeconomically disadvantaged group in NSW smoke, compared to only 12.9% in the most advantaged group. As shown in Table 1, research on specific groups who face additional disadvantage reveals even higher smoking rates.

What accounts for these high smoking rates? One important factor is that the very disadvantaged face circumstances which make it more likely they will take up smoking and confront more barriers to quitting. Smoking and disadvantage are closely linked. Social deprivation in its various forms increases the risk of smoking, and, because it undermines physical health and has a significant financial cost, smoking deepens social disadvantage.

Social conditions associated with higher smoking rates include:
- low income
- poor housing
- family members and friends who smoke
- lone parenthood
- unemployment.

Very disadvantaged people are more likely to take up smoking because a larger number of their friends and family smoke and it’s more common in their local community.

### Table 1 – Reported smoking rates among disadvantaged groups*

<table>
<thead>
<tr>
<th>Group</th>
<th>Smoking Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single mothers</td>
<td>46%</td>
</tr>
<tr>
<td>Aboriginal people</td>
<td>50%</td>
</tr>
<tr>
<td>Young vulnerable people</td>
<td>65%</td>
</tr>
<tr>
<td>Homeless people</td>
<td>70%</td>
</tr>
<tr>
<td>People with schizophrenia**</td>
<td>62%</td>
</tr>
</tbody>
</table>

* Note: Some of this data is taken from research or intervention studies with specific groups of this population. In these cases the smoking rates quoted are indicative and cannot be assumed to apply to the population group as a whole.

** This figure is an average smoking rate for people with schizophrenia taken from studies across 20 nations.
But social disadvantage itself, whether experienced through poor housing, unemployment or homelessness, also contributes to higher smoking rates. In qualitative research, disadvantaged groups have revealed how they use smoking as a means of coping with the difficulties they face, providing escape from stress and anxiety, and relief from monotony and boredom.\textsuperscript{11,12} One commentator describes smoking as offering a brief “holiday from hopelessness”\textsuperscript{13}. Unfortunately, smoking provides only temporary release at best and ends up making people’s problems worse through its impact on health and finances.\textsuperscript{9}

### The barriers to quitting

Most smokers find it difficult to quit because nicotine is powerfully addictive. Twenty years ago, the US Surgeon General concluded that smoking causes physical dependence in a similar way to heroin or cocaine. Smoking has rapid effects on brain chemistry, and it’s these processes that underlie nicotine addiction and withdrawal.\textsuperscript{14}

The strength of the dependency created by smoking is shown in the finding that around 80% of current smokers have tried to quit at some time but have been unsuccessful.\textsuperscript{15}

It’s not just physical addiction that makes smoking hard to give up. Smoking is also reinforced by the social roles it plays: it enables mixing and interaction with other smokers, provides comfort and company, relieves boredom and marks the transition from one part of the day to the next.\textsuperscript{16}

Around 95% of all unaided attempts to quit will fail, and it is normal for people to make several attempts before they can finally stop smoking.\textsuperscript{17}

Disadvantaged smokers face additional barriers to quitting, including:

- greater exposure to powerful cues to smoke, especially having close family or friends who smoke or being exposed to smoking in other places\textsuperscript{10,18}
- a lack of social support, including not having the support of a partner, close family, friend or other person to help them quit\textsuperscript{12,19}
- a lack of accessible, affordable and appropriate quit smoking supports, such as nicotine replacement therapy (NRT)\textsuperscript{11}
- stress from life circumstances, which often overrides concerns about smoking and is a major cause of relapse for those trying to quit\textsuperscript{19,20}
- a lack of affordable and attractive recreation options\textsuperscript{21}
- a lack of confidence in their ability to quit\textsuperscript{12}
- a belief held by some health, community and welfare workers that disadvantaged people either don’t want to quit or are unable to do so.\textsuperscript{22}

Despite these barriers, studies show that many marginalised and disadvantaged people have a strong desire to stop smoking.\textsuperscript{23} Their major motivation for wanting to quit is a desire to address the negative effects that smoking has on both their physical health and their material wellbeing as well as its effects on those close to them, especially children.\textsuperscript{12,24}
2. Counting the cost of smoking

Smoking imposes an enormous burden on individuals, families and communities. The health impacts of smoking are well established. We are now learning more about how smoking contributes to material hardship and deepens financial disadvantage among the already vulnerable.

Tobacco-related deaths within Australia compared with other causes – 2003

The impacts of smoking on health

Smoking is the leading cause of preventable death in Australia. The figure exceeds the combined deaths caused by motor vehicle accidents, homicide, suicide, breast cancer, AIDS and illicit drug use.

Half of all long-term smokers are likely to die because of smoking. Long-term smokers lose an average 13 years of life compared to non-smokers. Even when not fatal, smoking-related disease and disability cause distress and lead to reduced quality of life for smokers and those close to them, often for many years. Because of their higher smoking rates, the already vulnerable bear a disproportionate share of the burden of premature death, sickness and disease caused by smoking.

Table 2 – Smoking-related disease and disability

Smokers have much higher rates of:
- Cancer, including lung, throat, mouth, bladder and kidney cancer
- Stroke and cardiovascular disease
- Emphysema and other lung diseases.

Smokers experience more:
- respiratory illness, such as pneumonia and bronchitis
- vision and hearing loss
- impotence and reduced fertility.
Second-hand smoke: The consequences for children

Second-hand smoke is also referred to as environmental tobacco smoke. It is made up of sidestream smoke (smoke emitted directly into the atmosphere from a cigarette) and mainstream smoke (smoke that is drawn into the smoker’s lungs and then exhaled). The inhalation of second-hand smoke is called passive smoking.

Exposure to second-hand smoke is related to a variety of health problems in children, including SIDS, asthma, respiratory infections (such as pneumonia and bronchitis), middle ear infections and learning difficulties.²⁷,³¹

Children exposed to smoke in the home are more likely to be ill and to miss school.³⁵

For children from vulnerable families, this can add yet another layer of educational disadvantage on top of other factors. It can have a significant impact on their learning and achievement during school years and, ultimately, affect their life opportunities.

Smoking during pregnancy

While smoking among all pregnant women in NSW is around 15%, it is much higher for more disadvantaged mothers. Teenage mothers have smoking rates over 40%, and Indigenous mothers more than 55%.²⁹,³⁰

Smoking during pregnancy is a serious concern. The 4,000 or so toxic chemicals contained in tobacco smoke are absorbed into the pregnant woman’s bloodstream and pass to the baby through the umbilical cord.²⁷,³¹ Smoking also causes constriction of the blood vessels in both the umbilical cord and placenta, reducing the amount of nutrients and oxygen available to the growing baby.

Smoking during pregnancy has been shown to cause:²⁷,³¹

- increased risk of premature birth
- increased risk of still birth
- a twofold increase in the risk that the baby will be of low birth weight and not properly developed
- a threefold increase in the risk of sudden infant death syndrome (SIDS) for babies born to mothers who smoke before and after birth

Research also indicates links between maternal smoking and later child development problems. There is some evidence that smoking in pregnancy impairs children’s cognitive development, and clearer evidence that it increases the risk of learning and behaviour problems.³²,³³
The impact of smoking on material wellbeing

It is clear that regular smoking creates significant financial stress for people on very low incomes. A ‘packet a day’ smoker spends approximately $70 a week, or $3,640 a year, on tobacco.

Using limited income for smoking means there is less money available for essentials such as food, clothes and housing. A US study found that people with severe mental illness spent an average of 28% of their monthly income on cigarettes. In an interview for the Tackling Tobacco Program an ex-homeless person commented, “When I was on the street, smoking was my sustenance”.

Households where people smoke are twice as likely to experience severe financial stress than non-smoking households and to report “going without meals” or “being unable to heat the home”. Recent Australian and overseas research has confirmed the link between smoking and financial disadvantage. In one survey, respondents were asked if, in the last six months, they had spent money on cigarettes rather than on household essentials such as food. Over 40% of smokers on low incomes indicated they had done so.

In another study, conducted over three years, respondents were asked a series of questions about their inability to afford rent, heating, food and other household expenses. Two groups were identified: those who were smokers throughout the three years of the study and those who had been smokers in the study’s first year but who had quit during the second year and remained smoke-free during the third year. The results showed that those who stopped smoking were 42% less likely to report financial stress than those who continued to smoke.

Smoking contributes in no small way to material hardship, and it is also clear that quitting can help alleviate financial stress. Unfortunately, facing financial stress can make it harder to quit.

A UK study of low-income mothers found that the main reason they took up smoking again after quitting was the pressure of everyday problems. An Australian study also found that smokers with greater financial stress were more likely to relapse after quitting.

Smoking is closely linked with disadvantage, can reinforce disadvantage and can cause additional harm to people who already face many difficulties in their lives. It is therefore an important social justice issue.

The relationship between smoking and disadvantage has many facets and needs to be addressed on a range of levels. Community service agencies are well placed to help disadvantaged and vulnerable people address the complex issues raised by smoking as part of their holistic response to clients’ needs.
3. What can organisations do to tackle smoking

Smoking can’t be dismissed solely as a matter of personal choice; it is closely connected to factors of social disadvantage and, for many smokers, it is powerfully addictive. Without appropriate interventions and support, disadvantaged people are more likely to start smoking and to face additional barriers to quitting. This makes smoking a social equity issue.

The high smoking rates among the most disadvantaged in our community, and the disproportionately negative impacts of smoking on these individuals, provide a compelling case for community service organisations to do more to address smoking.

The nature of their work, the values that drive them, and the skills and relationships that staff have with clients put community service organisations in a unique position to help improve the health and wellbeing of disadvantaged smokers.

As with many social issues, reducing smoking-related harm requires strategies at different levels. Community service organisations are well placed to implement a range of actions – client, organisational and community-wide – to address the negative effects of smoking among the groups they serve.

Working at the client level

There are simple things that community services staff can do to help their clients quit smoking. Offering emotional support and encouragement to quit, providing brief quit smoking advice, and referring people to a support service such as their GP or Quitline can all help. Some organisations may want to provide more intensive assistance for clients or staff, such as by providing individual counselling or a quit group.

While gaining extra knowledge about smoking will assist staff to support clients to quit, the approaches that work with smoking are similar to the approaches that community services already use to support other positive life changes with their clients.

Staff can help their clients develop self-confidence by setting goals, identifying improvements and celebrating successes, both small and large. This positive and consistent support is crucial, as it is common for people to make several attempts at quitting before being successful. People who receive support from family, friends or others are more likely to be ready to quit, and are around 50% more likely to successfully give up smoking than those who receive no support.42
A review of the literature on smoking and disadvantage found that disadvantaged groups were just as interested in quitting as other groups in the community and, when given appropriate support, were also as successful in quitting.\textsuperscript{22}

The review also found that the way programs and interventions were delivered was critical to their success. The more successful approaches had the following characteristics:

- They were based on relationships of trust.
- Clients had long, regular and stable contact with the service.
- Smoking was addressed holistically, alongside other life issues.
- Emotional and practical support was provided.
- The client’s self-efficacy was supported and enhanced.

The fact that community services already have expertise in these areas underscores the critical role they could play in helping reduce the negative impacts of smoking on their clients.

Working at the organisational level

Legislation currently bans smoking in a range of public settings, including enclosed areas of the workplace, on public transport and in restaurants, hotels and clubs.

These restrictions are intended to protect people from the harm associated with second-hand smoke. However, a number of other benefits flow from smoking restrictions, including that:

- some people are prompted to quit
- others reduce the amount they smoke
- fewer people are likely to take up smoking
- there is less risk of relapse in smokers who have quit, due to reduced triggers and cues to smoke.\textsuperscript{43}

In the same way, the policies of community service organisations and how these policies shape the service environment have an effect on smoking behaviour.

Making premises totally smoke-free has around twice the effect on how much people smoke as compared with premises where smoking is allowed in some areas.\textsuperscript{44}

In addition to providing, as far as possible, a smoke-free workplace, community organisations can also consider ways to influence smoking in other aspects of their work with clients, such as recreational and leisure activities, home visits and setting casework goals.
As with alcohol and gambling, community service organisations can publicly add their voice to support these types of measures and highlight the adverse impacts that smoking has on already disadvantaged groups.

For instance, there is an urgent need for ongoing advocacy to make affordable NRT available for disadvantaged smokers. Community service organisations could approach their Area Health Service or pharmaceutical companies for access to affordable NRT, or join others to lobby the Commonwealth Government to have NRT subsidised for priority groups.

Other areas for advocacy include lobbying for quit smoking services and support that better meet the specific needs of disadvantaged groups.

Many community organisations play an advocacy role in addressing the causes of social disadvantage. While this advocacy is often focused on issues such as access to better housing, employment programs or strengthening vulnerable families, it could also contribute to positive results in relation to smoking. This is because, alongside its other negative effects, social deprivation creates vulnerability to smoking and other addictive patterns of behaviour.9,24

Working at the wider community level

In recent years, a number of initiatives taken at the community level have helped reduce rates of smoking. These include:

- quit smoking public awareness and information campaigns
- higher taxes, which increase the cost of smoking
- banning tobacco advertising and regulating the promotion and retail selling of tobacco.

These steps can help an organisation fulfil its duty of care by reducing the number of occasions where smoking is modelled as a ‘routine’ behaviour and by limiting exposure to tobacco smoke for all concerned.

It may also be possible for organisations working with children, young people and their families to influence their clients’ home environment. Smoking restrictions at home help reduce the overall level of smoking and increase the quit rate among adults.46 They can also significantly reduce the exposure of children and young people to the harmful effects of second-hand smoke.46

Voluntarily restricting smoking at home also has a preventative aspect because it can limit the uptake of smoking among teenagers. This limiting of uptake occurs even when parents remain smokers but no longer smoke inside the house.47

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Reasons to address tobacco and disadvantage

As well as being well placed to respond there are other reasons why community service organisations should do more about smoking:

- addressing smoking aligns with their values – a commitment to social justice and fairness
- addressing smoking is consistent with their mission – improving the wellbeing and opportunities of people with whom they work
- addressing smoking provides real benefits to clients – better health, more money and greater control over life.

This last point is worth emphasizing. Clients who quit smoking will enjoy substantial benefits, both immediate and longer term.
4. Addressing some common concerns

While community service organisations that work with disadvantaged groups may recognise the harm caused by smoking, they may also be hesitant to take action. This can be because of issues that relate to the clients or their own services. This section sets out some responses to commonly raised questions and concerns that services may have.

“Smoking is one of the few pleasures of very disadvantaged people. We feel uncomfortable asking them to give it up”

Smoking does provide some pleasure (though at times this may be more that a cigarette provides relief from the symptoms of nicotine withdrawal), but despite this around 80% of smokers have tried to quit. Even more (around 90%) regret having taken it up in the first place. All people who quit smoking need alternative activities to fill that place in their lives. Community service organisations can help their clients find affordable, enjoyable activities to replace smoking. What a tragedy if the only pleasure available to vulnerable people is one that shortens and reduces their quality of life and adds to their material hardship.

“Smoking is a personal choice”

It’s often argued that people make an informed choice to smoke. However, the issue is more complex than that:

- Most smokers take up and become addicted to smoking when they are teenagers, before the legal age of informed consent.
- Nicotine is powerfully addictive, and this undermines the argument that continued smoking is a free choice. The fact that around 80% of smokers have unsuccessfully tried to quit at some time indicates the strength of nicotine dependency.
- Research has found that most adult smokers are not fully aware of the dangers of smoking. While 55% identify the risk of lung cancer, only one third understand the link between smoking and heart disease or emphysema, and less than 10% know how smoking contributes to stroke and vascular disease.
“People have a right to smoke”
Like alcohol, cigarettes are legal products, but they harm both the smoker and other people even when used as the manufacturer intended. Compelling evidence about the harm caused by passive smoking has led to laws being passed to protect people from second-hand smoke by prohibiting smoking in a wide range of enclosed public places, including the workplace, public transport, cinemas, restaurants, pubs and clubs. (See Section 8 ‘Smoking, tobacco and the law’).

While most community service organisations provide outdoor smoking areas for clients and staff who smoke, they are under no legal obligation to do so. Some groups may want to maintain these areas out of recognition and understanding of their clients’ circumstances. However, it is also possible to show respect for clients who smoke (and recognise the right of all to health and wellbeing) by providing support for those who want to quit and having service environments which support that choice.

“Disadvantaged people are not interested in quitting”
While disadvantaged smokers may face more obstacles to quitting than others, numerous studies and consultations show they do want to stop smoking. In NSW around 50% of the smoking population expressed an interest in quitting in the next six months. Research on the quit intentions of vulnerable groups, including those with the highest smoking rates, has revealed they have a similar and at times greater desire to quit as the general population.

A community service agency on the north coast of NSW recently surveyed its clients (people living with mental illness) about interest in quit smoking activities. One client responded by saying,

“Thanks so much for offering this program. I’ve been wanting to quit for ages but there’s never been any support available for me.”

Recounted by Andrew Hamilton in a personal email on 21 May 2008 regarding a smoking cessation project conducted by New Horizons.
“Disadvantaged people are not able to quit”

Studies show that disadvantaged people are as able to quit smoking as anyone else, as long as they are given appropriate support. They may be more vulnerable to relapse, as the factors that contribute to smoking uptake – financial and social stress, boredom, friends and peers who smoke – are also factors that can trigger a person to start smoking again. There is also evidence that disadvantaged smokers are less commonly asked about their smoking or offered assistance to stop smoking.

“Many of our staff smoke”

Having staff who smoke need not be an obstacle to giving clients information about smoking or supporting clients to quit or change their smoking behaviour. Staff who smoke can acknowledge their own difficulty in quitting while reinforcing the importance of clients taking even small steps, such as smoking outside to lessen their children’s exposure to smoke. Many staff who smoke will be interested in quitting and may appreciate the active support and understanding of their employer to do so. Organisations that take active steps to address tobacco and provide support to quit can use this in their agency promotion and recruitment.

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During a discussion on making their service smoke-free, one staff member of a large community service organisation said,

“I’m actually glad this is coming in as it makes it easier for me to not smoke while I’m at work. I generally smoke most while I’m at work and that’s made it harder for me to quit. Now I have extra incentive.”

Recounted by Andrew Hamilton in a personal email on 21 May 2008 regarding a smoking cessation project conducted by New Horizons.
“We don’t have the expertise to deal with tobacco”

One of the most effective things staff can do is ask their clients about smoking and encourage and support them to quit. They can also refer clients to others for practical advice on quitting. While gaining extra knowledge about smoking would be useful, the approaches that work with vulnerable people to address smoking are the approaches that community services already use to support clients to make other positive life changes 22,53.

“We don’t want to be seen as wowsers”

Many community service organisations already express strong and public concern about the destructive effects of gambling and alcohol addiction. Taking a strong stand on tobacco, coupled with compassion and active support for disadvantaged smokers, can improve the health and financial wellbeing of clients and help them gain more control over their lives.

“NRT is too expensive for our clients and we can’t afford to subsidise them”

While using NRT almost doubles the chances of a quit attempt being successful, the vast majority of people who quit do so without NRT or any other intervention 50,54. Most people take several attempts to quit, and encouragement and support to keep trying are important factors in their ultimate success. Organisations wanting to secure affordable NRT for their clients could approach their Area Health Service or pharmaceutical companies that manufacture NRT. They could also lobby governments to provide affordable NRT for the most disadvantaged. Recently the Pharmaceutical Benefits Advisory Committee stated that NRT for Aboriginal and Torres Strait Islander people would be listed on the Pharmaceutical Benefits Scheme 55.
5. What to put in your organisation’s policy

An organisation-wide policy can provide a clear statement on your position on smoking, and guidelines for how staff and clients can deal with smoking issues. The policy should ideally cover all areas which could be affected, including the service environment, workplace systems and casework practice.

Organisations may like to consider the following areas when developing a policy.

**Smoke-free environments**

Service environments should be as smoke-free as possible. For some organisations this will mean having a complete ban on smoking on the premises, while for others it might mean setting aside a space for smokers to use.

If designated smoking areas are provided, they should:
- be located outdoors and be well ventilated to ensure no smoke will drift indoors
- be located away from public areas so there is no impact on either the service or visitors.

If possible, designated smoking areas should be out of view of group and social areas. This helps reduce modelling of smoking and lessens visual cues for those trying to quit. Designated smoking areas should be safe and functional but not provided with recreational amenities so that they become places to socialise.

**Smoking breaks**

It is recommended that if staff smoke they do so during their own time or within paid break periods. They should do this in the designated smoking areas only or, if smoking is banned, beyond service buildings and grounds.

**Smoking with service users**

Staff have a duty of care to safeguard the health and safety of clients. They are also often in a position of being role models for clients, particularly children and young people.

While staff should be open and honest about their own tobacco use, they should:
- not smoke in the presence of clients
- refrain from using tobacco as a means of engaging with clients
- not purchase tobacco products for clients or supply tobacco products to them.
Home visits and other settings

Community organisations are required to provide a safe working environment for staff during home visits and in other service settings. This can be a problem when clients smoke.

To respond to this, organisations can:

• give information to clients about the dangers of passive smoking and the need to safeguard the health and safety of staff
• request that clients not smoke during home visits or other meetings; alternatively, staff and clients could meet outside or have breaks so the client can smoke outside
• provide management support in the event that clients do not cooperate with the policy
• negotiate arrangements for playgroups, group work programs, leisure activities and excursions along the same lines.

Assistant for smokers to quit

Assistance comes in many forms and can be given to clients, staff and volunteers. It may include:

• providing information about smoking and tips on how to quit. Information could include impacts on health and financial wellbeing, the effects of passive smoking, the nature of nicotine dependence and the benefits of quitting. Information could be provided to staff in induction or training programs
• asking clients about their smoking as part of routine casework and goal-setting and providing support and encouragement to quit
• providing information and referrals to help people quit smoking, such as Quitline or a local GP or pharmacist. Staff could be allowed to talk to Quitline during work time.

Additional support could include:

• providing brief quit smoking intervention training for staff to use with clients, with a focus on smoking intervention as a routine part of casework practice
• providing access for staff and/or clients to free or subsidised NRT
• developing new, or modifying existing, casework tools and resources that could be used to explore smoking issues with clients, such as using a motivational interviewing approach.

More substantial support might involve:

• providing funding for some staff to receive more intensive quit smoking training
• developing or accessing group or individual quit smoking programs and offering them to interested staff and clients
• providing free or subsidised NRT to all staff and clients who request it as a routine part of agency practice.
Data collection

Collecting and recording information about a client’s smoking status at intake or on other occasions signals to the client and staff that it as an issue worthy of attention. Sometimes simply asking people if they smoke prompts a request for assistance to quit.

Results to do with smoking – such as reduced consumption, increased readiness to quit or making a quit attempt – could be included in outcomes reporting. Collecting this data would also help develop more accurate knowledge about smoking in a client group and would help your organisation to identify the benefits of having a smoking policy.

Advocacy

Organisations can support disadvantaged smokers by advocating for changes at the broader community level, including:

- provision of affordable NRT, particularly for disadvantaged smokers
- continued efforts to reduce social inequality, enhance opportunity and address the structural causes of disadvantage, as social deprivation increases the risk of drug dependencies such as smoking.9

Investment and other income policy

A commitment to addressing smoking and disadvantage will mean that community service organisations:

- do not make capital investments in any tobacco company, or with any business that has substantial capital interest or investments in tobacco companies
- do not accept any financial or in-kind support from tobacco companies.
In community services, everyone benefits from doing more about smoking

Benefits for staff and volunteers

- Healthier work environment
- Help for smokers to quit
- Supportive environment for ex-smokers to remain non-smokers.

Benefits for clients

- Immediate financial benefit – more money for essentials
- Significant health benefits
- Boost to self-confidence and sense of control.

Benefits to the organisation

- Improved work and service environment
- Reduced staff absenteeism
- Healthy progressive image (for clients and staff)
- An additional strategy to improve client wellbeing.
An organisation-wide policy can provide a clear statement of your position on smoking and the practical actions you will take to help reduce smoking-related harm.

There is no one ‘right’ way to develop or update a smoke-free policy for your organisation. However, there are a number of common elements that can help make the process more effective. You can use or adapt these steps to fit your organisation’s needs and circumstances.

Cancer Council NSW acknowledges with thanks its use of the information in this section, which is drawn from Smokefree Policy Guidelines for Workplaces (Cancer Council Queensland and Queensland Health, Brisbane, 2006).

**Step 1: Build a case for change and establish support for action**

If you are developing a new policy on smoking and tobacco, or revising an existing policy, it is important to present a solid and well-argued case for change.

You will need to answer a number of questions of management, staff, volunteers and clients, such as:

- Why is it important for the organisation to address smoking?
- What are the costs – in time and money – involved in doing more about smoking?
- What benefits will it provide for clients, staff and the organisation?

In particular, the broad support of management or senior staff is essential if a smoking policy is to be successfully introduced into the organisation.

The material provided earlier in this resource may help address some of these issues. Section 9 ‘Further information, resources and advice’ will also be useful.

You may want to collect information on issues specific to your organisation and clients. For example, if your organisation works with families with young children, you may want to learn more about the impact of passive smoking on children.

It may also be useful to provide case studies of other community service organisations that have successfully implemented or revised a policy on smoking.
Step 2: Consult with staff, volunteers and clients

Once support for change is established, the next step is to talk to as many people as possible in the organisation to gather their ideas on what should be included in the new or revised policy. This can happen through regular staff meetings, special forums, surveys, email feedback, suggestion boxes or other means.

Some organisations may choose to establish a special task group or designate an existing group (such as an occupational health and safety committee) to oversee this process. Whatever process is used, it is important that the views of all groups affected by the policy, including clients and volunteers, are heard and taken into account.

Discussion on the policy should include information about why the policy is being introduced, including the impacts of smoking on disadvantaged groups. Topics covered during the consultation phase could include:

- the adequacy of the current policy on smoking, if one exists
- what the new policy should cover and which items are of most importance
- how the new policy could be implemented
- particular issues or concerns and how these might best be addressed.

Some organisations may want to conduct an anonymous smoking survey as part of the consultation phase to provide information on the numbers of staff and clients who currently smoke, attitudes to smoking, and what support people need to quit smoking.

After collecting the feedback and views of management, staff members, clients and volunteers, the task of preparing a draft smoking policy and implementation plan for the organisation can begin.

Step 3: Draft the policy

The main elements of the draft policy are the rationale and the policy components.

The rationale briefly explains why your organisation has a smoking policy. It may also set out principles that will guide the organisation’s approach to reducing smoking-related harm among staff and clients.

The following rationale provides an example that your organisation may be able to use or modify. It is adapted from Addressing Tobacco in Mental Health, Policy Statement (South Australian Department of Health):

*In recognition of the harm caused by smoking, the links between smoking and disadvantage and our duty of care to safeguard the health and wellbeing of service users, staff and volunteers, we are committed to the following principles:*

- All staff, clients and volunteers within our services should be protected from exposure to environmental tobacco smoke
• All staff, clients and volunteers should be supported to not start smoking or resume or increase their tobacco use while within our service
• All staff, clients and volunteers should be provided with information on the risks of smoking and encouragement and support to consider cutting down or quitting smoking
• All staff, clients and volunteers should be offered support and assistance when experiencing nicotine withdrawal and when trying to quit smoking.

The policy components clearly state how you will address smoking- and tobacco-related issues. Careful thought should be given to areas that are important for your organisation. This could include taking action on the following:
• designated smoking areas
• smoking in vehicles
• staff smoking with clients
• providing support for staff and/or clients to quit
• funding from tobacco companies.

A more extensive list of areas which the smoking policy might cover is provided in the examples in Section 5 ‘What to put in your organisation’s policy’. While comprehensive policies are likely to be more effective in reducing smoking-related harm, it is important that organisations develop a policy that is suited to and can be successfully implemented in their situation.

Once the policy has been drafted, you may wish to circulate it for further comment from managers, staff and clients. These comments can then be integrated into a revised policy.

Step 4: Develop an implementation plan

The next step is to develop an implementation plan for the policy. The implementation plan should cover issues such as timing, monitoring and dealing with non-compliance.

There should be clear timeframes for introducing each component of the policy. Smokers will need time to adjust to the changes, especially those involving smoking restrictions. It may be useful to implement the policy in stages, with interim arrangements for a set period before the full policy is applied. This interim period would be a good time to start giving support to staff, volunteers and clients who may be interested in quitting smoking.

The plan should also identify who is responsible for implementing different elements of the policy and how monitoring will occur.

Organisations should also consider how they will handle non-compliance. There may be existing procedures for responding to non-compliance by staff and volunteers. Non-compliance by clients,
during a home visit for example, needs to be handled in a positive and non-confrontational way. It is important that staff have guidelines to follow in such circumstances and have the support of management to resolve any situations that may arise.

Step 5: Put the policy in place

The policy, including any revisions made during its development, will need to be approved before its implementation. This may require sign-off by senior staff, the executive officer or the board of management. Whatever the process, it is important that there is strong support for the policy and its implementation from the organisation’s leadership.

The implementation plan and timetable should be followed closely, as a common reason for a policy failing is poor implementation. Some of the more visible and well-supported elements of the policy should be put in place as soon as possible to maintain momentum and goodwill. It is important to identify how any problems that emerge should be dealt with and who will take responsibility. Grievances or issues that arise when the policy is implemented need to be addressed promptly and in a constructive way.

Step 6: Review the policy

Regular monitoring should be an essential part of the implementation plan, especially in the early stages when the policy is being rolled out. It is important to check that the policy is working effectively and to identify any changes or adjustments that need to be made.

If changes to the policy need to be made, they should be clearly communicated to everyone concerned.

A time should be set to undertake a comprehensive review of the policy, for example between 12 months and three years after its implementation. If the organisation conducted a smoking survey during the initial consultation phase, this could be repeated to identify the changes that have occurred.

A review should provide an opportunity for staff, volunteers and clients to gauge the policy’s success or otherwise, make comments on how it is working, and suggest improvements. The policy should then be revised accordingly.

A review also provides a good opportunity for management to acknowledge the efforts and cooperation of all parties in developing and implementing the policy and to celebrate any benefits.
7. Organisations taking action

New Horizons Enterprises Limited

New Horizons is a community-based organisation which provides services in supported accommodation, supported employment and aged care for over 2,000 people. Employing more than 400 staff, it operates services in the Sydney, Central Coast, Hunter, Mid North Coast and Northern Rivers regions. New Horizons has developed a smoke-free workplace policy which appears below.

NEW HORIZONS SMOKE FREE POLICY

Prohibition of Smoking

• Service Recipients
  New Horizons service recipients are prohibited from smoking at any time:
  – in a property owned, leased or operated by New Horizons, or
  – in a vehicle owned by New Horizons.
  New Horizons respects the rights of service recipients (who either own their home or who are leasing their home from parties other than New Horizons) to smoke in their own homes. However, where possible, staff should encourage them to respect the rights of staff and others to a smoke-free environment and to refrain from smoking in their presence, as well as advise the service recipients of the health risks associated with smoking and of the quit smoking programs available.

• Staff
  New Horizons prohibits its staff from smoking any time they are:
  – with a service recipient
  – in a property owned, leased or operated by New Horizons, or
  – in a vehicle owned by New Horizons.

• Exceptions/Provision of Designated Smoking Areas
  Where practicable, New Horizons currently provides designated smoking areas. However, it is aimed to phase out these facilities following the development and implementation of the New Horizons Quit Smoking Program. Until such time, designated smoking areas should:
  – be small areas designated for smoking rather than a gathering point for social interaction
  – be signposted as a designated area
  – be located outdoors and away from doors and windows
  – be located in a discrete position which:
Smoking Breaks & Duty of Care

Staff are not entitled to take smoke breaks other than at times nominated for general breaks, eg morning tea or lunch, and on the proviso that service recipients are not being neglected.

Any staff person who leaves a service recipient in need of ongoing support on his or her own while they go for a smoke will be considered to have breached their duty of care to the service recipient and will be dealt with as per the normal New Horizons disciplinary process.

Consequences of Breach of Policy

While all efforts will be made to help individuals to meet the requirements of this policy, it now forms part of the health and safety policy of New Horizons. Any breach of this policy will lead to the normal disciplinary procedures being adopted.

New Horizons Quit Smoking Program

New Horizons will provide assistance, as part of its Employee Assistance Program, to service recipients, staff and their partners who have difficulty not smoking for prolonged periods, or who wish to quit smoking. New Horizons may assist in meeting the cost of providing NRT (nicotine replacement therapy) patches, counselling, hypnotherapy or any other appropriate quit smoking therapy or strategy. Those staff who wish to access these programs should contact the HR Department.
Leichhardt Women’s Community Health Centre

The Leichhardt Women’s Community Health Centre successfully applied for a Cancer Council NSW Community Initiative Scheme grant in 2006. Leichhardt Women’s Community Health Centre (LWCHC) is a community-based, not-for-profit women’s health centre providing low-cost medical and complementary health services for women living in Sydney’s inner west. The grant enabled the centre to further develop its policy and practice around smoking.

Roxanne Cameron McMurray, the centre manager, explains what steps LWCHC has taken to support its staff and clients.

What prompted the project?
We were already doing quite a lot to address smoking but it became obvious we did not have a structured approach and we could improve things.

We discussed the issue in our planning day in 2006. The staff had different attitudes and levels of confidence in addressing smoking. Some felt that clients had enough to deal with already or that smoking was a low priority for them.

But generally staff felt they could be doing more about smoking and that our centre could have a better system around smoking. We wanted to provide better support for clients to quit or at least reduce their exposure to tobacco smoke.

What did you do next?
After deciding we could do more, we applied for a small grant under the Community Initiative Scheme. We used this money to conduct a one-day training and discussion session around smoking cessation. About 80% of staff attended, which was great.

As a result, we decided to update our smoking policy and procedures and make our centre a place where people could get on the path to quitting.
What changes did you make?

Our smoking policy now clearly states that staff will not smoke with clients, and that everyone has the right to be protected from tobacco smoke.

All frontline staff ask questions about tobacco use and the things that trigger smoking for clients. We see if they are interested in quitting and, if they are, what support they would like, and tell them what we can provide.

We’ve developed a tobacco use form that records the action that clients want about their smoking. This form stays on the client’s file so we can follow up on any agreed actions.

A question has been included in our annual client survey about how much people smoke and whether there’s been a change as a result of coming to our centre.

We include information on tobacco and disadvantage in our orientation program for new staff and students, as well as in our community education groups – we hold around 40 each year.

We have agreed that the courtyard is the only place where smoking is allowed, and only if no one there objects.

We’re also planning a pamphlet to tell the organisations that refer to us about our focus on providing quit smoking support to clients.

Have there been any major challenges as you have taken these steps?

We had some genuine disagreement about the courtyard and smoking – we really had to work those issues through. But I’ve been surprised by the willingness of all staff to put this up as a relevant issue. It would have been understandable if some wanted to sidestep it, but they were all concerned about the impacts of smoking.

The staff were just so receptive to integrating it into the whole program. No one has really raised a concern about clients not coming because of our position on smoking. It’s more they see that we have an obligation to act on this issue on social equity grounds.
8. Smoking, tobacco and the law

The State and Commonwealth tobacco control legislation of most relevance to community service organisations in NSW is briefly described below.

**Passive smoking/second-hand smoke**

The NSW Smoke-free Environment Act 2000 prohibits smoking in a wide range of public places that are defined as ‘enclosed’ under the Act. Such a place is one in which a member of the public is entitled to use or that is open to, or is being used by, the public or a section of the public (whether on payment of money, by virtue of membership of a club or other body, or otherwise) 56.

Under the NSW Occupational Health and Safety Act 2000, employers are obliged to ensure the health, safety and welfare at work of all their employees and any others in their place of work 57. The organisation charged with administering and enforcing this Act, WorkCover NSW, interprets this obligation as requiring the elimination of smoking from all indoor areas of a workplace 57.

**Sponsorship by tobacco interests**

In NSW the promotion of a tobacco product, brand name, trademark or name of a tobacco product manufacturer or distributor by any person is prohibited under the NSW Public Health Act 1991 58.

The Commonwealth Tobacco Advertising Prohibition Act 1992 prohibits any publicity that promotes or is intended to promote smoking and/or tobacco products 59.
9. Further information, resources and advice

For enquiries about this resource or the Tackling Tobacco Program
Tackling Tobacco program Co-ordinator,
Cancer Council NSW
Phone: (02) 9334 1900

For fact sheets on smoking and other tobacco-related information
Cancer Institute NSW
Phone: (02) 8374 5600
Web: www.cancerinstitute.org.au
Smoking fact sheets can be obtained from:

For confidential telephone quit smoking advice and support for smokers and the families and friends of smokers
Call the Quitline (for the cost of a local call) 13 7848
An interpreter service is available for people not fluent in English.

For Quit Kits and other smoking information resources and materials
Better Health Centre
The Better Health Centre is the NSW Department of Health’s publications warehouse and distribution centre. This is where you order printed copies of NSW Health publications.
Address: Locked Bag 5003,
Gladesville NSW 2111
Phone: (02) 9879 0443
Resources can also be obtained from:

For information about legislation relating to tobacco and smoking
NSW Health
Phone: (02) 9391 9000
Email: nswhealth@doh.health.nsw.gov.au
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