Tackling tobacco: reframing smoking and the role of community service organisations in reducing smoking-related harm

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Introduction
Smoking has generally not been a focus of community organisations that address the needs of disadvantaged children, families and young people. Agencies have concerned themselves with matters such as child protection, family strengthening, providing stable accommodation and addressing domestic violence. Smoking has been seen more as a matter of personal choice or even personal empowerment. But personal choices and subsequent behaviours are influenced by many factors, not least the experience of disadvantage (Wilkinson and Marmot, 2003).

This paper argues for a change in the way that community service organisations perceive and respond to the issue of tobacco. It suggests that while personal choice remains a consideration, there are compelling reasons to consider smoking as an important social justice issue. It also suggests that child, youth and family welfare organisations are well placed to make an important contribution to reducing tobacco related harm, and so improve the wellbeing of the people with whom they work. There are two main reasons to see smoking as a social justice issue: the prevalence of smoking among the disadvantaged, and the impacts of smoking on the disadvantaged.

Smoking prevalence and disadvantage
Smoking rates in Australia for the population as a whole have declined to around 20% (Carter et al, 2001). This figure compares favourably with the majority of developed nations. However, when we examine smoking rates by socio-economic position a different picture emerges. The table below shows smoking rates for men and women for five different socio-economic groups in NSW. A clear gradient can be seen. People from the higher socio-economic positions have the lowest smoking rates. Men and women in the lowest socio-economic position have significantly higher rates of smoking.

Current smoking by socio-economic position persons aged 16 and over NSW 2005
Source: Report of the NSW Chief Health Officer 2005
When we consider the smoking rates for groups that face additional disadvantage the contrasts are even more stark.

Smoking rates for single mothers are around 45% and are likely to be higher for those on welfare payments and facing additional problems. The general smoking rate for Aboriginal people is around 50% and as high as 80% in some communities. Estimates of smoking rates for people with severe mental illness, the homeless and those with substance abuse problems all exceed 70%. Anecdotal evidence also suggests high smoking rates among vulnerable young people including those in out-of-home care (The Cancer Council NSW, 2006a).

Smoking in pregnancy to and exposure of children to passive smoking are also a concern. In NSW in 2003 the overall rate of smoking in pregnancy was around 15% but over 58% for Indigenous mothers (Laws et al, 2006). Very high rates (42%) have also been reported for teenage mothers (Bai et al, 2000).

In NSW about 10% of children live in households where caregivers state they always/usually/sometimes smoke inside. However disadvantaged families are more likely to smoke in the house and this increases any children’s exposure to tobacco smoke. (NSW Health, 2005)

How is it that our most vulnerable groups have such high smoking rates and what is the connection with disadvantage?

**Disadvantaged groups are more likely to take up smoking**
A big part of the difference in smoking rates between less and more advantaged groups is explained by the fact that more disadvantaged people take up smoking in the first place. One explanation for this is that people are much more likely to start smoking if people around them smoke, particularly parents and peers (Coleman, 2004).

But the nature of disadvantage itself contributes to higher smoking rates. Difficult social conditions such as low income, poor housing, lone parenthood and social isolation generate stress, anxiety and a sense of lack of control over life. When sustained, these conditions have powerful effects on physical and mental wellbeing and also make people more vulnerable to substance use, including smoking, as a way of gaining relief from the pain of their circumstances (Wilkinson and Marmot, 2003). This understanding is reflected in findings from the “Smoking among Disadvantaged Women” study in Canada. Researchers found smoking was closely woven into these women’s experience of poverty, isolation and raising children. Smoking was a means of coping with daily struggles and crises and their feelings of fear, anxiety and anger (Stewart et al 1996a). Similar themes emerge in research with marginalised young people in Australia who saw smoking as a means to cope with stress or boredom or as an expression of defiance (Carter et al, 2001).

**Disadvantaged groups are less likely to quit smoking.**
Firstly, we should note that all smokers find it difficult to quit. The main reason for this is that nicotine is potently addictive. In 1988 the US Surgeon General determined that smoking produces significant bio-chemical change in the human brain similar to the changes produced by heroin or cocaine. It is these effects that underlie the process of nicotine addiction and withdrawal (US Surgeon General, 1988).
The fact that over 80% of smokers have tried to quit at one time or another but been unsuccessful underscores the strength of the dependency that smoking creates. Around 90% of all unaided attempts to quit will fail and it is normal for people to have to make several attempts before they can finally stop smoking. Alongside physical dependency the social roles that smoking plays—enabling social mixing; providing comfort and company; relieving boredom and marking the transition from one part of the day to the next, tend to reinforce smoking. Part of the task of quitting is finding ways other than smoking to address these issues. (Carter et al, 2001).

As well as the difficulties named above research on disadvantaged smokers has identified additional barriers they face in stopping smoking (Stewart et al, 1996b; Roddy et al, 2006; Owens and Springett, 2006; Browne et al, 1999; Pullon et al, 2003). These include:

- A lack of social support. Not having support from partners and close family is a crucial barrier but the absence of support from friends and peers is also an issue.
- A lack of confidence in or negative perceptions of services or health professionals.
- The pressing nature of life circumstances. The role of smoking in coping with stress overrides concerns and thoughts of the long term benefits of quitting
- Availability and accessibility of support services. Not having services close by or lacking transport or child care is a barrier to quitting
- The belief (held by workers) that disadvantaged people aren’t interested in quitting, can’t quit or it’s unfair to raise the subject

Despite these barriers many marginalised people do desire to stop smoking. Australian studies of people with mental illness, in prison and in drug treatment programs showed between 46% and 80% concerned about smoking and wanting to quit (Baker et al, 2006).

It is no surprise that a major motivation to stop smoking is its enormous effects on health and also finances. These impacts provide the second reason to see smoking as a social justice issue.

The impacts of smoking on health and material wellbeing

Health impacts
Smoking is a leading cause of preventable death in Australia. Each year about 19,000 Australians die from smoking related causes. That exceeds the combined deaths caused by AIDS, suicide, breast cancer, homicide, falls, illicit drug use and motor vehicle accidents. One half of all long-term smokers will die due to smoking (Ministerial Council on Drug Strategy, 2004). We know that socio-economic position affects health, including death rates. Smoking, by itself, has been estimated to cause between one third and two thirds of the difference in death rates between men in the lowest and highest socio-economic groups (Siahpush et al, 2006).

Smoking is also a major cause of disease and disability. Compared to non-smokers long-term smokers suffer much higher rates of cancer (including lung, throat, mouth, bladder and kidney), heart disease, stroke and cardiovascular disease. They are also more likely to experience, vision and hearing loss, reduced fertility and impotence. All
this causes enormous pain, distress and reduced quality of life for individuals and their families (Ministerial Council on Drug Strategy, 2004).

Smoking during pregnancy is also a significant concern. Babies born to women who smoke have a greater chance of prematurity, low birth weight, stillbirth and Sudden Infant Death Syndrome. Smoking in pregnancy also has developmental impacts in childhood and beyond with greater risk of cognitive impairment, learning deficits, impaired attention and impulse control problems (Laws et al, 2006; Mortensen et al, 2005)

Exposure of children to passive smoking is also related to health problems. Children exposed to tobacco smoke are at greater risk of risk of Sudden Infant Death Syndrome, asthma, other respiratory infections, middle ear infections and learning and behaviour problems (The Cancer Council NSW, 2006b)

Because of their higher smoking rates it is the already vulnerable who bear a disproportionate share of the health burden that tobacco imposes. But the negative impacts of tobacco are not limited to health problems.

**Impacts on material wellbeing**

A packet a day smoker will spend approximately $70 a week or $3640 a year on tobacco. Intuitively, it makes sense that smoking will create financial stress for those smokers on very low incomes. Recent Australian research (Siahpush et al, 2006) comparing the financial stress of continuing smokers (across all income levels) to individuals who had recently given up smoking confirms this view. Continuing smokers were significantly more likely to have experienced hardship (eg not being able to pay the rent or heat the home) than recent quitters (63.3% vs. 50.0%). In another study participants were asked if they had spent money on tobacco they knew would be better spent on essentials such as food. Researchers found 42% of low-income smokers had spent money on tobacco rather than essentials. These findings underscore the fact that smoking can contribute to and exacerbate financial hardship in the short term and that quitting can help alleviate financial stress (Siahpush et al, unpublished)

Smoking may also contribute to hardship and reduce opportunity indirectly. Children exposed to tobacco smoke are more likely to be ill, (due to infections, asthma and other respiratory diseases) and so miss school (Gilliland et al 2003).This can impact on school performance and longer-term employment opportunities.

Smoking then is entwined with disadvantage and causes great additional harm to people who already have more than their share of difficulties to face. What can and should be done in response to this situation and what role can community service organisations play?

**What can be done?**

Tobacco needs to be tackled at a number of levels to be addressed successfully. This includes strategies directed at changing the social environment which supports smoking (mass media campaigns, limits on advertising and sales, regulation of smoking in public places) as well as strategies directed to individuals to assist them to stop smoking (eg evidence based services such as cessation counselling - group and individual- and pharmacotherapies like Nicotine Replacement Therapy).
Collectively, these strategies have been effective in reducing overall smoking rates in Australia.

But it is apparent that alongside efforts aimed at the population as a whole, we must direct attention to the most disadvantaged groups whose smoking rates remain very high. It is to that issue we now turn. This section draws from research in Canada, the UK and New Zealand to identify what approaches may be most useful for addressing smoking with disadvantaged groups before describing ways that child, youth and family organisations can better integrate a concern about tobacco in their work.

**What works with disadvantaged groups?**

Research into smoking cessation programs for vulnerable groups is quite limited but some surveys and actual interventions have been conducted (Stewart et al, 1996; Roddy et al, 2006; Owens and Springett, 2006; Browne et al, 1999; Pullon et al, 2003)

The most effective approaches had the following characteristics:

- **A non-judgmental and empowering approach** - A personal, non-threatening approach was most effective. There was an emphasis on working with clients to set goals and develop a sense of self-efficacy. One program (Browne et al, 1999) used an explicitly solution focussed model that looked for and emphasised client strengths.

- **Provision of social support** - Support from peers and/or partners as well as staff and volunteers was seen as a vital component of services. Support happened in different ways - one to one counselling, home visits and groups. Peer support and mutual aid with people from similar life situations was a common and valued feature of services.

- **Flexibility and accessibility** - This has several dimensions- offering different sites, times and methods of service; providing transport where necessary; catering for needs at various stages of quitting and; using engaging resources–flip charts, information cards, video etc designed specifically for the group.

- **Well trained staff** - Staff varied in their background and formal qualifications. Some programs used midwives or nurses, others used smoking support workers drawn from other occupations. Two programs used trained peer leaders. All programs emphasised training around smoking cessation, the methodology of the specific program and capacity to provide advice to people at different stages of quitting smoking.

- **A holistic approach** - The capacity of programs to deal not just with smoking but place it in the context of other pressing life issues was important. Researchers observed that disadvantaged women who attended community-based services wanted comprehensive programs to address the complexities of their lives (Stewart et al 1996a).

It will be apparent that many of the characteristics named above are also valued and commonly applied within the child and family welfare sector. The types of approach that work with vulnerable people to address smoking are also the approaches that services already use to support other positive life changes for children, families and
young people. Community sector organisations commonly operate from a strengths-based perspective with a focus on working with service users to make positive changes. They strive to be flexible and are keenly conscious of making their services easy to use and welcoming. Community organisations don’t need to be told about the value of social support - that is their modus operandi. And while services are funded for specific purposes, many agencies operate from a holistic perspective and strive to address multiple factors that impact on their service user’s wellbeing.

A major strength of child, family and youth services is that they are in a position to provide prevention and early intervention regarding smoking. Helping young people to stop smoking will maximise the benefit of quitting and minimise any damage caused. Working with families with children not only holds the promise of helping parents to stop smoking. It also limits the harm to children through passive smoking and reduces the chances those children will take up smoking themselves.

All this suggests that child, youth and family welfare services are well placed to make a telling contribution to tackling tobacco and reducing the burden of harm that it imposes on their service users. That view was expressed by participants in the ‘Smoking among Disadvantaged Women’ study (Stewart et al, 1996b). Women using non-health related support organisations (such as women’s centres) said they trusted those organisations and saw them as appropriate deliverers of smoking cessation services. They stated they would use such services if they were available. The types of services the women saw as being provided included information and referral, education around smoking and health risks (including passive smoking), as well as support groups and cessation services.

If we accept then, that child youth and family services are well placed to address tobacco, what steps can they take in this direction?

**What can child, youth and family service organisations do to better address tobacco?**

The most important thing that child, youth and family services can do to reduce smoking related harm is to build an organisational commitment to address tobacco as part of their routine operations. That commitment will then express itself in action at different levels: organisational policy; staff training; casework practice; program development; and advocacy.

All organisations can adopt smoke-free workplace policies and review other policies to see if they support, or act as a barrier, to people quitting. Policies could cover provision of support to staff who wanted to quit smoking or adjustments to home visiting policy in light of concerns about passive smoking. Area Health Services have adopted policy changes in this area. As agencies have a responsibility for the health of children and young people in care, finding ways to support young people in out-of-home care programs (as well as carers) to stop smoking is another important area to address.

Integrating concerns about tobacco into programs and practice could embrace many strategies. The simplest is to provide referral to existing services such as Quitline or quit clinics in community health centres. Providing tailored information to service users about smoking and developing resources for staff to help them address smoking as part of normal case work practice are other options. Training for staff around smoking is another clear need. This could include developing training or...
making use of existing opportunities. For example, NSW Health is soon commencing its Telehealth project offering training in evidence based brief intervention for smoking across multiple sites in NSW. Some organisations may be in a position to implement smoking cessation projects to support service users who want to quit. This could include providing free counselling and/or subsidised nicotine replacement therapy or other supports. The Cancer Council NSW has recently established a small grants program called the Community Initiatives Scheme to encourage projects of this kind.

Finally, welfare agencies have an important role to play in advocacy. Advocacy around the causes of disadvantage is fundamental to many organisations’ mission and will contribute to reducing smoking in the long term. But advocacy supporting legislative limits on tobacco sales and smoking in public places would also be helpful, as would support for greater government investment in services to help people quit.

These are just some examples of the things child, youth and family welfare organisations can do to address tobacco. Such a response is more likely as community organisations reflect on the connection between disadvantage and smoking, and reframe tobacco as an important social justice issue. As they take steps in line with that conviction organisations can know that their action holds the promise of contributing very significant benefits for the people they serve.

References


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