



Lifting the Burden
Tobacco Control
and Social Equity Strategy
July 2006 to June 2011

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Foreword

Tobacco control is a social justice issue

The harm inflicted by tobacco use on individuals and the community has been costed at more than \$21 billion each year¹. But this statistic, staggering though it is, does not adequately express the heartbreak of a life cut short or compromised in its quality due to tobacco-related illness.

Over the past 30 years, smoking rates have declined significantly in Australia. That is very welcome. However despite this achievement smoking rates for some population groups give us cause for concern. People who experience multiple and aggravated forms of social disadvantage continue to smoke at very high rates in many instances. It is these low-income and socially disadvantaged groups who bear the greatest burden of tobacco related illness in Australia.

Tobacco use contributes to poverty, and does so in both direct and complex ways. The cost of tobacco-related illness impacts severely on low-income and socially disadvantaged individuals and their families. Tobacco-related illness and death can result in the loss of family breadwinners and so contribute to long-term disadvantage, for example, through its severe impact on family stress and finances and the longer term effects of this on children's education and life prospects. Smoking also imposes an immediate financial burden on those who are addicted to tobacco and their families. For people who are on low incomes and the disadvantaged, the financial burden exacerbates the impact of poverty by reducing the funds available to cover the essentials of decent food, clothing and stable housing.

These are serious social justice issues that must be faced. And they must be addressed. For too long tobacco use among low-income and socially disadvantaged population groups has not received sufficient priority for action.

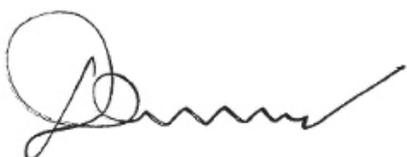
The Cancer Council NSW and the Council of Social Service of New South Wales (NCOSS) fully appreciate the complexities associated with the problem of smoking and social disadvantage. However, the fact that a problem is complex and difficult is no justification for ignoring it. There are many helpful responses that can and must be made. Some of these are not difficult, and can be achieved without significant additional resources. Others are far more challenging, and require not only new resources, but also new approaches and collaborations between governments, sectors, and population groups. We still have a great deal to learn about how to best assist members of low-income and socially disadvantaged groups to resist or quit smoking, but these lessons will never be learnt unless we make a start.

That brings us to this Strategy. Over the next five years The Cancer Council NSW will undertake work in nine major areas to 'lift the burden' of tobacco-related harms among low-income and socially disadvantaged groups in NSW. It will do this in partnership with government, non-government agencies, social services, population groups, and researchers. This is very much a first investment in the area, and the focus will be on learning what works to inform future investments.

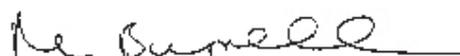
The Cancer Council NSW and NCOSS recognise that individuals who smoke deserve support and encouragement to quit smoking, and not criticism for the fact that they do smoke. This is especially the case for those persons who smoke for reasons linked to their social disadvantage. Therefore, this Strategy, not only encompasses creating better immediate support for those who wish to stop smoking, but also changing the social environment that affects a person's capacity to resist smoking in the first place or to choose to quit smoking later on.

It is important to thank all those who have contributed their expertise and insight in the development of this Strategy. We look forward to working with you in its implementation.

While the everyday focus of community service organisations and The Cancer Council NSW are somewhat different, we share an overriding concern to improve the situation of the people - the children, young people and adults - with whom we work. We believe that by working together on this project, The Cancer Council NSW and social service organisations will make a powerful contribution to social justice and wellbeing for some of the most disadvantaged groups in NSW.



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Introduction

The Cancer Council NSW (TCCN) has a long standing commitment to reducing death and disability caused by the use of tobacco products. Tobacco use is both a result of social disadvantage and also contributes to, and exacerbates social disadvantage and inequity^{2,3}. In response, TCCN has developed the Tobacco Control and Social Equity Strategy to guide collaborative efforts to reduce smoking related harm among the most disadvantaged groups in NSW. By 'most disadvantaged' we mean people who, in addition to low income, face a number of other difficulties such as mental illness, domestic violence, unemployment, homelessness, drug and alcohol problems, criminal justice issues, limited education and social isolation. This introduction explains the rationale for the Strategy, outlines its main objectives and focus areas, and describes how it will be implemented over the next five years.

Why do we need a Tobacco Control and Social Equity Strategy?

Three factors underpin the critical need to address smoking in relation to very disadvantaged groups. These are: the high prevalence of smoking among the most disadvantaged; the severe impacts of smoking on the most disadvantaged, and the additional barriers that disadvantaged groups face in resisting, or quitting smoking.

Prevalence of smoking

While smoking rates across the Australian population have dropped to between 17 and 21%^{2,4,5} they are higher for more disadvantaged groups and much higher for the most vulnerable. Smoking rates for the unemployed are

nearly 30%⁶ and are similar for young people in their late teens and early twenties⁷. Rates for low-income single parents, the vast majority of whom are female, are over 40%⁸. The general smoking rate for Aboriginal people is around 50% but as high as 80% in some communities^{9,10}. Tobacco use among people with a mental illness is extremely high, ranging from 60-80%^{5,7,11}.

It is not just active smoking that causes harm. Exposure to the smoke produced by others (environmental tobacco smoke) is also harmful. Children are particularly at risk. In 2001, 10.1% of households with children aged 0-12 stated that they sometimes/usually/always smoked inside the home. Disadvantaged parents are more likely than better off parents to smoke in the house and/or car and this greatly increases their children's exposure to tobacco smoke^{2,7}.

Impacts of tobacco use

Tobacco use, especially long-term use, causes great harm to people's physical, personal and financial wellbeing². Smoking is the leading cause of death and disease in Australia. In the coming year more than 19,000 Australians will die from smoking related causes¹. One half of all long-term smokers will die due to smoking, and on average, smokers lose 13-14 years of their lives^{1,13}. The years before death are often lived with an increasing degree of illness and disability, requiring medical treatment. This not only affects the smoker's ability to work and their quality of life but also has a significant impact on family finances and relationships². Long-term smokers suffer much higher rates of cancer (of the lung, esophagus, bladder and kidney), heart disease, stroke and cardiovascular disease than non-smokers^{2,12,13}. They are also more

likely to experience disability, vision and hearing loss, reduced fertility and impotence. All this causes enormous suffering, pain and personal distress as well as the erosion of individuals' and family's quality of life.

Because poverty and multiple disadvantage are linked to higher rates of smoking the tragic reality is that it is the already vulnerable and marginalised who bear a disproportionate share of the burden of death, disease and grief caused by tobacco^{2,11,14}.

We are also now realising that lifetime smoking is not only linked with, but also contributes to, poverty and disadvantage in the short and longer term. For example, money spent on tobacco reduces the funds that low-income individuals or families have to purchase essentials such as food, clothing and accommodation as well as less harmful forms of leisure and recreation^{2,15}. Households that smoke are three times more likely to experience severe financial stress and report "going without meals" and "being unable to heat the home" than non-smoking households¹⁵. Children exposed to tobacco smoke are more likely to be ill and miss school, which in the longer term affects their school performance and reduces their employment prospects^{2,12}.

Barriers to resisting and quitting smoking

Most smokers do not make an "informed choice" to start smoking². All smokers, including very disadvantaged smokers, are subject to factors that lessen their capacity to make a well considered decision to commence smoking or to quit once they have started. Most people (about 90%) start smoking in their teenage years and before they have a sense of the

consequences^{2,12}. Smoking is potently addictive - in the same sense that heroin is addictive. Nicotine in tobacco alters the brain's neurotransmitter systems and contributes to a powerful dependence on tobacco². This undermines intentions to quit. Also, while most people know that smoking is not good for them, many are not fully aware of the extent and severity of the harm that smoking causes⁴.

In addition to the above, the most disadvantaged smokers face other barriers which make quitting more difficult and complex^{2,4,5,18}. These include the higher rates of smoking among family and friends, the role of smoking in providing some comfort, enjoyment and relaxation in the face of trying and stressful circumstances, the function of smoking in aiding social mixing, or simply coping with boredom, and the role of smoking as self medication. Other factors that can make it more difficult for more disadvantaged people to resist or stop smoking are the relative inaccessibility of smoking cessation resources and the affordability of nicotine replacement therapy^{2,4,5}. Taking account of, and finding ways to address these complexities associated with smoking and social disadvantage will be a crucial and ongoing task of the Strategy.

Despite the substantial barriers noted above we know that nearly 80% of smokers have tried to quit at some time and that over half of smokers at any one time intend to quit within the next six months^{6,19}. The same desire to quit is evident even among the most disadvantaged and heavy smokers. For example, studies have shown 46%-80% of people in drug treatment are interested in stopping smoking and 75% of prison inmates want to quit⁵. But we

also know that around 95% of unaided efforts to quit will be unsuccessful and that most smokers take several attempts to finally stop^{2,4}. This, as well as underscoring the highly addictive nature of tobacco, emphasises the need to devise better strategies to support very disadvantaged smokers who want to stop smoking^{2,5}.

What does the Tobacco Control and Social Equity Strategy involve?

This section outlines the approach the Strategy will take and its main aims and focus areas.

The Approach

A critical feature of the Strategy is that it is designed to be strongly collaborative. Through this Strategy, TCCN aims to combine the skills and expertise of both the tobacco control and social service sectors. Our intention is to work together with social service agencies, Area Health Services and other groups to develop more effective approaches to tobacco control and social disadvantage. Our aim is to build on current initiatives and work through existing relationships and networks, not duplicate efforts.

The Strategy was developed in consultation with both representatives of social service agencies and experts in the area of tobacco control. The Cancer Council NSW has taken account of their feedback in the design of the Strategy and will continue to be guided by this and subsequent advice as the project unfolds.

Objectives and Key Result Areas

The central objective of the Strategy is to contribute to a reduction in smoking-related harm among the most disadvantaged groups in NSW. These include vulnerable young people,

Aboriginal and Torres Strait Islanders, people who are homeless, people with a mental illness, those with drug and alcohol problems, low-income single parents and those in correctional settings.

Because the factors that contribute to smoking operate at a number of levels, the Tobacco Control and Social Equity Strategy must also work at a number of levels in order to be effective^{2,3}. The Strategy's nine Key Result Areas cover issues like developing awareness of the risks and consequences of smoking amongst disadvantaged groups and the people who work with them, the need for better targeted individual and family resources to support quit attempts, having organisational policies and procedures that support tobacco control (such as smoke free work places), initiatives in local environments to lessen exposure to tobacco smoke and better regulatory and legislative controls to support smoking reduction among the most disadvantaged.

While the Strategy includes support for behaviour change it emphasises understanding how smoking behaviour is shaped and facilitated by environment and the need to make environmental changes that support healthier behaviours^{3,11}. Of course initiatives like this cannot ultimately succeed if the social factors that create disadvantage in the first place and result in social ills such as tobacco use go unchallenged and unchanged. For this reason a vital element of the strategy is to support policies to secure improvements in education, employment and housing and initiatives that strengthen families and communities and reduce isolation^{2,3,11}.

The approach and objectives of the Strategy are consistent with and

supportive of the goals and objectives of both the *National Tobacco Strategy 2004-2009* and the *NSW Tobacco Action Plan 2005-2009*. Our hope is that this Strategy can be a catalyst for change and further stimulate the development of effective approaches to reduce smoking related harm among the most disadvantaged. To this end, we will advocate that both State and Federal Governments play a role in resourcing and widely implementing the most effective and promising interventions identified or developed in the course of this Strategy.

How will the Tobacco Control and Social Equity Strategy be implemented?

The Tobacco Control and Social Equity Strategy will be progressively implemented over the next five years, guided by two key intentions. The first is to put into practice the best of what we know currently about tobacco control and smoking reduction for the most disadvantaged groups. The second is, through the operation of action research projects, to learn more about what works best to reduce smoking among the most vulnerable. This knowledge can then be applied more widely in the future.

The Cancer Council NSW does not believe that it is either right or fair that already vulnerable groups bear a disproportionate share of the harmful effects of tobacco use. Given the extent of tobacco use and its effect in shortening and impoverishing human life, reducing smoking among the most disadvantaged is an urgent social justice issue, and one that demands sustained action. This Strategy is our contribution to that effort.

Tobacco Control & Social Equity Strategy



The Cancer Council NSW

Community Service Organisations, Area Health Services and other groups



The Approach	Target Groups (the most disadvantaged)	Methods	Results
Working together	Vulnerable youth	Raising awareness and understanding	Reduction in smoking related harm
	Low-income single parents	Case work resources and tools	
	People with mental illness	Organisational policies to support tobacco control	
	Aboriginal and Torres Strait Islanders	Better smoking cessation supports	
Building on existing networks and resources	People with drug and alcohol problems	Action-research	Improved physical, social and financial wellbeing
	Homeless people	Influencing environments to reduce smoking	
	People in the NSW prison system	Advocacy to reduce disadvantage	

Orientation to the Strategy

Our Strategy is focused on achieving positive results in nine areas (Key Result Areas) over the next five years.

These Key Result Areas are:

1. Better awareness and understanding of smoking risks among social service agencies and their staff.
2. Building the capacity of social service agencies to contribute to tobacco control efforts.
3. Better awareness and understanding of smoking risks among socially disadvantaged population groups.
4. Action-research to identify practical strategies to support tobacco control in specific population groups.
5. Better smoking cessation support for low income and socially disadvantaged groups.
6. Fostering harm limiting behaviour among socially disadvantaged smokers.
7. Better integration of tobacco control into responses to social disadvantage.
8. A better evidence-base in relation to tobacco control and social disadvantage.
9. Supporting policy and legislative initiatives to address social disadvantage and enhance tobacco control.

In the following pages each Key Result Area is outlined in more detail. Firstly we describe under the heading *The issues*, the main reasons each Key Result Area has been selected for attention. Then, under *Our response*, we outline in broad terms what we hope to achieve within that area. Both the issues and response sections were shaped and informed by two rounds of consultations with representatives of social service agencies and experts in tobacco control. The next section in each Key Result Area identifies a number of *Strategies* which we consider can best contribute to those achievements. Finally in the section on *Indicators of success* we outline how we will assess the progress of the Strategy. These statements are aspirational and hence are expressed as though they have already been realised. It is important

to note that these indicators are suggestive only. As the Strategy takes shape and generates concrete actions and projects we will develop more specific performance indicators and the means to assess the extent to which they have been achieved. This will be the subject of a separate evaluation plan that will be developed for the Strategy further down the track.

Key Result Area 1

Better awareness and understanding of smoking risks among social service agencies and their staff

The issues

While social service agencies and their staff have a general knowledge of the health risks of smoking, most do not fully appreciate the disproportionate disease burden carried by socially disadvantaged groups due to tobacco use. Nor are most social service agencies and their staff completely aware of the ways in which smoking exacerbates disadvantage and contributes to poverty. This is understandable given that social service agencies are established to address a range of other serious and pressing issues that affect vulnerable groups. Evidence also suggests that, to a significant extent, smoking is still viewed as normative by social service workers, some of whom may personally smoke, including in their interactions with service users. A consequence is that the relationship between smoking and disadvantage is not fully understood, and the impact of smoking in maintaining and magnifying disadvantage is significantly underestimated.

Our response

Our objective in this Key Result Area will be to raise significantly the level of awareness and understanding in the social service sector of the health and social costs of smoking and its relationship to poverty and social disadvantage. We aim to demonstrate that smoking is an important issue for the professional practice of social services, and that tobacco control is an important social justice issue that warrants the sector's support and involvement. We aim to change the perception in some parts of the sector that smoking is normative or a relatively minor harm, and promote positive (non-smoking) practices within social services.

Key Result Area 1

Better awareness and understanding of smoking risks among social service agencies and their staff

Strategies

- 1.1** We will make presentations at conferences, seminars, and 'expos' conducted in the social service sector highlighting:
- The health risks and social costs of smoking
 - The disproportionate disease burden now carried by socially disadvantaged groups due to higher smoking incidence
 - The relationship between smoking and social disadvantage.
- 1.2** We will liaise with NCOSS, and other lead agencies in the social service sector, to convene a biennial conference, seminar or forum on tobacco control from a social justice perspective.
- 1.3** We will submit articles in social service sector newsletters, journals and magazines highlighting:
- The health risks and social costs of smoking
 - The disproportionate disease burden now carried by socially disadvantaged groups due to higher smoking incidence
 - The relationship between smoking and social disadvantage.
- 1.4** We will conduct professional briefings for senior staff of social service agencies highlighting:
- The health risks and social costs of smoking
 - The disproportionate disease burden now carried by socially disadvantaged groups due to higher smoking incidence
 - The relationship between smoking and social disadvantage.
- 1.5** We will offer these professional briefings in association with social service sector peaks and in interagency fora.
- 1.6** We will commission the development of a range of resources promoting tobacco control as a social justice issue and describing the relationship between smoking and social disadvantage. We will distribute these widely across the social service sector.

Key Result Area 1

Better awareness and understanding of smoking risks among social service agencies and their staff

1.7 We will provide or contribute to professional education highlighting the implications for practice of:

- The health risks and social costs of smoking
- The disproportionate disease burden now carried by socially disadvantaged groups due to higher smoking incidence
- The relationship between smoking and social disadvantage.

This will include our participation in Anti-Poverty Week, and similar events.

1.8 We will generate articles in the media that highlight:

- The health risks and social costs of smoking
- The disproportionate disease burden now carried by socially disadvantaged groups due to higher smoking incidence
- The relationship between smoking and social disadvantage.

Key Result Area 1

Better awareness and understanding of smoking risks among social service agencies and their staff

Indicators of success

We will know the Strategy has been effective if:

- Many staff of social service agencies have attended conference/seminar sessions where The Cancer Council NSW has outlined the health risks and social costs of smoking, the disproportionate disease burden now carried by socially disadvantaged groups, the relationship between smoking and social disadvantage, and the implications of this for professional practice.
- A large readership has been exposed to many articles The Cancer Council NSW has published in a wide variety of newsletters, journals and magazines across the social services sector. These describe the health risks and social costs of smoking, the disproportionate disease burden carried by socially disadvantaged groups, the relationship between smoking and social disadvantage, and the implications of this for professional practice.
- Many senior representatives of social service agencies have participated in face to face personal, sectorial, and cross sectorial briefings conducted by The Cancer Council NSW. These will have covered the health risks and social costs of smoking, the disproportionate disease burden carried by socially disadvantaged groups, the relationship between smoking and social disadvantage, and the implications of this for professional practice.
- A range of resources for the Strategy have been distributed across the social service sector highlighting tobacco control as a social justice and equity issue.
- The public at large has become much more aware of the health risks and social costs of smoking, the disproportionate disease burden carried by socially disadvantaged groups, the relationship between smoking and poverty and the implications of this for professional practice as a result of The Cancer Council NSW's public education efforts, including strategic articles in the media during Anti-Poverty Week and at other times.

Key Result Area 2

Building the capacity of social service agencies to contribute to tobacco control efforts

The issues

Tobacco control is not currently a priority among social service organisations. They are busy working with their clients to address pressing issues such as homelessness, mental health problems, domestic violence and child protection concerns. Our hope is that, as awareness of the potent relationship between smoking and disadvantage develops, interest in tobacco control as a way of addressing social disadvantage will also grow. That will require building capacity in social service agencies to implement tobacco control initiatives at a number of levels: in staff training, in organisational policy and in casework practice. It also requires, as with other social problems, interventions that are evidence-based and which operate across a continuum from prevention and early intervention to assisting the most chronic and heavy users with more intensive interventions.

Our response

Our objective in this Key Result Area is to assist social service agencies to build an internal organisational environment that is capable of supporting effective tobacco control interventions with service users. Our focus will be on the education of agency staff at all levels about the health risks and social costs of tobacco, and assisting agencies to develop strategic and operational policies that effectively respond to tobacco use. We will develop guidelines and 'tool kits' for casework interventions that will support socially disadvantaged service users to resist or quit smoking. We will also assist social service agencies to include tobacco control in their advocacy work. These measures will incorporate the principles of evidence-based primary health care.

Key Result Area 2

Building the capacity of social service agencies to contribute to tobacco control efforts

Strategies

- 2.1** We will develop prototype curricula for staff induction and in-service education and training about the health risks and social costs of tobacco, about the relationship between tobacco use and poverty, and about the implications of this for professional practice. We will assist social service agencies to incorporate these curricula into their own staff training programs. This will include support to tailor the curricula to each agency's particular circumstances, and to develop a strategic plan to provide for the initial and recurring education and training of all agency staff, including senior management staff.
- 2.2** We will develop a seminar/workshop curriculum for social service agencies on the principles of evidence-based practice and primary intervention frameworks for tobacco control. We will market this seminar/workshop across the social service sector. We will pitch advertising to attract managerial staff as well as front-line workers.
- 2.3** We will develop strategic and operational policy commitments that encompass best practice approaches to tobacco control at the agency and casework levels. We will encourage adoption of these policy commitments by social service agencies. We will offer and provide assistance to social service agencies to tailor these policy commitments, where necessary, to individual agency circumstances.
- 2.4** We will develop prototype guidelines for casework interventions that provide ethical and practical guidance for caseworkers working with service users who smoke. We will encourage adoption of these guidelines by social service agencies. We will offer and provide assistance to social service agencies to tailor these guidelines, where necessary, to individual agency circumstances.
- 2.5** We will develop a prototype casework tool kit that provides ethical and practical guidance to caseworkers aimed at equipping them to effectively respond to service-user smoking. We will encourage adoption of this tool kit by social service agencies. We will offer and provide assistance to social service agencies to tailor this tool kit, where necessary, to individual agency circumstances.

Key Result Area 2

Building the capacity of social service agencies to contribute to tobacco control efforts

Indicators of success

We will know the Strategy has been effective if:

- Staff from many social service agencies have attended staff induction or in-service education training developed by The Cancer Council NSW about the health risks and social costs of tobacco, and the relationship between tobacco use and social disadvantage. A quarter of participants will have been at the level of first tier operational manager and above. As a result, there will be substantial changes in agency and sector perceptions of tobacco use and an increase in internal and external tobacco control activity.
- Staff from many agencies have attended education and training developed and provided by The Cancer Council NSW on evidence-based practice and primary intervention frameworks for tobacco control. A quarter of participants will have been at the level of first tier operational manager or above. This has contributed to the incorporation of an evidence-based approach, and primary intervention framework, in tobacco control initiatives.
- Social service agencies have adopted strategic and operational frameworks that incorporate tobacco control measures. These policy frameworks are tailored to individual agency requirements and may cover issues such as:
 - A commitment to educate and train all staff on the health risks and social costs of tobacco, and the relationship between tobacco use and poverty.
 - The establishment of smoke-free workplaces covering all premises owned or operated by the agency, and smoke-free services and functions of the agency.
 - Assistance for employees who smoke, for example, providing free nicotine replacement therapy and free access to counselling for employees as a component of employee assistance programs.
 - A commitment to provide service users with active assistance to resist or quit smoking, for example, distributing free nicotine replacement therapy and facilitating free access to counselling.

Key Result Area 2

Building the capacity of social service agencies to contribute to tobacco control efforts

- A commitment to collect and report data on workforce and service user smoking rates, and to monitor smoking prevalence in these groups over time.
- A commitment to making a decline in the prevalence of workforce and service user smoking over time a key performance indicator for managerial staff.
- A commitment to ethical investment that precludes investment of agency capital in the tobacco industry.
- A commitment to social advocacy for tobacco control.
- Social service agencies have adapted to their specific circumstances and implemented 'prototype' casework guidelines and 'tool kit' resources developed by The Cancer Council NSW that provide practical guidance and support for staff working with service users who smoke.

Key Result Area 3

Better awareness and understanding of smoking risks among socially disadvantaged population groups

The issues

While the population as a whole has become more aware of the health impacts of tobacco use there is also evidence that, in general, smokers tend to under-estimate the health risks of smoking. This is even more likely to be the case among the most disadvantaged smokers who may have lower levels of education and literacy or may face other problems that limit their capacity to fully comprehend the dangers of smoking. The most disadvantaged smokers may consider current problems as more pressing and view health issues as a matter for the distant future. Despite these barriers we know that concerns about health provide the most common motivation to quit smoking. For this reason it is vital to make accurate, engaging and persuasive health risk information available to the most disadvantaged groups. This will require developing or making better use of existing resources that present information about smoking in a way that is culturally or service user-group appropriate and communicates well with the intended audience. Gaining consumer input and advice in this process will be vital.

Our response

Our objective in this Key Result Area will be to develop education and information products that explain the health risks and social costs of smoking, and which are tailored to meet the communication needs of specific population groups. Such education and information products will generally be developed and used alongside other tobacco control and smoking cessation initiatives, consistent with the evidence that print material on its own is unlikely to be effective. We will assess what current resources are available and adapt them as required, as well as developing new resources where there is a clear gap or need. In developing new education and information products we will consult with tobacco control experts as well as consumers and organisations that represent the intended target groups. We will also work with others to plan how best to disseminate the material so it reaches those target groups.

Key Result Area 3

Better awareness and understanding of smoking risks among socially disadvantaged population groups

Strategies

- 3.1** We will commission the development of tailored education and information products for specific very disadvantaged groups from specialist education and information providers.
- 3.2** We will ensure that expert advice from user group representatives is enlisted in the development and testing of these education and information products.
- 3.3** We will incorporate these education and information products in the action research projects with partner agencies to be undertaken pursuant to Key Result Area 4 of this Strategy.
- 3.4** We will evaluate the effectiveness of these education and information products in increasing understanding of the consequences of smoking, the benefits of quitting and changed attitudes to smoking in targeted population groups, and incorporate any modifications suggested by such evaluations.
- 3.5** We will make representations to NSW Health to assume responsibility for the ongoing development and broad-based distribution of these population group specific education and information products.
- 3.6** We will make representations to NSW Health to develop and distribute specific education and information products for additional population groups.
- 3.7** We will raise awareness of the need for tailored education and information products for specific population groups within the social services sector, and seek the sector's assistance in representations to NSW Health to develop such products.

Key Result Area 3

Better awareness and understanding of smoking risks among socially disadvantaged population groups

Indicators of success

We will know the Strategy has been effective if:

- A select number of population group specific education and information products about the health risks and social costs of smoking have been developed and distributed by The Cancer Council NSW through a wide variety of health and social service sector agencies that work with those groups.
- Input and advice from individuals and groups representing the target population has been sought and has shaped the development and distribution of the resources.
- These education and information products, particularly when combined with other elements of the Strategy, have contributed to increased awareness of the risks of smoking and change in individuals' attitudes to smoking.
- There is strong and compelling evidence about the effectiveness of these education and information products in raising awareness and contributing to changed attitudes to smoking, to underpin representations to NSW Health for their production and distribution and to commission further products aimed at additional socially disadvantaged population groups.
- The NSW social service sector has been an active and influential ally in efforts to secure these objectives.

Key Result Area 4

Action-research to identify practical strategies to support tobacco control in specific population groups

The issues

Although the higher prevalence of tobacco use, and the consequent disproportionate disease burden carried by socially disadvantaged population groups have been sufficiently demonstrated to warrant immediate action, there has been surprisingly little research into the type of interventions that will assist specific socially disadvantaged population groups to resist or quit smoking. There is therefore a very limited evidence base to assist in the development of more effective tobacco control measures for these groups.

Our response

Our objective in this Key Result Area is to conduct action-research to identify those practical strategies that will assist socially disadvantaged smokers to resist and quit smoking. We will achieve this by conducting, on a time-limited basis, a number of small-scale intensive tobacco control programs for specific population groups in partnership with social service agencies. These pilots will establish base-line smoking rates in particular sub-population groups (through tailored data collection), introduce a range of tobacco-control strategies, including education and information products, counselling and support, and access to pharmacotherapies such as nicotine replacement therapy. We will evaluate the effectiveness of these pilot projects and incorporate findings into broader based and mainstream public health programs.

Key Result Area 4

Action-research to identify practical strategies to support tobacco control in specific population groups

Strategies

- 4.1** We will undertake an action-research pilot project to identify those strategies that will be most effective in achieving a substantial reduction in smoking rates in a selected Aboriginal population group. We will conduct this trial in partnership with the selected population group and social service agencies highly skilled in working with Aboriginal communities including at least one indigenous controlled organisation.
- 4.2** We will undertake an action-research pilot project to identify those strategies that will be most effective in achieving a substantial reduction in smoking rates among vulnerable young persons. We will conduct this trial in partnership with representatives of vulnerable young persons and a social service agency highly skilled in working with vulnerable young persons and their support networks.
- 4.3** We will conduct an action-research pilot project to identify those strategies that will be most effective in achieving a substantial reduction in smoking rates among persons with psychiatric disability. We will conduct this trial in partnership with representatives of residents, and social service agencies working with this group.
- 4.4** We will conduct briefings for relevant government officials and non-government health and social service sector agencies on the findings of these pilot projects.
- 4.5** Subject to the success of the pilot projects, we will make representations to the NSW Health Minister, NSW Health, and other relevant politicians and health and social service agencies to incorporate the findings of these pilot projects into broad-based public health and social service programs.
- 4.6** Subject to the success of the pilot projects, we will make representations to the NSW Health Minister, NSW Health, and other relevant politicians and officials seeking to secure a commitment for a Government funded innovative grants program from which to fund further initiatives of this nature for other population groups.

Key Result Area 4

Action-research to identify practical strategies to support tobacco control in specific population groups

Indicators of success

We will know the Strategy has been effective if:

- A strong evidence-base of practical strategies to assist socially disadvantaged smokers has been developed through strategic action-research.
- These strategies have been widely communicated across the health and social service sectors.
- These strategies have been incorporated into broad-based public health policy and programs.
- Various social service agencies convinced about the relationship between tobacco use and social disadvantage and the accumulating evidence about what works to reduce smoking related harm among disadvantaged groups, have sought to engage with The Cancer Council NSW and other potential sponsoring bodies in similar projects focused on different population groups.
- There is strong and compelling evidence about the effectiveness of action-research to contribute to new knowledge and positive outcomes in tobacco control for disadvantaged populations to underpin representations to Government to establish an innovative grants program to fund such initiatives.

Key Result Area 5

Better smoking cessation support for low income and socially disadvantaged groups

The issues

Research shows that quit rates vary according to socio-economic status, with the most disadvantaged having the lowest quit rates. The reasons for the difference in quit rates is not well understood. However, it plausibly results from a combination of having less access to smoking cessation supports and also the presence of factors that either act as additional barriers to quitting or reinforce smoking for the most disadvantaged. The former may include factors like lack of transport, difficulties engaging with telephone services (for cultural and language reasons) and the prohibitive cost of nicotine replacement therapy. The latter includes the prevalence of smoking among family, friends and the local community, the stressful nature of current circumstances for which smoking is believed to provide some relief, (despite contrary evidence) and the sheer lack of attractive and affordable alternatives to smoking. Taken together, these factors highlight the need to do more to provide cessation supports that are effective, available and accessible for the most disadvantaged groups. This approach is consistent with both the *National Tobacco Strategy 2004-2009*, which advocates putting extra effort into reaching groups among whom the burden of tobacco related disease and disadvantage is high, and the *NSW Tobacco Action Plan 2005-2009*, which identifies similar priority sub groups as this Strategy.

Our response

Our objective in this Key Result Area will be to increase significantly the availability and effectiveness of cessation supports for socially disadvantaged groups. These will include brief intervention, counselling and group work support as well as access to affordable pharmacotherapies such as nicotine replacement therapy. It will also include supporting and facilitating the use of existing resources such as the Quitline, by social service agencies and their service users. We aim to identify, through consultation with our partners, effective interventions for particular disadvantaged groups and to promote their dissemination through a range of outreach strategies undertaken in partnership with social service agencies. Where knowledge about what works is very limited or inconclusive we will aim to find out what interventions or combinations of interventions are more effective with specific groups by implementing and evaluating some pilot projects. If successful in these pilots, we will make representations for Government commitment to develop and fund projects of this type across NSW for a range of socially disadvantaged groups.

Key Result Area 5

Better smoking cessation support for low income and socially disadvantaged groups

Strategies

- 5.1** We will raise awareness of the need for better cessation support for low income and socially disadvantaged smokers within the social service sector and seek the sector's assistance in representations to NSW and Federal Health Ministers, other relevant parliamentarians, and health agencies to develop such products.
- 5.2** We will engage in consultation with both tobacco control and smoking cessation experts and social service agencies to determine best practice for the above initiatives and for cessation services for the most disadvantaged groups generally.
- 5.3** Subject to the results of an evaluation of the effectiveness of pilot projects, we will make representations to the NSW Government and health agencies to develop and fund a range of smoking cessation intervention services for socially disadvantaged smokers.
- 5.4** We will make representations to NSW and Federal Health Ministers, other relevant parliamentarians, and health agencies calling for a range of pharmacotherapies, including nicotine replacement therapy, to be made available on a no or very low cost basis to socially disadvantaged groups.
- 5.5** We will make representations to NSW and Federal Health Ministers, other relevant parliamentarians, and health agencies calling for the introduction of cessation programs for socially disadvantaged population groups that include the distribution of a range of no or low cost pharmacotherapies, including nicotine replacement therapy, through a wide range of government and non-government service outlets across the health and community service sectors.
- 5.6** We will negotiate with NSW Health to provide free pharmacotherapies, including nicotine replacement therapy, for use in the action research projects proposed under Key Result Area 4 of this Strategy.

Key Result Area 5

Better smoking cessation support for low income and socially disadvantaged groups

Indicators of success

We will know the Strategy has been effective if:

- There is a strong body of evidence compelling the Federal and New South Wales Governments, through their respective health authorities, to introduce cessation programs for socially disadvantaged groups. These embrace brief intervention and more intensive cessation counselling as well as making available a range of affordable pharmacotherapies, including nicotine replacement therapy through a wide variety of government and non-government service outlets across the health and community service sectors.
- The NSW Government has provided a range of pharmacotherapies at no or low cost, including nicotine replacement therapy, for use in the action research projects proposed under Key Result Area 4 of this Strategy.
- The NSW Government, at the Area Health Service level, has agreed to develop and fund a range smoking cessation interventions for very disadvantaged smokers as a result of the action-research projects proposed under Key Result Area 4 of this Strategy.
- The NSW social service sector was an active and influential ally in efforts to secure these objectives.

Key Result Area 6

Fostering harm limiting behaviour among socially disadvantaged smokers

The issues

It is unrealistic to expect all socially disadvantaged smokers to be willing or capable of quitting smoking, even in circumstances where they better understand the health risks, and even if more effective smoking cessation support services are in place. Some people will be unable to overcome their pharmacological and psychosocial dependence on smoking, while others may find it too difficult to forego the emotional and social role that smoking plays in their lives. However, these individuals may be willing to change their behaviour in ways that can limit the harm caused by their smoking both to themselves and others.

Our response

Our objective in this Key Result Area will be to articulate harm limiting strategies that might be adopted by socially disadvantaged smokers. We will then develop information and education products that will inform socially disadvantaged smokers, and those health and social services that engage with them, about these strategies, and encourage their utilisation. The use of nicotine replacement therapy for nicotine maintenance purposes as an alternative to smoking is one example we will explore.

Key Result Area 6

Fostering harm limiting behaviour among socially disadvantaged smokers

Strategies

- 6.1** We will identify and document a range of harm limiting behaviours that might be adopted to reduce the harm caused by both direct and passive smoking.
- 6.2** We will tailor advice about these harm limiting behaviours to specific population groups where necessary and appropriate.
- 6.3** We will commission the development of a series of information and education products designed to promote harm limiting behaviour among socially disadvantaged smokers. These products will be developed in relation to at least the following priority groups:
- In-home workers who work in environments where occupants or visitors use tobacco.
 - Unborn children whose parents, other relatives, and their associates use tobacco.
 - Children and young people whose parents, relatives, other adult caregivers, and their associates use tobacco.
 - Adults in a carer relationship where either the person caring or being cared for uses tobacco.
 - Persons with respiratory conditions whose relatives and associates may use tobacco.
- 6.4** We will raise awareness among social service agencies of the benefits of smokers adopting harm limiting behaviour for their own and others' benefit. We will seek their commitment to introduce information and education strategies about harm limiting behaviours into casework interventions with socially disadvantaged smokers.
- 6.5** We will examine the use of nicotine replacement therapy as one harm limiting strategy among smokers for whom other smoking cessation strategies are ineffective.

Key Result Area 6

Fostering harm limiting behaviour among socially disadvantaged smokers

Indicators of success

We will know the Strategy has been effective if:

- A broad range of harm limiting strategies has been articulated and communicated to socially disadvantaged smokers and the social service sector through a range of media. As a result, there has been a significant reduction in the level of health risk, including from environmental tobacco smoke, to particularly at risk groups, which include:
 - In-home workers who work in environments where occupants or visitors use tobacco.
 - Unborn children whose parents, other relatives, and their associates use tobacco.
 - Children and young people whose parents, relatives, other adult caregivers, and their associates use tobacco.
 - Adults in a carer relationship where either the person caring or being cared for uses tobacco.
 - Persons with respiratory conditions whose relatives and associates may use tobacco.

Key Result Area 7

Better integration of tobacco control into responses to social disadvantage

The issues

A key factor in the lack of attention to tobacco control for socially disadvantaged groups is that smoking is typically seen as a minor or less urgent harm that does not warrant priority action. There are various reasons for this. Social services may be overwhelmed by demand for existing programs, and feel incapable of taking on what they may perceive as an additional responsibility or function. In the face of urgent and serious issues, agencies may resent the suggestion that focus and resources should be extended to a perceived secondary or low priority issue such as smoking. Agencies may view tobacco control as outside their role and function, and be concerned that funding bodies will not permit them to work in this area. In part, this problem arises because many agencies appear to believe that tobacco use is an issue that is separate and distinct from social disadvantage, and that 'stand-alone' programs and services must respond to it. However, tobacco is intertwined with social disadvantage and is not separate from it. While smoking may not appear to present with the immediacy and urgency of issues such as unemployment, homelessness and domestic violence, its longer-term effects can be as severe. Additionally, smoking typically has an unrecognised 'present' serious impact that can both cause and exacerbate acute social stress. Income spent on tobacco instead of necessities may be a significant contributing factor to financial and personal stress that results in further problems. The ill-health caused by smoking may also create additional barriers to employment. While it is true that specific initiatives are also required to address tobacco use among socially disadvantaged population groups, it must also be recognised that tobacco control strategies and resources can be better integrated into existing social services as an important additional means to improve the well-being of targeted groups in the short and longer term. This will better enable the access of disadvantaged people who want to resist or quit smoking to support when they need it. The *National Tobacco Strategy 2004-2009* strongly supports the inclusion of measures to reduce tobacco use in State and Federal government initiatives to support children, families and communities.

Our response

Our objective in this Key Result Area will be to articulate the ways in which tobacco control concerns can and ought to be better connected to existing and future programs and responses to social disadvantage.

Key Result Area 7

Better integration of tobacco control into responses to social disadvantage

Strategies

- 7.1** We will discuss with the Australian and New South Wales Governments, in consultation with service providers, how better to connect tobacco control measures and smoking cessation supports and resources to existing government funded programs that target groups at higher risk of smoking related harm so that those who want to resist or quit smoking can get access to support in a timely manner.
- 7.2** We will seek discussion with major social service providers regarding the integration of tobacco control measures and access to smoking cessation supports and resources into agency level strategic policy, staff education and service delivery.
- 7.3** We will highlight the positive impact of integrating tobacco control measures and provision of smoking cessation supports into responses to social disadvantage in representations to Ministers and other parliamentarians, to the health and social service sectors, and to the public generally, in an effort to motivate action in this area.

Key Result Area 7

Better integration of tobacco control into responses to social disadvantage

Indicators of success

We will know the Strategy has been effective if:

- The Federal and New South Wales Governments have promoted better connections between tobacco control measures and human services programs directed to groups at higher risk of smoking related harm.
- Major service providers have integrated tobacco control measures, including assistance for smoking cessation, into their responses to social disadvantage at the strategic policy, program development, service delivery and individual case-work levels.

Key Result Area 8

A better evidence-base in relation to tobacco control and social disadvantage

The issues

Although there is a significant body of smoking prevalence information available for specific socially disadvantaged groups, this information is incomplete and discontinuous in many instances. Ongoing research is required to establish reliable prevalence rates in specific population groups, and to measure prevalence rate variations over time. We also need better knowledge about those factors that lead to the take-up, maintenance and cessation of smoking among different socially disadvantaged groups and more generally, greater understanding of the complex and multifaceted relationship between tobacco use and social disadvantage. There is also a very specific clinical issue concerning the claimed therapeutic effects of tobacco use on psychiatric symptoms and medication, which we need to understand better.

Our response

Our objective in this Key Research Area is to promote publicly funded data-collection, research and reporting that will provide better information about prevalence of tobacco use among socially disadvantaged population groups over time. As part of this we will examine the need for smoking prevalence monitoring strategies for specific segments of the population e.g. people with a mental illness. We will also promote, and in specific cases commission directly, research that will assist us to better understand the relative effectiveness of different approaches and strategies on tobacco control for socially disadvantaged population groups, and the complex relationship between tobacco use and social disadvantage. This will include a review of the evidence regarding the relationship between smoking and mental illness, particularly the effects of smoking on psychiatric symptoms and medications, and consideration of options for non-toxic alternatives.

Key Result Area 8

A better evidence-base in relation to tobacco control and social disadvantage

Strategies

- 8.1** Together with key stakeholders and expert informants, we will investigate and test options for improving the availability of reliable and replicable data on smoking prevalence within specific disadvantaged populations.
- 8.2** We will make representations to the NSW Government seeking to secure a commitment that NSW public authorities will collect data on the prevalence of tobacco use, as a mandatory element of all client information and profiling for NSW administered health and social services. Additionally, we will seek to secure a commitment to the public reporting of this data at intervals of not more than 3 years.
- 8.3** We will make representations to the NSW Government seeking to secure a commitment to the commissioning and reporting of quantitative and qualitative research into the prevalence of tobacco use among specific socially disadvantaged population groups.
- 8.4** We will commission directly and report on quantitative and qualitative research into the prevalence of tobacco use among specific socially disadvantaged groups to address identified research gaps, where such research will assist in demonstrating the need for tobacco control measures for this group.
- 8.5** We will develop a priority research agenda for tobacco use and social disadvantage and in partnership with appropriate academics, seek funding to address identified gaps in research knowledge.
- 8.6** We will institute a review of evidence regarding the impact of tobacco use on psychiatric symptoms and medications, and investigate alternatives to any therapeutic effect that tobacco use may have on such symptoms.

Key Result Area 8

A better evidence-base in relation to tobacco control and social disadvantage

Indicators of success

We will know the Strategy has been effective if:

- There are feasible models for collecting reliable and replicable data on smoking prevalence amongst disadvantaged populations, which we can recommend to NSW public authorities as a way to consistently report the prevalence of tobacco use among socially disadvantaged population groups at periods of not greater than 3 years. This provides clear evidence of the efficacy of current tobacco control measures for these groups.
- There is a strong and growing body of evidence on the relative effectiveness of different approaches and strategies for tobacco control in relation to socially disadvantaged population groups. This has improved significantly the efficacy of tobacco control measures for these groups.
- There is a strong and growing body of evidence on the multifactorial relationship between tobacco use and social disadvantage. This has significantly strengthened support for tobacco control across the government, tobacco control, and social service sectors.
- The impact of tobacco on psychiatric symptoms is better understood and non-toxic alternatives have been identified and are widely promoted and utilised within the mental health sector. This has contributed to a decline in smoking rates among persons with psychiatric disability.

Key Result Area 9

Supporting policy and legislative initiatives to address social disadvantage and enhance tobacco control

The issues

There are a number of population level initiatives that can contribute to reducing smoking levels and preventing the uptake of smoking. These include strategies on pricing, promotion and availability of tobacco products as well as regulatory steps to limit smoking. The regulation of tobacco use in public places and work places has had a significant positive impact in reducing tobacco use. There are many valuable effects of this regulation - it not only reduces smoking rates among individuals in public places and work places, it also reduces the impact on others of environmental tobacco smoke, and it helps lessen the perception of tobacco smoking as 'normal' social behaviour. Recent restrictions on tobacco use in enclosed areas of pubs and clubs are a good example. However, there remains a great deal to be achieved in terms of the regulation of public out-door areas, and all workplaces, to make them tobacco free.

However, in order to reduce health inequalities, including those associated with tobacco use, we must not focus exclusively on the individual and environmental influences on the problem. We must also address the structural factors, such as employment, poverty, housing and education which lead to entrenched disadvantage in the first place and which then contribute to high smoking rates among some groups and lead to the sort of health inequalities we are trying to prevent. In other words, as the *National Tobacco Strategy 2004-2009* expresses it, we have to address the social, economic and cultural determinants of health.

Our response

Our objective in this Key Result Area will be to continue to address the environmental factors that contribute to tobacco use and tobacco related harm. This will include continued action to address smoking in public places, further reduce the availability of tobacco and eliminate all remaining forms of tobacco promotion. In addition, we will lend our active support to the policy initiatives of social service agencies that seek to address and/or ameliorate the underlying causes of disadvantage. This will include support for policies to improve education, employment and housing of the most disadvantaged as well as initiatives aimed at strengthening families and communities. Such an approach is consistent with strategies advocated in the *National Tobacco Strategy 2004-2009*.

Key Result Area 9

Supporting policy and legislative initiatives to address social disadvantage and enhance tobacco control

Strategies

- 9.1** We will make representations to NSW parliamentarians seeking to secure a commitment to legislation to eliminate environmental tobacco smoke in outdoor venues.
- 9.2** We will make representations to NSW parliamentarians seeking to secure a commitment to legislation to ensure genuinely smoke free workplaces.
- 9.3** We will raise awareness within the social services sector of the need for better regulation of tobacco, and seek the sector's assistance in representations to NSW parliamentarians about this issue.
- 9.4** We will continue to advocate for tighter regulation of tobacco, including the promotion, pricing and availability of tobacco products.
- 9.5** We will raise awareness within the social services sector of the benefits to socially disadvantaged groups from tighter regulation of tobacco , and seek the sector's assistance in representations to relevant parliamentarians and service delivery and enforcement agencies to secure such regulation.
- 9.6** We will contribute to the NCOSS pre-budget submission by highlighting the relationship between tobacco use and social disadvantage and calling for initiatives to address smoking among disadvantaged groups.
- 9.7** Where possible and appropriate we will support the social policy and advocacy initiatives of our community service partners, which are designed to address the social causes of disadvantage.
- 9.8** We will incorporate knowledge and evidence in relation to smoking prevalence, the impacts of smoking and effective interventions to reduce smoking related harm among the most disadvantaged, into the ongoing policy and advocacy work of The Cancer Council NSW.

Key Result Area 9

Supporting policy and legislative initiatives to address social disadvantage and enhance tobacco control

Indicators of success

We will know the Strategy has been effective if:

- New policy and legislative initiatives in tobacco control have been enacted that address the environmental factors that contribute to tobacco-related harm, and impacts on smokers in a way that addresses equity.
- The NSW social service sector was an active and influential ally in efforts to secure better regulation of tobacco.
- The Cancer Council NSW has actively supported social policy initiatives from peak community service agencies seeking to address the underlying causes of disadvantage that inevitably lead to health inequities.

References

1. Collins DJ, Lapsley HM. Counting the cost: estimates of the social cost of drug abuse in Australia in 1998-1999. Canberra: National Drug Strategy Monograph Series, No 49, Commonwealth Department of Health and Ageing; 2002.
2. Ministerial Council on Drug Strategy. National Tobacco Strategy, 2004-2009: The Strategy. Canberra: Australian Government Department of Health and Ageing; 2005.
3. Wilkinson R, Marmot M, editors. Social determinants of health: the solid facts. World Health Organisation; 2003.
4. Carter S, Borland R, Chapman S. Finding the strength to kill your best friend – smokers talk about smoking and quitting. Sydney: Australian Smoking Consortium and GlaxoSmithKline Consumer Health Care; 2001.
5. Baker A, Ivers RW, Bowman J, Butler T, Kay-Lambkin FJ, Wye P, et al. Where there's smoke, there's fire: high prevalence of smoking among some sub-populations and recommendations for intervention. *Drug and Alcohol Review* 2006 25: 85-96.
6. Public Health Division. The Health of the people of New South Wales- Report of the Chief Health Officer. Sydney: NSW Department of Health; 2004.
7. NSW Department of Health. NSW Tobacco Action Plan 2005-2009. North Sydney: NSW Department of Health; 2005.
8. Siahpush M, Borland R, Scollo M. Prevalence and socio-economic correlates of smoking among lone mothers in Australia. *Australian and New Zealand Journal of Public Health* 2002; 26: 36-39.
9. Australian Institute of Health and Welfare. Statistics on drug use in Australia in 2002. Canberra: Drug Statistics Series No. 12, AIHW; 2003.
10. Sweet M. High smoking rates among Aboriginal community cause financial hardship. *British Medical Journal* 2002; 324 (7349): 1296.
11. Ministerial Council on Drug Strategy. National tobacco strategy, 2004-2009, meeting the challenges of the next five years supporting documents. Canberra: Australian Government Department of Health and Ageing; 2005.
12. Gilliland FD, Berhane K, Islam T, Wenten M, Rappaport E, Avol E, et al. Environmental tobacco smoke and absenteeism related to respiratory illness in school children. *American Journal of Epidemiology* 2003; 157 (10): 861-869.

- 13.** US Department of Health and Human Services. The health consequences of smoking: what it means to you. Atlanta: National Center for Chronic Disease Prevention and Health Promotion; 2004.
- 14.** Tobias M, Cheung J. Inhaling inequality: tobacco's contribution to health inequality in New Zealand. Wellington: Public Health Intelligence, Occasional Bulletin No 7, Ministry of Health; 2001.
- 15.** Siahpush M, Borland R, Scollo M. Smoking and financial stress among Australian Households. *Tobacco Control* 2003; 12: 60-66.
- 16.** Siahpush M, Borland R, Scollo M. Is household smoking status associated with expenditure on food at restaurants, alcohol, gambling and insurance? Results from the 1998-99 Household Expenditure Survey, Australia. *Tobacco Control* 2004; 13: 409-414.
- 17.** Hill D, Borland R. Adults' accounts of onset of regular smoking: influences of school, work and other settings. *Public Health Reports* 1991; 109: 181-185.
- 18.** Marsh A. Tax and spend: a policy to help poor smokers. *Tobacco Control* 1997; 6: 5-6.
- 19.** Trotter L, Mullins R, Boulter J, Borland R. Key findings of the 1996 and 1997 household studies. In Trotter I, Mullins R, editors. *Quit Evaluation Studies Number 9*. Melbourne: The Anti-Cancer Council of Victoria; 1998.

Appendix A

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