



# Clearing the smoke

**Best practice smoking cessation strategies  
for people with multiple disadvantages**

---

**Clearing The Smoke: Best practice smoking cessation strategies for people with multiple disadvantages** was produced as a resource for the Tackling Tobacco program, a project of Cancer Council NSW.

Tackling Tobacco is a free program for not-for-profit community sector organisations, which aims to reduce smoking-related harm among priority population groups with high smoking rates in NSW. Through the program, Cancer Council NSW supports community service organisations to address smoking and provide clients and staff with the support they need to quit.

The priority population groups for the program include:

- ▶ At risk young people
- ▶ Low income families
- ▶ Aboriginal and Torres Strait Islanders
- ▶ People with severe mental illness
- ▶ People with drug and alcohol dependencies
- ▶ People experiencing homelessness
- ▶ Other groups with high smoking prevalence

ISBN 9781921041754

**Suggested citation:**

*Cancer Council NSW. Clearing the smoke: Best practice smoking cessation strategies for people with multiple disadvantages.*  
Sydney: Cancer Council NSW; 2016.

Any enquiries about or comments on this publication should be directed to:

Tackling Tobacco program  
Cancer Council NSW  
153 Dowling Street  
Woolloomooloo NSW 2011

**Phone:** (+61 2) 9334 1911

**Email:** [tacklingtobacco@nswcc.org.au](mailto:tacklingtobacco@nswcc.org.au)

**Web:** [www.cancercouncil.com.au/tacklingtobacco](http://www.cancercouncil.com.au/tacklingtobacco)

---

---

# Contents

<b>Acknowledgements</b>	<b>2</b>
<b>1. Snapshot of key research findings</b>	<b>3</b>
<b>2. Smoking and disadvantage</b>	<b>5</b>
<b>3. What strategies were used?</b>	<b>6</b>
<b>4. What were the results?</b>	<b>7</b>
<b>5. What makes an effective cessation strategy?</b>	<b>9</b>
<b>6. Implications for health and welfare organisations</b>	<b>11</b>
<b>7. Find out more</b>	<b>13</b>
<b>References</b>	<b>14</b>

---

---

# Acknowledgements

This publication was written by the Tobacco Control Unit of Cancer Council NSW.

Information contained in this document is based on two literature reviews commissioned by the Cancer Council NSW:

- Wise M, Hickey K, Palmer J. Taking action: A review of the literature on smoking cessation programs among six special populations. Tackling Tobacco Program Research Series Number 2. Sydney: Cancer Council NSW; 2008.
- Ragg M, Ahmed T. Smoke and mirrors: A review of the literature on smoking and mental illness. Tackling Tobacco program Research Series Number 1. Sydney: Cancer Council NSW; 2008.

In addition, all information in this document was reviewed and updated in 2016 by Cancer Council NSW.

We acknowledge the work of the Commonwealth Government's National Tobacco Strategy 2012 to 2018 and would also like to thank the many people who contributed to this work and commented on the drafts for this document.

---

# 1. Snapshot of key research findings<sup>1,2</sup>

## Smoking and social disadvantage

- ▶ People who experience chronic or multiple forms of disadvantage are much more likely to smoke as compared to people in the general community.
- ▶ Smoking rates in disadvantaged groups are generally higher than for the general population, and have been reported as high as 88% in some groups.
- ▶ Many smokers in disadvantaged groups are aware of the negative consequences of smoking, would like to quit smoking and have made attempts to quit.
- ▶ Smokers who experience discrimination in other areas of their lives can also experience discrimination in relation to giving up smoking. For example, health professionals routinely advise patients to quit smoking and yet some believe that smoking is beneficial to people with mental illness and discourage them from quitting.
- ▶ Services that work with disadvantaged groups have great potential to help reduce smoking. To realise this potential requires making support for quitting smoking a part of routine service and care.

## Elements of effective interventions

- ▶ Best practice approaches that work with smokers in the general community are likely to be successful with those in disadvantaged groups. However, interventions need to be adapted to address the particular needs and circumstances of each group.
- ▶ The most effective interventions commonly include a combination of counselling (individual or group) and nicotine replacement therapy (NRT). More intensive interventions are generally more successful, and offering a supportive environment is also important.
- ▶ Having people from the same cultural background or target population involved in the development and delivery of the program can be important for some groups.
- ▶ People are more likely to attempt to give up smoking if they believe they can be successful. Effective interventions help build confidence in a person's ability to quit.



---

## Measuring success

- ▶ There are two parts to quitting: making a quit attempt, and remaining a non-smoker long term despite urges to start smoking again.
- ▶ It takes several quit attempts to successfully stop smoking. The more quit attempts a person makes, the more likely they are to be able to stop smoking for the long term.
- ▶ Quit rates (such as the number of people who have stopped smoking 12 months after the intervention) are the most commonly reported measure of effectiveness in published studies but may not be the most useful for small programs.
- ▶ Other success measures include reduction in smoking, changed attitude to smoking, increases in quit attempts and increased confidence that quitting is possible.
- ▶ The drop-off in quit rates over time can be caused by a number of factors, including the impact of the smoker's environment on their smoking behaviour.
- ▶ While the reported quit rates appear to be small in some of the studies reviewed, most were comparable with results achieved using similar interventions in the general community.
- ▶ Low success rates can be demotivating for organisations running quit smoking programs. It is important to have realistic expectations and to celebrate small successes.
- ▶ There may be a delayed effect of an intervention, with participants who had not quit smoking at the end of the intervention initiating their own quit attempts at a later time.

## The role of service providers

- ▶ Providing an environment which is supportive of non-smoking enhances the effectiveness of interventions by presenting a consistent message and reducing opportunities for relapse.
- ▶ Many health and welfare organisations do not have a formal policy on smoking cessation and do not provide quit smoking interventions as part of their routine service or casework.
- ▶ The negative attitudes of some health and welfare professionals can be a major barrier to quitting for smokers in marginalised groups.
- ▶ Health and welfare services have great potential to help their clients quit smoking. Programs that have regular and frequent contact with clients and help them with a range of issues provide an ideal setting for quit programs.
- ▶ Health and welfare professionals say they need support and training to adapt and deliver 'best practice' quit smoking interventions with smokers in disadvantaged groups.

# 2. Smoking and disadvantage

Over the last 30 years, smoking rates in Australia have fallen significantly. Today less than 13% of people in the general community are daily smokers.<sup>3</sup>

However, these good results have not been shared across the whole community.

People who experience significant disadvantage in their lives continue to smoke at rates sharply higher than the rest of the community.<sup>4</sup> As a result, they also bear the largest burden of tobacco-related harm, both in direct and indirect costs to health and material wellbeing.

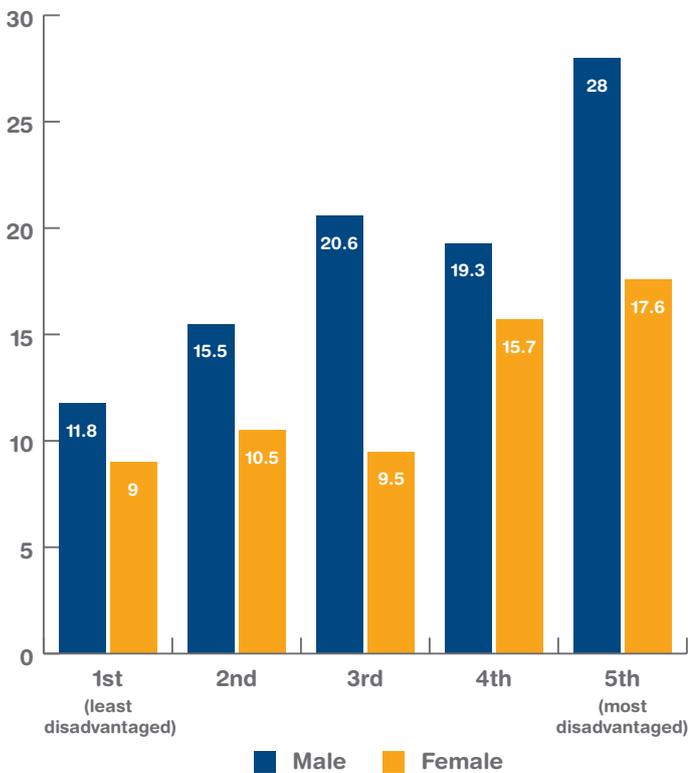
Despite the success of public education campaigns and legislation to regulate smoking, the gap in smoking rates between the most disadvantaged and the least disadvantaged in our community has not closed.

Looking at the rates among severely disadvantaged populations, the difference in smoking prevalence is even greater. In Australia, smoking rates are highest among the following groups:

- Aboriginal and Torres Strait Islander people ..... 32%<sup>5</sup>
- People experiencing homelessness ..... 83%<sup>6</sup>
- People with a mental illness ..... 20–90%<sup>2</sup>
- People with drug and alcohol problems ..... 51–91%<sup>2</sup>
- Young people ‘at risk’ ..... 65%<sup>7</sup>
- Single mothers ..... 46%<sup>8</sup>

To encourage and support people in these groups to quit smoking, it is crucial to develop sustained and systematic strategies that have a strong evidence base and take account of the particular barriers they face in quitting smoking.

**Percentage current daily or occasional smoking by socioeconomic disadvantage, persons aged 16 years and over, NSW, 2014**



Source: New South Wales Population Health Survey 2014 (HOIST), NSW Department of Health

## Literature reviews on smoking cessation

In 2007 Cancer Council NSW commissioned two reviews of the available peer-reviewed and published research on quit smoking programs among significantly disadvantaged populations.

The Australian Centre for Health Promotion at the University of Sydney focused on programs run with communities of low-income lone parent families, Aboriginal and Torres Strait Islander people, at-risk adolescents, homeless people, people with mental illnesses, and users of alcohol and other drugs. Because of the special issues around mental illness, especially the impact of cessation on the management of symptoms, an additional literature review was commissioned from Dr Mark Ragg and Dr Tanya Ahmed to look at the broader issues of the relationship between smoking and mental illness.

The goal of the literature reviews was to identify approaches that had been effective in helping disadvantaged people to quit smoking and the factors that contributed to or hindered their success. It was just as important to look at those interventions that had not worked, and identify the reasons behind this, as it was to look at interventions that had worked.

The full literature reviews are published as two separate publications.<sup>1,2</sup> This document aims to summarise the main findings of the reviews and provide additional information from research of cessation programs among the general population to provide guidance on what approaches are likely to be most effective with disadvantaged populations.

---

## 3. What strategies were used?

The studies included in the literature reviews looked at quit smoking programs run by a range of medical, health and welfare organisations in Australia and overseas.

The programs tended to use a combination of the following strategies:

- motivational interviewing, either brief or extended
- individual counselling, either brief or extended
- small group counselling, including groups led by someone from the same cultural or language group
- pharmacotherapy, particularly nicotine replacement therapy, bupropion and varenicline.

### Counselling

Counselling provides a structured environment where people can talk through and address the issues, attitudes and behaviours that can make it difficult to give up smoking. Both individual and group counselling were used by the studies examined in this review. While programs had a range of counselling approaches, two of the most commonly adopted were:

**Motivational interviewing:** a relatively new form of counselling that is used to help change patterns of drug, alcohol and tobacco use. It looks at the client's ambivalence to changing and encourages them to express their concerns and reasons for changing. A key goal is to change the client's view of the costs and benefits of tobacco use in a non-confronting way.

**Cognitive behavioural therapy (CBT):** widely used for depression and anxiety but also useful for other mental health conditions and increasingly used with addictions such as smoking. CBT is based on the idea that the way we think affects our feelings and behaviour. It helps people identify negative, distorted and irrational thinking that leads to self-defeating behaviour and to replace this with more realistic and helpful thinking (cognitive restructuring). This can help people cope better with day-to-day challenges and increase control of how they respond to their circumstances.

### Pharmacotherapies

Pharmacotherapies have been shown to assist some smokers to quit, in general doubling the success rate of a particular intervention.<sup>9</sup> Pharmacotherapies are not a substitute for counselling or other motivational interventions and should be used in conjunction with other support services for the smoker. There are currently three types of pharmacotherapies registered for use in Australia, each having a different mode of action:

**Nicotine replacement therapy (NRT)** to replace some of the nicotine obtained from cigarettes and to reduce the withdrawal symptoms a person feels when they stop smoking. It is available in a range of forms, including patches, gum, inhalers and lozenges. NRT delivers nicotine more slowly to the brain than cigarettes and is preferable to smoking because it does not contain the toxic substances of cigarettes, such as 'tar', and does not produce strong dependence.

**Bupropion (trade name Zyban)** is a form of antidepressant medication which, like NRT, helps to moderate withdrawal symptoms and cravings when a person quits smoking. It is available only on prescription and may not be suitable for people with other medical issues, such as having a history of seizures or currently using other antidepressants.

**Varenicline (trade name Champix)** is a new class of medication developed specifically for smoking cessation. It targets nicotine receptors in the brain to alleviate withdrawal symptoms and reduce the 'reward' effect associated with smoking. It is available only on prescription. The US Food and Drug Administration has reported cases of adverse events associated with the use of varenicline, including new-onset depressed mood, suicidal ideation, and changes in emotion and behaviour within days or weeks of initiating treatment. They recommend that patients taking varenicline are monitored for behaviour and mood changes. Further information can be found on the FDA website [www.fda.gov.au](http://www.fda.gov.au). At the time of the literature reviews, no studies were identified using varenicline in disadvantaged populations in Australia.

A tricyclic antidepressant called nortriptyline is also sometimes used for smoking cessation, although it is not registered for that purpose in Australia.

---

## 4. What were the results?

Quit rates from cessation programs in the general community range between 5% and 40% depending on the type of intervention and whether or not NRT has been used.<sup>9</sup> The definition of 'quit' used in different studies varies, however, ranging from not smoking at the end of the intervention to not smoking at a follow-up survey 12 months after the intervention.

The studies in the literature reviews generally reported lower quit rates for disadvantaged people, although some results were on par with those achieved in the general community. However, simply measuring quit rates may underestimate the benefit of a program, as few studies measured the number of subsequent quit attempts where the person returned to smoking after a program, or changes in attitudes or beliefs, both of which increase the likelihood of future quit attempts. Some studies noted barriers that can make quitting more difficult for very disadvantaged smokers.

Taken together, the results of the studies reviewed are encouraging and indicate that quit smoking programs can be effective with people in marginalised groups. They also demonstrate the need for sustained, systematic, comprehensive and tailored approaches – with individuals and with groups – to optimise the impact of the program in the long term.

### Quit rates

**Aboriginal smokers** – A study looking at the effectiveness of nicotine patches and/or brief advice among a group of 111 Aboriginal smokers found that quit rates using the nicotine patches (15%) were similar to results found with other groups.<sup>10</sup>

**Young people** – A group of 191 young people aged 13–17 hospitalised for psychiatric illness or substance abuse received either motivational interviewing (two 45-minute sessions) or brief advice (10 minutes). At 12 months, quit rates in the motivational interviewing group were 14%, compared to 9.9% for the brief advice group.<sup>11</sup>

**Low-income mothers** – A group of 303 low-income mothers attending a paediatric clinic were assigned to an intervention group or a control group. The intervention group received a quit smoking message from the child physician, a quit smoking guide and a 10-minute motivational interview with a clinic nurse, as well as three-monthly follow-up phone counselling calls. At 12 months, quit rates in the intervention group were 13.5%, compared to 6.9% for the control group.<sup>12</sup>

**People experiencing homelessness** – A total of 41 people experiencing homelessness received five individual motivational interviewing sessions looking at their interest in quitting, confidence in quitting and barriers to quitting. Participants then took part in five small group sessions where they were assigned to a group that focused on smoking alone or to one that also discussed barriers to quitting and other life issues. All patients also received NRT in the form of a patch or lozenge. At 26 weeks, quit rates in the 'smoking only' intervention group were 15.4%, compared to 26.7% in the 'smoking and life issues' group.<sup>13</sup>

### Intention to quit

The research shows that a large number of smokers in disadvantaged groups are well aware of the health and financial costs of smoking. Many said they wanted to quit. Findings included the following:

- Of 179 clients attending a methadone maintenance program, 165 (92%) were smokers. A total of 61% of these smokers said they intended to quit within six months and 78% scored highly (greater than 5 on a scale of 11) in terms of readiness to quit.<sup>14</sup>
- Of 236 respondents to a questionnaire placed in settings used by homeless people, 69% were smokers. Of this group, 72% had tried to quit at least once and 37% said they were ready to quit within six months.<sup>15</sup>
- Following a number of community-wide programs run in remote Aboriginal communities over the course of a year, the number of people thinking about giving up smoking or intending to quit had increased from 61% to 72%.<sup>16</sup>

---

Environmental issues, such as living with other smokers and a lack of confidence in their ability to quit, were major barriers for many people in these groups.

Interventions that address these issues are likely to be more effective in moving people from an ‘intention to quit’ to making a successful quit attempt.

### Adverse effects

The studies in the reviews indicated that quit smoking attempts were not detrimental to people achieving other drug or alcohol treatment outcomes.<sup>10,17,18</sup>

### Alternative measures of success

Quit rates are not the only measure of success. Some studies measured reductions in the number of cigarettes smoked and the amount of money spent on cigarettes<sup>16</sup>, an increased readiness to quit<sup>19</sup>, or confidence in one’s ability to quit<sup>20,21</sup> as alternative measures for assessing the effectiveness of a program.

While quitting smoking is the ultimate goal, many organisations recognise that with disadvantaged populations who are dealing with a range of challenging life issues, small changes can be significant. Organisations should also ask participants about what sort of outcomes they would like to achieve and how ‘success’ should be measured.

### What are the barriers to quitting?

The reviews uncovered a number of factors which could underpin the low quit rates among disadvantaged groups:

- ▶ Smoking being considered ‘normal’ by most people in their community or peer group<sup>15</sup>
- ▶ living in difficult and stressful conditions in which smoking is seen as some relief<sup>22</sup>
- ▶ being surrounded by other smokers, especially immediate family and friends<sup>16</sup>
- ▶ low self-efficacy and low confidence in their ability to quit<sup>23,24</sup>
- ▶ NRTs, such as patches, being too expensive or not available.<sup>25</sup>

- ▶ Limited reach of quit smoking campaigns among marginalised groups.<sup>25</sup>
- ▶ Lack of availability of quit smoking interventions for marginalised groups.<sup>26</sup>
- ▶ Lack of knowledge of best practice interventions among health and welfare professionals.<sup>27</sup>
- ▶ Lack of organisational commitment to quit smoking interventions among health and welfare services.<sup>28</sup>
- ▶ Quit smoking not being a part of the routine care provided by many health and welfare services.<sup>29</sup>
- ▶ Negative attitudes of health and welfare staff – that smokers in disadvantaged groups don’t want to quit, can’t quit, or have more important issues to deal with.<sup>30</sup>
- ▶ Health and welfare staff smoking themselves, or smoking with clients to build rapport.<sup>29</sup>

### Addressing negative attitudes

A number of studies found that the attitudes and beliefs of service staff made it difficult for smokers in marginalised groups to get the help they needed to quit.<sup>23,24,25,27,29</sup>

Some staff were sceptical about their clients’ interest in quitting or ability to quit. Others considered smoking “the least of their clients’ problems” or as “their little bit of pleasure”.<sup>30</sup> Some smoked themselves or smoked with their clients to build rapport.

These findings indicate that different standards are often applied by staff to smoking among disadvantaged groups as compared to other sectors of the community where smoking is universally regarded as harmful.

This highlights the need for staff training to challenge these attitudes and beliefs as a precursor to changing practice. Staff may also need training in the practical aspects of how to incorporate smoking cessation activity into their casework, as lack of confidence can be a barrier to staff addressing smoking issues with clients.

---

## 5. What makes an effective cessation strategy?

The literature reviews looked specifically at programs targeted at disadvantaged populations. They confirmed anecdotal evidence that there are very few published high-quality evaluations on quit smoking programs with people in disadvantaged groups. This makes it hard to draw definite conclusions about what strategies and approaches can be considered the best practice approach to working with these groups.

On the other hand, almost all the studies in the reviews 'point in the same direction'. They indicate that quit smoking programs with people in disadvantaged groups can deliver positive results and that there are some common factors that help make them successful.

The results also indicate that the lessons learned from cessation activity targeted at general populations are useful when working with disadvantaged communities. The development of the Australian National Tobacco Strategy 2004–2009 included a comprehensive review of best practice cessation interventions.<sup>31</sup> The review, along with other background research, is available on the National Drug Strategy website: [www.nationaldrugstrategy.gov.au](http://www.nationaldrugstrategy.gov.au).

Drawing together the experience from work with general and disadvantaged populations indicates that best practice approaches to cessation combine the following factors.

### 1. Doing something is more effective than doing nothing

General population studies indicate that less than 1% of smokers will quit unprompted. Studies from the literature reviews indicate that disadvantaged smokers have little confidence in their capacity to quit and so are less likely to initiate a quit attempt by themselves. Like other smokers, disadvantaged smokers need reminders, encouragement and support to help them quit.

### 2. Increase the number of quit attempts

On average it takes multiple attempts – some studies say as many as 14<sup>32,33</sup> – before a person successfully quits smoking. The more quit attempts a person makes, the more likely they are to eventually succeed. Encouraging and supporting quit attempts moves people closer to finally stopping smoking. Organisations that support their clients to quit smoking need to recognise that relapse is part of the process and build in multiple opportunities for people to make a quit attempt.

### 3. Build confidence in quit ability

Smokers who express a high level of 'intention to quit' and have confidence in their ability to quit are significantly more likely to try and to succeed. Many smokers in disadvantaged groups say they lack confidence that they can successfully quit smoking. Smoking interventions with vulnerable groups need to use approaches and strategies that recognise their strengths, notice their successes and build their confidence.

---

#### **4. Make interventions accessible**

Quit smoking interventions need to be accessible. They are most likely to be successful when they are delivered in trusted environments where people regularly go to receive services or support. This includes settings such as mental health services, accommodation services, drug and alcohol services, family support services and youth services. Such settings provide credibility to reinforce the importance of quitting, as well as the opportunity for smokers to make repeated attempts.

#### **5. Create a positive environment**

Participants in a number of studies made the simple point that giving up smoking is even more difficult if you are grappling with other issues (such as homelessness or drug and alcohol dependency) at the same time, and if many people around you smoke. Organisations that address smoking along with other life issues, provide emotional and practical support, and create a smoke-free service environment can make the process easier for their clients.

#### **6. Make interventions part of routine care**

Health and welfare organisations have great potential to reduce smoking-related harm, but much of this is unrealised. Given the high rates of smoking among some client groups, organisations that make quit smoking interventions a part of their routine service can make a significant contribution to lowering these rates and improving the general health and wellbeing of their clients.

#### **7. Small interventions can make a difference**

Even small interventions, such as asking people if they want to give up smoking or talking them through the options for quitting, can make a difference. Research indicates that doctors who provide simple quit smoking advice can contribute to a reduction in rates of smoking of about 2.5%.<sup>31</sup> It is likely that prompting and support from other trusted health and welfare workers may have a similar benefit.

#### **8. Adapt best practice approaches**

Best practice approaches that work with people in the general community are likely to be successful with people in marginalised groups. Of course, these approaches will need to be adapted to meet the particular needs and circumstances of each group. The literature reviews showed that the most successful interventions involved a combination of counselling, either individual or group, and pharmacotherapies such as NRT. Non-personal approaches, such as putting brochures in a waiting room or providing nicotine patches without advice and support, have been shown to have limited impact.

#### **9. Involve group members as 'leaders'**

Involving members of the client group in developing and leading quit smoking programs makes a difference. Their advice ensures that interventions properly address the reasons why people take up smoking, the barriers they face in giving up and the most appropriate ways to provide information.

#### **10. Recognise the importance of culture and social networks**

Programs delivered by people from the same cultural background showed signs of success, by helping to create a sense of connectedness, empathy and trust among participants. There are also cultural and social perspectives and experiences that can be addressed only from 'within' the group.

#### **11. Have realistic expectations, celebrate the small successes, and persist**

Very disadvantaged smokers face circumstances that may make quitting smoking harder and may increase their relapse rate. Organisations that provide programs for disadvantaged smokers need to recognise that, just as with programs aimed at dealing with other challenging issues, success may be hard to measure, especially in the short term. While successful quitting is the ultimate goal, smoking less, knowing more about the health risks, or being more open to quitting are good indicators of a change in the right direction.

## 6. Implications for health and welfare organisations

Smoking cessation is a critical health issue, but it is also an issue of equity and social justice. The community cost of smoking in terms of finances, health and wellbeing is carried more heavily by the most disadvantaged sector of the community than by the most advantaged.<sup>8,34,35</sup>

Quitting improves an individual's finances and material wellbeing, not just by freeing the money spent on cigarettes for other uses but also through health improvements which may reduce disability and incapacity to work or care for others.<sup>38</sup> In addition, stopping smoking can help improve a person's overall wellbeing, build their self-esteem and develop their confidence to address other issues in their life.

Health and welfare organisations working with very disadvantaged groups are in an ideal position to assist their clients to quit smoking.<sup>14,37</sup> They see clients regularly, they understand the issues their clients face, they have strong relationships with their clients, and they have the skills and expertise to support the complex behaviour changes which are required.

Combined with the professional skills of their staff, these organisations have the fundamentals to support their clients by developing and delivering successful quit smoking interventions or by referring them to other agencies which can assist.

The literature reviews highlighted the benefits obtained by clients of health and welfare organisations that make quit smoking interventions part of their routine service and case work.<sup>28</sup> Such a commitment would obviously require organisational change and support, as well as appropriate training and support for staff.

Health and welfare organisations working with very disadvantaged groups are in an ideal position to assist their clients to quit smoking.<sup>14,37</sup>



---

## What can organisations do?

There are a number of practical steps that organisations working with very disadvantaged people can take to increase their commitment to and delivery of quit smoking interventions, including:

- ▶ making the support of smoking cessation among staff and clients a part of 'core business' and a priority for resource investment, through a formal policy or as part of the organisation's strategic goals
- ▶ supporting staff to give up smoking
- ▶ providing quit smoking programs and/or referral as a part of routine care and casework
- ▶ making premises and client areas 'smoke-free zones'
- ▶ providing appropriate training and support for staff, including challenging attitudes and beliefs about the need for people in disadvantaged groups to quit smoking
- ▶ developing evidence-based plans or guidelines for quit smoking approaches among specific client groups, based on community-wide best practice
- ▶ collecting data on quit smoking activities and regularly reporting back to staff
- ▶ evaluating the quit smoking outcomes that are being achieved.

*Smoking cessation will be achieved through small incremental steps on a long journey which will lead to real benefits in their wellbeing.*

## The way ahead

There is no magic bullet which will solve the challenges faced by disadvantaged people who want to quit smoking. However, over the last 40 years of successful anti-smoking activity, which has driven down smoking rates in the general community, it has become clear which approaches work best and deliver the most cost-effective impacts.

Unfortunately, as the literature reviews indicate, only a small number of quit smoking interventions with people in marginalised groups have been rigorously evaluated. However, the reviews have highlighted that the problem behind the current high rates of smoking among disadvantaged groups is not that the interventions don't work but that they are attempted with so few people.

Health and welfare organisations need not wait until the research is done before acting. In fact their own expertise and experience in dealing with complex social and behavioural issues among disadvantaged people can contribute to the shared knowledge about best practice approaches for these groups.

Like the many complex issues faced by disadvantaged people, smoking cessation will be achieved through small incremental steps on a long journey which will lead to real benefits in their wellbeing. A commitment to act by the organisations that support disadvantaged people is a first step on that journey.

---

## **7.** Find out more

### **For enquiries about this document or the Tackling Tobacco program**

#### **Cancer Council NSW**

Phone: (02) 9334 1911

Web: [www.cancercouncil.com.au/tacklingtobacco](http://www.cancercouncil.com.au/tacklingtobacco)

### **For other tobacco-related information**

#### **Cancer Institute NSW**

Phone: (02) 8374 5600

Web: [www.cancerinstitute.org.au](http://www.cancerinstitute.org.au)

### **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) on 13 1848

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) 9816 0452

Web: [www.health.nsw.gov.au/tobacco/Pages/publications-resources.aspx](http://www.health.nsw.gov.au/tobacco/Pages/publications-resources.aspx)

### **For information about legislation relating to tobacco and smoking**

#### **NSW Health**

Phone: (02) 9391 9000

Email: [nswhealth@doh.health.nsw.gov.au](mailto:nswhealth@doh.health.nsw.gov.au)

Web: [www.health.nsw.gov.au/tobacco/pages/default.aspx](http://www.health.nsw.gov.au/tobacco/pages/default.aspx)

---

# References

1. Wise M, Hickey K, Palmer J. Taking action: A review of the literature on smoking cessation programs among 6 special populations. Tackling Tobacco Program Research Series Number 2. Sydney: Cancer Council NSW; 2008.
2. Ragg M, Ahmed T. Smoke and mirrors: A review of the literature on smoking and mental illness. Tackling Tobacco Program Research Series Number 1. Sydney: Cancer Council NSW; 2008.
3. Australian Institute of Health and Welfare. National Drug Strategy Household Survey detailed report 2013. Canberra: Australian Institute of Health and Welfare, 2014. Drug statistics series no. 28 Cat no. PHE 183.
4. Australian Bureau of Statistics. Tobacco smoking in Australia: A snapshot 2004-2005 (No. 4831.0.55.001). Published 15 September 2006. Australian Bureau of Statistics; Canberra. (Accessed 12 June 2008).
5. Australian Institute of Health and Welfare. National Drug Strategy Household Survey detailed report 2013. Canberra: Australian Institute of Health and Welfare, 2014, Drug statistics series no. 28 Cat no. PHE 183.
6. Scutella R, Johnson G, Moschion J, Tseng Y, Wooden M. Wave 1 findings from Journeys Home: A longitudinal study of factors affecting housing stability RMIT University: Melbourne Institute of Applied Economic and Social Research, 2012.
7. Youthblock Health and Resource Service, unpublished data from Smoking Survey 2007, Camperdown, Sydney.
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: 132-5.
9. Lancaster T, Stead L, Silagy C, Snowden A. Effectiveness of interventions to help people stop smoking: Findings from the Cochrane Library. *British Medical Journal* 2000; 321(7527):355-358.
10. Baker A, Ivers RG, Bowman J, Butler G, Kay-Lambkin FJ, Wye P, Walsh RA, Pulver LJ, Richmond R, Belcher J, Wilhelm K, Wodak A. Where there's smoke, there's fire: High prevalence of smoking among some sub-populations and recommendations for intervention. *Drug and Alcohol Review* 2006; January 2006:85-96.
11. Brown RA, Kahler CW, Niaura R, Abrams DB, Sales SD, Ramsey SE, Goldstein MG, Burgess ES, Miller IW. Cognitive behavioural treatment for depression in smoking cessation. *Journal of Consulting and Clinical Psychology* 2001; 69:471-80.
12. Miller KE. Smoking cessation at pediatric clinics for low-income women (tips from other journals). *American Family Physician* 2003; 68:1658.
13. Okuyemi KS, Thomas JL, Hall S, Nollen NL, Richter KP, Jeffries SK, Caldwell AR Ahluwalia JS. Smoking cessation in homeless populations: A pilot clinical trial. *Nicotine & Tobacco Research* 2006; 8:689-99.
14. Clemmey P, Brooner R, Chutuape MA, Kidorf M, Stitzer M. Smoking habits and attitudes in a methadone maintenance treatment population. *Drug and Alcohol Dependence* 1997; 44:123-32.
15. Connor S, Cook R, Herbert M, Neal S Williams J. Smoking cessation in a homeless population: There is a will, but is there a way? *Journal of General Internal Medicine* 2002; 17; 369-72.
16. Ivers RG, Farrington M, Burns CB, Baillie RS, D'Abbs PH, Richmond RL, Tipiloura E. A study of the use of free nicotine patches by Indigenous people. *Australian and New Zealand Journal of Public Health* 2003; 27:486-90.
17. Burling TA, Burling AS, Latini D. A controlled smoking cessation trial for substance-dependent inpatients. *Journal of Consulting and Clinical Psychology* 2001; 69:295-304.
18. Shakeshaft AP, Bowman JA, Sanson-Fisher RW. Community-based drug and alcohol counselling: Who attends and why? *Drug and Alcohol Review* 2002; 21:153-62.
19. Colby SM, Monti PM, Barnett NP, Rohsenow DJ, Weissman K, Spirito A, Woolard RH, Lewander WJ. Brief motivational interviewing in a hospital setting for adolescent smoking: A preliminary study. *American Psychological Association* 1998; 66:574-8.
20. Chen H-H, Yeh M-L. Developing and evaluating a smoking cessation program combined with an internet-assisted instruction program for adolescents with smoking. *Patient Education and Counseling* 2006; 61:411-18.

- 
21. Brown RA, Ramsey SE, Strong DR, Myers MG, Kahler CW, Lejuez CW, Pallonen RNUE, Kazura AN, Goldstein MG, Abrams DB. Effects of motivational interviewing on smoking cessation in adolescents with psychiatric disorders. *Tobacco Control* 2003; 12(Suppl IV):iv3-iv10.
  22. Lacey L, Manfredi C, Balch G, Warnecke R, Allen K, Edwards C. Social support in smoking cessation among black women in Chicago public housing. *Public Health Reports* 1993;108,3; *Health Module*:387-94.
  23. Arnsten JH, Reid K, Bierer M, Rigotti N. Smoking behavior and interest in quitting among homeless smokers. *Addictive Behaviors* 2004; 29:1155-61.
  24. Okuyemi K, Caldwell A, Thomas J, Born W, Richter K, Nollen N, Braunstein K, Ahluwalia J. Homelessness and smoking cessation: Insights from focus groups. *Nicotine & Tobacco Research* 2006; 8:287-96.
  25. Stanton WR, Gillespie AM, Lowe JB. Reviewing the needs of unemployed youth in smoking intervention programmes. *Drug and Alcohol Review* 1995; 14,101-08.
  26. Benowitz NL. Smoking cessation trials targeted to racial and ethnic minority groups. *JAMA* 2002; 288:497-99.
  27. Thorndike AN, Ferris TG, Stafford RS, Rigotti NA. Rates of US physicians counseling adolescents about smoking. *Journal of the National Cancer Institute* 1999; 91:1857-62.
  28. Bowman JA, Walsh RA. Smoking intervention within alcohol and other drug treatment services: A selective review with suggestions for practical management. *Drug and Alcohol Review* 2003; 22,73-82.
  29. Walsh RA, Bowman JA, Tzelepis F, Lecathelinais C. Smoking cessation interventions in Australian drug treatment agencies: A national survey of attitudes and practices. *Drug and Alcohol Review* 2005; 24:235-44.
  30. Ritchie D, Parry O, Gnich W, Platt S. Issues of participation, ownership and empowerment in a community development program: Tackling smoking in a low-income area in Scotland. *Health Promotion International* 2004; 19,1; *Health Medical Complete*:51-59.
  31. Miller M, Wood L. Smoking cessation interventions: Review of evidence and implications for best practice in health care settings. Canberra: Australian Government, Department of Health and Ageing; 2001.
  32. Chapman S. Public health advocacy and tobacco control: Making smoking history. Carlton: Blackwell Publishing Ltd; 2007.
  33. Zhu SH, Wong S, Tang H, Shi CW, Chen MS. High quit ratio among Asian immigrants in California: Implications for population tobacco cessation. *Nicotine and Tobacco Research*,9:1,S505-14.
  34. Siahpush M. Smoking and financial disadvantage: Research overview. Presentation at the launch of the Tobacco Control and Social Equity Strategy. Sydney, 30 October 2006.
  35. Siahpush M, Borland R, Scollo M. Smoking and financial stress among Australian households. *Tobacco Control* 2003; 12:60-66.
  36. Siahpush M, Spittal M, Singh G. Smoking cessation and financial stress. *Journal of Public Health* 2007; 29(4):338-42.
  37. Stewart MJ, Brosky G, Gillis A, Jackson S, Johnston G, Kirkland S, Leigh G, Pawliw-Fry B, Persaud V, Rootman I. Disadvantaged women and smoking. *Canadian Journal of Public Health* 2006; 87:257-60.

**Cancer Council NSW**

153 Dowling Street  
Woolloomooloo NSW 2011

**Phone:** (+61 2) 9334 1911

**Email:** [tacklingtobacco@nswcc.org.au](mailto:tacklingtobacco@nswcc.org.au)

**Web:** [www.cancercouncil.com.au/tacklingtobacco](http://www.cancercouncil.com.au/tacklingtobacco)

