Addressing Smoking in Community Service Organisations

A Policy Toolkit

Government of South Australia
SA Health

Heart Foundation

Cancer Council SA

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

Rev. Harry Herbert, Executive Director, UnitingCare NSW.ACT at the launch of the Tackling Tobacco Program (then called the Tobacco Control and Social Equity Strategy), October 2006

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Acknowledgement:

This resource was reproduced with the kind permission and assistance of Cancer Council NSW, Tackling Tobacco Program. The South Australian and New South Wales Programs aim to reduce the harm caused by tobacco use among disadvantaged population groups by supporting community service organisations to assist their staff and clients to stop smoking and adopt harm reduction behaviours. The target groups for the Programs include:

- People living with a mental illness
- Vulnerable young people
- Aboriginal people and Torres Strait Islander people
- Low-income single-parent families
- People with drug and alcohol problems
- Homeless people, and those at risk of homelessness
- People in the prison system.

Enquiries about the **Quit SA Tackling Tobacco in Community Services Project** should be directed to:

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Foreword

Tobacco as a social justice issue

There has been a major change in smoking rates in Australia since clear evidence of the health effects of smoking first emerged in the 1950s and early 1960s. Rates for males have dropped from around 70% in the 1940s to less than 20% in 2011. Although rates for women were lower in the 1940s, rising to 33% in the 1970s, they have similarly dropped to less than 20%. These changes can be attributed to effective mass media campaigns, increasing tobacco control legislation and quit smoking programs such as the Quitline.

However, the news is not as good for people living with social disadvantage. The decline in smoking rates has been far less for the more disadvantaged groups within the population such as the homeless, Aboriginal people and those living with a mental illness. Research done by the Cancer Council of Victoria (Siahpush & Borland, 2001) has shown that smoking is inversely related to socioeconomic status. Those who can least afford to smoke are more likely to take up smoking and have greater difficulty quitting. Although education, income, and index of relative socio-economic disadvantage are independently related to smoking rates, those living within the highest category of disadvantage are twice as likely to smoke as those living within the lowest category irrespective of education and income. This research emphasised the influence of social and cultural context on smoking behaviour, the social determinants that lead to smoking and make quitting difficult and relapse more likely.

Smoking is a huge preventable health problem that is now affecting the socially disadvantaged more than any other group. It accounts for over 15,000 deaths a year, 7.8% of the total burden of disease and injury, and represents a social cost of $31.5 billion dollars a year. Around 20% of Aboriginal deaths a year are smoking related and those living with a mental illness are consuming one third of all cigarettes sold. The burden of disease and deaths due to smoking has shifted to more socially disadvantaged communities. Community service organisations have a key role to play in developing and implementing strategies to support these communities in addressing the problem of smoking.

In July 2006, Cancer Council NSW initiated a program aimed at reducing tobacco use amongst socially disadvantaged population groups. The Tackling Tobacco Program: Action on Smoking and Disadvantage works to raise awareness of the link between smoking and disadvantage, provide training for community service workers to enable them to affect changes in their communities and to produce resources to help facilitate social change. Cancer Council SA introduced a similar program in 2008 known as Tackling Tobacco in Community Services.

This project works by partnering with social and community service organisations to address smoking within particular settings. These organisations work with a range of socially disadvantaged groups such as people living with a mental illness, people with drug and alcohol problems, homeless people, single mothers, Aboriginal people and vulnerable young people. Smoking rates within these groups are up to four times higher than the general population and the poorest households are spending nearly 20% of their limited income on tobacco. There is no question that this is an important area of work.

This policy tool kit provides background information on the links between smoking and disadvantage. It also contains practical guidelines and ideas for how community service organisations can make a difference through organisational policy, service environment and practice.

What we know is that those who live with social disadvantage want to quit as much as the general population. What we need to do is be more creative about how we go about this because what's working for the general population is not working for those affected by social disadvantage. This tool kit is a great start in the right direction.

Dr Terry Evans

Coordinator Cessation Services/Quit SA
Cancer Council SA

Siahpush, M., & Borland, R. (2001). Socio-demographic variations in smoking status among Australians aged 18: multivariate results from the 1995 National Health Survey. Aust NZ J Public Health , 25, 438-442.

1. The facts about smoking and disadvantage

While smoking rates in Australia have declined in recent years to around 15% of the population, men and women in the lowest socioeconomic group continue to have significantly higher rates of smoking than the rest of the community. More than a quarter (28.2%) of the most socioeconomically disadvantaged group in SA smoke, compared to only 12.7% in the most advantaged group.[2] As shown in Table 1, research on specific groups who face additional disadvantage reveal even higher smoking rates.

Table 1 – Reported smoking rates among disadvantaged groups*

Single mothers	45%	[3]
Aboriginal people	50%	[4]
Young vulnerable people	65%	[5]
Homeless people	70%	[6]
People with severe mental illness*	62%	[7]

** This figure is an average smoking rate for people with schizophrenia taken from studies across 20 nations.*

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

What accounts for these high smoking rates? One important factor is that the very disadvantaged face circumstances which make it more likely they will take up smoking and confront more barriers to quitting.

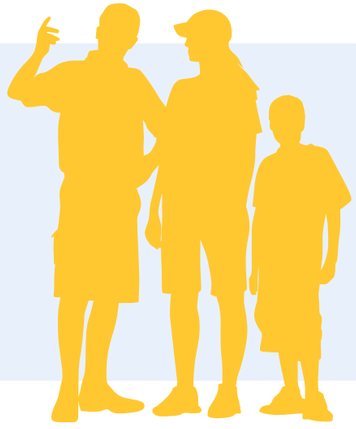
Smoking and disadvantage are closely linked. Social deprivation in its various forms increases the risk of smoking, and, because it undermines physical health and has a significant financial cost, smoking deepens social disadvantage.[8 9]

Social conditions associated with higher smoking rates include:

- low income
- poor housing
- family members and friends who smoke
- lone parenthood
- unemployment
- incarceration

Very disadvantaged people are more likely to take up smoking because a larger number of their friends and family smoke and it's more common in their local community.[10]

But social disadvantage itself, whether experienced through poor housing, unemployment or homelessness, also contributes to higher smoking rates. In qualitative research, disadvantaged groups have revealed how they use smoking as a means of coping with the difficulties they face, providing escape from stress and anxiety, and release from monotony and boredom.[11 12] One commentator describes smoking as offering a brief "holiday from hopelessness".[13] Unfortunately, smoking provides only temporary release at best and ends up making people's problems worse through its impact on health and finances.[9]



The barriers to quitting

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

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

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

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

Disadvantaged smokers face additional barriers to quitting, including:

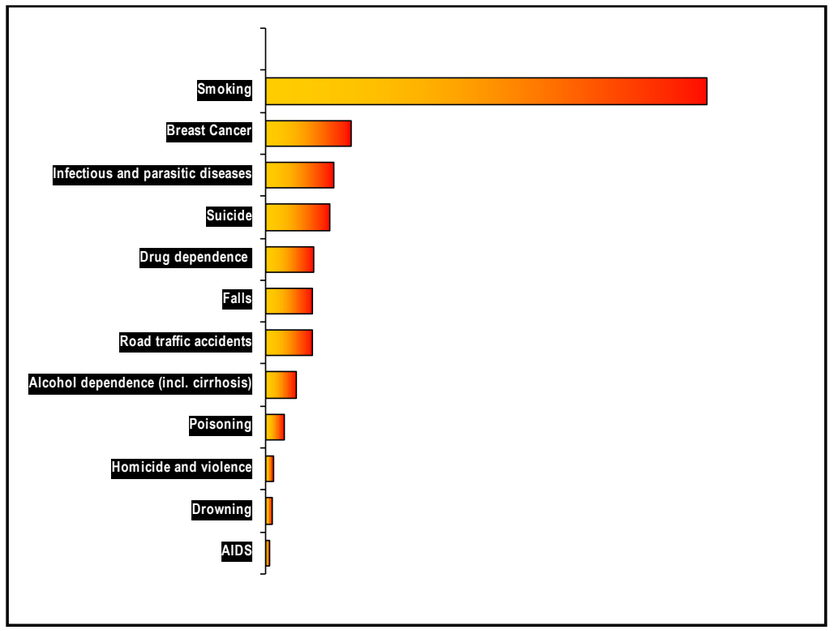
- greater exposure to powerful cues to smoke, especially having close family or friends who smoke or being exposed to smoking in other places [10 18]
- a lack of social support, including not having the support of a partner, close family, friend or other person to help them quit [11 19]
- a lack of accessible,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

Despite these barriers, studies show that many marginalised and disadvantaged people have a strong desire to stop smoking.[23] Their major motivation for wanting to quit is a desire to address the negative effects that smoking has on both their physical health and their material wellbeing as well as its effects on those close to them, especially children. [11 24]

2. Counting the cost of smoking

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

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



Source: Begg S, Vos T, Barker B, Stevenson C, Stanley L, Lopez AD. The burden of disease and injury in Australia 2003. PHE 82. Canberra: Australian Institute of Health and Welfare; 2007.

The impacts of smoking on health

Smoking is the leading cause of preventable death in Australia.[25] Each year more than 15,000 Australians die from smoking.[25] The figure exceeds the combined deaths caused by motor vehicle accidents, homicide, suicide, breast cancer, AIDS and illicit drug use.

Half of all long-term smokers are likely to die because of smoking.[26] Long-term smokers lose an average 13 years of life compared to non-smokers.[27] Even when not fatal, smoking-related disease and disability cause distress and lead to reduced quality of life for smokers and those close to them, often for many years.[28] Because of their higher smoking rates, the already vulnerable bear a disproportionate share of the burden of premature death, sickness and disease caused by smoking.

Table 2 – Smoking-related disease and disability

Smokers have much higher rates of:

- Cancer, including lung, throat, mouth, bladder and kidney cancer
- Stroke and cardiovascular disease
- Emphysema and other lung diseases.

Smokers experience more:

- respiratory illness, such as pneumonia and bronchitis
- vision and hearing loss
- impotence and reduced fertility. [27]

Smoking during pregnancy

While smoking among all pregnant women in SA is around 15%, it is much higher for more disadvantaged mothers. For instance, rates of smoking amongst indigenous mothers are more than 52%. [29 30]

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

Smoking during pregnancy has been shown to cause:

- increased risk of premature birth
- increased risk of still birth
- twice the risk that the baby will be of low birth weight and not properly developed
- a threefold increase in the risk of sudden infant death syndrome (SIDS) for babies born to mothers who smoke before and after birth. [27 31]

Research also indicates links between maternal smoking and later child development problems. There is some evidence that smoking in pregnancy impairs children's cognitive development, and clearer evidence that it increases the risk of learning and behaviour problems. [32 33]

Second-hand smoke: The consequences for children

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

Exposure to second-hand smoke is related to a variety of health problems in children, including Sudden Infant Death Syndrome (SIDS), asthma, respiratory infections (such as pneumonia and bronchitis), middle ear infections and learning difficulties.[34]

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

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

For assistance with maternal smoking and associated concerns, contact the Quitline. Phone: (+61 8) 8291 4282

The impact of smoking on material wellbeing

It is clear that regular smoking creates significant financial stress for people on very low incomes. If a smoker spends approximately $70 a week on tobacco, that works out to $3,640 a year, literally up in smoke.

Using limited income for smoking means there is less money available for essentials such as food, clothes and housing. A US study found that people with severe mental illness spent an average of 28% of their monthly income on cigarettes.[36] In an interview for the NSW Tackling Tobacco Program an ex-homeless person stated, "When I was on the street, smoking was my sustenance".

Households where people smoke are twice as likely to experience severe financial stress than non-smoking households and to report 'going without meals' or 'being unable to heat the home'.[37]

Recent Australian and overseas research has confirmed the link between smoking and financial disadvantage. In one survey, respondents were asked if, in the last six months, they had spent money on cigarettes rather than on household essentials such as food. Over 40% of smokers on low incomes indicated they had done so.[38]

In another study, conducted over three years, respondents were asked a series of questions about their inability to afford rent, heating, food and other household expenses. Two groups were identified: those who were smokers throughout the three years of the study and those who had been smokers in the study's first year but who had quit during the second year and remained smoke-free during the third year. The results showed that those who stopped smoking were 42% less likely to report financial stress than those who continued to smoke.[39]

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

A UK study of low-income mothers found that the main reason they took up smoking again after quitting was the pressure of everyday problems.[40] An Australian study also found that smokers with greater financial stress were more likely to relapse after quitting.[41]

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

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

Reasons to address tobacco and disadvantage

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

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

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

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

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

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

This last point is worth emphasising. Clients who quit smoking will enjoy substantial benefits, both immediate and longer term.

3. What can community organisations do to tackle smoking?

Working at the client level

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

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

Staff can help their clients develop self-confidence by setting goals, identifying improvements and celebrating successes, both small and large. This positive and consistent support is crucial, as it is common for people to make several attempts at quitting before being successful. People who receive support from family, friends or others are more likely to be ready to quit, and are around 50% more likely to successfully give up smoking than those who receive no support.[42]

A review of the literature on smoking and disadvantage found that disadvantaged groups were just as interested in quitting as other groups in the community and, when given appropriate support, were also as successful in quitting.[22]

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

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

This highlights the critical role that community organisations could play in helping reduce the negative impacts of smoking on their clients.

Working at the organisational level

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

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

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

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

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

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In addition to providing a smoke-free workplace, community organisations can also consider ways to influence smoking in other aspects of their work with clients, such as recreational and leisure activities, home visits and setting casework goals.

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

It may also be possible for organisations working with children, young people and their families to influence their clients' home environment. Smoking restrictions at home help reduce the overall level of smoking and increase the quit rate among adults. [45] They can also significantly reduce the exposure of children and young people to the harmful effects of second-hand smoke. [46]

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

Working at the wider community level

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

- quit smoking public awareness and information campaigns
- higher taxes, which increase the cost of smoking
- banning tobacco advertising and regulating the promotion and retail selling of tobacco
- the inclusion of nicotine patches and Champix medication on to the Pharmaceutical Benefits Scheme.

As with alcohol and gambling, community service organisations can publicly add their voice to support these types of measures and highlight the adverse impacts that smoking has on already disadvantaged groups.

For instance, there is an urgent need for ongoing advocacy to make affordable more options for Nicotine Replacement Therapies (NRT) available for disadvantaged smokers. Community service organisations could approach their local Health Service or pharmaceutical companies for access to more affordable NRT, or join others to lobby the Commonwealth Government to have more NRT options (such as nicotine lozenges, gum, inhalator and oral spray) subsidised for priority groups.

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

Many community organisations play an advocacy role in addressing the causes of social disadvantage. While this advocacy is often justifiably focused on issues such as access to better housing, employment programs or strengthening vulnerable families, it could also contribute to positive results in relation to smoking. This is because, alongside its other negative effects, social deprivation creates vulnerability to smoking and other addictive patterns of behaviour. [8 24]

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

4. Addressing some common concerns

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

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

Smoking does provide some pleasure (though at times this may be more that a cigarette provides relief from the symptoms of nicotine withdrawal), but despite this around 80% of smokers have tried to quit. [15] Even more (around 90%) regret having taken it up in the first place. [38 48] All people who quit smoking need alternative activities to fill that place in their lives. Community service organisations can help their clients find affordable, enjoyable activities to replace smoking. What a tragedy if the only pleasure we allow vulnerable people is one that shortens and reduces their quality of life and adds to their material hardship.

"Smoking is a personal choice"

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

- Most smokers take up and become addicted to smoking when they are teenagers, before the legal age of informed consent. [49 50]
- Nicotine is powerfully addictive, and this undermines the argument that continued smoking is a free choice. The fact that around 80% of smokers have unsuccessfully tried to quit at some time indicates the strength of nicotine dependency. [15]
- Research has found that most adult smokers are not fully aware of the dangers of smoking. While two-thirds identify the risk of lung cancer, only one-quarter understand the link between smoking and heart disease and less than 10% know how smoking contributes to emphysema, stroke and vascular disease. [51]

"People have a right to smoke"

Like alcohol, cigarettes are legal products, but they harm both the smoker and other people even when used as the manufacturer intended. Compelling evidence about the harm caused by passive smoking has led to laws being passed to protect people from second-hand smoke by prohibiting smoking in a wide range of enclosed public places, including the workplace, public transport, cinemas, restaurants, pubs and clubs [50] (see Section 8 'Smoking, tobacco and the law').

While many community service organisations provide outdoor smoking areas for clients and staff who smoke, they are under no legal obligation to do so. It is possible to show respect for clients who smoke (and recognise the right of all to health and wellbeing) by providing support for those who want to quit and having 100% smoke-free service environments which support that choice.

"Disadvantaged people are not interested in quitting"

While disadvantaged smokers may face more obstacles to quitting than others, numerous studies and consultations show they do want to stop smoking. In NSW around 50% of the smoking population expressed an interest in quitting in the next six months. [52]

Research on the 'quit intentions' of vulnerable groups, including those with the highest smoking rates, has revealed they have a similar and at times greater desire to quit as the general population. [23 38]

An agency for homeless people in Central Adelaide recently embedded a "Systems Approach" to addressing smoking amongst clients and staff of the service. Staff at the site ask about smoking as standard care, and the centre is now 100% smoke-free. Post implementation surveys showed strong acceptance by staff and clients, and gratitude from the clients for the support to attempt cutting down or quitting.

"I'd wake up in the middle of the night, coughing and wheezing. I'm 55, I thought, 'I can't die yet.' It took a while, but then, Boom! I quit. I'm saving $140 per fortnight….It's only been 3 months, but I'm feeling good. After 35 years……Without your support, I'd still be smoking."

Robert, ex-client of Hutt St Centre

"Disadvantaged people are not able to quit"

Studies show that disadvantaged people are as able to quit smoking as anyone else, as long as they are given appropriate support. [22] They may be more vulnerable to relapse, as the factors that contribute to smoking uptake – financial and social stress, boredom, friends and peers who smoke – are also factors that can trigger a person to start smoking again. There is also evidence that disadvantaged smokers are less commonly asked about their smoking or offered assistance to stop smoking. [22]

"Our services don't have the time or resources to address smoking"

While running a comprehensive quit smoking program may be beyond the scope of many organisations, there are a number of simple and inexpensive things that can be done to address smoking:

1. Have a site which is 100% smoke-free.
2. Have a policy which is practical, workable, and enforced.
3. Make it policy that staff do not smoke with clients.
4. Offer staff, volunteers and clients who smoke support to quit, if they wish.
5. Train staff and volunteers in cessation strategies.
6. As part of usual care, ask clients about their smoking and if they are interested in quitting. Record the intervention in case notes.
7. Refer those who want to quit to appropriate services, like Quitline (13 7848) or a local GP, for advice.
8. Offer personal encouragement and support to clients trying to quit.

Steps 6 – 8 should be included as part of an organisation's routine casework practice and don't require a lot of additional time or resources. While it may take several attempts for a person to quit, encouraging people to make quit attempts is one of the most effective ways to help them stop smoking and to reduce overall smoking prevalence.

"Many of our staff smoke"

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

"We don't have the expertise to deal with tobacco"

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

Quit SA e-Quitskills Training can provide training in smoking cessation skills and motivational interviewing for Community Services workers.

During a discussion on making their service smoke-free, one staff member of a service for homeless people said,

"It was an important element to not have staff and volunteers exposed to tobacco smoke. The partnership, Hutt St Centre, RDNS, and Quit SA all working together, made it work so successfully."

Recounted by Sarah Soteriou,
Manager, Client Services,
Hutt St Centre for Homeless

Go to **http://www.quitsa.org.au/aspx/how_can_you_help.aspx** for more information about the role of service providers. To register for e-Quitskills training go to: **www.quitsa.org.au/register_for_training.aspx**

Note that Quit SA also offer 3-day Quitskills training for Aboriginal Health Workers. For more information, or to register for the training, please go to the Quit SA website: **www.quitsa.org.au** or telephone the Training Team Leader on (08) 8291 4266.

"We don't want to be seen as wowsers"

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

"NRT is too expensive for our clients and we can't afford to subsidise them"

While using NRT almost doubles the chances of a quit attempt being successful, the vast majority of people who quit do so without NRT or any other intervention. [50 54] Most people take several attempts to quit, and encouragement and support to keep trying are important factors in their ultimate success. Organisations wanting to secure affordable NRT for their clients could approach pharmaceutical companies that manufacture NRT. Recently, Nicotine patches have been added to the Pharmaceutical Benefits Scheme (PBS). Services could lobby governments to provide more options around affordable NRT for the most disadvantaged.

For more information on the use of NRT products, go to:

Action on Smoking & Health Guidleines: go to the Quit SA website: **http://www.quitsa.org.au/cms_resources/ASHNRTguide07.pdf**

The Royal Australian College of General Practitioners: Supporting smoking cessation: a guide for health professionals. **www.racgp.org.au/Content/NavigationMenu/ClinicalResources/RACGPGuidelines/smoking/Smoking-cessation.pdf**

In community services, everyone benefits from doing more about smoking

Benefits for staff and volunteers

- Healthier work environment
- Help for smokers trying to cut down or quit
- Supportive environment for ex-smokers to remain non-smokers.

Benefits for clients

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

Benefits to the organisation

- Improved work and service environment
- Reduced staff absenteeism
- Healthy progressive image (for clients and staff)
- An additional strategy to improve client wellbeing.

"social deprivation increases the risk of drug dependencies such as smoking"

5. What to put in your organisation's policy

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

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

Smoke-free environments

Quit SA recommends that service environments be 100% smoke-free. This eliminates confusion around where and when people can smoke. It also lessens visual cues for those trying to quit, and provides strong support for those attempting to quit. If people wish to still smoke they are simply asked to do so off-site. Some organisations may choose to used a staged approach, transitioning towards a completely smoke-free service by using designated smoking areas for a limited time.

Smoking breaks

It is recommended that if staff smoke they do so during their own time or within unpaid break periods. Ideally, staff should do this off-site.

Smoking with service users

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

While staff should be open and honest about their own tobacco use, ideally they should:

- not smoke in the presence of service users
- refrain from using tobacco as a means of engaging with service users
- not purchase tobacco products for service users or supply tobacco products to them.

Home visits and other settings

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

To respond to this, organisations can:

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

Assistance for smokers to quit

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

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

Additional support could include:

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

More substantial support might involve:

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

Quit SA can assist your organisation with the design and implementation of resources around brief intervention. Contact Quit SA on (08) 8291 4282.

Data collection

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

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

Advocacy

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

- a greater proportion of State and Commonwealth revenue derived from cigarettes being spent on public education and smoking cessation initiatives
- support for legislation and other mechanisms to limit tobacco promotion and regulate tobacco use
- quit smoking support and services that better meet the specific needs of disadvantaged population groups
- provision of affordable NRT, particularly for disadvan-taged smokers
- continued efforts to reduce social inequality, enhance opportunity and address the structural causes of disadvantage, as social deprivation increases the risk of drug dependencies such as smoking. [8]

Investment and other income policy

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

- do not make capital investments in any tobacco company, or with any business that has substantial capital interest or investments in tobacco companies
- do not accept any financial or in-kind support from tobacco companies.

6. Steps to developing and implementing your policy

An organisation-wide policy can provide a clear statement of your position on smoking and the practical actions you will take to help reduce smoking-related harm.

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

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

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

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

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

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

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

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

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

It may also be useful to provide case studies of other community service organisations that have successfully implemented or revised a policy on smoking.

Step 2: Consult with staff, volunteers and service users

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

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

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

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

"Some organisations may choose to establish a special task group to oversee this process"

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

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

Step 3: Draft the policy

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

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

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

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

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

The policy components clearly state how you will address smoking- and tobacco-related issues. Careful thought should be given to areas that are important for your organisation. This could include taking action on the following:

- smoke-free sites
- smoking in vehicles
- staff smoking with clients
- providing support for staff and/or clients to quit
- funding from tobacco companies.

While comprehensive policies are likely to be more effective in reducing smoking-related harm, it is important that organisations develop a policy that is suited to and can be successfully implemented in their situation.

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

Step 4: Develop an implementation plan

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

There should be clear timeframes for introducing each component of the policy. Smokers will need time to adjust to the changes, especially those involving smoking restrictions. It may be useful to allow time in advance of full implementation to start giving support to staff, volunteers and service users who may be interested in quitting smoking.

"Regular monitoring should be an essential part of the implementation plan"

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

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

Step 5: Inform everyone: staff, volunteers, clients and the general public

Good communication is critical to ensure that all accept the new policy and practices. Delivery of information about the change needs to happen early and often, with a positive theme outlining to all the benefits of a smoke-free site. It is very useful to cite some examples of other agencies that have successfully embedded smoke-free strategies. There should be a nominated person/people who can deal with concerns people may have about the policy and practices.

Step 6: Put the policy in place

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

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

Step 7: Review the policy

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

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

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

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

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

7. Organisations taking action: 2 case studies

This section provides examples of what has been done by two organisations in SA – Hutt Street Centre for Homeless and Cadell Training Centre – to more fully address the issue of tobacco.

Example 1: Hutt Street Centre

Hutt Street Centre (HSC) is a frontline agency for homeless and vulnerable people in Adelaide. The clients of the service are very disadvantaged, many live with mental illness and financial hardship. The service provides meals, washing facilities, and provides daily access to the Royal District Nursing Services (RDNS), a visiting GP, and legal and social workers. HSC is one of the busiest inner city agencies; for the period 2010-11 HSC case managed over 1600 individuals, and provided over 50,000 meals. In the same period, RDNS nurses provided almost 2,600 individual services to clients at the service.

Many clients of the service have complex and diverse needs – they may live with a mental illness, and/or alcohol or other drug problems, and are living in circumstances of significant disadvantage. A large percentage of them smoke tobacco.

Responding to concern about the harm caused by actice and passive smoking at the site, in mid-2010 management at the Centre met with Quit SA to discuss how to design and roll out smoke-free initiatives.

An important factor in ensuring the success of the initiative was good communication between all involved with the service. Management conducted surveys with staff, volunteers and clients, and consulted to ensure that all opinions were considered in designing and implementing strategies.

Many clients expressed an interest in getting off the smokes. HSC was eager to provide support for those clients, and to de-normalise smoking amongst this population.

Quit SA provided outreach at the site for 3 months before implementation, and workers were amazed at the number of clients who took the opportunity to have a chat, cut down their smoking, and attempt cessation. Many chose to use the (limited) free NRT products that were offered to minimise withdrawal.

RDNS generously funded the installation of robust butt bins in the street out the front of the service. Clients who still chose to smoke were asked to extinguish their butts there, before entering the site. New signage was put up on HSC buildings, proclaiming the HSC did not permit smoking on-site.

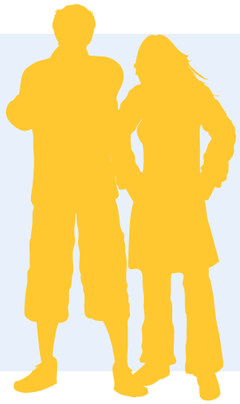
On World No Tobacco Day May 31 2011, without any fanfare or trouble, the site became entirely smoke-free.

Post-implementation surveys revealed ready acceptance of the initiative, and strong support for the change. Clients expressed sincere gratitude for the opportunity to try to cut down or quit, and for some who have quit, it has been a truly life-changing experience.

Teri Lucas
Quit SA,
Tackling Tobacco in Community Services
Project Officer

Example 2: Cadell Training Centre

Smoking rates in all South Australian prisons are very high, it is estimated that about 80% of prisoners smoke. Smoking is a normalised behaviour; boredom and the stress of being incarcerated are often cited as reasons for smoking. Currently, in South Australian Correctional facilities, prisoners can still smoke indoors, and in their



cells, with no uniform restrictions. Prisoners may be housed with 2 or more prisoners in a windowless cell, and currently prisoners may smoke through the night. Some prisoners say that they did not smoke until they entered prison; the stress of imprisonment, boredom and the influence of being in a cell with prisoners who smoke causes them to start smoking once imprisoned. It is very difficult, then, for those who have quit to remain off the smokes.

Smoking-related illnesses in prisoners are common place. Changing established practices in some settings can be like turning an ocean liner. Cessation work in prisons is made more challenging with the obvious constraints around managing incarcerated persons, many with mental health problems and personality issues. Many of the State's facilities have dedicated teams providing effect and efficient intervention around smoking.

Prisons around SA have dedicated staff providing valued care around smoking cessation, and this is acknowledged and celebrated. Quit SA is grateful to be involved with this work.

The following case study is an overview of practices at Cadell Training Centre (CTC).

CTC provides accommodation for up to 167 low-security prisoners in a rural environment on land covering approximately 1,600 hectares.

CTC is an example of excellence using a "systems approach" to addressing tobacco use.

In the last 7 years, much good work has happened at this prison. Since the first contact with the prison, offering the support of Quit SA to Prison Health Centre staff, the staff now ask smoking status as standard care, record this, and offer support around quitting. Initially, one nurse was nominated as the Primary facilitator. Now, most of the Health Centre staff have received Quitskills training in brief intervention and provide cessation support.

Addressing smoking is now a standard component of care at CTC. Addressing smoking is seen as an important issue. Many prisoners are attempting to quit, with remarkable success for a large percentage of those who "give quitting a go".

Health Centre staff dispense nicotine patches for a low weekly cost. Prisoners in the CTC Quit Smoking Program are required to telephone Quitline for additional support, and a faxable referral form is sent to Quit SA to enrol individuals for Quitline services.

Staff acknowledge the difficulty of stopping smoking in the prison environment and understand that most people require multiple quit attempts before they can maintain a life free from tobacco. Health Centre staff, and other prison staff provide real support, maintaining a calm and optimistic attitude to barriers and "slip-ups".

Stopping smoking is often the catalyst to greater change – prisoners at Cadell are able to undertake employment-focussed education programs, from numeracy and literacy to computers programs. In addition, they are able to obtain licences to be work-ready. Education and training, and alternative activities are key to filling the time that previously would have been taken up by smoking.

Teri Lucas
Quit SA,
Tackling Tobacco in Community Services
Project Officer

8. Smoking, tobacco and the law

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

Passive smoking / second-hand smoke

In South Australia, Section 19 (1) of the Occupational Health, Safety and Welfare Act 1986, imposes on all employers a duty to ensure, so far as is reasonably practical, that their workers are safe from injury and risks to health while at work. [56]

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

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

The issue of provision of a designated area is a contentious one, and as such can generate a barrier to implementing smoke-free strategies. However, the World Health Organisation (WHO) clearly states that involuntary exposure to tobacco smoke places non-smokers at risk of the same range of diseases seen in those who choose to smoke. WHO estimates that passive smoking kills around 600,000 people a year. With tobacco smoke indiscriminate in its impact, it is safest and easiest to make a site 100% smoke-free, rather than create confusion and unnecessary expense with installation of designated smoking areas.[57]

Sponsorship by tobacco interests

In SA the promotion of a tobacco product, brand name, trademark or name of a tobacco product manufacturer or distributor by any person is prohibited.

The Commonwealth Tobacco Advertising Prohibition Act 1992 prohibits any publicity that promotes or is intended to promote smoking and/or tobacco products. [58]

9. Further information, resources and advice

For enquiries about this resource or the Quit SA Tackling Tobacco in Community Services Project, information about smoking and other tobacco-related information, or for other smoking cessation information, resources and materials:

Quit SA

Phone: (08) 8291 4141

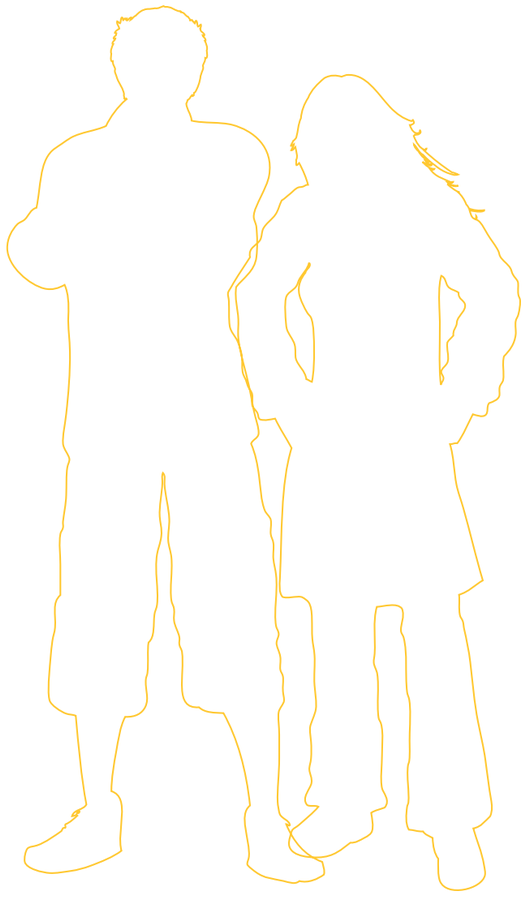
Web: **www.quitsa.org.au**

Quit SA e-Learning site: **www.equitsa.org.au**

For confidential telephone quit smoking counselling and support call the Quitline (on a landline, for the cost of a local call) on **13 7848 (13 QUIT)**

A free interpreter service is available for people not fluent in English.

For information about legislation relating to tobacco and smoking go to: **www.tobaccolaws.sa.gov.au**



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