OVERVIEW

The evidence reviewed in this document indicates that:

• A number of population groups in Australia have higher smoking rates than the general population. This includes people who are unemployed, are sole parents, have a mental health issue, have a substance use problem, are in prison, are experiencing homelessness or are Aboriginal and/or a Torres Strait Islander.

• High smoking rates are contributing to health and financial inequalities in the most disadvantaged groups in our communities.

• Current surveys and monitoring tools are not adequately capturing or monitoring smoking rates in disadvantaged populations in Australia and trend data are not routinely collected for these groups.

• There are numerous psychological, social, economic and cultural factors that influence smoking rates in disadvantaged population groups.

• Social disadvantage and smoking rates are intrinsically linked. As levels of disadvantage accumulate, smoking rates increase.

• People from disadvantaged groups are more likely to encounter social environments where smoking remains the norm and where little support is provided for quit attempts. It is important to understand the role that smoking plays in the lives of disadvantaged smokers.

• There is a systematic reinforcement of smoking behaviour in disadvantaged groups among service providers. Disadvantaged clients are less likely to be asked about their smoking, or asked if they would like to quit.

• Tax increases, mass media anti-smoking campaigns and smoke-free legislation reduce smoking rates in all population groups and play a vital role in reducing smoking-related disparities.

• Assistance to quit smoking through the use of pharmacotherapies, cessation counselling, brief interventions and smoke-free policies are efficacious in disadvantaged groups and can increase smoking cessation rates.

• There is merit in tailoring cessation services to the different needs of disadvantaged groups and delivering cessation strategies within organisations that are already accessed by these groups.

• Social and community service providers have an important role to play in tobacco control.
INTRODUCTION

Smoking rates among adults across Australia have been steadily declining over many years as a result of a range of tobacco control strategies. The 2010 National Drug Strategy Household Survey found that there are fewer people aged 14 years or older taking up smoking now than in previous times (57.8% have never smoked in their lives compared to 49% in 1991) and nearly a quarter of the population are ex-smokers.¹ Despite these achievements closer analysis of smoking rates shows that a number of population groups in Australia have a higher prevalence of smoking compared to the general population. Among the most disadvantaged groups smoking rates are up to five times higher than the population average.²

Why does this difference in smoking rates need to be addressed?

The difference in smoking rates is concerning for a number of reasons but in particular because high smoking rates result in increased health and financial inequalities in the most disadvantaged groups in our communities.

By the most disadvantaged we mean people who, in addition to low income, face a number of other issues such as mental illness, sole parenthood, unemployment, family violence, homelessness, drug and alcohol problems, criminal justice issues, limited education, and social isolation.

Those experiencing disadvantage are bearing a disproportionate share of the harm caused by tobacco including higher rates of death and disease from tobacco related illnesses. Research shows that tobacco is a major contributor to the differences in mortality between the least and most advantaged.³ People with mental illness,⁴ severe drug and alcohol dependence,⁵ and prisoners⁶ are more likely to die of tobacco related causes than the general population. Smoking accounts for 17% of the health gap between Indigenous and non-Indigenous Australians.⁷

The growing disparity in smoking rates contributes to increased social stigma and marginalisation as smoking becomes less accepted in the general community, and is also contributing to financial inequalities. Tobacco contributes to poverty through the cost of tobacco related illness, loss of a family breadwinner, and the impact on family finances and stress.⁸ In particular, tobacco use exacerbates the impact of poverty by reducing funds available to cover food, clothing and stable housing.⁹,¹⁰
CURRENT LEVELS OF SMOKING AMONG DISADVANTAGED GROUPS

Australian smoking rates are among the lowest in the world. In 2010 the daily smoking rate for Australians aged 14 years and older was 15.1%, a reduction from 24.3% in 1991. However, the picture is not the same for all Australians and reductions have been slower among groups facing multiple personal and social difficulties and challenges. Findings from a range of Australian studies show high smoking rates among sole parents, Aboriginal and/or Torres Strait Islander peoples, people with mental health disorders (including mild, moderate and severe), people who are homeless, people with substance use disorders and prisoners (see Table 1).

Table 1: Estimates of smoking rates in different population groups, Australia

<table>
<thead>
<tr>
<th>GROUP</th>
<th>PERCENTAGE WHO SMOKE</th>
<th>SOURCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>AUSTRALIAN GENERAL POPULATION</td>
<td>15.1</td>
<td>1</td>
</tr>
<tr>
<td>PEOPLE IN LOW SOCIO-ECONOMIC GROUPS</td>
<td>24.6</td>
<td>1</td>
</tr>
<tr>
<td>PEOPLE EXPERIENCING UNEMPLOYMENT</td>
<td>27.6</td>
<td>1</td>
</tr>
<tr>
<td>PEOPLE WITH A MENTAL ILLNESS</td>
<td>32.4</td>
<td>13</td>
</tr>
<tr>
<td>SOLE PARENTS</td>
<td>36.9</td>
<td>1</td>
</tr>
<tr>
<td>ABORIGINAL AND TORRES STRAIT ISLANDERS</td>
<td>47.7</td>
<td>14</td>
</tr>
<tr>
<td>PEOPLE LIVING WITH PSYCHOSIS</td>
<td>66</td>
<td>15</td>
</tr>
<tr>
<td>PRISONERS</td>
<td>74</td>
<td>16</td>
</tr>
<tr>
<td>PEOPLE EXPERIENCING HOMELESSNESS</td>
<td>77</td>
<td>17</td>
</tr>
<tr>
<td>YOUNG PEOPLE IN CUSTODY</td>
<td>79</td>
<td>18</td>
</tr>
<tr>
<td>PEOPLE WITH SUBSTANCE USE DISORDERS</td>
<td>85</td>
<td>2</td>
</tr>
</tbody>
</table>

*Note: this data are from a range of different studies from different years. Different research methods have been used therefore meaningful comparisons cannot be made between the different groups.

As well as higher smoking rates, people from disadvantaged groups also tend to have higher levels of dependency on nicotine, report smoking a greater number of cigarettes each day, smoke more intensively and also smoke for more years than the general population. Tobacco-related disparities exist between population groups in exposure to tobacco smoke at all points on the continuum of tobacco use. This includes higher foetal exposure to tobacco smoke (women from disadvantaged groups are more likely to smoke during pregnancy), exposure to second-hand smoke in childhood, and people’s exposure to tobacco throughout life in the communities in which they live.
The link between disadvantage and higher smoking rates

There is a relationship between increased disadvantage and increased smoking prevalence.\textsuperscript{51} This is illustrated in a study from the UK that found that for every indicator of disadvantage added (for example being unemployed, a sole parent, living in poor housing) smoking increased by 5% per indicator up to four indicators. The difference in smoking rates increased at a higher rate between four and five indicators (10%) and by an additional 15% between five and six or more indicators.\textsuperscript{52}

In fact, many social and economic factors across people’s life course from childhood to old age combine to entrench smoking in the lives of those facing multiple disadvantage. \textsuperscript{37, 51, 53} For example, a study of women in the UK showed they were at increased odds of being a heavy smoker if they experienced childhood disadvantage, left school aged 16 or less, were a mother at age 22 or younger, or if they experienced severe disadvantage as an adult compared to non-smokers and that the relationship between smoking and disadvantage is cumulative: \textsuperscript{53} as the number of experiences of disadvantage accrue smoking rates increase.\textsuperscript{51, 53, 54}

Current surveys and monitoring tools are not adequately capturing or monitoring smoking rates in disadvantaged populations in Australia and trend data are not routinely collected for these groups. Population based surveys do not capture, for example, people who are experiencing homelessness, without phone access, or who are mentally or physically unable to respond to surveys.
FACTORS INFLUENCING SMOKING LEVELS AMONG HIGH SMOKING PREVALENCE GROUPS

Higher smoking rates in different population groups are associated with a range of interacting psychological, social, economic and cultural factors that influence people taking up smoking, smoking patterns and behaviours and attempts to quit (see Figure 1).

Enablers to smoking

Research has identified a range of factors that influence uptake and patterns of smoking, including:
- low income, poor housing and unemployment;
- nicotine exposure during childhood;
- financial pressure and stress;
- anxiety and depression;
- parental and peer example;
- targeted and more intensive marketing by the tobacco industry; and
- a lower likelihood of working indoors.

In particular, population groups with higher smoking rates are more likely to be in environments where smoking is the norm and to have family and friends who smoke. Pro-smoking environments influence the uptake of smoking, smoking patterns and quitting intentions. For example, research shows that children who grow up in households where adults smoke are themselves more likely to take up smoking.

Barriers to quitting

A range of factors have been identified as barriers to quitting, including:
- heavier nicotine dependence;
- lower awareness of the harms of smoking;
- being unaware of, or having misconceptions about, available cessation services;
- the perceived cost and the time it takes to access nicotine replacement therapy (NRT);
- financial stress;
- lack of support for quitting among family and friends;
- lower levels of confidence in ability to stop smoking; and
- regarding smoking as their ‘only pleasure’ and having a role in relieving boredom.

Researchers highlight the pivotal role that smoking plays as a perceived coping mechanism for people experiencing multiple disadvantage and suggest that it is an important factor influencing high smoking levels. Smoking is often seen as a means of coping with stressful circumstances such as financial pressure, living in unsafe environments and limited opportunities for enjoyment and recreation. Research has shown that disadvantaged smokers are as interested in quitting as other smokers, but are less likely to succeed without further assistance.
A systematic reinforcement of smoking

Smoking as a health issue is often overlooked or ignored by service providers as it is seen as ‘the least of clients’ problems’ or as ‘their little bit of pleasure’. Across a range of health, social and community service providers there are beliefs that people from disadvantaged groups are not interested in quitting, cannot quit, or that it is unreasonable to raise the subject. As a result, people facing multiple disadvantage are less frequently asked about their smoking and whether they would like to quit.

Historically, smoking has been accepted as part of normal routine and therapy and sometimes promoted in services such as mental health facilities and drug and alcohol rehabilitation, often resulting in a pro-smoking organisational culture. In addition, workers employed in these sectors are more likely to be smokers thus impacting upon the provision of smoking cessation services. For example, a review suggests that smoking among Aboriginal health workers is a barrier to the delivery of smoking cessation to Aboriginal and/or Torres Strait Islander peoples. Aboriginal health workers report that their own smoking inhibits their provision of cessation advice to clients as they fear appearing hypocritical.
Key points

• There are numerous psychological, social, economic and cultural factors that influence high smoking rates in disadvantaged population groups.

• As levels of disadvantage increase/accumulate, smoking rates increase.

• People from disadvantaged groups are more likely to be in environments where smoking is the norm and where little support is provided for quit attempts.

• It is important to understand the role that smoking plays in the lives of disadvantaged smokers.

• There is subtle but systematic reinforcement of smoking behaviour in disadvantaged population groups among service providers.

• Disadvantaged smokers are less likely to be asked if they want to quit.

EXISTING INTERVENTIONS AND PROGRAMS TO REDUCE LEVELS OF SMOKING AMONG DISADVANTAGED GROUPS

Informed by an emerging body of evidence, there is a growing interest in Australia in addressing the disparities in smoking rates between population groups. The National Tobacco Strategy 2012-2018 demonstrates a strong commitment to reducing the social and health inequalities associated with tobacco. Reducing smoking rates in populations with high prevalence of smoking has been highlighted as one of the nine priority action areas.

Evidence indicates that smoking cessation can reduce health and economic disparities. Quitting smoking improves a person’s finances by releasing funds spent on tobacco, and also through health improvements which may reduce disability and incapacity to work or care for others. However, there is limited published research on effective strategies for reducing smoking in highly disadvantaged groups.

What works?

Population wide strategies such as tax increases, mass media and smoke-free legislation have been shown to be effective in reducing smoking across all socio-economic groups and have had a greater impact on people from lower socio-economic groups.

• There is strong evidence for increased taxation as a policy to reduce tobacco related disparities. A review of population tobacco control interventions concluded that “increasing the price of tobacco is therefore the population intervention for which we found the strongest evidence as a measure for reducing smoking-related inequalities in health.” (p.235) Taxation has been shown to prompt quit attempts and reduce consumption of tobacco.

• Evidence shows that mass media anti-smoking campaigns prompt help-seeking behaviours such as calling the Quitline, increase quit intentions, increase cessation activity and reduce smoking rates.
There is strong evidence that smoke-free legislation prompts quit attempts and reductions in consumption. Research has shown that comprehensive smoke-free policies covering workplaces and venues like bars and clubs, as well as cigarette price increases, are as likely to discourage smoking among low socio-economic status (SES) groups as among high SES groups.

Population-wide strategies reduce uptake and experimentation of smoking among adolescents across all socio-economic groups, in particular adolescents from low socio-economic groups. During a period of low tobacco-control funding and activity in Australia (1992-1996) smoking prevalence increased among 12-to-15 year olds; however, the greatest increase was among lower socio-economic groups.

What looks promising?

Several themes are emerging from the literature looking at more targeted approaches to reducing smoking rates. There is a growing body of literature exploring the merits of encouraging better use of existing cessation services and treatments in disadvantaged population groups and integrating smoking cessation support into social and community service settings. Both have an emphasis on tailoring cessation support to the social and cultural circumstances of the smoker.

**TAX INCREASES**

- Higher cigarette price is associated with lower prevalence of smoking.
- Lower income groups are more responsive to price.
- A 10% rise in price resulted in a 3.2% decline in prevalence among low income smokers.

**ANTI-SMOKING MEDIA CAMPAIGNS**

- Highly emotional anti-smoking advertisements generate greater recall, are perceived as more effective and influence smoking beliefs and increase quit attempts.
- People in low SES groups are particularly responsive to emotional or personal testimonial advertisements.
- Greater exposure to these advertisements is associated with greater likelihood of quitting. For each 10 additional exposures the odds ratio of quitting is 1.15 times as high.

**SMOKE-FREE LEGISLATION AND POLICY**

- Smoke-free policies prompt quitting and reductions in tobacco consumption across all socio-economic groups.
- Smoke-free pubs and clubs have been shown to have a bigger impact on lower SES population with reductions in consumption reported by 40% of smokers.
- Smoke-free workplaces reduce social inequalities in secondhand smoke exposure.

**FIGURE 2: A SUMMARY OF POPULATION-WIDE TOBACCO STRATEGIES AND THEIR IMPACT ON LOW INCOME GROUPS**
Encouraging better use of existing cessation services and treatments in groups with high smoking prevalence

Improving access to tools that are known to help people quit (i.e. counselling, quitting medications and behavioural interventions) may represent the most promising approach for reducing smoking rates in disadvantaged groups.75

- There is robust evidence that the chances of quitting successfully are increased when using quitting medications in combination with supportive counselling.76-78 Quitting medications are particularly effective in smokers with high nicotine dependence.

- There have been numerous studies exploring the efficacy of evidence-based treatments such as pharmacotherapies, quit counselling, motivational interviewing and brief interventions in disadvantaged population groups.5, 79, 80 There is strong evidence for the acceptability of these interventions within these groups and also evidence for successful quit attempts.

- Some groups have been researched more than others. There are numerous studies and reviews studying people with a mental health issue 79, 81-84 and drug and alcohol issues.55, 86 For other population groups such as people who are homeless,46, 87,113 prisoners88 and Aboriginal and/or Torres Strait Islander peoples 89, 90 there are only a small number of studies with small sample sizes. However, these studies provide some evidence that pharmacotherapies, cessation counselling, brief interventions and organisational smoke-free polices can assist these groups. This evidence is summarised in Figure 3.

<table>
<thead>
<tr>
<th>POPULATION GROUP</th>
<th>PHARMACOTHERAPIES</th>
<th>PHARMACOTHERAPIES AND QUIT COUNSELLING/SUPPORT</th>
<th>MOTIVATIONAL INTERVIEWING AND BEHAVIOURAL INTERVENTIONS</th>
<th>ORGANISATIONAL SMOKE-FREE POLICIES</th>
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<tr>
<td>ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLES</td>
<td>SHOWS PROMISE</td>
<td>SHOWS PROMISE</td>
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<td>NO EVIDENCE PUBLISHED TO DATE</td>
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<tr>
<td>PRISONERS</td>
<td>SHOWS PROMISE</td>
<td>SHOWS PROMISE</td>
<td>NO EVIDENCE PUBLISHED TO DATE</td>
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<td>PEOPLE WITH SUBSTANCE USE DISORDERS</td>
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<tr>
<td>PEOPLE EXPERIENCING HOMELESSNESS</td>
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<td>SHOWS PROMISE</td>
<td>SHOWS PROMISE</td>
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</tr>
</tbody>
</table>

FIGURE 3: TOBACCO INTERVENTIONS FOR DISADVANTAGED GROUPS: A SUMMARY OF THE EVIDENCE
Although the research demonstrates that smoking cessation support services and pharmacotherapies work with a range of population groups, it has been found that people facing multiple disadvantage have poorer access to these services.91, 92 The challenge is to find ways to improve access to cessation methods.

- When quitting medications are subsided or free, use by disadvantaged smokers increases.93, 94
- Offering free or low-cost NRT has been shown to increase calls to Quitline.95 A trial intervention conducted in Australia, which offered subsidised NRT in addition to a Quitline service, found that the offer of subsidised NRT recruited double the number of low-income smokers, compared to the offer of the Quitline service alone.96
- Since February 2011 the Australian Government has made a range of pharmacotherapies available on the PBS thus substantially reducing the cost. This has resulted in a high uptake in low income groups (76.4% of prescriptions for the nicotine patch were for concessional card holders).97
- Better use of existing quit services can be encouraged through promoting direct referrals from health and social and community service organisations and delivering cessation support that is sensitive to the diverse needs of different population groups.98
- Programs are more successful when tailored to the local environment and local needs of different population groups. Key elements include:
  » a non-judgmental, holistic and empowering approach; 40
  » delivery that recognises the role of smoking in people’s lives and the other issues they are facing; 45, 75, 99
  » provision of social support, flexibility and accessibility; 40, 100
  » well-trained staff; 40, 101 and
  » for Aboriginal and/or Torres Strait Islander communities, consideration of family and community factors, in addition to supporting the individual.50, 60

Integrating smoking cessation support into social and community service settings

Social and community service providers such as mental health facilities, drug and alcohol services, family services, and services for homeless people cater for populations with high smoking rates. They have been identified as ideal settings and partners in reducing smoking rates in disadvantaged groups.102, 103 Bringing cessation services to disadvantaged smokers in familiar environments has been recommended as a vital strategy to increase utilization of cessation methods as it has been argued that these groups are unlikely to seek support elsewhere.104 There is a growing body of research in Australia and internationally exploring the role of these services in tobacco control.

- Surveys of smokers who are clients of community services indicate they are open to receiving smoking cessation assistance from these services as they are a trusted source of advice and support and can offer more personalised support.92, 100, 104-106
- The integration of smoking cessation support in organisations already working with disadvantaged groups has been shown to be effective in decreasing smoking rates.82, 107-109
- Adoption of smoke-free policies by social and community service providers encourages a change in beliefs and behaviour about the acceptability of smoking and reduces triggers for relapse.91, 109-111
- Recommended approaches for social and community service providers include: 59, 104, 106, 110-112
  » reviewing and revising organisational smoke-free policies;
  » changing practices to de-normalise smoking;
» supporting staff to quit;
» training staff to build their confidence in delivering smoking cessation advice or referrals;
» making active quit support a part of clients’ routine care, including asking them about their smoking and interest in quitting, and providing active referrals to Quitline; and
» changing systems to record and monitor smoking status.

Key points
• Tax increases, mass media anti-smoking campaigns and smoke-free legislation actively reduce smoking rates in all population groups including low-income and disadvantaged groups and have a vital role in preventing the widening of disparities in smoking.
• Pharmacotherapies, cessation counselling, brief interventions, and smoke-free policies are effective in disadvantaged population groups.
• There is merit in tailoring cessation services to the different needs of disadvantaged population groups and delivering cessation strategies in the organisations accessed by these groups.

KEY SUCCESSES AND CHALLENGES

This review of the evidence illustrates some of the key successes and challenges in addressing the issue of smoking and disadvantage.

Successes
• Whole-of-population approaches are effective across all groups and have been shown to reduce some of the disparities in smoking rates.
• Pharmacotherapies and counselling are effective among disadvantaged population groups and targeted approaches have been successful in increasing access and use.
• Provision of free or subsidised NRT increases use of effective cessation methods by disadvantaged groups.
• Social and community service providers are increasingly recognising tobacco use as an important issue for their clients. Some services have reported success and acceptance of smoke-free policies and cessation interventions among clients and staff.

Challenges
• Changing cultural values and behaviours relating to smoking across the social and community services sector and successfully integrating tobacco control into core business.
• Improving access to and affordability of medications and cessation support.
• Changing broader social attitudes to the role of smoking in the lives of disadvantaged people and improving awareness of the health and economic benefits of cessation.
• Improving surveillance and monitoring to adequately capture smoking rates and trends among all disadvantaged groups.
• Strengthening the body of research that explores effective smoking cessation interventions among disadvantaged groups.
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