# Tobacco and Aboriginal people in NSW

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**Abstract:** Tobacco use is a major cause of morbidity and mortality for Aboriginal people in NSW. Few interventions to reduce the harm resulting from tobacco use have been developed specifically for this population. However, brief interventions for smoking cessation, pharmacotherapies such as nicotine replacement therapy, bupropion and varenicline, quit groups and interventions aimed at reducing smoking by pregnant women and hospital inpatients are likely to be effective. Broader population interventions such as anti-tobacco advertising, price rises for tobacco products and prevention of sales to minors are also likely to be effective in reducing the harm resulting from tobacco use.

The 2004–05 National Aboriginal and Torres Strait Islander Health Survey reported that approximately 50% of Aboriginal and Torres Strait Islander people used tobacco, more than double the prevalence rate in the general Australian population.[1] In 2006, 17.7% of the New South Wales (NSW) population aged 16 years and over reported that they were current smokers.[2] In NSW, in 2002–2005, 43.2% of Aboriginal people in NSW, interviewed by phone, reported smoking daily or occasionally.[3] The prevalence of tobacco use among pregnant Aboriginal women in NSW was 55.3% in 2005, compared with 14.3% for all NSW mothers.[4]

The use of tobacco is probably the major preventable cause of premature mortality and morbidity among Aboriginal people.[5] The life expectancy of Aboriginal and Torres Strait Islander people is 15–20 years less than that for the general population, with much of this difference due to tobacco use.[6] Tobacco also contributes to elevated morbidity and levels of hospitalisation for Aboriginal people.

The present article will present evidence-based interventions which may reduce the harm resulting from tobacco use by Aboriginal people in NSW, to inform decision making when planning and funding anti-tobacco activities. The NSW Tobacco Action Plan (2005–2009) prioritises tobacco control for Aboriginal people, with greater health equity as an ultimate aim.[7] Yet the area of tobacco control for this population has been characterised by limited program delivery and minimal formal research or evaluation of tobacco interventions.[8,9] Research from other populations can inform planning tobacco programs for this setting and will also be discussed in this article.

## Providing advice on smoking cessation

There is good evidence that brief advice from health professionals (doctors, nurses and others) can help about 6% of smokers quit.[10–12] At least two well-designed trials of such advice for Aboriginal and Torres Strait Islander smokers are underway in Queensland and the Northern Territory (NT). In NSW, the Smokecheck program, which entails training health professionals working with Aboriginal smokers in the delivery of smoking cessation advice, is about to be implemented and evaluated. Competency-based training in the delivery of smoking-cessation advice is also being delivered, including to some health professionals who work with Aboriginal communities. There is anecdotal evidence that Aboriginal Health Workers may not always be comfortable delivering such advice to smokers in their community, particularly if they themselves are smokers. However, it is important that opportunistic advice on cessation be given at every opportunity; for example, in Aboriginal medical services, other community health services and hospital settings.

## Pharmacotherapies

There is evidence that nicotine replacement therapy (NRT) and bupropion increased cessation rates in other populations.[13] A pre- and post-trial of NRT conducted in the NT showed free nicotine patches assisted 15% of Aboriginal smokers to quit over a 6-month period.[14] Although NRT is likely to be inaccessible to many Aboriginal smokers because of its cost, some health services – for example, some Aboriginal Medical Services – choose to fund or subsidise NRT for smokers. Bupropion had not been evaluated specifically in an Indigenous setting, but recent results of a pilot program of bupropion use in correctional facility inmates, which included Aboriginal inmates, are encouraging. Varenicline has only recently been licensed for use in smoking cessation; however, two studies demonstrated that the abstinence rate was approximately 23% at 12 months, more than that for bupropion or placebo.[15,16]

## Tobacco interventions for pregnant women

Interventions to assist pregnant women to quit in other populations are successful in decreasing tobacco use and in increasing birthweight.[17] Aboriginal infants are more

likely than others to have a low birth weight, and smoking by pregnant women may contribute to this. While a randomised trial of an intensive smoking-cessation intervention is underway, antenatal services for Aboriginal women (for example, in Aboriginal Medical Services and in public hospitals) should ensure that smoking-cessation advice is given to all pregnant smokers, and that they are offered referral to a specialist quit service where it is available. Pregnant women may also be offered NRT.[18]

## Hospital-based smoking cessation interventions

There is evidence in other populations that high intensity interventions with inpatients result in higher quit rates.[19] While there have been no trials of hospital-based cessation services for Aboriginal inpatients, as for all other inpatients who are smokers, they should be offered cessation support. According to the recommendations in NSW Health's *Guide for the Management of Nicotine Dependent Inpatients* all nicotine-dependent inpatients should be identified, informed of the smoke-free workplace policy and advised of their options for managing their nicotine withdrawal during their stay in hospital, for example through the provision of a three day supply of NRT.[20] They should also be offered further support in cessation following discharge.

## Paid or unpaid media advertising

Reports from other populations show that media campaigns can result in a small reduction in the prevalence of smoking and may have prevented uptake among young people.[21] In a survey of Aboriginal people in the NT, most recalled anti-tobacco advertising and some smokers had quit as a result of seeing this advertising.[22]

## Quit courses or support groups and quitlines

Quit courses and quitlines are effective for other populations but mainstream courses and quitlines may be relatively inaccessible or inappropriate for Aboriginal people.[23–25] There have been no evaluations of quit courses or quitlines for Aboriginal people, or of Aboriginal people's use of mainstream services. However, they are likely to be useful for some people.

## Sponsorship of cultural, sporting and community events

Events that are smoke free are effective in reducing exposure to environmental tobacco smoke and may promote a quit message.[26] Sponsorship has been used in Aboriginal anti-tobacco programs; however, such activities have not been evaluated.

## Health promotion materials

The use of health promotion materials, including self-help materials, may help smokers to quit, although the evidence is unclear.[27] Aboriginal people are likely to prefer materials that: are targeted at their own community; use visual media; or are easy to read, colourful and include pictures of local or well known people.[28]

## Control of advertising and sales promotion

Control of the advertising and promotion of tobacco products is likely to reduce consumption.[29] The effect of tobacco-advertising restrictions have not been evaluated for Indigenous people; however, as for other populations, it is likely to reduce consumption. Health warnings may be effective in reducing tobacco use, but their effect has not been evaluated for Aboriginal people. Written warnings may be less useful for people with low literacy skills.

## Changes in taxation and tobacco pricing

Increases in price of tobacco products reduce consumption in other populations.[30] The effects of taxation and pricing changes have not been evaluated for Aboriginal people, but has the potential to decrease consumption. Increases in the price of tobacco products may result in financial hardship for smokers who do not reduce consumption and, for example, result in less money for food.

## Legislation and policy on smoke-free public places and public transport

Interventions aimed at making public places smoke free are effective in reducing exposure to environmental tobacco smoke.[31] There are no reports on the effect of smoke-free areas legislation on Aboriginal people, although policies banning smoking in mainstream organisations may have had some effect on encouraging some Aborignal people to quit. Under the NSW *Smoke-free Environment Amendment Act 2004*, from July 2007, all enclosed areas of hotels, clubs and nightclubs that are open to the general public must be completely non-smoking. Licensed venues should display 'no smoking' signs in prominent positions in all smoke-free areas and remove all ashtrays, matches, lighters and other items used for smoking from smoke-free areas.[32]

## Preventing sales to minors

Restricting sales to minors may reduce access to tobacco, but does not necessarily prevent uptake of tobacco use.[33] There are no published examples of the effect of enforcing restrictions on sales to Aboriginal minors, but this is likely to be an important strategy in this population.

## Conclusion

There has been little research and evaluation of anti-tobacco interventions for Aboriginal people, and limited population-specific service delivery in tobacco control in NSW. The implementation of Smokecheck, a program designed to train health professionals working with Aboriginal smokers, is encouraging. While the role of specialist tobacco workers in Aboriginal communities requires evaluation, access to mainstream specialist tobacco workers and pharmacotherapies to assist cessation

is important. Broader population health measures such as advertising campaigns and restrictions on smoking in public places are also likely to reduce the harm resulting from tobacco to Aboriginal people in NSW.

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