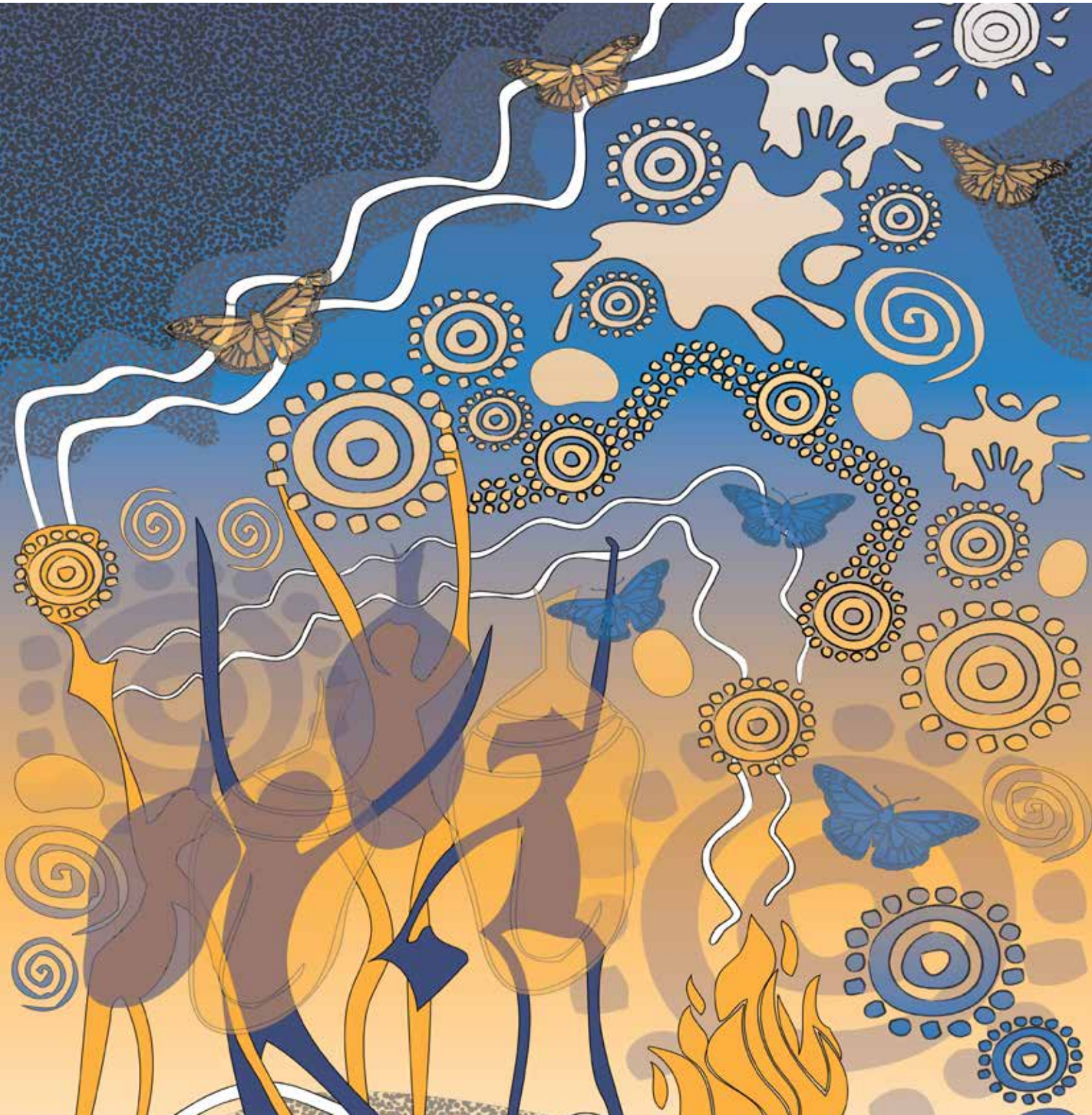
Aboriginal Health & Medical Research Council of New South Wales

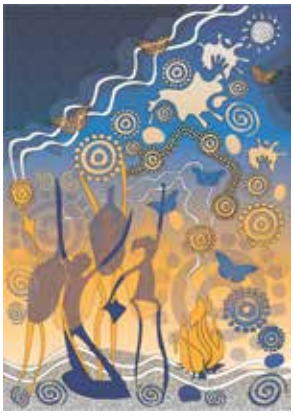
NSW GOVERNMENT Health

The ATRAC Framework:

A Strategic Framework for Aboriginal Tobacco Resistance and Control in NSW



Smoke Healing



Artwork: Ms Carissa Paglino

I have taken inspiration from the life cycle of a butterfly to represent a healing journey; in this case it represents the journey of quitting smoking. The cocoon surrounding the people portrays the restriction and hold that smoking has on our lives. We become enveloped by the addiction. This artwork shows:

- The dotted patterns and meeting circles represent the dreaming. I wanted to emphasise that smoking is not part of our dreaming or our culture. I want to communicate that smoking ceremonies are our culture, smoking tobacco is not.
- The fire represents the art of an Aboriginal smoking ceremony and how that promotes physical recovery and spiritual wellness that occurs when you give up the smokes. This healing process is represented by the butterflies as they have broken free of the cocoons.
- For thousands of years Aboriginal people have used message stones to bring them luck and safe guard them against evil spirits. I have scattered some representations of these stones around the artwork.
- The sun at the top shows the positive outcomes of giving up smoking. The artwork flows from bottom to top into a point, this shows the people heading for one common positive goal and that is to give up smoking together. Support from family and friends is very important, this is why I have shown a group of people, not just 1 person, as we should all come together as a community and help each other.
- The white lines flowing through the earth, the fire, the sky and the people represent the concept of life-death-life.

Aboriginal Health & Medical Research Council of NSW
Level 3, 66 Wentworth Ave, Surry Hills NSW 2010
PO Box 1565, Strawberry Hills NSW 2012
Tel. (02) 9212 4777
Fax. 02 9212 7211
www.ahmrc.org.au

NSW Ministry of Health
73 Miller Street
NORTH SYDNEY NSW 2060
Tel. (02) 9391 9000
Fax. (02) 9391 9101
TTY. (02) 9391 9900
www.health.nsw.gov.au

SHPN (CPH) 140461
ISBN 978-1-76000-117-9

Further copies of this document can be downloaded from the websites of the AH&MRC www.ahmrc.org.au and NSW Health www.health.nsw.gov.au

December 2014

Acknowledgment:
We would like to acknowledge the Aboriginal peoples who are the traditional custodians of New South Wales, and pay our respect to Elders past and present.

Suggested citation:
Aboriginal Health & Medical Research Council of NSW and NSW Ministry of Health 2014. *The ATRAC Framework: A strategic framework for Aboriginal tobacco resistance and control in NSW*. Sydney.

Contents

Foreword

Smoking is an issue of significant ongoing concern to Aboriginal communities and the NSW health system.

The Aboriginal Health and Medical Research Council of NSW (the AH&MRC) and the NSW Ministry of Health have worked in partnership to develop the ATRAC Framework: A Strategic Framework for Aboriginal Tobacco Resistance and Control in NSW (the ATRAC Framework) to assist in planning and coordinating efforts to reduce Aboriginal smoking across NSW.

The ATRAC Framework is designed to guide and inform the efforts of everyone working in Aboriginal tobacco resistance and control in NSW, by identifying evidence, key principles and best practice approaches for reducing Aboriginal smoking in NSW.

The Action Areas of the ATRAC Framework reflect a wholistic view of Aboriginal health and describe ways we can address smoking by building on existing programs and activities that already have momentum in Aboriginal communities across NSW. The ATRAC Framework promotes a partnership approach and aims to achieve more integrated, coordinated and client-focused approaches to addressing smoking rates among Aboriginal people.

We commend the work of the NSW Aboriginal Health Partnership Sub-Committee on Tobacco Resistance and Control, as well as all Aboriginal and non-Aboriginal health professionals throughout NSW whose combined knowledge and expertise have contributed to the development of the ATRAC Framework.

Yours sincerely

Ms Sandra Bailey
Chief Executive Officer
Aboriginal Health and Medical Research Council of NSW

Dr Kerry Chant
Chief Health Officer and Deputy Secretary
Population and Public Health
NSW Ministry of Health

Part one: Introduction

Aboriginal people are the first peoples of Australia and have strong, complex and diverse cultures and communities. The Aboriginal cultures of Australia are the oldest in the world. One of the reasons Aboriginal cultures have survived for so long is their ability to adapt and change over time with their surroundings.[1]

Smoking is the most preventable cause of poor health and early death among Aboriginal people in Australia.[2] Smoking rates among Aboriginal people are currently more than double those of the general population.[3] Reducing smoking prevalence and exposure to second-hand smoke is therefore critical to improving the life expectancy and health of Aboriginal people in NSW.[4] The strength and resilience of Aboriginal people provides the foundation for future efforts to reduce smoking rates and improve health.[1]

The ATRAC Framework and its uses

The NSW Ministry of Health and the Aboriginal Health and Medical Research Council (AH&MRC) have worked in collaboration to develop *'The ATRAC Framework: A Strategic Framework for Aboriginal Tobacco Resistance and Control in NSW'* (referred to as 'the ATRAC Framework'). The 'ATRAC' name of the Framework was agreed by the NSW Ministry of Health and the AH&MRC and is similar to the name of the AH&MRC – Tobacco Resistance and Control (A-TRAC) Program which has delivered a range of tobacco resistance and control activities since 2009, funded by the NSW Ministry of Health.

The ATRAC Framework identifies relevant evidence, key principles and best practice approaches for reducing Aboriginal smoking and harms relating to tobacco use in NSW. The ATRAC Framework aims to guide and inform the efforts of anyone working in Aboriginal tobacco resistance and control and assists in planning and coordinating efforts to reduce Aboriginal smoking and related harms by supporting the integration and coordination of best practice approaches.

The ATRAC Framework has been developed to be relevant and useful for a broad range of different stakeholders who play various and important roles in addressing tobacco smoking for Aboriginal people in NSW. These include Aboriginal leaders and communities, Aboriginal community controlled health organisations, government agencies, non-government organisations, and a range of other health and related organisations. The ATRAC Framework will help to inform decision making about resource allocation, planning, implementation and evaluation of existing and future Aboriginal tobacco resistance and control activities at local, regional and state levels.

The approach

The ATRAC Framework focuses on building the strengths and capacity that already exist in Aboriginal communities. There is considerable knowledge and expertise in Aboriginal communities across NSW about tobacco issues, including knowledge about how to resist tobacco, how to challenge social norms that support smoking, how to assist smokers who want to quit and other actions to address smoking.[5]

A partnership approach is emphasised throughout the ATRAC Framework. Key partners in Aboriginal tobacco resistance and control in NSW include Aboriginal communities, the AH&MRC, Aboriginal Community Controlled Health Services (ACCHSs), the NSW Ministry of Health, NSW Health Pillars such as the Cancer Institute NSW, Local Health Districts (LHDs), the Australian Government Department of Health, Primary Health Networks (formerly known as Medicare Locals), non-government organisations, research organisations, and private sector health professionals and organisations.

The ATRAC Framework is based on a wholistic definition of Aboriginal health:

> *"Aboriginal health means not just the physical well-being of an individual but the social, emotional and cultural well-being of the whole Community in which each individual is able to achieve their full potential as a human being thereby bringing about the total well-being of their Community. It is a whole of life view and includes the cyclical concept of life-death-life."*[6]

Fast Facts about Smoking

30% of Aboriginal people have never smoked.*[52]

Almost half of Aboriginal people aged >15 years in NSW are current smokers (48.2%) compared to 21.6% of non-Aboriginal people.*[52]

Around 1 in 5 Aboriginal people die from smoking-related illnesses.[3]

Around 10% of Aboriginal people who smoke started smoking at age 13 years.[3]

Almost half (48%) of Aboriginal women who are pregnant report smoking.[52]

Key factors that influence young Aboriginal people to be non-smokers include:

- Having non-smoking parents or family;
- Having seen the harmful effects of smoking on the health of friends and family;
- Concern that smoking will affect fitness and sporting activities; and
- The high cost of cigarettes.[40, 53]

* These estimates are from the National Aboriginal and Torres Strait Islander Social Survey and the National Health Survey

The development of this Framework

The development of the ATRAC Framework has been overseen by the NSW Aboriginal Health Partnership Sub-Committee on Tobacco Resistance and Control. This group was established by the AH&MRC and the NSW Ministry of Health under the auspices of the NSW Aboriginal Health Partnership. Membership of the Sub-Committee is included in Appendix 1.

The ATRAC Framework has been informed by a consultation process that included staff working in ACCHSs, NSW Health Pillars, LHDs and other organisations. The consultation process included brainstorming sessions, consultation visits to ACCHSs, a workshop for ACCHS staff prior to the A-TRAC program symposium, interviews and discussions with a range of staff from LHDs, non-government organisations and other relevant agencies, and a workshop at the NSW Ministry of Health Closing the Gap Forum in October 2013.

A number of themes that emerged from the consultation process have been incorporated in the ATRAC Framework including:

- The importance of Aboriginal leadership and the significant involvement of Aboriginal people, communities and organisations in developing and implementing tobacco resistance and control activities;
- The importance of partnerships involving a range of organisations at the local, regional and statewide level and the challenges of developing and sustaining partnerships over time especially when groups have differing approaches or priorities;
- The importance of taking a long term and committed approach in decreasing smoking prevalence in Aboriginal communities;
- That Aboriginal tobacco resistance and control is 'everyone's business' it should not just be left to one part of health service organisations or only be the responsibility of specialist workers;
- The benefits of integrating tobacco resistance and control activities into other health programs to increase effectiveness and reach as well as having specialised/stand-alone approaches to tobacco resistance and control activities;
- The importance of access to tobacco resistance and control training, particularly about brief intervention for all relevant staff, and of specialist training for Aboriginal people working in tobacco resistance and control, as well as ongoing networking, support and mentoring;
- The importance of sharing success stories, including evidence about what works as well as what does not work and not 'reinventing the wheel'; and
- The importance of recognising the social determinants of Aboriginal health and of taking them into account when designing and delivering tobacco resistance and control programs.

There was strong support from those who participated in the consultation process for the development of the ATRAC Framework and the action areas identified.

Factors that influence smoking prevalence among Aboriginal people

A range of population and individual level factors contribute to high smoking prevalence among Aboriginal people in NSW. These include:

Socioeconomic inequities

Living in poverty, leaving school early and unemployment are major factors which can increase the likelihood of smoking and poor health.[7,8] The high rate of smoking among Aboriginal people is strongly linked to socioeconomic disadvantage.[7]

Social contexts and pressures

People who are exposed to smoking behaviours and live in circumstances where smoking is seen as the social norm, will be more likely to take up smoking (particularly children).[9,10] These factors can also discourage smokers from attempting to quit and may make it harder to quit successfully.[11]

Addiction

Addiction is the main reason that all regular smokers continue to smoke.[12,13] Nicotine is one of the main ingredients in tobacco and is a powerful drug that provides the smoker with short term pleasant sensations.[13] However if the person does not smoke again within a short time, they begin to experience unpleasant withdrawal symptoms.[13]

Stress and other factors

Experiencing multiple life stressors (for example 'the Stolen Generation') can make it harder to quit smoking because stressful events can act as triggers to smoke.[14-16] Other factors such as institutionalisation, mental illness, alcohol and other drug use, grief and loss may impact on smoking rates.[17]

Less access to preventive and other health services

Factors such as language barriers, racism, transport problems, living in remote or isolated areas and limited Aboriginal involvement in the design and delivery of health services can reduce Aboriginal peoples' access to health services.[7]

Part two: The evidence

The evidence around what works in reducing Aboriginal smoking is increasing as more programs are developed, implemented and evaluated. A number of factors that are critical to the success of tobacco resistance and control programs have been identified.[7] These include:

- Design, implementation and evaluation of programs by Aboriginal communities;
- Comprehensive multi-component programs;
- Long term funding for sustainable programs; and
- Coordination and partnerships to prevent duplication of effort between communities, non-government organisations and government agencies.[7]

Programs that address the social determinants of health such as enhancing early childhood development, improving education experiences, improving working conditions and employment opportunities, and empowering communities can reduce inequities and can also have benefits in terms of reducing smoking prevalence.[7]

In relation to specific tobacco control programs, there is evidence to support the following interventions to reduce Aboriginal smoking:

- Provision of brief advice on quitting from health professionals in combination with medication (e.g. nicotine replacement therapy or NRT)[18];
- Training Aboriginal Health Workers* and other health professionals to deliver quitting support and advice[19];
- Multi component tobacco resistance and control programs[20,21];
- Quit groups[7,22]; and
- Intensive culturally appropriate smoking cessation advice and support.[23]

Interventions with strong evidence of effectiveness in the general population are also important to consider, even though evidence demonstrating their effectiveness among Aboriginal people may be limited. These interventions include:

- Tobacco pricing policies[24,25];
- Mass media campaigns[21,26];
- Smoke-free legislation[8,9];
- Restricting tobacco advertising[8];
- Cessation support[27,28]; and
- Intervention for pregnant women.[29,30]

* In this document, the term 'Aboriginal Health Worker' is understood to be an Aboriginal and/or Torres Strait Islander person who is in possession of a minimum qualification within the fields of primary health care work or clinical practice, and is inclusive of Aboriginal and Torres Strait Islander Health Practitioners who are acknowledged to be one speciality stream of Aboriginal Health Workers. This definition has been derived from that used by the National Aboriginal and Torres Strait Islander Health Worker Association, https://www.natsihwa.org.au/

Multi component tobacco programs

Multi component programs that take a whole of community approach, are integrated with existing health and community programs and focus on a range of tobacco issues relevant to Aboriginal communities are more likely to be successful in reducing Aboriginal smoking.[7,21] Within multi component programs, many of the activities reinforce and strengthen each other. For example, training of Aboriginal Health Workers enhances their ability to provide brief interventions and messages about the benefits of quitting. In turn, these strategies are reinforced by smoke-free legislation and policies and media campaign messages.[21] It is also important to ensure that tobacco control programs are linked to a range of other relevant health priorities identified by the community and integrated with other chronic disease prevention initiatives.

Media campaigns

Mass media campaigns use television and other media such as print, radio, internet and cinema communication to communicate with large numbers of people. They are effective at increasing community awareness about particular health-related issues and can motivate behaviour change (e.g. quit attempts) among individuals.[8,26] Mass media campaigns also have indirect effects by influencing social norms and helping to shape the agenda for change.[9] They are most effective when campaign messages are part of a comprehensive tobacco program.[8]

Well-funded mass media campaigns are effective in reducing smoking prevalence among adults and young people in the general population, and in some cases among Aboriginal populations, particularly where the messaging resonates with Aboriginal communities.[8,26,31,32] Mass media has been shown to be effective in reducing smoking across all socio-economic groups.[9] There are relatively few evaluation studies published on the success of mainstream mass media in reaching Aboriginal people.

The evaluation of the Western Australia *Bubblewrap* campaign reported that Aboriginal people found the campaign messages to be believable and relevant to them. The majority of surveyed Aboriginal smokers had thought about cutting down the amount they smoked and more than two thirds (68%) had thought about quitting as a result of seeing these advertisements.[32]

The evaluation of the National Tobacco Campaign reported that although Aboriginal people were aware of the health risks associated with smoking and recall of mainstream campaign messages was high, the campaign was unsuccessful in increasing quit attempts or reducing smoking prevalence.[7,21,33] The evaluation also reported that many Aboriginal smokers would prefer localised campaigns developed in partnership with local Aboriginal communities and elders, reflecting local needs and priorities.[33]

There is a need to build the evidence base about the role of social marketing for tobacco resistance and control among Aboriginal communities.

Brief advice from health professionals

Brief advice from health professionals (doctors and nurses and others) can aid smokers to quit.[7,27] The combination of brief advice and medication has also been shown to be effective in increasing cessation among Aboriginal smokers.[19] These interventions have other advantages – they are quick, inexpensive and non-invasive.[7] A randomised controlled trial of a locally developed intensive tobacco intervention delivered to Aboriginal smokers in the Kimberley resulted in an 11% cessation rate in the intervention group compared to a 5% cessation rate in the 'normal care' group (non-significant difference).[23]

For Aboriginal people, brief advice should be given in a way that is culturally appropriate, supportive and non-coercive.[7,23]

Medications to support quitting

Common medications to help people quit smoking include NRT and other drugs such as bupropion and varenicline. There is good evidence that NRT (nicotine patches, gum, lozenges and inhalers) can be effective in increasing the quit rate among smokers in both the general population and among Aboriginal smokers.[7,19] A study of Aboriginal smokers in a remote community in the Northern Territory compared brief intervention advice with brief intervention and free NRT. At 6 month follow up, quitting rates were higher among the group who received brief interventions and free NRT (15%) compared to the group who only received brief intervention advice (1%).[18]

Evidence on the effectiveness of bupropion and varenicline for Aboriginal people is not available, but these medications may be useful to assist some Aboriginal people who smoke to quit, especially when combined with support and advice from a health professional.[7,19,34] Nicotine patches have been available to Aboriginal people at a subsidised cost since December 2008 and in 2010 this was extended to include medications such as varenicline and bupropion.[35]

Quit groups

There is evidence that quit groups are more effective than self-help resources or no intervention.[36] The evidence is unclear whether quit groups are more effective than individual counselling or brief interventions.[36] An evaluation of an Aboriginal quit group provided at an Aboriginal medical service in Victoria reported a quit rate of 19%.[7,22]

In the general population, while medication and cessation support can increase the likelihood of successful quitting, there is evidence that most people quit on their own, without these supports[37]. It has been suggested that improving confidence to quit (self-efficacy) among Aboriginal people who smoke is likely to be an important approach to improving quit rates.[7,16,37]

Telephone services

The Quitline is a telephone service that provides access to evidence based resources, advice, support and counselling to smokers who want to quit. Telephone counselling is effective especially if people have 3 or more calls as part of their counselling and follow up.[28]

Awareness and broad understanding of the role of the Quitline is high among Aboriginal smokers, health workers and practitioners in NSW.[38] However, research with Aboriginal smokers and health practitioners in NSW found low levels of smokers reporting they had used the Quitline services and few health workers or practitioners interviewed had recommended the Quitline to clients, or recalled clients accessing the Quitline services.[38]

Aboriginal smokers identified a number of strengths of the Quitline service such as confidentiality, access for people in remote areas or who are socially isolated and the availability of sustained support during quit attempts.[38] A major barrier preventing Aboriginal smokers from accessing the service was reluctance to speak to an unknown person on the telephone with most Aboriginal smokers preferring face to face support in their local area. The cost of calls from mobile phones was identified as another barrier. Health workers or practitioners also noted the benefits of linking cessation support with existing services such as drug and alcohol and mental health services and grief counselling. Health workers or practitioners also indicated the importance of wholistic support and Aboriginal specific smoking cessation resources.[38]

Programs for pregnant women who smoke

There is evidence that quit smoking interventions for pregnant women can reduce smoking prevalence during pregnancy, improve birth weight and reduce premature birth and other pregnancy complications in the general population.[30] A literature review prepared to inform the Victorian Aboriginal Community Controlled Health Organisation (VACCHO) Smoking Amongst Pregnant Aboriginal Women Research Project, concluded that tobacco control activities with pregnant Aboriginal and Torres Strait Islander women should include building the capacity of existing services and staff to provide brief interventions and cessation support for pregnant women and their families, support for health workers to quit, smoke-free policies and environments, community based approaches to challenge the acceptability of smoking in Aboriginal communities, and broader strategies to reduce social disadvantage.[39] A randomised controlled trial of a brief intervention for pregnant Aboriginal women showed no significant effect on cessation rates but the authors commented that this was due to small sample size and possible contamination (contact) between the two groups.[29,39]

Training health professionals to deliver cessation advice

Training health professionals in smoking brief interventions increases the likelihood of them identifying smokers and providing smoking cessation advice.[7,40] While it is likely that training Aboriginal Health Workers to provide brief smoking cessation intervention with clients will contribute to increased quit rates[19], training alone has little effect in reducing the number of smokers and should be combined with other evidenced based strategies.[7]

In general, these training programs focus on enhancing the skills and confidence of Aboriginal Health Workers and other relevant staff in delivering smoking cessation advice and tobacco programs. The evaluation of the NSW SmokeCheck program found that health workers who participated in the program were more confident in discussing tobacco use with their clients and providing information and advice about quitting. Health workers were also more likely to provide advice about NRT and discuss other tobacco issues such as the health risks of second-hand smoke.[41]

Pricing and taxation

Increasing the price of tobacco is one of the most effective strategies to reduce tobacco related harm and reduce inequities associated with smoking.[9,24-26] 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"*.[9,24]

Increasing the price of tobacco through taxation has been shown to prompt quit attempts and reduce consumption of tobacco especially among those who are sensitive to price changes, such as low income smokers and children.[9,25,26, 40,42] The cost of cigarettes has been cited by Aboriginal people as one of the reasons they quit smoking.[31,40]

Part three: The ATRAC Framework

Purpose

The ATRAC Framework has been developed to establish an integrated approach to tobacco resistance and control in Aboriginal communities in NSW, and to:

- Increase the capacity of Aboriginal communities to resist tobacco use and be active in tobacco control;
- Enhance and strengthen the efforts of ACCHSs and other Aboriginal community organisations to undertake tobacco resistance and control activities;
- Enhance and strengthen the efforts of government and non-government health organisations, and other relevant groups, to implement effective Aboriginal tobacco control activities;
- Build skills and support in the workforce to undertake effective Aboriginal tobacco resistance and control work, particularly amongst Aboriginal Health Workers and other health professionals working with Aboriginal people; and
- Improve the integration and coordination of Aboriginal tobacco control efforts and strengthen partnerships.

Goal and objectives

The goal of an integrated approach to tobacco resistance and control is to reduce the smoking prevalence and the harmful impacts of tobacco use among Aboriginal people and communities.

The objectives are to:

- Increase the number of Aboriginal people who quit smoking;
- Increase smoke-free homes, workplaces and public places;
- Shift Aboriginal community attitudes away from smoking being a norm; and
- Prevent uptake of smoking by Aboriginal people, particularly young people and children.

Areas for action

The actions recommended in the ATRAC Framework are organised in 6 key areas of action:

1. *Leadership, partnerships and coordination;*
2. *Community action, awareness and engagement;*
3. *Workforce development;*
4. *Supportive environments;*
5. *Quitting smoking; and*
6. *Evidence, evaluation and research.*

Area for action 1: Leadership, partnerships and coordination

Rationale

Building on current efforts to engage Aboriginal leaders and community members on tobacco control issues and continuing to raise the profile of tobacco use as a serious health issue for Aboriginal communities are important approaches to reduce Aboriginal smoking. Promotion of quitting and smoke-free messages at community events can also raise awareness.

Actions to increase awareness and support for tobacco resistance and control activities can be extended beyond the health sector to involve other organisations such as Aboriginal sporting organisations, local government or groups working with Aboriginal young people. Integrating tobacco control efforts with other health programs across Aboriginal specific and mainstream health services also offers opportunities to increase the reach of tobacco resistance and control efforts and assist more Aboriginal people who smoke.

Developing strong local, regional and statewide partnerships to plan and deliver Aboriginal tobacco activities, services and programs could reduce duplication and enhance the delivery of programs.

Recommended Actions

A. Ensure and foster Aboriginal community leadership on tobacco resistance and control, including through involving Aboriginal people, communities and community controlled organisations in the development, implementation and evaluation of all programs targeting Aboriginal people;
B. Engage and support Aboriginal community Elders, board members from ACCHSs and other Aboriginal community organisations, land council representatives, and Aboriginal community members including young people to become advocates and leaders in Aboriginal tobacco resistance and control;
C. Strengthen Aboriginal tobacco control networks and networking activities;
D. Support approaches to Aboriginal tobacco resistance and control that are planned and integrated with existing programs and other health programs, for example: healthy lifestyles, chronic disease, maternal and child health, drug and alcohol, diabetes prevention, mental health, and prisoner health;
E. Promote and support partnerships and collaboration between different sectors and organisations;
F. Ensure effective integration between Aboriginal tobacco resistance and control activities and programs funded by state and Commonwealth governments and non-government organisations; and
G. Ensure Aboriginal communities, and their representative organisations such as ACCHSs and the AH&MRC, have opportunities to input meaningfully into the review and development of new tobacco control policy and communication on tobacco control legislation.

Area for action 2: Community action, awareness and engagement

Rationale

Engaging Aboriginal communities in planning and developing local tobacco control activities can mobilise communities and help to make smoke-free environments and quitting 'everyone's business'. People, especially children, who live in communities where smoking is very common and seen as the social norm, are more likely to take up smoking. The same factors can also discourage smokers from attempting to quit and may make it harder to quit successfully. Therefore it is critical to shift attitudes and beliefs that smoking is the norm for Aboriginal people.

Programs that are likely to have the greatest success in reducing smoking in Aboriginal communities are multi-component programs with a whole of community focus that address a range of tobacco issues relevant to communities.[7,21,40] The elements of these programs will depend on local community priorities, but could include projects such as advocacy and action on smoke-free events, quit smoking programs, family and peer based projects, promotion of smoke-free homes and working with retailers to ensure responsible selling practice.[43]

Aboriginal people are aware that smoking is harmful to health, but report less knowledge of the specific negative health effects that are associated with smoking.[31,32] Mainstream social marketing campaigns have been effective at increasing knowledge of tobacco related health risks, motivating quit attempts and reducing smoking prevalence in the general population.[4,9] The effectiveness of these campaigns with Aboriginal people has not been well evaluated. Following the national Aboriginal *Break the Chain* Campaign in 2011, over half of the Aboriginal people interviewed (57%) indicated they were planning to reduce the amount they smoke or quit altogether. Aboriginal people who had recently quit smoking mentioned that they were encouraging family and friends to quit smoking.[31]

Many Aboriginal people who smoke believe that tobacco resistance and control programs (including media campaigns) should be developed at the local community level in partnership with local Aboriginal communities, with the participation of elders and other community leaders in developing and delivering campaign messages that reflect local needs and priorities rather than mainstream campaign messages.[33]

Recommended Actions

A. Strengthen and support Aboriginal community efforts in tobacco resistance and control at the local community level;
B. Engage Aboriginal community organisations such as sporting groups, youth groups and education providers in tobacco resistance control activities or events;
C. Disseminate success stories and share experiences about effective local approaches;
D. Develop, implement and evaluate localised approaches to promoting quitting and reducing exposure to second-hand smoke, developed by communities;
E. Develop appropriate tools and resources to support and assist Aboriginal communities in their development of effective localised educational and promotional campaigns, for example a toolkit of resources;
F. Refine and evaluate the effectiveness of media campaign strategies that have been tested with Aboriginal people to ensure cultural appropriateness to reach more Aboriginal smokers through television and radio and social media and increase representation of Aboriginal people in mainstream mass media campaigns;
G. Develop and implement specific approaches to facilitate communication with Aboriginal communities about changes to tobacco control legislation; and
H. Promote smoke-free role models within the community, particularly to young people.

Area for action 3: Workforce development

Rationale

A well-trained and motivated workforce is essential for the effective delivery of tobacco resistance and control activities for Aboriginal people and communities. Training Aboriginal Health Workers, health professionals and other relevant staff in providing smoking brief interventions can increase the likelihood that smokers are identified and provided with smoking cessation advice.[7,19,40] To ensure staff are adequately skilled in brief intervention, training needs to be delivered regularly in a range of locations and settings, to take account of staff turnover and maximise accessibility. The SmokeCheck project is one model of brief intervention training that was designed specifically for Aboriginal community contexts and was successfully implemented in NSW.[41]

Ongoing support and mentoring of staff after training is completed is also required. It is important that brief intervention tobacco control training is available to Aboriginal Health Workers, as well as all relevant staff in ACCHSs and mainstream health services.[41] Provision of accredited specialist training in tobacco control is important in terms of building the capacity of Aboriginal Health Workers. Providing access to relevant and culturally appropriate training on tobacco resistance and control and advocacy skills for Aboriginal community members, youth leaders, role models and champions can increase confidence and skills to promote smoke-free messages.

Workforce development and training approaches should not occur in isolation from other strategies. A comprehensive approach to capacity building appropriately considers and links workforce development with broader strategies of organisational change, resource allocation, leadership and partnership development.

Recommended Actions

A. Train, employ and support specialised positions for Aboriginal workers to focus on tobacco control and smoking cessation in ACCHSs and other health care settings;

B. Provide a range of accredited training programs in brief intervention and other areas of tobacco resistance and control for relevant staff in ACCHSs, Aboriginal community organisations, LHDs, and Primary Health Networks as well as Aboriginal community members including young people;

C. Embed tobacco control skills into primary qualifications training for Aboriginal Health Workers and other health professional groups and incorporate tobacco resistance and control training into training for other relevant programs;

D. Build linkages and partnerships between specialised tobacco control workers, relevant staff in mainstream health services and staff in specific areas such as drug and alcohol, chronic disease prevention, mental health, maternal and child health and prisoner health; and

E. Support and mentor workers in tobacco resistance and control at the local, regional and state level through networks, events, forums, and workshops, and through the development of career pathways for specialist Aboriginal tobacco control workers.

Area for action 4: Supportive environments

Rationale

Creating supportive environments is an approach that focuses on creating environments or settings where healthy choices become easier to make. In relation to Aboriginal tobacco resistance and control there are a number of important environments or settings, including the community, schools, health services and prisons.

Community is the most important environment that has the potential to support healthy and smoke-free choices and lifestyles for Aboriginal people. There is an important role for community leaders, local smoke-free ambassadors and role models in promoting quitting and smoke-free messages and increasing community engagement on tobacco issues. The involvement of parents in community approaches to tobacco resistance and control is particularly important because children of non-smoking parents are less likely to take up smoking, and schools also have an important role to play in ensuring children are well informed about the health impacts of smoking.[40,44] Developing and promoting smoke-free community events also increases awareness and engagement with tobacco resistance and control.

Health service settings that are, or could be, involved in Aboriginal resistance and control activities include ACCHSs, LHDs, Primary Health Networks, private health care providers including general practices, and some non-government organisations.

Health care organisations in NSW have smoke-free workplace policies in accordance with funding conditions and relevant legislation. While the content of these policies varies between organisations, the most comprehensive policies include a focus on smoke-free environments including workplaces, cars, and outdoor areas as well as policies and support for clients and staff to quit smoking.

The NSW Health Smoke-free Health Care Policy aims to reduce the risks to health associated with tobacco use by clients, staff and visitors to NSW Health facilities and the community's exposure to second-hand smoke.[55] The policy also outlines the responsibility of the health care sector to encourage and support all clients and staff who are smokers to quit smoking.

Encouraging and supporting staff in organisations such as ACCHSs, LHDs and Primary Health Networks who want to quit smoking is an important component of Aboriginal tobacco resistance and control activity. Most Aboriginal Health Workers agree that being a smoker is a barrier to delivering smoking cessation or brief interventions. Therefore supporting staff to quit smoking will increase their confidence in providing interventions to clients.[41]

Smoking rates among prisoners are very high and Aboriginal people are over-represented in prisons, making this an important setting for tobacco control efforts. Surveys of NSW prisoners show that Aboriginal people in prison are more likely to smoke than non-Aboriginal people in prison and the vast majority want to quit.[45]

With Australian prisons increasingly becoming smoke-free, it will be important to ensure prisoners are supported to reduce tobacco consumption.

Recommended Actions

A. Mobilise and engage Aboriginal communities on tobacco resistance and control issues especially in promoting smoke-free homes, cars, workplaces and shifting Aboriginal community attitudes away from smoking being a norm;

B. Promote smoke-free role models and smoke-free events for Aboriginal people through ACCHSs and other Aboriginal community organisations, LHDs, Primary Health Networks and in the broader Aboriginal community;

C. Tailor retailer education activities (with a focus on sales to minors) for Aboriginal communities;

D. Develop and support the implementation of comprehensive smoke-free workplace policies for health services and custodial settings that include a focus on smoke-free environments, support for clients and staff to quit smoking, access to NRT and brief intervention training for staff;

E. Improve skills of Aboriginal and non-Aboriginal clinical staff, including those working in prisons, to counsel Aboriginal patients to quit smoking and to promote and support quitting;

F. Ensure tools to support smoking assessment and cessation support are integrated into patient information management systems for health services used by Aboriginal people and that staff are trained and supported to use these tools effectively;

G. Promote coordination and integration of Aboriginal tobacco resistance and control programs with other health programs in particular healthy lifestyle, chronic disease, mental health, drug and alcohol, and maternal and child health;

H. Integrate tobacco control programs for Aboriginal people in prison with other tobacco resistance and control programs, with other health services (e.g. mental health and drug and alcohol) and with other relevant programs and services in the community who can support ex-smokers to stay quit on release from prison; and

I. Build on existing coverage of the health risks of tobacco smoking in the school curriculum, and ensure its relevance and appropriateness for Aboriginal children and their families.

Area for action 5: Quitting smoking

Rationale

Most Aboriginal people who smoke want to quit and have made several attempts to do so.[16,31,40] However many Aboriginal people report a lack of confidence in their ability to quit successfully, with influences being previous unsuccessful quit attempts, many years of smoking from a young age and the lack of successful role models who have quit for good.[38]

Brief advice from health professionals can help smokers to quit.[7,27,46] Health professionals providing brief advice to smokers can increase quit rates by 1-3% above quit rates among smokers trying to quit without support or advice.[27] These interventions are quick, inexpensive and non-invasive.[7,40] It is important that these interventions are given in a way that is culturally appropriate and non-threatening.[7,47]

There is also good evidence that NRT (including nicotine patches, gum, lozenges and inhalers) can be effective in increasing the quit rate among smokers in both the general population and amongst Aboriginal people who smoke.[7,18] NRT can increase smokers' quit rates by 50-70%.[48] Subsidised nicotine patches and other medications are available at a subsidised price to Aboriginal people through the Pharmaceuticals Benefits Scheme (PBS) co-payment scheme.[35] Other NRT products can be bought over the counter and are sometimes funded by other means for specific groups, such as antenatal clients or hospital inpatients.

Good evidence of effectiveness for pharmacotherapies such as varenicline and bupropion has been demonstrated in mainstream populations especially when combined with brief intervention advice and quitting support. These medications are available to Aboriginal people at a discounted price through the Closing the Gap scheme.

Fast Facts about Quitting

Around 22% of Aboriginal people are ex-smokers. Nearly two-thirds (62%) of Aboriginal smokers have tried to quit or reduce their smoking in the last 12 months.[3]

Reasons smokers give for trying to quit/reduce smoking are general health, cost, and encouragement from family and friends.[3]

Quitting smoking provides health benefits no matter how long a person has smoked. The benefits of quitting are felt not just by smokers but also by the children and other family members around them. For example, children are less likely to start smoking if they have non-smoking parents and exposure to second-hand smoke is reduced.[8, 12, 15]

The use of pharmaceuticals, quitting support, brief interventions and smoke-free policies can increase quitting rates.[9, 52]

Pregnancy can be an important time when women and their families may consider quitting smoking. Quit smoking programs for pregnant women have been successful in decreasing tobacco use, increasing birth weight and reducing premature births and other pregnancy complications in the general population.[40]

ACCHSs and other primary and community health services deliver a range of services to support Aboriginal people who smoke to quit, including through activities integrated with primary health care activities such as arranging access to NRT or referral to the Quitline or other specialist smoking cessation advisors, as well as hosting specific tobacco control programs such as quit groups. Some studies in mainstream settings suggest that quit groups are more effective in supporting smokers to quit than self-help resources or no intervention.[7,36] Evaluation of one Victorian ACCHS quit group reported a cessation rate of 19%.[22]

Telephone based services, such as the Quitline, can be used to deliver effective smoking cessation support for smokers seeking to quit.[28] A number of barriers for Aboriginal people accessing the Quitline service have been identified, and efforts are currently being made nationally to enhance the Quitline services to be more accessible and appropriate for Aboriginal people.[38] The introduction of Aboriginal staff to the Quitline has increased the number of Aboriginal people calling the service.[16]

Concerns about the relationship between cannabis use and nicotine addiction are relevant to Aboriginal tobacco resistance and control efforts. Research in the North Coast of NSW has suggested that young people (particularly young men) can become dependent on tobacco by initially mixing it with cannabis.[49] Subsequently, long-term cannabis users find it difficult to quit smoking tobacco because of the reinforcing influence of their cannabis use, demonstrating a need to provide tobacco cessation support, including cessation advice and pharmacotherapies, to people who identify as cannabis smokers.

Recommended Actions

A. Increase access and availability of culturally appropriate smoking cessation support options available to Aboriginal people who smoke, including pregnant women and their families. This support should be routinely available through ACCHSs, mainstream health services including hospitals and prisons, and routinely provided by a range of health professionals including Aboriginal Health Workers, nurses, doctors, drug and alcohol workers, mental health workers, social workers, and family workers;
B. Increase awareness of, and access to, a full range of NRT products and other pharmacotherapies by Aboriginal people;
C. Develop and implement policies and systems in ACCHSs and mainstream health services that support the provision of brief interventions for smoking cessation for Aboriginal people who smoke;
D. Consider and evaluate approaches to support quitting such as quit groups based in health organisations or workplaces, including specific groups for Aboriginal people;
E. Continue to develop the Quitline to be appropriate and accessible for Aboriginal people, raise awareness and increase referral to the service;
F. Widely promote information about role models, quit attempts and success stories;
G. Link smoking cessation services with other health services provided by ACCHSs and LHDs (e.g. healthy lifestyles, chronic disease prevention programs, drug and alcohol programs, mental health, maternal and child health programs, and prisoner health programs);
H. Explore and evaluate the effectiveness and appropriateness of the use of incentives to support quitting in an Aboriginal community context; and
I. Develop programs that address the combination of cannabis and tobacco use for relevant communities.

Area for action 6: Evidence, evaluation and research

Rationale

Aboriginal communities have considerable knowledge and expertise about Aboriginal tobacco resistance and control. Support and resources are required to ensure that this knowledge can be collected, shared and used effectively to build the evidence base and inform future tobacco control programs and activities to reduce the numbers of Aboriginal people who smoke.

Developing strategies to address the gaps in data about smoking amongst Aboriginal people to inform future programs and policies is a priority. For example, while there is data available on smoking prevalence for Aboriginal people over time through the National Aboriginal and Torres Strait Islander Health and Social Surveys and the NSW Population Health Survey, there is little data available on the knowledge, attitudes and beliefs of Aboriginal people about smoking and how these might change over time. Projects are underway that will contribute useful knowledge about Aboriginal people and smoking, such as the Talking about the Smokes project[50] and the Aboriginal Smoking and Health Survey developed by the Cancer Institute NSW, with support from ACCHSs and the AH&MRC.

Programs to reduce smoking rates for Aboriginal people are being implemented in communities across NSW and Australia, and evaluating the success of these programs is important. Building in project evaluation at the local level helps to refine and direct programs during implementation, and also builds stronger evidence about effective community approaches.[51] It is important to build the skills and capacity of ACCHSs to undertake research and evaluation and ensure mainstream organisations have assistance to develop and use culturally appropriate evaluation methods and approaches. Development of partnerships between research organisations and those working in tobacco control could enhance research and evaluation efforts on tobacco resistance and control in NSW.

Recommended Actions

A. Strengthen and enhance local Aboriginal community and ACCHS capacity in research and project evaluation;
B. Support mainstream organisations to develop and use research and evaluation methods and approaches that are appropriate for an Aboriginal community context;
C. Develop transferrable models for evaluating community Aboriginal tobacco resistance and control initiatives;
D. Ensure Aboriginal communities are consistently provided with feedback on research and evaluation project outcomes;
E. Develop and support research and evaluation partnerships between research organisations and ACCHSs, as well as other organisations involved in Aboriginal tobacco control including LHDs, Primary Health Networks, and non-government organisations;
F. Disseminate evidence that already exists about effective programs and approaches to Aboriginal tobacco resistance and control; and
G. Improve the quality and use of population health data about smoking by Aboriginal people at local, regional and state levels, including its use for monitoring and reporting on progress with achieving reductions in smoking prevalence by Aboriginal people in NSW.

Part four: Roles in Aboriginal tobacco resistance and control

NSW Ministry of Health: The NSW Ministry of Health supports the executive and statutory roles of the NSW Minister for Health and Medical Research and monitors the performance of the NSW public health system, known as NSW Health. The NSW Ministry of Health has specific responsibilities in relation to improving the health and well-being of people in NSW through approaches which focus on whole populations. This includes responsibility for statewide tobacco control policy development and program implementation, *NSW Health Tobacco Strategy 2012-2017*, legislation and reporting on progress towards the goals and objectives outlined in government plans. The NSW Ministry of Health also has a role in coordinating, building capacity and in some circumstances funding tobacco control programs and policies to improve the health of people in NSW, including reducing the smoking prevalence among Aboriginal people.

The NSW Ministry of Health acknowledges the important of working in partnership and the ongoing commitment with Aboriginal communities and other agencies. This approach will provide a strong foundation and underpin the effort to reduce tobacco smoking among Aboriginal people.

Aboriginal Health & Medical Research Council: The Aboriginal Health & Medical Research Council of NSW (AH&MRC) is the peak representative body of Aboriginal communities on health in NSW. The AH&MRC supports and represents member Aboriginal Community Controlled Health Services (ACCHSs). Roles of the AH&MRC in Aboriginal tobacco resistance and control have included:

- Supporting and building the capabilities of ACCHSs and the Aboriginal health workforce, including workers specifically focused on Aboriginal tobacco resistance and control;
- Developing, delivering and evaluating social marketing campaigns in collaboration with local Aboriginal communities;
- Developing tools and resources to support local NSW Aboriginal communities and ACCHSs;
- Undertaking and advising about research and evaluation in NSW and nationally;
- Hosting events including regional workshops and statewide symposiums;
- Establishing and maintaining statewide communication networks;
- Developing and delivering accredited training for Aboriginal Health Workers;
- Contributing to policy development at state and national levels;
- Collaborating with other parts of the ACCHS sector nationally, and with a range of government agencies and non-government organisations; and
- Providing Aboriginal leadership at the NSW state level.

Aboriginal Community Controlled Health Services: Aboriginal Community Controlled Health Services (ACCHSs) are incorporated Aboriginal organisations, initiated by and based in a local Aboriginal community, that deliver wholistic and culturally appropriate primary health care services to their community. Roles of ACCHSs in Aboriginal tobacco resistance and control have included:

- Developing, implementing and evaluating local programs for local communities;
- Developing and delivering local social marketing and health promotion campaigns;
- Developing and using local resources;
- Employing, training and supporting Aboriginal health workforce including workers specifically focused on Aboriginal tobacco resistance and control and Aboriginal Health Workers in a range of roles;
- Training the ACCHS workforce in brief intervention;
- Delivering brief intervention through clinical and other health programs;
- Providing cessation support services, including facilitating access to pharmacotherapies and specialist support;
- Undertaking, participating in, and advising about research and evaluation;
- Contributing to policy development at local, state and national levels;
- Collaborating with other ACCHSs and the AH&MRC and with a range of government agencies and non-government organisations; and
- Providing Aboriginal leadership at the local and regional level.

Local Health Districts: Local Health Districts (LHDs) are responsible for the delivery of health care services to a geographically defined, local population, across a wide range of settings, and within the framework of a Service Agreement with the NSW Ministry of Health, for the purpose of maximising the health of its local population. There are 7 metropolitan LHDs and 8 rural and remote LHDs in NSW that provide public hospitals, community, family and children's health centres, ambulance services and an extensive range of specialty services including mental health, dental, allied health and public health. Local Health Districts work closely with the NSW Ministry of Health and community organisations to strengthen the effort to reduce smoking rates among people in NSW, including in Aboriginal communities.

Cancer Institute NSW: The Cancer Institute NSW is the first statewide, government funded cancer control agency. The tobacco control program of the Cancer Institute NSW is responsible for the design, development and delivery of social marketing campaigns as well as the provision of funding, management and policy of the NSW Quitline and iCanQuit that provide support services to smokers. The Cancer Institute NSW also undertakes population based research on tobacco, evaluation and monitoring of anti-tobacco social marketing campaigns and statewide smoking cessation services. The objectives of the Cancer Institute NSW are to:

- Reduce the incidence of cancer in the community;
- Increase the survival rate for cancer patients;
- Improve the quality of life of cancer patients and their carers; and
- Provide a source of expertise on cancer control for the government, health service providers, medical researchers and the general community.

The Cancer Institute NSW is committed to working in partnership with the AH&MRC and ACCHSs on a range of initiatives which reduce variations in cancer outcomes in Aboriginal people. These include the development of culturally appropriate services and developing the skills of the workforce which provide services to Aboriginal people.

Quitline: The Quitline provides an evidence-based smoking cessation service for smokers seeking to quit using telephone assistance. For the cost of a local call (except mobiles), professional telephone advisors provide individually tailored information, advice, encouragement, and support and counselling to help smokers quit. The advisors are able to assist smokers at whatever stage they may be at in the quitting process and provide advice to family and friends of smokers and to health professionals about the best evidence for quitting smoking. Since 2011, the Aboriginal Quitline Enhancement Project has enabled the employment of two Aboriginal Quitline counsellors, and other activities to promote and enhance the Quitline for Aboriginal people. The Prison Quitline provides telephone based smoking cessation services to those in custody including Aboriginal men, women and young people in custody in the NSW custodial and juvenile justice settings.

Justice Health and Forensic Mental Health Network: Justice Health and Forensic Mental Health Network is a Statutory Health Corporation established under the *Health Services Act (NSW) 1997* and is funded by the NSW Ministry of Health. Justice Health and Forensic Mental Health Network provides health care in a complex environment to people in the adult correctional environment, to those in courts and police cells, to juvenile detainees and to those within the NSW forensic mental health system and in the community. Justice Health provides health care and cessation support to Aboriginal adults and young people in custody.

Australian Government Department of Health: The Department's role is to achieve the Australian Government's priorities (outcomes) for health. It does this through the development of policies, funding of primary health care and other services, management of programs and undertaking research and regulatory activities. The Department of Health is responsible for national tobacco policy and regulatory activities and oversees the implementation of the National Tobacco Strategy.

Primary Health Networks: The establishment of Primary Health Networks was announced by the Australian Government in May 2014, to replace the national network of Medicare Locals that had been established in 2011.The Australian Government has stated its intention that Primary Health Networks will be efficient corporate organisations responsible for improving patient outcomes in their local areas by ensuring that services across the primary, community and secondary sectors align and work together in the interest of patients. The scope of Primary Health Network roles and activities relating to Aboriginal tobacco resistance and control were yet to be established, at the time the ATRAC Framework was finalised.

Non-government and community service organisations: A range of community service organisations have begun to integrate tobacco resistance and control activities to better support their clients who smoke. These organisations have important opportunities to initiate and support brief interventions and other tobacco control activities with their Aboriginal clients to reduce smoking prevalence and improve health. Some organisations such as the National Heart Foundation and Cancer Council NSW have been active in tobacco control policies, programs and advocacy for many years. Other community-based organisations include groups not specifically focused on health, such as sporting clubs, schools, unions and Aboriginal organisations have the potential to engage in Aboriginal tobacco resistance and control activities and promote quitting and smoke-free messages.

Part five:
Monitoring achievements

The NSW Ministry of Health in partnership with the AH&MRC will work with other government agencies and non-government organisations to assess the use and value of the ATRAC Framework. It is planned this will occur through the activities of the Aboriginal Health Partnership Sub-Committee on Tobacco Resistance and Control.

Progress with reaching NSW 2021 targets on smoking prevalence among Aboriginal people is one of the ways the potential impacts of collective action on Aboriginal tobacco resistance and control informed by the ATRAC Framework can be assessed. Progress towards reaching targets will be monitored at the local level, and at a NSW level through the NSW Population Health Survey.

Those using the ATRAC Framework are encouraged to evaluate their policies, programs and activities, and contribute their achievements and what they have learnt to strengthen the evidence base about achieving Aboriginal tobacco resistance and control.

Appendix one

The NSW Aboriginal Health Partnership Sub-Committee on Tobacco Resistance and Control

Co-chairs		
Dr Jo Mitchell	Director	Centre for Population Health, NSW Ministry of Health
Ms Jasmine Sarin	Senior Project Officer	Aboriginal Health and Medical Research Council of NSW
Members		
Ms Caron Bowen*	Acting Manager	Centre for Aboriginal Health, NSW Ministry of Health
Ms Pauline Deweerd	Aboriginal Health Network Coordinator	St Vincent's Health Australia Sydney
Dr Jenny Hunt	Public Health Medical Officer	Aboriginal Health and Medical Research Council of NSW
Ms Jody Irwin	Regional Tackling Smoking Program	Bullinah Aboriginal Health Service
Ms Mayanne Lafontaine	Program Manager, Tobacco Control	Cancer Institute NSW
Ms Kerri Lucas	Public Health Manager	Aboriginal Health and Medical Research Council of NSW
Ms Peta Lucas	Manager, Strategic Regulatory and Policy Branch	Centre for Population Health, NSW Ministry of Health
Mr Andy Mark	Regional Health Promotion Coordinator	National Heart Foundation (NSW Division)
Ms Shani Prosser	Manager, Health Advancement	Justice Health and Forensic Mental Health Network
Ms Peta Sutton	Deputy CEO	South Coast Medical Service Aboriginal Corporation
Ms Ros Tokley	Manager Health Promotion, Healthy Communities	Mid North Coast Local Health District
Mr Scott Walsberger	Manager, Tobacco Control Unit	Cancer Council NSW

* Member for part period

Appendix two

ATRAC Framework Working Group

Ms Jo Coutts	Aboriginal Health and Medical Research Council of NSW
Dr Jenny Hunt	Aboriginal Health and Medical Research Council of NSW
Ms Kerri Lucas	Aboriginal Health and Medical Research Council of NSW
Ms Jasmine Sarin	Aboriginal Health and Medical Research Council of NSW
Ms Amanda Leonard	NSW Ministry of Health
Ms Peta Lucas	NSW Ministry of Health
Ms Audrey Maag	NSW Ministry of Health
Dr Jo Mitchell	NSW Ministry of Health
Ms Dias Soewido	NSW Ministry of Health
Ms Colleen Smyth	NSW Ministry of Health

Appendix three

Other contributions

Dr Rowena Ivers
Ms Kate Purcell

References

1. NSW Ministry of Health, *Aboriginal Health Plan 2013-2023*. Sydney: NSW Ministry of Health, 2012.
2. Vos T et al. *Burden of Disease and Injury in Aboriginal and Torres Strait Islander People: the Indigenous Health Gap.* International Journal of Epidemiology 2008; p.1-8.
3. Australian Bureau of Statistics. *The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples 2010*. Canberra: Australia Bureau of Statistics, 2011.
4. Australian Government Department of Health. *National Tobacco Strategy 2012-2018*. Canberra: Australian Government, 2012.
5. Aboriginal Health & Medical Research Council. *A-TRAC symposium report: Let's Tackle Tobacco Together*. Sydney: Aboriginal Health & Medical Research Council, 2011.
6. National Aboriginal and Islander Health Organisations (NAIHO). *Definition of Aboriginal Health restated in the National Aboriginal Health Strategy [NAHS]* 1989; Available from: www.naccho.org.au/aboriginal-health/definitions.
7. Ivers R. *Anti-tobacco programs for Aboriginal and Torres Strait Islander people 2011. Produced for the Closing the Gap Clearinghouse*. Canberra and Melbourne: Australian Institute of Health and Welfare and Australian Institute of Family Studies, 2011.
8. Centre for Disease Control and Prevention. *Reducing Tobacco Use: A Report of the Surgeon General*. Atlanta, GA: US Department of Health and Human Services, 2000.
9. Australian National Preventative Health Agency. *Evidence Brief – Smoking and Disadvantage 2013.* Canberra. Available from www.anpha.gov.au
10. Richter M et al. *Parental occupation, family affluence and adolescent health behaviour in 28 countries.* International Journal of Public Health 2009; 54(4): 203-212.
11. Voigt K. *Smoking and social justice.* Public Health Ethics, 2010.
12. US Department of Health and Human Services. *The health consequences of smoking. A report of the Surgeon General*. Rockville, Maryland: Public Health Service, Office of the Surgeon General, 2004.
13. American Cancer Society. *Is smoking really addictive?* Available from: www.cancer.org/cancer/cancercauses/tobaccocancerquestionsaboutsmokingtobaccoandhealth/questions-about-smoking-tobacco-and-health-is-tobacco-addictive.
14. DiGiacomo M et al. *Stressful life events, resources and access: key considerations in quitting smoking at an Aboriginal Medical Service.* Australian and New Zealand Journal of Public Health 2007; 31(2): 174-176.
15. Wood L et al. *Indigenous women and smoking during pregnancy: knowledge, cultural contexts and barriers to cessation.* Social Science & Medicine 2008; 66(11): 2378–2389.
16. Cancer Institute NSW. *Aboriginal Smoking and Health Survey: Key findings.* Sydney: Cancer Institute NSW, 2014.
17. Ivers R. *Indigenous Australians and Tobacco: A Literature Review*. Darwin: Cooperative Research Centre for Aboriginal and Tropical Health, 2001.
18. Ivers R et al. *A study of the use of free nicotine patches by Indigenous people.* Australian and New Zealand Journal of Public Health 2003; 27(5): 486–490.
19. Power J, Grealy C, and Rintoul D. *Tobacco interventions for Indigenous Australians: a review of current evidence.* Health Promotion Journal Australian 2010; 20(3): 186-194.

20. Centre for Excellence in Indigenous Tobacco Control. *Strategies to Tackle Smoking [Online]*. Available from: www.ceitc.org.au/strategies-tackle-smoking.

21. Ivers R et al. *Evaluation of a multi-component community tobacco intervention in three remote Australian Aboriginal communities.* Australia and New Zealand Journal of Public Health 2006; 30(2): 132-136.

22. Adam K, Rumbiolo D, and Charles S. *Evaluation of Rumbalara's 'No More Dhonga' short course in giving up smokes.* Aboriginal and Islander Health Worker Journal 2006; 30(5): 20-21.

23. Marley J et al. *The Be our Ally Beat Smoking (BOABS) study, a randomised controlled trial of an intensive smoking cessation intervention in a remote aboriginal Australian health care setting [Online].* BMC Public Health 2014; 14:32.

24. Thomas S et al. *Population tobacco control interventions and their effects on social inequalities in smoking: systematic review.* Journal of Tobacco Control 2008; 17: 230-237.

25. Chaloupka F, Straif K and Leon ME. *Effectiveness of tax and price policies in tobacco control.* British Medical Journal 2011; 20(3): 235-238.

26. Wakefield M et al. *Impact of tobacco control policies and mass media campaigns on monthly adult smoking prevalence.* American Journal of Public Health 2008; 98(8): 1443-1450.

27. Stead L, Bergson G and Lancaster T. *Physician advice for smoking cessation.* Cochrane Database of Systematic Reviews, 2008.

28. Stead L, Perera R and Lancaster T. *Telephone counseling for smoking cessation.* Cochrane Database of Systematic Reviews, 2006.

29. Eades S et al. *An intensive smoking intervention for pregnant Aboriginal and Torres Strait Islander women: a randomised controlled trial.* Medical Journal of Australia 2012; 197(1): 42-46.

30. Lumley J et al. *Interventions for promoting smoking cessation during pregnancy.* Cochrane Database of Systematic Reviews, 2009.

31. Australian Government Department of Health. *The Indigenous Anti-Smoking Campaign - 'Break the Chain'. Executive Summary [Online]*. Available from: www.quitnow.gov.au/internet/quitnow/publishing.nsf/Content/btc-indsurvey-execsumm.

32. Cancer Council WA. *Bubblewrap Campaign Summary [Online].* 2008. Available from: www.cancerwa.asn.au/resources/2009-MSH-Wave-19-2008-Bubblewrap-Campaign-Summary.pdf.

33. Commonwealth Department of Health and Aged Care. *Australia's National Tobacco Campaign. Evaluation Report Volume One.* Canberra: Commonwealth Department of Health and Aged Care, 1999.

34. Ivers R et al. *Television and delivery of health promotion programs to remote Aboriginal communities.* Health Promotion Journal of Australia 2005a; 16(2): 155–158.

35. National Prescribing Scheme. *Brief item: Nicotine patches for Aboriginal and Torres Strait Islander people*. 2008. Available from: http://www.nps.org.au/publications/health-professional/nps-radar/2008/december-2008/brief-item-nicotine.

36. Stead L and Lancaster T. *Group behaviour therapy programmes for smoking cessation.* Cochrane Database of Systematic Reviews, 2005.

37. Chapman S and MacKenzie R. *The Global Research Neglect of Unassisted Smoking Cessation: Causes and Consequences.* PLoS Med 2010; 7(2) e1000216.

38. Aboriginal Health & Medical Research Council and Cancer Institute NSW, *Qualitative Research Report - Quitline Enhancement Project*. Sydney: Aboriginal Health & Medical Research Council and Cancer Institute NSW, 2011.

39. Van der Sterren A and Goreen Narrkwarren Ngrn-toura - Healthy Family Air: A Literature Review to Inform the VACCHO Smoking amongst Pregnant Aboriginal Women Research Project team. *Goreen Narrkwarren Ngrn-toura – Healthy Family Air: A Literature Review to Inform the VACCHO Smoking amongst Pregnant Aboriginal Women Research Project*. Aboriginal and Islander Health Worker Journal 2010; 34(6): 12-13.

40. Winstanley M, Van Sterren A and Knoche D. *Tobacco Use among Aboriginal people and Torres Strait Islanders,* Updated (2012) in *Scollo MM, Winstanley MH*, in *Tobacco in Australia: Facts and Issues. Fourth Edition*. Melbourne: Cancer Council Victoria, 2012, p. 32. Available from www.TobaccoInAustralia.org.au.

41. Hearn S et al. *Evaluating NSW SmokeCheck: A culturally specific smoking cessation training program for health professionals working in Aboriginal health.* Health Promotion Journal of Australia 2011; 22(3): 189-195.

42. Scollo M and Winstanley M. *Chapter 13. The pricing and taxation of tobacco products in Australia - Section 13.5 Impact of price increases on tobacco consumption in Australia*, in *Tobacco in Australia: Facts and Issues [Online]*. Melbourne: Cancer Council Victoria, 2012. Available from www.TobaccoInAustralia.org.au.

43. Boffa J et al. *Reducing the harm from Alcohol, Tobacco and Obesity in Indigenous Communities. Key Approaches and Actions. Produced for the National Preventative Health Taskforce* 2009.

44. Johnston V and Thomas D. *Smoking behaviours in a remote Australian Indigenous community: the influence of family and other factors.* Journal of Social Science and Medicine 2008; 67(11): 1708–16.

45. Indig D et al. *2009 NSW Inmate Health Survey: Aboriginal Health Report*. Sydney: Justice Health, 2010.

46. Lancaster T and Stead L. *Self-help interventions for smoking cessation.* Cochrane Database of Systematic Reviews, 2005(3).

47. NSW Ministry of Health. *The Final Report of the NSW SmokeCheck Aboriginal Tobacco Prevention Project 2007-2008*. Sydney: NSW Ministry of Health, 2010.

48. Stead L et al. *Nicotine replacement therapy for smoking cessation.* Cochrane Database of Systematic Reviews, 2008.

49. Banbury A et al. *Smoking mull: a grounded theory model on the dynamics of combined tobacco and cannabis use among adult men.* Health Promotion Journal of Australia 2013; 24(2): 143-50.

50. National Aboriginal Community Controlled Health Organisation. *Talking About the Smokes [Online]*. Available from www.naccho.org.au/research-health/talking-about-the-smokes/.

51. Buckskin M et al. *Aboriginal Families Study: a population-based study keeping community and policy goals in mind right from the start.* International Journal for Equity in Health 2013; 12: 41.

52. Centre for Epidemiology and Evidence. *The health of Aboriginal people of NSW: Report of the Chief Health Officer 2012*. Sydney: NSW Ministry of Health, 2012.

53. Victorian Aboriginal Health Service. *Cigarette Smoking. Study of Young People's Health and Well-being* in Chapter 8 *Tobacco in Australia Facts and Issues 2013*. Fitzroy, Melbourne: Victorian Aboriginal Health Service, 1999.

54. Johnston F et al. *The Maningrida 'Be Smoke-free' project*. Health Promotion Journal of Australia 1998; 8: 12-17.

55. NSW Ministry of Health. *NSW Health Smoke-free Health Care Policy*. Policy Directive No. PD2015_003. Sydney: NSW Ministry of Health, 2015. Available on www.health.nsw.gov.au/policies/pd/2015/PD2015_003.html

Aboriginal Health & Medical Research Council
of New South Wales

NSW GOVERNMENT Health