



**Reducing smoking** in the  
ACT among Aboriginal and Torres  
Strait Islander women who are  
pregnant or who have young children

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Anke van der Sterren  
& Carrie Fowlie





## ATODA Monograph Series, No.1

# Reducing smoking in the ACT among Aboriginal and Torres Strait Islander women who are pregnant or who have young children

Anke van der Sterren and Carrie Fowlie

Alcohol Tobacco and Other Drug Association ACT

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ATODA Monograph Series

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## ATODA

This monograph forms part of the Alcohol Tobacco and Other Drug Association ACT (ATODA) Monograph Series.

ATODA is the peak body for the alcohol, tobacco and other drug sector in the Australian Capital Territory (ACT).

ATODA's vision is an ACT community with the lowest possible levels of alcohol, tobacco and other drug related harm, as a result of our, and related, sectors' evidence-informed prevention, treatment and harm reduction policies and services.

ATODA works collaboratively to provide expertise and leadership in the areas of social policy, sector and workforce development, research, coordination, partnerships, communication, education, information and resources. ATODA is an evidence-informed organisation.

The ways we work, and the outcomes we strive to achieve, reflect our commitment to the values of population health, human rights, social justice and reconciliation between Aboriginal and Torres Strait Islander people and other Australians.

ATODA strives to achieve better interaction and integration between alcohol, tobacco and other drug researchers, policy workers, practitioners, consumers and their friends and families in the ACT and region. We hope this will:

- Enhance research utilisation in policy development and its implementation
- Support knowledge transfer and exchange
- Mobilise knowledge
- Support demonstration of research impact
- Improve the quality of our practice and services
- Improve the health and wellbeing of our community

Monographs in the series are:

No 1. Reducing smoking in the ACT among Aboriginal and Torres Strait Islander women who are pregnant or who have young children

We hope this Monograph contributes to the sector, and is a useful resource towards our shared goal of a healthy, strong and supported community.



Carrie Fowlie  
Executive Officer, ATODA

## Acknowledgements

We acknowledge the Traditional Owners and continuing custodians of the lands of the ACT and we pay our respects to the Elders, their families and ancestors.

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## List of acronyms

ABS	Australian Bureau of Statistics
ACT	Australian Capital Territory
AIHW	Australian Institute of Health and Welfare
AMAP	Aboriginal Midwifery Access Program
AMIHS	Aboriginal Maternal and Infant Health Services
ATODA	Alcohol, Tobacco and Other Drug Association ACT
BOS	Birth Outcome System
BSF	Building Strong Foundations (for Aboriginal Children, Families and Communities)
GP	General Practitioner
MACH	Maternal and Child Health
NGO	Non-government Organisation
NIDAC	National Indigenous Drug and Alcohol Committee
NRT	Nicotine Replacement Therapy
NSW	New South Wales
PBS	Pharmaceutical Benefits Scheme
SIDS	Sudden Infant Death Syndrome
TCH	The Canberra Hospital

## Executive summary

The ACT is fortunate to have a body of knowledge and expertise related to tobacco control within Aboriginal and Torres Strait Islander communities. By enhancing and expanding our efforts, more sustainable and longer term solutions to smoking and pregnancy in the Aboriginal and Torres Strait Islander community can be fostered to build wellbeing and strong communities.

- Key stakeholders across non-government, community controlled and government services in the ACT have been consulted in the latter part of 2014 and early 2015 to identify strategies to address the high smoking rates amongst Aboriginal and Torres Strait Islander pregnant women in the ACT.
- Smoking rates during pregnancy among Aboriginal and Torres Strait Islander women remain high in the ACT (54% in 2007–11), and the smoking rate among non-Aboriginal and Torres Strait Islander women with Aboriginal children is also likely to be high.
- Addressing smoking during pregnancy among Aboriginal and Torres Strait Islander women requires a focus beyond simply the woman and the antenatal period. It is crucial to provide smoking prevention and cessation support during the pre-pregnancy, antenatal, postpartum, and early childhood periods, and to offer this support to women, their partners and other members of their households and communities.
- Mothers of about half of the Aboriginal and Torres Strait Islander babies born in the ACT receive their antenatal care through the antenatal program at Winnunga Nimmityjah Aboriginal Health Service. The other half receive their care through hospitals and general practitioners in the ACT, and a significant proportion receive their antenatal care in New South Wales.
- There are strong antenatal, postpartum and early childhood programs in a range of settings across the ACT to support pregnant Aboriginal and Torres Strait Islander women and babies. This includes a comprehensive Aboriginal Midwifery Access Program (AMAP) at Winnunga Nimmityjah Aboriginal Health Service that provides care and support for women and their families during the antenatal, birth and postpartum periods.
- Women accessing care through Winnunga Nimmityjah Aboriginal Health Service also have access to well-established, evidence-informed and effective smoking cessation support and expertise provided by tobacco-specific Aboriginal and Torres Strait Islander workers (through the *No More Boondah* program) and other staff at the service.
- Specialist smoking cessation and support is, however, not systematically available in other parts of the health system for Aboriginal and Torres Strait Islander pregnant women (e.g. at The Canberra Hospital). Generally the main smoking cessation services provided in the broader system tend to be brief interventions, referral to the Quitline, provision of brochures and other information, and prescribing nicotine replacement therapy (NRT).

- Pregnant Aboriginal and Torres Strait Islander smokers may face a number of barriers to accessing these mainstream smoking cessation activities, and these activities are generally not well coordinated or comprehensively delivered. Best practice recommends ongoing, targeted and comprehensive support to smokers, including psychosocial support and follow up, particularly for those who find it difficult to quit. This is generally not available to women in the mainstream service sector. There are, therefore, significant gaps in the best practice delivery of smoking cessation services in the ACT.
- The priority areas of action that have emerged are:
  1. Ensure the continuity and further enhancement of smoking cessation services delivered by, and based at, Aboriginal and Torres Strait Islander community controlled services
  2. Provide targeted, ongoing comprehensive tobacco-specific support in mainstream services for Aboriginal and Torres Strait Islander women who are pregnant and/or who have young children
  3. Provide a full course of all forms of subsidised NRT to women and their families
  4. Build the capacities of health workers to provide Aboriginal and Torres Strait Islander pregnancy and smoking cessation specific supports, including brief interventions and NRT
  5. Strengthen data collection and reporting in relation to the Aboriginal and Torres Strait Islander status of women and their babies, and the smoking status of mothers
  6. Embed smoking cessation activities across the pre-pregnancy, post-partum and early childhood periods
  7. Strengthen smoking cessation and health promotion information and resources
  8. Ensure smoking cessation services for women include partners and families
  9. Maintain and strengthen the governance of Aboriginal and Torres Strait Islander smoking cessation policy, planning and evaluation
- Specific actions under each of these priority areas are detailed in the concluding table.

# 1. Introduction

Taking a holistic approach to Aboriginal and Torres Strait Islander health that is locally designed, and operated, is necessary for an ACT community where Aboriginal and Torres Strait Islander people have good health and wellbeing and live in strong communities. The ACT is fortunate to have a body of knowledge and expertise related to tobacco control within Aboriginal and Torres Strait Islander communities. By enhancing and expanding our efforts (in line with the areas of action suggested in this report), more sustainable and longer term solutions to smoking and pregnancy in the Aboriginal and Torres Strait Islander community can be fostered.

## Who this report is for

Reducing smoking among Aboriginal and Torres Strait Islander women who are pregnant or have young children and their families is in the scope of multiple institutions and organisations in the ACT. While ACT Health is in a position to implement and/or fund a large number of the areas of action suggested in this report, other organisations and services may find these recommendations of use to them in acting on this issue or advocating for changes to service delivery and policy in the ACT. This document is, therefore, aimed at anyone who is seeking to reduce tobacco use among Aboriginal and Torres Strait Islander women who are pregnant or who have young children in the ACT. Some of the suggested actions will also be relevant to the Aboriginal and Torres Strait Islander community more generally, to pregnant women generally, and indeed to the broader tobacco control context.

## Background

The ACT Government has committed to reduce and maintain the daily smoking rate in the ACT to under 10% by 2018. However, there is a need to ensure that sub-populations are not 'left behind' and specific measures, initiatives, and resources are implemented to work towards achieving health equity across the Canberra community.

The Aboriginal and Torres Strait Islander Tobacco Control Advisory Group (TCAG) identified smoking during pregnancy as a key priority for response in the ACT and it was also identified and reported in the ACT Chief Health Officer's Report (ACT Health 2012). In 2007–09, there were significantly higher rates of smoking among pregnant Aboriginal and Torres Strait Islander women in the ACT compared to other pregnant women (50.5% compared to 11.3%) (ACT Health 2013). Smoking during pregnancy is acknowledged to result in a range of adverse health outcomes for mothers and babies, and to contribute to the development of a range of illnesses during childhood and adulthood (US Department of Health and Human Services 2004).

To address this issue, ACT Health contracted the Alcohol Tobacco and Other Drug Association ACT (ATODA) to undertake a project that will contribute to the overall goal of reducing smoking rates in the ACT among women in the Aboriginal and Torres Strait Islander community who are pregnant or who have young children by increasing the provision of, and access to, appropriate smoking cessation advice and quit maintenance support for this group. The project is being conducted in two phases: a scoping exercise (this report), followed by the

development of initiatives in response to its findings. This report documents the results of a review of the published and unpublished literature, and interviews with key individuals and services in the ACT involved in providing care and support to Aboriginal and Torres Strait Islander women who are pregnant or who have young children.

The report aims to:

- Scope the current health and social care pathways for Aboriginal and Torres Strait Islander women who are pregnant and/or who have young children, and identify the current points at which smoking cessation advice and treatment and quit maintenance support is given to this group;
- Identify points at which appropriate smoking cessation advice and treatment and quit maintenance support could be given, and suggest ways in which this could be delivered and achieved;
- Review the published and unpublished literature to identify best practices in smoking cessation among pregnant Aboriginal and Torres Strait Islander women, and to identify and describe existing activities and programs that may inform initiatives in the ACT; and
- Suggest initiatives to increase the provision of and access to smoking cessation advice and quit maintenance support for Aboriginal and Torres Strait Islander women who are pregnant or who have young children.

## Data collection strategy

As a quick scoping exercise, data collection for this project has not involved consulting with pregnant Aboriginal and Torres Strait Islander women themselves. Although ATODA remains committed to consumer participation in processes such as this, it has been beyond the capacity and timeline of this project to undertake that extensive exercise. As the project does not directly capture or reflect the views of Aboriginal and Torres Strait Islander women themselves, there are clear limitations to the information collected. However, workers who have direct and indirect contact with this group have been interviewed, and it is hoped that an adequate snapshot of the needs of this group and the gaps in the service system has been obtained in this way.

The following data collection strategy has been used:

- Internet-based scope of existing programs and services for Aboriginal and Torres Strait Islander women who are pregnant or who have young children:
  - in the ACT and around Australia
  - search using Google search engine; and
  - targeted searches using databases located at [www.ceitc.org.au](http://www.ceitc.org.au) and [www.healthinfonet.ecu.edu.au](http://www.healthinfonet.ecu.edu.au)
- Searching through websites of state and territory health departments and key non-government organisations (Cancer Council, Heart Foundation, Asthma Foundation)
- Appraisal of known existing reviews of smoking in pregnancy, particularly among Aboriginal and Torres Strait Islander people (Lumley, *et al.* 2009; Greaves, *et al.* 2011; BRC Marketing and Social Research 2005; US Department of Health and

Human Services 2014; Myers, West & Hajek 2009; Baxter, *et al.* 2009; van der Sterren & Goreen Ngrn-toura—Health Family Air Project Team 2010; CEITC nd; Winstanley, van der Sterren & Knoche 2011)

- Database search through Discovery (University of Melbourne) using key search terms: Aboriginal\*; Indigen\*, smok\*, tobacco\*, Torres Strait Island\*, pregnan\*
- Interviews and discussions with key stakeholders from the following programs and services:
  - Staff from various areas of ACT Health:
    - Health Promotion, Health Improvement
    - Epidemiology, Health Improvement
    - Policy & Government Relations, Strategy & Corporate
  - ACT Medicare Local
  - The Canberra Hospital
    - The Centenary Hospital for Women
    - Social Work Department
  - Cancer Council ACT
  - Core of Life Program, ACT Health
  - Gugan Gulwan Youth Aboriginal Corporation
  - Maternal and Child Health Program, ACT Health
  - Maternity and Women’s Health, Calvary Hospital
  - Pharmacy Guild ACT Branch
  - West Belconnen Community Health Centre
  - Winnunga Nimmityjah Aboriginal Health Service
  - Research programs that include projects on Aboriginal and Torres Strait Islander tobacco control in the ACT: Australian Institute of Aboriginal and Torres Strait Islander Studies; University of Canberra
  - Programs and activities for pregnant Aboriginal and Torres Strait Islander women in other parts of Australia:
    - Quit for New Life
    - Stickin’ It Up the Smokes

The discussions involved Aboriginal and Torres Strait Islander workers and other workers in a range of positions, including:

- Specialist tobacco workers;
- Midwives;
- Medical Officers;
- Youth workers;
- Child Health Workers;
- Program and Centre managers/coordinators;
- Researchers; and
- Policy Officers and Managers of ACT Government policy units

The finalised report also incorporates feedback on earlier drafts received at two meetings involving stakeholders from various areas of ACT Health and the community controlled and mainstream service sectors.

While an attempt was made to achieve a representation across a range of programs, services and professions, it is acknowledged that there are likely to be additional stakeholders who may need to be consulted on the implementation of some of the specific actions suggested in this report.

Notes from the interviews and discussions were reviewed for themes and collated for inclusion in the report. As much as possible, the report reflects the variety of ideas and opinions of the participants, not just majority views. Every attempt has been made to maintain the anonymity of the participants, but occasionally this is not possible as individuals may be identifiable based on their positions and/or organisations.

## Comments on terms and definitions

### Aboriginal and Torres Strait Islander terminology

Throughout this report, terminology recommended by ACT Health has been used (see: [health.act.gov.au/health-services/aboriginal-torres-strait-islander/news/aboriginal-and-torres-strait-islander-terminology](http://health.act.gov.au/health-services/aboriginal-torres-strait-islander/news/aboriginal-and-torres-strait-islander-terminology)). Thus, the term 'Aboriginal and Torres Strait Islander' has been used to refer to the diverse cultural and language groups of the traditional owners and custodians of the continent of Australia. No disrespect is intended by this choice of terminology.

### Including non-Aboriginal and Torres Strait Islander mothers

Although this report refers throughout to Aboriginal and Torres Strait Islander women, many of the issues discussed and actions suggested are equally relevant, and should be extended to, non-Aboriginal and Torres Strait Islander women with Aboriginal and Torres Strait Islander babies.

ACT data shows that a significant number of women who are not of Aboriginal and Torres Strait Islander descent have Aboriginal and Torres Strait Islander babies, and so are connected into the Aboriginal and Torres Strait Islander community. The strong association of smoking with socioeconomic status and social relationships means that this group is likely to experience similarly high levels of smoking. Non-Aboriginal and Torres Strait Islander men and women who are part of the ACT Aboriginal and Torres Strait Islander community access the same services as their family members, including antenatal care and smoking cessation services. Strategies to address the impact of smoking on children in the Aboriginal and Torres Strait Islander community must take into consideration non-Aboriginal and Torres Strait Islander women whose partners and children are of Aboriginal and Torres Strait Islander descent.

### 'Counselling' and brief interventions

It is important to make the distinction between 'counselling' as an approach to smoking cessation and counselling as a professional activity. In smoking cessation, 'behavioural counselling' is often advocated as a technique that can be used as a component of brief interventions. Brief interventions are a way that health workers can use a limited amount of time to raise awareness, share knowledge and get a person to think about making changes to improve their health status. Brief interventions can occur as a one-off or over multiple sessions and last anything from one minute to an hour (Territory Health Services 2002).

'Behavioural counselling' in this context may include activities such as providing information on health effects, increasing self-efficacy, goal setting, and assisting or facilitating coping and social support (Lorenatto, West & Michie 2012). Such 'behavioural counselling' can be delivered by any health worker who has received appropriate training in delivering smoking cessation support. These health workers do not need to be trained as professional

counsellors, who are practitioners with tertiary qualifications that enable them to deliver cognitive behavioural therapies, family therapies, and medical and other therapeutic interventions. In this report, the majority of references to ‘counselling’ relates to ‘behavioural counselling’ as a smoking cessation technique that can be delivered by any health worker with smoking cessation training.

### Antenatal, postpartum and early childhood

These stages of pregnancy and post-pregnancy are defined as follows:

- Antenatal refers to the time during which a woman is pregnant, up to the birth of the baby
- Postpartum (also called postnatal) refers to the period beginning immediately after the birth of the baby up until about six weeks after the birth
- Early childhood is being used in this report to refer to the period beginning from six weeks following the birth of the baby up until around 5 or 6 years of age.

## Organisation of this report

Following this introduction, the following sections will outline the principles underlying the report and then provide an overview of the data around tobacco use among Aboriginal and Torres Strait Islander women who are pregnant and/or who have young children. A brief overview of the ACT policy context will be followed by a scope of the current health care pathways available to these women and their families in the ACT, including around smoking cessation. The report then describes the enablers and barriers for smoking cessation among mothers of Aboriginal and Torres Strait Islander babies and children, and the limitations in smoking cessation service delivery. Section 7 discusses the various activities and programs that form part of best practice in service delivery to this group, and presents information on activities that are currently being undertaken in the ACT and elsewhere in Australia. Throughout the report, the views and opinions of the various participants in the consultation are reported under the appropriate subject headings.

The report concludes by making a series of suggested actions that relate both specifically to smoking cessation for Aboriginal and Torres Strait Islander women during the antenatal, postpartum and early childhood periods (Table A), and actions on tobacco control that could be undertaken within the health system generally (Table B). Actions undertaken with sub-populations such as pregnant Aboriginal and Torres Strait Islander women risk being undermined unless implemented within a systematic, comprehensive and targeted approach to smoking cessation more broadly, as well as across all sub-populations with high smoking rates.

A number of topics have been elaborated in supplementary documents that will be available following this report, including:

- “Improving messages around the safety of prescribing nicotine replacement therapy (NRT) in pregnancy in the ACT”
- “Smoking cessation training options available to health workers in the ACT, and principles to guide the choice of training providers”
- “How to measure success in smoking cessation activities for pregnant Aboriginal and Torres Strait Islander women: strengthening the evidence”

## 2. Principles underlying this report

A number of principles form the basis of this report, shaping the approach taken to the analysis of the information and the suggested areas of actions. These principles could be applied more universally to the consideration of smoking cessation during pregnancy and more generally within Aboriginal and Torres Strait Islander communities.

### Woman-centred approach

This report takes a woman-centred approach to smoking during pregnancy, and recognises that there are significant health benefits to quitting for *both* the mother and the baby. Quitting temporarily during pregnancy will reduce harm to the foetus, and supporting women to quit even if it is just during pregnancy is a worthwhile aim in itself. However, while reducing harm to the foetus and improving birth outcomes is central, this must be balanced with the overall goal of supporting women to quit for the sake of their own health. Encouraging woman-centred as opposed to foetus-centred care will help to reduce the stigma and blame felt by many pregnant woman who smoke, particularly when they find it difficult to quit during pregnancy.

### Harm reduction approach

While smoking abstinence may be an ultimate goal, harm reduction must be included in the suite of responses to smoking cessation among pregnant women, in line with the principles articulated in Australian and ACT Government policies—the National Drug Strategy (Ministerial Council on Drug Strategy 2011) and the ACT Alcohol Tobacco and Other Drug Strategy (ACT Government 2010). Harm reduction in tobacco control aims to encourage smokers to “move themselves down the risk spectrum by choosing safer alternatives to smoking—without demanding abstinence” (Sweanor, Alcabes & Drucker 2007). This approach is best suited for groups in which smoking rates are high, and for hardened smokers who are unable to quit using other methods. High levels of dependence on any substance (in this case nicotine) require approaches that better engage with people in ways that are relevant to their circumstances. Critics of a harm reduction approach to smoking argue that such an approach may lead to maintained, not reduced, harm (Greaves, *et al.* 2011).

#### Harms from tobacco use in Aboriginal and Torres Strait Islander communities

Aboriginal and Torres Strait Islander women and men who smoke are at increased risk for a range of tobacco-related illnesses, such as cancers, respiratory diseases, and cardiovascular disease (US Department of Health and Human Services 2004). Tobacco smoking accounts for 12.1% of the burden of disease among Aboriginal and Torres Strait Islander people (more than any other risk factors), and accounts for 20% of deaths and 17% of the health gap between Aboriginal and Torres Strait Islander people and other Australians (Vos, *et al.* 2007; Vos, *et al.* 2009).

Tobacco use also leads to significant social effects and financial strain for Aboriginal and Torres Strait Islander families (Briggs, Lindorff & Ivers 2003). The National Aboriginal and Torres Strait Islander Tobacco Control Project undertaken in 2001 concluded that tobacco

use may cause serious financial and social problems for some families and was seen to undermine family and community structures, lead to concerns for personal safety, and to contribute to poor nutrition when incomes were diverted to tobacco purchases. Participants reported that the cultural obligation to share cigarettes and other goods increased stress in some communities, and that expenditure on tobacco represented a significant proportion of family income among households with one or more smokers (Lindorff 2002). Premature death of Elders and parents from smoking-related illnesses also results in social, cultural and economic disruption for children and families.

The adverse health effects associated with smoking in pregnancy are well documented. Smoking is a risk factor for preterm delivery, complications in childbirth, foetal growth restriction, stillbirth, low birth weight and infant mortality, adverse health outcomes in childhood, and sudden infant death syndrome (US Department of Health and Human Services 2004). Aboriginal and Torres Strait Islander women and babies have higher rates of these outcomes than other women and babies, and several studies have shown the association between smoking and poor pregnancy outcomes for Aboriginal and Torres Strait Islander women. Babies and children exposed to second-hand smoke experience higher rates of sudden infant death syndrome (SIDS) and a range of diseases and conditions, such as asthma, acute respiratory infections, and middle ear infections (Winstanley, van der Sterren & Knoche 2011). Babies of smoking mothers are also more likely to develop chronic disease as adults (Mendelsohn, Gould & Oncken 2014).

#### Tobacco harm reduction during pregnancy

Harm reduction when applied to smoking during pregnancy is controversial, and highlights a mismatch between policy goals and treatment practice and how people live their lives. Policy goals are focused on improving foetal health outcomes, and measure success through quit rates achieved during pregnancy, birth outcomes (such as prematurity and birth weight), and the cost to the health system of treating premature and ill babies. Smoking-related harms to the mother or her partner or family members are not central in the policy discussion around smoking during pregnancy, and yet the costs of those harms to the community are also significant.

The policy goals contrast to the practice environment, where the health and wellbeing of the mother and her baby are front and centre of antenatal care. While the health of the foetus is clearly important, modern midwifery practice also focuses on the wellbeing of mothers more broadly, and advocates for woman-centred care (Australian Health Ministers' Advisory Council 2014). This means considering the range of complex interconnected health and social factors that may impact on smoking behaviour and the success of smoking cessation activities. For example, quitting smoking may be too challenging when a woman is dealing with multiple economic stressors and lives with a controlling partner. Harm reduction strategies for pregnant smokers may include (DiClemente, Dolan-Mullen & Windsor 2000 in Greaves, *et al.* 2011):

- reducing the number of cigarettes smoked;
- stopping smoking for brief periods of time at critical points in the pregnancy and around delivery;
- engaging in health-protection behaviours such as taking vitamins and exercising;
- reducing exposure to second-hand smoke; and
- addressing partner smoking.

The challenge is how to practically achieve this goal in the context of treating dependence. Engaging with people who are highly dependent on nicotine, and who are in situations of

broader health and social need, require harm reduction approaches that better engage with real life circumstances.

Perhaps the most controversial harm reduction approach for smoking in pregnancy is reducing the number of cigarettes smoked per day as opposed to complete abstinence. There is still some uncertainty in the literature over whether reducing the number of cigarettes smoked during pregnancy will improve birth and health outcomes for the foetus, but many argue that reducing exposure to the damaging effects of cigarettes is better than no change in exposure at all, particularly for heavy smokers who continue to smoke throughout their pregnancies (Greaves, *et al.* 2011). There may also be very good practical reasons for encouraging a woman to cut down as opposed to quitting, such as not wanting to alienate women from antenatal care. Building a woman's confidence, self-efficacy and self-esteem by supporting smoking reduction may in the long term be more beneficial to the health of the mother and baby, even when she is not able to completely quit smoking during pregnancy. Smoking reduction may eventually lead to quitting in the context of on-going advice and support received during regular antenatal care appointments. Encouraging smoking reduction where cessation cannot be achieved is also consistent with woman-centred smoking cessation support advocated above.

## Life course approach

A woman-centred approach requires taking a life-course approach to smoking cessation, rather than focusing simply on the antenatal period. Opportunities for women and their partners to quit smoking should not only be available during antenatal care, but also during the pre-pregnancy, postpartum, and early childhood periods, and then on into later adulthood. Even if a woman has not been able to quit during pregnancy, she should continue to be supported to make quit attempts in the postpartum and early childhood periods, as this could have considerable benefits for her own health, and her subsequent pregnancies. The focus of this report is, therefore, not simply on addressing smoking in pregnancy by supporting smoking cessation among pregnant women, but also through prevention activities that encourage young people to not take up smoking and to quit before they get pregnant, and to encourage women to quit or stay quit postpartum and beyond.

## Smoking cessation interrelated with other wellbeing issues

Furthermore, smoking must not be considered in isolation from the range of other health, social and economic issues that can occur concurrently. Thus, smoking cessation measures can be implemented within the context of healthy lifestyle initiatives more generally (e.g. exercise, healthy eating, drug and alcohol use). Similarly, smoking is interrelated and concurrent with a range of health and social issues. Effectively impacting on smoking cessation will be enhanced through interventions that address these other issues. On an individual-level this may include services and programs for alcohol and other drugs, mental health, stress reduction, domestic violence and improving self-esteem; on a broader systemic-level, this includes addressing issues such as poverty and racism.

## Whole-of-community approach

Women should be considered within their social context where their partners, extended family, household members, and the broader community impact on and influence their smoking behaviours. Reducing smoking-related harm among women and their babies, therefore, requires a whole-of-community approach that provides supports for all members of the Aboriginal and Torres Strait Islander community to quit smoking if they wish.

## Building on the success in the community controlled sector

The National Indigenous Drug and Alcohol Committee (NIDAC) produced a position statement on funding of drug and alcohol interventions for Aboriginal and Torres Strait Islander people. This document recommends: prioritising the provision of interventions by Aboriginal and Torres Strait Islander community controlled organisations; delivering mainstream services in partnership with these organisations; and supporting the capacity building of these local community controlled organisations (NIDAC 2013). Box 1 below describes the features of these community controlled organisations, and the range of services available through the two community controlled organisations in the ACT that deliver smoking-cessation services: Winnunga Nimmityjah Aboriginal Health Service; and Gugan Gulwan Youth Aboriginal Corporation.

In line with the NIDAC guidelines, smoking cessation services and activities that are currently offered through the Aboriginal and Torres Strait Islander community controlled sector should receive on-going funding and be strengthened and supported to build further capacity in this sector. In the ACT, the comprehensive smoking cessation program, *No More Boondah*, provided by Winnunga Nimmityjah Aboriginal Health Service provides support to community members who want to quit; it is the only program of its kind in the ACT and the most comprehensive program offered for *any* smokers. The development of new smoking cessation programs for pregnant women should be: respectful of Aboriginal and Torres Strait Islander social and cultural values; build on, strengthen and extend existing community controlled programs; and involve the community controlled sector in the development and implementation of specific activities located in mainstream services.

### Box1: Aboriginal and Torres Strait Islander community controlled organisations in the ACT

Aboriginal and Torres Strait Islander community controlled organisations are built on a model that enables local communities to actively participate in the development and delivery of services. The local Aboriginal and Torres Strait Islander community governs the organisation through an Aboriginal and Torres Strait Islander Board, and the management of the service and/or delivery of services are primarily undertaken by Aboriginal and Torres Strait Islander staff.

Aboriginal community controlled health organisations deliver services according to a primary health care model. Underpinning service delivery in these organisations is the Aboriginal definition of health (National Aboriginal Health Strategy Working Party 1989):

*...not just the physical well-being of an individual but ... the social, emotional and cultural*

*wellbeing 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.*

Service delivery in these organisations is comprehensive, targets the social determinants of health, and seeks to promote, strengthen and maintain the social and cultural integrity of Aboriginal and Torres Strait Islander communities.

Winnunga Nimmityjah Aboriginal Health Service, founded in 1988, and currently located at Boolimba Crescent Narrabundah, provides comprehensive primary health care to Aboriginal and Torres Strait Islander people in the ACT region. This includes a range of clinical and social health services including: general and specialist health care; dental care; midwifery services; early childhood services; social and emotional health and wellbeing programs; substance misuse programs; support groups for various sub-groups (e.g. men's, women's, Elders); tobacco cessation services; and a home maintenance program (Winnunga Nimmityjah Aboriginal Health Service 2013).

Gugan Gulwan Youth Aboriginal Corporation, is located in Wanniasa and aims "to provide an effective and efficient youth service for Aboriginal and Torres Strait Islander youth and their families in the ACT and surrounding region". Services include: a Drug and Alcohol program; a Child, Youth and Family Support Program and Reconnect Program. A large number of group based and outreach programs are also available. The service gives support to parents and families, and focuses on skills development for young people (Gugan Gulwan Youth Aboriginal Corporation nd).

## Universally strong system of tobacco control providing a range of options based on best-practice

Addressing smoking cessation during pregnancy requires providing a universally strong system of tobacco control that provides options for *all* smokers to quit; focused activities can then be integrated for specific sub-groups (such as pregnant women). All smokers should be given every opportunity to quit by having access to a range of options that are based on best-practice, and that provide them with choice and control over which method will suit them best. Maximising options for smoking cessation requires tobacco control in the ACT to be embedded into the core business of all ACT Health funded and delivered services and to be central to the practice of all health workers across the Territory.

### 3. Describing the issue: ACT data and the policy context

The following section of the report presents information on the available data regarding tobacco and Aboriginal and Torres Strait Islander women and babies in the ACT (and nationally), and provides a statement of the current policy context.

#### Aboriginal and Torres Strait Islander women and babies in the ACT

In 2012, 122 Aboriginal and Torres Strait Islander women gave birth in the ACT, of which about a quarter (30) were non-ACT residents (Australian Institute for Health & Welfare 2012). However, these figures from the National Perinatal Data Collection only relate to mothers who identify as Aboriginal and Torres Strait Islander.

A more accurate representation of the potential impacts of smoking in pregnancy is from the Aboriginal and Torres Strait Islander identification-status of babies born in the ACT. This figure was only collected in the Perinatal Data Collection for the first time in 2012. It is important to consider this figure, as non-Aboriginal and Torres Strait Islander women partnered into the Aboriginal and Torres Strait Islander community are exposed to many of the same aspects of the social-cultural context, social disadvantage and barriers to quitting as women who identify as Aboriginal and Torres Strait Islander. In 2012, there were 167 Aboriginal and Torres Strait Islander babies born in the ACT—123 (74%) had an Aboriginal and Torres Strait Islander mother, while 44 (26%) had a non-Aboriginal and Torres Strait Islander mother (Australian Institute of Health & Welfare 2012).

According to the 2012–13 Winnunga Nimmityjah Aboriginal Health Service Annual Report, 75 babies were born to women who received comprehensive antenatal care through the service's Aboriginal Midwifery Access Program (AMAP) (including Aboriginal and Torres Strait Islander *and* non-Aboriginal and Torres Strait Islander women) (Winnunga Nimmityjah Aboriginal Health Service 2013). Therefore, the mothers of approximately 45% (75 out of 167) of all Aboriginal and Torres Strait Islander babies born in the ACT (including those from NSW) received comprehensive antenatal care through the AMAP program at Winnunga Nimmityjah Aboriginal Health Service<sup>1</sup>. This compares to 27.6% for data collected in 2004–08 (Wong, *et al.* 2011). Taking into consideration the numbers of Aboriginal and Torres Strait Islander babies from New South Wales born in the ACT, it can be deduced that approximately half of Aboriginal and Torres Strait Islander babies who received antenatal care in the ACT received their care at Winnunga Nimmityjah Aboriginal Health Service. Clearly it is necessary to ensure that Winnunga Nimmityjah Aboriginal Health Service continues to receive adequate funding for the AMAP program, and to consider the need for additional support for services to this client group (such as through the Maternal and Child Health program).

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<sup>1</sup> Note that this figure is calculated using 2012 data from the Perinatal Data Collection, and 2012–13 data from Winnunga Nimmityjah Aboriginal Health Service—as the data is not directly comparable, the figure is reported as an approximation.

## Tobacco use among Aboriginal and Torres Strait Islander women in the ACT who are pregnant or who have young children

Data from the Maternal and Perinatal Data Collection (2007–11) shows that the smoking rate among pregnant Aboriginal and Torres Strait Islander women is 54%, considerably higher than the smoking rate among *all* pregnant women (10.2%)<sup>2</sup> (Figure 1). While smoking rates during pregnancy among Aboriginal and Torres Strait Islander women appear to be increasing over time, the increase is not statistically significant. The ACT rate reported for pregnant Aboriginal and Torres Strait Islander women (54%), is also higher than the current smoking rate reported for all Aboriginal and Torres Strait Islander women aged 15 years and over in the ACT—28.3% (Australian Bureau of Statistics 2014). Several factors may account for this difference, including improved data collection on Aboriginal and Torres Strait Islander status in hospitals, and small numbers leading to issues with significance of the data.

Another consideration is that the overall smoking rate for Aboriginal and Torres Strait Islander women refers to women of all ages, while the smoking rate for pregnant women relates to age groups in which smoking rates are recorded to be higher. Smoking rates are higher among younger Aboriginal and Torres Strait Islander women, and rates decline with age. This is partly illustrated by ACT data from 2002–11 that shows that smoking rates during pregnancy among Aboriginal and Torres Strait Islander women was higher for younger women aged under 20 years (68.0%), and decreased with age: 59.2% for 20–24 year olds; and under forty-percent for those over 25 years old. Comparative rates among non-Aboriginal and Torres Strait Islander women were: 44.4% for under 20 years olds; 28.6% for 20–24 year olds; and under ten-percent for those aged 25 years or more (ACT Health 2014).

Figure 1: Smoking status of pregnant women by Aboriginal and Torres Strait Islander status, ACT 2001–2011

	2001–03	2004–06	2007–09	2007–11
<b>Aboriginal and Torres Strait Islander</b>	39.2	45.0	50.5	53.7
<b>Non-Aboriginal and Torres Strait Islander</b>	13.3	13.7	11.3	
<b>All women</b>				10.2

Sources: ACT Maternal and Perinatal Data Collection: 2001–03, 2004–06, 2007–09 from ACT Health 2013; 2007–11 from National Health Performance Authority 2014.

While the smoking rate among non-Aboriginal and Torres Strait Islander mothers of Aboriginal and Torres Strait Islander babies born in the ACT is not known, it is likely to be similar. It is also not clear whether the smoking rates differ between the mothers of Aboriginal and Torres Strait Islander babies who seek antenatal care through Winnunga Nimmityjah Aboriginal Health Service and those who have various other types of antenatal care in the ACT. Wong, *et al.* (2011) report that between 2004–08, the smoking rate for *all* women accessing antenatal care at Winnunga Nimmityjah Aboriginal Health Service was 59.4% (n=187), and

<sup>2</sup> Note that this comparison is between Aboriginal and Torres Strait Islander women giving birth in the ACT and all women giving birth in the ACT—Aboriginal and Torres Strait Islander women are a subset of this group.

among Aboriginal and Torres Strait Islander women attending the antenatal program the smoking rate was 63.8% (n=130).

A clear association between smoking status and low birth weight is shown in Figure 2, with higher rates among smokers compared to non-smokers. Data for 2009–12, shows the proportion of babies born in the ACT with low birth weight is higher among Aboriginal and Torres Strait Islander women than among all women in the ACT (11.6% compared with 4.3%). However, the proportion attending at least one antenatal visit in the first trimester of pregnancy is higher for Aboriginal and Torres Strait Islander women in the ACT compared to all women in the ACT (50.8% compared to 45.2%)<sup>3</sup> (National Health Performance Authority 2014). This rate of early presentation provides an excellent opportunity for the earlier delivery of smoking cessation activities.

Figure 2: Low birth weight babies by mothers' smoking status, Aboriginal and Torres Strait Islander ACT residents, 2000–2008

	2000–02	2003–05	2006–08
<b>Smoker</b>	17.0	16.7	17.1
<b>Non-smoker</b>	7.0	9.3	6.4

Source: Epidemiology Branch, ACT Health 2011.

Across Australia, exposure of babies and children to second-hand smoke in the home continues to be a significant issue, with 2008 data showing that 63% of Aboriginal and Torres Strait Islander children aged 0–14 years lived in a household with members who were current daily smokers (ABS 2007). In 2008, 20.8% of Aboriginal and Torres Strait Islander children lived with at least one daily smoker who smoked inside; this proportion has declined significantly from 28.4% in 2004 (Thomas & Stevens 2014). This decline was significant among the most disadvantaged Aboriginal and Torres Strait Islander children, although they were still more likely to be exposed to second-hand smoke in the home than other children (Thomas & Stevens 2014).

## Problems with the data

Participants in the consultation raised a number of issues with the quality of the data collected and reported about smoking rates among pregnant women in the Aboriginal and Torres Strait Islander community in the ACT.

### Aboriginal and Torres Strait Islander status

There was concern for under-reporting of the Aboriginal and Torres Strait Islander status of babies, thereby creating an inaccurate picture of the impact of smoking on the health of Aboriginal and Torres Strait Islander babies. Participants made the following observations:

- Sometimes the question, “Are you of Aboriginal and/or Torres Strait Islander origin?” is not asked at all;
- Even when the question may be asked of the mother, the Aboriginal and/or Torres Strait Islander status of the father and baby may not be recorded—ACT Health staff reported occasionally finding out incidentally later that the baby is Aboriginal and/or Torres Strait Islander; and

<sup>3</sup> Note that the comparisons for low birth weight and antenatal visits is between Aboriginal and Torres Strait Islander women giving birth in the ACT and *all* women giving birth in the ACT—Aboriginal and Torres Strait Islander women are a subset of this group.

- There continue to be a range of reasons (largely related to stigma) why women choose not to have their or their baby's Aboriginal and/or Torres Strait Islander status recorded.

#### Information about Aboriginal and Torres Strait Islander women in mainstream antenatal care

Some Aboriginal and Torres Strait Islander pregnant women (or mothers of Aboriginal and Torres Strait Islander babies) choose to attend antenatal services other than Winnunga Nimmityjah Aboriginal Health Service. Little is known about the similarities and differences between these two groups of women, including in socio-economic status, smoking rates and pregnancy complications. The Aboriginal community controlled sector tends to care for the most vulnerable in the Aboriginal and Torres Strait Islander community, and so the group of women attending antenatal care at Winnunga Nimmityjah Aboriginal Health Service may have different smoking rates and cessation needs to those attending mainstream services. Wong, *et al.* (2011) found possible (and likely) differences between these groups based on 2004–08 data, but statistical differences could not be assessed as the Aboriginal Midwifery Access Program (AMAP) clients were a subset of the dataset used for Aboriginal and Torres Strait Islander women who gave birth in the ACT. This study found that, compared to all Aboriginal and Torres Strait Islander women giving birth between 2004–08 in the ACT, a greater proportion of AMAP clients were ACT residents and smoking during pregnancy, but rates of caesarean delivery, preterm and low birth weight babies was lower (but these differences were not statistically significant) (Wong, *et al.* 2011).

In addition, there is little information about why some women choose not to use the antenatal services at Winnunga Nimmityjah Aboriginal Health Service. Anecdotally, the reasons include: choosing a service that fits their personal circumstances; concerns for privacy; wanting to avoid particular relationships; a lack of awareness of the existence of the service (especially for women on the north-side of Canberra); distance from the service and transportation; and not being actively referred to the service. More detailed information about these reasons could help to improve service access and delivery for Aboriginal and Torres Strait Islander women and their children and families.

#### Smoking status disclosure

Another issue with data collection on tobacco use is that some pregnant women may not disclose their smoking status or accurately describe how much they are smoking. Studies have shown that the disclosure of smoking status can be significantly improved through the use of a multiple choice answer format as opposed to simply asking the 'yes/no' question 'do you smoke?' (Gould, Bittoun & Clarke 2014; Mendelsohn, Gould & Oncken 2014). For example, asking the question, "Which of the following statements best describes your cigarette smoking?" and providing the options (Australian Health Ministers' Advisory Council 2012):

- a. I smoke daily now, about the same as before finding out I was pregnant
- b. I smoke daily now, but I've cut down since I found out I has pregnant
- c. I smoke every once in a while
- d. I quit smoking since finding out I was pregnant
- e. I wasn't smoking around the time I found out I was pregnant and I don't currently smoke

### Collecting the right data to measure success

When establishing and evaluating smoking cessation activities for pregnant Aboriginal and Torres Strait Islander women, it is important to choose an appropriate measure of success. Commonly, this measure is whether a woman has quit at a particular point of time in the pregnancy (or at birth). However, such measures may not capture the complexity of a woman's quitting journey, and so may underestimate (or overestimate) the success of a program. For example, asking a woman, "did you smoke in the second half of your pregnancy?" may illicit the answer "yes", but fails to pick up that she actually reduced her consumption from 25 cigarettes per day to 5 per day for most of her pregnancy, and then stopped smoking altogether for the last month of her pregnancy. An accurate reflection of the complexities of smoking cessation and reduction in this group can be achieved with more nuanced methods of data collection.

## The tobacco control policy context

The following ACT and national policies shape and influence the delivery of tobacco control, antenatal and postpartum initiatives targeting Aboriginal and Torres Strait Islander women and their families:

Tobacco-related policies:

- Aboriginal and Torres Strait Islander Peoples Complementary Action Plan 2003–09
- ACT Aboriginal and Torres Strait Islander Tobacco Strategy
- ACT Alcohol, Tobacco and Other Drug Strategy 2010–2014
- Future directions for tobacco reduction in the ACT 2013–2016
- National Drug Strategy 2010–2015
- National Tobacco Strategy
- Tackling Indigenous Smoking Initiative

Maternity policies and guidelines:

- ACT Health Maternity Shared Care Guidelines
- Clinical Practice Guidelines: Antenatal Care—Module 1
- Improving women's access to health care services and information: A Strategic Framework 2010
- National Guidance on Collaborative Maternity Care
- National Maternity Services Plan 2010
- National Partnership Agreement regarding Indigenous Early Childhood Development
- Primary Maternity Services in Australia: A Framework for Implementation
- 'The characteristics of culturally competent maternity care for Aboriginal and Torres Strait islander women' (prepared for the Australian Health Ministers' Advisory Council)

Other policies:

- National Aboriginal and Torres Strait Islander Health Performance Framework 2012
- National Aboriginal and Torres Strait Islander Health Plan 2013–2023
- National Preventive Health Strategy

Policy development, program delivery, and funding of smoking prevention and cessation activities are the responsibility of multiple areas within the ACT Government, with primary

responsibility located within ACT Health. While Aboriginal and Torres Strait Islander-specific tobacco control activities are generally funded through Policy and Government Relations (ACT Health), other tobacco control activities that are also relevant to Aboriginal and Torres Strait Islander smokers (such as Quitline, free-NRT provision through non-government organisations, legislation, and data collection) are fragmented across a number of areas without a clear central responsibility for coordination. In addition, no on-going tobacco-specific positions in policy or service provision within ACT Health were identified through the consultation.

## 4. Scope of the current health and social care pathways for Aboriginal and Torres Strait Islander women who are pregnant and/or who have young children in the ACT

The following section of the report identifies the scope of the current health and social care pathways for Aboriginal and Torres Strait Islander women who are pregnant and/or who have young children in the ACT, and the current points at which smoking cessation advice and treatment and quit maintenance support is given to this group.

### Antenatal, postpartum and early childhood services for mothers of Aboriginal and Torres Strait Islander babies in the ACT

Aboriginal and Torres Strait Islander pregnant women can receive comprehensive and continuous antenatal care through the Aboriginal Midwifery Access Program (AMAP) at Winnunga Nimmityjah Aboriginal Health Service, or through various antenatal services offered through mainstream services (Figure 3). This includes shared care with a general practitioner of their choice, midwifery/specialist care at Calvary Hospital or The Canberra Hospital (TCH) or other private providers. Across all of these programs, Aboriginal and Torres Strait Islander women are likely to have contact with various types of health workers, particularly if their pregnancies are complicated: midwives; doctors; specialists; social workers; Aboriginal Liaison Officers; allied health workers; mental health workers; and Aboriginal and Torres Strait Islander Tobacco Control Workers (at Winnunga Nimmityjah Aboriginal Health Service). Most (82% in 2005–08) Aboriginal and Torres Strait Islander women resident in the ACT give birth in public hospitals (Epidemiology Branch, ACT Health 2011); consultation participants had the impression that a larger proportion of these births are through The Canberra Hospital than Calvary Hospital.

On discharge from hospital following the birth, mothers are referred (with their consent) to the ACT Health Maternal and Child Health (MACH) program. Women are offered a home visit from a MACH nurse, and thereafter can attend MACH services as regularly as they wish. These MACH nurses operate in various community health settings, and through various outreach programs. MACH services may be co-located with other community programs such as playgroups. Clients of Winnunga Nimmityjah Aboriginal Health Service have limited access to two MACH nurses through a weekly 3-hour visit. Some participants in the consultation remarked on the reluctance of Aboriginal and Torres Strait Islander women to engage with the MACH program (other than through Winnunga Nimmityjah Aboriginal Health Service) because of shame surrounding their personal circumstances, not knowing or relating to the nurses, and fears of child protection issues.

Figure 3: Antenatal, birthing, postpartum and early childhood services available to women in the Aboriginal and Torres Strait Islander community who are pregnant and/or who have young children, and their partners and families

	Winnunga Nimmityjah Aboriginal Health Service	The Canberra Hospital	Calvary Hospital	Private GP/ midwife/ obstetrician & hospitals	Community Health Centres
Antenatal	Aboriginal Midwifery Access Program (AMAP)	Shared Care (with GPs) The Canberra Midwifery Program (CMP) Continuity of Care at Canberra Hospital Program (CatCH) Antenatal Clinic Support Programs: 'Step Ahead' Program (young parents)—includes outreach clinics and services at The Junction and Canberra College Substance Use in Pregnancy Support (SUPS) IMPACT (clients of ACT Mental Health and/or on Opioid Replacement Therapy)	Continuity of Midwifery Care Services (CMCS)	Through private hospitals or practitioners operating privately in public hospitals	Midwives and GPs Shared Care
Birth	n/a (but support given)	Birth Centre Delivery Suite	Birthing Suite	John James Memorial Hospital; private midwife	n/a
Postpartum (first 6 weeks following delivery)	AMAP Access to Postnatal ward midwives & Midcall home visiting services MACH home visits	Postnatal ward midwives Midcall home visiting services MACH home visit			Maternal and Child Health nurse home visit
Early childhood (after 6 weeks following delivery)	Two MACH nurses attend one day per week for 3 hours	MACH nurses in the community			MACH nurses; playgroups (including Aboriginal and Torres Strait Islander specific); various support groups (e.g. women's, men's, young parents)

## Assessment of smoking status and referral to cessation support in mainstream services

Although smoking status was reported to be assessed at each visit of women to the AMAP midwife, women may be assessed less frequently at the various antenatal programs at The Canberra Hospital and Calvary Hospital. The Canberra Hospital programs use the Birth Outcome System (BOS) that prompts midwives to ask about smoking status and to offer smoking cessation support and referral as necessary at the 12- and 20-week visits. Midwives may assess smoking status more frequently, but are not prompted to do so. Women attending a pre-admission visit are also asked about their smoking status. Shared care guidelines include a checklist recommending GPs talk to women about smoking and offer referral to cessation supports at the pre-conception and first visit (6–10 weeks) (ACT Health 2008).

Support and referral in these contexts was reported to include undertaking limited brief interventions, and providing women with information through brochures or websites, providing them with the Quitline number (but relying on them to call themselves)<sup>4</sup>, and referring them to see a doctor to be assessed for NRT use. Some young pregnant women can potentially access one-on-one cessation support from the Cancer Council ACT through the fortnightly Smoking Cessation Clinic at the Junction Youth Health Service, and by request through other programs like Canberra College Cares. While MACH nurses at Winnunga Nimmityjah Aboriginal Health Service are able to refer women to the *No More Boondah* program (see below), community-based MACH nurses are limited to providing brochures, information about the Quitline, and referral to doctors to prescribe NRT patches. While the limited range of smoking cessation information and referral options available to health workers are better than providing nothing, there is significant room to improve in aligning smoking cessation care for Aboriginal and Torres Strait Islander women to best practice.

## Assessment of smoking status and referral to cessation support in the community controlled context

Unlike programs in the mainstream context, the options for referral to smoking cessation support in the Aboriginal and Torres Strait Islander community controlled context are broader, systematic and long-standing. At Winnunga Nimmityjah Aboriginal Health Service, workers routinely refer smokers to the health service's comprehensive cessation support program, *No More Boondah*, from all areas of the health service, including the AMAP and MACH programs, and other support groups in the organisation (Box 2). Workers at Gudan Gulwan Youth Aboriginal Corporation provide smoking prevention and cessation activities within their programs and also refer people to the *No More Boondah* program (Box 3).

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<sup>4</sup> Access to the Quitline can be through self-referral (ie by calling the Quitline directly), or through fax referral by a health worker (with the permission of the client). The client provides their phone number on the referral form and authorises a Quitline counsellor to make contact at a later time to provide smoking cessation advice and support.

## Box 2: Antenatal and Smoking Cessation Programs at Winnunga Nimmityjah Aboriginal Health Service

### The Aboriginal Midwifery Access Program (AMAP)

This program was established at Winnunga Nimmityjah Aboriginal Health Service in 2001 and provides access to antenatal care and midwives in a culturally appropriate setting to mothers of Aboriginal and Torres Strait Islander babies. The program offers (Wong, *et al.* 2011):

- Full antenatal care from the first presentation in pregnancy;
- Home visits where necessary;
- Assistance with appointments for antenatal investigations and specialist care;
- Transport;
- Birth support;
- Postpartum follow-up; and
- Immunisations

Elements of the program that promote good practice in smoking cessation, include:

- Culturally relevant care in a culturally relevant environment
- Assessment at every visit of smoking status and, where relevant, assessing progress towards quitting (or reducing) smoking
- Capacity to offer longer consultations if more time is required to offer smoking cessation advice
- Referral into the *No More Boondah* program (see below)—while it is sometimes difficult to encourage women to take up the option of the Program, there is anecdotally good success with women who do
- On-site availability of general practitioners and specialists
- Existing close and trusting relationships with the women, including previous knowledge of their health status and history

### No More Boondah

The *No More Boondah* smoking cessation program started in approximately 2004. The team includes a Healthy Lifestyle worker and two Aboriginal and Torres Strait Islander Tobacco Control Workers. The program follows best practice guidelines in smoking cessation. Elements of this comprehensive program include (Dries, *et al.* 2014):

- Brief face-to-face interventions
- Group support
- On-going client support
- Phone and text follow-up
- Nicotine replacement therapy (with some subsidised by the health service) and other pharmacotherapies
- Home and workplace outreach
- Health promotion in the community

Key components of the success of this program are that it is:

- Staffed by specialist tobacco workers who are strongly connected to the local Aboriginal and Torres Strait Islander community
- Staffed by workers who are highly trained and skilled in the delivery of brief interventions, motivational interviewing and smoking cessation
- Integrated into the organisation so that all areas of the health service—including youth, antenatal (AMAP), and early childhood areas—refer to it, and so that the program can work closely with other areas to provide comprehensive services (e.g. GPs providing NRT

prescriptions)

- Directed to all members of the family and household to support the quit attempts of smokers
- Able to provide smoking cessation support across the life course
- Flexible in its delivery of follow up to meet the needs of individuals, providing one-on-one, group, and outreach interactions

### Box 3: Smoking Cessation Activities at Gugan Gulwan Aboriginal Youth Corporation

Gugan Gulwan Youth Aboriginal Corporation provides smoking cessation information and activities within a range of existing programs, with a specific focus on young people aged 12 – 25 years old. As such, smoking cessation is built into the core business of the service. Some of the programs in which smoking cessation advice or other activities occur include:

- Drug and Alcohol Program
- Young Men's Mentoring Group
- Street Beat Outreach Program
- Young Women's Group
- Young Mum's Group

Gugan Gulwan Aboriginal Youth Corporation have demonstrated particular expertise in relation to youth engagement and social marketing regarding Aboriginal and Torres Strait Islander tobacco control through their participation in the *Beyond Today* campaign.

## 5. Enablers and barriers for smoking cessation for mothers of Aboriginal and Torres Strait Islander babies and children

Understanding what motivates people to take up smoking and to continue to smoke is crucial to the development of initiatives for smoking cessation and prevention. This section of the report presents information from key stakeholders who were asked to discuss the enablers and barriers to accessing and delivering smoking cessation support to women in the ACT, and their comments are reported here. There is little published literature available on the enablers and barriers specifically for Aboriginal and Torres Strait Islander women in the ACT, but studies in other parts of Australia and with pregnant women in other parts of the world point to similar issues. Information on the attitudes to smoking and smoking cessation needs of Aboriginal and Torres Strait Islander pregnant women is to be further investigated through a research project being undertaken at Winnunga Nimmityjah Aboriginal Health Service.

### Motivation to reduce the harmful effects of smoking

Studies in Aboriginal and Torres Strait Islander communities have found that many women want to protect their unborn or young children from the harmful effects of smoking. A study conducted in Queensland and Western Australia reported a high degree of willingness among pregnant Aboriginal and Torres Strait Islander women who smoked to engage with quit attempts and that women who quit smoking during pregnancy tended to remain quit for the duration of their pregnancy (Eades, *et al.* 2012). Two Queensland studies have found that pregnant Aboriginal and Torres Strait Islander women had low nicotine dependence (and could therefore theoretically quit more easily), and one of these also found that over half were thinking of giving up (Panaretto, *et al.* 2009; Heath, *et al.* 2006).

Other studies have shown that some women do quit smoking when pregnant, but a larger proportion report reducing their consumption during pregnancy (Passey, *et al.* 2012; Wood, *et al.* 2008). Passey, *et al.* (2012) have found that 68% of women who were smoking at the beginning of their pregnancies were motivated to either quit (21%) or reduce their smoking (47%). This study found that many pregnant Aboriginal and Torres Strait Islander women are motivated to quit, but more comprehensive care and programs are needed to support them to deal with life circumstances, stressors and the social environment (Passey, *et al.* 2012). Furthermore, while programs should have an ultimate goal of abstinence, they should have embedded within them harm reduction approaches that support women who choose to reduce their smoking rather than quitting; this is consistent with alcohol and other drug practice generally.

Even where women may not be able to quit smoking, studies show a high willingness to protect babies and young children from second-hand smoke in the home. A Northern Territory study of pregnant Aboriginal women found that the birth of the child was associated with many smoking households becoming smokefree indoors. At the antenatal visit (30–37 weeks) 31% of women were exposed to indoor smoking in the home; at seven months after the birth this figure had fallen to 16% (Johnston, *et al.* 2011).

Participants in the consultation noted that some Aboriginal and Torres Strait Islander women they had worked with wanted to quit smoking for the sake of the baby's health and were happy to receive support to do so. However, they found that many young women were not ready to, or interested in, quitting. Some women were reluctant to disclose their smoking status, although bringing up smoking multiple times during subsequent sessions eventually led to their disclosure. This illustrates the value in routinely asking women if they are smokers in every antenatal consultation. The use of graphic imagery of the effects of smoking on the foetus and salient stories about other women in the community was seen as possibly being an effective means of shifting (particularly young) women towards wanting to reduce harm by cutting down or quitting.

## Knowledge of, and attitudes about, the effects of smoking and about various cessation methods

Studies differ on the levels of knowledge about smoking risks and the benefits of quitting among pregnant Aboriginal and Torres Strait Islander women. Several studies have shown that while women are generally aware of the negative consequences of smoking, they have more limited knowledge of how smoking impacts on specific illnesses, and on the health of the foetus (Gilligan, *et al.* 2009; Passey, *et al.* 2012; Gould, Munn, Watters, *et al.* 2013). One Queensland study reported high knowledge among pregnant women with no differences between smokers and non-smokers (Gilligan, *et al.* 2009), while another study has found knowledge to be generally significantly lower among pregnant women who were smokers compared to non-smokers (Passey, *et al.* 2012). The participants of the latter study were younger, had attained lower levels of education, and were more rural and remote than the Queensland sample.

However, as with other health behaviours in the population generally, a person's knowledge of the health effects of smoking does not necessarily translate into behaviour change. A study of pregnant Aboriginal and Torres Strait Islander women in New South Wales, for instance, found that of the pregnant women who were smoking at the time of the survey, 65% reported that quitting would increase the chance of having a healthy baby. However, 50% thought that quitting would be harder during pregnancy because of all the worries, and 35% thought that there was no point in quitting if they were around a lot of smoke from other people (Passey, *et al.* 2012). Clearly, information alone is not sufficient to support quitting, and the provision of information needs to be complemented by offering a range of activities and programs that promote self-efficacy within the socio-cultural context of women lives and smoking cessation options that support quitting within the real-life context (Gould, Munn, Watters, *et al.* 2013; Gould, Munn, Avuri, *et al.* 2013).

Some participants in this consultation remarked that although the women they work with (both Aboriginal and Torres Strait Islander and other women) have heard about the negative health effects of smoking, they find it difficult to believe that this applies to them. High smoking rates, intergenerational smoking, and their own previous experiences, or those of their family members (particularly their mothers and aunts), influences the attitudes of some Aboriginal and Torres Strait Islander women to smoking. So, it is common for health workers to hear comments such as: "I smoked with the other kids, and they're OK"; or "My mum smoked with me and I'm OK". Other family members often reinforced these attitudes. As noted above, graphic images and salient stories were seen as one way to shift these attitudes.

## Pregnancy as a motivator for quitting

Among non-Aboriginal and Torres Strait Islander women, being pregnant (especially the first pregnancy) has been found to be an important factor in smoking cessation (Penn & Owen 2002). A study in the UK found that a first pregnancy is an opportunity for successful quitting (and staying quit postpartum) regardless of the level of social disadvantage of women; the authors of this study suggested that a focus on smoking cessation services for women in their first pregnancy is likely to be successful (Graham, Hawkins & Law 2010). Pregnancy is often seen as a teachable moment for smoking cessation as motivations to quit may be stronger, and there are increased contacts with health workers during the antenatal and postpartum periods (Hellerstedt, *et al.* 1998).

While some studies in Aboriginal and Torres Strait Islander communities have found motivations to cut down or to quit to be quite high (Passey, *et al.* 2012; Heath, *et al.* 2006; Eades, *et al.* 2012), this may not translate into high quitting rates as the barriers to quitting may be too difficult to overcome. One researcher has noted that for Aboriginal and Torres Strait Islander women in her study, pregnancy may not be a 'teachable' moment as "pregnancy in itself was much less of a blip on the radar of these women's lives...it wasn't this big life change, I'm going to re-evaluate all my lifestyle behaviour" (*Health Report* 2008). Smoking cessation activities aiming to reduce smoking during pregnancy should, therefore be aimed more broadly than just the antenatal period, as this is not necessarily the most effective time to be intervening with this hardened smoking group.

## Social and cultural context of smoking

The PhD project undertaken by Raglan Maddox from the University of Canberra in the ACT has clearly demonstrated the importance of the social and cultural context to both maintaining smoking status and encouraging quitting behaviour (Maddox, *et al.* under review). This has also been previously widely observed in a number of studies in Aboriginal and Torres Strait Islander communities (Lindorff 2002; Johnston, *et al.* 2011), including studies involving pregnant and/or postpartum women and their families (Wood, *et al.* 2008; Gilligan, *et al.* 2009; Passey, Gale & Sanson-Fisher 2011; Johnston, *et al.* 2011; Passey, D'Este & Sanson-Fisher 2012; Gould, Munn, Avuri, *et al.* 2013). Self-reported barriers to quitting have been reported to include:

- The normalisation of smoking within communities—everyone around them is smoking, and this makes it difficult to break away and quit (Passey, Gale & Sanson-Fisher 2011);
- Smoking has a number of perceived social benefits as it is an opportunity for 'yarning', relaxation, time-out and sharing (Wood, *et al.* 2008; Passey, Gale & Sanson-Fisher 2011; Passey, D'Este & Sanson-Fisher 2012); and
- For some women, there are significant household and family pressures to continue smoking, including partners who are not supportive of quitting (Wood, *et al.* 2008).

On this last point, studies have found significant associations between Aboriginal and Torres Strait Islander women smoking during pregnancy and: the numbers of smokers in the household (Gilligan, *et al.* 2009; Johnston, *et al.* 2011); and having a partner who smokes (Gilligan, *et al.* 2009).

Studies have found that the tobacco use attitudes and behaviours of partners of pregnant women play a powerful role in determining whether pregnant women quit smoking and remain quit postpartum (Bottorff, *et al.* 2005; Bottorff, *et al.* 2006; Greaves, Kalaw & Bottorff 2007). Male partners who play a supportive role during pregnancy can increase the chances of successful smoking cessation by pregnant women (Graham 1996; Perreira & Cortes 2006; Stewart, Broskey, *et al.* 1996; Stewart, Gillis, *et al.* 1996). However, tobacco-related interactions between partners can be highly complex and variable. For instance, the enactment of power differences in these relationships can significantly influence smoking and cessation behaviours. For example, Maddox, *et al.* (in review) have observed the potential impact of power relationships on the capacity for some Aboriginal and Torres Strait Islander pregnant women in the ACT to quit smoking or to reduce exposure to second-hand smoke in the household. Changes to smoking behaviours within relationships can alter how couples interact with each other (Bottorff, *et al.* 2006; Doherty & Whitehead 1986; Thompson, *et al.* 2004), and concern for the impact of these changes can cause stress for pregnant women and so discourage them from quit attempts (Wakefield & Jones 1998).

Participants in this consultation specifically remarked on the need to work intensely with the close family and household members of pregnant women so as to change attitudes and to promote their encouragement and support of pregnant women to quit.

## Stress

In tobacco use and control studies among Aboriginal and Torres Strait Islander people, the most commonly cited reason for smoking is as an alleviator of stress. Stressors for many Aboriginal and Torres Strait Islander people are multiple, constant and occur concurrently. Such stressors have been reported to include: socio-economic issues (e.g. housing, financial concerns); family and work expectations and responsibilities; relationship problems; family violence; racism; and life-altering events, such as deaths in the extended family (Kerdel & Brice 2001; Heath, *et al.* 2006; DiGiacomo, *et al.* 2007; Wood, *et al.* 2008; Gilligan, *et al.* 2009; Passey, Gale & Sanson-Fisher 2011).

The antenatal period is widely accepted as a time of high stress, and stress is the most widely cited reason to continue smoking or to relapse among pregnant Aboriginal and Torres Strait Islander smokers. Pregnant Aboriginal and Torres Strait Islander women have identified using smoking as a way to manage difficult life circumstances and the related stressors; stressful events are seen as triggers to relapse (Passey, Gale & Sanson-Fisher 2011; Gilligan, *et al.* 2009; Wood, *et al.* 2008; Heath, *et al.* 2006). High stress during pregnancy is particularly the case for young women, women who are economically disadvantaged, and for women with unplanned pregnancies (Greaves, *et al.* 2011). Aboriginal and Torres Strait Islander pregnant women are over-represented in all these categories (Hilder, *et al.* 2014; Australian Bureau of Statistics 2012), and are therefore likely to find it more difficult to quit smoking during their pregnancies. Supporting women to manage stressors is, therefore, crucial to impacting on smoking cessation, including through providing skills training in coping strategies and problem solving, and support groups that incorporate education, social support, relaxation and other stress reduction techniques (Passey, *et al.* 2012).

## Relapse during postpartum and early childhood periods

Even for women who quit during pregnancy, a significant proportion take up smoking again after the birth of the baby. Most smokers make multiple quit attempts—as many as 8–11—before successfully quitting (Durcan, *et al.* 2002; US Department of Health and Human Services 2001). Mainstream studies show that up to 70% of women who stop smoking during pregnancy resume smoking within the first six months after giving birth (Fingerhut, *et al.* 1990; Levitt, *et al.* 2007; Mullen, *et al.* 1997; Roske, *et al.* 2006). Likewise, for Aboriginal and Torres Strait Islander women in one Northern Territory study, self-reported smoking rates were 45% during pregnancy, and 63% at 7 months postpartum (Johnston, *et al.* 2011).

While a range of individual factors impact on postpartum relapse (such as support from her partner to stay quit), stress is a clear contributing factor. For Aboriginal and Torres Strait Islander mothers, the stressors listed above are amplified by the significant life changes that occur in the postpartum period. Many women relapse during the period of 2 weeks to 4 months after birth when infant irritability and crying is greatest and therefore becomes a contributing stressor (Gaffney 2006; Greaves, *et al.* 2011). Furthermore, in the postpartum period factors that may have contributed to a woman being smoke-free during the pregnancy are absent; for example, quitting out of concern for the development of the foetus and being exposed to comprehensive care and support from a health worker (Greaves, *et al.* 2011). Stotts, *et al.* (2000) suggest that relapse levels are high because for many pregnant women who make a quit attempt the motivation for quitting is largely external (i.e. for the baby, not for themselves) and so they have not resolved their feelings about smoking. They suggest that while the Stages of Change model classifies pregnant smokers as in the 'action' phase (because they are making quit attempts), this is actually a misclassification, and many of these women are not actually ready to quit<sup>5</sup>.

The postpartum (up to six weeks after birth) and early childhood periods are key periods during which women and their partners (as well as other household members) should be offered comprehensive support if they are to convert their smoking cessation effort into a long-term cessation commitment. Furthermore, this support needs to continue well beyond the postpartum period and throughout the early childhood years to remain effective (Greaves, *et al.* 2011). For this reason, it is crucial that smoking cessation is embedded in services that women will access over the long term, such as maternal and child health services, general practices, play groups, and support groups.

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<sup>5</sup> See the section, 'Smoking cessation advice from health workers—brief interventions and behavioural counselling' in Section 7 for an explanation of the Stages of Change model.

## 6. Limitations of tobacco service delivery to mothers of Aboriginal and Torres Strait Islander babies and children

This section of the report presents information from key stakeholders who were asked to discuss service delivery limitations and opportunities for improvement. Several issues were consistently raised during the consultations with health workers for this project, and these are consistent with issues raised in the literature.

### Time constraints

Midwives in mainstream settings consistently raise time constraints as the main barrier to them being able to deal effectively with smoking by their clients (Ellerman, Ford & Stillman 2011). Participants in this consultation from mainstream services reported that while smoking status is routinely asked and recorded, following this up with meaningful cessation advice and support is generally seen as almost impossible in the context of time-constrained consultations. For example, a pre-admission antenatal consultation is allocated one hour during which time a number of health measurements and tests need to be undertaken or ordered, and a range of pregnancy-related information and health advice needs to be given. Issues such as smoking sometimes need to be deferred to the next consultation when health workers must rely on patient notes to remind them to return to the issue. Often, by that time, other issues have also arisen that must be dealt with, particularly where patients have complex needs. In the MACH program, smoking is one of many issues that nurses must deal with in a relatively brief period of time. Health workers affirmed that smoking is clearly an important issue, but delivering services in a time-constrained context to women with complex health and social needs who may be reluctant to quit (or even disclose their smoking status) was a challenge for them.

An advantage of delivering antenatal, postpartum and early childhood care through the AMAP program in the community controlled context is that consultation times can be more flexible to allow midwives and support workers to give greater attention to issues like smoking cessation. As women in the AMAP program are generally existing clients of Winnunga Nimmitjyah Aboriginal Health Service, the midwife will often know the women. The midwife is able to review each woman's notes before her appointment to tailor and streamline the antenatal consultation accordingly, including focusing on smoking cessation when necessary.

### Confidence and skills to provide smoking cessation advice

The literature suggests that pregnant women are not routinely asked about smoking by each of the health workers that see them during their pregnancy (Ellerman, Ford & Stillman 2011). Studies with pregnant Aboriginal and Torres Strait Islander women have documented reasons why health workers may be reluctant to provide smoking cessation advice including: skills gaps; pessimism about the effectiveness of the interventions; concern that their advice may push women away from antenatal care; and their own smoking status (Passey, D'Este & Sanson-Fisher 2012; Hughes 2011; Wood, *et al.* 2008). Despite concern from some health

workers that providing smoking cessation advice may damage the therapeutic relationship with their clients, receiving advice and support from health workers (midwives, doctors, Aboriginal Health Workers) is seen as helpful (Passey, Sanson-Fisher & Stirling 2014), and is indeed expected (Passey, *et al.* 2012; Eades, *et al.* 2012).

Based on their observations, consultation participants thought it likely that women were not asked by every health worker they saw during pregnancy. Even when smoking cessation is raised it is done so cautiously so as to ensure women will return for future visits; with this in mind smoking may be raised in the context of more general discussions around the effects of second-hand smoke and Sudden Infant Death Syndrome (SIDS). Participants noted that, in their experience, some general practitioners and other health workers lack knowledge and confidence about the prescription of NRT during pregnancy (this is discussed further in the NRT section later in this report).

## Lack of appropriate and best practice cessation supports

As already discussed above, women attending the AMAP program who wish to quit smoking are referred to the *No More Boondah* program that provides them with comprehensive support on a one-to-one or group basis. However, health workers in the mainstream sector reported only a limited number of resources that they could use to provide smokers with assistance. Some workers in mainstream services refer their clients to *No More Boondah*, while others were not aware of it. If a woman does not want to access *No More Boondah*, there are very few options for appropriate programs. Health workers were able to provide the following services and resources:

- Pregnancy-specific printed information and self-help type brochures
- Websites from which information could be sourced
- Quitline phone number or (less frequently) a fax referral to the Quitline
- Referral to see a doctor for the prescription of NRT patches
- One-on-one support from the Cancer Council ACT delivered at the Smoking Cessation Clinic at The Junction Youth Health Service, and on a request basis through other locations
- Smoking Cessation Clinic accessed through Central Outpatients at The Canberra Hospital—provide specialist intensive smoking cessation counselling; operates for two and a half hours per week

Participants did not feel that these options were adequate to provide support to mothers of Aboriginal and Torres Strait Islander babies who want to quit, nor to their partners and families. Other barriers were seen to prohibit access by some women to particular cessation supports. This includes for example:

- Brochures and printed information are sometimes not easily available, and are easily discarded by women
- Lack of access to a reliable phone inhibits call-backs from the Quitline
- Quitline is perceived by some people, including workers, as inappropriate and irrelevant to their needs, thus reducing referral to and uptake of this service
- Cost is a barrier to accessing intermittent forms of NRT (such as gum, lozenges, spray) that are not listed on the Pharmaceuticals Benefits Scheme (PBS)
- A range of practical, economic and other barriers for some women in accessing a doctor for assessment for NRT
- Services may not be available when a woman is motivated to quit

## Improved policies, procedures and processes to support service delivery

Stakeholders suggested a number of improvements to processes and procedures that would better support the delivery of smoking cessation activities through the mainstream services to the mothers of Aboriginal and Torres Strait Islander babies and children. This included, for example, more comprehensive reminders within clinical programs to prompt health workers to discuss smoking with women—specifically this referred to occasions when health workers needed to postpone more extensive discussions about smoking cessation to a future consultation because of time limitations, and the need to prompt them at the following consultation to return to the issue. Other policy and procedure improvements were related to the provision of nicotine replacement therapy and these are discussed further below (see the section on NRT in Section 7).

## 7. Smoking cessation activities and programs for mothers of Aboriginal and Torres Strait Islander babies and children, and their families (evidence and availability in the ACT)

While smoking-related illness and social and economic burdens from tobacco use continue to impact on Aboriginal and Torres Strait Islander communities, there has also been considerable success in recent years addressing tobacco use and smoking-related harms in these communities. A large investment in tobacco programs and enormous effort from dedicated community members has led to the development of a range of best-practice programs and initiatives, including programs specifically for pregnant women and their families. Nationally, this has contributed to an overall reduction in the prevalence of current daily smoking among Aboriginal and Torres Strait Islander people (from 49% in 2002 to 42% in 2012–13) (Australian Bureau of Statistics 2014).

This section will review the published and unpublished literature to identify best practice in smoking cessation among pregnant Aboriginal and Torres Strait Islander women, and to identify and describe existing activities and programs that may inform initiatives in the ACT.

### Targeted ongoing comprehensive tobacco specific supports

Best practice in smoking cessation to pregnant women is to provide comprehensive and targeted ongoing support and follow up to women and their partners and families. Providing comprehensive supports may include several of a range of multiple and recurrent activities including:

- Brief interventions
- Follow up
- Support groups
- Behavioural counselling
- Nicotine replacement therapy
- Other pharmacotherapies such as Champix
- Case management
- Active referral to the Quitline
- Tailored health information
- Self-help materials
- Contingency management activities (incentives)
- Specific relapse prevention support
- Specific partner support

Several researchers have found that providing targeted advice to pregnant women, and longer, more comprehensive interventions are likely to reduce smoking in this group (Baxter, *et al.* 2009; Campbell & Murphy 2009). Another study recommends flexible home visits and targeted multi-session treatment delivered by well-trained staff (Lee 2006). A review by Lumley, *et al.* (2009) found that multifaceted interventions are effective at reducing the number of women who smoke while pregnant by about 6% overall.

Aboriginal Community Controlled Health Services in a number of states and territories deliver comprehensive antenatal and postpartum care programs, and some also deliver on-site Maternal and Child Health (MACH) programs. A number of these programs have augmented and enhanced their existing antenatal and postpartum services by incorporating a suite of specific smoking cessation activities. A number of trials and studies of these comprehensive smoking cessation supports to Aboriginal and Torres Strait Islander pregnant women and their families have been undertaken in the past few years with mixed results. One randomised control trial in Queensland and Western Australia provided tailored advice and support from health workers (not tobacco-specific workers), engaged partners to support the quit attempt, and offered NRT. While the study found no significant difference between the intervention and usual care groups, the authors attributed this to contamination between the control and intervention groups; this meant that women in the control group also had some exposure to the intervention. Overall, the implementation of the intervention increased the focus on tobacco control in these services, and the smoking rate fell by 11% across both groups (Eades, *et al.* 2012).

Another program in New South Wales provided counselling, specific information and self-help resources, subsidised NRT, quit support groups, family/household support, and an incentives-based program offering rewards in gradually increasing amounts until 6 months post partum. Although the number of women enrolled in the program was small (n=19), 84% of women made quit attempts, and 42% were quit at 36 weeks into the pregnancy (Hefler & Thomas 2013). In a maternal and child health program in New South Wales a comprehensive support program that included stress reduction, information and support, brief intervention, and encouraging the use of cessation services found a decrease in smoking prevalence during the course of the program (although numbers were small) (Homer, *et al.* 2012).

An innovative program, *Quit for New Life*, delivered in New South Wales provides a standard model of care for smoking cessation activities delivered to pregnant Aboriginal and Torres Strait Islander women and women who identify as having an Aboriginal baby. The program includes providing brief interventions, educational resources, Quitline referrals, free NRT, and extended follow up care to women and their families attending Aboriginal Maternal and Infant Health Services across New South Wales. Box 4 provides a detailed description of this program.

#### Box 4: Quit for New Life

(Sources: NSW Ministry of Health 2013; personal communication with the Program Coordinator, Centre for Population Health, NSW Health)

##### Where the program is being delivered

Quit for New Life is a smoking cessation support program for pregnant Aboriginal women and women who identify as having an Aboriginal baby. The program is a partnership between the Centre for Population Health, NSW Ministry of Health and NSW Kids and Families. The program is delivered in Local Health Districts throughout NSW principally through Aboriginal Maternal and Infant Health Services (AMIHS) and Building Strong Foundations for Aboriginal Children, Families and Communities (BSF) programs. However, the program is also being delivered in a small number of mainstream settings, such as hospitals. In theory, the program should reach approximately sixty-percent of Aboriginal and Torres Strait Islander pregnant women in New South Wales.

### Model of care

The Quit for New Life Program provides a standard model of care through these settings to Aboriginal and Torres Strait Islander women, their partners and household members that includes:

- Brief interventions;
- Educational resources;
- Quitline referral;
- Subsidised NRT; and
- Extended follow up care.

Some locations have also developed social marketing campaigns to support their programs

### Follow up care

Funding is provided to each service and can be utilised at the discretion of the service to implement the standard model of care. In many locations, this has involved employing one or more smoking cessation workers to provide follow-up smoking cessation support for at least three months postpartum to women and their families. However, the period of follow up care is dependent on the resourcing and is at the discretion of each service.

### NRT provision

Each site is responsible for making its own protocols around the provision of NRT, including who is responsible for assessing women and if necessary providing them with NRT. Services can purchase their own stock of NRT from their funding allocation for the project and provide NRT directly to eligible women and their partners. Alternatively, some services provide eligible women and/or their partners with a voucher that is redeemable at a local community-based pharmacy, and paid for from funding that is centrally administered.

Site-specific program protocols include specifying who at the service can recommend NRT to pregnant women and their partners. Some sites may require that a doctor sees the pregnant woman, but many sites have put in place nurse-initiated protocols, that may or may not include a doctor's review within 24-hours. Other health workers can speak informatively to women and their partners about NRT, but may choose to refer her to the pharmacy where the woman and/or her partner can be assessed by the pharmacist, and then redeem their voucher for subsidised NRT (without necessarily being reviewed by a doctor).

### Training

The program implementation is supported by the training of relevant workers at each site, and repeated when necessary (for example, when new workers are employed). In addition, an online suite of learning modules is being developed to support skills development. Competency in assessing pregnant women for the provision of NRT can be increased by attending the nicotine addiction and smoking cessation 3-day training course offered through the Brain and Mind Research Institute at the University of Sydney.

### Barriers and challenges to program implementation

The primary challenge faced by the program is how to ensure that the protocols are imbedded into routine practice so as to maintain the sustainability of the program in the long term. Among the other barriers and challenges faced in implementing this program is:

- Difficulties with recruiting specialist smoking cessation workers, particularly in rural locations.
- The time taken to engage stakeholders in the development of protocols for the delivery of the program, particularly those around the provision of NRT.

- Some practitioners are not keen to recommend NRT to pregnant women. However, most of these practitioners became more enthusiastic once they were provided with education on the scientific evidence, and when senior medical officers in NSW Health signed off on the protocols.
- In some services, workers have inadequate support from managers to implement the program.
- The program relies on routinely collected data that does not accurately reflect the actual impact of the program on quitting and smoking reduction among pregnant women. For example: women are classified as 'smoking' or 'not smoking' according to whether they smoked at all in particular time-periods, even if they quit during that time-period, thus potentially under-estimating the quitting rate during pregnancy; and information about how much pregnant women have cut down their smoking, that could be used as a marker of success of the program, is not collected or utilised.

#### Progress of the program

There have been delays to implementing the program across the state, and the extent of implementation of the program has been variable from service to service with three or four services currently accounting for about eighty-percent of program participants. Funding has been extended to the program to enable it to be implemented and evaluated properly.

In some locations around the country, hospitals also run Aboriginal and Torres Strait Islander-specific programs and clinics specifically to support Aboriginal and Torres Strait Islander women and their families. For example, the Boomagan Caring Outreach Midwifery Service at the Toowoomba Hospital and the Nangnak Baban Murrup Clinic at the Mercy Hospital for Women in Melbourne both offer Aboriginal and Torres Strait Islander-specific antenatal services. The Nangnak Baban Murrup Clinic provides care to three target groups (Aboriginal and Torres Strait Islander patients, young women, and women with chemical dependency issues) from a team of health workers that include: doctors; midwives; Aboriginal Hospital Liaison Officers; social workers; and a variety of allied health and other specialists<sup>6</sup> (Mercy Health 2011).

As described previously in Box 2, Winnunga Nimmityjah Aboriginal Health Service provides comprehensive antenatal, postpartum and early childhood care to women and their families through the Aboriginal Midwifery Access Program (AMAP) and the MACH Program. Workers in these programs actively assess and advise on smoking cessation and are able to refer women, their partners and families to receive a range of comprehensive smoking cessation supports through the *No More Boondah* program. While the success of the program with pregnant women specifically is not known, the *No More Boondah* program has shown success with smokers generally (potentially including pregnant women and their partners and family members). An unpublished evaluation of the program shows that it has been successful at engaging community members, and at supporting them to quit smoking, particularly with increased numbers of encounters and when NRT and other pharmacotherapies were also used. Of the program participants, 29.8% ceased smoking and a further 23.9% reduced their smoking. An effect on reducing smoking cessation rates remained at 2 and 6 months follow up; 39% of those who had quit smoking were still quit at six-months (Dries, *et al.* 2014). A key component of the program's success is the

<sup>6</sup> See also: <http://www.mercyhealth.com.au/hcmhs/patients/Pages/Mercy-Hospital-for-Women.aspx>

employment of Aboriginal and Torres Strait Islander specialist tobacco workers who can focus on providing smoking cessation advice and follow up support.

Several consultation participants were keen to offer similarly comprehensive services to Aboriginal and Torres Strait Islander women and their families who do not attend Winnunga Nimmityjah Aboriginal Health Service. They made a number of different suggestions for services that could be offered in mainstream services:

- A specialist tobacco worker to provide smoking cessation support. This could be through referral to a *No More Boondah* worker providing outreach to mainstream antenatal services (with extra capacity given to *No More Boondah* to deliver this).
- A group-based antenatal program, modelled on a US program trialled elsewhere in Australia, “Centering Pregnancy”, that could provide opportunities for women attending antenatal care to come together in groups to share their experiences, gain information and learn skills to assist them through their pregnancies. This could be offered while they are waiting for their antenatal appointments, and could include smoking cessation advice and support (Schindler Rising, Powell Kennedy & Kilma 2004; Teate, *et al.* 2011; Teate, Leap & Homer 2013).
- An Aboriginal and Torres Strait Islander-specific clinic that could include any of the following components (based on suggestions from consultation participants):
  - An antenatal clinic that provides appointment-based care to Aboriginal and Torres Strait Islander women;
  - An outreach postpartum service to visit and support Aboriginal and Torres Strait women and their families;
  - Aboriginal and non-Aboriginal health and social welfare professionals working side by side to increase cultural security;
  - Strong partnerships and referral relationships with the Aboriginal Liaison Officers at the hospital to support cultural security and assist with social, emotional and cultural wellbeing of the patients;
  - Co-location of the *Core of Life* Program;
  - Possibility of the delivery of other programs, such as partner support programs (including smoking cessation programs for partners); and
  - Strong partnerships and linkages to the MACH Program, including the capacity to bring MACH nurses into the program to meet women and their families during the antenatal period so as to start building trust and bonds.

## Relapse prevention

A Cochrane Review has found that there are currently no evidence-based strategies for postpartum relapse prevention (Lumley, *et al.* 2009); however, some studies and evaluations suggest that comprehensive ongoing interventions may be more successful at reducing postpartum relapse. These studies suggest that interventions should include the following elements (Greaves, *et al.* 2011):

- Stress-reduction and addressing stressful situations as a central component, including: psychosocial reinforcement of women’s intentions to maintain abstinence; incorporating tools and strategies for managing stressful incidents; addressing women’s involvement with a social network that smokes; paying attention to other factors such as mental health issues (Roske, *et al.* 2006; Ashford, *et al.* 2009).
- Combinations of different interventions are more successful than individual interventions, such as using tailored information, counselling, social support, tailored

biological feedback and the use of incentives (Edwards, *et al.* 2009; Gadowski, *et al.* 2011; Gillies, *et al.* 1990; Hannover, *et al.* 2009).

- Resources to manage high-risk potential relapse situations, and enhance confidence and motivation for quitting, e.g.: self-help materials (in print or video formats); tailored letters or newsletters; one-on-one brief counselling sessions (either in person or by telephone); and chart reminders.
- Programs that focus on providing some of the elements above to partners so as to increase his support for quitting.

Such ongoing and comprehensive interventions are not available to Aboriginal and Torres Strait Islander women in the ACT, other than women who attend Winnunga Nimmityjah Aboriginal Health Service (although individual components of these interventions, such as self-help materials, may be available).

## Support for partners

As described above, partners are crucial to the process of maintaining smoking status and/or supporting smoking cessation among Aboriginal and Torres Strait Islander women. Furthermore, other family members, in particular those living in the same household or who have frequent interactions with the women, are influential in a woman's smoking status. While a Cochrane Review of smoking cessation interventions for pregnant and/or postpartum women that include or target partners shows a lack of effective interventions (Hemsing, *et al.* 2011), other studies and evaluations suggest that targeted and comprehensive approaches are likely to be successful in supporting partners to quit. Elements of such an approach include (Hemsing, *et al.* 2009):

- Providing personalized information, advice and support tailored to the individuals' circumstances, including addressing specific barriers;
- Delivering interventions to the partner by a person other than the pregnant women;
- Providing advice about the danger tobacco smoke poses to pregnant woman and baby before and after birth; and
- Delivering a multicomponent intervention that comprises three or more elements and multiple contacts.

Although it is important to address partners' smoking so as to better support pregnant smokers to quit, Greaves, *et al.* (2007) suggest intervention approaches that address couples' smoking in a 'delinked' fashion, addressing a woman's smoking alone, rather than in the company of her partner. This allows for a more tailored approach and allows the health workers to deal with issues that are partner-specific. This is a particularly useful approach when the woman's partner is reluctant to allow her to quit.

At Winnunga Nimmityjah Aboriginal Health Service partners can be referred to the *No More Boondah* program for specific and tailored support. In addition, support for partners is available through various men's and youth groups offered both at the Health Service and thorough Gugan Gulwan Youth Aboriginal Corporation. Smoking prevention for young men is also delivered through these groups. In the mainstream sector, there are few options for support for partners should they show an interest in quitting; brief interventions, brochures, referral to the Quitline, and NRT or other pharmacotherapies are the only options.

## Smoking cessation advice from health workers—brief interventions and behavioural counselling

In various mainstream settings, the provision of brief smoking cessation advice delivered by health workers (including doctors and nurses) is likely to be associated with increased quit attempts and reduced smoking prevalence (Stead, Bergson & Lancaster 2008; Rice & Stead 2008). The success of smoking cessation advice and counselling<sup>7</sup> from Aboriginal Health Workers has not been evaluated; some evaluated programs had brief interventions as part of the overall program, and so success could not be attributed to these components (Winstanley, van der Sterren, & Knoche 2011). In a study of 25 Aboriginal smokers and ex-smokers from remote Northern Territory communities, participants reported that brief advice from Aboriginal Health Workers was influential in their decision to quit, particularly when they were delivered in the context of acute health events (Johnston & Thomas 2010).

The most widely used approaches in delivering brief advice and counselling for smoking cessation support are based on the Stages of Change approach to smoking cessation that includes assessment of the patient's quitting stage (recently quit, preparing to quit, thinking about quitting, not interested in quitting, relapsed) and bases advice given to the client on this assessed stage (Prochaska & DiClemente 1986). Application of the stages of change to brief intervention advice and counselling involves the use of the 5As approach—that is: **Ask**, **Advise**, **Assess**, **Assist**, **Ask again**—and motivational interviewing. This forms the basis for the current ACT Health 'Smoke-free Assessment and Support' form that is used in the assessment of pregnant women during their antenatal visits (*Australian Capital Territory. Smoke-Free Pregnancy & Families. Resource Folder*). The 5As approach is also explicitly recommended in the general Royal Australian College of General Practitioners *Supporting smoking cessation: a guide for health professionals* (Zwar, *et al.* 2011) and the maternity-specific Clinical Practice Guidelines for the Mater Health Services in Brisbane (Flenady, *et al.* 2005). In relation to guidelines for Aboriginal and Torres Strait Islander smokers, the Stages of Change and 5As approaches are central to the (formerly) widely used SmokeCheck program adapted for use by health workers in several states and territories for Aboriginal and Torres Strait Islander smokers (NSW Department of Health 2010).

Although there has been criticism of the Stages of Change approach (West 2005), it (and the 5As) remains the basis of smoking cessation advice and support given in Australia. Despite widespread use of advice and counselling techniques based on the Stages of Change, there is, however, limited evidence of their effectiveness in influencing smoking behaviour both in the general population (Riemsma, *et al.* 2003) and with pregnant women (Lumley, *et al.* 2009; Hettema & Hendricks 2010 in Gould, *et al.* 2014). In contrast, reviews and meta-analyses of studies of various behaviour change techniques have found that counselling that includes providing information on the health effects, increasing self-efficacy and goal-setting, and facilitating coping and social support are more associated with successful programs than Stages of Change-based approaches (Lorencatto, West & Michie 2012; Mendelsohn, Gould & Oncken 2014).

Several sets of clinical guidelines, therefore, suggest a modified approach based on ABC: **A**sk, **B**rief Intervention, **C**essation support. This modified approach does not rely on assessing the stage of change of the patient, but instead recommends giving smoking cessation advice and support to *all* smokers. Notably, smoking cessation guidelines in New

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<sup>7</sup> See notes on the definitions of 'counselling' and brief interventions in section 1, 'Comments on terms and definitions'.

Zealand explicitly reject the Stages of Change model and utilise the ABC approach for all smokers, including pregnant women who smoke (Ministry of Health 2007; Ministry of Health 2014). Other guidelines in Australia related to smoking in pregnancy, while not explicitly suggesting the ABC approach, do advocate providing all pregnant smokers with personalised advice on how to stop smoking and information about available services (Australian Health Ministers' Advisory Council 2012). A recent article by Gould, Bittoun and Clarke (2014) also suggests a modified approach to guide health workers to support pregnant Aboriginal and Torres Strait Islander smokers, and recommends that all pregnant smokers be offered brief advice and support regardless of their readiness to quit using the ABCD approach (Gould, Bittoun & Clarke 2014):

- **A**sk about smoking;
- **B**rief advice to quit and offer all pregnant smokers assistance with quitting;
- **C**essation aids; and
- **D**iscuss family, social and cultural context for smoking and challenges for quitting.

In the ACT, moving from the use of 5As in smoking brief interventions to some other acronym (ABC, or ABCD) would be difficult as the 5As form the basis of current assessment guidelines, paperwork and training across the country. However, two components of the alternative approaches could be made more explicit in the application of the 5As approach to pregnant Aboriginal and Torres Strait Islander women in the ACT, and ACT Health could take an important leadership role in adopting these principles:

- That all pregnant women should be offered smoking cessation advice and support, regardless of the stage of change they are assessed at; and
- Emphasising the importance of discussing the family, social and cultural context for smoking and the challenges for quitting when assessing the woman.

Best practice advocates for the integration of smoking brief intervention advice and behavioural counselling into all services that deliver antenatal care, sexual and reproductive health (pre- and post-pregnancy) and child health care (NSW Health 2006), and indeed all health services, particularly those provided to sub-populations with high smoking rates. Such advice and counselling should be delivered by all health workers in the ACT health system to all men and women who smoke, and at each visit.

## Smoking cessation training

The success of brief advice and counselling from health workers to Aboriginal and Torres Strait Islander women relies on: these health workers being skilled and confident in talking to women about smoking and delivering information about cessation options; and on the availability of appropriate follow up support and/or programs and resources to which women who are pregnant or who have young children, and their partners, can be referred.

Training in providing brief advice and counselling in smoking cessation is required to a broad range of workers who are likely to come into contact with Aboriginal and Torres Strait Islander young women and men, and families. It is particularly important that this training is tailored and delivered by credible trainers according to the professional group. For example, doctors will respond better to training delivered by a doctor. For information on the range of training options available to health workers in the ACT, and a checklist to inform the choice of training providers for particular professional groups please refer to this report's supplementary

document “Smoking cessation training options available to health workers in the ACT, and principles to guide the choice of training providers”.

## Nicotine replacement therapy

Nicotine Replacement Therapy (NRT) is a safe and effective medication used to support smokers to quit or reduce smoking (Stead, *et al.* 2012). It involves the delivery of nicotine into the body through either the skin or orally (through the lining of the mouth), and is available in a range of doses and types (patches, gum, inhalator, lozenges, spray and strips). A standard course of NRT is considered to be 8–12 weeks. While patches are available on the PBS (up to one course of 12–weeks per 12–months), other forms of NRT are not<sup>8</sup>. However, all forms of NRT are available for purchase over-the-counter at pharmacies, supermarkets or convenience stores.

The evidence from randomised control trials for the effectiveness of NRT use in pregnancy for smoking cessation is limited (Lumley, *et al.* 2009; Coleman, *et al.* 2012; Sanson-Fisher & Stirling 2014), although clinical studies suggest greater effectiveness (Mendelsohn, Gould & Oncken 2014). Best practice in the provision of NRT is to couple it with comprehensive multi-session counselling, as this appears to increase the success of NRT use (Allen, *et al.* 2012). Pharmacological interventions, such as NRT, have shown limited effectiveness at preventing smoking relapse among postpartum women and girls (Gaffney 2006; Levitt, *et al.* 2007; Piasecki, *et al.* 2002).

Although nicotine has been shown to be toxic to the foetus, studies have found no evidence of an association between NRT use during pregnancy and adverse outcomes for the foetus. There is little evidence for the safety of NRT use during pregnancy, and insufficient evidence for statistically significant positive or negative impacts on birth outcomes (Coleman, *et al.* 2012). Nicotine (whether from cigarettes or NRT) may affect fetal brain and lung development, but the longer-term effects are not clear (Fiore, *et al.* 2008; Shea & Steiner 2008). Nicotine gum and patches have been found to increase the mother’s blood pressure and heart rate, with a corresponding smaller increase in the heart rate of the foetus; however, the effect from NRT is smaller than from smoking (Coleman 2007; Fiore, *et al.* 2008). There is no evidence that the blood levels of nicotine are higher with NRT than smoking (Coleman, *et al.* 2007).

Pregnant women who continue to smoke cigarettes expose the foetus to nicotine as well as a number of other chemicals known to be toxic to the foetus (Zwar, *et al.* 2011). As NRT is known to be very effective at helping some people to quit or cut down smoking (Stead, *et al.* 2012), it could in fact be considered harmful to withhold NRT from pregnant smokers who are not able to quit smoking using other methods (Coleman, Britton & Thornton 2004). Although NRT use during pregnancy is not free from risk, it is considered by smoking cessation experts to be safer than continuing to smoke cigarettes (Zwar, *et al.* 2011; see also, the Australian Association of Smoking Cessation Professionals: [aascp.org.au](http://aascp.org.au)). Prescribing NRT in pregnancy should consider the likelihood and benefits of quitting against the risks of pharmacotherapy and the continuation of smoking (Flenady, *et al.* 2005).

Best practice in providing smoking cessation advice to a pregnant or breastfeeding woman is to recommend that she first attempt to quit using counselling and support without any

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<sup>8</sup> <http://www.pbs.gov.au/browse/medicine-listing>

pharmacological assistance. If this attempt is unsuccessful, then offering intermittent, short-acting forms of NRT (such as lozenge, gum, spray, oral strips or inhalator) is considered to be safer as the nicotine dose to the foetus will not be constant (Bittoun & Femia 2010; Zwar, *et al.* 2011; Australian Health Ministers' Advisory Council 2012; Quit Victoria 2013). For more dependent pregnant smokers, it may be necessary, and more effective, to use combination therapy (NRT patch and an oral intermittent form) (Gould, Bittoun & Clarke 2014; Mendelsohn, Gould & Oncken 2014). The accepted evidence is that during pregnancy, NRT is safer than continuing to smoke.

In mainstream health services in the ACT, NRT is currently primarily available as patches on prescription from a doctor (covered by the PBS), or in other intermittent forms from pharmacies on the advice of a doctor (not covered by the PBS). Women who are in-patients in the birthing centre or for emergency care at The Canberra Hospital can access NRT (patches and other forms) through the hospital for 7–days. Comprehensive multi-session counselling is not offered, contrary to the recommended best practice (Allen, *et al.* 2012).

### Providing NRT to pregnant Aboriginal and Torres Strait Islander women and their families

As described in Box 4 above, a component of the *Quit for New Life* program involves providing free NRT to pregnant women, their partners and household members through antenatal and postpartum services throughout New South Wales. The woman, her partner or household member attend a service and are assessed by a health worker who is able to either recommend and provide particular forms of NRT, or who can refer the client to a pharmacy for assessment. NRT can be provided directly from the service (for eligible services) or through a voucher redeemed at a local pharmacy (NSW Ministry of Health 2013).

Such a program in the ACT could build upon existing tobacco control programs involving the provision of NRT for smoking cessation. The ACT Pharmacy Guild is rolling out a program to improve NRT availability to pregnant women attending Winnunga Nimmityjah Aboriginal Health Service. The Alcohol Tobacco and Other Drug Association ACT is currently rolling out a voucher-based NRT program (the *We CAN Program*) within health and community non-government organisations and involving local community pharmacies. Although not pregnancy-specific or Aboriginal and Torres Strait Islander specific, the program could be adapted with the *Quit for New Life* guidelines to suit the provision of NRT to pregnant Aboriginal and Torres Strait Islander women.

Furthermore, an important component of the *Quit for New Life* program is its ongoing availability to women postpartum, and a program in the ACT to provide free NRT with the aim of reducing smoking in pregnancy should also provide NRT to women in the postpartum and early childhood periods. This could assist women to quit before subsequent pregnancies.

### Issues with the provision of NRT to pregnant women

*Cost:* The main barrier to the provision of NRT to pregnant Aboriginal and Torres Strait Islander women is the cost, and there is evidence of better smoking cessation outcomes for people experiencing disadvantage when NRT is provided free of charge (Hartmann-Boyce, *et al.* 2013). Intermittent forms of NRT (gums, lozenges, inhalers) that are considered safer for

pregnant women are not available on the PBS, thus reducing accessibility for low income women (Gould, *et al.* 2011).

*Lack of awareness of safety and effectiveness in pregnancy:* Another barrier to the provision of NRT during pregnancy is a lack of awareness among both community members and health workers of the safety and effectiveness of NRT use in pregnancy, and how various forms should be used properly to be most effective. In a study of attitudes of Aboriginal and Torres Strait Islander pregnant women and service providers to the helpfulness of various smoking cessation strategies, over half in each category of participant felt that free NRT would be very or somewhat helpful (women, current smokers 56%; women, ex-smokers 62%; and service providers 74%) (Passey, Sanson-Fisher & Stirling 2014). One-third of antenatal service providers to Aboriginal and Torres Strait Islander women in a related study thought, in contradiction to the guidelines, that NRT should not be used in pregnancy (Passey, D'Este & Sanson-Fisher 2012).

Anecdotally, it seems that general practitioners may be reluctant to prescribe NRT to pregnant women, and a small number of studies confirm this (Gould, Bittoun & Clarke 2014). Ethical principles guiding the practice of medical workers advocate non-maleficence (“first do no harm”) in the care of patients. Consequently doctors and pharmacists who rely on the categorization system for prescribing during pregnancy are not likely to prescribe Category D drugs, such as nicotine, to women during pregnancy.

Making NRT available to pregnant women where it is necessary, therefore, requires overcoming the reluctance of health workers to prescribe or recommend it. While this reluctance is appropriate (due to the toxicity of nicotine), the question of whether to prescribe NRT or not should be considered for each individual. NRT prescription is warranted where a pregnant woman is a dependent smoker, unable to quit using other methods, and where NRT is likely to help her to quit. However, unless health workers have undertaken specific training on smoking cessation, they are unlikely to have the knowledge to unpack the complexity and subtlety involved in reconciling recommending this Category D drug to a pregnant woman.

Furthermore, a pregnant woman’s success with using NRT will be enhanced by receiving appropriate doses and advice around the correct use of particular forms of NRT. Nicotine metabolism is faster in pregnancy requiring the provision of higher doses of NRT, and interactions with caffeine and other drugs require specific advice on the concurrent reduction of these substances. Some forms of NRT are more or less appropriate for some women; for example, patches are not recommended for people with some skin conditions, and asthma may be aggravated by the use of a NRT inhalator. Health workers who are responsible for providing NRT to pregnant women require specific training and information on appropriate dosing and forms of NRT (Mendelsohn, Gould & Oncken 2014; Gould, Bittoun & Clarke 2014).

*Ineffective processes to provide NRT to women and their partners:* Guidelines from the Royal Australian College of General Practitioners recommend that NRT is only available to pregnant women on advice from a doctor. Hospitals and health centres in the ACT currently follow these recommendations. This may suit some settings and some women; for example, at Winnunga Nimmityjah Aboriginal Health Service women are able to be seen relatively quickly by a GP, and are able to access limited amounts of intermittent forms of NRT through a scheme subsidised by the health service.

In the hospital setting, however, these limitations present a number of challenges to midwives. Pregnant women attend the hospital in one of three ways: to birth; because of medical complications during the pregnancy that require urgent medical attention; and for antenatal care. In the first two cases, women and their partners may attend at any time of the day or night when a doctor is not available to approve NRT use, and/or when the hospital pharmacy is unable to dispense it. Furthermore, as inpatients, women are only able to access subsidised NRT through the hospital pharmacy during their hospital stay to manage their withdrawal symptoms. Seven–days of NRT is available upon discharge, but thereafter they can then only access NRT through standard means (ie patches on the PBS with a doctor’s prescription, or by purchasing it over the counter themselves). During antenatal care, a woman or her partner who expresses an interest in quitting may not be able to see a doctor straight away, and may not be able to afford to purchase intermittent forms of NRT from a pharmacy.

Participants in this consultation from The Canberra Hospital suggested that NRT could be available at the antenatal clinics and birthing units themselves and dispensed by midwives. This could enable all forms of NRT to be available to pregnant women and their partners. There is precedent for the appropriate assessment and dispensing of NRT by health workers other than doctors through the *Quit for New Life* program (NSW Ministry of Health 2013). Some NSW Health Local Health District guidelines for prescribing by midwives also allow NRT to be given to pregnant women so long as this is reviewed by a doctor within 24 hours (NSW Health Hunter New England Local Health District 2008a; NSW Health Hunter New England Local Health District 2008b).

## Youth-specific prevention and cessation activities

Considering the high levels of stress, anxiety and other life changes that can accompany pregnancy, the antenatal period is a challenging time for a woman to be attempting to quit. It follows that supporting Aboriginal and Torres Strait Islander women, particularly young women, to quit smoking before becoming pregnant, or indeed to never take up smoking is most likely to result in reduced rates of smoking during pregnancy. The known association between a woman smoking during pregnancy and her partner smoking suggests, in addition, that initiatives should target both young men and young women.

Several stakeholders interviewed for this report commented on the difficulty in encouraging and supporting young Aboriginal and Torres Strait Islanders to quit smoking before becoming pregnant. They perceived a general lack of readiness to quit and a high number of unplanned pregnancies in this younger age group. They also reinforced the data that Aboriginal and Torres Strait Islander women are more likely to become pregnant at younger ages (compared to the broader population), and that smoking rates are also higher in these younger ages groups. However, they pointed to the potential to influence smoking rates through the delivery of targeted programs and activities through existing services such as Gugan Gulwan Youth Aboriginal Corporation, The Junction Youth Health Service, and school based health services, and through enhancing referral relationships to and from these services.

Prevention programs and activities delivered to young women and men that include components to discourage the uptake of smoking will also have an indirect impact on smoking rates during pregnancy. Stakeholders generally spoke highly of programs such as *Core of Life* that incorporate tobacco control messages into a more general pregnancy and sexual

health education session. These sessions target both boys and girls of high school age and are delivered in a variety of school and youth settings. Although an Aboriginal and Torres Strait Islander-specific program, in the ACT *Core of Life* is delivered to mixed audiences. Although the purpose of this report is not to review *Core of Life*, it is relevant that positive comments about this program included the value of graphic educational materials and active role plays that were felt to engage young people with the information. It was, however, also mentioned that ideally an Aboriginal and Torres Strait Islander person should be involved in co-presenting the program, and that the program would benefit from being physically located outside the ACT Health office.

## Self-help materials

Self-help materials—such as, brochures, books, videotapes, CDs, audiotapes, reactive telephone lines, and internet-based information—can help smokers who are not exposed to other interventions to quit, but the effect is small (Lancaster & Stead 2005). Printed self-help materials can be effective and affordable (World Health Organization nd), but they are most likely to be effective for pregnant Aboriginal and Torres Strait Islander women and their families when tailored to their needs; i.e. they are both culturally relevant, and relevant to their life circumstances. Culturally relevant materials may include those that feature pictures of, and stories from, local or well-known community members (Ivers 2003). The *Stickin' It Up the Smokes* campaign for Aboriginal and Torres Strait Islander women in South Australia (described further below) included a pregnancy record book (to provide information and document pregnancy milestones) with quitting stories from local pregnant women and young mothers. This has not yet been evaluated but appears to have been well-received by the community. Another program, *Give Smokes the Flick* developed resources for health workers providing services to pregnant Aboriginal and Torres Strait Islander women that linked quitting smoking to financial savings. These resources were not delivered in isolation, but alongside the provision of NRT samples and on-going follow-up by smoking cessation workers. An evaluation found that the program resulted in a reduction in smoking and led some women to quit smoking (Hughes 2011).

Evaluations of tailored self-help provided to non-Aboriginal and Torres Strait Islander women show that they appear to have some impact on quitting rates: one was a women-held pregnancy record book, with specific healthy-lifestyle advice and activities (Wilkinson, Miller & Watson 2010); and the other was booklets sent to women and their partners to coincide with specific times during their pregnancies (Brandon, *et al.* 2012). Several Aboriginal and Torres Strait Islander self-help resources not specifically directed at pregnancy have also been developed including the *Blow Away the Smokes* DVD that provides a guide to quitting cigarettes (see: [www.blowawaythesmokes.com.au](http://www.blowawaythesmokes.com.au)).

## Health information

As reported above, there are still knowledge gaps among pregnant Aboriginal and Torres Strait Islander women, their partner and families around antenatal smoking risks. Among women, this may be particularly associated with younger age, less education and lower socioeconomic status. Passey, *et al.* (2012) have commented that, based on their findings, providing information to pregnant women about the specific risks associated with smoking

and the benefits of quitting may help to motivate women to quit. The authors suggest the development of specific appropriate resources that could be used by antenatal providers to assist them to better explain the risks associated with antenatal smoking. Other studies have suggested the value of providing more tangible and explicit illustrations of the effects of smoking on the foetus and babies, such as ultrasounds and carbon monoxide monitors (Greaves, *et al.* 2011).

Based on reviews of studies on smoking in pregnancy in Aboriginal and Torres Strait Islander communities, Gould, *et al.* (2014) recommend a range of strategies to increase the knowledge of the harms of smoking in pregnancy and the salience of antismoking messages to Aboriginal and Torres Strait Islander pregnant women. This includes (Gould, *et al.* 2014):

- addressing specific effects of maternal smoking on baby and mother;
- targeting first-time mothers;
- promoting quitting in early pregnancy and pre-conception;
- making fetal exposure to smoking more tangible;
- targeting messages to counter misconceptions and resistance;
- focusing on the incongruence between maternal desire to protect and their continued smoking behaviour;
- supporting positive attitudes and behaviours;
- emphasising the importance of positive role models for smoke-free Aboriginal and Torres Strait Islander communities; and
- promoting the message that with effective treatment, quitting can be a manageable option.

There have been a number of pregnancy-specific information resources developed across the country, several of them Aboriginal and Torres Strait Islander specific (Winstanley, van der Sterren & Knoche 2011). There have not been any Aboriginal and Torres Strait Islander pregnancy-specific brochures or health education resources developed in the ACT. However, resources through *No More Boondah* and *Beyond Today* provide some general information about smoking cessation and available quitting services. The impact of many of these resources is not known as they are mostly not evaluated.

Having 'hard core', 'in your face' and tangible teaching/education tools was mentioned by two stakeholder services as potentially valuable to get the message of the harms of smoking across to the Aboriginal and Torres Strait Islander women and their families who they work with. Likewise, they mentioned the potential value of resources with salient stories illustrating the experiences of other women in the community to counteract the misconceptions around smoking in pregnancy. Among some of the messages that these and other stakeholders pointed to were:

- Quitting at anytime during pregnancy has health benefits; while women who quit before conception or in the first trimester have the same birth outcomes as non-smokers (on a population-level), there are still benefits even if a woman quits later in the pregnancy (Mendelsohn, Gould & Oncken 2014);
- Smoking increases the risks during pregnancy; just because women know someone else who was not negatively affected does not mean their baby will not be affected if they continue to smoke;
- NRT is safe and effective to use in pregnancy with the advice of a health worker; and
- Having a small baby can affect the health of the baby in the postpartum and early childhood periods, and throughout their lives.

## Social marketing

Social marketing is considered an important component of a comprehensive tobacco action program (Ipsos-Eureka Social Research Institute and Winangali 2010), and is most effective when well-funded and sustained over time (Wakefield, *et al.* 2008). Evaluations of the impact of various mainstream anti-smoking campaigns have shown high general awareness of the advertisements and high recall of messages, but no measureable effect on quitting rates among Aboriginal and Torres Strait Islander people (National Tobacco Campaign 1999; Ivers, *et al.* 2005). Other evaluations of mainstream campaigns have also shown that they prompted Aboriginal and Torres Strait Islander people to think about cutting down or quitting (Boyle, *et al.* 2010; Stewart, *et al.* 2011). Stewart, *et al.* (2011) found that mainstream advertisements with strong graphic imagery depicting emotive first-person narratives about health effects were particularly motivating.

An evaluation of the Aboriginal and Torres Strait Islander *Breaking the Chain* advertisement showed: it had high prompted recall; was seen to effectively communicate the message, “your smoking affects others”; and had a high level of self-identification with the content of the advertisement. Further, the campaign was reported to elicit action around reducing the amount smoked and discussing smoking and health with family and friends (Australian Government 2011). Another Aboriginal and Torres Strait Islander social marketing campaign in South Australia, *Give up smokes for good* has found good recall of campaign messages but it has been difficult to measure the direct impact on smoking rates ([www.giveupsmokesforgood.org.au](http://www.giveupsmokesforgood.org.au)). Other specific campaigns, including those created by Miwatj Aboriginal Corporation (Skinnyfish Music 2011) and Gippsland and East Gippsland Aboriginal Corporation (Wilson 2011), have not been evaluated to measure their impact.

The Aboriginal Health Council of South Australia has developed a social marketing campaign entitled *Stickin’ It Up the Smokes* that is specifically aimed at pregnant Aboriginal and Torres Strait Islander women. This unique campaign includes a range of posters, a pregnancy record book, a specially developed rap song, a facebook page, the use of pregnant (or formerly pregnant) anti-smoking ambassadors, pendant rewards for women who stay smokefree, and various merchandise items. This campaign has not yet been evaluated, but has been well-received in the community, and is the only campaign of its kind in the country ([www.facebook.com/StickinituptheSmokes](http://www.facebook.com/StickinituptheSmokes)).

The *Quit for You, Quit for Two* campaign has been rolled out by the Commonwealth government and includes advertisements and mobile phone applications designed to encourage and support smoking cessation among pregnant women and their partners generally. While there are no Aboriginal and Torres Strait Islander-specific resources, Aboriginal and Torres Strait Islander people do feature in the advertisements ([www.quitnow.gov.au](http://www.quitnow.gov.au)).

In the ACT, the recently launched *Beyond Today* campaign features champions from the local Aboriginal and Torres Strait Islander community with specific messages around smoking cessation. The resources launched for this campaign do not include smoking-in-pregnancy-specific resources<sup>9</sup>.

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<sup>9</sup> While a pregnancy-specific poster was developed it did not become part of the campaign.

## Quitlines

The Quitline has been shown to improve quit rates when used as part of an anti-smoking campaign (Stead, Perera & Lancaster 2007), and quit rates are further improved by the provision of NRT in conjunction with telephone counselling (Maher, *et al.* 2007; Boles, *et al.* 2009). International evidence shows that quitlines can be acceptable and effective for Indigenous people (Maher, *et al.* 2007; Boles, *et al.* 2009; Hayward, *et al.* 2007; Grigg, Waa & Bradbrook 2008). An evaluation of the Quitline in South Australia shows that the proportion of Aboriginal and Torres Strait Islander people registering for the service was comparable to other callers. However, Aboriginal and Torres Strait Islander callers received significantly fewer callbacks, and were significantly less likely to set a quit date or to be successfully quit at three-months (Cosh, *et al.* 2012). Pregnant and postpartum women are less likely to use telephone support if they have to initiate contact (Dennis & Kingston 2008).

Smokers in the ACT access the Quitline through the NSW service, and can access an Aboriginal and Torres Strait Islander counsellor for culturally-specific support. Data from the NSW Quitline indicate that 387 calls were made by ACT residents in the six months between January to June 2014, with 125 Quit packs distributed to ACT residents during that period. In that six month period, 15 Aboriginal and Torres Strait Islander people from the ACT called the service. It is not reported whether or not they utilised the Aboriginal and Torres Strait Islander-specific counsellor (Lester & Crosbie 2014).

Participants in the consultation from mainstream services indicated that they routinely provide pregnant Aboriginal and Torres Strait Islander women with the Quitline number, but few reported sending fax referrals to the service. Most women reportedly told their service provider that they were not interested in using the Quitline service. Quit packs are sent to ACT residents from the Cancer Council ACT and the information within them is tailored to the needs of the caller; e.g. if a woman discloses that she is pregnant, she will be sent pregnancy-specific quit information. In the second half of 2014, the Cancer Council ACT has not received a request to send out a pregnancy- and Aboriginal and Torres Strait Islander-specific Quit pack.

## Contingency-management activities (incentives)

Contingency management activities or incentives used in smoking cessation are payments or rewards of some type that can be used to encourage people to quit smoking. They could be in the form of cash, vouchers, gifts, or prizes as part of contests. Providing subsidised NRT could also be thought of as a quit-smoking incentive. A number of studies have noted the success of incentives-based programs in promoting smoking cessation among pregnant women (Radley, *et al.* 2013; Tappin, *et al.* 2015). A Cochrane Review has found that the most successful smoking cessation interventions to reduce the proportion of women who continue to smoke in late pregnancy were those that provided incentives (Lumley, *et al.* 2009). Furthermore, these interventions (and in particular those with incentives) are effective regardless of the socioeconomic status of the women (Kavanagh, *et al.* 2010). Studies have found that combinations of tailored information, counselling and incentives may be a promising approach to smoking cessation among women of lower incomes (Greaves, *et al.* 2011).

The use of incentives may be a successful approach for use with pregnant Aboriginal and Torres Strait Islander women, although their use may not be acceptable in some communities. A program for pregnant Aboriginal and Torres Strait Islander women in rural New South Wales delivered a comprehensive program of counselling, provision of specific resources, free NRT, quit support groups, and family/household support. It also included an incentives-based program offering rewards in gradually increasing amounts until 6-months post partum (Northern Rivers University Department of Rural Health 2010). The program showed some success with these participants, although the number of women participating was small, and the success could not be attributed to any single component of the program (Hefler & Thomas 2013). A related study found good support for the use of 'rewards for women who stop smoking with vouchers to get things for the mother or baby': 63% among pregnant Aboriginal and Torres Strait Islander women who smoke; and 56% among workers who provide services to these women (Passey, Sanson-Fisher and Stirling 2014). A roundtable hosted by the Lowitja Institute and the Menzies School for Health Research, and attended by the Aboriginal and Torres Strait Islander community controlled sector considered the acceptability and usefulness of incentives with pregnant women. Participants approached the use of incentives with caution, and on balance were not enthusiastic about its use in smoking cessation programs with pregnant Aboriginal and Torres Strait Islander women (Hefler & Thomas 2013).

Tobacco incentive based programs are not currently operating in the ACT for pregnant Aboriginal and Torres Strait Islander women.

## Legislation

Legislation such as control on tobacco advertising and packaging, changes in taxation and tobacco pricing, smokefree workplaces, public places and health facilities, and preventing sales to minors have impacted significantly on smoking rates in the Australian community generally (Bardsley & Olekalns 1999; Stead & Lancaster 2005; Farkas, *et al.* 1999; Chapman, *et al.* 1999). This legislation is also likely to have an impact on the Aboriginal and Torres Strait Islander community in the ACT, although there is no specific evidence for this (Ivers 2011). There is also no evidence that there has been a particular impact on smoking rates among pregnant Aboriginal and Torres Strait Islander women as a direct result of this legislation. Although not evaluated, smokefree workplace policies implemented at Winnunga Nimmityjah Aboriginal Health Service and Gugan Gulwan Youth Aboriginal Corporation have impacted on exposure by community members to second-hand smoke, and may have reduced smoking in the community.

## 8. Summary of priority areas, key points and suggested actions

This report has considered the views and experiences of stakeholders, and the literature. The following section summarises the key areas identified for further improvement. Two tables are presented: the first outlines areas and actions that are Aboriginal and Torres Strait Islander and pregnancy specific (Table A); and the second considers the broader smoking cessation areas and actions that are required in order to both support and enable those in the first table (Table B).

## Table A: Aboriginal and Torres Strait Islander and pregnancy specific priority areas, key points and actions

Principles underlying the development, implementation and evaluation of these actions:

- Each action is developed and implemented in consultation with Aboriginal and Torres Strait Islander people. The specific stakeholder group may differ between recommendations, for example: community leaders; workers in the community controlled sector; and pregnant Aboriginal and Torres Strait Islander women.
- Where Aboriginal and Torres Strait Islander expertise is required in the implementation of these actions, it should be purchased. This is with reference to the following points:
  - It is best practice to involve Aboriginal and Torres Strait Islander people in the design, development, implementation and evaluation of programs and policies about Aboriginal and Torres Strait Islander people and communities (i.e. 'Nothing about us without us').
  - The ACT Government and other organisations routinely purchase external expertise (e.g. evaluation, cultural knowledge).
  - The development, implementation and evaluation of smoking cessation activities for Aboriginal and Torres Strait Islander people by mainstream services requires expert advice held in the community controlled sector, including in: cultural knowledge; accessing the Aboriginal and Torres Strait Islander community; delivering tobacco cessation; providing antenatal care to mothers and babies in the ACT; and providing health and other programs to young people, women and men.
- The responses to these actions should be endorsed and monitored by the ACT Aboriginal and Torres Strait Islander Tobacco Control Advisory Group.
- Any actions that are implemented should be evaluated, and these evaluations should be properly resourced.

	Priority areas	Key points	Actions
1.	<p><b>Ensure the continuity and further enhancement of smoking cessation services delivered by, and based at, Aboriginal and Torres Strait Islander community controlled services</b></p>	<ul style="list-style-type: none"> <li>• It is best practice for services for Aboriginal and Torres Strait Islander people to be delivered by Aboriginal and Torres Strait Islander people wherever possible.</li> <li>• Smoking cessation programs are currently delivered by Aboriginal and Torres Strait Islander community controlled services including for pregnant women, young mums and men.</li> <li>• These programs are well established, demonstrate good practice and are oversubscribed.</li> <li>• There are no equivalent smoking cessation programs in mainstream antenatal or other settings.</li> <li>• Aboriginal and Torres Strait Islander community-controlled tobacco funding is due to expire through the Commonwealth Tackling Indigenous Smoking Initiative (March 2015) and the ACT Aboriginal and Torres Strait Islander Tobacco Control Strategy (June 2015).</li> </ul>	<p>1.1. Maintain the current funding levels to smoking cessation services and positions in Aboriginal and Torres Strait Islander community controlled services.</p> <p>1.2. Increase tobacco services and positions in Aboriginal and Torres Strait Islander community-controlled services in order to meet client demand and to provide in-reach into other settings (e.g. The Canberra Hospital) (see Action 2.3).</p>
2.	<p><b>Provide targeted, ongoing comprehensive* tobacco-specific support in mainstream services for Aboriginal and Torres Strait Islander women who are pregnant and/or who have young children</b></p> <p>(*Comprehensive can include: multiple and recurrent activities such as brief interventions, groups, counselling, NRT, case management, active referral to the Quitline, tailored health information, self help materials, and follow up)</p>	<ul style="list-style-type: none"> <li>• It is best practice is to provide targeted, on-going comprehensive smoking cessation support to pregnant women who smoke, and to women who smoke and have young children.</li> <li>• Health workers in mainstream settings who work with pregnant women often do not have the capacity to include smoking cessation in consultations.</li> <li>• In the ACT there are limited smoking cessation options health workers can offer women. The most common are brochures and/or providing the Quitline number.</li> <li>• Health workers in mainstream settings may not be aware of the Aboriginal Midwifery Access Program (AMAP) or the <i>No More Boondah</i> program at Winnunga Nimmityjah Aboriginal Health Service.</li> <li>• Women and their families should have choice and control over their antenatal services.</li> <li>• Equivalent tobacco cessation care should be provided in</li> </ul>	<p>2.1. Increase awareness of, and (where chosen) referrals to, Aboriginal and Torres Strait Islander community controlled tobacco programs, such as <i>No More Boondah</i>, of women and their partners by health workers in mainstream pre-pregnancy, antenatal, postpartum and early childhood services.</p> <p>2.2. Increase awareness of, and (where chosen) referrals to, the Aboriginal Midwifery Access Program (AMAP) of women and their partners by mainstream antenatal health workers and services.</p> <p>2.3. Provide an additional specialist tobacco Aboriginal and Torres Strait Islander worker to deliver comprehensive smoking cessation support to women who are pregnant or who have young children, and their partners and families which could:</p>

		<p>all antenatal services, including for Aboriginal and Torres Strait Islander women and their families.</p> <ul style="list-style-type: none"> <li>• Care would be enhanced with the provision of Aboriginal and Torres Strait Islander specific and comprehensive smoking cessation support activities in mainstream antenatal settings.</li> <li>• It is best practice to provide subsidised NRT in all-forms alongside a comprehensive program to smokers to assist them to quit. This could include providing: brief interventions (including 'behavioural counselling'<sup>10</sup>); educational resources; Quitline referrals; and follow-up care through a specialised smoking cessation worker.</li> <li>• The <i>Quit for New Life</i> Program in New South Wales offers this range of services through a range of antenatal and postpartum services to Aboriginal and Torres Strait Islander women, their partners and household members.</li> </ul>	<ul style="list-style-type: none"> <li>• Strengthen linkages across community controlled and mainstream services.</li> <li>• Ideally this position would be based at an Aboriginal and Torres Strait Islander community controlled service (as suggested in Action 1.2) to in-reach into mainstream services, but alternatively, the position could be located at a mainstream service (e.g. The Canberra Hospital, Calvary Hospital, West Belconnen Child Health Centre).</li> </ul> <p>2.4. Investigate the feasibility of establishing a coordinated program for Aboriginal and Torres Strait Islander women and their families within a mainstream service (such as The Canberra Hospital) staffed by Aboriginal and Torres Strait Islander people, including those with tobacco cessation expertise. The model of care could:</p> <ul style="list-style-type: none"> <li>• Include a range of services across pre-pregnancy, antenatal, postpartum and early childhood care;</li> <li>• Build on the expertise of existing areas and positions within ACT Health, such as <i>Core of Life</i>, the antenatal clinics, Aboriginal Hospital Liaison Officers, and MACH Nursing Program.</li> </ul> <p>2.5. Consider adapting for the ACT the New South Wales Health funded <i>Quit for New Life</i> program, including:</p> <ul style="list-style-type: none"> <li>• The delivery of brief interventions, educational resources, Quitline referrals, and follow-up care through a specialised smoking cessation worker</li> <li>• Providing access to subsidised NRT—either</li> </ul>
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<sup>10</sup> Behavioural counselling is an approach used in smoking cessation that can be delivered by any health worker with smoking cessation training. It does not relate to a service specifically delivered by a trained and qualified counsellor.

			<p>on-site or through a voucher system with community pharmacies</p> <ul style="list-style-type: none"> <li>• Developing protocols to enable the delivery of the program.</li> </ul>
3.	<p><b>Provide a full course of all forms of subsidised NRT to women and their families</b></p>	<ul style="list-style-type: none"> <li>• It is recommended that primarily intermittent forms of NRT (e.g. gum) are provided to pregnant women.</li> <li>• Only patches are available on the PBS (one course of up to 12-weeks per 12 month period); this form of NRT is not primarily recommended for pregnant women.</li> <li>• The cost of NRT is a barrier, particularly for people experiencing disadvantage.</li> <li>• ACT Health generally provides NRT for management of withdrawal symptoms for hospital inpatients (e.g. up to 7 days). For pregnant women this covers birthing and medical emergencies but not antenatal services.</li> <li>• A course of NRT is defined by best practice as 8 – 12 weeks.</li> <li>• ACT community based NRT programs have greater flexibility and scope than hospital based programs.</li> <li>• The current Royal Australian College of General Practice guidelines suggest that pregnant women can access NRT; however, only on recommendation from a medical officer.</li> <li>• There is general reluctance amongst medical officers to prescribe NRT for pregnant women, including a lack of awareness of the guidelines and confusion due to the classification of nicotine.</li> <li>• New South Wales Guidelines in some Local Health Districts and services allow midwives and others to provide NRT to pregnant women (in some cases, if reviewed by a medical officer within 24 hours).</li> </ul>	<p>3.1. ACT Health to make available full courses of subsidised NRT to support Aboriginal and Torres Strait Islander women and their partners:</p> <ul style="list-style-type: none"> <li>• Attending antenatal care through mainstream services</li> <li>• Who are discharged from inpatient care (i.e. The birthing unit)</li> <li>• Accessing post-partum and early childhood services through the MACH Program; and</li> <li>• Accessing antenatal, postpartum and early childhood care through Winnunga Nimmityjah Aboriginal Health Service.</li> </ul> <p>3.2. ACT Health to strengthen and expand existing ACT community based subsidised NRT programs with the aim of providing services equal to those provided through the New South Wales Health funded <i>Quit for New Life</i> program</p> <p>3.3. ACT Health to consider adapting New South Wales Health Midwife Prescribing Guidelines which enables health workers (other than medical officers) to authorise NRT use by pregnant women.</p> <p>3.4. ACT Health to review the NRT discussion paper to be provided as a supplement to this report, “Improving messages around the safety of prescribing nicotine replacement therapy (NRT) in pregnancy”, and consider implications for the ACT.</p>

<p><b>4. Build the capacities of health workers to provide Aboriginal and Torres Strait Islander pregnancy and smoking cessation specific supports, including brief interventions* and NRT</b></p> <p>(*Brief interventions are one-on-one, can be one off or multisession, and can take from 1 – 60 minutes)</p>	<ul style="list-style-type: none"> <li>• Providing smoking cessation advice and support through brief interventions is associated with increased quit attempts and reduced smoking prevalence.</li> <li>• All health workers should routinely offer smoking brief interventions.</li> <li>• Training can increase health workers skills and confidence in providing smoking brief interventions.</li> <li>• Current tobacco cessation guidelines (based on the Stages of Change Model) may not be the most effective or appropriate for pregnant women.</li> <li>• Gould, Bittoun &amp; Clarke (2014) suggest smoking cessation guidelines for Aboriginal and Torres Strait Islander pregnant women emphasising two components: <ul style="list-style-type: none"> <li>○ Offer smoking cessation advice and support to <i>all</i> pregnant women at every engagement;</li> <li>○ Emphasise and discuss the family, social and cultural contexts of smoking.</li> </ul> </li> <li>• Different health workers often prefer training tailored to, and delivered by workers from, their area/s of expertise (e.g. General Practitioners, Aboriginal Health Workers, Pharmacists, Midwives).</li> <li>• Different health workers often require different types of smoking specific training in length, type of delivery, scope, etc. (e.g. Medical officers in prescribing NRT to pregnant women or Aboriginal Health Workers in tobacco specific group work).</li> <li>• Few smoking cessation training programs sufficiently address pregnancy. This can be addressed through tailoring the training according to key guidelines (See discussion paper to be provided as a supplement to this report, “Smoking cessation training options available to health workers in the ACT, and principles to guide the choice of training providers”)</li> </ul>	<p>4.1. ACT Health to consider adopting, and reflecting in organisational documents and processes, the smoking cessation guidelines for Aboriginal and Torres Strait Islander pregnant women suggested by Gould, Bittoun &amp; Clarke (2014), including:</p> <ul style="list-style-type: none"> <li>• Offering smoking cessation advice and support to all pregnant women at every engagement;</li> <li>• Emphasising and discussing the family, social and cultural contexts of smoking.</li> </ul> <p>4.2. Deliver smoking cessation training that is tailored to the needs of different health workers at least once a year. This may require purchasing interstate and/or specialist training (e.g. Pharmacy Smoking Cessation Counseling from the Australian Association of Smoking Cessation Professionals; Quitskills: Smoking Cessation Training for Indigenous Health Workers from Cancer Council SA)</p> <p>4.3. Smoking cessation training should be identified and purchased according to the discussion paper to be provided as a supplement to this report, “Smoking cessation training options available to health workers in the ACT, and principles to guide the choice of training providers”</p>
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5.	<p><b>Strengthen data collection and reporting in relation to the Aboriginal and Torres Strait Islander status of women and their babies, and the smoking status of mothers</b></p>	<ul style="list-style-type: none"> <li>• The Aboriginal and Torres Strait Islander status of women and babies is inconsistently recorded.</li> <li>• The Aboriginal and Torres Strait Islander status of babies born in the ACT is under reported. Non-Aboriginal and Torres Strait Islander women with Aboriginal and Torres Strait Islander babies may not have the status of their babies recorded.</li> <li>• The Aboriginal and Torres Strait Islander status of both mothers and babies is often identified at different stages of antenatal care, including post-birth.</li> <li>• This leads to an inaccurate picture of the impact of smoking on the health of Aboriginal and Torres Strait Islander babies.</li> <li>• The Aboriginal and Torres Strait Islander status of babies was only first reported through the National Perinatal Data Collection in 2012. This is not referenced in the 2014 ACT Chief Health Officers Report.</li> <li>• Best practice in assessing smoking status suggests asking the question through multiple choice to improve accuracy of disclosure.</li> <li>• The choices of success-measures in smoking cessation programs must be considered carefully. The measures used (e.g. quitting, reducing smoking), and when and how this data is collected will affect how a program's success is rated.</li> </ul>	<p>5.1. Review ACT Health pre-pregnancy, antenatal, post-partum and early childhood intake processes (e.g. forms) so that at every stage where a woman is asked about their Aboriginal and Torres Strait Islander status, they are also asked about the status of their baby.</p> <p>5.2. ACT Health to strengthen training in collection of Aboriginal and Torres Strait Islander status data, particularly through intake processes.</p> <p>5.3. ACT Health to consider advocating the use of a multiple choice question to assess the smoking status of all patients.</p> <p>5.4. The ACT Chief Health Officer to consider including and regularly reporting on the Aboriginal and Torres Strait Islander status of babies, and the smoking status of their mothers (so, <i>both</i> Aboriginal and Torres Strait Islander <i>and</i> non-Aboriginal and Torres Strait Islander mothers) through the Chief Health Officer's Report.</p> <p>5.5. Evaluation measures implemented for new and existing smoking cessation programs in the ACT should consider issues identified in the supplementary paper, "How to measure success in smoking cessation activities for pregnant Aboriginal and Torres Strait Islander women: strengthening the evidence"</p>
6.	<p><b>Embed smoking cessation activities across the pre-pregnancy, post-partum and early childhood periods</b></p>	<ul style="list-style-type: none"> <li>• The antenatal period is not necessarily the most effective time to provide smoking cessation activities to pregnant Aboriginal and Torres Strait Islander women.</li> <li>• In order to meaningfully prevent uptake of smoking and reduce smoking rates it is important to: <ul style="list-style-type: none"> <li>○ Take a woman-centred approach which promotes lifelong self-efficacy for health; and</li> <li>○ Embed smoking cessation services across the pre-pregnancy, post-partum and early childhood</li> </ul> </li> </ul>	<p>6.1. Maintain current funding levels and positions for smoking cessation in youth Aboriginal and Torres Strait Islander community controlled services.</p> <p>6.2. Support the MACH program to further embed smoking cessation within their work, including providing additional capacity for MACH Nurses to engage with Aboriginal and Torres Strait Islander women in both mainstream and community controlled</p>

		<p>periods</p> <ul style="list-style-type: none"> <li>• Aboriginal and Torres Strait Islander community controlled youth programs are ideal settings to provide smoking prevention and cessation support.</li> </ul>	settings.
7.	<b>Strengthen smoking cessation and health promotion information and resources</b>	<ul style="list-style-type: none"> <li>• Often people do not have the necessary information, resources, infrastructure and support to make and maintain healthy choices. This can be compounded by disadvantage, context and history.</li> <li>• There are intergenerational misconceptions of the negative effects of smoking and its impact on pregnancy (e.g. 'I/my mother/my sister smoked during pregnancy and the baby is okay').</li> <li>• Key positive messages about smoking may not be reaching pregnant women (e.g. quitting any time during pregnancy has benefits).</li> <li>• Using tailored information and resources (e.g. Carbon monoxide monitors, ultrasounds) can be effective motivational tools.</li> <li>• There are intergenerational misconceptions about the efficacy and effectiveness of smoking cessation treatments (e.g. NRT).</li> <li>• Graphic smoking related images and messaging can be effective and resonate with Aboriginal and Torres Strait Islander women and families.</li> </ul>	<p>7.1. Purchase resources that can be used by health workers in Aboriginal and Torres Strait Islander community controlled and mainstream settings for one-on-one and group work (e.g. Carbon monoxide monitors, Aboriginal and Torres Strait Islander pregnancy and smoking information, graphic images of the negative impacts of smoking)</p> <p>7.2. Investigate the feasibility of adapting a comprehensive Aboriginal and Torres Strait Islander pregnancy and smoking social marketing campaign in the ACT (such as <i>Stickin' It Up the Smokes</i>) that includes salient stories about local women.</p>
8.	<b>Ensure smoking cessation services for women include partners and families</b>	<ul style="list-style-type: none"> <li>• The socio-cultural context is influential in both maintaining smoking and encouraging cessation.</li> <li>• Smoking is normalised (e.g. high smoking rates, high acceptability, perceived benefits) amongst men and women intergenerationally. Therefore, remaining a non-smoker and making quit attempts are more difficult, less support is available, and the likelihood of relapse is increased.</li> <li>• For some women there are significant household and family pressures to continue smoking, including partners who smoke and/or are not supportive of quitting.</li> </ul>	<p>8.1. Smoking cessation policies, programs and activities for Aboriginal and Torres Strait Islander women generally, and pregnancy specifically, should have equivalent comprehensive supports for partners and families (e.g. subsidised NRT availability to partners and household members as well as the woman herself).</p> <p>8.2. Smoking cessation activities for partners should be tailored to their individual circumstances and this may require one-on-one support and / or group support</p>

		<ul style="list-style-type: none"> <li>• Power difference in relationships influence smoking and cessation behaviours.</li> <li>• Partners who play a supportive role during pregnancy can increase the chances of successful smoking cessation by pregnant women.</li> <li>• Aboriginal and Torres Strait Islander people experience higher levels of stress than the broader population.</li> <li>• Stress is a major reason cited for smoking.</li> <li>• Changes in smoking behaviours and pregnancy itself can cause stress to the woman, partner and family.</li> </ul>	<p>(e.g. Men’s Group).</p> <p>8.3. Smoking cessation activities (including brief interventions) should emphasize and discuss the family, social and cultural contexts of smoking (see 4.1).</p> <p>8.4. Existing and new Aboriginal and Torres Strait Islander groups and programs should be resourced to have smoking cessation embedded within them (e.g. men’s, women’s, Mums and Bubs, youth, family violence).</p>
<p><b>9.</b></p>	<p><b>Maintain and strengthen the governance of Aboriginal and Torres Strait Islander smoking cessation policy, planning and evaluation</b></p>	<ul style="list-style-type: none"> <li>• The ACT Aboriginal and Torres Strait Islander Tobacco Control Strategy expired at the end of 2014.</li> <li>• Dr Raglan Maddox, University of Canberra, is currently evaluating the strategy.</li> <li>• The strategy facilitated an increased focus on tobacco control in the Aboriginal and Torres Strait Islander community, ACT Health and other organisations.</li> <li>• The strategy identifies and sets priorities and has a governance group that has had good participation and engagement, including by Aboriginal and Torres Strait Islander community controlled organisations.</li> <li>• There is a more sophisticated and nuanced approach to Aboriginal and Torres Strait Islander tobacco control than there was 4 years ago.</li> <li>• This report, and the process of developing it, is an example of the different needs and strategies required for sub-populations of smokers.</li> <li>• Ongoing smoking cessation policies and programs are required to build on achievements to date.</li> </ul>	<p>9.1. Utilise this report to inform the evaluation of the Aboriginal and Torres Strait Islander Tobacco Control Strategy 2010/11 – 2013/14.</p> <p>9.2. Based on the evaluation report and further consultations with stakeholders, update and develop a new Aboriginal and Torres Strait Islander Tobacco Control Strategy (e.g. 2015 – 2018):</p> <ul style="list-style-type: none"> <li>• As priority areas in the next strategy include: Aboriginal and Torres Strait Islander babies; pre-pregnancy, antenatal, postpartum and early childhood periods; and partners and families.</li> <li>• Maintain a governance structure, whose membership includes community members, community controlled services, ACT Health, independent tobacco researchers and other relevant NGOs.</li> </ul>

## Table B: Prioritise and embed smoking cessation within the health system generally, and for populations with high smoking rates specifically

Despite important reductions in daily smoking rates at a populations level, approximately 35,000 Canberrans remain daily smokers. Many of these people experience disadvantage and are not offered or provided smoking cessation services as part of their usual care in health or community service settings.

Smoking rates amongst sub-populations remain unacceptably high, with few changes over the last ten years; for example people accessing drug treatment (up to 90%), people accessing mental health services, people in prison, people accessing homelessness services, etc. Within these populations Aboriginal and Torres Strait Islander people are over-represented. Without a systematic, comprehensive and targeted approach to smoking cessation across all sub-populations with high smoking rates we risk undermining and diminishing activities undertaken, such as with pregnant Aboriginal and Torres Strait Islander women who smoke, and pregnant women more generally.

### Smoking cessation activities in the ACT

There is a misconception that there are comprehensive smoking cessation supports available in the ACT. However, this does not appear to be the case. It is difficult to know the nature, extent and scope of smoking cessation activities as they appear to be spread thinly across the ACT, some are funded short term, and there is not a single place to access coordinated and current information.

- Screening, brief intervention and referral are basic universal smoking cessation support activities that can be delivered by diverse workers with limited smoking cessation training (e.g. one day), and these activities should be applied in all health and community settings, particularly where sub-populations with high smoking rates access services. Based on consultations for this report, it does not appear that these smoking cessation activities are systematically provided through government and non-government health and community settings in the ACT.
- The primary tobacco cessation supports identified which are provided by health workers are:
  - limited brief interventions (e.g. 5As);
  - health information and self-help brochures;
  - provision of the Quitline number; and
  - limited nicotine replacement therapy (mostly patches through the PBS, generally not full courses of intermittent forms).
- Ongoing smoking cessation support is available through the Tobacco Action Officer from the Cancer Council ACT (one-on-one or group smoking cessation support)
- More intensive psychosocial counseling is provided primarily by a psychiatrist through the Smoking Cessation Clinic at The Canberra Hospital.

### Limitations and barriers to accessing current smoking cessation services in the ACT

- There are limited smoking cessation supports available in the ACT, and these are often not coordinated within specific health and other settings to provide best practice smoking cessation options to smokers.
  - The impacts of brief interventions, health information and NRT are further enhanced by the availability of on-going, repeated and tailored psychosocial support.

- There is a lack of information about the smoking cessation support activities in the ACT, how they interrelate and who they are suitable for. For example, the Smoking Cessation clinic at The Canberra Hospital is inappropriate for a smoker only requiring repeated brief interventions (as opposed to the intensive smoking therapy offered by a Psychiatrist through the Smoking Cessation clinic).
- There are a number of barriers to delivering and accessing smoking cessation services. For example:
  - Often health workers feel they don't have time or skills to do brief interventions—they may feel that they will undermine the therapeutic relationship if they provide smoking cessation advice in the context of more pressing health and social issues;
  - Lack of access to targeted tobacco brief intervention training that caters to the specific needs of different groups of workers (e.g. MACH Nurses, Medical Officers, GPs, nurses, midwives, allied health workers, medical specialists, social workers, drug and alcohol workers, mental health workers, youth workers);
  - Appropriate brochures and printed materials are sometimes not easily available, especially those targeting smokers at particular life-stages, and tailored to the needs of specific sub-groups in which smoking rates remain high;
  - Lack of access to a reliable phone inhibits call-backs from the Quitline;
  - Quitline is perceived as inappropriate and ineffective, reducing referral to and uptake of this service;
  - Cost is a barrier to accessing intermittent forms of NRT (such as gum, lozenges, spray) that are not listed on the Pharmaceuticals Benefits Scheme (PBS);
  - There are a range of practical, economic and other barriers for some smokers in accessing a doctor for assessment for NRT; and
  - Services may not be available when a smoker is motivated to quit.
- There is a lack of coordination and responsibility for tobacco control activities in the ACT; activities are currently split across the ACT Government and non-government organisations.

## Key principles that should underpin the delivery of smoking cessation services in the ACT

- A universally strong system for smoking cessation that provides options for all smokers to quit is required, without this any targeted services for Aboriginal and Torres Strait Islander pregnant women will be undermined.
- All smokers should be given every opportunity to quit by having access to a range of options based on best practice.
- Smokers should be given choice and control over which evidence based options are suitable for them and provided with opportunities to try different approaches.
- Smoking cessation should be central to the practice of all health workers and be embedded within all ACT Health funded and delivered services, particularly those that work with people with high smoking rates.

Given the information above, the following specific actions could be undertaken to strengthen smoking cessation services for all smokers in the ACT, and particular sub-populations with higher smoking rates such as pregnant Aboriginal and Torres Strait Islander women.

	Priority areas	Key points	Actions
1.	<p><b>Improve active referrals to and delivery of the Quitline in the ACT for the general population, and specifically for subpopulations, especially Aboriginal and Torres Strait Islander people and people experiencing disadvantage.</b></p>	<ul style="list-style-type: none"> <li>• The ACT Quitline is delivered as part of Quitline services in NSW.</li> <li>• The Quitline is not a 24/7 service in the ACT.</li> <li>• The Quitline is not regularly and actively referred to, and ACT specific information is unsatisfactory.</li> <li>• The level of availability of an Aboriginal and Torres Strait Islander Quitline worker is uncertain, as is the incidence of referral to this worker.</li> <li>• The Quitline can be acceptable and effective to smokers from lower socio-economic backgrounds, and to sub-populations such as Aboriginal and Torres Strait Islander people.</li> <li>• However, the Quitline is perceived by some people in these sub-populations to be ineffective and culturally irrelevant.</li> <li>• Some health workers who service these sub-populations also view the Quitline as ineffective and irrelevant and consequently do not refer clients.</li> </ul>	<p>1.1. Review the materials provided in the ACT Quitpack to ensure relevance to the local context, and to ensure the availability of targeted resources for various sub-populations. Undertake a regular review of these materials to ensure ongoing relevance.</p> <p>1.2. Review the protocols, and implementation of these protocols, for the referral of Aboriginal and Torres Strait Islander people to a specific Quitline worker.</p> <p>1.3. Undertake a targeted campaign and training to increase fax/email/web-based referrals to the Quitline by health workers.</p> <p>1.4. Undertake community-based education and promotion activities to increase the appeal of the Quitline to the general community and health workers.</p> <p>1.5. Ensure that the ACT Smoking Cessation Services Directory (see Action 4.2, below) is provided to the NSW Quitline service so that more relevant local information can be provided during calls.</p>

<p><b>2.</b></p>	<p><b>Improve access to all forms of NRT, in particular to disadvantaged groups through subsidised programs.</b></p>	<ul style="list-style-type: none"> <li>• It is best practice to provide subsidised NRT in all-forms alongside psychosocial interventions (including support from the Quitline) to smokers to assist them to quit.</li> <li>• ACT Health generally provides NRT for patients to manage withdrawal symptoms (e.g. for hospital inpatients for up to 7 days, although this can be extended in some circumstances).</li> <li>• A course of NRT is 8–12 weeks.</li> <li>• Only patches (one course once per 12 month period) are available through the Pharmaceutical Benefits Scheme (PBS); this form of NRT is not primarily recommended for pregnant women. Intermittent forms of NRT (e.g. gum, inhalator, spray) are not available on the PBS, but can be bought over the counter at pharmacies, supermarkets, etc.</li> <li>• Some GPs are reluctant to prescribe or recommend NRT, particularly to pregnant women.</li> <li>• Access to NRT is not automatically offered through the NSW Quitline (although advise about its use is given).</li> </ul>	<p>2.1. Expand the provision and distribution of full courses (8–12 weeks) of all forms of nicotine replacement therapy within community-based settings, in particular through subsidized programs that target disadvantaged sub-populations (see Action 3.2, below)</p> <p>2.2. Enhance effectiveness of NRT provision through the concurrent provision of ongoing psychosocial support, including linking NRT availability with smoking cessation support received through health workers, smoking cessation specialists, and the Quitline.</p> <p>2.3. Enhance profession-specific training available to a range of health workers on the provision of NRT alongside brief interventions (including general practitioners, medical officers, pharmacists, nurses, midwives, community workers).</p>
<p><b>3.</b></p>	<p><b>Develop and implement smoking cessation strategies for sub-populations with high smoking rates</b></p>	<ul style="list-style-type: none"> <li>• Population level tobacco control strategies have been effective at reducing the smoking rate at a population level.</li> <li>• However there are sub-populations with persistently high smoking rates (e.g. people with mental health issues and/or alcohol and other drug issues; prisoners; people who are homeless). Smoking rates in Aboriginal and Torres Strait communities are also higher, and Aboriginal and Torres Strait Islanders are over-represented in these sub-populations with high smoking rates.</li> </ul>	<p>3.1. Implement smoking cessation strategies and programs with specific priorities and targets to address smoking in disadvantaged groups with high smoking rates.</p> <p>3.2. Implement programs that mirror those proposed for pregnant Aboriginal and Torres Strait Islander women (see Table A) within other community and government settings that provide services to disadvantaged groups with high smoking rates (e.g. subsidised NRT provision; brief interventions; tailored health information and self-help materials; comprehensive, ongoing and tailored psychosocial support).</p> <p>3.3. Enhance the <i>Future Directions in Tobacco Control</i> policy</p>

		<ul style="list-style-type: none"> <li>• These sub-populations require comprehensive interventions similar to those outlined above for Aboriginal and Torres Strait Islander smoking and pregnancy.</li> <li>• Such targeted services will, however, be undermined by the absence of strong smoking cessation activities within the general health system in the ACT.</li> </ul>	<p>document to include health-specific tobacco control interventions, particularly for sub-populations with high smoking rates.</p> <p>3.4. Enhance the <i>ACT Alcohol, Tobacco and Other Drug Strategy</i> and the <i>ACT Aboriginal and Torres Strait Islander Tobacco Control Strategy</i> policy documents to include health-specific tobacco control interventions that target sub-populations with high smoking rates.</p>
4.	<p><b>Coordination and communication of what smoking cessation supports and treatments are available in the ACT (threshold, must be above basic, universally expected brief intervention, screening, referral and information provision)</b></p>	<ul style="list-style-type: none"> <li>• Currently there are few smoking cessation referral points in the ACT. Health workers within the ACT, and services such as the Quitline have limited knowledge of and options for referral to smoking cessation supports.</li> <li>• The spectrum and scope of smoking cessation support available in the ACT is unclear.</li> <li>• Clarification of the available services, and the service-gaps will enhance referral, treatment-matching, service planning and resource allocation.</li> <li>• This could be achieved by mapping and documenting smoking cessation activities within services according to domains such as: <ul style="list-style-type: none"> <li>○ target group</li> <li>○ frequency of availability</li> <li>○ type and length of support (e.g. brief intervention, brief therapy, intensive therapy)</li> <li>○ range of services</li> <li>○ approach taken (e.g. abstinence, harm reduction)</li> <li>○ trained staff available</li> <li>○ duration of program or treatment</li> <li>○ availability and cost of pharmacotherapies</li> </ul> </li> <li>• Such mapping should focus on services that provide smoking cessation activities beyond the</li> </ul>	<p>4.1. Undertake a mapping exercise to identify what smoking cessation and support activities are delivered through a range of settings in the ACT. This would involve:</p> <ol style="list-style-type: none"> <li>a) identifying the range of settings within which smoking cessation and support activities are available;</li> <li>b) defining the possible range of activities within the service system (including clarifying counseling versus other psychosocial activities);</li> <li>c) mapping services (a) against these activities (b);</li> <li>d) collecting and documenting the details of service delivery (e.g. target groups, availability, approach, staff, duration of program).</li> </ol> <p>4.2. Develop an ACT Smoking Cessation Service Directory that documents the information collected in the mapping exercise suggested in Action 4.1.</p> <ul style="list-style-type: none"> <li>• Make this document available publicly and specifically for health and other workers who support sub-populations with high smoking rates.</li> <li>• Regularly update the directory.</li> </ul>

		<p>basic, universally-expected activities (ie brief interventions, screening, information provision and referral).</p> <ul style="list-style-type: none"> <li>• This mapping will also enable clarification of the availability of smoking cessation ‘counselling’ across services. The word ‘counselling’ is routinely used to refer to a variety of smoking cessation psychosocial support activities delivered by a variety of health workers. Such ‘counselling’ requires smoking cessation training, but not tertiary qualifications in counselling. This is sometimes inconsistent with the definition of counselling used by ACT Health across its funded services that requires particular activities, qualifications and professional registration.</li> </ul>	
5.	<p><b>Provide intensive smoking cessation treatment through the Smoking Cessation Clinic at The Canberra Hospital for smokers requiring intensive psychosocial therapy such as that delivered by a psychiatrist</b></p>	<ul style="list-style-type: none"> <li>• The Smoking Cessation Clinic at The Canberra Hospital offers intensive psychosocial therapy delivered by a psychiatrist. It is available weekly for 2.5 hours to any staff and patients of the hospital through the outpatient clinic.</li> <li>• For most smokers who need some extra support to quit, repeated and tailored brief interventions and psychosocial supports will be adequate (possibly alongside other measures such as providing NRT). Most do not need intensive therapy delivered by a psychiatrist.</li> <li>• Any health worker with appropriate training can provide smoking brief interventions.</li> <li>• Any health professional with counseling qualifications (e.g. psychologist, Social Worker) can deliver tobacco cessation counseling once they have undertaken specialist tobacco cessation training.</li> <li>• Intensive psychosocial therapy delivered by a psychiatrist (or similar) is valuable in assisting</li> </ul>	<p>5.1. Limit utilization of the current Smoking Cessation Clinic at The Canberra Hospital to people who need more intensive smoking cessation treatment delivered by a psychiatrist (for example, smokers referred from Mental Health ACT)</p>

		<p>hardened and highly dependent smokers, particularly those with comorbidities, such as mental illness.</p> <ul style="list-style-type: none"> <li>• The Smoking Cessation Clinic in its current form should be reserved for certain high needs people (e.g. smokers with serious mental health problems who find it difficult to quit).</li> </ul>	
6.	<p><b>Provide more comprehensive smoking cessation psychosocial supports throughout the health system</b></p>	<ul style="list-style-type: none"> <li>• The Smoking Cessation Clinic at The Canberra Hospital could be expanded to provide additional smoking cessation support though not at the level provided by a psychiatrist, but by health workers with specialist smoking cessation training. Demand for such a service is unclear, but could be expected to be high if accompanied by promotion, health education activities, and a variety of modes of delivery (such as through groups) offered throughout TCH and through community outreach.</li> <li>• A Tobacco Action Officer from the Cancer Council ACT provides health promotion and smoking cessation support to individuals (e.g. through The Junction Youth Health Service) and groups throughout the ACT. This is one position for the entire ACT.</li> <li>• Smoking cessation psychosocial supports could be expanded into Smoking Cessation clinics, programs or groups delivered in other health settings in the ACT, once demand for these services is assessed.</li> </ul>	<p>6.1. Examine the feasibility of expanding the current Smoking Cessation Clinic at The Canberra Hospital to provide greater scope of smoking cessation support to smokers who wish to quit.</p> <p>6.2. Examine the feasibility of implementing similar Smoking Cessation clinics, programs or groups in other health settings in the ACT (e.g. Belconnen Community Health Centre, new northside hospital).</p> <p>6.3. Provide opportunities for smoking cessation training to support workers delivering services through these smoking cessation clinics, programs or groups.</p> <p>6.4. Aim to have smoking cessation services delivered routinely and systematically through every health service in the ACT.</p>

## References

- Allen, M., Barnes, C., Dalley, A., Hardie-Boys, N., Marwick, J. and Glover, M. (2012). Best Practice Framework for Dedicated Pregnancy Smoking Cessation Services. Report for the Ministry of Health. Allen & Clarke.
- Ashford, K. B., Hahn, E., Hall, L., Rayens, M. K., and Noland, M. (2009). 'Postpartum smoking relapse and secondhand smoke'. *Public Health Reports*, 124(4):515-526.
- Australian Bureau of Statistics. (2007). Tobacco smoking—Aboriginal and Torres Strait Islander people: a snapshot, 2004–05. Canberra: ABS, Last modified 5 July 2007.
- Australian Bureau of Statistics (2012). The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples, Oct 2010. Cat.no.4704.0. Last modified 19 December 2012.
- Australian Bureau of Statistics (2014). National Aboriginal and Torres Strait Islander Health Survey: Updated Results, 2012–13. Cat no. 4727.0.55.006. Accessed from <http://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/4727.0.55.0062012-13?OpenDocument> on 25 August 2014.
- Australian Health Ministers' Advisory Council. (2014). Clinical Practice Guidelines: Antenatal Care – Module II. Canberra: Australian Government Department of Health. Accessed 13 February 2015 at [www.health.gov.au/antenatal](http://www.health.gov.au/antenatal)
- Australian Health Ministers' Advisory Council (2012). Clinical Practice Guidelines: Antenatal Care – Module 1. Canberra: Australian Government Department of Health and Ageing. Accessed 15 January at [www.health.gov.au/internet/publications/publishing.nsf/Content/clinical-practice-guidelines-ac-mod1~part-b-lifestyle-considerations~tobacco-smoking](http://www.health.gov.au/internet/publications/publishing.nsf/Content/clinical-practice-guidelines-ac-mod1~part-b-lifestyle-considerations~tobacco-smoking).
- ACT Health (2008). Maternity Shared Care Guidelines. Canberra: ACT Health.
- ACT Government (2010). ACT Alcohol, Tobacco and Other Drug Strategy, 2010–2014. Canberra: ACT Government.
- ACT Health (2012). Australian Capital Territory Chief Health Officer's Report 2012. Canberra: ACT Health.
- ACT Health (2013). The Health of Aboriginal and Torres Strait Islander People in the ACT 2006 to 2011. Health Series Number 58. Epidemiology Section, Population Health Division.
- ACT Health (2014). Australian Capital Territory Chief Health Officer's Report 2014. Canberra: ACT Government.
- Australian Bureau of Statistics (2012). The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples, Oct 2010. 4704.0. Released 19 Dec 2012. Canberra: ABS. Accessed at [www/abs.gov.au](http://www.abs.gov.au) on 25 August 2014.
- Australian Government (2011). Indigenous Anti-Smoking Campaign: Break the Chain. Quantitative Campaign Effectiveness: Research—Executive Summary October 2011. Accessed 20 January 2014 at [www.quitnow.gov.au/internet/quitnow/publishing.nsf/Content/btc-indsurvey-execsumm](http://www.quitnow.gov.au/internet/quitnow/publishing.nsf/Content/btc-indsurvey-execsumm). Last updated 31 October 2013.
- Australian Government Department of Health and Ageing (2011). Every cigarette you don't smoke is doing you good. National Tobacco Campaign—Break the Chain. Australian Government Department of Health and Ageing, 2011, viewed 5 September 2011. Available from: <http://www.health.gov.au/internet/quitnow/publishing.nsf/Content/ntc-break-the-chain>

Australian Capital Territory. Smoke-Free Pregnancy & Families. Resource Folder. (2008) Resource folder produced for use by ACT Health with content produced by the Australian Government Department of Health and Ageing, Quit South Australia and Quit Victoria.

Australian Health Ministers' Advisory Council (2012). Clinical Practice Guidelines: Antenatal Care—Module 1. Canberra: Australian Government Department of Health and Ageing.

Australian Institute for Health and Welfare (AIHW) (2012). Australia's mothers and babies. 2012. Perinatal Statistics Series Number 30. Cat. No. PER 69. Canberra: AIHW.

Bardsley, P. and Olekalns, N. (1999). The impact of anti-smoking policies on tobacco consumption in Australia. *Health Promotion Journal of Australia*, 9(3):202–5.

Baxter, S., Blank, L., Guillaume, L., Messina, J., Everson-Hock, E. and Burrows, J. (2009). Systematic review of how to stop smoking in pregnancy and following childbirth. Sheffield: School of Health and Related Research (SchARR), University of Sheffield.

Bittoun, R. and Femia, G. (2010). 'Smoking cessation in pregnancy'. *Obstetric Medicine*, 3(3): 90-93.

Boles, M., Rohde, K., He, H., Maher, J.E., Stark, M.J., Fenaughty, A., and O'Connor, T. (2009). 'Effectiveness of a tobacco quitline in an indigenous population: a comparison between Alaska Native people and other first-time quitline callers who set a quit date'. *International Journal of Circumpolar Health*, 68:170–81.

Bottoff, J.L., Kalaw, C., Johnson, J.L., Chambers, N., Stewart, M., Greaves, L., and Kelly, M. (2005). 'Unraveling smoking ties: How tobacco use is embedded in couple interactions'. *Research in Nursing and Health*, 28(4), 316-328.

Bottoff, J.L., Kalaw, C., Johnson, J.L., Stewart, M., Greaves, L., and Carey, J. (2006). 'Couple dynamics during women's tobacco reduction in pregnancy and postpartum'. *Nicotine and Tobacco Research*, 8(4), 499-509.

Boyle, T., Shepherd, C.C.J., Pearson, G., Monteiro, H., McAullay, D., Economo, K., and Stewart, S. (2010). 'Awareness and impact of the 'Bubblewrap' advertising campaign among Aboriginal smokers in Western Australia'. *Tobacco Control*, 19(1):83–6.

Brandon, T.H., Simmons, V.N., Meade, C.D., Quinn, G.P., Lopez Khoury, E.N., Sutton, S. and Lee, J. 'Self-help Booklets for Preventing Postpartum Smoking Relapse: A Randomized Trial'. *American Journal of Public Health*, 102:2109–15.

BRC Marketing & Social Research (2005). Promoting Smokefree Pregnancies: A Review of International and New Zealand Literature. Summary, BRC 3029. Prepared by BRC Marketing & Social Research for the Ministry of Health New Zealand.

Briggs, V.L., Lindorff, K.J. and Ivers, R.G. (2003). 'Aboriginal and Torres Strait Islander Australians and tobacco'. *Tobacco Control*, 12(suppl. 2):ii5-8.

Centre for Excellence in Indigenous Tobacco Control. (nd). National symposium on smoking in Aboriginal and Torres Strait Islander communities. Discussion paper on proposed topics. Unpublished discussion paper prepared by Anke van der Sterren, Centre for Excellence in Indigenous Tobacco Control (CEITC).

Chapman, S., Borland, R., Scollo, M., Brownson, R., Dominello, A. and Woodward S. (1999). 'The impact of smoke-free workplaces on declining cigarette consumption in Australia and the United States'. *American Journal of Public Health*, 89(7):1018–23.

- Coleman, T. (2007). 'Recommendations for the use of pharmacological smoking cessation strategies in pregnant women'. *CNS Drugs*, 21(12): 983–993.
- Coleman, T., Chamberlain, C., Davey, M.A., Cooper, S.E. and Leonardi-Bee, J. (2012). 'Pharmacological interventions for promoting smoking cessation during pregnancy'. *Cochrane Database of Systematic Reviews*, 9:CD010078.
- Coleman, T., Britton, J. and Thornton, J. (2004). 'Nicotine replacement therapy in pregnancy'. *BMJ*, 328(7446): 965–966.
- Coleman, T., Thornton, J., Britton, J., Lewis, S., Watts, K. and Coughtrie, M.W. (2007). 'Protocol for the smoking, nicotine and pregnancy (SNAP) trial: double-blind, placebo-randomised, controlled trial of nicotine replacement therapy in pregnancy. Rockville, MD, U.S. Department of Health and Human Services, Public Health Service'. *BMC Health Services Research* 7(2).
- Cosh, S., Maksimovic, L., Ettridge, K., Copley, D. and Bowden, J.A. (2012). 'Aboriginal and Torres Strait Islander utilisation of the Quitline service for smoking cessation in South Australia'. *Australian Journal of Primary Health*, 19(2):113–18.
- Dennis, C. and Kingston, D. (2008). 'A systematic review of telephone support for women during pregnancy and the early postpartum period'. *Journal of Obstetric, Gynecologic, and Neonatal Nursing*, 37(3):301–14.
- DiClemente, C. C., Dolan-Mullen, P., and Windsor, R. A. (2000). 'The process of pregnancy smoking cessation: Implications for interventions'. *Tobacco Control*, 9(Suppl. 3):16-21.
- DiGiacomo, M., Davidson, P., Davison, J., Moore, L. and Abbott, P. (2007). 'Stressful life events, resources and access: key considerations in quitting smoking at an Aboriginal Medical Service'. *Australian and New Zealand Journal of Public Health*, 31(2):174-6.
- Doherty, W.J., and Whitehead, D.A. (1986). 'The social dynamics of cigarette smoking: A family systems perspective'. *Family Process*, 25(3), 453-459.
- Dries, D., Herceg, A., Webb, C. and Chapman, P. (2014). 'An evaluation of the 'No More Boondah' smoking cessation program at Winnunga Nimmityjah Aboriginal Health Service'. Unpublished paper prepared for submission to the Australian and New Zealand Journal of Public Health as a requirement for an ANU Medical Research Project.
- Durcan, M.J., White, J., Jorenby, D.E., Fiore, M.C., Rennard, S.I. and Leischow, S.I. (2002). 'Impact of prior nicotine replacement therapy on smoking cessation efficacy'. *American Journal of Health Behaviours*, 26: 213–20.
- Eades, S., Sanson-Fisher, R., Wenitong, M., Panaretto, K., D'Este, C., Gilligan, C. and Stewart, J. (2012). 'An intensive smoking intervention for pregnant Aboriginal and Torres Strait Islander women: a randomised controlled trial'. *Medical Journal of Australia*, 197:42–46.
- Edwards, M. J., Geiser, T., Chafin, C., Weatherby, N. L., and Smith, C. M. (2009). 'S.M.A.R.T. mothers are resisting tobacco: Prenatal smoking cessation in WIC mothers'. *Journal of Allied Health*, 38(3):170-176.
- Ellerman, A., Ford, C. and Stillman, S. (2012). 'Smoking cessation'. In Scollo, M.M. and Winstanley, M.H. (eds). *Tobacco in Australia: Facts and issues*. 4th edn. Melbourne: Cancer Council Victoria; 2012. Last updated 2011. Available from [www.tobaccoinaustralia.org.au/chapter-7-cessation](http://www.tobaccoinaustralia.org.au/chapter-7-cessation).
- Epidemiology Branch, ACT Health (2011) *Maternal and Perinatal Health in the ACT, 1999-2008*, Canberra: ACT Government.

- Farkas, A., Gilpin, E., Distefan, J. and Pierce, J. (1999). 'The effects of household and workplace smoking restrictions on quitting behaviours'. *Tobacco Control*, 8(3):261–5.
- Fingerhut, L. A., Kleinman, J. C., and Kendrick, J. S. (1990). 'Smoking before, during, and after pregnancy'. *American Journal of Public Health*, 80(5):541-544.
- Fiore, M. C., Jaen, C.R., Baker, T.B., Bailey, W.C., Benowitz, N.L., Curry, S.J. et al (2008). *Treating Tobacco Use and Dependence: 2008 update. Clinical Practice Guideline*. US Department of Health and Human Services.
- Flenady, V., New, K. and MacPhail, J. (2005). *Clinical Practice Guideline for Smoking Cessation in Pregnancy*. Brisbane: The Centre for Clinical Studies, Mater Health Services, Brisbane in consultation with the Clinical Practice Guideline Working Party on Smoking Cessation in Pregnancy.
- Gadomski, A., Adams, L., Tallman, N., Krupa, N., and Jenkins, P. (2011). 'Effectiveness of a combined prenatal and postpartum smoking cessation program'. *Maternal and Child Health Journal*, 15(2):188-197.
- Gaffney, K. F. (2006). 'Postpartum smoking relapse and becoming a mother'. *Journal of Nursing Scholarship*, 38(1):26-30.
- Gillies, P. A., Power, F. L., Turner, I. D., and Madely, R. (1990). 'Successful antismoking interventions in pregnancy—Behaviour change, "clinical indicators" or both?'. Paper presented at the The Global War: The 7th World Conference on Tobacco and Health, Perth, Australia.
- Gilligan, C., Sanson-Fisher, R., D'Este, C., Eades, S. and Wenitong, M. (2009). 'Knowledge and attitudes regarding smoking during pregnancy among Aboriginal and Torres Strait Islander women'. *Medical Journal of Australia*, 190(10): 557–61.
- Gould, G. S., Bittoun, R. and Clarke, M.J. (2014). 'A Pragmatic Guide for Smoking Cessation Counselling and the Initiation of Nicotine Replacement Therapy for Pregnant Aboriginal and Torres Strait Islander Smokers'. *Journal of Smoking Cessation*. DOI: <http://dx.doi.org/10.1017/jsc.2014.3> Published online: 31 March 2014.
- Gould, G., Munn, J., Avuri, S., Hoff, S., Cadet-James, Y., McEwen, A. and Clough, A. (2013). "'Nobody smokes in the house if there's a new baby in it": Aboriginal perspectives on tobacco smoking in pregnancy and in the household in regional NSW Australia'. *Women and Birth*, 26:246-53.
- Gould, G., Munn, J., Watters, T., McEwen, A. and Clough, A. (2013). 'Knowledge and views about maternal tobacco smoking and barriers for cessation in Aboriginal and Torres Strait Islanders: a systematic review and meta-ethnography'. *Nicotine and Tobacco Research*, 15 (5):863-74.
- Gould, G.S., Watt, K., Stevenson, L., McEwen, A., Cadet-James, Y. and Clough, A.R. (2014). 'Developing anti-tobacco messages for Australian Aboriginal and Torres Strait Islander peoples: evidence from a national cross-sectional survey'. *BMC Public Health*, 14: 250.
- Gould, G.S., McEwen, A. and Munn, J. (2011). 'Jumping the Hurdles for Smoking Cessation in Pregnant Aboriginal and Torres Strait Islander Women in Australia'. *Journal of Smoking Cessation*, 6(1):33–36.
- Graham, H. (1996). 'Smoking prevalence among women in the European community, 1950-1990'. *Social Science and Medicine*, 43(2), 243.
- Graham, H., Hawkins, S.S., and Law, C. (2010). 'Lifecourse influences on women's smoking before, during and after pregnancy'. *Social Science and Medicine*, 70: 582-7.

- Greaves, L., Kalaw, C., and Bottorff, J. L. (2007). 'Case studies of power and control related to tobacco use during pregnancy'. *Women's Health Issues*, 17(5), 325-332.
- Greaves, L., Poole, N., Okoli, CTC., Hemsing, N., Qu, A., Bialystok, L., and O'Leary, R. (2011). *Expecting to Quit: A best practices review of smoking cessation interventions for pregnant and post-partum women* (2nd ed.). Vancouver: British Columbia Centre of Excellence for Women's Health.
- Grigg, M., Waa, A. and Bradbrook, S. (2008). 'Response to an indigenous smoking cessation media campaign - it's about whanau'. *Australian and New Zealand Journal of Public Health*, 32(6):559-64.
- Gugan Gulwan Youth Aboriginal Corporation. (nd). *Gugan Gulwan Youth Aboriginal Corporation Information Package*. Accessed 10 January 2015 at: [www.gugan-gulwan.com.au/download/info\\_package\\_2013.pdf](http://www.gugan-gulwan.com.au/download/info_package_2013.pdf)
- Hannöver, W., Thyrian, J. R., Röske, K., Grempler, J., Rumpf, H.-J., John, U., and Hapke, U. (2009). 'Smoking cessation and relapse prevention for postpartum women: Results from a randomized controlled trial at 6, 12, 18 and 24 months'. *Addictive Behaviors*, 34(1):1-8.
- Hartmann-Boyce, J., Stead, L.F., Cahill, K. and Lancaster, T. (2013). 'Efficacy of interventions to combat tobacco addiction: Cochrane update of 2012 reviews'. *Addiction*, 108(10): 1711-1721.
- Hayward, L.M., Campbell, H.S., and Sutherland-Brown, C. (2007). 'Aboriginal users of Canadian quitlines: an exploratory analysis'. *Tobacco Control*, 16(suppl. 1):i60-4.
- Health Report. (2008). 'Indigenous women and smoking during pregnancy' (radio program). ABC Radio National. 14 July 2008.
- Heath, D., Panaretto, K., Manassis, V., Larkins, S., Malouf, P., Reilly E, and Elston, J. (2006). 'Factors to consider in smoking interventions for Indigenous women'. *Australian Journal of Primary Health*, 12(2):131-5.
- Hefler, M. and Thomas, D. (2013). *The Use of Incentives to Stop Smoking in Pregnancy among Aboriginal and Torres Strait Islander Women*. Melbourne: The Lowitja Institute.
- Hellerstedt, W.L., Pirie, P.L., Lando, H.A., Curry, S., McBride, C., Grothaus, L. and Nelson, J.C. (1998). 'Differences in preconceptional and prenatal behaviors in women with intended pregnancies'. *American Journal of Public Health*, 88:663-6.
- Hemsing, N., O'Leary, R., Chan, K., Okoli, C. and Greaves, L. (2009). *Interventions to Improve Partner Support and Partner Cessation During Pregnancy*. NICE Rapid Review. British Columbia: Centre of Excellence for Women's Health.
- Hettema, J. E., and Hendricks, P.S. (2010). 'Motivational interviewing for smoking cessation: a meta-analytic review'. *Journal of Consulting Clinical Psychology*, 78(6), 868-84.
- Hilder, L., Zhichao, Z., Parker, M., Jahan, S., Chambers, G.M. (2014). *Australia's mothers and babies 2012*. Perinatal statistics series no. 30. Cat. no. PER 69. Canberra: AIHW.
- Hughes, D. (2011). *The Rural Research Capacity Building Program 2009 Final report for research project: Give Smokes the Flick—a qualitative evaluation of two quit smoking resources for Aboriginal pregnant women*. Lismore: North Coast Health Promotion.
- Ingall, G. and Cropley, M. (2010). 'Exploring the barriers of quitting smoking during pregnancy: a systematic review of qualitative studies'. *Women and Birth*, 23:45-52.

- Ipsos-Eureka Social Research Institute and Winangali. (2010) Developmental research to inform the National Action to Reduce Smoking Rates social marketing campaign. Prepared for the Department of Health and Ageing. Sydney: Ipsos-Eureka Social Research Institute and Winangali.
- Ivers, R., Castro, A., Parfitt, D., Bailie, R., Richmond, R. and D'Abbs, P. (2005). 'Television and delivery of health promotion programs to remote Aboriginal communities'. *Health Promotion Journal of Australia*, 16(2):155–8.
- Ivers, R.G., (2003). 'A review of tobacco interventions for Indigenous Australians'. *Australian and New Zealand Journal of Public Health*, 27(3):294 - 299
- Ivers, R. (2011). Anti-tobacco programs for Aboriginal and Torres Strait Islander people. Resource sheet no.4 produced for the Closing the Gap Clearinghouse. Canberra: Australian Institute of Health and Welfare and Australian Institute of Family Studies.
- Johnston, V. and Thomas, D. (2010) 'What works in Indigenous tobacco control? The perceptions of remote Indigenous community members and health staff'. *Health Promotion Journal of Australia*, 21(1):45–50.
- Johnston, V., Thomas, D.P., McDonnell, J., Andrews, R.M. (2011). 'Maternal smoking and smoking in the household during pregnancy and postpartum: Findings from an Indigenous cohort in the Northern Territory'. *Medical Journal of Australia*, 194(10):556-9.
- Kavanagh, J., Oliver, S., Chamberlain, C., Caird, J., Barnett-Page, E. and Thomas, J. (2010). 'Smoking cessation in pregnancy: re-analysing equity in a Cochrane Review'. Presented at the 18th Cochrane Colloquium and the 10th Campbell Colloquium, Keystone, Colorado, 18-22 October 2010.
- Kennedy, D. (2014). 'Classifying drugs in pregnancy'. *Australian Prescriber*, 37(2): 38–40.
- Kerdel, K., and Brice, G. (2001). Exploring the smokescreen—reducing the stress: action research on tobacco with Aboriginal primary health care workers in Adelaide. Adelaide: Aboriginal Health Council of South Australia.
- Lancaster, T. and Stead, L.F. (2005). 'Individual behavioural counselling for smoking cessation'. *Cochrane Database of Systematic Reviews*. Issue 2. Art. No.: CD001292. DOI: 10.1002/14651858.CD001292.pub2.
- Lester, D. and Crosbie, D. (2014). ACT Quitline Report. January to June 2014. Unpublished report, St Vincent's Hospital, Sydney.
- Levitt, C., Shaw, E., Wong, S., and Kaczorowski, J. (2007). 'Systematic review of the literature on postpartum care: Effectiveness of interventions for smoking relapse prevention, cessation, and reduction in postpartum women'. *Birth*, 34(4):341-347.
- Lindorff, K.J. (2002). Tobacco time for action: National Aboriginal and Torres Strait Islander Tobacco Control Project Final report. Canberra: National Aboriginal Community Controlled Organisation.
- Lorencatto, F., West, R., Michie, S. (2012). Specifying evidence based behavior change techniques to aid smoking cessation in pregnancy. *Nicotine and Tobacco Research*, 14(9):1019–26.
- Lumley, J., Chamberlain, C., Dowswell, T., Oliver, S., Oakley, L., and Watson, L. (2009). 'Interventions for promoting smoking cessation during pregnancy'. *Cochrane Database of Systematic Reviews*, 3:CD001055.
- Maddox, R., Davey, R., Cochrane, T., Lovett, R. and van der Sterren, A. (under review). 'The Smoke Ring: Social network analysis of the ACT Aboriginal and Torres Strait Islander community and the impact on smoking – a longitudinal mixed method study'. *Public Health Research and Practice*. [under review]

Maher, J.E., Rohde, K., Dent, C.W., Stark, M.J., Pizacani, B., Boysun, M.J., Dilley, J.A. and Yepassis-Zembrou, P.L. (2007). 'Is a statewide tobacco quitline an appropriate service for specific populations?' *Tobacco Control*, 16(suppl.1):i65–70.

Mendelsohn, C., Gould, G.S. and Oncken, C. (2014). 'Management of smoking in pregnant women'. *Australian Family Physician*, 43(1): 46-51.

Mercy Health (2012). Nangnak Wan Myeek. Community Consultation Report. Mercy Health. Accessed 2 December 2014 at:  
[www.mercyhealth.com.au/au/ourorganisation/Documents/Nangnak%20Wan%20Myeek%20Community%20Consultation%20Report.pdf](http://www.mercyhealth.com.au/au/ourorganisation/Documents/Nangnak%20Wan%20Myeek%20Community%20Consultation%20Report.pdf)

Ministerial Council on Drug Strategy (2011). *National Drug Strategy 2010–2015. A framework for action on alcohol, tobacco and other drugs*. Canberra:Department of Health and Ageing.

Ministry of Health (2007). *New Zealand Smoking Cessation Guidelines*. Wellington: Ministry of Health.

Ministry of Health (2014). *The New Zealand Guidelines for Helping People to Stop Smoking*. Wellington: Ministry of Health.

Mullen, P. D., Richardson, M. A., Quinn, V. P., and Ershoff, D. H. (1997). 'Postpartum return to smoking: Who is at risk and when'. *American Journal of Health Promotion*, 11(5):323-330.

Murphy M and Mee V. (1999). 'Chapter 6: The impact of the National Tobacco Campaign on Indigenous communities: a study in Victoria'. In Hassard, K., (editor), *Australia's National Tobacco Campaign: evaluation report vol.1*. Canberra: Department of Health and Aged Care.

Myers, K., West, O., and Hajek, P. (2009). Rapid review of interventions to prevent relapse in pregnant ex-smokers. Report to National Institute for Health and Clinical Excellence. Available at:  
[www.nice.nhs.uk/nicemedia/live/11754/46458/46458.pdf](http://www.nice.nhs.uk/nicemedia/live/11754/46458/46458.pdf).

National Aboriginal Health Strategy Working Party. (1989). *National Aboriginal Health Strategy*. Canberra: National Aboriginal Health Strategy Working Party.

National Health Performance Authority (2014). *Healthy Communities: Child and maternal health in 2009–2012*. Sydney: National Health Performance Authority. Accessed at [www.myhealthycommunities.gov.au](http://www.myhealthycommunities.gov.au) on 25 August 2014.

National Indigenous Drug and Alcohol Committee (NIDAC). (2013). *Funding of Alcohol and Other Drug Interventions and Services for Aboriginal and Torres Strait Islander People*. Canberra: NIDAC.

NSW Health (2006). *National clinical guidelines for the management of drug use during pregnancy, birth and the early development years of the newborn*. Sydney: NSW Department of Health.

NSW Health (2010). *Final Report—The NSW SmokeCheck Aboriginal Tobacco Prevention Project 2007–2008*. Sydney: NSW Department of Health.

NSW Health Hunter New England Local Health District (2008a). *Midwife Initiated Medicine Protocol. Nicotine Replacement Therapy (NRT). July 2008/Version 1*. NSW Health Hunter New England Local Health District. Accessed on 27 January 2015 from  
[www.hnehealth.nsw.gov.au/\\_\\_\\_data/assets/pdf\\_file/0010/49951/Midwife\\_Initiated\\_Medicine\\_Protocol\\_for\\_NRT.pdf](http://www.hnehealth.nsw.gov.au/___data/assets/pdf_file/0010/49951/Midwife_Initiated_Medicine_Protocol_for_NRT.pdf)

NSW Health Hunter New England Local Health District (2008b). *Smoke-free Health Service: Flowchart—ND Maternity Patients*. Issued: July 2008. NSW Health Hunter New England Local Health District. Accessed on 27

January 2015 from [http://www.hnehealth.nsw.gov.au/\\_\\_data/assets/pdf\\_file/0005/49946/Flowchart\\_-\\_Nicotine\\_Dependent\\_MATERNITY\\_Patients.pdf](http://www.hnehealth.nsw.gov.au/__data/assets/pdf_file/0005/49946/Flowchart_-_Nicotine_Dependent_MATERNITY_Patients.pdf)

NSW Ministry of Health (2013). Quit for new life NRT Protocol. Centre for Population Health, NSW Ministry of Health. TRIM Ref H13/83643.

Northern Rivers University Department of Rural Health (2010). 'Stop Smoking in its Tracks' project takes off! NRUDRH News:Winter. Available from: [www.nrudrh.edu.au/doclib\\_udrh/public/NewsLetters/Winter2010\\_2.pdf](http://www.nrudrh.edu.au/doclib_udrh/public/NewsLetters/Winter2010_2.pdf).

Panaretto, K., Mitchell, M., Anderson, L., Gilligan, C., Buettner, P., Larkins, S. and Eades, S. (2009). 'Tobacco use and measuring nicotine dependence among urban Indigenous pregnant women'. *Medical Journal of Australia*, 191(10):554–7.

Passey, M.E., D'Este, C.A., and Sanson-Fisher, R.W. (2012). 'Knowledge, attitudes and other factors associated with assessment of tobacco smoking among pregnant Aboriginal women by health care providers: a cross-sectional survey'. *BioMed Central Public Health*, 12:165.

Passey, M.E., D'Este, C.A., Stirling, J.M., and Sanson-Fisher, R.W. (2012). 'Factors associated with antenatal smoking among Aboriginal and Torres Strait Islander women in two jurisdictions'. *Drug and Alcohol Review*, 31: 608–616.

Passey, M.E., Gale, J.T., and Sanson-Fisher, R.W. (2011). "'It's almost expected": rural Australian Aboriginal women's reflections on smoking initiation and maintenance: a qualitative study'. *BioMed Central Women's Health*, 11:55.

Passey, M., Sanson-Fisher, and Stirling, J.M. (2014). 'Supporting Pregnant Aboriginal and Torres Strait Islander women to Quit Smoking: Views of Antenatal Care Providers and Pregnant Indigenous Women'. *Maternal and Child Health Journal*, 18:2293–99.

Penn, G. and Owen, L. (2002). 'Factors associated with continued smoking during pregnancy: analysis of socio-demographic, pregnancy and smoking-related factors'. *Drug and Alcohol Review*, 21:17–25.

Perreira, K. M., and Cortes, K. E. (2006). 'Race/ethnicity and nativity differences in alcohol and tobacco use during pregnancy'. *American Journal of Public Health*, 96(9), 1629-1636.

Piasecki, T. M., Fiore, M. C., McCarthy, D. E., and Baker, T. B. (2002). 'Have we lost our way? The need for dynamic formulations of smoking relapse proneness'. *Addiction*, 97(9):1093-1108.

Prochaska, J.O., and DiClemente, C. (1986). 'Towards a comprehensive model of change'. In, Miller, W.R. and Heather, N. (eds). *Treating Addictive Behaviours: Processes of change*. New York:Plenum Press.

Queensland Health (2007). *SmokeCheck Evaluation Report 2006*. Brisbane: Queensland Government.

Quit Victoria (2013). *Pregnancy, quitting smoking and nicotine replacement products. Fact sheet for health professionals*. Carlton South, Victoria: Quit Victoria.

Radley, A., Ballard, P., Eadie, D., MacAskil, S., Donnelly, L. and Tappin, D. (2013). 'Give It Up For Baby: outcomes and factors influencing uptake of a pilot smoking cessation incentive scheme for pregnant women'. *BMC Public Health*, 13:343.

Rice, V.H. and Stead, L.F. (2008). 'Nursing interventions for smoking cessation'. *Cochrane Database of Systematic Reviews*. CD001188. DOI:10.1002/14651858.CD1188.pub.3.

- Riemsma, R.P., Pattenden, J., Bridle, C., Sowden, A.J., Mather, L., Watt, I.S. and Walker, A. (2003). ‘ Systematic review of the effectiveness of stage based interventions to promote smoking cessation’ . *BMJ*, 326(7400):1175 - 7.
- Roske, K., Hannover, W., Grempler, J., Thyrian, J. R., Rumpf, H., John, U., and Hapke, U. (2006). ‘Post-partum intention to resume smoking’. *Health Education Research*, 21(3):386-392.
- Shea, A. K. and M. Steiner (2008). ‘Cigarette smoking during pregnancy’. *Nicotine and Tobacco Research*, 10(2):267–278.
- Skinnyfish Music. (2011). *Miwatj Health No Smoking Videos*. Winnellie, Northern Territory: Skinnyfish Music, 2011, viewed 21 August 2011. Available from: <http://www.skinnyfishmusic.com.au/site/programs/102-no-smoking-videos/402-miwatj-health-no-smoking-videos->
- Stead, L.F. and Lancaster, T. (2005). ‘Interventions for preventing tobacco sales to minors’. *Cochrane Database of Systematic Reviews*. Issue 1. Art. No:CD001497. DOI:10.1002/14651858.CD001497.pub2.
- Stead, L.F., Bergson, G. and Lancaster, T. (2008). ‘Physician advice for smoking cessation’. *Cochrane Database of Systematic Reviews*. CD000165. DOI:10.1002/14651858.CD000165.pub3.
- Stead, L.F., Perera, R. and Lancaster, T. (2007). ‘A systematic review of interventions for smokers who contact quitlines’. *Tobacco Control*, 16(suppl. 1):i3-8.
- Stead, L.F., Perera, R., Bullen, C., Mant, D. and Lancaster, T. (2008). ‘Nicotine replacement therapy for smoking cessation’. *Cochrane Database of Systematic Reviews*. CD000146. DOI:10.1002/14651858.CD000146.pub3.
- Stead, L.F., Perera, R., Bullen, C., Mant, D., Hartmann-Boyce, J., Cahill, K. and Lancaster, T. (2012) ‘Nicotine replacement therapy for smoking cessation’. *Cochrane Database of Systematic Reviews* DOI: 10.1002/14651858.CD000146.pub4.
- Stewart, M.J., Brosky, G., Gillis, A., Jackson, S., Johnston, G., Kirkland, S., Leigh, G., Pawliw-Fry, B.A., Persaud, V. and Rootman, I. (1996). ‘Disadvantaged women and smoking’. *Canadian Journal of Public Health*, 87(4), 257-260.
- Stewart, M.J., Gillis, A., Brosky, G., Johnston, G., Kirkland, S., Leigh, G., Persaud, V., Rootman, I., Jackson, S. and Pawliw-Fry, B.A. (1996). ‘Smoking among disadvantaged women: Causes and cessation’. *Canadian Journal of Nursing Research*, 28(1), 41-60.
- Stewart, H.S., Bowden, J.A., Bayly, M.C., Sharplin, G.R., Durkin, S.J., Miller, C.L., Givans, S.E., Warne, C.D. and Wakefield, M.A. (2011). ‘Potential effectiveness of specific anti-smoking mass media advertisements among Australian Indigenous smokers’. *Health Education Research*, 26(6):961–75.
- Stotts, A. L., DiClemente, C. C., Carbonari, J. P., and Mullen, P. D. (2000). ‘Postpartum return to smoking: Staging a “suspended” behavior’. *Health Psychology*, 19(4):324-332.
- Sweanor, D., Alcabes, P. and Drucker, E. (2007). ‘Tobacco harm reduction: How rational public policy could transform a pandemic’. *International Journal of Drug Policy*, 18(2):70–74.
- Tappin, D., Bauld, L., Purves, D., Boyd, K., Sinclair, L., MacAskill, S., McKell, J., Friel, B., McConnachie, A., de Caestecker, L., Tannahill, C., Radley, A., and Coleman, T. (2015). ‘Financial incentives for smoking cessation in pregnancy: randomized controlled trial’. *BMJ*, 350:h134.
- Territory Health Services. (2002). *The Public Health Bush Book: a resource for working in community settings in the Northern Territory*. Darwin: Territory Health Services.

- Thomas, D.P. and Stevens, M. (2014). 'Aboriginal and Torres Strait Islander smoke-free homes, 2002 to 2008'. *Australian and New Zealand Journal of Public Health*, 38:147–53.
- Thompson, K.A., Parahoo, K.P., McCurry, N., O'Doherty, E., and Doherty, A.M. (2004). 'Women's perceptions of support from partners, family members and close friends for smoking cessation during pregnancy—Combining quantitative and qualitative findings'. *Health Education Research*, 19(1), 29-39.
- US Department of Health and Human Services. (2014). *Smoking Cessation Interventions in Pregnancy and Postpartum Care. Executive Summary. Evidence Report/Technology Assessment Number 214.* Agency for Healthcare Research and Quality. Rockville, Maryland: US Department of Health and Human Services, Public Health Service, Office of the Surgeon General. Available at [www.effectivehealthcare.ahrq.gov/reports/final.cfm](http://www.effectivehealthcare.ahrq.gov/reports/final.cfm).
- US Department of Health and Human Services (2004). *The health consequences of smoking. A report of the Surgeon General.* Rockville, Maryland: US Department of Health and Human Services, Public Health Service, Office of the Surgeon General.
- U.S. Department of Health and Human Services. (2001). *Women and Smoking. A Report of the Surgeon General.* Rockville, Maryland: U.S. Department of Health and Human Services, Public Health Service, Centers for Disease Control, Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health.
- van der Sterren, A. and Goreen Ngrn-toura—Healthy Family Air. (2010). *Goreen Narrkwarren Ngrn-toura. Healthy Family Air: a literature review to inform the VACCHO smoking amongst pregnant Aboriginal Women Research Project.* Melbourne:Victorian Aboriginal Community Controlled Health Organisation and the Centre for Excellence in Indigenous Tobacco Control.
- Vos T, Barker B, Begg S, Stanley L and Lopez AD. (2009). 'Burden of disease and injury in Aboriginal and Torres Strait Islander Peoples: the Indigenous health gap'. *International Journal of Epidemiology*, 38(2): 470–7.
- Vos T, Barker B, Stanley L and Lopez A. (2007). *The burden of disease and injury in Aboriginal and Torres Strait Islander peoples 2003.* Brisbane: School of Population Health, The University of Queensland.
- Wakefield, M., Durkin, S., Spittal, M.J., Siahpush, M., Scollo, M., Simpson, J.A., Chapman, S., White, V. and Hill, D. (2008). 'Impact of tobacco control policies and mass media campaigns on monthly adult smoking prevalence'. *American Journal of Public Health*, 98(8):1443–50.
- Wakefield, M.A., and Jones, W. (1998). 'Effects of a smoking cessation program for pregnant women and their partners attending a public hospital antenatal clinic'. *Australian and New Zealand Journal of Public Health*, 22(3), 313-320.
- Walker, N, Howe, C, Bullen, C, Grigg, M, Glover, M, McRobbie, H, Laugesen, M, Parag, V, and Whittaker, R. (2012). 'The combined effect of very low nicotine content cigarettes, used as an adjunct to usual Quitline care (nicotine replacement therapy and behavioural support), on smoking cessation: a randomized controlled trial', *Addiction*, 107(10): 1857-1867.
- West, R. (2005). 'Time for change: putting the Transtheoretical (Stages of Change) Model to rest'. *Addiction*, 100:1036–39.
- Wilkinson, S., Miller, Y. and Watson, B. (2010). 'The effects of a woman-focused, woman-held resource on preventive health behaviors during pregnancy: the pregnancy pocketbook'. *Women and Health* 2010;50(4):342–58.
- Wilson, J. (2011). *It's lights, camera and action in East Gippsland.* ABC Gippsland, 2011:12 Jul. Available from: <http://www.abc.net.au/local/audio/2011/07/12/3267610.htm>

Winnunga Nimmityjah Aboriginal Health Service (2013). 2012–13 Annual Report. Canberra: Winnunga Nimmityjah Aboriginal Health Service ACT Inc.

Winnunga Nimmityjah Aboriginal Health Service. (2013). Winnunga Nimmityjah. Strong Health. Caring for the Community. Canberra: Winnunga Nimmityjah Aboriginal Health Service ACT Inc.

Winstanley, M., van der Sterren, A, and Knoche, D. (2011). 'Tobacco use among Aboriginal peoples and Torres Strait Islanders'. in Scollo, M.M. and Winstanley, M.H. [editors]. Tobacco in Australia: Facts and issues. 4th edn. Melbourne: Cancer Council Victoria. Last updated September 2011.

Wong, R., Herceg, A., Patterson, C., Freebairn, L., Baker, A., Sharp, P., Pinnington, P. and Tongs, J. (2011). 'Positive impact of a long-running urban Aboriginal medical service midwifery program'. Australian and New Zealand Journal of Obstetrics and Gynaecology, 51:518-22.

Wood, L., France, K., Hunt, K., Eades, S. and Slack-Smith, L. (2008). 'Indigenous women and smoking during pregnancy: knowledge, cultural contexts and barriers to cessation'. Social Science and Medicine, 66:2378–89.

World Health Organization (nd). Provisions of tobacco cessation support in the Americas. FCTC WHO Framework Convention on Tobacco Control Regional Studies Series Paper R/1, Geneva:World Health Organization.

Zwar, N., Richmond, R., Borland, R., Peters, M., Litt, J., Bell, J., Caldwell, B. and Ferretter, I. (2011). Supporting smoking cessation: a guide for health professionals. Melbourne:The Royal Australian College of General Practitioner



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