Directions
Pathways to Recovery

Directions Health Services welcomes the opportunity to provide input into the ACT Government's budget process.

Proposed Service Need

Stop Smoking Service

Directions Health Services proposes the introduction of a dedicated stop smoking service to address the dependency of entrenched smokers to tobacco products. Offering guided support through a tailored combination of group programs, individual counselling and medication, the objective of such a stop smoking service would be to provide structured, customised quit smoking support to entrenched smokers who have been unable to address their smoking with less intensive supports. The outcomes anticipated include improving the health, wellbeing and life outcomes for participants and ameliorating the significant economic costs and systemic burden arising from tobacco use.

Context

With the Australian Bureau of Statistics National Health Survey recording a daily smoking prevalence of 16.1% for adults (and marginally lower for young people) and the National Drug Strategy Household Survey indicating a prevalence of 14.2 %, smoking remains one of the major causes for ongoing health concerns in the Australian context. Tobacco has been identified by the National Drug Strategy 2017 – 2026 as one of the priority substances to be addressed, whilst the ACT government identifies the promotion of healthy lifestyle behaviours to 'minimise the risk of developing chronic disease'[1] as integral to its preventative health focus. In its current Strategic Framework, the ACT Government Population Health Division cites smoking cessation as a key example of a primary preventative intervention that operates to reduce the burden of disease at a population level.

The ACT has the lowest rate of daily smoking of all Australian states and territories, with daily smoking prevalence at 13%. However, the 15 year trend of progressive decline has slowed significantly in the past few years, seemingly plateauing. Tobacco use has been identified as the leading contributor to burden of disease in Australia for those aged between 45-84 years,[2] with cancer, respiratory disease and cardiovascular diseases all significant markers of this burden. Tobacco use has been reported as a significant cost to Australian society, both intangibly, through burden of disease measurements, and tangibly in economic terms. Scollo & Winstanley noted that in 2003, 15 551 deaths and 204 778 DALYs (disability adjusted life years)[3] resulted from tobacco use, contributing to 20% of cancer disease burden and 9.7% from cardiovascular disease. According to the AIHW, in 2016 tobacco's contribution

[1] ACT Government Health Directorate Population Health Division Strategic Framework 2013 - 2017

[2] AIHW 2016 *Australia's Health*

[3] in Scollo and Winstanley (eds) *Tobacco in Australia: Facts and issues* (2017)

to the disease burden had risen to 22% due to cancer, 36.2% due to respiratory disease and 12% due to cardiovascular disease.

Colins and Lapsley (2008)[4] conservatively estimated the social costs of smoking to be in the vicinity of $31.5 billion. Their estimate encompassed both tangible elements ($12 billion) - including lost productivity, health care for smoking related illness, fires - and intangible elements ($19.5 billion) – such as loss of life, loss of enjoyment of life during smoking related illness and psychological costs of premature death (for family/friends). According to Colin and Lapsley's calculations, households bear 50.3% of this cost, business absorbs 42.1% and government 7.6%.

Higher smoking prevalence and associated harms are disproportionately impacting people in lower socioeconomic population groups. It has been observed that smokers from this cohort are more dependent upon nicotine, less motivated to pursue cessation and more sensitive to the financial ramifications of their nicotine dependency[5]. This group also suffers from higher premature mortality rates than groups higher on the socioeconomic scale, with a causal link drawn between relative disadvantage and premature mortality. Lung cancer and COPD (Chronic Obstructive Pulmonary Disease) are prominent causes of this premature mortality, particularly in the 45 years + cohort. The incidence of COPD in low socioeconomic groups, at a rate which is almost 4 times greater than that experienced by the highest socioeconomic groups, is particularly concerning and warrants increased targeted intervention.

Intervention Model

Interventions that address smoking within low socioeconomic and disadvantaged groups have been identified as a high priority, driven by both clinical and economic imperatives for health and wellbeing outcomes[6]. Research indicates that behavioural interventions, particularly, show increasing promise as a methodology to support cessation for highly disadvantaged groups[7]. Combinations of counselling and medication have consistently produced moderately successful outcomes, with the recognition that smoking behaviours in socially disadvantaged populations were "reflective of individual circumstances and social and environmental context." Smoking often functions as a platform for social interaction and as a coping mechanism for difficulties in life circumstances. Similar rationales for higher smoking dependency have been noted across other disadvantaged cohorts – those experiencing homelessness, Aboriginal and Torres Strait Islander people and those experiencing mental health issues. The psychological dependence on smoking requires a high intensity, nuanced approach in order to promote and support cessation. Targeted programming would aim to increase accessibility to the particular disadvantaged cohorts noted.

This approach has proven successful for the UK NHS Stop Smoking Service (SSS), which delivers a combination of behavioural support and medication based interventions delivered by specialist practitioners, skilled in working therapeutically with this population cohort.

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[4] Collins d & Lapsley H *The Costs of tobacco, alcohol and illicit drug use to Australian society in 2004/5*. P3 -2625 Canberra; Department of Health and Ageing 20008

[5] Siahpush et al *Socioeconomic variations in nicotine dependence, self-efficacy, and intention to quit across four countries: Findings from the International Tobacco Control*

[6] Greenhalgh, Stillman & Ford 2016 *Interventions for Particular Groups* in Scollo and Winstanley (eds) *Tobacco in Australia: Facts and issues* (2017)

[7] Bryant, Bonevski *et al* (2011), cited Greenhalgh, Stillman & Ford 2016 *Interventions for Particular Groups* in Scollo and Winstanley (eds) *Tobacco in Australia: Facts and issues* (2017)

The SSS has recorded 41% abstinence rates at 4 weeks from quit date, with a successful cessation rate of 8% at 12 months from quit date, biochemically validated through carbon monoxide (CO) breath testing.

Lessons learnt from the UK Stop Smoking Service indicate that the comprehensiveness of service characteristics have direct impact upon the cessation success rate. Evaluation of the SSS notes that support from specialist practitioners, coupled with a continuum of support options (open and closed behavioural support groups, one to one counselling and medication support) lead to increased cessation success. Further, evaluation of the SSS indicated significantly higher outcomes achieved through open group behavioural interventions, than those achieved by other modes of service. Provision of ancillary support services, such as childcare, significantly increased participant engagement. The evaluation also recognised the value of skilled counsellors able to support increased resilience and address psychological distress and mental health (as both contributors to, and comorbidities with, nicotine dependency) as key additional elements for smoking cessation success. [8]

This approach is in line with the multipronged approach that is considered best practice for people with alcohol, other drug dependency and other addictions.

The program would target the estimated 45,000 people in the ACT who are continuing to smoke. The focus would be on recruiting participants who had not succeeded to reduce or quit smoking utilising existing supports. Referral sources could include the person themselves and GPs, specialists or other health practitioners who are in contact with people whose health is likely to be significantly impacted by their inability to address their smoking.

The estimated cost of piloting this program in the ACT is in the vicinity of $500,000 per annum, utilising specialist Alcohol Tobacco and Other Drugs (ATOD) counsellors for behavioural therapy and support, complemented by GP support for medication and health oversight (for those participants who don't have their own GP).

Contact Details:

Bronwyn Hendry

Chief Executive Officer

Directions Health Services

Bronwyn.Hendry@directionshealth.com

(02) 6132 4800

0417 827 776

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[8] Dobbie, Hiscock *et al* (2015) *Evaluating Long Term Outcomes of NHS Stop Smoking Services (ELONS): a prospective cohort study* in *Health Technology Assessment* No 19.95 NIHR Journals Library