Smoking and Tobacco

Author: Dr Rosalie Schultz (adapted from Dr Rowena Ivers[1])

Topic Reviewers: Dr Rowena Ivers (MSHR); Central Australian Alcohol and Other Drugs Services; Janet Fletcher (RAN, Ngukurr Clinic); Sally Matthews (MSHR), Mt Liebig Clinic staff

Prevalence of use of tobacco

Numbers of users

In the National Aboriginal and Torres Strait Islander Survey conducted among Indigenous people around Australia in 1994, 54% of Indigenous Australians stated that they used tobacco.[2] However, there are communities in the Northern Territory where 83% of men and 70% of women smoke.[3] By comparison around 22% of all Australians use tobacco, according to the Australian Institute of Health and Welfare nationwide survey of all Australians.[4] Australians are exposed to environmental or passive smoke, as well as a large number using tobacco themselves.

Who uses tobacco?

In both Indigenous[5,6] and non-Indigenous people[7] use of tobacco is more common among people with lower levels of education and higher unemployment levels. Unemployment and lower levels of education are both more common among Indigenous than non-Indigenous people. Therefore, lower levels of education and higher unemployment levels may account for some of the extra users of tobacco among Indigenous people.

Health effects of tobacco

Tobacco causes about 15% of deaths in Australia.[8] Illness and death from tobacco are commonly through[9]:

- ischaemic heart disease
- chronic obstructive airways disease (chronic bronchitis, emphysema, asthma)
- lung cancer
- other cancers, including mouth and throat, oesophagus, pancreas, cervix, kidney
- stroke
- pneumonia

All of these causes of death are more common among Indigenous than non-Indigenous people.[9]

Other health problems associated with tobacco use include:

- cataracts and blindness[10]
- ear infections (which can lead to hearing problems and deafness[11])
- infertility[12]
- SIDS (sudden infant death syndrome) among infants of people exposed to environmental smoke[13]

A survey of rural Indigenous people in NSW found that smokers were less likely than non-smokers to report that they were in very good or excellent health.[5]

Chewing tobacco may cause infertility, cardiovascular disease and cancer in the mouth.[14] Chewing tobacco does not expose non-users to environmental smoke.

Even among people who use very little tobacco, the risk of some of these illnesses related to tobacco is higher than the risk in non-users. There is no safe level of smoking.[15] There is no information about whether there is a safe level of chewing tobacco.

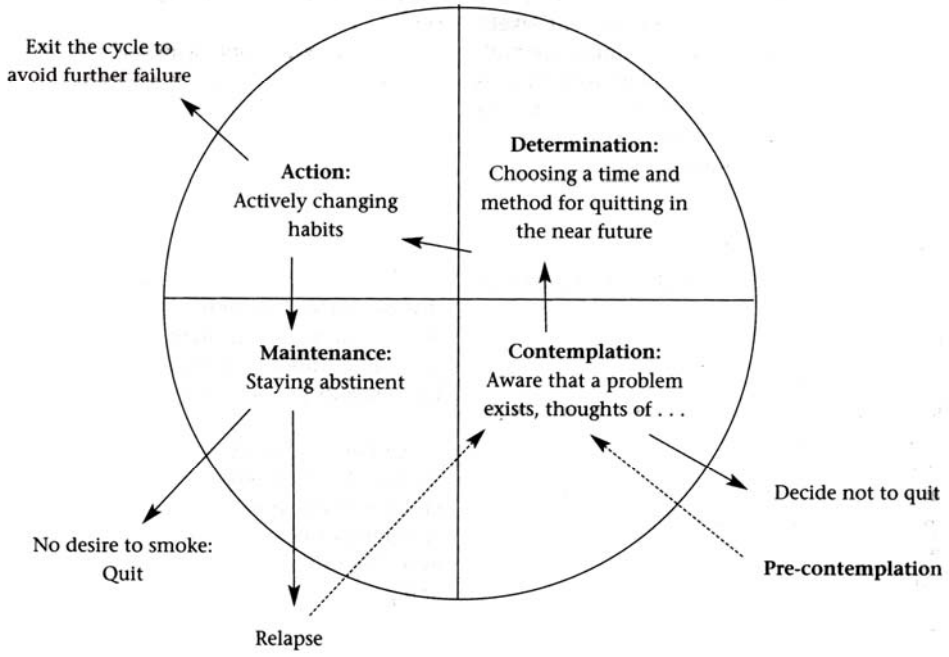
People at special risk. The risk of health problems from using tobacco is greater among people who already have illnesses from tobacco, especially ischaemic heart disease and chronic obstructive airways disease ('COAD', asthma or emphysema). Diabetes causes thickening of the walls of blood vessels. Smoking also causes disease in blood vessels. People with any of these health problems are at particular risk from smoking.[16]

Children who are exposed to tobacco smoke are at increased risk of respiratory infections compared with children not exposed to tobacco smoke. This is true for children born to mothers who smoke, who are exposed even before they are born. Therefore, pregnant women and people who live with children have a special reason to stop smoking.[17]

Helping people quit using tobacco

The Northern Territory Government's Department of Health and Community Services (DHCS) has produced a guide to dealing with a number of public health issues that are prominent in Indigenous communities, the Public Health Bush Book. It is written for remote clinics and contains a lot of useful material about tobacco and smoking. Copies were supplied to all NT clinics and can be obtained through the DHCS.

Schematic model of stages a person might move through in their tobacco use (adapted from ref 23).



How people quit

Studies in the USA show that most people who quit using tobacco quit without any assistance. Quitters quit all at once, without cutting down first or changing to lighter products.[18,19]

Despite this, a study of users of tobacco in the USA found that they believed they would be more likely to quit with health concerns, legislative changes, restrictions on sales or increased taxes on tobacco.[19]

Role of health professionals

Many Indigenous tobacco users support the role of doctors and other health professionals in aiding quitting. They expect the doctor's job is to diagnose and give personalised advice, and that health professionals have detailed knowledge of the body's internal organs. Health professionals, particularly doctors, can provide a reason for the Indigenous person to change.[20]

Indigenous health workers may feel uncomfortable asking their kinfolk about private behaviours such as smoking, and non-Indigenous health workers may be better able to fill that role in encouraging quitting.[21]

How to do it

The first step to help people quit is to find out whether they use tobacco.[22] When you know that a client smokes you are then in a position to assess how ready they are to quit, and move them through stages of behaviour change towards quitting and remaining a non-user.

Encouraging non-users and recent quitters with positive messages about not smoking may help them to continue not using tobacco and feel good about their health habits.

A model of behaviour change developed by Prochaska and Di Clemente[23] is well-accepted as a description of the process of changing habits including smoking, weight control and alcohol use. This model proposes a series of stages of change which people may move through in their efforts to change. The stages are in a circle rather than a line, and people may leave the circle at various points, or continue to go around if they relapse. Health professionals may be able to facilitate behaviour change by encouraging progression through the stages from pre-contemplation to contemplation to determination to action to maintenance, and back to contemplation if there is a relapse.

Medications to help people quit

Medications have been demonstrated in clinical trials to increase the likelihood of quitting. Nicotine replacement, such as patches or gum, has been shown in non-Indigenous people to increase the likelihood of long-term abstinence. The addition of bupropion, an antidepressant medication, further increases the likelihood of long-term quitting.[24] Bupropion should not be used in people with previous seizures or psychiatric conditions.[25]

Health professionals who smoke

Health professionals who smoke are less likely to encourage their clients to quit.[26] Therefore, health professionals who are non-users could prioritise assisting their colleagues to quit.

References

1. Ivers R. Indigenous Australians and Tobacco: a literature review. Menzies School of Health Research. Cooperative Research Centre for Aboriginal and Tropical Health, Darwin, 2001.
2. Australian Bureau of Statistics. National Aboriginal and Torres Strait Islander Survey 1994: Health of Indigenous Australians (Cat. No. 4395.0). Australian Bureau of Statistics, Canberra, 1996.
3. Hoy WE, Norman RJ, Hayhurst BG, Pugsley DJ. A health profile of adults in a Northern Territory Aboriginal community, with an emphasis on preventable morbidities. Aust N Z J Public Health 1997; 21:121–6.
4. Australian Institute of Health and Welfare. 1998 National Drug Strategy Household Survey: First results (Cat. No. PHE 15). Australian Institute of Health and Welfare (Drug Statistics Series), Canberra, 1999.
5. Guest C, O'Dea K, Carlin J, Larkins R. Smoking in Aborigines and persons of European descent in southeastern Australia: prevalence and associations with food habits, body fat distribution and other cardiovascular risk factors. Aust J Public Health 1992; 16:397–402.
6. Hogg RS. Variability in behavioural risk factors for heart disease in an Australian Aboriginal community. J Biosoc Sci 1994; 26:539–51.
7. Hill DJ, White VM, Scollo MM. Smoking behaviours of Australian adults in 1995: trends and concerns. Med J Aust 1998; 168:209–13.
8. English D, Holman C, Milne E, Winter M, Hulse G, Codd J. The quantification of drug caused morbidity and mortality in Australia 1995 (Vol. 2). Australian Government Publishing Service, Canberra, 1995.
9. Measey M, d'Espaignet E, Cunningham J. Mortality and morbidity attributable to smoking, Northern Territory 1986–1995. Territory Health Services, Darwin, 1998.
10. Taylor HR. Prevalence and causes of blindness in Australian Aborigines. Med J Aust 1980;1, 71–6.
11. Strachan DP, Cook DG. Health effects of passive smoking. 4. Parental smoking, middle ear disease and adenotonsillectomy in children. Thorax 1998; 53:50–6.
12. Baird D, Wilcox A. Cigarette smoking associated with delayed conception. JAMA 1985; 253:2979–83.
13. United States Surgeon General. The health benefits of smoking cessation: Executive summary. US Department of Health and Human Services, Atlanta, 1990.
14. Council on Scientific Affairs. Health effects of smokeless tobacco. JAMA 1986; 255 (8):1038–44.
15. Single E, Rohl T. National drug strategy: mapping the future. An evaluation of the National Drug Strategy 1995–1997. Commonwealth of Australia, Canberra, 1997.
16. Rosengren A, Welin L, Tsipogianni A, Wilhelmsen L. Impact of cardiovascular risk factors on coronary heart disease and mortality among middle aged diabetic men: a general population study. Br Med J 1989; 299:1127–31.
17. DiFranza J, Lew R. Morbidity and mortality in children associated with the use of tobacco products by other people. Pediatrics 1996; 97:560–8.
18. Fiore M, Novotny T, Pierce J, Giovino G, Hatziandreu E, Newcomb P, Surawicz T, Davis R. Methods used to quit smoking in the United States. JAMA 1990; 263: 2760–5.
19. Pederson LL, Bull SB, Ashley MJ, MacDonald JK. Quitting smoking: why, how, and what might help. Tob Control 1996; 5 209–14.
20. Brady M. Giving Aboriginal people the excuse to stop drinking: the role of the health professional. Paper presented at the CARPA conference, Alice Springs, 14–15 March 1998.
21. Sibthorpe B. 'All our people are dyin': Diet and stress in an urban Aboriginal community. Unpublished Doctor of Philosophy, Australian National University, Canberra, 1988.
22. Australian Medical Association and Australian Pharmaceutical Manufacturer's Association. Indigenous smoking: issues and responses (draft). Canberra: Australian Medical Association and Australian Pharmaceutical Manufacturer's Association, Canberra, 2000.
23. Prochaske JO, Di Clemente CC. Transtheoretical therapy: toward a more integrative model of change. Psychotherapy: theory, research and practice 1982; 19:276–88.
24. Silagy C, Mant D, Fowler G, Lodge M. Meta-analysis on efficacy of nicotine replacement therapies in smoking cessation. Lancet 1994; 343 (8890):139–42.
25. National Prescribing Service. Zyban (bupropion) for smoking cessation: potential for interactions with psychotropic drugs. Therapeutic Advice and Information Service, Melbourne, undated.
26. Miwa K, Fujita M, Inoue H, Sasayama, S. Is smoking behaviour in patients with coronary heart disease influenced by whether their attending physician smokes? Tob Control 1995; 4:236–8.