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10 August 2015

Hazelwood Mine Fire Inquiry
Att: Professor John Catford
PO Box 24
Flinders Lane VIC 8009

Dear Professor Catford,

Re: Hazelwood Mine Fire Inquiry submission

Thank you for the invitation to make a submission to the Inquiry.

The Latrobe Valley population potentially has large-scale imminent and existing respiratory health issues given the combination of exposure to environmental air pollution with high levels of smoking and social disadvantage. There is a compelling argument to combat smoking in order to reduce health and financial inequities caused by smoking in the Latrobe Valley community.

Quit Victoria suggests that—with community participation and participatory action research as guiding principles—the following key objectives could be addressed:

1) Mobilise the local health and community sector
2) Engage and involve multiple components of the community
3) Build capacity in existing health and community services
4) Enhance access to existing evidence-based interventions

Quit Victoria has a keen interest in addressing smoking prevalence at the community level in rural and regional Victoria. We have proven capabilities in the objectives set out above, plus existing resources and some of the capacity required to achieve real community change. We would be delighted and honoured to be part of helping to improve the health and wellbeing of the Latrobe Valley community.

Yours sincerely,

Sarah L. White, PhD
Director, Quit Victoria

Introduction

Smoking is one of the leading causes of death and disease in Australia. In 2003, tobacco caused more than 1 in every 10 deaths in Australia, and more disease and injury in Australia than any other single risk factor[1].

Smoking impacts particularly on lung health. Cigarette smoke contains many chemicals, as well as cancer-causing substances, that interfere with the body's method of filtering air and cleaning out the lungs. Cigarette smoke also contains irritants that cause direct damage to lung tissue[2]. Active smokers in childhood and adolescence have both reduced lung function and impaired lung growth[3]. Smokers have higher levels of bronchitis, asthma and emphysema[4]. Secondhand smoke (SHS) exposure among children is associated with a wide variety of adverse health risks, including: asthma, otitis media, respiratory infections, impaired lung growth and function, decreased exercise tolerance, cognitive impairments, behaviour problems, and sudden infant death syndrome[5].

Smoking also causes financial stress and hardship, not only to individual smokers, but also to their family and community. Smoking contributes to poverty and disadvantage through the costs of tobacco-related illness, loss of the family breadwinner, impact on family stress and finances, and the impact on children's education and employment opportunities[6] Households that smoke are three times more likely to experience severe financial stress and report going without meals and being unable to heat the home than non-smoking households[7].

The Latrobe Valley population potentially has large-scale imminent and existing respiratory health issues given the combination of exposure to environmental air pollution with high levels of smoking and social disadvantage. The prevalence of current smokers in the Latrobe Valley community is 19.8%, which is higher than the Victorian average of 15.7%[8]. Additionally, the Latrobe Valley is classified in the most disadvantaged category when using the Index of Relative Socioeconomic Disadvantage[9]. This means that the level of smoking-related harm experienced by the Latrobe Valley community could be higher than that experienced by most Victorians. Smoking cessation provides valuable opportunities for residents within the Latrobe Valley to improve both their physical and mental health[10], and could also help to address financial disparities between the Latrobe Valley and the rest of Victoria.

Most smokers want to quit, even smokers experiencing severe social disadvantage (e.g. severe mental illness or homelessness)[1112]. Improving access to evidence-based smoking cessation

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[1] Begg S, Vos T, Barker B, Stevenson C, Stanley L and Lopez A. The burden of disease and injury in Australia 2003. PHE 82. Canberra: Australian Institute for Health and Welfare, 2007. Available from: http://www.aihw.gov.au/publications/index.cfm/title/10317

[2] US Department of Health, Education and Welfare. Smoking and Health: A report of the Surgeon General, Rockville, Maryland: US Department of Health, Education and Welfare, Public Health Service, Office of the Assistant Secretary for Health, Office on Smoking and Health, 1979.

[3] US Department of Health and Human Services. Preventing tobacco use among young people: A report of the Surgeon General. Atlanta, GA: US Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2012. Available from: http://www.cdc.gov/tobacco/data_statistics/sgr/2012/

[4] Scollo, MM and Winstanley, MH. Tobacco in Australia: Facts and issues. 4th edn. Melbourne: Cancer Council Victoria; 2012. Available from www.TobaccoInAustralia.org.au

[5] Scollo, MM and Winstanley, MH. Tobacco in Australia: Facts and issues. 4th edn. Melbourne: Cancer Council Victoria; 2012. Available from www.TobaccoInAustralia.org.au

[6] Scollo MM, Winstanley MH. Tobacco in Australia: facts and issues. 4th edn. Melbourne: Cancer Council Victoria; 2012 Available from: http://www.tobaccoinaustralia.org.au/.

[7] Siahpush M, Borland R, Scollo M. Smoking and financial stress. Tob Control 2003 Mar;12(1):60-6 [Abstract available at http://www.ncbi.nlm.nih.gov/pubmed/12612364

[8] Victorian Department of Health. Victorian population health survey 2011-12: Selected findings - 2. Modifiable health risk factors. 2014

9 Victorian Government. Health Status of Victorians available from http://www.health.vic.gov.au/healthstatus/atlas/html/index.htm accessed 23/07/2015

[10] Taylor G, et al. Change in mental health after smoking cessation. BMJ. 2014;348.

[11] Siru R, et al. Assessing motivation to quit smoking in people with mental illness: a review. Addiction. 2009;104(5):719-33.

support represents the most promising approach for reducing smoking in high prevalence and disadvantaged communities[13]. The most effective smoking cessation interventions combine cognitive-behavioural smoking cessation support with stop smoking pharmacotherapies[14]. Cognitive behavioural interventions include telephone (Quitline) or face-to-face support (either one-to-one or in groups), while pharmacotherapies include nicotine replacement therapy (NRT), varenicline or bupropion. Of the three pharmacotherapies, NRT is the most widely available and has the lowest risk profile. Sadly, these effective interventions are underutilised. Only around 10% of quit attempts are aided by personalised advice programs, mainly from Quitline, and only around half are facilitated by evidence-based cessation medications[15]. Many smokers are reluctant to actively seek smoking cessation treatment themselves due to ambivalence common to any addiction (eg "I want to quit but I'm not sure how I'll cope") combined with the belief that quitting is something that they should be able to do on their own, and lack of awareness of the effectiveness of smoking cessation treatment[16].

While smokers can be reluctant to seek treatment themselves, they are very receptive to offers of cessation assistance[17]. However, despite the burden that smoking places on health services, cessation treatment has not been institutionalised into the health care system. While Australian guidelines recommend that in all encounters with health professionals the issue of smoking should be raised and help provided to quit[18], this is not routine practice. An enormous number of smokers could benefit from routine provision of a brief intervention (<5 minutes) from a health professional that i) asks about smoking, ii) advises patients to quit, iii) provides assistance on how to access NRT or other pharmacotherapies and offers proactive referral, i.e. organises for cessation services (eg Quitline or local cessation support) to contact the smoker.

Quit Victoria has a keen interest in addressing smoking prevalence at the community level in rural and regional Victoria. The beliefs and norms of a community can influence quitting behaviours. In Australia, we have seen a significant shift in the way that smoking is viewed[19]. Once a highly visible and acceptable practice, smoking is increasingly viewed as a socially unacceptable, undesirable behaviour[20.]This view has been driven and reinforced by legislation and anti-smoking mass media, and is demonstrated by increased concern about SHS, and reduced acceptability of the tobacco industry, which in turn have added to the momentum of the denormalisation of smoking[21.]

There is a clear need and a compelling argument to resource and prioritise smoking cessation treatment within health and community services and to develop and implement a community led direct marketing campaign to combat smoking and improve health and wellbeing status in the Latrobe Valley community.

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[12] Segan C, Maddox S & Borland R. Homeless clients benefit from smoking cessation treatment delivered by a homeless persons' program. Nicotine and Tobacco research, (in press).

[13] Carlsten, Chris et al. "Personalized Medicine and Tobacco-Related Health Disparities: Is There a Role for Genetics?" Annals of Family Medicine 9.4 (2011): 366–371. PMC. Web. 23 July 2015.

[14] Stead, L.F. and T. Lancaster, *Behavioural interventions as adjuncts to pharmacotherapy for smoking cessation*, in *Cochrane Database of Systematic Reviews, Issue 12.*2012.

[15] Borland, R., et al., *Cessation assistance reported by smokers in 15 countries participating in the International Tobacco Control (ITC) policy evaluation surveys.* Addiction, 2012. **107**(1): p. 197-205**.**

[16] Carter S, Borland R, Chapman S. Finding the strength tokill your best friend—smokers talk about smoking and quitting. Sydney: Australian Smoking Cessation Consortium and GlaxoSmithKline Consumer Healthcare, 2001.

[17] Tzelepis F et al. Active telephone recruitment to quitline services: Are nonvolunteer smokers receptive to cessation support? Nicotine and Tobacco Research, 2009: 11(10), 1205-15.

[18] Zwar, N., et al., *Supporting smoking cessation: a guide for health professionals.*, 2011, Melbourne: The Royal Australian Collge of General Practitioners.

[19] Christakis N, and Fowler, JH. The collective dynmaics of smoking in a large social network. The New England journal of medicine. 2008;358(21):2249-58

[20] Chapman S, and Freeman, B. Markers of the denormalisation of smoking and the tobacco industry. Tobacco control. 2008;17(1):25-31.

[21] Chapman S, and Freeman, B. Markers of the denormalisation of smoking and the tobacco industry. Tobacco control. 2008;17(1):25-31.

Any relevant activities and initiatives that you currently provide in the Latrobe Valley

Quit Victoria is currently involved in the delivery of a number of activities in the Latrobe Valley Community. These activities include;

1. **Training of health professionals in local services**

This training provides workers with an opportunity for learning and practising the 3As model of brief intervention (Ask, Advise, Assist) as a way of supporting health professionals to routinely connect their clients with cessation support. Training in this technique has been delivered into both mainstream health services (e.g. Latrobe Regional Hospital) and those services with a focus on supporting clients who are vulnerable to poor health and wellbeing outcomes (e.g. Latrobe Community Health Service). In 2015, Quit Victoria delivered two health professional training activities, providing cessation education to a total of 23 participants in the Latrobe Valley.

2. **Training of workplace health professionals in collaboration with the Healthy Together Latrobe initiative.**

This training equips participants with the information, resources, skills and accreditation to run smoking cessation support courses within their workplace (e.g. AGL Loy Yang), as well as to provide support for helping smokers to quit on a one-on-one and peer-to-peer basis. Quit Victoria most recently trained five workplace health professionals (in May 2015), and recognises the opportunity to scale this up within the Latrobe Valley community.

3. **Delivery of cessation support through Quitline**

The Victorian Quitline service is highly effective[2223], and has provided support to smokers wanting to quit since 1992. The Quitline number is on every cigarette pack and the service provides opt in (self-referred) and health professional referred support to smokers in the form of personalised telephone based counselling support. Callers can receive smoking cessation written materials (a “Quit pack”), be advised about on-line resources (quit.org.au), have a one-off counselling session with a Quit advisor, and/or sign up to a course of call-back counselling whereby Quitline initiates phone calls on a predetermined schedule, modified to meet client needs. Call-back sessions are designed to guide smokers through implementing and managing the early weeks of a quit attempt. Call-backs generally consist of up to two calls prior to their nominated quit date, and a further four calls in the month after quitting, three in the first two weeks. All counselling support is provided by highly trained professional telephone counselling staff and there are tailored protocols for smokers with special needs e.g. mental health issues, pregnancy, youth. The Victorian Quitline also encompasses the Victorian Aboriginal Quitline service in which indigenous counsellors provide a culturally-relevant service. Within the last twelve months, the Victorian Quitline has received 207 calls from residents of the Latrobe Valley. Almost 65% of callers requested being a part of the proactive call back service to provide ongoing support to address their smoking. Of these callers, 27.5% disclosed that they had experienced mental illness. In addition, the Victorian Quitline received 45 referrals of smokers from health professionals based in the Latrobe Valley. With a targeted and community led program of health education plus capacity building of all health and community services in the Latrobe Valley, Quit anticipates that both self and health professional referral numbers would dramatically increase and more smokers would access proven cessation interventions.

4. **Partnerships with Aboriginal health and community services**

Through partnerships with Deadly Sport Gippsland and Gippsland and East Gippsland Aboriginal Cooperative (GEGAC), Quit has sponsored and supported a number of community events to encourage and support the Aboriginal community to tackle smoking. These sponsored

[22] Railton R. 2013-14 evaluation of the Victorian Quitline, Cancer Council Victoria, Melbourne, 2015.

[23] Borland R, Segan C, Livingston P, Owen N. The effectiveness of call-back counselling for smoking cessation: a randomised trial. Addiction 2001;96:881 –9.

events include an Indigenous round football and netball fixture, and two women's health days where Quit promoted smokefree messaging and the Aboriginal Quitline programme. Quit also contributed to building local Aboriginal health worker capacity through delivering tailored training for health workers working within Aboriginal communities.

Any recommendations for strategies, approaches or programs that you think would assist.

Quit Victoria recommends that all strategies, approaches or programs should be developed utilising Participatory Action Research (PAR). PAR is an approach to research in communities that emphasizes participation and action by the community. Adopting this approach will lead to increased participation and ownership by the local community and will ensure that the needs of the community are being met. The sensitivities of being directed what to do (identified in the initial Inquiry) can be avoided, and community pride and action harnessed, by working closely with the community to plan and implement a smokefree program. The recommendations we suggest herein, therefore, are broad objectives that would be planned in detail with community leaders and participation.

Quit Victoria suggests that—with community consultation and PAR as guiding principles—the following key objectives could be addressed to reduce health and financial inequities caused by smoking:

1) Mobilise the local health and community sector
2) Engage and involve multiple components of the community
3) Build capacity in existing health and community services
4) Enhance access to existing evidence-based interventions

1) Mobilise the local health and community sector

To best effect changes in smoking prevalence in the Latrobe Valley community, Quit recommends that all state-funded health services in the Latrobe Valley be mandated to provide at least a brief cessation support to all smokers. This might require some (minimal) additional resourcing of health care services and health professionals in order to facilitate and prioritise the provision of smoking cessation support. However, this additional resourcing is entirely justified given the exceptional circumstances within the Latrobe Valley. Bringing cessation services to disadvantaged smokers in environments with which they are familiar is recommended as a vital strategy to increase the utilization of effective cessation interventions[24]. In addition, we recommend that all clients identified as smokers are offered face to face cessation support and a referral to the Quitline plus an offer of free or subsidised combination NRT (ie. patch plus gum/lozenge/inhalator). The face to face cessation support would be reinforced by having funded positions located within the local health and community sector whose role it is to offer cessation support to smokers. For clients who self-refer into the Victorian Quitline, we recommend that NRT could be mailed to the client at their home so as not to create an inequity for smokers who prefer telephone based support alone.

2) Engage and involve multiple components of the community

There are currently more former smokers in the Latrobe Valley than current smokers (25.5% compared to 19.8%) and an increasing proportion have never taken up smoking (53.8%)[25]. This suggests that the population-level social marketing campaigns have effectively reached much of the Latrobe Valley community. Quit Victoria will continue its current health education activities

[24] Franco, L., Welsby, D, Eccleston, P, & Furber, S, A qualitative study about smoking cessation with clients of community service organisations that work with disadvantaged families. Health Promot J Austr, 2011. 22: p. 153-5.

[25] Victorian Department of Health. Victorian population health survey 2011-12: Selected findings - 2. Modifiable health risk factors. 2014

targeting both health and community workers and smokers with clear calls to action to further mobilise the community into action to address smoking prevalence.

We would propose, however, also specifically engaging the Latrobe Valley community, potentially through community events or local media, to ensure the current momentum for positive change is harnessed to address smoking. We would also actively engage with workplaces and schools under the auspices of the Achievement Program (conducted by the Cancer Council Victoria on behalf of the Victorian Government), which recognises and supports the promotion of health and wellbeing in a range of community settings. Quit could, perhaps, facilitate the implementation the Tobacco component of the Achievement Program initiatives.

Quit also has a number of ideas around engaging with local businesses and service providers to engage them in the activities (see below).

3) Build capacity in existing health and community services

Support and advice from a health professional has been demonstrated to increase motivation to quit among smokers and improve quitting outcomes[26]. There is scope to do far more with health and community settings in the Latrobe Valley in this aspect, and Quit Victoria might seek to work, for example, with the local council to map and approach all health and community settings and practitioners to help improve the routine delivery of brief interventions for smoking cessation (that include offering a call from Quitline) and also to identify local resources and capacity and identify points of community contact and opportunities for provision of more intensive smoking cessation support at the local level.

Quit would also seek to provide any further required training around cessation support including the prescription of nicotine replacement therapy (NRT) by health practitioners. Smokers who use NRT during a supported quitting attempt are almost twice as likely to quit smoking successfully than those quitting alone[27].

4) Enhance access to existing evidence-based interventions

Cost can be a barrier to people accessing NRT, particularly in low socioeconomic status populations, despite some forms of NRT being subsidised or free on the Pharmaceutical Benefits Scheme. Quit Victoria could assess whether relationships can be developed with local pharmacies to be “official providers” of (subsidised) NRT or could potentially have prescribing health practitioners attend community events.

Bolstered access to Quitline support through increased referrals and through an offer of proactive Quitline support would be a major goal. Improved referral processes into the Victorian Quitline from health and community workers within the Latrobe Valley community would increase the number of residents who access to evidence based cessation support. Building health and community workers’ confidence in Quitline, e.g. through education about the service delivered by Quitline advisors, streamlining of referral processes and feedback to referring practitioners re client outcomes will facilitate this increase. Quitline referral also assists in relieving the anxiety often experienced by health and community workers who feel that—when they perform a brief intervention with a smoking client—they need to have all the answers.

Quit could even assess the feasibility of identifying smokers across the Latrobe Valley and then proactively calling those householders (or a defined subset thereof). NSW research has shown that while many smokers are reluctant to call the Quitline service proactively, they would be happy to talk about their smoking if the Quitline service called them[28]. Given that relapse back to smoking is common (as it is for all addictions), Quit Victoria has also conducted a pilot study with Victorian Quitline callers to assess if they were willing to use the service again if the

[26] Zwar, N., et al., *Supporting smoking cessation: a guide for health professionals.*, 2011, Melbourne: The Royal Australian Collge of General Practitioners.

[27] Cahill K, Stevens S, Perera R, Lancaster T. Pharmacological interventions for smoking cessation: an overview and network meta-analysis. Cochrane Database of Systematic Reviews 2013, Issue 5

[28] Tzelepis F et al. Active telephone recruitment to quitline services: Are nonvolunteer smokers receptive to cessation support? Nicotine and Tobacco Research, 2009: 11(10), 1205-15.

Quitline proactively called them. Over half (58%) were reached and were willing to participate. Among the 'current smokers' contacted, over half (53%) re-engaged with Quitline. This demonstrates that smokers are willing to re-engage with quitting support services if their initial quit attempt was unsuccessful.

Many smokers experience improved outcomes as a result of being co-managed by both the Victorian Quitline and a trusted health professional. Development of a referral process for smokers who call the Victorian Quitline into local health services (who are providing face to face support and supporting access to NRT) will provide improved outcomes for smokers in the Latrobe Valley community.

Any evidence that is available to support interventions that you might recommend, including any cost benefit analysis that you may have available.

1. The Victorian Quitline Service is effective in assisting smokers to quit

A randomised controlled trial has demonstrated the effectiveness of Victoria's Quitline callback service[29], and that health professional proactive referral to Quitline improves smokers' quit rates[30]. Further research has shown that Victoria's Quitline is effective for smokers with depression[31] and that Victoria's Quitline helps reduce smoking among homeless smokers[32].

A recent evaluation of the Victorian Quitline service was conducted between October 2013 and October 2014[33]. Among smokers at initial contact with Quitline (n=704), 39% were quit at the time of the one month interview, and 33% of respondents were quit six months later. (The six month quit rate reduced to 25% if all non-respondents were assumed to be smoking.) Significant reductions in cigarette consumption were recorded among those who continued to smoke at the one month and six month follow-up interviews.

Respondents were highly likely to report having used a variety of quitting aids and services during the evaluation period with 69% reporting having used at least one quitting aid or service. Use of the call-back service, the Quitpack (printed quit resources) and stop smoking medications (e.g. NRT) during the evaluation period were all associated with increased likelihood of being quit at six months.

Almost all respondents (92%) were either very or somewhat satisfied with the service received form the Quitline and the same proportion (92%) were very likely to say that they would recommend Quit's services to friends or family members.

Quitlines have a number of advantages including that they are cost effective, easily accessible, can be tailored to the individual, and can be used either as a one-off or multiple times for extended support[34]. As a result they have become an important tool in smoking cessation treatment in many countries.

2. Quitline services are cost effective

[29] Borland R, Segan C, Livingston P, Owen N. The effectiveness of call-back counselling for smoking cessation: a randomised trial. Addiction 2001;96:881 –9**.**

[30] Borland, R., et al., *In-practice management versus quitline referral for enhancing smoking cessation in general practice: a cluster randomized trial.* Family Practice, 2008. **25**(5): p. 382-389.

[31] Segan CJ, et al. Helping smokers with depression to quit smoking: collaborative care with Quitline. Medical Journal of Australia. 2011;195(3):S7-11.

[32] Segan C, Maddox S & Borland R. Homeless clients benefit from smoking cessation treatment delivered by a homeless persons' program. Nicotine and Tobacco research, (in press).

[33] Railton R. 2013-14 evaluation of the Victorian Quitline, Cancer Council Victoria, Melbourne, 2015.

[34] Borland, R. and C.J. Segan, *The potential of quitlines to increase smoking cessation.* Drug and Alcohol Review, 2006. **25**(1): p. 73-78.

Data from the Victorian Quitline has been used to demonstrate the cost-effectiveness of introducing callback services in other Australian states and territories[35]. Call-back counselling for smoking cessation is an intervention that both improves health and achieves net cost savings, due to the cost offsets being greater than the cost of the intervention. If cost offsets are excluded, the cost per quitter is $773 (95% uncertainty interval, $769–$779), and the incremental cost–effectiveness ratio for introducing callback counselling is $294 per disability-adjusted life years (95% uncertainty interval, $293–$298).

A cost-effectiveness analysis of the Swedish Quitline service in 2004 reported that 31% of 1131 smokers who used Quitline in the study had quit smoking after one year[36]. The accumulated life years gained in this study was 2,400, and the cost per life year saved equivalent to USD 311–401[3]. The cost per life year gained for Quitline was less than half that of General Practitioner counselling and similar to the cost of brief advice[3,37].

3. Cold calling recruitment increases the reach of Quitline to smokers

Active phone recruitment, also known as cold calling, can be an effective method of recruiting smokers into Quitline services. An Australian randomised controlled trial in 2011 demonstrated that over half of 3,008 smokers contacted in the study were successfully recruited to Quitline[38]. This suggests that the reach of Quitline services can be enhanced if cold calling is incorporated[39].

4. Face-to-face interventions increase cessation outcomes

A brief two to three minute face-to-face intervention by a health professional increases successful cessation rates by 1-3%[40]. This is almost double the rate compared to individuals quitting successfully unassisted[41]. Intensive counselling support from a specialist yields an approximate cessation rate of 10% at 12 months[8].

5. Nicotine Replacement Therapy improves cessation outcomes

NRT is an effective product to assist smokers to quit. People who use the nicotine patch are almost twice as likely to quit and stay stopped[42]. A randomised controlled trial found that using the patch in conjunction with counselling or Quitline was more cost-effective than counselling alone[43],[44]. More than one form of NRT (e.g. patch plus gum or lozenge) can be used concurrently with increased success rates and no safety risks[45].

6. Community behaviours and beliefs impact on quitting behaviour

[35] Lal A, Mihalopoulos C, Wallace A & Vos T. The cost effectiveness of callback counselling for smoking cessation. Tobacco Control, 2014 23(5) 437-442.

[36] Tomson, T., Helgason, Á. R., & Gilljam, H. (2004). Quitline in smoking cessation: A cost-effectiveness analysis. International Journal of Technology Assessment in Health Care, 20(4), 469-74

[37] Parrot S, Godfrey C, Raw M, et al. Guidance for commissioners on the cost effectiveness of smoking cessation interventions. Thorax. 1998;53 (Suppl 5):1-38.

[38] Tzelepis F, Paul CL, Duncan SL, Walsh RA, Wiggers J, Knight J. Increasing the reach of quitlines through active telephone recruitment: do cold-called smokers differ from quitline callers? Nicotine Tob Res. 2012 Dec;14(12):1488-93

[39] Cummins , S. E. , Bailey , L. , Campbell , S. , Koon-Kirby , C. , & Zhu , S. H. (2007). Tobacco cessation quitlines in North America: A descriptive study . Tobacco Control , 16 , i9 – i15

[40] Stead LF, Buitrago D, Preciado N, Sanchez G, Hartmann-Boyce J, Lancaster T. Physician advice for smoking cessation. The Cochrane database of systematic reviews. 2013;5

[41] West R, McNeill A, Raw M. Smoking cessation guidelines for health professionals: an update. Thorax 2000;55:987-99

[42] Cahill K, Stevens S, Perera R, Lancaster T. Pharmacological interventions for smoking cessation: an overview and network meta-analysis. Cochrane Database of Systematic Reviews 2013, Issue 5

[43] Wasley, M.A.; McNagny, S.E.; Phillips, V.L.; Phil, D.; Ahluwalia, J. The cost-effectiveness of the nicotine transdermal patch for smoking cessation. Prev. Med. 1997, 26, 264-270.

[44] Kahende J, Loomis B, Adhikari B and Marshall L. A review of economic evaluations of tobacco control programs. International Journal of Environmental Research and Public Health. 2009;651–68

[45] Zwar, N., et al., *Supporting smoking cessation: a guide for health professionals.*, 2011, Melbourne: The Royal Australian Collge of General Practitioners.

A 2008 study indicated that, while smokers became more socially marginalised as community prevalence reduces, they appeared to be more likely to quit smoking under the collective pressures of their community as smoking behaviours became more socially unacceptable[46].

The study also found that the dynamics of relationships and smoking play a significant role in quitting behaviours. For example the closer someone was to the smoker, the more influence they had on the person quitting[1]. This finding was reinforced by an evaluation on the Victorian Quitline Service in 2012 which found that callers were more likely to be quit at six months if they did not live with another smoker[47].

What capacity and resources your organisation may be able to offer to support improvements in the health of the Latrobe Valley communities in the next few years

Quit Victoria has capacity and resources to support health improvements in the Latrobe Valley. We note, again, that we recognise community consultation and involvement in tailoring our existing resources, developing a targeted plan and implementing that plan will be critical to the success of what we can offer.

- **Cessation support expertise**

Quit Victoria is the lead tobacco control organisation for Victoria. Funded by VicHealth, the Victorian Department of Health and Human Services and the Cancer Council Victoria, Quit has been responsible for designing, delivering and evaluating tobacco control measures since 1985. Quit Victoria is dedicated to ending the pain, suffering and costs caused by tobacco. Key cessation interventions delivered by Quit Victoria include the Victorian Quitline, Victorian health education campaigns about the health impacts of tobacco use, and innovations of cessation support tools and resources for populations that are at high risk of tobacco related health disparities.

- **Quitline support to Latrobe Valley residents**

Quit Victoria would look to enhance access to Quitline support in the Latrobe Valley Community via a number of strategies:

1. Targeted community health education social marketing and/or health education campaign(s) to promote messages about the health impacts of tobacco use, and its impact on the health and wellbeing of the local community and available cessation services
2. A strategy of proactive offer of Quitline services to all smoking residents of the Latrobe Valley region, using the protocols tested within the Newcastle community described above[48].
3. Reinforced referral pathways into the Quitline from all health and community service organisations and tailored training to all staff within these settings on referral processes and rationale
4. Referral pathways into local health and community services from the Victorian Quitline for any Quitline caller from the Latrobe Valley who would benefit from combined face to face and Quitline support

[46] Christakis N, and Fowler, JH. The collective dynamics of smoking in a large social network. The New England Journal of Medicine. 2008;358(21):2249-58.

[47] Hayes L, Baker, J, and Durkin, S. 2010-2011 Evaluation of the Victorian Quitline. Melbourne, Australia: Centre for Behavioural Research in Cancer, Cancer Council Victoria, 2012.

[48] Tzelepis F, Paul CL, Duncan SL, Walsh RA, Wiggers J, Knight J. Increasing the reach of quitlines through active telephone recruitment: do cold-called smokers differ from quitline callers? Nicotine Tob Res. 2012 Dec;14(12):1488-93

- **Capacity building training activities across all community access points**

Quit Victoria could map and then provide tailored training to build capacity for delivering cessation support within local and community health services and other key community access points. This training could be delivered via a number modalities, face to face, webinar and via the Quit Victoria eLearning hub. This training would have two emphases:

1. Building capacity within health services to provide brief intervention and face to face cessation support
2. Brief intervention training and Quitline referral skill development for all other settings and for health and community workers who don't feel confident to provide cessation support.

- **Achievement Program for Workplace Settings in the Latrobe Valley**

Through it's close association with the Achievement Program[49] (delivered by the Cancer Council Victoria), Quit Victoria could support an enhanced roll out into Latrobe Valley workplace settings The Victorian Achievement Program delivers recognises achievements in promoting health and wellbeing and supports the development of safe, healthy and friendly environments for learning, working and living in Workplace Settings and Workforces. The benchmark for the Achievement Program for Workplace Settings in relation to tobacco use is "*Reducing smoking rates among staff and promoting a smokefree workplace helps protect the entire workforce from the harms of tobacco smoke."*

- **Smokefree Sports and Smokefree Smiles**

Quit Victoria is currently delivering two initiatives that could be rolled out in the Latrobe Valley immediately to improve access to cessation supports and smokefree recreation environments across the Latrobe Valley community.

1. Smokefree Sports is an initiative that aims to provide local sporting groups with the tools and resources they need to create completely smokefree environments for their club and facilities. The resources available include a smokefree policy toolkit, communication and key message tools, simple and easy to read key steps to creating a smokefree sports club.
2. Smokefree Smiles is a project funded by the Victorian Department of Health and Human services which developed a suite of tools, resources and online training tools tailored for oral health settings. The project aims to increase brief interventions being delivered within oral health settings, and referrals from oral health providers into the Victorian Quitline Service. This project could be promoted into public and private Latrobe Valley oral health settings through existing relationships with Australian Dental Association Victoria (ADAV) and Dental Health Services Victoria (DHSV).

- **Program management and coordination support and evaluation (program and campaign) expertise.**

Quit Victoria is the lead agency for developing, delivering and evaluating tobacco control initiatives in Victorian settings and has established an exceptionally strong track record over the past 25 years. Quit Victoria, being part of the Cancer Council Victoria, has ready access to world leading expertise in smoking cessation research and program evaluation.

[49] http://www.achievementprogram.healthytogether.vic.gov.au/