Northern Territory
Tobacco Action Plan
2019 - 2023

NTGovHealth | health.nt.gov.au

NORTHERN TERRITORY GOVERNMENT

Contents

1. Ministerial foreword

It is widely recognised that tobacco use is the largest cause of preventable death and chronic disease in Australia. Most Territorians recognise that smoking tobacco causes major harm to a person's health and that this harm magnifies when others, for example children, friends and work colleagues, are exposed to second hand smoke.

The Northern Territory Government is committed to providing leadership and being innovative, setting ambitious goals and maintaining evidence-based, population-wide approaches we know work.

The Northern Territory (NT) has the highest smoking rate in Australia, and will continue to face many significant challenges for tobacco control during the life of this plan.

These include:

- **achieving reductions in smoking rates for some population groups**
- **adapting quickly to the changing media environment to communicate smoke-free messages**
- **responding to emerging technologies and internet mediated promotions and sales**
- **ensuring adherence to Australia's obligations under article 5.3 of the Framework Convention on Tobacco Control, which requires parties to protect tobacco control policies from commercial and other vested interests of the tobacco industry.**

The NT Tobacco Action Plan 2019–2023 (Action Plan) provides clear strategic direction for anyone working in tobacco control to implement specific activities with an aim to produce improved health outcomes across the Territory. It focuses efforts on providing increased awareness on the harmful effects of tobacco smoking, support for people to quit, greater access to clinical interventions, and implementation and monitoring of smoke-free workplace policy and legislative support across the NT.

This action plan will be monitored by the Northern Territory Tobacco Control Action Committee (NTTCAC). The Action Committee will engage all sectors of the community to take action on denormalising smoking, providing support for those seeking to quit, and preventing uptake.

The Action Plan reflects the Northern Territory Government's commitment to providing the leadership and support that is necessary to address tobacco issues within our community.

Natasha Fyles

Minister for Health
The Honourable Natasha Fyles MLA

Executive summary

$764 mill

Each year smoking costs the NT $764 million in social (including health) and economic productivity costs. This is $5,150 per person aged over 14 years.

Young adults

23.2% of young adults across the Territory are choosing not to establish patterns of smoking.

9%

AT LEAST

of the total Australian burden of disease and injury is conributed to by smoking.

- 22% of cancers
- 36% of respiratory diseases
- 12% of cardiovascular diseases
- 3.5% of endocrine disorders.

LESS THAN HALF

49% of Aboriginal Territorians aged 15 and over self-reported as current smokers in 2014-15, compared to 41.9% nationally and 3.7% fewer children were exposed to secondhand smoke within the same period.

50-59 years

Daily smoking in 2016 was highest among those aged 50-59 in the NT, almost twice that found for this age group nationally.

17.2%

of Territorians aged 14 or over reported daily smoking in 2016.

52.6%

of males reported as never having had a cigarette in 2016. Noting a Statistically significant change between 2013 and 2016.

58.2%

of females reported as never having had a cigarette in 2016. Another statistically significant increase from 55.3% 2013

11.3%

fewer women between 2013 - 2015 reported as smoking during the first 20 weeks of pregnancy.

Statistics do not include data from remote communities.

2. Executive summary

Smoking is the largest preventable cause of disease and death in Australia, contributing to 9% of the total Australian burden of disease and injury. It causes 22% of cancers and contributes to 36% of respiratory diseases, 12% of cardiovascular diseases and 3.5% of endocrine disorders (AIHW, 2016).[1] One in five deaths in the NT is the result of a smoking-related illness, and tobacco is the single greatest contributor to the low life expectancy of Aboriginal Territorians.

Each year smoking costs the NT $764 million in social (including health) and economic productivity costs. This is $5,150 per person aged over 14 years.[2]

Improving the lives of all Territorians.

Smoking rates in the NT general population are higher than national rates. Smoking rates for Aboriginal people and young people are higher in the NT than nationally.

The goal of the Action Plan is to improve the health of all Territorians by reducing the harm caused by tobacco consumption and exposure to tobacco smoke, and to prevent uptake by young people. A feature of the Tobacco Action Plan is its focus on some of the most disadvantaged groups in our society. Many of these groups have much higher rates of smoking than the general population. Special emphasis is placed on reducing harm for Aboriginal Territorians, who suffer the greatest burden from tobacco use.

To address these needs, the population-wide approaches that have been effective and delivered substantial reductions in smoking prevalence in the past will be maintained and complemented with additional targeted approaches to assist disadvantaged groups to quit smoking.

The focus areas for action under this plan:

1. **Media campaigns** – de-normalising smoking and promoting positive role models
2. **Smoke free spaces** – homes, workplaces and public settings
3. **Sustaining quit attempts and preventing relapse**
4. **Priority populations**
   - Pregnant women and their families
   - Children and adolescents
   - People with mental illness
   - People released from NT prisons

There have been substantial improvements in tobacco control in the NT in recent years. In February 2019, the Northern Territory Government passed amendments to the *Tobacco Control Act 2002* and Tobacco Control Regulations to bring the NT in line with best practice in other jurisdictions. These amendments will take effect from 1 July 2019.

The NT is the first jurisdiction in Australia to implement a minimum age of at least 18 years of age for a person to be able to sell tobacco and electronic cigarettes (E-cigarette) products. E-cigarettes will be regulated like tobacco products to reduce children's exposure to marketing. Smoke-free buffer zones around community venues and events will be increased.

3. Key statistics

Tobacco use in the NT from the National Drug Strategy Household Survey 2016[3] and the 2017 Aboriginal Torres Strait Islander Health Performance Framework.[4]

In 2016, 17.2%[5] of Territorians aged 14 or over reported daily smoking, Table 1. Daily smoking among males (18.6%) was higher than among females (15.7%). Male smokers had declined steadily from 27.5% found in 2010 while female daily smokers had fluctuated over the same period. The proportions reporting daily smoking in the NT for both males and females were approximately 50% more than the same proportions nationally.

Large proportions of male (52.6%[6]) and female (58.2%[7]) reported having never smoked, with increases seen for both male and females since 2013.

Table 1: Tobacco smoking status, people aged 14 years or older, NT and Australia, 2010 to 2016 (per cent)

	NT			Australia		
Smoking status	**2010**	**2013**	**2016**	**2010**	**2013**	**2016**
Males						
Daily	27.5	23.8	18.6	16.4	14.5	13.8
Ex-smoker[(a)]	23.3	27.2	24.1	26.4	26.0	24.1#
Never smoked[(b)]	45.3	45.4	52.6#	53.7	55.7	58.8#
Females						
Daily	16.8	18.5	15.7	13.9	11.2	10.7
Ex-smoker[(a)]	25.0	23.9	23.6	21.8	22.2	21.6
Never smoked[(b)]	54.9	55.3	58.2	61.8	64.5	65.6
Others						
Daily	22.3	21.3	17.2	15.1	12.8	12.2
Ex-smoker[(a)]	24.1	25.7	23.9	24.1	24.0	22.8#
Never smoked[(b)]	49.9	50.1	55.2	57.8	60.1	62.3#

(a) Smoked at least 100 cigarettes or the equivalent amount of tobacco in their life and reported no longer smoking.
(b) Never smoked 100 cigarettes (manufactured and/or roll-your-own) or the equivalent amount of tobacco.
Statistically significant change between 2013 and 2016.

Source: *National Drug Strategy Household Survey 2016*, State and Territory chapter, supplementary data tables, Table 7.3.

Daily smoking in 2016 was highest among those aged 50-59 (27.4%[8], Table 2), a proportion almost twice that found for this age group nationally (14.3%). Daily smoking among 30-39 year olds in the NT was found to have declined significantly between 2013 and 2016, from 27.6% to 15.2%.[9]

Table 2: Daily tobacco smoking status, people aged 14 years or older, NT and Australia, 2010 to 2016 (per cent)

	NT			Australia		
Ae Group (Year)s	2010	2013	2016	2010	2013	2016
14-19	*6.4	*15.0	**4.8	6.9	7.0	3.0#
20-29	25.7	20.3	19.2	18.0	15.2	14.8
30-39	20.9	27.6	15.2#	18.5	13.7	14.0
40-49	30.7	20.3	19.1	19.5	16.2	16.9
50-59	26.1	24.9	27.4	17.4	15.0	14.3
60+	16.0	15.5	13.5	9.1	8.8	8.2

* Estimate has a relative standard error of 25% to 50% and should be used with caution.(b) Never smoked 100 cigarettes
** Estimate has a high level of sampling error (relative standard error of 51% to 90%), meaning that it is unsuitable for most uses.
# Statistically significant change between 2013 and 2016.

Source: *National Drug Strategy Household Survey 2016*, State and Territory chapter, supplementary data tables, Table 7.5.

Almost half, 49.3%, of Aboriginal Territorians aged 15 and over self-reported as current smokers in 2014-15, compared to 41.9% nationally. Analysis by the Australian Institute of Health and Welfare suggests that this proportion has fluctuated around 50% since at least 1994.

Table 3: Proportion of current smokers, NT and Australia, Aboriginal Australians aged 15 and over, 1994, 2002, 2008, 2012–13 and 2014–15

	1994[(a)]	2002[(b)]	2008 [(b)]	2012-13[(b)]	2014-15[(b)]
NT	49.9	55.5	52.7	54.1	49.3
Australia	51.8	51.2*	46.8*	43.7	41.9

* Represents statistically significant differences at the p < 0.05 level. Differences between rates were tested between year 2002, 2008 and 2014–15, using 2014–15 as the reference category.
(a) In the 1994 NATSIS, respondents were not asked how frequently they smoked cigarettes.
(b) Includes persons who smoke daily, persons who smoke at least once a week but not daily, and those who smoked less than weekly.
(c) The number of current smokers expressed as a percentage of the total population in the same group. Source: *National Drug Strategy Household Survey 2016*, State and Territory chapter, supplementary data tables, Table 7.5.

Source: Aboriginal Institute of Health and Welfare (AIHW) 2017. *Aboriginal and Torres Strait Islander health performance framework 2017*: supplementary online tables. Cat. no. WEB 170. Canberra: AIHW, Table 2.15.1.

4. Policy context

The Action Plan is informed by relevant policy frameworks at the international, national and NT level including:

- **World Health Organisation (WHO) Framework Convention on Tobacco Control**
- **Council of Australian Governments (COAG) National Healthcare Agreement**
- **COAG National Partnership Agreement on Preventive Health**
- **Aboriginal Health Plan 2015-2018**
- **National Tobacco Strategy**
- **National Aboriginal and Torres Strait Islander Peoples Drug Strategy**
- **NT Health Promotion Framework**
- **NT Chronic Conditions Prevention and Management Strategy 2010-2020**

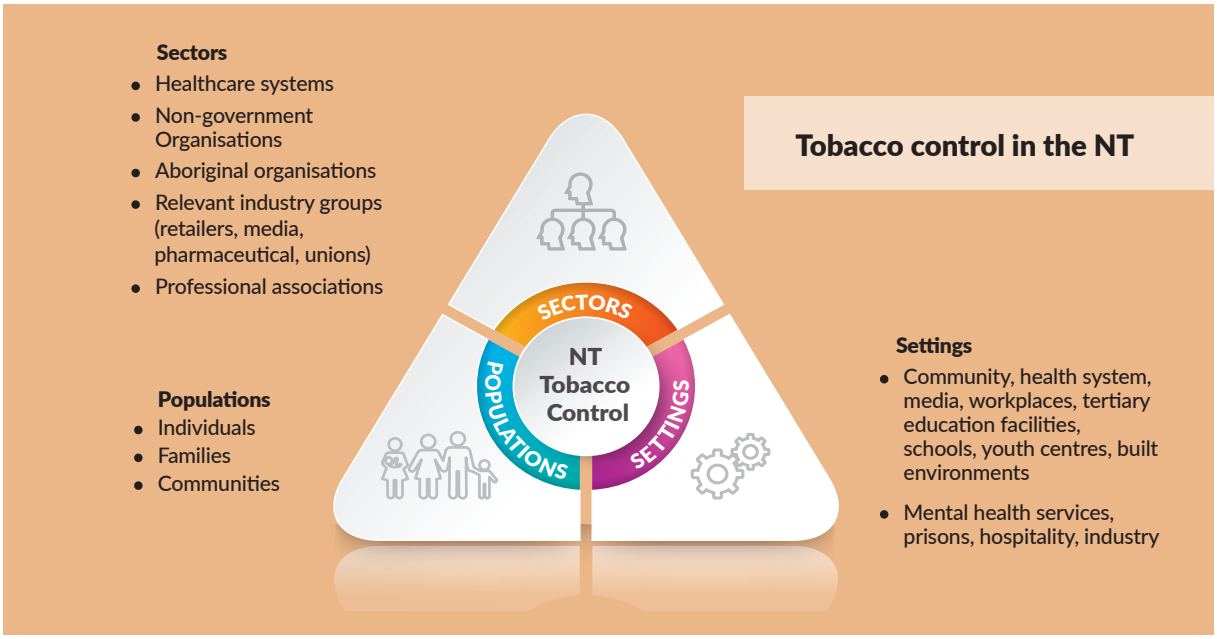
While the focus of this Action Plan is on what the NT will do, it is recognised that there are a number of reforms outside the control of the NT Government that would further reduce the harm caused by tobacco. Of critical importance is increasing the price of tobacco, plain packaging of tobacco products, eliminating the remaining forms of tobacco advertising and enhancing national anti-tobacco public education campaigns.

The Action Plan builds on the coordinated government and non-government tobacco control measures undertaken in previous years. Successful implementation is dependent on effective partnerships and collaboration between all stakeholders and the community. It is envisioned that through strong partnerships, community participation, and a shared commitment that health can be achieved for all Territorians.

The Action Plan will link with other NT Government frameworks including *Starting Early for a Better Future Early Childhood Strategy and The Best Opportunities in Life, Child and Adolescent Health and Well Being* Strategic Plan and ensure that these are integrated where possible to maximise the impact of harm reduction to improve health and lower smoking rates.

Central to this Action Plan is the use of evidence based interventions and programs shown to be effective in reducing smoking prevalence, protecting staff and the public from second-hand smoke, reducing exposure to smoking and tobacco products and improving the monitoring of tobacco sale and supply. It is therefore essential that all aspects of this Action Plan are subject to regular evaluation of their implementation and, importantly, their effectiveness in the NT setting.

Figure 1: Approach to tobacco control in the NT.



5. Goal

To improve the health of the people of the NT and to eliminate or reduce their exposure to tobacco related harms.

6. Guiding principals

Local participation - implemented activities will be sustainable, build capacity in communities, and enable people to increase control over and improve their health.

Reducing inequity - addressing the differences in health status in the community by recognising and responding to the special needs of those groups whose health is poorest, especially Aboriginal people.

Evidence based - where available, tobacco control activities will be informed by credible data and multiple, complementary strategies across the continuum of health promotion actions will be encouraged.

Collaborative - actions will require stakeholders across all sectors to collaborate efforts and work together to achieve shared outcomes.

Evaluate - processes and impacts of activities will be monitored wherever possible and evaluated, with information disseminated with community consent.

7. Objectives

Reduce the number of people using tobacco

- **Prevent the uptake of smoking especially by children and young people**
- **Prevent exposure to second-hand smoke and the harm it causes**
- **Reduce smoking among Aboriginal people and other populations with high smoking rates**
- **Decrease tobacco related death and disease**

Delivering a comprehensive tobacco control strategy requires action in a variety of settings. Key settings for tobacco control in NT include workplaces, schools, media, the built environment, health services (particularly mental health services), the hospitality industry and prisons.

Key partners and stakeholders include the healthcare system, social service organisations, non-government organisations, Aboriginal organisations, relevant industry groups (retailers, media, pharmaceutical etc.), unions and professional associations.

8. Focus areas for action

8.1. Media campaigns:

Denormalising smoking and promoting positive role models

There is strong evidence that public education campaigns are one of the most effective population strategies to reduce tobacco consumption. Public education campaigns help to personalise the health risks of smoking and increase people's sense of urgency about quitting.

Given the influence of family relationships in the uptake and prevalence of smoking, and quitting smoking; family-centred initiatives based in the home and community are likely to be an influential part of tobacco action programs in Aboriginal communities.[10] In addition, community esteem and respect for elders and older community members means supporting them to quit may contribute to initiating more widespread declines in negative smoking behaviours through role modelling.[11]

8.2. Smoke-free spaces:

homes, workplaces and public settings

There is no level of exposure to second hand smoke that is free of risks. Evidence now shows that passive smoking or exposure to second-hand smoke can lead to serious harm, such as cancers and cardiovascular disease. It can lead to ear infections and hearing loss in babies and children.[12]

Smoke-free environments are the only proven way to protect people adequately from the harmful effects of second hand smoke.[13] Smoke-free environments not only protect non-smokers, they also help smokers who want to quit.[14] Placing the responsibility for enforcing smoke-free places on facility owners and managers is the most effective way to ensure that the laws are enforced.

The awareness that second hand smoke is dangerous makes smoking a safety issue in the workplace, in entertainment venues including hotels, casinos, restaurants and clubs, in vehicles and in the home.

8.3. Sustaining quit attempts and preventing relapse

A large national epidemiological project found the proportion of Aboriginal and Torres Strait Islander daily smokers who want to quit, have made a quit attempt in the past year, live in smoke-free homes and work in smoke-free workplaces is similar to that of the general population. However, a much lower proportion of Aboriginal and Torres Strait Islander daily smokers had been able to successfully sustain quit attempts.[15]

There is robust evidence that the chances of quitting successfully increased when using quitting medications in combination with supportive counselling. To further assist quitting by low-income people, the Australian Government has made nicotine patches available to concession cardholders under the Pharmaceutical Benefits Scheme (PBS) since February 2011. Similarly, population approaches can also prevent relapses, e.g. greater spending anti-tobacco television campaigns.[16]

8.4. Priority populations

- **Pregnant women and their families**
- **Children and young people**
- **People with mental illness**
- **Prisoners released from NT prisons**

Many babies are affected by smoking in pregnancy. Smoking during pregnancy can result in poor health outcomes for the newborn persisting into early childhood.

Smoking has been rising among Aboriginal mothers and falling among non-Aboriginal mothers in the NT.

In 2014 Aboriginal mothers were more than five times as likely to report smoking before 20 weeks of pregnancy when compared with non-Aboriginal mothers (46% and 9% respectively). Of those women who reported smoking before the first 20 weeks of pregnancy, non-Aboriginal mothers were more likely to have ceased smoking post 20 weeks gestation than Aboriginal mothers (36% and 16% respectively).[17]

Table 4: Smoking prevalence among pregnant women

	1997-1999	2000-2002	2003-2005	2006-2008	2009-2011	2013-2014
NT Aboriginal	42.1%	45.6%	52.3%	42.1%	42.1%	42.1%
NT non-Aboriginal	22.7%	21.3%	21.5%	17.4%	13.4%	10%

Source: Department of Health, 2014.

The proportion of Aboriginal children living in a household with a smoker, where no one usually smoked inside increased from 40% to 48%.

People living with mental illness have a high prevalence of smoking and smoking more heavily than the general population.

People with chronic mental illness have a significant gap in life expectancy due to smoking and increased prevalence of chronic diseases such as cardiovascular disease.

9. Enhancing workforce capacity

To effectively achieve change across the population, key frontline workforces need to be engaged to undertake brief interventions, refer people to appropriate treatment interventions and encourage and enforce smoke free spaces. There are many sources of information and resources that frontline workers can access to support their interactions with people. Of particular focus for this action plan will be Aboriginal health workers, local council officers, midwives and early childhood nurses and people working in mental health settings.

10. Monitoring and evaluation

The National Tobacco Strategy (NTS) 2012- 2018 was developed by the Intergovernmental Committee on Drugs (IGCD) Standing Committee on Tobacco, with input from the Commonwealth, State and Territory Governments and the community. The Strategy 2012 - 2018 set out the national framework to reduce tobacco related harm in Australia.

Through the Council of Australian Government (COAG) National Partnership Agreement on Preventive Health (NPAPH) the NT Government committed to the following performance benchmark: 'By 2018, reduce the national smoking rate to 10% of the population, and halve the Indigenous smoking rate, over the 2009 baseline'. This target was not achieved and more work needs to be done.

A mid-point review of progress was undertaken to assess whether Australia was on track to meet the COAG performance benchmark for tobacco. Progress was measured against each of the outcome indicators specified in the NTS (and an additional six indicators), at the midpoint of the Strategy.

These indicators covered five smoking phases: exposure, uptake, transition, established smoker and cessation. The majority of indicators showed positive progress, particularly for exposure to tobacco smoke, uptake of smoking, transition to established smoking, and regular smoking among young people, adults and Aboriginal people. Statistically significant improvements from the baseline to the midpoint estimates reported in 11 of the 14 indicators and the remaining three indicators showed no significant change. None showed unfavourable change.

There are also specific data sets, such as the Aboriginal Institute of Health and Welfare (AIHW) Australian Health of Prisoners 2018 report that collects information at discharge, which can be used to monitor actions from this plan.

Table 5: Indicator results by smoking phase

			Baseline[a]	Midpoint[b]
Exposure	✓	Indicator 5.2: Fewer women smoking while pregnant (first 20 weeks)	12.9%	11.3%
	✓	Indicator 6: Fewer children exposed to second-hand smoke at home	6.1%	3.7%
	✓	Indicator 7: Fewer adults exposed to second-hand smoke at home	4.0%	2.4%
Uptake	✓	Indicator 9: People are delaying the onset of tobacco smoking	15.4 years	15.9 years
	✓	Indicator 10: Fewer people trying cigarettes (secondary school students)	23.3%	19.1%
	✓	Indicator 10: Fewer people trying cigarettes (adults)	62.5%	57.0%
Transition	✓	Indicator 2: Fewer young people making the transition to established patterns of smoking (secondary school students)	3.5%	2.7%
	✓	Indicator 2: Fewer young people making the transition to established patterns of smoking (young adults)	29.4%	23.2%
Established Smoker	✓	Indicator 1: Fewer young people smoking regularly	6.7%	5.1%
	✓	Indicator 13: Fewer young people smoking	8.9%	7.5%
	✓	Indicator 3: Fewer adults smoking regularly	18.9%	14.5%
	≈	Indicator 14: Current adult smokers smoking occasionally (weekly or less than weekly)	9.0%	9.6%
	✓	Indicator 8i: Fewer adults smoking regularly among Aboriginal and Torres Strait Islander people	47.7%	44.4%
	✓ ✓	Indicator 8ii: Fewer adults smoking regularly among people of low socioeconomic status[c]	28.5%[d] 21.4%[e]	22.1%[d] 17.4%[e]
Cessation	≈	Indicator 4: More smokers attempting to quit	44.8%	46.7%
	≈	Indicator 11: Adult ever-smokers are quitting at a younger age	35.3 years	35.4 years
	✓	Indicator 12: More adult ever-smokers no longer smoking	47.4%	51.8%

✓ significant and favourable trend ≈ no significant change

(a) Baseline data collection year ranges from 2007–08 to 2011. (b) Mid-point data collection year ranges from 2013 to 2014–15.
(c) Index of Relative Socio-Economic Advantage and Disadvantage 2011. (d) Lowest socioeconomic quintile. (e) Second-lowest socioeconomic quintile.

11. Priority areas

KEY ACTION AREA 1: Media campaigns

Denormalising smoking and promoting positive role models

Activity	How can it be done
Implement campaigns and programs to encourage parents to quit.	Support strategies that target parents to discourage tobacco use and protect children from secondhand smoke by making homes and cars smoke free.
	Marketing campaigns to promote the Quitline service focussing on social media platforms and specific targetting. To develop and motivate (provide incentives) the NT Quitline educators group to deliver programs in the NT.
	Provide promotional materials to Families as First Teacher (FaFT) centres to discourage tobacco use and protect children from secondhand smoke by making homes and cars smoke-free.
	Grass roots radio shows including community based programs Produce materials in the most commonly spoken Aboriginal languages in the NT.
Develop materials suitable for school-aged children about the health impacts of smoking.	Link promotional materials to the Australian Curriculum Promote materials to school staff. Support learning materials with professional learning.

KEY ACTION AREA 2: Smoke-free areas

Activity	How can it be done
Local councils are supported to implement tobacco control measures.	Develop guide for local government councils on strategies to reduce harms from tobacco use.
	Councils to develop a smoking management plan.
	Promotion of smoke-free lifestyles at sporting and cultural events.
	Increase smoke-free public spaces.
	Display signs in areas where smoking is prohibited.
	Conduct education campaigns to ensure the community is aware of the risks associated with exposure to second-hand smoke, particularly for children.
All youth or family events supported by government are completely smoke-free.	Any event that receives government funding, including in kind support, required to be smoke-free.
Support remote communities with enforcement of tobacco control policies and legislation.	Provide education on legislation to a broad range of stakeholders.
	Work with the Local Government Association of the NT (LGANT) to implement smoke-free policies for all their buildings and workforce.
	Develop partnerships between Department of Health and local councils who choose to implement tobacco control policy.
Work with Aboriginal groups and communities to move towards smoke free workplaces, community based events and cultural festivals.	Support community developed and driven tobacco control initiatives.
	Provide specialised expertise to ensure community initiatives to reduce smoking are evidence-based.
	Provide information and promotional materials to encourage uptake of smoke free events.

KEY ACTION AREA 3: Supporting quit attempts and preventing relapse

Activity	How can it be done
Improve access to tobacco cessation information, treatment and services available, including culturally appropriate counselling for Aboriginal people and communities.	Aboriginal healthcare staff to be trained in brief intervention, pharmaceutical therapies and other healthcare tobacco control activities.
	Identify culturally appropriate resources, and evaluate the effectiveness and suitability of these resources.
	Increase promotion of NT Quitline through marketing.
	Increase awareness and use of Nicotine Replacement Therapy products available through the Pharmaceutical Benefits Scheme (PBS).
Develop and implement strategies to tackle the high levels of smoking by Aboriginal health staff.	Increase localised and personalised support in the workplace, free nicotine replacement therapy, intensive follow-up, and support for families of Aboriginal health staff to quit alongside them, incentives for staff to quit and smoke free workplace policies.
	Increase training in functions of nicotine replacement therapy and application on this new knowledge to lead and co-ordinate health information and provide personalised support for community members.
	Provide training for non-Aboriginal health staff to gain an understanding of the cultural relevance of smoking in Aboriginal society and the barriers to quitting, and future efforts to promote smoking cessation in Aboriginal Health Workers.
	Provide clinical supervision to Aboriginal health staff to reinforce new knowledge and gain a deeper understanding of experiences and work practices.
Increased focus on smokers accessing health services.	All health professionals assess and record smoking status of patients and offer brief interventions to promote quitting at every consultation opportunity. All patients accessing key parts of the healthcare system have smoking status assessed and noted on the patient record, including: emergency departments, hospital in-patients, community health services in urban and remote locations, alcohol and other drugs specialist treatment services in the government and NGO sectors.

Activity	How can it be done
Ensure pharmacotherapies for tobacco cessation are available for all Aboriginal clients.	Promote the inclusion of Nicotine Replacement Therapy (NRT) or pharmacotherapies as core items on standard drug lists in remote clinics servicing Aboriginal people.
	Identify barriers to provision of pharmacotherapies to Aboriginal people in remote communities and take action to overcome barriers.
Ensure staff are informed about best practice, and have appropriate resources to educate patients and communities about smoking and smoking cessation.	Map and collate existing evidence-based resources. Update and disseminate regularly.
	Identify guidelines for best practice for delivering services for Aboriginal clients.
Align tobacco cessation initiatives with economic development and other projects in communities that have a focus on tackling poverty, racism and other causes of chronic stress.	Liaise with organisations that are providing, or will provide, new or increased levels of services to communities to plan to roll out tobacco cessation programs and similar activities and events.
Develop and implement strategies for young people in custody to stop smoking, or the uptake of smoking, once they leave the youth justice setting.	Provide QUITLINE groups in youth detention settings Provide NRT (1 for 1) and education on entry to Youth Detention.
Develop and implement strategies for adult prisoners in custody pre-release and in the community once they leave the prison setting.	Engage family members to provide community support to the prisoner on release in an attempt to maintain abstinence. To develop a program to deliver to prisoners in the NT in an attempt to get them to continue abstinence post release and to become QUIT educators (mentors/role models) post release. To develop some prisoners to provide support mentoring and role model roles in the prison but also on release into the community. To assist to make prisoners smoke-free champions on release from prison to further influence members in their own communities.

KEY ACTION AREA 4: Priority populations

Activity	How can it be done
Develop information about the specific effects of tobacco use that applies to young women, pregnant women and their families.	Produce fact sheets, brochures, health messages describing effects of smoking specifically for young women, pregnant women and their families.
	Produce information specifically for young Aboriginal women, pregnant Aboriginal women and their families.
	Gender-sensitive information about, and protection from, second hand smoke and occupational exposure to tobacco or nicotine.
Incorporate effective interventions for children and teenagers who smoke.	Raise young people's awareness about making healthy, independent choices, negative effects of smoking and advantages of being smoke free. Promote Australian curriculum linked resources for primary middle and senior school to use.
	Develop and implement strategies for young people in custody to stop smoking, or the uptake of smoking, once they leave the juvenile justice setting.
	Provide training in best practice smoking cessation (particularly brief interventions) to a range of health professionals and health workers in mental health.
	Include this information in middle/senior school sexuality education programs e.g. core of life.
	Promote *youth* specific quit programs through school counsellors and allied health professionals that work in schools.
Improve access to tobacco cessation information, treatment and cessation services, including appropriate counselling for people accessing mental health services.	Embed screening and brief intervention in healthcare practice within primary and tertiary health systems.
	Strengthen partnerships with mental health organisations to build the capacity of these groups to contribute to tobacco control efforts.

Activity	How can it be done
Mental health care provider settings implement smoke free policy and encourage an anti-smoking culture.	Actively work with staff to ensure implementation and enforcement of smoke free areas in all aspects of delivering mental healthcare. This includes vehicles, home visits, facilities etc.
	Staff actively promote quitting and provide free smoking cessation services as mandatory component of care.
	Establish partnerships with services that provide cessation training.
Increase collaboration and referral with smoking cessation services.	Ensure that ways for clients to access NT Quitline and other smoking cessation services are appropriate and promoted.

11. References

1 Alcohol, tobacco and drugs N*ational Health Survey Data (2019)* Australian Institute Health and Welfare (AIHW)
<https://www.aihw.gov.au/reports/alcohol/alcohol-tobacco-other-drugs-australia/notes>

2 Whetton S, O'Neil M, Halim SA. *Harms from and costs of tobacco consumption in the Northern Territory. South Australia Centre for Economic Studies, 2012.*

3 Note that the NDSHS results are not representative of remote Aboriginal populations.

4 The Aboriginal and Torres Strait Islander health performance framework 2017 uses data from several sources including:
National Aboriginal and Torres Strait Islander Survey 1994, National Aboriginal and Torres Strait Islander Social Survey 2002, National Aboriginal and Torres Strait Islander Social Survey 2008, National Aboriginal and Torres Strait Islander Health Survey 2012–13, National Aboriginal and Torres Strait Islander Social Survey 2014–15.

5 Margin of Error (MOE) = 2.9 (MOE is equivalent to the width of a 95% confidence interval)

6 MOE = 6.0

7 MOE = 4.6

8 MOE = 6.9

9 MOE = 5.6

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

11 Murphy M, Mee V. Chapter 6: *The impact of the national tobacco campaign on Indigenous communities: A study in Victoria, in Australia's national tobacco campaign: Evaluation report vol 1.* Hassard K, Editor Canberra: Department of Health and Aged Care; 1999.

12 Couzos S, Metcalf S, Murray R. *"Ear Health" In Aboriginal primary health care: an evidence based approach*, edited by Couzos and Murray, 308-354. South Melbourne, Vic: Oxford University Press, 2008; Qureishi A, Lee Y, Belfield K, Birchall J, Daniel M.
Update on otitis media - prevention and treatment, *Infection and Drug Resistance.* 2014; 7(14): 15-24.

13 U.S. Department of Health and Human Services, The health consequences of smoking – 50 years of progress: a report of the Surgeon General. – Atlanta, GA, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2014.

14 World Health Organization, *WHO global report: mortality attributable to tobacco*, Switzerland, 2012.

15 Thomas D, Davey M, Briggs V, Borland R. Talking About The Smokes, *Journal of the Australian Medical Association.* 2015; 202 (10).

16 Mirte A, Kuipers G, Beard, Emma, West, Robert, Brown, Jamie. *Associations between tobacco control mass media campaign expenditure and smoking prevalence and quitting in England: a time series analysis.* Tobacco Control. 2018. Online First.
https://tobaccocontrol.bmj.com/content/27/4/455

17 Hall J, Case A, O'Neil L. *Northern Territory Midwives' Collection.* Mothers and Babies 2013. Darwin: Department of Health, 2015

Northern Territory

Tobacco Action Plan 2019 - 2023

Alcohol and Other Drug Service

health.nt.gov.au