



Justice Health submission to the Preventative Health Taskforce discussion paper, *Australia: the healthiest country by 2020.*

AUSTRALIA: THE HEALTHIEST COUNTRY BY 2020

General comments on the document

The document is well written and comprehensive.

Introduction p xiv, dot point one: “There is a need for tailored approaches and services to reach indigenous and other disadvantaged groups”.....strongly agree with this but would also include research into strategies and approaches that work with disadvantaged and hard to reach groups as there is little evidence into what works but approaches are usually more resource intensive, take longer and have modest results in comparison to more mainstream approaches. This complexity needs to be acknowledged for the subsequent allocation of appropriate planning, resources, timeframes evaluation measures and anticipated outcomes.

Need to acknowledge somewhere that with an ageing population and physiological predisposing factors there will always be a level of chronic disease.

P3, 1.3, fourth dot point: “Growing discrepancies in health status.....” .This should also refer to people in custody. Collectively across Australia this is a substantial population group with significant over-representation of indigenous Australians and other at risk populations including people with mental illness. The custodial population exhibits multiple co-morbidities including very high rates of smoking, illicit drug and alcohol use, infectious and chronic disease. There are very high rates of recidivism and familial and generational incarceration. Identifying and responding to the chronic health needs of this group with comprehensive policies, strategies and services that focus on both the custodial environment but also traverse into the community setting, may have long term benefits at an individual, family, community and population level.

Specific Comments: Overweight and Obesity

General comments	
<p>2.7 p14</p> <p>Dot point 4: “Embed physical...”.....include all government agencies and institutional settings including the adult custodial and juvenile detention setting as health promoting environments with lifestyle education and choices. Possible long term benefits of this to individuals, families and communities.</p> <p>Dot point 6: “Close the gap...” What does “disadvantaged” mean in this context? This group should include people in custody. The disadvantage for this population is the underlying causes and predisposing lifestyle factors for obesity and chronic disease prior to incarceration being compounded by lack of access to the basic strategies to achieve or maintain a healthy weight / lifestyle including exercise, fresh fruit & vegetables. Is there a responsibility for government agencies such as custodial services to provide an environment that is supportive of healthier lifestyle choices? (Even as part of the rehabilitation process).</p>	
Are the priorities for action appropriate? If not, what would you propose we do as a nation?	
See above.	
Comments on specific priorities (Page 15-18)	
The Taskforce believes that in order to halt and reverse the rise in overweight and obesity the major actions are:	
<p>PRIORITY 1: Reshape industry supply and consumer demand towards healthier products.</p> <p>ACTIONS: Review taxation system, regulate fat, salt and sugar content, subsidies for rural fresh food transportation.</p>	
<p>PRIORITY 2: Protect children and others from inappropriate marketing of unhealthy foods and beverages.</p> <p>ACTIONS: Curb inappropriate advertising and promotion.</p>	
<p>PRIORITY 3: Improve public education and information.</p> <p>ACTIONS: Develop effective media and public education campaigns, and enhance food labelling.</p>	
<p>PRIORITY 4: Embed physical activity and healthy eating in everyday life.</p> <p>ACTIONS: School, community and workplace programs.</p>	<p>See above.....include all government agencies and settings including custodial setting.</p>
<p>PRIORITY 5: Reshape urban environments towards healthy options.</p> <p>ACTIONS: Adoption of consistent planning design, and reorientation of environments through infrastructure.</p>	
<p>PRIORITY 6: Strengthen, skill and support primary health care and the public health workforce to support people in making healthy choices.</p> <p>ACTIONS: Expand supply of relevant allied health workforce, clinical guidelines.</p>	
<p>PRIORITY 7: Improve maternal and child health.</p>	

Specific Comments: Overweight and Obesity

ACTIONS: Promote infant feeding guidelines.	
PRIORITY 8: Close the gap for disadvantaged communities. ACTIONS: Support ongoing research.	See above (general comments on section).
PRIORITY 9: Build the evidence base, monitor and evaluate the effectiveness of actions. ACTIONS: Develop national research agenda, ensure safe industry practice and develop national food strategy.	

Specific Comments: Overweight and Obesity

Specific Questions posed by the Taskforce (Page 18)	
What is a realistic target for 2020?	
How can key players be engaged from the outset?	
What is the best combination of 'learning by doing' and at the same time, building the evidence base?	
What can individuals and families do to be physically activity, eat well and maintain healthy body weight?	
In what ways can high-risk groups be supported?	Not just focus on obesity but context in which people live their lives and the multiple contributing factors to obesity and chronic disease: whole of life approach. Look at strategies that might work with hard to reach groups with <i>realistic</i> timeframes, resources and expected outcomes. This should also include a healthier settings approach for government funded institutions e.g. health and custodial facilities.

SECTION 3 – THE CASE FOR PREVENTION: TOBACCO	
General comments	
<p>3.3 High-risk groups. This section should also refer to people with mental illness and people in custody as two major high-risk groups with extremely high rates of smoking and nicotine dependence (and resulting chronic disease) requiring a strategic and coordinated response. Clearly these high rates of smoking impact on the health of individuals and families. If long term improved health outcomes and chronic disease prevention are the ultimate aim of any reduction in smoking prevalence, then the issue of smoking for these high risk groups is not (or shouldn't be) only a priority whilst people are incarcerated or in health institutions but must extend beyond this into the community. Enforced cessation due to a smoke free environment whether a custodial centre or mental health / health institution is not necessarily synonymous with long term quitting and improved health outcomes. Evidence from overseas suggests most inmates will smoke again following release from a smoke free centre. Therefore strategies and support must extend beyond the custodial / mental health / institutional environment to release / discharge to work towards longer term quitting and health improvement. Both aspects should be dealt with in planning. There is also very high representation of Aboriginal people in the custodial population, the overwhelming majority of these smokes.</p>	
Are the priorities for action appropriate? If not, what would you propose we do as a nation?	
Comments on specific priorities (Page 24-28)	
The Taskforce believes that in order to reduce the prevalence of daily smoking to 9% or less, Australia needs to:	
<p>PRIORITY 1: Ensure that cigarettes become significantly more expensive.</p> <p>ACTIONS: increase cost of tobacco products</p>	<p>Presumes that cost will be a prohibitive factor and people will choose other purchases over tobacco. Concerns that could increase familial poverty if parents continue to smoke and children / other family members will have access to less for some disadvantaged groups.</p>
<p>PRIORITY 2: Further regulate supply of tobacco products and exposure to tobacco smoke</p> <p>ACTIONS: eliminate forms of promotion – point of sale and packaging, states / territories tighten legislation to second-hand smoking, sale to minors, states / territories to licence retailers, make tobacco a classifiable element in movies, improve consumer information, legislate to ensure full reporting and governmental controls over all products</p>	
<p>PRIORITY 3: Increase the frequency, reach and intensity of public education campaigns</p> <p>ACTIONS: Develop effective media and public education campaigns.</p>	
<p>PRIORITY 4: Ensure all smokers in contact with health services are given encouragement and support to quit.</p> <p>ACTIONS: Disseminate information, implement programs, increase availability of Quitline to specific populations, subsidise NRT.</p>	<p>Good. Need to provide free or very heavily subsidised NRT to some groups to force a cultural shift, e.g. people in custody, people with mental illness.</p>

Specific Comments: Tobacco

PRIORITY 5: Ensure access to information treatment and services for people in highly disadvantaged groups.

ACTIONS: Fund media advertising, programs, NRT for Indigenous people, fund organisations to raise awareness, fund research to evaluate strategies, ensure all state-funded human service agencies and correctional facilities are smoke free.

Good..... “highly disadvantaged” or groups with very high prevalence rates of smoking?

Need to fund and target all of these for other disadvantaged / hard to reach groups who are at considerable risk of chronic disease related to smoking and other co-morbidities. This includes people with mental illness and those in custody. The rates of smoking for these groups are similar to Indigenous Australians.

Undoubtedly, ensuring all state-funded human service agencies and correctional centres are smoke free provides a strong message and leadership. This should also be accompanied by a settings / environmental approach (including broader policy, programs. services i.e. not limited only to smoking) conducive to healthier choices and options for people in those institutions and agencies.

Smoking in the custodial setting is a very complex issue that requires a nationally led comprehensive response to achieve chronic disease prevention and improved health status for most of the custodial population. Is a smoke-free correctional centre one in which there is only partial smoking (outside only) or no smoking at all?

Enforced cessation (whilst in custody) does not necessarily result in long term quitting (with all the associated health benefits) for custodial populations but undoubtedly reduces exposure to Environmental Tobacco Smoke for staff and inmates during the period of incarceration. Reports from USA suggest that most inmates return to smoking soon after release following incarceration in smoke free facilities. A comprehensive approach including provision of support and programs whilst people are in custody and on release could achieve long term quitting. This all requires planning and resources.

The prevalence rates of smoking amongst people with mental illness are generally very high. The prevalence rates of mental illness within the NSW custodial population are also extremely high. Most people in custody affected by mental illness are not housed in inpatient facilities. Nevertheless, they would undoubtedly benefit from coordinated support and services including access to NRT to reduce their smoking whether as patients in the general custodial community or as clients of community mental health services in the general community.

Specific Comments: Tobacco

Specific Questions posed by the Taskforce (Page 28)	
Do you support our government taking progressively increasing the tax on tobacco products to the levels in places such as Ireland, researching \$20 for a pack of 30?	
Do you support the government investing in \$40-50m a year in public education?	Needs to be targeted and supported by other strategies.
Should we prohibit all remaining forms of promotion of tobacco products and mandate plain packaging?	
Should we move by 2020 to a system where cigarettes are sold only through a limited number of specially licensed outlets?	
What more can we do to protect children and adults from exposure to second-hand smoke?	

SECTION 4 – THE CASE FOR PREVENTION: ALCOHOL	
General comments	
Are the priorities for action appropriate? If not, what would you propose we do as a nation?	
Comments on specific priorities (Page 39-41)	
The Taskforce believes that in order to reduce the prevalence of harmful drinking, Australia needs to:	
<p>PRIORITY 1: Reshape consumer demand towards low-risk drinking</p> <p>ACTIONS: Develop effective media, social marketing, public education campaigns</p>	
<p>PRIORITY 2: Reshape supply towards lower-risk products</p> <p>ACTIONS: Review taxation system, develop a stage approach to restrict advertising, remove tax deductibility for advertising</p>	
<p>PRIORITY 3: Improve public safety</p> <p>ACTIONS: Enforce legislation on responsible serving of alcohol through intelligence led policing</p>	
<p>PRIORITY 4: Close the gaps for disadvantaged communities</p> <p>ACTIONS: commission research of effective strategies to address the social determinants of alcohol</p>	
<p>PRIORITY 5: Strengthen, skill and support primary health care to help people in making healthy choices.</p> <p>ACTIONS: Develop and disseminate information and training</p>	
<p>PRIORITY 6: Improve maternal and child health</p> <p>ACTIONS: Screening and advice</p>	
<p>PRIORITY 7: Build the evidence base</p> <p>ACTIONS: Model safer patterns of consumption, collect and analyse nationally consistent data.</p>	
Specific Questions posed by the Taskforce (Page 41)	
<p>What are the most important issues that can engage support from individuals, communities, industry and governments, and drive cultural change?</p>	
<p>What prevention strategies work best for high-risk groups, particularly among young people and in indigenous communities?</p>	

SECTION 5 – SUPPORTING PREVENTION

General comments

Settings should include the custodial and juvenile justice setting and all government funded institutions and interventions should include integrated policy, education, services addressing the three priority areas and the development of realistic timeframes and goals. A sustainable settings approach that is health promoting along a whole of life continuum rather than focused on one particular risk factor or disease is more conducive and most likely to effect cultural change and impact on individual behaviour and choices.

SECTION 6 – MEASURING PERFORMANCE

General comments

For the hard to reach / disadvantaged/ poorly motivated groups it is necessary to have realistic timeframes and outcome indicators. Working with such groups to effect change is often resource intensive with modest outcomes. This must be reflected in planning PIs otherwise it sets programs up to fail. For example, is a reduction in the rate of smoking an outcome in itself for people who are finding it difficult to quit?

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Are there any perceived omissions or other relevant information?

It could be useful to have a number of additional discussion documents that feed into the overarching 2020 document that are focused on high risk environments and / or populations in more detail. The 2020 document is very broad and the technical papers reflect single health issues, what is also required is greater detail bringing the three main issues and any other major chronic disease related issues for population groups or particular environments (i.e. not a disease / issue driven approach: different services and strategies for each issue delivered to the same population or setting) but an integrated approach. This should include people in custody (both adult and young people) and Indigenous Australians. This would provide greater contextual information and guidance to inform the next stage of planning.

TECHNICAL PAPERS

General comments on the technical paper - [Obesity in Australia: a need for urgent action](#)

TECHNICAL PAPERS

General comments on the technical paper - [Tobacco control in Australia: making smoking history](#)

Please see general comments regarding Tobacco in response to 2020 document.

P viii : 12. Subsidise and or provide free NRT to highly disadvantaged groups including people in custody.

Pix : The revised Australian National Tobacco Strategy should include an appendices / summary or scoping document that presents the complexity of smoking in the custodial setting and with custodial populations. The document could identify strategies to respond to the high prevalence rates of smoking in the custodial environment and options to progress.

P38. 3.5...need more detail here. Specify what the initiatives are and give examples. Again a more detailed section or appendices regarding the custodial environment would provide a more useful starting point. There is a pool of knowledge regarding smoking in the custodial setting and this should be harnessed to create a more detailed starting point for action. Maybe a national workshop (as was held in 2008 for Indigenous Australians) regarding smoking in prisons which brings together key players from custodial and prison health services and academics would be a way to start.

P42. For CALD groups need to also work with alternative health providers (e.g. Chinese Medicine practitioners).

P43. Need much more detail regarding the issue, complexity and context of smoking in prisons. Whilst Richmond et al's research is encouraging, the very strict criteria for inclusion into the clinical trial (use of alternative pharmaceuticals) and the degree of patient supervision required means that currently, this would be not be appropriate as a smoking cessation option for the *majority* of inmates. A cessation program which is accessible to the majority and simple to implement is essential. In all custodial jurisdictions access by health services to inmates is limited and there are competing health priorities. Therefore any broad smoking cessation program must be simple and brief with the capacity to respond to the more complex needs of some inmates (e.g. those on mental health related medications) who will require more follow up.

A coordinated and strategic national response to tobacco in prisons is required which brings together key stakeholders including health service providers and custodial services. As previously mentioned, smoke free prisons (enforced cessation) are not necessarily synonymous with long term quitting. If however smoke free prisons (and this must be defined: partial or totally smoke free?) are introduced inmates should be assessed for their nicotine dependence and managed accordingly to prevent withdrawal. Support strategies must also be devised for release. Whilst some inmates may use the opportunity of incarceration to improve their health and fitness options to do so are limited. A more conducive and health promoting environment (improved access to lifestyle information, healthier eating options and exercise and smoking cessation programs) would be a great start. Misspelt reference: Awofeso.

TECHNICAL PAPERS

General comments on the technical paper - [Preventing alcohol-related harm in Australia: a window of opportunity](#)