Smoking Cessation Brief Intervention at the Chairside: The Role of Public Oral Health Services

An evaluation of
NSW Health Policy Directive
PD2009_046

Smoking Cessation
Advice Given

November 2013

NSW MINISTRY OF HEALTH

Centre for Oral Health Strategy NSW
1 Mons Road
WESTMEAD NSW 2145
Tel. (02) 8821 4300
Fax. (02) 8821 4302
www.health.nsw.gov.au

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Acronyms and Abbreviations

3As	Ask, Approach, Advise
5As	Ask, Advise, Assess, Assist, Arrange
AHS	Area Health Service
AMS	Aboriginal Medical Service
COHS	Centre for Oral Health Strategy
GSAHS	Greater Southern Area Health Service
GWAHS	Greater West Area Health Service
HNE	Hunter New England
ISOH	Information System for Oral Health
JHFMHN	Justice Health and the Forensic Mental Health Network
LHD	Local Health District
NBM	Nepean Blue Mountains
NCAHS	North Coast Area Health Service
NRT	Nicotine Replacement Therapy
NSCCAHS	Northern Sydney Central Coast Area Health Service
NSW	New South Wales
OHP	Oral Health Promotion
RFDS	Royal Flying Doctors Service
SESIAHS	South Eastern Sydney Illawarra Area Health Service
SOHE	State Oral Health Executive
SSWAHS	Sydney South West Area Health Service
SWAHS	Sydney West Area Health Service
SWS	South West Sydney
WHO	World Health Organisation

Area Health Service (AHS) – Local Health District (LHD)

SESIAHS	South Eastern Sydney Illawarra Area Health Service	South Eastern Sydney LHD^
		Illawarra Shoalhaven LHD^
SSWAHS	Sydney South West Area Health Service	Sydney LHD*
		South West Sydney LHD*
SWAHS	Sydney West Area Health Service	Western Sydney LHD
		Nepean Blue Mountains LHD
GSAHS	Greater Southern Area Health Service	Southern LHD*
		Murrumbidgee LHD*
NSCCAHS	Northern Sydney Central Coast Area Health Service	Northern Sydney LHD^
		Central Coast LHD^
NCAHS	North Coast Area Health Service	Mid North Coast LHD^
		Northern NSW LHD^
HNE	Hunter New England	Hunter New England LHD
GWAHS	Greater West Area Health Service	Western NSW LHD
		Far West LHD

*Provision of services still occur under old AHS boundaries ^Recently split into LHDs

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Executive Summary

Background

In 2009 the Centre for Oral Health Strategy (COHS) developed and implemented the policy directive *PD2009_046, Smoking Cessation Brief Intervention at the Chairside: the Role of Oral Health / Dental Services*.[1]

The policy was accompanied by a comprehensive training package targeting public oral health/dental staff across NSW. The purpose of the training package was to ensure that oral health professionals had a clear understanding of the minimum requirements for the provision of smoking cessation brief interventions with appropriate dental patients, at the chairside.

The policy and training package aligns with NSW government priorities to further reduce smoking prevalence and sets out a clear protocol for undertaking chairside smoking cessation interventions based on the 3As (Ask, Approach, Advise) model.

This report presents the results of an evaluation of the implementation of the policy and the delivery of the training package. The evaluation focused in particular, on determining the factors that mediate policy utilisation and outcomes.

Methods

A mixed methods approach using both quantitative and qualitative methods was employed. Information was gathered from a number of sources through the following means:

I. Post training evaluation forms
II. Surveys of clinicians
III. Qualitative semi structured phone interviews with Oral Health Promotion (OHP) Coordinators from each of the Local Health Districts (LHDs)
IV. Document review
V. Data extraction from the Information System for Oral Health (ISOH) database
VI. Informal discussions with the NSW OHP Manager and other relevant COHS staff

Key Findings

Notable achievements

- 85% of clinical staff surveyed were aware of the policy.
- The majority of clinical staff who responded to the survey reported that they ask, approach and advise patients regarding smoking cessation at least 'sometimes', and many staff do this more frequently.
- There has been an increase in recorded interventions in ISOH since the policy was implemented in 2009.

- The training package was mostly considered to be concise, simple and easy to deliver and most staff reported a level of confidence after training.

Barriers and enablers

- The OHP Coordinator is instrumental in implementing all oral health programs and policies, and plays a pivotal role in implementing this policy directive.
- The degree of support, resources and concordant priorities within the LHD including that of managers, OHP Coordinators and clinical staff is fundamental in mediating training delivery, and policy implementation and outcomes.
- Restructuring of health service boundaries had left some areas without resources.
- Training is an important tool for promoting awareness, understanding and confidence, which are central in determining policy outcomes. Lack of resources and competing priorities meant that provision of training had not always been maintained and had not reached a lot of staff. Consequently, some staff had no knowledge of the policy or felt uncomfortable to implement the intervention.
- Several barriers to providing the smoking cessation brief intervention were identified by staff including: lack of time; lack of confidence; lack of training; competing clinical priorities; negative responses from patients; and difficulty approaching young people especially when parents were present.

Recommendations

The evaluation results informed a set of recommendations. The principal recommendations are:

1. COHS should mandate and support LHDs to employ designated OHP Coordinators.
2. The 3A model should be refined given the evidence suggests that undertaking a stage of change assessment in the intervention may be of limited value.
3. The extent and expectations of the brief intervention should be clarified, including how to make Quitline referrals and how and when to record the item number 191.
4. Flexibility in the provision of the brief intervention should be promoted.
5. There should be more accountability around reporting and recording of information.
6. The content and delivery of the training package should be reviewed to offer more education and practical support around approaching patients and making Quitline referrals. Options for training delivery that improve accessibility, sustainability and coverage should be considered.
7. A question about smoking status should be mandatory on the medical history and should be used as a prompt for clinicians to initiate the brief intervention.
8. The ISOH database and the use of the item number 191 should be refined so that it is a more reliable and meaningful indicator of brief intervention activity.
9. A framework for measuring outcomes should be established. For example, monitoring referrals made to the Quitline by public dental clinics in NSW.

1. Background

1.1 Why is smoking cessation important in oral health?

Tobacco (smoking) is recognised as the leading preventable cause of morbidity and premature mortality in Australia. Smoking greatly increases the risk of many cancers and is a major cause of chronic obstructive pulmonary disease and cardiovascular diseases[2]. Smoking continues to impose a significant burden on the health system and economy and remains an important public health challenge. Whilst smoking rates in Australia have decreased substantially in recent years[3] they remain unacceptably high, particularly among Aboriginal people, and people from low socioeconomic and other disadvantaged groups.[4] Given this, reducing smoking is a key commitment of the NSW Government, and robust targets have been set to reduce smoking in order to combat chronic disease and rising health costs.[4]

The causal link between smoking and periodontal disease and oral cancer is well understood within the field of oral health.[5] The inclusion of smoking cessation services into dental visits is therefore seen as an important prevention strategy.[6] This is particularly the case in countries like Australia, where access to adult public dental care is for concession card holders only.[7] These populations are amongst the most disadvantaged groups in the community and have much higher rates of smoking than the general population.[4] As a result, smoking cessation interventions are particularly relevant to this group.

The World Health Organisation (WHO) recommends that brief opportunistic interventions should be undertaken by all health professionals in the course of their routine work.[8] Health professionals are well placed to deliver cessation advice to smokers because they are considered an important source of credible information[9] and smokers expect to receive quitting advice from health care professionals.[10, 11] Furthermore, the cumulative effect of smoking cessation interventions by more than one type of health professional has the potential to substantially increase quitting and readiness to quit in the population.[12] The National Institute for Health and Clinical Excellence, United Kingdom, deems that brief interventions for smoking cessation are cost and time effective and recommends that all health professionals should refer people who smoke to an intensive support service.[13]

In a systematic review of physician advice for smoking cessation, Stead et al found that a brief advice intervention is likely to increase the quit rate by 1-3%.[14] Whilst this is a modest impact at the individual level, there is potential for substantial population benefit, because it can, cumulatively, motivate large numbers of smokers to make a quit attempt. In order to translate this into public health benefit, the frequency with which smokers are identified and offered support needs to increase.[14]

The 5As *(Ask, Advise, Assess, Assist, Arrange)* (Table 1) is the framework most commonly referred to with regard to smoking cessation brief interventions and is considered the gold standard.

Table 1: the 5As smoking cessation brief intervention

The 5As smoking cessation brief intervention[8, 15]
Ask about and record smoking status
Advise smokers of the benefit of stopping in a personalised and appropriate way
Assess motivation to quit (using stages of change model)
Assist smokers in their quit attempt.
Arrange follow up

Originally developed as part of the United States Department of Health's Clinical Practice Guideline in 2000 and then updated in 2008,[15] the model is based on the principle that smokers should be given a brief intervention to address smoking at every consultation.

The WHO Europe[8] developed a series of evidence based recommendations in 2002 on the treatment of tobacco dependence informed by a number of authoritative reviews and guidelines, which reflect the 5As approach. In the United Kingdom, guidance around smoking cessation brief interventions proposes similar steps[13] and in Australia, the Royal Australian College of General Practitioners (RACGP) has also adopted the 5As, which has been standard practice since 2004.[16]

Whilst the popularity of the 5As approach continues, there is growing evidence that suggests the value of using stage based (stages of change) interventions in smoking cessation may be overestimated. A systematic review of stage based interventions aimed at influencing smoking behaviour found that despite their widespread, uncriticised use there is limited evidence for their effectiveness.[17]

West suggests that one of the shortfalls of the stages of change approach is that it fails to acknowledge that behaviour change can arise from a response to a trigger in even apparently unmotivated individuals.[18] Similarly, Aveyard et al have found that when smoking cessation treatment was offered routinely to patients, a much higher proportion accepted than would be predicted by surveys of smoker's willingness to quit immediately.[19]

In New Zealand, this has been considered and a three-step approach has been adopted in the form of ABC *(Ask, Brief Advice, Cessation Support).* This approach is based on the concept that all people who smoke should be advised to stop smoking and supported to stop, regardless of whether or not they are interested in quitting.[20]

More recently the RACGP in their smoking cessation guide for health professionals, has shifted the emphasis away from the stages of change model as an approach to smoking cessation because the evidence does not support the restriction of quitting advice only to smokers who are perceived to be in a stage of readiness.[21]

Despite consensus in scholarly circles that the 5As is the best practice model for smoking cessation interventions, in practice, it can seem technical and has the potential to be time consuming. Lack of time and expertise are consistently reported by health professionals as barriers to providing smoking cessation interventions.[22]-[23] Trotter and Worcester found that Australian dentists are willing to ask and advise patients about smoking, but are less inclined to provide assistance or follow up to help patients quit. The same dentists were also more likely to be 'opportunistic' rather than systematic in their approach to prevention.[24] A lack of protocols or guidelines for best practice smoking cessation interventions was identified in one study as an important systemic barrier within the private dental profession.[25]

1.2 Organisational context of oral health promotion in NSW

In NSW oral health promotion is organised through the NSW Oral Health Promotion Network (the 'Network'). The Centre for Oral Health Strategy (COHS), NSW OHP Manager develops strategic directions and structures for OHP across NSW, directs OHP policies and programs state wide, and convenes the Network meetings.

The objective of the Network, as stated in the Terms of Reference, is to ensure oral health promotion efforts in NSW are collaborative, well coordinated, based on evidence-based practice, and continuously delivered in an effective and efficient manner. The membership includes OHP coordinators or their representatives from each LHD, and representation from community groups, dental/oral health associations and industries, allied health, and tertiary education institutions.

The Network, which has been operating since 2005, provides a structure for the coordination of statewide oral health promotion policies, programs and resources, and the dissemination of health promotion information at the local level. LHD OHP Coordinators play a key role in the implementation of statewide policies and programs at the local level.

1.3 Smoking cessation brief intervention

In line with statewide oral health promotion priorities,[26] COHS introduced the policy directive *Smoking cessation brief intervention at the chairside: role of public oral health/dental services* in 2009.[1] The policy directive sets out the minimum requirements for public oral health staff to provide a smoking cessation brief intervention using the 3As (*Ask, Approach, Advise)* approach. This requires staff to **ask** patients about their smoking status; **approach** smokers about their interest in quitting; and **advise** them of the NSW Quitline and refer, as appropriate, as shown in Table 2.

Table 2: the 3As smoking cessation brief intervention

The 3As smoking cessation brief intervention[1]
Ask about and record smoking status
Approach smokers about their interest in quitting
Advise of NSW Quitline and refer as appropriate

The policy and the accompanying comprehensive training package were developed by the NSW OHP Network in collaboration with other oral health professionals and experts in the field of smoking cessation. The final draft of the training package was presented for discussion at the Network meeting on 4 December 2008. The draft package was then piloted with a number of oral health staff in the then Area Health Services' (AHS). The package was completed and approved by the Chief Health Officer in June 2009.

Once printed, the training package was distributed to all OHP Coordinators, or delegates, in each AHS. The package included a PowerPoint presentation and a DVD which covered the following topic areas:

- Mortality caused by smoking
- Reasons why people smoke
- How smoking affects general health and oral health
- Benefits of quitting
- The brief intervention
- The role of the dental professional
- How to record the information/resources available.

The learning outcomes specified that participants should be able to:

- Describe the negative health and oral health effects of smoking
- Discuss with patients the benefits of quitting
- Provide resource information to patients on quitting
- Refer patients to the Quitline
- Record smoking cessation information in patient notes and ISOH.

The training package was rolled out in public dental services across NSW in July 2009, giving OHP coordinators in each LHD the responsibility of facilitating training for all oral health staff.

The Australian Schedule of Dental Services and Glossary,[27] which is the universally accepted coding system for dental treatment in Australia, had no item number for provision of smoking cessation advice. Due to this an item number (191) was introduced alongside the policy so clinicians could record 'smoking cessation advice given' in the Information System for Oral Health (ISOH).

1.4 Evaluation of smoking cessation brief intervention at the chairside policy

The policy directive had a review date initially set for July 2010. However, by 2012 no formal review or evaluation had been conducted since implementation. This evaluation was commissioned by COHS in April 2012 to address this issue.

As part of the initial program design some measures had already been established alongside the policy for the purposes of monitoring and evaluation. These included:

(i) Training session evaluations
Evaluations of the training were to be conducted after each session using a standard process evaluation form, which measured participants' views on the training and their level of confidence to implement the policy.

(ii) Data collection
Smoking cessation brief intervention data is recorded in ISOH using the item number 191 ('smoking cessation advice given'). The policy states that clinicians should record this item in ISOH completing the smoking cessation brief intervention, and is thus an indicator of activity.

(iii) Reporting
The policy states that Oral Health Clinical Directors / Managers in each LHD (previously Area Health Service) are required to report on activity pertaining to smoking cessation intervention activity in public oral health services. Statistics are required to be extracted from ISOH and OHP Coordinators are expected to report on these statistics through the NSW OHP Activity Report Card, and later as a standing agenda item at Network meetings through LHD reports.

Aside from this, no specific outcome measures were identified. At the time this evaluation was conducted, monitoring and reporting back to COHS had been inconsistent.

This evaluation was undertaken as part of a quality assurance exercise by COHS to look at issues around implementation, reporting, and barriers to adherence of this policy directive. It was envisaged that recommendations from this evaluation would inform specific changes to the policy directive and accompanying training package.

Figure 1 is a logic map of the smoking cessation brief intervention policy and related activities, developed by the authors. It sets out the key resources and inputs as well as the activities, which includes distributing the policy and training package, training clinical staff, and providing resources.

The expected outcomes are categorised according to timeframe, with immediate, medium term and longer term outcomes all identified. This logic map was used to inform the evaluation design and specific evaluation questions and is used as a framework for presenting results.

1.5 Scope of the evaluation

This evaluation uses the logic map as a framework to focus on the activities and outcomes of the policy, with a particular focus on the barriers and enablers. The key areas are:

(i) **Activity outcomes**: provision of, and attendance at, smoking cessation brief intervention training;

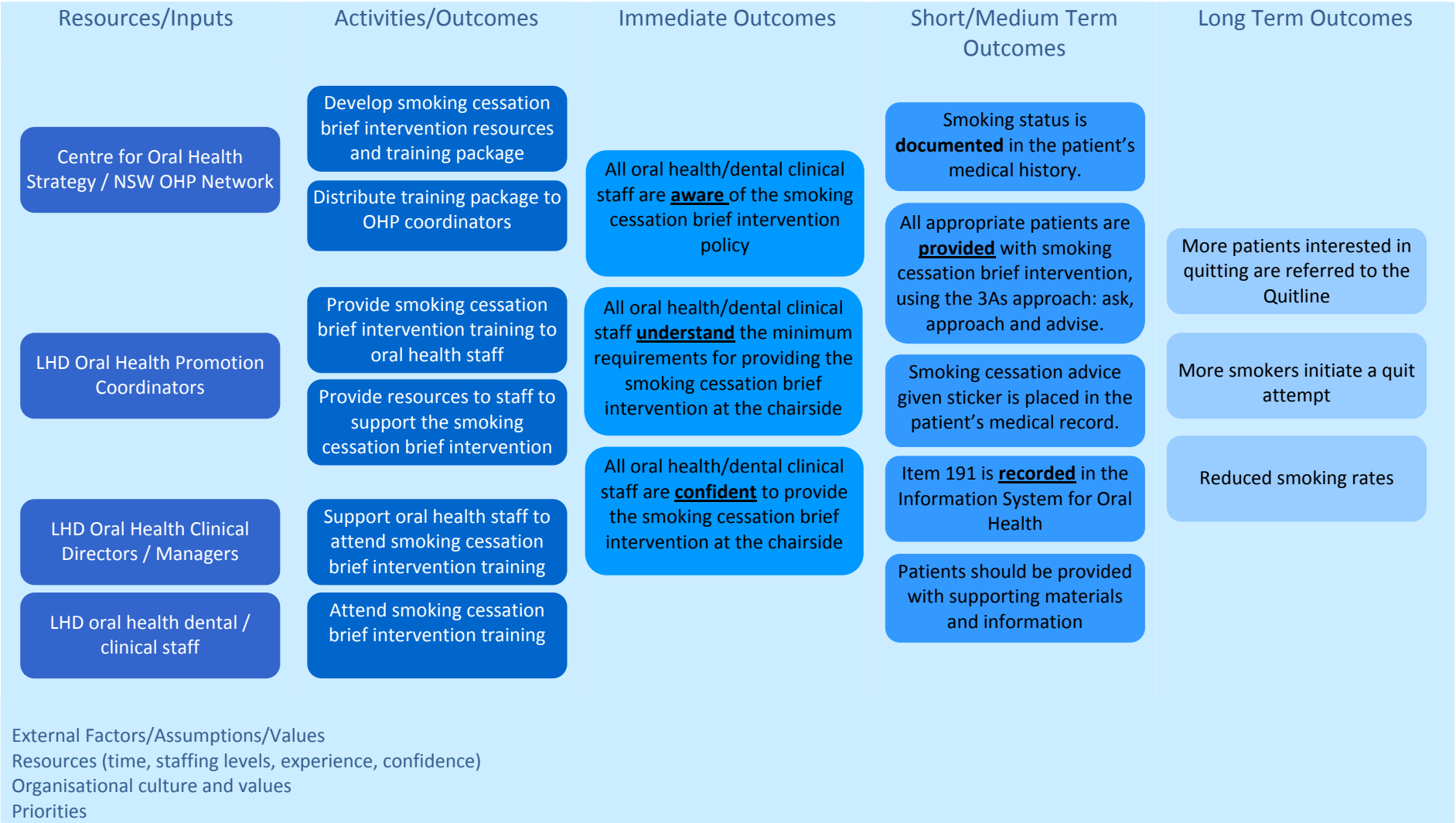
(ii) **Immediate outcomes**: awareness and understanding of the policy, and confidence to implement the brief intervention;

(iii) **Short-medium outcomes**: using the 3As model to undertake smoking cessation interventions with patients, and record procedures in the clinical record and in ISOH; and

(iv) **Long term outcome**: indicators of patient's interest in quitting.

Due to limited time, resources and a lack of established infrastructure, the evaluation does not explore outcomes relating to referrals to the Quitline, or decrease in smoking rates among patients.

Figure 1: Map of PD2009_046 *Smoking Cessation brief intervention at the Chairside*



2. Methods

2.1 Evaluation approach

This evaluation was conducted between April and November 2012, using a mixed methods (qualitative and quantitative) design. This enabled a broad insight into the implementation of the training program, policy and brief intervention at various levels across the state.

Data were gathered using a variety of sources that would provide important information about the outcomes of the policy, and the barriers and enablers that impact on policy implementation. These included:

I. Post training evaluation forms
II. Surveys of clinicians
III. Qualitative semi structured phone interviews with OHP Coordinators
IV. Document review
V. Data extraction from the ISOH database
VI. Discussions with the NSW OHP Manager and COHS staff

2.2 Study population

The study population comprised of a range of individuals. These included:

I. Training participants across the state
II. OHP Coordinators, or their representative, from each of the 15 LHDs and Justice Health and the Forensic Mental Health Network (JHFMHN)
III. Clinicians (dental officers, oral health therapists, dental therapists) working within public dental/oral health services in NSW
IV. The NSW OHP Manager and other relevant COHS staff

2.3 Data collection techniques

I. Post training evaluations

The training package included post training evaluation forms (Appendix A) to be completed by participants, who were asked to rank their views on the training organisation, content and presentation, using a five point Likert scale. In addition, participants were asked to rank their level of confidence to undertake various aspects of the smoking cessation brief intervention with patients. Results were then collated into an 'Evaluation Report Template' (Appendix B) by the trainer and forwarded to the NSW OHP Manager at COHS.

II. Document review

A review of various documents was undertaken. This included: the policy documents; the training package along with accompanying literature and resources; and the Network meeting minutes and relevant communications. The aim of this part of the evaluation was to gain a broad overview of the policy and its components as well as the plans for implementation. This method was used both as a comparison measure and to inform the design of other data collection methods.

III. Interviews with OHP coordinators

Semi structured interviews were undertaken with OHP coordinators across NSW. An OHP coordinator, or their delegate, from each of the 15 LHDs and JHFMHN was approached for interview to capture the full range of views across the state. The same interviewer conducted all of the interviews via the telephone and followed an interview guide (Appendix C), which was developed in consultation with COHS staff. Interviews were digitally recorded and transcribed verbatim. A thematic analysis was undertaken by the lead investigator and the interpretation of the data was reviewed by a second investigator.

IV. Surveys of clinicians

The survey (Appendix D) was designed in consultation with staff members at COHS and piloted amongst a small group of OHP Coordinators prior to distribution.
A series of questions were asked of participants that would provide broad information about policy implementation. OHP Coordinators were initially asked to distribute the surveys to clinicians within their LHD. In order to get an idea of the sample size, OHP coordinators were required to indicate approximately how many staff had been sent survey. To improve the reach and maximise the response rate a second round of surveys was distributed. In July 2012, all clinicians in the NSW Health state wide email directory were emailed the survey directly and encouraged to complete it, and the closing date for completion was extended.

V. Data extraction from ISOH

The ISOH database is used to manage patient interactions with public oral health services in NSW and is managed by COHS. Demographic data and information about dental services received are entered into ISOH when a patient attends a public dental clinic in NSW. In accordance with the policy directive, clinicians who complete the smoking cessation brief intervention with a patient should record the item number 191 (smoking cessation advice given) in ISOH. These statistics are reported to COHS through the OHP Activity Report, which was established alongside the policy as a method of monitoring smoking cessation brief intervention activity by clinicians. An extraction of de-identified data from ISOH was undertaken to gain a snapshot of smoking cessation brief intervention activity across the state.

VI. Discussions with NSW OHP Manager and COHS staff

Informal discussions were conducted with the NSW OHP Manager and key COHS staff. These discussions provided the evaluator with a detailed insight into the composition and function of oral health promotion across NSW, and the development and implementation of the training package and policy.

2.4 Ethics

Ethics advice was sought from the Cancer Institute, who, because of the nature of the study, gave exemption from a full ethics application and referred us to the ethics advisory panel at the University of New South Wales (UNSW). Ethics approval was gained from the UNSW Medical and Community Human Research Ethics Advisory Panel (Appendix E).

3. Results

The results of the implementation of the smoking cessation brief intervention policy will be presented using the **Outcomes** detailed in the logic map as a framework for documentation.

Activity outcomes

- Provide smoking cessation brief intervention training
- Attend smoking cessation brief intervention training

Immediate outcomes

- All oral health/dental clinical staff are **aware** of the smoking cessation brief intervention
- All oral health/dental clinical staff **understand** the minimum requirements for providing the smoking cessation brief intervention at the chairside
- All oral health/dental clinical staff are **confident** to provide the smoking cessation brief intervention at the chairside

Short-medium outcomes

- Smoking status is **documented** in the patient's medical history
- All appropriate patients are **provided** with the smoking cessation brief intervention using the 3As approach
- 'Smoking cessation advice given' sticker is placed in the patient's medical record
- Item 191 is **recorded** in the Information System for Oral Health
- Patients are provided with supporting materials and information

These areas will be explored with a particular focus on the **factors that mediate policy outcomes**, specifically the barriers and enablers to policy utilisation.

3.1 Clinician survey and interviews

Clinician survey

A total of 122 survey responses were received from clinicians across NSW. It is estimated that the population sample size was about 400 (a response rate of 30.5%). Only one response was excluded because the individual was not a clinician.

Table 4 provides a breakdown of responses by LHD. There were no responses received from Far West LHD and response rates in some other areas were minimal dropping to as low as 0.82% of possible respondents.

Table 3: Survey response rate by LHD

LHD	FREQUENCY	%
CENTRAL COAST	12	9.84
HUNTER NEW ENGLAND	20	16.39
ILLAWARRA SHOALHAVEN	4	3.28
JUSTICE HEALTH	1	0.82
MID NORTH COAST	1	0.82
MURRUMBIDGEE	12	9.84
NEPEAN BLUE MOUNTAINS	3	2.46
NORTHERN NSW	2	1.64
NORTHERN SYDNEY	15	12.30
SOUTH EASTERN SYDNEY	1	0.82
SOUTH WEST SYDNEY	6	4.92
SOUTHERN NSW	7	5.74
SYDNEY	4	3.28
WESTERN NSW	14	11.48
WESTERN SYDNEY	20	16.39
FAR WEST	*MISSING*	

Interviews

Interviews were conducted with a total of 10 OHP coordinators from the following LHDs: Hunter New England; Justice Health and the Forensic Mental Health Network; Murrumbidgee and Southern NSW; Nepean Blue Mountains; Northern NSW; Northern Sydney; South Eastern Sydney; Illawarra Shoalhaven; Sydney; South West Sydney; Western NSW; and Far West.

Interview participants had varied roles:

- Designated OHP Coordinators
- OHP Coordinators who also worked in clinical roles - Northern NSW; Nepean Blue Mountains ; Sydney; South West Sydney; Western NSW
- Acting OHP Coordinator - Sydney and South West Sydney
- Oral Health Manager – Far West had no designated OHP Coordinator at the time of the evaluation
- Dental therapist who was responsible for coordinating aspects of the policy part time - Western NSW did not have an OHP Coordinator at the time of the evaluation.

At the time of the evaluation there was reportedly no one suitable to interview in Central Coast, or Mid North Coast, and we were unable to contact a representative from Western Sydney.

3.2 Smoking cessation brief intervention training

Provision of training

LHD OHP Coordinators are responsible for ensuring that all clinical staff receive adequate training and have access to regular periodic updates

OHP Coordinators play a key role in the implementation of statewide policies and programs at the local level, and had a significant role in facilitating the training component of this policy.

At the time of the evaluation NSW Health was undergoing structural boundary change from Area health Services to Local Health Districts. This left some areas without OHP Coordinators, and some were in the process of re-establishing themselves. Some areas had OHP Coordinators who were acting, part time, or were new to the role, having not previously had anyone in the position.

Training sessions were reported back to COHS using the training evaluation templates. A total of 15 post training evaluation templates were returned between October 2009 and August 2011.

Table 6 shows there were a total of 27 smoking cessation brief intervention training sessions reported with 436 participants attending. Only Hunter New England and South Eastern Sydney/Illawarra Area Health Services reported on providing training in 2011, and there were no reports of training via the training evaluation templates in 2012.

It should be noted that there was inconsistency both in the frequency of reporting training, as well as how the evaluation templates had been completed. One evaluation template from Hunter New England Area Health Service was excluded from the analysis as it was incomplete.

Table 4: Training sessions reported to COHS 2009-2012 by AHS

TRAINING SESSIONS						
AREA HEALTH SERVICE (NUMBER OF TRAINING SESSIONS)						
SESIAHS (104) 104 participants	15/03/10^	18/03/10^	25/03/10^	29/03/10^	20/04/10^	23/04/10^
	16/06/10 Sutherland	06/08/10 Sutherland	27/07/11 Sutherland	10/08/11 Sutherland		
SSWAHS (2) 78 participants		11/03/10 Narellan	25/03/10 Sydney			
SWAHS (1) 7 participants	17/11/09 Westmead					
NSCCAHS (1) 86 participants	10/11/09 Berowra					
NCAHS (6) 84 participants	02/10/09 Richmond	02/10/09 Ballina	10/12/09 Coffs/Clarence	16/12/09 Tweed/Byron	17/12/09 Port Macquarie	18/12/09 Kempsey
HNE (2) 43 participants	03/11/10 John Hunter*	24/05/11 Newcastle				
GSAHS	-	-	-	-	-	-
GWAHS (5) 34 participants	20/10/09 Mudgee	27/10/09 Orange	28/11/09 Bathurst	03/03/10 Dubbo	25/03/10 Forbes	
JHFMHN	-	-	-	-	-	-

^Various locations across SESIAHS from Daceyville to Nowra – specifics not given
*Data from evaluation report was excluded as was incomplete
-No data available

Some jurisdictions did not conduct training at all. JHFMHN had no one in the OHP Coordinator role for a lengthy period of time. An interviewee from one LHD reported having no knowledge of the specific policy directive and training package, Since the boundary restructure there had been no OHP Coordinator for this LHD, as the person who had fulfilled this role in the AHS was located in the other LHD created by the split.

Models of training

The extent of training in each LHD varied dramatically. The changes from Area Health Services to Local heath Districts caused significant changes to the organisation and delivery of oral health promotion in some LHDs. Geographical distance was identified as having important implications for the delivery of training sessions and other oral health promotion programs at the local level. OHP coordinators in Southern and Murrumbidgee, and HNE referred specifically to the challenges of geographical distance and the implications this had for training and support. In Far West, remoteness was an issue, highlighted by the fact that they had a contract with the Royal Flying Doctor Service to do their adult clinical work. Again, this had significant implications both for training and service delivery.

When interviewed, LHD OHP Coordinators who had been involved in the delivery of the training package, reported on the training models they had employed. These included:

- Holding specific training sessions
- Providing opportunistic training at clinicians' meetings
- Holding training as part of orientation for new staff
- Adopting a train the trainer model to reach new staff at different sites across the LHD, which was seen as a good way to manage the challenge of providing training across LHDs, increasing 'reach'.

Some OHP Coordinators had the sole responsibility for managing all oral health promotion programs and policies and their implementation. Other OHP Coordinators had established OHP working groups or committees, which enabled the workload to be shared.

OHP coordinators in some LHDs were exploring ways to train staff by using dental assistants to deliver training to clinicians, and using senior clinicians to distribute information to ground staff. Others were looking at ways to ensure the sustainability of policy outcomes by introducing strategies such as providing **regular updates** or refreshers for clinical staff, or **integrating training** into staff orientation packages.

> *'I think it has to be part of the orientation package, which is what I'm promoting and pushing … and then at different stages, just have like a health development, um, a professional development day and then always include smoking cessation…' (Interview with OHP Coordinator, regional NSW)*

Some jurisdictions had actively encouraged clinicians to undertake smoking cessation brief interventions with patients prior to the policy being implemented in 2009. For JHFMHN this was part of a bigger move within Corrective Services to promote smoke free environments and increase accessibility to NRT within gaols.

For JHFMHN a major contextual challenge that has been identified is that most gaols are not smoke free. This has implications for patients who are interested in quitting or trying to quit, particularly if they are sharing a cell with someone who is a smoker.

Attendance at training

All oral health/dental clinical staff are required to attend smoking cessation brief intervention training

The sessions provided clinical staff with information to assist them deliver the smoking cessation brief intervention to all appropriate patients at the chairside and complete the required documentation in the medical record and in ISOH. Data from the clinicians surveys indicated that only 51% (n=61) of respondents had received training on the policy directive as shown in Table 7.

Table 5: Training of clinicians stratified by LHD

LHD	NO	YES	TOTAL
CENTRAL COAST	6	6	12
HUNTER NEW ENGLAND	10	8	18
ILLAWARRA SHOALHAVEN	0	4	4
JUSTICE HEALTH	1	0	1
MID NORTH COAST	0	1	1
MURRUMBIDGEE	1	11	12
NEPEAN BLUE MOUNTAINS	3	0	3
NORTHERN NSW	0	2	2
NORTHERN SYDNEY	7	8	15
SOUTH EASTERN SYDNEY	0	1	1
SOUTH WEST SYDNEY	5	1	6
SOUTHERN NSW	1	5	6
SYDNEY	2	2	4
WESTERN NSW	6	8	14
WESTERN SYDNEY	15	4	19
TOTAL	57	61	118
PERCENT TOTAL	**48%**	**51%**	**100%**

Frequency missing = 4

Perceptions of the training

Training evaluation templates that were returned to COHS between October 2009 and August 2011 revealed that the majority of participants ranked the training positively on all three aspects: organisation, content and presentation (Table 8).

Table 6: Post training rankings of organisation, content and presentation of training

TRAINING	Evaluations / participants	Poor				Excellent
ORGANISATION	379/435		8	97	126	148
CONTENT	383/435	1	6	81	135	160
PRESENTATION	380/435	1	9	81	126	163

Participants had a variety of positive comments about the organisation, content and presentation of the training. These are listed below:

- Most thought the presentation was concise, informative, clear and easy to follow.
- Many enjoyed the DVD and commented that it was helpful to have clear examples of how to approach patients.
- Some found it useful to know about the health aspects of quitting, how to approach patients, and understanding the needs of smokers (why they smoke, and that it may take several attempts to quit).
- Some would have liked more detail, and more information on the medical side.

Some participants expressed concerns specifically regarding the feasibility of implementing the brief intervention at the chairside. These included:

- Concerns about lack of time to undertake the intervention.

- Concerns about how receptive patients would be to cessation advice, and what sort of responses they would encounter from patients.

Most of the OHP Coordinators interviewed who had been involved in the delivery of the training package perceived that the training package was good. They reported it was generally well received with some participants finding the information provided in the training session thought provoking and interesting.

Training outcomes

- All oral health/dental clinical staff are **confident** to provide the smoking cessation brief intervention at the chairside

Confidence

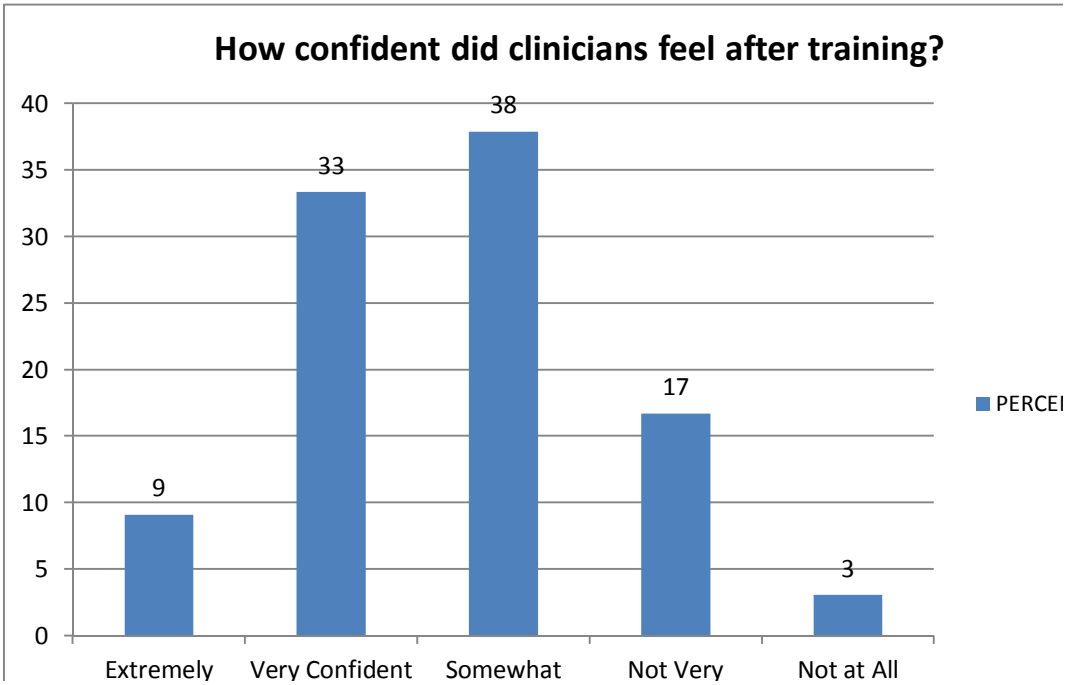
Over half of participants who completed the post training evaluation form between October 2009 and August 2011, ranked themselves as having a level of confidence to undertake aspects of the policy. Around a quarter of participants were neutral and around 10% and under reported low confidence levels. See Table 9.

Table 7: Post Training rankings of confidence 2009-2011

CONFIDENCE LEVELS	Evaluations/ participants	Not confident				Very confident
TALK ABOUT SMOKING RELATED HEALTH ISSUES WITH PATIENTS	361/435	19 (5%)	24 (7%)	96 (27%)	111 (31%)	113 (31%)
DISCUSS WITH PATIENTS THE BENEFITS OF QUITTING	368/435	14 (4%)	25 (7%)	97 (26%)	119 (32%)	113 (30%)
PROVIDE INFORMATION TO PATIENTS ON QUITTING	374/435	10 (3%)	15 (4%)	93 (25%)	116 (31%)	140 (37%)
REFER PATIENTS TO THE QUITLINE	345/435	10 (3%)	16 (4%)	87 (25%)	94 (27%)	138 (40%)
RECORD INFORMATION IN PATIENT'S NOTES AND ISOH	357/435	14 (4%)	16 (4%)	89 (25%)	87 (24%)	151 (42%)

When clinicians surveyed for the present evaluation were asked to rank their level of confidence after receiving smoking cessation brief intervention training, Figure 1 shows that under half reported feeling 'extremely confident' or 'very confident', just over a third ranked themselves as feeling 'somewhat confident', and around 20% were 'not very confident' or 'not at all confident'. This was a reduction in rankings given in the post training evaluation forms (shown in Table 9) which were completed directly after training suggesting that time since training may be a factor affecting confidence levels.

Figure 2: 2012 Survey respondents' rankings of confidence post training



Source: Survey of clinicians, 2012

Note: Some data is missing as this question was only asked of clinicians who had participated in training.

Interviews with OHP Coordinators reflected this. Many commented that clinicians were not always comfortable or confident to address the issue of smoking cessation with patients.

Barriers and enablers to the provision of training

Having a designated OHP Coordinator

Having a designated OHP Coordinator was considered to be one of the most important factors influencing oral health promotion outcomes. This was particularly the case with regard to this policy directive, where the OHP coordinator was key in coordinating delivery of staff training, and supporting staff with the ongoing implementation of the policy and provision of resources.

> *'… within our health area we don't actually have someone designated as the oral health promotion person … at this stage it's [training] not even in my job description, so, you know, I'm a dental therapist at this clinic, not a oral health promotion person …' (Interview with Dental Therapist, regional NSW)*

Priorities

Priorities of managers, OHP Coordinators, staff and the LHD more broadly, impacted how resources were distributed and in turn how oral health programs and policies were implemented. One OHP Coordinator stated that the smoking cessation training and policy implementation was competing for resources with other programs like Aboriginal health and child protection, and this was also reflected in some other LHDs. The individual priorities of the manager responsible for delivering training

were also an important variable with regards to the frequency and sustainability of training. Some OHP Coordinators reported that smoking cessation brief intervention training was considered by some to be a low priority.

> *'…It's all at the mercy of the local sites, and I know too, that we've had a quite a number of new dental officers … and we're still not reaching them ... because depending on the priority of that manager or that site, smoking cessation either makes it on, because it's competing with infection control and clinical issues, and um, occupational health and safety...' (Interview with OHP Coordinator, regional NSW)*

One OHP Coordinator, whose background was as an oral health therapist, commented on the degree of influence she felt she had within adult services to successfully promote oral health promotion.

> *'I have very little influence, ah, in adult services and they're not particularly interested in health promotion as a group, they're mainly dentists who deal with … clinical …' (Interview with OHP Coordinator, regional NSW)*

Geographic distance

OHP coordinators in some rural and regional LHDs referred specifically to the challenges of geographical distance and the implications this had for training and support. In Far West, remoteness was an issue, highlighted by the fact that they had a contract with the Royal Flying Doctors Service (RFDS) to do their adult clinical work and in some cases clinicians were providing clinical services in remote locations without a dental assistant or other support. This had significant implications both for training and service delivery.

Sustainability

Other LHDs had made an initial investment in training, which had then 'fallen by the wayside';

> *'…training was ticked off then that's it' (Interview with OHP Coordinator, regional NSW)*

Apathy

One OHP Coordinator referred to a lack of interest from dental staff at a particular site as being a real barrier to providing ongoing training and promoting the policy directive.

For some sites an interaction of multiple factors was reported. For example, one LHD stated that a lack of time, infrastructure, staff resources and clinic space were all barriers to providing oral health promotion in general.

3.3 Improvements

Training resources

Most OHP Coordinators agreed that the training package was concise, appropriate and easy to deliver. Nonetheless, there were many suggestions for how it could be

improved ranging from changes to content, mode of delivery and accompanying resources. These included:

- Update the DVD and PowerPoint slides
- Include more scientific references
- Include role plays as part of the training, especially around how to approach patients in a non-judgemental way
- Provide information on ways to help patients to quit
- Provide a shortened version to give as a refresher
- Make the training available online
- Involve the health promotion unit in training delivery.

It was highlighted by a few OHP Coordinators that the training needed to remain brief. This was important so that clinicians would not be overloaded with information. However, one suggestion for improvement included allocating more time for training.

In terms of resources it was suggested that:

- More resources and brochures are needed to give to patients that make the link between smoking and oral health explicit
- More resources that are relevant to young people are needed (young people don't relate to pictures of old people in brochures, thinking it will never happen to them)
- Access to use of a 'Smokerlyzer' to demonstrate carbon dioxide in the lungs.

The evaluation also highlighted a need to clarify what is expected from the training evaluation templates, including how and when to complete them, and the process for returning them to COHS. It was suggested that more accountability in terms of what is expected around this would probably increase the accuracy and frequency with which they are completed, thereby improving their reliability as a future source of evidence.

Training content

Several OHP coordinators identified that more training and support was needed around the 'Approach' part of the intervention. In particular, more information was needed on how to do this in a non judgemental way, how to manage patients that became angry or aggressive, presented with pain, and how to support patients who may have had unsuccessful quit attempts in the past.

The Southern and Murrumbidgee LHDs had developed a response to patients' presenting with pain where clinical staff would try and book patients to return for a prevention session after pain issues had been resolved. Other suggestions included: referral to hygienist or oral health therapist; or employing a dedicated staff member such as a hygienist to do smoking cessation. However, others indicated that clinicians should be able to use their discretion as to whether or not to undertake the intervention, or how far to go with it, so that situational factors (patient's disinterest or level of pain etc) could be taken into account. It was also suggested

clinicians' attitudes toward smoking and providing smoking cessation brief interventions were explored as part of the training.

Evaluation measures

Improving the evaluation indicators was identified as an important means of being able to easily assess policy implementation. Respondents suggested:

- Feedback from the Quitline regarding referrals made and patients followed up should be facilitated.
- Clarification around the correct use of the item number 191 to make it a more reliable indicator of brief intervention activity.
- Make provision for the recording of smoking status in ISOH to provide an indication of the proportion of smokers seen who should be receiving the intervention, increasing the value of the item number 191 as an evaluation indicator.

Accountability

One OHP Coordinator suggested that more accountability around reporting is needed. She said:

> *'…I think as a policy, probably there is not enough accountability, um, but no one's called me up and said 'how many [training] sessions have you provided?', you know, I'm not, we're not reporting it back to COHS that, these are the sessions … these are the evaluations, we should be ... reporting a lot more back to them…' (Interview with OHP Coordinator, metropolitan NSW)*

3.4 Delivery of smoking cessation brief intervention

- All oral health/dental clinical staff are **aware** of the smoking cessation brief intervention
- All oral health/dental clinical staff **understand** the minimum requirements for providing the smoking cessation brief intervention at the chairside
- All oral health/dental clinical staff to **provide** all appropriate patients with smoking cessation brief intervention, using the 3As approach.

Awareness

The survey of clinicians found that 85% (n=102) of clinicians were **aware** of the *Smoking cessation brief intervention at the chairside* policy directive.

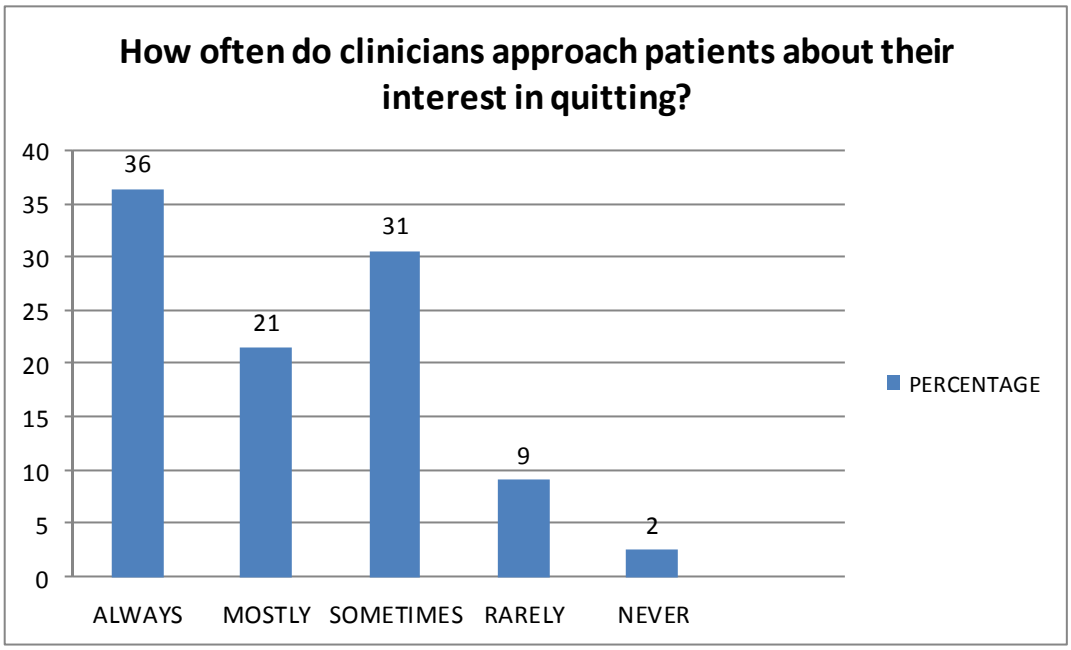
Understanding

Most OHP coordinators thought the brief intervention and the use of the 3A model was straightforward, easy to use and not too invasive. However, a few OHP coordinators reflected that clinicians might be confused about the detail required in a brief intervention and it was identified that the policy and the training package would benefit from further clarification around this issue.

The survey of clinicians found:

- 71.9 % (n=77) of respondents reported they **provide** the brief intervention using the **3As approach**.
- 65% of survey respondents reported they found the 3As approach fairly easy or easy to undertake.
- Almost 50% of all survey respondents reported they always **ask about smoking status**. Most respondents reported that they 'ask' at least sometimes and in many cases more often.
- The majority of clinicians surveyed reported they **approach** patients about their interest in quitting at least sometimes. Many respondents approached patients more frequently, as shown in Figure 2.

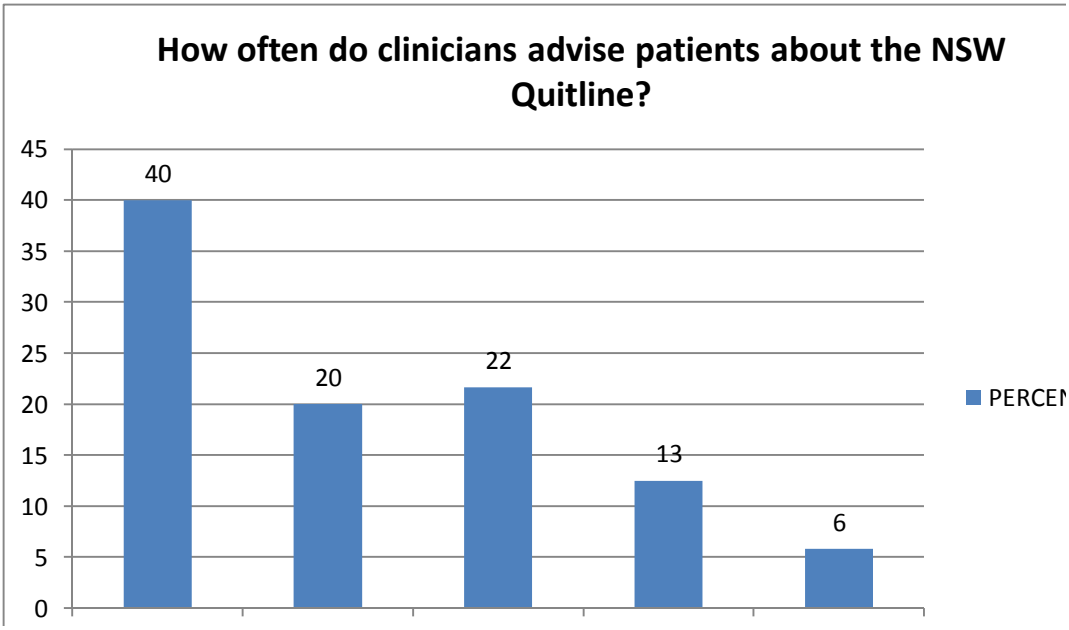
Figure 3: Frequency with which clinicians approach patients about their interest in quitting



Source: Survey of clinicians, 2012

Clinicians who responded to the survey reported they **advise** patients who are interested in quitting at least sometimes, and in many cases more frequently. The results are presented in Figure 3.

Figure 4: Frequency with which clinicians advise patients about the NSW Quitline



Source: Survey of clinicians, 2012

Most OHP coordinators thought the brief intervention and the use of the 3A model was straightforward, easy to use and not too invasive and a few talked of the value of incorporating the intervention into everyday business, making it part of a routine, and asking the questions as part of general discussion. However, one OHP Coordinator felt that the 3A model was too prescriptive and regimented.

> *'…tobacco cessation cannot be done like that … every patient is different … [it should be] guidelines rather than policy' (Interview with A/OHP Coordinator, metropolitan NSW)*

Others revealed that they may undertake smoking cessation brief interventions with patients, but may not always follow the 3A model. A few reflected that clinicians might be confused about the detail required in a brief intervention and the training package would benefit from further clarification around this issue.

3.5 Documenting and recording

Medical records

All oral health/dental clinical staff should **document** smoking status in the patient's medical history

Several LHDs reported they had a question about smoking status on their medical history. Those who had a question about smoking on the medical history form reported that 'Asking' should be the easiest part, and saw this as a 'trigger' or 'prompt' for the intervention. Having a smoking question on the medical history form facilitated this well and helped the intervention to flow.

One LHD did not have a smoking question on the medical history form at the time of the evaluation. They reported that 'asking' about smoking status was perceived as more of a hurdle.

All oral health/dental clinical staff should place a 'smoking cessation advice given' sticker in the patient's medical record

The survey of clinicians indicated that the 'smoking cessation advice given' stickers were not utilised very well by clinicians. Just over half of respondents reported that they rarely or never use them. Further detail is provided in Section 3.6.

Data recording

All oral health/dental clinical staff should **record** the smoking cessation brief intervention in ISOH using the item number 191

The item number 191 'smoking cessation advice given' was developed so clinicians could record in the ISOH database that the brief intervention had been undertaken. It was intended to be a measure of chairside brief intervention activity by clinicians.

The Survey explored when clinicians were recording the item number 191. Respondents were invited to make multiple selections of occasions where they recorded the item number in ISOH. The results found the following variations:

- 8% reported recording 191 when a patient was asked about their smoking status
- 7% reported recording 191 when a patient stated they are a smoker
- 25% reported recording 191 when a smoker was given cessation advice, regardless of whether the patient expressed an interest in quitting
- 29% reported recording 191 when a smoker expressed interest in quitting and was given advice accordingly
- 18% reported recording 191 when a smoker was interested in quitting and is referred to the NSW Quitline.

These results should be interpreted with caution because survey respondents were able to make multiple selections However, despite this limitation, these results highlight the enormous variation in the interpretation of how this item number should be utilised.

12% of respondents reported that they never use the item number. A variety of reasons were provided:

- Forgot to record it
- Unaware of the existence of item number 191 and the statistical importance of its use
- Time constraints.

Since July 2009 when the policy directive was implemented and the item number 191 was introduced, there has been an increase in the recording of the item number in ISOH. Figures 5 and 6 show the monthly cumulative totals for item number 191 recorded in ISOH between July 2009 and September 2012 for adults and children respectively. It should be noted that the scales are different in each graph. Both graphs show that there has been a linear increase in recording of the item number. For adults, figures for September 2012 have more than doubled on figures recorded in September 2009.

Figure 6: Monthly cumulative totals of brief interventions recorded in ISOH July 2009-September 2012

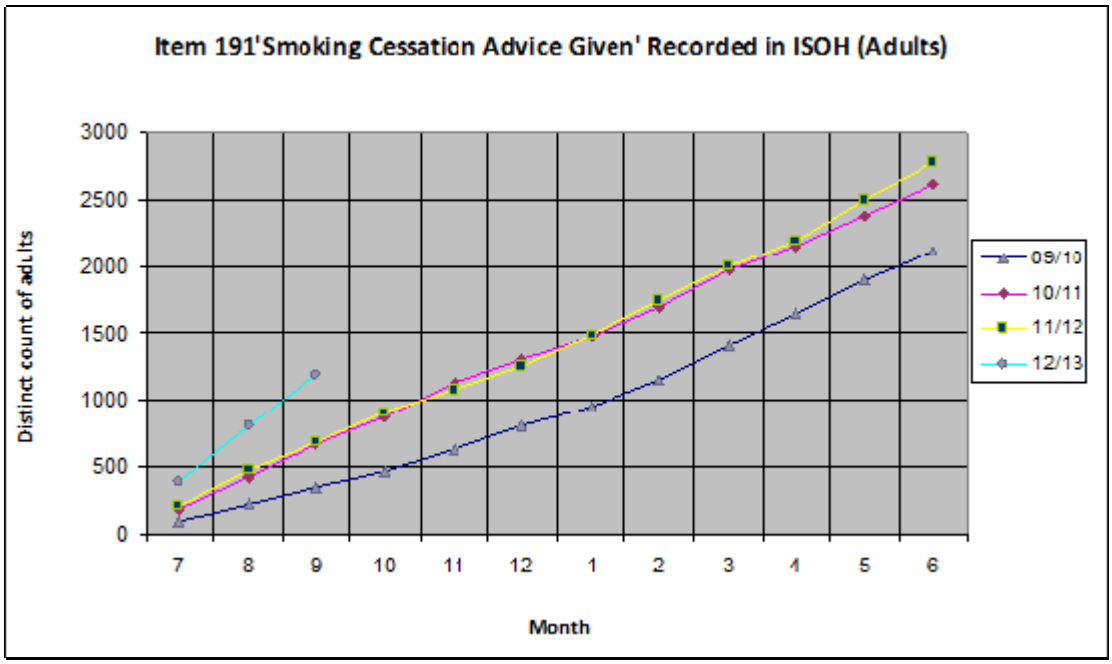
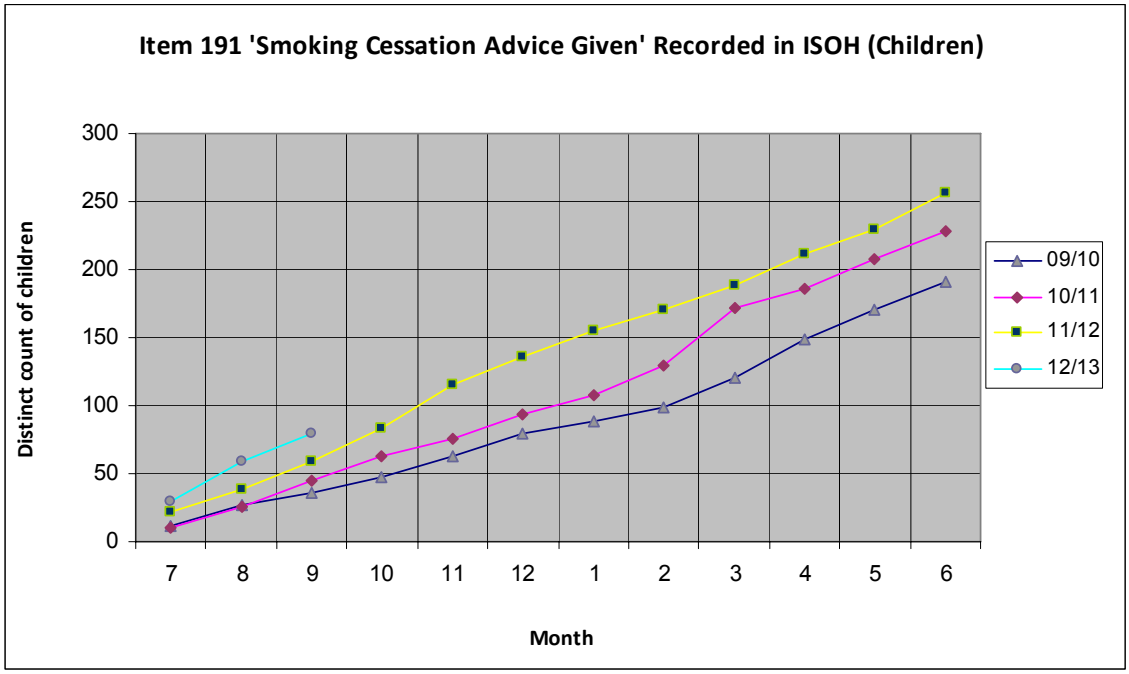


Figure 5: Monthly cumulative totals of brief interventions with children recorded in ISOH July 2009-September 2012



3.6 Supporting materials

All public dental/oral health staff should provide patients with supporting materials and information

There were four written resources identified in the policy directive and training package as supporting materials for the smoking cessation brief intervention. These included:

- *Smoking and Your Oral Health*
  This brochure was developed by the then SWAHS and sponsored by COHS for statewide distribution. The brochure provides information about the health effects of smoking, particularly in relation to oral health, as well as the benefits of quitting and information on how to contact the Quitline.
- *Quitline Brochure*
  This brochure was developed by the Cancer Institute and NSW Health. The brochure provides information on how to access the Quitline.
- *Quitline Fax Referral Forms*
  This is a referral form that clinicians use when a patient consents to be referred to the Quitline. This form is completed and faxed to the Quitline, who are responsible for direct follow up with patients.
- *'Smoking Cessation Advice Given' Stickers*
  These are small silver stickers that say 'smoking cessation advice given'. They are placed in the patient's clinical record to indicate that the smoking cessation brief intervention has been given.

Although not specified in the training manual as a resource as such, some OHP Coordinators had used the 3As flowchart from the training package (Appendix F) as a visual aid at the chairside. It was used to prompt clinicians to undertake the intervention.

Maintaining and distributing resources

The policy states that the OHP coordinator is responsible for maintaining and distributing resources to clinicians. Included with the training package is a resource ordering form, which should be completed and returned to the Resource Distribution Unit. The resources specifically required for the smoking cessation brief interventions are highlighted on the order form in red (Appendix G).

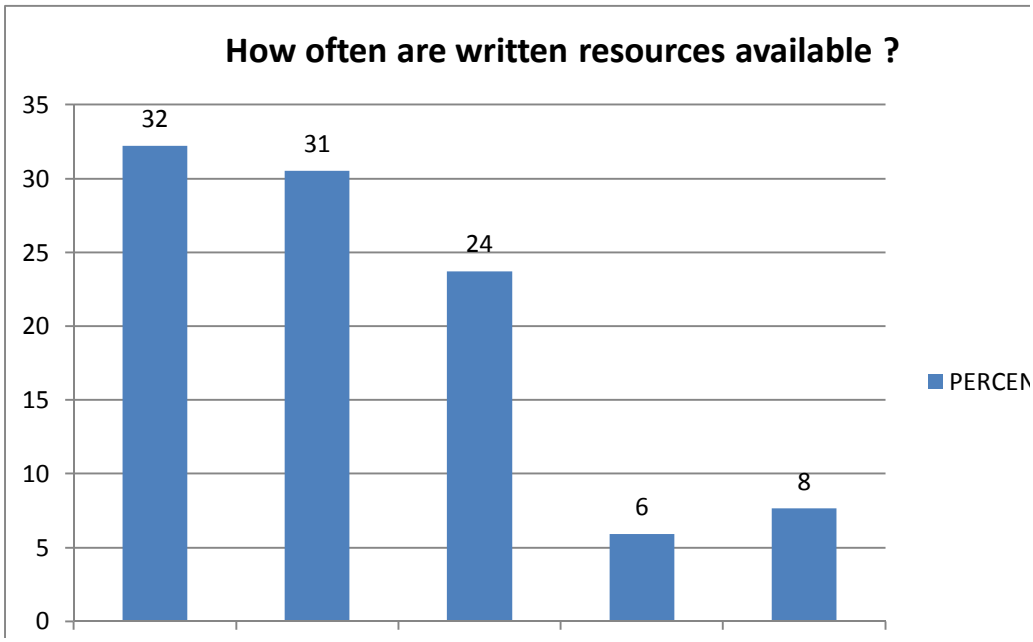
Interviews revealed that most OHP coordinators were facilitating provision of resources for clinical staff. However some were unsure of how to obtain certain resources and others were unsure if the resources were being used by clinicians.

> *'…I don't think people realise, either that the stickers ['smoking cessation advice given' stickers] are available, and where we get them from, because I don't even know…' (Interview with OHP Coordinator, regional NSW)*

Availability and utilisation of resources

The majority of survey respondents reported that written resources were available at least sometimes, but often more frequently. The full results are presented in Figure 7.

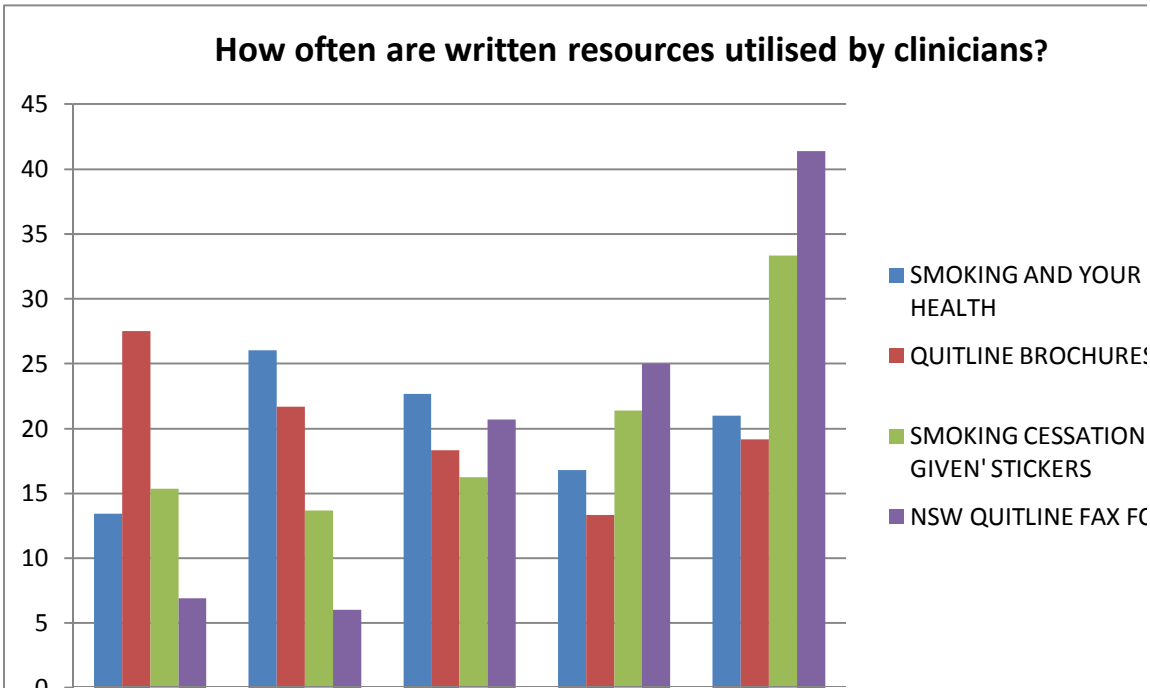
Figure 7: Availability of written resources



Source: Survey of clinicians, 2012

Figure 8 shows that survey respondents reported using 'Smoking and Your Oral Health' and the 'Quitline' brochure at least sometimes and often more frequently while the 'Smoking Cessation Advice Given' stickers and the 'NSW Quitline Fax Forms' were not as well utilised.

Figure 8: Utilisation of written resources by clinicians

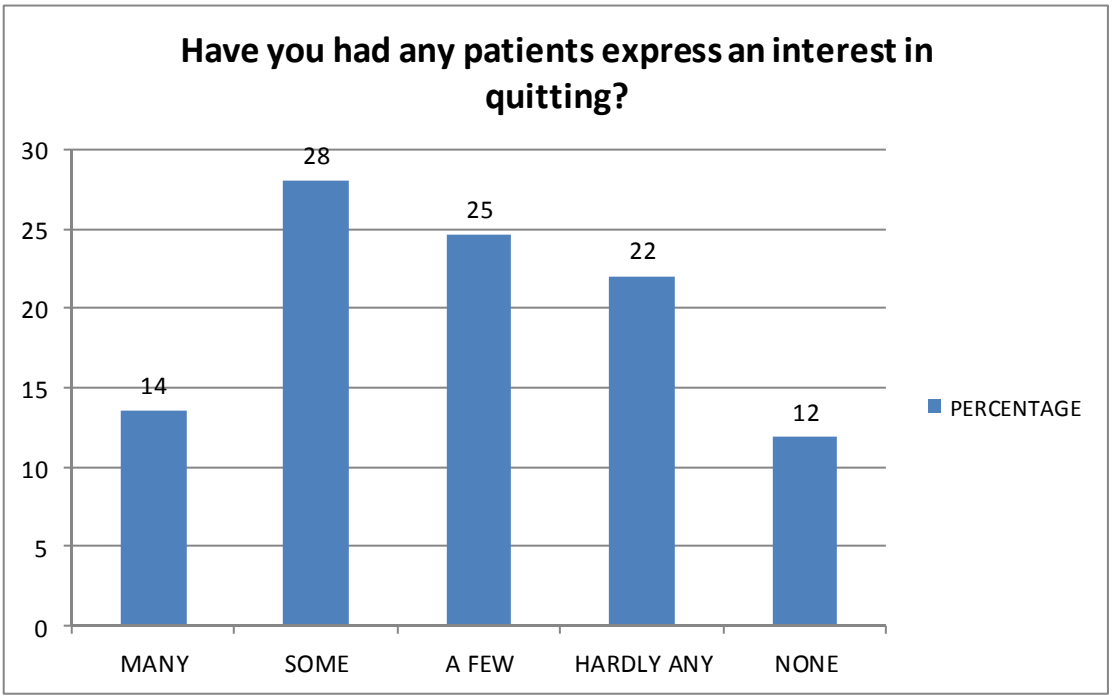


Source: Survey of clinicians, 2012

3.7 Patients who expressed an interest in quitting

The survey asked clinicians to estimate how many patients had expressed an interest in quitting. Figure 9 shows that the majority of clinicians surveyed had seen at least a few patients who had expressed an interest in quitting.

Figure 9: Clinician reports of patient's interest in quitting



Source: Survey of clinicians, 2012

3.8 Barriers and enablers to delivery of smoking cessation brief intervention

Clinicians and OHP Coordinators referred to several barriers to delivery of the smoking cessation brief intervention at the chairside. These are discussed in detail below.

Patient presentation

Clinicians reported that some patients were very resistant or disinterested. A few OHP coordinators reported that patients had responded negatively to the smoking cessation intervention.

> *'I had a couple of teenagers that I knew were smoking and they shrugged at me and looked the other way … I wasn't quite happy to pursue something, especially when one of them was really sullen, with what looked like to me a big barrier to what I needed to do…' (Interview with OHP Coordinator, regional NSW)*

A dental therapist who was interviewed stated that some patients responded with aggression. This was reported to be intimidating for clinicians and often resulted in lack of confidence in undertaking the intervention, or avoiding the intervention altogether.

'I have reports of adult patients becoming very aggressive and saying 'don't give me a lecture, I don't want to talk about it I'm here for my teeth' … before they even start … and that can be …, we don't always have overly confident dentists who can say, 'no hang on mate, this is just a part of my job, it's a part of my policy', [it] can be quite intimidating to some of our dentists …' (Interview with Dental Therapist, regional NSW)

Evaluation participants also referred to the issue of patient pain. It was recognised that patients in pain would probably not be receptive to a cessation message, presenting another conflict for clinicians.

'… we have a lot of patients in pain, and it's…, they're beyond listening at that particular point in time, they, um, want their tooth fixed and that's just it …' (Interview with Dental Therapist, regional NSW)

Confidence

Many OHP Coordinators, some of whom were also working in clinical roles, commented that clinicians were not always comfortable or confident to deliver a smoking cessation message to patients. This OHP Coordinator said:

'… even though you provide the training and information, unless that dental assistant or that [clinician], do you know, is confident to impart the message, or be part of that ah… prevention message at the chairside, they won't do it ....'(Interview with OHP Coordinator, regional NSW)

They reported that delivering the intervention can feel like they are lecturing or patronising patients. This was reinforced by some patients who actually did take offense or become angry and aggressive. OHP Coordinators stated that the level of confidence clinicians have is a key factor in whether the smoking cessation brief intervention is delivered.

Children

A few OHP Coordinators reported that it was difficult for clinicians working with children and young people under the age of 18 to address the issue of smoking. This was particularly the case if parents were present for the consultation. Some clinicians had made a decision that patients were not of smoking age, or had stated they would not ask children under the age of 10 years.

'… if the parents are present I think that the, some of the child staff find it difficult to talk to the kids about that [smoking] with the parents present … or the child's not going to admit that on the medical history, and the parents are often the ones who fill out the medical history for them so they're not going to tick 'yes, my kid smokes'…' (Interview with OHP Coordinator, regional NSW)

Forgetting

One OHP Coordinator felt that the issue for clinicians was actually remembering to undertake the intervention. They pointed out that clinicians are often more focused on diagnosis and treatment.

Availability of training and resources

Some clinicians reported that the unavailability of information and resources, and lack of training were barriers to policy implementation. Others reported lack of awareness of the Quitline and understanding of the procedures for making referrals were also barriers. Areas that did not have an OHP Coordinator were more likely to report that training was not happening in their LHD this in turn reduced the possibility of implementing the policy.

Cynicism

The survey of clinicians revealed that 67% of respondents were unsure as to whether it was an effective way to assist patients to quit smoking. Some OHP Coordinators reflected that some clinicians are really committed to smoking cessation and 'do it religiously', while other clinicians don't see it as their job. Clinicians with an interest in smoking cessation were identified to have more of a tendency to take it on.

4. Discussion

4.1 Limitations

There are a number of limitations to the methodology used for this evaluation. These are discussed in detail below.

I. Survey of clinicians

The clinicians' survey sample size was small. Workforce estimates as at 30 June 2012 indicate there were 410.7 full time equivalent dentist and dental/oral health therapist positions across the state of NSW, so the sample of 122 is a small representation.

In some areas no clinicians returned surveys or the response rate was poor, which impacted the ability to make generalisations from the data gathered. There was also some inherent bias in the way the survey sample was accessed. In the first instance relying on OHP Coordinators to distribute the surveys to staff, and in the second instance, forwarding surveys via email to clinicians who have an email address on the NSW Health website state wide email directory. The former is problematic in that there was no control over accessing the sample and ensuring even distribution. The latter was flawed in that the statewide email directory did not list email addresses for all clinicians meaning that some clinicians would not have been given an opportunity to complete and return a survey. It should also be noted that the surveys were based on self report, and clinicians may have misrepresented how frequently they undertake various aspects of the intervention. The sample was also subject to self selection bias.

II. Post training evaluations

With respect to the post training evaluation templates (which were collated by the trainer after training and forwarded to COHS between October 2009 and August 2011), there was inconsistency both in the frequency of reporting, and how the evaluation templates had been completed. The training evaluation templates also were not likely to be an accurate representation of all training sessions conducted within in the LHDs. Most of the training evaluation templates that were completed and returned to COHS after training, occurred in 2009 and 2010, and in a couple of instances 2011. This was inconsistent with anecdotal reports of training having occurred in some LHDs much more recently. Bias may also exist in how trainers chose to interpret, collate and report on feedback given by participants.

III. Interviews with OHP Coordinators

Despite efforts to interview all 16 OHP Coordinators or their delegates, only 10 were interviewed meaning that not all views were represented in the interviews. This is a result of some areas not having a designated OHP Coordinator, or having an OHP Coordinator that was unavailable or unreachable after several attempts. As with all interviews, interviewer bias exists, although some biases were reduced by having a single interviewer conduct all the interviews. Bias also exists in the analysis, although rigour was improved by having the thematic analysis reviewed by a second investigator.

IV. Data extraction from ISOH

There were several issues that compromised the interpretability of the data extracted from ISOH relating to the use of the item number 191, which is used by clinicians to record in the database that the smoking cessation brief intervention has been undertaken. ISOH is flawed in that it can give frequency counts of use of the item number 191, but as smoking status is not recorded in ISOH currently, there is nothing that can be used as a denominator to make the data more meaningful. Issues highlighted by this evaluation around inconsistency in how and when the item number was being recorded means that item number 191 is not likely to be an accurate reflection of smoking cessation brief interventions being implemented by clinicians.

4.2 Major findings

Notable achievements

The evaluation identified a number of notable achievements in regards to the policy and its implementation. These include:

- 85% of staff surveyed reported they were aware of the policy.
- The majority of clinical staff who responded to the survey reported that they 'ask, approach and advise' patients regarding smoking cessation at least sometimes, and many staff do this more frequently.
- There was a linear increase in recorded interventions in ISOH since the policy was introduced in 2009.
- The training package was mostly considered to be concise, simple and easy to deliver and most staff reported a level of confidence after training.

Key barriers and enablers

Several barriers and enablers were identified. These included:

- The OHP Coordinator was instrumental in implementing all oral health programs and policies, and played a pivotal role in implementing the smoking cessation brief intervention policy directive.
- The degree of support, resources and concordant priorities within the LHD including that of managers, OHP Coordinators and clinical staff was fundamental in mediating training delivery, and policy implementation and outcomes. Restructuring of area boundaries had left some areas without resources and trying to re-establish themselves.
- Training was an important tool for promoting awareness, understanding and confidence which are central in determining policy outcomes. Lack of resources and competing priorities had meant that provision of training had not always been maintained and many staff had not received any training. As a result some staff did not know about the policy or did not feel comfortable to implement the intervention.
- Several barriers to providing the smoking cessation brief intervention were identified by staff. These included lack of time, lack of confidence, lack of

training, other clinical priorities, negative responses from patients, and difficulty approaching young people especially when parents were present.

Other factors

There were a number of other factors identified which help to explain the impact of the policy. These include:

- Clinicians had mixed views about the smoking cessation brief intervention. Most saw the importance of it, but cited a number of obstacles to actually undertaking the intervention. This included a sense among some staff that provision of smoking cessation advice was patronising or judgemental.
- There may have been some confusion amongst staff about the complexity of the brief intervention.
- Some staff may undertake a smoking cessation brief intervention but not always follow the 3A model.
- Most staff reported they were aware of the policy however this did not necessarily translate into practice.
- Having a question about smoking status on the medical history form was useful as a trigger to prompt clinicians to proceed with the intervention.
- Resources were helpful, but not always accessible and not always used. Staff identified that specific resources to support the intervention were available at least sometimes and in many cases more often, but were utilised to varying degrees. Several staff commented that they would like more access to resources.
- Item number 191 to record 'smoking cessation advice given' in ISOH was used poorly, and there was little consistency in when it was recorded. Many clinicians reported that they did not know about the item number 191 or forgot to use it.
- The training package was generally considered to be concise, simple and effective however most staff thought it needed to be reviewed and updated.
- More accountability around reporting is needed to ensure it is timely and accurate.

4.3 Considering the evaluation findings

The importance of context

Emerging from this evaluation was a strong sense that oral health promotion varies dramatically in its interpretation, structure and function across the state. Contextual factors play a key role in determining outcomes of oral health promotion policy and program implementation.

OHP Coordinators were identified to be instrumental in the implementation of the smoking cessation brief intervention policy directive specifically, in coordinating and/or delivering training, support, facilitating resource provision and monitoring and reporting back to COHS. COHS has acknowledged the importance of the OHP Coordinator role and made provision for this in the draft document *'LHD public oral health programs: performance and reporting' 2011/12.*[29] Section 6, page 9 states:

> All LHDs are expected to have an OHP Coordinator employed at least 0.5 to 1 FTE to coordinate oral health promotion activities. These roles will be block-funded under the Activity Based Funding model being developed for implementation in 2012/13 state wide.

However, as highlighted in this evaluation, policy implementation does not rest with the OHP Coordinator alone, and other factors were identified to mediate successful or unsuccessful outcomes. Resources and priorities are difficult to separate as they interact at various levels. They may both facilitate and be a product of organisational contexts and structure, and they intersect with the delivery of training and implementation of policy. Priorities affect how resources are allocated, and resources, or lack thereof, force decisions about priorities and so they have the capacity to act as both barriers and enablers to oral health promotion policy, programs and practice state wide.

An important factor which was particularly relevant at the time of this evaluation was the role the geographical context played and the impact of the restructuring of AHS' into smaller LHDs. This restructuring and its resultant redistribution of resources and realigning of priorities had been significant, and consequently, some areas were still in the process of re-establishing themselves. Physical distance and remoteness were also identified to be key challenges for some areas particularly in relation to delivery of training and provision of ongoing support to clinical staff.

A combination of these factors was found to affect communication of policies and programs from the state level. In the case of the smoking cessation brief intervention policy directive, attendance at the Network Meeting was a key conduit for the distribution of policy information and resources. However, attendance at this meeting relied on LHDs having concordant priorities and the available resources (including the OHP Coordinator and supporting staff) to attend this meeting, which for some, may have involved travel across NSW. If LHDs cannot always support staff to attend Network meetings, then alternative channels for communication have been utilised. This might include videoconferencing into meetings as well as staying in touch via other forums, and regularly consulting meeting minutes and other relevant documents. However, whether these alternatives are sought or not, largely depends on the priorities of the LHD and its staff.

Training

The role of training with regard to the implementation of this policy is significant. The evaluation identified a link between training in smoking cessation interventions and increased confidence of clinicians to undertake them. It is, however, important to qualify that this does not necessarily translate into practice.

Interestingly this evaluation observed variation in rankings of confidence recorded immediately after training, and retrospective rankings of confidence post training that were reported in the survey of clinicians. This may indicate how experiences of delivering the intervention at the chairside as well as time since undertaking training, may manipulate clinician confidence, which both underscores the myriad of factors that influence policy outcomes, and signifies the importance of regular training updates as well as ongoing support from colleagues and management.

It is well documented in the literature that training of health workers in smoking cessation interventions is likely to lead to increased engagement in smoking cessation activity with patients.[30] However, as illustrated in this evaluation, training alone may not be sufficient to increase brief intervention activity amongst clinicians. Clinicians need to feel confident and supported by staff and management, and need to feel like they have the resources (including time) to undertake the interventions, but it is also important that they see smoking cessation as a priority themselves.

Despite the importance of training and its centrality to the policy, delivery was subject to a variety of barriers and enablers (resources, priorities, geography, restructuring etc) as previously discussed. The evaluation highlights that training should be accessible and regular, and provide sufficient detail on how to approach patients, so both the content and delivery need to be reviewed and consideration needs to be given to developing models of training delivery that promote sustainability. Online training was identified by a few evaluation participants as being a possible option for delivery that would increase accessibility, frequency, sustainability and allow for better monitoring of who has received training.

An emerging body of evidence suggests that delivering training online can effectively teach clinical skills,[31] and some studies have shown that it can be equally as effective as delivering training face to face, with the added advantage of being more accessible, particularly for those in rural or remote areas.[32] As an example, the National Drug Research Institute in Western Australia has developed free smoking cessation brief intervention online training suitable for anyone working in smoking cessation. Its primary goal is to educate participants about tobacco smoking in Australia and the relevant policies, as well as allowing them to achieve competencies for delivering brief interventions and undertaking motivational interviewing.[33] There may be significant benefits to developing online smoking cessation brief intervention training for oral health staff as a solution to the challenges of geographical distance and limited resources faced in many LHDs.

Provision of the smoking cessation brief intervention

The evaluation findings revealed that smoking cessation brief interventions may not always be undertaken according to the prescribed 3A model. Some clinicians may approach the intervention with more fluidity and a few OHP Coordinators suggested that the model need not be so regimented. It also emerged that there may be some confusion amongst staff as to the degree of detail that is expected in a brief intervention.

Some respondents indicated that there needed to be further clarification about what the 'Approach' part of the model entailed. Currently the 'Approach' part hints at a stage based assessment, by asking patients how they feel about their smoking, and if they could imagine themselves quitting. However, given the literature suggests that using a stage based approach is limited in value,[17] particularly when time is a constraint, the mandatory inclusion of this step should be reviewed.

A need for clear communication with clinicians about the extent of the intervention was also identified. This is needed to reinforce the message that the brief intervention does not entail providing detailed assessment, counselling or follow up, because this is the role of the Quitline.

Respondents also referred to a need for additional training and support, particularly around the practicalities of delivering the brief intervention and managing patient responses. Clinicians stated that additional guidance around how to manage smoking cessation with patients who were challenging or difficult, or were under the age of 18 would be of use.

Resources

There were mixed views on the usefulness of written resources, with some clinical staff requesting they would like access to more resources and a wider range. However, accessibility and utilisation of resources was reported to varying degrees. Some clinical staff reported a lack of knowledge about how Quitline referrals work, which corresponds to reports that the Quitline Referral Fax Forms were not well utilised. This highlights a need for further training around Quitline referral processes and attention to ensure that referral forms are easily accessible to clinicians. Additionally, the evaluation findings highlight a need for developing or sourcing supporting literature and written resources that are culturally appropriate and acceptable to a wide range of audiences. Specifically, a need for resources that are suitable for young people was identified. Culturally appropriate resources for use with Aboriginal patients or patients from culturally and linguistically diverse (CALD) backgrounds should also be included as part of the package.

Recording the smoking cessation brief intervention

Unfortunately the data extraction from ISOH relating to the item number 191 did not provide an accurate and meaningful indication of smoking cessation intervention activity in NSW. This was the case for two reasons: firstly, as ISOH did not record information about patient smoking status, there was nothing with which to compare recording of item 191 in the way of prevalence of smokers who should have received the intervention; secondly, as the evaluation findings point out, there was inconsistency in how and when this item number was recorded, and reports of clinicians either not knowing about the item number, or forgetting to record it. This suggests that data extracted from ISOH was likely to be underreported or misreported. Information from ISOH must therefore be interpreted with caution. Despite this, these findings suggest a need for further clarification in the policy as to what item number 191 means, and more training for staff about how and when it should it be used. It also underscores the importance of ensuring that new and current staff receive appropriate training, are clear on the protocols, as well as supported and reminded about what is expected in terms of recording the smoking cessation brief intervention in ISOH.

Accountability and reporting

The evaluation identified a clear need for more accountability around reporting. This accountability is needed particularly with regard to OHP Coordinators reporting information back to COHS, for example reporting on training activities that have happened in the LHDs. This essentially requires a greater expectation from COHS to ensure this information is reported in a consistent and timely manner. Moreover, accountability and reporting should also be considered in terms of COHS and the Oral Health Promotion Network reporting upwards to the State Oral Health Executive (SOHE). Including reports on oral health promotion activities on the SOHE

agenda, should help to raise its profile and garner broader support for oral health promotion programs and policies. This may help to shift the culture away from a purely clinical focus.

Perceptions of the smoking cessation brief intervention

Clinicians and OHP coordinators had mixed perceptions of the smoking cessation brief intervention. Whilst some staff acknowledged that cessation advice was important particularly given its relevance to oral health, they also expressed sentiments that giving advice to quit could feel judgemental and patronising. This suggests there is a level of incongruence around the provision of smoking cessation advice which may contribute to poor policy adherence. It is possible that this sense of uneasiness around conducting smoking cessation brief interventions is reinforced when patients respond negatively, either by being unreceptive or offended by clinician advice to quit smoking, or in some cases becoming angry or aggressive. Clinicians need to be armed with strategies for managing difficult responses from patients, and should be trained to assess a patient's receptiveness to cessation advice and tailor the intervention accordingly. Additionally, it emerged that clinicians may benefit from further clarification around their role in administering a brief intervention with an emphasis on that fact that the brief intervention is about referral to the Quitline, rather then provision of extensive assessment, counselling and support.

Longer term outcomes

The outcome measures included in this evaluation are restricted to retrospective reports from clinicians about whether they felt patients had been interested in quitting. This does suggest that there has been a level of interest from patients, however more accurate measures could and should be established. Preliminary discussions with the NSW Quitline indicate that there is capacity to monitor referrals made by public dental services to the NSW Quitline. Discussions with OHP Coordinators reveal that outcome measures such as number of referrals to the Quitline, and the outcome of follow up made by the Quitline, may in fact reassure clinicians that brief interventions can be effective, if not successful.

5. Recommendations

The evidence from this evaluation supports several recommendations. These are detailed below.

1) Support OHP Coordinators to implement OHP programs and policies

Given OHP Coordinators were identified to be instrumental in the implementation of the smoking cessation brief intervention policy directive, COHS should mandate and support the LHDs to employ them, as well as encourage the LHDs to facilitate the attendance of their OHP Coordinator or delegated representative at Network meetings. COHS and the Network should also provide direction, support and mentoring to OHP Coordinators to enable successful delivery of oral health promotion programs and policies at the local level.

2) Refine the 3A model

The existing 3-step model should be further refined so that the emphasis is shifted away from undertaking a stage based assessment of readiness to quit. Currently the 'Approach' step of the model entails asking questions such as; 'how do you feel about being a smoker?' and 'could you imagine quitting?' Refining this to simply asking 'are you interested in quitting' and/or 'would you like some information on quitting' would make this a more straightforward, accessible and simple tool for clinicians to use, as well as being in line with the current evidence.

3) Promote a more flexible approach to undertaking brief interventions

Clinicians should be allowed flexibility in how they undertake the smoking cessation intervention. Acknowledging that clinicians can and should make a professional judgement about how receptive a patient is to quit advice, and encouraging clinicians to consider contingencies for these scenarios (for example getting a patient to return for a preventative session) would be of value.

4) Clarify the brief intervention steps and processes

Given there may be some confusion amongst clinicians as to the extent of the intervention it would be beneficial to further clarify in the policy and in the training what is expected and emphasise that brevity is key and that the provision of counselling and follow up is the role of the Quitline. Further instruction is also needed around how to make Quitline referrals, and how and when to record the item number 191 in ISOH. A process for managing patients under the age of 18 should also be developed.

5) Review and update the training package

Both the content and model of delivery of the training package need to be reviewed and updated. Content needs to specifically address issues around how to 'Approach' patients and provide practical support and examples to clinicians of how to manage this in a variety of situations including what to do if the patient should react negatively. The DVD was identified as a valuable resource, but should be improved

and redone. Options for delivering training, such as making it available online, should be considered to improve coverage, access and sustainability.

6) Promote the use of the medical history as a prompt

The inclusion of a question about smoking status should be included on all medical history forms. This should be emphasised to clinicians as a tool for initiating the brief intervention.

7) Develop a more meaningful ISOH item number 191

At the time of the evaluation the ISOH item number 191 offered little in the way of meaningful data, and existed simply as a measure of brief intervention activity recorded by clinicians. Improving the utility of this item number would involve establishing a comparative measure. One way of doing this would be to record patient smoking status in ISOH, which would provide a denominator figure of the population of smokers seen in public oral health services who should be receiving a smoking cessation brief intervention.

8) Improve reporting and accountability

Reporting on smoking cessation brief intervention training activity has been inconsistent to date. There were irregularities both in the frequency of reporting, and how the evaluation templates had been completed. This in itself highlights a need to clarify what is expected from the training evaluation templates. This includes how and when to complete them and the process for returning them to COHS. Increased accountability around reporting of information back to COHS would enhance the accuracy and frequency of reporting and improve the reliability of these measures as a future source of evidence.

9) Establish measurable outcomes

Establishing a framework for monitoring referrals made by public dental clinics to the NSW Quitline would be a good way to measure the impact of the policy in tangible terms and would be simple to initiate. The NSW Quitline has indicated that a list of all public dental clinics in NSW would be needed so that they could code where referrals had come from. This could potentially provide evidence of successful policy utilisation.

6. Appendices

Appendix A: Evaluation form template

Why is Smoking Cessation Important in Oral Health?
PARTICIPANT EVALUATION FORM

Date:	Position:	Venue:

Instructions: Please place a check mark in the appropriate box that indicates your rating.

Overall training:	**Poor**				**Excellent**
1. Training organisation					
2. Training content					
3. Presentation of the training					

Comments:

How confident are you to…	**Not confident**				**Very confident**
4. talk about smoking-related health issues with my patients					
5. discuss with patients the benefits of quitting					
6. provide information to patients on quitting					
7. refer patients to the Quitline					
8. record information in patient's notes and ISOH					

Comments:

8. **What did you find most useful from the training?**

9. **How could the training be improved?**

10. **Any further comments?**

Thank you for taking the time to complete this evaluation

Appendix B: Training participants' evaluation forms

Why is Smoking Cessation Important in Oral Health? *EVALUATION REPORT TEMPLATE*

Training date:	
Presenter's name:	
Position:	
Area Health Service:	
Training venue:	
No. of participants	

How did the participants rate the training session?

Overall training:	**Poor**				**Excellent**
Training organisation					
Training content					
Presentation of the training					
Comments					

How did the participants rate their confidence levels?

Confidence Levels:	**Not confident**				**Very confident**
Talk about smoking-related health issues with my patients					
Discuss with patients the benefits of quitting					
Provide information to patients on quitting					
Refer patients to the Quitline					
Record information in patient's notes and ISOH					
Comments:					

What did you find most useful from the training?	
How could the training be improved?	
Any further comments?	

Return to NSW Oral Health Promotion Coordinator, 02 8821 4302 (fax), email :jennifer_noller@wsahs.nsw.gov.au

Appendix D: Survey of clinicians

Policy Directive: Smoking Cessation Brief Intervention at the Chairside

Survey for Clinicians

The Centre for Oral Healthy Strategy NSW is evaluating the 2009 policy directive Smoking Cessation Brief Intervention at the Chairside: The Role of Public Oral Health/Dental Services http://www.health.nsw.gov.au/policies/pd/2009/PD2009_046.html.

Purpose of the evaluation:

- assess the sustainability of oral health staff providing ongoing smoking cessation brief interventions
- explore any barriers that prevent the policy from being sustainable
- review the benefits and limitations of the 3As (Ask, Approach, Advise) as a method of providing smoking cessation brief interventions to patients.

Instructions for completing the questionnaire:

- You can complete this form on your computer by entering text into the shaded grey area and clicking on boxes to select your response.
- If you complete the questionnaire manually handwrite your responses by placing a cross in the box (☒) and writing your comments in the comments box.

Date for completion: Please complete and return by **Friday 6th July 2012** via email to Greer Dawson email: gdaws@doh.health.nsw.gov.au or fax: 02 8821 4302.

Contact: If you wish to discuss anything further please contact Greer Dawson at the Centre for Oral Health Strategy on 02 8821 4313 or email: gdaws@doh.health.nsw.gov.au.

Your participation in this evaluation is very much appreciated.

Job Title:	
Local health District:	

	Yes	No
1. Do you know about the policy directive PD2009_046 Smoking Cessation Brief Intervention at the Chairside: The Role of Public Oral Health/Dental Services?	☐	☐
2. Have you attended a training session on this policy?	☐	☐

	Extremely Confident	Very Confident	Somewhat Confident	Not Very Confident	Not at All Confident
a) If yes, how confident did you feel after the training about providing a smoking cessation brief intervention at the chairside?	☐	☐	☐	☐	☐

	Yes	No
3. Do you use the 3As (Ask, Approach, Advise) as a method of providing smoking cessation brief interventions to patients?	☐	☐

	Always	Mostly	Sometimes	Rarely	Never
4. Do you *Ask* each 'appropriate' patient about their smoking status?	☐	☐	☐	☐	☐
5. Do you *Approach* all patients who smoke about their interest in quitting?	☐	☐	☐	☐	☐
6. Do you *Advise* patients interested in quitting about the NSW Quitline?	☐	☐	☐	☐	☐
7. Do you provide patients interested in quitting with relevant information?	☐	☐	☐	☐	☐
8. If there are times when you do not do these things, please comment on what prevents you from doing so?	Comment				
9. How do you find using the 3As approach (Ask, Approach, Advise)?	Easy	Fairly Easy	Neither	Fairly Difficult	Difficult
	☐	☐	☐	☐	☐

	Always	Mostly	Sometimes	Rarely	Never
10. Is written material available to you to complete the intervention?	☐	☐	☐	☐	☐
11. For patients who smoke, how frequently do you use the brochure *Smoking and Your Oral Health*?	☐	☐	☐	☐	☐

12. For patients who smoke and are interested in quitting, select how frequently you use the following resources?					
	Always	Mostly	Sometimes	Rarely	Never
a) *Quitline Brochures*	☐	☐	☐	☐	☐
b) *Smoking Cessation Advice Given stickers*	☐	☐	☐	☐	☐
c) *Referral to NSW Quitline Fax Form*	☐	☐	☐	☐	☐

13. When do you use item number 191 to record that smoking cessation brief intervention has been done in the Information System for Oral Health (ISOH)? (Select as many as appropriate)	
a) When a patient is asked about their smoking status	☐
b) When a patient states they are a smoker	☐
c) When smokers are given cessation advice regardless of their interest in quitting	☐
d) When smokers express interest in quitting and are given advice accordingly	☐
e) When smokers interested in quitting are referred to the NSW Quitline	☐
f) I never use this item number	☐
14. If there are times when you do not enter item number 191 in to ISOH, please comment on what prevents you from doing so?	Comment

15. Do you think the Smoking Cessation Brief Intervention at the Chairside is an effective way of helping patients quit smoking?	Yes	No	Don't Know
	☐	☐	☐

16. Have you had any patients express an interest in quitting?	Many	Some	A Few	Hardly Any	None
	☐	☐	☐	☐	☐
17. Do you have any comments or suggestions that might make this intervention simpler and more effective?	Comment				

Thank you for taking the time to complete this survey. Please email or fax completed forms to Greer Dawson email: gdaws@doh.health.nsw.gov.au or fax: 02 8821 4302 by **Friday 6th July 2012.**

Appendix C: Interview Guide: Oral Health Promotion Coordinators

NB: this is to be read to participants prior to interviewing to gain their consent.

The Centre for Oral Healthy Strategy NSW is evaluating the 2009 policy directive Smoking Cessation Brief Intervention at the Chairside: The Role of Public Oral Health/Dental Services

The purpose of this evaluation is to:

- Assess the sustainability of oral health staff providing ongoing smoking cessation brief interventions;
- Explore any barriers that prevent the policy from being sustainable;
- Review the benefits and limitations of the 3As (Ask, Approach, Advise) as a method of providing smoking cessation brief interventions to patients.

With your consent this interview will be recorded and transcribed verbatim. Data will be analysed and used to write up an evaluation report for COHS and may be included in papers for submission to peer reviewed journals.

Information may be identifiable by local health district.

Questions

Context

What is the structure for oral health promotion in your LHD?
Who?
What positions?
Who are you directly accountable to?
How is information communicated?

What is your view on the smoking cessation brief intervention at the chairside?

Can you tell me about the general feeling of oral health staff towards providing chairside smoking cessation brief interventions?

Training

Has there been any smoking cessation brief intervention training in your LHD?
(If no, why not? Any plans to start? What are the barriers?)
Who is involved in coordinating and delivering the training on the policy?
If you have been involved, then:

- What do you think about the effectiveness of the training?
- Can you please describe your experience of delivering the training?
- What feedback did you receive, and in what form?
- Would you consider anything else needs to be included?
- How do you ensure that all clinicians receive training?

Implementation
Thinking about the policy in practice:
What do you think prevents/enables adherence to the policy?
In practice, what works/what doesn't work?
How does your LHD support the implementation of the policy?

Model
Can you briefly outline what the 3As are?
Who developed this model?
What is the rationale for using this model?
In your view, what are the benefits/limitations of the 3As model in practice?

Do you have any suggestions for improving the policy?

Do you have any other comments?

Appendix E: Ethics approval

UNSW

Medical and Community Human Research Ethics Advisory Panel

6 June 2012

Ms Dawson Greer
SPHCM/Centre for Oral Health Strategy NSW

Reference: *"Evaluation of Policy Directive PD2009_046 Smoking Cessation Brief Intervention at the Chairside: the Role of Public Dental / Oral Health Services"*
Reference Number: 2012-7-21
Reference: *Dawson, Noller, Seale, Skinner*

At its meeting of 5 June 2012 the Medical and Community Human Research Ethics Advisory Panel was satisfied that this project is of minimal ethical impact and meets the requirements as set out in the National Statement on Ethical Conduct in Human Research. Having taken into account the advice of the Panel, the Deputy Vice-Chancellor (Research) has approved the project to proceed.

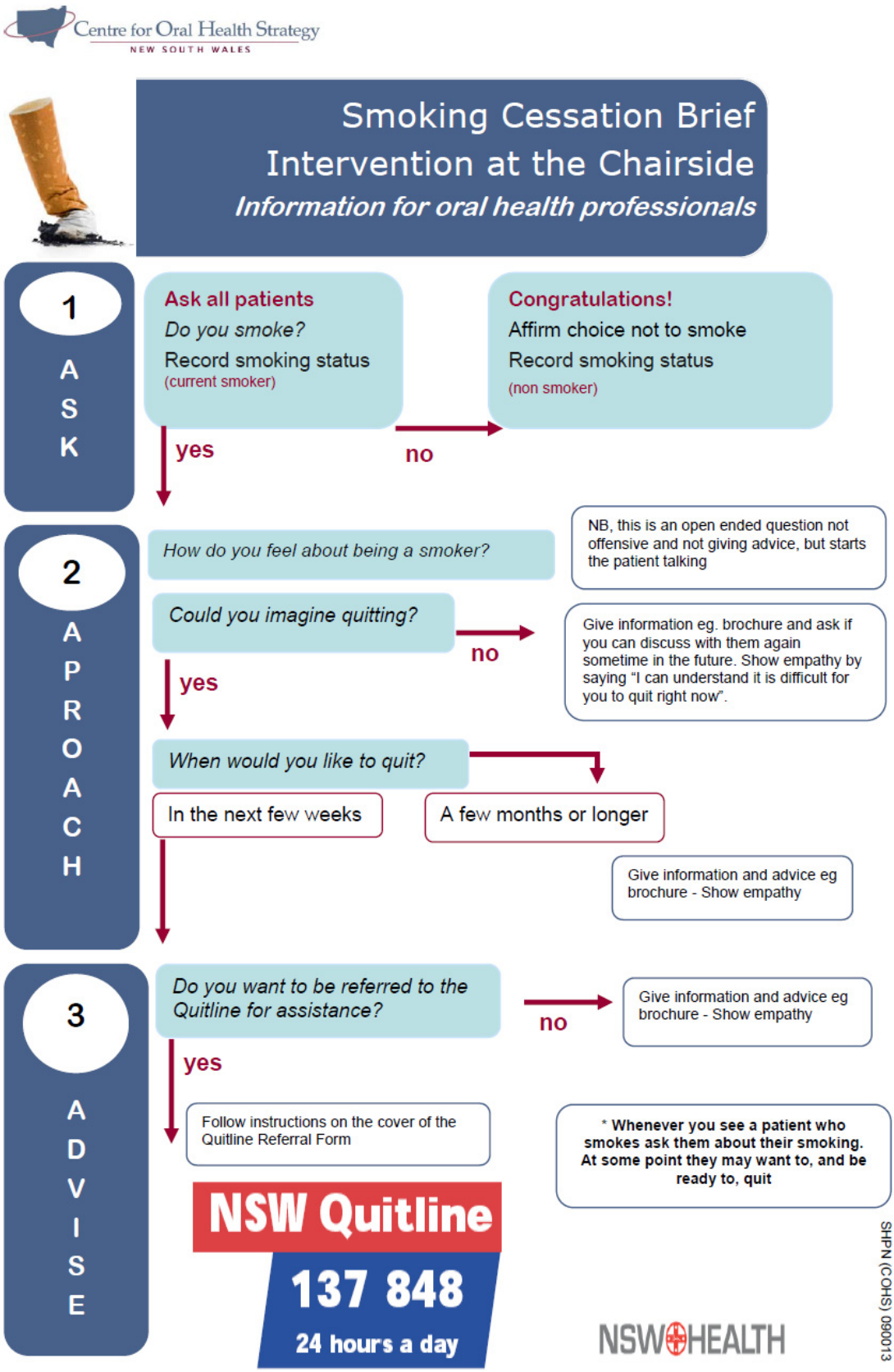
This approval is valid for 12 months from the date of the meeting. Please provide a copy of this letter to your Head of School.

Yours sincerely

A/Professor Heather Worth
Chair
Medical and Community Human Research Ethics Advisory Panel

THE UNIVERSITY OF NEW SOUTH WALES
UNSW SYDNEY NSW 2052 AUSTRALIA
Tel: +61(2) 9385 2517, Fax: +61(2) 9313 6185
Email: sphcm@unsw.edu.au
Web: www.sphcm.med.unsw.edu.au
ABN 57 195 873 179
CRICOS Provider No. 00098G

Appendix F: Training package: Smoking cessation intervention flowchart



Appendix G: Resource distribution unit order form

Centre for Oral Health Strategy
NEW SOUTH WALES

NSW HEALTH

Resource Distribution Unit
ORDER FORM

Distribution Unit	**THE CENTRE FOR HEALTH ADVANCEMENT**
Supplying publications for:	**NSW HEALTH**
FAX	02 9879 0994
PHONE	02 9879 0443
EMAIL	tobinfo@doh.health.nsw.gov.au
Resource Distribution Unit, Bldg 41, Old Gladesville Hospital, Victoria Rd, Gladesville NSW 2111	

Quit Kits & Quit resources			**QTY**
Quit Kits	Quit Kit - information for smokers to quit	**QMAN07**	
Quit Book	Quit Because You Can	**QNB01**	
Quit Information	Choosing the best way to Quit	**070501**	
Brochure	Quitline brochure	**040129**	
Brochure	Products to help you quit smoking	**010062**	
Brochure	Smoking & Your Oral Health		
Stickers	Smoking Cessation Advice Given		
Guide	Quit pocket guide	**QWB01**	
DVD	Health Smart Nicotine Replacement Therapy -explanation & treatment	**060085**	
VIDEO	Health Smart Nicotine Replacement Therapy -explanation & treatment	**040105**	
DVD	Quit Stories - People and their Quit Stories, and more.	**040107**	
Cessation Fact Sheet - For General Use and Health Professionals			
Fact Sheet - printed	Car and home smoke free zone	**040058**	
Fact Sheet - printed	Cardiovascular Disease and smoking	**040056**	
Fact Sheet - printed	Nicotine & other poisons	**040057**	
Fact Sheet - printed	Supporting someone to quit	**040061**	
Fact Sheet - printed	Benefits of quitting	**04141**	
Fact Sheet - printed	Getting ready to quit	**060180**	
Fact Sheet - printed	Nicotine dependence and withdrawal	**04039**	
Fact Sheet - printed	Smoking & Pregnancy	**040137**	
Cessation - Online Multi Cultural Communication - For General Use and Health Professionals			
NRT Brochure	Products to help you quit smoking - in different languages (see website:)		**online only**
	http://www.mhcs.health.nsw.gov.au/mhcs/topics/Smoking.html		
Cessation Poster - For General Use and Health Professionals			
NTC Posters **A2** (60cm x 42cm) A2	Eye - macular degeneration	**020681**	
NTC Posters **A2** (60cm x 42cm) A2	Lung tumour	**020684**	**out of stock**
NTC Posters **A2** (60cm x 42cm) A2	Thinking of quitting - let us talk..	**020688**	
NTC Posters **A2** (60cm x 42cm) A2	Aorta	**020685**	
NTC Posters A3 (42cm x 30cm) A3	Aorta	**QNPA01**	**out of stock**
NTC Posters A3 (42cm x 30cm) A3	Brain	**QNPB03**	
NTC Posters A3 (42cm x 30cm) A3	Lung Tumour (Multilingual) (A3)	**QNPL02**	
NTC Posters A3 (42cm x 30cm) A3	Kids are fast learners	**07801**	
NTC Posters A3 (42cm x 30cm) A3	When you smoke you inhale over 4,000 chemicals	**07802**	
Poster A3 (42cm X 30cm)	Lady Killer (Cancer Institute)	**040604**	
Posters Misc.	WNTD - generic black & white - earth crushes cig.	**WNTD01**	

Centre for Oral Health Strategy NEW SOUTH WALES

NSW HEALTH

ETS - Car & Home Smoke Free Zone - For Parents and Carers of Young Children			
Car & Home Smoke free Zone	ETS- Car & Home smoke free zone ATSI Poster	**040601**	
Car & Home Smoke free Zone	ETS- Car & Home smoke free zone ATSI Brochure	**040602**	
Parents	ETS- Car & Home smoke free zone Brochure	**020695**	
Car & Home Smoke free Zone	ETS- Car & Home smoke free zone poster A1 (84cm X 60cm)	**030698**	
Car & Home Smoke free Zone	ETS- Car & Home smoke free zone Multilingual Poster (A3)	**030697**	
Car & Home Smoke free Zone	ETS- Car & Home smoke free zone brochure - Arabic	**040607**	
Car & Home Smoke free Zone	ETS- Car & Home smoke free zone brochure - Chinese	**040608**	**out of stock**
Car & Home Smoke free Zone	ETS- Car & Home smoke free zone brochure - Greek	**040609**	
Car & Home Smoke free Zone	ETS- Car & Home smoke free zone brochure - Italian	**040610**	
Car & Home Smoke free Zone	ETS- Car & Home smoke free zone brochure - Spanish	**040611**	
Car & Home Smoke free Zone	ETS- Car & Home smoke free zone brochure - Vietnamese	**040612**	
No Smoking Signs - For Personal Use and Smoke-free Workplaces			
Sticker	International No Smoking Symbol - large 15cm circle	**QST01**	
Sticker	International No Smoking Symbol - small 7 cm circle	**QST02**	
Sticker	Symbol + words "No smoking" 11cm W X 21cm H	**QST07**	
Sticker	Symbol + words "Smoke Free Zone" 15cm W X 23 cm H	**QST08**	
Sticker	Symbol + words "Quitline 13 7848"	**060109**	
Cessation - Health professionals			
Cessation guides / Health Professionals	Let's take a moment quit smoking brief intervention - a guide for all health workers	**050162**	
Health professionals	*Let's take a moment* quit smoking brief intervention - flow chart	**050163**	
Health professionals	Management of nicotine dependent inpatients - flow chart	**020010**	
Health professionals	Management of nicotine dependent inpatients - summary of evidence	**020009**	**online only**
Health professionals	Quitline FAX referral forms - pad	**0440621**	
Quit DVD	Health Smart NRT DVD with subtitles - 8 languages	**060085**	
Quit Video	Health Smart NRT Video	**040105**	
Guidelines	National Clinical Guidelines for the Management of Drug Use During Pregnancy, Birth and the Early Development Years of the Newborn	**060002**	

Contact Name	**PHONE**	
Organisation		
Department		
Address Detail (Unit/Bldg/Level/Ward):		
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