



Quit for new life



Promising service models

Smoking during pregnancy is a NSW Health priority because of the increased risk of health problems for the developing baby. Aboriginal mothers' smoking in pregnancy has decreased by a third over the last generation. Further efforts are needed to build on this improvement, as over 40% of Aboriginal women continue to smoke tobacco when pregnant.

The NSW Ministry of Health funded the implementation of the *Quit for new life* initiative (QFNL) by local health districts (LHDs) from 2013-2018. QFNL was designed to embed best-practice smoking cessation care in routine service delivery for women having an Aboriginal baby.

This snapshot outlines three promising QFNL service models, including key features, strengths, challenges and sustainability. These models may be a good source of practical ideas for service managers.

QUIT FOR NEW LIFE

QFNL was designed to strengthen tobacco cessation care provided by clinical services in contact with women who smoke (or recently quit) and who are having an Aboriginal baby.

Objectives of QFNL

- Build **capacity** of maternal, and child and family health, services for evidence-based tobacco cessation as part of routine care for all eligible clients.
- Provide **smoking cessation care** and support to eligible clients.
- Reduce clients' **exposure to second hand smoke** at home.
- Reduce smoking **relapse**.

Core QFNL interventions

Under QFNL, brief advice plus 'core interventions' are offered to eligible clients at all maternal, and child and family health, service visits to support quitting and prevent smoking relapse. Core interventions are:

- referral for behavioural counselling to a tobacco treatment specialist (e.g. NSW Quitline)
- support (e.g. follow up and/or advice on nicotine replacement therapy (NRT) if clinically appropriate).

Culturally appropriate advice

QFNL builds on the strength of Aboriginal culture and acknowledges the social context of smoking in Aboriginal communities. Involvement by Aboriginal Maternal and Infant Health Services (AMIHS) and Building Strong Foundations for Aboriginal Children, Families and Communities (BSF) services support a culturally-responsive approach.



THREE PROMISING QFNL SERVICE MODELS

Participating LHDs implemented QFNL to suit local needs. Each LHD developed a QFNL 'sustainability plan' to guide the transition of clinical practice change beyond the funding period. Features of three promising QFNL service models are outlined below.

The NSW Ministry of Health and LHDs supported local service implementation of QFNL in various ways. These included training, policies, guidelines, procedures, consumer publications, free NRT, data monitoring, networking and governance. Services could also refer to the Aboriginal Quitline for extended, culturally-appropriate behavioural counselling and follow-up.

NORTHERN NSW LOCAL HEALTH DISTRICT (NNSW): REFERRAL MODEL

LHD CONTEXT

NNSW is a geographically large regional area with about 15,000 Aboriginal people, which is around 5% of the LHD's population.

REFERRAL MODEL

In NNSW staff from maternal, and child and family health, services referred women identified as smokers to a centralised QFNL team consisting of a manager and two health promotion officers with clinical backgrounds.

KEY FEATURES

- Referring health professionals trained to initiate a smoking cessation discussion and refer to a centralised QFNL team.
- QFNL team mostly contacted clients by phone.

WHY THIS MODEL?

- Large geographic area covered by NNSW LHD.
- To reduce time burden on midwives and AMIHS staff.



BENEFITS

- Centralised QFNL team trained in evidence-based cessation.
- Team appreciated dedicated time for cessation care as it allowed them to build rapport and deliver higher quality practice.
- Team valued opportunity to assist householders with quitting, and help create a “smoke-free” environment for their clients.



CHALLENGES

- Despite strong efforts by a skilled QFNL team, there was limited success with capacity building of referral staff and engagement with clients through phone counselling.
- Short-staffed clinics and high staff turnover often meant that staff lacked time to support smoking cessation. Many staff lacked confidence in addressing smoking.
- Team members reported that some clients considered smoking a relatively less important problem.

SUSTAINABILITY

- Opt-out referral model was trialled. This model took the form of a specialist outpatient cessation clinic called *You Me & Baby Smokefree*.
- The trial was successful and the clinic has been approved to continue.
- Key features of this model in NNSW were that:
 - it was for ALL pregnant women who smoke
 - eligible women were referred to the clinic unless they chose not to be
 - QFNL was embedded and delivered by an Aboriginal midwife (an identified position)
 - it offered face-to-face support, as well as phone support
 - it was resourced via activity-based funding which was predicted to cover the cost of two full-time nurses
 - the clinic is being transitioned to Drug and Alcohol services.



BENEFITS OF NEW MODEL

- Central clinic with champions at other locations who meet women face-to-face.
- Staff could offer many clients extra service such as samples of different types of NRT and carbon monoxide (CO) breath expiry monitor readings.
- Staff were happier as a result of a less taxing, more satisfying approach.
- Staff described an increase in the number of clinicians referring.

SOUTH WESTERN SYDNEY LOCAL HEALTH DISTRICT (SWS): REFERRAL MODEL

LHD CONTEXT

SWS is a metropolitan LHD with a large geographic area and around 17,000 Aboriginal people (about 1.8% of the LHD's population).

REFERRAL MODEL

At least one individual is employed to provide smoking cessation advice. In SWS staff from maternal, and child and family health, services referred women identified as smokers to the Smoking Care Advisor (SCA) (an identified Aboriginal position) to receive cessation support.

KEY FEATURES

- Very positive response by staff and clients to the temporary appointment of an SCA with a home visiting option.
- SCA received referrals from healthcare providers, as well as through other programs, events and word-of-mouth.
- Referred women received follow-up phone call and ongoing support through face-to-face counselling and NRT. Home visiting was offered.
- Model included use of a CO breath expiry monitor, tangible incentives for quit milestones (e.g. baby hats) and flexible scheduling of appointments/re-entry to the program.

WHY THIS MODEL?

- To reduce the additional time burden on clinic staff.
- To allow continuous smoking cessation care (often limited due to competing demands in the clinic, and staff turnover).
- Smoking cessation is complex and requires ongoing support.
- To engage household members who smoke to support the client through a smoke-free home and car.



BENEFITS

- Provides a central point of referral.
- Timeliness and flexibility for clients, household members and referring clinics.
- SCA was in a strong position to champion cessation care, provide culturally-appropriate support, provide referring health professionals with training, troubleshooting and support, as well as offer home visits.
- Home visits were more acceptable to clients than helplines and provided an opportunity to:
 - involve household members who smoke
 - assist clients and cohabitants to obtain free NRT
 - encourage a smoke-free home and show how to achieve this.



“Being Aboriginal, [the SCA] is known in the community, and has that rapport as well, or people are often open to building that rapport with her.” (Stakeholder comment)

CHALLENGES

- Some referring health professionals lacked awareness of QFNL and appropriate cessation strategies, particularly on how to conduct a conversation about smoking.
- High staff turnover in referring services and time pressures.
- Clients preferred to see a health professional in person instead of using the NSW Quitline.
- SCA could distribute vouchers for free NRT but was unable to supply NRT direct due to health policy guidelines requiring clinical expertise.



SUSTAINABILITY

- LHD business case demonstrated a decline in local smoking rates in line with the 2% annual target under QFNL which lead to decision to fund a permanent full-time Aboriginal SCA position.
- This position was transitioned to local Drug and Alcohol services and the Substance Use in Pregnancy Program (SUPPS).
- Stakeholders perceived a drop in client referrals and a fall-off in acceptance of QFNL after the end of the program funding period in mid-2018. SWS elected to fund free NRT for their QFNL clients.



HUNTER NEW ENGLAND LOCAL HEALTH DISTRICT (HNE): CAPACITY BUILDING MODEL

LHD CONTEXT

HNE comprises a very large geographic area with many maternity services. It is home to approximately 53,000 Aboriginal people, which is close to 6% of the LHD's total population.

CAPACITY BUILDING MODEL

In this model QFNL is integrated into the role of all existing staff in maternal, and child and family health, services.

KEY FEATURES

- There was investment in existing AMIHS, BSF and New Directions services to increase their capacity to provide smoking cessation support.
- One manager and two full-time support officers were employed to support implementation of QFNL in the funding period only.
- Clients who identified as smokers received cessation support during regular antenatal or postnatal appointments. Training was provided to clinic staff and implementation was guided and monitored by health behaviour researchers.
- Clinic staff provided NRT, referrals to the NSW Quitline, as well as continuing support through short-term goal setting, practical tips and behavioural counselling. Additional phone contact or follow-up appointments could be made if needed.
- The original *stages of change* approach was reviewed and revised to a *Swap to Stop* approach in which support is offered directly regardless of readiness to quit.



WHY THIS MODEL?

- Large size of the LHD and funding constraints for employing multiple SCAs.
- Invested in training existing staff to continue best-practice cessation as part of routine care beyond the funding period.

BENEFITS

- Building the capacity of existing services to deliver cessation care (e.g through staff training, policy, protocols and KPIs).
- A decentralised approach as needed for this large LHD.

CHALLENGES

- Limited opportunity to provide additional follow-up outside of the standard schedule of visits.
- Clients' preference was for face-to-face support and the NSW Quitline was not often utilised.

SUSTAINABILITY

- Funds for new positions were not required.
- Cessation is not dependent on dedicated staff positions.
"We're offering it, we're still passionate ... it's built into our everyday work." (Stakeholder comment)
- Strategies used to build capacity included: group activities to create ongoing team spirit; training; methods to collect data and generate feedback; clinical guidelines for provision of NRT and use of CO breath expiry monitors; and embedding KPIs in management reporting.
- Towards the end of funding, support officers gradually ended their assistance, rather than stopping abruptly.
- HNE elected to continue to supply free NRT under their routine service budget for QFNL clients after the funding period.



Also see the short video **Sustaining Quit for new life – three promising case studies** and other resources related to smoking during pregnancy at www.health.nsw.gov.au/tobacco



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