Final Report

The NSW *SmokeCheck* Aboriginal Tobacco Prevention Project

2007 - 2008

NSW HEALTH

cancer institute NSW

THE UNIVERSITY OF SYDNEY

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The Final Report of the NSW *SmokeCheck* Aboriginal Tobacco Prevention Project 2007-2008

Sydney School of Public Health, The University of Sydney

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Acknowledgements

Many organisations and people have contributed to the NSW *SmokeCheck* Aboriginal Tobacco Prevention Project.

We would like to acknowledge the support of NSW Health and the Cancer Institute NSW. While our thanks also go to the many Aboriginal health workers, and other health professionals whose enthusiastic participation in the *SmokeCheck* training workshops gave meaning to the Project, and its goal to strengthen the capacity of services to reducing smoking rates in Aboriginal communities.

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Executive summary

Tobacco smoking is the leading cause of death and the greatest contributor to the burden of disease amongst Aboriginal populations in Australia (Penm 2008, p.39). Rates of smoking in NSW Aboriginal communities are more than double those of other Australians (Australian Bureau of Statistics & Australian Institute for Health and Welfare 2008, p.65).

In response, Aboriginal people have been identified as an "at risk population" in the *NSW Tobacco Action Plan 2005-2009*. The objectives of this plan include reductions in tobacco-related morbidity and mortality among Aboriginal people and the implementation of *SmokeCheck*.

The NSW *SmokeCheck* Project was established in 2005 in collaboration between the NSW Department of Health, the Cancer Institute NSW, and the Australian Centre for Health Promotion at The University of Sydney. The *SmokeCheck* intervention is an evidence-based smoking cessation brief intervention designed to assist Aboriginal people who smoke to quit. Following pilot testing to confirm the efficacy of the intervention a statewide program was established to train all Aboriginal health workers (AHWs) and other health professionals in NSW who work primarily with Aboriginal clients and communities to deliver the *SmokeCheck* intervention. Health service managers were also provided with training to encourage and support them to integrate the *SmokeCheck* intervention into the routine practice of their services and to support their staff in the delivery of the intervention.

The *SmokeCheck* intervention is an Aboriginal-specific smoking cessation brief intervention based on the trans-theoretical model and motivational interviewing. Following pilot testing of the brief cessation program and written resources, the NSW Department of Health and the Cancer Institute NSW contracted the Australian Centre for Health Promotion to train all AHWs and other health professionals in NSW who work with Aboriginal clients to deliver the *SmokeCheck* intervention to each of their Aboriginal clients who smoke. The training program aimed to maximise the health professionals' understanding of smoking and its impact on the health of Aboriginal communities, and to increase their knowledge, skills and confidence in advising clients who smoke to quit and in providing them with appropriate support and encouragement to quit.

A comprehensive evaluation of the *SmokeCheck* Project's training program included process measures and a quasi-experimental design to assess the extent to which the training program met its intended objectives and hence, its impact.

The *SmokeCheck* training workshops were successfully delivered across NSW to health professionals who work in Area Health Services, in non-government organisations and in community-based organisations. In all, 519 people were trained in 63 workshops, including 35 per cent (n=199) of the NSW AHWs workforce. Forty eight per cent (n=250) of the participants identified themselves as Aboriginal. The process evaluation confirmed that the training was very well received by both health professionals and managers.

The results of the impact evaluation found statistically significant increases (p= 0.000) in the proportion of participants who reported (after the training) increased confidence in:

1. Talking to their clients about the health effects of smoking increased by 22 per cent (from 53% to 75%)

2. Raising the possibility of 'quitting' with clients making health visits for unrelated health reasons increased by 27 per cent (from 43% to 70%)

3. Assessing clients' stage of change for smoking cessation/readiness to quit doubled (from 31% to 62%)

4. Raising smoking as a point of discussion with clients increased by 24 per cent (from 42% to 66%).

There were statistically significant increases (p=0.034) in the number of health professionals:

1. Providing advice about nicotine replacement therapy (NRT) increased by 15 per cent (from 51% to 66%)

2. Providing advice/information about environmental tobacco smoke increased by 12 per cent (from 37% to 49%)

3. Providing advice on cutting down tobacco use by 10 per cent (from 55% to 65%).

Importantly:

- AHWs' perceptions of the importance of offering smoking cessation advice to their Aboriginal clients increased by 9 per cent (from 87% to 96%) (p=0.07) and AHWs' perceptions that it is easier to offer this advice after participating in a *SmokeCheck* training workshop increased by 25 per cent (from 33% to 58%) (p=0.039)

- Number of AHWs who live in smoke free homes increased by 11 per cent (84% to 95%) (p=0.045)

- Availability of culturally appropriate written resources to support clients to quit increased by 19 per cent (41% to 60%) (p=0.000).

The results demonstrate that, in one year, the *SmokeCheck* training program reached a total of 519 health professionals employed in Aboriginal Community Controlled Health Services and Area Health Services in NSW. The training was received by 199 (35%) of all the AHWs employed in NSW. Furthermore, the findings confirm that the *SmokeCheck* training program reached a high proportion of the workforce that delivers services to Aboriginal clients with sufficient intensity to achieve a statistically significant, positive impact on their knowledge, skills and confidence. This is a vital prerequisite for the subsequent routine delivery of the *SmokeCheck* intervention to their clients. The results also pointed to the need for organisational development on the part of health services to ensure that smoking cessation becomes a standard component of AHWs and other health professionals' clinical and health promotion roles. These findings will assist and inform future Project and policy development and progress towards a reduction in Aboriginal smoking prevalence in NSW.

We are pleased to present to you a summary of the Final Report for Phase One of the *SmokeCheck* Project.

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Acronyms

ACCHO	Aboriginal Community Controlled Health Organisation
ACCHS	Aboriginal Community Controlled Health Service
ACCHRS	Aboriginal Community Controlled Health Related Service
ACHP	Australian Centre for Health Promotion
AH&MRC	Aboriginal Health and Medical Research Council
AHS	Area Health Service
AHW	Aboriginal Health Worker
AMA	Australian Medical Association
AMS	Aboriginal Medical Service
ETS	Environmental Tobacco Smoke
GSAHS	Greater Southern Area Health Service
GWAHS	Greater Western Area Health Service
HNEAHS	Hunter New England Area Health Service
NACCHO	National Aboriginal Community Controlled Health Organisation
NCAHS	North Coast Area Health Service
NGO	Non-Government Organisation
NRT	Nicotine Replacement Therapy
NSCCAHS	Northern Sydney Central Coast Area Health Service
NSW	New South Wales
NSW Health	New South Wales Department of Health
PAC	Partnership for Aboriginal Care
SESIAHS	South Eastern Sydney Illawarra Area Health Service
SSWAHS	Sydney South West Area Health Service
SWAHS	Sydney West Area Health Service
TobNet	NSW Tobacco Control Network

Introduction

This report contextualises the high smoking rates in NSW Aboriginal communities and provides a detailed description of the development and implementation of the NSW *SmokeCheck* Project. This Project provided an evidence based smoking cessation training program for health professionals with a professional responsibility to assist Aboriginal people who may be thinking about making a quit attempt. The description of the Project is offered as a constructive contribution to a field in which research evidence remains limited, and in the hope that it extends understandings of a smoking cessation intervention with the potential to contribute to reducing smoking rates in Aboriginal communities.

A primary focus of the report is a discussion of the *SmokeCheck* Project, outcomes and the processes lead to the achievement of these. From the Project's inception, these processes have played a critical role in shoring up support and engaging health and other services across both the Aboriginal Community Controlled Health Service and NSW Area Health Service sectors. Importantly it is the relationships established with health services that lead to the recruitment of over 500 health professionals to the *SmokeCheck* training workshops, and the development of partnerships to address smoking in Aboriginal communities.

Another significant component of the report is an outline and discussion of the research findings arising from the Project's qualitative and quantitative survey evaluations. Surveys assessed a range of criteria including: smoking status and behaviour, smoking in the home and workplace, intentions to quit smoking, confidence in the delivery of a brief smoking cessation intervention and in assessing clients' stage of motivation to quit smoking. In addition to surveys, a semi-structured questionnaire evaluated participants' feedback about the relevance and applicability of workshop information to practice, and to the *SmokeCheck* resources.

In presenting this report the *SmokeCheck* Project Team acknowledges the unstinting commitment of the many health professionals working to make a difference in Aboriginal communities and the time they gave to participate in the training program. In particular the Team recognises Aboriginal health workers (AHWs) and their critical role in offering clients smoking cessation advice and support. It has been the invaluable insights of AHWs and their willingness to share their stories and experiences that have assisted us to more completely grasp the complexities associated with tobacco use in Aboriginal communities.

A range of specific terms are used throughout the report to discuss both tobacco use amongst Aboriginal people and service provision as it is associated with this field of health care. A key term that requires clarification is 'Aboriginal' which is used to refer to Aboriginal people. The term acknowledges that Torres Strait Islanders are a separate people, and Aboriginal people the original inhabitants of NSW. Other terms used regularly are defined in the Glossary/Acronyms.

The Report is organised in five sections:

Section 1: The Project

Section 2: NSW *SmokeCheck*: Evidence based smoking cessation intervention

Section 3: Research evaluation

Section 4: Results

Section 5: Discussion and recommendations.

SECTION 1

The project

Section summary

This section details the context and background of the *SmokeCheck* Project. It begins with a discussion of the relationship between social and economic wellbeing, the social determinants of health, health effects of tobacco, and the high rates of smoking in NSW Aboriginal communities which are estimated to be more than double those of other Australians (Australian Bureau of Statistics & Australian Institute for Health and Welfare 2008, p.65). The inherent need for AHW education and training is highlighted, as it plays a crucial role in the development of a specifically targeted initiative to reduce smoking rates amongst Aboriginal people who are some of the most socio-economically disadvantaged and health compromised people in NSW.

The *SmokeCheck* Project has as its major focus the development of a training program in evidence based, best practice smoking cessation brief intervention for AHWs and other health professionals working primarily with Aboriginal communities. Its goals, objectives and outcomes seek to reduce tobacco related morbidity and mortality of Aboriginal people in NSW.

The Project was introduced by the NSW Department of Health as a key strategy for reducing smoking rates amongst Aboriginal people and building the capacity of AHWs and other health professionals in NSW.

Project management took a strategic approach, and sought to engage with the maximum number of health professionals, services and communities, and to maintain as much flexibility as possible. Strategies focused on ensuring the *SmokeCheck* smoking cessation brief intervention training reached all NSW Area Health Services and Aboriginal Community Controlled Health Services and maximised the participation of as many health professionals as possible, with a primary responsibility for the health care of Aboriginal clients. A research evaluation study was also an integral component.

The Project framework encompassed identifying sites, developing a comprehensive contact database, determining the denominator of AHWs in NSW, developing manager workshops, planning a workshop schedule, and offering two rounds of training workshops to satisfy demand.

1.1 Introduction

This section introduces the NSW *SmokeCheck* Project. The section begins with a description of the context of tobacco use in Aboriginal communities with a focus on four key elements including the NSW Aboriginal population, social and economic wellbeing, the health effects of tobacco and AHWs education and training. This is followed by an outline of the development of the *SmokeCheck* Project and discussion of some management issues. The section concludes with a detailed description of the Project's framework.

1.2 Context / background

1.2.1 Population

Population data is a useful indicator for understanding the size and scope of the health needs of specific population groups. In NSW for example, Aboriginal people comprise the largest resident Aboriginal population (29%) of any Australian state or territory (ABS & AIHW 2008, p.4). Within this population of approximately 134,888 people, 40 per cent are younger than 15 years of age, with a progressive decline by 5-year age group, a life expectancy of 59 years for males and 65 years for females, and mortality rates highest amongst those aged between 35-54 years. This is in contrast to the non-Aboriginal population, in which approximately 20 per cent of people are aged less than 15 years with no decline until after the age of 55 years, resulting in a greater life expectancy of 77 years for all males and 82 years for all females (ABS & AIHW 2008, p.4). With smoking rates in Aboriginal communities double those of other sectors of the population, this population data provides some indication of the extent of the problem.

The NSW Population Health Survey offers more specific evidence. It shows for example, that between 2002 and 2005, 43.2 per cent of Aboriginal adults were current smokers, with the highest prevalence found amongst young adults, specifically males aged 16-24 years, and especially those residing in rural areas where rates were

44.4 per cent compared to 41.2 per cent in urban areas (NSW Department of Health 2006, p.20). Moreover, high smoking rates were also found amongst Aboriginal women who were pregnant, with more than half of this group smoking during pregnancy – a proportion three times that of all pregnant women in NSW in 2004 (NSW Department of Health 2005c, p.43). The *NSW Chief Health Officer's Report 2008* states that 'Aboriginal mothers and babies… continue to experience worse outcomes than other[s]' (NSW Health 2008, p.98).

In light of these statistics and projections of an increase in the Aboriginal population, the development of specific and targeted projects such as the NSW *SmokeCheck* Project is arguably well justified.

1.2.2 Social and economic wellbeing

The associations between education, employment and income as predictors of a population's socioeconomic wellbeing and health are complex, and not sufficiently explained (Carson, Dunbar, Chenall & Bailie 2007, p.137). International research however, indicates that the number of years of formal education, as well as the qualifications people achieve are associated with positive physical functioning and perceived health (Biddle 2007, p.5). In Australia, The *Health and Welfare of Australia's Aboriginal and Torres Strait Islander People 2008*, reports higher levels of educational attainment are associated with improved health outcomes (ABS & AIHW 2008, p.23). In relation to tobacco use, research about the relationship between the social determinants of health and smoking amongst Aboriginal people finds the most socio-economically disadvantaged Aboriginal people are the least likely to be non smokers (Thomas, Briggs, et al 2008, p.110). Importantly, this same research notes that within Aboriginal populations, it is the elevated numbers of disadvantaged people who ever start smoking, and not the smaller numbers who quit, that explain the higher smoking rates (Thomas et al, 2008, p.115).

Some research suggests that associations between socio-economic status and smoking are not necessarily causal, making the point that Aboriginal people may be more likely to smoke as a consequence of a possible reluctance, or inability to quit (Wise, Hickey & Palmer 2007, p.14) or perhaps because smoking is not perceived as a health priority amongst the many other health issues that demand attention. Other research describes the complex interplay of smoking in Aboriginal populations and stress, and 'the pervasiveness of stress as a significant barrier to cessation' (DiGiacomo, Davidson, et al 2007 p.174).

In many Aboriginal communities where stress is a lived daily reality it is therefore not surprising that smoking rates remain high.

Chapman (2007) also warns about making a causal link between socio-economic status and the inevitability of smoking, and proposes that taking such a position miscalculates disadvantaged populations and their 'responsiveness to the same factors that have reduced smoking in all social strata' (p.201).

With the fact that no reduction in smoking rates amongst Aboriginal communities, ongoing requests for support to quit (Lindorff 2002, p.49), and evidence that brief advice can help 6 per cent of smokers to quit (Ivers 2000, p.65), attention should not be diverted from this population. Special efforts are needed to reduce smoking rates amongst Aboriginal people who are amongst some of the sickest, most socio-economically disadvantaged people in Australia.

The effects of high rates of smoking also manifest in the economic and social wellbeing of Aboriginal families and communities. The spiralling cost of tobacco products for example erode family budgets while medical care for complex and chronic tobacco related health conditions such as cardiovascular and respiratory disease is an added community cost. On the other hand, the social impact of tobacco related diseases on Aboriginal families and communities may be experienced in pain and suffering, and the loss of cultural knowledge and human capital as well as community capacity and productivity, as people become chronically ill and disabled or die prematurely (Collins & Lapsley 2005, p.12). This is also the case when Aboriginal children are diagnosed with tobacco related health conditions such as otitis media, pneumonia or asthma, with social costs including family disruption, and/or breakdowns in community networks as children are absent from school when sick or seeking treatment away from home.

1.2.3 Health effects of tobacco

Tobacco smoking is the leading cause of death and greatest contributor to the burden of disease amongst Aboriginal populations in Australia, with an estimated one in four Aboriginal people aged over 18 years with cardiovascular disease also indicating former smoker status (Penm 2008, p.39). Specifically, the direct inhalation of tobacco smoke increases the risk of a number of conditions including coronary heart, cerebro-vascular and respiratory disease, as well as a range of cancers. This disease burden in Aboriginal communities is obvious in hospital separation data which estimates that tobacco smoking contributes to more drug related hospitalisations and deaths than alcohol and illicit drug use combined (ABS & AIHW 2008, p.138), although this may be an underestimate, with only 56 per cent of Aboriginal deaths registered accurately (SCRGSP 2007, p.3.2).

The health effects of tobacco on infants also contributes to higher rates of Aboriginal morbidity and mortality, with increased risks of low birth weight, sudden infant

death and respiratory illness recorded for Aboriginal babies born to mothers who smoke (Graham, Jackson Pulver, et al 2007, p.511). Similarly, environmental tobacco smoke (ETS) impacts not just on the health of non smokers but also that of infants and children. Although recent legislation has reduced the potential for ETS to impact on the health of non smokers, and in particular on children who are less able to advocate on their own behalf, the links to respiratory infections such as asthma, and pneumonia, and higher rates of otitis media amongst Aboriginal children (Jacoby, Coates, et al 2008, p.599) should not be underestimated.

1.2.4 Aboriginal health worker education and training

The education and training of AHWs was another contextual issue considered by the *SmokeCheck* Project. In the field of Aboriginal health where health promotion plays such an important role, sustainable skills and competencies are '… essential for the growth of health promotion as a discipline and for its practitioners to be increasingly effective as social change agents' (Keleher & Joss 2007, p.235). This is especially true for AHWs who fulfill crucial roles particularly in advocacy and health promotion, and who are often the first contacts in front line health service provision to communities. But to undertake these roles effectively AHWs also require access to education and training. As AHWs themselves point out "increased educational opportunities and appropriate career pathways and remuneration are a priority of Aboriginal organisations and are urgently needed to allow the ongoing development of AHWs as a profession and to attract more Aboriginal people into this important work" (Abbott, Gordon & Davison 2008, p.161).

1.3 Project development

The NSW *SmokeCheck* Project was developed in response to the concerns of NSW Health about the high rates of smoking in NSW Aboriginal communities. In 2002 these concerns were discussed at a forum to identify priorities, including the need to:

- Increase the capacity and skills of all health professionals to deliver best practice smoking cessation intervention
- Encourage AHWs to quit smoking.

Later that same year an Aboriginal Tobacco Control Advisory Committee was established with representation from:

- Aboriginal Health & Medical Research Council of NSW (AH&MRC)
- Centre for Aboriginal Health, NSW Department of Health
- Aboriginal Workforce Development Unit, NSW Department of Health
- Area Managers of Aboriginal Health
- NSW Aboriginal Chronic Care Program, NSW Department of Health
- Drug Programs Bureau
- Centre for Health Advancement, NSW Department of Health
- National Heart Foundation of Australia (NSW Division).

The subsequent release of the *NSW Tobacco Action Plan 2005-2009* and its identification of Aboriginal people as an 'at risk population' reflected the commitment of NSW Health to reduce tobacco use amongst this 'target group' (NSW Department of Health 2005a, p.15). The Plan's six 'Focus Areas' specified a comprehensive series of implementation activities, timeframes and an evaluation, and introduced the *SmokeCheck* Project as a key strategy for reducing smoking rates amongst Aboriginal people in Focus Areas 1 and 2.

Specifically, Focus Area 1: Smoking Cessation, states that its objective is to 'reduce the number of people in NSW who smoke', and recommends the implementation of:

> *'the SmokeCheck tobacco control program for Aboriginal and Torres Strait Islander peoples providing Aboriginal health workers training in evidence based brief intervention, ETS and related family and community protection issues and strategies, tobacco control legislation, and prevention strategies at local level' (NSW Department of Health 2005a, p.24*)

The objective of Focus Area 5: 'Capacity Building' is 'to increase the capacity of NSW Health to contribute to the administration and implementation of the *NSW Tobacco Action Plan 2005-2009* so that the harm associated with the use of and exposure to tobacco products is reduced'. This Focus Area specifies the need to:

'Build the capacity of Aboriginal health workers and non-aboriginal health workers who work with Indigenous communities in NSW in the delivery of evidence based best practice smoking cessation interventions through the implementation of the pilot training program – *SmokeCheck*' (NSW Department of Health 2005a, p.38).

To meet the objectives of this Plan, the NSW Department of Health developed the *SmokeCheck* Aboriginal tobacco prevention project, the major focus of which was the

development of a training program for AHWs and other health professionals working primarily with Aboriginal communities. The development of this program began with the NSW Health evidence based smoking cessation guidelines *'Let's take a moment, quit smoking brief intervention – a guide for all professionals'* which were used to inform a training presentation and the design of a set of smoking cessation resources specifically for Aboriginal clients. With the completion of this preliminary work and new funding from the NSW Department of Health and the Cancer Institute NSW, a Project brief was forwarded to the Australian Centre for Health Promotion (ACHP), School of Public Health at The University of Sydney for consideration. In response to the brief, a Project proposal was elaborated outlining the Project's goal, objectives and desired program outcomes as well as a research component to evaluate the effectiveness of the *SmokeCheck* training on the capacity and skills of health workers in NSW to deliver best practice smoking cessation interventions.

A contract between the NSW Department of Health and the ACHP was subsequently negotiated for commencement in late 2006. The NSW *SmokeCheck* Project goal, objectives, program outcomes and research proposal are outlined below.

1.4 Goal, objectives and outcomes

Goal

To reduce tobacco related morbidity and mortality among Aboriginal people in NSW.

Objectives

Specifically the Project objectives were to:

1. Build the capacity of Aboriginal health workers (AHWs) and other health professionals who work predominantly with Aboriginal communities in NSW, in the delivery of evidence based best practice smoking cessation interventions

2. Build the capacity of AHWs to plan, implement and evaluate local tobacco health promotion projects

3. Increase awareness among Aboriginal communities and health services in NSW of tobacco related legislation

4. Increase awareness among Aboriginal communities and health services of effective strategies to minimise exposure to environmental tobacco smoke

5. Build the capacity of AHWs to train others in tobacco control

6. Increase the motivation of AHWs who smoke to quit smoking.

Outcomes

Desired program outcomes:

1. Reduced prevalence of smoking among Aboriginal people in NSW and especially among AHWs

2. Increased access to smoking cessation services

3. Increased access to and ability to use culturally appropriate tobacco control resources among AHWs

4. Establishment of new and strengthening of existing partnerships between mainstream and AHWs, particularly those working in maternal and child health services and vascular health programs

5. Uptake and implementation of the *SmokeCheck* tobacco control initiatives and resources by Aboriginal Health Units in Area Health Services and community controlled Aboriginal Medical Services (AMS) in NSW.

1.5 Project management

Management of the NSW *SmokeCheck* Project commenced with the engagement of a Project Manager and a Senior Aboriginal Trainer. Initial tasks undertaken at this time included the recruitment of an Administrative Officer, support for the Senior Aboriginal Trainer to undertake the NSW Health tobacco and smoking cessation course and preliminary research to determine the number of AHWs employed in NSW. With the introduction of a new Project Manager in June 2007 the Project moved to a new management phase to focus on the development of three priority areas, including:

1. Strategies to ensure that the *SmokeCheck* training workshops would reach as many NSW Area Health Services and Aboriginal Community Controlled Health Services as possible

2. Strategies to maximise the participation of all health professionals with a primary responsibility for the health care of Aboriginal clients in training workshops

3. In appropriate evaluation study.

Although the management of each of the above was facilitated by pre-existing relationships between the ACHP and Aboriginal communities, a range of issues still required careful consideration.

For example:

- The geographical distribution of health service provision to Aboriginal communities across NSW

- Health service types (Area Health Services, Aboriginal Community Controlled Health Services and non-government organisations)

- The specificity of service provision (specialist, generalist, clinical, comprehensive primary health care)
- The relationships/partnerships between and within health services
- The community access to health services
- Key contacts with a responsibility for tobacco control
- The number of AHW positions (filled and vacant)
- Existing Aboriginal specific tobacco control/smoking cessation programs on offer
- Existing health professional tobacco control and smoking cessation training
- Tobacco use legislation, policy, pharmaceutical & treatment developments
- Current research in tobacco control and smoking cessation
- Capacity of services to release staff to participate in training
- Training needs (skills & knowledge) of health professionals
- Capacity of services to support health professionals to implement the *SmokeCheck* intervention
- Challenges faced by health and other services to deliver the *SmokeCheck* intervention.

Managing these issues necessitated a strategic approach, critical components of which were then needed to engage with the maximum number of health professionals, services and communities, and maintain as much flexibility as possible. This required phone calls, emails, and meetings to introduce the Project and establish relationships. It also called for time to listen to practitioner's stories about front line service delivery in individual Aboriginal communities. Perhaps most importantly however it necessitated a level of resourcing to achieve the Project's objectives.

The key research principles outlined in the *Strategic Framework for Improving Aboriginal and Torres Strait Islander Health through Research* (National Health & Medical Research Council 2002, p.4) played a critical role in this approach, informing the Project's involvement with Aboriginal communities, respect for culture, explicit and consultative communication style, and adherence to ethical guidelines. The generous contributions made by individuals, services and communities, regular Project team and executive committee meetings to discuss issues in a timely manner have also played a role and ensured that the Project has stayed on track. While the knowledge of tobacco and addiction specialists, health managers, team leaders, health promotion expert through forums such as NSW Tobacco Control Network (TobNet) and Aboriginal Health Forums have helped to keep the Project oriented and up to date with current information and changes as they have occurred in the field.

1.6 Project framework

1.6.1 Identifying sites

The first step in establishing the framework of the *SmokeCheck* Project was to identify the location and number of Aboriginal Community Controlled Health Services and 'mainstream' health services (offered through NSW Health). To achieve this, the eight NSW Area Health Services were identified and plotted on a geographical wall map of the state (Appendix 1A). The eight Area Health Services are:

- Greater Southern Area Health Service (GSAHS)
- Greater Western Area Health Service (GWAHS)
- Hunter New England Area Health Service (HNEAHS)
- North Coast Area Health Service (NCAHS)
- Northern Sydney Central Coast Area Health Service (NSCCAHS)
- South Eastern Sydney Illawarra Area Health Service (SESIAHS)
- Sydney South West Area Health Service (SSWAHS)
- Sydney West Area Health Service (SWAHS).

The next step was to identify each 'mainstream' health and Aboriginal Community Controlled Health Organisation service and program within each Area Health Service with a primary responsibility for health service provision to Aboriginal people, ascertaining their size, operational and auspicing status, and programs. To assist in this process the Aboriginal Health and Medical Research Council's Aboriginal Medical Service Full Membership 2006-2008 contact list (Appendix 1B) was used. When each service was identified a phone call was made to speak to a 'key contact' to introduce and discuss the Project. Many of these phone discussions had a 'snowball' effect, wherein contacts provided the details of other services, programs and people who they thought might be interested or able to offer advice and support. The result of this consultation process was an inventory of services and key contact people who could provide advice about the organisation of *SmokeCheck* training workshops. Indeed, it was this invaluable advice that

optimised participation and ensured *SmokeCheck* training workshops were held in the most appropriate, accessible sites and venues in each Area Health Service. In Greater Western Area Health Service for example multiple contacts offered advice about the geographic enormity of the Area Health Service and its division into clusters, nominating a range of different sites for the training workshops. This resulted in a total of nine workshops, with one each held in: Menindee, Broken Hill, Dareton and Balranald in the remote cluster; Orange, Forbes, and Dubbo in the central cluster and Bourke and Coonamble in the northern cluster.

Other considerations that came to light through consultations were the need to:

- Hold workshops in "neutral" locations, this enabled services from both the Area Health Service and Aboriginal Medical Service to access the workshops making it more likely to increase participation
- Provide a conducive learning environment
- Respect the experience and knowledge of key contacts about their local communities and services and seek their advice about where to run training workshops
- Consider travel and time efficiencies, such as distance between towns, Aboriginal Medical Service and other services to ensure a central accessible location for services in surrounding areas
- Consider the appropriateness of training venues
- Be aware of other local smoking cessation training programs.

1.6.2 Database development

The development of the electronic NSW *SmokeCheck* contact database had two aims. Firstly to record the details of all key contacts (people and services) with a primary responsibility for tobacco control, health promotion, or clinical or primary health care service provision (generalist and specialist) to Aboriginal people, and secondly to record the details of all training workshops participants.

As the result of an existing relationship between the ACHP and services in Area Health Services, in particular the Partnership for Aboriginal Care (PAC) the initial database entries comprised key contacts from North Coast Area Health Service (NCAHS), with new contacts added as the *SmokeCheck* Project expanded across NSW. Importantly, the database information which was submitted voluntarily, password protected and backed up through the University's IT department, recorded the names, professional roles, employee organisation, email, phone number and addresses of all contacts resulting in a database with the details of 521 people and 235 services.

As a comprehensive source of information the *SmokeCheck* database has been an invaluable project management and research tool that has enabled the Project to:

- Promote networks between training workshop participants and services
- Offer ongoing support to services' for tobacco control
- Provide a confidential forum in which to share and discuss ideas
- Disseminate and update information about tobacco control measures and activities.

In relation to research, the database has enabled:

- Effective distribution of surveys and survey information
- Efficient updating of contacts' details
- Accurate tracking of participant numbers.

1.6.3 Determining the denominator

A priority of the *SmokeCheck* Project was to 'build the capacity of Aboriginal health workers (AHWs) in the delivery of evidence based best practice smoking cessation interventions'. In managing this priority it was therefore vital to maximise the participation of AHWs in the *SmokeCheck* training workshops. To achieve maximum participation to the Project, it was first necessary to determine the number of AHWs employed in services throughout NSW. Direct enquiries to Aboriginal Employment Coordinators in each Area Health Service about possible centralised records of the number of AHWs in NSW led to a variety of responses. Additional research also found that ABS census data (2006) recorded 844 people working as AHWs in 2001, while a national count reported in the also varied (Curtin Indigenous Research Centre 2000). In May 2007, the ACHP commenced its own preliminary count, focusing on the number of people employed as AHWs. This number which was referred to as the 'AHW denominator' defined the role of 'AHW' as:

> *"Any practitioner of Aboriginal or Torres Strait Islander descent or others with a generalist or specialist primary responsibility for the health care of Aboriginal clients."*

To ensure the count would be as accurate as possible, a thorough process was followed, with information accessed from:

- The AH&MRC 2006-2007 Full Membership list to contact each of the 48 NSW Aboriginal Community Controlled Health Organisations (275 AHWs)
- NSW Health Aboriginal Workforce Development Unit and Aboriginal Employment Coordinators (342).

This process resulted in a denominator of 617 AHWs in NSW. To adjust for previous vacancies, possible workforce changes and to check for reliability, a second denominator count was conducted in 2007. To determine this count the same processes were employed resulting in a denominator count of 504, with an additional 51 vacant AHW positions also identified. As differences between the two counts could not be clarified, it was decided an average of the counts would provide the most reliable information. This resulted in a denominator of an estimated 560.5 AHWs currently employed in NSW. (For more detailed information see Appendix 1C).

Determining the estimated denominator ensured that the *SmokeCheck* training workshops were offered in areas employing large numbers of AHWs, which in turn helped to maximise AHWs access.

1.6.4 Manager workshops

A two hour *SmokeCheck* workshop for managers was also developed by the ACHP to supplement and enhance the impact of the *SmokeCheck* training presentation for front line health professionals. The rationale for this was twofold. Firstly, managers who fulfill critical roles in supporting staff to provide *SmokeCheck*, should also have a clear understanding of the brief interventions. Secondly, managers are perhaps best placed to lead organisational change processes that might support the integration of the *SmokeCheck* brief intervention and also sustain its use.

Seventeen manager workshops, in which 49 managers/ team leaders/program coordinators participated, were held during the Project implementation. Managers also met and discussed *SmokeCheck* in two separate informal meetings. The evaluation of the *SmokeCheck* manager training workshops is described in more detail in Section 2.

1.6.5 Workshop schedule

The *SmokeCheck* training schedules for health professionals was developed in conjunction with the research evaluation of the *SmokeCheck* Project and the decision to use a quasi-experimental research design. This research design which is discussed in Section 3 determined the sequence in which training workshops were scheduled. In addition, the AHW denominator and consultation with services also played a role in determining appropriate dates and sites for workshops. Other considerations affecting the workshop schedules were the individual needs of communities and services, as well as travel arrangements. Issues that were dealt with for example included ensuring:

- When possible that health services themselves participated in the organisation of training workshops. This required balancing the need for collaboration while not creating extra work for health services many of whom are already overstretched
- The *SmokeCheck* training workshop dates did not conflict with other service provision such as clinic days or other community events such as funerals or school holidays
- All health professionals, but in particular AHWs, had access to workshops. To support this, the Project was able to offer resources to support transport and accommodation for staff to attend.

The workshop schedule is discussed in detail in Section 2 while site locations are identified in Appendices 4A & 4B.

1.6.6 First round and second round training workshops

To maximise participation opportunities for all health professionals, two rounds of the *SmokeCheck* training were offered. At the commencement of the Project it was difficult to predict exact levels of participation although Interest escalated as the Project unfolded and training workshop information was distributed and continued as the first round of training was delivered, resulting in requests for additional workshops to be offered.

After considering budget and time constraints, a decision was made to offer a second round of the *SmokeCheck* training workshops. In the first instance, these were subsequently scheduled for the same sites as first round workshops. But as additional requests were made other workshops were also scheduled for new sites. Second round training resulted in an increase in participation rates. Differences in the first and second round workshop schedule are described in further detail in Section 4.

1.7 Conclusion

Smoking rates in Aboriginal communities are double those of other sectors of the population, with elevated numbers of disadvantaged people who ever start smoking, and not the smaller numbers who quit, explaining the higher smoking rates (Thomas, Briggs,

Anderson & Cunningham 2008, p.115). A consequence of this is that tobacco smoking is the leading cause of death and greatest contributor to the burden of disease amongst Aboriginal populations in Australia (Penm 2008, p.39).

Consideration is given to the complex interplay of factors influencing smoking in Aboriginal populations, in particular the importance of education and training in building the capacity of all health professionals working with Aboriginal communities were key factors in the development of the *SmokeCheck* Project. And the specific focus on the crucial roles of AHWs in health promotion ensured the Project achieved its outcomes as planned.

SECTION 2

The NSW *SmokeCheck*: An evidence based smoking cessation intervention

Section summary

This section describes the training component of the *SmokeCheck* Project. A multidisciplinary team of Aboriginal and non-Aboriginal researchers from the Australian Centre for Health Promotion (ACHP), The University of Sydney administered the *SmokeCheck* Project, managing its implementation and evaluation. A Reference Group comprising the NSW Department of Health, the Cancer Institute NSW, and the AH&MRC provided guidance and support.

The training included a smoking cessation brief intervention education program for AHWs and other health professionals, and a separate program for managers, team leaders and program coordinators. Based on other smoking cessation training programs including Smokescreen and the Queensland *SmokeCheck* Project, the NSW *SmokeCheck* training was disseminated during 2007- 2008.

The focus of the training program was the *SmokeCheck* brief intervention and culturally-specific resources, based on the trans-theoretical 'Stages of Change' model and the '5As' approach which requires practitioners to ask, assess, advise, assist and arrange follow up for clients who smoke. The curriculum covered topics to maximise practitioners' understanding of smoking as it impacts on Aboriginal communities, and how to conduct a brief intervention using the *SmokeCheck* resources, and advise and treat clients who smoke.

The *SmokeCheck* resources were developed in consultation with AHWs ensuring their appropriateness and suitability for use with Aboriginal clients. They include a video/DVD demonstrating brief motivational interviewing, a *SmokeCheck* poster targeting pregnant women, practitioner desktop guidelines, and five health promotion pamphlets for use by practitioners to support and provide advice to clients about tobacco use, its health effects and making a quit attempt. The managers training introduced the *SmokeCheck* brief intervention and resources, but focused on issues of organisational change that might support the integration of the *SmokeCheck* intervention and resources into routine front line health service provision.

2.1 Introduction

This section describes the two core components of the NSW *SmokeCheck* Project. These are the *SmokeCheck* smoking cessation brief intervention training program for AHWs and other health professionals with a primary responsibility for the health care of Aboriginal people in NSW, and a workshop for managers, team leaders and program coordinators. The section begins with an overview of the origins of the health professional training program, followed by an outline of the curriculum, program structure and approach to teaching. A comprehensive description of the *SmokeCheck* resources is then provided. Details of the workshop for managers are also described. The section concludes with a discussion about the importance of training that strengthens the knowledge, skills and confidence of all health professionals to undertake an opportunistic smoking cessation brief intervention, as a routine part of caring for the health of Aboriginal people who smoke.

2.2 Origins of the NSW *SmokeCheck* training program

The evidence upon which the current version of the NSW *SmokeCheck* training program is based was derived from several previous programs. For example, Smokescreen, developed in the 1990s (Richmond, Webster, Elkins, Mendelsohn & Rollnick 1991) was developed for general practitioners to use with people who smoke. Like *SmokeCheck*, that program was based on the Stages of Change Model (Prochaska & DiClemente 1983, p.393), a theory that assesses people's readiness and motivation to quit smoking, and uses the 5As approach (ask, assess, advise, assist, arrange follow up) to giving advice. Over time, these have been demonstrated to be key factors in supporting smoking cessation. The Smokescreen program has been evaluated over a 22 year period of trials which have demonstrated its effectiveness and sustainability (Zwar, Richmond, Borland, Stillman, Cunningham & Litt 2005, p.463). *The Smoking Cessation Guidelines for Australian General Practice* (Zwar et al 2005, p.463) and

the NSW Health *Let's take a moment quit smoking brief intervention – a guide for all health practitioners* (NSW Department of Health 2005b) are other programs that provided evidence supporting aspects of the development of the NSW *SmokeCheck*.

SmokeCheck developed by Queensland's Tropical Public Health Unit was the first time in Australia that the Stages of Change model was adapted to test its relevance and efficacy in Aboriginal communities. An evaluation of Queensland *SmokeCheck* demonstrated positive outcomes for both participants undertaking the training and for clients who received smoking cessation advice and support based on the training (Queensland Health 2007, p.9).

Among health professionals, the Queensland *SmokeCheck* training led to 'significant increases in self efficacy, role legitimacy and confidence in discussing smoking with clients' (Queensland Health 2007, p.9). Importantly, Aboriginal clients who received the *SmokeCheck* intervention reported:

- A reduction in nicotine dependence and daily cigarette intake
- Increased motivation, readiness to change and quit attempts
- Awareness of adverse affects associated with smoking (Queensland Health 2007, p.20).

Based on the success of the Queensland program, the NSW Department of Health, established a statewide pilot program to develop an Aboriginal-specific smoking cessation program based on the Queensland model. The NSW program was developed and pilot tested to confirm its efficacy over a two year period. The NSW Department of Health, in partnership with the AH&MRC and the Cancer Institute NSW pilot tested the *SmokeCheck* intervention with AHWs and other health professionals working with Aboriginal clients. The pilot testing confirmed the program's efficacy and identified a high level of interest in smoking cessation among AHWs and communities across the state.

With the efficacy of the *SmokeCheck* training program established, the NSW Department of Health and the Cancer Institute NSW selected the Australian Centre for Health Promotion (ACHP), The University of Sydney to administer the *SmokeCheck* Project across NSW. A multidisciplinary team was established under Mr Shane Hearn, Chief Investigator, to manage the Project's implementation and to design and implement the evaluation research. A Reference Group was also established, chaired by the NSW Department of Health and including membership from the Cancer Institute NSW, the AH&MRC, an Aboriginal Health Area Manager in NSW Health and from the community controlled sector, and The University of Sydney.

2.3 Curriculum development

The NSW *SmokeCheck* training program first delivered by the ACHP was based on an electronic presentation initially developed by the NSW Department of Health in 2005 and trialed with AHWs at the Maari Ma Health Service in Broken Hill. This initial presentation was expanded by the ACHP to include information about:

- The history of tobacco use in Australia
- Smoking prevalence by age, gender, Area Health Services, in Aboriginal populations and other populations in Australia and overseas
- Why people smoke?
- Beliefs about smoking
- What's in tobacco?
- Aboriginal people & smoking related morbidity and mortality
- Immediate and long term health effects of tobacco on males, females and during pregnancy
- Environmental tobacco smoke (ETS) and strategies for preventing exposure
- Nicotine addiction & dependence
- Nicotine replacement therapy (NRT) & how to use it
- Understanding 'quitting', immediate and long term benefits
- Trans-theoretical model, 'Stages of Change Model'
- Use of *SmokeCheck* evidence-based brief intervention for smoking cessation
- Case studies.

Feedback from participants about the curriculum resulted in minor iterations. These included the addition of specific topics, such as the social determinants of Aboriginal health and health promotion, and changes to group activities and the length of the presentation. Other minor program improvements included updating information about:

- Government legislation and policy
- Tobacco use statistics
- Campaigns targeting Aboriginal health (Oxfam's *Close the Gap*)

- Changes to pharmaceutical prescribing and treatment advice
- New smoking cessation pharmaceutical products (Varenicline).

For the final curriculum outline see Appendix 2A.

The minor adjustments to curriculum content and teaching were a response to issues that were identified after the training had been implemented in several locations. One issue was that workshop participants comprised a wide variety of health professionals from different disciplines and cultural backgrounds, with varying levels of education. This required the trainers to pay careful attention to language use and to the level at which information was pitched. An inclusive teaching style, the explanation of technical terms, and opportunities for discussion enabled the trainers to promote inclusiveness and ensure the contributions of all participants were valued.

A second issue was the need for the curriculum to include specific and comprehensive information about tobacco use in Aboriginal communities. The rationale for this was to optimise the capacity of all workshop participants regardless of their roles, to learn how to effectively support Aboriginal clients to address their smoking. The inclusion of information that maximises practitioner understanding of smoking in Aboriginal communities may help to minimise the need for referrals to Aboriginal tobacco control specialists. This is particularly important in light of the limited number of trained Aboriginal health promotion or tobacco control specialists (Ivers 2001, p.62). In a review of tobacco use in Aboriginal communities, the Australian Medical Association (AMA) notes the need for a skilled workforce in this field, and recommends all health professionals should undertake such specialist training (Australian Medical Association & Australian Pharmaceutical Manufacturer's Association 2000, p.40).

The third curriculum issue to be considered was the necessity to include information about the social determinants of Aboriginal health in the presentation, to promote a more comprehensive understanding of underlying issues contributing to Aboriginal health and smoking status. The aim of this was to make sure that all workshop participants, but non-Aboriginal participants in particular, were provided with opportunities for learning about tobacco use in its broadest context of Aboriginal primary health care and health promotion, not just from clinical treatment perspectives. This is in keeping with the view that health services have a responsibility to protect and promote the health of the communities they serve, as do all health professionals. And that to achieve this it is critical "… that programs and initiatives are planned in a way that appreciates the constraints people face in changing behaviour and that the health professional engages in action to remove the structural constraints to healthy behaviour" (Baum & Simpson 2006, p.178).

Careful consideration of the issues above has contributed to the capacity of the *SmokeCheck* training program to maintain a rigorous, informed curriculum and inclusive teaching style. Facilitator reflections, workshop notes, participant feedback and the consideration of participant skill levels have been used to support this and ensured that each of the 13 minor iterations of the training workshops was able to meet participant needs as far as possible.

2.4 Training workshop structure

In addition to the curriculum considerations above, the structure of each *SmokeCheck* training workshop was individually planned. Meticulous planning took into account workshop participant numbers and travel logistics, with arrangements typically resulting in a six hour training schedule broken into four sessions, commencing at 9.30am and finishing at 3.30pm. The content of these is outlined below:

Table 1: Overview of *SmokeCheck* training program structure

Session	Time	Topics
Introduction	9.30-10.00	Introduction ■ Completion of evaluation surveys ■ Ice breaker ■ History of tobacco use ■ Smoking prevalence
Session 1	10.00-10.45	■ Impact of tobacco on Aboriginal Australians ■ Cigarettes content ■ Tobacco use in Australia
Session 2	11.00-12.30	■ Social determinants of health ■ Nicotine dependence ■ Health effects ■ Environmental tobacco smoke
Session 3	1.00-2.15	■ Health promotion ■ Stages of change ■ *SmokeCheck* resources ■ How to undertake a brief intervention ■ Motivational interviewing
Session 4	2.30-3.30	■ Nicotine replacement therapy ■ Case studies/practice session ■ Conclusion/summary

This curriculum and training program schedule was structured to facilitate a range of learning objectives as follows. On completion of the *SmokeCheck* training workshop participants would be able to:

1. Describe the *SmokeCheck* Project
2. Identify changes in the prevalence of tobacco use in specific sectors of the Australian population
3. Describe the context of tobacco use in Australian society and in particular amongst Aboriginal populations in Australia
4. Describe the physiology of nicotine dependence
5. Describe how to assess nicotine dependence using the Fagerstrom test
6. Discuss the health effects of smoking, with reference to the effects on specific groups, for example the health effects on pregnant women, women and men
7. Describe environmental tobacco smoke (ETS), the health effects of ETS, & issues associated with ETS and Aboriginal people
8. Define the term 'health promotion' with reference to *SmokeCheck* and smoking cessation
9. Describe the social determinants of Aboriginal health
10. Describe the *SmokeCheck* resources
11. Describe the 'Stages of Change' model of behavior change
12. Discuss other smoking cessation interventions, including: nicotine replacement therapy (NRT), Bupropion (Zyban), Varenicline (Champix) and the Quitline
13. Demonstrate in a practice setting the implementation of a smoking cessation brief intervention using the *SmokeCheck* resources.

The *SmokeCheck* training curriculum outline, session aims and learning objectives are described in further detail in Appendix 2B.

2.5 The *SmokeCheck* brief intervention

At the core of the *SmokeCheck* training is a session that instructs participants how to effectively undertake a smoking cessation brief intervention with Aboriginal clients using the *SmokeCheck* resources. A component of this session is a demonstration of the resources in use, followed by an opportunity for all workshop participants to practice using the resources by undertaking a smoking cessation brief intervention role play based on a series of case studies.

The following description of the *SmokeCheck* intervention begins with an outline of the trans-theoretical 'Stages of Change' model on which the intervention is based. The '5As' approach that requires professionals to ask, assess, advise, assist and arrange follow up for clients who smoke, and the NSW *SmokeCheck* resources are also described.

Transtheoretical 'Stages of Change' model

The *SmokeCheck* brief intervention is underpinned by the Transtheoretical (stages of change) model. Developed by Prochaska and DiClemente (1983) this model is founded on the principle that behaviour change is a dynamic process rather than an event. In a comprehensive description of the model, Nutbeam and Harris (2004) identify two dimensions. The first of these is the five individual stages of change including (p.17):

1. Pre-contemplation
2. Contemplation
3. Determination or preparation
4. Action
5. Maintenance.

The second dimension is the processes of change relevant to the different stages. Processes include for example that:

- It is possible to describe a number of 'Stages of Change' common to the majority of behaviour change processes
- Individuals have varying levels of motivation or readiness to change
- An individual's confidence in their capacity to change and to overcome barriers may impact on the way in which they progress through each stage (Nutbeam & Harris, 2004, p.17).

The NSW *SmokeCheck* brief intervention which has drawn on this model identifies the following stages of change for quitting smoking:

1. Not ready to quit (pre contemplation)
2. Unsure (contemplation)
3. Ready to give up (action)
4. Recently quit and staying an ex smoker (maintenance)
5. Lapse/Relapse (resumption of smoking).

5As approach to supporting behaviour change

Identifying each client's stage of change and readiness to make a quit smoking attempt, requires professionals to use an evidence based framework commonly referred to as the '5As' approach. The approach acknowledges that "the smoker's own motivation to stop is a key issue and that advice is provided based on the smoker's readiness to quit" (Zwar et al 2005, p.462).

When using this approach to structure a smoking cessation brief intervention with clients, health professionals should:

1. Ask all clients: do you smoke tobacco?
2. Advise: all clients who smoke to quit in a non confrontational but clear manner
3. Assess: client's stage of change and nicotine dependence
4. Assist: clients with information and advise depending on the their stage of change and readiness to make a quit attempt
5. Arrange: follow up for clients attempting to quit or refer to a GP or the Quitline.

(NSW Health 2005b, p.7; Fiore, Bailey, & Cohen 2000, Zwar et al 2005)

Endorsed by the World Health Organization this approach was promoted during 'World No Tobacco Day' in 2005 to encourage all health professionals to take some responsibility for informing patients about the health consequences of smoking and to assist them with quitting. The value of the 5As approach is its capacity to identify the stage of change of every individual client who participates in the intervention. Also its role in demonstrating that a majority of current smokers are either not ready (40%) or unsure about quitting (40%) (Prochaska & Velicer 1997 cited in Woody, DeCristofaro & Carlton 2008, p.407), and the need for health to offer support to all people who smoke regardless of whether they are ready, particularly as findings from another study indicate that the 5As approach has the potential to increase quit attempts. For example research conducted amongst Chilean women, who have the highest smoking rates in Latin America, found that women who received the brief intervention based on the 5As approach made more than double the rate of quit attempts when compared with women who had not received the intervention (Puschel et al 2008 p.240).

A critical element of the 5As approach is the use of motivational interviewing to encourage people who smoke to think about their behaviour. While to date there has been no evaluation of the effects of training health staff to give advice to Aboriginal people about tobacco (Ivers 2001, p.61), there is some evidence to support the use of motivational interviewing with this group. Research conducted in the Northern Territory for example suggests that Aboriginal people who drink may respond more negatively in situations where they are spoken to in a 'rough way' about their drinking. Motivational interviewing, by contrast, takes a flexible and measured approach, that allows people to explore their own problems and develop their own solutions thereby respecting the autonomy of the individual (highly 'culturally appropriate') and the 'self determination' of the decision (highly politically correct) (Brady 1995 cited in Ivers 2001, p.56). To facilitate health professionals in conducting the brief intervention using the 5As model as a form of practice a set of resources was developed. The following section describes these.

2.6 Resources

The NSW *SmokeCheck* Project resources have been designed to guide and support health professionals to undertake an effective smoking cessation brief intervention with Aboriginal people. The resources include:

1. 5As practitioner smoking cessation desktop guidelines
2. Pamphlets
3. A DVD ' Bernard's Choice' demonstrating brief motivational interviewing
4. Poster
5. An electronic power-point *SmokeCheck* training presentation.

The desktop guidelines, pamphlets, DVD and poster are described below. The training presentation which was described earlier is also considered a resource and is distributed to those services who participate in the training for their discretionary 'in house' use.

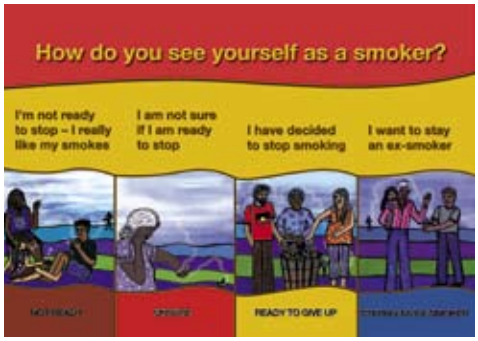
Desktop smoking cessation guidelines and pamphlets

The two components of the *SmokeCheck* resources are the desktop practitioner guidelines and a set of five pamphlets for the use of clients. Together these resources are designed to support health professionals in initiating and undertaking a smoking cessation brief intervention one on one with clients. As outlined earlier, these resources are all informed by the Transtheoretical, 'Stages of Change' model, and use the 5As approach.

The desktop practitioner guidelines consist of an illustrated double sided, A4 sized laminated card. One side of this card is headed with the question 'How do you see yourself as a smoker?' Underneath this heading are four statements and corresponding colour coded

graphics that respond to the question and represent a stage of behaviour change. The four statements are:

- I'm not ready to stop – I really like my smokes
- I am not sure if I am ready to stop
- I have decided to stop smoking
- I want to stay an ex-smoker.



The reverse side of the card provides a four step structured 'script' to guide health professionals in undertaking the smoking cessation brief intervention using the 5As approach and motivational interviewing in the most time effective manner. The four steps are:

Step 1: Asking the client whether they smoke and how much, then listening to their story

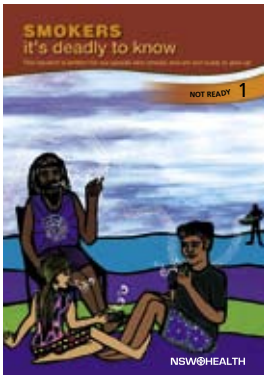
Step 2: Asking the client how they feel about their smoking and identifying their stage of change

Step 3: Matching the stage of change based on how the person describes themselves in the previous step, following the guidelines and using the *SmokeCheck* pamphlet that corresponds to the stage of change that has been determined

Step 4: Recording the client's stage of change and advice that was given, reinforcing positive changes and inviting the client to return for another visit.

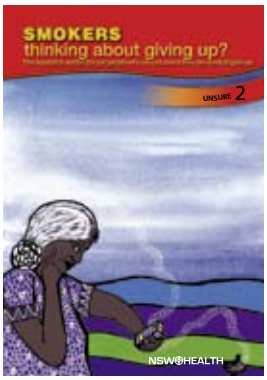
A set of five colour-coded *SmokeCheck* pamphlets support the use of the desk top guidelines. The graphic design of each pamphlet corresponds to that of the stage of change illustrated on the desktop guidelines. The pamphlets are a source of information for health professionals to use with clients during the intervention as well as a take home resource for clients to refer to. A fifth pamphlet has been added to the set focusing on smoking and pregnancy. Pamphlets and the information they present are as follows:

- **Pamphlet 1: Not ready to quit (pre-contemplation)**



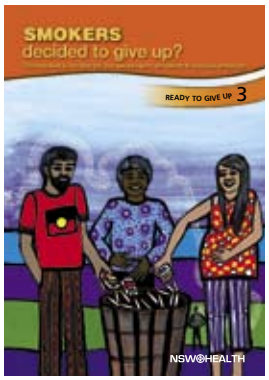
This pamphlet describes a stage when clients who smoke are either not considering making a quit attempt, or who are making a decision to remain smoking. Pamphlet 1 refers to "things people like about smoking" and "things people don't like about smoking". It also offers information about the health effects of tobacco and environmental tobacco smoke, encouraging clients who are not ready to quit, to consider the effects of their smoking on others, particularly children.

- **Pamphlet 2: Unsure (contemplation)**



The 'unsure' stage describes clients who are thinking about quitting smoking but who may not yet be ready to take the next step to making the attempt. This pamphlet offers more detailed information about the health effects of tobacco and describes issues related to the good and bad things about giving up tobacco. The pamphlet is designed to be used by health professionals in conjunction with a motivational interviewing approach to the consultation.

- **Pamphlet 3: Ready to give up (action)**

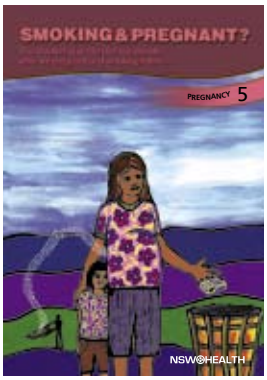


This pamphlet is for clients assessed as being in the 'action stage'. That is clients who are in the process of quitting or have recently quit smoking. Information provided in this pamphlet encourages clients to reflect on their smoking behaviour and discusses the advantages and disadvantages of strategies such as stopping smoking altogether at once and cutting down. The pamphlet also offers brief information about cravings and strategies to manage these. Information about NRT and some psychological issues associated with nicotine withdrawal also described.

Pamphlet 4: Recently quit and staying an ex-smoker (maintenance)

This pamphlet is for use with clients who used to smoke but who no longer do and who are considered to be in the maintenance stage. The pamphlet which focuses on the benefits of quitting offers brief advice about strategies that may support a client's non-smoking status.

- **Pamphlet 5: Smoking and pregnancy**

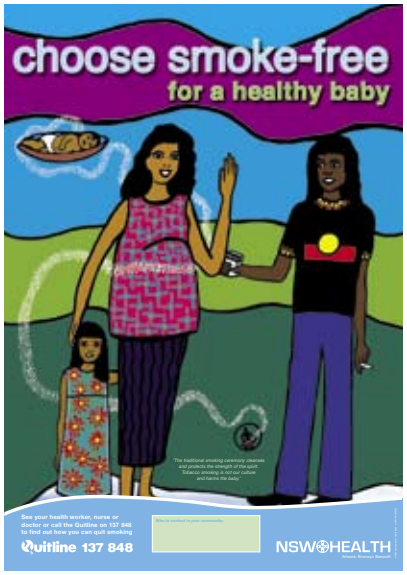


The fifth pamphlet in the series focuses on pregnancy, the health effects of smoking on mothers and babies. The pamphlet gives practical quitting advice and offers encouragement to mothers to quit.

- ***Bernard's Choice* training DVD**

The twelve minute DVD which demonstrates the 5As approach to a smoking cessation brief intervention using motivational interviewing was developed by Queensland Health. There are two scenarios in the DVD, the first of which demonstrates an ineffective brief intervention and the second of which demonstrates the effective way.

- **Poster**



The poster which employs the 'choose smoke free for a healthy baby' message promotes the *SmokeCheck* brand by using the same illustrations as are used in the fifth *SmokeCheck* pamphlet for women who are pregnant and smoking.

To ensure these resources would have the utmost applicability for use with Aboriginal people their design and purpose was given careful consideration and informed by a strategic consultative process. Ivers (2001) reports that such consultation is critical and reports two studies which sought to identify elements that might contribute to the appropriate development of health promotion materials about tobacco for Aboriginal communities (p.31). These were:

- Involvement of the target community in the development of resources
- Simplicity in presentation
- Colorful illustrations and photographs that depict culturally appropriate images
- Specific resources for communities being targeted, rather than generic resources for all Aboriginal people
- Not too much information, with use of simple, short, familiar words
- Humour and cartoons
- Aboriginal colours, art and drawings
- Messages about the effect of tobacco on the family
- Use of storytelling
- Use of everyday role models, not just famous role models.

(O'Connor, Parker, Mieklejohn, Oldenburg & Alati 1999; AMA & APMA 2000 cited in Ivers 2001, p.75)

Some of these elements are apparent in the NSW *SmokeCheck* resources. The use of graphics by Ms Bronwyn Bancroft the award-winning NSW Aboriginal artist, for example, has ensured that the practitioner desk top guidelines, pamphlets and poster are appropriate for use in NSW Aboriginal communities. Consultations with AHWs throughout the resource development process also contributed to ensuring their suitability for use with Aboriginal clients. In addition a focus group of more than 50 Aboriginal Vascular Health Program workers, and representatives from the AH&MRC and the Aboriginal Collaborative Centre for Health Promotion (ACCHP) reviewed early drafts of the *SmokeCheck* resources to ensure their cultural relevance.

2.7 Managers workshop

Information presented in the two hour manager's workshop focused on the *SmokeCheck* brief intervention and resources and organisational change to support the integration of the intervention and resources into routine front line health service provision. The presentation of such information acknowledges that in some communities health service provision may be affected by workforce constraints and limited infrastructure and that the integration of *SmokeCheck* may necessitate organisational change to address these issues. It also acknowledges that front line health professionals require organisational support, including the support of managers, if changes to their practice are to be sustained. Information presented in the manager workshops included:

- Current tobacco legislation
- Workplace policies
- Evidence supporting the use of smoking cessation brief interventions
- Practical strategies for organisational change that support the use of the *SmokeCheck* brief intervention.

Organisational logistics resulted in manager workshops being delivered concurrently with health professional workshops. On occasions this resulted in some managers also participating in the health worker workshops.
The two hour manager workshop schedule is outlined in Table 2 on page 24.

Table 2: Overview of *SmokeCheck* manager program structure

Session	Duration	Topics
Introduction	5 min	■ Introduction of workshop ■ Managers pre survey
Session 1: *SmokeCheck* Overview	50 min	■ Context of tobacco in NSW ■ Tobacco smoking amongst Aboriginal populations ■ Brief interventions ■ The evidence for *SmokeCheck* ■ The *SmokeCheck* intervention
Session 2: Organisational change	50 min	■ Organisational change ■ Barriers to organisational change ■ Identifying strategies to support organisational change and the integration of *SmokeCheck* into routine service provision ■ The role of managers in organisational change
Conclusion	5 min	■ Conclusion

2.8 Conclusion

Barriers preventing the delivery of tobacco cessation information or programs by AHWs in a previous key study in NSW (Mark, McLeod, Booker & Ardler 2005, p.24) identified the lack of professional development opportunities in tobacco cessation and the lack of information and support that AHWs could use when speaking with community members as areas that needed improvement. Baker, Ivers, Bowman, Butler, Kay-Lambkin, Wye, Walsh, Pulver-Jackson, Richmond, Belcher, Wilhelm & Wodak (2006), also recommended that greater success in smoking cessation among Aboriginal people and communities would be achieved when programs that had been designed with and for Aboriginal people, using culturally-specific resources, were delivered by AHWs and other health professionals who had been trained appropriately to work with Aboriginal communities (p.91). The *SmokeCheck* was developed in response to such findings and has delivered a quality intervention based on evidence and theory. It aimed to address the identified lack of professional development in tobacco cessation and provide a service that is specifically designed and delivered with and for Aboriginal people in NSW.

SECTION 3

Evaluation

Section summary

The *SmokeCheck* evaluation assessed the impact of the training on the capacity of health professionals to implement the *SmokeCheck* brief intervention with Aboriginal clients. The evaluation included a process evaluation and impact evaluation using a quasi-experimental design.

The process evaluation was to determine the acceptability and effectiveness of the training. The indicators used were participation rates, factors that hindered or facilitated the delivery of the workshops and feedback on participants' routine use of the *SmokeCheck* brief intervention.

The impact evaluation was based on a quasi-experimental study design and measured pre (P1 & P2) and post training evaluation outcomes, with intervention group participants attending workshops at baseline and control group participants attending workshops at a later stage. The indicators used to assess the impact of the training included:

- Knowledge, confidence, motivation, skills and actions of all health professionals to deliver smoking cessation brief interventions to Aboriginal clients
- Policies and protocols in place within health services to support this activity.

The study design allowed for the statewide dissemination of the training, as well as the administration of pre, post and follow up surveys to measure the skills, knowledge and confidence of health professionals to deliver smoking cessation advice to Aboriginal clients and the availability of resources to support such advice.

Data administration required systematic processes for distribution, collection and managing of the P1, P2 and post surveys prior to training, at training and post training. Data analysis included descriptive statistics and significance levels of results.

Processes involved in the planning and implementation of the Project that were evaluated include: the organisation of workshops, recruitment of participants, time and travel logistics, the distribution of the resources, and careful research design. The evaluation demonstrates the critical importance of collaboration, attention to detail, and teamwork to achieve effective health promotion program outcomes.

3.1 Introduction

This section describes the stages in the evaluation of the NSW *SmokeCheck* Project and contributes to research evidence about the effectiveness of smoking cessation training programs designed specifically to support health professionals working with Aboriginal clients. The process evaluation stage sought to ensure that the elements of the Project were sufficient in a number of areas. These include sufficient in its quality, delivery in reaching target audience(s) and intensity to have an impact on the intermediate variables of interest (often, knowledge, skills, confidence), and achieved the intended outcomes (often, behaviours or, in some cases morbidity or mortality). Hawe (2004) also makes the point that a health promotion intervention takes place within 'a context that contributes (positively or negatively) to achievement of health outcomes' (p.26).

3.2 Aims

The aim of the evaluation was to assess the impact of the *SmokeCheck* training on the capacity of all health professionals who participated in the training to implement a routine smoking cessation brief intervention with Aboriginal clients. The Project did not aim to evaluate the impact of the *SmokeCheck* on smoking prevalence or other health outcomes among the Aboriginal clients. However, if the Project was to have an impact on the capacity of the health professionals it was first necessary to establish that the Project, as delivered, met criteria that are known as process indicators. The evaluation included two stages. The first included process evaluation, the second included impact evaluation using a quasi-experimental design.

3.3 Process evaluation

Process evaluation offers an analysis of program 'acceptability' and 'integrity' – an assessment of whether it met the needs and priorities of its recipients, whether it was implemented as planned, and contributed to the 'success in achieving program objectives' (Nutbeam 1998, p.40). Process evaluation also assesses the scale and intensity of the activities undertaken and records the context in which the intervention is occurring and the amount of time and energy it took (Nutbeam 1998, p.39). The measures used to determine the acceptability and effectiveness of the *SmokeCheck* Project included assessing the extent to which health professionals and managers from all services and regions participated in the training, identifying factors that hindered or facilitated the delivery of the workshops; and feedback on participants' routine use of smoking cessation brief interventions.

To this end, the process evaluation included measures of:

- Training workshops conducted (AHWs & Managers)
- Participating health services
- Participants (by professional role and identity)
- *SmokeCheck* resources distributed.

Feedback forms comprising a semi-structured questionnaire asked all participants for comments about the relevance and applicability of workshop information to practice, and to the *SmokeCheck* resources. Feedback forms were used to assess participants' satisfaction with the workshops and to adjust the intervention accordingly – to make it more relevant, comprehensible and acceptable to the participants.

The *SmokeCheck* trainers also completed a workshop process checklist at the end of each training session. Information such as the number of participants, the number of resources distributed and contextual details affecting workshop delivery were recorded for later analysis.

3.4 Impact evaluation

The indicators used to assess the impact of the intervention were:

- Knowledge, confidence, motivation, skills and actions of AHWs and other health professionals to deliver smoking cessation interventions to Aboriginal clients
- Policies and protocols in place within health services to support this activity.

Pre and post surveys administered to training workshop participants and to managers were used to measure changes in these indicators. Indicators of impact which were assessed included:

- Health professional knowledge about:
  - The importance of offering advice to clients about quitting smoking
  - Key elements of smoking cessation interventions
  - Approaches that can be used at the community level to promote smoking cessation.
- Health professional confidence about:
  - Talking to clients about how smoking affects their health
  - Talking with clients who smoke about quitting
  - Assessing clients readiness to quit smoking
  - Initiating a conversation about smoking even when the client has come to the health service for another reason
  - Advising clients to use nicotine gum or patches.
- Health professional perceptions of:
  - How important it is to offer advice to clients about quitting
  - How easy or difficult it is to give brief advice to clients about quitting smoking during regular visits
  - Their own smoking status
  - Smoking in the home
  - Smoking in the workplace.
- Other impact measures included:
  - Access to quit smoking resources
  - Access to culturally appropriate quit smoking resources
  - Other quit smoking training
  - Comparisons of the above measures were made between the intervention and waiting list control groups to measure changes in the above indicators.

Specifically evaluation results were determined using descriptive statistics and summaries of survey items, as reported in Section 4.

3.5 Outcome evaluation

Given the intensity of intervention necessary to train as many health professionals as possible to deliver the smoking cessation brief intervention, and the time needed for this training to translate into routine practice, the *SmokeCheck* evaluation did not measure outcomes in terms of smoking rates amongst health service clients. Although it was possible to measure smoking prevalence among workshop participants using the pre and post surveys, this outcome was not the primary focus of the evaluation.

3.6 Impact study design

A quasi-experimental design was selected because important considerations in the choice of this design were the Project's statewide context, organisational setting, access to comprehensive resources, predetermined two year timeline and ethical considerations as well as the need for evidence of program effectiveness (Nutbeam and Bauman 2006 p.68). A quasi-experimental design includes an intervention group (that receives the intervention) and a control or comparison group which does not receive the intervention and compares their results with those of an intervention group (Nutbeam and Bauman, 2006, p.61). Before and after measures are then collected and analysed for observed differences between and within the non intervention and intervention groups. In the *SmokeCheck* Project the 'intervention' was the health professional training workshop as described in Section 2.

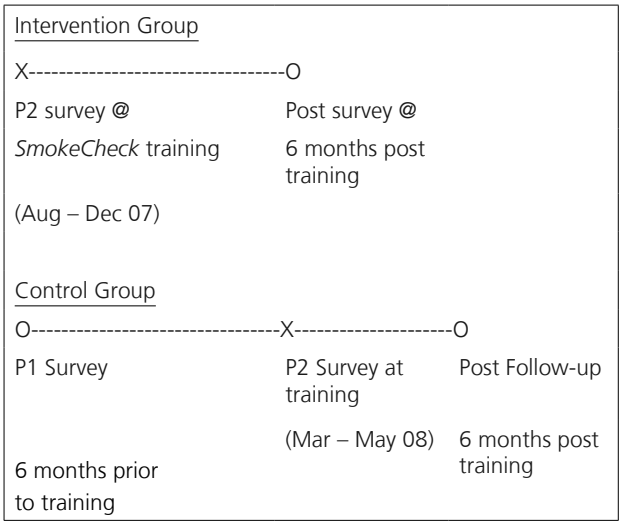
In the *SmokeCheck* Project, allocation of Area Health Services and Aboriginal Community Controlled Health Services to intervention and waiting list control groups was purposive and predetermined by NSW Area Health Services at a ratio of 3:1. Allocation to either group was based on geographical considerations and organisational logistics, resulting in a mixed group of services from six rural and metropolitan Area Health Services being allocated to the intervention group, and services from two Area Health Services (one metropolitan and one rural) to the waiting list control group. This allocation is outlined in Table 3.

Table 3: Intervention and waiting list control groups by area health services

Intervention	Waiting list control
■ Greater Southern ■ Hunter New England ■ North Coast ■ Northern Sydney Central Coast ■ South Eastern Sydney Illawarra ■ Sydney South West	■ Greater Western ■ Sydney West

Due to ethical considerations, it was imperative that all services in NSW Area Health Services were offered the *SmokeCheck* Project training intervention within the Project's two year timeline restrictions. The quasi-experimental design allowed for the statewide dissemination of the intervention and the administration of pre and post base line and follow up surveys to measure the skills, knowledge and confidence of health professionals to deliver smoking cessation advice to Aboriginal clients and the availability of resources to support such advice. Figure 1 below illustrates the *SmokeCheck* Project research design.

Figure 1: Research design (Baseline represents the commencement of the first *SmokeCheck* workshop)



The intervention group participants completed two surveys 'P2', the first at baseline (at the commencement of the *SmokeCheck* training workshop), and the second, 'post' survey approximately six months after the workshop. The waiting list control group completed three surveys, the first 'P1' survey at baseline, six months prior to attending the training workshop, the second 'P2' at the training workshop, and the third 'post survey' at 12 months from baseline (see Table 4).

Table 4: *SmokeCheck* survey distribution

Number of surveys	Intervention group participants	Waiting list control group participants
1	A 'P2' survey at the start of the *SmokeCheck* training	A 'P1' workshop survey at baseline 6 months prior to the *SmokeCheck* training (print or online)
2	A follow up 'post' survey 6 months post *SmokeCheck* training (print or online)	A 'P2' survey at the *SmokeCheck* training workshop
3		A follow up 'post' survey 6 months post *SmokeCheck* training (print or online)

3.6.1 Surveys

The survey instruments which were developed by the *SmokeCheck* research team were piloted with a small group of AHWs to check for acceptability and ease of comprehension, and feedback was incorporated into the final survey design. Both pre (P2) and post surveys asked the same questions, were designed to take approximately 15 minutes to complete, and were accompanied by a participant information sheet (See Appendices 3A – C). Surveys asked questions about their smoking status and behaviour, smoking in the home and workplace, intentions to quit smoking, confidence regarding aspects of delivering a smoking cessation brief intervention and assessing clients' stage of motivation to quit smoking.

Surveys not administered during training workshops were distributed by mail, e.g. waiting list control group 'P1' and all post surveys. To ensure their comprehensibility and assist their return, these surveys were accompanied by a cover letter, participant information sheet and stamped self-addressed envelope. An email to every workshop participant also ensured these surveys were made accessible via a link to 'Survey Monkey' an online survey tool. Email follow up reminders with both the survey web link and survey attached were also sent to all workshop participants.

3.6.2 Survey & site codes

All surveys were de-identified, using a coding process to facilitate future matching of surveys for pre and post comparison. In addition to personal survey codes, generic and individual site codes were created for each workshop site. Generic site codes were allocated to Area Health Services, and individual site codes were allocated to the sites at which training workshops were delivered. As an example, the generic site code for Greater Southern Area Health Service was 200, while the individual workshop site codes for Wagga Wagga and Griffith were 203 and 204 respectively. The allocation of generic and individual site codes maximised the potential for tracking and matching pre and post surveys. Once received, all survey results were entered into EpiData, an analytical software program. Pre and post surveys were matched by site codes and personal codes on each (see Appendix 3F). This matching of surveys by site and personal codes ensured accurate data analysis.

3.7 Data administration

Coordinating the distribution and collection of pre and post surveys was a complicated process that entailed establishing a systematic process for its management. This process was adapted and adjusted to meet the requirements of the two waiting list control group Area Health Services. Adjustments to the dissemination of surveys were also made during the training workshops, and at follow up to training. Data administration is explained in further detail in the following sections.

3.7.1 P1 surveys – waiting list control groups

P1 surveys were distributed throughout the two Area Health Services listed in Table 1, including Greater Western Area Health Service and Sydney West Area Health Service .

Distributing P1 surveys to services throughout these two Area Health Services was perhaps one of the most difficult of all the tasks associated with the Project evaluation. It was a challenge to distribute as many surveys as possible and optimise the survey return rate without revealing too much information about the Project, in order to avoid cross-contamination. To facilitate this process, a key point-of-contact person in the two Area Health Services was recruited and asked to assist with:

- Identification of services and potential survey participants
- Distribution and collection of surveys
- Encouraging staff to complete surveys and maximise responses.

To achieve higher response rates, it was necessary to:

- Make a considerable number of phone calls to identify appropriate key contacts
- Adhere to NSW Health protocol and ensure designated personnel managed the distribution of surveys, regardless of their interest or support for Project

- Consider the geographical size of Area Health Services (especially in Greater Western Area Health Service) to ensure surveys were distributed throughout different clusters
- Label surveys, i.e. develop site codes to ensure consistency in matching pre and post surveys at the data analysis stage
- Develop and use processes appropriate for Aboriginal Community Controlled Health Organisations as well as Area Health Services
- Have numerous contacts within Area Health Services to distribute surveys
- Allocate sufficient time to provide information about the *SmokeCheck* Project and evaluation.

3.7.2 Pre (P2) workshop survey distribution – intervention and waiting list control groups

Both intervention and waiting list control groups were invited to complete a pre workshop *SmokeCheck* survey on the day of, prior to the commencement of the first workshop session. Completion of the survey was voluntary. Of 519 participants in both the health professional and managers workshops, only 20 people either declined or did not complete the survey, (n=499) resulting in a 96 per cent completion rate.

3.7.3 Post survey distribution

Follow up post surveys were sent approximately six months after the commencement of the 'first round' training workshops (baseline). Due to time constraints, participants completing the 'second round' training were sent follow up post surveys three months after the training workshops. First round survey distribution is illustrated in Figure 1.

Post surveys were sent by mail, with a cover letter, participant information sheet, and a return addressed stamped envelope. These were also emailed as PDF attachments with an option to link to the survey online through Survey Monkey. A week later, participants were then emailed a reminder, reiterating the options to complete the survey online, or to print out the survey attached (PDF) and return it via fax or post. Based on response rates for post surveys, up to four email reminders were sent (See Appendix 3G).

3.8 Data analysis

A chi-square test was used to compare differences in independent proportions and McNemar's test to compare differences in paired proportions. Independent means were compared using independent t-tests or the Mann-Whitney U Test, while paired means were compared using paired t-tests or the Wilcoxon Signed Ranks Test. All comparisons were 2-sided and were considered statistically significant at P values less than 0.05. Also, SPSS Version 15.0 (SPSS Inc., Chicago, Illinois) was used for all analyses.

3.9 Conclusion

At the outset, the NSW *SmokeCheck* Project evaluation research aimed to contribute to evidence about the implementation of a culturally safe statewide training program for health professionals and managers, with a primary responsibility for health care provision in Aboriginal communities. The extent to which the *SmokeCheck* intervention was implemented in a 'real-life' setting has been well documented in this report. The evaluation of processes involved in the planning, and implementation of the training, including the organisation of workshops, recruitment of participants, time and travel logistics, the distribution of the resources, and careful research design has demonstrated the critical importance of collaboration, attention to detail, and teamwork. The process evaluation showed that such processes enable health promotion projects such as the *SmokeCheck* Project to be culturally acceptable and reach a wide audience thereby optimizing the potential to achieve the Project's objectives. Section 4 reports on the impact of the intervention – on the extent to which the intervention met its objectives.

SECTION 4

Results

Section summary

Process evaluation results:

- Sixty three *SmokeCheck* training workshops including 46 health professional and 17 manager workshops were conducted in all NSW Area Health Services at to 38 locations from 2007 to 2008
- One hundred and ninety services participated, including 128 from the NSW Area Health Services, 32 from the Aboriginal Community Controlled Health Services sector and 20 non-government organisations
- Overall training was attended by a total 519 participants, including 470 health professionals and 49 managers. Of these 250 (48.2%) participants indicated Aboriginal descent, while 199 (42.3%) participants identified their roles as AHWs
- Ninety per cent of feedback form respondents (n=459) agreed or strongly agreed that curriculum content, workshop structure and delivery was to their satisfaction.

Impact evaluation results:

- No differences between the intervention (n=297) and control groups (n=77) at baseline (n=374)
- Intervention group (165 matched pairs) survey results (P2 – Post) showed increases in:
  - Confidence of all health professionals in talking about health effects (22%), advising clients to quit (27%), assessing readiness to quit (31%) and bringing up the issue of smoking (24%) (p=0.000)
  - Number of health professionals providing advice/information about NRT (15%), ETS (12%), and cutting down tobacco use (10%) (p=0.034)
  - Number of health professionals, specifically AHWs who state that it is important (p=0.007) and easy (p=0.039) to offer smoking cessation advice to Aboriginal clients
  - Number of AHWs who live in smoke free homes (9%) (p=0.045)
  - Availability of culturally appropriate resources (20%) (p=0.000).
- In the control group (28 matched pairs) there was no change from P1-P2
- Pre and post manager surveys (25 matched pairs) there were no significant changes
- Between September 2007 to January 2009, 9831 items from the *SmokeCheck* resources were ordered through the NSW Department of Health Centre for Health Advancement Resources Distribution Unit.

4.1 Introduction

The results reported in this section include the process and impact evaluation of the *SmokeCheck* Project. The section begins with process evaluation results including estimates of the reach of the program workshops and includes information on the number of services, AHWs, other health professionals and managers who attended the training workshops (received the intervention), and compares these with the Project's proposed targets. Feedback from workshop participants were collected to assure the quality of the training is also reported. These are followed by the impact evaluation results including: baseline self-completed questionnaire findings, changes in control and intervention groups (before and after surveys) and the differences between these. The numbers of *SmokeCheck* resources that have been distributed have also been reported.

4.2 Process evaluation results

4.2.1 Workshops

Over 24 months, 63 *SmokeCheck* training workshops, including 46 health professional and 17 manager workshops were conducted in 8 NSW Area Health Services at 38 locations. The workshops were offered in two rounds. During the first round, 44 training workshops, including 29 health professional and 15 manager workshops, were held between August 2007 and June 2008. The health professional workshops trained 308 people, while 41 people attended the managers' workshops. A second round of workshops were held between March and September 2008, including 15 health professional and two managers' workshops. Second round workshops trained 156 health professionals and 8 managers, made a total of 164 participants. This information is summarised in Tables 5 and 6.

Justice Health employed the *SmokeCheck* Team to run a workshop for health professionals employed in correctional centre's and jails throughout the State in November 2008. Participants in this workshop have not been included in the final evaluation results or analysis.

Table 5 below lists the number of *SmokeCheck* training workshops and their site locations. Appendices 4A and 4B identify locations on a state map of NSW.

Table 5: Location and number of workshops by area health services and site locations

Area Health Service & number of health professional workshops	Workshop site locations
Greater Western (9 locations, 10 workshops)	Coonamble, Bourke, Orange, Forbes, Dareton, Broken Hill (x2), Menindee, Balranald and Dubbo
Greater Southern (5 locations, 6 workshops)	Narooma, Wagga Wagga (x2), Griffith, Albury, and Bega
Hunter New England (5 locations, 6 workshops)	Newcastle (x2), Taree, Tamworth, Moree and Armidale
North Coast (7 locations, 10 workshops)	Lismore, Casino, Coraki, Grafton (x2), Coffs Harbour, Kempsey, and Port Macquarie (x3)
Northern Sydney Central Coast (2 locations, 2 workshops)	Gosford and Wyong
South Eastern Sydney Illawarra (3 locations, 4 workshops)	La Perouse, Wollongong (x2), and Nowra
Sydney South West (2 locations, 3 workshops)	Camperdown (x2) and Liverpool
Sydney West (4 locations, 5 workshops)	Katoomba, Rooty Hill (x2), Penrith and Parramatta

Table 6: Location and number of managers' training workshop

Area Health Services & number of manager workshops	Workshop site locations
Greater Western (2 locations, 2 workshops)	Orange and Forbes
Greater Southern (2 locations, 3 workshops)	Wagga Wagga (x2) and Griffith
Hunter New England (2 locations, 2 workshops)	Newcastle and Tamworth
North Coast (3 locations, 4 workshops)	Port Macquarie, Coraki, Coffs Harbour and Lismore Teleconference
Northern Sydney Central Coast (1 location, 1 workshop)	Wyong
South Eastern Sydney Illawarra (2 locations, 2 workshops)	La Perouse and Nowra
Sydney South West (1 location, 1 workshop)	Bankstown
Sydney West (2 locations, 2 workshops)	Rooty Hill and Parramatta

4.2.2 Organisational factors affecting participation numbers

Over the 18 month period in which the Project was disseminated throughout the state, demand for the *SmokeCheck* training and participation rates increased. It was observed that services or organisations with dedicated health promotion or tobacco control teams were often able to create greater interest, more demand for workshops and higher participation rates.

Workshops with 20 or more participants included:

- Rooty Hill/Penrith (SWAHS): 32 participants and 3 managers
- Wollongong (SESIAHS): 29 participants
- Broken Hill (GWAHS): 25 participants
- Wagga Wagga (GSAHS): 25 participants and 7 managers
- Port Macquarie (NCAHS): 21 participants and 5 managers
- Newcastle (HNEAHS): 20 participants and 1 manager.

4.2.3 Participation by service type

A range of services participated in the *SmokeCheck* training, including Aboriginal Community Controlled Health Organisations, NSW Area Health Services, and other non-government organisations. The total number of services participating was 190 with 128 being part of NSW Area Health Services, 32 from Aboriginal Community Controlled Health Services and 20 from non-government organisations.

Participation by Aboriginal Community Controlled Health Organisations (ACCHO)

The Aboriginal Health and Medical Research Council (AH&MRC), the peak body representing Aboriginal Community Controlled Health Organisations (ACCHOs) in NSW, with a membership comprising 48 organisations invited its members to participate in the *SmokeCheck* training workshop. In response, 30 (63%) AH&MRC member organisations participated in the *SmokeCheck* training with one or more staff members attending a workshop. In addition, two Aboriginal Community Controlled Health Related Services (ACCHRSs) also participated. These included Yarrabin Outreach a disability support service in Cobar, and Marrin Weejali Aboriginal Corporation a housing and welfare assistance organisation in Western Sydney.

Participation by the NSW Area Health Services

The NSW Area Health Services include more than 220 public hospitals, 500 community, family and children's health centres, and an extensive range of generalist and other specialist services (http//:www.health.nsw.gov.au). Of the 128 services taking part in the *SmokeCheck* training, the majority of participants were recruited from community health centres and others from:

- Aboriginal Health Units
- Drug and Alcohol Services
- Health Promotion Units
- Hospitals
- Mental Health Services
- Population/Public Health Units.

Non-government organisation participation

Thirty non-government organisations (NGOs) participated in the *SmokeCheck* workshops as follows:

- Association of Children's Welfare Agency
- Auswide Projects (employment skills training centre)
- Barnardos
- Broken Hill Skills Centre (employment skills training centre)
- Caulfield's Healthy Heartbeat (The Samaritans)
- Connections (employment skills training centre)
- Heart Foundation
- Home Start Kempsey/Maclean
- Health Link (remote health program)
- Macleay Vocational College (employment skills training centre)
- Nambucca Valley Care Unit (community health service)
- New Horizons On Track Community Programs
- Outback Division
- Supported Accommodation Assistance
- TAFE
- The Cancer Council NSW (several branches)
- The Men's Shed (NFP charity specialises in men's health).

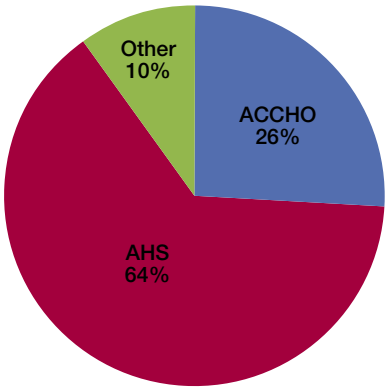
Health professional staff from nine government affiliates, universities and Divisions of General Practice also attended, including:

- Brighter Futures Early Intervention Program (Department of Community Services)
- Department of Ageing and Disability
- Magistrates Early Referral Into Treatment (MERIT)
- New England Division of General Practitioners
- Penrith City Council
- Riverina Division of General Practice
- Southern Cross University
- University of NSW Rural Clinical School
- University of NSW, Coffs Harbour Campus.

4.2.4 Participant data

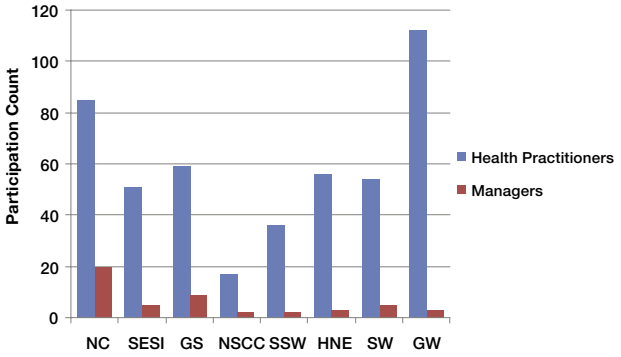
Registration data from individual workshops indicates 682 people registered to attend either the one day health professional or manager's workshops. However, a total of 519 participants actually attended, including 470 health professionals and 49 managers. The attendance rate was 76.1 per cent of those who registered.
As described above participants came from a variety of services. Three hundred and thirty five (64%) of participants were employed by NSW Area Health Services, 133 (26%) by Aboriginal Community Controlled Health Organisations and 51 by non-government and other organisations, as illustrated in Figure 2 below.

Figure 2: *SmokeCheck* participants by service type



As indicated in Figure 3a there was significant variation in participation across Area Health Services. For example, Greater Western Area Health Service is the largest geographical Area Health Service with the highest overall health professional but lowest manager participation rates. While North Coast Area Health Service, which also recorded high health professional participation had the highest number of managers attending a workshop. In contrast, workshops in Northern Sydney Central Coast Area Health Service had the lowest participation for both health professionals and managers.

Figure 3a: Health practitioners and managers participation in the *SmokeCheck* training by area health service



While these participation results may be an indicator of the overall size of the NSW Health workforce and the Aboriginal population in each Area Health Service, they should also be considered in light of the distribution and staffing levels of Aboriginal Community Controlled Health Organisations and other related services. As a result of the specific efforts made to maximise the participation of all AHWs and managers, 250 (48.2%) participants, identified as Aboriginal descent, with Greater Western Area Health Service and North Coast Area Health Service recording the highest number of Aboriginal participants.

Figure 3b: Participants by Aboriginality

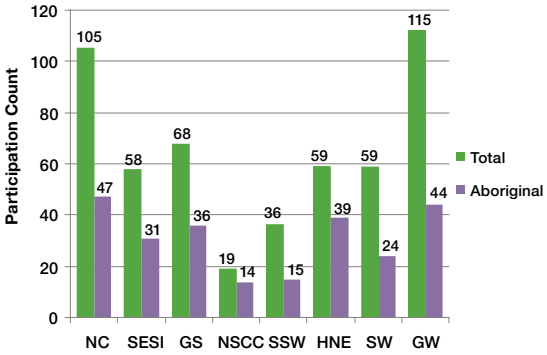


Table 7 below summarises the number of workshops held across area health service, number of health professionals and manager participants, and participant identity.

Table 7: Summary of workshops and participation by area health service

Area Health Service	Workshops			Participants			Aboriginal		AHWs
	2007	2008	Total	Health professional	Manager	Total	Aboriginal	Aboriginal participants as a % of total	
GW	-	12	12	112	3	115	44	38%	36
GS	6	3	9	59	9	68	36	53%	29
HNE	6	2	8	56	3	59	39	66%	30
NC	8	6	14	85	20	105	47	45%	39
NSCC	2	1	3	17	2	19	14	74%	12
SESI	5	1	6	51	5	58	31	53%	25
SSW	3	1	4	36	2	36	15	42%	10
SW	-	7	7	54	5	59	24	41%	18
TOTAL	**30**	**33**	**63**	**470**	**49**	**519**	**250**	**48%**	**199**

4.2.5 Aboriginal health worker reach

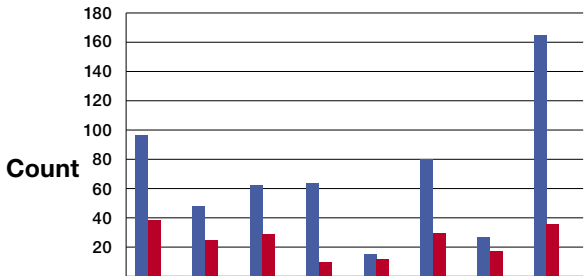
Section 1.6.3 described the use of a conservative denominator estimate to check that the *SmokeCheck* training workshops were offered to as many AHWs as possible. The conservative estimate established that there were substantial differences in the number of AHWs employed within the geographical area covered by each Area Health Service. The conservative denominator estimate indicating the number of AHWs employed in each NSW Area Health Service is as follows in Table 8 below. For a detailed denominator estimate for each service see Appendix 1C.

Table 8: Aboriginal health workers denominator by area health service

Area Health Service	AHW denominator estimate
Greater Western	165.5
Greater Southern	62.5
Hunter New England	80
North Coast	97
Northern Sydney Central Coast	15.5
South Eastern Sydney Illawarra	49
Sydney South West	64
Sydney West	27
TOTAL DENOMINATOR ESTIMATE	561

Overall 199 (42.3%) workshop participants identified their roles as AHWs, representing 35.5 per cent of the total NSW AHWs workforce. Northern Sydney Central Coast Area Health Service had the highest participation rate overall with 12 AHWs from a total of 15, or 77 per cent attending a *SmokeCheck* workshop. Other Area Health Services recording higher than average AHWs participation rates were Sydney West Area Health Service with 18 (67%) AHWs and South Eastern Sydney Illawarra Area Health Service with 25 (51%) AHWs participating. Whereas only 36 (22%) AHWs from Greater Western Area Health Service attended the *SmokeCheck* workshops. Some reasons for variations in participation are related to staff turnover, service size, workloads and other commitments for example involvement in other education programs. These issues are further discussed in Section 5. Figure 4 below illustrates these variations.

Figure 4: Aboriginal health workers participation by denominator and area health service



	NC	SESI	GS	SSW	NSCC	HNE	SW	GW
Denominator AHW	97	49	62.5	64	15.5	80	27	165.5
Aboriginal Health Worker Participants	39	25	29	10	12	30	18	36
Percentage Reach	44%	56%	52%	20%	84%	43%	78%	24%

4.2.6 Participation results against project targets

Results indicate that overall participation and number of the *SmokeCheck* training workshops has exceeded the estimated targets originally projected. A total of 519 health professionals have completed the *SmokeCheck* training compared to the 400 originally projected and 63 workshops have been held, compared with the 40 that had been proposed.

4.2.7 Quality assurance

At the conclusion of each health professional and manager *SmokeCheck* workshops, participants were invited to provide feedback on the comprehensibility and usefulness of the workshop, and on their level of satisfaction with the quality and content of the training. Although a total of 459 feedback forms were received from the 519 workshop participants, not all components of the form were completed by every respondent.

The feedback form constituted five questions. Question 1 asked respondents to use a Likert scale and check boxes to rate how strongly they agreed or disagreed with 11 statements about the workshop. Questions 2 to 4 were open-ended questions about the best aspects of the day, suggested improvements and other comments. Question 5 asked respondents to indicate their identity as Aboriginal descents.

Question 1a-k responses

To assess responses to Question 1a-k, statements were grouped into three categories:

- Curriculum content
- Workshop structure
- Workshop delivery.

With a maximum composite score of 100 for the above categories, individual responses were then calculated. Results showed that over 90 per cent of respondents either positively agreed or strongly agreed to eleven statements on curriculum content, workshop structure and delivery and that it was to their satisfaction. This strong approval rating indicated that the program was on track and meeting the needs of AHWs.

Table 9: Workshop feedback

	Positive statements	Respondents who strongly agreed or agreed	Total respondents	Total %
Question 1:a-k	The course was taught at a level that I could understand.	454	458	99%
	The information presented will help me in my job	445	458	97%
	The material presented was interesting and easy to understand.	454	458	99%
	There was a right mix of practical and theory.	436	458	95%
	The course encouraged participation.	453	459	99%
	Resources and training notes were effective and easy to understand.	453	459	99%
	Session outcomes and structure of the session were clearly outlined.	448	459	98%
	The trainer was enthusiastic about the course and was easy to understand.	455	459	99%
	The trainer was knowledgeable about quitting smoking methods.	451	459	99%
	There was enough time allowed for questions.	450	459	98%
	A secure and comfortable learning environment was provided.	452	459	99%

Feedback indicated that the majority of respondents were satisfied with the information presented in workshops, finding it relevant, easy to understand and applicable to practice.

Question 2 to 4 responses

Overall responses to the open-ended questions indicated that the best aspects of the training were the workshop content, specifically the resources, practical activities, Aboriginal focus, population data and information about NRT. In addition the relaxed, supportive environment and the structure of the day, group discussion, sharing of information, experiences, and networking were all rated highly. While most respondents reiterated that curriculum content was presented in a way that made it easy to understand, and that trainers were knowledgeable, enthusiastic and motivated (see Appendix 4E). Importantly, feedback suggested respondents were pleased to have access to free resources specifically designed for using with Aboriginal clients. On the whole the workshop was rated as enjoyable, useful, educational and motivational, with some respondents feeling encouraged to consider their own smoking status.

Suggestions about improvements were minimal, but included factors associated with the venue, such as location, parking, noise and comfort levels. Time management was one issue raised by some participants who objected to the variations that sometimes had to be made to the workshop schedule as a result of travel mishaps. A few respondents also stated that if workshops had been promoted more widely, then perhaps there would have been an increase in attendance levels, while others criticised the lack of participation by clinical managers.

Question 5 responses

In an effort to distinguish potential differences in the satisfaction of Aboriginal and non-Aboriginal participants, feedback forms requested participants' Aboriginality. There was no significant difference in responses to the questions on the feedback form for Aboriginal and non-Aboriginal respondents (refer to Appendix 4G).

4.3 Impact evaluation results

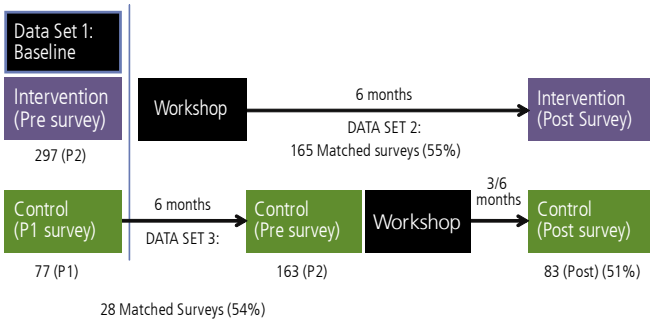
4.3.1 Data set 1: Baseline survey results

As explained in Section 3, 'baseline' represents the commencement of the *SmokeCheck* training workshops, at which time P1 surveys were issued to the control group and P2 surveys were issued to the intervention group (see Figure 5). A total 374 pre (P2) surveys was completed, 77 by control group respondents six months prior to attending a workshop, and 297 by intervention group participants at the beginning of the *SmokeCheck* workshops. Results show no statistically significant difference between the two groups (P>0.05) at baseline. For example the number of respondents who indicated their work position as an AHW (p=0.065) were 27 out of 74 (36%) in the control group and 142 out of 293 (48%) in the intervention group.

The baseline survey results have therefore been combined to include the findings from both the intervention group participants (P2 surveys) and the control group participants (P1 surveys).

Importantly, in interpreting the impact evaluation results it is worth noting that some survey questions were not answered.

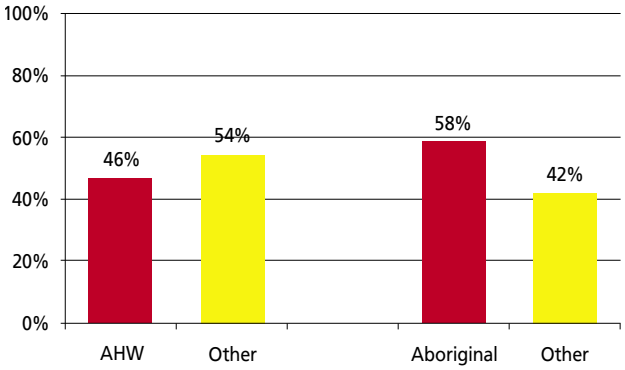
Figure 5: Intervention & waiting list control group survey distribution



Aboriginality and professional role

Baseline results show that the *SmokeCheck* workshops reached the Project's target Aboriginal audience with 213 (58%) participants indicating that they were Aboriginal descents, compared to 150 (42%) indicating non-Aboriginal. One hundred and sixty nine (46%) respondents were AHWs while the other respondents were from other health professions. See Figure 6 below.

Figure 6: Participation by professional role and Aboriginality



Role requirements

Of the 283 (78%) survey respondents who specified that they had a primary responsibility for the care of Aboriginal clients, 227 (63%) stated this work was undertaken 'all the time' while 56 (15%) indicated they did so 'often'. In relation to perceptions of providing smoking cessation advice to clients, 299 (90%) of all respondents agreed that this was part of their role.

Confidence in assessing and advising clients about smoking

Five survey questions (questions 5-9) measured respondents' confidence in assessing and advising clients about smoking cessation including:

Q5. How confident do you feel that you could talk with your clients about how smoking affects their health?

Q6. How confident do you feel that you could talk with clients who smoke about quitting?

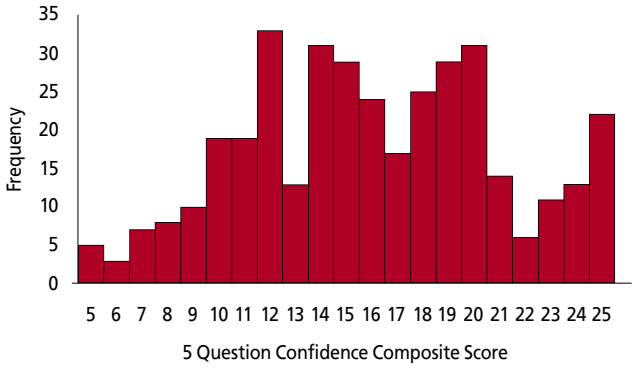
Q7. How confident do you feel that you could assess your client's readiness to quit smoking?

Q8. When a client comes to you for another reason how confident do you feel bringing up smoking?

Q9. How confident do you feel you could advise a client about using either gum or patches?

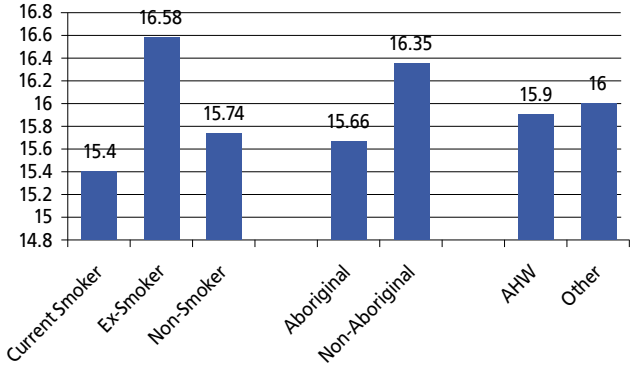
Each question was then allocated a score of 1 (least confident) to 5 (very confident), and the items were summed, resulting in a total composite score with a range between 5 to 25 for each respondent. For example a respondent who indicated moderate confidence (score of 3) to all five questions was allocated a composite score of 15 (3x5) for confidence. For these survey questions about confidence (mean score=16, sd=5). These results are represented below in Figure 7.

Figure 7: Composite scores for survey questions 5-9 (n=369)



A cross-tabulation compared survey respondents' confidence by three criteria including smoking status, identity and role. Results show that in relation to assessing and advising clients about smoking (questions 5-9), respondents who were ex-smokers were more confident than respondents who were either current or non-smokers. Results also indicate that for the most part, Aboriginal respondents were less confident than non-Aboriginal respondents which was not significant (p=0.190) and similarly by role, which was significantly different (p=0.001) where AHWs are less confident than other health professionals. Figure 8 below illustrates these results.

Figure 8: Mean confidence scores: Level of confidence in assessing and advising clients about smoking by smoking status, Aboriginality and professional role



Importance and ease of offering advice

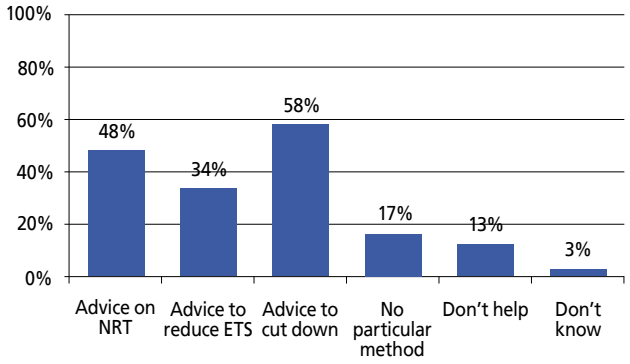
Survey questions 10 to 12 assessed practitioner attitudes about the importance of offering smoking cessation advice (question 10), ease of offering such advice (question 11) and what type of advice is provided (question 12). 329 (89%) of all respondents stated that it is 'important' or 'very important' to offer smoking cessation advice, but only 179 (49%) indicated that it is 'easy' or 'very easy' to give such advice. Results from a cross-tabulation to assess views about the importance and ease of offering smoking cessation advice by identity and role found the same differences between Aboriginal and non-Aboriginal respondents, and AHWs and other health professionals. For example 144 (86.8%) AHWs stated that giving smoking cessation advice was important, whilst only 76 (46%) found it easy, whereas 179 (91.8%) other health professionals stated it was important and 100 (51.6%) found it easy.

Methods used to help clients quit smoking

In response to the question about methods used to help clients to quit smoking 180 (48.1%) respondents provided advice about NRT, 126 (33.7%) advised about ways to reduce ETS, and 218 (58.3%) encouraged clients to cut down. While 62 (16.6%) respondents indicated they used

no particular method, 47 (12.6%) stated that they did not help at all, and only 10 (2.7%) stated that they 'did not know'. Figure 9 below represents these results.

Figure 9: Methods used to help clients quit smoking



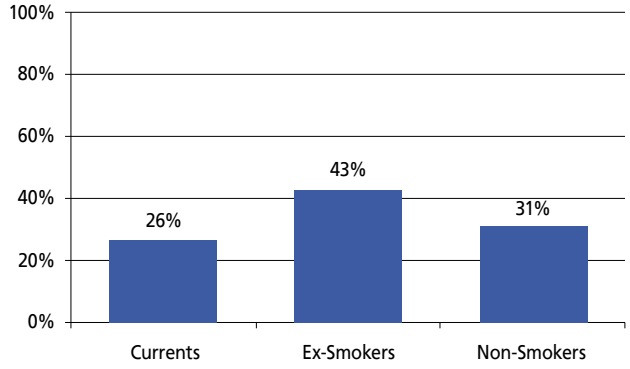
Smoking status

For the purpose of data analysis, smoking status was defined as:

- Current smoker: daily or occasional smoking
- Ex-smoker: don't smoke but used to, tried it a few times but never smoked regularly
- Non-smoker: never smoked.

Of all 361 respondents, 95 (26%) identified themselves as current smokers, while 154 (43%) reported ex-smoking status, and a further 112 (31%) stated that they had never smoked.

Figure 10: Participants' smoking status

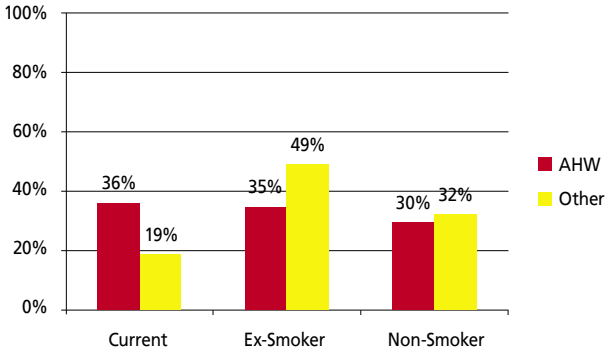


Of the 95 respondents who identified as current smokers, 17 (18.1%) stated that they were planning to quit in the next month, and 36 (38.3%) planned quitting in the next 6 months.

Smoking status by professional role

Compared to other health professionals, responses to the survey question 13 about smoking status shows that AHWs were nearly twice as likely to be current smokers, with rates at 36 (18.7%) and 58 (35.8%) respectively. Also AHWs were less likely to be ex-smokers, with data indicating that only 56 (34.6%) AHWs compared to 95 (49.2%) other health professionals declaring ex smoker status.

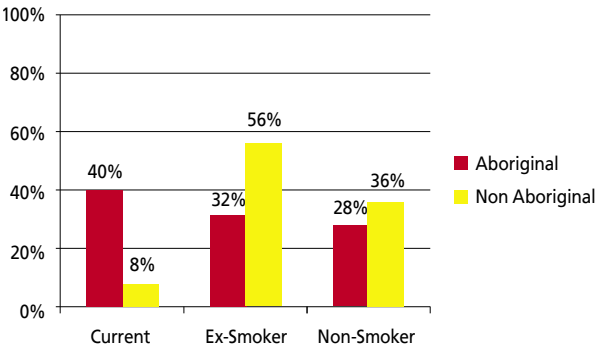
Figure 11: Smoking status by professional role



Smoking status by identity

Baseline data reporting on smoking status by identity which shows that Aboriginal respondents are five times more likely to be current smokers is consistent with national Aboriginal smoking prevalence rates. For example, 80 (40.2%) respondents declared current smoking status compared to 12 (8.2%) non-Aboriginal respondents. Also, Aboriginal respondents were less likely to be ex-smokers, with 63 (31.7%) compared to 82 (55.8%) non-Aboriginal respondents indicating ex-smoking status. Moreover, in relation to non-smoking status, Aboriginal respondents were also less likely to be non smokers. For example, 56 (28.1%) Aboriginal respondents compared to 53 (31.6%) non-Aboriginal respondents indicated non-smoking status. Smoking status by Aboriginal and non Aboriginal identity is represented in Figure 12.

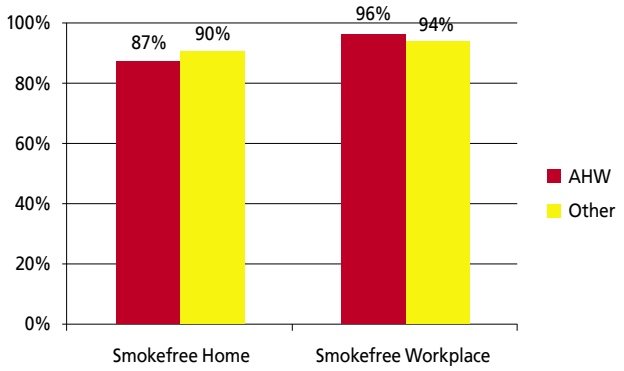
Figure 12: Smoking status by Aboriginality



Smoking at home and work

In relation to smoking at home and work 319 (88.8%) respondents reported that their homes were smoke free, compared to 339 (95.1%) respondents who reported that their workplaces were smoke free. There was a minimal difference between AHWs and other health professionals in reporting smoke free homes, with 144 (87.3%) AHWs and 175 (90.3%) other health professionals stating that their homes were smoke-free. There was also approximate numbers of 157 AHWs (96.3%) and 102 other health professionals 182 (93.6%) describing their workplaces as smoke-free (see Figure 13 below).

Figure 13: Smoke free home and workplace by professional role



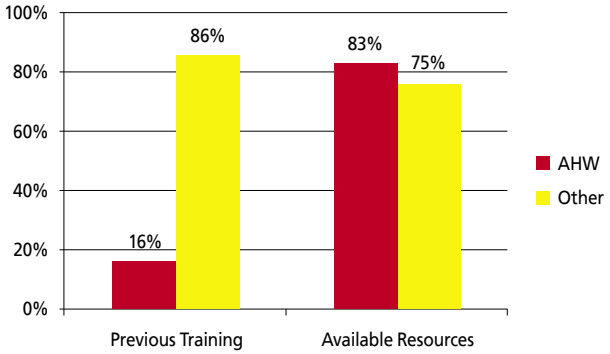
Resources

Responses to the question about the availability of quit smoking resources in workplaces, and their cultural appropriateness showed that 278 (78.8%) respondents had access to resources at work, although only 116 (40.7%) said resources were culturally appropriate. When asked to list specific resources the majority of respondents identified NRT, printed material such as brochures, posters, stickers, and Quitline resources as being available in their services, (See Appendices 3A and 4A).

Training

When questioned about participation in prior smoking cessation training, 71 (19.8%) respondents stated that they had attended courses in the previous six months. Of this group, most respondents specified their participation in the NSW Health Telehealth smoking cessation training. Other courses listed by respondents included: Renee Bittoun's Nicotine Addiction & Smoking Cessation Training, work based training programs and those offered by organisations such as the Cancer Council NSW and QuitVic (see question 19 Appendix 4A).

Figure 14: Attending training and access to resources by professional role



4.3.2 Data set 2: Changes in control group (p1 –> p2)

The control group completed two surveys, the baseline survey (P1) approximately six months prior to training, and the second survey (P2) at the commencement of the training workshop. Using the respondents' personal codes it was possible to match individual surveys from the P1 (n=77) and P2 (n=166) data sets to create a matched pair data set of 28 for analysis.

Of the 28 matched surveys, there were no significant differences (see Appendix 4H). As there were no *SmokeCheck* workshops held between the time the P1 and P2 surveys were administered, there was no significant change in the mean scores for Questions 5-9 relating to the confidence, skills and behaviour of the 28 respondents. These results confirm that non-exposure to the *SmokeCheck* training did not result in any change in these confidence measures. In addition, the results demonstrate there was no contamination from other tobacco cessation training programs that may have been on offer at the same time.

In recognition that matched pairs constituted a small sample size, an independent analysis was also conducted on the P1 (n=77) and P2 (n=166) data sets. Results of the independent analysis showed there were significant differences for five questions (see Table 10 below) in the Aboriginal identity of respondents, and between the five questions about the confidence of health professionals to talk with clients about smoking, readiness to quit and use of NRT. These differences are found in Appendix 4I and the implications of these discussed in Section 5. Table 10 summarises the differences.

Table 10: Differences for unmatched analyses by waiting list control group [prior to intervention]

Survey criteria	Significance (p value)	% P1 survey respondents	% P2 survey respondents
Aboriginal identity	p=0.000	65% Aboriginal	41% Aboriginal
Frequency working with Aboriginal clients	p=0.048	85% worked 'often' or 'all the time',	70% worked 'often' or 'all the time'
Advising clients to reduce ETS	p=0.007	26% advised clients to reduce ETS	44% advised clients to reduce ETS
Smoking status	p=0.031	30% current smoking status	18% current smoking status
Smoking cessation training in the previous 6 months	p=0.002	86% no previous training.	66% no previous training

4.3.3 Data Set 3: Changes in those exposed to the *SmokeCheck* intervention (p2 –> post)

As described earlier in this section (4.3.1), the intervention group completed two surveys, one at baseline at the commencement of the *SmokeCheck* training workshop (P2) and the other approximately six months after baseline (post). Using respondents' personal codes, individual pre and post surveys were paired creating a total data set of 165 matched pairs. Data from the pre and post surveys was then analysed to ascertain whether training had any effect on the knowledge, skills and attitudes of health professionals' to provide a smoking cessation brief intervention to Aboriginal clients. Intervention group pre and post comparisons were based on matched pair survey responses as follows:

- All health professionals (n=165) (Refer to Appendix 4Ja)
- AHWs (n=66) (Refer to Appendix 4Jb)
- All health professionals who had no smoking cessation training in previous 6 months (n=116) (Refer to Appendix 4Jc).

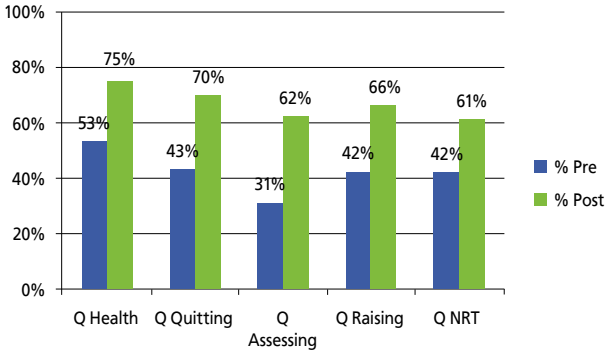
Confidence in assessing and advising clients about smoking

Results show a statistically significant increase in the confidence of all intervention group respondents including AHWs in response to five questions.

Table 11: Statistical significant increases in confidence for all health professionals (intervention group) and Aboriginal health workers

Confidence questions	Statistical significance of changes in whole intervention group	Statistical significance of changes in AHW
1.Talking to their clients about the health effects of smoking	p=0.000	p=0.000
1.Raising 'quitting' with clients making health visits for unrelated health reasons	p=0.000	p=0.000
2.Assessing clients' stage of change for smoking cessation/ readiness to quit,	p=0.000	p=0.000
3.Raising smoking as a point of discussion	p=0.000	p=0.000
4.Advice about NRT.	p=0.000	p=0.000

Figure 15: All health professionals' level of confidence in assessing and advising clients about smoking

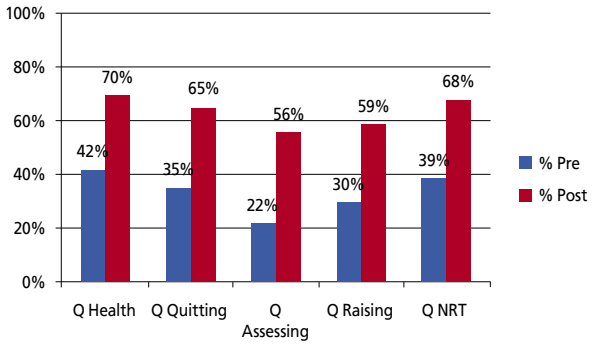


Specifically for example, a comparison of pre survey and post survey results indicates that the confidence of all intervention group respondents to assess clients' stage of change for smoking cessation/readiness to quit, doubled, from 51 (31%) at baseline expressing confidence, compared to 101 (62%) at the post intervention follow-up assessment.

But perhaps more importantly, a comparison of AHW pre and post survey responses to all five questions showed that their levels of confidence also rose considerably. For example, while only 14 (22%) AHWs provided pre survey responses stating they were 'confident' or 'very confident' to assess client's stage of

change for smoking cessation, 37 (56%) AHWs post survey responses indicated they were 'confident' or 'very confident'. Similarly, an increase in AHW responses to the question about confidence to raise 'quitting smoking' with clients making health service visits for other health reasons, from 23 (35%) in the pre survey, to 35 (65%) in the post survey, was also noted.

Figure 16: Aboriginal health workers' level of confidence in assessing and advising clients about smoking

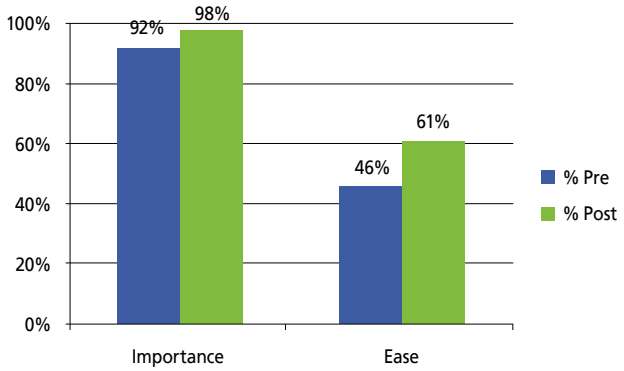


Importance and ease of offering advice

Following the training workshops, the survey data results also showed statistically significant increases in the number of all health professionals who state that 'it is important' (p=0.007) and 'easy to offer smoking cessation advice' (p=0.039) to Aboriginal clients. However, some critical differences emerged between AHWs and other health professionals, with AHWs indicating that it was easier to offer such advice after participating in the *SmokeCheck* training.

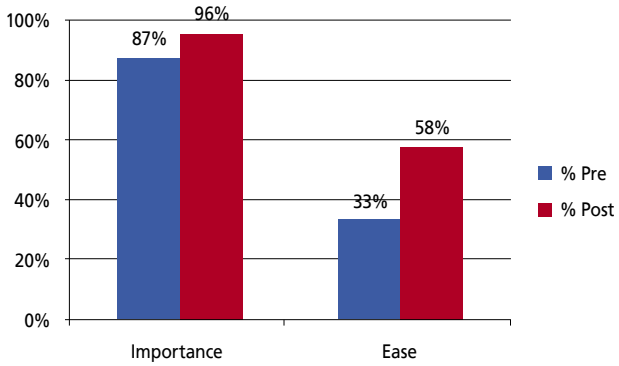
For all health professionals there was an increase from 146 (92%) pre survey respondents to 161 (98%) post survey respondents, who considered it 'important' or 'very important' to offer smoking cessation advice. A more substantial increase was evident, in relation to the ease of offering advice, with 71 (46%) health professional pre survey respondents compared to 99 (61%) health professional post survey respondents stating that it was easier to offer advice after participating in a *SmokeCheck* workshop as illustrated below in Figure 17 below.

Figure 17: All health professionals' responses on the importance and ease of offering smoking cessation advice



An increase was also noted in a comparison of AHW pre and post survey responses to the question about the importance of offering advice which was not significant (p=0.24) and ease of offering smoking cessation advice which was significant (p=0.012) to Aboriginal clients. For example, 55 (87%) AHW pre survey respondents compared to 63 (96%) AHW post survey respondents stated that it was important to offer smoking cessation advice to Aboriginal clients, while 21 (33%) AHW pre survey respondents compared to 38 (58%) AHW post survey respondents stated that it was easier to offer this advice after participating in a *SmokeCheck* workshop.

Figure 18: Aboriginal health workers' responses on the importance and ease of offering smoking cessation advice



Similarly, changes occurred in relation to smoking cessation training in the previous six months where a non significant (p=0.083) increase in the importance of offering advice was shown and ease of offering smoking cessation advice which was significant (p=0.014) to Aboriginal clients was demonstrated. For example, 109 (92%) respondents with no training in the previous 6 months to the pre survey compared to 114 (97%) post survey respondents stated that it was important to offer smoking cessation advice to Aboriginal clients, while 47 (40%) respondents compared to 67 (57%) of post survey respondents stated that it was easier to offer this advice after participating in a *SmokeCheck* workshop.

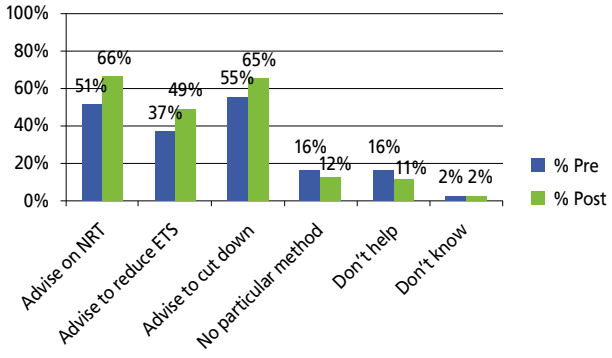
Methods used to help clients quit smoking

In general, the post survey data shows that after the *SmokeCheck* training workshops there were significant increases in the number of health professionals, including AHWs and those who had not undertaken any training in the previous six months, who stated that they provided advice about NRT, reducing ETS, and cutting down tobacco use. The number of health professionals who stated that they offered advice about NRT significantly increased (p=0.001) from 84 (51%) pre survey respondents to 108 (66%) post survey respondents. Similarly significant increases for, 61 (37%) health professionals in the pre survey compared to 81 (49%); health professionals in the post survey stated that they provided information about reducing ETS (p=0.006).

And also a significant increase (p=0.034) from 90 (55%) health professionals in the pre survey to 106 (65%) health professionals in the post survey providing advice about cutting down tobacco use.

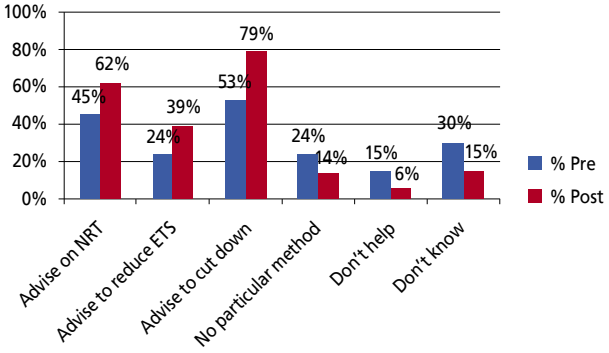
In contrast, the number of health professionals who stated that they 'used no particular method' decreased, though not significantly, from 26 (16%) pre survey respondents to 20 (12%). In addition there was a decrease in the number respondents who stated that they 'did not help clients to quit smoking', from 26 (16%) in the pre survey to 18 (11%) in the post-survey. In relation to health professionals who did not know whether they helped clients to quit smoking there was no change between the pre and post-surveys, with only 4 (2%) responses recorded in each survey.

Figure 19: Types of smoking cessation advice offered by all health professionals



In relation to the advice provided by AHWs to clients about NRT, reducing ETS, and cutting down smoking there were also significant differences noted between pre and post survey responses. Firstly, for example, there was a significant increase (p=0.019) in the number of AHWs from 30 (45%) pre survey respondents to 41 (62%) post survey respondents who stated that they gave advice about NRT. Secondly, there was a significant increase (p=0.031) from 16 (24%) pre survey to 26 (39%) AHW post survey respondents advising how to reduce ETS, and lastly a significant increase (p=0.000) from 35 (53%) pre survey to 52 (79%) AHW post survey respondents who stated that they provided advice to cut down smoking. Encouragingly, those AHWs who stated that they used 'no particular method' to support clients to make a quit smoking attempt, decreased, though not significantly from 16 (24%) to 9 (14%), while the number who 'provide no help', decreased from 10 (15%) to 4 (6%). AHWs who answered 'don't know' to this question about how they support clients to quit, went from 2 (3%) in the pre survey to 1 (1.5%) in the post survey.

Figure 20: Types of smoking cessation advice offered by Aboriginal health workers



Smoking status

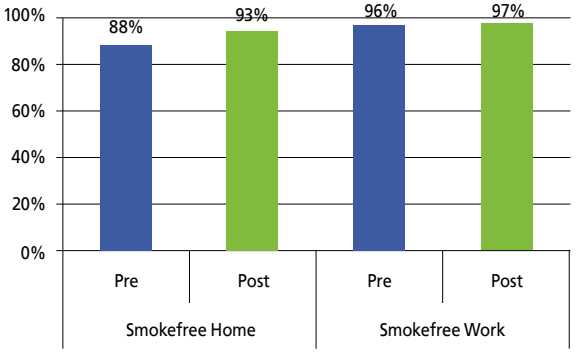
There was no significant change (reduction) in personal smoking status for all health professionals (p=0.69) and specifically AHWs (p=0.55) and health professionals who had no smoking cessation training in the previous 6 months (p=0.75). Similarly for those respondents who currently smoke there was no significant change in readiness to quit, where (p=0.70) for all health professionals, (p=0.78) AHWs and (p=0.85) for health professionals who had no smoking cessation training in the previous 6 months.

Smoking at home

For all health professionals there was no significant difference in reported smoking in their home (p=0.096). More importantly however, the results show that after participating in a *SmokeCheck* training workshop, more AHWs reported that their homes were smoke free (p=0.045).

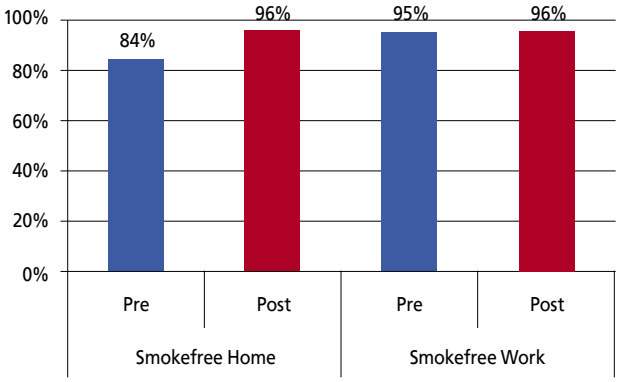
Figure 21 below illustrates the increase for all health professionals from 139 (88%) pre survey to 154 (93%) post survey respondents who stated that their homes were smoke free. A minor increase from 153 (96%) pre survey, to 160 (97%) post survey respondents also reported smoke free workplaces. However these increases were not significant.

Figure 21: Changes in smoke free home and workplace by all health professionals



There was however a significant increase (p=0.045) in the number of AHW pre and post survey responses to the question about smoke free homes. Pre survey responses indicated 53 (84%) AHWs compared to 63 (95%) AHW in post survey responses resided in smoke free homes. Reports about smoke free workplaces also showed minimal change (p=0.74), with 60 (95%) and 63 (96%) AHWs in pre and post surveys respectively, indicating that their workplaces were smoke free.

Figure 22: Changes in smoke free home and workplace by Aboriginal health workers



Resources

There was a significant increase in the availability of culturally appropriate smoking cessation resources in the workplace for all health professionals (p=0.000), including AHWs (p=0.070). Figure 23 below shows a 20 per cent increase in the number of respondents who indicated that they have access to culturally 'appropriate' or 'very appropriate' resources in their workplace, an increase from 51 (41%) to 90 (60%) health professionals. Interestingly, the increase in the post survey respondents specifying access to culturally appropriate resources is attributable to health professionals other than AHWs as illustrated in Figure 24. A possible reason for the increase may be a raised awareness resulting from the *SmokeCheck* training workshops.

Figure 23: Access to culturally appropriate resources by all health professionals

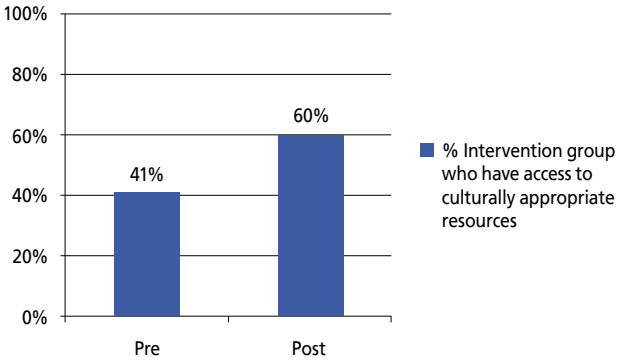
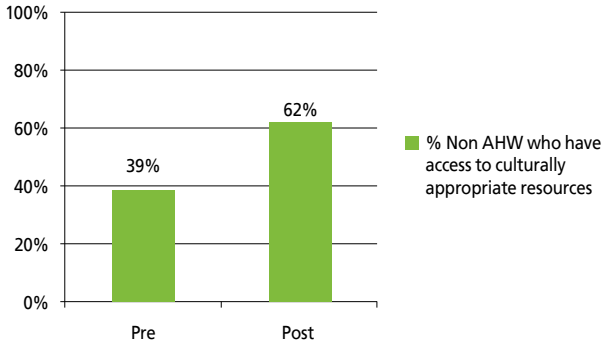


Figure 24 below demonstrates the significant increase in access to culturally appropriate resources (p=0.000), from 27 (39%) in the pre to 56 (62%) in the post survey was largely for health professionals other than AHWs.

Figure 24: Access to culturally appropriate resources by health professionals other than Aboriginal health workers



Thematic analysis from post workshop surveys

In the post workshop surveys a number of open ended questions were asked (see Appendix D) including:

- Attendance at more than one *SmokeCheck* workshop and reasons why
- Other smoking cessation training courses attended in the last 6 months
- Availability of quit smoking resources in the workplace
- Any other comments.

Results from each of these questions are as follows.

Attendance: Twelve people indicated attendance at more than one *SmokeCheck* workshop. Reasons for this included attending the pilot program, attending the manager's training session, or organisational support to participate more than once.

Other smoking cessation training: Of the small number of respondents who indicated attendance at other training, the following courses were specified; the NSW Health Telehealth smoking cessation training, Renee Bittoun's Nicotine Addiction & Smoking Cessation Training, generic and specialist in-service training. There were substantial differences in the number of people who responded to this question, for example 113 responses to the pre survey and 31 to the post. One reason for this difference may have been that fewer courses were offered or accessed in this time period.

Availability of quit smoking resources: There was a substantial increase in the number of people identifying access to print and audio visual material in the post survey (74%) compared to the pre survey (52.5%). In the post survey, 42 per cent of respondents who answered this question identified *SmokeCheck* resources. Other resources specified included pharmacotherapies (NRT), and the Quitline information (see Appendix 4D).

Any other comments: Other comments in the post survey were similar to feedback findings and included expressions of appreciation and satisfaction for the workshop. Specific positive comments were made about the workshop's focus on Aboriginal communities, with a number of requests for more training and resources.

4.3.4 Comparison of changes within control & intervention group

Data analysis included a comparison of P1 and P2 survey results in the control group, as well as P2 and post survey results in the intervention group. That there was no change in the control group in the six month period between P1 and P2 surveys demonstrates that non-exposure to the *SmokeCheck* training program has no effect on the capacity of AHWs and other health professionals working with Aboriginal clients. In contrast, the changes in the P2 to post surveys from the intervention group demonstrated that exposure to the *SmokeCheck* training had some positive effect on the capacity of AHWs and other health professionals working with Aboriginal clients. The lack of any change in the control group comparison, in contrast to the change in the intervention group confirms that exposure to the *SmokeCheck* program results in positive outcomes.

4.3.5 Data Set 4: Pre and post managers survey

Managers who were recruited to participate in the pre and post *SmokeCheck* workshop surveys. Manager surveys included both open-ended text and check box questions, and sought respondents' views about:

- The roles of AHWs to offer smoking cessation advice
- How easy or difficult it is for AHWs to offer smoking cessation advice
- The confidence of all health professionals to offer smoking cessation advice
- Their confidence to build service capacity to deliver *SmokeCheck*
- Plans and/or policy to support smoking cessation initiatives
- Quit smoking resource availability and their cultural appropriateness
- Workplace smoking cessation policy development and implementation
- Previous smoking cessation training
- Support for staff to deliver *SmokeCheck*
- The importance of health promotion and organisational change
- Their own smoking status, and in relation to home and workplace.

Surveys also asked respondents to identify their professional roles (question 1), Aboriginality (question 2) and to describe the *SmokeCheck* program (question 3). Responses to the check box questions were collated and analysed quantitatively, whereas open-ended text responses were analysed thematically.

This section reports on manager survey results including:

1. Manager pre survey results
2. Changes in pre and post surveys
3. Thematic Analysis of open-ended questions text based responses.

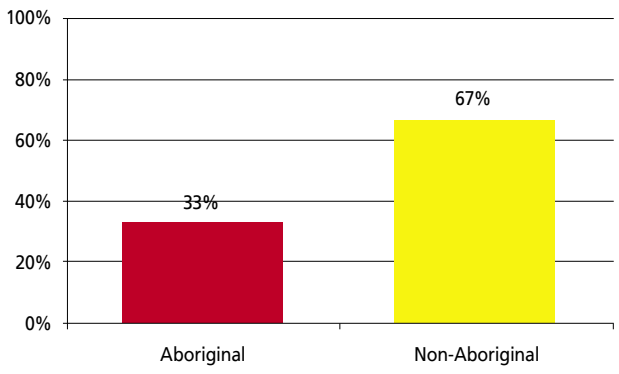
Manager pre survey results

Forty-four managers attended the *SmokeCheck* Manager workshops and completed a pre survey. The results of this report on manager's Aboriginality, smoking status, home and work smoke free environment.

Aboriginality

Of the 44 managers, 18 identified as Aboriginal descent (42%), and 25 as non-Aboriginal (58%), see Figure 25 below.

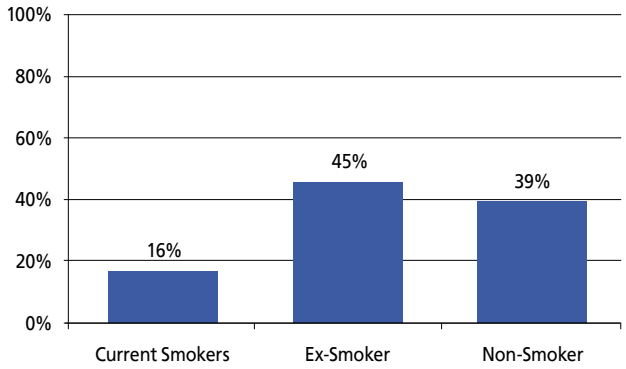
Figure 25: Managers attending the *SmokeCheck* training by Aboriginality



Smoking status

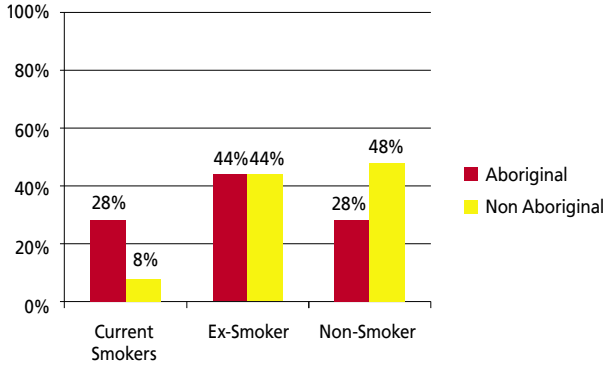
Eight managers (16%) specified 'current' smoking status, 20 'ex-smoker' status (45%), and 17 'non-smoker' status (39%). Six of those managers (75%) who specified 'current' smoking status, stated that they were planning on quitting within the next one to six months, see Figure 26 below.

Figure 26: Managers' smoking status



Measures of manager's smoking status by identify, shows that five Aboriginal managers (28%) compared to two non-Aboriginal managers (8%) specified 'current' smoking status. In addition, Aboriginal managers indicated they are far less likely than non-Aboriginal managers to be non-smokers, five (28%) compared to 12 (48%), as in Figure 27 below.

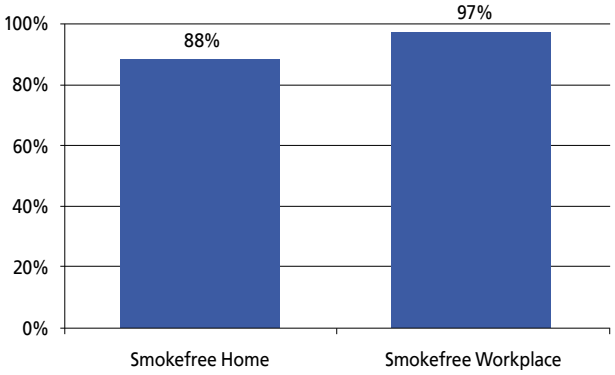
Figure 27: Managers' smoking status by Aboriginality



Smoke free environments

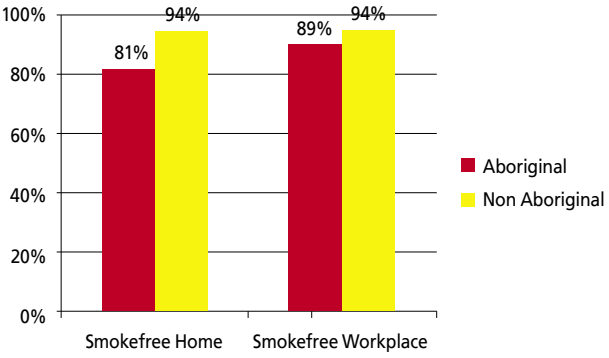
Most managers stated that they lived and worked in smoke free environments, although four managers (12%) revealed that there was 'occasional' or 'daily' smoking in their homes. Thirty three managers (97%) reported working in a smoke free workplace, and only one (3%) reported frequent smoking at work, see Figure 28.

Figure 28: Managers' responses on changes in smoke free home and workplace



In addition, a few more Aboriginal managers than non-Aboriginal managers reported higher rates of ETS in the home, for example 13 (82%) compared to 16 managers (89%) respectively. While 16 Aboriginal and non-Aboriginal managers (94%) reported their workplaces were smoke free. Figure 29 below shows these comparisons.

Figure 29: Managers' responses on smoke free home and workplace by Aboriginality



Managers' perceptions of aboriginal health worker role in smoking cessation

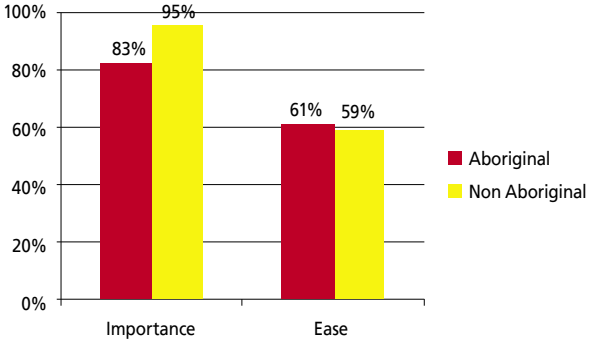
In response to a question about the provision of smoking advice, 41 managers (95%) overall, stated that it was the role of AHWs to provide such advice to clients.

Managers' perceptions of importance and ease of offering advice

In response to a question about the importance of such advice, 41 (91%) overall, reported that it was very important for every client who smokes to be offered advice about quitting, with 15 Aboriginal managers (83%) and 24 non-Aboriginal managers (96%) indicating it was either 'important' or 'very important'. There was general agreement between Aboriginal and non-Aboriginal managers about how easy staff might find it to offer advice. For example 11 Aboriginal managers

(61%) and 13 non-Aboriginal managers (59%) agreed it was easy to very easy to give advice.

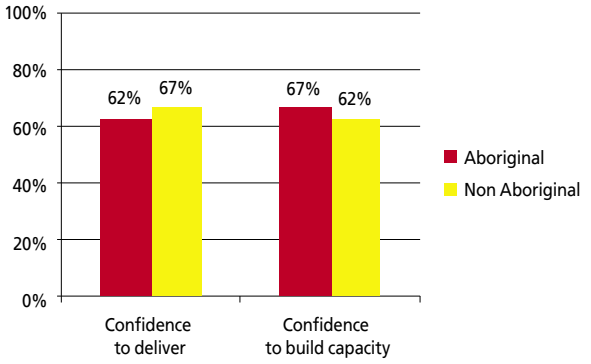
Figure 30: Managers' responses on the importance and ease of offering smoking cessation advice by Aboriginality



Managers' confidence

Two questions sought to gauge the confidence of managers in relation to the routine provision of the *SmokeCheck* brief intervention, with results showing that 25 managers (63%) overall, stated they were either 'confident' or 'very confident' about the capacity of their staff and service to undertake this. Fourteen non-Aboriginal managers (67%), compared to 11 Aboriginal managers (61%) reported being confident about the delivery of the intervention. While, 13 non-Aboriginal managers (62%) and 12 (67%) Aboriginal managers were confident about building service capacity as in Figure 31 below.

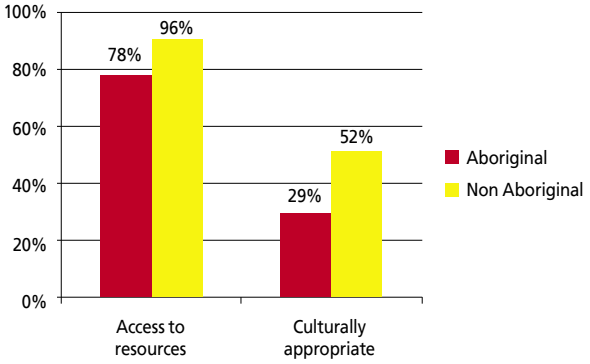
Figure 31: Managers' level of confidence to build service capacity and deliver the *SmokeCheck* intervention by Aboriginality



Availability of resources

Thirty seven managers (88%) overall, reported their services made quit smoking resources available to clients, while 16 managers (43%) stated that these resources were culturally appropriate. Fourteen Aboriginal managers (78%), and 20 non-Aboriginal managers (96%) indicated that quit smoking resources were not available. In contrast, only four Aboriginal managers (29%) indicated that resources were culturally appropriate compared to 12 non-Aboriginal managers (52%).

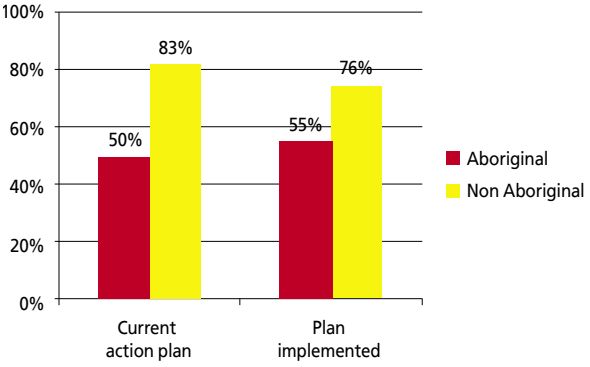
Figure 32: Managers' responses on access to culturally appropriate quit smoking resources by Aboriginality



Policy

Thirty managers (70%) reported that their services had a current policy and/or action plan about smoking cessation. Two managers (7%) stated policies/action plans were fully implemented whereas nineteen managers (61%) stated policies were 'mostly implemented'. 10 managers (32%) indicated policies as either 'partly' or 'a little implemented'. There was no difference between the response of Aboriginal or non-Aboriginal managers to these to questions as Figure 33 shows.

Figure 33: Managers' responses on smoking cessation action plan and implementation in place by Aboriginality



Prior training

Managers were asked about quit smoking training offered in their services in the previous six months, and how well this was received by staff. 20 managers (49%) specified that their services had had prior training, and of these 17 (85%) stated that the training had been well received. 21 managers (51%) indicated that their services had had no previous training within the previous six months.

Organisational change

Using a scale of importance 0-10, managers rated four key elements of organisational change including:

1. Establishing a task group or coalition to identify, support and facilitate changes that are needed

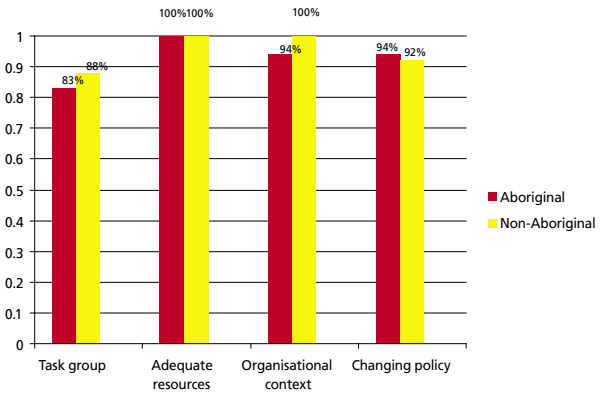
2. Identifying and providing adequate resources for change to take place

3. Taking into account the organisational context (e.g. internal/external influences, barriers) when implementing change

4. Changing policy to outline the organisations commitment to tobacco control.

Figure 34 below shows most managers reported that these organisational elements were either 'important' or 'very important'. There were no differences between Aboriginal and non-Aboriginal manager's responses.

Figure 34: Managers' responses on the importance of organisational change key elements



Changes in pre and post manager surveys

Twenty eight pre and post manager surveys were matched, and no significant changes were found. Possible reasons for this are discussed in Section 5 Discussion and Recommendations.

Managers surveys: Thematic analysis

Participant roles: The combined results of the 28 matched pre and post surveys indicates that the majority of managers described their roles as health promotion specialists, Chief Executive Officers or health service managers. Others described their roles specifically as Aboriginal Health Managers, Practice Managers, Clinical Nurse Consultants, or Program Coordinators in specialist areas such as Population Health, Equity and Communities and Healthy for Life. The details of these results are presented in Q1 in Appendix 4F.

Descriptions of *SmokeCheck*: 20 manager responses to this question described *SmokeCheck* as an 'Aboriginal specific', 'culturally appropriate brief intervention' and 'resources', while other survey responses described it as 'useful, valuable, informative, good, great or excellent'. A smaller number of respondents described *SmokeCheck* as 'educational'.

Quit smoking resources: Most managers identified the availability of quit smoking resources, in particular Quitline information and fax referrals as well as NRT and the prescription medication Champix (Varenicline). A significant number also identified the *NSW Health Smoke Free Workplace*, and Car and Home policies. Generic resources variously described as 'brochures, pamphlets, stickers, posters, fact sheets and manuals' were also described. A smaller number of managers specifically identified the *SmokeCheck* resources, and the Cancer Council NSW (see Q9a, Appendix 4F).

Awareness of policies: There was extensive manager awareness of the existence of the *NSW Smoke Free Workplace Policy*. Also, post survey responses identified the *SmokeCheck* and other training, as well as support mechanisms such as NRT to assist staff to quit. A smaller number of managers explained that although a smoking cessation policy was part of their service's Action Plan it had not yet been implemented. (see Q10a, Appendix 4F).

Prior quit smoking training: Of all managers, 20 per cent reported that staff in their services had participated in the NSW Health Telehealth smoking cessation training in the previous six months. A range of other training programs were identified including: the *SmokeCheck*, Renee Bittouns 'Nicotine Addiction & Smoking Cessation Training', and the *New South Wales Health Smoke Free Workplace Policy* and the NSW Cancer Council workshops. Two respondents also identified Aboriginal specific training programs, including the 'Clean Air Dreaming' program and 'GUTS' Give Up The Smokes.

Support for staff: Approximately 50 per cent of managers stated that they encouraged and supported staff to attend the *SmokeCheck* workshop, use the accompanying resources and deliver brief interventions. Some however reported having inadequate resources, including a lack of staff to provide brief interventions. Some managers described being 'unsure' about how to support the delivery of *SmokeCheck* (see Q16, Appendix 4.3C).

Health promotion: Responses to the question about the common characteristics of a health promoting organisation, elicited a number of examples. These included for example: dedicated health promotion staff and resources such as promotion boards and newsletters, free NRT and quit programs for staff, the *NSW Health Smoke Free Workplace Policy*, and other healthy lifestyle programs.

Organisational change: In post surveys, managers were asked to elaborate on organisational change strategies implemented in their services during the previous six months. The most common response was the establishment of 'smokefree areas and centres'. Other strategies specified were the provision of resources, the setting up of task groups and reviewing or changing clinical guidelines and practice.

Other comments: Only a few managers offered additional feedback. This included a request for further training to build capacity and staff skills to deliver smoking cessation brief interventions and advise about NRT. One manager indicated that a high workload was an issue.

4.3.6 *SmokeCheck* resources

An important component of the *SmokeCheck* has been the distribution of print-based and audio visual resources at workshops. All participants received a pack of 5-10 of each of the *SmokeCheck* pamphlets, desktop guidelines and posters as well as a resource folder with the Bernard's Choice DVD and additional NSW Health smoking cessation health promotion information (see Section 2.6). The NSW Department Health Centre for Health Advancement Resource Distribution Unit has played an important role in managing and monitoring the distribution of these resources. The continuous ordering of resources following the delivery of the training is an additional measure of the Project's impact on the implementation of the *SmokeCheck* brief intervention. Data from the NSW Department of Health Centre for Health Advancement Resource Distribution Unit indicates resources have been distributed across all Area Health Services (see Appendix 4L).

The seven items of the *SmokeCheck* resources are calculated as on item individually, and include:

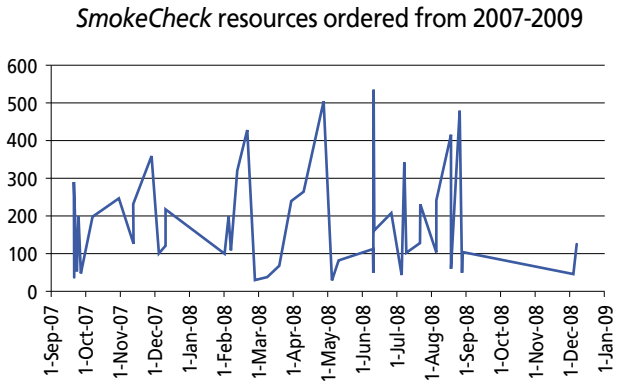
- Pamphlet 1: Not ready
- Pamphlet 2: Unsure
- Pamphlet 3: Ready to give up
- Pamphlet 4: Staying an ex-smoker
- Pamphlet 5: Smoking and Pregnancy
- Desktop tool card
- Poster

In all 9,831 resources were ordered through the NSW Department of Health Centre for Health Advancement Resource Distribution Unit between September 2007 and January 2009. North Coast Area Health Service ordered the most resources with a total of 3092 (31%) followed by 1767 (18%) from Hunter New England Area Health Service and 1764 (18%) from South Eastern Sydney Illawarra Area Health Service. The following table lists the resources distribution by each Area Health Service and the following Figure 35 displays the resources ordered over the last 14 months. See Appendix 4L for detailed distribution of resources across regions.

Table 12: Distribution of *SmokeCheck* resources by area health service

Area Health Service	Count of *SmokeCheck* resources ordered
Greater Western	182
Greater Southern	1,319
Hunter New England	1,767
Justice Health	46
North Coast	3,092
Northern Sydney Central Coast	40
South Eastern Sydney Illawarra	1,764
Sydney South West	1,205
Sydney West	416
Total	**9,831**

Figure 35: *SmokeCheck* resources ordered from September 2007 to January 2009



4.4 Conclusion

The following outcomes were achieved by the *SmokeCheck* Project. The Project was designed to strengthen the capacity of all health professionals and in particular AHWs, through training, to deliver a smoking cessation brief intervention to all their clients who smoke. The training, which reached 519 health professionals including 35 per cent of the NSW AHWs workforce, was received positively. In addition, the evaluation showed that exposure to the training resulted in increases in:

- The confidence of all health professionals in talking about the health effects of smoking, advising clients to quit, assessing readiness to quit and bringing up the need to quit smoking
- The number of health professionals providing advice/ information about NRT, ETS, and cutting down tobacco use
- The number of health professionals who state that it is 'important' and 'easy' to offer smoking cessation advice to Aboriginal clients, specifically AHWs
- The number of AHWs who live in smoke free homes
- The availability of culturally appropriate resources.

Conversely, the results demonstrated that there was no change in the skills, knowledge or attitudes of the control group.

SECTION 5

Discussion and recommendations

Section summary

The *SmokeCheck* Project was a 'population-wide' dissemination study that sought to train all AHWs and other health professionals working with Aboriginal clients and integrate the *SmokeCheck* intervention into their clinical and health promotion roles across services in NSW. Numerous elements of the design and delivery of the Project contributed to its extensive reach and maximised participants' satisfaction.

The impact evaluation results showed that improvements were achieved across a number of areas for all workshop participants, in particular there were statistically significant increases in the confidence and in skills and knowledge about NRT, ETS and cutting down tobacco use. These results were in the direction expected, achieving the Project's desired outcomes. One of the implications of the above changes for Aboriginal clients who smoke is more effective health service provision. This in turn has the potential to promote quit attempts, and decrease the exposure of Aboriginal family members to the harmful effects of tobacco use. The Project also presented challenges, limitations and opportunities for improvement in research evaluation, project management, while participants also raised issues.

The findings from the Project suggest an intensive, bottom-up approach combined with an extensive, top-down approach will:

- Increase the confidence of all AHWs and other relevant health professionals in offering brief intervention on smoking cessation to all Aboriginal clients
- Ensure that all health services across NSW integrate the *SmokeCheck* intervention into routine service delivery, adopting management, information systems, and evaluation methods to support it
- Increase the number of NSW Aboriginal communities that express support for an evidence based range of public and individual tobacco control measures – including public policy and community mobilisation.

In particular, the Project is in a position to utilise existing relationships to facilitate partnerships and networks to meet the continued requests for additional workshops, and strengthen the capacity of AHWs, other health professionals and services to address the high rates of smoking in Aboriginal communities.

5.1 Introduction

To reduce the prevalence of smoking in Aboriginal communities it is first necessary to ensure that all people who smoke receive an evidence based intervention that encourages and supports them to quit. The *SmokeCheck* Project was established to provide training and educational resources for all AHWs and as many other Aboriginal and non-Aboriginal health professionals who work primarily with Aboriginal clients, to deliver an evidence based, culturally-specific smoking cessation brief intervention.

The Project was conceived as a replication or dissemination program. The efficacy of the brief smoking cessation intervention had been established, and the efficacy of the *SmokeCheck* training program had also been established through a pilot project that preceded this statewide intervention. The *SmokeCheck* intervention included a training program for AHWs and other health professionals and a second workshop to assist managers and health professionals to incorporate brief smoking cessation advice and support into the routine clinical and health promotion practice of all health professionals working in 'real world' conditions across services in NSW. Specifically, the Project's objective was to build the capacity of the maximum possible number of AHWs and other health professionals to deliver a smoking cessation intervention to Aboriginal clients.

The report has described in detail the extensive efforts made to ensure the *SmokeCheck* Project was delivered as planned, that it reached its intended audiences, was considered to be comprehensible and applicable to health service practice, and that it met its stated objectives and outcomes.

5.2 Process evaluation: Reach and satisfaction

The process evaluation demonstrated the reach and overall participant satisfaction with the training. A total of 519 health professionals were reached by the program. Of these, 199 identified their roles as AHWs, meaning that the Project reached 35.5 per cent of the total NSW AHWs workforce. Given that training was delivered over a period of only 13 months this is a significant achievement.

The evaluation of the training found that more than 90 per cent of respondents were satisfied with the curriculum content, workshop structure and training delivery, agreeing that they found it relevant, easy to understand, and applicable to practice. These outcomes demonstrate that a health research project which makes meaningful and practical contributions and that is designed specifically for Aboriginal communities has the potential to achieve results not just in one or two services or communities but across a much wider audience.

Many elements have contributed to the success of the *SmokeCheck* Project in reaching its intended audiences and in ensuring their satisfaction with the training and resources they received. The elements included the genesis of the Project and its theoretical framework, partnerships, the knowledge, skills and commitment of the Project team, the quality of the educational resources, quality assurance and the organisational support provided by the NSW Department of Health (including financial support) and by the School of Public Health, The University of Sydney.

Planning, development & theoretical framework

The Project developed in response to demand from experienced, knowledgeable AHWs and other health professionals. The long lead times, planning phase and pilot testing, resulted in a training program that was delivering a culturally-specific smoking cessation brief intervention underpinned by theory and evidence which met global and local standards of cultural specificity and quality health promotion. The planning phase also included extensive attention to fostering positive relationships and collaborations with Aboriginal health services across the state to ensure the quality and accessibility of the training, and a comprehensive data base. Consequently ongoing communication between all contacts and the *SmokeCheck* team and the achievement of high levels of involvement with all health services, AHWs and other health professionals was encouraged and maintained.

Partnerships

Partnerships with organisations and individual services were also important to the Project. Relationships with Reference Group members such as the AH&MRC and the NSW Department of Health facilitated access to individual Aboriginal Community Controlled Health Service and Area Health Service throughout NSW. This invaluable support assisted the organisation and delivery of workshops and the administration of the evaluation research. Existing networks, with a similar responsibility for promoting Aboriginal health and reducing smoking prevalence, were also utilised. The NSW Tobacco Control Network (TobNet), the Aboriginal Chronic Care Program, and NSW Health Telehealth smoking cessation training sessions for example, all contributed to the identification of contacts and the promotion of *SmokeCheck*. In addition, the commitment of the Cancer Institute NSW and the NSW Minister for Health was essential to the Project's ongoing success. A Ministerial launch provided the initial promotion and platform the Project required. These organisations provided high level political support and active commitment to the policy idea of active intervention to reduce smoking rates in Aboriginal communities.

Project team

The Project's Chief Investigator provided Aboriginal leadership, bringing long experience in Aboriginal health promotion, research and management to the task. The Project team comprised of Aboriginal and non-Aboriginal members, incorporated a mix of experience, skills, and determination. They ensured that training was delivered as planned and that data collection was given equal priority. The Project team, as a whole, included skilled researchers/health professionals with expertise in working with Aboriginal communities and in intervention research and tobacco control.

Resources

Sufficient resourcing was critical in allowing the Project to reach its intended audiences with the requisite intensity, to achieve its full delivery as planned and to conduct the evaluative research. Appropriate funding enabled a full response to the demand for training which was offered at multiple sites in two rounds. Importantly it supported the travel necessary to cover the extensive geographical distances and liaise with key contacts, as well as provided the capacity to subsidise the travel of some AHWs to attend the training and ensured the sourcing of appropriate venues conducive to learning. Time was another vital resource element necessary to ensure that the Project's goals were achieved, and that contributed to the capacity of the Project to maintain

a level of flexibility and meet the training needs of individual services. Furthermore, with additional time an even greater reach could have been achieved.

Quality assurance

Ongoing quality assurance measures of the training saw the application of participant feedback form responses about workshops and highlighted factors that were important to the success of the training. Using a quality assurance approach meant that the *SmokeCheck* Project developed a high level of credibility and respect among AHWs, other health professionals, and health managers delivering services to Aboriginal communities, community members and experts in the field. The Project team's understanding of the organisational and community contexts in which health services, including tobacco control are offered contributed to this credibility. Another significant point was that in areas where there were good relationships between Aboriginal Community Controlled Health Services and Area Health Services staff there was often increased health professional attendance at training workshops. In these areas workshop registrations sometimes exceeded the capacity of the venue, so that it was necessary to offer and conduct second round workshops.

The most positive feedback indicated high morale and motivation amongst participants when groups were able to share personal experiences. Interestingly, participants who smoked viewed training positively, with some commenting, for example, that they were "Glad I came along today. I am a smoker and wasn't too keen to come initially. I felt that I would be an outcast at today's workshop due the fact that I smoke"; "…great to see it explained to non smokers what it is like to crave smoking. I feel more confident about quitting and assisting others to quit".

Organisational support

If the *SmokeCheck* intervention was to be integrated into the routine practice of all health professionals, it was clear that organisational support by their employing agencies would be necessary. A two-hour manager's workshop was therefore added to the *SmokeCheck* training schedule. On the one hand the function of these workshops was to consolidate organisational understanding of the *SmokeCheck* intervention, and on the other hand, it proposed organisational change strategies to facilitate the integration and systemisation of *SmokeCheck* into routine service provision.

5.3 Impact evaluation: Were the objectives met?

The evaluation design enabled the Project to assess its impact on the knowledge, attitudes and confidence of AHWs and the other health professionals. It also enabled assessment as to whether the changes detected were the result of exposure to the *SmokeCheck* training alone rather than the result of other possible influences.

A primary objective of the *SmokeCheck* Project was to build the capacity of AHWs and other health professionals who work predominantly with Aboriginal communities in NSW, in the delivery of evidence based best practice smoking cessation interventions. Another objective was to increase AHWs capacity to plan, implement and evaluate local tobacco health promotion projects and train others in tobacco control. Other objectives were to increase awareness of tobacco related legislation, minimise ETS exposure, and motivate AHWs who smoke to quit. This focus on AHWs capacity was based on the understanding that AHWs are best placed to deliver brief interventions to Aboriginal clients, to increase the likelihood of the smoking cessation brief intervention being successful (Rose and Jackson Pulver, 2004, p.241).

The evaluation found that, when capacity is considered broadly in terms of all professionals' confidence, knowledge and skills, improvements were achieved in the following areas. There were statistically significant increases in the confidence of all workshop participants including AHWs in five areas:

1. Talking to clients about the health effects of smoking
2. Raising 'quitting' with clients making health visits for unrelated health reasons
3. Assessing clients' stage of change for smoking cessation/readiness to quit
4. Raising smoking as a point of discussion
5. Advice about NRT.

Moreover, statistically significant increases were found in participants' knowledge and skills in terms of NRT, ETS and cutting down tobacco use. Conversely, there was also a decrease in the number of participants who used no particular method to advise and who did not help clients to quit smoking.

The implications of the changes above are that all health professionals including AHWs are more confident, knowledgeable and skilled in using evidence-based smoking cessation interventions. Importantly this means that Aboriginal clients who smoke are more likely to have

access to professionals who are more confident, skilled and knowledgeable in helping them to quit. It is reasonable to predict, therefore, that they will facilitate an increase the number of quit attempts on the part of their clients, and contribute to a decrease in the exposure of Aboriginal family members to the harmful effects of tobacco smoke.

An interesting finding was a statistically significant increase in AHWs who reported that after participating in the *SmokeCheck* training, their homes became smoke free, suggesting that although AHWs who smoked were unable to commit to a quit attempt, they nevertheless recognised that making their home smoke free would contribute to the health of their families. In the short term this outcome might also impact on Aboriginal children's perceptions of tobacco use as the norm, and in the long term result in fewer children adopting the habit.

One objective which was not achieved was participants' smoking status and readiness to quit. Although anecdotally some AHWs stated that they did quit, or were considering doing so within the next 1 to 6 months, the changes detected in the survey results were not statistically significant. This is in line with other evidence, which shows that training is only one aspect of a multi-component approach necessary for influencing a person's readiness to quit smoking (Bittoun 2005).

Other results (see Section 4) drawing on unmatched, independent data for the control group showed differences between P1 (pre-pre) and P2 (pre) survey respondents.

- More Aboriginal people completed P1 surveys than attended workshops (65.3% of P1 survey respondents identified as Aboriginal compared to 41% of respondents who came to workshops and completed P2 surveys).
- P1 survey respondents worked with Aboriginal clients more often (84.5% of P1 survey respondents indicated they work with Aboriginal clients 'often' or 'all the time', compared to 69.7% of P2 survey respondents).
- Half the number of P1 survey respondents or 26 per cent indicated they advised clients to reduce ETS compared to 44.2 per cent P2 survey respondents.
- More smokers filled out P1 surveys (29.9% of respondents of the P1 survey indicated they are current smokers compared to 17.8% of P2 survey respondents).
- More people who had had previous training attended workshops than those who filled out P1 surveys but did not attend (85.5% of the P1 survey respondents indicated they had no previous training, compared to only 66% of participants of P2 survey).

Comparison of P1 and P2 responses showed many respondents to the P1 survey did not attend the training 6 months later. Although the study did not include specific follow up to determine the reasons for non-attendance, the above data show that Aboriginal respondents tended to have no previous training, did not already offer smoking cessation advice to clients, worked predominantly with Aboriginal clients and were more likely to be current smokers. Conversely respondents, who did attend training and completed P2 surveys tended to be non-Aboriginal, work less with Aboriginal clients, already offered smoking cessation advice (e.g. ETS), had already had training, and were more likely to be non-smokers.

Despite ongoing efforts to make the workshops as accessible as possible to AHWs in particular, the findings indicate that the targeted groups were not always reached. It is likely that reasons for this included:

- Heavy workloads that meant P1 survey respondents were not able to be released from work to attend training
- Supervisors may have asked staff to complete P1 surveys but then did not encourage attendance at training
- Respondents identified as smokers may find it easier to fill out a 5-10 minute survey re smoking rather than attend a full day of training
- Some health professionals may not see smoking cessation advice as part of their role
- Organisational constraints, high staff turnover and continuous demand on AHWs to undertake training.

The discrepancy between intention to attend and actual attendance highlights the need to work with existing organisational systems to explore options and to encourage the highest possible participation.

In summary, evaluation of the impact of the *SmokeCheck* training intervention showed the confidence and ability to deliver the brief smoking cessation intervention increased significantly among health professionals who attended training. Participants were also significantly more likely to report that they had access to the culturally-appropriate *SmokeCheck* resources. These results were in the direction expected and confirmed that the Project had achieved its desired outcomes.

Conversely, the findings showed that there were no changes in the knowledge, skills and confidence of AHWs and other health professionals who had not been exposed to the training. This validates the evaluation findings. The fact that the Project has been able to demonstrate significant impact, especially relating to

confidence to deliver smoking cessation advice, is meaningful. This is particularly important given that it is harder to attribute change effects in an environment where there is considerable alternative background noise (i.e. smoking control campaigns and local anti-smoking projects) to a specific intervention.

5.4 Challenges and limitations

Reflecting on the evaluation of the Project it has been important to consider not just the Project's strengths and achievements, but also challenges, limitations and opportunities for improvement. In general this has required detailed attention to the ethical design and practical requirements of conducting research in Aboriginal communities and acknowledging:

- Processes underpinning Aboriginal research such as those outlined in the National Health and Medical Research Road Map
- The need for training and education to make a difference to Aboriginal health service provision
- The role of health professionals in health promotion service provision to Aboriginal communities
- The role of AHWs in service provision to Aboriginal communities
- More specifically it has entailed considering particular evaluation issues which are discussed below.

5.4.1 Evaluation challenges

One of the first challenges associated with the evaluation research was the need to maximise the distribution of P1 surveys amongst the control group. However, when the Project began there was no reliable measure of the number and location of AHWs in NSW. Nor was there any specific method for measuring the effectiveness of the distribution of surveys to this population. For example there was no way to discern whether the survey distribution strategies of mailing, emailing and providing the survey web link enabled all intended recipients to respond, or whether they had the requisite knowledge/skills or internet access to complete the survey. A strategy that could have helped to address this challenge may have been a preliminary field trip to promote the *SmokeCheck* training and to distribute P1 surveys in person. While this was considered at the commencement of the Project the strategy was not implemented due to time constraints.

Differences between individual and organisational views about how the survey distribution process should be undertaken was another challenge, with some citing the need to follow strict organisational protocols, and others who were available to provide support, not always in a position to follow through because 'protocols' precluded it. This challenge points to the need for flexibility, time and adequate resourcing to consider and fulfill the unique needs of individual services.

Matching P1 and P2 survey forms and maintaining strict confidentiality also posed a challenge. It was anticipated that the creation of personalised survey codes would streamline the P1 and P2 survey matching process, but the reality proved more complex. The complexities associated with the creation of personal codes included the fact that some participants did not know their mother's maiden name, some left the code blank and others varied their codes between completing surveys, despite instructions for creating the code being provided on every survey. As a recommendation for the future it was noted that more time should be given to explaining the coding procedure, drawing people's attention to possible pitfalls and providing opportunities for the clarification of difficulties.

5.4.2 Project challenges

One important challenge was that for some participants, the *SmokeCheck* training was largely a reiteration of their existing skills and knowledge. This resulted in a 'ceiling effect', in that there was no room for these participants to significantly improve or for the Project to change outcomes that it set out to achieve. Related to this was that training appeared, in some instances, to attract non-Aboriginal participants who were already accessing training at every opportunity, rather than those who were not. While the *SmokeCheck* Project did not exclude any health professionals from attending the training, it did seek purposefully to maximise AHW's participation. The Project was based on the understanding that improving the skills and knowledge of this group is a priority in keeping with the *National Strategic Framework for Aboriginal and Torres Strait Islander Health: Framework for action by Governments*, (NATSIHC, 2003, p.20). An implication of this for the future is that consideration should be given to the development of new strategies and for the continuation of training in particular for this group.

Another challenge was anecdotal feedback indicating that some AHWs who smoked may not have participated in the training because they perceived that it would be focused on their personal smoking status and readiness to quit. Although it was a primary Project objective to increase the motivation of AHWs who smoke to quit, the training was careful to take a non-judgmental and inclusive approach that did not single out those who smoked.

In view of the fact that there was no significant increase in the number of AHWs who made quit attempts (and/or who quit smoking) after the training it is important that there be on-going, targeted quit smoking strategies that build on the *SmokeCheck* training and which have the

capacity to support AHWs and other health professionals who smoke, to make a quit attempt themselves.

In addition to the above, there were some challenges associated with the offer to services to participate in the training which were beyond the Project's control. For example, some Aboriginal Community Controlled Health Services were unable to participate because of small staff numbers, while other services indicated they were classified as 'outposts' and auspiced by others, or were no longer operational. A few services chose not to participate without providing a reason. Associated with this shortfall in attendance, was the challenge posed by the even more limited attendance of managers, program co-ordinators and senior health professionals and the shortage of managerial support for the implementation of the *SmokeCheck* training in some sites, despite the Project's efforts to facilitate this.

As the workshops unfolded and in discussions amongst participants, a number of other issues presenting as potential challenges to the integration of *SmokeCheck* into the routine practice of all health professionals and services became apparent. These were noted as:

- A lack of managerial commitment to the universal adoption of the intervention into routine client care, and the perception of some that smoking cessation is the responsibility of individual front line health professionals rather than of the whole health service
- Gaps in health professionals' knowledge and skills to implement evidence-based, tobacco control measures, and limited confidence expressed by some AHWs to offer quit advice that in turn highlights the need for ongoing support and relevant, culturally specific information about reducing the prevalence of smoking in Aboriginal communities
- Confusion about the most effective smoking cessation brief intervention related to the promulgation of multiple individual tobacco control programs offered by a variety of organisations
- The diverse range of client data collection systems being used across services with access sometimes limited to specific health staff.

5.4.3 Challenges raised by managers

In recognition that ultimately, the Project will have succeeded only when the *SmokeCheck* intervention has been adopted systematically into the routine practice of all health professionals working with Aboriginal clients, health professionals attending the *SmokeCheck* manager's workshops raised critical issues. One issue expressed by a number of health promotion managers for example, was their lack of authority to influence service provision, including decisions about whether 'tobacco control' is identified as a priority. In response many managers agreed that tobacco control should be a focus of the Aboriginal Health Plans and dealt with via the National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes, rather than being the responsibility of individual AHW or health promotion staff. This confirmed the importance of engaging managers in the workshops and further discussion about the need for organisational support.

Another issue was the high staff turnover that led some managers to question how they could maintain the skill and knowledge base of all health professionals to deliver the *SmokeCheck* intervention. Although all managers who attended the *SmokeCheck* training were supplied with a smoking cessation resource folder as well as a copy of the *SmokeCheck* training presentation, it has been suggested that a *SmokeCheck* training manual might serve to encourage and enable in-house training to address this issue.

Being a non-Aboriginal manager in an Aboriginal field was raised by some managers who expressed the view that they did not feel they had a mandate to institutionalise the *SmokeCheck* intervention. Again this issue points to the need for collaboration within and between services so that the intervention can be supported at the level of policy and practice.

Some managers pointed out their services were divided into teams, with the potential for tobacco use to be dealt with by either a clinical or Alcohol and other Drug team (AOD). As each team used different data bases with no link between them, and as the clinical team had a much larger database (2000 clients) than the AOD team (200 clients), managing the health implications of smoking for individual clients was made more complex.

Managers also expressed concerns about the perceived hypocrisy of discouraging clients to smoke if they and/or AHWs (and others) were smokers. Although managers recognised the need for a comprehensive and enforced the *NSW Health Smoke Free Workplace Policy* some noted that multiple associated issues should be considered. One manager for example, expressed the view that if a smoke free workplace policy was to be introduced she would worry about the service's duty of care to clients, as clients would have to cross the road to the public car park to smoke, making them more vulnerable to accidents.

These findings point to the need for some 'top down' investment in mandating and supporting health services and managers to introduce and enforce organisational changes, such as that which is required if the *SmokeCheck* Project is to achieve its goal of reducing the prevalence of smoking in Aboriginal communities in NSW.

5.4.4 Aboriginal health workers: The key to success

The fulcrum upon which all such initiatives rest is Aboriginal health workers (AHWs). Their professional knowledge, skills and experiences integrated with community, family cultural knowledge and understanding, make this group essential to the success of all initiatives to promote the health of their communities. For tobacco control initiatives such as *SmokeCheck* specifically at the service level, it requires focusing on the needs of AHWs who fulfill critical positions as mediators between service providers and communities (Hearn and Wise, 2004, p.317). Working with AHWs encourages debate and strengthens the understanding of challenges and systemic issues associated with the provision of smoking cessation advice to clients.

To reduce the prevalence of smoking in Aboriginal communities, evidence suggests that the *SmokeCheck* Project will need to be complimented by the active involvement of the NSW Department of Health, the Cancer Institute NSW, the AH&MRC and other statewide agencies in developing statewide policy, in developing social marketing campaigns that aim to increase Aboriginal smokers' motivation to quit, and to build political and community support for initiating and for implementing changes in legislation at local and community levels. Furthermore, a focused organisational development approach will be needed to support health service managers to commit to changes in service objectives, staff roles, monitoring systems and equipment, and reporting/accountability mechanisms.

Such 'top down' support, combined with intensive, service-specific work with individual health services and their staff, will lead to the integration of smoking cessation into routine service delivery to clients and build organisational infrastructure and capacity to support and evaluate the impact of this work.

The findings from the *SmokeCheck* Project suggest that an intensive, bottom-up approach combined with an extensive, top-down approach will:

- Increase the confidence of all AHWs and other relevant health professionals in offering brief intervention on smoking cessation to all Aboriginal clients
- Ensure that all health services across NSW integrate the *SmokeCheck* intervention into routine service delivery, adopting management, information systems, and evaluation methods that encourage and support the program's being offered to all Aboriginal clients
- Increase the proportion of the populations of Aboriginal communities in NSW that express support for an agreement to the introduction and enforcement of an evidence-based range of public and individual tobacco control measures – including public policy and community mobilisation.

5.5 Conclusions and recommendations

The *SmokeCheck* Project has demonstrated that an evidence based approach to designing and delivering a population-wide health promotion intervention that has, itself, been developed based on theory and evidence of best practice, can achieve significant, positive intermediate outcomes (Nutbeam 1998, p.41). However, if the full capacity of the *SmokeCheck* Project to make a difference to smoking rates in Aboriginal communities is to be realised, it is essential that it be integrated into the routine practice of all health service staff providing primary health care to Aboriginal clients as part of a wider comprehensive approach to tobacco control in communities. The *SmokeCheck* Project is in a unique position, as one Aboriginal specific evidence based intervention, that has successfully achieved state wide reach and engaged a comprehensive range of health and other services across both NSW Area Health Services and Aboriginal Community Controlled Health Services. In particular, it is in a position to utilise the relationships already established to facilitate ongoing partnerships and networks to meet the continued requests for additional workshops, and strengthen the capacity of AHWs, other health professionals and services to address the high rates of smoking in Aboriginal communities.

In essence, the lessons learned from the *SmokeCheck* Project point to the need to build an integrated Aboriginal smoking cessation and prevention program across the state – drawing on the strengths and contributions of both the *SmokeCheck* Project and other interventions to meet the varied needs of different services and communities. It will also be necessary to develop equally complex, sophisticated approaches to prevent the uptake of smoking among young Aboriginal people and to change the social norms pertaining to the acceptability of smoking across communities and within homes and workplaces.

Therefore, the success and efficacy of the *SmokeCheck* Project, allows confidence in predicting that in the next two years, another 20 per cent of the AHWs workforce and other health professionals can be reached. In this way, the dissemination and use of the *SmokeCheck* brief intervention has the potential to ultimately make a positive impact in decreasing Aboriginal smoking rates, and consequently the health of Aboriginal people.

Drawing on multiple data sources to evaluate a health promotion project such as the *SmokeCheck* program provides more opportunity for understanding changes that are observed, possible causal relationships between these changes and all aspects of the Project, as well as more relevant and sensitive evidence (Nutbeam 1998, p.40). A vital advantage of such research evidence, particularly in the field of Aboriginal health where there is abundant descriptive research but often limited evaluation of health interventions (Thomas & Anderson 2006, p.501), is its contribution to informing other research projects. Project evaluations that demonstrate positive research processes, impact and outcomes, may give rise to situations wherein research from other settings can be more easily applied thus preventing the need to reinvent the research wheel or waste resources (Thomas & Anderson 2006, p.501).

Glossary

Aboriginal Health and Medical Research Council (AH&MRC)

The Aboriginal Health and Medical Research Council of New South Wales (AH&MRC) is the NSW affiliate of the National Aboriginal Community Controlled Health Organisation (NACCHO). The AH&MRC is the recognised peak body of Aboriginal communities on Aboriginal health matters in NSW. It has a membership of over 60 organisations, comprised of Aboriginal Community Controlled Health Services (ACCHS), also known as Aboriginal Medical Services (AMS). The AH&MRC provides vital health and health related services in association with its member organisations (http://www.ahmrc.org.au/).

Aboriginal Health Worker (AHW)

1. The roles of Aboriginal health workers vary across Australia, but include: clinical functions (often as the first point of contact with the health workforce, particularly in remote parts of the country); liaison and cultural brokerage; health promotion; environmental health; community care; administration, management and control; and policy development and program planning (http://www.healthinfonet.ecu.edu.au/html/html_programs/programs_health_workers_1.htm#summary).

2. An Aboriginal or Torres Strait Islander person employed in an identified position in the NSW Public Health System and who provides health services or health programs directly to Aboriginal people regardless of whether the person is employed in a generalist or specialist position. It encompasses all/any areas, irrespective of the award that covers employment of the worker (http://www.health.nsw.gov.au/policies/ib/2005/pdf/IB2005_001.pdf).

Aboriginal Community Controlled Health Services (ACCHS) or Aboriginal Medical Service (AMS)

A primary health care service initiated and operated by the local Aboriginal community to deliver holistic, comprehensive, and culturally appropriate health care to the community which controls it (through a locally elected Board of Management) (http://www.naccho.org.au/aboutus/aboutus.html).

Area Health Service (AHS)

There are eight Area Health Services, four metropolitan and four rural, in NSW that have the main responsibility for health care delivery in a wide range of settings, from primary care posts in the remote outback and rural areas to metropolitan tertiary health centres (http://www.health.nsw.gov.au/services/index.asp).

National Aboriginal Community Controlled Health Organisation (NACCHO)

The national peak Aboriginal health body representing Aboriginal Community Controlled Health Services throughout Australia aims to ensure that Aboriginal people have greater access to effective health care across Australia. NACCHO provides a coordinated holistic response from the community sector, advocating for culturally respectful and needs based approaches to improving health and well being outcomes through Aboriginal Community Controlled Health Services/AMSs (http://www.naccho.org.au/aboutus/aboutus.html).

Nicotine Replacement Therapy (NRT)

The aim of nicotine replacement therapy (NRT) is temporarily to replace much of the nicotine from cigarettes to reduce motivation to smoke and nicotine withdrawal symptoms, thus easing the transition from cigarette smoking to complete abstinence. NRT is available as skin patches that deliver nicotine slowly, and chewing gum, nasal spray, inhalers, and lozenges/tablets, all of which deliver nicotine to the brain more quickly than from skin patches, but less rapidly than from smoking cigarettes. (Stead LF, Perera R, Bullen C, Mant D, Lancaster T. Nicotine replacement therapy for smoking cessation. Cochrane Database of Systematic Reviews 2008, Issue 1. Art. No.: CD000146. DOI: 10.1002/14651858.CD000146.pub3).

OXFAM Close the Gap Campaign

Close the Gap is Australia's largest campaign to improve Indigenous health. The campaign calls on governments to commit to closing the life expectancy gap between Indigenous and non-Indigenous Australians within a generation and is supported by a diverse group of organisations across Australia http://www.oxfam.org.au/campaigns/indigenous-health/).

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Appendix 1A:
NSW Health Area Health Services

Appendix 1B:
Aboriginal Health & Medical Research Council

Aboriginal Health & Medical Research Council of New South Wales

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Membership Aboriginal Community Controlled Health Services (ACCHS)

	Member	Phone / Fax / E-mail	Contact Names
1	**Aboriginal Medical Service Co-Operative Limited** P.O. Box 1174 Strawberry Hills NSW 2012 36 Turner Street Redfern NSW 2016	Phone: 9319 5823 Fax: 9319 3345 Em: amsredfern@amsredfern.org.au	CO: Naomi Mayers Chair: Sol Bellear Contact: Naomi Mayers
2	**Aboriginal Medical Service Western Sydney Co-op Ltd** 2 Palmerston Road PO Box 3160 Mt Druitt Village NSW 2770	Phone: 9832 1356 Fax: 9625 4152 Em: frank@darukams.org.au / Joanne@darukams.org.au	CEO: Frank Vincent Chair: Kevin Cavanagh Contact: Joanne Delaney
3	**Albury Wodonga Aboriginal Health Service Inc.** 587 Englehardt Street Albury PO Box 3040 Albury NSW 2640	Phone: 6042 1200 Fax: 6021 3966 Em: craig.taylor@nsw.edu.au	CEO: Vacant Chair: Craig Taylor Contact: Craig Taylor Mobile: 0447 421 200
4	**Armajun Aboriginal Health Service Incorporated** 152 Otho Street PO Box 865 Inverell NSW 2360	Phone: 6774 9450 or 6774 9470 Fax: 6774 9455 Em: reception@armidaleams.com.au	A/CEO: Jason Dalton Chair: Eddie Briggs Contact: Elva Taylor
5	**Armidale & District Services Inc (Pat Dixon Medical Centre Aboriginal Medical Service)** PO Box 1057 Armidale 100 Taylor Street Armidale NSW 2350	Phone: 6774 9450 / 6774 9470 Fax: 6774 9455 Em: reception@armidaleams.com.au	A/CEO: Jason Dalton Chair: Eddie Briggs Contact: Elva Taylor
6	**Awabakal Newcastle Aboriginal Co-Operative Ltd** 64 Hannell Street Wickham NSW 2293 P.O. Box 323 Hamilton NSW 2293	Phone: 4969 4711 Fax: 4969 5711 Em: rmcguinness@awabakal.org	A/CEO: Kevin McKenny Chair: Leonard Wright Contact: Richard McGuinness Mobile: 0419 316 024

	Member	Phone / Fax / E-mail	Contact Names
7	**Balranald Aboriginal Health Service Incorporated** 115A Market St PO Box 210 Balranald NSW 2715	Phone: 03 5020 0330 Fax: 03 5020 0333 Em: ba62446@bigpond.net.au	CEO: Danny Kelly Chair: Patricia Winch Contact: Danny Kelly
8	**Biripi Aboriginal Corporation Medical Centre** Old Pacific Highway, P.O. Box 616 Taree NSW 2430	Phone: 6552 2154 / 6552 7579 Fax: 6551 0483	A/CEO: Amanda Bridge Chair: John Clark Contact: Amanda Bridge Mobile: 0419 421 908
9	**Bourke Aboriginal Health Service** 61 Oxley Street P.O. Box 361 Bourke NSW 2840	Phone: 6872 3088 Fax: 6872 2749 Em: bahs@bahs.com.au Judy.johnson@bahs.com.au	CEO: Judith Johnson Chair: Yvonne Howarth Contact: Judith Johnson Mobile: 0407 944 283
10	**Brewarrina Aboriginal Health Service Ltd – Auspiced by Walgett AMS** P.O. Box 396 Walgett NSW 2832	Phone: 6839 2150 Fax: 6839 2499 Em: walgettams@bigpond.com	CEO: Christine Corby Walgett AMS Chair: George Fernando Contact: George Fernando & Christine Corby Mobile: 0418 212 23
11	**Brungle Aboriginal Health Service** C/O 9 Bray Street NSW Brungle NSW 2722 PO Box 707 Tumut NSW 2720	Phone: 6944 9036 Fax: 6944 9042 Em: brungle.admin@rivmed.or	Cord: Rhonda French & Rebecca Russell Chair: Sonia Piper Contact: Sonia Piper
12	**Bulgarr Ngaru Medical Aboriginal Corporation** 131-133 Bacon Street Grafton NSW 2460 PO Box 1256 Grafton NSW 2460	Phone: 6643 2199 / 6642 2484 Fax: 6643 2202 Em: bulgarr@bigpond.com.au	CEO: Scott Monaghan Chair: Graham Purcell Contact: Scott Monaghan Mobile: 0427 282 835
13	**Condobolin Aboriginal Health Service Inc.** 99 Bathurst Street PO Box 321 Condobolin NSW 2877	Phone: 6895 4311 Fax: 6895 4322 / 6895 2008 Em: ceo.cahs@westerv.net.au	CEO: Cecil Lester Chair: Pauline Martin Contact: Cecil Lester
14	**Cobar Aboriginal Health Service Inc.** 23 Railway Pde Cobar NSW 835	Phone: 6836 4454	Chair: Gwen Troutman Contact: Elaine Ohlsen / Gwen Troutman Mobile: 0431 405 578
15	**Coomealla Health Aboriginal Corp** 51 Stuart Place Dareton P.O. Box 256 Dareton NSW 271	Phone: 03 5027 4226 / 03 5027 4824 Fax: 03 5027 4429 Em: lgray@chac.macmildura.org	CEO: Lyndon Gray Chair: Rex Smith Contact: Lyndon Gray Mobile: 0407 858 419

	Member	Phone / Fax / E-mail	Contact Names
16	**Coonamble Aboriginal Health Service Inc.** RTC Centre Castlereagh Street PO Box 36 Coonamble NSW 2829	Phone: 6822 5217 Fax: 6822 5220 Em: tedf@wachs.net.au	P/Cord: Ted Fernando Chair: Wayne Fernando Contact: Ted Fernando Mobile: 0428 427 698
17	**Cumbo-Gunerah Aboriginal Health Service Inc**. 1/157 Marquis Street Gunnedah NSW 2380	Phone: 6742 0037 Fax: Mail Only	Chair: Ellen Draper Contact: Ellen Draper / Joyce Dorrington
18	**Cummeragunja Housing & Development Aboriginal Corp** (Viney Morgan Clinic) – 10 Tongala Ave Cummeragunja via Barmah NSW 3639 (PO Box 421 Moama 2731	Phone: 03 5869 3343 Fax: 03 5869 3492 Em: jcalleja@vineymorganams.com.au	CEO: Julie Calleja Chair: Rochelle Patten Contact: Julie Calleja Mobile: 0409 439 136
19	**Dharah Gibinj Aboriginal Medical Service Aboriginal Corp** 43 Johnston Street Casino NSW 2470 PO Box 14 Casino NSW 24	Phone: 6662 3514 Fax: 6662 4849 Em: ceo@casinoams.com	CEO: Jeff Richardson Chair: Gloria Williams Contact: Jeff Richardson
20	**Dhoongang Aboriginal Health Service Inc.** 1/77 Yarrawabee Road Port Macquarie NSW 2444	Phone: 6582 8357 Fax: 6583 8172	CEO: Vacant Chair: Mark Holten Contact: Marion Hampton Mobile: 0423 385 505
21	**Durri Aboriginal Corporation Medical Service** 15-19 York Lane Kempsey NSW 2440 P.O. Box 136 KEMPSEY NSW 2440	Phone: 6562 4919 Fax: 6562 7069 Em: jstirling@durri.org.au	CEO: Janelle Stirling Chair: Gerald Hoskins Contact: Janelle Stirling Mobile: 0438 283 171 (ceo) 0418 966 741 (chair)
22	**Euraba Mungindi Aboriginal Health Service Inc.** 47 Goodiwindi Street Mungindi NSW 2406	Phone: 6753 2422 Fax: 6753 2433 Em: mungindi@piusx.com.au	CEO: Lexie Hattersley Chair: Michael Flicle Contact: Casey Orcher Mobile: 0428 284 424
23	**Galambila Aboriginal Health Service Inc.** Crn High & Boambee Street Coffs Harbour NSW 2450 PO BOX 1431 Coffs Harbour NSW 2450	Phone: 6652 0850 Fax: 6652 2563 / 6652 0899 Em: dkennedy@galambila.org.au/ galambila@bigpond.com	CEO: Dave Kennedy Chair: Alex Webb Contact: Dave Kennedy Mobile: 0408 431 225

	Member	Phone / Fax / E-mail	Contact Names
24	**Griffith Aboriginal Medical Service Incorporated** 5 Wiradjuri Place Griffith NSW 2680 PO Box 1424 Griffith NSW 2680	Phone: 6964 4533 / 6962 7650 Fax: 6964 8785 Em: smeredith@griffithams.org.au	CEO: Stacey Meredith Chair: Steve Meredith Contact: Stacey Meredith Mobile: 0428 644 533
25	**Illawarra Aboriginal Medical Service Aboriginal Corporation** 150 Church Street Wollongong NSW 2500 (PO Box 1161 Sth Coast Mail Centre NSW 2521	Phone: 4229 9495 Fax: 4226 3566 Em: merrilyn@illawarraams.com.au Website: www.illawarraams.com.au	A/CEO: Merrilyn Nowlan Chair: Daryl Quirk Contact: Merrilyn Nowlan Mobile: 0410 315 016
26	**Katungul Aboriginal Corporation Community & Medical Services** 26 Princes Highway NSW 2546 P.O. Box 296 Narooma NSW 2546	Phone: 4476 2155 Fax: 4476 1967 Em: damien@katungul.org.au Website: www.katungul.org.au	CEO: Damien Matcham Chair: Wayne Parsons Contact: Damien Matcham Mobile: 0431 331 408
27	**Menindee Aboriginal Health Service Inc**. Yartla Street PO Box 109 Menindee NSW 2879	Phone: 0880 914 237 / 0880 914 487 Fax: 0880 914 254 Em: nyampaahc@bigpond.com	CEO: Leasa Kelly Chair: Jan Fennell Contact: Cheryl Johnstone Mobile: 0429 607 029
28	**Murrin Bridge Aboriginal Health Service Inc.** 36 Nyampa Street Murrin Bridge NSW 2672 PO Box 62 Lake Cargelligo NSW 2672	Phone: 6898 1533 Fax: 6898 1544 Em: mbahs@bigpond.com	CEO: Christine Peckham Chair: Iris Johnson Contact: Jacqueline Dutton Mobile: 0447 005 811
29	**Nambucca Valley Aboriginal Health Service Incorporated** Shop 13/42 Bowra Street Nambucca Heads NSW 2448 PO Box 131 Nambucca Heads NSW 2448	Phone: 6568 9055 Fax: 6568 9796 Em: bwilson.ngurrala@bigpond.com / Tracy.cohen@hotmail.com	CEO: Vacant Chair: Beryl Wilson Contact: Tracey Cohen Mobile: 0428 664 997
30	**Ngambra Aboriginal Health Service Inc**. PO Box 150 Queanbeyan NSW 2620	Fax: 6299 3941	Chair: Matilda House Contact: Matilda House Mobile: 0406 074 492
31	**Orange Aboriginal Health Service Incorporated** 14 Palmer Street Orange NSW 2800 PO Box 98 Orange NSW 2800	Phone: 6361 7855 Fax: 6361 7866 Em: ceo@oams.net.au	CEO: Jamie Newman Chair: Deborah Kenna Contact: Jamie Newman Mobile: 0428 979 711

	Member	Phone / Fax / E-mail	Contact Names
32	**Parkes Aboriginal Health Service Inc.** 19B Church Street Parkes NSW PO Box 767 Parkes NSW 2870	Phone: 6862 4324 Fax: 6862 4929 Em: parkesac@hotmail.com.au	CEO: Annette Sloane Chair: Cheryl Gaidzionis Contact: Annette Sloane
33	**Peak Hill Aboriginal Medical Service Incorporated** PO Box 151 51 Caswell Street Peak Hill NSW 2869	Phone: 6869 1640 Fax: 6869 1646 Em: phams@crt.net.au	Cord: Christine Peckham Chair: Val Keed Contact: Christine Peckham – 0427 954 322 & Val Keed Mobile: 0405 453 632
34	**Pius X Aboriginal Corporation** Anne Street P.O. Box 363 Moree NSW 2400	Phone: 6752 1099 Fax:6752 5154 Em: Ceo@piusx.com.au / admin@piusx.com.au	CEO: Donna Taylor Chair: Liz Taylor Contact: Donna Taylor Mobile: 0427 284 079
35	**Riverina Medical & Dental Aboriginal Corporation** PO Box 458 Wagga Wagga 14 Trail Street Wagga Wagga NSW 2650	Phone: 6923 5200 Fax: 6921 7120 Em: ceo@rivmed.org	CEO: Ann Baker Chair: Val Weldon Contact: Ann Baker Mobile: 0428 210 563
36	**South Coast Medical Service Aboriginal Corporation** 51-53 Berry Street Nowra NSW 2541 PO Box 548 Nowra NSW 2541	Phone: 4428 6666 / 4428 6609 / 4428 6629 Fax: 4428 6602 Em: anne@southcoastams.org.au Website www.southcoastams.org.au	CEO: Anne Greenaway Chair: Bruce Yuke Contact: Anne Greenaway Mobile: 0410 662 443
37	**Tamworth Aboriginal Medical Service Inc.** 131 Marius Street Tamworth 2340 NSW PO Box 253 Tamworth NSW 2340	Phone: 6766 5211 Fax: 6766 5711 Em: coordinator@tams.org.au	CEO: Robert Barker-Salt Chair: Joseph Trindall Contact: Robert Barker-Salt
38	**Tharawal Aboriginal Corporation** 187 Riverside Drive Airds NSW 2560 P.O. Box 290 Campbelltown NSW 2560	Phone: 4628 4837 Fax: 4628 2725 Em: tharawal@westnet.com.au / dcwright@westnet.com.au	CEO: Darryl Wright Chair: Ivan Wellington Contact: Darryl Wright Mobile: 0428 797 337
39	**Thubbo Aboriginal Medical Co-op Ltd** 133 Bourke Street P.O. Box 435 Dubbo NSW 2830	Phone: 6884 8211 / 6884 8212 Fax: 6884 8218 Em: ceo1@thubboams.com.au	CEO: Irene Peachey Chair: Levenia Howey Contact: Irene Peachey

	Member	Phone / Fax / E-mail	Contact Names
40	Tobwabba Aboriginal Medical Service Inc. 68A McIntosh Street PO Box 48 Forster NSW 2428	Phone: 6555 7162 Fax: 6555 6864 Em: cabarita@pnc.com.au	CEO: Chair: Donna Hall Contact: Donna Hall / Eunice Peachey
41	**Toomelah Aboriginal Health Service Inc.** House 19 Toomelah Via Boggabilla NSW 2049 P.O. Box 261 Boggabilla NSW 2409	Fax: Mail Only Em: toomcoop@bigpond.com	CEO: Chair: Contact:
42	**Walgett Aboriginal Medical Service Co-0perative Limited** 37 Pitt Street P.O. Box 396 Walgett NSW 2832	Phone: 6828 1059 / 6828 1611 Fax: 6828 1201 Em: walgettams@bigpond.com Website: www.walgettams.com.au	CEO: Christine Corby Chair: George Fernando Contact: Christine Corby Mobile: 0418 212 230
43	**Walhallow Aboriginal Health Service Incorporated** 1/42 Greg Norman Drive Tamworth NSW 2340	Phone: 02 6762 1819 Fax: Mail Only	CEO: Chair: Annie Taylor Contact: Annie Taylor Mobile: 0428 618 584
44	**Wanaruah Aboriginal Health Service Inc**. 19 Maitland Street PO Box 127 Muswellbrook NSW 2333	Phone: 6543 1288 / 6543 1962 Fax: 6542 5377 Em: wanarua@bigpond.net.au	CEO: Darren Ah See Chair: Sandra Newman Contact: Darren Ah See Mobile: 0428 453 545
45	**Weimija Aboriginal Corporation** 202 Patton Street Broken Hill NSW 2880	Phone: 08 8087 2263 Fax: 08 8087 1197	CEO: Paul Maher Chair: Edna Kelly Contact: Paul Maher
46	**Wellington Aboriginal Corp Health Service** 68 Maughan Street Wellington NSW 2820 PO Box 236 Wellington 2820	Phone: 6845 3545 / 6845 4077 Fax: 6845 2656 / 6845 4499 Em: darrena@wachs.net.au	CEO: Darren Ah See Chair: Sandra Newman Contact: Darren Ah See Mobile: 0428 453 545
47	**Yerin Aboriginal Health Service Inc**. 37 Alison Road Wyong NSW PO Box 466 Wyong NSW 2259	Phone: 4351 1040 Fax: 4351 1037 Em: yerinabhealthservice@bigpond.com / cathiesinclair@yerin.org.au	Manager: Cathie Sinclair Chair: Phillip Peterson Contact: Cathie Sinclair Mobile: 0421 630 013
48	**Yoorana-Gunya Family Violence Healing Centre Aboriginal Corp** 15 Spring Street PO Box 802 Forbes NSW 2871	Phone: 6851 5111 Fax: 6851 6860 Em: yooranag@bigpond.net.au	CEO: Donna Bliss Contact: Donna Bliss Mobile: 0428 523 840

Appendix 1C: Denominator count

Area	AHS / AMS	Location	Name	1st count	2nd count	Average
1. Greater Western						
Greater Western AHS	AHS	Broken Hill	Broken Hill Health Service	80	100	90
Far West	AMS	Balranald	Balranald Aboriginal Health Service Incorporated	3	4	3.5
Far West	AMS	Dareton	Coomealla Health Aboriginal Corp	7	7	7
Far West	AMS	Broken Hill	Maari Ma Aboriginal Health Service	9	11	10
Far West	AMS	Wilcannia	Wilcannia Aboriginal Health	3	4	3.5
North West	AMS	Bourke	Bourke Aboriginal Health Service	6	7	6.5
North West	AMS	Brewarrina	Brewarrina Aboriginal Health Centre	2	1	1.5
North West	AMS	Cobar	Cobar Community Health	2	1	1.5
North West	AMS	Walgett	Walgett Aboriginal Medical Service Co. Ltd.	14	10	12
North West	AMS	Coonamble	Coonamble Aboriginal Health Service	2	1	1.5
Central West	AMS	Dubbo	Thubbo Aboriginal Co-op. Ltd.	1		0.5
Central West	AMS	Wellington	Wellington Aboriginal Corp Health Service.	8	8	9
Central West	AMS	Parkes	Parkes Aboriginal Health Service Inc		2	
Central West	AMS	Condobolin	Condobolin Aboriginal Health Service	12	1	9
Central West	AMS	Peak Hill	Peak Hill Aboriginal Medical Service Inc		1	
Central West	AMS	Lake Cargelligo	Murrin Bridge Aboriginal Health Service Inc		4	
Central West	AMS	Orange	Orange Aboriginal Health Service		3	3
Central West	AMS	Forbes	Yoorana-Gunya Family Violence Health Centre		1	1
Central West	AMS	Woodstock	Weigelli Centre Aboriginal Corp		3	3
Total					**169**	**163**

2. Greater Southern						
Greater Southern AHS	AHS	Albury	Albury Base Hospital	40	25	32.5
Greater Southern	AMS	Griffith	Griffith Aboriginal Medical Service Inc.	2	2	2
Greater Southern	AMS	Brungle	Brungle Aboriginal Health Service	0	1	0.5
Greater Southern	AMS	Wagga Wagga	Riverina Medical & Dental Aboriginal Corporation	25	8	16.5
Greater Southern	AMS	Albury	Albury Wodonga Aboriginal Health Service Inc.	2	1	1.5
Greater Southern	AMS	Moama	Viney Morgan Clinic	2	2	2
Greater Southern	AMS	Narooma	Katungul Aboriginal Corporation Community & Medical Services	10	5	7.5
Total				**81**	**44**	**62.5**

3. South Eastern Sydney Illawarra						
South Eastern Sydney Illawarra AHS	AHS	Wollongong	Wollongong Hospital	14	18	21
South Eastern Sydney Illawarra AHS	AHS	Randwick	Royal Hospital For Women		10	
Illawarra	AMS	Wollongong	Illawarra Aboriginal Medical Service Aboriginal Corporation	7	9	8
Illawarra	AMS	Nowra	South Coast Medical Service	14	2	8
Illawarra	AMS	Nowra	Waminda- Women's Health & Welfare Aboriginal Corp	7	9	8
Illawarra	AMS	Nowra	The Oolong Corporation	5	3	4
Total				**47**	**51**	**49**

4 & 5. Greater Metropolitan						
Sydney South West AHS	AHS	Camperdown	Sydney South West Area Health Service, King George Building	41	31	36
Sydney South West Zone AHS	AHS	Liverpool	Liverpool Hospital			
Sydney West AHS	AHS	Penrith	Nepean Hospital	14	14	14
Central	AMS	Redfern	Aboriginal Medical Service Co-Operative	20	17	18.5
Sydney West	AMS	Campbelltown	Tharawal Aboriginal Corporation	4	15	9.5
Sydney West AHS	AMS	Mount Druitt	Daruk – Aboriginal Medical Service Western Sydney	8	10	9
Sydney West AHS	AMS	Emerton	Marrin Weejali Aboriginal Corporation	4	4	4
Total				**91**	**91**	**91**

6. Northern Sydney Central Coast						
Northern Sydney & Central Coast AHS	AHS	Gosford	Gosford Hospital	10	10	10
Central Coast	AMS	Newcastle	Awabakal Newcastle Aboriginal Co-operative Ltd.	5	4	4.5
Central Coast	AMS	Wyong	Yerin Aboriginal Health Service Inc. Eleanor Duncan Centre	7	4	5.5
Total				**22**	**18**	**20**

7. Hunter/New England						
Hunter/ New England AHS	AHS	Wallsend		75	57	66
Hunter	AMS	Tamworth	Tamworth Aboriginal Medical Service	3	4	3.5
Hunter	AMS	Armidale	Armidale & District Services	1	0	0.5
New England	AMS	Inverell	Armajun Aboriginal Health Service Incorporated	1	0	0.5
New England	AMS	Mungindi	Euraba Mungindi Aboriginal Health Service Inc	2	1	1.5
New England	AMS	Moree	Pius X Aboriginal Corporation	3	6	4.5
Total				85	68	76.5

8. North Coast						
North Coast AHS	AHS	Kempsey	Jacaranda Building	68	28	48
Mid North Coast	AMS	Taree	Biripi Aboriginal Corporation Medical Centre	15	4	9.5
Mid North Coast	AMS	Forster	Tobwabba Aboriginal Medical Service Inc.	4	0	2
Mid North Coast	AMS	Port Macquarie	Partnership Aboriginal Health	3	4	3.5
Mid North Coast	AMS	Kempsey	Durri Aboriginal Corporation Medical Service	15	11	13
Mid North Coast	AMS	Coffs Harbour	Galambila Aboriginal Health Service	2	3	2.5
Mid North Coast	AMS	Nambucca Heads	Nambucca Valley Aboriginal Health Service Incorporated	1	1	1
North Coast	AMS	Grafton	Bulgarr Ngaru Medical Aboriginal/Burygilgil & Malabugilmah Health Outpost	8	5	6.5
North Coast	AMS	Casino	Dharah Gibinj Aboriginal Medical Service Corp	10	6	8
North Coast	AMS	Alstonville	Namatjira Haven Drug & Alcohol Healing Centre	9	1	5
Total				135	63	99
Total				**617**	**504**	**561**

Governance	Position	Description	Example
Area Health Service (AHS)	Aboriginal health worker	Someone who is aboriginal or someone working in a designated Aboriginal Health position	Aboriginal liaison officer, aboriginal cardiovascular officer.
Aboriginal Medical Service (AMS)	Aboriginal health worker	Someone who is aboriginal or someone working in a designated Aboriginal Health position	Sexual Health Worker, Drug & Alcohol Officer.

Appendix 2A: *SmokeCheck* curriculum

Brief Motivational Intervention for Smoking Cessation

Facilitators

Ms Miranda Rose
SmokeCheck Manager
School of Public Health
University of Sydney

Ms Hannah Nancarrow
SmokeCheck Trainer
School of Public Health
University of Sydney

Time	Facilitators	Session	Aim	Learning Objectives/Outcomes
9:00am	Miranda	Welcome & Introduction to *SmokeCheck* Team	To welcome participants to the workshop and provide an overview of the *SmokeCheck* Project.	■ Participate in Evaluation & complete Workshop Survey ■ Outline the *SmokeCheck* Project
9.30am	Hannah	The history, prevalence and impact of smoking as it relates to Aboriginal and non-Aboriginal populations in Australia	To outline the prevalence of tobacco in Australia in particular amongst the Aboriginal population.	■ Discuss the prevalence and distribution of smoking in Australia compared to the Aboriginal population ■ Discuss the health burden (mortality and morbidity) and social impact that tobacco has on Australia and in particular the Aboriginal population ■ Describe the structure of a cigarette
10.00am	Miranda	Context of Tobacco (Including determinants of health)	To expand participants knowledge of the context of tobacco use in Australian society and in particular amongst Aboriginal populations in Australia.	■ List and describe the social determinants of health as they impact on Aboriginal people ■ Explain the historical, social, economic and political context of tobacco use in relation to Aboriginal populations in Australia ■ List and describe particular problems associated with smoking among Aboriginal people
10.30am Morning Tea				
11.00am	Hannah	Nicotine Dependence	To provide an overview the physiology of nicotine dependence and describe how to assess nicotine dependence using the Fagerstrom test.	■ Describe the physiology of nicotine dependence ■ Use the Fagerstrom test to assess clients' nicotine dependence and provide feedback

Time	Facilitators	Session	Aim	Learning Objectives/Outcomes
11.30am	Miranda	Health Effects of Smoking	To expand participants knowledge on the health effects of smoking of Indigenous people, with reference to the effects on specific groups within this population. For example the health effects on pregnant women, women and men.	■ Discuss the scientific evidence on tobacco and its specific health effects. ■ List a broad range of diseases associated with health effects of smoking. In particular: cardiovascular disease, respiratory disease, cancer and recall the specific health effects for pregnant women, women and men.
12.30pm	Hannah	Environment Tobacco Smoke (ETS)	To describe ETS, the health effects of ETS, & in particular issues associated with ETS and Indigenous people.	■ Describe the components of cigarette smoke. ■ List several health effects caused by ETS. ■ List and describe issues impacting on Indigenous people in regards to ETS.
12.45pm Lunch				
1.30pm	Miranda	Health Promotion	To give an overview health promotion theory and practice, with specific reference to *SmokeCheck* and smoking cessation.	■ Define the concept of 'health promotion' and describe its relationship to smoking cessation strategies.
1.45pm	Miranda	Stages of Change	To provide workshops participants with skills to implement a smoking cessation brief interventions using the Stages of Change model of behaviour change. To introduce and demonstrate the use of the *SmokeCheck* resources.	■ Describe the Transtheoretical Stages of Change HP Model ■ List the stages in the 'Stages of Change' Model. ■ Define 'brief Intervention'. ■ Demonstrate and explain the use of motivational interviewing techniques to increase clients motivation to quit. ■ Participate in a 'Stages of Change' activity. ■ Receive and read through the *SmokeCheck* resources with trainer and learn appropriate techniques and uses.
	Hannah	Other Smoking Cessation interventions: Pharmacotherapy's (including NRT and Bupropion) Self-Help (Quitline, Cold Turkey) Group Therapy	To introduce and examine a range of other smoking cessation interventions, for example: NRT, Bupropion (Zyban), Varenicline (Champix) and QUIT.	■ Describe nicotine replacement therapy including correct use, benefits and contraindications. ■ Describe Bupropion (Zyban) including its correct use, benefits and contraindications. ■ Discuss the content, type of intervention and support provided by the Quitline. ■ Explain factors associated with running smoking cessation groups.
3.00pm Afternoon Tea				
3.15pm	Hannah	Case Studies	To provide workshop participants with practice in providing the *SmokeCheck* brief intervention based on the 'Stages of Change' model of behaviour change and in using the associated *SmokeCheck* resources.	■ Provide brief smoking cessation intervention matched to clients personal circumstances including relevant health issues, level of nicotine dependence, stage of change and history using case studies. ■ Demonstrate provision of advice and information to clients using the *SmokeCheck* resources.

Time	Facilitators	Session	Aim	Learning Objectives/Outcomes
3.30pm	Miranda	Discussion: Barriers and practical examples for health services	To discuss perceived barriers to the implementing *SmokeCheck*	■ Discuss potential barriers to using the *SmokeCheck* resources and providing smoking cessation brief intervention.
3.45pm	Hannah/ Miranda	Close	To facilitate participant feedback using feedback forms. To provide workshop participants with *SmokeCheck* resources.	■ Provide feedback regarding the workshop.
3.00pm Afternoon Tea				

Appendix 3A:
Pre (P2) workshop survey – intervention group

SmokeCheck pre workshop survey

Thank you very much for participating in the *SmokeCheck* workshop. This survey is not a test. It is to show us whether our workshop meets your needs. We will use this information to help us make the workshop better for next time. We would be grateful if you would agree to take part in this evaluation by answering all the questions in this survey and returning the survey to us.

Please make sure that these are **your** answers. Do not talk about your answers with other people.

Please do NOT write your name on this form. But to help us compare each person's answers before and after the workshop, we will ask you to create your own personal code using the instructions below.

To make your personal code, please write

☐	☐	☐☐
The **first letter** of your **mother's first name** (e.g. If her name is Betty, then write 'B').	The **last letter** of **your first name** (e.g. If your name is Peter, then write 'R'; if your name is Margaret, write 'T').	The **day** of the month that you were born on (e.g. if you were born on March **15**, 1976, then you write 15).

When you have finished filling in this survey, please return it to the presenter.

Please answer the following questions by ticking the box that corresponds to your response.

1.	**What is your work position?**		☐ Aboriginal Health Worker		☐ Other
2.	**Are you of Aboriginal or Torres Strait Islander descent?**		☐ Yes	☐ No	☐ Both
3.	**How often do you work with Aboriginal clients?**		☐ Never	☐ Hardly ever	☐ Sometimes
			☐ Often	☐ All the time	
4.	**Do you see giving advice on stopping smoking as part of your role?**		☐ Yes	☐ No	☐ Don't know
5.	**How confident do you feel that you could talk with your clients about how smoking affects their health?**				
	☐ Not at all confident	☐ A little confident	☐ Moderately confident	☐ Confident	☐ Very confident
6.	**How confident do you feel that you could talk with clients who smoke about quitting?**				
	☐ Not at all confident	☐ A little confident	☐ Moderately confident	☐ Confident	☐ Very confident
7.	**How confident do you feel that you could assess your client's readiness to quit smoking?**				
	☐Not at all confident	☐A little confident	☐ Moderately confident	☐ Confident	☐ Very confident
8.	**When a client comes to you for another reason how confident do you feel bringing up smoking?**				
	☐ Not at all confident	☐ A little confident	☐ Moderately confident	☐ Confident	☐ Very confident

9.	**How confident do you feel that you could advise a client about using either nicotine gum or patches?**				
	☐ Not at all confident	☐ A little confident	☐ Moderately confident	☐ Confident	☐ Very confident
10.	**How important do you feel it is for every client who smokes to be offered advice about quitting?**				
	☐ Not at all confident	☐ A little confident	☐ Moderately confident	☐ Confident	☐ Very confident
11.	**How easy or difficult do you feel it would be to give brief advice to clients about quitting smoking during regular visits?**				
	☐ Very difficult	☐ Difficult	☐ Neither easy nor difficult	☐ Easy	☐ Very easy
12.	**How do you help clients to quit smoking? [You can choose more than one answer]**				
	☐ I provide advice on nicotine replacement therapy				
	☐ I advise them on ways to reduce environmental tobacco smoke				
	☐ I encourage clients to cut down on the number of cigarettes they smoke				
	☐ I don't use any particular method				
	☐ I don't help clients to quit smoking				
	☐ Don't know				
13.	**Which of the following best describes your smoking status? This includes cigarettes, cigars and pipes?**				
	☐ I smoke daily				
	☐ I smoke occasionally				
	☐ I don't smoke but I used to [go to Q15]				
	☐ I've tried it a few times but never smoked regularly [go to Q15]				
	☐ I've never smoked [go to Q15]				
	☐ Don't know [go to Q15				
14.	**Which of the following best describes how you feel about your smoking?**				
	☐ I am not planning on quitting within the next 6 months				
	☐ I am planning on quitting within the next 6 months				
	☐ I am planning on quitting within the next month				
	☐ I have not smoked in the past 24 hours but was smoking 6 months ago				
	☐ have not been smoking in the past 6 months				
	☐ Don't know				
17.	**Are there quit smoking resources available in your workplace for you to use with clients? If Yes, can you list them?**				

18.	**How culturally appropriate are the quit smoking resources available in your workplace?**				
	☐ Not at all appropriate	☐ A little appropriate	☐ Moderately appropriate	☐ Appropriate	☐ Very appropriate
19.	**Have you had any other training about advising clients to quit smoking in the last 6 months? If Yes, what was the name of the training course?**				

Thank you very much for completing this survey!

If you have any questions, please feel free to contact us on (02) 9036 7113.

Appendix 3B: Pre (P1) workshop survey – waiting list control group

SmokeCheck pre-workshop survey

Thank you very much for participating in *SmokeCheck*. Because many services are participating in the *SmokeCheck* program, we are not able to come to your area and run the workshop until early next year. In the meantime we would appreciate it very much if you could help us with the workshop evaluation.

This survey is not a test. It is to show us whether our workshop meets your needs. We will use this information to help us evaluate the training workshop and make it better for next time. We would be grateful if you would agree to take part in this evaluation by answering all the questions in this survey and returning the survey to us.

Please make sure that these are your answers. Do not talk about your answers with other people.

Please do NOT write your name on this form. But to help us compare each person's answers before and after the workshop, we will ask you to create your own personal code using the instructions below.

To make your personal code, please write

☐	☐	☐☐
The **first letter** of your **mother's first name** (e.g. If her name is Betty, then write 'B').	The **last letter** of y**our first name** (e.g. If your name is Peter, then write 'R'; if your name is Margaret, write 'T').	The **day** of the month that you were born on (e.g. if you were born on March **15**, 1976, then you write 15).

When you have finished filling in this survey, please post it to us using the self-addressed stamped envelope provided to ***SmokeCheck*, Australian Centre for Health Promotion, Edward Ford Building A27, The University of Sydney 2006.**

Please answer the following questions by ticking the box that corresponds to your response:

1.	**What is your work position?**	☐ Aboriginal Health Worker		☐ Other
2.	**Are you of Aboriginal or Torres Strait Islander descent?**	☐ Yes	☐ No	☐ Both
3.	**How often do you work with Aboriginal clients?**	☐ Never	☐ Hardly ever	☐ Sometimes
		☐ Often	☐ All the time	
4.	**Do you see giving advice on stopping smoking as part of your role?**	☐ Yes	☐ No	☐ Don't know

5.	**How confident do you feel that you could talk with your clients about how smoking affects their health?**				
	☐ Not at all confident	☐ A little confident	☐ Moderately confident	☐ Confident	☐ Very confident
6.	**How confident do you feel that you could talk with clients who smoke about quitting?**				
	☐ Not at all confident	☐ A little confident	☐ Moderately confident	☐ Confident	☐ Very confident
7.	**How confident do you feel that you could assess your client's readiness to quit smoking?**				
	☐ Not at all confident	☐ A little confident	☐ Moderately confident	☐ Confident	☐ Very confident
8.	**When a client comes to you for another reason how confident do you feel bringing up smoking?**				
	☐Not at all confident	☐A little confident	☐Moderately confident	☐Confident	☐Very confident

9.	**How confident do you feel that you could advise a client about using either nicotine gum or patches?**				
	☐Not at all confident	☐A little confident	☐Moderately confident	☐Confident	☐Very confident
10.	**How important do you feel it is for every client who smokes to be offered advice about quitting?**				
	☐Not at all important	☐A little important	☐Moderately important	☐Confident	☐Very confident
11.	**How easy or difficult do you feel it would be to give brief advice to clients about quitting smoking during regular visits?**				
	☐Very difficult	☐Difficult	☐Neither easy nor difficult	☐Easy	☐Very easy
12.	**How do you help clients to quit smoking? [You can choose more than one answer]**				
	☐I provide advice on nicotine replacement therapy				
	☐I advise them on ways to reduce environmental tobacco smoke				
	☐I encourage clients to cut down on the number of cigarettes they smoke				
	☐I encourage clients to cut down on the number of cigarettes they smoke I don't help clients to quit smoking				
	☐Don't know				
13.	**Which of the following best describes your smoking status? This includes cigarettes, cigars and pipes?**				
	☐I smoke daily				
	☐I smoke occasionally				
	☐I don't smoke but I used to [go to Q15]				
	☐I've tried it a few times but never smoked regularly [go to Q15]				
	☐I've never smoked [go to Q15				
	☐Don't know [go to Q15]				
14.	**Which of the following best describes how you feel about your smoking?**				
	☐I am not planning on quitting within the next 6 months				
	☐I am planning on quitting within the next 6 months				
	☐I am planning on quitting within the next month				
	☐I have not smoked in the past 24 hours but was smoking 6 months ago				
	☐I have not been smoking in the past 6 months				
	☐Don't know				
15.	**Which of the following best describes your home situation?**				
	☐My home is smoke-free (smoking is allowed outside only)				
	☐People occasionally smoke in the house				
	☐People frequently smoke in the house				
	☐Don't know				

16.	**Which of the following best describes your workplace situation?**
	☐My workplace is smoke-free (smoking is allowed outside only)
	☐People occasionally smoke in the workplace
	☐People frequently smoke in the workplace
	☐Don't know
17.	**Are there quit smoking resources available in your workplace for you to use with clients? If Yes, can you list them?**

18.	**How culturally appropriate are the quit smoking resources available in your workplace?**				
	☐Not at all appropriate	☐A little appropriate	☐Moderately appropriate	☐Appropriate	☐Very appropriate
19.	**Have you had any other training about advising clients to quit smoking in the last 6 months? If Yes, what was the name of the training course?**				
				☐Yes	☐No

Thank you very much for completing this survey!

If you have any questions, please feel free to contact us on (02) 9036 7113.

Appendix 3C: Post workshop survey

SmokeCheck follow-up survey

Thank you very much for participating in *SmokeCheck*. This survey follows up on the *SmokeCheck* workshop that you may have attended approximately six months ago.

This survey is not a test. It is to show us whether our workshop has met your needs. We will use this information to help us evaluate the training workshop and make it better for next time. We would be grateful if you would agree to participate in this next step of the evaluation by answering all the questions in this survey and returning the survey to us.

Please make sure that these are your answers. Do not talk about your answers with other people.

Please do NOT write your name on this form. But to help us compare each person's answers before and after the workshop, we will ask you to create your own personal code using the instructions below.

To make your personal code, please write

☐	☐	☐☐
The **first letter** of your **mother's first name** (e.g. If her name is Betty, then write 'B').	The **last letter** of y**our first name** (e.g. If your name is Peter, then write 'R'; if your name is Margaret, write 'T').	The **day** of the month that you were born on (e.g. if you were born on March **15**, 1976, then you write 15).

When you have finished filling in this survey, please post it to us using the self-addressed stamped envelope provided to ***SmokeCheck*, Australian Centre for Health Promotion, Edward Ford Building A27, The University of Sydney 2006.**

Please answer the following questions by ticking the box that corresponds to your response.

1.	**What is your work position?**	☐ Aboriginal Health Worker		☐ Other
2.	**Are you of Aboriginal or Torres Strait Islander descent?**	☐ Yes	☐ No	☐ Both
3.	**How often do you work with Aboriginal clients?**	☐ Never	☐ Hardly ever	☐ Sometimes
		☐ Often	☐ All the time	
4.	**Do you see giving advice on stopping smoking as part of your role?**	☐ Yes	☐ No	☐ Don't know
5.	**Did you attend a *SmokeCheck* workshop around 6 months ago?**	☐ Yes	☐ No (Go to Q14)	☐ Don't remember (Go to Q9)

6.	**Did you attend more than one SmokeCheck workshop?**		☐ Yes	☐ No (Go to Q9)	☐ Don't remember (Go to Q9)
7.	**How many workshops did you attend?**				
8.	**If you attended more than one workshop, why did you go more than once?**				
9.	**How useful was the workshop for you?**				
	☐ Not at all usefu	☐ A little useful	☐ Moderately useful	☐ Useful	☐ Very useful
10.	**How relevant was the *SmokeCheck* training to your work?**				
	☐ Not at all relevant	☐ A little relevant	☐ Moderately relevant	☐ Relevant	☐ Very relevant
11.	**How often have you used the *SmokeCheck* skills at work?**				
	☐ Never	☐ Hardly ever	☐ Sometimes	☐ Often	☐ All the time
12.	**How much did you enjoy the *SmokeCheck* workshop?**				
	☐ Not at all	☐ A little	☐ Some of it	☐ A lot	☐ Very much
13.	**How satisfied are you with the *SmokeCheck* training?**				
	☐ Not at all satisfied	☐ A little satisfied	☐ Moderately satisfied	☐ Satisfied	☐ Very satisfied
14.	**Have you had any other training about advising clients to quit smoking in the last 6 months?**			☐ Yes	☐ No
15.	**How confident do you feel that you could talk with your clients about how smoking affects their health?**				
	☐ Not at all confident	☐ A little confident	☐ Moderately confident	☐ Confident	☐ Very confident
16.	**How confident do you feel that you could talk with clients who smoke about quitting?**				
	☐ Not at all confident	☐ A little confident	☐ Moderately confident	☐ Confident	☐ Very confident
17.	**How confident do you feel that you could assess your client's readiness to quit smoking?**				
	☐ Not at all confident	☐ A little confident	☐ Moderately confident	☐ Confident	☐ Very confident
18.	**When a client comes to you for another reason how confident do you feel bringing up smoking?**				
	☐ Not at all confident	☐ A little confident	☐ Moderately confident	☐ Confident	☐ Very confident
19.	**How confident do you feel that you could advise a client about using either nicotine gum or patches?**				
	☐ Not at all confident	☐ A little confident	☐ Moderately confident	☐ Confident	☐ Very confident

20.	**How important do you feel it is for every client who smokes to be offered advice about quitting?**				
	☐ Not at all important	☐ A little important	☐ Moderately important	☐ Important	☐ Very important
21.	**How easy or difficult is it for you to give brief advice to clients about quitting smoking during regular visits?**				
	☐ Very difficult	☐ Difficult	☐ Neither easy nor difficult	☐ Easy	☐ Very easy
22.	**How do you help clients to quit smoking? [You can choose more than one answer]**				
	☐ I provide advice on nicotine replacement therapy				
	☐ I advise them on ways to reduce environmental tobacco smoke				
	☐ I encourage clients to cut down on the number of cigarettes they smoke				
	☐ I don't use any particular method				
	☐ I don't help clients to quit smoking				
	☐ Don't know				
23.	**Which of the following best describes your smoking status? This includes cigarettes, cigars and pipes?**				
	☐ I smoke daily				
	☐ I smoke occasionally				
	☐ I don't smoke but I used to [go to Q25]				
	☐ I've tried it a few times but never smoked regularly [go to Q25]				
	☐ I've never smoked [go to Q25]				
	☐ Don't know [go to Q25]				
24.	**Which of the following best describes how you feel about your smoking?**				
	☐ I am not planning on quitting within the next 6 months				
	☐ I am planning on quitting within the next 6 months				
	☐ I am planning on quitting within the next month				
	☐ I have not smoked in the past 24 hours but was smoking 6 months ago				
	☐ I have not been smoking in the past 6 months				
	☐ Don't know				
25.	**Which of the following best describes your home situation?**				
	☐ My home is smoke-free (smoking is allowed outside only)				
	☐ People occasionally smoke in the house				
	☐ People frequently smoke in the house				
	☐ Don't know				

26.	**Which of the following best describes your workplace situation?**				
	☐ My workplace is smoke-free (smoking is allowed outside only)				
	☐ People occasionally smoke in the workplace				
	☐ People frequently smoke in the workplace				
	☐ Don't know				
27.	**Are there quit smoking resources available in your workplace for you to use with clients? If Yes, can you list them?**			☐ Yes	☐ No (go to Q29)
28.	**How culturally appropriate are the quit smoking resources available in your workplace?**				
	☐ Not at all appropriate	☐ A little appropriate	☐ Moderately appropriate	☐ Appropriate	☐ Very appropriate
29.	**If you have any questions or comments, please let us know.**				

Thank you very much for completing this survey!

If you have any questions, please feel free to contact us on (02) 9036 7113.

Appendix 3D: Feedback form

SmokeCheck feedback form

How would you rate today's workshop? Please indicate your agreement with each statement by placing a tick in the box corresponding to your answer.

	Strongly disagree	Disagree	Undecided	Agree	Strongly agree
1.	**The course was taught at a level that I could understand.**	☐	☐	☐	☐
2.	**The information presented will help me in my job.**	☐	☐	☐	☐
3.	**The material presented was interesting and easy to understand.**	☐	☐	☐	☐
4.	**There was a right mix of practical and theory.**	☐	☐	☐	☐
5.	**The course encouraged participation.**	☐	☐	☐	☐
6.	**Resources and training notes were effective and easy to understand.**	☐	☐	☐	☐
7.	**Session outcomes and structure of the session were clearly outlined.**	☐	☐	☐	☐
8.	**The trainer was enthusiastic about the course and was easy to understand.**	☐	☐	☐	☐
9.	**The trainer was knowledgeable about quitting smoking methods.**	☐	☐	☐	☐
10.	**There was enough time allowed for questions.**	☐	☐	☐	☐
11.	**A secure and comfortable learning environment was provided.**	☐	☐	☐	☐

What were the best aspects of the training?			
What could have been done better?			
Do you have any other comments?			
Are you of Aboriginal or Torres Strait Islander descent?	☐ Yes	☐ No	☐ Both

Thank you very much for completing this feedback form!

If you have any questions, please feel free to contact us on (02) 9036 7113.

Appendix 3E:
Manager's pre workshop survey

SmokeCheck managers survey

Thank you very much for participating in the *SmokeCheck* managers' workshop. We would appreciate it if you could help us with the workshop evaluation.

This survey is not a test. It is to show us whether our workshop meets your needs. We will use this information to help us evaluate the managers' workshop and make it better for next time. We would be grateful if you would agree to take part in this evaluation by answering all the questions in this survey and returning the survey to us.

Please make sure that these are your answers.
Do not talk about your answers with other people.

Please do NOT write your name on this form. But to help us compare each person's answers before and after the workshop, we will ask you to create your own personal code using the instructions below.

To make your personal code, please write

☐	☐	☐☐
The **first letter** of your **mother's first name** (e.g. If her name is Betty, then write 'B').	The **last letter** of y**our first name** (e.g. If your name is Peter, then write 'R'; if your name is Margaret, write 'T').	The **day** of the month that you were born on (e.g. if you were born on March **15**, 1976, then you write 15).

When you have finished filling in this survey, please post it to us using the self-addressed stamped envelope provided to ***SmokeCheck,* Australian Centre for Health Promotion, Edward Ford Building A27, The University of Sydney 2006.**

Please answer the questions by ticking the box next to the response that corresponds to your answer, e.g.,

Yes	No	Both

OR

Answer the questions by making a mark on the line close to the response that best corresponds to your answer, e.g.,

							X							
Not at all important			A little important			Moderately important			Important			Very important		

Please turn over the page to begin the survey

1.	**What is your work position?**			
2.	**Are you of Aboriginal or Torres Strait Islander descent?**	☐ Yes	☐ No	☐ Both
3.	**How would you describe the *SmokeCheck* program?**			
4.	**Do you see giving advice on stopping smoking as part of an Aboriginal Health Worker's role?**	☐ Yes	☐ No	☐ Don't know
5.	**How important do you feel it is for every client who smokes to be offered advice about quitting?**			

Not at all important	A little important	Moderately important	Important	Very important

6.	**How easy or difficult do you feel it would be for your staff to give brief advice to clients about quitting smoking during regular visits?**

Very difficult	Difficult	Neither easy nor difficult	Easy	Very easy

7.	**How confident are you that you and your staff can deliver the *SmokeCheck* program in your Service?**

Not at all confident	A little confident	Moderately confident	Confident	Very confident

8.	**How confident are you that you can build the capacity of your Service to deliver the *SmokeCheck* program?**

Not at all confident	A little confident	Moderately confident	Confident	Very confident

9.	**Are there quit smoking resources available in your workplace for your staff to use with clients?**	☐ Yes	☐ No (Go to Q10)
9.1	**If yes, can you list them?**		
9.2	**How culturally appropriate are the quit smoking resources available in your workplace?**		

Not at all appropriate	A little appropriate	Moderately appropriate	Appropriate	Very appropriate

10.	**Does your service currently have a policy and/or action plan about smoking cessation?**	☐ Yes	☐ No (Go to Q11)
10.1	**If yes, can you describe them briefly?**		
10.2	**If yes, to what extent do you think these are implemented?**		

Not at all implemented	Implemented a little bit	Partly implemented	Mostly implemented	Fully implemented

11.	**Which of the following best describes your smoking status? This includes cigarettes, cigars and pipes?**		
	☐ I smoke daily		
	☐ I smoke occasionally		
	☐ I don't smoke but I used to [go to Q13]		
	☐ I've tried it a few times but never smoked regularly [go to Q13]		
	☐ I've never smoked [go to Q13]		
	☐ Don't know [go to Q13]		
12.	**Which of the following best describes how you feel about your smoking?**		
	☐ I am not planning on quitting within the next 6 months		
	☐ I am planning on quitting within the next 6 months		
	☐ I am planning on quitting within the next month		
	☐ I have not smoked in the past 24 hours but was smoking 6 months ago		
	☐ I have not been smoking in the past 6 months		
	☐ Don't know		
13.	**Which of the following best describes your home situation?**		
	☐ My home is smoke-free (smoking is allowed outside only)		
	☐ People occasionally smoke in the house		
	☐ People frequently smoke in the house		
	☐ Don't know		
14.	**Which of the following best describes your workplace situation?**		
	☐ My workplace is smoke-free (smoking is allowed outside only)		
	☐ People occasionally smoke in the workplace		
	☐ People frequently smoke in the workplace		
	☐ Don't know		

15.	**Has your Service received any other training about advising clients to quit smoking in the last 6 months?**	☐ Yes	☐ No (Go to Q16)
15.1	**If yes, what was the name of the training course?**		

15.2	**How was this training received by your workforce?**				
	Very poorly received neutral	Poorly received Well received	They were Very well received	Appropriate	Very appropriate

16.	**How do you plan to support and encourage staff to deliver the *SmokeCheck* program in your Service?**

17.	**In today's workshop we will be discussing the common characteristics of health promoting organisations. What are some health promoting characteristics of your organisation?**

18.	**The following list contains some ways in which Health Service Managers may contribute to organisational change. How important would you rate each one?**

	Not at all important		A little important		Moderately important		Important		Very important	
Establishing a task group or coalition to identify, support and facilitate changes that are needed.										
Identifying and providing adequate resources for change to take place.										
Taking into account the organisational context (e.g., internal/external influences, barriers) when implementing change.										
Changing policy to outline the organisation's commitment to tobacco control.										

Appendix 3F: Site codes

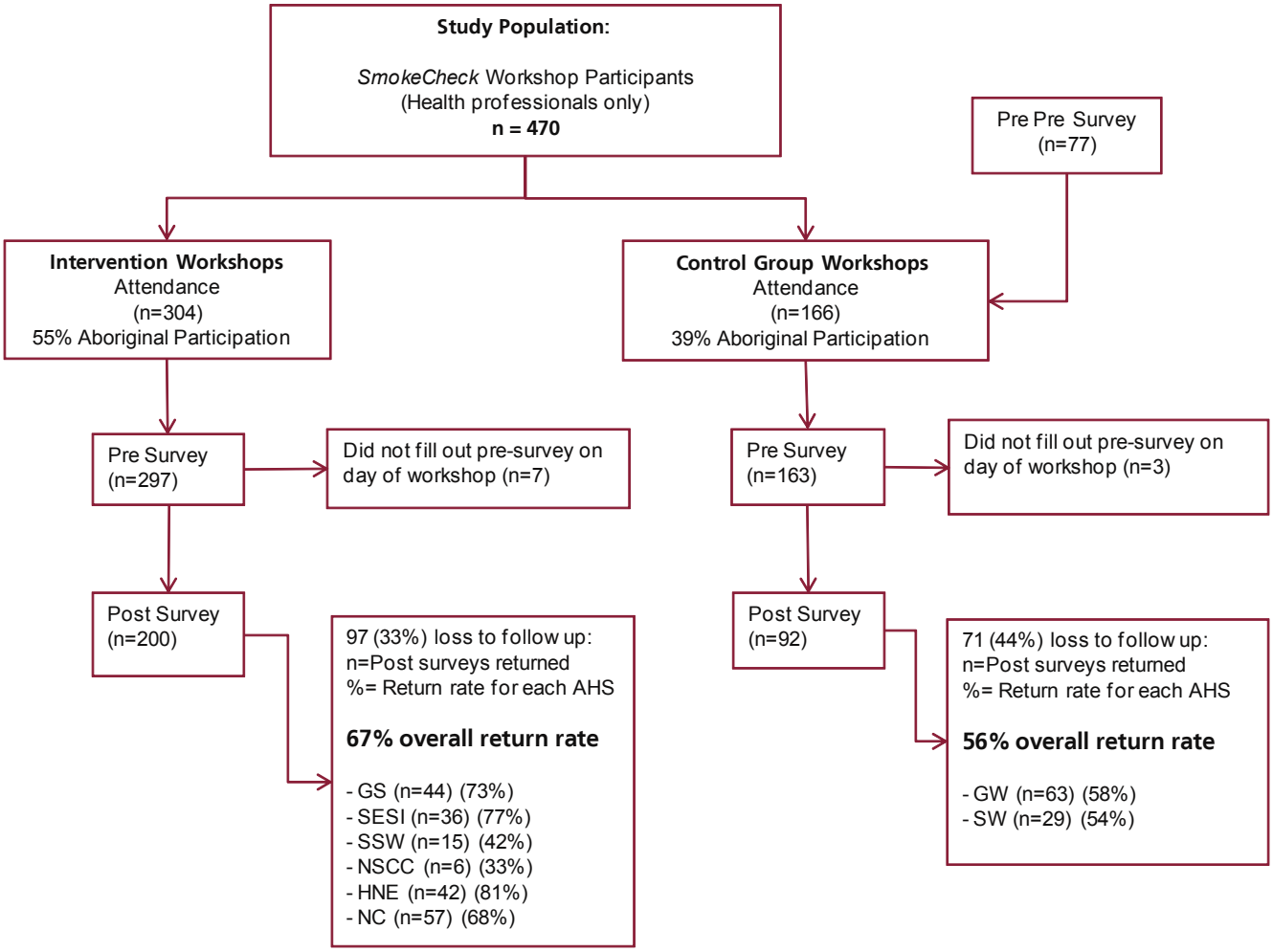
Area code	Area name	Site Code	Site name
WAITING LIST GROUP		100	Unknown P1
100	Greater Western (C101)	101	Balranald Aboriginal Health Service
if unknown location returned, allocate 100, 200, etc		102	Bourke Aboriginal Health Service
		103	Brewarrina Aboriginal Health Service
		104	GWAHS – Broken Hill
		105	Cobar Aboriginal Health Service
		106	Condobolin Aboriginal Health Service
		107	Coomealla Health Aboriginal Corp
		108	Coonamble Aboriginal Health Service
		109	Maari Ma Health
		110	
		111	Murrin Bridge Aboriginal Health Service
		112	Orana Haven Aboriginal Corporation
		113	Orange Aboriginal Health Service
		114	Peak Hill Aboriginal Medical Service
		115	Thubbo Aboriginal Medical Co-op
		116	Walgett Aboriginal Medical Service Co-op
		117	Weigelli Centre Aboriginal Corp
		118	Wellington Aboriginal Corp Health Service
		119	Yoorana-Gunya Family Violence Healing Centre
		120	GWAHS – Orange
		121	GWAHS – Dubbo
		122	GWAHS – Wilcannia
		123	GWAHS – Bathurst
		124	GWAHS – Wentworth
		130	Survey Monkey
	Workshops	↓	
		150	Bourke
		151	Orange

Area code	Area name	Site Code	Site name
		152	Forbes
		153	Coonamble
		154	Dareton
		155	Broken Hill
		156	Menindee
		157	Balranald
		100	Unknown Post
		100	Survey Monkey
	Second Round	160	Dubbo
		161	Broken Hill
800	Sydney West (D101)	800	P1 Unknown
		801	Blacktown
		802	Mt Druitt Community Health Centre
		803	Nepean Hospital
		804	Winan Gidyal – Mt Druitt Hospital
		805	Wentworthville
		806	Western Sydney AMS (DARUK)
		830	Survey Monkey
	Workshops	↓	
		810	Katoomba
		811	Rooty Hill 1
		812	Rooty Hill 2
		800	Unknown SWAHS
		800	Survey Monkey
		820	Parramatta
		821	Penrith
HW INTERVENTION			
200	Greater Southern	200	Survey Monkey
		200	Unknown GS
		203	Wagga Health Workers
		204	Griffith Health Workers
		303	Narooma Health Workers
	Second Round	206	Albury

Area code	Area name	Site Code	Site name
		207	Wagga Wagga
		208	Bega
		200	Survey Monkey
		300	Survey Monkey
300	South Eastern Sydney & Illawarra	300	Unknown SSIAHS
		301	Wollongong Health Workers
		302	Nowra Health Workers
		304	La Perouse Health Workers
	Second Round	310	Wollongong
400	Sydney South West	400	Survey Monkey
		401	University of Sydney Health Workers
		402	Liverpool Health Workers
	Second Round	410	Sydney
		400	Survey Monkey
500	Northern Sydney & Central Coast	500	Survey Monkey
		501	Gosford Health Workers
		502	Yerin (Second Round)
		500	Survey Monkey
600	Hunter New England	600	Survey Monkey
		600	Unknown GSAHS
		601	Newcastle Health Workers
		603	Taree Health Workers
		604	Tamworth Health Workers
		606	Moree Health Workers
	Second Round	610	Newcastle
		611	Armidale
		600	Survey Monkey
700	North Coast	700	Survey Monkey
		700	Unknown NCAHS
		702	Coffs Harbour Health Workers
		704	Port Macquarie Health Workers 1
		705	Port Macquarie Health Workers 2

Area code	Area name	Site Code	Site name
		706	Grafton Health Workers
		708	Coroki Health Workers
	Second Round	700	Unknown NCAHS
		700	Survey Monkey
		720	Lismore
		721	Casino
		722	Grafton
		723	Kempsey
		724	Port Macquarie
100	Greater Western	100	Survey Monkey
		158	Dareton Managers
		159	Forbes Managers
		162	Broken Hill
		161	Menindee
200	Greater Southern	200	Unknown
		201/2	Wagga Managers 1
		205	Griffith Managers
300	South Eastern Sydney & Illawarra	300	Unknown
		305	La Perouse Managers
		306	Nowra Managers
500	Northern Sydney & Central Coast	500	Survey Monkey
		502	Yerin Managers
600	Hunter New England	600	Unknown
		602	Newcastle Managers
		605	Tamworth Managers
600	Hunter New England	700	Unknown
		701	Coffs Harbour Managers
		703	Port Macquarie Managers
		707	Coroki Managers
		709	North Coast Managers – 2nd visit
		813	Rooty Hill Managers

Appendix 3G:
SmokeCheck evaluation flow chart

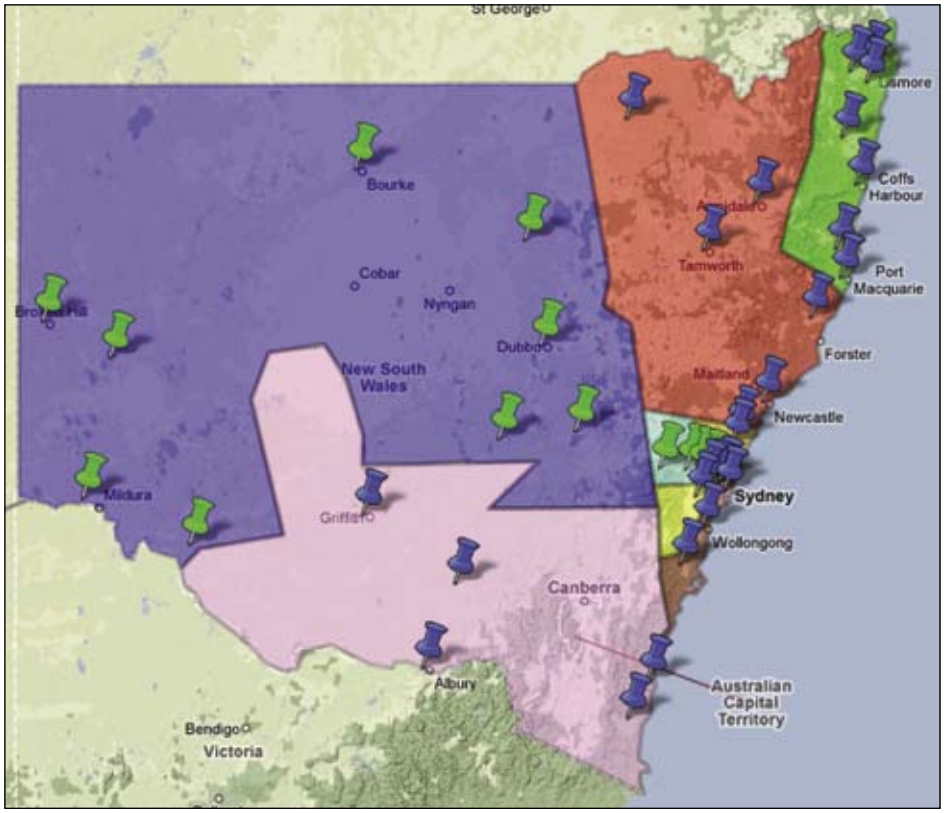


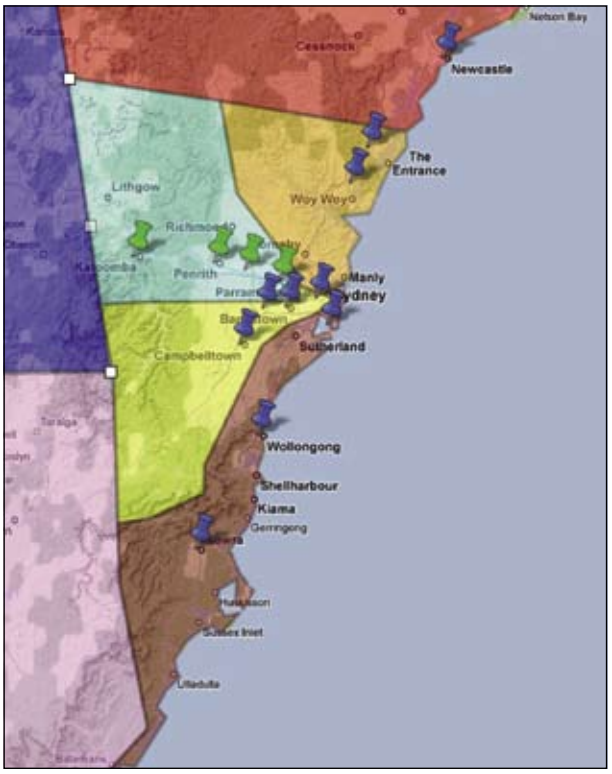
89* (55%) loss to follow up:

- n=Post surveys returned
- %=Return rate

45% overall return rate (to date)

Appendix 4A:
Locations of health professional workshops



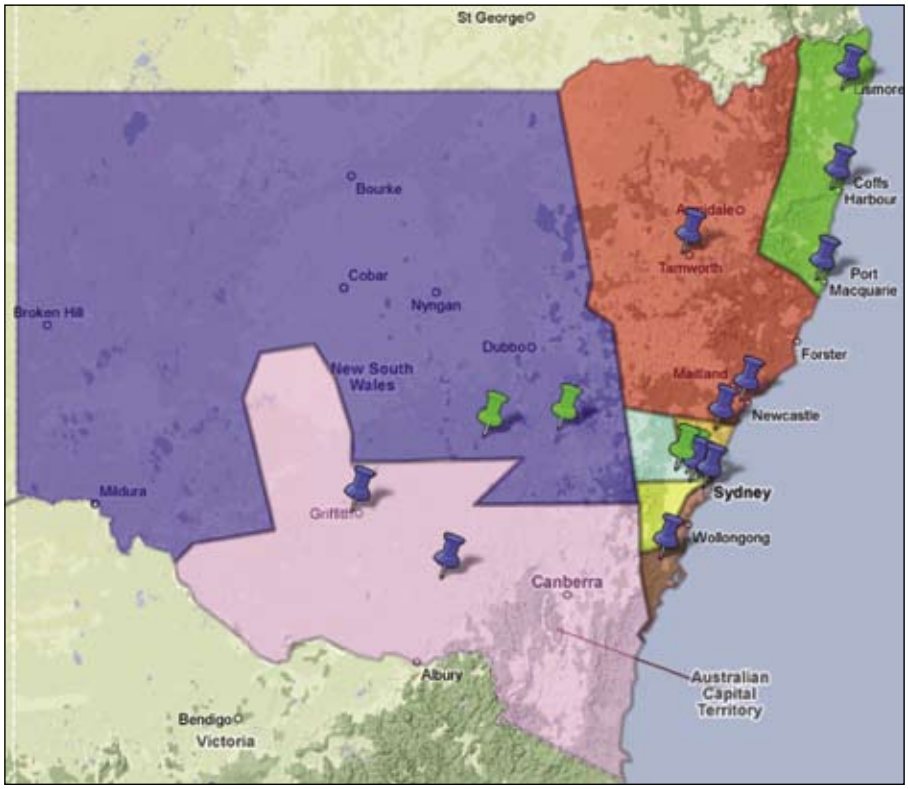


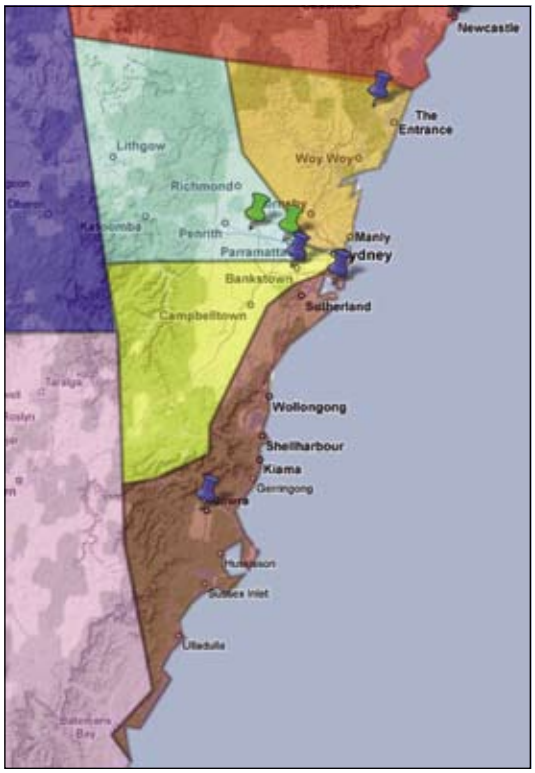
SmokeCheck

Rate this map – Write a comment

- **Greater Western**
- **Greater Southern**
- **Hunter New England**
- **North Coast**
- **Sydney West**
- **Sydney South West**
- **North Sydney Central Coast**
- **South Coast Illawarra**

Appendix 4B:
Locations of manager workshops





SmokeCheck

Rate this map – Write a comment

- **Greater Western**
- **Greater Southern**
- **Hunter New England**
- **North Coast**
- **Sydney West**
- **Sydney South West**
- **North Sydney Central Coast**
- **South Coast Illawarra**

Appendix 4C:
Pre (P2) survey open-ended survey results

AHW PRE (P2) – ALL – OPEN ENDED RESULTS	
Q 17b QUIT SMOKING RESOURCES	
TOTAL PRE:	537
TOTAL PRE w/ answer to Q17b:	312
NRT: patches/gum/lozenge/inhaler/micro tab:	164
Resources: brochures/pamphlets/posters/stickers/CD&DVD/fact sheets:	164
Quitline: Quit kits/Quit packs/Fax referrals:	122
Smoking cessation programs/Quit smoking programs:	23
Advice/support/counselling:	18
No/not sure/don't know:	17
Smokefree initiatives, e.g. resources/guides/policy:	10
SmokeCheck resources:	8
Zyban/Champix:	6
Doctor/GPs/RNs:	5
Other workers, e.g. AOD:	4
Q19 ANY OTHER TRAINING	
TOTAL PRE:	537
Total PRE w/ answer to Q19:	113
NSW Health Telehealth smoking cessation training:	75
Nicotine Addiction & Smoking Cessation Training (Renee Bittoun, USYD)	13
AMS training, e.g. Maari Ma, Redfern, South Coast:	7
SmokeCheck training:	7
Cancer Council (Tracey Greenberg)/Quit VIC training:	6
Area wide tobacco working group:	2
Grad Dip Indigenous Health Substance Misuse (USYD:	1
AOD training in NT:	1
Australian Family Physician Jan/Feb 08:	1
Smokefree training:	1
Tobacco and youth:	1
Health Coaching (not specific to smoking:	1
UNSW medical course:	1
SANE program, supporting mental health:	1
Practical NRT:	1
Asthma Educators Course:	1

Appendix 4D:
Post survey open-ended survey results

AHW POST – OPEN ENDED RESULTS	
Q8 IF ATTENDED MORE THAN ONE, WHY?	
TOTAL PRE w/ answer to Q17b:	312
Pilot program attended	4
Manager's session also attended	3
Also came to University of Sydney training	2
Sent by organisation	2
Because of high smoking rates	1
Q14 TRANING COURSES ATTENDED LAST 6 MTHS	
NSW Health Telehealth Smoking Cessation Training	15
Nicotine Addiction & Smoking Cessation Training (Renee Bittoun, USYD)	5
Inservices, e.g. Respiratory Physician; Oral Health staff, ETS screening, etc.	4
SmokeCheck	2
Barnardos Smoke Free Kids Project	1
Sydney Uni- Grad Dip Ind Health substance Misuse course	1
Pharmaceutical company training, e.g. Pfizer	1
Chronic Disease in the Community (Cessnock)	1
Other, e.g. motivational interviewing/relapse prevention	1
Q27 QUIT SMOKING RESOURCES	
TOTAL POST:	187
TOTAL POST w/ answer to Q27:	123
Resources: brochures/pamphlets/posters/stickers/CD&DVD/fact sheets:	91
SmokeCheck resources:	52
Quitline: Quit kits/Quit packs/Fax referrals:	45
NRT: patches/gum/lozenge/inhaler/microtab:	42
Doctor/GPs/RNs/clinic:	7
Other workers, e.g. AOD:	5
Smokefree initiatives, e.g. resources/guides/policy:	5
Advice/support/counselling:	4
No/not sure/don't know:	2
Smoking cessation programs/Quit smoking programs:	2
CO2 Monitor:	1

Q29 ANY OTHER COMMENTS	
Good workshop overall, e.g. resources, presentation, presenters – thank you	17
Would like more training/resources	8
Tailored to Aboriginal communities	6
Ultimately people's choice, e.g. how to address elders not covered	4
More information on NRT dosages, other quit smoking aids & barriers to quitting	3
Role model' issue, i.e. feel hypocritical giving quit advice as still a smoker	2
Pitched at too high a level for some workers/communities	1
Inspired to think about own smoking, e.g. 3 quit attempts in past 6 months	1

Appendix 4E:
Feedback form open-ended survey results

FEEDBACK FORMS – OPEN ENDED RESULTS	
Q2 BEST ASPECTS OF TRAINING	
CONTENT	
Resources	94
Knowledge/information	63
Aboriginal focus/culturally specific, i.e. client based	53
Practical, e.g. activities/case studies	37
Interesting/informative/educational	31
Presentation, i.e. statistics	30
NRT & nicotine dependence information	24
Relevant/useful/effective	22
Good reinforcement of previous training	8
Stages of change	6
Effects of smoking	6
STRUCTURE	
Discussion & group interaction/dynamics, e.g. small groups	65
Networking/meeting people	12
ENVIRONMENT	
Everything/all good	76
Relaxed/friendly/fun atmosphere & enjoyable day	37
Venues/food/structure of the day	27
TRAINERS	
Clear/easy to understand	48
Trainers motivated/enthusiastic & knowledgeable	33
Q3 WHAT COULD HAVE BEEN DONE BETTER	
Nothing	89
Venue issues, i.e. location, directions, temperature, comfort, parking etc.	17
Time issues, i.e. more time/time management	16
More attendance & promotion, i.e. more clinical/managers attending	11
More information/explanation of NRT	10
Presentation handouts could have been given out	9
Food comments, e.g. need for equal	9
More activities/practical rather than theoretical, e.g. power point	7
Hard to hear, noise issues	4

Presentation issues, e.g. hard to read at times	3
Physiology of smoking how it affects the body, i.e. too basic for medical staff	3
More cultural knowledge	2
Supply NRT as well	2
Interruptions, i.e. children in venue	1
Ensure smoker & Aboriginal people present	1
Q4 ANY OTHER COMMENTS	
Good workshop overall, e.g. resources, presentation, presenters – well done	94
Thank you	55
Enjoyable/motivational	23
Inspired to think about own smoking	8
Tailored to Aboriginal communities	7
Copies of presentation/hand outs requested	5
Would like more training	4
Local input, i.e. local AHEO to assist in some way	1
Role model & 'duty of care' should be introduced	1

Appendix 4F: Managers pre and post open-ended survey results

MANAGERS PRE & POST – QUALITATIVE RESULTS	
Q1 WORK POSITION	
Health Promotion Manager/Officer	
CEO/Manager	94
Manager Aboriginal Health	63
Practice Manager	53
Clinical Nurse (Midwifery) Consultant/Specialist	37
Senior / Population Health Officer	31
Program Manager	30
Program Coordinator – Equity/Healthy for Life/Health Dev	24
Network Coordinator	22
RN/Nurse	8
Supervisory Manager	6
Project Officer	6
Office Manager	
Health Worker	65
Trainer	12
Medical Director	
Management trainee	76
TOTAL:	37
	27
Q3 DESCRIBE SMOKECHECK	
culturally appropriate/Aboriginal/ATSI	48
program/brief intervention	33
good/great/excellent	
resources	
informative/educational	
useful/valuable	
capacity building/skills	
information/knowledge	
training	
no/don't know yet	
related to staff	
promote non-smoking, etc.	
new/long time coming	
supportive	

Q9a RESOURCES	
Quit kits/packs, Quitline, QUIT info/resources, fax referrals	
NRT: patches, gum, lozenges	
Medication/Champix	
The NSW Health Smoke Free Workplace Policy and Car & Home Smoke Free zone resources	
NSW Health resources	
Resources: brochures, pamphlets, stickers, posters, fact sheets, manuals, DVD	
SmokeCheck resources	
Support	
ETS information	
Treatments/hypnotherapy	
Cancer Council	
Smoking cessation programs	
No/unsure	
Q10a POLICY & ACTION PLAN IN SERVICE	
Smoke Free Workplace Policy	
SmokeCheck & other training/brief intervention	
Support staff to quit, e.g. NRT	
Part of Action Plan/Business Plan	
No/unsure	
Q15a TRAINING COURSES	
NSW Health Telehealth smoking cessation training	
SmokeCheck	
Nicotine Addiction & Smoking Cessation Training (Renee Bittoun, USYD)	
Smoke Free Workplace Policy workshop	
Unsure/did not attend	
Maari Ma/GWAHS	
Quit NSW/VIC & Cancer Council	
Others, e.g. Clean Air Dreaming Project & GUTS Program	
Q16 SUPPORT FOR STAFF TO DELIVER SMOKECHECK	
Continued training/education & encourage attendance/delivery	
Encourage/support staff to use SmokeCheck, i.e. BI & resources	
Resources	
Unsure/not enough resources for delivery, e.g. staff	
Programs	
Used in clinic settings/part of Health Checks	
Need to increase staff confidence/smoking status of staff	
Funding of NRT	
Integrate into strategies	

Q17 HEALTH PROMOTING CHARACTERISTICS OF ORGANISATION	
Health promotion & prevention/harm minimisation/education	
Staff & resources, e.g. promotion board/newsletters	
Free NRT, quit programs	
Smoke Free Workplace Policy, etc.	
Lifestyle/holistic programs	
N/A or unsure	
Ottawa Charter principles – reorient services, provide supportive environments	
Implementing Public Health policy/Population Health	
Community participation/development	
Q21a ORGANISATIONAL CHANGE STRATEGIES	
Smoke free areas/health centre	
Provide resources/staff/task group	
Clinical guidelines review/change in clinic practice	
Programs, e.g. pregnancy, quit courses	
N/A or not at this stage	
HP Promotion Indicators	
NRT Program implementation for staff/inpatients	
Intranet	
Action Plan implementation	
Q22 OTHER COMMENTS	
Follow up to training to keep on agenda/continued training to build skills/confidence on BI & NRT	
Managers' workshop useful/informative	
Workload too high/difficult	
NCAHS – number of initiatives to promote good health & smokefree	

Appendix 4G:
Table of significance test: Feedback form

Feedback form

Aboriginal and non-Aboriginal comparisons. (n=460)

Q	Topic	p value	Significant difference
1.	**How would you rate today's workshop?**		
	a. The course was taught at a level I could understand.	0.272	no
	b. The information presented will help me in my job.	0.918	no
	c. the material presented was interesting and easy to understand.	0.407	no
	d. There was a right mix of practical and theory.	0.494	no
	e. The course encouraged participation.	0.182	no
	f. Resources and training notes were effective and easy to understand.	0.823	no
	g. Session outcomes and structure of the session were clearly outlined.	0.129	no
	h. The trainer was enthusiastic about the course and was easy to understand.	0.797	no
	i. The trainer was knowledgeable about quitting smoking methods.	0.486	no
	j. There was enough time allowed for questions.	0.709	no
	k. A secure and comfortable learning environment was provided.	0.645	no
2.	**What were the best aspects of the training?**	**N/A**	
3.	**What could have been done better?**	**N/A**	
4.	**Do you have any other comments?**	**N/A**	
5.	**Are you of Aboriginal or Torres Strait Islander descent?**	**N/A**	

Appendix 4H: Table of significance test: Changes in matched control

Control group comparisons. P1 (control) and pre (control)

Matched data sets (n=28)

Q	Topic	p value	Significant difference
1	**Work position (AHW/other)**	**0.63**	**no**
2	**Descent**	1.0	no
3	**Frequency of working with Aboriginal clients**	0.33	no
4	**Smoking cessation advice part of your role?**	0.50	no
5	**Confidence talking about – smoking affects health**	0.33	no
6	**Confidence talking about – quitting**	0.095	no
7	**Confidence talking about – assess readiness to quit**	0.18	no
8	**Confidence talking about – bringing up smoking**	0.82	no
9	**Confidence talking about – NRT**	0.14	no
10	**Important to offer advice**	0.56	no
11	**How easy to give advice**	0.64	no
12	**How do you help clients quit?**		
	a. use NRT	1.0	no
	b. reduce ETS	0.18	no
	c. advise to cut down	0.55	no
	d. none	1.0	no
	e. don't help	0.50	no
	f. don't know	1.0	no
13	**Smoking Status**	0.71	no
14	**Readiness to quit**	1.0	no
15	**ETS at home**	0.28	no
16	**ETS at work**	0.66	no
17a	**Quit smoking resources available at work**	1.0	no
18	**Resources culturally appropriate?**	0.38	no
19a	**Other quit smoking training in last six months**	0.22	no

Appendix 4I: Table of significance test: Changes in independent control

Control group comparisons. P1 (control) and pre2 (control)
Analysed as independent data sets (not matched).

Q	Topic	p value	Significant difference
1	**Work position (AHW/other)**	**0.33**	**no**
2	**Descent**	0.000	yes
3	**Frequency of working with Aboriginal clients**	0.048	yes
4	**Smoking cessation advice part of your role?**	0.18	no
5	**Confidence talking about – smoking affects health**	0.76	no
6	**Confidence talking about – quitting**	0.93	no
7	**Confidence talking about – assess readiness to quit**	0.40	no
8	**Confidence talking about – bringing up smoking**	0.63	no
9	**Confidence talking about – NRT**	0.63	no
10	**Important to offer advice**	0.087	no
11	**How easy to give advice**	0.19	no
12	**How do you help clients quit?**		
	a. use NRT	0.37	no
	b. reduce ETS	0.007	yes
	c. advise to cut down	0.40	no
	d. none	0.85	no
	e. don't help	0.39	no
	f. don't know	0.77	no
13	**Smoking Status**	0.031	yes
14	**Readiness to quit**	0.090	no
15	**ETS at home**	0.15	no
16	**ETS at work**	0.47	no
17a	**Quit smoking resources available at work**	0.19	no
18	**Resources culturally appropriate?**	0.36	no
19a	**Other quit smoking training in last six months**	0.002	yes

Appendix 4Ja: Table of significance test: Changes in intervention – all participants

Intervention group comparisons. Pre and post all participants (n=165)

Matched data sets. All significance tests two-sided.

Q	Topic	p value	Significant difference
1	**Work position (AHW/other)**	**1.0**	**no**
2	**Descent**	0.5	no
3	**Frequency of working with Aboriginal clients**	0.004	yes
4	**Smoking cessation advice part of your role?**	0.42	no
5	**Confidence talking about – smoking affects health**	0.000	yes
6	**Confidence talking about – quitting**	0.000	yes
7	**Confidence talking about – assess readiness to quit**	0.000	yes
8	**Confidence talking about – bringing up smoking**	0.000	yes
9	**Confidence talking about – NRT**	0.000	yes
10	**Important to offer advice**	0.007	yes
11	**How easy to give advice**	0.039	yes
12	**How do you help clients quit?**	0.001	yes
	a. use NRT	0.001	yes
	b. reduce ETS	0.006	yes
	c. advise to cut down	0.034	yes
	d. none	0.36	no
	e. don't help	0.13	no
	f. don't know	1.0	no
13	**Smoking Status**	0.69	no
14	**Readiness to quit**	0.70	no
15	**ETS at home**	0.096	no
16	**ETS at work**	0.41	no
17a	**Quit smoking resources available at work**	0.50	no
18	**Resources culturally appropriate?**	0.000	yes

Appendix 4Jb: Table of significance test: Changes in intervention – Aboriginal health workers

Intervention group comparisons. Pre and post AHW (n=66)

Matched data sets. All significance tests two-sided.

Q	Topic	p value	Significant difference
1	**Work position (AHW/other)**	**0.016**	**yes**
2	**Descent**	1.0	no
3	**Frequency of working with Aboriginal clients**	0.66	no
4	**Smoking cessation advice part of your role?**	0.13	no
5	**Confidence talking about – smoking affects health**	0.000	yes
6	**Confidence talking about – quitting**	0.000	yes
7	**Confidence talking about – assess readiness to quit**	0.000	yes
8	**Confidence talking about – bringing up smoking**	0.000	yes
9	**Confidence talking about – NRT**	0.000	yes
10	**Important to offer advice**	0.24	no
11	**How easy to give advice**	0.012	yes
12	**How do you help clients quit?**	0.001	yes
	a. use NRT	0.019	yes
	b. reduce ETS	0.031	yes
	c. advise to cut down	0.000	yes
	d. none	0.12	no
	e. don't help	0.11	no
	f. don't know	1.0	no
13	**Smoking Status**	0.55	no
14	**Readiness to quit**	0.78	no
15	**ETS at home**	0.045	yes
16	**ETS at work**	0.74	no
17a	**Quit smoking resources available at work**	0.55	no
18	**Resources culturally appropriate?**	0.070	yes – weak

Appendix 4Jc:
Table of significance test: Changes in intervention – no training in previous 6 months

Intervention group comparisons. Pre and post NO OTHER TRAINING IN LAST 6 MONTHS (n=118)

Matched data sets. All significance tests two-sided.

Q	Topic	p value	Significant difference
1	**Work position (AHW/other)**	**1.0**	**no**
2	**Descent**	1.0	no
3	**Frequency of working with Aboriginal clients**	0.080	no – weak
4	**Smoking cessation advice part of your role?**	0.77	no
5	**Confidence talking about – smoking affects health**	0.000	yes
6	**Confidence talking about – quitting**	0.000	yes
7	**Confidence talking about – assess readiness to quit**	0.000	yes
8	**Confidence talking about – bringing up smoking**	0.000	yes
9	**Confidence talking about – NRT**	0.000	yes
10	**Important to offer advice**	0.083	no
11	**How easy to give advice**	0.014	yes
12	**How do you help clients quit?**	0.001	yes
	a. use NRT	0.015	yes
	b. reduce ETS	0.030	yes
	c. advise to cut down	0.052	yes
	d. none	0.42	no
	e. don't help	0.096	Yes/no – weak
	f. don't know	1.0	no
13	**Smoking Status**	0.75	no
14	**Readiness to quit**	0.85	no
15	**ETS at home**	0.12	no
16	**ETS at work**	0.74	no
17a	**Quit smoking resources available at work**	0.54	no
18	**Resources culturally appropriate?**	0.005	yes

Appendix 4K:
Table of significance test: Change in managers

Managers comparisons. Pre and post (n=29)

Matched data sets. All significance tests two-sided.

Q	Topic	p value	Significant difference
1	**Work position**	**N/A**	
2	**Descent**	0.50	no
3	**How would you describe the *SmokeCheck* program?**	N/A	
4	**Smoking cessation advice part of AHW role?**	1.0	no
5	**Important to offer advice**	0.46	no
6	**How easy to give advice**	0.083	no
7	**Confidence staff delivery of SmokeCheck**	0.84	no
8	**Confidence in building capacity of service to deliver *SmokeCheck***	0.97	no
9	**Quit smoking resources available at work**	1.0	no
	a. List them	N/A	
	b. Resources culturally appropriate?	0.091	no
10	**Smoking cessation policy and/or action plan?**	1.0	no
	a. Describe	N/A	
	b. Extent of implementation	0.91	no
11	**Smoking Status**	0.33	no
12	**Readiness to quit**	0.32	no
13	**ETS at home**	0.66	no
14	**ETS at work**	1.0	no
15	**Service received other training last 6 months?**	0.42	no
	a. Name of course	N/A	
	b. How well received?	0.50	no
16	**Plan and support staff to deliver SmokeCheck**	N/A	
17	**Health promoting characteristics of service**	N/A	
18	**Health Service Managers contribution to organisational change**		
	a. Task group	0.14	no
	b. Resources	0.69	no
	c. Organisational context	0.29	no
	d. Policy change	0.70	no

Appendix 4L:
Distribution of *SmokeCheck* resources

SmokeCheck resources distribution by area health service

Information provided by the NSW Department of Health Centre for Health Advancement Resource Distribution Unit

AHS Region	Service/Site	Location	No of Resources	Date
GS	Albury Wodonga Aboriginal Health	Albury	49	27-Sep-07
GS	Griffith Base Hospital	Griffith	200	8-Oct-07
GS	Riverina Medical & Dental Aboriginal Corp.	Wagga Wagga	360	28-Nov-07
GS	Griffith CHC	Griffith	200	5-Feb-08
GS	Griffith Community Health Centre	Griffith	70	20-Mar-08
GS	Tumut CHC	Tumut	85	12-May-08
GS	Albury Wodonga Aboriginal Health	Albury	255	12-Jun-08
GS	Albury Wodonga Aboriginal Health	Albury	100	6-Aug-08
Total			1319	
GW	Bourke Primary & Community Health	Bourke	42	7-Jul-08
GW	Maari Ma Health	Broken Hill	140	6-Aug-08
		Total	182	
HNE	Birra-Li John Hunter Hospital	New Lambton	100	5-Dec-07
HNE	Biripi AMS	Taree	120	11-Dec-07
HNE	Gunnedah CHC	Gunnedah	220	11-Dec-07
HNE	Gunnedah CHC	Gunnedah	100	1-Feb-08
HNE	Birra-Li John Hunter Hospital	New Lambton	110	7-Feb-08
HNE	Community Health – Inverell	Inverell	210	27-Jun-08
HNE	Community Health – Gunnedah	Gunnedah	342	9-Jul-08
HNE	John Hunter Hospital	New Lambton Heights	240	6-Aug-08
HNE	Inverell CHC	Inverell	50	29-Aug-08
HNE	Armidale CHC	Armidale	50	29-Aug-08
HNE	Glen Innes CHC	Glen Innes	100	29-Aug-08
HNE	Inverell CHC	Inverell	125	8-Dec-08
		Total	**1767**	

AHS Region	Service/Site	Location	No of Resources	Date
NC	Galambila Health Clinic	Coffs Harbour	210	21-Sep-07
NC	Area Health Promotion – North Coast AHS	Kempsey	290	21-Sep-07
NC	Cancer Council NSW	Ballina	40	21-Sep-07
NC	Ballina Community Health	Ballina	52	21-Sep-07
NC	Health Promotion – North Coast AHS	Port Macquarie	92	21-Sep-07
NC	Health Promotion – North Coast AHS	Kempsey	145	21-Sep-07
NC	Partnership for Aboriginal care	Port Macquarie	56	24-Sep-07
NC	Cancer Council NSW	Coffs Harbour	201	25-Sep-07
NC	Dharah Gibinj' Aboriginal Medical Service	Casino	100	1-Feb-08
NC	Mid North Coast Division of General Practice	Coffs Harbour	430	21-Feb-08
NC	Durri Care Unit	Kempsey	31	6-May-08
NC	Ballina Community Health	Ballina	280	12-Jun-08
NC	Tweed OTP – North Coast AHS	Tweed Heads	535	12-Jun-08
NC	Community -Maternal & Infant Outreach	Kyogle	50	12-Jun-08
NC	Home Start – Kempsey-Macleay	West Kempsey	102	10-Jul-08
NC	Durri AMS	Kempsey	418	19-Aug-08
NC	Casino CHC	Casino	60	19-Aug-08
		Total	**3092**	
NSCC	Eleanor Duncan Aboriginal Health Service	Wyong	40	10-Mar-08
		Total	**40**	
SSI	Shoalhaven Div. Of G.P.	Nowra	249	31-Oct-07
SSI	Heart Foundation – Kiama	Kiama	130	13-Nov-07
SSI	Health Promotion – Unanderra	Unanderra	320	12-Feb-08
SSI	Health Promotion – Unanderra	Unanderra	30	28-Feb-08
SSI	Health Promotion – Unanderra	Unanderra	240	31-Mar-08
SSI	South Coast Aboriginal Medical Service	Nowra	505	28-Apr-08
SSI	Health Promotion – Unanderra	Unanderra	160	12-Jun-08
SSI	Heart Foundation	Kiama	130	23-Jul-08
		Total	**1764**	
SSW	Aboriginal Chronic Care Program	Hoxton Park	230	13-Nov-07
SSW	Narellan Community Health	Narellan	265	11-Apr-08
SSW	Quitline	Darlinghurst	232	23-Jul-08
SSW	Narellan Community Health	Narellan	478	26-Aug-08
		Total	**1205**	
SW	Hawkesbury District Health Service	Windsor	116	12-Jun-08
SW	Population Health Sydney West AHS	Parramatta	300	8-Jul-08
		Total	**416**	
		TOTAL:	**9831**	

SHPN (CHA) 090186