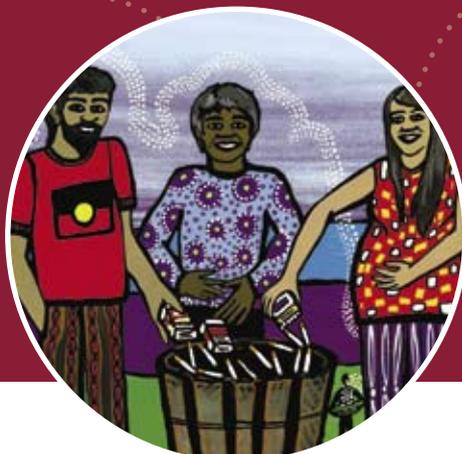


The NSW *SmokeCheck* Aboriginal Tobacco Prevention Project 2007 - 2008



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Artwork: Bronwyn Bancroft

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

Sydney School of Public Health, The University of Sydney

Disclaimer: Content within this publication was accurate at the time of publication.
February 2010

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

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We also would like to acknowledge Ms Bronwyn Bancroft, the award winning NSW Aboriginal artist, who has been engaged to produce original culturally appropriate artwork for resources of this project.

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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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May 2009

SECTION 1

About this report

The NSW *SmokeCheck* Aboriginal Tobacco Prevention Project was launched in 2007. The Project was funded by the NSW Department of Health and the Cancer Institute NSW, and administered by the Australian Centre for Health Promotion, School of Public Health, The University of Sydney.

This report is a summary of the full report titled, the *Final Report of the NSW SmokeCheck Aboriginal Tobacco Prevention Project 2007-2008* and should be read in conjunction with the full report. It has been prepared to provide a broad range of health professionals, health service managers, administrators and funding agencies engaged in tobacco control across NSW and Australia with information about the design, delivery, and evaluation of the NSW *SmokeCheck* Project's training program, and to discuss the implications of these for future tobacco control initiatives to reduce the prevalence of smoking in Aboriginal communities.

This summary of the design and delivery of the *SmokeCheck* training program is offered as a constructive contribution to a field in which research evidence remains limited, and in the hope that it extends understandings of factors that contribute, positively, to the implementation of a smoking cessation intervention that has the potential to contribute to reducing the prevalence of smoking in Aboriginal communities.

This report commences with a summary of the context of tobacco use in Aboriginal communities. It then outlines the *SmokeCheck* Project and discusses its development and implementation as well as its specific training and resource components. It follows with a description of the research findings from the Project's evaluation and a discussion of future issues that were identified from the evaluation for the Project as well as for other tobacco control efforts that seek to improve the health and wellbeing of Aboriginal people in NSW.

This report should be read in conjunction with the '*NSW Tobacco Action Plan 2005-2009*', the '*Guide to the Management of Nicotine Dependent Inpatients*' and '*Let's take a moment, quit smoking brief intervention*'. These documents are available from the NSW Department of Health website www.health.nsw.gov.au

Understanding the problem

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).

- It has been estimated that one in four Aboriginal people aged over 18 years with cardiovascular disease are also indicating former smoker status (Penm 2008, p.39);
- 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 (Mahers et al 1999, NSW Department of Health 2005a, p.21);
- Tobacco smoking contributes to more drug related hospitalisations and deaths in the Aboriginal population than alcohol and illicit drug use combined (Australian Bureau of Statistics & Australian Institute for Health and Welfare 2008, p.138), and this may be an underestimate, with only 56 per cent of Aboriginal deaths registered accurately (SCRGSP 2007, p.32);
- The health effects of tobacco smoking 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 et al 2007, p.511); and
- Environmental tobacco smoke (ETS) has negative effects on the health of non smokers, including infants and children. The links to respiratory infections such as asthma, and pneumonia, and higher rates of otitis media amongst Aboriginal children (Jacoby et al 2008, p.599) should not be underestimated.

The rates of smoking in NSW Aboriginal communities have been estimated to be more than double those of other Australians (Australian Bureau of Statistics & Australian Institute for Health and Welfare 2008, p.65).

The *NSW Population Health Survey* shows 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 Department of Health 2008, p.98).

The most socio-economically disadvantaged Aboriginal people are likely to be smokers (Thomas et al 2008, p.110).

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 (Australian Bureau of Statistics & Australian Institute of Health and Welfare 2008, p.23). Research about the relationship between the social determinants of health and smoking amongst Aboriginal people finds that within Aboriginal populations, it is the very high numbers of disadvantaged people who start smoking, and not the smaller numbers who quit, that explain the higher smoking rates (Thomas et al, 2008, p.115).

There has been a perception among health professionals that Aboriginal people have been reluctant to quit, partly because there are many significant pressures in their lives (Wise et al 2008, p.14).

Some research suggests that associations between socio-economic status and smoking are not necessarily causal, and that perhaps smoking is not perceived as a health priority by Aboriginal people given the many other health issues and life pressures that demand attention. Other research describes the complex interplay in Aboriginal populations between smoking and stress, with 'the pervasiveness of stress being proposed as a significant barrier to cessation' (DiGiacomo et al 2007 p.174).

The high rates of smoking also affect the economic and social wellbeing of Aboriginal families and communities (Collins & Lapsley 2005).

The spiralling cost of tobacco products 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. The social impact of tobacco related diseases on Aboriginal families and communities may also 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.

- Despite the long-standing evidence of the high prevalence of smoking in Aboriginal communities and its multiple, serious effects on health and quality of life, there has been very limited investment in culturally-specific, sustained tobacco control initiatives that are delivered across the population.

There is evidence that a comprehensive range of strategies is needed to reduce the incidence and prevalence of smoking in populations. Among these, one of the most important first steps is to ensure that all people who smoke are offered expert advice and support to quit. The role of the health sector is critical in this given that a large majority of people in the population visit their primary health care professionals at least once each year, and people who smoke are more likely than non-smokers to require medical treatment for acute and/or chronic illness (Girgis and Ward, 2003). There is good evidence too, that brief interventions by health professionals are effective in persuading and supporting people to quit smoking (World Health Organization 2004).

Aboriginal health workers are key navigators in effective aboriginal health promotion. Their cultural knowledge, community and family connectedness, professional roles, skills, and experience in delivering health care to their communities, combined with their commitment to their communities mean that they are the most important first point of contact – both for Aboriginal communities wanting to take action to improve their health, and for non-aboriginal health workers who are committed to aboriginal health promotion. (Hearn & Wise 2004).

In view of the centrality of the AHW's role in the provision of health care it is important that their employers ensure that they have access to '*increased educational opportunities, appropriate career pathways and remuneration as a priority ...*' (Abbott et al 2008, p.161)

SmokeCheck: An evidence based smoking cessation intervention

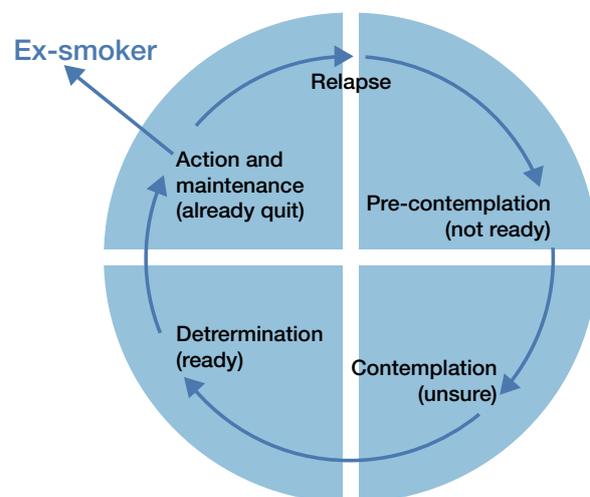
SmokeCheck, developed by Queensland Health's Tropical Public Health Unit was the first time in Australia that the Stages of Change model was adapted to test its relevance and efficacy in Aboriginal communities.

An evaluation of the Queensland *SmokeCheck* program demonstrated positive outcomes for both participants (health professionals) undertaking the training and for clients who received smoking cessation advice and support based on the training (Queensland Health 2007, p.9). These included:

- 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 pilot project to develop an Aboriginal-specific smoking cessation program based on the Queensland model. The NSW project was developed and pilot tested to confirm its efficacy over a two year period. The NSW Department of Health 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.

The NSW *SmokeCheck* brief smoking cessation intervention is 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. Smokescreen, developed in the 1990s (Richmond et al 1991) for general practitioners to use with people who smoke, *The Smoking Cessation Guidelines for Australian General Practice* (Zwar et al 2005, p.463) and the NSW Department of Health's *Let's take a moment quit smoking brief intervention – a guide for all health professionals* (NSW Department of Health 2005b) are other programs that have provided evidence supporting aspects of the development of the NSW *SmokeCheck* intervention.



Sources: DiClemente & Prochaska 1983; Richmond et al 1991; 1998 Zwar et al 2004.

SECTION 4

The NSW *SmokeCheck* Project

The *NSW Tobacco Action Plan 2005-2009* has reflected the commitment of NSW Health to reduce tobacco use among Aboriginal people (NSW Department of Health 2005a, p.15). The Plan identified six 'Focus Areas' for action. The *SmokeCheck* Project was developed to meet the objectives of Focus Area 1: Smoking Cessation and Focus Area 5: Capacity Building.

In 2006 the NSW Department of Health contracted the Australian Centre for Health Promotion (ACHP), School of Public Health, The University of Sydney to implement Phase One of the NSW *SmokeCheck* Project and to evaluate its effectiveness in building the capacity of AHWs and other health workers in NSW to deliver evidence-based brief smoking cessation interventions to all their Aboriginal clients who smoke.

4.1 Management of the *SmokeCheck* Project

4.1.1 The *SmokeCheck* team

The NSW *SmokeCheck* Project was developed and managed by a multidisciplinary team of Aboriginal and non-Aboriginal researchers, trainers and health promotion professionals from the Australian Centre for Health Promotion (ACHP) and Faculty of Medicine, The University of Sydney. A steering committee comprising representatives of the NSW Department of Health, the Cancer Institute NSW, the Aboriginal Health and Medical Research Council of NSW (AH&MRC), an Area Manager of Aboriginal Health, the Aboriginal Community Controlled sector and The University of Sydney provided guidance and support.

As well, the Project developed strong links with a range of tobacco and addiction specialists, health managers, team leaders, and health promotion experts through forums such as the NSW Tobacco Control Network (TobNet) and Aboriginal Health forums.

What is the NSW *SmokeCheck* Project?

5.1 Goal

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

5.2 Objectives

The Project objectives were to:

1. Build the capacity of Aboriginal health workers (AHWs) and other 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.

5.3 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.

Core components of the NSW *SmokeCheck* training program

The NSW *SmokeCheck* training program is designed to assist AHWs and other health professionals with a primary responsibility for the health care of Aboriginal people in NSW to build and strengthen their knowledge, skills and confidence in delivering brief smoking cessation advice and support to each of their Aboriginal clients who smoke.

In order to contribute effectively to reducing the prevalence of smoking in Aboriginal communities in NSW, it was first important that the NSW *SmokeCheck* training reach all, or at least as many as possible, of the AHWs and other relevant health professionals in NSW. It was also important that the training itself be relevant, comprehensible, accessible and satisfactory to participants. In addition to provide training to AHWs and other health professionals, the NSW *SmokeCheck* Project developed a training program for service managers and administrators. This was intended to assist in ensuring that workplace structures and processes would support the AHWs to deliver the brief smoking cessation advice and support to each of their clients who smoke. Finally, it was necessary to evaluate the NSW *SmokeCheck* training program to assess the extent to which participation in the training program resulted in positive changes in participants' knowledge, skills, and confidence in delivering the brief smoking cessation intervention and in using the appropriate resources in support. It was also important to assess whether participation in the training contributed to making participants' homes and workplaces smoke free.

6.1 A strategic management approach

The NSW *SmokeCheck* Project adopted a strategic management approach to ensure that the Project achieved its goals. It was determined that there needed to be careful, detailed planning to ensure that all AHWs and other relevant health professionals had ready access to the training workshops, and that all health services including those of the Aboriginal Community Controlled Health Services, Area Health Services, and non-government organisations were well informed about the Project, its goals and methods.

The first steps in the Project entailed consideration of the following issues:

- The geographical distribution of health services provided 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's 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.

The *Strategic Framework for Improving Aboriginal and Torres Strait Islander Health through Research* (National Health & Medical Research Council 2002, p.4) also played a critical role in the management of the Project by informing its involvement with Aboriginal communities, respect for culture, explicit and consultative communication style, and adherence to ethical guidelines.

6.2 Steps to implementation

Step 1 Identifying sites

The first step in establishing the framework of the *SmokeCheck* training program was to identify the location and number of Aboriginal Community Controlled Health Services and 'mainstream' health services offered through NSW Area Health Services:

- 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 (SESAHS)
- Sydney South West Area Health Service (SSWAHS)
- Sydney West Area Health Service (SWAHS)

A consultation process followed with key agency contacts. This resulted in the development of an inventory of services and contact people who could provide advice about the organisation and best location of the *SmokeCheck* training workshops. The consultation also identified a range of issues critical for the final design of the workshop program and implementation.

Step 2 Database development

The Project developed an electronic *SmokeCheck* contact database in order 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 to record the details of all training workshops participants. The data base has provided the Project with the ability 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

For the research purposes, the database has enabled:

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

Step 3 Determining the denominator: the number of AHW positions in New South Wales

Determining the denominator was necessary to ensure that the *SmokeCheck* training workshops were held in locations accessible to the majority of AHWs in that Area or region, which in turn helped to maximise AHWs access. In order to identify the denominator, the role of the AHWs was defined 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.'

Information on the number of AHW positions in NSW was obtained from the following sources:

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

Two counts were undertaken and an average of the counts provided the most reliable information. This resulted in a denominator count of an estimated 560.5 AHWs currently employed in NSW. This was the number of AHWs that the *SmokeCheck* Project invited to participate in its training program's workshops during the 13 month period in which the training was delivered.

Step 4 Delivering the SmokeCheck training workshops

The *SmokeCheck* training program was then planned taking into account participant numbers and travel logistics with arrangements typically resulting in a 6-hour training schedule broken into four sessions (see Table 1).

Table 1: Overview of *SmokeCheck* training program structure

Session	Time	Topics
Introduction	9.30-10.00	<ul style="list-style-type: none"> ■ Introduction ■ Completion of evaluation surveys ■ Ice breaker ■ History of tobacco use ■ Smoking prevalence
Session 1	10.00-10.45	<ul style="list-style-type: none"> ■ Impact of tobacco on Aboriginal Australians ■ Cigarettes content ■ Tobacco use in Australia
Session 2	11.00-12.30	<ul style="list-style-type: none"> ■ Social determinants of health ■ Nicotine dependence ■ Health effects ■ Environmental tobacco smoke
Session 3	1.00-2.15	<ul style="list-style-type: none"> ■ Health promotion ■ Stages of change ■ <i>SmokeCheck</i> resources ■ How to undertake a brief intervention ■ Motivational interviewing
Session 4	2.30-3.30	<ul style="list-style-type: none"> ■ Nicotine replacement therapy ■ Case studies/practice session ■ Conclusion/summary

Learning objectives

The training program was structured to achieve a range of learning objectives.

On completion of training, 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.

A workshop for managers, team leaders and program coordinators

Information presented in the two-hour manager's workshop focused on the *SmokeCheck* brief intervention and resources and included information about organisational change to support the integration of the intervention and resources into routine front line health services. 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.

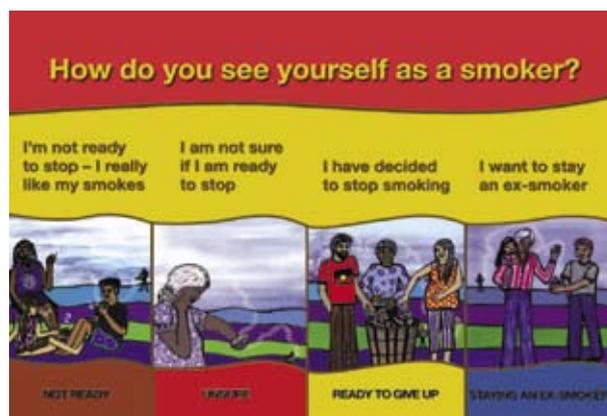
Table 2: Overview of *SmokeCheck* training program structure for managers

Session	Duration	Topics
Introduction	5 min	<ul style="list-style-type: none"> Introduction of workshop Managers pre survey
Session 1: <i>SmokeCheck</i> Overview	50 min	<ul style="list-style-type: none"> Context of tobacco in NSW Tobacco smoking amongst Aboriginal populations Brief interventions The evidence for <i>SmokeCheck</i> The <i>SmokeCheck</i> intervention
Session 2: Organisational change	50 min	<ul style="list-style-type: none"> Organisational change Barriers to organisational change Identifying strategies to support organisational change and the integration of <i>SmokeCheck</i> into routine service provision The role of managers in organisational change
Conclusion	5 min	<ul style="list-style-type: none"> Conclusion

6.3 *SmokeCheck* Project resources

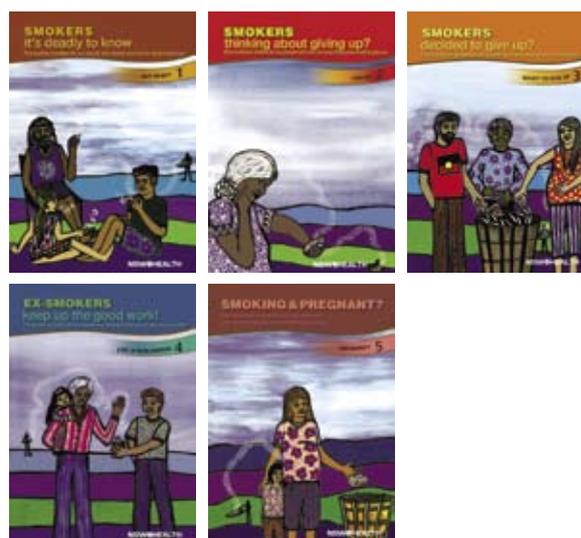
There are five NSW *SmokeCheck* Project resources that have been designed to guide and support health professionals to undertake an effective smoking cessation brief intervention with Aboriginal people. The resources are:

1. 5As practitioner smoking cessation desktop guidelines



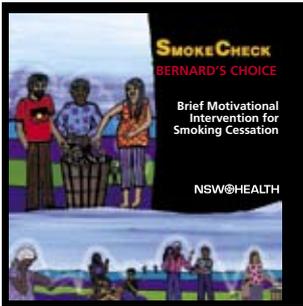
These comprise of the desktop practitioner guidelines and a set of five pamphlets for the use of clients. Together these resources are designed to support health professionals in initiating and undertaking a smoking cessation brief intervention one-on-one with clients. These resources are all informed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

2. Pamphlets



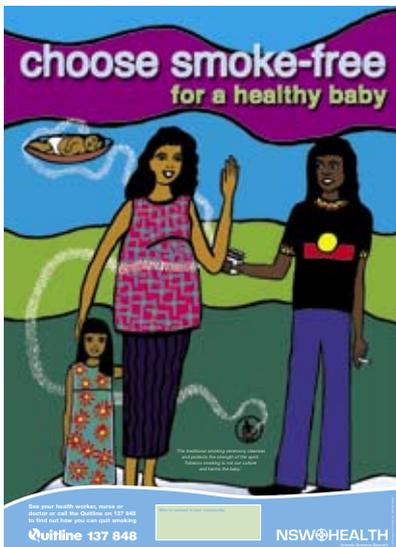
The pamphlets are a source of information for health professionals to use with clients during the intervention as well as a take home resource for clients to refer to. A fifth pamphlet has been added to the set focusing on smoking and pregnancy.

3. A DVD 'Bernard's Choice' demonstrating brief motivational interviewing



The twelve minute DVD which demonstrates the 5As approach to a smoking cessation brief intervention using motivational interviewing was developed by Queensland Health.

4. Poster



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

5. An electronic power-point *SmokeCheck* training presentation

The training presentation is also considered a resource and is distributed to those services who participate in the training for their discretionary 'in house' use.

Evaluation

The evaluation of the *SmokeCheck* training program was conducted in two stages. The first was process evaluation, the second was impact evaluation using a quasi-experimental design.

The process evaluation assessed the reach, quality, relevance and acceptability of the training to participants, using a semi-structured questionnaire that was completed at the end of each of the workshops.

The impact evaluation of the *SmokeCheck* training program assessed the effects of the training program on the capacity of the AHWs and other health professionals to implement the *SmokeCheck* brief intervention with Aboriginal clients. Although smoking prevalence among workshop participants was measured before and after participation in the training, this outcome was not the primary focus of the evaluation.

7.1 Process evaluation

The process evaluation included measurement of the number of people who registered to attend the workshops, the number of AHWs and other health professionals who attended, whether participants were Aboriginal or non-Aboriginal, and the title or nature of their current roles.

In addition, the following measures were used to determine the **acceptability and effectiveness** of the *SmokeCheck* training program:

- The extent to which health professionals and managers from all services and regions participated in the training
- Factors that hindered or facilitated the delivery of the workshops
- Feedback on participants' routine use of smoking cessation brief interventions.

Survey instruments

Immediately following the workshop, participants were asked to complete a semi-structured questionnaire asking for comments about the relevance and applicability of workshop information to practice, about the relevance and applicability of the *SmokeCheck* resources, and about their satisfaction with the workshops.

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

7.2 Impact evaluation

A quasi-experimental waiting-list control design was used to evaluate the impact of the program.

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.

Survey instruments

Pre and post surveys were used to measure changes in these indicators and were administered to training workshop participants and to managers.

Design

For ethical reasons it was imperative that all services in NSW Area Health Service were offered training in the *SmokeCheck* brief intervention within the Project's two year time frame. The quasi-experimental design of the evaluation permitted 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.

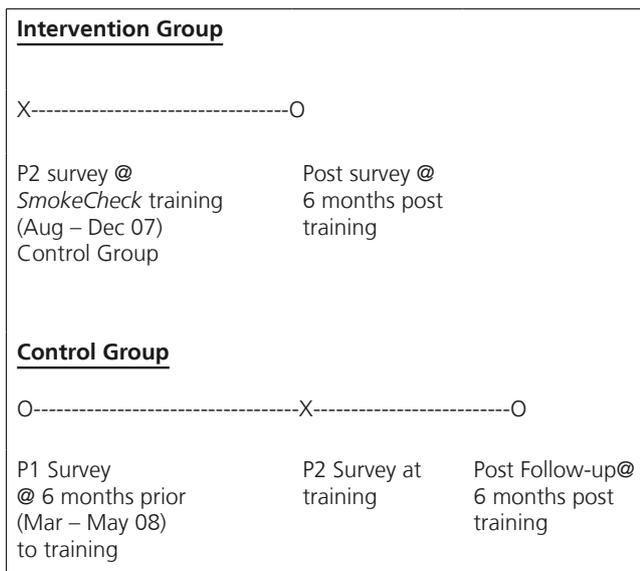
The **intervention group** participants completed two surveys, the first (P2) at baseline (at the commencement of the *SmokeCheck* training workshop), and the second, 'post' survey, approximately six months after the workshop. The waiting list **control group** completed three surveys, the first 'P1' survey at baseline which was 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 3 Survey Distribution).

Table 3: *SmokeCheck* survey distribution

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

Figure 1 below illustrates the *SmokeCheck* training program research design.

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



Data administration and analysis

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 testing.

What did the NSW *SmokeCheck* training program achieve?

Section summary

Process evaluation result:

- Sixty three *SmokeCheck* training workshops including 46 health professional and 17 manager workshops were conducted in all NSW Area Health Services at 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 (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.

Discussion of findings

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 Aboriginal health workers (AHWs). The Project therefore 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 program 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.

9.1 Elements of success for the *SmokeCheck* training program

Many elements have contributed to the success of the *SmokeCheck* training program 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.

The long lead times, planning phase and pilot testing, resulted in a training program that delivered 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 database.

- A strong partnership approach.

The Project had a strong partnership component. This assisted the organisation and delivery of workshops and the administration of the evaluation research. Partnerships included the Project's Steering Committee and existing networks with similar responsibility for promoting Aboriginal health and reducing smoking prevalence. As well, the NSW Tobacco Control Network, the Aboriginal Chronic Care Program, and the NSW Health Telehealth smoking cessation training sessions contributed to the identification of key 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 committed and skilled 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 relevant experience, skills, and determination.

- Quality resources.

Sufficient funding permitted the Project to reach its intended audiences with the requisite intensity to achieve its 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. It also 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 necessary to ensure that the Project's goals were achieved. The combination of sufficient money and time contributed to the capacity of the Project to maintain a level of flexibility and to meet the training needs of individual services.

- Ongoing quality assurance mechanisms.

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.

- 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. The two-hour manager's workshop consolidated organisational understanding of the *SmokeCheck* intervention, and it proposed organisational change strategies to facilitate the integration and systemisation of *SmokeCheck* into routine service provision.

9.2 Were the objectives met?

The evaluation found that health professionals' confidence, knowledge and skills, improved significantly. Importantly, the evaluation design enabled an assessment to be made as to whether the changes detected were the result of participation in the *SmokeCheck* training program alone rather than the result of other possible influence.

- Improvements in health professionals' confidence.

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.

As well, there was a decrease in the number of participants who used no particular method to advice and who did not help clients to quit smoking.

- Improvements in professionals' knowledge and skills.

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.

- No change in 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).

- Increases in AHWs reporting that after participating in the *SmokeCheck* training program, their homes became smoke free.

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.

- There were clear differences between the tobacco control work of AHWs and other health professionals.

Aboriginal respondents who completed a pre survey but didn't subsequently attend a *SmokeCheck* training workshop 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 the respondents who attended training and completed P2 surveys tended to be non-Aboriginal, work less often 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.

9.3 What does all this mean?

- The confidence and ability to deliver the brief smoking cessation intervention increased significantly among health professionals who attended the training program.

The fact that there was no change in the knowledge, skills and confidence of AHWs and other health professionals who had not been exposed to the training is a significant finding. The Project has been able to demonstrate significant impact in relation to confidence to deliver smoking cessation advice. This is particularly important as it is difficult 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.

- Improved access to a skilled and confident health professional for Aboriginal clients seeking to quit smoking.

It is reasonable to predict, therefore, that health professionals will be better placed to facilitate an increase in 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.

- Identifiable differences emerged between Aboriginal and non-Aboriginal health professionals engaging in the *SmokeCheck* training program.

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.

The way forward

10.1 Aboriginal health workers: the key to success

Aboriginal health workers (AHWs) are an essential group to the success of all initiatives to promote the health of their communities. For tobacco control initiatives such as the *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).

10.2 A statewide coordinated approach

To reduce the prevalence of smoking in Aboriginal communities, evidence suggests that the work of 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. Further initiatives need to be developed that seek 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.

10.3 Organisational development

A focused organisational development approach is important for providing support to health service managers so they can make changes in service objectives, staff roles, monitoring systems and equipment, and reporting/accountability mechanisms.

10.4 Integrate smoking cessation into routine service delivery to clients

Such 'top down' support, combined with intensive, service-specific work with individual health services and their staff, could 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.

10.5 Conclusion

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

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 to improving the health of Aboriginal people.

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