

The tobacco control guide

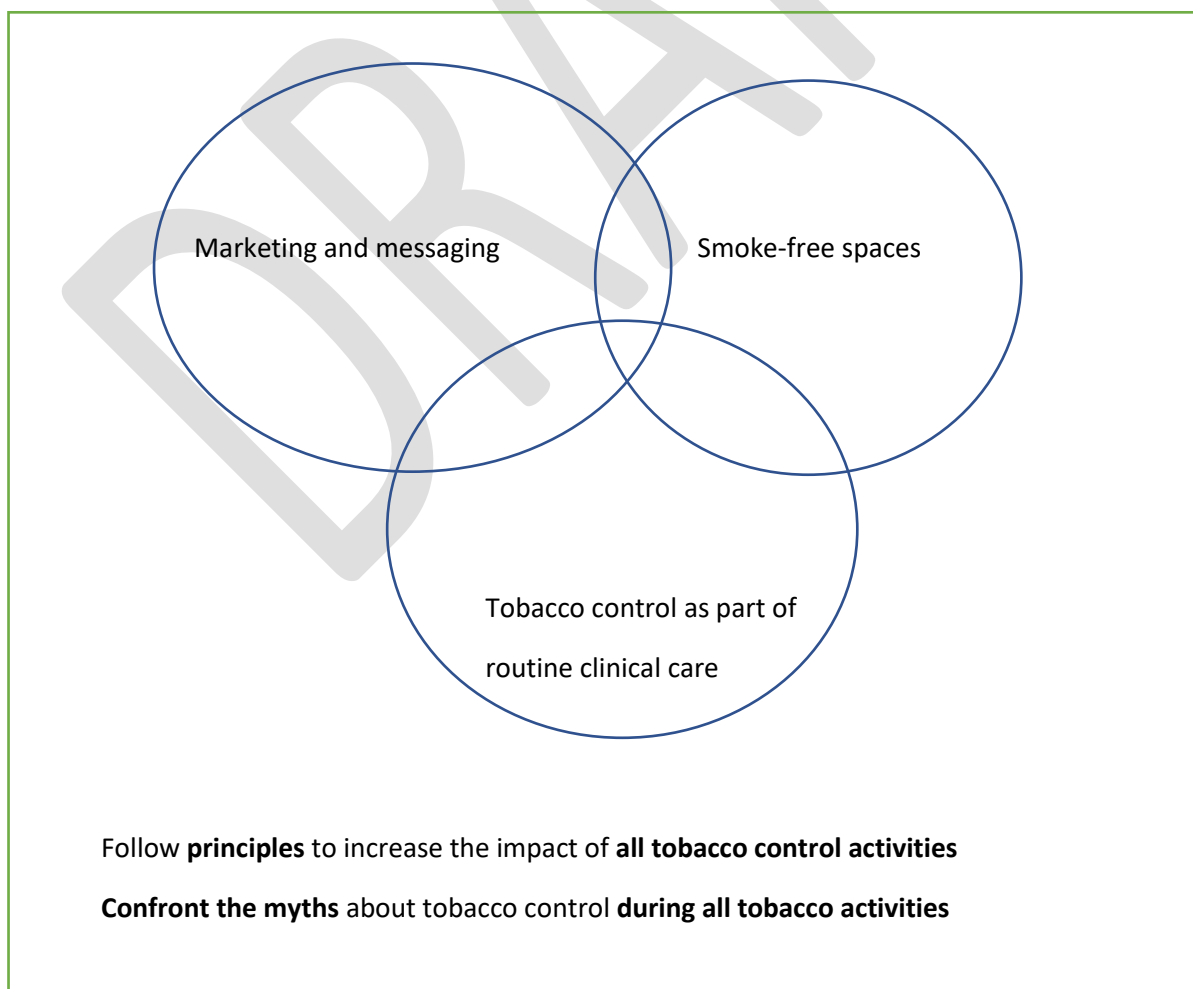
Informing continuous quality improvement (CQI) towards a system-wide comprehensive approach to tobacco control in NT health services

The tobacco control guide is based on research evidence and consultations with health providers in NT. It will assist NT health services to make achievable improvements in tobacco control and smoking prevalence. Improved tobacco control will reduce Aboriginal adult smoking from 63% in the remote Northern Territory and reduce the harm smoking causes to communities and families.

Health staff at all NT health services already participate in CQI to improve the services they provide. The plan-do-study-act (PDSA) cycles are based on principles of structured information sharing and planning in health teams. All elements of the PDSA cycle are essential, and staff are encouraged to work together to identify a small number of activities from the tobacco control guide, based on local priorities and capacity, and work through the PDSA cycle at regular team meetings, rather than taking on too many activities at a single meeting and not following up progress regularly.

The tobacco control guide describes the three key areas of tobacco control activities all NT health services should consider first. After these activities and policies are well-established, health services can then consider other activities. All tobacco control activities should follow seven key principles and confront four myths.

Figure 1. Key elements of the tobacco control guide



Principles to increase the impact of all tobacco control activities

1. Local Aboriginal involvement in activities
2. Engage with local health service leadership (board, executive, clinic managers) for clear messages of support for tobacco control activities
3. Provide tobacco control training and capacity building for staff
4. Make sure activities reach as many people as possible
5. Make sure activities are at sufficient intensity to support behaviour change
6. Focus on the activities below, before considering other activities
7. Use CQI processes to monitor, reflect and improve tobacco control activities

Confront the myths about tobacco control during all tobacco activities

1. Not true: 'Nothing is working', 'no one has quit'.
2. Not true: 'Smoking is a low priority compared to other health issues and diseases'.
3. Not true: 'Smoking helps with managing stress'.
4. Not true: 'Asking about smoking is not culturally appropriate', 'asking about smoking undermines the clinical relationship'.

When confronting myths, always start with the true stories and facts and only then explain why the myth is incorrect.

1. True: 'We are seeing real improvements in smoking, e.g. fewer kids taking it up', identify local champions who have successfully quit.
2. True: '23% of the health gap is just due to smoking'
3. True: 'Mental health and well-being improves after successfully quitting'.
4. True: 'Smokers expect clinicians to talk about quitting smoking'.

The three most effective areas of tobacco control activities for all NT health services

1. Marketing and messaging

- a. How can we best spread these messages?
 - i. Using local Aboriginal people to have these discussions and to share these messages, e.g. tobacco action workers, AOD workers, local champions who have successfully quit
 - ii. Talking with groups of community members, households
 - iii. Use props/resources when talking with community members (e.g. carbon monoxide monitors, such as the Smokerlyser)
 - iv. Posters
 - v. Social media
 - vi. Community events
 - vii. Make sure that with a combination of media and approaches you reach as many people as possible with enough intensity to change behaviour.
- b. What messages should we include in this marketing?
 - i. Messages created by and featuring local Aboriginal people, information, and images where possible, but also messages featuring other Aboriginal people
 - ii. Non-Aboriginal messages, especially messages selected as locally relevant by local Aboriginal people

- iii. Clear, unambiguous messages with new information, but also reinforce established messages (avoid humorous messages as they are often ambiguous and don't work)
 - iv. Strengths-based messages that emphasise that quitting is achievable as well as confronting messages about the harms caused by smoking
 - v. Messages about cost and protecting the health of others (e.g. from second-hand smoke) as well as messages about the harms caused by smoking
 - vi. Messages that confront the myths above.
 - vii. All messages refer people to the clinic for individual cessation support
2. **Smoke-free spaces** to protect others from second-hand smoke
- a. Where?
 - i. Health service
 - ii. School
 - iii. Store
 - iv. Community events
 - v. Ovals, courts and sporting facilities
 - vi. Other local organisations and meeting places
 - vii. Homes
 - viii. Cars
 - b. How?
 - i. Help organisations and families establish smoke-free rules or policies
 - ii. Keep helping organisations and families maintain or improve smoke-free rules or policies
 - iii. Provide marketing and materials (e.g signs) to support smoke-free rules or policies
 - iv. Employ local Aboriginal people to talk with local organisations and families
3. **Tobacco control as part of routine clinical care**
- a. Provide consistent individual cessation support for smokers
 - i. Ask and provide brief advice to quit to all smokers at every clinical consultation, not just at health checks or for presentations most obviously linked to smoking or when raised by patient
 - ii. Ensure medicines to assist cessation (at minimum: varenicline, NRT patches and gum) are available and offered
 - iii. Ensure all clinical staff understand clear pathways for follow-up or referral to support smokers to sustain quit attempts
 - b. Provide consistent individual cessation support for all pregnant women
 - c. Protect children from second-hand smoke
 - i. Advise parents and carers to quit and to establish a smoke-free home and car.
 - ii. Advise smokers to protect children from their second-hand smoke
 - d. Training
 - i. Ensure all clinical staff are trained to provide brief advice (e.g. by Cancer Council South Australia's Quitskills program).