3. National action to reduce Indigenous smoking rates (Measure A1) and helping Indigenous people reduce their risk of chronic disease (Measure A2)

3.1. Description of measures

The aims of the A1 and A2 measures are to reduce smoking rates and improve healthy lifestyle behaviours by increasing the awareness of preventable chronic disease risk factors and healthy lifestyle choices among Aboriginal and Torres Strait Islander people. A further aim is to increase the capacity of participating Health Services to support Aboriginal and Torres Strait Islander people to reduce their risk of chronic disease. Measures A1 and A2 have had a significant workforce implementation and training component. They are addressed together in this report as the workforce was deployed in teams and the measures have similar program logics.

The intention of measure A1 was to expand and up-skill a non-clinical tobacco control workforce – Regional Tobacco Coordinators (RTC) and Tobacco Action Workers (TAW), and, to a lesser extent, existing Health Service staff – capable of designing and delivering tobacco control programs based on best available evidence. It was expected that, with these initiatives in place, Aboriginal and Torres Strait Islander people exposed to tobacco cessation activities would have a greater awareness and improved understanding of the services available to them and seek assistance from these services in their attempts to quit smoking.

Similar to measure A1, measure A2 focuses on expanding and up-skilling a non-clinical workforce that will work to improve healthy lifestyle choices for individuals, families and communities. In addition to the design and delivery of community-based activities, the Healthy Lifestyle Workers (HLW) were to refer to Health Services both people at risk of developing chronic disease as well as those with an established chronic disease. It was expected that by participating in A2 activities, Aboriginal and Torres Strait Islander people would have an improved understanding of the risk and implications around chronic disease, and that Health Services would then be able to offer them more support.

The expected outputs and results of this measure are outlined in the National Framework program logic (Appendix A). An analysis of the key findings of the SSE are described in relation to these outputs and results and are presented in Table 3.5.

The key elements of these two measures included:

- **Funding to establish a national network of teams, consisting of Regional Tobacco Coordinators, Tobacco Action Workers and Healthy Lifestyle Workers.** Teams could be hosted in any organisation, including AHSs, DGPs, State Government or non-government organisations. Regardless of where the teams were based, it was intended that services provided by the teams would be accessible to all Health Services within the geographical region. A condition of funding

included the development and implementation of a workplace smoke-free policy within 12 months.\textsuperscript{15,16}

- **A funding program to support training and programs of learning and development for the new workforce.** The intention was to build the Aboriginal and Torres Strait Islander health workforce in the medium to longer term along with providing individuals with marketable qualifications and skill sets. Host organisations were responsible for developing tailored training programs together with individual workers, and identifying relevant accredited training courses. Funding to undertake the training courses is included in the annual funding provided to each host organisation.

- **Additional training in brief interventions for around 1000 existing workers,** such as nurses and AHWs.\textsuperscript{17}

- **Funding and resources to support and to undertake community development activities.** Host organisations could apply for up to $110 000 per annum. All organisations with funding allocation for these measures were provided with a range of toolkits and resources. The contents included training and reference materials, such as ‘Talkin’ Up Good Air’ developed by the Centre for Excellence in Indigenous Tobacco Control (CEITC), the ‘Healthy Deadly Strong’ toolkit developed by the Australian Indigenous HealthInfoNet at Edith Cowan University, and the Community Health Action Pack developed by DoHA for the *Live Longer!* campaign.\textsuperscript{16,19,20}

- **Additional resources were made available** including: A plain language guide to Nicotine Replacement Therapy (NRT) ‘Medicines to help Aboriginal and Torres Strait Islander people to stop smoking: a guide for Health Workers’ and an accompanying consumer booklet, ‘Medicines to help you stop smoking’. The guide covered best practice use of all forms of NRT.\textsuperscript{21}

- **Enhancements to Quitline** smoking cessation services to make them more accessible and appropriate for Aboriginal and Torres Strait Islander Australians.\textsuperscript{22}

- **Funding was provided to NACCHO to facilitate effective workplace smoking policies.** This project aimed to assist all Aboriginal Community Controlled organisations become smoke-free workplaces. A new Smoke Free Support Officer position within NACCHO was created. The funding agreement commenced August 2011 and is due to end on 30 June 2014.\textsuperscript{23}

\textsuperscript{15} DoHA, National Action to Reduce Indigenous Smoking Rates, and Helping Indigenous People Reduce their Risk of Chronic Disease, measure update, 12 August 2011.
\textsuperscript{16} DoHA, National Action to Reduce Indigenous Smoking Rates, and Helping Indigenous People Reduce their Risk of Chronic Disease, measure update, 13 July 2010.
\textsuperscript{17} DoHA, National Action to Reduce Indigenous Smoking Rates, Fact Sheet, op cit.
\textsuperscript{19} Centre for Excellence In Indigenous Tobacco Control (CEITC) (accessed 15 December 2012).
\textsuperscript{20} The Hon. Warren Snowdon, MP, New health promotion resource to help close the gap [media release] (accessed 15 December 2012).
\textsuperscript{22} DoHA, National Action to Reduce Indigenous Smoking Rates, Fact Sheet, op cit.
\textsuperscript{23} NACCHO (accessed 21 November 2012).
3.2. State of implementation – national context

The main achievements of measures A1 and A2 at the time of the final evaluation cycle, at a national level and of relevance to the SSE, are summarised below. This information has been extracted from information supplied by DoHA over the course of the evaluation period. The national level achievements are described in relation to the core components of the measures.

3.2.1. A national network of Regional Tackling Smoking and Healthy Lifestyle teams

DoHA representatives consulted with the National Tobacco Control Technical Reference Group and the Indigenous Health Partnership Forums in each State and Territory to determine the regions for workforce implementation, and other aspects of the program such as the approach to brief interventions.

In March 2010, Dr Tom Calma was appointed as the National Coordinator - Tackling Indigenous Smoking.24

In November 2010 DoHA reported a redesign of these measures resulting in the deployment of teams to create a more concentrated effort in each region (herein referred to as ‘Regional Tackling Smoking and Healthy Lifestyle teams’). This refinement meant the first stage of workforce roll-out was slower than initially expected.

The majority of funding agreements nationally for Regional Tackling Smoking and Healthy Lifestyle activities (including variations to OATSIH funding agreements) were executed by February 2011. Nationally, most organisations funded for these teams were AHSs.

The workforce of RTC, TAW and HLWs was funded in a staged roll-out over 57 regions plus the ACT (21 regions plus ACT in 2010–2011, a further 19 funded in 2011–2012 and 17 in 2012–2013).

3.2.2. Training and programs of Learning and Development

Generally, two types of training, or support for training, were made available: workforce induction and orientation workshops; and a program of learning and development tailored for individual workers (to facilitate access to more formalised training leading to qualifications, particularly Certificates III or IV, and in recognition of experience and skills).

Three induction and orientation workshops have been held: to provide orientation, to showcase available resources and programs, and to build networks across the new workforce. Induction training had two streams: ‘Talkin’ Up Good Air’ and Smoke Check brief intervention training; and Living Stronger Training.25 A ‘Welcome Workshop’ for Regional Tackling Smoking and Healthy Lifestyle teams was held in Canberra in December 2010, and a second information-sharing workshop in December 2011. The workshop also included organisations about to receive funding for workers and other stakeholders, such as some of the NACCHO affiliates and Quitline workers. DoHA reported a high attendance at these workshops.

Additionally, Regional Tackling Smoking and Healthy Lifestyle teams were invited to participate in the Live Longer Conference held in October 2012, along with successful Round 1 and Round 2 Local Community Campaign grant recipients (see Chapter 4).

Organisations employing Regional Tackling Smoking and Healthy Lifestyle teams had been funded to support those workers through Vocational Education and Training courses. Each worker had to develop a training plan. Job descriptions identified minimum entry and achievement levels: TAW aiming for Certificate II (initially as entry level), III or higher, and RTCs working towards Certificate IV at minimum. Training plans were to reflect these goals if required.\(^\text{26}\)

DoHA reported that some training for the RTCs and TAWs was to be provided by the Centre for Excellence in Indigenous Tobacco Control (CEITC). This training was to draw on CEITC’s resource ‘Talkin’ Up Good Air’ as well as specific modules developed about how to be a Regional Tackling Smoking and Healthy Lifestyle worker. As of July 2012, six training events had occurred (Cairns, Freemantle, Darwin, Nhulunbuy and two in Victoria) and CEITC was to undertake more activity after this date. On 27 September 2012 a NACCHO e-communique announced CEITC was inviting AHSs throughout Australia to register their interest in hosting or participating in the two-day training workshop for TAWs or HLWs in tobacco control. CEITC reported that workshops were scheduled for the last few months of 2012 in Launceston, Darwin, Alice Springs, Broome and Brisbane. These two-day workshops replaced the ‘Talkin’ Up Good Air’ one-day workshop and propose to be more comprehensive by focusing on Aboriginal and Torres Strait Islander-specific smoking cessation, community development, work plan and project development, event planning, evaluation and smoke-free workplace policy development.\(^\text{27,28}\)

In July 2012 DoHA reported that QUIT SA had been funded to provide the Quitskills training across Australia. Quitskills is a nationally accredited program on smoking cessation based on three units of competency from a Certificate IV in Population Health (assess readiness for and effect behaviour change; provide information on smoking and smoking cessation; provide interventions to clients who are nicotine dependent). This training has been specifically tailored for AHWs and other people working in Aboriginal and Torres Strait Islander organisations. DoHA states that this may be a good way for TAWs to address their vocational education training needs, and as of July 2012 training had occurred in Port Augusta/Whyalla.\(^\text{29}\)

Smoking cessation training, including brief intervention, has been provided to other health and community workers, with the aim of reaching 1000 trainees over the period of implementation. In 2010–2011 DoHA reported that more than 200 workers were trained nationally, and that funding had been provided to Quit Victoria to deliver brief intervention training in Victoria and NT. These involved group sessions with workers from across the country. In July 2012 this activity was reported as completed.\(^\text{30}\)

The Flinders Human Behaviour and Health Research Unit was funded in 2012/2013 for the Flinders Closing the Gap program to be expanded to include the Flinders Tobacco Cessation Training Module. This module was to be integrated into the Chronic Disease Self-management support training funded through Measure B4, Helping Indigenous People Self-Manage their Risk of Chronic Disease (see Chapter

\(^{26}\) Ibid.

\(^{27}\) NACCHO Media, Training workshop opportunity for Aboriginal Tobacco Action Workers throughout Australia, 27 September 2012 [NACCHO Communique].

\(^{28}\) Centre for Excellence in Indigenous Tobacco Control (CEITC) - Training (accessed 10 October 2012).

\(^{29}\) QUIT SA - Training (accessed 9 October 2012).

9). It is also available as stand-alone training for people who have already completed the Flinders Closing the Gap program and is available to the Regional Tackling Smoking and Healthy Lifestyle workforce.31

3.2.3. Resources and funding to support implementation

ICDP developmental research was completed in October 2010. This informed the development and implementation of the ‘Break the Chain’ advertising campaign launched in March 2011. This campaign included Australia’s first national Aboriginal and Torres Strait Islander focused anti-smoking advertising using national media (television, radio and print). It was run at the same time as the National Tobacco Campaign, the Australian Government tobacco control social marketing activity.32

Regional Tackling Smoking and Healthy Lifestyle teams had access to funding for local community development programs or resources. In 2010–2011, DoHA reported that 13 organisations were provided with regional campaign grants and sponsorship to deliver social marketing activities through their Regional Tackling Smoking and Healthy Lifestyle teams. These included the ‘Deadly Choices’ program in south-east Queensland and the Djurali program in Campbelltown.33

On 30 June 2010 DoHA reported that Edith Cowan University (HealthInfoNet) had been contracted to develop the ‘Healthy, Deadly and Strong’ resource packs, which were expected to be produced in early March 2011.

The ‘Healthy Deadly Strong’ toolkit was launched in December 2011 and distributed to all teams. It contained fact sheets on available resources, how to access them and appropriate use. Topics covered include nutrition, physical activity, alcohol, smoking, diabetes, and kidney and heart health.34

On 13 September 2012, the Australian Indigenous HealthInfoNet announced the launch of an online portal to support HLWs that would complement its existing resources, in particular its ‘Healthy, Deadly and Strong’ toolkit and guide. Features of the portal are downloadable copies of the toolkit and guide and key facts and resources relating to lifestyle factors and preventable chronic diseases. There is portal access through the HealthInfoNet website, plus links to the Closing the Gap Tackling Chronic Diseases and DoHA websites.35

Other resources for the Regional Tackling Smoking and Healthy Lifestyle teams included the Community Health Action Pack (CHAP), distributed to each team in December 2011, and the plain language guide to NRT. The CHAP booklets were also made available for download from the Live Longer! website, a resource we discuss in Chapter 4. More copies of the CHAP booklet were to be distributed to Regional Tackling Smoking and Healthy Lifestyle teams and the second round of Local Community Campaigns grant recipients sometime after July 2012.

With the widespread awareness and use of NRT, and the need to ensure good quality information and education for AHWs, the Tobacco Technical Reference Group recommended the development of a plain language guide to nicotine replacement therapy. The handbook Medicines to help Aboriginal and Torres Strait Islander people stop smoking: a guide for Health Workers and an accompanying consumer

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33 Ibid.
34 HealthInfoNet News, New online resource for Australia’s Indigenous Healthy Lifestyle Workers (accessed 8 October 2012).
35 Ibid.
booklet, *Medicines to help you stop smoking*, were launched in late 2011 as a free resource. The guide covers best-practice use of all forms of NRT with an emphasis on the nicotine patch listed on the PBS for Aboriginal and Torres Strait Islander people, which can be obtained free under the Closing the Gap scheme. DoHA reports that the entire first print-run of 5000 copies was distributed within a few weeks and reordering was available.

Organisations with Regional Tackling Smoking and Healthy Lifestyle workforce allocation were to be provided with a starting pack for the workforce containing training materials and references. The starting pack, designed for the funded organisation to build upon, was determined by a reference group and was to include materials such as ‘Talkin’ Up Good Air’ and the ‘Healthy, Deadly and Strong’ toolkit.

Healthy Community Days had initially been rolled out as part of the Local Community Campaigns program (see Chapter 4). In August 2011, DoHA reported that the Regional Tackling Smoking and Healthy Lifestyle teams were being encouraged to apply for funding to run Healthy Community Days. In July 2012, DoHA reported that it had become a part of new funding agreements to have Healthy Community Days on World No Tobacco Day.

### 3.2.4. Quitline enhancement

In the period 2009–2010, funding was provided for the enhancement of Quitlines in all States and Territories except Tasmania and the Northern Territory. In 2010–2011, DoHA reported that funding was in place for enhancement of Quitlines servicing all States and Territories.

Data obtained from the progress reports to DoHA available for this evaluation report (most as at 31 May 2012, one as at 29 February and one at 30 April 2012) show that services were at differing stages of enhancement. Changes to the Quitline services included the following:

- employment of Aboriginal Enhancement Officers/Liaison Officers and Aboriginal and Torres Strait Islander counselling staff
- the up-skilling of existing Quitline counsellors’ cultural competencies and understanding of specific target groups
- the commencement of a routine collection of Aboriginal and Torres Strait Islander status of Quitline callers
- consultation and development of culturally safe resource and support/referral processes
- Quitline enhancement representatives visiting AHSs to raise awareness and up-skill health professionals in the use of, and referral to, the enhanced Quitline
- providing tours of Quitline centres for AHWs as a way of up-skilling and familiarising them with the processes
- developing Quitline referral partnerships with Health Services in specifically identified areas of high Aboriginal and Torres Strait Islander populations, such as the NT remote service ‘100 Quit Club’
- marketing of the new orientation of the service.

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36 The Hon. Warren Snowdon MP [media release] - Regional Teams Tacking Aboriginal and Torres Strait Islander Smoking and Chronic Disease (accessed 21 November 2012).
DoHA reports that the Quitline services were also being encouraged to work with the Regional Tackling Smoking and Healthy Lifestyle teams. One service reported that it had developed a list of all AHSs and RTCs and TAWs in the State and added them to the referral list.

3.2.5. NACCHO Smoke Free Project

The NACCHO Smoke Free Project reported good progress from 30 June 2011 – 1 July 2012 including:

- Smoke Free Project Officer commenced in November 2011
- NACCHO Tackling Smoking Advisory Committee was created, made up of representatives from NACCHO affiliates, Quitline Victoria and CEITC, and as of July 2012 had met twice
- NACCHO’s smoke-free workplace policy was launched on 31 May 2012
- NACCHO board intensive tobacco leadership program was being developed with the first workshop planned for 2–5 September 2012. They are hosted throughout Australia for all member services – CEOs and Board members to June 2014
- NACCHO emailed a survey to all member services to identify the number of services that had implemented smoke-free workplace policies
- the priority for 2012–2013 was the Intensive Tobacco Leadership workshops, which support AHSs to develop and implement effective smoke-free workplace policies and assist with culturally secure social media campaigns.
3.3. Findings from Sentinel Sites

3.3.1. Progress with recruitment and position adaptations

**KEY POINTS**

- Expansion of the tobacco and healthy lifestyle workforce has generally progressed well.
- By the final evaluation cycle, Regional Tackling Smoking and Healthy Lifestyle teams had been established across the majority of Sentinel Sites.
- Some local adaptations were made to the measure design to facilitate recruitment to positions.

Overall, data from the Sentinel Sites indicated that recruitment to Regional Tackling Smoking and Healthy Lifestyle teams was largely on track across urban, regional and remote sites, with 20 of the 24 sites having coverage by these teams in the final evaluation period. Sixty-four per cent of those positions overall were filled, down from 74% in the preceding evaluation cycle, but this generally reflected an expansion in new positions not yet filled. The lack of appropriately skilled applicants and high turnover of staff continued to be issues of concern across several sites in all locations.

**Allocation of Regional Tackling Smoking and Healthy Lifestyle teams**

Over the period of the evaluation the Sentinel Sites had an increase in the number of sites in which funding for Regional Tackling Smoking and Healthy lifestyle teams have been invested (from around 60% to up to 83% sites represented). In the final evaluation period there were four remote sites, nine regional and seven urban sites where funding had been allocated (noting that three of the urban sites were in an area covered by the same organisation and team). The majority of positions were allocated to AHSs in Sentinel Sites, as was intended in the design of the measures. Only one regional site had a team allocated to a State government health service.

The funding approach had been to allocate a complement of four staff to a Regional Tackling Smoking and Healthy Lifestyle team: one RTC, one TAW and two HLWs (with the exception of one urban site: one TAW, one HLW). Over the evaluation period, consistent with the intended staggered implementation, there has been further investment of TAW positions to the teams; one additional TAW in the 2011–2012 year and then again in the 2012–2013 year. This resulted in 15 of the Sentinel Sites being covered by a team with three TAWs allocated by the final evaluation period (includes the three urban sites covered by the same team in the total of 15).

Recruitment was similar for urban and regional sites in the latter three evaluation cycles, with most teams complete, or close to complete by the final evaluation cycle. At the final evaluation cycle, six of the seven urban sites had nearly full recruitment (three sites were covered by one team) and the remaining site had a half filled team (with some staff turnover in existing positions and some new positions under recruitment). Of the nine regional sites that had been allocated positions, six had near full recruitment, two were new teams undertaking recruitment and one team had low recruitment across all evaluation periods. The four remote sites had two nearly full teams, and two low to half-filled teams. Difficulty with recruitment was the main constraint in establishing teams for these two sites.

**Recruitment progress**

Table 3.1 presents the state of allocation and recruitment to positions. The dates of DoHA-reported data do not align well with the evaluation cycles, and information from DoHA reports have been
supplemented with information obtained at the time of the site visits, as described in table notes and Appendix C.

These positions generally have responsibility for geographic regions larger than the areas encapsulated by specific Sentinel Sites. In three urban sites one organisation was funded for the team that covered a large region, including the three sites. It should be noted that the positions for these three urban sites are only counted once in this table. In the final evaluation period, the organisation had been funded for a second team. This allowed the organisation to expand the number of positions, with one large team operating across the region. Not all workers referred to in this table were operating in the Sentinel Sites. At least two remote and one regional site had team members allocated to different organisations, some outside the sites.

Table 3.1: Regional Tackling Smoking and Healthy Lifestyle team allocation and recruitment in Sentinel Sites, March 2011 – October 2012

<table>
<thead>
<tr>
<th>Team allocation and recruitment</th>
<th>Evaluation cycle 2</th>
<th>Evaluation cycle 3</th>
<th>Evaluation cycle 4</th>
<th>Evaluation cycle 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall % positions filled</td>
<td>55% (23/42)</td>
<td>69% (40/58)</td>
<td>74% (55/74)</td>
<td>64% (67/105)</td>
</tr>
<tr>
<td>Overall % RTC position uptake</td>
<td>50% (5/10)</td>
<td>86% (12/14)</td>
<td>80% (12/15)</td>
<td>83% (15/18)</td>
</tr>
<tr>
<td>Overall % TAW position uptake</td>
<td>55% (6/11)</td>
<td>60% (9/15)</td>
<td>68% (19/28)</td>
<td>50% (25/50)</td>
</tr>
<tr>
<td>Overall % HLW position uptake</td>
<td>57% (12/21)</td>
<td>66% (19/29)</td>
<td>77% (24/31)</td>
<td>73% (27/37)</td>
</tr>
</tbody>
</table>

*The first evaluation cycle is not included as only stage 1 sites had been engaged (n=8) and no recruitment data had been available. In the second evaluation cycle there were 18 sites with signed participation agreements. From the third evaluation cycle onwards all sites had been established (n=24).

*In evaluation cycles 3, 4 and 5 three urban sites were covered by the one Regional Tackling Smoking and Healthy Lifestyle team. The team has been counted once for the three sites. In evaluation cycle 3 it was a single team of 4 positions, by evaluation cycle 4 it was a team of five recruited staff and the final team had expanded to two teams working together as a team of 10 recruited positions. Varying numbers of the team members provide services across the region depending on the program needs.

Notes: The data are presented as 1.0 position equals 1.0 FTE or less (e.g., 1.5 FTE recruited is recorded as two positions filled). The intention is to show the investment in a site as positions allocated and recruited, not actual numbers of people employed (as there can be more than one person per FTE).

All DoHA sources have been updated to reflect site visit findings, up to four months after DoHA data source.


Regional Tobacco Coordinator positions

The overall recruitment status of RTCs to Sentinel Sites over the last three evaluation cycles has been relatively stable with an average of 83% RTC positions filled. Only three RTC positions were vacant at the time of the final evaluation, one of which was a new allocation.
**Tobacco Action Worker positions**

The trend in overall TAW positions shows there has been an increase in the number of positions in existing teams over the last three evaluation cycles, plus new teams established in three sites. Between the third and final evaluation periods there had been 35 TAW positions allocated in Sentinel Sites. In the final evaluation cycle, of the vacancies for all positions (n=38) in the Regional Tackling Smoking and Healthy Lifestyle teams, the majority (25/38) were TAWs. Sixteen of the vacant TAW positions were new allocations for the 2012–2013 year and not yet filled, one was previously filled but vacant in the final evaluation period and eight had not been filled over the evaluation (two in one site that had been allocated in 2010).

The relatively lower recruitment for these positions, averaging 59% over the last 3 periods, is partly due to newly allocated positions that had not yet been filled.

**Healthy Lifestyle Worker positions**

Over the last three evaluation periods, on average, 72% of HLW positions were filled. Of the 37 HLW positions allocated, 10 positions were vacant in the final evaluation cycle with four of those newly allocated. Despite recruitment attempts, four positions in two sites had never been filled and have remained vacant since being allocated in 2010. The majority of other sites had full recruitment of HLW positions across the evaluation period.

**Local adaptations to positions to overcome recruitment challenges**

Despite considerable progress in recruitment, some specific challenges were noted. The most commonly reported reason for delays or difficulty in recruiting was the time taken for funding for the positions to be available to the employing organisations, the small pool of suitably skilled people to draw on and the availability of people with interest and skills in delivery of tobacco control programs.

To overcome some of these recruitment barriers and to better suit local contexts, host organisations in a number of Sentinel Sites adapted the RTC, TAW and/or HLW positions or requirements for these positions or implemented certain recruitment strategies. DoHA has requested that it should be made clear in this report that a number of these local adaptations were not consistent with DoHA specifications for the positions. The local adaptations identified over the evaluation period included:

- Pooling of (or supplementing) funding from different sources to support establishment of more generalist positions. For example, in a remote site, the AHS pooled State and Commonwealth Closing the Gap funding to create generalist health promotion positions. Furthermore, in a regional site, funding for ICDP positions (OW and HLW) was pooled and position descriptions changed, to reflect a broader role in supporting families to access Health Services.

- Specification that applicants for the Regional Tackling Smoking positions should be non-smokers. While duty statements produced by DoHA referred to ‘demonstrate quitting behaviour’, at least one site felt that it was important for people in Tackling Smoking positions to be non-smokers and had made this a selection criteria. In some sites non-smoking status was not considered to be an essential selection criterion, as this was perceived to be unrealistic, potentially limiting the pool of applicants, given the high smoking rates among the local population.

- Dual-roles/positions (Regional Tackling smoking and/or healthy lifestyle role combined with clinical duties into one position). In three Sentinel Sites, it appeared that Tackling Smoking and/or Healthy Lifestyle positions also had a clinical aspect to their role. It is possible that the reason behind combining these positions was to fit with skills of best available candidates for the role. However, there is some concern over the ability of workers to carry out clinical roles as well as
the defined responsibilities of the positions. For example, it was evident from information gathered at interview in a non-remote site that, due to clinical demands, the TAW had been unable to spend time doing tasks in the tackling smoking role. This was also evident at a remote site, where the interview did not take place because the worker had yet to commence in the tackling smoking aspect of her role. For these workers, the clinical role seemed to have the potential to ‘overshadow’ the role of Regional Tackling Smoking and Healthy Lifestyle positions, perhaps reflecting the priorities of the organisation or staff that may be in supervisory positions within the organisation, or the particular background of the worker.

- Recruiting workers from programs where funding has ceased. For example, in a remote site funding for an existing program ceased and workers from that program were appointed to HLW positions. This enabled ongoing employment of the workers and continuity in programs delivered in the community.

- Targeted or staggered recruitment to positions. For example, in one remote site, the AHS delayed recruitment processes for the TAW and HLW positions until the RTC position was established to create a mentoring or supervisory team structure. Recruiting local people to the new positions was also an important consideration for program effectiveness (see Vignette below).

**Vignette – Local people to facilitate successful community-based health promotion**

The AHS in a remote site prefers to recruit local people to Tobacco Action Worker and Healthy Lifestyle Worker positions. A suggested recruitment strategy for the region has been to run a ‘Healthy Lifestyle Summit’ where community and health professionals come together and are informed of the healthy lifestyle worker role and healthy lifestyle message.

Experience indicates that it takes several years for workers from outside the community to effectively engage community groups in determining health promotion priorities and strategies, and to facilitate activities with potential to change health behaviours and lifestyles.

'It takes at least a year to develop the relationship with the community and for community to trust, as for years people having been going out to community and asking questions and researching and taking away intellectual property from community. It’s at least another year to start to be effective and the third year just as they are effective the funding [usually] runs out.' (AHS, program manager)

Local adaptations of the Regional Tackling Smoking and Healthy Lifestyle teams had implications for training and other capacity issues, including requirements to build a broader range of skills and knowledge to support health promotion, for people working in these positions and for their managers.

### 3.3.2. Skilled and equipped tobacco and healthy lifestyle workforce

**KEY POINTS**

- There was a high level of engagement in various training activities across the Regional Tackling Smoking and Healthy Lifestyle teams.

- Where it had been accessed, training was generally valued by interviewees.

- There has also been considerable activity in developing and distributing toolkits and resources to support the workforce in their roles.

- The important influence of high-level support for individual workers became evident in the later evaluation cycles.
An important prerequisite for the design and delivery of smoking cessation and healthy lifestyle programs and services is an adequately skilled and equipped workforce. To achieve this, these measures supported a range of training and professional development opportunities for the new tobacco and healthy lifestyle workforce and for existing workers such as practice nurses and AHWs, together with access to funding, toolkits and other resources.

The staged rollout and time taken to recruit to new positions meant that it was too early to assess satisfaction with training in the first two evaluation cycles. In the later evaluation cycles, steady progress had been made with recruitment and interviewees were better able to comment on the training and the extent to which the training had equipped staff with knowledge and skills to fulfil their roles.

A relatively small number of workers have accessed and participated in brief intervention training. It was, therefore, not possible to gather substantive information on the extent to which these workers were satisfied and/or felt that the brief intervention training provided them with the necessary skills to fulfil their roles.

**Satisfaction with training for new workforce**

By the time of the final evaluation period, there was a high level of engagement by Regional Tackling Smoking and Healthy Lifestyle teams in the various training activities. This appeared to be facilitated by the dedicated funding made available to host organisations to cover travel and accommodation costs for these workers. In the final evaluation period when asked whether ‘training provided to ICDP workers has equipped them with skills to fulfil roles’, 85% (17/20) of RTCs, TAWs and HLWs either strongly or partly agreed with this statement.

Regional Tackling Smoking and Healthy Lifestyle team members generally felt the training activities, particularly the workshops, had been useful and practical. The workshops were valued in building confidence and ability to talk with the community, particularly about smoking and physical activity; and for the opportunity to network and hear about what other workers were doing.

> ‘Lots of show and tell – it’s really good to learn about how other teams have worked, showing the know-how.’ (AHS, regional site)

> ‘We have been able to access huge amounts of training – we have been treated so well ... The induction was invaluable as I came back knowing just what was expected. Expectations [were] clearly identified and this was helpful as this is a new role for the organisation.’ (AHS, urban site)

Some considered the ‘show and tell’ style workshop as less valuable, possibly because the content was not at the level of what was required of the positions.

> ‘I didn’t think it was training, it was just packages that they were showing you. It was more information sharing. We need more on-the-job skill development.’ (AHS, urban site)

As the Regional Tackling Smoking and Healthy Lifestyle teams became established there was a general consensus among individual workers and their managers about the need for on-the-job training. This was to ensure an appropriate level of skills and understanding was developed in relation to the varied skills of individual workers and their professional roles and responsibilities. The additional funding made available for individualised programs for learning and development was considered particularly
important in supporting workers to achieve standard competencies as well as further accredited training.

‘When we recruit, their skills do not match the requirements of the job. Even though the selection criteria do match it does not flow on to the jobs. Good things about the team is that there is funding to do individual professional development training as required.’ (AHS, urban site)

‘A population health diploma [has been] commenced by both HLWs and this was identified through the training plan developed as part of the funding agreement.’ (AHS, urban site)

Further training implications appeared to be linked to the design of the workforce and to the adaptations of these positions that were made to suit local contexts (as described in the section above). One intention of the workforce redesign was to deploy workers in teams to facilitate a regional approach for working together. A number of interviewees commented on the importance of taking a team approach to training.

‘This strengthens the team capacity to carry out the duties or the role and provide support to each other.’ (AHS, urban site)

‘So that we get a better understanding of each of the ‘pillar’s rather than just staying concentrated in specific areas of activities. It would be a much better environment to work as a team.’ (AHS, urban site)

For those workers in positions that had been created through a pooling of funds (e.g., generalist positions) and those in a ‘dual role’ position (i.e., both clinical and health promotion components) there were expectations to attend different orientation workshops (for other ICDP workers, e.g., OWs). This meant time away from their role and family and was of particular concern to these workers as it presented barriers to their ability to attend training opportunities.

**Awareness and perceptions of funding and resources to support development of programs and activities**

Alongside the workforce training element under these measures, there has been considerable activity in the development and distribution of toolkits and resources. All organisations with funding allocation for these measures were provided by DoHA with a range of toolkits and resources to support the Regional Tackling Smoking and Healthy Lifestyle teams in their roles.

Awareness of the toolkits and resources available under these measures increased over the course of the evaluation, particularly among workers who had attended the workshop where these toolkits and resources had been promoted. However, it was difficult to ascertain the extent to which these toolkits and resources were being used or have assisted in the development of evidence-based programs and services. Whether or not these national resources were meeting an existing need was also unclear. It appears that lack of resources may not be a major issue, and that locating locally relevant resources and understanding how they can be applied and sustained in varying contexts is a greater challenge for the effective implementation of these measures.

‘There’s plenty [of resources]. People don’t realise what’s out there. It’s about knowing where to look and how to get them.’ (AHS, remote site)
‘I have a store room full of flip charts, posters and resources ... The investment in resources doesn’t make the difference, it is about long-term projects that have stable workforce, which is hard in a remote context, to engage community so it can carry on through workforce turnover, and is an approach that the community wants.’ (AHS, remote site)

‘The information needs to be simplified for Aboriginal people.’ (AHS, remote site)

‘Any educational resources can be used but they need to be culturally suitable.’ (AHS, remote site)

Policy level leadership and practical support

The important influence of high-level leadership and support in steering the implementation of the Regional Tackling Smoking and Healthy Lifestyle initiatives became evident in the fourth and final evaluation cycles. Across Sentinel Sites, interviewees made specific reference to the National Coordinator, Dr Tom Calma (by name) and the DoHA Measure Manager, commenting on their leadership and ongoing practical support for the Regional Tackling Smoking and Healthy Lifestyle teams. Communication between workers and the National Coordinator and/or Measure Manager, was particularly evident (and helpful) in cases where individual workers felt unsupported or were lacking direction at the local level.

‘I found out through talking to Tom Calma and the department and others that it is not the way the program is meant to run.’ (AHS, regional site)

‘... Tom Calma said we are not involved in clinical service delivery therefore this qualification does not really match the job description.’ (AHS, urban site)

An AHS in a regional site was proposing to create generalist positions from the TAW and RTC funding. However, following discussions with the National Coordinator, the TAW and RTC roles in this site remained focused on tackling smoking.

‘This is what Tom Calma wanted and we did not want to upset him.’ (AHS, regional site)
3.3.3. Design and delivery of tobacco control and healthy lifestyle programs and services

**KEY POINTS**

- The design and delivery of tobacco control and healthy lifestyle initiatives was slow initially, gaining momentum once Regional Tackling Smoking and Healthy Lifestyle teams were established in the Sentinel Sites.
- Programs and services varied and included individual client support, health education and community campaigns, and implementation of smoke-free workplace policies.

A major role envisaged for the Regional Tackling Smoking and Healthy Lifestyle teams was to design and deliver smoking cessation and healthy lifestyle programs and services in their local communities. The effectiveness of the workforce in being able to achieve this was dependent on a number of factors including the length of time in the position, skills and experience of individual workers, workforce leadership and support, and the availability and accessibility of locally relevant tools, resources and training.

Findings from the early evaluation cycles indicated many workers were in the ‘meet and greet’ stage and there was limited program activity. By the fourth and final evaluation cycles it was evident there were a range of activities being supported and delivered at a site level. It was not possible within the scope of the SSE to ascertain the degree to which these initiatives integrated evidence-based principles.

3.3.4. Strategies within Health Services to support clients

Brief interventions, referrals to Quitline and support programs, raising awareness of medications available on PBS (e.g., patches) and encouraging clients to have regular health checks were common strategies used by Health Services to support smokers in their attempts to quit smoking and lead a healthier lifestyle.

The need for greater access to face-to-face support for smoking cessation for Aboriginal and Torres Strait Islander people, particularly in remote communities, emerged during the evaluation. Although Quitline could potentially play a role in one-to-one support for smoking cessation, it is plausible that face-to-face support may be more effective and appropriate for some Aboriginal and Torres Strait Islander communities. Interviewees consistently indicated that this service was not being accessed by members of remote communities due to language barriers and low telephone ownership. We have noted that a number of participants indicated they had called the Quitline but no one had got back to them or they were dissatisfied with the support. In a regional site, there were examples of ICDP workers facilitating access to Quitline by calling on behalf of community members.

‘No-one is going to ring up Quitline. Aunty needs someone to sit and support to give up smoking.’ (DGP, regional site)

‘If someone wishes to give it up it is their choice, if they want to make that choice with medication or patches, or I can ring Quitline for them.’ (AHS, regional site)

Culturally appropriate and supportive tobacco counsellors (face-to-face) was considered an important service for assisting Aboriginal and Torres Strait Islander smokers in their attempts to quit smoking. An interviewee noted that the role of the Regional Tackling Smoking and Healthy Lifestyle team is one that requires ‘incredibly supportive counselling services’. There are indications that in some cases the TAW/RTC are offering this type of support.
3.3.5. Community-based initiatives

Services and programs developed and implemented by the Regional Tackling Smoking and Healthy Lifestyle teams have progressed steadily across sites and over the evaluation period, with the exception of sites where there have been delays in recruitment or changes in staffing. The program of work delivered by teams varied in the Sentinel Sites. Some examples of the diversity of work conducted in relation to the ICDP Tackling Smoking and Healthy Lifestyle measures included:

- **Social marketing activities:** raising community awareness of healthy lifestyle choices using nationally and locally developed campaign materials at events such as health expos, Healthy Community Day events (see Chapter 4) NAIDOC and Closing the Gap celebrations.

- **Health education and skill development:** activities aimed at improving knowledge and understanding of healthy lifestyle choices and developing healthy lifestyle skills. Examples include smoke check brief intervention and smoking cessation programs, cooking and walking groups, ‘Deadly Choices’ program and traditional Aboriginal and Torres Strait Islander games.

- **Smoke-free workplaces:** Strategies to support AHSs implement their smoke-free policies. In one AHS, staff who leave the building to smoke are required to cover the organisational logo on their uniform. In this and in other AHSs, QUIT groups are being organised for staff and patients. Smoke-free workplaces are discussed further below.

The sheer range of existing tobacco control and healthy lifestyle initiatives (funded at both State and national levels) made it difficult for interviewees and community focus group participants to know whether the initiatives were funded and delivered through the ICDP Tackling Smoking measure or through some other source.

This context of multiple initiatives at a local level suggests that there may be some benefit in ensuring complementarity of measures A1 and A2 in relation to these other initiatives, recognising that these other initiatives are subject to their own funding timelines and shifting priorities in the funding agencies.

It was difficult to ascertain the extent to which the interventions implemented at community level were in accordance with best practice. There were some examples of how Regional Tackling Smoking and Healthy Lifestyle workers engage with community, such as the ‘Talking not Telling’ story below.

Some key informants also highlighted the cultural importance of establishing relationships between community and individual workers.

‘... me being from the south west, this is not my country. I don’t come from here so it’s very important for me to meet with the Aboriginal Elders first – particularly the Chairman and get his approval as they are a very traditional community.’ (AHS, remote site)
Vignette – Talking not telling

An urban Healthy Lifestyle Team is finding a ‘talking not telling’ approach effective when working with young people in an eight-week school program about Smoking and Healthy Lifestyle. They use conversation, interactive activities and communication games to talk about nutrition, chronic disease, sexual health, substance abuse, physical activity and smoking. Young people have the choice to participate.

‘There are young people who are asking or talking about quitting smoking which has been a great outcome ... Once they know that you are there to help not just to deliver and go away that’s when the building of trust happens.’

Some people in the wider community question the effectiveness of the approach used in schools. ‘I wonder if they listen?’

However, the team, comprising young workers, attributes much of the program’s apparent success to the way it engages with young people. ‘Communication is the key in building this trust ... [and they] support the fact that [we use] positive message such as, it is ‘deadly not to smoke’, it is ‘deadly to eat good food’.’

The relatively small number of positions, large distances and large service populations were consistently raised as issues impacting on the effectiveness of the Regional Tackling Smoking and Healthy Lifestyle teams. These issues were identified by a number of stakeholder interviewees as the major challenges for the Regional Tackling Smoking and Healthy Lifestyle teams, in relation to how to implement a program and to have effective reach across a large area.

‘I think it is too much to expect [teams] to go out [across the region], even though they might not think that. Looking at it, you just go ‘wow’ to achieve the goals that COAG and Government would like them to achieve. I don’t think it is possible, just because of the sheer distance and the capacity of staff to do that work.’ (AHS, regional site)

‘This will be a challenge and I am sceptical of the impact the workers will make on a remote satellite clinic.’ (NACCHO, remote site)

‘[For] all the team to cover a huge geographic area and Aboriginal and Torres Strait Islander population is a challenge.’ (AHS, urban site)

The large geographic area covered by these teams has required the teams to prioritise service delivery to particular parts and population groups within their area. In one urban site the priorities set by the team did not always match the expectations of local stakeholders. This was reflected in perceptions by some stakeholders that they were ‘missing out’ on programs, and that programs run by these teams were not necessarily addressing the priorities identified by all local stakeholders.

‘Our mob’s missing out. They seem to do a lot more of the big events, promotional events where you’ve got celebrities. Need to provide local community stuff to have a real impact on kids and families. Not the one off stuff.’ (Community focus group, urban site)
**Vignette – extending reach**

One urban Regional Tackling Smoking and Healthy Lifestyle team highlighted the limitations of their health promotion program to facilitate change, because of the expectation for them to cover a large, densely populated region with a single team, and described some of the strategies they are using to maximise their impact in the face of this challenge.

‘In the Deadly Choices program at school we may be able to accommodate only 30 people where we should be covering more. At community days we [see] around 200 people, when we should be getting at least 500.’

A number of strategies are being used to reach more people, for example, a trainee is being mentored by the team coordinator and a lesson guide is available on school presentations. Community and sporting days focus on activities and resources that are easy to show people and engage them to talk about chronic disease, effects of smoking and how to stay active for at least 30 minutes a day – diagrams, smoking and activity stations, pamphlets and a trailer with a big screen TV.

The organisation running the program is linking its work with other healthy lifestyle and training programs for Aboriginal and Torres Strait Islander people that are offered by the city council, State government and the NACCHO affiliate.

**Interventions to support smoke-free workplaces**

Over the course of the evaluation, there was an increasing trend in the percentage of stakeholder interviewees who either partly or strongly agree with the statement, ‘workplaces have implemented smoke-free workplace policies as a result of the new tobacco workforce;’ from 30% (7/23) in the third evaluation cycle to 74% (25/34) in the final evaluation cycle. This was particularly influenced by interviewees from the Aboriginal Health Sector, with 96% (23/24) agreement with this statement among AHS interviewees in the final evaluation cycle. This high level of agreement is consistent with the development and implementation of a workplace smoke-free policy being a condition of funding for these organisations.

Concern over the number of Health Service staff who smoke (including board members) presented challenges to gaining support for, and enforcement of, smoke-free policies. Key informants highlighted that more programs were needed to support Health Service staff and strategies to create non-smoking environments and workplace culture.

‘Services still have too many workers who smoke around services. Need more training and policies to reduce smokers in Health Services and to enforce non-smoking environment.’ (AHS, urban site)

‘A smoke-free workplace requires such a big shift in culture. When I first started here six and a half years ago, 50% of the workforce would have smoked. We are currently down to about two per cent, that’s been a massive smoking culture change and largely due to the smoking policy we did have in place; that came well before the ICDP.’ (AHS, regional site)

‘Smoke-free workplaces are becoming more common – that is the way it is and get used to it. Supported from the top down, staff have to accept that’s it.’ (NACCHO affiliate, regional site)
**Vignette – Smoke-free workplaces**

An AHS in a regional city has used measure A1 funding to support their existing smoking cessation efforts and to implement fully a smoke-free workplace policy. Success has led to plans to use A1 and A2 funding to take strategies to other services in the region.

Prior to the ICDP (in 2009) staff were consulted about establishing a smoke-free workplace policy. Although this policy was challenging to implement, when RTC funding became available the environment became more conducive to implementing the ‘Our Space’ smoke-free policy and rolling it out to community and clients. As a result, the approach was taken that staff should lead by example before such a policy could apply to clients. Smoking cessation programs were delivered internally under ‘time to quit’ funding through the substance misuse program.

‘As professional health workers we need to set an example if we wish to tackle chronic disease and close the gap. We cannot educate our people and tell people to quit smoking and here we are smoking. It is about internally let’s work together [to quit] and ... then take message to community and roll it out.’

In the 12 months that Regional Tobacco Coordinator and Tobacco Action Workers have been employed they have engaged with the service’s network of sites, using A1 funding to market the ‘Our Space’ concept and to offer support and assistance to reduce the number of people smoking. They work closely with two Healthy Lifestyle Workers (A2 measure funding) who support people who have quit to adopt healthy lifestyle practices. They plan to promote the approach to other AHSs in the region through a train-the-trainer model.

‘[We] have a large area to cover so will … sell the idea to the site first through networking and linking and communicating. Focus on areas where the AHS wishes to engage, start where strengths are [and] assist where needed ... One thing in favour of the project being successful and rolling out to a large area is that the budget is healthy. With a workforce of five or six people and budget ... a lot can be achieved.’

**Organisation and management characteristics**

Key organisational and management factors emerged as being important in the effectiveness of the Regional Tackling Smoking and Healthy Lifestyle teams. These factors included an adequate level of organisational stability, adequate supervision of staff, particularly in sites where workers were required to cover large geographic areas, and good team functioning.

Organisations with clear structure and purpose, and a stable workforce in a supportive working environment, were in a better position to implement the measures more effectively. More advanced programs of work were evident in organisations with good supervision and where individual team members have clearly described and understood their roles and responsibilities.

‘We’re all on the same page, and this adds capacity to the system.’ (AHS, urban site)

In the final evaluation cycle, when most of the Regional Tackling Smoking and Healthy Lifestyle teams were established in Sentinel Sites, 90% (18/20) of interviewees either strongly or partly agreed that having the workforce deployed in teams provided a supportive environment for workers. There was no clear difference in responses across remote, regional and urban locations.

A supportive supervisory structure enabled workers to link with others who have established credibility in the community and to cover communities that are separated by large geographic distances.
‘It’s unrealistic to think a new non-Aboriginal person will be able to make much of a difference unless she works closely with our Health Promotion Officers who have established credibility.’
(AHS, remote site)

Where clear direction and leadership were lacking, the capacity of Regional Tackling Smoking and Healthy Lifestyle teams’ to design and implement a comprehensive program of work was inhibited.

‘The previous RTC was responsible for the tobacco part of it. I just had to focus on the nutrition side – so I don’t know much about the tobacco programs.’ (AHS, regional site)

‘I’m just going off my job description. Feels like we just sink or swim.’ (AHS, remote site)

‘I’ve basically just come into the position and learning everything myself as well and I know the Healthy Lifestyle Workers are the same. I do weekly meetings with the HLW over the phone just to see how she’s going and what she’s doing. I don’t want her to feel like I felt; coming into the position with not having any support. We don’t want to be left in the lurch. [Organisation] are lucky that people are staying in their position.’ (AHS, remote site)

3.3.6. Awareness of the regional Tackling Smoking and Healthy Lifestyle workforce

KEY POINTS

- There has been growing awareness of the Regional Tackling Smoking and Healthy Lifestyle positions overall and across sites. Awareness was greater in urban sites and remote sites than in regional sites.
- Despite awareness of the Regional Tackling Smoking and Healthy Lifestyle teams increasing, at the time of the final evaluation cycle there continued to be limited awareness of these positions, particularly in regional sites and particularly among General Practice staff.
- These patterns of awareness were consistent with recruitment progress, challenges of achieving high population coverage and the focus of work of these teams.
- Awareness of the Regional Tackling Smoking and Healthy Lifestyle teams among Health Service staff across sectors is relevant to the effectiveness of these measures, as these workers have a role in developing partnerships and supporting Health Services to deliver smoking cessation and healthy lifestyle activities and/or facilitating appropriate referrals.

Since the commencement of the SSE, there has been growing awareness of the Regional Tackling Smoking and Healthy Lifestyle positions overall and across sites (Table 3.2). Awareness appears consistent with greater numbers of people being recruited to these positions and increasing knowledge of the ICDP more generally across the Sentinel Sites.

Over the course of the evaluation, awareness of Regional Tackling Smoking and Healthy Lifestyle positions was greater in urban sites and remote sites than in regional sites. Lower awareness in the regional sites reflects difficulties with recruitment and staffing changes. The difference in awareness levels of these positions between urban, remote and regional sites was less marked in the final evaluation cycle.

In Sentinel Sites, the vast majority of Regional Tackling Smoking and Healthy Lifestyle teams were based in AHSs, and as expected, interviewees from AHSs were generally more aware of the positions.
compared with interviewees from private General Practice or DGPs. Responses to the question ‘are you aware of the following positions … [name]?’ are summarised in Table 3.2 below.

**Table 3.2: Trends in managers’ and clinicians’ awareness of Regional Tackling Smoking and Healthy Lifestyle workforce (% who responded ‘yes’), overall and by sector**

<table>
<thead>
<tr>
<th>Interview statements</th>
<th>Sector</th>
<th>Evaluation cycle 3</th>
<th>Evaluation cycle 4</th>
<th>Evaluation cycle 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are you aware of a Regional Tobacco Coordinator position that is responsible for providing services in this Sentinel Site?</td>
<td>Overall</td>
<td>55% (n=64)</td>
<td>78% (n=54)</td>
<td>76% (n=45)</td>
</tr>
<tr>
<td></td>
<td>Aboriginal Health Sector</td>
<td>60% (n=30)</td>
<td>88% (n=25)</td>
<td>86% (n=28)</td>
</tr>
<tr>
<td></td>
<td>General Practice Sector</td>
<td>50% (n=34)</td>
<td>69% (n=29)</td>
<td>59% (n=17)</td>
</tr>
<tr>
<td>Are you aware of a Tobacco Action Worker position that is responsible for providing services in this Sentinel Site?</td>
<td>Overall</td>
<td>36% (n=64)</td>
<td>52% (n=54)</td>
<td>72% (n=46)</td>
</tr>
<tr>
<td></td>
<td>Aboriginal Health Sector</td>
<td>40% (n=30)</td>
<td>68% (n=25)</td>
<td>82% (n=28)</td>
</tr>
<tr>
<td></td>
<td>General Practice Sector</td>
<td>32% (n=34)</td>
<td>38% (n=29)</td>
<td>56% (n=18)</td>
</tr>
<tr>
<td>Are you aware of a Healthy Lifestyle Worker position that is responsible for providing services in this Sentinel Site?</td>
<td>Overall</td>
<td>43% (n=60)</td>
<td>64% (n=53)</td>
<td>74% (n=46)</td>
</tr>
<tr>
<td></td>
<td>Aboriginal Health Sector</td>
<td>52% (n=29)</td>
<td>64% (n=25)</td>
<td>82% (n=28)</td>
</tr>
<tr>
<td></td>
<td>General Practice Sector</td>
<td>35% (n=31)</td>
<td>64% (n=28)</td>
<td>61% (n=18)</td>
</tr>
</tbody>
</table>

n = number of people who responded. Included in the denominator are the respondents who indicated ‘don’t know/can’t say’.
Aboriginal Health Sector includes: AHS, NACCHO State and Territory affiliates.
General Practice Sector includes: General Practice, DGP and Division SBOs.

Over the course of the evaluation, including in the final cycle, there remained some GPs who were simply not aware of the positions, with a typical response being ‘I’m not aware of any of healthy lifestyle workforce positions.’

Lack of engagement with General Practice was also evident in interviews with staff of DGPs in a number of sites and staff of the SBOs who indicated that they were aware of the positions, but there had been minimal or no contact between this workforce and private General Practices. In some cases, interviewees were confused about areas of program responsibility, service delivery and links with State-based workforce. This was particularly evident in sites implementing the Healthy for Life program and where there had been significant investment in a State-based tobacco workforce.

‘I don’t know what has happened with this workforce. I know the positions are RTC, HLW and TAW and these have been given to the ACCHO sector to manage, but I don’t think they must be established yet, as we haven’t heard anything about status of plans to integrate with other ICDP funded workers or how General Practitioners will be able to access the services.’ (SBO, regional site)

‘I know there are a couple of lifestyle worker positions that work out of the DGP, and I know that there are a couple of positions at the Aboriginal Health Service. The ICDP positions at the DGP work very well with the State-based healthy lifestyle positions.’ (DGP, regional site)
3.3.7. Better access to resources to support smoking cessation and healthy lifestyle activities in Health Services

**KEY POINTS**

- Regional Tackling Smoking and Healthy Lifestyle teams have had a limited role in increasing access to smoking cessation and healthy lifestyle resources in General Practices, with most work focused in AHSs.
- This appears to be related to lack of awareness of the roles (including their intended scope or responsibilities more generally), lack of communication and/or collaborative working relationships, including capacity to engage with clinicians, to support working across large geographic regions or populations, owing to workload in the AHSs.
- Healthy community days were identified as an opportunity to improve links between the healthy lifestyle and clinical teams.

The National Framework indicates that one of the intentions of measures A1 and A2 is to ensure that Health Services have access to evidence-based resources to support smoking cessation and healthy lifestyle activities. At a local level, provision for this is primarily through the services and support offered by the Regional Tackling Smoking and Healthy Lifestyle teams. There is also national support available through enhanced Quitline, national social marketing campaigns and availability of NRT through PBS; access to these components of the measures is discussed below and in the following sections.

**Linkages between Regional Tackling Smoking and Healthy Lifestyle teams and clinical teams**

There was generally limited evidence of linkages between Regional Tackling Smoking and Healthy Lifestyle teams and clinical teams. Interviews with GPs indicated that limited awareness of these workers was a barrier for the development of collaborative working relationships or an ability, on their part, to access support from the teams. Clinicians suggested some contact by the teams and possibly media or other means of communication would better enable them to make appropriate referrals.

’It makes it difficult to work together when you don’t know who they are. I’ve had no communication, any offer to meet and greet or to work collaboratively.’ (DGP, regional site)

’It would be good if they can keep us up-to-date of what they are doing, that would be fine. If they can send us emails, or pamphlets to remind us so that we can put them on the notice board that would be more beneficial and people can be more aware.’ (GP, urban site)

There appear to have been different expectations regarding roles of these workers, and this is to some extent due to different interpretations of – and some inconsistency in – documentation regarding this measure. This is an example of a more general need for improved communication and coordination across the ICDP.

By the final evaluation period, despite increased awareness of the Regional Tackling Smoking and Healthy Lifestyle teams, linkages between GPs/clinicians and the Regional Tackling Smoking and Healthy Lifestyle teams were still limited.
‘[There is] more work to be done on linking with the other sections of Health Service such as tobacco and healthy lifestyle teams. We are looking to develop a system to do this. They previous have functioned a little bit independently.’ (AHS, regional site)

There was evidence that the use of social networking media such as Facebook and Twitter had generated some interest and enquiries for GP services within the community. This has also created interest to develop events and programs for particular community groups.

Referrals between clinicians and the services offered by Tackling Smoking and Health Lifestyle teams, was an issue for clients, who reported a lack of support programs and follow-up in their efforts to quit smoking. For example, health service providers ‘talk about smoking’ or clients were prescribed Nicotine Replacement Therapy (NRT) but then there was no ongoing support.

‘Doctors do support you and nurses support you, but when you come home and start again ... there is no practical support medium to long term.’ (Community focus group, regional site)

‘The AHS gives out tablets and patches but then when I go home there’s no support from clinic staff.’ (Community focus group, regional site)

‘The AHW, doctors and nurses speak about smoking and tell you that you have to do it [give up], that’s not support. Need support not be told what to do.’ (Community focus group, urban site)

In one regional site, the Healthy Lifestyle Worker is an accredited dietitian and there was a perception that clinicians in the AHS were referring to the position more often as due to the ability to offer dietetic services rather than general advice and support. The HLW in this site also noted that generally referrals from GPs for services offered through the healthy lifestyle programs were not being received.

‘Doctors refer patients to see me one on one probably because I am an accredited dietitian rather than a healthy lifestyle worker – so ticking two boxes. Generally the doctors are not referring patients to healthy lifestyle programs such as community kitchen or exercise group.’ (AHS, regional site)

Over consecutive SSE reporting periods there has been a perception from interviewees (particularly clinicians) that clinicians can refer clients to the RTC and TAW to provide quit smoking support. This perception may arise from documentation provided by DoHA (Factsheets, job descriptions and referral pathways) that indicates that the RTC and TAW are to deliver smoking cessation programs according to their skill level and qualifications, and that they will be trained to effectively deliver smoking cessation programs (including specific reference to brief interventions). The perception may also be because many stakeholders use the term ‘referral’ in a more general sense to connect people to activities – for example, to cover referral to group programs, and encouragement of follow-up and self-referral by clients. Further, in contrast to the common perception among clinicians, the RTC and TAW generally perceive themselves as not being responsible for providing individual level interventions (such as brief interventions), but rather undertaking community based health promotion type work. Consistent with the perspective of the RTC and TAWs, the DoHA has indicated over the course of the SSE that the TAW and RTC do not provide a ‘service’ to which individual clients can be referred. There is a need to address the mismatch between the expectations of clinicians and the RTC and TAWs, the ambiguity of program documentation, and the need to create potential for adaptation to meet local needs and circumstances.
**Vignette – Referral pathways**

A large AHS in a regional site have found that having the Healthy Lifestyle team referral form outside the computer system was a barrier to clinical staff referring their clients to the Healthy Lifestyle team. This is being overcome by building an electronic template and ensuring access to the computer system by all teams in the Health Service.

‘If a [patient] is identified as a smoker they are asked if they want to do something about it. The plan is that [an electronic] referral will immediately be sent to [the Healthy Lifestyle Team]. We will see if [members of] the tobacco team [are] available on the spot.’

Thus an improved computer system will be able to opportunistically link clients with Tobacco and Healthy Lifestyle Workers.

**Awareness and uptake of Nicotine Replacement Therapy**

Awareness of the availability of NRT patches and medication was high among community focus group participants. PBS Co-payment measure data also showed increasing uptake of NRT during the period of ICDP implementation. The extent to which advice and prescription of NRT is integrated into evidence-based behaviour change communication campaigns was not able to be ascertained in this evaluation.

Specific comments were made about ‘patches and tablets’ in community focus groups with some community members referring to ‘champix’. Key informants also spoke about the availability of NRT on the PBS and considered this as a positive step in supporting a larger group of clients in their attempts to quit smoking.

‘Now that these are on PBS, people don’t have to miss out.’ (DGP, regional site)

‘The [community activities] have had a great impact on people’s interest to stop smoking. I have had patients who came to me saying ‘I have heard that patches are available through PBS – [I] would like to do this …’ (AHS, urban site)

A review of the uptake of NRT through an examination of the PBS Co-payment measure data showed that over the period of implementation of ICDP, there has been an overall general upward trend in number of Aboriginal and Torres Strait Islander people prescribed NRT (Figure 3.1).

The number of NRT prescriptions per 1000 Aboriginal and Torres Strait Islander people aged ≥15 years increased about three-fold between September – November 2010 and March – May 2011, with no further increase to March – May 2012. There was a slight seasonal dip in September 2011 – February 2012 for both regional Sentinel Sites and the rest of Australia (Figure 3.2). A greater number of NRT prescriptions per 1000 people were given for Sentinel Sites than for the rest of Australia throughout the period. There were no NRT prescriptions recorded in remote Sentinel Sites, as NRT should be available under S100 supply arrangements in remote locations. The changes in NRT PBS item number prescriptions are difficult to interpret in the context of new items becoming available in 2011.

The number of NRT prescriptions per 1000 Aboriginal and Torres Strait Islander people aged 55 or more was approximately twice that for those aged 15 to 54 years, with similar patterns between Sentinel Sites and the rest of Australia (Figure 3.3).
Figure 3.1: Number of prescriptions for nicotine replacement therapy per 1000 Aboriginal and Torres Strait Islander people aged ≥15 years for Sentinel Sites and the rest of Australia by quarter, September 2010 – May 2012

Figure 3.2: Number of prescriptions for nicotine replacement therapy per 1000 Aboriginal and Torres Strait Islander people aged ≥15 years by remoteness of Sentinel Sites and the rest of Australia and quarter, September 2010 – May 2012
3.3.8. Better access to smoking cessation and healthy lifestyle resources for communities

KEY POINTS

- A range of community-level activities in relation to these measures were evident, including social marketing events, group work and one-to-one support to motivated clients.
- Some of these activities involve linkages or brokerage between clients and other resources, for example, Regional Tackling Smoking team calling Quitline on behalf of clients who experience barriers to doing it themselves.
- These activities take place in the context of a range of other pre-existing tobacco control and healthy lifestyle initiatives at both State and national levels.
- Community focus group discussions indicated a generally high level of community awareness of the workforce.

Community awareness of the Regional Tackling Smoking and Healthy Lifestyle teams has increased over the evaluation, in some sites more than others.

Community focus group discussions showed community members in remote sites to be less likely than those in urban and regional areas to be aware of the Regional Tackling Smoking and Healthy Lifestyle team and programs and services. This is consistent with stage of program implementation in remote sites and the limited awareness among the private General Practice sector, described above. Regional Tackling Smoking and Healthy Lifestyle teams appear not to have extended their reach to the clients of General Practices in their regions. Youth community focus groups also showed lower awareness.
The level of awareness of the teams appears to be influenced by the length of time workers had been in positions and the extent to which programs have been delivered in communities. As indicated above, at the time of the third evaluation cycle, workers were newly recruited and many were in the ‘meet and greet’ phase and there was little evidence of program activity. In the later evaluation cycles, several community focus group participants were able to name individual workers and describe some healthy lifestyle and tobacco related initiatives (although, not all were ICDP funded programs). This was particularly evident in community focus groups held in urban sites.

3.3.9. Community awareness, understanding, health seeking behaviours and smoking status

KEY POINTS

- Awareness of risk factors for chronic disease among community focus group participants was high prior to ICDP implementation. Pre-existing programs, including national social marketing campaigns and promotion related to plain packaging legislation, appears to have contributed to the high levels of awareness.

- There has been a general increasing trend over the course of the evaluation in perceived changes in client behaviour towards healthier lifestyles, as reflected in clinicians’ responses.

- Over the course of the evaluation, self-motivation was consistently noted as key for people to quit smoking and adopt healthier lifestyles.

- At Health Service level, there was a notable lack of recording of smoking status in clinical information systems, with implications for identifying ‘target’ groups and monitoring effectiveness of community-based activities.

Changes in awareness and understanding

Awareness of risk factors for chronic disease among community focus group participants was high prior to ICDP implementation. Existing programs, including national social marketing initiatives and promotion related to plain packaging legislation, were identified by community focus group participants in earlier evaluation cycles and these appear to have contributed to the high levels of awareness in the community of the risks of smoking and healthy lifestyle behaviours. Community focus group participants spoke of smoking, poor nutrition and lack of exercise and their consequences, including problems with heart, lungs, throat and stomach. Participants appeared to be well aware of the health issues and risks associated with chronic disease, stating ‘Yeh, we live it’.

Changes in help seeking behaviours

There has been a general increasing trend over the course of the evaluation in perceived changes in client behaviour towards healthier lifestyles. Over the course of the evaluation, clinicians were asked to respond to a series of statements regarding their perceptions of community health seeking behaviours related to these measures. The proportion of clinicians agreeing with the statement ‘there has been increased interest from patients to seek support to implement healthy lifestyle choices in the past six months’ has shown a general trend of increase across the evaluation period with some decline evident in the fourth evaluation period before increasing in the final evaluation period. A similar trend was evident in the proportion of clinicians agreeing with the statement ‘there has been increased interest from patients seeking support to quit smoking in the past six months’. To the extent that the decline in agreement with these statements in the fourth evaluation period may be real, the change may reflect a
better understanding about the complexities of behaviour change, and this should inform a more solid platform for planning and program implementation.

Table 3.3: Trends in clinicians’ perceived changes in client behaviour (% who responded ‘strongly agree’ or ‘partly agree’), overall and by rurality

<table>
<thead>
<tr>
<th>Interview statements</th>
<th>Rurality</th>
<th>Evaluation cycle 1</th>
<th>Evaluation cycle 2</th>
<th>Evaluation cycle 3</th>
<th>Evaluation cycle 4</th>
<th>Evaluation cycle 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Over the past six months there has been an increased interest from Aboriginal and Torres Strait Islander people seeking support to quit smoking.</td>
<td>Overall</td>
<td>57% (n=16)</td>
<td>52% (n=33)</td>
<td>56% (n=25)</td>
<td>40% (n=20)</td>
<td>80% (n=20)</td>
</tr>
<tr>
<td></td>
<td>Remote</td>
<td>71% (n=7)</td>
<td>20% (n=5)</td>
<td>50% (n=8)</td>
<td>33% (n=3)</td>
<td>80% (n=5)</td>
</tr>
<tr>
<td></td>
<td>Regional</td>
<td>50% (n=4)</td>
<td>59% (n=17)</td>
<td>33% (n=6)</td>
<td>40% (n=10)</td>
<td>50% (n=2)</td>
</tr>
<tr>
<td></td>
<td>Urban</td>
<td>40% (n=5)</td>
<td>55% (n=11)</td>
<td>73% (n=11)</td>
<td>43% (n=7)</td>
<td>85% (n=13)</td>
</tr>
<tr>
<td>Over the past six months, there has been an increased interest from Aboriginal and Torres Strait Islander people seeking support to implement healthy lifestyle choices.</td>
<td>Overall</td>
<td>13% (n=16)</td>
<td>39% (n=33)</td>
<td>65% (n=23)</td>
<td>55% (n=20)</td>
<td>65% (n=20)</td>
</tr>
<tr>
<td></td>
<td>Remote</td>
<td>43% (n=7)</td>
<td>60% (n=5)</td>
<td>75% (n=8)</td>
<td>67% (n=3)</td>
<td>60% (n=5)</td>
</tr>
<tr>
<td></td>
<td>Regional</td>
<td>50% (n=4)</td>
<td>29% (n=17)</td>
<td>50% (n=4)</td>
<td>50% (n=10)</td>
<td>50% (n=2)</td>
</tr>
<tr>
<td></td>
<td>Urban</td>
<td>40% (n=5)</td>
<td>46% (n=11)</td>
<td>64% (n=11)</td>
<td>57% (n=7)</td>
<td>69% (n=13)</td>
</tr>
</tbody>
</table>

n = number of people who responded to statement. Included in the denominator are the respondents who indicated ‘don’t know/can’t say’.

A greater percentage of clinicians in the Aboriginal Health Sector strongly or partly agreed to these statements related to Aboriginal and Torres Strait Islander people seeking support.

In the final evaluation cycle, 47% of interviewees strongly or partly agreed to the statement ‘the availability of support provided through the HLWs has led to more adult health assessments, GP Management Plans or team care arrangements’. There has been an increasing trend in agreement with this statement over the evaluation period. Across the evaluation cycles a greater proportion of interviewees in urban and remote sites agreed with the statement, compared with interviewees in regional sites. This may reflect recruitment progress and/or relatively less focus in these aspects of care by HLWs in regional sites compared to urban and remote locations. Limited capacity of the HLWs or an existing capacity within services (and, therefore, no need for the HLW to take on this role) were cited as reasons for the perception that HLWs had not led to increased adult health assessments, GP Management Plans (GPMP) or Team Care Arrangements (TCA).

Over the course of the evaluation, self-motivation was consistently noted as key for people to quit smoking and adopt healthier lifestyles.

‘There are supports available, but you make it work if you want to … we still go around and smoke … you got to help yourself, the will power … knock off yourself to give up smoking.’

(Community focus group, regional site)

‘Awareness is there. There has been some behaviour change, but it’s up to the individual.’

(Community focus group, regional site)

Some participants went so far as saying that this is the reason they don’t feel the need to go to the clinic for help.
‘Stop smoking programs need to respect that it’s my business and people can make their own choices.’ (Community focus group, regional site)

One of the strategies to increase motivation to change identified by informants was to target younger age groups in order to put pressure on parents – a positive impetus for change, based on parents concern about the effects of their behaviour on young children (e.g., secondary smoke) and the respect of their children. This strategy is consistent with a growing body of literature showing that relationships between people, within families and communities, take precedence over other influences, such as an individuals’ knowledge of chronic disease, on health behaviours.

‘It’s not just about educating the kid. That kid could go home and educate the parent and that’s a big thing that doesn’t happen. There are a lot of kids that come to youth group that have spoken about things that happen. They want their families to change, their parents to do this and do that and smoking does come up. They want their parents to quit smoking.’ (Community focus group, urban site)

Given the stage of implementation of these measures, the complex long-term nature of behaviour change and challenges of attributing impact to specific public health initiatives, it could not be expected that these measures have had a significant role in achieving change in levels of smoking (or healthy lifestyle behaviours more generally) at this stage.

**Changes in smoking status**

At Health Service level, there was a notable lack of recording of smoking status in clinical information systems. Documentation of smoking status is an important step in the implementation of brief interventions and smoking cessation measures in Health Services. This lack of documentation has implications for identifying ‘target’ groups and monitoring effectiveness of tobacco control activities.

Enquiring about and recording smoking status is an important first step in the implementation of brief interventions and smoking cessation measures in Health Services. A number of General Practices and AHSSs provided clinical indicator data on smoking status. Although these data have serious limitations, including that they are derived from General Practices identified as being particularly interested in Aboriginal and Torres Strait Islander health, they do give a sense of the extent of under-documentation and the accuracy of documented key indicators, including smoking status. Limitations of the clinical indicator data are discussed further in Appendix E.

In the final evaluation period, 12 AHSSs and 24 General Practices provided clinical indicator data. Data were analysed for Health Services with over 100 Aboriginal and Torres Strait Islander patients identified on their clinical information system. Among these Health Services, a much higher proportion (26/28) provided data on the smoking status of their patients than in previous evaluation periods.

For those AHSSs and General Practices that provided clinical indicator data on smoking status, 51% and 72% of patients respectively had smoking status recorded (Table 3.4). Among the sub-set of patients with diabetes, 77% of AHSS patients and 82% of GP patients had smoking status recorded. Rates of ‘current smoking’ reported for patients of both sectors combined were around 35%. This is higher than for the Health Services that provided data for the fourth evaluation period, where the corresponding figure was 30%. This difference is likely to be due to the additional services providing relevant data for the final evaluation period, and the difference in recorded smoking status between these services and those that provided relevant data for the fourth evaluation period. These differences, and the wide variation between both AHSSs and General Practices in the recording of smoking status and the proportion of patients identified as smokers, highlight the sensitivity of these clinical indicator data to
changes in the range of services that provide relevant data. In the fourth evaluation period, limitations of these data as a result of under-documentation of smoking status were highlighted. Although this continues to be a limitation, the extent of under-documentation is considerably less.

The limitations of currently available clinical indicator data for monitoring smoking rates are also highlighted by the difference between the rates reported through these clinical information systems on smoking rates among the general Aboriginal and Torres Strait Islander population of close to 50%. The reported rates through the clinical indicator data are nevertheless considerably higher than reported rates for the general Australian population of around 15%.

Encouraging primary health care services to improve the accuracy and completeness of recording smoking status could be a useful focus for the Regional Tackling Smoking and Healthy Lifestyle teams to encourage appropriate targeting, delivery and monitoring of smoking cessation – such as brief interventions and broader tobacco control activities.

**Table 3.4: Clinical indicators provided by Health Services for Aboriginal and Torres Strait Islander people**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>AHS Mean</th>
<th>AHS n</th>
<th>AHS Min</th>
<th>AHS Max</th>
<th>GP Mean</th>
<th>GP n</th>
<th>GP Min</th>
<th>GP Max</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proportion of all patients who have had their smoking status recorded in the past 12 months</td>
<td>51.3%</td>
<td>10</td>
<td>15.0%</td>
<td>91.1%</td>
<td>71.8%</td>
<td>16</td>
<td>33.8%</td>
<td>96.1%</td>
</tr>
<tr>
<td>Proportion of all patients who have had their smoking status recorded in the past 12 months and are recorded as ‘smoker’</td>
<td>30.7%</td>
<td>5</td>
<td>9.6%</td>
<td>51.5%</td>
<td>32.2%</td>
<td>16</td>
<td>13.4%</td>
<td>54.8%</td>
</tr>
<tr>
<td>Proportion of patients with type 2 diabetes who have had their smoking status recorded in the past 12 months</td>
<td>76.8%</td>
<td>3</td>
<td>50.0%</td>
<td>91.9%</td>
<td>82.1%</td>
<td>16</td>
<td>0.0%</td>
<td>100.0%</td>
</tr>
<tr>
<td>Proportion of patients with type 2 diabetes who have had their smoking status recorded in the past 12 months and are recorded as ‘smoker’</td>
<td>30.4%</td>
<td>3</td>
<td>21.6%</td>
<td>35.1%</td>
<td>28.2%</td>
<td>16</td>
<td>0.0%</td>
<td>66.7%</td>
</tr>
</tbody>
</table>

Note: n = number of services.

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3.3.10. Enablers and constraints to effective implementation

**KEY POINTS**

- Dedicated workforce with team structures and strategic focus required for implementation and was enabled by high-level flexibility for local adaptation and a feeling of being a ‘collective’ workforce. Organisations needed to have the values and capacity to provide support and ability to tailor the workforce structure and focus of work to meet local context imperatives.

- Workers were more effective when they had existing connections or ability to develop connections with the community, access to training and professional development, good working relationships with staff within the organisation and across other service providers, and willingness to work outside normal working hours (to support Healthy Community Day events).

- Pre-existing skills of individual workers helped to activate measure implementation, but could operate as constraints when coupled with competing demand for their skills (e.g., for the clinical skills of AHWs recruited to teams where host organisations had high clinical workloads).

- Generally, a history of health promotion activities (including workers and programs or services) meant that organisations were better positioned to implement the measures at a site level, while a perceived lack of organisation and/or sector role in health promotion limited engagement with A1 and/or A2 measure activities.

- Improved health promotion capacity of the general primary health care workforce supported implementation of these measures and was activated by collaborative activity between clinical and Regional Tackling Smoking and Healthy Lifestyle teams.

- Community demand for more follow-up support indicated a need for greater integration of smoking cessation services with evidence-based behaviour change programs.

- Health Service system constraints in documenting and monitoring brief intervention and smoking status had implications for identifying ‘target’ groups and monitoring effectiveness of community-based activities.

- Enabling linkages that emerged were joint training and networking opportunities for ICDP workers, and development of multidisciplinary team approaches to chronic disease self-management, that involved Regional Tackling Smoking and Healthy Lifestyle workers.

- Constraints to complementary linkages included the wide range of initiatives, stakeholders and service providers in local areas, lack of collaboration between sectors and/or organisations and lack of awareness or clear role definitions for different workers. Vast geographic distances and large service populations were also constraining factors.

Effective implementation of this measure would enable services to support a skilled and equipped workforce to deliver, enhance access and increase demand for evidence-based programs and services that reduce risk factors for chronic disease. This chapter has outlined a range of enablers and constraints that influenced the extent to which implementation could be achieved at a local level.

The main mechanisms through which this measure appeared to achieve change are described below, and shown in the central boxes in Figure 3.4. Enablers and constraints related to each of the main mechanisms are shown in Figures 3.5–3.9, and described in the accompanying text.
Figure 3.4: Enablers and constraints to effective implementation of the National Action to Reduce Aboriginal and Torres Strait Islander Smoking Rates and Helping Indigenous People Reduce their Risk of Chronic Disease measures

**Dedicated workforce with team structures and strategic focus**

The establishment (i.e., recruitment and retention) of a dedicated workforce with team structures and strategic focus was an important mechanism through which Measures A1 and A2 could achieve the aim of designing and delivering a range of programs and services to reduce risk factors for chronic disease in Aboriginal and Torres Strait Islander communities. In the Sentinel Sites, it was apparent that establishment of this workforce was influenced by a number of factors. Key factors were the way the measures were implemented; the ability of the host organisations to integrate the new workforce; and the characteristics of the individual workers. The key enablers and constraints for the mechanism ‘Dedicated workforce with team structures and strategic focus’ are summarised in Figure 3.5.
Figure 3.5: Enablers and constraints to achievement of dedicated workforce with team structures and strategic focus

Since the A1 and A2 Measures included a significant and new investment in positions and a plan to deploy these positions in regional teams, the collective capacity of workers in these teams would be expected to be a key factor in influencing the design and delivery of local programs and services, and indeed this was evident in the Sentinel Sites. In host organisations with an established Regional Tackling Smoking and Healthy Lifestyle team (i.e., individual workers recruited to allocated positions), as envisaged in the design of the measure, there was greater likelihood that these teams were able to design and deliver a broader range of smoking cessation and healthy lifestyle programs and services and subsequently offer more support for the local targeted population when compared with host organisations with less collective capacity (i.e., not all Tackling Smoking and Healthy Lifestyle positions filled).

Flexibility in program implementation at a high level was also an enabler for establishing a dedicated workforce. Funding and policy changes at a national level enabled workers with similar roles to form teams. The appointment of Dr Tom Calma, as the National Coordinator - Tackling Indigenous Smoking was associated with positive effect. Dr Calma played a key role in promoting the national agenda while influencing the establishment of site level workers, particularly the Tackling Smoking workforce. He created a feeling among workers of being part of something greater – a ‘collective’ workforce. While position descriptions for the new workforce – RTC, TAW, HLW – were prescribed at the national level, there was some scope for adaptation. This enabled host organisations to negotiate modifications to roles and selection criteria with DoHA to suit local contexts.

Factors related to the characteristics of the individual workers also enabled the establishment of this new workforce. These included existing connections or ability to develop connections with the community (often in relation to Aboriginal and Torres Strait Islander people’s identity and cultural obligations) and the ability to tailor the focus of work and/or the approach to deploying workers in order to meet community needs and/or local context imperatives. Individual worker capacity was often enhanced through access to training and professional development (see related mechanism below). Other enablers associated with establishing the new workforce included prior and good working relationships with staff within the organisation and across other service providers (see mechanism related to complementary linkages described below), and a willingness to work outside normal working hours (for example, on weekends to support Healthy Community Day Events).
Pre-existing skills of individual workers was a factor that activated the mechanism. For example, some clinically qualified workers recruited from within host organisations or from a predominately clinical role (e.g., AHWs; allied health professionals) experienced difficulty engaging in Tackling Smoking or Healthy Lifestyle team roles because of two factors. This was particular an issue in settings where high clinical workloads within host organisations placed ongoing demands on their clinical skills. Lack of full engagement could also be influenced by limitations in health promotion knowledge and skills. To some extent, training and professional development opportunities were able to counter limitations in worker skills and knowledge, but where organisational structures and support were lacking, including, for example, local orientation processes; this appeared to be a constraint to the effective implementation of community-based smoking and healthy lifestyle activities (see discussion related to organisational environments below).

A dedicated Tackling Smoking and Healthy Lifestyle team with a strategic focus was difficult to achieve in contexts where there were limited numbers of suitably qualified/or eligible individuals who were interested in these positions; large geographic areas and/or large service populations; unsuitable people recruited to positions or where individual workers operate in silos. To some extent, where such factors impacted significantly, the flexibility in the measure design and program implementation enabled host organisations to overcome these barriers, for example, adaptations to position descriptions and recruitment processes to suit local circumstances and further funding for additional workers (i.e., Tobacco Action Workers) in the last three evaluation periods. It was evident that certain organisational environments were not only more likely to activate a dedicated workforce with team structures and strategic focus, but also, organisational environments with values and capacity to provide support needed to be operating at a site level for the workforce to effectively design and develop the programs and services as envisaged in the program design.

**Organisational environment with values and capacity to provide support**

Even when generous funding was made available, particular characteristics of host organisations were important influences on the extent to which the new and existing workers could effectively engage in, and deliver A1 and A2 measure activities at a local level. The new Regional Tackling Smoking and Healthy Lifestyle workers needed to design and implement new initiatives as well as work in partnership with communities and local service providers and to build on existing programs and services. At an organisational level, this required a clear vision of how the measures, including the new workforce, should work and a strategic approach to training, learning and development to achieve a workforce capable of designing and delivering tobacco and healthy lifestyle initiatives based on best available evidence. The key enablers and constraints for the mechanism ‘Organisational environment with values and capacity to provide support’ are summarised in Figure 3.6.
Figure 3.6: Enablers and constraints to achievement of organisational environment with values and capacity to provide support

For many host organisations, the organisational development dimension of integrating a non-clinical workforce (Regional Tackling Smoking and Healthy Lifestyle team) into a predominately clinical environment was challenging. It was evident that in organisations with strong leadership coupled with effective corporate management including the ability to establish structures and processes were more likely to facilitate workers to engage in A1 and A2 activities using team approaches. These structures and processes fostered more support for individual workers and validated their role within the broader function of the organisation. Supportive organisational environments, where health promotion is valued by people at different levels in the organisation, emerged as an important enabler for worker retention, satisfaction and facilitated a shared understanding of roles within teams and across the organisation. This also often resulted in more well-developed programs of work. By contrast, in organisations without clear direction and leadership, or structures that promote collaboration with only a few (or one) and often marginalised Tackling Smoking and Healthy Lifestyle workers, staff expressed feelings of isolation and a lack of direction for their day-to-day role, thereby limiting their capacity to design and deliver new initiatives.

Generally, a history of health promotion activities (including workers and programs or services) meant that organisations were better positioned to implement the measures at a site level. This is well demonstrated both by the regional support organisation in an urban site and where existing workers and/or programs continued (due to availability of funding through these measures) after alternative funding came to an end. A perceived lack of an organisational and/or sectoral role in health promotion, led to limited engagement with A1 and/or A2 measure activities.

Capability of the new health promotion workforce

The capability of the new health promotion workforce was identified as a key mechanism through which these measures were able to achieve change at a local level. Dedicated funding for a program of learning and development enabled new workers to develop a range of relevant knowledge and skills and to access resources (i.e., funding and tools to support practice. This gave the workforce the necessary capacity to design and deliver local community-based activities. The key enablers and constraints for the mechanism ‘Capability of the new health promotion workforce’ are summarised in Figure 3.7.
Figure 3.7: Enablers and constraints to achievement of capability of the new health promotion workforce

Organisations with commitment to, and leadership in, creating an environment conducive to workforce learning and development were more likely to improve the capability of the new health promotion workforce. In these organisations, there was greater capacity to determine worker training needs, arrange access to workforce development (including on-the-job and networking opportunities), and provide practical support for new staff through planned supervision, team-based approaches to learning which was facilitated by worker co-location.

As already highlighted (above), pre-existing staff competency was a significant factor that activated this mechanism – this was most evident when workers with prior health promotion experience and/or professional training were recruited to Regional Tackling Smoking and Healthy Lifestyle worker roles and where individual workers were intrinsically motivated and committed to community-based work.

Some factors that enabled the new positions to respond to local needs simultaneously constrained the capability of the new workforce to work effectively. Local modifications to the roles of Regional Tackling Smoking and Healthy Lifestyle workers resulted in differing expectations, confusion and lack of clarity of workers roles. Without a clear and shared understanding of worker roles, partnerships with other health professionals and local service providers were also difficult to establish. Additionally, a program of learning and development that was relevant and accessible for individual workers was more challenging to achieve (for example, where roles of OW and HLW were combined).

Despite a range of system-wide resources made available to support the RTC, TAW and HLW workforce, their introduction, in September 2011, was well after orientation and role establishment for many of these workers. This impacted on workforce capability. During the final two evaluation rounds a number of people in these roles were still not aware of the online resources or had not utilised them, on occasions because of the timing of publication, but more frequently because workers were uncertain how best to use them for planning community health promotion activities.

**Improved health promotion capacity of the general primary health care workforce**

The A1 and A2 measure components had the potential not only to increase capacity of organisations by increasing the number of positions and developing the knowledge and skills of a new workforce, but also through improving health promotion capacity among the existing health workforce. While this is an
important mechanism that needs to be operating to support Aboriginal and Torres Strait Islander people in their attempts to quit smoking and to adopt healthy lifestyles, at this early stage of implementation there were few examples where this mechanism was being successfully activated across the Sentinel Sites. The key enablers and constraints for the mechanism ‘Health promotion capacity of the general primary health care workforce’ are summarised in Figure 3.8.

Figure 3.8: Enablers and constraints to achievement of health promotion capacity of the general primary health care workforce

Where there was collaborative activity between clinical and Regional Tackling Smoking and Healthy Lifestyle teams, this mechanism was more likely to be activated. Clinicians needed to be aware and also see the potential benefit of services and health promotion programs for improving client outcomes. Collaboration was evident in sites where health checks were incorporated in Healthy Community Day events and where clinicians perceived the workers in these positions as credible (for example, a HLW was also an accredited dietitian). Clinicians also valued the availability of NRT on PBS for improving their capacity to provide support to clients. However, community demand for more follow-up support indicated a need for greater integration of smoking cessation services (such as NRT and brief intervention) with evidence-based behaviour change programs (see complementary linkages).

It was evident that there were also Health Service system constraints to activating this mechanism. Systems for documenting and monitoring brief intervention and smoking status were clearly lacking in Health Services’ clinical information systems. This lack of documentation has implications for identifying ‘target’ groups and monitoring effectiveness of community-based activities.

Complementary linkages with ICDP funded and other activities and services

Responsive program leadership at a high level was a key enabler to activating complementary linkages with ICDP funded and other activities and services. This was evident through policy changes at a national level related to combining Measures A1 and A2 (establishing Regional Tackling Smoking and Healthy Lifestyle teams) and later in the evaluation, incorporating the Healthy Community Day events element of A3 measure. Collectively, this provided a comprehensive, system wide approach to increasing awareness and reducing risk factors for chronic disease. The key enablers and constraints for the mechanism ‘Complementary linkages with ICDP funded and other activities and services’ are summarised in Figure 3.9.
### Constraints
- Lack of awareness of workers
- Lack of awareness of existing services and programs
- Unrealistic expectations of role and coverage
- Lack of understanding of ICDP as a package — across various levels of the health system

### Mechanism
Complementary linkages with ICDP funded and other activities and services

### Enablers
- Joint networking and training opportunities
- Awareness of local context and existing services and programs

#### Figure 3.9: Enablers and constraints to achievement of complementary linkages with ICDP funded and other activities and services

While the risk factor reduction measures (A measures) did not include any activities that were directly targeting linkages with chronic disease prevention and management measures (B measures) or workforce expansion and support (C measures), some linkages between different ICDP measures did emerge. For example, ICDP workers jointly attended training and networking opportunities or attended training that had not been intended by the measure design (for example, Regional Tackling Smoking and Healthy Lifestyle workers participate in OW orientation). There were also examples of more systemic changes, such as developing multidisciplinary team approaches to chronic disease self-management, that involved Regional Tackling Smoking and Healthy Lifestyle workers (see Chapter 9). Where these occurred, this was an enabler for developing linkages between different components of the ICDP.

A particular challenge to programs implemented under this measure is how to work in a complementary way with the range of initiatives underway and the range of stakeholders and service providers in the local area. This mechanism was more likely to be activated in contexts where there were opportunities to showcase work (for example, the Live Longer! conference) and where there was a prior history of working together (for example, where funding was used for the continuation of existing programs).

The common constraints identified for complementarity with ICDP funded and other activities and services included a lack of collaboration between sectors and/or organisations and a lack of awareness or clear role definitions for different workers. This made teamwork and partnerships more difficult. Vast geographic distances and large service populations was also a constraint to activating this mechanism because workers had to prioritise programs of work to certain areas and/or population groups.

### 3.4. Summary and conclusions

This section consists of three parts. The first describes the key findings of the Sentinel Sites Evaluation in relation to the outputs and results specified in the National Framework program logic (Table 3.5). This section is fundamental to understanding progress with implementation in relation to the original planning and design of the ICDP and, therefore, to meeting the objectives of the SSE. The second provides a more general concise summary of key findings of the SSE, and the third identifies key policy considerations emerging from the SSE findings.


3.4.1. **Key findings in relation to the program logic**

The table below describes the key findings of the SSE in relation to the outputs and results specified in the National Framework program logic.

*Table 3.5: Summary of key findings in relation to the program logic – National Action to Reduce Aboriginal and Torres Strait Islander Smoking Rates and Helping Indigenous People Reduce their Risk of Chronic Disease measures*

<table>
<thead>
<tr>
<th>Time frame</th>
<th>Expected outputs</th>
<th>Summary of key findings from SSE</th>
</tr>
</thead>
</table>
| **Outputs for year 1 and beyond** | RTCs and TAWs are recruited.  
HLW positions are filled.  
Training is well received and well regarded.  
HLW are equipped for roles through training.  
Design and delivery of enhanced or new smoking cessation services, programs and communication activities.  
Participation in Measure A2 activities is high.  | Recruitment to RTC, TAW and HLW positions has generally progressed well. There has been a progressive increase in the number of funded positions over the course of the evaluation, with a particularly marked increase in the number of TAW positions. Where there are vacant positions this is generally because newly allocated positions are yet to be filled. There are a small number of sites that continue to experience difficulty with recruitment to these positions. Some services had overcome difficulties with recruitment by adapting positions to suit local circumstances.  
Perceptions of the training were generally positive, particularly with regard to the networking and information-sharing opportunities. There is a need for further work on clarifying the competencies required for these roles and enhancing access to training programs that address the specified competencies.  
High-level leadership and the development of regional teams have been a positive influence on program delivery and communication activities. A range of new resources have been developed and distributed. Awareness of the resources was variable and the extent to which the resources were meeting local needs was unclear. It appears that supporting the effective application of available resources by local teams is now a greater priority than the development of new resources. There is a lack of information on levels of participation (or population coverage) in relation to these measures, specifically including the extent to which programs are reaching those most in need. More importantly, there is a lack of information and of systems for monitoring, evaluating and enhancing the quality of programs being implemented at the local or regional level. It is clear that the large geographic areas and/or the large size of populations to be covered by the teams is a major constraint on achieving high levels of community participation in program activities. In addition to the need to enhance participation through continuing to build the new workforce, supporting grassroots community developments and enhancing synergies with other complementary programs is likely to encourage community participation. |
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<tr>
<th>Time frame</th>
<th>Expected outputs</th>
<th>Summary of key findings from SSE</th>
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<tr>
<td>Expected early results for years 2–4</td>
<td>Better access to smoking cessation resources, services and materials for health professionals. Primary health care services involved in A2 are able to offer more support for Aboriginal and Torres Strait Islander people with or at risk of chronic disease.</td>
<td>Following the early evaluation cycles where teams were still being established, more recent evaluation cycles indicate that a range of activities are being supported and delivered at the local level, including brief interventions, support for access to Quitline, provision of information on NRT, social marketing and health education and skill development. There is a continuing need to enhance availability of locally relevant counselling services particularly where telephone support does not meet local needs. There is a strong indication that the new teams have been a positive influence on the implementation of smoke-free workplaces (particularly in the AHS sector), although high levels of smoking among staff and board members continues to present a challenge to effective implementation. There is some evidence that services are actively supporting smoking cessation efforts among staff.</td>
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<tr>
<td>Research, monitoring and evaluation are being used to inform future smoking cessation communication activities and program development.</td>
<td>Monitoring and evaluation processes show an emphasis on reporting on contractual requirements with limited attention to monitoring and reporting quality of health promotion activities. There is also limited evidence of effective support or use of systems that enhance both the quality of health promotion as well as the quality of reporting. Providing reports that demonstrate compliance with contractual requirements do not necessarily provide meaningful information that can be used for the purpose of informing future activities and programs and/or evidence-based strategic planning, monitoring and evaluation at the local health service or regional level. Furthermore, the potential of health service clinical information systems to provide meaningful data on smoking status and trends is constrained by the patchy state of clinical information systems, lack of staff capability to use data for population health purposes and lack of systems to provide data at a regional level.</td>
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<td>Participating services are smoke-free workplaces or implementing smoke-free policies.</td>
<td>See above.</td>
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<tr>
<td>Time frame</td>
<td>Expected outputs</td>
<td>Summary of key findings from SSE</td>
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<td>Individuals and communities in contact with measure A1 are more aware of health risks associated with smoking, of resources available to help them quit or cut back and more inclined to seek assistance as part of quit attempts.</td>
<td>There appeared to be a high level of awareness of risk factors among community members, which predated the ICDP. In the final evaluation cycle clinicians indicated an increased interest from Aboriginal and Torres Strait Islander people seeking support to quit smoking. Individual motivation and broader structural barriers were highlighted as constraining efforts to quit, indicating the need for a broad social determinants approach that reduces structural barriers and enhances self-efficacy.</td>
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<td>Participants in Measure A2 activities have an improved understanding of their risk of developing chronic disease and what having a chronic disease would mean.</td>
<td>There are clear indications that the measure is having a positive impact on the capacity of the health workforce to promote smoking cessation among Aboriginal and Torres Strait Islander people, and to provide increased options and tailored support in the prevention and management of chronic conditions. However, there is a need to enhance the potential for adaptation to meet local community needs and to enhance community engagement.</td>
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<td>Expected medium-term results for years 4+</td>
<td>The health workforce is better informed and resourced to promote smoking cessation among Aboriginal and Torres Strait Islander people. Health Services are better able to provide increased options and tailored support for Aboriginal and Torres Strait Islander people with or at risk of chronic disease seeking to improve or manage their condition. Demand for Aboriginal and Torres Strait Islander specific smoking cessation programs and support services is strong. Increased participation in health lifestyle activities and positive changes towards healthy lifestyle behaviours among Aboriginal and Torres Strait Islander people.</td>
<td>As indicated above, in the final evaluation cycle clinicians reported an increased interest in seeking support to quit smoking by Aboriginal and Torres Strait Islander people. By comparison, clinicians indicated a lower level of interest in seeking support to implement healthy lifestyle choices in the early evaluation cycles. This increased in the third evaluation cycle but does not show any further increase in the most recent cycles. These data are based on a small number of interviews, and there are no established systems to monitor indicators of this type on a broader scale or over the longer term.</td>
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### 3.4.2. Key findings

This section provides a summary of the key findings in relation to the National Action to Reduce Indigenous Smoking Rates and Helping Indigenous People Reduce their Risk of Chronic Disease measures.

**Progress with recruitment and position adaptations**

Expansion of the tobacco and healthy lifestyle workforce has generally progressed well, with Regional Tackling Smoking and Healthy Lifestyle teams established across most Sentinel Sites. The vast majority of positions were allocated to AHSs.

Some local adaptations were made to the measure design to facilitate recruitment to positions, for example, recruitment to RTC before recruiting to other positions and amendments to position descriptions to meet local context imperatives.

**Skilled and equipped tobacco and healthy lifestyle workforce**

There was a high level of engagement in various training activities throughout the Regional Tackling Smoking and Healthy Lifestyle teams and this appeared to be facilitated by the dedicated funding made available to host organisations. Where it had been accessed training was generally valued by interviewees.

A relatively small number of workers accessed and participated in brief intervention training. This made it difficult to gauge the extent to which the training provided the necessary skills for workers to fulfil their roles.

There has also been considerable activity in developing and distributing toolkits and resources to support the workforce in their roles. Awareness of the resources was variable and the extent to which the resources were meeting local needs was unclear.

The important influence of high-level support for individual workers became evident in the later evaluation cycles.

**Design and delivery of tobacco control and healthy lifestyle programs and services**

Design and delivery of programs and services gained momentum over the course of the evaluation. The program of work delivered by teams varied across sites and included individual client support, health education and community campaigns, and implementation of smoke-free workplace policies. It was not possible to ascertain the quality or effectiveness of these initiatives, including the degree to which they integrated evidence-based principles.
The range of tobacco control and healthy lifestyle initiatives implemented at a local level made it difficult for interviewees and community focus group participants to tease out whether the initiatives they were aware of were funded and delivered through ICDP or another program.

The length of time in positions, the skills and experiences of individual workers, workforce leadership and support (including adequate supervision), and the availability and accessibility of locally relevant tools resources and training greatly influenced workers’ effectiveness in being able to design and deliver programs and services. Small numbers of positions, long distances and large service populations also impacted on the effectiveness of the workforce.

**Awareness of the Tackling Smoking and Healthy Lifestyle workforce**

There has been a growing awareness of the Tackling Smoking and Healthy Lifestyle positions overall, with greater awareness in urban and remote sites than in regional sites. However, there continued to be limited awareness of these positions, particularly among General Practice staff. Some confusion emerged as to areas of program responsibility, service delivery and links with the State-based workforce.

These patterns of awareness were consistent with recruitment progress, the challenge of achieving high population coverage, the focus of work for these teams and increasing knowledge of the ICDP more generally across sites.

**Better access to resources to support smoking cessation and healthy lifestyle activities in Health Services**

Regional Tackling Smoking and Healthy Lifestyle teams have had a limited role in increasing access to smoking cessation and healthy lifestyle resources in General Practices, with most work focused in AHSs. This appears to be related to a lack of awareness of the roles (including their intended scope or responsibilities more generally), limited communication and/or collaborative working relationships, a lack of capacity to engage with clinicians, and limited capacity for working across large geographic regions or populations owing to high workload in the AHSs.

There was generally little evidence of linkages between Regional Tackling Smoking and Healthy Lifestyle teams and clinical teams, with Healthy Community Day events identified as an opportunity to improve links between the two.

**Better access to smoking cessation and healthy lifestyle resources for communities**

Generally, there were high levels of community awareness of the workforce, social marketing initiatives and some smoking cessation services including Quitline and NRT. A range of community-level activities were evident, including social marketing events, group work and one-to-one support for motivated clients. These activities take place in the context of other pre-existing tobacco control and healthy lifestyle initiatives at both State and national levels.

The need for greater face-to-face and practical follow-up support for smoking cessation emerged. Although awareness of NRT availability and Quitline was high among community members, and a small but general upward trend in NRT prescriptions was observed, there was a lack of support programs and follow-up services. Some activities involved linkages or brokerage between clients and other resources, for example, the Regional Tackling Smoking team calling Quitline on behalf of clients who experience barriers to doing it themselves.
Community awareness, understanding, health seeking behaviours and smoking status

Awareness of risk factors for chronic disease among community focus group participants was high prior to ICDP implementation.

There has been an increasing trend over the course of the evaluation in perceived changes in client behaviour towards healthier lifestyles, as reflected in clinicians’ responses. Self-motivation was consistently noted as key for people to quit smoking and adopt healthier lifestyles.

At Health Service level, there was a notable lack of recording and monitoring of smoking status in clinical information systems, with implications for identifying ‘target’ groups and monitoring the effectiveness of community-based activities.

3.5. Policy considerations

This section identifies key policy considerations emerging from the SSE findings:

a) Continue working with Health Services to create and/or strengthen supportive workplace environments to host teams of Regional Tobacco Coordinators, Tackling Smoking and Healthy Lifestyle workers. Provide support to establish good team structures, including suitable supervisory arrangements and articulating roles and responsibilities among team members, and develop a strategic focus of work that meets local context imperatives and skill sets of individual workers.

b) Provide support to Health Services to plan, implement, evaluate, document and share findings of successful (and lessons from) tobacco control and healthy lifestyle programs and services. This could be achieved by encouraging Health Services to use health promotion quality improvement tools that include assessment of systems to support best practice. Support development of resources to assist Health Services in strengthening systems for health promotion, aligned with quality improvement processes and including support to meet staff training needs identified through these processes.

c) Continue a funding program to support training and programs of learning and development for this workforce. Work with stakeholders in each jurisdiction to ensure the roles of the Regional Tackling Smoking and Healthy Lifestyle teams are clarified and align with recognised health promotion competencies. Further work is needed to enhance access to training programs that address these specified competencies.

d) Consider increasing investment in evidence-based initiatives that improve self-motivation and quit attempts. Strategies that have been effective in de-normalising smoking include broad social marketing campaigns (not health education), reduction of tobacco industry marketing (e.g., plain packaging and banning retail displays) and smoke-free promotion of spaces and events (e.g., smoke-free workplaces). Smoke-free laws, taxes and price increases (including the promotion of such) are also effective means for changing social norms.

e) Consider strengthening systems that support greater integration of clinical services with evidence-based behaviour change programs at a local level. Support development of partnerships between clinical Health Services, the Regional Tackling Smoking and Healthy Lifestyle teams and community-based organisations and health promotion organisations. Ensure community members have better access to a range of services and are supported and enabled in their efforts to lead healthier
lifestyles and manage their chronic disease more effectively. Better systems for capturing smoking behaviours (including smoking status and consumption), brief interventions and community-based initiatives are important for monitoring progress and informing development of future activities at national, regional and local levels.