THE TOBACCO CONTROL GUIDE

The tobacco control guide is based on research evidence and consultations with health providers in NT. It will assist NT health services to make achievable improvements in tobacco control and smoking prevalence. Improved tobacco control will reduce Aboriginal adult smoking from 50% in the Northern Territory and reduce the harm smoking causes to communities and families.

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

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

Key elements of the tobacco control guide

NORTHERN TERRITORY GOVERNMENT

Aboriginal Health Forum

AMSANT

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THE THREE MOST EFFECTIVE AREAS OF TOBACCO CONTROL ACTIVITIES FOR ALL NT HEALTH SERVICES

1. MARKETING AND MESSAGING

a. How can we best spread these messages?

i. Using local Aboriginal people to have these discussions and to share these messages, e.g. tobacco action workers, AOD workers, local champions who have successfully quit

ii. Talking with groups of community members, households

iii. Use props/resources when talking with community members (e.g. carbon monoxide monitors, such as the Smokerlyser)

iv. Posters

v. Social media

vi. Community events

vii. Make sure that with a combination of media and approaches you reach as many people as possible with enough intensity to change behaviour.

b. What messages should we include in this marketing?

i. Messages created by and featuring local Aboriginal people, information and images where possible, but also messages featuring other Aboriginal people

ii. Non-Aboriginal messages, especially messages selected as locally relevant by local Aboriginal people

iii. Clear, unambiguous messages with new information, but also those which reinforce established messages (avoid humorous messages as they are often ambiguous and don't work)

iv. Strengths-based messages that emphasise that quitting is achievable as well as confronting messages about the harms caused by smoking

v. Messages about cost and protecting the health of others (e.g. from second-hand smoke) as well as messages about the harms caused by smoking

vi. Messages that confront the false myths

vii. All messages refer people to the clinic for individual cessation support

2. SMOKE-FREE SPACES TO PROTECT OTHERS FROM SECOND-HAND SMOKE

a. Where?

i. Health service

ii. School

iii. Store

iv. Community events

v. Ovals, courts and sporting facilities

vi. Other local organisations and meeting places

vii. Homes

viii. Cars

THE THREE MOST EFFECTIVE AREAS OF TOBACCO CONTROL ACTIVITIES FOR ALL NT HEALTH SERVICES

b. How?

i. Help organisations and families establish smoke-free rules or policies

ii. Keep helping organisations and families maintain or improve smoke-free rules or policies

iii. Provide marketing and materials (e.g signs) to support smoke-free rules or policies

iv. Employ local Aboriginal people to talk with local organisations and families

3. TOBACCO CONTROL AS PART OF ROUTINE CLINICAL CARE

a. Provide consistent individual cessation support for smokers

i. Ask and provide brief advice to quit to all smokers at every clinical consultation, not just at health checks or for presentations most obviously linked to smoking or when raised by patient

ii. Ensure medicines to assist cessation (at minimum: varenicline, NRT patches and gum) are available and offered

iii. Ensure all clinical staff understand clear pathways for follow-up or referral to support smokers to sustain quit attempts

b. Provide consistent individual cessation support for all pregnant women

c. Protect children from second-hand smoke

i. Advise parents and carers to quit and to establish a smoke-free home and car

ii. Advise smokers to protect children from their second-hand smoke

d. Training

i. Ensure all clinical staff are trained to provide brief advice (e.g. by Cancer Council South Australia's Quitskills program).

Principles to increase the impact of all tobacco control activities

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

Confront the false myths about tobacco control during all tobacco activities

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

1. **True**: 'Mental health and well-being improves after successfully quitting smoking'. **It is not true** that 'Smoking helps with managing stress'.
2. **True**: 'We are seeing real improvements in smoking, e.g. fewer kids taking it up'. Identify local champions who have successfully quit. **It is not true that** 'Nothing is working' or 'no one has quit'.
3. **True**: 'More than a third of all Aboriginal deaths are due to smoking'. **It is not true** that 'Smoking is a low priority compared to other health issues and diseases'.
4. **True**: 'Smokers expect clinicians to talk about quitting smoking'. **It is not true** that 'Asking about smoking not culturally appropriate' or 'asking about smoking undermines the clinical relationship'.