

**TOBACCO SMOKING CESSATION SUPPORT  
FRAMEWORK**

The Northern Territory Department of Health and Families

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## INTRODUCTION FROM THE EXECUTIVE DIRECTOR

National smoking rates have been steadily decreasing since the advent of the Quit message in the late 1980s and are continuing to do so. This trend has been reflected in the overall Northern Territory smoking rates, however the rate of smoking in the Northern Territory of 28 percent<sup>i</sup> is still much higher than the National average, which is now below 18 per cent<sup>ii</sup>. The rate of smoking amongst Aboriginal peoples is even higher than the Northern Territory average, estimated at over 52 percent for people 18 years and over during 2004/05<sup>iii</sup>.

Tobacco smoking increases the risk of cancers, cardiovascular and respiratory diseases and other illnesses. It is the greatest single risk factor for health and has been estimated to cause 10 per cent of the total Australian burden of disease<sup>iv</sup>; 12.5 per cent for Aboriginal Australians<sup>v</sup>. In the Northern Territory between 1986-1995, nearly 20 per cent of adult deaths have been directly attributed to smoking<sup>vi</sup>. The health risks from smoking occur not just for smokers, but also for those who are exposed to the environmental tobacco smoke that they and their cigarettes emit. "Scientific evidence has firmly established that there is no safe level of exposure to [Environmental Tobacco Smoke]"<sup>vii</sup>.

The Department of Health and Families (DHF) has developed the Tobacco Smoking Cessation Framework and related documents to present a consistent approach to tobacco cessation across the Department by providing tobacco cessation guidelines to clinicians, allied health, community support, managers, policy officers and other Departmental staff in acute and community settings.

The Framework and supporting documents also support to the implementation of the DHF Smoke-free Policy and remind us that tobacco cessation is the responsibility of staff across the Department, from the acute sector to community based services.

This framework provides an overall picture and a comprehensive mix of best practice strategies for smoking cessation that are supported by the DHF. It is relevant to clinicians, nurses, and allied health professionals working with individuals through to those who work in smoking cessation at the population level. The Framework is supported by smoking cessation guidelines that expand on the Framework and clinical guidelines to guide medical, nursing and allied health staff in assisting individuals to quit.

It is expected that all medical, nursing and health staff in acute care settings and many community service staff will incorporate tobacco cessation into their practice.

Barbara Patterson  
Chief Health Officer  
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## **FRAMEWORK INTENT**

This framework outlines the smoking cessation support approach taken by the Northern Territory Department of Health and Families (DHF). It provides the strategic approach to cessation and the way it will be promoted and supported across the agency. It also provides specific guidance on smoking cessation support practice.

The purview of the Framework covers:

- cessation services and treatment;
- the promotion of Quit and smoke free messages;
- community support and education.

While recognising the importance of tobacco control, including legislation and regulation, along with the social, economic and cultural determinants of health, the Framework does not extend to these areas. It is recognised, however, that there is an interrelationship between cessation and these other areas and that they must be taken into consideration when developing tobacco cessation policy and programs.

## **SMOKING CESSATION SUPPORT FRAMEWORK PRINCIPLES**

Tackling smoking rates in the Northern Territory will take a substantial effort by all health personnel due to the Territory having the highest smoking rates in Australia (more than ten percent above the national smoking rate) and not having the economies of scale experienced by many of the Southern jurisdictions. This is exemplified by the diversity of cultural and socioeconomic mixes and a small population in a large geographic area.

Central to the Department's Smoking Cessation Support Framework is the integration of tobacco smoking cessation support into the practice of health professionals, including but not exclusive to, medical officers, nurses, and community workers and health promotion professionals. In this way individuals and populations can be targeted in a broad approach.

A sustained effort with significant resource investment across the DHF will be required to maintain a continuing decline in Northern Territory Smoking Rates. The DHF will provide smoking cessation support to Territorians across the life-span (see appendix A), both individually and to the population as a whole, using evidence based practice. There will be a systematic and targeted approach to providing cessation support, with an emphasis on strategic life events, for example during pregnancy, on diagnosis of cardiovascular disease or on admission to a mental health facility. It is recognised that many people are open to the quit smoking message during these life events and contact with the health system is an opportunity for health staff to sell the quit smoking message.

With this in mind, the Tobacco Smoking Cessation Support Framework subscribes to the following core principles:

## Department of Health and Families Core Principles for Smoking Cessation

- Smoking is not a free and informed choice.
- Substantial improvements in health outcomes for Aboriginal and Torres Strait Islander people can be achieved through smoking cessation.
- Quitting smoking has immediate and long-term health, quality of life and economic benefits for individuals and the community.
- A reduction in Northern Territory smoking rates requires a targeted approach across the life-span.
- Significant resource investment and a sustained effort is required to maintain a continuing decline in Northern Territory Smoking Rates.
- Smoking cessation support to individuals and communities is the responsibility of the health and community services sector.
- Department of Health and Families staff are well placed to provide cessation advice and interventions to smokers.
- To affect a decline in smoking rates, Department of Health and Families staff need to integrate tobacco smoking cessation practice into their general work activities.

Appendix B provides more detail on the individual principles.

### **BEST PRACTICE IN SMOKING CESSATION SUPPORT IN THE NORTHERN TERRITORY**

The DHF will provide individuals and the community with evidence based cessation support, as outlined by the World Health Organisation (WHO). The WHO publication *Policy recommendations for smoking cessation and treatment of tobacco dependence*<sup>viii</sup>, recommends that smoking cessation systems include:

1. A public health approach that seeks to change the social climate and promote a supportive environment;
2. A health systems approach that focuses on promoting and integrating clinical best practices (behavioural and pharmacological) which help tobacco-dependent consumers increase their chance of quitting successfully;
3. A surveillance, research and information approach that promotes the exchange of information and knowledge so as to increase awareness of the need to change social norms.

The DHF Smoking Cessation Support Framework has been developed within the context of the WHO recommendations and is one part of the DHF Tobacco Control agenda.

## **DHF TOBACCO SMOKING CESSATION SUPPORT FRAMEWORK**

The DHF Tobacco Smoking Cessation Support Framework is represented below in Figure 1. The elements of this diagram are expanded in the DHF *Tobacco Smoking Cessation Support Guidelines* and link in with the WHO *Policy recommendations for smoking cessation and treatment of tobacco dependence* and the Health Promotion Interventions Model. The components of the Framework are explained in more depth in a separate document, the DHF Tobacco Smoking Cessation Support Framework Guidelines. The DHF Smoking Cessation Support Framework Clinical Guidelines operationalises the individual support aspects of these documents.

Figure 1: DHF Tobacco Smoking Support Framework

# DHF Tobacco Smoking Cessation Support Framework

## Identify Tobacco Use

**Individual**  
Ask all DHF patients and clients\* their smoking status.

\* Where resources allow.  
\*\* Community development principles are to be used by community based teams working on a population basis. Please see the Guidelines for more information on community development.

**Population**  
Identify tobacco smoking cessation needs within the Northern Territory and target populations with high smoking rates.

## Increase Health Literacy

**Individual**

1. Practice brief intervention to provide advice to all smokers on the effect smoking has on them and the benefits of quitting.
2. Use *SmokeCheck* and or *Lets take a moment* flip chart for brief intervention with Aboriginal patients and clients.

**Population**

1. Target populations that have high smoking rates with information resources about the health effects of smoking\*.
2. Use a social marketing approach to raise awareness in individuals and the broader community about the health effects of smoking\*.
3. Capitalise on opportunities to include tobacco cessation advice in health promotion activities.
4. Use community\*\* development principles when raising awareness about the health effects of smoking at the community level.

## Provide Cessation Support

**Individual**

1. Practice brief intervention to deliver cessation advice.
2. Promote best practice cessation techniques to individuals and the community, including:
  - Pharmacotherapies such as Nicotine Replacement Therapy (NRT), Bupropion, Varenicline
  - NT Quitline
  - Quit Fresh Start courses
  - SmokeCheck for Aboriginal clients
  - Counselling, e.g. Cognitive Behaviour Therapy or Motivational Interviewing
3. Make referrals where appropriate.
4. Deliver low cost Quit Fresh Start Programs in the community\*.

**Population**

1. Promote low cost Quit Fresh Start Programs in the community\*.
2. Work with communities to develop supportive environments for smokers to quit, using a community development approach.
3. Tailor individual and community smoking cessation interventions to meet the needs of Aboriginal people.

## **FRAMEWORK FOR COMMUNITY BASED TOBACCO SMOKING CESSATION FOR ABORIGINAL PEOPLE**

Smoking rates for Aboriginal people are over 52 percent with some remote communities in the Northern Territory being reported to have up to 80 per cent of the population engaged in smoking. The high smoking rates, a sense of social isolation for non smokers along with other pressing social issues such as domestic violence, alcohol and other substance use can lead to difficulties for individuals and communities prioritising tobacco smoking cessation. Further, some Aboriginal Health Workers (AHWs) report feeling uncomfortable when delivering smoking brief interventions as they are worried about appearing to be moralising or interfering. They also report feeling uncomfortable when providing advice to community elders or non-family members.

Due to the complexities presented in many Aboriginal communities, the DHF recommends staff use

### **Talkin' Up Good Air: Australian Indigenous Tobacco Control Resource Kit**

as the framework for tobacco cessation in remote and urban based Aboriginal communities.

The indigenous tobacco control resource Talkin' Up Good Air: Australian Indigenous Tobacco Control Resource Kit, developed by the Centre for Excellence in Indigenous Tobacco Control is consistent with the DHF Smoking Cessation Framework. It provides a smoking cessation model that is more culturally appropriate to indigenous Australians than other cessation models and gives health workers direction in: understanding the health effect of smoking; smoking cessation processes; community development processes; and developing and implementing smoking cessation projects. It also provides resources and further references for health workers.

Many Aboriginal Health Workers have found that Smoke Check, a brief intervention, developed by the Queensland Government, aids in engaging with their client group about tobacco issues, countering some of the discomfort experienced. The use of Smoke Check as a brief intervention is consistent with the indigenous tobacco control resource, Talkin' Up Good Air.

## APPENDIX A

### A Life-span Approach to Smoking Cessation Support

<b>Lifespan</b>	<b>Emphasis</b>	<b>Intervention</b>
Prenatal	Limit or no exposure to nicotine in utero.	Screening through midwives, offer advice and referral to cessation
Infancy	Limit or no exposure to Environmental Tobacco Smoke (ETS).	Cessation advice to mothers (and other family members) and an emphasis on smoke free environments to help prevent Sudden Infant Death Syndrome (SIDS).
Childhood and adolescence	Limit or no exposure to ETS, promoting risks and effects of smoking through education, preventing uptake through preventing access through legislation and price controls.	Smoke free environments, school based education and opportunistic education and mass media campaigns. Legislation banning sales to minors, increased price through taxation.
Adulthood	Limit or no exposure to ETS. Screening and advice. Increasing emphasis on cessation services. Smoking bans and controls.	Mass media campaigns encouraging cessation, general health advice, screening and advice through GP's Hospital and adult health checks, Chronic Disease Care Plans, cessation services (Quitline, NRT)

## APPENDIX B

### SMOKING CESSATION SUPPORT FRAMEWORK PRINCIPLES

The core principles of the Tobacco Smoking Cessation Support Framework are:

- Smoking is not a free and informed choice.
- Substantial improvements in health outcomes for Aboriginal and Torres Strait Islander people can be achieved through smoking cessation.
- Quitting smoking has immediate and long-term health, quality of life and economic benefits for individuals and the community.
- A reduction in Northern Territory smoking rates requires a targeted approach across the life-span.
- Significant resource investment and a sustained effort is required to maintain a continuing decline in Northern Territory Smoking Rates
- Smoking cessation support to individuals and communities is the responsibility of the health and community services sector.
- Department of Health and Families staff are well placed to provide cessation advice and interventions to smokers.
- To affect a decline in smoking rates, Department of Health and Families staff need to integrate tobacco smoking cessation practice into their general work activities.

#### **Smoking is not a free and informed choice**

Of all current smokers in Australia, more than 90% began smoking as teenagers, most exhibiting dependence at an age they are not considered mature enough to vote, drive or purchase alcohol. Many smokers have only a cursory understanding of the effects smoking has on their health and on their quality of life. The addictive nature of tobacco products further compromises the consumer's ability to make an informed choice<sup>ix</sup>.

#### **Substantial improvements in health outcomes for Aboriginal and Torres Strait Islander people can be achieved through smoking cessation.**

Smoking represents an estimated 12% of the burden of disease for Aboriginal and Torres Strait Islander people<sup>x</sup>, and has substantial effects on reduced overall life expectancy as well as infant mortality, low birth weight and SIDS<sup>xi</sup>. In the Northern Territory, between 1989 and 1995, nearly 20% of adult deaths (15 years and over) and 3% of hospital admissions for people aged 15 years and older have been directly attributed to smoking<sup>xii</sup>.

Data from 2004/05 shows that more than half (55.9%) of the Aboriginal and Torres Strait Islander population aged 18 years and over in the NT were current smokers. This prevalence is 1.8 times the NT non-Indigenous and 2.6 times the national rate<sup>xiii</sup>.

Smoking cessation can have a major impact on closing the gap on Aboriginal and Torres Strait Islander disadvantage, and as such should represent a high priority for the Department of Health and Families.

**Quitting smoking has short, medium and long-term health, quality of life and economic benefits for individuals and the community.**

The health benefits of smoking cessation begin within twenty-four hours of quitting. This includes all the nicotine leaving the system and the levels of carbon monoxide in the blood drops allowing more oxygen in the bloodstream. Blood pressure returns to its normal level within a month and the risk of dying from heart disease is half that of a continuing smoker after 12 months, becoming almost the same as a person who has never smoked after 15 years<sup>xiv</sup>. And this is only a fraction of the story. Visit [www.quit.org.au](http://www.quit.org.au) for more information on the benefits to the individual from quitting.

A pack a day smoker can save up to \$5 000 per year. The savings to the community are also large in terms of costs to the health system (including smokers, babies born to smokers and those affected by environmental tobacco smoke) and cost to business (lost productivity through absenteeism and premature loss of highly experienced employees)<sup>xv</sup>.

**A reduction in Northern Territory smoking rates requires a targeted approach across the life-span.**

As with other health issues, it is useful for children and young people to learn about the harmful nature of smoking tobacco products, especially with over 90% of people beginning smoking prior in teenage years<sup>xvi</sup>. However cessation programs need to target adults, both to assist cessation in the adult population and to assist in cessation and prevention of smoking with young people. Programs aimed at the general population have been found to reduce smoking rates in young people as well as adults. Another indirect effect of adults quitting is that their children will be less likely to smoke than children of adults who smoke.<sup>xvii</sup>

Appendix A outlines the many opportunities for targeting smoking cessation throughout the lifespan that should be considered when developing programs or interacting with individuals.

**Significant resource investment and a sustained effort is required to maintain a continuing decline in Northern Territory Smoking Rates.**

A sustained, holistic approach to cessation is required to decrease tobacco use in any jurisdiction<sup>xviii</sup>. The DHF recognises this requirement and will continue to advocate for adequate resources, based upon an assessed level of need.

**Smoking cessation support to individuals and communities is the responsibility of the health and community services sector.**

The DHF acknowledges that health and community services professionals in the public, private and not-for-profit systems are well placed to provide cessation support to tobacco smokers who wish to quit. This support might take the form of a brief intervention by medical or nursing staff, referral to cessation services such as Quitline (137 848), or a community services agency conducting smoking cessation courses such as Quit Fresh Start.

**Department of Health and Families staff are well placed to provide cessation advice and interventions to smokers.**

The DHF is the main health care provider in the Northern Territory, coming in contact with many Territorians each day. While recognising that smoking cessation is the

responsibility of the whole health sector, the DHF will take a lead role in providing cessation advice and interventions to smokers.

**To affect a decline in smoking rates, Department of Health and Families staff need to integrate tobacco smoking cessation practice into their general work activities.**

To benefit the greatest number of people, the DHF recognises that smoking cessation needs to be integrated into the practice of staff across the Department.

## APPENDIX C

### Policy Informing the DHF Smoking Cessation Framework

<b>Policy Informing the DHF Smoking Cessation Framework</b>	
<b>International</b>	<p>World Health Organisation: Policy recommendations for smoking cessation and treatment of tobacco dependence<sup>xix</sup></p> <p>Ottawa Charter for Health Promotion<sup>xx</sup></p> <p>Jakarta Declaration on Leading Health Promotion into the 21<sup>st</sup> Century<sup>xxi</sup></p>
<b>National</b>	<p>The National Drug Strategy: Australia's integrated framework 2004-2009<sup>xxii</sup></p> <p>National Tobacco Strategy, 2004-2009: <i>The Strategy</i><sup>xxiii</sup></p>
<b>Northern Territory</b>	Building Healthier Communities
<b>Department of Health and Families</b>	<p>Strategic Directions 2007-09</p> <p>Health Promotion Interventions Model</p> <p>DHF Smoke Free Policy<sup>xxiv</sup></p>

## APPENDIX D

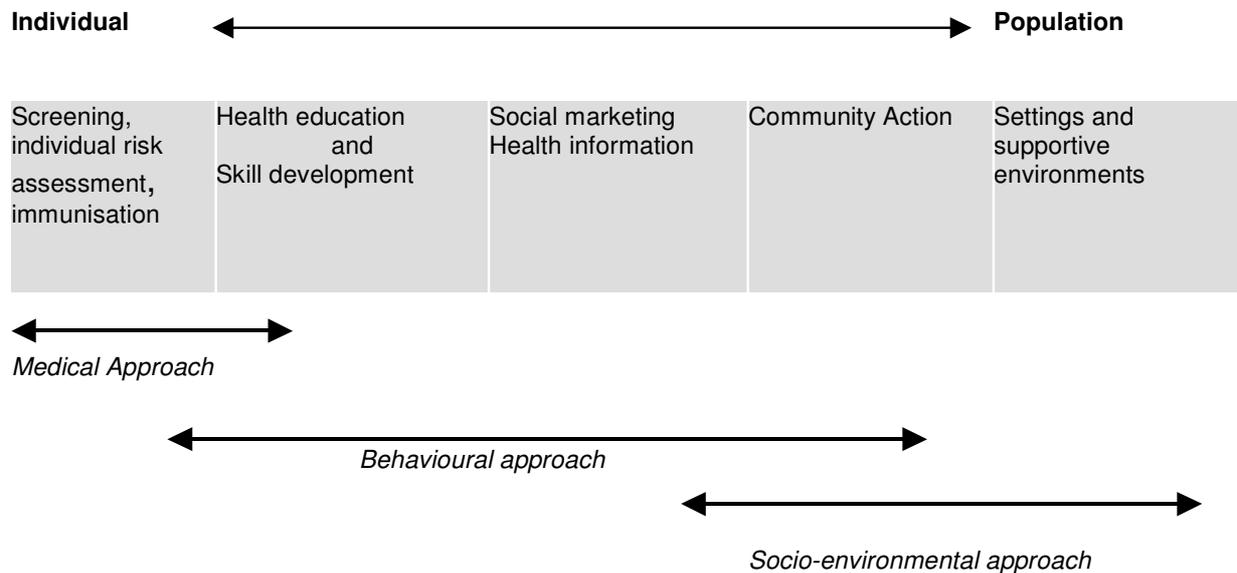
The Health Promotion Interventions Model is also integral to the Tobacco Smoking Cessation Support Framework, giving guidance on approaching tobacco cessation in a comprehensive manner across the spectrum of approaches (see below).

Smoking cessation support can be instigated across the health promotion continuum, with some approaches integrating multiple areas of action. For example, brief interventions can provide screening, assessment, health education and skill development, or community action might lead to a community advocating for an increase in health education on the effects of smoking and how to quit.

Tobacco control is another area inter-related with cessation that sits at the community action and creating supportive environment end of the continuum. It is not the purpose of this or supporting documents to cover the area of tobacco control.

The Health Promotion Interventions Model should be considered when developing any cessation program.

### THE HEALTH PROMOTION INTERVENTIONS MODEL



### Health Promotion Interventions Model

*Adapted from the Victorian Government Department of Human Services (2003, p44).*

The following categories, definitions and examples of health promotion interventions have been drawn from the Victorian Government Department of Human Services (2003, p45-53).

## **Screening, individual risk factor assessment and immunisation**

### *Definition*

Screening involves the systematic use of a test or investigatory tool to detect individuals at risk of developing a specific disease that is amenable to prevention or treatment. It is a population-based strategy to identify specific conditions in targeted groups before any symptom appear.

Individual risk factor assessment involves a process of detecting the overall risk of a single disease or multiple diseases. These can include biological, psychological and behavioural risks.

Immunisation aims to reduce the speed of vaccine-preventable diseases across targeted population groups.

### *Examples*

Common medical screening procedures include pap smears and blood pressure testing.

Disease risk assessments include the identification of a range of factors (depending on the specific purpose of the assessment) such as body weight, diet, family history activity levels, life circumstances and tobacco intake.

Risk assessment tools can also be used to assess susceptibility to risk conditions – for example, working with older community members to assess their physical environment for the risk of falls, individuals may self-administer some tools, but for tools requiring diagnostic interpretation, individuals should be referred to qualified professional staff.

Common immunisations include those for tetanus, measles, polio and influenza.

## **Social marketing and Health information**

### *Description*

Social marketing is often interpreted as the use of mass media, However, it may involve a wide range of media, from radio and television to highly targeted messages delivered through low technology media.

Developing relationships with local media contacts is not only vital to increase the chance of media coverage, but also enables providers to draw on the expertise from the media field. Establishing an ongoing relationship in this way would be beneficial for partnerships individual agencies and media contacts, and also would allow the development of new directions for social advocacy, using newer, more interactive technologies (for example, the Internet).

There is growing interest in the use of social marketing, not only as an influence on individual behaviour change but also as an advocacy tool for broader social and environmental change agendas.

Health information is provided in a range of formats. Written materials in the form of service directories, brochures, newsletters and magazines are common. Telephone information services, 'infotainment/edutainment' video options, the Internet and other computer programs are increasingly providing health information.

## **Health education and skill development**

### *Description*

Health education and skill development include the provision of education to individuals (through discrete planned sessions) or groups, with the aim of improving knowledge, attitudes, self-efficacy and individual capacity to change.

### *Examples*

Education may be offered proactively as part of the planned integrated health promotion program. Health education can also be offered as part of best practice direct care services.

These activities may take the form of individual or group sessions, such as healthy cooking classes, motivational counselling for physical activity and personal financial budgeting skills. Health education and skills development can also be a core component of secondary prevention programs, such as cardiac rehabilitation and support programs.

## **Community action (for social and environmental change)**

### *Description*

Community action aims to encourage and empower communities (both geographic areas and communities of interest) to build their capacity to develop and sustain improvements in their social and physical environments.

### *Examples*

Community members involved in decision-making committees is an example of community action for environmental health protection, as is a community-led advocacy group for the retention of open space.

Self-help and support groups for young mothers and people with chronic illness are other examples of community action that can foster social capital and enhance the wellbeing of communities.

Settings can be wide ranging, depending on the issue. For example, they may include workplaces, sport/recreation/hospitality venues, community service groups (taking action towards healthy practices and environments) and local government areas.

## **Settings and supportive environments**

### *Description*

It Includes:

Organisational development: this aims to create a supportive environment for integrated health promotion activities within organisations, such as schools, local

businesses and sporting clubs. It involves ensuring that policies, service directions, priorities and practices integrate health promotion principles.

Economic and regulatory activities: this involves the application of financial and legislative incentives or disincentives to support health choices. These approaches typically focus on pricing, availability, restrictions and enforcement.

Advocacy: this involves a combination of individual, peer and social actions designed to gain political commitment, policy support, structural change, social acceptance and systems support for a particular goal. It includes direct political lobbying.

#### *Examples*

Regulation and incentives have been used to increase immunisation coverage, with school entry certificates and child care payments linked to timely administration of childhood immunisation.

An example of economic and regulatory activities at the local level is stricter enforcement of regulations relating to the sale of cigarettes to minors, and advertising and competitions encouraging the sale of tobacco products.

#### Please Note:

The above information is drawn from: *Department of Human Services (2003). Integrated health promotion: A practice guide for service providers, p 43-53.*

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