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The Health Worker Smoking Study:

Indigenous Health Workers' personal use of tobacco and its impact on their ability to provide smoking cessation interventions

Thesis submitted by

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For the degree of Master of Science (Tropical Medical Science) by research

School of Public Health, Tropical Medicine and Rehabilitation Sciences

James Cook University

October 2013

STATEMENTS

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STATEMENT OF CONTRIBUTION

This research was initially co-supervised by Professor Alan Clough and Professor Rick Speare at James Cook University Cairns and Townsville (respectively), QLD. The supervisory team changed after data collection had occurred, with the removal of Alan Clough. The supervisory team thereafter has been Rick Speare as the Principal Supervisor, and Professor Kim Usher (JCU, Cairns) and Dr Reuben Bolt of Nura Gili Indigenous Programs Unit, University of NSW, Sydney as co-supervisors. Alan Clough and Rick Speare provided initial input and development to the research proposal, data collection and preliminary data analysis. Alan Clough has not had input thereafter. The data was re-analysed a second time with the change in supervision. All three supervisors have read and made a significant contribution to the editing of this thesis as supervisors. Additional assistance was provided by Petra Buettner for the quantitative analysis. All contributions and acknowledgements can be found in the preface.

The research presented in this thesis was financially supported by James Cook University, School of Public Health, Tropical Medicine and Rehabilitation Sciences, for my salary and data collection, up to July 2010 whilst I was an employee of the Top End Tobacco Project. This financial contribution ceased after my resignation. The NHMRC funded project, Building Indigenous Research Capacity (BIRC) (NHMRC #431504) provided a student scholarship stipend, in addition to funding for project activities related to data collection and feedback of data results to the communities.

ACKNOWLEDGEMENTS

First and foremost, to my son Jarrah, who has lived with this research, the thesis writing and the mood swings. He has witnessed the highs and lows, the joys and tears, the frustration and the *'a ha'* moments when the penny dropped. Studying a higher degree and by research takes its toll on the support around those studying. While a researcher *'does'* it, the family *'live'* with it. Jarrah has been very patient with all the hours I have spent away from him to conduct the activities and write this thesis. The impact of studying this MSc has taken its toll on my family, it hasn't been easy. His continued support, encouragement and stern advice when I do not take care of myself, has been vital. For such a young man I am extremely proud to be his mum.

At the time of confirmation of this study, my mother was undergoing treatment for breast cancer, we weren't quite sure of her prognosis. Thus having her present while I completed my confirmation seminar from the Shoalhaven campus of the University of Wollongong was a proud moment for her. Since that time Mum has completed all treatment and survived. This brought me home to the Shoalhaven to reconnect with her and my people after being away in QLD for many years. Mum's persistent message has always been to become educated to stand up there with the others and to not let anyone put me down. Her leadership as an Aboriginal woman and also as a member of the first intake Aboriginal students to attend University of Wollongong in the early 1980's, has always had an influence on me. Education is vital and I am truly grateful for the leadership my mother has shown in this respect.

I must acknowledge the support and contribution of my principal supervisor Rick Speare. The journey of this project has taught me many things. While I have gained many skills along the way, it is the belief that Rick has had in my ability to lead research that I have gained much respect and admiration for his support. I have learned that not all non-Aboriginal people are seeking to *'ride the backs'* of Aboriginal communities to advance their track record and build empires to be the *'Aboriginal expert'*. People like Rick really stand beside us, shoulder to shoulder, locked arms and ready to challenge the system and processes that continue to exclude Aboriginal people from being active participants in research. Rick has supported my development and learning to navigate the SAB, or *'secret academic business'*. He has educated me about the dominant syntax, to articulate my voice and be able to talk back to the system. Rick's selfless contribution to my development, both professionally and personally, is testament that true reciprocal partnerships can exist between student and supervisor. This relationship will not cease here with the submission of this thesis and will be ongoing with many new projects emerging.

My co-supervisor, Kim Usher, has also played a significant part in my journey thus far. I have learned more about bringing myself into the research. As a registered nurse Kim is aware of the role IHWs play in the health care team and is more than supportive of advocating for the role as health professionals in their own right. Kim and I are also connected through research projects that will extend beyond this thesis.

Both Rick and Kim's knowledge and support of Indigenous Research Methodologies has provided me with many *'ah ha'* moments and self-discoveries of where I *'fit'* and how I bring myself to the research in a way where I can comfortably state my standpoint and articulate my positioning within the Western academic field. This is sometimes difficult for Aboriginal scholars as we do not *'fit'* in one method, rather glean approaches and methods to best suit our individual styles and needs. This is not to say that all Aboriginal people are like this, there are in fact some Aboriginal people that take on the Western world views and approaches to research, that are their choice and I do not deny their right to do so.

My third supervisor is an Aboriginal scholar whom is from my own community. Having Dr Bolt as part of the team was to incorporate his development in supervising students but also out of respect for him being the first person from our community in the Shoalhaven to complete a PhD. Reuben has added insight to my thesis in the analysis and write up phase. Reuben has challenged my thoughts to present a balanced argument always encouraging me to ensure I have evidence to support my statements.

I have also had a great deal of support from another JCU staff member. Petra Buettner has provided me with support to complete the quantitative analysis of this research. Petra understands that I struggle at times with numbers and has been very gracious in providing her time to support and develop my knowledge in this area. I understand the need to ensure that I become a mixed method researcher to ensure that I can navigate both areas of the research field; Petra's guidance and patience through the analysis phase enabled me to reanalyze the quantitative data so that I learned how to complete the statistical analysis myself. This is true capacity building.

I must acknowledge the support of my peers as I am an Indigenous Researcher with the Building Indigenous Research Capacity project, a NHMRC funded project (#:431504). This project has been an immense support to my development and finding my feet in the academic world. I have shared my journey with my BIRC family. All whom have been involved have made a significant contribution to my development and support; in particular Jenni Judd and my peers

and sisters; Yvette Roe, Layla Schreiber and Vicki Saunders. BIRC is a family and through the project a supportive and nurturing space has been created. Without the support of BIRC I probably wouldn't have completed this thesis.

In BIRC we have developed a set of key values; I uphold these values on a daily basis in all aspects of my life not just while I am present in the BIRC space. I will share these as below:

BIRC Values

Over a period of eighteen months the members of BIRC refined their values into ones that flowed into ways of acting. These became:

1. *Respect and honour BIRC.*

2. *Act with integrity; strengthen the trust and confidences of the space: be non-judgmental in our actions and words, and protect and uphold the individuals and the relationships in BIRC.*

3. *Welcome the challenge of this space: we are accountable to one another, we can/should challenge the orthodoxies where we live/work and practise.*

4. *Respect and construct Indigenous culture in this space: this is a special place where Indigenous values are heard and respected.*

5. *Honour the commitment that is generated from this space: acknowledge the obligations and ongoing individual and collective transformations that lead from BIRC.*

The two Senior Health Workers who supported this study were Stephanie Yirkanawuy Dhamarangi and Wanamula Gondara. We discussed the issue of IHW smoking and their concerns. Both felt this study was needed and encouraged and supported me to complete it. I am truly grateful for their guidance and encouragement to undertake this project. They both have provided me with a lot of knowledge and understanding about working in Arnhem Land. I hope to return to Galiwin'ku to visit and spend time in the future.

Lastly, many family members have passed away since I have started this research journey. Getting to the ripe old age of 50 or even 60, if we're lucky in the Aboriginal community, is unfortunately the reality. Cancer has affected many people in my family, seven family members

in total with five passing away and two having undergoing treatment. Cancer has also affected many people in my community. In 2011 two of my uncles passed away as a result of cancer. Both were smokers and both were very influential in helping to raise me. As we went through sorry business and buried these two very important Elders from our family, I contemplated leaving the research field. I questioned myself *"why am I doing this, if my own family are passing on from this horrible condition in which tobacco would have been a contributing factor?"* However I could hear them saying to me – *"keep going Marl"*.

This thesis is dedicated in memory of my family members that I love so dearly and miss every day. Farthy, Uncle Bernie, Aunty Bren, Aunty Jen and Uncle Des all of whom were called to rest as a result of cancer related conditions. I'd like to make a special mention of my young cousin, Nicholas, whom passed away in February 2012. It is with you all in my heart that I continue to do what I am doing in your memory, honoring the paths that you have laid and the influence you have all had on me.

ABSTRACT

Indigenous Health Workers (IHWs) are key members of the health care team delivering vital services to Indigenous communities throughout Australia. The IHW bridges the gap and often language barriers between the non-Indigenous health professional and the community. IHWs deliver a broad range of activities from primary health care, clinical care, health education, health promotion and community development. This important role extends from the generalist IHW to specific and specialized fields.

Tobacco is the leading most preventable health risk factor with smoking in Indigenous communities remaining significantly higher than in the non-Indigenous population. Smoking contributes to a higher level of the burden of disease and mortality in Indigenous Australians. Council of Australian Government (COAG) initiatives has seen a large injection of funding across the country with communities delivering various programs in an attempt to reduce the smoking rate in the Indigenous Australian population.

This project emerged from the results of the baseline survey of the Top End Tobacco Project (TETP) which was located in the three TETP study communities of Galiwin'ku, Gunbalyana and Ngukurr. I was employed as a Project Officer with James Cook University to implement the intervention components after the completion of the baseline survey. When discussing the results of the survey with the Chief Investigator, I became aware that community members, who had spoken about their smoking history, mentioned the clinic or doctor as providing them with information about addressing their smoking. There was no mention in any of the data that community members had received advice from an IHW. This concerned me. Given their pivotal role within the health team, my knowledge and experience as an Aboriginal Health Worker myself, I wondered why IHWs were not part of the provision of information. I spoke with two senior Health Workers from Galiwin'ku. Both thought research on IHW smoking needed to be explored. Both gave their blessings and encouraged me to undertake this study.

Smoking in IHWs has been discussed for a number of years. The literature review for this study, which was published in the Australian New Zealand Journal of Public Health and the Aboriginal and Islander Health Worker Journal, identified that smoking in IHWs has been discursive and descriptive, and that, if IHWs smoked themselves, it impeded their ability to carry out the requirements of their roles and provide tobacco information and cessation advice to the community. The review further identified that the available empirical evidence supporting this assertion was limited and patchy and included non-peer reviewed literature. The studies examined were assessed by utilizing an established approach to classifying Indigenous health research. This approach identified the perpetual discursive nature of the published and grey literature in addition to the continual descriptiveness of the available research. Additionally, the review identified a level of ambiguity as to who in fact was speaking about IHWs. Clarity was needed to ascertain the view of the IHWs. Thus the published literature review called for further research to identify IHWs' personal views and opinions relating to IHWs smoking and the delivery of tobacco interventions.

The literature review, uncovered the absence of the IHWs' voices, with the exception of a few small studies. This thesis is written from the standpoint of an Aboriginal woman who is also an Aboriginal Health Worker, committed to the foundations of Aboriginal community control. This project is one of self-determination, IHW self-articulation and a learning journey from this viewpoint bringing forth the voices of the IHWs and other participants. The key focus was the IHWs themselves. Their voices are pivotal in this study and are brought forward to ensure they are heard.

This study explored the challenges and opportunities of IHWs' smoking, the ways in which barriers to proving advice can be overcome and what needs to happen for them to address their own smoking. The majority of participants were IHWs from the three remote NT communities, but also involved were Indigenous and non-Indigenous health professional's familiar with the

roles of IHWs in remote communities. The aim was to understand the impact of IHWs' smoking on the delivery of tobacco information and smoking interventions in these remote communities and to explore possible strategies to address any identified barriers.

This was a cross-sectional study using mixed methods. Semi structured individual interviews were conducted using a yarning approach with 43 health professionals. Quantitative data collected were basic demographic information related to the sample, smoking status and delivery of tobacco advice. The data was entered into Excel, transferred to SPSS and descriptive frequencies determined; significance was analyzed using Fishers Exact test, due to the small sample size. Qualitative results were analyzed by content analysis. Feedback to the communities and the participant's ensured analysis was interpreted in a way that was meaningful for the participants and best represented their opinions.

A total of 43 semi structured, individual interviews were conducted with 37.2% (n=16) IHWs, 34.9% (n=15) Allied Health Professionals, 14% (n=6) Registered Nurses, and 2.3% (n=1) Doctor. The sample included staff from the community controlled sector with 67% (n=29) and the government sector 32.6% (n= 14). Over half the sample 51.2% (n=22) were located in the three remote communities, with 58.1% (n=25) participants being Indigenous. Of the available IHWs in the three remote NT communities 67% participated, although absolute numbers were small (n=12). For the IHW 37.5% (n=6) were current smokers and 31.2% (n=5) former smokers. Current smoking status of the Indigenous participants overall 37.5% (n=9) in contrast to 5.6% (n=1) for the non-Indigenous participants. This difference was statistically significant (P=0.5).

The qualitative results add depth to understanding the issues encountered by IHWs. A content analysis identified five key themes with a further 23 sub themes. The five key themes were identified in response to specific questions were: Barriers to providing advice; Assisting IHWs to be comfortable in providing tobacco information and quit support; Support for IHWs to quit smoking; Providing information and education to the community; and Assisting IHWs to

provide information more effectively. Each theme is presented throughout the thesis by participant's role as; IHW, Other Indigenous Participants and Non Indigenous Participants. The thesis themes are divided into these categories to clearly articulate the IHW voice and reduce the risk of ambiguity of responses with participants.

This study has shown that for IHWs in these communities, personal smoking impeded their ability to provide tobacco information or cessation advice. Overwhelmingly, 80% of IHWs confirmed this outcome. Additionally, other participants supported this view. The perception that IHWs should not smoke was articulated in this study. However, depending on the participant's knowledge, experience and personal views some judgments of IHWs appeared somewhat harsh.

IHW smoking and stress appears to be directly linked. Stress was both personal and professional. This conclusion is supported by the literature as well as in the data from this study. Given that IHWs are most likely community members themselves, working in their own communities increases their likelihood of burning out. Not addressing the stress increases the potential of IHW fatigue posing a risk to an already reducing workforce of highly skilled and qualified IHWs. The link between community and IHWs needs to be taken into account as community connectedness can be a double-edged sword. It can often assist with the delivery of health care, but critical incidents within the workplace can become highly personal. Given the local connection, when a death or major incident occurs, the IHWs more often than not are connected to the person through familial or other ways. This impact adds to an already strained workforce. This can manifest as stress and smoking can be one sign of this. The support of clinical supervision may assist with IHWs also addressing stress, grief and loss commonly found in Indigenous communities. Clinical supervision is part of the psychology and social work practice which is now also becoming part of the nursing profession, particularly in the mental

health field. Given the current literature and evidence in this study, the connection with stress and smoking may be alleviated if workplace programs included clinical supervision for IHWs.

There are many benefits and incentives for employers to provide healthy lifestyle programs including tobacco cessation for their staff. Literature suggests smoking programs in the workplace improve the level of productivity in addition to a reduced level of sick leave through absenteeism. The costs associated with provision of such programs as opposed to the financial burden on employers through sick leave entitlements are self-evident. Therefore, smoking programs provided by the workplace would be an incentive to ensuring staff are well supported, healthier even if the harm minimization approach – cutting down with a view to quit - is available.

Before moving on to the recommendations from this study I want to discuss the concept of publishing papers, reports or research outputs in two or more formats (i.e., in parallel) with the purpose of reaching a broader audience to ensure the work is accessible to all. I have coined this concept as parallel publishing which supports knowledge translation of research practice. Ensuring praxis and good scientific practice, this term is used to describe a method or a process that may assist other Indigenous researchers or others from non-English speaking backgrounds when describing their approach or methodology in terms of dissemination of research findings. In Indigenous health this is particularly important to ensure that communities and their IHWs are included. An illustration is that the literature review was published as an academic document in the Australian and New Zealand Journal of Public Health and using modified language in the Aboriginal Islander Health Worker Journal. The first publication informs the academic community and mainstream decision makers; the second publication communicates to IHWs and community members.

The act of parallel publishing has been practiced for over a hundred years from the early 1900s to the present day as a method of reaching broader audiences. However, it has not been defined

nor characterized. "Parallel publishing" is a new concept and one that has been developed and reflected upon throughout this study and importantly it warrants further investigation and development.

Recommendations from this study include:

1. Undertake further research:

    a. To understand the underlying stressors IHWs experience in their personal and professional lives which may inhibit them from quitting smoking;

    b. To develop appropriate, holistic and comprehensive workplace tobacco programs for IHWs and other staff;

    c. To evaluate the impacts and outcomes of these programs on IHWs and whether there is a flow on affect to the community in which they work.

2. For employers to implement holistic and comprehensive smoking programs for staff with the following components:

    a. Access to pharmacotherapy's and other treatment modalities funded by employers;

    b. Personalized in person support to quit smoking;

    c. Access to group programs and support (where appropriate);

    d. Incorporate stress management as part of the program.

3. To incorporate tobacco units of competencies into all IHW training, becoming a core unit from Certificate IV lever or higher.

4. For employers provide clinical supervision for IHWs to assist with stress management, as support to alleviate and prevent IHW burn out.

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LIST OF ABBREVIATIONS, ACRONOMYS AND WORDS

BIRC   Building Indigenous Research Capacity

BUGA UP   Billboard Utilising Graffitists against Unhealthy Promotions

COAG   Council of Australian Governments

IHW   Indigenous Health Worker

JCU   James Cook University

NHMRC   National Health and Medical Research Council

NRT   Nicotine Replacement Therapy

PhD   Doctor of Philosophy

QLD   Queensland

TETP   Top End Tobacco Project

WHO   World Health Organization

Ngarali   Tobacco/smoke in the Yolngu Mata language of Arnhem Land NT

Chapter 1: Introduction

1.1 Overview of Thesis

In this thesis I present the findings of tobacco use in Indigenous Health Workers (IHWs) in three remote communities in Arnhem Land Northern Territory. The thesis describes whether IHWs efforts to address the high smoking rates in these communities are impeded by their own personal use of tobacco. This Introduction discusses the health promotion strategies used generally to discourage smoking, focuses on those relevant to Indigenous communities, highlights the special role of Indigenous Health Workers and introduces the issues caused by their smoking status.

1.2 Tobacco Smoking in the general Australian population

Tobacco smoking is the single most preventable cause of disease and mortality (Australian Institute of Health and Welfare, 2010). Smoking is a national and international issue that leads to long term health issues and premature death (Collins and Lapsley, 2008). The national cost to the health system as a result of people smoking was $31.5 billion in 2004-2005 (Collins and Lapsley, 2008). Further, smoking was a contributing factor to the 15,511 deaths in 2003 (Begg et al, 2007a and Begg et al, 2007b). In the non-Indigenous population smoking rates have reduced significantly since the 1960s to less than eighteen percent (Chapman, 2008).

1.3 Framework Convention on Tobacco Control

Internationally Australia is a party to the World Health Organization Framework Convention on Tobacco Control which encourages governments to ensure health of all people to reduce the tobacco epidemic across the globe. However, few of these approaches have been tested for use with Australia's Indigenous people, particularly those who reside in remote communities.

Australia has been a leader in reducing tobacco demand, supply through policies that have been lobbied for and advocated for since the 1960's. Guided by and informed by active researchers, strong policies and legislation with numerous strategies to address smoking can be linked to the significant reduction in the prevalence of tobacco use. Some of these strategies are for example; i) stringent policies and legislation to regulate the tobacco industry and commercial sale of tobacco; ii) implementation of smoke-free environments to aid in the de-normalisation of smoking in places such as restaurants, bars and public transport; iii) efforts to reduce demand for

tobacco by way of mass-reach media campaigns; and iv) prevention and cessation services (Chapman, 2008).

This work commenced in the late 1970s with leaders in the fight against tobacco in Australia such as Professor Simon Chapman, Professor Renee Bittoun, Rick Bolzen and Dr Arthur Chesterfield Evans. They all actively led a rather radical approach, at that time, to oust the tobacco companies and their methods of advertising. The BUGA UP campaign or Billboard Utilising Graffitists Against Unhealthy Promotions targeted billboard advertisements that promoted positive and encouraging messages of tobacco products (ABC Online, 2004 and Chapman, 1996). As a stance against the tobacco companies and the health consequences billboards were 're-faced' to divert the publics' attention away from the enticing pictures as portrayed by the tobacco companies (ABC Online, 2004). The acronym, BUGA UP, was tagged on each billboard that was altered (Fig. 1.1). It was deemed at the time a radical move to raise the awareness of the harms associated with tobacco as a means to reduce the impact in particular to young children (Chapman, 1996). This can be likened to the social marketing campaigns, which have over time, become common-place in a contemporary setting.

Figure 1.1: Examples of the BUGA UP billboard refacing.

Source: http://tobacco.health.usyd.edu.au/historical-images/

Source: http://www.bugaup.org/gallery_sample.htm

Today there are social marketing campaigns which aim to denormalize tobacco smoking. Coupled with strong tobacco regulations, legislation and licensing strategies aim to reduce the impact of tobacco and the associated long term complications. The Australian Government has set a goal of reducing the prevalence of tobacco smoking to less than nine percent by 2020 (Thomas, 2009). The following pictures are examples of the various social media campaigns designed to make smoking less attractive, particularly for younger people in an attempt to prevent or delay commencement of smoking (Figs.1.2 and 1.3).

Figure 1.2: Health messages on tobacco products.

Source: http://www.health.gov.au/internet/main/publishing.nsf/Content/tobacco-warn-A

The national *'Break the Chain'* anti-smoking campaign targets Indigenous families through the development of print and social marketing resources such as: posters, television and radio advertisements (Fig.1.3). This campaign is designed to assist in creating an awareness of the burden of health disease and mortality in Indigenous Australians (Roxon and Snowdon, 2011).

Figure 1.3: National Indigenous tobacco campaign- Break the Chain.

The following resources were made while I was employed with the Top End Tobacco Project. The purpose was to develop locally made resources that were translated into the local language so that community members could relate to the messages (Fig.1.4 and 1.5).

Figure 1.4: Localized posters developed into local language – Top End Tobacco Project.

Theme: Time to stop or slow down?
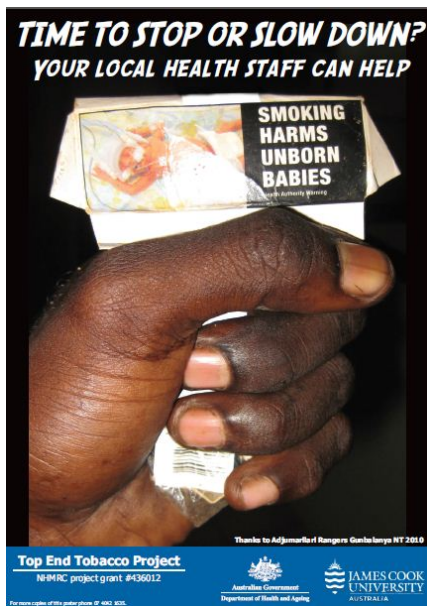
English	Kriol - Ngukurr
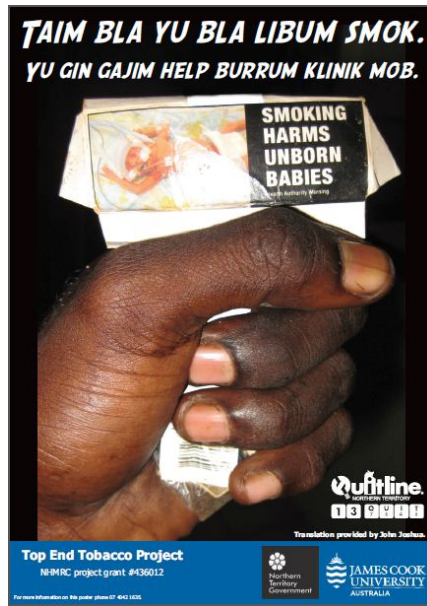
Sources:

English poster: http://www.healthinfonet.ecu.edu.au/uploads/resources/21463_65249-a3-poster---smoking-final.pdf

Kriol poster: http://www.healthinfonet.ecu.edu.au/uploads/resources/21463_73237-a3-poster---smoking---8-language-translations.pdf

Figure 1.5: Localised Stickers –Top End Tobacco Project.

Theme: Smoke free homes

Galiwin'ku:

Source: http://www.healthinfonet.ecu.edu.au/uploads/resources/21463_jcu-manymak-sticker-sept.pdf

Ngukurr:

Source: http://www.healthinfonet.ecu.edu.au/uploads/resources/21463_cleanairsticker_printready.pdf

New legislation has been implemented including tobacco products being sold in plain packaging with similar health warnings as shown above to remove the appeal of nice colored and brandings by tobacco companies (Chapman, 2012). Chapman (2012) articulates in his commentary on the removal of advertisements of tobacco products and the implementation of the less appealing packaging, how these actions may deter younger Australians taking up smoking and assist those not highly dependent to consider quitting. The plain packaging now displays health warnings while the attractive designs and colours have been removed; the brand name remains on the packaging (Fig.1.6).

Figure 1.6: Plain Packaging with Former Health Minister - Nicola Roxon May 2011.

Source: http://www.ashaust.org.au/lv3/action_plainpack.htm

"Skins" (covers for cigarette packets) bearing Aboriginal designs to hide stark health messages have recently been condemned by the National Aboriginal Community Controlled Health Organisation (NACCHO 2013) (Fig.1.7).

Figure 1.7: Skins with Aboriginal design sold to cover smoking health warnings.

Source: http://nacchocommunique.files.wordpress.com/2013/05/skins-2.jpg
(Thanks to Michelle Redman-MacLaren)

1.4 Tobacco Smoking by Indigenous Australians

In stark contrast to the reduction in smoking witnessed in the non-Indigenous population, for the Indigenous Australian population very little has changed (Clough et al, 2009 and Thomas, 2009). Further to this, the work of Thomas (2009) reports a smoking prevalence rate of 50% in the Australian Indigenous population. However, in some remote Aboriginal communities in Arnhem Land in the Northern Territory, smoking rates as high as 68 to 83 percent in men and 65 to 73 percent in women, substantially higher to the general population of up to and have been that way for more than twenty years (Clough et al, 2009, Clough et al 2002, Watson et al, 1988 and Hoy et al, 1997). The difference between non-indigenous and Indigenous smoking rates contributes significantly to the gap in health outcomes and goes some way towards explaining why Indigenous people continue to have greater health disparities than non-indigenous Australians (Thomas, 2009 and Vos et al, 2009). Smoking accounts for as much as 20% of deaths in Indigenous Australians (Vos et al, 2007). Tobacco accounts for a large burden of disease in Indigenous Australians and has been linked to being a major contributing factor to poor health outcomes related to heart disease, stroke, some cancers, lung diseases (Australian Health Ministers' Advisory Council, 2012).

1.4.1 Tobacco and Aboriginal communities in Arnhem Land Northern Territory

Tobacco is not a new product for the people of Arnhem Land (MacKnight, 1976, McKenzie, 1976, Sieffert, 2008 and Brady, 2002). Aboriginal Australians along the northern communities of Australia traded with the Macassan fisherman for items including tobacco. Records of such activities date back as early as the seventeenth century (MacKnight, 1976). The historical association of this trading relationship remains relevant in today's Arnhem Land society. Cultural activities and ceremonies particularly for those communities within North Eastern Arnhem Land have been passed on through the generations and are applied in a contemporary setting (MacKnight, 1976 and McKenzie, 1976).

As with other Indigenous communities throughout Australia during colonization, and in particular first contact, tobacco also formed part of the bartering system when explorers or missionaries arrived to create communities (Brady, 2002). Tobacco later became part of the payment system through rations that were issued for the work carried out on the missions and in the pastoral industry (McKenzie, 1976, Sieffert, 2008 and Cole, 1975). Additionally, during the First and Second World Wars rations also included the issuing of tobacco (Chapman, 2008 and Brady, 2002) .

From this early introduction and the idea that tobacco has become the 'norm', Indigenous Australians are now faced with the grim reality of addressing a contemporary issue that unnecessarily continues to claim the lives of Indigenous Australians.

1.5   Indigenous Health Workers

Indigenous Health Workers (IHWs) play a pivotal role in the delivery of health care in Indigenous communities. I utilize the term Indigenous interchangeably to represent both Aboriginal and Torres Strait Islander people. I use the term Indigenous Health Workers (or IHWs) with respect of the two cultures in Australia. I capitalize the words Health Workers as IHWs are a professional body of workers that are highly qualified and as such are recognized throughout this thesis.

IHWs are considered crucial to deliver culturally appropriate, safe and competent health services to communities (Thompson, 2010, DiGiacomo et al, 2007 and Genat et al, 2006). At the community level they form the link between the community and the clinic, often leading, coordinating and supporting health care services to the community, whilst also being community members themselves (Genat et al, 2006, DiGiacomo et al, 2007 and Thompson, 2010).

The role is complex. IHWs can be subject to high expectations of fellow colleagues on the one hand and the community on the other (Mark et al, 2005). These expectations can sometimes add undue pressure to this integral part of the health workforce (Mark et al, 2005). IHWs cannot be separated from their community, as they are immersed in the local culture and in most cases have local familial connections where they reside and work. They do not cease work at five, which can pose a great risk to IHW fatigue and burn out from not having respite from the dual role of community person and health professional (Coaby, 1984). It also means that they are looked upon by the community as people who can lead them in health matters.

1.5.1 IHWs: the key to closing the gap in tobacco smoking

IHWs are health professionals whose role includes a key focus on provision of health interventions within Indigenous communities (Thompson, 2010). Therefore, it is essential that IHWs are part of the development, implementation and evaluation of health programs to ensure that the interventions are culturally and location specific. Furthermore, as IHWs are more likely to reside in the communities, sustainability of programs are likely to be more successful if IHWs

are trained, mentored and supported to deliver the programs in their communities (Thompson, 2010).

1.6 Current policy context to addressing the health gap – the National Tackling Indigenous Smoking Campaign

The Council of Australian Governments (COAG) invested $100 million from 2010 to 2012 in an initiative lead by Dr Tom Calma titled 'Tackling Indigenous smoking campaign' (Snowdon, 2010). As part of this program, Tobacco Action Workers have been employed through the community-controlled and mainstream health sector to provide tobacco specific interventions to the community. These workers are unique in that their sole focus is on tobacco related programs, unlike IHWs who have a wider set of skills and run various programs as well as smoking intervention.

In order for front line workers such as Tobacco Action Workers and IHWs to effectively carryout their roles and implement anti-smoking programs, it is imperative to understand the barriers that may impede provision of support and/or specifically designed interventions to the community.

1.7 Goal of this thesis

This thesis will describe a study that was conducted in three remote Aboriginal communities in Arnhem Land, Northern Territory in relation to Indigenous Health Workers who smoke and the impact on their ability to provide tobacco cessation and/or information advice to their communities. The goal of this thesis is to bring forth the voices of IHWs themselves so that they can articulate their views and thoughts about delivering tobacco strategies in their communities and suggest ways to overcome the barriers they encounter. Whilst this study is located in these communities (making findings not generalisable), there is much to learn from the stories IHWs have shared as a result of being part of this work.

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Chapter 2:   Background for the Thesis

2.1:   Preamble

This chapter introduces the literature in relation to IHWs and their smoking status and provides a background for the aims of the thesis.   In keeping with my cultural responsibilities and ensuring knowledge translation occurs the literature review has been published in two forms; i) a formal academic journal article published in the mainstream *Australian and New Zealand Journal of Public Health* and ii) a parallel publication designed for IHWs published in the *Aboriginal and Islander Health Worker Journal*. I will describe parallel publication and its implication in more depth in Chapter 3: Methodology. After these publications I have included a reflective section on the literature review which sets out the aims of the thesis.

2.2:   Publications Arising from this Chapter

1. Thompson M, Robertson J, and Clough A. (2011). A review of the barriers preventing Indigenous Health Workers delivering tobacco interventions to their communities. *Australian New Zealand Journal of Public Health.* 35, (1): 47-53.

2. Thompson M. (2010). What are Indigenous Health Workers saying about their smoking status: Does it prevent them providing tobacco information and/or Quit Support to the community? *Aboriginal and Islander Health Worker Journal.* 34, (2): 3-5,8.

2.3   Publication 1: My Contribution

Publication 1: 90% contribution:

Thompson M., Robertson J., and Clough A. (2011). A review of the barriers preventing Indigenous Health Workers delivering tobacco interventions to their communities. *Australian New Zealand Journal of Public Health.* 35 (1):47-53.

I did the following:

- Conducted search of the literature
- Assessed relevance of literature as defined by inclusion and exclusion criteria
- Completed drafting process, relevant tables
- Completed final drafts with recommended changes as suggested by critical friends and co-authors
- Acted as corresponding author
- Amended final manuscript with peer review suggestions.

A review of the barriers preventing Indigenous Health Workers delivering tobacco interventions to their communities

Marlene Thompson, Jan Robertson

School of Public Health, Tropical Medicine and Rehabilitation Sciences, James Cook University, Queensland

Alan Clough

School of Public Health, Tropical Medicine and Rehabilitation Sciences and School of Indigenous Australian Studies, James Cook University, Queensland

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2.4: Publication 2: My Contribution

Publication 2: 100% contribution

Thompson M. (2010). What are Indigenous Health Workers saying about their smoking status: Does it prevent them providing tobacco information and/or Quit Support to the community? *Aboriginal and Islander Health Worker Journal*. 34, (2): 3-58.

- Based on Publication 1, but rewritten for a different target audience – IHWs. This article keeps within my cultural responsibilities of ensuring knowledge translation to Aboriginal communities and is the first parallel publication.

What are Indigenous Health Workers Saying About Their Smoking Status: Does it Prevent Them Providing Tobacco Information and/or Quit Support to the Community?

MARLENE A THOMPSON

School of Public Health, Tropical Medicine and Rehabilitation Sciences, James Cook University.

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2.5   Aims for the Thesis

From the published and grey literature reviewed, it was difficult to discern who was speaking about IHWs' smoking status.   Within the literature, the voices of the IHWs appear to be buried amongst those of their colleagues and fellow community members. The views and opinions of others, apart from the IHWs, appear to verbalize ideas and ways in which to address the issue of IHWs smoking. From the representations found in the literature, it seems that IHWs smoke tobacco in similar ways and at the same rates as their communities. However, there is very little evidence from IHWs themselves to substantiate these claims.

IHWs expressing their own views are needed in order to be able to better support IHWs that smoke and to help unravel whether they believe smoking impedes their ability to provide tobacco cessation advice, or whether it is the judgments and perceptions of the community and colleagues that impose these views upon IHWs.

This thesis has the following, hypothesis, goal and aims:

Hypothesis

Indigenous Health Workers' personal use of tobacco impedes their ability to provide smoking cessation interventions.

Goal

To assist IHWs to provide effective smoking strategies to their communities irrespective of their own smoking status.

Aims

1. To determine the barriers for IHWs to provide tobacco information and cessation advice;

2. To determine what might assist IHWs to be more effective in providing tobacco information and cessation advice and/or support strategies;

3. To determine what type of support could assist IHWs to quit smoking if their own smoking status is a problem for them in delivering anti-smoking programs.

Chapter 3: Methodology

Introduction

In this chapter I discuss the theoretical framework, methods, engagement strategies and standpoint in relation to the research. It is important to note that during the implementation of the study and analysis of the data, my viewpoint changed. This journey will be discussed later in this chapter.

3.1 Theoretical framework for the Top End Tobacco Project

The Health Worker Smoking Study was embedded within an established funded research project, The Top End Tobacco Project (NHMRC project grant: 436012 *Community action for smoking cessation*). The Top End Tobacco Project was implemented using a multiple-component, community-action intervention study designed to reduce tobacco smoking in three remote Indigenous communities in the Northern Territory. The project was the vehicle for my study and also contributed financial support for the data collection phase.

The Top End Tobacco Project utilised various implementation strategies. Those that are relevant to this study are: community-oriented which included mobilising and informing communities; assistance for IHWs to quit smoking; training for IHWs and community-based employees in brief smoking interventions; and training in the use of a wider range of nicotine replacement therapy (NRT). The project also collaborated with IHWs in each of the three communities to provide community developed interventions. It included a process evaluation component permitting interviews to be conducted with a range of clinicians and health service providers working in the communities, in the NT Government's Health Department and community-controlled health services.

I was employed as a Project Officer within the larger project. My role was to carry out various functions of the research project under the guidance of the Chief Investigator. A large component of my work included the delivery of tobacco training to IHWs, Community Workers and other staff within a range of services.

As a result of discussions with the Chief Investigator of the Top End Tobacco Project (Professor Alan Clough), specifically in relation to the data analysis of the baseline survey, I was concerned that of the 400 participants included in the study, none reported receiving quit advice or support from IHWs. I spoke to several senior IHWs from the study communities who were troubled

with the sometimes contradictory messages that IHWs, who currently smoked, sent to the community. This study arose as a result of this concern and the meetings with IHWs.

3.2   My Standpoint

This study was initially designed from a Western academic approach. This approach is positivist and hierarchal since it is built on authoritative statements of other academics and largely ignores the authority of non-academic information (Frith, 2009; Nakata, 2007). Science, in particular research, if viewed from the Western standpoint, perpetuates the idea that Western paradigms are the only objective and rational ideas (Tuhiwai Smith, 1999). In addition to this, the production of academic knowledge, notably through academic institutions such as universities, maintain a hold over knowledge, who participate in it, who own it and who write it (O'Brien, 2008). This approach to knowledge creation continues to exclude Indigenous communities through the power imbalance between researcher and the researched community, devaluing Indigenous communities as active participants in the research process. As a result, their voices can remain silent.

I bring to this study an Indigenous perspective. Combined with my growing knowledge of the academic system. First and foremost, in all I do I ensure that I meet my cultural responsibilities before the academic obligations. This is done by ensuring the research I participate in or lead, is culturally safe in addition to meeting the scientific rigor of the academy (West, 2012). At first I found it very difficult to conduct the study using a purely Western approach. The Western approach to research is underpinned by the dominant culture and production of knowledge or new evidence requires rigour and science (West, 2012). Further this approach silences the voices of the participants and becomes that of the researcher not the researched (West, 2012) Thus this approach; firstly excluded me as an Aboriginal person, secondly it did not support my cultural responsibilities and thirdly silenced my experience as being an Indigenous Health Worker.

Initially, I had some difficulty in approaching people for interviews owing to my discomfort with the research paradigm. However, over time during my enrolment, I learned and gained more knowledge and experience to allow me to comfortably approach potential participants. The methods utilised here included the Aboriginal cultural practices of yarning (Fredericks et al, 2011; Besserab and Ng'andu, 2010). Yarning is an Aboriginal conceptual form of communication and similar to the Western euphemism of 'chatting'. However yarning is and

can be more formal than a casual 'chat' with participants. With nurturing by my supervisors and my peers, I have been able to bring more of myself into the research process to enable me to interact with the system in a way that ensured I maintained my cultural responsibilities as an Aboriginal woman, Aboriginal Health Worker, and Aboriginal researcher.

My standpoint has developed over time during the analysis and write up of this thesis and as my skills have developed as an Aboriginal researcher. I adopt a critical Indigenous approach which is influenced by Indigenous scholars (Rigney, 1997; Tuhiwai Smith 1999), in addition to work in Indigenous feminism (Moreton-Robinson, 2000; Fredericks, 2008). The theoretical underpinnings of the research I conduct is drawn from critical theory and non-Indigenous scholar Freire (1970). Both the work of Freierian pedagogy (Freire, 1970) and the work of Rigney (2001) attempts to create change to generate research that as Rigney states *'advocates for those most oppressed'*.

Table 3.1: Articulation of standpoint based on the work of Crotty (1998).

Epistemology	Theoretical perspective	Methodology	Methods
CriticalIndigenist research	- Indigenous feminist standpoint theory. - Critical theory.	- Action research. - Community based research. - Survey research. - Mixed methods. - Content analysis. - Quantitative analysis. - Yarning. - Dadirri. - Parallel publishing.	- Survey sample. - Questionnaire. - Semi structured interviews. - Indigenous methods of engagement. - Content analysis. - Quantitative analysis. - Community feedback and data analysis validation. - Focus groups. - Translation of research outcomes to community.

In conducting the literature review I identified the IHWs voices were silent. Previous studies identified in the review acknowledged that IHW smoking inhibited their ability to provide tobacco interventions however the voice of who was speaking for whom was unclear. Thus this study was designed to take into account the experiences of the IHWs and articulate their voice in order to gain clarity relating to the issue. This is work is also advocated by Fredericks (2008)

ensuring cultural safety and following cultural protocol is adhered to when working with the community. I adopt an Indigenous paradigm which is influenced by Aboriginal ways of being, doing and knowing (Martin 2003) while always attempting to not ensure that I do not cause harm (Sherwood 2009) and perpetuate the history of research (Tuhiwai Smith, 1999) that has caused many communities to distrust research and the researchers.

My work is transformative and emancipative in that it brings forth the voices of the participants in order for their ideas and views to be heard to make change so as to better understand the impacts of smoking in IHWs and how workplaces can better support them in their roles

While during the initial twelve months of working on the larger tobacco project I attempted to 'fit' within a paradigm that was designed by a non-Indigenous researcher, I found there was a collision between the two world views: the one I had lived and breathed for all my existence, and the new academic, Western system that I found quite difficult at times. Completing the study through a purely empirical manner that excluded my Aboriginal ways of being, knowing and doing, meant I felt like a fish out of water. However, this journey has provided me with many lessons; an important one of self-discovery. By undergoing this process, I have come to view research as a potentially informative career path; the realisation of the lack of fit between Indigenous and non-indigenous ways of knowing and being, the integration of new learning's, and the development of awareness of my own standpoint, which I am now able to articulate, has helped me to move onwards to where I am now comfortable to undertake research with Indigenous communities.

The methods applied in this research have been drawn from my lived and personal experiences as a Yuin woman. Supported by community development skills I have gained working with Indigenous communities I have been able to bring that experience to research. This can be evidence from the time of approaching potential participants, creating a safe discussion using Aboriginal English to engage in a conversation or what is known in the Indigenous Australian context as a 'yarn'. Yarning is and has been a method of communication and engagement for many thousands of years.

I draw from the work of Aboriginal scholars, Professor Aileen Moreton Robinson (Moreton-Robinson, 2000), Professor Maggie Walter (Moreton-Robinson and Walter, 2009) ,and Associate Professor Bronwyn Fredericks (Fredericks, 2008, Fredericks et al, 2011; Moreton-Robinson and Walter, 2009), whose work has informed my knowledge around standpoint theory

and enhanced my understanding of what that means for me as an Aboriginal woman, Aboriginal Health Worker, and Aboriginal researcher. These learning's have helped to shape how I claim the space within a Western thought driven academic/research system. I also acknowledge the work of Professor Lester Irabinna Rigney, who helped me to realise the importance for my work to be scientifically rigorous while finding ways to bring forth the voices of Indigenous people (Rigney, 1997 and Rigney, 2001). In addition, his work has helped me to understand that research is inevitably political, and to realise the importance of research being transformative and emancipative, and committed towards self-determination. I am also influenced by the work of Professor Martin Nakata who insists that we must ensure research is represented from an Indigenous view point and is written by an Indigenous person; in my case, as an Aboriginal women, mother, wife, Aboriginal Health Worker, researcher, and educator (Nakata, 2002).

Therefore, the methods I apply to the research I conduct are guided first and foremost by my position as an Aboriginal woman from the Yuin Nation, of the Dharawal and Dhurga language groups of the South Coast of New South Wales. My cultural responsibilities to family and community are inherent in each daily activity I undertake. This responsibility is embedded within the relational accountability (Wilson, 2008) that I as an Aboriginal woman believe is vital and enables me to connect with other Aboriginal communities, researchers and Aboriginal Health Workers. My approach is emancipatory, transformative and inclusive of Aboriginal and Western world views combining both qualitative and quantitative methods. As an Aboriginal researcher, I am able to walk between the two worlds which requires traversing two different epistemological foundations assisted through the use of reflexivity, and strengthened by my awareness that it is impossible to be removed from the research I do, as I am embedded within it (Wilson, 2008). This cannot be changed; only embraced.

The implementation of this study, my involvement with the Building Indigenous Research Capacity project (BIRC, NHMRC Project Grant #: 431504) with James Cook University, has assisted me to develop my understanding of articulating an Indigenous paradigm, research praxis and to identify an Indigenous standpoint. In writing this thesis I have struggled with gaining new knowledge around research methods. I have also learned much more about being an Aboriginal woman who has undertaken what Rigney calls *'the journey of academic contradiction'* (Rigney, 2001). This is the process where Indigenous scholars move from being the object or subject of research to becoming the researcher themselves; a self-determining position for Indigenous people and their communities (Rigney, 2001). It has been through the conduct and writing of the research, attendance at BIRC workshops and seminars, and reading of texts written by Indigenous scholars that have assisted my development in this area. Whilst I did

not initially apply these learning's in the development and data collection phase of this study, I have been able to use these skills in the data analysis and write up stage where I used this new knowledge to help me make sense of the theoretical underpinnings of the Western academic system. The reader is asked to bear in mind my pronounced shift in understanding from when I began this work to when I started data analysis.

3.3   Methods

I utilised a mixed method approach through the use of a survey instrument that included quantitative and qualitative data collection. When approaching potential participants, I ensured I followed Indigenous protocols. Utilising a yarning method I completed 43 surveys, through semi-structured interviews, with Indigenous and non-Indigenous health professionals. Communities were revisited to discuss the findings. Since I wanted to ensure that key messages from the study reached all my IHW colleagues, I chose to publish in both mainstream and discipline specific journals. I call this new concept for research dissemination "parallel publishing" and will discuss it in section 3.4.

3.3.1   Sample

The participants for this study were Indigenous and non-Indigenous health professionals involved with providing services to three remote Aboriginal communities; Galiwin'ku, Gunbalanya and Ngukurr. Some participants came from the communities and others were staff from services located in regional towns (Katherine and Nhulunbuy), or the capital city (Darwin), and were included in the sample as they provided regional support services to all three communities. These participants worked alongside IHWs and were regarded as colleagues. Potential participants were identified based on the staffing levels within the communities and were opportunistically approached to participate. Since staff turnover in the communities was high, it was important to attempt to interview as many IHWs as possible and to also speak with their colleagues.

Additionally, three IHWs from other States of Australia were included in the interviews. The purpose of this was to triangulate the data with the views of IHWs employed elsewhere to assess whether there were any differences or similarities in views of IHWs from other states in comparison to those in the remote communities of Arnhem Land. These participants were interviewed in Darwin. Table 4.1 in Chapter 4 provides a description of the participants.

3.3.2   Sample size

The original target was to interview a sample of sixty participants. This figure was thought to be comparable to previous studies conducted as identified in the literature review (Thompson et al, 2011). However, after conducting forty interviews and a preliminary analysis, after all communities had been visited, I suspected data saturation had been reached for the qualitative data since in the last few interviews, I was getting no new information (Hesse-Bieber and Leavy, 2011). I discussed this with Supervisors Clough (former Principal Supervisor) and Speare (current Principal Supervisor), who both suggested I conduct a further three – five more interviews and assess whether any new information was found. I completed an extra three interviews, to make a total of forty three, and found no new information. Supervisors Clough and Speare agreed that saturation had been reached and no further interviews were required.

3.3.3   Yarning as a method

A culturally appropriate and validated method of sharing of stories, known as yarning, was adopted to bring out the personal views of IHWs in relation to the study questions (Bessarab and Ng'andu , 2010; Fredericks et al, 2011). Additional interviews were also conducted with the IHW's colleagues. Ensuring my approach to participants was respectful and true to my own cultural responsibility; I adapted my way of interacting with the participants as required. The interview instrument was utilised as a tool to seek the information. However, the process of yarning with people with whom I already had an established working relationship, assisted in the process of gathering the information. I utilised local terminology where I knew some of the local language, and took the time to listen and hear what was being said. This enabled a strong discussion with some interviews lasting for 30 to 40 minutes depending on how much time people had and what they had to say.

3.3.4 Semi structured interviews

A semi structured interview using a yarning approach was conducted face to face using a two page interview instrument guide (see Appendix 1). Information sought from each participant consisted of: five demographic questions (age, ethnicity, gender, employer, position in organisation) and questions on smoking status (current smoker, not smoking now but previous smoker, never smoked). Closed questions were then asked to seek direct information about IHWs perceptions around smoking and health interventions in the form of yes/no responses. These were followed by questions to obtain more detailed information through the yarning method, allowing the issue to be explored in depth:

1. Is smoking by Health Workers a barrier to them helping the community to change? A yes/no response were sought with further exploratory question following: Please explain why?

2. What could help Health Workers to be comfortable to give tobacco information or quit support?

3. What kind of support could help Health Workers to quit?

4. Do you provide information or education about tobacco to the community? A yes/no response was required with further exploratory questions following:

   - If yes, what sort?

   - If not, why not?

   - What could help you provide information about tobacco with the community more effectively?

5. Do you provide quit support to individuals or community? A yes/no response was required with further exploratory questions following:

   - If yes, what sort?

   - If no, why not?

   - What do you need to be able to provide quit support?

Participants who were current smokers were also asked: i) if they were not thinking about quitting, thinking about quitting, or if they were actively trying to quit; and ii) to describe any quit attempts. Assessing where participants were in the form of the stages of change model (Prochaska and DiClemente, 1983) was to provide a brief intervention and offer cessation support if the participants were actively trying to quit. I offered quit support whilst in the community to any IHW who wanted it.

Unique codes were assigned to each interview sheet to de-identify participants and maintain their confidentiality. Codes using the first three letters of the community following by three numbers were utilised. For example; NGU004 = fourth participant from Ngukurr, GAL010 = tenth participant from Galiwinku, DAR006 = sixth participant from Darwin.

3.3.5 Quantitative data analysis

All interviews used a paper based interview instrument (see Appendix 1) with responses written on individual forms. Quantitative data was entered and coded into statistical software package SPSS v20 (IBM, 2012). The quantitative analysis used frequency distributions to assess the demographics of the sample by percentages and numbers. Additionally, the Fishers Exact test

was utilised to test for significance between variables and whether any associations or relationships could be drawn from the data. The Fishers Exact test was utilised due to some questions having a small sample to complete the test as not all participants answered the questions resulting in missing data.

3.3.6 Qualitative data analysis – survey data and follow up

Individual interviews and focus group feedback was transcribed verbatim onto individual forms and subsequently entered into a Microsoft Excel spreadsheet (Microsoft, 2007). A dual analysis content of i) content analysis; and ii) critical Indigenous analysis, was originally attempted. Both analyses were explored in relation to tobacco use by the IHWs. Common themes were identified with coding data completed through a thematic analysis. Data were analysed by responses to questions with initial themes and subthemes developed (Creswell, 2009). As the study was initially conducted through an empirical methodology and did not initially include a critical Indigenous stance, the critical Indigenous analysis could not be applied as the initial questions asked did not seek information of inequality and/or social injustice. I searched the transcripts for evidence of oppressive forces and unjust circumstance (Kincheloe and McLaren, 2005); i.e., issues related to power struggles, issues of dominance, colonial impact and issues related to social situation. A standard content analysis was then undertaken by seeking common themes within the data (Sproule, 2010).

3.3.7 Community feedback

Community feedback was delivered to all study communities. Regional communities were provided with feedback with the exception of Katherine since staff at Katherine were not available at the time of travel to the community. Feedback included participants from the study communities and others who were newly appointed to positions. These feedback sessions were aided by a flip chart detailing the quantitative and qualitative results of the study. At the time of visiting the communities some participants were unavailable due to being on leave, study and/or family commitments, and thus did not receive feedback. Group and individual sessions were conducted to provide the feedback of results of the study. Individual feedback was time consuming; however, it provided further opportunities to discuss the results of the study at length.

New participants that were present at the time of the feedback were asked to complete a consent form to participate and their personal details recorded. Field notes recorded all participants' contributions to the feedback. A total of eight feedback sessions were delivered with a total of

seven additional participants. Additional information uncovered through this process is described in the following results chapter.

3.4 Parallel publishing – maintaining my cultural and academic responsibilities

Ensuring I maintain my cultural responsibility is essential; as is my responsibility to ensure I meet my requirements as a researcher in an academic field. As stated previously in my standpoint, navigating the Western academic system is a challenge and particularly so for Indigenous Australians that have historically been excluded from being active participants in the research process (Fredericks, 2008; Moreton-Robinson, 2000; Nakata, 2002; Smith, 1999). Moreover, the representation about Indigenous Australians during this time has been viewed through the lens of the non-Indigenous researcher in the position of observer who has written the context of the representation of the Indigenous subject (Fredericks, 2008; Moreton-Robinson, 2000; Nakata, 2002; Smith, 1999). Consequently, misrepresentations have been recorded as fact by the impartial 'observer' who has over time purported judgements upon and about Indigenous Australians through their writings based on their observations informed by their standpoint and theoretical lens.

What does this have to do with parallel publishing? This is an important question. In terms of parallel publishing I believe the former writings about Indigenous Australians have significant relevance. Enabling communities to read and participate actively in the knowledge process is crucial. Thus, writing through a variety of formats ensures that Indigenous communities are able to participate in the Western academic world and its systems. Parallel publishing provides the opportunity for those whom speak English as a second or third language or those not exposed to the research jargon and terminology, to gain insight into the research activity that may assist in the delivery of health care to the community.

Publishing program information, research progress and/or outcomes is common practice throughout the Western academy. This is done typically in academic journals and is also a means of acknowledging the contributions of participants (Temple-Smith et al, 2009). In addition, publishing provides the opportunity for funding to be formally recognised through outputs and is an important aspect of research and delivering the results to the academy to further the scientific base. A researcher's development and career progression is also dependent on the number of publications, including the impact factor of the journal (Temple-Smith et al, 2009). Additional factors for academic career progression includes grants including the amount of research funding received and supporting postgraduate research students to completion (Sanson-Fisher et al, 2008).

There is a large gap in provision of the outputs of research to the lay person, community or people to whom the study relates. The participants may not only be excluded from participating in the writing but also from accessing the final published product. How then does the published literature and those who write articles: i) meet the needs of a peer review process and, ii) ensure the research and/or publication is translated into practice at the service provider and/or community level and, iii) ensure the participants are able to access the outcome to which they have contributed opinions, time and trust?

Publishing solely for the purpose of the academy and policy makers can exclude some people and communities from firstly actively participating as an author and secondly being able to access the published content. The latter, ensuring publications are accessible to all people and communities, is of particular focus.

Generally, publishing articles for the different stages of a project may suffice to meet reporting requirements and research outputs of a project (Gabriel, 2010). However, multiple publications may be required depending on the scope of the study and the target audience. Translating research into accessible publications is important. Also important is the ability to adapt and modify publications as necessary to ensure the publication is accessible to the different target audiences. This is even true within the medical profession where there has been recognition of the need for highly specialised papers published in discipline specific journals to be rewritten and published in less-specialised language to make the message accessible to general clinicians (Rosenbaum, 2012).

3.4.1 The emerging parallel publishing concept

Parallel publishing is publication of the same data and its interpretation in more than one peer reviewed journal to make it accessible to different target groups. Ensuring the research is accessible to individuals, communities and Indigenous Health Workers (in the context of this study) is vital. Therefore, reporting the research findings in both mainstream academic journals and Indigenous specific journals, such as the Aboriginal and Islander Health Worker Journal, is important.

There appears to be limited published information on what may constitute parallel publishing. Although the term appears to be new, the concept behind parallel publishing has been implemented in the Western academic system for many years. Anton Breinl, the leader of research on tropical health and medicine from the Australian Institute of Tropical Medicine in the early 20th century, and after whom the current JCU public health centre is named, wrote in

such a way that would meet the criteria of parallel publishing. In 1914 a paper was written in the Medical Journal of Australia titled *"On the occurrence and pathology of endemic glandular fever a specific fever occurring in the Mossman District of North Queensland"* (Breinl, Preistley Fielding, 1914). This paper was written for a specific audience, General Practitioners in Australia, describing the symptomatology of the condition and treatment advice. The following year, Breinl et al (1915) published another paper in an international journal, the Journal of Tropical Medicine and Hygiene. Titled the same as the previously published paper, the authors modified the transcript to suit the targeted audience with an international focus. Some parts of the parallel paper included excerpts of the original paper verbatim. An acknowledgement in the second paper is made informing the readers of the former publication.

As the label implies, parallel publishing, serves the same purpose, publishing in more than one journal to reach a varied audience. Additionally the concept ensures accessibility to all potential readers regardless of educational, language barriers and knowledge around science or the research field. A parallel publication is published in parallel with another whereby the information is modified and changed to suit the target audience. The whole article is not an exact replication of the original article. In this case a publication would constitute a dual publication or be otherwise known as self-plagiarism (Bird, 2002; Loui, 2002 and Lowe, 2003).

The considerations to parallel publishing include issues around copyright laws with the signing of the licensing to the publishing journal. Guidelines developed for the editors of medical journals discuss this under the heading *"Duplicate Submission"* (ICMJE, 2009). They state that *"Most biomedical journals will not consider manuscripts that are simultaneously being considered by other journals."* However, they qualify this general principle with the statement *"However, editors of different journals may decide to simultaneously or jointly publish an article if they believe that doing so would be in the best interest of public health."* An amazing example of making an exception to the rules around duplicate submission is the simultaneous publication of the PRISMA guidelines (Preferred Reporting Items for Systematic Reviews and Meta-analyses) in 10 different journals (Moher, Liberati, Tetzlaff, Altman, The PRISMA group, 2009).

Parallel publishing is not, dual publishing, nor is it dual submission. There are considerable modifications made to a parallel paper. Under copyright and editorial conditions there is a need to ensure the parallel paper is not included in systematic reviews or meta-analyses as separate studies. Therefore, the parallel paper requires an acknowledgement of the originally published paper (Anderson, 2006; Hegyvary 2005 and Lowe, 2003).

3.5 My experience of translating information for Indigenous people and communities

The experience of translating information to Indigenous people and communities has been an ongoing activity for me as an Aboriginal Health Worker. In my various roles I often translated health information for Indigenous clients to assist in explaining complex concepts, for example, when a client is diagnosed with type-two diabetes. Receiving information regarding a new diagnosis may not be meaningful to the client initially. This is perhaps because medical terminology and clinical jargon combined with the emotional reaction can overload clients. The provision of information and education is required in order for the client to understand the diagnosis and prevention of long term complications. Thus, provision of health information delivered through a respectful and meaningful manner the client understands is important to ensure they are able to make informed decisions about their health care.

Language that is used to describe health information is vital. It would be disrespectful to use terminology and jargons the client may not understand; thus adding to their confusion. So as part of the knowledge translation process I utilise the most appropriate language based on my knowledge of the community. As I am Aboriginal, I am able to speak Aboriginal English. Additionally, from lived experience, I am also able to speak Torres Strait Creole. I utilised this ability to translate information to the clients in language they are able to understand in a respectful and meaningful manner, conceptualised in local cultural knowledge.

3.6 Translating research with Indigenous communities

As I have moved away from supporting individual clients to research, I apply the same methods to the translation and interpretation of research for Indigenous communities. Ensuring communities have the ability to receive, understand and comprehend the research is important. This knowledge and experience I utilise on a regular basis every day in my current work as an Aboriginal researcher. Translating research into a format that community can understand isn't about *'dumbing'* it down; it is providing an explanation as to how research can be implemented in a meaningful and respectful manner. Whilst this study is a Masters level, the concept of parallel publishing will be explored in future research I conduct.

3.7   Ethical considerations

The Health Worker Smoking Study was approved as an addendum to the existing ethics for the Top End Tobacco project NHMRC #436012 with ethics approvals granted by the Menzies School of Health Research and Northern Territory Department of Health and Families. As the

study formed part of my Masters, ethics was also required by JCU. Approvals were granted by the following:

1. Menzies School of Health Research and NT Department of Health and Families HREC dated 27th July 2009, ref # 07/07 (see Appendix 3);
2. James Cook University Human Research Ethics Committee, ref# H2572 (see Appendix 4).

Prior and informed consent of participants was obtained at the time of approach when invited to participate in the study. This included discussing the purpose of the study, reading through the information sheet. Participation also included discussion around the ethics and the process should a participant seek to make a complaint.

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Chapter 4: Results

Introduction

As described in Chapter 3 Methods this study used a mixed methods approach. In the quantitative section, I provide a description of the sample, the demographics and complete a statistical analysis to assess the level of association between variables. The qualitative analysis uses content analysis to identify themes.

4.1 Quantitative analysis

4.1.1   Participants

The 43 participants were predominantly female (67.4%) health professionals working in the non-government sector (67.4%) and 58.1% were Indigenous (Table 4.1). The majority of the sample was employed within the community controlled sector (67.4%). A slightly larger proportion of health service staff from regional towns and a capital city serviced the communities with 51.2% of participants from these areas. The participants were mostly employed as Indigenous Health Workers or Allied Health Professionals (including Indigenous staff), 37.2% and 34.9% respectively.

Table 4.1: Description of participants (n=43).

Characteristic	Number (%)
Gender	
Male	14 (32.6%)
Female	29 (67.4%)
Employer	
Government	14 (32.6%)
Non-Government	29 (67.4%)
Location	
Remote community	18 (41.9%)
Regional town or Capital city	22 (51.2%)
From other state	3 (7.0%)
Indigenous status	

Indigenous		25 (58.1%)	
Non Indigenous		18 (41.9%)	
Position held			
Indigenous Health Worker		16 (37.2%)	
Indigenous Community Worker		5 (11.6%)	
Allied Health Professional		15 (34.9%)	
Registered Nurse		6 (14.0%)	
Doctor		1 (2.3%)	

4.1.2 Smoking status

A total of 42 participants provided information about their smoking status (Table 4.2). Within the sample Indigenous participants had a higher prevalence of current smoking than non-indigenous participants (37.5% vs. 5.6%). Females were more likely to be current smokers compared to males (25.0% vs. 21.4%). The prevalence of current smoking was higher in those employed in the non-government sector (31.0% vs. 7.7 %). For the IHWs the prevalence of current smoking was 37.5%.

Table 4.2: Sample characteristics within each variable and smoking status.

Characteristic	Smoking status n (%)			Fishers Exact Test
	Never	Former	Current	p-value
Indigenous	8 (33.3%)	7 (29.2%)	9 (37.5%)	0.035*
Non Indigenous	12 (66.7%)	5 (27.8%)	1 (5.6%)	
Female	14 (50%)	7 (25.0%)	7 (25.0%)	0.837
Male	6 (42.9%)	5 (35.7%)	3 (21.4%)	
Non-government	13 (44.8%)	7 (24.1%)	9 (31.0%)	0.246
Government	7 (53.8%)	5 (38.5%)	1 (7.7%)	
IHW**	5 (31.2%)	5 (31.2%)	6 (37.5%)	0.178
Non IHW	15 (57.7%)	7 (26.9%)	4 (15.4%)	

*p-values results of exact Fisher's tests;
** for the statistical test the characteristic was re-coded into Indigenous health worker yes, no.

4.1.3 Smokers and their intention to quit

All participants were asked if they were a current, former, never smoker. Those that provided information as a current smoker were asked questions about their smoking (Table 4.3). A total of eleven participants stated they were current smokers with IHWs accounting for 54.5% (n=6), Indigenous Community Workers 36.4% (n=4) and one Registered Nurse (9.1%). The smokers were asked where they considered they were on the stages of change model in relation to quitting smoking. One participant stated he/she was not thinking about quitting (9.1%), eight (72.7%) participants stated they were thinking about quitting, with two (18.2%) participants stating they were actively trying to quit at the time of interview. Quit attempts were discussed

with eight (72.7%) participants stating they had attempted to quit before. These quit attempts varied in length with 42.9% (3) stating they were abstinent for one to three weeks, one (14.3%) participant stayed abstinent for up to a year, and three (42.9%) participants stated they were abstinent for longer than a year. The most common method of quitting was by participants going 'cold turkey' (85.7%); two (14.3%) had used NRT. The reasons for wanting to quit included health 3 (42.9%), pregnancy, breastfeeding or caring for children 2 (28.6%), playing sport 1 (14.3%), or other reasons 1 (14.3%).

Table 4.3: Characteristics of the smokers (n=11).

Characteristic	*Number (%)
Position held	
IHW	6 (54.5%)
Indigenous Community Worker	4 (36.4%)
Registered Nurse	1 (9.1%)
Stage of change	
Not thinking about quitting	1 (9.1%)
Thinking about quitting	8 (72.7%)
Actively trying to quit	2 (18.2%)
Previous quit attempts	
Yes	8 (72.7%)
Length of quit attempts	
1-3 weeks	3 (42.9%)
1 – 12 months	1 (14.3%)
Greater than 1 year	3 (42.9%)
Methods of quitting	
Cold turkey	6 (85.7%)
Pharmacotherapy (NRT)	2 (14.3%)
Reasons for quitting	
Health	3 (42.9%)
Pregnancy, breastfeeding, caring for children	2 (28.6%)
Playing sport	1 (14.3%)
Other	1 (14.3%)

*Not all participants answered all questions.

4.1.3 IHW smoking status and providing tobacco advice

For further analysis, the IHWs were grouped and recoded to enable statistical analysis to be conducted with this group within the larger sample. A clear majority of IHWs stated that IHWs' smoking was a barrier (Table 4.4). However, most IHWs stated that they did provide tobacco information and gave quit support (Table 4.4).

Table 4.4: Responses of IHWs to smoking and support questions.

Questions (number of participants answered)	Yes n (%)	No n (%)	Fishers Exact
Is IHW smoking a barrier? (n= 15)	12 (80%)	3 (20%)	0.059
Do you provide tobacco information? (n=16)	15 (93.8%)	1 (6.2%)	1.000
Do you provide quit support? (n=14)	12 (85.7%)	2 (14.3%)	1.000

The response from participants who were not IHWs to the question whether IHWs smoking was a barrier to providing quit advice was similar, with 100% saying "yes" out of the 22 who answered this question.

When never smokers and former smokers were combined into a single group the results was not statistically significant (Table 4.5).

Table 4.5: Responses of IHW by their smoking status.

Questions (number of participants answered)	Never smoked n (%)	Former smoker n (%)	Current smoker n (%)	Fishers Exact
Is IHW smoking a barrier? (n= 15) YES	5 (41.7%)	4 (33.3%)	3 (25.0%)	.725
Do you provide tobacco information? (n=16) YES	5 (33.3%)	5 (33.3%)	5 (33.3%)	1.000
Do you provide quit support? (n=14) YES	3 (25%)	4 (33.3%)	5 (41.7%)	.725

4.2 Themes from Qualitative Questions

4.2.1 Barriers to providing advice

Barriers that impede IHWs ability to provide tobacco information and/or cessation advice were grouped into three themes: mixed messages (Table 4.6), role of IHW compromised when they smoke (Table 4.7); community knowledge of IHW's smoking status impacts on delivery of education (Table 4.8).   To make the results more meaningful they are divided by the participant's respective professions and Indigeneity.   Presenting the results in this way demonstrates the views of IHWs themselves and those of their colleagues.

Table 4.6: Barriers that impede IHWs being able to provide tobacco information and/or cessation advice to their communities.

Theme	Participant group	Analysis
Mixed messages	IHWs	• Community don't want to listen/speak to IHWs if they smoke • Some IHWs identify providing tobacco information when also a smoker can be difficult • Community members view IHWs as key health professionals who need to model healthy behaviours as an example to the community
	Other Indigenous participants	IHWs that smoke: • Thought to give mixed messages • Lack credibility • Seen as hypocritical • Community will not take IHWs seriously if they smoke
	Non Indigenous participants	• IHWs shame to provide information if they smoke • Ask limited questions (may not be able to broach the subject with community) • Has a reduced impact on the effectiveness of strategies with community • A perception within the community could be that IHWs are health professionals and should know better • The role of IHWs and the community expectation that IHWs lead by example

Analysis of the themes supported by participant quotes.

Theme: Mixed messages

Indigenous Health Worker responses

IHWs themselves felt that to provide tobacco information and/or cessation advice would give mixed messages to the community.

> *"Sending out mixed messages and you can't because they see you with a cigarette"*

IHWs described the difficulty they experienced in providing health information about smoking to their community.

"Difficult to provide health information if IHWs are smoking themselves"

Community members may view IHWs as people with knowledge and people they look up as health professionals. Some community members see them as people that need to model healthy behaviours to the community. Thus if IHWs don't smoke, it may encourage the community to address their own smoking.

"Community members may see IHWs as someone to look up to if they themselves quit"

Other Indigenous Participant's responses

The other Indigenous participants supported the idea that, if IHWs smoked and provided tobacco information and/or cessation support, they would be giving mixed messages.

"Gives half-hearted messages"

Credibility, where IHWs were considered as being hypocritical and were thus not taken seriously, were other ways of describing mixed messages.

"IHWs who smoke lack credibility within the community "do as I say not as I do"
"Hypocritical to give information themselves"
"Hard to take IHWs seriously if they're not practicing what they preach".
"No good to be a IHW and talk to patients if you smoke"

Non-Indigenous Participant's responses

The perception of IHWs and their role within the community could add to the reason for credibility being an issue. As a health professional and role model there appears to be an expectation that IHWs should not smoke. This then imposes a responsibility and pressure on IHWs to conform and lead by example based on to these perceptions and expectations.

"If you're a IHW you should know better might be the perception in the community"
"IHWs pressured to put up a good example"
"Community people feeling they are doing things and not leading by example"

Table 4.7: Role of IHW compromised when they smoke.

Theme	Participant group	Analysis
Role of IHW compromised when they smoke	**IHWs**	• IHWs need to have knowledge • The role of IHWs are valued and important • IHWs are reluctant to broach the subject as community know who smokes • IHW duty of care to provide information to the community
	Other Indigenous participants	None identified
	Non Indigenous participants	• Duty of care is to provide information whether a IHW smokes or not • The role of the IHW needs clarification and the scope of their work • Own personal views and judgments of others (colleagues and community) impacts on IHWs being able to deliver basic screening procedures (BI's)

Theme: Role of IHW compromised when they smoke

Indigenous Health Worker responses

IHWs have a vital role in provision of health information to the community. This study demonstrates IHWs' role and the expectations placed on them in terms of fulfilling this role.

> *"IHWs are important people"*
> *"Role of IHWs important"*

Given that IHWs have a significant role to play and the communities have high expectations of them, if IHWs smoke, it could make them feel reluctant to provide tobacco information through implementation of brief interventions. It was reported by participants in this study that community members do not want to talk about smoking with IHWs if they smoke.

> *"IHWs reluctant to provide brief interventions and community don't want to speak to IHWs if they smoke"*

Whilst the reluctance to speak with community about smoking and added pressures of community perceptions weigh heavily on IHWs, their role as an educator remain. The duty of

care to provide information so that community members can make informed decisions is highlighted in these next responses. However, the contradiction and pressures of community knowledge is prevalent and is linked with IHWs not completely fulfilling their role as an educator.

> *"Every IHW should deliver the health service to the community whether they smoke or not"*

Non Indigenous Participant's responses

The perspectives of the non-Indigenous participants were similar. The views were that IHWs would be less likely to fulfil their duty of care as a result of the lack of credibility and/or community perceptions that IHWs shouldn't smoke.

> *"Less likely to provide brief interventions due to own issues"*
>
> *"Telling/educating/informing people not to smoke doesn't hold much credibility"*

The non-Indigenous participants articulated their views in relation to IHWs smoking giving mixed messages. These participants thought that where IHWs smoked they would be less likely to provide tobacco information and/or cessation support and may be reluctant to broach the smoking question during the screening process with clients.

> *"Feel shame to provide information if they smoke"*
>
> *"Less likely to ask smoking related questions (to do BI's or in screening process)"*

Therefore, if the community is aware of IHW smoking, attempts to address or reduce the smoking rates may be less effective.

> *"Less of an impact if a smoker advises another to quit and continues to smoke"*

In comparison with the health sector, a non-Indigenous participant highlighted their knowledge of Doctors that smoke and their ability to fulfil their role in provision of information to clients.

> *"I know a lot of Dr's that smoke and still provide tobacco information"*

The role of the IHW continues to be misunderstood. This study identified the need for clarity of the role of the IHW and the extent of their capacity in providing tobacco information and/or tobacco advice.

> *"IHW role poorly defined; there is confusion of the role and what they do"*

Table 4.8: Community knowledge of IHW smoking status impacts on IHW delivery of education.

Theme	Participant group	Analysis
Community knowledge of IHW smoking status impacts on IHW delivery of health education activities	**IHWs**	• Cannot underestimate community knowledge and its impact • Shame related the community knowledge about who smokes and the community not listening to those that do
	Other Indigenous participants	None identified
	Non Indigenous participants	None identified

<u>Theme: Community knowledge of IHW smoking status impacts on IHW delivery of education</u>

Indigenous Health Workers responses

Local knowledge of community members has an impact on whether IHWs are able to deliver education messages to the community about smoking. Where the community are aware that IHWs smoke, provision of education is likely to be less effective. Thus this impedes the ability of IHWs to provide information if the community are not willing to listen to people that smoke. As a result, IHWs either withdraw and become shamed or still try to provide information to the community to meet their duty of care. The former is more likely to occur with the following comments suggesting 'shame' is an issue for IHWs.

> *"Sometimes, especially if they are smokers themselves as they are locally known"*
> *"Community knows if he/she is smoking, they might laugh and not listen"*

For those people that stated smoking was not a barrier for IHWs to provide tobacco information and/or cessation advice, personal choice, empathy and the IHW job role were raised. An IHW stated that they would be more empathetic to the struggle smokers have when trying to give up.

> *"Experience as a smoker I can relate, having more knowledge/understanding of what a smoker going through"*

Another IHW suggested that it was a personal choice whether IHWs and the community smoked and it would be up to them to decide when to quit. Additionally IHWs and the community are aware of the health risks associated with smoking. The IHWs stated:

"Community will give up if they want to"

"IHWs are aware smoking bad for their health"

"IHWs will know themselves if they want to quit or not, it's up to them"

The job role of IHWs was also identified in this question relating to the need to still deliver the health information for community to make informed decisions about their health. Separating themselves and their smoking is important to ensure duty of care is maintained and the community is able to receive information.

"It's not about them, it's about the knowledge they have about giving information to their clients"

4.2.2 Assisting IHW to be comfortable in providing tobacco information and quit support

In response to the question "What could help IHWs to be comfortable to give tobacco information and/or quit support?" two themes were identified: build confidence through increasing knowledge (Table 4.9); cease smoking (Table 4.10).

Table 4.9: Build confidence through increasing knowledge by attending training.

Theme	Participant group	Analysis
Build confidence through increasing knowledge by attending training	IHWs	• Building IHW capacity to increase confidence and knowledge • Nationally accredited courses that focus specifically on tobacco • Improve courses on brief intervention, motivational interviewing and comprehensive quit support
	Other Indigenous participants	• Build confidence to deliver tobacco strategies • Nationally accredited course that are aligned with competency based training • Tobacco Action Workers will need training that is more structured
	Non-Indigenous participants	• Need to increase knowledge through education and training to increase IHW knowledge and pass the information on. • Further training is required for tobacco cessation, harms, quitting methods, cue exposure

Theme: Build confidence through increasing knowledge

Indigenous Health Worker responses

Building capacity of IHWs through knowledge development to build confidence was a strong theme that came from the participants. Gaining an understanding and increasing knowledge was suggested as ways to increase the confidence to deliver tobacco activities.

> *"Being confident in delivering tobacco information"*
> *"Get an understanding of the big words, terminology, and medication"*

More training to gain further knowledge was called for by the IHWs that participated in this study. Whilst general health information was sought further insight into delivering brief interventions, motivational interviewing and quit support were suggested as ways to increase IHWs knowledge and skills through improved training options.

> *"More training to be clear about health and smoking, what's causing lung disease"*
> *"Better understanding of tobacco resistance, more training on tobacco issues"*
> *"Better training on brief intervention, more motivational interviewing, more comprehensive quit support"*

Other Indigenous participants' responses

The other Indigenous participants strongly supported the need to build capacity to increase IHW confidence to improve service delivery of tobacco programs to the community.

> *"Need to be confident to deliver the information"*

Additionally the other Indigenous participants urged for building capacity and training. More specifically nationally accredited training to enable participants to undertake training that is aligned with national competency standards that could contribute to a formal qualification. Through the implementation of the COAG funded 'Tackling Smoking' campaign the Tobacco Action Workers were identified as potential participants of such training to support community develop and arm the workers and IHWs with the necessary skills to address tobacco. A participant also identified that currently there are no structured courses available for IHWs; therefore, a course that is specifically designed for tobacco is required.

> *"Align with current courses, certificate, and competencies"*
> *"These new positions are going to need training. General training about tobacco. Roll out of these positions need to include 5-10 competencies in the training."*
> *"There's no structured training."*

Non Indigenous participant's responses

The non Indigenous participants also identified the need to increase IHW confidence through knowledge and education.

> *"Need to give people in that role information"*
>
> *"Increase in knowledge and skills around smoking cessation that empowers them and increases confidence to pass that on"*
>
> *"Training, more education about tobacco harms, quitting methods, triggers etc"*

Table 4.10: IHW stopping smoking.

Theme	Participant group	Analysis
IHW stopping smoking	IHWs	To be comfortable to deliver tobacco information IHWs need to be non smokers
	Other Indigenous participants	IHWs to quit themselves to increase their confidence to be able to provide tobacco information to the community
	Non-Indigenous participants	• Pressure on IHWs and some may smoke for similar reasons to the communities • A call for IHWs to quit themselves to lead by example • Acknowledgement of people quitting and the social exclusion/isolation from their social network • Duty of care remains with the separation of the personal smoking story to that of the community

<u>Theme: IHW stopping smoking</u>

Indigenous Health Worker responses

IHWs' smoking came up as an issue again. In this context participants identified the need for IHWs to be supported to feel that they can credibly meet the requirements of their positions as a health educator.

> *"Need to throw away everything away, drinking, tobacco, from their lives to be health and good role models"*
>
> *"Clients know I smoke, be a non-smoker"*
>
> *"IHWs that don't smoke"*

Other Indigenous participants' responses

The other Indigenous participants also identified the need for IHWs to address their smoking which could assist them to be more comfortable in providing tobacco information and quit support to their communities. These participants supported the role that IHWs could play in being a role model to community if they address their smoking.

"More comfortable if they don't smoke and show they are role models to community"

Non Indigenous participants' responses

The non-Indigenous participants identified a number of issues relating to the reasons why IHWs may smoke. The role that IHWs have within communities to lead by example, but also maintain their local and familial connections may be difficult to manage at times. There also remains the urge for IHWs to quit themselves so they can lead by example.

> *"It must be a lot of pressure to lead by example. Some IHWs may smoke due to reason similar as community smoking"*
>
> *"Difficult for smokers to quit if they are going to give up and there is exclusion from their social group"*
>
> *"Support for them to cease smoking themselves"*
>
> *"Getting the message across that as IHWs they should lead by example"*
>
> *"Don't have to be a non smoker, just have to give the story/facts"*

4.2.3 Support for IHW to quit smoking

In response to the question "What kind of support could help IHW to quit?" two themes were identified: supportive environments (Table 4.11); access to pharmacotherapies (Table 4.12).

Table 4.11: Supportive environments.

Theme	Participant group	Analysis
Supportive environments	**IHWs**	• IHWs should be ready to address their smoking status and not be forced. • Workplaces need to provide support and be supportive • IHWs being open and sharing about their needs that could assist them to quit • Organisational and workplace support programs • Ensuring localised support is available to assist people in their quitting/cutting down journey • Ensuring families, workplaces and social networks are supportive
	Other Indigenous participants	• Providing encouragement and support to IHWs • Develop a national campaign to address the smoking of IHWs which may assist to build credibility • Worker incentives • Support of former smokers ('tobacco champions') whom could support others
	Non-Indigenous participants	• Increase opportunities for training which may act as a brief intervention to encouraging IHWs to addressing their smoking • In person support is needed • A holistic approach to quitting ensuring people are well supported with the information to make informed

		decisions about their smoking
		• Supporting IHWs through a variety of ways – group/individual support

Theme: Supportive environments

Indigenous Health Worker responses

The IHWs provided a number of suggestions as to how IHWs could be assisted to quit. In addition, a qualifier came from the group that IHWs needed to be supported and not pushed (or coerced) into quitting. Sharing and supporting IHWs were clear key messages.

> *"Should come from the IHW if they want support to quit. If they are ready, I would sit with them, tell ngarali story and show resources. I would share my ngarali story"*
> *"IHWs share their own ideas how to quit"*
> *"Talk and support them to quit ngarali, they have to share their problem with us"*
> *"Support them at work"*
> *"If you force people to give up, you get a negative reaction"*

 A participant further qualified supportive environments by describing the need for workplaces and social networks to be supportive as well.

> *"Create environment that allows them to quit, family and social networks, provide support, individual need to support for the family and social network"*

When supporting IHWs within the workplace, proving both individual and group support was thought to be important.

> *"Organizational support, peer support in workplace individualized support.*
> *"Workplaces need to support IHWs, quitting together"*
> *"Support in the workplace, sharing with other IHWs"*

Those supporting IHWs needed to be mindful that quitting may be difficult; thus, as a support network it was important to understand the quitting journey by being supportive and understanding.

> *"Understand the mood swing/withdrawal stages"*

"Quit buddy, keeping me away from smokes"

Other Indigenous participants' responses

Other Indigenous participants further elaborated on the supportive environments. This group identified the need for encouragement and support within the work place as well as having personal support by those that have quit before.

> *"Encouragement and support from local AOD worker"*
> *"Supporting each other in the workplace"*
> *"Get a non-smoker to provide some support"*
> *"An ex-smoker – that would be right person because they have been through it before"*

Providing assistance with NRT was also thought to be another strategy for workplaces.

> *"Assistance with NRT, get people talking- how we might give it a go, support in the workplace with patches etc".*

Providing worker incentives in workplaces was another suggestion that could assist and motivate IHWs to address their smoking.

> *"Worker incentives in the workplace"*

Campaigns across the country targeting IHWs were thought to be another way of motivation.

> *"National campaign that targets IHWs across the board"*

Participating in courses and cessation groups were ideas that might assist IHWs.

> *"Quit smoking course – as a client initially "*
> *"Systematic approach to quit support in learning from others, taking part of quit groups and personalize it"*

Non Indigenous participants' responses

The non-Indigenous participants had similar views as other with the need to be supportive and encouraging of IHWs to quit. The role of groups was thought to be important.

> *"Support as part of employment"*
> *"Someone to be there when pressure builds and becomes too much"*
> *"Supporting IHWs to be non-smokers through group environments with other smokers"*

"Show 'em its possible, stories about other successful quitters"

"Monitoring from supportive staff, friends and family"

"Quit courses, someone to talk to in the community, group support"

A participant further articulated the interconnectedness of quitting and for the approach to be individualized for each person. Further qualifying the need to understand that there are many factors to supporting people by walking with them through their journey.

"Unique for each individual, need someone that is walking with them to help choose a path for them. Need to look at everything to do with life, coping mechanisms – the whole spectrum. Need to walk with people through that process"

Provision of training may be the vehicle to commence the thinking process for IHWs that smoke to consider the harms and look at their own smoking.

"Training might be a motivator for them to quit"

"Give them information/tools to quit"

Within the workplace making cessation a priority by the clinics were thought to be a way to assist IHWs to address their smoking behaviors. Using the idea of setting goals and time frames with rewards may entice people to cut down and/or quit smoking.

"Make cessation a priority by clinics; use it as a project setting goals, strategies, time frames and rewards"

Table 4.12: Access to pharmacotherapies.

Theme	Participant group	Analysis
Access to pharmacotherapy's	**IHWs**	• Ensuring pharmacotherapies are available for IHWs that want to address their smoking • Giving the full information about the pharmacotherapies to ensure people are informed about the medications and how they work.
	Other Indigenous participants	• Important that access to pharmacotherapies is available • Access to pharmacotherapies
	Non-Indigenous participants	• The inclusion of paid NRT within workplaces may entice more smokers to attempt to quit • More training around pharmacotherapies could support the community further in their journey to cutting down/quitting • Provision of pharmacotherapies by workplace, particularly where new smoke free policies are being implemented

<u>Theme: Access to pharmacotherapies</u>

Indigenous Health Worker responses

The IHWs stated there was a need for an increased availability of and access to NRT. Additionally, more information is required in relation to the use of NRT, and its effects.

> *"Availability of NRT, more access to NRT"*
>
> *"Tell story about medication, how people should take their tablets, patches – how to use the patches"*
>
> *"Sometimes Dr's and Nurses give the patches and don't explain about the patches"*

Other Indigenous participants' responses

Other Indigenous participants supported provision of NRT.

> *"Giving medicines (NRT)"*

Non Indigenous participants' responses

The non Indigenous participants supported access to NRT to assist with quitting. A subsidy for NRT was suggested for those that need to purchase the product.

> *"Would be good to be able to have capacity to provide more education on NRT and other pharmacological products to increase use to support quitting"*
>
> *"NRT subsidy"*

4.2.4 Providing Information and Education to the Community

Participants who answered "Yes" to the question "Do you provide information and/or education to the community?" were encouraged to provide details about their activities in this area. Four themes were identified: health promotion / health education activities (Table 4.13); settings where activities took place (Table 4.14); brief interventions (Table 4.15); providing information to family and friends (Table 4.16); quit courses (Table 4.17).

Table 4.13: Health promotion/health education activities.

Theme	Participant group	Analysis
Health promotion/health education activities	IHWs	• A broad range of health education and health promotion activities are provided by IHWs. • Various resources are utilised to assist in delivering these activities • Messages include the importance of second hand/passive smoking • Sharing of information is important

	Other Indigenous participants	• A broad range of health education and health promotion activities are provided • Community are involved in discussions with the role of Elders important
	Non-Indigenous participants	• A broad range of health education and health promotion activities are provided • Provision of information so that people can make informed decisions about their options to address their smoking

Theme: Health promotion/health education activities

Indigenous Health Worker responses

The IHWs stated they provided a range of health promotion/health education activities to the community that included: individual and group education; and using models and a variety of resources and methods to help deliver health information to the community. This education was based on a broad range of health issues.

> *"One on one education, group work"*
> *"Small group work with men's health group"*
> *"Demonstration using models"*
> *"Talk to young kids, ages 14-15 years"*
> *"When people come to the clinic, general information"*
> *"Deliver tobacco messages, activities on smoking with kids/families"*
> *"Share information, ngarali story"*
> *"Developing DVD's, going to community and giving information"*
> *"Yarning with the community"*

Other Indigenous participant's responses

Other Indigenous participants stated they provided a broad range of health promotion/health education activities to the community.

> *"Education awareness"*
> *"One to one, group work"*
> *"Passive smoking around children"*
> *"Not to smoke in the house or where children are playing"*
> *"Try to help Elders think about ngarali"*

Non Indigenous participant's responses

Non Indigenous participants articulated that in their own roles they performed similar community based activities as IHWs and other Indigenous participants.

> *"One on one session every community visit to every adult client"*
>
> *"Health education to health providers, interested parties"*
>
> *"Tobacco cessation sessions, posters, pamphlets, talks on NRT, brief interventions and motivational interviewing to small community groups"*

A non-Indigenous participant also stated they provided information specific on tobacco cessation that incorporated provision of information to make informed decisions about quitting.

> *"At AMS, outline different options, most people went cold turkey, discussed pharmacotherapy options"*

Table 4.14: Environments/settings where activities take place.

Theme	Participant group	Analysis
Environments/settings where activities take place	**IHWs**	• A variety of community settings are included when delivering tobacco activities
	Other Indigenous participants	None identified
	Non-Indigenous participants	• A variety of community settings are included when delivering tobacco activities

Theme: Environments/settings where activities take place

Indigenous Health Worker responses

Delivery of health promotion/health education by the IHWs to the community occurred in various places.

> *"Education in the homes and schools"*
>
> *"Home visits"*

Non Indigenous participants' responses

Non Indigenous participants also utilized a range of sites to deliver the health promotion/health education activities.

> *"Sports and rec, schools"*

Table 4.15: Brief interventions, motivational interviewing, screening process.

Theme	Participant group	Analysis
Brief interventions, motivational interviewing, screening process	**IHWs**	• Provision of community education help deliver tobacco information through the use of resources such as the story board.
	Other Indigenous participants	None identified
	Non-Indigenous participants	None identified

Theme: Brief interventions, motivational interviewing, screening process

Indigenous Health Worker responses

IHWs suggest further training in brief interventions. They also stated they used the tools to share health messaged out in the community and when community members presented at the clinic.

> *"Train IHWs in brief interventions"*

> *"IHWs go out and have tools to share the story. We sometimes give the story when people come to the clinic"*

Table 4.16: Providing information to family and friends.

Theme	Participant group	Analysis
Providing information to family and friends	**IHWs**	Community education isn't just limited to IHWs and their professional role. Sharing their knowledge extends beyond the work place to incorporate information, sharing of knowledge with family and friends
	Other Indigenous participants	None identified
	Non-Indigenous participants	None identified

Theme: Providing information to family and friends

Indigenous Health Worker responses

IHWs stated that they provided health information and education to members of their families in addition to their professional roles.

> *"I try to encourage family with bad asthma and lung disease from ngarali, gunga and kava"*

> *"Share information with family and friends"*

"Speak to family, my sons to quit"

"I talk to my family and friends about my journey and how I quit, take home pamphlets"

Table 4.17: Quit courses.

Theme	Participant group	Analysis
Quit courses	IHWs	None identified
	Other Indigenous participants	Courses that are modified for Aboriginal people
	Non-Indigenous participants	Courses that are modified for Aboriginal people

Theme: Quit courses

Other Indigenous participant's responses

Courses to assist in delivery of health education/health promotion of tobacco messages were suggested that were designed specifically for Indigenous people.

"Quit courses modified for Aboriginal people"

Non Indigenous participant's responses

In order to deliver health messages to community non Indigenous participant's provided programs on smoking cessation through a range of mediums.

"Quit tobacco courses"

"Smoking cessation presentations"

4.2.5   Assisting IHWs to provide information more effectively

In response to the question "What could help you provide information about tobacco with the community more effectively?" three themes were identified: resources required (Table 4.18); time to deliver tobacco activities (Table 4.19); provision of cessation support (Table 4.20)

Table 4.18: Resources required.

Theme	Participant group	Analysis
Resources required	IHWs	• Resources highlighted include; • Need for social marketing to incorporate real life situations – not animated/cartoon pictures • Financial support to: • purchase/develop resources • Ensure program continuity • Assess and evaluate current programs to investigate

		what is happening elsewhere and what works
	Other Indigenous participants	• Resources that are translated into the local language.
		• Improve access options by having localised in-person support and programs where community people can be referred to.
	Non-Indigenous participants	• Resources that assist with translating information about the harms of smoking; i.e., the use of the Smokerlyzer, social marketing products
		• There is a need to improve access to in-person support to assist those to address their smoking
		• There is a need to improve referral pathways for quit support

Theme: Resources required

Indigenous Health Worker responses

IHWs highlighted the need for many types of resources when trying to provide health promotion/health education activities to the community. Models, resource materials, funding and the development of tools are vital to assist in the delivery of health promotion and health education activities.

> *"Make pictures to help understand"*
>
> *"Need to have the right tools ie; resources models"*
>
> *"Real life stuff. Animated stuff don't work, don't look real. Use real people"*
>
> *"More financial support to get more material, more funding to help meet the cost to go to homelands and share this information"*
>
> *"Funding for resource development"*
>
> *"Ongoing funding for continuity"*

IHWs also recognised the need to identify potential programs to implement, evaluate activities;

> *"Pull all programs together to know what works and what doesn't, look at what's happening elsewhere"*

Other Indigenous participants' responses

Resources are often not available in the communities. Therefore, access was limited. The development of resources into local language was another method to assist with information sharing with the community.

> *"IHWs in cities have resources that can have an influence on which way they want to go. There's a lack of options in the remote communities like quit courses/programs to tap into and access to services for themselves"*
>
> *"Appropriate resources that local people could translate into local language"*

Non Indigenous participants' responses

Non Indigenous participants also identified a need to use a range of resources that were available to them to assist in delivery of health promotion/health education.

> *"Smokerlyzer"*
>
> *"Access to human support when they need it, this is to be able to speak to someone straight away"*
>
> *"Staff – another person to assist with quit support"*
>
> *Pictorial information, social marketing e.g. posters in stores/community places*
>
> *Limited resources and referrals points*

A participant stated they thought there was too much reliance on paper based information with more personal support required as well.

> *"Too dependent on pamphlets that may not be that helpful, more personal support is needed"*

Table 4.19: Time to deliver tobacco activities.

Theme	Participant group	Analysis
Time to deliver tobacco activities	**IHWs**	None identified
	Other Indigenous participants	None identified
	Non-Indigenous participants	- Time is limited to deliver tobacco programs, sessions - Tobacco is often not a top priority and can be viewed as less important as other health and social issues - Staff time constraints impede the ability to provide good quality support to people when they are motivated to address their smoking

Theme: Time to deliver tobacco activities:

Non-Indigenous participants' responses

The non-Indigenous participants stated that there wasn't enough time given to smoking strategies which required more regular visits to the communities and time given whilst there. Addressing tobacco wasn't always a priority with other drug issues, crisis intervention and/or other pertinent issues being of concern and needing addressing.

> *"Never given the time in AMS around smoking"*
>
> *"Health services/clinics are not pro-active"*

"Time constraints as a Dr impedes delivery of education/information sharing"

"More intensive time in communities"

"More regular visits and more time on visits"

"Higher priority people tend to knee jerk to other drug use"

"Less crisis / DV / alcohol / sniffing / cannabis / housing / educated / parenting issues etc that seem to always require immediate action and resources. Tobacco is always poor cousin"

Table 4.20: Provision of cessation support.

Theme	Participant group	Analysis
Provision of cessation support	**IHWs**	• Quit support is limited; however, IHWs do provide support where possible • Referrals are made to doctors and nurses for assistance with pharmacotherapies
	Other Indigenous participants	None identified
	Non-Indigenous participants	Minimal cessation support is provided mostly education and training.

Theme: Provision of cessation support

Indigenous Health Worker responses

IHWs stated they provided information to the community about medication that could assist community with quitting, provide referral pathways and sharing of stories to promote health messages.

"Tell ngarali story, I help my brother in law with patches"

"One to one support. Referrals to doctors for tablets/patches. Promote health activities, eating exercise"

"Provide some information about tablets, patches and gum"

Non Indigenous participant's responses

Non Indigenous participant's provided examples of how they supported people to quit which included provision of education, behavior change strategies, referral to the Quit line in addition to provision of pharmacotherapies.

"To community by providing education/training opportunities for individuals and groups to be the trained person in the community"

"Behaviour change strategies, homelands can't access quit line"

"Quit number, provide pharmacotherapies"

4.2.6. Emerging themes across questions

Two additional themes emerged across the data: normalization of smoking in communities and with IHWs (Table 4.21); pressures that IHWs encounter in their job (Table 4.22).

Table 4.21: Normalization of smoking.

Theme	Participant group	Analysis
Normalisation of smoking	IHWs	Smoking is linked to the family life and the normalization within families.
	Other Indigenous participants	None identified
	Non-Indigenous participants	- Smoking is perceived as a 'normal' thing to do. - Peer pressure – un-cool not to smoke - If community members see health professionals smoking they may themselves continue to smoke as well. - If people of influence within the community smoke, this continues to normalize smoking

Theme: Normalization of smoking

Indigenous Health Worker responses

An IHW described smoking as being linked with their parents as a comfort mechanism. This was linked to being safe for them as it reminded them about what their parents did.

"I associated smoking with being safe as my parents smoked, gave me comfort that reminded me of my parents. I felt safe because that's what my parent did"

Non Indigenous participant's responses

Non Indigenous participants provided their perceptions about the normalisation of smoking in communities and with IHWs. Acceptance of smoking was seen to be influenced by family members and/or significant people within the community.

"It is acceptable if persons of influence are engaging in smoking"

"People look to all health professionals to understand what it means to be healthy. However they equate their lifestyle with how health professionals behave, thus if health professionals smoke they normalise this"

"Some IHWs may not perceive smoking as a health issue, just an unrelated thing to do"

"Uncool 'not' to smoke"

Table 4.22: Pressures IHWs encounter in their jobs.

Theme	Participant group	Analysis
Pressures IHWs encounter in their jobs	**IHWs**	None identified
	Other Indigenous participants	Pressures IHWs are under especially living and working in their own community can be difficult and they do not have the ability for respite from the community
	Non-Indigenous participants	Non identified

<u>Theme: Pressures IHWs encounter in their jobs</u>

Other Indigenous participants' responses

The pressures on IHWs and their role both in the community and professionally were suggested as an area of discussion.

> *"Living and working in the community as a HW, especially if you're a local HW there's not enough respite from the community or limited breaks for the HW's. Local people have more pressures than Dr's and Nurses or other HW's from other communities. There is fairly constant pressure on local HW's"*

4.3. Community feedback

During the feedback of the data to the communities, participants provided further clarification, support and/or new discussion points. Only new themes and units of meaning derived from the feedback are included (Tables 4.23 to 4.28).

Table 4.23: Helping IHWs to quit.

Theme	Participant group	Analysis
Helping IHWs to quit	**IHWs**	• Workplace support needed • Provision of pharmacotherapies in the workplace • Education and workshops for IHWs as well as community members • Personal support • Campaigns/quitting programs for IHWs, making it competitive may entice more

		• Strong workplace policies
	Other Indigenous participants	IHWs may become social outcasts if wanting to quit and excluded from their social group. Thus, there is a 'social' pressure to continue to smoke
	Non Indigenous participants	• Workplace support needed • Provision of pharmacotherapies in the workplace • Workplaces that have supportive policies to assist IHWs to quit • Smokers attempting to quit can assist further as they have a lived experience of quitting • Seek other/alternative methods which might assist

Theme: Helping IHWs to quit

Indigenous Health Worker responses

The IHWs that participated in the community feedback supported previous issues raised by those that completed the survey. In order to assist IHWs to quit, suggestions included a broad range of approaches focusing on workplace support, provision of pharmacotherapies, policies, and making quitting programs competitive between friends.

"Smoking campaign with all the IHWs"

"Support in the workplace"

"Patches and gum in the workplace"

"No smoking areas"

"No smoking policies"

"Make it competitive – friends who challenge each other to quit"

Other Indigenous participants' responses

Other Indigenous participants stated there was a social pressure for IHWs to smoke.

"Social pressure to continue to smoke"

Non Indigenous participants' responses

Non Indigenous participants reiterated previous ideas that could support IHWs to quit smoking. A new idea was the use of an alternate therapy such as hypnosis.

"Subsidized/workplaces should support and fund NRT, quit groups"

"If they're trying to stop, can be empathetic"

"What is the opportunity of doing hypnosis in the community? Indigenous people are spiritual people"

Table 4.24: The role of IHWs.

The role of IHWs was revisited with participants further reinforcing the importance of the role.

Theme	Participant group	Analysis
Role of IHWs	**IHWs**	- IHWs roles pivotal in the community - IHWs ability to translate health information - IHWs ability to speak in local language assists with knowledge translation - More recognition for the role IHWs play
	Other Indigenous participants	None stated
	Non Indigenous participants	None stated

Theme: Role of IHWs

Indigenous Health Worker responses

The pivotal role of IHWs was reiterated by participants given their ability to translate health information and knowledge to the community.

> *"IHWs are important people"*
>
> *"IHWs are important people, they can sit with people and talk about any problem. People come and sit and listen and share stories…. [Like] scabies, helping the people to understand. Tell story about medication, how people should take their tables, patches, how to use the patches".*

An IHW sought to recognize their role as a professional group.

> *"More acknowledgement of the IHWs position and pay incentives. Sometimes seen as the 'Jackie-Jackie'"*

Table 4.25: Impacts affecting IHWs.

Theme	Participant group	Analysis
Impacts affecting IHWs	**IHWs**	Pressures of living and working in the community impacts

		on IHWs' wellbeing
and their smoking	**Other Indigenous participants**	None stated
	Non Indigenous participants	The role of the kinship system can have a major impact in the way communication occurs within communities

Theme: Impacts affecting IHWs and their smoking

Indigenous Health Worker responses

IHWs suggested the pressure of being within the community on a fulltime basis impacted on their smoking.

> *"24hours/7 days a week with community"*
> *"Community pressures"*

Non Indigenous participant's responses

Non Indigenous participants provided more details of the kinship structures and how that may impede provision of health information to community being dependent on who could speak to whom, based on this system.

> *"Kinship system important in all peoples' lives. Relationships = interactions with others. Disrespectful / not appropriate to tell certain people not to smoke (ie; child – mother, father, elders, uncle, aunty)"*

Table 4.26: Consistent information by health staff to ensure consistent messages.

Theme	Participant group	Analysis
Consistent information by health staff to ensure consistent messages are given	**IHWs**	None stated
	Other Indigenous participants	Need for consistent messages by all staff and the support of colleagues to ensure IHWs are believed and supported within the workplace
	Non Indigenous participants	None stated

Theme: Consistent information by health staff to ensure consistent messages are given

Other Indigenous participant's responses

Consistent health messages delivered by staff are required. This group suggested the need for a uniform approach to providing information with the IHWs being supported in their roles.

> *"Consistent information across staff to give the same message"*
>
> *"Sometimes Drs and IHWs won't discuss issues if they present the clinic with associated illness"*
>
> *"Drs should be backing up IHWs"*

Table 4.27: Time constraints to provide smoking cessation and/or information to community.

Theme	Participant group	Analysis
Time constraints to provide smoking cessation and/or information to community	IHWs	Brief interventions are done; however, continued and sustained efforts to support people to stay abstinent are minimal due to limited time constraints
	Other Indigenous participants	None stated
	Non Indigenous participants	IHWs mostly delivering brief interventions, GP's do not have the time during consultations

Theme: Time constraints to provide smoking cessation and/or information to community

Indigenous Health Worker responses

The IHWs supported and reiterated previous comments relating to time. This group stated that whilst brief interventions were able to be completed, there wasn't much time to provide follow up and support for people wanting to quit.

> *"Brief intervention done but not much time for support"*
>
> *"No follow up in the community – no time"*
>
> *"IHWs are flat out and don't have the time, good quality counseling, unable to give counseling"*

Non Indigenous participant's responses

Time constraints by Doctors were further supported with little time for brief interventions which IHWs are more likely to provide. The general consult time was short and brief.

> *"GP's not delivering brief interventions, IHWs are. Time factor and cost of GP's time usually a consult is 12 minutes"*

Table 4.28: Training for IHWs and Tobacco Action Workers.

Theme	Participant group	Analysis
Training for IHWs and Tobacco Action Workers	**IHWs**	Formal training courses do not have smoking as a formal qualification
	Other Indigenous participants	• Training for the Tobacco Action Workers are needed with that incorporates a wide base of knowledge • IHW training needs to ensure brief interventions and motivational interviewing is covered
	Non Indigenous participants	None stated

Theme: Training for IHWs and Tobacco Action Workers

Indigenous Health Worker responses

Training was raised and further supported by this group with their need to have formal tobacco training within existing courses.

> *"No training in smoking at Batchelor"*

Other Indigenous participant's responses

Further support for training for IHWs and the Tobacco Action Workers was suggested that is nationally accredited with a basic knowledge about tobacco.

> *"Tobacco Action Workers need training, need to make nationally accredited. Similar to AOD Cert IV specifically on tobacco could include:*

- *Basic harms*
- *Brief interventions*
- *Health promotion project*
- *Case management*
- *Evaluation*
- *Pharmacotherapies/medicine"*

> *"IHW training should include brief interventions and Motivational Interviewing"*

Chapter 5:   Discussion

5.1 Chapter Overview

This study suggests that IHWs' ability to provide tobacco information or cessation advice to their community is adversely influenced if they smoke.   This result appears to support the conclusions from the literature review (Chapter 2) which identified that members of the community and other health professionals also believed this to be the case. The literature review uncovered a judgmental view of IHWs who smoke, as the majority of publications were written by non-Indigenous authors. This study is unique in that it captures the voices of IHWs and in doing so, they identify the need to address this 'conundrum' and propose a range of solutions. The qualitative component was done to allow the voices of the IHWs to be heard.

5.1.1 Legislative and policy impact on Indigenous tobacco smoking

Tobacco smoking remains the most preventable risk factor for the morbidity and mortality of Indigenous Australians and accounts for 600 Indigenous deaths each year and accounts for seventeen percent of the burden of disease in Indigenous communities (Vos et al, 2009). Despite the high prevalence of smoking, recent reports by Thomas (2012a and 2012b) describe a slight decline in prevalence of tobacco use in addition to a decline in intensity of smoking. Thomas (2012a) suggests the decline in smoking prevalence could have been influenced by the broader focused National Tobacco Campaign (1997-2005) . The increase in taxes on tobacco, social marketing strategies and smoke free area legislation could also have had some impact on Indigenous Australian smokers (Scollo and Winstanley 2008).

The influence of policy changes, increase in taxation and targeted efforts to reduce tobacco smoking through COAG initiatives will contribute further to decreasing the prevalence of smoking in Indigenous communities. The identified solutions presented by IHWs in this study help to equip and better position them to deliver smoking programs and strategies both professionally and personally, even while some of them may smoke themselves.

5.1.2 Ottawa Charta: A framework for action

The Ottawa Charter for Health Promotion provides a framework for health interventions to be developed, implemented and evaluated. The Ottawa Charter came from the International conference on Health Promotion in Ottawa, 1986 (World Health Organization, 1986). Responding to the new approach to public health the focus of Health Promotion has been to

enable individuals and communities to increase their control of their health and wellbeing. More specifically the Ottawa Charter includes the following statement:

> *"Health Promotion is the process of enabling people to increase control over, and to improve, their health. To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment….. Health promotion is not just the responsibility of the health sector, but goes beyond healthy lifestyles to wellbeing".*

Focusing on a population approach, the Ottawa Charter provides a framework to change the health of individuals and communities. The work by Laverack and Labonte (2000) describe two approaches to utilizing health promotion to empower communities to improve their health and wellbeing. This work details both 'top down' and 'bottom up' techniques. For the purpose of this part of the thesis I will include examples of how a 'bottom up' approach may be able to support IHWs in the workplace supported by the data from this study and current literature. I will focus on one area of the Ottawa Charter – Create Supportive Environments.

5.2 Hypothesis of this study

This study showed that IHWs interviewed in this study in the three remote communities thought that smoking does impede their ability to provide tobacco cessation advice or information to the community. Of all the other participants, one hundred percent (n=22), including those that were Aboriginal and non-Aboriginal, had similar perceptions. The finding supports the literature, including the literature review for this study (Adams and Walker, 2006; Andrews et al, 1996; Andrews et al, 1997; Lindorff, 2002; Mark et al, 2005; Pilkington et al, 2009; Thompson et al, 2011; West et al, 1998). There was minimal difference of opinions in the study between participants regardless of their ethnicity.

The minor differing opinions were expressed by three of the 12 smokers in the sample. They stated IHW smoking was not an issue. A participant explained their views in this way; *"Experience as a smoker can relate, have more knowledge and understanding of what a smoker going through"*. This empathetic view was later followed up with a qualifier of the health risks associated with smoking, *"Health Workers are aware smoking is bad for their health"*. Of the other eight smoking IHWs, data already presented has identified that IHWs feel they cannot provide tobacco information and/or cessation advice if they smoke themselves.

The discussions around IHWs smoking may be either positive or negative, depending on who is speaking and individual personal views on the topic. From the literature review, factors impacting on the attitudes about IHW smoking was dependent on whether the participants sharing their views were: i) IHWs themselves; ii) their smoking status; and iii) whether they had strong personal views about what IHWs perhaps 'should' and 'shouldn't' be doing as a health professional (Thompson et al, 2011). From this study data suggests a range of opinions. Some have strong views; *"No they shouldn't give information [if they smoke]"*. With other participants views are much less judgmental *"Many people feel that a person cannot show the way if they cannot walk it themselves"*. The majority of participants concluded there is a need to address IHW smoking. This study provides suggestions as to how this issue could be done.

5.3 Why do IHWs smoke?

There are concerns about IHWs smoking. Firstly, due to the health issues and secondly, owing to the role of IHWs as an important part of the health care team. An important new aspect of my study is listening to IHWs about what they would suggest might work in addressing this 'conundrum'. Smoking in IHWs has been a topic of discussion for some time as identified in the literature review (Thompson et al, 2011). Since the literature review was published, two more studies have been conducted, one with Aboriginal Health students in Western Australia (Hoad and Hayward , 2012) and another with IHWs in South Australia (Dawson et al, 2012a; Dawson et al, 2012b). Both studies identified stress as a key factor for IHWs continuing to smoke. The fact that the topic of smoking by IHWs and now Aboriginal Health Students is being investigated across the country is encouraging.

5.3.1 Smoking is a personal choice

The concept of smoking being a personal choice was stated by a number of participants. Interestingly, not all of these participants were smokers: *"Health Workers are normal people and shouldn't be treated any different. Their choice, freedom of choice"*. The relevance of this finding is when IHWs smoke in their own personal time and away from the workplace, what would be a considered a non-work related activity, then becomes a work issue because of the nature of their work role. It brings a fundamental question; should a person modify their out of work behavior because of the potential impact on their work role?

5.3.2 Social pressure to smoke

During the feedback process a participant described the link with social pressure to continue to smoke: *"Tried to give up. Stopped for one week…. Social pressure to continue to smoke"*.

Social pressure by peers and family members continues to inhibit smokers' ability to cut down or quit smoking (Nuygen et al, 2012). Smoking is an enjoyable and pleasurable experience for some people, and the social connectedness between people that smoke is a large part of the experience and one which is difficult to remove from people's lives (Dawson et al, 2012a; Poland et al, 2006). When addressing smoking it is important to factor in the social and family networks as a support for people taking action to quit. The literature indicates that families are ineffective in supporting smoking cessation (Park et al, 2012). This has yet to be explored within the Indigenous community context.

5.3.3 IHWs smoking and the link with stress

Stress has been found in a number of studies as a potential reason for the continuation of smoking or the reason for relapse. The work of Dawson et al (2012a) identified the link between stress, including the impact of grief and loss. Personal and professional stressors were identified in my study and provide insight to the complexities encountered by IHWs. As a result, to address the stress, grief and loss experienced, some IHWs may utilize smoking as a coping mechanism.

IHWs in these communities have spoken about stress with such comments as *"there is fairly constant pressure on local IHWs"*, *"Sometimes they stress out, any stress, work or family stress, might need stress management"*. From these comments stress appears to be constant and common in each community. Those that smoke may utilize smoking as a way to cope. The nicotine would provide the feel good lift that would appear to address their stress and worries (Dawson et al, 2012a).

 The impact of grief and loss was highlighted in this study by a IHW participant. The context was in speaking about the community in general not directly about IHWs. *"Some people, ladies, when their Husbands die…. Missing their husbands so need to find things to do and take up smoking or play cards"*. Given that grief and loss is a constant occurrence in Indigenous communities IHWs, like other community members, share similar experiences. Although not investigated in this study in depth, the presented quote eludes to the connection that smoking may be perceived as a form of stress relief and perhaps to relieve boredom (Dawson et al, 2012a).

There remains a gap in the literature about the reasons why IHWs continue to smoke, even after they may have participated in tobacco training. An IHW who smokes commented *"I got a certificate for doing smoking training yet I still smoke"*. Further research is needed to explore

the stressors IHWs encounter. Dawson et al (2012a) articulate some of these issues. To address the smoking prevalence the underlying causes need to be identified in order for effective action to be implemented.

5.3.4 Community connectedness between IHWs and the communities

IHWs are in high demand to assist with the health care of the community and are a constant resource in terms of provision of primary health care and assisting in the translation of complex health conditions with clients (Dawson et al, 2012a; Genat et al, 2006). IHWs based in these communities are commonly local people with familial and community connections (Thompson et al, 2011). Where strong relationships are established, the IHWs are able to engage with the community in a culturally safe and secure manner. The importance of the IHW role has been highlighted throughout this study.

IHWs have established trust and rapport with the community members; thus, enabling the delivery of health care to the community. During a follow up interview, a participant stated: *"People do trust me and what I say is truth"*. This role is important as it means that more people are likely to visit the clinic and seek the help or get the advice they require. The data also reinforces the role of the IHWs and the ability for community members to access health care services.

IHWs also have the added pressure of being part of the bigger community network. As a result of this relational connectedness (Wilson, 2008), IHWs are likely to be affected by grief and loss similar to that of the community and called upon by community members outside of work hours (Dawson et al, 2012a). This dual role of community member and key IHWs may contribute to burn out of IHWs; particularly those with strong local ties. If sufficient workforce support is not provided, there is a real risk of IHW burn out resulting in them leaving their jobs (Coaby, 1984). An IHW expressed this: *"Living and working in the community as a Health Worker, especially if you're a local Health Worker, there's not enough respite from the community or limited breaks"*. This study identified that IHWs had limited time away from the community; as such this potentially could increase the risk of burn out.

IHWs that are registered as practicing Aboriginal Health Workers in the Northern Territory also work after hours. An issue with the on-call role is that there is very little, if any, clinical supervision provided. This may be a particular issue for IHWs who have experienced grief or loss or been exposed to critical incidents in the workplace and broader community (Pack, 2012).

Thus, IHWs may smoke tobacco in these communities at similar levels to the community members as a coping mechanism for stress (Dawson et al, 2012a).

Participants felt that IHWs could possibly be under pressure to lead by example and to not smoke tobacco: *"It must be a lot of pressure to lead by example"*. Within the current evidence base there is a consistent message of this 'conundrum' that was previously identified in the literature review for this study (Thompson et al, 2011), but confirmed in the field by the IHWs themselves .

5.4 Comparison between views of the participant groups: were there any differences?

Although there were some differences between participant's views on the issue of IHWs smoking, the differences were minor. Perceptions were dependent on whether participants were community people and/or colleagues of IHWs and whether they were smokers. A small number of participants stated smoking didn't impede their ability to provide tobacco information or cessation advice. These participants were smokers themselves who reported that smoking was the choice of individuals and they would quit if they wanted to: *"Community will give up if they want to"*. Another participant commented: *"It's not about them, it's about the knowledge they have about giving information to their clients"*. Both participants were smokers.

5.5 Smoking in other professions?

Given that IHWs are most likely to be local community members themselves they can become the focus of negative opinions that 'they should know better'. Other health professionals such as doctors, nurses and allied health professionals also come up against this stigma. However, these health workers may not necessarily have the same pressure to quit as is witnessed in the IHW workforce.

In a review, Smith and Leggat (2008) described the decline in tobacco smoking by Australian physicians. The review links the knowledge of the health hazards associated with tobacco smoking as being one of the key factors of the physicians quitting smoking. By the late 1970s a significant decline in self-reported smoking was identified through a number of studies. Further to this, as the connection with tobacco and lung cancer became more widely known, professional bodies such as the Australian Medical Association advocated more broadly and opposed the use of tobacco throughout the 20th century (Smith and Leggat, 2008). Physicians over time have progressively become involved with the anti-tobacco movement (Smith and Leggat, 2008).

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While Physicians' smoking has declined, literature exploring smoking by nurses provides another viewpoint. The nursing profession has not been as successful as the physicians in reducing prevalence of smoking. A study completed in 2009 in Canada was conducted with the purpose of describing how nurses that smoked were able to provide health promotion interventions to clients who also smoked (Radsma and Bottorff, 2009). The 23 nurses in this mostly qualitative study had some experience of caring for clients who smoked and had smoking related conditions. This paper provided evidence highlighting similar experiences for nurses, as for IHWs, when contemplating the discussion of smoking with clients. Eighteen of the 23 nurses were current smokers who reported they too had difficulties in engaging with the clients owing to their smoking. The difference between the nurses in this paper and my study is that the clients may not have known the nurses personally; thus, the common knowledge of who the smokers were among the nurses was not something the nurses had to contend with. As a result the nurses themselves felt a level of personal internal conflict due to their own knowledge about their personal smoking habits.

Radsma and Bottorff (2009) noted that while caring for clients the nurses were continuously reminded of their own smoking and *'their need to smoke'*. Further to this, nurses felt a certain unease and inner conflict about their inability to provide tobacco interventions. Thus the nurses in this study concurred that they felt the need to be professional in their role including the need to conceal their tobacco use from the knowledge of clients.

The issue of inner conflict in IHWs was identified in my study and can be linked to the experiences of IHWs in the remote communities. The nurses in the Canadian study (Radsma and Bottorff, 2009) felt the need to maintain their professionalism by conducting the basic requirements of their roles and to not smoke at work in an attempt to conceal their smoking status, further ensuring that they maintained their anonymity and credibility as a health professional. However, in the IHW context anonymity is difficult given the connectedness of Indigenous communities, as described in the work of Dawson et al where local community members may approach them and perhaps at their own residences for assistance outside of work hours (Dawson et al, 2012a). For IHWs in communities there is 'no place to hide' and their smoking status is well known.

5.6 Ambivalence and providing tobacco cessation information and advice.

A major theme identified in this study was about IHWs smoking and giving mixed messages to community. It was viewed by the participants that while an IHW may be able to provide information to the community, this information may be received with confusion by community

members. For example, on one hand an IHW speaks of the need to quit smoking for the health benefits of the client, yet they are smoking themselves. This conundrum creates contention. The community may pull away and the IHW may be reluctant to provide any smoking information if it is common community knowledge that they smoke.

The participants in this study believe that the community needs to be able to trust the information coming from an IHW as they hold health knowledge and need to be able to provide consistent messages. The impact of local communities being aware of the smoking habits of IHWs reinforces the pressure for IHWs to fulfill a role of leading by example rather than to behave in a way that contradicts their anti-smoking advice. Thus, the community may view IHWs with less credibility and respect if they smoke and provide health information. This assertion is also supported in the literature (Thompson et al, 2011 and Thompson, 2010).

Some IHWs in this study suggested they are not quite ready to share information for the fear of being ignored or having a community member expressing their dissent at the IHWs current use of tobacco. The consequence of IHWs withdrawing the delivery of health information is that they may not meet their duty of care as a health professional. IHWs are a key part of the delivery of culturally safe and secure health information and services; therefore, if IHWs were to absent themselves from provision of tobacco information and cessation advice due to their own internal conflict, it would impede passing vital health care advice to community members.

Engle and Arkowitz (2006) describe this internal conflict by labeling this inner resistance as being approach-avoidance conflict. To borrow from this work the authors describe this as being:

> *"The more one side of the person tries to change, the more the other side pulls him or her back from these attempts; and the more the person pulls backs from attempts to change, the more he or she is pulled toward trying to change."*

Similar statements were made by the IHWs. IHWs understand the health implications yet are ambivalent to making changes for reasons which were not explored in this study. Topics such as ambivalence and the reasons why IHWs continue to smoke, even after being part of training and increasing their health knowledge about smoking, need to be discussed and addressed in a supportive environment.

Excluding IHWs from delivering tobacco programs or provision of cessation advice, irrespective of whether they smoke or not, may have a negative impact as lived experience can often assist with developing cessation strategies based on the stories shared. A smoker and former smoker

has the lived experience of nicotine addiction and the process of quitting. This knowledge can assist with their own lived experience since smokers and former smokers are well versed to identify and work with individuals and community groups to developing workable strategies to support cessation efforts. There appears to be little published on the value of ex-smokers as role models. However, this strategy is already being employed in social marketing to reduce smoking in the wider Indigenous community. Fig 5.1 is an advertisement *Quit Smoking and Break the Chain* from Koori Mail and shows a proud Aboriginal mother with her two children and the comment: "If I can do it. I reckon we all can." Adapting this strategy for IHWs who quit should be attempted.

If IHWs were to actively participate in quit programs or actively attempt to reduce their tobacco consumption, their credibility may increase. Moving through the stages of change (Prochaska and DiClemente, 1983) from pre-contemplation to action is a journey that may require support. Consistent and permanent behavior modification may take many attempts, however, as each quit attempt is made, more learning's are identified and there is may be more likelihood of success to quitting (Caponnetto et al, 2012).

5.7 What are the barriers?

For IHWs smoking is multifaceted. The position they hold as community member and as a health professional can create complexities and have an impact on how they approach smoking. The risk of quitting and being socially isolated or excluded from their social group is very real and a major barrier that emerged from this study. The issue of normalization of smoking was revealed as being a considerable influence to the continuation of smoking.

5.7.1 Credibility

The issue of credibility was raised regularly. IHWs that smoked and provided tobacco information and cessation advice were perceived to be giving mixed messages impacted by community knowledge of IHWs that smoke: *"Really sending out missed messages and you can't cos they see you with a cigarette"*. IHWs were open about this issue, further suggesting that IHWs credibility would be questioned. *"It's hard to give education when we as educators are smoking"*. They are also aware of their duty of care to provide information as part of their roles; however, they are reluctant to provide health information and/or quit support to community members or any health message on the basis of being seen as hypocritical. *"Important to pass message to community, we are the messenger, community know if he or she are smoking. They might laugh and not listen"*.

5.7.2 Limited access to support

Poor access to localized and personalized support was another barrier. The participants in this study felt that it was important to have localized support to help keep them motivated: *"Quit buddy keeping me away from the smokes"*. The remote communities have very little local resources to seek support: *"There's a lack of options in remote communities, like quit courses, programs"*. Some can speak with Elders and IHWs that have quit. However, IHWs speaking to people can be impacted upon by their positioning within the complex kinship structure in these traditional communities. The kinship structure provides a system for which life is organized in an Aboriginal cultural context. There is a process and system in place for how people communicate. This is a very real issue with IHWs not being able to communicate with certain community members as a result of the customary lore that has governed these communities since time immemorial. Therefore, IHWs may be limited to whom they can speak to: firstly about their own smoking, and secondly, about the smoking in the community. Although this cultural environment is complex, IHWs are able to navigate their way through this system. Nonetheless, this issue needs to be acknowledged as the communities in this study still maintain strong cultural connections. The inability to converse with certain members where avoidance relationships exist can impede any effort to provide health information to the community. Additionally, for IHWs to address their own smoking, the avoidance relationship impacts on them seeking localized support for themselves. While some communities may have local people as role models to support individuals including IHWs, the kinship structure and avoidance relationships are concepts that need to be respected in these communities and must be acknowledged.

5.7.3 Lack of information and knowledge about smoking and its effect on the body

A lack of information and knowledge by IHWs about smoking and its effects on the body's systems is another barrier. There is limited knowledge in the community about providing comprehensive cessation support and general tobacco information. This lack of knowledge impedes the IHWs' ability to provide health messages as they are unsure how to firstly apply and translate these concepts in local language. Another issue is that IHWs are uncertain about the functions of nicotine replacement therapy. Thus, provision of training and the application of this new knowledge are required for IHWs to lead and coordinate health information relating to tobacco. Further research is required to understand whether an increase in knowledge assists IHWs to move into the action phase to addressing their smoking.

5.7.4 Minimal or a lack of referral pathways in the community

Another barrier to quitting for IHWs is the lack of access to referral pathways in the remote communities ensuring follow up is available and to provide cessation support. Prescribing of pharmacotherapies is the responsibility of the doctors and accredited nurse practitioners, since as part of the prescribing process, there needs to be personal counseling and support (Australian Government, 2011c). However, the doctors and nurses are unable to provide quit support and have very little time to provide this to community members. The one doctor interviewed in this study stated: *"Never given the time in the AMS around smoking. Need to look at everything to do with life, coping mechanisms – the whole spectrum. Need to walk with people through that process"*

A number of non-Indigenous participants reported time to provide anything beyond a brief intervention as being an inhibitor. Time to provide the in-person support is needed. Successful abstinence is more likely to occur with personal support with the aid of pharmacotherapies (Bittoun, 2009). Given that NRT in the form of patches and varenicline (Champix) are available on the PBS for Indigenous Australians, part of the conditions to prescribe these pharmacotherapies is that in-person support should be provided. This is an unrealistic expectation for the doctors and some nursing staff, given that they are most often involved with acute care. Thus, community members are typically not provided with adequate support for the pharmacotherapy to be of any use as they will mostly likely not use the pharmacotherapy as intended. This then places the client at a potential risk of relapse.

5.8. Addressing the barriers

We also need to understand that as IHWs are starting to think more about their smoking and take action to quit that they require better support to do so. In this project I offered quit support to the participants of this study who smoked. While I was in the community, they were able to cut down their smoking; however it was difficult to maintain contact once I left. I attempted to keep in contact with the IHWs by phone and as time passed this contact ceased until I arrived back in the community for the next field trip three months later.

In terms of the stages of change model (Prochaska and DiClemente, 1983), smoking history was asked of each participant who smoked. With this information I was able to gauge where participants were at regarding their smoking; thus, enabling me to identify the type of intervention to employ when providing brief interventions. The positive news was that when asked about their smoking eight out of the ten smokers stated they were thinking about quitting.

A small number of participants stated they were ready to cut down and some did while I was in the community after the discussions I had with them. Uppal et al (2013) and Hughes et al (2012) found the intention to quit smoking varied on a daily basis dependent on individuals' motivations. Although this is a small sample, it provides some evidence that, if localized support is available, IHWs may be more inclined to take up the support.

5.8.1 What are IHWs doing about smoking - for community and for themselves?

Study participants strongly supported the important role of IHWs, especially in their role as cultural knowledge holders and health translators (DiGiacomo et al, 2007; Genat et al, 2006 and Thompson, 2010). The issue of IHWs that smoke and provide tobacco information and cessation advice to the community continued to be a common topic of conversation throughout this study. This discussion may be one that continues in the future until evidence suggests a decrease in prevalence in the general Indigenous Australian population and also within the IHW profession.

Ensuring that IHWs are supported to address their smoking may be a key strategy in assisting the broader Indigenous population to quit. The study I have conducted supports the action of addressing IHW smoking as a very strong and clear theme. The literature also suggests IHWs addressing their own smoking may be a positive strategy (Adams and Walker, 2006; Andrews et al, 1996; Andrews et al, 1997; Harvey et al, 2002; Lindorff, 2002; Mark et al, 2005; Pilkington et al, 2009; West et al, 1998; Dawson et al, 2012b). Current evidence suggests that personal support in combination with pharmacotherapies, for the highly dependent smoker are important (Conigrave and Lee, 2012). From this study the participants have identified key strategies to assist IHWs in how their smoking could be addressed.

This study highlights IHWs' ownership of their smoking in these communities. The smoking participants openly stated their position as a smoker, recognized the associated health risks and the community perceptions that come with being an IHW and smoking. The smoking IHW participants acknowledge that to be able to provide tobacco information and cessation advice they may need to firstly address their own smoking, before they can support others in the community. Consequently, this may rebuild their credibility as health professionals. IHWs addressing their smoking need not be in isolation from the community. IHWs can participate with community members through individualized or group programs and seek further support from other community members who have quit themselves and/or supported other health staff to

quit. An approach such as this may reinforce that IHWs are people too, thus '*cutting some slack*' with the negative judgments on IHWs.

While this study also reports a small number of IHWs stating smoking is a personal choice, there are major health concerns and costs associated with smoking tobacco (Conigrave and Lee, 2012; Vos et al, 2009). IHWs that openly choose to smoke have reasons for their reluctance to quit. To address their smoking may require patient and ongoing support from their families and their workplaces (Conigrave and Lee, 2012). There may be reasons behind their continued use, such as self-medicating to manage stress and they may not like or know how to cope with the nicotine withdrawals if they are dependent smokers. On the other hand, IHWs as with other smokers, may enjoy the smoking experience. Identifying why these smokers continue to smoke and their understanding regarding the health consequences is important. IHWs should be continued to be supported in the workplace and in the community and while education and increasing knowledge might provide them with necessary information they may not be ready to change. As noted in this study, telling or coercing people to quit could have adverse effects: *"If you force people to give up you get a negative reaction"*. However, this should not exclude them from receiving support.

This study also highlights the very personal journey of a smoker. While it is important that IHWs lead by example, not everyone has the ability to address their smoking as an individual. Additionally not all smokers want to quit. Social networks, family environments and community expectations may pressure IHWs to continue to smoke. If an IHW decides to quit individually, without the support of their family and social network, the feeling of isolation can be problematic if it is expected by these groups to continue to smoke. Becoming the '*odd one out*' or the social/family outcast may create a barrier for IHWs to addressing their smoking (Nguyen et al 2012). Working through these issues with IHWs at the point where they may express an interest in quitting is where workplaces can create supportive environments so that, while at work, IHWs can reduce their consumption and progressively use those skills in the other aspects of their lives.

Given the main health risk factors are related to smoking, nutrition, alcohol and physical activity, provision of brief advice as a minimum in the form of brief interventions is imperative (Clifford et al, 2011; Conigrave and Lee, 2012). Thus there is a need to ensure that IHWs at the very least deliver health information in the form of brief interventions regardless of whether they smoke or not: *"Smokers should deliver information if they smoke or not"*. Operationally at the community level, IHWs may need to accept that some community members may not wish to

speak to a smoker. Therefore, establishing a referral process to another appropriate IHW or staff member would alleviate any issues that IHWs who smoke may encounter. Providing a referral pathway would also ensure that IHWs are completing their duty of care in offering brief advice at the time the referral is made and identifying an appropriate person to further support the client.

What is clear is that IHWs are reluctant to provide tobacco information where they have not undertaken adequate training about the causes of ill health, supporting community members to quit and the current pharmacotherapies that are available to support the community are important strategies: *"Get an understanding of the big words, terminology, medication"; "better training on brief interventions, more motivational interviewing, more comprehensive quit support"*. Some IHWs are openly providing tobacco information and cessation advice even with very little training or information. Even while they have some knowledge, they are still meeting the requirements of their positions and their highly valuable educational role.

If IHWs were to address their smoking, it may create a ripple effect and raise some interest in the community. Therefore, this would assist IHWs to lead by example. Pressure to quit smoking should, however, be taken into context. That being the acknowledgement, those IHWs are likely to have similar reasons for smoking to community members. The quitting journey for a smoker is personal; in some people it may take more than one attempt (Conigrave and Lee, 2012). Thus realistic expectations are required.

5.8.2 Training

Participants stated that improving their knowledge may increase IHWs' interest in delivering health messages about tobacco and also contribute to acting as a brief intervention to address their smoking: *"Training might be a motivator for them to quit"*. The desire for better provision of training for IHWs is an important finding. The participants in this study highlighted that training in all aspects of provision of tobacco information or cessation, and moving beyond the brief intervention to more comprehensive quit support would also contribute positively to reducing tobacco consumption.

5.8.3 Formal qualifications

The participants of this study, in particular the IHWs, have called for more training around tobacco use as well as formal training leading to accreditation. The vocational sector provides IHW training programs from Certificate III to Advanced Diploma levels (Community Services and Health Training, 2003, Community Services and Health Industry Skills Council, 2005).

Depending on the job role IHWs are able to choose to specialize in specific areas such as environmental health, drug and alcohol, mental health and nutrition (Community Services and Health Training, 2003, Community Services and Health Industry Skills Council, 2005).

There are no specific courses designed for IHWs with a sole focus on tobacco, to support individuals and communities to address their smoking. However, there are tobacco related units of competencies; i) HLTPOP403c – Provide information on smoking and smoking cessation, provides information on smoking and smoking cessation, and ii) HLTPOP404c – Provide interventions to clients who are nicotine dependent provides interventions to clients who are nicotine dependent (Australian Government, 2012a, Australian Government, 2012b). These competencies can be included in training packages such as the Certificate IV in Aboriginal Torres Strait Islander Primary Health Care; Community Care stream. These competencies remain as electives only.

Through my work with smoking and as a result of conducting this study, I was asked to sit as a member of a reference group to develop a short course with a cluster of competencies addressing smoking. The NSW Aboriginal Health College is presently designing the course outline of a cluster of competencies for workers in the tobacco field. The skills attained will enable IHWs or other health staff to work in the tobacco cessation role while also obtaining a formal qualification. However, IHWs in a generalist or specialist role will enroll in the Certificate IV and Diploma in Aboriginal and Torres Strait Islander Primary Health Care. In these awards, where the bulk of IHWs are trained, smoking remains as an elective. Given that smoking is the number one preventable killer in Indigenous communities, it would be beneficial for these courses to ensure the electives that are undertaken include the two previously mentioned competencies: HLTPOP403c and HLTPOP404c. These competencies will provide all IHWs with the basic skills and knowledge to engage with community members and initiate the tobacco conversation.

The current available tobacco training programs include: Smoke check (QLD Government, 2012) and Talking Up Good Air (Centre of Excellence in Indigenous Tobacco Control, 2008) which are both workshop based. Statements of attendance or participation are provided. Whilst they both provide sound training, and positive skills development and are based on evidence, these workshops are not currently eligible for VET sector Recognition of Prior Learning (RPL) as they are not competency based nor do they assess competence (NSW Department of Health, 2010; Centre for Excellence in Indigenous Tobacco Control, 2008). This problem could be addressed by adding an elective assessment component to the short course; so for participants

that wanted a Certificate of Competence, not just a Certificate of Attendance, they could chose to do the add-on assessment component. This would allow the short course to be used for VET recognition.

In order to respond to IHWs requests regarding the need for formal qualifications so that their training is recognized and respected for the positions they hold as a professional group of health care workers, these formal training processes that offer formal recognition may entice IHWs to further their skills and knowledge and provide career pathways beyond the VET sector to a University degree. This process would enable IHWs to obtain qualifications which would benefit themselves, their families and their communities.

5.9 Creating supportive environments

In this study a common theme or comment was made in relation to the need for IHWs to have supportive environments to address their smoking. Workplaces have been suggested by the participants on a number of occasions as potential sites for support. The Ottawa Charter provides a framework for action (World Health Organization, 1986) and includes principle of *'Create Supportive Environments'*. There are two important components to supportive environments; i) the workplace is a potential intervention site for smoking cessation to occur, and ii) IHWs having access to clinical supervision as a workforce intervention to assist with stress, burn out and potential self-medication.

5.9.1 The workplace as an intervention site

Addressing smoking in workplaces is now more than just an interest of the employer. Agencies that provide funding now requires grant recipients to have smokefree policies and procedures (Australian Government, 2012c and Walsh et al, 2011). The data from this study provides potential strategies to address IHW smoking. Workplaces provide an opportunity to target health interventions towards employee health and wellbeing (Ivers, 2003). Approaching a health issue such as employee smoking may assist IHWs to make changes within a supportive environment with the peer support of their colleagues (Ivers, 2003). Evidence of programs that support staff is the Waminda Health and Wellbeing program (Firth et al, 2012). This workplace implements a healthy lifestyle program that encompasses smoking, nutrition, physical activity for staff and community members.

5.9.2 Incentives for employers

There is some evidence suggesting that workplace smoking cessation programs work (Cahill, Moher, Lancaster, 2008 and Kouvonen et al, 2012). Of particular interest to the employer is the

amount of time employees are absent from the workplace that can be directly related to their smoking and the workplace outputs or productivity. The work of Halpern et al (2001) report on their evaluation relating to smoking status, productivity and absenteeism. The authors suggest that productivity is increased and absenteeism is decreased among former smokers in comparison to current smokers. Further to this, absenteeism is reduced over the years of smoking cessation.

Very little, if any, research exists evaluating the effectiveness of workplace interventions in Indigenous communities (Ivers, 2003). However, Ivers (2003) suggests that workplace interventions could work to reduce prevalence in smoking. A Cochrane review on Workplace interventions for smoking cessation (Cahill, Moher and Lancaster, 2008) reports that workplace smoking cessation programs may assist in quit attempts, where programs are supported by incentives and competitions among staff. However, there are limitations with these programs, as there is a gap requiring further research to assess the effectiveness of such programs and whether they are likely to result in any significant decrease in the smoking prevalence, particularly for IHWs.

5.9.3 Holistic workplace support

Workplaces provide an opportunity for comprehensive, holistic support that incorporates current evidence base practice (Ivers, 2003). An overwhelming response was that participants of this study identified the need for workplaces to support IHWs: *"Workplaces need to support Health Workers"*. Strategies from this study suggest potential support strategies for example: i) individualized and group (where appropriate) support: *"We need to talk among ourselves as a group, a 'support group'"*; ii) access to pharmacotherapies supplied by the employer: *"NRT and monitoring from support staff"*; iii) use of brief interventions, motivational interviewing techniques to support IHWs to quit: *"Use brief interventions and motivational interviewing skills to dig down into these areas to find deep meaningful reason and feelings why to stop or change"*; iv) building the capacity of IHWs to learn new information through training opportunities: *"staff capacity building, training need to be incorporated into routine practice"*; and v) mentoring and support for IHWs to implement new knowledge to support community members to address their smoking: *"Need more support of IHWs, in my job developing tools for IHWs to support giving quit messages to their clients"*.

5.9.4 Workforce issue – the need for clinical supervision for IHWs in remote communities

As a strategy for reducing the potential risk of IHW fatigue and burn out, clinical supervision is an interesting option for the IHW workforce. Clinical supervision developed from within the mental health field and has been brought into other professions such as nursing (Yegdich, 2001). The concept of clinical supervision is reflective thought processing to gain a deeper understanding of experiences and work practices; thus, improving further work activities is a potential benefit (Fowler, 1996). A participant related stress as an issue: *"Sometimes they stress out, any stress, work of family stress. Might need stress management".* IHWs in the study communities are mostly local people and experience the same grief and loss as that of the community as they will most likely be connected in some way. This is important since IHWs are connected to the community more closely than other health professionals.

Clinical supervision could provide the support and respite needed for IHWs in these remote communities. Modifying clinical supervision practice to suit the needs of IHWs is important. While the process of clinical supervision is mostly confined to the social sciences/psychology fields, there is an increase in its use within nursing fields. The Victorian Dual Diagnosis Initiative (2012) has developed a clinical supervision model specific for Aboriginal workers in the drug and alcohol and mental health fields. The *Our Healing Ways* model is a potential framework for the process of enacting clinical supervision that is culturally safe and secure for IHWs. While the program is fairly new and hasn't been evaluated, the model exists to support Aboriginal workers in this sector to reduce the impact of worker burn-out. The model focuses on the relationship of the supervisor and considers the community connectedness where the workplace supervisor may be in the workplace, or have some connection for example be related to the employee being supervised.

5.9.5 The use of Quitline as a support mechanism

The use of Quitlines by participants was not asked during the survey. However, during feedback some participant's views were that people in the remote communities may not use Quit lines, but the service may be of use to those from urban communities. Further, there is a gap in those utilizing the Quitline: *"Quitline gap, urban people might use it".* Elaboration of this point was not sought as it was not the main topic of discussion.

5.10 Limitations of this study

It is important to address limitations of this study, particularly the representativeness of the sample, how participants were selected and data saturation.

5.10.1 Representativeness of the sample: rurality

In terms of a national perspective the sample in this study was made up of predominantly health professionals based in rural and remote communities with 72.1% (n= 31) from rural and remote communities in NT. This is slightly less than the findings from the 2006 Census of 81% for rural representation in the NT (Australian Bureau of Statistics, 2007).

5.10.2 Representativeness of the sample: IHW workforce in the three remote communities

The purpose of the study was to hear from IHWs about their or their peers provision of tobacco information and cessation advice. Therefore, it was important to recruit IHWs from the three remote communities, regional town and capital city that serviced the communities that were the focus of this study. I recruited 16 participants who were employed in IHW positions at the time of the study, twelve of whom worked in the three remote communities. At that time eighteen IHWs were employed in these three communities; hence this study interviewed 67% of the locally based IHW workforce. When visiting the communities, it was difficult to interview all IHWs for a number of reasons. The main reason was due to their delivering health services to the community and having an active role in the service in Senior IHW roles. Although the absolute number of IHWs from the remote communities is low, the percentage participation is high, reflecting the small number of participants in the most important sub-group of the sample population. The other four IHWs included two from regional communities and another two from a Capital city from another state. The IHWs are the largest participant group in this survey making up 37.2% (n=16) of the participants. Other Indigenous workers interviewed were Indigenous Community Workers which included ancillary support staff (i.e., child care workers, transport officers, community education workers) who were employed to deliver and support the community in a health educator role but who were not employed as an IHW specifically. An additional two Indigenous participants employed as allied health professional were included. Both provided services directly to the remote communities in this study. Of the two, one was permanently based in one of the remote communities and the other was based in Darwin. These workers were included as they supported IHWs in daily activities as colleagues within the workplace and provided their perspective to the study.

I interviewed three other participants from other states while I was in Darwin, two were IHWs and the third was an Indigenous allied health professional who was a former IHW. This approach was used as a method of triangulation to seek the perspectives of other IHWs and assess whether their views were different or similar to the IHWs in the NT. My analysis of the data showed that their views were similar.

The non-Indigenous participants included allied health professionals, registered nurses and a doctor. All of these participants delivered a service to the three remote communities and were included as they worked alongside the IHWs. The non-Indigenous participants were also service providers. In the remote communities, the registered nurses were hard to reach as they were in similar busy positions to the IHWs, often managing clinics at the time I approached them to participate in the interviews, and therefore they lacked time to participate. Of the six nurses, four were in roles of direct service delivery with a clinical focus.

Non Indigenous allied health professionals made up 25.58 % (n=11) of the sample. These participants were based in the regional communities and the Capital city. All provided allied health services in the form of health promotion, health education and specific services such as drug and alcohol support, nutrition and physical activity. All participants worked in the remote communities alongside IHWs, other services and community members to deliver their activities.

Within the sample one doctor (2.3%) was interviewed. Accessing doctors in the remote communities was far more difficult than approaching nurses. All doctors were engaged with clinical activities and were sometimes in the community for a day or shorter periods of time. They did not reside in the communities: thus, engaging these participants was difficult due to their availability. By chance I was introduced to a doctor. I seized the opportunity to recruit him/her into the study. The doctor had worked in Arnhem Land for some time and also in a capital city and was aware of the local culture in the communities. The doctor had also worked alongside IHWs in remote communities and an urban capital city (Darwin) settings and was able to draw from these experiences to participate in this study.

5.10.3 Selection method

Participants were chosen for their likelihood of being able to speak about the issue of IHWs smoking and its impact in remote NT communities. The selection method was appropriate for the qualitative study, the most important aspect. However, the sample for the quantitative study is not ideal as the selection method is not randomized or systematic; thus, participants were recruited opportunistically. Although to counter this criticism, a high proportion of the key sub-group of remote IHWs was sampled. Owing to the lack of a systematic sampling strategy from the quantitative perspective, only simple quantitative statistical analyses were done.

5.10.4 Data saturation

For the qualitative component of the study data saturation was reached with 40 participants since three additional participants added no new data. I consider this is not a limitation of the qualitative study.

5.10.5 Providing feedback to the communities

When providing the feedback to the communities involved, I attempted to meet with all the participants. However, this was again difficult due to the mobility of staff and the activities the participants were involved in. Contacting all participants was difficult as some had moved on to other positions, some were away from the community for training; some were attending to sorry business. I was able to take the results to other communities in the Nhulunbuy region where I met with two IHWs, an Indigenous Community Worker, a Doctor and a Registered Nurse. This enabled me to have discussions with additional people about their views on the issue of IHWs smoking. Their views were similar to those of the participants in this study and there was agreement on the issue that smoking by IHWs impeded their ability to provide tobacco information and cessation advice.

Conclusion

The findings of this research provide new approaches and perspectives to understanding the issues around IHW smoking and their ability to provide tobacco information and cessation advice. This chapter has discussed the barriers and ways to address them. The views of the IHWs have been utilized to inform the Discussion, bringing forth a balanced view of their role, their smoking behavior and suggestions for improvement. Further research is required to identify the prevalence of smoking in IHWs and the reasons why they smoke. This research provides insight to assist with identifying the underlying reasons for IHW smoking. IHWs are valued members of the community and health team and, if they were able to address their smoking, this may also have a positive effect on the broader community's attempts to addressing their smoking status.

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Chapter 6: Conclusion and recommendations

6.1   Conclusions

This study identifies that smoking in IHWs impedes their ability to deliver tobacco information and cessation advice to the community. There is a real sense of "shame" associated with IHWs who smoke. Participants highlighted issues around credibility, with community members seeing IHWs as being hypocritical and providing mixed messages. This position compromises their role as a health professional. Local community knowledge and community connectedness of knowing who smokes adds to the complexity of community members receptiveness to anti-smoking information.   This allows IHWs no "space to hide" unlike most other health professionals who are less connected with the communities they serve.

Added to this are IHWs' own personal battles with smoking. The stress that IHWs face in their professional and personal lives adds to the possibility that they continue to smoke for stress relief. This can be the situation even after they have attended training and increased theirnew health knowledge about smoking. Consequently IHWs withdraw, avoid the situation altogether and do not broach the topic of smoking for fear of ridicule and criticism. IHWs struggle with smoking much the same as the community members they serve.

This study adds voices of IHWs to the literature and the suggestions proposed by them which may assist with addressing their smoking. The purpose of this study was to present the voices of the IHWs to allow their struggles to be heard. As in the general community, smoking cessation may take many attempts.   The data presented provides a snap shot of the experiences IHWs encounter. One positive aspect raised is that the journey and lessons in lapses and relapses will provide former or currently smoking IHWs with the valuable personal experience to share with community members and clients they may end up supporting.

Given this new knowledge, how then, do IHWs meet their roles as health educators and providers of tobacco information?

The role of the workplace as an intervention site cannot be understated. Creating a supportive and nurturing environment is a key recommendation of this study. The participants in this study made a clear call for workplaces to provide smoking programs for their staff. Provision of such programs would benefit overall productivity, in addition to addressing a key risk factor to improve the health of employees. Programs within the workplace are likely to be successful

given the small amount of literature. Evidence suggests that relapses occur within the first week with 50-75% of smokers (Bittoun, 2009). Therefore pharmacotherapies at the expense of the workplace should assist with reduction or quit attempts (Bittoun, 2009).

Participants in this study called for an increase in their knowledge and skills. Currently the opportunities to build capacity to support community members in provision of tobacco information rely heavily on workshop based training. While this is welcomed, and skills are attained, a gap remains for accredited VET training specifically focusing on smoking. Competencies on tobacco are included in with other substance use training courses. Thus IHWs, who undertake training in a generalist field or in other specialist areas, will not have access to this training unless it is part of the respective courses or chosen as an elective. Given that IHWs will not broach the smoking topic with community members already, it may be they may not wish to attend the training for similar reasons.

Training within the VET sector by Registered Training Organisations for IHWs is usually delivered by community controlled organizations that have many years of experience in designing and delivering training in the health, social and community sectors. These organizations provide training using a culturally safe and secure approach that ensures IHWs are well supported. Provision of new training awards specifically targeted on smoking cessation delivered by Indigenous RTOs would seem appropriate.

The interesting link between smoking and stress emerged from this study. IHWs are under immense pressure in their professional and personal lives. They simply cannot leave work to return home and rest each evening or weekend without the community expecting them to respond to community requests. This constant pressure without adequate support can lead to IHW burn-out in an already strained workforce. Clinical supervision that both assists IHW to deal with these stresses and with delivery of tobacco cessation programs may be an effective model.

6.2   Recommendations

1. Undertake further research:
   a. To understand the underlying stressors IHWs experience in their personal and professional lives which may inhibit them from quitting;
   b. To develop appropriate quit programs for IHWs;
   c. To evaluate the impacts and outcomes of these programs on IHWs and the communities they serve.

2. For employers to implement holistic and comprehensive smoking programs for staff with the following components:
   a. Access to funded pharmacotherapies
   b. Personalized in-person support
   c. Access to group programs and support (where appropriate)
3. To incorporate tobacco unit of competencies into all IHW training and becomes a core unit from the Certificate IV level or higher.
4. To incorporate clinical supervision into workforce practice for all IHWs.

6.3   Publications Arising from this Chapter

The following paper was written to get into the mainstream literature some of the lessons learnt from this study.

Thompson M. (2011). The best bang for our buck: recommendations for the provision of training for tobacco action workers and Indigenous health workers. *Contemporary Nurse.* 37(1): 90-91.

Publication 3: 100% contribution:

- Wrote the manuscript
- Acted as corresponding author
- Amend final manuscript with peer review suggestions.

References:

Bittoun R. (2009). Tobacco, eds. Latt N, Conigrave K, Saunders JB, Marshall EJ, Nutt D. Oxford Specialist Handbooks. Oxford University Press.

The best bang for our buck: Recommendations for the provision of training for tobacco action workers and Indigenous health workers

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ABSTRACT

While smoking rates among Australians in general have declined over the past two decades, rates for Aboriginal Australians have remained high and continue to contribute to the overall poor health of Aboriginal people. Aboriginal health workers are proposed as one way to help reduce smoking rates for Aboriginal people however there is a need for specifically developed courses to train health workers to deliver smoking interventions.

JAMES COOK
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HEALTH WORKER SMOKING STUDY

INTERVIEWS WITH INDIGENOUS HEALTH WORKERS, COMMUNITY WORKERS AND OTHER HEALTH PROFESSIONALS

CONSENT STATEMENT

I, _____agree to be in this study.

I agree (check item):

Yes ☐   No ☐

To be interviewed by the researchers about my views regarding tobacco smoking and about the available options for reducing the very high rates of tobacco smoking in Indigenous communities in the NT.

This consent form and information about the research has been explained to me by: _____

I understand that I do not have to be in the study if I don't want to. I can contact Alan Clough (07 4042 1798 or 0447 784 227) to take me off the study any time.
Signed

_____(participant)

Witness _____ Date _____

	#

Demographics	

Gender ☐Male ☐Female	Status ☐ Indigenous ☐Non Indigenous	Position Held ☐Health Worker ☐Doctor ☐Nurse ☐Community Worker ☐Allied Health Other: _____ How long have you worked in this community? _____
Do you work for: ☐Government agency ☐Community Controlled Service Smoking status ☐Current ☐Never ☐Former _____ (time since last use)		What is your experience of working with Indigenous communities around tobacco? _____ Would you like to have the interview recorded? ☐Yes ☐No Would it be ok if I called you to discuss anything further? ☐Yes ☐No Contact details: _____ Would you like me to visit you again to give the results? ☐Yes ☐No

Health Workers and smoking

1. Is smoking by Health Workers a barrier to them helping the community to change? YES   NO   UNSURE

Please explain, why;

2. What could help Health Workers to be comfortable to give tobacco information or quit support?

3. What kind of support could help Health Workers to quit?

Providing tobacco information / quit support

4. Do you provide information / education about tobacco to the community? ☐Yes ☐No 4.1. If yes, what sort: 4.2. If no, why not?	5. Do you provide quit support to individuals/community? ☐Yes ☐No 5.1. If yes, what sort 5.2. If no, why not?
What could help you provide information about tobacco with the community more effectively?	What do you need to be able to provide quit support?

Current Smokers – Would you be happy to answer questions about your smoking ☐ Yes ☐ No

4. Are you

☐ Not thinking about quitting   ☐ Thinking about quitting   ☐ Actively trying to quit

4.1. Where do you mostly smoke? -
_____

---

5. Did you ever try to stop using tobacco? ☐ Yes ☐ No

5.1. If yes, For how long _____ How many times _____   When
_____

5.2. Why did you stop/give up
_____

5.3. How did you stop/give up
_____

5.4. Where did you stop/give up
_____

5.5. Why did you start again
_____

5.6. If no; why haven't you tried to stop/give
up?_____

Would you like to share anything else that you think is important to help Health Workers provide information to the community or help people who want to quit smoking?

Thank you for your time. Your information will help to understand how Health Workers are helping
community members to quit smoking and how this support can be expanded in the future.

HEALTH WORKER SMOKING STUDY PARTICIPANT INFORMATION

THIS IS FOR YOU TO KEEP

Smoking causes a lot of health problems in Australia. These days only about two out of every ten people in Australia smoke. In Aboriginal communities in the 'Top End' of the Northern Territory the figure is a lot higher; about eight out of every ten people smoke.

The Top End Tobacco Project
James Cook University is implementing a multiple component intervention study to support Aboriginal communities in the 'Top End' of the Northern Territory to encourage community people to cut down or quit smoking. The project has been funded by Australia's National Health and Medical Research Council and will continue to June 2011.

As part of this project the Team interviewed community people and key personnel in the health system about their views on tobacco smoking and options available to reduce the very high levels of smoking in Indigenous communities in the NT and study communities.

The Health Worker Smoking Study
The Health Worker Smoking Study (HWSS) is part of Top End Tobacco Project strategies to assist Indigenous Health Workers (IHW's). This project aims to identify whether the smoking status of Health Workers is a barrier to them providing tobacco information/quit support to the community. Further, identify how such barriers can be overcome and what support is needed to assist Health Workers who would like to quit.

The HWSS is assisting Marlene Thompson to complete a Masters in Science that will be upgraded to a PhD in 2010, with James Cook University. Supervisor for the HWSS is Associate Professor Alan Clough and Co Supervisor Rick Speare.

Ethics for the HWSS has been approved through the Human Research Ethics Committee, NT Dept of Health and Families and Menzies School of Health Research.

You can say 'no' and you can pull out of this study any time.

For more information regarding the HWSS please call:
Alan Clough: **P:** 07 4042 1657   **Email:** alan.clough@jcu.edu.au
Marlene Thompson: **P:** 07 4042 1667   **Email:** marlene.thompson@jcu.edu.au

To make a complaint about the HWSS study please contact:
The Sectertary, Human Research Ethics Committee of the NT Dept of Health and Families and the Menzies School of Health Research
P: 08 8922 7922   **Email:** ethic@menzies.edu.au

For a more detailed description please turn over

Question
Aboriginal and Torres Strait Islander Health Workers Smoking Status: Is it a barrier to affecting change within the community?

Aims
This research will investigate:
- To what extent does IHW's smoking status influence their ability to provide tobacco advice in remote Northern Territory (NT) Indigenous communities?
- What is the evidence that IHW's own smoking status is a barrier to helping the community to change?
- If AHW's smoking status is a barrier to supporting others to quit, what are their perceived barriers?

Study setting
This research is an adjunct to the current project "The Top End Tobacco Project" (NHMRC Grant #436012) that is implementing a multiple-component, community-action intervention to reduce tobacco smoking in three remote Indigenous communities in the Northern Territory. The TETP provides the vehicle for collecting information for the Health Worker Study. Intervention strategies are community-orientated and include mobilising and informing communities; assisting health workers to qui; training for Health Workers and community-based employees in brief intervention and training in the use of a wider range of NRT. A baseline data survey of 400 people was completed in early 2009.

It is envisaged this study will provide the basis of a Masters study that will be upgraded into a PhD in 2010.

Background and need for the project
Indigenous Health Workers (IHW's) are pivotal in delivery of health care to Indigenous communities. While also being part of the community, they deliver a diverse range of health services including tobacco information and/or cessation.

Tobacco cessation is complex and requires a holistic approach that is inclusive of not only the individual but the family and community environment. The role that IHW's play is essential to address the disparity of tobacco use between Indigenous and Non Indigenous communities. They are of a particular importance to the communities in remote Arnhem Land where smoking rates remain high compared to the broader Indigenous and Australian population.

An assertion that IHW's personal tobacco use may be a barrier to providing support in the community requires further investigation, of which this study proposes to explore. Some IHW's maybe uncomfortable with providing tobacco information however if provided with support themselves, they may become 'Tobacco Champions' for the community. With such a mandate to provide culturally appropriate, acceptable and accessible information IHW's are in a prime position to lessen the burden of mortality and morbidity associated with the use of tobacco.

Methods
- Literature review of current and previous research with a focus on IHW's across Australia
- Data analysis of interviews with community people aged 16 years and over (as part of NHMRC Grant #436012).
- Interviews and focus groups with IHW's and other working in health-related areas.

Outputs
- Identify barriers to IHW's supporting smokers to quit, including their own smoking status.
- Document the views of other Community Workers and Health Professionals, including Doctors and Nurses, regarding the smoking status of IHW's and barrier to assist change within the community.
- Identify strategies to assist IHW's to address tobacco use/quit support for themselves.
- Identify strategies to assist IHW's to address tobacco use/quit advice to the community.
- Describe the efforts community people are making to change their smoking with a particular focus on support provided by IHW's.

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The Human Research Ethics Committee of NT Department of Health and Families and Menzies School of Health Research (HREC) is constituted and operates in accordance with the NH&MRC National Statement on Ethical Conduct in Human Research (2007)

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