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Rapid Evidence Summary

Barriers and enablers to embedding smoking cessation support in community service organisations

A Rapid Evidence Summary prepared by the Sax Institute
for the Tasmanian Department of Health—August 2021

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This report was prepared by Luke Wolfenden and Laura Wolfenden.

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Executive summary

Community service organisations represent a particularly valuable setting in which to provide smoking cessation support to those experiencing disadvantage. An understanding of the barriers and enablers to the provision of such support is required to develop appropriate and effective strategies to make the most of opportunities to address tobacco use in the sector. The Tasmanian Council of Social Services (TasCOSS) seeks to better understand the current and potential role of community service organisations in supporting smoking cessation among their clients. The aim of this Rapid Evidence Summary is to provide guidance regarding the development of TasCOSS's smoking cessation project and to inform future consultations within the sector.

The research question the Rapid Evidence Summary addresses is: *"What are the barriers and enablers to embedding preventive health initiatives, specifically smoking cessation support, into the routine work of community service organisations?"*

The authors undertook systematic searches of electronic scientific bibliographic databases (e.g. MEDLINE) and grey literature (e.g. government websites) to identify research reporting the barriers and enablers to smoking cessation support provided by community service organisations. Studies from Australia, Canada, New Zealand, the US and the UK were eligible. Additionally, we conducted targeted Google (and Scholar) literature searches to identify studies describing the barriers or enablers to supporting the provision of preventive care targeting key chronic disease risks more broadly (e.g. nutrition, physical activity, obesity, alcohol use).

In total, we identified 19 studies that reported factors (barriers and enablers) relating to community service organisation provision of smoking cessation support. These most frequently concerned characteristics of service staff. For example, a perception among staff that service users lacked interest in quitting and had limited capacity to do so given other life events and circumstances; a lack of staff knowledge, skills and confidence to support cessation; and concerns that addressing tobacco use might affect staff–client relationships. Factors related to smoking cessation interventions themselves, including the time required to deliver (or for clients to attend) them and the costs of cessation treatments, were also reported. Common organisational factors influencing the provision of smoking cessation support included organisational capacity, resources, high staff turnover, competing priorities and supportive policy. The studies identified few process factors or broader system or contextual factors as barriers or enablers; however, they did report a lack of external referral options and difficulties integrating with other primary care services. Barriers and enablers to the provision of preventive care broadly in community service organisations were largely similar to those for supporting smoking cessation. However, a number of unique barriers were identified across different priority populations and for different risk factors.

This Rapid Evidence Summary indicates that a large number of factors influence the integration of smoking cessation (and other preventive healthcare) support into community service organisations,

necessitating multi-strategic approaches that have the capacity to address these in order to improve care.

Introduction

Chronic diseases are the leading cause of death in Australia and represent a considerable burden on individuals and communities.[1] Tobacco use, physical inactivity, diet, obesity and excessive alcohol use are the primary modifiable risk factors for chronic disease.[2] Many of these risk factors are more prevalent among priority populations in the community. For example, reported use of tobacco increases with measures of socioeconomic disadvantage.[3] Relative to the general population, smoking is particularly prevalent among those with mental illness, who are homeless, use other substances, or are Aboriginal or Torres Strait Islander.[4–6] The higher rates of tobacco use and other chronic disease risk factors explains, in part, the significant gap in life expectancy among members of these priority populations in Australia compared with the community at large.[7]

The implementation of evidence-based chronic disease prevention programs has been recommended in settings providing access to priority community groups.[8, 9] A particularly valuable setting to access disadvantaged groups and provide smoking cessation support is the community service sector. Community service organisations (also known as community managed organisations), are non-government, not-for-profit organisations that provide welfare services, such as financial and material support, personal and social support, and general information and advice, to individuals in need.[10]

Those accessing support through community service organisations report interest in improving their health, including ceasing smoking.[11] They also believe it is both appropriate and acceptable for the staff of these organisations to provide smoking cessation support.[10] Nonetheless, research undertaken in community service organisations suggests the provision of preventive healthcare is suboptimal. For example, a 2018–19 survey of 76 community service organisations that support people with a mental health condition in NSW found that 13% provided support to most service users for smoking cessation, 30% for nutrition, 24% for alcohol consumption and 35% for physical activity.[12]

A range of factors may impede the routine provision of smoking cessation support and other preventive healthcare by the staff of community service organisations. These factors need to be understood in order to develop appropriate and effective strategies to enhance the provision of preventive healthcare by these organisations and their staff. This is the context in which this Rapid Evidence Summary was undertaken. It seeks to identify the barriers and enablers of preventive healthcare broadly and smoking cessation care specifically by the community service organisation sector.

Context for the Rapid Evidence Summary

The *Tasmanian Tobacco Control Plan 2017–2021* identified that people experiencing disadvantage, specifically those from low socioeconomic areas, were a priority population for smoking cessation intervention. Community service organisations have a key role to play in reducing tobacco use and related health inequities. The Tasmanian Government's *No One Left Behind* plan[13] aims to reduce the prevalence of smoking by people in priority population groups; a key strategy to this end involves training staff at community service organisations.

The Tasmanian Council of Social Services (TasCOSS) seeks to better understand the current and potential role of community service organisations in supporting smoking cessation among their clients. This builds on previous work in Tasmania, and aims to generate different insights and solutions through being led by an organisation outside the Alcohol, Tobacco and Other Drugs (ATOD) sector.

This Rapid Evidence Summary seeks to provide guidance regarding the development of TasCOSS's smoking cessation project and to inform future consultations within the sector. Specifically, the Rapid Evidence Summary will be used to:

- Understand the barriers and enablers to embedding preventive health strategies into community service organisations, specifically smoking cessation support for clients
- Contribute to broader conversations on the role of community service organisations in supporting smoking cessation and preventive health initiatives within Australia.

The audience for this Rapid Evidence Summary includes TasCOSS and the Tasmanian Tobacco Control Coalition and will be available to inform work undertaken by Australian health policy makers, the community sector, ATOD sector and Cancer Council Australia.

Research question

What are the barriers and enablers to embedding preventive health initiatives, specifically smoking cessation support, into the routine work of community service organisations?

Methods

Research design

The authors conducted a search of the scientific and grey literature to identify the most pertinent research to address the question. As the primary focus of the Rapid Evidence Summary, we undertook systematic searches of electronic scientific bibliographic databases (e.g. MEDLINE) and grey literature (e.g. government websites) to identify research reporting the barriers and enablers to smoking cessation support provided by community service organisations. Targeted searches then identified research reporting barriers and enablers to the provision of preventive healthcare more broadly.

Inclusion criteria

1. Qualitative or quantitative studies, or reviews of such literature, that report data describing the barriers or facilitators (enablers) to the provision of smoking cessation support by staff of community service organisations. Barriers were defined as *"factors which hinder the implementation process and reduce the probability of successful implementation"*.[14] Enablers were defined as *"factors which increase the probability of successful implementation"*.[14] Barriers and enablers may include (but are not limited to): infrastructure; funding; grant application processes; reporting requirements; intake and referral systems; provision of skills development and awareness raising for staff about tobacco use and smoking cessation interventions; and access to effective brief interventions. Community service organisations were defined as *"non-government, not-for-profit organisations that provide welfare services, such as financial and material support, personal and social support, and general information and advice, to individuals in need"*.[10] Aboriginal community controlled organisations and medical services were included within this definition
2. Studies published in English
3. Studies from Australia, Canada, New Zealand, the US and the UK
4. Studies focused on any population were included but the following were of particular interest: Aboriginal and Torres Strait Islander communities; people living in low socioeconomic areas; people with mental illness; pregnant women; young people (12–24 years); and middle-aged men.

Searches

The authors searched MEDLINE, PsycInfo and ProQuest Social Sciences databases to identify studies that met the inclusion criteria. Human research, English-language and publication-date restrictions (2011–current) were applied to the search. These databases provided coverage across fields of medicine, psychology (including addiction) and social science. The search strategy is described in Appendix A. Google (and Scholar) literature searches were undertaken to identify grey (and academic) literature including searches of websites and organisations suggested by the Tasmanian Department of Health. We also screened reference lists of related systematic reviews identified as part of the search.[15] Additionally, we conducted targeted Google (and Scholar) literature searches to identify studies describing the barriers or enablers to support the provision of preventive care targeting key chronic disease risks more broadly (e.g. nutrition, physical activity, obesity, alcohol use) by staff of community service organisations. We used a combination of terms and searched the first 100 citations of each, sorted by relevance. The same inclusion criteria were otherwise applied. A single reviewer conducted the searches, screened the citations and extracted and collated the data.

Synthesis

We used the Consolidated Framework for Implementation Research (CFIR)[16] to synthesise the findings. The CFIR is one of the most comprehensive frameworks describing factors influencing the implementation of evidence-based interventions, and is frequently used as a synthesising framework in reviews of barriers and enablers to implementation. Specifically, we extracted information from included studies, grouped identified barriers and enablers, and then classified them into one of the five framework domains:

1. Individual factors: include staff knowledge and attitudes about the intervention, self-efficacy, stage of change and other attributes. These primarily pertain to the staff of community service organisations responsible for the delivery of tobacco or preventive healthcare
2. Characteristics of the intervention: include the complexity, fit, adaptability appropriateness, design and cost of smoking cessation or preventive care interventions in community service organisations
3. Inner-setting factors: include features of structural, political and cultural contexts through which the implementation process will proceed, and encompass the structure and networks of the organisation, its culture and readiness for implementation. These factors typically pertain to the community service organisation in which smoking cessation or preventive care is (or is to be) delivered
4. Outer-setting factors: the broader system, economic, political and social context within which an organisation resides including external policies and incentives, resources and social pressure
5. Implementation processes: include project planning and engagement, external change agents, execution processes and reflective practices.

When looking at studies that reported the prevalence of staff attitudes towards the provision of tobacco or other preventive healthcare, unless these were explicitly identified as a barrier or enabler, we classified supportive attitudes of >50% as an enabler and unsupportive attitudes of >50% as a barrier.

Research findings

Following systematic searches of the literature, we included 19 studies describing barriers or enablers to smoking cessation care in community service organisations. The citations managed in the screening process are shown in Appendix B. Appendix C includes the full citation details of the included studies. In addition, targeted searches identified one review and eight further studies meeting the eligibility criteria describing barriers and enablers to the provision of preventive care more broadly. These studies are cited in Appendix D.

Barriers and enablers to smoking cessation support

Twelve of the 19 included studies describing barriers to smoking cessation support were conducted in Australia. Approximately half the included studies used quantitative methods such as cross-sectional surveys; the remainder employed qualitative or mixed methods. Of the 19 studies, 12 included services explicitly for people with a mental illness[17–19, 10, 20–27], two explicitly for Aboriginal and/or Torres Strait Islander people[28, 21], six for people living in low socioeconomic areas[19, 20, 29, 26, 27, 30], and two for young people aged 12–24 years.[21, 31] The population focus of five studies[32, 33, 10, 20, 34] was unclear; however, a number of studies included organisations providing supported housing and serving diverse population groups. A full description of the characteristics of included studies is provided in Appendix E.

Barriers

A large number of barriers were reported. The most common related to the characteristics or attitudes of community service staff (individual factors), in particular, a lack of expertise, knowledge, skill or confidence in providing smoking cessation support; a belief that service users were not interested in quitting; a view that cessation support may be better provided by other (external) agencies, or that smokers have a right to use tobacco. The most frequent barriers pertaining to the organisation (inner setting) included a lack of time, capacity, resources and availability of appropriate tobacco-related programs for service users. The most frequently reported barrier related to characteristics of the intervention was the cost to service users of nicotine replacement therapy (NRT). Few studies cited broader system level (outer setting) or process-related barriers.

Table 1—Barriers to the integration or implementation of smoking care in community service organisations (presented within columns from most to least frequently cited)

Individual factors (i.e. service staff factors)	Characteristics of the intervention (i.e. its complexity, fit and appropriateness)	Inner setting (organisational factors)	Outer setting (broader system or contextual factors)	Process factors
Lack of staff expertise, knowledge, skill or confidence supporting cessation[20, 28, 21, 23, 25, 34, 27]	Cost of nicotine replacement therapy (NRT)[19, 20]	Lack of staff time and capacity within their existing workload[18, 32, 19, 25, 34]	Lack of external referral options[23]	Access to NRT and integration with primary care services[25]
Belief services users were not interested in quitting[17, 19–21, 29, 25]	Time required to deliver intervention[10]	Lack of resources and tobacco-related programs for clients[29, 34, 27]	Cost of external tobacco treatments[23]	Timing of when support was provided, specifically, service users having to be 'stable' for intervention to be effective[19]
View that support would be better provided by other expert agencies[32, 19, 10]	Intervention difficult to deliver[10]	Lack of training[32, 22]		
Cessation support perceived as a low priority (or not their role)[32, 22, 31]	Extended periods between receiving training and delivering intervention[25]	Lack of organisational support[28, 34]		

Table 1—Barriers to the integration or implementation of smoking care in community service organisations (presented within columns from most to least frequently cited)

Individual factors (i.e. service staff factors)	Characteristics of the intervention (i.e. its complexity, fit and appropriateness)	Inner setting (organisational factors)	Outer setting (broader system or contextual factors)	Process factors
Belief that service users have a right to smoke[18, 20, 34]	Lack of prompts to remind staff to provide care[23]	Lack of supportive policies[18]		
Role of tobacco use in building trust with service users or that addressing it may be perceived as judgmental[32, 22, 24]	Requirement for participants to attend for cessation support[29]	Conflicting work priorities[19]		
Belief that quit attempts were too stressful for service users in the context of dealing with other issues[22, 27]		High staff turnover[20]		
Belief that smoking helped service users[19, 29]				
Concern addressing tobacco use may cause relapse in mental health recovery[17]				

Table 1—Barriers to the integration or implementation of smoking care in community service organisations (presented within columns from most to least frequently cited)

Individual factors (i.e. service staff factors)	Characteristics of the intervention (i.e. its complexity, fit and appropriateness)	Inner setting (organisational factors)	Outer setting (broader system or contextual factors)	Process factors
Staff reluctance to raise the issue[32]				
Staff smoking status[22]				
Belief by staff that interventions do not work[25]				

Enablers

Frequently reported individual enablers to the provision of smoking cessation support included staff with confidence, knowledge and skills in providing smoking cessation support; a belief that staff should challenge service users' 'decision' to smoke; and that doing so would not harm the staff – service-user relationship. The view that community service organisations have a role in supporting service users to quit, and the provision of training in intervention delivery were the most commonly reported organisational (inner setting) and intervention-related enablers respectively. None of the included studies reported broader system level (outer setting) enablers, and just one reported a process-related enabler.

Table 2—Enablers of the integration or implementation of smoking care in community service organisations (presented within columns from most to least frequently cited)

Individual factors (i.e. service staff factors)	Characteristics of the intervention (i.e. its complexity, fit and appropriateness)	Inner setting (organisational factors)	Outer setting (broader system or contextual factors)	Process factors
Staff confidence, knowledge or skills in providing cessation support[33, 20, 21, 31, 27]	Provision of training for intervention delivery[17, 18, 27]	Belief organisations have a role in supporting clients to quit[32, 20, 28, 34]	Lack of external referral options[23]	Processes to assess service-user smoking status on entry to the service[27]
Belief staff should challenge their 'decision' to smoke[17, 20, 21, 34]	Being able to provide free NRT[17, 20]	Adequate allocation or availability of resources[33, 34]		
Belief addressing smoking would not have a negative impact on the staff – service-user relationship[17, 10, 20, 21]	Receptivity of service users to intervention[10]	Organisational support[21, 34]		
Belief that smoking cessation care is something they should provide to service users[17, 20, 28, 21]	Conducting information sessions to encourage discussion by clients[25]	Financial support[34]		

Table 2—Enablers of the integration or implementation of smoking care in community service organisations (presented within columns from most to least frequently cited)

Individual factors (i.e. service staff factors)	Characteristics of the intervention (i.e. its complexity, fit and appropriateness)	Inner setting (organisational factors)	Outer setting (broader system or contextual factors)	Process factors
Belief that cessation is feasible for service users[21, 23, 34]	Supportive policies and guidelines[17]	Alignment of cessation support with organisational focus[32]		
Belief that service users are interested in quitting[17]	Availability of cessation resources[17]	Sufficient time for staff[23]		
Belief smoking cessation is beneficial to them[20]	Having staff with lived experience deliver intervention facilitates acceptance by service users[24]	Organisational leadership[25]		
Belief smoking cessation support is effective[25]		Supportive policy[34]		
Being a past smoker[27]				
Strong staff relationship with clients[10]				

Barriers and enablers to preventive care

The search identified a review by Bartlem[35] looking at initiatives to improve physical health for people in community based mental health programs. It included 21 studies that also reported barriers and enablers. We extracted the barriers and enablers from each eligible study included in the Bartlem review and reclassified them against the Consolidated Framework for Implementation Research (Appendix F). Additionally, targeted searches identified another eight studies.[36–43] The majority of these (n=5) included staff or community service organisations providing services for Aboriginal and/or Torres Strait Islanders (e.g. Aboriginal Medical Service)[36–38, 41, 42], two for those with a mental illness[39, 44] and one study for Asian Americans and Pacific Islanders.[43]

Barriers

Staff-related barriers (individual factors) were reported most frequently, namely a lack of staff knowledge, skill, confidence or time; a belief service users were not interested in health behaviour change, or had more pressing needs; and a reluctance to address these issues with service users. The perceived difficulty in delivering preventive interventions, their cost and their accessibility to service users were the most commonly cited intervention-related barriers. A lack of capacity, funding, resources and high staff turnover were common organisational barriers to preventive care provision. Broader system or context barriers included a lack of referral options, and the (in)appropriateness of existing mainstream preventive services. Process barriers reported by the included studies related to the lack of, or difficulty using, electronic systems to support preventive care, and poor integration of electronic and paper records.

Table 3—Barriers to the integration or implementation of prevention care in community service organisations (presented within columns from most to least frequently cited)

Individual factors (service-staff factors)	Characteristics of the Intervention (i.e. its complexity, fit, appropriateness)	Inner setting (organisational factors)	Outer setting (broader system or contextual factors)	Process factors
Lack of staff expertise, knowledge, skill, confidence or time[37-40, 35]	Intervention perceived as difficult to deliver[36, 37, 35]	A lack of staff time and capacity within their existing workload[36–38, 40, 42]	Lack of external referral options[36, 38]	Lack of awareness and expertise of staff using electronic systems to support screening processes (for alcohol)[38]
Belief that service users had more pressing needs[39, 40, 35]	The cost associated with the intervention for service users (e.g. healthy foods)[36, 40]	A lack of funding or resources[37, 39, 40, 35]	Mainstream services may be inappropriate[40]	Poor integration of electronic and paper records[38]
Belief services users were not interested in physical health behaviour change[40, 35]	Intervention accessibility (e.g. requirement for participants to attend for support)[36, 40]	High staff turnover[36, 42]	Unstable nature of service-users' housing, finance and lack of insurance[35]	

Table 3—Barriers to the integration or implementation of prevention care in community service organisations (presented within columns from most to least frequently cited)

Individual factors (service-staff factors)	Characteristics of the Intervention (i.e. its complexity, fit, appropriateness)	Inner setting (organisational factors)	Outer setting (broader system or contextual factors)	Process factors
Staff reluctance to raise the issue or concern that it may offend service users[38, 35]	The time required to deliver the intervention[35]	A lack of training[36]	Stigma attending D&A services[37]	
Negative attitudes of staff or lack of staff readiness[40, 35]	A lack of guidelines for preventive care[35]	Lack of organisational support or priority[40]		
Belief by staff that interventions do not work[38]				
Staff's own health behaviours[35]				
Competing demands of complex service users[39]				

Enablers

The most common staff-related enablers (individual factors) were staff confidence, knowledge and skill in providing preventive care followed by strong relationships with service users. Enablers classified as related to the ‘characteristics of the intervention’ included perceived adaptability and affordability of preventive care interventions and their capacity to be integrated into existing models of care. We identified a large variety of outer-setting enablers for preventive care. These included perceived community need, partnerships with other sectors, stable funding and the availability of preventive care referral networks. There was also a range of process enablers, including embedding intervention into the role of all staff, government incentives to support service-user follow-up and capturing service users’ health needs and outcomes to enable coordinated follow-up.

Table 4—Enablers of the integration or implementation of preventive care in community service organisations (presented within columns from most to least frequently cited)

Individual factors (service-staff factors)	Characteristics of the Intervention (i.e. its complexity, fit, appropriateness)	Inner setting (organisational factors)	Outer setting (broader system or contextual factors)	Process factors
Staff confidence, knowledge or skills in providing preventive care[37, 40, 41, 35]	Adaptability of an intervention for different contexts or service-user groups[40, 35, 43]	Supportive organisational culture[35, 43]	Local orientation to the culture, language, and diversity of their (Aboriginal) service populations[42]	Embedding the intervention into the role and training of all staff[35]
Strong staff relationship with service user[36, 35]	Staff education and training[40]	Adequate allocation or availability of resources[42, 43]	Community need for preventive (healthy eating) programs[43]	Links between health services and communities[42]
The service user had a condition (alcohol-related) that staff perceived put them at risk[38]	Intervention or programs that are affordable or free[40]	Organisational support[42, 43]	Organisation's social standing in the community[43]	Community initiated service provision and engagement in all aspects of service development[42]
Belief addressing physical health would not have a negative impact on the staff –	Programs undertaken in a welcoming and supportive environment[40]	The role of Aboriginal workforce in increasing access, engagement	Partnerships with other sectors[40]	Integration of mental and physical health service delivery[42]

Table 4—Enablers of the integration or implementation of preventive care in community service organisations (presented within columns from most to least frequently cited)

Individual factors (service-staff factors)	Characteristics of the Intervention (i.e. its complexity, fit, appropriateness)	Inner setting (organisational factors)	Outer setting (broader system or contextual factors)	Process factors
service-user relationship[38]		and trust with Aboriginal service users[42]		
Belief that intervention is effective[43]	Brief assessment tools that facilitate feedback and service-user discussion[37]	Financial support[40]	Advocacy for physical healthcare by the community service organisation sector[40]	Medicare-funded Indigenous-specific preventive health assessments[42]
	Interventions that can be integrated within existing models of care[35]	Alignment of preventive care with staff role or organisational focus[38]	Stable government funding[40]	Flexible funding to enable services to be responsive to community needs[42]
	Having staff with lived experience[40]	Ongoing staff training[42]	Availability of preventive care referral networks[36]	Commonwealth funded incentives to support service-user follow-up care[42]

Table 4—Enablers of the integration or implementation of preventive care in community service organisations (presented within columns from most to least frequently cited)

Individual factors (service-staff factors)	Characteristics of the Intervention (i.e. its complexity, fit, appropriateness)	Inner setting (organisational factors)	Outer setting (broader system or contextual factors)	Process factors
	Brief interventions for some risks (smoking) easier than others[36]	Learning support systems[42]		Capturing service-user physical health needs and outcomes to enable coordinated intervention and follow-up[40]
		Systems for recruiting and retaining staff[42]		
		Clear roles of staff in delivering care[42]		

Comments

Key findings in context

The Rapid Evidence Summary indicates that a variety of factors influence (barriers or enablers) the integration of smoking cessation support or preventive healthcare more broadly in community service organisations. The most frequently reported factors across the studies reviewed were those pertaining to service staff (characteristics of individuals), characteristics of the intervention and organisational (inner setting) factors. Many of these—such as the belief that service users lack the motivation and capacity to quit (or improve other health behaviours); a lack of staff knowledge, skills, confidence or time; limited organisational resources or funding; and the existence (or otherwise) of organisational leadership—are similar to those reported in studies of barriers and enablers to such care in other community and clinical settings.[45–47] Some, however, appear more specific to the community service organisation setting. These include concerns regarding the financial capacity of clients and their ability to afford, for example, NRT or healthy food, or to attend formal health behaviour change programs; concerns that by addressing tobacco or other health behaviours staff may jeopardise their relationship with service users; and high staff turnover within the community service sector. Furthermore, the complex challenges faced by users of community service organisations in terms of their mental health, housing and other life circumstances may also be distinguishing barriers to smoking cessation care provision in the sector.

Interestingly, outer-setting and process factors were less commonly identified in the included studies. Factors such as prevailing political, social and economic contexts are likely to be highly influential on the capacity of organisations and their staff to implement smoking cessation (and preventive health) support.[48, 49] However, these are distal to 'front-line' community service organisation staff, and so less likely to emerge from studies that seek their views, although they may manifest in more proximal factors such as staff-perceived lack of resources or organisational priority. Nonetheless, greater exploration of outer-setting barriers or enablers may be useful to inform strategies to improve smoking cessation support that consider these broader contextual factors. This could be achieved by soliciting the views of community service organisation executives or other representatives of agencies responsible for their funding or performance monitoring. Process factors, including the procedures, and systems that coordinate and reinforce organisational activities, were also rarely identified by the studies included in this Rapid Evidence Summary. This was surprising given the prominence of such factors in implementation theoretical frameworks, and as these (e.g. performance monitoring systems) have been suggested to be important in implementing and sustaining implementation of evidence-based practices in reviews of community service organisations and other settings.[50, 51]

Barriers specific to population groups or service types

The majority of studies identified in the Rapid Evidence Summary were undertaken in community service organisations assisting people with mental health conditions, or addressed tobacco use. However, studies involving organisations serving groups including homeless and Aboriginal and Torres Strait Islander people, or addressing other health risks including alcohol use, nutrition, physical activity and preventive care more broadly, were also included. While there were considerable similarities in the reported barriers and enablers across these groups, there was some variability. The role of staff smoking in building trust and rapport with clients was evident, particularly in studies involving users of mental health services.[35] The use of medications was also suggested to be a barrier to motivation for behaviour change among those with a mental health condition.[35] Stigma associated with attending drug and alcohol services was seen as a barrier to providing brief interventions for alcohol among community service organisations.[37] Other studies reported that staff felt brief intervention may be more difficult for other health risks (nutrition, physical activity) than for smoking.[36] While less frequently reported, the importance of process and outer-setting factors in the provision of preventive care was particularly evident in studies involving Aboriginal community service organisations (e.g. Aboriginal Medical Services); that is, the role of the Aboriginal workforce in building trust with Aboriginal service users, and the importance of community connection and engagement of Aboriginal communities across all aspects of service development and delivery.[42] Such findings suggest that the characteristics of the community service organisations and the nature of the communities they serve need to be considered in efforts to improve the provision of smoking and broader preventive care by community service organisations.

Implications for practice

There is considerable scope to improve the provision of preventive healthcare by community service organisations.[52] The variety of factors identified in the included studies that impede or facilitate smoking cessation, or preventive healthcare broadly, suggest multiple strategies will be required to improve its provision by community service organisations. Training and professional development of the community service sector appears to be needed even for the provision of brief interventions. However, more intensive and specialised support over prolonged periods will maximise the impact of tobacco cessation and other interventions targeting chronic disease risk factors such as alcohol, nutrition and physical inactivity. Coupling the routine provision of brief intervention by community service organisation staff with referral to more specialised support may represent one means to achieve this. However, a number of studies included in this Rapid Evidence Summary found existing health promotion services are often considered inappropriate for service users.

As previous systematic reviews[52] have identified, barriers to quitting differ across priority populations, including those with a mental illness (e.g. maintenance of mental health), Indigenous groups (e.g. cultural and historical norms), those who are homeless (e.g. competing priorities) and at-risk youth (e.g. high accessibility of tobacco). Therefore, modification of existing preventive health specialist services may be required to better meet the needs of service users. Such modification has occurred for some services. For example, in NSW, the *Get Healthy Service* provides evidence-based information and coaching services for up to six months for a range of chronic disease risks, and has

been tailored to support the needs of some priority populations including pregnant women and Aboriginal Australians.[53, 54] Similar services exist to support smoking cessation.[55] The use of such free telephone-based services as an adjunct to brief intervention provided by community service organisations may overcome many of the financial and logistical barriers to support faced by service users identified by the studies included in this Rapid Evidence Summary. Indeed, reviews of community service interventions that have used referral to physical healthcare providers have found these can be effective.[35] An alternative strategy, suggested by Hancock and colleagues, is that community service organisations could be seen as transition services where confidence and capacity is built first, enabling service users then to engage with mainstream physical health services.[40]

Achieving sustained improvement in the provision of preventive healthcare will likely require strategies that move beyond capacity building and seek to achieve service integration. Reviews of initiatives to improve such care provision by community based mental health services have found those that were effective included a suite of implementation support strategies[35], such as, for example, making the physical health needs of service users an organisational priority that is supported by policy, with clear guidelines and delineation of roles. This should be embedded in position descriptions, performance reviews and criteria for promotion, and should be strengthened by systems of monitoring and accountability. Additionally, organisational systems should support the coordination of care, including the routine assessment of physical health needs on entry to the service, care prompts and reminders, processes of referral and links to the community. Studies included in this Rapid Evidence Summary identified many of these suggested strategies as important enablers, and they were supported by implementation frameworks[16, 48] and previous systematic reviews of practice change initiatives in this sector.[50] Further, such implementation support strategies are likely already undertaken by community service organisations to facilitate the delivery of other ‘core’ activities of the sector, suggesting integration of physical health into such organisational processes and infrastructure may be feasible. Broader system barriers, such as specific and stable funding for physical healthcare, are no doubt powerful determinants of organisational activity but may be less amenable to change in fiscally constrained environments. Nonetheless, the availability of funding for community service organisations tied to measures of preventive care, or the modification of existing agreements to incorporate this expectation, may facilitate change.

Implications for research

Despite the broad scope of the Rapid Evidence Summary, we failed to identify research on barriers and enablers for a number of priority populations often served by community service organisations, in particular, pregnant women and middle-aged men. Furthermore, there was relatively little research describing barriers to obesity, physical activity and nutrition interventions in this setting. It is likely that unique barriers to the provision of care for these groups exist and further research examining them is needed to best inform efforts to improve the physical health of service users. Additionally, many of the identified barriers and facilitators are contextually bound. For example, the perceived availability of appropriate referral services will likely vary across jurisdictions (in line with actual service availability). Place-based research examining factors most likely to be context-dependent may be important in regions (e.g. Tasmania) where action is being considered. Notwithstanding this context-dependence and the finding of some variation across factors and population groups identified and discussed

above, a key finding of the Rapid Evidence Summary is the remarkable consistency of many of the barriers and enablers identified across studies. Such findings suggest there are likely a core set of factors influencing care provision in this setting, providing the basis for the development and execution of strategies to improve care. Research is warranted to test the effects of such strategies on measures of improvement in care.

Limitations

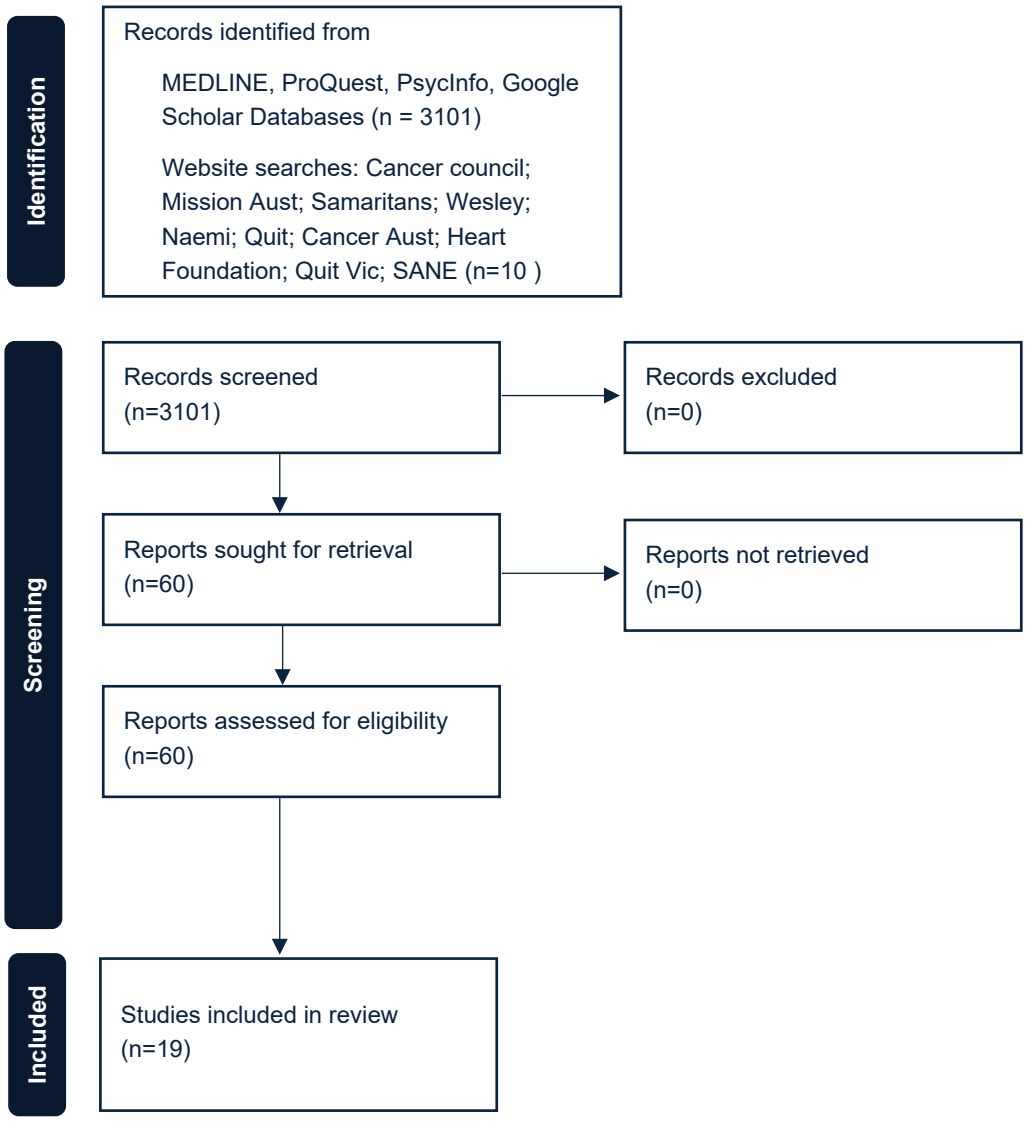
The Rapid Evidence Summary should be considered in the context of a number of limitations. The literature identified was dominated by studies undertaken in community service organisations serving people with mental illness, and focused on tobacco. Such findings may reflect prior funding priorities for mental health and tobacco, and the interest of a small number of research groups dominating work in this space. The extent to which the reported barriers and enablers can be generalised to organisations serving other priority populations may be limited. While the Rapid Evidence Summary categorised and collated the findings of included studies, these studies varied in terms of their size, sample representativeness and the methods used to assess barriers and enablers. The attributes of individual studies should be considered when interpreting the findings. Finally, the search to identify research reporting barriers and enablers to providing preventive healthcare broadly was not systematic, increasing the potential that relevant eligible studies were not identified.

Appendix A: Search strategy

Database	Setting terms[44]	Barrier/enabler terms[56]	Smoking terms[57]
MEDLINE and PsycInfo	Community organi$ation or community service organi$ation or community managed organi$ation, or foundation, or charit* or third sector or social welfare organi$ation or 'not for profit' or housing	Barrier* or imped* or hinder* or enable* or facilitate* or support*	Smoke or smoking or tobacco, or nicotine or quit or smoking cessation
ProQuest Social Sciences	ab(community organisation OR community service organisation OR community managed organisation OR social welfare organisation OR charity OR foundation OR third sector organisation OR third sector organization OR community organization OR community service organization OR community managed organization OR social welfare organization; or housing or not for profit) AND ab(barrier OR enable OR support OR facilitate OR impediment OR hinder) AND ab(smoke OR smoking OR tobacco OR nicotine OR quit OR smoking cessation)		

*The terms for setting, barrier/enabler, and tobacco will be combined with an 'AND' command. The terms have been developed based on those used in similar reviews.[44, 56, 57] The following limits were also applied to the databases: English language, human and date filters (2011–current).

Appendix B: PRISMA diagram reporting search for barriers and enablers to service provision of smoking cessation support



Appendix C: Citation of included studies addressing smoking

1. Alizaga NM, Nguyen T, Petersen AB, Elser H, Vijayaraghavan M. Developing Tobacco Control Interventions in permanent supportive housing for formerly homeless adults. Health Promot Pract 2020;21(6):972–82.
2. Bonevski B, O'Brien J, Frost S, Yiow L, Oakes W, Barker D. Novel setting for addressing tobacco-related disparities: a survey of community welfare organization smoking policies, practices and attitudes. Health Educ Res 2013;28(1):46–57.
3. Bryant J, Bonevski B, Paul C, Hull P, O'Brien J. Implementing a smoking cessation program in social and community service organisations: A feasibility and acceptability trial. Drug Alcohol Rev 2012;31(5): 678–84.
4. Bryant J, Bonevski B, Paul C, O'Brien J, Oakes W. Delivering smoking cessation support to disadvantaged groups: a qualitative study of the potential of community welfare organizations. Health Educ Res 2010;25(6):979–90.
5. Cookson C, Strang J, Ratschen E, Sutherland G, Finch E, McNeill A. Smoking and its treatment in addiction services: Clients' and staff behaviour and attitudes. BMC Health Serv Res 2014;14:304.
6. Ennals P, Hall C, Johnson SE, Lawrence D, Mitrou F, McNaught E et al. Kick the Habit: The effectiveness of a Consumer Centred Tobacco Management (CCTM) approach in enabling mental health consumers to reduce or quit smoking—a pilot study. Report on findings. Preston, Victoria: Neami National, 2019.
7. Himelhoch S, Riddle J, Goldman HH. Barriers to implementing evidence-based smoking cessation practices in nine community mental health sites. Psychiatr Serv 2014;65(1):75–80.
8. Hull P, Salmon AM, O'Brien J, Chapman K, Williams K. Can social and community service organisations embrace tobacco control for their disadvantaged clients? Health Promot J Austr 2012;23(3):188–93.
9. Johnson JL, Moffat BM, Malchy LA. In the shadow of a new smoke free policy: A discourse analysis of a health care providers' engagement in tobacco control in community mental health. Int J Ment Health Syst 2010;4:23
10. Kerr S, Woods C, Knussen C, Watson H, Hunter R. Breaking the habit: a qualitative exploration of barriers and facilitators to smoking cessation in people with enduring mental health problems. BMC Public Health 2013;13:221.
11. Martin MB, Martin SL. Healthy Amistad: improving the health of people with severe mental illness. Issues Ment Health Nurs 2014;35(10):791–5.
12. Mental Health Coordinating Council. Breathe Easy—lifting the burden of smoking. Final Project Report July 2009.
13. Mental Health Coordinating Council. Report on the Smoking Survey of MHCC Member Organisations. November 2008.
14. O'Brien J, Salmon A, Geikie A, Jardine A, Oakes W. Integrating smoking care in community service organisations to reach disadvantaged people: findings from the Smoking Matters project. Health Promot J Aust 2010; 21(3):176–82.
15. O'Brien J, Bonevski B, Salmon A, Oakes W, Goodger B, Soewido D. An evaluation of a pilot capacity building initiative for smoking cessation in social and community services: The Smoking Care project. Drug Alcohol Rev 2012;31(5):685–92.

16. Parnell A, Box E, Chapman L, Bonevski B, Anwar-McHenry J, Pettigrew S. Receptiveness to smoking cessation training among community service organisation staff. Health Promot J Austr 2020;31(3):418–22.
17. Parnell A, Box E, Bonevski B, Slevin T, Anwar-McHenry J, Chapman L et al. Potential sources of cessation support for high smoking prevalence groups: a qualitative study. Aust NZ J Public Health 2019;43(2):108–13.
18. Parnell A, Box E, Biagioni N, Bonevski B, Anwar-McHenry J, Slevin T et al. Factors influencing the willingness of community service organisation staff to provide smoking cessation support: a qualitative study. Aus NZ J Public Health 2020;44(2):116–20.
19. Sung, H. Evaluation of Tobacco Control Policies in San Francisco Homeless Housing Programs. Health Promotion Practice; Thousand Oaks. Vol 18. Iss 4. July 2017. 571-580

Appendix D: Citation of included studies describing barriers and enablers to the provision of preventive care more broadly, including non-tobacco chronic disease risks

1. Bailie J, Matthews V, Laycock A, Schultz R, Burgess CP, Peiris D et al. Improving preventive health care in Aboriginal and Torres Strait Islander primary care settings. Globalization and Health 2017;13:48.
2. Bartlem K, Fehily C, Wynne O, Gibson L, Lodge S, Clinton-McHarg T et al. Implementing initiatives to improve physical health for people in community-based mental health programs: an Evidence Check rapid review brokered by the Sax Institute (www.saxinstitute.org.au) for the NSW Ministry of Health, 2020
3. Chwastiak L, Cruza-Guet M-C, Carroll-Scott A, Sernyak M, Ickovics J. Preventive counseling for chronic disease: missed opportunities in a community mental health center. Psychosomatics 2013;54(4):328–35.
4. Clifford A, Shakeshaft A. Evidence-based alcohol screening and brief intervention in Aboriginal Community Controlled Health Services: Experiences of health-care providers. Drug Alcohol Rev 2011;30(1):55–62.
5. Clifford A, Shakeshaft A, Deans C. How and when health-care practitioners in Aboriginal Community Controlled Health Services deliver alcohol screening and brief intervention, and why they don't: A qualitative study. Drug Alcohol Rev 2012;31(1):13–19.
6. Hancock N, Cowles C. How NSW mental health community managed organisations assist people living with mental health conditions to address their physical health needs: A scoping study and review of literature. Sydney. Mental Health Coordinating Council and University of Sydney, 2014.
7. Leong J, Jang SH, Bishop SK, Brown EVR, Lee EJ, Ko LK. “We understand our community”: implementation of the Healthy Eating Healthy Aging program among community-based organizations. Transl Behav Med 2021;11(2):462–69.
8. Lovett R, Dance P, Guthrie J, Brown R, Tongs J. Walan Girri: developing a culturally mediated case management model for problematic alcohol use among urban Indigenous people. Aust Health Rev 2014;38(4):440–446.
9. Panaretto K, Coutts J, Johnson L, Morgan A, Leon D, Hayman N. Evaluating performance of and organisational capacity to deliver brief interventions in Aboriginal and Torres Strait Islander medical services. Aust NZ J Public Health 2010;34(1):38–44.

Appendix E: Characteristics of included studies addressing smoking

Appendix E: Characteristics of included studies addressing smoking

Citation and country	Study aim, design and sample	Study population and sample size	Methods and measures to assess barriers, enablers	Identified barriers and enablers
Alizaga et al. 2020[34] US	Aim: to examine the implementation of smoke-free policies and cessation services in permanent supportive housing (subsidised housing with onsite or closely linked supportive services) for formerly homeless persons. Design: mixed methods. A cross-sectional survey and qualitative interview.	The study was conducted in 23 permanent supported housing sites in the San Francisco Bay area of the US. Participants completed a questionnaire and in-depth semi-structured interviews. Participants included agency directors. Sample size: Six property management staff and 24	Questionnaires examined characteristics of smoke-free policies, attitudes towards smoke-free policies, and cessation services. Interviews examined how environmental, personal and behavioural factors influenced adoption of policies and implementation of cessation programs. Interviews also assessed attitudes towards and barriers to implementing	(D = director, M = manager, S = service staff) All % show agreement rates. <u>Barriers</u> **Inner setting:** • Lack of resources to support cessation (M=57%; S=NR) • Constraints to staff time (D=67%; S=54%) • We have adequate organisational support and resources to support quitting (M=17%; S=38%). **Characteristics of individuals**: • Lack of appropriate expertise

Appendix E: Characteristics of included studies addressing smoking

Citation and country	Study aim, design and sample	Study population and sample size	Methods and measures to assess barriers, enablers	Identified barriers and enablers
	Sample: not reported/ unclear.	service staff.	policies and cessation supports.	(D=83%; M=61%; S=71%) • Lack of priority for tenants (D=68%; M=65%; S=88%) • Concerns for tenant rights to smoke (D=50%; M= 26%; S=NR). <u>Enablers</u> **Inner setting:** • Lack of resources to support cessation (D=33%) • Smoke-free polices are important (D=100%; M=91%; S=88%) • Constraints to staff time (M=48%) • Smoke-free polices help our tenants quit (D=83%; M=61%; S=58%) • Changes to smoking policy to protect non-smokers from second-hand smoke (D=83%; M=96%; S=88%) • If we have a strict smoke-free policy it will reduce our occupancy rate (D=17%; M=26%; S=25%) • Support to quit should be part of the

Appendix E: Characteristics of included studies addressing smoking

Citation and country	Study aim, design and sample	Study population and sample size	Methods and measures to assess barriers, enablers	Identified barriers and enablers
				care we provide (D=100%; M=91%; S=88%) • We have adequate organisational support and resources to support quitting (D=50%) • Having a no-smoking policy indoors will reduce maintenance costs (D=67%; M=57%; S=63%) • Monetary constraints make it hard to offer cessation services (D=33%; M=30%; S=42%) • Concerns for occupancy rates (D=17%; M=13%; S=NR). **Characteristics of individuals:** • Cessation is not a feasible goal for our clients (D=17%; M=13%; S=17%) • We should not interfere with tenants' decision to smoke (D=33%; M=22%; S=25%).

Appendix E: Characteristics of included studies addressing smoking

Citation and country	Study aim, design and sample	Study population and sample size	Methods and measures to assess barriers, enablers	Identified barriers and enablers
Bonevski et al. 2013[21] Australia	Aim: to describe smoking policies and practices within non-government social and community service organisations in NSW; to describe the views of staff and management towards smoking and cessation; and to investigate factors associated with attitudes favourable towards smoking cessation support. Design: cross-sectional study. Sample: women, children, families, homeless people, vulnerable youth, people with mental illness, people with drug	Population: participants were recruited from member organisations of the NSW Council of Social Service that provided services to clients, who were disadvantaged youth and/or families and/or adults, and/or Indigenous and/or those experiencing mental illness. Sample size: 93 executive officers and 56 project managers completed the surveys from 142 eligible organisations.	The survey was adapted from an instrument previously used in the setting with evidence of internal consistency. Attitudes and beliefs were assessed using a 5-point Likert Scale. Participants completed a telephone survey.	Community service organisation staff believed/reported: <u>Barriers</u> **Characteristics of individuals:** • Our staff have the knowledge and skills to provide cessation support (49% agree) • Our clients who smoke are interested in quitting (28% agree) • For clients the benefits of cessation outweigh the disadvantages of smoking (14% agree). <u>Enablers</u> **Inner setting:** • Our staff have the organisational support to provide smoking cessation support (59% agree) • Smoking is not something our organisation should give more attention to as we have other

Appendix E: Characteristics of included studies addressing smoking

Citation and country	Study aim, design and sample	Study population and sample size	Methods and measures to assess barriers, enablers	Identified barriers and enablers
	and alcohol problems and Aboriginal people.			priorities (30% agree). **Characteristics of individuals:** • Our staff have the confidence to provide cessation support (65% agree) • Smoking increases our client's disadvantage (78% agree) • Smoking is something our program should give more attention to (56% agree) • Sometimes it is useful for a staff member to smoke with clients to build trust and rapport (10% agree) • It is up to clients whether they smoke or not (45% agree) • Our clients are not really able to quit smoking (18% agree) • Quit smoking support should be part of normal care at our organisation (68% agree).

Appendix E: Characteristics of included studies addressing smoking

Citation and country	Study aim, design and sample	Study population and sample size	Methods and measures to assess barriers, enablers	Identified barriers and enablers
Bryant et al. 2010[32] Australia	Aim: to explore the perceptions of community welfare service managers, staff and clients about the acceptability of providing and receiving cessation support, barriers to providing support, and the types of support considered appropriate and feasible. Design: qualitative and included in-depth interviews and focus groups. Sample: not reported/ unclear.	Population: participants were recruited from 11 social services offered by six non-government community welfare organisations in NSW. The services provided by these organisations included child, youth and family, early intervention services, community care centres, residential drug and alcohol services and outreach services for the homeless. All eligible staff at eligible services were invited to participate in focus groups. Managers involved in the day-to-day operation of services were invited to participate in a telephone interview.	Study protocols were used to guide focus groups and interviews to support discussion of attitudes and policies about smoking care currently offered, and attitudes and preferences for implementing cessation support into routine care.	Barriers **Inner setting:** • Managers and staff reported discouraging clients from giving up smoking as it was considered a coping mechanism in a time of crisis • Smoking cessation not part of staff role • Inadequate staff time • Inadequate training. **Characteristics of individuals:** • Smoking builds trust between staff and clients • A minority of staff believed providing quit advice would negatively impact their ability to provide welfare support and would be better provided through external specialist services • Most frequently reported barrier was low perceived priority of providing support to clients

Appendix E: Characteristics of included studies addressing smoking

Citation and country	Study aim, design and sample	Study population and sample size	Methods and measures to assess barriers, enablers	Identified barriers and enablers
		Sample size: participants included eight managers, 35 staff and 32 clients.		• Reluctance to raise the issue with clients • Concern clients may perceive advice to quit as judgmental. <u>Enablers</u> **Inner setting:** • Providing support considered a good fit with organisations' focus on wellbeing.
Bryant et al. 2012[10] Australia	Aim: to determine the feasibility and acceptability of integrating the delivery of smoking cessation support into usual care at one social and community service organisation supporting individuals recovering from mental illness who need help managing daily	Population: six support workers who completed a three-month follow-up; five support workers who completed a six-month follow-up. Sample size: nine support workers participated in training and completed the initial survey.	Procedures: support workers participated in a one-day training workshop and were invited to complete a pen and paper survey prior to training and at follow-up.	<u>Barriers</u> **Intervention characteristics:** • Providing quit support is not too difficult; 3/5 agree • Providing quit support does not take up too much time; 2/5 agree. **Characteristics of individuals:** • It would be better to refer clients to external quit programs; 4/5 agree.

Appendix E: Characteristics of included studies addressing smoking

Citation and country	Study aim, design and sample	Study population and sample size	Methods and measures to assess barriers, enablers	Identified barriers and enablers
	activities. Design: pre–post study without control. Sample: not reported/ unclear.			<u>Enablers</u> **Intervention characteristics:** • The majority of my clients were receptive to talking about their smoking; 4/5 agree. **Characteristics of individuals:** • Providing quit support has had a negative effect on my relationship with clients; 0/5 agree • I would be happy to attend further training; 5/5 agree • I would recommend training to other support workers; 5/5 agree.
Cookson et al. 2014[31] UK	Aim: to establish smoking behaviour and attitudes towards nicotine dependence treatment among clients and staff in substance abuse	Population: staff from four community drug treatment services, one inpatient detoxification unit, and two residential rehabilitation services.	The staff questionnaire included assessment of views of the appropriateness and feasibility of the provision and receipt of nicotine dependence treatment in the context of	<u>Barriers</u> **Characteristics of individuals:** • Treatment for smoking was rated by staff as significantly less important than treatment for other substances a client may also be using alongside

Appendix E: Characteristics of included studies addressing smoking

Citation and country	Study aim, design and sample	Study population and sample size	Methods and measures to assess barriers, enablers	Identified barriers and enablers
	treatment settings. Design: cross-sectional survey with staff and clients of seven community and residential addiction services in or with links to the South London and Maudsley NHS Foundation Trust. Sample: unclear though a proportion were aged under 24 years old.	Sample size: 145 staff participated in the survey.	treatment for other addictions.	their primary addiction. Enabler **Characteristics of individuals:** • The median rating of staff confidence in supporting smoking cessation of clients was 7 (out of 10) (IQR=4).
Ennals et al. 2019[25] Australia	Aim: to test the feasibility of conducting smoking intervention research in the context of a community mental health setting and with	Participants: drawn from eight community mental health service sites of one national organisation (Neami) in Australia. Sample size: not	Questionnaires were developed by the research team with input from consumer focus groups. Feedback about implementation of Kick the	Staff-reported barriers included: Barriers **Intervention characteristics:** • Delay between training and program start (resulting in a loss of knowledge and confidence in 'starting the

Appendix E: Characteristics of included studies addressing smoking

Citation and country	Study aim, design and sample	Study population and sample size	Methods and measures to assess barriers, enablers	Identified barriers and enablers
	multiple sites. Design: pilot pre–post study evaluating the impact of the Kick the Habit intervention. Sample: people with mental illness.	reported.	Habit was obtained from site managers and research assistants. Site managers provided unstructured feedback. Research assistants completed a questionnaire post-intervention.	conversation') • Need for more practical training. **Inner setting:** • Limited capacity within existing workload • Motivation was also tied to capacity and competing demands on staff time and more pressing things that staff needed to discuss, such as the NDIS • Difficulties in starting a conversation with consumers, especially if the consumer was experiencing a crisis and the support worker felt they were not in the 'right place' to talk about smoking. **Characteristics of individuals:** • Negative attitudes, low motivation • Lack of belief in the program • Staff did not believe that smoking cessation programs worked for their

Appendix E: Characteristics of included studies addressing smoking

Citation and country	Study aim, design and sample	Study population and sample size	Methods and measures to assess barriers, enablers	Identified barriers and enablers
				clients and they had preconceived notions about the desire by consumers to reduce their tobacco use or quit smoking • Staff who were also smokers were less motivated • Initial low motivation was linked to low confidence and uncertainty as to how to introduce the program and work with consumers. **Process:** • Many participants would have liked free access to NRT for a longer period. Some had difficulties getting their GP to prescribe further NRT after the program ended and others had already used their annual quota • Greater variety of NRT needed; patches were not suitable for everyone but the cost of other types of NRT were often prohibitive.

Appendix E: Characteristics of included studies addressing smoking

Citation and country	Study aim, design and sample	Study population and sample size	Methods and measures to assess barriers, enablers	Identified barriers and enablers
				Enablers **Intervention characteristics:** • One site found running an information session for consumers was helpful by encouraging participation and generating discussion • Confidence and support for the program, which grew over time. **Inner setting:** • Ongoing support and leadership. **Characteristics of individuals:** • Belief that it works • The right training at the right time.
Himelhoch et al. 2014[23] US	Aim: to evaluate the resources, barriers and willingness to use evidence-based smoking cessation interventions in	Population: staff from five psychosocial rehabilitation services and four community mental health clinics, in four	Clinicians were required to report their agreement on a 5-point Likert Scale to evaluate smoking cessation resources.	Barriers **Intervention characteristics:** • Lack of prompts to advise to quit (63%).

Appendix E: Characteristics of included studies addressing smoking

Citation and country	Study aim, design and sample	Study population and sample size	Methods and measures to assess barriers, enablers	Identified barriers and enablers
	mental health care settings. Design: a cross-sectional study. Sample: people with mental illness.	counties in Maryland, US. These nine centres were government-funded mental health centres. Sample size: 95 clinicians participated in the study.	Barriers to providing smoking cessation services were assessed using a series of items requiring clinicians to report their agreement on a 4-point Likert Scale.	**Outer setting:** • Lack of referral options (75%) • Counselling expensive (59%) • (Un)affordability of NRT (75%) or bupropion (58%). **Characteristics of individuals:** • Lack of confidence in supporting quitting (74%) • Perceived patient not interested (77%). Enablers **Inner setting:** • Lack of time (43%). **Characteristics of individuals:** • Cessation may worsen psychiatric symptoms (23%) • Perceived lack of success of quitting in this population (48%).

Appendix E: Characteristics of included studies addressing smoking

Citation and country	Study aim, design and sample	Study population and sample size	Methods and measures to assess barriers, enablers	Identified barriers and enablers
Hull et al. 2012[20] Australia	Aim: to assess the effectiveness of a grants program to support multi-level changes in service culture, smoking-related policy and cessation support. Design: mixed methods, pre–post design. Quantitative methods were used to assess changes in activities and attitudes as well as the acceptability and feasibility of addressing smoking within community service organisations. Sample: not reported/ unclear.	Population: qualitative data were collected via case studies based on key informant interviews. Participants were drawn from services participating in a grant scheme by a non-government social and community service organisations (SCSOs) participating in a grant scheme, administered by Cancer Council NSW. Located in NSW. These organisation provided services relating to mental health, drug and alcohol, Indigenous health, at-risk youth, and women and families, general disadvantage and	The survey assessed smoking-related policy, organisational attitudes towards smoking and current worker practices. Qualitative components required staff to respond to open-ended questions regarding project outcomes and barriers to project implementation.	Barriers **Intervention characteristics:** • Concerns were expressed that the expiry of NRT funding would limit project sustainability. **Inner setting:** • Important barriers to addressing tobacco control issues in SCSOs include staff turnover and staff attitude. **Characteristics of individuals:** • I have sufficient knowledge about smoking care to assist clients (33% agree) • Clients are not interested in quitting (42% disagree) • We do not know if our clients are interested in quitting (39% disagree) • Some services reported barriers associated with staff attitudes, for example, some staff championing

Appendix E: Characteristics of included studies addressing smoking

Citation and country	Study aim, design and sample	Study population and sample size	Methods and measures to assess barriers, enablers	Identified barriers and enablers
		HIV health. Sample size: 161 staff completed baseline surveys. 115 staff completed surveys at follow-up. Sample size for qualitative study component not recorded.		'smokers' rights'. <u>Enablers</u> **Intervention characteristics:** • Projects working with people with mental illness reported that being able to provide free NRT was important. **Inner setting:** • Our organisation could do more to address smoking (69% agree). **Characteristics of individuals:** • Clients should receive help to quit (84% agree) • Support to help people quit smoking should be routine care (76% agree) • Addressing smoking will improve clients' wellbeing (82% agree) • Smoking contributes to disadvantage and we should act (65% agree) • The skills I use to support clients

Appendix E: Characteristics of included studies addressing smoking

Citation and country	Study aim, design and sample	Study population and sample size	Methods and measures to assess barriers, enablers	Identified barriers and enablers
				could also help assist them to quit (63% agree) • Clients have enough other problems without worrying about smoking (58% disagree) • Smoking is a personal choice we should not interfere (51% disagree) • Smoking with clients is sometimes useful to build trust (58% disagree) • Smoking has benefits for the client that may outweigh the associated problems (64% disagree) • SCSO clients responded positively to smoking cessation assistance within mental health settings.
Johnson et al. 2010[19] Canada	Aim: to examine the perceptions of healthcare providers, both professional and para-professional, in relation to their roles in tobacco	Population: the study took place in two community mental health teams (who provide case and medication management, diagnosis, counselling	Interviews required participants to expand on three broad open-ended questions related to: 1) issues surrounding smoking in the workplace;	<u>Barriers</u> **Intervention characteristics:** • Nicotine replacement therapies did not 'work' and they were costly and problematic • Lack of training and knowledge

Appendix E: Characteristics of included studies addressing smoking

Citation and country	Study aim, design and sample	Study population and sample size	Methods and measures to assess barriers, enablers	Identified barriers and enablers
	control in the community mental health system. The study took place following the establishment of a new policy restricting tobacco use inside all mental health facilities and on their grounds. Design: qualitative interviews. Sample: the community resource centres noted a drop in services to a range of clientele, some of whom were at high risk for other health issues (e.g. homelessness, substance use).	and psychosocial rehabilitation), two community resource centres (provide drop-in service for a range of clients, some of whom are at risk of homelessness and substance use) and two mental health housing units (offer social service and community support outreach) within an urban health service district in Western Canada. Sample size: 42 professionals and 49 para-professionals.	2) challenges in addressing tobacco use in the workplace; 3) the types of support policies or resources they would find useful in supporting client smoking cessation.	regarding tobacco use. **Inner setting:** • Both para-professionals and professionals viewed the scope of their role in smoking cessation to be limited • Multiple roles and conflicting priorities were offered as reasons for not being able to assume this role • Taking on the issue of tobacco use was portrayed as adding to the 'workload' in an already 'overwhelming' multidisciplinary team environment. **Characteristics of individuals:** • Smoking with clients outdoors functioned as a therapeutic tool • Quitting smoking was difficult and potentially harmful for clients. Tobacco use was described as providing relief from symptoms

Appendix E: Characteristics of included studies addressing smoking

Citation and country	Study aim, design and sample	Study population and sample size	Methods and measures to assess barriers, enablers	Identified barriers and enablers
				associated with mental illness • The discourse that smoking 'helped' clients was present in interviews across all settings • Tobacco was lauded for providing the clients' 'only joy in life' • The discourse that framed tobacco use as an individual choice focused on the autonomy of clients • Some explained how they did not assess client smoking when they first met because it would seem 'judgmental' • Clients were described as 'reluctant to quit' and lacking 'motivation'; the social role of cigarettes was presented as beneficial for clients • Providers dismissed the role of directly supporting client tobacco cessation. Rather, they framed this role as belonging to an 'expert' • The timing of targeted interventions

Appendix E: Characteristics of included studies addressing smoking

Citation and country	Study aim, design and sample	Study population and sample size	Methods and measures to assess barriers, enablers	Identified barriers and enablers
				was important; it meant that the client had to be 'stable' and it had the tone of the expert taking charge when timing was 'appropriate', when the client was 'activated in their recovery process'.
Kerr et al. 2013[22] Scotland	Aim: to explore the barriers and facilitators to smoking cessation in people with mental health problems. Design: qualitative study. Sample: people with mental illness.	Population: participants were recruited from three health boards in the west and south of Scotland. Health and social care professionals (HSCP) were recruited with the assistance of managers in community mental health teams, and included psychiatrists, mental health nurses, occupational therapists, psychologists, general practitioners and social	Data were collected during one-to-one interviews with participants in person or via telephone. An interviewer guide was used to support discussion of barriers and facilitators and explored through the lens of social cognitive theory.	<u>Barriers</u> **Inner setting:** • The majority of the HSCPs stated that they had not undertaken any smoking cessation training. **Characteristics of individuals:** • A small number HSCPs did not believe they had a role in raising smoking/smoking cessation • Fear of damaging relationships appeared to get in the way of effective delivery of smoking cessation interventions • Raising the issue of smoking was

Appendix E: Characteristics of included studies addressing smoking

Citation and country	Study aim, design and sample	Study population and sample size	Methods and measures to assess barriers, enablers	Identified barriers and enablers
		workers. Sample size: 44 health and social care professionals participated in the study.		hypocritical if you were a smoker yourself • Smoking was not considered to be a priority when clients had other addictions • There was concern that attempting to stop smoking could be too stressful for many • Many of the HSCPs reported that people with MHPs are often reluctant to engage with mainstream services. This meant it could be difficult to gain access to the type of support that was required to successfully stop smoking.
Martin et al. 2014[24] US	Evaluate the impacts and challenges of implementing the Healthy Amistad program (a comprehensive lifestyle intervention that used a	Individuals with severe mental illness (n=118), who were members of Amistad (i.e. voluntary walk-ins to the centre).	An annual survey was distributed each year from 1999. On-site observations were conducted by trained research assistants to determine what aspects of	*** This was taken from the discussion; there is not data collection on barriers. <u>Barriers</u> **Intervention characteristics:** • Hiring persons with a lived

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Citation and country	Study aim, design and sample	Study population and sample size	Methods and measures to assess barriers, enablers	Identified barriers and enablers
	Peer Support and Recovery Program as its platform for operations). Design: cross-sectional survey, on-site observations, key information interviews. Sample: people living with severe mental illness.	Sample size: 118 clients.	Healthy Amistad were implemented with fidelity. Scripted key informant interviews were tailored to the director, peer-patient navigator (PPN), and peer activities coordinator to assess their views regarding the processes and impact of Healthy Amistad. An Intercept Survey was developed to determine member awareness and perception of Healthy Amistad programming.	experience of mental illness to serve in the roles of PPN and activities coordinator: “given their need to deal with their own illness, they were not always as accountable as could be considered ideal for an intervention”. Enablers **Intervention characteristics:** • Hiring persons with a lived experience of mental illness to serve in the roles of PPN and activities coordinator: individuals were well accepted by their peers in their new roles.
Mental Health Coordinating Council 2008[17] Australia	Aim: to gain an insight into the attitudes, policies and practices regarding smoking within the Mental Health Coordinating Council member	Population: the survey was completed by senior staff or executive officers from member organisations. Participating member	A self-completed survey included assessments of attitudes regarding smoking, details of organisational smoking policies and guidelines, current practices	Barriers **Characteristics of individuals:** • Quitting smoking will cause clients to have a relapse in their mental illness (56%)

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Citation and country	Study aim, design and sample	Study population and sample size	Methods and measures to assess barriers, enablers	Identified barriers and enablers
	organisations. Design: cross-sectional study. Sample: people with mental illness.	organisations primarily provided centre-based support work and education services. Sample size: surveys were completed by 38 members.	in dealing with smoking, level of interest in more support for clients to quit.	• Quitting is not a priority for our clients (50%). <u>Enablers</u> **Intervention characteristics:** • Strategies suggested to assist organisations help clients quit: able to provide free or subsidised NRT (74%); staff training (68%); seminars and resources for staff (47%); policies and guidelines (45%). **Characteristics of individuals:** • People with a mental illness should be urged to quit or reduce smoking (55%) • People who want to quit should receive support (95%) • Helping to quit should be part of the support we provide (76%) • Smoking contributes to our clients' disadvantage (79%) • Smoking with a client can help de-

Appendix E: Characteristics of included studies addressing smoking

Citation and country	Study aim, design and sample	Study population and sample size	Methods and measures to assess barriers, enablers	Identified barriers and enablers
				escalate a tense situation (35%) • Smoking with a client can help build staff rapport (12%) • We should not interfere with a client's right to smoke (48%) • Our clients are not interested in cessation (29%).
Mental Health Coordinating Council 2009[18] Australia	Aim: to evaluate the Breathe Easy Project, which seeks to reduce tobacco-related harm in people with mental health problems accessing organisations within the community mental health sector. Design: mixed methods including surveys of consumers and staff, focus groups with consumers, exit	Population: staff from five Mental Health Coordinating Council organisations participated as demonstration sites for the project. Sample size: 28 staff and managers completed the baseline survey, 23 the interim survey and 11 the final survey.	Surveys assessed staff attitudes, policies and practices regarding smoking. Exit interviews were conducted with staff at each of the sites at the end of the project and included assessment of barriers to working with consumers on smoking cessation and other supports perceived as useful for their service to address smoking.	Barriers **Inner setting:** • Time was identified as one of the biggest barriers • Lack of smoking policies. **Characteristics of individuals:** • Attitudes of staff; smoking considered a personal choice. Enablers **Intervention characteristics:** • Training provided useful information and skills (92%)

Appendix E: Characteristics of included studies addressing smoking

Citation and country	Study aim, design and sample	Study population and sample size	Methods and measures to assess barriers, enablers	Identified barriers and enablers
	interviews with staff and surveys of Mental Health Coordinating Council members. Sample: people with mental illness.			• Workshop was useful (92%).
O'Brien et al. 2010[33] Australia	The aim: to present an evaluation of demonstration sites involved in the Smoking Matters Project. Design: pre- and post study, without control. Sample: not reported/ unclear.	Population: demonstration sites were member organisations of the Association of Children's Welfare Agencies. These were all primarily youth focused. Sample size: 63 participants completed baseline surveys; of these 34 completed surveys at follow-up.	The sites were offered staff training, smoking care resources and policy support. Surveys were undertaken with staff participating in training at baseline and follow-up (three months). Surveys assessed confidence, knowledge and skills to address smoking.	<u>Enablers</u> **Inner setting:** • The organisation has the resources to support a client to quit (54%). **Characteristics of individuals:** • I feel confident providing an appropriate referral (67%) • I feel confident in helping a young person quit (78%) • I feel confident telling young people about the benefits of quitting (98%) • I feel confident informing the clients of the risks of smoking (94%)

Appendix E: Characteristics of included studies addressing smoking

Citation and country	Study aim, design and sample	Study population and sample size	Methods and measures to assess barriers, enablers	Identified barriers and enablers
				• I feel confident in raising the issue with young people (92%) • I believe I possess the skills to address tobacco use with clients (72%) • I am aware of the health effects of smoking (92%) • I am certain of my role in addressing tobacco use with clients (59%) • I would NOT find it too awkward to address client tobacco use (90%) • I think addressing tobacco use with young people is important (97%).
O'Brien et al. 2012[28] Australia	Aim: to evaluate a smoking care intervention—a two-year organisational capacity building strategy which consisted of seminars, smoking cessation training and NRT	Population: the organisations were social and community organisations working with disadvantaged clients in NSW, Australia (government and non-government). Services	Staff attending training completed brief surveys assessing attitudes to smoking and provision of care and confidence in providing care.	<u>Barriers</u> **Inner setting:** • Our staff have the organisational support to provide smoking cessation advice and support to clients (47% agree). **Characteristic of individuals:**

Appendix E: Characteristics of included studies addressing smoking

Citation and country	Study aim, design and sample	Study population and sample size	Methods and measures to assess barriers, enablers	Identified barriers and enablers
	grants—for social and community service organisations. Design: pre–post study, without control. Sample: one-fifth of clients were of Aboriginal or Torres Strait Islander descent.	included those focused on mental health, accommodation and family support, youth services, drug and alcohol, and emergency relief. Sample size: 442 of 600 staff who took part in training completed pre-training surveys and of these, 306 completed post-intervention surveys.		• Our staff have the confidence to provide cessation support to clients (39% agree). <u>Enablers</u> **Inner setting:** • Support to quit smoking should be part of the normal care our program provides (82% agree) • Smoking is something our program should give more attention to (74% agree) • Smoking is not something our program should give more attention to as we have other priorities (7% agree). **Characteristics of individuals:** • Disadvantaged people who smoke should receive help to quit (90% agree) • We should not interfere with our clients' decision to smoke (19%

Appendix E: Characteristics of included studies addressing smoking

Citation and country	Study aim, design and sample	Study population and sample size	Methods and measures to assess barriers, enablers	Identified barriers and enablers
				agree) • Our clients who smoke are not really interested in quitting (18% agree) • Our clients are not really able to quit smoking (9% agree) • Sometimes it is useful for a staff member to smoke with a client as a way of building trust and rapport (10% agree) • For our clients, the benefits of smoking outweigh the disadvantages of smoking (8% agree) • Smoking increases our clients' disadvantage (72% agree).
Parnell et al. 2019[26] Australia	Aim: to explore sources of cessation support for disadvantaged smokers and identify factors influencing decisions to use these. Design: qualitative; semi-	Population: clients of a not-for-profit CSOs located in metropolitan and regional Western Australia who smoked. Sample size: 84 clients.	Method: an interview guide was used to direct discussion on topics related to the clients' tobacco use, tobacco-control regulations, experience and interest in quitting, and sources of	<u>Enabler</u> **Inner setting:** • CSO clients reported that they had formed trusting relationships with CSO staff, which enabled them to feel comfortable in seeking or

Appendix E: Characteristics of included studies addressing smoking

Citation and country	Study aim, design and sample	Study population and sample size	Methods and measures to assess barriers, enablers	Identified barriers and enablers
	structured interviews. Sample: community service organisations (CSOs) servicing people with a mental illness, who experience homelessness or have alcohol and other drug problems.		cessation support.	receiving support from them.
Parnell et al. 2020a[30] Australia	Aim: to assess community service organisation staff members' interest in receiving smoking cessation training; to explore factors associated with interest; and identify preferred smoking cessation support information. Design: cross-sectional	Population: participants were recruited from peak bodies in the community services sector. Staff members who worked or volunteered at the relevant organisations participated. Participants represented CSOs responsible for supporting people with a mental illness, those experiencing or at risk of	The survey assessed participants' interest in receiving assistance to support clients to quit, the format in which they would like to obtain information, and the comprehensiveness of tobacco policy in place at their service.	<u>Enablers</u> **Characteristics of individuals:** • 53% of respondents reported that they would be interested in receiving smoking cessation training or resources to assist clients quit. Interest was highest among community managed organisations (CMOs) primarily supporting those with a mental illness (61%), Aboriginal or Torres Strait Islander people (57%), people experiencing

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Citation and country	Study aim, design and sample	Study population and sample size	Methods and measures to assess barriers, enablers	Identified barriers and enablers
	survey. Sample: CSOs servicing people with a mental illness, who experience homelessness or have alcohol and other drug problems.	homelessness; and those experiencing alcohol or other drug dependence. Sample size: 242 staff participated.		or at risk of homelessness (57%), alcohol or other drugs (54%) families and children (49%) and youth (43%).
Parnell et al. 2020b[27] Australia	Aim: to explore factors influencing community service organisation staff members' willingness to provide tobacco cessation support to clients experiencing disadvantage. Design: qualitative, semi-structured face-to-face interviews. Sample: the main groups	Population: staff were recruited from seven CSOs in Western Australia that provided alcohol and other drug, homelessness and mental health services to clients. These services were located in regional and metropolitan areas in WA. Sample size: 29 staff	Interviews explored the criteria used to determine whether discussions about quitting were initiated with a client, the availability and nature of cessation support within the organisation and personal tobacco use.	<u>Barriers</u> **Inner setting:** • A lack of sustainable tobacco-related programs and the lack of availability of quit resources at CSOs. **Characteristics of individuals:** • Belief that it was inappropriate to expect clients to address their tobacco use at the same time as they were dealing with other issues • Not qualified to offer advice • More comfortable discussing tobacco

Appendix E: Characteristics of included studies addressing smoking

Citation and country	Study aim, design and sample	Study population and sample size	Methods and measures to assess barriers, enablers	Identified barriers and enablers
	serviced by the CSOs were people living with a mental illness (60%), those experiencing or at risk of homelessness (41%), and people experiencing alcohol and other drug dependence.	members participated.		use with clients if they had voluntarily raised the issue. <u>Enabler</u> **Intervention characteristics:** • Training and experience in helping clients address other forms of drug dependence. **Characteristics of individuals:** • Confidence in being able to approach clients to provide cessation advice appeared to be the primary determinant of whether staff members offered cessation support • Past smokers felt equipped to offer cessation advice to clients because of their personal experience • More willing to talk to a client about their tobacco use if they had an established relationship. **Process:**

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Citation and country	Study aim, design and sample	Study population and sample size	Methods and measures to assess barriers, enablers	Identified barriers and enablers
				• Processes at services to assess client tobacco use on entry to the service.
Sung et al. 2017[29] US	Aim: to describe institutionalised smoking-related policies and cessation programs and perceived barriers and receptivity to instituting tobacco-control interventions in homeless housing programs. Design: qualitative study combining a structured survey with open-ended interviews. Sample: people who experience	Population: The sample included administrators of nine homeless housing program agencies in San Francisco. The participating agencies served families (5/9), individual adults (3/9), veterans (1/9) and youth (1/9), and all offered supportive services such as case management, wellness, mental health and substance use counselling.	The semi-structured interview was based on a previously validated template developed by the RAND Survey Research Group and assessed characteristics of participating programs; each program's smoking-related policies and programs; barriers perceived by administrators preventing the establishment of tobacco-control policies and programs and receptivity to their implementation.	Facility administrators' perceived barriers to instituting tobacco-control policies in their programs are organised into two categories: administrative and cultural. Barriers **Characteristics of interventions:** • They felt traditional programs, in which participants are expected to attend multiple weekly meetings, were unrealistic for their clients. **Inner setting:** • Administrative: A lack of resources for smoking cessation. Three of the administrators stated they had not been trained to assist clients with

Appendix E: Characteristics of included studies addressing smoking

Citation and country	Study aim, design and sample	Study population and sample size	Methods and measures to assess barriers, enablers	Identified barriers and enablers
	homelessness.			smoking cessation and were unaware of what services were available or effective. **Characteristics of individuals:** • Cultural—eight out of nine administrators expressed the opinion that quitting smoking was not a priority for their clients • Consistent with past research, five out of nine administrators stated they felt smoking was a reasonable coping mechanism for clients • Three of nine administrators stated they perceived smoking was lower risk than alcohol and other drug use • They noted clients were not motivated to quit by long-term benefits and felt they were more responsive to immediate incentive • The final barrier identified was that preventive health was not a priority

Appendix E: Characteristics of included studies addressing smoking

Citation and country	Study aim, design and sample	Study population and sample size	Methods and measures to assess barriers, enablers	Identified barriers and enablers
				for their client.

Appendix F: Characteristics of included studies addressing other health conditions

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Citation and country	Study aim, design and sample	Study population and sample size	Methods and measures to assess barriers, enablers	Identified barriers and enablers
Bailie et al. 2017[42] Australia	Aim: to describe stakeholder-identified priority evidence-practice gaps, stakeholder perceptions of barriers and enablers and suggested strategies for improving preventive care. Design: mixed methods. Sample: Aboriginal and/or Torres Strait Islanders.	Health clinical audit data from 137 primary health care (PHC) centres in Australia. Survey of stakeholders who have an interest in Indigenous PHC service delivery (clinicians, managers, policy officers, and academics) relating to interpretation of these data (n=152).	Priority evidence-practice gaps and associated barriers, enablers and strategies to address the gaps were identified and reported back through two stages of consultation. Stage one used reports of cross-sectional clinical preventive care audit and systems assessment data. Stakeholders were asked whether the priorities aligned with their experience, to rank	<u>Barriers</u> **Characteristics of individuals:** • Lack of skills • Lack of time • Competing demands • Staff skill mix. **Inner setting:** • High staff turnover • Lack of staffing. <u>Enablers</u> **Inner setting:**

Appendix F: Characteristics of included studies addressing other health conditions

Citation and country	Study aim, design and sample	Study population and sample size	Methods and measures to assess barriers, enablers	Identified barriers and enablers
			the priorities, and to determine whether other priorities should be included. In stage two, an online survey of stakeholders, respondents were asked (using findings from stage one and their experiences in primary healthcare) to identify a) barriers and enablers to improvement and b) new or existing strategies to address the gaps using a published survey instrument.	• Role of Aboriginal health practitioners in increasing access to, acceptability of and trust in health services, and Indigenous staff in engaging clients in their own health • Dedicated resources • Clear role definition • Ongoing staff training and learning support systems • Regional support systems for recruiting and retaining staff, especially management support. **Outer settings:** • Local orientation to the culture, language and diversity of their service populations. **Process:** • Links between health services and communities

Appendix F: Characteristics of included studies addressing other health conditions

Citation and country	Study aim, design and sample	Study population and sample size	Methods and measures to assess barriers, enablers	Identified barriers and enablers
				• Community initiated service provision and engagement in all aspects of service development • Integration of mental and physical health service delivery • Medicare-funded Indigenous-specific preventive health assessments • Flexible funding to enable services to be responsive to community needs • Commonwealth-funded incentives to support follow-up.
Bartlem et al. 2020[35] Australia	Aims: i and ii) what have been effective preventive healthcare interventions for mental health consumers delivered by community managed organisations (CMOs) and what are effective ways services can deliver	The review included publications reporting intervention trials, evaluations or service improvement initiatives aiming to improve the physical health or delivery access to physical healthcare for CMO consumers of community	A search was conducted across MEDLINE, CINAHL and Google Scholar, as well as CMO websites for peer-reviewed and grey literature. Data regarding barriers and enablers were extracted from 29 identified intervention studies and evaluations.	<u>Barriers</u> **Intervention characteristics:** • Time required to deliver the interventions • Lack of experience of staff/ difficulty in delivery/ technical requirements to deliver some interventions • Lack of guidelines to support effective implementation.

Appendix F: Characteristics of included studies addressing other health conditions

Citation and country	Study aim, design and sample	Study population and sample size	Methods and measures to assess barriers, enablers	Identified barriers and enablers
	or facilitate physical healthcare? iii) What have the barriers and enablers been for community mental health services to deliver or facilitate preventive healthcare? Design: systematic review. Sample: people with mental illness.	managed mental health organisations. The review was limited to English-language publications from 2010–2020 in countries with health systems comparable to Australia.		**Inner setting:** • Limited budgets • Staff availability. **Characteristics of individuals:** • Clients' mental health medication, other needs, limited motivation to change • Staff reluctance to address these issues • Incongruence with own behaviours of staff • Lack of staff knowledge, confidence, technical or other skills. **Outer setting:** • The unstable nature of client housing and finances, and lack of insurance. **Process:** • Processes of referral of clients to cessation services and a lack of

Appendix F: Characteristics of included studies addressing other health conditions

Citation and country	Study aim, design and sample	Study population and sample size	Methods and measures to assess barriers, enablers	Identified barriers and enablers
				clarity regarding who and how this was done. <u>Enablers</u> **Characteristics of individuals:** • Relationship with clients • Being flexible and supportive, motivated and competent. **Intervention characteristics:** • Interventions that could be integrated within existing models of care • Interventions that were contextually appropriate and tailored to the needs of consumers. **Inner setting:** • Supportive organisational culture • Promotion of preventive health to staff and consumers • Project managers with appropriate qualifications and skills.

Appendix F: Characteristics of included studies addressing other health conditions

Citation and country	Study aim, design and sample	Study population and sample size	Methods and measures to assess barriers, enablers	Identified barriers and enablers
				Process: • Embedding the intervention into the role and training of all staff.
Chwastiak et al. 2013[39] US	Aim: 1) to determine the prevalence of counselling by community mental health centre clinicians about the cardiovascular risk factors of smoking, poor nutrition and sedentary lifestyle ; and 2) to identify correlates associated with the provision of this preventive counselling. Understanding mental health clinician characteristics that are associated with the provision of counselling about CVD risk factors	Population: mental health clinicians at an urban community mental health centre providing comprehensive psychiatric and substance abuse services to approximately 2400 uninsured and low-income residents in New Haven, Connecticut. Sample size: 154 staff members.	Clinicians were asked about the major barriers to performing more cardiovascular risk monitoring of clients, including client-level barriers (clients do not have adequate resources to change health behaviour; clients are not motivated to change behaviour; clients have too many problems that need to be addressed); and provider-level barriers (I do not have enough time to address these issues; I do not have enough training to address these issues; I feel	<u>Barriers</u> **Inner setting:** • Clients lacked adequate resources to accomplish the behaviour changes necessary to decrease cardiovascular risk • Competing demands of these complex clients interfere with providing more specific counselling • Lack of provider time • Lack of provider training. **Characteristics of individuals:** • Clinicians'' perception that their clients did not think that health behaviour changes were important for decreasing cardiovascular risk;

Appendix F: Characteristics of included studies addressing other health conditions

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	could identify targets for interventions to increase counselling about CVD risk by mental health clinicians. Design: cross-sectional survey. Sample: people with mental illness.		uncomfortable providing advice because I do not have a healthy lifestyle).	clients were not motivated to change health behaviour risk.
Clifford et al. 2011[37] Australia	Aim: to describe the experiences of healthcare providers supported to implement evidence-based alcohol Screening and Brief Intervention (SBI) in two Aboriginal Community Controlled Health Services (ACCHSs).	Population: Healthcare providers supported to implement evidence-based alcohol SBI at one ACCHS located in a large rural centre and the other in a metropolitan centre. 32 healthcare workers who participated in	Survey domains measured changes in healthcare providers' confidence to: identify at-risk drinkers; talk with at-risk drinkers; provide an alcohol brief intervention; and help address alcohol misuse in the Indigenous community.	<u>Barriers</u> **Characteristics of individuals:** • A minority of workshop participants reported to be confident or very confident to give a brief intervention to at-risk drinkers: 32% **Characteristics of the intervention:** • Long and complex alcohol assessment tools; AUDIT-C more

Appendix F: Characteristics of included studies addressing other health conditions

Citation and country	Study aim, design and sample	Study population and sample size	Methods and measures to assess barriers, enablers	Identified barriers and enablers
	Design: mixed methods—surveys and qualitative interviews. Sample: Aboriginal and/or Torres Strait Islanders.	training completed the survey. Sixteen healthcare workers participated in interviews.	Semi-structured focus group and individual interviews were conducted with healthcare providers who delivered alcohol SBI. Initially, healthcare providers were asked to describe their most recent experiences in alcohol SBI, followed by interviewer prompts to elicit their perceptions and experiences of: barriers and enablers to alcohol SBI; patient reactions to alcohol SBI; and using patient resources.	feasible to deliver than the longer AUDIT. **Inner setting:** • Lack of patient education materials targeting binge drinking • A lack of time and resources prevented routine follow-up. **Outer setting:** • A barrier commonly identified by clinical and community Aboriginal Health Workers (AHWs) was the stigma of attending a D&A service. <u>Enablers</u> **Characteristics of individuals:** • Majority of workshop participants reported to be confident or very confident at identifying at-risk drinkers: 68% • The majority of workshop participants reported to be confident or very

Appendix F: Characteristics of included studies addressing other health conditions

Citation and country	Study aim, design and sample	Study population and sample size	Methods and measures to assess barriers, enablers	Identified barriers and enablers
				confident at talking with at-risk drinkers to help them change their behaviour: 52%. **Characteristics of the intervention:** • Brief assessment tools—AUDIT-C considered useful for initiating patient feedback and discussions about drinking.
Clifford et al. 2012[38] Australia	Aim: to examine healthcare practitioners' perceptions of, and practices in, alcohol screening and brief intervention in Aboriginal Community Controlled Health Services (ACCHSs).	Population: 37 purposively selected health staff across four rural and one metropolitan ACCHS in NSW.	Interview questions were informed by the findings of qualitative studies exploring the perceptions of healthcare practitioners regarding alcohol SBI delivery in Indigenous and non-Indigenous primary healthcare settings, and notes recorded during field visits to participating ACCHSs. Qualitative data	<u>Barriers</u> **Characteristics of individuals:** • GPs concerned that asking a patient about their alcohol use would identify complex problems they had neither the time nor the expertise to treat • Nurses and AHWs expressed concerns that alcohol screening could offend patients and damage rapport

Appendix F: Characteristics of included studies addressing other health conditions

Citation and country	Study aim, design and sample	Study population and sample size	Methods and measures to assess barriers, enablers	Identified barriers and enablers
	Design: qualitative. semi-structured group interviews. Sample: Aboriginal and/or Torres Strait Islanders.		were analysed using Framework Analysis.	• Healthcare practitioners expressed scepticism as to the effectiveness of alcohol BI. **Outer setting:** • A lack of appropriate alcohol referral options. **Process:** • Health workers were generally unaware of the alcohol screening function in Medical Director (MD), while GPs and RNs were unaccustomed to using it for this purpose • Alcohol information in electronic and paper records was generally poorly linked and inconsistent. <u>Enablers</u> **Characteristics of individuals:**

Appendix F: Characteristics of included studies addressing other health conditions

Citation and country	Study aim, design and sample	Study population and sample size	Methods and measures to assess barriers, enablers	Identified barriers and enablers
				• Healthcare practitioners were more likely to intervene with patients with risky drinking when they perceived it would not hinder patient rapport • Or when the presenting patient condition was likely to be alcohol-related • Or they perceived the patient to be at high risk. **Inner setting:** • Healthcare practitioners' perceptions of how well alcohol SBI fitted within their role appeared to influence their willingness to deliver it.
Hancock et al. 2014[40] Australia	Aim: to critically examine how well the current practices being used by NSW community managed organisations (CMOs) align with best emerging and available	Studies reviewed included reports of the effectiveness of a physical health program for people with a mental health condition, involved adults and were	A review of PubMed and Google Scholar databases was conducted for peer reviewed and grey literature. An online survey developed in consultation with a	<u>Barriers</u> **Characteristics of individuals:** • Negative attitudes of health professionals (21%) • Lack of consumer interest (28%)

Appendix F: Characteristics of included studies addressing other health conditions

Citation and country	Study aim, design and sample	Study population and sample size	Methods and measures to assess barriers, enablers	Identified barriers and enablers
	evidence internationally regarding physical healthcare. ** The study includes a range of other aims. Design: scoping review and mixed methods (online survey and semi-structured interviews). Sample: people with mental illness.	published in the previous 10 years. Surveys (n=35) were undertaken with staff, consumers and carers who were from organisational members of the Mental Health Coordinating Council. They represented community organisations that were predominately mental health-focused, or had a broader scope but operated mental health programs. One organisation was a disability employment service. Semi-structured interviews were	reference group (Mental Health Coordinating Council) and disseminated to staff of CMOs. The survey assessed operational provision of physical healthcare and barriers. Semi-structured interviews were conducted with the use of a guide with program staff, consumers and carers.	• Lack of staff skills and knowledge (14%) • Lack of time • Consumers have more pressing needs • Negative attitudes of staff. **Inner setting:** • Staff workload (45%) • Lack of funding (76%) • Lack of resources (48%) • Not a focus of the organisation. **Characteristics of the intervention:** • Costs to clients • Accessibility to clients. **Process:** • Lack of screening/ individual health checks. **Outer setting:** • Mainstream physical health services may not be appropriate.

Appendix F: Characteristics of included studies addressing other health conditions

Citation and country	Study aim, design and sample	Study population and sample size	Methods and measures to assess barriers, enablers	Identified barriers and enablers
		conducted with 30 staff, consumers and carers (including 14 front-line staff). Staff roles included program managers, mental health nurses, support workers, consultants and team leaders.		<u>Enablers</u> **Characteristics of individuals:** • Staff with lived experience • Program delivery by staff with expertise and skill. **Inner setting:** • Funding dedicated to physical health initiatives • Education and training for staff. **Outer setting:** • Partnerships with other sectors including health • Advocacy for physical health improvement by the CMO sector • Government funding. **Characteristics of the intervention:** • Interventions that can be tailored and individualised • Programs that are affordable or free

Appendix F: Characteristics of included studies addressing other health conditions

Citation and country	Study aim, design and sample	Study population and sample size	Methods and measures to assess barriers, enablers	Identified barriers and enablers
				• Programs undertaken in a welcoming and supportive environment. **Process:** • Capturing and measuring consumer physical health needs and outcomes to enable coordinated care.
Leong et al. 2021[43] US	Aim: to examine processes that facilitated the implementation of a Healthy Eating Healthy Aging program (HEHA) among community based organisations (CBOs) serving older AAPIs. Sample: Asian Americans and Pacific Islanders.	The study was conducted in CBOs serving Asian Americans and Pacific Islanders that implemented the HEHA program in the US. Population: Eighteen semi-structured interviews were conducted with CBO directors or senior managers responsible for leadership (n=12).	A semi-structured interview guide was created and informed by the Consolidated Framework for Implementation Research (CFIR) to capture how HEHA played into the five domains of CFIR: (a) intervention characteristics, (b) outer setting, (c) inner setting, (d) characteristics of the individuals, and (e) process.	<u>Enablers</u> **Characteristics of the intervention:** • HEHA's adaptability to different AAPI subgroups • Perceptions of how successfully HEHA was bundled and assembled. **Outer setting:** • Community's need for healthy eating programs and how the HEHA program meets that need.

Appendix F: Characteristics of included studies addressing other health conditions

Citation and country	Study aim, design and sample	Study population and sample size	Methods and measures to assess barriers, enablers	Identified barriers and enablers
				• The CBO's structural characteristics and social standing in the community. **Inner setting:** • Resources dedicated to the implementation and ongoing operations, including funding, training, education, physical space and time • The culture of the CBO. **Characteristics of individuals:** • Desire to learn the contents of the HEHA program and deliver them successfully • Beliefs about the quality of the HEHA program and its ability to promote healthy eating.

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Citation and country	Study aim, design and sample	Study population and sample size	Methods and measures to assess barriers, enablers	Identified barriers and enablers
Lovett et al. 2014[41] Australia	Aim: to describe the design and implementation of a culturally mediated case management model at Winnunga Nimmityjah Aboriginal Health Service (Winnunga) for Indigenous clients who consume alcohol at problematic levels. Design: cross-sectional quantitative survey. Sample: Aboriginal and/or Torres Strait Islanders.	Population: staff of Winnunga Nimmityjah Aboriginal Health Service in Canberra were invited to participate. 34 staff participated (19 Indigenous), who provide services direct to service users.	The survey was completed online asking '...what do you think you might NEED in order to offer brief intervention to clients?' Questions were framed taking a holistic approach to clients' health and sought individual staff members' confidence in talking to clients about their country and mob, problematic alcohol use, treatment options, impact of alcohol use on the family, and tobacco and other drug use, including injecting behaviours, bloodborne viruses and drug use in pregnancy.	<u>Enablers</u> **Characteristics of individuals:** • Confident/very confident asking clients with problematic drinking about their country/mob (73%–76%) • Confident/very confident talking with clients with problematic drinking about treatment options, accommodation needs, employment needs, education (68%–74%) • Confident/very confident providing information to clients with problematic drinking about smoking, safe injecting, bloodborne viruses, prevention of overdose, treatment for heroin, amphetamine or benzodiazepine use (55%–76%) • Confident/very confident identifying at-risk drinkers (68%) • Confident/very confident talking with at-risk drinkers (71%)

Appendix F: Characteristics of included studies addressing other health conditions

Citation and country	Study aim, design and sample	Study population and sample size	Methods and measures to assess barriers, enablers	Identified barriers and enablers
				• Confident/very confident providing brief intervention for alcohol problems when not asked for help (52%) • Confident/very confident talking to pregnant women about alcohol, tobacco, treatment for illegal drug use (73%–82%).
Panaretto et al. 2010[36] Australia	Aim: to assess brief intervention (BI) activity and organisational capacity to address smoking, nutrition, alcohol and physical activity (SNAP framework) and key clinical prevention activities in Aboriginal and Torres Strait Islander medical services in Queensland.	Population: staff of four urban Aboriginal and Torres Strait Islander medical services in Brisbane. Three participating services were community controlled and the other was a state-funded community health service. All clinical staff (Aboriginal Health Workers, nurses, doctors	The survey assessed knowledge and attitudes pertaining to brief intervention, screening tools available, how often staff thought they should provide brief intervention to patients, availability and use of referral services and provision of training. Staff focus groups at each site examined barriers and enablers to brief intervention	<u>Barriers</u> **Inner setting:** • 92% of staff reported they needed more training • 49% of staff reported they had received appropriate training for brief interventions • Lack of time • Staff turnover. **Characteristics of the intervention:** • Lack of an easy way to assess nutrition

Appendix F: Characteristics of included studies addressing other health conditions

Citation and country	Study aim, design and sample	Study population and sample size	Methods and measures to assess barriers, enablers	Identified barriers and enablers
	Design: mixed methods—staff surveys and focus groups. Sample: Aboriginal and/or Torres Strait Islanders.	and practice managers) of participating services were invited to participate in surveys and focus groups. The survey was completed by 39 staff and focus groups by 32 staff.	delivery. Issues explored included the role of workforce, IT, management support, past training and perceived support needs.	• The impact of low socioeconomic families coping with increasing costs of food as part of healthy eating intervention • Difficulty for people to attend follow-up appointments. **Outer setting:** • A lack of referral networks for physical activity (44%). <u>Enablers</u> **Outer setting:** • Perceived availability of referral networks for smoking (67%), nutrition (100%), alcohol management (77%). **Characteristics of individuals:** • The relationship with the patient. **Characteristics of the intervention:** • Smoking perceived as easier to address than other risks.

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