

Smoking cessation advice and non-pharmacological support in a national sample of Aboriginal and Torres Strait Islander smokers and ex-smokers

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doi:10.5694/mja15.00293

Quitting smoking reduces the risk of smoking-related death, with greater benefits from quitting at a younger age.¹ Receiving brief advice to quit from health professionals and more intensive support from specialist clinics and courses, stop-smoking medicines, telephone quitlines, websites and printed materials have been shown to increase successful quitting.²⁻⁸ In Australia, just over half of smokers have been recently advised to quit, and a similar proportion of those who have tried to quit have used stop-smoking medicines.^{9,10} Fewer smokers are referred to or use other cessation support services.⁹⁻¹¹

In 2012–2013, Aboriginal and Torres Strait Islander adults had 2.5 times the smoking prevalence of other Australian adults, and those who had ever smoked were less likely to have successfully quit (37% v 63%).¹² There is a long history of widespread training in how to give brief advice for health professionals working with Aboriginal and Torres Strait Islander peoples.¹³ In recent years, the national Tackling Indigenous Smoking program has increased funding to support this training, enhancement of the telephone Quitline service to be more culturally appropriate, and other local cessation support activities.¹⁴

Here, we describe recall among a national sample of Aboriginal and Torres Strait Islander smokers and recent ex-smokers of having received advice to quit smoking and referral to non-pharmacological cessation support from health professionals, and examine the association of advice and referrals with making a quit attempt. We examine the use of stop-smoking medicines elsewhere in this supplement.¹⁵

Abstract

Objectives: To describe recall among a national sample of Aboriginal and Torres Strait Islander smokers and recent ex-smokers of having received advice to quit smoking and referral to non-pharmacological cessation support from health professionals, and their association with quit attempts.

Design, setting and participants: The Talking About The Smokes project used a quota sampling design to recruit 1721 smokers and ex-smokers who had quit ≤ 12 months previously from communities served by 34 Aboriginal community-controlled health services and one community in the Torres Strait. Baseline surveys were conducted from April 2012 to October 2013. Results for daily smokers were compared with 1412 Australian daily smokers surveyed by the International Tobacco Control Policy Evaluation Project between 2006 and 2011.

Main outcome measures: Participants' recall of having been: seen by a health professional in the past year, asked if they smoke, advised to quit, and referred to other cessation support services; and having made a quit attempt in the past year.

Results: Compared with other Australian daily smokers, higher proportions of Aboriginal and Torres Strait Islander daily smokers saw a health professional in the past year (76% v 68.1%) and were advised to quit smoking (75% v 56.2% of those seen). Most Aboriginal and Torres Strait daily smokers who saw a health professional recalled being asked if they smoke (93%). Aboriginal and Torres Strait Islander daily smokers who had been advised to quit were more likely to have made a quit attempt in the past year than those who had not (odds ratio, 2.00; 95% CI, 1.58–2.52). Among all Aboriginal and Torres Strait Islander smokers and recent ex-smokers who had been advised to quit, 49% were given a pamphlet or brochure on how to quit, but fewer were referred to the telephone Quitline (28%), a quit-smoking website (27%) or a local quit course, group or clinic (16%).

Conclusion: Most Aboriginal and Torres Strait Islander daily smokers recalled being recently advised by a health professional to quit, which was associated with making a quit attempt.

Methods

The Talking About The Smokes (TATS) project surveyed 1643 Aboriginal and Torres Strait Islander smokers and 78 recent ex-smokers (who had quit ≤ 12 months before), using a quota sampling design based on the communities served by 34 Aboriginal community-controlled health services (ACCHSs) and one community in the Torres Strait. It has been described in detail elsewhere.^{16,17} Briefly, the 35 sites were selected based on the distribution of the Aboriginal and Torres Strait Islander population by state or territory and

remoteness. In 30 sites, we aimed to interview 50 smokers or recent ex-smokers and 25 non-smokers, with equal numbers of women and men, and those aged 18–34 and ≥ 35 years. In four large city sites and the Torres Strait community, the sample sizes were doubled. People were excluded if they were aged under 18 years, not usual residents of the area, staff of the ACCHS or deemed unable to complete the survey. In each site, different locally determined methods were used to collect a representative, although not random, sample.

Baseline data were collected from April 2012 to October 2013. Interviews

were conducted face to face by trained interviewers, almost all of whom were members of the local Aboriginal and Torres Strait Islander community. The survey was completed on a computer tablet and took 30–60 minutes. A single survey of health service activities was also completed at each site. The baseline sample closely matched the distribution of age, sex, jurisdiction, remoteness, quit attempts in the past year and number of daily cigarettes smoked reported in the 2008 National Aboriginal and Torres Strait Islander Social Survey (NATSISS). However, there were inconsistent differences in some socioeconomic indicators: our sample had higher proportions of unemployed people, but also higher proportions who had completed Year 12 and who lived in more advantaged areas.¹⁶

We asked all smokers and recent ex-smokers whether they had seen a health professional in the past year and, if so, whether they had been asked if they smoke and, if so, whether they had been encouraged to quit. We asked those who had been encouraged to quit about pamphlets or referrals to the Quitline, quit-smoking websites, or quit courses or clinics they had received. We also asked all smokers and recent ex-smokers whether they had sought out these services themselves, and about quit attempts and sociodemographic factors. At each site, we asked questions about tobacco control funding and staff positions to determine if the health service had resources dedicated to tobacco control. The questions reported here are described in detail in Appendix 1.

The TATS project is part of the International Tobacco Control Policy

Evaluation Project (ITC Project) collaboration. Interview questions were closely based on those in ITC Project surveys, especially the Australian surveys.¹⁸ TATS project results were compared with those of 1412 daily smokers newly recruited to Waves 5–8 (2006–2011) of the Australian ITC Project. The ITC Project survey was conducted by random digit telephone dialling. We only used data from the newly recruited participants as questions for recontacted participants referred to advice received since the previous survey rather than in the past year. Slightly different definitions of smokers between the TATS project and ITC Project surveys meant that only daily and weekly smoker categories were directly comparable. We concentrated our comparisons on daily smokers. We have also concentrated our other descriptions of recall of advice and associations between variables within the TATS sample on daily smokers.

The project was approved by three Aboriginal human research ethics committees (HRECs) and two HRECs with Aboriginal subcommittees: Aboriginal Health & Medical Research Council Ethics Committee, Sydney; Aboriginal Health Research Ethics Committee, Adelaide; Central Australian HREC, Alice Springs; HREC for the Northern Territory Department of Health and Menzies School of Health Research, Darwin; and the Western Australian Aboriginal Health Ethics Committee, Perth.

Statistical analyses

We calculated the percentages and frequencies of responses to the TATS project questions, but did not include

confidence intervals for these as it is not considered statistically acceptable to estimate sampling error in non-probabilistic samples. We compared results for daily smokers with those in the Australian ITC Project surveys, which were directly standardised to the distribution of age and sex of Aboriginal and Torres Strait Islander smokers reported in the 2008 NATSISS.

Within the TATS project sample, we assessed the association between variables using simple logistic regression, with confidence intervals adjusted for the sampling design, using the 35 sites as clusters and the age–sex quotas as strata in Stata 13 (StataCorp) survey [SVY] commands.¹⁹ *P* values were calculated using adjusted Wald tests.

Reported percentages and frequencies exclude those refusing to answer or answering “don’t know”, leading to minor variations in denominators between questions. Less than 2% of daily smokers answered “don’t know” or refused to answer each of the questions analysed here.

Results

Three-quarters of Aboriginal and Torres Strait Islander daily smokers (76%) reported having seen a health professional in the past year (Box 1). Of these, 93% said they were asked if they smoked, and 75% also reported being advised to quit. These proportions are higher than those among Australian daily smokers in the ITC Project.

Within the TATS project sample, Aboriginal and Torres Strait Islander daily smokers who had been advised to quit by a health professional had twice the odds of having made a quit attempt in the past year, compared with those who did not recall being advised to quit (Box 2).

The proportion of Aboriginal and Torres Strait Islander daily smokers who had been advised to quit increased with age and was higher among women, those with post-school qualifications and those whose local health service had dedicated tobacco control resources; the

1 Daily smokers' recall of receiving advice to quit when seeing a health professional in the past year*

	Australian ITC Project, % (95% CI)†	TATS project, % (frequency)‡
Seen a health professional	68.1% (64.8%–71.1%)	76% (1047)
Of those seen		
Asked if he/she smokes‡	—	93% (968)
Advised to quit	56.2% (52.3%–59.9%)	75% (782)

ITC Project = International Tobacco Control Policy Evaluation Project. TATS = Talking About The Smokes. *Percentages and frequencies exclude refused responses and “don’t know” responses. †Results are for daily smokers (*n* = 1412) newly recruited to Waves 5–8 of the Australian ITC Project (2006–2011) and were age- and sex-standardised to smokers in the 2008 National Aboriginal and Torres Strait Islander Social Survey. ‡Results are for Aboriginal and Torres Strait Islander daily smokers (*n* = 1377) in the baseline sample of the TATS project (April 2012 – October 2013). §Not asked in the Australian ITC Project. ◆

proportion was lower among the unemployed (Box 3). There was more sociodemographic variation in having seen a health professional than in recalling being advised to quit (Appendix 2).

Among all Aboriginal and Torres Strait Islander smokers and ex-smokers who were advised to quit, 49% were given a pamphlet or brochure on how to quit, and lower proportions were referred to the telephone Quitline (28%), a quit-smoking website (27%) or a local quit course, group or clinic (16%) (Box 4). Most of those who received pamphlets said they read them (70%, 321/457), but lower proportions reported following up on other referrals. Daily smokers who were referred to each resource were non-significantly more likely to have made a quit attempt in the past year than those who had been advised to quit but not referred (Box 2). We also found that 13% of smokers and recent ex-smokers (215/1696) had sought out quit information or services themselves, and that 62% (1047/1692) had been encouraged by family or friends to quit or to maintain a quit attempt.

A higher proportion of the Aboriginal and Torres Strait Islander daily smokers who had been advised to quit by a health professional in the past year had been given a pamphlet, compared with other Australian daily smokers in the ITC Project (50% [390/778] v 29.6% [95% CI, 25.4%–34.3%]).

Discussion

Daily smokers in our Aboriginal and Torres Strait Islander sample were more likely than those in the broader Australian ITC Project sample to recall having been advised to quit by a health professional in the past year. This was in part due to being more likely to have been seen by a health professional, but mainly due to a greater proportion of those seen being advised to quit.

Strengths and limitations

The main strength of this study is its large, nationally representative sample of Aboriginal and Torres Strait Islander smokers and ex-smokers. However, the sample was

2 Aboriginal and Torres Strait Islander daily smokers who made a quit attempt in the past year, by recall of being advised to quit and referred to cessation support

	Attempted to quit in the past year		
	% (frequency)*	Odds ratio (95% CI)†	P‡
All daily smokers (n = 1354)			
Advised to quit by a health professional in the past year			< 0.001
No	39% (223)	1.0	
Yes	56% (433)	2.00 (1.58–2.52)	
If advised to quit by a health professional in the past year (n = 777)‡			
Given a pamphlet			0.053
No	52% (203)	1.0	
Yes	60% (230)	1.34 (1.00–1.79)	
Referred to telephone Quitline			0.15
No	55% (306)	1.0	
Yes	60% (125)	1.25 (0.92–1.68)	
Referred to quit-smoking website			0.48
No	55% (305)	1.0	
Yes	58% (121)	1.13 (0.80–1.6)	
Referred to quit course, group or clinic			0.19
No	55% (357)	1.0	
Yes	61% (73)	1.30 (0.88–1.92)	

*Percentages and frequencies exclude those answering “don't know” or refusing to answer. †Odds ratios calculated using simple logistic regression adjusted for the sampling design. ‡P values calculated using adjusted Wald tests. §Only participants who recalled being advised to quit by a health professional were asked about referral to cessation support resources. ◆

not random and there were some sociodemographic differences compared with a random sample of the population.¹⁶

Our survey was conducted face to face, whereas the comparison Australian ITC Project surveys were conducted by telephone, potentially leading to differential social desirability bias. Further, some ITC Project surveys were conducted much earlier than the TATS project survey, and although many questions were identical on both surveys, the order and structure of the comparison ITC Project questionnaire was different. While we are confident that the large difference in recall of health professional advice between the TATS project and ITC Project samples is real, we have not described the differences in referral to cessation support as, except for the question about pamphlets, the questions were not directly comparable.

The main limitation of our study is that partnering with ACCHSs to recruit participants may have led to a selection bias towards people with closer connections to the health

services, inflating the percentage who recalled being seen by a health professional. However, this percentage was similar to that reported in the 2004–2005 National Aboriginal and Torres Strait Islander Health Survey.¹⁶ We also report a higher prevalence of having received advice among only those who had seen a health professional, which would be less affected by this bias. Our results are also based on patient recall, not clinical records. Australian general practice research has found that clinical records poorly record health advice and poorly agree with patient recall of referrals to other cessation services.¹⁰ Some patients will have misremembered or forgotten advice and referrals they received, but we would expect that advice and referrals that were useful for quitting would be more likely to be remembered.

Comparisons with other studies

The proportion of smokers who had seen a health professional and recalled being asked if they smoke was similar to that among a sample of pregnant Aboriginal and Torres

3 Aboriginal and Torres Strait Islander daily smokers who recalled being advised to quit by a health professional in the past year, by sociodemographic factors (*n* = 1366)

Characteristic	Advised to quit by a health professional		
	% (frequency)*	Odds ratio (95% CI) [†]	<i>P</i> [‡]
Total	57% (782)		
Age (years)			0.001
18–24	48% (136)	1.0	
25–34	55% (203)	1.29 (0.93–1.79)	
35–44	58% (188)	1.47 (1.01–2.16)	
45–54	62% (145)	1.72 (1.15–2.57)	
≥55	71% (110)	2.61 (1.67–4.06)	
Sex			0.003
Male	52% (342)	1.0	
Female	62% (440)	1.50 (1.15–1.95)	
Indigenous status			0.74
Aboriginal	57% (694)	1.0	
Torres Strait Islander or both	59% (88)	1.07 (0.73–1.56)	
Labour force status			< 0.001
Unemployed	48% (226)	1.0	
Not in labour force	65% (273)	2.00 (1.47–2.71)	
Employed	59% (282)	1.57 (1.20–2.05)	
Highest education attained			0.007
Less than Year 12	54% (380)	1.0	
Finished Year 12	57% (206)	1.17 (0.91–1.51)	
Post-school qualification	66% (194)	1.72 (1.23–2.41)	
Treated unfairly because Indigenous in past year			0.72
No	58% (342)	1.0	
Yes	57% (423)	0.96 (0.75–1.22)	
Remoteness			0.33
Major cities	54% (194)	1.0	
Inner and outer regional	60% (430)	1.25 (0.86–1.81)	
Remote and very remote	54% (158)	0.98 (0.64–1.52)	
Area-level disadvantage			0.18
1st quintile (most disadvantaged)	55% (285)	1.0	
2nd and 3rd quintiles	61% (357)	1.28 (0.94–1.74)	
4th and 5th quintiles	54% (140)	0.97 (0.68–1.38)	
Local health service has dedicated tobacco control resources			0.05
No	52% (207)	1.0	
Yes	60% (575)	1.38 (1.00–1.91)	

* Percentages and frequencies exclude those answering “don’t know” or refusing to answer. † Odds ratios calculated using simple logistic regression adjusted for the sampling design. ‡ *P* values calculated for the entire variable, using adjusted Wald tests. ◆

Strait Islander women who smoked, who were only slightly more likely to be advised to quit (81% of pregnant smokers v 75% of daily smokers in our sample).²⁰

SmokeCheck, a commonly used training program to increase health professionals’ skills in giving brief quit-smoking advice to Aboriginal and Torres Strait Islander patients, has been shown to improve participants’

confidence in regularly providing brief advice.^{21,22} The long history of such training programs, along with support for and promotion of brief interventions in ACCHSs, may have contributed to advice being given more often to Aboriginal and Torres Strait Islander smokers than other smokers.

We found that the likelihood of receiving advice to quit from health

professionals increased with participant age, as in earlier Australian ITC Project research.⁹ Most of the focus of chronic disease prevention is on older patients, but there is an opportunity to increase the provision of advice about smoking to younger patients.

Our finding that a high proportion of Aboriginal and Torres Strait Islander daily smokers recalled receiving this advice is encouraging, as even brief advice from a doctor increases cessation, with minimal additional benefit from more extensive advice or follow-up.² Provision of brief advice is achievable even in very busy primary care settings and, as we found, can reach most of the population. In both urban and remote settings, Aboriginal and Torres Strait Islander interviewees in qualitative research have emphasised that advice and support from health professionals was a significant factor in their quit attempts.^{23–25} Consistent with this, we found that recalling advice from a health professional to quit was associated with making a quit attempt. While it is possible that making an attempt may increase the likelihood of advice being recalled, or may have led to making a visit to a health professional, it seems reasonable to conclude that advice from health professionals is contributing to Aboriginal and Torres Strait Islander smokers’ motivation to try to quit.

The frequent use of pamphlets by Aboriginal and Torres Strait Islander smokers is positive but not likely to have much impact on cessation, as the additional effect of such printed material is only modest.⁶ In contrast, Cochrane reviews show a greater effect on cessation of telephone quitlines, more intensive individual counselling outside primary care, and quit groups.^{4,7,8} Currently, evidence for internet-based quit support is inconsistent but promising.⁵

A meta-analysis of two randomised controlled trials showed intensive cessation counselling programs for Aboriginal and Torres Strait Islander smokers were effective in increasing cessation.²⁶ We found that most people who attended special cessation programs said they were

specifically designed for Aboriginal and Torres Strait Islander peoples.

Quitlines can be a cost-effective element in cessation support, but there has been a perception of distrust and low usage of quitlines by Aboriginal and Torres Strait Islander people.¹³ In 2010, Aboriginal and Torres Strait Islander callers to the Quitline in South Australia received fewer calls back and were less likely to have successfully quit than non-Indigenous callers.²⁷ Since then, the Tackling Indigenous Smoking program has funded activity to improve the appropriateness and accessibility of the Quitline.

These non-pharmacological cessation support options benefit smokers who use them, but we found that most do not, as has been found in other contexts.⁹⁻¹¹ Indigenous and non-Indigenous Australian research has shown that many smokers see using cessation support as a sign of weakness and lack of willpower, which is a challenge in promoting these evidence-based services.^{24,28}

Acknowledgements: The full list of acknowledgements is available in Appendix 3.

Competing interests: No relevant disclosures.

Provenance: Not commissioned; externally peer reviewed.

Received 10 Mar 2015, accepted 11 May 2015.

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4 Aboriginal and Torres Strait Islander smokers and recent ex-smokers who recalled receiving or being referred to cessation support resources when advised to quit by a health professional (n = 960)*

	Pamphlet	Quit-smoking website	Telephone Quitline	Quit course, group or clinic
Received information or a referral	49% (460)	27% (252)	28% (266)	16% (149)
If so, read, used or attended it	70% (321)	22% (54)	16% (43)	44% (65)
If so, it was specifically for Aboriginal and Torres Strait Islander peoples	52% (168)	48% (26)	44% (18)	88% (56)

*Data only include smokers and recent ex-smokers who recalled being advised by a health professional to quit. Percentages and frequencies exclude those answering "don't know" or refusing to answer. ♦

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