Barriers and facilitators for health professionals referring Aboriginal and Torres Strait Islander tobacco smokers to the Quitline

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Abstract

Objective: To examine the barriers and facilitators among health professionals to providing referrals to Quitline for Aboriginal and Torres Strait Islander clients who smoke.

Methods: A brief online survey, based on the Theoretical Domains Framework, was completed by 34 health professionals who work with Aboriginal and Torres Strait Islander people in South Australia and the Northern Territory.

Results: Respondents who frequently made referrals had higher domain scores than less frequent referrers for 'Skills and knowledge' (M=4.44 SD=0.39 vs. M=4.09 SD=0.47, $p<0.05$) and 'beliefs about capabilities' (M=4.33 SD=0.44 vs. M=3.88 SD=0.42, $p<0.01$). Barriers to providing referrals to Quitline were lack of client access to a phone, cost of a phone call, preference for face-to-face interventions, and low client motivation to quit.

Conclusions: Health professionals working with Aboriginal and Torres Strait Islander clients should be supported to build their skills and confidence to provide referrals to Quitline and other brief cessation interventions. Building capacity for face-to-face support locally would be beneficial where phone support is not preferable.

Implications for public health: Engaging with health professionals who work with Aboriginal and Torres Strait Islander people to increase referrals to Quitline is strategic as it builds on their existing capacity to provide cessation support.

Key words: Aboriginal and Torres Strait Islander health, tobacco cessation, telephone counselling, health professionals

To reduce the burden of smoking for Aboriginal and Torres Strait Islander people,[1] the Australian Government provides funding for state-based Quitlines to improve accessibility and cultural appropriateness of their phone counselling smoking cessation services as part of the Tackling Indigenous Smoking initiative. In South Australia, Quitline employs two Aboriginal counsellors who provide phone counselling and work closely with health professionals across South Australia and the Northern Territory to encourage referrals to Quitline for Aboriginal and Torres Strait Islander clients. Telephone Quitlines are effective for smoking cessation;[2] however, fewer than 30% of Aboriginal and Torres Strait Islander smokers who are advised to quit report being referred to Quitline.[3] Improved understanding of health professionals working with Aboriginal and Torres Strait Islander people is needed to identify factors that encourage or inhibit Quitline referrals.

Health professionals' provision of cessation interventions may be influenced by beliefs about capabilities to address smoking,[4,5] perceived client receptiveness to intervention,[5,6] beliefs about effectiveness of intervention,[4] and health professional smoking status.[6] High smoking prevalence among health professionals working with Aboriginal and Torres Strait Islander clients has been identified as a barrier to discussing tobacco,[7,8] as has perceiving cessation as a low priority and concern for cultural sensitivities.[9] However, previous studies have not focused upon referrals to Quitline or facilitators for interventions.

This study investigates barriers and facilitators for making referrals to Quitline for Aboriginal and Torres Strait Islander people, guided by the Theoretical Domains Framework,[10] which is a framework for investigating implementation of evidence-based behaviours among health professionals. The Theoretical Domains Framework is comprised of 14 domains: knowledge; skills; social/professional role and identity; beliefs about capabilities; optimism; beliefs about

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consequences; reinforcement; intentions; goals; memory, attention and decision processes; environmental context and resources; social influences; emotion; and behavioural regulation.

Methods

Procedure and survey instrument

The study was a 15-minute online survey (also available via phone upon participant request) conducted in June and July 2016. Participants were asked about their experience and views towards making referrals to Quitline using 32 items based on the Theoretical Domains Framework (items displayed in Table 1; see Table 1 note regarding item dimension reduction into domains). Participants indicated their agreement with statements (items) within each domain on a 5-point scale.

Participants were asked to provide open-ended responses to questions regarding cultural appropriateness of Quitline and barriers to making referrals to Quitline.

Participation

Health professionals invited to participate were from South Australia and the Northern Territory and had previously referred Aboriginal and Torres Strait Islander clients to Quitline (n=16), or worked at organisations identified by the Aboriginal Quitline Liaison Officer that could potentially refer Aboriginal and Torres Strait Islander clients to Quitline (n=39). Nearly all (n=53) invited health professionals from 23 services worked at a community-based health service (e.g.

Table 1: Domain scores by frequency of referral to Quitline.

Domain (α)	Frequently refers^ (n=13) M (SD)	Less frequently refers (n=21) M (SD)	P value
Beliefs about capabilities (α = 0.74)	**4.33 (0.44)**	**3.88 (0.42)**	**0.005**
It is easy for me to initiate a discussion about smoking cessation with my clients			
I am confident that I can refer clients to the Quitline even when there is little time			
I am confident that I can refer clients to the Quitline even when they are not motivated to quit smoking			
When I refer clients to the Quitline I feel comfortable			
Referring clients to the Quitline is part of my role			
I think that I can influence my clients to quit smoking			
Positive beliefs about consequences of referring to Quitline (α = 0.85)	3.89 (0.47)	3.63 (0.60)	0.198
Quitline is a valuable service			
I intend to offer a Quitline referral to all of my smoking clients in the next month			
My attempts to provide referrals to the Quitline have resulted in the Quitline successfully contacting my client			
I am optimistic about the outcomes associated with referring clients to the Quitline			
I am confident that most clients referred to the Quitline will accept support from Quitline			
My attempts to provide referrals to the Quitline have resulted in a client successfully quitting			
Many smokers have quit after being referred to the Quitline by a health professional			
Negative beliefs about consequences of referring to Quitline (α = 0.75)	2.63 (0.78)	2.42 (0.64)	0.415
Many smokers lack motivation to quit and do not want assistance from me			
There is insufficient financial incentive to address smoking with my clients			
Quitting smoking is a low priority for my clients			
Referring clients to the Quitline is not worth the effort since few clients manage to give up smoking			
Referring clients to the Quitline will negatively affect my relationships with my clients			
The service that is offered by the Quitline is not suitable for my clients			
Referring clients to the Quitline does not fit into my way of working			
Skills and knowledge (α = 0.81)	**4.44 (0.39)**	**4.09 (0.47)**	**0.032**
I know that the Quitline has Aboriginal counsellors who provide assistance and advice			
I know how to raise the topic of smoking cessation			
I know how to refer smokers to the Quitline during a consultation with a client			
I have been trained in the Quitline referral process			
I have a clear plan of how I will refer clients to the Quitline			
I have a clear plan of how I will refer clients to the Quitline when patients/clients are not motivated to quit			
Environmental context and resources (α = 0.74)	4.04 (0.57)	3.63 (0.63)	0.063
Most people whose opinion I value approve of me addressing the topic of smoking in my role			
Addressing the issue of tobacco smoking is a high priority in my workplace			
My workplace culture supports making referrals to the Quitline			
My workplace provides the resources I need to make referrals to the Quitline			
My workplace has a central system for referring clients to the Quitline			
I have targets to meet regarding the number of clients referred to the Quitline			

α = Cronbach's alpha, scores of greater than 0.70 indicate acceptable internal consistency. M=Mean, SD=Standard deviation.

Mean scores are on a scale of 1-5, 1 = strongly disagree 5=strongly agree for each statement in the domain.

Scores on each domain were summed then averaged to be compared for participants that indicated they 'make a referral on behalf of clients to the Quitline to help them stop smoking if they agree' on a frequent basis (frequently or always) or on a less frequent basis (never, rarely, occasionally).

Significant results (p<0.05) shown in bold.

^There were no significant differences in the proportion of participants who frequently made referrals to Quitline by Aboriginal status or smoking status.

Note. While the survey items were initially designed to reflect all 14 domains of the Theoretical Domains Framework, some items did not have acceptable internal consistency (Cronbach's alpha of below 0.70) within the domain to which they were initially assigned. However, as there is some conceptual overlap across the domains of the Theoretical Domains Framework (10), the 32 items were able to be sorted to broadly represent four domains of the Theoretical Domains Framework with acceptable internal consistency: 'Beliefs about capabilities,' 'Beliefs about consequences (of referring to Quitline)' (this domain was split in two to reflect positive and negative beliefs about consequences), 'Skills and knowledge' (combined from the separate 'skills' and 'knowledge' domains) and 'Environmental context and resources.'

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Aboriginal Health Services, community mental health services, drug and alcohol services, etc.)

Thirty-four health professionals from 15 services completed the survey (participation rate = 61.8%); 28 online and six via phone.

Statistical analyses

The main outcome variable was whether participants 'make a referral on behalf of clients to the Quitline to help them stop smoking if they agree' on a frequent basis ('frequently'/'always'), or less frequently ('never'/'rarely'/'occasionally'). Scores for each statement within domains were summed and averaged to create an average score for each domain. *T*-tests were used to test for differences in average domain scores by frequency of Quitline referral.

Results were considered significant at $p<0.05$. Analyses were conducted in SPSS version 24.

Open-ended responses were matched to the Theoretical Domains Framework via an inductive approach. Responses regarding cultural appropriateness of Quitline were coded as the participant viewed Quitline as 'appropriate', 'unsure/depends on client' or 'not appropriate' for clients.

Ethical approval

This study received ethical approval from the Aboriginal Health Research Ethics Committee.

Results

Demographic/workplace characteristics and Quitline referral practices

Participants were 50% female, and 23.5% were current smokers. The majority (70.6%) of participants were Aboriginal and/or Torres Strait Islander, based in South Australia (82.4%) and working in community-based health services (94.1%). Most participants worked as Aboriginal Health Workers (44.1%), allied health professionals (17.6%) or nurses (17.6%). The majority (73.5%) of participants had received Quitskills training to develop skills to address smoking with Aboriginal and Torres Strait Islander clients.

Fewer than half (38.2%) of participants indicated that they frequently 'make a referral on behalf of clients to the Quitline to help them stop smoking if they agree' and this was done by recommending that clients call Quitline themselves (61.5%), or by phone (38.5%), fax (38.5%) or online form (23.1%).

Barriers and facilitators to making Quitline referrals

Facilitators to referring clients to Quitline

Table 1 shows average domain scores by frequency of Quitline referral ('frequently'/'always' vs. 'never'/'rarely'/'occasionally').

Barriers to providing referrals to Quitline

Twenty participants described barriers to referring clients to Quitline, which tended to reflect 'beliefs about consequences', i.e. health professionals did not refer when the consequences might not benefit the client.

The main barriers pertained to phone access/cost of a phone call (n=5), and clients not wanting support via phone (n=4):

> *Sometimes clients are reluctant to talk over the phone, they would rather one:one face-to-face.* (Aboriginal Health Worker)

Four participants indicated that clients lack motivation to quit, and four described issues with Quitline itself, e.g. service needs more community presence, clients don't know what to expect from Quitline.

Perceived cultural appropriateness of Quitline

In total, 75% of participants (n=32) indicated that they thought the service was appropriate, and the Aboriginal counsellors were particularly appreciated, for example:

> *I think it's wonderful that Quitline has Indigenous counsellors. I've heard that it makes the Indigenous clients more comfortable when discussing their smoking.* (Aboriginal Health Worker)

> *Most community here know at least one of the current Aboriginal Quitline operators.* (Program Coordinator)

Four participants were unsure or thought it depended on the client, and two did not think the service was appropriate.

Discussion

This study, guided by the Theoretical Domains Framework,[10] has identified that beliefs about capabilities facilitate provision of Quitline referrals to Aboriginal and Torres Strait Islander clients, which is consistent with findings from health professionals providing cessation interventions in general populations.[4,5] Skills and knowledge also helped provision of referrals, highlighting the importance of specialised cessation intervention training such as the Quitskills program. The Aboriginal Quitline counsellors were highly regarded by health professionals, demonstrating the benefit of enhancements to Quitline through the Tackling Indigenous Smoking initiative.

The main barrier to providing Quitline referrals was the use of the phone as a method of receiving cessation support. Some participants indicated that their clients have irregular phone access, highlighting the importance of building capacity within communities for health professionals to provide face-to-face support. The cost of a phone call for clients also discouraged some health professionals from referring clients to Quitline. It should be clarified to health professionals that making a referral to the Quitline call-back service removes cost burden from clients. Another barrier was low client motivation to quit, which is similar to the findings of Pilkington et al.[9] This demonstrates the importance of developing a health workforce trained in techniques to build motivation for behaviour change.

The present study had some limitations, namely the small sample size and lack of statistical power, although the industry of health professionals in South Australia/Northern Territory that could refer Aboriginal and Torres Strait Islander clients to Quitline is relatively small. Secondly, many participants had undergone Quitskills training and hence this sample may have had more positive attitudes towards Quitline than people not trained in Quitskills. Despite these limitations, this study forms a basis for the development of larger studies to further explore facilitators and barriers to health professional referral practices in this population.

Implications for public health

Health professionals working with Aboriginal and Torres Strait Islander clients who smoke have an important role in providing referrals to Quitline. Strategies which build upon existing drivers of referral, namely, programs to increase skills and confidence of health professionals, and which address barriers such as low client motivation, should be encouraged. Maximising rates of referral to Quitline should assist in the effort to reduce smoking in the Aboriginal and Torres Strait Islander population.

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