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"Imagine if I gave up smoking …": A qualitative exploration of Aboriginal participants' perspectives of a self-management pilot training intervention

Abstract

This paper reports on a pilot qualitative study investigating Aboriginal participants' perspectives of the Flinders Living Well Smoke Free (LWSF) "training intervention". Health workers nationally have been trained in this program, which offers a self-management approach to reducing smoking among Aboriginal clients. A component of the training involves Aboriginal clients volunteering their time in a mock care planning session providing the health workers with an opportunity to practise their newly acquired skills. During this simulation the volunteer clients receive one condensed session of the LWSF intervention imitating how the training will be implemented when the health workers have completed the training.

For the purpose of this study ten Aboriginal clients who had been volunteers in the mock care planning process, underwent a semi-structured interview at seven sites in Australia, including mainstream health services, Aboriginal Medical Services and remote Aboriginal communities. The study aimed to gauge their perspectives of the training intervention they experienced. Early indications suggest that Aboriginal volunteer clients responded positively to the process, with many reporting substantial health behaviour change or plans to make changes since taking part in this mock care planning exercise. Enablers of the intervention are discussed along with factors to be considered in the training program.

What is known about the topic?

- There is a paucity of research evaluating intervention programs and accompanying resources aimed at training health workers to support their Aboriginal clients to reduce smoking.

What does this paper add?

- This paper provides preliminary evidence that volunteer clients exposed to one condensed session of the Flinders LWSF program are positively predisposed to the intervention process.

Introduction

It is widely accepted that the health status of Aboriginal people is significantly poorer than that of non-Aboriginal people, with smoking being the single most preventable cause of ill health and death (Australian Institute of Health and Welfare, 2008) in the latter group. There has been a substantial reduction in daily smoking rates in the overall Australian population between 2001 and 2013: non-Aboriginal rates reducing from 24% to 16% and Aboriginal rates reducing from 51% to 41% (Australian Bureau of Statisics, 2013). However, smoking rates still remain unacceptably high for Aboriginal people, with research reporting rates of up to 82% in particular communities (Robertson et al., 2013). Despite recent promising signs that Aboriginal smoking rates are declining, it will be a number of years before the damage caused by smoking dissipates.

Despite the disproportionately high burden of smoking related harm endured by Aboriginal people, there is a notable lack of Indigenous-specific intervention programs (Ivers, 2003, Power et al., 2009) and accompanying resources (Clifford, 2010) aimed at addressing this harm. Furthermore, it is now estimated that around 75 per cent of Aboriginal smokers are thought to be trying to quit or are contemplating quitting (Clough et al., 2009) and therefore smoking intervention programs are well positioned to build up on this existing motivation for change.

In response to the alarmingly high rates of smoking, the Australian government announced its Indigenous Chronic Disease Package in late 2008, which included the Tackling Indigenous Smoking initiative. This has seen the roll out of Tobacco Action Workers Program nationally with Tobacco Action Workers working with Indigenous communities to reduce current smoking rates and discourage the uptake of smoking (Calma, 2011). Additionally, the National Preventative Health Strategy for Tobacco suggests that tobacco

support should not be limited to tobacco-specific workers but extended to all health professionals in Indigenous health settings, such as nurses and Aboriginal Health Workers, to maximise the extent of influence on the Indigenous population in regards to a critical health (National Preventative Health Taskforce, 2008).

The Flinders Program (FP), originally based on the Coordinated Care Trials conducted between 1997-2001, teaches health practitioners the principles of self-management and motivational enhancement through semi-structured Socratic questioning to address chronic conditions and encourage behaviour change with their clients. The FP consists of care planning, coordination and coaching. The FP tools (Partners in Health scale, Cue and Response interview and Problems and Goals assessment), which underpin these skills, are based on seven principles of self-management. They guide a shared assessment between the client and health worker of the client's self-management, which results in a client centred care plan with goals and priorities determined by the client. The FP has been successfully applied to a variety of settings including substance abuse issues within Vietnam Veterans (Battersby et al., 2013), mental health (Lawn et al., 2007), diabetes in rural Aboriginal populations (Battersby et al., 2008), chronic lung disease and heart disease (Rowett, 2005) and osteoarthritis (Crotty et al., 2009). The FP has been trialled in Aboriginal communities, specifically Port Lincoln Aboriginal Medical Services and Aboriginal Health Council South Australia, through partnerships spanning 20 years (Ah Kit et al., 2003, , Harvey and McDonald, 2003, Harvey et al., 2008, Harvey, 2009, Harvey et al., 2013, Battersby et al., 2008). More recently the program was adapted with Aboriginal and Torres Strait Islander members of the National Advisory group to create the Flinders Closing the Gap Program™ (FCTGP) of Chronic Condition Management. This program is funded through the Commonwealth 'Closing the Gap: Helping Indigenous Australians Self-Manage their Chronic Disease' Program as a measure within the Council

of Australian Governments' (COAG) National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes. FCTGP has been extended to include a specific module aimed at tackling the high rates of smoking within the Indigenous population, namely the Living Well, Smoke Free (LWSF) program. Health practitioners are provided 1-2 days training, dependent on their knowledge about smoking cessation and self-management, along with culturally-adapted resources and ongoing support with implementing the program within their practice. The training and resources were developed by Flinders Human Behaviour Health Research Unit (FHBHRU).

A key learning component of the current training program involves trialling the tools with volunteer clients in a mock care planning session providing the health workers with an opportunity to practise their newly acquired skills. During this simulation the volunteer clients, recruited from the health services, receive one condensed session of the LWSF intervention imitating how the training will be implemented, which in this paper is referred to as “training intervention”. It was an expectation that the “volunteer clients” would continue the process within their health service following the training intervention. When the program is implemented as intended, it is anticipated that clients will attend approximately 6-8 sessions with their health worker. Clients work through a series of exercises, such as “Conversation About Tobacco” and “Weighing It Up” (based on the Partners In Health scale and the Cue and Response interview) where they are asked open questions designed to resolve ambivalence in relation to their smoking and recognise areas where they require support. A further exercise, the My Tobacco Journey (based on the Problems and Goals assessment), is designed to capture the client’s main worry, and document how this impacts on their life. This process provides an opportunity for clients to set a specific goal that they wish to achieve in relation to their health.

The current project aimed to explore the experiences of the people who volunteered as clients for the training intervention and examine their thoughts and perceptions of the tools and the approach adopted by their health practitioner in relation to making changes to their tobacco smoking.

Method

Participating health services involved in the current research included mainstream health services, Aboriginal Medical Services and remote Aboriginal communities (seven sites in total from Victoria, Western Australia, South Australia and New South Wales). Workers (nurses and Aboriginal Health Practitioners) being trained in the LWSF program were asked to inform their clients who smoked about the training, provide information sheets and forward the details of interested clients to the trainers. Following the training, the researchers informed the volunteers about the research indicating that it would provide them an opportunity to offer feedback on the training resources and process. If they had time and interest they took part in an interview with the researcher. In total interviews were conducted with 10 participants (male, n=5; female, n=5), all of whom were Aboriginal and current smokers making up a sample of the volunteers who took part in the training. All interviewees provided their informed consent by way of a signing a consent form, which was read and explained to them, and received $40 gift voucher in appreciation of their time and contribution. No-one refused to be interviewed or to have their interview recorded and no-one withdrew their involvement during or following the interview.

Interviews were conducted face-to-face at the participating health services or at a convenient location where requested. Most were conducted one-to-one with the exception

of one interview where two researchers were present and one where two participants were present. Both female interviewers were employed as researchers by Flinders University. A qualitative interview guide was developed to explore: current smoking attitudes and behaviour, what worked/did not work well in the training intervention, the level of client involvement developing their care plan, how culturally appropriate the intervention was, and general comments on barriers and enablers to smoking interventions being implemented. This interview guide was followed loosely based on broad open ended questions to allow the participant to guide the interview. The researchers attended the Flinders training in order to build rapport with participants and make them feel more comfortable about taking part in the investigation but were not involved in the delivery of the training.

Ethics approval for the study was received from the Aboriginal Health Research Ethics Committee in South Australia, Social and Behavioural Research Ethics Committee, Mildura Base Hospital Human Research Ethics Committee (HREC), Western Australia Aboriginal Health Ethics Committee, Gold Coast Hospital and Health Service HREC and the Department of Health and Ageing Ethics Committee. Letters of support were provided by the management of the health services involved. Flinders University also contracted an Aboriginal Research Consultant who provided culturally specific advice and support throughout the project.

Data Analysis

Interviews were conducted between July and December 2013, lasted on average 30 minute and were audio recorded and transcribed verbatim.

Thematic analysis was used to analyse the entire data set rather than each open ended question individually in order to gain an accurate reflection of commonalities across the whole data. Braun and Clarke (2006) suggest this is an appropriate approach to take when exploring an under-researched area or when working with participants whose views on the topic are unknown. The researcher followed the guidelines suggested by Braun and Clarke (2006) and therefore, initially, the researcher familiarised themselves with the data by reading and re-reading the transcribed interviews. The researcher then developed initial codes representing interesting features of the data in a systematic fashion (line-by-line). Initial codes were then used to create early themes, reflecting the entire data set. Themes were then refined and named, which required ongoing analysis. The researchers (KC and IK) met frequently to discuss themes and agreement was achieved in all cases, with only minor discrepancies occurring regarding the name of the theme, which were resolved easily through discussion. The report was then produced using participants' own words, which accurately and succinctly reflected the description of each theme, and whilst frequency was not regarded as a precipitating factor to a theme, we attempted to reflect the extent to which the theme was common across the participant responses. We took a semantic approach to the data, which attempts to create themes based purely on what the participants reported. This inductive approach led the researchers to create themes that were strongly linked to the data. The process was a recursive one, whereby the researcher moved back and forth between the data and the data analysis. Themes were documented in a table on Microsoft Word document. Creation of themes was guided by the question: what aspects of the training and resources are acting as barriers and enablers to the participants making changes to their smoking behaviour?

Results

Analysis of the interviews revealed client perspectives, including barriers and enablers of the LWSF self-management program based on volunteer clients receiving one mock care planning session. This training intervention was an imitation of how the program will be implemented in a health care setting in future. Volunteer clients discussed their improved motivation to change following the training intervention, along with other enablers of the program (support, knowledge and culturally appropriate resources). Other themes emerged (culture, complex lives and nicotine addiction), which were discussed generally as barriers against implementation of the current self-management program.

Motivation to Change:

Although volunteers only received one condensed session of the program, all participants appeared to make a positive shift in their attitudes regarding their health in general or specific smoking behaviour change. It is not known whether this was as a result of the training intervention, although many participants indicated that the intervention directly encouraged deeper consideration of behaviour change.

"I've always thought how am I going to do this? I've always thought about it but the opportunity never arose and I see this as an opportunity to do that". (Participant 3)

"Before coming here, I did have thoughts about stop smoking and how it's affecting people and myself…but today made me think a little bit more I guess and maybe I'll go home tonight and think more intensely and…I might make the first step to do a plan or…to stop smoking." (Participant 4)

Although some participants admitted that the training intervention felt repetitive and could be a little confusing, generally the exercise appeared to allow participants to progress

within the Stages of Change (Prochaska and DiClemente, 1983), for example moving from pre-contemplation to contemplation.

Support:

The majority of participants identified the importance of support when changing behaviour, an important component of the current training intervention. Many participants had been referred to support groups after completing the training intervention. One particular participant went on to set up a smoking support group following the training intervention and many of the participants recognised the importance of having support while going through the training intervention:

"It's the person that's there sitting with you…is trying to get a better idea of what your status is on the smoking level…looking at it…and talking back and forth…it gives yourself and that person a better understanding of where you are with it". (Participant 5)

Participants emphasised the need for building a trusting relationship with the worker before revealing confidential and personal information, with an ex-smoker often being identified as the most appropriate person to support their attempts to quit smoking. Participants recognised that the training intervention made them feel listened to, involved in their care and their thoughts were acknowledged.

Increased knowledge:

A significant part of the training intervention is providing participants with knowledge around the impacts of smoking. Participants revealed that having more knowledge about smoking and how it impacts on health, made them more likely to quit smoking:

"If I understand what's going on in my body maybe I can help myself". (Participant 2)

Another participant admitted they were "blown away" by the information they received during the training intervention regarding oxygen levels and the impact this has on their health:

"…because I snore really bad, and that's associated obviously with the lack of oxygen so it's made me really…scared, like, but in a good way, like I know I need to give up." (Participant 9)

Culture:

Most participants found the training intervention and resources to be culturally appropriate and easy to use. Furthermore, many of the participants advocated for the intervention to be delivered in an Aboriginal Health Service where the workers have more empathy and understanding of their cultural requirements. However, it was also proposed that Aboriginal people's distrust of non-Aboriginal people prevents them from initiating, accepting and receiving appropriate healthcare. One participant proposed that Aboriginal people and non-Aboriginal people need to learn from one another:

"It's the coming together and accepting how we're going to accept each other…properly, honestly…somebody out bush can only give you so much information. Somebody in town can give you so much information. But together they can work…" (Participant 5)

Finally, due to the sensitivity of the issues Aboriginal people faced surrounding the "Stolen Generation" it was suggested that some clients may have been reluctant to admit to their "main worry", a question asked of them during the training intervention. Some of the participants interviewed admitted that they were reluctant to talk about their main problem, which was related to mental health issues surrounding their past. Many participants questioned how appropriately qualified the Aboriginal Health Worker was to help them, and also raised concerns about confidentiality.

Complex Lives:

An issue that was raised in all participant interviews was the complexity of people's lives. Many were suffering with complex mental and physical health issues, such as depression, gambling addiction, schizophrenia, emphysema and sleep apnoea. Amongst the communities visited numerous other health related issues were identified, including homelessness, domestic violence, drug and alcohol abuse, grief and loss, a lack of meaningful activity and a loss of personal identity. Many participants admitted that smoking was not a priority:

"Oh it relaxes me, and especially with this emphysema…I'll have a smoke and then I'll start coughing something shocking…it helps me in a way, yeah it gives me a benefit because I can breathe a lot better". (Participant 2)

Despite such complex issues being faced, all participants interviewed appeared to make a positive shift in their thought processes or behaviour in relation to their smoking following the training intervention.

After successfully tackling many mental and physical health problems, one participant perceived quitting smoking as the last hurdle:

"Imagine if I gave up smoking, I'd be doing a marathon run!" (Participant 1)

Addiction:

A major barrier to tackling smoking raised by all participants was the difficulty of quitting smoking. Participants provided many reasons why they continue to smoke, such as boredom, having a partner who smokes, smoking being part of their lifestyle, dealing with anxiety and stress, having finances available to purchase cigarettes and having to go through withdrawal, with all participants making previous quit attempts. All of the participants interviewed had been smoking for several decades; the majority of participants smoking since they were teenagers.

However, during the training intervention, participants were able to identify reasons to quit smoking; whether this was as a direct result of the training intervention is unclear. It also appeared that the training intervention played some role in resolving the ambivalence that the participants were facing around their smoking and helped some develop a quit smoking plan. One participant revealed that the training intervention made the challenge of quitting seem more manageable:

"From all those questions it made me think, okay, I'm not so bad, like, I can, you know, I can make change". (Participant 9)

Discussion

There is a paucity of research investigating Indigenous health intervention programs (Ivers, 2003, Power et al., 2009) comprising complementary resources (Clifford, 2010). The Flinders LWSF intervention and training is in its infancy and this small but important analysis of the participant experiences of the training intervention suggests that despite many barriers, the Aboriginal participants we spoke to responded positively to the training intervention. Many of the respondents appeared to progress through the Stages of Change, some from pre-contemplation to contemplation, others from contemplation to action (Prochaska and DiClemente, 1983) in relation to their smoking behaviour. Furthermore, participants revealed that they were able to consider the barriers to change and proceed to formulate plans to achieve their goals. Whether this was as a result of the intervention remains unclear and requires further investigation. Nevertheless, follow-up telephone calls to a sample of the participants (n = 3) revealed that individuals had adhered to their commitments made during the training intervention. This was an unexpected outcome because the participants had only received a condensed version of the intended intervention, which would normally be 6-8 sessions involving more in-depth discussion and care planning. This important revelation provides a promising indication that the intervention can be used by health workers to support their Aboriginal clients who want to address their smoking.

Our study had several limitations. Researchers were time restricted, reflecting funding limitations, and therefore, only a small sample of participants was interviewed. Also, the health workers trained in the LWSF intervention all had varied backgrounds, some already possessing a strong understanding of concepts such as motivational interviewing and self-management while others had little or no understanding prior to the current training. Finally, it is assumed that the participants had volunteered to support the training because they already had an interest in addressing their smoking behaviour, and therefore the

current sample may be biased (Neuman, 2005). The present paper therefore demonstrates early indications of volunteer client experiences of the training intervention, which has the potential to impact positively on the large number of Aboriginal people that have been identified as motivated to quit smoking (Clough et al., 2009). Further data is required to examine client perspectives after they have received the full intervention over 6-8 sessions, which includes care planning and follow up with their health worker.

Implications and Conclusion

This was a preliminary exploration on the perspectives of volunteers who received a mock care planning session based on a self-management approach to quitting smoking. These early positive indicators have potentially important implications for the methods that health care workers might employ to support Aboriginal smokers to manage their smoking behaviour. For instance, the worker who is responsible for delivering the LWSF program to their Aboriginal smoking clients will need to consider their clients' current circumstances, noting that although their complex lives may act as a barrier to change, it is still possible to move through the stages of change using the LWSF intervention. It may also be worth considering advising their clients to consider medication or nicotine replacement therapy to manage the physical component to reducing or quitting smoking whilst their clients complete the LWSF program. These are important considerations for any Aboriginal specific tobacco intervention programs and given the limited research in this area further research is required to evaluate the LWSF program, or a similar intervention, on a larger scale.

In conclusion, the LWSF program offers a potentially effective intervention that targets smoking among Aboriginal people. The current paper describes a pilot intervention program and perceptions of volunteer client and therefore further research is required. Health practitioners should consider the barriers and enablers of the LWSF program prior to implementation. Further research could also explore the perceptions of the workers delivering the program in order to investigate the barriers and enablers of implementing such an intervention in their workplace.

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Conflicts of Interest

None declared.

References

AH KIT, J., PRIDEAUX, C., HARVEY, P. W., COLLINS, J. P., BATTERSBY, M. W. & MILLS, P. D. 2003. Chronic disease self-management in Aboriginal communities: Towards a sustainable program of care in rural communities. *Australian Journal of Primary Health,* 9**,** 168-176.

AUSTRALIAN BUREAU OF STATISICS. 2013. *Australian Aboriginal and Torres Strait Islander Health Survey: First Results, Australia, 2012-13* [Online]. Available: http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/39E15DC7E770A144CA257C2F00145A66?opendocument [Accessed 14/01/14 2014].

AUSTRALIAN INSTITUTE OF HEALTH AND WELFARE. 2008. *Australia's Health 2008* [Online]. Canberra: CAT no. AUS 99. Available: www.aihw.gov.au.

BATTERSBY, M. W. 2005. Health reform through coordinated care: SA HealthPlus. *BMJ: British Medical Journal,* 330**,** 662.

BATTERSBY, M. W., BEATTIE, J., POLS, R. G., SMITH, D. P., CONDON, J. & BLUNDEN, S. 2013. A randomised controlled trial of the Flinders Program™ of chronic condition management in Vietnam veterans with co-morbid alcohol misuse, and psychiatric and medical conditions. *Australian and New Zealand Journal of Psychiatry,* 47**,** 451-462.

BATTERSBY, M. W., KIT, J. A., PRIDEAUX, C., HARVEY, P. W., COLLINS, J. P. & MILLS, P. D. 2008. Research implementing the Flinders Model of self-management support with Aboriginal people who have diabetes: Findings from a pilot study. *Australian Journal of Primary Health,* 14**,** 66-74.

BRAUN, V. & CLARKE, V. 2006. Using thematic analysis in psychology. *Qualitative Research in Psychology,* 3**,** 77-101.

CALMA, T. 2011. Tackling Indigenous Smoking. *Of Substance: The National Magazine on Alcohol, Tobacco and Other Drugs,* 9**,** 28.

CLIFFORD, A. P., LISA R. JACKSON; RICHMOND, ROBYN; SHAKESHAFT, ANTHONY P.; IVERS, ROWENA 2010. Brief intervention resource kits for Indigenous Australians: generally evidence-based, but missing important components. *Australian and New Zealand Journal of Public Health,* 34**,** S80-S86.

391 CLOUGH, A., ROBERTSON, J. & MACLAREN, D. 2009. The gap in tobacco use between remote
392 Indigenous Australian communities and the Australian population can be closed. *Tobacco*
393 *control,* 18**,** 335-336.
394 CROTTY, M., PRENDERGAST, J., BATTERSBY, M. W., ROWETT, D., GRAVES, S. E., LEACH, G. & GILES, L.
395 C. 2009. Self-management and peer support among people with arthritis on a hospital joint
396 replacement waiting list: a randomised controlled trial. *Osteoarthritis and Cartilage,* 17**,**
397 1428-1433.
398 HARVEY, P. W. 2009. Science, research and social change in Indigenous health – evolving ways of
399 knowing. *AHR,* 33**,** 628-636.
400 HARVEY, P. W. & MCDONALD, P. J. 2003. The Science of the COAG coordinated care trials. *Australian*
401 *Journal of Primary Health,* 9**,** 109-113.
402 HARVEY, P. W., PETKOV, J., KOWANKO, I., HELPS, Y. & BATTERSBY, M. W. 2013. Chronic condition
403 management and self-management in Aboriginal communities in South Australia: outcomes
404 of a longitudinal study. *AHR,* 37**,** 246-250.
405 HARVEY, P. W., PETKOV, J., MISAN, G., WARREN, K., FULLER, J., BATTERSBY, M. W., CAYETANO, N. &
406 HOLMES, P. 2008. Self-management support and training for patients with chronic and
407 complex conditions improves health related behaviour and health outcomes. *Australian*
408 *Health Review,* 32**,** 330-338.
409 IVERS, R. G. 2003. A review of tobacco interventions for Indigenous Australians. *Australian and New*
410 *Zealand journal of public health,* 27**,** 294-299.
411 LAWN, S., BATTERSBY, M. W., POLS, R. G., LAWRENCE, J., PARRY, T. & URUKALO, M. 2007. The
412 mental health expert patient: findings from a pilot study of a generic chronic condition self-
413 management programme for people with mental illness. *International Journal of Social*
414 *Psychiatry,* 53**,** 63-74.
415 NATIONAL PREVENTATIVE HEALTH TASKFORCE 2008. Tobacco Working Group - Technical Report No
416 2, Tobacco Control in Australia: making smoking history. Australian Government: Canberra.

NEUMAN, W. L. 2005. *Social research methods : qualitative and quatitative approahes*, Pearson International ed

POWER, J., GREALY, C. & RINTOUL, D. 2009. Tobacco interventions for Indigenous Australians: a review of current evidence. *Health Promotion Journal of Australia,* 20**,** 186-194.

PROCHASKA, J. O. & DICLEMENTE, C. C. 1983. Stages and processes of self-change of smoking: toward an integrative model of change. *Journal of consulting and clinical psychology,* 51**,** 390.

ROBERTSON, J., CONIGRAVE, K., IVERS, R., HINDMARSH, E. & CLOUGH, A. 2013. Addressing high rates of smoking in remote Aboriginal communities-New evidence for GPs. *Australian family physician,* 42**,** 492-496.

ROWETT, D., SIMMONS, S., CAFARELLA, P., FRITH, P. 2005. *Informed Partnerships for Effective Self-Management of Chronic and Complex Lung Diseases* [Online]. Available: http://www.flinders.edu.au/medicine/fms/sites/FHBHRU/documents/publications/Informed%20Partnerships%202005.pdf.