Smoking cessation for Australian general practice

Evaluation of best practice guidelines

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General practitioners are the first point of contact for patients seeking health advice as more than 80% of Australians consult with a GP at least once a year.[1] Evidence shows that the GP can play a powerful role in assisting smokers to quit.[1–4]

The *Smoking cessation guidelines for Australian general practice* were developed by GPs and smoking cessation experts.[5] We report on an evaluation of the introduction of the guidelines into practice.

Method

The evaluation was a 'before after' evaluation of the use of the guidelines by general practices. It included self selected GPs in urban and rural areas, group and solo practices, serving indigenous communities, and those with culturally and linguistically diverse patient populations. General practitioners and other clinical staff were trained in the guideline's smoking cessation methods during a 2 hour session.

A questionnaire administered to practice clinical staff before training addressed roles and practices in smoking cessation, and confidence in smoking cessation skills. A telephone call 2 weeks after training was made by General Practice Education Australia (GPEA) medical educators to enhance adoption of the guidelines, reinforce training in smoking cessation, and address problems. At 3 months, a questionnaire was sent to participants that assessed use of the guidelines, confidence in smoking cessation skills, barriers to implementation, skills to assist special groups and elicited feedback and identified changes required to the guidelines. Those who did not respond were followed up by telephone. At both pretraining and 3 month follow up, confidence in smoking cessation skills was rated on a 4-point scale from 'not at all confident' to 'very confident'. We conducted repeated measures analyses of variance (ANOVAs) for each dependent variable of interest.

Results

Fourteen general practices participated from New South Wales, Victoria, Queensland, ACT, Northern Territory and Western Australia, and included 55 staff: 28 GPs, 12 practice nurses, 12 Aboriginal health workers and three others (counsellor and students). All the GPs were employed in group practices: 17 were women, half were working full time, had worked an average of 15 years in practice, two consulted in a language other than English, on average they saw 76 patients each every week, and over a quarter of the GPs had completed training in smoking cessation since graduation.

At 3 months, 42 general practice staff (31 GPs and 11 other practice staff) responded. Most, 81% (34/42) claimed they were currently using the guidelines, of whom 19% used them every day; 14% used them 3–4 times per week; 36% 1–2 times per week; 19% less than once per

Table 1. Change in confidence levels following attendance at training workshop and 3 months

Area of confidence	Questionnaire mean (SD) (higher means indicate greater confidence) Start of training	At 3 months	Significance
Systematically identify and record smokers	3.2 (0.65)	3.5 (0.57)	0.59
Allocate smokers to stage of change	2.6 (0.8)	3.2 (0.48)	<0.001
Provide appropriate brief interventions	2.4 (0.67)	3.0 (0.59)	<0.001
Skills in brief motivational interviewing	2.6 (0.77)	3.1 (0.52)	<0.001
Provide smoking cessation advice to special groups	2.5 (0.77)	2.8 (0.69)	<0.01
Negotiate follow up	2.3 0.69)	2.8 (0.72)	<0.01
Counsel on relapse prevention	2.2 (0.72)	2.7 (0.77)	<0.001

week; and 11% less than once per month. Nearly all (90%) said they would continue to use them. Nearly half (42%, 17/42) had implemented changes in their general practice that identified clear roles for the practice staff in smoking cessation.

They found the most useful aspects of the guidelines were: allocating smokers to their stage of readiness to change (73%), referral to the Quitline (68%), identifying and recording patient smoking status (61%), information on nicotine replacement therapies and bupropion (58%), and advice to smokers about quitting (58%).

Some general practice staff (24 GPs and seven practice nurses) completed questionnaires at both the start of training and 3 months later: GPs' confidence significantly improved in that time for six out of the seven domains measured (*Table 1*). There were 42 general practice staff who reported at 3 months that the guidelines provided them with definite smoking cessation skills to advise pregnant (63%) and lactating women (56%), adolescents (39%), those with a mental illness (37%), indigenous people (24%), and those from culturally and linguistically diverse backgrounds (15%).

There was no significant improvement on systematically identifying and recording smokers between start the of training and 3 month follow up. No significant differences were found for type of clinician (GP vs. other), nor significant effect among GPs by gender, age, or days worked per week.

Discussion

The evaluation was based on self report from a self selected group of interested general practices. Therefore, it is possible that the results may not be representative of Australian general practices, nor may the self reported behaviours reflect their actual behaviour in practice. A random sample of general practices and a control group would have been preferable.

Nevertheless, the results demonstrated that, following introduction of the guidelines, GPs and practice nurses were significantly more confident to allocate smokers to their stage of readiness to quit smoking, and to provide brief interventions, motivational interviewing and relapse prevention counselling. We could not separate the effect of the training from that of guideline use. Training may be an important strategy to support dissemination of the guidelines. Because staff thought that a useful part of the guidelines was referral to the Quitline, dissemination of guidelines is likely to lead to increased referrals and may stretch the capacity of Quitline.

By 3 months, GPs thought they definitely had the adequate skills to assist special groups stop smoking. This was most notably the case for pregnant and lactating women, adolescents and those with a mental illness. Different approaches will need to be added to the guidelines to deal with other high risk groups such as those from culturally and linguistically diverse backgrounds and indigenous communities.

We are particularly encouraged that 3 months following training, over 40% of GPs reported improving smoking cessation processes in their practices. Common barriers to using the guidelines included being too busy, too time consuming, and patients being nonresponsive to advice about smoking cessation, previously reported.[6,7] Factors that facilitate uptake of tobacco interventions include: support through the practice infrastructure,[8] providing assistance on how to use limited time more effectively,[9] and providing incentives and appropriate training.[10] The guidelines link to the SNAP framework that seeks to address the first of these factors.[11] We tried to address the time issue by providing a minimal intervention – referral to Quitline.

Further research to measure the extent of use of various components of the guidelines is needed, such as was carried out for the Smokescreen Program.[12] A study to assess the efficacy of the guidelines is also needed.[12]

Implications of this study for general practice

What is already known

- Advice from GPs about smoking cessation is effective
- It has the potential to reach large numbers of smokers.

What this study found

- Introduction of smoking cessation guidelines into a self selected sample of 14 practices was followed by a high rate of continuing use of the guidelines at 3 months
- There was an increase in confidence in smoking cessation counselling skills by self report
- Most useful aspects of the guidelines were:
  - allocating smokers to stage of readiness to change based on the Smokescreen Program
  - referral to Quitline
  - identifying and advising smokers, and
  - providing information on pharmacotherapies.

Conflict of interest: none declared.

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