

Report on Cessation Education Services Offered in Indian Clinics

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Abstract: When AITEN began its Cessation campaign in 1993, the goal was to work through the Indian Health Services (IHS) funded clinics and their staff to reach patients and commercial tobacco use American Indians. In order to do this, AITEN staff had to not only change the way the clients saw commercial tobacco, but also try and change the way clinic healthcare providers perceived the problem of tobacco abuse among American Indians. AITEN developed culturally relevant materials and training sessions with the help of clinic staff and Indian people. AITEN then gave these materials and services to participant clinics. The healthcare providers were surveyed to determine their current policies and overall use of these materials, and the clients were surveyed to determine how effectively the materials and training provided to the clinic staff had reached them, as well as how they perceive those materials and messages. Surveys were conducted by the Institute for Social Research at CSUS and by AITEN staff and subcontractors. The surveys were given over the telephone and in person during the summer of 2000. Sample groups included 38 health care providers (medical workers such as physicians and nurses, Clinic Directors, and Community Health Representatives) sampled from 20 different clinics, and 205 clients from 19 Indian clinics. The results show that at least 16 clinics are currently using AITEN materials. On the other hand, there are distinct differences in the reported rates of providers questioning patients about tobacco use during clinic visits. Tobacco cessation services are still widely lacking among Indian clinics, primarily due to lack of funding and concern (both within the clinic and the community).

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Background:

The American Indian Tobacco Education Network (AITEN) has been housed within the California Rural Indian Health Board (CRIHB), headquartered in Sacramento, CA, since 1993. Throughout that time, the AITEN staff worked closely with an Advisory Committee (AC) and professionals in various fields to develop tobacco-related educational materials such as brochures, booklets, posters, curriculums, and protocols. The AC is comprised of both youth and adult California residents who are members of American Indian tribes. By networking with people who represent the communities that AITEN serves, as well as media and medical professionals who gave critical technical support and background information, a set of cessation education materials and services was developed. These materials were then distributed to Indian clinics throughout California by mail and through AITEN subcontractors in southern California. The educational and training materials were all developed with the central goal of providing a culturally relevant angle on the issues surrounding commercial tobacco abuse. This included acknowledgement of the important role that tobacco plays in Native American culture, as well as distinctions between traditional tobacco use and commercial tobacco abuse, and sacred tobacco versus commercial tobacco products.

AITEN held special training sessions to provide cultural information and technical assistance for people who work within the Native American communities of California. Participants from Indian clinics and Local Lead Agencies were invited to these Training of Trainers, and encouraged to use an AITEN developed protocol when addressing an Indian client about tobacco cessation.

Now, toward the end of the granting period for AITEN at CRIHB, we have examined the level of clinic utilization of materials and training sessions that were developed and provided by AITEN. The medical providers were surveyed to determine their current policies and overall use of those materials. The clients were surveyed to determine how effectively they are reached by the materials and education provided to the clinic, as well as the overall appeal of the posters, brochures, booklets and videos, as they speak to cultural relevancy.

Purpose:

The AITEN Scope of Work projected that cessation education services would be institutionalized in 70-90% of California's 22 IHS funded tribal and urban programs in California, as demonstrated by the presence of tobacco specific protocols and client awareness of intervention. This would demonstrate not only the clinical staff's approval of the scientific and medical soundness of such materials, but also the overall appeal of those materials to the American Indian population, which has reserved a very specific and sacred place for the tobacco plant in its culture.

For the most part, the traditional and sacred uses of the tobacco plant include prayer, offering, healing, and a sign of respect when given as a gift. However, sacred tobacco (a plant that is indigenous to the Americas) must be gathered or grown and

cultivated in a manner that is in accordance with traditional tribal protocol, which often is spiritually based. After harvest, Indian people pray and or explain to the tobacco plan the role it will play. The smoke from tobacco leaves is thought to carry prayers up to the Creator, and sacred tobacco was smoked during special events or ceremonies. The origin and uses of sacred tobacco vary from tribe to tribe, but it is generally treated as a gift from the Creator and considered a medicine, not to be mistreated or misused.

The sacred and traditional uses of tobacco have been tainted with the advent of commercial tobacco products. Currently Native Americans are suffering at astronomical rates from the effects of commercial tobacco. A study performed in 1991 by the American Indian Cancer Control Project in Berkeley, California showed that 40% of all American Indian deaths in California are due to tobacco-related causes.¹ Furthermore, the death rate among American Indians due to tobacco abuse is double the death rate of other Americans in the United States due to tobacco.¹ To complicate matters, the cultural relevance of tobacco seems likely to contradict some of the messages delivered through the general campaign against smoking and smokeless tobacco. Clearly special measures must be taken to address the epidemic of tobacco-related disease and death within this ethnic group. For this reason, AITEN provided the aforementioned, culturally relevant materials and educational services to Indian clinics, waited, and then went back to examine the effects.

Methodology:

In October of 2000, AITEN developed a simple, one-page survey to assess the level of utilization of AITEN's tobacco cessation educational materials and services. Drafts were written and revised by AITEN staff and staff from the Institute for Social Research (ISR) at California State University, Sacramento. These surveys were mailed to 23 different Indian clinics across California, including a detailed protocol for completing the survey and a self-addressed, stamped envelope to speed the survey's return. The survey was meant to be completed by someone on the clinic staff, and involved a simple observation of the materials available to clients in the waiting room. There was also a quick assessment component where the staff were asked about any shared knowledge from the Training of Trainers session held in March of 2000, and the presence and use of the Protocol developed by AITEN and distributed to those who attended the training.

In addition to the survey of clinic utilization, the packets also included 10 surveys for clients in the waiting room. These client surveys were meant to poll the clients' opinions about those materials developed by AITEN. Survey questions asked about the location and appearance of materials, as well as their overall appeal. The clinic staff was asked to include these surveys as part of the patient intake, and to complete as many as possible before the end of November.

In a separate survey delivered earlier in the year, the clinic healthcare providers were asked questions about their currently used cessation education practices and materials, as well as their opinions about various aspects of tobacco education. These surveys were conducted by the ISR over the telephone in the early part of 2000 and included 38 health care providers (including medical workers such as physicians and nurses, Clinic Directors, and Community Health Representatives) sampled from 20

different clinics. The survey results were analyzed by ISR using the Statistical Package for Social Sciences (SPSS version 9.0), and the summary delivered to AITEN in October of 2000. Questions offered both numbered, specific responses for statistical analysis and open-ended responses to gauge specific opinions.

Finally, clients from 19 Indian clinics were surveyed by both ISR staff (over the telephone) and subcontractors (in-person) to assess how well they were receiving those materials through the healthcare providers at the clinics. These surveys were conducted both within the clinics and at social events outside of the clinics, such as Pow Wows, from June to September of 2000. For those surveys that were conducted outside of clinics, the participants were asked to identify the clinic that they normally use for their healthcare services. Participants were traded promotional items (such as key chains and pens) for completed surveys. The results were then delivered to ISR for statistical analysis and summarization using the SPSS v. 9.0.

Results:

Provider Surveys

The collected information included a survey taken by 38 health care providers sampled from 20 American Indian Clinics in California. Of those providers surveyed, 38% are Native American, and when questioned about their involvement with the local American Indian community, the providers said that they are involved anywhere from “very” to at least “a little” in 90% of the surveys. The participants included Physicians, Nurses, a Public Health Nurse, Community Health Representatives, a Dentist, Clinic Directors and Program Directors (in various capacities.) When asked about how long they had worked at that clinic, 25% said they had been there a year or less, 31% for two to three years, 23% for four to eight years, and 21% had worked at the clinic for more than eight years.

The next set of questions asked about clinic policies and practices. One respondent said that their clinic is not smoke free, whereas the other 37 respondents said their clinic was smoke free. Of those smoke free clinics, 8% of them became smoke free less than three years ago, 24% became smoke free four to eight years ago, 22% more than eight years ago, and the respondent was not sure about the date in 46% of the cases. According to the respondents, 96% of the clinics asked patients whether or not they smoke or chew tobacco. As for the consistency of such questions, the respondents said that clients are asked about smoking or chewing practices almost always in 13 of the cases, most of the time in 10, some of the time according to two respondents, and two respondents said that their clinic hardly ever asked.

There were other descriptions of how consistently patients are asked if they smoke or chew tobacco, including “especially pre-natal patients are asked”, “no protocol to do it, she just does it,” and “health history is on patient questionnaire, not sure if everyone is asked.” The responses also included “Question is on the intake form—does not seem as important as other health care issues”, “it is on the admin form, so don’t ask every visit,” and “it is on a written form, she is the only one who asks.” These comments

generally seem to point toward a trend of having the questions on patient intake forms, but not always being verbally asked by a healthcare provider.

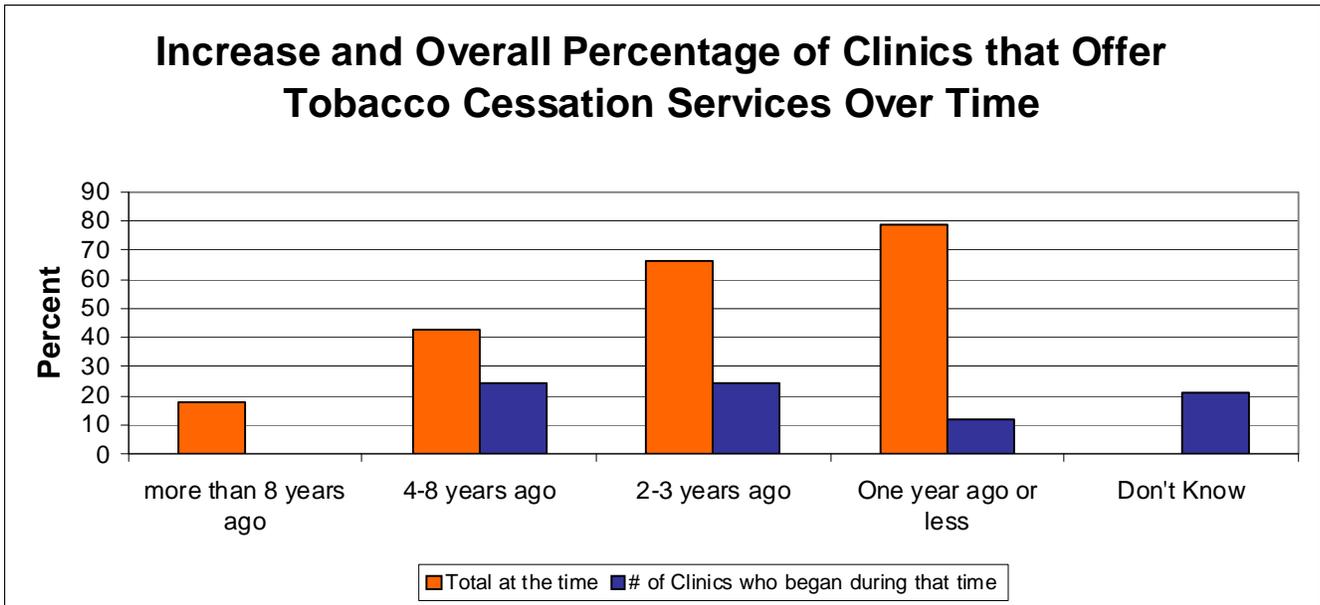
The survey asked why the respondents think that patients aren't asked if they smoke or chew tobacco, and the results showed that not a single respondent thought it was due to a lack of time or interest. The responses that were included "not a big concern with everyone in general, have more emphasis on diabetes," "those who smoke themselves (doctors) don't want to know if patients smoke or not," and "there is no stamp for the form, procedure doesn't include it." Clearly most common reason for skipping over the issue of tobacco use is that there simply isn't a place for such questions on the form that the provider uses during the patient-provider meeting. The comments also seem to indicate that the concern is not great enough among the clinic staff to change such forms and have them include room for information specifically about the client's use of tobacco.

The next set of questions asked about the services that these clinics offer to help patients stop abusing commercial tobacco. The cessation services most often listed by the respondents were referral to the California Smokers' Helpline and one-on-one counseling. The next most frequently recommended services were referral to an outside cessation service and other services such as educational media (brochures, posters, presentations) and Nicotine Replacement Therapy (patches or gum.) Traditional healing methods were recommended to patients, and included arranging a meeting between the patient and a traditional healer from either within or outside the community, having a traditional elder perform a ceremony, and using a sweatlodge. Classes and support groups were offered, but were often conducted by other agencies or programs (such as the public health department.)

Table 1: This table shows the types tobacco cessation services and programs offered by clinics, as well as their prevalence among those clinics sampled. The total number of respondents for this set of questions was N=38, but respondents often marked more than one of the choices for those services offered by their clinic.

Services Offered by Clinic to Clients Who Smoke or Chew	Percent
One-on-one Counseling	55.3
Referral to the California Smokers' Helpline	55.3
Referral to other outside services	44.7
Other Services	42.1
Traditional Healing Methods	31.6
Support Groups	26.3
Classes	26.3

According to the respondents: 18% said that their clinic had begun offering cessation services within the last year; 24% said two to three years ago; 24% said four to eight years ago; 12% more than eight years ago; and 21% did not know when their clinic began offering smoking cessation services.



Graph 1: This graph displays the number of clinics offering smoking cessation services in years before present day, as well as the increase between each time period (as estimated by the difference between reported rates in consecutive time periods.) The total number of respondents was N=33.

Another question asked the participants how often their clinic’s providers refer patients who smoke to a cessation educational program. The results showed that 29% made such referrals almost always, 16% did so most of the time, 16% did so some of the time, and 16% “hardly ever” made such referrals. Nearly 10% weren’t sure about the rate of cessation educational program referral by providers in their clinic. Some of the open-ended comments regarding this question were, “If the patient will go, they write up referrals when the patient is ready,” “Only if patient is interested, don’t want to irritate them about it,” and “Patients are referred to an in-house psychologist, so it is confidential. [The respondent] has no ideas of the numbers.” Another response explained how the area is very rural, and it is hard to ask patients to drive in on a frequent basis.

When the survey respondents were questioned about potential barriers to providing smoking cessation services, they were given a list of potential barriers, as well as the opportunity to provide other barriers that were not listed on the survey. The already-listed choices showed the following response rates (see Table 2)

Table 2: This table shows the percent of respondents who either answered Yes, No, Don't Know or Not Applicable to questions about barriers to offering smoking cessation services at the clinics. The number of respondents to each question varied between N=36 (for c and e) and N=37 (for a, b and d.)

"Please indicate whether each barrier is a problem for your clinic":	Yes	No	Don't Know	Not Applicable
a) There is no one at my clinic to provide smoking cessation educational programs	16.2%	81.1%	0.0%	2.7%
b) There is no funding to provide those services	40.5%	48.6%	8.1%	2.7%
c) Community members do not like or accept them	30.6%	50.0%	16.7%	2.8%
d) No one has asked for them	18.9%	70.3%	8.1%	2.7%
e) Other barriers	75.0%	16.7%	5.6%	2.8%

One of the commonly mentioned “other barriers” to clinic smoking cessation services was client transportation to and from the clinic on a regular basis. Other barriers included a lack of concern in the area, priority on other health concerns, funding to buy patches or quitting incentives, and overall support or enthusiasm from both the community and the clinic staff.

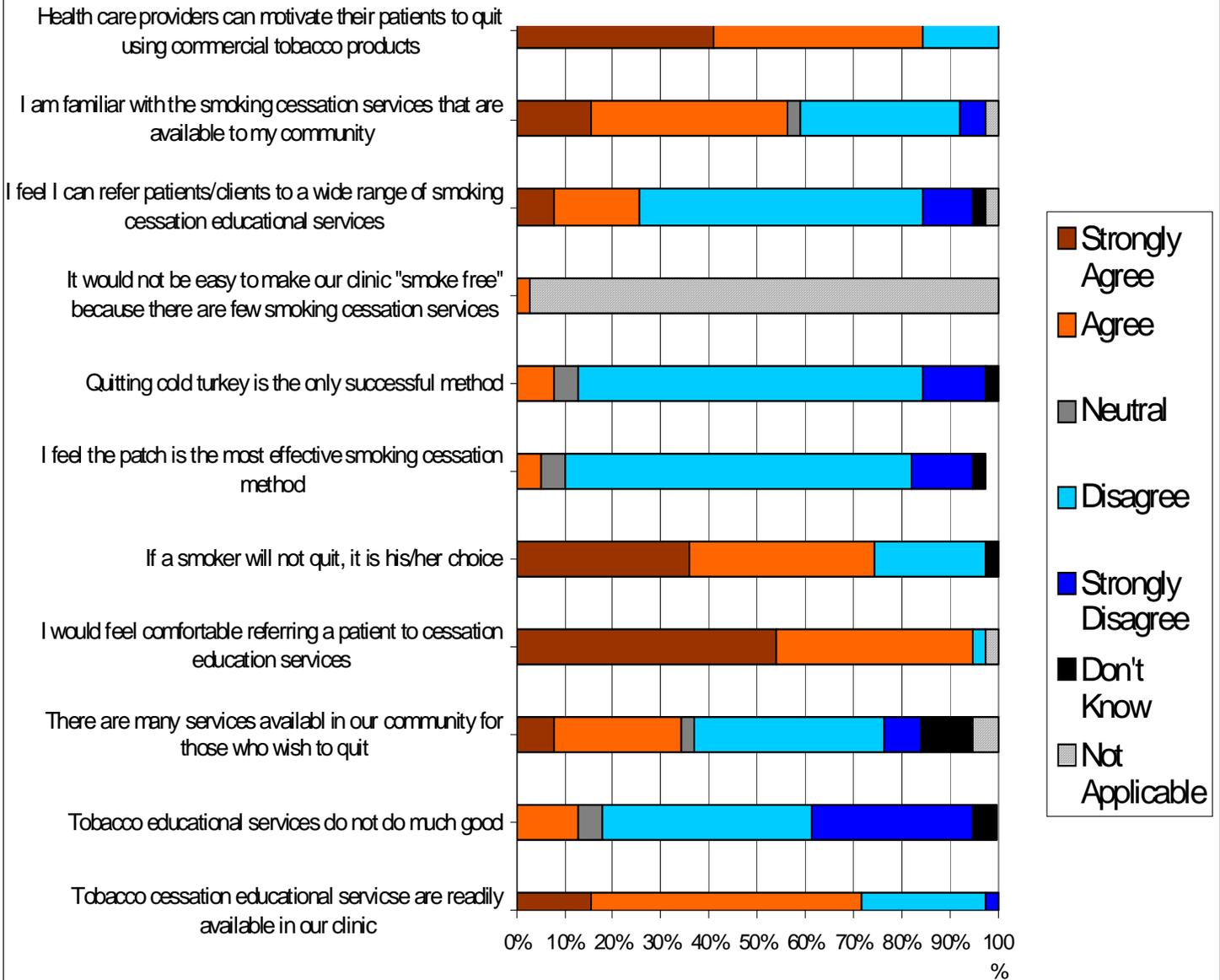
The providers were also asked, “Would your clinic support a smoking or chew cessation program or services if...” and were given several listed options as well as the opportunity to list other factors that would increase the cessation services offered. The results for the listed choices are on Table 3. Other factors that would make the clinics represented by these participants more likely to support a cessation program were collaboration with other Indian health agencies, more demand from the patients, and support from the local Indian casino’s.

Table 3: This table shows the percentage of respondents who answered Yes, No, Don't Know or Not Applicable to questions where they were asked if various solutions would encourage their clinic to support tobacco cessation services. The number of respondents for each question varied, with N=36 for (a), N=37 for (b)-(d), and N=32 for (e).

"Would your clinic support a smoking or chew cessation program or services if..."	Yes	No	Don't Know	Not Applicable
a) services were easily available for your population	83.3%	2.8%	8.3%	5.6%
b) Clinic staff had the time	81.1%	5.4%	8.1%	5.4%
c) Someone in your clinic was trained or certified to provide those services	62.2%	10.8%	5.4%	21.6%
d) Clinic staff knew more about the services	78.4%	8.1%	5.4%	8.1%
e) Other factors	62.5%	34.4%	3.1%	0.0%

Finally, the clinical providers were given a series of statements and asked for their level of agreement with each, on a scale from Strongly agree to Strongly disagree, with the added options of Don't know and Not applicable. The first few statements were used to assess the providers’ general feelings toward tobacco educational services, both in the clinic and the community. The next set of statements explored the respondents’ general feelings about tobacco cessation, such as effective methods for quitting, as well as the efficacy of providers motivating their patients to quit. The results are summarized in Graph 2.

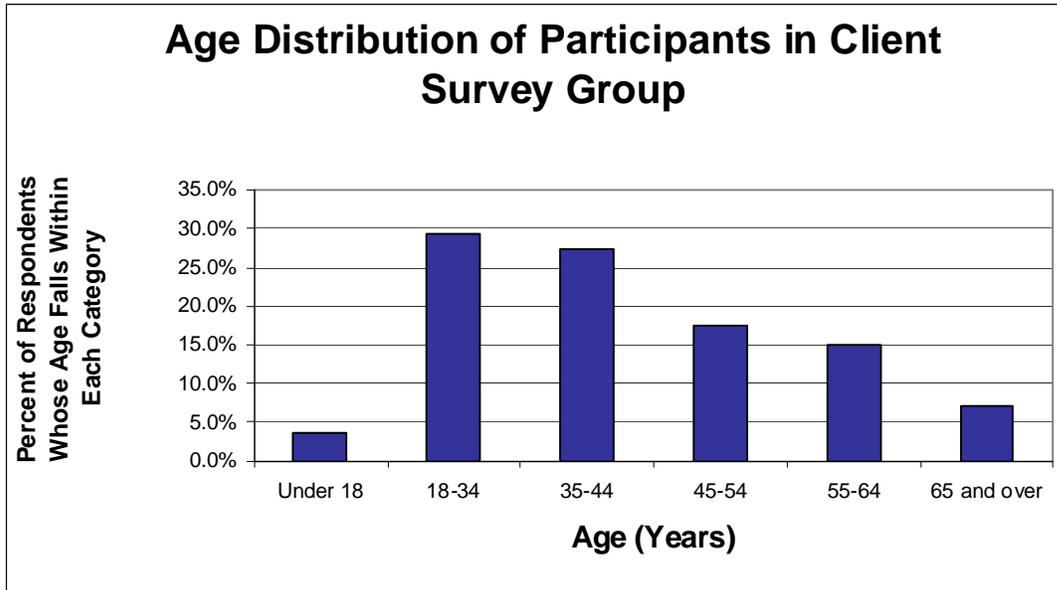
Level of Agreement with Statements About Tobacco Cessation Services



Graph 2: This graph shows the level of agreement or disagreement that respondents had when responding to specific statements about tobacco educational and cessation services. These results give an overall indication of the level of importance that tobacco abuse holds within the group of healthcare providers represented in this survey.

Client Surveys

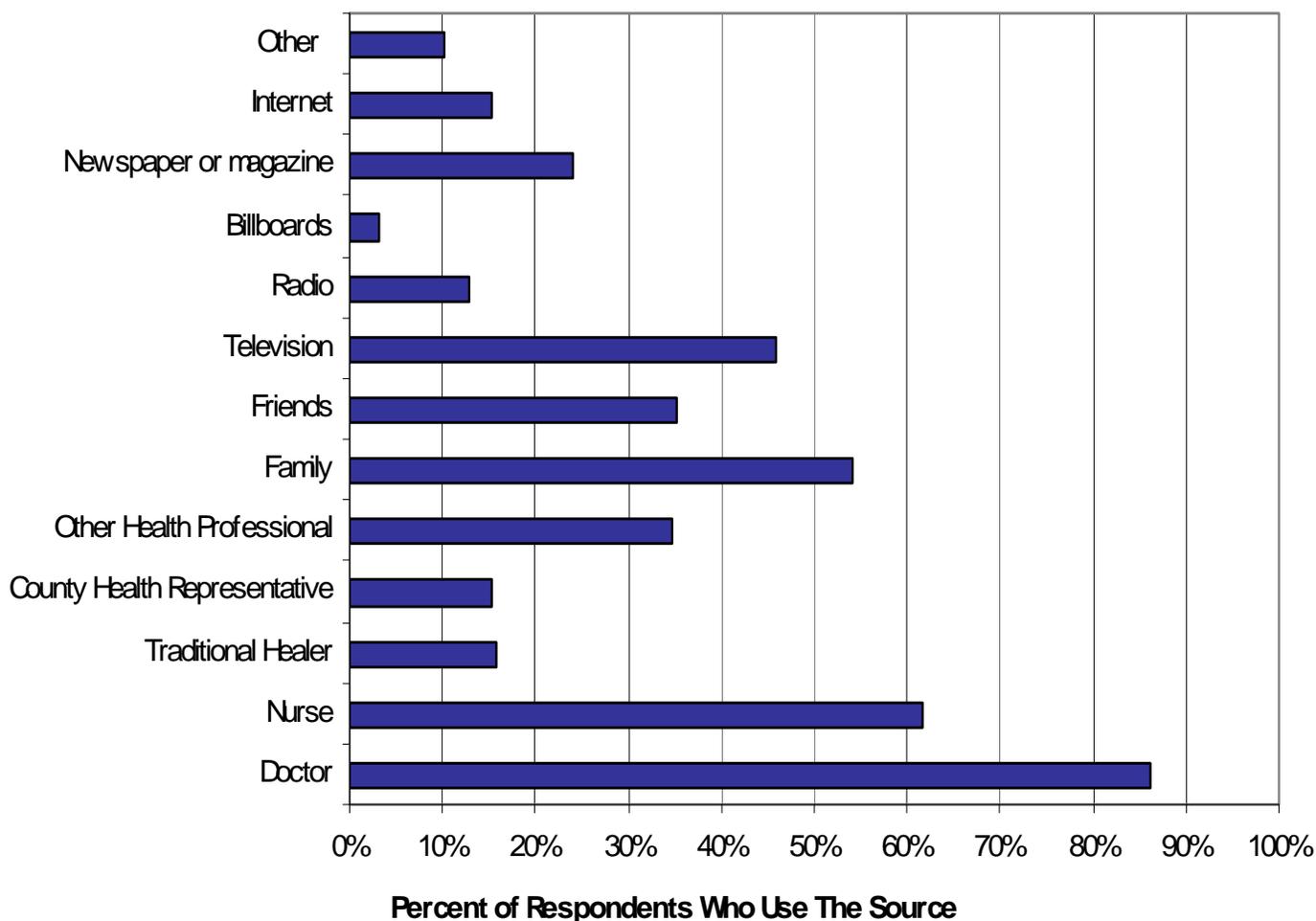
The client survey population included 205 respondents, with a gender breakdown of 35% male and 65% female. The participants were clients from 19 different Indian clinics in California. Respondents represented 55 different tribal memberships, and two respondents claimed to be non-Indian, but may have claimed tribal affiliation. The age breakdown for the survey group (see Graph 3) was 4% under 18, 29% between the ages of 18 and 34, 27% between the ages of 35 and 44, 18% between 45 and 54, and 15% between 55 and 64 years of age. Those who were 65 years or older totaled 7% of the sample group.



Graph 3: This graph shows the age breakdown for the participants in the client survey sample group. While the total number of surveys completed was 205, only 194 participants offered information on their age.

The survey results showed that the most frequently listed sources for health information were doctors (86%) and nurses (61%). The next highest ranked information sources were family and television, followed by friends and other health professionals. Respondents also listed responses such as work, books, sweat lodge, self and spirits as sources for health information (see Graph 4).

Percent Distributions for Client Sources of Health Information



Graph 4: This graph shows those sources of health information that the American Indian clients represented in this sample group rely upon. Clearly the most heavily used sources are people, particularly healthcare professionals, as well as television. Other forms of media, primarily print media such as magazines and billboards, do not have as strong an impact as the spoken words of a human being. Respondents were allowed to chose more than one of the listed options when answering this question, but the total number of respondents was N=196.

When asked if their clinic was smoke-free, 82% of the respondents (N=186) said Yes, and 6% said No; 12% of the respondents were not sure.

Another question asked the clients if their clinic offers “any of the following for people who want to quit smoking” then listed six different choices for cessation services, along with the option for those who don’t know, or other responses. The results summarized in Table 4 show that nearly half of the respondents did not know what their clinic offers in the way of smoking cessation services. Some of the other responses that

people gave for services offered by their clinic were medications, nicotine gum, nicotine replacement patches, and pamphlets.

Table 4: This table shows the percentage of respondents (N=174) who chose each of the following responses to the question listed in the top of the table regarding what the clinic offers to help people quit smoking. Respondents were allowed to give multiple answers in response to this question. It is possible that the number of people who answered that they did not know what the clinic offers is inflated, as respondents could have misinterpreted that answer to mean that they did not know all of the services that the clinic offers.

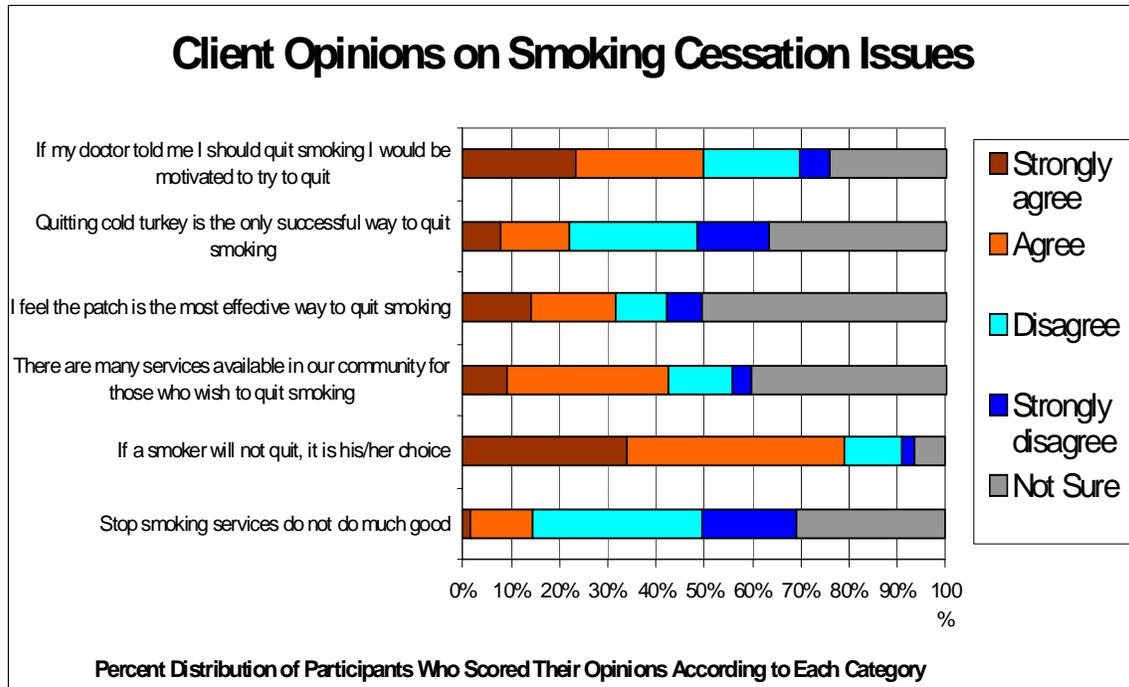
"Does your clinic offer any of the following for people who want to quit smoking?"	
I do not know what the clinic offers	49%
Referral to other outside services	27%
One on One Counseling	25%
Referral to California Smokers' Helpline	20%
Support Groups	13%
Classes	12%
Other	8%
Traditional Healing Methods	7%

It was possible that respondents who said they did not know what their clinic offers for people who want to quit smoking simply misinterpreted the question and thought that Don't Know meant that they aren't aware of *all* of the services offered by the clinic. However, there was a second question that asked the respondents to agree or disagree if their clinic has services for people who want to stop using tobacco. The results showed that 43% agreed that their clinic does offer such services, 1% strongly disagreed, and 37% weren't sure. This reinforces the findings of the previously discussed survey question and addresses the problem of misinterpretation. Evidently a large portion—at least one-third of the respondents—do not know about how their clinic is equipped to help them quit smoking.

The respondents were also asked if they agreed or disagreed with the statement "Stop smoking services do not do much good." The results showed that 15% of respondents (N=188) agreed with the statement, 55% disagreed with the statement, and 31% were not sure (see Graph 5).

The survey included a question about the availability of services in the community for those who wish to quit smoking, once again asking respondents if they agreed or disagreed with the statement that there are many of such services. Respondents (N=188) were largely unsure (40%), while 17% disagreed with the statement and 43% agreed (see Graph 5).

A strong majority of the respondents (79%) agreed that if a smoker will not quit, it is his or her choice. Far fewer (15%) thought that it is not a smoker's own choice to quit, and 6% were not sure (see Graph 5).



Graph 5: The responses of participants show their level of agreement or disagreement with statements about smoking cessation issues related to availability as well as efficacy. A useful way of examining the graph is to group the two categories of agreement as well as the two categories of disagreement, and compare these groupings with each other, as well as the overall percentage of people who are not sure how they feel about each statement. This simple comparison gives an indicator of the faith that clients have in smoking cessation services.

Another set of questions gauged client opinions on methods for smoking cessation, including a doctor’s advice to quit smoking. The first suggestion was the nicotine replacement patch method: 96 respondents were not sure if the patch is the most effective cessation method, 60 agreed that the patch is the most effective way to quit, and 34 thought that the patch is not the most effective method. The next suggestion was quitting “cold turkey”: 70 respondents were not sure if this is the most effective means to smoking cessation, 79 disagreed and thought that quitting cold turkey is not the most effective method, and 42 respondents thought that cold turkey is the most effective way to quit smoking. A comparison of these two methods shows that more people favored the patch than quitting cold turkey. However, it is possible that a doctor’s endorsement of either of these methods could increase client buy-in, as 50% of respondents (N=192) said that if their doctor told them they should quit smoking, they would be motivated to try and quit.

One set of questions related to environmental tobacco smoke for those who potentially do not smoke revealed that 76% of respondents (N=195) had family members or friends who smoke. When asked about where their family members or friends smoke, 71% of respondents said outside, 38% said in a car, 36% said inside at home, and 19% said at work. Some other places that respondents listed were outside the work building, in a separate room, and at family gatherings.

The next question targeted those who do smoke and could potentially be contributing to environmental tobacco smoke. The results showed that 65% of respondents (N=194) have smoked cigarettes and 1% have smoked cigars at least 100 times in their life. This is used as an index by AITEN for determining those who are actually smokers, rather than first-time or occasional experimentation. The mean age when this group began smoking was 15.75 years old, and 82% began smoking before the age of 19. A second measure for determining those who are current smokers was the question, “Have you smoked cigarettes or cigars in the last 30 days?” The results showed that 55% of the respondents (N=193) had. This group smoked an average of nearly 10 cigarettes a day. The spread of cigarette smoking rates is represented in Table 5 below.

Table 5: The data presented below give an indication of the smoking rates of those who are smokers in the respondent group (N=112). The category of “Less than and up to a ½ pack a day” had those who do not smoke filtered out, to prevent non-smokers from inflating the response rate.

"On average, when you smoked during the past 30 days, about how many cigarettes (or cigars) did you smoke a day?"	Less than and up to a 1/2 pack a day	34.0%
	Between 1/2 pack and 1 pack a day	19.8%
	Between 1 pack and 2 packs a day	21.7%
	More than 2 packs per day, less than 3	20.8%
	More than 3 packs a day	3.8%

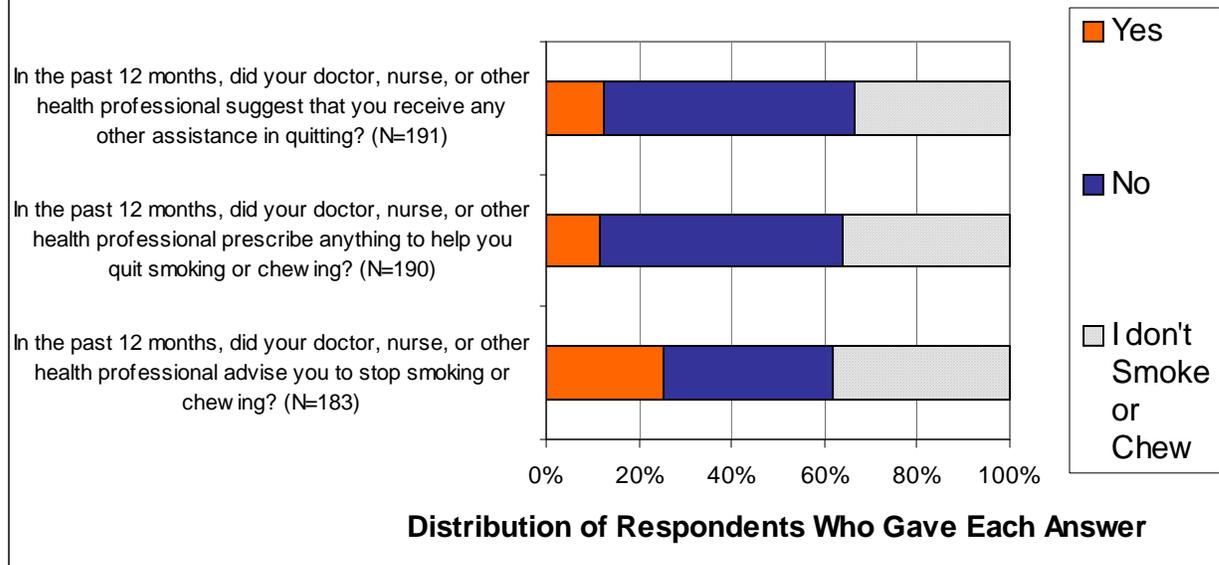
In addition, this group of people smoked most often outside (91%), in their car 50% of the time, and they smoked inside at home 36% of the time. Nearly a quarter of the respondents (24.5%) also admitted to smoking at work. Other locations listed were in the bedroom, at ceremonies, outside at work, and at Pow Wows.

Of those who smoke, nearly 37% planned to quit within the next six months and 12% weren't sure (N=101). More than half (57%) of the respondents have quit smoking for one day or longer.

Survey participants were also asked about chewing tobacco or snuff use. A large number (83%) of respondents (N=189) have used chewing tobacco or snuff less than 20 times in their life, and nearly all (91%) do not use it at all now (N=183). For those who do still use chewing tobacco or snuff, it was mostly occasional use rather than everyday. A similar question asked how many times during the last 30 days respondents had used chewing tobacco or snuff: 69% had used six times or less, 25% had used between 10 and 29 times, and 6% had used 30 or more times.

The final part of the survey probed the areas of clinic tobacco cessation services and their actual utilization by clients. The results are summarized in the graph below (See Graph 6.) Survey participants were also asked how successful they were in quitting, if they had used any of the clinic's cessation services. A total of 25 people responded, and showed that nearly a quarter of them (24%) had quit for more than half a year, 16% quit for three to six months, 12% quit for one to three months, and 24% quit for less than one month. Five of the respondents had quit for less than three days.

Client Responses To Questions Regarding the Assertiveness of Clinic Tobacco Cessation Measures



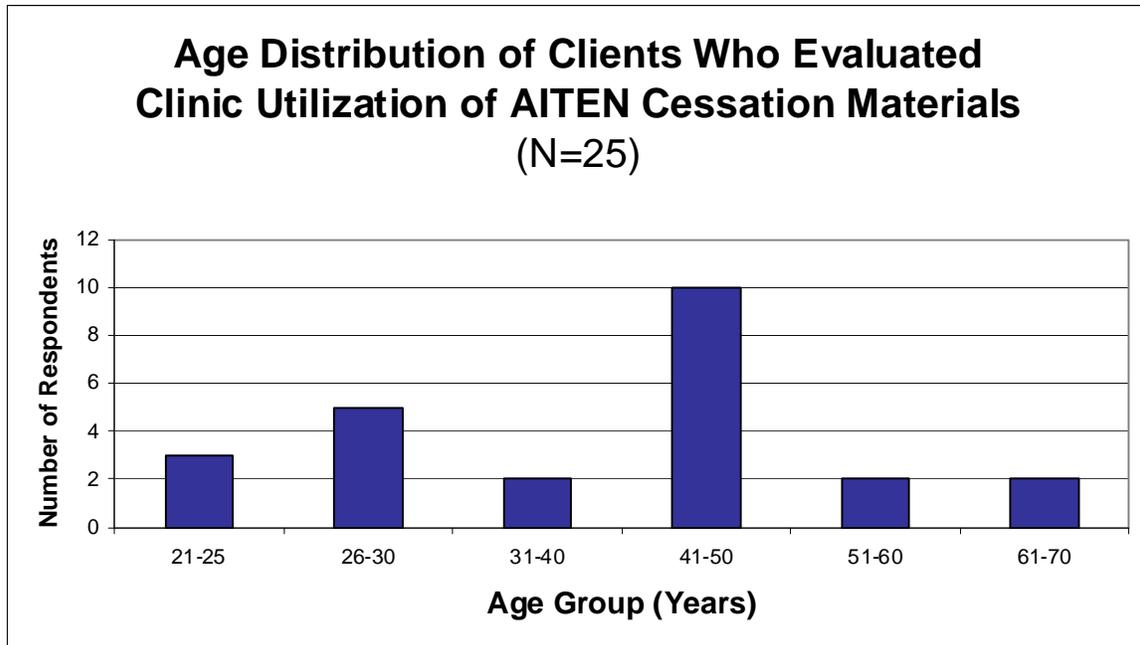
Graph 6: Respondents were asked for Yes or No answers for questions related to clinic healthcare providers' efforts to encourage those clients who participated in this survey to quit abusing commercial tobacco. The respondents who do use commercial tobacco and answered No to a question have been separated from those who do not smoke or chew.

The survey was also used to determine how to improve client utilization of those services offered by their clinic. The results are summarized in Table 6 below.

Table 6: This table shows those changes that could be made to clinic services to increase client utilization. The majority of those answers that were listed as "other" were related to the client's actual decision and motivation to quit. Respondents were allowed to give multiple responses to the question, but the overall response rate was N=97.

"Would you use the Clinic's services to help you quit smoking or chewing if:"	
Services were more culturally sensitive	40.2%
You had the time	40.2%
You knew more about the services	57.7%
I don't smoke or chew	55.6%
Other	10.2%

As for the clinic utilization surveys, 16 clinics completed a self-evaluation of the types of AITEN cessation materials that were in place during November of 2000, and 25 clients gave their opinions on the materials that were used in three of those clinics. The age distribution of those client respondents is given in Graph 7.



Graph 7: The age distribution for respondents who filled out a one-page survey regarding AITEN cessation materials while they were in the waiting room or in the examining room. These clients were sampled from three different clinics.

Nearly three quarters of those surveyed (76%) are current smokers, and they had spent an average of 19.6 minutes in the waiting room before they had completed the survey. A total of 92% said that they had noticed AITEN’s posters in the clinic waiting room, either that day or in the past, but only 76% said that any of them stood out or were especially appealing (few actual descriptions were given). Nearly everyone who noticed the posters said that they were placed well on the wall, such that they were easily noticed and readable. As for rating the other materials for their appeal or accessibility, 40% said that the pamphlets (“Your Life is Our Future” and The California Smokers’ Helpline) stood out to them, and 36% noticed AITEN’s promotional items (keychains and pens). Overall, 80% of the respondents felt that their clinic was doing a good job of presenting AITEN’s cessation materials and making them readily available.

Discussion

When AITEN began its Cessation campaign in 1993, the goal was to work through the IHS funded clinics and their staff to reach patients and increase the tobacco cessation rates among American Indians. In order to do this, AITEN staff had to not only change the way the clients saw commercial tobacco, but also try and change the way clinic healthcare providers perceived the problem of tobacco abuse among American Indians. Indian communities largely suffer high rates of alcoholism, substance abuse, depression and suicide^{5,6}. For this reason, it is easy for tobacco to be overlooked. Nonetheless, studies have shown that tobacco has serious health effects, and the risk rates based upon use are much higher among Native Americans than among any other ethnic group in the United States. A report from the Surgeon General stated that nationally,

lung cancer is the leading cause of cancer death among American Indians and Alaska Natives.² Furthermore, American Indians and Alaska Natives have the highest prevalence of smoking among all American men, women, and youth. The AITEN was developed to combat nicotine addiction and commercial tobacco abuse precisely for these reasons, as well as the need for a culturally relevant approach when doing so.

Collaboration with the Indian clinics was critical to not only reaching the Indian communities, but also for reinforcing the message that tobacco kills with the expert opinion and endorsement of healthcare professionals who are respected by their patients.

In January of 2000, AITEN began sending introductory letters to about 20 Indian clinics, explaining the Cessation campaign and the benefits of involvement for clinics. All materials and technical assistance were to be provided free of charge, as well as valuable all-expense-paid training sessions for a clinic delegate, or Community Health Representative (CHR.) These CHR's would collaborate with AITEN staff as Cessation Committee Members, and would not only act as a liaison between AITEN and the rest of the clinic staff, but also would also have input and involvement in the material development and program planning.

Letters were sent again, and followed up with telephone calls presenting the same content as the letters. During the CRIHB Board Meeting in the Spring of 2000, AITEN staff were included in the meeting agenda and explained the Cessation campaign face to face with those Indian Clinic Directors and Board Members present at the meeting, inviting them to join. After the clinic directors approved the campaign workplan and agreed to join AITEN in the Cessation Campaign, those clinics were then assessed to determine what cessation services were already in place, prior to AITEN assistance. The appropriate and complementary level of assistance was then offered to each clinic.

Some clinics refused to be involved, and were therefore respectfully bypassed in the repeated attempts to encourage clinic involvement. Once the Cessation Committee was formed, the task of revising already developed anti-smoking material at AITEN was begun, with the input of the Cessation Committee members. One example of a revision was that made to the brochure, "It's Your Life"; the original message was focused more on the individual, which seemed to contradict the general beliefs of Native Americans, which are much more group oriented. As a result, the title and eventual slogan was changed to "Your Life is Our Future", in an attempt to make the materials more appealing to Indians, as well as give them a sense of identity and community. Other similar changes were made to brochures and booklets.

The first of three Cessation Training of Trainers was held in Sacramento during March of 2000, where the CHR's were given the newly revised cessation educational materials, as well as a day-long training on how to establish or reinforce cessation services within the clinics. CHR's were also given a protocol, built from protocols written in the National Cancer Institutes Manual for Physicians³ and the American Indian Cancer Control Project Clinic Protocol⁴. The participants later evaluated that training, and suggested that subsequent training sessions should be longer and more in-depth. The next two training sessions were conducted in southern California by AITEN staff and subcontractor Dolores Lewis, but were not able to meet the suggested length of two days.

Finally, in November of 2000, the clinic staff and their clients were surveyed to assess the level of institutionalization and efficacy of those cessation educational materials developed by AITEN and given freely to the Indian clinics.

The results of the November 2000 clinic utilization surveys showed that at least 16 IHS funded clinics are currently using some form of the educational resources made available through AITEN (clinic cessation protocol, pamphlets, posters and promotional items.) This meets the requirement established in the Scope of Work that “cessation educational services will be institutionalized in 70-90% of California’s 22 IHS funded tribal and urban programs.” The most commonly listed materials present in the waiting room were pamphlets, posters and promotional items. The clients appeared to prefer the AITEN developed materials because of their cultural sensitivity. The items that were most frequently noticed by clients in the waiting rooms of the clinics were posters, followed by the California Smokers’ Helpline and the “Your Life is Our Future” pamphlets, as well as pens and keychains.

One of the interesting points that came out of comparing the client and provider survey responses is the overall buy in for cessation aids, including counseling, educational materials, self-help or Nicotine Replacement therapies (NRT). The survey responses for the providers show that they were certainly more decided in their opinions on cessation aids. The providers were either in agreement or disagreement with each of the statements listed in Graph 2 (statements about the efficacy of using the patch, quitting cold turkey, educational services, etc.), whereas when the clients were asked similar questions (Graph 5), far more responded that they did not know. The clients also appear to rely heavily on the information that they receive from their healthcare providers. As a result, it could be inferred that a physician or nurse’s endorsement of any particular cessation aid might influence a patient’s belief in the efficacy of that method.

Another important aspect of these cessation-aid questions is the apparent finding that clients appear to have more faith in NRT than do the providers. The statement was given such that the participants were asked to either agree or disagree that the patch is the most effective way to quit smoking. Providers could have interpreted this statement as being too black and white, and for that reason could have chosen to disagree, simply because they do not believe that the patch is always the *most effective* treatment method. This does not necessarily mean that they don’t support using the patch. On the other hand, the clients who agreed that the patch is the most effective treatment method may have tried to quit previously using other cessation aids, and only been successful when using the patch. In this comparison the most important underlying factor is probably the exposure that each group of respondents has to smokers who are trying to quit; healthcare providers are more likely to have witnessed the successes of multiple techniques, whereas the experience of the clients is likely more limited.

By the same token, the providers had more faith in the education as a means to help people quit smoking than did the clients. The providers disagreed with the statement “Tobacco educational services do not do much good” in 76.9% of the responses, whereas only 54.8% of the clients disagreed. The difference between the two group responses can be attributed to just over 30% of the clients feeling unsure, and 13% of the providers apparently having little belief in the power of education. Another interesting point is that the providers had much more faith in their ability to persuade clients to quit abusing tobacco (84.6%) than the clients did (50%).

One of the interesting points that came out of the study is the ranking of media among the other sources of health information. Each of the media related sources (including radio, billboards, newspapers, magazines and the Internet) ranked low

compared human sources of information—with the exception of television. The sources of Community Health Representative and Traditional Healer might have ranked low simply because they are generally sparse. There might be one CHR at a clinic, and only a couple of Traditional Healers in a community. In any case, physicians, nurses and family members appear to have the greatest opportunity to educate American Indians. This is not surprising, as many of the Indian communities in California are very rural, oftentimes not even having telephones (and therefore no Internet.)

When asked about the regularity with which clinic staff question clients about their use of tobacco, the answers differed substantially between the client and provider groups. The providers seemed to think that clients are asked far more regularly than the clients reported they are. In nearly 95% of the provider responses, participants said that healthcare workers at their clinic ask patients whether or not they smoke or chew tobacco. In contrast, the clients who smoke said that they were advised to quit smoking or chewing during the last 12 months in only 25% of the responses. As for the consistency of asking patients if they smoke or chew tobacco, the 43% of providers responded that they asked almost always and 33% said that their clinic asks most of the time. On the other hand, clients who do smoke or chew responded that they were prescribed something to help them quit smoking or chewing only about 12% of the time. Clearly there is inconsistency between the clinic cessation services that are reported by the providers and those reported by the clients.

Of those clinics sampled, one admitted to not being smoke-free, and two said that they do not ask clients if they use tobacco products at all. Some of the reasons cited by the health care providers for not consistently asking patients if they smoke or chew tobacco were “In the past, we’ve had negative responses to the question, so now we ask less,” “Those who smoke themselves (doctors) don’t want to know if the patients smoke or not,” and “It’s not a big concern with everyone in general, we have more emphasis on diabetes.” Other reasons why healthcare providers do not consistently ask patients about their tobacco use are that there isn’t a block for the question on the admission form, or because they only ask first-visit patients about tobacco abuse, but do not ask again during subsequent visits. None of the clinics is denying clients advice about smoking cessation and services, but on the other hand, not all of them are taking the extra step of asking clients if they smoke or chew tobacco--and more important--if they’re interested in quitting.

Responses to the survey revealed that nearly all of the obstacles to smoking cessation program implementation by clinics are economic. A good portion of the clinics surveyed suffer from a lack of funding for extra tobacco-specific cessation services. Other obstacles include difficulty with client transportation and childcare. A few of the clinics also gave other barriers to tobacco cessation services, such as “There isn’t a big enough concern in this area,” and one person surveyed even admitted that fellow employees had said specifically NOT to talk about smoking cessation services, because they were against the classes. Another provider surveyed admitted that when the office manager was trying to quit smoking, the clinic adopted pro-cessation measures including special training for staff, but that when the office manager was no longer interested in quitting, support for the cessation program was removed.

The results of the client surveys also seem to indicate that chewing tobacco use rates among American Indians in California appear to be less than those found in

previous nationwide studies. One of the survey questions asked respondents if they have used chewing tobacco or snuff more than 20 times in their entire life, revealing that 17% of the survey group have. This question was used to pull out the number of respondents who either currently or in the past would have met AITEN's definition of habitual smokeless tobacco users; however, these respondents may have quit using smokeless tobacco after using it habitually.

A different question asked simply how often the respondents used chew or snuff presently. The response to this question was very encouraging: 91% of those surveyed said that they do not use chew or snuff at all now. When these results are compared to those of the previous question, it appears that half of those people who have experimented with tobacco 20 times or less in their lifetime are no longer using smokeless tobacco. Previous studies performed by the IHS have shown that a total of 16% of American Indians use smokeless tobacco, compared to 6.7% of the general population. The results of this study, if the previously mentioned inferences are made, show that 17% of the respondents (N=189) either are or used to use smokeless tobacco, but that only 9% of them (N=183) are currently using. This is a much lower value—36% less--than that of the survey conducted by The American Indian Cancer Control Project in 1991.

While this statistic is lower than that found earlier this decade, it is still higher than the other ethnic groups (3.4% for whites, 3% for African Americans, 0.8% for Hispanics, and 0.6% for Asian Americans and Pacific Islander), and certainly higher than that describing the national population of American Indians in the Surgeon General's report of 1998 (4.5%). The fact remains that there is still a disproportionately large percentage of the American Indian population who are using smokeless tobacco, and thereby putting their health at risk.

Weaknesses and Lessons Learned

While the idea for this cessation campaign was born more than seven years ago, during the initial AITEN grant writing process, it was not developed and completed without barriers or flaws. The greatest barrier to perfecting execution of the cessation campaign was the inconsistent staffing at AITEN, which led to shortened timelines for particular activities. Due to the frequent vacancy of the Family and Community Health Department Director position and the long vacancy of the AITEN Project Manager position at CRIHB, there often was not a liaison between the AITEN staff and the AC members to facilitate shared activity, nor was there someone to help enforce deadlines for remaining AITEN staff.

Another technical weakness of the campaign is the potential flaws in the design of the surveys. As mentioned earlier in both the Results and the Discussion sections of this paper, there are specific areas of both the client and the provider surveys where questions could be misinterpreted. As a result, the outcomes of those particular questions become more difficult to compare.

Still another potential complication related to the survey design is the differences in background and experience between providers and clients. As mentioned in the Discussion section, providers are likely to have had much more experience than the clients have had with people who are trying to quit smoking. This difference in

background has the potential to skew the results of the provider survey based upon perspective, rather than direct experience. The expected differences in level of education between the providers and the clients is also likely to have an effect on the way the two groups interpret questions or statements, therefore effecting their responses.

Sometimes questions that are similar between the two surveys are difficult to compare because they were not stated in exactly the same way. This discrepancy allows for difference in interpretation, and therefore invites error into the comparison.

And as mentioned earlier, the timeline of the study was greatly compromised due to the gaps in leadership at AITEN. The entire course of the study, from invitation to participate to the writing of this report, was less than a year. Ideally, more time would have been allowed for training and for clinic utilization of educational material, prior to the final surveying of providers and clients. It is possible that providers were annoyed with the rush of the study, and therefore were less likely to become highly involved in the cessation campaign.

Overall, the results of the cessation campaign were very positive. The AITEN was able to establish a connection with clinics in California, making future collaboration more likely as well as more efficient. The information revealed in both the client and the provider surveys is valuable for both defining the state of tobacco use and attitudes among American Indians in California, as well as the difficulties that Indian clinics face in implementing a cessation program. Providers can use this study to determine the client perspective on clinic services and smoking cessation, as well as potential weaknesses in clinic protocols. Hopefully this information will be used to build and improve upon the cessation services offered by Indian clinics in the future.

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