



TOBACCO CESSATION AND TREATMENT

Worldwide, 1.3 billion people smoke and, unless urgent action is taken, 650 million of them will die prematurely due to tobacco use.¹ According to the World Health Organization, “Current statistics indicate that it will not be possible to reduce tobacco-related deaths over the next 30-50 years, unless adult smokers are encouraged to quit.”² Millions of people quit every year, but many more don't and quit attempt success rates remain low. Tobacco cessation can be a cost effective method of disease prevention for adults. In the United States, for example, it is more cost effective than mammograms, pap smears, and screenings for colorectal cancer or hypertension.³

Nicotine: The Basis of Addiction

Tobacco contains nicotine, a powerful and highly addictive substance. Most tobacco products deliver nicotine to the brain very effectively, bringing on the rapid onset and maintenance of addiction. This addiction leads to the unfortunate situation where an otherwise rational, motivated, knowledgeable person, who understands the risks of tobacco, continues to use it.⁴

Evidence of the dependence-producing properties of tobacco has been accumulating for years. In 2000, The Royal College of Physicians summarized this body of research by concluding that nicotine is an addictive drug on par with heroin and cocaine and that the primary purpose of smoking tobacco is to deliver a dose of nicotine rapidly to the brain.⁵ Studies from numerous countries show that although an overwhelming majority of tobacco users want to quit, less than half make a quit attempt each year, and very few of those succeed in quitting long-term. While up to 40 percent of those using tobacco will make a serious quit attempt in any given year, as few as three percent actually achieve long-term abstinence.⁴

- Surveys in the United States have found up to 70 percent of tobacco users report a strong interest in quitting.⁴
- A 2002 report indicated that 45.6 percent of Australian smokers intended to quit smoking in the next six months.⁶
- A 2003 study on behalf of Ireland's Office of Tobacco Control, indicated that 76 percent of Irish smokers intend to quit; 67 percent of those wishing to quit have previously attempted to quit.⁷

Tobacco Industry Impediments to Cessation

In addition to the impediments to cessation caused by insufficient government policies and the addictive nature of nicotine, the tobacco industry itself presents numerous barriers to cessation efforts through its significant economic and political resources.

Lack of significant regulation has allowed the industry to create and promote products, such as “light” or “low tar” cigarettes, that purport to offer harm reduction but do not reduce overall disease risks. The heavy promotion of these products to health conscious smokers “at risk” of quitting smoking has served to manipulate their addiction by offering justification for continued smoking, even though there is no evidence these products reduce the risk of disease.

Either directly, or through bogus front groups, the tobacco industry attacks scientific evidence on the effects of smoking and states publicly that smoking is either not as harmful as critics contend or that “everything” is harmful. Several companies still do not admit that smoking is addictive. These public relations strategies are so far removed from science they would not work for most consumer products. Yet smokers are often strongly motivated to find ways to justify their dependence to smoking, and while others might recognize these strategies as attempts to trick consumers, smokers may view them as a beacon of hope in their efforts to justify continued smoking thereby avoiding the hardship of a cessation attempt.⁴

The Important Role of Health Care Providers

Article 14 of the World Health Organization Framework Convention on Tobacco Control (FCTC) – a treaty signed and ratified by 145 countries from all regions of the world - calls on governments to incorporate the “diagnosis and treatment of tobacco dependence and counseling services on cessation of tobacco use in national health and educational programmes.” As the International Union Against Cancer states, health-care professionals “have a duty to provide counseling and treat tobacco dependence as they would any other disease or addiction.”⁸ A 2002 report from the New Zealand National Advisory Committee on Health and Disability, *Guidelines for Smoking Cessation (2002)*,⁹ found that “there is good evidence that even brief advice from health professionals has a significant effect on smoking cessation rates.”

Yet many healthcare providers lack the proper tools to treat tobacco dependence. A research paper on the United Kingdom’s 24 medical schools, for example, found that there was no mention of smoking or smoking cessation in the published curriculum material of 10 of those schools.¹⁰ In the United States, one study found that only 15 percent of tobacco users who saw a physician in the prior year were offered assistance with quitting, while only 3 percent were scheduled for a follow-up appointment to address the topic.¹¹ If prevention and management of smoking are to become part of mainstream medicine, medical students and staff must be educated and trained in the necessary skills to enable them to treat tobacco addiction in their patients.¹⁰

Implementing the FCTC

Article 14 of the FCTC calls on countries to “promote cessation of tobacco use and adequate treatment for tobacco dependence.” Given the diversity of countries’ economic situations, regulatory regimes and health care systems, the effort to treat tobacco dependence requires a multi-faceted approach. Therefore, a tobacco control program should not only encourage tobacco users to quit but also provide assistance in doing so. Treatment services can be provided through health care providers, schools, government agencies and community organizations. These services can include:

- **Health education**, through tobacco product packaging, the media, schools, community groups and health care providers, should describe the health hazards of smoking and provide cessation strategies. A 2003 report from the World Health Organization concluded that “a supportive environment, which includes...an increase in information, will improve the likelihood of smokers quitting.”²
- **Counseling** is effective in helping smokers to quit. Intensive behavioral support by appropriately trained smoking cessation counselors is the most effective non-pharmacological intervention for smokers who are strongly motivated to quit.¹² The U.S. Centers for Disease Control and Prevention recommends identification of and advice to smokers, provision of brief counseling and full range of treatment services including pharmaceutical aids, intensive behavioral counseling and follow up visits for cessation.¹³ Among services recommended by the U.S. Preventive Services Task Force, tobacco cessation counseling is ranked in the highest priority category, with the lowest usage rate.³ To date counseling has not been utilized to maximum effect.
 - Many **Maternal and Child Health Clinics** provide successful smoking cessation programs. Pregnancy is an appropriate time to achieve smoking cessation and successful interventions produce clear, short term and cost effective benefits.¹⁴ Pregnancy also offers multiple windows of opportunity for smoking cessation intervention.¹⁵ The most effective interventions are done during routine pre-natal visits. Using messages and self-help materials tailored for pregnant smokers substantially increases abstinence rates during pregnancy.¹⁶ Successful interventions for post-partum cessation initiated toward the end of the pregnancy shift motivation from protecting the pregnancy to protecting the woman’s post-partum health and to the ultimate goal of creating a smoke-free family.¹⁵
- Governments can require tobacco companies to prominently present **cessation-oriented messages on all cigarette packages** and at points-of-sale. These messages could include telephone numbers of “quit-lines” which smokers can call for advice about quitting. An analysis in the United States revealed quit-line counseling increased smokers' chances of long-term abstinence by about 30%.¹¹ Because they can be designed with few barriers to their use (i.e., availability in many languages, extended hours of operation, no transportation requirements), quit-lines have potential to reach a wide range of smokers in countries which have adequate telephone services.
- Governments can “**level the regulatory playing field**” between tobacco products and pharmaceutical nicotine products. In most countries, tobacco products are largely unregulated while products that help people quit are classified as pharmaceuticals and are strictly regulated. In the words of the World Health Organization, it is important “to ensure that the future market for nicotine does not continue to be dominated by the most contaminated product, the cigarette.”¹⁷
- Governments must provide **protection from secondhand smoke**. Laws requiring smoke-free workplaces and public places, including public transit, health care institutions, education and sports facilities, restaurants and bars, motivate and reinforce attempts at quitting.

In countries where **publicly funded health insurance** exists, consideration should be given to making evidence-based tobacco dependence treatments reimbursable. Lack of insurance coverage and lack of access and availability serve as barriers to the use of these treatments. Each country has to weigh costs versus benefits, but in some cases extending tobacco treatment insurance coverage to all would be a positive step. If available, insurance coverage increases the likelihood that smokers will use intensive services.¹⁸

- Although they can be costly and are not available in all parts of the world, **pharmacological aids** such as nicotine replacement therapy (NRT), including nicotine gum, inhaler, nasal spray, lozenge and patch, as well as non-nicotine-based stop-smoking medications such as bupropion and varenicline, can be utilized to assist tobacco users to quit. NRT delivers low doses of nicotine without delivering the many other harmful substances found in tobacco smoke and can significantly increase the success rate of other cessation efforts.⁴

In summary, the most effective approaches to promote cessation of smoking and other tobacco use incorporate both treatment services for the individual tobacco user and population-level policy interventions that encourage tobacco users to quit. These population-level approaches include increases in the price of tobacco products, comprehensive laws requiring smoke-free workplaces and public places, programs to educate the public about the harms associated with tobacco use and the benefits of quitting, and health insurance reimbursement for tobacco cessation treatments.

Campaign for Tobacco-Free Kids

Resources on the Web:

WHO: Policy Recommendations for Smoking Cessation and Treatment of Tobacco Dependence: http://www.who.int/tobacco/resources/publications/tobacco_dependence/en/index.html

U.S. Department of Health and Human Services, Treating Tobacco Use and Dependence: A Clinical Practice Guideline, 2000 : www.surgeongeneral.gov/tobacco/default.htm

QuitNet - Resources to help tobacco users quit <http://www.quitnet.com/>

¹ World Health Organization. The World Health Report 2003 – Shaping the future [monograph on the Internet]. Geneva: World Health Organization; 2003. Available from: <http://www.who.int/whr/2003/en/>.

² World Health Organization. Policy Recommendations for Smoking Cessation and Treatment of Tobacco Dependence [monograph on the Internet]. Geneva: World Health Organization; 2003. Available from: http://www.who.int/tobacco/resources/publications/tobacco_dependence/en/.

³ Coffield AB, Maciosek MV, McGinnis JM, Harris JR, Caldwell MB, Teutsch SM. Priorities Among Recommended Clinical Preventive Services. American Journal of Preventive Medicine. 2001; 21(1):1-9.

⁴ Pan American Health Organization (PAHO). Nicotine Addiction and Smoking Cessation. Policy Brief. 1999.

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- ⁵ Royal College of Physicians. Nicotine Addiction in Britain. London: Royal College of Physicians; 2000. Available from: <http://www.rcplondon.ac.uk/pubs/books/nicotine/>.
- ⁶ New South Wales Department of Health [page on the Internet]. North Sydney: New South Wales Department of Health; c2007 [updated 2005 Dec 15]. Tobacco Facts. Available from: <http://www.health.nsw.gov.au/public-health/health-promotion/tobacco/facts/>.
- ⁷ Office of Tobacco Control. Survey reveals 76% of Irish smokers want to quit. Press Release. 2003 Apr 3. Available from: <http://www.otc.ie/article.asp?article=49>.
- ⁸ International Union Against Cancer. Helping Smokers Stop: Ensuring Wide Availability of Smoking Cessation Interventions [page on the Internet]. Belfast: Ulster Cancer Foundation; 1993. Available from: http://www.globalink.org/tobacco/fact_sheets/09fact.htm.
- ⁹ New Zealand National Advisory Committee on Health and Disability. Guidelines for Smoking Cessation [monograph on the Internet]. Wellington: National Health Committee; 2002. Available from: http://www.nzgg.org.nz/guidelines/0025/Smoking_Cessation_full.pdf.
- ¹⁰ Roddy E, Rubin P, Britton J. A study of smoking and smoking cessation on the curricula of UK medical schools. Tobacco Control. 2004; 13(1):74-77.
- ¹¹ US Department of Health and Human Services. Treating Tobacco Use and Dependence: A Clinical Practice Guideline [monograph on the Internet]. Washington, DC: US Department of Health and Human Services Public Health Service; 2000. Available from: http://www.surgeongeneral.gov/tobacco/treating_tobacco_use.pdf.
- ¹² Coleman Tim. ABC of Smoking Cessation: Use of simple advice and behavioral support. British Medical Journal. 2004; 328:397-399. Available from: <http://www.bmj.com/cgi/content/full/328/7436/397>.
- ¹³ Pbert L, Ockene J, Ewy B, Leicher E, Warner D. Development of state wide tobacco treatment specialist training and certification programme for Massachusetts. Tobacco Control. 2000; 9(4):372-381.
- ¹⁴ Melvin C, Dolan-Mullen P, Windsor R, Whiteside H, Goldenberg R. Recommended cessation counseling for pregnant women who smoke: a review of the evidence. Tobacco Control. 2000; 9:iii80-iii84.
- ¹⁵ DiClemente C, Dolan-Mullan P, Windsor R. The process of pregnancy smoking cessation: implications for interventions. Tobacco Control. 2000; 9:iii16-iii21.
- ¹⁶ US Preventive Services Task Force. Counseling to Prevent Tobacco Use and Tobacco-Caused Disease: Recommendation Statement [monograph on the Internet]. Washington, DC: Agency for Healthcare Research and Quality, US Department of Health and Human Services; 2003. Available from: <http://www.ahrq.gov/clinic/3rduspstf/tobaccoun/tobcounrs.pdf>.
- ¹⁷ World Health Organization Scientific Advisory Committee on Tobacco Product Regulation (SACTob). SACTob Recommendation on Nicotine and the Regulation in Tobacco and non-Tobacco Products [monograph on the Internet]. Geneva: World Health Organization; 2003. Available from: <http://whqlibdoc.who.int/publications/2003/9241590920.pdf>.
- ¹⁸ Fiore M, Croyle RT, Curry SJ, Cutler CM, Davis RM, Gordon C, et al. Preventing 3 Million Premature Deaths and Helping 5 Million Smokers Quit: A National Action Plan for Tobacco Cessation. American Journal of Public Health. 2004; 94(2):205-210.