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ADDRESSING BARRIERS TO TOBACCO CESSATION

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ABSTRACT

Tobacco control research conceptualises smoking initiation not as a single event, but as a process that occurs through a series of stages. Despite the high prevalence of tobacco use among people with substance use disorders, tobacco dependence is often overlooked in addiction treatment programs. Barriers that contribute to the lack of attention given to this important problem include staff attitudes about and use of tobacco, lack of adequate staff training to address tobacco use, unfounded fears among treatment staff and administration regarding tobacco policies, and limited tobacco dependence treatment resources. Specific clinical, program, and system-level changes are recommended to fully address the problem of tobacco use among alcohol and other drug abuse patients.

KEYWORDS: Barriers, smoking, tobacco, tobacco cessation

INTRODUCTION

Tobacco smoking is one of the most significant public health problems worldwide[1]. If current consumption continues, estimates for the numbers of worldwide deaths attributable to smoking will reach ten million by 2020. The World Health Organisation estimates that globally over one billion people currently smoke tobacco[2]. Smoking contributes a large public health and medical burden to society. Tobacco smoking remains the single greatest cause of preventable illness and death worldwide[3]. Smoking tobacco has been identified as an important cause of various oral diseases and pathologies. It is one of the most important factors predisposing to pre-cancerous lesions and cancer of the oral cavity. It also increases the risk of periodontal diseases, complications after extractions, increased rates of implant failures, staining of teeth, dental restorations, prosthesis, loss of taste perception and halitosis[1]. Tobacco affects every organ of the body and contributes to a number of major modern-day diseases, not least of which, lung cancer and cardiovascular disease[2]. Within the health behaviour literature, factors that prevent an individual from undertaking health behaviour change have been referred to as barriers. Barriers are often conceptualised as either structural or individual psychosocial factors. Structural barriers include systems, organisations and the relationship between systems and individuals, for example, lack of accessible smoking cessation programmes. Individual barriers refer to the subjective experience of the individual, for example, physical addiction to nicotine.[4]

MISCONCEPTION OF QUITTING TOBACCO

Tobacco is a highly addictive drug, which makes quitting by older smokers especially difficult. Misinformation and misconceptions among older people can lead them to believe that quitting is unnecessary or impossibly difficult. Any older

smokers believe that smoking cessation in later life does not have any benefits and anti-smoking aids (such as nicotine-replacement patches) have risks attached.[5] Another common belief is that, because they have smoked for a long time, all the possible damage has already happened and so there would not be any benefit from quitting. Age is positively related to nicotine dependence and this could represent a significant barrier to cessation for older smokers. Numerous factors serve as either barriers or facilitators to smoking among older smokers. Cultural influences, including the social environment and attitudes of family, friends, and co-workers toward smoking within a cultural group may impact on smoking status and ongoing contact with smokers can help prevent older smokers from quitting[6].

ROLE OF HEALTH SECTOR AND TOBACCO CESSATION

Hospitals play an exemplary role in implementing smoke-free policies and enforcing them. There exist a substantial number of smokers who may be willing to stop smoking if adequate help and support is available. Although the legislation banned smoking in public places since 2004, the ban was not proven to be as effective[2]. Some research suggests that they do not seek smoking cessation support from doctors because of feelings of mistrust or because of previous negative experiences with doctors. Some therapists believe that smoking serves as an effective coping tool to deal with cravings for other substances such as heroin and cocaine[7]. Dental professionals are in an excellent position for delivering advice and counseling to smokers. According to the literature, the reported barriers to such activity include lack of time, resources, remuneration, training, and fear of damaging dentist-patient rapport[1] .In many countries, even though the majority of smokers want to stop smoking and many try to do so, they have difficulty succeeding[8].

BARRIERS FOR TOBACCO CESSATION

Five major themes were identified as barriers to the provision of smoking cessation services:

- Lack of time
- Patient not ready or unwilling to change
- Inadequate patient resources
- Inadequate clinician resources and skill
- Inadequate clinical skills in smoking cessation

Lack of Time

Limited time available during a patient encounter is a major barrier to the provision of cessation services. Most of our patient's walk-in having multiple problems. When we get into counseling with patients, it takes longer time. Time limitations sometimes interact with other barriers, such as language and culture thereby increasing the counseling time and involvement of a translator.

Patient's Unwillingness to Change

Engaging patients in cessation activities is difficult when patients are not ready to quit. The biggest barrier encountered from patient's side is they enjoy smoking. Many smokers believe that smoking cigarettes help them to relax. This perspective was consistent with the fact that clinicians often did not pursue cessation among their smoking patients until the smokers requested assistance in quitting.

Inadequate Patient Resources

The barriers include patient's income that can either be no income or low income. They have no health insurance and they are unable to purchase pharmacotherapy. On the other hand the cost of nicotine replacement still is less than the cost of a carton of cigarettes.

Inadequate Clinician Resources and Skill

Inadequate access to a number of resources needed to provide cessation services for the underserved, including pharmaceuticals for low-income patients and those without prescription drug coverage have been known. Among providers practicing in urban organizations that offered cessation services at a cessation specialty clinic, only specialty clinic providers had prescribing privileges for drugs to aid tobacco use cessation, which is perceived as a barrier.

Inadequate Clinical Skills in Smoking Cessation

Staff members in addiction treatment settings often receive little or no training in treating tobacco dependence. At the social and community level, a lack of support to quit from health professionals and other service providers was identified.[9]

METHODS OF SMOKING CESSATION

Over the past 10 years, many addiction treatment agencies have begun to better address tobacco dependence and have benefited from program-level interventions. Education and other motivational enhancement interventions can help less motivated patients to incrementally increase their commitment to quit. Motivated patients can aim for tobacco abstinence and be effectively treated when psychosocial and medication treatments are blended into the "treatment as usual."

Psychosocial Interventions for Smoking Cessation:

Smoking cessation using telephone supports have suggested that continuous personal contact improve cessation rate. Continuous telephone counseling is more effective than less intense interventions such as educational self-help materials only.[10]

Pharmacological Methods of Smoking Cessation:

The pronounced withdrawal symptoms and tobacco craving that occur on trying to quit smoking may be offset by various pharmacological therapies summarized as below.

- **Nicotine replacement therapy (NRT):** Nicotine replacement therapy has been shown to be effective and should be available in all smoking cessation programs. NRT is available as nicotine patches in various dosages (absorbed slowly through the skin), and as chewing gums, lozenges, sublingual tablets, sprays and inhalers (absorbed through the oral or nasal mucosa).
- **Bupropion:** This was developed as a non-tricyclic antidepressant. The usual dose for smoking cessation is 150 mg once a day for three days increasing to 150 mg twice a day, continued for 7 to 12 weeks.
- **Nortriptyline:** This is a tricyclic antidepressant. The recommended regimen is a period of titration (10 - 28 days) before the quit attempt, and a 12-week therapeutic dose of 75 to 100 mg daily.
- **Varenicline:** This is a selective nicotinic receptor partial agonist. The standard regimen is 1 mg twice a day for 12 weeks. Varenicline has emerged as one of the most effective drugs in promoting smoking cessation.
- **Cystisine:** This is pharmacologically similar to varenicline. The standard regimen is a 25-day course, gradually reducing from six 1.5 mg tablets a day to two tablets a day by the end of the treatment period.[11]

CURRENT RECOMMENDATIONS FOR SMOKING CESSATION

Agency for Health Care Policy and Research produced a comprehensive monograph on smoking cessation, which emphasizes the value of smoking cessation intervention by healthcare professionals and outlines methods found to be of value:

1. Every person who smokes should be counseled on smoking on every visit to the physician's office. Maintenance of cessation should be frequently discussed with patients who have quit.

2. Every patient should be asked about tobacco use; smoking status should be recorded and updated at regular intervals.

3. Cessation interventions as brief as 3 minutes are effective, with more intensive intervention being more effective.

4. Clinicians should receive training in patient-centered counseling methods.

5. Office systems that facilitate delivery of smoking cessation intervention should be

established.

6. Links with other personnel and organizations should be established to provide smoking cessation intervention (nurses, smoking cessation specialists, multiple risk factor intervention programs.[12]

CONCLUSION

Tobacco dependence is one of the most common substance use disorders and a leading cause of morbidity and mortality in addiction treatment programs. Despite the existence of effective, evidence-based nicotine dependence treatments, tobacco dependence is commonly ignored. The provision of advice alone significantly increases the smoking cessation rate, and even minimal counseling yields a further benefit. Intervention with patients who have already suffered a cardiac event yields particularly striking benefits. Presence of barriers to smoking cessation across all components of a patient's life, including individual and social barriers, government and workplace intent and access to physician counseling make it very difficult for a patient to quit smoking permanently, leading to relapses. Therefore, any comprehensive smoking cessation program should be multicomponent and try to target as many as those barriers.

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