Call to action: Training in tobacco addiction in Canada

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Tobacco addiction is responsible for >37,000 deaths and economic costs of $17 billion in Canada (1), and continues to be the most preventable cause of morbidity and mortality in this country. Given the 7000 chemicals and 60 known carcinogens present in tobacco smoke, the secondary impact on individuals exposed to second- and third-hand smoke can be substantial. While the negative consequences associated with tobacco use are well documented and appear on every cigarette package in Canada with a link to a telephone quit line, approximately 15% to 20% of Canadians continue to smoke, on average, one cigarette per waking hour, with most smokers having made no serious quit attempt in the previous year. Consequently, achieving smoking cessation for these individuals presents a substantial challenge for health care practitioners. In addition to policy interventions such as smoke-free spaces, taxation and advertising bans, clinical interventions are also effective in addressing this endemic addiction. Pursuing assistance for cessation is imperative because a minimum of one tobacco-related death is prevented for every two smokers who quit using tobacco products (2).

Smokers often have repeated contact with a variety of health care practitioners in primary, secondary and tertiary settings. Smokers expect and want health care practitioners to treat their tobacco addiction (3). Clinical practice guidelines suggest that the combination of counselling with evidence-based pharmacotherapy (monotherapy with nicotine replacement therapy [NRT], bupropion slow release, or varenicline or combination therapy of two forms of NRT, bupropion and NRT or varenicline and, in some cases, NRT and varenicline) can achieve long-term cessation in up to 30% of smokers who make a quit attempt. Counselling can be as brief as several minutes and can be delivered by a variety of health care practitioners (4-7). The findings of two Cochrane meta-analyses revealed that counselling from physicians has increased cessation rates by 66% (4), while advice from nurses has enhanced quit rates by 29% (5). More intensive interventions that have included behavioural counselling and NRT are also effective, and can be provided to patients depending on available resources (6). Health care practitioners have also reported success in aiding hospitalized patients in their cessation efforts. Hospitals represent an ideal setting for health care practitioners to implement smoking cessation interventions because these facilities are smoke- or tobacco-free (8). Such institutions can enable smokers to concentrate on achieving cessation without the presence of external stimuli, which may interfere with the success of their cessation attempt (8). Consequently, health care practitioners could experience fewer obstacles and encounter more receptive smokers in hospital settings. While hospitalized patients can successfully obtain tobacco cessation, practitioner-based counselling interventions will need to incoporate supplementary follow-up contact for a minimum of one month following patient discharge (8).

Unfortunately, achieving competence in treating tobacco addiction in undergraduate and graduate health care practitioner training falls short due to a variety of issues, leaving a workforce unable and sometimes unwilling to intervene effectively and consistently with tobacco-addicted patients. Training practitioners is an effective strategy for improving smoking cessation rates (9). However, effectively integrating cessation strategies in usual clinical practices without introducing onerous tasks and challenges to staff represents a substantial concern for health care practitioners (5,8). Barriers include the expense, time and effort involved in dissemination, the practitioner's beliefs, confidence and familiarity with resources (10), and the lack of organization and system support for interventions (9). It is critical that practitioners accept the responsibility for providing smoking cessation counselling to patients, are confident in their abilities to deliver cessation strategies, and are proficient in referring patients to additional and appropriate cessation resources (10). Collectively, it is necessary to engage practitioners in comprehensive tobacco cessation training programs that can help them achieve these competencies that are not possible in short 1 h training opportunities alone. Inconsistencies among health care practitioners in delivering smoking cessation counselling to patients (10) further strengthens the case for providing standardized tobacco cessation training across various disciplines of the health care system. Through ongoing professional development, health professionals will not only become knowledgeable in the fundamentals of tobacco cessation strategies and community-based resources, they can also acquire a sense of their role in facilitating smoking cessation. Furthermore, providing training to health care practitioners may alleviate anxiety and enable them to feel more confident in delivering cessation counselling (9). Education efforts directed toward health care practitioners should consider adopting the '5 A's' smoking cessation framework for both brief and intensive interventions. The 5 A's model involves: asking patients about their recent use of tobacco products; advising patients to stop smoking completely either abruptly or gradually; assessing patient's motivational readiness for cessation; assisting patients during their cessation attempts; and arranging follow-up sessions with practitioners. This 5 A's model represents an approach that is simple, brief and, most importantly, effective in aiding smokers to quit using tobacco products. In some situations, screening and treating is also proving to be effective in very busy clinics.

In Canada, there have been investments in developing trainers and educators, notably in Ontario, Quebec, British Columbia, Alberta and, to a lesser extent, in other jurisdictions, to create a force-multiplier effect. These practice leaders, also known as 'champions', train others in cessation and are also involved in policy change and advocacy such as tobacco-free spaces, creation of medical directives and program development, to name a few. These agents for change are critical to ensure that staff are supported to help overcome practitioner barriers and build the necessary capacity in any health system to identify and treat patients with tobacco addiction. An example of such a program is the Training Enhancement in Applied Cessation Counselling and Health (TEACH) Project. TEACH is an internationally recognized

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knowledge translation program designed with the purpose of bridging the research practice gap and thereby enhancing the capacity to implement intensive smoking cessation counselling among practitioners. More recently, the Certified Tobacco Educator certification was launched by the Canadian Network for Respiratory Care (CNRC) to recognize practitioners in Canada who provide smoking cessation and prevention services. This advance is a major milestone in setting standards for evidence-based care delivery to smokers in Canada. There are several education programs across the country that are recognized by the CNRC for this certificate. The names of these programs can be found at www.cnrchome.net.

In summary, while health care practitioners possess the opportunity to encourage, counsel and provide smokers with the necessary resources to facilitate cessation (4,6,9), many practitioners do not offer such services (10). Misperceptions of their role, lack of confidence and being unaware of external resources may influence the ability of practitioners to provide effective smoking cessation counselling (10). Training and ongoing coaching in smoking cessation counselling across various disciplines of the health care system is necessary and long overdue. Adequate and appropriate smoking cessation training by practice leaders in a practical manner is one of the best evidence-based ways to enhance the competence of practitioners to improve cessation rates among their patients. High-quality training programs now exist across the country. The return on investment for society is substantial and needs to be a mainstream activity in all health care settings. The opportunities to implement counselling within practitioner practices have never been better.

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REFERENCES

1. Rehm J, Gnam W, Popova S, et al. The costs of alcohol, illegal drugs, and tobacco in Canada, 2002. J Stud Alcohol Drugs 2007;68:886-95.
2. Lam TH. Absolute risk of tobacco deaths: One in two smokers will be killed by smoking: Comment on "Smoking and all-cause mortality in older people". Arch Intern Med 2012;172:845-6.
3. Ulbricht S, Klein G, Haug S, et al. Smokers' expectations toward the engagement of their general practitioner in discussing lifestyle behaviors. J Health Commun 2011;16:135-47.
4. Stead LF, Buitrago D, Preciado N, Sanchez G, Hartmann-Boyce J, Lancaster T. Physician advice for smoking cessation. Cochrane Database Syst Rev 2013;5:CD000165.
5. Rice VH, Hartmann-Boyce J, Stead LF. Nursing interventions for smoking cessation. Cochrane Database Syst Rev 2013;8:CD001188.
6. Mdege ND, Chindove S. Effectiveness of tobacco use cessation interventions delivered by pharmacy personnel: A systematic review. Res Social Adm Pharm 2014;10:21-44.
7. Brothwell DJ. Should the use of smoking cessation products be promoted by dental offices? An evidence-based report. J Can Dent Assoc 2001;67:149-55.
8. Rigotti NA, Clair C, Munafo MR, Stead LF. Interventions for smoking cessation in hospitalised patients. Cochrane Database Syst Rev 2012;5:CD001837.
9. Carson KV, Verbiest ME, Crone MR, et al. Training health professionals in smoking cessation. Cochrane Database Syst Rev 2012;5:CD000214.
10. Tremblay M, Cournoyer D, O'Loughlin J. Do the correlates of smoking cessation counseling differ across health professional groups? Nicotine Tob Res 2009;11:1330-8.