Guest Editorial

Kim Hamlett-Berry, PhD

Smoking Cessation Treatment: How Do We Improve Our Reach?

On January 11, 1964, Dr. Luther Terry issued the first U.S. Surgeon General report that outlined the health consequences of smoking.[1] At the time, the prevalence of smoking among adults in the United States was 42.4%, and there were few—if any—effective treatments available to help people quit smoking. Terry chose a Sunday to issue the report to minimize any potential adverse effects on the stock market and to increase the coverage of the report in Sunday newspapers. The report's conclusions, which were based on a review of over 7,000 scientific documents, raised national awareness of the increased risks of lung cancer, emphysema, and cardiovascular disease associated with smoking. Since the addictive nature of nicotine was not yet well understood, however, the report did not classify smoking as an addiction but rather as a "habit."[1]

Today, smoking is widely recognized to be a chronic, addictive disorder with a high potential for relapse. A number of effective, evidence-based smoking cessation treatments (both behavioral and pharmacologic) are now available,[2] and access to these treatments is expanding. All 50 states now have telephone quitlines that offer free counseling, and there is increased coverage of smoking cessation treatments by Medicare and private insurers. Additionally, population-level tobacco control policies, such as cigarette tax increases and smoke-free bans, are being implemented more broadly.

Dr. Hamlett-Berry is the director of the Office of Public Health Policy and Prevention at the VHA Public Health Strategic Health Care Group, Washington, DC.

In 2006, the prevalence of smoking among U.S. adults was 20.8%.[3] While this figure represents a dramatic decrease from the national prevalence in 1964, it has not changed significantly since 2004, which suggests that the steady decrease in smoking seen during the previous seven years has slowed.[3] Smoking continues to be the leading cause of preventable death and disease, accounting for approximately 440,000 deaths in the United States each year.[4] Smoking cessation treatment—in the form of combined counseling and pharmacotherapy—has been described as the gold standard of cost-effective preventive medicine interventions, but many smokers still do not receive assistance in quitting from their health care providers.

Since multiple interventions and quit attempts often are required before individuals attain abstinence from smoking, it may well take some time before the full impact of population-based tobacco control measures are known. There is evidence, however, that these approaches can be effective in reducing the prevalence of smoking. In 2002, the New York City Department of Health and Mental Hygiene implemented a multicomponent tobacco control strategy that included increased taxation of cigarettes, smoke-free workplaces and public spaces, increased access to cessation, and an extensive media campaign with graphic messages about the health effects of smoking. Since then, the prevalence of smoking among New York City residents has declined steadily from 21.6% to 17.5% in 2006 (a 19% decrease).[5]

It is critical that we expand and promote population-level interventions at the community, state, and national level if we want to address effectively the problems associated with smoking and tobacco use. But we also need to keep in mind those populations of smokers who we may be leaving behind. As population-based approaches continue to broaden, what will the remaining population of smokers look like in 10 years? Which smokers still have not been reached through these approaches and still find it difficult or nearly impossible to quit? What will be needed to increase the reach and effectiveness of smoking cessation interventions?

> ***We...need to keep in mind those populations of smokers who we may be leaving behind.***

In a 1996 article published in the journal *Addiction*, Dr. John R. Hughes argued that the shifting population of smokers would be an essential component shaping future smoking cessation interventions.[6] Hughes found a lesser decline in the prevalence of smoking among people who were less educated, were poor, or had psychiatric illnesses, compared with other populations.[6] This trend per-

Continued on page 15

Continued from page 12

sists more than a decade later, as the high prevalence of smoking among individuals with psychiatric disorders continues to be well documented.[7,8] Moreover, a 2006 CDC report found that the prevalence of tobacco use has remained high among U.S. adults who earned a General Education Development (GED) diploma (46%), those who completed only nine to 11 years of school (35.4%), and those living below the federal poverty level (30.6%).[3]

Hughes has suggested that, in addition to considering psychological, psychiatric, or behavioral factors in our definition of comorbidity, we also should include broader challenges, such as poverty, single parenthood, unemployment, and other chronic stressors that epidemiologic studies have found to be strongly related to increased initiation of smoking and decreased cessation.[9,10] In 2005, 46.6 million—or 15.9%—of all Americans were without health insurance,[11] meaning that increased coverage of smoking cessation was of little or no benefit to them. What is needed to extend access to evidence-based cessation treatments to these populations? What tobacco cessation or health marketing messages will be as effective in reaching them as the tobacco industry messages that contributed to initiation of use?

While smoke-free bans in the workplace have been very effective and are increasing nationally, significant occupational disparities remain with regard to the reach of these policies. In fact, the workers who may be missed by these policies are some of those who smoke at the highest rates. For example, the prevalence of smoking has declined significantly among white-collar workers while remaining higher among blue-collar workers. In 1978, blue-collar workers were 38% more likely to smoke than white-collar workers, but by 1997, they were 75% more likely to do so. At the same time, blue-collar workers are more likely to work in settings that are not smoke free and less likely to have access to smoking cessation programs through health insurance or workplace health promotion programs.[12–15]

There is a pressing need to address these disparities and increase access to effective smoking cessation interventions for the populations of smokers who either have yet to be reached through existing population-based approaches or have comorbidities that may make cessation more difficult. Research is needed to identify and develop models of care that will integrate these interventions into existing community or workplace settings that are currently part of their everyday lives, as opposed to models that would refer them out to other agencies. New and innovative delivery models to prevent smoking initiation through effective, meaningful messages about the health effects of smoking and secondhand smoke and about the availability of effective treatment are needed to address existing barriers to at-risk populations. There have been remarkable advances in smoking cessation treatment and tobacco control since 1964. As we continue to build on this success, it will be important to make sure that we don't leave some of the most vulnerable smokers behind. ●

Author disclosures

The author reports no actual or potential conflicts of interest with regard to this editorial.

Disclaimer

The opinions expressed herein are those of the author and do not necessarily reflect those of Federal Practitioner, *Quadrant HealthCom Inc., the U.S. government, or any of its agencies. This article may discuss unlabeled or investigational use of certain drugs. Please review complete prescribing information for specific drugs or drug combinations—including indications, contraindications, warnings, and adverse effects—before administering pharmacologic therapy to patients.*

REFERENCES

1. National Library of Medicine. The Reports of the Surgeon General: The 1964 report on smoking and health. http://profiles.nlm.nih.gov/NN/Views/Exhibit/narrative/smoking.html. Accessed October 21, 2008.
2. Fiore MC, Jaen CR, Baker TB, et al. *Clinical Practice Guideline—Treating Tobacco Use and Dependence: 2008 Update*. Rockville, MD: US Dept of Health and Human Services, Public Health Service; May 2008. http://www.surgeongeneral.gov/tobacco/treating_tobacco_use08.pdf. Accessed October 23, 2008.
3. Centers for Disease Control and Prevention. Cigarette smoking among adults—United States, 2006. *MMWR Morb Mortal Wkly Rep*. 2007;56(44):1157–1161.
4. Centers for Disease Control and Prevention, Coordinating Center for Health Promotion. *Targeting Tobacco Use—The Nation's Leading Cause of Preventable Death, 2008*. Atlanta, GA: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. http://www.cdc.gov/nccdphp/publications/aag/osh.htm. Updated March 11, 2008. Accessed October 21, 2008.
5. Centers for Disease Control and Prevention. Decline in smoking prevalence—New York City, 2002–2006. *MMWR Morb Mortal Wkly Rep*. 2007;56(24):604–608.
6. Hughes JR. The future of smoking cessation in the United States. *Addiction*. 1996;91(12):1797–1802.
7. el-Geubaly N, Cathcart J, Currie S, Brown D, Gloster S. Smoking cessation approaches for persons with mental illness or addictive disorders. *Psychiatr Serv*. 2002;53(9):1166–1170.
8. Grant BF, Hasin DS, Chou SP, Stinson FS, Dawson DA. Nicotine dependence and psychiatric disorders in the United States: Results from the National Epidemiologic Survey on Alcohol and Related Conditions. *Arch Gen Psychiatry*. 2004;61(11):1107–1115.
9. Flint AJ, Novonty TE. Poverty status and cigarette smoking prevalence and cessation in the United States, 1983–1993: The independent risk of being poor. *Tob Control*. 1997;6(1):14–18.
10. Hughes JR. Comorbidity and smoking. *Nicotine Tob Res*. 1999;1(suppl 2):S149–S152.
11. DeNavas-Walt C, Proctor BD, Lee CH. *Income, Poverty, and Health Insurance Coverage in the United States: 2005*. Washington, DC: US Census Bureau; August 2006. Current Populations Reports P60-231. http://www.census.gov/prod/2006pubs/p60-231.pdf. Accessed October 23, 2008.
12. Holman CD, Corti B, Donovan RJ, Jalleh G. Social health: Association of the health-promoting workplace with trade unionism and other industrial factors. *Am J Health Promot*. 1998;12(5):325–334.
13. Morris WR, Conrad KM, Marcantonio RJ, Marks BA, Ribisl KA. Do blue-collar workers perceive the worksite health climate differently than white-collar workers? *Am J Health Promot*. 1999;13(6):319–324.
14. Howard J. Smoking is an occupational hazard. *Am J Ind Med*. 2004;46(2):161–169.
15. Barbeau EM, McLellan D, Levenstein C, DeLaurier GF, Kelder G, Sorenson G. Reducing occupation-based disparities related to tobacco: Roles for occupational health and organized labor. *Am J Ind Med*. 2004;46(2):170–179.