

# Barriers and supportive factors in certified tobacco cessation counselors in Sweden

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## Dear Editor,

In 2005, Sweden ratified the WHO Framework Convention on Tobacco Control (FCTC). Article 14 highlights the importance of tobacco cessation. In 2005, a national standard for certification of tobacco cessation practitioners was adopted in Sweden and six years later a similar standard, the Gold Standard Program (GSP) was introduced. In 2018 there were 18 approved education centers in Sweden and one GSP-training program.

Results from Swedish and Danish cessation counselors have shown optimistic results regarding tobacco quit rates<sup>1,2</sup>. Others have identified barriers for tobacco cessation in various health-care personnel, including a shortage of tobacco cessation experts to refer the patient to<sup>3</sup>, as well as perceived lack of time for counseling<sup>4</sup> and training in tobacco cessation<sup>5</sup>. To our knowledge, no previous study has explored the characteristics of Swedish tobacco cessation counselors.

An electronic survey was distributed in April 2018 to those who had been certified from 2006 to April 2018 (n=902). The survey involved multiple-choice questions regarding sex, education, current employment, working conditions, and time spent on smoking cessation. The survey was anonymous, and did not involve any patients or sensitive material.

There were 586 (65%) responders. As shown in Table 1, the overwhelming majority (93.9%) were women. The dominating occupation was nurse/midwife and 76% stated being active in tobacco cessation. The majority of respondents (75.5%) reported that they spent 0.5–2 hours per week on tobacco cessation and considered the overall possibilities to conduct tobacco cessation as ‘moderate’. Most responders saw 0–2 new patients per month in predominantly individual sessions.

The replies to questions dealing with various aspects of support in the work place ranged from moderate to very good for different variables. Although little time was spent on tobacco cessation, the possibilities to spend time on tobacco cessation was stated as moderate by 39% of the respondents; thus, there seems to be no major hindering factor for conducting tobacco cessation, as opposed to what has been reported<sup>4</sup>.

In contrast to what has been reported from the tobacco cessation database in Denmark, where most tobacco cessation was conducted in a group setting<sup>2</sup> according to the GSP program, our respondents reported mostly individual cessation sessions. When stratifying by type of cessation education, all those with solely GSP education (n=36) reported individual cessation sessions, even though group-based interventions are more cost-effective than individual consultations<sup>6</sup>. A reason for the dominance of individual cessation sessions could be a low inflow of patients from primary care, possibly due to the deprioritizing of smoking-related diseases such as chronic obstructive pulmonary disorder<sup>7</sup>.

Our results show that most consultations with Swedish cessation counselors are

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on an individual basis. We also found that little time is spent on tobacco cessation, despite that more than 50% consider their 'overall possibilities to conduct tobacco cessation' as moderate. Further studies are warranted to examine the reasons behind the short time spent on tobacco cessation and how more patients in need could benefit from this treatment.

**Table 1. Characteristics of tobacco cessation counselors (Total N=586)**

Characteristics	n (%)
<b>Sex (n=586)</b>	
Male	36 (6.1)
Female	550 (93.9)
<b>Education (n=586)</b>	
Nurse, midwife	415 (70.8)
Psychologist	1 (0.2)
Dental hygienist	31 (5.3)
Dentist	0 (0)
Public health practitioner	23 (3.9)
Physician	2 (0.3)
Other	114 (19.5)
<b>Current position (n=584)</b>	
Nurse, midwife	386 (66.1)
Psychologist	1 (0.2)
Dental hygienist	31 (5.3)
Dentist	0 (0.0)
Mainly cessation counselor	36 (6.2)
Physician	2 (0.3)
Other	128 (21.9)
<b>Work place (n=585)</b>	
Primary care public	285 (48.6)
Primary care private	106 (18.1)
Hospital	85 (14.5)
Occupational health care	19 (3.2)
Other health care center	37 (6.3)
Other	53 (9.0)
<b>Type of cessation education (n=586)</b>	
Diploma D	486 (82.9)
GSP	36 (6.1)
Diploma D + GSP	18 (3.1)
Other	46 (7.8)
<b>Year of diploma training (n=586)</b>	
Before 2005	25 (4.3)
2005–2008	45 (7.7)
2009–2012	92 (15.7)
2013–2016	269 (45.9)
2017–2018	155 (26.5)
<b>Active in cessation (n=571)</b>	

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**Table 1. Continued**

Characteristics	n (%)
Yes, active	434 (76.0)
No demand	38 (6.7)
No, new job	48 (8.4)
No, service stopped	13 (2.2)
No, other reason	36 (6.3)
Retired	2 (0.3)
<b>Doctor's readiness to prescribe<sup>a</sup> (n=484)</b>	
Easy	354 (73.1)
Varies between different physicians	109 (22.5)
Resistance	21 (4.3)
<b>Hours per week spent on cessation (n=458)</b>	
0.5–2	346 (75.5)
2.5–5	74 (16.1)
5.5–10	18 (3.9)
>10.5	20 (4.4)
<b>New patients per month (n=462)</b>	
0–2	288 (62.3)
3–4	111 (24.0)
5–6	35 (7.6)
7–10	11 (2.4)
>10	17 (3.7)
<b>Group vs individual cessation (n=467)</b>	
Individual	435 (93.1)
Group	32 (6.9)
<b>Follow-up (n=468)</b>	
Face-to-face	208 (44.4)
Telephone	223 (47.6)
No system	14 (3.0)
Other	23 (4.9)
<b>Cessation in workplace (n=483)</b>	
I work alone	261 (54.0)
I work in a team	222 (46.0)
<b>Management of patient information (n=473)</b>	
Registering in the clinic's own system	450 (95.1)
Registering in own computerized system	11 (2.3)
Registering on paper	12 (2.5)
<b>Referral routines (n=452)</b>	
I get written referrals and replies	195 (43.1)

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Table 1. Continued

Characteristics	n (%)
No routines for referrals or replies	257 (56.9)
<b>Support from manager (n=558)</b>	
Very good	234 (41.9)
Moderate	215 (38.5)
Small/none	56 (10.0)
Bad	53 (9.5)
<b>Support from administrative personnel (n=554)</b>	
Very good	172 (31.0)
Moderate	227 (40.9)
Small/none	104 (18.8)
Bad	51 (9.2)
<b>Possibilities to affect work environment (n=558)</b>	
Very good	132 (23.7)
Moderate	243 (43.5)
Small/none	35 (6.3)
Bad	148 (26.5)
<b>Possibilities to spend time on cessation (n=551)</b>	
Very good	82 (14.9)
Moderate	215 (39.0)
Small/none	76 (13.8)
Bad	178 (32.3)
<b>Possibilities for continuing cessation education (n=553)</b>	

Continued

Table 1. Continued

Characteristics	n (%)
Very good	82 (14.8)
Moderate	254 (45.9)
Small/none	50 (9.0)
Bad	167 (30.2)
<b>Overall possibilities to conduct cessation (n=549)</b>	
Very good	117 (21.3)
Moderate	301 (54.8)
Small/none	36 (6.6)
Bad	95 (17.3)
<b>Knowledge about guidelines (n=518)</b>	
Yes, we adhere to guidelines	279 (53.9)
Known, but not always practiced	157 (30.3)
Known only by the cessationers	38 (7.3)
Mostly unknown	44 (8.5)
<b>Where do your patients come from? (n=471)</b>	
Many different caregivers (hospital, primary care, other)	137 (29.1)
Only or almost only from own caregiver	334 (70.9)
<b>Is it important for you that the survey is anonymous? (n=586)</b>	
No	230 (39.2)
Yes	166 (28.3)
No opinion	190 (32.4)

a Prescription of replacement therapy, varenicline and bupropion.

## REFERENCES

1. Helgason AR, Tomson T, Lund KE, Galanti R, Ahnve S, Gilljam H. Factors related to abstinence in a telephone helpline for smoking cessation. *European journal of public health*. 2004;14(3):306-310. doi:10.1093/eurpub/14.3.306
2. Rasmussen M, Fernandez E, Tonnesen H. Effectiveness of the Gold Standard Programme compared with other smoking cessation interventions in Denmark: a cohort study. *BMJ open*. 2017;7(2):e013553. doi:10.1136/bmjopen-2016-013553
3. Helgason AR, Lund KE. General practitioners' perceived barriers to smoking cessation—results from four Nordic countries. *Scandinavian journal of public health*. 2002;30(2):141-147. doi:10.1080/14034940210133799
4. Naughton F, Hopewell S, Sinclair L, McCaughan D, McKell J, Bauld L. Barriers and facilitators to smoking cessation in pregnancy and in the post-partum period: The health care professionals' perspective. *British journal of health psychology*. 2018;23(3):741-757. doi:10.1111/bjhp.12314
5. Abatemarco DJ, Steinberg MB, Delnevo CD. Midwives' knowledge, perceptions, beliefs, and practice supports regarding tobacco dependence treatment. *Journal of midwifery & women's health*. 2007;52(5):451-457. doi:10.1016/j.jmwh.2007.03.019
6. Bauld L, Chesterman J, Ferguson J, Judge K. A comparison of the effectiveness of group-based and pharmacy-led smoking cessation treatment in Glasgow. *Addiction*. 2009;104(2):308-316. doi:10.1111/j.1360-0443.2008.02446.x
7. Sandelowsky H, Hylander I, Krakau I, Modin S, Stallberg B, Nager A. Time pressured deprioritization of COPD in primary care: a qualitative study. *Scandinavian journal of primary health care*. 2016;34(1):55-65. doi:10.3109/02813432.2015.1132892

## CONFLICTS OF INTEREST

The authors have completed and submitted the ICMJE Form for Disclosure of Potential Conflicts of Interest and none was reported.

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