For Best Practices in Health
CDBPS-H
Pour des Bonnes Pratiques en Santé

World Tobacco Day 31 May 2016

"Get ready for plain packaging, to reduce demands, to save lives"

World No Tobacco Day (31 May) is organised by the World Health Organization to draw attention to the health risks associated with the use of tobacco and what can still be done to reduce tobacco consumption around the world.

"Plain packaging reduces the attractiveness of tobacco products. It kills the glamour, which is appropriate for a product that kills people," says WHO Director-General Dr Margaret Chan. "It restricts tobacco advertising and promotion. It limits misleading packaging and labelling. And it increases the effectiveness of health warnings."

In support of World No Tobacco Day 2016, The Centre for the Development of Best Practices in Health, is providing this highlight of relevant plain language summaries of Cochrane Systematic Reviews on behavioural, specific populations, lifestyle management, pharmacotherapy and technological interventions that address tobacco addiction.

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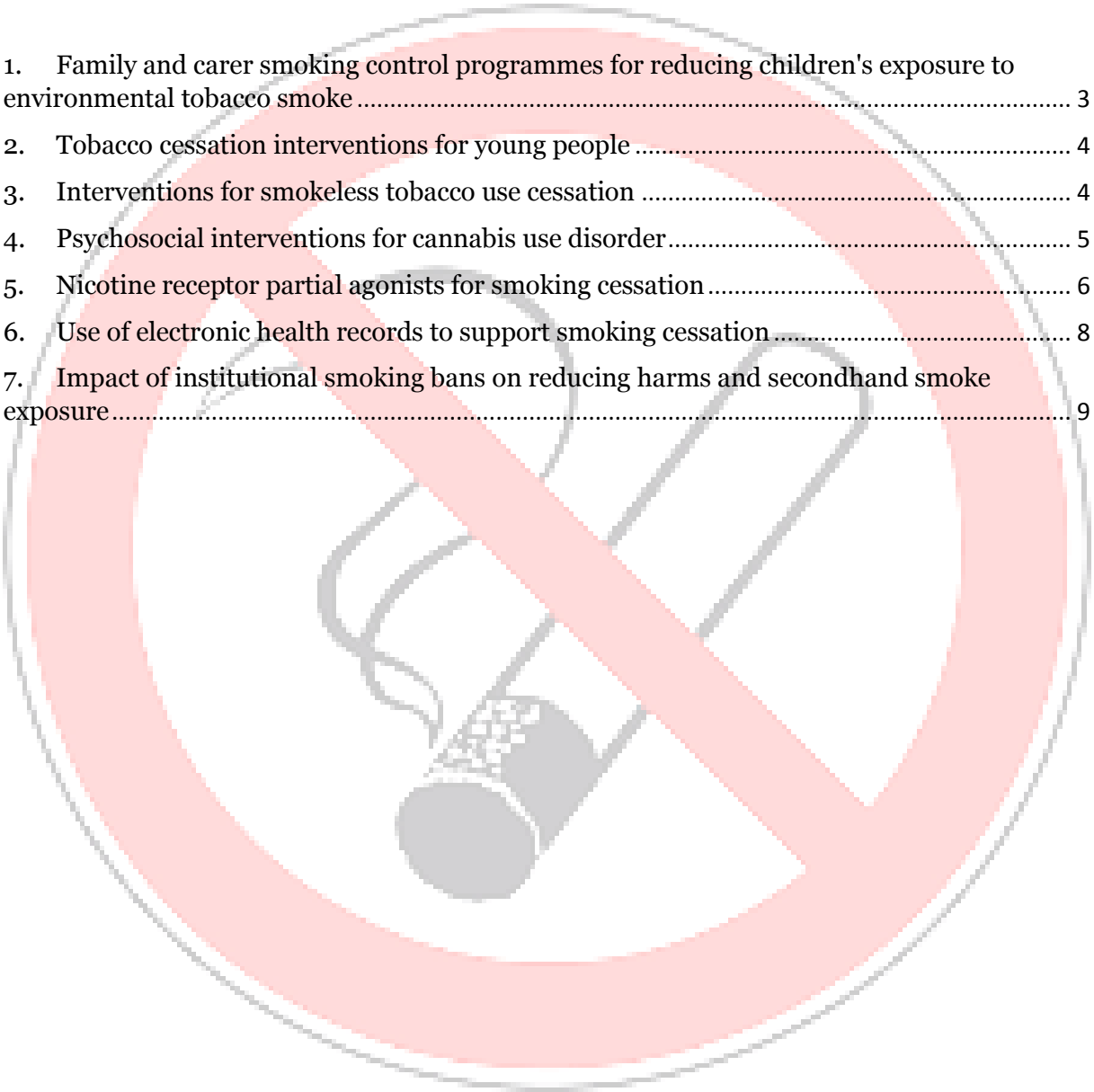

1. Family and carer smoking control programmes for reducing children's exposure to environmental tobacco smoke

Children exposed to cigarette smoke (environmental tobacco smoke) are at greater risk of lung problems, infections and serious complications including sudden infant death syndrome. Preventing exposure to cigarette smoke in infancy and childhood might therefore significantly improve children's health worldwide. Parental smoking is a common source of cigarette exposure for children. Older children are also at risk of exposure to cigarette smoke in child care or educational settings.

Objectives

To determine the effectiveness of interventions aiming to reduce exposure of children to tobacco smoke.

Methods

A review of the research on the effect of interventions aimed at family and caregivers to reduce children's exposure to tobacco smoke was undertaken by researchers in the Cochrane Collaboration. Family and caregivers were defined as parents and other family members, child care workers and teachers involved with the care and education of infants and young children (aged 0 to 12 years). We searched a number of databases for relevant research. This was an update of a previously undertaken review, and the date of the most recent search was September 2013. Two authors independently assessed the research studies and documented all the information needed.

Results

Fifty-seven studies of mixed quality were included in this review. Only 14 studies reported an intervention that was successful at reducing children's exposure to tobacco smoke. These studies used a range of interventions, including seven that used more intensive counselling methods or motivational interviewing. Of the 42 studies that did not show a significant reduction in child tobacco smoke exposure, 14 used more intensive counselling methods or motivational interviewing. One study did not aim to reduce children's tobacco smoke exposure, but reduce symptoms of asthma, and successfully reduced symptoms using motivational interviewing.

Authors' conclusions

Although several interventions, including parental education and counselling programmes, have been used to try to reduce children's tobacco smoke exposure, their effectiveness has not been clearly demonstrated. The review was unable to determine if any particular interventions reduced parental smoking and child smoke exposure more effectively than others, although seven studies were identified that reported intensive counselling or motivational interviewing provided in clinical settings was effective.

Citation: Baxi R, Sharma M, Roseby R, Polnay A, Priest N, Waters E, Spencer N, Webster P. **Family and carer smoking control programmes for reducing children's exposure to environmental tobacco smoke**. Cochrane Database of Systematic Reviews 2014, Issue 3. Art. No.: CD001746. DOI: 10.1002/14651858.CD001746.pub3.
http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD001746.pub3/epdf

2. Tobacco cessation interventions for young people

Worldwide, between 80,000 and 100,000 young people start smoking every day and up to one in four UK and American young people smoke. Many adolescent tobacco programmes focus on preventing teenagers from starting to smoke, but some programmes have been aimed at helping those teenagers already smoking to quit. We identified 28 studies of mixed quality (around 6000 participants) that researched ways of helping teenagers to quit. Programmes that combine a variety of approaches, including taking into account the young person's preparation for quitting, supporting behavioural change and enhancing motivation show promise. The number of trials and participants are beginning to be adequate to provide evidence to judge effectiveness. Medications such as nicotine replacement and bupropion have not yet been shown to be successful with adolescents, and some adverse events have been reported. Trials so far have had different definitions of quitting and many smaller trials did not have enough participants for us to be confident about wider application of the results. Some approaches may be worthy of consideration but there is still a need to provide better evidence before the likely success and costs of large scale service programmes can be estimated accurately.

Citation: Stanton A, Grimshaw G. **Tobacco cessation interventions for young people.** Cochrane Database of Systematic Reviews 2013, Issue 8. Art. No.: CD003289. DOI: 10.1002/14651858.CD003289.pub5.
http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD003289.pub5/epdf

3. Interventions for smokeless tobacco use cessation

Background

Smokeless tobacco is any product in which tobacco is held in the mouth so that nicotine is absorbed through the lining of the mouth. Smokeless tobacco is less dangerous than cigarettes and other products where tobacco is burnt and nicotine absorbed through the lungs. However, smokeless tobacco still leads to nicotine addiction and can be harmful, especially to the mouth. Many types of smokeless tobacco are used around the world, including chewing tobacco, snuff and snus. The risks to health vary with the type of product.

Methods

We reviewed the evidence from randomized trials about interventions to help people stop using smokeless tobacco, including nicotine replacement therapy, other pharmacotherapies and behavioural support. This evidence is current to June 2015. Trials had to report the number of participants who had stopped using smokeless tobacco or other products after six months.

Results

We found 34 relevant trials covering over 16,000 participants. All except one were conducted in the USA. Some studies in dental health clinics provided advice about oral health problems to smokeless tobacco users whether or not they were interested in stopping. Some studies recruited users who wanted to stop.

Sixteen trials with 3,722 participants tested pharmacotherapies. Twelve studies tested different types of nicotine replacement therapy (five gum, two patch, five lozenge). The evidence suggests that the nicotine lozenge might help people quit, but the quality of evidence was low and more research is needed. There was not enough evidence to be sure whether nicotine gum or patches could help. Two trials of varenicline (a medication that helps smokers to quit) suggested it can also help people quit using smokeless tobacco.Two small trials of bupropion (an antidepressant that helps smokers to quit) did not find that bupropion helped people quit using smokeless tobacco.

Seventeen trials with 12,394 participants tested behavioural support. The behavioural support could include brief advice, self-help materials, telephone support, access to a website, and combinations of elements. There was a lot of variation in results with some trials showing clear evidence of benefit and some not showing any effect. We could not be certain what the important elements of effective support were, but providing access to telephone support generally seemed to be helpful.

Citation: Ebbert JO, Elrashidi MY, Stead LF. **Interventions for smokeless tobacco use cessation.** Cochrane Database of Systematic Reviews 2015, Issue 10. Art. No.: CD004306. DOI: 10.1002/14651858.CD004306.pub5.
http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD004306.pub5/epdf

4. Psychosocial interventions for cannabis use disorder

Background

Cannabis use disorder is the most common illegal substance use disorder in the general population. Despite the large number of cannabis users seeking treatment, clinical trials conducted to explore the effectiveness of psychosocial interventions for cannabis use disorder are rare.

Study characteristics

Review authors included a total of 23 studies involving 4045 adult participants who used cannabis frequently. This review included participant groups made up of at least 70% daily or near daily users, or reported to have cannabis use disorder, or seeking treatment for cannabis use. Average age of participants was 28.2 years. Most participants were male (72.5% on average, excluding two trials that recruited only females). Most (15) studies were conducted in the USA, two in Germany, two in Australia and one each in Brazil, Canada, Switzerland and Ireland.

Studies compared seven different intervention types: cognitive-behavioural therapy (CBT), motivational intervention (MET), a combination of MET and CBT (MET + CBT), contingency management (CM), social support (SS), mindfulness-based meditation (MM) and drug education and counselling (DC).

Key findings

Similar to other illicit drug disorders, cannabis use disorder is not easily treated by psychosocial interventions provided in out-patient and community settings. CBT in individual and group sessions and MET in individual sessions were the most consistently explored treatments; they have demonstrated effectiveness over control conditions. In particular, psychosocial treatment was consistently effective over no treatment in reducing the frequency of cannabis use (with nine studies showing superior outcomes and four showing comparable outcomes), quantity used per

occasion (seven studies showing superior outcomes and two showing comparable outcomes) and severity of dependence (with seven studies showing superior outcomes and two showing comparable outcomes). In contrast, treatment was not likely to be more effective than no treatment in improving cannabis-related problems (with four studies showing superior outcomes and seven showing comparable outcomes), motivation to quit (with no studies showing superior outcomes and three showing comparable outcomes), other substance use (with no studies showing superior outcomes and seven showing comparable outcomes) or mental health (with no studies showing superior outcomes and five showing comparable outcomes). Comparison of studies reporting treatment gains was possible for a subset of studies with short-term follow-up of approximately four months. This analysis found that those receiving any intervention reported fewer days of cannabis use, used fewer joints per day and reported fewer symptoms of dependence and fewer cannabis-related problems. High-intensity interventions of more than four sessions and those delivered over longer than one month, particularly MET + CBT interventions, were most effective. In addition, interventions were completed as intended by most participants. Notably, three studies investigated the effectiveness of psychosocial intervention compared with treatment as usual delivered at psychiatric out-patient centres and reported little evidence of significant group differences in treatment outcomes. Finally, results from six studies, which included contingency management adjunct treatments, were mixed but suggested that improvements in cannabis use frequency and severity of dependence were likely when combined with CBT or with MET + CBT. Invesigators reported no adverse effects.

Quality of evidence

Evidence is current to July 2015. Two review authors (Le Foll and Copeland) received donations of nabiximols (Sativex) from GW Pharma, although no review authors received direct funding to complete this review. The quality of evidence among primary outcomes was very low to moderate and suffered, as no trial assessed all treatment outcomes of interest, and variability among included measures was great. In addition, assessment of other substance use, including tobacco use, or use of additional treatments during the trial period was scarce. Participant drop-out was also a concern; on average, more than 20% of participants across studies were lost at final follow-up, but most studies addressed attrition bias via appropriate analysis plans. In contrast, we found little evidence of selective reporting or selection bias.

Citation: Gates PJ, Sabioni P, Copeland J, Le Foll B, Gowing L. **Psychosocial interventions for cannabis use disorder**. *Cochrane Database of Systematic Reviews* 2016, Issue 5. Art. No.: CD005336. DOI: 10.1002/14651858.CD005336.pub4.
http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD005336.pub4/epdf

5. Nicotine receptor partial agonists for smoking cessation

Background

When people stop smoking they experience cravings to smoke and unpleasant mood changes. Nicotine receptor partial agonists aim to reduce these withdrawal symptoms and the pleasure people usually experience when they smoke. The most widely-available treatment in this drug type is varenicline, which is available world-wide as an aid for quitting smoking. Cytisine is a similar medication, but is only available in Central and Eastern European countries and through internet sales.

Study characteristics

We searched for randomised controlled trials testing varenicline, cytisine or dianicline. We found 39 studies of varenicline compared to placebo, bupropion or nicotine patches. We also found four trials of cytisine, one of which compared it to nicotine replacement therapy. We include one trial of dianicline, which is no longer in development, and so not available to use as a quitting aid. To be included, trials had to report quit rates at least six months from the start of treatment. We preferred the strictest available definition of quitting, and results which had been biochemically confirmed by testing blood or bodily fluids.We conducted full searches up to May 2015, although we have also included several key trials published after that date.

Key findings

From the information we found (27 trials, 12,625 people), varenicline at standard dose more than doubled the chances of quitting compared with placebo. Low-dose varenicline (four trials, 1266 people) roughly doubled the chances of quitting, and reduced the number and severity of side effects. The number of people stopping smoking with varenicline was higher than with bupropion (five trials, 5877 people) or with NRT (eight trials, 6264 people). Based on the evidence so far, we can calculate that varenicline delivers one extra successful quitter for every 11 people treated, compared with smokers trying to quit without varenicline.

The most common side effect of varenicline is nausea, but this is mostly at mild or moderate levels and usually clears over time. People taking varenicline appear to have about a 25% increased chance of a serious adverse event, although these include many which are unrelated to the treatment. We also note that more people were lost from the control groups than from the varenicline groups by the end of the trials, which may mean that the count of events in the control groups is lower than it should be. After varenicline became available to use, there were concerns that it could be linked with an increase in depressed mood, agitation, or suicidal thinking and behaviour in some smokers. However, the latest evidence does not support a link between varenicline and these disorders, although people with past or current psychiatric illness may be at slightly higher risk. There have also been concerns that varenicline may slightly increase heart and circulatory problems in people already at increased risk of these illnesses. The evidence is currently unclear whether or not they are caused or made worse by varenicline, but we should have clearer answers to these questions when a further study is published later this year.

Quality of the evidence

The varenicline studies were generally of high quality, providing evidence that we consider to be reliable and robust. We rate the quality of the evidence comparing varenicline with NRT as moderate quality (we are reasonably confident of the stability of the evidence), since in some of them the participants knew which treatment they were receiving (i.e. non-blinded open-label trials). We judge the evidence from the cytsine trials to be of low quality (we have limited confidence in the evidence), as there are only two trials, with relatively low numbers included.

Citation: Cahill K, Lindson-Hawley N, Thomas KH, Fanshawe TR, Lancaster T. **Nicotine receptor partial agonists for smoking cessation.** *Cochrane Database of Systematic Reviews* 2016, Issue 5. Art. No.: CD006103. DOI: 10.1002/14651858.CD006103.pub7.
http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD006103.pub7/epdf

6. Use of electronic health records to support smoking cessation

In many countries a large investment is being made in technology to computerize patient medical records. One potential of electronic health records (EHR) is that they could be used to remind doctors and other clinic staff to record tobacco use, to give brief advice to quit, to prescribe medications and to refer to stop smoking counselling. They could also help refer people to these services and be used to measure how well a clinic was doing. EHRs could also help make the delivery of tobacco use treatments standard practice by providing electronic referrals for additional treatment services (e.g., referral to a telephone tobacco quit line). We included 16 studies in this review, nine of which were observational studies so were lower quality than randomized controlled trials. Of the recommended actions for doctors with tobacco using patients we found only modest improvements associated with the EHR changes. Specifically, documentation of tobacco use and referral to cessation counselling appear to increase following EHR changes. However, these studies did not test for and/or demonstrate an increase in the number of people who quit smoking.

L'utilisation d'un dossier de santé électronique améliore-t-elle vraiment l'administration de traitements de sevrage tabagique aux patients ?

Dans de nombreux pays, un investissement important est fait en matière de technologie pour informatiser les dossiers médicaux des patients. Les dossiers de santé électroniques (DSE) ont, entre autre, la possibilité d'être utilisés pour rappeler aux médecins et autres personnels cliniques de recueillir des informations sur la consommation de tabac, de donner de brefs conseils de sevrage, de prescrire des médicaments et d'adresser à une consultation de sevrage tabagique. Ils pourraient aussi faciliter l'orientation vers ces consultations et les mesures de performance des établissements. Les DSE pourraient également contribuer à l'intégration des traitements du tabagisme dans la pratique courante, en permettant l'orientation électronique des patients vers des services supplémentaires (par exemple, une consultation téléphonique de sevrage tabagique). Nous avons inclus dans cette revue 16 études, dont neuf étaient des études d'observation et donc de moins bonne qualité que les essais contrôlés randomisés. Parmi les mesures recommandées aux médecins vis-à-vis de patients fumeurs, nous n'avons trouvé que de modestes améliorations associées à des changements liés aux DSE. Plus précisément, l'évaluation du tabagisme et l'orientation vers des consultations de sevrage semblent augmenter suite aux changements liés aux DSE. Cependant, ces études n'ont ni évalué ni démontré d'augmentation du nombre de personnes ayant arrêté de fumer.

Notes de traduction:Traduction réalisée par le Centre Cochrane Français
Citation: Boyle R, Solberg L, Fiore M**. Use of electronic health records to support smoking cessation**. Cochrane Database of Systematic Reviews 2014, Issue 12. Art. No.: CD008743. DOI: 10.1002/14651858.CD008743.pub3.
http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD008743.pub3/epdf

7. Impact of institutional smoking bans on reducing harms and secondhand smoke exposure

Since some countries banned smoking in public places in 2004, there has been a reduction in secondhand smoke exposure (being affected by smoke from other people's cigarettes), and health has improved for smokers and nonsmokers. Being exposed to secondhand smoke can increase the chances of illness and death, and so a number of international health organisations support the introduction of methods to reduce exposure to tobacco and secondhand smoke, including smoking bans.

Studies have shown that workplaces providing services to help smokers to stop smoking have been effective. Services can include providing nicotine replacement therapy (NRT) and counselling support to help smokers quit. However, it is not known if policies that stop people smoking in institutions are effective. Whilst smoking is banned in many public places, it is not banned in all of them. Smoking is allowed in some healthcare organisations, universities and prisons.

Study characteristics

We searched for studies that measured whether introducing a smoking policy or ban, in hospitals, universities or prisons, reduced secondhand smoke exposure and helped people to quit smoking. The study could be in any language. It had to report information on health and smoking before the policy or ban started and for at least six months afterwards. We have included 17 studies in this review. Twelve studies provide evidence from hospitals, three from prisons and two from universities. The evidence is up-to-date to June 2015.

Key results

We grouped together 11 of the included studies, involving 12,485 people, and found that banning smoking in hospitals and universities increased the number of smoking quit attempts and reduced the number of people smoking. In prisons, there was a reduction in the number of people who died from diseases related to smoking and a reduction in exposure to secondhand smoke after policies and bans were introduced, but there was no evidence of reduced smoking rates.

Quality of the evidence

We found no relevant high-quality studies to include in our review. Future high-quality research may lead to a change in these conclusions and it is not possible to draw firm conclusions from the current evidence. We need more research from larger studies to investigate smoking bans and policies in these important settings.

Citation: Frazer K, McHugh J, Callinan JE, Kelleher C. **Impact of institutional smoking bans on reducing harms and secondhand smoke exposure**. *Cochrane Database of Systematic Reviews* 2016, Issue 5. Art. No.: CD011856. DOI: 10.1002/14651858.CD011856.pub2.
http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD011856.pub2/epdf

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