



EUROPE

*European Partnership
to Reduce Tobacco Dependence*

*WHO
Evidence Based
Recommendations*

*on the Treatment
of Tobacco
Dependence*



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Contents

About these recommendations	2
Professional endorsement	3
Introduction	3
Terminology	3
Why these recommendations are timely	3
Purpose of these recommendations	4
Scientific basis and review process	4
Recommendations	5
1. Recommendations for brief interventions	5
2. Recommendations for smoking cessation specialists	5
3. Pharmacotherapies	6
4. Recommendations for specific groups	6
5. Recommendations for health care purchasers and systems	6
References	7

World Health Organization

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About these recommendations

These recommendations on treatment of tobacco dependence have been written by Martin Raw as an initiative of the WHO European Partnership Project to Reduce Tobacco Dependence. The recommendations were commissioned by the World Health Organization and have drawn on the experience of a number of European countries, including the four original target countries of the WHO European Partnership Project to Reduce Tobacco Dependence, France, Germany, Poland and the United Kingdom.

The recommendations were discussed in two European WHO meetings on evidence-based treatment in London in November 1999 and in Barcelona in October 2000. They were revised in light of feedback at and following those meetings, as well as feedback from a wide variety of individuals and organizations, including the professional associations that have endorsed them.

As these are evidence-based recommendations and this is a rapidly developing field, the recommendations will need periodic updating. Comments are thus welcome, as are organisations that would like to add their name to the list of endorsers.

It is recognised that individual countries will translate and adapt these recommendations to suit their own terminologies and healthcare systems, but it is hoped that throughout this process countries will stay as close as possible to the evidence base.

Professional endorsement

At the time of going to press the following organizations have endorsed these guidelines: European Medical Association on Smoking or Health, European Nurses and Midwives Against Tobacco, Europharm Forum, The European Review Group on Prevention and Health Promotion in Family Medicine and General Practice (EUROPREV), Society for Research on Nicotine and Tobacco (SRNT Europe), ASH England, ASH Scotland, British Medical Association, Comité Nacional de Prevención del Tabaquismo (Spain), Czech Medical Association, Danish Medical Association, Dentistry against Tobacco (Sweden), Georgian Medical Association, Norwegian Medical Association, Swedish Medical Association, Quit (UK), Slovenian Medical Association, World Self-Medication Industry.

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Terminology

Tobacco dependence treatment includes (singly or in combination) behavioural and pharmacological interventions such as brief advice and counselling, intensive support, and administration of pharmaceuticals, that contribute to reducing or overcoming tobacco dependence in individuals and in the population as a whole. A *smoking cessation specialist* is someone trained and paid to deliver skilled support to smokers who need help in stopping, over and above brief opportunistic advice. They need not be medically trained but should not be offering this support unpaid and squeezed into their normal work, as the evidence suggests this is not effective.

Why these recommendations are timely

Tobacco dependence is recognized as a condition in the WHO's International Classification of Diseases (ICD-10)¹ and the American Psychiatric Association's Diagnostic and Statistical Manual (DSM-IV)². In Europe millions of smokers want to stop smoking and many have tried to do so but have difficulty succeeding because tobacco use is such a powerful addiction³. Although the majority of cessation attempts are unaided, the success rate of these unaided attempts is low. Smoking is a chronically relapsing condition, and even in the general population of smokers trying to stop, the relapse rate is high. The natural population cessation rate, measured over a long period in one country where the tobacco control movement is long established, is only about 2% each year³.

Tobacco use is recognized as a major cause of lung cancer, cardio-vascular disease, and chronic obstructive lung disease (including bronchitis and emphysema) and causes 1,200,000 deaths each year in WHO's European region (14% of all deaths). Unless more is done to help the 200 million European adult smokers stop, the result will be 2,000,000 European deaths a year by 2020⁴.

Support and treatment to help smokers stop is one of a range of approaches to tobacco control. It is an issue not just for individual health professionals in their work with smokers, but for the entire health-care system. It complements other approaches (like policies to tax tobacco products, restrictions on their use and advertising, regulation of their contents and labelling, public information and education) but addresses a specific group: those who want to stop and need help⁵. However it is acknowledged that education remains crucially important in informing smokers about the dangers of smoking and motivating them to stop, and in many countries health education campaigns are conducted by the health care system. Furthermore, preventive approaches with young people, if effective, prevent disease 30-50 years in the future, whereas smoking cessation in current adult smokers brings population health gain more quickly, over 20 to 30 years.⁶

However, support and treatment to help smokers stop is not yet widely available. It is generally not integrated into European healthcare systems, although some countries are now making a start. Paradoxically, in contrast to the restricted availability of help for smokers in stopping (including pharmaceutical products designed to alleviate tobacco withdrawal), the tobacco products whose use causes the enormous burden of death and disease described above are extremely widely available.

Purpose of these recommendations

These recommendations propose the core interventions that should be integrated into healthcare systems, interventions that have been shown to work by a large and consistent international body of evidence. They are *deliberately* brief and general, rather than comprehensive, and detail should be sought from the reviews and guidelines they draw on (see below). This is because there is such a diversity of social and health-care systems throughout Europe, including different regulatory and pharmaceutical treatment product licensing regimes. We hope each country will use these core evidence based recommendations as a skeleton on which they will add their own country specific detail. Because the recommendations are brief, they

need to be read bearing in mind the context set out in this introduction. They also cover the roles of individual health professionals working to help and treat smokers as well as the roles of the wider healthcare system. This is important as public health impact will be a result not only of individual clinical effectiveness but also of coverage – hence the importance of engaging the entire system locally, nationally and internationally.

Scientific basis and review process

These recommendations reflect a global movement towards evidence-based medicine, and reflect the fact that an increasing number of countries are adopting evidence-based guidelines for the treatment of tobacco dependence. A number of authoritative reviews and guidelines have been used as the basis for these recommendations: US DHHS Public Health Service Clinical Practice Guideline *Treating tobacco use and dependence*, 2000⁷; *Conclusions: Smoking Cessation Methods*, National Institute of Public Health and Swedish Council on Technology Assessment in Health Care, Sweden (1998)⁸; *Conclusions and Recommendations of the Consensus Conference*, France (1999)⁹; *Smoking cessation guidelines for health professionals: an update*, England, 2000¹⁰; the Cochrane Library Systematic Reviews¹¹. These reviews and guidelines draw on hundreds of well controlled trials, and emphasize not only that treatment for tobacco dependence is effective, but also that it is extremely cost effective: *Guidance for Commissioners on the Cost Effectiveness of Smoking Cessation Interventions*, England, 1998¹²; *Curbing the Epidemic. Governments and the Economics of Tobacco Control*, 1999¹³.

These WHO recommendations are complemented by a WHO report on the regulation of tobacco dependence treatment products, which emerged from a meeting held in Helsinki in October 1999. The Helsinki report notes the contrast between the easy availability of tobacco products and tobacco dependence treatment products, which are much harder to obtain, and urges the development of regulatory approaches which will redress this imbalance.⁵

The evidence supports the development of three main types of intervention for health care systems:

RECOMMENDATIONS

brief opportunistic interventions delivered by health professionals in the course of their routine work; more intensive support delivered by treatment specialists, often in what have been called 'smokers clinics'; pharmacological aids, which approximately double cessation in minimal or more intensive settings. The principal aids in the last category are nicotine replacement therapy (NRT) and bupropion, which is now widely available in Europe. NRT can in Europe be found on prescription, over-the-counter and on general sale. Bupropion is a prescription only medicine.

Although the evidence base is stronger for some health professionals than others, the involvement of health professionals in offering smokers help should be based on factors such as their access to smokers and level of training and skill, rather than professional discipline. Thus the recommendations for health professionals are relevant for all health professionals and not only those based in primary care. The essential features of individual smoking cessation advice have been described as the four As: ask (about smoking at every opportunity); advise (all smokers to stop); assist (the smoker to stop); arrange (follow-up)¹⁴. The updated US guideline has introduced a new A in between advise and assist: assess willingness to stop.⁷

It is hoped that periodically, as new evidence becomes available, as well as experience gained from the implementation of these recommendations, they will be revised and updated.

1. Recommendations for brief interventions

As part of their normal clinical work, health professionals should provide brief interventions including the following essential features:

Ask about and record smoking status, keep record up to date;

Advise smokers of the benefit of stopping in a personalised and appropriate manner (this may include linking the advice to their clinical condition);

Assess motivation to stop;

Assist smokers in their stop attempt if possible; this might include the offer of support, recommendation to use NRT or bupropion and accurate information and advice about them, referral to a specialist cessation service if necessary;

Arrange follow up if possible.

If help can be offered a few key points can be covered in a few minutes:

- set a stop day and stop completely on that day
- review past experience and learn from it (what helped? what hindered?)
- make a personalised action plan
- identify likely problems and plan how to cope with them
- ask family and friends for support

Smoking and smoking cessation should be part of the core curriculum of the basic training of all health professionals.

2. Recommendations for smoking cessation specialists

The health care system should offer treatment as back up to brief opportunistic interventions for those smokers who need more intensive support. This support can be offered individually or in groups, and should include coping skills training and social support. A well-tested group format includes around five

sessions of about one hour over about one month with follow-up. Intensive support should include the offer of or encouragement to use NRT or bupropion (as appropriate) and clear advice and instruction on how to use them.

3. Pharmacotherapies

At the moment the principal aids in this category are nicotine replacement therapy (NRT) and bupropion. There are currently six NRT products: patch, gum, nasal spray, inhalator, tablet, lozenge. Smokers of 10 or more cigarettes a day who are ready to stop should be encouraged to use NRT or bupropion as a cessation aid. Health professionals who deliver smoking cessation interventions should give smokers accurate information and advice on these products. In Europe NRT can be found on prescription, over-the-counter and on general sale. Bupropion is a prescription only medicine and on current evidence should remain so. Evidence on the effectiveness of bupropion is currently limited to medium to heavy smokers receiving behavioural support.

4. Recommendations for specific groups

Treatment research has tended to focus on health professionals such as doctors (especially in primary care), nurses, midwives, pharmacists, and smoking cessation specialists. However advising and supporting smokers in stopping is an activity for the whole health care system and should, eventually, be integrated into as many settings as possible throughout the system. This includes hospital and community settings. However in many countries there is still high smoking prevalence among health professionals, so in addition to the education and training recommended below, health professionals should where appropriate be targeted for help in stopping smoking.

Hospital staff should ask about patients' smoking status prior to or on admission, offer brief advice and assistance to those interested in stopping. Patients should be advised of the hospital's smoke free status before admission. Hospital patients who need it should also be offered NRT or bupropion.

Healthcare premises and their immediate surroundings should be smoke free.

Pregnant smokers should receive clear and accurate information on the risks of smoking to the fetus, and be advised to stop smoking. They should be offered specialist support to stop.

Cessation interventions shown to be effective with adults should be considered for use with young people, with the content modified as necessary.

5. Recommendations for health care purchasers and systems

Purchasing treatment for tobacco dependence represents an extremely cost effective way of reducing ill health and prolonging life. Health care purchasers should purchase tobacco dependence treatments, choosing a blend of interventions relevant to local circumstances but emphasising those interventions which have the strongest evidence base.

Because tobacco dependence treatment is so cost effective, it should be provided by public and private health care systems. Access to both behavioural and pharmaceutical treatments should be as wide as possible with due regard to local regulatory frameworks and other circumstances. Mechanisms should be found to increase the availability of treatment to low-income smokers, including at a reduced cost or free of charge.

Health professionals should be trained to advise and help smokers stop smoking, and health care purchasers should ensure the provision of adequate training budgets and training programmes. Education and training for the different types of interventions should be provided not only at the post-graduate and clinical level, but should start at under-graduate and basic level, in medical and nursing schools and other relevant training institutions.

Telephone help lines can be effective and are very popular with smokers. Although more research is needed on their effectiveness, they seem likely to provide a valuable service to smokers and should be made available where possible.

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The recommendations set out the core interventions to support treatment of tobacco dependence that should be integrated into healthcare systems. They cover the roles of individual health professionals working to help and treat smokers as well as the roles of the wider healthcare system. It is hoped that countries will use these recommendations as a reference for developing their own country specific recommendations.

Comments and details of organizations wishing to endorse the recommendations should be addressed to :

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