EASY READ

Mid-term review of the Ten-Year Tobacco Control Strategy for Northern Ireland

Evidence Review

Institute of Public Health

This is an Easy Read summary of a detailed report developed by the Institute of Public Health for the Department of Health in Northern Ireland. Click here to access the main report and other details of the strategy review.

What is the Ten-Year Tobacco Control Strategy?

The Mid-term Review of the Ten-Year Tobacco Control Strategy for Northern Ireland (2012-2022) looks at how well the strategy has been working so far and how to take it forward. This Evidence Review is part of the Mid-term Review.

The strategy is aimed at three groups: children and young people, pregnant women and their partners who smoke, and disadvantaged people who smoke.

The goals of the 10-year strategy are:

1. Fewer people start to smoke
2. More people stop smoking
3. People are protected from second-hand smoke.

The review looks into what works and what doesn't work, based on research published across the world. It uses this evidence to make suggestions on changes that could be made to activity under the strategy.

Choosing the evidence

To choose high-quality evidence, **peer-reviewed literature** and 'grey' (unpublished or non-commercial) sources of evidence, such as research papers or government reports, were used.

We selected:

International studies (in English) at the level of **systematic review** – the highest level of evidence

- Grey literature on tobacco control policies in Ireland and the UK.

We did not include:

- Evidence on e-cigarettes and nicotine-inhaling devices, which are already under review separately by health agencies
- Research funded by the tobacco industry.

As a result, 2,791 sources of evidence identified by our initial searches were reduced to 86, all produced between January 2012 and June 2018.

1. Evidence on the first goal: Fewer people starting to smoke

How effective are schools' policies and programmes?

There was only limited evidence that school-based policies can prevent young people from starting to smoke. However, the most successful policies were those that applied to the whole school, set clear rules and were consistently enforced.

Methods that worked:

- Adding smoking prevention programmes to the curriculum, for all students
- Providing training and resources for staff running the programmes
- Using peer-led activities, where students help to create or run stop smoking programmes.

Other methods with less high-quality evidence of success included the **Health Promoting Schools Framework** and incentives (such as rewards) aimed at children and teenagers.

How effective are other measures?

- Within family-based programmes, where the parents take a strong lead, young people tend to be less likely to start smoking.
- Stop smoking advice from GPs and pharmacists can help. Studies showed children and young people had not started to smoke three years after getting this advice (whether they had received it face-to-face, in print or by phone).

Have regulations and laws made a difference?

Regulations and laws have had some success in preventing and reducing the use of tobacco. Laws include:

- Higher taxes on tobacco
- Removal of vending machines
- Changing cigarette packs so they are plainer and have picture warnings
- Banning the display of tobacco packs at shop counters.

Laws have made tobacco less appealing, more expensive and harder for children to buy. Previous laws continue to play a part, such as the minimum age for buying tobacco and ensuring smoke-free workplaces.

Evidence showed that laws to restrict smoking in cars were helping to protect children from second-hand smoke and make parents more aware of the risks. However, no evidence was available on whether this law helped prevent children from starting to smoke.

2. Evidence on the second goal: More people stop smoking

(a) Using medication to help people stop smoking

Which stop smoking treatments work?

Nicotine replacement therapy: Using a combination of different types of nicotine replacement therapy (NRT) was the most successful medication for helping smokers to stop. NRT can include patches, gum, tablets and nasal sprays. NRT significantly helped people who smoked at least 15 cigarettes a day. Evidence suggests it was more effective at higher doses than lower doses, and when it was used consistently over at least six months.

Non-nicotine medications: Taking bupropion was as effective as using only one type of NRT. Taking varenicline was more effective than taking bupropion alone or using only one type of NRT. Varenicline was shown to help smokers stop and also to prevent them from re-starting.

Which treatments don't work?

Medications which were not good at helping people to stop smoking include nicotine vaccines, silver acetate and opioid antagonists such as naltrexone.

Where do we need more evidence?

People with different genes or from **different ethnic groups** may react differently to stop smoking medications, but there was not enough evidence to act on. There was not enough evidence to show if antidepressants used with NRT could help smokers to stop.

(b) Using behavioural approaches

How successful are measures to change people's behaviour?

Behavioural approaches use different methods to reach smokers and then support them to stop smoking. Results were mixed.

Counselling

- Motivational interviewing (a form of counselling) was shown to be more effective than giving brief advice on stopping, especially when GPs did the interviewing.
- People who received counselling or advice from nurses (at GP surgeries or hospitals) were more likely to stop smoking for at least six months than people who did not.
- These treatments were found to be more effective when the programme lasted longer than one month.

Messaging using phones and the internet

- Mobile phone messaging can help people stop smoking for up to three months, with mixed results after six months
- Some people found phone support and quitlines helpful
- Automated call systems do not appear to help people stop smoking
- Using the internet was not more effective than other methods.

Giving advice and information

- Printed self-help leaflets used on their own may have a small effect
- Long-term success depended on doctors being thorough in identifying which of their patients smoke, and providing them with clear advice
- Treatments that last under one month, without continuing support, were not effective.

Incentive schemes

Incentive schemes increased the numbers of people who stopped smoking, but only while the schemes were in place.

Campaigns

- Evidence was mixed on whether mass media campaigns supported people to stop smoking, but they did drive people to seek support.
- It was not clear whether recruitment drives to get people to join stop smoking programmes were successful (but targeting individual smokers with personal and persistent messages may be effective).

Support for patients with heart disease

Phone support (or phone counselling) was successful, but there was no clear evidence that one-off measures, such as giving written advice, was effective for people with heart disease.

(c) Combining medication and behavioural approaches

Combined medication and behavioural approaches were more effective than either approach used alone. The following issues may make a difference, according to evidence.

Is it better to target individuals or a group?

- Approaching individual smokers, including in the workplace, was more effective than general programmes about smoking or changing your lifestyle.
- Group therapy was more effective than self-help approaches, but not necessarily more effective than personal advice from a doctor, nurse or pharmacist.
- Individual behavioural support in person or by phone, when offered with medication, had a small but important effect, and was more successful than less intensive forms of support such as brief advice sessions.

What can be effective in getting smokers to join a stop smoking programme?

- Using healthcare settings, such as hospitals, to get smokers to sign up to stop smoking programmes
- Starting intense behavioural therapies in hospital, with continuing support for more than one month after discharge
- Starting intensive treatment for patients awaiting surgery at least four weeks before surgery. This was effective in changing smoking behaviour in the long term and reducing the risk of poor outcomes after surgery.

Does exercise help?

Starting exercise-based programmes helped smokers to stop in the short term (three months) but there was only limited evidence that they worked after 12 months.

Who do combined approaches help?

Combined medication and behavioural approaches were effective for:

- People with **COPD** (lung disease)
- People living with HIV/AIDS, at least in the short term
- People with current and past depression – bupropion could be helpful
- Patients with schizophrenia – bupropion and varenicline can be used
- People in treatment or recovery from alcohol or drug dependence – although the evidence was low quality
- Users of smokeless tobacco (such as chewing) and water pipes.

Who can help smokers to stop?

Healthcare professionals, including dentists, who were trained to run stop-smoking programmes were effective. These included doctors, dentists, pharmacists, nurses, health visitors, nurse practitioners, psychologists and GP assistants. Healthcare professionals who received training were more likely to ask patients to set a quit date, make follow-up appointments, and provide counselling and self-help materials and prescription of a quit date. However, staff working in the health service were all effective in supporting smokers to stop, even those without specialist training. Long-term use of varenicline may help people from relapse.

What could help pregnant women to stop smoking?

- **NRT** helped to reduce the number of women smoking near the end of their pregnancy. Evidence was weaker on the numbers who were still not smoking by the time of their last follow-up appointment after the baby was born. There was no evidence that NRT affected pregnancy or infant health.
- **Behavioural support** (such as counselling) combined with NRT was effective in helping women to stop smoking during pregnancy, according to some evidence. This meant that fewer babies were born with low birthweight or needing intensive care.
- **Phone support** and quitlines helped some women to stop smoking during pregnancy, but evidence on their overall value was mixed.

Incentives offered at the end of pregnancy and after childbirth could be effective. Pregnant women were more likely to stop smoking with support from a 'significant other' (who also received incentives, according to evidence).

- There was not enough evidence on whether providing limited or detailed feedback to women on **ultrasound scans** had any effect on those who were smoking during pregnancy.

What doesn't work?

Behavioural approaches did not appear to prevent people from starting to smoke again. Programmes that targeted people's lifestyles, such as promoting healthy eating and fitness, did not effectively reduce smoking.

Where is more evidence needed?

More research is needed to find out whether it was better to stop smoking gradually or abruptly. There was very little evidence on how to stop smoking among people from different ethnic or cultural backgrounds or among young people.

(d) Evidence on the role of healthcare systems

Electronic reminder systems enabled GP surgeries and hospitals to keep more accurate records about which patients smoked and which had been referred to counselling or stop smoking programmes.

(e) Evidence on how regulations affect the number of smokers stopping

Evidence showed that making cigarette packs plain with picture warnings reduced smoking by making it less appealing. It was unclear whether changing the size of cigarettes affected the number of cigarettes that people smoked.

3. Evidence on the third goal: Protecting people from tobacco smoke

The most effective ways of reducing adults' and children's exposure to second-hand smoke were smoke-free legislation and smoke-free policies in institutions (such as hospitals, universities and prisons).

There was only limited evidence on what may reduce second-hand smoke in private households and public places without smoking bans.

What helps reduce pregnant women's exposure to second-hand smoke?

There was not enough evidence on whether support aimed specifically at a woman's friends or partner could help her to avoid second-hand smoke.

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