

## Specific Populations: Youth

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### *Overview of Evidence*

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The following recommendations, and supporting evidence, have been extracted from existing clinical practice guidelines to inform the development of the CAN-ADAPTT Summary Statements.

In 2009, CAN-ADAPTT worked with the Guidelines Advisory Committee (GAC) to conduct a literature search (years: 2002-2009) to identify existing clinical practice guidelines (CPGs). Five existing clinical practice guidelines were identified as meeting the high quality criteria set out in the [AGREE Instrument](#). The recommendations contained in these high quality CPGs have been used as the evidence base for the CAN-ADAPTT guideline development process. Click [here](#) to view CAN-ADAPTT's guideline development process flowchart.

#### **U.S. Department of Health and Human Services Public Health Service (2008)**

Clinicians should ask pediatric and adolescent patients about tobacco use and provide a strong message regarding the importance of totally abstaining from tobacco use. (*Strength of Evidence = C*)

Counseling has been shown to be effective in treatment of adolescent smokers. Therefore, adolescent smokers should be provided with counseling interventions to aid them in quitting smoking. (*Strength of Evidence = B*)

Secondhand smoke is harmful to children. Cessation counseling delivered in pediatric settings has been shown to be effective in increasing abstinence among parents who smoke. Therefore, to protect children from secondhand smoke, clinicians should ask parents about tobacco use and offer them cessation advice and assistance. (*Strength of Evidence = B*)

### **Institute for Clinical Systems Improvement (2004)**

*(Birth to 10 years):* Smoke exposure (in home, at day care, etc.) should be established at nearly every visit. Tobacco use status of all patients (and in the case of infants and children, the use status of everyone in the home) should be established. (*Class of Evidence = D, M, R, X*)

*(10 years and above):* Patient's tobacco use and second hand smoke exposure should be established at nearly every visit. (*Class of Evidence = D, M, R, X*) Adolescents should have usage re-assessed at nearly every visit, regardless of whether there is a chart notation of non-use. (*Class of Evidence = A, C, D, M, R*)

*(10 years and above):* "Pre-contemplators" benefit from non-confrontational messages about the importance of quitting and the awareness that provider help is available when ready. (*Class of Evidence = R*)

*(10 years and above):* "Contemplators" should receive support and respectful urging to quit. A patient in "preparation" should set a quit date, receive self-help information and be encouraged to accept follow-up after the quit date. (*Class of Evidence = A, M, R*)

*(10 years and above):* If a patient's parent, sibling or friend uses tobacco, patients should be assisted in developing refusal skills and given educational materials. (*Class of Evidence = A*)

### **New Zealand Ministry of Health (2007)**

Offer smoking cessation interventions that incorporate known effective components (such as those identified in the previous sections) to young people who smoke. (*Grade = √*)

NRT can be used by young people (12-18 year olds) who are dependent on nicotine (that is, NRT is not recommended for use by occasional smokers) if it is believed that NRT may aid the quit attempt. (*Grade = C*)

## *Background*

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Youth have their own social network of individuals whom they trust and who exert influence over them. Healthcare practitioners may or may not be part of these networks. Cooperative efforts to provide non-smoking messages between adults other than healthcare practitioners might increase effectiveness. Community mobilization in tobacco use prevention provides a model for shared efforts between parties.

Tobacco use habits among youth evolve during adolescence and the timing and trajectory of smoking and addiction differ between youth depending on factors such as access to tobacco, genetic predisposition, family and peer influence etc. There are no guidelines as to what constitutes “smoking” in youth so consensus is needed as to when a youth is considered to be a smoker (the recommendation is that first puff be viewed as a risk factor for continued smoking).

There is as yet, no widely accepted, standardized youth-specific definition of nicotine dependence for use by clinicians. Similarly there are no validated screening tools, which would help practitioners identify when a youth is dependent. What is needed is a tool that helps clinicians identify youth at risk of sustained smoking and nicotine dependence before these outcomes are established (i.e., before it is too late), since successful intervention among dependent youth is challenging. Research is needed to better understand what clinicians should ask about in identifying youth at risk for sustained smoking. Work is ongoing to develop a prognostic tool for identifying adolescents at risk of becoming daily smokers, who may benefit from counseling aimed at preventing sustained smoking (Karp et al, forthcoming).

Regarding the effectiveness of treatments for youth, more research needs to be done. There are few RCTs testing cessation interventions for youth. Among 16

trials reviewed recently<sup>1</sup>, 3 school-based programs and one in a clinic setting provided evidence of effectiveness. An intervention that combined NRT and behavioural counselling also showed promise.

There is little evidence to date on whether or not to recommend NRT to youth and this issue requires further research. As indicated in the UK and New Zealand guidelines, however, measures for treating smoking cessation in adults may be suitable for youth.

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### *CAN-ADAPTT Summary Statements*      *[Comment on the discussion board](#)*

CAN-ADAPTT's development process reflects a dynamic opportunity to ensure that its guideline is practice informed and addresses issues of applicability in the Canadian context. It did not review the primary literature to inform the development of its Summary Statements. It has built, as outlined in Harrison's ADAPTE process, from the evidence and recommendations contained in existing guidelines (see above). The CAN-ADAPTT Guideline Development Group has provided the below Summary Statements for external review pending its review and allocation of level of evidence and grade of recommendation at its upcoming summer meeting 2010.

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<sup>1</sup> Gervais A, O'Loughlin J, Dugas E, Eisenberg MJ, Wellman RJ, DiFranza JR: "A systematic review of randomized controlled trials of youth smoking cessation interventions". *Drogues, sante et societe* 2007, 6 (Supplement II): ii1-ii26

**Summary Statement #1 –**

**Health practitioners, who work with youth should obtain information about their patients/clients tobacco use (cigarettes, cigarillos, waterpipe, etc) on a regular basis, and identify those at high risk of sustained smoking.**

**Summary Statement #2 –**

**Counselling that supports abstinence from tobacco and/or referral to effective community-based cessation programs should be encouraged for young smokers, and in particular those at high risk of sustained smoking.**

**Summary Statement #3 –**

**Counselling for parents/guardians in pediatric healthcare settings may be useful in raising awareness of the harmfulness of secondhand smoke on the child or adolescent.**

## *Clinical Considerations*

## *Comment on the discussion board*

- Youth, unlike adults who are more established in their tobacco use habits, are in the process of cigarette use onset with its concomitant nicotine dependence. The following issues relate to youth smoking habits.
  - Ask questions in multiple ways to ascertain use of tobacco products and use language and terminology youth may be familiar with.
  - Be aware of the evolution of tobacco use onset as there are important milestones in the natural history from “first puff “ to nicotine dependence. Smoking trajectory should be monitored as intermittent smoking can quickly become regular. Ask, for example about “puffing” or “trying” in addition to regular use (sustained smoking).
  - Use direct inquiry or a validated prognostic or screening tool to identify those at high risk of continued smoking. Identify those with additional health risks (eg. Asthma).
  - Any child consuming tobacco products should be advised to stop. The effectiveness of the 5 As has not been established, however, asking and advising “are the entry points for providing effective interventions” (US).
- Types of Smoking Cessation Treatments.
  - Non-clinical smoking cessation programs may be a resource for referral to counter pressures to initiate and continue tobacco use.
  - There are no studies on whether short counselling is effective in youth. Motivational intervention techniques can be adapted for youth (US).
  - NRT (NZ) and bupropion SR use (US) show little evidence of being effective in young smokers, but have been shown to be safe. The New Zealand guidelines recommend interventions for youth that are effective in adults, that is, interventions using multi-session support.
- Advise parents about the harms of their smoking or of secondhand smoke in relation to their child(ren). Counselling of parents in pediatric settings or “...during child hospitalizations increase parents’ interest in stopping smoking, parents’ quit attempts and parents’ quit rates...” (US).

### *Tools/Resources*

[Contribute a tool/resource via email](#)

[Contribute a tool/resource via discussion board](#)

Title	Description	Resource
Upcoming prognostic tool	<ul style="list-style-type: none"> <li>The development of a nomogram as a prognostic tool for use by healthcare practitioners in clinical settings to identify adolescents at risk of becoming daily smokers, who may particularly benefit from counselling aimed at preventing daily smoking.</li> </ul>	Upcoming prognostic tool for use by clinicians to identify youth at high risk of sustained smoking.
<a href="#"><u>Quit4Life</u></a>	<ul style="list-style-type: none"> <li>Health-Canada sponsored website with profiles and activities to support youth in smoking cessation.</li> </ul>	Interactive and personalized 4 week web program.
<a href="#"><u>Stupid.ca</u></a>	<ul style="list-style-type: none"> <li>An anti-tobacco movement created for youth, by youth, funded by Ontario's Ministry of Health Promotion.</li> </ul>	Educational resource for Youth.
<a href="#"><u>Leave the Pack Behind</u></a>	<ul style="list-style-type: none"> <li>LTPB delivers smoking cessation and prevention support to post-secondary students who smoke or are at risk of starting to smoke.</li> </ul>	Resources for smokers, friends of smokers and health professionals.
<a href="#"><u>BLAST program</u></a>	<ul style="list-style-type: none"> <li>BLAST (Building Leadership for Action in Schools Today) is a youth leadership tobacco prevention program developed by the Lung Association of Alberta &amp; NWT. It challenges youth to think critically about the tobacco industry and its products, and the social and health effects from tobacco.</li> </ul>	Program to empower youth to become leaders and advocates in their schools and communities
<a href="#"><u>Youth Action Committee on Tobacco Issues/National Forum on Youth and Young Adult Tobacco Control Issues</u></a>	<ul style="list-style-type: none"> <li>Forums facilitated by Health Canada, formed of youth interested in informing anti-tobacco programs targeted to youth and future directions for tobacco control in Canada. Representatives are recruited from each province and territory.</li> </ul>	Information on youth anti-tobacco forums

*Research Gaps*

*Comment on the discussion board*

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- Evaluate the effectiveness of using the 5A's in paediatric clinics to treat both adolescents and parents. With youth, at what points do clinicians intervene and how often?
- Explore the safety and effectiveness of medications in adolescents, including bupropion SR, NRT, Varenicline, and a nicotine vaccine
- Investigate the effectiveness of counselling interventions designed specifically to motivate youth to stop using tobacco
- Investigate the effectiveness of child-focused versus family-focused or peer-focused interventions as well as interventions accessed via the Internet, quitlines, and school-based programs
- Research strategies for increasing the efficacy, appeal, and reach of counselling treatments for adolescent smokers
- Evaluate interventions that prevent sustained smoking in youth
- What should clinicians ask about in identifying youth at risk for sustained smoking?
- To what extent should other addictions be addressed?
- How to develop best practices that acknowledge the range of specific situations encountered by youth?

## *References*

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**U.S. Department of Health and Human Services Public Health Service.** (2008, May). Clinical practice guideline: Treating tobacco use and dependence: 2008 update.

**Ministry of Health.** (2007, August). New Zealand smoking cessation guidelines. Wellington: Ministry of Health.

**Institute for Clinical Systems Improvement (ICSI).** (2004, June). Tobacco use prevention and cessation for infants, children and adolescents. Retrieved October 24, 2007 from:  
[http://www.icsi.org/tobacco\\_use\\_prevention\\_and\\_cessation\\_for\\_children/tobacco\\_use\\_prevention\\_and\\_cessation\\_for\\_infants\\_\\_children\\_and\\_adolescentsn\\_and\\_adolescents\\_\\_full\\_version\\_.html](http://www.icsi.org/tobacco_use_prevention_and_cessation_for_children/tobacco_use_prevention_and_cessation_for_infants__children_and_adolescentsn_and_adolescents__full_version_.html)