

APACT 2013

Luncheon Seminar 4 (August 20th, Makuhari, Chiba)

Future challenges of tobacco dependence treatment from Japan experience

Masakazu Nakamura, MD

**Osaka Center for Cancer and
Cardiovascular Diseases Prevention**

Contents

- 1. Tobacco dependence treatment services in the world**
- 2. Achievements of tobacco dependence treatment in Japan**
- 3. Maximizing the effects of pharmacotherapy**
- 4. Health professional training**
- 5. Toward promoting smoking cessation at population level**

Tobacco dependence treatment in the world

WHO Framework Convention of Tobacco Control (FCTC)

“MPOWER”

Monitor tobacco use and prevention policies

Protect people from tobacco smoke

Offer help to quit tobacco use

Warn about the dangers of tobacco

Enforce bans on tobacco advertising,
promotion and sponsorship

Raise taxes on tobacco

(WHO REPORT ON THE GLOBAL TOBACCO EPIDEMIC, 2008)

WHO Framework Convention on Tobacco Control

Article 14 Demand reduction measures concerning tobacco dependence and cessation

- **Develop and disseminate appropriate, comprehensive and integrated guidelines based on scientific evidence and best practices**
- **Include diagnosis and treatment of tobacco dependence and counseling services on cessation of tobacco use in national health and education programmes, plans and strategies**

Guidelines for implementation of Article 14 of the FCTC (Demand reduction measures concerning tobacco dependence and cessation)

1. Develop and disseminate comprehensive guidelines
2. Address tobacco use by health-care workers and others involved in tobacco cessation
3. Develop training capacity
4. Use existing systems and resources
5. Establish population-level approaches
Mass communication, Brief advice, Quitlines
6. Establish more intensive individual approaches
Specialized tobacco dependence treatment services.
7. Make medications available
8. Consider emerging research evidence and novel approaches and media

5-8 Key component of a system for supporting smoking cessation and treatment

A survey of tobacco dependence treatment services in 121 countries

Hembadoon Piné-Abata¹, Ann McNeill², Rachael Murray¹, Asaf Bitton³, Nancy Rigotti^{4,5} & Martin Raw¹

UK Centre for Tobacco Control Studies, Division of Epidemiology and Public Health, University of Nottingham, Nottingham, UK,¹ UK Centre for Tobacco Control Studies, National Addiction Centre, Institute of Psychiatry, King's College London, London, UK,² Division of General Medicine, Brigham and Women's Hospital, Department of Health Care Policy, Harvard Medical School, Boston, MA, USA,³ Department of Medicine, Harvard Medical School, Boston, MA, USA⁴ and Tobacco Research and Treatment Center, General Medicine Division, Massachusetts General Hospital, Boston, MA, USA⁵

Basic Treatment Infrastructure and National Cessation Support Systems

Items	Proportion
National treatment guidelines	44%
A government official for treatment	41%
National treatment strategy	44%
Encouraged brief advice	56%
Quitlines	36%
Nation-wide treatment network	17%

Response rate: 73% (121/166)

(Pine-Abata H, et al. *Addiction*. 108: 1476-1484, 2013)

A survey of tobacco dependence treatment services in 121 countries

Hembadoon Piné-Abata¹, Ann McNeill², Rachael Murray¹, Asaf Bitton³, Nancy Rigotti^{4,5} & Martin Raw¹

UK Centre for Tobacco Control Studies, Division of Epidemiology and Public Health, University of Nottingham, Nottingham, UK,¹ UK Centre for Tobacco Control Studies, National Addiction Centre, Institute of Psychiatry, King's College London, London, UK,² Division of General Medicine, Brigham and Women's Hospital, Department of Health Care Policy, Harvard Medical School, Boston, MA, USA,³ Department of Medicine, Harvard Medical School, Boston, MA, USA⁴ and Tobacco Research and Treatment Center, General Medicine Division, Massachusetts General Hospital, Boston, MA, USA⁵

Availability and Affordability of Medication

	Availability		Affordability	
NRT	51%	(97%)	81%	(94%)
Bupropion	17%	(42%)	70%	(80%)
Varenicline	52%	(83%)	48%	(64%)
Cystine	10%	(3%)	100%	(100%)

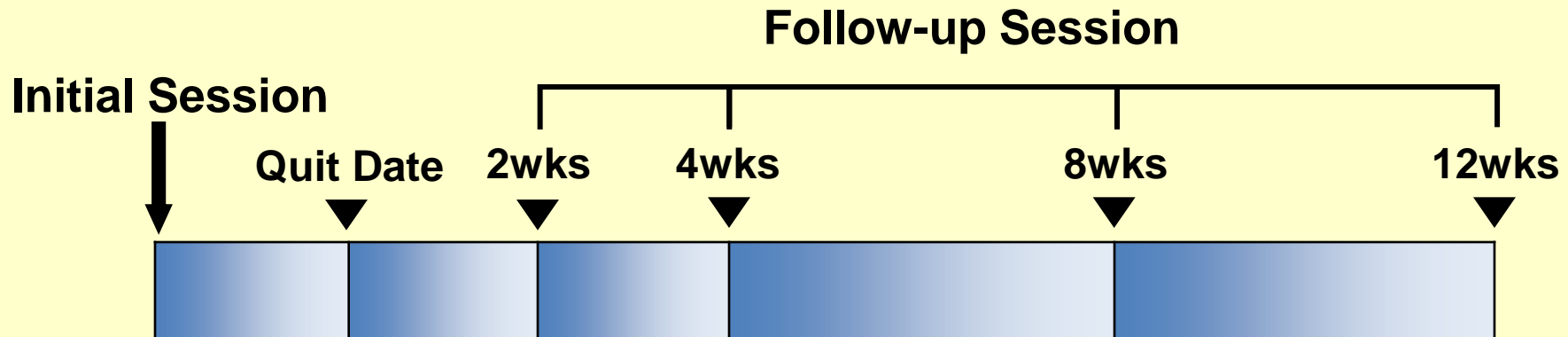
(); Proportion in high income countries

Achievements of tobacco dependence treatment in Japan

Coverage of Smoking Cessation Treatment by Public Health Insurance in Japan (2006)

■ Reimbursed Treatment Program

1. **Counseling** by doctor a/o co-medicals (**12 weeks** for **5 sessions**)
2. Prescribed **nicotine patch** or **varenicline** (maximum for 12 weeks)



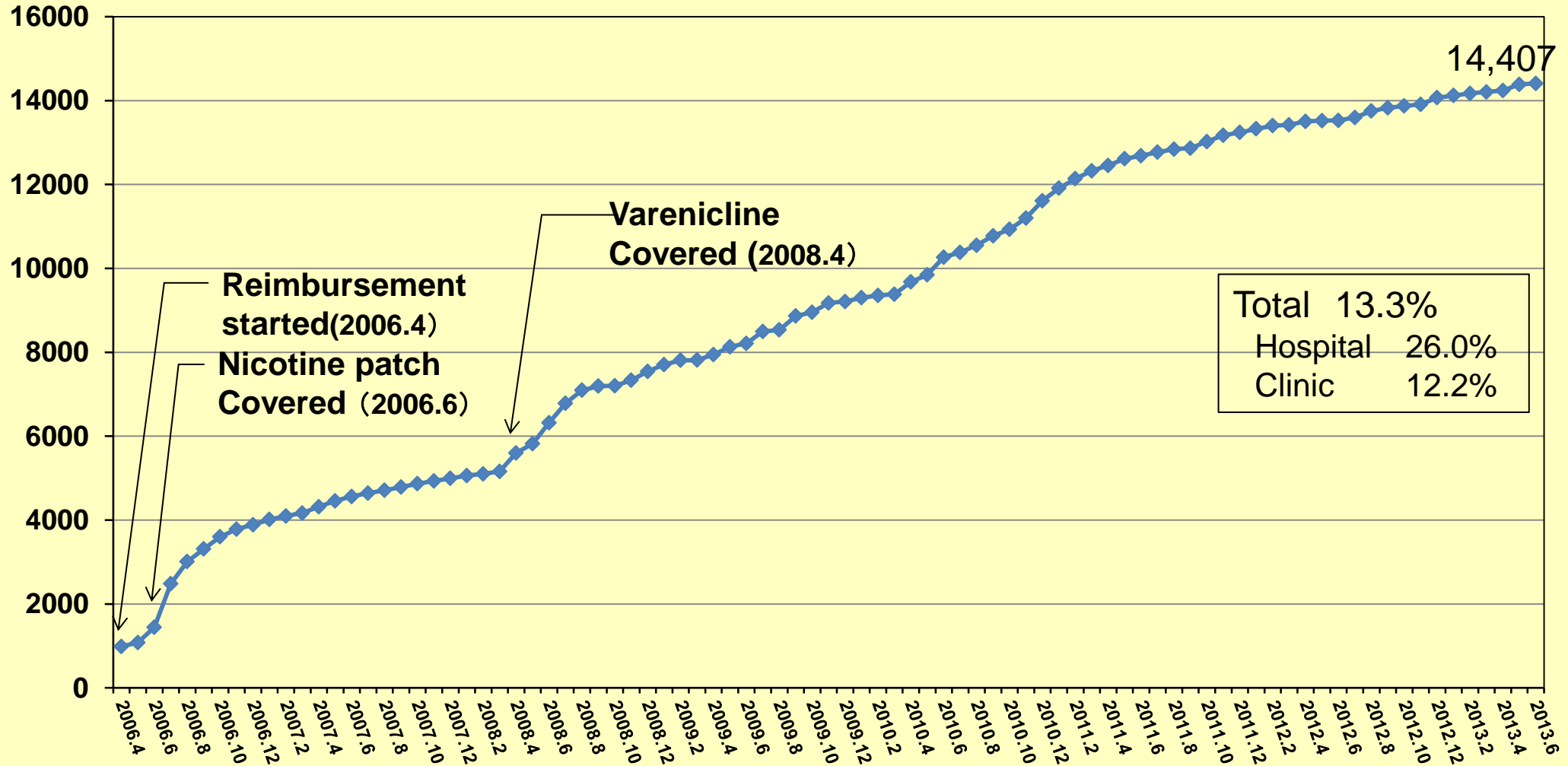
■ The minimum standard of a qualified service

1. follow the standard manual
2. equip with **CO monitor** and **confirm smoking status at every visit**
3. total smoking ban on the premises
4. report the abstinence rate among treated smokers

Trend of number of registered medical facilities

Number of registered medical facilities

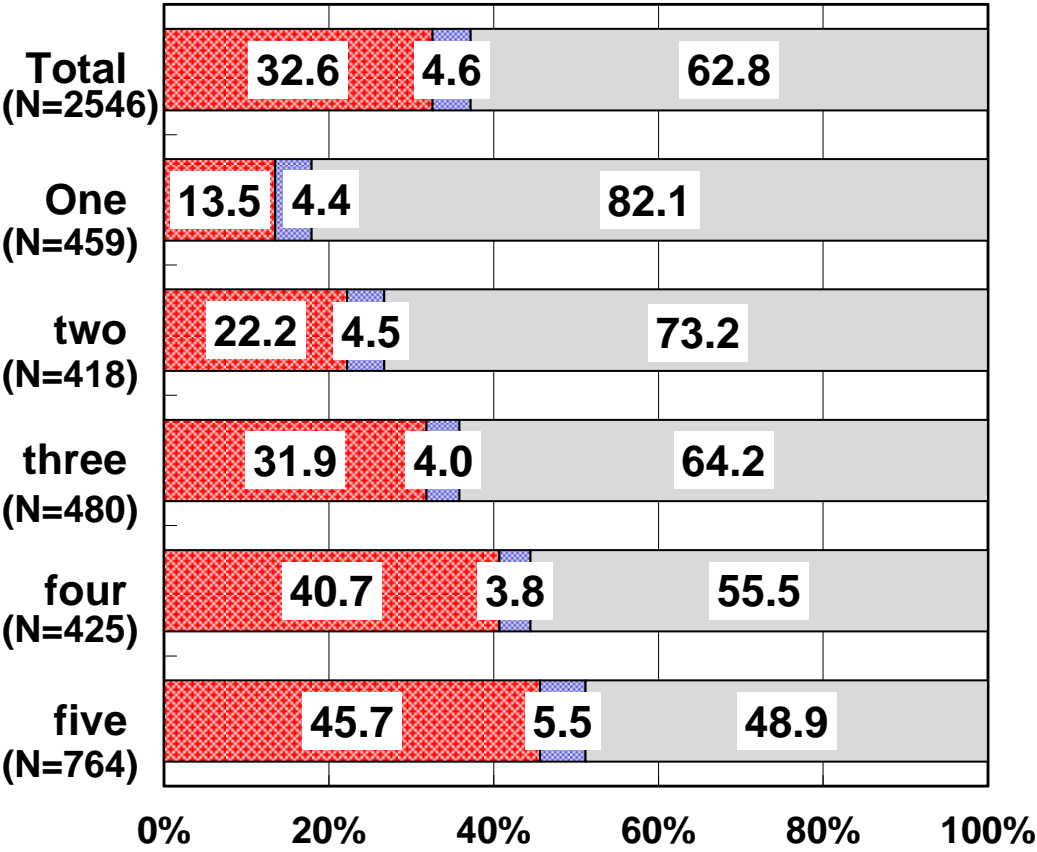
June 28, 2013



(Japan Society for Tobacco Control)

9 Month Sustained Abstinence Rates at One Year Follow-up by Number of Treatment Sessions

2007 Follow-up Survey

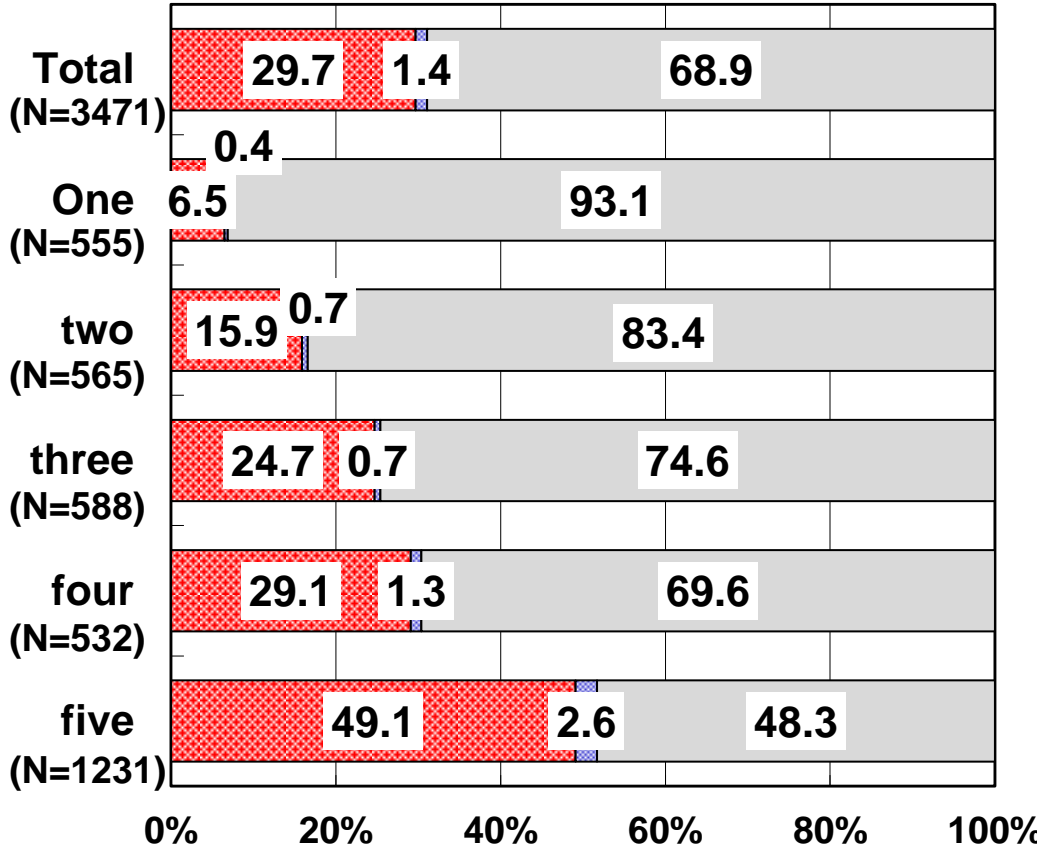


■ Sustained Quitters ■ Quitters at least for one week ■ non-quitters

* response rate 61.2% (279/456)

(Central Social Insurance Medical Council, October 10, 2007)

2009 Follow-up Survey

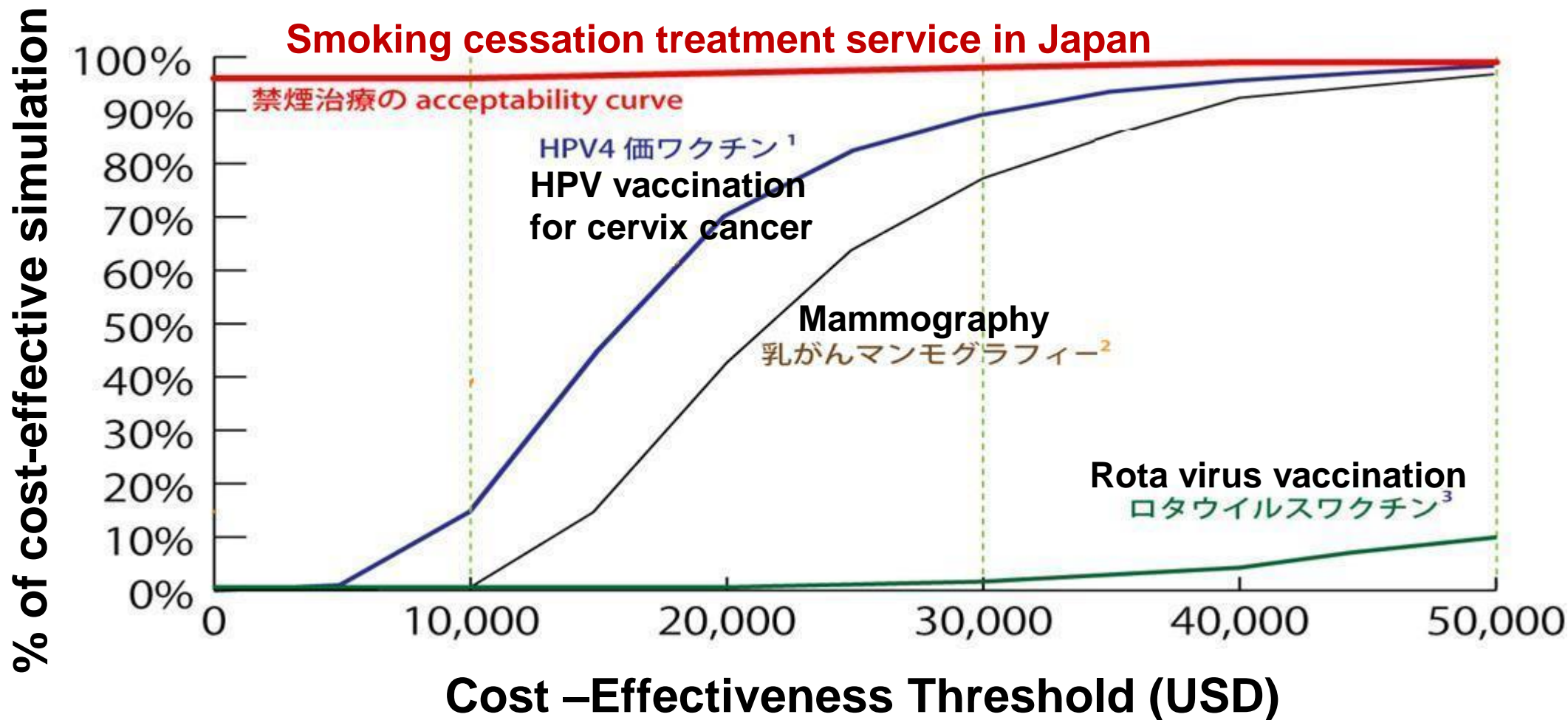


■ Sustained Quitters ■ Quitters at least for one week ■ non-quitters

* response rate 47.5% (712/1500)

(Central Social Insurance Medical Council, November 10, 2009)

Probabilistic Sensitivity Analysis



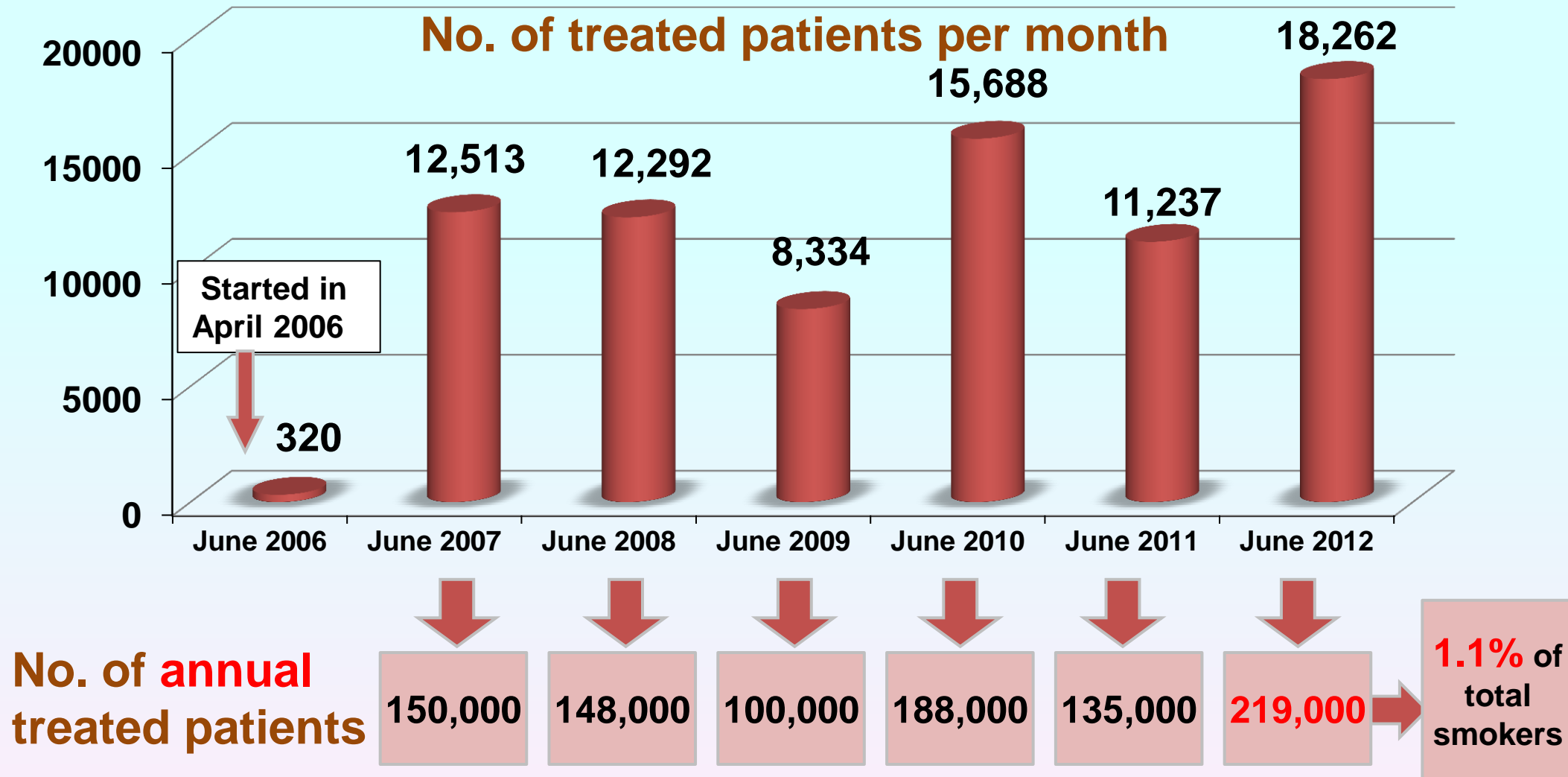
<HPV> Brisson M, et al. Vaccine 2007; 25(29): 5399-408.

<Mammography> Onuki K, et al. J Jpn Assoc Breast Cancer Screen 1997; 6: 145-51.

<Rota virus vaccination> Igarashi A, et al. ISPOR 12th Annual European Congress, Paris; 26 Oct 2009 (poster presentation),

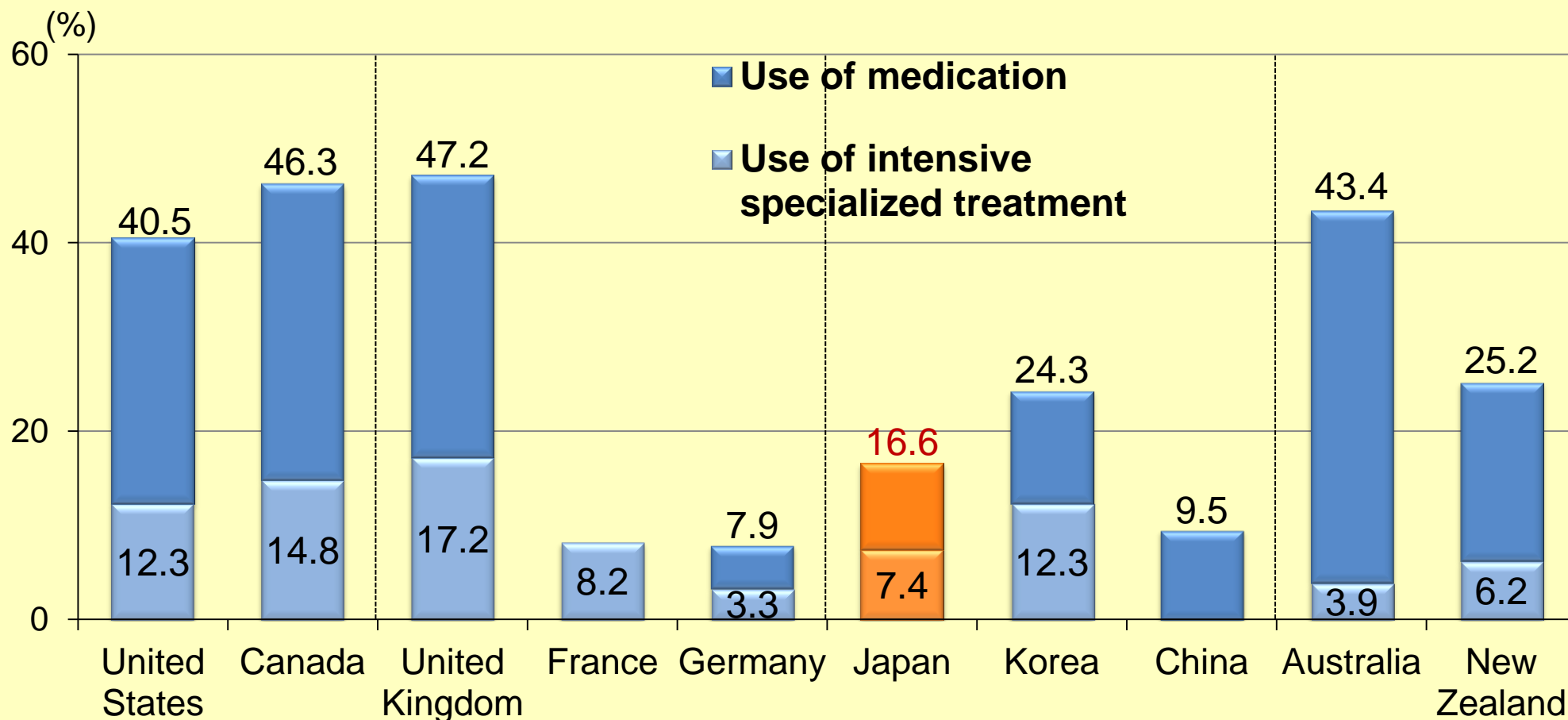
No. of new treated patients

Estimation using the survey of medical care activities by MHLW



(Survey of Medical Care Activities in Public Health Insurance, MHLW, 2006-2012)

Use of medication and intensive specialized treatment among quit attempters

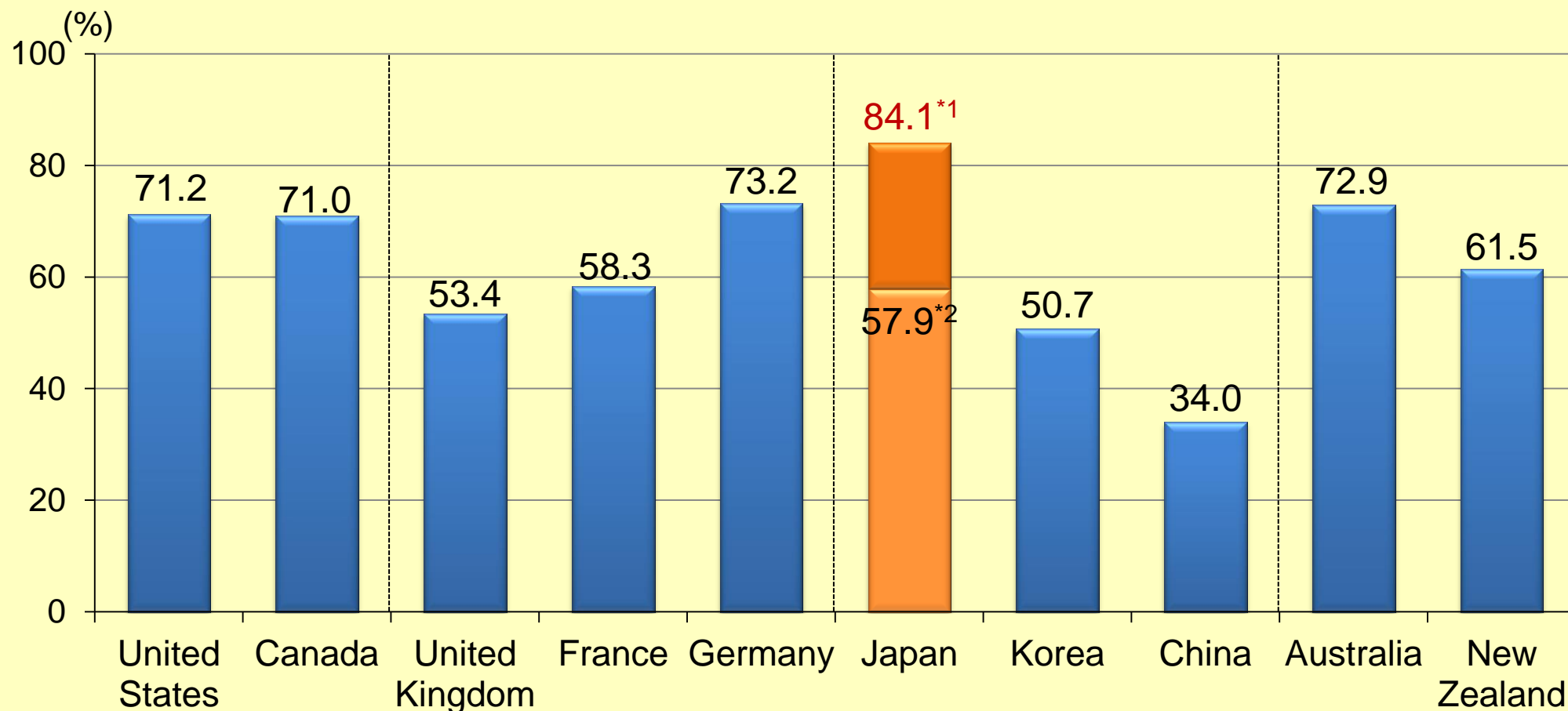


International Tobacco Control Policy Evaluation Project: FCTC Article 14 Tobacco Dependence and Cessation Evidence from the ITC Project, 2010. <http://www.itcproject.org/keyfindi/itcessationreportpdf> (Borland R, et al: Addiction. 2012; 107(1):197-205.)

Except Japan (Smokers Cohort Survey Conducted by MHLW funded Research, 2010 Survey)

Interval is one year except Germany and France (6 months)

Visit to physicians or other health professionals



International Tobacco Control Policy Evaluation Project: FCTC Article 14 Tobacco Dependence and Cessation Evidence from the ITC Project, 2010. <http://www.itcproject.org/keyfindi/itcessationreportpdf> (Borland R, et al: Addiction. 2012; 107(1):197-205.)

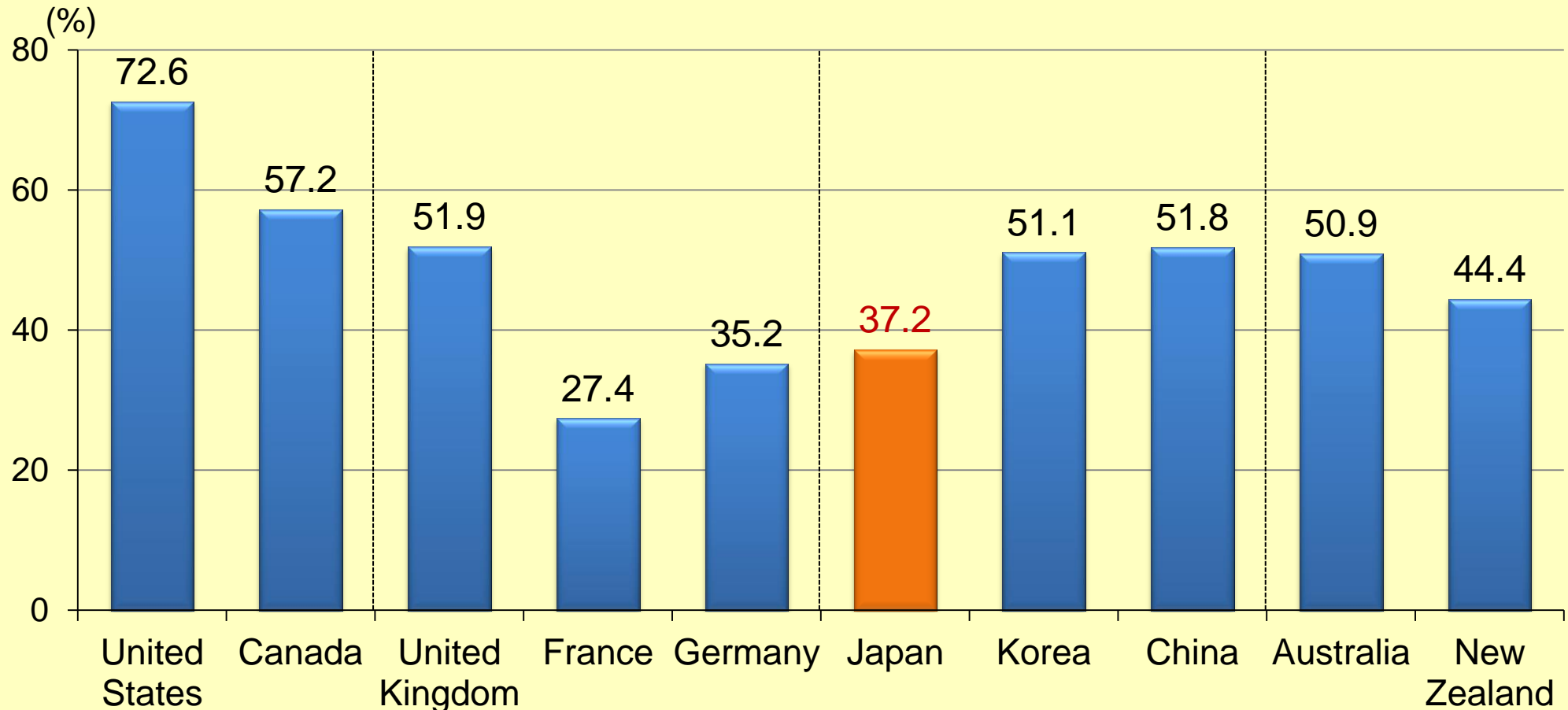
Except Japan (Smokers Cohort Survey Conducted by MHLW funded Research, 2010 Survey)

Interval is one year except Germany and France (6 months)

*1 medical visits or health examination

*2 medical visits only

Advice to Quit from Physicians or other health professionals by Country



International Tobacco Control Policy Evaluation Project: FCTC Article 14 Tobacco Dependence and Cessation Evidence from the ITC Project, 2010. <http://www.itcproject.org/keyfindi/itcessationreportpdf> (Borland R, et al: Addiction. 2012: 107(1):197-205.)

Except Japan (Smokers Cohort Survey Conducted by MHLW funded Research, 2010 Survey)

*Interval is one year except Germany and France (6 months)

Enforcement of smoking cessation intervention at Specific Health Examination and Health Guidance (the Second term 2013-17)

1. Health examination is a good opportunity for motivating smokers toward smoking cessation.
2. Providing brief advice and information to smokers is requested from the day of the health examination.
3. Referral to smoking cessation clinic and other resources to motivated smokers is needed.

標準的な健診・保健指導
プログラム
【改訂版】

平成25年4月

厚生労働省 健康局

**Revised Standard
Program (2013)**
(by Ministry of Health,
Labor and Welfare)

Maximizing the effects of pharmacotherapy

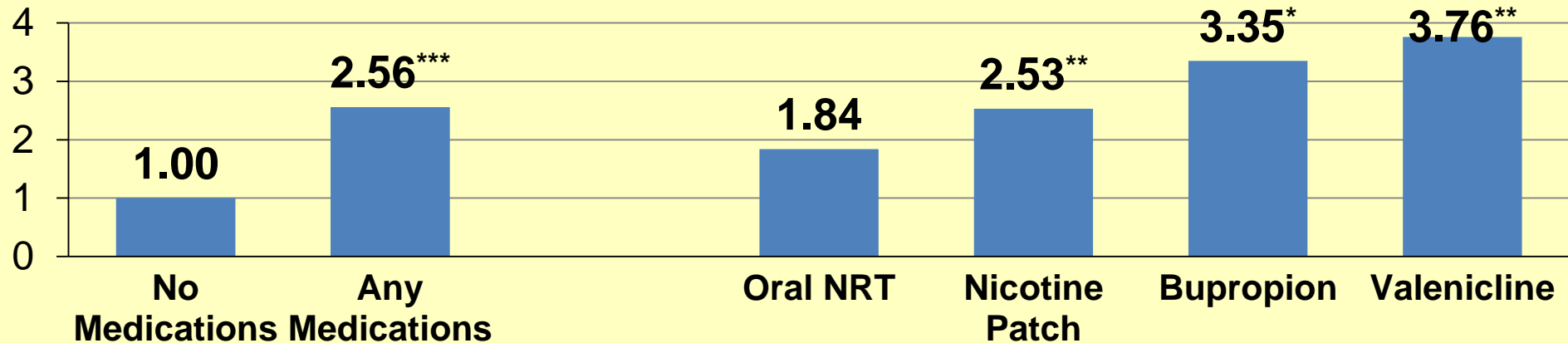
EFFECTS OF PHARMACOTHERAPIES FOR SMOKING CESSATION - Cochrane Review

	MEDICATION (NUMBER OF TRIALS)	ODDS (95%CI)
NRT	GUM(55)	1.49 (1.40-1.60)
	PATCH(43)	1.64 (1.52-1.78)
	NASAL SPRAY(4)	2.02 (1.49-2.73)
	INHALER(4)	1.90 (1.36-2.67)
	SUBLINGUAL TAB.(6)	1.95 (1.61-2.36)
	ORAL SPRAY(1)	2.48 (1.24-4.94)
	TOTAL	1.60 (1.53-1.68)
	BUPROPION(36)	1.69 (1.53-1.85)
	VARENICLINE(14)	2.27 (2.02-2.55)

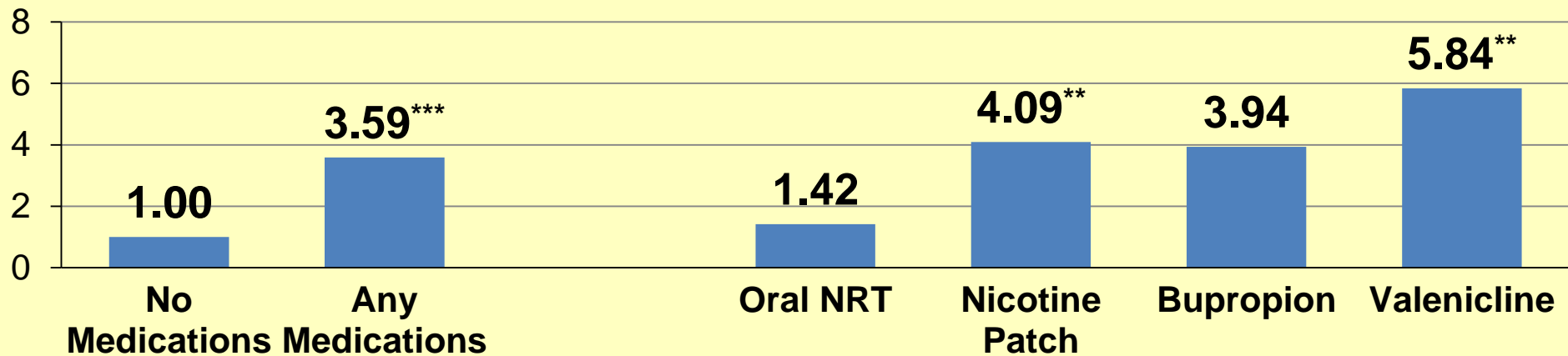
(Cochrane Review NRT: Stead, 2012 / Bupropion: Hughes, 2007/ Varenicline: Cahill, 2012)

Effectiveness of Stop-smoking Medications in Real-world Settings —ITC Four Country Study—

● 1 month abstinence



● 6 month sustained abstinence



* $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$

(Kasza KA, et al: Addiction. 108(1): 193-202, 2013)

Effectiveness of medications relative to the nicotine patch

Medication	Number of arms	Estimated odds ratio (95% C.I.)
Nicotine Patch (reference group)	32	1.0
Monotherapies		
→ <u>Varenicline (2 mg/day)</u>	5	<u>1.6 (1.3–2.0)</u>
Nicotine Nasal Spray	4	1.2 (0.9–1.6)
High-Dose Nicotine Patch (> 25 mg; standard or long-term)	4	1.2 (0.9–1.6)
Long-Term Nicotine Gum (> 14 weeks)	6	1.2 (0.8–1.7)
Varenicline (1 mg/day)	3	1.1 (0.8–1.6)
Nicotine Inhaler	6	1.1 (0.8–1.5)
Clonidine	3	1.1 (0.6–2.0)
Bupropion SR	26	1.0 (0.9–1.2)
Long-Term Nicotine Patch (> 14 weeks)	10	1.0 (0.9–1.2)
Nortriptyline	5	0.9 (0.6–1.4)
Nicotine Gum	15	0.8 (0.6–1.0)
Combination therapies		
→ <u>Patch (long-term; > 14 weeks) + NRT (gum or spray)</u>	3	<u>1.9 (1.3–2.7)</u>
→ Patch + Bupropion SR	3	<u>1.3 (1.0–1.8)</u>

(AHRQ, Treating Tobacco Use and Dependence 2008 Update)

Nicotine replacement therapy to increase the chance of success

Outcome	No. of studies	No. of participants	Risk Ratio
Higher dose gum (4mg gum)	5	856	1.43(1.12-1.83)*
Higher dose patch	8	5101	1.14(1.01-1.29)
Combinations of NRT (patch plus rapid type)	9	4664	1.34(1.18-1.51)
Combination of NRT and Bupropion	4	1991	1.24(1.06-1.45)
Pre-cessation initiation	8	2774	1.18(0.98-1.41)

* High dependency smokers: 1.85(1.36-2.50)

(Stead LF, et al. Cochrane Database of Systematic Reviews 2012)

Tobacco: harm-reduction approaches to smoking

Issued: June 2013

NICE public health guidance 45
guidance.nice.org.uk/ph45

NICE has accredited the process used by the Centre for Public Health Excellence at NICE to produce guidance. Accreditation is valid for 5 years from January 2010 and applies to guidance produced since April 2009 using the processes described in NICE's 'Methods for the development of NICE public health guidance' (2009). More information on accreditation can be viewed at www.nice.org.uk/accreditation



NEWS

Smokers can use nicotine replacement products to reduce harm, says NICE

Gareth Iacobucci

BMJ

The National Institute for Health and Care Excellence (NICE) has signalled a radical shift in the approach to tackling tobacco related harm in England and Wales by recommending the use of licensed products that contain nicotine for patients who don't think that they would be able to stop smoking in one step.

Previous advice to doctors and other health professionals has focused on encouraging patients to quit in one step by setting specific dates to stop smoking completely.

But NICE said that its new public health guidance was the first in the world to recommend licensed products such as nicotine gum or patches for helping people—particularly those who are “highly dependent” on nicotine—to cut the amount they smoke.¹

It advises doctors to consider suggesting the “harm reduction approach” to people who may not be able to stop smoking in one go, to those who want to stop smoking without necessarily giving up nicotine, and to those who might not be ready to stop but want to reduce the amount they smoke.

The guidance maintains that the best way to reduce tobacco related harm is to stop smoking completely and that the best chance of doing this is still to quit in one step. But NICE said that it had issued the new advice in recognition of the fact that nicotine replacement approaches can help people who have been unable to stop by using the standard method.

It encourages health professionals to offer all types of licensed nicotine containing products—including patches, gum, and lozenges—to people who smoke, either singly or in combination, depending on smokers' preference and level of dependence. But it says that using more than one product is “more likely to be successful, particularly for more dependent smokers.”

NICE advises doctors to reassure patients that licensed nicotine containing products are “a safe and effective way of reducing the amount they smoke . . . either in the short or long-term.”

Patients should also be reassured that “it is better to use these products and reduce the amount they smoke than to continue smoking at their current level,” it adds.

The guidance urges doctors to discuss strategies for reducing the number of cigarettes that their patients smoke and to offer follow-up appointments to review progress.

It says that doctors should also explain to patients how to use licensed nicotine containing products correctly—to help them control cravings, prevent compensatory smoking when trying to stop smoking, and reduce the amount they smoke.

Patients who ask about electronic cigarettes should be advised that they are not currently regulated by the Medicines and Healthcare Products Regulatory Agency but “are likely to be less harmful than cigarettes.”

Mike Kelly, director of NICE's Centre for Public Health, said, “If you are a smoker, quitting smoking is the best way to improve health, and stopping in one step is most likely to be successful. This guidance recommends harm reduction as an additional new option particularly for those who are highly dependent on smoking who want to quit but can't just stop in one go.”

Linda Bauld, who chaired the NICE guidance development group and is professor of health policy at the University of Stirling, said, “People who find it hard to stop smoking in one step are more likely to stop smoking in the longer term if they cut down and are more likely to successfully stop if they use nicotine replacement therapy when they cut down.”

Paul Aveyard, a NICE guidance developer, GP, and professor of behavioural medicine at the Oxford University, said, “Whatever approach people wish to try, they should be advised that there are no circumstances when it is safer to smoke than to use licensed nicotine containing products and that experts believe that lifetime use of these products will be considerably less harmful than smoking.”

John Britton, chairman of the Royal College of Physicians' tobacco advisory group, said, “We would encourage all smokers to take up the opportunities presented by this guidance and, if they can't quit using nicotine altogether, to switch as much as they can to an alternative nicotine product. This guidance has the potential to change millions of lives for the better. We commend it.”

¹ National Institute for Health and Care Excellence. Tobacco: harm-reduction approaches to smoking. Jun 2013. guidance.nice.org.uk/ph45.

Cite this as: *BMJ* 2013;346:f3663

© BMJ Publishing Group Ltd 2013

Harm reduction approaches

Target: Highly dependent smokers who

- may not be able (or do not want) to stop smoking in one step
- may want to stop smoking, without necessarily giving up nicotine
- may not be ready to stop smoking, but want to reduce the amount they smoke.

Methods:

- Stopping smoking, but using one or more NRT products as long as needed to prevent relapse
 - Cutting down prior to stopping smoking
 - Smoking Reduction
 - Temporary abstinence from smoking
- with the help of one or more NRT products, may be used as long as needed to prevent relapse
- without using NRT

Nicotine Replacement Therapy for Harm Reduction- Cochrane Review

Outcome	No. of studies	No. of participants	Risk Ratio
Reduction in cigarettes/day of >50% of baseline or cessation	9	3429	1.72(1.41, 2.10)
Cessation at long-term follow-up	9	3429	1.73(1.36, 2.19)

Authors' conclusions

There is insufficient evidence about long-term benefit to support the use of interventions intended to help smokers reduce but not quit smoked tobacco use. Some people who do not wish to quit can be helped to cut down the number of cigarettes smoked and reduce their CO levels by using nicotine gum or nicotine inhaler. **Because the long-term health benefit of a reduction in smoking rate is unclear, but is likely to be small, this application of NRT is more appropriately used as a precursor to quitting.**

(Stead LF, et al. Cochrane Database of Systematic Reviews 2007)

Health professional training

The Effects of Training Health Professionals in Smoking Cessation

Outcome	No. of studies	No. of participants	Risk Ratio
Patient smoking cessation			
Point prevalence	14	13459	1.36(1.20-1.55)
Continuous abstinence	8	9443	1.60(1.26-2.03)
Health Professionals Performance			
Asking patients to set a quit date	8	4332	4.98(1.79-13.88)
Make a follow-up appointment	7	3114	3.34(1.51-7.37)
Counseling of smokers	14	8531	2.28(1.41-3.67)
Provision of self-help material	9	4925	3.52(1.56-7.91)
Provision of NRT	9	5073	1.57(0.72-3.42)
Prescription of a quit date	3	1172	14.18(6.57-30.61)

(Carson KV, et al. Cochrane Database of Systematic Reviews 2012)

Relationship Between Counseling Skills of Trained Health Professionals and Abstinence Rates

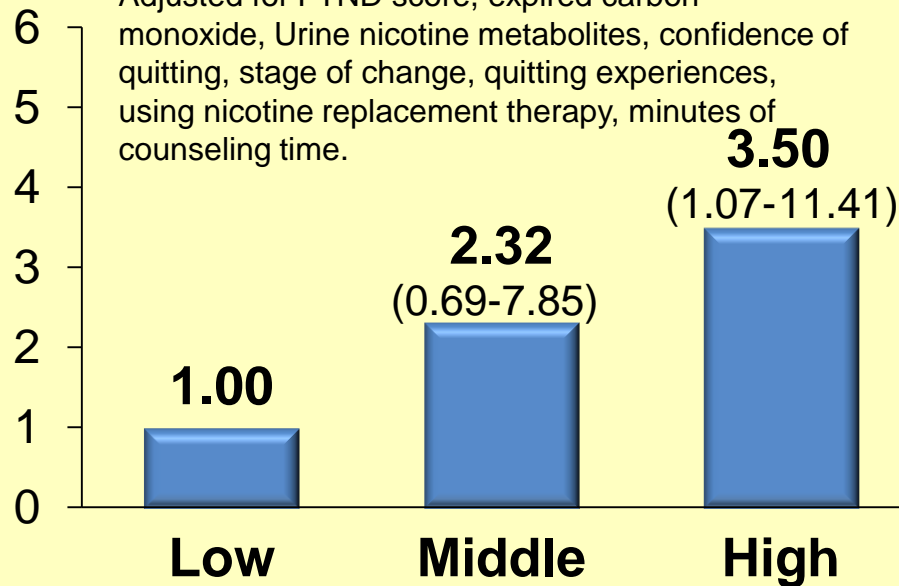
Subjects; 858 smokers, 23 trained health professionals

Evaluation of Skills;

Videotaped interaction between each trainer and a simulated smoker was evaluated using a structured evaluation form before and after the training.

Point Prevalence Abstinence Rate at 6 Month Followup

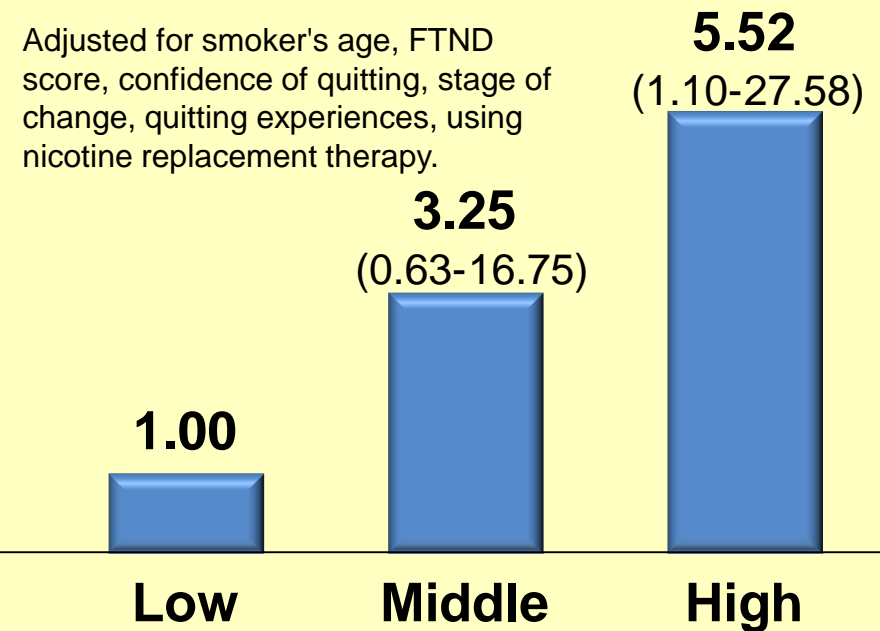
Adjusted for FTND score, expired carbon monoxide, Urine nicotine metabolites, confidence of quitting, stage of change, quitting experiences, using nicotine replacement therapy, minutes of counseling time.



Level of Counseling Skills

6 Month Sustained Abstinence Rate at 1 Year Followup

Adjusted for smoker's age, FTND score, confidence of quitting, stage of change, quitting experiences, using nicotine replacement therapy.



Level of Counseling Skills

Total skill score (0-24): Low (0-10), Middle(11-13), High(14-24)

(Hagimoto, Nakamura et al., Report of the Third Term Comprehensive Control Research for Cancer supported by FY 2013 MHLW grants)

J-STOP

Japan Smoking cessation Training Outreach Project



Purpose:

To **standardize the quality**
and **improve the accessibility**
by providing training program for
physicians and co-medicals

Organization:

Japan Medical-Dental Association
for Tobacco Control

2008

Development of
the program

2009

Pilot
implementation

2010~

National
implementation

J-STOP: Outline of Three Training Programs

	SCT program (Smoking cessation treatment)	SCA program (smoking cessation advice)	SCS program (Smoking cessation support)
Situations	Smoking cessation clinics	Routine medical practice Pharmacies/drug stores	Regional or occupational health services
Contents	Smoking cessation treatment in accordance with standard procedures	Motivating smokers to quit smoking and providing information in a short time	Motivating smokers to quit smoking and providing information in a short time, and smoking cessation counseling
Subjects	Physicians and co-medicals	Physicians and co-medicals Pharmacists at pharmacies/drug stores	Regional or occupational health instructors
Required time (estimated)	10 to 12 hrs	3 to 4 hrs	4 to 5 hrs

For more information, go to J-STOP website at <http://www.j-stop.jp>.

J-STOP

Search

Contents of the SCT Program

Goal: To learn methods of smoking cessation treatment in accordance with standard procedure



Short lecture

Proposal for smoking cessation in routine medical practice



Study Using Texts

1. Influence of smoking on health
2. Effects of smoking cessation
3. Nicotine dependence
4. Smoking cessation counseling
5. Pharmacotherapy for smoking cessation
6. Nicotine dependence management fee
7. Actual situation of smoking cessation treatment
8. System intervention for smoking cessation
9. Role of health professionals in tobacco control

※ special courses: pregnancy, adolescent, psychiatric patients



1. Case conference

Methods of smoking cessation treatment for cases who have difficulty with smoking cessation .(2 cases)

2. Q&A sessions

Pharmacotherapy :10questions

Counseling :10questions

3. Virtual Counseling

1. Case A (smoking cessation treatment)
2. Case B (smoking cessation treatment)
3. Case C (enhance motivation at health checkup)
4. Case D (enhance motivation at clinical practice)
5. Case E (enhance motivation at clinical practice)

The Five Cases for Virtual Counseling

click

ケースを選択してください

TOPへ戻る

Case A 45 y.o. Female
Smoker with a history of
depression
(smoking cessation
treatment)

ケースA (禁煙治療)

女性・45歳
【禁煙ステージ】
準備期

【学習目標】

合併症がない健康な人に対するニコチンパッチを使った一般的な治療内容や禁煙後の体重増加について、アドバイスの方法を学びます。

ケースB (禁煙治療)

男性・65歳
【禁煙ステージ】
準備期

【学習目標】

急性心筋梗塞の既往がある男性喫煙者に対するチャンピックスを使った一般的な禁煙治療の方法や再喫煙時のアドバイスの方法を学びます。

Case B 65 y.o. Male
Smoker after MI
(smoking cessation
treatment)

ケースC (動機付け)

男性・28歳
【禁煙ステージ】
無関心期

【学習目標】

無関心期の喫煙者に対する禁煙の働きかけと情報提供や繰り返し働きかけを行うことが重要であることを学びます。

Case C 28 y.o. Male
Young smoker with acute
pharyngitis
(enhance motivation at
clinical practice)

ケースD (動機付け)

男性・51歳
【禁煙ステージ】
関心期

【学習目標】

健診の場で行う短時間の禁煙アドバイスの方法や肥満でない喫煙者に対する禁煙の動機付けについて学びます。

Case D 51 y.o. Male
“healthy” middle-aged
smoker
(enhance motivation at
health checkup)

ケースE (動機付け)

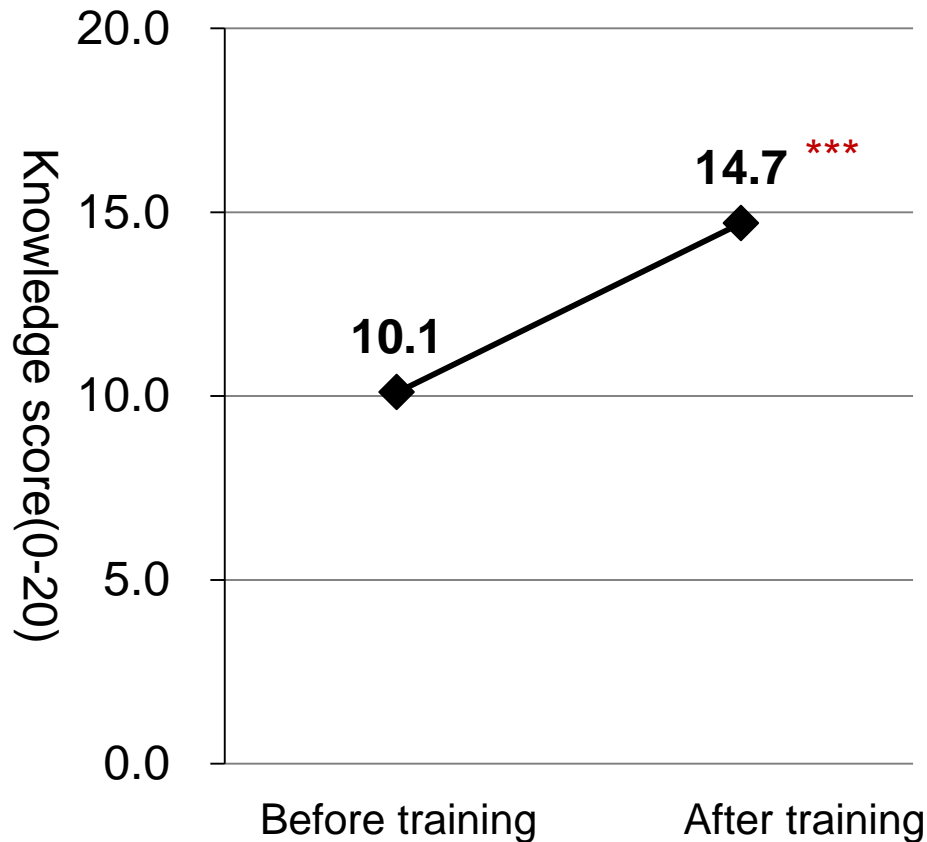
女性・32歳
【禁煙ステージ】
関心期

【学習目標】

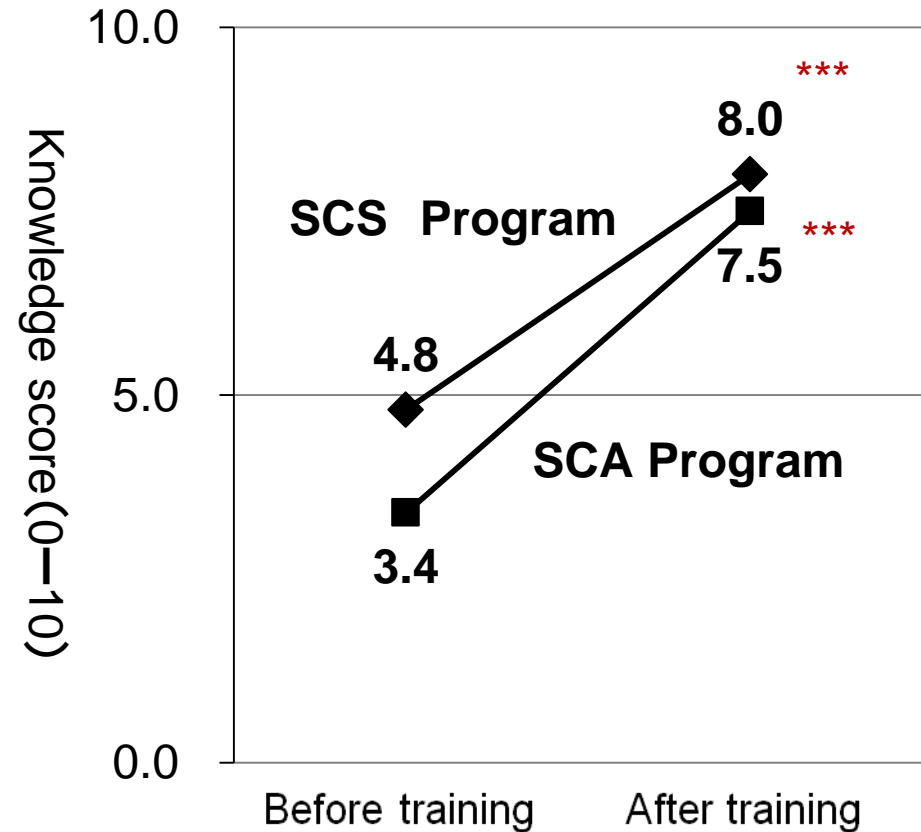
受動喫煙のリスクに対する情報提供や喫煙する母親に対する禁煙の情報提供と動機付け支援の方法を学びます。

Case E 32 y.o. Female
Smoker with an asthmatic
child
(enhance motivation at
clinical practice)

Change in Trainee's Knowledge



SCT Program(N=226)



SCS Program(N=162)

SCA Program(N=202)

Wilcoxon signed rank sum test

*** $p < 0.001$

Change in Trainee's Attitude

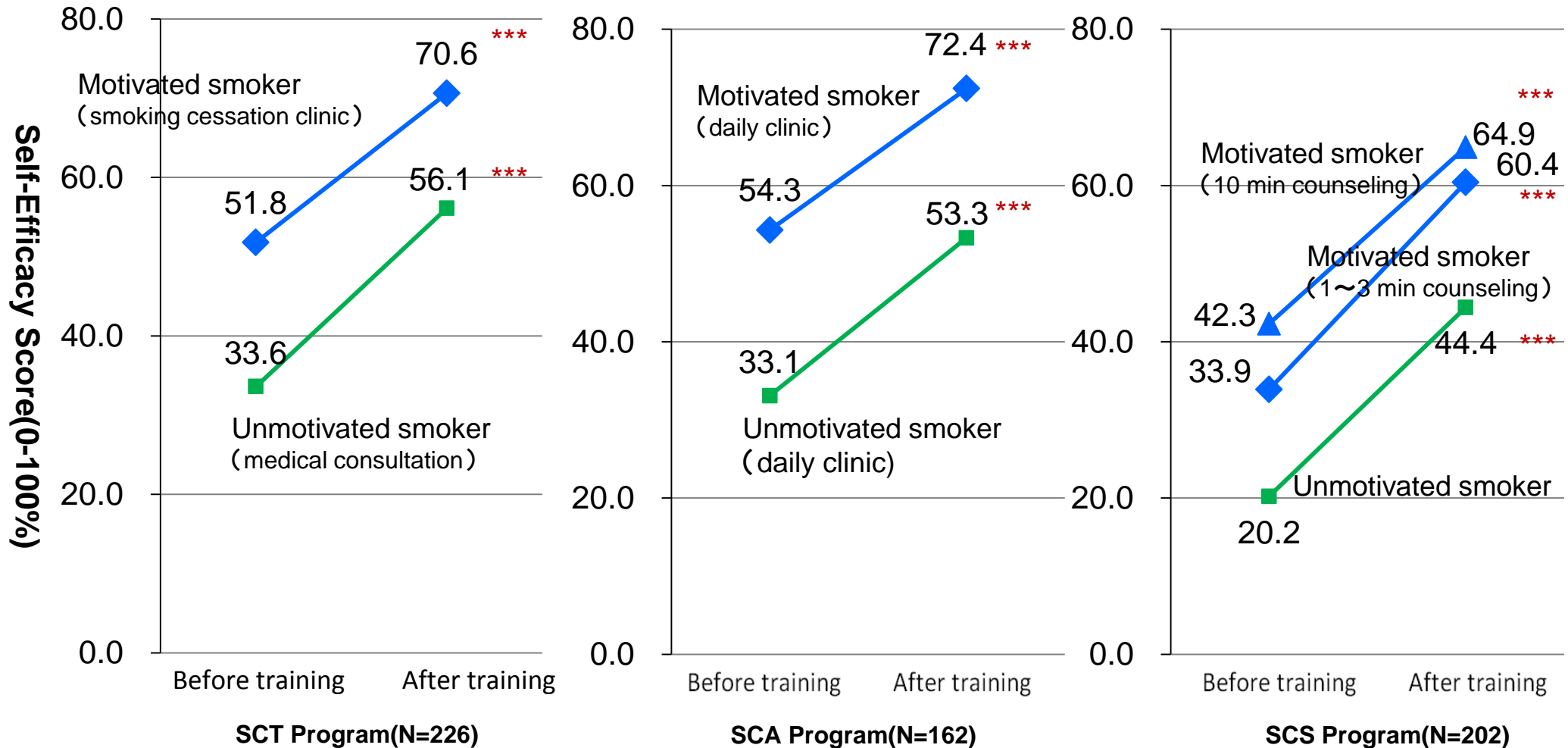
	SCT Program(n=226)		SCA Program(n=162)		SCS Program(n=202)	
	Before training	After training	Before training	After training	Before training	After training
Smoking is nicotine dependence	2.11	2.60***	2.03	2.57***	2.28	2.56***
SCT is not effective for a lot of work(inverse scoring)	0.54	1.23***	0.62	0.86	0.68	1.25***
Smoking cessation counseling is effective	2.08	2.44***	1.93	2.40***	1.94	2.34***
Medication for smoking cessation is effective	1.94	2.44***	1.85	2.39***	1.89	2.47***
Quitting smoking is a prerequisite condition for health	2.50	2.65**	2.17	2.59***	2.23	2.51***
Learning knowledge and skills for SCT is important	2.58	2.68*	2.49	2.60*	2.64	2.76**

Range is -3 to +3 for each content area.

(3 : Strongly agree, 2: Agree, 1: Somewhat agree, 0: undecided, -1: Somewhat disagree, -2: disagree, -3: Strongly disagree)

Wilcoxon signed rank sum test (* p<0.05 ** p<0.01 *** p<0.001)

Change in Trainee's Self-Efficacy



Range of Self-Efficacy Score is 0 to 100. Wilcoxon signed rank sum test *** p<0.001

Change in Trainee's Behaviors

	SCT Program(n=226)		SCA Program(n=162)		SCS Program(n=202)	
	Before training	After training	Before training	After training	Before training	After training
Ask about smoking status	2.96	3.01	2.51	2.46	2.59	2.74*
Advise smokers to quit	2.62	2.66	1.70	1.93**	2.14	2.30**
Asses readiness to quit	2.27	2.44*	1.61	1.84**	2.49	2.51
Assist smokers to quit (1~3 minutes)	2.59	2.64	2.30	2.23	2.55	2.56
Assist smokers to quit (higher intensity)	—	—	—	—	1.51	1.83***
Arrange for follow-up visits for relapse prevention	2.61	2.75*	2.32	2.35	—	—

Range is 0 to 4 for each content area (0: none, 1: few, 2: some, 3:many, 4: most)

Wilcoxon signed rank sum test (* p<0.05 ** p<0.01 *** p<0.001)

Enforcement of smoking cessation intervention at Specific Health Examination and Health Guidance

(the Second term 20013-17)

■Smoking Cessation Manual (2nd version) **(Ministry of Health, Labour and Welfare)**

禁煙支援マニュアル
(第二版)

厚生労働省 健康局
がん対策・健康増進課編

【Contents】

Basic knowledge for Intervention
Lecture slides and explanation

Manual for Intervention

Brief intervention(ABR method),

Standard intervention(ABC method)

Video viewing for studying counseling
Educational materials

Contents of the SCS Program

Goal: To learn methods to motivate patients to quit smoking and provide information in a short time at health services such as health checkup and comprehensive medical examination and for smoking cessation counseling



Short lecture

“Behavior science of smoking cessation support”
“Smoking cessation support that can be provided in a short time at health checkup and other health services”



Study Using Texts

1. Influence of smoking on health
2. Effects of smoking cessation
3. Nicotine dependence
4. Pharmacotherapy for smoking cessation



1. Counseling Study

Short-time support (1~3min) ABR
Standard support (10min) ABC

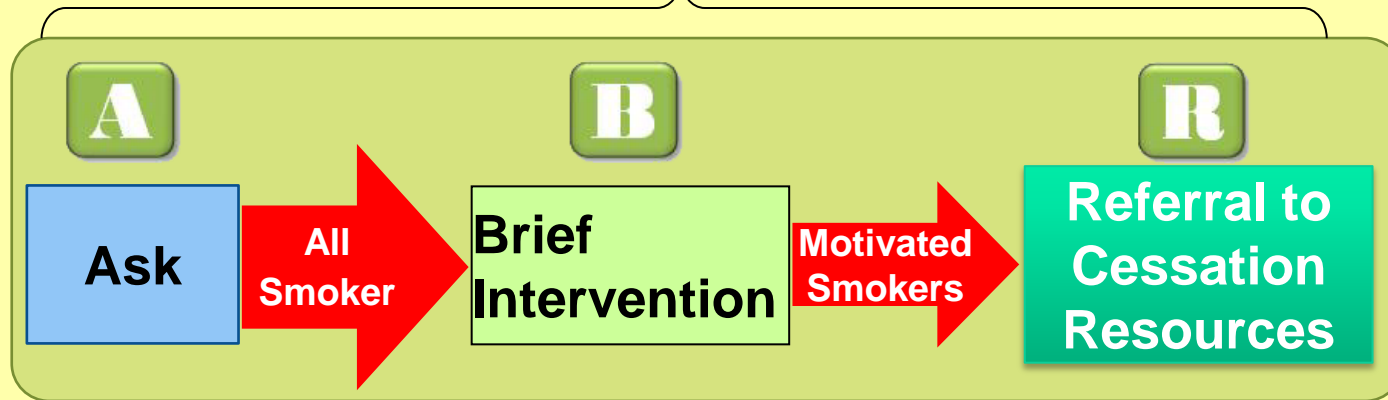
2.Q&A sessions

Pre-contemplation / contemplation 5Q
Preparation stage 10Q

The Methods of Smoking Cessation Intervention

Brief Intervention (“ABR” method)

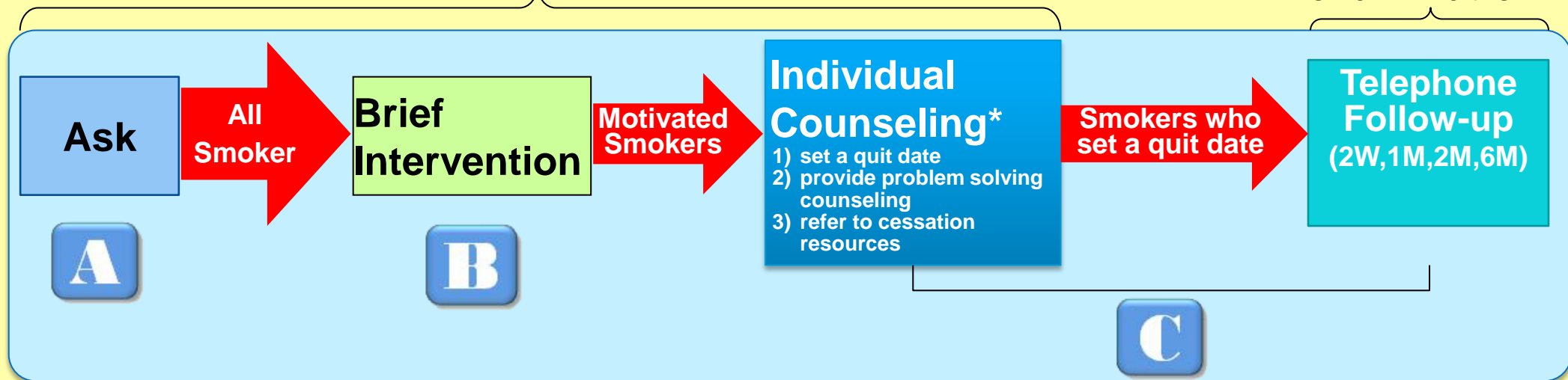
On the day of the health examination



Standard Counseling (“ABC” method)

On the day of the health examination

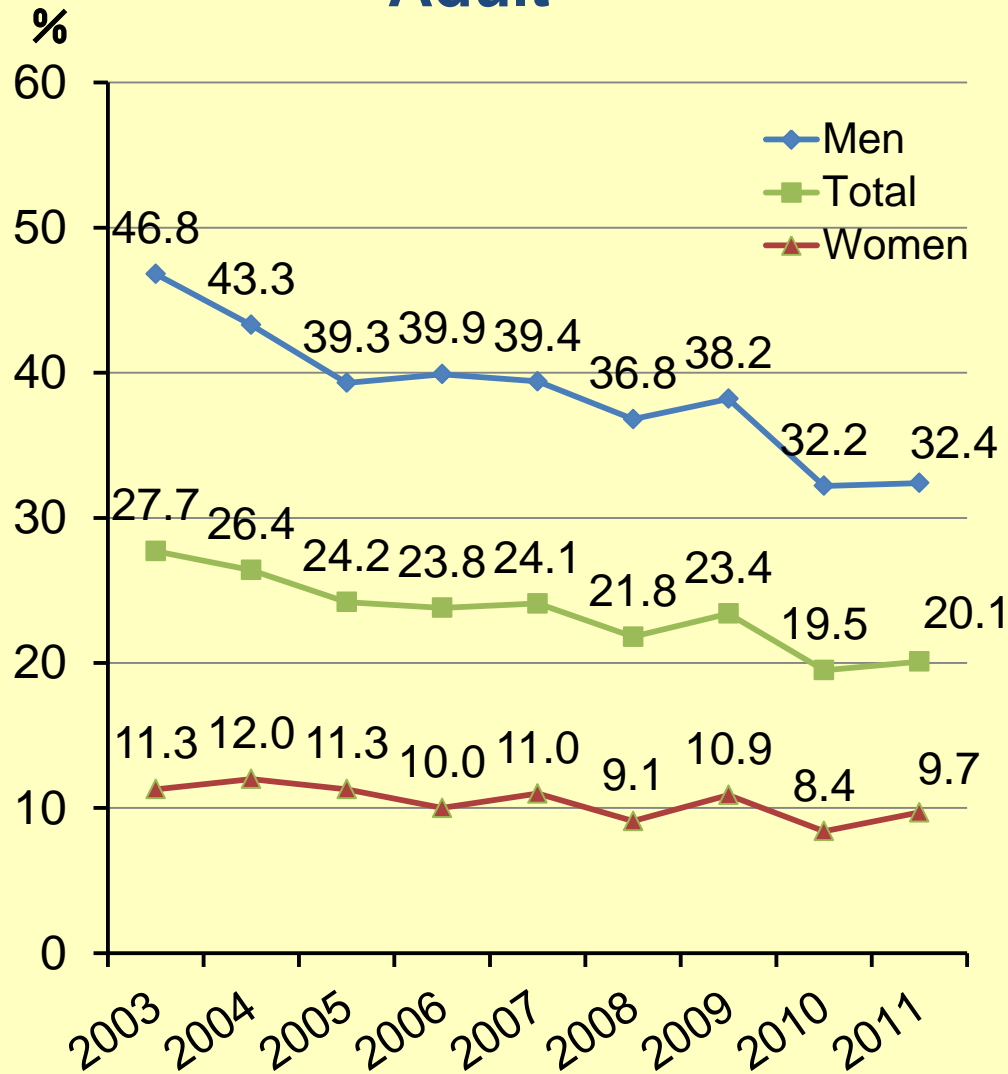
After the health examination



**Toward promoting smoking
cessation at population level**

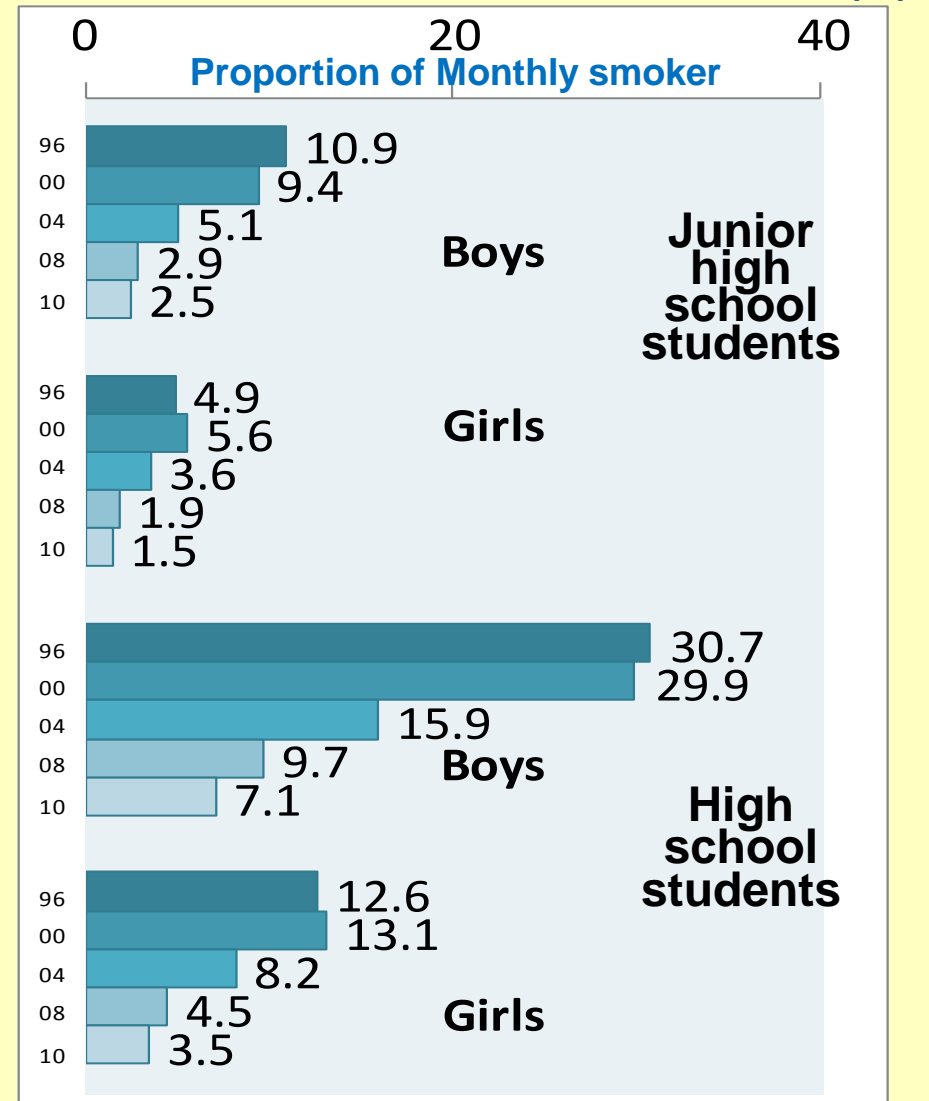
Trend of Smoking Prevalence

Adult



National Health and Nutrition Survey

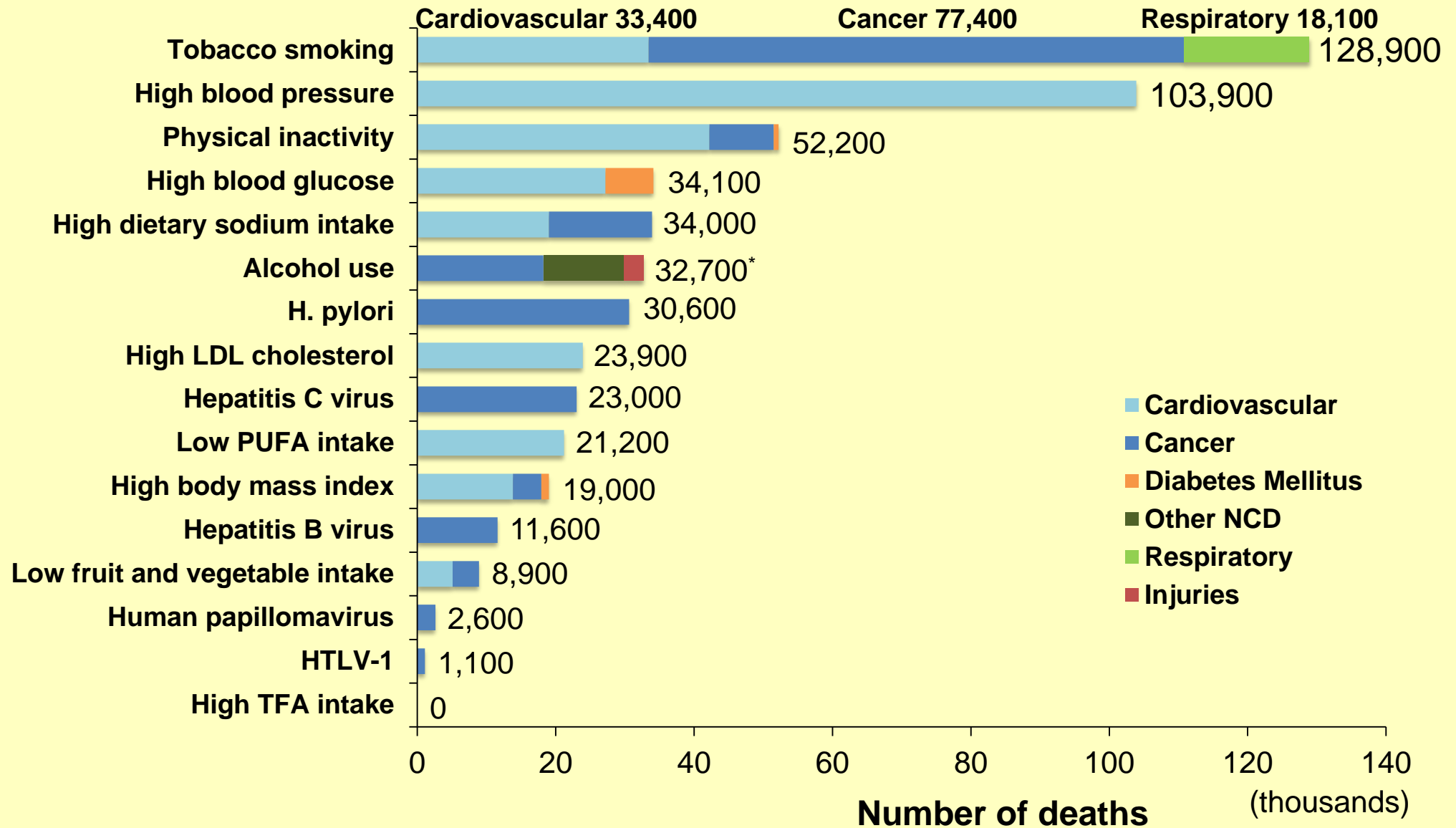
Adolescence



MHLW funded research report

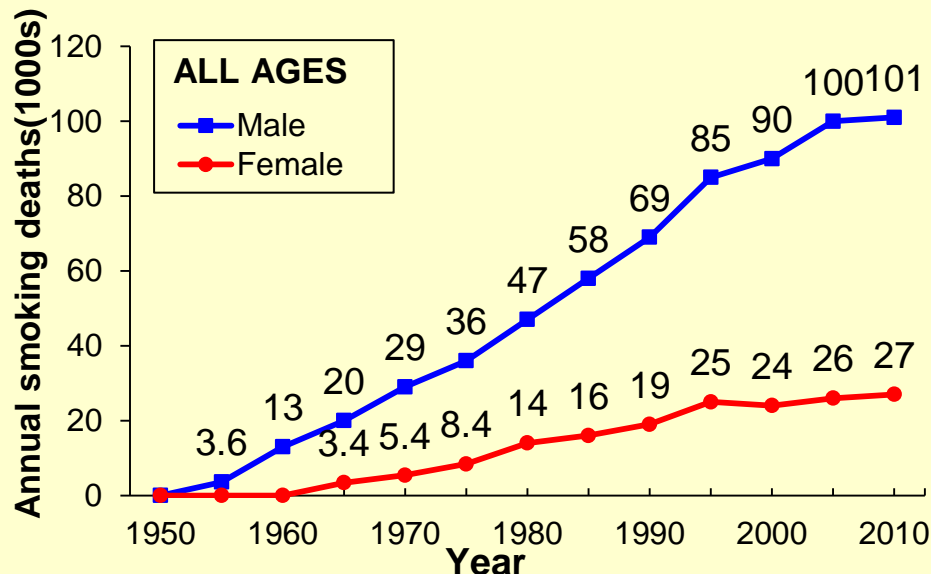
Except 2004 (Osaki Y, et al: Environ Health Prev Med. 2008; 13: 251-226)

The number of deaths attributable to risk factors in Japan, 2007



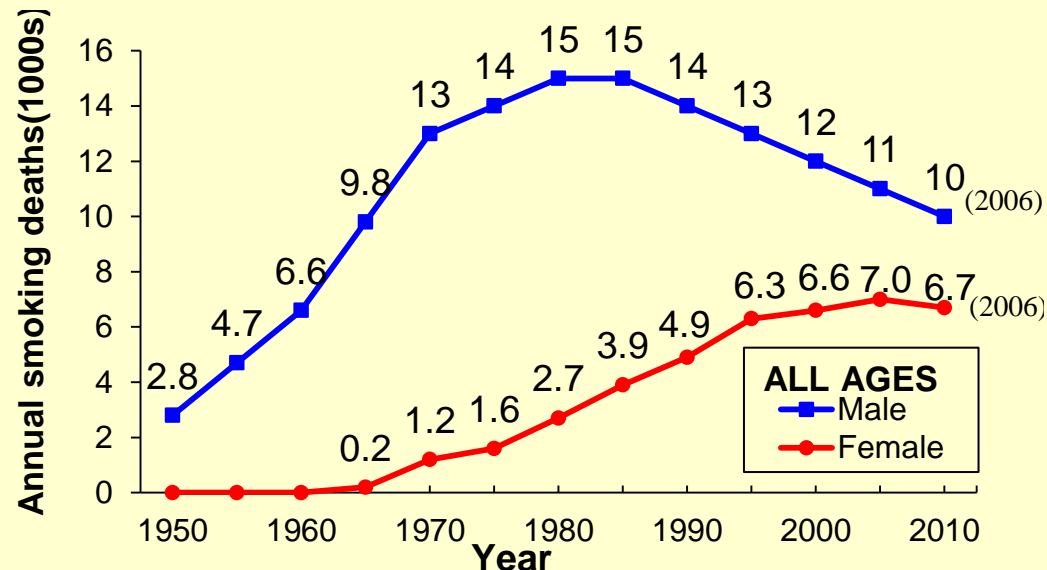
JAPAN:1950-2009

Smoking-attributed deaths:thousands per year



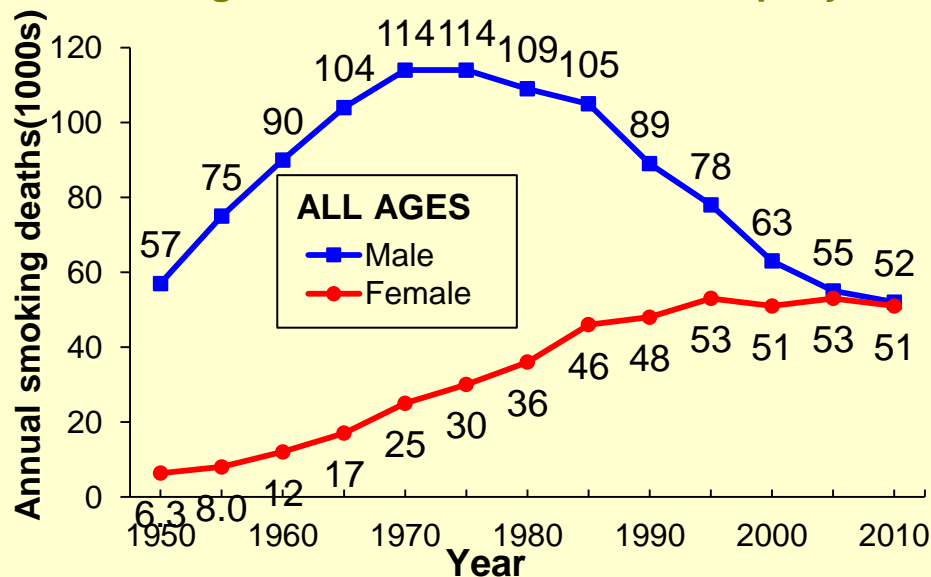
AUSTRALIA:1950-2006

Smoking-attributed deaths:thousands per year



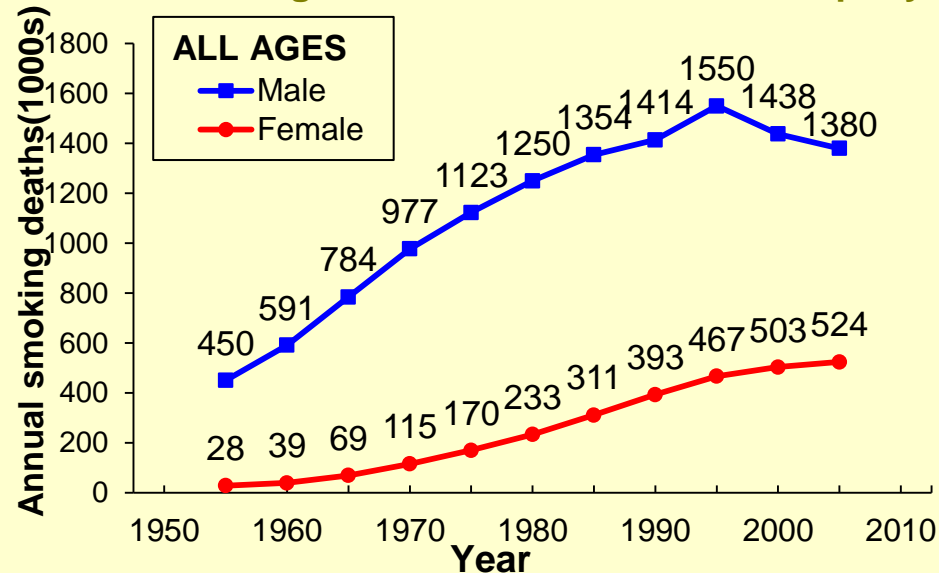
UNITED KINGDOM:1950-2009

Smoking-attributed deaths:thousands per year

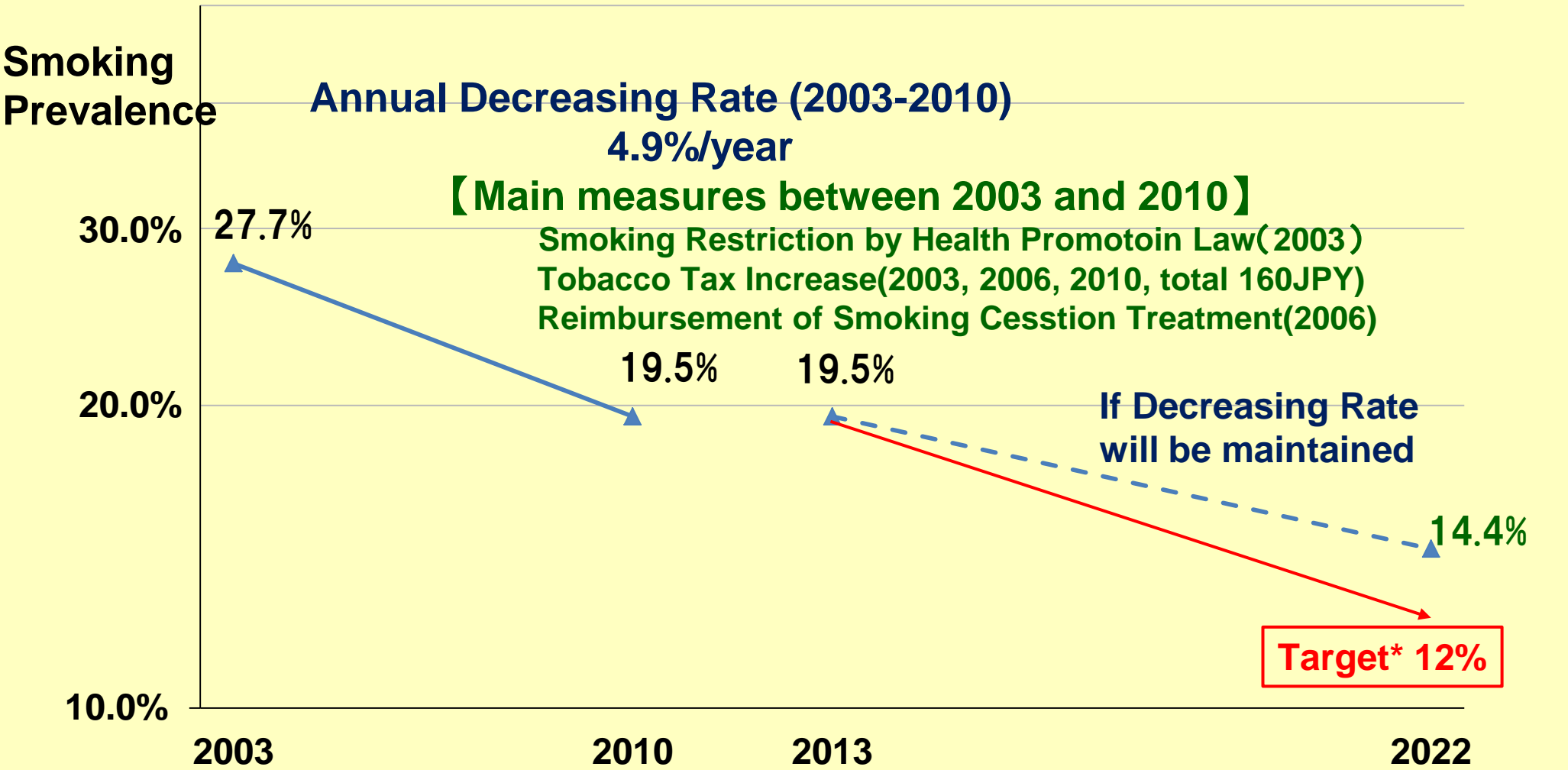


ALL DEVELOPED COUNTRIES:1955-2005

Smoking-attributed deaths:thousands per year

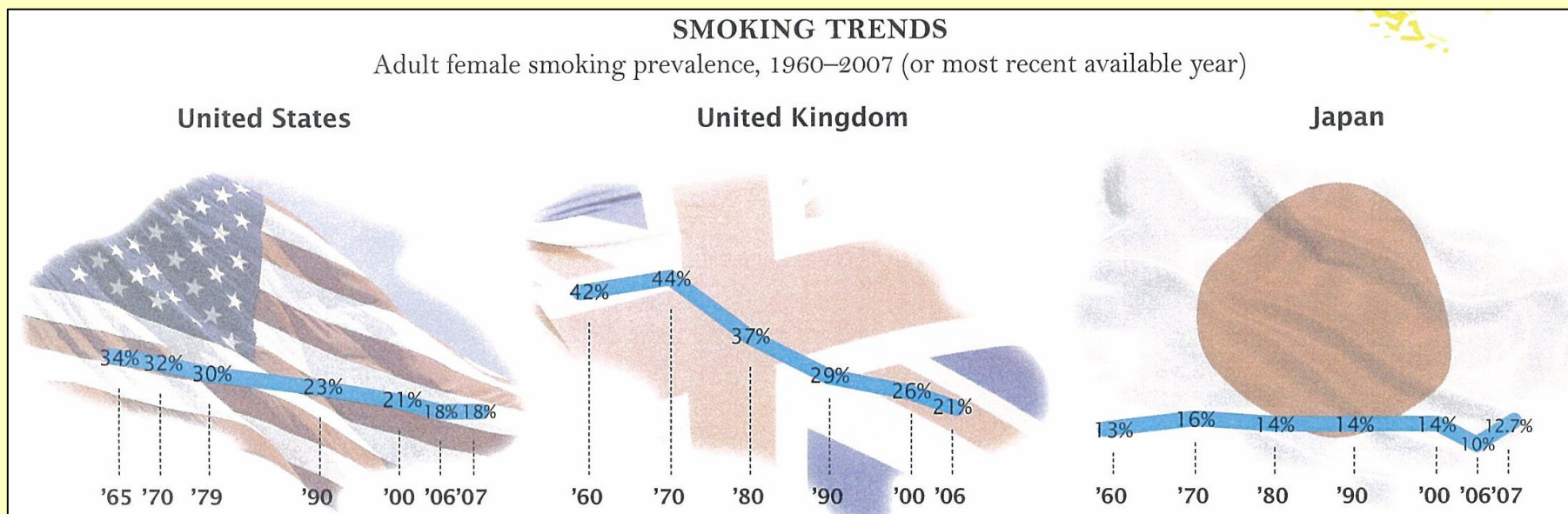
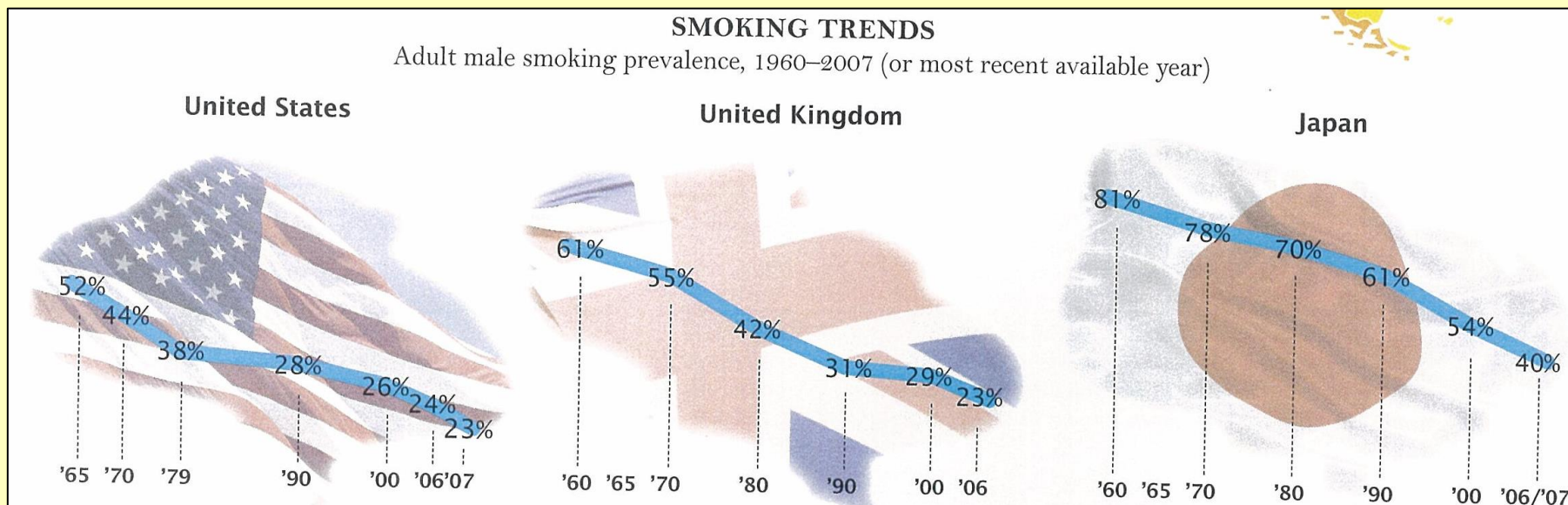


To Achieve Adult Smoking Prevalence Target



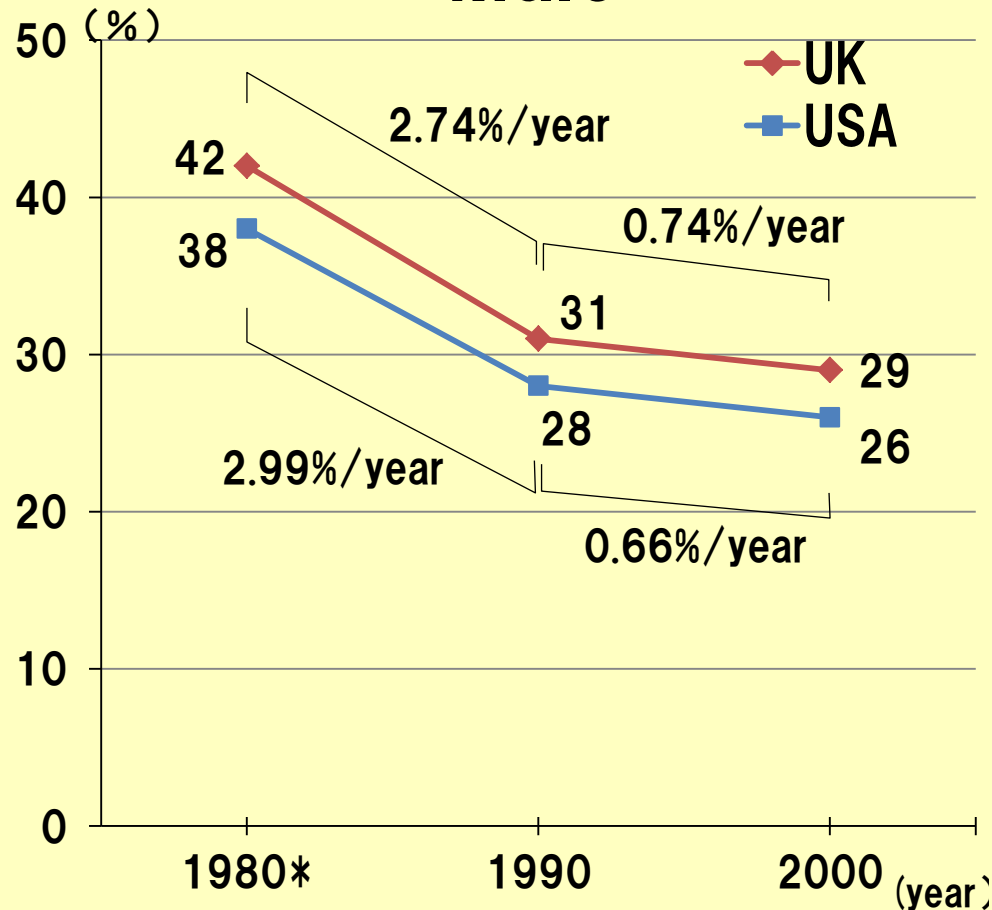
* **Target** was set on the assumption that those who wish to give up smoking(37.6%)will all quit

Trend of Smoking Prevalence in USA, UK and Japan

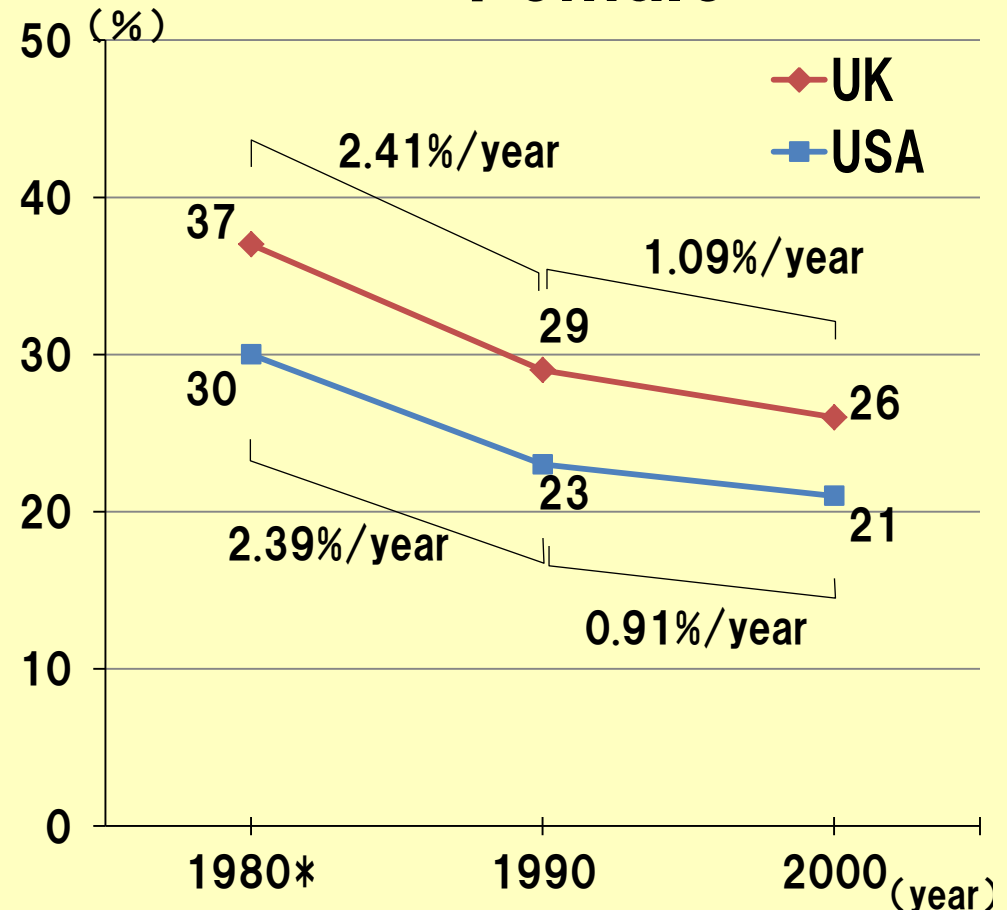


Trend of Smoking Prevalence in USA and UK

Male



Female



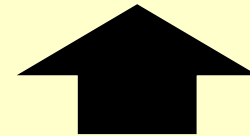
* For the USA, the data of 1979

To Promote Smoking Cessation

Quit attempt 

×

Cessation rate 



Comprehensive tobacco control

- Tax increase
- Smoking ban in public places
- Advertising ban
- Warning labels
- Mass media campaign
- Advise from health professionals

Promotion of effective treatment utilization

- Mass media campaign
- Quitline
- Accessibility to treatment including reimbursement
- Health professionals training
- Effective and novel approach for treatment

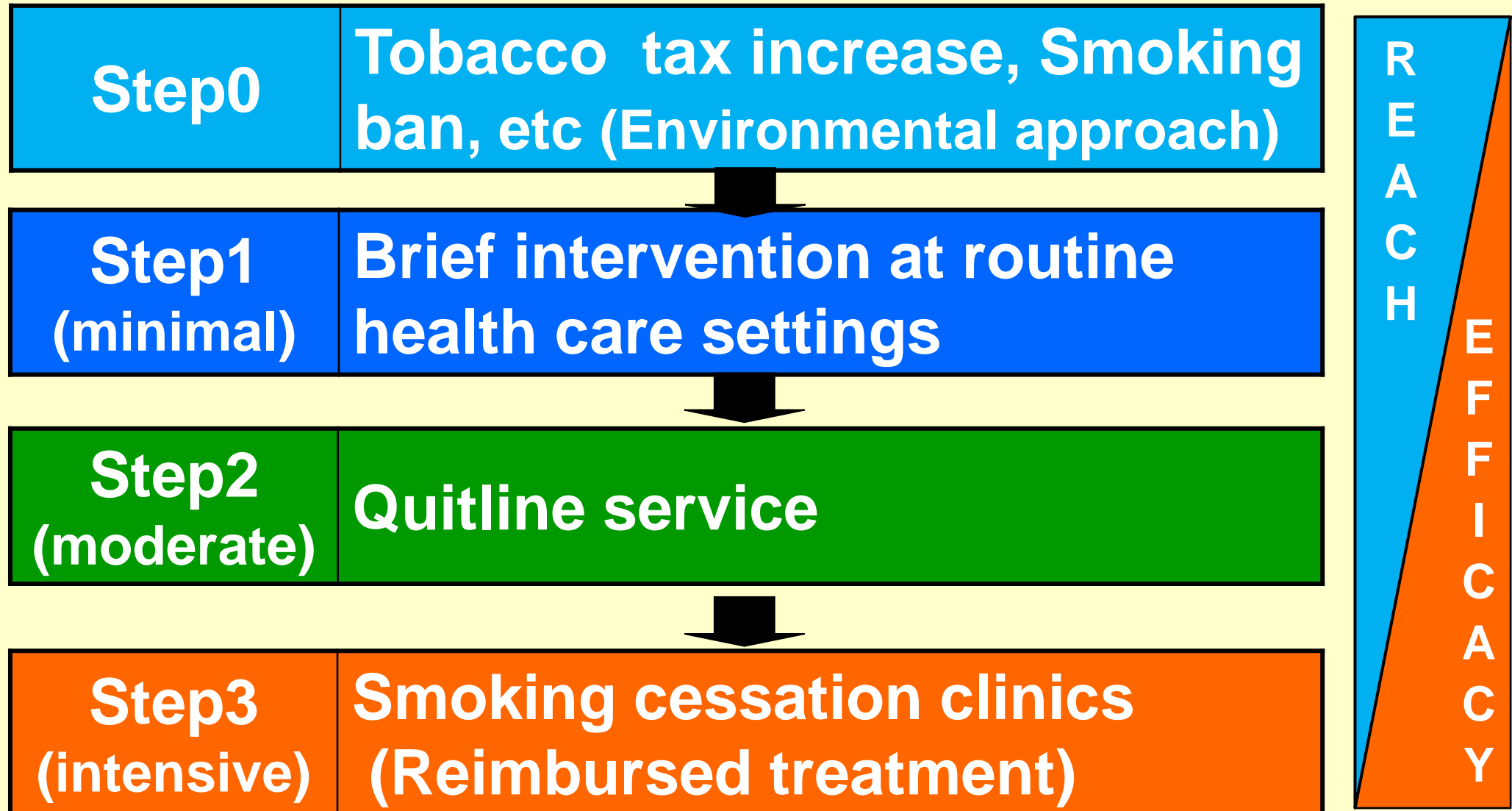
Evaluation of tobacco control policies

		Japan	China	Korea	India	Thailand	Singapore	Australia	New Zealand	UK
Smoking prevalence	Male	37.8	48.8	50.2	27.2	35.6	24.9	18.8	21.5	19.4
	Female	10.3	2.1	4.8	2.3	1.5	4.3	16.1	19.5	16.9
	Total	24.1	25.4	27.5	14.8	18.5	14.6	17.5	20.5	18.1
M (Monitoring)		Ex	F	Ex	Ex	Ex	G	Ex	Ex	Ex
P (Smoke-Free)		P	P	P	—	Ex	—	Ex	Ex	Ex
O (Cessation)		G	F	Ex	G	Ex	Ex	Ex	Ex	Ex
W (Warning)		F	F	F	P	Ex	Ex	Ex	Ex	G
W (Media Campaigns)		P	Ex	Ex	Ex	G	Ex	Ex	Ex	Ex
E (Advertising Bans)		P	G	P	G	G	G	G	G	G
R (Taxation)		G	F	G	F	G	G	G	G	Ex

Ex: Excellent G: Good F: Fair P: Poor —: Not categorized*

* due to difficulty of evaluation because the law allowed for the provision of DSRs.

Public Health Model for Promoting Smoking Cessation at Population Level



Summary

To promote smoking cessation at population level and reduce overall smoking prevalence

- (1) increase demand for cessation interventions by media campaigns, higher tobacco price and smoke free-environments**
- (2) facilitate access to cessation services by proactive interventions at routine medical activities and quitline services**
- (3) disseminate effective treatment options to increase the likelihood of success**
- (4) institutionalize the comprehensive care management system for smokers based on stepped care model**

Thank you for your attention