Tobacco Dependence Program

The Nicotine Challenger

Spring 2001 **This issue: New Jersey State Tobacco Strategies** Volume 9, Number 2

A View From The Director

As some of you may know, I only arrived in this country (from the UK) about six months ago. Since my arrival in New Jersey, I've been struck by two things. The first is the complex nature of the US healthcare system - so complex that even those who have been working in it for years admit to remaining puzzled by it. It is certainly going to be a challenge to integrate tobacco dependence treatment into such a complex system. The other thing which has impressed me is the rapid progress which is being made to tackle tobacco dependence in New Jersey. Over the past few months we have seen the launch of the free telephone counseling and advice service 1-866-NJ STOPS, the launch of the internet site designed to help New Jersey smokers quit, www.nj.quitnet.com, and the training and setting up of nine specialist tobacco dependence clinics to provide face-to-face treatment. The many people around the state who have worked for these developments for years should feel proud that their hard work is coming to fruition and that some of the funds from the Master Settlement Agreement are being used to help existing smokers to quit.

Of course this is just the beginning of New Jersey's comprehensive tobacco control program! The youth-led anti-tobacco movement REBEL was recently launched, there are plans to set up another six treatment clinics, and later in the year we will see the implementation of the provisions in the licensure standards for residential addiction services which require entirely smoke-free treatment for addictions. These are indeed busy and challenging times for tobacco control in New Jersey.

The Tobacco Dependence Program at UMDNJ-School of Public Health is a part of the comprehensive program being set up by New Jersey with funds from the Master Settlement Agreement. The Tobacco Dependence Program is dedicated to reducing the harm to health caused by tobacco use and we aim to do this through education, treatment, research and advocacy. We have increased the size of the Nicotine Challenger in order to help keep you informed of the many developments that are taking place. On April 23rd we held a conference on "Young People and Tobacco" which outlined current trends in youth tobacco use in New Jersey as well as ways in which individual providers can implement treatment strategies for young people. We will also hold our annual conference, "Addressing Tobacco Dependence In The New Millennium: State Of The Art For Clinicians," on June 7th. Among the invited speakers are Scott Leischow Ph.D., Director of Tobacco Control at the National Cancer Institute and our own Professor John Slade. We hope that this will provide an opportunity for you to learn more about developments in treatment for tobacco dependence.

Warm Regards,
Jonathan Foulds PhD
jonathan.foulds@umdnj.edu

CHAMPION VS. TOBACCO
SUSAN GOLDMAN

Susan Goldman, Director of Prevention Services, Division of Addiction Services at the NJ Department of Health and Senior Services, has enjoyed an impressive public health career for close to 24 years. Her evolution to a passionate tobacco control advocate is the story that makes her this issue's Champion vs. Tobacco.

In the 1980s, while working in the area of people with disabilities, and later, mothers and children, Susan Goldman began to appreciate the importance of prevention in both human and health costs. "So much money could be freed for positive things we need as a society if we just could prevent problems," Ms. Goldman remarked.

A smoker since her college days, when she began smoking for weight control, Ms. Goldman began to experience health consequences in the mid-80s. Then, in an effort to enforce the DOH "no smoking at your desk" policy, John Slade made a presentation which got her attention, but not in a very positive way. "I had a right to smoke!" she thought. "Meanwhile I was coughing in the morning and grabbing a cigarette first thing. I was unable to get through the day without a cigarette every two hours." Simultaneously, her husband, also a smoker, discovered he had cardiac damage. Suddenly, the problems caused by smoking became much more personal—it was not theoretical any longer.

Not everyone who stops smoking becomes a tobacco control advocate, but through her work in Maternal and Child Health, as the effects of smoking in mothers on their children became more apparent to her, Susan Goldman did. "My real passion for tobacco control came in 1995, when my husband was diagnosed with lung cancer," she remembered. "It stopped me absolutely cold and the passion of why we must control tobacco entered my life."

Her husband passed away from lung cancer in 1996 and Susan Goldman's passion as a tobacco-control advocate has grown continually since. "The more I talk to people who are affected, whether from heart disease, pulmonary disease or cancer, the more I do my job with compassion," she said.

Today, New Jersey is putting together a comprehensive, sophisticated and integrated program of tobacco control. The task is to help communities understand the impact of tobacco and how it negatively affects them, while increasing awareness of the cost both individually and collectively. Susan Goldman's life and professional experience can only add to the long-term goal of changing social norms.

Training and Education Seminars

Tobacco Treatment Specialists Training

The Tobacco Dependence Program has completed its 2nd intensive 8-day Tobacco Dependence Treatment Specialist training for professionals throughout the state. Attendees at the first training, held in November of 2000, were from the eight pilot sites funded by the state that have opened tobacco treatment clinics. The second training was completed in February 2001 and was attended by pilot site staff along with professionals from other organizations. The next intensive training is scheduled for June of 2001.

Tobacco Seminars

Since October, monthly training seminars have been held to present information on current tobacco issues, and to allow time for attendees to network with other professionals interested in tobacco research and treatment. Refreshments follow the one-hour presentations which are held at UBHC in Piscataway. Upcoming seminars include:

Monday, May 7–4:30 PM, *The NJ Tobacco Control Program,* Susan Lenox Goldman, MFA–Director of Prevention Unit
NJ Department of Health and Senior Services

Monday, June 4, *Curbing the Tobacco Epidemic: The Role of Workplace Tobacco Control Policies and Programs,* Omowunmi Osinubi, M.D.
UMDNJ, EOHSI

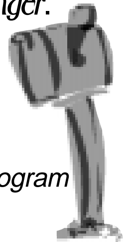
Conferences

Annual Conference—Addressing Tobacco Dependence in the New Millennium: State of the Art for Clinicians
Thursday, June 7, 2001
New Jersey Hospital Association

For further information on any of these events, please contact Nancy Speelman at 732 235-8218 or e-mail nancy.speelman@umdnj.edu.

We Welcome Your Comments and Suggestions

Please let us know what you think about *The Nicotine Challenger*.



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The Nicotine Challenger

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The Nicotine Challenger is a publication of the *Tobacco Dependence Program.*
Newsletter design & production by Pressing Issues, Inc. (732) 549-9054

The ***Tobacco Dependence Program,*** UMDNJ-School of Public Health, helps programs, organizations and clinicians deal with tobacco issues and nicotine dependence. The program is funded by a grant from the New Jersey Department of Health and Senior Services, Division of Addiction Services.

Products and services include:

- consultation
- education and training
- policy & program development
- treatment planning
- staff recovery workshops
- tobacco dependence treatment

Nicotine Anonymous Meeting Schedule

New Jersey

Please call the Tobacco Dependence Program *office at (732) 235-8212 with additions, deletions or corrections to this list.*
Call the contact person to confirm current information about meeting times and locations.

Bergen County

Wednesday, 7:00 PM, Westwood
Pascack Valley Hosp, 250 Old Hook Rd.
1st Floor Conference Room
201-666-2523: Nancy W.

Saturday, 7:00 PM, Teaneck
St. Marks Episcopal Church
Grange & Chadwick Roads
201-947-3305: Bill C.

Camden County

Monday, 7:00 PM, Cherry Hill
Kennedy Hospital - 5th floor
Chapel Avenue/Cooper Landing Road
856-786-9101: Lee Ann D.

Essex County

Thursday, 8:00 PM, East Orange
E.O. General Hospital
80 South Munn Avenue
973-226-8471: Charles

Hudson County

Monday, 7:30PM, Jersey City
St. Francis Hospital
25 McWilliams Place, 1st Floor
201-798-8453: Rich M.

Thursday, 8:00 PM, Kearny
Talbot Hall
100-140 Lincoln Highway
973-589-1114: Juanita

Mercer County

Friday, 7:00 PM, Hamilton
Hamilton Hospital
Whitehorse & Klocker Roads
Cafeteria—Doctor's Dining Room
609-587-4244: Bob M.

Middlesex County

Monday, 7:30PM, Metuchen
Centenary United Methodist Church
200 Hillside Avenue, Room 20
732-549-5955: Jane G.

Tuesday, 7:30 PM, Edison
Mortgage Money Mart
1199 Amboy Avenue - Tano Mall
1st building, in front, 1st floor
732-548-9423: Frank N.

Monmouth County

Wednesday, 7:00 PM, Manasquan
First Presbyterian Church
16 Virginia Avenue at South Street
732-449-0007: Larry U.

Thursday, 8:00 PM, Ocean
First Thursday of month only
Ocean Fitness Center - Lower Level
1602 Highway 35 South
732-531-1179: Alfia D.

For NY, NJ, PA Nicotine Anonymous meeting information, call 516-665-0527

Morris County

Thursday, 6:30 PM, Boonton
St. Clare's Hospital
Community Conference Room
Powerville Road
973-586-3359: Goran P.

Passaic County

Tuesday, 7:00 PM, Clifton
Athenia Reformed Church
770 Clifton Avenue
973-283-1733: Tasia M.

Sussex County

Monday, 7:30 PM, Port Jervis, NY
Mercy Hospital 4th Floor Day Room
160 East Main Street
717-491-4641: Paul

Union County

Friday, 7:30 PM, Plainfield
Cross of Life Lutheran Church
1240 East 7th Street
732-388-1271: Judy M.

New Jersey's Tobacco Dependence Treatment Clinics

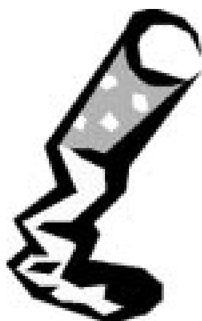
Catholic Community Services Inc., Mt. Carmel Guild
Newark 973-596-3858

Kennedy Memorial Hospital University Medical Center
Cherry Hill 856-488-6514

Medical Center of Ocean County Behavior Health Systems
Brick 732-295-6417

New Hope Foundation
Freehold 732-308-0113

Plainfield Health Center
Plainfield 908-753-6401



Rowan University
Glassboro 856-256-4527

Saint Barnabas Behavioral Health Center, Beth Israel Site Medical Center
Newark 973-926-7026

UMDNJ-School of Public Health, Tobacco Dependence Program
New Brunswick 732-235-5222

University Behavioral Healthcare, Mercer/Trenton Addiction Center
Trenton 609-396-4526

Challenges & Strategies on Becoming Tobacco-Free

In the Residential Licensure Standards adopted on November 15, 1999 by the New Jersey Department of Health and Senior Services, tobacco was given parity with alcohol and other drugs of abuse. The licensure standards provide for comprehensive alcohol, tobacco, and other drug treatment for patients through screening, assessment, diagnosis, education, treatment planning, and continuing care. In addition, the provisions mandate that “the use of tobacco products and spit tobacco on the grounds of free standing treatment facilities shall be phased out by November 15, 2001” (8:42A-3.11(a)). As this date fast approaches, we would like to share with you some of the challenges faced and strategies developed by various facilities as they addressed the provisions relating to tobacco.

The programs that have successfully met the challenge of the new licensure standards have all stressed the importance of the administration's commitment to a tobacco-free environment and to integrating tobacco treatment into all aspects of the program. This commitment is the foundation for implementing change and establishing a tobacco-free policy.

Successful programs have also established a committee dedicated specifically to addressing tobacco policy and developing a comprehensive plan of action, including an implementation timeline. This strategy minimizes the conflicts that inevitably occur when issues are addressed by one or two individuals. Typically, a staff member who is in a policy-making capacity chairs the committee. Other committee members represent different departments as well as administration. A flexible timeline outlines the steps for implementing the plan of action, provides a way to monitor progress and ensures that goals are met in a timely fashion. Programs report that instituting changes in small steps eases the adjustment for both staff and clients. Allocating sufficient time to plan and implement the policy is essential.

Programs note the importance of addressing staff concerns and ambivalence regarding a tobacco-free policy. Without the support of staff, efforts are undermined and changes are difficult to implement. Programs that have become tobacco-free report that they provided training to all staff on the rationale for treating tobacco in the chemical dependency setting.

Another important issue for programs to address is smoking staff members. It is especially important for programs to acknowledge the challenge a tobacco-free policy presents for staff who smoke and to provide support for those who wish to quit. Some offer voluntary "For Smokers Only" workshops facilitated by the Tobacco Dependence Program for staff wishing to address their tobacco use. Facilities are encouraged to check their healthcare plans to see if coverage for nicotine dependence treatment is includ-

ed and to advocate for its coverage when healthcare plans are chosen. It is imperative, however, that programs clearly state their expectations about compliance with the new policy as well as the consequences for violations. A number of programs note that smoking staff report cutting down tobacco use substantially or quitting entirely.

Clinical staff often express concern about their lack of knowledge regarding tobacco dependence treatment and question its efficacy with a client not interested in quitting smoking. These concerns are addressed through clinical training. which builds on staff's existing skills in treating other substances of abuse. The National Institute on Drug Abuse’s Principles of Drug Addiction Treatment (1999) state that treatment does not have to be voluntary to be effective and reinforces the experience clinicians have in addressing clients' use of substances other than the one that may have brought them into treatment. Most programs adopt a stage-based model of treatment (Prochaska and DiClemente) using interventions based on a client's level or motivation to address tobacco use.

With regard to consequences for tobacco policy violations, approaches tend to vary by client and program. For example, in residential programs where clients work during the day, on-campus violations may be differentiated from off-campus violations. In general, however, violation of the tobacco policy is seen as a clinical issue requiring clinical interventions. Consequences range from creating contracts to revocation of privileges or demotion to a lower phase of treatment. Some programs have adopted a policy where repeated violations of the tobacco policy are evaluated as part of overall program compliance. When tobacco violations are seen as a demonstration that the client is not serious about treatment. Tobacco use may be the way they are acting out.

Programs have handled the period of final transition to tobacco-free status in a variety of ways. Some programs feel that special recognition would be counterproductive if the message is that tobacco is no different than other drugs. Other programs have held ceremonies the night before, with clients and staff acknowledging the loss while welcoming in their new tobacco-free status. One halfway house made the transition on a Friday and held a relapse prevention workshop for all residents that day. The residents also stayed home that weekend and participated in fun-filled, resident-planned activities.

The issue of nicotine replacement therapy (NRT) also varies among programs. Some offer the nicotine patch, which has the least behavioral reinforcement associated with it. Other programs are opposed to use of any medication because of religious or philosophical conflicts. However, many programs would like to offer NRT to ease the process of physical withdrawal, understanding that NRT doubles quit rates and is the humane way to deal with clients in withdrawal. While lack of funding for

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pharmacotherapy has presented an obstacle for many programs, some have been able to fund NRT for clients.

For smokers, seeing others smoke is a primary trigger for relapse. This can occur at 12-step meetings, outside activities, work, visits home or when they are part of a larger facility where another program allows tobacco use. One facility uses this as an opportunity to practice newly-learned coping skills and counselors assist clients in developing and utilizing these skills to avoid relapse to tobacco use. These skills can then be easily translated to skills for coping with triggers to use alcohol and other drugs. Suggesting that clients go and stay inside the building at non-smoking meetings (to avoid the smokers outside the door), finding a non-smoking sponsor and going to tobacco-free activities are other solutions. Talking about triggers and reaching out for support are other ways to practice staying clean, sober and tobacco-free.

We have listed some of the challenges involved in becoming tobacco-free. Recognizing that each facility and treatment modality has its own set of issues. We believe chemical dependency programs can make this transition and begin to address tobacco dependence with the same commitment as they have other drugs of addiction. Our staff is available as a resource for this work and we also encourage programs to communicate with one another and share their experience, strength and hope.

Let your colleagues know what works and let us know as well, so we can pass on your experiences creating a tobacco-free environment.

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Martha Dwyer, M.A., CADC, Addictions Consultant, martha.dwyer@umdnj.edu

Helping Young People Stop Smoking

Ninety percent of adults state they had their first cigarette before the age of 18, and, while quitting smoking is generally thought of as an adult decision, many young people report that they regret ever starting to smoke and would take part in treatment programs if they were available. The challenge, therefore, is to offer help that is effective and age-appropriate.

One approach to treating young smokers is to utilize adult techniques and adapt them for this age group. The Clinical Practice Guideline for Treating Tobacco Use and Dependence developed by the Public Health Service of the U.S. Department of Health and Human Services recommends, for example, that "counseling and behavioral interventions shown to be effective with adults should be considered for use with children and adolescents. The content of these interventions should be modified to be developmentally appropriate."

Successful quit-smoking interventions for youth should, for example, focus on the immediate consequences of smoking, including bad breath and stained teeth. In general, there is a perceived lack of negative consequences of smoking among youth, who also tend to underestimate the addictive nature of nicotine. Programs should offer education on coping skills, alternate activities, healthy lifestyles, and role modeling to assist with potential peer pressure from friends who smoke. In addition, follow up or booster sessions should be offered for continued support.

It is recommended to use youth-oriented programs when available.Programs such as the NOT (Not on Tobacco) program from the American Lung Association, have been used in Florida where a decrease in youth smoking has been noted. NOT uses a gender-sensitive, group intervention model. The program teaches a total health approach to quitting smoking. The NOT program is specifically designed for young people motivated to quit smoking. Other programs such as TAP (Tobacco Awareness Program), END (Ending Nicotine Dependence) and TEG (Tobacco Education Group) are also multiple group session quit-smoking programs. TAP addresses young people at the preparation, action and maintenance stages of change and TEG is an alternative-to-suspension program with a focus on smokers who are at the precontemplative or contemplative stages of change.

Studies suggest that young people may have a more difficult time quitting smoking than adults. This can be attributed to lack of social support and a lack of access to nicotine replacement therapy, which is not commonly prescribed for children and adolescents. "Since there is no evidence that buproprion SR or nicotine replacement is harmful for children and adolescents", according to the Clinical Practice Guideline, "clinicians may consider their use when tobacco dependence is obvious."

The recently established NJQuitline and, in particular, NJQuitnet may appeal to young people, as they have increasing access to the internet at home, as well as at school and the local library. These resources provide quit-smoking information in a non-threatening and anonymous manner.

Please contact the Tobacco Dependence Program for more information regarding quit- smoking programs and resources for young people.

Mia H. Zimmermann, B.A., Consultant for Young People Services, *mia.hanos@umdnj.edu*

Visit us online!

www.tobaccoprogram.org

Check out this website!

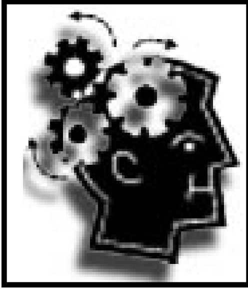
NJ REBEL

(Reaching Everyone by Exposing Lies)

www.njrebel.com

REBEL is a grassroots movement developed by teens throughout New Jersey with the goal of preventing and reducing tobacco use by their peers.

Tobacco Dependence and Mental Illness



This is our first column on Tobacco Dependence and Mental Illness. Our goal is to increase awareness about the latest clinical research findings on tobacco and mental illness and to describe innovative mental health program approaches to addressing tobacco dependence. We welcome questions and comments. In addition, the Tobacco Dependence Program is available to help your mental health program address tobacco.

Tobacco Dependence is known to be common among individuals with mental illness. However, the new data that 42% of cigarettes smoked in the US are by the mentally ill is still an eye-opener and should be a call to seriously address tobacco in mental health treatment settings. Smoking is associated with more frequent hospitalizations, higher rates of other substance use disorders, and increased death and illness among individuals with mental illness. Some disorders have especially high rates, for example, schizophrenia (88%) and mania (70%). Within such illness, smoking seems to be strongly correlated with the severity of illness. People with mental illness smoke more and inhale deeper and thus are at greater risk to the adverse effects of cigarette smoking than the general population.

A recent study on schizophrenia and tobacco dependence treatment, from the Yale University group where Dr. Ziedonis initially developed a Tobacco Dependence and Mental Health Clinical and Research Program, and where Dr. Tony George continues to develop new research initiatives provides hope that treating tobacco dependence in individuals with schizophrenia can work. This study found that treatment was about 3 times more effective when a patient is given Nicotine Replacement Therapy and is receiving one of the new atypical antipsychotic medications compared to the traditional medications. This study was published in the American Journal of Psychiatry in November 2000– Nicotine Transdermal Patch and Atypical Antipsychotic Medications for Smoking Cessation in Schizophrenia by Tony George, Doug Ziedonis, Alan Feingold, et al. Patients who had been taking the newer "atypical" antipsychotics, especially risperidone and olanzapine, had much higher abstinence rates (55.6%) than patients on typical antipsychotic medications (22.2%). Endpoint smoking cessation rates in patients who received atypical agents approached those observed in studies of the effects of the nicotine transdermal patch in smokers who were not psychiatric patients. These findings are in agreement with previous anecdotal reports that indicate a benefit of atypical antipsychotics in substance dependence. Previous studies with clozapine, an atypical antipsychotic, have also shown an improvement in smoking cessation rates. In future columns, we will present other recent research and updates on model mental health treatment program approaches that address tobacco dependence.

Forty-two percent of all cigarettes purchased in the US are purchased by individuals with mental illness! JAMA, November 2000

Consultation Help: The Tobacco Dependence Program, formerly the *Addressing Tobacco Project,* has expanded to provide services to NJ Mental Health programs to help them treat tobacco use by mental health consumers. The program's consultation services are free to NJ mental health programs. The Tobacco Dependence Program views tobacco use as an addiction and one that needs to be treated through an integrated approach. The treatment of tobacco dependence is best accomplished through a public health integration model, in which the treatment is incorporated into an agency's current modalities and delivery of services. Individuals with mental illness, and particularly people with severe and persistent mental illness, have historically been overlooked as recipients of tobacco dependence treatment.

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Website Review: www.nj.quitnet.com

One of the new services which has been funded by the New Jersey Department of Health and Senior Services (via the Master Settlement Agreement) to help smokers quit is an internet site (www.nj.quitnet.com). The site attempts to bring proven scientific methods to the Web to deliver support to smokers whenever they need it. So what can you or your clients expect when logging on to this site?

One of the great advantages of the New Jersey Quitnet site is that it contains a number of interactive and personalized services. An example of this is the peer-to-peer support page that uses a "chatroom" format to allow hundreds of people, who are trying to quit, talk to and encourage each other. When you click onto this page and read the comments and responses of other smokers who are going through the same experience as you, it really has the feeling of an online support group. If you want to ask your fellow quitters a question or encourage someone else, then this page enables you to do so.

Another page on the site enables you to ask questions directly to one of the quitnet's expert counselors. Again you simply post your question on the site, and you should get a reply later that day. It is also very instructive to read the questions and answers already posted, as very often other smokers have had the same experiences and have asked the same questions.

In addition to these interactive components, the site has a number of other informative components, such as a review of pharmaceutical aids for stopping smoking, a quitting guide, and a directory of face-to-face services available in New Jersey.

I found the site to be user friendly, containing reliable high quality advice and information. I happily recommend it to smokers who are thinking of quitting, and I usually emphasize the importance of registering on the site, rather than just browsing. To register you have to type in some very simple pieces of personal information, which are guaranteed to be confidential. You then get an ID number which enables access to more of the interactive features of the site. An example here is the "Q Gadget", which automatically calculates the amount of life-time and money you have saved since quitting and informs you of this every time you log in. Overall this is an excellent site which is well worth a visit.

Jonathan Foulds Ph.D., Director, jonathan.foulds@umdnj.edu

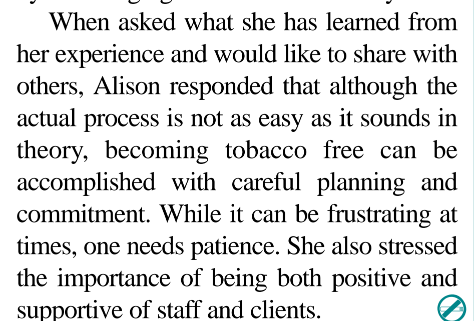
Integrity House Update

Integrity has now joined the pioneers who have made the commitment to address and treat tobacco dependence on par with alcoholism and other drug dependencies. On January 1st, Integrity House became a tobacco-free campus; tobacco use is not permitted in program buildings or on the grounds. As a therapeutic community, Integrity's treatment philosophy is based on the concept of facilitating change through peer pressure and role modeling. Alison Schwartz, MPH, MSW, Director of Prevention Services at Integrity House describes it as "self help, mutual help." Change begins with a segment of the community initiating the process. The rest of the community then joins in the effort and the change becomes a community project.

A nicotine committee of staff volunteers was formed to spearhead the process of addressing tobacco. The results of their discussion filtered out into the greater Integrity community. Alison says this process has been thought-provoking for staff, most of whom have begun the paradigm shift towards giving tobacco parity with other drugs of abuse. A number of staff and clients indicated they were relieved that smoking was being addressed. She notes that a number of staff have begun to address their own tobacco use; some have quit smoking while others are either contemplating or preparing to quit. Integrity has taken a positive approach, one of support as opposed to chastisement, with those who struggle with tobacco dependence. Alison says, “Staff feel supported that they don't ‘have to’ stop, but know they cannot smoke during their shift. Tobacco dependence is viewed by us as part of the disease concept—as an illness or disease; therefore, we treat it with a medical model rather than chastisement.” Their supportive stance is reflected in the tremendous support staff provide to their colleagues who have quit their tobacco use and the continued support of those who still struggle with quitting.

Integrity moved in stages towards its tobacco-free goal, allowing staff and clients to adjust to the change. Integrity began implementing "smoke free" days on campus and gradually increased them in number. Ultimately residents were told that effective January 1st they could not smoke while in the program. To ease the discomfort of physical withdrawal, Integrity permits use of nicotine replacement therapy in the form of the patch if it is prescribed by a doctor and approved by Integrity. The client or the client's family covers the cost of the patch. Integrity runs psychoeducational groups specific to tobacco issues as well as a weekly support group for clients. Although it is not possible to monitor client behavior 24 hours a day, Alison said it appears that most residents are complying with the new policy even when off campus. Client violations of the policy result in a therapeutic intervention in which the client receives a contract and the violation is used as a learning experience.

Families of the residents were also prepared in advance. The family therapist began talking about the rationale behind the upcoming policy change a few weeks before the actual tobacco-free date. Families were encouraged to show their support of the client's progress in dealing with tobacco by not bringing tobacco to the facility.



When asked what she has learned from her experience and would like to share with others, Alison responded that although the actual process is not as easy as it sounds in theory, becoming tobacco free can be accomplished with careful planning and commitment. While it can be frustrating at times, one needs patience. She also stressed the importance of being both positive and supportive of staff and clients.

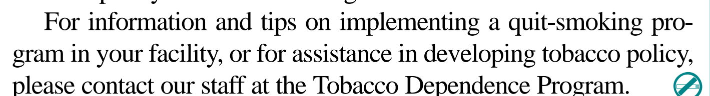
Martha Dwyer, M.A., CADC, Addictions Consultant, martha.dwyer@umdnj.edu

Freehold Township High School Tackles Tobacco Use By Students

Through collaboration by the administration, the student assistance counselor, and the Freehold Municipal Alliance, coupled with innovative interventions with students who use tobacco, Freehold Township High School has developed a comprehensive tobacco policy for students and a program for intervening with students who use tobacco. In 1997, at Freehold Township High School, there were 170 violations of the school's tobacco policy. As of January 2001 the number has dwindled to 30. This is a decline of 82%.

Kathleen Andrejco, Student Assistance Counselor (SAC), believes the decline is a combination of administrative support for tobacco control, and policy enforcement efforts. The school increased supervision at lavatories, implemented a quit-smoking program and fostered parental involvement with this very important issue. Current policy states students are not allowed to use tobacco in the building or n school grounds or during school-sponsored events. Students who violate the policy receive a one-day suspension and a mandatory re-entry conference that a parent must attend. Vice-Principal Linda Jewel is committed to conducting re-entry conferences, because parental involvement with their child's tobacco use often results in reduced future incidents. This is congruent with research that shows parental involvement has the greatest impact on young people's tobacco use. At the time of re-entry, the student is mandated to take part in two educational sessions relating to tobacco led by the SAC. Ms. Andrejco later conducts a formal assessment of the student’s tobacco use. Students who express a desire to quit using tobacco are then referred to the school's quit-smoking program, Stop Tobacco Use Now (STUN), which was developed with support from the Freehold Township Municipal Alliance. This voluntary nine-session program is facilitated by the SAC during school hours and includes tips for quitting. Ms. Andrejco reports that many people credit the STUN program with significant reduction in student violations. She. however, credits the more complete initiative of policy, commitment from school administration and the involvement of students' parents as some reasons for the positive results experienced at her school.

We commend Freehold Township High School for their commitment and foresight in addressing tobacco policy as well as treating students' tobacco use.



For information and tips on implementing a quit-smoking program in your facility, or for assistance in developing tobacco policy, please contact our staff at the Tobacco Dependence Program.

Mia H. Zimmermann, B.A., Consultant for Young People Services, mia.hanos@umdnj.edu

TOBACCO 101

A TOBACCO AND NICOTINE TUTORIAL

By John Slade, M.D.

A different subject is featured in this column in each issue of The Nicotine Challenger. Please send questions or suggestions for topics to Dr. Slade at the **Tobacco Dependence Program.**

New Jersey's tobacco control program compared with the best state programs

The cigarette kills half of continuing smokers, and the vast majority of those who smoke, regret having started and want to stop. At the same time, public health and clinical efforts to reduce tobacco use work. They save lives, especially the lives of people who do not want to be the customers of the cigarette manufacturers.

The cigarette industry spends $150 million each year to market their deadly, addictive products in New Jersey, persuading people to start and continue smoking, by saying, in effect, that it is a great thing to do. The industry is concerned with selling product, so it cynically minimizes concerns and pretends that its products are fine. After all, if there were a really bad problem with cigarettes, they wouldn't be legal, right?

Addictive? Philip Morris, RJ Reynolds, Brown & Williamson and Lorillard play with the word. The litany they use is that they only want to sell to adults who chose to smoke. The audacity of this pious assertion is breathtaking. If they actually were to limit cigarette sales to this group, to those who freely choose to smoke, their customer base would be enormously reduced.

Up against this polished juggernaut, New Jersey's Department of Health and Senior Services is beginning to spend $30 million per year on efforts to reduce tobacco use in the state. This money comes directly out of the pockets of smokers, whose purchases of cigarettes finance the manufacturers' payments under the Master Settlement Agreement on a pay-as-you-go basis. Over time, if DHSS puts in the field a good mix of programs, media and policies, the program will reduce tobacco use in the state and save lives.

We know this can be done because it has already been done in California and in Massachusetts.

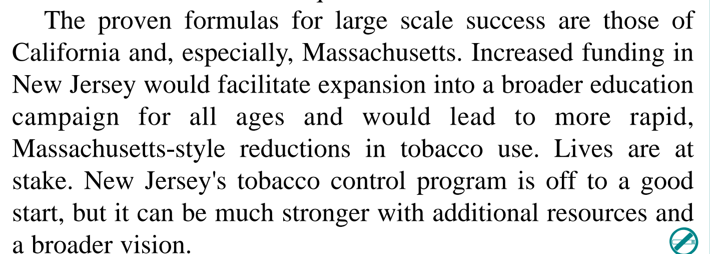
In California, a state-funded tobacco control program has been in operation since 1989. That program, funded at about $3.75 per capita, has reduced tobacco use in the state by a third and has cut lung cancer deaths by 14%. An estimated 33,300 Californians did not die of heart disease between 1990 and 1997 because of the program.

In Massachusetts, a similar program got underway about 5 years later than the program in California. There, the funding was more generous, up to $7 per capita. Massachusetts experienced a more rapid reduction in tobacco use than did California, so in only a few years, it saw a 1/3 reduction in tobacco use. The daily adult cigarette smoking rate in Massachusetts is now less than 15%, the lowest of any state in the nation, and lower than that of any country in the world.

California's program has had its ups and downs, with changes in policies and in funding levels that seem to be directly related to the long arm of the tobacco companies' political influence. When the program was blunted, benefits became much smaller. Overall, the diminished effectiveness of the California program after 1992 resulted in 8,300 more deaths from cardiovascular disease than would have occurred had the program been permitted to continue on its pre-1992 trajectory.

A major feature of the programs in both California and Massachusetts has been a large and very visible media campaign to talk with the public at large about tobacco. This effort has provided a context for local community efforts and has helped motivate people to quit. It complements parts of the program that are specific for youth, making it clear that tobacco is a problem all ages have to wrestle with.

In New Jersey, the available funds are at about the same per capita level as those in California (and about half that of the current Massachusetts program), but the strategy adopted is one that focuses on young people to a greater extent than the California and Massachusetts programs. For instance, there are no current plans in New Jersey for mass media that provides general public education about tobacco, only an effort aimed at young people and a smaller effort directed towards publicizing the toll-free quitline and the quitnet internet service.



The proven formulas for large scale success are those of California and, especially, Massachusetts. Increased funding in New Jersey would facilitate expansion into a broader education campaign for all ages and would lead to more rapid, Massachusetts-style reductions in tobacco use. Lives are at stake. New Jersey's tobacco control program is off to a good start, but it can be much stronger with additional resources and a broader vision.

Note: For more information about California's experience, see Stanton A. Glantz and Edith D. Balbach, Tobacco War, Berkeley, University of California Press, 2000. Full text available on line at http://escholarship.edlib.org/ucpress/tobacco-war.xml.

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MICA Program Celebrates One Year Tobacco-Free

The Circle Program, a 90-day inpatient program for dually-diagnosed patients in Pueblo Colorado, marked its first tobacco-free anniversary this past January. This 30-bed, voluntary unit is part of the state hospital system in Colorado. Patients admitted to the program have an Axis I diagnosis (i.e., Schizophrenia, Schizoaffective Disorder, Bipolar, Major Depression, or even eating disorder) as well as an Axis I substance abuse disorder. There is a 3-4 month waiting list for this very comprehensive program. Although the ward is co-ed, most groups are gender specific. The program employs cognitive behavioral approaches to treatment using the Strategies for Self Improvement and Change model. There are the typical counseling groups, a Behavior Awareness Group using strategies one might find in a therapeutic community, and even a group on Criminal Thinking used to address many of the issues faced by patients with Axis II diagnoses. In the past year, 5 physicians were trained in acupuncture to address detoxification, relaxation, craving, and hopefully to assist patients in dealing with their tobacco issues as well.

Under the direction of Dr. Elizabeth Stuyt, a board-certified addiction psychiatrist, the program prepared for 6 months to become tobacco-free. Dr. Stuyt provided staff education about tobacco dependence, its impact on the population served by the program and the rationale for integrating tobacco dependence treatment into the treatment setting. Staff who used tobacco were encouraged to address their own use and were offered support for quitting. A one-day retreat for Circle Program staff offered the opportunity to voice concerns and to process feelings about becoming tobacco-free. It was important to Dr. Stuyt to have buy-in and a a willingness to try from her staff. During the course of the one-day retreat, many fears were addressed. Some staff were angry, while others were concerned that the focus on tobacco would undermine the other work being done with patients. There were even tears from some as they processed this very emotional issue. She received everyone's commitment that they would be willing to support the policy change.

Following the retreat, Dr. Stuyt began facilitating a group for patients about tobacco. Her staff provided the educational component of this group. The program adopted a protocol of not separating tobacco from the other drugs of addiction including alcohol. “Anytime you use the word ‘alcohol’ or ‘cocaine’ in teaching about addiction, you use the word ‘tobacco’,”she said. For the months prior to going tobacco-free, the entire staff talked about the intent of the program becoming tobacco-free with patients. They even told patients, “It might not happen while you're here, but it will happen with this program.”

December 1st, one month prior to the tobacco-free date for clients, staff were no longer allowed to be identifiable as tobacco users. From that point forward, staff couldn't talk about their own continued tobacco use with clients, or be seen by clients smoking; staff could neither bring paraphernalia onto the unit nor show evidence of having used tobacco, such as having the odor of tobacco on their clothes. Although there were still staff who continued to use tobacco, they were compliant and respectful of the policy as it related to them. Dr. Stuyt remarked that all her staff, including those who use tobacco are supportive of the policy and are helpful to clients in addressing their own tobacco use and, in fact, several used the date to quit smoking.

Since becoming tobacco-free, there has been no decrease in census. No patients have refused admission to the unit and no patient has left the program because of the tobacco-free policy. No patient has been discharged because of non-compliance with the tobacco policy. What has become apparent at the Circle Program is that patients who violate tobacco policy have trouble complying with rules in general—the tobacco policy is just one of many infractions. The inability to comply with the tobacco policy has become a marker that a patient may not be ready or willing to work on the issues that brought the patient into treatment in the first place.

Dr. Stuyt admits that no patient entered her program with the intent of stopping smoking. However, what she finds so exciting is that some patients report, “I really want to keep this up” as they prepare for discharge. For each issue presented during the patient's initial assessment, including smoking and their motivational level, based on the Stages of Readiness for Change Model, is assessed. Dr. Stuyt reports that 75% of patients leave the Circle Program expressing a desire to stay stopped.

Prior to the implementation of a tobacco-free policy, Dr. Stuyt reported there were problems on the unit with positive drug screens for substances such as marijuana and alcohol. However, since the institution of the tobacco-free policy a year ago, there hasn't been a single positive drug screen.

Another observation that was particularly exciting was the active participation by Circle Program patients in the recreation program at the hospital. Prior to becoming tobacco-free, patients used their free time to sit around and smoke, and patients as a whole did not participate in recreational activities during free time. Now, patients are using this time to walk the track at the hospital and/or to work on homework assignments.

Dr. Stuyt has collected data on 100 patients prior to becoming tobacco-free and additional data on 180 patients since the implementation of a tobacco-free policy. She is hoping to get appropriate funding to study in greater detail, the results of the tobacco-free policy on treatment outcomes. Based on patient reports, having addressed tobacco while in treatment appears to have increased their awareness about relapse with other drugs of addiction and may have even improved their resolve to remain clean and sober. Many patients, however, struggle with tobacco use after discharge and often report that they regret any tobacco use after treatment. Their concern about smoking is heartening in light of the fact that, for most patients, tobacco was not an issue at all before treatment.

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Women and Smoking

A Report of the Surgeon General 2001

Women now account for 39 percent of all smoking-related deaths each year in the United States, a proportion that has more than doubled since 1965, according to a report on women and smoking by Surgeon General David Satcher. The report concludes that the increased likelihood of lung cancer, cardiovascular disease, and reproductive health problems among female smokers makes tobacco use a serious women's health issue.

Meanwhile, increased marketing by tobacco companies has stalled progress in smoking cessation by women, and recent increases in smoking among teenage girls threaten to wipe out any progress that has been made in the last few decades.

Dr. Satcher said, “Women not only share the same health risk as men, but are also faced with health consequences that are unique to women, including pregnancy complications, problems with menstrual function, and cervical cancer.”

Women and Smoking: A Report of the Surgeon General summarizes patterns of tobacco use among women, factors associated with starting and continuing to smoke, the health consequences of smoking, tobacco marketing targeted at women, and cessation and prevention interventions.

The report calls for increasing public awareness of the devastating impact of smoking on women's health; exposing and countering the tobacco industry's targeting of women; encouraging public health policymakers, educators, medical professionals, and women's organizations to work for policies and programs that deglamorize and discourage tobacco use; reducing disparities related to tobacco use and its health effects among different ethnic/racial populations; decreasing nonsmokers' exposure to environmental tobacco smoke; and mounting comprehensive statewide tobacco control programs proven to be effective in reducing and preventing tobacco use.

The report outlines key solutions for preventing and reducing smoking among women, including:

- ***Encouraging quitting for women of all ages.*** Quitting results in immediate health benefits for both light and heavy smokers, including improvements in breathing and circulation. The excess risk of coronary heart disease is substantially reduced after one or two years of smoking cessation. The increased risk for stroke associated with smoking is reversible after quitting smoking. When smokers quit, their lungs begin to heal and their risk of lung disease drops. Smoking cessation also improves quality of life and physical functioning.
- ***Implementing science-based smoking cessation interventions into widespread clinical practice.*** This action would be as cost-effective as other medical interventions such as mammography and treatment of high blood pressure.
- ***Enacting comprehensive statewide tobacco control programs.*** Results from states such as Arizona, California, Florida, Maine, Massachusetts, and Oregon show that science-based tobacco control programs have successfully reduced smoking rates among women and girls. California is now starting to observe the dramatic public health benefits of its sustained efforts. Between 1988 and 1997, the incidence rate of lung cancer among women declined by 4.8 percent in California but increased by 13.2 percent in other regions of the US.
- ***Encouraging a more vocal constituency on issues related to women and smoking.*** Concerted efforts are needed from women's and girls' organizations, women's magazines, public health policymakers, medical groups, and volunteer organizations to call public attention to lung cancer and other smoking-related diseases among women, and to call for policies and programs that deglamorize and discourage tobacco use. This effort should draw from the success of advocacy campaigns to reduce breast cancer.

A full copy of *Women and Smoking: A Report of the Surgeon General* and other related information is available on the CDC's Web site: www.cdc.gov/tobacco/sgr_forwomen.htm

Philip Morris Offers Free Book Covers

This [Philip Morris decorative] book cover is just the latest example that the war is not over. . . Tobacco companies aren't going away. . . . They have to get new customers. They know if they get you when you're young, they get you for life.

Rhode Island Lt. Gov. Charles J. Fogarty. The furor over Philip Morris' book covers, millions of which have been sent to middle and high schools, is covered in, FREYER, F., Book Covers Cloud Message On Tobacco Use, Critics Say Providence Journal-Bulletin, Saturday, September 23, 2000.

As a condition of the Attorney General's settlement with the tobacco companies, Phillip Morris is prohibited from advertising to youth. In spite of this, Primedia's Cover Concepts Marketing Services is distributing 13 million "free" book covers on behalf of Phillip Morris. The inclusion of the Phillip Morris name on the cover unequivocally promotes the Phillip Morris brand name and provides a de facto marketing benefit to its tobacco products.

California State Superintendent of Public Instruction Delaine Eastin, to County and District Superintendents. Letter to schools from Delaine Eastin, California Superintendent of Public Instruction, on Philip Morris' 'Think! Don't Smoke' book covers Tobacco BBS, Monday, November 27, 2000.

NJ Communities Against Tobacco Coalitions

Contact your local Community Against Tobacco for information about tobacco free events taking place in your community. The website contains the telephone number of each county's CAT. You can also call (609) 984-3317 to find out about the CAT in your area, by visiting the website: www.state.nj.us/health/as/assist.htm

Available from the Tobacco Dependence Program

Please check ✓ the item(s) you would like to receive

- ❐ ***Drug-Free is Nicotine Free: A Manual for Chemical Dependency Treatment Programs***
  $35 (in NJ), $50 (outside NJ) plus $7.50 per manual for shipping & handling
- ❐ **"Helping Your Clients Deal with Tobacco" guide**
  $5.00 including shipping & handling

FREE FOR THE ASKING

- **Information Packet**
- ***A Show of Hands: Directions for Creating a Banner***
- **Article: Smokescreen: Nicotine-Dependent Staff**
- **Article: Integrating Nicotine Dependence into Chemical Dependency Treatment**
- **Pharmacology Fact Sheet**
- ***Revised* Audio-Visual Resource List**
- ***New* Clinical Resources for the Treatment of Tobacco Dependence**
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