

# The Nicotine Challenger

Summer 2006

This issue: **Advances in Tobacco Treatment**

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## A View From The Director

by *Jonathan Foulds, PhD*

### *Are Menthol Cigarettes More Dangerous?*

Every now and again when conducting research one stumbles across an unexpected finding that leads the research in a whole new direction. This happened here at the Tobacco Dependence Program recently when we were analyzing the factors that are related to successfully quitting smoking in our Tobacco Dependence Clinic. While our first study (Foulds et al, 2006a) found some expected relationships (e.g. those who smoke first thing in the morning have a lower quit rate), we also found that people who smoke menthol cigarettes have a lower one-month quit rate than those smoking non-menthols, even when controlling for differences in other predictive factors. This led us to wonder what could have caused this effect. Our colleague, Dr. Jill Williams, had recently published a study examining nicotine intake in smokers suffering from schizophrenia, compared with smokers without schizophrenia (Williams et al, 2005). She found that smokers with schizophrenia get higher nicotine, cotinine and carbon-monoxide levels per cigarette. However, we had never examined the effect of menthol cigarettes on nicotine intake in that study. When Dr. Williams reexamined the data, she found that smokers of menthol cigarettes obtained higher nicotine, cotinine and carbon monoxide levels than smokers of non-menthols, regardless of whether or not they suffered from schizophrenia. In that study, the blood and carbon monoxide samples were taken immediately after participants smoked an afternoon cigarette and so appear to be more related to increased smoke intake from menthol cigarettes, rather than metabolic differences.

While we were trying to understand these results, a paper was published in the *New*

## Proyecto Vida: Latino Deje de Fumar— An Update

By *Roena Vega*

In the previous Challenger issue, we introduced Proyecto Vida: Latino Deje de Fumar which translates to, Project Life: Latino Quit Smoking. This project was funded in July 2005, by the New Jersey Health Initiatives, Robert Wood Johnson Foundation. The project goals were to increase the number of Latinos seeking tobacco cessation services at the Tobacco Dependence Clinic. Proyecto Vida:

Latino Deje de Fumar has now been in operation for 10 months and the number of Latinos seeking tobacco cessation services at the Tobacco Dependence Clinic has grown substantially.

The overall strategy for increasing use of services was to create a community marketing campaign that included community outreach, neighborhood canvassing, advertising in Latino-focused venues and partnering with grass roots organizations that would serve as conduits for information dissemination. Free nicotine replacement therapy has been made available for this project.

The marketing strategy coupled with providing culture and language appropriate services has proven to be a successful method for increasing the number of Latinos seeking services to quit smoking from the Tobacco Dependence Clinic. As the ultimate goal is to reverse the upward trend of Latino smokers, education and prevention have also become important components to Proyecto Vida via community outreach providing information on the harms of tobacco at various middle schools and high schools.

Proyecto Vida: Latino Deje de Fumar kicked off in January 2006 and since then the number of Latino clients entering the clinic for services has gradually increased. To compare with the previous year's data: in January 2005, 8% of clients seeking tobacco cessation services were Latino, in January 2006, the rate had increased to 19%. In February 2005, the percentage of Latino clients was 8%; in February 2006, the rate had increased to 13%. In March 2005, 9% were Latino clients; in March 2006, there were 18% Latino clients. Most impressive have been the increases in April and May 2006, where the percentage of Latino clients has been 21% and 35%, respectively.

The next step of the project will be to train other smoking cessation organizations to provide culturally sensitive services and market their services to Latino communities throughout New Jersey.

In May, our website [www.proyectovidanofume.org](http://www.proyectovidanofume.org) is scheduled to go live and will be providing information and education for organizations providing smoking cessation services for the Latino community.



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**New Staff at the Tobacco  
Dependence Program**

**Jyoti Dasika, MPH**

*Program Development Specialist*

The Tobacco Dependence Program would like to welcome Jyoti Dasika into her new role as Program Development Specialist. Jyoti began working for the Program in 2003 as a Research Assistant, collecting follow-up data on clinic patients. Since then, she has also assisted on the Youth Quit2Win project, which is a program dedicated to helping high school youth quit smoking. Her current role will focus on coordinating the Middlesex Partnership Against Tobacco program. The aim of this community partnership will be to promote public health education on tobacco control, prevention and treatment within Middlesex County.

Jyoti obtained her undergraduate degree in Public Health and Political Science from Rutgers University and holds a Masters degree in Public Health from UMDNJ-School of Public Health, with a concentration in Health Systems and Policy.



**Tip of the Month**

A member of one of our treatment groups recently shared a great tip with others in her group. She needed a ride to the shore and made arrangements with an acquaintance who was happy to have a rider to share the cost of gas and tolls. She knew he smoked. She wanted to share the ride anyway. She had quit smoking 10 weeks ago. She remembered a scene in a movie where detectives applied Vicks Vaporub to the inside of their noses to mask really unpleasant odors during investigations. On the day of the trip, she applied her nicotine patch, packed her Commit lozenges and Nicotrol Inhaler. She also applied a coat of Vicks Vapo Rub to the inside of her nose. Her driver smoked. She did not. Her excellent planning got her through a difficult situation. Thanks for an excellent idea!

**A Nationwide  
Collaborative Art Project**

*Be Counted...*



*Hands of Hope*

(Artwork in logo by Garrett V., Hillsborough, NJ 08844 USA Age 6, 4/14/04)

Mail to (or for more information, contact):  
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The **Tobacco Dependence Program** is dedicated to reducing the harm to health caused by tobacco use. We do this through education, treatment, research and advocacy.

The **Tobacco Dependence Program**, UMDNJ-School of Public Health, helps programs, organizations and clinicians deal with tobacco issues and nicotine dependence.

**Products and services include:**

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



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*England Journal of Medicine* showing that African American and Native Hawaiian smokers have much higher rates of death from lung cancer than other ethnic and racial groups. The study did not measure whether the participants smoked menthol or non-menthol cigarettes, but we were aware that a much higher proportion of African American smokers (around 70%) smoke menthols as compared with other groups (20-30%). For our hypothesis that menthol cigarettes could play a role in these increased lung cancer rates to be correct, it would require that Native Hawaiians also have high rates of menthol cigarette smoking. When we looked into this, we found that sure enough, Native Hawaiians are the only other ethnic/racial group to smoke menthol cigarettes at a rate comparable to African Americans. The *New England Journal of Medicine* agreed to publish our letter highlighting the potential role of menthol cigarettes in explaining the differential lung cancer rates (Foulds et al, 2006b).

But we still had to try to figure out the likely mechanism whereby menthol cigarettes appear to be harder to quit, deliver higher amounts of nicotine and carbon monoxide, and may be more likely to cause lung cancer. Dr. Kunal Gandhi, a researcher who had helped analyze our clinic data as part of his Master's degree in Public Health research project, continued to examine the clinic data to try to explain the fact that the menthol/non-menthol difference in quit rates was much bigger in our Latino and African American patients than in our White (non-Latino) patients. He found that Latino and African American menthol smokers smoke fewer cigarettes per day than non-menthol smokers, but that this wasn't the case for Whites. He found that when we looked at unemployed White patients, their quit rates were much lower if they smoked menthols as compared to those smoking non-menthols, whereas for employed Whites, there was only a slight menthol effect on quit rates (which were higher regardless of the type of cigarettes smoked). These findings led to our current theory of how menthol cigarettes can be more addictive and more harmful to health. Our hypothesis is that this "menthol effect" is much stronger in circumstances in which the smoker reduces their daily cigarette consumption. Typical situations where a smoker would do this are (a) if the price increases so that they can no longer afford to smoke as many cigarettes or (b) when smoke-free legislation restricts smoking in public places. In this situation, a pack-a-day smoker may be forced to cut down to only 10 cigarettes per day. We know that the natural reaction of the nicotine addict to such a reduction in cigarettes per day is to increase their puff volume per cigarette in an attempt (often subconscious) to obtain their

usual nicotine dose. For a smoker of regular cigarettes it is more difficult to inhale twice as much smoke per cigarette because of the harshness of the smoke. However, the menthol smoker will also inhale twice as much menthol, with its cooling effects to counteract the harshness. Thus we believe that menthol makes it easier to inhale more smoke (and therefore nicotine) per cigarette via its inherent cooling properties, and that this effect is most apparent when the smoker is reducing cigarette consumption. In New Jersey, we have recently had the largest increase in cigarette taxes in the nation, and so groups with lower incomes (e.g. unemployed Whites) have been forced to reduce their cigarette consumption. However, in those groups, those smoking menthol cigarettes are able to inhale more nicotine per cigarette, and hence become more addicted.

Clearly we need more research to help us understand the effects of mentholation and other cigarette design and ingredient characteristics on smoker behavior. But we are now fairly confident about these menthol effects and are concerned about the implications for high risk groups here in New Jersey. Latino smokers in New Jersey are increasingly smoking menthol brands, as are young smokers. Our studies suggest that this may cause these groups to become more addicted and to suffer higher rates of smoking-caused diseases. Also warranting concern here are pregnant women who smoke menthol cigarettes. If our hypotheses are correct, these women may believe they are reducing the harmful effects by reducing the number of cigarettes they smoke, but the menthol may enable them to inhale much more from each cigarette, thus causing more harm to their health and that of their unborn child. For now, we think the evidence is clear and consistent enough that we should be warning menthol smokers about the increased risks associated with smoking these cigarettes.

Foulds J, Gandhi KK, Steinberg MB, Richardson D, Williams J, Burke M, Rhoads GG. Factors associated with quitting smoking at a tobacco dependence treatment clinic. *American Journal of Health Behavior* 2006; 30:400-412

Foulds J, Williams JM, Gandhi KK. Racial differences in lung cancer. *New England Journal of Medicine* 2006; 354; 18: 1952 (let.)

Williams JM, Ziedonis DM, Abanyie F, Steinberg ML, Foulds J, Benowitz NL. Increased nicotine and cotinine levels in smokers with schizophrenia and schizoaffective disorder is not a metabolic effect. *Schizophr Res.* 2005; 79:323-335.

## Tobacco Dependence Treatment Specialist Training

### *Become a Tobacco Dependence Treatment Specialist*

University of Medicine and Dentistry of New Jersey—School of Public Health, Tobacco Dependence Program

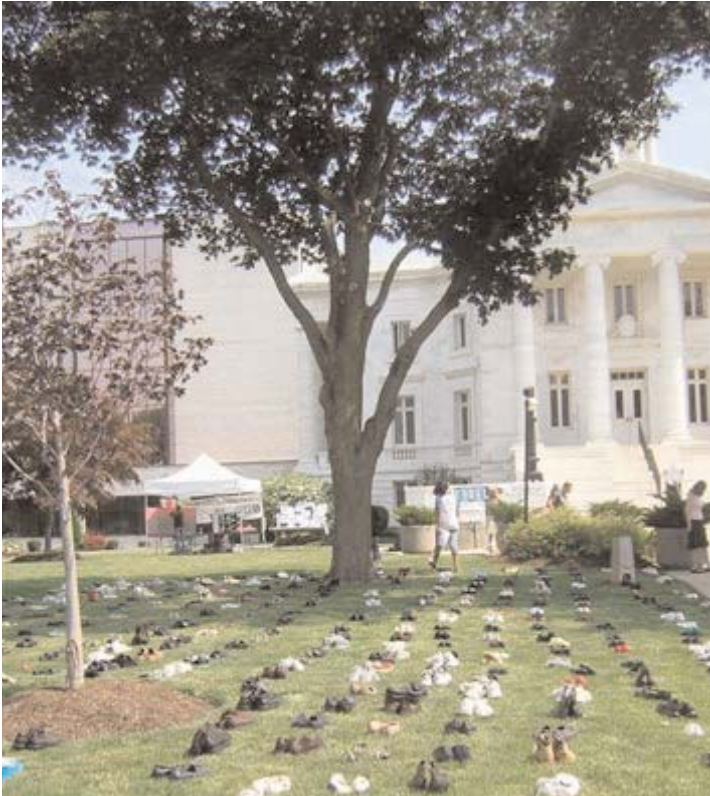
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2006 Dates: September 25-29 2007 Dates: January 22-26, April 2-6, June 11-15, September 24-28

To Register, visit our website at: [www.tobaccoprogram.org](http://www.tobaccoprogram.org).

Contact [nancy.speelman@umdnj.edu](mailto:nancy.speelman@umdnj.edu) or [joan.maurer@umdnj.edu](mailto:joan.maurer@umdnj.edu) or 732-235-8220 for more information.

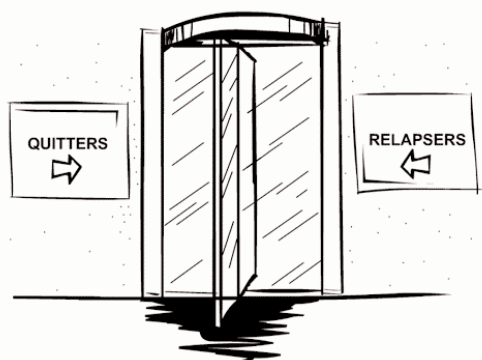
## REBEL Students of Somerset County, New Jersey Coordinate World No Tobacco Day Activity



May 31, 2006 1200 pairs of shoes were collected and laid on the lawn of the courthouse by New Jersey's youth-driven organization REBEL (Reaching Everyone by Exposing Lies) to symbolize the 1200 people each day who die from tobacco-related illness. The event was organized by Somerset County REBEL Coordinator Lauren Connolly, in conjunction with the Board of Freeholders, Cancer Coalition and Council on Alcoholism and Drug Dependency. Guest speakers included Laryngectomee Bob Belloff and Somerset Hospital Quitcenter Coordinator, Chris Kotzen. Above, Brianne Alecci and Joe Salih, Hillsborough HS, REBEL students displayed signs educating the public about the harms of tobacco use. Booths with educational materials were displayed by UMDNJ-SPH Tobacco Program – Clinic, Youth Quit2Win and Hands of Hope; Somerset County Cancer Coalition/American Cancer Society and REBEL. Brenda Esler of the Council shared an emotional story of her father's death – exactly one year ago – due to a tobacco-related illness.

# If At First You Don't Succeed, Try, Try Again!

By Eugene Han, MPH



“This is my last cigarette, and I’m quitting after this.”

Most smokers are regrettably familiar with this perennial promise, which more often than not, ends disappointingly in relapse. While the prevalence of smoking among adults in the US has gradually been declining, about one out of every five adults continues to smoke, according to the CDC. The issue of relapse is central to the problem; tobacco is an addictive substance, and despite the initial effectiveness of treatment interventions, the vast majority of smokers eventually return to smoking after trying to quit. As clinicians, what should we do with these relapsed smokers? Most smokers who relapse are willing to make another quit attempt, but given limited clinical resources, is it worth the effort to re-treat these recidivist smokers?

Several studies have been conducted in an attempt to answer this question, and the results have been discouraging. In 1993, smokers who had failed to quit from

an earlier nicotine patch study were enrolled in a second study to determine if repeat treatment with the patch would help them achieve abstinence. All 52 participants who had failed to quit with the patch in the first study relapsed to smoking within six months in the repeat study. Similarly, a study conducted in 2000 took unsuccessful quitters from an earlier patch study and allocated them to repeat treatment with either the nicotine inhaler or nicotine nasal spray. The quit rates after six months were 5% and 0%, respectively. Other studies on repeat treatment have reported similarly poor cessation outcomes, and the implications of these results are dispiriting for relapsed smokers who have tried to quit with formal cessation therapy – the chances of quitting are worse if you’ve already tried and failed.

However, it is important to note that all of these repeat studies were designed as clinical trials, and it remains to be seen whether repeat treatment of relapsed smokers in the “real world” results in better outcomes.

For his fieldwork project as a student of the UMDNJ School of Public Health, Eugene Han decided to research the “real world” results of repeat treatment of relapsed smokers in a clinical practice setting. Along with Dr. Jonathan Foulds, Dr. Michael Steinberg, and Kunal Gandhi, Eugene designed and conducted a retrospective study to examine 1745 consecutive patients who attended the UMDNJ Tobacco Dependence Clinic from 2001 to 2005 to quit smoking.

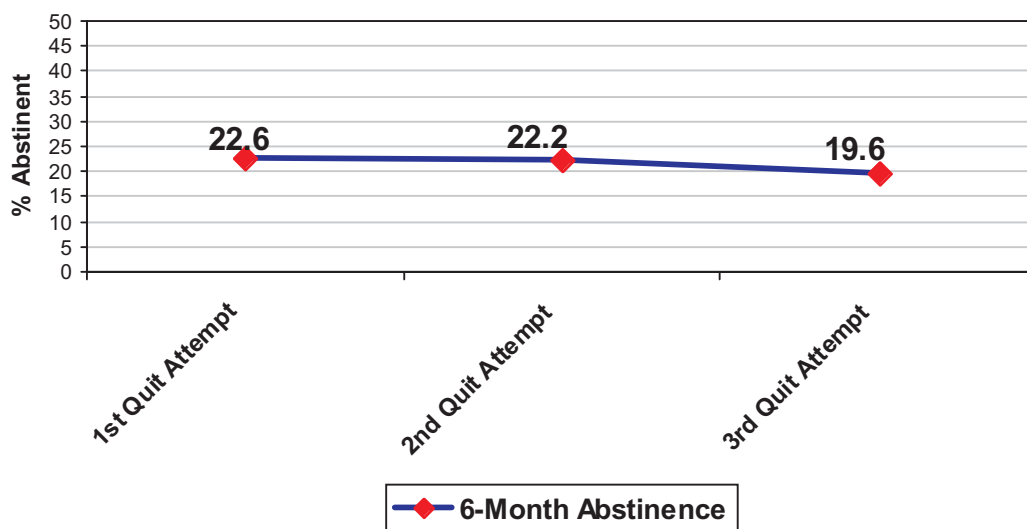
The results showed that patients who relapsed and returned for repeat treatment had consistent and respectable 6-month quit rates after each repeated quit attempt at the clinic (see figure). This suggests that patients have as good a chance of quitting the second or third time around as they do on their first quit attempt, which differs markedly from previous studies which showed that repeat treatment results in poorer cessation outcomes.

This disparity is probably due to the differences between clinical trials and clinical practice - the breadth and intensity of treatment at the clinic, as well as the ability to adjust therapy according to patients’ needs’ may explain the improved outcomes reported in this current study.

It appears that in clinical practice, re-treating relapsed smokers is a worthwhile endeavor, and clinicians should therefore encourage unsuccessful quitters to try again. The results of the study also suggest that patients who return for repeat treatment have higher markers of nicotine dependence (including waking up in the middle of the night to smoke

and smoking sooner upon waking in the morning) and are more likely to have a history of mental health treatment, so these factors should be taken into consideration when re-treating relapsed smokers. Quitting tobacco is often a complex process rather than a singular event, and clinicians should be prepared to assist smokers through repeated cycles of abstinence and relapse before long-term success is achieved

**Abstinence Outcomes of Consecutive Quit Attempts**



# What's New in Tobacco Dependence Treatment in New Jersey?

By Donna Richardson, LCSW, LCADC, CTTS

An effective tobacco dependence treatment professional in New Jersey's Quitcenters is a hybrid: one part clinician, one part marketer, one part politician, one part insurance analyst, one part billing specialist, one part gambler, one part grant writer, one part communications specialist, one part diplomat, one part interpreter of research data, one part medical sociologist. Several recent developments in the treatment of tobacco dependence in New Jersey highlight the many hats we wear, the diversity of skill helpful to our mission of treating tobacco dependence, the "never a dull moment" reality of those of us who do this treatment.

## New Medicine

Today's Quitcenter clinician, having mastered the logic of nicotine replacement medicines and created a passable explanation of bupropion, is now fielding questions from patients about the newly FDA-approved Chantix (varenline). Patients and prospective patients are asking, "Does it work?", "When can I get it?", "How much will it cost?", "Will my insurance pay for it?" and "What are the side effects?" Clinicians are answering: "Chantix does look promising although not dramatically more so than our current medicines. Dr. Steinberg in our Clinic will be prescribing it when it is available. You could also speak to your primary care physician about it. Pfizer is expected to release Chantix at the end of the summer. New medicines are often more expensive than older effective medicines. A good guess would be \$150 a month. We don't know yet how much it will cost. There may be a delay in insurance reimbursement for the medicine. Side effects are said to be minimal. We'll know more about that as more people try the drug." A new tool in our toolbox can only be good news.

## New Prescription Drug Coverage

Medicare D has changed things, just as we were beginning to draw some conclusions. For a period of time in the young life of New Jersey Quitcenters, PAAD (Pharmaceutical Assistance to the Aged and Disabled) covered (at drug stores willing to do the paperwork!) the nicotine patch, as well as all prescription nicotine replacement medicines. Now, it depends on the plan selected. We have seen good

results with patients who have selected AARP and we are watching closely to see what other carriers offer. It shouldn't be kept a secret and we plan to collect as much information as possible and pass it on.

## New Laws

Not surprisingly, smokers in treatment expressed their opinion about New Jersey's implementation of clean air legislation. As the media covered the debate and the story, as a few impassioned citizens made the argument for smoking as a civil right, our patients were solicited for their input. Some volunteered to be interviewed. Some anxiously awaited the date. Some smoked their last cigarette in a New Brunswick bar with other smokers, with a sense of history. Few tobacco dependent people were on the GASP (Group Against Smoking Pollution) team during the debate, but a quick and dirty survey reveals that nearly everyone who is trying to quit, or even thinking about trying to quit, is quite pleased about the law. The law is clearly viewed as helpful to people trying to quit by those same people.

What *hasn't* changed: Tobacco dependent people are hungry for a dose of hope that quitting tobacco is possible. We do our best work when we offer that up.



## Doctors Need to do Better

By Michael Steinberg, MD, MPH, CTTS



One of the strengths and at the same time, shortcomings of the Tobacco Dependence Treatment field is the important role that physicians play in helping smokers quit. Physicians have been shown in several studies to carry a

great deal of impact in their messages to smokers. Additionally, physicians are key in prescribing and advising about cessation medications. Unfortunately, data has shown that physicians are not always meeting expectations with regard to their delivery of tobacco dependence treatment.

In two recent studies published by faculty at the UMDNJ-Tobacco Dependence Program, we have illustrated the need for continued improvement of physician involvement in smoking cessation. These studies explored data at both the national and the state level.

The first study analyzed data from a national database, the National Ambulatory Medical Care Survey. This survey is conducted through the Center for Disease Control and Prevention, and gathers information from doctor-patient encounters regarding the care of many conditions. We examined data from 2001-2002 (approximately 58,000 encounters), specifically looking at how physicians counseled and utilized cessation medications. In summary, our findings were:

- 30% of physician-patient encounters did not identify the patients' tobacco use status
- Less than 25% of encounters with a tobacco user resulted in counseling
- Female smokers and smokers 65 years or older were much less likely to receive a cessation medication
- Having a tobacco-caused disease and having the patient ask the doctor for help in quitting were most predictive of that smoker receiving a cessation medication

We concluded that more work still needs to be done in systematically identifying smokers during medical visits, improving counseling rates among physicians, and encouraging physicians to prescribe cessation medications, especially to certain groups of smokers (women and older smokers). These issues will become even more critical as more prescription medications enter the market for smoking cessation.

The second study was conducted here in New Jersey and focused on awareness and referral patterns of physicians to the State's Tobacco Treatment Services (NJ Quitline, NJ Quitnet, and NJ Quitcenters). The NJ Physician Census was conducted

by surveying 4,600 physicians who have direct patient care. The primary outcomes were awareness of and referral to any of the NJ Quitservices. Responses varied by specialty:

- 36% of the overall sample was aware of Quitservices
  - Pulmonary 69%
  - Family practice 65%
  - Cardiology 60%
  - Pediatrics 55%
  - General internal medicine 53%
  - OBGYN 50%
  - Oncology 41%
  - Psychiatry 20%
  - Ophthalmology 11%
  - Orthopedics 8%
- Overall, referral rates were similar across groups (about 40-60% of those aware had referred patients)
- Higher rates of awareness and referral were seen among physicians who were
  - Younger
  - Women
  - Non-white
  - Non-US trained
  - More teaching and clinical hours per week

Our conclusions included a need to target certain physicians who are likely to treat high numbers of smokers yet have low awareness of services (e.g. psychiatrists).

These articles can be found at:

Steinberg MB, Akincigil A, Delnevo CD, Crystal S, Carson JL; Gender and age disparities for tobacco dependence treatment: Results of the 2001-2002 National Ambulatory Medical Care Survey; *Am J Prev Med*; 30(5); 405-12; 2006.

Steinberg MB, Alvarez MS, Delnevo CD, Kaufman I, Cantor JC; Disparity of Physicians' Utilization of Tobacco Treatment Services; *Am J Health Behaviors*; 30(4); 375-386; 2006.

As tobacco treatment specialists, we need to continue to educate physicians of their important role in helping their patients stop smoking by identifying, counseling, and prescribing effective medications.



## Special Thank You to Bernice Order-Connors, LCSW, LCADC



A special thank you is owed to Bernice Order-Connors for her dedication to tobacco dependence treatment over the past 12 years. Ms. Connors joined forces with Dr. John Slade in 1994 as part of the “Addressing Tobacco in the Treatment of Other Addictions,” later to become the UMDNJ, School of Public Health, Tobacco Dependence Program. She worked closely with Dr. Slade and the State of New Jersey in the development of licensure standards of tobacco policies and tobacco dependence treatment into addiction facilities.

She was on the faculty of UMDNJ- SPH and was the TDP’s Special Projects Coordinator. Over the years, she expanded her expertise in policy and clinical skills from addictions treatment to mental health and provision of services to young people. She was a national trainer on these topics and served as a consultant to several states’ departments of addiction services as they moved to integrate tobacco dependence treatment into clinical treatment.

Bernice presented at national conferences, as well as our 5-Day Tobacco Dependence Treatment Specialist Training. She was the lead author of the manual, *Drug-Free is Nicotine-Free*, which is a model utilized nationally to provide steps for treatment facilities to go tobacco free.

With great sadness, the Tobacco Dependence Program says “goodbye” to Bernice. Her enthusiasm and dedication to her work with us and throughout the country will be greatly missed. Bernice has returned to working with students in a school setting...another love of hers, to which she has brought her many gifts and talents!

Best wishes to a special colleague,  
Nancy Speelman Edwards

“Bernice’s understanding of recovery from tobacco addiction within addictions treatment is unparalleled, as is her ability to pass that on to others in the field.”

Jonathan Foulds, PhD  
Director, Tobacco Dependence Program

“Bernice’s work on developing organizational change interventions to better address tobacco in addiction treatment settings, are leading to major changes in the treatment culture around the country. Behind the scenes, she has been a catalyst, working with John Slade, Jonathan Foulds and myself. Our work together has changed policy in New Jersey, helped save lives of individuals in addiction recovery, enhanced clinician skills and lead to our new National Institute of Drug Abuse RO1 Study of organizational change. Thanks so much, Bernice – you have had a tremendous impact on promoting recovery and wellness.”

Doug Ziedonis, MD, MPH  
Medical Director, Tobacco Dependence Program

“While staffing the TDP booth in Boston at the Conference on Tobacco or Health, 99.9% of the requests from attendees were Bernice-related. That was my first clear understanding of Bernice’s national reputation as the # 1 US advocate for the implementation of tobacco dependence treatment in addiction settings.”

Donna Richardson, LCSW, LCADC, CTTS  
Clinic Coordinator, Tobacco Dependence Program

“Bernice is the only person I know who can actually be in three different places at one time.”

Mike Steinberg, MD, MPH, CTTS  
Clinic Medical Director, Tobacco Dependence Program

“Bernice was incredible resource in Ohio’s development of ATOD treatment. Her enthusiasm and light spirit is greatly missed.”

Aimee Maychack, CCDC I, CTTS  
Tobacco Dependence Project (Ohio)

“It was truly delightful working with Bernice at the TDP; I learned a great deal from her about training and treating tobacco dependence in addiction treatment centers.”

Stacey Zelenetz, LCSW, LCADC, CTTS  
Clinician, Tobacco Dependence Program

“Bernice lights up a room with her enthusiasm. Through her efforts, thousands of people have new hope for a better life.”

Terry A. Rustin, MD  
Associate Professor, University of Texas at Houston Health Science Center

“Bernice was a wonderful presence for addictions providers, always bringing the issue of tobacco dependency to the fore, helping to raise consciousness and spur the field to action. Her trainings were dynamic and appreciated by all. She is a friend who will be sorely missed.”

Barbara Schlichting  
President, Addiction Treatment Providers of NJ

# Integrating Tobacco Into Addiction Treatment Facilities: A Student's Experience

By Corynna Hines, BS

*Corynna Hines is currently a student in both the MSW program at Rutgers School of Social Work and the MPH program at UMDNJ-School of Public Health. The project described in this article was part of her field practicum for the MSW degree.*

Embarking upon my second semester internship at the Tobacco Dependence Program led me to a project involving consultation work with an addiction treatment agency in Trenton, NJ. The agency serves approximately 600 clients in an outpatient setting. The project immediately piqued my interest. Substance users in treatment have a higher rate of tobacco use when compared to any other group. This is problematic because they are more likely to be killed by their tobacco smoking than by their other substance use. Cigarette smokers with a history of drug addiction are also more likely to experience disability and premature mortality. More alarming evidence indicates that 85 to 98 percent of patients in methadone maintenance programs smoke (Richter, Choi, McCool, Harris & Ahluwalia, 2004, p. 1258). Cigarette use perpetuates the addiction cycle and exacerbates ill health.

Few addiction treatment services provide assessment and treatment of their clients' tobacco use. Inevitably, this contributes to the intractability of nicotine addiction. This knowledge incited an increased drive to tackle this project avidly. The project focused on assisting a methadone maintenance treatment program with the establishment of its first psychosocial tobacco cessation group. Most clients want to quit, so agency support is necessary.

Addictions treatment agencies have a demand for smoking treatment and, yet, few do so routinely (McCool, Richter, & Choi, p. 358). Health professionals have contributed to the stigmatization of addicts. Staff beliefs and attitudes precipitate this negative characterization. Some feel smoking cessation will compromise patients' recovery from illicit drug and/or alcohol use, that patients are unwilling or unable to quit, or that quitting is of miniscule concern (McCool, Richter, & Choi, p. 358). The personal biases of health professionals have resulted in nicotine addiction remaining on the periphery of addiction treatment.

Only 18% of U.S. methadone maintenance facilities provide smoking cessation counseling and only 12% provide nicotine replacement therapy (Nahvi, Richter, Li, Modali, & Arnsten, 2006). The agency I worked with is a rarity due to its expressed interest in a quit group and request for assistance. Priority for their clients' nicotine addiction and their other drug addictions is deemed equal.

Prior to my work with the agency, a tobacco-free policy that prohibited smoking in or on facility grounds was implemented. This created an environment conducive for a quit group. It also allowed clients to become more receptive to smoking cessation. Thus, staff trainings occurred. I met regularly with them at their site location. In order to facilitate the planning phase of the project, we developed client assessment forms for tobacco use as well as quit group protocols. We also secured nicotine

patches, a carbon-monoxide monitor and tubes along with clinic space for group sessions.

Clients at the facility initially expressed interest in smoking cessation with their individual counselors. A flyer advertising an upcoming quit group, was created and posted around the facility. Eighty-eight clients responded to the flyer. Subsequently, 41 completed the self-administered tobacco assessment form and an initial cohort of 21 received a structured assessment. Clients were eligible for the quit group upon completion of the structured assessment and on a first-come, first-served basis. The quit group offers free nicotine replacement therapy via transdermal nicotine patches and psychosocial support via open group sessions. The group meets once per week. The goal is to encourage a target quit date so that group participants could strive towards smoking cessation and maintain a longevous quit state. Psychosocial interventions have been adapted successfully for smokers with schizophrenia and depression (Steinberg, Hall, & Rustin, 2003, p. 470). Similarly, special populations, composed of substance abuse clients, can maintain their quit status with a comprehensive approach and minimal barriers (client-perceived or otherwise real).

The first quit group session presented much success. Clients responded well to the intervention. Out of the eleven clients who participated in the first session, eight set their target quit date (TQD) for the next day. Thus, seven patches, equivalent to one week's supply, were distributed to each of those clients. In addition, two of the remaining clients set their TQD for the following week and the other client's TQD was scheduled for the week after that one.

Two-week follow-up (equivalent to three group sessions) was measured via statistical analysis of group descriptive data and an evaluation form requesting a staff member's prognosis of group members. (Please note: Although evaluation provided essential feedback, responses did not accurately capture whether or not the intervention would be effective in the long run, due to its formative stage.) In the evaluation, the staff member reported feeling that the clients are benefiting from the quit group and reported very good progress of group clients with regard to their quit status. The staff member also felt that it is very likely for clients who have not expressed a target quit date to do so because of their participation in group sessions.

The group was comprised of 7 women and 4 men. Group members were between the ages of 30 and 53 years old. The average age of smoking initiation was 12 years old – 28 years



*continued on page 10*

spent smoking was the average. They smoke an average of 129 cigarettes per week (CPW) and, on average, have tried to quit smoking twice. Their average methadone dose in the week prior to the first group session was 104mg. One out of the eight group members who received the patches after the first group session self-terminated due to transportation issues. Thus, of the seven who received patches at the first group session and participated in group during the second session, 6 out of the 7 (86%) reduced their Carbon Monoxide (CO) level by the second group session. Their exhaled CO level reduced from an average baseline measurement of 20 parts per million (PPM) to an average of 11ppm. Moreover, they decreased their self-reported cigarettes per week (CPW) from an average of 156 to 47 by the second week.

One female client self-reported that no cigarettes were consumed from the first to the second group session, a time span of a week. This was biochemically verified via her baseline CO level. It reduced from 19ppm in the first group session to 2ppm by the second group session. During the third group session, 3 out of the initial 11 first group session members did not return. The 8 out of 11, who did return to the third group session, attended all three consecutive sessions. On average, they self-reported a reduction of 115 weekly cigarettes over the time frame of three smoking cessation group sessions. Their average CPW at the first group session was 156 and by the third group session it had decreased to 41 CPW.

Conducting this project revealed that setting up a smoking quit group at a Methadone Maintenance Treatment Program is feasible. Clients expressed interest in quitting smoking. Furthermore, they participated in smoking cessation treatment and showed positive signs of behavior change. It remains to be seen whether these changes can be sustained and how many can quit smoking in the longer term. Addictions treatment agencies should determine whether their focus will be on smoking reduction or cessation. Nicotine addiction is worth incorporation into drug treatment services. This perspective is a paradigm shift from the pervasive mainstream notion of condoning tobacco use among substance abuse users. Healthcare providers in drug treatment settings must take responsibility for holistically treating their clients. This project definitely offered a start for the agency in Trenton, NJ and I am grateful for contributing to their progress.

#### References

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## IMPORTANT DATES



### 5-Day Tobacco Dependence Treatment Specialist Training

September 25-29, 2006

January 22-26, 2007

April 2-6, 2007

June 11-15, 2007

September 24-28, 2007

### 2-Day Youth Quit2Win Training

October 4 & 5, 2006

January 22-26, 2007

March 5 & 6, 2007