

The Nicotine Challenger

Summer 2008

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A View From The Director *by Jonathan Foulds, PhD*

Importance of Adequately Funding Comprehensive Tobacco Control in New Jersey

Here in New Jersey, our Comprehensive Tobacco Control Program (CTCP) started in 2000 with funding of \$32.5 million via the Master Settlement Agreement (MSA). At that time the Centers for Disease Control and Prevention (CDC) recommended a \$45 million minimum annual expenditure on tobacco control. The program was set up to follow CDC guidelines with components for media, evaluation, community activities, youth prevention, and smoking cessation. Unfortunately, the post-9/11 recession caused severe budgetary problems for the state, and funding was drastically cut by 66% to \$11 million in 2004 and has remained at that level. The state brings in approximately \$1 billion per year from tobacco sources (MSA plus tobacco taxes), but only spends around 1% of those revenues on tobacco control. Even worse, New Jersey spends less on tobacco control than it receives in excise tax from illegal cigarette sales to children (\$11.5 million)! The CDC updated its funding recommendations for New Jersey to \$120 million (\$13.75 per person per year, and 12% of total tobacco-related revenue to the state) in 2007, but CTCP funding has not changed and is now less than 10% of the CDC recommendation.

Despite being considerably underfunded, the New Jersey CTCP has had many notable achievements:

- Over the years 2000 to 2007, cigarette taxes were increased from 80 cents per pack to \$2.575 per pack (highest state tax in the country).
- Legislation was passed to ban smoking in all workplaces and indoor public places (implemented in 2006, adding casinos in 2008).
- The number of cigarettes being smoked by New Jersey youth was cut by 50% from 1999 to 2006.
- Adults cigarette smoking fell from 21% during the mid 1990s to 17.1% in 2007, the lowest level recorded

Some may ask for early signs of a health impact. One early response to reduced smoking is a reduced rate of heart attacks. The number of reported inpatient hospitalizations caused by acute myocardial infarctions in New Jersey was above 22,000 every year from 1995 to 2003 (24,278 in 2000), but dipped below 22,000 in 2004 and continued to fall to under 20,000 in 2006. This reduction from the year 2000 to 2006 was evident for every age group over age 15. Although this reduction cannot be solely attributed to the accomplishments of New Jersey's CTCP, it is quite likely that many heart attacks were prevented by the state's overall reduction in smoking prevalence. In tough financial times, one must not overlook the cost savings to the healthcare system from reduced hospital admissions

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Tobacco Dependence Should Get its Due as a Chronic Condition *by Michael B. Steinberg, MD MPH*

Most smokers are aware of the numerous health risks associated with smoking, and the majority report wanting to quit ⁽¹⁾. Seven first



line medications have been approved by the Food and Drug Administration for cessation including: NRT (patch, gum, lozenge, inhaler, nasal spray); bupropion; and varenicline ⁽²⁾. Despite the proven benefits of these medications, a mere 17% of all smokers utilize pharmacotherapy for tobacco dependence each year ⁽³⁾.

Many smokers are misinformed about the safety of nicotine medications and other available cessation pharmacotherapies. The majority of smokers incorrectly reported that nicotine was the primary cause of cancer and only one-third correctly stated that the nicotine patch was less likely to cause a heart attack than cigarette smoking ⁽³⁾. In actual fact, NRT is safe even in high doses ⁽⁴⁾ and in high-risk populations such as those with existing cardiovascular disease ⁽⁵⁾. While dependence on NRT is possible, the overall chance of addiction as reported in the literature is very low, generally under 10% ⁽⁶⁾. Although the optimal duration of treatment remains unclear ⁽⁷⁾, a single, brief treatment with NRT will result in long-term abstinence in only a minority of smokers as relapse is a hallmark of this chronic condition. An estimated 30% of those who quit smoking by using NRT and achieve abstinence at 12 months subsequently relapse ⁽⁸⁾.

Extending the duration of NRT treatment for longer periods may be beneficial ⁽²⁾ and could actually prevent relapse ⁽⁹⁾. In clinical trials, nicotine inhaler use extended for up to 1 year increased abstinence rates at 12 months compared to placebo ⁽¹⁰⁾, and in the Lung Health Study, 31% of subjects continued using nicotine gum safely and effectively for over 1 year. Some participants continued gum use for up to 5 years without any serious side effects ⁽¹¹⁾. Additionally, data indicate that use of bupropion and varenicline for up to 1 year are effective and safe ^(12,13). Long-term medication use in patients requiring extended courses of treatment is also supported by the updated Public Health Service (PHS) Guidelines ⁽²⁾. Since quitters using long-term pharmacotherapy are exposed to lower levels of nicotine with an elimination of the 4,000 toxins found in cigarette smoke, there is a clear overall health benefit if the individual is no longer smoking cigarettes ⁽⁹⁾.

For some smokers, long-term pharmacotherapy is the difference between tobacco abstinence and life-long smoking. Long-term use of nicotine replacement therapy is much safer than continuing to smoke cigarettes. Healthcare providers should remain open-minded to patients who may require a unique course of treatment. Although

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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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for MIs, lung cancer, premature babies, respiratory disease and the many other diseases caused by smoking.

Some highlight the CTCP's successes and seem to be under the misguided impression that smoking is so rare nowadays that there is no longer a need for robust tobacco control programs. The reality is that, according to our latest data (2006), New Jersey's 7th through 12th graders smoke 90 million cigarettes a year. This does not include the significant proportions smoking cigars and bidis or chewing tobacco. Yet in that scenario of incredible success despite serious underfunding, New Jersey's Comprehensive Tobacco Control Program is being threatened with further cuts. With New Jersey's youth smoking 90 million cigarettes per year and an overall 43 packs per person consumed annually, it would be foolish to believe that the work for tobacco control in New Jersey is complete. We are only beginning to see the return on investment in terms of reduced health effects from tobacco. To cut the program now would result in a reversal of our progress, and directly cause more heart attacks, more cases of lung cancer and emphysema, and more premature births.

We can agree that times are tough, and money is needed for other important causes (like healthcare for uninsured smokers), but a far better way to fund these is to increase the excise tax on cigarettes. Tobacco control spending provides an excellent return on investment, and it is for this reason that CDC recommends that New Jersey should spend \$120 million, rather than be considering a reduction in the already mediocre funding. Even in times of economic distress, a dollar spent on tobacco control is a dollar well spent on improving health and reducing healthcare costs.

- Full details and evaluation of New Jersey's Comprehensive Tobacco Control Program can be found at:
www.nj.gov/health/as/ctcp/research.htm
- For more details on the toll of tobacco in New Jersey:
www.tobaccofreekids.org/reports/settlements/toll.php?StateID=NJ
- For the CDC's best practices for Comprehensive Tobacco Control (2007):
www.cdc.gov/tobacco/tobacco_control_programs/stateandcommunity/best_practices/
- For evidence of a direct effect on health in one of the first states to implement tobacco control:
www.cdc.gov/MMWR/preview/mmwrhtml/mm4947a4.htm

long-term use is considered "off-label", patients should be encouraged to remain smoke-free, and if extended courses of pharmacotherapy will assist them, treatment should be continued, encouraged, and reimbursed.

Given the chronic, relapsing nature of tobacco dependence, rather than considering cessation medications as a short-term aid in smoking cessation, treatment and its coverage should be in line with other long-term illnesses and conditions, such as asthma, depression, and diabetes. The neurobiochemical effects of tobacco use are well documented and result in measurable and lasting changes in brain structure (e.g. upregulation of nicotinic receptors) and function (e.g. changes in the electroencephalograph), some of which can be objectively measured by imaging techniques, especially in the mesolimbic "reward" center⁽¹⁴⁾. These biological changes are a hallmark of a chronic medical condition, and discontinuation of tobacco use results in physiological changes within the brain and a subsequent withdrawal syndrome⁽²⁾.

Pharmacotherapies have been proven effective in treating these withdrawal symptoms, but a major barrier to obtaining treatment is insurance coverage. Despite the cost-effectiveness of tobacco treatment medications in comparison to other commonly prescribed medical interventions, a number of insurance carriers often do not cover proven cessation therapies and/or their duration is severely curtailed⁽²⁾. With other serious addictions, such as heroin, the long-term use of proven medications (methadone) to prevent relapse is commonly provided, whereas this is not the case with tobacco treatment medications, despite the fact that tobacco kills far more of its users than any other addiction. Tobacco dependence is viewed by physicians and insurers like other addictions that do not garner the same respect as "medical" diagnoses, and in fact bring with them a certain

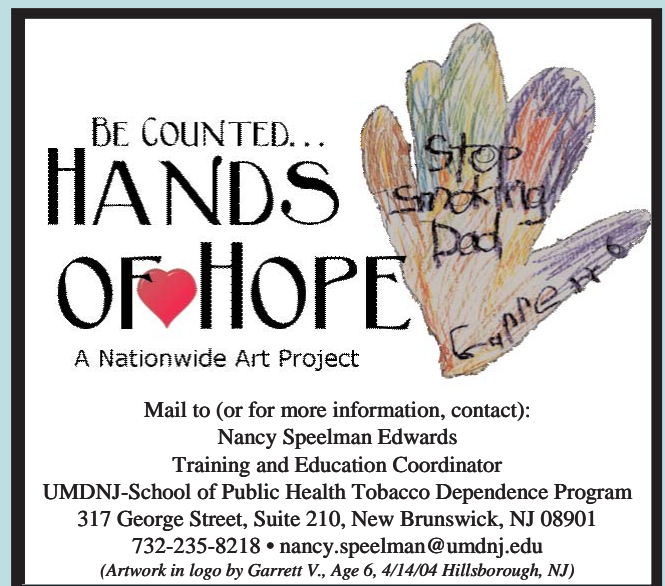
stigma. The reality is that tobacco use kills more people than many classic medical diseases. It should not matter whether the site of disease is in the lung with airway hyper-reactivity (asthma), the adipose tissue with insulin resistance (diabetes), or in the nucleus accumbens (tobacco dependence). The outcomes of morbidity and mortality are what should be concerning patients, healthcare providers, and payers. It is time to move beyond the antiquated categorization of tobacco use as just a bad habit, and deal with providing effective treatment. Thus, tobacco dependence should be regarded by these stakeholders as the chronic medical condition that it represents. The long-term use of medications for the treatment of tobacco dependence can result in continued abstinence and the associated reduction in health consequences.

In summary, the prevalence of tobacco use and death rates caused from smoking are higher than those of other chronic conditions, such as diabetes. Both conditions are improved with comprehensive, cost-effective treatments including combined pharmacotherapy and behavioral components. However, while long term treatments for diabetes are commonly reimbursed by health insurance, those for tobacco dependence are often not. Covering both behavioral and pharmacological measures to assist in smoking cessation will increase the demand for and accessibility to effective treatment options, and has been called for by the National Institutes of Health in their "State of the Science Conference Statement"⁽¹⁵⁾. Improving the availability of these benefits will expand the number of smokers utilizing treatment and will increase smoking abstinence rates⁽²⁾. Tobacco dependence should be recognized as a chronic illness requiring effective treatments for as long as the condition exists.

Excerpt from a recently published article (Steinberg MB, Schmelzer AC, Richardson DL, Foulds J; The case for treating tobacco dependence as a chronic disease; *Annals of Internal Medicine*; 148(7):554-7; 2008)

References

- Centers for Disease Control and Prevention. Cigarette Smoking Among Adults—United States, 2000. *Morb Mort Wkly Rep.* 2002;51(29):642-5.
- Fiore MC, Bailey WC, Cohen SJ, Dorfman SF, Goldstein MG, Gritz ER, et al. Treating Tobacco Use and Dependence. Clinical Practice Guideline. Rockville, MD: U.S. Department of Health and Human Services. Public Health Service. June 2000. Updated 2008 (in press).
- Bansal MA, Cummings KM, Hyland A, Giovino GA. Stop-smoking medications: Who uses them, who misuses them, and who is misinformed about them? *Nicotine Tob Res.* 2004;6(Suppl 3):303-10.
- Hatsukami D, Mooney M, Murphy S, LeSage M, Babb D, Hecht S. Effects of high dose transdermal nicotine replacement in cigarette smokers. *Pharmacol Biochem Behav.* 2007;86(1):132-9.
- Benowitz NL, Gourlay SG. Cardiovascular toxicity of nicotine: implications for nicotine replacement therapy. *J Am Coll Cardiol.* 1997;29(7):1422-31.
- West R, Hajek P, Foulds J, Nilsson F, May S, Meadows A. A comparison of the abuse liability and dependence potential of nicotine patch, gum, spray and inhaler. *Psychopharmacology.* 2000;149(3):198-202.
- Rigotti, NA. Treatment of Tobacco Use and Dependence. *New Engl J Med.* 2002;346:506-12.
- Etter JF, Stapleton JA. Nicotine replacement therapy for long-term smoking cessation: a meta-analysis. *Tob Control.* 2006;15:280-5.
- Sims T, Fiore MC. Pharmacotherapy for Treating Tobacco Dependence—What is the Ideal Duration of Therapy? *CNS Drugs.* 2002;16(10):653-62.
- Croghan IT, Hurt RD, Dakhil SR, Croghan GA, Sloan JA, Novotny PJ, et al. Randomized Comparison of a Nicotine Inhaler and Bupropion for Smoking Cessation and Relapse Prevention. *Mayo Clin Proc.* 2007;82(2):186-95.
- Murray RP, Bailey WC, Daniels K, Bjornson WM, Kurnow K, Connett JE, et al. Safety of nicotine polacrilex gum used by 3,094 participants in the Lung Health Study. *Chest.* 1996;109(2):438-45.
- Hays JT, Hurt RD, Rigotti NA, Niaura R, Gonzales D, Durcan MJ, et al. Sustained-release bupropion for pharmacologic relapse prevention after smoking cessation. a randomized, controlled trial. *Ann Intern Med.* 2001;135(6):423-33.
- Williams KE, Reeves KR, Billing CB Jr, Pennington AM, Gong J. A double-blind study evaluating the long-term safety of varenicline for smoking cessation. *Curr Med Res Opin.* 2007;23(4):793-801.
- Leshner AI. Addiction Is a Brain Disease, and It Matters. *Science.* 1997;278:45-7.
- National Institutes of Health State-of-the Science Conference Statement: Tobacco Use: Prevention, Cessation, and Control. *Ann Intern Med.* 2006;145(11).



Treating Medically Ill Smokers in the Hospital

by Michael B. Steinberg, MD MPH

Smokers with medical illnesses have higher incidence of further complications and progression of disease ⁽¹⁾ than those who quit, so it is critical that these smokers quit whenever possible. Quitting smoking reduces the risk of recurrent myocardial infarction, restenosis of coronary interventions, and cardiac sudden death. However, only 50% of smokers quit after suffering a myocardial infarction. Despite the general perception of physicians, knowledge about specific health effects of tobacco use is not universally understood. While over 75% of smokers are aware of the link between lung cancer and smoking, only one-third link it to heart disease ⁽²⁾. Continuing smokers are at the highest risk of cardiac death and thus require maximal efforts to assist them in quitting. However, due to their medical conditions, they often do not receive adequate treatment for tobacco dependence ⁽³⁾, especially pharmacotherapy, as prescribers are cautious with certain conditions, such as cardiac disease. These concerns still exist primarily from a few case reports of cardiac complications in those using nicotine medications in the early 1980's, despite numerous subsequent studies demonstrating the contrary.

Recent Public Health Service Clinical Guidelines and reviews have demonstrated the efficacy of medications to help smokers quit ^(4,6). There is also evidence that smokers with significant nicotine dependence may benefit from higher intensity treatment regimens, including combinations and extended durations of medications. There are data that combinations of medications ^(5, 7-9) and extended duration of treatments ⁽¹⁰⁾ may be beneficial, and may not be associated with increased adverse events ⁽¹¹⁾. Smokers with medical illness, including cardiac disease, who continue to smoke are by definition significantly dependent and therefore may require more intensive interventions to assist them.

With many medical conditions, we take a step-wise approach to intensity of therapy, gradually increasing intensity as interventions fail. However, some medical situations are critical enough that they require intensive interventions from the outset to maximize the chance for effect. For example, following myocardial infarction, patients are placed on a combination of secondary prevention medications including lipid lowering medications, beta-blockers, and aspirin. In regards to tobacco dependence treatment, especially among the most high-risk smokers with chronic medical illnesses who are already hospitalized, we need to take a similar intensive, front-loaded approach. Data indicates that the early days of a quit attempt are critical, so early success is important. In addition, the early weeks following an acute coronary event are a critical period for recurrent events, thus, a critical period for smoking cessation.

Particularly evident are the tobacco effects seen within the hospital. Smoking leads to many diagnoses that result in hospitalization and there are numerous surgical complications associated with continued tobacco use. It is within this setting that the patient's chronic medical conditions have progressed to the point of requiring acute medical care. It is also an environment that has been shown to be conducive to tobacco interventions. Patients are feeling especially vulnerable during hospitalization, thus creating

Night-Smoking: A New Tool for Measuring Tobacco Dependence

by Michelle T. Bover, MPH

A recent study here at the UMDNJ-School of Public Health's Tobacco Dependence Program found that more than half of smokers who have tried to quit using our Tobacco Dependence Clinic reported sometimes waking at night to smoke (night-smoking). We also found that individuals identified as night-smokers were significantly more likely to resume smoking within six months, indicating that this behavior is a strong predictor of relapse and an important indicator that the more intensive and sustained treatment may be required.

We were surprised to see how many patients report waking at night to smoke. In fact, of the over 2,300 subjects included in our analysis, 51 percent were identified as night-smokers during their assessment interview. Clinicians typically estimate how addicted a smoker is based on how many cigarettes they smoke per day or how soon they smoke after waking in the morning. However, we found that night-smoking was not only a significant predictor, but a stronger predictor of relapse-to-smoking within six months than these traditional markers of tobacco dependence. Additionally, among all patients who relapsed, night-smokers had a shorter average time to relapse than patients that were not night-smokers.

So what can we learn from this study? For one, clinicians should assesses night-smoking behavior whenever treating tobacco dependence. We believe that the wording of our night-smoking assessment item ("Do you sometimes awaken at night to smoke or use tobacco?") is ideal because it is both simple and distinguishes between waking at night to smoke due to cravings as opposed to smoking at night while awake for some other reason. Once night-smokers are identified, we may need to modify the traditional approaches used to help these individuals to quit smoking. For example, this group of smokers may benefit from counseling and tailored pharmacotherapy, such as avoiding cessation medications that can cause sleep disturbances and using a 24-hour nicotine patch.

The study, which is the first of its kind to identify the characteristics and outcomes of night-smokers in a real-world patient population, appeared in the February issue of the International Journal of Clinical Practice and is currently available at www.tobaccoprogram.org/staffarticles.htm.



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Smoke Screen is Clouding the Truth about Smoking & Mental Illness

by Jill Williams, MD

There has been a lot of recent controversy across the country about whether or not all smoking should be banned in psychiatric hospitals. Psychiatric hospitals and clinics may be the only remaining parts of the American health care system that often don't treat smoking. At state funded psychiatric hospitals, administrators are trying to pass policies that restrict all tobacco use in these facilities-not only in buildings but on all adjacent outdoor areas or "grounds". Tobacco-free hospital policies are intended to create a healthy environment for everyone who comes there to receive care, visit a patient or work. These policies can help people in the hospital "detox" from smoking and receive necessary treatment for tobacco addiction. People with serious mental illness are dying 25 years earlier than other people in the US and often their deaths are from tobacco-caused illnesses like heart disease. Not enough is being done to help.

It is important to keep in mind that smoking is already highly restricted in the hospital setting. This means that there are a lot of rules about who, when and where patients are allowed to smoke. From what I've seen from visiting hospitals across the country, I'm not sure that the way that people are allowed to smoke now in psychiatric hospitals is really helping anyone or giving patients that much control over their environment. Smoking is often used as a reward for patients who have been cooperative. For example, patients earn "privileges" to go outside to smoke. That usually means that the first few days of the hospital stay when patients are having the most nicotine withdrawal, they are not allowed to smoke. Furthermore, most hospitals do not allow anyone to smoke indoors. Facilities often allow only a certain number of smoke-breaks per day (usually 3 or 4) or restrict the number of cigarettes allowed to be smoked to less than 10 per day. Smokers are at risk for having nicotine withdrawal symptoms if they smoked much more before coming to the hospital. Since patients are not allowed to hold onto their tobacco and lighters, staff (usually nursing or rehabilitation

techs) must give out and then take away these things for smoke breaks. There can be a lot of arguing and conflicts between patients and staff about tobacco products and smoking. Studies of psychiatric hospitals that have gone tobacco-free report fewer behavior problems and less violence after the policies took effect. Staff also say there is more time to provide treatments when hospitals go tobacco-free.

Many other places in this country are becoming smoke-free. Fourteen states have already banned smoking in public places such as restaurants and bars. Smoking is often banned in many workplaces, including government buildings, and schools. Smoking is often banned in train and bus stations, and on airplanes. Smoking is banned in movie theaters, museums, bowling alleys, libraries, stores, bingo halls and churches. As people with mental illnesses try to live in the community it will be harder for them to fit in if they are still smoking. Smokers have a harder time finding jobs and housing. Smoking is not allowed at most general medical hospitals. Therefore, if psychiatric hospitals and clinics become the only part of health care that continues to have smoking that may cause people with mental illnesses to be further removed from society. On the other hand, if we use the hospital as a treatment site, we can give smokers a better chance at quitting. That means providing access to all the tobacco treatment medications and having group and counseling available in the hospitals for all smokers. No one should have to suffer when they give up smoking- medications lessen the craving and withdrawal associated with quitting cold turkey.

Given what we know about the negative effects of smoking, both in the hospital and in the real world, it seems clear that making psychiatric hospitals and clinics smoke-free will have tremendous benefit for patients, in the short and the long-term.

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A Student's Perspective

by Hannah Kim, BS

I began my internship at the Tobacco Dependence Program as a senior at Rutgers University, pursuing a dual degree in Public Health and Sociology. Now recently graduated (May 2008), I hope to soon have a job in a public health-related field. I have been assisting Dr. Jonathan Foulds, PhD by creating consumer-friendly brochures for smokers on the use of nicotine replacement therapy, which is designed for distribution to smokers both in and outside of the Tobacco Dependence Program office. Additionally, I have created charts for inclusion in a report advocating policy change on Nicotine Replacement Therapy Labels.

Working at the Tobacco Dependence program has been an incredible experience. I have learned so much about tobacco dependence and the use of nicotine replacement therapy. Attending the 5 day certified tobacco treatment specialist program and working with staff members who are dedicated to helping people quit smoking has helped me realize that I would enjoy working with educators to help people quit. I began my internship feeling unsure about my post-graduation future, but my experience at the Tobacco Dependence Program has uncovered a desire to pursue a career in public health program coordination, and I hope to one day organize programs that teach and motivate today's youth about the effects and consequences of drug addiction.

New Staff at the Tobacco Dependence Program

Erin M. Bunger, BS

Research Assistant

Erin Bunger joined the Tobacco Dependence Program as a part-time Research Assistant at the end of 2007. She is responsible for completing follow-up phone interviews with Clinic clients and assists with the organization of Clinic follow-up data that is included in monthly, quarterly, and annual reports to New Jersey's Comprehensive Tobacco Control Program. Erin is also a Project Assistant/Coordinator at the Bloustein Center for Survey Research within Rutgers University. In this capacity, she manages substance use survey projects in New Jersey middle and high schools. Erin earned her B.S. in Psychology with minors in Women's and Diversity Studies, from Susquehanna University in Selinsgrove, Pennsylvania, and will begin her Master of Public Health degree at the University of North Carolina, Chapel Hill, this fall.

PROJECT WIN

A New Program for Helping Youth Quit Smoking... On-line Staff Education, One-to-One Quit Coaching and Group

by Nancy Speelman Edwards, C.S.W., L.C.A.D.C., C.T.T.S.

The Tobacco Dependence Program of the University of Medicine and Dentistry of New Jersey-School of Public Health will be offering a new program to schools this fall. After 5 years of implementing the Youth Quit2Win Cessation Program, we recognized additional needs to be addressed in the school setting:

- 1) There is limited staff time allowed for attending out-of-school training.
- 2) There is usually only one Student Assistance Counselor (SAC) in a school and this is the staff identified to facilitate the group. This person tends to be quite overwhelmed by many other issues facing high school students, making addressing tobacco use lower on their priority list.
- 3) It is important that more than one staff is identified to help students to quit smoking.
- 4) At times it may be difficult for students to miss class to attend in-school groups.
- 5) There is a need to address students who have violated school tobacco policies.
- 6) We often found school administrators insisting violators of school smoking policies be allowed to attend the quit group sessions. These sessions are designed for youth smokers who identified themselves as motivated to quit and willing to gain support in a group setting. While merging these two different populations of smokers may be convenient, we often found it disruptive to the group process.
- 7) While reviewing school policies, we found tobacco use on school grounds was often not treated the same as other drugs of abuse. Whereas, the consequences for use of other drugs always included a counseling component, smoking on school grounds usually meant a punitive response, such as a fine and/or detention. Clearly a response must be given, but school personnel and parents need to recognize the importance of helping students with their nicotine addiction. All too often, we see school staff turn their heads or hear adults comment, "Well at least they are not doing cocaine or heroin," thereby condoning their addictive behaviors.

Project WIN (Win Independence from Nicotine) is intended to address all of these issues. An on-line training program will be made available to school professionals to utilize at their own pace. This will allow administration to encourage several staff throughout the school to become more knowledgeable about nicotine addiction through easy-to-access on-line training and



allow more staff the ability to offer one-to-one "coaching" to their students. It provides information on topics every smoker should know, along with handouts, questionnaires and activities for students to work on independently. In addition, this program will enable schools to provide education to students who have violated school tobacco policy rules as an "alternative to suspension." The program is not intended to be punitive but instead to challenge the students to think about their tobacco use. It is important for adults and especially school personnel to recognize the role tobacco use plays in the addiction process. Students who smoke learn to become dependent on a substance in order to relieve undesirable symptoms of withdrawal and/or cope with everyday life. In addition, while students are experiencing withdrawal symptoms, it makes it almost impossible for them to focus on their studies. We also know that with most other forms of drug of abuse, a student's first drug experience usually begins with tobacco or alcohol. And, most adult smokers began using tobacco before 18 years of age.

The overall goal of Project WIN is to help more staff within the school environment learn about nicotine addiction, and, in turn, to help more students quit. Staff throughout the school will stop turning their head to this deadly disease and instead aid in their student's success as a non-smoker, allowing their students to attain their lifelong dreams!

a "teachable moment", they are placed in a setting of forced abstinence, and they can be monitored closely during intense interventions, if needed. Therefore, the hospital setting is an important setting for intervention.

Previous studies looking at the effect of hospital interventions for smokers have shown some effect. A previous review reported that those interventions that are effective require at least a moderate amount of intensity and follow-up⁽¹²⁾. These studies have used both behavioral interventions, delivered by varying personnel, and some have utilized various forms of nicotine replacement therapies. However, pharmacological results in this population have been mixed, and there are no published data utilizing combination medications within the hospital setting. What remains unclear is the optimal treatment modality and intensity (counseling, medications, or both), the optimal follow-up (telephone, face-to-face) and who is best to deliver these interventions (physicians, nurses, psychologists, counselors, etc.). Some of the limitations to previous studies in this population include a lack of utilization of combination pharmacotherapy, and a limited physician role in most interventions, often delivering only brief advice. In addition, the advantage of initiating medication treatment during hospitalization is not well understood. In theory, treating tobacco withdrawal during hospitalization could influence physiologic responses that might worsen outcomes, such as catecholamine related hyperglycemia. Also, the relief of physical withdrawal symptoms themselves is a benefit to the patient, improving quality of comfort, and the confidence and familiarity of using these medications in the hospital may increase utilization following discharge.

System-based interventions have been recommended by the Public Health Service Guidelines (4) as effective ways to improve tobacco dependence treatment. Since they can result in universal identification, facilitate hospital-based treatment, and link to outpatient follow-up, they seem ideally suited for this setting. Unfortunately, current policies by the Joint Commission for Accreditation of Healthcare Organizations (JCAHO) only require hospitals to have a smoke-free indoor policy, and offer some type of cessation help. Many hospitals choose to just do the minimum (usually a discharge pamphlet) in order to achieve compliance.

What is needed in order to bolster our knowledge of treating hospitalized smokers are more data regarding 1) effectiveness of high-intensity interventions during hospitalization; 2) impact of these interventions on clinical outcomes; and 3) the benefit of system-wide implementation of comprehensive tobacco control measures within the hospital, from smoke-free campuses to on-site treatment and follow up for all patients and employees. This is an important and interesting field of research for the coming years.

References

1. US Department of Health and Human Services. The Consequences of Smoking: A Report of the Surgeon General. US Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health. 2004.
2. Weinstein ND, Slovic P, Waters E, Gibson G. Public Understanding of the Illness Caused by Cigarette Smoking. *Nicotine and Tobacco Research*. 2004; 6(2):349-55.
3. Critchley J & Capewell, S. Smoking Cessation for the Secondary Prevention of Coronary Heart Disease. *Cochrane Database of Systematic Reviews*. 2003;2.
4. Fiore MC, Bailey WC, Cohen SJ, et al.. Treating Tobacco Use and Dependence: Clinical Practice Guideline. Rockville, MD US: Department of Health and Human Services; 2000.
5. Silagy C, Lancaster T, Stead L, Mant D, Fowler G. Nicotine Replacement Therapy for Smoking Cessation. *Cochrane Database of Systematic Reviews*. 2002; 3.
6. Hughes JR, Goldstein MG, Hurt RD, Shiffman S. Recent Advances in Pharmacotherapy of Smoking. *JAMA*. 1999; 281(1): 72-76.
7. Bohadana A, Nilsson F, Rasmussen T, Martinet Y. Nicotine Inhaler and Nicotine Patch as a Combination Therapy for Smoking Cessation. *Archives of Internal Medicine*. 2000; 160(20): 3128-34.
8. Kornitzer M, Boutsen M, Dramaix M, Thijs J, Gustavsson G. Combined use of Nicotine Patch and Gum in Smoking Cessation. *Preventive Medicine*. 1995; 24(1): 41-7.
9. Blondal T, Gudmundsson LJ, Olafsdottir I, Gustavsson G, Westin A. Nicotine Nasal Spray with Nicotine Patch for Smoking Cessation: A Randomized Trial with Six Year Follow-up. *BMJ*. 1999; 318:285-9.
10. Hurt RD, Wolter TD, Rigotti N, et al.. Bupropion for Pharmacologic Relapse Prevention to Smoking: Predictors of Outcome. *Addictive Behaviors*. 2002; 27:493-507.
11. Murray RP, Bailey WC, Daniels K, et al.. Safety of Nicotine Polacrilex Gum Used by 3,094 Participants in the Lung Health Study. *Chest*. 1996; 109:438-445.
12. Rigotti NA, Munafò MR, Murphy MFG, Stead LF. Interventions for smoking cessation in hospitalised patients. *Cochrane database of systemic reviews*. 2002;Vol 2.



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**Proyecto Vida:
Latino Deje de Fumar**

has developed language and culturally sensitive services to help members of the Hispanic community quit smoking.

The program kicked off in January of 2006 and the response from the Hispanic community has been overwhelming.

For more information, visit www.proyectovidanofume.org

"Looking GREAT and feeling...good?" Smoking & Health in the LGBTQQ Community

by Jose A. Cruz, MSW, LSW

Some of us use a daily checklist that reminds us to go to the gym, sun ourselves at a tanning salon before a public appearance, eat low carbs, get fabulous haircuts, and smell like success...all to look as toned and youthful as physically possible. Just as with various groups in a community, the LGBTQQ (Lesbian, Gay, Bisexual, Transgender, Queer, & Questioning) has been impacted by certain trends, but smoking continues to take its toll. According to the American Cancer Society, tobacco use kills at least 30,000 gay and lesbian people each year in the United States.



Tobacco Companies reach the LGBTQQ community with direct and indirect advertisements, as well as through event sponsorship. Many of us still watch Carrie light up on reruns of "Sex and the City," and cigars are often used as a masculine symbol among gay men, especially in the leather community. Smoking is used as an ice-breaker, a social past-time that, with time, becomes itself a "best friend." It is that friend that is ever-present at various meeting

places and, though no longer permitted inside, right outside the front door of our favorite bars and clubs. What many of us don't realize, however, is that by increasing the number of wrinkles, staining our teeth and making us smell bad, smoking is undoing all our efforts to improve our appearances ... and killing us, one puff at a time.

As the LGBTQQ community has various groups and sub-groups, healthcare providers must meet the challenge of being culturally competent and humble when treating its members. We live in a time when being knowledgeable about challenges that groups face is a necessity to provide effective treatment. One way to do this may be to visit a local agency that provides support groups, such as Women's Social Support Group or Men Supporting Men Group, or by attending LGBTQQ community-sponsored social events.

At the Tobacco Dependence Program, there is an opportunity to get treatment to quit smoking, but there are also chances to enlist members of LGBTQQ groups to get involved and share information at community events. The Tobacco Dependence Program hopes to soon partner with the Pride Center of New Jersey in efforts to bring tobacco dependence education and treatment to members of this community that is in desperate need of anti-smoking intervention. The LBTQQ community is invincible, strong, fresh and full of style...we want to keep it that way.

Training and Education News

by Amy C. Schmelzer, MS

The Tobacco Dependence Program's Training and Education department has been extremely busy the last few months preparing and executing a number of trainings. The Certified Tobacco Treatment Specialist (CTTS) trainings of January and March were filled to capacity. A total of 84 health care providers and professionals completed the week-long tobacco program and, upon completion of the post-training coursework, are eligible for application directly to the certification board for CTTS certification. While two 5-Day trainings have been completed thus far this calendar year, June will prove to be an exceptionally busy month, as the CTTS training team will be traveling to Orlando, Florida to provide a 5-Day training to 50 healthcare professionals, then returning home to run another 5-Day training in New Brunswick, NJ.

Although the training team has been keeping busy with the CTTS training, numerous 1-Day trainings have been scheduled as well. In March, the Tobacco Dependence Program offered a comprehensive one-day training open to beginners in the tobacco field. This training covered numerous aspects of the tobacco industry, including: the public health ramifications of tobacco use, the tobacco industry's effective marketing strategies to promote tobacco sales and use, and medications available to help people quit. Participants were able to receive continuing education credits for attending. In May, the training staff offered an advanced training to those professionals that have completed the 5-day CTTS training. The scope of this training included the latest information on helping people quit smoking, updates on available cessation medications, and complex case presentations from both the participants and the Tobacco Dependence Program staff. Participants were eligible to receive continuing education credits for attending this 6-hour training.

The staff traveled to Trenton, New Jersey in May to train the Department of Corrections (DOC) staff in how to help their clients abstain from and quit tobacco. The training and education staff is also traveling offsite to Brooklyn, New York in June to perform additional one-day trainings. Healthcare professionals will be trained on various topics including but not limited to treatment planning, available cessation medications in, and the latest research on nicotine and tobacco. Keep checking the Training portion of the Tobacco Dependence Program website for more training updates!

2008 Training Schedule

Jun 2-6	Tobacco Treatment Specialist Training Orlando, FL
Jun 16-20	Tobacco Treatment Specialist Training New Brunswick, NJ
Oct 16-17	Youth Quit2Win Training New Brunswick, NJ
Oct 20-24	Tobacco Treatment Specialist Training New Brunswick, NJ