

The Nicotine Challenger

Winter 2007-08

This issue: Reaching Out

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A View From The Director

by Jonathan Foulds, PhD

How can we make tobacco treatment available to more smokers?

Although the US Public Health Service Clinical Practice Guideline for the Treatment of Tobacco Use and Dependence recommends that physicians ask all patients about their tobacco use, and all smokers be offered an approved medication to help them quit, this is clearly not happening¹. An analysis of the 2001-2 national Ambulatory Care Survey² found that tobacco counseling occurred in 22.5% of visits by tobacco users, and cessation medications were prescribed on only 2.4% of occasions (with the odds being 15 times higher if the patient requested it). These rates are no higher than were found in this survey in 1991. A different study involving direct observation of physician encounters with patients³ found that of 244 smokers identified, physicians provided assistance with smoking cessation for 38% (range among practices = 0%-100%). Bupropion and nicotine replacement therapies were discussed with smokers in 31% and 17% of encounters, respectively. Numerous other studies have documented poor adherence of physicians to the basic recommendations in the 1996 and 2000 Tobacco Treatment Guidelines¹ regarding the "5 As" (Ask, Advise, Assess, Assist, Arrange), with particularly low rates of "assisting" on use of medications and "arranging" follow-ups.⁴⁻⁶ This partly relates to lack of familiarity with the Guideline,⁷ but time constraints and the perception that smokers are unreceptive to counseling were the two most common barriers cited by both physicians and office managers in one study⁸. Thorndike et al⁹ reported that there has been a small increase in physicians' rates of patients' smoking status identification and a small decrease in rates of counseling smokers over the decade 1993-2003. This lack of progress may reflect barriers in the US health care environment, including limited physician time to provide counseling.

A National Commission on Prevention Priorities, led by former US Surgeon General Dr David Satcher, ranked 25 preventive healthcare interventions for their population impact and cost-effectiveness¹⁰. Three interventions achieved the top ranking on both of these measures (total score=10): daily aspirin for people over 40, childhood immunizations, and brief counseling and pharmacotherapy for tobacco use. Of all the interventions evaluated, the tobacco intervention was estimated to have by far the biggest impact on Quality-Adjusted Life Years saved if widely implemented (1.3 million annually). Under-treatment of tobacco dependence therefore represents a major failure in the US healthcare system. So what are the causes and potential remedies? Here are my thoughts:

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CHANTIX: MIRACLE PILL OR DANGEROUS DRUG?

by Michael B. Steinberg, MD MPH
Medical Director and Associate Professor

The answer is **neither**...

Chantix (varenicline) is the latest FDA approved medication to be used for treating tobacco dependence. In the clinical trials to date and in early anecdotal reports from tobacco treatment clinicians, Chantix is performing very well as an effective aid to help smokers quit. Here at the Tobacco Dependence Clinic, we are prescribing Chantix quite actively, and have found it to be a very useful, effective, and well-tolerated medication both for smokers who have never used pharmacotherapy and those who have battled tobacco dependence with other medications in the past. Despite these results, smokers (and providers) need to be continually reminded that this is not a "magic-bullet" and that all pharmacological agents perform better when made part of a comprehensive tobacco dependence treatment plan.

Recently, widely broadcasted case reports have aroused concern over the safety of Chantix, but the forces at play here are complex:

- In the few thousands of subjects enrolled in Pfizer's published clinical trials, there did not seem to be concerning reports of erratic behavior, depression, or suicidal ideation
- It should be noted that in these early trials (as customary for many initial trials), subjects were screened out for many psychiatric and medical illnesses
- The current market of Chantix is estimated around 3,000,000 users, much greater numbers than were able to be studied in clinical trials
- It stands to reason that now that the medication is out in the general public, previous rare effects might present themselves more commonly (this is why post-marketing surveillance is so important)
- The reports of erratic behavior in the media are not clearly linked solely to the use of this medication, because there are often several factors in play. For example, stopping smoking



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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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can, on its own, influence mood. Additionally, other substance use, such as alcohol, may have been involved in some of these case reports.

- However, desire of the general media climate (i.e., TV, newspaper, magazine) to sell a story, combined with easy access to (often times unreliable) internet information sources, can cause an increase in the perceived risk of a side-effect to a level much higher than the actual risk.

So what should a prudent clinician do?

My opinion is that we need to take these recent reports in their proper context. We should continue to practice close, appropriate monitoring, and not panic. After all, Chantix remains an important part of the pharmacologic arsenal for tobacco dependence treatment. It is a proven effective medication and has good trial safety data for up to 1 year of use. The few case reports seem to be isolated instances of erratic behavior, depression, etc., and have involved other factors (e.g., history of mental illness, alcohol use). In addition, quitting smoking has its own set of withdrawal symptoms that can affect mood and behavior. The reasonable response to this is to:

1. Continue to use this effective medication in our general population of smokers
2. Monitor patients on Chantix for mood changes, erratic behavior, or other side effects (as would be part of good clinical practice), and report instances as appropriate.
3. Allow the FDA to explore these reports with due scientific rigor
4. Let the evidence inform the process - do not abandon an effective and life-saving treatment solely due to media reports.
5. Have an open dialogue with patients regarding their individual choice of medication

As dedicated clinicians, we aim to improve the lives and well being of those we are privileged to care for, and we must let the evidence guide us in safely and effectively achieving this goal.

Causes

1. Although very thorough evidence-based reviews and clinical practice guidelines are available, most clinicians are unaware of them, and few healthcare systems require that they be followed in the same way that guidelines on the treatment of other comparable disorders (e.g., hypertension) are followed. If the healthcare system (whether that be the hospital system or the health plan) does not explicitly value tobacco treatment one should not be surprised that busy clinicians are not going out of their way to find and follow clinical guidelines on this issue.
2. Clinicians have found that it is not simple to get paid for tobacco treatment interventions. Where these are covered by health plans there may be high copays or deductibles, payments are frequently low, and certain effective treatment components are not covered (e.g., over the counter nicotine replacement therapy or group treatment). Therefore, for both clinicians and patients, there is uncertainty about what (if any) treatment components are covered, and this itself is a barrier to treatment provision.
3. Clinicians are unsure about the effectiveness of tobacco treatment. Their experience is that of 50 patients counseled and offered a medication, 40 will still be smoking when they are seen a year later. This can seem unrewarding compared to some other clinical interventions.

Solutions

1. All the effective components of tobacco treatment should become covered benefits of all health plans. Model benefit designs have already been described and widespread adoption of these would take away that doubt/barrier¹¹. This will


require both patients and employers to ask for it, as well as insurance companies to offer and provide it.

2. We need to ensure that a new tier of healthcare provider can be trained and eligible for reimbursement for tobacco treatment. Physicians' and other prescribers' time is valuable and the counseling component is best provided by counselors who have been trained to specialize in that work. In large hospitals or high population densities, this tobacco counseling can be provided face-to-face in specialist clinics, but in areas that are more rural this can best be provided via telephone "quitlines" and interactive websites. This will require that more tobacco treatment counselors be trained and approved for reimbursement by health plans. Standards for Practice for Tobacco Treatment Specialists have been developed by the Association for the Treatment of Tobacco Use and Dependence (ATTUD): <http://www.attud.org/public/survey.php>
3. Steps 1 and 2 above will enable physicians to move to a model where they routinely ask patients about tobacco use, advise them to quit, offer to prescribe a med, and then refer on to a local counselor or quitline (ideally via an electronic or "fax-to-quit" service). The physician intervention needn't require more than one or two 15-minute appointments, and the counselor intervention would consist of 4-8 30-minute sessions.

I'd be interested to hear from clinicians regarding what they think could be done to improve tobacco treatment provision. For the patients, I think the advice must be to ask your clinicians for help; and, for clinicians, to move towards working in a proactive, rather than reactive, mode.

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11. For details, see <http://www.tobaccoprogram.org/cftfinsurance.htm>

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

New Staff at the Tobacco Dependence Program



Michelle T. Bover, MPH

Research Teaching Specialist

Michelle joined TDP in November 2006 as a part-time Research Assistant and took a full-time position in November 2007. Although born and raised a “Jersey Girl”, Michelle attended college at University of Maryland, where she earned a B.S. in Biological Sciences, specializing in physiology and neurobiology, and a minor degree in Community Health in 2005. She returned to New Jersey and received her Master of Public Health degree, with concentration in Epidemiology, in May 2007 from UMDNJ-School of Public Health, at which time she was inducted into Delta Omega Honorary Society in Public Health. Proficient in SAS, SPSS, Access, and Excel, Michelle embraces her role as the Program “data geek” She currently contributes to several ongoing research projects, assists with poster and presentation development, builds and maintains databases, compiles monthly, quarterly, and annual reports to the CTCP, and is responsible for the annual Clinic report and the semi-annual Program newsletter. Michelle is excited to contribute to the many TDP activities and aspires to one day earn her PhD in Epidemiology.



Amy C. Schmelzer

Training and Research Assistant

Amy Schmelzer received her bachelor's degree in Cell Biology and Neuroscience with a minor in Psychology from Rutgers University-Rutgers College. Currently, she is obtaining two Master's degrees from UMDNJ. She will graduate from the Graduate School of Biomedical Sciences in May 2008 with a MS in Biomedical Sciences and will graduate from the School of Public Health the following year with a Masters in Public Health, concentrating in Health Education and Behavioral Science. Amy works closely with Dr. Michael Steinberg, MD, MPH on inpatient and outpatient smoking cessation trials and assists the Training and Education Department in the planning of the Certified Tobacco Treatment Specialist training. After completing her graduate coursework, Amy is interested in attending medical school and will utilize the knowledge gained during her time at the Tobacco Dependence Program to encourage cessation in smoking patients.



Adejoke A. Ojo, MSW, LSW

Mental Health Clinician

Adejoke obtained a Bachelor Degree in Guidance & Counseling in 1991. She is a Licensed Social Worker, skilled in individual and family assessment. She completed the Tobacco Dependence Treatment Specialist training in February, 2005. She received her Master in Social Work from Rutgers University, School of Social Work in May, 2006.

Adejoke first came to the Tobacco Dependence Program in September, 2004, as an intern. During that time, Adejoke demonstrated excellent social work skills and great interpersonal relationship with her clients, staff and other professionals. She returned to the program as a part time clinician in August, 2007, due to her interest in addiction and tobacco treatment. Adejoke has brought with her several years of experience as a seasoned social worker with concentration in Children and Families. She has prior working experience in Public Social Services with the City of New York and state of New Jersey. She is interested in issues related to cultural and language diversity.

First Impressions

My experience as a first year Master of Social Work intern at the Tobacco Dependence Program has been wonderful thus far. I have learned a lot about tobacco dependence, its importance, and how it impacts health, and working with an exceptional staff has benefited my understanding of evidence-based treatment. I have had the privilege of working with both treatment groups and schools and have had the opportunity to advocate for the clinic on multiple occasions. Finally, the friendly environment at TDP has me looking forward to each day I spend there. I could not possibly ask for a better field placement, and I am excited to experience what the future brings!

Lisa Giacomiazio, B.A., MSW Candidate

I am impressed with how clients continue to come back for treatment at the TDP even if they relapsed. The overall feedback I get from the clients I have seen is that the service they received was either very good or excellent, and the TDP clearly has an excellent reputation in the larger community.

Kurt Bopp, B.A., MSW Candidate

ON THE ROAD: Work-based Tobacco Dependence Treatment

by Donna Richardson, LCSW, LCADC, CTTS

The Tobacco Dependence Clinic offers on-site tobacco dependence treatment for employees in their workplaces. We at the Clinic agree with the Center of Disease Control that these groups save the lives of smokers and the money of their employers¹; but more relevant to our Clinic mission, we see work-based groups as an excellent means to reach tobacco users who are underserved or unlikely to seek treatment. We think it makes good sense to go out on the road to the place where most adults spend most of their time: their jobs. Our work-based treatment has focused on *helping the individual employee* quit smoking. We have partnered with our regional American Cancer Society, whose focus has been to *change the workplace* as an entity and to provide financial incentive for employers. For example, we have not provided consultation to employers who are looking to make change through rules and regulations about tobacco use on the premises; but we have advised Human Resource (HR) personnel to select health insurance options that provide financial support for evidence based treatments, including nicotine replacement medicines, bupropion and varenicline, for employees.

At our Clinic, the process of treating individuals in their workplaces typically begins with a phone contact from a workplace HR representative. This contact is an opportunity for discussion of workplace forces that may have motivated the call as well as a time to collect specific information on the number of employees who smoke, location of worksite, and desired time frame. Additionally, when possible, viewing the website of the worksite provides a helpful overview. After gathering the necessary background information, we prepare a one page proposal and enclose brochures of Clinic and Work-based Treatment. Knowing that one size does not fit all, we label the proposal as a document that can be adapted to the specific needs of a workplace. The initial document may be identical to the final document, or it may be drastically altered by legal departments of the respective groups. We have also learned that we will prepare more proposals than will be accepted, and we understand that our proposals are sometimes solicited for reasons other than hiring us (e.g., to provide counterarguments to requests for treatment).

Once our proposal is accepted, it's show time. We quickly fix on a day for an Information Session that will accommodate the worksite's needs as well as our staffing capability.

Step 1: An Information Session held at the worksite is publicized and hosted by the employer. Lunch or snack is sometimes provided as an incentive. Our medical director and clinical social worker make an informal presentation during which there is discussion of logistics (time, day of week, confidentiality) and treatment specifics (medications, personnel) and ample time allowed for questions and answers. We schedule assessment appointments with employees who accept our offer of treatment. At this and all other sessions, it is important that we set a friendly yet professional tone.

Step 2: Our model requires an individual one hour assessment conducted in a private setting at the worksite (sometimes a challenge in some workplaces) by a clinical social worker where a clinician-patient relationship is established as data regarding demographics, tobacco use history, previous quit experience, medical and behavioral health history, triggers and cues to smoke, withdrawal symptoms, motivation and importance of quitting is collected². At this step, the goals include committing to a quit date, measuring

expired carbon monoxide rate, and establishing a treatment plan that includes medication(s) to manage withdrawal symptoms and direction for behavioral change. Typically one to two full days are required for assessment (15 one hour assessments makes for two full days); and, when necessary due to a large-size group, our medical director leads a small team of clinical social workers, social workers, or social work interns to complete assessments. Stop-Smoking Group sessions are then scheduled to meet weekly during lunch break or at shift change and commence soon after assessments are completed.

Step 3: Group begins. We provide our 6 week group, 60 minutes per group. While maintaining a consistent theme of withdrawal symptom and trigger management, each week covers a specific topic:

Session 1: Preparation -- (medication(s) and treatment plan, what to do on your quit date)

Session 2: Quit Date -- Just make it through today.

Session 3: 8 days tobacco free

Session 4: Hardest part is over

Session 5: Should be getting easier

Session 6: Celebration, 4 week follow-up data collected.

Additionally, we tell employees that we are committed to their tobacco-free states and that they can visit us at our Clinic location even though group is ending.

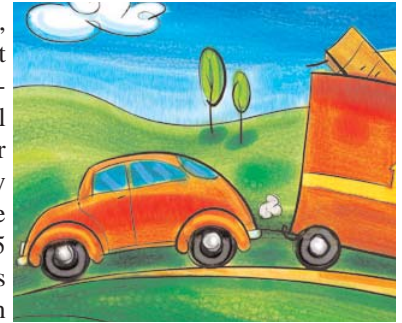
Step 4: Contact employee by phone 6 months after quit date to collect follow-up and patient satisfaction data. At this point, we learn if the individual is smoking, and, if so, how long s/he stayed smoke-free. We treat tobacco dependence as a chronic condition, and individuals that have relapsed are invited to return to our Clinic for a new quit attempt.

Despite evidence that implementing tobacco control programs in workplaces is both medically and financially prudent,¹ tobacco prevention and cessation practices remain the most underutilized clinical prevention practice among US employers, who cite reasons such as high cost, lack of access to return-on-investment information, interference with work time, concerns about intruding into employee's lives, and feelings among non-smokers that spending money only on smokers is unfair for not implementing such programs³. We at the Clinic appreciate these concerns and do our best to work with employers to implement a tobacco cessation treatment program that works for their workplace.

1. Centers for Disease Control and Prevention. Save Lives, Save Money: Make Your Business Smoke-Free. Atlanta, Georgia: U.S. 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, June 2006.

2. Clinic assessment tools can be accessed at our website: www.tobaccoprogram.org

3. Survey of Employers Reveals Their Barriers to Supporting Tobacco-Control Programs. Partnership for Prevention Grant Results; Robert Wood Johnson Foundation: 2007.



Bright Students with a Dark Future

by Nancy Speelman Edwards

Did you know that approximately 80% of adult smokers began smoking before the age of 18, or that everyday, nearly 4,000 young people under the age of 18 try their first cigarette? The tobacco industry is well aware of these statistics and lures prospective clients to use their products at an early age. They know that once teens start smoking, they will most likely continue for years until they are forced to stop due to illness or death. Tobacco addiction is the most common addiction in the United States, and in 2000, the Surgeon General labeled cigarette smoking as a pediatric disease.

As a result of the Master Settlement Agreement, a major lawsuit against major tobacco companies, in 1998 the tobacco industry agreed to no longer directly market to youth. Clever as they are, they switched their focus to college age students. They do this through sponsoring large events/parties on campuses and give away "free cigarettes and other promotional items." They even pay large sums of money to actors/actresses - including those that do not smoke, but have a strong influence on our youth - to "light up" on screen! Strategic signage placement is another common tactic. We all know that an adult smoker, looking to buy cigarettes, will find them with or without in-store advertisement. Yet, have you ever walk into a convenience store and notice where the signs are placed for cigarette products? Right next to the cash register, where everyone can see and sometimes even low enough for a two year old to read! The fact is, the more a store sells...the less it cost them to buy the product. Additionally, incentives are offered for placing the tobacco industry's marketing signs/displays in strategic places.

In 2003, The Tobacco Dependence Program at UMDNJ-School of Public Health was given the task of creating a new program to help students quit smoking through a grant from the NJ Department of Health and Senior Services. This new curriculum challenges youth to think about their smoking by telling them the truth about their tobacco use, incorporating life skills, and, most of all, ruining their smoking experience by getting them angry at the industry for lying to them and looking at topics that hit home with teens. Through introducing various topics each week and providing a support group within the school setting, our latest research shows that 90% of the students who participate reduce their tobacco use.

In our work with student assistance counselors, school nurses, teachers, REBEL students and coordinators, it is all too common to hear "nobody cares about smoking in our school, we have bigger problems... cocaine... heroin... gangs", "teachers turn their heads", "administration doesn't enforce or there are

punitive responses", "students are fined...but it is their parents that end up paying", "staff smoke with students", "many times it is the parents who buy their teens cigarettes to avoid another fight with them", or "I feel like I am the only person in the whole school fighting this battle".

As outrageous as some of these statements may sound, we hear them all too often. Unfortunately, due to lack of current knowledge on the part of school administrators and staff it is understandable why with the "No Student Left Behind" laws everyone is busy tending to their own domains in their school. English teachers care about teaching English, Math teachers care about Math, etc. But smoking directly effects learning! Maybe it's time for schools to take students smoking more seriously and not just write it off as another passing adolescent phase. Understanding tobacco dependence and how it is not "just a habit" but a "chronic addiction" that effects learning may help motivate school professionals to focus on helping their students quit.

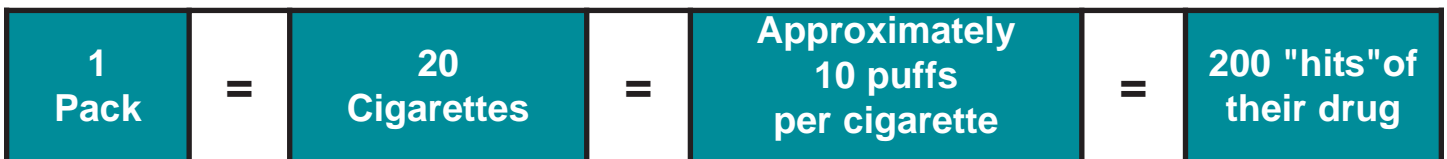


We must also emphasize tobacco's role as a gateway drug among young people. The fact is, the adolescent whose drug involvement progresses to substance abuse typically begins with legally available drugs such as alcohol and tobacco, before progressing to marijuana use, and eventually to other drugs or combinations of drugs such as heroin, cocaine, and ecstasy. Polydrug use is more common among adolescents than adults. In fact, among smokers 12 to 17 years of age, two-thirds have also used an illegal drug, and, among those smoking more than one pack per day, eighty percent have used an illegal drug. (NIDA, Diagnosis & Treatment of Drug Abuse in Family Practice, Morrison MA. Addiction in adolescents. West J Med 1990;152:543-46).

So how can we expect a student to focus on their studies, when clearly the diagnostic criteria for someone experiencing nicotine withdrawal include difficulty concentrating/attention problems, restlessness, and frustration? These symptoms may begin within a few hours after their last cigarette, forcing students to focus not on their schoolwork, but on where and how they will get their next "hit" of nicotine. And when students get their "hit," the symptoms go away, and they quickly learn that a drug relieves their symptoms. In addition to the pharmacological effects of nicotine, many behavioral factors can also affect the severity of withdrawal symptoms. For some, just the smell and sight of a cigarette reinforces the pleasurable effects of smoking and can make withdrawal or craving worse.

Most students do not know that there are over 4000 chemicals in tobacco smoke, 60 of which are carcinogens...cancer causing!

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Some occur from the process of drying and curing tobacco. Some are added by the tobacco industry to enhance cigarette flavor and function and to increase the body's absorption of - and addiction to - nicotine. Some occur from the burning process (like carbon monoxide). Whether it an adolescent or an adult smoker, nicotine is the active ingredient in cigarettes which causes the addiction to occur. It activates the reward pathway in the brain, similar to other drugs of abuse. Recently, NIDA-funded researchers have shown in animals that acetaldehyde, another chemical constituent of tobacco smoke, dramatically increases the reinforcing properties of nicotine and may also contribute to tobacco addiction. In addition, the investigators further report that this effect is age-

The American Psychological Association Diagnostic Criteria for Nicotine Withdrawal includes:

- A) Daily use of nicotine for at least several weeks.
- B) Abrupt cessation of nicotine use, or reduction in the amount of nicotine used, followed within 24 hours by four (or more) of the following signs:
 - Dysphoric or depressed mood
 - Insomnia
 - Irritability, frustration, or anger
 - Anxiety
 - Difficulty concentrating
 - Restlessness
 - Decreased heart rate
 - Increased appetite or weight gain
- C) The symptoms in Criterion B cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- D) The symptoms are not due to a general medical condition and are not better accounted for by another mental disorder.

related, with adolescent animals displaying far more sensitivity to this reinforcing effect, suggesting that the brains of adolescents may be more vulnerable to tobacco addiction. In our Youth Quit2Win Program, we have found that many students were smoking at the same rates as adults; however, it is important to note that current tobacco cessation medications are not approved for people under 18 unless under the direction of a prescribing physician.

In conclusion, we have found that talking to a teen about how tobacco use can kill them in the future is not what hits home. Giving them the facts about what is used to make cigarettes, how the industry lies to them, how it affects their looks and sexual responses has far more impact! Adding life skills to the Youth Quit2Win curriculum, which teaches students to cope with stress and peer pressure, fosters independence, and promotes healthy decision-making, has also shown to be effective.

For more information about the Youth Quit2Win Program, check our website at www.tobaccoprogram.org or contact Nancy Speelman Edwards by phone 732-235-8218 or email nancy.speelman@umdnj.edu.

A Student's Perspective

by Amy Schmelzer, B.A.

I am a full-time UMDNJ student completing a Masters of Science program at the Graduate School of Biomedical Science in Newark. I will graduate in May 2008 with my MS in Biomedical Sciences. Concurrently, I am obtaining my Masters in Public Health at the New Brunswick/Piscataway School of Public Health, concentrating in Health Education and Behavioral Science. Prior to graduate school, I attended Rutgers College and graduated with a BA in Cell Biology and Neuroscience with a minor in Psychology. After completing the MS and MPH programs, I hope to attend medical school and apply my education and work experience towards effectively communicating with and educating patients on the many behavioral decisions that impact their health. After learning about the dangers of smoking during my time here at the Tobacco Dependence Program, educating patients on the negative health implications of continued tobacco use will remain a top priority in my future healthcare endeavors.

I have been assisting Dr. Michael Steinberg, MD, MPH on two smoking cessation studies. The first study is an outpatient study investigating the efficacy of combination pharmacotherapy in medically ill smokers. The second study is an inpatient study conducted at Robert Wood Johnson University Hospital using Chantix (varenicline). After working with these groups of patients, I have experienced the importance of educating and supporting medically ill smokers during the process of quitting smoking and witnessed first-hand that even medically ill smokers can be successfully treated as outpatients or inpatients for tobacco dependence. Furthermore, I have seen how each study highlights the medical necessity of successfully quitting in those patients already experiencing the damaging effects of continued tobacco use.

In addition to my research contributions at the Program, I recently started assisting the Training and Education team in coordinating the 5-day Certified Tobacco Treatment Specialist (CTTS) training. Trainings are held at least four times per year, attracting healthcare professionals from around the world. After course completion, CTTS training participants are well-prepared to treat tobacco dependence in patients using evidence-based treatment. After completing the training myself, I have a much better understanding of the tobacco field as well as the tobacco dependence addiction chemistry, program development, and treatment options available to help smokers quit.

Working at the Tobacco Dependence Program has been a great experience. I have learned so much about the public health and tobacco industries working alongside the top professionals in the field. Staff members are extremely helpful, informative, and dedicated to the best patient care for their clients. The knowledge gained during my time at the Tobacco Dependence Program will further enhance my future career goals of becoming a physician and public health researcher. Treating smokers both before and after the development of smoking-related illness is essential in providing the best medical care for the patient and should be a top priority for all physicians.

Remembering Nicotine Replacement Therapy

by Michael B. Steinberg, MD, MPH

In the stampede to use the latest and "greatest" cessation medication to hit the market, Chantix (varenicline), the benefit and usefulness of nicotine medications (or nicotine replacement therapy) has fallen out of favor. However, it is important to remember that latest does not necessarily mean "greatest" for everyone, and, in spite of this enticing "Chantix buzz," we must not forget about NRT.

Nicotine medications, having been available for over 20 years now, have been well-researched and have established a long track record of use. By using nicotine medications, as opposed to bupropion or varenicline, to treat tobacco dependence, no new substances are introduced into a smoker's body. In fact, nicotine medications typically provide much less nicotine than most tobacco products, but without the dangerous chemicals. Despite these facts, there remains a misperception that nicotine causes the numerous health effects of smoking. To combat this common myth when first meeting a smoker for treatment, we like to clearly establish a few facts so they can make an informed decision about cessation medications:

1. The 4000+ toxins in tobacco smoke - not nicotine - are the cause of the many health consequences of tobacco use.
2. Nicotine's primary role is as the addictive substance in tobacco products.
3. Nicotine withdrawal accounts for the cravings and withdrawal symptoms after quitting, and cessation medications are designed to lessen these symptoms.
4. If you reduce withdrawal symptoms during a quit attempt, you will feel more comfortable and will be more likely to succeed.

Even beyond these, there is a great deal of confusion regarding the use of nicotine medications. These are fostered by public

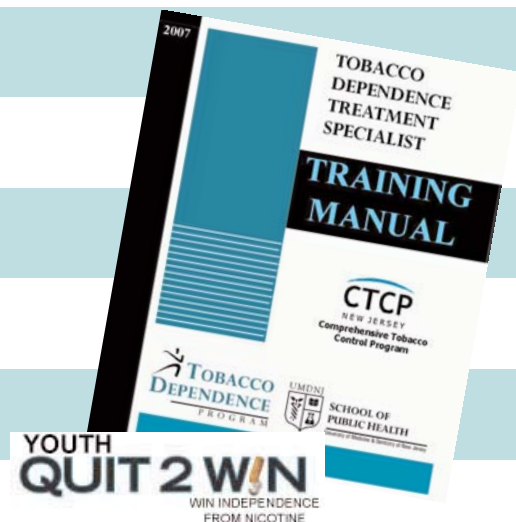
perception (e.g., if you smoke with the patch on you will explode) and by package labeling (e.g., do not combine this nicotine product with other nicotine products). These beliefs are contrary to the evidence-based data we have on the use of these medications. Specifically, recent publications have called for a new perspective on how we use nicotine medications (Kozlowski, et al., 2007). These "new" ideas include reminding smokers that:

1. Nicotine medications are much safer than smoking.
2. Nicotine medications are not "magic bullets", but can help you quit.
3. Use nicotine medications for as long as you feel it necessary in order to maintain independence from tobacco.
4. One dose does not fit all - depending on your own circumstances, you may need more or less nicotine medication(s), which may include combining medications.

The truth of the matter is that tobacco dependence is a chronic condition, and so we should consider its treatment in the same sense as we do for other chronic conditions. For example, we commonly use combination pharmacotherapy in the treatment of diabetes and hypertension, so why not for tobacco dependence? We usually prescribe medications for diabetes and hypertension on a long-term basis...why not for tobacco dependence? Certainly, tobacco dependence leads to as much, if not more, death and disease as these other processes. Furthermore, our healthcare system's reimbursement activities should also mirror those of traditional medical care, providing for state-of-the-art treatment (including combinations of medications) for as long as is necessary to achieve the desired clinical outcome. We may still have a ways to go in universally establishing tobacco dependence as a chronic condition, but through treatment and education, we can each help achieve this goal.

2008 Training Schedule

Mar. 7-8	Treating Tobacco Dependence in Mental Health Settings: A two-day CME Training Conference for Psychiatrists, Psychiatric Advanced Practice Nurses and Other Mental Health Professionals
Mar. 11	One Day Training - The Latest on Stopping Smoking
Mar. 31-Apr 4	Certified Tobacco Treatment Specialist Training
Jun. 16-20	Certified Tobacco Treatment Specialist Training
Jul. 28-30	2-Day Youth Quit2Win Training
Sept. 22-26	Certified Tobacco Treatment Specialist Training
Oct. 20-21	2-Day Youth Quit2Win Training



For details, registration, and current schedules visit www.tobaccoprogram.org, call (732) 235-8212 or email info@tobaccoprogram.org

Learning From My Clients

by Jose A. Cruz, MSW

How do you effectively reach a complex community comprised of individuals belonging to a vast number of groups and subgroups? What can make treatment and intervention more effective? Clearly, as health providers, we resolve to notify prospective clients about vital services, ensure satisfaction to our current patients, and encourage an unremitting and positive change in the population we assist. In order to do this, we must provide services not dictated by static guidelines or inadequate and limited trainings focused on soaking up general population descriptions. After all, to care for human beings who are brilliantly complex and differ on an endless list of factors, only an open, lifelong, and ever-changing approach will do. That is why it is an exhilarating challenge for me to reach out to the diverse communities across New Jersey.

It is almost impossible to claim expertise on all the overt characteristics and qualities that groups possess, not to mention all the subtle nuances. In my case, these would be the tools needed to assess new clients and understand how smoking's role is perceived within their respective cultures, as well as within their individual lives, which are each uniquely defined by geography, socioeconomic status, community, etc. This is undoubtedly important when dealing with the introduction of nicotine and cessation medications, discussion of behavioral change, or evaluation of treatment adherence. Take for example, how nicotine gum can be viewed as socially disrespectful and therefore unappealing by one Latino individual but perfectly acceptable by another. How can this inconsistency exist? Easily, when one considers how age or specific country of origin shape individuals' attitudes. Furthermore, knowledge of how long a person has lived in the United States can be the key to understand this disparity.

One could take this issue as commonsensical: each client is different - mystery solved. However, the importance of respect as defined by a Latino family or community is a common thread among the members of this "umbrella" term. The significance of respect, stigma, and even paradigms are implicit and shaped by these units, so certain personal factors may shape different views, while central beliefs remain similar. The same goes for assuming that membership of a certain group ensures a connection with a community sharing certain characteristics. This is evident in emergent marketing to different Latino groups; however, messages designed specifically for individuals from one Latin American country may not influence a person from another. For example, anti-tobacco images using soccer motifs may resound for some part of the Mexican community while it may not be as popular for many individuals from the Dominican Republic. These details may seem insignificant, but they are essential in


As providers, we must become the eager students...



forming successful ties with clients. Clearly, this approach not only benefits the interactions I have with the diverse community I work in, but also broadens my sense of what it actually means to identify with various groups.

Finding and taking in each fiber is essential when it comes to reaching out. Although believing one has a full, absolute understanding of a community is quite precarious, it is the first step in acknowledging and appreciating what can be learned from each patient we treat. As providers, we need to become the eager students, for each client's personal tale helps unravel the mysteries of cultures, beliefs, and communities. All you have to do is listen.

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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 <http://proyectovidanofume.org/>

Recent Events...

Great American Smoke Out

Jose Cruz and Lisa Giacomiazio joined REBEL at the Rutgers College Avenue Student Center on November 15, 2007. To demonstrate the difficulty of quitting and the need for support, students were challenged to give up smoking for the day.



Hot Off the Press!

Bover MT, Foulds J, Steinberg MB, Richardson D, Marcella SW. Waking at night to smoke as a marker for tobacco dependence: Characteristics and relationship to treatment outcome. *Int J Clin Pract.* Feb 2008; 62(2):182-190.

Foulds J, Delnevo C, Zeidonis D, Steinberg M. Health Effects of Tobacco, Nicotine, and Exposure to Tobacco Smoke Pollution. Chapter for: Handbook of the Medical Consequences of Alcohol and Drug Abuse pp 423-459. Haworth Press, Binghamton, NY 2008.

Williams JM, Gandhi KK, Steinberg ML, Foulds J, Ziedonis DM, Benowitz NL. Higher nicotine and carbon monoxide levels in menthol cigarette smokers with and without schizophrenia. *Nicotine Tob Res.* Aug 2007;9(8):873-81.



Several TDP staff attended the National Conference on Tobacco or Health in Minneapolis, MN to supervise an exhibit booth, present posters, and lead discussions about our latest accomplishments and research findings.

ON THE HORIZON...

- A recently awarded grant from Rutgers Community Health Foundation will fund a new outreach program targeting people of color in New Brunswick
- The TDP is partnering with The Den in New Brunswick to present a fun-filled smoke-free February evening
- We are adding a space for clients can share their quitting experiences on our websites. A similar space will be available to our Spanish-speaking clients on the Proyecto Vida website