

The Nicotine Challenger

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A View From The Director



On June 7th 1962, President John F. Kennedy approved the formation of a committee of the U.S. Public Health Service to review the growing scientific evidence on smoking and health. On January 11th, 1964, U.S. Surgeon General Luther L. Terry released the landmark report on Smoking and Health. This report was important, not because it was the first to identify a relationship between smoking and health, but because it was the first comprehensive report on this issue to identify cigarette smoking as being causally related to lung cancer and respiratory diseases such as emphysema. It marks a point after which the tobacco industry should have no excuses for continuing to produce and market such a deadly product.

I mention this historic event now because we are approaching its 40th anniversary and it seems appropriate to look at what has changed since then and what challenges remain. To me it is remarkable that forty years after that report, the tobacco industry is still producing and marketing pretty much the same product, in just as deadly a form, and over one in five Americans continue to smoke them. The tobacco industry has therefore managed to adapt to what should have been extremely challenging circumstances – circumstances that would have threatened the very existence of most other industries. They developed a range of products, such as light cigarettes, that gave the impression of being less harmful. For most of the past forty years they have worked to generate the perception that there is some controversy or doubt about the harmfulness of cigarettes. They have diversified so that their fortunes are linked to those of other consumer-friendly products such as macaroni and beer. All the while they have been major contributors to the campaign funds of both of the leading political parties, guaranteeing high level political influence. Most recently the tobacco companies have started to admit that smoking is harmful to health and we even have the surreal experience of watching TV advertisements from Phillip Morris telling us that smoking causes disease and death and that we should go to their website for help to quit!

Over that same time period there have been some important positive events on the tobacco control side. The scientific evidence that passive smoking causes serious illness has strengthened legislation protecting smoke-free air. Experience in states such as California has shown that when this issue is properly addressed it produces a marked reduction in cigarette smoking and improvement in health (together with improved business at bars and restaurants). The recognition that cigarettes are addictive in the same way as heroin and cocaine, and that nicotine is the drug causing the addiction has also been important and has been linked to improvements in treatment.

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This edition of the Challenger would like to recognize the important and groundbreaking work of the New Jersey Institute for Continuing Education in Tobacco (NJICET or the Institute). The Institute is a comprehensive training and technical assistance program made available free-of-charge to New Jersey organizations and made possible by a grant from the New Jersey Department of Health and Senior Services (DHSS). The primary goal of the Institute is to advance the knowledge and skill-level of those professionals working in the field of tobacco control via *interactive* skill-based training. During these times of reduced statewide tobacco control funding, the Institute serves to focus on a new way to build and ensure the capacity of tobacco control throughout the State. Brian Obser, M.Ed., CHES, Program Director of the Institute, states that “the Institute’s programming is interactive, participant-centered and instructed by faculty with practical and academic expertise in related topics. This Institute is the first of its kind in the country and promises to provide those in New Jersey comprehensive technical assistance, access to the “NJ Promising Practices” and “NJICET Sharing Database” as well as direct links to State and National tobacco control organizations, trainings and resources.” Trainings are delivered through two- to three-hour interactive training modules that were developed in partnership with the Princeton Center for Leadership Training. The Institute currently offers five tobacco training modules in the areas of policy, community, youth prevention, evaluation and science-based initiatives. Trainings are brought to the client and rely mostly on group and individual activities to induce learning. For more information visit The Institute’s website at www.njicet.org.

NJICET is sponsored by New Jersey Department of Health and Senior Services through the Comprehensive Tobacco Control Program.



Visit our website

www.tobaccoprogram.org

*for a listing of our products
and services, to find a*

*Quitcenter near you and for the
latest in tobacco control news.*

New Staff at the Tobacco Dependence Program



Patricia Repetto, M.Ed.

Ms. Repetto is the administrator of the Tobacco Dependence Program. She brings eight years of experience in tobacco-related curriculum development and clinician training. She previously worked for the New York City Department of Health, Tobacco Control Program as Director of Cessation. She has direct experience in the development of a citywide network of treatment clinics, integrating treatment into mental health and addiction programs and developing population-based tobacco treatment initiatives. She completed the Massachusetts Tobacco Treatment Specialist training in 2000 and has since created quitting programs for the New York City Department of Health and various private companies based in Manhattan. She is co-author of the American Cancer Society's "Make Yours a Fresh Start Family" Provider Training Manual and author/co-producer of "Breaking the Chains of Addiction" training video.

Communicate with us!

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The Nicotine Challenger.

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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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Public awareness of the health effects of smoking has undoubtedly increased and is the main reason smoking prevalence has fallen to around 20% and why over 75% of remaining smokers in this country say they want to quit. It is also positive that lawmakers have recognized that tobacco tax increases are a simple, popular way to boost revenues and improve public health at the same time.

Despite these positive steps there is a long way to go. It is bizarre that manufacturers of such a deadly product are not losing even more lawsuits, based on the damage caused by their products. It is strange that such a deadly product not only remains on the market but also is allowed to be advertised in magazines and public places, and is relatively unregulated by the government. In New Jersey it is bizarre that in many public places (bars, restaurants, bowling alleys, etc.) both the families who visit them and the people who work there still have to breathe air containing harmful amounts of other people's tobacco smoke. It is strange that tobacco addiction is the biggest cause of death and disease in this country, and effective treatments exist, but they are not widely practiced by health services. A major concern is that despite our best efforts, a sizable minority of our young people is taking up tobacco smoking and is becoming

addicted before they leave school. Finally, there is the disappointment that despite pronouncements at the time of the Master Settlement Agreement, only a tiny proportion of the revenue from the MSA is being spent on tobacco control.

Here in New Jersey, we are making progress – although sometimes it can seem painfully slow. More public places are electing to go smoke-free and we just need to convince our politicians to follow the will of the people with proper legislation. More New Jersey smokers are trying to quit, with over 100,000 contacting New Jersey's treatment services. Fewer and fewer New Jersey youth are using tobacco, with the REBEL youth movement playing an important part in the state's tobacco control movement. We at the Tobacco Dependence Program are pleased to have a part in these positive developments, having treated over a thousand of New Jersey's addicted smokers, trained over a thousand health professionals in tobacco treatment and also worked with New Jersey schools and the REBEL youth movement. With the new year and the fortieth anniversary of the 1964 report almost upon us, I hope you will work with us to give tobacco control the priority it deserves in 2004.

Jonathan Foulds, PhD



The Tobacco Dependence Clinic Reaches Out to the Community

Since its inception in January 2001, the Tobacco Dependence Clinic at UMDNJ-School of Public Health has seen more than 1,000 patients for an initial assessment. The numbers of patients seen each month at the clinic has steadily increased through the years the clinic has been open. While this trend is encouraging, we recognize that access to the clinic may be a barrier preventing some people from pursuing treatment for their tobacco dependence. To address this issue, the clinic has been expanding its services outside of the office to better reach certain populations. Currently the clinic is running Stop Smoking Groups for Rutgers University, the Job Corps and various major corporations in the New Brunswick area. Below is an overview of some of our work with these communities.

Rutgers University

Donna Richardson, LCSW, CADC, Michael Steinberg, MD, Anitha Varughese, LCSW, and Olivia Wackowski, MPH, participated in the monthly meetings of Rutgers University's Tobacco Coalition during the 2002-2003 academic year. The Tobacco Coalition at Rutgers is chaired by Adrienne Coleman, MS, Department of Health Education at Rutgers. Inclusion of UMDNJ/SPH staff in the Coalition has resulted in increased collaboration between RU's Health Services and the Tobacco Dependence Program. One example of the collaborative efforts is the ongoing development of *Stop Smoking at Rutgers* groups staffed by the Clinic at on-campus locations. The first 6-week group was held at the Merle V. Adams Lounge in the Cook College Student Center. The second 6-week group was held in a basement lounge in Demarest Hall on the College Avenue campus. Patients in both groups completed the required assessment interview. Treatment plans were formulated and reviewed by Dr. Steinberg, an internist and alumnus of Rutgers College. When indicated by their treatment plan, students were provided the Nicoderm patch and/or the Nicorette gum, free



of charge. Students succeeding in the treatment groups took the statewide Quitcenter, Quitline and Quitnet information home to parents and friends. Follow-up data was collected at four weeks and six months after the quit dates. Groups are currently underway at the Recovery Housing on Cook College Campus. Lessons learned to date include the desirability of scheduling groups during the first six weeks of the semester and the ongoing struggle students face as they work to remain smoke-free in a highly social environment.

The Corporate Community

Work-based Stop Smoking Groups provide convenience to employees and savings to employers. The clinic offered its first Stop Smoking Group to employees at The Robert Wood Johnson Foundation where Michael Steinberg, MD, and C. Brooke Lange, MA, LPC provided treatment. Michael Steinberg, MD, and Donna Richardson, LCSW, CADC have provided subsequent work-based groups to employees at Firmenich, Inc. in Plainsboro and at SBI/Ivy Mortgage Corporation in Branchburg. Firmenich, Inc. participated in the American Cancer Society's Worksite Tobacco Initiative to defray the cost of work-based treatment. Informational sessions offer contemplating workers an opportunity to meet clinic staff, ask questions and sign up for individual assessment appointments. Assessments are then completed at the workplace prior to the first group meeting. Treatment plans are formulated during the assessment and medications are then provided or prescribed. Groups are held weekly for six weeks at lunchtime. Support to stop and stay stopped quickly develops between coworkers. Carbon monoxide is measured in the context of the group to keep the group within its one-hour time frame. Follow-up occurs at four weeks and six months after the quit date. The clinic is currently in discussion with other major corporations regarding implementation of Stop Smoking Groups at their worksites.



Attention Tobacco Treatment Providers! A New Organization Exists to Support Tobacco Treatment!

by Patricia Repetto, M.Ed.

A new national organization has been formed to promote and increase access to evidence-based tobacco treatment for tobacco users. The Association for the Treatment of Tobacco Use and Dependence (ATTUD) is a voluntary coalition of individuals and organizations dedicated to the effective treatment of tobacco use and dependence. ATTUD hopes to fill the need for a reliable and respected resource of evidence-based treatment for providers of tobacco dependence treatment.

Background:

ATTUD was formed in response to the overwhelming need for providers of tobacco dependence treatment to exchange information on best practices, innovations in treatment and gaps in the empirical base of tobacco treatment. While the PHS Guidelines for the Treatment of Tobacco Use and Dependence were welcomed as a great starting point to addressing consistent and evidence-based approaches in dealing with nicotine addiction. Research questions continue to be tested and important advances made that can benefit tobacco treatment providers.

What started as a dialogue between researchers and providers in the field of tobacco treatment has grown to a formal organization consisting of a wide array of members representing academic/research settings, medical institutions, insurers, and community-based programs. ATTUD was developed by a 24-member planning committee and is led by a 10-member board of directors. ATTUD will be holding its first inaugural meeting at the National Conference on Tobacco or Health on December 13th, 2003. ATTUD is supported



entirely on membership fees and the voluntary efforts of its members. Future plans include incorporating as a 501-C-3 and pursuing grant related funding.

Closing the Gap/Meeting the Need:

ATTUD's primary goal is to serve as a reliable and respected resource of evidence-based tobacco use and dependence treatment for the health care community, regulatory agencies, private foundations, and providers of tobacco treatment training, with the ultimate goal of assisting tobacco users. ATTUD will provide a forum for tobacco treatment providers to engage in discussion regarding issues such as effective treatment interventions, reimbursement for the treatment of nicotine addiction as well as training and certification issues. ATTUD will do this via the creation of a member-only listserv, an annual meeting dedicated to unique tobacco treatment issues, and possibly a journal. In addition, ATTUD will work to establish standards for core competencies in the training and credentialing of tobacco treatment specialists and to serve as an advocate and voice for tobacco users to promote the awareness and availability of effective tobacco treatments.

How to Join:

Membership to ATTUD is open to any individual who is currently active or has been historically active in the treatment of tobacco use and dependence. An annual \$75 membership fee entitles you to receive updates/newsletter, free attendance at annual meetings, summaries of research outcomes, advice and policy statements, access to a list-serve, active participation in the organization and full voting rights. An annual student membership of \$35 is available for students who can provide proof of student status. A membership application is available and can be downloaded at www.tobaccoprogram.org.



Expanded Resources for Addiction Treatment Providers

By Martha Dwyer, MA, CADC

New Jersey's Department of Health and Senior Services (DHSS) has recently expanded the resources available to addiction treatment providers in New Jersey in meeting their tobacco dependence treatment needs.

Addiction treatment providers can now work with their local Quitcenter to enhance existing tobacco dependence treatment. This collaboration will broaden the range of services in terms of both level of treatment intensity and types of interventions tailored to patients' motivation to address their tobacco use (Stage of Readiness for Change). Quitcenter staff will support providers in a variety of ways depending on the program's treatment needs. Services for patients might include individual counseling for patients, tobacco-specific psycho-educational groups or work with specific subpopulations, such as patients using NRT or those highly motivated patients who are ready to develop a quit plan. Quitcenters will also be able to provide their regular services at the addiction treatment site for tobacco dependent staff, increasing staff access to treatment.

In addition to enhancing tobacco dependence treatment offered by addiction providers, this collaborative effort will strengthen the continuum of care for tobacco dependent patients. Clients will become familiar with quitcenter staff and services while in treatment for chemical dependence. This in turn, increases the likelihood of individuals reaching out to a quitcenter following discharge.

The DHSS has also expanded the availability of free nicotine replacement therapy (NRT) to include tobacco dependent staff of qualified residential addiction treatment programs. This resource builds on an initiative instituted in late 2001 when free NRT, both patch and gum, was made available to clients of residential programs to ease the discomfort of withdrawal and support client motivation to quit. The Tobacco Dependence Program will continue to serve as the distribution point for NRT to residential programs and will monitor both staff and client NRT usage.



2003 New Jersey Laryngectomee Conference “Our Future is Now”

by Nancy Speelman, CSW, CADC, CMS

A conference was held on Saturday, September 20th at the New Jersey Hospital Association Conference Center in Princeton, New Jersey for laryngectomees and professionals in the field. Participants attended from the entire tri-state area, along with other parts of the



Members of the conference planning committee Bob Belloff, Nancy Speelman, Marty Murphy and Roy Boyd. Bob and Marty regularly visit middle and high schools to share the stories of their tobacco dependence and its consequences, which included laryngectomy surgery.

United States. This event began on Friday evening with a “Meet and Greet,” followed on Saturday with a day of special speakers and workshops.

The Conference began with Opening Remarks by Pierce Frauenheim, Vice Principal and football coach of Immaculata High School in Somerville, New Jersey. Pierce shared very encouraging words to

his audience of fellow laryngectomees. His presentation was followed by a Doctors’ Panel consisting of Mary Ann Deccicco, DMD from Skillman, New Jersey, Dennis Fuller, PhD from St. Louis University, Marc Geller, PhD of Somerset, New Jersey and Donald Richardson, MD Chief of Speech Pathology and Audiology from Philadelphia Veterans Hospital.

Workshops were presented on Esophageal Speech, Medicare and the Laryngectomee, Electrolarynx, Maximizing TEP Usage, Heat Moisture Exchange, Emergency Procedures, Understanding Tobacco Dependence, Alcohol and the Laryngectomee, Advocacy and a Family Panel.

The conference was well received and provided a forum for participants to ask questions about the life-altering surgery, exposure to various vendors and new equipment, along with connecting and relating with other laryngectomees. Continuing education credits were given to Speech Pathologists through Tracey Daly of Community Medical Center. Several vendors and organizations supported the event by donations or sponsoring various parts of the conference. Included in that list are the American Cancer Society, Atos Medical, Eagle Medical Supply, Griffin Laboratories, Inhealth Technologies, Kapitex, LTD, USA, Lauder Enterprises, Luminaud, Inc. Professional Speech Aids, Siemens Hearing Instruments, Ultra-Voice, and the University of Medicine and Dentistry of New Jersey, School of Public Health, Tobacco Dependence Program.

The conference was coordinated by Carolyn Anderson, Bob Belloff, Roy and Pat Boyd, and Marty Murphy of the Somerset County Miracle Voice Club of New Jersey. Other committee members include, Jim Batissa of the Garden State Nu-Voice Club, Jason Plaia of the American Cancer Society, Nancy Speelman of UMDNJ, SPH, Tobacco Dependence Program, Tracey Daly of Community Medical Center, along with laryngectomee sales representatives Dan Fitzgerald and Stan Murk.



*Wishing you
Happy Holidays
and a
Tobacco-Free
2004
From
the staff of the
Tobacco Dependence
Program*



A Look Back at Iraq: Troops, Tobacco, and RJ Reynolds

By: Olivia Wackowski, MPH

The road to war with Iraq sparked heated debate and controversy all over the world. Yet, once the war began, another debate festered among the troops themselves – a debate about their rights to tobacco.

Historically, tobacco has had a significant role in the military and in wartime. During World War I, tobacco companies made new customers for themselves by providing free cigarettes to troops. By World War II, cigarettes were provided to soldiers as a part of their rations. Smoking and dipping were seemingly a part of military culture, and according to the Department of Defense, 51% of those serving in the military smoked in 1980. However, access to smoking in the military has changed in more recent years. As a result of the 1998 Master Settlement Agreement, cigarettes are no longer freely distributed to soldiers (even though they can still be purchased duty-free at military exchanges, commissaries, ships, etc.) and, as of 2002, all Department of Defense facilities have been smoke-free. Yet, despite these efforts, approximately 34% of the service members smoke, compared to about 23% of all Americans.

During this Iraqi war, soldiers were able to supply themselves with cartons of cigarettes and tins of dip while they were camped in Kuwait. Troops received tobacco in the mail from home or bought tobacco themselves at the camp PX (post exchange) truck. However, once in the desert of Iraq, troops' tobacco stores quickly ran out, leading to a bit of desperation and irritability. Troops argued that tobacco helps to relieve boredom, helps them relax and also stay awake for long nights. The threat of health risks posed by tobacco has been expressed as a low priority, given the immediate danger of their environment. Finally, the lack of tobacco was repeatedly framed as a blow to morale. One marine summarized these ideas in a letter:

“We are aware it is not politically correct for companies such as Philip Morris to send cigarettes to our exhausted troops - the vengeful, ticked-off non-smokers would have a fit. Who cares? If these soldiers can put their lives at risk and sacrifice themselves for their families in a dangerous, hostile environment for months on end, then why should they suffer the added stress of not being able to enjoy a smoke after being shot at by the enemy? Soldiers' rations used to include cigarettes, not because we were oblivious to the health risk, but because we enjoyed them. If we can lay our lives down to fight for a nation that, coincidentally, was founded partially thanks to tobacco, a simple pack per day should be a no-brainer . . . For the high percentage of smokers in the military, tobacco deprivation is a morale killer. Low morale leads to poor performance, and none of us wants to face what that might lead to.”

Such narratives could be used to garner support for potential future efforts to resume military tobacco distribution. It should be noted, interestingly, that the author of the above letter introduced himself as a marine and a son of a retired Philip Morris employee.

Troops were still able to obtain tobacco in Iraq from unexpected sources including Iraqi farmers and young Iraqi boys who sold the

soldiers local Sumer cigarettes for about \$2.50- \$10 a pack. Along the way, journalists exchanged cigarettes with soldiers for stories.

In the meantime, RJ Reynolds said that it was looking for ways to ship cigarettes to US soldiers. While Philip Morris seemingly agreed that free distribution would be a violation of the MSA, RJ Reynolds expressed a different opinion.

Tommy Payne, the senior vice president for external relations, said that the MSA was no obstacle in this effort, that even though it barred free samples among the 46 states that signed the agreement, the agreement says nothing about other countries. Payne said, “Our military guys over in Iraq, we don't think it falls within that (agreement). It would be a clear stretch of the imagination to say that our military men and women who are fighting over there shouldn't be able to get a pack or two or a carton of cigarettes.” It is not known whether RJ Reynolds succeeded in its attempt.

Interestingly, the European Union filed a lawsuit against RJ Reynolds for allegedly smuggling billions of dollars worth of cigarettes into Iraq between 1990 and 1997, violating the US economic sanctions that banned any American company to do business with Iraq. Investigators believe that cigarettes arrived in Iraq from a purposely circuitous route, from Puerto Rico to Spain to Cyprus to Beirut, Lebanon, to the port of Mersin in Turkey. There are allegedly witnesses who have seen RJR people show up on the border with Iraq. A reporter addressed Tommy Payne on the subject and said: “World-famous RJR products, like Camel and

Winston, are in Baghdad in plentiful quantity. They've been there for ten years and I'd like you to tell me how they got there.” Payne answered, “Well, I don't know how they got there.” Sure you don't, Tommy.

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From www.trinketsandtrash.org



The Perils of Secondhand Smoke

By Patricia Repetto, MEd

In March of this year, New York City (NYC) implemented the country's most restrictive legislation to date banning smoking in public places, including restaurants, bars, bingo parlors and even city-owned vehicles. Highlighting secondhand smoke as a workplace issue and claiming that smoke-free air is every employee's right, NYC, spearheaded by the Department of Health, overwhelmingly convinced city councilmen that secondhand smoke was an issue that needed to be dealt with for health as well as financial reasons. NYC employed some of this country's best trained epidemiologists who discovered that working an 8-hour shift in a smoky bar exposes bartenders to the same amount of carcinogens as smoking half a pack a day and that levels of pollution in a smoky bar were 20 times that of the Lincoln Tunnel at rush hour. Coupled with existing research that has shown that secondhand smoke exposure leads to a 30% increase in heart attacks, councilmen quickly realized the financial implications of the added health burden produced by secondhand smoke. What was once a far-shot in city councils and state legislatures nationwide is now becoming the norm and the saying, "If you can make it here, you can make it anywhere," is ringing true for public health officials considering the same type of smoke-free legislation elsewhere in the United States.

The Fall Of Tobacconism As We Know It In The USA:

In 1995, California became the first state to ban smoking in restaurants and followed with a smoking ban in bars in 1998. Delaware became the second state in 2002 to adopt similar legislation. Since the passing of the 2003 Smoke-Free Workplace Act in NYC, other large municipalities such as Houston and Boston, as well as states, such as New York and Maine, have declared similar legislation with many others considering the same action. The trend is catching on like wildfire and spreading to small towns, counties, municipalities and cities. While there is a lack of consistency among the smoking bans (some contain exemptions for owner-operated bars, outside dining areas, etc.), never before in this country has the

issue of secondhand exposure been debated in so many legislative houses simultaneously.

Warning: This Public Ban, Although Favorable To Your Health, May Not Be A Lasting Thing:

Despite the favorable trend towards smoke-free air, the resistance is very much alive and fighting to overturn each public smoking ban. The Tobacco Industry is front and center in the fight to repeal the bans, with efforts not visible to the human eye. The industry conducts the majority of its fighting in the coffers of city and state legislative houses, often lining the pockets of politicians to ensure a vote against the ban or for the inclusion of language in a legislative bill unrelated to public health. To add further insult to injury, the industry has created fictitious organizations, "front groups," that conduct non-random and unscientific public opinion polls designed to confuse the public. The survey/poll results always show indication of a negative effect of the smoking ban, whether it is lower restaurant/bar revenues, a decline in jobs or citizens displeased with the smoking ban. Furthermore, the front groups releasing these results are given names markedly similar to the names of legitimate organizations that are supportive of the bans, such as the Empire State Restaurant and Bar Association (fictitious) and not to be confused with the New York State Restaurant and Bar Association (legitimate). The end result is mass confusion among the public as to the true effectiveness of the smoking ban.

Closing Thoughts:

For those readers who live in states, cities and localities with public smoking bans, beware of the resistance that could be working to overturn these laws. Should you have any question as to the validity of a public opinion survey/poll that denounces the smoking ban, or you wish to find out more about the law in your geographical area, you can refer to www.smokecreeen.org or contact Joe Cherner at joe@smokefree.org.



Recent Publications by Tobacco Dependence Program Staff

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Nicotine Vaccine as an Aid for Tobacco Dependence Treatment

by Michael B. Steinberg, MD, MPH

The concept of using a vaccine to immunize against drugs of dependence has been studied over the past three decades. Now these principles are being applied to tobacco. Over the last few years, early stage clinical trials have examined the safety and efficacy of nicotine vaccination for treating tobacco dependence. It is hoped that further studies will show this to be an effective tool in treating this most prevalent addiction.

The principle behind vaccination is that a small amount of a substance (antigen) is injected into a host. The host's immune system will recognize this antigen as foreign, and this will lead to an immune response (i.e. the production of antibodies). Antibodies are specific to certain characteristics on the antigen's surface.

After an initial vaccination, the immune system keeps a memory of the antigen, and if it is introduced in the future, the immune cells are able to produce a large amount of antibodies fairly quickly. These antibodies will bind to the antigens, and allow for other host's defenses to eliminate them.

Since all drugs of dependence exert their influence on the brain, it is important to understand the concept of the blood-brain barrier. There are certain structures as part of the brain's circulation that limit substances entering into the brain. Certain molecules that are too large cannot pass through this "blood-brain barrier" and, therefore, cannot affect brain physiology. In the case of vaccination, this is very important. While the nicotine molecule is small enough to pass freely into the brain, the combined structure of nicotine-antibody is too large to enter, thus, reducing nicotine's effect on the brain. This would, in theory, prevent some of the "kick" that a smoker experiences from the nicotine surge, and could reduce the rewarding effects of smoking, and thus reduce the drive for continued consumption.

In animal studies, the nicotine vaccine has been shown to be effective in reducing the distribution of nicotine to the brain by 65% (Pentel, 2000). Vaccination of rats against nicotine reduces nicotine distribution to the brain even at nicotine doses twice the estimated binding capacity of the antibodies (Satoskar, 2003). This suggests that the vaccine not only sequesters nicotine, but

also directs it away from the brain by some other mechanism. Vaccination of other drugs, such as cocaine, has shown a similar finding that relatively small levels of antibody have a more than expected effect on drug distribution to the brain (Fox, 1996). In animals, antibodies were produced to nicotine even with the continued administration of nicotine to the subject. Therefore, these vaccines could be used even while a subject continues to smoke, and the antibodies would be present when a cessation attempt was made.

There are a few pharmaceutical companies that are working on clinical trials of nicotine vaccine in human subjects. TA-



NIC, a novel nicotine vaccine has been studied in Phase I safety and immunogenicity trials in Belgium by Xenova Research Limited (St. Clair-Robert, 2003). The vaccine is designed to induce nicotine antibodies that would bind free nicotine in the blood. Bound nicotine will not be able to cross the blood-brain barrier. The Phase I trials show that the vaccine is safe and immunogenic using up to six vaccinations during weeks 0-8 and a booster at nine months.

Nabi Biopharmaceuticals has also developed a nicotine vaccination, NicVAX. Phase I trials show safety and antibody response up to 63 days post-vaccination (Lindmayer, 2003). Local reactions were mild to moderate. Single dose vaccine produced antibodies as early as seven days post-vaccination, and these were maintained over four months.

The company has recently announced (August, 2003) initiation of Phase II trials of its vaccine at three study sites testing three dosage levels of the vaccine. A total of 63 patients, divided into three groups, will be

administered up to four doses of the vaccine. Primary endpoints will evaluate nicotine-specific antibody levels, trends in smoking habits during the trial, and safety and tolerability of the vaccine.

The clinical utility for smoking will be that in a vaccinated individual, nicotine will not have the same effect on the brain, and thus smoking may not become as addictive. The implications for current smokers as a tool for cessation, former smokers as a tool for relapse prevention, and never smokers (possibly youth) as a tool for primary prevention, are varied and complex. In addition, this vaccination has potential implications for pregnant women and nicotine's effect on the developing fetus. Obviously, more data and research are required in the years to come. However, this is a novel, interesting, and potentially useful method of treatment for tobacco dependence in the future.

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Massachusetts Senate Approves Smoking Ban

Closing out this year's legislative session, the Massachusetts Senate approved a bill that would ban smoking in public places, including restaurants, taverns, and nightclubs, the Boston Globe reported November 20, 2003.

"It's one of the most concrete victories for workers' health and public health that we've seen in Massachusetts in a long time," said Diane Pickles, executive director of Tobacco-Free Massachusetts, an advocacy group.

Under the measure, violators of the ban could face fines of up to \$300. The bill exempts nursing homes, private clubs, fraternal organizations, and cigar bars.

Prior to the statewide ban, about 100 cities in Massachusetts, including Boston, had adopted some form of smoking ban in public places.

The Massachusetts House of Representatives passed the ban a month ago. Minor differences between the House and Senate bills need to be worked out in committee. The ban is expected to take effect July 5, 2004 if approved by Gov. Mitt Romney.

Tobacco Dependence Treatment Provider Certification

by Michael Burke, EdD, MHS

Effective tobacco dependence treatment can provide significantly more health benefits at a lower cost than most other behavioral health interventions or medical treatments. Unfortunately, the millions of smokers who try to quit each year are bombarded with misinformation and advertisements for a variety of "cures" that in many cases are nothing more than bogus, expensive, and ineffective treatment scams.

We know from clear and compelling research what works and what does not work for helping smokers to quit successfully. The evidence has been compiled by the United States Public Health Service, Centers for Disease Control, and is available in the volume *Treating Tobacco Use and Dependence: A Clinical Practice Guideline* (PHS Guidelines).¹ This and other evidence-based tobacco treatment resources can be accessed at http://www.surgeongeneral.gov/tobacco/tr eating_tobacco_use.pdf.

The huge public health consequences, in terms of both mortality and morbidity, of continued tobacco use and failed treatment efforts make it imperative that valid and effective treatments are available to consumers seeking to become tobacco-free. Professional groups and state boards can assure the public that tobacco treatment professionals have met a standard in quality of practice by providing training, certification and licensing based upon proven practices. A number of states and national efforts have already begun addressing this issue.

In New Jersey, more than 150 behavioral health and medical professionals have completed prerequisites and training to be qualified as Tobacco Dependence


Treatment Specialists (TDTS). The criteria for becoming a TDTS were developed collaboratively by the New Jersey Department of Health and Senior Services, national expert reviewers, tobacco treatment professionals and the University of Medicine and Dentistry School of Public Health Tobacco Dependence Program, which are described in the *New Jersey Guidelines for Tobacco Treatment*.² The New Jersey guidelines outline prerequisites and training objectives that must be met before a health-care provider is considered a tobacco dependence treatment specialist. These include evidence-based tobacco-specific assessment, counseling, and treatment knowledge and skills. Discussions are currently underway in New Jersey regarding the creation of a professional or state certification for tobacco treatment professionals.

A number of states have developed Tobacco Treatment Certifications. Two that have been reviewed in the literature are the Massachusetts Tobacco Treatment Specialist Certification Program³ and the Arizona Tobacco Cessation Skills Certification.⁴ Both of these certifications require extensive training based upon the PHS Guidelines and offer a Specialist training similar to that provided in New Jersey. Both states have a two-tier certification: one that covers basic skills in tobacco treatment and a second that provides more extensive treatment specialist training. Arizona also offers a more advanced tobacco treatment program manager certification.

To protect consumers, the messages regarding effective tobacco treatments need to be loud and clear. We know what works. Specialist training that prepares

professionals in the provision of evidence-based treatment should be the quality standard for all those who profess to provide tobacco treatment. With the current cacophony of quit smoking advertisements, we need to provide clear direction toward valid treatments and qualified treatment providers for those consumers who want help in becoming tobacco-free.

If you are interested in learning more about the Tobacco Dependence Treatment Specialist Training offered by the Tobacco Dependence Program, please visit our website, www.tobaccoprogram.org. If you would like to be involved with the tobacco treatment certification process in New Jersey, please contact Dr. Burke for more information at: michael.burke@umdnj.edu or 732-235-8225.

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Website Review: www.licensedtokill.biz

By: Olivia Wackowski, MPH

"Licensed to Kill, Inc. is a tobacco company. We knowingly kill people for profit. And we're proud of it. In fact, it is the explicit aim of our corporation. Just check our articles of incorporation..."

These are the welcoming first words on the "home page" of Licensed to Kill, Inc. (L2K), the new tobacco company in town, based in Richmond, Virginia. It is a new tobacco company that willingly admits its industry kills people every year, and urges people to "accept that fact, get over it, and move on."

But, wait a minute, is this for real? Well, yes and no...

The website is, for sure, a parody of tobacco companies, a quite clever and humorous parody, at that. The slogan of the unique "company" is: "We're Rich. You're Dead!" In the "what makes us different" section, "L2K" claims that, unlike other tobacco companies, they openly admit that smoking causes lung cancer, that they do not say one thing publicly and another thing privately, they do not hide behind an "altruistic-sounding name," and that they acknowledge to marketing openly to young people ("duh! It's plain common business sense"). Their "cigarette brands" include titles such as "Global Massacre," "L2K," "Genocide," "CHAIN," "Serial Killer," and "WOMD" (short for "Weapon of Mass Destruction). The user is invited to read the sarcastic "message from the CEO," who is appropriately named "Rich Fromdeth" (also note the jab at President Bush):

"A lot of people seem to feel that killing for profit is morally wrong or something. They seem to forget that we live in a free country, founded upon the principle of free

enterprise...The strength of our country derives from the strength of its economy. When people smoke our cigarettes, our company's stock value goes up. Likewise, our country's GDP goes up... Remember, when our economy fell into a slump following 9/11? What did our President do? He told us to go out and shop. He might as




well have told us to "go out and smoke." Every cigarette smoked represents money earned and a stronger American economy. What if there were no tobacco companies? It would be a bleak world indeed. Not only would tens of thousands of our employees around the world be out of a job, so would thousands and thousands of hospital bed manufacturers, nurses, and cancer specialists. When I go to bed at night, I think of these employees who, thanks to our company, have a roof over their heads and food on their tables. I think of our stockholders, who we are enriching. And I think of my big fat bank account that keeps on growing and growing, and my fabulous mansions and villas around the world..."

Other pages worth reading through include sections on "corporate citizenship" (a comment about political contributions), "global expansions," "investment rating," "press releases," "critic's corner," and FAQ's." Some of the FAQ's are especially amusing. One

question asks, "Considering the issues around killing and products that kill, why aren't you diversifying into other areas?" Answer: "... what would we diversify into? Twinkies? They haven't got any nicotine!"

What is *not* fictional on this website is the Articles of Incorporation. Technically, Licensed to Kill, Inc. is a real company given corporate certification from Virginia. The punch line is this: the *purpose of the company*, as written in the approved articles of incorporation, is "the manufacture and marketing of tobacco products in a way that each year kills over 400,000 Americans and 4.5 million other persons worldwide."

Licensed to Kill, Inc. was the idea of Essential Action, a consumer activist organization founded by Ralph Nader in 1982. Basically, the group not only wanted to parody tobacco companies, but also wanted to make a point about corporations and states' roles in the foundation of companies in the U.S. According to a spokeswoman for Essential Action, Ms. Anna White, the group "wanted to show how easy it is to incorporate a company in the U.S. and how the government has literally given corporations a license to do whatever they want, regardless of the threats to public health and safety." They admitted that any other state would also have granted the certification, but chose Virginia because it is the new home state of Philip Morris headquarters.

Essential Action succeeded in pulling off this witty and telling scheme. See the website for yourself, and enjoy the creative writing that we know is based on some very real truth. 

Study: Smoking During Pregnancy Increases ADHD Risk

New research from the United Kingdom finds that women who smoke during pregnancy put their unborn child at risk for attention-deficit hyperactivity disorder (ADHD), Reuters reported November 20, 2003.

For the study, researchers at the University of Wales College of Medicine surveyed pregnant women to determine if they smoked and analyzed Conduct Disorder Symptoms in 1,452 pairs of twins.

While genetic factors were linked to most cases of ADHD in the twins, lead researcher, Dr. Anita Thapar, said the study also found that smoking during pregnancy significantly influenced the development of ADHD symptoms in the children.

"Our findings extend previous work by being the first to demonstrate that the association of prenatal smoking with ADHD remains even when the genetic contribution to ADHD symptoms is included," Thapar and her research team concluded.

The study's findings are published in the November 2003 issue of the American Journal of Psychiatry: <http://ajp.psychiatryonline.org/>.

Thapar, A., et al. (2003). Maternal Smoking During Pregnancy and Attention Deficit Hyperactivity Disorder Symptoms in Offspring. American Journal of Psychiatry, 160(11): 1985-1989.

Quit Smoking Support for High School Students

by Mia Hanos Zimmermann, MPH

Last spring the Tobacco Dependence Program, through the New Jersey Department of Health and Senior Services, piloted Quit Smoking Support Groups for young people in several high schools throughout the State. These pilot groups were designed to provide support to young smokers who want to quit.

The Tobacco Dependence Program and school staff launched recruitment for students. A variety of methods were used, including tobacco-awareness assemblies and advertisement of the group on closed circuit television. In addition, the Tobacco Dependence Program conducted staff training on tobacco dependence and the importance of offering quit smoking services to students, which in turn resulted in word-of-mouth referrals from teachers, coaches and counselors.

The groups were modeled after similar quit smoking groups available at the Quitcenters in New Jersey. While this model is effective in helping adults quit smoking, important modifications were made to meet the needs of young people. For example, the groups were conducted during the school day in order to foster attendance among students who are often busy with extra-curricular activities after school. In addition, non-smoking support buddies were invited to participate in the group. The buddy's role was to provide support for smoking friends during the week or on the weekends during the quit attempt. Students who are part of a quit smoking group may be concerned about the stigmatization by teachers and coaches with knowledge of their participation in the group. Allowing buddy participation can help to alleviate this concern. Medications, such as nicotine patch or gum, were not used in the group. Although medications were not an integral part of the group process, students who expressed a need for medication were advised to contact their physician or local Quitcenter for assistance.

The groups were run on a weekly basis over a period of six weeks, and were held during rotating class periods throughout the school day. An assessment was conducted with each student individually prior to the start of the groups. In addition, students had their carbon monoxide levels checked during the assessment and prior to each group meeting.

School staff were instrumental in arranging for the group meetings at their respective schools. Staff recruited students, procured space for the group, obtained consent forms, and interfaced with teachers and other school staff to facilitate student attendance. Staff also observed and assisted with facilitation of the groups.

Evaluation of this pilot project is in progress. We anticipate reporting the results in the near future. In the meantime, new groups were started this fall, which will add to the data already collected.

If you are interested in learning more about this project or if you are interested in having a Quit Smoking Support Group at your school, please contact Mia Zimmermann at 732-235-8230 or mia.hanos@umdnj.edu



Keep me on the Tobacco Dependence Program announcement list!

Mail to: **Tobacco Dependence Program**
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Training Opportunities at the Tobacco Dependence Program

February 2-6, 2004

5-Day Tobacco Dependence Treatment Specialist Training

The Tobacco Dependence Program developed this training for professionals who work at NJ Quitcenters, along with professionals from other organizations throughout New Jersey and the country.

Participants gain state-of-the-art treatment techniques from the Tobacco Dependence Program's team of trainers. Topics include: The History of Tobacco and Public Health Issues; Guidelines for Treatment; Medical Complications Caused by Tobacco and ETS; Biology of the Brain, Addiction and Tobacco Dependence; Nicotine Replacement Therapy and Other Pharmacological Treatments; Counseling Theory and Practice; Motivational Interviewing; Treatment Continuum and Key Strategies; Intake, Assessment and Treatment Planning; Group Counseling Skills; Working with Special Populations and Cultural Competency.



*For more information about these and other training opportunities,
and to register for training, please visit our website, www.tobaccoprogram.org*

The Nicotine Challenger

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