

# The Nicotine Challenger

Winter 2006

This issue: Tobacco, Co-morbidity and Stigma

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## A View From The Director

by Jonathan Foulds, PhD

This past fall, our annual conference focused on “Tobacco, Comorbidity and Stigma” and aimed to identify groups whose tobacco addiction was not being properly addressed because of stigma. Part of the rationale for this topic came from a concern that by trying to “de-normalize” tobacco use (for good reasons), society could end up blaming the smoker in an unhelpful way. One example of this is that many women who continue to smoke in pregnancy deny their smoking when talking to health professionals – partly because of anticipated disapproval. The result is that they are not offered help to quit. It has always been the philosophy of the Tobacco Dependence Program to support the de-normalization of smoking in society, but to balance this by offering effective treatment to the addicted smoker. Many of the articles in this edition of the Challenger touch on these important issues.

I’m pleased to say that I’ve had to re-write this article a few times to keep pace with the positive developments in tobacco control in New Jersey. Now we are approaching the Spring of 2006 with a comprehensive smoke-free air law passed and due to be implemented on April 15th. The age-of-sale for tobacco products has been increased from 18 to 19 in New Jersey. Governor John Corzine is also proposing a 35 cent increase in excise tax per pack of cigarettes for the 2006-7 budget. While I would like to see an extra \$1.00 tax per pack rather than 35¢, and smoke-free air for casino employees and patrons as well, there can be no denying that these past few months have seen massive positive strides for tobacco control and future health in New Jersey. Those who advocated for these policies, and the legislators who supported them, deserve enormous credit.

Looking to the near future, we can expect that the smoke-free bars and restaurants, and likely increased cost per pack, will reduce smoking in young people and prompt many adults to try to quit. Now, more than ever, it is critical that we have an adequately funded Comprehensive Tobacco Control Program, with properly funded smoking cessation services, designed to turn smokers’ aspirations to quit into success stories. In 1999, the Centers for Disease Control (CDC) recommended that New Jersey should spend a minimum of \$45 million annually on tobacco control. Current expenditure is \$11 million. Now is the perfect time to restore the funding to CDC recommended levels so that the combination of policy and services can really make smoking history in New Jersey. The future healthcare cost savings would more than pay for this relatively small investment in the health of the people of New Jersey.

## Tobacco, Co-morbidity and Stigma

by Jill M. Williams, M.D.



Stigma is an important factor to consider in the area of tobacco use in the mentally ill. Smoking itself is clearly stigmatized as evidenced by the fact that people label “smoking” and associate it with a negative stereotype. Although there is evidence that smokers are stigmatized and perhaps even discriminated against in some situations, it is the positive effects of stigma and not the negative ones that get more attention in the smoking cessation literature.

Stigmatizing smokers may help increase the motivation for smokers to quit in order to remove the effects of stigma. Societal effects which stigmatize smokers are also positive since these help to change the culture towards quitting and healthier living.

There is abundant evidence that people suffering from a mental illness are victims of stigma which results in many negative effects including shame, mistrust of others, discrimination and further difficulty integrating into society. What is not known are the effects of being both a smoker and having a mental illness. It is

*continued on page 3*

## Tobacco Dependence Treatment Specialist Training

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**New Staff at the Tobacco  
Dependence Program**



**Roena RabeloVega**

*Community Outreach Coordinator*

Roena RabeloVega was born in Oakland, California. As the child of Mexican origin parents she was reared in a Spanish speaking household. She received her undergraduate education in American Studies at San Francisco State University and her graduate work in Journalism at the University of Texas at Austin. Her professional experience in public health and related work, spans 25 years. This experience includes monitoring health problems in immigration detention facilities of INS contractors; doing background research and editing for public health research projects at the University of California, Berkeley; conducting interviews and writing health-related articles for the largest Spanish-language newspaper in San Antonio, Texas, and professional academic journal editing. Roena is coordinating the TDP *Proyecto Vida: Latino Deje de Fumar* initiative, which is funded by the Robert Wood Johnson Foundation to provide culturally competent tobacco cessation services to the Latino community of New Jersey.

Her professional goal is to develop long range strategies for more effective communication of health promotion information and improving health literacy in Latino communities where income and education levels are near or below the poverty line.

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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:**

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possible that there is an additive effect of increased stigma leading to further marginalization from society. Alternatively, it is possible that the stigma from smoking is perceived as less important than the stigma of having a mental illness and these are difficult research questions to assess. It is curious, though, that people with a serious mental illness cite that their greatest priority is securing housing and employment, yet the evidence supports that smokers are greatly stigmatized in access to both.

In addition to the stigma experienced by an individual, there are also the effects of societal stigma: the US vs THEM mentality that keeps groups apart. When considering how societal stigma may affect smokers with mentally illness, 3 groups emerge as important. These include the Mental Health System, the Tobacco Control Community and Mental Health Advocacy Groups. The effects of potential societal stigma may emerge in the form of discrimination, neglect or so called, “counter-advocacy”.

Do smokers with mental illness suffer discrimination? They are not considered a priority group within tobacco control, despite high smoking prevalence, low quit rates and the tremendous health burden they incur as a consequence of tobacco use. They suffer reduced access to tobacco cessation services, as there is both a lack of specialized treatment and little evidence-based research to direct treatment. Surveillance of tobacco use patterns in this group is lacking. Virtually none of the Master Settlement Funds were directed towards this group of smokers. This trend continues as new data collection systems for Quitlines and other national resources omit questions on mental health indicators.

Some of the measures used effectively by Tobacco Control to reduce tobacco use in other populations include prevention, treatment, advocating for and allocating resources, surveillance and research on tobacco use trends, and litigation against the tobacco industry. Despite research indicating that people with a mental illness smoke at increased rates and consume a disproportionately high amount of tobacco product in the US, little of these efforts have been directed towards helping this group. The controversial theory that smokers in the US are “hardening” and becoming more difficult to treat is highly suggestive of a changing smoking population that is mostly co-morbid for mental illness or other addiction.

Is the paucity of attention and resources merely an issue of neglect? Nearly 10 years ago, the American Psychiatric Association (APA) recommended that psychiatrists should treat tobacco dependence in all patients being seen for a psychiatric disorder who smoke. Yet we know that most mental health services lack tobacco dependence treatment. Psychiatrists continue to play a small role and tobacco dependence remains under-diagnosed and under-treated in mental health settings.

Smoking remains fairly entrenched within many mental health treatment systems as an accepted part of the treatment culture. Smoking is still the norm in group homes and residences for the mentally ill and outpatient treatment programs almost universally have designated outdoor smoking shelters on their grounds. State psychiatric hospitals in New Jersey still sell tobacco products in the stores. Perhaps most importantly, mental health staff frequently do

not believe that it is possible for individuals with mental illness to quit smoking.

In addition to discrimination and neglect, there may be opposing forces which are actually preventing or slowing movement in this area. We refer to this as “counter-advocacy” since it represents advocacy in the wrong direction, usually by mental health advocates. Tobacco use is devalued as a problem for people with mental illness. Since its effects are not acute, it remains a low priority. Both family members and professionals remain uneducated about the risks of smoking and benefits of quitting, with unfounded concerns of violence or other untoward effects that could result. These family and other advocates have been protecting the use of tobacco instead of advocating for increased access to tobacco treatment.

One national mental health advocacy organization has a public policy statement stating

“We **encourage** all state psychiatric hospitals... to provide...a designated smoking area for consumers to smoke. We recognize

the need that many consumers have to smoke. “Mental health advocates have successfully lobbied for exemptions to strict clean indoor air regulations for facilities for the treatment of mental disorders in several states.

Despite these difficulties there is evidence that mental

health consumers do want to address their smoking and are receptive to beginning this discussion. A leader in this area has been the Mental Health Association in New Jersey (MHANJ), the state branch of a national advocacy organization of mental health consumers. MHANJ has become interested in helping its constituency address tobacco use and in November 2004 adopted a Public Policy Statement of 11 recommendations entitled, “Regarding the Use of Tobacco among Mental Health Consumers” ([http://www.mhanj.org/tobacco\\_policy\\_paper\\_nov\\_2004.pdf](http://www.mhanj.org/tobacco_policy_paper_nov_2004.pdf)).

CHOICES (Consumers Helping Others Improve their Condition by Ending Smoking) is an innovative program targeting smokers with mental illness in New Jersey. The project employs mental health peer counselors to communicate the important message to smokers with mental illness that addressing tobacco is important. Consumer Tobacco Advocates to visit mental health centers, self-help centers and health fairs and also provide resources about places in New Jersey where smokers with mental illness can receive tobacco dependence treatment. Peer driven efforts which educate mental health consumers about the risks of smoking and benefits of quitting, are vital to increase consumer demand for tobacco treatment services.

In conclusion, the effects of individual stigma on smokers with mental illness are unknown. It is unclear how this additional stigma will be perceived although there is concern that it could have negative effects, which further marginalize this group and keep them from accessing treatment. To address societal stigma, concentrated efforts by the mental health, tobacco control and advocacy organizations will be needed to bring greater attention and resources to this vast problem. The population urgently needs increased access to treatment. Increasing consumer demand for services may be an important step in effecting change.



## Hispanic Outreach: *Proyecto Vida: Latino Deje de Fumar*

By Roena Rabelo Vega

In July 2005, the Tobacco Dependence Program was awarded funding by the Robert Wood Johnson Foundation (New Jersey Health Initiatives), for the purpose of developing a culturally competent tobacco cessation outreach service for Latino smokers in New Jersey.

**Facts** Smoking and other forms of tobacco use cause serious social, economic, and health problems in every community without discrimination to age, ethnicity, or gender. Smoking is the single biggest cause of premature death and disease in the United States with 440,000 premature deaths and 8.6 million cases of tobacco-caused illnesses per year. It is responsible for 87% of all lung cancer deaths in the United States and is the leading cause of cancer deaths among Hispanics. It kills over 10,000 New Jersey residents per year and over 200,000 additional residents will suffer smoking caused diseases.

**Tobacco Use Among Latinos** A recent study in New Jersey found cigarette use to be high among Hispanic men at 23.1% and growing quickly among Hispanic origin youth. In middle school students, 35.6% of Hispanics have tried smoking cigarettes compared to 31.1% non-Hispanic blacks, and 18.1% non-Hispanic white students. This upward trend affecting the Hispanic community is due in part to social, cultural and economic factors; for example, as Hispanic adolescents begin the acculturation process, their behavior begins to resemble that of non-Hispanic whites. One explanation may be that adolescents who are more acculturated are more likely to spend time with friends who smoke, which creates a social norm tolerant of smoking and also increases their access to cigarettes. Also, multi-ethnic adolescents (those who identify with two or more ethnic groups) appear to be at higher risk of smoking initiation as well.

**Tobacco Marketing Campaigns** In August 2005, Time Magazine reported Latino consumer spending had reached \$800 billion, a figure that tobacco companies have known for some time and have coined “Latinos” as the hottest emerging market for their product. The level of Latino consumer spending coupled with the age factor—that one third of US-based Latinos are under 18 years of age, make them a strategic focus for tobacco marketing. These marketing strategies are causing an increase in Latino smokers while the number of non-Hispanic smokers declines.

**Under-utilization of Smoking Cessation Services** New Jersey residents have three options for smoking cessation services that follow Public Health Service Guidelines. NJ Quitcenters are specialist centers that provide face-to-face tobacco dependence treatment at low or no cost. These centers are located in New Brunswick, Newark, Camden, Somerset, and Trenton. NJ Quitline is a toll-free telephone counseling service for tobacco users and NJ Quitnet is a free Internet site providing information designed to help smokers quit, chat rooms, and “ask the expert” services. While approximately 10% of New Jersey smokers are Latino, only 3% of those using quit smoking services are Latino.

**Proyecto Vida: Latino Deje de Fumar** is a program that aims to increase utilization of smoking cessation services by Latino smokers in New Jersey by providing language and culturally appropriate tobacco cessation services. Part of the overall strategy for increasing use of services is by marketing the program to the Latino community via community outreach, print media, neighborhood canvassing, and using Latino client based grass roots organizations as conduits for information dissemination. Informing the community is only part of the equation; providing culture and language appropriate services is the critical component to increasing Latino utilization of tobacco cessation services. Ultimately, the goal is to change the upward trend of Latino smokers through information, education, and clinical services.



A variety of cultural factors must also be addressed as the Hispanic community encompasses a varied population with cultural, economic, and even political peculiarities. While Spanish is the language Latinos have in common, other factors must be considered when conducting outreach and then providing tobacco cessation services to Latinos. The most recent influx of Latino immigrants to New Jersey is from southern Mexico and Guatemala. Quite often, these Latinos are undocumented immigrants without the protections afforded to legal immigrants, including access to health care. Further, the fear of deportation makes these immigrants less likely to seek social services in buildings that appear too daunting. Developing a solid community message and reputation to allay fears of legal repercussions for seeking services is key to reaching out to this community.

While some Latinos from Columbia or Santo Domingo have legal immigration status, many remain without health insurance or are underinsured. Latinos from Puerto Rico or Cuba are most likely to have some form of insurance, and speak English, yet, may feel more comfortable speaking in Spanish.

This project embraces the fact that social, political and cultural differences exist between Latinos from different countries; however, by partnering with a variety of grassroots organizations we have been able to provide information, education, and treatment for anyone in the Hispanic community who wishes to stop smoking. An important component to this project will be to train other smoking cessation organizations to provide culturally sensitive services throughout New Jersey for their Latino community.

The Tobacco Dependence Clinic is known for providing state of the art smoking cessation services to all clientele; we strengthen our mission by extending those same services to the Latino community in the culture and language of their preference.

**Current State of Affairs** From September 2005, to March 27, 2006 the number of Latino clients who have come to the Tobacco Dependence Program for services has increased from 3% to a peak of 20% since the inception of the project in July 2005.

# Treating Elderly and Medically-Ill Smokers

by Michael B. Steinberg, MD, MPH

Tobacco remains the leading cause of premature death in our society, and the list of tobacco-caused diseases continues to expand as outlined by the latest Surgeon General's Report. Despite the detrimental health effects, smokers continue to use tobacco. This paradox is especially striking among those smokers who have already been harmed by a tobacco-caused disease. There are data indicating that up to 58% of smokers diagnosed with cancer continue to smoke, and that those cancer patients who continue to smoke have poorer response to treatment, higher recurrences, and higher rates of second malignancies. Besides cancer, smokers with cardiac and pulmonary disease have higher incidence of further complications and progression of disease, so it is also critical that these smokers quit whenever possible. The factors involved in a medically ill smoker continuing to damage his/her health are not fully understood, and the optimal strategies for treating these smokers remains unclear. However, considering the grave importance for these smokers to quit, intensive treatments are warranted.

There are a number of issues that come into play when treating elderly and medically ill smokers. Elderly smokers often feel that they have smoked for so long that "they could never quit", "the damage is already done...there's no point in quitting now", or they "haven't gotten sick yet, so why quit"? Medically ill smokers may comment that "I was fine until I quit smoking...then I got lung cancer or had a heart attack. I might as well start again". It is important to remember that most smokers want to quit and they continue to smoke because they are addicted. This is also true for elderly and medically ill smokers.

## *I'm Too Old to Quit*

Today, people reaching age 65 can expect to live another 15-19 years (about one-fifth of their lives). Tobacco-caused diseases are illnesses of the elderly with 94% of tobacco-caused deaths occurring in people age 50 and older and 70% occurring in persons 65 and older. Therefore, elderly smokers should be strongly encouraged to stop smoking. In fact, there are some data that indicate that older smokers actually have more success in quitting than their younger counterparts.

Damage is already done – why not just keep smoking?

It is important in dealing with any patient that we are not missing any underlying depressive disorder. This type of resignation or hopelessness could be an early warning sign. In the absence of depression, it is important to educate smokers as to the wide range of benefits of cessation. These benefits start early on with lower blood pressure, lower carbon-monoxide, better stamina, smell, and taste. Within 2-4 weeks, respiratory infections decrease, and in 4-12 weeks, lung function improves. Within 2 weeks, there is an increase in HDL (good) cholesterol, and in 2-3 months, improved circulation. At 1 year, there is a 50% reduction in heart attack risk, in 5 - 15 years, the risk of heart attack and stroke equals never-smoker level. As for cancer, at 10 years after stopping, the risk of lung cancer is reduced by half.

In terms of medically ill smokers with cardiovascular disease, there is a high recurrence rate in continued smokers with heart attack and previous cardiac interventions. The risk of death following angioplasty and bypass surgery is increased by 75% in continuing smokers. For continuing smokers with cancer, there are

worse symptoms, poorer surgical outcomes, lower survival, and more metastases and subsequent malignancy in smokers with lung cancer, and there is less response to treatment and decreased survival in smokers with head and neck cancers who continue to smoke. It is also important to remind a smoker that just because



you have one tobacco caused disease doesn't protect you from another. People with cancer can still have heart attacks and develop lung disease. Finally, this is not simply a length-of-life issue, but higher quality of life issue. Smokers spend about 1-2 additional years with disability, despite a shortened overall life span, and have more acute and chronic illness, more restricted activity days, more bed-disability days, more work absenteeism, and make 6 more visits to the doctor annually.

## *I haven't gotten sick yet, so why quit?*

There is a belief that you personally are immune to the health effects of tobacco. "It won't happen to me". Most smokers do not believe that *they* are at increased risk for heart disease or lung cancer, even if they understand that such risks exist in the general population. Despite a lack of obvious and visible health impacts right now, there are clear benefits of quitting early. Men who quit smoking before age 30 had normal life expectancy; by quitting before 40, smokers lived one year less than those who never smoked; those who quit by 50 increased life expectancy by six years; and those who quit by 60 added an average of three years to their life. Therefore, even quitting in your 60's can add *real time* to your life, not just a few weeks. These patterns are also seen with lung cancer risk, which decreases with earlier cessation and improved lung function, which can return to normal in those who quit before age 40.

## *I was fine until I quit smoking...then I got lung cancer!*

There is a belief that smoking today causes lung cancer tomorrow. In reality, the time course between exposure to a cancer causing agent and the development and diagnosis of cancer can often take 20-30 years. The peak of lung cancer incidence in the mid-1980's among males is a result of the peak smoking rates from the mid 1960's, when 54% of adult males were smokers. The sequence of smokers quitting and soon after being diagnosed with cancer is obviously a shocking and frustrating experience. It is important to educate patients that the decades of smoking prior likely resulted in the cancer, not the recent stopping. Also, considering the poorer outcomes of smoking with a cancer diagnosis, there is no reason to go back to smoking after such a diagnosis.

It is important to remember that smokers of all ages and health status will benefit from cessation. One is never too old, young, healthy, or sick to stop smoking. Do not give into the "rationalization of addiction" that smokers often succumb to, and drives them to continue to smoke in the face of serious medical illness.



## The John Slade NJ Activist of the Year Award Given to Two Recipients: Jim O'Brien and Janis Mayer-Obermeier

By Bernice Order-Connors, LCSW, CADC

*This year's John Slade NJ Activist of the Year Award was presented at the Tobacco Dependence Program's national conference on September 29<sup>th</sup>, 2005 at the Hyatt Regency in New Brunswick. This award, given annually, seeks to commemorate and remember the many achievements of Dr. John Slade and seeks to honor an individual, who, like Dr. Slade, possesses an advocate's spirit and demonstrates leadership and/or achievement in the field of tobacco control.*

*This year, the review committee for the John Slade award faced a tremendous challenge, when two nominees emerged who both are advocates and leaders in NJ. Ultimately, the committee found that tobacco control in NJ would not wear the face it has today without either advocate and chose to honor both Ms. Janis Mayer Obermeier, (Manager of Youth and School Programs, New Jersey State, Department of Health and Senior Services) and Mr. Jim O'Brien, (Executive Director of the Addiction Treatment Providers of New Jersey). Both have contributed so richly to reducing tobacco use in New Jersey.*

### Janis Mayer-Obermeier

In the letters nominating Ms Janis Mayer-Obermeier, she is described by colleagues as, "a force in the Youth advocacy anti-tobacco movement, a woman who transformed the Youth and Schools unit at the New Jersey Department of Health and Senior Services into a vital force in the lives of New Jersey's youth, with a crystal clear vision for a youth empowerment movement, which would help to change the social norms of tobacco in New Jersey. She clearly respects youth and the energy and creativeness they possess. She never ceases to believe that one person can make a difference and shares this with the Youth she works with. Janis is not only an advocate for prevention of tobacco use, but believes in helping those youth who are already addicted to nicotine."

"Janis' passion is most visible through the programs that she has created through her work at NJDHSS: REBEL 2, NJ's middle school youth prevention program designed to teach students refusal skills and life skills; REBEL, NJ's state-wide, tobacco prevention movement for high school students that empowers, educates, and activates over 5,000 NJ youth to reject tobacco use and make healthy lifestyle decisions; and REBEL U, NJ's college-age mentorship and empowerment program established and chartered on nine NJ campuses. In addition, each year, with the aid of the Media and Communications Unit, Janis continues to implement statewide events that may draw significant media attention to tobacco control efforts in the state. These events include the Annual Statewide REBEL Summit (hosting over 1,000 high school students) and the Annual Statewide REBEL Tobacco Learning Institute- a multi-day, overnight, intensive tobacco education and training for NJ REBEL members; a first of its kind in the nation.

Before coming to the State, Janis served as New Jersey's first Student Assistance Counselor. Because of her enthusiasm for helping youth deal with addiction issues, Janis made sure that the Youth component of the Comprehensive Tobacco Control Program included cessation programs. It is her vision not only to inspire a generation of youth to not begin smoking, but to support those who already are addicted in their efforts to stop." Her contributions in Tobacco education, advocacy, and cessation are improving New Jersey's Youth quality of life.

Janis has inspired and continues to inspire not only the youth of these various programs, but everyone she comes in contact with, nationwide. Her work as a motivational speaker only enhances her ability to ignite passion among all of those with whom she associates."

### Jim O'Brien

It is hard to imagine that tobacco treatment in the addiction treatment community would be where it is today without the leadership and commitment that Jim O'Brien has brought to the field both as a director of a treatment program and as Director of Addiction Treatment Providers. Jim is the voice of addiction treatment in New Jersey.

Jim has been instrumental in making tobacco treatment accessible to addiction treatment providers throughout the addiction treatment system. When the NJ CTCP de-funded its initiatives in the NJ addictions treatment community, (which were considered a national model program), Jim found funding to continue these initiatives and found ways to not only maintain the existing level of services but to increase them. Jim found the means to continue making the training and consultancy services available. When funding cuts by the NJ CTCP threatened to cut the free nicotine replacement therapy (NRT) that had been made available to the residential programs, Jim went to bat at the State to save NJ's groundbreaking program. Not only was funding restored for the NRT, but the program was also expanded to include both inpatient and outpatient programs. He also pushed for recognition of the fact that treatment facility staff use tobacco at higher rates and are also in need of assistance for quitting.

In a quiet way, Jim has always made sure to include tobacco into addiction treatment. Whether it was inviting the Tobacco Dependence Program to have a booth at the annual ATP conference or the presence of a tobacco plenary speaker at the conference, or purchasing resources such as posters for providers, tobacco issues were always brought to the forefront as a topic of concern for addiction treatment providers. When ATP opened its first 2-week Addictions College this past year, Jim was sure to have a 6-hour tobacco component included in the curriculum. His commitment to seeing that addictions professionals are properly trained in the management of tobacco and nicotine dependence is clearly present.

There is real leadership and commitment from Jim O'Brien to see that NJ continues to bring state of the art addiction treatment that includes the treatment of tobacco to clients who enter the addiction treatment system."

New Jersey has benefited greatly from the contributions of both Jim O'Brien and Janis Mayer-Obermeier, two advocates who have challenged the norms of tobacco use in two very different and vulnerable populations in our State. We are pleased to have the opportunity to acknowledge the work of Jim O'Brien and Janis Mayer-Obermeier in awarding them the John Slade NJ Activist of the Year Award.

# Youth Stigma and Tobacco Use

by Nancy Speelman, CSW, LCADC, CMS

Addressing youth and their addiction to tobacco is an ongoing challenge. Unfortunately, most of the literature on treatment of nicotine addiction focuses on the adult smoking population. Yet, we know that ninety percent of cigarette smokers start smoking before reaching age 18 and most continue to smoke for decades.

**The Facts:** There are 4.5 million US youth who are current (defined as any use in the past 30 days) cigarette smokers. Nationally, 4,000 adolescents experiment with tobacco every day, and 2,000 other adolescents under the age of 18 become new, regular daily smokers. Moreover, one-third of youth who become regular daily smokers this year will die from a tobacco-caused illness such as heart disease, stroke or cancer. The US Surgeon General labeled cigarette smoking as a “pediatric disease” in 2000.

The good news is that smoking rates amongst youth are on the decline. However, throughout the country, there is an emerging trend of cigars, smokeless tobacco (chew), bidis and kretek use by teens. These alternatives to cigarettes provide the nicotine fix at a lower price and are available at non-traditional outlets, making it easier for youth to purchase.

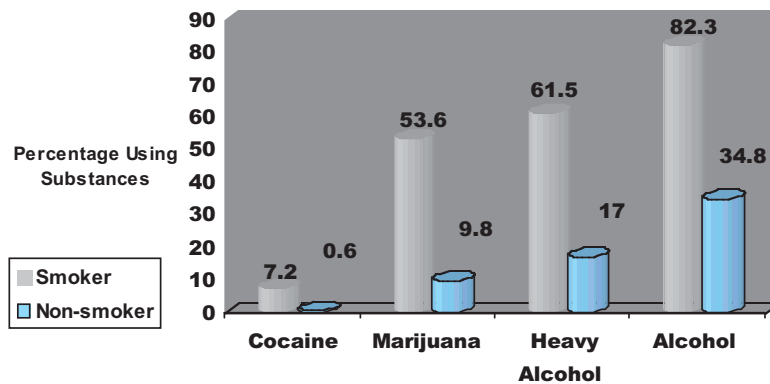
Studies are finding that young people become addicted to nicotine at much lower levels of consumption than previously understood. In addition, young people who use tobacco are much more likely to report using other addictive substances including cocaine, marijuana, alcohol, and inhalants.

We know that adolescents rarely quit tobacco spontaneously and that common reasons for youth tobacco use include peer pressure, wanting to make friends, to look cool or more grown up, to help relax and avoid weight gain.

In working with adolescents, health concerns are not commonly the key element in motivating them to quit. Most teens tend to feel that they will live forever and unless they have directly witnessed someone suffering some form of a tobacco related illness or death, this is not their main concern for quitting. While developing and implementing New Jersey’s Youth Quit2Win Program, we have found that key motivators include educating youth about the amount of money they will save if they quit, how the tobacco industry deceives them and the toxic chemicals in cigarettes.

For instance, helping teens calculate that an average 1 pack a day smoker spends over \$20,000 on cigarettes in ten years – enough money to purchase a small new

**Current youth cigarette smokers and non-smokers in the United States (1998) and prevalence of other substance use.**



car – carries weight. Or informing them that common chemicals used in making cigarettes or in tobacco smoke include arsenic, embalming fluid, and acetone, etc. can have an impact! It can also be effective to review the health consequences of smoking from different angles, including infertility, sudden

infant death syndrome, lower birth weights and spontaneous abortion, impotence or early aging (wrinkles, damaged skin).

Focus groups with teens have shown that many teens want to quit smoking but are afraid to quit because they think they will fail. New Jersey’s Quit2Win in-school support program markets “You Don’t Have To Do It Alone!” We have found that staff who are sensitive in working with adolescents and know the “Do’s and Don’ts” of adolescent treatment make the best counselors. After 22 years of working directly with adolescents, my thoughts on developing a good therapeutic relationship would be “Don’t try to act like them or be their friend...be honest...sensitive...and let them tell you when they want your advice! Remember adolescence is a time to separate and become your own person. Let them know that it is THEIR CHOICE if they try to quit or not.”

**For more information about supporting youth tobacco cessation or upcoming trainings on: Youth QUIT2WIN – Win Independence from Nicotine,** University of Medicine and Dentistry of NJ, School of Public Health, Tobacco Dependence Program, call Nancy Speelman at 732-235-8218 or check our website [www.tobaccoprogram.org](http://www.tobaccoprogram.org)



Bidis (top left) are imported cigarettes from India and are available in multiple flavors.

Kreteks (right), or clove cigarettes, are imported from Indonesia.

Smokeless tobacco/snuff (bottom left)



Photos: [www.trinketsandtrash.org](http://www.trinketsandtrash.org)

# Testing Therapy Manuals developed for Mental Health Clinicians to better Address Tobacco amongst patients with Serious Mental Illness.

by Douglas Ziedonis, MD, MPH

Most patients with serious mental illness are tobacco dependent and most mental health clinicians have not been trained on how to treat tobacco dependence. The American Psychiatric Association Treatment Guidelines on Tobacco Dependence has identified that between 70 and 90% of individuals with serious mental illness are tobacco dependent. Tobacco users with serious mental illness are at the same risks for increased morbidity and mortality – and this is why tobacco must be better addressed in this population. In addition, tobacco use is associated with higher rates of hospitalization, psychotic symptoms, suicidal ideation, other drug abuse, medication related side effects, and higher doses of medications due to increased metabolism of many psychotropic medications. On average about 25% of their limited and fixed disability income goes to tobacco products. Smokers with schizophrenia are heavy smokers, who make fewer quit attempts and are only about half as likely to be successful in a quit attempt, compared to other smokers. Thus there is a need for tailored interventions and ones that focus on motivating clients to make quit attempts. Our approach was developed with a goal to help train all mental health staff to better address tobacco dependence. There have been requests from mental health staff and leaders for increased training on this topic and specific treatment tools that can be integrated into the mental health treatment setting.

At UMDNJ we have several behavioral therapy development studies that have targeted the issue of tobacco dependence amongst psychiatric patients, including a National Institute of Drug Abuse R01 study to develop two therapy manuals for two different “doses” of psychosocial treatment for tobacco dependence. All patients in the study also receive the NRT patch. This grant includes developing a training program for mental health clinicians (who are the therapists in the study) and several outcome studies. The two versions are: (1) Medication Management – a nine session treatment approach that fits into the typical ongoing 20 minute medication management sessions; and (2) Treating Addiction To Nicotine in Schizophrenia (TANS) – which doubles the number of sessions and the length of each session (to fit into a traditional 45 – 50 minute therapy session).

These two approaches have been developed with the input of mental health consumers and staff with whom we have treated or worked closely with. Their feedback has been incorporated into the sessions to make the treatment practical and easy to use. Traditional approaches to tobacco dependence treatment have not been particularly successful in this group, and treatment must address the unique problems of serious mental illness, including the culture of the mental health system that has been permissive and encouraging about ongoing tobacco use. Clinical issues that must be addressed include managing serious psychotic and mood symptoms, low motivation, poor social skills, cognitive limita-

tions, and the difficulty forming a therapeutic alliance. Treatment for treating tobacco dependence in smokers with serious mental illness must attempt to increase and/or maintain intrinsic motivation to change, improve self-efficacy to manage smoking cues, and elicit external support from the patients’ social networks.

The **Tobacco Medication Management Treatment approach** is a relatively low intensity treatment; however it is more intensive

than the typical brief interventions done in primary care settings and is designed with real-world applicability for busy outpatient mental health clinicians. The **Tobacco Medication Management Treatment** is designed for the outpatient setting and tailored to the needs of patients with schizophrenia. Medication compliance and education are emphasized throughout and there are sections on monitoring psychiatric symptoms, and understanding medication interactions with tobacco. This manual provides concise, practical information that can be incorporated into the clinician’s daily practice, with useful tools for

the office, including patient education materials and handouts. The treatment sessions are written in a clear and simple style to minimize cognitive difficulties and repetition is also a theme throughout. The seven key components of Medication Management Treatment are: Be empathic, supportive, and express hope; Provide education about tobacco dependence, treatment, and recovery; Provide education and medication monitoring about nicotine patch use; Monitor tobacco, schizophrenia and other mental health symptoms; Help them learn about what triggers their cravings and thoughts about smoking and how they will avoid or manage those triggers; Address slips, relapses, and increase their motivation using the 5 Rs; and work with other Mental Health Providers involved in the case.

The TANS approach is more intensive and the manual guides the clinician on how to integrate and modify Motivational Enhancement Therapy, Relapse Prevention / Coping Skills Training, specific tobacco dependence treatments, and Social Skills Training approaches into a single therapy approach. Both therapies are designed specifically to address the special difficulties encountered in this population when they try to quit smoking. We expect both treatment conditions to significantly increase the chances of success over traditional approaches that have not been tailored for the seriously mentally ill. This therapy is provided as an adjunctive treatment to their usual outpatient psychiatric treatment.

The results of the study so far appear very encouraging. The Mental Health staff are very satisfied with the training, the manuals, and their experience in helping patients with serious mental illness address tobacco. We have been very impressed with the ability of the staff to incorporate tobacco dependence treatment



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skills into their work. To date, preliminary analyses found improvements in about 50% of the subjects and similar findings in the two conditions in regards to total abstinence and reduction of cigarette use. Other goals of our treatment is for the individual to abstain from tobacco by increasing internal motivation to quit, increasing self-efficacy to manage tobacco cues, and eliciting external support from their social network.

Of note, we have also been developing a Group Educational Psychosocial Treatment approach for low-motivated smokers with serious mental illness that we have labeled as “Learning about Healthy Living.” This “covert operation” approach to tobacco treatment has been very successfully piloted in 6 partial hospital /day treatment mental health sites in New Jersey this past year. The aim of the Health Living approach is to help tobacco users with a serious mental illness who state that they are not ready to quit smoking or may not even be contemplating quitting. Presumably, this approach would be helpful for all smoking clients with serious mental illness. The topics in the educational sessions include healthy eating, exercise, stress management, being “duped” by the tobacco industry, cost of tobacco use, harmful effects of tobacco use, etc. The goals of Learning about Healthy Living are to increase a person’s knowledge and motivation to work towards a tobacco-free lifestyle and to live a healthier life. The group treatment format is easily implemented in most mental health settings and provides additional support to group members. We have had excellent feedback from patients and staff about this treatment approach also; in fact, we also have had a surprising number of these “lower motivated” individuals actually request to enter tobacco dependence treatment and try to quit tobacco use. Combined the three treatment approaches can provide a mental health program and clinical staff several excellent tools to better address tobacco dependence amongst patients with serious mental illness. Information on these approaches can be received by contacting Dr. Ziedonis at 732-235-4341 or speaking with staff at the Tobacco Dependence Program.

## The Challenges of Mental Illness and Tobacco Cessation

by Stacey Zelenetz, LCSW, LCADC

Every Tuesday morning at 11 AM, our group of clients who suffer from mental illness and want to “quit smoking and stay stopped” meet here at the Tobacco Dependence Program Clinic in New Brunswick. Of the 7 to 10 people that regularly attend, their psychiatric diagnoses range from mood disorders such as Major Depression and Bipolar Disorder to Schizoaffective Disorder and Schizophrenia. But they all share a common “Tobacco Dependence” diagnosis that isn’t noted often enough in psychiatric charts. This is an ongoing group; our member with the longest time quit is one year and 8 months at the time of writing. The other members are anywhere from “still cutting down, hoping to get to zero cigarettes a day” to 4 days smoke-free, 14 days smoke-free, 30 days smoke-free, 2 months smoke-free and 7.5 months smoke-free. The group discusses all the typical subjects one would expect any group of people struggling with an addiction to talk about; struggles with triggers, how to manage stress without using tobacco, weight management, gratitude for being abstinent, staying positive, distracting the mind from the craving. The group also discusses mental illness and the interaction between having a mental illness and being dependent on a substance, often in a treatment community that has a “culture of smoking”. Many members chime in when one laments the day he started smoking, not the usual “beginning with teenagers to be cool, popular or glamorous”, but starting during his first psychiatric hospital stay after his first psychotic break at age 21. “An older patient showed me how to smoke, and how to inhale deeply to get the most out of it. And then, if you wanted to get off the locked unit, you had to smoke to be able to go out for a smoke break.” Now, he complains of “being the only one in the group home who doesn’t smoke because I am trying to quit. They are not supposed to smoke inside of the home, but they do and I have a hard time keeping away from it”.



As sufferers of mental illness, these folks are no strangers to feeling stigmatized in society. They are quite aware that people “look at them funny”, hesitate to shake their hands and want to have little contact with them. There is a double-whammy, however, when they are seen as “less than”, or of a “weak character” for smoking in addition to their mental illness. Sometimes this tie binds them even “closer to smoking” because it’s “something we all do together”. And of course, they are correct. Smoking rates in the mentally ill population are 2 to 4 times higher than the general public. Those who are quitting complain about the “culture of smoking” among consumers of mental illness services and how smoking is accepted in treatment facilities, group homes and residences. One complains that “my psychiatrist tells me that it may be too hard for me to quit smoking because of my mental illness, but that’s just not true, I know I can do this, I wasn’t born smoking”. Another reports that he sees one of the psychiatrists at his Partial Hospitalization Program smoking with the patients in the smoking area. He shares that, “When he tells me that maybe it’s too hard for me to quit because of my mental illness I don’t know if it’s a doctor or a smoker I’m talking to. I don’t know if I should believe him.”

Tobacco dependence remains quite devalued as a problem in patients who suffer from mental illness. However, the American Psychiatric Association Practice Guidelines for Treatment of Patients with Nicotine Dependence from 1996 stated that psychiatrists “should treat tobacco dependence in patients who smoke and are being seen for a psychiatric disorder, smokers who have failed initial treatments for smoking cessation and need more intensive treatments and psychiatric patients who smoke and are temporarily confined to smoke-free wards”.

So, if you know people who suffer from mental illness and are trying to quit or to stay quit, remind them that they are not condemned to smoke, and refer them to our group!

# Should Pregnant Smokers Use Cessation Medications?

by Michael B. Steinberg, MD, MPH

A significant number of women who smoked prior to becoming pregnant quit when they learn they are pregnant or soon after. However, a notable proportion (reportedly 10%), continue to smoke during pregnancy. Numerous studies have suggested that this estimate is vastly underestimating the true smoking rates as this behavior carries high social stigma. In addition, 70% of those women who quit during pregnancy will be smoking again at 6 months post-partum. Smoking cessation during pregnancy not only benefits the mother's health, but obviously the health of the unborn child. Tobacco has numerous detrimental effects on fetal health including low birth weight, premature labor, placental abnormalities, and congenital defects, on infant health including SIDS, and is also associated with childhood illnesses, such as ear infections, asthma, and developmental problems into adolescence. The annual smoking-attributable costs for complicated births in the United States were \$1.4 billion, estimated in 1995 dollars. Clearly, assisting pregnant women to stop smoking is a high priority for public health.

The benefit of smoking cessation is highest earlier in pregnancy, with babies born to women who quit early reaching normal birth-weight. However, there is continued benefit to stopping smoking at any point during pregnancy. For those that continue to smoke, the first-line tobacco dependence treatments in pregnancy are behavioral, motivational, and social interventions. However, these interventions demonstrate modest success, and effectiveness diminishes as cigarette consumption increases. A woman who is still smoking at the time of her first prenatal visit is likely to have high dependence on tobacco, and may benefit from more intensive interventions. Current clinical practice guidelines recommend considering nicotine replacement therapy (NRT), if "a pregnant woman is otherwise unable to quit, and when the likelihood of quitting, with its potential benefits, outweighs the risks of the pharmacotherapy and potential continued smoking."

Nicotine itself has potential harms for the developing fetus. It is a neurotoxin that can affect neurological development. For this reason, nicotine is not routinely recommended by the FDA for use in pregnancy. However, one must consider the risk/benefit ratio of using NRT versus smoking in pregnancy.

Numerous trials have demonstrated the safety and efficacy of NRT in helping *non-pregnant* adults quit smoking, roughly doubling the likelihood of abstinence. NRT delivers lower doses of nicotine than smokers receive from their tobacco, while eliminating 4000 toxins and carcinogens found in tobacco smoke, thus making an argument for relative safety compared with smoking in pregnancy. Also, NRT delivers nicotine to the brain at a slower rate, making them less addictive than cigarettes. Therefore, in non-pregnant adults, NRT is clearly safer than smoking and is moderately effective in helping smokers quit.

Despite the well-documented risks of smoking during pregnancy, clinicians have been reluctant to use NRT in this population. There are many barriers to providers' using effective treatment, such as NRT, during pregnancy, including fear of malpractice, lack



of training, and concern over the addictive nature of NRT. However, the most commonly reported barrier was the lack of evidence demonstrating safety and efficacy of these products in pregnancy. This is a key obstacle to effectively implementing the Public Health Service (PHS) and American College of Obstetrics and Gynecology (ACOG) Guidelines. A few small studies have demonstrated the short-term safety of nicotine patches and gum in pregnant women, as well as less adverse circulatory responses in the mother and fetus among gum users versus continued smokers. However, they have failed to produce conclusive results regarding abstinence, although one patch trial showed that despite similar abstinence rates, mean birth-weight was significant-

ly improved in the patch group. This is good evidence for the safety of NRT as it shows that the even in women with relatively low quitting success, nicotine/toxin exposure was sufficiently reduced to improve birth weight, which is often used as a marker for other harms in pregnancy.

Bupropion (Zyban) is another FDA approved cessation medication. This medication is actually a Class B medication (no fetal harm in animal models, but no human data) for use in pregnancy. The issue with bupropion is that there is a 1/1000 risk of seizures, which could be catastrophic in a pregnant woman. For this reason, many providers favor the known potential risks of NRT to those of bupropion in considering cessation medications.

Obstetricians commonly prescribe medications to treat serious medical conditions during pregnancy that carry with them risks to the fetus. This is seen in the treatment of asthma, psychiatric diseases, and seizure disorders in pregnancy. The general public health opinion is that use of NRT during pregnancy is safer than smoking. It generally delivers lower doses of nicotine while eliminating 4,000 other toxins. However, fear of malpractice and lack of experience with these medications is a deterrent to prescribers. Many feel that inaction (not prescribing NRT) that results in a woman continuing to smoke (by her own "choice" – even though we know this is an *addiction*) is "safer" from a liability standpoint than delivering cessation treatment and risking an adverse event. This is unfortunate as the risk of an adverse event is certainly higher if the woman continues to smoke than if she uses NRT. What is needed is a shift in societal perspective and a handle on litigation.

The rationale for using medications considers that:

- Many women who smoke prior to pregnancy quit when they become pregnant
- Those continuing to smoke are likely most dependent
- Majority of women who are still smoking into their 2<sup>nd</sup> trimester will not spontaneously quit
- Limited success rates with non-pharmacological interventions
  - Can try for limited time, but if not working, need to increase intensity of treatment
- Medications have proven efficacy
- Need to compare potential risk of medications to known risk of smoking