TOBACCO DEPENDENCE PROGRAM
UMDNJ SCHOOL OF PUBLIC HEALTH
University of Medicine & Dentistry of New Jersey

The Nicotine Challenger

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A View From The Director

by Jonathan Foulds, PhD

Importance of Adequately Funding Comprehensive Tobacco Control in New Jersey

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

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

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

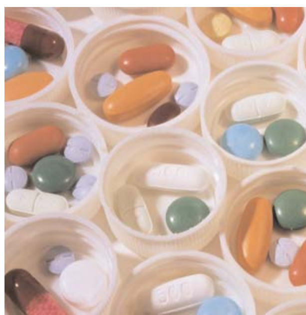
Some may ask for early signs of a health impact. One early response to reduced smoking is a reduced rate of heart attacks. The number of reported inpatient hospitalizations caused by acute myocardial infarctions in New Jersey was above 22,000 every year from 1995 to 2003 (24,278 in 2000), but dipped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

continued on page 2

Tobacco Dependence Should Get its Due as a Chronic Condition

by Michael B. Steinberg, MD MPH

Most smokers are aware of the numerous health risks associated with smoking, and the majority report wanting to quit [1]. Seven first line medications have been approved by the Food and Drug Administration for cessation including: NRT (patch, gum, lozenge, inhaler, nasal spray); bupropion; and varenicline [2]. Despite the proven benefits of these medications, a mere 17% of all smokers utilize pharmacotherapy for tobacco dependence each year [3].



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

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

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

continued on page 3

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The ***Tobacco Dependence Program*** is dedicated to reducing the harm to health caused by tobacco use. We do this through education, treatment, research and advocacy.

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

Products and services include:

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

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

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

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

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