

Oklahoma Tobacco Use Prevention & Cessation Advisory Committee

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Members

Marshall Cheney, M.A., Oklahoma Public Health Association
James M. Crutcher, M.D., M.P.H., (Chair) Commissioner of Health and State Health Officer
Sherri Edwards, Ph.D., Oklahoma Psychological Association
Stephen O. Glenn, D.D.S., Oklahoma Dental Association
Sarah A. Houk, American Cancer Society
Gayle Jones, Oklahoma State Department of Education
Andrea LaFazia, Oklahoma Department of Mental Health and Substance Abuse Services
Sarah Maple, L.P.C., Oklahoma Substance Abuse Alliance
Julie Myers, Behavioral Health and Youth Program Representative
Jacqueline “Jackie” Myles, Community-based Youth Program Representative
Erica “Janel” Pasley, Youth Representative
Forest “Frosty” Peak, Retail Business Representative
H.T. Scott, Oklahoma Alcoholic Beverage Laws Enforcement Commission
Sheila Simpson, D.O., Oklahoma Osteopathic Association
Janet M. Spradlin, Ph.D., American Heart Association
Kay Todd, Ph.D., American Lung Association of Oklahoma
Yolanda R. Varela, Youth Representative
Francene Weatherby, RNC, Ph.D., Oklahoma Nurses Association

The Advisory Committee gratefully acknowledges the invaluable contributions of the many individuals, organizations and agencies who developed previous State Plans to reduce tobacco use in Oklahoma, including the members of the Governor’s Task Force on Tobacco Use Prevention and Cessation and the Oklahoma Alliance on Health or Tobacco. Their collective efforts provided the basis for this document.

Preface

In May 2001, the Oklahoma State Legislature adopted the Tobacco Use Prevention and Cessation Act, creating the Tobacco Use Prevention and Cessation Advisory Committee. The Advisory Committee was charged with several responsibilities related to the planning, implementation and oversight of a comprehensive program to reduce tobacco use in Oklahoma.

This revised State Plan, most recently approved by the Advisory Committee in September 2005 and updated with the latest statistical data in September 2006, is hereby respectfully submitted to state leaders and to all the people of the Great State of Oklahoma.

As described on the following pages, Oklahoma continues to have a serious problem and a serious opportunity to take effective action. The following introductory facts are offered to all who may consider helping to ensure the full implementation of this State Plan:

- 1) **Tobacco is a killer.** Tobacco addiction kills almost 6,000 Oklahomans each year. Exposure to secondhand tobacco smoke kills hundreds more. As our leading cause of premature death, tobacco kills more Oklahomans than alcohol, auto accidents, AIDS, suicides, murders, and illegal drugs combined.
- 2) **Tobacco costs all of us a lot of money.** Tobacco addiction cost Oklahomans over \$2 billion in medical expenses and lost productivity every year, or an average of about \$600 per person.
- 3) **Tobacco use is epidemic.** Over 600,000 adult Oklahomans, or about one in four, currently smoke. Oklahoma per capita cigarette consumption rates are well above the national average.
- 4) **Our children are becoming addicted.** Over 70,000 Oklahoma children already use tobacco. Each year, about 7,300 more Oklahoma children get hooked.
- 5) **Oklahomans who use tobacco don't want to.** Among Oklahomans who smoke, three-fourths of adults and one-half of middle and high school youth want to completely quit smoking.
- 6) **Tobacco companies continue to deceive.** Hundreds of millions of dollars are spent in tobacco company public relations ads in Oklahoma, while decades-old practices continue behind the scenes to enhance the addictive qualities of tobacco products and to aggressively promote these products using themes that are appealing to youth.
- 7) **Tobacco companies influence public policy.** Tobacco companies still find it beneficial in Oklahoma to make contributions to the political process and to employ numerous influential lobbyists.
- 8) **Statewide prevention and cessation programs have yet to be supported at even the minimum recommended funding levels.** Although wisely created by state leaders and Oklahoma voters, the Tobacco Settlement Endowment Trust is protected so that only the earnings can be used to fund programs to improve the health and well-being of all Oklahomans. It is projected that the endowment will not generate sufficient earnings to support an effective, statewide tobacco prevention and cessation program for at least ten years, even if the all of the earnings are dedicated to this purpose.

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Executive Summary

Overview of the Problem

Tobacco use is harmful, causing thousands of deaths annually in Oklahoma and costing our state's businesses, taxpayers and individuals more than \$2 billion every year. Further, tobacco products are highly addictive, attracting about 7,300 new users under age 18 each year in Oklahoma, one-third of whom will die prematurely as a result.

Millions of dollars are spent in tobacco company public relations ads while decades-old practices continue behind the scenes to enhance the addictive qualities of tobacco products and to aggressively promote these products using themes that are appealing to youth. It's estimated that the tobacco industry spends over \$250 million annually on advertising and promotion in Oklahoma alone. Tobacco companies still find it highly beneficial in Oklahoma to make contributions to the political process and to employ influential lobbyists at the State Capitol.

In the face of powerful resistance, combating this addiction requires aggressive action. The Tobacco Use Prevention and Cessation Advisory Committee has reviewed the latest scientific information on this subject and formally recommends to state leaders a package of policy efforts and programs to enable Oklahoma to significantly reduce tobacco use and its damages.

Policy efforts will curb youth access to tobacco, permit local communities to set higher local standards if they choose, discourage and reduce consumption, and protect the public from the adverse health outcomes of secondhand smoke. Programs will diminish demand and help users to quit. Together they will cut use, saving lives, suffering and money.

There is no single magic-bullet solution. A coordinated, multifaceted approach is essential. Local and state, school and community, public and private must all work together to simultaneously address the three goals of prevention, cessation, and protection.

Solutions

Three simultaneous comprehensive approaches are necessary to effectively reduce the harm caused by tobacco use:

Prevention. Over 75 percent of all Oklahoma smokers became regular users during their teenage years. If Oklahoma would fully implement proven programs and policies to reduce the number of young people from taking up tobacco use, the number of users would gradually decline.

Cessation. To most effectively curtail tobacco use within the coming decade there must also be a reduction in the number of current tobacco users through programs and policies that encourage cessation.

Among Oklahomans who smoke, *three-fourths of adults and one-half of middle and high school youth want to completely quit smoking.* Recent developments in tobacco dependence treatments have led to new guidelines, providing improved direction for this second essential approach.

Protection. The third necessary approach is protection for all Oklahomans to prevent involuntary exposure to the damaging effects of secondhand smoke from those who continue to smoke, by eliminating smoking inside all enclosed public places and workplaces. This also serves to support efforts to reduce youth initiation and to promote cessation among youth and adults.

Comprehensive Programs

The evidence is clear that the most effective strategy for program intervention is a comprehensive approach that combines all of the “Four Cornerstones” of Community, Counter-marketing, Classroom, and Cessation initiatives. Any of these program elements in isolation will have only limited impact on Oklahoma’s devastating tobacco problem, while a combination of all approaches develops a synergistic effect, which has proven to be successful in other states.

Community programs provide essential training and technical assistance for local programs. Oklahoma’s Turning Point Initiative is an example of a community-based coalition approach that is beginning to change the face of public health in Oklahoma. With technical assistance from local health departments, Turning Point coalitions across the state make informed decisions to determine how best to address their own local public health priorities. Other key community-based programs include the youth-led “Students Working Against Tobacco” (SWAT) movement.

School-based programs are needed to provide training, materials and technical assistance to local districts to strengthen and enforce “no use” tobacco policies, to deliver evidence-based tobacco use prevention curricula, and to link with community tobacco use prevention efforts. School-based programs also include alternative-to-suspension and cessation treatment for youth.

Counter-marketing media campaigns educate the public and reduce demand for tobacco products. The planning of campaigns to discourage youth from initiation of tobacco use should involve youth leaders from across Oklahoma and messages should be tested for effectiveness.

Cessation assistance should include resources for programs to encourage health systems to fully implement the recommendations of the U.S. Public Health Service *Clinical Practice Guidelines on*

Treating Tobacco Use and Dependence. Based on cost per life year saved, treatment for addiction to tobacco products ranks higher in cost-effectiveness than virtually all other preventive health programs, including mammography, colon cancer screening, pap tests, hypercholesterolemia and pharmacologic treatment of mild to moderate hypertension. *Treatment of nicotine dependence has been called the “gold standard” of cost-effective interventions.*

A centerpiece of the tobacco dependence treatment programs is the free statewide Oklahoma Tobacco Helpline, launched in August 2003 by the Oklahoma Tobacco Settlement Endowment Trust. This new service provides individualized assessment, ongoing counseling, and referral for medical follow-up or face-to-face counseling in the community. Still needed is a system of reasonable compensation to practitioners for treating tobacco use and dependence. Insurance plans should be required to cover these services to the extent possible, and the state should pay for similar services for the uninsured, as currently provided for Oklahoma Medicaid clients.

Policy Recommendations

Nowhere is the synergy of comprehensive program and policy efforts more evident than in the implementation of smokefree policies. It has been repeatedly demonstrated that such policies dramatically increase cessation rates among smokers. Other favorable outcomes include improved employee health, reduced healthcare costs, improved productivity, decreased turnover, and reduced employer liability for providing unsafe workplaces.

The Advisory Committee strongly recommends that this State simply end smoking inside all enclosed public places and workplaces. This could be accomplished with little expense while providing great benefits. It is also important to repeal “preemption” from state tobacco law which now prohibits local citizens of a community to pass any

ordinance on the subject of smoking in public places that is stricter than the state law, even if a majority of people in that community wish to do so.

The recent increase in the state tobacco excise tax will act as a significant deterrent to consumption, especially among youth. A major obstacle to garnering support from the business community for the recent tax increase has been an inequity in the price of tobacco products between state-licensed tobacco retailers and tribal smokeshops. State leaders have recently seen major breakthroughs in their efforts to negotiate new agreements with the tribal nations, finding creative opportunities to collaborate in a manner that is mutually beneficial to the state and the tribes.

Stronger civil penalties were recently enacted for stores that sell illegally to persons under 18. Active enforcement of this new measure will be important to ensure illegal sales are effectively curbed. This will not harm the majority of sellers, who do not violate the law. Again, the “preemption” clauses in state tobacco laws should be repealed, permitting communities to set stronger requirements if their residents desire. State and local law enforcement agencies need resources to check compliance at each of the approximately 6,000 licensed retail outlets no less than twice each year.

If enforcement of existing Oklahoma laws is insufficient to stop impersonal sales such as via the internet or direct mail, legislation should be passed to require face-to-face purchase of tobacco products so age can be properly verified. New state law also requires that all self-service displays of tobacco products and all vending machines that dispense tobacco products are allowed only in places not accessible to persons under age 18.

Following is a summary of the State Plan public policy recommendations:

- Enforce new state law to ensure that tobacco vending machines are not placed in areas accessible to minors.
- Enforce new state law to ensure that self-service displays of tobacco products are not allowed in areas accessible to minors.
- Prohibit all free sampling of tobacco products.
- Require face-to-face sales and prohibit all internet sales of tobacco products.
- Enforce new state law that extends the penalties for selling tobacco products to youth to apply to owners and managers of retail outlets, including possible temporary suspension of state tobacco licenses for repeated illegal sales at a given retail outlet.
- Eliminate preemptive language in the Oklahoma Prevention of Youth Access to Tobacco Act so that local communities may adopt youth access ordinances stricter than the state law.
- Eliminate preemptive language in the Oklahoma Smoking in Public Places and Indoor Workplaces Act so that local communities may adopt smoking ordinances stricter than the state law.
- Adopt local prevention of youth access to tobacco ordinances and local clean indoor air ordinances that most effectively utilize the powers allowed by state law.
- Extend state law to eliminate smoking in all indoor public places and workplaces.
- Require all health insurance plans to provide coverage for tobacco cessation services and products.
- Further increase the state excise taxes on tobacco products to continue to help reduce tobacco use among youth.
- Continue to negotiate new state tobacco tax compacts with all tribal nations engaged in the sale of commercial tobacco products in Oklahoma, thereby continuing to seek collaboration to achieve needed excise tax increases in a manner that is mutually beneficial to the state and the tribal nations.

In almost all cases, reductions in sales of tobacco products as a result of these policies and programs are gradual. Such shifts are a constant feature of our economy; consumers are likely to spend the money thus saved on other products, perhaps from the same merchants. There is no contest between the short-term private interest in revenue from sales that cause great public harm versus the public preference for and benefits from reduced tobacco use.

Fiscal Considerations

Based on experiences in other states and best practice recommendations of the U.S. Centers for Disease Control and Prevention, an annual investment of \$22 million to \$56 million is needed to implement an effective, comprehensive statewide tobacco use prevention and cessation program in Oklahoma.

The Advisory Committee estimates that \$33 million annually, or about \$10 per person, is needed for programs adequate to achieve the goals set in this plan. This is contrasted by the more than \$600 per person per year in this state for costs of healthcare and other economic damages caused by tobacco use.

Tobacco settlement payments to the State of Oklahoma are divided between the Oklahoma State Legislature, Oklahoma Attorney General's Office, and the Oklahoma Tobacco Settlement Endowment Trust. Over time, increasing proportions of tobacco settlement payments will be deposited into the endowment.

Although wisely created by state leaders and Oklahoma voters, the endowment is protected so that only the earnings can be used to fund programs to improve the health and well-being of all Oklahomans. It is projected that the endowment will not generate sufficient earnings to support an effective, statewide tobacco prevention and cessation program for at least ten years even if the all of the earnings are dedicated to this purpose.

Outcomes

Full implementation of this plan now will cut current tobacco use rates in half by 2010. Underage use will be slashed. Demand will be cut and youth access will be sharply curtailed. Some cost savings, such as reduced neonatal care expenses for low birthweight infants, will be seen almost immediately.

Other savings will gradually grow, eventually reaching hundreds of millions of dollars per year. Life expectancy will start to increase and prevalence of diseases caused by tobacco use and exposure to secondhand smoke will be favorably modified. Oklahoma's reputation will be enhanced as a more healthful place in which to live, work, locate a business and raise a family.

If we fail to respond effectively, Oklahoma stands to see reduced settlement payments while continuing to pay the costs in both human suffering and medical care. As other states effectively reduce tobacco use through proven programs and policies, settlement payments will be reduced nationwide even if Oklahoma's tobacco addiction rates and related medical care costs remain high.

Oklahoma can no longer afford to wait. Oklahoma can no longer afford to allow the tobacco industry to foster ineffective, preemptive public policy. We need to gain notoriety for having effectively reduced tobacco use and not for having been the state most willing to allow tobacco industry domination.

Oklahoma has a history of being fiercely independent, coming together to address our problems, and pride in a job well done. It's time to take a stand against the tobacco industry's manipulation; it's time to help addicted smokers quit smoking; it's time to assure that Oklahoma's future generations will have every opportunity for health, happiness and prosperity, free from the grip of an industry with no greater concern for the lives and fortunes of Oklahomans than protecting their own bottom line.

Part I

Findings & Recommendations

The Problem

Tobacco use in Oklahoma is a very costly problem, both in human and economic terms. It leads to the premature death of almost 6,000 of our state's citizens every year, with the attendant suffering of patients and families alike. The economic damages exceed \$2 billion annually in this state, an average of more than \$600 for every Oklahoman.

While some of the harms resulting from tobacco use are widely known, many others are poorly understood by the public. The following summary demonstrates the seriousness of the problem, which is why the recommendations in this report are so important.

Health Effects of Smoking

Smoking causes many serious diseases, leading to more than 400,000 premature deaths in the United States each year including almost 6,000—or an average of 16 each day—here in Oklahoma.

Smoking causes 87 percent of lung cancer cases, 82 percent of deaths from chronic obstructive pulmonary disease, 21 percent of deaths from heart disease, and 18 percent of deaths from strokes.

Oklahoma has the eleventh highest smoking-caused death rate in the nation. The life expectancy of Oklahoma smokers is 14 years less than nonsmokers.

As the state's leading preventable cause of death, smoking kills more people than alcohol, illegal drugs, car accidents, suicide, homicide, and AIDS combined!

Tobacco smoke contains at least 250 chemicals known to be toxic or carcinogenic.

Oklahoma Consumption Rates

Oklahoma cigarette consumption exceeds 345 million packs per year or 98 packs per person annually. This compares to the national average of just 75 packs and other states with as few as 32 packs per person per year.

It is not surprising that prevalence rates are also high in Oklahoma, especially among certain groups. Of particular concern—because they are an indicator of future consequences from this addiction—are the prevalence rates among this state's youth.

Youth Smoking

Tobacco addiction is a disease that typically begins in childhood. Nationwide, rates of youth tobacco addiction increased sharply from the late 1980s to the mid 1990s, with some decline more recently.

In Oklahoma, 33 percent of children in grades 9-12 and 15 percent of children in grades 6-8 used tobacco products in 2005. A November 2000 Centers for Disease Control and Prevention (CDC) report showed that Oklahoma has a particularly poor record of discouraging teen smoking. Nine percent of all Oklahoma middle school students smoked their first whole cigarette before age 11.

About one-half of Oklahoma youth smokers report they would like to quit, but indicate they have difficulty doing so.

Spit Tobacco

Many people believe smokeless or “spit” tobacco is a safe alternative to smoking. Yet smokeless tobacco causes a wide range of problems that include short term discoloration and abrasions of teeth, dental caries, receding gums, leukoplacia (a pre-cancerous lesion of the mouth), nicotine addiction, and a significantly increased risk of becoming a cigarette smoker. Prolonged use can lead to cancers of the mouth, a common result even among teens and young adults.

Prior to 1975, rates of smokeless tobacco use were highest among persons over age 50. In the early 1970s, however, the tobacco industry extended its lines of moist snuff products and began marketing them aggressively to males between the ages of 18 and 30. Carrying the round tin can in the back jeans pocket consequently became a popular status symbol among boys and young men.

Rates of student use of spit tobacco in our state are alarming. In the 2005 Oklahoma Youth Tobacco Survey, 15.4 percent of middle school students and 25.3 percent of high school students reported having ever used it. Among boys, 6.9 percent in middle school and 20.3 percent in high school reported current use. Six percent of all middle school boys reported first using spit tobacco before age eleven.

Secondhand Smoke

Smoking kills nonsmokers, too. Environmental tobacco smoke (ETS) has been identified as a cause of cancers, emphysema, heart disease, stroke and sudden infant death syndrome (SIDS). There is no level of exposure recognized as safe.

The federal government and the World Health Organization have officially classified ETS as a known human (Class A) carcinogen.

The Oklahoma State Department of Health estimates that exposure to secondhand smoke kills more than 700 nonsmokers in Oklahoma each year. ETS also exacerbates many health problems and causes many cases of bronchitis, pneumonia, inner ear infection and asthma in infants and children.

ETS leaves hazardous traces in the air long after the smoke is no longer visible. It also includes dangerous components in particles so fine they cannot be filtered easily from the air. Effective

separation of smoking from nonsmoking spaces requires not just fully enclosed physical separation, but also negative air pressure so there is no escape of air from the smoking space, and separate ventilation systems with exhaust of smoke-contaminated air to the outside.

Maternal and Infant Health

The impact of smoking on maternal and child health is tremendous. For the pregnant woman, smoking dramatically increases heartbeat and blood pressure, which in turn can have a negative impact on both her own health and that of her baby. Even more dangerous is the crossover of the poisons in inhaled cigarette smoke to the placenta. Carbon monoxide, arsenic and tar are just some of the deadly poisons that reach the developing fetus. The results are tragic, costly and can be deadly.

Smoking during pregnancy nearly triples the risk of low birth weight babies, increases the risk of miscarriages, pre-term birth, and stillbirth and accounts for at least 10 percent of all infant deaths.

In Oklahoma, over 550 low birth weight deliveries are directly attributable to maternal smoking, costing Oklahomans an excess of \$14.4 million each year in hospital costs alone.

Smoking during pregnancy and infant exposure to secondhand smoke both directly increase the risk of SIDS.

Almost one-third of Oklahoma women smoke in the three months prior to pregnancy, and two-thirds of those (18 percent) are still smoking in the third trimester. More than half of the women who quit during pregnancy resume smoking within four to six months after giving birth.

Secondhand smoke causes bronchitis or pneumonia in at least 2,250 Oklahoma infants each year. An estimated 216,000 Oklahoma children are exposed to secondhand smoke at home each day, including 40 percent of all 2-year-olds.

The Victims

Those most likely to use tobacco are our more vulnerable population. They include children, Oklahomans with less education and lower incomes, and people from ethnic communities. It is to these segments of the population that the tobacco industry has been so successful in their marketing strategies.

Economic Costs

In addition to the heavy toll of health damages from tobacco use, there are also considerable economic damages. Most obvious are the expenses of healthcare for illnesses caused by tobacco use. These were most recently calculated for Oklahoma in 1998 at \$907 million per year, about half of which was from taxpayer funding, including \$170 million for Medicaid.

Further, there are significant non-medical costs estimated at \$1.3 billion for lost productivity. This brings the total economic costs to well over \$2 billion annually in Oklahoma, or an average of over \$600 per person—smokers, nonsmokers and children alike.

Other Considerations

Another part of the problem of tobacco use in Oklahoma is a series of obstacles faced by no other public health problem.

Addiction. These products are very highly addictive. Nicotine addiction is one of the hardest addictions to break.

The tobacco industry. The tobacco industry is dependent on new customers and continuing demand for its products. It has enormous resources and its products are the most heavily marketed in the world. In large part thanks to the addictive characteristics of nicotine, the industry is able to pass along sizable costs—such as litigation settlements and extensive marketing—to its customers with relatively small reductions in sales. The industry aggressively protects and pursues its sales, not only through direct marketing of its products but also through many other means, including strong lobbying efforts, political activity and sophisticated (and expensive) public relations.

No other public health improvement effort faces this degree of relentless industrial opposition.

Complacency. Though Americans would like to see tobacco use decline—especially among children—many have become resigned to the difficulty of making further reductions because they are not aware of the successful results where the latest strategies and programs have been employed. The “conventional wisdom” often seems to be that little can be done.

Similar attitudes may have been shared by some Oklahomans, in which case the findings and recommendations in this report may help dispel any misperceptions.

The Solutions

Three approaches are needed to effectively reduce the harm caused by tobacco use:

Prevention. When Oklahoma prevents additional young people from taking up tobacco use, the number of users will gradually decline, eventually eliminating the problem. Prevention is an essential approach.

Cessation. To most effectively curtail tobacco use within the coming decade, there must also be a reduction in the number of current tobacco users through cessation. Fortunately, most users now want to quit. Recent developments in tobacco dependence treatments have led to new guidelines, providing improved direction for this second essential approach.

Protection. The third necessary approach is protection for all Oklahomans to prevent involuntary exposure to the damaging effects of secondhand smoke from those who continue to smoke, by eliminating smoking in enclosed public places and workplaces. This also serves to support efforts to reduce youth initiation and promote cessation among youth and adults.

Beyond identifying these approaches, the challenge of reducing tobacco use becomes more complex, as it involves changing behaviors of large populations. But a number of states, communities and organizations have experimented in recent years with various types and combinations of interventions. Published evaluations of these pioneering efforts have led to a sizable body of evidence about what works, and the following recommendations for Oklahoma are based on this Advisory Committee's review of the latest information from across the nation combined with its knowledge of Oklahoma.

One key concept is the need for a balanced array of **comprehensive programs**. No single type of program has been shown to be particularly effective without support from the other programs described. When combined, however, community-based, school-based, media, cessation and enforcement programs together have shown success on a consistent basis. To simplify this report, each group of program elements will be described under one of the three approaches where it is especially relevant. But the importance of each group of programs overlaps into all three of the approaches, and this **synergy** among the major groups of programs is important to achieving results.

Because both are important and intertwined, policy and program recommendations are presented together under each of the three approaches. Desired outcomes and several implementation recommendations common to all the programs are described in subsequent sections. The scale of the programs required is discussed with their costs and potential funding sources in Part II.

Approach 1: Prevention

Over 75 percent of all Oklahoma smokers became regular users during their teenage years. While this Advisory Committee recommends educating the public to discourage tobacco consumption at any age, the primary emphasis of the prevention campaign should focus on children and adolescents under age 18 and should involve community, school, media and other efforts.

Preventing initiation of tobacco addiction requires a combination of evidence-based programs involving communities, schools, media and enforcement of youth access laws plus policies to make these products less accessible to persons under 18.

Prevention: Community Programs. Oklahoma's local communities are the real battleground for the next generation of tobacco users. That's because people most often come together to protect their communities—especially their children. Messages from parents, teachers, churches and the community-at-large have a great deal of influence on youth, particularly when the youth themselves are involved as leaders in the effort.

Oklahoma's Turning Point Initiative is an example of a community-based coalition approach that is changing the face of public health in Oklahoma. With technical assistance from local health departments, Turning Point coalitions make informed decisions to determine how best to address their own local public health priorities.

Coalitions made up of diverse groups of people representing businesses, educators, law enforcement, youth, health care providers, churches, civic groups and others are needed in every community throughout the State. These coalitions will have the ability to guide activities to educate youth and adults about how our youth are targeted by tobacco advertising, promote tobacco dependence treatment for both youth and adults who use tobacco, explore the best ways the community can address the problems of public exposure to secondhand smoke, and help assure that each new generation of children receives consistent messages on the true nature of tobacco addiction.

Distinct youth-led organizations to combat tobacco use are among the important elements of community programs. These groups should have both local and state level activities to provide

leadership development and input into statewide programs. SWAT (Students Working Against Tobacco) is such a statewide program that has been launched with support through the State Health Department.

Prevention: Specific Populations. For some communities in Oklahoma, such as ethnic groups, statewide or regional activities are important in addition to local ones.

Ethnic populations in Oklahoma have suffered a disproportionate share of tobacco industry marketing and advertising campaigns, in many cases resulting in higher smoking rates and disproportionate harm from tobacco-caused diseases. Statewide ethnic tobacco education networks and materials are needed to help eliminate such disparities.

Prevention: School-based programs. Most smokers start smoking daily in grades 6 through 9. And those who start smoking at young ages find it hardest to quit.

For these reasons, school-based programs specifically designed to prevent kids from using tobacco products and to help young smokers and spit tobacco users to quit, are critically important. Such programs can reach children and teenagers when they are most vulnerable to starting a tobacco habit—or before their use has become an addiction.

A report from another state, but well-publicized in Oklahoma, revealed disappointing results from a well-intentioned school curriculum implemented in isolation without supporting community and media programs. This underscores the need for a comprehensive variety of mutually supportive programs.

School-based programs are most effective in the short and long term when they are part of an overall system of tobacco use prevention initiatives that link them with media campaigns that educate the public,

local programs that support tobacco-free communities, and increased local efforts that limit youth access to tobacco products.

Assistance should be provided to schools throughout the state to assist in implementing tobacco use prevention and cessation programs that are proven successful and driven by students, parents, staff, and school boards at the local level. Every school in Oklahoma needs to have ready access to training, materials, and technical assistance to effectively adopt the CDC Guidelines for School Health Programs to Prevent Tobacco Use and Addiction, including a K-12 curriculum strategy using specialized tobacco use prevention curricula, creating school policies prohibiting tobacco use, and offering tobacco dependence treatment services to students, faculty and staff.

Prevention: Public Education Media Campaigns (Counter-marketing). Tobacco is America's most heavily marketed product. It's estimated that the tobacco industry now spends over \$250 million annually on advertising and promotion in Oklahoma alone. Despite the commendable restrictions in the 1998 Master Settlement Agreement (MSA) between Oklahoma and other states limiting certain practices of marketing tobacco to youth, it would be naive to believe the tobacco industry will not continue its sophisticated and well-funded marketing and promotional efforts. In fact, tobacco industry marketing expenses have actually doubled since the MSA was signed.

One indication of their marketing success is the brand preference of Oklahoma children. Though the industry claims their ads focus solely on adults, 79 percent of underage smokers in Oklahoma prefer one of the three most heavily advertised brands: Marlboro, Camel, or Newport. Only about one in three adults choose these brands.

To counter industry marketing, Oklahoma needs to ensure an ongoing and extensive advertising and media campaign to deglamorize the fictional imagery portrayed by the tobacco industry. Such a public education campaign sends and reinforces powerful messages—helping to create a public awareness that will support, rather than contradict, school and parental efforts to deter children from tobacco use. The ads should be selected with help from Oklahoma youth and tested for effectiveness. Production costs can be minimized as many ads already produced and used successfully in other states are available.

Allowing youth to play an essential role in the state's media campaign will empower youth leadership against tobacco while directly helping to decrease Oklahoma's youth prevalence rate.

To be effective in reaching the target audience, paid placement of ads through television, radio, outdoor and print media is needed. Simultaneous public education media campaigns are also needed to promote smoke-free environments, raise public awareness on the health and legal consequences of providing tobacco products to youth, and to promote use of tobacco dependence treatment services.

Prevention: Enforcement. Enforcement of tobacco sales laws enhances their efficacy both by deterring violators and by sending a message to the public that the state and community leadership believes the policies are important. State and local law enforcement agencies need resources to check compliance at each of the approximately 6,000 licensed retail outlets no less than twice each year, with additional checks conducted as necessary to respond to complaints and repeat violators.

With active enforcement, the new, stronger civil penalties will be effective in reducing the number of stores that sell illegally to persons under 18. This will not harm the majority of sellers, who do not violate the law. The present state preemption provision in the Prevention of Youth Access to Tobacco Act should be repealed, permitting local communities to set stronger requirements if their residents desire.

If enforcement of existing Oklahoma laws is insufficient to stop impersonal sales such as via the internet or direct mail, new legislation should be passed to require face-to-face purchase of tobacco products so age can be properly verified. Appropriate enforcement mechanisms and penalties should be provided.

Vending machine sales of tobacco products are another channel by which age cannot be verified. It is important to ensure full compliance with the new state law to restrict these sales to places not accessible to persons under age 18.

State law should prohibit all free samples of tobacco products. Currently, these cannot legally be given to persons under 18. However, free samples of addictive tobacco products distributed to adults by mail or during various public events readily find their way into the possession of children.

Approach 2: Cessation

The vast majority of Oklahoma's 600,000 adult tobacco users want to quit, but have been unable to do so. Recent breakthroughs in tobacco addiction treatment make it possible to help, but systems for matching individuals with services, the services available, and the means of paying for referrals and services all are woefully inadequate.

The Surgeon General's report in 2000, *Reducing Tobacco Use*, observes "Tobacco dependence is best viewed as a chronic disease with remission and relapse."

Historically, most smokers who quit have done so on their own without assistance from formal cessation treatment programs. These independent efforts need to be encouraged and supported. With the large numbers who still smoke, however, something additional is needed. There is much new knowledge about managing nicotine addiction, which should be applied to help Oklahomans.

Beyond information and self-help manuals, individual and group counseling and pharmacological aids are among the interventions providing increased chances of quitting.

The success of cessation counseling and advice typically increases with the intensity of the program, the duration and the follow-up. Proactive telephone advice and counseling, as now provided by the new Oklahoma Tobacco Helpline, has been shown to be clearly effective in helping individuals quit.

Healthcare systems and a variety of clinicians must be engaged together in additional tobacco dependence treatment efforts. Many of the state's healthcare professional organizations have identified reduction of tobacco use as a priority, but there is a need for systems, including insurance plans, to seriously address this problem.

Physicians and other healthcare professionals should (1) ask patients about smoking and other tobacco use; (2) advise them to quit; (3) assess willingness to make a quit attempt; (4) assist those who want to quit; and (5) arrange follow-up with those trying to quit. To assure that this happens, third-party payers, including the state's Medicaid program, should provide reasonable reimbursement and other incentives to a variety of providers.

Insurance coverage for the above services, for referral treatment services, and pharmacotherapies for smoking cessation should be required to the extent possible by state law, and coverage should extend to multiple quit attempts when needed. Research has identified several means to increase the likelihood of successful cessation, but multiple attempts often are needed.

The Helpline should be expanded as necessary to serve all Oklahomans who use tobacco and are interested in quitting. Ideally, an extensive, year-round public education campaign would be maintained to make citizens aware of the Helpline, to encourage tobacco users to quit, and to encourage them to make use of the Helpline.

Cessation materials and programs should be developed for various age groups, ethnic groups, workgroups and other specific populations. Tobacco dependence treatment should be encouraged through school, community and workplace programs. There should also be treatment efforts to assist users of other forms of tobacco, particularly spit tobacco.

The Advisory Committee recommends that state government continues to support and participate in initiatives to bring together clinicians, insurers, providers of specialized treatment services and other interested parties to facilitate advances in tobacco dependence treatment in Oklahoma.

Approach 3: Protection

Nonsmokers should be protected from involuntary exposure to hazardous tobacco smoke, which can be accomplished most economically through public policy. Oklahoma should protect all its citizens with a simple clean indoor air law for all enclosed public places and workplaces.

Among the first findings described in this plan was the fact that exposure of nonsmokers to environmental smoke—both secondhand smoke and “sidestream smoke” direct from the burning tobacco product—is harmful, contributing to serious chronic diseases and killing more than 700 Oklahomans every year, more than are killed in all motor vehicle accidents.

A second fact is that persons with breathing disabilities, including an estimated 180,000 Oklahoma adults and children with asthma, are limited in the public places that they can enter because of the risk of acute reactions to secondhand smoke.

Third, it must be understood that harmful ingredients of secondhand smoke can remain in the air for many hours, well beyond the time the smoke is visible or readily detectable to most people.

The Advisory Committee strongly recommends that this State simply end smoking inside all enclosed public places and workplaces. Experience elsewhere indicates there would be very little implementation and enforcement expense, but very great benefits.

It is also important to repeal the pre-emptive provision from state law which now prohibits the citizens of a community to pass any ordinance on the subject of smoking in public places that is stricter than state law, even if a majority of people in that community wish to do so.

Other favorable consequences of smokefree policies are added incentives for more smokers to successfully quit, improved employee health and reduced healthcare costs, improved productivity,

decreased turnover, and reduced employer liability for providing unsafe workplaces.

Nowhere is the synergy of comprehensive program and policy efforts more evident than in the implementation of smoke free policies. It has been repeatedly demonstrated that smoke free policies dramatically increase successful cessation rates among smokers.

Internal tobacco industry documents released to the public as a result of state lawsuits across the nation revealed that the tobacco industry has long viewed smoke-free policies as a powerful threat because they reduce sales volume by increasing smokers’ successful quit attempts. One such example is the following quote, excerpted from a 1992 Philip Morris Tobacco Company interoffice correspondence entitled “Impact of Workplace Restrictions on Consumption and Incidence”:

“Total prohibition of smoking in the workplace strongly affects industry volume. Smokers facing these restrictions consume 11-15% less than average and quit at a rate that is 84% higher than average... Clearly, it is most important for PM to continue to support accommodation for smokers in the workplace...”

Finally, in addition to protecting the public from exposure to secondhand smoke and increasing cessation rates among smokers, smoke free policies help to assure that there will be fewer opportunities for children to be exposed to smoking as an accepted norm within our society. Public education resulting in changes in public policies will also help to increase adoption of voluntary smokefree policies within homes.

Implementation

The following information applies generally to program organization and administration.

Public Health Advisory Committee

The Tobacco Use Prevention and Cessation Advisory Committee was created in May 2001 through the Tobacco Use Prevention and Cessation Act to review and recommend a State Plan for Tobacco Use Prevention and Cessation to the Oklahoma State Department of Health, periodically review progress towards meeting the objectives of the State Plan, approve applications for or Invitations To Bid for contracts proposed by the State Health Department, and make recommendations for the award of contracts from the Tobacco Use Reduction Fund for qualified tobacco use prevention or cessation treatment programs.

The Advisory Committee consists of 20 members including representatives of the Oklahoma Psychological Association, American Cancer Society, Oklahoma Public Health Association, Oklahoma Osteopathic Association, Oklahoma Dental Association, Oklahoma State Medical Association, American Heart Association, Oklahoma Nurses Association, Quality Behavioral Services Alliance, American Lung Association, and the Oklahoma Institute for Child Advocacy. Other appointees include two persons between 12 and 18 years of age and one person with experience in retail business.

Also serving or represented on the Advisory Committee is the State Commissioner of Health, the State Superintendent of Public Instruction, the Commissioner of the Department of Mental Health and Substance Abuse Services, and the Director of the Alcoholic Beverage Laws Enforcement Commission.

Subcommittees of this Committee are available to serve as “evaluation teams” to review all responses to Invitations To Bid and applications for contracts and make final recommendations for the award of contracts. No subcommittee member will be an applicant or recipient of funds for the program component proposed.

This Committee strongly recommends that the Oklahoma Tobacco Use Prevention and Cessation

Act be amended to add a twenty-first member, selected from a list provided by the Native American Tobacco Coalition of Oklahoma.

Community Partnerships

Though certain programs are statewide, as a general rule it is recommended that the programs in this plan be implemented primarily at the local level and in partnership with private and public organizations and individuals, so long as this can contribute to effectively reducing tobacco use.

The behavioral changes needed to achieve these goals require community and individual commitment and a cultural norm change. State action alone cannot achieve such goals. But state actions in concert with those of others can be a major positive force in helping to reach them.

As fiscal agents for local level services identified by community coalitions and partnerships, County Health Departments should provide oversight and coordination between community coalitions and those who are funded to deliver services. County Health Departments should administer local contracts as may be needed, following all appropriate state and county procurement procedures.

Lead Agency

The breadth of needed state program elements will involve multiple agencies or departments. However, there should be a designated lead agency to provide coordination. This role can be met best by the State Department of Health, Tobacco Use Prevention Service. With program and management staff primarily supported through a grant from the CDC, this office has the greatest experience and concentration of qualified personnel to continue leadership of such programs in conjunction with other departments as needed.

Outcomes

Oklahoma can reduce tobacco use by half within the next decade, saving both lives and money.

Monitoring Progress

An annual evaluation will be provided by an independent contractor to determine the overall effectiveness of the programs in the State Plan by measuring the following:

1. Tobacco consumption;
2. Smoking rates among the population targeted by the programs; and
3. The specific effectiveness of any other program funded.

The annual evaluation shall include a comparison with baseline surveillance data collected prior to the creation of the 2001 Oklahoma Tobacco Use Prevention and Cessation Act.

All funded programs will be evaluated to determine their overall effectiveness in preventing or reducing tobacco use according to the program's stated goals. Evaluation of specific programs will include a comparison with data from previous years if it is a multiyear program.

Several surveys will be conducted to monitor trends related to tobacco use in Oklahoma. One surveillance tool will be the Oklahoma Youth Tobacco Survey (OYTS). The OYTS will be administered to measure tobacco use and behaviors towards tobacco use by individuals in grades six through twelve. The OYTS will:

1. Involve a statistically valid sample of the individuals in each of grades six through twelve;
2. Be made available to the public, along with the resulting data, excluding respondent identities and respondent-identifiable data, within sixty (60) days of completion of the survey; and
3. Be compared with data from previous years, including initial baseline data collected prior to the creation of the 2001 Oklahoma Tobacco Use Prevention and Cessation Act.

What Can Oklahoma Expect?

As stated earlier in this report, the latest available prevalence rate information for regular tobacco use among youth in Oklahoma is 33 percent of high school students and 15 percent of middle school students. The annual consumption rate of cigarettes is 98 packs per Oklahoman (smokers, nonsmokers, and children) per year. As indicated in Appendix A, these data represent significant progress since 2001 when this State Plan was first adopted.

Also as indicated in Appendix A, full implementation of this state plan would cut baseline rates in half by 2010.

Oklahoma can dramatically reduce cigarette consumption. Underage use can be slashed. Demand will be cut, and youth access will be curtailed.

Under this plan, most Healthcare providers will screen for tobacco use and refer users to behavioral counseling and assistance programs, which will be readily accessible. A Helpline with professional counseling will continue to be available anytime to all Oklahomans.

All Oklahomans will be free from involuntary exposure to harmful secondhand smoke inside their workplaces and in all enclosed public places.

Communities will be free to implement further ordinances regarding tobacco sales and use if their citizens so desire.

Some cost savings will be evidenced almost immediately, such as reduced neonatal care expenses for underweight babies. Other savings will gradually grow, eventually reaching hundreds of millions of dollars per year.

Life expectancy will start to increase, and prevalence of diseases caused by tobacco use and exposure to secondhand smoke will be favorably modified.

Oklahoma's reputation will be enhanced as a more healthful place in which to live, work, locate a business and raise a family.

Part II

Other Considerations

Funding Levels & Sources

The scale of interventions and resources needed should be commensurate with the damages caused by the problem if they are to be successful. Experience shows reductions in tobacco use are directly related to the scale of the intervention campaign.

Funding Levels

Based on experiences in other states and recommendations of the Centers for Disease Control and Prevention, an annual investment of \$22 million to \$56 million is needed to implement an effective, comprehensive statewide tobacco use prevention and cessation program in Oklahoma.

This Advisory Committee believes \$33 million annually, or about \$10 per person, is needed for programs adequate to achieve the goals set in this plan for the coming decade. Any reduction in scale below \$33 million annually will compromise attainment of these outcomes. A majority of the funds should be spent at the local level with appropriate centralized coordination and support.

Evidence is clear that the most effective strategy for program implementation is a comprehensive approach that combines all of the “Four Cornerstones” of Community, Counter-marketing, Classroom, and Cessation initiatives. Any of these program elements in isolation will have only limited impact on Oklahoma’s devastating tobacco problem.

Despite the limited funding now available, a firm commitment to the comprehensive approach must be maintained. Comprehensive local level program activities should be implemented on a county-by-county basis as funding becomes available until all communities within the State of Oklahoma are included. Certain program elements, such as the Helpline or counter-marketing media campaigns, are more efficiently implemented statewide due to economies of scale.

The following recommendations for funding are based on current information regarding effectiveness and necessary components of a comprehensive program. These judgments should be reviewed periodically by the Tobacco Use Prevention and Cessation Advisory Committee, as previously addressed in this plan.

Funding Allocations

Four essential program areas – the “Four Cornerstones” – should receive 85 percent of the recommended funding: (1) Community programs, (2) Classroom programs, (3) Counter-marketing public education media campaigns, and (4) Cessation programs. The following table shows the general allocation among these areas at the effective funding level recommended in this State Plan.

Type of Program	Recommended Funding	Approx. % of \$33 million
Community	\$8.0 million	25%
Classroom (school-based programs)	\$5.0 million	15%
Counter-marketing	\$6.5 million	20%
Cessation (treatment)	\$8.3 million	25%

The additional 15 percent should be for enforcement, administration, and surveillance and evaluation of program effectiveness.

Community programs funding will provide statewide training and technical assistance, plus funds for local programs, which will be the largest investment in this category. A major new community-based tobacco control initiative, funded by the Oklahoma Tobacco Settlement Endowment Trust, was launched in late 2004.

In addition, the statewide youth-led SWAT (Students Working Against Tobacco) movement is a community program. Community programs should continue to include statewide Ethnic Tobacco Education Networks and other programs to help communities address the needs of specific populations disproportionately effected by tobacco caused death and disease.

School-based programs will cover training, materials and technical assistance to local districts to strengthen and enforce “no use” tobacco policies, to deliver evidence-based tobacco use prevention curricula, and to link with community tobacco use prevention efforts. They will also cover the pilot program authorized in 2000 for school nurses in rural districts with responsibilities for tobacco prevention activities. Continuation of state funding for these curricula and school nurse programs will be subject to careful review of evaluation data. School-based programs will also cover alternative-to-suspension and cessation treatment programs for youth and adolescents.

The **Counter-marketing budget** should be used to educate the public and to reduce demand for tobacco products. The planning of campaigns to discourage youth from initiation of tobacco use should involve youth leaders from across Oklahoma, and messages should be tested for effectiveness. Production costs can be minimized by drawing from materials developed in other states and available for sharing through the CDC’s Media Campaign Resource Center. These media should supplement messages from other sources including the American Legacy Foundation.

The **Cessation budget** should include resources for informative materials and for programs to encourage health systems to fully implement the recommendations of the U.S. Public Health Service Clinical Practice Guidelines on *Treating Tobacco Use and Dependence*.

A free state-wide Helpline should continue to be a centerpiece of the tobacco dependence treatment programs to help disseminate these services. This key service provides individualized assessment, ongoing counseling, and referral for medical follow-up or face-to-face counseling in the community. Of course, the greater the promotion and utilization of this service, the better the anticipated results and benefits.

This Advisory Committee recommends that the Helpline be viewed as an opportunity for a partnership with private insurers to encourage them

to make tobacco dependence treatment a fully covered benefit for their clients.

The other major expenditure under “*cessation*” should be for a system of reasonable compensation to practitioners for treating tobacco use and dependence. Insurance plans should be required to cover these services to the extent possible, and the state should pay for similar services for the uninsured, as currently provided for Oklahoma Medicaid clients.

Central **administrative costs** of programs, including costs associated with the Tobacco Use Prevention and Cessation Advisory Committee, should be kept to no more than five percent in addition to the budgeted programs. Also, an additional 10 percent of the program costs should be budgeted for **surveillance and evaluation** systems to assure collection of data essential to assessing effectiveness of the programs.

In the area of **enforcement**, Oklahoma’s experience to date with two similar compliance check systems shows the average unit cost of such investigations in this state to be about \$60. With approximately 6,000 retail sales outlets, the recommended two compliance checks per year plus additional ones pursuant to complaints and in special situations will be approximately \$1 million. The ABLE Commission is responsible for this enforcement under current law but to date has received no appropriations for it. Their future funding also should permit adequate merchant education programs and materials to proactively assist compliance with Oklahoma’s laws restricting sales to persons under age 18.

Potential Funding Sources

The Advisory Committee is convinced significantly more state resources are needed above current levels to enable Oklahoma to start to catch up with national norms and to reach the attainable goals described in this plan.

Though the newly-created Tobacco Settlement Endowment Trust is an obvious source to help fund these programs, the Trust is constitutionally-protected so that only the earnings can be used to support programs to improve the health and well-being of all Oklahomans. The projected earnings available to the Board of Directors of the Trust will not entirely support an effective statewide tobacco use prevention and cessation program for at least 10 years, even if the Trust dedicates most or all of its earnings to this purpose, *which this Advisory Committee would urge*.

A small but significant portion of the new tobacco tax revenue was set aside for reducing tobacco use. The State of Oklahoma will need to appropriate additional support to fully implement this State Plan.

Local matching funds from public and/or private sources should be encouraged to the greatest extent practical. The federal Medicaid “match” should not be considered a major source of funding for the tobacco use prevention and cessation program, though it should be utilized wherever possible. Although some potential exists for securing federal matching funds for specific types of activities, these opportunities thus far have proved to be very limited.

The State Health Department has received a grant from the CDC for tobacco use reduction activities, but those are in addition to and not included within the state-funded expenditures recommended here.

Costs & Benefits

Sustained implementation of the programs recommended in this report will be cost effective as well as effective in reducing tobacco use. Full implementation will cost under \$10 per person annually, contrasted with more than \$600 per person per year in this state for costs of health-care and other economic damages caused by tobacco use. Cutting the problem in half will be well worth this investment.

Tobacco Dependence Treatment for Pregnant Women

An example of early savings will result from reductions in smoking by women during pregnancy. For every dollar invested in smoking cessation for pregnant women, it is estimated about \$6 should be saved in neonatal intensive care costs and follow-up care associated with low birth-weight deliveries.

Findings of research conducted in Oklahoma concluded the number of low birth weight deliveries due to maternal smoking could be cut in half within five to six years by implementing a comprehensive tobacco use prevention and cessation program. This would save Oklahomans at least \$7 million annually in short-term hospital costs alone.

Lifetime Healthcare Savings

Other healthcare cost savings will be greater, but they will be achieved more gradually. Estimated lifetime medical expenditures for male smokers as compared to male never smokers are 21 percent higher for moderate smokers (fewer than 25 cigarettes per day) and 47 percent higher for heavy smokers (25 or more cigarettes per day). Estimated lifetime medical expenditures for female smokers as compared to female never smokers are 14 percent higher for moderate smokers and 41 percent higher for heavy smokers.

Approximately one-half of the costs for treating diseases caused by smoking in Oklahoma is paid by public funds (Medicare, Medicaid, and other federal and state sources). Group health insurance plans, individual health insurance policies and individual payments cover the balance of these costs.

Relative Cost-effectiveness

Based on cost per life year saved, treatment for addiction to tobacco products ranks higher in cost-effectiveness than virtually all other preventive health programs, including mammography, colon cancer screening, pap tests, hypercholesterolemia and pharmacologic treatment of mild to moderate hypertension.

Treatment of nicotine dependence has been called the “gold standard” of cost-effective interventions.

Other Cost Savings

Savings also will be realized by cutting absenteeism and reduced productivity. Other indirect savings will result from reduced property losses from fires caused by cigarettes or cigars and lowered costs of cleaning and maintenance made necessary by tobacco smoke, spit tobacco waste, and tobacco-related litter.

The Advisory Committee believes the recommendations in this plan will provide significant overall cost savings for government, businesses and individuals in addition to the tremendous benefits in human terms.

Business Considerations

The Advisory Committee endeavors to consider concerns of persons legitimately engaged in tobacco products commerce or other businesses that might be impacted by changes resulting from these recommendations. Many of these concerns are unfounded, based on experience in other states. None outweigh the public health interests and overall economic benefits of accomplishing the goals of the recommended programs.

Healthy Oklahomans, Healthy Business

The Advisory Committee believes the fears of lost income that have been expressed by some engaged in tobacco sales are overstated, though not intentionally. In almost all cases, reductions in sales of tobacco products as a result of these policies and programs are gradual. Such shifts are a constant feature of our economy; consumers are likely to spend the money thus saved on other products, perhaps from the same merchants. The Advisory Committee believes that there is no contest between the short-term private interest in revenue from sales that cause great public harm versus the public preference for and benefits from reduced tobacco use.

Other businesses become concerned about lost sales from prospective smoking bans in public places. However, in one study after another, analysts using sales tax data and other objective criteria have found no adverse effect of smoking restrictions, including complete bans, on restaurant business. Indeed, several of the studies have found a tendency for smoking restrictions to increase business. Similar findings are found from analysis of the effects of smoking restrictions in bars and of the impacts of restaurant and bar restrictions on tourism.

The tobacco industry has prompted numerous rebuttals, focusing on limited studies with methodological or data flaws and also results of their own surveys of subjective opinions of owners of

affected businesses. These tobacco industry supported critiques have not matched the empirical analysis and objective standards of the public health literature.

Smuggling of tobacco products between states that have disparities in excise state rates is a legitimate concern. However, evidence shows that the fears raised by the tobacco industry often exaggerate the magnitude of the problem to combat increased taxes that will discourage purchase of its products. Indeed, the tobacco industry itself appears to tolerate and actively encourage smuggling, as indicated by recent court cases in which tobacco industry executives have been found guilty of complicity in smuggling operations.

This is not a tobacco producing state, but Oklahoma has its own localized tobacco-related issues. Several of the Tribal Nations within our state's boundaries currently include specialized tobacco sales outlets among their revenue producing enterprises. Although this presents an unusual situation that creates special implications for public policy related to the sale of tobacco, the Advisory Committee suggests that the State of Oklahoma demonstrate leadership in protecting the health of its citizens. The recent renegotiations of the compacts governing payments in lieu of the tobacco excise tax presents an opportunity to address these issues in a constructive fashion.

Native Americans & Tobacco

The Advisory Committee gratefully acknowledges the Native American Tobacco Coalition of Oklahoma for providing the following information.

This State Plan would not be complete without inclusion of the relationship between the State of Oklahoma and Native Americans. Indian Nations are sovereign governments, recognized in the U.S. Constitution and in hundreds of treaties. Tribal governments provide a broad range of governmental services on tribal lands throughout the U.S., including law enforcement, environmental protection, emergency response, education, health care, and basic infrastructure.

The sovereign status of tribal governments is recognized by the State of Oklahoma. Each Indian Nation has a government-to-government relationship with the State of Oklahoma. This relationship is unique, especially regarding tobacco. Thirty-five (35) of the state's thirty-eight (38) federally recognized tribal governments have entered into tobacco tax compacts with the State of Oklahoma.

Oklahoma is unique in that it has the second largest number of Native Americans, behind California. Eight percent of the state's population is Native American, making it the largest ethnic group in the state. More than 263,000 Native Americans live in Oklahoma, yet there are no reservations in the state. Native Americans in Oklahoma reside in both urban and rural areas, with high concentrations in certain counties. Population estimates for 1998 indicate that nearly half of the Native American residents in Oklahoma are less than 21 years of age.

Tobacco use in Native American culture is a complex issue due to the economic implication, as well as the sacred use of tobacco. Historically, programs designed for prevention, cessation and protection do not take into account the unique

relationship between Native Americans and tobacco. Tobacco has traditional and spiritual use among Native American people. The tobacco plant is a sacred gift from the Creator, with uses specific to each tribe. This traditional aspect must be included in prevention, cessation and protection programs.

Rates of smoking among Native Americans have been substantially higher than smoking rates of any other subgroup in the U.S. In Oklahoma, this is also true. Based on data from the 2005 Behavioral Risk Factor Surveillance System (BRFSS), 29.1% of Native American adults reported current smoking, as compared to 25.0% of all adults. Previous findings revealed that Native American males in Oklahoma are nearly twice as likely to report current use of smokeless tobacco as compared to all males (19.6% versus 10.1%).

Some Native American tribes have instituted prevention, cessation and protection programs that parallel the solution as outlined in the State Plan. Due to limited resources, collaboration is in place between Universities, as well as inter-tribal cooperation.

A firm commitment to the comprehensive approach must recognize and address the spiritual aspect of tobacco in each tribe, disproportionate use by Native Americans, and the sovereignty of each Nation.

Readiness

Oklahoma is prepared to undertake these increased activities to realize the health benefits and economic savings from significantly reduced tobacco use.

Oklahoma has progressed over the past decade, laying a foundation for a cooperative effort to effectively reduce tobacco use.

Voluntary health organizations, healthcare groups, youth and education organizations, faith groups, public agencies and others have built a coalition, developing experience working together on this issue. The media have been helpful in educating the public. State government has gained experience and expertise. The State Board of Health and several private organizations have identified tobacco use reduction as a top priority. Oklahoma's new public-private Turning Point program encourages partnerships as recommended in this State Plan. Public opinion polls show strong public support.

Until recently, financial resources have been limited to foundation grants, contributions from Oklahomans (groups, businesses and individuals), and a federal grant from the CDC to assist the State Health Department. The first state funds were appropriated for fiscal year 2001. The first earnings from the Oklahoma Tobacco Settlement Endowment Trust were allocated for fiscal year 2003.

These initial, limited funds are a good start, but they represent only a small part of the needed programs recommended in this report.

The continued ramping up of state funding as recommended is essential to significantly reduce tobacco use in this state. The people and agencies are ready. Combined with the recommended policy changes, these programs can enable Oklahomans to achieve the outcomes of this State Plan.

Part III

Appendices

Appendix A: Measures & Target Outcomes

MEASURE	2001 BASELINE	2005 UPDATE	2010 TARGET OUTCOME
Prevention			
Reduce tobacco use by high school students.	Any Form: 42 percent Cigarettes: 33 percent Spit Tobacco: 13 percent Cigars: 20 percent <i>Source: 1999 Oklahoma Youth Tobacco Survey</i>	Any Form: 33 percent Cigarettes: 23 percent Spit Tobacco: 12 percent Cigars: 17 percent <i>Source: 2005 Oklahoma Youth Tobacco Survey</i>	Any Form: 21 percent Cigarettes: 16 percent Spit Tobacco: 6 percent Cigars: 10 percent
Reduce tobacco use by middle school students.	Any Form: 21 percent Cigarettes: 17 percent Spit Tobacco: 7 percent Cigars: 9 percent <i>Source: 1999 Oklahoma Youth Tobacco Survey</i>	Any Form: 15 percent Cigarettes: 10 percent Spit Tobacco: 4 percent Cigars: 5 percent <i>Source: 2005 Oklahoma Youth Tobacco Survey</i>	Any Form: 10 percent Cigarettes: 8 percent Spit Tobacco: 3 percent Cigars: 4 percent
Cessation			
Reduce annual per capita consumption of cigarettes.	108 packs per capita per year <i>Source: Oklahoma Tax Commission</i>	98 packs per capita per year <i>Source: Oklahoma Tax Commission</i>	54 packs per capita per year
Reduce cigarette smoking by adults.	All Adults: 29 percent Caucasian: 29 percent African American: 24 percent Native American: 42 percent Hispanic: 25 percent <i>Source: 2001 Oklahoma Behavioral Risk Factor Surveillance System</i>	All Adults: 25 percent Caucasian: 24 percent African American: 25 percent Native American: 29 percent Hispanic: 25 percent <i>Source: 2005 Oklahoma Behavioral Risk Factor Surveillance System</i>	12 percent among all adult population groups

Protection			
Increase the number of Oklahoma households with children that have smokefree home policies.	62 percent <i>Source: 2001 Oklahoma Behavioral Risk Factor Surveillance System</i>	77 percent <i>Source: 2005 Oklahoma Behavioral Risk Factor Surveillance System</i>	85 percent
Increase the proportion of Oklahoma adult workers reporting smokefree policies for work areas and for public areas at their worksites.	Work areas: 81 percent Public areas: 72 percent All areas: 69 percent <i>Source: 2001 Oklahoma Behavioral Risk Factor Surveillance System</i>	Work areas: 87 percent Public areas: 80 percent All areas: 77 percent <i>Source: 2005 Oklahoma Behavioral Risk Factor Surveillance System</i>	100 percent

Appendix B: Summary of Public Policy Recommendations

1. Enforce new state law to ensure that tobacco vending machines are not placed in areas accessible to minors.
2. Enforce new state law to ensure that self-service displays of tobacco products are not allowed in areas accessible to minors.
3. Prohibit all free sampling of tobacco products.
4. Require face-to-face sales only. Prohibit all internet sales of tobacco products.
5. Enforce new state law that extends the penalties for selling tobacco products to youth to apply to owners and managers, including possible temporary suspension of state tobacco licenses for repeated illegal sales at a given retail outlet.
6. Eliminate preemptive language in the Oklahoma Prevention of Youth Access to Tobacco Act so that local communities may adopt youth access ordinances stricter than the state law.
7. Eliminate preemptive language in the Oklahoma Smoking in Public Places and Indoor Workplaces Act so that local communities may adopt smoking ordinances stricter than the state law.
8. Adopt local prevention of youth access to tobacco ordinances and local clean indoor air ordinances that most effectively utilize the powers allowed by state law.
9. Extend state law to eliminate smoking in all indoor public places and workplaces.
10. Require all health insurance plans to provide coverage for tobacco cessation services and products.
11. Further increase the state excise taxes on tobacco products to continue to help reduce tobacco use among youth .
12. Continue to negotiate new state tobacco tax compacts with all tribal nations that are engaged in the sale of commercial tobacco products in Oklahoma, thereby continuing to seek collaboration to achieve needed excise tax increases in a manner that is mutually beneficial to the state and the tribal nations.

Appendix C: Qualified Programs & Funding Criteria

Qualified Tobacco Use Prevention or Cessation Programs

Programs eligible for contracts to be awarded to implement this State Plan shall include, but not be limited to:

1. Media campaigns directed to youth to prevent underage tobacco use;
2. School-based education programs to prevent youth tobacco use;
3. Community-based youth programs involving tobacco use prevention through general youth development;
4. Enforcement and administration of the Prevention of Youth Access to Tobacco Act, and related retailer education and compliance efforts;
5. Cessation programs for youth; and
6. Prevention or cessation programs for adults.

No less than 70 percent of the dollar value of the contracts awarded shall be for programs one through five.

Minimum Criteria Required for Tobacco Use Prevention or Cessation Programs

The Oklahoma State Department of Health, after recommendation by the Tobacco Use Prevention and Cessation Advisory Committee, may award monies for qualified tobacco use prevention or cessation treatment programs to contractors identified through competitive bids (Invitation to Bid process) or through proposed contracts with other government agencies. The Tobacco Use Prevention and Cessation Advisory Committee may not recommend the award of a contract unless it makes a specific finding, as to each applicant or bidder, that the program proposed to be funded is in compliance with nationally recognized guidelines, or scientific evidence of effectiveness. These guidelines and scientific findings shall include the following “sentinel” documents as well as other current documents endorsed by the U.S. Centers for Disease Control and Prevention.

1. Best Practices for Comprehensive Tobacco Control Programs, U.S. Department of Health and Human Services, Centers for Disease Control and Prevention
2. Program and Funding Guidelines for Comprehensive Local Tobacco Control Programs, National Association of County and City Health Officials
3. Treating Tobacco Use and Dependence, Clinical Practice Guideline, U.S. Department of Health and Human Services, Public Health Service
4. Reducing Tobacco Use, A Report of the Surgeon General, (2000) U.S. Department of Health and Human Services
5. Community Preventive Services Guide, Task Force on Community Preventive Services
6. Guidelines for School Health Programs to Prevent Tobacco Use and Addiction, U.S. Department of Health and Human Services, Centers for Disease Control and Prevention

In addition, the Advisory Committee will not recommend the award of a contract unless the contractor attests and assures that it will not accept funding from nor have an affiliation or contractual relationship with a tobacco company, any of its subsidiaries or parent company during the term of the contract.

Additional Considerations for Program Funding

In addition to the required criteria, the Tobacco Use Prevention and Cessation Advisory Committee will consider the following before recommending program funding:

1. In the case of media campaigns directed to youth to prevent underage tobacco use, whether the campaign provides for sound management and periodic evaluation of the campaign's relevance to the intended audience, including audience awareness of the campaign and recollection of the main message.

Whether the messages or themes of proposed media campaigns have been demonstrated to be effective in changing attitudes or beliefs related to tobacco and in reducing demand for cigarettes and/or other tobacco products among youth.

When the invitation to bid specifies that the contractor's role in the delivery of the media campaign is limited to purchasing of the airtime and related services, whether the contractor will collaborate with OSDH and/or other OSDH contractors to help ensure proper evaluation of the campaign.

2. In the case of applications or Invitations To Bid to fund school-based education programs to prevent youth tobacco use, whether there is credible evidence that the program is effective in reducing youth tobacco use. Specifically, the Committee will consider whether the program meets the U.S. Centers for Disease Control and Prevention *Guidelines for School Health Programs to Prevent Tobacco Use and Addiction*.
3. In the case of community-based youth programs involving youth tobacco use prevention through general youth development, whether the program:
 - a. has a comprehensive strategy with a clear mission and goals,
 - b. has professional leadership,
 - c. offers a diverse array of youth-centered activities in youth-accessible facilities,
 - d. is culturally sensitive, inclusive and diverse,
 - e. involves youth in the planning, delivery, and evaluation of services that affect them,
 - f. offers a positive focus including all youth, and
 - g. places emphasis on the utilization of a variety of youth-led community activities designed to expose and counteract deceptive tobacco industry marketing practices.

Regarding community coalitions, whether the activities will effectively educate and involve communities in preventing tobacco use, promoting tobacco dependence treatment, and protecting the public from exposure to secondhand tobacco smoke.

4. In the case of enforcement and administration of the Prevention of Youth Access to Tobacco Act and related retailer education and compliance efforts, whether such activities and efforts can reasonably be expected to reduce the extent to which tobacco products are available to individuals under eighteen (18) years of age.
5. In the case of youth cessation, whether there is credible evidence that the program is effective in long-term tobacco use cessation. Long-term effectiveness shall be defined as a quit rate of at least 20 percent six (6) months after the program.
6. In the case of adult programs, whether there is credible evidence that the program is effective in decreasing tobacco use. Regarding adult cessation treatment programs, whether the proposal meets the U.S. Public Health Service *Clinical Practice Guideline on Treating Tobacco Use and Dependence*.

Appendix D: Bibliography

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