# 7. Program Services: Reaching the Individual

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## Contents

## 7. Program Services: Reaching the Individual

*The three critical components of the American Stop Smoking Intervention Study (ASSIST)—mass media, policy, and program services—were highly interrelated. However, the approach to the delivery of program services was very different from the ways in which mass media and policy interventions were provided. The role of program services, as defined in ASSIST, was to guide and support individuals in making changes consistent with tobacco-free norms. Program services are usually considered individual-level interventions, whereas policy, environmental, and, at times, strategic use of the media are systems-level strategies. These latter interventions are directed at changing organizations, communities, and the society in which people live.*

*Considerable research and dissemination of evidence-based, individual-level interventions had occurred, and various organizations and health-care providers were providing services by the late 1980s. However, research findings indicated that without supportive social and physical environments, individual behavior changes and their benefits were often short-lived. Research at that time had demonstrated the effectiveness of applying policy and environmentally focused strategies to tobacco prevention and control as well as combining individual- and systems-level change interventions. Limited work had been done on disseminating evidence-based policy and environmental interventions. Work also remained to be done on building the state- and local-level capacity to deliver these interventions.*

*ASSIST planners focused on strengthening state and community capacity to implement the policy and environmental interventions needed to support individual behavior change. They determined that promoting policy change and media advocacy would have the greatest long-term impact on behavior change and that the funding of program services would be a low priority for ASSIST. The National Cancer Institute's (NCI) contracts with the states prohibited them from spending substantial funds directly on program services, but those prohibitions were not intended to diminish the importance of, or the need for, program services. The strategy was to build states' capacity to offer program services without using public funds to pay for them. Anticipating that the strategic use of media and media advocacy would result in policy development and that the implementation of policies would stimulate the need for improved and expanded individual-level services, ASSIST contractors were required to encourage, advise, and partner with appropriate community organizations to ensure that program services were provided.*

## The Challenge of Services Delivery: Setting Priorities

### Support for Individual Change

In addition to mass media and policy, the ASSIST model incorporates interventions that concentrate on individual behavior change as an essential element of a comprehensive tobacco control program. Called *program services* in ASSIST, these individual-level interventions (cessation, prevention of tobacco use initiation, and education of the general public) were defined as "smoking control activities involved directly in assisting individuals to make behavioral changes."[1(p4)]

NCI's *Standards for Comprehensive Smoking Prevention and Control*, which informed the design and planning of the ASSIST project, represented the composite of what had been learned from NCI's smoking research initiative and from other related research studies. These *Standards* define the interactions and interrelationships of the three types of interventions that are included in the ASSIST model—mass media, policy, and program services—as follows:

> The mass media and policy components of a comprehensive smoking and prevention intervention raise awareness of the smoking issue and motivate people to make changes in their behavior relative to smoking. Such efforts must be accompanied by a wide range of program services that guide and support individuals in making those changes. Most program services are delivered via the identified channels for smoking prevention and control, that is, through the health care system, worksites, schools, and community networks.[2(p27)]

ASSIST was innovative in its approach to providing program services. Whereas ASSIST staff engaged directly in media and policy intervention activities, they used indirect methods to stimulate and expand the capacity of others to do the direct delivery of the individually focused program services. This indirect approach to providing program services was supported by several factors. After years of research on individually focused tobacco control interventions, the evidence was there to guide the application of these findings.

When ASSIST was conceptualized, the effectiveness of various program services had been established, and these findings were being disseminated and implemented. As research from NCI, the National Institute on Drug Abuse (NIDA), and other researchers provided a scientific foundation for these individually focused efforts, a proliferation of programs and services developed to help people avoid tobacco use.[3–7] Tobacco cessation programs and school prevention programs were abundant. However, these interventions were resource intensive, and their benefits, when achieved, were often short-lived.[8–11] Avoiding tobacco use or maintaining a quit attempt often required a Herculean personal effort in a climate where tobacco use was glamorized in the media, championed by friends, and practiced at worksites and public places.

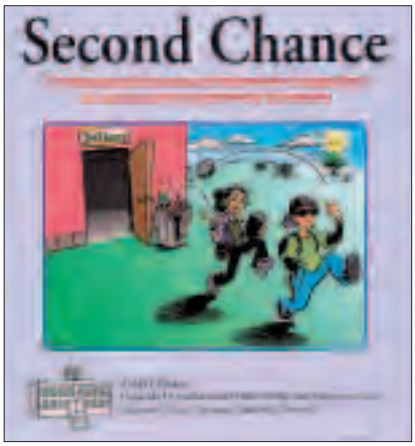
Studies demonstrated the effectiveness of policy and environmental-level changes and of combining this approach

with the individual approach.[12] This was documented in NCI monograph number 1, *Strategies to Control Tobacco Use in the United States: A Blueprint for Public Health Action in the 1990's*, on strategies to control tobacco use: "The current state of the art in combating tobacco use combines multiple environmental changes with multiple programs directed to individuals in different stages of the smoking initiation and cessation process."[9(px)]

Program services were an integral part of ASSIST's policy-based approach to tobacco prevention and control, but the emphasis had shifted from individual-level to policy- and environment-level interventions to complement the already existing capacity to deliver program services. When they received their contracts, the ASSIST awardees were instructed about the prohibition on direct funding of program services. The intent of this restriction was not to diminish the importance of program services. The goal was to increase the number of program services, monitor and ensure the quality of existing program services, and enhance their reach and effectiveness. The ASSIST objectives for program services are listed below:

> By 1998, major community groups and organizations that represent the priority populations and have broad-based statewide reach should be involved in ASSIST activities.
>
> By 1998, worksites reaching major target populations will adopt and maintain a tobacco use cessation focus.
>
> By 1998, 100 percent of all schools serving grades K through 12 will use a tested, efficacious tobacco use prevention curricula.
>
> By 1998, at least 75 percent of primary medical and dental care providers will routinely advise cessation and provide assistance and followup for all of their tobacco-using patients.[13(p3)]

*Students participate in a tobacco use prevention activity*




*Self-directed tobacco use prevention program booklet used in Colorado*

(See table 2.1 in chapter 2 for a list of all of the ASSIST program objectives.)

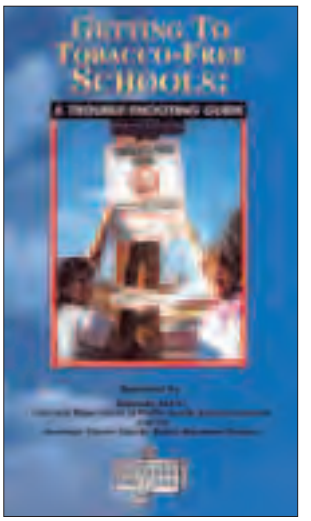
As ASSIST progressed from the planning phase to the implementation phase in 1993, the need for a transition from direct to indirect provision of program services was reiterated. Financial restrictions for program services were spelled out in detail in ASSIST training materials, including the following prohibitions:

- No funds will be provided to develop new smoking prevention, cessation, and education materials.
- No funds will be provided for labor to support the delivery of smoking prevention, cessation, or education programs.[14]

The director of the NCI ASSIST project stressed that program services were an essential component of a comprehensive tobacco control program, but he reminded state staff of the spending restrictions. He cited a checklist of imprudent use of funds on program services that included (1) duplication of services, (2) services with negligible effect, (3) services that were not the primary responsibility of ASSIST state or local staff, (4) services that were part of an unsustainable effort, and (5) updating of materials. He described specific examples of misuse of funds: (1) a media campaign encouraging smoking cessation that exceeded the cap on media spending or was not coordinated with other ASSIST activities, (2) delivery of curriculum training for large numbers of teachers that could be better accomplished by departments of education, and (3) paying for labor to staff a cessation hotline.[14]

The ASSIST funding itself, $140 million, seemed enormous at that time but would have been quickly depleted if the 17 ASSIST states were unconstrained in their use of the funds to develop and directly provide program services. The indirect approach to providing program services freed ASSIST funds to address

*A student studies material on the consequences of smoking*




*Materials and activities for tobacco-free schools in Colorado*

the gaps in policy, media, and environmental interventions that were needed for a comprehensive tobacco prevention and control program.

### The Contract

NCI's use of a contract mechanism, rather than a grant or cooperative agreement, ensured that expenditures for program services remained focused on ASSIST program goals. Instead of state-level agencies proposing their plan of action to NCI, NCI specified what was to be done, how it was to be done, and how much could be spent. States developed annual action plans within the confines of the requirements. The contract mechanism helped state program managers limit program service expenditures of their local contractors.

One reason that NCI used a contract mechanism to fund ASSIST was to help insulate program managers and other state staff from political pressures within their health departments and states. Early on, NCI staff acknowledged the politically sensitive nature of bold tobacco control interventions and the potential influence of the tobacco industry. Therefore, NCI elected to use contracts and require specific deliverables to help ensure that precious resources were not diverted to ineffective or inconsequential interventions. Once state staff became comfortable with the intent of the contract approach, they embraced this model.

This directive approach from NCI was critical to maintaining the integrity of ASSIST. The challenge was to filter these funding restrictions down to the local level. When ASSIST funds arrived in the states, there was an expectation at the local level that cessation program efforts could be expanded to draw in more smokers and pay for more staff time. That was not allowed under the contract.

The contractual restrictions for program services meant that health department staff had to partner with service providers within the communities. The ASSIST staff collaborated with organizations to promote and support existing services so that they would be prepared to meet the anticipated increase in demand for services stimulated by policy interventions and an environment where nonsmoking was becoming the norm. This was a challenge for many of the local staff and volunteers, health department contractors, and the American Cancer Society (ACS); with time and continued monitoring and support, however, the transition from direct to indirect provision of program services was realized.

## The Role of ASSIST in Service Provision

### Types of Program Services

Program services in the ASSIST project were grouped into the following three categories:

1. Smoking Education of the General Public: Education of the general public to raise individuals' awareness and shape attitudes on tobacco issues
2. Cessation: Support for smoking cessation, such as physician counseling, group cessation classes, and self-help materials

3. Prevention of Tobacco Use Initiation: Education to prevent tobacco use, such as school-based prevention curricula and parent-based interventions[1]

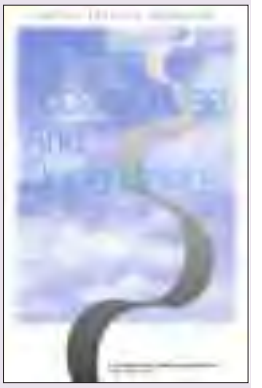
The "ASSIST Program Guidelines" specified that these three types of program services would be offered in a variety of settings, for example, in physicians' offices, outpatient clinics, workplaces, schools, and community facilities.[1] Organizations such as ACS, the American Lung Association (ALA), and the American Heart Association (AHA) each had programs designed to educate the general public about the health effects of tobacco and to provide smoking cessation classes. Smoking cessation programs were also available through hospitals, health maintenance organizations, worksite wellness programs, and many private entrepreneurs. To reduce early adoption of tobacco use, schools were enjoined to provide coordinated school health education, which included drug, alcohol, and tobacco use prevention.

For guidance on allowable activities and how ASSIST was to ensure that program services would be provided, program managers could refer to the "ASSIST Program Guidelines,"[1] which offered examples in each program service area of activities that could provide self-help materials and referral guidelines for smokers:

- Identify current resources that provide smoking cessation resources and encourage them to target priority worksites with their marketing efforts . . .
- Identify model worksites in which intensive smoking cessation activities are occurring, and promote them through business media targeted to business owners in priority industry areas.[15(pp4–5)]

Of the three types of program services, one—smoking education for the general public—could be provided directly by ASSIST staff. In addition, to ensure the provision of all program services, staff were to (1) identify existing program services, (2) increase capacity for

**Treating Tobacco Use and Dependence**



The Public Health Service guideline *Treating Tobacco Use and Dependence* presents strategies for providing appropriate treatments for current and former tobacco users. The guidelines were designed to assist clinicians and smoking cessation specialists, as well as health-care administrators, insurers, and purchasers in identifying and assessing tobacco users and in delivering effective tobacco dependence interventions. The guidelines were based on an exhaustive systematic review and analysis of the scientific literature from 1975 to 1999 and included more than 50 meta-analyses.

*Source:* Fiore, M. C., W. C. Bailey, S. J. Cohen, S. F. Dorfman, M. G. Goldstein, E. R. Gritz, R. B. Heyman, et al. 2000. *Treating tobacco use and dependence. A clinical practice guideline.* Rockville, MD: U.S. Department of Health and Human Services, Public Health Service. www.surgeongeneral.gov/tobacco/treating_tobacco_use.pdf

services delivery, and (3) identify and market science-based program services.[16] Each activity is elaborated on below.

## Identification of Existing Program Services

All states conducted a site analysis. The 1991 "ASSIST Program Guidelines" directed staff to analyze the target populations, identify channels for reaching those populations, ascertain existing tobacco control resources (including policy and media initiatives and existing program services), and identify the site's potential resource capability.[16]

These site analyses yielded specific quantitative information on the availability of program services. Those data proved very useful for the ASSIST planners and also formed the basis for community resource guides that were developed in most states. Excerpts from South Carolina and Wisconsin's site analyses are presented in a sidebar on page 292.

## Increase in Capacity for Services Delivery

The passage below from the "ASSIST Program Guidelines" illustrates the intent of the ASSIST planners to stimulate increased program services capacity:

> The intent of ASSIST is not to create a new institution devoted to smoking control but rather to increase the capacity for existing groups and organizations to sustain and enhance their role as smoking control agents beyond the life of ASSIST.[17(p2)]

ASSIST staff were to identify groups whose memberships and constituencies were likely to contain smokers targeted by ASSIST and to help those groups become smoking cessation agents.[18] The ASSIST states used a variety of strategies to support the development of prevention and cessation program services, such as train-the-trainer programs, the development of materials, and awareness days to attract attention to cessation programs. Illustrative activities in Virginia and Missouri are described below:

- **Virginia.** Seven training workshops were held in Virginia for health-care providers and substance abuse treatment counselors. Topics ranged from nicotine addiction to developing and implementing a smoke-free policy for treatment facilities. The state certification board for substance abuse counselors adopted a policy requiring that anyone applying for recertification undergo 6 hours of training on the theory and treatment of nicotine addiction. In addition, 35 coordinators of a mentoring program for pregnant and parenting teens were trained in a smoking-cessation protocol.
- **Missouri.** Presentations on prevention of tobacco use, delivered in Missouri schools, focused on the health hazards of tobacco use. More than 1,108 sixth graders were reached. In addition, more than 80 teachers and counselors received training from two local coalitions concerning instruction on prevention of tobacco use.[19]

Case study 7.1 illustrates the benefits of an assessment of the North Carolina Safe and Drug-Free Schools Program. The assessment data revealed significant shortcomings, and dissemination of

**Program Services Identified through Site Analysis Data**

**South Carolina**

- ALA has 72 trained facilitators working in the Freedom From Smoking program. In 1991, participants in the program included 1,500 people in 120 worksites.
- AHA's Heart at Work program has a smoking cessation module that includes the Calling It Quits kit. During 1991–92, this kit was used by 9,000 employees from 36 companies. AHA also has a peer-oriented smoking intervention program for middle and high school students, called Save a Sweet Heart, which served 6,894 students in 41 schools in the state during the 1991–92 school year.
- During 1991, 68% of the 421 participating elementary schools were involved in the Smoke-Free Class of 2000 tobacco use prevention program, with 51,180 students participating.
- NCI offers a train-the-trainer program to provide smoking cessation training for physicians. This program is used only for training residents in Preventive and Family Medicine programs at the University of South Carolina School of Medicine.

**Wisconsin**

- Most cessation programs offered are modules that were developed by ACS, ALA, or AHA. Eighty-one percent of hospitals offer tobacco cessation programs at their facilities.
- Programs related to tobacco or smoking are offered by 85% of local public health agencies. Counseling about the health risks of smoking is offered by 82% of these agencies, group smoking cessation is offered by 21%, and referrals to smoking cessation programs are offered by 70%.
- Both ACS and ALA offer worksite smoking cessation programs. In 1990, ALA helped 300 companies with 30,000 employees develop and implement smoking policies and cessation programs.
- According to a survey of 541 schools that was conducted in April 1990, 93% of those surveyed offered smoking prevention or cessation programs during the previous year.
- During ACS's 1989–90 Fresh Start smoking cessation programs, 7,840 smokers participated and 37% remained smoke-free 1 year later.

*Sources:* Center for Health Promotion, South Carolina Department of Health and Environmental Control. *South Carolina Project ASSIST. Site Analysis.* Contract Number N01-CN-15382. October 1, 1992. Columbia: South Carolina Department of Health and Environmental Control; Wisconsin Department of Health, Tobacco-Free Wisconsin Coalition. *ASSIST Wisconsin Project: Site Analysis Report.* October 1, 1992. Milwaukee: Wisconsin Department of Health.

those results led to increased demand for more effective tobacco-free school policies and increased capacity for delivering direct program services.

The focus of tobacco control efforts on groups likely to contain targeted smokers is illustrated by case study 7.2. The Mother's Stress Management Task Force in Massachusetts involved a number of groups that work with low-income women in workshops that offered stress management techniques as an alternative to smoking. Those groups had little previous involvement in tobacco control, and this initiative is a case in which new capacity was created in program services.

### Case Study 7.1
### Helping Schools Shift to a Tobacco-Free Norm in North Carolina

**Situation:** The 1994 Pro-Children Act (20 USC 6083) included restrictions on smoking inside all school facilities for any school accepting federal funding. Assessment of data collected by ASSIST staff and coordinators of the Safe and Drug-Free Schools Program in 90 of the 122 North Carolina (NC) school districts showed that all districts restricted tobacco use by students and that 95% of them restricted tobacco use by employees—both requirements of the Pro-Children Act. Most policies were not comprehensive, and in a few cases, the policies were not fully in compliance with the federal law. Most student policies did not address enforcement procedures. Of those that did, most used out-of-school suspension as the penalty. Coordinators of the Safe and Drug-Free Schools programs expressed an interest in alternatives to suspension programs. Working with the NC Department of Public Instruction, ASSIST informed school districts about the results of the assessment; this disclosure resulted in (1) an increased demand for technical assistance with developing and enforcing tobacco-free school policies and (2) the opportunity to expand program services, as described below.

**Program Services Provided:** A new partner was brought into the effort—the dropout prevention and substance abuse prevention staff at the NC Department of Public Instruction.

Together, the ASSIST Schools Task Force, ASSIST staff, and NC Department of Public Instruction staff proposed a plan that included the following three elements:

1. A four-session educational alternative to suspension for student violators
2. A tobacco-cessation program for youths
3. A variety of promotions to encourage a tobacco-free norm

As a result of publicizing and implementing this plan, the task force gained new volunteers from the schools and expanded tobacco use prevention education and tobacco cessation program services. A local coalition piloted activities in one of its high schools to learn more about what approaches improve enforcement.

ASSIST developed *Tobacco Free Schools in North Carolina: A Handbook for School Administrators*. The handbook educated school administrators regarding model policies on tobacco use and appropriate implementation of those policies. The North Carolina School Boards Administration also distributed to their districts a strong model policy on tobacco use.

Working with a pilot school in Charlotte, North Carolina, ASSIST was able to broaden the handbook to include the following three components:

1. An educational alternative to suspension for students caught violating the school's tobacco use policy

2. Sample activities for the prevention and control of tobacco use
3. A reference to Tobacco-Free Teens, a voluntary cessation class developed by the American Lung Association of Minnesota

When the manual was complete, 10 high schools across North Carolina were recruited to pilot this tobacco-free schools program. As more schools instituted and then enforced tobacco-free school policies, the demand for model policies, enforcement strategies, tobacco use prevention education, and cessation services grew. Working with the NC Department of Public Instruction, ASSIST used the manual on tobacco-free schools that had been pilot-tested and began offering regional training events to school districts interested in creating tobacco-free school environments.

*— Melissa Albuquerque, former ASSIST Field Director for North Carolina and Program Consultant, Office on Smoking and Health, CDC*

*Sources:* Adapted from T. Enright Patterson and G. Davenport-Cook. 1997. Helping schools shift to a tobacco-free norm. In *Entering a new dimension: A national conference on tobacco and health* (Case studies, September 22–24, 1997). Rockville, MD: ASSIST Coordinating Center. 209–10; 1994 Pro-Children Act. 20 U.S. Code 6083.

## Identification and Marketing of Evidence-based Program Services

Effectively marketing existing prevention and cessation services that had been proven to be effective was an important strategy, as cited in the "ASSIST Program Guidelines." In the mass media section of the guidelines, one objective related to the marketing of cessation services was to "provide critical information to smokers about the effectiveness and availability of cessation services."[17(p2)]

The "ASSIST Program Guidelines" suggested that communities use information gleaned in their site analysis to compile a resource guide to cessation services. Many such resource guides had been developed by the end of ASSIST,[16] and these guides were important for marketing program services.

Successful marketing also occurred in Michigan where a smoking cessation hotline was set up for Medicaid recipients. Case study 7.3 describes how Michigan established and marketed cessation programs that were needed as a result of a policy that mandated coverage of cessation services for the Medicaid population.

As illustrated in case study 7.4, Colorado's new tobacco-free schools law prompted a number of public and private organizations to sponsor and promote tobacco cessation programs for teens.

The effectiveness of physician counseling of smokers to quit, coupled with structured follow-up, was cited in the "ASSIST Program Guidelines": "When advice is coupled with structured follow-up programs and/or pharmacologic agents, cessation rates of 18 to 27 percent

### Case Study 7.2
### Diapers, Dishes, and Deep Breathing: Stress Management and Smoking Cessation for Low-income Mothers in Massachusetts

**Situation:** The Tobacco-Free Greater Franklin County Coalition in Massachusetts convened the Mother's Stress Management Task Force in 1995. By using stress management techniques taught in pilot workshops, the task force sought to offer low-income mothers concrete alternatives to smoking. All area providers who served low-income women and their families were invited to participate in the task force. Representatives from Head Start, adult literacy programs, a family planning agency, a community college, and other organizations met monthly to plan the intervention. Many of these organizations were only peripherally involved in tobacco control before the creation of the task force; this intervention helped to institutionalize tobacco control as a permanent program component in many agencies.

**Program Services Provided:** A curriculum was made available to agencies working with low-income women (including literacy programs, homeless shelters, and other tobacco control programs) and to partners with local coalitions. With state funds from the Massachusetts Department of Public Health, the coalition hired a part-time substance abuse counselor for the position of stress management specialist. Based on the curriculum "Diapers, Dishes, and Deep Breathing," 4- and 5-week workshops were offered regularly to clients in various settings to teach coping skills, develop individual stress management plans, and motivate smoking cessation attempts. The workshops used a harm-reduction model, encouraging women to reduce smoking if they were not ready to quit.

A 3-week workshop series was piloted in four areas of the county; thus it was accessible to nearly all of the region's rural residents. Food, childcare, and transportation were offered to participants. The pilot workshops were advertised through newspapers, local radio stations, and human service agencies. Each session was 2 hours long and was facilitated by two task force members. The workshops were conducted at local agencies, libraries, and schools—familiar locations in which the women would be comfortable.

Task force members subsequently developed the curriculum "Diapers, Dishes, and Deep Breathing." A fourth week was added to the curriculum to give participants more time to support each other and to share experiences. Another session was added on creating personal stress-reduction action plans. With a grant from the Massachusetts Department of Public Health, the curriculum was made available to the general public and to agencies working with low-income women. The curriculum has been distributed to more than 20 literacy programs for use in adult education classes.

*Source:* Jerome, K. 1998. Diapers, dishes, and deep breathing: Stress management and smoking cessation for low income mothers. In *No more lies: Truth and the consequences for tobacco*. (Case studies at the Fourth Annual National Conference on Tobacco and Health, October 26–28, 1998.) Rockville, MD: ASSIST Coordinating Center. 87–92.

### Case Study 7.3
### Smoking Cessation Quitline for Michigan Medicaid Recipients

**Situation:** Successful policy advocacy efforts by ASSIST resulted in coverage for all Michigan Medicaid patients, beginning in 1997, for nicotine patches, gum, and Zyban.

**Program Services Provided:** Concern about the availability and promotion of smoking-cessation services and information for Medicaid clients led to the development of a free smoking cessation counseling service by telephone for Medicaid patients. This service was funded by the Michigan State Health Department's Tobacco Program. Partners included Michigan State University and the Michigan Public Health Institute.

As often happens with these types of programs, it took a couple of years to find a contractor, negotiate a contract, and get the quitline up and running; it ran from January 2000 through December 2002. During that time, 1,785 clients were served by the quitline, and quit rates ranged from 10% to 30%. Six 15-minute counseling sessions and two 5-minute follow-up sessions were offered. The sessions were based on modules that follow the Agency for Health Care Policy and Research (now known as the Agency for Healthcare Research and Policy) guidelines. Nine health plans in Michigan referred Medicaid clients who were smokers to this service. Many were self-referred after seeing the quitline number. The quitline was also promoted by periodic mailings to Medicaid clients. Quit kits were sent to each participant, and individual pharmacies and physicians were notified via fax of the participants' enrollment in the program. Although this particular quitline was defunded, another statewide quitline that Medicaid clients may access has since been initiated (with CDC and American Legacy funds).

*—Mikelle Robinson, former Project Manager, and John K. Beasley, former Project Director, Michigan Department of Public Health, and currently with the Tobacco Section of the Michigan Department of Health and the Michigan Public Health Initiative, respectively*

*Sources:* The Smoking Cessation Clinical Practice Panel and Staff. 1996. The Agency for Health Care Policy and Research smoking and cessation clinical practice guideline. *Journal of the American Medical Association* 275 (16): 1270–80; Fiore, M. C., W. C. Bailey, S. J. Cohen, S. F. Dorfman, M. G. Goldstein, E. R. Gritz, R. B. Heyman, et al. 2000. *Treating tobacco use and dependence. A clinical practice guideline.* Rockville, MD: U.S. Department of Health and Human Services, Public Health Service. www.surgeongeneral.gov/tobaccotreating_tobacco_use.pdf.

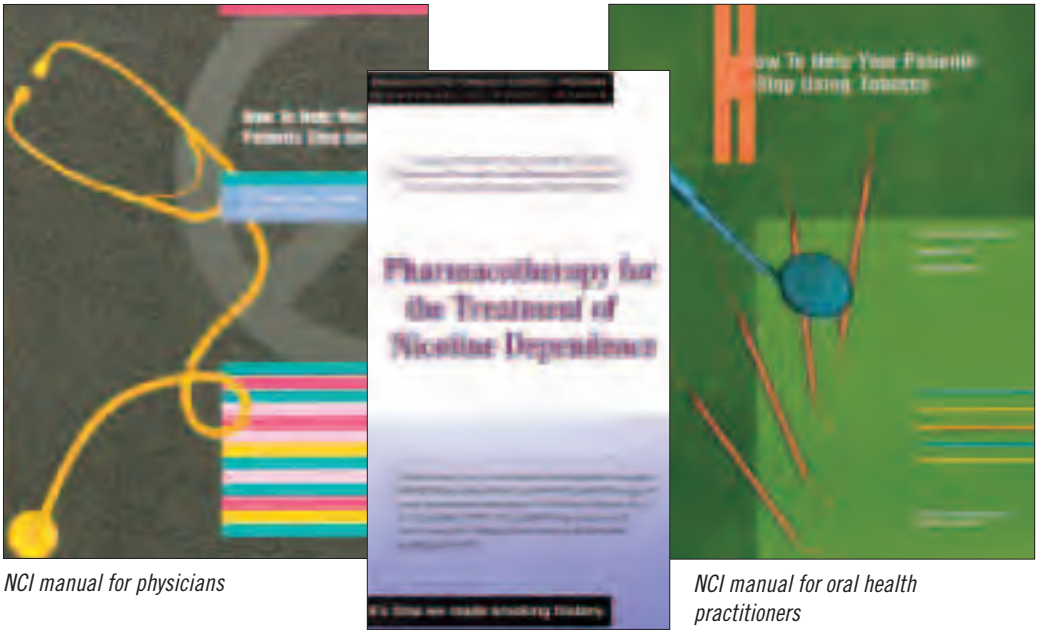
### Case Study 7.4
### Colorado Tobacco-Free Schools Law Creates Demand for Cessation and Prevention Programs

**Situation:** In 1994, the Colorado State Legislature passed the state's first tobacco-free schools law (Statute 25-14-103.5), prohibiting the use of all tobacco products on school property by students, teachers, staff, and visitors, and requiring enforcement of the policy. Between 1994 and 1995, the percentage of school districts reporting tobacco-free status increased from 51% to 76%, and by 1999, 84% were tobacco free. The increased number of smoke-free environments in the tobacco-free schools produced an immediate increase in the demand for youth cessation programs, to which community organizations responded.

**Program Services Provided:** Inquiries about cessation programs were often directed to the ALA, which had just launched a new drive to train educators to facilitate a program for youth on cessation of tobacco use. The Colorado State Department of Education offered additional financial support to any alternative high school willing to provide a tobacco use cessation program for its students. In addition to ALA's statewide efforts to provide youths with a tobacco cessation program, Kaiser Permanente in Denver sponsored a drop-in tobacco cessation support group for teens. Throughout the state, local administrators and teachers provided imaginative cessation programs (e.g., a 2-day retreat to a mountain camp and a nonsmoker's running group in which members received a new pair of running shoes).

The demand also rose for information and training on evidence-based programs on prevention of tobacco use. A local education training organization, the Rocky Mountain Center for Health Promotion and Education, took the opportunity to begin delivering teacher training programs on tobacco prevention. New alliances were formed. ASSIST staff worked closely with the state's school nurse consultant to provide training to school nurses statewide on teens and tobacco use. Staff also made annual appearances at statewide conferences for principals and school board members. Local ASSIST staff actively engaged area school administrators to help with implementation. The Colorado State Board of Health requested regular briefings on the status of tobacco-free schools in the state and gave certificates of merit to those districts that were tobacco free.

*—Jane Pritzl, former ASSIST Field Director, Colorado Department of Public Health and Environment, and current Intervention Scientist, Division of Adolescent and School Health, CDC*




*NCI manual for physicians*

*Massachusetts Department of Health brochure*

*NCI manual for oral health practitioners*

have been reported."[20(p1)] State ASSIST staff were encouraged to identify and train other health-care practitioners, such as public and occupational health nurses, dental hygienists, and pharmacists to conduct such interventions.[20] The "ASSIST Program Guidelines" also promoted the identification and training of individuals not in health-care roles who could deliver brief interventions supporting smoking cessation. Cessation aids such as print, video, or audio products as well as cessation materials tailored to the needs of a specific priority population (e.g., students) could be used by existing coalitions, organizations, agencies, community groups, and individuals who had access to the education community. This referral to cessation services through a cessation directory is another example of the marketing of proven program services during ASSIST.[21] The North Carolina experience described below is illustrative of ASSIST training of health-care practitioners in cessation counseling.

- **North Carolina.** North Carolina focused cessation efforts on pregnant women and developed an award-winning program, "Counseling Women Who Smoke," designed to meet the needs of practitioners working with pregnant women. Between 1995 and 1998, 557 North Carolina health-care providers were trained in the program, and several local communities formed Smoke-Free Baby clubs to supplement the program. In 1998, the American College of Obstetricians and Gynecologists chose this program as one of the best in the nation and disseminated a module based on it. The

Women's Health Branch of the North Carolina Division of Public Health now requires cessation counseling and referral to be implemented in its contracts with 87 local health departments.

## Smoking Education for the General Public

Tobacco use affects everyone. It affects those who do not use tobacco products through exposure to environmental tobacco smoke, increased health-care costs, and loss of family or friends. It affects tobacco users directly by damaging their personal health. Education programs that reach the public with information about tobacco use can help individuals make informed decisions about quitting or not initiating tobacco use. Effective programs reinforce social attitudes that support a tobacco-free norm. Ideally, a tobacco use prevention education program is directed to a defined population and is sensitive to the social, economic, and cultural issues affecting that population. ASSIST planners made public education about the hazards of tobacco a required component, but the NCI "Standards for Comprehensive Smoking Prevention and Control" specified that such public education support "overall smoking prevention and control goals."[2(p32)]

State health department staff conducted educational workshops for policymakers. At these workshops, policymakers could learn about the negative health effects of environmental tobacco smoke, the benefits of policy change in reducing tobacco use, and ways to draft and implement effective changes in policy. (See chapter 4 for a discussion of ASSIST tobacco use prevention education activities that were encouraged for each channel.) Examples are presented below:

- **West Virginia.** West Virginia disseminated 270,000 "Through With Chew" campaign inserts to all weekly newspapers in the state, and 66,000 inserts were delivered to all elementary and middle schools for distribution to second, fourth, and seventh graders. Print and radio media publicized events and information regarding the "Through With Chew" campaign.[19]
- **Wisconsin.** At least five local coalitions conducted media advocacy to alert the public to the impacts of tobacco advertising. Specific media activities included running editorials in newspapers, sending letters to the editor, placing articles on tobacco in seven monthly tribal publications, providing news releases, and developing a counteradvertising billboard in cooperation with a parents' program.[19]

In 1993, when Denver passed a clean indoor air ordinance that affected all businesses with more than 5 employees and all restaurants with seating for more than 25 patrons, there was a need for organizations to conduct outreach to businesses by offering tobacco use prevention education in the workplace. State and local health departments worked with local employers' councils to help businesses implement this new ordinance, thus creating new capacity with these new workplace education programs. This aspect of the Colorado experience is described in case study 7.5.

The experience of the University of Maine at Farmington, described in case study 7.6, demonstrates that once a policy has been implemented, educating the affected individuals about the policy is a prerequisite to their accepting it and complying with it. At the University of Maine, when a policy was implemented requiring a smoke-free campus within 5 years, students provided educational services campus-wide to explain the policy and to promote adherence to it.

ASSIST identified specific high-risk populations as priority populations (adolescents, ethnic minorities, blue-collar workers, unemployed people, and women), and the states' partners designed many of their activities to serve those populations. Examples of such activities are described below.

- **Massachusetts.** Massachusetts launched an advertising campaign about smoke-free homes to increase awareness among the general public (especially adults and African Americans) about the harmful effects of secondhand smoke. Promotional materials for the campaign were provided to local programs. Newspaper ads, "swiss cheese" press releases, and a guide for local media outlets were also created.
- **New Mexico.** New Mexico conducted focus groups with Vietnamese men to ensure that a trainer's cessation program would be culturally appropriate for this population. Workshops, conducted in Vietnamese, were attended by six Vietnamese smokers, who were recruited via flyers inserted into a regional Vietnamese newspaper. Two Vietnamese men interested in becoming smoking cessation facilitators in their community completed their training. In another effort, train-the-trainer sessions were conducted to prepare 23 community members throughout the state to offer youth smoking cessation programs.
- **Washington State.** Training for smoking-cessation counseling, using the NCI "4 A's" of patient counseling about smoking—namely, Ask, Advise, Assist, and Arrange—took place in Washington State with an emphasis on underserved populations, including American Indians and farm workers. As part of World No Tobacco Day, King County purchased a full-page no-smoking advertisement in the *Seattle Times* that included a request form for a smoking-cessation guide and a smoke-free restaurant guide. Several hundred requests for the free materials were received.[19]

## Interaction between Policy and Program Services

The interaction between policy and program services can be self-perpetuating. Program services such as smoking education of the general public can facilitate policy development, and policy implementation can stimulate an increase in program services. An example is the federal Synar Amendment, which requires states to enact and enforce youth access laws or risk forfeiture of block grants for substance abuse prevention and treatment. Efforts to comply with the Synar Amendment stimulated demand for program services, particularly for educating store owners regarding

### Case Study 7.5
### Employers: "Anybody Going to Tell Us What's Going On?"

**Situation:** In Denver, Colorado, the 1993 clean indoor air ordinance was passed without provisions for communication about or enforcement of the ordinance. Advocates hoped that media coverage of the ordinance would help businesses understand how the new law applied to them, but calls to state and local health agencies made it clear that the ordinance was not well understood. The city needed additional resources to successfully implement the ordinance.

**Program Services Provided:** Colorado ASSIST partnered with the City of Denver's local health department to disseminate the ordinance to businesses, to help provide business leaders with technical assistance on implementation, and to develop a training workshop to help Denver businesses and other employers throughout the state comply with the ordinance.

The local and state health departments collaborated on the production of a brochure to educate Denver businesses about the new law. The brochure was intended to provide initial notification about the law and to provide opportunities for follow-up. One panel of the flyer was a query/mailer asking employers to describe the policy that they intended to implement (100% smoke free or a designated smoking area within the limits of the law). It also invited them to request additional information and assistance. Initially, more than 5,000 brochures were mailed. The large number of employers who returned the tear sheet provided the city with policy information and an organized method for dealing with questions. After the first year, the local health department took over the printing and distribution of the brochure. The brochure became part of the application packet for a business license sent to any business new to Denver and was used by both the Metro Chamber of Commerce and the Small Business Administration.

For more intensive assistance, the private Denver-based Mountain States Employers Council (MSEC) volunteered a training staff and the use of their training facility to present workshops on the new Denver clean indoor air ordinance and associated workplace issues. The organization's legal staff taught a section on the legal implications of not providing a smoke-free workplace, and staff from the Colorado ASSIST Tobacco Control Program taught about the health issues and ways to support employees making the transition to a smoke-free workplace.

Multiple training sessions were held successfully in Denver, and the MSEC decided to disseminate the workshop regionally for business members in other parts of the state. In subsequent programs, they provided urban and rural employers with discussions on tobacco restrictions in their regions and encouraged them to put policies in place. The alliance between the ASSIST state staff, the Denver City and County health department staff, and the MSEC proved to be useful beyond these training

***Case Study 7.5 (continued)***

workshops. When other issues arose, such as clean indoor air ordinances and workplace smoking policies, pro bono legal guidance was often provided to ASSIST staff by MSEC for the price of a phone call.

After the first rush was over, the Denver Department of Public Health took all complaints about compliance; conducted all investigations; and provided technical assistance to hotels, restaurants, and other employers in making the law a success.

*—Jane Pritzl, former ASSIST Field Director, Colorado Department of Public Health and Environment, and current Intervention Scientist, Division of Adolescent and School Health, CDC*

**Case Study 7.6**
**Clearing the Smoke at the University of Maine**

**Situation:** A 1987 smoke-free policy that prohibited smoking within all institutional buildings at the University of Maine at Farmington (UMF) was replaced in the 1998–99 academic year by a new policy that outlined a 5-year plan progressing toward an entirely smoke-free campus. UMF was awarded an $80,000 grant by the Partnership for Tobacco-Free Maine, the state ASSIST coalition, to implement the policy on campus.

**Services Provided:** To make a smoke-free policy acceptable, the Tobacco-Free Maine project at UMF focused on two goals:

1. Ensure that information provided by students and faculty about tobacco issues would be uniform and accurate
2. Support student efforts to address their concerns about tobacco use on campus

To identify opportunities for integrating media presentations on tobacco control issues into the undergraduate curriculum, students first conducted a survey of course syllabi and content and then distributed information to the faculty.

In addition, a broad-based media campaign was essential for a successful campus dialogue about the effects of tobacco and secondhand smoke. Developed in a senior-level course on health education planning, the following five projects served as a campus-wide media campaign:

1. A Second Annual Health Beaver 5K walk/run, with a smoke-free theme—"Catch the Fever: Be a Smoke-free Beaver"
2. *The Art of Being Smoke-Free*—an exhibit showing the artist's idea of how tobacco affects the life of the entire community, coupled with a modern dance piece

entitled "Death with Smoking," which portrayed the personal effects of tobacco on youths
3. Females Against Secondhand Smoke and Tobacco (FASS/T)—a multimedia campaign spread broadly across the campus with the message "Tobacco Is Killing ME" (Maine), especially focusing on college women and factors that predispose them toward smoking
4. No Butts About It—a community gathering about tobacco use cessation services
5. Kickin Butts—a dissemination of smoking cessation media materials on the availability of local cessation services for smokers in the college population

The undergraduate curriculum initiative proved practical and timely, as the five media projects collectively served as a catalyst in shifting the social climate toward acceptance of a tobacco-free culture.

One first-year student testified to the effectiveness of the program:

"A while back, when I finally decided to quit for the sixth and final time, a good friend named June gave me a Quit Kit. The kit is put out by the Partnership for a Tobacco-Free Maine. In it there are flyers, articles, and reasons for quitting. Surprising enough many of the reasons in the kit were some of the same reasons I have. Some are: I want to feel better about myself, I want to quit coughing that sick mucus up, and I want to get back into sports. I want to take a second and thank June for all her support. She has been my new 'Saving Grace.'" (Stephen Akeley, May 4, 1999)

*Source:* Adapted from G. L. Bryant and L. Gamble. 1999. Clearing the smoke on campus: Policy change through grassroots advocacy. In *Tobacco-free future: Shining the light* (Case Studies of the Fifth Annual National Conference on Tobacco and Health, August 23–25, 1999). Rockville, MD: ASSIST Coordinating Center, 23–8.

enforcement strategies. In turn, these efforts motivated additional policy changes that would further limit youth access to tobacco products. This effect—whereby policy change and demand for program services stimulate each other—was a common phenomenon during ASSIST. (See case study 7.7.)

The relationship between policy and program services can be seen readily in school settings, particularly in schools with tobacco-free policies. In Colorado, school districts were governed by the state's Tobacco-Free Schools Law. This policy included a loophole, however, that allowed school boards to exempt any school or school property if "extraordinary circumstances exist" that warrant an exception. Hence, the state policy essentially allowed for voluntary implementation. Because of voluntary efforts of schools to implement the state's tobacco-free policy, coupled with assistance and materials provided from Colorado ASSIST to schools, the demand for prevention and cessation programs grew.[22] The wide array of program services that were developed to

### Case Study 7.7
### Strengthening the Enforcement of the Youth Access Law in North Carolina

**Situation:** The Synar Amendment, a component of the Alcohol, Drug Abuse and Mental Health Administration Reorganization Act of 1992, requires each state to conduct specific activities to reduce youth access to tobacco products. States were required to "enforce the youth access law in a manner that can reasonably be expected to reduce the extent to which tobacco products are available to individuals under age 18."

**Program Services Provided:** NC ASSIST worked collaboratively with the NC Substance Abuse Services Section and other partners on six major actions to reduce tobacco sales to minors:

1. Educate state and local law enforcement officers on the federal Synar Amendment, state law, and model enforcement strategies. Training programs were conducted across the state and were tailored to motivate and strengthen enforcement efforts of the state's youth access to tobacco law. ASSIST staff conducted 1-day regional training sessions that reached more than 500 state and local officers. Enforcement checks were made by minors attempting to buy cigarettes; the results were reported in the media and conveyed how easy it was for the minors to buy cigarettes. The initial buy rate was 64%. Voluntary health agencies, ASSIST coalition members, and state and local law enforcement officers began a 2-year process to educate community and state decision makers, including the attorney general and the governor, about the importance of enforcing the youth access law.
2. Collaborate with key state and local partners to strengthen the state's youth access to tobacco law. Key voluntary agencies, law enforcement, and youth advocates worked with the NC Attorney General and key legislators during the 1997 legislative session of the NC General Assembly. The efforts resulted in important legislation that greatly strengthened the law, effective December 1, 1997.
3. Work with the governor's office on an executive order to create a designated statewide enforcement agency. In 1997, the governor signed Executive Order 123 designating the NC Division of Alcohol Law Enforcement (ALE) as the lead state agency to implement model merchant education and enforcement of the state's youth access to tobacco law.
4. Create a Governor's Interagency Workgroup on Reducing Tobacco Sales to Minors. Executive Order 123 also established a Governor's Interagency Workgroup on Reducing Youth Access to Tobacco Products.
5. Obtain a contract with the U.S. Food and Drug Administration to enforce the federal youth access to tobacco rules. The contract funded ALE to conduct 400

compliance checks per month to enforce the federal Food and Drug Administration rules and the state law.

6. Educate merchants about tobacco and the youth access law. To improve compliance, the governor's office called a meeting of the retail merchants statewide whose compliance with the law was low. Local ASSIST coalitions engaged youths and adults in retailer education regarding the new state youth access to tobacco law. One model merchant education program was conducted by UJIMA—an African American youth leadership initiative created through ASSIST. The NC Department of Health and Human Services designed and distributed merchant education materials across the state.

Since 1997, combined enforcement and educational efforts have reduced the rate at which minors can purchase tobacco products from 50% in 1996 to 19% in 2001. This reduction in sales to minors exceeded North Carolina's established Synar targets for compliance. Health and Wellness Trust Fund Commission resources from the Master Settlement Agreement have been allocated to ALE to enforce the access to tobacco laws in 2002–2005.

*—Jim D. Martin, former ASSIST Field Director and currently with the North Carolina Department of Health and Human Services*

support tobacco-free school policies ultimately contributed to the passage of the tobacco-free schools legislation. This example illustrates how program services can complete the cycle by stimulating demand for policy change.

## Strength in Comprehensiveness

Comprehensive tobacco control programs include a multifaceted approach to the community's needs. The combined media, policy, and program services interventions address the critical issues of raising consciousness of the problem, motivating the community to take action, presenting the solutions in the strongest light to garner support from policymakers, and meeting the needs of individuals and communities once policies are in place. The strong focus of ASSIST on policy interventions stimulated others to provide program services and to develop capacity. Service programs were generated by private vendors, nonprofit organizations, schools, and government organizations. Program development and delivery often brought together these diverse entities as partners. Ultimately, the policy focus helped to strengthen community linkages and infrastructures that made it possible to create a national tobacco prevention and control program. Those strengthened linkages also made it possible for ASSIST state personnel and top federal government officials to maintain the integrity of the program. They did this

while the tobacco industry aggressively sought to interfere with ASSIST and the public health policies toward which ASSIST personnel were working, as described in chapter 8.

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## Additional Resources

Program Services Case Studies:

1. Minnesota—Reducing Tobacco Use Among Teenagers Through a Comprehensive Tobacco Control Program. www.healthierus.gov/steps/summit/prevportfolio/programs/tobacco.htm#minnesota.
2. Nebraska—Implementing a Comprehensive Tobacco Control Program to Reduce Tobacco Use. www.healthierus.gov/steps/summit/prevportfolio/programs/tobacco.htm#nebraska.
3. Oregon—Reaching Target Groups With High Rates of Tobacco Use Through Comprehensive Tobacco Control: A Policy-Based Approach. www.healthierus.gov/steps/summit/prevportfolio/programs/tobacco.htm#oregon.
4. Washington State—Identifying and Eliminating Disparities in Tobacco Use Through a Cross-Cultural Workshop. www.healthierus.gov/steps/summit/prevportfolio/programs/tobacco.htm#washington.
5. Achievements in Tobacco Cessation: Case Studies. June 2000. U.S. Public Health Service. www.surgeongeneral.gov/tobacco/smcasest.htm.