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10064 SENATE HEALTH EDUCATION & SOCIAL SERVICES

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Supplant the cigarettes

Officials from several states squeezed an immense settlement from tobacco companies last year using a cost argument. It costs government to treat people with tobacco ailments, the officials said, so government has a right to collect. Pay up, they told the tobacco companies, or we will pursue you as far as our courts can carry us. The companies paid.

Now the states, including Alaska, must decide what to do with the money. The honorable thing would be to spend a substantial chunk on an anti-tobacco campaign. If the state is so concerned about how much tobacco is costing our society that it will coerce millions from the tobacco companies, then the state ought to use that coerced money to reduce tobacco's use.

After all, that was the real goal of all this legal maneuvering, right? Let's stick to it.

The state of Alaska expects to receive a staggering $669 million from the settlement during the next 25 years. That's about $26 million a year on average.

Few in Juneau seem interested in applying any substantial chunk of this money to solving the problem, though. Legislators have proposed no increase in spending on tobacco education. The governor asked for $3 million.

A coalition of anti-smoking groups has created a plan that would spend about $8 million. They developed the plan by looking at what has worked in other states. It's a credible proposal and deserves support.

Of course, one can argue that the state could reasonably apply the tobacco money elsewhere in the budget. For example, it could help offset the increases in Medicaid spending. Some of those increases are presumably related to smoking (although some studies have concluded that the government's overall health care costs are actually reduced by smoking because smokers die sooner and faster).

But Medicaid just deals with the end result. If we were so concerned about smoking that we forced tobacco companies to pay government penalties, then we ought to make sure our government spends those penalties in a way that discourages that behavior. Anything less gives the government a bizarre financial interest in the continuance of such behavior.

Let's put our money where our mouths are. The dollars will supplant a few cigarettes.

To: Alaska legislators

From: Citizens To Protect Kids from Tobacco

(Cancer Society
Heart Association
Lung Association
AK Native Health Board)

FY 1

Healthwise *continued*

Because Zyban carries a slight (one in 1,000) risk of seizures, Harvard Vanguard's Adelman prefers starting patients off with a nicotine patch. But for smokers who find they crave the ritual and hand-to-mouth activity of smoking, nicotine gum, the inhaler or nasal spray may work better, he says. The nasal spray gets nicotine into your system fastest, while the inhaler most closely replicates the act of smoking. The gum's advantage is that it's available without a prescription; most smokers will need the 4mg version.

To help the most intractable smokers, specialists now combine Zyban with nicotine-replacement products, using double patches or patches plus gum or an inhaler. "Most patches deliver only half the nicotine a smoker would get from one pack a day. So some may find nicotine replacement hasn't worked well simply because they're being underdosed," says the Mayo Clinic's Hurt. Some doctors keep patients on the products for several months rather than the 10 to 12 weeks most manufacturers recommend.

But to avoid dangerously high blood pressure or nicotine overdosing (40mg to 60mg is considered lethal, but individual tolerances can vary), combining products or straying from dosage instructions should be done only under a doctor's supervision. And while nicotine replacement is safer than smoking, new studies from the University of Minnesota suggest that using nicotine replacement for more than three to six months may damage blood and lung cells, possibly leading to artery disease, bronchitis or both.

Why you may need a support group

"Smoking is a way of coping with stress as well as of obtaining pleasure, so break-

Christopher Smith/Impact Visuals

Healthwise by Andrea Rock

Quitting Time for Smokers

New products and programs can quadruple your chances of success.

IF YOU'RE among the millions of smokers who resolve to quit each New Year's Day, only to find yourself a few days later dejectedly puffing away, take heart. A revolution in medical understanding of how smokers get hooked has led to new approaches to quitting that can increase your chances of success from the 5% typical of cold-turkey quitters to 20% or more. And at least part of the $206 billion tobacco settlement will go to funding programs to help you.

Recent studies provide clues to why breaking an addiction to nicotine is so difficult—even more difficult than kicking heroin or cocaine, according to Steven Adelman, medical director of substance abuse services for Harvard Vanguard Medical Associates. Nicotine stimulates brain cells to release a pleasure-inducing chemical called dopamine. "Each puff of a cigarette is a hit, a neurobiological mini-orgasm that is repeated millions of times, which explains why smokers yearn for that experience much longer than people addicted to many other pleasure-giving substances," Adelman says.

To still quitters' cravings, doctors and counselors have come to rely on various forms of nicotine replacement—from the now familiar skin patches to the cigarette-like Nicotrol Inhaler introduced last year. And the new drug Zyban targets the pathways of nicotine addiction in the brain, rather than replacing nicotine. The table at right details the cost, side effects and percentages of smokers who are still off cigarettes a year after quitting while using each of these products. Although you may see ads touting a product's success among those who've used it for a month or two, the one-year success rate is the best indicator of effectiveness, says Richard Merrick, whose 10-week smoking-cessation program at Kaiser Permanente in Harbor City, Calif. has an astounding 57% one-year quit rate.

How Zyban helps

Richard E. Hurt, director of the Mayo Clinic's $3,000 eight-day inpatient program, which has helped 43% of its severely addicted clients kick the habit, generally recommends that smokers start taking Zyban—the first pill to be approved by the FDA as a smoking-cessation aid—about a week before they plan to quit. The drug, which is also sold as an antidepressant called Wellbutrin SR (the initials stand for sustained release), lessens the desire to smoke by raising dopamine levels in the brain, just as cigarettes do. Zyban also whittles the average quitter's five-pound weight gain.

Zyban has no effect on 15% to 20% of smokers who try it, says Linda Ferry, a researcher at Loma Linda University School of Medicine, who first discovered that the drug helped people quit smoking. Experts suggest giving Zyban a one-month trial; most people take it for 12 weeks. Some health plans don't cover Zyban, but a few less than forthcoming smokers have gotten around that by asking doctors to diagnose them with depression and prescribe Wellbutrin SR, which is generally covered.

TOOLS FOR THE WOULD-BE NONSMOKER

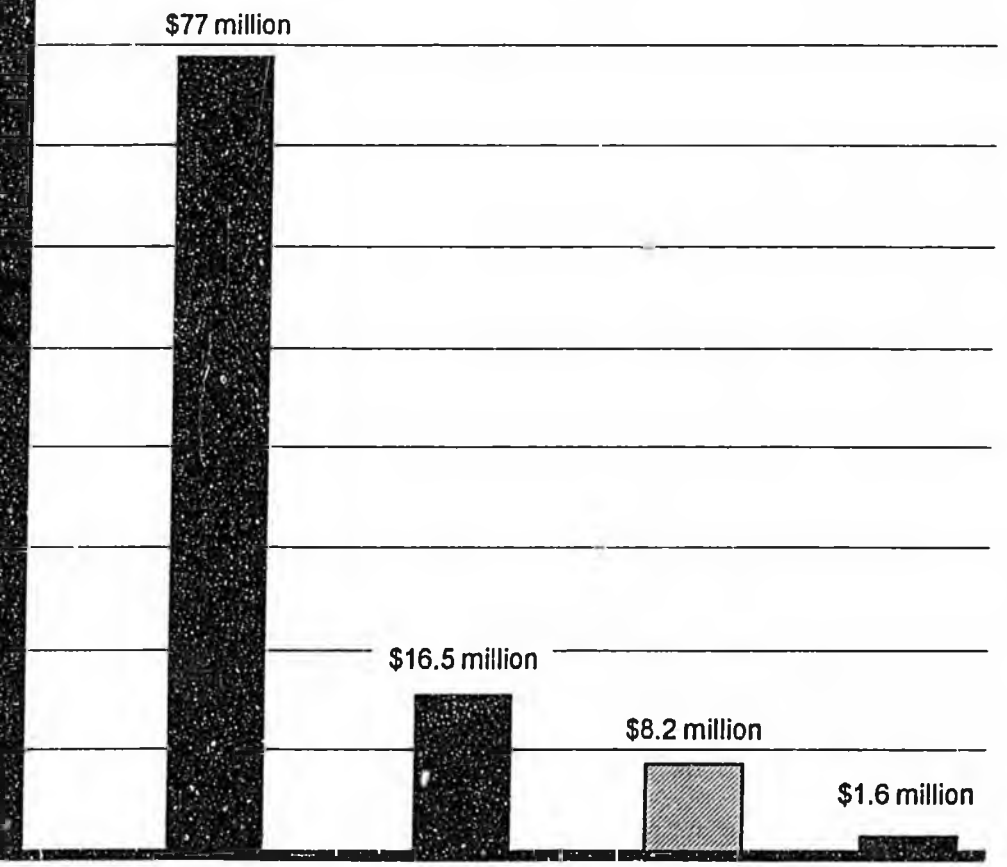
Consult your doctor before using any nicotine-replacement product, particularly if you have heart disease or are taking medication for asthma or depression.

Product	How it works	One-year quit rate	Monthly cost
Nicorette gum	Average smoker chews six to nine pieces daily; each piece has 4mg of nicotine. Side effect: jaw pain	10% to 15%	$120
Nicotine-replacement patches (Nicoderm and Nicotrol are both sold over the counter; other brands are sold by prescription only)	Smokers apply skin patches daily, absorbing doses of nicotine that range from 7mg to 21mg. Side effect: skin irritation	10% to 15%	108
Nicotrol Nasal Spray (prescription only)	Delivers 0.5mg per spray; can be used daily for up to six months. Nicotine hits bloodstream faster than gum, patch or inhaler	10% to 15%	120
Nicotrol Inhaler (prescription only)	Patient puffs on plastic mouthpiece containing nicotine cartridge to receive 4mg of nicotine, or about one-third the blood level delivered by a cigarette.	10% to 15%	160
Zyban (prescription only)	Two tablets a day changes brain chemistry to relieve cravings. Also reduces weight gain that occurs after quitting. Side effects: dry mouth, insomnia and a one in 1,000 risk of seizure	23%	$84 to $100

Sources: Sol Schiffman of the University of Pittsburgh (nicotine-replacement success rates), Nicotrol Consumer Products, SmithKline and Glaxo Wellcome

million

ALASKA
COST OF TOBACCO USE
and REVENUES FROM TOBACCO
compared with
COST OF COMPREHENSIVE
TOBACCO CONTROL



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Average Annual Revenue[1] from Tobacco Taxes and Settlement Payments

CDC Best Practices Tobacco Control for Alaska (high end)

Comprehensive Tobacco Control[2] (ATCA Plan)

CURRENT LEVEL OF STATE FUNDING[3]

ls taxes on tobacco products (estimated at $47 million/year) plus tobacco settlement settlement
r approximately $30 million/year). With implementation of a comprehensive tobacco control program,
uld decline somewhat as tobacco consumption was reduced.
esults and the documented experience of states like California and Massachusetts, best practices
shed by the national Centers for Disease Control and Prevention (August 1999) recommends $8.1
ding of a comprehensive tobacco control program in Alaska.
d $1.4 million from the tobacco settlement plus $200,000 from other general funds. In addition to these
of Health and Social Servcies received approximately $780,000 in federal funds for tobacco control as
od and Drug Administration (FDA) for vendor compliance checks.

1/23/00

TOTAL PAYMENTS TO STATES THROUGH 2025
(WITHOUT ANY OFFSETS, REDUCTIONS, AND ADJUSTMENTS OTHER THAN THE PREVIOUSLY SETTLED STATES REDUCTION)

Date	12/28/98	1999	01/10/00	04/15/00	Total 2000	01/10/01	04/15/01	Total 2001
Type of Payment			Initial Payment	Annual Payment		Initial Payment	Annual Payment	
Amount	$2,400,000,000.00	$0.00	$2,472,000,000.00	$3,939,750,000.00	$6,411,750,000.00	$2,546,160,000.00	$4,377,500,000.00	$6,923,660,000.00
Alabama	$38,787,139.20	$0.00	$39,950,753.38	$63,671,513.19	$103,622,266.57	$41,149,275.98	$70,746,125.77	$111,895,401.75
Alaska	$8,194,048.80	$0.00	$8,439,870.26	$13,451,043.23	$21,890,913.50	$8,693,066.37	$14,945,603.59	$23,638,669.96
American Samoa	$365,208.00	$0.00	$376,164.24	$599,511.76	$975,676.00	$387,449.17	$666,124.18	$1,053,573.34
Arizona	$35,373,228.00	$0.00	$36,434,424.84	$58,067,364.59	$94,501,789.43	$37,527,457.59	$64,519,293.99	$102,046,751.57
Arkansas	$19,873,586.40	$0.00	$20,469,793.99	$32,623,734.17	$53,093,528.17	$21,083,887.61	$36,248,593.53	$57,332,481.34
California	$306,334,929.60	$0.00	$315,524,977.49	$502,867,932.87	$818,392,910.36	$324,990,726.81	$558,742,147.64	$883,732,874.45
Colorado	$32,900,673.60	$0.00	$33,887,693.81	$54,008,512.01	$87,896,205.81	$34,904,324.62	$60,009,457.79	$94,913,782.41
Connecticut	$44,556,895.20	$0.00	$45,893,602.06	$73,142,928.28	$119,036,530.33	$47,270,410.12	$81,269,920.31	$128,540,330.43
Delaware	$9,491,268.00	$0.00	$9,776,006.04	$15,580,509.63	$25,356,515.67	$10,069,286.22	$17,311,677.36	$27,380,963.58
D.C.	$14,570,839.20	$0.00	$15,007,964.38	$23,918,943.22	$38,926,907.60	$15,458,203.31	$26,576,603.58	$42,034,806.89
Florida	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Georgia	$58,906,980.00	$0.00	$60,674,189.40	$96,699,489.36	$157,373,678.76	$62,494,415.08	$107,443,877.06	$169,938,292.14
Guam	$526,490.40	$0.00	$542,285.11	$864,266.90	$1,406,552.01	$558,553.67	$960,296.55	$1,518,850.22
Hawaii	$14,444,760.00	$0.00	$14,878,102.80	$23,711,976.34	$38,590,079.14	$15,324,445.88	$26,346,640.38	$41,671,086.26
Idaho	$8,718,316.80	$0.00	$8,979,866.30	$14,311,661.92	$23,291,528.23	$9,249,262.29	$15,901,846.58	$25,151,108.87
Illinois	$111,701,932.80	$0.00	$115,052,990.78	$183,365,704.06	$298,418,694.85	$118,504,580.51	$203,739,671.18	$322,244,251.69
Indiana	$48,955,279.20	$0.00	$50,423,937.58	$80,363,150.51	$130,787,088.09	$51,936,655.70	$89,292,389.46	$141,229,045.16
Iowa	$20,872,008.00	$0.00	$21,498,168.24	$34,262,705.63	$55,760,873.87	$22,143,113.29	$38,069,672.93	$60,212,786.21
Kansas	$20,008,108.80	$0.00	$20,608,352.06	$32,844,561.10	$53,452,913.17	$21,226,602.63	$36,493,956.78	$57,720,559.41
Kentucky	$42,267,806.40	$0.00	$43,535,840.59	$69,385,245.94	$112,921,086.54	$44,841,915.81	$77,094,717.72	$121,936,633.52
Louisiana	$54,128,474.40	$0.00	$55,752,328.63	$88,855,273.76	$144,607,602.39	$57,424,898.49	$98,728,081.95	$156,152,980.44
Maine	$18,464,412.00	$0.00	$19,018,344.36	$30,310,486.32	$49,328,830.68	$19,588,894.69	$33,678,318.14	$53,267,212.83
Maryland	$54,250,968.00	$0.00	$55,878,497.04	$89,056,354.66	$144,934,851.70	$57,554,851.95	$98,951,505.18	$156,506,357.13
Massachusetts	$96,935,496.00	$0.00	$99,843,560.83	$159,125,575.15	$258,969,236.03	$102,838,867.71	$176,806,305.73	$279,645,173.43
Michigan	$104,446,742.40	$0.00	$107,580,144.67	$171,455,855.57	$279,036,000.24	$110,807,549.01	$190,506,506.19	$301,314,055.20
Minnesota	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Mississippi	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Missouri	$54,590,426.40	$0.00	$56,228,139.19	$89,613,596.84	$145,841,736.03	$57,914,983.37	$99,570,663.15	$157,485,646.52
Montana	$10,194,218.40	$0.00	$10,500,044.95	$16,734,446.64	$27,234,491.59	$10,815,046.30	$18,593,829.60	$29,408,875.90
Nebraska	$14,279,599.20	$0.00	$14,707,987.18	$23,440,854.56	$38,148,841.74	$15,149,226.79	$26,045,393.96	$41,194,620.75
Nevada	$14,638,442.40	$0.00	$15,077,595.67	$24,029,918.10	$39,107,513.77	$15,529,923.54	$26,699,909.00	$42,229,832.54

Prepared by Laurie Loveland

TOTAL PAYMENTS TO STATES THROUGH 2025
(WITHOUT ANY OFFSETS, REDUCTIONS, AND ADJUSTMENTS OTHER THAN THE PREVIOUSLY SETTLED STATES REDUCTION)

Date	12/28/98	1999	01/10/00	04/15/00	Total 2000	01/10/01	04/15/01	Total 2001
Type of Payment			Initial Payment	Annual Payment		Initial Payment	Annual Payment	
Amount	$2,400,000,000.00	$0.00	$2,472,000,000.00	$3,939,750,000.00	$6,411,750,000.00	$2,546,160,000.00	$4,377,500,000.00	$6,923,660,000.00
New Hampshire	$15,982,416.00	$0.00	$16,461,888.48	$26,236,134.77	$42,698,023.25	$16,955,745.13	$29,151,260.85	$46,107,005.98
New Jersey	$92,807,911.20	$0.00	$95,592,148.54	$152,349,986.73	$247,942,135.27	$98,459,912.99	$169,277,763.03	$267,737,676.02
New Mexico	$14,313,352.80	$0.00	$14,742,753.38	$23,496,263.21	$38,239,016.59	$15,185,035.99	$26,106,959.12	$41,291,995.10
New York	$306,288,744.00	$0.00	$315,477,406.32	$502,792,116.32	$818,269,522.64	$324,941,728.51	$558,657,907.03	$883,599,635.53
North Carolina	$55,974,840.00	$0.00	$57,654,085.20	$91,886,198.29	$149,540,283.49	$59,383,707.76	$102,095,775.88	$161,479,483.63
North Dakota	$8,784,331.20	$0.00	$9,047,861.14	$14,420,028.69	$23,467,889.82	$9,319,296.97	$16,022,254.10	$25,341,551.07
No. Marianas	$202,502.40	$0.00	$208,577.47	$332,420.35	$540,997.82	$214,834.80	$369,355.94	$584,190.74
Ohio	$120,900,235.20	$0.00	$124,527,242.26	$198,465,292.35	$322,992,534.60	$128,263,059.52	$220,516,991.50	$348,780,051.02
Oklahoma	$24,867,288.00	$0.00	$25,613,306.64	$40,821,207.46	$66,434,514.10	$26,381,705.84	$45,356,897.18	$71,738,603.01
Oregon	$27,543,796.80	$0.00	$28,370,110.70	$45,214,863.93	$73,584,974.64	$29,221,214.03	$50,238,737.71	$79,459,951.73
Pennsylvania	$137,924,611.20	$0.00	$142,062,349.54	$226,411,869.57	$368,474,219.11	$146,324,220.02	$251,568,743.97	$397,892,963.99
Puerto Rico	$26,910,657.60	$0.00	$27,717,977.33	$44,175,526.37	$71,893,503.69	$28,549,516.65	$49,083,918.19	$77,633,434.83
Rhode Island	$17,253,729.60	$0.00	$17,771,341.49	$28,323,075.50	$46,094,416.98	$18,304,481.73	$31,470,083.89	$49,774,565.62
South Carolina	$28,232,445.60	$0.00	$29,079,418.97	$46,345,323.98	$75,424,742.95	$29,951,801.54	$51,494,804.42	$81,446,605.96
South Dakota	$8,374,699.20	$0.00	$8,625,940.18	$13,747,592.16	$22,373,532.33	$8,884,718.38	$15,275,102.40	$24,159,820.78
Tennessee	$58,581,468.00	$0.00	$60,338,912.04	$96,165,141.06	$156,504,053.10	$62,149,079.40	$106,850,156.74	$168,999,236.14
Texas	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Utah	$10,677,285.60	$0.00	$10,997,604.17	$17,527,431.64	$28,525,035.81	$11,327,532.29	$19,474,924.05	$30,802,456.34
Vermont	$9,868,442.40	$0.00	$10,164,495.67	$16,199,664.98	$26,364,160.65	$10,469,430.54	$17,999,627.75	$28,469,058.29
Virginia	$49,073,882.40	$0.00	$50,546,098.87	$80,557,845.08	$131,103,943.95	$52,062,481.84	$89,508,716.75	$141,571,198.59
Virgin Islands	$416,623.20	$0.00	$429,121.90	$683,913.02	$1,113,034.92	$441,995.55	$759,903.36	$1,201,898.91
Washington	$49,278,196.80	$0.00	$50,756,542.70	$80,893,239.93	$131,649,782.64	$52,279,238.99	$89,881,377.71	$142,160,616.69
West Virginia	$21,275,049.60	$0.00	$21,913,301.09	$34,924,323.61	$56,837,624.70	$22,570,700.12	$38,804,804.01	$61,375,504.13
Wisconsin	$49,728,936.00	$0.00	$51,220,804.08	$81,633,156.50	$132,853,960.58	$52,757,428.20	$90,703,507.23	$143,460,935.43
Wyoming	$5,960,277.60	$0.00	$6,139,085.93	$9,784,168.20	$15,923,254.13	$6,323,258.51	$10,871,298.00	$17,194,556.50
TOTAL	$2,400,000,000.00	$0.00			$6,411,750,000.00			$6,923,660,000.00

Prepared by Laurie Loveland

TOTAL PAYMENTS TO STATES THROUGH 2025
(WITHOUT ANY OFFSETS, REDUCTIONS, AND ADJUSTMENTS OTHER THAN THE PREVIOUSLY SETTLED STATES REDUCTION)

Date	01/10/02	04/15/02	Total 2002	01/10/03	04/15/03	Total 2003
Type of Payment	Initial Payment	Annual Payment		Initial Payment	Annual Payment	
Amount	$2,622,544,800.00	$5,690,750,000.00	$8,313,294,800.00	$2,701,221,144.00	$5,690,750,000.00	$8,391,971,144.00
Alabama	$42,383,754.26	$91,969,963.50	$134,353,717.76	$43,655,266.88	$91,969,963.50	$135,625,230.39
Alaska	$8,953,858.36	$19,429,284.67	$28,383,143.03	$9,222,474.11	$19,429,284.67	$28,651,758.78
American Samoa	$399,072.64	$865,961.43	$1,265,034.07	$411,044.82	$865,961.43	$1,277,006.25
Arizona	$38,653,281.31	$83,875,082.18	$122,528,363.50	$39,812,879.75	$83,875,082.18	$123,687,961.94
Arkansas	$21,716,404.45	$47,123,171.59	$68,839,576.03	$22,367,896.58	$47,123,171.59	$69,491,068.17
California	$334,740,448.62	$726,364,791.93	$1,061,105,240.54	$344,782,662.08	$726,364,791.93	$1,071,147,454.00
Colorado	$35,951,454.36	$78,012,295.12	$113,963,749.48	$37,029,997.99	$78,012,295.12	$115,042,293.11
Connecticut	$48,688,522.42	$105,650,896.40	$154,339,418.82	$50,149,178.09	$105,650,896.40	$155,800,074.49
Delaware	$10,371,364.81	$22,505,180.57	$32,876,545.38	$10,682,505.75	$22,505,180.57	$33,187,686.32
D.C.	$15,921,949.41	$34,549,584.66	$50,471,534.06	$16,399,607.89	$34,549,584.66	$50,949,192.55
Florida	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Georgia	$64,369,247.53	$139,677,040.18	$204,046,287.72	$66,300,324.96	$139,677,040.18	$205,977,365.14
Guam	$575,310.28	$1,248,385.52	$1,823,695.79	$592,569.58	$1,248,385.52	$1,840,955.10
Hawaii	$15,784,179.26	$34,250,632.49	$50,034,811.75	$16,257,704.64	$34,250,632.49	$50,508,337.13
Idaho	$9,526,740.16	$20,672,400.55	$30,199,140.72	$9,812,542.37	$20,672,400.55	$30,484,942.92
Illinois	$122,059,717.92	$264,861,572.53	$386,921,290.46	$125,721,509.46	$264,861,572.53	$390,583,081.99
Indiana	$53,494,755.37	$116,080,106.29	$169,574,861.67	$55,099,598.04	$116,080,106.29	$171,179,704.33
Iowa	$22,807,406.69	$49,490,574.80	$72,297,981.49	$23,491,628.89	$49,490,574.80	$72,982,203.69
Kansas	$21,863,400.70	$47,442,143.81	$69,305,544.52	$22,519,302.73	$47,442,143.81	$69,961,446.54
Kentucky	$46,187,173.28	$100,223,133.03	$146,410,306.31	$47,572,788.48	$100,223,133.03	$147,795,921.51
Louisiana	$59,147,645.45	$128,346,506.54	$187,494,151.98	$60,922,074.81	$128,346,506.54	$189,268,581.35
Maine	$20,176,561.53	$43,781,813.58	$63,958,375.11	$20,781,858.38	$43,781,813.58	$64,563,671.96
Maryland	$59,281,497.51	$128,636,956.73	$187,918,454.24	$61,059,042.44	$128,636,956.73	$189,696,899.16
Massachusetts	$105,924,033.74	$229,848,197.44	$335,772,231.18	$109,101,754.75	$229,848,197.44	$338,949,952.19
Michigan	$114,131,775.48	$247,658,458.05	$361,790,233.53	$117,555,728.75	$247,658,458.05	$365,214,186.79
Minnesota	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Mississippi	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Missouri	$59,652,432.87	$129,441,862.10	$189,094,294.97	$61,442,005.85	$129,441,862.10	$190,883,867.95
Montana	$11,139,497.69	$24,171,978.48	$35,311,476.17	$11,473,682.62	$24,171,978.48	$35,645,661.10
Nebraska	$15,603,703.60	$33,859,012.14	$49,462,715.74	$16,071,814.70	$33,859,012.14	$49,930,826.85
Nevada	$15,995,821.25	$34,709,881.70	$50,705,702.95	$16,475,695.89	$34,709,881.70	$51,185,577.59

TOTAL PAYMENTS TO STATES THROUGH 2025
(WITHOUT ANY OFFSETS, REDUCTIONS, AND ADJUSTMENTS OTHER THAN THE PREVIOUSLY SETTLED STATES REDUCTION)

Date	01/10/02	04/15/02	Total 2002	01/10/03	04/15/03	Total 2003
Type of Payment	Initial Payment	Annual Payment		Initial Payment	Annual Payment	
Amount	$2,622,544,800.00	$5,690,750,000.00	$8,313,294,800.00	$2,701,221,144.00	$5,690,750,000.00	$8,391,971,144.00
New Hampshire	$17,464,417.49	$37,896,639.11	$55,361,056.59	$17,988,350.01	$37,896,639.11	$55,884,989.12
New Jersey	$101,413,710.38	$220,061,091.94	$321,474,802.32	$104,456,121.69	$220,061,091.94	$324,517,213.64
New Mexico	$15,640,587.07	$33,939,046.85	$49,579,633.92	$16,109,804.68	$33,939,046.85	$50,048,851.53
New York	$334,689,980.36	$726,255,279.13	$1,060,945,259.50	$344,730,679.78	$726,255,279.13	$1,070,985,958.91
North Carolina	$61,165,218.99	$132,724,508.64	$193,889,727.63	$63,000,175.56	$132,724,508.64	$195,724,684.20
North Dakota	$9,598,875.88	$20,828,930.32	$30,427,806.20	$9,886,842.16	$20,828,930.32	$30,715,772.48
No. Marianas	$221,279.84	$480,162.72	$701,442.56	$227,918.24	$480,162.72	$708,080.96
Ohio	$132,110,951.31	$286,672,088.94	$418,783,040.25	$136,074,279.85	$286,672,088.94	$422,746,368.79
Oklahoma	$27,173,157.01	$58,963,966.33	$86,137,123.34	$27,988,351.72	$58,963,966.33	$86,952,318.05
Oregon	$30,097,850.45	$65,310,359.02	$95,408,209.46	$31,000,785.96	$65,310,359.02	$96,311,144.98
Pennsylvania	$150,713,946.62	$327,039,367.16	$477,753,313.78	$155,235,365.02	$327,039,367.16	$482,274,732.18
Puerto Rico	$29,406,002.15	$63,809,093.64	$93,215,095.79	$30,288,182.21	$63,809,093.64	$94,097,275.85
Rhode Island	$18,853,616.18	$40,911,109.05	$59,764,725.24	$19,419,224.67	$40,911,109.05	$60,330,333.72
South Carolina	$30,850,355.58	$66,943,245.75	$97,793,601.33	$31,775,866.25	$66,943,245.75	$98,719,112.00
South Dakota	$9,151,25..93	$19,857,633.11	$29,008,893.05	$9,425,797.73	$19,857,633.11	$29,283,430.84
Tennessee	$64,013,551.78	$138,905,203.76	$202,918,755.54	$65,933,958.34	$138,905,203.76	$204,839,162.10
Texas	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Utah	$11,667,358.26	$25,317,401.26	$36,984,759.52	$12,017,379.01	$25,317,401.26	$37,334,780.27
Vermont	$10,783,513.46	$23,399,516.08	$34,183,029.54	$11,107,018.86	$23,399,516.08	$34,506,534.94
Virginia	$53,624,356.29	$116,361,331.78	$169,985,688.07	$55,233,086.98	$116,361,331.78	$171,594,418.76
Virgin Islands	$455,255.42	$987,874.36	$1,443,129.78	$468,913.08	$987,874.36	$1,456,787.45
Washington	$53,847,616.15	$116,845,791.02	$170,693,407.17	$55,463,044.64	$116,845,791.02	$172,308,835.66
West Virginia	$23,247,821.12	$50,446,245.21	$73,694,066.34	$23,945,255.76	$50,446,245.21	$74,391,500.97
Wisconsin	$54,340,151.05	$117,914,559.39	$172,254,710.44	$55,970,355.58	$117,914,559.39	$173,884,914.97
Wyoming	$6,512,956.26	$14,132,687.40	$20,645,643.66	$6,708,344.95	$14,132,687.40	$20,841,032.35
TOTAL			$8,313,294,800.00			$8,391,971,144.00

TOTAL PAYMENTS TO STATES THROUGH 2025
(WITHOUT ANY OFFSETS, REDUCTIONS, AND ADJUSTMENTS OTHER THAN THE PREVIOUSLY SETTLED STATES REDUCTION)

Date	Each 4/15 in	Total Payments in	Each April 15 in 2008-2017			Total Payments	Each 4/15 in	Total Payments	Total Payments
	2004 to 2007	Years 2004-07				In 2008-2017	2018 to 2025	In 2018-2025	through 2025
Type of Payment	Annual Payment		Annual Payment	SCF Payment	Annual Total		Annual Payment		
Amount	$7,004,000,000.00	$28,016,000,000.00	$7,142,999,999.92	$861,000,000.00	$8,003,999,999.92	$80,039,999,999.16	$8,003,999,997.00	$64,031,999,976.00	$204,528,675,919.16
Alabama	$113,193,801.23	$452,775,204.93	$115,440,223.04	$6,499,999.82	$121,940,222.86	$1,219,402,228.64	$129,355,109.18	$1,034,840,873.47	$3,231,302,062.69
Alaska	$23,912,965.75	$95,651,862.99	$24,387,537.74	$14,739,285.08	$39,126,822.82	$391,268,228.19	$27,327,152.74	$218,617,221.90	$816,295,847.16
American Samoa	$1,065,798.68	$4,263,194.72	$1,086,950.31	$1,549,999.75	$2,636,950.06	$26,369,500.62	$1,217,968.68	$9,743,749.44	$45,312,942.43
Arizona	$103,230,870.68	$412,923,481.52	$105,279,569.83	$26,306,153.66	$131,585,723.50	$1,315,857,234.98	$117,969,715.34	$943,757,722.69	$3,150,676,533.62
Arkansas	$57,997,749.64	$231,990,998.58	$59,148,761.52	$6,499,999.82	$65,648,761.34	$656,487,613.43	$66,278,410.62	$530,227,284.95	$1,687,336,137.07
California	$893,987,436.22	$3,575,949,744.86	$911,729,334.21	$44,539,881.29	$956,269,215.50	$9,562,692,154.99	$1,021,626,989.83	$8,173,015,918.66	$25,452,371,227.47
Colorado	$96,015,132.46	$384,060,529.82	$97,920,629.80	$20,271,470.10	$118,192,099.90	$1,181,920,999.01	$109,723,746.41	$877,789,971.32	$2,888,488,204.57
Connecticut	$130,031,872.49	$520,127,489.97	$132,612,459.34	$28,526,111.29	$161,138,570.63	$1,611,385,706.29	$148,597,245.44	$1,188,777,963.49	$3,922,564,409.03
Delaware	$27,698,683.78	$110,794,735.12	$28,248,386.38	$6,499,999.82	$34,748,386.21	$347,483,862.06	$31,653,378.77	$253,227,030.15	$839,798,606.27
D.C.	$42,522,565.73	$170,090,262.93	$43,366,460.17	$6,499,999.82	$49,866,459.99	$498,664,599.89	$48,593,748.71	$388,749,989.71	$1,254,458,132.83
Florida	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Georgia	$171,910,203.30	$687,640,813.20	$175,321,899.22	$8,061,953.70	$183,383,852.92	$1,833,838,529.20	$196,454,778.23	$1,571,638,225.81	$4,889,360,171.97
Guam	$1,536,474.48	$6,145,897.94	$1,566,967.05	$1,549,999.75	$3,116,966.80	$31,169,668.05	$1,755,845.48	$14,046,763.87	$58,478,873.38
Hawaii	$42,154,624.60	$168,618,498.40	$42,991,216.95	$20,358,508.59	$63,349,725.54	$633,497,255.39	$48,173,274.58	$385,386,196.66	$1,382,751,024.72
Idaho	$25,442,954.53	$101,771,818.11	$25,947,890.38	$6,499,999.82	$32,447,890.20	$324,478,901.97	$29,075,586.52	$232,604,692.14	$776,700,449.75
Illinois	$325,983,473.89	$1,303,933,895.55	$332,452,877.49	$23,392,718.22	$355,845,595.72	$3,558,455,957.15	$372,525,945.75	$2,980,207,565.99	$9,352,466,670.47
Indiana	$142,867,823.13	$571,471,292.53	$145,703,149.72	$22,815,781.93	$168,518,931.64	$1,685,189,316.43	$163,265,856.07	$1,306,126,848.57	$4,224,513,435.98
Iowa	$60,911,476.68	$243,645,906.72	$62,120,313.81	$23,427,992.53	$85,548,306.34	$855,483,063.41	$69,608,146.65	$556,865,173.23	$1,938,119,996.63
Kansas	$58,390,330.85	$233,561,323.39	$59,549,133.82	$15,930,511.30	$75,479,645.11	$754,796,451.11	$66,727,042.82	$533,816,342.58	$1,792,622,689.52
Kentucky	$123,351,548.34	$493,406,193.38	$125,799,558.80	$6,499,999.82	$132,299,558.62	$1,322,995,586.18	$140,963,134.29	$1,127,705,074.33	$3,515,438,608.17
Louisiana	$157,964,931.12	$631,859,724.50	$161,099,871.93	$22,626,396.37	$183,726,268.30	$1,837,262,682.97	$180,518,462.06	$1,444,147,696.45	$4,644,921,894.48
Maine	$53,885,309.02	$215,541,236.08	$54,954,706.21	$11,435,783.06	$66,390,489.27	$663,904,892.72	$61,578,814.00	$492,630,511.98	$1,621,659,143.36
Maryland	$158,322,408.28	$633,289,633.12	$161,464,443.51	$28,313,373.69	$189,777,817.20	$1,897,778,171.98	$180,926,978.21	$1,447,415,825.70	$4,711,791,161.02
Massachusetts	$282,890,089.16	$1,131,560,356.64	$288,504,269.97	$41,425,316.25	$329,929,586.21	$3,299,295,862.14	$323,279,879.04	$2,586,239,032.31	$8,327,367,339.92
Michigan	$304,810,409.90	$1,219,241,639.62	$310,859,617.06	$22,189,497.41	$333,049,114.48	$3,330,491,144.78	$348,329,885.77	$2,786,639,086.19	$8,748,173,088.76
Minnesota	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Mississippi	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Missouri	$159,313,061.04	$637,252,244.18	$162,474,756.57	$13,358,294.46	$175,833,051.03	$1,758,330,510.31	$182,059,071.98	$1,456,472,575.81	$4,589,951,302.16
Montana	$29,750,127.36	$119,000,509.46	$30,340,542.51	$8,995,298.36	$39,335,840.87	$393,358,408.74	$33,997,718.35	$271,981,746.81	$922,135,388.18
Nebraska	$41,672,630.33	$166,690,521.33	$42,499,657.12	$6,499,999.82	$48,999,656.94	$489,996,569.40	$47,622,463.31	$380,979,706.51	$1,230,683,401.51
Nevada	$42,719,854.40	$170,879,417.62	$43,567,664.19	$8,871,146.47	$52,438,810.66	$524,388,106.58	$48,819,205.39	$390,553,643.09	$1,283,688,236.55

Prepared by Laurie Loveland

TOTAL PAYMENTS TO STATES THROUGH 2025
(WITHOUT ANY OFFSETS, REDUCTIONS, AND ADJUSTMENTS OTHER THAN THE PREVIOUSLY SETTLED STATES REDUCTION)

Date	Each 4/15 in	Total Payments in	Each April 15 in 2008-2017			Total Payments	Each 4/15 in	Total Payments	Total Payments
	2004 to 2007	Years 2004-07				in 2008-2017	2018 to 2025	in 2018-2025	through 2025
Type of Payment	Annual Payment		Annual Payment	SCF Payment	Annual Total		Annual Payment		
Amount	$7,004,000,000.00	$28,016,000,000.00	$7,142,999,999.92	$861,000,000.00	$8,003,999,999.92	$80,039,999,999.16	$8,003,999,997.00	$64,031,999,976.00	$204,528,675,919.16
New Hampshire	$46,642,017.36	$186,568,069.44	$47,567,665.62	$7,740,069.71	$55,307,735.33	$553,077,353.27	$53,301,[illegible]57.34	$426,410,858.72	$1,382,089,772.38
New Jersey	$270,844,420.85	$1,083,377,683.41	$276,219,545.71	$24,512,261.89	$300,731,807.59	$3,007,318,075.92	$309,514,383.74	$2,476,115,069.89	$7,821,290,567.66
New Mexico	$41,771,134.59	$167,084,538.35	$42,600,116.27	$8,574,937.50	$51,175,053.77	$511,750,537.67	$47,735,031.57	$381,880,252.56	$1,254,188,178.53
New York	$893,852,651.24	$3,575,410,604.96	$911,591,874.32	$47,245,999.12	$958,837,873.44	$9,588,378,734.41	$1,021,472,960.86	$8,171,783,686.86	$25,475,662,146.81
North Carolina	$163,353,241.40	$653,412,965.60	$166,595,117.55	$16,723,245.19	$183,318,362.74	$1,833,183,627.37	$186,676,091.33	$1,493,408,730.64	$4,736,614,342.55
North Dakota	$25,635,606.55	$102,542,426.21	$26,144,365.73	$14,971,173.90	$41,115,539.64	$411,155,396.37	$29,295,744.54	$234,365,956.33	$866,801,129.67
No. Marianas	$590,969.50	$2,363,878.02	$602,697.77	$1,549,999.75	$2,152,697.52	$21,526,975.20	$675,345.50	$5,402,764.03	$32,030,831.72
Ohio	$352,827,186.39	$1,411,308,745.57	$359,829,325.01	$23,952,757.40	$383,782,082.40	$3,837,820,824.05	$403,202,284.24	$3,225,618,273.93	$10,108,950,073.41
Oklahoma	$72,571,035.48	$290,284,141.92	$74,011,265.91	$26,860,355.26	$100,871,621.17	$1,008,716,211.65	$82,932,405.45	$663,459,243.59	$2,298,589,443.67
Oregon	$80,381,980.33	$321,527,921.31	$81,977,225.23	$20,802,259.38	$102,779,484.61	$1,027,794,846.05	$91,858,562.29	$734,868,498.35	$2,456,499,343.32
Pennsylvania	$402,509,990.35	$1,610,039,961.41	$410,498,124.08	$28,045,086.95	$438,543,211.03	$4,385,432,110.30	$459,978,578.1[illegible]	$3,679,828,625.44	$11,539,620,537.41
Puerto Rico	$78,534,269.10	$314,137,076.38	$80,092,844.68	$14,233,822.11	$94,326,666.79	$943,266,667.94	$89,747,043.06	$717,976,344.50	$2,339,130,056.59
Rhode Island	$50,352,134.22	$201,408,536.86	$51,351,412.72	$9,432,046.64	$60,783,459.36	$607,834,593.59	$57,541,188.19	$460,329,505.56	$1,502,790,407.17
South Carolina	$82,391,687.08	$329,566,748.30	$84,026,816.22	$11,470,353.93	$95,497,170.15	$954,971,701.46	$94,155,206.04	$753,241,648.33	$2,419,396,605.93
South Dakota	$24,440,163.83	$97,760,655.33	$24,925,198.49	$6,499,999.82	$31,425,198.31	$314,251,983.15	$27,929,621.82	$223,436,974.57	$748,649,989.25
Tennessee	$170,960,250.78	$683,841,003.12	$174,353,094.13	$6,499,999.82	$180,853,093.95	$1,808,530,939.54	$195,369,195.71	$1,562,953,565.65	$4,847,168,183.19
Texas	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Utah	$31,159,878.48	$124,639,513.90	$31,778,271.27	$15,719,889.17	$47,498,160.44	$474,981,604.38	$35,608,747.46	$284,869,979.70	$1,028,815,415.53
Vermont	$28,799,404.40	$115,197,617.62	$29,370,951.69	$15,648,784.35	$45,019,736.04	$450,197,360.40	$32,911,255.39	$263,290,043.13	$962,076,246.97
Virginia	$143,213,946.80	$572,855,787.22	$146,056,142.49	$6,499,999.82	$152,556,142.31	$1,525,561,423.12	$163,661,397.74	$1,309,291,181.94	$4,071,037,524.05
Virgin Islands	$1,215,845.37	$4,863,381.49	$1,239,974.80	$1,549,999.75	$2,789,974.55	$27,899,745.51	$1,389,438.37	$11,115,506.97	$49,510,108.23
Washington	$143,810,204.33	$575,240,817.31	$146,664,233.22	$49,634,438.95	$196,298,672.18	$1,962,986,721.76	$164,342,786.27	$1,314,742,290.13	$4,519,060,668.16
West Virginia	$62,087,686.42	$248,350,745.66	$63,319,866.37	$19,608,765.29	$82,928,631.66	$829,286,316.59	$70,952,290.39	$567,618,323.12	$1,932,829,131.11
Wisconsin	$145,125,611.56	$580,502,446.24	$148,005,745.77	$22,538,279.90	$170,544,025.67	$1,705,440,256.72	$165,846,001.50	$1,326,768,011.98	$4,284,894,172.37
Wyoming	$17,394,076.80	$69,576,307.18	$17,739,276.21	$6,499,999.82	$24,239,276.03	$242,392,760.28	$19,877,525.79	$159,020,206.31	$551,554,038.00
TOTAL		$28,016,000,000.00				$80,039,999,973.33		$64,031,999,976.00	$204,528,675,893.33

Status Report
Tobacco Control and Cessation – Year 1 Program Initiation
American Lung Association of Alaska

Notice of Grant Award signed by Department of Health and Social Services (DHSS) and American Lung Association of Alaska (ALAA) on September 29, 1999; initial payment transmitted October 5, 1999.

Priorities for expenditure of the available funds set by the statewide Alaska Tobacco Control (ATCA) Steering Committee during a 2-day meeting in June 1999 at which time allocation of the $1.4 million was established in consideration of: 1) total funding needed in the amount of $8.2 million for comprehensive Alaska program [see *The Alaska Tobacco Control Program: A Plan for the Future*, March 1999 (ATCA Plan)]; and 2) the proven experience of other successful state programs. [Note: The national Centers for Disease Control and Prevention (CDC) *Best Practices for Comprehensive Tobacco Control Programs*, August 1999, 'low-end' budget for Alaska = $8.1 million/year, the 'high end' budget = $16.5 million/year.] The ATCA Plan identifies seven program areas:

Media/Counter-marketing	$1,000,000
Cessation Programs	$1,400,000
School-based Programs	$750,000
Tobacco-free Partnership Projects	$1,800,000
Community Programs	$2,000,000
Enforcement	$600,000
Program development, Management, Evaluation	$650,000
TOTAL:	$8,200,000

As a common core element of all successful state tobacco control programs, public education through media/counter-marketing to off-set tobacco industry marketing and sales promotions was identified as the highest priority for the American Lung Association of Alaska (ALAA) program effort. Cessation services and youth data collection were also recognized as priority first year efforts. Based on successful state tobacco control and cessation programs (e.g., California, Massachusetts, Oregon), ATCA identified the following priorities for use of first-year funding:

- $700,000 Implementation/evaluation of statewide media/counter-advertising
- $275,000 Funding cessation pilot projects with strong evaluation components
- $200,000 Youth tobacco use data, specifically in Anchorage (there is no youth tobacco use data for Anchorage since 1995)
- $85,000 Program management, support and travel (1.25 FTE)

ALAA agreed to implement the project at a ten percent indirect rate.

Status of ALAA Program Implementation
(initial 3 months of project)

Tobacco Use Dependence/Cessation - Pilot Projects ($275,000)

- RFP prepared, released for the cessation pilot projects. Received 22 proposals from across the state, representing varying project scopes, budgets, target populations, and spectrum of expertise. Funding requests represented by the 22 proposals totaled approximately $1.1 million.

- All 22 tobacco proposals reviewed by a Proposal Evaluation Committee, including staff from the UAA Institute of Circumpolar Health Studies (under a professional services contract to assist with project evaluation) as well as a representative of the Mayo Clinic. The following is a summary of the four highest scored proposals selected:

  - ✓ Anchorage Neighborhood Health Center: $9,352. Proposal to target pregnant women and mothers and will include implementation of the American Cancer Society's "Make Yours' a Fresh Start Family" program. This program targets cessation interventions with nicotine addicted pregnant women and the mothers of young children.

  - ✓ Cook Inlet Tribal Council – Ernie Turner Center (Anchorage): $77,532. Proposal to target nicotine dependent patients at the Ernie Turner Center, both inpatient and outpatient and to incorporate nicotine addiction treatment into the alcohol and drug treatment regimen.

  - ✓ Yukon Kuskokwim Health Corporation (Bethel): $84,572. Proposal to target adult Alaska Natives of the southwestern region of Alaska who seek services at Yukon Kuskokwim Delta Regional Hospital. The focus of the project will be to implement a hospital-wide system that ensures that tobacco use status is assessed and tracked on all patients. Using AHCPR clinical guidelines nicotine dependent patients will be offered appropriate assistance, intervention and follow-up based on their assessed "readiness to quit."

  - ✓ Ketchikan General Hospital: $57,227. Proposal to target health care providers in Ketchikan and surrounding communities. The focus of the project will be to provide a research-based training on tobacco cessation for health care providers, to increase their awareness of effective, research-based tobacco use cessation models and to encourage their adoption of such models in their practice.

Funding for the above four projects totals approximately $230,000. In addition, the cessation program budget will be used to fund:

- ✓ Quit Kits (i.e., information about cessation that can be used by individuals providing information about state of the art techniques, nicotine replacement therapies, prescription drugs, etc.) will be produced for dissemination statewide to health care providers, grantees, and other health care organizations.

- ✓ Professional "best practices" cessation training in Anchorage and Fairbanks for health care providers (e.g., doctors, dentists, nurses, clinicians) based on nationally recognized AHCPR Guidelines regarding state of the art cessation intervention services.

In addition, up to $27,500 (up to 10% of the program budget as recommended by CDC's best practices guidelines) will be used for professional program evaluation technical assistance to be provided by the UAA Institute for Circumpolar Health Studies under contract to ALAA.

Public Education: Media/Counter-Advertising Campaign ($700,000)

- The public education media/counter-marketing program was identified by ATCA as the core priority for funding under the ALAA program efforts and is a central feature of all successful state tobacco control programs.

- RFP developed, contractor selected (Ken Flynn Alaska) in mid-December for "Wave I" of the media campaign using media resources from the national CDC Media Campaign Resource Center (i.e., best existing ads produced in other states available for use at minimum cost).

- Three public education media/counter-marketing themes have been chosen by ATCA, patterned after successful Massachusetts and California programs which demonstrate that programs must not be youth-only (i.e., *both* adult and youth audiences must be targeted):

  1. Cessation: promote quit attempts – targeting current smokers
  2. ETS: Educate regarding lethal effects of second-hand smoke – targeting general public
  3. Youth prevention: deter youth initiation of smoking – targeting youth

- Wave I is currently underway (started at the end of December). The first two themes are addressed in Wave I. Media placement for Wave I has focused on major "urban" markets in Anchorage, Fairbanks, Juneau, Kenai, and MatSu. Wave I has primarily used TV, radio and theater slides.

- Media plan for Wave I developed with technical assistance from the national Centers for Disease Control and Prevention together with Alaska-based media firm to assure optimal and cost-effective reach/frequency to communicate media messages.

- Wave II will expand and encompass all three themes, reaching to markets statewide and involve other types of media in addition to radio and TV within the funds available. Some limited "Alaska-specific" ads (creative) will be developed during Wave II, to more carefully target Alaska population groups with high incidence of, or at high risk for, tobacco use.

Youth Tobacco Use - Baseline Data ($200,000)

- There is a significant deficit in youth baseline data for Anchorage, due to the Youth Risk Behavior Survey (YRBS) not being conducted there in 1999. No youth tobacco use data has been collected in Anchorage since 1995.

- ALAA has been working closely with the national CDC, the Anchorage School District administration, and the Anchorage Safe and Drug Free Schools Program to facilitate implementation of the Alaska Youth Tobacco Survey (AYTS) this spring.

- Necessity for affirmative, written parental consent for all school-based surveys, including voluntary and anonymous surveys such as the AYTS, as result of new state law (HB 70), has made it unclear whether it will be possible to obtain a statistically valid sample to implement AYTS and collect youth tobacco data in Anchorage.

COMPREHENSIVE STATEWIDE TOBACCO PREVENTION PROGRAMS EFFECTIVELY REDUCE TOBACCO USE

There is considerable evidence that public education efforts, community and school-based programs, helping smokers quit, and strictly enforcing laws that establish smoke-free areas and restrict youth access to tobacco products can each significantly reduce tobacco use. Research and experience also shows that these individual elements are most effective when they are all integrated into a comprehensive program. California, Massachusetts, Florida, and Oregon have already followed this comprehensive approach with considerable success, and other states are following their lead.

The experiences in California, Massachusetts, and other states establish the following key points:

1) When adequately funded, comprehensive state tobacco prevention programs can quickly and substantially reduce tobacco use.

2) State tobacco prevention programs must be insulated against the inevitable attempts by the tobacco industry to reduce program funding and otherwise interfere with the programs' successful operation.

3) The programs' funding must be sustained over time both to protect initial tobacco use reductions and to achieve further cuts.

Program Success – California

In 1988, California voters approved Proposition 99, a ballot initiative that increased state cigarette taxes by 25 cents per pack, with 20 percent of the new revenues (over $100 million per year) earmarked for health education against tobacco use. California launched its new Tobacco Control Program in Spring 1990. Despite increased levels of tobacco marketing and promotion, a major cigarette price cut in 1993, tobacco company interference with the program, and periodic cuts in program funding, the program has still reduced tobacco use substantially.

- Since the passage of Proposition 99, cigarette consumption in California has declined by 38 percent, or twice as much as the decline of only 16 percent in the rest of the country.[1]

- Since the passage of Proposition 99, adult smoking in California has declined at twice the rate it declined in the previous decade. From 1988 to 1996, adult smoking in California decreased from 26.7 percent to 18.1 percent.[2]

- Even after the tobacco industry was successful in dramatically reducing the funding for tobacco use prevention efforts in California, cigarette consumption still declined more in California than in the rest of the country.[3]

- While teenage smoking increased significantly throughout the country from 1990 to 1993, smoking among California teenagers remained constant.[4]

- Since 1993, smoking among 8th graders in California has varied from 12 to 14 percent while increasing from 17 to 22 percent in the rest of the country.[5]

- Since 1992, smoking among 10th graders in California has remained relatively constant at 18 to 19 percent while increasing from 22 to 32 percent in the rest of the country.[6]

- More than 1.3 million Californians have quit smoking because of the California Program.[7]

- A study published in the *American Journal of Public Health* found that the California anti-tobacco media campaign reduced sales of cigarettes by 232 million packs between the third quarter of 1990 and the fourth quarter of 1992. This reduction was independent of the decreases in consumption brought about by the tax increase.[8]

- An analysis of national data on youth smoking showed that, between 1992 and 1994, the national increase in youth smoking rates was slowed significantly in California as a result of the combined effect of a tax increase and a strong tobacco control program.[9]

- The proportion of California tobacco retailers who failed compliance checks for selling tobacco products to minors decreased from 52 percent in 1994 to 21.7 percent in 1997.[10]

- The proportion of California's indoor workers exposed to secondhand smoke at work was cut in half, falling from 29 percent in 1990 to less than 12 percent in 1996.[11]

- The proportion of California children and adolescents exposed to secondhand smoke in the home decreased from 29 percent in 1992 to 13 percent in 1996.[12]

Program Success -- Massachusetts

In 1992, Massachusetts voters approved a referendum known as Question 1 that increased the state cigarette tax by 25 cents per pack. Part of the new tax revenues were used to fund the Massachusetts Tobacco Control Program (MTCP), which began in 1993. As in California, despite some reductions in funding encouraged by the tobacco industry, the program has achieved considerable success. Data from 1999 demonstrate success in reducing tobacco use among both children and adults.

- Between 1995 and 1999, current smoking among Massachusetts high school students was reduced by 15 percent (from 34.4% to 30.3%).[13]

- Since 1993, the use of spit (smokeless) tobacco by high school males has declined by over 50 percent (from 17.0% to 8.1%).[14]

- The proportion of state tobacco retailers found making illegal sales to youth during compliance checks has fallen from 48 to less than 10 percent since the inception of the program.[15]

- Overall cigarette consumption in Massachusetts has declined by 30 percent since 1992, compared to a decrease of just 8 percent in the rest of the country (excluding California).[16]

- Adult smoking prevalence in Massachusetts has declined from 22.6 to 19.1 percent since the program began, resulting in 150,000 fewer smokers in the state.[17]

- Those who do smoke in Massachusetts are smoking less. The proportion of smokers who smoke 15 or more cigarettes per day declined from 69 percent in 1993 to 59 percent in 1999.[18]

- The proportion of Massachusetts smokers who were advised to quit by their doctor increased from 46 percent in 1993 to 60 percent in 1998.[19]

- Among Massachusetts smokers who try to quit, the success rate has increased from 17.1 percent in 1993 to 24 percent in 1999.[20]

- Between 1990 and 1996, smoking among pregnant women in Massachusetts declined by almost 50 percent (from 25% to 13%).[21]

- An analysis of national data on youth smoking showed that, between 1992 and 1994, the national increase in youth smoking rates was slowed significantly in Massachusetts as a result of the combined effect of a tax increase and a strong tobacco control program.[22]

Early Success in Florida

With funding from its 1997 settlement with the tobacco industry, the state of Florida funded a comprehensive tobacco prevention targeted at youth and modeled on the programs in California and Massachusetts. This innovative program that actively involves youth in its design and implementation has produced early success:[23]

- Less than a year after the initiation of Florida's Tobacco Pilot program, current smoking was reduced by 19 percent (3.5 percentage points) among middle school students and 8 percent (2.2 percentage points) among high school students.

- The proportion of Florida middle school students using any form of tobacco (cigarettes, cigars, or spit tobacco) declined by 21 percent from 1998 to 1999. The proportion of high school students using any form of tobacco declined by 8 percent.

After less than five months of Florida's new Tobacco Pilot Program, more than 90 percent of teens in the state were aware of the program, and over half were aware of the campaign logo. The Florida campaign had an immediate impact on teen attitudes regarding smoking, as evidenced by the following:

- From April to September of 1998, the proportion of Florida teens who "strongly agree" that smoking has nothing to do with whether a person is cool increased from 45 to 59 percent.

- From April to September, the proportion of Florida teens who "strongly agree" that tobacco companies try to get young people to smoke because older people quit smoking or die increased from 29 to 42 percent.

Early Success in Oregon

In 1997, the state of Oregon implemented a Tobacco Prevention and Education Program (TEPP) modeled on the California and Massachusetts programs with revenue from a tobacco tax increase. This program has already achieved declines in overall tobacco consumption.[24]

- From 1996 to 1998, tobacco consumption in Oregon declined by 11.3 percent, with almost half the decline (5%) attributable to a comprehensive tobacco prevention program.

- Preliminary data suggests that the prevalence of adult smoking in Oregon has already declined by 6.4 percent.

- Between 1996 and 1998, smoking among pregnant women in Oregon declined by 14 percent (from 17.7% to 15.2%).[25]

[1] Pierce, JP et al., *Tobacco Control in California; Who's Winning the War? An Evaluation of the Tobacco Control Program, 1989-1996.* La Jolla, CA: University of California, San Diego; 1998.
[2] *California's Tobacco Control Program: Preventing Tobacco Related Disease and Death*; Tobacco Control Section, California Department of Health Services, April 3,1998.
[3] Pierce, JP et al., "Has the California Tobacco Control Program Reduced Smoking?" *Journal of the American Medical Association*, September 9, 1998. Volume 280, No. 10.
[4] Pierce, JP et al., *Tobacco Control in California; Who's Winning the War? An Evaluation of the Tobacco Control Program, 1989-1996.* La Jolla, CA: University of California, San Diego; 1998.
[5] *Independent Evaluation Consortium. Final Report of the Independent Evaluation of the California Tobacco Control Prevention and Education Program: Wave 1 Data, 1996-1997.* Rockville, Maryland: The Gallup Organization, 1998.
[6] *Independent Evaluation Consortium. Final Report of the Independent Evaluation of the California Tobacco Control Prevention and Education Program: Wave 1 Data, 1996-1997.* Rockville, Maryland: the Gallup Organization, 1998.
[7] *California's Tobacco Control Program: Preventing Tobacco Related Disease and Death*; Tobacco Control Section, California Department of Health Services, April 3, 1998.
[8] Teh-Wei Hu, Hai-Yen Sung, Keeler TE. "Reducing Cigarette Consumption in California: Tobacco Taxes vs an Anti-Smoking Media Campaign." *Am J Public Health* 1995; 85(9):1218-1222.
[9] Chaloupka, FJ and Grossman M. *National Bureau of Economic Research Working Paper, No. 5740, September 1996.*
[10] *California's Tobacco Control Program: Preventing Tobacco Related Disease and Death*; Tobacco Control Section, California Department of Health Services, April 3, 1998.
[11] Pierce, JP et al., *Tobacco Control in California; Who's Winning the War? An Evaluation of the Tobacco Control Program, 1989-1996.* La Jolla, CA: University of California, San Diego; 1998.
[12] Pierce, JP et al., *Tobacco Control in California; Who's Winning the War? An Evaluation of the Tobacco Control Program, 1989-1996.* La Jolla, CA: University of California, San Diego; 1998.
[13] Massachusetts Youth Risk Tobacco Survey: 1999.
[14] Massachusetts Youth Risk Tobacco Survey: 1999.
[15] *Independent Evaluation of the Massachusetts Tobacco Control Program: Fifth Annual Report, January 1994 to June 1998.* Abt Associates, Inc.
[16] *Independent Evaluation of the Massachusetts Tobacco Control Program: Fifth Annual Report, January 1994 to June 1998.* Abt Associates, Inc.
[17] Massachusetts Tobacco Survey: 1993; Massachusetts Adult Tobacco Survey: FY 99
[18] Massachusetts Tobacco Survey: 1993; Massachusetts Adult Tobacco Survey: FY 99
[19] *Independent Evaluation of the Massachusetts Tobacco Control Program: Fifth Annual Report, January 1994 to June 1998.* Abt Associates, Inc.
[20] Massachusetts Tobacco Survey: 1993; Massachusetts Adult Tobacco Survey: FY 99
[21] *Independent Evaluation of the Massachusetts Tobacco Control Program: Fifth Annual Report, January 1994 to June 1998.* Abt Associates, Inc.
[22] Chaloupka, FJ and Grossman M. *National Bureau of Economic Research Working Paper, No. 5740, September 1996.*
[23] *1999 Florida Youth Tobacco Survey*: Volume 2, Report 1; Florida Department of Health, April 15, 1999.
[24] *Decline in Cigarette Consumption Following Implementation of a Comprehensive Tobacco Prevention and Education Program -- Oregon, 1996-1998.* Morbidity and Mortality Weekly Report (MMWR), U.S. Centers for Disease Control and Prevention (CDC), 26 February 1999.
[25] *Tobacco Prevention and Education Program Report – 1999.* Oregon Health Division.

Wave I - Theme : Promoting Cessation

Objective:	Prompt current tobacco users to consider/make quit attempts	
Primary Target:	Current smokers ages 19-50	
Secondary Targets:	Youth (smokers and non-smokers), General Public	
Media markets:	Anchorage, Fairbanks, Juneau, Kenai Peninsula, Mat-Su Valley	
Budget:	$75,000 (including media buyer/advertising firm compensation)	
Time period:	December –February	
TV spots:	"Truth – Pam Laffin"	(0:30)
	"Simple Things"	(0:30)
Radio spots:	"Bob Merman – What Happened"	(0:60)
	"Video Dating"	(0:60)
Theater slides:	"I miss my lung, Bob"	
	"Bob, I've got emphysema"	

Notes: This collection of media materials from the successful California and Massachusetts programs communicates several mutually reinforcing messages to move current smokers along the "quit contemplation/quit attempt/quit success" continuum. These messages also benefit other populations (youth, general public).

- Putting a "human face" on the suffering and share the experience of real people with whom smokers can identify (especially "Pam Laffin" and "Bob Merman") is especially effective. (This has been affirmed by viewer reaction to the Alaska-produced "Robert Dorgan" ad involving an Alaska throat cancer victim.)

- Focus group research shows that use of *real people* in ads can impact viewers strongly and make them think seriously about their current tobacco addiction and/or whether they would ever start smoking (in the case of kids).

- For youth, the "Pam Laffin" spot has been found to be effective in communicating the message that *this could happen to them.* Most youth think the harms of smoking come late in life if at all. This ad about a young woman (age 26) who started smoking as a teen and has since had a lung removed resonates with young adults.

- Anti-smoking ads before movies can help neutralize the effect that smoking 'role models' have on youth. These ads reposition smoking from a perception of 'forbidden fruit' to a perception of 'tainted' and help nullify glorified smoking.

- The humorous "I miss my lung, Bob" and "Bob, I've got emphysema" expose the truth behind smoking through parody of the ubiquitous 'Marlboro Man.' These ads are especially pertinent to youth as Marlboro is by far the leading brand among kids.

- The ads provide a supportive environment/message for the vast majority of smokers that wish to quit (especially "Simple Things").

Wave I - Theme: Secondhand Smoke – The 3rd Leading Killer

Primary Target:	General public ages 25-50	
Secondary Targets:	Current Smokers, Youth	
Objective:	Educate about health impact of second-hand smoke.	
Media markets:	Anchorage, Fairbanks, Juneau, Kenai Peninsula, Mat-Su Valley	
Budget:	$75,000 (including media buyer/advertising firm compensation)	
Time period:	December –February	
TV spots:	"ETS - Kids"	(0:30)
	"Millie"	(0:30)
Radio spots:	"Secondary Smoke"	(0:60)
	"Secondhand Sound"	(0:60)
Theater slides:	"Care if I smoke? Care if I die?"	
	"Your scent is intoxicating. Yours is carcinogenic."	

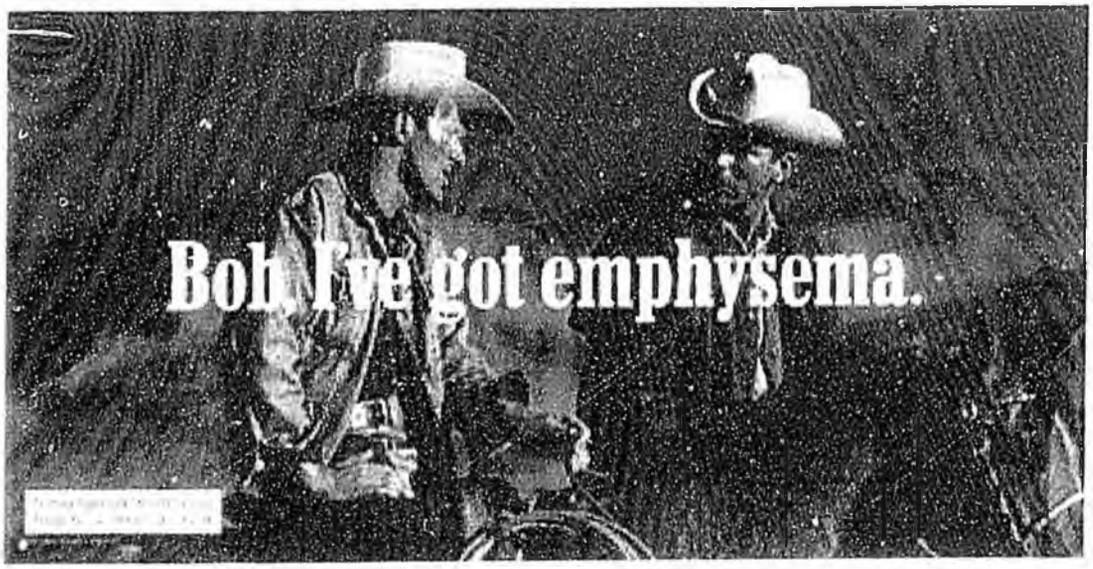
Notes: Basic public understanding of the harms caused by second-hand smoke is very poor. This collection of media materials communicates several mutually reinforcing messages about the lethal effects of second-hand smoke, the third leading cause of preventable death. These messages generally impart basic factual information about the third leading cause of preventable death. There is no serious debate in the scientific community regarding the fatal effects of second-hand smoke. However, the tobacco industry has done a good job of confusing this issue in the public mind. A listing of the adverse health effects of second-hand smoke (also referred to as "environmental tobacco smoke" or ETS) is attached. These messages help educate all target populations (general public, current smokers, and youth).

- Putting a "human face" on the disease and suffering caused by second-hand smoke is especially effective ("Millie"). Smokers as well as non-smokers can feel empathy for those who are harmed by involuntary smoking effects ("Millie" and "ETS-Kids").

- Second-hand smoke is especially harmful to children ("ETS – Kids"). This is a problem in home environments as well as in public places such as restaurants. The Rhode Island Department of Health recently issued a health alert strongly recommending that parents not take their children to restaurants that allow smoking.

- The adverse health impacts of ETS are far more serious than most people appreciate. Second-hand smoke is not merely an inconvenience as promoted by the tobacco industry ("Secondary Smoke"). It is estimated that second-hand smoke kills up to 62,000 people each year in America from heart disease alone making it the third leading cause of preventable death after active smoking and alcohol abuse. Other lethal effects of ETS include cancer and include SIDS.

- Individual rights should be respected and no one is talking about prohibition. But the choice to smoke by some should not be imposed on all; secondhand smoke does not respect artificial boundaries indoors and will flow throughout indoor environments ("Secondhand Sound").


Bob, I've got emphysema.


"Mind if I smoke?"
"Care if I die?"


I miss my lung, Bob.

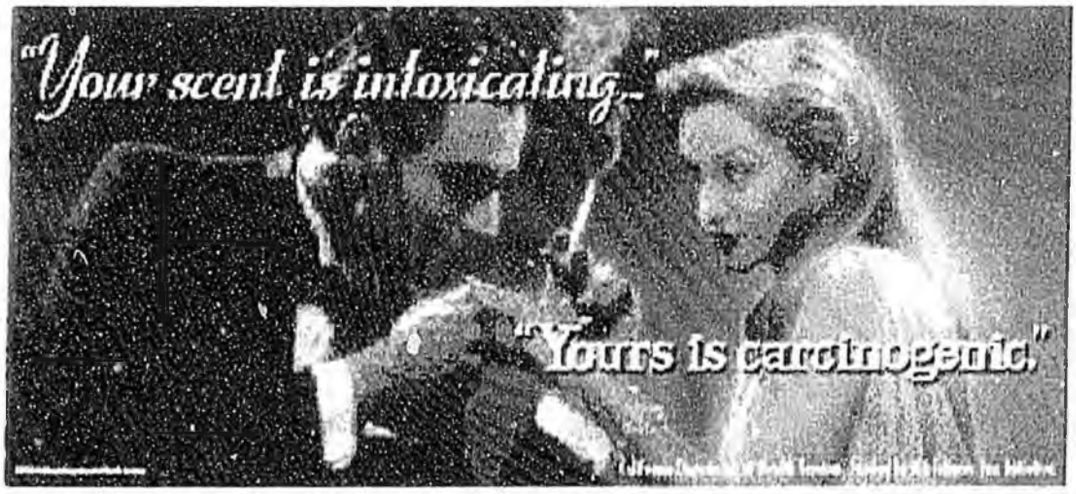

"Your scent is intoxicating..."
"Yours is carcinogenic."

Table ES.1
Health Effects Associated with Exposure to Environmental Tobacco Smoke

Effects Causally Associated with ETS Exposure

Developmental Effects
Fetal Growth: Low birthweight or small for gestational age
Sudden Infant Death Syndrome (SIDS)

Respiratory Effects
Acute lower respiratory tract infections in children
(*e.g.*, bronchitis and pneumonia)
Asthma induction and exacerbation in children
Chronic respiratory symptoms in children
Eye and nasal irritation in adults
Middle ear infections in children

Carcinogenic Effects
Lung Cancer
Nasal Sinus Cancer

Cardiovascular Effects
Heart disease mortality
Acute and chronic coronary heart disease morbidity

Effects with Suggestive Evidence of a Causal Association with ETS Exposure

Developmental Effects
Spontaneous abortion
Adverse Impact on cognition and behavior

Respiratory Effects
Exacerbation of cystic fibrosis
Decreased pulmonary function

Carcinogenic Effects
Cervical cancer

ETS – Kids

Length: **:30**

(MUSIC, SFX THROUGHOUT: PEOPLE INHALING SMOKE)

Secondhand smoke is bad for kids. Did you know that?

I learned it in school. Even in big rooms, the cigarette smoke goes everywhere.

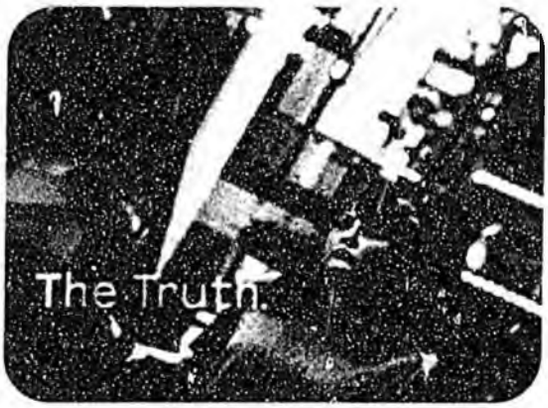
And when you breathe it in, you could get asthma. That's the truth.

It makes me really scared.

Does it make you really scared?

The Truth – Pam Laffin

Length: :30



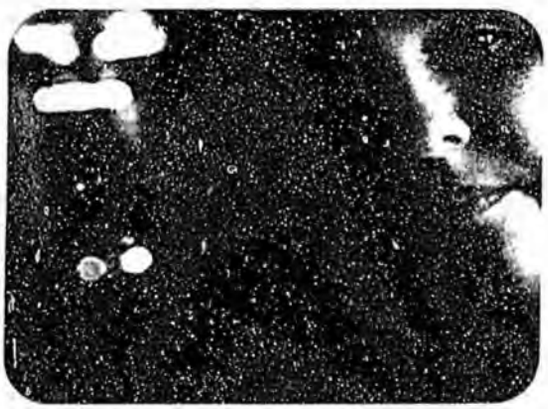
LAFFIN: I started smoking when I was ten because I wanted to look older.

And I got hooked. Cigarettes gave me asthma and bronchitis, but I couldn't quit.

I didn't quit until I got emphysema and had a lung removed.

I was 24; I'm 26 now. My medication, which I'll take for the rest of my life,

left me with this fat face and a hump on my neck.



I started smoking to look older, and I'm sorry to say, it worked.

Best Practices

for Comprehensive Tobacco Control Programs

CDC

CENTERS FOR DISEASE CONTROL AND PREVENTION

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention
National Center for Chronic Disease Prevention and Health Promotion
Office on Smoking and Health

August 1999

NOTE: A justification for each program element and the rationale for the budget estimates are provided in Section A.
An upper and a lower estimate are presented for each budget category.
The funding required for implementing programs will vary depending on state characteristics, such as sociodemographic factors, tobacco use prevalence, and other factors. Therefore, the funding ranges presented here are illustrative.

I. Community Programs to Reduce Tobacco Use

Upper Estimate	**$2,419,000**	Formula: $1,200,000 (statewide training and infrastructure) + $2.00 per capita
Lower Estimate	**$1,277,000**	Formula: $850,000 (statewide training and infrastructure) + $0.70 per capita

II. Chronic Disease Programs to Reduce the Burden of Tobacco-Related Diseases

Upper Estimate	**$4,161,000**	Formula: See attached section
Lower Estimate	**$2,766,000**	Formula: See attached section

III. School Programs

Upper Estimate	**$1,584,000**	Formula: $750,000 (statewide training and infrastructure) + $6 per student (K-12)
Lower Estimate	**$1,056,000**	Formula: $500,000 (statewide training and infrastructure) + $4 per student (K-12)

IV. Enforcement

Upper Estimate	**$791,000**	Formula: $300,000 (inter-agency coordination) + $0.80 per capita
Lower Estimate	**$413,000**	Formula: $150,000 (inter-agency coordination) + $0.43 per capita

V. Statewide Programs

Upper Estimate	**$610,000**	Formula: $1.00 per capita
Lower Estimate	**$244,000**	Formula: $.40 per capita

VI. Counter-Marketing

Upper Estimate	**$1,828,000**	Formula: $3.00 per capita
Lower Estimate	**$610,000**	Formula: $1.00 per capita

VII. Cessation Programs

Upper Estimate	**$2,965,000**	Formula: $1 per adult (screening) + $2 per smoker (brief counseling) + $137.50 per served smoker (50% of program cost for 10% of smokers) + $275 per served smoker (100% of program cost for 10% of publicly financed smokers)
Lower Estimate	**$646,000**	Formula: $1 per adult (screening) + $2 per smoker (brief counseling)

Subtotal (I to VII above)

Upper Estimate	**$14,358,000**
Lower Estimate	**$7,032,000**

VIII. Surveillance and Evaluation

Upper Estimate	**$1,436,000**	Formula: 10% High Estimates Subtotal
Lower Estimate	**$704,000**	Formula: 10% Low Estimates Subtotal

IX. Administration and Management

Upper Estimate	**$718,000**	Formula: 5% High Estimates Subtotal
Lower Estimate	**$352,000**	Formula: 5% Low Estimates Subtotal

Total Program Annual Cost

Upper Estimate	**$16,512,000**
Lower Estimate	**$8,088,000**

Per Capita Funding Ranges

Upper Estimate	**$27.10**
Lower Estimate	**$13.27**

Office on Smoking and Health
Centers for Disease Control and Prevention
Telephone Number: 770-488-5705
http://www.cdc.gov/tobacco
E-Mail Address: tobaccoinfo@cdc.gov

Introduction

The goal of a comprehensive tobacco control program is to reduce disease, disability, and death related to tobacco use by

- Preventing the initiation of tobacco use among young people.
- Promoting cessation among young people and adults.
- Eliminating nonsmokers' exposure to ETS.
- Identifying and eliminating the disparities related to tobacco use and its effects among different population groups.

The Centers for Disease Control and Prevention (CDC) has prepared these best practices to help States assess options for comprehensive tobacco control programs and to evaluate their local funding priorities. This document draws on "best practices" determined by evidence-based analyses of excise tax-funded programs in California and Massachusetts and by CDC's involvement in providing technical assistance in the planning of comprehensive tobacco control programs in other States with excise tax-funded programs (Oregon and Maine) and in the four States that individually settled lawsuits with tobacco companies (Florida, Minnesota, Mississippi, and Texas).

Reducing tobacco use requires a partnership between the Federal government and States. The Federal government has undertaken a number of important activities that provide a foundation for State action. Scientific data about the extent of tobacco use, the impact of tobacco use, and interventions to reduce tobacco use have been generated and disseminated by several Federal government agencies including the National Institutes of Health, the Centers for Disease Control and Prevention, the Substance Abuse and Mental Health Services Administration, and the Agency for Health Care Policy and Research.

The Federal government has supported a number of surveys of tobacco use among adults and youth through the Centers for Disease Control and Prevention (Behavioral Risk Factor Survey, National Health Interview Survey, and Youth Risk Behavior Survey), the National Institutes of Health (Current Population Survey and Monitoring the Future Study), and the Substance Abuse and Mental Health Services Administration (National Household Survey on Drug Abuse). SAMHSA's household survey is of particular note because it will collect annual data on brands of cigarettes and other forms of tobacco used by young people and adults.

The Federal government also has sponsored research on the health impact of tobacco use, determinants of tobacco use, and interventions to reduce tobacco use. The majority of this research has been supported by the National Institutes of Health's National Cancer Institute (NCI); however, other Institutes also have been involved, including the National Institute on Drug Abuse, National Institute of Child Health and Development, and the National Heart, Lung, and Blood Institute. Besides supporting disease-specific research, NCI has supported intervention studies including mass media and school trials and large-scale demonstration projects such as COMMIT and ASSIST. The Centers for Disease Control and Prevention also supports applied research through its Prevention Research Centers; this research has a particular focus on racial/ethnic and gender differences in tobacco use determinants and patterns.

Furthermore, multiple Federal government agencies support programs to prevent and reduce tobacco use. SAMHSA implements the Synar regulation to reduce youth access to tobacco products through State-level compliance activities. FDA is implementing the minors' access provisions of its tobacco regulations through contracts with States for enforcement efforts and educational interventions, including retailer outreach and media campaigns. The Agency for Health Care Policy and Research has published clinical practice guidelines on smoking cessation and has worked with a variety of health care organizations to ensure that the guidelines are implemented. Additionally, CDC supports several programs to prevent and reduce tobacco use including the National Tobacco Control Program, which in FY 1999 will fund all 50 States, the District of Columbia, and the territories to establish core tobacco use prevention and reduction programs. CDC has also developed educational and media programs including the Media Campaign Resource Center, which makes high-quality, anti-smoking advertising materials available for use by States and organizations.

Although the Federal government has undertaken a number of critical activities to curb tobacco use, State and local community action is required to ensure the success of tobacco control interventions. In acknowledgment of the unique role that States and communities play in tobacco control efforts, these best practices provide technical information to assist States in designing comprehensive programs.

CORRECTION

THE FOLLOWING DOCUMENT(S)
HAVE BEEN REFILMED TO
ASSURE LEGIBILITY OR PAGINATION

Introduction

The goal of a comprehensive tobacco control program is to reduce disease, disability, and death related to tobacco use by

- Preventing the initiation of tobacco use among young people.
- Promoting cessation among young people and adults.
- Eliminating nonsmokers' exposure to ETS.
- Identifying and eliminating the disparities related to tobacco use and its effects among different population groups.

The Centers for Disease Control and Prevention (CDC) has prepared these best practices to help States assess options for comprehensive tobacco control programs and to evaluate their local funding priorities. This document draws on "best practices" determined by evidence-based analyses of excise tax-funded programs in California and Massachusetts and by CDC's involvement in providing technical assistance in the planning of comprehensive tobacco control programs in other States with excise tax-funded programs (Oregon and Maine) and in the four States that individually settled lawsuits with tobacco companies (Florida, Minnesota, Mississippi, and Texas).

Reducing tobacco use requires a partnership between the Federal government and States. The Federal government has undertaken a number of important activities that provide a foundation for State action. Scientific data about the extent of tobacco use, the impact of tobacco use, and interventions to reduce tobacco use have been generated and disseminated by several Federal government agencies including the National Institutes of Health, the Centers for Disease Control and Prevention, the Substance Abuse and Mental Health Services Administration, and the Agency for Health Care Policy and Research.

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Although the Federal government has undertaken a number of critical activities to curb tobacco use, State and local community action is required to ensure the success of tobacco control interventions. In acknowledgment of the unique role that States and communities play in tobacco control efforts, these best practices provide technical information to assist States in designing comprehensive programs.

Introduction

In this guidance document, CDC recommends that States establish tobacco control programs that are comprehensive, sustainable, and accountable. This document draws upon "best practices" determined by evidence-based analyses of comprehensive State tobacco control programs. Based upon this evidence, specific funding ranges and programmatic recommendations are provided. Local analysis of each State's priorities should shape decisions regarding funding allocations for each recommended program component. The funding required for implementing programs will vary depending on state characteristics, such as demographic factors, tobacco use prevalence, and other factors. Although the type of supporting evidence for each of the recommended nine program components differs, evidence supports the implementation of some level of activity in each program area. In general, States typically have selected a funding level around the middle of the recommended ranges. Current allocations range from $2.50 to over $10; however, no State is currently implementing all of the recommended program components fully. Approximate annual costs to implement all of the recommended program components have been estimated to range from $7 to $20 per capita in smaller States (population under 3 million), $6 to $17 per capita in medium-sized States (population 3 to 7 million), and $5 to $16 per capita in larger States (population over 7 million).

The Health Consequences of Tobacco Use[1]

Tobacco use is the single most preventable cause of death and disease in our society. Annually, tobacco use causes more than 430,000 deaths and costs the Nation approximately $50–$73 billion in medical expenses alone. Tobacco use is addictive: nearly 70% of smokers want to quit smoking, but only 2.5% are able to quit permanently each year. Most smokers start smoking as adolescents. The number of American teenagers taking up daily smoking jumped 73% between 1988 and 1996. Each day, more than 6,000 persons younger than age 18 try their first cigarette, and more than 3,000 become daily smokers. One in three teens who are regular smokers will eventually die of smoking-related causes.

Other tobacco products also have serious health consequences. Use of smokeless tobacco is associated with leukoplakia and oral cancer. Although very little was known until recently about the health risks of cigar smoking, there is now strong evidence of causal relationships between regular cigar use and cancers of the lungs, larynx, oral cavity, and esophagus. These consequences are of particular concern because in 1997, 22% of high school students smoked cigars and 9.3% used smokeless tobacco.

The risks of tobacco use extend beyond actual users. Nearly 9 of 10 nonsmoking Americans are exposed to environmental tobacco smoke (ETS). Exposure to ETS increases nonsmokers' risk for lung cancer and heart disease. Among children, ETS is also associated with serious respiratory problems, including asthma, pneumonia, and bronchitis. Additionally, substantial evidence now links ETS with sudden infant death syndrome and low birth weight.

The consequences of tobacco use have become an issue of global concern. The World Health Organization estimates that 3 million people die every year of tobacco-related diseases. Without effective international tobacco control programs, the death toll will increase to as many as 10 million people by 2030, and 7 million of these deaths will occur in developing countries. Successful programs in the United States to reduce tobacco use will provide valuable models to help other countries successfully address the growing tobacco use epidemic.

Efficacy of Comprehensive Tobacco Control Programs: California and Massachusetts

Evidence supporting the programmatic recommendations in this guidance document are of two types. Recommendations for chronic disease programs to reduce the burden of tobacco-related diseases, school programs, cessation programs, enforcement, and counter-marketing program elements are based primarily upon published evidence-based guidelines. Other program categories rely mainly upon the evidence of the efficacy of the large-scale and sustained efforts of two States (California and Massachusetts) that have been funding comprehensive tobacco prevention and control programs using State tobacco excise taxes. Increasing excise taxes on cigarettes reduces tobacco consumption rates. But more importantly, when the excise taxes support effective community, media, and school programs to prevent tobacco use, decreases in per capita consumption will continue even if industry lowers tobacco prices to preexcise tax values.[2] The tobacco industry itself has concluded that "the California campaign and those like it represent a very real threat to the industry in the intermediate term..."[3] and "the environment for the sale and use of tobacco products in California continues to deteriorate. And because California serves as a bellwether State, tobacco-related steps taken there often find their way into other States."[4]

Best Practices

This document provides evidence to support each of nine specific elements of a comprehensive program. However, in addition to highlighting the importance of the individual program elements, it is equally critical to recognize why these individual components must work together to produce the synergistic effects of a comprehensive program.[5] Reducing the broad cultural acceptability of tobacco use necessitates changing many facets of the social environment. This scale of societal change is a complex process that must be addressed by multiple program elements working together in a comprehensive approach. For example, school programs are effective in isolation, but evidence indicates that their efficacy is greatly increased when combined with community programs and media campaigns.[6] Through evidence-based analyses in California and Massachusetts, in-depth involvement with settlement States, and published evidence of effective tobacco control strategies, CDC recommends that States establish tobacco control programs that contain the following elements:

- Community Programs to Reduce Tobacco Use.
- Chronic Disease Programs to Reduce the Burden of Tobacco-Related Diseases.
- School Programs.
- Enforcement.
- Statewide Programs.
- Counter-Marketing.
- Cessation Programs.
- Surveillance and Evaluation.
- Administration and Management.

For each of these categories, the best practices that follow provide

- Justification for the program element.
- Budget estimates for successful implementation.
- Core resources to assist implementation.
- References to scientific literature.

All core resources listed in this document, or the contacts to obtain them, are available from CDC's Office on Smoking and Health. To request copies, please call 770-488-5705 (press 2 or 3) or send an E-mail to tobaccoinfo@cdc.gov.

General Planning Resources

Advocacy Institute Tobacco Control Project. The Money is Coming! The Money is Going! Strategic Advisory Series Online Publication. 1998. (http://www.scarcnet.org/hsap/intrmon.htm).

American Cancer Society. Advocating for State Tobacco Control: An American Cancer Society Planning Guide. June 1998.

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Centers for Disease Control and Prevention, Office on Smoking and Health. State Tobacco Control Highlights—1996. Atlanta, GA: Centers for Disease Control and Prevention, 1996. (Updated on http://www.cdc.gov/tobacco/statehi/statehi.htm).

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Texas Inter-Agency Tobacco Task Force. Legislative Plan. October 1998.

U.S. Department of Health and Human Services. Office of Public Health and Science. Healthy People 2010 Objectives. Chapter 3. Tobacco Use. Washington, DC: U.S. Department of Health and Human Services, September 15, 1998. (http://web.health.gov/healthypeople/2010Draft/object.htm).

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1 U.S. Department of Health and Human Services. Office of Public Health and Science. Healthy people 2010 objectives. Tobacco use. Washington, DC: U.S. Department of Health and Human Services, September 15, 1998;3:1-24 (http://web.health.gov/healthypeople/2010Draft/object.htm).

2 Centers for Disease Control and Prevention. Cigarette smoking before and after an excise tax increase and antismoking campaign—Massachusetts, 1990–1996. *MMWR* 1996;45:966–70. (http://www.cdc.gov/epo/mmwr/preview/mmwrhtml/00044337.htm).

3 Verner KL. California antismoking campaign funding (letter), January 29, 1991. RJ Reynolds Litigation Document, Minnesota Depository, Bates No.: 507755351–5354.

4 California Department of Health Services. A model for change: the California experience in tobacco control. Sacramento, CA: California Department of Health Services, October 1998.

5 Controlling the smoking epidemic. Report of the WHO Expert Committee on Smoking Control. Geneva: World Health Organization, 1979. WHO Technical Report Series, No.: 636.

6 U.S. Department of Health and Human Services. Preventing tobacco use among young people: a report of the Surgeon General. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 1994.

1-LS0247\I.1
Ford
1/26/00

AMENDMENT #1

OFFERED IN THE SENATE

TO: CSHB 37(FIN)

Page 2, line 4, following "States;":

Insert "this subparagraph does not apply to cigarettes sold or intended to be sold as duty-free merchandise by a duty-free sales enterprise under 19 U.S.C. 1555(b); however, this subparagraph does apply to duty-free cigarettes that are brought back into the state for resale in the state;"

AMENDMENT #2

OFFERED IN BY

TO: Proposed CS for House Bill 37( )
(1-LS0247\I)

Page 1, line 7:

Add to existing subsection (g):

(g) A person who is required to hold a business license endorsement under this section, or under AS 43.50.010, or agrees to be licensed under AS 43.50.010 or an agent or employee of the person, may not

Page 2, line 9:

Add to existing subsection (i):

(i) The commissioner of commerce or commissioner of revenue may seize cigarettes that do not comply with this section. After notice and an opportunity for hearing, the commissioner of commerce or commissioner of revenue shall destroy cigarettes seized under this subsection.

The Alaska Tobacco Control Program

A PLAN FOR THE FUTURE

prepared by the
Alaska Tobacco Control Alliance
March 5, 1999

This Plan for the Future is dedicated to the memory of Dorris Ann Brewer of Soldotna, Alaska, shown here with her granddaughter, Olivia. Dorris died of complications from emphysema on June 29, 1997. She was 59 years old.

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"The scientific evidence shows us that price increases coupled with the implementation of effective tobacco control programs can dramatically reduce the use of tobacco products. Alaska has led the way with increasing the price of tobacco products, and now has the opportunity to put in place proven tobacco prevention programs."

Michael Eriksen, M.D.
Director, Office on Smoking and Health
Centers for Disease Control and Prevention

INTRODUCTION

Formed in 1992, the Alaska Tobacco Control Alliance (ATCA) is a statewide coalition of organizations and individuals working to reduce the leading cause of preventable death in Alaska—tobacco use.

While tobacco prevention and control activities have increased since ATCA was initially formed, current efforts fall far short of what is needed to effectively counter tobacco industry tactics and reach state and national goals for tobacco use reduction.

In 1996, the federal Centers for Disease Control and Prevention (CDC) estimated that 18,000 Alaskans currently under the age of 18 would eventually die prematurely from tobacco-caused disease. Passage of the 71¢/pack tobacco tax increase in 1997 led to a revised estimate of approximately 14,000 premature deaths—a 22% decrease. While the tobacco tax increase was an important first step, 14,000 deaths represents a staggering loss and one which Alaskans should not accept as inevitable. It should also be noted that the 14,000 estimated deaths does not include the future smoking-related deaths among Alaskan adults who currently smoke.

With the passage of the tobacco tax increase in 1997 and Alaska's settlement with the tobacco industry in 1998, state government will soon be collecting over $70 million annually from tobacco sources, yet the current state budget for tobacco control (general fund dollars) is only $200,000. (See bar graph on inside back cover.)

Both the State of Alaska and the U.S. Department of Health and Human Services have set a goal of reducing smoking prevalence to no more than 15%. Alaska's current smoking rate is 27%. This goal can only be accomplished if we invest significant resources in tobacco prevention and cessation programs. The CDC has recommended a spending level for Alaska of $8.7 to $17.7 million to achieve a 44% reduction in smoking prevalence and similar reductions in smokeless tobacco use.

This plan outlines a comprehensive, long-term program for reducing tobacco-caused addiction, disease, and death. It calls for a broad-based collaborative effort involving state and local policy makers, the professional health care community, businesses, educators, parents, and children. It incorporates strategies proven to be effective in fighting the tobacco epidemic.

Success will require resources and partnerships including both the public and private sectors. To significantly reduce tobacco use and decrease the human and economic costs, Alaska must institute a plan that will prevent children from becoming addicted, help youth and adults who want to quit, and protect non-smokers from secondhand smoke.

The goals are within reach. It is time to move ahead and achieve them.

ATCA Steering Committee:

Alaska Council on Prevention of Alcohol and Drug Abuse
American Cancer Society, Western Pacific Division
Alaska Dental Society
Alaska Department of Health and Social Services
American Heart Association - Alaska Affiliate
Alaska Health Fair, Inc.
Alaska Native Health Board
Alaska Native Medical Center
Alaska Public Health Association
Alaska State Medical Association
American Lung Association of Alaska
Anchorage School District
Bristol Bay Area Health Corporation
KD Consulting
Municipality of Anchorage, Department of Health and Human Services
Nome Community Center - Young Teen Center
Rural Alaska Community Action Program
Sitka Prevention and Treatment Services
Southeast Alaska Regional Health Consortium
Tanana Chiefs Conference

HEALTH IMPACTS OF TOBACCO

SINCE THE FIRST U.S. SURGEON GENERAL'S REPORT on smoking and health was published in 1964, more than 10 million Americans have died from smoking-related causes.[1]

Nothing kills like tobacco.

- **Smoking is the leading cause of preventable death** in Alaska, as in the U.S. as a whole.[2]
- **Tobacco is responsible for one out of five deaths** in Alaska, or almost 500 deaths a year. From 1992-1994, smoking accounted for 19.8% of all deaths in Alaska.[3]
- **Almost 14,000 Alaskans under the age of 18 alive today** will eventually die from tobacco-caused illness unless current trends are reversed.[4]
- **Smoking kills half of all long-term users** and half of those people die in middle age from a variety of diseases including heart disease, lung cancer, other cancers, and respiratory illness.[5]
- **Almost all smokers first become addicted as children.** The average age of new smokers is 14.5.[6]
- **Smoking is not just a problem for smokers.** Secondhand smoke, also known as environmental tobacco smoke (ETS), is a significant cause of disease and death in non-smokers.

TOTAL NUMBER OF DEATHS AND ESTIMATED SMOKING-RELATED DEATHS IN ALASKA, 1992-94[9]

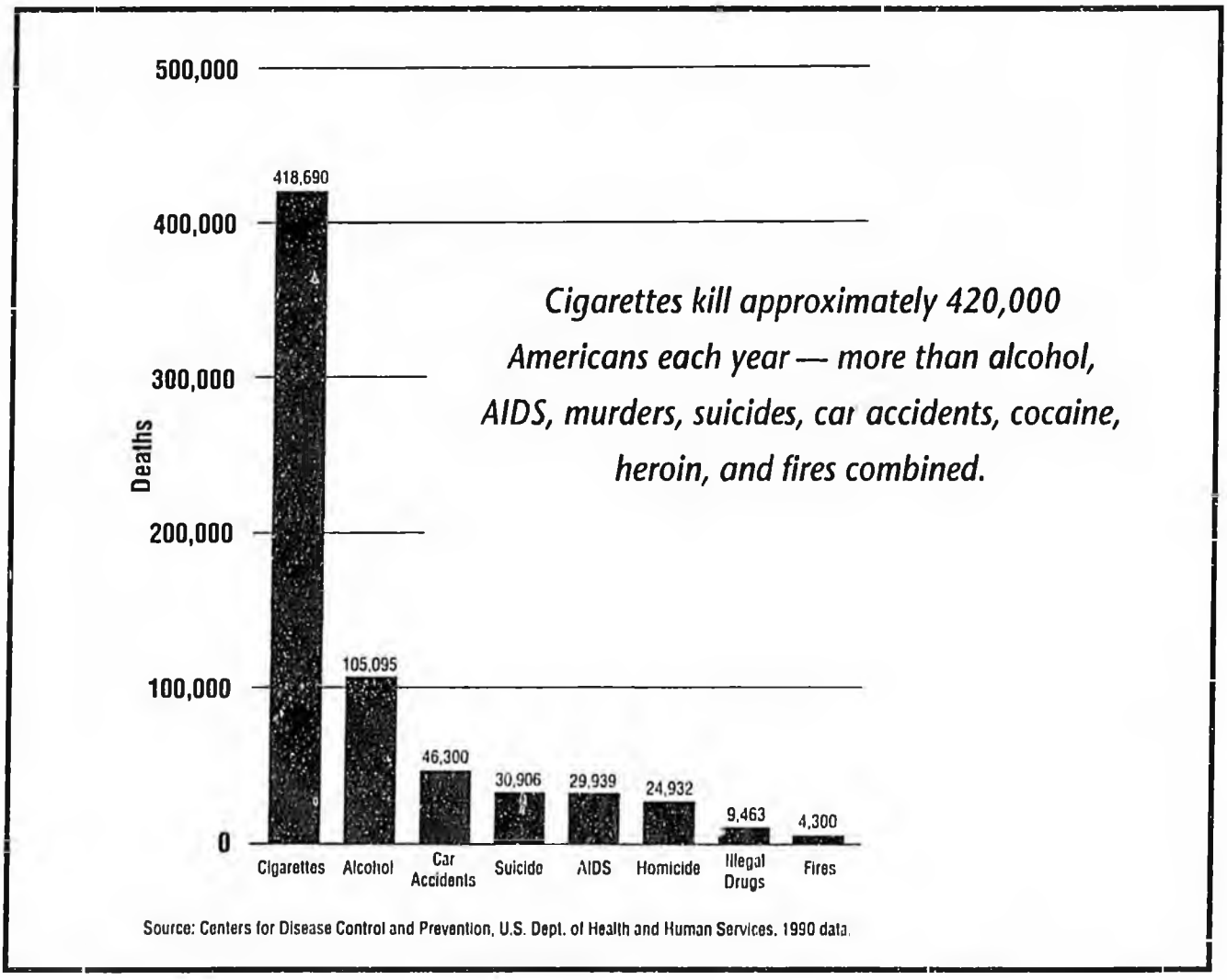
Cause of Death	Total # of Deaths	Smoking Related Deaths	Percent Smoking Related
Cardiovascular	2,010	533	26.5%
Cancers	1,655	546	33.0%
Respiratory	503	260	51.7%
Perinatal (<12 mos)	204	14	6.9%
TOTAL	7,159	1,416	19.8%

- **Secondhand smoke is the third leading cause of death** in this country, behind active smoking and alcohol abuse.[7]
- **The disease caused by tobacco use takes many forms.** Deaths related to cigarette smoking include a portion of cardiovascular disease; cancers of the lung, larynx, oral cavity, esophagus, pancreas, bladder, kidney, and cervix; chronic bronchitis, emphysema, and other respiratory deaths.[8]

HEALTH IMPACTS OF TOBACCO

- **Cigarettes kill approximately 420,000 Americans each year** — more than alcohol, AIDS, murders, suicides, car accidents, cocaine, heroin, and fires combined.[10]

- **Smoking can cause spontaneous abortion** in pregnant women who smoke, as well as premature birth and low birth weight infants. Maternal smoking can play a role in Sudden Infant Death Syndrome (SIDS).[11]



Source: Centers for Disease Control and Prevention, U.S. Dept. of Health and Human Services. 1990 data.

HEALTH IMPACTS OF TOBACCO

- **Secondhand smoke or environmental tobacco smoke (ETS)** causes cancer, heart disease, asthma, and other illnesses in non-smokers.[12]

- **Estimates of total annual deaths from ETS in the United States range from 40,036 to 76,912 with a mid-range estimate of 53,974.**[13] This means that for every eight smokers killed by tobacco, one non-smoker dies too.

- **In Alaska, that means about 60 people die each year** from illness and disease caused by secondhand smoke.

"Tobacco products are the cause of major morbidity and mortality among humans from the time of conception onward... At least three times as many infants die of SIDS caused by maternal smoking as are killed as a result of homicide or child abuse."

Joseph R. DiFranza, M.D.
University of Massachusetts

- **The effects of exposure to secondhand smoke are especially severe in children.** Respiratory health effects of ETS exposure in children include middle ear infections, asthma, bronchitis, and pneumonia. At least 6,200 children die each year in the U.S. because of their parents' smoking.[14]

- **Cigar smokers have similar death rates from oral, laryngeal, and esophageal cancers as do cigarette smokers** and face increased risk of lung cancer and chronic obstructive lung disease compared to non-smokers.[15]

- **Smokeless tobacco causes cancers of the mouth and pharynx** and may play a role in other cancers.[16]

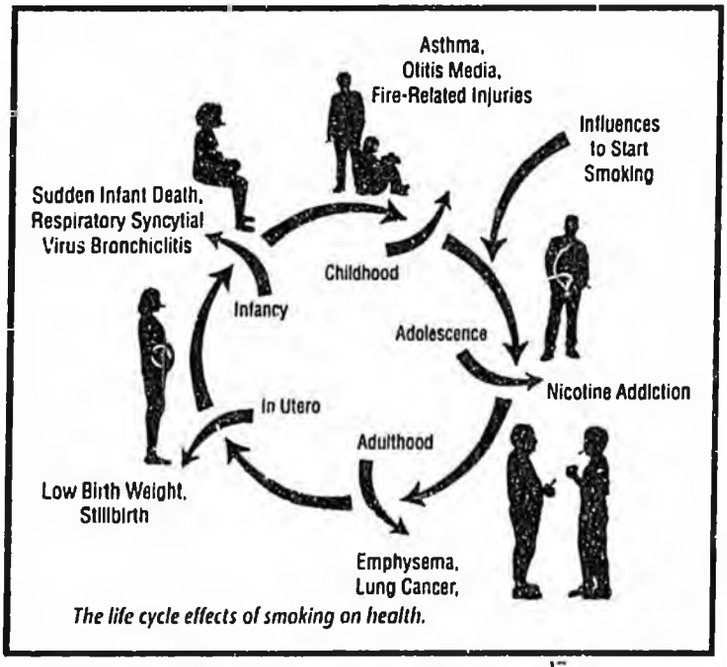


Figure 2. *The life cycle of the effects of smoking on health.*[17]

TOBACCO USE & NICOTINE ADDICTION

Tobacco addiction is a "pediatric disease."

Alaska has one of the highest smoking rates in the country with an adult smoking prevalence of 26.5%.[18] Eighty percent of those smokers report that they want to quit.[19]

- **Tobacco addiction is described as a "pediatric disease" because addiction nearly always starts in childhood** — 89% of smokers start before age 19 with 14.5 as the average age of initiation.[20] In Alaska, 84% of adult smokers report having started before between the ages of 10 and 20.[21]

- **Each day nationwide, some 3,000 youth under age 18 become daily smokers.**[22] These young people are targeted by the tobacco industry to replace the hundreds of thousands of adults who die or quit each year.

- **Smoking among high-school seniors in the U.S. is at a 19-year high.** The number of American teenagers taking up smoking as a daily habit jumped 73% between 1988 and 1996.[23]

- **Tobacco appears to be a "gateway drug" for teenagers.** Teens who smoke are far more likely than their nonsmoking peers to use other drugs.[24]

- **The 1995 Youth Risk Behavior Survey (YRBS) found 36.5% of Alaskan high school students were "current smokers,"** having smoked one or more cigarettes in the past 30 days, and 21.1% were "frequent smokers," having smoked on at least 20 of the last 30 days.[25]

TOBACCO USE AMONG HIGH SCHOOL STUDENTS, 1995

	Alaska	Alaska Native	U.S.
Current Smokers	36.5%	61.9%	34.8%
Frequent Smokers	21.1%	43.7%	16.1%
Smokeless Tobacco	15.6%	22.5%	11.4%

- **The 1995 YRBS also found that 15.6% of Alaskan high school students used smokeless tobacco,** including 22.5% of Alaska Natives students.

TOBACCO USE & NICOTINE ADDICTION

- **What starts as an experiment by youth soon becomes a long-term addiction** with 70% of adolescent smokers wishing they had never started smoking in the first place.[26]

- **The U.S. Surgeon General's office reports that nicotine dependence is the most common form of drug addiction** and one of the most difficult to overcome. Researchers widely regard nicotine to be as addictive as heroin or cocaine.[27]

"Well, do you think I chose to smoke? Do you believe that I took a cigarette and said, 'I think I'll smoke this one and then maybe four hundred thousand more?' "

47-year old smoker speaking of addiction
as reported by Dr. David Kessler

- **Of the 20 million Americans who try to quit smoking each year,** only 3% have long-term success.[28]

- **Some cessation strategies have proven successful** in helping smokers quit, including behavioral counseling, nicotine replacement therapy, the prescription drug bupropion, and encouragement from doctors.[29] A combination of these strategies can boost 1-year success rates above 50%.[30] However, these strategies are currently underutilized.

- **Limited information about options, the expense of cessation services, and lack of insurance coverage** often hampers tobacco users who want to quit but do not know how to effectively overcome their nicotine addiction.

Alaska Natives suffer 23.2% of smoking-related deaths, although Natives comprise only 16.5% of the state's population. The disproportionate impact of tobacco use on Natives is due to extremely high rates of tobacco use in the Native population (45.1%).[31]

ECONOMIC IMPACTS OF TOBACCO USE

In addition to the human suffering from disease and death, tobacco burdens all members of society with economic costs associated with preventable health care expenditures and lost worker productivity.

- **Current and former smokers in the U.S. generate over $500 billion in excess health care costs** over the course of their lives,[32] even though smokers die an average of eight years younger than non-smokers.[33]

- **Total medical expenditures attributable to smoking amount to over $70 billion a year in the U.S.** In Alaska, total medical expenditures attributable to smoking are estimated at $154 million annually.[34] Of this total, Medicaid pays $23.6 million.[35]

- **The total state and federal tax burden from tobacco-caused health costs in Alaska** is estimated to be $70 million a year, or $320 a year per household.[36]

- **Tobacco use also impacts the economy through lost worker productivity** due to illness and early death. These costs are borne largely by Alaskan employers.

MEDICAL COSTS ATTRIBUTABLE TO SMOKING IN ALASKA

Total annual health care expenditures in Alaska directly related to smoking	$154,000,000
Total annual state Medicaid payments directly related to smoking	$23,600,000
Additional expenditures in Alaska for health and developmental problems of infants caused by their mothers' smoking or being exposed to secondhand smoke during pregnancy[37]	$8,000,000

THE TOBACCO INDUSTRY

As a public health threat, tobacco use is distinct not only by virtue of the staggering magnitude of the disease and death caused by the product, but also because of the powerful industry that profits from tobacco use. Tobacco is the only consumer product that kills when used exactly as intended, yet it is also one of the least regulated products.

"The difference between malaria and tobacco is that mosquitos don't hire PR firms and make campaign contributions."

Stanton Glantz, MD
University of California, San Francisco

- **Nicotine addiction is big business.** The industry spends $5 billion a year on advertising and promotions alone, averaging $13 million a day.[38]

- **Studies show that youth are more influenced by tobacco advertising than are adults.** For example, the three most heavily advertised brands of cigarettes (Marlboro, Camel, and Newport) are preferred by 86% of underage smokers but only 35% of adult smokers. Marlboro, the most advertised brand, constitutes about 60% of the youth market but only about 25% of the adult market.[39]

- **According to the CDC, youth oriented advertising and promotional campaigns have played a key part in the sharp increase in youth smoking rates** since Joe Camel made his debut in 1988. Youth smoking is currently at a 19 year high.[40]

- **While tobacco companies say that they don't want kids to smoke,** they have fought with tremendous resources to defeat all serious efforts to reduce youth tobacco use. The defeat of anti-tobacco legislation in Congress (the "McCain bill") is a recent example.

"Today's teenager is tomorrow's potential regular customer."

1981 Philip Morris internal document

- **In spring 1997, RJ Reynolds sent a spokesperson to Alaska** to try to persuade legislators that a tobacco tax increase would lead to a huge smuggling problem. In December 1998, an RJ Reynolds affiliate pled guilty to federal criminal charges stemming from a scheme to smuggle untaxed cigarettes into Canada.[41]

THE TOBACCO INDUSTRY

- **When other dangerous consumer products, drugs and health threats** such as DDT, asbestos, and PCEs have been brought under strict regulation, why has so little progress been made to reduce the disease and death caused by tobacco? The answer lies in the tobacco lobby's extraordinary economic and political power. Tobacco is so addictive and so profitable, it yields billions of dollars in profits a year—a massive treasury to fuel a multifront war against the underfunded forces of public health.

"Leave it to the tobacco industry to call inhaling 43 known carcinogens refreshing."

message on poster
California Dept. of Health Services

- **In its successful bid to kill comprehensive tobacco control legislation in Congress in 1998,** the industry hired one lobbyist for every two and a half members of Congress and spent $40 million on the most expensive political advertising campaign ever undertaken on a piece of pending legislation. Independent analysis by the Annenberg Public Policy Center described statements in the industry ads as "false," "misleading," and "deceptive."[42]

Profits premised on addiction, resulting in disease and death.

- **Tobacco companies use their huge profits to promote their products. Messages to use tobacco are visible everywhere,** even in remote Alaska, where Marlboro, Camel, and Winston logos are found on caps, bags, and shirts—items that are particularly appealing to youth.

- **In public statements, the tobacco industry has long denied that tobacco is addictive,** even in sworn statements to Congress. However, internal company documents reveal that the industry has known about the addictive properties of nicotine for decades.[43]

- **Tobacco company documents disclosed in litigation revealed industry efforts to skew the scientific record** by paying scientists to write letters to journals questioning secondhand smoke as a cause of cancer. The industry paid 13 scientists more than $156,000 to write letters to prominent journals and the Tobacco Institute paid $10,000 for a single letter.[44]

A VISION FOR THE FUTURE: ELEMENTS OF A STATE PLAN

Healthy People 2000 national objectives and Healthy Alaskans 2000 objectives both call for reducing smoking prevalence to no more than 15% in youth and adults. This is a huge challenge in a state with one of the highest smoking rates in the nation. Smokeless tobacco use is also a serious problem in Alaska.

"The most important public health issue of our time."

C. Everett Koop, MD

To significantly reduce tobacco use and decrease the human and economic costs, Alaska must establish and fund a comprehensive plan that will:

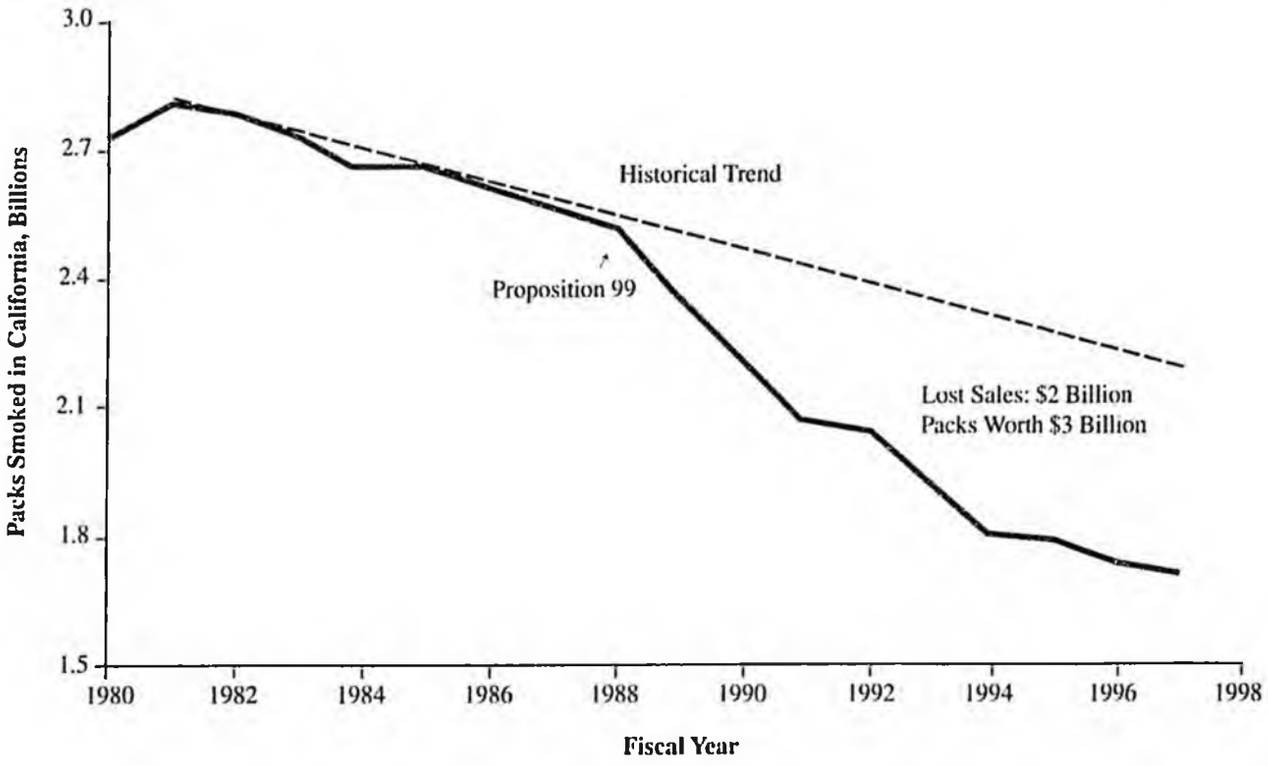
- prevent children from becoming addicted,
- help youth and adults who want to quit, and
- protect nonsmokers from secondhand smoke.

Experts agree there is no "magic bullet" that will quickly change social norms about tobacco use and end the tobacco epidemic. All elements of a comprehensive strategy must be supported. The most effective and efficient program will utilize a coordinated, decentralized approach that puts the great majority of resources into communities and organizations outside of state government.

Such an effort must involve kids, parents, teachers, health workers, law enforcement personnel, employers, and policy makers. Community-based projects, school-based projects, and state-of-the art cessation services are key components. Equally critical to the overall program is a sophisticated, high-profile statewide media campaign that will raise public awareness of tobacco issues and support other prevention and cessation efforts. Coordination, evaluation, and enforcement are other elements of a comprehensive tobacco control program.

Recently the Centers for Disease Control and Prevention has assisted states by developing program and funding guidelines for comprehensive state tobacco control programs. The CDC guidelines were developed through evidence-based analyses in California and Massachusetts, where large, comprehensive state programs funded with tobacco tax revenues have been in existence for several years. In these two states, per capita consumption of tobacco has declined more rapidly than in the rest of the country and tobacco use among youth has slowed in comparison to national trends. In California, cigarette consumption has declined more than 40% overall; Massachusetts has seen a 31% reduction in smoking since its program was implemented.[46]

DECLINE OF TOBACCO CONSUMPTION IN CALIFORNIA, 1980-1997[46]



In 1988, California voters approved a 25¢ per pack cigarette tax increase with 20% of the revenues dedicated to programs to reduce tobacco use. Since then, smoking consumption in California has declined by more than 40%.

A VISION FOR THE FUTURE: ELEMENTS OF A STATE PLAN

CDC recommends that states establish tobacco control programs that are comprehensive, sustained over time, and that utilize community partnerships. For Alaska, the CDC recommends $8.7 million per year as a minimum level of funding for an effective statewide program, with an optimum funding level of $17.7 million per year.[47]

In developing this plan for Alaska, Alaska Tobacco Control Alliance work group members studied the CDC guidelines, spoke with individual program people at CDC, consulted with experts in other states, considered the unique characteristics of our state, and built a plan "from the bottom up." That is, members identified the essential elements of a comprehensive program and then determined what it would really take to implement those programs in Alaska.

"We must not allow the past to become the future."

Work group members also understood the need to be pragmatic, particularly in light of the state's current fiscal challenge and other important needs confronting policy makers. For this reason, the budget for the Alaska Tobacco Control Program totals only $8.2 million – less than even the minimum funding level recommended by CDC. This figure represents only about 30% of the average annual payment to Alaska from the state's settlement with the tobacco industry.

In the words of one CDC official, there is a "dose-response relationship" between funding for tobacco control and reductions in tobacco use. That is, greater funding results in greater reductions. An annual funding level of $8.2 million should be thought of as the *minimum* needed for a comprehensive program in Alaska. Increased funding can be expected to result in larger and more rapid declines in tobacco use among youth and adults.

The following pages provide more detail on the seven central components of the Alaska Tobacco Control Program:

Community Programs	$2 million
Cessation Programs	$1.4 million
Countermarketing	$1 million
School-Based Programs	$750,000
Tobacco-Free Partnership Projects	$1.8 million
Enforcement	$600,000
Program Development, Management, and Evaluation	$650,000
TOTAL	$8.2 million

COMMUNITY PROGRAMS TO REDUCE TOBACCO USE

Community efforts to change public attitudes and behaviors about tobacco represent a key component in any comprehensive program to reduce tobacco addiction. Such efforts must involve as many community members as possible in planning and carrying out public awareness campaigns and other activities to promote tobacco-free social norms. Coordination and technical assistance will ensure that community partners are accountable for effective project implementation.

For example...

Community efforts could include:

- local coalitions of parents, youth, business people, religious leaders, health workers, and other concerned individuals implementing a campaign to encourage voluntary smoke-free home policies.
- efforts to encourage tobacco merchants to check ID and refuse sale to underage customers.
- peer training programs such as Teens Against Tobacco Use, in which teenagers serve as educators and role models for younger children.
- campaigns designed to reduce "social sources" of tobacco to minors (e.g., adults giving or buying tobacco for use by kids).
- efforts to increase the number of smoke-free workplaces and public places.
- community health fairs that include tobacco prevention and cessation information and workshops.
- special pilot projects to explore and evaluate innovative approaches for tobacco use reduction.

Costs and funding

A minimum budget of $2 million is recommended for Community Programs.

- Within this program, grants would be provided to non-profit organizations, local government agencies, local businesses, ethnic organizations, and other community partners.
- Approximately three-fourths of the funds would be used to support community coalitions in their efforts to address the three major areas of tobacco control (reducing youth initiation, protecting nonsmokers from ETS, and promoting cessation for youth and adults).
- Approximately one-fourth of the funds would be distributed as grants to conduct and evaluate pilot programs that are community or regionally based.

When communities change their outlook and their policies about tobacco use it's more likely that tobacco users will be able to quit, and less likely that young people will begin using tobacco... Coalitions of community members are especially important when involved in efforts to change community norms.

from "Tobacco Prevention and Education Program Report - 1999"
Oregon Health Division

The vast majority of smokers want to quit. Those who succeed greatly reduce their risk of smoking-related disease and early death. In addition, helping adults to quit smoking protects their children from the dangers of secondhand smoke and can reduce the number of newborn babies who suffer or die as a result of "passive smoking." Cessation programs that include counseling and pharmaceutical support can increase success rates dramatically. Other components of a statewide tobacco control program, such as community-based projects and a high profile media campaign, will help motivate smokers to take advantage of cessation services.

For example...

The following are characteristics of an effective tobacco cessation component:

- The program must include a statewide, toll-free "Quit Line" that allows callers to talk to trained cessation counselors. Up to six follow-up calls will be made to "quitters" to provide additional support during those critical early days and weeks.
- Callers with insurance coverage for cessation products (nicotine replacement therapy or bupropion) will be linked to providers. Callers without insurance coverage for cessation will be provided with appropriate cessation products free of charge.
- A systematic effort must be made to train health care providers (doctors, dentists, community health aides) in implementing the Clinical Practice Guidelines for smoking cessation developed by the federal Agency for Health Care Policy and Research.
- Success of the cessation component will be greatly enhanced by a strong marketing effort (e.g., paid media), referrals to the Quit Line by health care providers, and community campaigns to promote cessation.

Costs and funding

A minimum budget of $1.4 million is recommended for the Cessation Program.

- It is estimated that operation of a statewide Quit Line would cost $850,000 per year. In other states, contracts have been made with universities, HMOs, and non-profit health organizations to provide Quit Line services.
- Costs for pharmaceutical cessation products for Quit Line participants who do not have insurance coverage are estimated at $300,000.
- A statewide training program targeting health care providers could be funded with $250,000 through contract with one or more non-profit organizations.
- Paid media costs are included in the Countermarketing budget.

"As cigarette taxes and tobacco settlement dollars increasingly provide support for social and health care programs, it is morally imperative for us as a society to use a portion of this money to ensure that motivated tobacco users have easy access to proven help for quitting."

Tim McAfee, MD, Group Health of Puget Sound

COUNTERMARKETING

No one knows better than the tobacco industry the power of advertising and product promotion. Health advocates can use these same tools with powerful impact. Research shows that tobacco countermarketing promotes quitting, decreases the likelihood of initiation, and supports school and community efforts to create tobacco-free social norms.

For example...

A countermarketing campaign should include the following characteristics to be most successful:

- It must incorporate paid media, public relations, and special events and promotions in a coordinated effort that is integrated with the other elements of a comprehensive tobacco control plan.
- It must be well-funded so the media component can achieve the reach necessary to be effective. This effort must be sustained over the long term.
- There should be no restrictions on the content of the messages, and the campaign must operate completely independent of tobacco industry input.
- The campaign should include ads that expose tobacco industry tactics, hard-hitting messages about secondhand smoke, and messages that encourage smoking cessation and promote the Quit Line.

Costs and funding

A minimum budget of $1 million is recommended for a statewide countermarketing campaign.

- The countermarketing campaign will be implemented through one or more contracts with advertising/public relations firms.
- The countermarketing budget covers development of new ads for Alaska, payment of talent fees for ads developed in other states (available through the CDC Media Resource Center), and paid placement of ads on television, radio, in print formats, movie screens, and on public transit vehicles.

"A strong media campaign is a key element of any tobacco control effort... To compete with tobacco industry advertising, anti-tobacco advertisements need to be ambitious, hard-hitting, explicit, and in-your-face..."

Lisa Goldman and Stanton Glantz, University of California, San Francisco, describing results of their research on the effectiveness of paid antismoking advertising

SCHOOL-BASED PROGRAMS

While almost all children know that "smoking is bad for you," this fact alone has not prevented a dramatic increase in youth smoking since 1988. The Centers for Disease Control and Prevention has evaluated school-based tobacco prevention programs and issued guidelines for choosing and implementing an effective program. When these guidelines are followed, a school-based program can reduce smoking prevalence significantly.

For example...

CDC guidelines specify 7 critical components in an effective school-based program:

- tobacco-free policy for students and adults
- effective tobacco prevention curriculum in grades K-12, with special emphasis on middle school students
- training for school staff
- parent and family involvement
- linkage and coordination with local coalitions and communities
- cessation support
- evaluation of effectiveness

Student instruction should:

- decrease the social acceptability of tobacco use and show that most young people do not smoke.
- expose tobacco industry motives and tactics in encouraging youth tobacco use.
- develop students' skills in assertiveness, goal setting, problem solving, and resisting pressure from the media and peers to use tobacco.

Costs and funding

A minimum budget of $750,000 is recommended for School-based Programs.

- Funds will be awarded directly to school districts on a competitive basis. Programs will be supported by statewide technical assistance through the Department of Education and the Department of Health and Social Services. (Funds to DOE will be passed through from DHSS.)
- Accountability is important. Based upon the experience of several states in funding school programs, CDC recommends that funds be awarded to school districts that have clearly-stated performance objectives consistent with CDC guidelines.
- The School-based Programs budget will cover the costs of training and technical assistance to school personnel, curriculum materials for students and teachers, and project staffing within the school districts. Curricula that might be used are Towards No Tobacco Use, Life Skills Training, Project Alert, Get Real About Tobacco, and the Alaska Community-Oriented Tobacco Project. Approximate cost per student is $7, to reach about 100,000 students.

"All funded school projects are working with community partners and local coalitions. Students are involved in visits to retailers to assure that they are checking ID and refusing to sell tobacco to youth... They participate in community education events and are involved in promoting smoke-free policies."

— from "Tobacco Prevention and Education Program Report - 1999"
Oregon Health Division

TOBACCO-FREE PARTNERSHIP PROJECTS

Within this component, a variety of external partners will expand project reach and impact by targeting at-risk populations, incorporating tobacco prevention and cessation efforts within other health programs, and providing critical networking, communications, technical assistance, and research services from outside the state bureaucracy. Like the Quit Line and counteradvertising campaign, these projects are statewide in scope.

For example...

Statewide partnership contracts could fund:

- prevention and cessation programs targeting special populations such as Alaska Natives, pregnant women, drug/alcohol treatment clients, and low income families.
- programs to include tobacco education in campaigns to reduce heart disease, asthma, and dental disease.
- enhanced networking through a statewide tobacco control website and newsletter.
- a statewide clearinghouse of tobacco control materials.
- statewide conferences for tobacco prevention and cessation training.
- statewide youth advocacy projects.
- research programs to evaluate the effectiveness of tobacco control interventions.

Costs and funding

A minimum budget of $1.8 million is recommended for Tobacco-Free Partnership Projects.

- Contracts would be awarded on a competitive basis to such groups as
  - professional associations (e.g., doctors, dentists, nurses)
  - non-profit health organizations
  - universities and research groups
  - public relations firms, communications firms, private contractors
- Contract awards might range from $50,000 to $200,000.
- A statewide Quit Line is included in the Cessation component. Likewise, the statewide Countermarketing campaign is a separate component within the comprehensive tobacco control program.

"An R.J. Reynolds planning document concluded that 'the California campaign, and those like it, represents a very real threat to the industry in the intermediate term...' "

from "A Model for Change: The California Experience in Tobacco Control"

ENFORCEMENT

Enforcement of tobacco control policies enhances their efficacy both by deterring violations and by sending a message to the public that community leadership believes the policies are important. Existing laws and new laws in the areas of youth access, tax compliance, and clean indoor air all require enforcement for maximum impact.

For example...

- Prior to 1997, Alaska's law prohibiting the sale of tobacco products to minors had never been enforced, and was widely ignored by merchants. In communities where police are now enforcing the law, compliance has improved dramatically (as measured by undercover compliance checks).

Other state laws currently requiring enforcement in Alaska include:

- a ban on self-service tobacco displays.
- restrictions on smoking in certain worksites and public places.
- restrictions on the placement of cigarette vending machines.
- the requirement that a state tax be paid on all tobacco purchases.
- the requirement of a special business license endorsement for merchants who sell tobacco.

Costs and funding

A minimum budget of $600,000 is recommended for the Enforcement component.

- Approximately $110,000 will be provided to the Alaska Department of Law, primarily for the enforcement of laws relating to youth access to tobacco.
- Approximately $110,000 will be provided to the Alaska Department of Revenue for enforcement of laws regarding payment of state tobacco taxes.
- Approximately $80,000 will be provided to the Alaska Department of Commerce for enforcement of laws relating to tobacco vendor licensing.
- Approximately $300,000 will be provided to the Alaska Department of Public Safety, to support local police departments in enforcing state tobacco control laws.

"The small body of evidence examining the effects of active enforcement on youth smoking suggests that it is an important and essential element of a comprehensive effort to reduce young people's use of tobacco. However, young people may turn to social sources (e.g., older friends and family members) of tobacco products as commercial sources are reduced. Therefore, it is critical that minors' access restrictions be combined with a comprehensive tobacco control program that reduces the availability of social sources and limits the appeal of tobacco products."

— from "Program and Funding Guidelines for Comprehensive Tobacco Control Programs," Centers for Disease Control and Prevention, January 1999

PROGRAM DEVELOPMENT, MANAGEMENT, & EVALUATION

Ultimate accountability for the wise use of state tobacco control program dollars must rest with the Alaska Department of Health and Social Services. A comprehensive statewide program cannot work smoothly and effectively without sufficient investment in program planning and coordination. Likewise, surveillance and evaluation provide critical feedback and help ensure accountability.

For example...

The Department of Health and Social Service's leadership role includes the following:

- In consultation with other public health groups (such as those represented by the Alaska Tobacco Control Alliance), the Department will develop and implement a comprehensive and effective statewide tobacco prevention and cessation program, which includes grants to external partners.
- Tobacco control program staff within the Department will closely monitor grants and provide technical assistance to grantees.
- Program staff will represent the state in meetings with other organizations and government entities, within Alaska and nationally, to learn and share information on effective program planning and implementation. Program staff may serve as media spokespersons on tobacco issues.
- The Department will have primary responsibility for ongoing data collection (surveillance) and evaluation to assess program effectiveness.

Costs and funding

A minimum budget of $650,000 is recommended for Statewide Coordination and Evaluation.

- $350,000 is budgeted for personnel costs, including office expenses and travel. Staff would likely include a Tobacco Control Program director, two staff to handle grants management and technical assistance, and a researcher.
- $300,000 is budgeted to support implementation and analysis of three critical statewide surveys: the Behavioral Risk Factor Surveillance System, the Youth Risk Behavior Survey, and the Pregnancy Risk Assessment Monitoring System.

"Smaller states, or states with less money, should concentrate first on establishing a state level administrative office for the program that is adequate for leading, planning, evaluating, and monitoring the local program and media components."

from "A Model for Change: The California Experience in Tobacco Control"

CONCLUSION

Every week in Alaska, the equivalent of two to three classrooms of kids join the ranks of new smokers. Soon they become statistics for increased respiratory illnesses and increased doctor visits. Later they show up more frequently in hospitals. Some endure heart surgery, lung surgery, or years tethered to an oxygen tank because of the damage caused by tobacco. Eventually, a third of them will die prematurely from smoking-caused disease. Throughout those years and beyond, they and their loved ones suffer. Meanwhile, millions of dollars in precious resources are spent on tobacco-related medical care in our state.

Because 20 percent of all deaths in Alaska are caused by tobacco use, reducing nicotine addiction is one of the most important things we can do to enhance the quality of life for Alaskans.

We know what works. Because the people of California, Massachusetts, Arizona, and Oregon voted on statewide ballot initiatives to raise state tobacco taxes and dedicate a portion of the new revenues to comprehensive tobacco control programs, researchers and health advocates throughout the country have now seen that investing substantial resources in coordinated, comprehensive tobacco control programs will lead to substantial reductions in tobacco use.

Past experience with tobacco control efforts nationwide indicates that five principles should guide the development of a successful state program to prevent and reduce tobacco use:

- **It must be comprehensive.** Stopgap or partial measures will meet with only partial success.
- **It must be well-funded.** Unless properly financed, tobacco prevention will have little effect against the marketing efforts of the tobacco industry.
- **It must be sustained over a long period of time.** While short-term attitudinal changes can occur relatively early, it will take years to achieve the significant behavioral and cultural changes necessary to reduce tobacco use substantially and maintain low levels.
- **It must operate free and clear of political and tobacco industry influence.** History warns us that the tobacco industry will employ every manner of tactics to divert money from tobacco prevention and to interfere with any tobacco control efforts that are undertaken.
- **It must address high-risk and diverse populations.** The needs of special populations must be taken into account in designing and disseminating the various elements of the tobacco control program.

We know what works and we have the resources to fight this war and win. The time to act is now.

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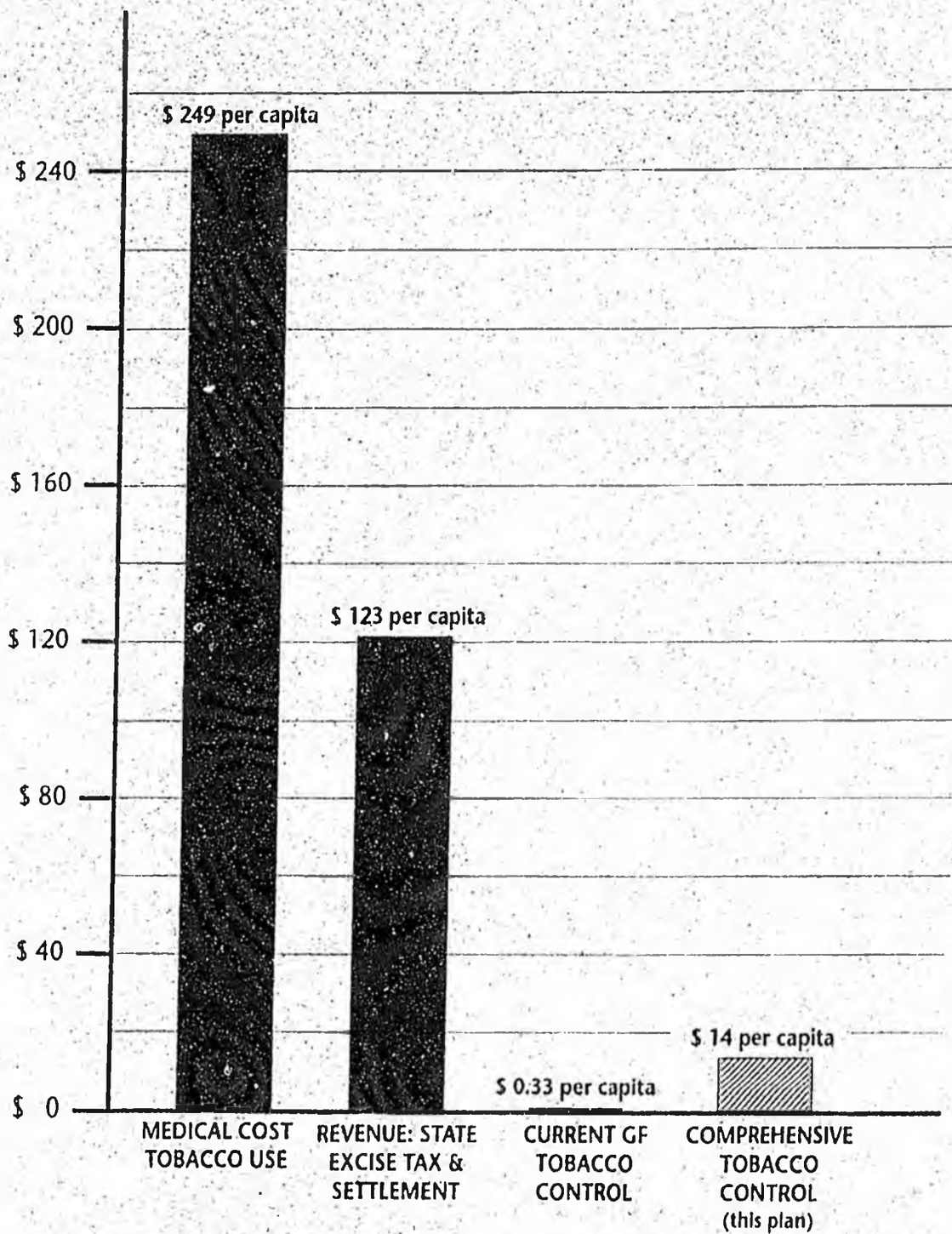
ALASKA: THE COST OF TOBACCO USE, STATE TOBACCO REVENUE, CURRENT GENERAL FUND SPENDING for TOBACCO CONTROL, and PROPOSED SPENDING, ATCA PLAN (annual, per capita)



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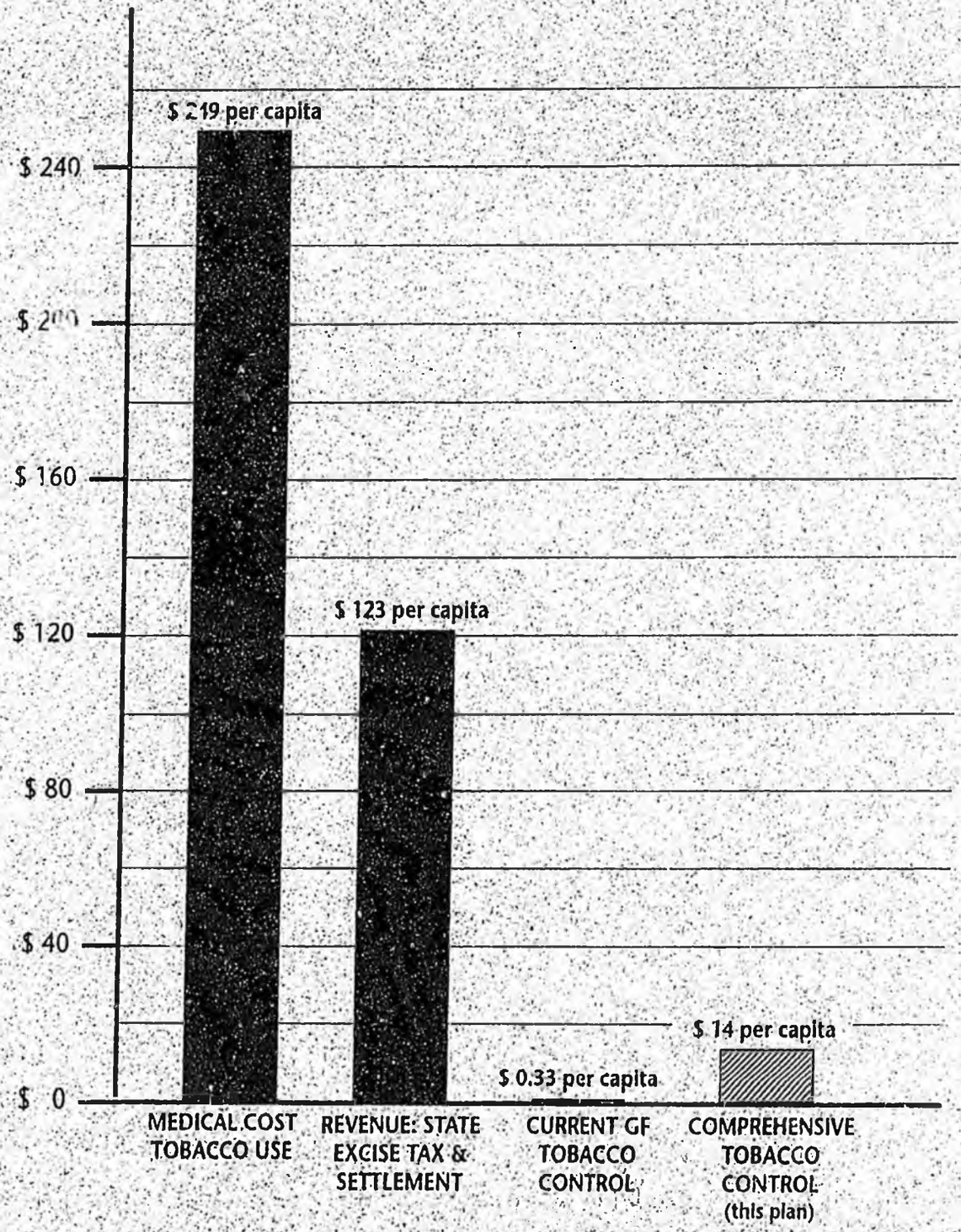
CORRECTION

THE FOLLOWING DOCUMENT(S)
HAVE BEEN REFILMED TO
ASSURE LEGIBILITY OR PAGINATION

ALASKA: THE COST OF TOBACCO USE, STATE TOBACCO REVENUE, CURRENT GENERAL FUND SPENDING for TOBACCO CONTROL, and PROPOSED SPENDING, ATCA PLAN (annual, per capita)



The Alaska Tobacco Control Alliance
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HB

70

No

FISCAL NOTE

Bill Version: CSHB 70 (HES)
(H) Publish Date: 4/21/99

STATE OF ALASKA
1999 LEGISLATIVE SESSION

Revision Date/Time (Note if correction)
Dept. Affected: Education
Title: An Act relating to questionnaires or surveys administered in public schools
BRU
Component
Sponsor: Representative Dyson
Requester: House HESS
Component Serial No.

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2000	FY 2001	FY 2002	FY 2003	FY 2004	FY 2005
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0
CAPITAL EXPENDITURES						
CHANGE IN REVENUES ( )						

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (Specify Type)						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY99) cost: 0.0

POSITIONS

Full-time						
Part-time						
Temporary						

ANALYSIS: *(Attach a separate page if necessary)*

This bill prohibits the administration of school questionnaires or surveys, whether anonymous or not, that inquire into the personal or private family affairs of a student not a matter of public record or subject to public observation unless written permission is obtained from the student's parent or guardian.

*There is no cost to the department, but there is a cost to the school for obtaining parent or guardian permission. This cost cannot be determined at this time.

Prepared by: Barbara Thompson
Phone: 465-8727
Division: Teaching and Learning Support
Date/Time: 4/1/99 2:46 PM
Approved by Commissioner: Richard S. Cross
Date: 4/1/99
Agency: Department of Education

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COMMITTEE COPY

SENATE COMMITTEE REPORT

DATE: 5/3/99

FURTHER:

DATE TURNED IN TO OFFICE: 5/12/99

HESS Committee considered CS FOR HOUSE BILL NO. 70(RLS) am

"An Act relating to questionnaires or surveys administered in public schools."

and recommends:

[ ] be **replaced** with _____ CS _____ (_____)

[ ] adopt **previous** _____ CS _____ (_____)

[✓] attached amendment(s)

[ ] adopt Letter of Intent by _____ Committee

[ ] further referral to the _____ Committee

Senate Bill:
[ ] same title
[ ] new title

House Bill:
[ ] same title
[ ] technical title
[ ] new: SCR# _____

SIGNING DO PASS	*DP*	*OTHER RECOMMENDATIONS*	*NR*	*DNP*	*AM*
	✓			✓	
	✓				
CHAIR: Rita Miller	✓	*CHAIR:*			

NEW FISCAL NOTE(S):

Department	Date	Zero	Fiscal
DOE	4/1	✓	

PREVIOUS FISCAL NOTE(S):*

Department	Date	Zero	Fiscal

[ ] **APPROPRIATION -- no fiscal note**

***include fiscal notes accompanying Governor's bill**

COMMITTEE: SENATE HESS

DATE: MAY 12, 1999

Subject of meeting:

HB 70- PUBLIC SCHOOL SURVEYS

SIGN-IN

PLEASE PRINT! NAME	ADDRESS (MAILING) & (ZIP)	PHONE	REPRESENTING	DO YOU WANT TO TESTIFY ?

Alaska State Legislature

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10928 Eagle River Rd., Suite 140
Eagle River, Alaska 99577
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FAX (907) 694-1015

- Session (Jan - May) -
Alaska State Capitol
Juneau, Alaska 99801-1182
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- Internet -
http://www.akrepublicans.org

REPRESENTATIVE FRED DYSON

MEMORANDUM

May 4, 1999

To: Senator Mike Miller, Chair
Senate Health, Education & Social Services Committee

From: Representative Fred Dyson

Subject: Request to schedule CSHB 70

Please schedule a HESS Committee hearing on CSHB 70, "An Act relating to questionnaires or surveys administered in public schools." Attached is a Sponsor Statement and backup for your review.

Alaska State Legislature

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REPRESENTATIVE FRED DYSON

CSHB 70
Sponsor Statement

"An Act relating to questionnaires or surveys administered in public schools."

Alaska State Law (AS 14.03.110) requires parental consent for student questionnaires. There has been some confusion over "passive" versus "active" parental consent. A controversy arose recently with the use of the anonymous "Youth Risk Behavior Survey," sponsored by the Alaska's Department of Health and Human Services (DHSS). The successful completion of the "Youth Risk Behavior Survey" is reported to be necessary for the securing of Federal grant funds.

The survey was administered by some districts without parental permission. Some schools, and districts, chose to not use the survey, in deference to parental concerns. Other districts obtained legal opinions indicating that they did not require "active" parental consent in apparent contradiction of the intent of the legislature. While parents were upset with the lack of involvement offered, the survey was considered by many to be too invasive and far too personal. Samples of some of the questions are included in the bill packet.

The immediate solution to the dilemma would appear to be getting active parental consent for the surveys. However, public health officials maintain that it would be impractical to handle the logistics and that too few parents would respond positively. Committee Substitute for CSHB 70 attempts to solve this dilemma by allowing for a once a year blanket parental consent for anonymous questionnaires and surveys. The sponsor anticipates that each district or school would obtain the blanket annual anonymous questionnaire permission at the time of student registration. With automation, the school should be able to enter and retrieve the list of authorized questionnaire recipients. Public health officials argue that even this won't work. Even with all-inclusive annual parental permission, CSHB 70 requires that parents and students be given two weeks notice before the anonymous survey and another opportunity to decline to participate.

CSHB 70 tries to strike a practical balance between the rights of parents to control the educational experience of their children while allowing public officials to obtain apparently needed information and the grants that follow.

No: 1

FISCAL NOTE

Bill Version: CSHB 70(HES)
(H) Publish Date: 4/21/99

STATE OF ALASKA
1999 LEGISLATIVE SESSION

Revision Date/Time (Note if correction)
Dept. Affected: Education
Title: An Act relating to questionnaires or surveys administered in public schools
BRU
Component
Sponsor: Representative Dyson
Requester: House HESS
Component Serial No.

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2000	FY 2001	FY 2002	FY 2003	FY 2004	FY 2005
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous	*	*	*	*	*	*
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0
CAPITAL EXPENDITURES						
CHANGE IN REVENUES ( )						

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (Specify Type)						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY99) cost: 0.0

POSITIONS

Full-time						
Part-time						
Temporary						

ANALYSIS: *(Attach a separate page if necessary)*

This bill prohibits the administration of school questionnaires or surveys, whether anonymous or not, that inquire into the personal or private family affairs of a student not a matter of public record or subject to public observation unless written permission is obtained from the student's parent or guardian.

*There is no cost to the department, but there is a cost to the school for obtaining parent or guardian permission. This cost cannot be determined at this time.

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CS FOR HOUSE BILL NO. 70(RLS) am

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-FIRST LEGISLATURE - FIRST SESSION

BY THE HOUSE RULES COMMITTEE

Amended: 4/30/99
Offered: 4/28/99

Sponsor(s): REPRESENTATIVES DYSON, Rokeberg, Kapsner, Croft

A BILL

FOR AN ACT ENTITLED

"An Act relating to questionnaires or surveys administered in public schools."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

*** Section 1.** AS 14.03.110 is amended to read:

Sec. 14.03.110. Questionnaires and surveys administered in public schools. A school district, principal or other person in charge of a public school, or teacher in a public school may not administer or permit to be administered in a school a questionnaire or survey, whether anonymous or not, that inquires into **personal or** private family affairs of the student not a matter of public record or subject to public observation unless written permission is obtained from the student's parent or **legal** guardian.

*** Sec. 2.** AS 14.03.110 is amended by adding new subsections to read:

(b) For an anonymous questionnaire or survey, written permission required under (a) of this section may be obtained annually and is valid until the commencement of the subsequent school year or until the parent or legal guardian who gave permission submits a written withdrawal of permission to the school principal.

(c) If a school administers to a student a questionnaire or survey that is not anonymous, the school shall obtain the written permission required under (a) of this section from the student's parent or legal guardian at least two weeks before the questionnaire or survey is administered. The school shall give a parent or guardian an opportunity to review the questionnaire or survey administered in the school and shall give the parent or guardian written notice regarding

(1) how the questionnaire or survey will be administered to the student;

(2) how the results of the survey or questionnaire will be used; and

(3) who will have access to the questionnaire or survey.

(d) A student may refuse to participate in a questionnaire or survey administered in a public school. A student's parent or legal guardian may refuse to allow the student to participate in a specified questionnaire or survey.

1999 Youth Risk Behavior Survey

This survey is about health behavior. It has been developed so you can tell us what you do that may affect your health. The information you give will be used to develop better health education for young people like yourself.

DO NOT write your name on this survey. The answers you give will be kept private. No one will know what you write. Answer the questions based on what you really do.

Completing the survey is voluntary. Whether or not you answer the questions will not affect your grade in this class. If you are not comfortable answering a question, just leave it blank.

The questions that ask about your background will be used only to describe the types of students completing this survey. The information will not be used to find out your name. No names will ever be reported.

Make sure to read every question. Fill in the ovals completely. When you are finished, follow the instructions of the person giving you the survey.

Thank you very much for your help.

5. How tall are you without your shoes on?

Directions: Write your height in the shaded blank boxes. Fill in the matching oval below each number.

Example

Height	
Feet	Inches
5	7
3	0
4	1
5	2
6	3
7	4
	5
	6
	7
	8
	9
	10
	11

Height	
Feet	Inches
3	0
4	1
5	2
6	3
7	4
	5
	6
	7
	8
	9
	10
	11

6. How much do you weigh without your shoes on?

Directions: Write your height in the shaded blank boxes. Fill in the matching oval below each number.

Example

Weight		
Pounds		
1	5	2
0	0	0
1	1	1
2	2	2
3	3	3
	4	4
	5	5
	6	6
	7	7
	8	8
	9	9

Weight		
Pounds		
0	0	0
1	1	1
2	2	2
3	3	3
	4	4
	5	5
	6	6
	7	7
	8	8
	9	9

The next 10 questions ask about violence-related behaviors.

12. During the past 30 days, on how many days did you carry a **weapon** such as a gun, knife, or club?
    A. 0 days
    B. 1 day
    C. 2 or 3 days
    D. 4 or 5 days
    E. 6 or more days

13. During the past 30 days, on how many days did you carry a **gun?**
    A. 0 days
    B. 1 day
    C. 2 or 3 days
    D. 4 or 5 days
    E. 6 or more days

14. During the past 30 days, on how many days did you carry a weapon such as a gun, knife, or club **on school property?**
    A. 0 days
    B. 1 day
    C. 2 or 3 days
    D. 4 or 5 days
    E. 6 or more days

15. During the past 30 days, on how many days did you **not** go to school because you felt you would be unsafe at school or on your way to or from school?
    A. 0 days
    B. 1 day
    C. 2 or 3 days
    D. 4 or 5 days
    E. 6 or more days

16. During the past 12 months, how many times has someone threatened or injured you with a weapon such as a gun, knife, or club **on school property?**
    A. 0 times
    B. 1 time
    C. 2 or 3 times
    D. 4 or 5 times
    E. 6 or 7 times
    F. 8 or 9 times
    G. 10 or 11 times
    H. 12 or more times

CORRECTION

THE FOLLOWING DOCUMENT(S)
HAVE BEEN REFILMED TO
ASSURE LEGIBILITY OR PAGINATION

1999 Youth Risk Behavior Survey

This survey is about health behavior. It has been developed so you can tell us what you do that may affect your health. The information you give will be used to develop better health education for young people like yourself.

DO NOT write your name on this survey. The answers you give will be kept private. No one will know what you write. Answer the questions based on what you really do.

Completing the survey is voluntary. Whether or not you answer the questions will not affect your grade in this class. If you are not comfortable answering a question, just leave it blank.

The questions that ask about your background will be used only to describe the types of students completing this survey. The information will not be used to find out your name. No names will ever be reported

Make sure to read every question. Fill in the ovals completely. When you are finished, follow the instructions of the person giving you the survey.

Thank you very much for your help.

Directions

- o Use a #2 pencil only.
- o Make dark marks.
- o Fill in a response like this: A B C D.
- o To change your answer, erase completely.

1. How old are you?
   - A. 12 years old or younger
   - B. 13 years old
   - C. 14 years old
   - D. 15 years old
   - E. 16 years old
   - F. 17 years old
   - G. 18 years old or older

2. What is your sex?
   - A. Female
   - B. Male

3. In what grade are you?
   - A. 9th grade
   - B. 10th grade
   - C. 11th grade
   - D. 12th grade
   - E. Ungraded or other grade

4. How do you describe yourself? **(Select one or more responses.)**
   - A. American Indian or Alaska Native
   - B. Asian
   - C. Black or African American
   - D. Hispanic or Latino
   - E. Native Hawaiian or Other Pacific Islander
   - F. White

5. How tall are you without your shoes on?

Directions: Write your height in the shaded blank boxes. Fill in the matching oval below each number.

Example

Height	
Feet	Inches
5	7
3	0
4	1
5	2
6	3
7	4
	5
	6
	7
	8
	9
	10
	11

Height	
Feet	Inches
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5	2
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Weight		
Pounds		
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1	1	1
2	2	2
3	3	3
	4	4
	5	5
	6	6
	7	7
	8	8
	9	9

Weight		
Pounds		
0	0	0
1	1	1
2	2	2
3	3	3
	4	4
	5	5
	6	6
	7	7
	8	8
	9	9

The next 5 questions ask about personal safety.

7. **When you rode a motorcycle** during the past 12 months, how often did you wear a helmet?
   A. I did not ride a motorcycle during the past 12 months
   B. Never wore a helmet
   C. Rarely wore a helmet
   D. Sometimes wore a helmet
   E. Most of the time wore a helmet
   F. Always wore a helmet

8. **When you rode a bicycle** during the past 12 months, how often did you wear a **helmet?**
   A. I did not ride a bicycle during the past 12 months
   B. Never wore a helmet
   C. Rarely wore a helmet
   D. Sometimes wore a helmet
   E. Most of the time wore a helmet
   F. Always wore a helmet

9. How often do you wear a seat belt when **riding in** a car driven by someone else?
   A. Never
   B. Rarely
   C. Sometimes
   D. Most of the time
   E. Always

10. During the past 30 days, how many times did you **ride** in a car or other vehicle **driven by someone who had been drinking alcohol?**
   A. 0 times
   B. 1 time
   C. 2 or 3 times
   D. 4 or 5 times
   E. 6 or more times

11. During the past 30 days, how many times did you **drive** a car or other vehicle **when you had been drinking alcohol?**
   A. 0 times
   B. 1 time
   C. 2 or 3 times
   D. 4 or 5 times
   E. 6 or more times