military commissaries, cigarettes sell for approximately 35 percent less than in civilian stores (Blake 1985). A 1985 survey of active duty military personnel found that nearly one-half smoked cigarettes, one-quarter smoked cigars or a pipe, and almost one-fifth used chewing tobacco, snuff, or other smokeless tobacco (Bray et al. 1986; Herbold 1987). Cigarette use was more common among nonofficers and varied by pay grades, with those at the lower end of the pay scale exhibiting a higher prevalence of smoking. A 1986 Department of Defense (DOD) report estimated that smoking-related health care costs to the military were 209 million dollars in 1984 (DOD 1986).

In March 1986, prompted by the medical evidence linking smoking with disease and the high prevalence of smoking among military personnel, the Secretary of Defense initiated an intensive antismoking campaign to be conducted at all levels of all services (DOD 1987). In April 1986, a DOD smoking reduction framework defined three smoking reduction goals for the military: (1) to reduce active duty smoking and other tobacco use by 10 percent per year, (2) to provide smoking reduction information and motivation and cessation assistance to DOD personnel, and (3) to specify designated places and times where smoking can occur to minimize effects of smoking on nonsmokers (DOD 1987).

Print and audiovisual materials for the campaign were obtained from voluntary and Federal agencies. In addition, in 1986, DOD allocated 97,000 dollars for publications and 324,000 dollars for antismoking on military radio and television PSAs (DOD 1987).

Each branch of the service developed its own smoking control plan consistent with the overall goals of DOD (DOD 1987). The U.S. Air Force (USAF) modified the curricula at the Basic Military Training School, the USAF Officer Training School, the USAF Academy, and the Air Force Reserve Officers' Training Corps to include mandatory classes on the hazards of using tobacco products. Similar course material was included in all professional military education for all officers and enlisted personnel.

In June 1986, the Air Force Surgeon General directed that there be on-base smoking cessation classes at every medical treatment facility in the Air Force. Nicotine-containing chewing gum was made available in all pharmacies, and tobacco sales were discontinued at all Air Force medical treatment facilities. Smoking was banned in all hospital and clinic facilities. Smoking was also prohibited on aeromedical evacuation flights, and the Officer Training School banned smoking during duty hours.

In July 1986, the Army banned the use of tobacco products in basic training and restricted smoking in other military courses. Army training centers and service schools incorporated antitobacco information into the curriculum. Smoking cessation courses were offered to soldiers, retirees, and family members. In November 1986, the Army participated in GASO.

In March 1987, the Navy Medical Commander directed that all naval hospitals offer group smoking cessation programs and prohibited the sale of tobacco in medical and dental facilities. Curricula for all Navy personnel include information on the health risks of tobacco use. Naval hospitals stock nicotine-containing gum for members in formal cessation classes. The Navy participated in the 1986 GASO.

The Marine Corps smoking control program is similar to that offered by the Navy. Guidance and smoking cessation materials are disseminated at all accession training commands and formal schools. Family Service Centers and Alcohol Counseling

Centers provide cessation programs. Smoking is prohibited in all medical and dental facilities.

To monitor the impact of the smoking control program, DOD conducts annual tobacco use surveys of military personnel (DOD 1987). Comparison of the 1982 and 1985 DOD worldwide surveys on alcohol and nonmedical drug use among military personnel revealed that the percentage of active duty smokers has dropped significantly from 53 percent in 1982 to 46 percent in 1985 (DOD 1987) (see Chapter 5). Between November 1986 and March 1987, the monthly dollar sales of tobacco products in military commissaries dropped by 18 percent (DOD 1987). The evidence available to date suggests that the DOD antismoking campaign has been successful (DOD 1987; Institute for the Study of Smoking Behavior and Policy 1988). The impact of the campaign is still being monitored, and the issue of tobacco sales pricing policies is being reassessed.

State Health Departments

A 1987 survey of State and territorial health agencies found that 33 of 52 (61 percent) reported having sponsored smoking cessation programs (CDC 1987). Most State plans focus on prevention rather than smoking cessation.

Several States have established programs to encourage cessation by pregnant women. New Jersey, Maryland, and Pennsylvania have developed protocols for use in State-supported maternity clinics (Coye 1988; US DHHS 1986a). New York has conducted a mass media education initiative, "Healthy Mothers, Healthy Babies," to encourage pregnant women to refrain from alcohol and tobacco use (US DHHS 1986a). Many local health departments also have established programs that provide cessation activities although these are not consistently cataloged.

Three State health departments, Colorado, Maryland, and Missouri, in collaboration with the Division of Reproductive Health of CDC, are developing and implementing a Smoking Cessation in Pregnancy (SCIP) Project to be used in public prenatal clinics. The purpose of the project is to reduce the incidence of low birthweight among women using publicly funded prenatal care services. One of the interventions used will be directed at helping the women to stop smoking. It is anticipated that approximately 4,000 women will be involved in the project and that 2,000 smokers will be exposed to the smoking cessation intervention.

Commercial Ventures in Smoking Control

As the number of smokers attempting to stop has increased, so have commercial ventures to develop and market cessation aids and services. Today, for-profit stop-smoking programs can be found in almost all major cities in the United States (Schwartz 1987). This Section provides a brief review of commercial ventures in smoking cessation, focusing first on the development and marketing of pharmacologic aids, followed by a discussion of nonpharmacologic aids and behavioral and motivational programs. Pharmacologic aids have been reviewed in the 1988 Surgeon General's Report on nicotine addiction (US DHHS 1988). The description of commercial ventures in smok-

ing control is selective. Those nonpharmacologic programs described were chosen because they provide a historical perspective and have well-used national networks.

Pharmacologic Cessation Aids

Smoking deterrent drug products have been available since the early part of this century. Early drug treatments included herbs and spices and mouthwashes that altered the taste of tobacco so that smoking was less pleasant (Schwartz 1969). In 1936, Dorsey (1936) developed lobeline sulfate capsules to minimize the craving for tobacco. Lobeline sulfate is the active ingredient in Nikoban and Bantron, two popular nonprescription cessation aids available in most drugstores today. In 1982, a Food and Drug Administration (FDA) panel that reviewed smoking deterrent drug products concluded that the data were insufficient to demonstrate the effectiveness of lobeline as a smoking cessation aid (FDA 1982). A similar conclusion was reached regarding the effectiveness of drug products such as chewing gums, mouthsprays, and tablets containing silver acetate (FDA 1982). In its proposed monograph for over-the-counter (OTC) smoking deterrent drugs (FDA 1985), FDA tentatively adopted this panel's conclusions, but FDA has not yet issued a final rule. Silver acetate when combined with tobacco creates an unpleasant metallic taste in the mouth that presumably serves to discourage smoking.

Clonidine, a drug used to treat high blood pressure, currently is being investigated as an aid to help people stop smoking (Glassman et al. 1988). Interest in clonidine as a smoking cessation aid was stimulated by Glassman and colleagues (1984), who demonstrated a reduction in cigarette urges associated with its use. It is speculated that clonidine may relieve nicotine withdrawal symptoms through its effect on the central nervous system's adrenergic mechanism (Glassman et al. 1984, 1988; US DHHS 1988). Boehringer Ingelheim Pharmaceuticals, Inc., currently is conducting studies to evaluate the effectiveness of a clonidine transdermal patch as a smoking cessation aid. Clonidine is not currently approved for marketing as a smoking cessation aid by FDA.

To date, the most successful and effective drug product developed to assist smokers in stopping is nicotine polacrilex gum, a nicotine-containing chewing gum (US DHHS 1988). It is marketed by Lakeside Pharmaceuticals, a Division of Merrell Dow. Nicotine-containing gum was developed on the premise that nicotine is the primary reinforcer of smoking. It was reasoned that a product that could deliver nicotine into the body in a form with lower potential to produce dependence could aid smokers in stopping (Fernoe, Lichtneckert, Lundgren 1973).

Nicotine-containing gum was first developed and manufactured by A.B. Leo in Sweden in 1971. Early studies with the gum showed poor results. However, a carbonate buffer added to improve absorption of nicotine improved cessation rates (Axelsson and Brantmark 1977). The main benefit associated with gum use is the alleviation of withdrawal symptoms. Several studies have demonstrated the effect of nicotine-containing gum in relieving irritability, anxiety, problems in concentrating, restlessness, and hunger (Hughes and Miller 1984; Schneider, Jarvik, Forsythe 1984; US DHHS 1988). Studies suggest that the gum does not fully replace the nicotine provided by cigarette smoke. Benowitz, Jacob, and Savanapridic (1987) reported that chewing 2-

mg nicotine gum on an hourly schedule for 10 hr yielded blood nicotine levels comparable to one-third that achieved while smoking. Use of a 4-mg nicotine gum causes a greater increase in blood nicotine levels and may increase cessation rates (Tonnesen et al. 1988). However, only the 2-mg dose is approved for use in the United States (US DHHS 1988).

Numerous studies have reported on the efficacy of nicotine polacrilex gum in achieving smoking cessation (Schwartz 1987; US DHHS 1988). Many of these studies are well-controlled double-blind investigations comparing nicotine-containing gum with a placebo gum (British Thoracic Society 1983; Campbell, Lyons, Prescott 1987; Fagerstrom 1982; Fee and Stewart 1982; Hall et al. 1987; Hjalmarson 1984; Jamrozik et al. 1984; Jarvis et al. 1982; Puska, Bjorkqvist, Koskela 1979; Schneider et al. 1983; Tonnesen et al. 1988). No studies to date have compared nicotine-containing gum with other cessation drug products, such as those containing lobeline or clonidine (US DHHS 1988). Not all studies have shown nicotine polacrilex gum to be effective (British Thoracic Society 1983; Campbell, Lyons, Prescott 1987; Fee and Stewart 1982; Jamrozik et al. 1984). Long-term cessation rates (over 1-year followup) vary widely from 3 to 49 percent (US DHHS 1988). Nicotine-containing gum has become an increasingly popular adjunct to behaviorally based cessation programs. Studies suggest that behaviorally based treatment in conjunction with nicotine polacrilex gum tends to be more effective than the same program without gum, or compared with gum alone (Fagerstrom 1982; Hall et al. 1987; Killen, Maccoby, Taylor 1984).

FDA approved the marketing of nicotine-containing gum in the United States as a prescription smoking cessation aid in January 1984 (IMS 1984). The product became available to the public in mid-March of that year. It retails for about 18 dollars for a box of 96 pieces. A mailing piece introducing the gum was circulated to 77,000 physicians (IMS 1984). In the 4 months after FDA approval of nicotine polacrilex gum, Merrell Dow spent more than 4 million dollars to launch the product (IMS 1984). Over 80 percent of promotion dollars was used for in-person promotion in physicians' offices and other health care settings. The result of this massive promotional campaign was one of the fastest selling prescription products ever introduced (IMS 1984). Sales were 42 million dollars in 1984, 46 million dollars in 1985, 54 million dollars in 1986, and 60 million dollars in 1987.

As part of its promotional campaign, Merrell Dow has supported many medical symposia on smoking, underwritten the cost of a newsletter on smoking cessation sent to over 40,000 physicians annually, and helped support the development and distribution of training materials on smoking cessation for health professionals.

Since the gum was introduced in March 1984, an estimated 4 to 6 million smokers (approximately one-tenth) have used it. Surveys of gum users show that two-thirds of prescriptions are generated by the patient rather than the physician. Lakeside advertising in public media (which does not mention the product or brand name) encourages smokers to ask their physicians for help in stopping smoking. The commercial success of nicotine polacrilex gum is likely to encourage other pharmaceutical companies to consider developing and marketing cessation drug products. Several nicotine-containing products are under investigation as cessation aids, including nasal nicotine solutions, nicotine dermal patches, and nicotine aerosols (US DHHS 1988).

Nonpharmacologic Cessation Aids

A variety of nonpharmacologic aids have been produced over the years to assist smokers in reducing or stopping smoking, including filter systems, smokeless cigarettes, self-help books, audiotapes, and more recently, videos (Schwartz 1987). Evidence regarding the effectiveness of these cessation aids is extremely limited or nonexistent. Many companies have developed cigarette filter systems to help people stop smoking. The basic idea behind a filter system as a cessation aid is to reduce the amount of nicotine taken in, allowing smokers to wean themselves from the chemical addiction (Schwartz 1987). One of the most popular filter systems available, One Step at a Time, manufactured by Teledyne Water Pik, was first marketed in 1977 and is sold primarily through chain drugstores and advertised in conjunction with local retailers. The filter system consists of four reusable filters, each of which further reduces the amount of tar, nicotine, and carbon monoxide from cigarette smoke. Each of the filters is to be used for 2 weeks. The One Step at a Time filter system sells for about 10 dollars. Teledyne Water Pik also markets a single filter system called Step Four, which is the fourth filter in the filter system and sells for about 5 dollars. In the FDA's 1980 response to a petition filed by Action on Smoking and Health for the regulation of cigarette filters as medical devices (FDA 1980), the agency concluded that some of the labeling and advertising for detached cigarette filters established intended therapeutic uses for One Step at a Time and certain other products. Thus, One Step at a Time and certain other detached cigarette filters were considered as medical devices within the agency's jurisdiction.

Smokeless cigarettes that simulate the taste of tobacco smoke are another popular cessation aid. E-Z Quit, a smokeless cigarette sold through a mail order company, consists of a plastic cigarette with three menthol flavor capsules. The product sells for about 10 dollars and is widely advertised in popular magazines and newspapers. E-Z Quit was designed to deliver flavoring ingredients through inhalation, and was intended and labeled for use as a smoking deterrent. Products so formulated and labeled are regarded by the FDA as drugs and have been included in the agency's ongoing OTC drug review. Under this review, in 1982 an Advisory Review Panel (FDA 1982) concluded that the data are insufficient to demonstrate the effectiveness of such products as smoking deterrents. In 1985 the FDA tentatively concurred with this conclusion in its proposed monograph (FDA 1985). A final rule has not yet been issued.

Dozens of different how-to-quit-smoking books have been produced. Many of the books are written by former smokers and psychologists who provide a wide range of suggestions on how to stop smoking. Studies evaluating the efficacy of quit-smoking books have reported mixed results (Cummings et al. 1988; Davis, Faust, Ordentlich 1984; Glasgow and Lichtenstein 1987; Glasgow and Rosen 1978; FDA 1982). In general, the findings of studies comparing the effectiveness of different quit-smoking books suggest that no one book appears to be better than any other. The addition of a personal contact to the provision of written materials appears to enhance quitting behavior (Flay 1987b; Kottke et al. 1988). Many bookstores also sell audiotapes on how to stop smoking. In 1985, ALA produced "In Control,"® a smoking cessation video program that smokers can use at home on a videocassette recorder. "In Control" runs for 2 hr and consists of 13 segments that viewers are encouraged to see on different days. Users also receive a 124-page viewer guide and a 20-min audiotape with motivational and relaxation messages. The package sells for 60 dollars. A recent evaluation of the program, which did not use a control group, involved 100 smokers and found that 53 completed the program, with 31 verified abstinent by carbon monoxide testing 1 month after completion. Twenty-one of the 100 smokers who started the program

were not smoking 1 year after completing it and 16 of these reported total abstinence during the 1-year followup period (Marston and Bettencourt 1988). ACS recently produced the ACS Freshstart video, a 21-day program that focuses on maintaining cessation (i.e., quit day is day 1). The video sells for about 20 dollars.

Recently, Health Innovations, Inc., developed and began marketing a computer-assisted smoking cessation program called "LifeSign." "LifeSign" consists of a credit-card-sized microcomputer and self-help booklet. The microcomputer is used to assist smokers in designing a tailored, gradual cutdown program that helps the smoker withdraw from the nicotine in cigarettes. Two studies of "LifeSign" show validated 6-month cessation rates of 18 and 28 percent (Frederiksen et al. 1988). However, both of these studies were based on small samples of self-selected smokers and did not involve comparisons with other cessation interventions.

Stop-Smoking Programs

Hypnosis has long been advocated as an effective treatment for stopping smoking (Schwartz 1987). A review of smoking cessation treatments listed in the telephone yellow pages of 47 U.S. cities found that hypnosis was the most frequently advertised service (Schwartz 1987). Hypnotists accounted for 31 percent of all services listed. The intent of hypnosis as a smoking cessation treatment is often to increase personal motivation to stop smoking (Spiegel 1970). This is usually done by posthypnotically suggesting a link between smoking and unpleasant experiences (e.g., "smoking is a poison"). Many hypnosis techniques are similar to behavioral therapy methods (e.g., relaxation training, increased awareness of smoking cues), making it difficult to distinguish the specific effects of hypnosis. Spiegel (1970) suggests that hypnosis alone does not make a person stop smoking, but when combined with motivation, helps the subject concentrate on changing his or her smoking behavior. Schwartz's review of 31 hypnosis trials concluded that hypnosis, when used as the only cessation method, is ineffective (Schwartz 1987).

More recently, acupuncture has been touted as an effective treatment for smoking cessation (Schwartz 1987). Acupuncture involves the use of needles or staplelike attachments placed in the nose or ear (Schwartz 1987). The mechanism by which acupuncture may help a person stop smoking is not clear. Several investigators suggest that acupuncture relieves smoking withdrawal symptoms, although there is little evidence to support this claim (Fuller 1982; Schneideman 1981). Others suggest that the effect of acupuncture is psychological and depends on personal motivation to stop smoking (Machovec and Man 1978; Martin and Waite 1981). Studies that evaluate acupuncture as a smoking deterrent vary widely in the methods used and in the cessation rates reported (Schwartz 1987).

One of the oldest and most successful commercial cessation programs is SmokEnders, which was started by a former smoker, Jacquelyn Rogers, in 1969. Headquartered in New Jersey, SmokEnders has chapters or franchises in many U.S. cities and in several foreign countries (Schwartz 1987). The program consists of six 2-hr sessions held over a 6-week period. Classes are conducted by former smokers who are graduates of the SmokEnders program. The program emphasizes motivation for stopping and brand switching, as well as behavioral and cognitive skills for gradually reducing the amount smoked. In 1985, Comprehensive Care Corporation purchased the license to operate SmokEnders. However, the program is basically the same as the one developed by Rogers in 1969. The cost of the program varies by location, ranging from 225 to 300 dollars. Since SmokEnders was established in 1969, an estimated 600,000 smokers have completed the program.

The Schick Stop Smoking program, started in 1971, was the first well-known commercial program to use counterconditioning techniques to help people stop smoking (Smith 1988). The Schick Stop Smoking program includes three phases: a 1-week preparation phase, a 1-week counterconditioning phase, and a support phase (Smith 1988). In the preparation phase, smokers are instructed to keep a record of each cigarette smoked. The counterconditioning phase of the program consists of five 1-hr treatment sessions held on consecutive days. Two counterconditioning techniques—mild electric shock to the wrist and quick puffing on a cigarette—are used to attach negative experiences to common cues for smoking. In the support phase, clients return to the center for group counseling, receive weekly telephone contacts, and have one additional counterconditioning session. The program is run by trained nonmedical personnel and treats about 2,000 smokers annually. The cost of the program is 595 dollars.

Worksite and Hospital Wellness Programs

Stimulated by both public and private initiatives, an increasing number of businesses have adopted policies that either limit or ban smoking at work (Bureau of National Affairs 1987; Orlandi 1986; US DHHS 1986b; Martin, Fehrenbach, Rosner 1986) (see Chapter 7). This trend has resulted in an increased demand for smoking control programs offered at worksites. Worksite programs have the advantage of having an available defined population that can potentially be reached. Many organizations have attempted to capitalize on the demand by developing and marketing smoking control programs specifically for worksites (Newsweek, August 29, 1988). The efficacy of worksite smoking programs was reviewed in the 1985 Surgeon General's Report (US DHHS 1985a), which presented somewhat disappointing results. Since that review, other outcomes have been somewhat more encouraging (e.g., Omenn et al. 1988).

In 1980, Control Data Corporation began marketing "Stay Well," a health promotion program designed for businesses (Anderson and Jose 1987). The smoking control component of the "Stay Well" program is called "How to Quit Smoking" and consists of eight 1-hr group sessions conducted over 7 weeks. The program emphasizes nicotine fading and behavioral coping skills. When the program was first introduced in 1980, classes were conducted by staff from Control Data. However, this proved to be costly and limited the geographical reach of the program. In 1982, the "Stay Well" program began licensing hospitals to deliver and market the program. Today, there are 50 licensed distributors located in most major population centers. More than 600 corporations have used the "How to Quit Smoking" program. The cost of the program varies by distributor, ranging from 35 to 80 dollars per smoker.

Johnson and Johnson, Inc., has recently begun marketing "Live for Life" (LFL), a wellness program designed for the workplace (Wilbur 1983). The smoking cessation component of LFL includes an annual health screen with medical advice on smoking, environmental changes to support nonsmoking, and regularly scheduled stop-smoking classes. Classes consist of 14 1-hr sessions held over a 3-week period. Smoke holding, group support, relaxation training, and behavioral coping skills are the primary elements of the program (Shipley et al. 1988). A recent report on the effectiveness of the

LFL stop-smoking program showed that in four companies exposed to the program, 23 percent of smokers were not smoking 2 years later compared with 17 percent in three matched comparison companies (Shipley et al. 1988). Among smokers in the LFL companies, 21 percent enrolled in the stop-smoking classes and 32 percent of these were not smoking after 2 years (Shipley et al. 1988).

In 1976 the American Institute for Preventive Medicine began marketing a stop-smoking program called "Smokeless." The program includes five 1-hr sessions held on consecutive days, plus three maintenance classes spread over 2 weeks (Powell and McCann 1981). The program instructs smokers in a wide range of behavioral and cognitive coping skills and includes some mild counterconditioning procedures (e.g., "pinky puffing" (puffing a cigarette while holding it between the pinky and ring finger)), loud white noise, filters dipped in anti-nail-biting solution). "Smokeless" has recently been adapted into a self-help format that sells for 39 dollars. The self-help program is packaged in an attractive kit with six booklets and a relaxation audiotape. The Institute also markets a guide for establishing a smoking policy in the workplace. "Smokeless" is licensed to hospitals or businesses to use and market program materials. Hospitals in turn will offer the program to people in the community. Corporate affiliates offer the program solely to their own employees. Each hospital affiliate is responsible for marketing the program in a defined geographic region. Since 1983, 250 hospitals and several large corporations have been licensed to conduct "Smokeless," although this does not mean that they actually run the program. The Institute conducts a 3-day training seminar on how to run the program and provides each trainee with a set of materials. The Institute also assists hospital affiliates in marketing the program. Program materials are sold to the affiliate hospital or corporation for 30 dollars per person. The fee for "Smokeless" varies by affiliate, ranging from 75 to 225 dollars per smoker.

Smoke Stoppers is another commercial stop-smoking program that licenses hospitals and other outlets to use its materials. The program is marketed by the National Center for Health Promotion in Ann Arbor, MI. The format of Smoke Stoppers is similar to that of "Smokeless," with five classes in the first week, followed by three maintenance sessions. Outlets certified to conduct Smoke Stoppers programs are given exclusive rights to market the program in a defined geographical region. All Smoke Stoppers instructors are required to be former smokers and must attend a 40-hr training program. Program materials are sold to affiliates at a cost of 39 dollars per person. The fee charged to smokers varies by outlet, averaging about 150 dollars per person. Smoke Stoppers was established in 1977 and has licensed over 300 outlets to conduct programs.

One of the 1990 Health Objectives for the Nation calls for at least 35 percent of all workers to be offered employer/employee-sponsored or -supported smoking cessation programs either at the worksite or in the community. While there are no national data available to measure the percentage of all workers who have access to such a program, a 1985 survey, the National Survey of Worksite Health Promotion Activities, gathered data on smoking cessation programs in worksites with 50 or more employees, which is reflective of approximately 58 percent of the U.S. workforce (US DHHS 1987). Preliminary analyses indicate that approximately 36 percent offer some kind of smoking cessation program. Due to the incompleteness of the data, evaluation of progress toward achievement of the objective cannot be adequately accomplished.

In addition to offering cessation programs, businesses are increasingly providing incentives to employees to encourage them to stop smoking (Orleans and Shipley 1982). A small ambulance company in Oregon offered a 5 dollar monthly bonus to any employee who did not smoke during work hours. As an added incentive, the accumulated bonuses for the year were matched at Christmastime. After 1 year, 4 of the 16 smokers claimed abstinence from smoking at work (Rosen and Lichtenstein 1977). Smokers employed at a hospital in upstate New York were offered the chance to win a 250 dollar cash prize if they stopped smoking for 1 month. Of all smokers, 14 percent enrolled in the contest, and 36 percent of these enrollees were not smoking 3 months after the contest ended (Cummings, Hellmann, Emont 1988). A common type of incentive is the offer to pay part or all of the cost to attend a cessation program. Campbell Soup Company splits the cost for employees to attend an onsite smoking cessation program (Schwartz 1987). General Motors absorbed 75 percent of the fee for a smoking cessation program offered to employees (Schwartz 1987). The evidence available does suggest that incentives can serve as a useful adjunct to other cessation services in the workplace (Klesges, Vasey, Glasgow 1986; US DHHS 1985b).

Summary

The Chapter 8 Appendix includes a chronology of key events that have influenced smoking education and cessation activities over the past 25 years. The antismoking campaign of the 1960s focused primarily on educating the public about the health hazards of tobacco use (Warner 1986). An assumption underlying the early antismoking efforts was that an informed public would discontinue smoking. This assumption was not without merit in that cigarette consumption did fall significantly in response to information about the dangers of cigarette use (Hamilton 1972; Warner 1977, 1981, 1986). However, the assumption that smokers merely needed to be motivated to stop ignored the addictive nature of smoking and the fact that many found it extremely difficult to stop smoking (US DHHS 1988).

The 1970s saw an increased emphasis on devising methods to assist smokers in stopping and staying off cigarettes (Schwartz 1987), with special attention to cognitively based self-management approaches.

The 1980s have seen a renewed emphasis on educating the public about the hazards of tobacco use and increased efforts to recruit smokers to attempt cessation. Such an emphasis seems appropriate given the fact that the vast majority of smokers need first to be persuaded to stop before efforts are directed at offering assistance in stopping.

The national voluntary agencies, especially ACS, ALA, and AHA, have played a significant role in educating the public about the hazards of tobacco use. This has been achieved through a wide variety of interventions including the distribution of educational materials, sponsorship of cessation programs, and production and dissemination of PSAs that carry an antismoking message. Although the smoking education efforts of the national voluntary health agencies have been the most visible of any group, some critics note that more might have been accomplished if a higher level of interagency collaboration had existed. In 1978, a blue ribbon panel of experts commissioned by ACS to study the problem of smoking and the effectiveness of antismoking activities

concluded that the major voluntary health organizations should actively pursue increased coordination of their efforts and resources in producing materials to assist smokers in quitting (ACS 1978).

Until the 1980s, the voluntary health agencies focused their efforts on educating the public about the facts on smoking and health and did little to initiate political and legal challenges to the tobacco industry (Patterson 1987). The formation of the Tri-Agency Coalition on SmokingORHealth in1982 represented a major shift in the smoking control focus of the voluntary health agencies. The Coalition was formed primarily to promote cooperation in obtaining legislation on smoking control issues.

Government smoking control efforts have been characterized by some observers as modest (ACS 1978). OSH, the only Federal agency devoted exclusively to the smoking issue, today has a budget that, in real dollars, is roughly one-half of the budget in 1966 when its predecessor, the National Clearinghouse, was established. (See Chapter 7.) Federal spending on smoking control has increased over the years, with the majority of funds supporting research rather than interventions. In recent years, there has been a shift away from supporting biomedical research on the hazards of tobacco to supporting studies on the behavioral aspects of smoking, including smoking cessation. However, there is little evidence of transfer of research findings to community settings, and some observers have questioned whether limited public health resources should be disproportionately expended on treating smokers individually or in small groups, to the exclusion of mass media and public relations efforts aimed at changing the social, economic, and political environment that supports smoking (Chapman 1985). NCI now emphasizes support of studies that investigate effective application and dissemination of smoking programs (Fanning 1988;NCI1986b)and NHLBI is supporting large community programs of applied research that include smoking (US DHHS 1984, 1986a).

The opportunity to develop and market cessation aids and programs has expanded in the past decade as more smokers have attempted to stop. The use of pharmacologic therapies to aid cessation increased markedly with the introduction of nicotine polacrilex gum in 1984. Alternative methods of nicotine replacement are currently under investigation along with other pharmacologic cessation approaches (e.g., clonidine) (US DHHS 1988). In addition to pharmacologic aids, behaviorally oriented cessation programs, particularly those targeting worksites, have increased in the past decade. Likewise, greater efforts are now being made to increase involvement of physicians and other health care professionals in smoking intervention.

In general, different types of smoking cessation strategies (e.g., condition- or cognition-based) have been emphasized during different time periods, new strategies have been added, and some specific behaviorally oriented smoking cessation strategies appear to have changed relatively little in the past 25 years. The packaging and marketing of these programs have also become more sophisticated, with an increased emphasis on targeting specific groups of smokers (e.g., pregnant women, Hispanics, blacks). There has been a gradual shift in the way cessation interventions are promoted from approaches that largely require smokers to seek assistance on their own to more aggressive strategies that actively recruit smokers to seek help and stop. Examples of active recruitment strategies include televised stop-smoking clinics (Flay 1987b) and contests and competitions to promote abstinence behavior (Cummings, Hellmann, Emont 1988;

King et al. 1987; Klesges, Vasey, Glasgow 1986). The level of smoking cessation activity has increased in recent years, spurred by regulatory decisions restricting smoking (Chapter 7) and changing public perceptions and attitudes regarding tobacco use (Chapter 4).

A significant event in terms of promoting smoking cessation activities of the national organizations was the 1967 FCC ruling applying the Fairness Doctrine to broadcast cigarette advertising. This policy prompted organizations to become involved in activities such as production of PSAs. The next chapter will cover this and other policy activities. Evidence indicates that the resulting increase in the volume of antismoking messages helped contribute to a substantial decline in cigarette consumption (Hamilton 1972; Warner 1977, 1981, 1986).

The last 25 years have seen an increase in smoking cessation research and the implementation of numerous public health approaches designed to help people stop smoking. Working toward an integrated approach of policies and programs in the available community networks seems to be a direction in which the smoking-and-health campaign is moving (US DHHS 1986b).

PART III. ANTISMOKING ADVOCACY AND LOBBYING

Nature and Objectives of Advocacy and Lobbying

Individual citizens and organized groups have played an active role in the development of public and private policies affecting smoking and the cigarette product. Their activities range from efforts to inform and educate individuals and the public at large about the health consequences of smoking to advocacy and lobbying to influence policies and legislation to prevent or reduce smoking. The latter are considered in this concluding part of the present chapter as a bridge between voluntary antismoking activities and mandated activities (Chapter 7). Advocacy and lobbying are undertaken voluntarily by private citizens and organizations, but with the intent of influencing smoking-related laws and regulations.

Development and implementation of health information and education strategies are oriented toward providing or imparting information to teach or instruct, often with a view toward influencing thought and behavior. Earlier parts of this Chapter and other sections of this Report address information and education activity as a component of health education efforts designed to provide antismoking messages. As discussed in this Chapter, several such efforts incorporate advice and instruction on how to remain or become a nonsmoker.

Advocacy encompasses efforts to shape opinion in support of public policy. Lobbying, in its strictest sense, means directly attempting to influence legislators, especially in favor of a special interest. Frequently, lobbying also is used to mean directly trying to influence officials to take desired action, or to influence the political process toward a specific outcome. Despite these definitions, advocacy and lobbying activities often overlap and their distinction is not always clear.

A primary purpose of these pursuits is to shift perceptions and attitudes about smoking: to change from viewing smoking as a matter of personal choice toward viewing smoking as a significant public health problem requiring adoption of public health policy interventions. Antismoking advocacy and lobbying both recognize and act on the fact that smoking is a political as well as a health, social, and economic issue.

Few antismoking advocacy and lobbying efforts have been studied systematically, making it difficult to attribute changes in policy or public opinion to a specific group or activity. Furthermore, little exists in the published literature on smoking that describes the advocacy and lobbying activities of groups or individuals or evaluates the impact of those activities on public awareness or public and private policies regarding smoking. For example, the available data show that public support for restrictions on smoking in public and at work has increased substantially in recent years (Chapter 4). A temporal relationship can be demonstrated between this increasing support and the growth of antismoking advocacy and lobbying activities targeted at these same issues. It is not clear, however, to what extent changing public attitudes led to or followed advocacy efforts.

Analyses of the relationship between legislative lobbying activities and the enactment of legislation have been predominantly qualitative. For example, an analysis of lobbying efforts for the introduction and subsequent passage of the Comprehensive Smoking Education Act of 1984 (Public Law 98-424) concluded that the Coalition on Smoking OR Health, a group representing ACS, AHA, and ALA, significantly influenced passage of the Act. The analysis also concluded that the "woeful miscalculations of the tobacco lobbyists" made a significant contribution to the outcome (Pertschuk 1986).

Objectives

Smoking-and-health advocacy and lobbying efforts during the 25 years since the first Surgeon General's Report have centered on a number of specific objectives, including: broader and more effective dissemination of information on the hazards of smoking; provision of increased resources for research, public education, and prevention; reduction in consumption and encouragement of cessation by smokers; prevention of uptake by children and adolescents; creation of public support for policies to restrict or prevent smoking; protection of nonsmokers from exposure to environmental tobacco smoke; regulation of the contents and emissions of the cigarette; regulation of the marketing, promotion, and advertising practices related to tobacco products; limitation on access through restriction of the sale and distribution of cigarettes (e.g., through vending machines and free samples); increase in the price of smoking through taxation of cigarettes; and stimulation or creation of public demand for political action on a specific policy or issue. Many of the advocacy and lobbying groups active since 1964 have pursued a variety of these objectives with varying degrees of activism and political involvement.

The origin and objectives of the National Interagency Council on Smoking and Health, the first major organization created in response to the 1964 Surgeon General's Report, provide an illustration of the variety of purposes diverse groups may want to achieve, individually or jointly.

Following the release of the Report, Surgeon General Luther Terry called together representatives from the major national voluntary health agencies to discuss what actions might be taken in response to the Report. One result of this meeting was the creation of the National Interagency Council on Smoking and Health, which included among its members the voluntary health agencies, a variety of medical and health professions groups, organizations such as the National Congress of Parents and Teachers, and Federal agencies such as the Public Health Service and the Veterans Administration. By 1969, the Council's membership included 25 national organizations and 3 Government agencies.

The purpose of the Council was "(1) to use its professional talents to bring to the nation—particularly to the young—an increasing awareness of the harmfulness of cigarette smoking; (2) to encourage, support and assist national,State,and local smoking and health programs; and (3) to generate and coordinate public interest and action related to this area of health" (Diehl 1969). The Council's statement of purpose reflects an early perception that stimulating some form of public interest and action would be necessary to achieve other Council purposes related to smoking and health.

The Council did not initiate its own programs of education or intervention, however, and operated on a very small budget contributed by the member organizations. Its activities in the area of advocacy were extremely limited, although it spawned much activity at the State and local levels that has carried over into the present. The Interagency Council became the principal national forum for the exchange of information and coordination of efforts among the many groups concerned about smoking.

In addition to the National Interagency Council, there were 40 State and many city interagency councils in operation with the primary function of coordinating and stimulating action by member groups (Diehl 1969). These State and local interagency councils consisted, in large part, of the State and local affiliates of the national groups represented in the National Interagency Council.

Troyer and Markel (1983) analyzed the announcements and proposed actions of health groups regarding smoking as reported in the press during the period 1954–78. They found that through 1973, the overwhelming majority of announcements and actions (26 of 29) were targeted toward education and persuasion, while during the period 1974–78, almost all (9 of 10) were focused on laws and regulations restricting smoking. The reasons for the initial apparent prioritization of information and education activities are not known, but it is clear that during the early period of antismoking efforts, the major groups considered their primary contributions to be made by informing the public and testifying before legislative groups, not by lobbying for specific regulations or motivating the public to political action. For example, AHA stated in 1967 that "its 'proper responsibility' involved testimony on the health hazards of smoking, not legal action" (Troyer and Markel 1983).

Over the years, the national voluntary agencies and other significant organizations have continued their critical information and education activities, as described in Parts I and II of this Chapter. More recently, many of these organizations have begun to supplement their more traditional educational campaigns with more active efforts in support of specific heath policy outcomes. Accordingly, they have emerged as strong advocates in support of antismoking policies. In addition, as part of a health strategy,

some have developed specific components within their organizations, and sometimes have fostered special coalitions to advocate or lobby for specific purposes on behalf of their organizations.

A significant example is the Coalition on SmokingOR Health, an organization formed in 1982 to initiate and coordinate antismoking lobbying activity on behalf of ACS, AHA, and ALA, and to supplement the more traditional information and education approaches of these three organizations. The Coalition's statement of purpose reflects its emphasis on political action in support of smoking and health issues:

> To more effectively bring tobacco and health issues to the attention of federal legislators, administrators and other public officials; . . . to work with legislators and other government officials to enact policies which will discourage tobacco use, further educate the public about the hazards of tobacco use, and limit the demand for and marketing of this deadly product in the future (ACS 1988).

Organizational Characteristics

Five relatively distinct types of groups operating at the national, State, or local level carry out smoking control advocacy and lobbying activities. The first group, and perhaps the largest and most visible, is composed of the three major national voluntary health agencies (ACS, ALA, and AHA) and their State and local affiliates. Each of the three agencies concentrates primarily on research and public education related to the diseases of interest to the agencies, and delivery of services to those affected by such diseases. In addition to forming the Coalition on Smoking OR Health, each also has become more focused on leadership in health policy development, and has increased its level of interest and participation in advocacy and lobbying. Much of what the voluntary health agencies are allowed to do in this regard may be affected by both their Internal Revenue Code status as nonprofit agencies and the Tax Reform Act of 1976, which specifies permissible lobbying activites by nonprofit groups.

The second group is made up of special focus or special population organizations that have targeted their efforts on a particular aspect of the smoking problem or a specific approach. This group includes such organizations as Action on Smoking and Health (ASH), which has pursued a legal action campaign to force legislators and regulatory bodies to address a variety of aspects of the smoking problem; Stop Teenage Addiction to Tobacco (STAT), which focuses on teenage tobacco issues; the Tobacco Products Liability Project (TPLP), which, as a public health strategy, supports efforts to bring product liability lawsuits against cigarette manufacturers; and Doctors Ought to Care (DOC), founded to provide physicians with a rallying point for health promotion and antismoking advocacy, especially through counteradvertising. These groups are more involved in advocacy than in lobbying.

The third group is composed of health and health professions organizations such as the American Medical Association, American Public Health Association, American Dental Association, American Academy of Pediatrics, American College of Chest Physicians, American Medical Women's Association, American Academy of Family Physicians, American Society of Internal Medicine, American College of Obstetricians and Gynecologists, and American Association for Respiratory Care. These groups in-

creasingly have promoted a role for their members as advocates for smoking control in their respective communities, in addition to engaging, as organizations, in advocacy and lobbying activities at the Federal level.

Organizations devoted to the rights of and protections for nonsmokers make up the fourth group. This would include organizations such as Americans for Nonsmokers' Rights, the only national antismoking group devoted solely to clean indoor air legislation. Other examples would be the numerous State and local groups that have formed independent chapters of Group Against Smoking Pollution (GASP) or that focus on nonsmoker protection and nonsmokers' rights. There are approximately 85 such groups at the State and local level (unpublished data, OSH).

The fifth group is made up of antismoking coalitions (groups of organizations) operating at the national, State, and local levels. Such coalitions have formed increasingly as the voluntary health agencies and other organizations have become more active in advocacy and lobbying and have found common interests. The National Interagency Council on Smoking and Health, referred to earlier, was the first major antismoking coalition formed, but, as discussed, it did not engage in advocacy or lobbying. The National Interagency Council no longer is active, but a number of State interagency councils remain active (US DHHS 1986d).

The most prominent coalition today is the Coalition on Smoking OR Health, also discussed earlier. The apparent successes of this Coalition and the growth of the "nonsmokers' rights" movement have led to an increasing number of State-level coalitions formed to undertake a variety of public education and advocacy activities and to pass specific antismoking legislation. In addition, goals such as the achievement of a smoke-free society by the year 2000 have spurred the formation of additional coalitions aimed at advocacy and lobbying activity in support of these broad goals.

The resources represented by and available to these five groupings are difficult to estimate. The large voluntary and professional organizations have many thousands of members, but no data are available to determine what number are involved actively in advocacy or lobbying or what resources may be directed to those purposes. The smaller groups, such as ASH, have modest budgets and staffs, but collectively represent a significant number of volunteers and dues-paying supporters.

The Tobacco Lobby

In discussing the nature and scope of antismoking lobbying, it is important to consider the nature of the political environment in which this takes place. An influential component of this environment has been the "tobacco lobby." The lobbying activities of the tobacco lobby do not vary greatly from the activities of other groups on behalf of other interests or causes, groups with vested economic or political interests using a variety of approaches to influence the outcome of legislation (Pertschuk 1986).

The term "tobacco lobby" has been used throughout the past 25 years as a generic description of those interest groups whose political activities have been directed toward protecting tobacco and cigarette interests from adverse policies. The groups included most often in this description are: the cigarette manufacturers and other commercial firms involved in the manufacture, marketing, and sale of cigarettes; the Tobacco In-

stitute, the trade association representing the cigarette manufacturers; the tobacco farmers and those commercial firms involved in the trading of unmanufactured tobacco; and the registered lobbyists representing these various interests.

As in the case of antismoking advocacy and lobbying, there is little in the published literature on which to base a detailed analysis of the activities or impact of the tobacco lobby. It is difficult to determine the precise composition of the lobby at any point in time, and particularly at those points during which efforts of the lobby have been alleged to have had significant impact on the outcome of legislative or regulatory efforts to control smoking or the cigarette product. The available data indicate that since 1964, the cigarette manufacturers and the Tobacco Institute often have played the lead role in developing strategies and initiating lobbying against antismoking legislation and regulation.

The available historical record indicates that, unlike the voluntary health agencies, the tobacco lobby and its constituent members have engaged in active lobbying throughout the years. Among the legislative outcomes purportedly influenced by the tobacco lobby at the national level are the following: negotiating provisions of the Cigarette Labeling and Advertising Act of 1965 to ensure that the Federal Trade Commission would be precluded from regulating cigarette advertising for 3 1/2 years (1965); negotiating provisions of the Public Health Cigarette Smoking Act of 1969 to include preemption of State regulation of cigarette advertising (see Chapters 7 and 8; see also Friedman 1975; Fritschler 1975); and precluding the Consumer Product Safety Commission from exercising jurisdiction over cigarettes (1972). At the State level, influences attributed to the tobacco lobby relate to defeat of statewide nonsmokers' rights legislation in California on two separate occasions (1978, 1980; Whelan 1984). There are numerous anecdotal reports of tobacco lobby opposition to efforts to pass other State and local ordinances restricting smoking. It is difficult to establish the extent of the tobacco lobby's influence on these events, or to determine what combination of interest groups and individuals was involved.

Antismoking Advocacy and Lobbying: 1964 to the Present

Early Efforts

A succession of legislative and regulatory actions aimed at labeling the cigarette as dangerous and restricting the advertising and marketing practices of the cigarette manufacturers marked the period following the 1964 Surgeon General's Report. (See next chapter.) Throughout the period from 1964–69, the major national voluntary agencies provided extensive expert medical testimony in support of these initiatives but did not lobby actively for their passage. While the expert testimony contributed to the decision process, more aggressive advocacy and direct lobbying that supplemented these efforts undoubtedly influenced the process as well. One important example is the citizen petition that John F. Banzhaf III filed, as an individual, with the Federal Com-

munications Commission (FCC) contending that smoking should be subject to the Fairness Doctrine. This action led to the FCC ruling that the Fairness Doctrine applied to cigarette advertising. As a result, stations broadcasting cigarette commercials were required to donate time to antismoking messages (see Chapter 7).

In the process of pursuing this legal course, Banzhaf founded ASH as a legal action arm for the antismoking community and launched an ongoing series of legal challenges to advance smoking control policies. ASH played a major role in establishing the legal concept of the right of nonsmokers to be free from exposure to tobacco smoke. A major component of that effort was pressure brought to bear on the Federal Aviation Administration to require separate smoking and nonsmoking areas on commercial flights. Through these and other initiatives, which other organizations also supported, ASH introduced the principle of private legal activism to influence legislation and other decisions on smoking and health issues.

Nonsmokers' Rights

The specific origin of concerns about the health hazards to nonsmokers of exposure to environmental tobacco smoke is difficult to date. In 1971, ASH already had targeted restrictions on smoking on airliners and in public as major regulatory initiatives. Dr. Jesse Steinfeld, U.S. Surgeon General from 1969–73, called official attention to the hazards of ETS for the first time in the 1972 Surgeon General's Report (US DHEW 1972) and was outspoken throughout his public career on the need to protect nonsmokers.

During the mid-1970s, groups concerned about nonsmokers' exposure to environmental tobacco smoke began to appear around the United States. One of the largest, California GASP, was the forerunner of Americans for Nonsmokers' Rights, the principal national antismoking group devoted solely to clean indoor air legislation. California GASP was founded in 1976 as a nonprofit public interest group and became Californians for Nonsmokers' Rights (CNR) in 1978. That year, CNR succeeded in placing a statewide proposition on the California ballot seeking restrictions on smoking in public. Although defeated in a vote preceded by a well-funded campaign by the tobacco lobby (Wong 1978), this initiative set the stage for repeated and increasingly successful smoking ordinances at the community level in California and in other States and cities. As Americans for Nonsmokers' Rights, the group reports having assisted in the passage of scores of city and county ordinances (Americans for Nonsmokers' Rights 1988).

ALA also has played an important role in public education and advocacy on the issue of protecting nonsmokers. Due in large part to its strong interest in promoting clean air, ALA was the first of the three national voluntary health organizations to become involved in the nonsmokers' rights issue. In fact, ALA did so early in the 1970s with a campaign stressing the concept that nonsmokers objected to involuntary exposure to tobacco smoke.

As it evolved, the nonsmokers' rights issue introduced a new element in the growth of antismoking advocacy and lobbying: a basis for involving nonsmokers in activities other than encouraging smokers to quit or discouraging initiation among teenagers.

Resulting initiatives provided a new rallying point outside the traditional focus of the voluntary health agencies and at the same time appealed to and prompted greater activity among those groups.

The effect of this element in the smoking control movement has yet to be fully evaluated. Surveys of public attitudes about smoking and the need to restrict it to protect nonsmokers show a widespread acceptance of these principles and an increasing consensus that the social acceptability of smoking is declining (Chapter 4).

Coalition Building and the Growth of Advocacy

As mentioned previously, ACS, AHA, and ALA in 1982 formed a tripartite Coalition on Smoking OR Health, primarily to coordinate their Federal legislative activities related to smoking control. The creation of the Coalition came at the end of a long period of gradual expansion in the public policy activities of the three voluntary organizations. The National Commission on Smoking and Public Policy, a study group ACS established in 1976, added impetus to the concept of the Coalition by recommending the three voluntary health agencies do more to support public policy initiatives to control smoking (ACS 1978). The Coalition has served as a mechanism for coordinating and implementing lobbying efforts of the three agencies. At the time the Coalition was established, ACS, AHA, and ALA also increased the staffs and resources of their individual public policy components.

Through the Coalition, the three voluntary health agencies have worked with other organizations and coalitions with common interests in support of smoking control policies, relating to health warning labels, tobacco advertising, smoking on airlines, the tobacco excise tax, and the price support program. Successful antismoking efforts the Coalition supported have included: passage of the Comprehensive Smoking Education Act of 1984, which requires four rotating warning labels on cigarette packages and advertisements, as well as disclosure to the Secretary of Health and Human Services of additives used in the manufacture of cigarettes; passage of the Comprehensive Smokeless Tobacco Health Education Act of 1986, banning advertising for smokeless tobacco in the electronic media and requiring warning labels on packages and advertisements; permanent extension of the Federal excise tax at 16 cents per pack as a provision of the Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99-272); and banning of smoking on commercial domestic airline flights scheduled for flight time of 2 hr or less as part of the fiscal year 1988 Department of Transportation appropriations bill (see Chapter 7). One analyst has concluded that the Coalition has enabled the three national voluntary health agencies to take the initiative in a variety of areas, placing the tobacco lobby in a reactive posture (Pertschuk 1986).

Other factors that have accompanied the Coalition's efforts are believed to have contributed to the Coalition's success and to an apparent steady increase in the level of antismoking advocacy and lobbying throughout the United States. One of these factors is the recruitment of new allies and the energizing of old ones. In addition to the Coalition, other groups and organizations have taken more aggressive positions. For example, the American Council on Science and Health has been an aggressive advocate on all aspects of smoking control. Another example is the American Medical Associa-

tion, which has become involved in a major effort to mobilize its members at the State and local levels, in addition to using its considerable influence in Washington, in support of antismoking legislation (Lundberg 1985; AMA Council on Scientific Affairs 1984; American Medical Association 1987).

Another important factor is the growth in knowledge and sophistication of the advocates and lobbyists themselves. Drawing on the experience and expertise of other public interest groups, the antismoking interests have become significantly more proficient at employing their resources. In addition, through its Smoking Control Advocacy Resource Center, the Advocacy Institute, a public interest advocacy strategy and skills training resource, has contributed new thinking and coordination to the effort to counter the influence of the tobacco lobby (Advocacy Institute 1987a, 1987b).

One of the most important aspects of the growth of antismoking advocacy and lobbying has been the increase in State and local activity. The creation of coalitions and the success of local antismoking ordinances appear to have encouraged more groups and individuals to become politically active. Surveys and studies of trends in local and State smoking control ordinances (US DHHS 1986d) indicate that the restrictiveness of those ordinances is increasing, as is public support. (See also Chapter 7.)

CONCLUSIONS

Part I. Smoking Prevention Activities

1. Diverse program approaches to the prevention of smoking among youth grew out of antismoking education efforts in the 1960s. These approaches include media-based programs and resources; smoking prevention as part of multicomponent school health education; psychosocial prevention curricula; and a variety of other resources developed and sponsored by professional and voluntary health organizations, Federal and State agencies, and schools and community groups.
2. Psychosocial curricula addressing youths' motivations for smoking and the skills they need to resist influences to smoke have emerged as the program approach with the most positive outcomes. Evolution in program content has been accompanied by a shift since the 1960s in prevention program focus from youths in high school and college to adolescents in grades 6 through 8.
3. Existing prevention programs vary greatly in the extent to which they have been evaluated and used. Psychosocial prevention curricula have been intensively developed over the last decade and have been the most thoroughly evaluated and best documented; however, they are generally not part of a dissemination system. More widely disseminated smoking prevention materials and programs, such as those using mass media and brochures, have not always been as thoroughly evaluated; however, they have achieved wider use in the field.
4. The model of stages of smoking behavior acquisition underlies current smoking prevention programs and suggests new intervention opportunities, ranging from prevention activities aimed at young children to cessation programs for adolescent smokers.

5. There has been and continues to be a lack of smoking prevention programs that target youth at higher risk for smoking, such as those from lower socioeconomic backgrounds or school dropouts.

Part II. Smoking Education and Cessation Activities

1. During the past 25 years, national voluntary health agencies, especially the American Cancer Society, the American Heart Association, and the American Lung Association, have played a significant role in educating the public about the hazards of tobacco use.
2. Individual and group smoking cessation programs evolved from an emphasis on conditioning-based approaches in the 1960s, to the cognitively based self-management procedures of the 1970s, to the relapse prevention and pharmacologically based components of the 1980s.
3. There has recently been an increased emphasis on targeting specific groups of smokers for cessation activities (e.g., pregnant women, Hispanics, blacks).
4. Packaging and marketing of self-help smoking cessation materials have become more sophisticated and there is more of an emphasis on relapse prevention, while much of the content has changed relatively little over the years.
5. Mass-mediated quit-smoking programs have become an increasingly popular strategy for influencing the smoking behavior of a large number of smokers.
6. The 1980s have seen an increase in the promotion of smoking control efforts in the workplace in response to increasing demand and opportunity for worksite wellness programs and smoking control policies.
7. In the last decade there has been an increasing interest in involving physicians and other health care professionals in smoking control efforts. Medical organizations have played a more prominent role in smoking and health during the 1980s than they had in the past.

Part III. Antismoking Advocacy and Lobbying

1. Lobbying and advocacy efforts have expanded through the increasing commitment of the national voluntary health agencies to political action and the formation of coalitions at the local, State, and national levels.
2. Antismoking advocacy and lobbying have evolved over the past 25 years and now focus on a growing number of local, State, and national legislative and regulatory initiatives designed to reduce smoking, regulate the cigarette product, and prevent the uptake of smoking by children and adolescents.

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