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Minority Concerns for Passage of a Comprehensive National Tobacco Control Legislation

Briefing: February 23, 1998

APIAHF

Asian & Pacific
Islander American
Health Forum
National Advocates for Asian & Pacific Islander Health

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Asian & Pacific Islander American
Health Forum
National Advocates for Asian & Pacific Islander Health

January 30, 1998

Kevin Thurm, Deputy Secretary
Department of Health and Human Services
200 Independence Avenue. S.W.
Washington, D.C. 20201

Dear Deputy Secretary Thurm:

Thank you again for your tremendous leadership and personal commitment in developing the Asian American and Pacific Islander Initiative (AAPI Initiative) for the Department of Health and Human Services (DHHS). We are pleased to forward to you a copy of our commentary and response to the draft framework for the AAPI Initiative. Our commentary and response draws upon our eleven years of leadership in initiating and convening many events where Asian American and Pacific Islander health professionals have given voice to their issues, concerns and hopes for the improvement of the health of our Asian American and Pacific Islander communities throughout the United States and the Pacific jurisdictions. We are deeply committed to participate and contribute to the DHHS process for developing and implementing this critical AAPI Initiative.

While we commend the efforts made by DHHS to develop this AAPI Initiative and to solicit input from the Asian American and Pacific Islander communities, we are concerned that there still is a lack of a clear implementation plan for the AAPI Initiative. Specifically, we are concerned that there has not been any institutional base identified within the DHHS for the implementation of the AAPI Initiative nor any DHHS budget or human resources designated for the AAPI Initiative.

Therefore, on behalf of our membership and community based organization constituencies, the Asian and Pacific Islander American Health Forum proposes that the DHHS immediately adopt an implementation strategy that maximizes the potential for, according to the draft framework, "sustained, collaborative efforts within HHS, and between the Federal government and community based organizations." We urge that such an implementation strategy include the following elements:

- designate senior level DHHS staff and administrative staff support within your office of the Deputy Secretary to ensure consistency and leadership in the implementation of the AAPI Initiative;

- establish a process to require DHHS operations divisions to identify specific budget and human resources to implement their AAPI Initiative workplans in a timely, specific and measurable manner;
- establish a DHHS-wide standing committee made up of high-ranking agency and bureau staff to coordinate and monitor implementation of the AAPI Initiative;
- establish a Asian American and Pacific Islander community advisory panel for the AAPI Initiative, representative of a wide array of competencies, professional experience and constituencies, to provide guidance and expertise directly to the DHHS operations divisions and staff divisions in the implementation of each of their AAPI Initiative workplans;
- provide periodic updates to local Asian American and Pacific Islander communities on the progress of the implementation of the AAPI Initiative through DHHS Regional Offices;
- provide periodic briefings to members of the Asian Pacific American Congressional Caucus on DHHS' progress on the implementation of the AAPI Initiative;
- institutionalize the DHHS Initiative through a Presidential Executive Order similar to other health initiatives for minority communities, especially given the necessity of the involvement of other Cabinet departments and agencies in the implementation of the AAPI Initiative (e.g. Departments of State and Interior on Pacific jurisdiction issues, Department of Justice on immigration issues, Department of Education on health professions development and training issues, Department of Labor on occupational health issues, Environmental Protection Agency on environmental health issues, etc.).

Thank you again for your leadership on behalf of our Asian American and Pacific Islander communities. We look forward to your response to our proposal for implementation and look forward to continuing to work with you on this Initiative.

Sincerely,

Tessie Guillermo
Executive Director

cc: Dennis Hayashi, Co-Chair, DHHS Working Group
Kathy Buto, Co-Chair, DHHS Working Group

ASIAN & PACIFIC ISLANDER AMERICAN HEALTH FORUM RECOMMENDATIONS FOR IMPLEMENTATION OF DHHS ASIAN AMERICAN AND PACIFIC ISLANDER INITIATIVE

In response to the call for comments regarding the Framework for the Department of Health and Human Services' Asian American and Pacific Islander Initiative to meet the health and human services needs of Asian Americans and Pacific Islanders, the Asian & Pacific Islander American Health Forum (the Health Forum) is submitting this document. This document parallels the structure of the Framework and focuses on its six areas. The document includes the outline of issues, specific short-term activities, general longer term activities and list of specific recommendations under the Framework's goals and objectives.

The recommendations are compiled from several national conferences from 1986 to 1997. The conferences include: the *First National Health Summit of Asian American and Pacific Islander Health Organizational Leaders* (1995), *Pacific Islander and Asian American Conference on Health Research and Research Training* (1996), *Voices from the Community: A Call to Action for Asian and Pacific Islander Health in the New Millennium* (1997) and other Health Forum national conferences (1990, 1988 and 1986). Specific recommendations made by the Health Forum are found separately in the general comments sections preceding the goal statements

I. ACCESS AND UTILIZATION OF HEALTH AND HUMAN SERVICES

In the past, many AAPI populations had lower access and utilization of health and human services due to reasons such as lack of awareness of existing programs and reluctance or stigma attached to the programs. The enactment of the 1996 welfare reform law also affected immigrant eligibility for federal, state and local programs which often deter individuals who are, in fact, eligible for the programs from seeking any health and human services. Therefore, it is important for HHS to conduct outreach (including use of AAPI language materials and community outreach workers) with appropriate AAPI languages, especially for Southeast Asians such as Hmong, Laotian, Cambodian and Vietnamese.

Short term activities

We urge that immediate short-term activities include comprehensive outreach to AAPI populations on eligibility for public health insurance, public health and nutrition programs. Specifically,

- Outreach and education under the State Children's Health Insurance Program (SCHIP) and Children's Health Care Initiative is critical in providing health care coverage for working poor families. The scope, at minimum, should be top ten states where AAPIs reside. Given that implementation is largely left up to the states, HCFA should coordinate with the states to ensure that AAPI parents and community members are fully aware of eligibility criteria.

- Given the restriction under SCHIP that prohibits enrollment of Medicaid eligible children, HCFA should use Operation Restore Trust activities to inform AAPIs who are eligible for Medicaid and Medicare of their entitlement.
- Begin aggressive outreach and education for the Maternal and Child Health programs.
- Focus on immigrant children including AAPI children in the Childhood Immunization program.
- Outreach and recruitment on nutrition programs such as Healthy Start and WIC.

We believe these activities can be initiated immediately and with minimal resources given that these are existing programs. In addition to these programs, aggressive outreach and education should be conducted for preventive care programs to other populations such as women and elderly.

One consistent recommendation that was discussed in the conferences listed above is cultural and linguistic competency. We believe this can be started by considering AAPI populations as customers of HHS. Without such change in attitude or recognition of our population, any attempt to serve our population will be fragmented and inadequate. Therefore, in the short-term, we urge all HHS agencies, especially in the regional offices with large number of AAPI populations, to develop plans on how to establish standards for cultural and linguistic competency. The focus areas that were mentioned in the various recommendations include: the National Immunization Program, disease prevention and health promotion, smoking cessation, substance abuse and mental health programs.

Related to the issue of cultural competency and access to health care is current methods by which Medically Undeserved Areas/Medically Undeserved Populations are designated. The Health Forum urges HRSA to take action on the recommendations indicated in the joint study conducted by AAPCHO and the Health Forum and funded by HRSA, BPHC, in 1995 to assure a more appropriate mechanism in allocating primary health care funding to the AAPI communities throughout the U.S.

Long term activities

In the long term, all public health programs should have a specific outreach plan for AAPI populations with evaluation mechanisms for effectiveness.

In addition, as the objectives for the Healthy People 2010 are being developed, it is critical to include specific AAPI objectives. These objectives will facilitate various HHS agencies in allocating resources to target AAPI populations in the programs they administer. The number of AAPI specific objectives included in the Healthy People 2010 can be increased if local, state and regional baseline data are incorporated into the development of objectives. For the long-term viability of the AAPI Initiative, it must

be integrated into Department-wide mechanisms to prioritize resource allocation such as Healthy People 2010.

GOAL 1: Improve health and well-being of AAPIs by increasing their access to and utilization of health and human services.

Objective 1.1. Develop strategies to eliminate the disparities and increase AAPI participation in major preventive health activities.

CDC: develop, fund and implement specific preventive health programs targeting Asian Americans and Pacific Islanders including but not limited to specific requests for proposals on preventing cardiovascular diseases, cancer, hepatitis B, diabetes, tuberculosis, STDs, HIV/AIDS, malnutrition, teen pregnancy, infant mortality, suicide, violence and substance abuse and promoting mental health, occupational health and safety and environmental health (AAPI Summit, 1995; APIAHF Voices Conference, 1997; APIAHF Conference, 1990; APIAHF Conference, 1988; APIAHF Conference, 1986; National API HIV/AIDS Recommendations, 1996)

CDC: develop, fund and implement specific preventive health programs targeting Asian Americans and Pacific Islanders to increase the rates of immunizations and reduce the rates of chronic diseases among Asian Americans and Pacific Islanders (AAPI Summit, 1995)

OMH, HRSA, AHCPR and CDC: develop a Department task force to develop standards for linguistic access and cultural competence in all federally funded health programs and services (AAPI Summit, 1995; APIAHF Voices Conference, 1997; APIAHF Conference, 1990; APIAHF Conference, 1988)

OMH, HRSA, AHCPR and CDC: develop standards for training, certification and quality assurance for health services and health education interpreters in all federally funded health programs and services (APIAHF Voices Conference, 1997; APIAHF Conference, 1990; APIAHF Conference, 1988)

HCFA: expand Medicaid and Medicare reimbursements to include bilingual/bicultural interpretation services (APIAHF Conference, 1990)

HCFA: ensure that Medicaid managed care plans include specific, enforceable requirements for linguistic access and cultural competence (APIAHF Voices Conference, 1997; National API HIV/AIDS Recommendations, 1996)

CDC: establish and maintain an Asian American and Pacific Islander Advisory Committee to identity gaps and resources in CDC programs for Asians and Pacific Islanders (AAPI Summit, 1995)

HCFA: ensure that Medicaid reimbursements include screening and immunization costs for Hepatitis B (APIAHF Conference, 1990)

Objective 1.2. Designate a lead agency for ongoing assessment of AAPI access to health services and dissemination of information on effective methods to assure access to services.

HRSA: develop and disseminate training curricula on linguistic access and cultural competence for all health care providers serving Asian American and Pacific Islander populations (AAPI Summit, 1995; APIAHF Voices Conference, 1997)

HRSA: expand definition of Medically Underserved Populations/Medically Underserved Areas to include racial/ethnic specific health factors, availability of linguistically accessible and culturally competent health service providers and socioeconomic factors such as recent population growth (APIAHF Conference, 1990)

HRSA: specifically support the establishment of additional community health centers in Asian American and Pacific Islander communities through CHC start-up funds

AHCPR: ensure active participation of Asian American and Pacific Islander practitioners and experts in developing all AHCPR clinical guidelines (AAPI Summit, 1995)

AHCPR: fund a specific request for proposals to identify rates of uninsurance and underinsurance among Asian Americans and Pacific Islanders and to evaluate strategies to decrease those rates

Objective 1.3. Improve the health status of Native Hawaiians and Pacific Islanders through strategic development of effective health services system infrastructure and capacity.

AHCPR: investigate and evaluate options for the optimal organization and delivery of health care services in the Pacific Islands that include consideration of appropriate cultural, socioeconomic and geographic factors (AAPI Summit, 1995; APIAHF Conference, 1990)

CDC: promote and fund collaborations among governmental and non-governmental partners in the Pacific Islands (AAPI Summit, 1995)

Objective 1.4. Develop strategies for increasing AAPI community participation in selected human service programs.

CDC: increase the number of funded community capacity-building and leadership development programs (e.g. technical assistance and training, collaborations, coalition-building, community mobilization and advocacy) for Asian American and Pacific

Islander communities and community organizations (AAPI Summit, 1995; APIAHF Voices Conference, 1997; APIAHF Conference, 1990; National API HIV/AIDS Recommendations, 1996)

Office of Civil Rights: actively monitor, investigate and prosecute denials, delays or differences in the provision of all federally funded health and human services based on race, national origin or primary language; increase community education activities about civil rights protections in Asian American and Pacific Islander communities (APIAHF Voices Conference, 1997; APIAHF Conference, 1990; APIAHF Conference, 1988)

II. ASIAN AMERICAN AND PACIFIC ISLANDER DATA

The current state of knowledge regarding health status, utilization and other related statistics for AAPI populations is incomplete and fragmented. The causes for such sporadic availability of data include: growing but still small size of the population, heterogeneity within the AAPI populations which makes aggregated data inappropriate, and inadequate level of action and resources allocated to collect, analyze and disseminate data on the AAPI populations. This is related to a lack of prioritization of the AAPI communities' needs as populations at risk.

We see the Year 2000 Census as an important opportunity to ensure that the AAPI data for the next decade can appropriately describe the health status of the AAPI populations. With the new sets of denominators established by the Census, we could have a more accurate picture of the AAPI population before the Census data become outdated. One step in having the data responsive to the needs of the community is the distinction between Asian Americans and Pacific Islanders under the new federal data collection directive. This Initiative is an excellent opportunity to establish the data agenda for the year 2000. One of the most prominent recommendations from the all the conferences as well as an ongoing policy priority of the Health Forum has been to improve data.

Our response to this section requires a definition of data to include: vital statistics and health surveillance programs; ongoing survey programs and other, similar activities which involve the systematic collection and analysis of health information for purposes of assessing the overall health status and services utilization of the population by federal, state and local governments, and any entities funded by government to do so.

The means to improved data include:

- Disaggregation of AAPI data into the national origin/ethnicity groups (such as, Vietnamese, Hmong, Filipinos, Chamorros) whenever feasible beyond the vital statistics currently collected in seven states, to include health surveillance and utilization. This includes the National Health Interview Survey, Behavioral Risk

Factor Survey and any other such ongoing survey programs funded and/or administered by the federal government.

- Intermediate disaggregation of the AAPI populations into regional groups with similar characteristics such as Southeast Asians, East Asians, South Asians and Pacific Islanders in all data collection programs within DHHS.
- Primary focus on underserved AAPI demographic populations such as women, the elderly and adolescents, as well as by key health issue areas such as: violence including domestic violence, mental health and substance abuse, environmental health and safety, HIV/AIDS, diabetes, cardiovascular and cerebral vascular diseases, cancers, tuberculosis and hepatitis B.
- Include key measures such as language, country of birth and immigration status in appropriate data collection instruments, particularly for surveillance and survey programs.
- Promote new data collection efforts on regional and local, ethnic population-specific data collection, analysis and reporting efforts that can serve as building blocks in developing knowledge about the AAPI populations' health.

Short term activities

As HHS takes steps to improve AAPI data, it should conduct an assessment of existing data by taking an inventory of health datasets that have a sufficient sample size for analysis at either the aggregate or disaggregate level. Through this process, the data collection agencies can determine what analysis can be done with existing data. Interested researchers and organizations can use the data to conduct research on AAPI health issues of interest. Moreover, national data such as the National Health Interview Survey, which can yield useful disaggregated data, should be systematically analyzed.

- The NCHS Cooperative Agreement grant mechanism authorized under the Disadvanataged Minority Health Improvement Act of 1990 should be examined for opportunities to aggressively support research on sampling methods for hard to count/reach AAPI ethnic populations.

- The Secretary of DHHS should create a federally based incentive mechanism for significant AAPI populated State and Local government vital statistics, surveillance, and health utilization data collection agencies to establish data collection standards which include the Census 2000 AAPI ethnic categories.

- The NCHS should be directed to fully implement the intent of the Disadvantaged Minority Health Improvement Act with regard to data issues, targeting community based investigators.

- In addition, in order to maximize the potential of Census 2000 and other data collection efforts, the AAPI health data agenda for the year 2000 should be developed in coordination with the AAPI communities.

Long term activities

- In the long run, a truly national sample of AAPI populations can only be obtained through national or multi-regional (e.g., Hispanic HANES) oversampling of AAPI populations on a health status in NHIS, HANES, MEPS and other national data collection systems.

- In the meantime, it is important to have a central location to house data and develop methodologies for AAPI research to ensure these resources are easily accessible. Therefore, we recommend a creation of a clearing house or center for AAPI and other minority health data.

- Furthermore, the NCHS should develop a mentoring mechanism to establish effective partnerships between community based health professionals and the health information professional community that would result in meaningful data collection efforts for the AAPI communities.

GOAL 2: Increase and improve the collection, analysis and dissemination of data about AAPI populations and sub-populations.

Objective 2.1. Increase and improve collection of data on AAPIs.

ASPE, NIH, AHCPR, HRSA and CDC: require adequate sampling and oversampling of Asian Americans, of Native Hawaiians and Other Pacific Islanders and of Asian American and Pacific Islander national origin/ethnicity/primary language groups in all national population-based health surveys (PIAA NIH Conference, 1996; AAPI Summit, 1995; APIAHF Voices Conference, 1997; APIAHF Conference, 1990; APIAHF Conference, 1986; APIAHF Conference, 1988; National API HIV/AIDS Recommendations, 1996)

NIH, AHCPR, HRSA and CDC: supplement national population-based health surveys with regional and local surveys that oversample Asian American and Pacific Islander populations (AAPI Summit, 1995; APIAHF Conference, 1990)

CDC: conduct specific and longitudinal morbidity and risk factor incidence and prevalence surveys for leading mortality and morbidity indicators among Asian Americans, among Native Hawaiians and Other Pacific Islanders and among specific Asian American and Pacific Islander national origin/ethnicity/primary language groups, including but not limited to specific requests for proposals on cardiovascular diseases, cancer, hepatitis B, diabetes, tuberculosis, STDs, HIV/AIDS, nutrition, teen pregnancy,

infant mortality, mental health, suicide, violence, substance abuse, occupational health and safety and environmental health (PIAA NIH Conference, 1996; AAPI Summit, 1995; APIAHF Voices Conference, 1997; APIAHF Conference, 1990; APIAHF Conference, 1988; APIAHF Conference, 1986; National API HIV/AIDS Recommendations, 1996)

ASPE, NIH, HRSA, SAMHSA, AHCPR and CDC: issue specific requests for proposals to develop and validate innovative sampling designs to investigate health issues among emerging populations and small groups (PIAA NIH Conference, 1996; AAPI Summit, 1995)

CDC and HRSA: provide supplemental grants to Community Health Centers for data collection and analysis (APIAHF Conference, 1990)

CDC: include variables such as place of birth, primary language, years lived in the United States, age and gender in all data collected on Asian Americans and Pacific Islanders (AAPI Summit, 1995; APIAHF Voices Conference, 1997; APIAHF Conference, 1990; APIAHF Conference, 1988; National API HIV/AIDS Recommendations, 1996)

CDC: issue specific requests for proposals to evaluate racial misclassification in health data collection (e.g. use of death and birth certificates, hospital discharge records, provider identification) and to identify and develop recommendations for methodologies to decrease the rate of racial misclassification (APIAHF Conference, 1990; APIAHF Conference, 1988; APIAHF Conference, 1986; National API HIV/AIDS Recommendations, 1996)

Objective 2.2. Increase and improve analyses and dissemination of data on AAPIs.

NIH, HRSA, AHCPR, SAMHSA and CDC: identify, compile and publicize the availability of all existing national and international data sets on Asian American and Pacific Islander health; make such data sets available to researchers working on Asian American and Pacific Islander health research (PIAA NIH Conference, 1996; APIAHF Conference, 1990)

NIH, HRSA, AHCPR, SAMHSA and CDC: establish and maintain a clearinghouse for existing national and international data sets on Asian American and Pacific Islander health (PIAA NIH Conference, 1996; APIAHF Voices Conference, 1997; APIAHF Conference, 1990; APIAHF Conference, 1986)

III. RESEARCH ON ASIAN AMERICAN AND PACIFIC ISLANDER HEALTH

Most of the recommendations made by community members over the years, and especially at the 1996 Honolulu conference can be summarized in three areas: Content; Participation/Conduct; and Analysis/Dissemination.

Content is addressed in such a way as to assure that cultural norms and standards are understood, respected and incorporated into research methodology because of the emphatic belief that current Western modes of research have little ability to be translated effectively in many AAPI communities. The concepts of "yin and yang," and "lokahi" are not just interesting cultural artifacts which may explain behavior. They are in fact deep patterns of living which constitute a driving force for their respective societies. For example, the orientation by a principal investigator towards non-bias and the objective collection of data by requiring a sterile, non-dichotomous interaction between investigator and subject, goes against many Eastern and Pacific codes of human interaction. This will often result in a frustrating effort for the individuals or groups involved in the research or at best, inaccurate information being given in a data collection effort. The closer people are to their culture, the more likelihood of this being true. The implications for gaining accurate information about immigrants and native people are thus very clear.

Furthermore, participants in all our conferences have recommended that any research conducted on AAPI populations have participation from the community in all aspects. This means that from the development of the research questions, to providing direction in the development of appropriate data collection methods, the analysis, and dissemination of the results, and finally, to the application of the research results in the form of program and policy changes, investigators should seek to be more than inclusive, but in fact be *led* by the target community in the conduct of research related to that community. The Health Forum believes this principle should be required as a preamble to any discussion of AAPI research. This would require that DHHS agencies, particularly at the National Institutes of Health and at the Agency for Health Care Policy and Research to broaden the membership of, and modernize the selection process within, their research review panels to incorporate these principles.

Finally, what often happens in the case of traditional academic research is that the results of the research are disseminated in such a way as to limit opportunities for the affected population to create understanding and make policy changes. The laborious process of preparing research findings for formal scientific journal publication, prior to making the research available for community action, must be modified so that relevant information that can be used to immediately affect the health of the population at-risk is readily available. In the case of AAPI populations, because so little research has been undertaken to date, it is critical that any research be immediately available to communities working to improve AAPI health. The Health Forum recommends that DHHS agencies which fund health research work with the scientific community to find ways in which important information can be made available in a timely way so that the public and affected communities can take prompt action to impact their health.

Moreover, the reasons that limit the existing health data on AAPI populations also limit the amount of research on the population. Given the change in the health care delivery system and recent policy changes in access to health care, it is critical to conduct research on the impact of these policy changes as well as traditional health research.

By definition, recommendations in this section are meant to address the investigator or government initiatives that explore health status, health behaviors, interventions and their methodologies and outcomes, which result from discrete, project oriented investigation by such entities or individuals. This is as opposed to the definition of data collection as provided above.

Short term activities

To develop a coherent research agenda, we recommend an inventory of AAPI research projects funded by HHS as well as an updated comprehensive bibliography of AAPI research.

The AAPI community research agenda should include:

- Basic epidemiological research on morbidity at the regional and local levels is necessary to develop the foundation for research agenda with a focus on areas such as: women's health, violence including domestic violence, mental health and substance abuse, environmental health and safety, HIV/AIDS, diabetes, cardiovascular- and cerebral vascular diseases, cancers, tuberculosis and hepatitis B.
- Effective methods for interpretation and other linguistic and cultural competency issues.
- Research on the impact of welfare reform and managed care on AAPI populations.
- Key short term activities to increase the relevance and utility of research on AAPI populations and articulating these criteria as part of all requests for proposal and integrating AAPI researchers and community members into the grant review process.

Long term activities

An AAPI community research agenda should be formed in conjunction with a plan to increase the availability of AAPI data.

GOAL 3: Increase the number of funded research projects and programs targeted towards AAPIs.

Objective 3.1. Conduct analyses of the major health and mental health and human service related problems facing AAPI communities.

NIH, HRSA, SAMHSA, AHCPR and CDC: immediately identify and fund specific research projects to establish baseline data for leading mortality and morbidity indicators among Asian Americans, among Native Hawaiians and Other Pacific Islanders and among specific Asian American and Pacific Islander national origin/ethnicity/primary language groups, including but not limited to specific requests for proposals on cardiovascular diseases, cancer, hepatitis B, diabetes, tuberculosis, STDs, HIV/AIDS, nutrition, teen pregnancy, infant mortality, mental health, suicide, violence, substance abuse, occupational health and safety and environmental health (PIAA NIH Conference, 1996; AAPI Summit, 1995; APIAHF Voices Conference, 1997; APIAHF Conference, 1990; APIAHF Conference, 1988; APIAHF Conference, 1986; National API HIV/AIDS Recommendations, 1996)

Objective 3.2. Evaluate the impact of major health and human service changes, including welfare reform and coverage of uninsured children, on the access to care and services of AAPI populations.

ACF, ASPE: evaluate the impact of the denial of eligibility for Medicaid for new immigrants (who enter the U.S. after 8/96) and "not qualified" immigrants under federal welfare reform on Asian Americans and Pacific Islanders (APIAHF Voices Conference, 1997)

ASPE, ACF and HCFA: evaluate the impact of the denial of eligibility for Medicaid for new immigrants and "not qualified" immigrants under state options under the federal welfare reform on Asian Americans and Pacific Islanders (APIAHF Voices Conference, 1997)

ASPE, ACF: evaluate the impact of the denial of eligibility for State Children's Health Insurance Program for new immigrants and "not qualified" immigrants on Asian Americans and Pacific Islanders

HCFA: document the fiscal costs of the ineligibility of certain immigrants for federally funded health programs such as Medicaid and State Children's Health Insurance Program

Objective 3.3. Develop a research agenda and solicit research proposals to increase clinical research and health care utilization information needed to reduce gaps in knowledge about AAPIs.

NIH, AHCPR, HRSA, SAMHSA and CDC: ensure that all review panels and study sections reviewing proposals for research in the Asian American and Pacific Islander communities include active participation by Asian Americans and Pacific Islanders,

including Asian American and Pacific Islander consumers; proactively solicit the assistance of Asian American and Pacific Islander community organizations in identifying Asian American and Pacific Islander participants for review panels and study sections (PIAA NIH Conference, 1996; AAPI Summit, 1995; APIAHF Voices Conference, 1997)

NIH, AHCPR, HRSA, SAMHSA and CDC: require all future research conducted on AAPI populations to utilize a community-based, participatory process that includes, at a minimum, evidence of participation of members of the subject community in the design, development, implementation and analysis of the research, an evaluation of the effectiveness of the research methodology for that subject community and a plan for the dissemination of the research findings and for ensuring access to the research data in the subject community (PIAA NIH Conference, 1996; AAPI Summit, 1995; APIAHF Conference, 1990; National API HIV/AIDS Recommendations, 1996; API HIV Technology Transfer Summit, 1997)

NIH: create and maintain an Asian American and Pacific Islander Research Advisory Council to identity and provide Asian American and Pacific Islander community resource persons, including Asian American and Pacific Islander consumers, to review grant applications, to oversee NIH projects and research relevant to Asian Americans and Pacific Islanders and to oversee the availability, accessibility and dissemination of data to Asian American and Pacific Islander communities (PIAA NIH Conference, 1996; AAPI Summit, 1995)

NIH, AHCPR, HRSA, SAMHSA and CDC: initiate specific research projects on the preventive and protective factors in Asian American and Pacific Islander cultural values, practices, customs and beliefs and their impact on health promotion and disease prevention (PIAA NIH Conference, 1996; AAPI Summit, 1995)

NIH, AHCPR, HRSA, SAMHSA and CDC: initiate specific research projects on the effectiveness of indigenous and traditional health care systems and practices of Pacific Islander and Asian American communities (PIAA NIH Conference, 1996; AAPI Summit, 1995)

HRSA, SAMHSA and AHCPR: initiate specific research projects to evaluate the cost effectiveness of bilingual/bicultural health service providers compared to utilizing health service interpretation methodologies (APIAHF Voices Conference, 1997)

NIH, AHCPR, HRSA, SAMHSA and CDC: conduct longitudinal and migration studies on Asian American and Pacific Islander populations (PIAA NIH Conference, 1996; APIAHF Voices Conference, 1997)

Objective 3.4. Include AAPIs on ongoing crosscutting research on health and human service issues, in developing new survey instruments, and by involving researchers familiar with AAPI issues in review groups and advisory panels.

NIH, HRSA, AHCPR, SAMHSA and CDC: ensure that all review panels and study sections include representation and active participation by Asian Americans and Pacific Islanders, including Asian American and Pacific Islander consumers; proactively solicit the assistance of Asian American and Pacific Islander community organizations in identifying Asian American and Pacific Islander participants for review panels and study sections (PIAA NIH Conference, 1996; AAPI Summit, 1995; APIAHF Voices Conference, 1997; APIAHF Conference, 1988; National API HIV/AIDS Recommendations, 1996)

NIH, HRSA, AHCPR, SAMHSA and CDC: require all future research projects to include sampling and recruitment methodologies that reflect the specific racial and ethnic composition of the entire population in the subject geographic area(s), including Asian Americans and Pacific Islanders (PIAA NIH Conference, 1996)

NIH, HRSA, AHCPR, SAMHSA and CDC: require use of culturally and linguistically appropriate methods of data collection in all federally funded research projects (PIAA NIH Conference, 1996; APIAHF Voices Conference, 1997; APIAHF Conference, 1990; APIAHF Conference, 1988)

NIH, HRSA, AHCPR, SAMHSA and CDC: issue specific requests for proposals to develop and validate innovative research and data collection methodologies that are culturally appropriate for Asian American and Pacific Islander populations (PIAA NIH Conference, 1996; AAPI Summit, 1995; APIAHF Voices Conference, 1997)

NIH, HRSA, AHCPR, SAMHSA and CDC: promote and fund increased collaborations between Asian American and Pacific Islander community organizations and academia, especially Asian American and Pacific Islander faculty and researchers in clinical medical research and behavioral science (PIAA NIH Conference, 1996; CDC API HIV Technology Transfer Summit, 1997)

IV. TRAINING

The aggregation of AAPI data has masked the lack of Southeast Asians and Pacific Islanders in HHS or HHS-sponsored training programs. The newly proposed OMB Directive 15 has provided an excellent opportunity to address the training issues for Native Hawaiians and Other Pacific Islanders (NH/PIs). As a separate race category, there will be more data and attention at the national level on training needs of NH/PIs. In addition, we recommend an analysis of Southeast Asians to determine whether there is an underrepresentation of this population in training programs.

The Health Forum has collected, analyzed and produced reports on the misalignment of the supply of AAPI health professionals and the demand by the AAPI community, by geography, language, ethnicity and specialty. It is clear from our studies that there are clearly many areas of need that still require attention by DHHS agencies such as HRSA and NIH. In particular, the conventional wisdom that there is an oversupply of graduate level health professionals available in the U.S. masks the underemployment of such professionals in the areas of biomedical and behavioral research and in the advanced practice nursing overall. Furthermore, there is little understanding that a large percentage of higher educated AAPI professionals in the U.S. at any given time are here as temporary workers filling a gap in the science and health profession workforce, rather than being reflective of their achievement in the U.S. educational system.

Moreover, mindful of the fact that the ultimate goals of these training programs are to increase research and services to underserved populations, HHS should look beyond the simple numeric representation at the national level for aggregate AAPI populations and evaluate how the training programs can address the unmet research and service needs of AAPI populations.

Short term activities

The Health Forum and others have urged HHS to look beyond simple aggregate data and examine whether providers who can appropriately serve AAPI populations (i.e., language proficiency in one of AAPI languages) are available and explore alternatives such as international medical graduates to meet the needs of the AAPI populations. Thus, disaggregation of data on present and future AAPI health and human services providers is a must.

Long term activities

With the collected data, HHS can institute training programs that can recruit specific underrepresented AAPI national origin/ethnic populations in wide ranging training programs from research to health care delivery.

GOAL 4: Increase outreach to and participation of AAPIs in HHS or HHS sponsored training programs.

Objective 4.1. Expand participation of underrepresented AAPI subpopulations in HHS training programs.

NIH: expand financial assistance and loan repayment/forgiveness programs for underrepresented Asian Americans and Pacific Islanders pursuing research careers, with a priority on those working with Asian American and Pacific Islander populations (APIAHF Conference, 1990)

NIH: designate Asian American and Pacific Islander primary care facilities for participation in loan repayment/forgiveness programs (APIAHF Conference, 1990)

HRSA: establish and maintain mentoring programs for Asian American and Pacific Islander health service providers (AAPI Summit, 1995)

NIH: establish and sustain a regional Research Center of Excellence for the Pacific Islands (PIAA NIH Conference, 1996)

NIH and CDC: provide funds for enhancing telecommunications and supporting opportunities for distance learning in the Pacific Islands (PIAA NIH Conference, 1996)

NIH: expand educational programs in underrepresented Asian American and Pacific Islander communities at the elementary through high school levels to develop interest in research careers (PIAA NIH Conference, 1996)

Objective 4.2. Develop specific outreach strategies for AAPIs for training programs in health professions and research areas where AAPIs are underrepresented.

NIH, HRSA, AHCPR and CDC: develop and implement specific outreach, recruitment, technical assistance and retention strategies for increasing the number of Asian Americans and Pacific Islanders in health professions education, training and placement programs (PIAA NIH Conference, 1996; AAPI Summit, 1995; APIAHF Voices Conference, 1997; APIAHF Conference, 1990; APIAHF Conference, 1988; National API HIV/AIDS Recommendations, 1996)

NIH: develop and implement a specific training program to increase the number of Asian American and Pacific Islander principal investigators funded through RO-1 grants, including bridging/partnership programs for Asian American and Pacific Islander junior researchers (PIAA NIH Conference, 1996; API HIV Technology Transfer Summit, 1997)

NIH and AHCPR: develop and implement training curricula that incorporate methodologies that are culturally competent for Asian American and Pacific Islander communities (PIAA NIH Conference, 1996)

AHCPR: sponsor a conference focusing on AHCPR's role in research and training to improve health outcomes for Asian Americans and Pacific Islanders (AAPI Summit, 1995)

V. WORKFORCE AND PARTICIPATION IN HHS OPERATIONS

Similar to the issue of training, there is no system in place within HHS to determine the national origin/ethnic make-up of the AAPIs in the department. Without being able to distinguish the national origin/ethnic populations, there will continue to be an underrepresentation of AAPI employees from some of the AAPI customer populations.

Short term activities

One key step is to develop a disaggregated data collection on AAPI staff in HHS.

Long term activities

Similar long term activities are continuing to monitor the composition of HHS's AAPI work force and developing programs to conduct, outreach, recruit and promote AAPI staff.

GOAL 5: Ensure that issues affecting underserved AAPI populations are addressed through representation in the HHS workforce and participation in HHS operations.

Objective 5.1. Increase the representation of AAPI employees on advisory boards, strategic planning committees, and task forces.

All OpDivs and StaffDivs: identify existing Asian American, Pacific Islander and Native Hawaiian employees within each division (AAPI Summit, 1995)

All OpDivs and StaffDivs: identify representation and participation of Asian American, Pacific Islander and Native Hawaiian employees on existing advisory boards, strategic planning committees, and task forces within each division

Objective 5.2. Partner with AAPI national and local research and policy organizations to identify external AAPI community representatives to participate in HHS grant programs and other internal/external activities.

Objective 5.3. Provide technical assistance to AAPI community organizations on HHS programs and activities, to increase both these organizations' knowledge base and capacity to participate, and HHS program staff awareness of AAPI health and human service issues.

Objective 5.4. Develop strategies for increasing recruitment of senior level AAPIs to SES and other line positions in HHS agencies.

Secretary's Office: identify Asian Americans, Pacific Islanders and Native Hawaiians in senior level positions; develop and implement a specific recruitment and promotion

strategy to increase the number of Asian Americans, Pacific Islanders and Native Hawaiians in senior level positions (AAPI Summit, 1995; APIAHF Conference, 1990)

VI. CROSS CUTTING COLLABORATION TO ENHANCE HHS CUSTOMER SERVICE TO AAPIs

Given that there will not be a specific appropriation for the AAPI Initiative, it is important for the AAPI Initiative to be incorporated into existing HHS Initiatives to meet the needs of AAPI populations. The members of the AAPI Initiative's Departmental Working Group should participate actively in shaping and implementing other initiatives. In turn, other Initiatives should seek the input of the AAPI DWG.

Short term activities

As a starting point, we recommend that the AAPI DWG obtain plans from the other HHS Initiative on how they will involve or outreach to AAPI populations. The priority initiatives should include: Health Care Quality, Children's Health Care, Healthy Start, Immunization, Women's Health, Domestic Violence, and Operation Restore Trust.

Long term activities

Any new or on-going HHS Initiative should have specific workplan and timeline for implementation in AAPI and other minority communities.

GOAL 6: Enhance HHS capacity to serve Asian Americans and Pacific Islanders.

Objective 6.1. Improve collaboration within the Department to increase coordinated approaches to meeting AAPI customer needs.

All OpDivs: promote the participation of Asian American and Pacific Islander consumers in all Department activities and programs (APIAHF Voices Conference, 1997)

All OpDivs: ensure that all public information campaigns and consumer outreach programs include written materials translated into primary Asian American and Pacific Islander languages (National API HIV/AIDS Recommendations, 1996)

All OpDivs: identify and utilize community and language media appropriate for media outreach to Asian American and Pacific Islander communities in all public information campaigns and consumer outreach programs

OMH, ASPE, CDC, NIH, HRSA, SAMHSA and AHCPR: ensure that all Department clearinghouses and resource centers specifically identify, collect, compile and disseminate information and resources on Asian Americans and Pacific Islanders and specifically identify, collect, compile and disseminate information and resources

available in Asian and Pacific Islander primary languages; such information and resources should be evaluated for quality and updated at least annually (AAPI Summit, 1995)

OMH and ASPE: promote greater collaboration among all racial/ethnic minority communities to develop a common minority health advocacy agenda (AAPI Summit, 1995; APIAHF Conference, 1988)

Objective 6.2. Ensure that HHS programs and initiatives meet the needs of AAPIs by strengthening partnerships with AAPI community organizations.

OMH, CDC, NIH, HRSA, SAMHSA and AHCPR: partner with Asian American and Pacific Islander community organizations to utilize existing or establish new community information and referral resources (e.g. informational hotlines) to disseminate health education and health promotion materials (AAPI Summit, 1995; National API HIV/AIDS Recommendations, 1996)

Minority Groups want the following principles to be included in any Comprehensive Tobacco Control Legislation

African Americans, Hispanic/Latinos, Asians and Pacific Islanders, and Native Americans represent 25% of the nation's population, a percentage that is rapidly increasing. In several states, the minority youth population comprises over half of the population. Minorities have been targeted disproportionately by the tobacco industry. As a result, minority smoking rates, especially minority youth rates are increasing at an alarming rate. Tax increases on tobacco products will be regressive for low-income and minority populations if effective, sustainable, culturally sensitive and language appropriate research, education, prevention and cessation programs are not fully funded and implemented. Comprehensive tobacco control legislation must address the needs of minorities and include specific language so that fair, equitable and adequate funding is assured. We therefore recommend:

1. Long term, sustainable, prevention and education public health programs should have national, state and local components. The programs should be comprehensive, multi-media, culturally sensitive and language appropriate in order to be effective for each of the minority and/ethnic subgroups to be impacted.
2. Cessation programs should be culturally sensitive, language appropriate and accessible locally and affordable for low-income persons as well as fully covered for those on Medicaid and/or Medicare. Medical and health delivery personnel should be trained and involved in these programs.
3. Comprehensive second hand smoke (ETS) campaigns and regulations should emphasize protection of families and individuals in their workplaces.
4. Minority community based organizations and/or those with a minority focus should be integral to the delivery of prevention, education and cessation programs.
5. Counter-advertising campaigns should be intensive, long term, sustainable and should have national as well as local programming to assure their effectiveness.
    - Must use multi-media: television, radio, print and electronic media
    - Must use ethnic language media outlets and services
    - Must be culturally and linguistically appropriate and
    - Must be based on extensive culturally appropriate research.
6. Minority institutions and organizations who serve primarily minorities should have adequate resources to conduct tobacco-related research in partnership with community based organizations.
7. HHS and related agencies must collect and analyze data on minorities and ethnic sub-groups with respect to patterns, preferences and use of all tobacco products.
8. Any tobacco related decision making body, advisory committee or entity at the federal, state or local level should have proportional representation from all minority groups.
9. Look back provisions must ensure smoking reductions among minority youth, must be tough and penalties should be non-tax deductible.
10. Transitional funds should be provided for minority organizations who receive tobacco sponsorship for civic, educational, cultural and athletic events and minority own

newspapers, magazines and companies dependent on tobacco advertising should also be eligible to receive funds.

11. Economic development assistance and training should be provided for minority communities impacted negatively by tobacco control legislation and regulation.
12. Legislation and/or any agreement related to the distribution of funds among the states should guarantee that Puerto Rico, Pacific Island Jurisdictions, other territories and Indian nations should receive fair and equitable treatment.
13. Federal funds generated from tobacco control legislation and federal funds to be returned to the states should be equitably distributed for minority public health programs in accordance with the minority smoking prevalence rate in each state.
14. Tobacco prices should be increased to at least $ 1.50 per cigarette pack to save lives and deter youth smoking. The funds should be used primarily for public health programs that can curb tobacco use and mitigate its regressive impact in minority and disadvantaged communities.
15. FDA should have full and unencumbered authority over tobacco products.
16. No marketing to children and youth should be allowed.
17. Broad disclosure of industry documents should be achieved.
18. State and local governments should not be preempted from establishing or retaining requirements equal to, or more stringent than, any federal tobacco control measure.
19. International tobacco control efforts should be adequately funded, US standards and regulations should prevail and no government agency should promote tobacco products abroad.

February 23, 1998

American Public Health Association
Association of Asian Pacific Community Health Organizations
American Association of Physicians of Indian Origin
Asian and Pacific Islander Health Forum

Hispanic Health and Education Working Group and Advocates

- American Psychiatric Association
- ASPIRA Association, Inc.
- Center for Health Policy Development, Inc.
- Hispanic Dental Association
- Hispanic Radio Network
- Institute for Puerto Rican Policy, Inc.
- InterAmerican College of Physicians and Surgeons
- Latino Council on Alcohol and Tobacco
- League of United Latin American Citizens (LULAC)
- Midwest Latino Health Research, Training and Policy Center for Medical Treatment and Effectiveness Program, University of Illinois
- National Council of La Raza (NCLR)
- National Hispanic Leadership Initiative on Cancer: *En Accion*
- National Hispanic Medical Association

Resources for Cross Cultural Health Care
Society for the Advancement of Chicanos and Native Americans in Science (SACNAS)
The Greenlining Institute

The Onyx Group

Summit Health Coalition
American Cancer Society
Association of Black Cardiologists, Inc.
Black Caucus of Health Workers
City of Opa-locka, Florida
Meharry Medical College
Morehouse School of Medicine
National Association for the Advancement of Colored People
National Association of Black County Officials
National Association of Black Social Workers, Inc.
National Association of Community Based Care
National Association of Health Services Executives
National Black Caucus of State Legislators
National Black Leadership Commission on AIDS
National Black Nurses Association
National Caucus and Center on Black Aged, Inc.
National Conference of Black Mayors, Inc.
National Dental Association
National Education Association
National Medical Association
National Medical Association, San Diego
National Pharmaceutical Association
National Urban League, Inc.
Tennessee Managed Care Network
The Congress of National Black Churches, Inc.
United Church Board for Homeland Ministries
Vermont Avenue Baptist Church

The organizations listed have adopted or endorsed their own consensus statements and/or individual documents contained in this package. They have not specifically signed on to this summary.

CCHI

MARCH 1996

Policy Brief

POLICY IMPROVING HEALTH

California's Anti-Tobacco Strategy

HERE AND NOW: TOBACCO POLICY IN 1996

Eight years ago, California launched what has grown into one of the most comprehensive and effective anti-tobacco programs in the nation. Beginning with the voters' enactment of Proposition 99 in 1988, and expanded through a variety of legislative and executive actions since then, California's multi-faceted strategy has become a national model for states seeking to reduce tobacco use and its associated illness, disability and productivity costs.

National reviews conducted by organizations including the U.S. Centers for Disease Control and Prevention (CDC) and the Coalition on Smoking OR Health recently ranked California's program as among the most effective of any state efforts aimed at reducing tobacco use[1]. The available data — discussed in detail later in this brief — strongly support the conclusion that the state's anti-tobacco policies have improved the health of Californians. And public surveys have shown that Californians' support for aggressive policies aimed at reducing tobacco consumption — including potential new tobacco tax increases of 25 cents or more — is strong and consistent[2].

Today, however, California's anti-tobacco strategy stands at a crossroads. Even as evidence pours in that state policies have made a major contribution to the health of California's adult population, teen smoking rates have jumped higher, past debates have been marked by significant differences over funding issues within the coalition of health advocates and health care providers supporting the overall strategy, and the tobacco industry remains fiercely opposed to existing policy, let alone any enhancement of it.

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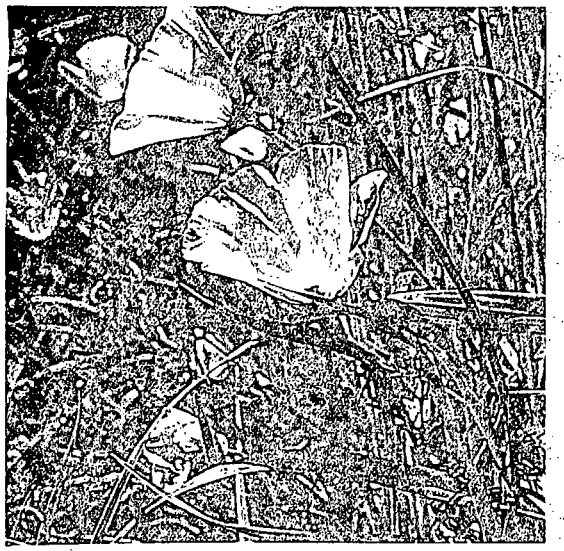

CCHI

MAY 1997

Policy Brief

POLICY IMPROVING HEALTH

Tobacco-Free Policies: An Update

HERE AND NOW: TOBACCO POLICY IN 1997

This is a critical and historic time in tobacco policy. Everyday newspapers and television news reports alert the public and policy-makers to a continuous stream of legal and legislative actions designed to limit tobacco use in California and across America. Because of the current breadth, volume, and complexity of approaches to control of tobacco, it is often difficult to keep abreast of tobacco control activity. Yet, the convergence of these activities and their cumulative impact contribute significantly to the growing momentum of the tobacco-free movement. This movement is important to the health of Californians and all Americans, as tobacco use is the leading cause of preventable premature death.

This policy brief was developed to:

- Summarize new legal, legislative and regulatory developments in tobacco control. It updates the California Center for Health Improvement's (CCHI) 1996 Policy Brief entitled "California's Anti-Tobacco Strategy" and is intended to provide a *point in time* overview of ongoing anti-tobacco activities.
- Describe progress and existing barriers to California's anti-tobacco strategy, which is a proven success.
- Highlight the interrelationship between national and state tobacco control efforts.
- Demonstrate the effectiveness of the expanded use of the media and focus on public policy change as interventions to improve health.
- Identify unresolved tobacco-related issues in which organizations, citizens and policy-makers can get involved to improve the health of all Americans.

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The demographics of help-seeking for smoking cessation in California and the role of the California Smokers' Helpline

Shu-Hong Zhu, Bradley Rosbrook, Christopher Anderson, Elizabeth Gilpin, Georgia Sadler, John P Pierce

Abstract

Objective **– To investigate and compare the demographics of California smokers seeking assistance to quit and those of smokers who called the California Smokers' Helpline, a large scale statewide smoking cessation service.**

Data sources **– The 1990, 1992, and 1993 California Tobacco Surveys, and screening interviews conducted with callers to the California Smokers' Helpline in its first 30 months of operation.**

Design **– For the California Tobacco Surveys, random digit dialled surveys of 24296 California adults in 1990, 8224 in 1992, and 30716 in 1993 were conducted, which included measures of smokers' attitudes toward their smoking and of their help-seeking behaviour for smoking cessation. In the California Smokers' Helpline, 23346 adult callers from August 1992 to January 1995 were surveyed. Demographic information was obtained on all surveys.**

Main outcome measure **– Seeking assistance to quit smoking.**

Results **– In the general smoking population, males were less likely to seek help in quitting smoking than females. The youngest group of adult smokers (18–24 years) was least likely to seek help. Hispanic, black and Asian smokers in California were only 40% as likely as white smokers to seek assistance. However, an ethnic breakdown of callers to the California Smokers' Helpline shows that Hispanics were as well represented in that programme as in the smoking population of the state. Blacks were actually overrepresented by a factor of 2. The Helpline also attracted younger smokers than those who sought assistance in general. Smokers from rural counties were as likely to call the Helpline as those from urban counties. The former were usually referred by health care providers, whereas the latter most often heard about the Helpline through the mass media.**

Conclusions **– The California Smokers' Helpline reached an ethnically and geographically representative sample of smokers. It appears suitable as a model for future programmes providing accessible smoking cessation service on a large scale.**

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Keywords: smoking cessation; self-help; California Smokers' Helpline; demographics

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Introduction

Studies have consistently shown that smokers who achieve long term cessation significantly reduce their risk of disability or early death and lower the health care costs to the community.[1] However, stopping smoking is an arduous process characterised by high recidivism.[2–4] With some assistance, smokers can improve their chance of success.[5,6] Therefore, a strong rationale exists for public funding of interventions that help smokers quit.[7]

Such public funding became available in California in 1989 with the passage of a voter sponsored initiative which increased the tobacco excise tax by 25 cents per pack. A portion of the revenues is channelled through the California Tobacco Control Program to fund a health education campaign to reduce the prevalence of cigarette smoking in the state.[8] Besides discouraging non-smokers from picking up smoking, the campaign encourages those who are already addicted to stop. Toward this end, the campaign funds a variety of smoking cessation programmes in diverse settings.[9]

Recognising that the majority of smokers who want to quit do not seek assistance to do so,[10,11] the Tobacco Control Program has taken creative approaches in making help more accessible. One such approach was the California Smokers' Helpline, which has been promoted within the on-going statewide antismoking media campaign. A principle guiding the design of the helpline was to make it as accessible as possible. This can be seen in three ways. First, the helpline does not charge the user for any of its services. Second, the helpline provides information through the mail and counselling over the telephone, eliminating the scheduling and transportation difficulties associated with traditional smoking cessation clinics. Third, access can be gained to the helpline not only in English but also in Spanish, Chinese, Vietnamese, and Korean, thus encouraging segments of the population

who might not use an English-only programme to seek help.

Patterned after an earlier randomised trial in San Diego County which showed the efficacy of telephone counselling for smoking cessation,[12] the California Smokers' Helpline was established in August 1992 to provide the following services statewide. (1) Callers who are ready to quit smoking receive individual telephone counselling. (2) Those who prefer to quit by themselves receive self-help kits. (3) Those who are merely contemplating quitting receive motivational materials. (4) All callers receive a list of other cessation programmes available in their county of residence. All of these services can be accessed with a single 1–800 number for each of the five languages mentioned above.

In this paper, we analyse the demographic characteristics of smokers who called the helpline during its first 30 months in operation and compare them with those of California smokers in general who sought assistance to quit smoking, as one way of evaluating the helpline's success in making cessation services more accessible. Of particular concern was the low utilisation of cessation assistance by ethnic minority smokers, which national population studies have highlighted.[10,13] As background information useful for determining public health needs, survey data concerning California smokers' attitudes about smoking and quitting smoking are also presented.

Methods

DATA SOURCES

California Tobacco Surveys (CTS)

These surveys were conducted in 1990, 1992, and 1993 and were all statewide random digit dialled surveys designed to assess smoking prevalence and gain information regarding a wide range of smoking behavior and attitudes. Detailed descriptions of the surveys, their designs, analytical methods and results are presented elsewhere.[14–18] Household response rates ranged from 70% to 75%. All surveys made use of a screener interview to enumerate household members. The 1990 and 1992 surveys interviewed all smokers and former smokers who quit smoking within the last five years as well as a randomly selected 28% of non-smokers. Response rates for the extended interview were 75% in 1990 and 71% in 1992. The 1993 survey interviewed the person providing the screening information for a response rate of over 99%. The numbers of persons interviewed in depth were 24296 in 1990, 8224 in 1992, and 30716 in 1993.

From the 1990 and 1992 CTS, we used data on the attitudes of current smokers toward smoking and smoking cessation. From the 1993 CTS, we used data on the help-seeking behaviour of current and former smokers. In this survey, subjects were asked whether they had been smoking a year before the interview. All those who said yes were asked for the dates and duration of any attempts to quit smoking lasting at least a day which they made during the year; concerning their most recent attempt, they were asked "Did you use counselling advice or self-help materials to adjust to life without cigarettes?", and "Did you use a prescribed medication or a nicotine patch to help you in your most recent quit attempt?" We classified all who gave an affirmative answer to either of these questions as having sought assistance to quit smoking during their most recent 24 hour attempt. Given the phrasing of the first question, it is not possible to distinguish between "counselling advice" and "self-help materials." Our definition of assistance, then, is necessarily broad. Current smokers were also asked how many cigarettes they smoked each day on average.

California Smokers' Helpline

The California Smokers' Helpline is operated by the Cancer Center of the University of California, San Diego. Since August 1992, the programme has provided services in English and Spanish. In March 1994, the helpline expanded to provide the same services in Chinese (both Mandarin and Cantonese dialects), Vietnamese, and Korean. Before that time, Asian language services were provided by a separate agency whose data are not included in this analysis. The results presented in this paper were derived from data from the helpline's first 30 months of operation, August 1992 to January 1995.

The helpline has been promoted in many different ways. Foremost is the method of appending the helpline's toll-free numbers to selected advertisements in the ongoing statewide media campaign, including television, radio, billboard, and newspaper ads. The helpline is also promoted through local health departments and various tobacco control projects funded by the Tobacco Control Section of the California Department of Health Services. The promotional activities have been so various that it is not possible to describe them all here. One particular time related effort by Los Angeles County, however, figures prominently among all the promotional activities in the state. That county, by far the most populous in California, has its own tobacco control media campaign budget. For the first six months of 1993 it conducted a media campaign specifically for the helpline. An analysis of the data both including and excluding this period follows, in order to suggest how such a large urban campaign may have affected the demographics of the statewide programme.

Every caller to the helpline first receives a six minute screening interview assessing smoking history, dependence, self efficacy, and readiness to quit, in order to determine what service would be most suitable. Demographic information is gathered at that time as well, including gender, age, education, ethnicity, and county of residence. How the caller heard about the helpline is also ascertained. From August 1992 to January 1995, the helpline obtained such information on 23346 callers who were at least 18 years old.

The 58 counties of California are grouped

into four categories, the first three of which are rural, mixed, and urban. With nearly a third of the state's population and an enormous share of state funding for tobacco control, the county of Los Angeles occupies a class by itself. We use the classification developed by the California Senate Committee on Local Government.[19]

STATISTICS

Respondents to the CTS surveys were given base weights reflecting their probability of being selected for an interview. These weights were further adjusted using census data to reflect the population of the state. With these weights, population estimates were made which were then used to establish the percentage of California smokers who belonged to various groups by age, gender, education, ethnicity, and geographical location.

The 95% confidence intervals for all percentages calculated from the CTS data were derived using variance estimates obtained with a Jackknife procedure[20]; χ^2 and design corrected t tests were performed using a procedure that was based on the Jackknife method.[21] Logistic regression was used to identify the independent demographic predictors of assistance seeking; we report adjusted risk ratios and 95% confidence intervals, again derived with a Jackknife procedure.

Table 1 Smokers' attitudes regarding smoking and smoking cessation

	1990 CTS % (95% CI)	*1992 CTS % (95% CI)*
n	9904	4681
I believe I am addicted to cigarettes		
agree	77.6 (1.4)	80.3 (3.0)
disagree	20.7 (1.5)	18.7 (2.8)
no opinion	1.6 (0.3)	0.9 (0.5)
My smoking is harming my health		
agree	84.4 (1.5)	85.9 (2.0)
disagree	12.4 (1.2)	11.8 (1.9)
no opinion	3.2 (0.7)	2.4 (0.5)
Helping smokers to quit is important		
agree	85.9 (1.1)	
disagree	9.7 (0.7)	
no opinion	4.4 (0.8)	

From the 1990 and 1992 California Tobacco Surveys. The last item was not included in the 1992 CTS.

Results

ATTITUDES REGARDING SMOKING AND SMOKING CESSATION

Table 1 presents results from the 1990 and 1992 California Tobacco Surveys regarding smokers' attitudes about their smoking. In both surveys, about 85% of smokers agreed that smoking was harming their health. More than three quarters of the smokers said they were addicted to cigarettes. In the 1990 survey, 86% of smokers agreed that "helping smokers to quit is important."

WHO SEEKS ASSISTANCE TO QUIT SMOKING?

In the 1993 California Tobacco Survey, 51.0% of the respondents who were smoking a year before the survey reported that they had made at least one quit attempt during the previous year. However, only 18.7% of those who did so sought any assistance to help them with their most recent attempt. This included 8.5% who only used nicotine replacement, 6.4% who only used counselling or self-help materials and 3.8% who used both nicotine replacement and counselling or self-help.

Table 2 presents results from the 1993 CTS regarding help-seeking behaviour. In the first column, the percentages of current and former smokers who sought assistance with their most recent attempt to quit are broken down according to gender, age, education, ethnicity, and type of county. In the second column, odds ratios based on these percentages show the relative likelihood of help-seeking for the demographic subgroups. In the third column, odds ratios adjusted for the number of cigarettes smoked per day are given, since a preliminary analysis showed that consumption was positively correlated with help-seeking. The odds ratios in the third column were based solely on current smokers at the time of the

Table 2 Demographics of help-seeking for smoking cessation in California

		Sought assistance % (95% CI)	*OR (95% CI)*	*OR (95% CI) adjusted for consumption*
n		3425	3425	2312
Gender	Male	15.2 (2.3)	1.0	1.0
	Female	23.4 (2.7)	1.54 (1.18, 2.01)	2.14 (1.54, 2.95)
Age (years)	18–24	8.2 (3.5)	1.0	1.0
	25–44	18.1 (2.5)	2.36 (1.58, 2.01)	2.37 (1.42, 3.97)
	45–64	28.9 (4.3)	4.04 (2.58, 6.32)	3.53 (2.11, 5.88)
	65+	23.7 (6.1)	3.00 (1.72, 5.22)	2.71 (1.35, 5.44)
Education (years)	< 12	13.2 (4.0)	1.0	1.0
	12	18.5 (2.4)	1.12 (0.71, 1.76)	1.14 (0.68, 1.92)
	13–15	21.3 (3.4)	1.27 (0.79, 2.02)	1.39 (0.86, 2.26)
	16+	23.9 (4.6)	1.45 (0.87, 2.41)	1.68 (0.92, 3.08)
Ethnicity	White	23.3 (2.2)	1.0	1.0
	Hispanic	8.4 (3.2)	0.38 (0.24, 0.58)	0.55 (0.34, 0.89)
	Black	9.9 (6.9)	0.36 (0.21, 0.63)	0.48 (0.24, 0.95)
	Asian	9.7 (7.2)	0.39 (0.21, 0.70)	0.58 (0.24, 1.45)
	Others	36.2 (19.8)	1.93 (0.68, 5.44)	2.05 (0.67, 6.27)
Type of county	Rural	26.8 (6.0)	1.0	1.0
	Mixed	22.1 (4.2)	0.87 (0.57, 1.34)	0.94 (0.57, 1.54)
	Urban	18.1 (2.1)	0.73 (0.51, 1.03)	0.67 (0.42, 1.09)
	Los Angeles	15.9 (4.0)	0.82 (0.51, 1.32)	0.84 (0.46, 1.54)

From the 1993 California Tobacco Survey. Column 2 ORs are for former and current smokers. Column 3 ORs are for current smokers only and are adjusted for cigarette consumption: relative to under 15 cigarettes a day, the ORs are 2.18 for 15–24 cigarettes and 3.28 for 25+ cigarettes.

survey, since the previous dependence level of former smokers was not ascertained.

The odds ratios in the second column show that female smokers were 54% more likely than male smokers to have sought assistance with their most recent attempt to quit. Moreover, the odds ratios in the third column show that, after adjusting for their lower average consumption, female smokers were more than twice as likely to have sought assistance.

Smokers at least 25 years old were more likely to have sought help than younger adult smokers. Even after adjusting for their lower consumption, younger adult smokers were less than half as likely to have sought help than older smokers.

Education seemed to be positively correlated with help-seeking, but the overlapping of confidence intervals for the odds ratios in both columns shows that this result was not statistically significant.

Smokers of ethnic minority backgrounds were less likely to have sought assistance than white smokers. The odds ratios in the second column show that Hispanic, black, and Asian smokers were less than 40% as likely as white smokers to have sought help. Even after adjusting for their lower level of cigarette consumption, Hispanic smokers were 55% as likely as whites to have sought assistance, and black smokers were only 48% as likely. The adjusted odds ratios for Asian smokers appeared similarly low, but did not reach statistical significance due to the small sample size of the group.

Smokers in rural counties appeared more likely to have sought assistance than smokers in more urban counties. The differences were not statistically significant, however, as indicated by the overlapping confidence intervals for the odds ratios in the second and third columns.

Table 3 Percentages of smokers in California, smokers who sought assistance in California and smokers who called the California Smokers' Helpline, by gender, age and education

		Smokers in California (%)	*Sought assistance* % (95% CI)	*Called the helpline* % (95% CI)
n		4078306	3425	23346
Gender	Male	56.5	46.9 (6.0)	48.1 (0.6)
	Female	43.5	53.1 (6.0)	51.9 (0.6)
Age (years)	18–24	14.2	8.5 (4.0)	13.8 (0.4)
	25–44	52.0	52.4 (5.3)	62.0 (0.6)
	45–64	25.6	31.1 (4.8)	21.1 (0.5)
	65+	8.3	8.0 (2.4)	3.1 (0.2)
Education (years)	< 12	25.8	16.6 (4.7)	15.9 (0.5)
	12	40.1	37.8 (4.8)	27.9 (0.6)
	13–15	21.9	28.1 (4.2)	37.2 (0.6)
	16+	12.2	17.5 (3.0)	19.0 (0.5)

From the 1993 California Tobacco Survey and the California Smokers' Helpline. Percentages for the state of California are estimated from the smoking prevalence rates at the time of the 1993 CTS.

Table 4 Percentages of smokers in California, smokers who sought assistance in California and smokers who called the California Smokers' Helpline, by ethnicity

	Smokers in California (%)	*Sought assistance* % (95% CI)	*Called the helpline, 8/92–1/95* % (95% CI)	*Called the helpline, excluding 1/93–6/93* % (95% CI)
n	4078306	3425	23346	13129
White	67.4	78.9 (4.9)	60.9 (0.6)	65.9 (0.8)
Hispanic	18.5	9.4 (3.4)	18.0 (0.5)	14.0 (0.6)
Black	7.0	4.3 (3.0)	14.2 (0.5)	12.8 (0.6)
Asian	5.0	2.6 (1.9)	2.5 (0.2)	2.5 (0.3)
Others	2.0	4.8 (3.5)	4.4 (0.3)	4.8 (0.4)

From the 1993 California Tobacco Survey and the California Smokers' Helpline. Percentages for the state of California are estimated from the smoking prevalence rates at the time of the 1993 CTS.

CALLERS TO THE CALIFORNIA SMOKERS' HELPLINE

The California Smokers' Helpline interviewed 23849 smokers from across California from 1 August 1992 to 31 January 1995, 23346 of whom were at least 18 years old. For the sake of comparability with the California Tobacco Surveys, which only interviewed adults, the 503 callers under 18 were excluded from this analysis.

Table 3 allows a comparison by gender, age, and education of California smokers who sought assistance to quit and those who called the helpline. The first column gives an estimated demographic breakdown of the entire adult smoking population in California, based on the smoking prevalence rates for the demographic groups obtained in the 1993 CTS. The second column shows the percentages for California smokers who sought assistance with their most recent quit attempt. The third column gives the same breakdown for smokers who called the helpline.

The table shows that the gender distribution of helpline callers was similar to that of the general population who sought help in California. The helpline participants tended to be younger, however, with higher proportions in the 18–24 and 25–44 year age groups than those in the general help-seeking population. The mean age for helpline callers was 37.1 (SD 12.0) years while the mean age for those who sought help in general was 39.4 (14.5) years ($p < 0.001$). Helpline callers were more likely to have had some college education than those in the general population who sought help to quit smoking.

ETHNIC COMPOSITION OF HELPLINE CALLERS

Table 4 continues the demographic comparison between those who sought help to quit smoking in general and those who called the California Smokers' Helpline. It presents an ethnic breakdown of both of these populations and of the state's entire smoking population. The first column gives the percentage of smokers who belonged to each ethnic group in California according to the 1993 CTS. The second column focuses on those who at the time of the 1993 CTS had sought assistance to quit smoking. The third column focuses on callers to the helpline.

The first two columns of table 4 show that minorities were underrepresented among smokers who sought assistance to quit. Hispanics accounted for 18.5% of the smokers in California, but only 9.4% of those who sought assistance. For blacks and Asians, the percentages were 7.0% and 5.0% of smokers versus 4.3% and 2.6% of those who sought assistance, respectively.

Comparison of the first and third columns shows that the California Smokers' Helpline

Table 5 Percentages of smokers in California, smokers who sought assistance in California and smokers who called the California Smokers' Helpline, by type of county

	Smokers in California (%)	Sought assistance % (95% CI)	Called the helpline, 8/92–1/95 % (95% CI)	Called the helpline, excluding 1/93–6/93 % (95% CI)
n	4078306	3425	23346	13129
Rural	7.2	10.3 (2.5)	10.7 (0.4)	14.1 (0.6)
Mixed	17.5	20.6 (4.5)	13.5 (0.4)	19.8 (0.7)
Urban	45.3	43.8 (4.7)	30.4 (0.6)	41.5 (0.8)
Los Angeles	29.7	25 3 (5.3)	45.4 (0.6)	24.4 (0.7)

From the 1993 California Tobacco Survey and the California Smokers' Helpline. Percentages for the state of California are estimated from the smoking prevalence rates at the time of the 1993 CTS.

Table 6 How callers to the California Smokers' Helpline heard about the program, by type of county

	Rural (%)	Mixed (%)	Urban (%)	Los Angeles (%)
n	2488	3138	7070	10550
Mass media	14.9	34.7	59.1	84.6
Healthcare provider	52.8	40.2	16.9	2.2
Family/friend	14.5	12.3	10.4	7.3
Other	17.4	12.3	12.8	5.5
Don't remember	0.4	0.5	0.8	0.5

From the California Smokers' Helpline.

achieved a better representation of minorities. The percentage of Hispanics among helpline callers, 18.0%, approached that of Hispanics among the smoking population, 18.5%. The representation of black smokers was more than twice as high among helpline callers as in the smoking population, 14.2% versus 7.0%. Asians were still underrepresented.

The percentages of Hispanic, black, and Asian smokers combined were 30.5% among the general smoking population but only 16.3% among those who sought assistance. Among Helpline callers the percentage was 34.7%.

Los Angeles County waged a large media campaign for the helpline from January to June 1993. To examine whether this campaign was responsible for the high rate of participation by minority smokers, the ethnic breakdown of helpline callers excluding the data from this period is given in the fourth column of table 4. Without the data from these six months, the representation of Hispanic and black smokers dropped somewhat. However, the overall representation of ethnic minority smokers still reached 29.7%, nearly the same as among California smokers.

GEOGRAPHIC DISTRIBUTION OF HELPLINE CALLERS

Table 5 continues the comparison between California smokers who sought help to quit and those who called the helpline, with regard to the urbanisation of their county of residence. The first column shows the percentage of California smokers in each type of county. The second column gives the percentages for those who sought help in general. The third and fourth columns give the percentages for callers to the helpline. As in table 4, the fourth column of table 5 excludes data from January to June 1993, when Los Angeles County ran a large promotional campaign for the helpline.

Comparison of the first two columns in table 5 shows that smokers in rural and mixed counties were somewhat better represented among those who sought assistance than smokers in urban counties and Los Angeles.

Comparison of the first and third columns shows that Los Angeles County accounted for a proportion of helpline callers that was much higher than its proportion of the state's smokers (45.4% versus 29.7%). The proportion of rural smokers, however, remained high (10.7% versus 7.2%). When the data taken during the Los Angeles County campaign were excluded, as shown in column 4, the share of Los Angeles dropped to 24.4%, while that of rural counties increased to 14.1%.

HOW CALLERS HEARD ABOUT THE CALIFORNIA SMOKERS' HELPLINE

Table 6 shows how callers from each of the four types of counties heard about the Smokers' Helpline. The sources are divided into four main categories: the mass media (TV, radio, billboards, and newspapers), health care providers, friends and family, and "other," which includes county health departments and non-profit or community organisations.

Comparison of the columns in table 6 shows that callers from Los Angeles and other urban counties heard about the helpline mostly through the mass media, while callers from mixed or rural counties were more likely to have heard about it from health care providers or from family and friends. The proportion of callers who heard about the helpline through the mass media ranged from a high of 84.6% in Los Angeles to a low of 14.9% in the rural counties. Conversely, the proportion of callers referred by their health care providers ranged from a low of 2.2% in Los Angeles to a high of 52.8% in the rural counties. Referral by family or friends showed the same trend, from 7.3% in Los Angeles to 14.5% in the rural counties.

Discussion

The 1990 and 1992 CTS showed that most smokers were worried about the effect of smoking on their health and many were indeed trying to quit. At the same time, a majority of them believed they were addicted to cigarettes. Thus it is not surprising that 86% of them thought it was important to help smokers quit.

However, the 1993 survey showed that only 18.7% of those who tried to quit smoking sought assistance. Furthermore, the demographic differences in help-seeking were notable. Male smokers were significantly less likely to seek help than female smokers. Younger smokers were less likely than older smokers. Less educated smokers also appeared less likely than more educated smokers.

Especially significant was the fact that ethnic minority smokers were less than 40% as likely to seek help as white smokers. The disparity remained even after adjusting for the lower consumption of cigarettes by minority

smokers. Correcting for the level of consumption, minority smokers were still less than 60% as likely to seek help as white smokers.

The California Smokers' Helpline was intended to help address this disparity. Funded by the Tobacco Control Section of the California Department of Health Services, the helpline was designed to make help for smokers as accessible as possible. In operation since August 1992, all of its services are offered free of charge and are accessed by telephone. Help is available in five languages, each with its own toll-free number. Services are provided which suit the caller's readiness to quit, including motivational literature, self-help quit kits, individual telephone counselling, and referral to local cessation programmes. Also, for those who receive counselling and wish to receive nicotine patches through Medi-Cal or other insurers, the helpline provides proof of enrollment. All a smoker has to do to gain access to these services is to call.[22]

Given the ethnic disparities in help-seeking among the state's smoking population, it is encouraging that during its first 30 months in operation, the helpline saw active participation by minority smokers. Ethnic minorities overall were as well represented among helpline callers as among the state's smokers. This was true even after excluding data gathered during a six month period when Los Angeles County, which has a high proportion of ethnic minority smokers, mounted an aggressive media campaign for the Helpline. In fact, including the data from this period actually caused minority smokers to be overrepresented among helpline callers. The large sample of smokers calling from different geographic areas gives confidence that the active participation of minority smokers was not accidental.

Offering a choice of languages certainly contributed to the helpline's success in recruiting minority smokers. Three quarters of the Hispanic callers used the Spanish line. The late addition of Asian-language services to the helpline (19 months into the 30 month period being considered) partly explains the low participation of this group. During the time before it was incorporated into the California Smokers' Helpline, the Asian helpline served over 1700 callers,[23] who were not included in this analysis.

There is no doubt that a statewide promotional effort was mostly responsible for the helpline's success in reaching a representative segment of the state's smoking population. Many of the state's and counties' advertisements for the helpline were targeted to minorities; some were in Spanish. Although no comprehensive data about these promotional efforts are available for analysis, since the media campaign was waged on different levels by different agencies, the self report of helpline callers gives some indication of their extent. Overall, 63% of the helpline's callers said that they heard about it through the mass media.

There were, however, some interesting geographical differences in how callers heard about the helpline. There was a strong correlation between the urban or rural character of the state's counties and how callers learned of the helpline. Most callers from urban counties were responding to mass media advertisements. The majority of callers from rural counties, on the other hand, were referred by health care providers. Appropriately for counties where the prevalence of smoking is higher than the state's average and where programmes are few, rural health care professionals have been playing an important role in directing smokers to accessible help.

While the helpline achieved a good representation of minority and rural smokers, it also attracted a younger group of smokers compared to those who sought help in general. Why this was so is difficult to ascertain. It could be that younger people in general are more comfortable using 1-800 services, or that the campaigns advertising them appeal more to younger people, or both. For example, one study of the 1-800 Cancer Information Service found that when advertised by a media campaign, the service attracted a younger segment of the smoking population.[24] In any case, from a public health perspective the optimal age to quit smoking is as early as possible. Smokers who quit when they are young are much less likely to experience health problems than those who wait till later.[1]

On the whole, callers to the helpline are more educated than the general smoking population. Given the greater prevalence of smoking among the less educated, however, greater efforts are needed to reach this part of the population.

The telephone has been considered by many to be a promising alternative medium for providing assistance with smoking cessation.[25-29]

The success of the statewide California Smokers' Helpline in reaching an ethnically and geographically representative group of smokers points to its potential to serve as a model for future publicly funded programmes that help smokers quit.

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1 US Department of Health and Human Services. *The health benefits of smoking cessation. A report of the Surgeon General*, 1990. Rockville, Maryland: Public Health Service, Centers for Disease Control, Office on Smoking and Health, 1990. (DHHS Publication No (CDC) 90-8416.)

2 Garvey AJ, Bliss RB, Hitchcock JL, Heinold JW, Rosner B. Predictors of smoking relapse among self-quitters: a report from the normative aging study. *Addict Behav* 1992; 17: 367-77.

3 Cohen S, Lichtenstein E, Prochaska J, Rossi J, Gritz E, *et al.* Debunking myths about self-quitting. *Am Psychol* 1989; 44: 1355-65.

4 US Department of Health and Human Services. *The health consequences of smoking: nicotine addiction. A report of the Surgeon General, 1988.* Rockville, Maryland: Public Health Service, Centers for Disease Control, Office on Smoking and Health, 1988. (DHHS Publication No (CDC) 88-8406.)

5 Schwartz, JL. *Review and evaluation of smoking cessation methods: the United States and Canada.* Washington, DC: US Department of Health and Human Services, 1987. (NIH Publication No 87-2940.)

6 Lichtenstein E, Glasgow RE. Smoking cessation: what have

we learned over the past decade? *J Consult Clin Psychol* 1992; 60: 518–27.
7 Smith NC. Marketing smoking cessation. In: *Smoking cessation: the organization, delivery and financing of services, July 13–14, 1989*. Institute for the Study of Smoking Behavior and Policy. Cambridge, MA: Puritan, 1990.
8 Bal DG, Kizer KW, Felten PG, Mozar HN, Niemeyer D. Reducing tobacco consumption in California. *JAMA* 1990; 264: 1570–4.
9 Elder JP, Kenney E. *Independent evaluation of efforts to prevent and control tobacco use in California: annual report to the California Department of Health Services, Tobacco Control Section*. Sacramento: California Department of Health Services, 1991.
10 Chapman S. Stop-smoking clinics: a case for their abandonment. *Lancet* 1985; i: 918–20.
11 Fiore MC, Novotny TE, Pierce JP, Giovino GA, Hatziandreu EJ, Newcomb PA, *et al*. Methods used to quit smoking in the United States: do cessation programs help? *JAMA* 1990; 263: 2760–5.
12 Zhu S-H, Pierce JP. *Telephone counseling for smoking cessation: a randomized trial*. Paper presented at the Fourteenth Annual Scientific Sessions of the Society of Behavioral Medicine, San Francisco, 1993.
13 US Department of Health and Human Services. *Report of the 1986 Adult Use of Tobacco Survey*. Rockville, MD: Government Printing Office, 1989. (1989-625-512: 10491.)
14 Burns D, Pierce JP. *Tobacco use in California 1990–1991*. Sacramento: California Department of Health Services, 1992.
15 Pierce JP, Farkas A, Evans N, Berry C, Choi W, Rosbrook B, *et al*. *Tobacco use in California 1992: a focus on preventing uptake in adolescents*. Sacramento: California Department of Health Services, 1993.
16 Pierce JP, Evans N, Farkas AJ, Cavin SW, Berry C, Kramer M, *et al*. *Tobacco use in California: an evaluation of the Tobacco Control Program, 1989–1993*. La Jolla: University of California, San Diego, 1994.
17 Pierce JP, Goodman J, Gilpin E, Berry C. *Technical report on analytic methods and approaches used in the Tobacco Use in California, 1990–1991 Report*. Sacramento: California Department of Health Services, 1992.
18 Pierce JP, Cavin SW, Mackey C, Rosbrook B, Berry C. *Technical report on analytic methods and approaches used in the 1993 California Tobacco Survey analysis*. Sacramento: California Department of Health Services, 1994.
19 California Legislature Senate Committee on Local Government. *Rural counties' fiscal problems*. Sacramento: State Capitol, 1985.
20 Efron B. *The jackknife, the bootstrap and other resampling plans*. Philadelphia: Society for Industrial and Applied Mathematics, 1982.
21 Rao JNK, Scott AJ. The analysis of categorical data from complex sample surveys: chi-squared tests for goodness of fit and independence in two-way tables. *J Am Stat Assoc* 1981; 76: 221–30.
22 Zhu S-H, Pierce JP, Stratton TL. *California Smokers' Helpline: an accessible telephone counseling service for diverse populations*. Paper presented at the 122nd Annual Conference of the American Public Health Association, Washington, DC, 1994.
23 Pierce JP, Anderson DM, Romano RM, Meissner HI, Odenkirchen JC. Promoting smoking cessation in the United States: effect of public service announcements on the Cancer Information Service telephone line. *J Natl Cancer Inst* 1992; 84: 677–80.
24 Nakashima D. *Asian and Pacific Islander Smokers' Helpline: final report to the California Department of Health Services, Tobacco Control Section*. Sacramento: California Department of Health Services, 1994.
25 Anderson DM, Duffy K, Hallet CD, Marcus AC. Cancer prevention counseling on telephone helplines. *Public Health Rep* 1992; 107: 278–83.
26 Debusk R, Miller NH, Superko HR, Dennis C, Thomas RJ, Lew HT, *et al*. A case-management system for coronary risk factor modification after acute myocardial infarction. *Ann Intern Med* 1994; 120: 721–9.
27 Lando HA, Hellerstedt WL, Pirie PL, McGovern PG. Brief supportive telephone outreach as a recruitment and intervention strategy for smoking cessation. *Am J Public Health* 1992; 82: 41–6.
28 Orleans CT, Schoenbach VJ, Wagner EH, Quade D, Salmon MA, Pearson DC, *et al*. Self-help quit smoking intervention: effects of self-help materials, social support intervention, and telephone counseling. *J Consult Clin Psychol* 1991; 59: 439–48.
29 Ossip-Klein DJ, Giovino GA, Megahed N, Black PM, Emont SL, Stiggins J, *et al*. Effects of a smokers' hotline: results of a 10-county self-help trial. *J Consult Clin Psychol* 1991; 59: 325–32.

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Telephone Counseling for Smoking Cessation: Effects of Single-Session and Multiple-Session Interventions

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Smokers (N = 3,030) were randomized to receive 1 of 3 interventions: (a) a self-help quit kit, (b) a quit kit plus 1 telephone counseling session, or (c) a quit kit plus up to 6 telephone counseling sessions, scheduled according to relapse probability. Both counseling groups achieved significantly higher abstinence rates than the self-help group. The rates for having quit for at least 12 months by intention to treat were 5.4% for self-help, 7.5% for single counseling, and 9.9% for multiple counseling. The 12-month continuous abstinence rates for those who made a quit attempt were 14.7% for self-help, 19.8% for single counseling, and 26.7% for multiple counseling. A dose–response relation was observed, as multiple sessions produced significantly higher abstinence rates than a single session. The first week after quitting seems to be the critical period for intervention.

Telephone counseling has attracted increasing interest as an alternative system for delivery of services in the field of smoking cessation (e.g., Anderson, Duffy, Hallet, & Marcus, 1992; Curry, McBride, Louie, Grothaus, & Wagner, 1992; DeBusk et al., 1994; Lando, Hellerstedt, Pirie, & McGovern, 1992; Orleans et al., 1991; Ossip-Klein et al., 1991; Prochaska, DiClemente, Velicer, & Rossi, 1993; Shiffman, Read, Maltese, Rapkin, & Jarvik, 1985). From the smoker's standpoint, its main attractions are accessibility and convenience. There are no transportation difficulties and fewer scheduling conflicts than in most other cessation programs. Also, receiving counseling in the privacy of one's home provides treatment access to individuals who might not normally seek "counseling" to quit smoking. These factors encourage smokers to use the service (Zhu et al., 1995).

Most studies on telephone counseling for smoking cessation have focused on the question of whether a brief intervention over the telephone can significantly increase the success rate for quitting smoking. The interventions that have been used vary in two respects: (a) whether the counseling calls are initiated by the counselor or by the client (proactive vs. reactive) and (b) the number of sessions provided (ranging from one to four). The results are somewhat mixed. While several studies have shown that such an intervention significantly increases the success rate (e.g., Orleans et al., 1991; Ossip-Klein et al., 1991), others report only a short-term effect, with the long-term outlook no better than that of self-help (e.g., Curry et al., 1992; Lando et al., 1992). Those studies that have shown a significant intervention effect for telephone counseling, however, did not include a randomized design to test for a dose–response relation between the number of sessions and the treatment effect.

The present study examined the effects of two levels of telephone counseling and compared them with the effects of a self-help approach. The lower intensity counseling consisted of one session before quitting. The higher intensity counseling included the same pre-quit session plus up to five sessions after the smoker had quit. We tested two hypotheses: (a) that counseling would produce a higher abstinence rate than a self-help quit kit, and (b) that multiple sessions of counseling would produce a higher abstinence rate than a single session.

The design of the telephone interventions used in this study was based on the following principles. First, substantial counseling effort should be spent on promotion of the client's motivation to change, a basic element of effective brief interventions for addictive behaviors (Miller & Rollnick, 1991). Second, the counselor should help the client develop effective coping strategies to overcome the urge to smoke (Shiffman, 1982). Third, follow-up sessions geared toward relapse prevention should be as timely as possible to maximize their effect (Zhu, 1993). This last point is a significant feature of the multiple counseling protocol in the present study and is explained later.

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Three Features of the UCSD Telephone Counseling Program

The University of California, San Diego (UCSD), telephone counseling program had three distinctive features: proactive counseling, a structured counseling protocol, and relapse-sensitive scheduling (Zhu, 1993).

Proactive Counseling

The UCSD Smokers' Helpline adopted a proactive counseling procedure; that is, once a smoker took the first step by calling for help, all subsequent sessions were initiated by the counselor. Calls were never made without the previous consent of the client, who retained the option of deciding later not to receive them. The proactive procedure is a form of "active helping" (Miller & Rollnick, 1991). It engenders good rapport, provides an opportunity to arrest faltering motivation, and reduces the attrition rate.

Structured Counseling Protocol

The UCSD Smokers' Helpline developed a structured counseling protocol with the following goals in mind. The first was to keep the counseling brief and focused by furnishing counselors with the essential ingredients of brief intervention (e.g., Miller & Rollnick, 1991). The second was to provide a counseling intervention that was sensitive to the different phases of the quitting process. Accordingly, the helpline developed a protocol containing six separate but related questionnaires to be used in sequence for up to six sessions, one before quitting and five afterward. The counseling session that occurred before smokers made a quit attempt focused on promoting the motivation to change, whereas the postquit counseling sessions focused on relapse prevention.

In the first session, before the quit attempt, smokers were first assessed on their smoking history, quitting history, and confidence about the impending quit attempt. Their desire to change and related fears (ambivalence characteristic of addictive behavior change) were acknowledged, discussed, and clarified. A significant portion of the counseling was then spent promoting smokers' self-efficacy for a successful attempt. This included asking smokers to identify the situations in which it would be most difficult to refrain from smoking once they had quit and to plan realistic strategies for coping with those situations. This was done in an effort to break down the seemingly overwhelming task of quitting into manageable components. This final portion of the first counseling session dealt with relapse prevention as well as motivation. The entire pre-quit session usually lasted about 50 min.

The follow-up sessions, for those who received multiple counseling, occurred after the quit attempt and focused on relapse prevention. First, clients were asked whether their anticipated difficult situations were indeed problematic. Previously formulated coping strategies were reviewed, and their efficacy was assessed. The emphasis at this point was on either the successful implementation of effective coping strategies or the development of new strategies to replace or augment those that once seemed promising but were subsequently found to be ineffective. Second, clients were encouraged to change their self-image as a smoker to that of a nonsmoker, a concept that was given increasing weight in the final sessions (Zhu, 1993). Although the latter stage of counseling was primarily concerned with relapse prevention, counselors often revisited the issue of motivation in these calls as well.[1]

Each of the five follow-up sessions took about 20 min. Therefore, if the client received all six sessions, the total counseling time would be under 3 hr. The time spent counseling was not long but was used judiciously as explained later.

Relapse-Sensitive Scheduling of Multiple Follow-Up Sessions

In contrast to the traditional schedule of weekly sessions, the helpline adopted a new scheduling method that arranged follow-up sessions according to the probability of relapse (Zhu & Pierce, 1995). A typical relapse curve takes the shape of a negatively accelerated function, as illustrated in Figure 1. The probability of relapse is much greater in the initial stage than in the later stages of quitting. In other words, smokers' need for help is strongest soon after they attempt to quit. Therefore, to optimize the effect of counseling, the helpline scheduled calls in a logarithmic manner rather than at equal intervals. The vertical dashed lines connected to the horizontal axis in Figure 1 indicate the timing of the five follow-up sessions: They occurred 1, 3, 7, 14, and 30 days after the quit attempt. Such a probabilistic arrangement has been called a relapse-sensitive schedule (Zhu & Pierce, in press).

Method

Subjects

Subjects were recruited from San Diego County mainly by including the helpline's toll-free telephone numbers in advertisements of the county's ongoing antismoking campaign. Smokers who called were screened for eligibility using three criteria: (a) readiness to quit within a week of first contacting the helpline, (b) readiness of any other smokers living in the same household to quit also, and (c) absence of more serious problems (e.g., current psychiatric conditions). Over a 17-month recruitment period, 3,030 smokers met these criteria. Of that number, 57% were female; 40% had fewer than 12 years of education; 81% were White, 8% were Black, 7% were Hispanic, 2% were Asian or Pacific Islander, and 2% were of other ethnic–racial backgrounds. The mean age of the subjects was 36.3 years (SD = 12.2). The mean number of cigarettes smoked per day was 20.2 (SD = 10.4), and the average number of years the subjects had smoked was 19.5 (SD = 11.8).

Design

Subjects were randomized into three groups. (a) The self-help group received a self-help quit kit on how to quit smoking, which included either *A Lifetime of Freedom From Smoking* by the American Lung Association or *The Cool Turkey Quitting Guide* by the Stanford Center for Research in Disease Prevention. The self-help group, despite the minimal intervention they received, served as a control group in this study. (b) The single counseling group received the same self-help ma-

[1] Training for the counseling protocol is available from Shu-Hong Zhu.

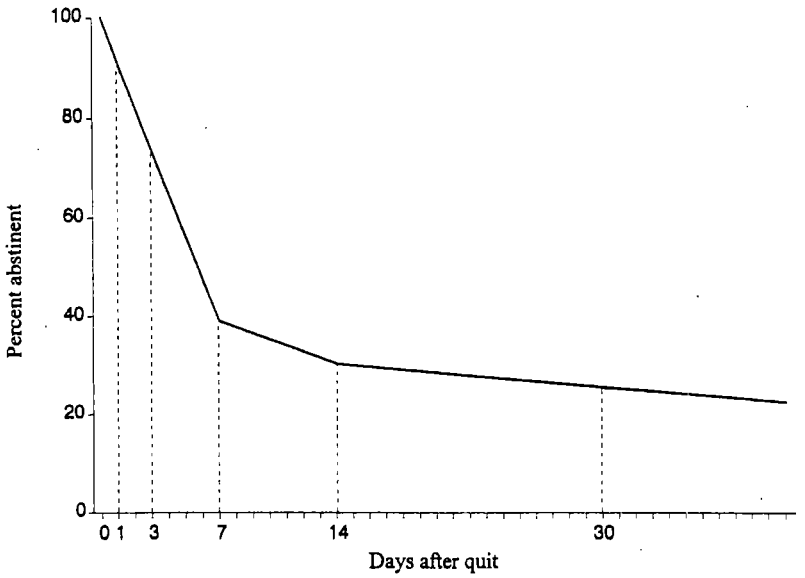

Figure 1. Relapse-sensitive scheduling of multiple counseling sessions.

terials and a 50-min pre-quit session of counseling. (c) The multiple counseling group received the same self-help materials, the pre-quit counseling session, and five follow-up sessions.

The subjects were randomized at the time of screening by the last two digits of their phone numbers. Those whose last two digits were from 00 to 29 were assigned to the self-help group. The rest (30–99) were divided between the two counseling groups according to whether the final digit was odd or even. Care was also taken to ensure that each counselor was assigned a comparable number of clients in both single and multiple counseling. Recruitment of subjects occurred from February 1, 1991 to June 30, 1992. Of those randomized over this period, 841 subjects were assigned to the self-help group, 1,143 to the single counseling group, and 1,046 to the multiple counseling group.

Counselors

Over the course of the study, 10 paid counselors worked on the project. Two of them were finishing graduate degrees in counseling psychology. The other eight were lay counselors. All counselors received about 45 hr of training with respect to the program protocol before they started counseling.

Evaluation Procedure

A separate group of evaluators, independent of the counseling staff, conducted up to four follow-up interviews per subject. For the self-help and single counseling groups, these interviews occurred at approximately 2, 4, 7, and 13 months from the date subjects were screened and entered the experiment. For the multiple counseling group, only the latter three interviews were sought because many of these subjects were still being counseled at 2 months. All participants were scheduled to receive both the first (2- or 4-month) and the last (13-month) evaluation interviews. Each intermediate interview, however, was scheduled only for those who reported not smoking at the previous evaluation interview. For any one scheduled evaluation call, the interviewers made 25 attempts to contact each subject, at various times of the day and on different days of the week, before classifying the subject as a noncontact.

Measures

Abstinence rate by intention to treat. Percentages were calculated of the subjects who were abstinent for given lengths of time during the 12-month period after screening. The lengths of abstinence considered were 1 week, 1 month, 3, 6, and 12 months. If a subject made more than one quit attempt, the longest quit attempt was used in the analysis. Those who did not receive the complete set of evaluations were analyzed using the data from those evaluations that they did receive. Those whom the helpline could not contact at all were treated as never having made any quit attempt.

The total percentage of subjects who could not be contacted for follow-up evaluations was 14.3% (14.3% for self-help, 16.6% for single counseling, and 12.3% for multiple counseling), with 11.4% having had their phone disconnected or having moved and left no forwarding number and 2.9% unavailable after 25 attempts or having declined the follow-up interviews.

The next two measures assessed the effect of counseling by focusing on the quit attempts that were initiated during the first 3 months after screening. Three months was the longest time that a subject would be in contact with a counselor. This period takes into account the time needed for self-help materials to arrive, the lag time between the first session and the quit date, and time lost to early failed quit attempts. For either measure, any quit attempts initiated after the first 3 months were not attributed to counseling.

Twenty-four-hour quit rate in the first 3 months. For subjects in each group, percentages were calculated for those quit attempts that lasted at least 24 hr within the period of counseling. A difference in 24-hr quit rates between the self-help group and the two counseling groups indicates the impact of counseling on whether smokers made a serious attempt to quit.

Duration of abstinence for quit attempts initiated in the first 3 months. A survival analysis of quit attempts made within the period of counseling estimates the percentage of subjects remaining abstinent over time, or an "abstinence curve." Such curves are paradoxically called relapse curves in the addiction literature (U.S. Department of Health and Human Services, 1988). Relapse is defined here as a return to smoking for more than 1 day after any period of abstinence. If subjects made more

than one quit attempt in the first 3 months, the most recent one was used in the analysis. A comparison of relapse curves for quit attempts initiated in the first 3 months provides a clear picture of the relapse-prevention effect of counseling.

Hazard function analysis of relapse curves. A hazard function illustrates a different aspect of the data displayed in a relapse curve. A hazard rate is defined as the rate of relapse at a time (t), given that the subjects have survived (i.e., not relapsed) to that point in time (Lee, 1992). Therefore, the hazard function provides the instantaneous relapse rate at any given time. Such an analysis is not concerned with the final abstinence rate; rather, its purpose is to reveal the underlying dynamics of the day-to-day relapse process. It serves to delineate the timely effects of counseling on the process of relapse that give rise to the differences between the final abstinence rates for the three groups.

Biomedical validation. A convenience sample of subjects who reported that they had been abstinent for at least 6 months at the time of the evaluation interview was contacted for a saliva cotinine test. Recognizing that the refusal rate for giving a saliva sample in such a low-intensity intervention was likely to be high (Glasgow et al., 1993; Velicer, Prochaska, Rossi, & Snow, 1992), this study offered $25 as an incentive. Of those who reported abstinence for at least 6 months, 219 (62.9%) were asked for a saliva sample. The majority of the remaining subjects were not asked because funding for biomedical validation was no longer available; 6 were not asked because they reported that they were using nicotine gum or patches at that time. Those who were not asked for a saliva sample did nevertheless continue to receive telephone evaluation. A significant percentage of those who were asked (44.3%) declined to provide a sample. Cotinine exceeding 10 ng/ml, a level sufficient to classify a subject as a current smoker (Haley, Axelrad, & Tilton, 1983), was present in 13.9% of the saliva samples. The high refusal rate, common for low-intensity intervention studies (e.g., 60% in Warnecke, Langenberg, Gruder, Flay, & Leonard, 1989), makes it unreasonable to attribute all refusals to a single cause (i.e., smoking; Glasgow et al., 1993; Velicer et al., 1992). However, it is important that there be no difference in refusal rates among study groups so that the difference in their abstinence rates based on self-report cannot be attributed to a higher misreport rate in any one group. The refusal rates in this study were 48.8% for self-help, 46.4% for single counseling, and 40.4% for multiple counseling. Although the numbers suggest that those who received counseling had a lower refusal rate, the difference between groups was not statistically significant, $\chi^2(2, N = 122) = 1.06, p = .59$. The maximum percentage who could have misreported their abstinence status in each group was obtained by adding the percentage who refused the test to the percentage who had a positive cotinine test result. This generated hypothetical misreport rates of 51.3% for self-help, 54.8% for single counseling, and 50.0% for multiple counseling. Again, the difference between groups was not statistically significant $\chi^2(2, N = 219) = .42, p = .81$. Therefore, the analyses which follow were based on self-report. However, an analysis based on the worst-case scenario is also presented.

Statistical Analysis

All the statistical tests were two-tailed tests with an alpha level of .05, because we had a priori hypotheses about the relative differences between the three groups. Log-rank tests were used to compare the relapse curves (Lee, 1992). The Statistical Analysis System (SAS 6.08) was used (SAS Institute, Inc., 1988).

Results

Overall Abstinence Rate by Intention to Treat

Table 1 shows the percentages of subjects who abstained from smoking for different lengths of time during the 12 months since the date of screening. For every length of time considered, the counseling groups had higher abstinence rates than the self-help group. Furthermore, the longer the period under consideration, the greater was the difference among groups. For example, subjects in multiple counseling were about 25% likelier than those in self-help to quit for 1 week but nearly twice as likely to quit for 12 months.

Comparison between the groups indicates that single counseling achieved higher abstinence rates than self-help for every quitting length (all ps $< .05$ except $p = .054$ for 12 months). Multiple counseling also achieved higher abstinence rates than self-help (all ps $< .005$). Furthermore, multiple counseling achieved greater abstinence rates than single counseling, although the difference in the 6-month abstinence rate was not significant (and $p = .058$ for 3 months).

Effect of Counseling on the 24-Hr Quit Rate in the First 3 Months

Table 2 shows the percentage of smokers who made a serious quit attempt, defined as lasting at least 24 hr, in the first 3 months after screening. The first row gives the quit rate for those whom the helpline was able to contact. Of the subjects in the self-help group, 58.8% made at least one serious quit attempt within the first 3 months. Significantly more smokers in single counseling, 66.7%, did so, $\chi^2(1, N = 1,683) = 11.07, p < .001$. A similar percentage of smokers in multiple counseling, 66.5%, made a quit attempt.

The second row gives the quit rate for each group if one were to assume that none of the noncontacts made a quit attempt. Under this conservative assumption, the quit rates decreased across all three groups. Still, about half of the subjects in self-help made a quit attempt and both counseling groups had significantly higher quit rates than the self-help group, $\chi^2(1, N = 1,984) = 5.34, p < .05$, and $\chi^2(1, N = 1,887) = 11.04, p < .001$, respectively.

Effect of Counseling for Relapse Prevention

Figure 2 shows the relapse curves for the subjects who did make a quit attempt within the first 3 months, as recorded in Table 2. These curves show that counseling helped to prevent relapse. They show, moreover, that multiple sessions prevented relapse better than a single session. The differences between groups in abstinence rates for these early quit attempts are more pronounced than the differences shown in Table 1, which are for quit attempts initiated at any time during the year after screening. Log-rank tests for the curves in Figure 2 show that the single counseling group was significantly less likely to relapse than the self-help group, $\chi^2(1, N = 1,045) = 9.03, p < .005$. Likewise, the multiple counseling group was significantly less likely to relapse than either the single counseling group, $\chi^2(1, N = 1,224) = 26.07, p < .0001$, or the self-help group, $\chi^2(1, N = 1,017) = 60.75, p < .0001$.

Table 3 presents additional data from these analyses of the relapse curves. The first row gives the 12-month continuous abstinence rates for those quit attempts made within the first 3 months. There is a 35% increase in the abstinence rate from

Table 1
Overall Abstinence Rate by Intention to Treat

Length of abstinence	% ± 95% confidence interval: Self-help (n = 841)	Single counseling (n = 1,143)	Multiple counseling (n = 1,046)	Treatment effect: $\chi^2(2, N = 3{,}030)$
1 week	41.4 ± 3.3	46.5 ± 2.9[a,b]	51.4 ± 3.0	19.0**
1 month	27.0 ± 3.0	32.9 ± 2.7[a,b]	38.4 ± 2.9	27.6**
3 months	18.6 ± 2.6	23.6 ± 2.5[a,b]	27.2 ± 2.7	19.3**
6 months	12.1 ± 2.2	15.7 ± 2.1[a]	17.0 ± 2.3	9.1*
12 months	5.4 ± 1.5	7.5 ± 1.5[a,b]	9.9 ± 1.8	13.9**

Note. Subjects who could not be contacted for evaluation were considered not to have quit.
[a] Single counseling is significantly different from self-help (except p = .054 for the 12-month quit rate).
[b] Single counseling is significantly different from multiple counseling (except p = .058 for the 3-month quit rate). Multiple counseling is significantly different from self-help for all five lengths of abstinence ($p < .005$).
* $p < .01$ for the overall treatment effect. ** $p < .001$ for the overall treatment effect.

self-help to single counseling and a nearly equal increase from single to multiple counseling.

The second row of Table 3 shows the median length of abstinence, or the time it took for half of the subjects in each group to relapse. It took only 5 days for half of the self-help group to relapse after their most recent quit attempts in the first 3 months. The median for single counseling was 11 days, twice as long as for self-help. And for multiple counseling it took over 2 months for half of the subjects to relapse, almost 6 times as long as for single counseling.

Figure 3 presents the hazard functions for the three relapse curves in Figure 2. A quick glance at these curves shows that the rate of relapse for all three groups approached the same asymptote before 1 month, with minimal fluctuations.

Figure 4 focuses on the first 30 days of the curves in Figure 3. It shows that the differences between the three groups occurred mostly within the first 2 weeks after quitting. A comparison between the self-help and multiple counseling groups shows a marked difference between the two groups at the beginning of the week, that diminished over time. By the end of the first week, the difference between the two groups was much smaller. Around 2 weeks, both curves approached the same asymptote. This same trend was true for the difference between self-help and single counseling and for that between single counseling and multiple counseling.

As a final note, we performed an analysis based on the assumption that all those who refused to provide saliva samples for cotinine testing were currently smoking, although both the literature (Glasgow et al., 1993; Velicer et al., 1992) and our experience in requesting the samples suggest that this assumption was not justified. In this worst-case scenario, about half of the subjects in each group would be considered to have misreported their abstinence status (see Method). This produced adjusted 12-month abstinence rates of 7.2% for self-help, 9.0% for single counseling, and 13.4% for multiple counseling. In this scenario, single counseling would no longer be significantly different from self-help, although multiple counseling would still have a significantly higher abstinence rate than self-help ($z = 2.25, p < .05$).

Table 2
Percentage of Quit Attempts Initiated in the First 3 Months Lasting at Least 24 Hr

Subjects who quit for at least 24 hr	% ± 95% confidence interval: Self-help	Single counseling	Multiple counseling
Evaluated subjects (n = 2,600)	58.8 ± 3.6	66.7 ± 3.0	66.6 ± 3.1
All subjects, with noncontacts considered as never quit (N = 3,030)	50.6 ± 3.4	56.0 ± 2.9	58.4 ± 3.0

Discussion

The results of this experiment indicate that telephone counseling can be an effective aid for smoking cessation. Even a single pre-quit session of telephone counseling can significantly increase both the incidence and duration of quit attempts. The results also show that a dose–response relation exists between the number of sessions offered and the duration of quit attempts. If the focus is narrowed to consider only those quit attempts initiated during the period of counseling, the effect of counseling on the abstinence rate is even more pronounced.

Brief Telephone Intervention

The fact that the single counseling group significantly outperformed the self-help group is encouraging. It is especially reassuring in view of the fact that approximately 35% of the subjects in single counseling did not receive the intended counseling. About 18% of the group either declined counseling or could not be reached by a counselor, although the evaluators later reached them. A further 17% could not be reached even by the evaluators; these were considered not to have quit. The single counseling group's improvement over the self-help group then adds to the increasing body of evidence that a well-conducted brief intervention can have a significant effect on addictive behavior change (Bien, Miller, & Tonigan, 1993; Heather, 1989; Orleans et al., 1991).

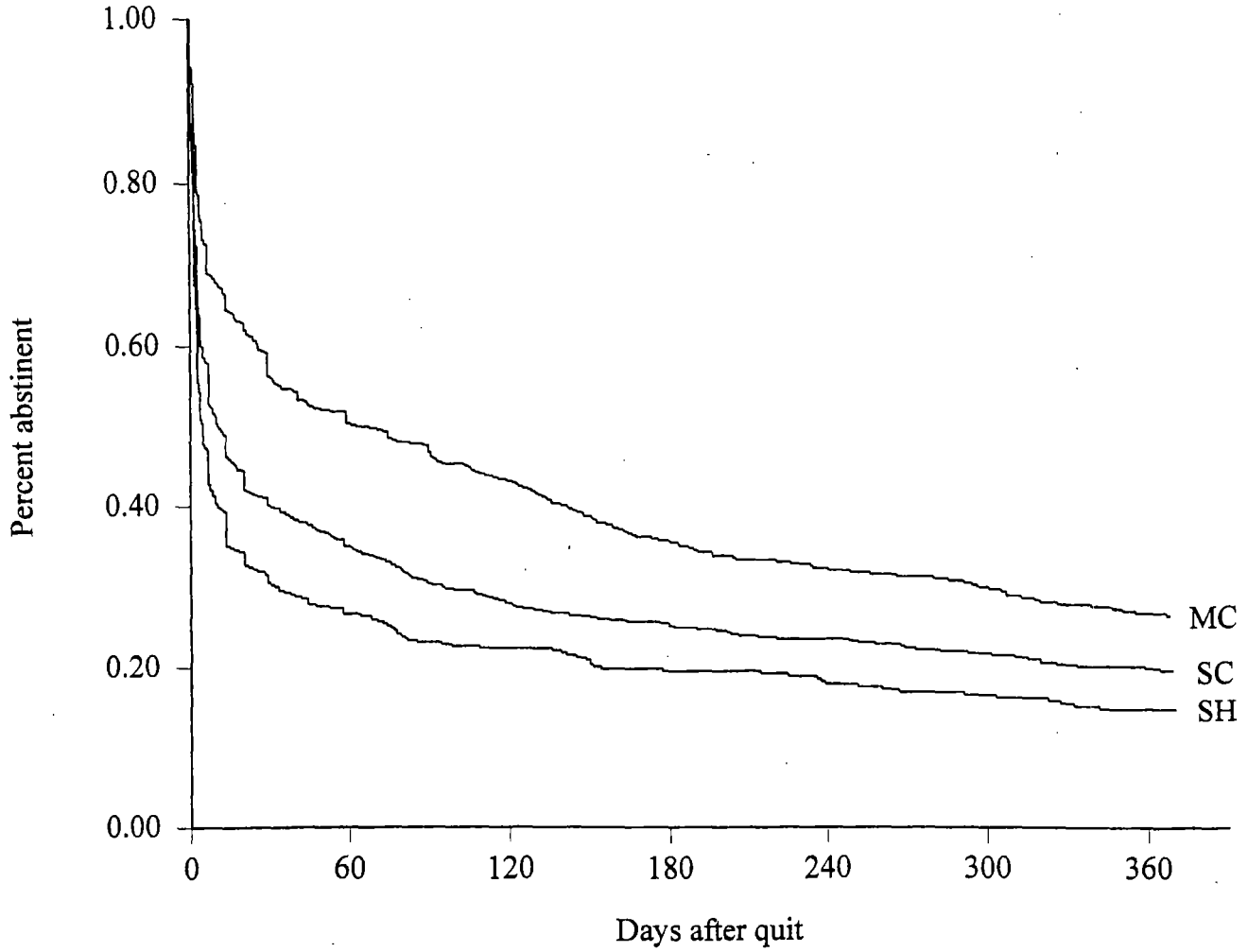

Figure 2. Relapse curves for self-help (SH), single counseling (SC), and multiple counseling (MC).

The single counseling intervention used in this study focused on two elements: promoting smokers' motivation to change (Miller & Rollnick, 1991) and preparing them for situations in which it would be difficult to resist the urge to smoke (Marlatt & Gordon, 1985). The first element was intended to increase the incidence of serious quit attempts; the second, to lower the relapse rate. To intervene effectively on both aspects within a limited time (about 50 min) is a challenging task. For this reason, the program developed a structured protocol to ensure that clients received thorough but focused counseling (Zhu, 1993). Counseling for both motivation and relapse prevention in a single pre-quit session was clearly effective. Not only were subjects in single counseling more likely to make a quit attempt than those in self-help (66.7% for single counseling vs. 58.8% for self-help), but of subjects who quit in both groups, those in single counseling were more likely to remain abstinent for 12 months (19.8% vs. 14.7%).

It is worth noting, however, that many of the subjects in single counseling voiced disappointment that no follow-up counseling would be forthcoming. They seemed to think that further sessions would help them avoid relapse. Their assumption was one of the original hypotheses of the researchers and was tested in the multiple counseling group.

Multisession Counseling With Relapse-Sensitive Scheduling

A critical feature of the multiple counseling protocol of this study was the use of relapse-sensitive scheduling for follow-up sessions. A typical relapse curve, as illustrated in Figure 1, shows that the rate of relapse is very high soon after quitting and then gradually levels off. As an example, without counseling 50% of the self-help group in this study relapsed within 5 days. Because of this known pattern of relapse, the helpline scheduled three sessions in the first week and two sessions during the rest of the month.

This relapse-sensitive schedule worked well with the proactive counseling procedure, which seemed to foster both accountability and social support. Under this procedure, accountability arose from the fact that clients knew a counselor would call as scheduled to see how they were doing. At the same time, contact with a caring counselor provided social support. This

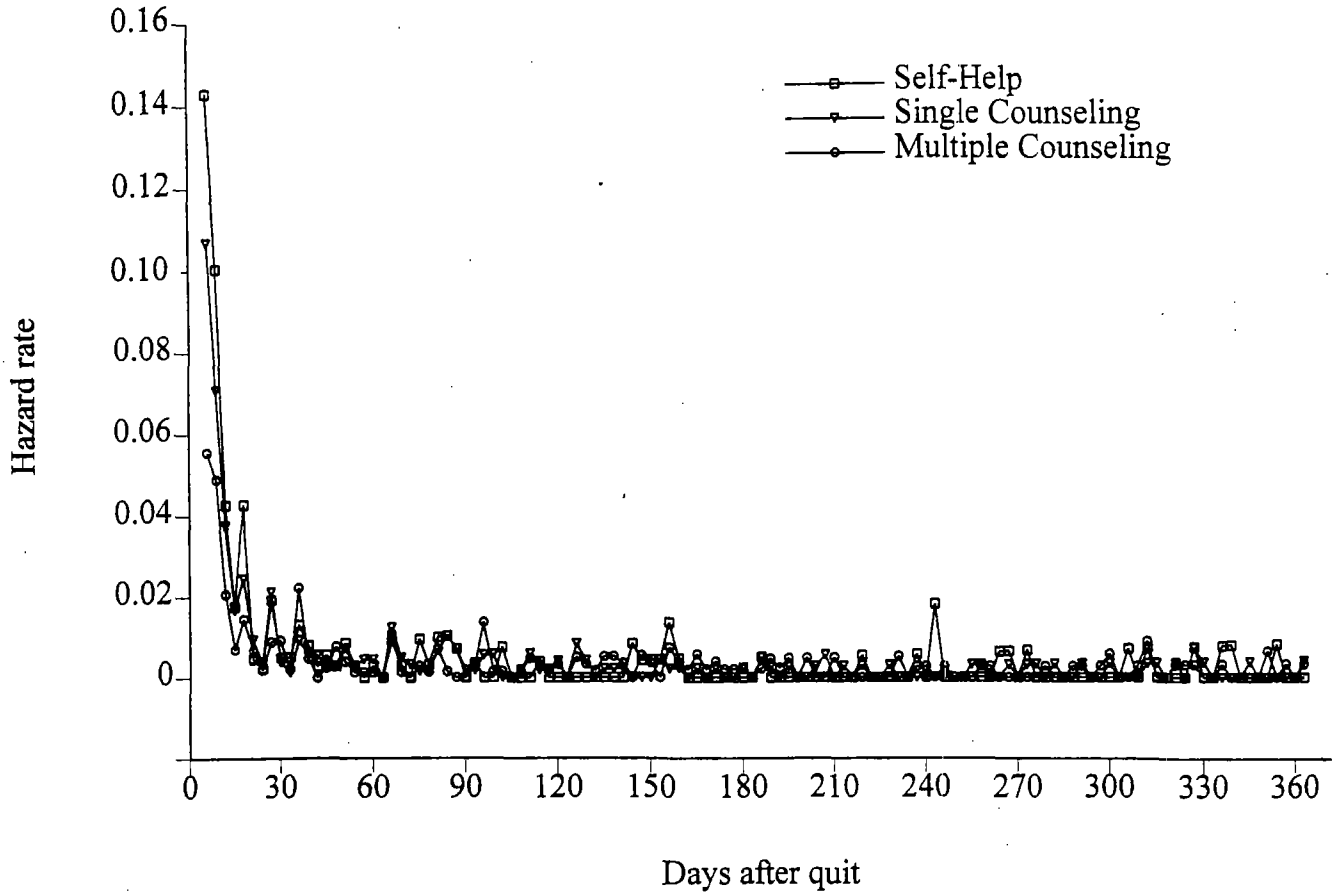

Figure 3. Hazard rates over 12 months for self-help, single counseling, and multiple counseling.

coupling of proactive counseling with relapse-sensitive scheduling provided accountability and social support when they were needed the most. Just as single-counseling subjects often voiced disappointment that they would receive no follow-up counseling, multiple-counseling subjects frequently expressed satisfaction that they did. The sixfold difference in median quitting length between multiple and single counseling (Table 3) confirms that the proactive procedure achieved its intended effect.

The hazard function analysis presented in Figure 4 provides additional support for relapse-sensitive scheduling. These curves, depicting instantaneous relapse rates, provide a clearer picture of the time course of relapse than a typical relapse curve. The hazard function for the self-help group, for example, shows a precipitous drop in relapse probability in the first week, which suggests that intervention must occur during this period to achieve an optimal effect. Indeed, this was the period for which the majority of the follow-up sessions were scheduled for the multiple counseling group. The curve for the multiple counseling group shows that these follow-up sessions significantly lowered the relapse rate during the first week, which in turn translated into a higher 12-month abstinence rate as shown in Figure 2.

Table 3
Twelve-Month Continuous Abstinence Rate and Median Length of Abstinence

Rate and length of abstinence	Self-help	Single counseling	Multiple counseling
12-month abstinence rate (%)	14.7	19.8	26.7
Median length of abstinence (in days)	5	11	63

It is worth noting that the first-week interval coincides with the peak period of self-reported withdrawal symptoms (Gross & Stitzer, 1989; Hughes, 1990). While this does not necessarily imply a direct link between withdrawal and relapse (U.S. Department of Health and Human Services, 1990), it is conceivable that the motivation to remain abstinent would dwindle with the onset and recurrence of withdrawal symptoms. At the same time, frequent cravings for cigarettes may intensify the feeling of the need to smoke. The relapse-sensitive scheduling of follow-up sessions, therefore, addressed the issues related to withdrawal and craving in a timely manner.

Moreover, as Zhu and Pierce (1995) pointed out, the probabilistic scheduling illustrated in Figure 1 is also preferable from a learning perspective, considering that the relapse curves for smoking cessation have the same shape as typical learning curves. Accordingly, if smoking cessation were conceived of as a learning process, then the curve in Figure 1 would argue for a relapse-sensitive scheduling of follow-up sessions, regardless of the presence of withdrawal symptoms.

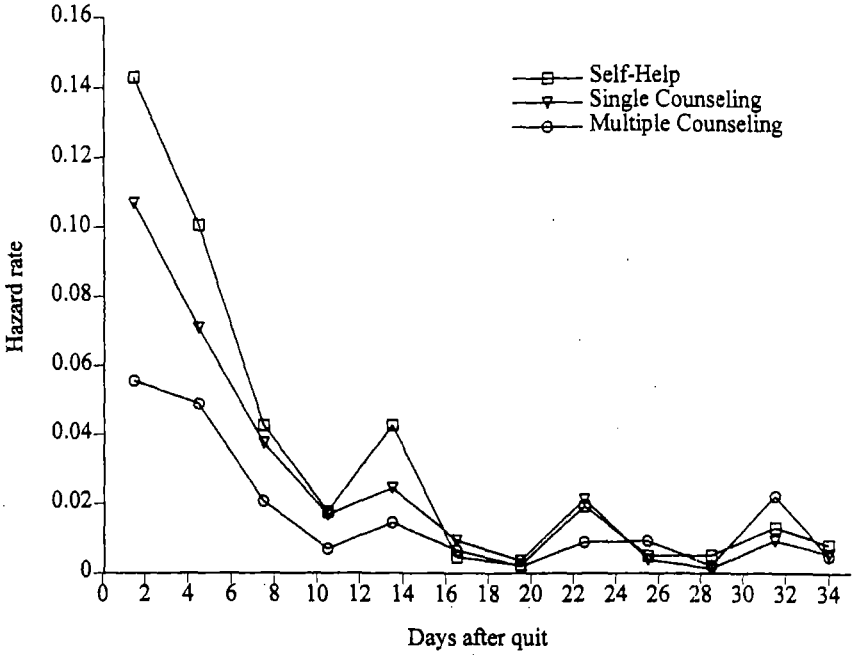

Figure 4. Hazard rates over 30 days for self-help, single counseling, and multiple counseling.

Another aspect of the pattern observed in Figures 3 and 4, which may have ramifications for the timing of brief interventions, is that the hazard curves for all three groups leveled off after 2 weeks, regardless of the intensity of intervention. This shows that those who quit smoking for 2 weeks had the same risk of relapse thereafter, regardless of group. The hazard function for the self-help group, for example, approximates the natural course of relapse. The curve for this group began to level off by the end of 1 week. Around the end of 2 weeks, the curve became asymptotic with minimal fluctuations. In other words, the risk of relapse for those who were still abstinent at 2 weeks was just as low as for those who were abstinent at 3, 6, or 9 months (Figure 3), suggesting no differential need for intervention at any time after 2 weeks for this group.

The hazard curves for the single and multiple counseling groups likewise leveled off at about 2 weeks. Before that time, as Figure 4 shows, the relapse risk was lower for single counseling than for self-help, and lower still for multiple counseling. This indicates that the pre-quit session for the single counseling group increased the number of subjects who managed to quit for 2 weeks, compared with self-help, and that the follow-up sessions in multiple counseling increased it even further. One might expect that counseling merely delayed the inevitable, that the extra subjects whom counseling enabled to quit for 2 weeks were at greater risk of relapsing later on. However, the hazard curves show that the relapse risk after 2 weeks was no greater for the counseling groups than for the self-help group. This suggests that interventions within 2 weeks of quitting can produce significant effects, but that interventions after 2 weeks (for those who have quit) are unlikely to produce additional significant effects.

In fact, one might even gather from the data in Figure 4 that the critical period for interventions, on average, is the first week after quitting smoking. This at least was true for the majority of smokers receiving counseling from the UCSD Smokers' Helpline. Such a strong statement would be difficult to make based solely on the relapse curves in Figure 2. However, the hazard functions describing instantaneous relapse probabilities over time, in Figures 3 and 4, do suggest such an interpretation. The idea that in smoking cessation there is a critical period for the delivery of counseling services, whether 1 or 2 weeks, deserves further investigation.

Dose–Response Relation

The hypothesis that there would be a dose–response relation between the number of sessions and the effect of counseling was supported in this experiment. However, some interesting patterns emerged when the effects of multiple counseling on quit attempts and the relapse process were examined separately. The follow-up sessions given to subjects in multiple counseling had little effect on the probability of their making a quit attempt (Table 2), relative to those in single counseling. The dose–response relationship was achieved not by increasing the quit rate but by reducing the relapse rate (Figure 2).

The data on the rate of quit attempts in Table 2 show that one session of counseling achieved about the same effect as multiple sessions. This was somewhat unexpected because subjects in the latter group had more contact with their counselors. Specifically, subjects in single counseling neither expected nor received any follow-up sessions, even if they failed to quit on the scheduled date. In contrast, those in multiple counseling who failed to quit as planned typically received more sessions. In these sessions, their counselor would address the difficulties responsible for their failure to quit as scheduled and encourage them to set a new quit date. The counselor would then schedule the next call according to that date. For this extra effort, however, there was apparently little return. By the end of the third month, there

was little difference in quit attempts between the two groups, as shown in Table 2.

This lack of a dose–response effect on quit attempts is to some extent consistent with the literature on brief intervention for addictive behaviors. In a recent review of interventions for problem drinking, for example, Bien et al. (1993) concluded that most studies failed to find a significant dose–response relation between the number of sessions and the treatment effect. One possible reason for this result is that the interventions studied were mostly motivational in nature; that is, once clients were motivated to change, further sessions were unlikely to produce any significant additional effect unless the added sessions changed focus (Miller & Rollnick, 1991; W. R. Miller, personal communication, February 7, 1995). It is obvious from the data in this experiment that continuing to counsel those who failed to quit as planned with the protocol used in this study had no immediate benefit. New strategies are needed if progress is to be made in this area.

The dose–response relation was, however, evident in the final abstinence rates in this study. In the multiple follow-up sessions responsible for this relation, the focus of counseling (for those who had made a quit attempt) changed to relapse prevention. Coping strategies discussed in the pre-quit counseling session were reviewed and their relative effectiveness evaluated. In addition, clients were urged to develop new strategies to replace ineffective ones. In later sessions, the focus shifted to self-image; that is, those who had quit were encouraged to begin seeing themselves as nonsmokers rather than as smokers who were simply not smoking. For example, they might be asked how they would respond if they were asked in a restaurant whether they wished to be seated in the smoking or nonsmoking section. Their response would then be discussed in the context of their changing self-image. Irrespective of the relative contributions of the various elements associated with the follow-up counseling (e.g., coping strategies, self-image, accountability, and social support), the relapse curves in Figure 2 show that subjects in multiple counseling were significantly less likely to relapse than those in single counseling.

It should be noted that the curve for multiple counseling in Figure 2 is a conservative estimate of the effect of the multisession counseling protocol on relapse prevention. Of the subjects in this group, 33% received no counseling, a percentage similar to that of single counseling. Of the remainder who did receive counseling, not all received the full six sessions. Some of them missed appointments or decided not to quit and dropped out early. On average, the subjects in multiple counseling received only four sessions.

The increased benefits of multiple counseling over single counseling confirm the consistency of this counseling approach. They suggest that the intervention tapped into the variables responsible for behavioral change in a predictable manner (Howard, Kopta, Krause, & Orlinsky, 1986).

The effectiveness of the telephone counseling protocol, in combination with the high accessibility and convenience of the telephone format, suggests that this approach to smoking cessation can be used with a broader population. Currently, statewide programs modeled on this approach are in operation in California and Massachusetts.

References

Anderson, D. M., Duffy, K., Hallet, C. D., & Marcus, A. C. (1992). Cancer prevention counseling on telephone helplines. *Public Health Report, 107,* 278–283.

Bien, T. H., Miller, W. R., Tonigan, J. S. (1993). Brief interventions for alcohol problems: A review. *Addiction, 88,* 315–336.

Curry, S. J., McBride, C. M., Louie, D., Grothaus, L. C., & Wagner, E. H. (1992, July). *Randomized trial of self-help smoking cessation intervention with non-volunteer smokers.* Paper presented at the Second International Congress of Behavioral Medicine, Hamburg, Germany.

DeBusk, R. F., Miller, N. H., Superko, R., Dennis, C. A., Thomas, R. J., Lew, H. T., Berger, W. E., Heller, R. S., Rompf, J., Gee, D., Kraemer, H. C., Bandura, A., Ghandour, G., Clark, M., Shah, R., Fisher, L., & Taylor, C. B. (1994). A case-management system for coronary risk factor modification after acute myocardial infarction. *Annals of Internal Medicine, 120,* 721–729.

Glasgow, R. E., Mullooly, J. P., Vogt, T. M., Stevens, V. J., Lichtenstein, E., Hollis, J. F., Lando, H. A., Severson, H. H., Pearson, K. A., & Vogt, M. R. (1993). Biochemical validation of smoking status: Pros, cons, and data from four low-intensity intervention trials. *Addictive Behaviors, 18,* 511–527.

Gross, J., & Stitzer, M. L. (1989). Nicotine replacement: Ten-week effects on tobacco withdrawal symptoms. *Psychopharmacology, 98,* 334–341.

Haley, N. J., Axelrad, C. M., & Tilton, K. A. (1983). Validation of self-reported smoking behavior: Biochemical analyses of cotinine and thiocyanate. *American Journal of Public Health, 38,* 1204–1207.

Heather, N. (1989). Psychology and brief intervention. *British Journal of Addiction, 84,* 367–370.

Howard, K. I., Kopta, S. M., Krause, M. S., & Orlinsky, D. E. (1986). The dose-effect relationship in psychotherapy. *American Psychologist, 41,* 159–164.

Hughes, J. R. (1990). Tobacco withdrawal in self-quitters. *Journal of Consulting and Clinical Psychology, 60,* 689–697.

Lando, H. A., Hellerstedt, W. L., Pirie, P. L., & McGovern, P. G. (1992). Brief supportive telephone outreach as a recruitment and intervention strategy for smoking cessation. *American Journal of Public Health, 82,* 41–46.

Lee, E. T. (1992). *Statistical methods for survival data analysis.* New York: Wiley.

Miller, W. R., & Rollnick, S. (1991). *Motivational interviewing: Preparing people to change addictive behavior.* New York: Guilford Press.

Marlatt, G. A., & Gordon, J. R. (1985). *Relapse prevention: Maintenance strategies in the treatment of addictive behavior.* New York: Guilford Press.

Orleans, C. T., Schoenbach, V. J., Wagner, E. H., Quade, D., Salmon, M. A., Pearson, D. C., Fielder, J., Porter, C. Q., & Kaplan, B. H. (1991). Self-help quit smoking intervention: Effects of self-help materials, social support intervention, and telephone counseling. *Journal of Clinical and Consulting Psychology, 59,* 439–448.

Ossip-Klein, D. J., Giovino, G. A., Megahed, N., Black, P. M., Emont, S. L., Stiggins, J., Shulman, E., & Moore, L. (1991). Effects of a smokers' hotline: Results of a 10-county self-help trial. *Journal of Consulting and Clinical Psychology, 59,* 325–332.

Prochaska, J. O., DiClemente, C., Velicer, W. F., & Rossi, J. (1993). Standardized, individualized interactive and personalized self-help programs for smoking cessation. *Health Psychology, 12,* 399–405.

SAS Institute, Inc. (1988). *SAS/STAT user's guide, Release 6.08 edition.* Cary, NC: Author.

Shiffman, S. (1982). Relapse following smoking cessation: A situational analysis. *Journal of Consulting and Clinical Psychology, 50,* 71–86.

Shiffman, S., Read, L., Maltese, J., Rapkin, D., & Jarvik, M. E. (1985). Preventing relapse in ex-smokers: A self-management approach. In G. A. Marlatt & J. R. Gordon (Eds.), *Relapse prevention: Maintenance strategies in the treatment of addictive behavior,* (pp. 472–520). New York: Guilford Press.

U.S. Department of Health and Human Services. (1988). *The health*

consequences of smoking: Nicotine addiction. A report of the surgeon general (DHHS Publication No. CDC 88-8416). Washington, DC: U.S. Government Printing Office.

U.S. Department of Health and Human Services. (1990). *The health benefits of smoking cessation: A report of the surgeon general* (DHHS Publication No. CDC 90-8416). Washington, DC: U.S. Government Printing Office.

Velicer, W. F., Prochaska, J. O., Rossi, J. S., & Snow, M. G. (1992). Assessing outcome in smoking cessation studies. *Psychological Bulletin, 111,* 23–41.

Warnecke, R., Langenberg, P., Gruder, C., Flay, B., & Leonard, J. (1989). Factors in smoking cessation among participants in a televised intervention. *Preventive Medicine, 18,* 833–846.

Zhu, S.-H. (1993, November). *Basic tenets of telephone counseling for smoking cessation.* A workshop conducted at the Sixth National Conference on Nicotine Dependence, American Society of Addictive Medicine, Atlanta.

Zhu, S.-H., & Pierce, J. P. (1995). A new scheduling method for time-limited counseling. *Professional Psychology: Research and Practice, 26,* 624–625.

Zhu, S.-H., Rosbrook, B., Anderson, C., Gilpin, E., Sadler, G., & Pierce, J. P. (1995). The demographics of help-seeking for smoking cessation in California and the role of the California Smokers' Helpline. *Tobacco Control, 4*(Suppl. 1), S9–S15.

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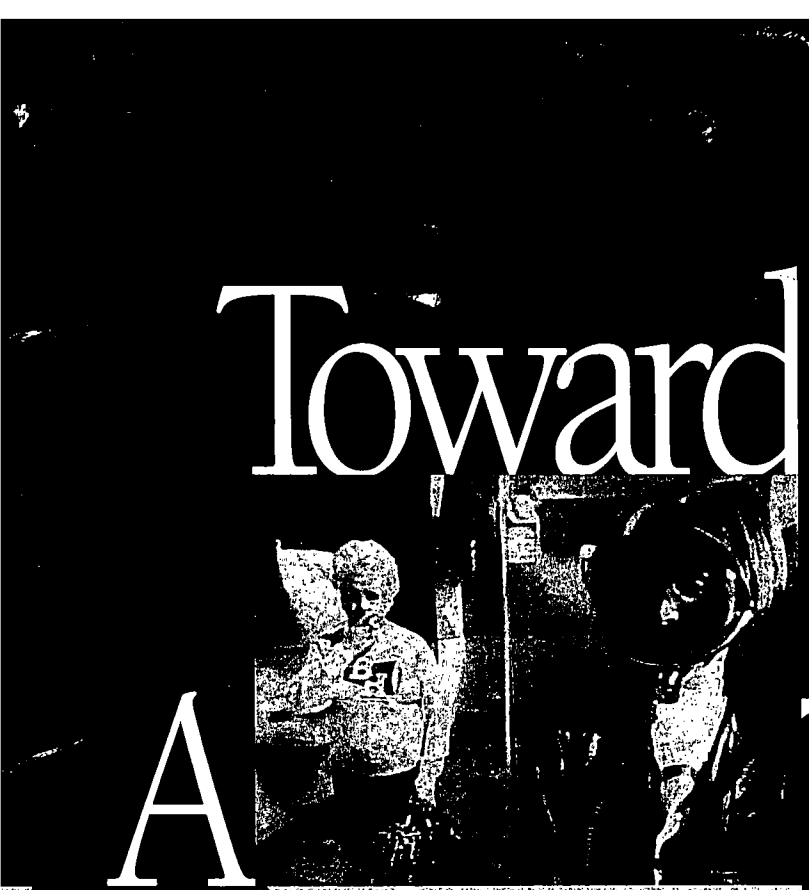

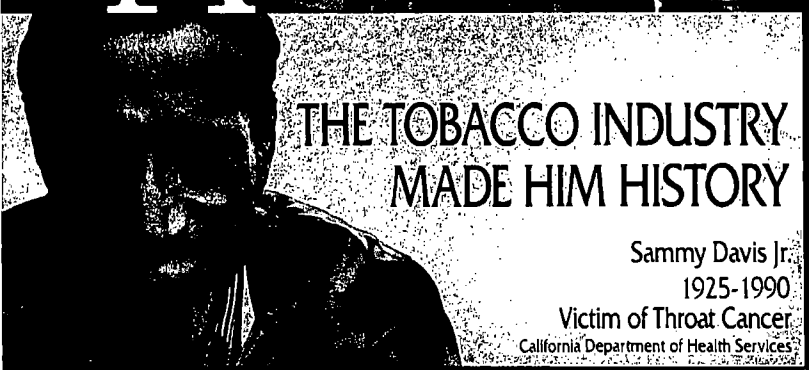

MASTERING THE CHALLENGES

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