Toward a Tobacco-Free California

2009–2011

ENDANGERED INVESTMENT

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Master Plan of the Tobacco Education
and Research Oversight Committee
January 2009

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Foreword

In 1989, the California State legislature authorized the expenditure of Proposition 99 funds, declaring that "keeping children and young adults from beginning to use tobacco and encouraging all persons to quit tobacco use shall be the highest priority in disease prevention for the State of California."

For the past 20 years, California has defined best practices for comprehensive tobacco control that have been modeled throughout the nation and world. As a result, tobacco-related disease and death in California has decreased significantly, while the best practices have helped improve public health and decrease healthcare expenditures. Today, California has the second lowest adult and youth smoking rates, and is reducing the rate of lung cancer incidence more than three times faster than the rest of the nation.

In 2009, California's tobacco control efforts stand at a crossroads. Looking back, the California Tobacco Control Program has helped smokers quit, protected workers from secondhand smoke, reduced youth access to tobacco, and confronted the tobacco industry's efforts to undermine public health and target California's diverse communities. Looking forward, California faces the challenge of fully serving the nearly four million youth and adult smokers while facing a stagnant tobacco tax that yields fewer resources to operate the program fully.

Since 1988, California has dropped from 1st to 30th in both tax and programmatic spending, and progress on key tobacco control indicators demonstrates that progress is slipping. In the past three years, cigarette consumption has flattened, and youth and adult smoking rates have increased. With a current annual budget of $92 million for tobacco control efforts, California fails to meet the $441.9 million annual funding recommendation of the Centers for Disease Control and Prevention (CDC).

It is the conclusion of the Tobacco Education and Research Oversight Committee (TEROC) that California's tobacco control movement has become threatened by funding declines and increased costs, creating an "Endangered Investment" that threatens past achievements and future progress.

With the 20th anniversary of the passage of Proposition 99, TEROC submits to the California Legislature the 2009-2011 Master Plan for comprehensive tobacco control efforts. Pursuant to its legislative mandate, the Master Plan reports the accomplishments and challenges in tobacco control and provides program and budget recommendations for the future.

In order to achieve the 2009–2011 Master Plan goal of a 10 percent adult and 8 percent youth smoking prevalence by the end of 2011, California must increase the tobacco excise tax by at least $1.50 per pack, with a 16.67 percent earmark ($0.25) dedicated to comprehensive tobacco control, education, and research. To offset the effects of inflation and further reduce smoking prevalence, TEROC recommends any tobacco tax increase be indexed annually to inflation increases.

A $1.50 tax increase would generate 275,000 quitters and prevent over 400,000 youth from starting to smoke. Ultimately, approximately 180,000 deaths due to smoking would be prevented.

It is clear from other states (e.g., Massachusetts and Florida) that without a renewed investment in tobacco control, progress toward a tobacco-free state will slow and could potentially regress. TEROC urges the Legislature to once again invest in tobacco control as the highest priority in disease prevention for the State of California.

Kirk Kleinschmidt, Chairman
January 2009

About the Tobacco Education & Research Oversight Committee

TEROC is a legislatively mandated oversight committee (California Health and Safety Code Sections 104365-104370) that monitors the use of Proposition 99 tobacco tax revenues for tobacco control and prevention education and for tobacco-related research. TEROC makes programmatic and budgetary recommendations to the California Legislature pertaining to California tobacco control efforts, and advises the California Department of Public Health, the University of California, and the California Department of Education regarding the administration of Proposition-99-funded programs.

TEROC publishes a Master Plan for tobacco control efforts, tobacco-use prevention education, and tobacco-related disease research in California every three years.

All TEROC meetings are open to the public. More information about TEROC, including meeting announcements, meeting minutes, press releases, and the previous Master Plan can be accessed online at http://www.cdph.ca.gov/services/boards/teroc/

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- Tobacco control community programs and schools throughout California, without which a comprehensive tobacco control program would not exist
- Members of the California tobacco control community who provided input into the development of the 2009–2011 Master Plan objectives and supporting strategies
- Members of the academic community whose research findings are contributing to a greater understanding of tobacco control
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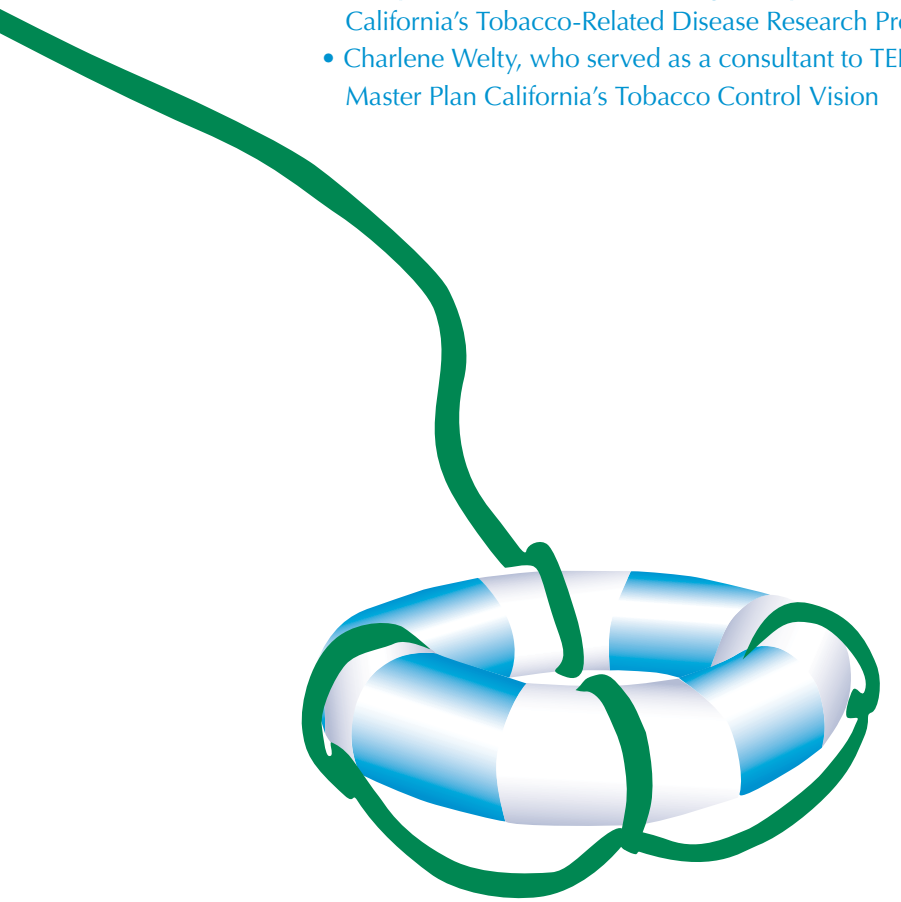
- Charlene Welty, who served as a consultant to TEROC and assisted in writing this Master Plan California's Tobacco Control Vision



Vision Statement

Vision:
A tobacco-free California

Mission:
To reduce tobacco-related illness and death

Goal:
To achieve smoking prevalence rates in California of 10 percent† for adults and 8 percent‡ for high-school-age youth by the end of 2011.

California's Proposition 99 tobacco control efforts are administered by three state agencies that work together toward the vision of a tobacco-free California.

The California Tobacco Control Program of the California Department of Public Health (CDPH/CTCP) administers the public health aspects of the program, including the Proposition-99-funded tobacco control activities of 61 local health departments, 35 community nonprofit organizations, 8 statewide training and technical assistance or cessation service projects, a statewide media campaign, and the evaluation of the effectiveness of the public health and school-based components. http://www.cdph.ca.gov/programs/Tobacco

The Safe and Healthy Kids Program Office of the California Department of Education (CDE/SHKPO) is responsible for administering the Tobacco-Use Prevention Education (TUPE) program in nearly 1,100 school districts, with the support of 58 county offices of education. http://www.cde.ca.gov/ls/he/at/tupe.asp

The Tobacco-Related Disease Research Program (TRDRP), administered by the University of California, funds research that enhances understanding of tobacco use, prevention and cessation, the social, economic, and policy-related aspects of tobacco use, and tobacco-related diseases. http://www.trdrp.org/

*The Appendix provides more detail on these agencies.

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† Based on combined California Adult Survey/Behavioral Risk Survey data, the 2007 California adult smoking prevalence rate was 13.8 percent.

‡ Based on the California Student Tobacco Survey, a nationally comparable school-based survey, the 2006 high school smoking prevalence rate was 15.4 percent.

Endangered Investment: Executive Summary

Two decades after the passage of the Tobacco Tax and Health Protection Act (Proposition 99), the Tobacco Education and Research Oversight Committee (TEROC) presents its eighth Master Plan in accordance with California Health and Safety Code Sections 104350-104480.

In 1989, enabling legislation for the California Comprehensive Tobacco Control Program established the goal of reducing tobacco consumption by 75 percent by 1999. While this has yet to be accomplished, Proposition 99 tobacco control funds have resulted in the following:

- A 35 percent decrease in adult smoking prevalence.[1]
- A 61 percent decline in per capita cigarette consumption.
- A decrease in lung cancer incidence at over three times the rate of decline seen in the rest of the nation.[2]
- A cumulative savings of $86 billion in healthcare expenditures from 1989 to 2004.[3]

California tobacco control efforts have not only impacted the life of every Californian, but have become the model for other states and countries around the world. In a span of 20 years, California has made considerable progress toward changing social norms, countering deceptive tobacco industry practices, and creating a tobacco-free state by reducing tobacco use, disease, and death. In fact, the Centers for Disease Control and Prevention (CDC) *Best Practices for Comprehensive Tobacco Control Programs—2007* states: "California has the potential to be the first state in which lung cancer is no longer the leading cancer cause of death."[4]

TEROC's 2009–2011 Master Plan

The 2009–2011 Master Plan's established goal is to achieve a smoking prevalence of 10 percent among adults and 8 percent among high school age youth by the end of 2011.

California's ability to build upon twenty years of achievement towards a tobacco-free California will require a renewed investment in tobacco control efforts. Success will require a commitment to raising the price of tobacco and sufficiently funding comprehensive tobacco control to address the nearly four million youth and adult smokers in California.

Objectives and Strategies for 2009–2011

TEROC recommends focusing on the following objectives and strategies during the 2009–2011 period in order to strengthen and support tobacco control efforts and achieve the adult and youth prevalence goals by the end of 2011.

Objective 1:
Strengthen the California Tobacco Control Program

Increasing the funding level and supporting the infrastructure of California tobacco control is essential to effectively reducing tobacco-related disease and death in the state. Strategies include:

- Raising the tobacco tax by at least $1.50 per pack, with at least 16.67 percent ($0.25) earmarked for tobacco control. To offset the effects of inflation, a tax increase should be indexed to inflation increases.
- Prohibiting the diversion of Proposition 99 funds to other state programs or services, including the California Cancer Registry.
- Improving the structure and function of tobacco control agencies through increased collaboration, increased media campaigns, policy-related research, and supporting the successful implementation of the new TUPE funding grant process for school-based tobacco-use prevention programs.

TEROC recommends that, at a minimum, the California tobacco control agencies be funded at the following levels for Fiscal Years 2009–2011:

Table 1: Budget Proposal for California Tobacco Control Agencies, Fiscal Years (FY) 2009–2011

Program Component	Original Tobacco Control Distribution	Actual FY 08-09 budget (in millions)	Recommended 08-09 budget (in millions)*	Recommended 09-10 budget (in millions)*	Recommended 10-11 budget (in millions)*
CDPH/CTCP	51%	$55.6	$164.3	$164.3	$164.3
CDE/SHKPO	25%	$23.1	$80.5	$80.5	$80.5
UC/TRDRP	24%	$14.6	$77.3	$77.3	$77.3
Total	100%	$93.3	$322.1	$322.1	$322.1

* Recommendations assume annual baseline of $91 million from the Health Education and Research Accounts, as well as the projected revenue from a $1.50 tax increase with a minimum 16.67 percent ($0.25) earmark. Future year recommendations assume constant revenue due to the average annual rate of inflation matching the annual decrease in tobacco consumption (3 percent).

Objective 2:
Eliminate Disparities and Achieve Parity in All Aspects of Tobacco Control

TEROC recognizes the impact from the direct and specialized targeting of California's diverse communities by the tobacco industry. Priority populations remain at a greater risk of tobacco use, disease, and death.[14, 15] As such, all Proposition-99-funded agencies should utilize evidence-based strategies to identify high-risk populations and develop specific interventions to eliminate disparities within California tobacco control efforts. Efforts must build the capacity of every community to achieve parity in tobacco control.

Objective 3: Decrease Secondhand Smoke Exposure

In 2006, two significant secondhand smoke reports were issued:

1) The California Air Resources Board classified secondhand smoke as a Toxic Air Contaminant.[16]
2) The United States Surgeon General's Report, *The Health Consequences of Involuntary Exposure to Tobacco Smoke* concluded, "there is no risk-free level of exposure to secondhand smoke."[17]

In order to reduce disease and death caused by exposure to secondhand smoke, TEROC supports the adoption of policies which protect all Californians from secondhand smoke exposure. In the next three years, emphasis should be given to eliminating exemptions found in California's smoke-free workplace law (Labor Code 6404.5), restricting smoking in multi-unit housing, adopting comprehensive smoke-free outdoor policies, and providing workplace protections in American Indian casinos.

Objective 4: Increase the Availability and Utilization of Cessation Services

Research shows that 75.3 percent of all smokers consider quitting in the next six months.[18] While numerous cessation services and a variety of Food and Drug Administration (FDA)-approved medications exist, many smokers are still unable to access or utilize appropriate treatments.

To make significant progress toward a tobacco-free California, an increase in the successful quit rate of current smokers is essential. To that end, a concerted effort is required across both public and private sectors. TEROC recommends increasing the availability and utilization of FDA-approved pharmacotherapy to uninsured smokers, increasing health plan coverage, ensuring the efficacy of workplace cessation services, and increasing the number of collaborative programs and policies which use the Clinical Practice Guideline for Treatment and which reduce barriers to receiving cessation services.[19, 20]

Objective 5: Limit and Regulate Tobacco Industry Products, Activities, and Influence

The tobacco industry continues to be a relentless adversary in California that must be regulated effectively. In the past three years, tobacco industry efforts have ranged from targeting California's diverse and vulnerable populations, to directly opposing state policies that would have significantly reduced tobacco use and increased healthcare coverage and services.[21-24]

TEROC recommends that tobacco control efforts focus on limiting the products, activities, and influence of the tobacco industry by creating strong state and local regulation of the tobacco industry, adopting strong local tobacco retailer licensing laws, restricting free distribution (sampling) of tobacco, prohibiting the sale of tobacco products by pharmacies and drug stores, requiring all schools in California to be tobacco-free regardless of funding, and removing the depiction of smoking in new youth-rated (G, PG, and PG-13) movies.

THE FIGHT

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Tobacco companies get into our communities and take our health, our money and our loved ones. But they can't take these things if we don't hand them over.

undo the addiction

Endangered Investment: Toward a Tobacco-Free California 2009-2011

The Tobacco Education and Research Oversight Committee (TEROC) presents its 2009–2011 Master Plan in accordance with California Health and Safety Code Sections 104350-104480, to serve as a report to the California Legislature. The Master Plan provides tobacco control recommendations regarding administrative arrangements, funding priorities, and the integration and coordination of programs by the three California tobacco control agencies: the California Department of Public Health, the University of California, and the California Department of Education. The Tobacco Tax and Health Protection Act (Proposition 99) required that the Master Plan establish a goal to achieve a 75 percent reduction in tobacco consumption in California by the year 1999.

There is much to be celebrated from the past 20 years since the passage of Proposition 99. California has reduced adult smoking prevalence by 35 percent, reduced per capita cigarette consumption by 61 percent,[1] and continues to reduce lung cancer incidence over three times faster than the rest of the nation.[2] In the first 15 years (1989–2004), California tobacco control efforts were associated with a cumulative savings of $86 billion dollars in healthcare expenditures, and are considered an effective strategy for further reducing healthcare costs.[3] Today, Californians are better informed about the dangers of smoking, have greater access to services and products to help them quit, and are better protected from exposure to toxic secondhand smoke.

While cigarette consumption has decreased significantly, California still has nearly four million smokers (3.6 million adults and 300,000 youth), and fails to reach the $441.9 million annual budget for tobacco control recommended by the Centers for Disease Control and Prevention (CDC).[4] Future progress is therefore questioned, as tobacco control funding continues to decline and the price of tobacco has remained unchanged for the past 10 years.

Significant disparity in smoking prevalence continues among California's numerous populations and communities. While 75.3 percent of smokers will consider quitting in the next six months, significant barriers to access and/or utilize proven cessation services remain. All the while, the tobacco industry continually undermines tobacco control efforts by targeting smokers and youth with marketing strategies, implementing price promotions, and contributing funds to campaigns and lobbying legislators to prevent the adoption of proposed tobacco taxes and tobacco control legislation.[21-24]

In this 2009–2011 Master Plan, TEROC reestablishes the 2006–2008 goal to achieve a smoking prevalence of 10 percent among adults and 8 percent among high school age youth by the end of 2011.

California's Tobacco Control efforts are an Endangered Investment. In order to achieve the 2009–2011 Master Plan goal of a 10 percent adult and 8 percent youth smoking prevalence, California must enact a tobacco tax increase and earmark funds to sufficiently fund tobacco control efforts.

The 2009–2011 Master Plan reflects TEROC's review of the California tobacco control agencies' progress and challenges during the past three years, highlights 20 years of tobacco control achievements, provides programmatic and budgetary recommendations, and presents five distinct objectives with corresponding strategies. The objectives and strategies are intended for the California Legislature and California's tobacco control agencies. Additional narrative has been provided to highlight important and emerging strategies.

Objectives and Strategies for 2009-2011

OBJECTIVE 1:
Strengthen the California Tobacco Control Program

Raise the Tobacco Tax

- In order to reduce tobacco use, lower healthcare costs, and further disease prevention, California must enact a new tobacco tax with the following provisions:
  - A tax increase of at least $1.50 per pack of cigarettes with an equivalent tax on other tobacco products, indexed incrementally to inflation.
  - A tax earmark of at least 16.67 percent (e.g. $0.25) for tobacco control.
  - An offset of any Proposition 99 funding declines resulting from decreased cigarette consumption.
- Eliminate untaxed or low-taxed sources of tobacco such as military commissaries, Internet stores, other states, and American Indian reservations.
- Research and disseminate information measuring the health impact, lives saved, and cost savings from present and future tobacco tax increases.

Reverse Tobacco Control Funding Declines

- Adjust funding of California Tobacco Control, Education, and Research initiatives to keep pace with inflation and preferentially fund program infrastructure to promote stability, continuity, and momentum.
- Prohibit the diversion of any funds from the Proposition 99 Health Education and Research Accounts to other state programs or services, including the California Cancer Registry.
- Impose a mitigation fee of at least $1.00 per pack of cigarettes in order to alleviate the harmful effects of tobacco use on the environment, such as contamination of waterways, highways, coastlines, sidewalks, and other areas by cigarette remnants (butts) and tobacco-related litter, and tobacco-related wildfires.
- Redirect existing revenue sources to compensate tobacco control agencies for funding declines. Sources include: Proposition 99 unallocated account, Proposition 10 accounts, general fund, and restricted reserve.

Improve the Structure and Function of the California Tobacco Control Program

- Ensure California tobacco control agencies and programs meet legislative requirements.
- Increase collaboration, cooperation, and communication among all agencies and programs working on tobacco control in California, including local and tribal governments.
- Monitor and support the implementation of Assembly Bill 647 (2007) to create a unified competitive grant mechanism to fund school-based anti-tobacco programs and cessation activities.
- Continue to implement a targeted mass media campaign as an integral component of comprehensive tobacco control.
- Maintain research on tobacco use in California, and continue to monitor, evaluate, and report the successes and challenges of California tobacco control.

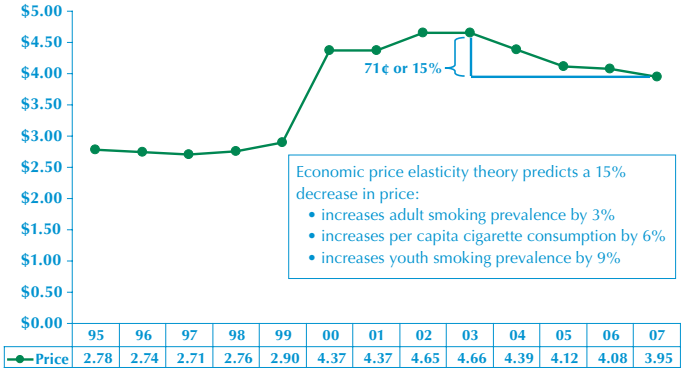
Historically, California has led the way in defining comprehensive tobacco control best practices.[4, 25-27] As the first comprehensive tobacco control program in the country, California tobacco control agencies have created an effective and sustained infrastructure for the development and delivery of programs, education and research. These efforts have decreased smoking and disease rates and increased the number of Californian lives saved.[28] Nevertheless, in order to further reduce tobacco-related disease and death in California, efforts need to focus on increasing the price of tobacco and funding for tobacco control.[4, 29]

Raise California's Tobacco Tax

California has failed to increase its tobacco tax in 10 years and is one of only six states without an increase since 2001.[11] As a result, California's tobacco tax and tobacco prevention spending ranks 30th among states, and will continue to drop unless the tobacco tax is increased with an earmark for tobacco control.

Figure 1

Average Price including Inflation (Adjusted to 2007 Dollars for a Pack of Cigarettes)



	95	96	97	98	99	00	01	02	03	04	05	06	07
Price	2.78	2.74	2.71	2.76	2.90	4.37	4.37	4.65	4.66	4.39	4.12	4.08	3.95

Source: Tax Burden on Tobacco and the California Consumer Price Index from the California Department of Finance. The average price is given in 2007 dollars. 2007 Price data is preliminary.

In the past four years (2003–2007), the real price of cigarettes has decreased by approximately $0.71 per pack. This effect has diminished the impact of past tax increases on cigarette consumption and use (Figure 1).

A tobacco tax is not only a revenue source to fund tobacco control, but the most effective strategy to decrease consumption, increase cessation, and reduce youth uptake. Significant benefits include lowering overall healthcare costs in California. Researchers estimated that smoking accounts for 16.2 percent of all Medi-Cal costs.[30] At a minimum, a $1.50 tobacco tax with a tobacco control earmark would generate 275,000 quitters among current smokers and prevent over 400,000 youth from starting. In the long run, approximately 180,000 deaths due to smoking would be prevented.[12]

TEROC recognizes that raising the price of tobacco is a vital tobacco control strategy that must allocate a significant amount (at least 16.67 percent) to tobacco control to accelerate progress in California. Furthermore, as a tobacco tax is a declining revenue source, TEROC supports efforts to minimize funding declines by providing backfill and including periodic tax adjustments to offset inflation.[29]

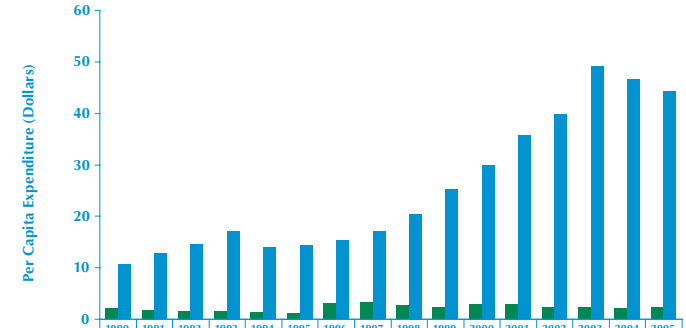
The CDC *Best Practices for Comprehensive Tobacco Control Programs—2007* (Best Practices) states: "California has the potential to be the first state in which lung cancer is no longer the leading cancer cause of death."[4] Unfortunately, this will never become a reality without a strong commitment throughout the state to further increase the price of tobacco and to adequately fund tobacco control efforts.

A tobacco tax increase should be viewed as a cost-effective policy intervention that will not only decrease California's smoking prevalence, but also significantly improve health and result in long-term savings in California healthcare costs.[31-33]

Increase Tobacco Control Spending

California's tobacco control spending falls far below federal recommendations and tobacco industry marketing expenditures. The 2007 CDC Best Practices recommends California spend $441.9 million annually on tobacco control to fund state and community interventions, media, cessation, surveillance and evaluation, and administration and management.[4]

Figure 2
Per Capita Tobacco Industry and Tobacco Control Expenditures in California, 1990-2005*



	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
Tobacco Control	$2.15	$1.73	$1.68	$1.44	$1.41	$1.20	$3.15	$3.38	$2.59	$2.25	$2.97	$3.01	$2.32	$2.27	$2.09	$2.24
Tobacco Industry	$10.70	$12.82	$14.65	$17.18	$13.94	$14.35	$15.23	$17.06	$20.37	$25.18	$29.97	$35.66	$39.86	$49.07	$46.61	$44.22

* California tobacco industry expenditures calculated as a proportion of U.S. expenditures based on total population size as reported by the U.S. Census Bureau. Both tobacco control and tobacco industry expenditures have been standardized to the U.S. 2005 dollar, based on the Consumer Price Index (CPI). Tobacco control expenditures are a combination of media campaign, competitive grant, local lead agencies (LLA), tobacco settlement fund, and California Department of Education HEA totals. Tobacco industry expenditures taken from the Federal Trade Commission Cigarette Report for 2005, issued 2007.

In spite of the progress made, the tobacco industry's clever marketing tactics, price promotions, and dollars spent to influence tobacco-related policy at the state and local levels have only increased over time. In 1990, the tobacco industry spent five times the amount California spent on tobacco control efforts (Figure 2). By 2005, the tobacco industry was spending 20 times more than California.

Reverse Tobacco Control Funding Declines

Tobacco funding declines are a product of decreased tobacco consumption, reductions in purchasing power, and the diversion of funds from Proposition 99 accounts to other state programs and services, including the California Cancer Registry. Funding declines weaken agency infrastructure, research, education, program delivery, and the media campaign.[13]

The American Lung Association's (ALA) annual "Report Card" on tobacco control for 2007 reflects California's continued funding decline. While local and statewide smoke-free and youth access policies reflect past gains, the ALA Report Card underscores California's need to increase the price of tobacco and reinvest in tobacco control.[34]

Budget recommendations

Tobacco control funding recommendations are based on many factors. For example, the 2003–2005 Master Plan funding recommendations were based proportionately to Tobacco Industry advertising and promotion expenditures.

A Healthcare Strategy:
In the first 15 years of California tobacco control efforts, $86 billion was saved in personal healthcare costs, representing a nearly 50-fold return on the $1.8 billion investment.[3]

A tobacco tax increase should be viewed as a cost-effective policy intervention that will not only decrease California's smoking prevalence, but also significantly improve health and result in long-term savings in California healthcare costs.[31-33]

The 2007 Institute of Medicine's (IOM) *Ending the Tobacco Problem: A Blueprint for the Nation* recommends an annual per capita range of $15 to $20,[29] while the CDC Best Practices recommends California have an annual budget of $441.9 million.[4]

ALA 2007 REPORT CARD
CALIFORNIA

Smoke-free policies..... A
Youth access ..... A
Tobacco control spending..... F
Tobacco taxes..... D

While a variety of recommendations exist, the only realistic funding source for California is a tobacco tax. As such, the Master Plan funding recommendations have been based on the tobacco tax recommendation with a funding earmark for Tobacco Control of $0.25 per pack.

Table 1 provides TEROC's recommended annual budget for California tobacco control agencies in fiscal years 2009–2011. The increase would more than double current tobacco control funding and would more closely reflect appropriate state tobacco control funding levels recommended by the IOM and the CDC.

Table 1: Budget Proposal for California Tobacco Control Agencies, Fiscal Years (FY) 2009–2011

Program Component	Original Tobacco Control Distribution	Actual FY 08-09 budget (in millions)	Recommended FY 08-09 budget (in millions)*	Recommended FY 09-10 budget (in millions)*	Recommended FY 10-11 budget (in millions)*
CDPH/CTCP	51%	$55.6	$164.3	$164.3	$164.3
CDE/SHKPO	25%	$23.1	$80.5	$80.5	$80.5
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Total	100%	$93.3	$322.1	$322.1	$322.1

* Recommendations assume annual baseline of $91 million from the Health Education and Research Accounts, as well as the projected revenue from a $1.50 tax increase with a minimum 16.67 percent ($0.25) earmark. Future year recommendations assume constant revenue due to the average annual rate of inflation matching the annual decrease in tobacco consumption (3 percent).

Monitor Agency Compliance with Legislative Mandate

As defined by California Health and Safety Code Sections 104350-104495 and 104500-104545, it is the duty of TEROC to provide oversight and ensure California's three tobacco control agencies meet their legislative mandate. Over the years, Proposition-99-funded agencies have faced significant changes. Most recently, the University of California Office of the President (UCOP) has been mandated to make organizational adjustments in order to decrease administrative costs, and subsequently increase research funding. They are currently in the process of creating a centralized procurement system among their various research programs, including TRDRP.

At this time, TEROC is very concerned with the UCOP proposal and process used to implement structural and administrative changes. While TEROC supports efforts to create efficiencies and improve California's tobacco control research, TEROC is dissatisfied with the level of detail the UCOP has provided concerning budget savings and the steps that will be taken to ensure TRDRP meets their legislative requirements.

TRDRP has played a critical role in the success of the California tobacco control effort, and its focus on policy and public health research are recognized nationwide for their

innovation. TRDRP should continue important research dissemination and work in collaboration with the CDPH/CTCP and CDE/SHKPO.

TEROC has requested the UCOP allow TRDRP a two-year moratorium from any major changes including a centralized grant review process, or until such time that the UCOP can provide a more concrete justification, including detailing the cost savings from the reorganization. The UCOP should also seek stakeholder input regarding any organizational changes that would alter TRDRP's mission, as set forth by legislation. For the 2009–2011 Master Plan, TEROC will continue to monitor and provide oversight for all agencies, specifically the proposed changes to TRDRP and how any new TRDRP structure addresses the goals set forth in the Master Plan.

Implement New TUPE Funding Grant Process for Schools

In January 2004, the Tobacco-Use Prevention Education (TUPE) Recommendations Task Force—a body of state and national experts in research, program evaluation, county and school district administration, and classroom program implementation—developed 11 recommendations to establish the ways in which schools can best work with youth, their families, and their communities to change social norms and individual behavior regarding the use of tobacco.[35] Based on these recommendations, the California Legislature enacted Assembly Bill (AB) 647 (Salas, Chapter 135, Statutes of 2007) to implement new grant requirements. Beginning July 2009, the changes will create a unified competitive grant mechanism for awarding school-based funds for anti-tobacco programs and cessation activities, and will replace the existing three separate funding mechanisms. This will allow the California Department of Education (CDE) TUPE to better deliver an effective, cost-efficient, evidence-based, statewide, and school-centered program.

Increase Media Campaign Spending

California's Tobacco Control Media Campaign is a vital component of a comprehensive program and helps provide support to the overall program direction throughout the State. The media campaign should reach general and priority populations, be culturally and linguistically appropriate, promote cessation and reductions in secondhand smoke exposure, and allow for flexibility to respond to new tobacco industry tactics.[36]

CDC *Best Practices* recommends that California spend $3.02 per capita annually (approximately $108 million) on the tobacco control media campaign. However, California media expenditures are now only $0.44 per capita and fail to reflect the significant increases in media placement costs over the past two decades.[12] Without a funding increase, continued decreases in purchasing power will reduce ad placement and the number of media markets served.

OBJECTIVE 2: Eliminate Disparities and Achieve Parity in All Aspects of Tobacco Control

- Incorporate cultural competency and parity standards, processes, and infrastructure for all Proposition-99-funded agencies. Efforts should not only advance knowledge, competencies, organizational practices, and program delivery for priority populations, but also strengthen community capacity in tobacco control, research and education.
- Increase the cultural capacity and infrastructure of TUPE programs and curriculum within schools. Programs should focus on cultural diversity, be culturally and linguistically appropriate for each school community, and involve students' families and neighborhoods in tobacco use prevention among youth.
- Identify innovative community and school programs for priority populations throughout the state for all Proposition-99-funded agencies.
- Research and evaluate tobacco use in priority populations to increase the effectiveness of Proposition-99-funded intervention strategies and policies.
- Develop mechanisms to identify, translate, and disseminate research and educational materials for application among tobacco control agencies and priority populations.
- Research and evaluate the associations between tobacco use, mental health, and substance abuse, and develop effective prevention and cessation strategies.

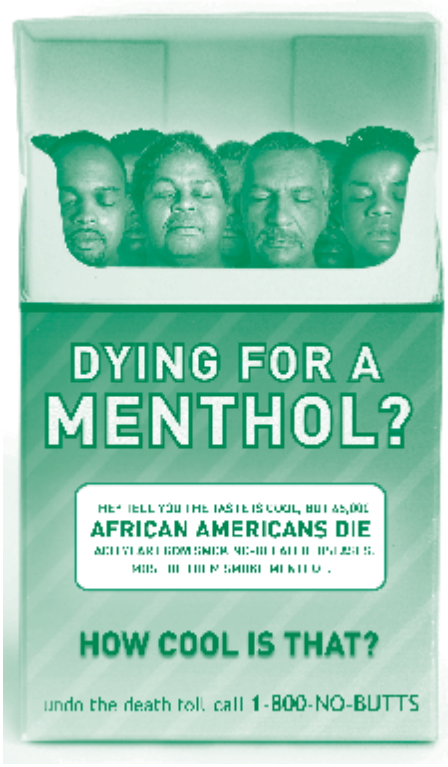
Priority Populations

California's tobacco-related priority populations comprise a variety of demographic groups, defined by race/ethnicity, language, sexual orientation, socioeconomic status, and field of employment (e.g. military or labor). These groups are disproportionately impacted with high rates of morbidity and mortality, secondhand smoke exposure, and economic hardship due to tobacco use. In addition to the many social factors contributing to these disparities, the tobacco industry directly targets specific communities and cultures to further exploit California's diverse social, racial, ethnic, and economic groups.[14, 15] The purpose of this objective is not to separate priority populations from the whole of tobacco control efforts, but rather to identify high-risk populations, eliminate tobacco-related disparities, and create parity in California.

Though California's smoking rates have declined overall, significant disparity exists among African Americans, American Indian and Alaska Natives, some Asian Americans and Pacific Islanders, Hispanic/Latino men, the lesbian, gay, bisexual, and transgender (LGBT) populations, and those with low socioeconomic status (SES).[14, 37, 38] Additional populations include blue and/or pink collar workers, the military, and rural residents.[39]

Eliminate Disparity

Internally, tobacco control agencies should develop appropriate approaches for identifying high-risk populations and develop specific strategies to eliminate tobacco-related disparities in California. Where appropriate, research should collect data related to tobacco use among specific populations (e.g., tracking LGBT representation among California Smokers' Helpline callers). Externally, program efforts should not be limited to priority populations, but should seek to improve the capacity of every community to address issues of disparity.



Achieve Parity

Programs and agencies should seek to achieve parity in tobacco control by building a significant knowledge base that allows agencies and programs to create evidence-based solutions. TEROC believes that tobacco control agencies should continue to develop and strengthen their infrastructure, research, evaluation, programs, and resources in order to achieve this objective.

Research Mental Health and Substance Abuse

In addition to the priority populations identified above, high rates of tobacco use exist among individuals with mental health and substance abuse disorders.[40, 41] These are factors which affect both general and priority populations in California. While the risk for tobacco use is well documented, further research is needed to understand the associated risk factors, and appropriate interventions or policies needed. Agencies should seek to improve the services and protections available to individuals with mental health or substance abuse disorders.

OBJECTIVE 3:
Decrease Secondhand Smoke Exposure

- Increase restrictions at the federal, state and local levels that eliminate secondhand smoke exposure. Protections include:
  - Eliminating exemptions found in Labor Code 6404.5;
  - Restricting smoking in multi-unit housing;
  - Classifying secondhand smoke as a public nuisance; and
  - Adopting comprehensive smoke-free outdoor policies.
- Increase tribal, community, and state efforts to protect workers employed within California American Indian casinos from secondhand smoke exposure, commensurate with protections afforded by California Labor Code (Section 6404.5), while respecting tribal sovereignty.
- Develop mechanisms to support consistent, local compliance and enforcement of all state and local smoke-free laws and tobacco-free school policies.
- Increase legislative, regulatory, and voluntary policies that restrict smoking in multi-unit housing.
- Promote voluntary smoke-free policies in private homes.
- Research and evaluate secondhand smoke exposure, including attitudes, beliefs, health effects, and policy implementation.
- Increase the knowledge, attitudes and practices of the public, policy makers, media, and the business community related to secondhand smoke and policies to eliminate exposure.
- Increase the knowledge, implementation, and compliance of California's smoke-free car law (Health and Safety Code 118947).
- Support the California Air Resources Board in adopting regulations related to the classification of secondhand smoke as a Toxic Air Contaminant.

Findings and Regulation

In 2006, the California Air Resources Board classified secondhand smoke as a Toxic Air Contaminant and the United States Surgeon General concluded, "there is no risk-free level of secondhand smoke."[16, 17] Along with cervical, lung, and breast cancer, secondhand smoke health risks include asthma, heart attack, sudden infant death syndrome, and stroke.[42]

Research on indoor ventilation systems and standards concludes that ventilation is not able to eliminate indoor secondhand smoke exposure.[16, 17] In fact, the American Society of Heating, Refrigerating and Air-conditioning Engineers (ASHRAE) concludes that "the only means of effectively eliminating health risks associated with indoor exposure is to ban smoking activity."[43]

Over the course of the 2006–2008 Master Plan, California has seen a dramatic increase in the number and type of secondhand smoke policies across the state, ranging from smoke-free beaches and comprehensive outdoor policies to smoke-free cars with minors and smoke-free multi-unit housing. The adopted policies reflect the latest research, as well as a

strong public desire to eliminate involuntary secondhand smoke exposure in California. Yet many locations and populations in California remain without adequate secondhand smoke protections.

Eliminate Labor Code Exemptions

In 1995, California became the first state to pass legislation banning smoking in most indoor workplaces [Assembly Bill (AB) 13]. While 14 exemptions were included in the state Labor Code (Section 6404.5) at the time of passage, AB 13 was considered the most comprehensive state policy. Since then, 22 states have adopted stronger and more comprehensive smoke-free indoor workplace policies. Today, California's exemptions preclude the CDC from acknowledging California as being a smoke-free state.[44] TEROC encourages the Legislature and the Governor to support updating the Labor Code to eliminate all smoke-free workplace exemptions, once again establishing California as a leader in smoke-free workplace protections.

Restrict Smoking in Multi-Unit Housing

With approximately 11 million Californians (34 percent) living in multi-unit housing, many are left unprotected from involuntary secondhand smoke exposure in their homes.[45] Multi-unit housing locations include apartments, townhouses, and condominiums.

Secondhand smoke can move into an adjacent unit through hallways, cracks in walls and floors, shared ventilation systems, or even through electrical outlets and plumbing fixtures.[17] Tenants are also exposed involuntarily on balconies, patios, and at other common areas of their residence. With greater rates of priority populations living in multi-unit housing, these populations have a greater risk for involuntary secondhand smoke exposure.[46]

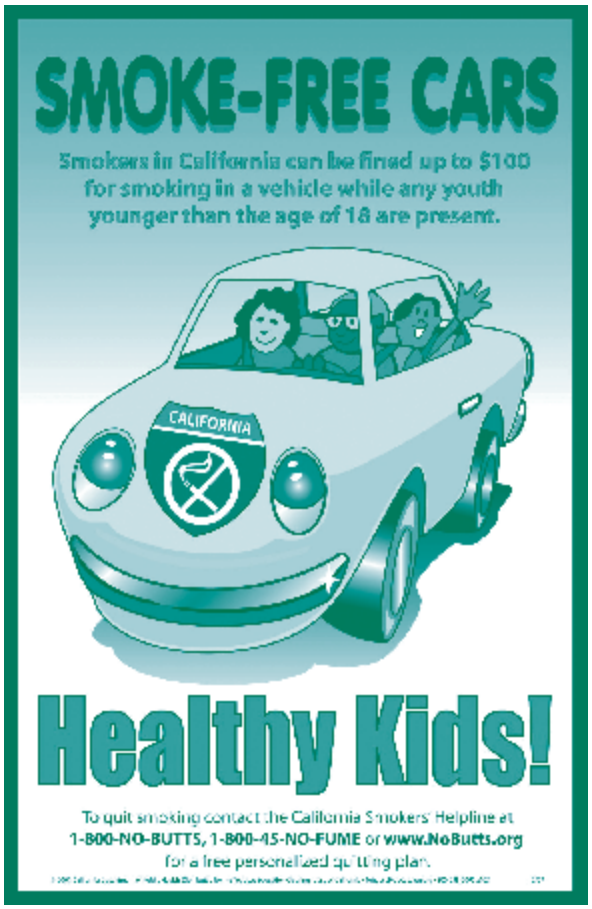
There are a number of approaches that can be utilized to increase protections from secondhand smoke within multi-unit housing. In the past three years, local legislative bodies have responded by adopting ordinances to create smoke-free multi-unit housing in their communities. Cities such as Calabasas, Belmont, Oxnard, and Oakland have adopted policies that include the following provisions:

- Restricting smoking in residential units, patios, balconies, and indoor and outdoor common areas;
- Limiting/restricting grandfathering provisions;
- Classifying secondhand smoke a nuisance;
- Requiring disclosure of smoking policies to prospective tenants or buyers.[8]

Classify Secondhand Smoke as a Nuisance

Classifying secondhand smoke as a public nuisance provides a legal avenue for individuals to take action to protect themselves from exposure. In 2007, the cities of Calabasas and Dublin classified secondhand smoke as a nuisance.[8] In the past, local municipalities and the state

government have imposed prohibitions on personal activities based on the existence of either a hazard or a nuisance. Similar to noise, odor, and lighting, drifting secondhand smoke not only interferes with one's "comfortable enjoyment of life or property,"[47] but also presents a significant health hazard.



Implement and Enforce the "Smoke-free Cars with Minors" Law

On January 1, 2008, California adopted a comprehensive smoke-free car law to protect youth under the age of 18 from involuntary exposure in a vehicle. In a car, the level of toxic secondhand smoke can be more than ten times greater than the level which the United States Environmental Protection Agency considers hazardous.[48] In fact, secondhand smoke can be absorbed by car fabric, car seats, toys and other car surfaces within minutes of a cigarette being smoked.[49, 50] With the passage of Senate Bill 7 in 2007 (Health and Safety Code, Section 118947), smokers can be fined up to $100 for smoking in vehicles when youth are present. TEROC supports implementation and enforcement of this law.

Adopt Comprehensive Smoke-free Outdoor Policies

Within one month of the California ARB classifying secondhand smoke as a Toxic Air Contaminant, the City of Calabasas became the first city in the nation to adopt a comprehensive smoke-free outdoor policy. A comprehensive smoke-free outdoor policy is defined as one that prohibits smoking in at least five of the seven major outdoor areas: outdoor dining areas, entryways, public events, recreation areas, service areas, sidewalks and worksites.[7]

In addition to the 2006 California ARB classification and United States Surgeon General's report on secondhand smoke, research concludes that outdoor secondhand smoke can present a nuisance and health hazard.[51] While specific locations, such as entryways, outdoor dining areas, and bus shelters have a greater risk for secondhand smoke exposure, several municipalities have found the health risks compelling enough to adopt a comprehensive outdoor policy. Smoke-free outdoor policies not only reduce exposure, but also have an impact on reducing smoking consumption by limiting the areas where smoking is allowed and reduce adult modeling of tobacco use to youth in the community. Outdoor policies also mitigate environmental impacts, such as litter and fire risk.

OBJECTIVE 4: Increase the Availability and Utilization of Cessation Services

- Increase availability and utilization of FDA-approved pharmacotherapy to uninsured smokers.
- Include smoking cessation coverage as a mandatory benefit under all health insurance plans. Cessation coverage should include culturally and linguistically proficient medical counseling and medically mediated treatment (nicotine replacement therapy and other pharmaceutical aids) when appropriate.
- Increase employer programs and policies which provide cessation services, create smoke-free campuses, and promote workplace wellness.
- Encourage healthcare providers and allied health professionals to routinely assess smoking status and to implement the Clinical Practice Guidelines on Tobacco Use and Dependence Update. (http://www.surgeongeneral.gov/tobacco)
- Increase collaborative programs that offer incentives and reduce barriers to cessation counseling and referrals within healthcare settings for all smokers.
- Research, evaluate, and promote strategies to increase cessation rates and support relapse prevention among priority populations, high school age youth, young adults, intermittent smokers, and individuals with mental illness or substance use disorders.
- Strengthen policies and programs to increase awareness and utilization of existing services, including the California Smokers' Helpline.
- Ensure that cessations materials are culturally and linguistically appropriate, and accessible to priority populations.
- Encourage state and county First 5 Commissions to increase financial commitment and support of programs and mass media that address smoking cessation and SHS exposure in their targeted populations.

Cessation continues to be a vital component of California's comprehensive programs. With a majority of smokers (75.3 percent) considering quitting in the next 6 months,[18] it is necessary to increase the availability and utilization of cessation services to assist the majority of smokers who are unable to quit on their own. While numerous cessation services and a variety of FDA-approved medications exist, many smokers are still unable to access or utilize appropriate treatments.

To make significant progress toward a tobacco-free California, an increase in the successful quit rate of current smokers is essential. To that end, a concerted effort is required across both the public and private sectors. TEROC recommends increasing the availability and utilization of FDA-approved pharmacotherapy to uninsured smokers, increasing coverage, ensuring the efficacy of workplace cessation services, and increasing the number of collaborative programs and policies which reduce barriers to receiving cessation services.

Implement Clinical Practice Guideline

The Clinical Practice Guideline on *Treating Tobacco Use and Dependence: 2008 Update* (the Guideline Update) specifies effective, evidence-based

treatments and practices to treat tobacco dependence. The Guideline Update identifies seven FDA-approved medications available for cessation treatment, supports both counseling and medication strategies, and emphasizes the effectiveness of tobacco cessation telephone helplines (quitlines) to increase quitting success. The Guideline Update calls not only on clinicians, but also health systems, insurers, and purchasers to increase the availability and utilization of services.[20] TEROC supports the use of the 2008 Guideline Update as a roadmap for clinicians to address tobacco cessation with their patients.

Increase Partnerships

As identified in the Guideline Update, partnerships are required to increase the availability, use, and effectiveness of cessation services. In recent years a number of California partnerships have developed. For example, the *Be Proactive: Help Your Patients Quit Smoking* campaign was established in 2004 as a collaboration to increase cessation rates among people with diabetes. The California Diabetes Program and California Tobacco Control Program worked together to target healthcare providers of diabetes patients to encourage them to refer their patients to the California Smokers' Helpline. Over a one year time period (2006–2007), the proportion of calls to the Helpline from people with diabetes increased by 14.4 percent (3,124 calls).

Further the California Smokers' Helpline (Helpline)

Since 1992, the Helpline has been a central element in the delivery of California cessation services. Established as the nation's first telephone cessation center, the Helpline provides tobacco cessation telephone counseling free of charge to all Californians. Data show that counseling provided by the Helpline approximately doubles the likelihood of successful quitting. The Helpline is not only efficacious, but is also a cost-effective, centralized cessation service.[52]

Today, one-on-one counseling services are available for adults, teens, pregnant women and smokeless tobacco users. Counseling and materials are culturally and linguistically appropriate, and are highly utilized by priority populations and low income smokers (approximately half

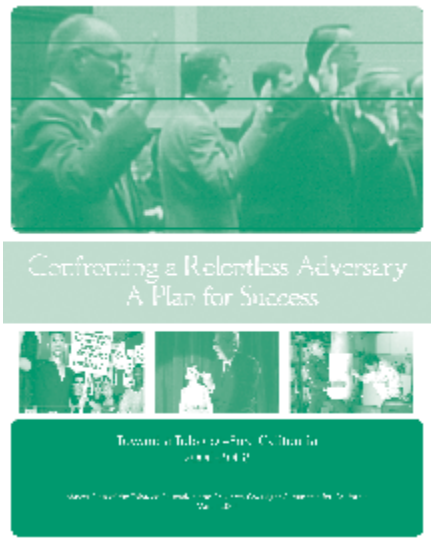
the callers have Medi-Cal). TEROC supports strengthening the Helpline to ensure that every Californian has access to cessation counseling throughout the state.

OBJECTIVE 5: Limit and Regulate Tobacco Industry Products, Activities and Influence

- Oppose any preemptive statewide tobacco control legislation (i.e., legislation that prohibits local governmental entities from adopting stronger regulatory measures).
- Prohibit the sale of tobacco products by pharmacies and drug stores.
- Prohibit free distribution of tobacco products or coupons at any event or location, as well as distribution by mail, Internet, or any other electronic or wireless technology
- Require all K-12 schools in California to be tobacco-free, and prohibit the acceptance of donations, funding, or sponsorships from the tobacco industry, including the display, use, or distribution of Tobacco Industry curriculum or materials.
- Increase the number of comprehensive tobacco-free school policies among academic institutions which include public, charter, and private schools, colleges, universities, and vocational institutions.
- Encourage system-wide adoption of tobacco-free policies at all academic institutions, and prohibit the acceptance of tobacco industry funding for research at all publicly funded institutions of higher learning in California.
- Ensure the accountability of the University of California Board of Regents Resolution for tobacco industry-funded research
- Increase the number of local tobacco retailer licensing laws with fees high enough to fund strong enforcement programs, and include adequate fines and penalties including license suspension and revocation.
- Continue to regulate, monitor, and report on tobacco industry practices, which include campaign and lobbying contributions, research initiatives, and targeting young adults, communities, and priority populations.
- Encourage members of the California Legislature and other public officials to refuse donations from the tobacco industry, its representatives, and its subsidiaries.
- Encourage all public and private organizations to refuse tobacco industry funds for event sponsorships and donations.
- Control direct marketing and targeting efforts of the tobacco industry, including promotions, sponsorships and advertising at public or private events, or locations such as rodeos, automotive events, concerts, community fairs and festivals, and other venues.
- Research the legal and economic implications of tobacco industry practices that reduce tobacco prices and strengthen strategies to restrict point-of-purchase distribution practices, such as multi-pack discounts, coupons, and buy-down programs.
- Support the efforts of the Attorney General of the State of California to hold the tobacco industry accountable by continuing to actively enforce laws and tobacco litigation findings or legal agreements such as the United States Department of Justice Racketeering conviction or the Master Settlement Agreement.
- Support efforts to decrease tobacco use in movies:
    - Rate new movies showing smoking “R”
    - Certify no pay-offs

- Require strong antismoking ads prior to smoking movies
- Stop identifying tobacco brands

- Support strong federal regulation of the tobacco industry.
- Support ratification of the World Health Organization's Framework Convention on Tobacco Control.
- Prohibit projects funded by California tobacco control agencies from promoting the use of reduced-risk tobacco products as either substitutes or complements to proven cessation strategies.



The 2006–2008 Master Plan, *Confronting a Relentless Adversary,* focused on the tobacco industry as a vector for the spread of tobacco-related disease and death in California. Though the Master Plan theme has changed for 2009–2011, TEROC continues to place a high priority on confronting the tobacco industry's continued attempts to undermine California's tobacco control efforts.

Between 2006 and 2009, the tobacco industry spent millions in California to prevent tobacco tax increases. In 2006, the industry spent over $62 million to defeat a $2.60 tobacco tax ballot initiative that lost by only 289,331 votes.[21, 53] More recently, the industry increased their lobbying expenditures to oppose a $1.75 per pack tobacco tax increase intended to fund healthcare reform (AB X1-1). From October 1, 2007, to March 31, 2008, Philip Morris USA Inc. alone spent $887,286 to lobby against healthcare reform and two other bills.[23]

TEROC supports strong regulation of the tobacco industry at every level of its operation. In order to effectively regulate and limit the products, activities, and influence of the tobacco industry, local, state, and federal controls must work together to protect Californian's lives and health from the ill effects of tobacco use. Efforts include holding the tobacco industry accountable for their 2006 conviction by the United States Department of Justice for violating the Racketeer Influenced and Corrupt Organizations (RICO) Act.[54]

Restrict Tobacco Industry Access to Academic Institutions

Without question, all academic institutions should be free from tobacco industry influence. Comprehensive tobacco-free policies should prohibit tobacco use, sales, and distribution on campus or at school-sponsored events. Policies must also restrict all tobacco industry advertisement, sponsorship, donations, gifts, funded research, and the use or distribution of tobacco industry curriculum or materials.[55]

Prohibit Tobacco-Industry-Funded Research

At this time, California public colleges and universities continue to allow tobacco-industry-funded research to be conducted. When challenged, opponents claim that any restriction will create a slippery slope and erode academic integrity. On September 30, 2007, the

Board of Regents of the University California adopted a resolution requiring a special review process to approve any future tobacco-industry-funded research.[56] TEROC questions the Resolution's impact on limiting tobacco industry influence on research, and supports efforts to ensure public accountability of the Resolution. Presently, policies and procedures are to be established by each campus "as needed."

Enforce Local, Tobacco-Retailer Licensing

The retail environment needs strong local, tobacco-retailer policies throughout California. Local policies are aimed at creating a level playing field for tobacco retailers to sell to adults, and preventing illegal sales to youth. Strong, tobacco-retailer-licensing policies must require an annual fee which adequately funds enforcement activities. Reasonable penalties include suspension or revocation of local licenses for violations of any tobacco control law. TEROC continues to encourage local governments to enact and enforce all local, tobacco-retailer-licensing laws with sufficient penalties to ensure compliance with the law.

"…defendants have marketed and sold their lethal products with zeal, with deception, with a single-minded focus on their financial success, and without regard for the human tragedy or social costs that success exacted."

– Judge Gladys Kessler, U.S. Department of Justice

Limit Point-of-Sale Advertising, Price Reductions, and Free Distribution

The tobacco industry continues to spend significant amounts implementing price-based marketing strategies to reduce the cost of tobacco products. At the point of sale, these strategies take the form of multi-pack discounts, coupons, and buy-down incentives.[57, 58] In-store advertising continues to be pervasive, especially within predominantly African-American neighborhoods.[59]

The free distribution of tobacco products occurs at bars, college fraternities and sororities, and community events such as rodeos, auto races, and LGBT Pride events. In return for free samples, tobacco companies often collect personal data from potential customers, and use the information to send them coupons and other promotional materials, as part of targeted direct mail advertising campaigns.

In 2007, Chico became the first city in California to prohibit the free distribution of smokeless tobacco and cigarettes. Policies such as this should not only restrict free distribution, but should also consider other strategies the tobacco industry will utilize in an effort to increase the availability of free or low-cost tobacco products. Strategies include the distribution of coupons for tobacco products in-person, through the mail, and with the use of other electronic or wireless technology.

Prohibit Tobacco Sales by Pharmacies and Drug Stores

TEROC objects to the continued sale of tobacco products in pharmacies and drug stores. Selling tobacco products sends misleading messages that conflict with a pharmacy's purpose of promoting health. With the urging of the healthcare community, tobacco control advocates,

and the general public, many of California's independent pharmacies have stopped selling tobacco products. In contrast, almost all chain drug stores continue to sell tobacco, many of which also display tobacco advertising.[60]

Since tobacco product sales by pharmacies and drug stores have low margins and typically make up less than 1 percent of their total sales, there is little reason to continue this practice.[61] Pharmacies and drug stores offer health-promoting products and services just down the aisle from displays of tobacco products.[62, 63] In fact, a 2003 study in San Francisco found that 55 percent of tobacco-selling pharmacies displayed over-the-counter cessation products right next to the cigarettes.[60]

On July 29, 2008, San Francisco became the first city in California to pass a tobacco-free pharmacy policy, prohibiting San Francisco pharmacies (excluding grocery stores) from selling tobacco products. TEROC calls for measures which prohibit pharmacies and drug stores from continuing to perpetuate tobacco addiction, disease, and death by selling or advertising tobacco products.

Restrict Exposure to Smoking in Movies

Continued research concludes that exposure to tobacco use in movies relates to positive attitudes about tobacco and tobacco use among youth.[64] Opponents of smoke-free movies claim that rating films based on tobacco use and product placement will compromise artistic integrity or creative choice.[65] Unfortunately, smoking and tobacco products continue to be depicted in movies, specifically in youth-rated (G, PG, and PG-13) films. In fact, by 2002, the amount of smoking in movies had reached a comparable level to that of the 1950s, specifically in youth-rated films.[66]

As countless individuals, organizations and agencies join the fight to limit the glamorization of tobacco use in film, some recent successes have been achieved. In 2007, the Motion Picture Association of America (MPAA) decided to include smoking as a factor in rating films, asking the following three questions: "Is the smoking pervasive? Does the film glamorize smoking? Is there a historic or other mitigating context?"[67] On July 11, 2008, six major Hollywood studios (Sony Pictures, Universal Studios, Time Warner, Paramount Pictures, Walt Disney Studios, and Twentieth Century Fox) agreed to include California's antismoking ads on DVDs of all new youth-rated movies that depict tobacco use.[68]

It is time the Movie Industry takes more responsibility. While Hollywood's response is a step in the right direction, they have not yet adopted a policy to rate new smoking movies as "R". Adoption of this policy would make all youth-rated films tobacco-free and help reduce teen smoking. TEROC will continue to support adoption and implementation of each policy recommendation, and push Hollywood to go beyond simple changes.

Restrict Tobacco Industry Sponsorship and Community Involvement

"Corporate responsibility" and "responsible business" are terms used today to indicate a business or industry's obligation and efforts to have a positive impact on society and the environment. While the tobacco industry tries to build good will and social acceptance by supporting community events, organizations, charitable causes, scholarships, sponsorships, and specialty media, they continue to market and sell an addictive and deadly product to the public.[69] In reality, their efforts are only window dressing aimed at increasing social acceptability while further targeting specific populations and age groups.

The tobacco industry is aware that negative attitudes about the tobacco industry are associated with a decreased desire to smoke and a greater desire to quit.[36] Tobacco control advocates should continue to reveal deceptive practices of the tobacco industry to the public and work to increase the number of public and private events and organizations that refuse tobacco industry funds, sponsorships, and donations.

Prohibit Promotion of "Reduced Risk" Tobacco Products

"Reduced risk" or "harm reduction" refers to cigarette alternatives that are viewed by some to decrease risk of certain types of tobacco-related disease. The strategy is seen as a substitute for cessation and is utilized by the tobacco industry to maintain addiction by encouraging smokers to use alternative tobacco products.

Without evidence, such products (namely non-combustible smokeless tobacco) are marketed as being "less harmful," and give users a false sense of safety. These products are also advertised as a means to avoid smoking restrictions. In reality, "reduced risk" products undermine tobacco control strategies by prolonging or even preventing quit attempts.[70]

Some tobacco control advocates also support efforts to promote "harm reduction" as a reasonable alternative for those who are considered unable or unwilling to quit. However, the strategy only substitutes certain disease risks for others, and fails to consider the negative health consequences. In reality, when considering the population-based impact from promoting smokeless tobacco, overall prevalence and healthcare costs are anticipated to increase.[71]

California's strategy of changing social norms concerning tobacco use and secondhand smoke has been successful at increasing cessation and decreasing the likelihood of initiation. TEROC's vision of a tobacco-free California does not support the harm reduction strategy and believes that promoting these products as an alternative to maintain an addiction will not reduce risk.

Conclusions for 2009-2011 Master Plan

Proposition 99 allowed California to lead the nation and world in reducing tobacco-related disease and death. In order to create a tobacco-free California, funds were invested to assist smokers in quitting, develop effective new state and local programs, establish a groundbreaking research program, educate the public through mass media campaigns, create smoke-free spaces and tobacco-free schools, and limit the deceptive practices of the tobacco industry. In 20 years, California has made significant strides, created evidence-based best practices which are used around the world, and has decreased cigarette consumption in California by 61 percent. These victories have not only protected health and saved lives, but have also reduced the significant healthcare costs related to tobacco use.

Despite these victories, the tobacco industry continues to undermine our progress and is now outspending California 20 times over. Their innovative marketing practices target California's high risk populations, and their campaign contributions and lobbying expenditures underscore that California is still a major battle ground.

TEROC's 2009–2011 Master Plan is a call to the Legislature that the funds invested in California Tobacco Control have become an endangered investment. To achieve reductions in smoking prevalence, California must increase the price of tobacco with a significant earmark to reinvest in tobacco control.

TEROC recommends a tobacco tax increase of at least $1.50 per pack with 16.67 percent ($0.25) earmarked to fund the California tobacco control agencies.

With this renewed investment, it is estimated that 275,000 California smokers would quit, and 400,000 youth would never begin smoking. The tax increase would save approximately 180,000 lives.

The next three-year period represents a critical milestone in California's tobacco control movement. There must be a commitment to protect progress, regain momentum, and realize the vision of a tobacco-free California.

Progress toward a Tobacco-Free California: 2006-2008

California's tobacco control progress is best measured by documenting changes in smoking prevalence, consumption, and tobacco-related disease and death. Below, TEROC reports the most current data and provides a three-year progress report concerning the objectives set forth in the 2006–2008 Master Plan.

Prevalence

The 2006–2008 Master Plan set a goal of reducing smoking prevalence in California to 10 percent among adults, and 8 percent among high school students, by the end of 2008. At the end of 2007 (the most recent data available), the smoking prevalence rate among adults was 13.8 percent. In 2006, smoking prevalence among high school age youth, grades 9 through 12, had increased to 15.4 percent (from 13.2 in 2004).

General adult population:

While the adult smoking prevalence rate in 2006 reached a historic all time low of 13.3 percent, prevalence increased to 13.8 percent in 2007 (Figure 3). Though this increase was not statistically significant, adult smoking prevalence had not increased since the definition of smoking was changed in 1996 to include more occasional smokers.

The overall prevalence decrease shows a 35 percent drop since the passage of Proposition 99 in 1988 by the California voters.

20 Years of Progress

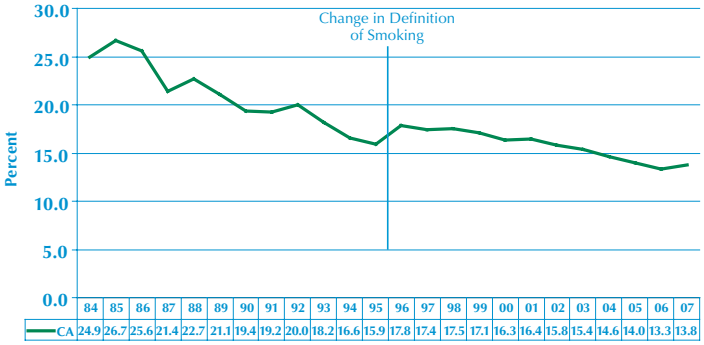
TEROC celebrates a major milestone: the 20th anniversary of the passage of the California Tobacco Tax and Health Protection Act (Proposition 99). In 1988, California voters made their intention loud and clear to create the first comprehensive statewide tobacco control program that would reduce the disease and death caused by tobacco use.

From the public and policy makers to the advocates and organizations throughout the state, TEROC applauds all of the hard work and dedication given. Without this commitment and support, the accomplishments made in the past 20 years would never have been achieved.

TEROC would like to highlight a number of significant milestones that had a direct impact in California to change social norms, reduce smoking prevalence and consumption, and reduce tobacco-related disease and death.

Figure 3

Smoking Prevalence Among California Adults, 1984-2007



	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	00	01	02	03	04	05	06	07
CA	24.9	26.7	25.6	21.4	22.7	21.1	19.4	19.2	20.0	18.2	16.6	15.9	17.8	17.4	17.5	17.1	16.3	16.4	15.8	15.4	14.6	14.0	13.3	13.8

Source: Behavioral Risk Factor Surveillance System (BRFSS) 1984-1992, BRFSS and California Adult Tobacco Survey data is combined for 1993-2007. The data is weighted to the 2000 California population. Note change of smoking definition in 1996 that included more occasional smokers.
Prepared by: California Department of Public Health, California Tobacco Control Program, March 2008.

Race/Ethnicity and Sexual Orientation:

The most current data (2005) show that African-American males have a higher smoking prevalence (21.3 percent) compared to males in all other major race/ethnicity groups, whose prevalence rates were between 14.9 and 17.2 percent. Additionally, African-American and non-Hispanic white females have significantly higher smoking prevalence (17.4 and 13.8 percent, respectively) compared to Hispanic (7.2 percent) and Asian/Pacific Islander (5.3 percent) females.

Furthermore, high smoking rates continue to be a major concern for many of California's priority populations. In 2006, CTCP published the results of five studies, funded from 2002–2004, regarding statewide tobacco use among active-duty military personnel, Asian Indian; Chinese; Korean; and LGBT populations in California. Active-duty military personnel stationed in California demonstrated a smoking prevalence of 21.6 percent, while the highest smoking prevalence, 30.4 percent, was observed in the LGBT population. Korean men had a smoking prevalence of 27.9 percent while overall Chinese and Asian Indian smoking prevalence rates were 7.7 percent and 5.5 percent respectively.[37-39, 72]

MILESTONES TOWARD A TOBACCO-FREE CALIFORNIA

November 1988: **Proposition 99 Passes**. Voters approve a tobacco tax increase of $0.25 with 20 percent of revenues dedicated to tobacco use prevention and cessation.

December 1989: **Local Lead Agencies Established**. Sixty-one county and city health departments receive guidelines to serve as Local Lead Agencies to conduct tobacco use education programs in their communities.

Socioeconomic status:

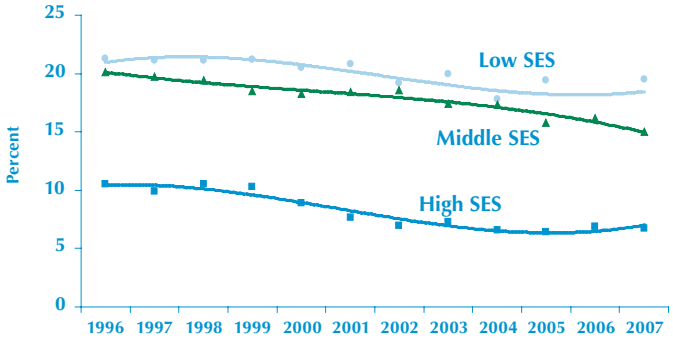
Across socioeconomic demographic groups, smoking remains more prevalent among those with low and middle socioeconomic status (SES) than the high SES group (Figure 4). Since 1996, smoking prevalence among high SES groups has been relatively low (below 10.0 percent) and declining faster than the low and middle SES groups where the prevalence rates have never dropped below 10.0 percent. Specifically, men of low SES continue to have greater smoking prevalence (26.8 percent), compared to women of low SES (13.6 percent) in 2007, which is partly a function of race/ethnicity. (Figure 5).

Gender:

Overall, smoking prevalence for both males and females has decreased since 1988 (33 percent for males, 46 percent for females). California men have consistently higher smoking prevalence compared to women (Figure 6).

Figure 4

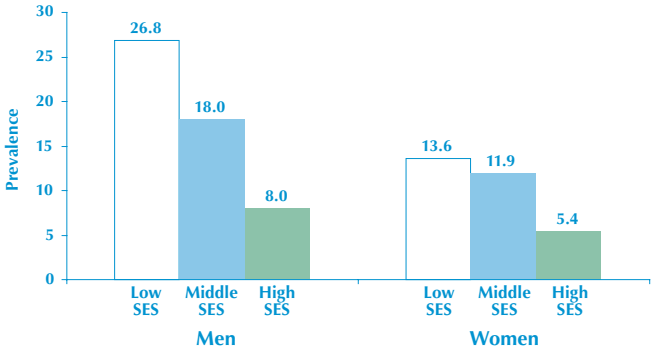
Smoking prevalence among California adults by SES status, 1996-2007



Source: Behavioral Risk Factor Surveillance System and California Adult Tobacco Survey data is combined for 1993-2005. The data is weighted to the 2000 California population.
Note change of smoking definition in 1996 that included more occasional smokers.
Prepared by: California Department of Public Health, Tobacco Control Section, February 2008.

Figure 5

Adult smoking prevalence in California by socioeconomic status and gender, 2007



Source: Behavioral Risk Factor Surveillance System and California Adult Tobacco Survey data, 2007. The data is weighted to the 2000 California population. **Note:** Low SES is defined as household income less than $25,000 and highest educational status is high school graduate. High SES is defined as household income of more than $50,000 and educational status is college undergraduate degree or more. **Prepared by:** California Department of Public Health, California Tobacco Control Program, July 2008.

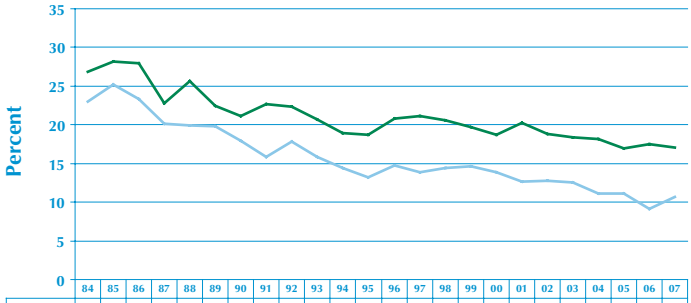
***April 1990*: California's Tobacco Education Media Campaign Launched.** California breaks new ground in public health education and prevention efforts with an unprecedented anti-tobacco use advertising campaign.

***February 1992*: California Smokers' Helpline Launched.** California becomes the first state to provide telephone cessation counseling and services free of charge.

California Smokers' Helpline
1-800-NO-BUTTS

Figure 6

Smoking prevalence among California adults by gender, 1984-2007

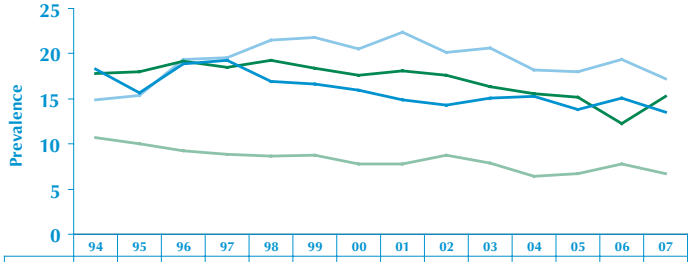


	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	00	01	02	03	04	05	06	07
Male	26.9	28.2	28.0	22.8	25.6	22.5	21.1	22.7	22.3	20.7	18.9	18.7	20.8	21.1	20.6	19.7	18.7	20.2	18.8	18.4	18.2	17.0	17.5	17.1
Female	23.0	25.2	23.3	20.1	19.9	19.8	17.9	15.8	17.8	15.8	14.4	13.2	14.8	13.9	14.4	14.6	13.9	12.7	12.8	12.5	11.1	11.1	9.1	10.7

Source: Behavioral Risk Factor Surveillance System (BRFSS) 1984-1992, BRFSS and California Adult Tobacco Survey data is combined for 1993-2007. The data is weighted to the 2000 California population.
Note change of smoking definition in 1996 that included more occasional smokers.
Prepared by: California Department of Public Health, California Tobacco Control Program, March 2008.

Figure 7

Smoking Prevalence among California Adults by Age Group, 1994-2007



	94	95	96	97	98	99	00	01	02	03	04	05	06	07
18-24	14.9	15.4	19.4	19.6	21.5	21.8	20.5	22.4	20.1	20.6	18.2	18.0	19.4	17.2
25-44	17.8	18.0	19.2	18.5	19.3	18.4	17.6	18.1	17.6	16.3	15.6	15.2	12.3	15.3
45-64	18.3	15.7	18.9	19.3	16.9	16.6	16.0	14.9	14.3	15.1	15.3	13.8	15.1	13.5
65+	10.7	10.0	9.2	8.9	8.7	8.8	7.8	7.8	8.8	7.9	6.4	6.7	7.8	6.7

Source: Behavioral Risk Factor Surveillance System (BRFSS) 1984-1992, BRFSS and California Adult Tobacco Survey data is combined for 1993-2007. The data is weighted to the 2000 California population.
Note change of smoking definition in 1996 that included more occasional smokers.
Prepared by: California Department of Public Health, California Tobacco Control Program, March 2008.

For the past few years prevalence rates have remained virtually unchanged (approximately 17 percent for men and 11 percent for women). However, it is important to note that adult female smoking dropped to 9.1 in 2006, only to increase in 2007. In general, the current flattening trend of adult smoking prevalence for both male and female smokers highlights the major concern of slowing progress in California.

Age:

Smoking prevalence, as seen in Figure 7, continued to decrease in all age groups except for 25- to 44-year-olds. In 2007, smoking among the 25- to 44-year-old age group increased to 15.3 percent, up from 12.3 percent in 2006. Among adults, 18- to 24-year-olds continued to have the highest smoking prevalence rate (17.2 percent) of any age group in 2007.

MILESTONES TOWARD A TOBACCO-FREE CALIFORNIA

***January 1994*: Breast Cancer Act of 1993 (AB 478) Increases Tobacco Tax.** The California Legislature raises the tax on tobacco by $0.02 per pack to research the cause, cure, treatment, early detection, and prevention of breast cancer.

***January 1995*: California Becomes the First Smoke-free State.** After more than 300 local smoke-free policies are adopted, California's smoke-free workplace law (AB 13) bans smoking in most indoor workplaces, except bars and gaming clubs, and provides the most sweeping workplace smoking ban in the nation.

Youth:

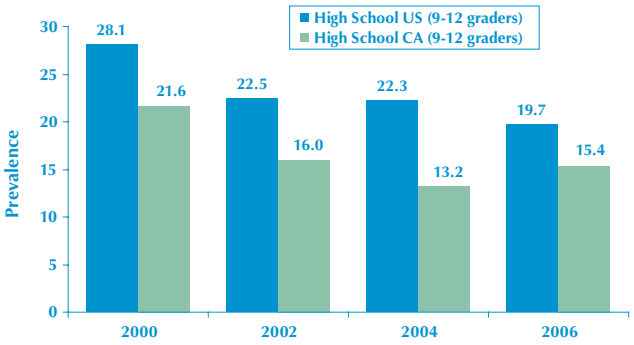
Overall, 30-day smoking prevalence rates among high school students (9th-12th grade) have declined in California and remain lower than the national average. However, California experienced an increase in smoking prevalence among all grade levels and demographic groups from 2004 to 2006 (Figure 8). While youth rates in California are lower than in the rest of the United States, the national average continued to decline during the same time period. Similar to adult smoking prevalence, youth smoking factors relate to price and tobacco industry marketing practices.

Consumption

There has been great success regarding consumption declines in California. From fiscal year 1989-1990 to fiscal year 2006-2007, per capita cigarette pack consumption declined by 61 percent in California, while the entire U.S. showed a decrease of 41 percent during the same time period (Figure 9). As consumption is largely a factor of price, the most significant declines have occurred in concert with a tobacco tax increase.

Figure 8

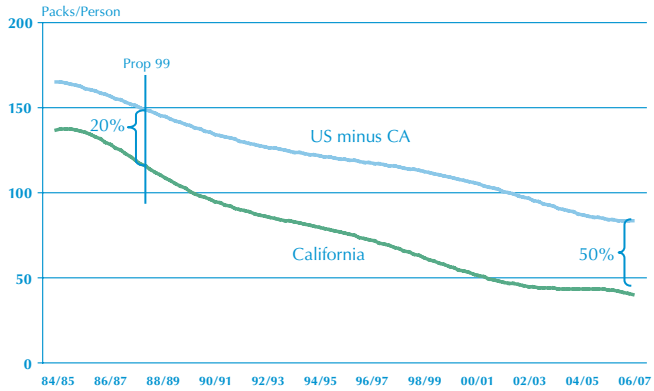
30-day smoking prevalence for California and U.S. high school (9th-12th grade) students, 2000-2006



Source: The U.S. data is from the National Youth Tobacco Survey collected by the American Legacy Foundation, which used passive parental consent. The 2002, 2004 and 2006 data is from the California Student Tobacco Survey. The 2002 and 2004 data collection used active parental consent while the 2006 used a mixed parental consent procedure.
Prepared by: California Department of Public Health, Tobacco Control Section, July 2007.

Figure 9

California and U.S. Adult Per Capita Cigarette Pack Consumption, 1984/1985-2006/2007



Source: California State Board of Equalization (packs sold) and California Department of Finance (population).
U.S Census, Tax Burden on Tobacco, and USDA. Note that data is by fiscal year (July 1-June 30).
Prepared by: California Department of Health Services, Tobacco Control Section, November 2007.

MILESTONES TOWARD A TOBACCO-FREE CALIFORNIA

***July 1995*: STAKE Act (SB 1927) Implemented.** The Stop Tobacco Access to Kids Enforcement (STAKE) Act is enacted to prevent illegal access to tobacco products by youth.

***January 1996*: Cigarette Vending Machines (AB 686) Eliminated.** The law prohibits the sale of tobacco products from all vending machines, except in establishments with public premises liquor licenses.

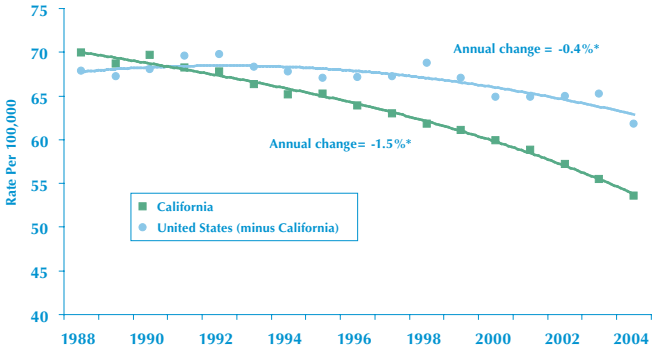
Presently, Californians annually consume nearly half as many cigarettes (40 packs) as other U.S. smokers (82 packs). The downward trend in per capita cigarette consumption reflects declines in the number of California smokers and the average number of cigarettes smoked per day, as well as an increase in the proportion of occasional smokers.

While per capita cigarette consumption in the state of California was one of the lowest in the nation in 2006-2007, consumption decreases are now leveling off.

Tobacco-related Disease and Death

Tobacco use remains the most preventable cause of death in California. As identified in the 2006–2008 Master Plan, greater smoking prevalence, lung cancer incidence and tobacco-related mortality continue to disproportionately impact California's diverse populations and communities.

Figure 10
Lung and bronchus age-adjusted cancer incidence rates, 1988-2004



Rates are per 100,000 and age-adjusted to the 2000 U.S. standard (19 age groups).
* The annual percent change is significantly different from zero (p<0.05).
Source: Cancer Surveillance Section. Prepared by: California Department of Health Services, Tobacco Control Section, 2007.

While smoking prevalence and consumption indicate immediate progress in California, tobacco-related disease and death demonstrate the real and long-term impact of California's tobacco control efforts. From 1988 to 2004, lung and bronchus cancer rates in California declined at over three times the rate of decline seen in the rest of the United States (Figure 10).

With future reductions in smoking prevalence and consumption in California, declines in smoking-related morbidity and mortality will continue. Greater strides need to be achieved in California by increasing the tobacco tax and funding for comprehensive tobacco control.

MILESTONES TOWARD A TOBACCO-FREE CALIFORNIA

March 1997: **New Wave of Advertising Launched**. The new media campaign includes ads that target the tobacco industry's manipulative advertising and promotional activities, the addictive nature of smoking, and the impact of secondhand smoke.

January 1998: **Smoke-free Bars Law Implemented**. The final phase of California's 1995 smoke-free workplace law takes effect, requiring bars, restaurant/bar combinations and gaming clubs to be smoke-free.

Master Plan 2006-2008

Achievements

The 2006–2008 TEROC Master Plan goals were to achieve smoking prevalence rates of 10 percent for adults and 8 percent for high-school-age youth by the end of 2008. The three-year plan established the following five objectives for California tobacco control:

1. Strengthen the California Tobacco Control Program;
2. Eliminate disparities and achieve parity in all aspects of tobacco control;
3. Decrease exposure to secondhand smoke;
4. Increase the availability of cessation services;
5. Limit and regulate the products, activities, and influence of the tobacco industry.[5]

Supporting strategies for each of these objectives were also discussed in the 2006–2008 Master Plan. The progress achieved for each objective is summarized below, highlighting trends, accomplishments, and challenges.

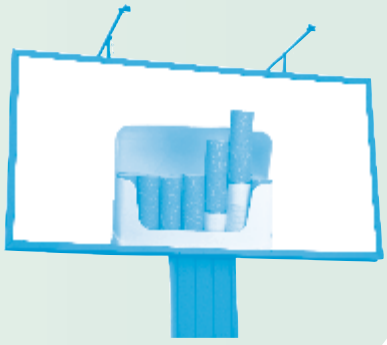
Objective 1: Strengthen the California Tobacco Control Program

California continues to define best practices and shape the future direction of comprehensive tobacco control. Accomplishments include:

- The Coalition to Protect All Californians from Tobacco (PACT) began utilizing the TEROC Master Plan during their annual Capitol Information and Education (I&E) Days. PACT members asked legislators to sign a resolution which supported the five TEROC Master Plan objectives. To date, 22 current and past state legislators have signed the PACT resolution. (http://www.center4tobaccopolicy.org/iedays)

MILESTONES TOWARD A TOBACCO-FREE CALIFORNIA

January 1998: **California's New Tobacco Billboard Law (AB 752) Implemented**. California law bans outdoor tobacco billboards within 1,000 feet of any public or private elementary, junior, or high school or public playground. The law was later superseded by the broader restrictions provided by the Master Settlement Agreement. Prior to this law, nearly half of all tobacco billboards statewide were located within 1,000 feet of schools.



- The California Tobacco Control Program statewide media campaign continues to receive awards for high quality general market and priority population ads which are linguistically and culturally appropriate for California's diverse populations. As of 2008, the campaign had received 155 national and international awards in advertising, eight of which were received in 2007. Despite the continued success, the media campaign budget remains far below an adequate level. With spending at approximately $15.7 million per year, equaling $0.44 per capita, the rate has fallen far below the CDC Best Practices annual recommendation of $3.02 per capita.[4] Additionally, recall of anti-smoking advertisements by the general public decreased between 2002 and 2005. The decrease parallels the decline in per capita expenditure on CTCP's anti-smoking media and reflects decreased public exposure to the media campaign.
- The adoption of Assembly Bill 647 (2007) created a new, streamlined grant process, eliminated entitlement funding, and increased the minimum funding levels for TUPE's county offices of education. The changes reflect two significant TUPE Task Force recommendations and will become effective with the 2009 funding cycle.[35]
- In 2006, 48 TRDRP-funded research grants were finalized, focusing on tobacco-related disease, tobacco use, secondhand smoke exposure, as well as tobacco control programs and policy.[73] Over the past three years, the Tobacco-Related Disease Research Program (TRDRP) funded 44 new research grants in both 2006 and 2007 (See www.TRDRP.org for a complete list).

Overall, funding for tobacco control agencies continues to decrease in both nominal and real terms. Table 2 shows tobacco control funding decreases over the last three years (2006 to 2008). In addition to taxable per capita cigarette consumption flattening in California, the real price of tobacco has decreased by approximately $0.71 per pack (2003-2007)[12] and funding continues to be diverted from the Proposition 99 Research Account to the California Cancer Registry.[13]

MILESTONES TOWARD A TOBACCO-FREE CALIFORNIA

***November 1998*: Master Settlement Agreement (MSA) with Tobacco Industry Signed**. Attorneys General of 46 states (including California), four U.S. Territories and the District of Columbia sign a $206 billion settlement regarding Medicaid lawsuits with the nation's five largest tobacco companies. While initially considered a victory, California's share of MSA payments were securitized in 2003 by the State Legislature. Additional counties and cities also securitized their payments, leaving only a small number of California communities with sustained MSA tobacco control funding.

Table 2: California Tobacco Control Agencies Actual Funding (in millions) for FY 2006-2008

	FY 2006-07	FY 2007-08	FY 2008-09
CDPH/CTCP	$60.0*	$54.4**	$55.6**
CDE/SHKPO	$22.8	$23.9	$23.1
TRDRP	$14.6	$16.6	$14.6
Total	**$97.4**	**$94.9**	**$93.3**

* $1.3 million was appropriated from the Proposition 99 Unallocated Account to support CDPH/CTCP State administration.
** $1.3 million was appropriated from the Proposition 99 Unallocated Account to support CDPH/CTCP State administration.

Proposition 86

TEROC endorsed the 2006 Tobacco Products Tax Initiative (Proposition 86) which would have helped achieve Objective 1 by raising the tobacco excise tax by $2.60/pack and funding tobacco use prevention and cessation programs, the enforcement of tobacco-related laws, and research on tobacco-related diseases. Additionally, funding would have gone to emergency services, nursing education, children's health insurance, cancer treatment, and other public health programs.

Unfortunately, the initiative lost by only 289,331 votes.[53] In opposition, the tobacco industry spent over $62 million, far exceeding the $16.8 million spent by initiative supporters.[13] Tobacco interest campaign contributions were directed to state legislative members and candidates, constitutional officers, political committees, and ballot initiative campaigning. The Center for Tobacco Policy and Organizing reported that tobacco interest expenditures were more than double the $30 million they spent in 1998 in an unsuccessful effort to defeat Proposition 10 (the most recent California tobacco tax increase of $0.50).[21]

MILESTONES TOWARD A TOBACCO-FREE CALIFORNIA

***November 1998*: Proposition 10 Passes.** California voters approve increasing the tobacco tax by $0.50 per pack to fund early childhood development programs, education on the dangers of secondhand smoke exposure for families with children up to five years of age and to fund smoking cessation services for pregnant women.

***June 2002*: R.J. Reynolds Tobacco Company Fined $20 Million.** San Diego Superior Court Judge Ronald S. Prager imposes a $20 million fine, finding that R.J. Reynolds advertised to target youth, in violation of the 1998 MSA.

Objective 2: Eliminate disparities and achieve parity in all aspects of tobacco control

From 2006 to 2008, Proposition-99-funded agencies continued to strengthen tobacco control efforts with priority populations through research, education, building agency capacity, and funding specific programs for priority populations.

CDPH/CTCP took several new steps to eliminate disparities and achieve parity in tobacco control. Specifically:

- Established the Local Programs and Priority Populations Unit in 2006 to focus on working with diverse populations.
- Updated the Communities of Excellence in Tobacco Control needs assessment manual and community indicators and assets to better build capacity and address achieving parity.
- Funded studies on tobacco use in the Vietnamese and Rural Native American/Alaska Native populations.
- Conducted three major priority-populations conferences: 1) Building Bridges, Working with Diverse Populations (2006); 2) Rural Pride Statewide, Reaching Beyond City Limits (2008); and 3) A Community Under Siege, the State of Black California and Tobacco Use (2008).
- Established the Capacity Building Network to provide high quality training and technical assistance to local projects working with priority populations.
- Enhanced media outreach to market Asian-language tobacco-cessation services of the California Smokers' Helpline.
- Required each of the 61 Local Lead Agencies to include a cultural competency objective aimed at strengthening each agency's ability to serve their community's diverse populations in their 2007–2010 local tobacco control plan.

CDE continued funding Tobacco-Use Prevention Education programs for the American Indian Education Centers. CDE also enhanced their California Healthy Kids Resource Center,

MILESTONES TOWARD A TOBACCO-FREE CALIFORNIA

***October 2003*: Cigarette and Tobacco Products Licensing Act (AB 71) Passes.** This law imposes new statewide licensing requirements on cigarette manufacturers, tobacco wholesalers/ distributors, and retailers.

***October 2003*: First Smoke-free Beach Ordinance Passes**: Solana Beach becomes the first city to pass a smoke-free beach ordinance.

allowing Local Educational Agencies to identify curricula and other resources that target priority populations. Priority youth include pregnant minors and minor parents, students identified as most at risk for beginning tobacco use, and current tobacco users.

TRDRP funded five grants in 2007 focusing on smoking among African Americans, American-Indian adolescents, and Cambodian Americans. In 2006-2007, TRDRP-funded grants were completed which focused specifically on diverse populations (e.g. ethnic groups, socioeconomic status, and sexual orientation). Findings include:

- Among smokers, African-American care-giving grandparents were more likely to have a smoking-related disease than African-American parents and non-African-American parents and this was particularly true for cardiovascular disease.[74]
- Although most African-American churches have a health ministry, they neither address tobacco control nor have a written anti-tobacco policy.[75]
- Unexpectedly, Korean and Chinese American undergraduates started smoking during college.[76]
- The first statewide random sample of Lesbian, Gay, and Bisexual households in California found that lesbians were 2-3 times more likely to be current smokers than women overall.[77]

Objective 3: Decrease Exposure to Secondhand Smoke

On January 1, 2008, California celebrated 10 years of smoke-free bars and established a new statewide law that prohibits smoking in cars when minors are present. Changing social norms and creating environments protecting Californians from secondhand smoke exposure continues to be an effective population-based cessation strategy that has been adopted by countless states and countries around the world. Nevertheless, many Californians and visitors continue to be involuntarily exposed to secondhand smoke and the associated negative health risks.

Over the past three years, decreasing exposure to secondhand smoke has been an area of considerable progress in California. Efforts were greatly strengthened in 2006 when the California Air Resources Board (ARB) declared secondhand smoke a toxic air contaminant,[16]

MILESTONES TOWARD A TOBACCO-FREE CALIFORNIA

***January 2004*: Smoke-free Entryways Law (AB 846) Implemented**. California law prohibits smoking within 20 feet of a main entrance, exit and operable window of all state and local government buildings, University of California, State University, and Community College buildings.

***January 2006*: Secondhand Smoke Classified as Toxic Air Contaminant**: The California Air Resources Board classification places secondhand smoke in the same category as other toxic air pollutants, such as benzene, arsenic, and diesel exhaust.

and the United States Surgeon General's Report on the Health Effects of Passive Smoking concluded "there is no risk-free level of exposure to secondhand smoke."[17] Today, secondhand smoke falls in the same category as the most toxic automotive and industrial air pollutants, and new and unprecedented policies have been adopted at both the local and state level. Policies include:

Cars:

- In 2007, Senate Bill 7 (Oropeza) banned the smoking of any cigarette, pipe, or cigar in a moving or parked vehicle while a youth younger than the age of 18 is present.

Housing:

- Beginning in 2006, the California Tax Credit Allocation Committee modified their regulations to include a tax credit for developers of low-income-housing projects that contain at least 50 percent contiguous nonsmoking buildings or sections.
- Local smoke-free multi-unit housing protections continue to grow in both policy and strategy. To date, California has adopted more than 17 local ordinances, resolutions and housing authority policies related to drifting secondhand smoke in multi-unit housing.[8] Notably, the city of Calabasas will make 80 percent of its apartments smoke-free by 2012.
- The city of Oakland adopted a policy requiring disclosure of smoking policies to potential renters/purchasers. A number of other cities have also declared secondhand smoke a nuisance for which renters may seek a legal remedy.[8]
- A poll among Hispanic/Latino renters in California conducted in 2006 concluded that, despite the fact that nearly all Latinos ban smoking in their homes, Latino renters have high rates of secondhand smoke exposure in multi-unit housing. Overall, Latinos are less

MILESTONES TOWARD A TOBACCO-FREE CALIFORNIA

***February 2006*: First Comprehensive Outdoor Smoke-Free Ordinance Passes**: The City of Calabasas becomes the first city in California to restrict smoking in all outdoor public places, including dining areas, entryways, public events, recreation areas, service areas, and sidewalks.

likely to smoke, are less tolerant of secondhand smoke, and they feel strongly about the reasons to reduce exposure to secondhand smoke.[46]

Outdoor Spaces:

- The City of Calabasas also became the first city to adopt and implement a comprehensive outdoor smoke-free policy in 2006. Comprehensive outdoor secondhand smoke policies protect major outdoor areas which include: dining areas, entryways, public events, recreation areas, service areas, sidewalks, and worksites. To date, 20 California cities and counties have comprehensive policies.[7]

Smoke-free Indian Gaming:

- J.D. Powers and Associates 2008 Southern California Indian Gaming Casino Satisfaction Study found that a majority (85 percent) of Southern California casino patrons would prefer a smoke-free casino.[78]

Tobacco-free Schools:

- Today, any school district (K-12) or county office of education (COE) in California that receives TUPE funding must be tobacco-free. This means tobacco use is not allowed at any time on district or COE property, owned or leased, or in district or COE vehicles.
- Since 2006, 31 public colleges and universities have adopted tobacco-free policies more restrictive than state law. Today, over 73 California campuses have a comprehensive smoke-free policy.

TRDRP research completed in 2006 found that:

- Compared to nonsmokers' cars, nicotine concentrations in smokers' cars were 4-7 times greater in dust, 10-24 times greater on surfaces, and 5-24 times greater in the air.[50]

MILESTONES TOWARD A TOBACCO-FREE CALIFORNIA

July 2007: **Local Education Agencies Law (AB 647) Passes**. In response to the 2005 TUPE Task Force Recommendations, the California Legislature makes significant changes to the requirements for allocation of TUPE funds to local education agencies. The new grant requirements create a unified competitive grant mechanism for awarding school-based funds for anti-tobacco programs and cessation activities.

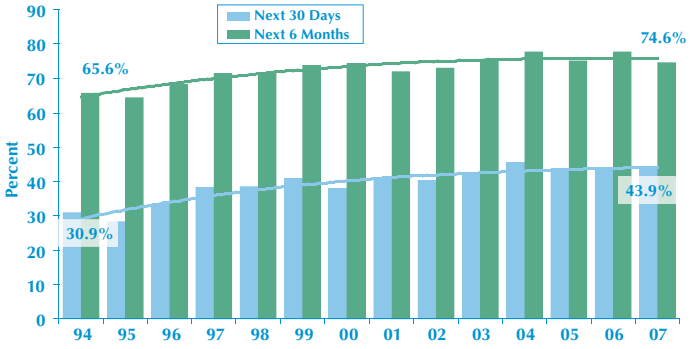
- Women exposed to secondhand smoke, were 20-37 percent less likely to conceive based on a highly sensitive laboratory test.[79]
- A greater percentage of Hispanics/Latinos reported secondhand smoke exposure compared to other ethnic groups.[80]

TRDRP-funded research in 2007 included: secondhand smoke in rental cars, the role of genes and secondhand smoke exposure in minority asthmatics, the economic impact of secondhand smoke exposure for communities of color, and a computer simulation for reducing secondhand smoke exposure. These findings were not available at the time of this publication.

Objective 4: Increase the Availability of Cessation Services

CTCP continues to create innovative ways to increase cessation services in California. In the 2006–2008 Master Plan, TEROC reported data indicating improvements in smokers' desire to quit. However, the price of cigarettes continues to be a significant factor in smoking prevalence and actual quit attempts.

Figure 11
Proportion of California Smokers Thinking About Quitting, 1994-2007



Sources: Behavioral Risk Factor Surveillance System and California Adult Tobacco Survey data, 1994-2005. The data is weighted to 2000 California population, weighted to 2000 California population.
Prepared by: California Department of Health Services, Tobacco Control Section, February 2007.

Over the years, an increasing majority of California smokers reported intentions to quit in the near future (Figure 11). In 2007, three quarters (74.6 percent) of California smokers reported plans to quit within the next six months, and 43.9 percent within the next month. However, these measures have remained relatively unchanged since 2002. Moreover, the actual percent of annual quit attempts

MILESTONES TOWARD A TOBACCO-FREE CALIFORNIA

***October 2007*: First Smoke-free Multi-unit Housing Ordinance Passes**: The City of Belmont becomes the first city to prohibit smoking in almost all multi-unit housing units, by prohibiting smoking in 100 percent of units that share common floors and/or ceilings.

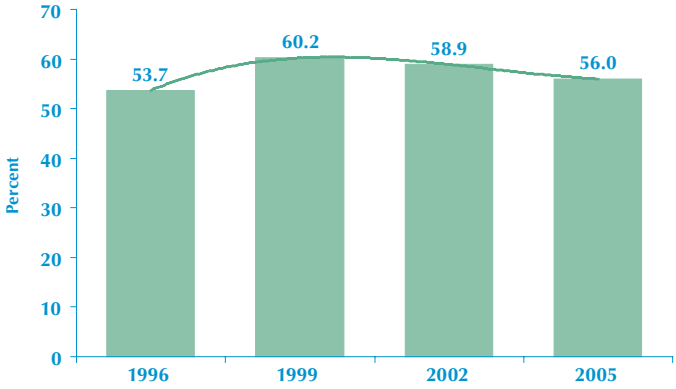
***January 2008*: Smoke-free Cars Law (SB 7) Implemented**. California law prohibits smoking in vehicles when minors under the age of 18 are present.

has decreased since the last tobacco tax increase in 1999 (Figure 12).

California Smokers' Helpline

In 2007, the California Smokers' Helpline (Helpline), a toll-free telephone service, celebrated 15 years of providing free cessation services. The Helpline was established as the nation's first quitline, and by 2007 had provided free and confidential statewide telephone counseling services to nearly 430,000 people since its inception in 1992.[6]

Figure 12
Percentage of Smokers Who Made at Least One Quit Attempt in the Last Year, 1996-2005



Source: California Tobacco Survey, 1996-2005.

The Helpline continues to reach a broad range of smokers. In 2007, 51.1 percent of Helpline callers were between the ages of 18 and 44. Additionally, low socioeconomic status smokers, having either Medi-Cal/Government insurance or no insurance coverage at all, constitute over two thirds (69.4 percent) of all Helpline callers.

The Helpline services, provided in six languages (English, Spanish, Mandarin, Cantonese, Vietnamese, and Korean), continue to be culturally and linguistically appropriate. The service is also available for the hearing impaired. Table 3 shows the self-identified race or ethnicity of callers, including smokers and families/friends, to the Helpline, 2006–2007.

Table 3: Self-identified race/ethnicity of California Smokers' Helpline callers, 2006–2007

RACE/ETHNICITY	% of Total
White/Caucasian	53.2 %
Hispanic/Latino	16.9 %
Black/African American	13.5 %
Asian/Pacific Islander	7.2 %
American Indian	4.0 %
Did not identify	1.8 %
Other	3.4 %

MILESTONES TOWARD A TOBACCO-FREE CALIFORNIA

July 2008: First Tobacco-free Pharmacy Ordinance Passes. The City of San Francisco ordinance bans the sale of tobacco products in all San Francisco drugstores, effective October 1, 2008. Grocery and "big-box" stores are excluded from the ordinance.

Approximately half of callers report that they heard about the Helpline through the state's media campaign, and 28.7 percent of callers report being referred by a healthcare provider.

In April 2008, CDPH, CTCP established the Tobacco Cessation Center, operated by the California Smokers' Helpline, to help build capacity among local agencies to support tobacco cessation. The Tobacco Cessation Center provides training and technical assistance to local organizations to help develop, implement, increase, and evaluate evidence-based and culturally appropriate tobacco cessation strategies. Any organization, regardless of funding, is able to utilize the Tobacco Cessation Center resources and services.

Schools

A 2007 revision of the Safe and Healthy Kids Annual Report now requires a school district which accepts any TUPE funds to report specific cessation programs used by the school district.

School districts reported on the 2006-2007 Safe and Healthy Kids Annual Report that 33,380 students had been identified as tobacco users. Almost all of those students (31,846) were served with special, targeted cessation and/or intervention services during the year.

Research

The TRDRP-funded research completed in 2006-2007 included findings that:

- Weekly smoking was reduced by a classroom approach to teen smoking cessation.[81]
- Telephone counseling was the only factor predicting sustained quit rates among enrollees in Blue Shield of California's Individual and Family Preferred Provider Organization (PPO) plans.[82]
- Nonsmokers, who called the Helpline to learn how to assist smokers to quit, were heavily involved in supporting a smoker's quit attempt.[83]

TRDRP cessation research funded in 2006–2007 focused on LGBT smokers, African-American smokers, college student smoking cessation, as well as self-change, positive mood, and self control in smoking cessation.

TRDRP and CDE collaborated and jointly funded a project to evaluate the "I Decide" youth tobacco cessation program, a school-centered tobacco cessation program. The program is currently being used in several school districts, and the evaluation is expected to be completed in 2010.

Many agencies have begun utilizing the Performance Partnership Model for smoking cessation at the state and local level. The model gathers a broad range of stakeholders and resources in order to create and implement a strategy with measurable outcomes. Examples include:

- Collaborative efforts between the California Diabetes Program and the California Smokers' Helpline expanded the "*Do you cAARd? Campaign*" to educate healthcare providers on the "*Ask. Advise. Refer.*" protocol, and increased the proportion of calls to the Helpline from people with diabetes by 14.4 percent in 2006–2007. During 2006–2007, the Helpline received 3,124 calls from people with diabetes, an average of 260 calls per month.

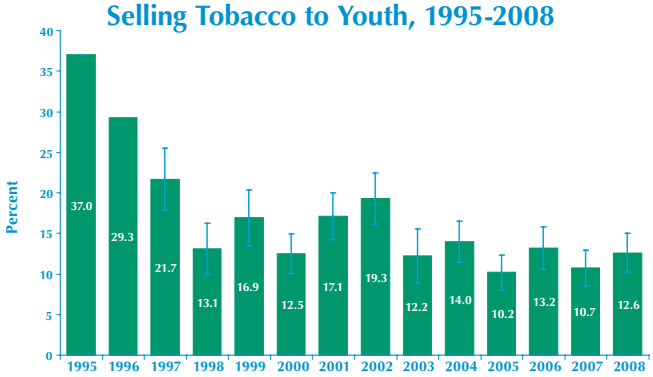
- The Los Angeles County Tobacco Control and Prevention Program partnered with the University of California, San Francisco Center for Smoking Cessation Leadership, the Robert Wood Johnson Foundation, IDEO Consulting Firm, and countless other local stakeholders to implement the performance partnership initiative: "It's Quitting Time LA" (http://laquits.org/). Strategies addressed: provider education, employer programs, media campaigns, funding cessation services, youth education, pharmacy pharmacotherapy support, and increasing calls to the Helpline. Five additional counties are currently in the process of developing and implementing their own performance partnership strategies.

Objective 5: Limit and Regulate the Products, Activities, and Influence of the Tobacco Industry

Limiting and regulating the tobacco industry, their strategies, and their influence remains a significant challenge in California. Since the 1998 Master Settlement Agreement, the tobacco industry has significantly increased their marketing expenditures with point of purchase advertising and price promotions.

Local communities are working to reduce youth access to tobacco products (See Figure 13). Since 2006, more than 30 local tobacco retail licensing (TRL) ordinances were enacted in California. To date, more than 70 local TRL policies exist; with approximately 53 policies that contain adequate fees and strong enforcement provisions. Provisions should include an annual license, a fee which sufficiently funds enforcement efforts, and fines and penalties which include license revocation.[9]

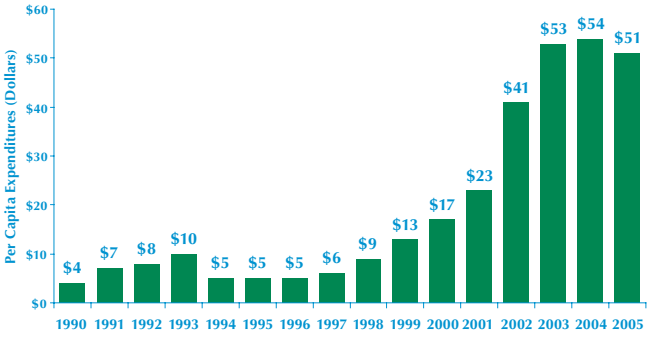
Figure 13
Percent of Retailers Selling Tobacco to Youth, 1995-2008



Attempted buy protocol 1995-1996; Actual buy protocol 1997-2008.
Source: Youth Tobacco Purchase Survey, 1995-2008.
Prepared by: California Department of Public Health, California Tobacco Control Program, July 2008.

California is the only state to systematically and consistently track tobacco industry sponsorship and retail advertising. From this data, we are able to better understand tobacco industry tactics and trends. As can be seen from Figure 14, tobacco industry per capita expenditures for price promotions (e.g., two-for-one) and coupons have increased significantly since 1999 and we know that the tobacco industry's use of price promotions continues to negate the impact of taxes.

Figure 14
Per Capita Tobacco Industry Expenditures for Price Promotions and Coupons in California, 1990 - 2005*



*California tobacco industry expenditures calculated as a proportion of U.S. expenditures based on total population size as reported by the U.S. Census Bureau. Both tobacco control and tobacco industry expenditures have been standardized to the U.S. 2005 dollar, based on the Consumer Price Index (CPI). Tobacco industry expenditures taken from the Federal Trade Commission Cigarette Report for 2005 issued 2007. Prepared by: California Department of Public Health, California Tobacco Control Program.

On December 4, 2007, the City of Chico became the first jurisdiction to establish a policy prohibiting the free distribution of smokeless tobacco and cigarettes within city limits.

On July 29, 2008, San Francisco became the first city in California to pass a tobacco-free pharmacy policy, prohibiting the sale of tobacco products in all San Francisco drugstores.

The Center for Tobacco Policy and Organizing continued to publish data on the tobacco industry's campaign contributions and lobbying expenditures in California. The periodic updates (beginning with the 2001-2002 election cycle) resulted in three legislators returning tobacco contributions in 2007.

In September 2007, the University of California (UC), Board of Regents adopted a resolution requiring the special review, approval, and reporting of future tobacco-industry-funded research.[56] Though each campus is required to have policies and an implementation procedure, the UC president has allowed Chancellors to elect to implement the policy "as needed."

CDE continued to prohibit school districts that receive TUPE competitive grant funding from accepting donations, funding, or sponsorships from the tobacco industry, including the display, use, or distribution of tobacco companies' curricula or materials.

TEROC has joined with many health, parent, civic, and community organizations to support the tobacco-free movies campaign, supporting the four tobacco-free movie strategies to remove tobacco use from youth-rated movies.

On May 10, 2007, the Motion Picture Association of America included smoking as a factor in the process of rating films.[67] And, on July 11, 2008, six major Hollywood studios (Sony Pictures, Universal Studios, Time Warner, Paramount Pictures, Walt Disney Studios and Twentieth Century Fox) agreed to include California's antismoking ads on all new G, PG, and PG-13 rated DVDs that depict tobacco use.[68] Though a step in the right direction, there is more that can be done by the movie industry to prohibit smoking in movies targeted to youth and families.

TRDRP-funded research completed in 2006-2007 found that:

- More than 56 percent of underage tobacco sales in Los Angeles occurred within 1,000 feet of a school.[84] The information was used by the Los Angeles City Attorney's Office to support a new city ordinance requiring tobacco vendors to register with the city and pay a yearly fee.
- Tobacco industry documents included targeting of psychosocial needs unrelated to smoking with carefully orchestrated advertising campaigns.[85]
- The tobacco industry was aware of the presence and potential risk of radioactive polonium 210 in cigarette smoke for over 40 years but actively failed to reveal its presence.[86]

In 2006-2007, TRDRP funded studies regarding the tobacco industry targeting of older persons, hookah smoking, and tobacco industry political strategies.

Significant Tobacco Control Legislation, 2006-2008

Assembly Bill (AB) or Senate Bill (SB), and Author	Description	Effective Date
AB 3010 – Blakeslee **Prohibiting tobacco use at state mental hospitals**	Authorizes the Director of the Department of Mental Health to prohibit smoking by patients and staff at any of the five state mental hospitals following the request of a hospital's director.	January 1, 2009
SB 625 – Padilla **Tobacco retailer license reinstatement fee**	Authorizes a $100 reinstatement fee as a precondition for reinstatement of an expired state tobacco retailer license.	January 1, 2008
SB 624 – Padilla **Tobacco products, minors**	Increases STAKE Act civil penalties, and allows local enforcement agencies to enforce illegal tobacco sales to minors under the STAKE Act without requiring a contract with the California Department of Public Health.	January 1, 2008
SB 7 – Oropeza* **Smoking in vehicles with minor passengers**	Prohibits smoking in a motor vehicle when a minor (17 years and younger) is present. Though a secondary offense, violations are punishable by a fine of up to $100.	January 1, 2008
AB 1585 – Lieber **Tobacco products, non-sale distribution**	Gift certificates, gift cards, and other similar offers were added to the definition of nonsale distribution of tobacco products. Coupons, coupon offers, and rebate offers are already included.	January 1, 2008
AB 647 – Salas* **Tobacco use programs**	Amends funding provisions for local education agencies, by allowing for one competitive grant process. Minimum funding amounts for the County Offices of Education were increased from $25,000 to $37,500.	July 1, 2009
AB 2067 – Oropeza **Smoking in enclosed spaces of buildings**	Clarifies Labor Code Section 6405.5, further prohibiting workplace smoking in designated areas of public covered parking lots.	January 1, 2007
AB 1880 – Blakeslee **State hospitals, care of the mentally disordered**	Requires a strategic plan from the Atascadero State Hospital to study staff and patient safety, manage violence, and improve health by regulating staff, patient, and visitor tobacco use.	January 1, 2007
AB 1749 – Horton **Cigarette and tobacco products licensing amendment**	Increases licensing and violation fees, and requires licenses for manufacturers and importers of other tobacco products. Also repeals the sunset provision of AB 71, and limits in-store placement of blunt wraps.	January 1, 2007
AB 178 – Koretz **Cigarette, fire safety and firefighter protection**	Prohibits the sale, manufacture, or distribution of cigarettes in California that do not meet the fire-safe standards of the American Society of Testing and Materials protocol for measuring the ignition strength of cigarettes.	January 1, 2007

* Legislation endorsed by TEROC

Additional information is available from www.leginfo.ca.gov and http://www.center4tobaccopolicy.org/statepolicies

Appendix

About the California Tobacco Control Agencies

It has been 20 years since California voters passed the California Tobacco Tax and Health Protection Act (Proposition 99) in November 1988. The revenue generated from the $0.25 per cigarette pack tax increase allowed California to create the nation's first comprehensive tobacco control program, which has been used as a model for other states and countries.

From the beginning, California's tobacco control agencies have focused on the creation of meaningful and long-lasting social norm change. The social norm change strategy involves changing the social and cultural attitudes surrounding tobacco use and the tobacco industry through public health education, hard-hitting media campaigns, and the support of state and local policy activities that expand and strengthen measures to protect against secondhand smoke exposure, restrict tobacco accessibility, and limit tobacco industry practices.

Over the last 20 years, California tobacco control agencies have educated the public about the addictive and harmful nature of tobacco, revealed the predatory marketing practices of the tobacco industry, and empowered Californians to take action to protect themselves, their families, and their communities from the dangers of tobacco use and secondhand smoke.

The strength and effectiveness of California's comprehensive program results from the partnership of its three constituent agencies: the California Department of Public Health, California Tobacco Control Program (CDPH/CTCP), the University of California's Tobacco-Related Disease Research Program (TRDRP), and the California Department of Education's Safe and Healthy Kids Program Office (CDE, SHKPO), which administers the Tobacco-Use Prevention Education (TUPE) program, along with oversight from the Tobacco Education and Research Oversight Committee (TEROC).

The California Department of Public Health/California Tobacco Control Program

CDPH/CTCP has often been called the pre-eminent tobacco control program in the world. It administers all aspects of the public health education component of the CTCP, including a statewide media campaign, tobacco control programs in local health departments, competitively selected statewide and community-based projects, as well as an extensive evaluation of the entire tobacco control program. CTCP focuses on four broad policy areas that act together to change social norms around tobacco use: reducing secondhand smoke exposure, revealing and countering tobacco industry influence, reducing the availability of tobacco, and promoting tobacco cessation services.

Additional information can be found at http://www.cdph.ca.gov/programs/Tobacco/Pages/default.aspx

Local and Statewide Programs

CTCP funds a variety of local and statewide projects that facilitate community norm change and provide infrastructure to support local tobacco control efforts. These projects work in coordination with each other to create effective and innovative tobacco control interventions throughout California.

County/City Local Health Departments

Each of the 58 county and three city health departments are designated as "Local Lead Agencies" (LLAs). As the lead tobacco control agency at the community level, the LLA is responsible for coordinating information, referral, outreach, and education activities within their respective health jurisdiction. Each LLA fosters and involves a community coalition to engage in grassroots community mobilization activities that promote social norm changes and educate the public about health issues related to tobacco use and tobacco industry strategies that promote tobacco use. In general, LLAs take the lead on local community policy development, facilitation of enforcement of tobacco control laws, and local provision of tobacco cessation services.

Local Competitive Grant Program

The local competitive grant program consists of a variety of local community-based projects that are either local interventions to address tobacco control priorities, or priority-population-focused intervention efforts. Nonprofit agencies funded as competitive grant projects include community-based organizations, voluntary health organizations, health clinics, ethnic organizations, alcohol and drug centers, labor organizations, youth organizations and universities. Agencies are also representative of the state by serving local communities in northern, central, and southern California.

Statewide Projects

Statewide projects feature a variety of programs specifically designed to provide technical assistance, resources, and/or services to the California tobacco control community. These projects provide technical support relating to education and advocacy work for creating smoke-free environments, grassroots organizing and community mobilization, technical support relating to the development or adaptation of local policies and providing advocacy and support for programs which target youth and the 18- to 24-year-old age group, and working with diverse populations.

California Smokers' Helpline

The California Smokers' Helpline (http://www.californiasmokershelpline.org/) provides intensive tobacco cessation telephone counseling for those who are ready to quit. Assistance is available in English, Spanish, Korean, Mandarin, Cantonese, and Vietnamese as well as for the hearing impaired. Tailored counseling services are provided for adults, teens, pregnant women, and chew tobacco users. The Helpline also provides self-help materials and a referral list to other tobacco cessation programs. The services provided by the Helpline are free of charge.

Tobacco Education Clearinghouse of California (TECC)

The Tobacco Education Clearinghouse of California (http://www.tobaccofreecatalog.org/) provides a broad array of resources and support services, including a complete catalog of tobacco education materials, professional research assistance and, a lending library of over 20,000 tobacco-related materials.

Tobacco Education Media Campaign

CDPH/CTCP produces an aggressive, internationally recognized Tobacco Education Media Campaign (http://www.tobaccofreeca.com/index.html). The media campaign utilizes paid advertising and public service announcements (television, radio, billboards, transit, and print) with thought-provoking messages to effectively communicate the dangers of tobacco use and secondhand smoke, and to counter pro-tobacco messages throughout California's ethnically diverse communities. In order to reach California's diverse population, the Tobacco Education Media Campaign creates products and conducts activities in several languages, including English, Spanish, Cantonese, Mandarin, Vietnamese, Korean, Laotian, Cambodian, Japanese, and Hmong.

Surveillance and Evaluation

CDPH/CTCP conducts surveillance and evaluation to scientifically assess program effectiveness. These efforts include the planning and implementation of epidemiologic studies examining the effectiveness of prevention interventions of tobacco use among youth and adults and tobacco-related diseases on a statewide basis. In addition, other programmatic efforts, including community programs and campaigns, are evaluated to determine success and improve interventions. Surveillance data are also collected for use in strategic planning and program direction.

The University of California's Tobacco-Related Disease Research Program

The Tobacco-Related Disease Research Program (TRDRP) is administered by the University of California and supports research that focuses on the prevention, causes, and treatment of tobacco-related disease and the reduction of the human and economic costs of tobacco use in California.

TRDRP has become one of the premier state programs and funders of tobacco-related research in the United States. TRDRP is committed to contributing scientific findings to improve tobacco control efforts in California. TRDRP's research is used for more effective prevention, detection, diagnosis, and treatment of tobacco-related disease. In the last twenty years, research funded by TRDRP has led to groundbreaking discoveries and advances pertaining to tobacco-related diseases, nicotine addiction, and cessation, and important local and state public health policies. Moreover, TRDRP has pioneered research into California's burgeoning multi-racial and multi-ethnic populations. Funding studies among Latinos, Chinese, Koreans, Cambodians, African Americans, American Indians, and the Hmong has made TRDRP a leader in this regard. Additionally, TRDRP has led the way in funding

community-based participatory research studies through the Community Academic Research Awards and the School Academic Research Awards, which bring together partners from the academy and the community/schools.

At the same time, TRDRP has been fundamental in building a tobacco-related research infrastructure in California marked by exceptional researchers who are nationally and internationally recognized as experts in the area of tobacco-related diseases and tobacco control research. Examples of TRDRP-funded research findings include the following:

- TRDRP-funded research has shown that there is no currently existing, feasible indoor ventilation technology that protects nonsmokers from exposure to secondhand smoke.
- TRDRP-funded epidemiological studies have reported significant associations between secondhand smoke exposure and health effects, including different types of cancer, a decrease in lung functioning, cardiovascular disease, and reproductive and developmental health effects.
- TRDRP-funded research was used by the California Air Resources Board to support their work in classifying secondhand smoke as a toxic air contaminant, and it played a role in the California Environmental Protection Agency report that classified secondhand smoke as a Class A carcinogen.
- TRDRP-funded researchers have made significant contributions to understanding the inception, progression, and devastating consequences of lung cancer, including demonstrating the link between secondhand smoke and lung cancer in nonsmokers.

Additional information can be found at http://www.trdrp.org/

The California Department of Education's Tobacco-Use Prevention Education Program

The purpose of the California Department of Education (CDE)/Safe and Healthy Kids Program Office (SHKPO)/Tobacco-Use Prevention Education (TUPE) program is to prevent or reduce youth tobacco use by helping young people make healthful tobacco-related decisions through tobacco-specific educational instruction and activities that build knowledge as well as social skills and youth development assets. TUPE is administered by the SHKPO with the assistance of 58 county offices of education serving more than six million students in over 9,000 schools in 1,000 Local Education Agencies (LEAs) across the state.

Funding from the TUPE program facilitates the planning and implementation of effective tobacco-use prevention education that is grounded in research,

meets the requirements of the TUPE legislation, responds to the unique character of each LEA's students and community, and gets results.

Collaboration with community-based tobacco control programs is an integral part of program planning. The school, parents, and the larger community must be involved in the program, so that students will be aware of a cohesive effort and concern for their health and, consequently, their ability to succeed in school.

In order to achieve the high school youth prevalence goal of the California Tobacco Control Program, funding from Proposition 99 is currently available to all LEAs in the state for TUPE programs in grades four through eight. Additional funding is available to LEAs to implement prevention programs for students in grades six through eight through a competitive grant process. LEAs must demonstrate a need for the additional funding and demonstrate how this funding will complement the entitlement funding for grades four through eight.

For students in grades nine through twelve, CDE awards competitive grants using Proposition 99 funds to LEAs to provide tobacco-use prevention services to students in the general population and students determined to be most at risk for tobacco use. In addition, the LEA must provide intervention and cessation services to students who currently use tobacco.

Beginning on July 1, 2009, Proposition 99 funding will change to provide support for LEA TUPE programs through an all-competitive-grant process for students in grades six through twelve. As with the previous competitive grants for students in grades nine through twelve, programs selected for funding must provide tobacco-use prevention services to students in the general population and students determined to be most at risk for tobacco use. In addition, the LEA must provide intervention and cessation services to students who currently use tobacco.

LEAs accepting TUPE funding from the CDE must implement and enforce a tobacco-free policy that prohibits the use of tobacco products anywhere, at anytime, on all district property and in district vehicles. LEAs must also agree not to accept any funds or materials from the tobacco industry for the purpose of educating students or parents regarding the use of tobacco.

Additional information can be found at http://www.cde.ca.gov/ls/he/at/tupe.asp

Local Education Support

CDE sponsors several projects to help county offices of education and LEAs plan and implement their TUPE programs:

- "Getting Results" features information about tobacco use prevention strategies that research shows to be effective and promising. http://www.gettingresults.org/
- The California Healthy Kids Survey allows for the systematic collection of measurable data to assist LEAs in determining whether programs and strategies being implemented actually do reduce tobacco use among youths. http://www.wested.org/cs/chks/print/docs/chks_reports.html

- The California Healthy Kids Resource Center provides assistance to LEAs, county offices of education, and the general public as a source of comprehensive information about health-related research and instructional materials to support effective programs for students. http://www.hkresources.org/
- The Safe and Healthy Kids Annual Report is an online reporting system for LEAs to report and track the implementation of curricula and other TUPE activities including teacher and parent training, student intervention and cessation services and services for pregnant and parenting teens. http://hk.duerrevaluation.com

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