# Panel discussion

Moderator: Saul Shiffman
Panellists: Diane Becker, Joyce Essien, Corinne G Husten

**Saul Shiffman**

I am going to ask Dr Husten to start by responding to the comment that we are stuck in our progress toward the Year 2000 goals.

**Corinne G Husten**

We are not stuck, but certainly we are not, as Dr Orleans said, proceeding at a fast enough pace to meet the Healthy People 2000 objectives. National prevalence is now 25% – 27.7% among males and 22.5% among females. There are several groups that still have a very high prevalence. Education is the major correlate with smoking: people with 16+ years of education have a prevalence rate of 14%; for high school graduates, it is 29%; for persons with nine to 11 years of education, it is 37%. That is a very high risk group. We also have high risk groups on racial and ethnic lines; American Indians and Alaskan natives especially have very high smoking rates.

Highest risk groups for men are primarily those with low education, American Indians and Alaskan natives, and African Americans; and for women, American Indians and the Alaskan natives. So we certainly have populations that have a very high prevalence, and overall it does not look like we are going to meet the Healthy People 2000 goals.

**Saul Shiffman**

Why are we stuck, and who are we failing to reach? I am hearing about several important populations, defined by ethnicity, by education, and maybe defined by amount of smoking. How are we failing to reach those groups?

**Joyce Essien**

It seems to me, having just come from a planning meeting to design a violence prevention intervention, that this ought to be achievable in comparison to what I have just spent the past week thinking about.

I wonder how different out strategies would be if the Year 2000 goal had been to *eradicate* smoking, and how different would be the research (randomised trials versus observational studies) and the resource distribution; and would a movement to eradicate smoking resemble the way in which our current effort is organised?

The answer to that question is probably no. When you think of smallpox eradication, those strategies started with the methods and approaches that we understand in public health, such as surveillance systems and outreach systems, but then there was also a strong moral purpose. It became a movement. I wonder what strategies should be designed and with whom we should join, if we were to organise a movement to achieve a goal of eradication.

**Diane Becker**

I would like to go back to the issue of what we think about smoking prevalence as it has been reported to us, and the differential issues that are related to underrepresented or minority populations. My work over the past 10 years has predominantly been in the urban African American community. Until I spent a considerable amount of time working with my colleagues across the country and in Baltimore, I accepted the fact that we were seeing some modest declines among segments of the African American population. However, after seven years of being funded by the National Heart, Lung and Blood Institute, and after doing an array of different kinds of surveys looking at the real prevalence in African American communities, it is clear that the prevalences are extremely underrepresented in what we see in national statistics if one examines urban African American communities where most African Americans live.

I would maintain that we really grossly underestimate the magnitude of the problem both in terms of cessation and in terms of adoption of smoking as a new habit. Specifically, among African American males in urban areas, the prevalence rates seem to be about 40–45%, and up to 50% in the lower socioeconomic strata of the non-working population. In women the figure is probably closer to 35%. If one looks at cessation rates, they are running, at best, at 2–3% per year. While young black males and young black females used to start smoking at an older age than in predominantly white teenagers, that is no longer true. We are seeing smoking at much younger ages. So now what are the solutions relative to everything we have talked about? I am not sure I have them, but the tobacco industry has figured out how to target to these populations.

Any of the strategies that we have talked about, group strategies, physician oriented

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strategies, even the very nice model of a multimodal intervention that is stage specific, are all for me completely non-viable in our target population, nor do they in any way represent the incredible expertise in marketing that the tobacco industry has. I would maintain that we need innovation in an array of different ways. The current programmes that would provide access to the current state of the art are simply not acceptable to my colleagues who work in the community.

**Saul Shiffman**

Let me just push you a bit. The programmes that we have just been discussing will not do. What will it take, and in what direction do we have to move, to be more effective?

**Diane Becker**

One reason why they will not work is that the state-of-the-art is not culturally sensitive to the urban African American community, and making it culturally sensitive is not a matter of putting black faces on pamphlets, nor is it a matter of lowering the literacy level. That is downright insulting and extremely arrogant. If you look at the upper socioeconomic sector blacks, we have similar problems. It is a function of major cultural differences in the way that people engage in social behaviour, and smoking is indeed a social behaviour, as well as an addictive behaviour.

The second thing is buying into the notion that treatments that we design in the mainstream culture are for mainstream culture, and that is not lost on my brothers and sisters in the African American community.

Look at what we in the treatment industry do when we bring out a product like nicotine replacement. We make it virtually inaccessible by virtue of its cost, and because it is linked to a physician model. We fall into the typical trap of what the African American community considers to be a kind of conspiracy. What we are providing when we look at nicotine replacement, for example, is something that will put money into mainstream America's pocket, and borrow as much as it can from the urban community. The tobacco industry has figured out very nicely how to do these very same things, manipulating the community without promoting the notion that they are, in fact, exploiting the community. Our treatment models do look like exploitation to inner city African American populations because they are not culturally sensitive. Tobacco marketing is.

What will it take? It will take models that understand the culture. One very simple way of looking at this is the fact that the African American culture in urban areas is deeply spiritual in nature, independent of whether someone goes to church or not. A church based programme may not necessarily work, but a spiritually based programme may. Ninety percent of African Americans of virtually every socioeconomic classification cite prayer as their major coping mechanism. Sixty five percent of urban African Americans attend church sometime during a year. Eighty percent of African Americans live with or are associated with someone who attends church. Some of the most effective ways to get substance abusers to come into treatment is to put a preacher out on the street, not in the church, and I guarantee you we will identify more people for treatment that way than we will by sending our traditional outreach workers out onto the street.

Does it work, does it last? I do not know. I would say one culturally bound way of doing business is to understand spirituality. As behavioural scientists, we often design interventions around taking control of our own behaviour. We are talking now about a higher power; allowing a higher power to take control. I also think if you gave nicotine replacement to every person free of charge in the urban environment, you would still have major problems because there are concerns about replacing a drug for a drug.

So what are the solutions? Basically, not only do things have to be accessible, but you have to provide an array of options including not only traditional medical and treatment options, but other options that are really culturally embedded. The second thing is that they have to be self directed by the culture. As long as they come through some major mainstream system, they will be suspect. You have to use issues that are popular in the community relative to youth. The inner city community is very concerned about their youth. I think that the billboard methods that the tobacco industry has used quite successfully, buying into whatever images attract black youth, are ways that we can begin to look at youth movements in the inner city community. Typical treatment models probably will not work, social and environmental models probably will.

**C Tracy Orleans**

Some data that I did not have time to show – and I wanted to re-emphasise the point that Dr Becker just made – gave the results of a very successful campaign in 14 matched communities, seven community pairs, that we are now midway through at the Fox Chase Cancer Center with an NCI grant. This campaign includes a mass media campaign using black-formatted radio as a channel to reach African Americans in Philadelphia, Atlanta, Houston, and many smaller inner city communities throughout the South. I think that the lessons learned there were that it took three years of careful work with African American smokers and gatekeepers in the African American community to develop a culturally sensitive guide, the *Pathways to freedom* guide. I wish that Robert Robinson could have been here to talk about that. It took another year of very careful pre-testing in the African American community to figure out not only the barriers to quitting, but the barriers to calling the Cancer

Information Service (CIS) 1–800 4CANCER for minimal help quitting.

What this campaign does is to use radio based messages to raise quitting motivation and awareness among African American smokers and to generate calls to the CIS. I have to say that we have been very successful with one low cost campaign costing less than the cost of one cigarette per African American smoker in the communities we targetted. We increased fourfold the proportion of African American callers into the CIS, and we are looking to see whether the *Pathways to freedom* guide and culturally sensitive counselling will get us better long term quit results with the African American smokers who called than standard approaches.

So while I think we do need a great deal of innovation, there are seeds of it in the work that Dr Becker has done and that is going on elsewhere. It has just taken a long time to get off the ground.

# Questions and answers

**JED ROSE:** I have a brief comment and then a question mainly directed to Dr Orleans. I noticed in one of the slides on the stepped care approach with tailoring the suggestion of using nicotine replacement in high dependent cigarette smokers. It was a plausible hypothesis a few years ago that it would only make sense to give nicotine to high nicotine dependent smokers, but now there are at least two published studies, one by Sachs and one by Stapleton and Russell, which clearly show that nicotine replacement augments success rates even in low nicotine dependent smokers. So even though we have painfully few predictors of success, I am afraid we are going to have to delete that one as a potential candidate, at least until more information comes in.

My broader question is directed at the conclusion that more resources should be put into disseminating existing treatments as opposed to developing new, innovative treatments. I really don't see how that follows from the experience of the last several years. How much money does the National Cancer Institute (NCI) spend on disseminating the current treatments, which admittedly are not that effective, compared with developing innovative new treatments that might be much more successful? If millions and millions of dollars had been pumped into developing new treatments over the last 10 or 20 years but outcomes were still disappointing, then it would seen reasonable to put money into dissemination. However, the impression I have is that most of the NCI's money is going into dissemination, and we know this has not produced very dramatic results. I conclude that we should be putting more money into developing more effective treatments.

**SAUL SHIFFMAN:** I do not think anyone can speak for NCI, but certainly NCI, as an agency, is radically committed to the dissemination strategy. I do not know how they are reacting to the results of community intervention trial for smoking cessation (COMMIT), but it certainly has not proved to be a big winner.

**C TRACY ORLEANS:** Dr Rose is absolutely correct that we have lost a major triage indicator. For transdermal nicotine, although not so clearly for nicotine gum, it is clear that all smokers are benefitting from nicotine replacement, including those with low to moderate levels of nicotine dependence. However, it is unlikely that a system will deploy those resources at a first level of treatment for all smokers, especially if they did not report difficulty in quitting in past attempts. So I think we are going to have to take another look at triage into nicotine replacement.

On the issue of better dissemination or better treatments, we really need both. At the end of my remarks, I did not have the time to say that I do not believe we need alternative treatment strategies at present or a move to harm reduction, because we have not been able to achieve cessation. I do not think that we have begun to tap the treatments we do have, and certainly we need to refuel and replenish our treatment arsenal, both pharmacological and behavioural.

**TERRY PECHACEK:** I am taking some responsibility for the priorities of NCI as they may still exist. It is clear that there was a rush to dissemination. I think COMMIT results are absolutely clear on that point. The phase II and phase III trials raised a number of warning flags which were not given sufficient weight. The COMMIT results have to be viewed in the context of a very strong trial. No strong randomised trial gives you a bad result. It may give you a result that you do not want, but it does not give you a wrong result. The result says that the dissemination of the existing technology is insufficient. Now the components of the protocol can be questioned, the relative emphasis of weight on certain policy aspects versus other components can be questioned, but fundamentally the staff achieved, at very high rates, the application of the existing technology, be that in physician training, policy consultations, work sites, or whatever.

The staff delivered currently available interventions for heavy smokers, those at the greatest risk, which call the nature of our technology into question. I think this is the fundamental aspect of the alternative strategies. We need to recognise that we lack effective treatments for heavy smokers. We do not have anything available for mass dis-

semination. That is a very powerful problem that cannot be glossed over.

Dr Becker's statements about other alternative populations are also very relevant, but we do not have anything for the mass population of smokers either, even though the other populations are important. If we are concerned about smoking cessation, should we not be doubling and tripling our fundamental research as opposed to our dissemination research?

**SAUL SHIFFMAN:** The metaphor that I have used in talking about this is the idea of seed corn. The farmer does not decide that either all the corn is going to go back into seed or all of it is going to be disseminated to market. The farmer does both. I think the problem is that NCI made a decision not to preserve any seed corn, and so we find ourselves in this situation. I do not think it can be either/or because we cannot ignore people who are currently smoking and perhaps in need of help, nor can we be so short sighted that we ignore the need for future development.

**DIANE BECKER:** We tend to think that dissemination is not a science, but it *is* a science. So when we talk about innovation, I think that learning how to disseminate what we know works is part of our alternative strategy. Just picking up the whole package and moving it out there, like we tend to do, is clearly not sufficient, and I maintain that knowing how to do that is exactly what the tobacco industry does.

So the things we do have that are effective can be studied scientifically, and efficacy and effectiveness trials could be done a bit better. But I agree with you completely. I am not satisfied; the state of the art is wholly inadequate so far as smoking cessation is concerned. I do not think there is much more we can say about that except that we do need innovative strategies, we need new models, and we need to know how to get what works disseminated.

**EDWARD ANSELM:** I have worked in the insurance industry, in hospitals, and with the corporate community doing health promotion, and I am very concerned about accountability for the future. We are making goals for the Year 2000. I am wondering what the accountability behind some of those goals might be. Just as an observation, I was here two years ago at *Who Quits, Who Pays*, and I notice at this conference, as at that one, there are no payers: insurance companies were not represented. It is really important who is going to be accountable within a corporate setting or a managed care organisation or the government if we do not meet some of the goals we are trying to define.

**C TRACY ORLEANS:** Accountability is a problem and it goes back to who pays. The single most important strategy for getting health plans to adopt even today's technology for smoking cessation would be to make it a HEDIS requirement. Employers judge managed care organisations by how well they meet HEDIS requirements.

Currently, there are only four prevention strategies in HEDIS: mammography screening, cervical Pap screening, immunisation, and cholesterol screening. If tobacco cessation counselling were included, there would be some accountability built into the system, and, like Mr Pinney, I do not have that much faith in the impact of the Agency for Health Care Policy and Research guidelines. No matter how science based and compelling the AHCPR guidelines are, they are not going to have regulatory force.

**JUDITH K OCKENE:** From a public health perspective, we do not necessarily need more treatments, but we do need better ways to disseminate them. I will agree that there is a lot of dissemination going on, but there is a missing link there. It is not just dissemination, it is the infrastructure that needs to be available in various facilities to accept that dissemination. When we think about reaching large numbers of people, it is really the provision for infrastructure, accountability, and guidelines that needs to be there in order for dissemination to work.

I would like to make a second point regarding the COMMIT trials. As was indicated by Dr Orleans, there was a 3% difference in the light to moderate smokers. In a less educated subgroup, there was an even greater percentage point difference. In the more educated, however, there was very little difference in the light to moderate smokers. In the less educated, meaning 12th grade and less, there was a 5.5% difference, and I think those data argue that the educational activities that were available were able to capture more of those individuals who are often not captured in our interventions.

I know we always talk about the half full and the half empty cup, but I would like to assert that the cup is half full, and that we need to continue to look at the missing links to enhance those efforts.