Tobacco control in the United States: the next generation of demonstration and research projects

As noted in the above commentary by Glantz, the landscape for tobacco control in the United States is changing dramatically due to unprecedented leadership in our national government,[28 29] state-based efforts to increase tobacco taxes and to sue tobacco companies,[30 31] and local measures to restrict the use of and access to tobacco. Based largely on the favourable evaluation results of the NCI's ASSIST trial, Glantz calls for a new NCI-coordinated programme (SCIENCE) for tobacco control research and development.

It is worth noting that the primary goal of ASSIST is to "reduce smoking prevalence

Tob Control: first published as 10.1136/tc.6.4.353 on 1 December 1997. Downloaded from http://tobaccocontrol.bmj.com/ on 20 March 2023 by guest. Protected by copyright.

among adults to 17 percent in ASSIST states by 1998"[33] (from a baseline of 24.1% in 1992–1993). This indicator is being measured by surveys at baseline (1992–1993), midpoint (1995–1996), and endpoint (1998–1999). To support his recommendation to launch SCIENCE, Glantz relies mainly on the work of Manley *et al*[34] examining per capita cigarette consumption in ASSIST states, compared with non-ASSIST states. This research showed a promising 7% difference in consumption between intervention and comparison states.[34] Despite this suggestive evidence, final data on the main outcome endpoint noted above will not be available for two to three years. As observed earlier in COMMIT,[35 36] secular (decreasing) trends in comparison states' smoking rates may lessen the likelihood that differences in smoking patterns between ASSIST and non-ASSIST states will be detected.

In light of these issues, does the evidence suggest that we should wait several years before deciding whether dissemination or a new round of demonstration and research trials, or both, are warranted? On this point, we agree with Glantz that the answer is emphatically "*No*". Plans for further work in this area should be developed with great urgency.

In conjunction with this urgency, consideration of strategic planning issues is needed. Glantz contends that "The issues of NCI's future research agenda for large-scale tobacco control interventions and the CDC's future expansion are fundamentally different questions which need to be addressed independently." However, we suggest it is essentially impossible to "un-couple" these issues—resources are always finite and public health efforts to control tobacco use relate to numerous federal agencies. The follow up to ASSIST should be a strategic national initiative in tobacco prevention and control, initially coordinated at the level of the US Secretary of Health and Human Services (HHS). Major input is essential from the Surgeon General, the relevant federal agencies, policy makers, academic researchers, public health practitioners (within and outside state and local public health agencies), and other community health advocates. Planning should consider numerous factors and programmes currently in the field, including ASSIST, COMMIT, the CDC's IMPACT programme, and the Robert Wood Johnson Foundation's SmokeLess States programme. The Secretary of HHS should articulate an agenda of explicit research questions that clearly outline the complementary roles of NCI and CDC. For example, the NIH and the CDC are jointly supporting a series of focused, competitive grants within the Community Prevention Study of the Women's Health Initiative.[37] A similar model should be considered for the present issues in tobacco control.

Glantz argues for new SCIENCE awards to research institutions and state and local tobacco control coalitions. We believe a clearer distinction is needed between roles in tobacco control demonstration (public health intervention) and those in tobacco control research.

Separate from research needs, tobacco control is a core public health function deserving of more attention from state and local health agencies due to the health burden from tobacco use and the availability of effective interventions.[38] In all likelihood, research institutions will have less "savvy" about day-to-day policy considerations, and public health agencies will be less inclined to conduct research. Therefore, careful consideration must be given to the design and programmatic structure of new grants and contracts. In a given geographical location (a state or large city), two parallel awards could be provided—one to a public health agency for intervention activities and another to a research institution for evaluation of interventions. Such a funding arrangement should accelerate the diffusion of research to practice. Widespread dissemination is especially appropriate following the completion of ASSIST because it represents the logical next phase after the conclusion of phase V research (demonstration and implementation).[39]

We will also highlight two related points. First, in developing the next generation of tobacco control demonstrations, it is critical that the array of potential interventions be evidence-based. These should take into account the "lessons learned" to date. For example, Oregon has developed a "toolkit" of best practices in tobacco control that illustrates the increasing sophistication of public health agencies.[40] A set of guidelines for community preventive services, currently under development, should augment these efforts.[41] Second, we are supportive of Glantz's notion to study the potential "dose-response" relationships between the size of various state-based tobacco control programmes and performance indicators. Such an evaluation should also take into account qualitative factors that may predict programme initiation and success.

In summary, we are in the midst of a critical period in the history of tobacco control in United States. We thank Glantz for stimulating more dialogue on future intervention and research in tobacco control—this discussion is critical for ensuring that public health opportunities are not missed.

ROSS C BROWNSON

Department of Community Health and Prevention Research Center,
School of Public Health, Saint Louis University,
3663 Lindell Boulevard,
St Louis, Missouri 63108–3342, USA;
email: brownson@slu.edu

RANDY SCHWARTZ

Division of Community and Family Health,
Maine Bureau of Health,
11 State House Station,
Augusta, Maine 04330, USA;
email: hwrschw@state.me.us

28 Statements by President Bill Clinton and the US Food and Drug Administration on regulations to restrict the marketing, sale, and distribution of tobacco to children. *Tobacco Control* 1995;4:299–309.

29 Davis RM. The ledger of tobacco control. Is the cup half empty or half full? (editorial). *JAMA* 1996;275:1284–24.

30 Bal DG, Kizer KW, Felten PG, Mozar HN, Niemeyer D. Reducing tobacco consumption in California: Development of a statewide anti-tobacco use campaign. *JAMA* 1990;**264**:1570–4.
31 Burns D, Benowitz N, Connolly GN, *et al.* What should be the elements of any settlement with the tobacco industry? *Tobacco Control* 1997;**6**:1–4.
32 US Department of Health and Human Services. *Major local tobacco control ordinances in the United States.* Smoking and Tobacco Control Monograph No 3. Bethesda, Maryland: Public Health Service, National Institutes of Health, 1993. (NIH Publication No 93-3532.)
33 Manley M, Lynn W, Epps RP, Grande D, Glynn T, Shopland D. The American Stop Smoking Intervention Study for Cancer Prevention: an overview. *Tobacco Control* 1997;**6**(suppl 2):S5–11.
34 Manley MW, Pierce JP, Gilpin EA, Rosbrook B, Berry C, Wun L-M. Impact of the American Stop Smoking Intervention Study (ASSIST) on cigarette consumption. *Tobacco Control* 1997;**6**(suppl 2):S12–16.
35 The COMMIT Research Group. Community Intervention Trial for Smoking Cessation (COMMIT): I. Cohort results from a four-year community intervention. *Am J Public Health* 1995;**85**:183–91.
36 The COMMIT Research Group. Community Intervention Trial for Smoking Cessation (COMMIT): II. Changes in adult cigarette smoking prevalence. *Am J Public Health* 1995;**85**:193–200.
37 Brownson RC, Riley P, Bruce TA. Demonstration projects in community-based prevention. *J Public Health Manag Pract* 1998;4:66–72.
38 Novotny TE, Romano RA, Davis RM, Mills SL. The public health practice of tobacco control: lessons learned and directions for the states in the 1990s. *Annu Rev Public Health* 1992;**13**:287–318.
39 Greenwald P, Cullen JW. The new emphasis in cancer control. *J Natl Cancer Inst* 1985;74:543–51.
40 Oregon Health Division. *Tool kit. Community based best practices to reduce tobacco use.* Portland, Oregon: Oregon Health Division, Tobacco Prevention and Education Program, September 1997.
41 Pappaioanou M, Evans C Jr. Development of a Guide to Community Preventive Services: a US Public Health Service initiative. *J Public Health Manag Pract* 1998;4:48–54.