

# Agenda

## Tobacco and Health Trust Fund Board

*Monday, April 16, 2012*

*9:30 a.m.*

*Followed by Public Hearing*

*10:00 a.m.*

*Legislative Office Building*

*Room 1C*

*Hartford, Connecticut*

- I. Welcome and Introductions
- II. Approval of December 2010 and March 2012 Minutes
- III. Follow-up on Board Requests
  - a. Revised Guiding Principles
  - b. Report on the Statewide Tumor Biorepository Feasibility Study
  - c. Executive Summary of the CHC Pregnant Women Program
  - d. Report on the Cessation Program for Individuals with Serious Mental Illness
  - e. School Based Anti-Tobacco Programs in Massachusetts
  - f. Summary on Cost Per Services, Successful Programs and Quit Rates
  - g. Proposal- AIC Adults and Youth
  - h. State Cigarette Excise Taxes versus Cessation Programs
  - i. States Tobacco Prevention Spending Levels
  - j. Report on Grassroots Prevention and Cessation Activities
- IV. Next Meeting

## D R A F T Meeting Summary

Tobacco and Health Trust Fund Board

Friday, December 17, 2010

10:00 a.m. – 12:00 Noon

Room 410

State Capitol

Hartford, Connecticut

Members Present: Anne Foley (Chair), Cheryl Resha, Elaine O’Keefe, Patricia Checko, Cindy Adams, Geralyn Laut, Norma Gyle, Larry Deutsch, Ellen Dornelas and Dianne Harnad.

Members Absent: Nancy Bafundo, Ken Ferrucci, Diane Becker, Doug Fishman, Rob Zavoski, Steve Papadakos, and Andy Salner.

Item	Discussion/Action
Welcome	The meeting was convened at 10:10 a.m.
Approval of November 2010 Minutes	Cindy Adams moved approval of the November minutes and the motion was seconded by Patricia Checko. The minutes were approved on a voice vote with one abstention by Ellen Dornelas.
Brief Interventions	Judith Cooney, Director of Smoking Cessation and Substance Abuse Day Programs for CT Veterans Affairs (VA) presented on brief intervention and cessation strategies. A summary of the discussion is as follows: <ul data-bbox="711 1745 1344 1873" style="list-style-type: none"><li>• Brief interventions for tobacco treatment typically consist of clinician guided intervention strategies that last for ten</li></ul>

	<p>minutes or less.</p> <ul style="list-style-type: none"> <li>• Brief Interventions can be used to encourage people to participate in more intensive treatment.</li> <li>• Brief interventions are cost effective strategies that improve smoking cessation rates. Program outcomes are doubled.</li> <li>• Brief intervention programs must include follow-up services.</li> <li>• VA Tobacco Cessation Program is based on the “5 A Model” : <ul style="list-style-type: none"> <li>○ Ask about smoking status</li> <li>○ Advice to quit</li> <li>○ Assess Dependence</li> <li>○ Assist to find appropriate treatment such as medication and counseling</li> <li>○ Arrange for follow up services.</li> </ul> </li> </ul> <p>Judith Cooney agreed to submit a written summary on brief intervention strategies presented at the meeting.</p>
Alternative Incarceration (AIC)	<p>Julie Revaz, Manager of Juvenile Programs and Services, and Jim Rushkowski, Court Planner from the Judicial Branch presented on the Alternative In the Communities (AIC) programs. Summary of the presentation is as follows:</p> <ul style="list-style-type: none"> <li>• Alternatives in the Communities Incarceration Program serve approximately 3,000 adults, 700 youth in the Youth Equipped for Success Program (YES) and an additional 225 high risk children through the home base intervention program.</li> <li>• The demographic breakdown of the YES program participants include: 80% male;</li> </ul>

	<p>20% female; 50% of the clients are African American; 25% are Latino and 25% are White.</p> <ul style="list-style-type: none"> <li>• Contingency Management techniques such as giving rewards and incentives for positive behavior should be part of a smoking cessation program.</li> <li>• Institutionalize brief interventions should cross all systems in which the tobacco users congregate and should not only be administered by health professionals.</li> <li>• Brief intervention strategies followed by more intensive treatment including nicotine replacement therapy (NRT) and counseling increases smoking cessation rates.</li> <li>• Providers must receive training on brief interventions.</li> <li>• Brief intervention program must include an evaluation component to report results.</li> </ul>
<p>Discussion of FY11 Funding Recommendations</p>	<p>After a lengthy discussion on possible disbursement recommendations for FY11, the board voted to explore developing a brief intervention program for adults and youth involved in AIC programs. The Judicial Branch was asked to develop and submit a proposal including program components such as, but not limited to:</p> <ul style="list-style-type: none"> <li>• Brief interventions strategies and referrals to more intense treatment such as counseling, nicotine replacement therapy and contingency management services.</li> <li>• Strategies to institutionalize brief</li> </ul>

	<p>interventions beyond health professionals.</p> <ul style="list-style-type: none"><li>• Determine the feasibility and cost effectiveness of providing carbon testing.</li><li>• Plan to train judicial staff.</li><li>• Describe how judicial will connect with the health care providers.</li><li>• Provide demographic data such as gender, ethnicity, number covered by Medicaid and those uninsured. Also include the number of case managers.</li></ul>
Next Meeting	The next board meeting will be on Friday, January 21 from 10:00 a.m. to 12:00 noon.

## D R A F T Meeting Summary

Tobacco and Health Trust Fund Board

Wednesday, March 28, 2012

3:00 p.m.

Room 410

State Capitol

Hartford, Connecticut

Members Present: Anne Foley (Chair), Cheryl Resha, Elaine O'Keefe, Patricia Checko, Geralyn Laut, Ellen Dornelas, Diane Becker, and Robert Zavoski.

Members Absent: Nancy Bafundo, Ken Ferrucci, Doug Fishman, Steve Papadakos, Larry Deutsch, Cindy Adams, and Andy Salner.

<b>Item</b>	<b>Discussion/Action</b>
Welcome	The meeting was convened at 3:10 p.m. Members and other attendees introduced themselves.
Approval of December 2010 Minutes	Due to the lack of a quorum, the December 2011 draft meeting minutes will be reviewed and approved at the next meeting.
Review Status of Trust Funds	The Chair reported that \$6,015,000 will be available for disbursement in both fiscal year 2012 and 2013. Upon completion of its recommendations, the Chair suggested that the board share with the Appropriations and Public Health Committees as soon as possible. This may not take place until after the current legislative session.
Review of Current Trust Fund Programs	The Department of Public Health provided a brief update on the current tobacco programs. Highlights include: <ul style="list-style-type: none"><li>• Quitline: remaining funds are available for</li></ul>

approximately 7 months at an average monthly cost of \$150,000-\$180,000. DPH is working with DSS to develop and implement a memorandum of understanding for reimbursement for tobacco cessation treatment rendered to Medicaid clients.

- Cessation Media Campaign: contract with Cronin and Company began advertisement of anti-tobacco efforts. The media campaign is starting the “Tobacco, It’s a Waste” Youth Campaign including a video contest to create a 30 second TV commercial. For 19-24 year old age group, a casting call will take place in September or October to produce a series of webisodes to air through social media.
- Community Based Cessation Programs: currently six sites are administering tobacco cessation program throughout the state. One of the sites, CommuniCare, Inc. is providing specialized tobacco cessation services to patients with severe mental health issues.
- Brief Intervention Counseling: Windham Community Memorial Hospital is offering brief interventions to emergency room patients, visitors, and their family members.
- Innovative Prevention Programs for School-Aged Youth: contracts up and running providing tobacco use prevention and cessation programs to youth.
- Evaluation: continue evaluation on the funded programs.

Board members requested additional information on the programs listed above, including, but not

	<p>limited to:</p> <ul style="list-style-type: none"> <li>• Report on the Statewide Tumor Biorepository Feasibility Study</li> <li>• Executive Summary of the CHC Pregnant Women Program</li> <li>• Cost per service, summary of successful programs and services, and report on quit rates.</li> <li>• Status report on the Cessation Program for individuals with serious mental illness.</li> <li>• Information regarding school based anti-tobacco programs in Massachusetts.</li> <li>• Detail proposal from the Judicial Branch regarding tobacco cessation programs targeted to AIC program participants, both adults and children.</li> <li>• The impact of increases in state cigarette excise taxes versus cessation programs resulting in reduced tobacco use.</li> <li>• CT's spending level on anti-tobacco efforts as compared to other states.</li> <li>• Information on grassroots prevention and cessation activities under the countermarketing media campaign.</li> </ul>
<p>Discussion of FY12 Funding Recommendations</p>	<p>Members discussed recommendations for the 2012 disbursement of \$6,015,000. Members suggested funding for: cessation programs, Quitline and a brief intervention program targeting the AIC population. Members agreed to hold a public hearing in April.</p>
<p>Next Meeting</p>	<p>The next meeting will be in April prior to the public hearing.</p>

3/9/12 - Tobacco and Health Trust Fund (numbers rounded)

	FY 12	FY 13	Comments
Balance as of 3/9/12	\$540,000		
Beginning of Year Unobligated Balance		\$2,998,000	
April Deposit	\$12,000,000	\$12,000,000	
Interest	\$3,000	\$15,000	
<i>Subtotal</i>	\$12,543,000	\$15,013,000	
Yet to Be Drawn Down: FY 12 Earmarks & Prior Years' Board Disbursements	(\$3,530,000)	-	\$1.1 million from FY 12 earmarks; \$2.4 million Board
FY 13 Earmarks	-	(\$5,350,000)	
Board Recommendations – FY 12 & 13	<u>(\$6,015,000)</u>	<u>(\$6,015,000)</u>	½ of current year deposit + prior year interest earned
EOY Unobligated Balance	\$2,998,000	\$3,648,000	

Revised

2012

## Tobacco & Health Trust Fund Board of Trustees

### Guiding Principles for Funding Decisions

*Adopted at the September 2001 Meeting and Amended at the July 2002 Meeting*

The following principles, which guide Board funding decisions, are not in priority order. Despite the focus on anti-tobacco efforts, other areas within the broad charge of the Board will not be dismissed without consideration.

1. **Sustainable programming.** Funding decisions should focus on programs that can be maintained without significant increases in use of trust fund dollars. Based on reasonable projections, budget forecasts will be used to help the Board identify future programming needs. In addition, resource development opportunities and other potential funding sources will be investigated.
2. **Consistent with existing public research and plan documents.** The Board will assess to what extent the proposed programming is consistent with existing research and plans, including, but not limited to:
  - Best Practices for Comprehensive Tobacco Control Programs by the U.S. Department of Health and Human Services Centers for Disease Control and Prevention, *October 2007*;
  - Connecticut Tobacco Use Prevention and Control Plan by the Connecticut Department of Public Health and the Department of Mental Health and Addiction Services; and
  - *The Guide to Community Preventive Services, The Community Prevention Services Task Force, U.S. Department of Health and Human Services*
3. **Complement and enhance existing programming and expenditures.** The State of Connecticut, as well as agencies external to state government, have made a commitment to programming in this area. To the greatest extent possible, funding decisions should build on existing programming to ensure the most efficient use of the Trust Funds resources.
4. **Focus on societal/environmental change.** The Board will support efforts that are designed to seek a cultural shift in the use of tobacco. The Board will not focus exclusively on efforts that treat individuals, but also on efforts that change the way society views tobacco and the

way systems work to control the use of tobacco. For example, population-based messages will be used, not just messages that are targeted to smokers.

5. **Cultural Sensitivity.** Recognizing that tobacco companies target their audience, the Board will ensure that marketing messages and other programming take into consideration differing cultural perspectives and languages.
6. **Effective and outcome-based efforts.** To the greatest extent possible, the Board will fund endeavors that are measurable, science-based, and proven to be effective.

## State Cigarette Excise Tax

- ✓ Tobacco tax increases are one of the most effective ways to reduce smoking, especially among kids
- ✓ Economic studies indicate that cigarette tax or price increases reduce both adult and underage smoking. General consensus is that every 10% increase in the real price of cigarettes reduces overall cigarette consumption by approximately 3%-5%, reduces the number of young adult smokers by 3.5%, and reduces the number of kids who smoke by 6% or 7% <sup>(1)</sup>
- ✓ Cigarette price and tax increases work even more effectively to reduce smoking among males, Blacks, Hispanics and lower income smokers<sup>(1)</sup>
- ✓ A cigarette tax increase that raises prices by 10% will reduce smoking among pregnant women by 7% <sup>(1)</sup>
- ✓ Interventions to increase the price of tobacco products are recommended by the National Academy of Sciences' Institute- *A Blueprint for the Nation*, the President's Cancer Panel, *Promoting Healthy Lifestyles*, and the US Surgeon General's Report, *Reducing Tobacco Use*. The evidence links the increased costs of tobacco products to (1) reduced tobacco use, (2) reduced initiation of tobacco use, and (3) increased tobacco cessation.

Source: (1) Campaign for Tobacco Free Kids – *Raising Cigarette Taxes Reduces Smoking, Especially Among*

## State Ranking of Tobacco Prevention Spending

- States are falling short of recommended funding levels for tobacco prevention programs set by the U.S. Centers for Disease Control and Prevention (CDC)
  - 23 states and the District of Columbia, including Connecticut, are spending less than 10% of the CDC recommended funding level. The CDC recommended spending level for Connecticut is \$43.9 million.
  - Connecticut is one of five states that rank 50<sup>th</sup> among other states in tobacco prevention spending.
  - 10 states are spending 10% - 24% of the CDC recommended funding level
  - 10 states are spending 25-49% of the CDC recommended funding level
  - 6 states are spending 0% or more of the CDC recommended funding level

*Source: Campaign for Tobacco-Free Kids*

## Appendix B



### TOBACCO-PREVENTION SPENDING vs. STATE TOBACCO REVENUES

[All amounts are in millions of dollars per year, except where otherwise indicated]

Despite receiving massive amounts of annual revenue from tobacco taxes and the state tobacco lawsuit settlements with the cigarette companies, the vast majority of states are still failing to invest even the minimum amounts recommended by the U.S. Centers for Disease Control and Prevention (CDC) to prevent and reduce tobacco use and minimize related health harms and costs.

State	Annual Smoking Caused Health Costs	FY 2012 State Tobacco Prevention Spending	CDC Annual Spending Target	Tobacco Prevention Spending % of CDC Target	Tobacco Prevention Spending Rank (1= high)	FY 2012 State Tobacco Settlement Revenues (est.)	FY 2012 State Tobacco Tax Revenues (est.)	Total Annual State Revenues From Tobacco (est.)	Tobacco Prevention Spending % of Tobacco Revenue
<b>States Total</b>	<b>\$96.7 bill.</b>	<b>\$456.7</b>	<b>\$3.7 bill.</b>	<b>12.4%</b>	<b>-</b>	<b>\$7.4 bill.</b>	<b>\$18.2 bill.</b>	<b>\$25.6 bill.</b>	<b>1.8%</b>
Alabama <sup>a</sup>	\$1.49 bill.	NA	\$56.7	NA	NA	\$98.0	\$141.9	\$237	NA
Alaska	\$169	\$10.8	\$10.7	101.3%	1st	\$31.9	\$89.0	\$100	10.8%
Arizona	\$1.3 bill.	\$18.0	\$68.1	26.4%	14th	\$105.2	\$338.1	\$443	4.1%
Arkansas	\$812	\$7.4	\$36.4	20.5%	17th	\$51.9	\$240.4	\$292	2.6%
California	\$9.14 bill.	\$70.0	\$441.9	15.8%	22nd	\$752.3	\$905.0	\$1.7 bill.	4.2%
Colorado	\$1.31 bill.	\$6.5	\$54.4	11.9%	25th	\$94.2	\$195.9	\$290	2.2%
Connecticut	\$1.63 bill.	\$0.0	\$43.9	0.0%	50th	\$128.5	\$381.1	\$509	0.0%
Delaware	\$284	\$9.0	\$13.9	64.9%	4th	\$27.7	\$126.2	\$153	5.9%
DC	\$243	\$0.0	\$10.5	0.0%	50th	\$39.6	\$36.3	\$75	0.0%
Florida	\$6.32 bill.	\$62.3	\$210.9	29.5%	13th	\$360.9	\$1,309.5	\$1.7 bill.	3.7%
Georgia	\$2.25 bill.	\$2.0	\$116.5	1.7%	40th	\$144.2	\$226.4	\$370	0.5%
Hawaii	\$336	\$10.7	\$15.2	70.3%	3rd	\$51.3	\$136.5	\$187	5.7%
Idaho	\$319	\$0.9	\$16.9	5.2%	34th	\$25.9	\$48.6	\$74	1.2%
Illinois	\$4.10 bill.	\$9.5	\$157.0	6.1%	33rd	\$280.5	\$576.1	\$856	1.1%
Indiana	\$2.08 bill.	\$10.1	\$78.8	12.8%	24th	\$133.8	\$467.2	\$601	1.7%
Iowa	\$1.01 bill.	\$3.3	\$36.7	8.9%	28th	\$68.9	\$225.2	\$294	1.1%
Kansas	\$927	\$1.0	\$32.1	3.1%	37th	\$60.4	\$100.5	\$160	0.6%
Kentucky	\$1.50 bill.	\$2.2	\$57.2	3.9%	36th	\$104.1	\$285.7	\$389	0.6%
Louisiana	\$1.47 bill.	\$8.4	\$53.5	15.8%	22nd	\$145.7	\$149.3	\$295	2.9%
Maine	\$802	\$9.4	\$18.5	50.6%	6th	\$52.9	\$144.4	\$197	4.8%
Maryland	\$1.96 bill.	\$4.3	\$63.3	6.8%	32nd	\$150.9	\$399.2	\$550	0.8%
Massachusetts	\$3.54 bill.	\$4.2	\$90.0	4.6%	35th	\$261.7	\$571.2	\$832	0.5%
Michigan	\$3.40 bill.	\$1.8	\$121.2	1.5%	41st	\$262.6	\$959.3	\$1.2 bill.	0.1%
Minnesota	\$2.06 bill.	\$19.5	\$58.4	33.4%	10th	\$165.1	\$468.7	\$633	3.1%
Mississippi	\$719	\$9.9	\$39.2	25.3%	15th	\$111.6	\$153.9	\$265	3.7%
Missouri	\$2.13 bill.	\$0.1	\$73.2	0.1%	45th	\$138.8	\$105.8	\$244	0.0%
Montana	\$277	\$4.7	\$13.9	33.8%	9th	\$31.5	\$88.1	\$119	3.9%
Nebraska	\$537	\$2.4	\$21.5	11.0%	26th	\$38.9	\$68.6	\$107	2.2%
Nevada	\$565	\$0.0	\$32.5	0.0%	50th	\$41.8	\$105.8	\$147	0.0%
New Hampshire	\$564	\$0.0	\$19.2	0.0%	50th	\$43.9	\$220.4	\$264	0.0%
New Jersey	\$3.17 bill.	\$1.2	\$119.8	1.0%	43rd	\$237.5	\$776.4	\$1.0 bill.	0.1%
New Mexico	\$461	\$5.9	\$23.4	25.3%	15th	\$40.8	\$97.5	\$138	4.3%
New York	\$8.17 bill.	\$41.4	\$254.3	16.3%	20th	\$754.5	\$1,580.7	\$2.3	1.8%
North Carolina	\$2.46 bill.	\$17.3	\$106.8	16.2%	21st	\$144.9	\$287.0	\$431	4.0%
North Dakota	\$247	\$8.1	\$9.3	87.0%	2nd	\$33.4	\$24.1	\$57	14.2%

State Spending vs. Tobacco Company Marketing

State	Annual Smoking Caused Health Costs in State	FY2012 Total Tobacco Prevention Spending	2008 Tobacco Company Marketing in State	Percentage of Tobacco Company Marketing that State Spends on Tobacco Prevention	Ratio of Tobacco Company Marketing to State Tobacco Prevention Spending
Minnesota	\$2.06 bill.	\$19.5	\$157.0	12.4%	8.1 to 1
Mississippi	\$719	\$9.9	\$161.9	6.1%	16.4 to 1
Missouri	\$2.13 bill.	\$60,000	\$349.0	0.0%	5,816 to 1
Montana	\$277	\$4.7	\$29.8	15.8%	6.3 to 1
Nebraska	\$537	\$2.4	\$66.5	3.6%	28.1 to 1
Nevada	\$565	\$0.0	\$94.1	0.0%	NA
New Hampshire	\$564	\$0.0	\$88.5	0.0%	NA
New Jersey	\$3.17 bill.	\$1.2	\$176.1	0.7%	142.1 to 1
New Mexico	\$461	\$5.9	\$39.7	14.9%	6.7 to 1
New York	\$8.17 bill.	\$41.4	\$360.3	11.5%	8.7 to 1
North Carolina	\$2.46 bill.	\$17.3	\$396.0	4.4%	22.9 to 1
North Dakota	\$247	\$8.1	\$28.0	28.9%	3.5 to 1
Ohio	\$4.37 bill.	\$0.0	\$440.1	0.0%	NA
Oklahoma	\$1.16 bill.	\$21.2	\$186.0	11.4%	8.8 to 1
Oregon	\$1.11 bill.	\$8.3	\$112.0	7.4%	13.5 to 1
Pennsylvania	\$5.19 bill.	\$13.9	\$452.8	3.1%	32.5 to 1
Rhode Island	\$506	\$372,665	\$27.3	1.4%	73.3 to 1
South Carolina	\$1.09 bill.	\$5.0	\$232.9	2.1%	46.6 to 1
South Dakota	\$274	\$4.0	\$23.4	17.1%	5.9 to 1
Tennessee	\$2.16 bill.	\$200,000	\$253.7	0.1%	1,268 to 1
Texas	\$5.83 bill.	\$5.5	\$622.4	0.9%	114.2 to 1
Utah	\$345	\$7.2	\$49.1	14.6%	6.8 to 1
Vermont	\$233	\$3.3	\$19.0	17.4%	5.7 to 1
Virginia	\$2.08 bill.	\$8.4	\$336.4	2.5%	40.2 to 1
Washington	\$1.95 bill.	\$750,000	\$122.5	0.6%	163.3 to 1
West Virginia	\$690	\$5.7	\$121.2	4.7%	21.5 to 1
Wisconsin	\$2.02 bill.	\$5.3	\$223.0	2.4%	42.0 to 1
Wyoming	\$136	\$5.4	\$24.5	22.0%	4.5 to 1

Campaign for Tobacco-Free Kids, November 18, 2011 / Meg Riordan

More information on tobacco company marketing is available at

[http://www.tobaccofreekids.org/facts\\_issues/fact\\_sheets/toll/tobacco\\_kids/marketing/](http://www.tobaccofreekids.org/facts_issues/fact_sheets/toll/tobacco_kids/marketing/).

More state information relating to tobacco use is available at

[http://www.tobaccofreekids.org/facts\\_issues/key\\_issues/](http://www.tobaccofreekids.org/facts_issues/key_issues/).

**Sources:**

CDC, *State Highlights 2006*, [and underlying CDC data and estimates]. See, also, CDC, "Annual Smoking-Attributable Mortality, Years of Potential Life Lost, and Economic Costs -- United States 2000-2004," *MMWR* 57(45), November 14, 2008. U.S. General Accounting Office (GAO), "CDC's April 2002 Report on Smoking: Estimates of Selected Health Consequences of Cigarette Smoking Were Reasonable," letter to U.S. Rep. Richard Burr, July 16, 2003, [http://www.gao.gov/new\\_items/d03042r.pdf](http://www.gao.gov/new_items/d03042r.pdf).

Campaign for Tobacco-Free Kids, et al., *A Decade of Broken Promises: The 1998 State Tobacco Settlement Thirteen Years Later*, 2011, <http://www.tobaccofreekids.org/reports/settlements/>.

CDC, *Best Practices for Comprehensive Tobacco Control*, October 2007, [http://www.cdc.gov/tobacco/tobacco\\_control\\_programs/stateandcommunity/best\\_practices/index.htm](http://www.cdc.gov/tobacco/tobacco_control_programs/stateandcommunity/best_practices/index.htm)

U.S. Federal Trade Commission (FTC), *Cigarette Report for 2007 and 2008*, 2011, <http://www.ftc.gov/os/2011/07/110729cigarettereport.pdf>. See also, FTC, *Smokeless Tobacco Report for 2007 and 2008*, 2011, <http://www.ftc.gov/os/2011/07/110729smokelesstobaccoreport.pdf>. Data for top 5 manufacturers only. State total is a prorated estimate based on cigarette pack sales in the state.



### SPENDING vs. TOBACCO COMPANY MARKETING

[All amounts are annual and in millions of dollars per year, except where otherwise indicated]

States are still failing to invest the amounts recommended by the U.S. Centers for Disease Control and Prevention (CDC) to prevent and reduce tobacco use and related health harms and costs – and a number of states have significantly reduced their tobacco prevention spending. At the same time, the tobacco industry continues to spend overwhelming amounts to market their products, despite the limited restrictions on its marketing activities contained in the November 1998 Master Settlement Agreement (MSA) with the states. From 1998 to 2008, the major tobacco companies have increased their spending to promote their deadly products by 52 percent.

As a result, the states are being massively outspent, with state tobacco prevention efforts amounting to only a small fraction of tobacco industry marketing. In North Carolina, for example, the tobacco industry spends \$396 to promote its deadly products for every single dollar the state spends to prevent and reduce tobacco use and its harms. To look at it another way, North Carolina's tobacco prevention spending amounts to just four percent of the tobacco industry's marketing expenditures in the state. Nationwide, the tobacco industry is outspending tobacco prevention funding in the states by 23 to 1.<sup>1</sup>

State	Annual Smoking Caused Health Costs in State	FY2012 Total Tobacco Prevention Spending	2008 Tobacco Company Marketing in State	Percentage of Tobacco Company Marketing that State Spends on Tobacco Prevention	Ratio of Tobacco Company Marketing to State Tobacco Prevention Spending
<b>Total</b>	<b>\$96.7 bill.</b>	<b>\$456.7</b>	<b>\$10.5 bill.</b>	<b>4.4%</b>	<b>23 to 1</b>
Alabama	\$1.49 bill.	NA	\$214.1	NA	NA
Alaska	\$169	\$10.8	\$19.0	57.0%	1.8 to 1
Arizona	\$1.3 bill.	\$18.0	\$119.3	15.1%	6.6 to 1
Arkansas	\$812	\$7.4	\$129.5	5.8%	17.4 to 1
California	\$9.14 bill.	\$70.0	\$656.3	10.7%	9.4 to 1
Colorado	\$1.31 bill.	\$6.5	\$139.6	4.6%	21.6 to 1
Connecticut	\$1.63 bill.	\$0.0	\$98.4	0.0%	NA
Delaware	\$284	\$9.0	\$68.4	13.2%	7.6 to 1
DC	\$243	\$0.0	\$13.5	0.0%	NA
Florida	\$6.32 bill.	\$62.3	\$734.2	8.5%	11.8 to 1
Georgia	\$2.25 bill.	\$2.0	\$348.7	0.6%	174.4 to 1
Hawaii	\$336	\$10.7	\$33.5	31.9%	3.1 to 1
Idaho	\$319	\$880,000	\$49.7	1.8%	56.5 to 1
Illinois	\$4.10 bill.	\$9.5	\$365.3	2.6%	38.5 to 1
Indiana	\$2.08 bill.	\$10.1	\$307.5	3.3%	30.6 to 1
Iowa	\$1.01 bill.	\$3.3	\$102.0	3.2%	31.3 to 1
Kansas	\$927	\$1.0	\$85.0	1.2%	85.0 to 1
Kentucky	\$1.50 bill.	\$2.2	\$356.8	0.6%	159.0 to 1
Louisiana	\$1.47 bill.	\$8.4	\$223.7	3.8%	26.5 to 1
Maine	\$602	\$9.4	\$43.1	21.7%	4.6 to 1
Maryland	\$1.96 bill.	\$4.3	\$144.1	3.0%	33.4 to 1
Massachusetts	\$3.54 bill.	\$4.2	\$164.8	2.5%	39.7 to 1
Michigan	\$3.40 bill.	\$1.8	\$313.0	0.6%	171.0 to 1

<sup>1</sup> These ratios are based on state and federal tobacco prevention expenditures in FY2012 versus tobacco industry marketing expenditures in 2008 (the most recent year for which data is available).

State Spending vs. Tobacco Company Marketing

State	Annual Smoking Caused Health Costs in State	FY2012 Total Tobacco Prevention Spending	2008 Tobacco Company Marketing in State	Percentage of Tobacco Company Marketing that State Spends on Tobacco Prevention	Ratio of Tobacco Company Marketing to State Tobacco Prevention Spending
Minnesota	\$2.06 bill.	\$19.5	\$157.0	12.4%	8.1 to 1
Mississippi	\$719	\$9.9	\$161.9	6.1%	16.4 to 1
Missouri	\$2.13 bill.	\$60,000	\$349.0	0.0%	5,816 to 1
Montana	\$277	\$4.7	\$29.8	15.8%	6.3 to 1
Nebraska	\$537	\$2.4	\$66.5	3.6%	28.1 to 1
Nevada	\$565	\$0.0	\$94.1	0.0%	NA
New Hampshire	\$564	\$0.0	\$88.5	0.0%	NA
New Jersey	\$3.17 bill.	\$1.2	\$176.1	0.7%	142.1 to 1
New Mexico	\$461	\$5.9	\$39.7	14.9%	6.7 to 1
New York	\$8.17 bill.	\$41.4	\$360.3	11.5%	8.7 to 1
North Carolina	\$2.46 bill.	\$17.3	\$396.0	4.4%	22.9 to 1
North Dakota	\$247	\$8.1	\$28.0	28.9%	3.5 to 1
Ohio	\$4.37 bill.	\$0.0	\$440.1	0.0%	NA
Oklahoma	\$1.16 bill.	\$21.2	\$186.0	11.4%	8.8 to 1
Oregon	\$1.11 bill.	\$8.3	\$112.0	7.4%	13.5 to 1
Pennsylvania	\$5.19 bill.	\$13.9	\$452.8	3.1%	32.5 to 1
Rhode Island	\$506	\$372,665	\$27.3	1.4%	73.3 to 1
South Carolina	\$1.09 bill.	\$5.0	\$232.9	2.1%	46.6 to 1
South Dakota	\$274	\$4.0	\$23.4	17.1%	5.9 to 1
Tennessee	\$2.16 bill.	\$200,000	\$253.7	0.1%	1,268 to 1
Texas	\$5.83 bill.	\$5.5	\$622.4	0.9%	114.2 to 1
Utah	\$345	\$7.2	\$49.1	14.6%	6.8 to 1
Vermont	\$233	\$3.3	\$19.0	17.4%	5.7 to 1
Virginia	\$2.08 bill.	\$8.4	\$336.4	2.5%	40.2 to 1
Washington	\$1.95 bill.	\$750,000	\$122.5	0.6%	163.3 to 1
West Virginia	\$690	\$5.7	\$121.2	4.7%	21.5 to 1
Wisconsin	\$2.02 bill.	\$5.3	\$223.0	2.4%	42.0 to 1
Wyoming	\$136	\$5.4	\$24.5	22.0%	4.5 to 1

Campaign for Tobacco-Free Kids, November 18, 2011 / Meg Riordan

More information on tobacco company marketing is available at

[http://www.tobaccofreekids.org/facts\\_issues/fact\\_sheets/toll/tobacco\\_kids/marketing/](http://www.tobaccofreekids.org/facts_issues/fact_sheets/toll/tobacco_kids/marketing/).

More state information relating to tobacco use is available at

[http://www.tobaccofreekids.org/facts\\_issues/key\\_issues/](http://www.tobaccofreekids.org/facts_issues/key_issues/).

**Sources:**

CDC, *State Highlights 2006*, [and underlying CDC data and estimates]. See, also, CDC, "Annual Smoking-Attributable Mortality, Years of Potential Life Lost, and Economic Costs -- United States 2000-2004," *MMWR* 57(45), November 14, 2008. U.S. General Accounting Office (GAO), "CDC's April 2002 Report on Smoking: Estimates of Selected Health Consequences of Cigarette Smoking Were Reasonable," letter to U.S. Rep. Richard Burr, July 16, 2003, [http://www.gao.gov/new\\_items/d03042r.pdf](http://www.gao.gov/new_items/d03042r.pdf).

Campaign for Tobacco-Free Kids, et al., *A Decade of Broken Promises: The 1998 State Tobacco Settlement Thirteen Years Later*, 2011, <http://www.tobaccofreekids.org/reports/settlements/>.

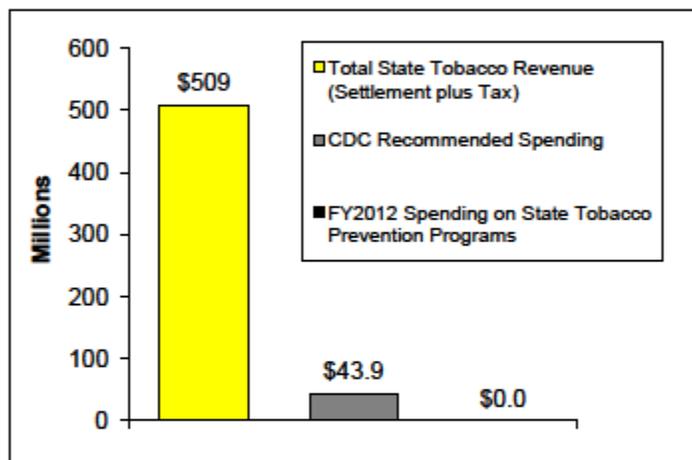
CDC, *Best Practices for Comprehensive Tobacco Control*, October 2007, [http://www.cdc.gov/tobacco/tobacco\\_control\\_programs/stateandcommunity/best\\_practices/index.htm](http://www.cdc.gov/tobacco/tobacco_control_programs/stateandcommunity/best_practices/index.htm)

U.S. Federal Trade Commission (FTC), *Cigarette Report for 2007 and 2008*, 2011, <http://www.ftc.gov/os/2011/07/110729cigarettereport.pdf>. See also, FTC, *Smokeless Tobacco Report for 2007 and 2008*, 2011, <http://www.ftc.gov/os/2011/07/110729smokelesstobaccoreport.pdf>. Data for top 5 manufacturers only. State total is a prorated estimate based on cigarette pack sales in the state.

### Connecticut

	FY2012	FY2011
<b>State Ranking</b>	50	45
<b>STATE SPENDING ON TOBACCO PREVENTION</b>	\$0.0	\$400,000
<b>% of CDC Recommended Spending (\$43.9 million)</b>	0.0%	0.9%

**Summary:** The U.S. Centers for Disease Control and Prevention (CDC) recommends that Connecticut spend \$43.9 million a year to have an effective, comprehensive tobacco prevention program. Connecticut currently allocates \$0.0 a year for tobacco prevention and cessation. This is 0.0% of the CDC's recommendation and ranks Connecticut 50th among the states in the funding of tobacco prevention programs. Connecticut's spending on tobacco prevention amounts to 0.0% of the estimated \$509 million in tobacco-generated revenue the state collects each year from settlement payments and tobacco taxes.



**Recent Developments:** Connecticut's tobacco settlement payments are folded into the general fund and allocated through the biennial budget process. In FY2009, the legislature changed the rules governing expenditure of funds from the state's Tobacco and Health Trust Fund (THTF). The Trust Fund's Board is now able to spend up to 50 percent of the amount the legislature adds to the principal Fund balance, if any, in that year, in addition to any interest that the fund has accumulated. During the 2010 legislative session, the legislature redirected the \$12 million in annual payments from the THTF to General Revenue for FY2011 and FY2012. In addition, the legislature transferred \$5 million from the fund to General Revenue, leaving only \$400,000 in the fund. In FY2011, that \$400,000 was available to be appropriated for tobacco prevention and cessation programs. However, recommendations for the use of these funds were never made and as a result, there was no spending on tobacco prevention and cessation in FY2011. For FY2012, no state funds were appropriated for the tobacco prevention and cessation program; however, Governor Dan Malloy (D) included support for tobacco cessation treatment for Medicaid enrollees in the state budget.

Connecticut is spending minimal amounts on tobacco prevention despite the fact that the state is receiving more tobacco-generated revenue than ever before as a result of a 40-cent cigarette tax increase, which went into effect on July 1, 2011, bringing Connecticut's total cigarette tax to \$3.40 a pack. In addition, the excise tax on snuff tobacco increased from 55 cents to one dollar per ounce and the tax rate on all other tobacco products was increased to 50 percent of the wholesale price.

Connecticut is receiving \$1.8 million in federal funds dedicated to tobacco prevention and control:

- \$1.1 million from the U.S. Centers for Disease Control and Prevention in a 12-month grant for the period beginning April 2011 (from annual appropriations).
- \$96,478 from the Prevention and Public Health Fund in the new health care reform law.
- \$615,539 from the Food and Drug Administration for enforcement of the Family Smoking Prevention and Tobacco Control Act, including the provision regarding tobacco sales to minors.

Tobacco's Toll in Connecticut	
Adults who smoke	13.2%
High school students who smoke	15.3%
Deaths caused by smoking each year	4,700
Annual health care costs directly caused by smoking	\$1.63 billion
Residents' state & federal tax burden from smoking-caused government expenditures	\$665 per household
Annual tobacco company marketing in state	\$98.4 million
Ratio of Tobacco Company Marketing to Total Spending on Tobacco Prevention	NA to 1

Appendix A



History of Spending for State Tobacco Prevention Programs FY2007 - FY2012

	FY2012		FY2011		FY2010		FY2009		FY2008		FY2007	
	Spending (\$millions)	Percent of CDC Rec. *	Spending (\$millions)	Percent of CDC Rec. *	Spending (\$millions)	Percent of CDC Rec. *	Spending (\$millions)	Percent of CDC Rec. *	Spending (\$millions)	Percent of CDC Min.	Spending (\$millions)	Percent of CDC Min.
States Total	\$456.7	12.4%	\$517.9	14.0%	\$569.3	15.4%	\$670.9	18.1%	\$717.2	44.8%	\$597.5	37.2%
Alabama**	NA	NA	\$0.9	1.5%	\$0.8	1.3%	\$1.2	2.1%	\$0.8	2.9%	\$0.7	2.6%
Alaska	\$10.8	101.3%	\$9.8	92.0%	\$9.2	86.0%	\$8.2	76.6%	\$7.5	92.5%	\$6.2	76.6%
Arizona	\$18.0	26.4%	\$19.8	29.1%	\$22.1	32.5%	\$21.0	30.8%	\$23.5	84.6%	\$25.5	91.8%
Arkansas	\$7.4	20.5%	\$11.8	32.4%	\$18.7	51.4%	\$16.0	44.0%	\$15.6	87.1%	\$15.1	84.3%
California	\$70.0	15.8%	\$75.0	17.0%	\$77.1	17.4%	\$77.7	17.6%	\$77.4	46.9%	\$84.0	50.9%
Colorado	\$6.5	11.9%	\$7.0	12.9%	\$11.1	20.4%	\$26.4	48.5%	\$26.0	105.9%	\$25.0	101.8%
Connecticut	\$0.0	0.0%	\$0.4	0.9%	\$6.1	13.9%	\$7.4	16.9%	\$0.0	0.0%	\$2.0	9.4%
Delaware	\$9.0	64.9%	\$8.3	59.5%	\$10.1	72.7%	\$10.7	77.0%	\$10.7	123.8%	\$10.3	119.4%
DC	\$0.0	0.0%	\$0.6	5.4%	\$0.9	8.1%	\$3.6	34.3%	\$3.6	48.1%	\$0.5	6.7%
Florida	\$62.3	29.5%	\$61.6	29.2%	\$65.8	31.2%	\$59.5	28.2%	\$58.0	74.0%	\$5.6	7.1%
Georgia	\$2.0	1.7%	\$2.0	1.8%	\$2.1	1.8%	\$2.3	2.0%	\$2.2	5.3%	\$2.3	5.4%
Hawaii	\$10.7	70.3%	\$9.3	61.1%	\$7.9	52.0%	\$10.5	69.1%	\$10.4	96.3%	\$9.1	84.0%
Idaho	\$0.9	5.2%	\$1.5	8.9%	\$1.2	7.1%	\$1.7	10.1%	\$1.4	12.6%	\$0.9	8.2%
Illinois	\$9.5	6.1%	\$9.5	6.1%	\$8.5	5.4%	\$8.5	5.4%	\$8.5	13.1%	\$8.5	13.1%
Indiana	\$10.1	12.8%	\$9.2	11.7%	\$10.8	13.7%	\$15.1	19.2%	\$16.2	46.6%	\$10.9	31.3%
Iowa	\$3.3	8.9%	\$7.3	20.0%	\$10.1	27.5%	\$10.4	28.3%	\$12.3	63.5%	\$6.5	33.6%
Kansas	\$1.0	3.1%	\$1.0	3.1%	\$1.0	3.1%	\$1.0	3.1%	\$1.4	7.8%	\$1.0	5.5%
Kentucky	\$2.2	3.9%	\$2.6	4.5%	\$2.8	4.9%	\$2.8	4.9%	\$2.4	9.4%	\$2.2	8.8%
Louisiana	\$8.4	15.8%	\$9.0	16.9%	\$7.8	14.8%	\$7.8	14.2%	\$7.7	28.3%	\$8.0	29.5%
Maine	\$9.4	50.6%	\$9.9	53.5%	\$10.8	58.4%	\$10.9	58.9%	\$16.9	151.2%	\$14.7	131.3%
Maryland	\$4.3	6.8%	\$4.3	6.9%	\$5.5	8.7%	\$19.6	31.0%	\$18.4	80.7%	\$18.7	81.7%
Massachusetts	\$4.2	4.6%	\$4.5	5.0%	\$4.5	5.0%	\$12.2	13.6%	\$12.8	36.2%	\$8.3	23.4%
Michigan	\$1.8	1.5%	\$2.6	2.1%	\$2.6	2.1%	\$3.7	3.1%	\$3.6	6.6%	\$0.0	0.0%
Minnesota	\$19.5	33.4%	\$19.6	33.6%	\$20.3	34.8%	\$20.5	35.1%	\$22.1	77.2%	\$21.7	75.8%
Mississippi	\$9.9	25.3%	\$9.9	25.3%	\$10.6	27.0%	\$10.3	26.3%	\$8.0	42.6%	\$0.0	0.0%
Missouri	\$0.1	0.1%	\$0.1	0.1%	\$1.2	1.6%	\$1.7	2.3%	\$0.2	0.6%	\$0.0	0.0%

	FY2012		FY2011		FY2010		FY2009		FY2008		FY2007	
	Spending (\$millions)	Percent of CDC Rec. *	Spending (\$millions)	Percent of CDC Rec. *	Spending (\$millions)	Percent of CDC Rec. *	Spending (\$millions)	Percent of CDC Rec. *	Spending (\$millions)	Percent of CDC Min.	Spending (\$millions)	Percent of CDC Min.
Montana	\$4.7	33.8%	\$8.4	60.4%	\$8.4	60.4%	\$8.5	61.2%	\$8.5	90.6%	\$6.9	73.7%
Nebraska	\$2.4	11.0%	\$2.9	13.3%	\$3.0	14.0%	\$3.0	14.0%	\$2.5	18.8%	\$3.0	22.5%
Nevada	\$0.0	0.0%	\$0.0	0.0%	\$2.9	8.9%	\$3.4	10.5%	\$2.0	14.8%	\$3.8	28.2%
New Hampshire	\$0.0	0.0%	\$0.0	0.0%	\$0.0	0.0%	\$0.2	1.0%	\$1.3	12.3%	\$0.0	0.0%
New Jersey	\$1.2	1.0%	\$0.6	0.5%	\$7.6	6.3%	\$9.1	7.6%	\$11.0	24.4%	\$11.0	24.4%
New Mexico	\$5.9	25.3%	\$7.0	29.8%	\$9.5	40.6%	\$9.6	41.0%	\$9.6	70.1%	\$7.7	56.2%
New York	\$41.4	16.3%	\$58.4	23.0%	\$55.2	21.7%	\$80.4	31.6%	\$85.5	89.2%	\$85.5	89.2%
North Carolina	\$17.3	16.2%	\$18.3	17.1%	\$18.3	17.1%	\$17.1	16.0%	\$17.1	40.2%	\$17.1	40.2%
North Dakota	\$8.1	87.0%	\$8.2	88.1%	\$8.2	88.2%	\$3.1	33.3%	\$3.1	38.4%	\$3.1	38.0%
Ohio	\$0.0	0.0%	\$0.0	0.0%	\$6.0	4.1%	\$6.0	4.1%	\$44.7	72.4%	\$45.0	72.9%
Oklahoma	\$21.2	47.1%	\$21.7	48.2%	\$19.8	44.0%	\$18.0	40.0%	\$14.2	65.1%	\$10.0	45.8%
Oregon	\$8.3	19.3%	\$7.1	16.6%	\$6.6	15.3%	\$8.2	19.1%	\$8.2	38.8%	\$3.5	16.3%
Pennsylvania	\$13.9	9.0%	\$14.7	9.5%	\$17.7	11.4%	\$32.1	20.6%	\$31.7	48.3%	\$30.3	46.2%
Rhode Island	\$0.4	2.5%	\$0.7	4.8%	\$0.7	4.6%	\$0.9	6.1%	\$0.9	9.5%	\$1.0	9.6%
South Carolina	\$5.0	8.0%	\$5.0	8.0%	\$2.0	3.2%	\$0.0	0.0%	\$2.0	8.4%	\$2.0	8.4%
South Dakota	\$4.0	35.4%	\$3.5	31.0%	\$5.0	44.2%	\$5.0	44.2%	\$5.0	57.5%	\$0.7	8.1%
Tennessee	\$0.2	0.3%	\$0.2	0.3%	\$0.2	0.3%	\$5.0	7.0%	\$10.0	31.0%	\$0.0	0.0%
Texas	\$5.5	2.0%	\$11.4	4.3%	\$11.4	4.3%	\$11.8	4.4%	\$11.8	11.4%	\$5.2	5.0%
Utah	\$7.2	30.4%	\$7.1	30.2%	\$7.1	30.1%	\$7.2	30.5%	\$7.3	47.7%	\$7.2	47.3%
Vermont	\$3.3	31.8%	\$4.5	43.4%	\$4.8	46.2%	\$5.2	50.0%	\$5.2	66.0%	\$5.1	64.5%
Virginia	\$8.4	8.1%	\$9.4	9.1%	\$12.3	11.9%	\$12.7	12.3%	\$14.5	37.3%	\$13.5	34.7%
Washington	\$0.8	1.1%	\$13.4	19.8%	\$15.8	23.5%	\$27.2	40.4%	\$27.1	81.1%	\$27.1	81.3%
West Virginia	\$5.7	20.3%	\$5.7	20.4%	\$5.7	20.5%	\$5.7	20.5%	\$5.7	40.0%	\$5.4	38.1%
Wisconsin	\$5.3	8.3%	\$6.9	10.7%	\$6.9	10.7%	\$15.3	23.8%	\$15.0	48.1%	\$10.0	32.1%
Wyoming	\$5.4	60.0%	\$5.4	60.0%	\$4.8	53.3%	\$6.0	66.7%	\$5.9	80.1%	\$5.9	79.9%
<b>Total</b>	<b>\$456.7</b>	<b>12.4%</b>	<b>\$517.9</b>	<b>14.0%</b>	<b>\$569.3</b>	<b>15.4%</b>	<b>\$670.9</b>	<b>18.1%</b>	<b>\$717.2</b>	<b>44.8%</b>	<b>\$597.5</b>	<b>37.2%</b>

Note: Annual funding amounts only include state funds

\* In 2007, the CDC updated its recommendation for the amount each state should spend on tobacco prevention programs, taking into account new science, population increases, inflation and other changes since it last issued its recommendations in 1999. In most cases, the updated recommendations are higher than previous ones. Starting in FY2009, this report assessed the states based on these new recommendations.

\*\* Alabama's tobacco prevention program budget for FY2012 was not available when this report went to press. In FY2011, Alabama budgeted \$860,000, which is just 1.5 percent of the CDC's recommendation.



## EDUCATION CONNECTION

A Regional Educational Service Center

355 Goshen Road  
P.O. Box 900  
Litchfield, CT 06759-0900  
Phone: 860.567.0863  
Fax: 860.567.3381

345 Main Street  
Danbury, CT 06810  
Phone: 203.791.1904  
Fax: 203.778.8076

[www.educationconnection.org](http://www.educationconnection.org)

April 16, 2012

Good morning. My name is Abby Peklo. I am the Interdistrict Grants and Development Coordinator for EDUCATION CONNECTION, the Regional Educational Service Center in Western CT. Our agency has a 45-year history of providing responsive and innovative programs and services to more than 30 school districts and their communities. Within the last 3 years, we have provided 2 large-scale and far-reaching tobacco prevention and cessation programs to 5 urban, high need districts - Danbury, New Britain, Torrington, Waterbury and Winchester, funded by the Connecticut DPH. *Healthy & Tobacco Free Schools* focused on prevention, education and cessation for middle and high school students. We educated district leadership about the importance of liberal tobacco-free policy language and policy *consistency* throughout school grounds. Through extensive signage and teacher training, we supported schools' efforts to extend smoke-free *beyond* the building, to recognize that parking lots, back entrances and football stadiums also need to stay tobacco free. We provided free tobacco cessation programs *at school*. Through our grant dollars, we created and funded tobacco education resource centers at more than a dozen school library media centers, creating sustainability to thousands of students *every day* who now have easy access to high quality tobacco education books, periodicals and digital media products. We funded hands-on educational materials to health classes, enabling students to learn beyond the textbook, to see and feel disgusting *but accurate* simulations of tobacco in a jar, infected gums, brown teeth and diseased lungs. Our second project, *KidsCAN Avoid Tobacco*, directly influences more than 14,500 K-8 students, with outreach extending to their communities. Our students help spread a positive tobacco-free message to many thousands of residents throughout the state and to others who visit Connecticut. Last spring, our students convinced Quassy Amusement Park to become tobacco-free. These young people helped to create *sweeping change* at a high traffic family amusement park. Thousands of visitors *each day* are now greeted by signage and regular PA announcements reminding them that their amusement park is proud to be tobacco free. During last baseball season, our students partnered with the Rock Cats to sponsor a tobacco-free family game night. 6,700 fans visited our project's interactive tobacco-education center, strategically placed at the stadium entrance. Thousands of residents took home educational materials, learned how to access the CT Quit Line and watched a stadium-sized positive tobacco-avoidance PowerPoint throughout the evening. Fans were greeted by employees wearing colorful project buttons and heard announcements every 15 minutes, reminding them to stay healthy and tobacco-free. Recently, one of our young students, a member of the project's Student Action Club, came up with a heart-warming innovative idea. He arranged for Friendly's Restaurant in Danbury to distribute our bi-lingual Smoke-Free Home and Car Pledge placements to patrons. Thanks to our 12-year old student, hundreds of children *every day* color their Smoke-Free Home and Car Pledge placements as they wait for their chicken tenders and Fribbles. *How great is that?* Our staff is in the schools and out in the community *every day*. They teach tobacco-free through math, science, digital media, dance, art and theater. Our project's imaginative and age appropriate educational innovations *will* change the statistics of tobacco use in Connecticut. On behalf of our projects' 39,000 students, their parents and their communities, I challenge you to do the math. Per student, at an estimated cost of \$8.27 worth of education, our projects cost less than a pack of cigarettes! The CDC has already proven the link between educating our youth and establishing life-long tobacco avoidance behaviors. Continued funding for education will help organizations like EDUCATION CONNECTION sustain *Healthy & Tobacco Free Schools* because we know that *KidsCAN Avoid Tobacco*. Thank you for listening and please watch for our student-designed billboards this November along Rt. 84. You'll recognize our *KidsCAN* logo and will remember how much our students need your continued support.

EDUCATION CONNECTION is an equal opportunity provider and employer.

To file a complaint of discrimination write JSOA Director, Office of Civil Rights, Washington, DC 20250-9410.



April 16, 2012

## Statewide Tobacco Education Program

Dear Esteemed Members of the Tobacco and Health Trust Fund,

I am Melisa Luginbuhl, I am here today representing ERASE and the 12 other Regional Action Councils for substance abuse prevention that make up the Connecticut Prevention Network. ERASE is responsible for the management of the CT Prevention Network's grant from the Department of Public Health's Innovative Tobacco Programs. The Connecticut Prevention Network urges you to encourage to continue to allocate funds to tobacco prevention programs.

As you are all well aware tobacco use is an epidemic among youth and adults with devastating and costly long term outcomes. Today's youth are bombarded with new tobacco products that continue to target them as future users (please see attached newsletter).

In April 2011, ERASE, on behalf of the Connecticut Prevention Network, was awarded a \$168,000, twenty three month grant for the development and implementation of The Statewide Tobacco Education Program (STEP). Together the Regional Action Councils created this curriculum, designed to reach at-risk populations, and to have the ability to be easily implemented in a variety of settings including summer camps, positive youth development programs, boys and girls clubs and traditional classroom locations. This innovative, activity-based curriculum for youth ages 5-14 includes five, one-hour sessions. The five sessions include the following topics; Introduction: Environment and the Media; Tobacco and the Body; The True Costs of Tobacco; and Dealing with Peer Pressure. All of which encourage activity and interaction rather than classroom-style lectures.

To-date the curriculum has been established, over 40 RAC staff and volunteers state wide have been trained in the implementation of STEP. This program has been provided to over 500 youth. By the conclusion of this grant, in March 2013, RAC's hope to reach up to 3,000 youth and have the outcomes fully evaluated.

The CT Prevention Network thanks the Tobacco and Health Trust Fund for this opportunity to expand our tobacco prevention efforts. Our hope is that the Tobacco and Health Trust Fund will continue to fund such program into the future.

All the best,

Melisa Luginbuhl, Prevention Coordinator, ERASE

# East of the River Action for Substance Abuse Elimination



NEWSLETTER

MARCH 2012

70 Canterbury Street, East Hartford, CT 06118 - (860) 568-4442 - <http://www.erasect.org>

## Welcome Message from ERASE's Executive Director, Bonnie Smith, MPH, CPH

*Tobacco is one of the most difficult substances to prevent among youth, since it is heavily marketed to this age group and is highly addictive. Unlike other substances such as alcohol and illicit drugs, health consequences are not often immediately seen when someone begins using tobacco. It is getting easier to overlook talking about tobacco use with youth as in many families and social groups, many adults no longer smoke or never started. This is great news, however it's essential to remember that minors are still exposed to tobacco products and many of them are especially appealing to young people. Some of the new products, highlighted in this newsletter, have little or no smell associated with use which eliminates one of the key signs someone is using tobacco.*

Tobacco companies are constantly coming up with ways to add to additional people to their products or keep current tobacco users interested. They spend billions of dollars every year to develop new products, with many of them made to appeal to youth. Many of these kid-friendly products are sold in convenience stores and look and smell like candy.

Cigars are popular among youth, as they are cheap and come in a variety of flavors, including honey, grape, strawberry and mint. A single cigar costs as low as \$.50 compared to an \$8.00 pack of cigarettes, making the price appealing as well. Youth are able to purchase one cigar with pocket change.

Electronic cigarettes are becoming increasingly popular due to the ease of concealing them. The electronic cigarettes, also known as e-cigarettes, are battery operated cigarettes that are designed to look like regular tobacco cigarettes. They contain a liquid with nicotine, that when heated

turns into a vapor that can be inhaled. The cigarette creates a vapor cloud that resembles cigarette smoke (Mayo Clinic).

Smokeless tobacco is a form that is well-liked among tobacco users. One type, dissolvable tobacco, can come in an assortment of styles. They often

resemble breath mints, such as tic tacs or breath strips (Campaign for Tobacco-Free Kids, 2011). These products provide a convenient opportunity for youth to use in classrooms and conceal in backpacks, purses or pockets.

Snus is a finely ground form of tobacco that is packed into small teabag-like packets. Snus is another form of smokeless tobacco that is popular.

Unlike regular chewing tobacco, snus does not require spitting, due to its lower amount of toxins and carcinogens (60 Minutes, 2010). The product allows users to use indoors and hide easily since there is no spitting necessary.

The prevention of tobacco use among youth is extremely important, with 1,300 adolescents under age 18 becoming new regular, daily users of tobacco each day (NCADA, 2009). This trend is what leads to the almost 6 million tobacco-related deaths in 2011 (Tobacco Atlas, 2012) and will only continue on this path, unless prevention measures are taken. These strategies need to first start in the home by informing friends and family about the products. Adults as role models, setting rules such as not allowing smoking in your home and talking to your kids also is effective.

In the ERASE region, the age of onset for tobacco use is 14 years old with about 18% of youth in grades 6-12 using in the past 30 days. Youth have reported seeing these new tobacco products in the schools, demonstrating the need for additional prevention measures and increased awareness among adults in all communities.



April 16, 2012

To: Members of Tobacco & Health Trust Fund Board

Please accept the following as written testimony from John O'Rourke, Program Coordinator for CommunicCare's tobacco cessation programming for the purposes of the public hearing on April 16, 2012.

#### **Program Summary & History:**

As part of a grant through the CT Department of Public Health, since October 2009, CommunicCare, Inc. (CCI) has been facilitating four subunit implementing tobacco cessation services in behavioral health settings in the state of Connecticut. CCI has contracted with nine agencies throughout the state to integrate tobacco cessation as a core component of their behavioral health services. The goal of the program is to provide tobacco treatment services to a population that has historically been underserved.

CCI partnered with a leading expert in the field of tobacco treatment, Douglas Ziedonis, MD and his team at the University of Massachusetts, Addressing Tobacco Through Organizational Change (ATTOC) Consultation Service. Together with OMASS, CCI implemented a model that accounts for people with both high as well as low motivation to address their tobacco use, to best meet the needs of the population. Services include: Tobacco Cessation Counseling, Nicotine Replacement and Medications (Chantix and Zyban). The model also assists the agencies in exploring their policies and practices on tobacco use, and subsequently work toward changing the organization's culture to support a healthier, tobacco-free environment. As part of this model, CCI and UMass developed a local tobacco cessation counselor to provide counseling services as well as an agency-level tobacco cessation champion to help guide agency leadership through the organizational change necessary to achieve sustainable successes.

Under this grant, Dr. Ziedonis and his team from UMass has provided the following services to CommunicCare and the subcontracting agencies:

- Designated UMass staff as resources responsive to the development needs of the CCI tobacco programming.
- Provided intensive training and hands-on development and follow up to CCI tobacco program staff to further develop their skills as program leadership for the statewide initiative.
- Participated in a two-day site visit at each subcontracting agency that provided the agency with instruction on how to best incorporate tobacco treatment into their agency's culture, direct training for all service staff on incorporation of tobacco treatment into general practice and an intensive environmental scan to give personalized feedback on how tobacco is currently addressed at the agency.
- Provided several one-day intensive trainings on Train The Trainers for program providers as well as advanced topics in tobacco treatment.
- Identified existing resources and assisted CCI in developing unavailable resources that could be used in a multi-modal approach to tobacco treatment, including group and individual treatment materials specific to lower and higher motivated clients, information on the use of NRT and other tobacco treatment medications, and strategies on how to better integrate tobacco treatment with other treatment and rehabilitation services.
- Provide a program evaluation of the ATTOC intervention and produce a summary report on the results of this organizational program evaluation.

The programming under CCI began in November 2009, with treatment services being launched at the two CCI agencies; MyCare and Bridges, a Community Support System... along with Fellowship Place in New Haven. In December 2010, new programming was launched at three subcontracting sites; Community Health Resources, Hartford Behavioral Health, and Re-Link. In the time that the program was running, CCI requested and was approved for funding to extend program for a third year in the existing agencies and to include new programming at two new agencies. Services began in July 2011 at Intercommunity and United Services.

Through this grant, CCI has contracted with the nine aforementioned agencies to work toward the reduction of tobacco use amongst the population of adults living with serious mental illness across the state of Connecticut. In addition to the tobacco cessation program, CCI has been reaching out to other organizations to provide support, education and services to areas that have not been receiving direct funding under this grant.

While still in negotiations, CCI has received approval to develop and provide services and expertise to agencies in two new service areas of Stamford and Bridgeport through 2013 with continued DPH funding.

**Program Mission/Purpose:**

The mission of the tobacco cessation program is to decrease the use of tobacco products among individuals who struggle with mental illness. The program offers a range of services from which participants choose the most appropriate based on their readiness to change their tobacco use. Services include education on the harmful effects of tobacco use, counseling, and supportive services to assist them in meeting their goals.

**Program Philosophy:**

The program's philosophy is based on research that states that rates of tobacco use among those with mental illness and addiction are far greater than those of the general population. This increased rate of tobacco use relates to a shorter life expectancy among people with mental illness and addiction. Providing tobacco cessation services tailored to the needs of those with mental illness and addiction will work to improve the health and wellness of this population in the state of Connecticut.

The Tobacco Cessation Program is led by CCI to encourage the use of the Department of Health and Human Services (DHHS) Treating Tobacco Use and Dependence Clinical Practice Guidelines and adaptations for people with mental illnesses using the Tobacco Cessation Leadership Network, the Bringing Everyone Along (BEA) guide and the "Addressing Tobacco through Organizational Change" (ATTOC) approach developed by the UMass ATTOC Consultation Service.

Given how serious the issue of tobacco and nicotine dependence is among people with mental illnesses and how important it is to address organizational culture and all treatment practices and protocols in relationship to tobacco use and treatment, the CCI / UMass team believes that it is imperative to engage in an organizational change process and a re-examining of clinical and counseling approaches so that tobacco cessation becomes embedded in all direct client practice. Without addressing organizational culture and change, the likelihood of continuing with tobacco cessation treatment is diminished. Organizational change is needed due to barriers in mental health agencies related to the culture in which it is considered "normal" to smoke. Training alone is not enough to get tobacco cessation embedded in the treatment culture of mental health agencies. The CCI / UMass team is helping with organizational policies, chart review, strategic planning, and the other steps necessary to implement change.

**Organizational and Culture Change:**

As part of the ATTOC model, the CCI tobacco cessation program has been assisting participating agencies to look at their policies and practices related to tobacco use and develop agency goals to address these areas. Agencies create goals in three areas: Patient Goals, Staff Goals and Environmental Goals. Each agency has a goal of reducing the rate of tobacco use amongst their patients as well as staff. In addition, each agency looks to increase the awareness and education of their patients and staff on the effects of tobacco. The goals related to their environment tend to be more specific to their agency culture and needs. To date, CCI has assisted five local mental health authorities to develop and establish tobacco-free policies. More agencies are preparing to take this same step in the coming months. In the agency that is not going to become tobacco-free, they are establishing a designated tobacco-free area that is set away from buildings and walkways to protect the health of the clients, staff and visitors to their campus.

Organizational change is not merely establish a tobacco-free policy. There are multiple layers to attaining the organizational and culture change to address this issue. CCI tobacco program leadership have developed the tools to be able to assist current and new agencies to address not only the environmental tobacco goals, but the patient and staff goals as well. The patient goals are typically to reduce the rate of tobacco use. Staff goals are typically a reduction of tobacco use amongst staff as well as increase the education level of staff on the issue of tobacco and how they can incorporate it into their treatment with clients.

In most agencies that CCI has worked with, there was questions pertaining to a client's tobacco use status at intake. Unfortunately, that's where the intervention typically stopped. Through the current grant, CCI leadership has been able to work with subcontracting agencies to develop a process where clients would receive comprehensive tobacco treatment as part of the general practice of the agency. Agency staff received intensive trainings on how to incorporate tobacco into their assessments and treatment planning. Staff were able to speak confidently about tobacco use in their clients, inform them about what help was available and direct them to a treatment appropriate to their actual motivation level to address their tobacco use.

CCI tobacco program staff has been working with other organizations to provide services in other areas of the state. To date, programming has been developed at Continuum of Care in New Haven, Community Mental Health

Affiliates and Parents Population for Transitional Living. In addition, CCT tobacco program leadership has been contacted by the Southeast Regional Mental Health Authority in Norwich, CT to assist them in developing strategies on how to best address tobacco in their setting.

CommonCare, Inc. is committed to continuing its efforts in the area of tobacco treatment in the state of Connecticut. We are requesting continued funding to provide continued support to the agencies that we have helped establish comprehensive programming as well as new agencies in different areas of the state that would benefit from addressing their policies and practices related to tobacco. As we move forward into an era where many of our targeted population will have access to tobacco treatment through Medicaid, it is imperative that the agencies and practitioners providing this treatment are supported in their agencies and communities.

Should you have any questions about current programming or further questions about CommonCare's ideas for future programming, please contact me by one of the following methods.

Sincerely,

John O'Rourke, MSW  
Program Coordinator  
CommonCare, Inc.  
14 Spearman Way  
Branford, CT 06405  
Phone: 203-483-2615 ext 338  
Email: jorourke@commoncare.org