Introduction

Tobacco use is the single most preventable cause of death and disease in the United States. An estimated 45 million American adults currently smoke cigarettes.[1] Smoking harms nearly every organ in the body and half of all long-term smokers die prematurely from smoking-related disease.[2] All tobacco products, including smokeless tobacco and cigars, cause cancer, and all forms of tobacco are addictive.[3,4] Secondhand smoke causes premature death and disease in children and adults who do not smoke.[5] There is no risk-free level of exposure to secondhand smoke.[5]

Most people begin using tobacco as adolescents. Although rates of youth smoking increased dramatically in the early 1990s, after increased implementation of evidence-based interventions, youth smoking declined 40% from 1997 to 2003. Unfortunately, recent data indicate this decline appears to have stalled.[6] Several factors may have contributed to this lack of continued decline. These factors include smaller annual increases in the retail price of cigarettes during 2003–2005 compared with 1997–2003, decreased exposure among youth to effective mass media smoking-prevention campaigns, less funding for comprehensive statewide tobacco-use prevention programs, and substantial increases in tobacco industry expenditures on tobacco advertising and promotion in the United States.[6] If current patterns of smoking persist in this country, more than six million youth will die more than 10 years prematurely due to smoking.[7]

In 1964 the Surgeon General's Advisory Committee concluded: "Cigarette smoking is a health hazard of sufficient importance in the United States to warrant appropriate remedial action."[8] Yet, since 1964, more than 12 million tobacco-related deaths have occurred in the United States.[2] Each year in this country, there are approximately 438,000 additional premature deaths from tobacco-related diseases.[9] Also, for every person who dies from tobacco use, 20 others currently suffer with at least one serious tobacco-related illness.[10]

In 2007, the Institute of Medicine (IOM) released *Ending the Tobacco Problem: A Blueprint for the Nation,* with the goal of reducing smoking "so substantially that it is no longer a significant public health problem for our nation."[11] The IOM Committee on Reducing Tobacco Use concluded that this ultimate goal could be achieved with a two-pronged strategy: strengthening and fully implementing traditional tobacco control measures, and changing the regulatory landscape to permit policy innovations.[11] The IOM Committee concluded that there was compelling evidence that comprehensive state tobacco programs could achieve substantial reductions in tobacco use, and that to effectively reduce tobacco use, "states must maintain over time a comprehensive integrated tobacco control strategy."[11] On the basis of this evidence, the lead recommendation in the IOM report stated:

> **Each state should fund state tobacco control activities at the level recommended by the CDC. A reasonable target for each state is in the range of $15 to $20 per capita, depending on the state's population, demography, and prevalence of tobacco use.[11]**

If, starting in fiscal year 2009, all states were to fully fund their tobacco control programs at the updated CDC-recommended level of investment described in this report, in 5 years, an estimated 5 million fewer people in this country would smoke, and hundreds of thousands of premature tobacco-related deaths would be prevented each year. Longer investments will have even greater effects. With fully funded and sustained state tobacco control programs and policies (e.g., increases in the unit price of tobacco products), IOM's best-case scenario of reducing tobacco prevalence to 10% by 2025 would be attainable.

States that have made larger investments in comprehensive tobacco control programs have seen cigarette sales drop more than twice as much as in the United States as a whole, and smoking prevalence among adults and youth has declined faster as spending for tobacco control programs increased.[12-14] In Florida, between 1998 and 2002, a comprehensive prevention program anchored by an aggressive youth-oriented health communications campaign, reduced smoking rates among middle school students by 50% and among high school students by 35%.[15] Other

Introduction

states, such as Maine, New York, and Washington, have seen 45% to 60% reductions in youth smoking rates with sustained comprehensive statewide programs.[16-18] Between 2000 and 2006, the New York State Tobacco Control Program reported that the prevalence of both adult and youth smoking declined faster in New York than in the United States as a whole.[18] Adult smoking prevalence declined 16% and smoking among high school students declined by 40%, resulting in more than 600,000 fewer smokers in the state over the 7-year intervention period.[18]

According to the American Cancer Society (ACS), even by the most conservative estimates, more than 40% of the reduction in male cancer deaths between 1991 and 2003 was due to the declines in smoking over the last half of the 20th century.[19] Before cigarette smoking became common, lung cancer was a rare disease. Now lung cancer is the leading cancer cause of death for both men and women, killing an estimated 160,000 people in this country each year.[20] ACS estimates that approximately 87% of these deaths are caused by smoking and exposure to secondhand smoke.[19] Additionally, more than 100,000 deaths from lung diseases, and more than 140,000 premature deaths from heart disease and stroke are caused each year by smoking and exposure to secondhand smoke.[2]

Research shows that the more states spend on sustained comprehensive tobacco control programs, the greater the reductions in smoking—and the longer states invest in such programs, the greater and faster the impact.[12] In California, home of the longest-running comprehensive program, smoking rates among adults declined from 22.7% in 1988 to 13.3% in 2006.[21] As a result, compared with the rest of the country, heart disease deaths and lung cancer incidence in California have declined at accelerated rates. Among women in California, the rate of lung cancer deaths decreased while it continued to increase in other parts of the country.[22] Overall, from 1987–1998, approximately 11,000 cases of lung cancer were avoided.[23] Since 1998, lung cancer incidence in California has been declining four times faster than in the rest of the nation.[22,24]

Because of this accelerated decline, California has the potential to be the first state in which lung cancer is no longer the leading cancer cause of death. Unfortunately, at the present time, this projection cannot be made for the rest of the nation.

Comprehensive Tobacco Control Programs

The mission of comprehensive tobacco control programs is to reduce disease, disability, and death related to tobacco use. A comprehensive approach—one that optimizes synergy from applying a mix of educational, clinical, regulatory, economic, and social strategies—has been established as the guiding principle for eliminating the health and economic burden of tobacco use.[25]

The goals for comprehensive tobacco control programs include:

- Preventing initiation among youth and young adults
- Promoting quitting among adults and youth
- Eliminating exposure to secondhand smoke
- Identifying and eliminating tobacco-related disparities among population groups

CDC has prepared these "best practices" to help states organize their tobacco control program efforts into an integrated and effective structure that uses and maximizes interventions proven to be effective and to operate at the scale that would be required to ultimately eliminate the burden of tobacco use. In *Best Practices for Comprehensive Tobacco Control Programs—August 1999,* recommendations were based on the extant scientific literature and the experience of large-scale, sustained state programs in California and Massachusetts.[26] After *Best Practices* was published in 1999, overall funding for state tobacco control programs more than doubled. States restructured their tobacco control programs to align with CDC's goals and programmatic recommendations. Eight states—Arizona, Arkansas, Colorado, Delaware, Indiana, Massachusetts, Minnesota, and Mississippi—have met CDC's minimum funding recommendation for one or more years; Maine has met the minimum funding recommendation every year. In fiscal year 2007, three states—Colorado, Delaware, and Maine—met the minimum recommended level of funding. With this growth in state capacity and a focus on proven interventions, evidence demonstrating the effectiveness

of comprehensive programs has steadily increased. *Best Practices for Comprehensive Tobacco Control Programs—2007* has utilized this robust evidence base to update the recommendations.

National Initiatives

A comprehensive approach to tobacco prevention and control requires coordination and collaboration across the federal government, across the nation, and within each state. The federal government has undertaken a number of important activities that provide a foundation for state action. Scientific data about the extent of tobacco use, its impact, and effective interventions to reduce its use have been generated and disseminated by several federal agencies, including CDC, the National Institutes of Health (NIH), the Substance Abuse and Mental Health Services Administration (SAMHSA), and the Agency for Healthcare Research and Quality.

NIH's National Cancer Institute (NCI) has supported innovative intervention studies, including mass media and school trials and large-scale demonstration projects such as the American Stop Smoking Intervention Study for Cancer Prevention (ASSIST) and Community Intervention Trial for Smoking Cessation (COMMIT).[25,27-29] CDC also provided state support through the Initiatives to Mobilize for the Prevention and Control of Tobacco Use (IMPACT) program.[25] In 1999, the National Tobacco Control Program (NTCP) was launched, combining NCI and CDC initiatives into one coordinated national program funded and managed by CDC. NTCP provides technical assistance and limited funding to all 50 states, the District of Columbia, and seven territories, as well as Tribal Support Centers and National Networks of specific populations. CDC funding is designed to support and leverage state funding for evidence-based interventions and to help states evaluate their program efforts. The National Network of Tobacco Cessation Quitlines was developed through a partnership among CDC, the NCI Cancer Information Service, the North American Quitline Consortium, and the states. This system provides callers from across the nation with a single, toll-free access point (1-800-QUIT NOW) that automatically routes them to their state's telephone-based cessation services. Additionally, SAMHSA implements the Synar regulation to reduce youth access to tobacco products through state-level retail compliance activities.

The federal government has also supported a number of national and state tobacco use surveys among adults and youth through the CDC (Behavioral Risk Factor Surveillance System, National Health Interview Survey, Youth Risk Behavior Surveillance System, national and state Adult Tobacco Surveys, and national and state Youth Tobacco Surveys), NIH (Current Population Survey Tobacco Use Supplement and Monitoring the Future Study), and SAMHSA (National Survey on Drug Use and Health). These surveys provide complementary data obtained from various populations that are useful and important for monitoring and evaluating progress in tobacco control.

National partners also play a critical role in tobacco prevention and control efforts. For example, the American Legacy Foundation's social marketing campaign, truth®, began in early 2000. It reinforces state-based youth prevention efforts and has been independently associated with substantial declines in youth smoking.[30] Americans for Nonsmokers' Rights provides extensive technical assistance and guidance to states and municipalities as they engage in the process of passing and implementing smoke-free indoor air policies as well as exposing tobacco industry strategies that can undermine smoke-free initiatives. The Robert Wood Johnson Foundation has supported research to document the effectiveness of policies and programs and helped to build the advocacy and communications infrastructure to advance those policies to reduce smoking and help people lead healthier lives. The American Cancer Society, American Heart Association, and American Lung Association provide strong national, state, and local advocacy leadership on tobacco control policy issues, as well as community support through local offices around the country. The Tobacco Control Legal Consortium, a network of legal programs supporting tobacco control policy change, works to assist communities and increase legal resources available for tobacco control. The Tobacco Technical Assistance Consortium supports the effectiveness of tobacco control programs by providing technical assistance and training to state and local programs, partners, and coalitions. The Campaign for Tobacco-

Introduction

programs, and provides technical assistance for policy interventions. The Association of State and Territorial Health Officials, the National Association of County and City Health Officials, and the National Association of Local Boards of Health provide state and local health officials with information and resources, including *Joint Policy Action Steps Toward Tobacco Use Prevention and Control,* which support the development and maintenance of strong state and local tobacco control policies and programs to achieve the *Healthy People 2010* tobacco use-related health objectives for the nation.[31,32]

Although a number of critical activities to curb tobacco use occur at the national level, state and local community action is essential to ensure the success of tobacco control interventions. Almost 90% of funds for tobacco control interventions come from the states through tobacco excise tax revenues and tobacco settlement payments. Furthermore, it is the policies, partnerships, and intervention activities that occur at the state and local levels that ultimately lead to social norm and behavior change. In acknowledging the essential and unique roles that states and communities play in tobacco control efforts, these best practices provide technical information and evidence-based benchmarks to assist states in designing comprehensive programs. Communities, in turn, support comprehensive programs by implementing evidence-based initiatives at the local level. For example, although the quitline portal number and structure of the National Network of Tobacco Cessation Quitlines were established through partnerships at the national level, states provide the foundation for this system by maintaining their quitline services and promoting their use through broadcast media. Communities can further promote this service through local channels, such as hospitals, health care systems, local newspapers, and community and civic organizations.

Implementing Best Practices for Comprehensive Tobacco Control Programs

This document draws upon best practices determined by evidence-based analyses of scientific literature and outcomes of comprehensive state tobacco control programs and interventions. CDC recommends that states implement evidence-based tobacco control programs that are comprehensive, sustainable, and accountable. This guidance document describes an integrated budget structure for implementing interventions proven to be effective and the recommended state investment that would be required to reduce, and ultimately eliminate, tobacco use in each state.

Best Practices for Comprehensive Tobacco Control Programs—2007 refines the guidance provided in 1999, reflecting additional state experiences in implementing comprehensive programs and new scientific literature since its original release.[33] A 2002–2003 evaluation of 10 states' implementation of *Best Practices—1999* found that the document provided an effective framework for tobacco control programs, but the number of categories was somewhat cumbersome to implement and convey to decision makers.[34]

In December 2006, technical consultation was sought from a panel of experts regarding the best available evidence to determine updated cost parameters and the metrics to calculate them for major components of a comprehensive tobacco control program. The panel generally agreed that although the types of interventions and funding formulas remained sound, funding estimates would be expected to increase to account for changes in state population and inflation since the 1999 publication. The panel also generally agreed that although none of the components should be eliminated, the framework should be consolidated into five categories to reflect the need for integrated approaches and the actual practices of state programs. A listing of participants in the expert panel is provided in Appendix A.

As a result of evidence-based analysis of tobacco excise tax-funded and tobacco settlement-funded programs, in-depth involvement with all 50 state tobacco control programs and the District of Columbia, and published evidence of effective tobacco control strategies, CDC recommends that states establish and sustain tobacco control programs that contain the following overarching components:

- State and Community Interventions
- Health Communication Interventions
- Cessation Interventions
- Surveillance and Evaluation
- Administration and Management

Information for each of these funding categories includes

- Justification for the program intervention
- Budget recommendations for successful implementation
- Core resources to assist implementation
- References to scientific literature

As with the funding guidance first published in 1999, recommended annual costs can vary within the lower and upper estimate provided for each state. Therefore, to better assist states, specific guidance is now provided regarding each state's recommended level of investment within their range. These recommended levels of annual investment factor in state-specific variables, such as the overall population; the prevalence of tobacco use; the proportion of the population that is uninsured, receiving publicly financed insurance, or living at or near the poverty level; infrastructure costs; the number of local health units; geographic size; the targeted reach for quitline services; and the cost and complexity of conducting mass media to reach targeted audiences, such as youth, racial/ethnic minorities, tobacco users interested in quitting, or people of low socioeconomic status. The 1999 funding formulas and 2007 adjustments are provided in Appendix B.

On the basis of these different factors, the annual investment needed to implement the recommended program components has been estimated to range from $9.23 to $18.02 per capita across 50 states and the District of Columbia. Among some states—particularly those with smaller populations, lower smoking prevalence, and inexpensive media markets without much state crossover—these recommended levels of investment are quite similar to the 1999 lower estimate adjusted for inflation. However, states with greater numbers of tobacco users, media markets that also include major metropolitan areas from neighboring states, or large and diverse populations may find recommended funding levels that are at the higher end of the funding range for some or all of the program components.

While each state's analysis of their priorities should shape decisions about funding allocations for each recommended program component, it remains clear that greater investments in comprehensive statewide programs lead to faster and larger declines in smoking rates and in smoking-related disease and death.[12-14]

Best Practices for Comprehensive Tobacco Control Programs—2007 provides evidence to support each of the five components of a comprehensive program. However, besides acknowledging the importance of the individual program components, it is equally important to recognize why these individual components must work together to produce the synergistic effects of a comprehensive program. A comprehensive approach, with the combination and coordination of all five program components, has shown to be most effective at preventing tobacco use initiation and promoting cessation.[33,35,36]

Each day in the United States—

- The tobacco industry spends nearly $36 million to market and promote its products.[37]
- Almost 4,000 adolescents start smoking.[38]
- Approximately 1,200 current and former smokers die prematurely from tobacco-related diseases.[9]
- The nation spends more than $260 million in direct medical costs related to smoking.[7]
- The nation experiences nearly $270 million in lost productivity due to premature deaths from tobacco-related diseases.[7]

The tobacco use epidemic can be stopped. We know what works, and if we were to fully implement the proven strategies, we could prevent the staggering toll that tobacco takes on our families and communities. We could accelerate the declines in cardiovascular mortality, reduce chronic obstructive pulmonary disease, and once again make lung cancer a rare disease. If we fully protected our children from secondhand smoke, more than a million asthma attacks and lung and ear infections in children could be prevented.[5,39]

Investing in and implementing what we know works will end the tobacco use epidemic.

Introduction

General Planning Resources

Institute of Medicine. *Ending the Tobacco Problem: A Blueprint for the Nation.* Washington, DC: National Academies Press; 2007.

Zaza S, Briss PA, Harris KW editors. *The Guide to Community Preventive Services: What Works to Promote Health?* New York: Oxford University Press; 2005. Available at http://www.thecommunityguide.org/tobacco/default.htm.

California Department of Health Services. *A Model for Change: The California Experience in Tobacco Control.* Sacramento: California Department of Health Services; 1998. Available at http://www.dhs.ca.gov/tobacco/documents/pubs/modelforchange.pdf.

U.S. Department of Health and Human Services. *Reducing Tobacco Use: A Report of the Surgeon General.* Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health; 2000. Available at http://www.cdc.gov/tobacco/data_statistics/sgr/sgr_2000/index.htm.

National Cancer Institute. *Community-Based Interventions for Smokers: The COMMIT Field Experience.* Tobacco Control Monograph No. 6. Bethesda, MD: National Institutes of Health; 1995. NIH Pub. No. 95-4028. Available at http://cancercontrol.cancer.gov/tcrb/monographs/6/index.html.

National Cancer Institute. *ASSIST: Shaping the Future of Tobacco Prevention and Control.* Tobacco Control Monograph No. 16. Bethesda, MD: National Institutes of Health; 2005. NIH Pub No.05-5645. Available at http://cancercontrol.cancer.gov/tcrb/monographs/16/index.html.

National Cancer Institute. *Evaluating ASSIST: A Blueprint for Understanding State-level Tobacco Control.* Tobacco Control Monograph No. 17. Bethesda, MD: National Institutes of Health; 2006. NIH Pub. No. 06-6058. Available at http://cancercontrol.cancer.gov/tcrb/monographs/17/index.html.

National Cancer Institute. *Greater Than the Sum: Systems Thinking in Tobacco Control.* Tobacco Control Monograph No. 18. Bethesda, MD: National Institutes of Health; 2007. NIH Pub No.06-6085. Available at http://cancercontrol.cancer.gov/tcrb/monographs/18/index.html.

National Association of County and City Health Officials, National Association of Local Boards of Health, and Association of State and Territorial Health Officials. *Joint Policy Action Steps Toward Tobacco Use Prevention and Control.* Washington, DC: National Association of County and City Health Officials; 2007. Available at http://www.naccho.org/topics/HPDP/documents/FINALJPAS7-07.pdf.

U.S. Department of Health and Human Services. *Healthy People 2010. Volume 2.* Washington, DC: U.S. Government Printing Office; 2000. Available at http://www.healthypeople.gov/Document/HTML/Volume2/27Tobacco.htm.

Centers for Disease Control and Prevention. Smoking & Tobacco Use website. Available at www.cdc.gov/tobacco.

Centers for Disease Control and Prevention. State Tobacco Activities Tracking and Evaluation (STATE) System. Available at http://www.nccd.cdc.gov/tobacco/STATEsystem.

References

1. Centers for Disease Control and Prevention. Tobacco use among adults—United States, 2005. *MMWR* 2006;55(42):1145–1148.
2. U.S. Department of Health and Human Services. *The Health Consequences of Smoking: A Report of the Surgeon General.* Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health; 2004.
3. Institute of Medicine. *Clearing the Smoke: Assessing the Science Base for Tobacco Harm Reduction.* Washington, DC: National Academies Press; 2001.
4. U.S. Department of Health and Human Services. *The Health Consequences of Smoking: Nicotine Addiction. A Report of the Surgeon General.* Rockville, MD: U.S. Department of Health and Human Services, Public Health Service, Centers for Disease Control, Center for Health Promotion and Education, Office on Smoking and Health; 1988.
5. U.S. Department of Health and Human Services. *The Health Consequences of Involuntary Exposure to Tobacco Smoke: A Report of the Surgeon General.* Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, Coordinating Center for Health Promotion, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health; 2006.
6. Centers for Disease Control and Prevention. Cigarette use among high school students—United States, 1991–2005. *MMWR* 2006;55(26):724–726.
7. Centers for Disease Control and Prevention. *Sustaining State Programs for Tobacco Control: Data Highlights 2006.* Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health; 2006.
8. U.S. Department of Health, Education, and Welfare. *Smoking and Health: Report of the Advisory Committee to the Surgeon General of the Public Health Service.* Washington, DC: U.S. Department of Health, Education, and Welfare, Public Health Service, Center for Disease Control; 1964. PHS Publication No. 1103.
9. Centers for Disease Control and Prevention. Annual smoking-attributable mortality, years of potential life lost, and productivity losses—United States, 1997-2001. *MMWR* 2005;54(25):625–628.
10. Centers for Disease Control and Prevention. Cigarette smoking-attributable morbidity—United States, 2000. *MMWR* 2003;52(35):842–844.
11. Institute of Medicine. *Ending the Tobacco Problem: A Blueprint for the Nation.* Washington, DC: National Academies Press; 2007.
12. Farrelly MC, Pechacek TP, Chaloupka FJ. The impact of tobacco control program expenditures on aggregate cigarette sales: 1981-2000. *Journal of Health Economics* 2003;22(5):843–859.
13. Tauras JA, Chaloupka FJ, Farrelly MC, Giovino GA, Wakefield M, Johnston LD, et al. State tobacco control spending and youth smoking. *American Journal of Public Health* 2005;954(2):338–344.
14. Farrelly MC, Pechacek TF, Thomas KY, Nelson D. The impact of tobacco control programs on adult smoking. *American Journal of Public Health.* In press.
15. Bauer UE, Johnson TM, Hopkins RS, Brooks RG. Changes in youth cigarette use and intentions following implementation of a tobacco control program. *JAMA* 2000;284(6):723–728.
16. Centers for Disease Control and Prevention. Youth Risk Behavior Surveillance System, Youth Online Comprehensive Results. Available at http://apps.nccd.cdc.gov/yrbss/.
17. Washington State Department of Health. *Tobacco Prevention & Control Program Progress Report, March 2007: Producing Results for a Healthier Washington.* Olympia, WA: Washington State Department of Health; 2007.
18. RTI International. *Fourth Annual Independent Evaluation Report of New York's Tobacco Control Program.* Albany, NY: New York State Department of Health; 2007.
19. American Cancer Society. *Cancer Prevention & Early Detection Facts & Figures 2007.* Atlanta: American Cancer Society; 2007.
20. American Cancer Society. *Cancer Facts & Figures 2007.* Atlanta: American Cancer Society; 2007.
21. California Department of Health Services. New data show 91 percent of California women don't smoke. News Release No. 07-37. May 22, 2007. Available at http://www.dhs.ca.gov/tobacco/documents/press/2007Releaseof2006PrevData.pdf.
22. Centers for Disease Control and Prevention. Declines in lung cancer rates—California, 1988–1997. *MMWR* 2000;49(47):1066–1069.
23. Barnoya J, Glantz S. Association of the California tobacco control program with declines in lung cancer incidence. *Cancer Causes and Control,* 2004;15(7):689-695.

24. California Department of Health Services. *California Tobacco Control Update 2006: The Social Norm Change Approach.* Sacramento: California Department of Health Services; 2006.
25. U.S. Department of Health and Human Services. *Reducing Tobacco Use: A Report of the Surgeon General.* Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health; 2000.
26. Centers for Disease Control and Prevention. *Best Practices for Comprehensive Tobacco Control Programs—August 1999.* Atlanta: U.S. Department of Health and Human Services; 1999.
27. National Cancer Institute. *Community-Based Interventions for Smokers: The COMMIT Field Experience*. Tobacco Control Monograph No. 6. Bethesda, MD: National Institutes of Health; 1995. NIH Pub. No. 95-4028.
28. National Cancer Institute. *ASSIST: Shaping the Future of Tobacco Prevention and Control*. Tobacco Control Monograph No. 16. Bethesda, MD: National Institutes of Health; 2005. NIH Pub No.05-5645.
29. National Cancer Institute. *Evaluating ASSIST: A Blueprint for Understanding State-level Tobacco Control*. Tobacco Control Monograph No. 17. Bethesda, MD: National Institutes of Health; 2006. NIH Pub. No. 06-6058.
30. Farrelly MC, Davis KC, Haviland L, Messeri P, Healton CG. Evidence of a dose-response relationship between "truth" antismoking ads and youth smoking prevalence. *American Journal of Public Health* 2005;95(3):425–431.
31. National Association of County and City Health Officials, National Association of Local Boards of Health, and Association of State and Territorial Health Officials. *Joint Policy Action Steps Toward Tobacco Use Prevention and Control*. Washington, DC: National Association of County and City Health Officials; 2007.
32. U.S. Department of Health and Human Services. *Healthy People 2010. Volume 2.* Washington, DC: U.S. Government Printing Office; 2000.
33. Zaza S, Briss PA, Harris KW, editors. *The Guide to Community Preventive Services: What Works to Promote Health?* New York: Oxford University Press; 2005.
34. Mueller NB, Luke DA, Herbers SH, Montgomery TP. The best practices: use of the guidelines by ten state tobacco control programs. *American Journal of Preventive Medicine* 2006;31(4):300–306.
35. Eriksen, M. Lessons learned from public health efforts and their relevance to preventing childhood obesity. In: Koplan JP, Liverman CT, Kraak VA, editors. *Preventing Childhood Obesity: Health in the Balance.* Washington, DC: National Academy of Sciences; 2005:343-375.
36. National Cancer Institute. *Greater Than the Sum: Systems Thinking in Tobacco Control.* Tobacco Control Monograph No. 18. Bethesda, MD: U.S. Department of Health and Human Services, National Institutes of Health, National Cancer Institute; 2007. NIH Pub No. 06-6085.
37. Federal Trade Commission. *Cigarette Report for 2004 and 2005.* Washington, DC: Federal Trade Commission; 2007.
38. Substance Abuse and Mental Health Services Administration, Office of Applied Studies, National Survey on Drug Use and Health, 2005 and 2006, Table 4.3B. Available at http://oas.samhsa.gov/NSDUH/2k6nsduh/tabs/Sect4peTabs1to4.pdf.
39. California Environmental Protection Agency. *Proposed Identification of Environmental Tobacco Smoke as a Toxic Air Contaminant.* Sacramento: Environmental Protection Agency, Office of Environmental Health Hazard Assessment; 2005.