August 2007

Fourth Annual Independent Evaluation of New York's Tobacco Control Program

Final Report

Prepared for

New York State Department of Health
Corning Tower, Room 710
Albany, NY 12237-0676

Prepared by

RTI International
3040 Cornwallis Road
Research Triangle Park, NC 27709-2194

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Inquiries about this report should be directed to:
Matthew C. Farrelly
E-mail: mcf@rti.org
Telephone: 919-541-6852

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EXECUTIVE SUMMARY

ES.1 Overview

The 2007 Independent Evaluation Report (IER) is RTI International's (RTI's) fourth annual assessment of the New York Tobacco Control Program (NYTCP). In previous reports, we praised NYTCP for developing and implementing a Strategic Plan that is grounded in evidence-based interventions, strengthening its selection of tobacco countermarketing advertisements, expanding the New York State Smokers' Quitline services, and enhancing the skills and capacity of funded Community Partners with training and technical assistance. We also noted in previous reports that the program's efforts have been impeded by bureaucratic and political delays. Another significant impediment to reducing tobacco use in New York is the significant cigarette tax evasion that effectively reduces the price that smokers pay for cigarettes. As a result of lower effective cigarette prices, smoking rates and cigarette consumption are higher than they would be if tax evasion was eliminated.

In the 2006 IER, we made the following recommendations:

- Avoid unplanned gaps in media implementation to maximize coordination between the New York State Department of Health (NYSDOH) and Community Partners and the Quitline.
- Dedicate a sufficient amount of the newly available program resources to achieve 60% awareness of media messages among New Yorkers.
- Maximize the efficiency of mass media efforts to promote the Quitline by increasing the use of cost-effective media (e.g., print and radio).
- More actively promote smoke-free homes and cars through the use of mass media that includes a call to action to limit smoking in homes and cars.
- Focus advocacy efforts to reduce cigarette advertising and promotions on large grocery stores and pharmacies that rely less on cigarette sales as a major source of revenue.
- Avoid gaps in Community Partner activities associated with annual contract renewals.

ES.2 Summary of Progress Since 2006 IER

As a result of past efforts to expand the program's capacity and effectiveness, NYTCP was positioned to take full advantage of the budget increase beginning April 1, 2006, by expanding existing initiatives. The program increased allocations for tobacco countermarketing efforts, community interventions (i.e., School Policy Partners, Cessation Centers, Community Partnerships), the New York Smokers' Quitline, and Promising Interventions grants, among other initiatives.

Once the program's media plan was fully implemented in early 2007, NYTCP was able to exceed the previous recommendation to reach at least 60% of its target audience with evidence-based advertisements. In addition to high levels of awareness, New Yorkers had

positive reactions to these advertisements in early 2007. Unfortunately, bureaucratic and political delays once again prevented NYTCP from implementing its media plan sooner and reaching its full potential in 2006. Despite the availability of additional resources for paid media, awareness of tobacco countermarketing messages among New Yorkers plateaued in 2006 after steady annual increases from 2003 to 2005. With respect to other recommendations from the 2006 IER, NYTCP made good progress. The program more actively promoted the New York State Smokers' Quitline with cost-effective Internet advertisements that contributed to record levels of Quitline service and nicotine replacement therapy (NRT) distribution in the past year. In addition, although the program did not include a call to action in advertisements focused on secondhand smoke exposure, the advertisements generally elicited positive feedback. Consistent with our recommendation, there appeared to be no significant gaps in Community Partner activities associated with contract renewals. Finally, the program conducted research to identify promising strategies to reduce point-of-purchase cigarette advertising.

ES.3 2007 IER Conclusions and Recommendations

Conclusions

Tobacco Use. It appears that NYTCP's recent and past efforts are beginning to have an impact on tobacco use. In 2006, the prevalence of youth and adult smoking declined faster in New York than in the United States as a whole. In addition, the use of other tobacco products by youth and adults also declined. However, tobacco use did not decline at the same rate among all adult populations in New York (e.g., Medicaid recipients, adults with self-reported mental health problems). NYTCP will need to address these gaps moving forward.

Tobacco Countermarketing. NYTCP continues to make progress with countermarketing efforts by using high quality, high sensation value messages. Unfortunately, NYTCP's progress has been slowed once again by unnecessary bureaucratic and political delays despite the program's efforts to plan in a timely manner.

New York State Smokers' Quitline. The Quitline continues to provide high quality service, and, with the additional NRT, smokers who call the Quitline are more likely to successfully quit compared with previous years when NRT was not available. In addition, the Quitline received a record number of calls in the past year. There are, however, periods when the demand for the Quitline exceeds its capacity, and the program must better coordinate paid media with Quitline capacity. Although the Quitline is a helpful resource for smokers, health care providers, and others in New York, it currently reaches approximately 3% of the smokers in New York. We recommend exploring ways to increase this reach to approximately 5%.

Community Mobilization. Turning to the Cessation Center initiative, recent data suggest that after the first 2 years of the intervention, the Cessation Centers are beginning to have an impact on short- and intermediate-term outcomes. Health care provider organization administrators are more aware of the Cessation Centers and of other cessation resources in the state. In addition, an increasing percentage of health care provider organizations have adopted formal guidelines for addressing smoking cessation. Although we did not observe progress in the ultimate objective—to increase systems that screen all patients for tobacco use and prompt providers to provide brief advice to quit—the Cessation Centers appear to be making good progress. With respect to other community-based interventions, it is difficult to evaluate their progress because their interventions are more diffuse. In addition, the goal of these initiatives is to change community norms about tobacco use by changing policies in a number of settings in order to curb the influence of tobacco advertising, sponsorship, and promotion. This is a challenging task, and the Community Partners are struggling to develop the necessary skills and strategies to effect change. It is likely that these initiatives will take years to have an impact.

Recommendations

In summary, we make the following recommendations:

- Avoid bureaucratic and political delays that hampered implementation of media campaigns in 2006.
- Better coordinate media campaigns and Quitline activities to ensure that the two are in sync and the highest quality of service is offered by the Quitline.
- Strengthen strategies and skills used by funded Community Partners to create policy and environmental change in New York communities.
- Support community initiatives with paid media campaigns by withdrawing funding from the Healthy Neighborhood and School Health Center programs to fund media campaigns that support funded partner efforts in their communities.

To achieve the NYTCP 2010 objective of 1 million fewer smokers, we recommend the following:

- Maintain funding at $85.485 million at a minimum and make full use of all program dollars for effective tobacco control interventions, specifically shifting funding from the Healthy Neighborhood and School Health Center programs in order to fund media campaigns.
- Raise the price of cigarettes by increasing the cigarette excise tax and reducing tax evasion through Indian reservation sales to non-Indians.
- Invest sufficiently in media and countermarketing to achieve a 60% reach of campaign messages and generate 230,000 calls per year to the Quitline.
- Support community policy and environmental change efforts with coordinated media messages.

1. INTRODUCTION

The 2007 Independent Evaluation Report (IER) constitutes RTI International's (RTI's) fourth and final annual independent assessment of the New York Tobacco Control Program (NYTCP) for this phase of the evaluation. According to the Health Care Reform Act (§1399-jj), the purpose of the independent evaluation is to "direct the most efficient allocation of state resources devoted to tobacco education and cessation to accomplish the maximum prevention and reduction of tobacco use among minors and adults." In previous IERs, we found that NYTCP's approach was solidly grounded in evidence-based strategies, that programmatic resources were invested appropriately, and that NYTCP established baseline indicators to monitor program progress in achieving its statutorily mandated objectives to change attitudes toward tobacco and to decrease smoking prevalence among youth and adults.

Beginning with the April 1, 2006, to March 31, 2007, fiscal year, the program's budget was nearly doubled, from $44 million to $85 million. NYTCP was able to put significant amounts of these new resources to work in 2006, primarily by adding funds to existing contracts. Some of the most significant additions include

- $13 million for tobacco countermarketing efforts;
- $4 million for Promising Interventions grants;
- $3 million for research and evaluation;
- $2 million for School Policy Partners;
- $2 million for enforcement of the Clean Indoor Air Law;
- $1.5 million for administration, including eight additional staff;
- $1.4 million for the New York State Smokers' Quitline to accommodate an increase in call volume;
- $1.2 million for Cessation Centers; and
- $1 million for Community Partnerships.

In addition, approximately $6 million was dedicated to two New York State Department of Health (NYSDOH) directives that are outside of NYTCP: the Healthy Neighborhood and School Health Center programs. The primary purpose of the Healthy Neighborhood program is to reduce lead exposure. This program is funded entirely from the NYTCP budget even though its primary focus is not tobacco control and it is not an evidence-based tobacco control intervention. The primary purpose of the School Health Center program is to increase access to medical care for students. This program also receives substantial

financial support from the NYTCP budget although it is not an evidence-based tobacco intervention. Given the focus of these programs, they will have little direct impact on key programmatic outcomes because they do not deliver a quantity of tobacco control interventions that is commensurate with the $6 million cost. Given the time required to create new initiatives, no new initiatives were implemented in 2006. In the current IER, we evaluate the impact of the overall program on key outcomes.

1.1 Recommendations and Responses to the 2006 IER

The 2006 IER included the following recommendations with respect to reaching programmatic goals:

- Avoid unplanned gaps in media implementation to maximize coordination between NYSDOH and Community Partners and the Quitline.
  - Ensure that the Quitline can anticipate increases in call volume due to countermarketing efforts and staff the Quitline appropriately.
- Dedicate a sufficient amount of the newly available program resources to achieve 60% awareness of media messages among targeted New Yorkers.
- Maximize the efficiency of mass media efforts to promote the Quitline by increasing the use of cost-effective media (e.g., print, radio).
- More actively promote smoke-free homes and cars through the use of mass media that includes a call to action to limit smoking in homes and cars.
  - Include a call to action to smokers in mass media messages to ban smoking in their homes.
  - Dedicate a time of the year to concentrate efforts to promote smoke-free homes and cars (e.g., back to school time).
- Focus advocacy efforts to reduce cigarette advertising and promotions on large grocery stores and pharmacies that rely less on cigarette sales as a major source of revenue.
- Avoid gaps in Community Partner activities associated with annual contract renewals.

We describe NYTCP's response to these recommendations in the body of this report.

1.2 Report Organization

The 2007 IER evaluates the following key interventions through calendar year 2006 and, where possible, early 2007:

- countermarketing efforts
- New York State Smokers' Quitline and Fax-to-Quit program
- community-based tobacco control initiatives

The remainder of the report is organized as follows. Chapter 2 compares trends in the prevalence of cigarette smoking in New York with national trends and presents other measures of tobacco use for New York, Chapters 3 through 5 evaluate the key interventions noted above, and Chapter 6 presents conclusions and recommends next steps for the program.

2. TOBACCO USE

In the 2006 Independent Evaluation Report (IER), we noted that New York's investments in tobacco control between 2002 and 2005 were on par with expenditures in the United States and had yielded trends in smoking-related outcomes that were, in turn, on par with the nation as a whole. Over that period, the New York Tobacco Control Program (NYTCP), using evidence-based strategies, steadily increased its capacity to implement tobacco control interventions. In fiscal year 2006–2007, however, the program's funding roughly doubled and would be expected to impact tobacco use trends beginning in 2007. This section presents and discusses trends in tobacco use in New York through 2006, including national trends in tobacco use where available. We also present differences in tobacco use by various population groups to highlight where the burden of tobacco use is highest. Finally, we examine the extent of tax evasion in New York in 2006.

2.1 Trends in Tobacco Use

As noted in the 2006 IER, investments in tobacco control have been shown to reduce the prevalence of youth (Taurus et al., 2005) and adult smoking (Farrelly et al., in press), but there is a lag between funding; implementation of program activities; and resulting changes in tobacco-related attitudes, knowledge, and behavior. This lag exists because tobacco use is an addictive behavior and because building the necessary program infrastructure (e.g., talented, trained staff; strategic plans) and changing behavior takes time.

By comparing trends in New York with trends in the United States as a whole, we can assess whether trends compare favorably with the average experience in the country 7 years after NYTCP began (in 2000). On average from 2002 through 2005, tobacco control expenditures in New York were on par with expenditures in the United States, with earlier years being somewhat below the national average and 2005 somewhat above average (Exhibit 2-1).

Exhibit 2-1. Per Capita Funding Allocations for Tobacco Control, Fiscal Years 2000–2005

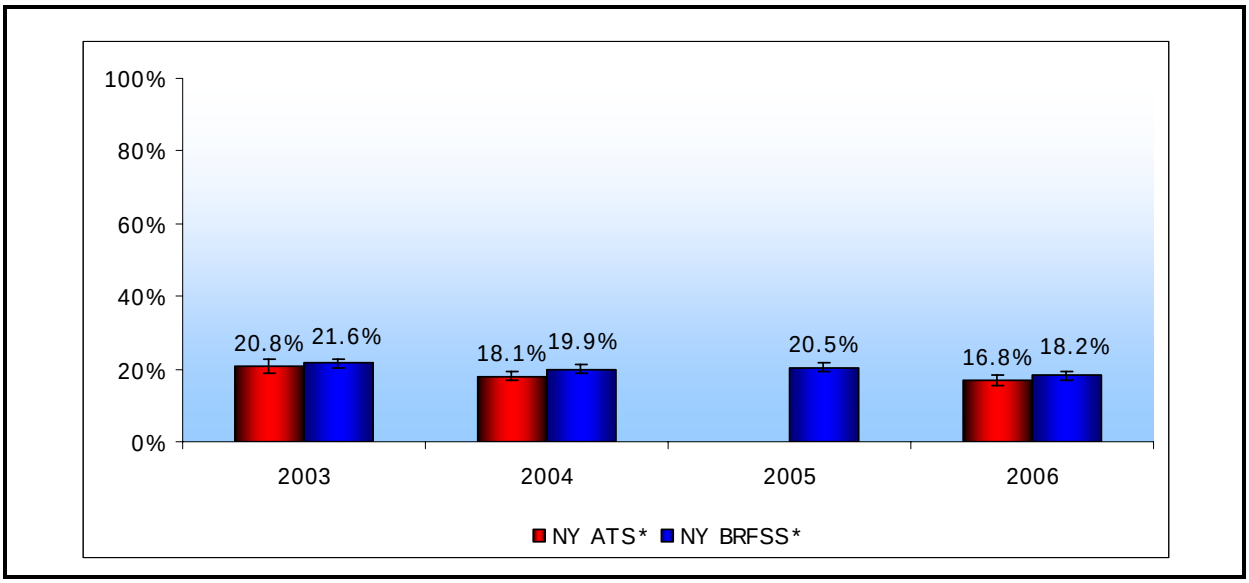
	Fiscal Year					
	2000	**2001**	**2002**	**2003**	**2004**	**2005**
New York	$0.67	$1.88	$2.28	$1.95	$2.02	$2.50
Rest of the nation	$1.86	$2.32	$2.78	$2.69	$2.05	$1.96

Using data from the annual National Health Interview Survey (NHIS), the New York Behavioral Risk Factor Surveillance System (BRFSS), and the New York Adult Tobacco Survey (ATS), we are able to compare trends in adult smoking between New York and the country as a whole. Comparing trends in tobacco use in New York with trends in the rest of the country provides indirect evidence of whether New York's tobacco control efforts are having an effect above the average. Exhibit 2-2 shows that, from 2000 to 2004, trends in the percentage of adult current smokers from the New York BRFSS tracked trends in the United States as a whole very closely. In 2005 and 2006, however, rates of smoking prevalence in New York appeared to diverge from rates in the nation as a whole. From 2003 to 2006, both the New York BRFSS and the ATS (presented graphically in Exhibit 2-3) show a statistically significant decrease in the percentage of adults who smoke compared with no change nationally. In addition, both New York surveys show that the prevalence of smoking is currently lower in New York than in the country as a whole. We do not provide estimates from the 2005 New York ATS (because of data problems described in the 2006 IER).

Exhibit 2-2. Percentage of Adults Who Smoke Nationally and in New York, 2001–2006 [95% Confidence Interval]

Year	National Health Interview Survey	New York BRFSS	New York ATS
2000	23.3 [22.8–23.8]	21.6 [20.0–23.2]	—
2001	22.7 [22.1–23.3]	23.2 [21.6–24.8]	—
2002	22.4 [21.7–23.0]	22.3 [20.8–23.8]	—
2003	21.6 [21.0–22.2]	21.6 [20.3–22.9]	20.8 [19.0–22.5]
2004	20.9 [20.3–21.5]	19.9 [18.7–21.1]	18.1 [16.9–19.2]
2005	20.9 [20.3–21.5]	20.5 [19.3–21.7]	—
2006	20.8 [20.1–21.5]	18.2 [16.9–19.5]	16.8 [15.2–18.4]

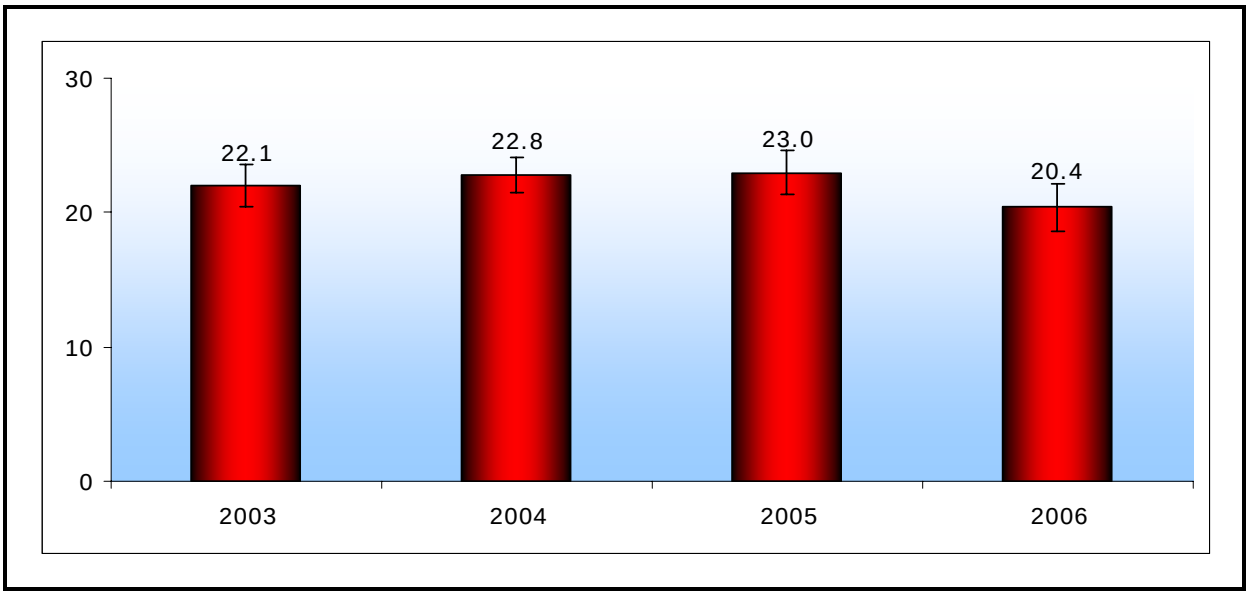
Exhibit 2-3. Percentage of New Yorkers Who Currently Smoke, New York ATS and BRFSS, 2003–2006



*Statistically significant downward trend from 2003 to 2006.

To assess the change in the number of cigarettes smoked by New York adults, we also present estimates of monthly cigarette consumption using the New York ATS. We calculated monthly cigarette consumption by multiplying the number of packs smoked per day by the number of days of smoking in the past 30 days. Exhibit 2-4 shows the average number of cigarette packs smoked by current smokers in the past 30 days. Although there has been no significant change in cigarette consumption from 2003 to 2006, monthly cigarette consumption declined significantly between 2005 and 2006.

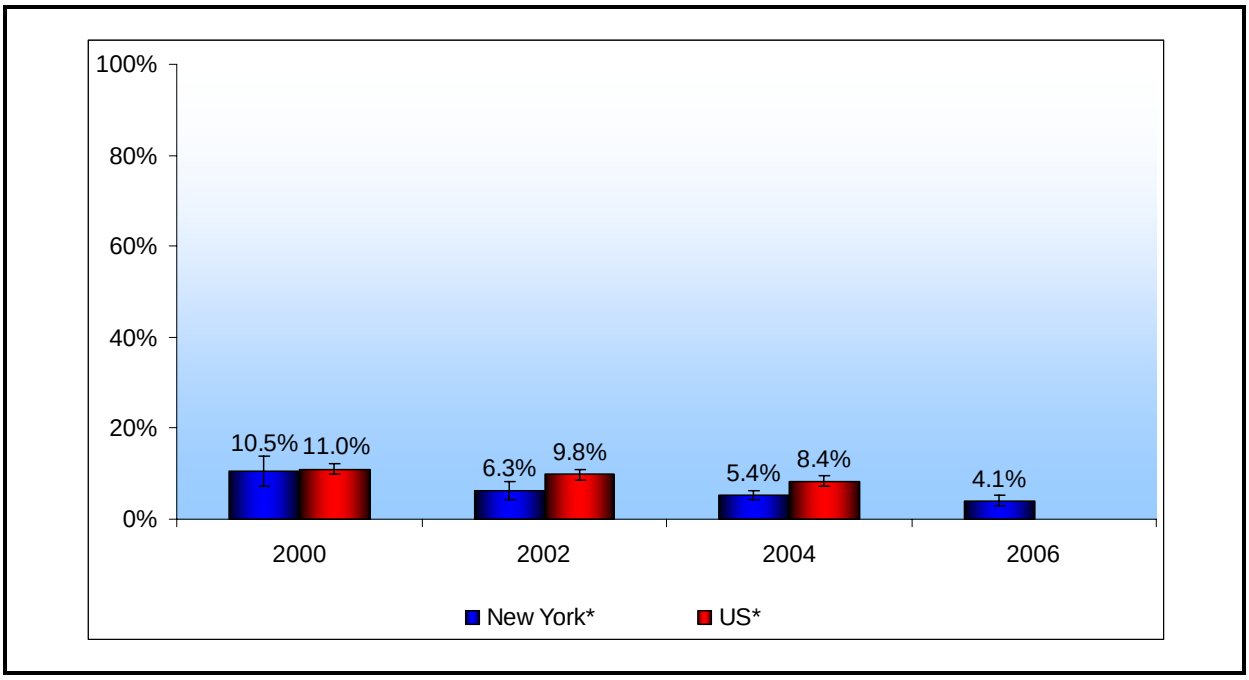
Exhibit 2-4. Average Number of Cigarette Packs Smoked by Current Smokers in the Past 30 Days, ATS 2003–2006



Note: Statistically significant difference between 2005 and 2006.

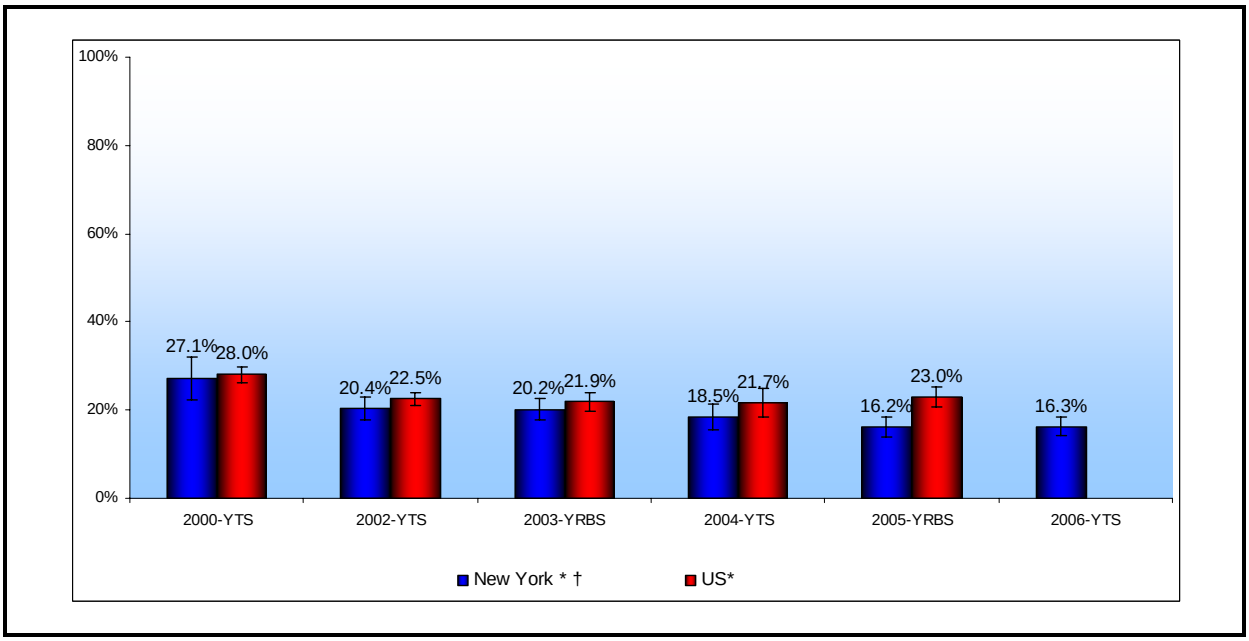
To assess changes in tobacco use among youth, we present data from the biannual New York Youth Tobacco Surveys (YTS) from 2000–2006, the National Youth Tobacco Surveys (NYTS) from 2000–2004, and the Youth Risk Behavior Surveillance System (YRBSS) from 2003–2005. Current smoking is defined as smoking on any days in the past month. The 2006 NYTS data are not yet available. From 2000 to 2004, the YTS and YRBS data show a statistically significant decline in the percentage of middle and high school students in New York and nationally who currently smoke (Exhibits 2-5 and 2-6). As of 2004, the percentage of middle school students who smoke was lower in New York than in the country as a whole, whereas the comparable percentage for high school students was statistically similar. From the 2004 to 2006 New York YTS, the change in the percentage of middle school students who smoke was marginally significant ($p < .08$). There was no change in the percentage of cigarette use among high school students from 2004 to 2006. However, data on current smoking among high school students from the 2003 and 2005 YRBSS from New York and the United States indicate that youth smoking rates are continuing to decline faster in New York than in the United States.

Exhibit 2-5. Percentage of Middle School Students Who Currently Smoke, New York YTS (2000–2006) and National YTS (2000–2004)



*Statistically significant downward trend from 2000 to 2004 and from 2004 to 2006.

Exhibit 2-6. Percentage of High School Students Who Currently Smoke, New York YTS (2000–2006) and National YTS (2000–2004) and New York and National Youth Risk Behavior Surveillance System Surveys (2003 and 2005)



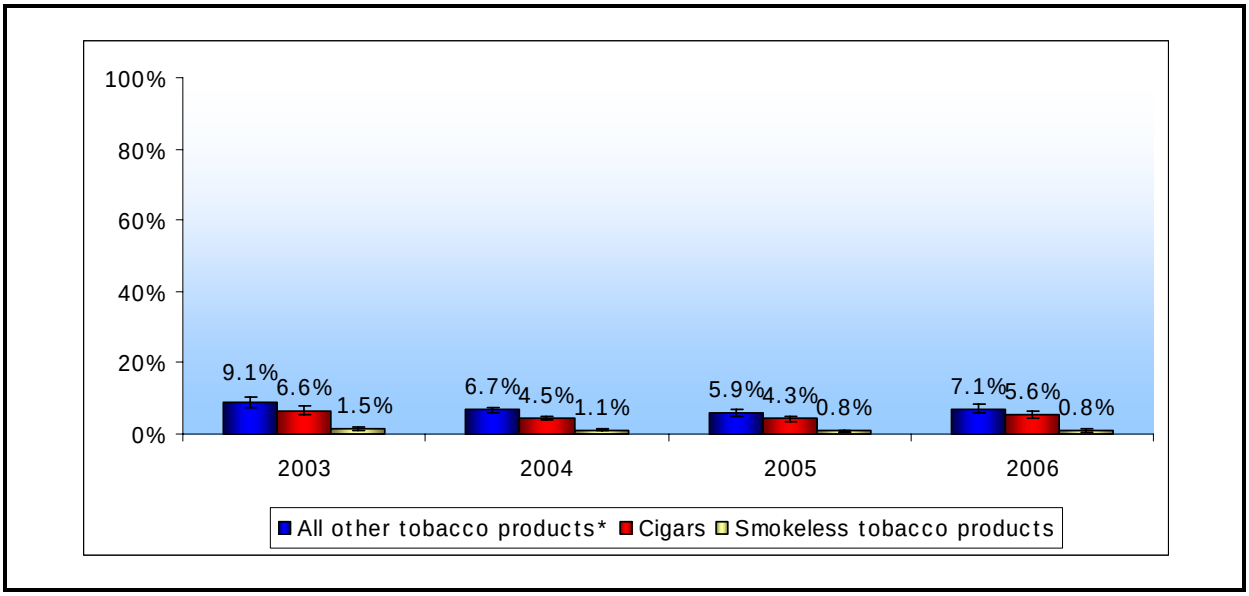
*Statistically significant downward trend for YTS from 2000 to 2004.

†Statistically significant downward trend for YRBSS from 2003 to 2005.

2.2 Trends in the Use of Tobacco Products Other Than Cigarettes

The percentage of adults who currently use at least one tobacco product other than cigarettes (i.e., cigars, cigarillos, chewing tobacco, snuff, dip, pipe tobacco, bidis, and kreteks) declined significantly from 2003 (9.1%) to 2006 (7.1%) (a 22% relative decline) (Exhibit 2-7). The most commonly used tobacco product after cigarettes is cigars. In 2006, the percentage of adults who reported currently smoking cigars was 5.6%, statistically unchanged from 2003. The percentage of adults who reported using smokeless tobacco was 1.5% in 2003 and 0.8% in 2006—this difference is not statistically significant.

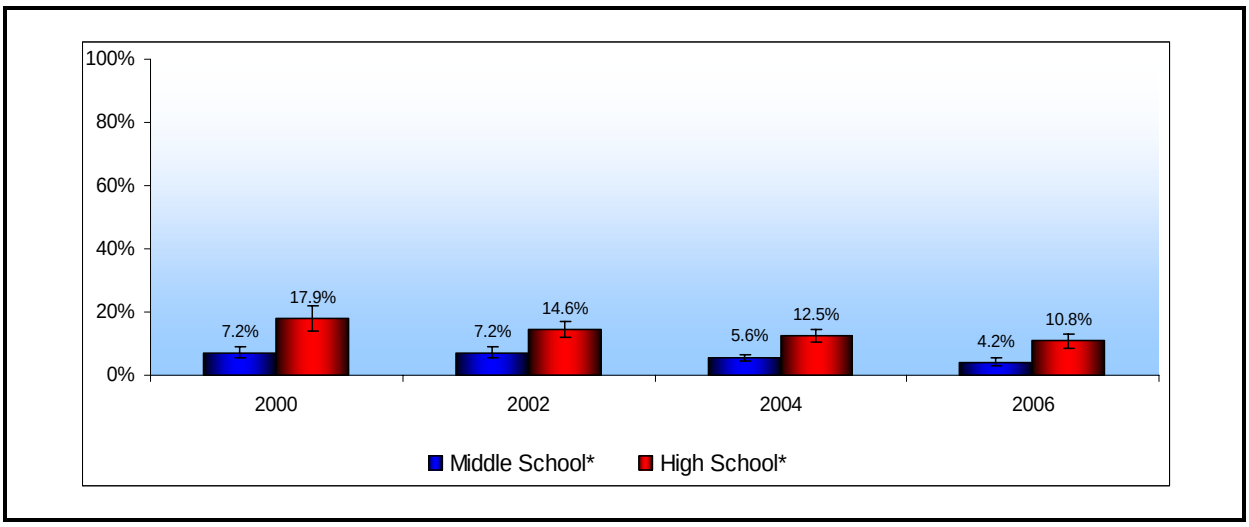
Exhibit 2-7. Percentage of Adults Who Currently Use Any Tobacco Product Other than Cigarettes, ATS 2003–2006



*Statistically significant downward trend from 2003 to 2006.

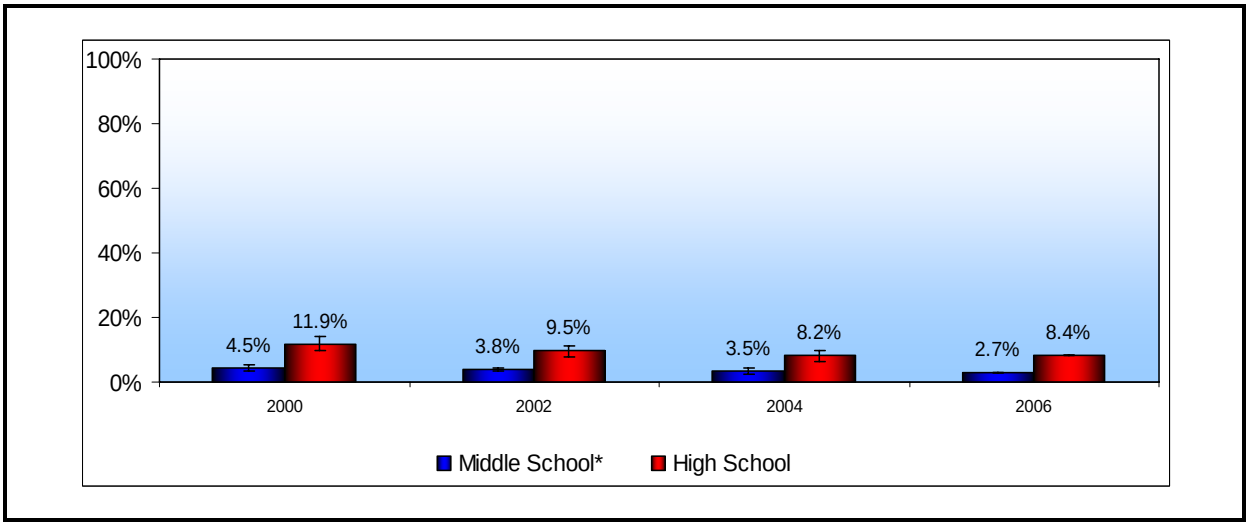
To assess changes in the use of other tobacco products among youth, we present data from the New York YTS from 2000 through 2006. Similar to cigarette smoking, current use of other tobacco products among youth is defined as use of at least one tobacco product other than cigarettes (e.g., cigars, smokeless tobacco, bidis, and kreteks) on any days in the past month. From 2000 to 2006, other tobacco product use declined from 7.2% to 4.2% among middle school students and from 17.9% to 10.8% among high school students (Exhibit 2-8). The declines among both groups are statistically significant between 2000 and 2006 but insignificant between 2004 and 2006. Similar to adults, the most commonly used tobacco product among youth other than cigarettes is cigars. In 2006, 2.7% of middle school students and 8.4% of high school students reported currently smoking cigars. Both of these results are statistically unchanged from 2004 (Exhibit 2-9). Finally, smokeless tobacco use was 1.7% among middle school students and 3.1% among high school students in 2006, unchanged from 2004 (Exhibit 2-10).

Exhibit 2-8. Percentage of Middle and High School Students Who Have Used Tobacco Products Other Than Cigarettes in the Past 30 Days, YTS 2000–2006



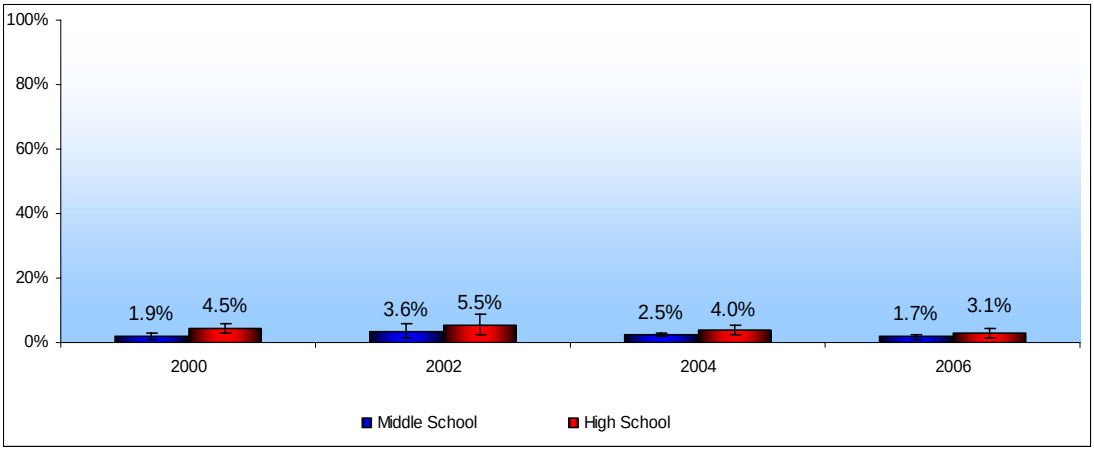
*Statistically significant downward trend from 2000 to 2006.

Exhibit 2-9. Percentage of Middle and High School Students Who Have Smoked Cigars in the Past 30 Days, YTS 2000–2006



*Statistically significant downward trend from 2000 to 2006.

Exhibit 2-10. Percentage of Middle and High School Students Who Have Used Smokeless Tobacco in the Past 30 Days, YTS 2000–2006



2.3 Differences in Tobacco Use by Selected Population Groups

Recently, the Centers for Disease Control and Prevention (CDC) identified the elimination of tobacco-related disparities as one of its primary challenges and goals. To address this concern in New York, the program has actively worked to identify population groups with high rates of tobacco use (Engelen, Farrelly, and Hyland, 2006). Statewide estimates of tobacco use often mask considerable variation between population groups. In the following sections, we identify differences in the prevalence of smoking and in the numbers of smokers statewide by geographic location, health insurance status, and mental health status. Specifically, we examine three specific populations: (1) respondents living in a rural setting compared with those living in an urban setting (determined by whether the respondent's county of residence falls within the boundaries of a Metropolitan Statistical Area [MSA] or not), (2) respondents who have no health insurance or are insured by Medicaid compared with those who have private insurance or Medicare, and (3) respondents who have frequent mental health problems compared with those who do not.

2.3.1 Smoking Prevalence Among New York Adults by Geographic Location

Exhibit 2-11 presents pooled smoking prevalence estimates for each of the eight tobacco control program areas. Overall, we found that smoking prevalence is lowest in the New York/ Long Island Area and highest in the North Central Area. Smoking prevalence is consistently higher in each area (other than South Central) among New Yorkers who live in rural areas of the state (non-MSA) than among those who live in urban settings (i.e., in an MSA) (Exhibit 2-12). However, smoking prevalence among both groups of smokers has decreased significantly from 2003 to 2006 (Exhibit 2-13).

Exhibit 2-11. Percentage of Adults Who Are Current Smokers by Area, ATS Q3 2003–Q4 2006 Combined

Area	Smoking Prevalence [95% Confidence Interval]		
	Overall	Within MSA	Outside MSA
Buffalo	21.4 [19.4–23.5]	20.6 [18.3–22.9]	23.3 [19.0–27.5]
Rochester	18.4 [16.2–20.6]	18.0 [15.6–20.5]	20.2 [14.7–25.7]
Hudson Valley	16.5 [14.3–18.7]	16.2 [14.0–18.5]	23.4 [11.5–35.2]
NYC/Long Island	15.3 [14.3–16.3]	15.3 [14.4–16.3]	—
North Capital	19.6 [16.7–22.6]	17.3 [13.2–21.4]	22.5 [18.4–26.5]
South Capital	21.5 [18.1–24.8]	19.4 [15.3–23.4]	27.1 [20.4–33.7]
North Central	23.3 [20.1–26.4]	22.5 [18.4–26.5]	24.7 [19.3–30.2]
South Central	19.3 [16.8–21.8]	19.2 [16.5–21.9]	18.0 [11.4–24.5]

Exhibit 2-12. Percentage of Adults Who Are Current Smokers by Area/MSA, ATS Q3 2003–Q4 2006 Combined

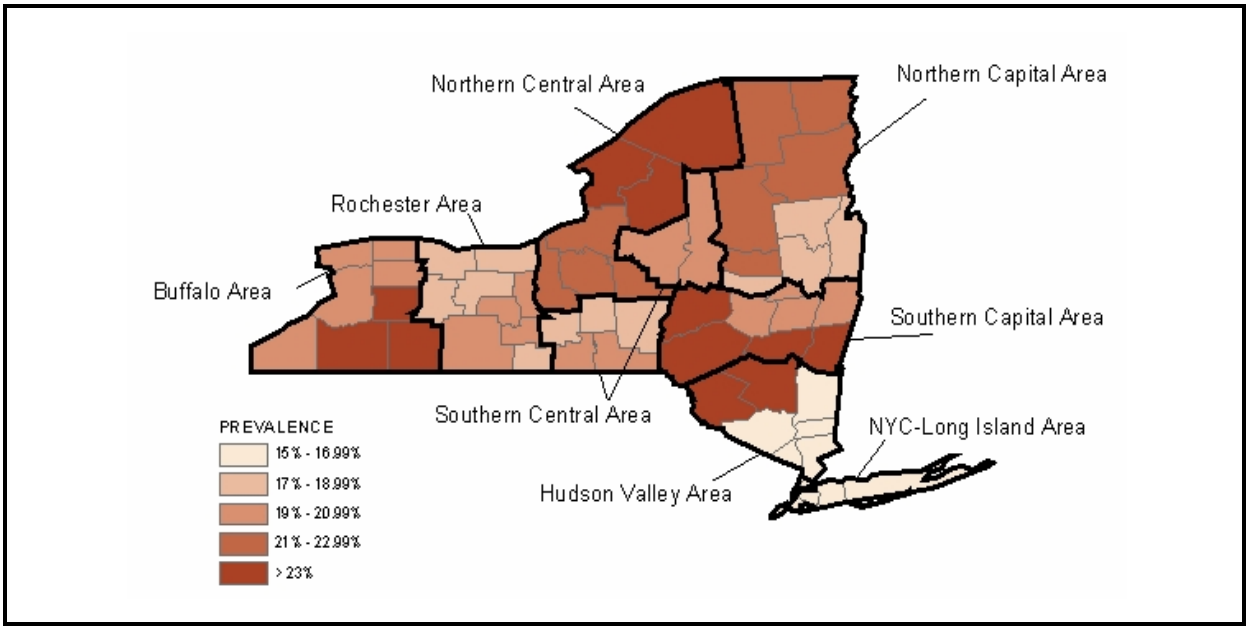
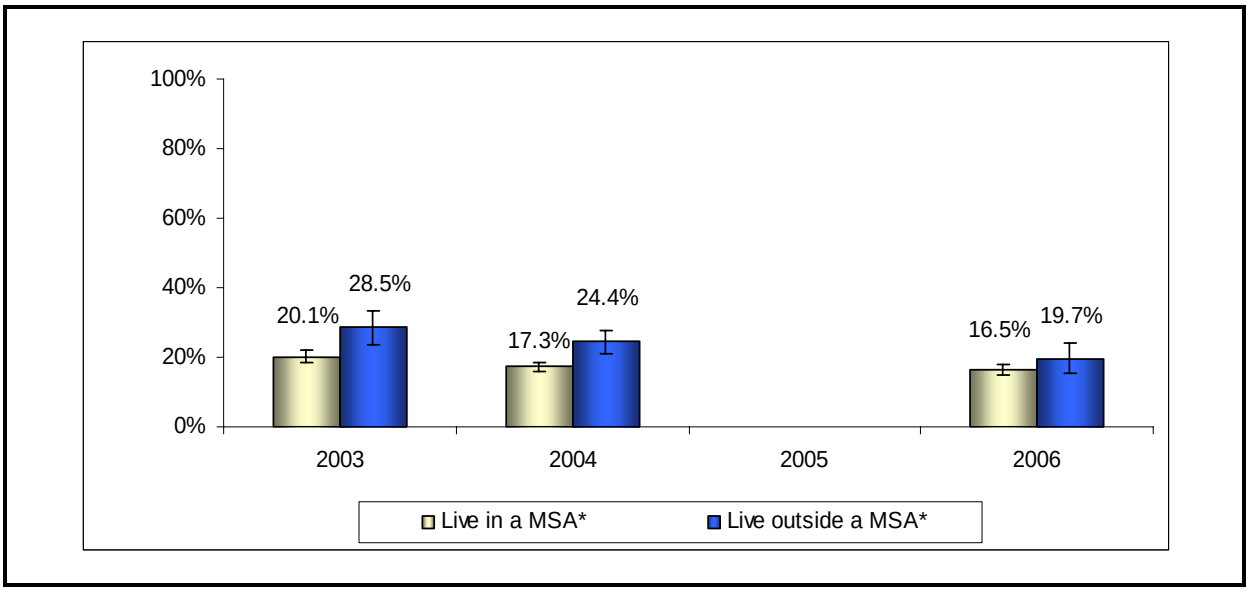


Exhibit 2-13. Percentage of Adults Who Are Current Smokers by MSA and by Year, ATS 2003–2006

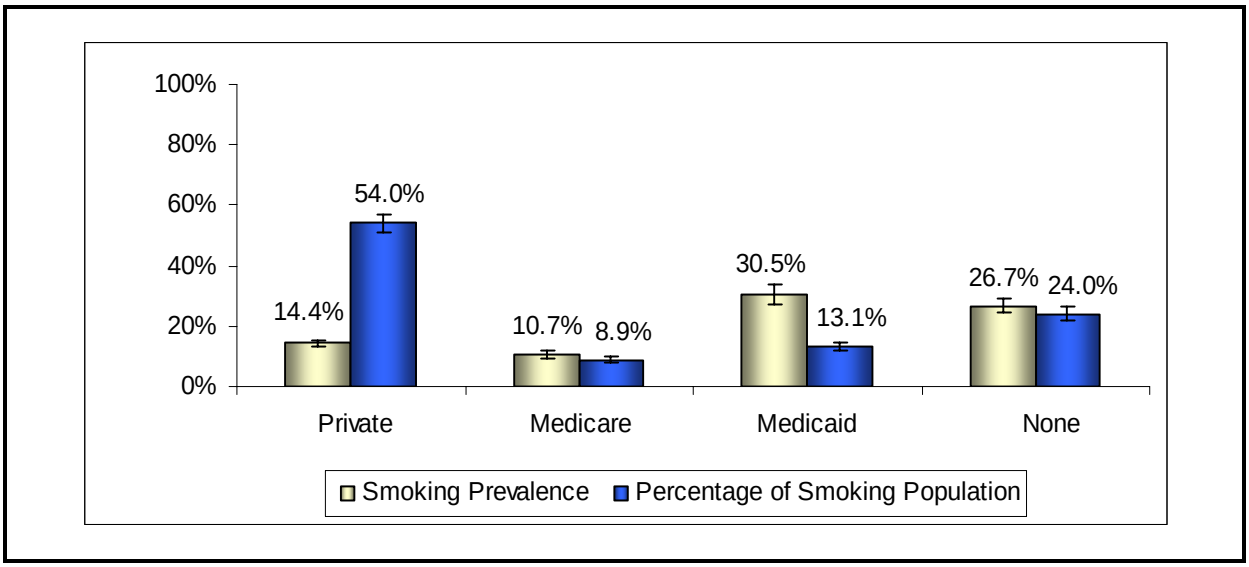


*Statistically significant downward trend from 2003 to 2006.

2.3.2 Smoking Prevalence Among New York Adults by Health Insurance Status

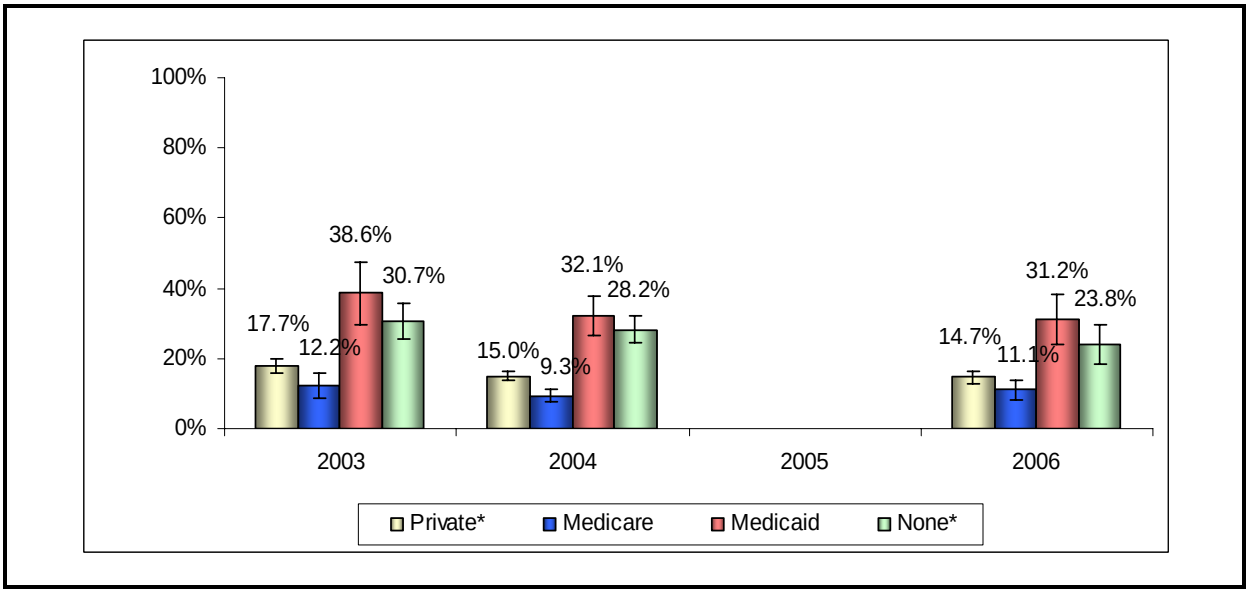
Exhibit 2-14 presents pooled estimates of smoking prevalence and the proportion of smokers by health insurance status. Although the majority of New Yorkers have private health insurance (64%), about 11% have no health insurance and about 6% are insured by Medicaid (results not shown). Seniors who qualify for Medicare (19%) account for the remaining percentage. Smoking prevalence is significantly higher among adults with Medicaid insurance (31%) and those without health insurance (27%) than among adults with other sources of health insurance. For adults between the ages of 18 and 64, smoking prevalence among individuals with Medicaid insurance (33%) and among those without any health insurance (27%) remains significantly higher than among adults with private health insurance (15%). However, smoking prevalence among adults with Medicare insurance (individuals under age 65 are eligible for Medicare if they are disabled or if they have end-stage renal disease) is significantly higher (23%) than among adults with private health insurance (results not shown).

Exhibit 2-14. Percentage of Adults Who Are Current Smokers by Insurance Status, ATS 2003–2006



Smoking prevalence among individuals who have private insurance as well as those who have no insurance both decreased significantly from 2003 to 2006. In contrast, smoking prevalence among individuals who are insured by either Medicaid or Medicare remained constant over the same period (Exhibit 2-15).

Exhibit 2-15. Percentage of Adults Who Are Current Smokers by Insurance Status and Year, ATS 2003–2006



*Statistically significant downward trend from 2003 to 2006.

2.3.3 Smoking Prevalence Among New York Adults by Mental Health Status

It has been estimated that people with a history of mental illness are about 90% more likely to consume cigarettes than those without such a history (Saffer and Dave, 2005). Smoking prevalence among individuals with serious mental illnesses has been estimated at 45%, with prevalence rates of 70% to 90% common among people with schizophrenia (Lucksted et al., 2004).

Although unable to estimate the prevalence of mental illness directly, the New York ATS asks respondents about their mental health. For the purposes of this report, individuals who reported mental health problems (including stress, depression, and problems with emotions) on 14 or more days in the past 30 days were coded as having some mental health problems or frequent mental distress. Overall, we found that smoking prevalence was significantly higher among individuals who reported some mental health problems (37%) than among individuals who did not (15%) (Exhibit 2-16). Individuals who reported having mental health problems represent 9.3% of the population and about 20% of the overall smoking population. The differences between the two groups are further highlighted by examining the change in smoking prevalence over time. Specifically, smoking prevalence among adults who have no reported mental health problems decreased significantly from 2003 to 2006. In contrast, smoking prevalence among adults who reported having mental health problems remained constant over the same period (Exhibit 2-17). It should be noted that a significant number of adult Medicaid recipients also have mental health and substance abuse problems (USDHHS, 1999).

Exhibit 2-16. Percentage of Adults Who Are Current Smokers by Mental Health Status, ATS Q3 2003–Q4 2006 Combined

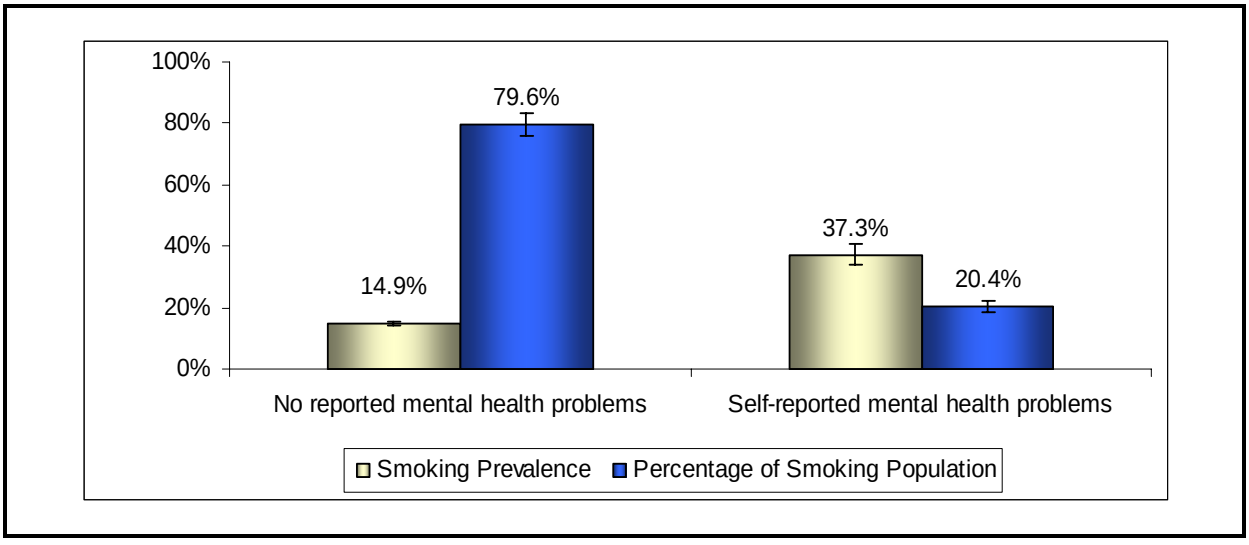
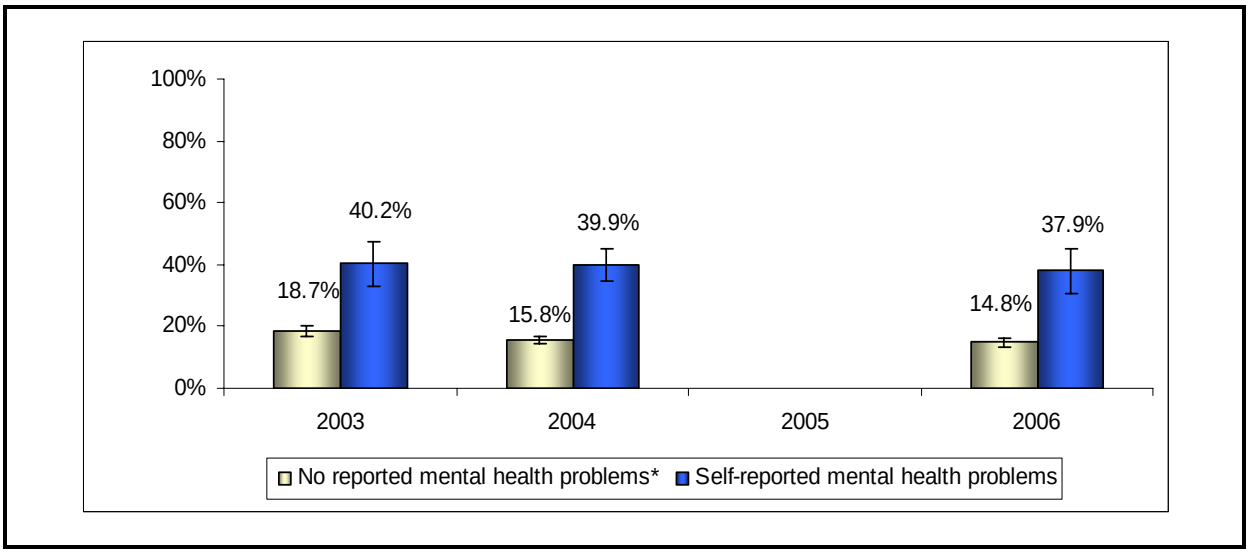


Exhibit 2-17. Percentage of Adults Who Are Current Smokers by Mental Health Status and Year, ATS 2003–2006



*Statistically significant downward trend from 2003 to 2006.

2.4 Tax Evasion

As noted in the 2005 IER, increases in the price of cigarettes have been shown to reduce the prevalence and intensity of cigarette smoking. As a result of the increases in cigarette excise taxes in New York State and City in 2002, we would expect to see declines in cigarette consumption and the prevalence of smoking in 2002 and 2003. However, because consumers can avoid the tax, the average price paid for cigarettes by smokers overall is lower than would be expected given the current tax. New York is somewhat unique in that it has a number of American Indian reservations that sell tax-free cigarettes.

In recent years, New York State has taken a number of steps to eliminate opportunities for non-Indians to purchase untaxed cigarettes. Under federal law, American Indians are not required to pay state excise and sales taxes on tobacco products. However, a U.S. Supreme Court ruling in 1994 found that sales of tobacco by Tribes and American Indian-owned businesses to non-American Indians, even when they occurred on reservations, were not subject to the same exemptions. In 2005, New York State, operating under this premise, enacted a state law that sought to collect the tax on all cigarettes sold by Tribes and American Indian-owned businesses to non-American Indians. However, recent enforcement of the law has been met with significant opposition from American Indian groups who have obtained a legal injunction preventing the state from collecting any taxes from these cigarette sales (Sokolowski, 2007). The injunction focuses on the failure of the state to provide and distribute special coupons allowing Americans Indians to continue buying cigarettes tax-free for their personal consumption. Although the injunction will likely be lifted once the state addresses the legal issues identified in the brief, the 2005 law could

potentially face a series of other legal challenges that could prevent its enforcement (Precious, 2007).

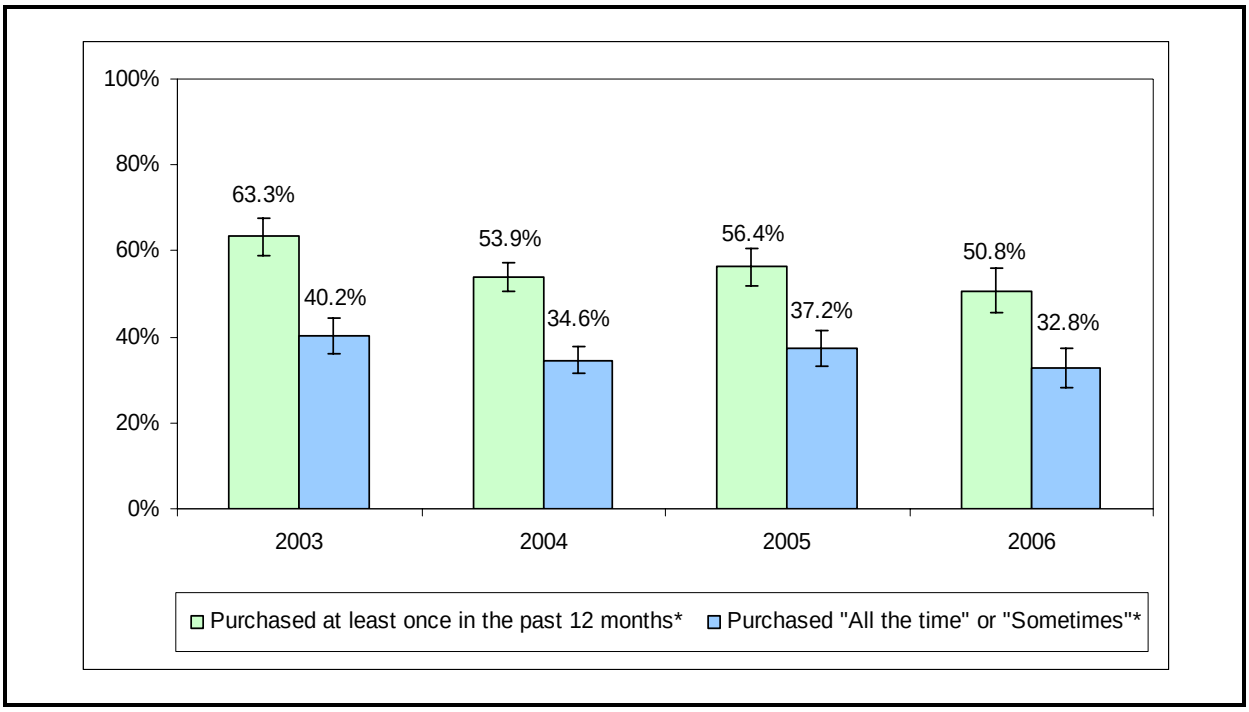
New York State has also enacted legislation targeting Internet tobacco retailers. Specifically, in 2003, a law went into effect making it "unlawful for any person engaged in the business of selling cigarettes to ship or cause to be shipped any cigarettes" to any person in [New York] who is not a licensed cigarette tax agent, a wholesale dealer, an export warehouse proprietor, or an employee of the U.S. government (New York State Public Health Law, Article 13-F, Section 1399-LL). As a result, shipments of cigarettes purchased over the Internet by commercial mail carriers (e.g., UPS, Federal Express, DHL) became illegal under state law. In addition, New York State, in conjunction with several other states, signed an agreement in 2005 in which credit card companies would "[adopt] policies to prohibit the use of credit cards for the illegal sale of cigarettes over the Internet; and [agree] to investigate and take action with respect to any Internet sellers identified by law enforcement agencies as using credit cards for illegal online cigarette sales" (NYSAG, 2005). Credit card companies have also provided access to records of all past purchases from online cigarette retailers, many of whom have been subsequently billed by New York State for unpaid excise taxes.

In the following sections, we examine the impact of these legislative changes on purchase rates of cigarettes from a variety of low or untaxed sources, including Indian reservations and the Internet, and on smoking prevalence. In addition, we examine the financial impact of tax evasion on state revenues from cigarette excise taxes.

2.4.1 Tax Evasion from Indian Reservations, the Internet, Neighboring States, Duty-Free Shops, and Toll-Free Lines

To assess the prevalence of tax evasion in New York, we used data from the ATS, which asks smokers to report whether they purchased cigarettes from several low- or untaxed sources in the past 12 months. Those who respond affirmatively are then asked how often they purchased from these sources: "always," "sometimes," or "rarely." The ATS includes separate questions for the various locations where smokers can purchase cigarettes tax free or at reduced tax levels: on American Indian reservations, in another state/country, from the Internet, from a toll-free number, and at duty-free shops. Exhibit 2-18 presents the percentage of smokers who reported purchasing from any one of these five locations in the past 12 months. From 2003 through 2006, the trends in both indicators of tax evasion have decreased significantly. However, in 2006, the overall level of tax evasion was significant, with 51% of smokers indicating that they had purchased cigarettes at least once from one of the five low- or untaxed sources and 33% indicating that they purchased cigarettes "sometimes" or "all the time" from these sources. Some of this decline from 2003 to 2006 in tax evasion may result from declining inflation-adjusted cigarette prices that declined by $0.26 in real terms from 2003 to 2006 (see Section 2.4.2).

Exhibit 2-18. Percentage of Smokers Who Purchased Cigarettes in the Past 12 Months from Low-Tax or Untaxed Sources, ATS 2003–2006



*Statistically significant downward trend from 2003 to 2006.

Exhibits 2-19 and 2-20 present the trends in the percentage of smokers who reported purchasing cigarettes “always” or “sometimes” from Indian reservations and over the Internet, respectively. In 2006, 28% of smokers indicated that they had purchased cigarettes at least once from an Indian reservation, whereas 20% indicated that they purchased cigarettes “sometimes” or “all the time” from a reservation. There has been no statistically significant trend from 2003 to 2006 in either of these indicators. In contrast, there have been significant changes in the percentages of smokers who purchase cigarettes over the Internet. Specifically, in 2006, 2% of smokers indicated that they had purchased cigarettes at least once over the Internet (down from 10% in 2003), whereas only 1% indicated they purchased cigarettes “sometimes” or “all the time” over the Internet (down from 6% in 2003). The trend in both of these Internet purchase outcomes over time is statistically significant. Exhibit 2-21 presents estimates of purchasing from other low- or untaxed sources, including neighboring states, duty-free shops, and toll-free phone numbers.

Exhibit 2-19. Percentage of Smokers Who Purchased Cigarettes in the Past 12 Months from Indian Reservations, ATS 2003–2006

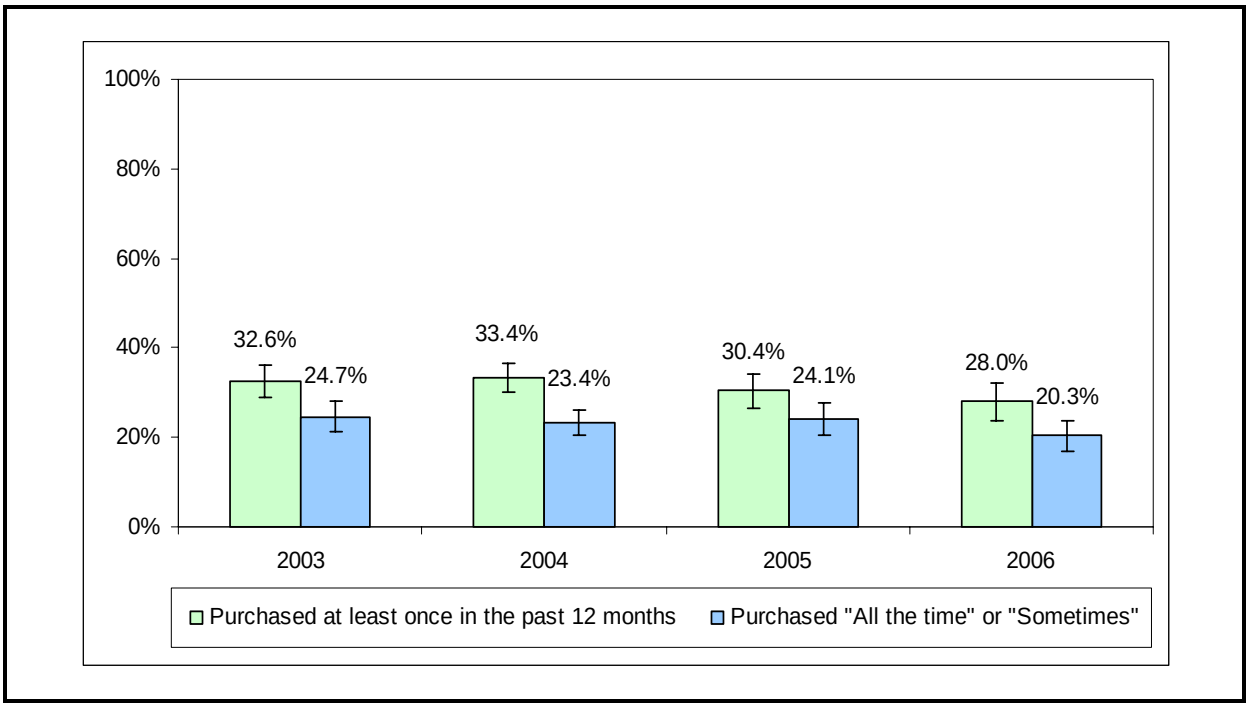
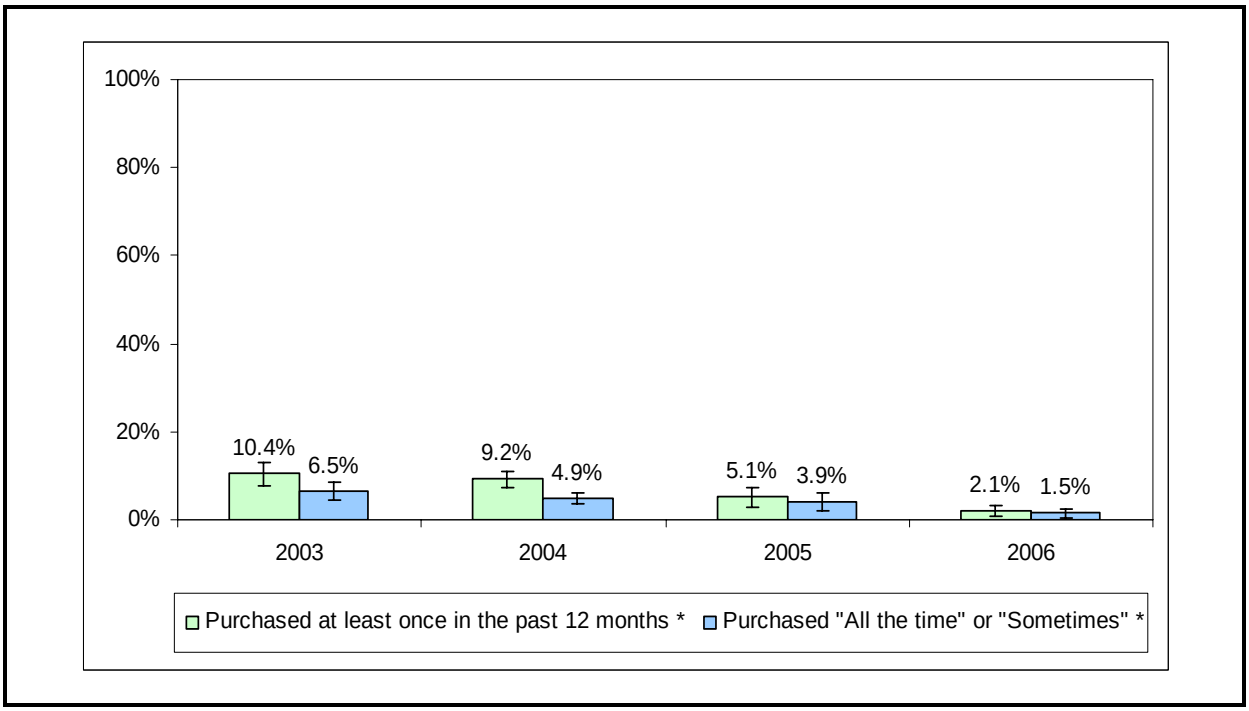


Exhibit 2-20. Percentage of Smokers Who Purchased Cigarettes in the Past 12 Months Over the Internet, ATS 2003–2006



*Statistically significant downward trend from 2003 to 2006.

Exhibit 2-21. Percentage of Smokers Who Purchased Cigarettes from Neighboring States, Duty-Free Shops, and Toll-Free Numbers, ATS 2003–2006

	Source					
	Neighboring States		Duty-Free Shops		Toll-Free Numbers	
Year	At least once *	Sometimes/ All the time	At least once	Sometimes/ All the time	At least once*	Sometimes/ All the time
2003	37.5 [33.1–41.9]	15.6 [12.4–18.8]	14.7 [11.4–17.9]	6.3 [4.1–8.5]	6.2 [4.1–8.3]	4.9 [3–6.7]
2004	32.8 [29.5–36.1]	12.0 [9.7–14.2]	14.5 [12.1–16.8]	5.7 [4.3–7.2]	5.8 [4.4–7.2]	3.4 [2.4–4.4]
2005	30.6 [26.4–34.7]	11.5 [8.7–14.3]	12.9 [9.9–15.8]	5.4 [3.5–7.3]	4.5 [2.6–6.4]	4.2 [2.3–6]
2006	28.9 [23.8–34]	13.8 [9.7–17.9]	12.7 [8.7–16.8]	4.8 [2.7–6.9]	3.1 [1.5–4.6]	2.4 [1–3.8]

*Statistically significant downward trend from 2003 to 2006.

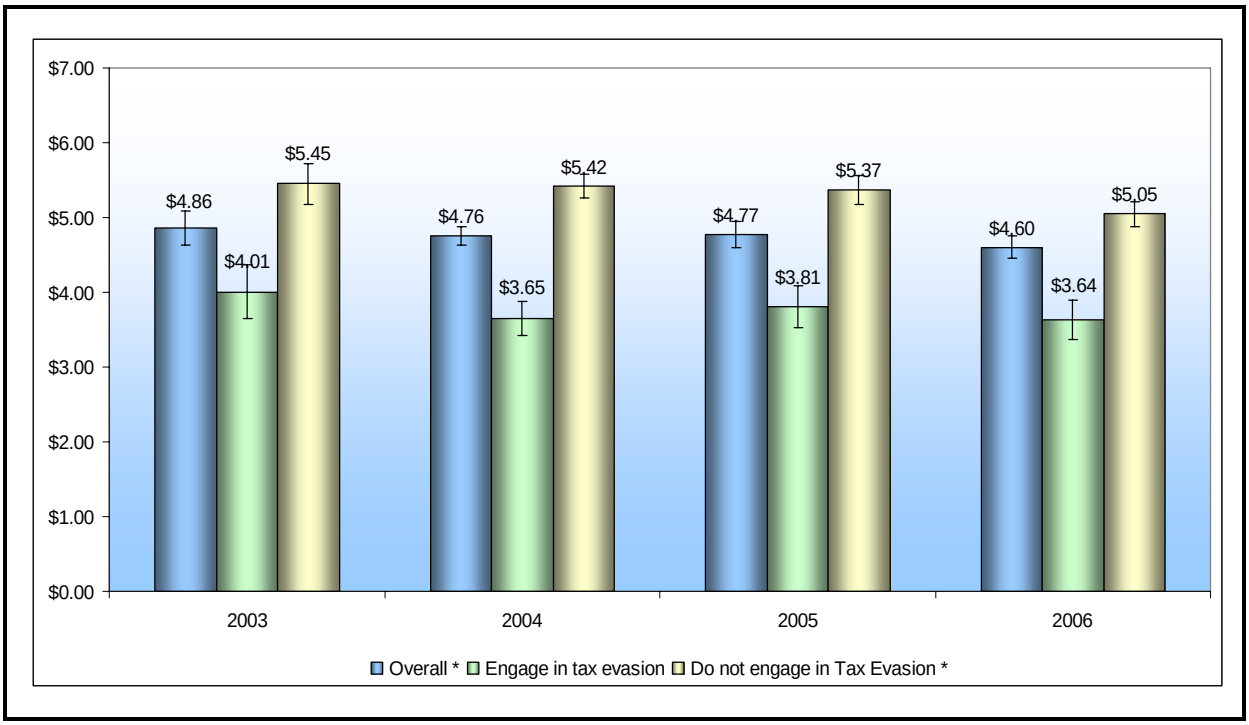
2.4.2 The Impact of Tax Evasion on Smoking

The extent of tax evasion in New York has significant implications for smoking rates within the state. As demonstrated in the previous section, the opportunities for smokers to evade state taxes by purchasing cigarettes from Indian reservations has remained unchanged, despite the efforts of the state legislature. As a result, the average price paid by smokers who evade the tax is significantly lower than the price paid by other smokers and has changed little over time (Exhibit 2-22). The benefit of eliminating this price discrepancy is significant. If the opportunities for smokers to evade taxes were completely eliminated, it would effectively increase the average price for cigarettes by about 42 cents,[1] resulting in 27,950 fewer smokers in 2008 and a total of 52,400 fewer smokers by 2010.[2]

[1] Difference between the price paid by tax-evading ($3.62) and non-tax-evading smokers ($4.87) in 2006, multiplied by the percentage of smokers who purchased cigarettes from low-tax or untaxed sources during that year.

[2] Assuming a short-term price elasticity of –0.12 and a long-term price elasticity of –0.23.

Exhibit 2-22. Average Price per Pack of Cigarettes by Smokers' Self Reported Frequency of Tax Evasion, ATS 2003–2006



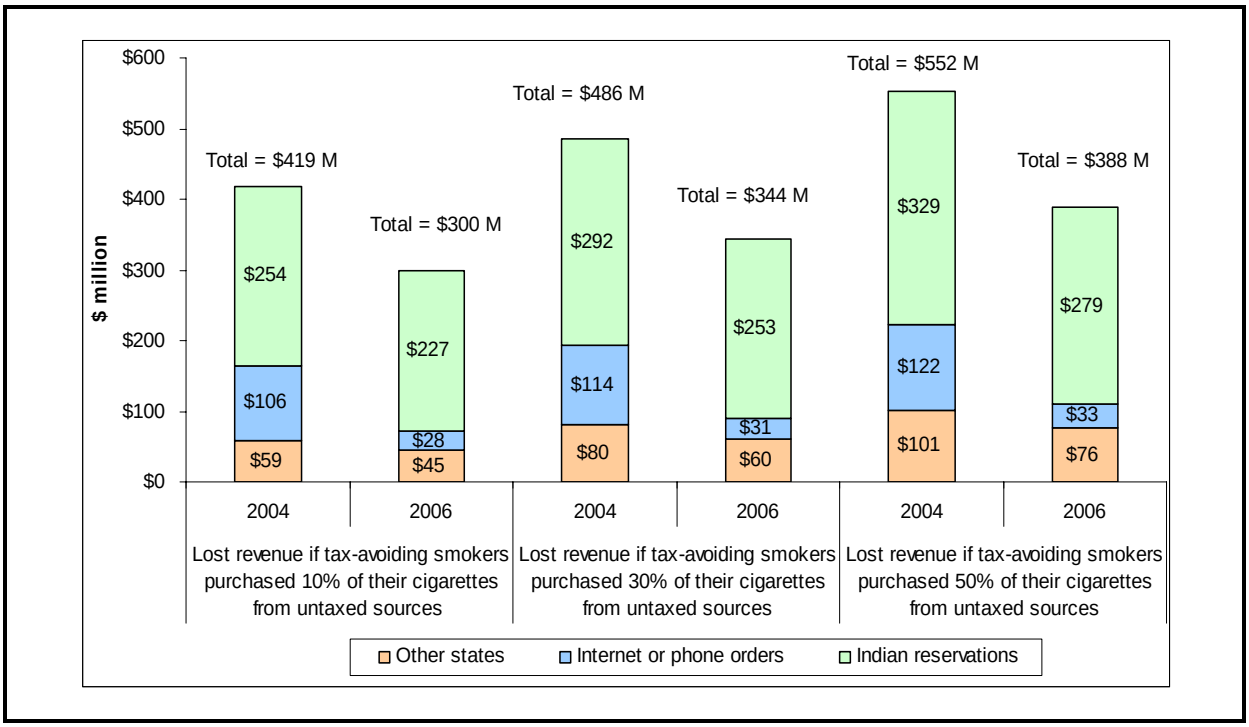
*Statistically significant downward trend from 2003 to 2006. Prices were adjusted for inflation to 2006 values using the overall Consumer Price Index.

2.4.3 The Financial Impact of Tax Evasion

Cigarette tax evasion leads to significant losses in tax revenue from uncollected excise and sales taxes. In New York State, cigarette sales on Indian reservations account for the largest portion of these uncollected taxes. We used the 2006 ATS data to estimate the revenue lost due to tax evasion behaviors in New York State. We first estimated the distance to an Indian reservation and to another state with lower cigarette taxes based on respondents' self-reported zip code. The percentage of smokers who reported buying cigarettes at each of the cheaper cigarette venues (Indian reservations, lower-tax neighboring states, over the Internet, or by telephone orders) was then calculated for those who lived within a certain distance from these sources. Using these estimates, we calculated the cigarette sales (in packs) from each of these lower-taxed venues to determine the revenue lost in New York State due to tax evasion.

In 2006, if tax-evading smokers in New York purchased just 10% of their cigarettes from Indian reservations, the state would have lost approximately $227 million in tax revenue, down from $254 million in 2004 (Exhibit 2-23). If tax-evading smokers had purchased 50% of their cigarettes from Indian reservations in 2006, New York State would have lost $279 million in tax revenue, down from $329 million in 2004. Internet and telephone order sales also account for a significant portion of uncollected taxes. In 2006, Internet and telephone

Exhibit 2-23. Estimated Lost Revenue in New York State in 2004 and 2006 from Tax Evasion



sales accounted for between $28 million and $33 million in uncollected revenue, down significantly from 2004, while sales from neighboring lower-tax states accounted for between $45 million and $76 million in uncollected tax revenue. The total state revenue loss from each untaxed source combined was estimated to be between $300 million and $388 million in 2006.

The decreases in lost revenue between 2004 and 2006 have several implications. The reductions in revenue loss arise from decreases in a number of factors, including smoking prevalence, smoking intensity, real excise tax rates, and purchase rates from each source. Overall, we see reductions in the purchase rate for cigarettes over the Internet and from toll-free numbers, suggesting that policies targeting these sources are having their intended effects. Purchases from neighboring states have also declined as a result of increasing excise taxes in neighboring states. However, we do not see a reduction in the purchase rate from Indian reservations (see Exhibit 2-19), suggesting that the policies to collect taxes from Indian reservations have not been enforced.

2.5 Programmatic Implications

In the 2006 IER, we noted that New York's average investment in tobacco control from 2002 through 2005 has yielded trends in smoking that are on par with the United States as a whole. In 2006, the program's budget was nearly doubled, presenting an opportunity to

build on the existing tobacco control infrastructure and to translate these additional funds into meaningful changes in public health. Overall, the data indicate that the program has been successful in doing just that. Specifically, smoking prevalence among adults and youth is currently decreasing at a faster rate in New York State than in the nation as a whole, with significant declines noted in both rural and urban areas of the state. Furthermore, the use of other tobacco products has also decreased significantly among both adults and youth. These successes are not restricted to declines in tobacco use. Significant changes in legislation pertaining to sales of cigarettes over the Internet have successfully translated into a lower incidence of tax evasion from this location and in turn have led to a decrease in lost revenues.

In addition to the noted successes, the data also indicated notable opportunities for improvement. Although population-level statistics reveal overall declines in smoking prevalence, specific groups may require additional focus. Smoking prevalence among individuals with self-reported mental health problems (20% of smokers) as well as individuals insured by Medicaid (13% of smokers) has remained constant. These two groups are likely to significantly overlap given the prevalence of mental illness among Medicaid recipients. These groups present an opportunity to intervene in a systematic way by reviewing findings from the Promising Practices Program and other programs addressing tobacco use and mental health to identify effective strategies. NYTCP should also work with the Office of Mental Health to implement appropriate interventions to address tobacco use and dependence in this population.

Another opportunity for the state lies in addressing the issue of tax evasion from Indian reservations. Despite the declines in the purchase rate of cigarettes from other low- or untaxed venues, the incidence of tax evasion from Indian reservations has remained largely unchanged since 2003. Meanwhile, it may be time for the state to consider a new round of cigarette excise tax increases. Specifically, although the declines in tax evasion and the resultant increases in revenue are clear advantages for the Program, they may also be indicative of the waning value of the last round of increases in 2002. As noted above, the inflation-adjusted average price paid by smokers declined $0.26 from 2003 to 2006. Going forward, it is imperative that the state eliminate the potential for tax evasion from reservations by enforcing existing laws. Otherwise, any subsequent increases in cigarette excise taxes will be severely diluted.

In summary, our findings indicate that the recent increases in investments in tobacco control have yielded promising results. Smoking prevalence has declined significantly in the state, and legislation and policies targeting Internet retailers of cigarettes have significantly lowered the incidence of tax evasion and have boosted state revenues. Moving forward, we recommend the following to maximize the impact of recent program expansion on tobacco use:

- Continue to focus on evidence-based interventions and building infrastructure.
- Address the growing gap in smoking prevalence between select populations in a systematic way (for example, by working with the Office of Mental Health).
- Work diligently to eliminate the opportunity for tax evasion from Indian reservations, which will increase the effective price and reduce cigarette use.

3. TOBACCO COUNTERMARKETING

3.1 Overview

Evidence shows that media campaigns can be an effective tool for reducing smoking prevalence when combined with other interventions (Hopkins et al., 2001; Farrelly, Niederdeppe, and Yarsevich, 2003; Farrelly, Crankshaw, and Davis, in press). Other studies (Biener, McCallum-Keeler, and Nyman, 2000; Niederdeppe et al., 2007) and previous Independent Evaluation Reports (IERs) for New York State indicate that countermarketing advertisements with high message sensation value (e.g., the use of intense images, strong emotions) produce higher rates of awareness and more favorable audience reactions. Our previous research indicates that exposure to New York Tobacco Control Program (NYTCP) countermarketing advertisements has been associated with short- and intermediate-term outcomes, such as increased awareness of and calls to the Quitline, intentions to quit, and knowledge of the health risks of smoking and exposure to secondhand smoke (SHS).

However, in our evaluation of NYTCP, we have found only inconsistent evidence that exposure to countermarketing advertisements is associated with longer-term outcomes among smokers, such as making a quit attempt, quitting for 6 months or longer, or adopting a smoke-free home policy. It is methodologically challenging to link exposure to countermarketing at a point in time to resulting behaviors that occur at a future time. However, there may be programmatic reasons for the mixed evidence of impact. For example, effects may not have been large enough or sustained enough to have a population-level impact. This may be because of NYTCP's inability to reach a substantial proportion of New York smokers with countermarketing advertisements due to gaps in delivery of media, insufficient resources, and mixed quality of messages. Some of our specific recommendations to NYTCP from the 2006 IER were to

- avoid unplanned gaps in media implementation to maximize coordination between the New York State Department of Health (NYSDOH) and Community Partnerships;
- invest in media sufficient to reach at least 60% of the target (i.e., adults or adult smokers;
- ensure that Community Partnerships consistently cultivate relationships with television and radio stations and cable companies to fully utilize opportunities for donated advertising time; and
- consider choosing additional SHS-focused messages that have been shown to be effective in encouraging smokers to adopt smoke-free homes and cars through themes such as "Take It Outside."

Although there have been gaps in media programming and insufficient resources in the past, the Program has made substantial progress in its countermarketing efforts in recent years. NYTCP has been diligent about developing media plans that have steadily increased

the proportion of advertisements with high message sensation value when aiming to promote behavior change (e.g., promoting cessation and the adoption of smoke-free homes).

In this chapter, we review NYTCP's implementation of mass media efforts during 2006, focusing on choice of television advertisements, advertisement quality, unplanned lapses in countermarketing efforts, and the impact of countermarketing on program outcomes. Using data from the Adult Tobacco Survey (ATS), a new online survey of smokers, and calls to the New York State Smokers' Quitline, we examine how New York adults responded to statewide tobacco countermarketing efforts.

3.2 Tobacco Countermarketing Efforts in New York

At the outset of 2006, NYTCP's media plan called for continued airing of advertisements highlighting the dangers of SHS and advertisements promoting smoking cessation. Following the doubling of the program budget in April 2006, however, the program revised its existing media schedule and proposed an ambitious plan to aggressively air advertisements starting in Q3 2006 and extending into Q1 2007. This plan included a large number of high sensation value advertisements aimed at promoting behavior change.

The new media plan included a schedule for advertisements to be run primarily by NYSDOH, a change from the previous year, when Community Partnerships were provided with an additional $6 million to collaboratively run statewide media. In the past year, the majority of these funds were used to supplement the number of "truth" youth prevention advertisements airing in New York. Exhibit 3-1 summarizes advertisements that aired between Q1 2006 and Q1 2007 and were tracked in the New York ATS and Media Tracking Survey (MTS). Consistent with our approach in previous IERs, this exhibit includes our subjective qualitative assessment of each advertisement's sensation value (previously referred to as "impact") based on the use of strong emotional appeals and/or intense images. Exhibit 3-2 shows the historical schedule of countermarketing advertisements aired by NYSDOH and the Community Partnerships since Q3 2003.

In 2006, NYTCP and its funded partnerships aired five new advertisements in support of the programmatic goal to eliminate exposure to SHS. Of these, we consider only one to have high sensation value: "Baby Seat," which aired in the third quarter of 2006. The other SHS-related messages—"Drive," "Inconsiderate Smoker," "Jasmine," and "It's Like They're Smoking"—all aired between the first and third quarters of 2006, with the latter also airing during the first quarter of 2007.

Exhibit 3-1. Statewide and Local Tobacco Countermarketing Television Advertising in New York, Q1 2006–Q1 2007

Title	ATS Quarter	Message Theme	NYSDOH/ Community Partnerships	Sensation Value
Baby Seat	Q3 2006	SHS	NYSDOH	High
It's Like They're Smoking	Q2–Q3 2006, Q1 2007	SHS	NYSDOH	Low
Jasmine	Q2–Q3 2006	SHS	NYSDOH/ Partnerships	Low
Drive	Q1–Q2 2006	SHS	Partnerships	Low
Inconsiderate Smoker	Q2 2006	SHS	Partnerships	Low
CIAA Testimonials	Q2 2006	SHS	Partnerships	Low
Every Cigarette Is Doing You Damage Series	Q1 2006	Cessation	Partnerships	High
Dead Twice—Curt Ward	Q2–Q3 2006	Cessation	NYSDOH	High
Tomorrow—Curt Ward	Q2–Q3 2006	Cessation	NYSDOH	High
In Their Own Words	Q4 2006, Q1 2007	Cessation	NYSDOH	Low
Not Like a Smoker	Q4 2006, Q1 2007	Cessation	NYSDOH	Low
Terrified—Byron Holton	Q1 2007	Cessation	NYSDOH	High
Life Without Byron—Byron Holton	Q1 2007	Cessation	NYSDOH	High
Choking to Death—Byron Holton	Q1 2007	Cessation	NYSDOH	High
Grandpa's Casket—Byron Holton	Q1 2007	Cessation	NYSDOH	High
Missing my Grandpa—Byron Holton	Q1 2007	Cessation	NYSDOH	High
Vacuum Cleaner	Q1 2007	Light Cigarettes	NYSDOH	Low
Truck Industry Documents	Q1 2007	Light Cigarettes	NYSDOH	Low
Do You Smell Smoke Series	Q1 2007	Social Acceptability	Partnerships	Low
They're Getting Smarter	Q1 2006	Social Acceptability	Partnerships	Low

Note: SHS = secondhand smoke

Exhibit 3-2. Historical Schedule of High and Low Sensation Value Tobacco Countermarketing Advertisements Aired by NYTCP and the Community Partnerships, Q3 2003 to Q1 2007

	2003						2004												2005												2006												2007			
Title	7	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4
Cessation Ads																																													
Cigarette Pack								L	L	L	L							L	L	L																										
Pam Laffin's Kids																			H	H	H																								
Quit Yet							L	L	L																																			
Quitting Takes Practice								L	L																																			
Bob Quits																		L	L																										
Every Cigarette is Doing You Damage Series																			H	H	H								H	H	H														
I Need You																			H	H	H																								
Judy Dying													H	H	H																													
Pam Laffin Series																		H	H	H																									
Quitting Is Hard													L	L	L	L	L	L																											
Curt Ward Series																																			H	H	H								
In Their Own Words																																									L	L	L		
Not Like a Smoker																																									L	L	L		
Byron Holton Series																																										H	H	H	
SHS Ads																																													
Baby Seat									H	H	H	H																					H	H	H	H								
Bartender													L	L	L								L	L	L																				
Clinical																							H	H	H																				
Drive																															L	L	L	L	L	L	L								
Front Porch									L	L	L	L	L																																
Heather Crowe													H	H	H	H	H	H	H				H	H	H																				
It's Like They're Smoking																				L	L	L	L	L	L									L	L	L	L	L				L	L		
Little Girl									L	L	L	L																																
Never Smoke									L	L	L	L																																
One Lung																							H	H	H																			
Outside the Bar	L	L	L																																									
Sign of the Times								L	L	L	L																																	
Waitress	L	L	L																																									
Careful Series																							L	L	L																			
CIAA Testimonials in Mall													L	L	L																				L	L								
Clean Indoor Air Testimonials for Business													L	L	L																													
Paul Decker													H	H	H																													
Smoke Free New York													L	L	L																													
Jasmine																																	L	L	L	L								
Inconsiderate Smoker																																		L	L	L								
Social Acceptability Ads																																												
Bigger Than Ever																									L	L	L																		
Breeding Ground																				H	H	H																						
Do you Smell Smoke? Series																				L	L	L												L	L	L								
Drive Along																																L	L	L										
They're Getting Smarter																															L	L												
Light Cigarette Ads																																												
Vacuum Cleaner																																											L	L	
Truck																																											L	L	
Pregnancy and Smoking																																												
Delivery Room																																											H	H	H	
Cradles																																											H	H	

Note: L indicates low sensation advertisement, and H indicates high sensation advertisement.

NYTCP aired 10 cessation-focused advertisements between Q1 2006 and Q1 2007, and all but two were high sensation value advertisements. There were also two low sensation value advertisements educating smokers about the dangers of light cigarettes in Q1 2007. Given the aim of these advertisements, it is reasonable to use low sensation value advertisements.

According to NYTCP's programming schedule, the high sensation value cessation series "Byron Holton" was slated to run during Q4 2006. Instead, these advertisements ran in Q1 2007, resulting in an unplanned gap in high sensation value cessation related messages during Q4 2006. Additional delays in scheduled cessation-related messages included "In Their Own Words" and "Not Like a Smoker," both of which were slated to run during Q3 and Q4 2006 but instead aired during Q4 2006 and Q1 2007.

The delays in media programming resulted from delays in approval of the Program's expenditure plan. Concerns were raised by the former administration about NYTCP's support of a pilot test in the Buffalo area of the "Become An Ex Smoker" cessation campaign from the American Legacy Foundation (Legacy). Specifically, in 2006, Legacy developed a new cessation-focused campaign and had invited NYTCP and several other states to participate in a pilot program to field-test the campaign. The NYTCP media plan included significant funds to air these advertisements in Buffalo. While the proposed media plan contained many messages unaffiliated with this particular campaign, approval of the entire expenditure plan was held up pending a decision to support the "Become An Ex Smoker" campaign. As a result, the entire series of SHS and cessation-related messages scheduled to be aired during the fiscal year was delayed.

In the section below, we present data on awareness of and reaction to the advertisements that aired in 2006 from the ATS and similar data for the Q1 2007 advertisements from the Media Tracking Survey Online (MTSO).

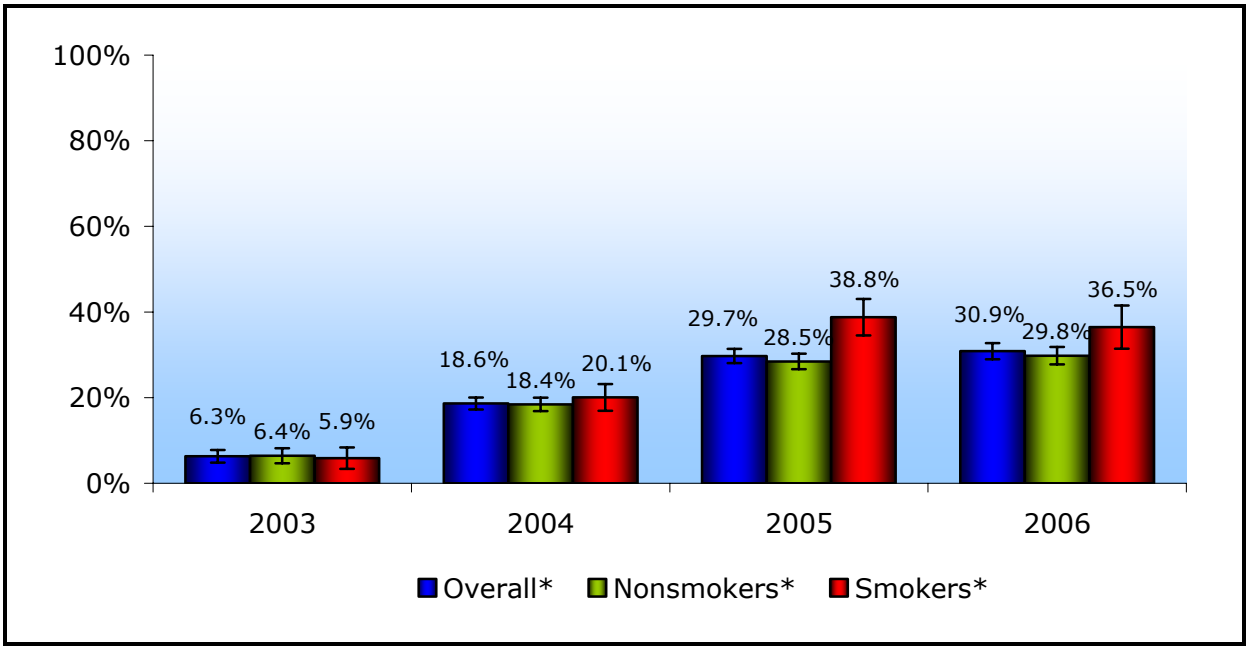
3.3 Awareness of and Reactions to Tobacco Countermarketing Efforts in New York

To capture exposure to NYTCP countermarketing efforts, we draw on the ATS and a new Web-based survey (described in Section 3.3.1). For 2006, we report self-reported recall of advertisements in the ATS. In each quarter of the ATS, respondents are asked if they have seen each antismoking television advertisement that has recently aired in New York State. Specifically, respondents are provided a brief description of each advertisement and then prompted to provide a description of what else happened in the advertisement if they indicate they have seen it. Those who can accurately describe the advertisement are considered to have "confirmed awareness." Those who recall an advertisement are then asked to indicate whether it "said something important" to them and if they talked to anyone about it. For the Web-based survey, we are able to play the actual advertisement for the respondent and then ask them how frequently they have seen it. In this survey, we also ask a more extensive set of questions aimed at gauging reactions to the advertisements (described in Section 3.3.1).

3.3.1 Awareness of Tobacco Countermarketing Advertisements

Exhibit 3-3 shows that awareness of NYTCP's advertising efforts has improved over time. Awareness increased steadily from 2003 to 2005 and then leveled off between 2005 and 2006. Similar trends are seen among smokers (6% to 37%) and nonsmokers (6% to 30%) between 2003 and 2006.

Exhibit 3-3. Annual Awareness of NYTCP Tobacco Countermarketing Television Advertisements (Statewide and Local), ATS 2003–2006

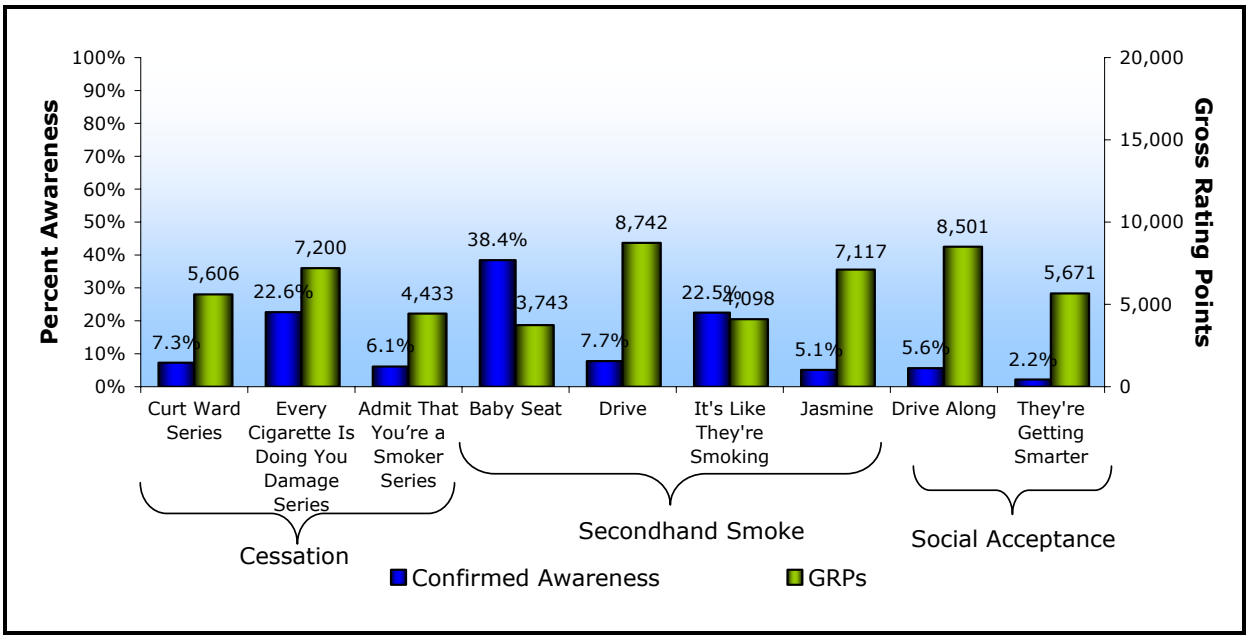


*Statistically significant upward trend from 2003 to 2006.

Exhibit 3-4 reports awareness of specific advertisements that aired in 2006. The advertisements that had the highest level of awareness include two SHS advertisements—"Baby Seat" (39%) and "It's Like They're Smoking" (23%)—and the three cessation advertisements aired as part of the "Every Cigarette Is Doing You Damage" (23%) campaign. Eight percent or fewer adults recalled each of the other advertisements. Awareness of specific advertisements did not vary significantly by smoking status other than for "It's Like They're smoking," where awareness was higher among smokers (30%) than nonsmokers (21%) (results not presented).

The differences in awareness relate to differences in the number of times the ads were aired on television, the salience of the advertisement to the viewer, and the ability of the brief description of the advertisement in the ATS to remind the respondent of the advertisement. For the latter, if the advertisement does not have very distinct features, it is difficult to describe the advertisement well enough to provide a mental image of the advertisement and therefore prompt recall for those who did see it.

Exhibit 3-4. Awareness of and Gross Rating Points for Specific Statewide NYTCP Tobacco Countermarketing Television Advertisements, ATS 2006



To measure the number of times that New Yorkers had the opportunity to see NYTCP advertisements on television, we examined gross rating points (GRPs) provided by New York media buyers who place NYTCP advertisements on television. GRPs are a standardized measure of exposure to advertisements and are calculated from television program ratings, provided by Nielsen Media Research. Ratings are based on quarterly surveys of adults' television viewing habits. GRPs can be thought of as a measure of both the "dose" and the advertisements "received" by the view (that is, the number of times the advertisements could have been viewed) and the number of viewers who saw the advertisements. To illustrate how GRPs are calculated, we present the following generic example: if a countermarketing advertisement was aired during a program that 40% of the New York adult population watched, the advertisement would receive 40 GRPs. Over the course of a campaign, the advertisement might run on the same weekly program for 8 weeks, resulting in a total of 320 GRPs (40 GRPs each week times 8 weeks). The advertisement might also be aired during two other programs with the same number of viewers ("reach") over the same time period, yielding a cumulative total of 960 GRPs for the campaign (320 GRPS from the first program plus 320 GRPs from the second program plus 320 GRPs from the third program). Exhibit 3-4 presents the total statewide GRPs obtained by NYTCP in 2006. These reports of GRPs come from NYSDOH and the Community Partnerships (from the Community Activity Tracking [CAT] system), both of which obtain the information from media buyers as part of the media buying agreement.

Because each countermarketing advertisement was supported at varying rates, simply comparing overall GRP levels provides little information as to the relative effectiveness of each advertisement. To understand an advertisement's relative impact, we calculated the number of percentage points of awareness for every 5,000 GRPs (an amount indicative of a well-supported campaign). This calculation shows that if each ad received 5,000 GRPs, the advertisements with the highest levels of awareness would be "Baby Seat" (69%), "It's Like They're Smoking" (27%), and "Every Cigarette Is Doing You Damage" (15%). The average level of awareness per 5,000 GRPs was 30% for high sensation value advertisements is compared to 8% for low sensation value advertisements. Clearly, elevated GRPs do not automatically translate into correspondingly high levels of confirmed awareness because "It's Like They're Smoking" performed very well based on this measure, whereas the "Curt Ward" series did not (7% per 5,000 GRPs). It should be noted, however, that some of the advertisements examined are targeted to specific audiences and would therefore have relatively low awareness in the general population. Because GRPs are reported for the overall population, we would expect that campaigns targeted to a subset of the population would be proportionally smaller as well. As a result, examining overall awareness per 5,000 GRPs should be valid even for campaigns targeted to specific audiences. However, we did not find that awareness was consistently higher for the target audience. One exception to this is the "Curt Ward" series, which targeted young adult smokers. For this series, we found that confirmed awareness was significantly higher among the target population (18.1%) compared with other smokers (5.7%).

For advertisements that aired in Q1 2007, we present data from the new MTSO. MTSO is a self-administered questionnaire provided dynamically over the Internet to adult current smokers in New York by Harris Poll Online (HPOL). A key feature of the survey is the ability to present videos of tobacco countermarketing messages as they appear on television. Using this approach, we can more easily and accurately gauge awareness of and reaction to a larger number of advertisements than is feasible with the ATS. This first survey elicits comprehensive data on awareness of and reaction to all advertisements that aired in Q1 2007 along with a few other advertisements included for comparison purposes. Approximately 3,000 current smokers were randomly selected from more than 4 million New Yorkers included in the HPOL panel. Panelists were invited to participate in the survey and were screened for eligibility (i.e., adult smokers aged 18 and older who live in New York).

The survey included the following advertisements that were aired by NYTCP in Q1 2007:

- four advertisements from the Byron Holton series (aired Q1 2007)
- "Vacuum Cleaner (aired Q1 2007)
- "Truck Industry Documents" (aired Q1 2007)
- "Cigarettes Are Eating You Alive" (aired in New York City in Q1 2007 by the Department of Health and Mental Hygiene [DOHMH])

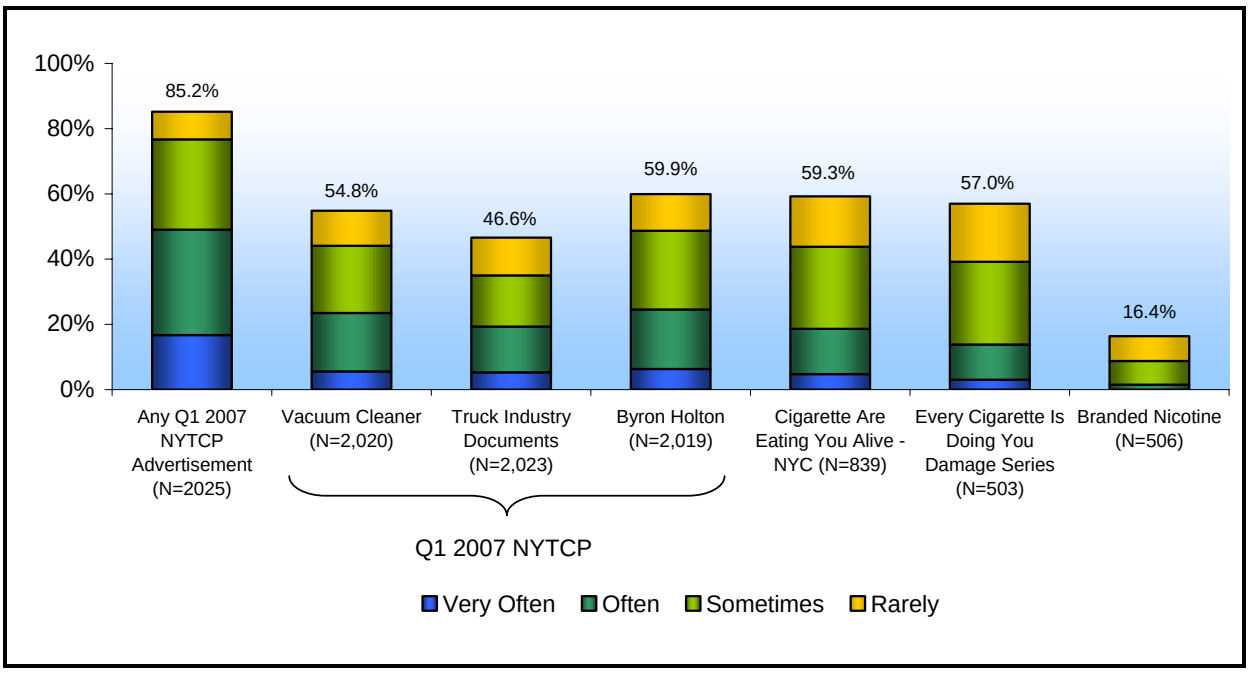
One thousand respondents viewed all of the advertisements listed above, with the exception of the last advertisement that was presented only to New York City residents. These individuals were then asked about their reactions to the advertisements. Another 1,000 respondents were shown still frames of the advertisements to determine whether they had previously seen the messages. However, unlike the first sample of respondents, these individuals were not asked to provide their reaction to each advertisement to keep the length of the survey reasonable. Finally, an additional 1,000 smokers were randomly assigned to view one advertisement from each of the following three sets of advertisements for comparison purposes:

- Pam Laffin or Rick Stoddard campaigns
- the "Brain" or "Lung" advertisement from the Every Cigarette Is Doing You Damage campaign
- a commercial nicotine replacement therapy (NRT) product advertisement or a Philip Morris' Quit Assist campaign advertisement

The first two pairs of advertisements come from high sensation value cessation campaigns that NYTCP has aired in the past. The Pam Laffin and Rick Stoddard series are emotional, testimonial-style messages that have been shown to be effective. The Every Cigarette Is Doing You Damage campaign relies on intense, graphic images. This campaign aired in New York State in Q1 2006 and elicited very positive responses (2006 IER). The last pair represents low sensation cessation value advertisements. Because these two performed similarly, we present data from the NRT advertisement only.

The survey indicates that 85% of smokers reported seeing any of NYTCP-sponsored advertisements at least "rarely" in Q1 2007 (Exhibit 3-5). About 60% of smokers had seen at least one of the four "Byron Holton" advertisements, followed by "Vacuum Cleaner" (55%) and "Truck Industry Documents" (47%). As a point of comparison, 59% of smokers living in New York City reported seeing the Q1 2007 New York City DOHMH-sponsored advertisement, "Cigarettes Are Eating You Alive," a high sensation advertisement that depicts extremely graphic images of a smoker's heart, lungs, mouth, and throat similar to the "Every Cigarette Is Doing You Damage" campaign. One advertisement from the latter campaign was also included for reference, and 57% of New York smokers said they had seen the advertisement at least rarely even though it had not aired in New York since January 2006. Finally, only 16% of respondents reported seeing the NRT advertisement on television.

Exhibit 3-5. Frequency of Seeing Specific Q1 2007 NYTCP Tobacco Countermarketing Television Advertisements (Statewide and Local) and Other Advertisements, MTSO Q1 2007

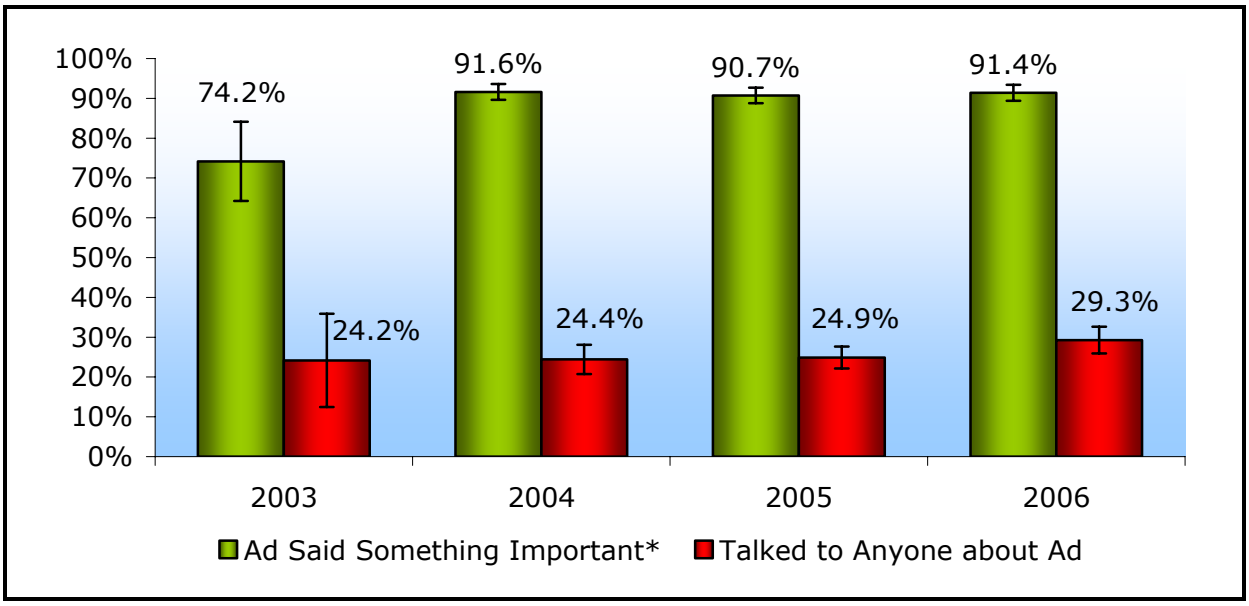


Although it is difficult to make direct comparisons between the ATS and the MTSO, these data suggest that if the advertisements that aired in Q1 2007 had aired as scheduled in 2006, they would have had a significant impact on overall awareness of NYTCP's countermarketing messages.

3.3.2 Reactions to Tobacco Countermarketing Advertisements

Turning to reactions to NYTCP-sponsored advertisements, we found substantial increases in the percentage of New Yorkers who agreed that countermarketing messages said something important to them (a change largely driven by changes among smokers) but no change in the percentage of New Yorkers who talked about the ads with others (Exhibit 3-6). Specifically, in 2006, 91% of respondents who had seen an NYTCP-sponsored advertisement indicated that it said something important to them, a significant increase from 2003 (74%) and consistent with ad performance in 2004 and 2005.

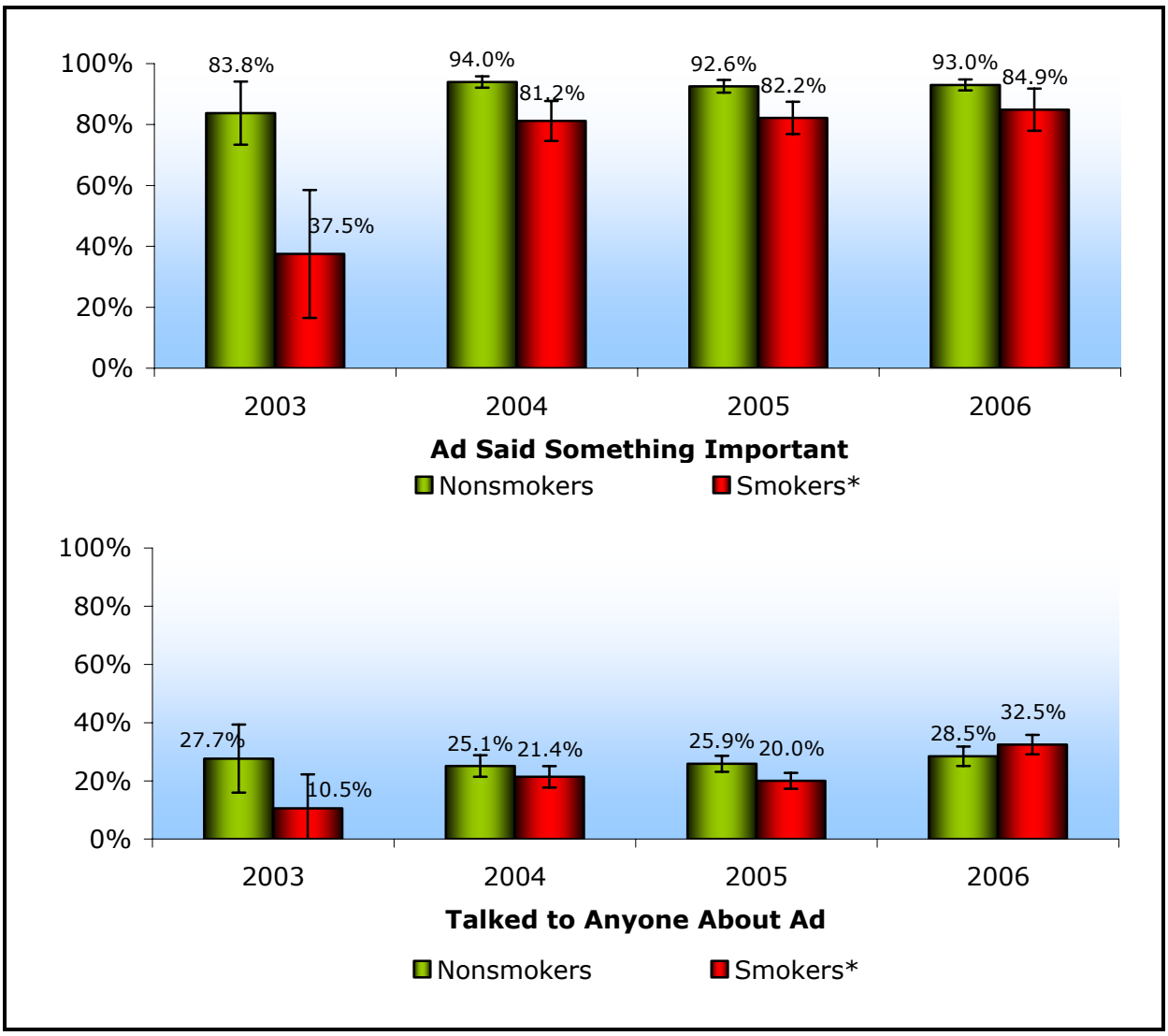
Exhibit 3-6. Annual Average Reactions to NYTCP Tobacco Countermarketing Television Advertisements (Statewide and Local), ATS 2003–2006



*Statistically significant upward trend from 2003 to 2006.

The increase is even more pronounced for smokers over the same period (37.5% to 84.9%) (Exhibit 3-7). Peer communication about advertisements is a measure of their salience and an indicator of message diffusion through social networks, which effectively extend the reach of countermarketing efforts. In their review of interpersonal communication in mass media campaigns, Southwell and Yzer (2007) conclude that interpersonal communication likely plays an important (and underappreciated) role in media campaign effects. In 2006, 33% of smokers indicated they talked to someone about an advertisement they had seen, a substantial increase from 2003 (11%), 2004 (24%), and 2005 (20%) (see Exhibit 3-7).

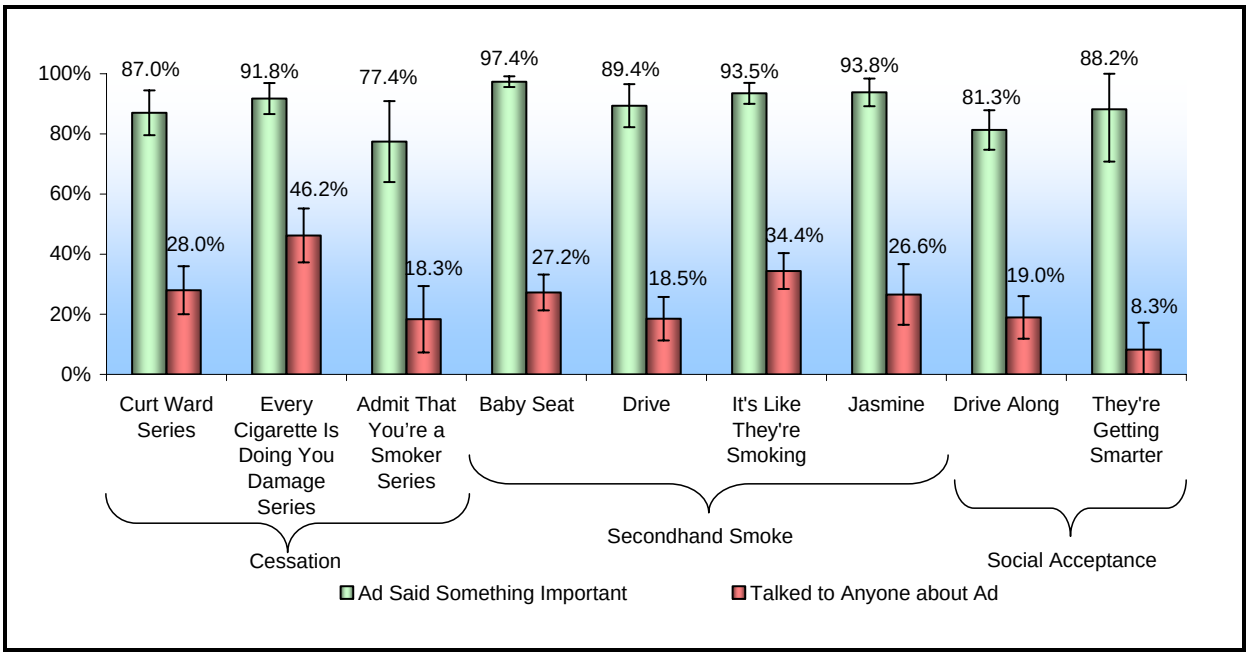
Exhibit 3-7. Annual Average Reactions to NYTCP Tobacco Countermarketing Television Advertisements by Smoking Status (Statewide and Local), ATS 2003–2006



*Statistically significant upward trend from 2003 to 2006.

Nearly half of adults (46%) who saw "Every Cigarette Is Doing You Damage" talked about it with others, followed by "It's Like They're Smoking" (34%) and "Baby Seat" (27%) (Exhibit 3-8). These three advertisements had the highest level of awareness per GRP.

Exhibit 3-8. Reactions to Specific NYTCP Countermarketing Advertisements Among Those Who Recalled Each Advertisement, ATS 2006



For the MTSO, we developed a series of questions to gauge reactions to advertisements along a number of dimensions. For this summary, we present two of these indicators—an indication of how "powerful" smokers found each advertisement (Exhibit 3-9) and whether the advertisement made them want to quit smoking (Exhibit 3-10). Overall, the advertisement with the most positive responses was New York City DOHMH's newly developed "Cigarettes Are Eating You Alive." Seventy-one percent of smokers found the advertisement to be either "very powerful" or "somewhat powerful," and 41% indicated that the ad made them want to quit. Of NYTCP advertisements that aired in Q1 2007, the "Byron Holton" series elicited the most positive responses: 56% indicated that these advertisements were either "very powerful" or "somewhat powerful," and 25% indicated that the advertisements made them want to quit. This series elicited similar reactions to the "Every Cigarette Is Doing You Damage" advertisements that aired in Q1 2006.

The other messages examined, all low sensation value messages, are aimed at educating smokers about light cigarettes and are not aimed at provoking immediate behavior change in the same way as the cessation-focused advertisements. As a result, it is not surprising that they were viewed as less "powerful" and less likely to lead a smoker to consider quitting. Overall, all NYTCP advertisements performed better than the NRT advertisement.

Exhibit 3-9. Percentage of Current Smokers Who Found Specific NYTCP Countermarketing Advertisements to be Powerful, Q1 2007 MTSO

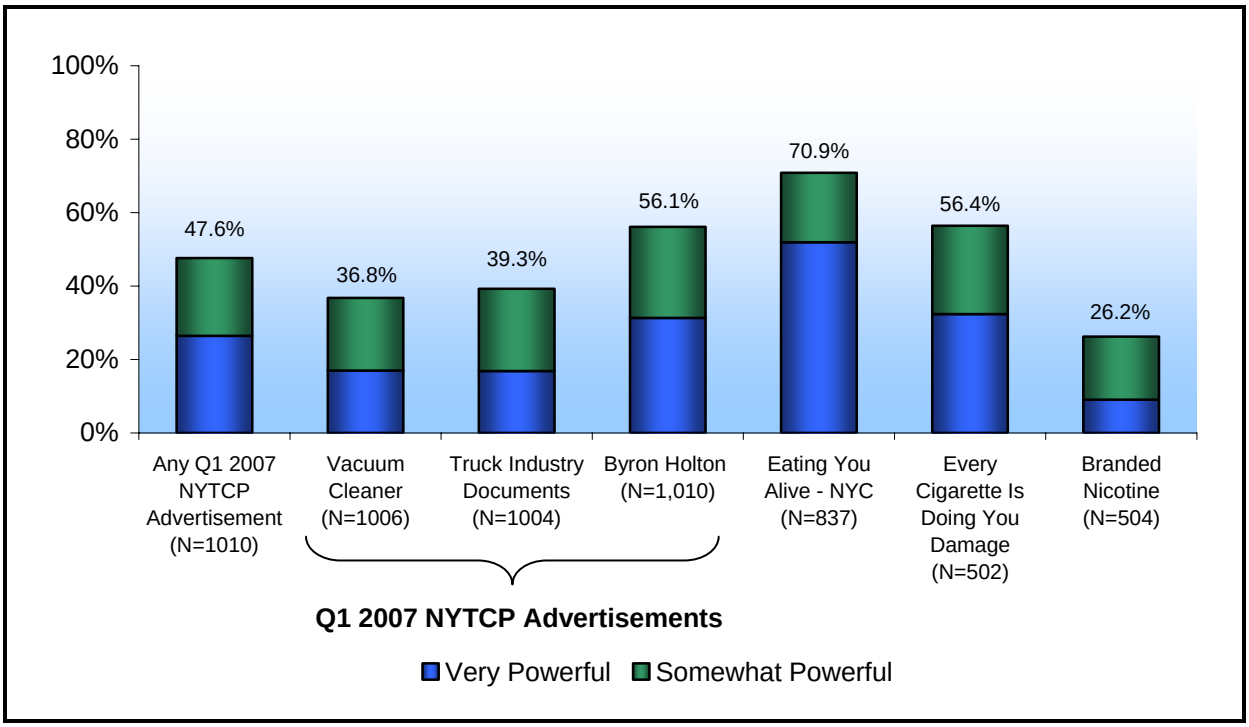
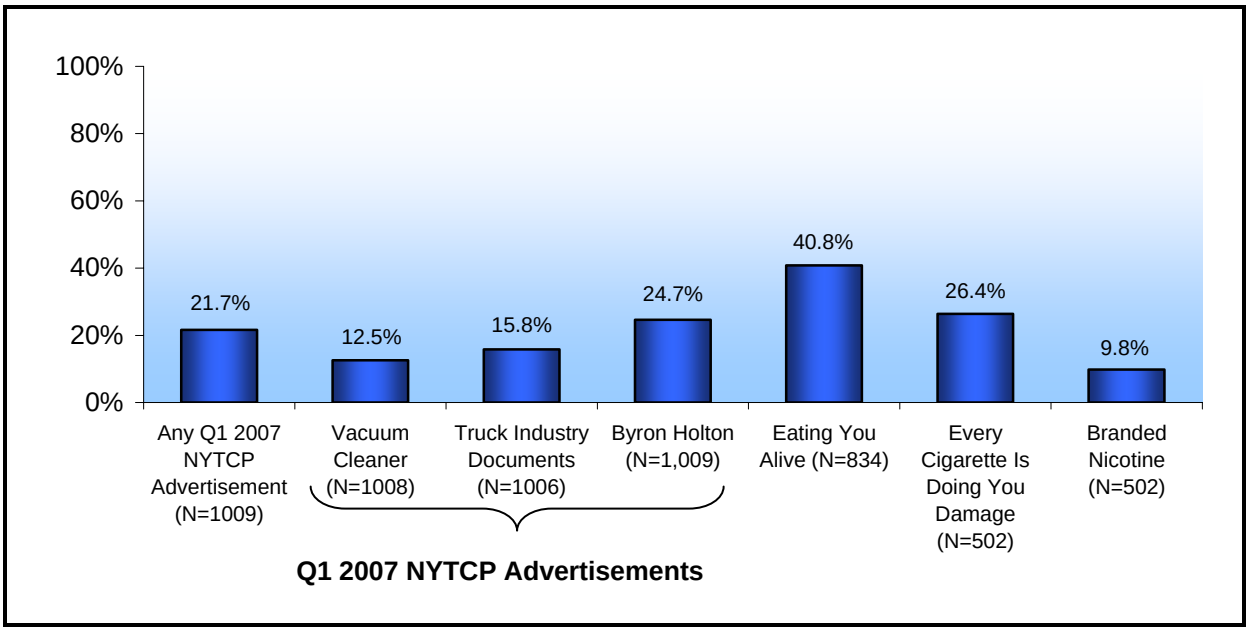


Exhibit 3-10. Percentage of Current Smokers Who Agreed That Specific NYTCP Countermarketing Advertisements Made them Want to Quit Smoking, Q1 2007 MTSO



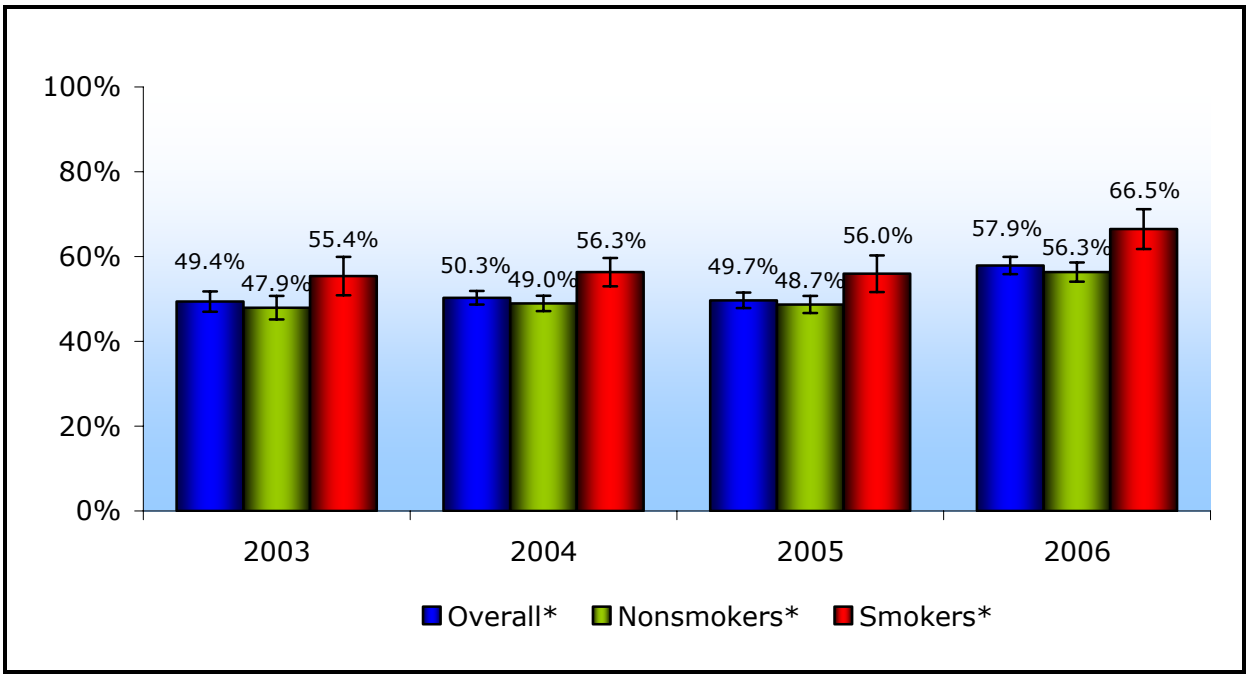
3.4 Influence of Countermarketing on Key Program Indicators

Because the intention of some mass media campaigns is to increase smoking cessation and reduce smoking prevalence, in this section, we examine changes and trends in key programmatic indicators using data from the ATS and the New York State Smokers' Quitline. These measures include awareness and use of the Quitline, attitudes and beliefs about smoking, intentions to quit and quit attempts, and adoption of smoke-free home policies.

3.4.1 Awareness and Use of the New York Smokers' Quitline

In addition to asking adults whether they have seen specific advertisements, adults are asked to report whether they have seen advertisements that promote a smoking cessation Quitline. This type of general awareness measure is a proxy for the salience of the advertisements that promote the Quitline. The percentage of adults who reported noticing advertisements for the New York State Smokers' Quitline (all countermarketing advertisements were tagged with the Quitline number since its inception in 2000)has increased from 2003 to 2006 overall and for smokers and nonsmokers (Exhibit 3-11). These changes happened largely from 2005 to 2006. Fifty-eight percent of adults noticed advertisements about calling the Quitline, a significant increase from 2005 (50%). Changes between 2005 and 2006 for smokers (56% to 67%) and nonsmokers (49% to 56%) were also statistically significant.

Exhibit 3-11. Percentage of Adults Who Have Noticed Advertisements About Calling a Quitline by Smoking Status, ATS 2003–2006



*Statistically significant upward trend from 2003 to 2006.

To understand which advertisements may have contributed the most to smokers' general awareness of advertisements that promote the Quitline, we performed logistic regressions of this general awareness indicator as a function of

- overall confirmed awareness of specific NYTCP-sponsored messages,
- confirmed awareness of cessation and SHS advertisements, and
- confirmed awareness of high and low sensation value cessation advertisements.

Other independent variables in the models include age, race/ethnicity, education, income, gender, and an indicator for living in New York City. These regressions show that there is a positive correlation between reporting noticing advertisements that promote the Quitline and confirmed awareness of any NYTCP advertisement (odds ratio [OR]=1.8, $p < .001$), cessation advertisements (OR = 1.6, $p < .01$), and SHS advertisements (OR = 1.7, $p < .01$). In addition, there is a positive correlation between noticing advertisements that promote the Quitline and high sensation value cessation advertisements (OR = 1.7, $p < 0.01$) but not low sensation value cessation advertisements (OR = 1.4, $p = .44$).

A related program indicator is the total number of first time callers who spoke with a Quitline specialist (Exhibit 3-12). This figure illustrates the increase in new callers to the Quitline over time.[1] To understand how these calls are influenced by countermarketing efforts, we examined the relationship between quarterly calls with Quitline specialists from 2000 to 2005 and GRPs overall and by sensation value and campaign theme (i.e., cessation, SHS).

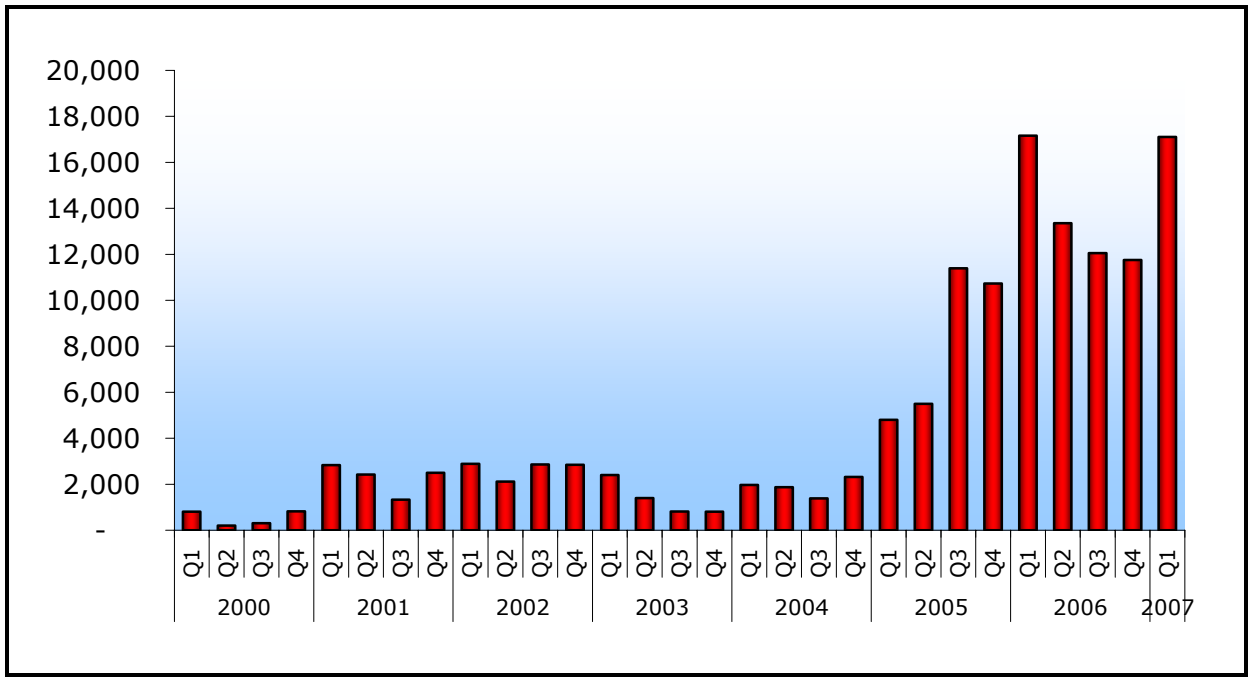
The data on GRPs come from Nielsen Media Research[2] and include information about the advertisements (time the advertisement aired, the sponsor, the GRPs for the advertisement, and a short description). Based on the advertisement description, we were able to identify nearly all of the advertisements sponsored by the state and its funded partners. We classified all advertisements as being of one of the following advertisement types:

- high sensation cessation
- low sensation cessation
- high sensation SHS health consequences
- low sensation SHS health consequences
- SHS messages in support of the Clean Indoor Air Act (CIAA)

[1] Callers to the Quitline with no record in the Quitline's database of callers are considered "new callers." It is possible that some of these callers have called in the past but were not identified as a previous caller because of a change in address or phone number.

[2] Nielsen Media Research routinely collects information on Americans' television watching habits to determine the frequency that various segments of the population watch specific television shows. These data are translated into television ratings for 210 media markets around the country.

Exhibit 3-12. Total Number of New Callers Who Spoke to a Quitline Specialist, New York State Smokers' Quitline, Q1 2000 to Q1 2007



We then use a regression analysis where quarterly total media market-level calls to the Quitline is the outcome of interest and the primary independent variable is quarterly television GRPs for 10 television media markets in New York State.

To calculate the relative effectiveness of different types of advertisements, elasticities are calculated based on the regression results. Elasticities provide a normalized measure of effect size that can be compared across models. Specifically, elasticities present the percentage change in the outcome variable for a given percentage change in an independent variable. For example, an elasticity of 0.17 implies that a 1% change in total GRPs for high sensation value cessation advertisements would lead to a 0.17% increase in the number of calls to the Quitline.

The regression results (Exhibit 3-13) indicate that high ($p < .001$) and low ($p < .02$) sensation value cessation advertisements are effective in promoting the Quitline but that the high sensation value advertisements have nearly twice the effect of the low sensation value advertisements—elasticities of 0.17 versus 0.09. In contrast, only the high sensation value SHS advertisements focusing on the health consequences of SHS appear to be effective in promoting the Quitline ($p < .001$) with an elasticity of 0.17.

Exhibit 3-13. Regression Results of Log Quarterly Call Volume on GRPs by Advertisement Sensation value

Independent Variable	Regression Coefficient (P value) [95% CI]	Advertising Elasticity [95% CI]	Mean Quarterly GRPs in 1000s
High sensation cessation GRPs	1.02 (0.000) [0.67, 1.37]	0.17 [0.11, 0.22]	0.16
Low sensation cessation GRPs	0.34 (0.020) [0.06, 0.62]	0.09 [0.02, 0.17]	0.27
High sensation SHS health consequences GRPs	2.55 (0.000) [1.78, 3.32]	0.17 [0.12, 0.23]	0.07
Low sensation SHS health consequences GRPs	−0.15 (0.62) [−0.77, 0.44]	−0.01 [−0.07, 0.04]	0.10
SHS CIAA support GRPs	−0.62 (0.24) [−1.65, 0.42]	−0.02 [−0.07, 0.02]	0.04

Consistent with previous research about the effectiveness of mass media efforts in promoting calls to quitlines, the current study finds strong evidence that television advertisements are effective. These results imply that advertisements focused on promoting cessation and those highlighting the dangers of exposure to SHS can be equally effective in promoting calls to the Quitline. These results also show that advertisements with stronger emotional content are more effective in prompting calls to the Quitline. It remains to be determined whether this increased response leads to better cessation outcomes.

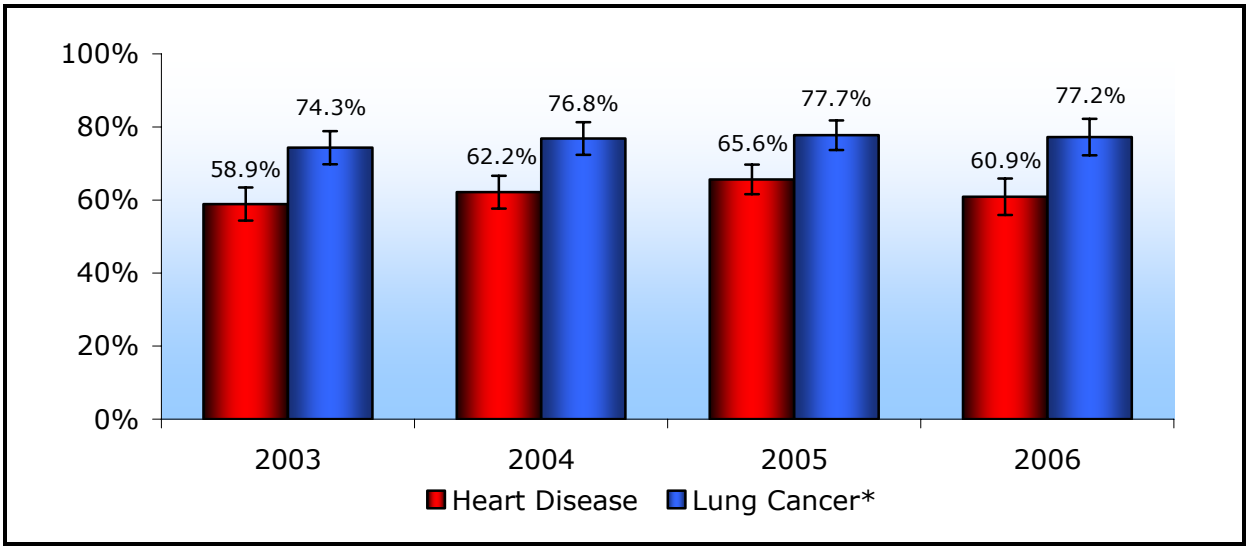
3.4.2 Beliefs about Smoking and Exposure to Secondhand Smoke

In this section, we present trends in beliefs about smoking and exposure to SHS that are germane to tobacco countermarketing advertisements that have aired in recent years. These include the following:

- smokers are at a higher risk for heart disease than nonsmokers,
- smokers are at a higher risk for lung cancer than nonsmokers,
- the harmful effects of cigarettes have *not* been exaggerated over time,
- breathing smoke from other people's cigarettes causes heart disease,
- breathing smoke from other people's cigarettes causes lung cancer, and
- breathing smoke from other people's cigarettes causes respiratory problems in children.

Exhibit 3-14 presents the trends in smokers' beliefs about their personal risk of having a heart attack or developing lung cancer compared with nonsmokers their age. There was no statistically significant change in either belief from 2003 to 2006. However, there was a statistically significant increase in smokers' belief about the risk of having a heart attack from 2003 to 2005, followed by a decline in 2006.

Exhibit 3-14. Percentage of Adult Smokers Who Believed They Have a Higher Risk of Heart Attack and of Lung Cancer than Nonsmokers their Age, ATS 2003–2006

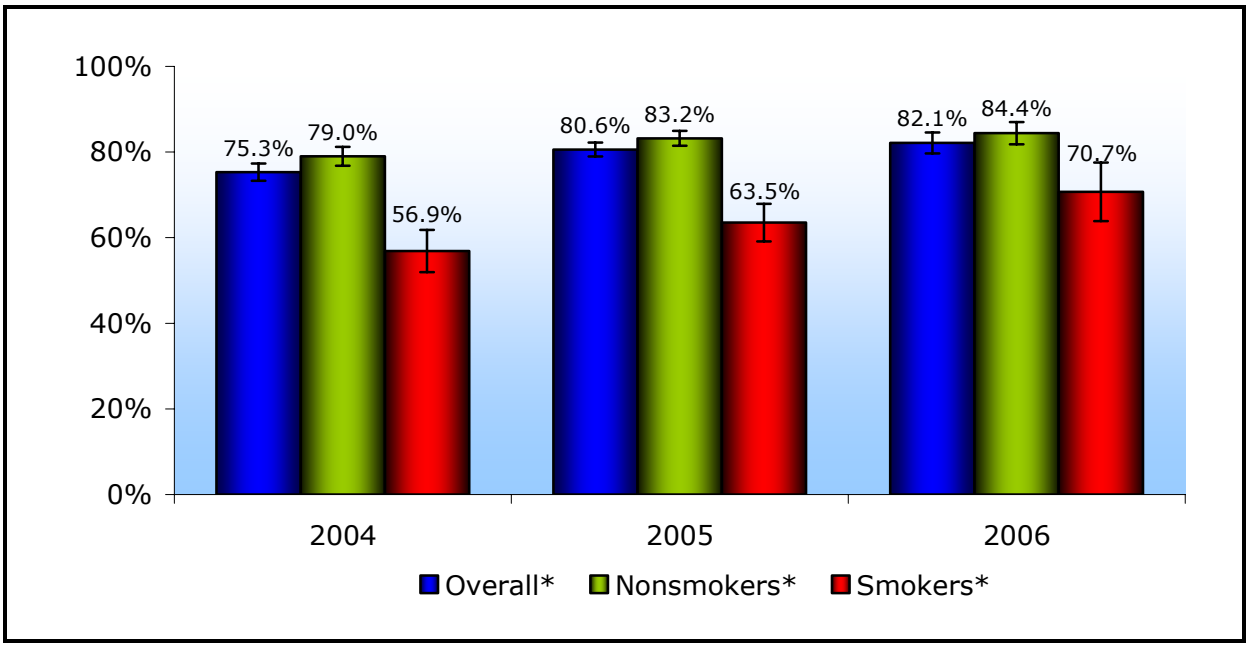


*Statistically significant upward trend from 2003 to 2005.

We found a substantial increase in the percentage of smokers and, to a lesser extent, nonsmokers who agree that the harmful effects of smoking have not been exaggerated. Overall, in 2006, 82.1% of respondents believe that the harmful effects of smoking have not been exaggerated, a significant increase from 2004 (75.3%) (Exhibit 3-15). Similar trends are seen among smokers (57% to 71%) and nonsmokers (79% to 84%) between 2004 and 2006.

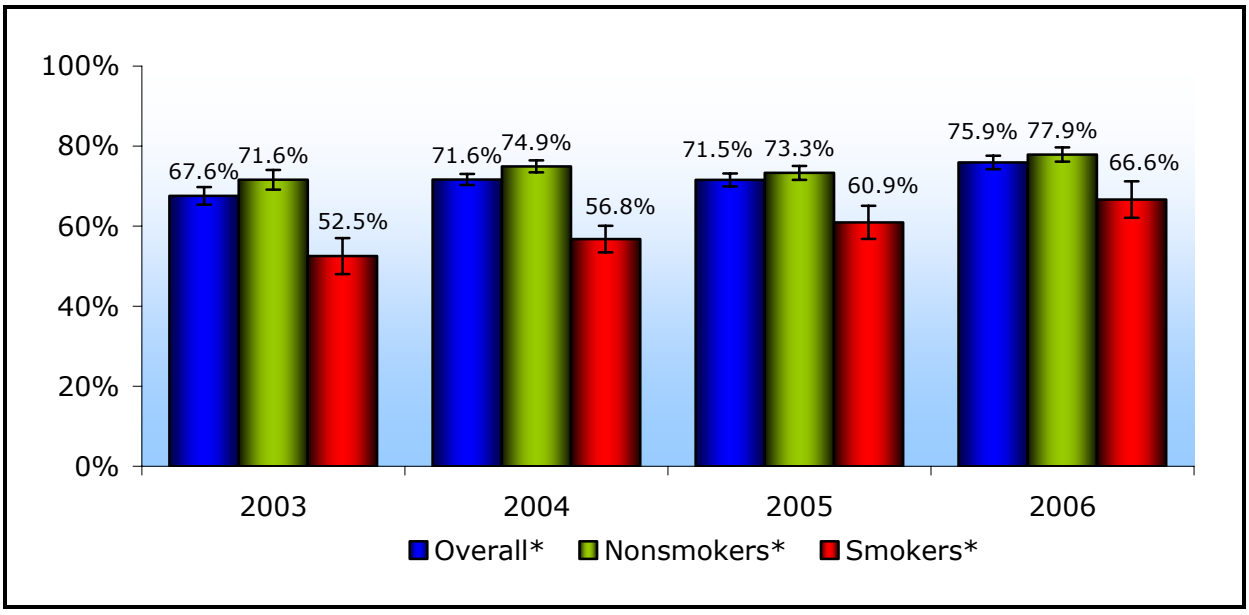
With respect to beliefs about the dangers of SHS exposure, smokers have increasingly acknowledged that exposure to SHS causes heart disease and lung cancer in adults and respiratory problems in children. The percentage of smokers who believe that SHS exposure causes heart disease increased from 53% to 67% from 2003 to 2006 (Exhibit 3-16). Similar trends among smokers are seen for lung cancer (65% to 71%) (Exhibit 3-17) and for respiratory problems in children (83% to 90%) (Exhibit 3-18). Nonsmokers also have increasingly acknowledged that exposure to SHS causes heart disease from 2003 to 2006 (from 72% to 78%). There are not statistically significant changes in nonsmokers' beliefs about the dangers of SHS and lung cancer and respiratory problems in children, likely due to the high level of agreement in 2003.

Exhibit 3-15. Percentage of Adults Who Believe the Harmful Effects of Cigarettes Have Not Been Exaggerated by Smoking Status, ATS 2003–2006



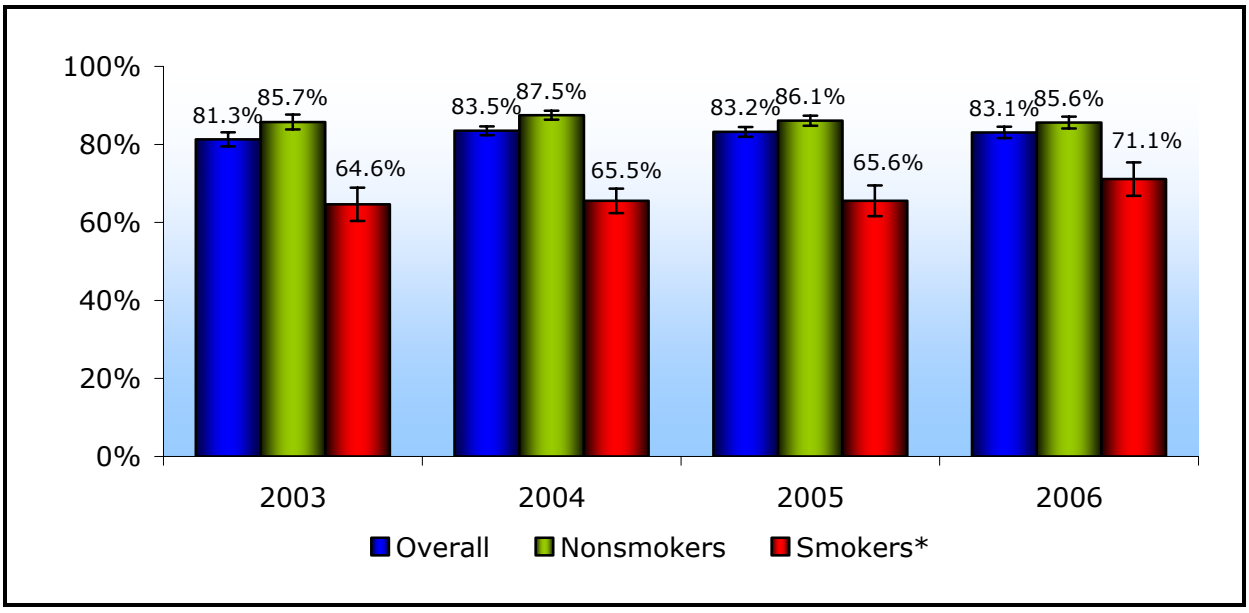
Note: Question first introduced in the Q3 2004 survey.
*Statistically significant upward trend from 2004 to 2006.

Exhibit 3-16. Percentage of Adults Who Believe Breathing Smoke from Other People's Cigarettes Causes Heart Disease, ATS 2003–2006



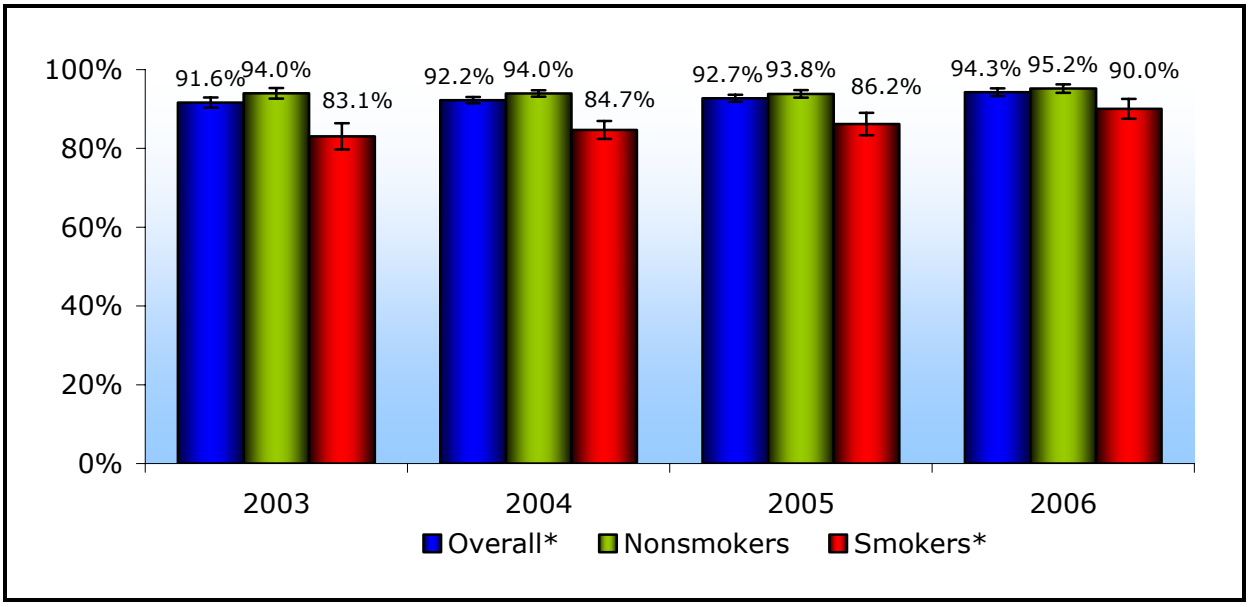
*Statistically significant upward trend from 2003 to 2006.

Exhibit 3-17. Percentage of Adults Who Believe Breathing Smoke from Other People's Cigarettes Causes Lung Cancer, ATS 2003–2006



*Statistically significant upward trend from 2003 to 2006.

Exhibit 3-18. Percentage of Adults Who Believe Breathing Smoke from Other People's Cigarettes Causes Respiratory Problems in Children, ATS 2003–2006



*Statistically significant upward trend from 2003 to 2006.

To determine whether the noted changes in smokers' beliefs about smoking and exposure to SHS are associated with NYTCP's countermarketing efforts, we used regression analysis to estimate the relationship between these beliefs and recall of tobacco countermarketing advertisements. Overall, the results suggest that recall of any countermarketing message is associated with both the acknowledgment that smoking causes heart disease (OR = 1.3, $p < .05$) and that the harmful effects of cigarettes have not been exaggerated (OR = 1.3, $p < .10$), although the latter was only marginally significant. There was no significant correlation between these indicators and specific types of media messages (SHS, cessation, high/low sensation value).

In contrast with attitudes about smoking, the association between beliefs about exposure to SHS and NYTCP's countermarketing efforts is much more pronounced. Specifically, recall of any countermarketing message (OR = 1.4, $p < .01$), any SHS advertisement (OR = 1.6, $p < .01$), any high sensation SHS advertisement (OR = 1.7, $p < .01$), and any low sensation SHS advertisement (OR = 1.4, $p < .10$) are all associated with the acknowledgment that exposure to SHS causes heart disease. Likewise, recall of any countermarketing message (OR = 1.3, $p < .05$), any SHS advertisement (OR = 1.6, $p < .01$), and any high sensation SHS advertisement (OR = 1.7, $p < .01$) are all associated with the acknowledgment that exposure to SHS causes lung cancer. Finally, recall of any countermarketing message (OR = 1.4, $p < .05$), any SHS advertisement (OR = 1.4, $p < .10$), and any low sensation value SHS advertisement (OR = 1.6, $p < .10$) are also associated (although some marginally) with the acknowledgment that exposure to SHS causes respiratory problems in children (Exhibit 3-19).

Exhibit 3-19. Regression Results of Beliefs about Confirmed Awareness of Countermarketing Advertisements on Beliefs about SHS, ATS, 2003–2006

Independent Variable	Causes Heart Disease— Odds Ratio (P)	Causes Lung Cancer— Odds Ratio (P)	Causes Respiratory Problems in Children— Odds Ratio (P)
All advertisements	1.4 (<0.01)	1.3 (<0.05)	1.4 (<0.05)
All SHS advertisements	1.6 (<0.01)	1.6 (<0.01)	1.4 (<0.1)
All high sensation value SHS advertisements	1.7 (<0.01)	1.7 (<0.01)	1.1 (0.73)
All low sensation value SHS advertisements	1.4 (<0.1)	1.3 (0.16)	1.6 (<0.1)

3.4.3 Cessation Behaviors and Intentions

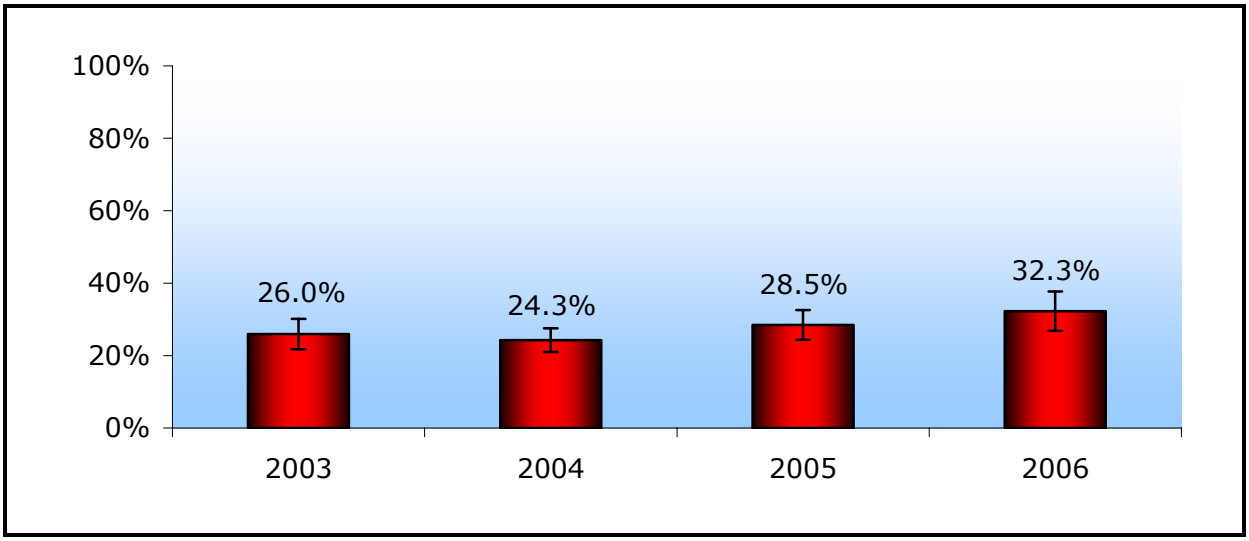
Turning to key longer-term programmatic outcomes, Exhibits 3-20 through 3-22 present trends for smokers for

- intending to quit in the next 30 days,
- making a quit attempt in the past 12 months, and
- having a successful quit attempt lasting 6 months or more.

Between 2003 and 2006, there was a significant increase in the percentage of adult smokers who have intentions to quit in the next 30 days and who made a quit attempt in the past 12 months (see Exhibits 3-20 and 3-21). In contrast, the percentage of adult current or former smokers who have maintained a quit attempt for more than 6 months in the past year increased significantly between 2003 and 2005 (see Exhibit 3-22) and decreased significantly in 2006 (statistically unchanged from 2003).

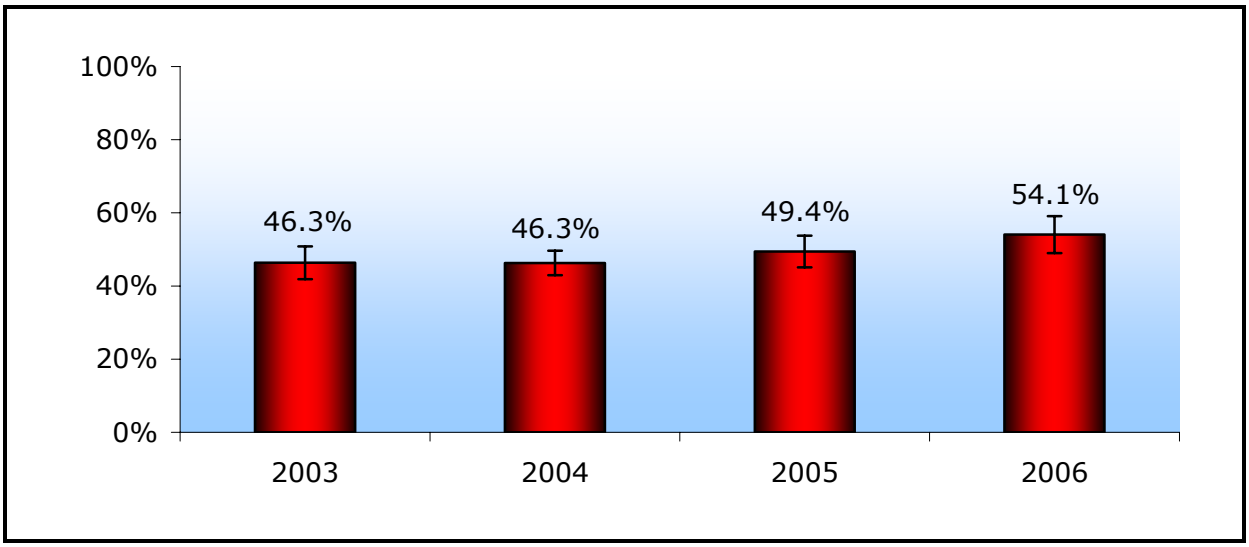
We examined the role of countermarketing messages in promoting the noted changes in cessation outcomes using regression analyses. Overall, we find that recall of any cessation-related message (OR = 1.4, $p < 0.1$), and particularly any low sensation value cessation message (OR = 2.3, $p < .01$), are associated (although marginally overall) with changes in intentions to quit in the next 30 days. It is possible that smokers who are thinking about quitting are more likely to recall low sensation value messages that rely more heavily on reasoning than on emotional appeals. This is in contrast with the finding below that those who have actually made a quit attempt have done so in response to high sensation advertisements.

Exhibit 3-20. Percentage of Adult Smokers Who Say They Intend to Quit in the Next 30 Days, ATS 2003–2006



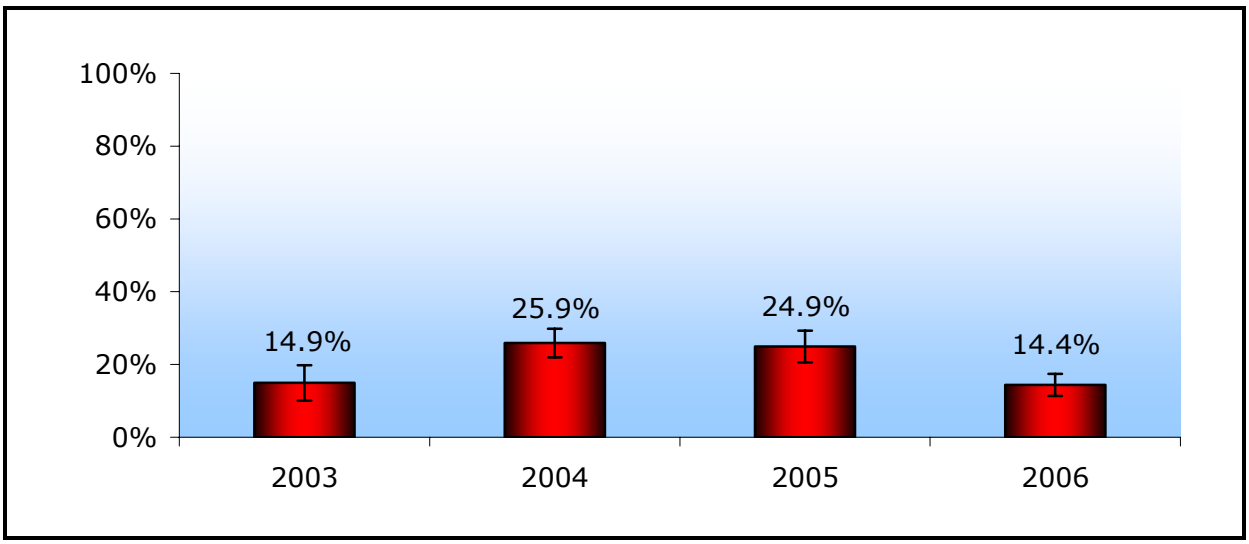
Note: Statistically significant upward trend from 2003 to 2006.

Exhibit 3-21. Percentage of Adult Smokers Who Made a Quit Attempt in the Past 12 Months, ATS 2003–2006



Note: Statistically significant upward trend from 2003 to 2006.

Exhibit 3-22. Percentage of Adult Current and Recent Former Smokers Who Made a Quit Attempt in the Last 12 Months and Have Remained Quit for 6 Months or More, ATS 2003–2006



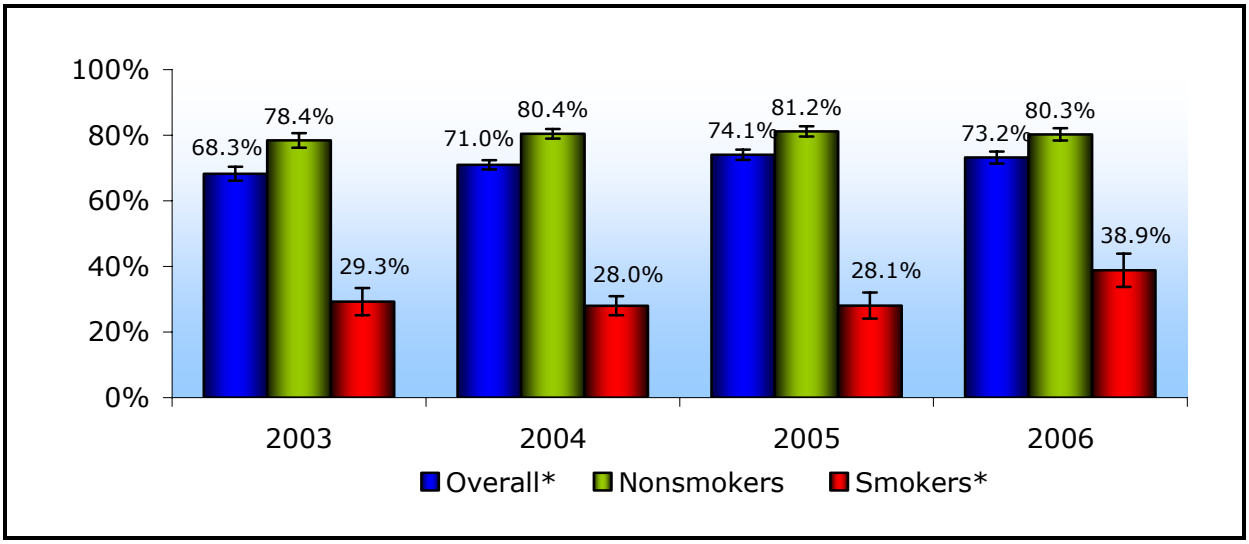
Note: Statistically significant upward trend from 2003 to 2004, no change from 2004 to 2005, and statistically significant downward trend from 2005 to 2006.

We also found a marginally significant relationship between recall of countermarketing messages and attempting to quit smoking. Specifically, we found that recall of any cessation-related message (OR = 1.3, $p < 0.1$), and particularly any high sensation value cessation message (OR = 1.3, $p < .01$), is associated with having made a quit attempt in the past 12 months.

3.4.4 Smoke-Free Home Policies

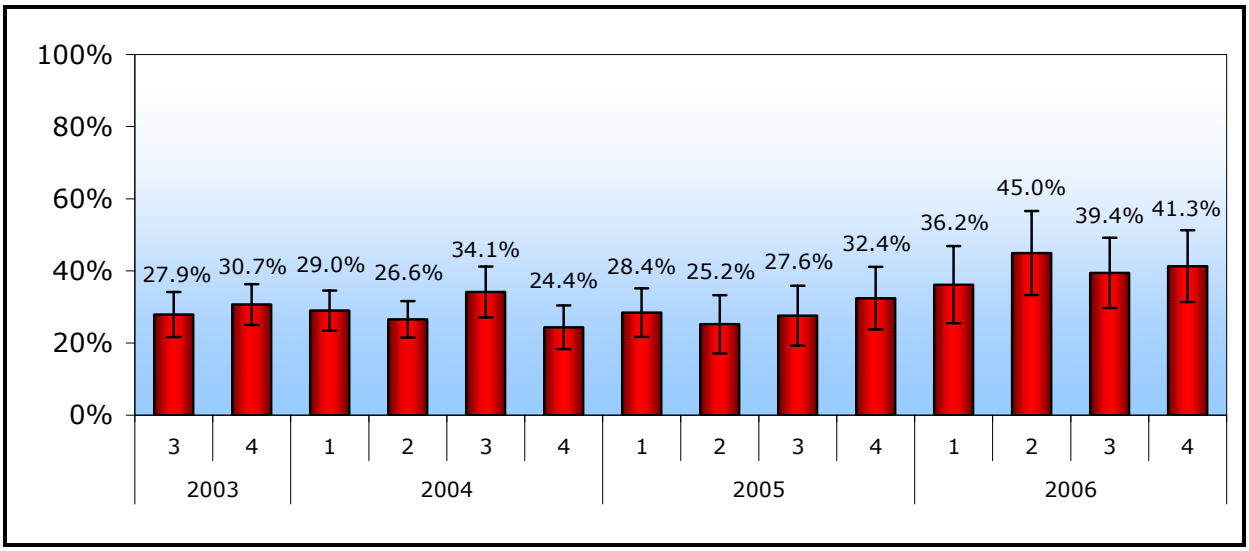
Our final programmatic indicator addresses a focus for NYTCP after implementation of the CIAA: voluntary restrictions on smoking in the home or in the car. With smoking banned in virtually all workplaces and public places, the remaining primary sources of exposure to SHS include private homes and cars. Because a significant source of exposure to SHS for infants and children is in homes, this venue represents a programmatic focus. In 2006, 39% of adult smokers lived in homes in which smoking was prohibited, a significant increase from 2003 (29%) (Exhibit 3-23). The quarterly trend in home smoking bans among smokers is illustrated in Exhibit 3-24. Overall, there are a number of possible explanations for the upward trends seen in these indicators. First, there was an increase in high-quality SHS countermarketing messages aired by the program in 2005 and 2006 compared with previous years. Furthermore, the release of the U.S. Surgeon General's Report on the Health Consequences of Involuntary Exposure to Tobacco Smoke on June 27, 2006, was highly publicized and may have made the issue more salient to smokers. Although Community Partnerships spent one-third of their activities on efforts to reduce SHS exposure in FY 2004–2005, this percentage dropped to less than 10% by FY 2006–2007 (to date). As discussed in Chapter 5, in the past year, the program shifted Community Partnership efforts away from activities aimed at promoting smoke-free homes and cars toward other activities.

Exhibit 3-23. Percentage of Adults Who Live in Smoke-free Homes by Smoking Status, ATS 2003–2006



*Statistically significant upward trend from 2003 to 2006.

Exhibit 3-24. Percentage of Smokers Who Live in Smoke-free Homes, ATS Q3 2003–Q4 2006



*Statistically significant upward trend from 2003 to 2006.

3.5 Programmatic Implications

It appears that by Q1 2007 NYTCP achieved our previous recommendation to reach more than 60% of New Yorkers by (1) investing necessary resources and (2) airing high sensation value tobacco countermarketing advertisements. Unfortunately, because of delays in approval of the expenditure plan by the Governor's office, relatively few advertisements were aired in the last 4 months of 2006. These delays reduced New Yorkers' exposure to countermarketing efforts, and we observed a leveling off of awareness after 3 years of steady progress. For NYTCP to achieve its ambitious goal of reducing the number of adult smokers by 900,000 by 2010, they will require more timely approvals of expenditure plans.

Overall, our findings indicate that awareness of countermarketing messages has increased dramatically from 2003 to Q1 2007, reaching well over 60% of New Yorkers. Other notable changes in program outcomes in recent years include

- increases in the number of calls to the Quitline;
- greater agreement among smokers that smoking causes lung cancer and that SHS exposure causes heart disease and lung cancer in adults, as well as respiratory problems in children;
- increases in the percentage of smokers who intend to quit in the next month and have tried to quit in the past year; and
- a sizeable increase between 2005 and 2006 in the percentage of smokers who live in homes where smoking is prohibited.

Our findings support the effectiveness of tobacco countermarketing advertisements in contributing to many of these changes. We found that recall of and exposure to countermarketing advertisements was associated with

- increased calls to the Quitline,
- increased acknowledgement of the dangers of exposure to SHS,
- increased knowledge of the dangers of smoking,
- intentions to quit smoking, and
- making a quit attempt.

In addition, we find support for the use of high sensation value advertisements when targeting behavior change. Recall of and exposure to high compared to low sensation value advertisements was associated with

- higher levels of recall for a fixed dose of television advertisements (or GRPs),
- more calls to the Quitline,
- greater percentage of the population recognizing the dangers of SHS exposure, and
- increased likelihood of making a quit attempt.

Furthermore, smokers were more likely to report talking to others about these advertisements, agree that the advertisements were "powerful," and report that the advertisements prompted them to want to quit. However, advertisements with graphic images or strong emotional content are not the only approach to elicit positive responses. We noted that the SHS advertisement "It's Like They're Smoking," depicting toddlers talking like adult smokers, performed well with limited airplay (27% awareness per 5,000 GRPs) and received high marks for both peer communication and saying something important. The progress in countermarketing efforts over time has helped contribute to substantial growth in first-time callers to the New York State Smokers' Quitline.

These findings reinforce our previous findings and indicate that NYTCP continues to make progress by developing media plans that commit more funds to countermarketing efforts and use high quality, high sensation value messages. Unfortunately, NYTCP's progress has been slowed once again by unnecessary bureaucratic and political delays despite the program's efforts to plan in advance.

Our findings also call for a more nuanced approach to characterizing and evaluating countermarketing efforts. Fortunately, the new online media tracking survey appears to be capable of providing more in-depth responses to specific messages and should provide

NYTCP with the direction they need to select the most promising advertisements. Moving forward, we recommend that NYTCP

- continue to air countermarketing messages that resonate with viewers, notably those that use significant emotional appeals, and intense or graphic images;
- avoid unplanned gaps in media implementation; and
- continue to invest in media sufficient to consistently achieve at least 60% awareness of countermarketing advertisements statewide.

4. NEW YORK STATE SMOKERS' QUITLINE

4.1 Overview of the New York State Smokers' Quitline

The New York Tobacco Control Program (NYTCP) promotes smoking cessation through media and countermarketing, policies (e.g., smoking bans, price increases), community action to denormalize tobacco use, health care systems to promote treatment of tobacco use and dependence, and cessation services offered to those who need or want help quitting. The latter services are offered primarily through the New York State Smokers' Quitline, managed by the Roswell Park Cancer Institute, under contract with the New York State Department of Health (NYSDOH). The Quitline service and its contribution to achieving NYTCP goals are the focus of this section.

Quitlines serve a number of purposes in a tobacco control program. They (1) provide an effective, evidence-based service for helping smokers quit smoking; (2) serve as a clearinghouse of information on smoking cessation for smokers, health care providers, and the general public; (3) allow a call to action for mass media messages designed to promote cessation; and (4) enhance the ability of health care providers to screen their patients for tobacco use by providing a resource to which smokers may be referred by their provider. Through each of these mechanisms, the New York State Smokers' Quitline is expected to add programmatic value to NYTCP and contribute to the achievement of NYTCP goals.

The New York State Smokers' Quitline was established in 2000 and has seen a steady increase in the number of callers it serves and the types of services it provides. The Quitline was funded at $2.4 million in 2006, an increase of $1.1 million from 2005. With increased funding, the Quitline increased staff and expanded the number of callers it can serve. However, actual expenditures by the Quitline were lower than the available dollars.

Smokers learn about the Quitline and how to access its services through a variety of Quitline promotions implemented or coordinated by NYTCP. Two significant efforts include the tobacco countermarketing efforts described in Chapter 3 and Cessation Center efforts to raise health care providers' awareness and use of the Quitline by referring patients to the Quitline (described in Chapter 5). Several evaluation questions are addressed in this chapter:

- Is the Quitline service effective in helping smokers quit successfully?
- Is the provision of nicotine replacement therapy (NRT) effective in boosting quit rates among those who access it?
- Are the NYTCP promotions of the Quitline effective in driving smokers who are ready to quit to the Quitline?
- Is the Quitline a cost-effective investment for NYTCP, including provision of NRT?

4.2 Use of Quitline Services

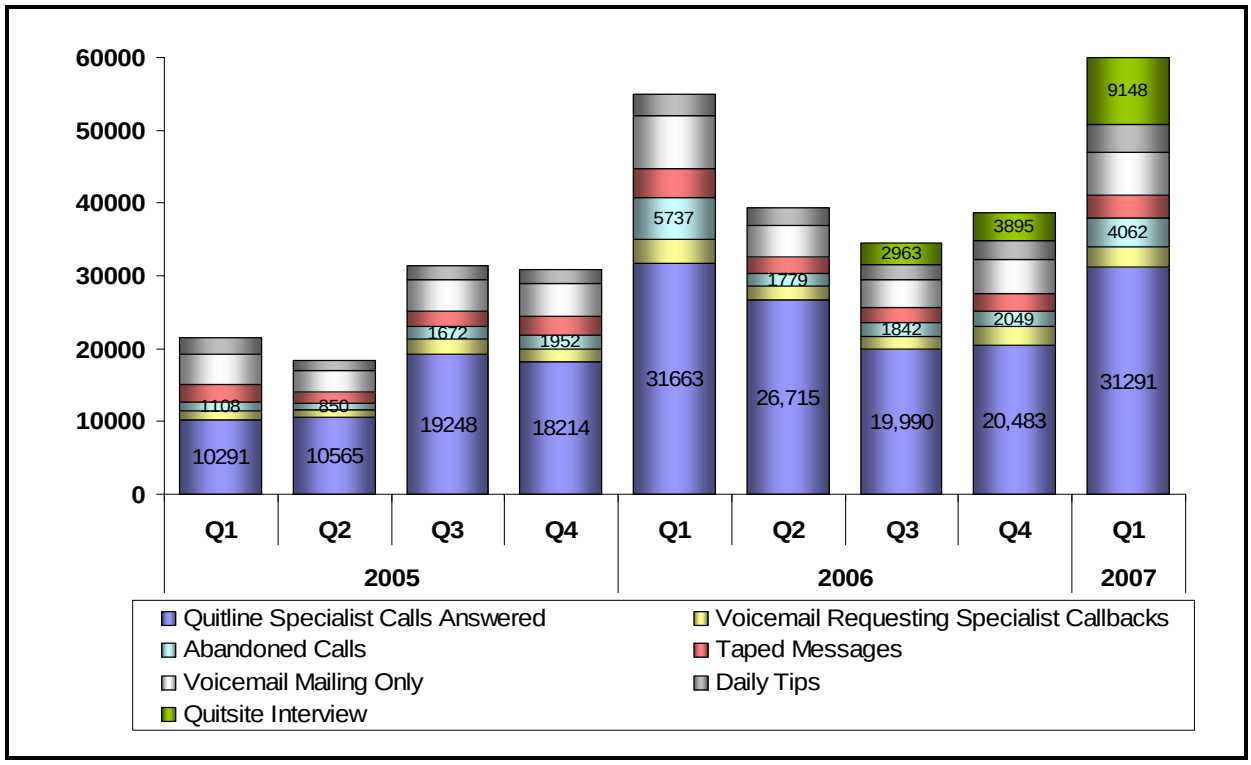
The Quitline's core service is quit smoking support provided by a Quitline specialist who works with the smoker to develop a quit smoking plan; assess eligibility for (and provide) NRT; send a packet of quit smoking information through the mail; and contact the caller again to offer encouragement, provide additional tips, and determine quit progress. This service is available to all New York residents by calling 1-866-NY QUITS (1-866-697-8487). Quitline specialists are available Monday through Friday from 9:00 a.m. to 9:00 p.m. and Saturday and Sunday from 9:00 a.m. to 1:00 p.m.

In addition to the core service, residents can access taped "tips of the day" and taped messages on a variety of topics, leave a voicemail message to receive informational materials through the mail, visit nysmokefree.com to obtain information about quitting smoking and register for free NRT, and be contacted by a Quitline specialist following a referral from a health care provider (Fax-to-Quit program). In this program, the Quitline specialist contacts the client based on the referral information; offers help with the quit process, including providing NRT to eligible clients; and sends a report to the provider describing the services the patient received and the patient's progress.

Total incoming calls to the Quitline were at a record level of 182,000 for the current period of Q2 2006 to Q1 2007. The call volume increased during the current period by about 36,000 calls or 24% compared with the same period last year. Exhibit 4-1 illustrates total incoming calls from Q1 2005 to Q1 2007. This exhibit also illustrates the types of services callers requested. For Q2 2006 to Q1 2007, the most common service requested was coaching and advice from a Quitline specialist (98,500 calls or 63%), followed by voicemail messages requesting a mailing with general information about smoking cessation (18,700 or 12%). Some of the callers who requested to speak with a specialist hung up before they spoke with a specialist. Abandoned calls during peaks in call volume decreased from 15% in Q1 2006 to 11% in Q1 2007.

Since its introduction in July 2006, the number of smokers who applied for NRT online steadily increased, as did the total number of people who visited the Quitsite (at www.nysmokefree.com). The increase is due to (1) a recorded message that encourages callers to use the Quitsite to apply for NRT while they wait to talk to a specialist, (2) an increase in the promotion of the Quitsite through online banner ads and roadblocks, and (3) improved Quitsite content (e.g., resulting in better placement in results of popular search engines, such as Google and Yahoo).

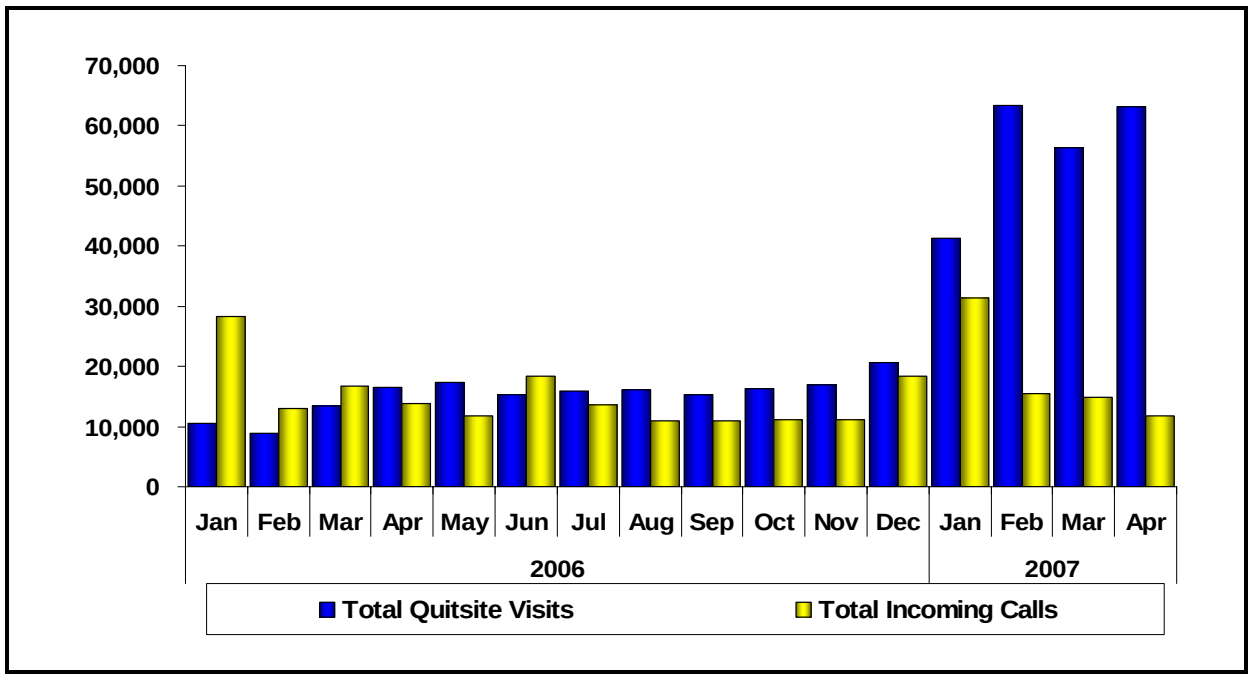
Exhibit 4-1. Quitline Calls by Type of Service Requested and Completed Quitsite Interviews, Quitline Call Tracking System, Q1 2005–Q1 2007



In 2006, the total number of people who called the Quitline roughly equaled the total number of people who visited the Quitsite (Exhibit 4-2). In the first 4 months of 2007, however, the total number of Quitsite visits (224,000) was three times the total number of incoming calls (73,000). Compared with the same period in 2006, these numbers indicate that NYTCP efforts to promote the Quitsite in 2007—including as a means for dealing with capacity constraints in distributing NRT—more than quadrupled (453%) the number of Quitsite visits.

Although smokers can qualify for free NRT online, they do not receive the coaching that telephone callers receive from a Quitline specialist. As a result, smokers who receive NRT via the Quitsite may have different quit rates than smokers who call to receive NRT and also speak with a specialist. Neither previous studies nor the current data can quantify the success rate in quitting smoking among those who receive NRT online compared with smokers who receive NRT and coaching. Some evidence suggests that using NRT without counseling support is as effective as using NRT with counseling support (Silagy et al., 2006), although other studies suggest that NRT and some form of support or counseling is better than NRT alone (e.g., Zhu et al., 2000).

Exhibit 4-2. Total Visits to the New York Smokers' Quitsite versus Total Incoming Calls to the Quitline, Quitline Tracking System, January 2006–April 2007



Although call volume to the Quitline has increased, to adequately assess the potential impact that the Quitline has on population-level quit rates, it is important to calculate Quitline use by smokers as a percentage of the population of smokers in New York. From Exhibit 4-1, 98,479 callers spoke to a Quitline specialist (54% of callers). Of these, 70,279 were new callers to the Quitline, whereas the others were calling back for support or other reasons. Using the prevalence of smoking from the Behavioral Risk Factor Surveillance System (BRFSS) in 2006 (18.2%), we estimate the total number of smokers in New York to be 2.7 million smokers. Therefore, the percentage of smokers who called the Quitline for the first time was 2.6%. Because not all smokers are interested in quitting, we also estimated the percentage of smokers interested in quitting who called the Quitline. In the 2006 ATS, 68.7% of smokers indicated that they seriously considered quitting in the next 6 months. Therefore, an estimated 3.8% of smokers seriously thinking about quitting called the Quitline for the first time between Q2 2006 and Q1 2007.

4.3 Satisfaction With and Impact of Quitline

Several randomized controlled trials have found telephone quitlines to be effective in promoting cessation (McAlister et al., 2004; Rabius et al., 2004; Zhu et al., 2002; Hopkins et al., 2001). In addition, evidence indicates that provision of NRT increases the odds of quitting by 50% to 100% (Silagy et al., 2006), increases the odds of remaining quit by 77% (Miller et al., 2005; Bauer et al., 2006; Cummings et al., 2006), and increases call volume

to quitlines (Cummings et al., 2006; An et al., 2006). NYTCP began offering free 2-week NRT starter kits to eligible smokers beginning in December 2004. To be eligible, the caller must be a New Yorker who is at least 18 years old, smokes 10 or more cigarettes per day, is willing to quit within 2 weeks, and has no medical contraindications. In this section, we discuss smokers' satisfaction with the Quitline and use of NRT, and we assess the effectiveness and impact of the Quitline, including the effect of NRT distribution on effectiveness.

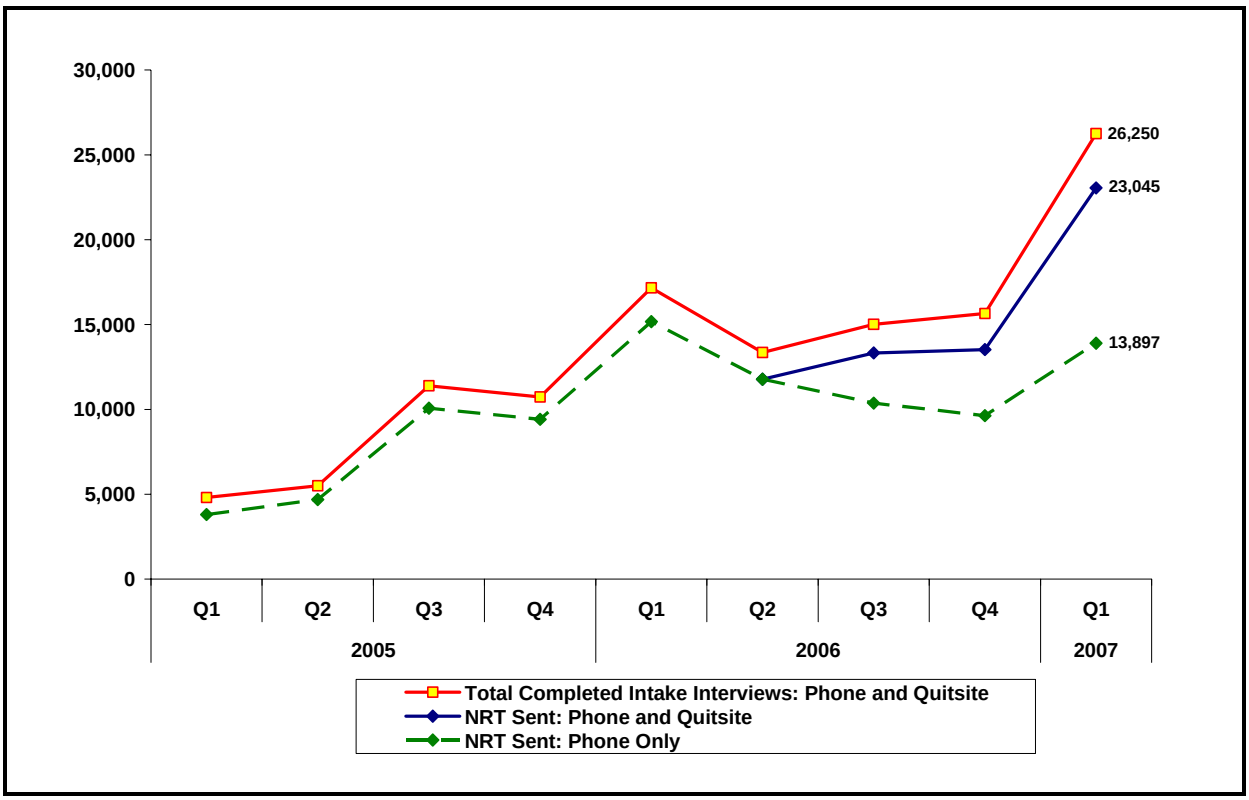
The Quitline conducts ongoing surveys of a random sample of callers to assess their satisfaction with the services they receive. Quitline callers are very satisfied with the service they receive. From June 2006 to May 2007, approximately 90% reported that they would seek help from the Quitline again and 92% reported being "very satisfied"; only 3% reported having trouble contacting the Quitline (Exhibit 4-3).

The distribution of free NRT starter kits has increased significantly as the volume of calls to the Quitline has increased. Exhibit 4-4 shows that the Quitline continues to experience an increased demand for free NRT and that the Quitsite played a key role in meeting this demand. Since it was introduced as an alternative in July 2006, an additional 16,000 smokers applied online and received NRT, increasing the total number of smokers receiving NRT. From Q2 2006 to Q1 2007, the Quitline distributed free NRT to 88% of the smokers who completed the intake interview. The remaining 12% were either ineligible or not interested in NRT.

Exhibit 4-3. Smokers' Satisfaction with the Quitline, Customer Satisfaction Surveys, June 2006 to May 2007

Satisfaction Measure	Frequency	Percentage
Trouble Contacting Quitline?	650	3.2%
On hold for a long time	161	0.8%
Specialists were busy with other clients	173	0.8%
Quitline was closed	29	0.1%
Satisfied with the Quitline?		
Very satisfied	16,199	92.0%
Mostly satisfied	1,113	6.3%
Somewhat satisfied	263	1.5%
Not at all satisfied	39	0.2%
Other Questions		
Would you seek help again from the Quitline?	18,435	89.5%
Will you recommend the Quitline?	18,455	89.6%
Did you share information with others?	14,070	68.3%

Exhibit 4-4. Number of Smokers Who Completed the Intake Interview, and Number of Smokers Who Received Nicotine Replacement Therapy, Quitline Call Tracking System, Q1 2005-Q1 2007



Historically, the Quitline has conducted several follow-up surveys of callers. Several 12-month follow-up surveys conducted before the start of distribution of NRT found quit rates of approximately 20% (respondents were considered quit if they had not smoked for 7 consecutive days prior to the survey date—7-day point prevalence). These quit rates excluded those who were lost to follow-up. To calculate quit rates in the period after distribution of NRT began, we used the most recent follow-up data to compute the quit rates (7-day point prevalence) for those who were qualified to receive NRT based on two methods. First, we excluded those who did not complete the survey and assumed they were missing (all clients). This method is comparable to the quit rates we have for the period prior to the start of NRT distribution. Second, we accounted for smokers eligible to receive NRT who did not complete the survey by assuming they were smokers.

The follow-up data prior to the distribution of NRT indicate that 20.4% of smokers quit smoking. After the distribution of NRT, the follow-up data indicate that 34.4% quit smoking. This comparison clearly suggests that the distribution of NRT has substantially improved quit rates in New York (Exhibit 4-5).

Exhibit 4-5. Expected Quit Rates for New York State Smokers Who Contacted the Quitline Before and After the Distribution of NRT Starter Kits, Quitline 12-Month Follow-Up Surveys

12-Month Follow-Up Data	Quit Rate—Formula 1 # quit/(# quit + # still smoking) not including those who could not be contacted	Quit Rate—Formula 2 # quit/(# quit + # still smoking + # who could not be contacted)
Prior to distribution of NRT: Q1 and Q2 2003	20.4%	9.7
After distribution of NRT: Q1 2006 to Q1 2007	34.4%	23.3%

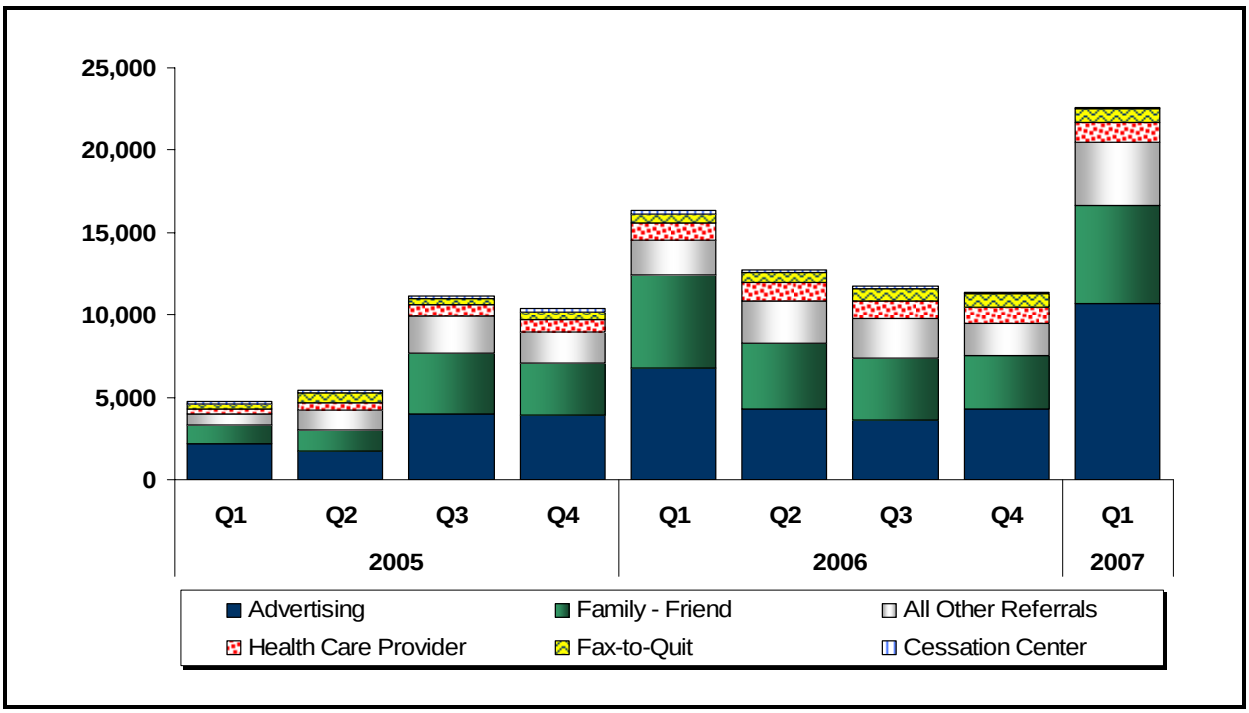
From Q2 2006 through Q1 2007, the Quitline sent about 61,700 free NRT starter kits. Using the quit rates from the most recent follow-up data (Q1 2006 to Q1 2007), the distribution of free NRT in New York translates into approximately 14,000 (using intent-to-treat quit rate of 23.3%) or 21,000 (using all clients quit rate of 34.4%) smokers who are expected to quit smoking.

4.4 How New Yorkers Heard about the Quitline

As indicated in the 2006 Independent Evaluation Report (IER), calls to the Quitline are largely driven by mass media efforts. As a result, if Quitline staffing and countermarketing efforts are not well coordinated, the Quitline can be overwhelmed by calls or overstaffed and inefficient. We also noted in the 2006 IER that there may be opportunities to more efficiently drive calls to the Quitline by shifting some resources away from television to radio and print advertising. In this section, we present data on the reasons callers cite for calling the Quitline. The major referral sources include advertising (and type of advertising), family or friend, and health care providers (directly or via Fax-to-Quit). NYTCP has an explicit objective to increase health care provider referrals to the Quitline.

As noted in Chapter 3, there was a significant increase in the percentage of adult smokers who had heard of the Quitline in 2006. Data from the intake interviews with callers asking to speak to a Quitline specialist for counseling show that paid advertising and referrals from family and friends were the most commonly cited sources of information about the Quitline (Exhibit 4-6). The number of callers who heard about the Quitline from paid advertising increased from 42% in Q1 2006 to 47% in Q1 2007. It is likely that many of the referrals from family and friends are a result of them seeing advertising and then referring their friend or family member to the Quitline.

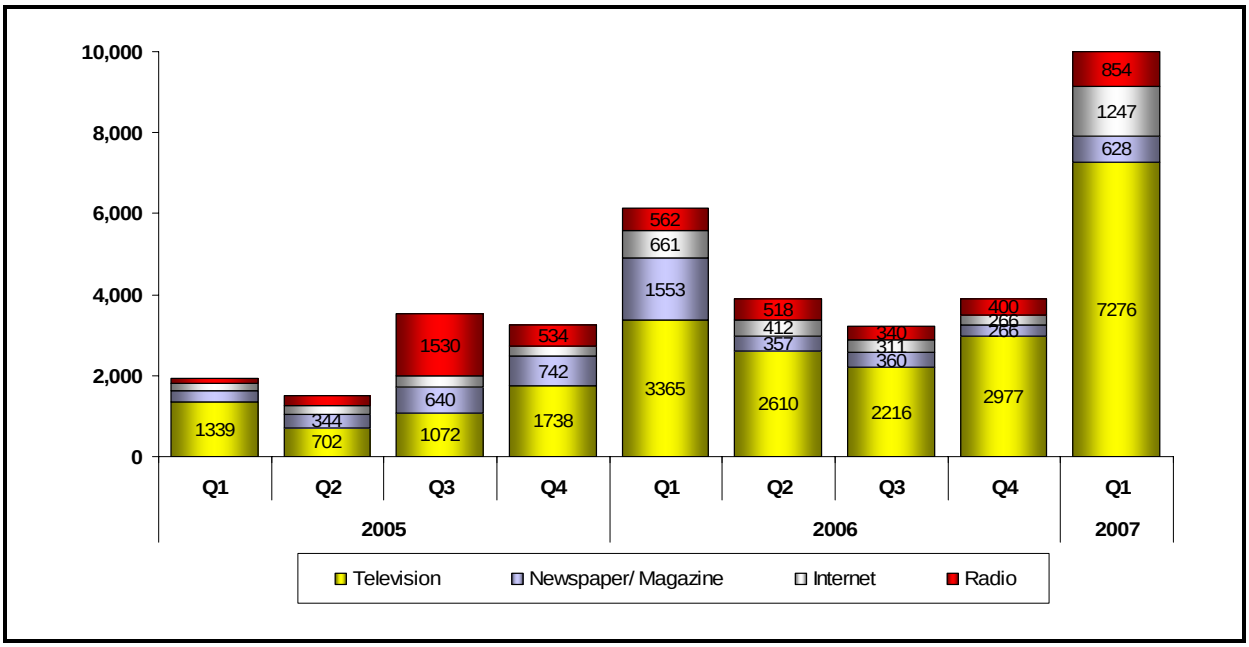
Exhibit 4-6. Total Number of New York State Smokers' Quitline Calls Requesting Counseling by Source of Referral, Quitline Call Tracking System Intake Interview, Q1 2005–Q1 2007



Cessation Centers continue to promote the Quitline to health care providers. Their efforts include increasing health care providers' awareness of the Quitline, promoting the Fax-to-Quit program, and directly referring smokers to the Quitline. The results show that the number of callers who said they had heard about the Quitline from Cessation Centers, health care providers, and Fax-to-Quit has increased in the past year. For example, the number of callers citing these sources increased from 5,612 (Q2 2005–Q1 2006) to 7,823 (Q2 2006–Q1 2007), a 39% increase from the previous period.

Because advertising continues to be the most commonly cited source of referrals, we examined the types of advertising mentioned by callers more closely (Exhibit 4-7). During Q2 2006 to Q1 2007, 21,000 smokers cited media advertising as their source of referrals. Specifically, 15,000 cited television (72%), 2,200 cited radio (11%), 2,100 cited the Internet (10%), and approximately 1,600 cited newspapers or magazines (8%). Exhibit 4-7 also indicates a shift in the distribution of newspapers or magazines and television during the peak periods of Q1 2006 and Q1 2007. In Q1 2006, newspapers or magazines accounted for 25% and television accounted for 55% of media referrals. In Q1 2007, however, newspapers or magazines accounted for only 12% and television accounted for 73% of media referrals. The high percentage of newspaper or magazines referrals in

Exhibit 4-7. Distribution of Advertising Referrals, Quitline Call Tracking System Intake Interview, Q1 2005–Q1 2007



Q1 2006 is likely tied to the "Every Cigarette Is Doing You Damage" campaign that first aired statewide in this quarter and garnered a significant amount of media attention. These findings and our previous research suggest that, although television is the primary source of the media referrals, other media sources are still viable for NYTCP to use to promote the Quitline. Radio, the Internet, and newspapers may be a viable way to complement television advertising in media markets where the cost of television advertising is relatively high. However, to accomplish the goal of reaching 60% of the adult target audience, the NYTCP will need to air television spots in all media markets.

As noted in Chapter 3, paid media serves many purposes. A well-designed and executed tobacco countermarketing campaign will grab the attention of viewers, change their attitudes and beliefs about smoking, and prompt smokers to change their behavior. Smokers may respond by calling the Quitline, quitting with other evidence-based methods (e.g., NRT), or quitting on their own.

4.6 Programmatic Implications

During the past year, the Quitline has continued to provide a high quality of service, with a few notable exceptions. Nine out of 10 callers report that they are very satisfied with the services they received. In addition, the quit rate among callers is significantly higher now than it was before NRT was offered. NYTCP successfully promoted the Quitsite, and Quitsite visits quadrupled as a result. Because the Quitline offered NRT starter kits via the Quitsite, the number of NRT starter kits distributed increased substantially from the previous year.

NRT distribution through the Quitline alone (excluding Quitsite distribution) increased 16% from the previous year.

However, during times of peak call volume, approximately 1 in 10 callers who wished to speak to a Quitline specialist hung up. Although this percentage decreased from the previous year (15%), this percentage remains too high. In addition, although Fax-to-Quit referrals increased, the percentage of successful callbacks to these smokers, on average, is only 34%. This is a relatively low percentage, and greater emphasis must be made to reach these smokers. This percentage may also be low if providers are referring smokers who are not ready to quit and are therefore not interested in the Quitline.

NYTCP, Cessation Centers, and Community Partnerships continued efforts to promote use of the Quitline. As a result, total calls to the Quitline increased by 24% compared with the same period the previous year. An example of this progress is that the number of smokers who were referred to the Quitline by Cessation Centers, health care providers, or Fax-to-Quit increased by 39% over the past year. Television advertisements continued to be the major source of referrals cited by smokers who spoke with a Quitline specialist. As noted in the 2006 IER, radio and newspapers are important media for promoting the Quitline and are used regularly by NYTCP. Additional radio and print advertising may be a cost-effective way to promote the Quitline at times when there are relatively few television advertisements (e.g., summer) to provide more stable call volume throughout the year. The findings above show that NYTCP successfully promoted the Quitsite.

As noted earlier, several other studies have shown that distribution of NRT via a quitline can promote calls to the quitline and increase quit rates (e.g., An et al., 2006; Bauer et al., 2006; Cummings et al., 2006). Including NRT in the Quitline services appears to have contributed to the increase in 12-month quit rate from 20.4% in 2003 to 34.4% in 2006. Based on the number of new callers in the past year, approximately 24,000 smokers (0.9% of all smokers) quit as a result of the Quitline. Of these, approximately 10,000 are attributable to the availability of NRT. We have no direct evidence that the availability of NRT independently increased calls to the Quitline. If NYTCP achieves its goal of 230,000 callers to the Quitline in 2007 through 2010, we estimate that approximately 120,000 (30,000 per year) smokers will quit. An additional 50,000 callers per year over this period would lead to an additional 26,000 smokers who would quit.

While the use of the Quitsite as an alternative venue to request NRT clearly has the potential to expand the use of NRT, it is unclear what impact this will have on quit rates. Smokers who request NRT online do not receive coaching from a Quitline specialist as their counterparts do who apply for NRT when calling. We do not yet know the relative effectiveness of NRT without coaching versus NRT with coaching.

We also do not know at this time which smokers are accessing the Quitsite. Preliminary evidence suggests that smokers who are accessing the Quitsite are more likely to be white,

have private insurance, and reside outside of New York City. We recommend that NYTCP review available data to ensure that they are effectively reaching smokers with the Quitline and Quitsite in sociodemographic groups with the highest smoking rates.

Despite these successes, only 3% of smokers call the Quitline for the first time each year. The recent increase in funding for paid media to promote the Quitline should further increase use. However, it might be necessary to increase the capacity of the Quitline and corresponding promotional efforts (e.g., by shifting resources from other programmatic efforts) to achieve NYTCP's goal of reducing the number of adult smokers by 900,000 by the year 2010. We recommend striving to reach 5% of smokers with the Quitline.

5. COMMUNITY MOBILIZATION

5.1 Overview of Community Mobilization Efforts

There is a general consensus in the field of tobacco control that community action is essential to preventing and reducing tobacco use, given the role of tobacco companies in establishing tobacco use as a norm in our society (Brandt, 2007). Community initiatives have been shown to positively affect health care and alcohol-related policies and outcomes (Conrad et al., 2003; Zakocs and Guckenburg, 2007) and to reduce alcohol-related traffic deaths (Hingson et al., 2005). They have also been effective in changing alcohol, tobacco, and drug-related policies (Hays et al., 2000) and in reducing smoking prevalence (Biglan et al., 2000). The earliest community-level intervention studies addressed tobacco use (Maccoby and Altman, 1988; Salonen et al., 1981) and have since become a core component of comprehensive tobacco use prevention and control programs (NCI, 1991, 2005). Within tobacco control, local policy advocacy has been particularly important because it has been difficult for the tobacco industry to monitor and counter activity in so many different communities (White et al., 2005). The consensus is based on quantitative and qualitative evaluations of community trials (NCI, 1995, 2006), but the quality of evidence is not on par with evidence of the impact of other interventions, such as tobacco countermarketing, quitlines, smoke-free policies, and tax increases. In some sense, the commitment to community interventions is a leap of faith on the part of tobacco control programs (in New York and elsewhere), based on their understanding of how previous community interventions have "worked."

There are significant challenges to documenting the effectiveness of community-based programs (Stokols, 1996; NCI, 2006, 2007), but reviews of the literature show that programs that have been effective are characterized by well-implemented, comprehensive interventions that are evidence-based (Roussos and Fawcett, 2000; Merzel and D'Afflitti, 2003). Well implemented accountability processes and strong technical assistance systems can increase the effectiveness of community-based efforts (Wandersman and Florin, 2003) and also aid in program evaluation, whereas integrated relationships with local institutions help ensure long-term sustainability of the tobacco control movement (Vollinger et al., 2005) but are harder to describe and document. The independent evaluation of the New York Tobacco Control Program (NYTCP), with its large investment in community programming, constitutes an opportunity to further inform both community evaluation strategies and specific factors that contribute to successful community programming. In the coming 5 years, with strong evaluation systems in place for many other program components, the independent evaluation will have an opportunity to advance the field of community program evaluation and better quantify the impact of the NYTCP community component.

Community programs serve many roles in NYTCP, which makes evaluation even more complex. They are responsible for educating the community about tobacco as a social, cultural, and health problem; keeping tobacco issues prominent in the minds of community members and leaders and setting the terms of the debate; responding to tobacco control opportunities as they emerge; advocating for effective tobacco control action; and accomplishing discrete objectives within their contractual work plan. In this chapter, we focus on the role of community programs in advancing discrete objectives within specific programmatic areas. Our understanding and evaluation of the impact of these efforts is hampered by a lack of comprehensive information on tobacco industry strategies and actions and the extent to which the tobacco industry has a presence in communities. Our efforts also are hampered by the absence of reliable information (especially retrospective information) on the extent to which standard tobacco control measures have been adopted by societal institutions (e.g., implementation of the Public Health Service Guideline by physician practices, implementation of tobacco-free grounds by schools). Over time, the independent evaluation will be able to build on the monitoring and evaluation systems established by NYTCP to better assess community program impact, but those systems currently are too new to provide the necessary information.

NYTCP funds four modalities of community partners to implement tobacco control initiatives at the local level that are linked to the NYTCP Strategic Plan: 19 Cessation Centers, 29 Community Partnerships, 46 Reality Check Youth Action Partners, and 31 Tobacco Free School Policy Partners. These four modalities are directed by NYTCP to focus on specific strategic objectives. The following sections describe each modality's focus, activities, and outcomes.

In the 2006 Independent Evaluation Report (IER), we noted that it is challenging to evaluate the impact of diffuse community interventions that aim to effect policy change, which generally takes years to accomplish. At the time of the 2006 IER, it was too early to assess the effectiveness of efforts to reduce tobacco industry retail advertising, but we recommended targeting advocacy strategies on large grocery stores and pharmacies that rely less on financial incentives provided by the tobacco industry. Partner efforts to promote smoke-free movies focused on educating the community about the issue and influencing the Motion Picture Association of America's (MPAA's) rating of movies, but it is difficult to associate these advocacy efforts with national change. We recommended that partners focus on continued advocacy for policy change rather than on broad-based community education. Partner efforts to promote tobacco-free magazines have resulted in an agreement with publishers to provide editions to schools that are free of tobacco advertising. We recommended that partners expand the number of magazines covered by the agreement. Finally, a year after implementation, we found that Cessation Centers had shown they had built capacity and increased efforts to promote cessation in health care settings, but no outcome data were available to assess their impact.

This chapter reviews partner efforts and changes in strategy over the past year, assesses available outcome data, and draws conclusions about the value of these efforts.

5.2 Cessation Centers

5.2.1 Overview of Cessation Center Initiative

NYTCP funds 19 Cessation Centers that focus on one primary objective: to increase the number of health care provider organizations that have a system to screen all patients for tobacco use, provide brief advice to quit at all visits, and provide assistance to quit successfully. Brief advice to quit smoking by a health care provider significantly increases the odds that a smoker will quit (Lancaster and Stead, 2004). Cessation Centers use the Public Health Service's clinical practice guideline on treating tobacco use and dependence to guide their work. This document provides a framework for cessation interventions with health care providers, recommending consistent identification and treatment of tobacco use, as well as implementation of organizational policies and systems to institutionalize cessation practices (Fiore et al., 2000). Comprehensive tobacco control programs can help ensure that health care organizations implement systems to support the guidelines and that providers are educated on effective systems and practices and provided with materials to facilitate implementation of the guideline's recommendations.

Cessation Centers advocate with health care administrators and providers to incorporate the clinical practice guideline into their policies and systems. They also encourage providers to (1) treat tobacco use and dependence, (2) promote Medicaid patients' use of New York State's Medicaid coverage of pharmacotherapy for smoking cessation, and (3) refer tobacco users to the New York State Smokers' Quitline. In the following sections, we describe Cessation Center efforts to institutionalize tobacco use identification and intervention in health care organizations across New York State. To evaluate their progress, we describe health care provider organization changes during the first two years of the Cessation Center initiative. These changes are documented by the following short-, intermediate-, and long-term key outcome indicators:

- awareness of and contact with Cessation Centers,
- awareness of the New York State Smokers' Quitline and Medicaid cessation benefits,
- written clinical guidelines for diagnosing and treating tobacco dependence treatment (hospitals) or a tobacco treatment standard of care for primary care practices,
- presence of systems that screen all patients for tobacco use and prompt providers to provide brief advice to quit, and
- provision of brief advice to quit.

Institutionalized clinical practice guidelines should result in more smokers being advised to quit by health care professionals and offered effective treatment. Therefore, we examine Adult Tobacco Survey (ATS) data to assess changes in the percentage of smokers who report that they were asked if they use tobacco, advised to quit, and provided assistance to quit. We consider whether Cessation Centers have made measurable progress over the past year and weigh the potential for impact, concluding with recommendations to maximize their effect.

5.2.2 Cessation Center Efforts to Promote Tobacco Use Screening and Intervention

Cessation Centers advocate for health care organizations to implement the Public Health Service guideline, including the "5As," which describe steps health care providers should take: ask if the patient uses tobacco, advise them to quit, assess their readiness to quit, assist with a quit attempt, and arrange for follow-up (Fiore et al., 2000). To document Cessation Center programmatic efforts and impacts, we used (1) the Community Activity Tracking (CAT) system, (2) interviews with health care provider organizations as part of the Health Care Organization and Provider Study (HCOPS), (3) site visit interviews conducted with staff at 13 of the 19 Cessation Centers in late 2006, and (4) ATS data.

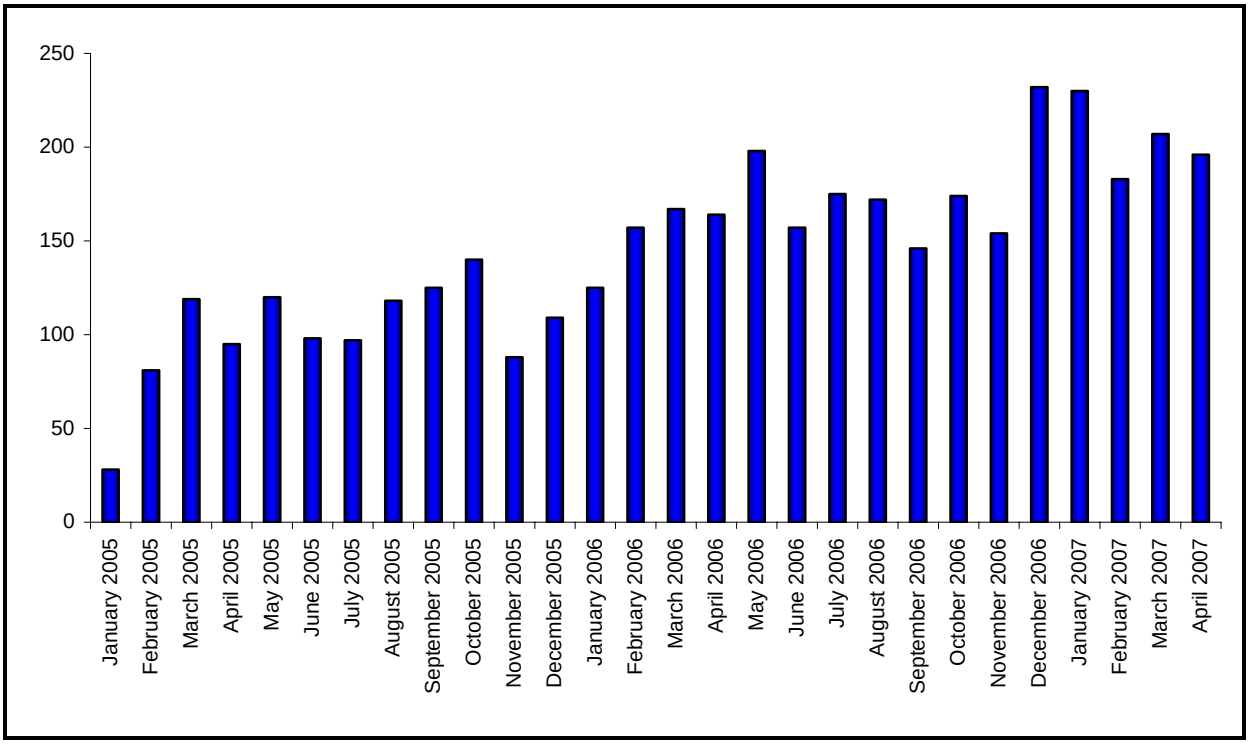
Cessation Centers enter information about their activities into the Community Activity Tracking (CAT) system. Monthly reports record Cessation Center contact with health care organizations, and quarterly reports record changes in targeted organizations' policy and practice. To date, two waves of HCOPS data have been collected: one in 2004–2005 and another (2 years later) in 2007. In the first wave, a sample of hospitals and medical practices within each of the 19 catchment areas served by the Cessation Centers were interviewed. All eligible hospitals in New York State were interviewed in 2007. This provides both longitudinal information to monitor hospital changes and greater precision to monitor area and statewide trends toward Cessation Center goals. In both survey administrations, we assessed staff knowledgeable about tobacco screening and assessment systems and practices in their organizations.

The ATS asks smokers a number of questions about their interactions with health care providers. These data provide a statewide perspective on health care providers' efforts to encourage smoking cessation.

Cessation Centers target hospitals, medical practices, outpatient clinics, dental offices, and substance abuse treatment centers and encourage them to implement tobacco use identification and treatment policies and systems. The process involves (1) identifying organizations interested in improving the way they address tobacco use, (2) engaging these organizations in a process to implement systems consistent with the Public Health Service's clinical practice guideline, (3) providing training and technical assistance to implement the systems, and (4) monitoring implementation and impact. In 2007, the Cessation Centers

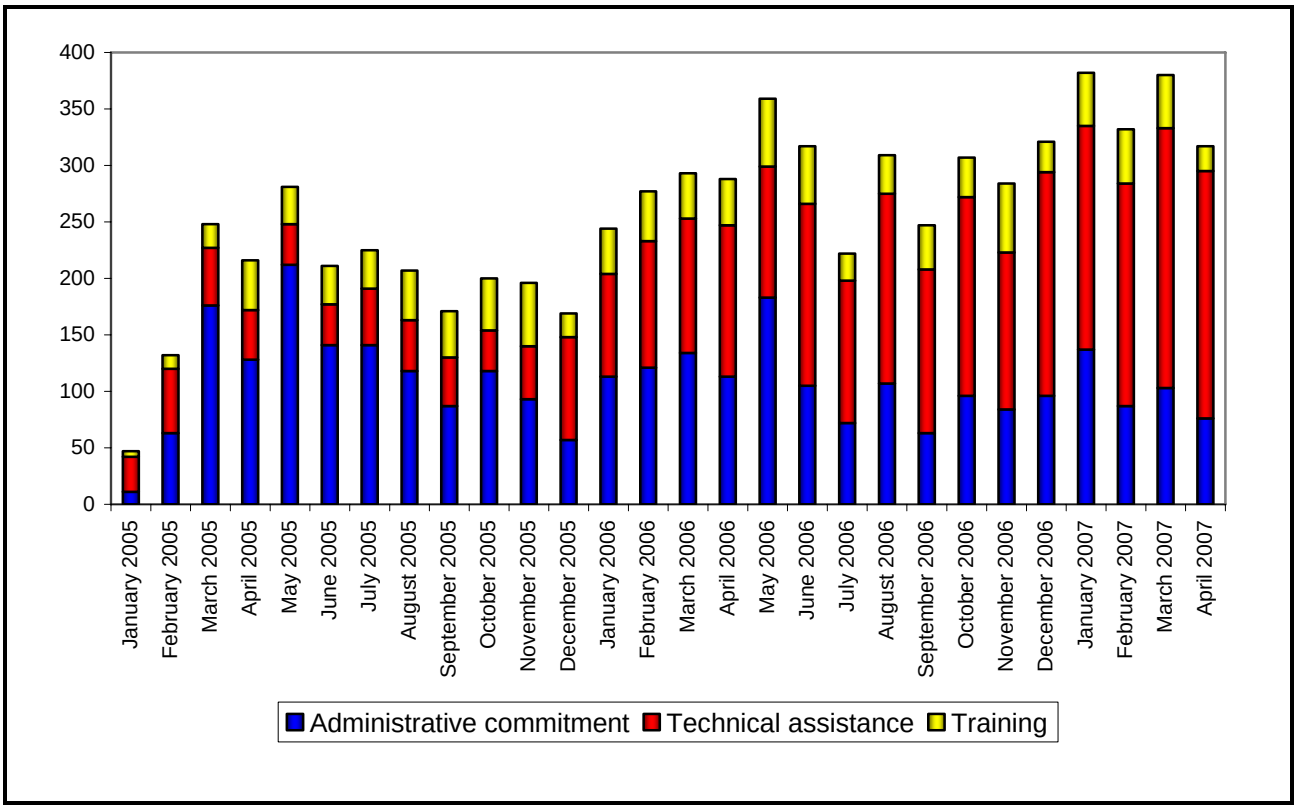
reported that they intend to engage 629 health care providers, up from 187 organizations in 2006. Medical practices make up much of the increase. The average number of organizations that Cessation Centers are actively working with each month increased by 31% from FY2006 to FY2007 (Exhibit 5-1), to about 600 organizations. This is consistent with the 25% increase in funding for the current fiscal year.

Exhibit 5-1. Number of Partnering Health Care Provider Organizations Actively Targeted by Cessation Centers, CAT System, January 2005–April 2007



As shown in Exhibit 5-2, the average number of monthly activities conducted by Cessation Centers also increased by 30% from FY2006 to FY2007. Consistent with the evolution of the Cessation Center initiative, Exhibit 5-2 shows that the proportion of activities focused on technical assistance has increased, whereas activities focused on engaging additional providers (administrative commitment) decreased and training activities remained stable.

Exhibit 5-2. Number and Type of Activities Conducted by Cessation Centers, CAT System, January 2005–April 2007

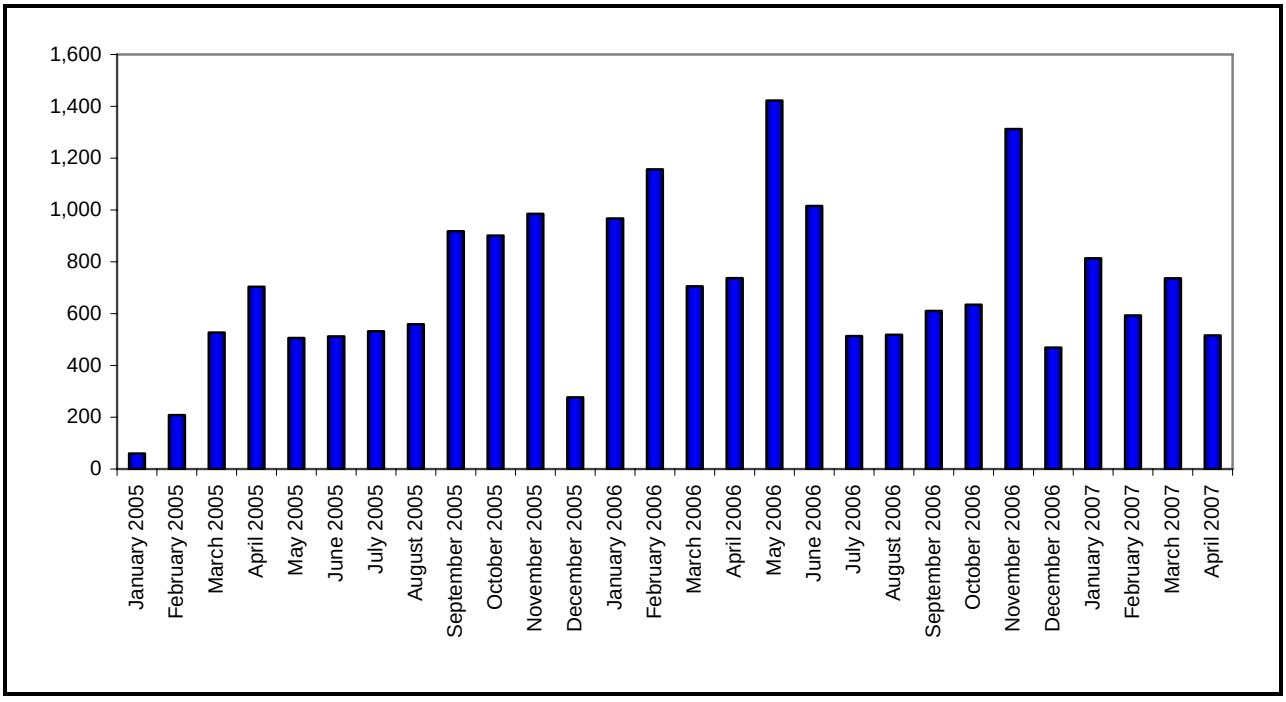


Administrative commitment activities include contacts (e.g., phone calls, e-mail, in-person meetings) with organizational administrators and providers at which information and materials are provided. The purpose of these meetings is to gain organizational support and commitment to institutionalize the Public Health Service guideline. Training involves direct provider training on treatment of tobacco use and dependence, the "5As" approach, and techniques for addressing tobacco use with patients. Technical assistance includes conducting follow-up visits to assess progress, provide guidance and feedback, distribute materials, and assist with policy change.

Cessation Center technical assistance and training includes "lunch and learns," where Cessation Center coordinators supply a meal for providers while they present information on cessation issues. This approach, also used successfully by pharmaceutical representatives, provides an opportunity to meet with providers in the very limited time they have available. Technical assistance also may involve providing and restocking materials, sharing news and techniques, collecting chart audit data, providing feedback on site progress, problem-solving, and helping keep providers motivated.

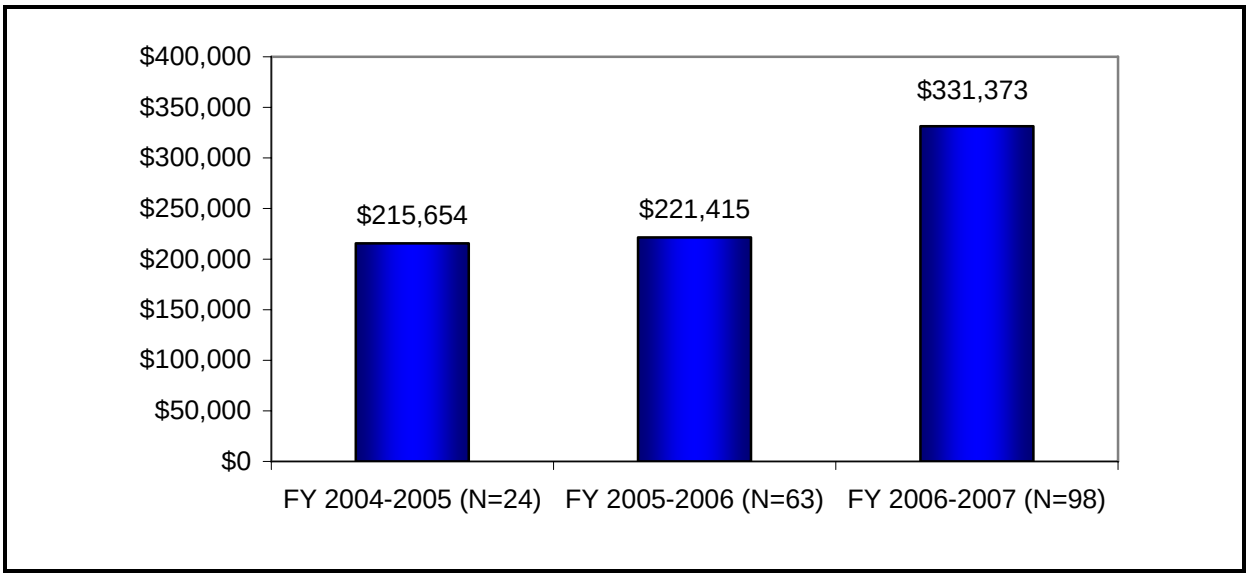
Cessation Centers focus on training health care organizations to include health provider training on tobacco assessment and intervention as part of their regular practice. However, Cessation Centers do offer direct cessation training to providers, and Exhibit 5-3 shows the number of health care providers they trained from January 2005 to April 2007. Cessation Centers reported training 9,151 providers during the 12 months from May 2006 to April 2007, and they trained 8,756 in the previous 12 months. Cumulatively, Cessation Centers have trained 19,612 health care providers in 1,079 trainings since January 2005.

Exhibit 5-3. Number of Health Care Providers Trained by Cessation Centers, CAT System, January 2005–April 2007



Cessation Centers also report in CAT on the stipends or mini-grants they provide to the health care provider organizations with which they are working. These stipends or mini-grants are offered to assist with changes to policy or systems, to make training opportunities available to health care providers, and to encourage (but not reimburse for) ongoing data collection. Exhibit 5-4 shows the amount of money provided, which has increased each year as the number of organizations receiving grants has increased. These counts relate to organizational awards and do not include payments to reimburse staff time spent collecting summary chart audit data for ongoing Cessation Center monitoring of provider compliance with tobacco recommendations.

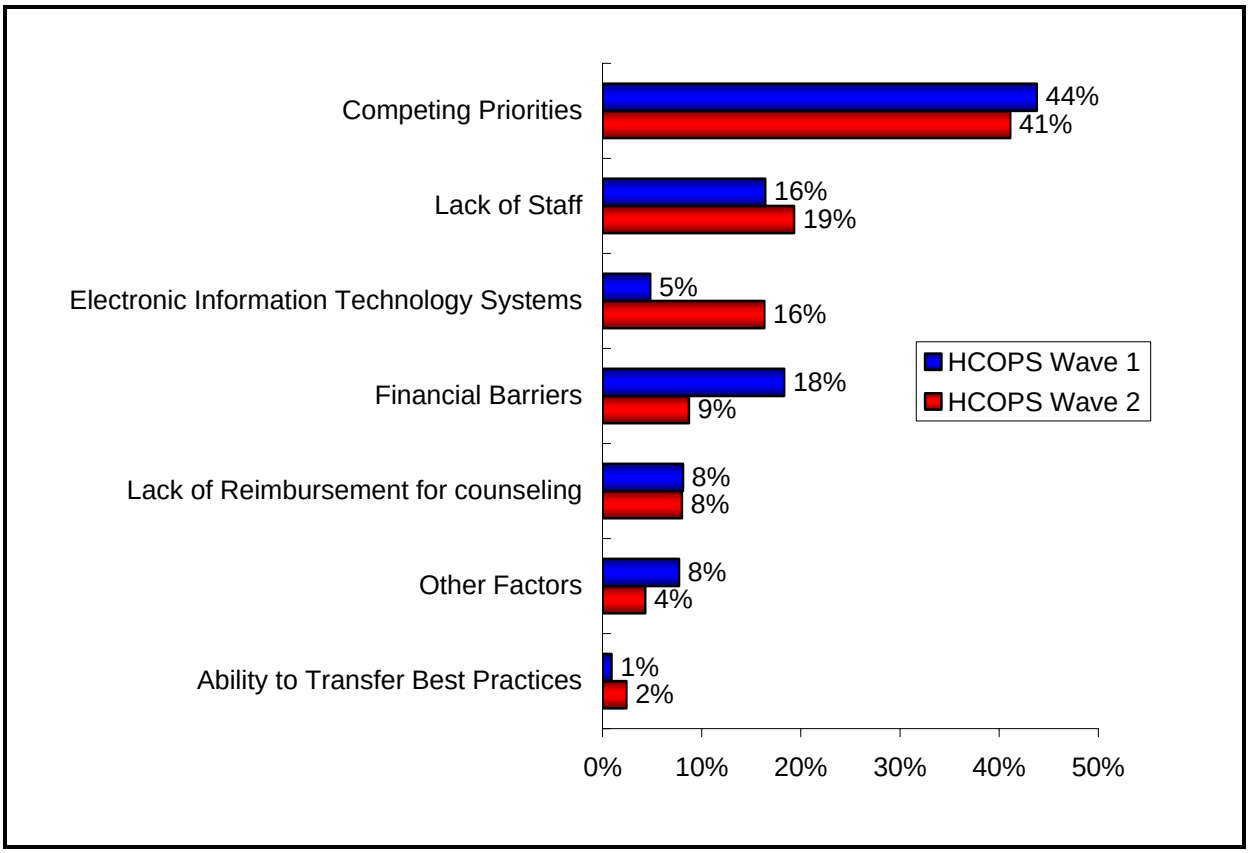
Exhibit 5-4. Stipends or Mini-Grants Awarded to Health Care Organizations by Cessation Centers, CAT System, FY 2004–2005 to FY 2006–2007



5.2.3 Opportunities and Challenges in Promoting Cessation in Health Care Provider Organizations

We identified common Cessation Center challenges by reviewing entries in the CAT system, HCOPS interviews, and site visit interviews. HCOPS interview questions asked health care organization administrators about barriers to implementing tobacco use screening and assessment systems at their organization. "Competing priorities" remained the most commonly reported barrier for health care provider organizations in both waves of the HCOPS (Exhibit 5-5). In wave 2, lack of staff (19%) was the second most frequently cited barrier, followed by lack of electronic information technology systems (16%) and financial barriers (9%) (financial barriers were the second most frequently mentioned barrier [18%] in wave 1). Based on site visit interviews with Cessation Center staff and CAT system reports, Cessation Center coordinators recognize these barriers. In addition, Cessation Center staff note additional barriers, including health care organization staff turnover and health care providers' reluctance to address tobacco use at every visit, especially during specialist and repeat obstetrical visits. At medical practices, the lack of pressure to maintain specific quality assurance practices for accreditation (as is required for hospital accreditation) posed a challenge not often found in hospitals.

Exhibit 5-5. Barriers Reported by Health Care Provider Organization Administrators, HCOPS Waves 1 and 2



Cessation Centers' approaches to improving provider organization receptivity, interaction, buy-in, and follow-through include provision of training and technical assistance in a timely and efficient manner, offers of mini-grants, and provision of nicotine replacement therapy (NRT) to provider offices for distribution to patients. Cessation Centers believe that trainings facilitated relationship-building by providing tools and resources and addressing misperceptions of Cessation Centers' roles. Another way Cessation Centers reported establishing a productive relationship was to work with hospitals interested in implementing a tobacco-free campus policy, helping them work through the policy change and through relationships established with that work, outlining the importance of having means to assess tobacco users' needs for treatment, and thus enhancing systems overall for tobacco use identification and treatment. Emphasis on the Cessation Center goals' alignment with Joint Commission on Accreditation of Healthcare Organizations (JCAHO) hospital accreditation requirements facilitated establishing, building, and maintaining relationships and progress with hospitals.

5.2.4 Assessing Changes in Health Care Provider Organization Outcomes

We used data from Waves 1 and 2 of HCOPS to document changes in health care provider organization administrators' awareness of key NYTCP-sponsored cessation resources, written clinical guidelines for diagnosing and treating tobacco dependence, and systems that screen all patients for tobacco use and prompt providers to provide brief advice to quit. In Exhibit 5-6, we present changes in health care organizations' awareness of the tobacco Cessation Centers funded by NYTCP between the two waves of HCOPS. Because Wave 2 included a census of all health care provider organization administrators, no confidence intervals are reported for the Wave 2 statistics. A difference is considered statistically significant between the two waves if the Wave 2 value is outside of the confidence interval from Wave 1. Overall, between Wave 1 and 2, the percentage of health care organizations that reported being unaware of the state Cessation Centers decreased significantly from 53.1% to 19.4%, whereas the percentage who reported having been contacted by a Cessation Center increased by 150%.

Exhibit 5-6. Awareness of Cessation Centers among Health Care Organizations, HCOPS Waves 1 and 2

	Wave 1	Wave 2	Wave 2 Including Additional Information from New Questions
Not aware	53.1% (45.2, 60.9)	28.9%	19.4%
Aware but no direct contact	21.0% (14.5, 29.4)	24.4%	15.7%
Aware and had contact[a]	25.9% (20.9, 31.6)	46.7%	65.0%

[a]Includes respondents who reported having had contact with a Cessation Center, who reported working with a Cessation Center to develop systems, and who reported being a Cessation Center.

A similar pattern was seen with regard to related cessation services (Exhibit 5-7). Specifically, awareness of the Medicaid pharmaceutical benefit increased from 61% in Wave 1 to 72% in Wave 2, awareness of the New York State Smokers' Quitline increased from 80% in Wave 1 to 97% in Wave 2, and the percentage of administrators who were aware of the Quitline that stated that their organization refers patients to the Quitline increased from 74% to 89%. Awareness of the Quitline's 2-week starter NRT kit increased from 67% to 88%, and awareness of the Fax-to-Quit program increased from 66% to 74%.

Exhibit 5-7. Awareness of Other NYTCP Cessation Promotion Activities among Health Care Organizations, HCOPS Waves 1 and 2

	Wave 1	Wave 2
Awareness of Medicaid benefit	61.0% (52.3, 69.1)	71.5%
Awareness of Quitline	79.7% (71.6, 85.9)	96.7%
Organization refers patients to Quitline (among those who were aware of the Quitline)	74.4% (61.7, 84.0)	89.3%
Awareness of specific Quitline programs among HCPOs aware of Quitline		
Free 2-week starter kit	67.0% (57.9, 74.9)	87.6%
Fax referral program	65.6% (57.1, 73.3)	73.7%

Note: HCPO = health care provider organization

Exhibit 5-8 presents the percentage of organizations that had written clinical guidelines or protocols for diagnosing and treating tobacco dependence. This percentage increased from 38% in Wave 1 to 56% in Wave 2. Another important indicator of Cessation Center impact is the presence of systems that (1) cue providers to determine a patient's smoking status, (2) document that status, and (3) document any interventions to address tobacco use. Overall, there was no change in the percentage of organizations that provided systems to cue or prompt providers to determine smoking status (see Exhibit 5-8). There was also no change in the percentage of organizations that provided both cue and documentation systems for their health care providers. These results are confirmed by CAT reports of policies and procedures. Cue systems cue providers to "Ask" and "Advise." Document systems prompt providers to document tobacco use status and cessation interventions. Written progress notes within the medical records constitute documentation of status and interventions.

Exhibit 5-8. Presence of Clinical Guidelines and Systems that Cue Providers among Health Care Organizations, HCOPS Waves 1 and 2

	Wave 1	Wave 2
Percentage of HCPOs with written clinical guidelines/ protocols for diagnosing and treating tobacco dependence	37.5% (29.6, 46.2)	55.9%
Cue systems	64.9% (56.2, 72.6)	69.4%
Both cue and document systems	53.4% (45.2, 61.4)	57.4%

Note: HCPO = health care provider organization

5.2.5 Trends in Related Measures from the Adult Tobacco Surveys

To monitor New Yorkers' self-reports of their health care providers' behavior, we analyzed data from the ATS. All respondents are asked if they have visited a doctor, nurse, or other health professional. Current smokers are asked whether any doctor, nurse, or health professional (1) asked if they smoked, (2) advised them to quit smoking, and (3) assisted them in their cessation efforts by doing any of the following:

- Prescribe or recommend a nicotine patch, nicotine gum, nasal spray, an inhaler, or pills such as Zyban?
- Suggest that you set a specific date to stop smoking?
- Suggest that you use a smoking cessation class, program, or counseling?
- Suggest that you call a telephone quitline?
- Provide you with booklets, videos, or other materials to help you quit smoking on your own?
- Schedule a follow-up visit to discuss your progress?

Based on these questions, we constructed three indicators of provider efforts to promote cessation: (1) asking smokers if they smoke, (2) advising smokers to quit, and (3) providing assistance for quitting based on a positive response to any of the six questions listed above.

Data from the ATS show that, among adult smokers who visited a health care provider in the past 12 months, the percentage who were asked about their smoking status and advised to quit by their health care provider has remained unchanged since 2003 (Exhibits 5-9 and 5-10). In contrast, the percentage of smokers who reported receiving assistance with quitting from their health care provider increased significantly from 2003 (37%) to 2006 (45%) (Exhibit 5-11), with the increase primarily occurring by 2005.

Exhibit 5-9. Percentage of Adult Smokers That Were Asked If They Smoked When They Visited a Health Care Provider in the Past 12 Months, ATS 2003–2006

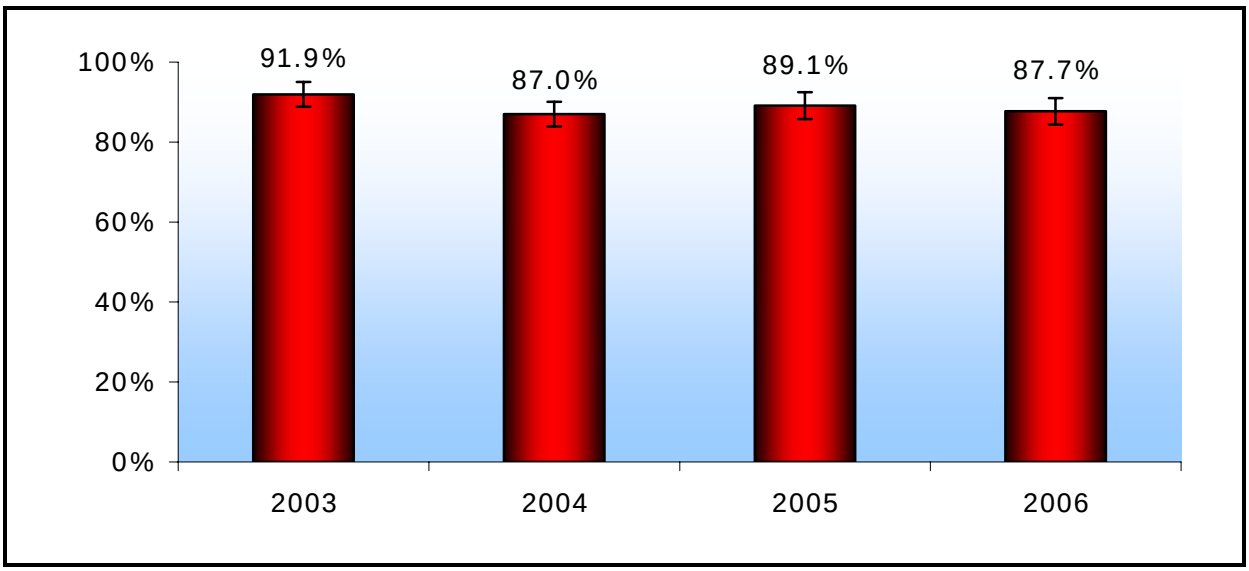


Exhibit 5-10. Percentage of Adult Smokers That Were Advised to Quit Smoking When They Visited a Health Care Provider in the Past 12 Months, ATS 2003–2006

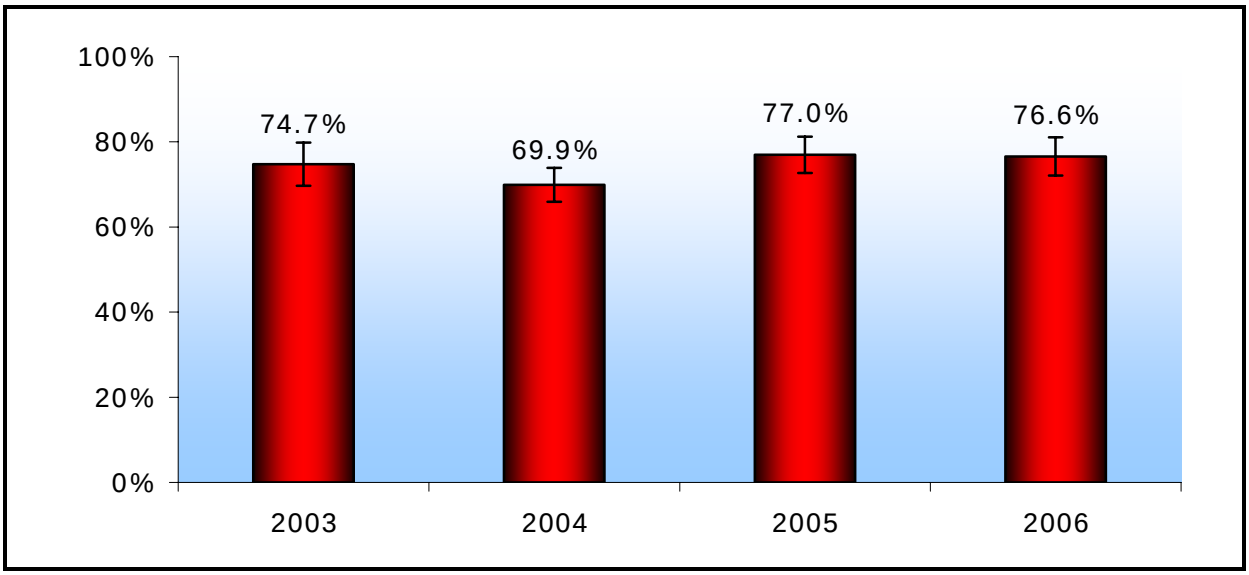
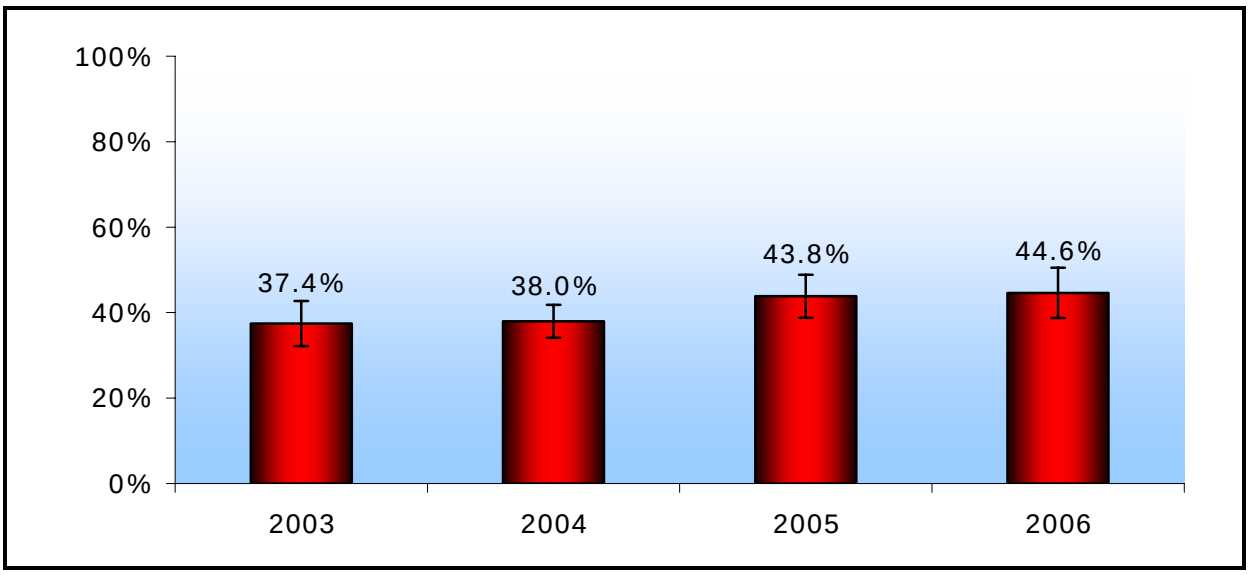


Exhibit 5-11. Percentage of Adult Smokers Who Report that their Health Care Provider Assisted Them with Smoking Cessation When They Visited a Health Care Provider in the Past 12 Months, ATS 2003–2006



Note: Statistically significant upward trend from 2003 to 2006.

5.2.6 Programmatic Implications

The Cessation Centers have made progress during their first 2 years in operation. In the past year, the Cessation Centers have increased the total number of activities they implemented by 37% over the previous year, and they have shifted from obtaining buy-in from health care provider organizations to providing technical assistance to organizations with whom they are collaborating, consistent with the level of maturity of the program and a 25% budget increase in August 2006. Cessation Center efforts have translated into increases in health care provider organization administrators' awareness of and contact with Cessation Centers. Nearly two-thirds of administrators reported having contact with a Cessation Center in 2007. Their awareness of the New York State Smokers' Quitline and related resources (e.g., Fax-to-Quit, free NRT starter kits) also increased from the baseline collection. More importantly, the percentage of health care provider organizations with written guidelines for diagnosing and treating tobacco dependence increased from 38% to 56% from the first to the second wave of data collection.

To date, we have not seen a change in the percentage of health care provider organizations with systems to cue providers to ask all patients if they use tobacco and advise them to quit. Although the literature affirms that system change is an evidence-based strategy, it provides little guidance about the time frame for accomplishing such a change. It is possible that sufficient time has not yet passed to allow for Cessation Center activities to make measurable progress toward meeting this goal. One study reported substantial implementation of system-level change within 2 years (Orleans et al., 2006; Fisher et al.,

2005), but this is probably a best case scenario because the hospitals in this case were willing partners in an intervention study. Implementation and organizational change probably occur more slowly in practice.

It is possible that change within organizations is incremental in the sense that the observed change in written guidelines within some organizations is an initial change that will be followed by broader system-level changes in the future. A benefit of establishing system-level change is that such changes can affect health care provider and hence smokers' behaviors for years to come with little support from NYTCP. In other words, effecting system-level changes may require greater up-front investments but may provide more lasting changes than the provision of cessation services such as the Quitline.

The barriers to the Cessation Centers' work are well-documented and intuitive: that health care administrators and providers have little time to interact with Cessation Center staff and have a number of competing priorities. Together, these data suggest that, although the Cessation Centers have done well in raising awareness of their efforts and making contact with health care provider organizations, they are faced with challenges that will require time and resources to overcome. Some Cessation Centers report that the lack of regulatory pressure to maintain specific quality assurance practices is an additional barrier for medical practices compared with hospitals. Thus, as the Cessation Centers branch out beyond hospitals to medical practices, they may face less support.

Another important consideration for the Cessation Center initiative is that most primary care is delivered outside of hospitals in independent medical practices. Data from the 2004 Medical Expenditure Panel Survey (MEPS) indicates that 92% of smokers' health care provider visits occur in office-based settings and 8% take place in hospital settings. In New York, there are approximately 2,155 group medical practices with two or more physicians. Together, these statistics suggest that Cessation Centers need to identify strategies to substantially extend their reach and effectiveness with medical practices if they are to have a significant statewide impact. In the past year, they have been exploring mass media approaches to reach a greater number of health care providers and build support for their work, which may prove to be an effective strategy. In conclusion, the Cessation Centers are making progress in their efforts to influence targeted organizations, but the long-term impact of this initiative statewide remains unclear.

5.3 Community Partnerships

5.3.1 Overview

NYTCP funds 29 Community Partnerships to mobilize communities to change norms which in turn reduces tobacco use. Community Partnership strategies have evolved over time, with efforts since 2004 focusing on decreasing the social acceptability of tobacco use by

- reducing the amount of tobacco advertising in the retail environment;

- decreasing tobacco industry sponsorship and promotion; and
- promoting the adoption of policies prohibiting tobacco use in outdoor areas, such as playgrounds, parks, beaches, and building entranceways.

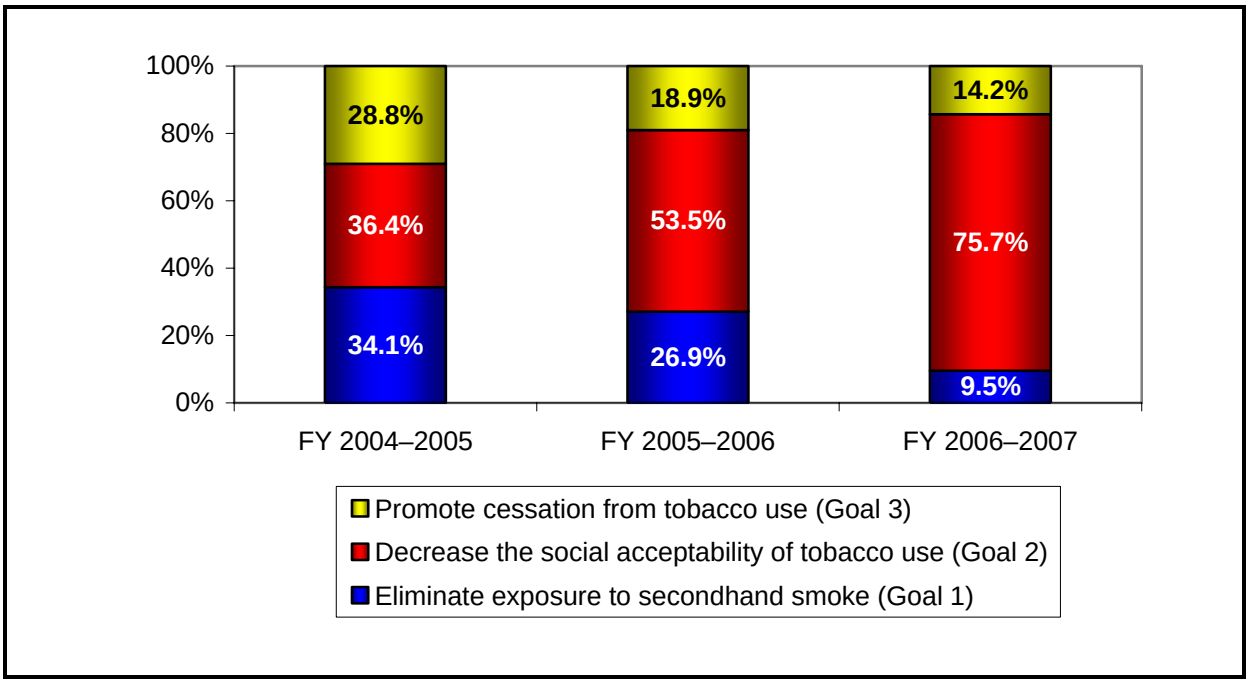
Information is entered monthly into CAT, which documents activities related to advocating with decision makers, paid media, community education, and policies and resolutions that have been adopted. The CAT system also captures data on policy changes, challenges encountered, and factors that contributed to successes. To assess the impact of efforts to reduce tobacco advertising in the retail environment, we relied on the Retail Advertising of Tobacco Study (RATS) that provides statewide data on the amount of indoor and outdoor advertising and the percentage of stores with promotions for cigarettes. Accurately assessing the impact of the Partnerships on sponsorship and promotion is more challenging because we do not yet have a system to track the true extent of tobacco industry sponsorship and promotion statewide. We do capture the number of related policies and resolutions that have been adopted by targeted organizations, but it is difficult to put these changes into perspective without a more systematic system for capturing the extent of the problem. Community Partnerships also report in the CAT system the number of local ordinances and resolutions that have been adopted in their communities. Support for these policies is also captured in the ATS. We assess the potential impact of Community Partnership efforts on programmatic objectives by reviewing available qualitative and quantitative process data and outcome data.

5.3.2 Description of Community Partnership Activities

At the direction of the NYTCP leadership, Community Partnerships have increasingly focused their efforts on decreasing the social acceptability of tobacco as a proportion of their reported activities, as shown in Exhibit 5-12. The shift away from activities aimed at eliminating exposure to SHS resulted from a decrease in effort advocating for smoke-free laws in the wake of the 2003 Clean Indoor Air Act and a lack of available evidence-based strategies for promoting smoke-free homes (with the exception of mass media). Remaining efforts focus on statewide paid media to educate the public about the dangers of exposure to secondhand smoke and limited efforts to advocate for smoke-free multi-unit dwelling policies. In addition, the Community Partnerships shifted their focus away from promoting cessation and toward the Advertising, Sponsorship, and Promotion (ASP) Statewide Initiative.

Partnership activities to decrease the social acceptability of tobacco use are grouped within the statewide "ASP" initiative to reduce or eliminate tobacco company advertising (A), sponsorship (S), and promotion (P) of tobacco products. The decreased social acceptability of smoking that occurred as a result of antismoking campaigns during the latter half of the

Exhibit 5-12. Distribution of Community Partnership Activities per Goal, CAT System, FY 2004–2005 to FY 2006–2007



Note: Goal 4 (prevent initiation of smoking by youth and young adults) is not included because it made up less than 1% of Community Partnership activities for each fiscal year.

20th century has consistently been cited as a factor in the concomitant drop in tobacco use during this period (USDHHS, 1989; Warner, 1977, 1989a, 1989b).Within the goal of decreasing the social acceptability of tobacco use, Community Partnerships conduct a variety of activities, including

- advocating with cigarette retailers to decrease tobacco advertising in the retail environment;
- encouraging community organizations to adopt policies prohibiting tobacco industry sponsorship;
- educating bar owners, event planners, and venues on reasons to establish policies to prohibit tobacco promotion; and
- advocating for adoption of policies prohibiting tobacco use in outdoor areas, including parks, playgrounds, and building entryways.

The first three sets of activities constitute the ASP activities and represented a new direction for community mobilization in New York when it began in January 2005. As noted in previous IERs, the ASP initiative is an effort to counter important tobacco industry influences. However, it also represents a new frontier as few states have developed and implemented such a comprehensive effort to curb tobacco industry influence. As a result,

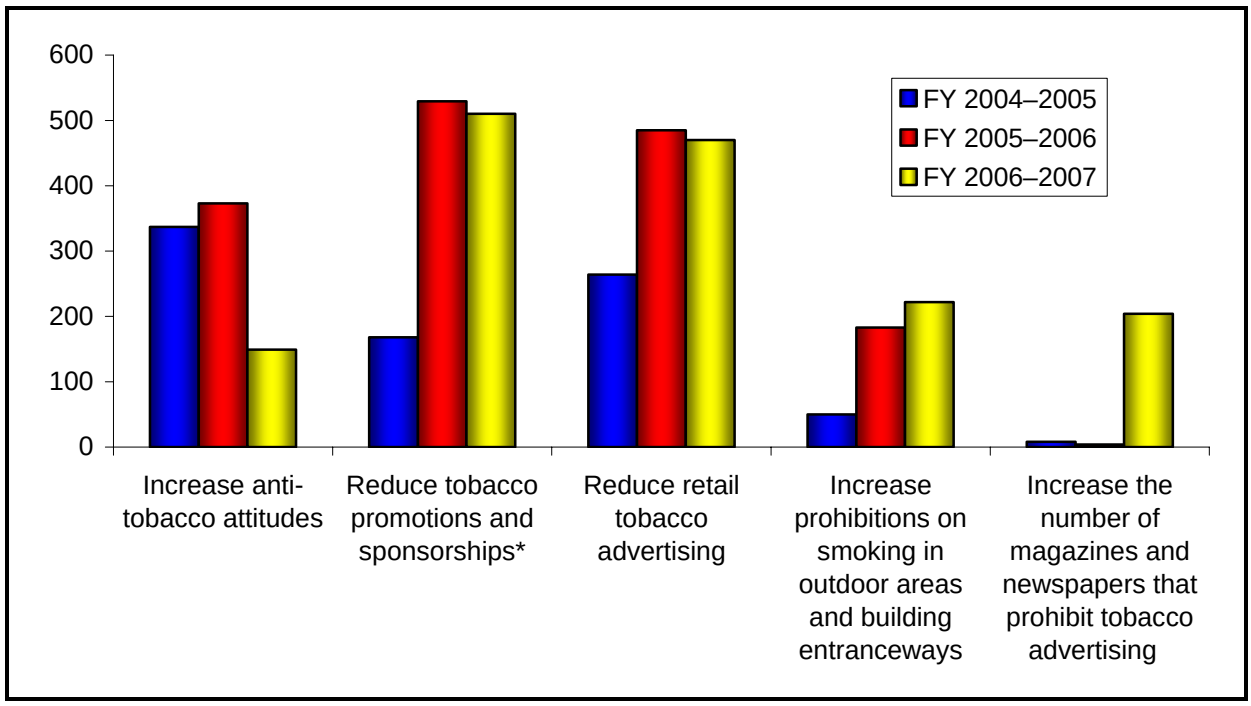
there is not an extensive evidence base of interventions for NYTCP to draw on. Therefore, it will take time to develop and fully implement this new initiative. At its inception, it was expected that Community Partnerships would go through a period of planning and training, followed by a period of initial implementation when Partnerships would begin to explore what strategies might prove to be effective.

Exhibit 5-13 shows the change in activities by objective over time with the goal of decreasing the social acceptability of tobacco use. This exhibit shows that in all years these top three activities Community Partnerships reported were those to increase antitobacco attitudes, reduce tobacco promotions and sponsorships, and reduce tobacco retail advertising. In 2005, in response to the ASP Initiative, there was a marked increase in activities to reduce tobacco promotions and sponsorships and reduce tobacco retail advertising. In 2007, however, activities to increase antitobacco attitudes decreased markedly, whereas activities to increase the number of magazines and newspapers prohibiting tobacco advertising increased significantly. The changes document the Community Partnerships' adoption of NYTCP directives. In addition, the decrease in activities to increase antitobacco attitudes represents the combination of greater specificity in activities driven by the ASP Initiative and an artifact of Community Partnerships initially using this as a "catch-all" category.

In addition to shifting the content of their activities, the strategies that Community Partnerships have used to achieve program objectives have also changed from January 2005 to April 2007. These strategy types, known as focus areas in the CAT system, include

- community education,
- policy advocacy targeted to organizational decision makers,
- paid media,
- government policy maker education,
- surveys, and
- surveillance of organizational policies and practices.

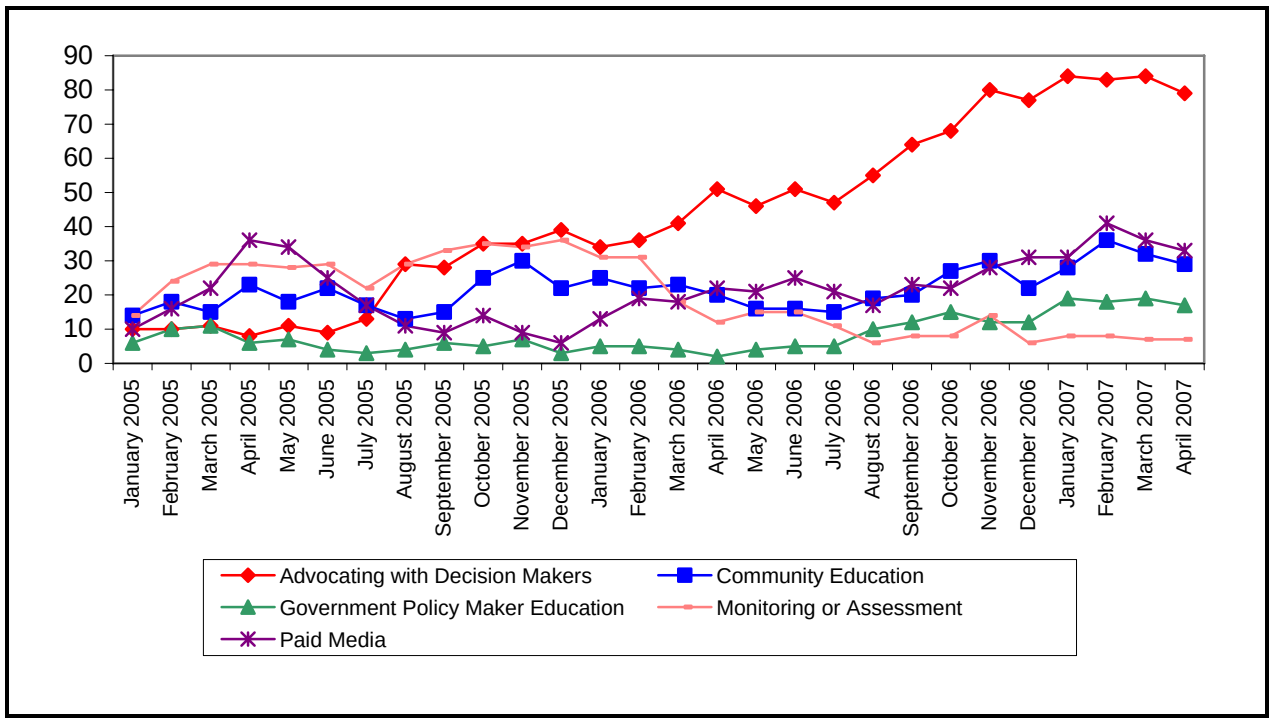
Exhibit 5-13. Community Partnership Activities per Objective within the Goal of Reducing Social Acceptability of Tobacco Use, CAT System, FY 2004–2005 to FY 2006–2007



*Combines three objectives: (1) increase the number of sporting, cultural, entertainment, art, and other events that have written policy prohibiting tobacco industry sponsorship; (2) reduce tobacco promotions in sporting, cultural, entertainment, art and other events in community, region, and state; and (3) reduce tobacco promotions occurring in bars, fraternities, and other "adult only" facilities.

Exhibit 5-14 shows how the type of activities that Community Partnerships conduct over time has changed for all objectives related to the goal of decreasing the social acceptability of tobacco use. Although there has been some variation in the type of activities Community Partnerships conducted, a notable trend is a continuous increase in advocacy with decision makers and a continuous decrease in community education. This indicates a change of approach from broadly disseminating information to community members to encouraging organizations to change their policies and practices. Paid media has remained relatively consistent, and other strategies have decreased. In addition, the overall number of activities increased beginning in August 2006 as a result of a 17% budget increase.

Exhibit 5-14. Community Partnership Activities per Focus Area within the Goal of Reducing the Social Acceptability of Tobacco Use, CAT System, January 2005–April 2007



The following sections address Community Partnership activities, focusing on several key objectives: retail tobacco advertising, tobacco industry sponsorship and promotion, and policies regarding tobacco use in outdoor areas.

5.3.3 Tobacco Advertising in Retail Outlets

Total advertising and promotional expenditures by the five major cigarette manufacturers were $13.11 billion in 2005, down from an historic peak of $15.15 billion in 2003 (FTC, 2007). As in previous years, the largest single category of expenditure was for incentive programs that ultimately reduce the price of cigarettes to consumers. This one category accounted for $9.78 billion (74.6% of all expenditures) in 2005. If these expenditures are spread proportionally across the country, this would imply that the industry spent an estimated $836 million in New York State on cigarette advertising and promotions in 2003, or $45 per New Yorker.

Retail cigarette advertising (e.g., signs, displays, functional items) and promotion (e.g., price discounts, buy-one-get-one-free type offers) is widespread in the United States (Terry-McElrath et al., 2002). In the 2006 IER, we found that 96% of cigarette retailers had either interior or exterior cigarette advertising. Furthermore, there is evidence that states with comprehensive tobacco control programs may experience higher levels of cigarette

advertising and promotion than states without such programs (Loomis, Farrelly, and Mann, 2006; Slater, Chaloupka, and Wakefield, 2001). A recent report showed that the percentage of total cigarette sales that is promoted was higher in New York State than in the remaining United States (Girlando et al., 2007). This report showed that in early 2005, 10% of all cigarettes sold were promoted compared with 2% in the remaining United States.

Retailer incentive programs are the primary mechanism through which cigarette companies influence the retail environment. The incentives offered to retailers include volume discounts, payments for prime shelf space and in-store displays, free signage, display racks, and functional items. For stores that sell large quantities of cigarettes, the incentive payments can be significant, reaching several thousand dollars per year (Feighery et al., 2004). In the only national study of tobacco retailer incentives, 65% of retailers reported participating in some form of cigarette company incentive program, and 80% of participants reported that cigarette companies controlled the placement of product and marketing materials in their stores (Feighery et al., 2004). Stores that participated in incentive programs (particularly those receiving the largest incentive payments) were more likely to have higher levels of cigarette advertising than stores not participating.

Promotions that lower the price of cigarettes, such as price discounts and buy-one-get-one-free type offers, are popular with smokers. Just over one-third of smokers will take advantage of a promotion every time they see one. Young adults, women, African-Americans, those with higher daily cigarette consumption, and those worried about the costs of smoking are most likely to use cigarette point-of-purchase promotions at every opportunity (White et al., 2005).

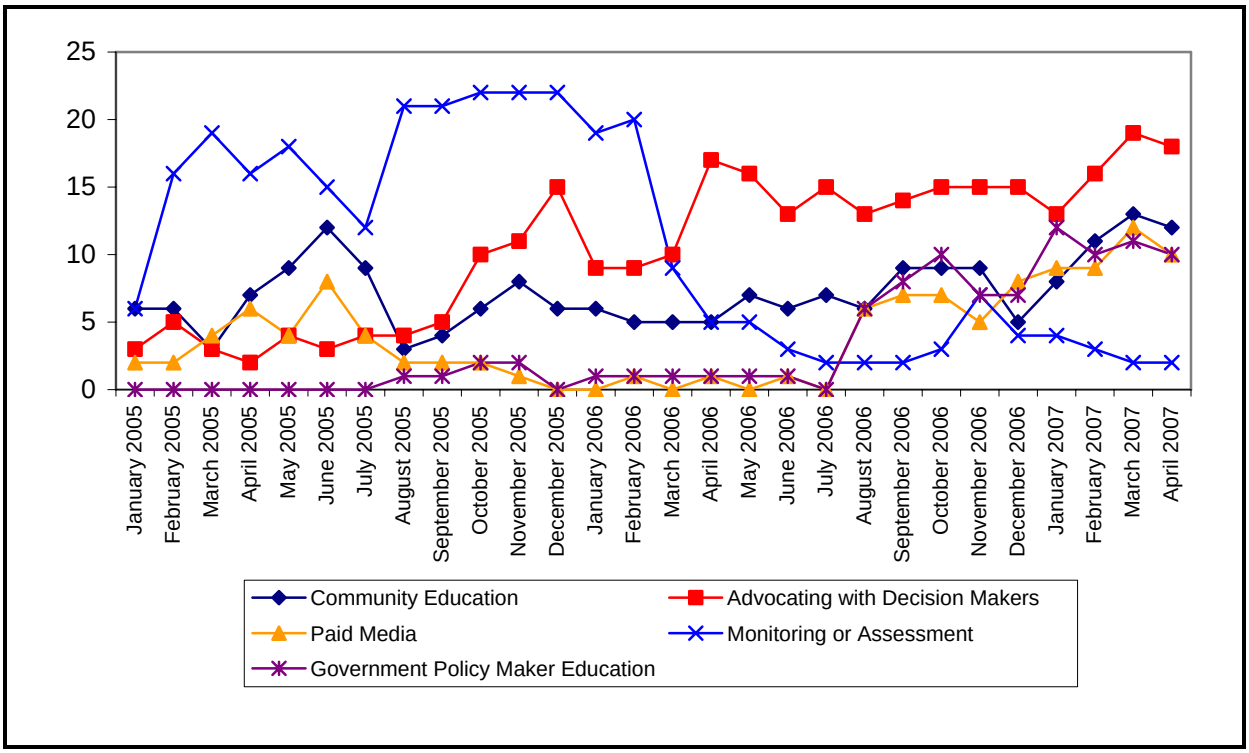
5.3.3.1 Programmatic Efforts to Reduce Retail Tobacco Advertising

NYTCP's Strategic Plan includes the following objective: reduce the amount of tobacco advertising in the retail environment. To assess progress in achieving this objective, RTI and NYTCP designed and implemented RATS. This system tracks point-of-purchase interior and exterior cigarette advertising, promotions (e.g., buy one get one free), prices, and product placement at licensed cigarette retail establishments in New York, beginning in November 2004. RTI also used data from the CAT system to document activities conducted, policy changes made, and notable barriers and solutions to addressing this issue from a community perspective, as well as qualitative interviews with Community Partnerships as part of the Community Partner Evaluation. The following sections detail partner efforts to decrease point-of-purchase and exterior advertising among New York tobacco retailers.

Community Partners addressed tobacco advertising in the retail environment through various strategies. Exhibit 5-15 shows the type of activity partners conducted related to

retail advertising between January 2005 and April 2007, based on entries in the CAT system. Community Partnerships most frequently engaged in advocacy with cigarette retailers. They also conducted an increased number of activities related to paid media and government policy maker education compared with previous years. The significant drop in monitoring/assessment activity is due primarily to shifting this activity to a paid contractor as part of the Independent Evaluation.

Exhibit 5-15. Community Partnership Strategies Related to Reducing Tobacco Advertising in the Retail Environment, CAT System, January 2005–April 2007



From August 2006 through April 2007, Community Partnerships primarily advocated with cigarette retailers, requesting that they voluntarily eliminate tobacco point-of-purchase advertising. A total of 17 of the 29 Community Partnerships reported targeting 120 cigarette retailers. They reported conducting 118 phone calls, conducting 64 in-person meetings, and sending 38 letters. Additionally, they sent 511 mass mailings to tobacco retailers. Community Partnerships also advocated with local officials. CAT data show that Community Partnerships made 52 presentations and wrote 141 letters to local officials requesting resolutions in support of reducing, rearranging, or eliminating tobacco retail advertising. Partners also ran paid media and conducted community education activities to raise awareness on this issue, including using "mock stores" that show how disproportionate

tobacco ads are compared with other types of advertising. Community Partnerships reported spending $56,428 on television ads, $25,965 on radio ads, and $10,113 on newspaper ads related to reducing tobacco advertising in the retail environment during this period. This represents less than 1% of the Community Partnership total budget.

Youth Partners also focused activities on this objective. CAT data show that they held meetings, made phone calls, and wrote letters on a smaller scale than the Community Partnerships to advocate for policy change. They also took part in community education events to raise awareness of this issue (data not shown).

The activities described in CAT show Community Partnerships targeted an average of seven tobacco retailers each, ranging from gas stations to grocery stores, delicatessens, and convenience stores.

Qualitative interviews by the Community Partner Evaluation team found that retailers were selected for intervention for a variety of reasons. Some partners sent out postcards and subsequently contacted retailers who responded. Some partners targeted stores with few ads, surmising they would be more likely to remove them, whereas others targeted stores with high numbers of ads because they felt changing those stores would make the biggest difference. Several partners approached municipalities from a beautification perspective, citing the ads as unsightly, or from a safety perspective, stating that ads in store windows block the view of what may be happening in the store. Community education efforts included sharing information and petition-signing at community events and using paid media to increase community awareness and subsequent mobilization on this issue. Community Partnerships have combined their efforts and targeted chain store corporate offices, advocating for tobacco product advertising policies that would apply to all of their stores.

Community Partnerships reported 11 earned media newspaper articles, three letters to the editor, and eight instances of radio or television earned media coverage related to tobacco retail activities. Community Partnerships reported that policies prohibiting tobacco advertisements were adopted by 41 stores, primarily at delis. However, it is unclear whether there was significant tobacco advertising at these delis before they adopted tobacco advertising bans. One policy was adopted by a grocery store and one at a pharmacy. Partners reported 20 municipality resolutions supporting these efforts. There were also 10 practice changes reported, most involving removal of exterior ads, as well as two regarding enforcement of an existing code or ordinance relating to advertising in general. Youth Partners conducted supporting activities related to reducing retail advertising.

5.3.3.2 Opportunities and Challenges in Decreasing Retail Tobacco Advertisements

Partners recorded barriers to their retail efforts and factors that facilitated change using the CAT system. In addition, Community Partnership interviews and two sessions from the 2006 Statewide Meeting focused on this issue. The following barriers to achieving this objective were identified:

- unreceptive (and sometimes hostile) tobacco retailers, most notably due to financial incentives from tobacco companies;
- replacement of cigarette advertisements by tobacco retailers or tobacco company representatives that were previously removed;
- failure by store owners to comprehend the impact of tobacco ads on youth initiation; and
- reports by store owners that cigarette branded functional items are useful (e.g., change trays, push/pull signs, trash cans, clocks).

Partners identified the following factors that could potentially facilitate achievement of this goal:

- using data in a compelling way, such as using photos and comparing the proportion of tobacco ads to other types of ads;
- replacing tobacco-promoting functional items with health-themed items;
- extending grocery store efforts to focus on health; and
- collaborating with Adolescent Tobacco Use Prevention Act enforcement to educate retailers and distribute information.

Community Partnerships have actively advocated for policy change with a number of retail chains, including Hannaford, Price Chopper, Wegmans, and Stewart's supermarkets. Hannaford officials stated that company policy prohibits youth-oriented displays on the tobacco kiosks and expressed willingness to enforce this policy. Hannaford is also piloting a program to place all tobacco products behind the customer service desk instead of in kiosks. The Price Chopper grocery store chain has agreed to cease advertising tobacco in its weekly flyers and is instituting a policy prohibiting children's merchandise from being displayed near tobacco products. Wegmans has discussed making Quitline materials available and removing ads for tobacco products from its weekly circular. Wegmans is also developing a policy regarding youth-oriented products near tobacco displays. After reports of initial progress with the Stewart's chain, efforts have stalled after the Partnerships reported receiving cold responses to their inquiries. Partnerships are planning additional advocacy with Stewart's, using published research articles and evidence of public support to promote their efforts.

Overall, Partnerships were frustrated by the difficulty and lack of experience they have working with retailers. Some have also expressed frustration that cigarette advertisements reappear in stores where they had worked to get them removed. They remained optimistic and determined to continue pursuing tobacco retailer policy change.

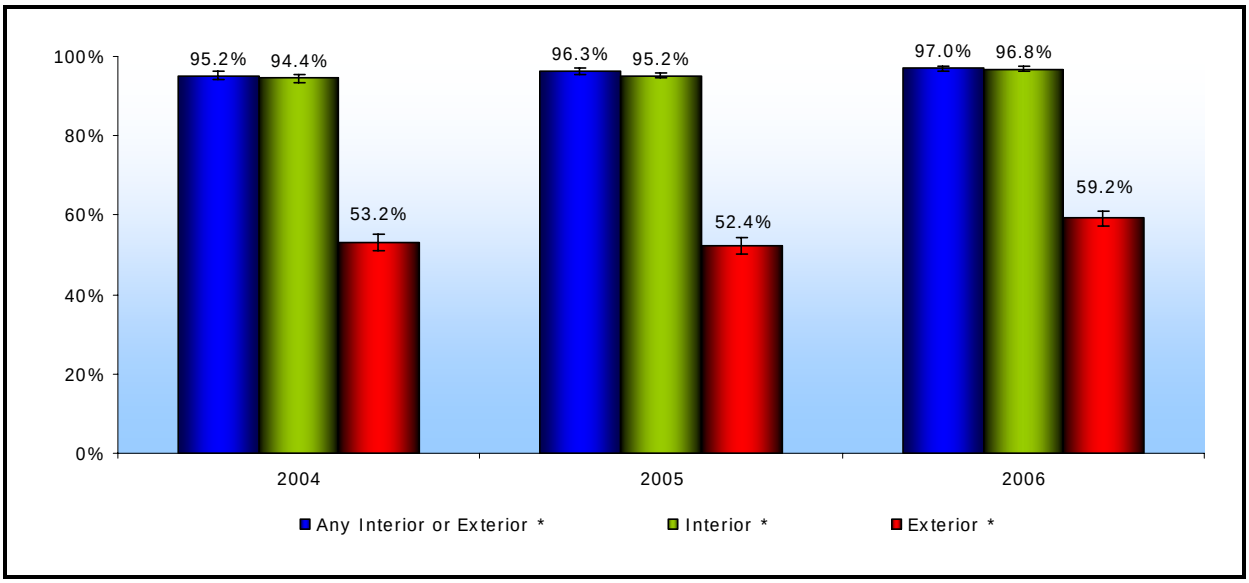
5.3.3.3 Reducing Tobacco Advertising and Promotions in the Retail Environment

As previously described, RATS tracks point-of-purchase interior and exterior cigarette advertising, promotions (e.g., buy-one-get-one-free), prices, and product placement at licensed cigarette retail establishments in New York, beginning in November 2004. This baseline data collection was performed by the subcontractor Research Diagnostics Inc. (RDI). RDI continued data collection in conjunction with New York partners from March 2005 through March 2006. Primary RATS data collection changed responsibility from the New York partners to RDI in June 2006.

The RATS data presented in this report were collected by RDI and NYTCP Community Partnerships between November 2004 and December 2006. A total 8,561 of surveys were collected. RDI collected 2,389 baseline surveys in November 2004; 1,123 surveys between March and December 2005; and 2,845 surveys between January and December 2006. NYTCP Community Partnerships collected 2,204 surveys between March 2005 and March 2006.

To capture the statewide prevalence of cigarette advertising, we examine the percent of retailers with interior or exterior cigarette advertising. Exhibit 5-16 presents trends in the prevalence of cigarette advertising overall and by whether the ads are interior or exterior. Overall, in 2006, 97% of retailers had interior or exterior ads, a significant increase from 2004 (95%). The percentage of retailers with interior ads, the driving force for the overall prevalence of cigarette ads, increased significantly from 94% in 2004 to 97% in 2006. Likewise, the percentage of retailers with exterior ads increased significantly from 53% in 2004 to 59% in 2006.

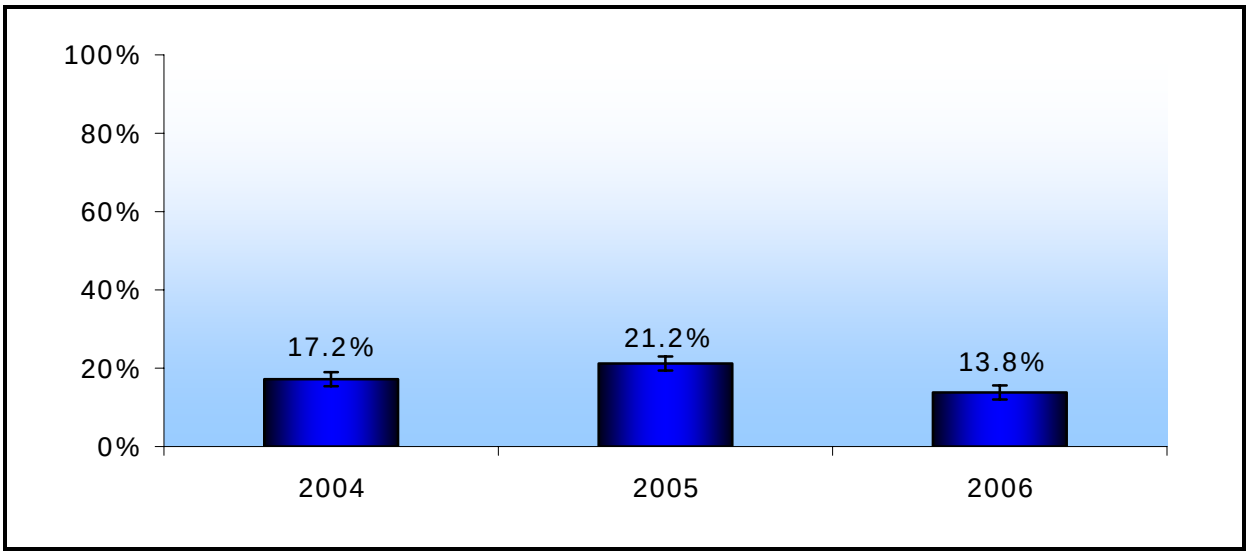
Exhibit 5-16. Percentage of Tobacco Retailers with Any Interior or Exterior Cigarette Advertising, RATS 2004–2006



*Statistically significant upward trend from 2004 to 2006.

In addition to monitoring interior and exterior advertising, we also examined the trend in the percentage of retailers selling cigarettes under a promotion, including buy-one-get-one-free, bundles (e.g., buy three for a given price), rebates, coupons and free gifts. Overall, we found a significant decreasing trend between 2004 (17%) and 2006 (14%) in the percentage of retailers selling cigarettes under a promotion (Exhibit 5-17).

Exhibit 5-17. Percentage of Tobacco Retailers with Any Cigarette Pack Purchase Promotions, RATS 2004–2006



Note: Statistically significant downward trend from 2004 to 2006.

5.3.3.4 Programmatic Implications for Decreasing Retail Tobacco Advertising

Reducing retail tobacco advertising is a worthy goal because of its influence on tobacco use, but achieving reductions of a magnitude that will significantly reduce smoking is a daunting task. Because of the tremendous financial leverage that tobacco companies have with retailers and the time that is required for the Community Partnerships to acquire the skills and tactics to successfully influence retailers, interventions that rely on voluntary compliance are not likely to have any meaningful effect for years to come. For ongoing efforts to curb cigarette advertising, the most promising course of action appears to be demanding strict enforcement of existing laws (as some Partnerships already do), advocating for ordinances that limit all forms of outdoor advertising, and putting pressure on politicians and communities to demand less advertising in retail stores.

In fact, over the past year Community Partnerships have shifted their focus somewhat by placing more emphasis on advocating with local officials to establish resolutions supporting the elimination of retail tobacco advertising, enforcing existing ordinances that limit outdoor advertising, and establishing new ordinances regarding all outdoor advertising. The fiscal year 2007–2008 Community Partnership and Youth Partner work plans require that Community Partnerships and Youth Partners include activities to obtain resolutions and ordinances in support of retail advertising reductions.

In the 2006 IER, we recommended that Community Partnerships concentrate their efforts on mass merchandisers, large grocery stores, and pharmacies because these retail channels are less likely to participate in tobacco industry incentive programs; have a lower percentage of stores with any exterior cigarette advertisements; and rely less on tobacco revenue as a percentage of total revenue than other channels. With respect to activities involving cigarette retailers, we continue to believe this is the best course of action. However, we recommend that NYTCP continue to sponsor focus groups with retailers and/or corporate officials from major chains to better understand what strategies might be effective to curb tobacco advertising. We also concur with the recent shift toward efforts to change local ordinances that restrict all forms of outdoor advertising, including tobacco.

5.3.4 Tobacco Industry Sponsorship and Promotion

As part of the ASP Initiative, NYTCP has identified tobacco industry sponsorship and promotion as important targets. Tobacco industry sponsorship includes funding events and organizations and enhances brand awareness and contributes to perceptions of tobacco use as normative and the tobacco industry as responsible corporate citizens (Rosenberg and Siegel, 2001). Tobacco promotions, consisting of giveaway events, contests, and events at bars and clubs, normalize tobacco use and have been associated with increases in young adult smoking prevalence (Rigotti et al., 2005; Katz and Lavack, 2002). The following objectives in the Strategic Plan focused on these efforts:

- Increase the number of sporting, cultural, entertainment, art, and other events that have a written policy prohibiting tobacco industry sponsorship.
- Reduce tobacco promotions in sporting, cultural, entertainment, art, and other events in the community, region, and state.
- Reduce tobacco promotions occurring in bars, fraternities, and other "adult only" facilities.

Community Partnerships focus a significant proportion of their work on trying to limit tobacco industry sponsorship and promotion. Approximately one-third of their efforts from 2006–2007 focused on activities related to reducing sponsorship and promotion. The following sections describe partner activities regarding sponsorship and promotion, based on CAT system reports. Currently, we have no comprehensive system for monitoring sponsorships and promotions. We relied on Community Partnerships' reports of organizations' voluntary policies limiting sponsorships and promotions.

5.3.4.1 Programmatic Efforts to Decrease Tobacco Industry Sponsorship and Promotion

Community Partnership activities focused on sponsorship and promotion are presented in Exhibit 5-18, which shows the type of activities over time. The majority of Partnership activities focused on sponsorship and promotion involve advocating with organizational decision makers to change their policies. Partner activities specific to tobacco industry sponsorship included persuading community organizations, venues, fairs, and businesses to adopt policies prohibiting acceptance of tobacco industry sponsorship. Activities included sending mailings to organizations requesting that they adopt a policy, sponsoring events with tobacco-free messages, running paid media advertisements, and conducting recognition events to bring positive attention to organizations that do pass policies. Partnerships reported in CAT that they sent targeted materials regarding sponsorship to 291 community organizations and 604 local event committees, and they distributed more than 3,000 letters in mass mailings. Many partners have campaigns on this issue titled "No Thanks Big Tobacco" and Web sites with information about this initiative that include sample policies and resolutions (see Exhibit 5-19). These efforts are directed to organizations that do not currently accept any tobacco industry funding and to those that do.

Exhibit 5-18. Community Partnership Strategies Related to Reducing Tobacco Sponsorship and Promotion, CAT System, January 2005–April 2007

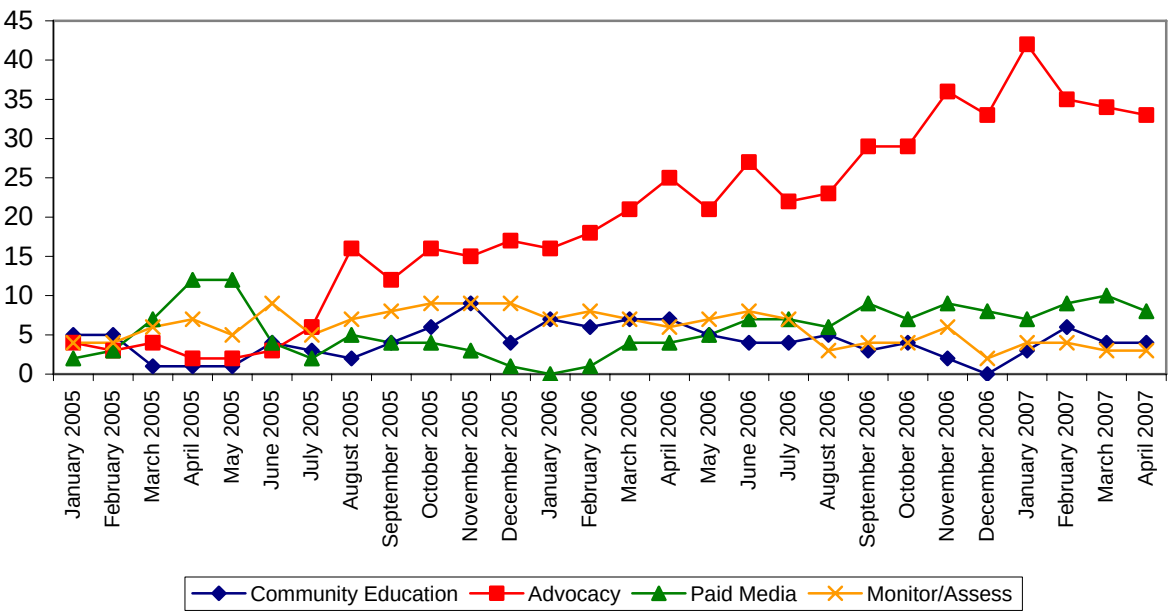


Exhibit 5-19. No Thanks Big Tobacco Web Site

Partnerships engaged in advocacy and paid media activities to eliminate tobacco industry promotions. Advocacy efforts included meeting with bar owners and event planners. Targeted letters were sent to 113 bars and 382 local event committees, and 1,550 letters were mass mailed to bars and nightclubs. Partners reported that 72 bars and nightclubs adopted policies prohibiting tobacco industry promotion. Partners reported in CAT that they mass mailed 995 letters to community organizations and 2,917 to local event committees regarding tobacco industry sponsorship policies. Partners also reported that 227 policies were adopted by community organizations, 12 by local event committees, and 2 by businesses. Community Partnerships reported 17 earned media newspaper articles focused on tobacco industry sponsorship strategies, as well as 12 instances of radio or television earned media.

Partnerships also focused efforts on eliminating tobacco sponsorship at the New York State Fair. Partnerships sent letters to the editor, sent letters to the State Fair director, and conducted a media campaign that targeted the State Fair director. These efforts and meetings between representatives from the New York State Department of Health, the Department of Agriculture, and the state fair culminated in this policy. In April 2007, it was announced that tobacco companies will not be allowed to sponsor any events on the fairgrounds, including the rodeo that the U.S. Smokeless Tobacco Company sponsored for several years (Nolan, 2007). The sale of tobacco products will no longer be allowed on the fairgrounds.

5.3.4.2 Opportunities and Challenges in Decreasing Tobacco Industry Sponsorship and Promotion

Partners described challenges they encountered in obtaining policies prohibiting tobacco sponsorship, including

- bureaucratic delays or "red tape" within organizations to officially adopt policies,
- organizations' hesitation to commit to a policy that would not allow them to accept money, and
- concerns about "policy" language sounding "too legal."

Partnerships believed that their successes in this area were attributable to their ability to leverage existing relationships that members had with community organizations and their ability to easily demonstrate to organizations that accepting tobacco sponsorship and promotion is antithetical to most organizational mission statements. Some Partnerships sponsored events or venues; they made continued sponsorship contingent on adopting an organizational policy rejecting tobacco industry sponsorship or promotion. One concern that we encountered was that Partnerships frequently mentioned the ease of getting commitments from organizations that have never had tobacco sponsorship. It is believed that demonstrating that organizations can be effective and successful without money from

tobacco companies will help build momentum and help establish a new community norm. The Partnerships accomplish this, in part, by publicly recognizing the organizations that have adopted policies rejecting tobacco industry sponsorship. To date, however, the Partnership successes have been primarily limited to low-impact targets.

With respect to efforts to prohibit tobacco promotions, a commonly reported barrier was difficulty in finding bars that have promotions. As a result, several Partnerships suspended their efforts because it was not perceived as a significant problem in their area. Others noted that bar owners' nontraditional hours made them difficult to reach, and a few found that bar owners were resistant because of lingering bitterness stemming from the Clean Indoor Air Act. Partnerships reported that including college students as advocates in their efforts facilitated policy adoption; as part of the tobacco industry's target audience, college students are more familiar with bar operations and events. Another successful strategy involved offering free publicity to bars that adopt policies restricting tobacco promotions.

5.3.4.3 Programmatic Implications: Sponsorship and Promotions

As previously noted, tobacco promotional efforts normalize tobacco use and have been associated with increases in young adult smoking. Dramatically curbing promotional efforts has the potential to decrease young adult smoking in the long-run. As with efforts to curb tobacco advertising in retail outlets, progress will be incremental. We urge Community Partnerships to limit their time and resources aimed at obtaining policies prohibiting tobacco promotion from bars, restaurants, and other organizations that have never accepted tobacco promotions in the past. We recommend focusing efforts where the Partnerships can have the greatest influence: bars frequented by young adults. Similarly, we recommend that Partnerships advocate for policy change with organizations that have received tobacco industry sponsorship in the past and investigate the potential for alternate funding for these organizations. Although this too will be challenging, we believe this would be a more efficient and effective use of Community Partnership resources.

5.3.5 Increasing Policies Prohibiting Tobacco Use in Outdoor Areas

The social acceptability of smoking decreased during the latter part of the 20th century, and this decrease is considered a major factor in the concomitant decreases in smoking prevalence (Burns, 1991). As a result, comprehensive tobacco control programs have focused both on changing individual smoking behavior and on changing the social environment to further decrease the social acceptability of smoking and promote and reinforce broader change. Restrictions on where people can smoke have been a key component of comprehensive tobacco control programs. Recently, new evidence has emerged suggesting that secondhand smoke exposure in outdoor areas may have a health impact (Klepeis, Ott, and Switzer, 2007). However, the rationale for prohibiting smoking in outdoor areas has been to create barriers (an environmental disincentive) to smoking and communicate that smoking is not a normative behavior (Burns, 1991; Thompson et al.,

1991). When enforced over time, formal rules (i.e., laws and policies) that restrict smoking are eventually internalized as social norms (Markle and Troyer, 1979).

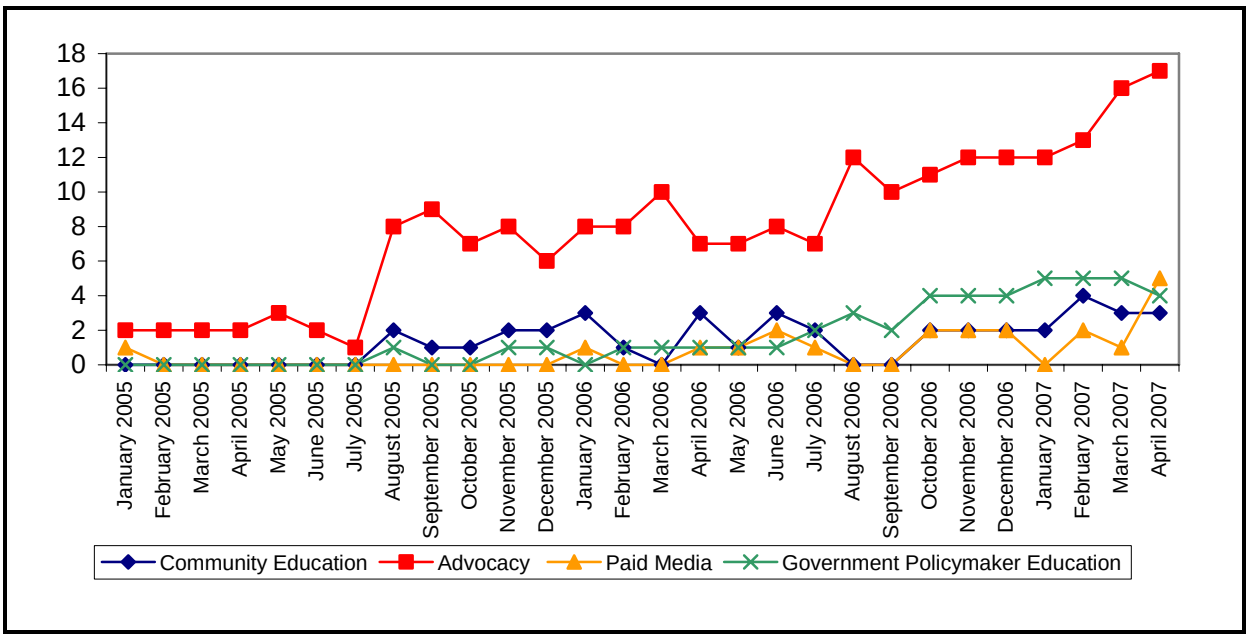
Although New York's strong Clean Indoor Air Act will continue to reduce tobacco use and protect nonsmokers in indoor spaces, smoking remains common in outdoor areas. As a result, smokers are regularly exposed to environments that can trigger relapse (Drobes, 2002; Drobes and Tiffany, 1997; Juliano and Brandon, 1998; Upadhyaya et al., 2004). In addition, exposure to public smoking influences tobacco-related youth attitudes and behaviors through social learning processes (Brandon et al., 2004) as evidenced by studies associating exposure to parent and peer smoking with increased adolescent smoking and smoking susceptibility (Graham et al., 1991; Leatherdale et al., 2006).

In the NYTCP Strategic Plan, policies prohibiting outdoor smoking are an opportunity to further reduce the social acceptability of tobacco use. The goal of Community Partnership efforts in this area is to increase the number of local laws, regulations, and voluntary policies that prohibit tobacco use in outdoor areas and in proximity to building entryways. This goal includes policies that prohibit outdoor smoking in parks, playgrounds, hospital campuses, local government buildings, businesses, and other locations. Partner efforts described in the following sections were recorded in the CAT system.

5.3.5.1 Programmatic Efforts to Increase Policies Prohibiting Tobacco Use in Outdoor Areas

Community Partnerships engage in a variety of activities to increase the number of policies that prohibit tobacco use in outdoor areas, including presentations to municipalities, businesses, and organizations; provision of signs; efforts to gain earned media and increase public awareness; and recognition events to highlight those who have passed such policies. Exhibit 5-20 shows the increase in activities focused on this objective over time. This increase is characterized by a significant increase in advocacy efforts. As part of their advocacy efforts, Community Partnerships sent mailings to 25 local elected officials, 23 businesses, 205 community organizations, and 781 health care provider organizations. They reported meeting with 25 local elected officials, 24 businesses, 28 community organizations, and 45 health care provider organizations. Community Partnerships reported 23 earned media newspaper articles covering the issue of outdoor smoking policies and 17 instances of earned media coverage on radio and television. Community Partnerships reported successful implementation of policies prohibiting outdoor smoking at seven hospitals, nine clinics, four playgrounds, seven community organizations, and government buildings in two counties. The number of policies adopted in hospitals may be underreported in CAT. NYTCP records indicate that, since 2004, 89 hospitals have either banned smoking on their campus or have set a date when the policy will be implemented.

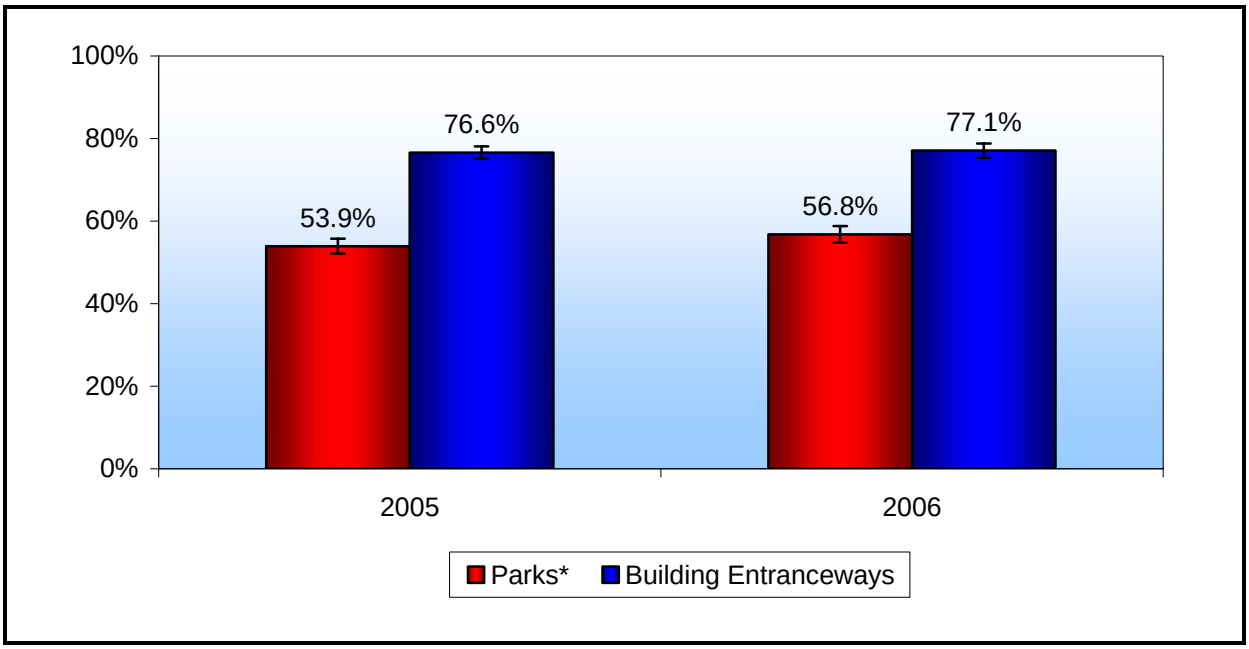
Exhibit 5-20. Community Partner Strategies Related to Promoting Policies Prohibiting Smoking in Outdoor Areas, CAT System, January 2005–April 2007



5.3.5.2 Opportunities and Challenges to Increase Policies Prohibiting Tobacco Use in Outdoor Areas

Partnerships reported challenges in pursuing outdoor tobacco use policies, including postponement of discussed action by decision-making bodies, low priority of the issue by targeted organizations, concerns about enforcing a potential policy, and concerns that such a policy would be unacceptably restrictive. Community Partnerships addressed these challenges by providing target organizations with evidence that the public supports these policies, providing no smoking signs to expedite change, and by remaining persistent. As illustrated in Exhibit 5-21, the majority of New Yorkers favor banning tobacco use in parks and building entranceways and the percentage has increased over time.

Exhibit 5-21. Percentage of Adults Who Favor Banning Smoke in Building Entranceways and Parks, ATS 2005–2006



*Statistically significant upward trend from 2005 to 2006.

5.3.5.3 Programmatic Implications for Policies Prohibiting Tobacco Use in Outdoor Areas

Community Partnerships' modest level of activity aimed at prohibiting tobacco use in outdoor areas is an appropriate long-term strategy to incrementally change the policy environment with the end goal of decreasing the social acceptability of tobacco use.

5.4 Youth Partners

5.4.1 Overview of Youth Partner Activities

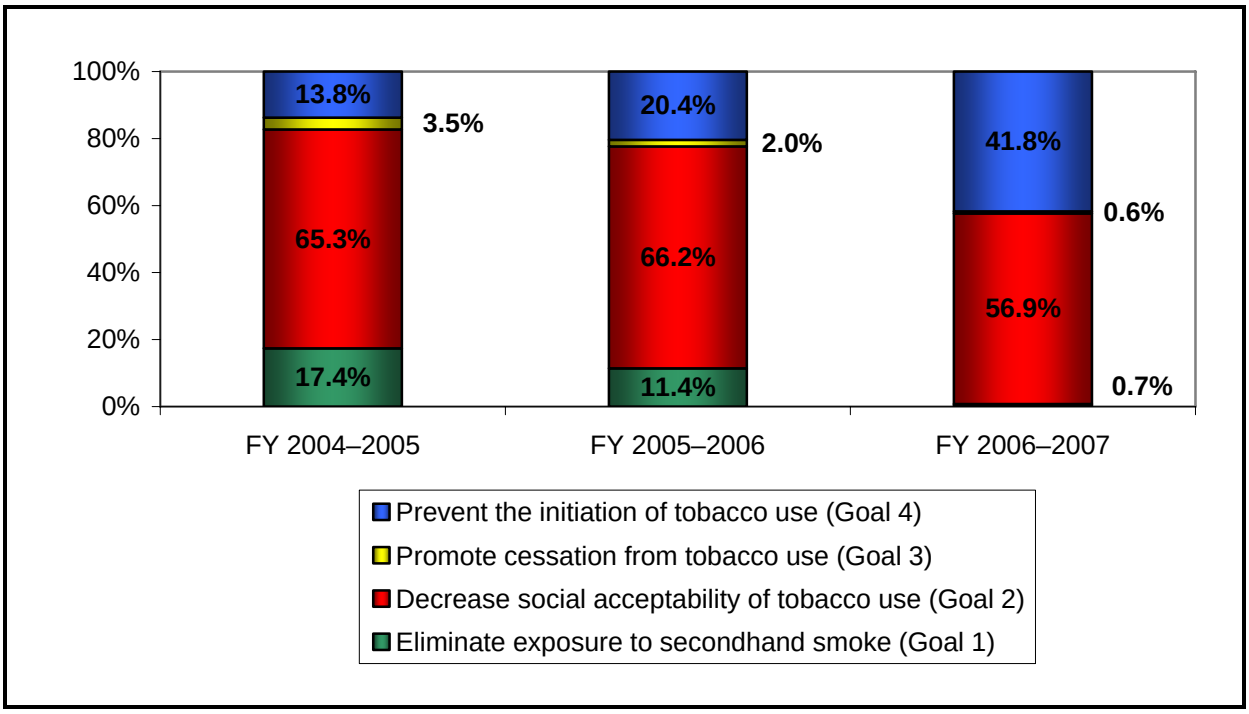
Reality Check Youth Action Programs (Youth Partners) engage youth to lead community action against tobacco and advocate for tobacco-related policies. For fiscal year 2006–2007, Youth Partners focused almost exclusively on two objectives:

- Eliminate smoking and tobacco imagery from movies rated G, PG, and PG-13 that contain smoking or tobacco product placement.
- Increase the number of magazines and newspapers that have a written policy prohibiting acceptance of tobacco company, retailer or product advertising.

Some Youth Partners also worked with county fairs, local event organizers, community organizations, and event venue representatives to encourage the adoption of policies prohibiting tobacco industry sponsorship and promotion. Youth Partners' increased focus on smoke-free movie efforts (see Exhibit 5-22) is responsible for the doubling of activities

classified under the goal of preventing the initiation of tobacco use in the past fiscal year. Their other primary focus area is on decreasing the social acceptability of tobacco use. The following sections describe Youth Partner activities, performance, and outcomes.

Exhibit 5-22. Distribution of Youth Partner Activities by Goal, CAT System, FY 2004–2005 to FY 2006–2007

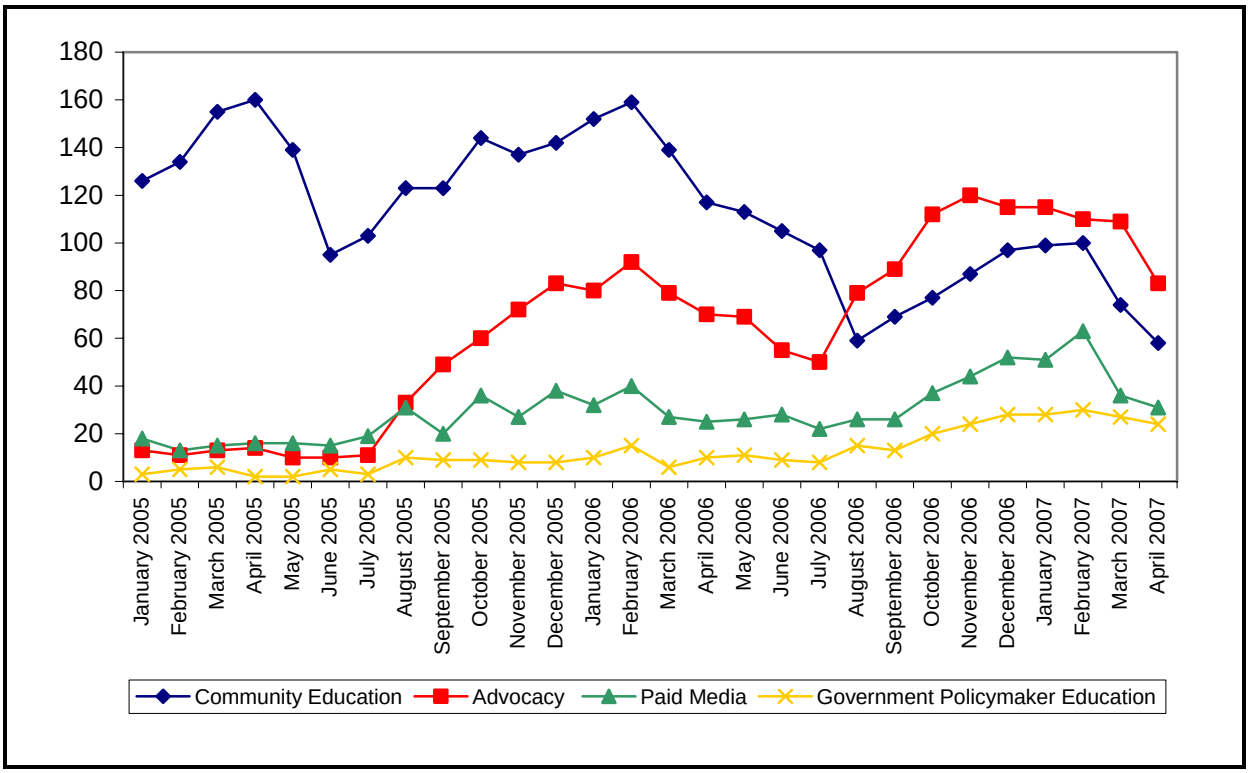


Initially, Youth Partners put the majority of their energy into conducting broad-based education and recruitment activities. The change in strategies is seen in Exhibit 5-23, with a shift from community education to relying primarily on advocacy efforts, with some activities focused on community education and paid media.

5.4.2 Smoke-Free Movies Initiative

There is mounting evidence that smoking in movies has a strong influence on youth smoking (Jackson, Brown, and L'Engle, 2007; Charlesworth and Glantz, 2005; Sargent et al., 2005; Dalton et al., 2003). A recent national study measured adolescents' exposure to movies and classified them into four quartiles of exposure (Sargent et al., 2005). The authors found that, after controlling for other influences, the adolescents in the highest exposure group had 2.6 times the odds of trying smoking compared with the lowest exposure group. Data from the New York Youth Cohort Survey presented in the 2006 IER showed similar results to this national study. Another study suggests that smoking in the movies accounts for 52% of adolescents who start smoking (Dalton et al., 2003).

Exhibit 5-23. Youth Partner Activities per Focus Area Across All Objectives, CAT System, January 2005–April 2007



To limit the influence of smoking in the movies, NYTCP has set two programmatic objectives in its Strategic Plan:

- Increase the percentage of adults who agree that movies rated G, PG, and PG-13 should not show actors smoking.
- Decrease the number of movies rated G, PG, and PG-13 that contain smoking or tobacco product placement.

Working on these two objectives is a main focus of the Youth Partners. Youth Partners engage parents, Parent Teacher Associations (PTAs), community organizations, and legislative bodies to work toward the adoption of resolutions supporting the R rating for movies that contain smoking or tobacco imagery. Youth Partners send these resolutions to the MPAA and to major movie studios. Activities under this initiative aim to build support for and apply pressure to the MPAA to change the movie rating system to require an "R" rating for movies that contain smoking or tobacco imagery. While achieving the desired policy change in Hollywood may take years, the Youth Partner efforts are part of a larger national effort that includes other state tobacco control programs, the national PTA, the American Association of Pediatricians, the American Legacy Foundation, and the Campaign for Tobacco-Free Kids.

The short-term goal of the Youth Partner activities is to increase awareness among community members, key opinion leaders, and Hollywood leaders about the influence of smoking in movies on youth tobacco initiation and use.

Youth Partner efforts in the past focused largely on raising awareness of the issue and encouraging community members to sign postcards to be delivered to the president and CEO of the MPAA and major studios, as well as actors, directors, and associations such as the Directors Guild. For the past year, partners have also put significant emphasis on seeking resolutions from parent organizations, municipalities, and organizations, and sending those to the MPAA and major movie studios. Data describing the efforts and impact of Youth Partner activities to achieve these objectives presented below are from the CAT system.

5.4.2.1 Programmatic Efforts to Promote Smoke-Free Movies

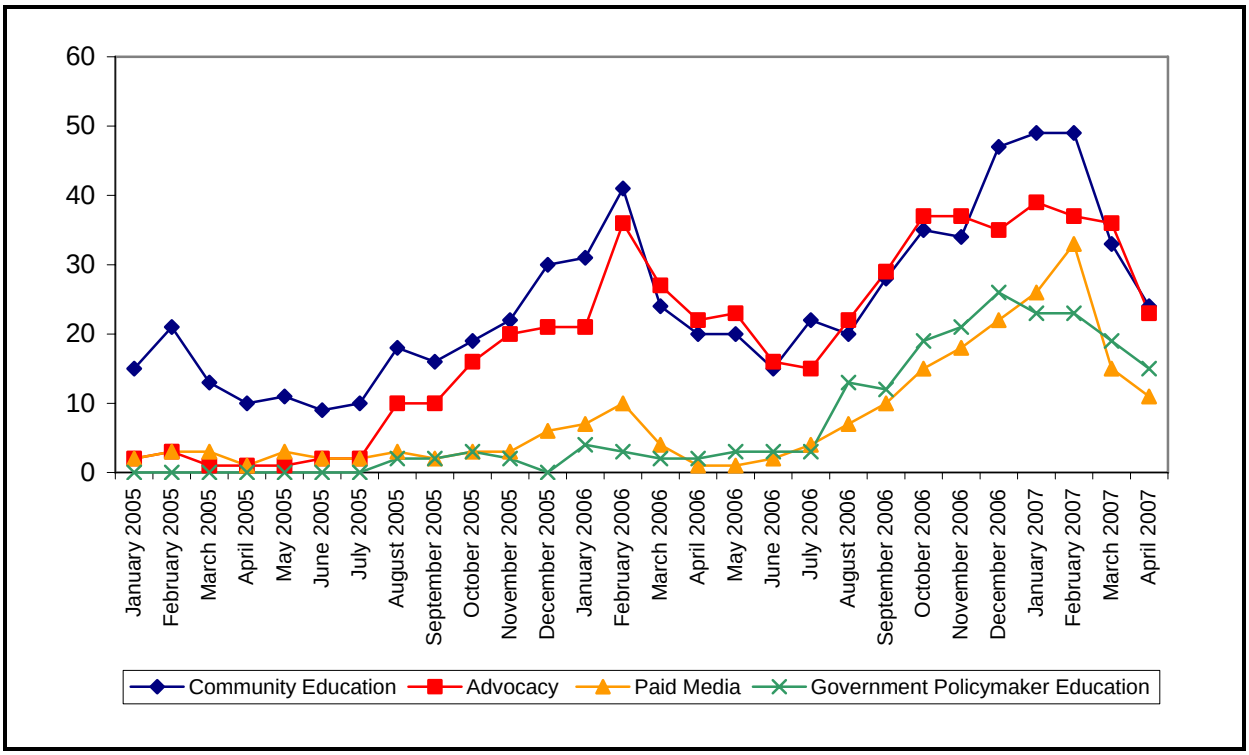
Youth Partner smoke-free movie activity increased over the past year in all focus areas (Exhibit 5-24). The average number of monthly activities more than doubled from FY2006 to FY2007. Community education and advocacy are the most commonly used approaches; paid media also increased significantly over the past year, which was a recommendation to NYTCP from the 2006 IER. Government policy maker education also increased, reflecting efforts to obtain municipality resolutions. The peak of activity in February of each year is consistent with the timing of the International Day of Action, which is a coordinated effort involving many states and nations focused on drawing attention to the impact of smoking and tobacco product placement in youth-rated movies and demanding change by the MPAA and studios.

Youth Partners reported spending $37,333 and $32,181 on smoke-free movies radio and newspaper ads, respectively (less than 1% of their total budget). Youth Partners also ran 181 theater slides with smoke-free movie messages during the first 9 months of the current fiscal year. In their advocacy efforts to obtain resolutions supporting R ratings for movies with smoking, Youth Partners made 51 presentations and sent 48 letters to municipalities. They also participated in 69 meetings and sent 78 letters to PTAs.

Other accomplishments included

- 36 earned media newspaper articles related to smoke-free movies, as well as two editorials and four letters to the editor;
- 88 resolutions adopted, 43 of them from PTAs, 33 from municipalities, and 12 from community organizations; and
- 2,054 letters to the MPAA, including resolutions and signed statements from community members.

Exhibit 5-24. Youth Partner Strategies Related to Promoting Smoke-Free Movies, CAT System, January 2005–April 2007



Although the number of letters sent to the MPAA is much smaller than the previous year's count of nearly 10,000, there was a bigger emphasis during the past year on organizational resolutions rather than on individual community member postcards.

The MPAA issued a press release on May 10, 2007, stating that it "will now consider smoking as a factor—among many other factors, including violence, sexual situations and language—in the rating of films." The press release also stated that "Three questions will have particular weight for our rating board when considering smoking in a film: Is the smoking pervasive? Does the film glamorize smoking? And, is there an historic or other mitigating context?" The MPAA rejected the proposed "R" rating for all movies that contain smoking as "extreme." Although the MPAA action was not consistent with the proposed change supported by NYTCP and other organizations, the MPAA appears to be recognizing public demands to address smoking in movies.

5.4.2.2 Opportunities and Challenges in Promoting Smoke-Free Movies

Youth Partners reported barriers to their smoke-free movie efforts, including delays in organizational responses to their efforts, Partners' lack of familiarity with the political process, and concerns on the part of organizations approached for support that the initiative constituted "censorship". Youth Partners also identified reasons for success with smoke-free

movie activities, such as participation and enthusiasm of youth and positive community awareness and response to the issue.

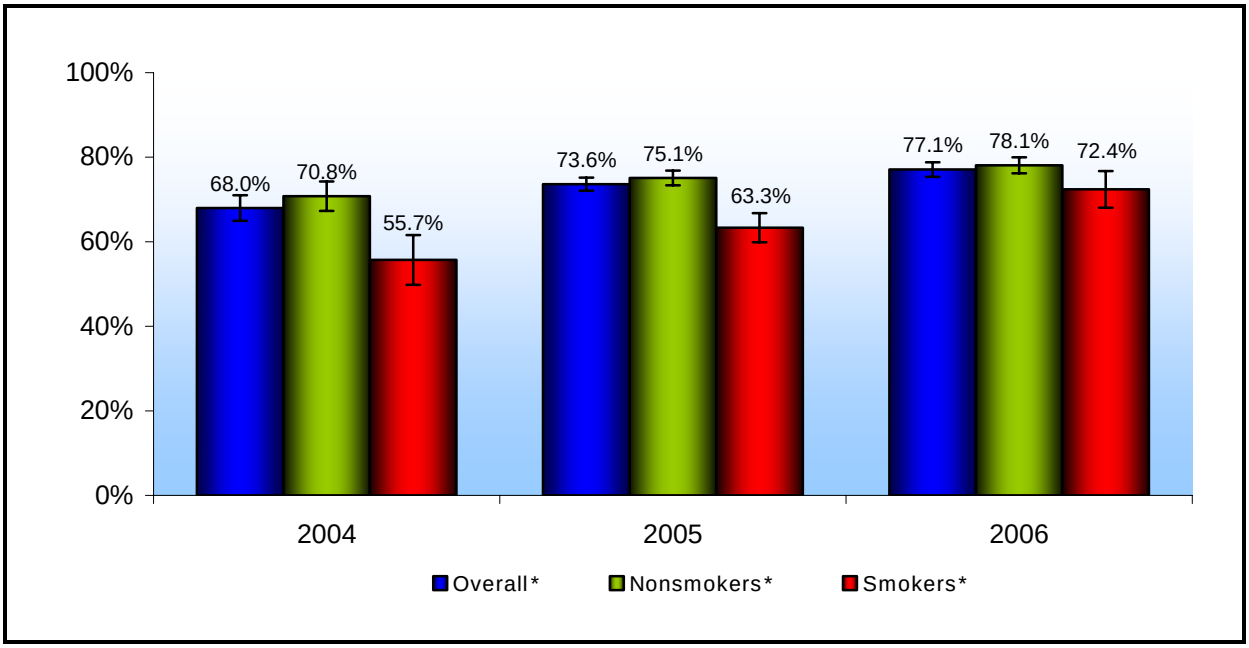
5.4.2.3 Beliefs about Smoke-Free Movies

To measure the progress of short-term outcomes that may respond to the smoke-free movie initiative, we included the following belief outcomes from ATS that have been included consistently from Q4 2003 to Q4 2006:

- Movies rated G, PG, and PG-13 should not show actors smoking.
- Actors' smoking in the movies encourages smoking among teens.

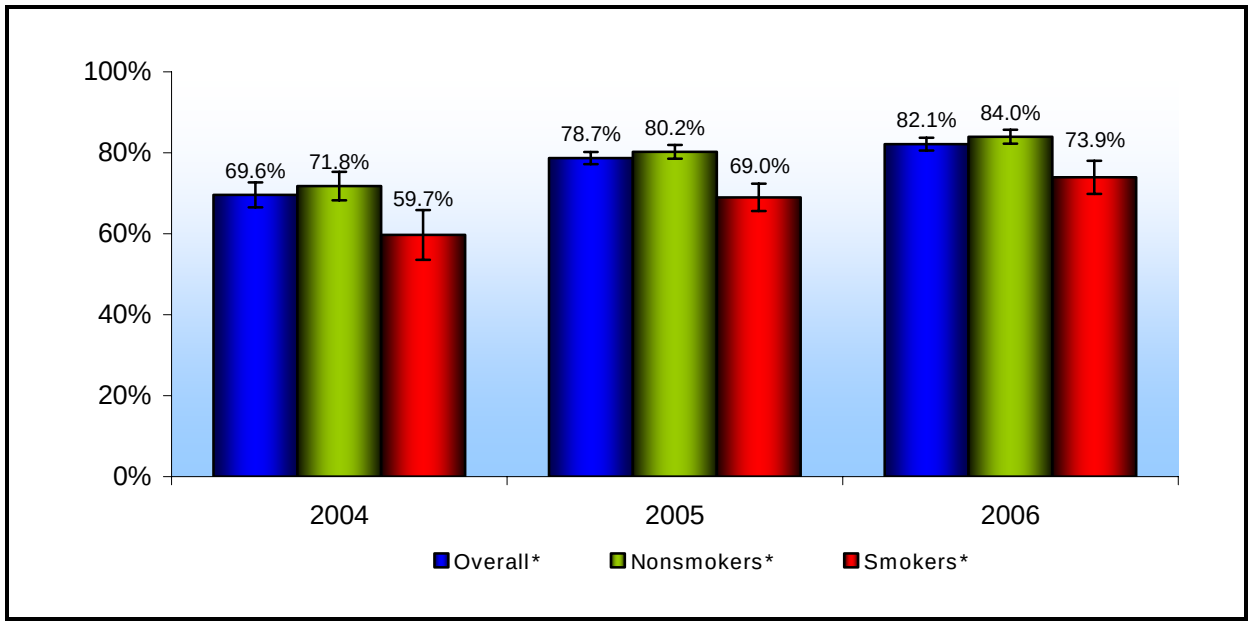
From 2004 to 2006, an increasing percentage of New Yorkers overall, smokers, and nonsmokers agree that smoking in the movies encourages smoking among teens (Exhibit 5-25) and that smoking should not be in movies rated G, PG, and PG-13 (Exhibit 5-26). The biggest percentage changes occurred among smokers. In 2006, 72% of smokers agreed that smoking in the movies encourages teen smoking, up from 56% in 2004—a 30% relative increase. The percentage of smokers who agree that actors should not smoke in movies rated G, PG, or PG-13 increased 24% in relative terms, from 60% to 74% from 2004–2006.

Exhibit 5-25. Percentage of Adults Who Agree that Actors Smoking in the Movies Encourages Smoking among Teens, ATS 2004–2006



*A statistically significant upward trend from 2004 to 2006.

Exhibit 5-26. Percentage of Adults Who Agree that Movies Rated G, PG, and PG-13 Should Not Show Actors Smoking, ATS 2004–2006



*A statistically significant upward trend from 2004 to 2006.

5.4.2.4 Programmatic Implications

The 2006 IER noted that Youth Partners too often considered youth-oriented activities as successful if they kept youth involved and interested rather than preparing youth to become effective advocates for change. Consistent with NYTCP efforts to promote effective advocacy among Partners, we found that Youth Partners engaged in more activities in FY2007 compared with the previous year. In addition, the data show that there were more sustained advocacy activities over the past year than in previous years, and monthly reports described more ongoing youth involvement in policy advocacy. We recommended that Youth Partners focus the smoke-free movie initiative efforts on advocacy for policy change rather than broad-based community education, and we found that such a shift occurred. The 2006 IER suggested that Youth Partners use focused strategic interventions; demonstrate popular support for policy change; and invest in paid advertisements aimed at changing social norms, including an evidence-based approach of airing ads in movie theaters before movies that contain smoking and through other mass media.

Data from the ATS show social norms about smoking in the movies are changing, especially among smokers. Although it is not clear if similar changes are occurring in the rest of the country, these changes are significant. In addition, the MPAA's decision to factor smoking in the movies into their rating system is likely the result of pressure from local, state, and national organizations as well as mounting evidence of the influence of smoking in the movies on youth smoking initiation. Although it is not possible to attribute this change to

the efforts of Youth Partners, it is quite likely that their efforts contributed to the change in the MPAA's official stance on smoking in the movies.

We recommend that Youth Partners continue their advocacy efforts to promote smoke-free movies, continuing to shift their focus from community education to advocacy.

5.4.3 Tobacco Advertisement-Free Magazines Initiative

As of 2005, tobacco companies' expenditures on magazine advertising in the United States were $45 million annually, down from $295 million in 2000 (FTC, 2007). Over that same period, advertising expenditures for newspapers dropped from $52 million to $2 million annually (FTC, 2007).

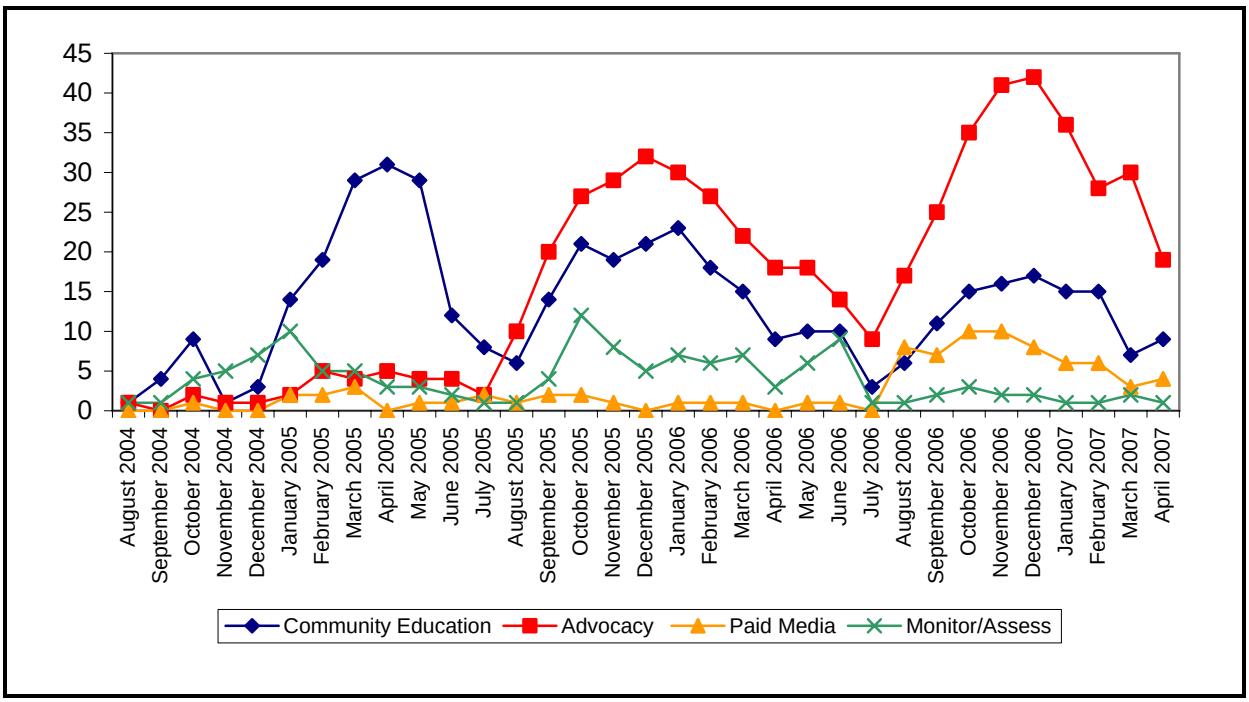
Youth Partners' work on the ASP Initiative also includes promoting tobacco advertisement-free magazines, addressing the following strategic objective: "Increase the number of magazines and newspapers that have a written policy prohibiting acceptance of tobacco industry product advertising." As a result of the 1998 Master Settlement Agreement, tobacco companies were prohibited from advertising to youth, but studies have shown that youth continue to be exposed to advertising, including through magazines. In June 2005, New York State Attorney General Eliot Spitzer announced an agreement between the National Association of Attorneys General and Time, Inc., and Newsweek to produce editions of *Time*, *People*, *Sports Illustrated*, and *Newsweek* for schools, free of tobacco advertisements. Youth Partners worked to share this information with schools and to monitor school library magazines, making sure they received tobacco advertisement-free editions. Additionally, the publishers of *Newsweek* allowed subscribers to request tobacco advertisement-free editions (Aspan, 2007), and both Community Partnerships and Youth Partners have worked to raise awareness of this opportunity among the public.

In 2006 and 2007, Youth Partners' activities included working with schools to ensure they are receiving tobacco advertisement-free editions and requesting resolutions from school boards supporting expansion of the current tobacco advertisement-free agreement to include more magazines. Youth Partners also promoted the tobacco advertisement-free editions of *Newsweek* to businesses and community members and encouraged publishers to expand tobacco advertisement-free editions to additional magazines. The following sections present information from the CAT system regarding the magazine initiative.

5.4.3.1 Programmatic Efforts to Promote Tobacco Advertisement-Free Magazines

Exhibit 5-27 shows the breakdown of Youth Partner activities directed toward magazine initiative by focus area. Advocacy is the most commonly used approach, followed by community education and paid media. Some Youth Partners also assessed whether schools had these editions of magazines and, if not, worked with librarians to request them. Entries in CAT stated that Youth Partners approached school boards to get resolutions, which could be shared with the magazine publishers and the New York Office of the Attorney General

Exhibit 5-27. Youth Partner Strategies Related to Promoting Tobacco Advertisement-Free Magazines, CAT System, August 2004–April 2007



(OAG) to show support for further reductions in tobacco advertisements in magazines. Youth Partners also encouraged community organizations and businesses to change their subscriptions to tobacco advertisement-free editions and request that more magazines offer this option. Community education efforts primarily involved making presentations at community events and schools, writing letters to the editor, and mailing postcards to community members that informed them of the option to request versions of *People*, *Time*, *Sports Illustrated*, and *Newsweek* that are free of tobacco advertising. Partners reported sending more than 1,500 cards directly to magazine publishers. In addition, community members were encouraged to send postcards to publishers.

Mailings were sent to school boards, businesses, and community organizations. Youth Partners targeted school boards with 46 meetings and 37 letters, businesses with 71 meetings and 521 letters, and community organizations with 22 meetings and 65 letters. Youth Partners reported sending more than 31,000 letters in mass mailings to community members and organizations with information about the magazine initiative. Nineteen news stories and two letters to the editor were published regarding the magazine activities.

Youth Partners reported resolution and practice changes regarding magazine tobacco advertising for a variety of organizations. Youth Partners reported receiving magazine resolutions from two community organizations, three municipalities, and 11 school boards.

They reported practice changes (i.e., requesting tobacco advertisement-free editions of magazines from publishers) for 16 health care provider organizations and one school board.

It should be noted that Community Partnerships also contributed to the tobacco advertisement-free magazine initiative, using paid media, advocacy, and community education to encourage businesses and community members to request *Newsweek* subscriptions without tobacco ads and to request that publishers make other magazines available with selective binding. Community Partnerships specifically reported sending 937 letters to businesses, participating in 69 meetings with businesses regarding this initiative, and sending more than 1,000 letters in mass mailings to individual and businesses.

5.4.3.2 Opportunities and Challenges in Promoting Tobacco Advertisement-Free Magazines

Youth Partners reported barriers to the magazine activities, including that they did not know if action was taken after postcards and information were distributed. Additionally, they encountered delays in receiving media materials from NYTCP and from vendors. Partners also found it challenging to get scheduled on school board agendas. Reasons for success cited by Youth Partners regarding magazine activities included support of school administrators and librarians, collaboration with other organizations, and professionally produced postcards. Some Youth Partners also reported that youth participation in these efforts was a "convincing factor" and enhanced the importance and credibility of the initiative.

5.4.3.3 Program Implications

The 2006 IER recommended that Youth Partners advocate with school librarians and school boards to continue to expand the number of magazines that are covered by the arrangement. There were reported efforts during the 2006–2007 fiscal year to include *Ebony, Essence, Jet, Field & Stream, Outdoor Life,* and *Popular Science*. The Youth Partner work plan for fiscal year 2007–2008 specifically focused on including these additional magazines in the agreement.

The Youth Partners have shown that they can effect policy change with respect to tobacco advertising in magazines. We recommend continuing these efforts, but we note that data from the Federal Trade Commission (FTC) suggest that tobacco companies are spending decreasing amounts on magazine advertising.

5.5 School Policy Partners

5.5.1 Overview

In fall 2001, NYTCP funded eight pilot School Policy Partners to conduct tobacco control activities in schools. These grants ended in 2005 when a new procurement resulted in 31 contracts. School Policy Partners work with schools and school districts, providing technical

assistance, guidelines, and support needed to develop, implement and enforce comprehensive tobacco-free policies. Despite near-universal school district policies prohibiting tobacco use and a state law that prohibits smoking in school buildings and on school grounds, New York schools are not yet tobacco-free.

A work group within NYTCP developed recommendations for school policies that included policies prohibiting tobacco use among students, staff, and visitors in school buildings, on school grounds, at school-sponsored events, and in all school vehicles. In addition, policies should require appropriate signage, mandate access to cessation resources, and include enforcement procedures. Not all school district policies currently meet these criteria. In addition, self-reported data from the New York Youth Tobacco Surveys (YTS) suggest that neither school district policies nor state law are being fully enforced; in 2004 and 2006, approximately one-third of middle school students and three-fourths of high school students reported seeing other students smoking on school grounds (Exhibit 5-28), and approximately 40% of students reported seeing adults smoking on school grounds (Exhibit 5-29).

The community-based approach to tobacco control is based on the observation that embedding antitobacco norms into the community environment is an intervention with wider reach than an intervention targeted at individuals (Vollinger et al., 2005), and worksite smoking bans are a core component of this approach (Bauer et al., 2005; Vollinger et al., 2005). The NYTCP School Policy Partners initiative focuses on making schools a tobacco-free worksite because schools are a core community institution. Changes that occur there become integrated into the community and sustained well beyond the time of the original intervention. Because schools are a central part of community life, the cues for behavior change that tobacco-free policies convey are consistently disseminated into the community.

The extant literature provides evidence that comprehensive, well-enforced tobacco-free school policies will reduce smoking among students, faculty, and administrators. Studies of worksite policy (Fichtenberg and Glantz, 2002; Bauer et al., 2005; Farrelly, Evans, and Sfekas, 1999; Brigham et al., 1994) and school policy (Rohde et al., 2001; Kumar, O'Malley, and Johnston, 2005; Evans-Whipp et al., 2004, 2007; Leatherdale and Manske, 2005; Wakefield et al., 2000; Turner and Gordon, 2004) demonstrate that smoke-free policies reduce the prevalence of smoking. Of particular importance, studies also indicate that nuances in implementation of school policies such as strictness of monitoring, allowances for staff smoking, closed campus policies, and provision of cessation services for students and staff, can enhance or reduce program effectiveness (Kumar, O'Malley, and Johnston, 2005).

Exhibit 5-28. Percentage of Middle and High School Students Who Saw Other Students Smoking on School Property, YTS 2004–2006

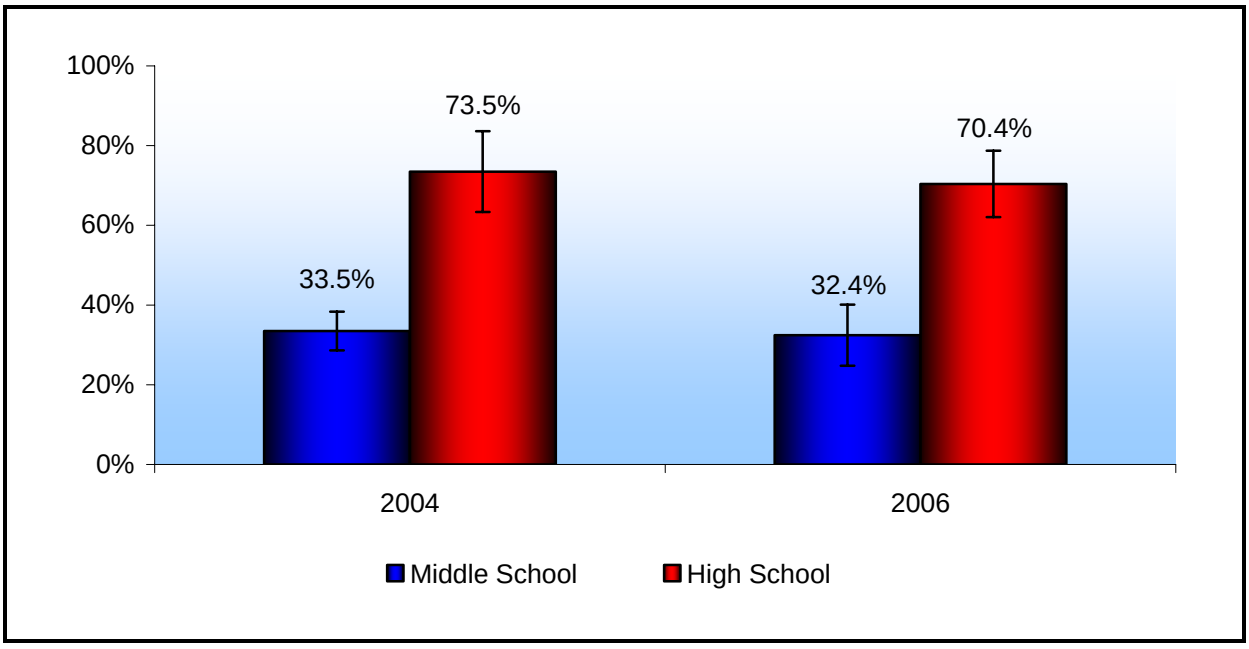
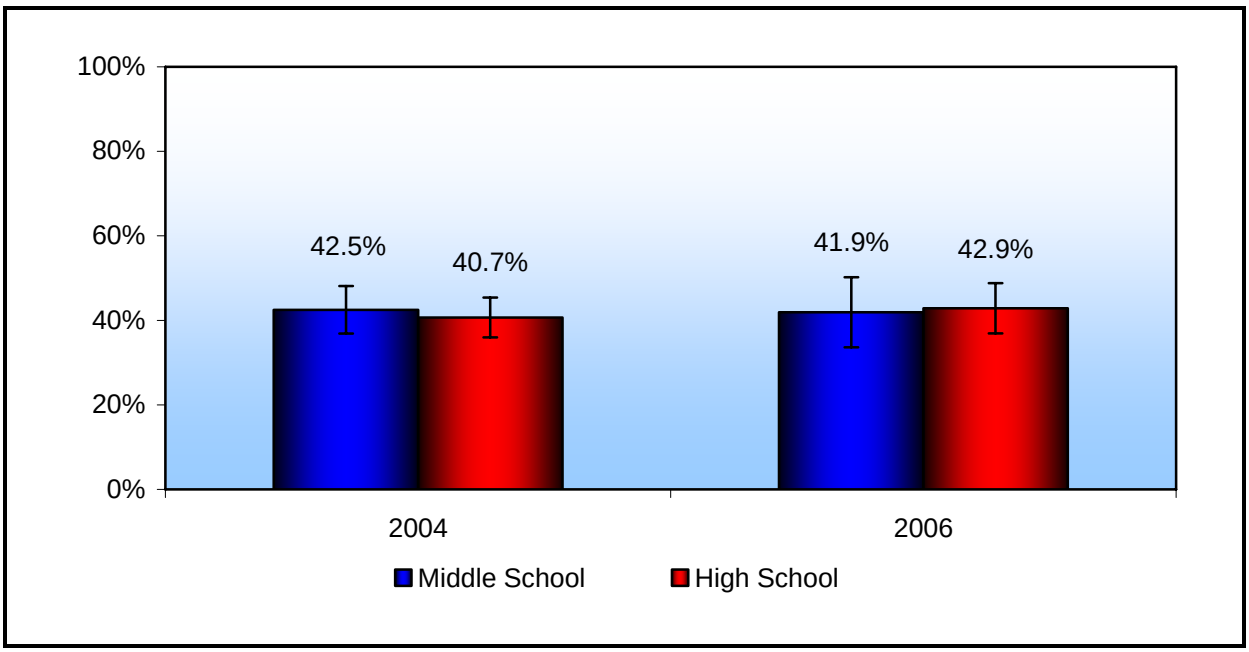


Exhibit 5-29. Percentage of Middle and High School Students Who Saw Adults Smoking on School Property, YTS 2004–2006

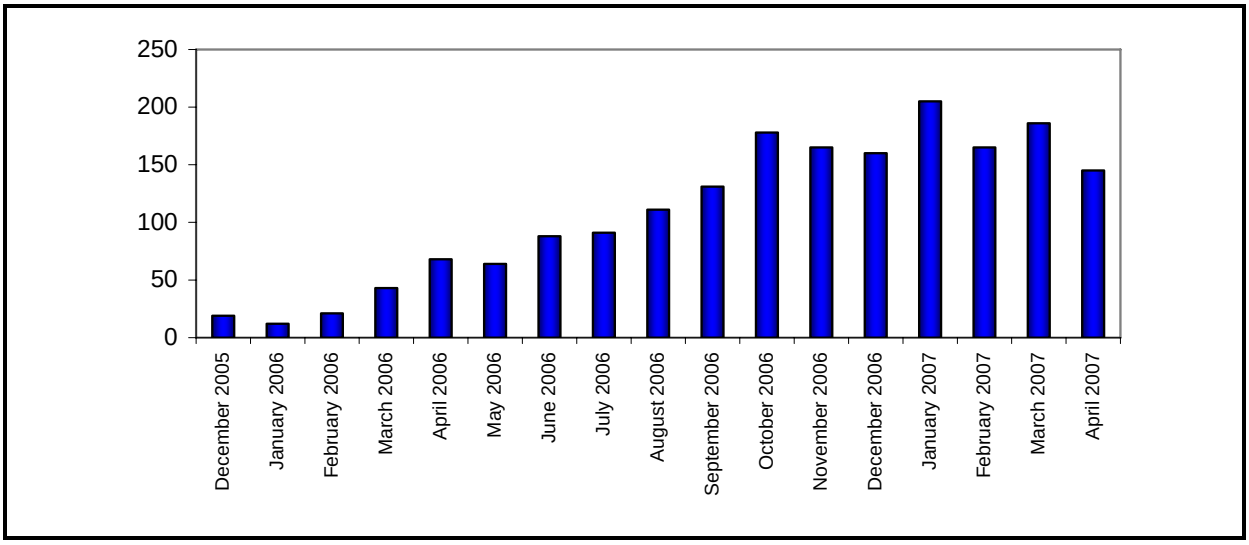


The following sections address the performance to date of School Policy Partners, using data from the CAT system. Because this initiative started in December 2005, with contracts executed in 2006, we do not present any outcome data to assess its progress.

5.5.2 Programmatic Efforts to Promote Tobacco-Free School Policies

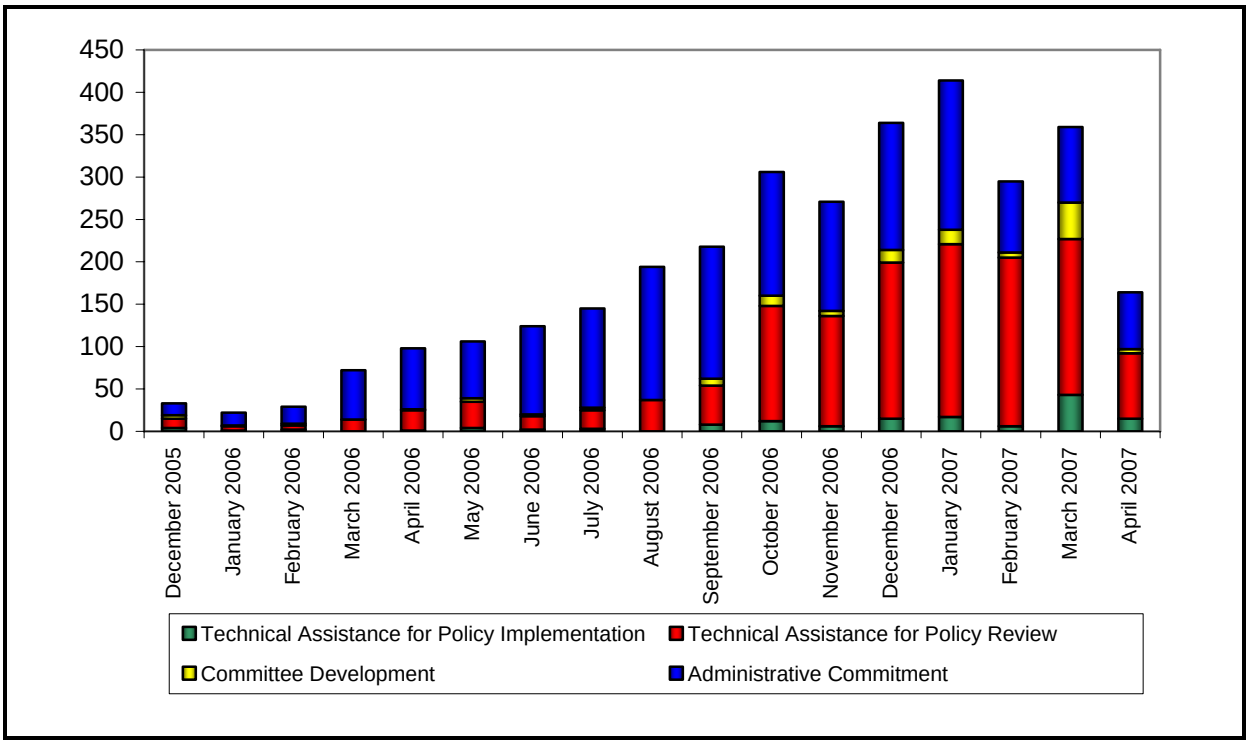
Data on School Policy Partner efforts are collected in the CAT system and through annual work plans, monthly reports, and quarterly policy updates. School Policy Partners conduct a range of activities in their efforts to help schools strengthen their policies. These activities include recruiting schools and districts, gaining administrative commitment, establishing committees, assisting with reviews of existing policy, drafting new policies, and developing plans and strategies for effective implementation and enforcement of policies. Exhibit 5-30 shows how the number of schools and districts engaged by School Policy Partners has increased over time. This demonstrates that School Policy Partners have built capacity within a relatively short period. To date, School Policy Partners have identified 451 schools as potential collaborators.

Exhibit 5-30. Number of Active Collaborations between School Policy Partners and Schools or Districts, CAT System, December 2005–April 2007



School Policy Partners' ongoing activities fall into four main categories: (1) obtaining buy-in from school administrators (administrative commitment), (2) recruiting a committee or working with an existing committee to work on a policy at the school or district level (committee development), (3) providing technical assistance for policy development and review (technical assistance for policy review), and (4) technical assistance for policy implementation. Exhibit 5-31 shows how School Policy Partner activities have changed over time, from initial efforts focusing primarily on gaining administrative commitment to a more recent emphasis on reviewing policies.

Exhibit 5-31. Number and Type of Activities Conducted by School Policy Partners, CAT System, December 2005–April 2007



School Policy Partners reported specific milestones for each school they work with; 105 schools finalized Memoranda of Understanding to work with School Partners, and 124 schools established a tobacco-free policy committee. Sixty schools reviewed their current policy, comparing it to the NYTCP minimum standard.

In their role as technical assistance resources for school committees, School Policy Partners provide resources, assistance, guidance, and some funding to ensure that policies meet criteria communicated by NYTCP. Activities reported on CAT included providing a tobacco-free school policy toolkit, sample policy documents, signs, and other materials. Some School Policy Partners arranged school assemblies to motivate students and adults on tobacco control issues. The amount of stipends distributed to schools to assist with policy change was $80,165 for fiscal year 2005–2006. For the first 6 months of fiscal year 2006–2007, stipends totaled $46,825, 2.3% of the School Policy Partner budget.

School Policy Partners report quarterly to the CAT system the status of the policy for each school or school district with which they are working, until the process is complete. NYTCP identifies 16 minimum criteria for a recommended tobacco-free school policy, and schools and districts working with School Policy Partners had an average of nine of the required components. The following components were most frequently reported as part of the existing policies: policy prohibits use of tobacco in school buildings and on school grounds

among students (97.5%), staff (84.0%), and visitors (81.5%). Notably, 70.6% of policies included enforcement procedures for student violations, but enforcement procedures were in place less often for staff (33.6%), and for visitors (23.5%).

5.5.3 Opportunities and Challenges in Promoting Tobacco-Free School Policies

School Policy Partners' challenges in pursuing tobacco-free school policies included competing priorities and lack of administrator interest, sometimes because schools felt that their current policies were sufficient. Other challenges included school staff turnover and staff tobacco use. School Policy Partners reported several factors that aided their progress, including working with existing wellness committees, aligning their project with other district initiatives or priorities, providing sample policies and useful materials to facilitate the process, and providing stipends. Committed school staff were also a key to successful work with targeted schools and districts.

5.5.4 Programmatic Implications for School Policy Partners

Data from the YTS indicate that, despite state law, student and faculty/staff smoking continues to occur on school property. The tobacco control literature has shown that smoke-free workplaces reduce the prevalence of smoking and the quantity smoked by those who continue to smoke. It is reasonable to assume that this literature is directly applicable to school settings, indicating that the School Policy Partner initiative is evidence-based. However, it should be noted that this initiative to effect policy change, like other NYTCP policy initiatives, will make incremental progress over time. To illustrate this point, the School Policy Partners report working with 451 schools, approximately 7% of all schools in New York State (6,746).

5.6 Overall Programmatic Implications for Community Partner Efforts

NYTCP has developed a multipronged approach to community mobilization in an attempt to change community norms about tobacco use. The program aims to create positive policy change in schools, health care organizations, magazines and newspaper publishers, the MPAA and movie studios, tobacco retailers, bars, and community organizations and events. It is a thoughtful plan with policy change at its core. Creating policy change is essential for a number of reasons. As we have seen with the Clean Indoor Air Law, the effects of policy can be far-reaching and have long lasting effects. In addition, policy advocacy is a wiser use of community resources than community-based public education because the latter is often an inefficient mechanism to effect change in community norms.

However, the road to policy change can be long. Efforts to change smoke-free laws began in the late 1980s and required nearly 20 years to enact a comprehensive statewide smoking ban. Although social norms about tobacco have changed in ways that may facilitate future

policy change and there are many lessons to draw on that might make policy advocacy more effective than in the early years of tobacco control, changing systems and policies is inherently a long process. In addition, in many cases, the program is confronting the influence of the tobacco industry that not only outspends NYTCP in New York State but has had decades to normalize tobacco use and integrate it into culture and society through movies, magazines, cultural organizations, retail stores, and other venues. Undoing these influences will take persuasion and persistence because not all of the strategies to combat these influences are well known or proven.

6. DISCUSSION AND FUTURE DIRECTIONS

6.1 Overview

From 2002 to 2005, the New York Tobacco Control Program (NYTCP) steadily increased its capacity to develop and implement evidence-based tobacco control interventions. On April 1, 2006, program funding nearly doubled (from $44 million to $85 million), and NYTCP quickly put the additional funding to work, hiring eight new staff, expanding existing interventions, and funding new interventions that were coming online. There is now indirect evidence that the program's efforts are having an impact on smoking. Adult smoking prevalence in New York declined from 20.5% in 2005 to 18.2% in 2006, while smoking prevalence in the United States remained constant during the same period. This translates to approximately 330,000 fewer smokers. Similarly, recent declines in youth smoking in New York outpaced declines in the United States overall. The fact that declines in smoking rates in New York have outpaced those in the United States suggests that there are factors unique to New York that are causing these differences. It is reasonable to assume that NYTCP's efforts and tobacco control policies in New York are responsible for these changes.

In this section, we review past successes and obstacles and make recommendations for moving forward. We also review the efforts that will be required in order for NYTCP to achieve its ambitious goal of reducing the number of smokers by 1 million (900,000 adults and 100,000 youth) by the year 2010.

6.2 Reviewing Past Successes and Obstacles and Making Recommendations for Future Directions

In the 2006–2007 fiscal year, approximately 30% of the NYTCP budget was devoted to tobacco countermarketing, more than any other single program component. Consistent with past independent evaluation recommendations, the program has dedicated an increasing share of the countermarketing budget to high sensation value television advertisements in recent years. As a result, New Yorkers' awareness of NYTCP's countermarketing advertisements has increased. The tobacco control literature and our own evaluation have demonstrated that tobacco countermarketing changes attitudes and intentions, drives calls to the Quitline, and promotes behavior change.

Earlier this year, the full weight of NYTCP's tobacco countermarketing budget was effectively put to use. The program aired a number of evidence-based advertisements and exceeded our previous recommendations by reaching more than 60% of New York smokers. However, once again in 2006, the program's progress was impeded by unnecessary bureaucratic and political delays. These delays reduced New Yorkers' exposure to countermarketing efforts, and we observed a leveling off of awareness in 2006 after 3 years of steady progress. For

NYTCP to achieve its ambitious goal of reducing the number of adult smokers by 900,000, the program will need to very effectively execute its media plans as it did in early 2007. NYTCP also cannot afford to have its progress impeded by the bureaucratic delays that have plagued its efforts for several years.

The recent successes of the countermarketing campaign have also helped the program achieve record numbers of calls to the New York State Smokers' Quitline. Overall, the Quitline has generally performed well as call volume has increased. Callers to the Quitline consistently report that they are very satisfied with the services they receive. In addition, the introduction of free nicotine replacement therapy (NRT) starter kits in December 2004 has led to increased quit rates among smokers who call the Quitline. There are, however, two areas of improvement for the Quitline. First, NYTCP and the Quitline need to better coordinate mass media efforts and Quitline capacity to minimize the number of callers who cannot reach a Quitline specialist during times of peak call volume. Second, the Quitline currently only reaches 34% of smokers who are referred to the Quitline via the Fax-to-Quit program. It is possible that the Quitline has difficulty reaching more smokers because health care providers may be referring smokers to the Quitline who are not really prepared to quit and as a result do not respond to Quitline attempts to reach them.

Turning to NYTCP's community-based efforts, the program has made significant investments in time and resources to develop and implement a range of interventions to combat the influence of the tobacco industry in multiple settings. In contrast to other interventions (e.g., Quitline, countermarketing), the community mobilization efforts require significant staff resources to provide guidance, oversight, and training. Therefore, it has been a significant accomplishment to design (or redesign) and implement the Community Partnership, Youth Partner, Cessation Center, and School Policy Partner initiatives since 2004.

With these initiatives, NYTCP aims to change community norms by engaging and fostering policy change in schools, health care organizations, magazine and newspaper publishers, tobacco retailers, bars, and other community organizations and events. The program's plan largely focuses on policy change. The focus on policy change is wise, but it is important to note that changing systems and policies is inherently a slow process. As previously noted, achieving a comprehensive Clean Indoor Air law required at least 15 years. Policy change also requires that Community Partners have all of the required skills and training to effectively advocate for community change. Advocating for policy change can be very challenging, especially for many community partners who are most comfortable with and experienced in community health education. Upcoming procurements for community programs should emphasize advocacy skills.

To date, NYTCP's Cessation Centers appear to be making steady progress toward their longer term objective to establish systems to screen all patients for tobacco use and advise

smokers to quit. The Cessation Centers have had an effect on formal guidelines for the treatment of tobacco dependence, and they have made health care providers more aware of available resources for cessation. They have also increased referrals to the Quitline. However, much more progress is needed to have a broad impact. The Cessation Centers have yet to change systems and policies in hospitals, and they must extend their reach to the thousands of group medical practices and physician offices where most smokers receive care. This may require innovative mass media strategies or other strategies.

It is more challenging to adequately assess the progress that the Community Partnerships have made over the past 2 years reducing cigarette advertising, sponsorship, and promotion. It is clear that tobacco companies invest heavily in advertising, marketing, and promotions at the point of purchase and in bars. Furthermore, the evidence that tobacco advertising and promotion increases the likelihood that adolescents will smoke has accumulated (Lovato et al., 2003). New evidence specifically associates point-of-purchase advertisements with increased likelihood of moving young people into the early stages of smoking, with stronger effects on younger (8th grade) children (Slater et al., 2007). Despite this evidence base, the tobacco industry has faced little restriction in their advertising at the point-of-purchase. Reports from the Federal Trade Commission have shown that the majority of tobacco industry advertising and promotional multibillion dollar spending occurs at the point of sale.

Given the available surveillance systems, it is less clear how pervasive tobacco company sponsorships are in other venues. A number of Community Partnerships have reported that organizations have adopted resolutions and policies prohibiting tobacco company sponsorships. However, it appears that in many instances these organizations never accepted tobacco sponsorships in the past. We recommend focusing efforts in this area on venues where sponsorship and promotion are common, such as in bars and nightclubs.

The Community Partnerships have faced significant barriers as they advocated with retailers for voluntary reductions of tobacco advertisements. Although it is possible that efforts to reduce tobacco advertising will follow a similar trajectory to the successful efforts to prohibit smoking in nearly all workplaces, a number of factors suggest that Community Partnerships will face additional challenges in reducing cigarette advertising. First, Community Partnerships are met with resistance from retailers who receive significant financial incentives from tobacco companies. Second, Community Partnerships are still in the exploratory phase of the intervention where they are identifying effective strategies. Third, it is not clear whether communities acknowledge the importance of reducing tobacco advertising in the same way that they recognized the health effects of secondhand smoke. As a result, it may be more difficult to mobilize communities around the issue of tobacco advertising. Fourth, there are approximately 24,000 cigarette retailers in the state, and Community Partnerships can interact with only a few per year. Finally, it is sometimes the case that tobacco advertising reappears in stores even after Community Partnerships have

successfully convinced retailers to remove it. However, there are cases of progress: for example, a few grocery store chains have agreed to make incremental changes and are receptive to further curbing tobacco adverting in their stores. We recommend focusing more effort on lobbying for strict enforcement of existing laws or advocating for ordinances that limit all forms of outdoor advertising and less effort trying to influence cigarette retailers. We also recommend exploring the efficacy of distributing tobacco countermarketing materials in cigarette retail outlets, such as paid advertising for the Quitline similar to what NYTCP has done in the past as part of its mass media efforts. Although some cigarette retailers may feel pressured by tobacco companies to continue tobacco advertising, they may be open to posting tobacco countermarketing materials, including replacing existing tobacco functional items, such as hand baskets, counter mats, and clocks. Such efforts may help counter the influence of tobacco advertising on social norms. In light of these barriers, it will likely take years for the Community Partnerships to have a meaningful impact on cigarette advertising statewide.

With respect to the Youth Partners, we have seen that they have become more involved in policy advocacy than in previous years. As with the Community Partnerships, it is difficult to assess the impact of Youth Partner efforts. The challenges to the evaluation include limitations in surveillance and monitoring systems that are difficult to address, a lack of adequate evaluation methods to address the inherent challenges in evaluating diffuse community interventions, and the lag time between intervention activities and ultimate impact. Social norms about smoking in the movies are changing as are polices at the national level, but it is not clear how Youth Partners have contributed to these changes. However, in light of shifting norms and policies, it appears sensible for the Youth Partners to continue these efforts. In addition, the Youth Partners have shown that they have been able to reduce tobacco advertising in magazines. Although tobacco company advertising has dropped significantly in recent years, the Youth Partner efforts can further reduce youth exposure to these efforts.

Finally, it is too early to know what impact the School Policy Partners will have. Clearly, changing policy in school environments holds the promise of reaching significant numbers of youth across the state. As with other efforts to change policy, we expect the progress to be steady and incremental.

For all community mobilization efforts, it appears that there could be greater coordination between Community Partner activities and NYTCP efforts. Specifically, we believe that targeted and coordinated mass media campaigns with messages that directly support and further legitimize community-based efforts may help focus Community Partner efforts on more central messages and enhance their ability to effect policy change at the local level. Currently, NYTCP airs a number of advertisements that expose the tobacco industry's manipulative marketing practices. These advertisements could be refocused somewhat to more specifically tie the messages to the issues that Community Partners are addressing

(e.g., pervasive point-of-sale advertising, bar promotions). This could be accomplished by shifting resources away from the Healthy Neighborhood and School Health Center initiatives, which are not tobacco control interventions.

Although community mobilization efforts are aimed at countering powerful pro-tobacco influences, they are unlikely to have a meaningful short-term impact on smoking rates by 2010; thus, NYTCP should consider temporarily shifting resources away from these efforts and toward mass media to increase the likelihood of reaching the 2010 goal.

6.3 Achieving the 2010 Goal of One Million Fewer Smokers

We believe that achieving the ambitious goal of reducing the number of smokers in New York by 1 million by 2010 hinges on five critical factors. First, funding for the program needs to be sustained at least at its current level of $85 million, and all funds should be dedicated to NYTCP activities. Currently, approximately $6 million of the NYTCP budget goes to the Healthy Neighborhood and School Health Center programs that have central missions that are unrelated to tobacco control and conduct few tobacco control activities. Given the focus of these programs, they will have little direct impact on key programmatic outcomes and they do not deliver a quantity of tobacco control interventions that is commensurate with the $6 million cost. These funds could be used to fund tobacco countermarketing to support existing NYTCP school- and community-based tobacco control initiatives.

Second, the price of cigarettes is a major determinant of quitting smoking for adults and becoming a regular smoker for youth and young adults. The current cigarette excise tax in New York is $1.50 per pack, the 14th highest state tax in the country. In addition to being a relatively low tax, a significant share of the benefits of the tax is being eroded by cigarette tax evasion, most notably from American Indian reservations. Because a significant percentage of smokers regularly evade the tax, the average price paid by smokers overall in the state is estimated to be $0.42 lower than if tax evasion did not exist. If tax evasion were eliminated by 2008, there would be 28,000 fewer smokers in that year and a total of 52,400 fewer smokers by 2010. However, this change along with current funding for the program is not likely to be sufficient to reach the 2010 goal. An increase in the tax by $1.40 per pack in 2008 would lead to an additional 117,400 fewer smokers in 2008 and a total of 222,100 fewer adult smokers by 2010. With these significant changes and the recent decline in smoking, there would be 602,000 fewer adult smokers by 2010. If NYTCP is to achieve its 2010 goal, additional efforts will be required to encourage an additional 298,000 adult smokers to quit.

Third, NYTCP must invest sufficiently in tobacco countermarketing to consistently expose at least 60% of smokers to high-quality, high sensation value messages. Recent experience suggests that the program's current approach and funding levels will be sufficient, provided that the delays and bureaucratic barriers that have existed in the past do not impede these

efforts. In 2006, smokers' awareness of tobacco countermarketing messages averaged 36.5%. If this increases to 60%, then we would estimate that an additional 90,000 smokers would make a quit attempt each year from 2007 to 2010 (based on findings from Chapter 3). If 25% of smokers who make a quit attempt remain quit, then the additional countermarketing will lead to 90,000 additional smokers who quit by 2010.

Fourth, the program will need to average 230,000 incoming calls to the New York State Smokers' Quitline from 2007 through 2010 and continue to distribute NRT to the 88% of new callers that request it. Given the smoking cessation quit rates, this should translate to an additional 120,000 fewer smokers (30,000 per year for 4 years). Increasing this volume to 300,000 incoming calls would translate to 157,000 fewer smokers.

Fifth, NYTCP will need to continue to mobilize community action to achieve policy changes that can contribute to declines in smoking by changing social norms and promoting cessation in health care settings. We recommend complementing community mobilization with coordinated countermarketing efforts that can help legitimize and extend the efforts to change policy and encourage community action. This will require additional funding for NYTCP activities. For example, NYTCP could complement Cessation Center efforts with mass media that encourages more health care providers to support smoking cessation. In addition, implementing targeted mass media campaigns that are coordinated with the efforts of Community Partnerships and Youth Partners may help facilitate local policy change by raising awareness of specific issues and lending credibility to local advocacy efforts. It is very difficult to assess what policy changes might occur and how many fewer smokers might result. We believe that it is reasonable to expect that these efforts will lead to approximately 50,000 fewer smokers through 2010.

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2007 IER Detailed Tables—Estimates by Year

AC. 2-3 Percentage of Adults Who Currently Smoke Every Day or Some Days, ATS 2003-2006.

Year	2003	2004	2005	2006
Estimate*	20.8%	18.1%	13.4%	16.8%
C.I.	[19.1-22.6]	[17.0-19.2]	[12.4-14.6]	[15.3-18.4]
N	3952	8236	7929	8742

AC. 2-4 Average Number of Cigarette Packs Smoked by Current Smokers in the Past 30 Days, ATS 2003-2006.

Year	2003	2004	2005	2006
Estimate	22.1	22.8	23.0	20.4
C.I.	[20.5, 23.6]	[21.5, 24.1]	[21.4, 24.6]	[18.7, 22.2]
N	964	1776	1228	1292

AC. 2-5 Percentage of Middle School Students Who Currently Smoke, YTS 2000-2006.

Year	2000	2002	2004	2006
Estimate*	10.5%	6.3%	5.4%	4.1%
C.I.	[7.7-14.2]	[4.7-8.5]	[4.5-6.5]	[3.1-5.3]
N	4050	4312	3777	2696

AC. 2-6 Percentage of High School Students Who Currently Smoke, YTS 2000-2006.

Year	2000	2002	2004	2006
Estimate*	27.1%	20.4%	18.5%	16.3%
C.I.	[22.6-32.2]	[17.9-23.2]	[15.8-21.5]	[14.2-18.6]
N	4516	3563	4103	4143

AC. 2-7a Percentage of Adults Who Currently Use Any Tobacco Product Other than Cigarettes, ATS 2003-2006.

Year	2003	2004	2005	2006
Estimate*	9.1%	6.7%	5.9%	7.1%
C.I.	[7.7-10.6]	[5.9-7.6]	[5.1-6.8]	[6.0-8.4]
N	3939	8197	7918	8745

AC. 2-7b Percentage of Adults Who Currently Smoke Cigars, ATS 2003-2006.

Year	2003	2004	2005	2006
Estimate*	6.6%	4.5%	4.3%	5.6%
C.I.	[5.4-7.9]	[3.9-5.2]	[3.7-5.1]	[4.6-6.8]
N	3951	8249	7963	8786

AC. 2-7c Percentage of Adults Who Currently Use Smokeless Tobacco, ATS 2003-2006.

Year	2003	2004	2005	2006
Estimate	1.5%	1.1%	0.8%	0.8%
C.I.	[1.0-2.3]	[0.8-1.5]	[0.5-1.2]	[0.5-1.4]
N	3953	8251	7972	8785

AC. 2-8 Percentage of Middle and High School Students Who Have Used Tobacco Products Other Than Cigarettes in the Past 30 Days, YTS 2000-2006.

Year	2000	2002	2004	2006
Middle School				
Estimate*	7.2%	7.2%	5.6%	4.2%
C.I.	[5.6-9.3]	[5.7-9.0]	[4.7-6.8]	[3.1-5.6]
N	4096	4192	3736	2758
High School				
Estimate*	17.9%	14.6%	12.5%	10.8%
C.I.	[14.3-22.1]	[11.9-17.6]	[10.8-14.5]	[8.8-13.3]
N	4589	3482	4126	4286

AC. 2-9 Percentage of Middle and High School Students Who Have Smoked Cigars in the Past 30 Days, YTS 2000-2006.

Year	2000	2002	2004	2006
Middle School				
Estimate	4.5%	3.8%	3.5%	2.7%
C.I.	[3.4-6.1]	[3.0-4.9]	[3.0-4.2]	[1.9-3.9]
N	4122	4305	3801	2810
High School				
Estimate	11.9%	9.5%	8.2%	8.4%
C.I.	[8.9-15.6]	[7.5-12.0]	[6.7-9.8]	[6.9-10.2]
N	4591	3528	4159	4304

AC. 2-10 Percentage of Middle and High School Students Who Have Used Smokeless Tobacco in the Past 30 Days, YTS 2000-2006.

Year	2000	2002	2004	2006
Middle School				
Estimate	1.9%	3.6%	2.5%	1.7%
C.I.	[1.2-3.0]	[2.0-6.1]	[2.0-3.1]	[1.0-2.8]
N	4126	4290	3784	2807
High School				
Estimate	4.5%	5.5%	4.0%	3.1%
C.I.	[3.4-6.1]	[3.1-9.5]	[2.8-5.6]	[2.0-4.9]
N	4574	3526	4146	4301

AC. 2-19 Percentage of Smokers Who Purchased from Low- or Untaxed Sources, ATS 2003-2006.

Year	2003	2004	2005	2006
Estimate*	63.3%	57.3%	56.4%	50.8%
C.I.	[58.8-67.7]	[53.4-61.1]	[52.0-60.7]	[45.7-55.9]
N	965	1369	1241	1307

AC. 2-20a Percentage of Smokers Who Purchased from an Indian Reservation in the Past 12 Months, ATS 2003-2006.

Year	2003	2004	2005	2006
Estimate	32.6%	31.9%	30.4%	28.0%
C.I.	[29.1-36.3]	[28.7-35.3]	[26.8-34.3]	[24.1-32.3]
N	960	1362	1233	1299

AC. 2-20b Percentage of Smokers Who Purchased "All the Time" or "Sometimes" from Indian Reservations, ATS 2003-2006.

Year	2003	2004	2005	2006
Estimate	24.7%	24.5%	24.1%	20.3%
C.I.	[21.6-28.1]	[21.6-27.5]	[20.8-27.7]	[17.0-24.1]
N	957	1362	1233	1292

AC. 2-21a Percentage of Smokers Who Purchased Cigarettes Over the Internet, ATS 2003-2006.

Year	2003	2004	2005	2006
Estimate*	10.4%	9.1%	5.1%	2.1%

C.I.	[8.1-13.4]	[7.3-11.3]	[3.4-7.7]	[1.2-3.8]
N	964	1365	1236	1301

AC. 2-21b Percentage of Smokers Who Purchased "All the Time" or "Sometimes" Over the Internet, ATS 2003-2006.

Year	2003	2004	2005	2006
Estimate*	6.5%	5.9%	3.9%	1.5%
C.I.	[4.7-8.9]	[4.5-7.7]	[2.3-6.5]	[0.7-3.2]
N	963	1364	1234	1301

AC. 2-22a1 Percentage of Smokers Who Purchased Cigarettes from Neighboring States, ATS 2003-2006.

Year	2003	2004	2005	2006
Estimate*	37.5%	31.4%	30.6%	28.9%
C.I.	[33.2-42.0]	[28.0-35.0]	[26.6-34.9]	[24.0-34.3]
N	961	1362	1240	1306

AC. 2-22a2 Percentage of Smokers Who Purchased "All the Time" or "Sometimes" from Neighboring States, ATS 2003-2006.

Year	2003	2004	2005	2006
Estimate	15.6%	12.5%	11.5%	13.8%
C.I.	[12.7-19.0]	[10.4-15.0]	[9.0-14.6]	[10.2-18.5]
N	960	1360	1238	1301

AC. 2-22b1 Percentage of Smokers Who Purchased Cigarettes from Duty-Free Sources, ATS 2003-2006.

Year	2003	2004	2005	2006
Estimate	14.7%	14.2%	12.9%	12.7%
C.I.	[11.7-18.2]	[11.9-16.8]	[10.2-16.1]	[9.2-17.3]
N	949	1353	1224	1286

AC. 2-22b2 Percentage of Smokers Who Purchased "All the Time" or "Sometimes" from Duty-Free Sources, ATS 2003-2006.

Year	2003	2004	2005	2006
Estimate	6.3%	6.2%	5.4%	4.8%
C.I.	[4.4-8.9]	[4.8-7.9]	[3.8-7.7]	[3.1-7.4]
N	949	1353	1223	1285

AC. 2-22c1 Percentage of Smokers Who Purchased Cigarettes from Toll Free Numbers, ATS 2003-2006.

Year	2003	2004	2005	2006
Estimate	6.2%	5.6%	4.5%	3.1%
C.I.	[4.4-8.6]	[4.3-7.4]	[3.0-6.8]	[1.8-5.1]
N	964	1361	1234	1300

AC. 2-22c2 Percentage of Smokers Who Purchased "All the Time" or "Sometimes" from Toll Free Numbers, ATS 2003-2006.

Year	2003	2004	2005	2006
Estimate	4.9%	3.7%	4.2%	2.4%
C.I.	[3.3-7.1]	[2.7-4.9]	[2.7-6.5]	[1.3-4.3]
N	964	1360	1233	1299

AC. 3-23a Percentage of Adults in Smoke-free Homes, ATS 2003-2006.

Year	2003	2004	2005	2006
Estimate*	68.3%	71.0%	74.1%	73.2%
C.I.	[66.1-70.4]	[69.5-72.4]	[72.5-75.6]	[71.3-75.0]
N	3944	8246	7960	8759

AC. 3-23b Percentage of Adult Nonsmokers in Smoke-free Homes, ATS 2003-2006.

Year	2003	2004	2005	2006
Estimate	78.4%	80.4%	81.2%	80.3%
C.I.	[76.1-80.5]	[78.9-81.8]	[79.6-82.7]	[78.3-82.1]
N	2955	6403	6634	7380

AC. 3-23c Percentage of Adult Smokers in Smoke-free Homes, ATS 2003-2006.

Year	2003	2004	2005	2006
Estimate	29.3%	28.0%	28.1%	38.9%
C.I.	[25.3-33.6]	[25.2-31.0]	[24.3-32.2]	[33.9-44.0]
N	984	1812	1269	1324

AC. Percentage of Adults in Smoke-free Cars, ATS 2003-2006.

Year	2003	2004	2005	2006
Estimate*	73.1%	77.7%	80.5%	77.8%
C.I.	[71.0-75.1]	[76.3-79.0]	[79.0-81.9]	[75.9-79.6]
N	3575	7212	7015	7698

AC. Percentage of Adult Nonsmokers in Smoke-free Cars, ATS 2003-2006.

Year	2003	2004	2005	2006
Estimate*	84.3%	87.8%	87.3%	87.3%
C.I.	[82.2-86.3]	[86.5-89.0]	[85.8-88.6]	[85.4-88.9]
N	2707	5646	5905	6535

AC. Percentage of Adult Smokers in Smoke-free Cars, ATS 2003-2006.

Year	2003	2004	2005	2006
Estimate	27.3%	28.6%	32.9%	29.5%
C.I.	[23.1-32.0]	[25.4-32.0]	[28.6-37.5]	[24.7-34.7]
N	863	1539	1065	1115

AC. Average Number of Hours in the Past 7 Days That Adults Spent in a Room Where Someone Was Smoking, ATS 2003-2006.

Year	2003	2004	2005	2006
Estimate*	NA	4.0	6.3	6.7
C.I.	NA	[3.5, 4.5]	[5.0, 7.6]	[5.2, 8.2]
N	NA	8054	1220	1352

AC. Average Number of Hours in the Past 7 Days That Adults Spent in a Vehicle Where Someone Was Smoking, ATS 2003-2006.

Year	2003	2004	2005	2006
Estimate*	NA	1.3	3.7	4.9
C.I.	NA	[1.0, 1.5]	[2.8, 4.6]	[3.5, 6.3]
N	NA	6446	763	948

AC. Average Number of Hours in the Past 7 Days That Adult Nonsmokers Spent in a Room Where Someone was Smoking, ATS 2003-2006.

Year	2003	2004	2005	2006
Estimate*	NA	1.0	4.4	5.3
C.I.	NA	[0.8, 1.1]	[3.1, 5.7]	[3.7, 6.9]
N	NA	6360	888	992

AC. Average Number of Hours in the Past 7 Days That Adult Smokers Spent in a Room Where Someone was Smoking, ATS 2003-2006.

Year	2003	2004	2005	2006
Estimate*	NA	18.8	12.7	10.2
C.I.	NA	[16.3, 21.3]	[9.2, 16.3]	[6.8, 13.7]
N	NA	1668	322	358

AC. Average Number of Hours in the Past 7 Days That Adult Nonsmokers Spent in a Vehicle Where Someone was Smoking, ATS 2003-2006.

Year	2003	2004	2005	2006
Estimate*	NA	0.3	2.0	3.4
C.I.	NA	[0.2, 0.5]	[1.1, 2.9]	[1.1, 5.6]
N	NA	4848	292	422

AC. Average Number of Hours in the Past 7 Days That Adult Smokers Spent in a Vehicle Where Someone was Smoking, ATS 2003-2006.

Year	2003	2004	2005	2006
Estimate	NA	4.9	5.3	6.1
C.I.	NA	[3.8, 6.1]	[3.8, 6.8]	[4.4, 7.9]
N	NA	1575	468	523

AC. Number of Days in the Past Week that Middle and High School Students Were in a Room with a Smoker, YTS 2000-2006.

Year	2000	2002	2004	2006
Middle School				
Estimate*	2.4	2.2	1.8	1.7
C.I.	[2.2, 2.7]	[1.7, 2.7]	[1.6, 2]	[1.4, 1.9]
N	3936	3984	3748	2777
High School				

Estimate*	3.1	2.7	2.3	2.1
C.I.	[2.8, 3.4]	[2.5, 2.9]	[2.1, 2.6]	[1.9, 2.4]
N	4543	3412	4166	4293

AC. Number of Days in the Past Week that Middle and High School Students Were in a Car with a Smoker, YTS 2000-2006.

Year	2000	2002	2004	2006
Middle School				
Estimate*	1.6	1.5	1.2	1.1
C.I.	[1.3, 1.8]	[1.1, 1.9]	[1, 1.4]	[0.9, 1.2]
N	3927	3971	3762	2778
High School				
Estimate*	1.9	1.7	1.5	1.3
C.I.	[1.6, 2.2]	[1.4, 2]	[1.3, 1.7]	[1.1, 1.5]
N	4544	3412	4177	4297

AC. Number of Days in the Past Week that Middle School Students Who Live With a Smoker Were in a Room with a Smoker, YTS 2000-2006.

Year	2000	2002	2004	2006
Middle School				
Estimate*	4.2	4.0	3.4	3.2
C.I.	[3.9, 4.4]	[3.5, 4.6]	[3.1, 3.7]	[2.9, 3.5]
N	1672	1464	1505	1080
High School				
Estimate*	4.2	4.0	3.4	3.2
C.I.	[3.9, 4.4]	[3.5, 4.6]	[3.1, 3.7]	[2.9, 3.5]
N	1672	1464	1505	1080

AC. Number of Days in the Past Week that Middle School Students Who Do Not Live With a Smoker Were in a Room with a Smoker, YTS 2000-2006.

Year	2000	2002	2004	2006
Middle School				
Estimate*	1.2	1.0	0.7	0.7
C.I.	[1, 1.3]	[0.8, 1.2]	[0.6, 0.8]	[0.6, 0.8]
N	2222	2445	2158	1656
High School				

Estimate*	2.0	1.6	1.3	1.1
C.I.	[1.8, 2.3]	[1.4, 1.8]	[1.2, 1.4]	[1, 1.3]
N	2667	2102	2537	2674

AC. Number of Days in the Past Week that Middle and High School Students Who Live With a Smoker Were in a Car With a Smoker, YTS 2000-2006.

Year	2000	2002	2004	2006
Middle School				
Estimate*	3.0	2.9	2.5	2.3
C.I.	[2.7, 3.3]	[2.4, 3.5]	[2.1, 2.9]	[2, 2.6]
N	1672	1461	1510	1077
High School				
Estimate*	1.1	0.9	0.8	0.6
C.I.	[0.9, 1.3]	[0.7, 1.1]	[0.6, 0.9]	[0.5, 0.7]
N	2670	2108	2551	2674

AC. Number of Days in the Past Week that Middle and High School Students Who Do Not Live With a Smoker Were in a Car With a Smoker, YTS 2000-2006.

Year	2000	2002	2004	2006
Middle School				
Estimate*	0.5	0.5	0.3	0.3
C.I.	[0.4, 0.7]	[0.4, 0.6]	[0.2, 0.4]	[0.2, 0.3]
N	2217	2442	2168	1660
High School				
Estimate*	1.1	0.9	0.8	0.6
C.I.	[0.9, 1.3]	[0.7, 1.1]	[0.6, 0.9]	[0.5, 0.7]
N	2670	2108	2551	2674

AC. Percentage of Indoor Workers Who Reported Seeing Smoking in their Work Area in the Past Week, ATS 2003-2006.

Year	2003	2004	2005	2006
Estimate	10.7%	10.0%	9.2%	7.4%
C.I.	[8.7-13.2]	[8.5-11.7]	[7.4-11.3]	[5.5-9.8]
N	1760	3616	3357	3444

AC. Percentage of Restaurant Patrons Who Saw Smoking Indoors in the Past 30 Days, ATS 2003-2006.

Year	2003	2004	2005	2006
Estimate*	9.0%	4.4%	4.1%	4.5%
C.I.	[7.7-10.5]	[3.7-5.2]	[3.2-5.2]	[3.3-6.0]
N	3334	6445	6042	2827

AC. Percentage of Bar Patrons, Who Saw Smoking Indoors in the Past 30 Days, ATS 2003-2006.

Year	2003	2004	2005	2006
Estimate*	32.8%	19.3%	22.7%	23.8%
C.I.	[28.1-37.8]	[16.6-22.3]	[18.8-27.2]	[17.6-31.3]
N	748	1564	1364	590

AC. Percentage of Middle and High School Students Who Have Been Asked for Proof of Age When Purchasing Cigarettes, YTS 2000-2006.

Year	2000	2002	2004	2006
Middle School				
Estimate	35.0%	22.3%	30.4%	29.2%
C.I.	[24.5-47.0]	[10.1-42.1]	[24.9-36.5]	[21.9-37.8]
N	211	213	182	126
High School				
Estimate	49.4%	54.7%	53.5%	54.6%
C.I.	[43.9-54.8]	[46.5-62.7]	[47.7-59.3]	[47.5-61.6]
N	913	527	549	490

AC. Percentage of Middle and High School Students Who Have Been Refused Sale of Cigarettes Because of Age, YTS 2000-2006.

Year	2000	2002	2004	2006
Middle School				
Estimate	37.2%	30.2%	39.8%	43.1%
C.I.	[27.9-47.6]	[23.7-37.5]	[34.6-45.3]	[35.3-51.3]
N	251	251	195	131
High School				
Estimate	31.8%	33.1%	35.9%	34.0%
C.I.	[25.8-38.5]	[24.7-42.8]	[29.7-42.7]	[28.4-40.2]
N	919	536	523	464

AC. Percentage of Adults Who Favor the Clean Indoor Air Act, ATS 2003-2006.

Year	2003	2004	2005	2006
Estimate*	32.8%	19.3%	22.7%	11.9%
C.I.	[28.1-37.8]	[16.6-22.3]	[18.8-27.2]	[10.2-13.8]
N	748	1564	1364	5672

AC. Percentage of Adult Nonsmokers Who Favor the Clean Indoor Air Act, ATS 2003-2006.

Year	2003	2004	2005	2006
Estimate*	75.8%	80.6%	85.3%	86.1%
C.I.	[73.3-78.1]	[79.1-82.0]	[83.9-86.6]	[84.4-87.7]
N	2909	6308	6561	7325

AC. Percentage of Adult Smokers Who Favor the Clean Indoor Air Act, ATS 2003-2006.

Year	2003	2004	2005	2006
Estimate*	28.2%	33.5%	42.9%	48.9%
C.I.	[24.2-32.6]	[30.3-36.9]	[38.6-47.3]	[43.8-54.1]
N	969	1768	1248	1302

AC. 5-20a Percentage of Adults Who Would Be in Favor of a Law Banning Smoking in Outdoor Public Places Such as Beaches or Parks, ATS 2005-2006.

Year	2005	2006
Estimate*	53.9%	56.8%
C.I.	[52.1-55.7]	[54.8-58.8]
N	7951	8780

AC. 5-20b Percentage of Adults Who Would Be in Favor of a Law Banning Smoking in the Entranceways of Public Buildings and Workplaces, ATS 2005-2006.

Year	2005	2006
Estimate	76.6%	77.1%
C.I.	[75.1-78.1]	[75.3-78.8]
N	7947	8779

AC. 3-16a Percentage of Adults Who Believe Secondhand Smoke Causes Heart Disease, ATS 2003-2006.

Year	2003	2004	2005	2006
Estimate*	67.6%	71.6%	71.5%	75.9%
C.I.	[65.3-69.7]	[70.2-73.0]	[69.9-73.1]	[74.2-77.6]
N	3943	8241	7964	8781

AC. 3-16b Percentage of Adult Nonsmokers Who Believe Secondhand Smoke Causes Heart Disease, ATS 2003-2006.

Year	2003	2004	2005	2006
Estimate*	71.6%	74.9%	73.3%	77.9%
C.I.	[69.1-74.0]	[73.4-76.4]	[71.5-75.0]	[76.1-79.6]
N	2957	6401	6639	7400

AC. 3-16c Percentage of Adult Smokers Who Believe Secondhand Smoke Causes Heart Disease, ATS 2003-2006.

Year	2003	2004	2005	2006
Estimate	52.5%	56.8%	60.9%	66.6%
C.I.	[48.0-57.0]	[53.4-60.0]	[56.7-65.0]	[61.9-71.1]
N	981	1809	1269	1324

AC. 3-17a Percentage of Adults Who Believe Secondhand Smoke Causes Lung Cancer, ATS 2003-2006.

Year	2003	2004	2005	2006
Estimate	81.3%	83.5%	83.2%	83.1%
C.I.	[79.4-83.0]	[82.3-84.6]	[81.9-84.4]	[81.6-84.5]
N	3947	8247	7971	8783

AC. 3-17b Percentage of Adult Nonsmokers Who Believe Secondhand Smoke Causes Lung Cancer, ATS 2003-2006.

Year	2003	2004	2005	2006
Estimate	85.7%	87.5%	86.1%	85.6%
C.I.	[83.7-87.5]	[86.3-88.6]	[84.7-87.3]	[84.0-87.1]
N	2959	6407	6644	7402

AC. 3-17c Percentage of Adult Smokers Who Believe Secondhand Smoke Causes Lung Cancer, ATS 2003-2006.

Year	2003	2004	2005	2006
Estimate	64.6%	65.5%	65.6%	71.1%
C.I.	[60.3-68.8]	[62.3-68.6]	[61.5-69.4]	[66.6-75.2]
N	983	1808	1271	1324

AC. 3-18a Percentage of Adults Who Believe that Breathing Smoke From Other People's Cigarettes Causes Respiratory Problems in Children, ATS 2003-2006.

Year	2003	2004	2005	2006
Estimate	91.6%	92.2%	92.7%	94.3%
C.I.	[90.2-92.8]	[91.4-93.0]	[91.8-93.6]	[93.2-95.2]
N	3949	8253	7981	8789

AC. 3-18b Percentage of Adult Nonsmokers Who Believe that Breathing Smoke From Other People's Cigarettes Causes Respiratory Problems in Children, ATS 2003-2006.

Year	2003	2004	2005	2006
Estimate	94.0%	94.0%	93.8%	95.2%
C.I.	[92.5-95.2]	[93.1-94.7]	[92.8-94.7]	[94.0-96.2]
N	2961	6414	6653	7407

AC. 3-18c Percentage of Adult Smokers Who Believe that Breathing Smoke From Other People's Cigarettes Causes Respiratory Problems in Children, ATS 2003-2006.

Year	2003	2004	2005	2006
Estimate	83.1%	84.7%	86.2%	90.0%
C.I.	[79.5-86.1]	[82.3-86.8]	[83.1-88.8]	[87.2-92.3]
N	983	1807	1271	1326

AC. Percentage of Middle and High School Students Who Think Secondhand Smoke is Harmful, YTS 2000-2006.

Year	2000	2002	2004	2006
Middle School				

Estimate*	90.2%	87.1%	92.1%	93.9%
C.I.	[87.8-92.1]	[83.1-90.2]	[90.4-93.5]	[92.2-95.3]
N	3954	4191	3742	2782
High School				
Estimate*	90.5%	90.9%	93.1%	95.4%
C.I.	[88.4-92.2]	[87.7-93.4]	[91.4-94.5]	[94.1-96.4]
N	4554	3505	4171	4292

AC. Percentage of Adults Who Believe Tobacco-Related News Stories are Negatively Slanted in the Media, ATS 2003-2006.

Year	2003	2004	2005	2006
Estimate	46.5%	45.3%	44.4%	48.0%
C.I.	[44.1-48.9]	[43.7-46.9]	[42.6-46.3]	[46.0-50.1]
N	3872	8023	7825	8578

AC. Percentage of Middle and High School Students Who Would Wear Tobacco Branded Attire, YTS 2000-2006.

Year	2000	2002	2004	2006
Middle School				
Estimate	22.1%	19.7%	20.5%	17.6%
C.I.	[18.6-26.1]	[15.6-24.6]	[18.6-22.6]	[14.4-21.5]
N	3936	3976	3653	2763
High School				
Estimate*	33.7%	28.2%	28.1%	27.7%
C.I.	[30.6-36.8]	[24.7-31.9]	[25.6-30.6]	[25.1-30.5]
N	4552	3420	4148	4277

AC Percentage of Middle and High School Students Who Have Seen Tobacco Advertising on the Internet, YTS 2000-2006.

Year	2000	2002	2004	2006
Middle School				
Estimate*	56.8%	68.7%	65.8%	68.3%
C.I.	[53.1-60.4]	[65.6-71.7]	[62.1-69.4]	[64.5-71.8]
N	4026	4059	3605	2742
High School				
Estimate*	57.5%	71.8%	72.1%	75.7%

C.I.	[54.2-60.6]	[69.1-74.4]	[69.2-74.8]	[73.4-77.9]
N	4576	3458	4127	4262

AC. Percentage of Middle and High School Students Who Have Seen Tobacco Advertising in Newspapers or Magazines, YTS 2000-2006.

Year	2000	2002	2004	2006
Middle School				
Estimate*	77.6%	77.2%	61.9%	60.9%
C.I.	[75.0-80.0]	[75.0-79.3]	[58.5-65.1]	[56.7-64.9]
N	3984	4051	3514	2705
High School				
Estimate*	84.7%	84.8%	76.4%	74.8%
C.I.	[82.4-86.8]	[82.4-87.0]	[74.3-78.4]	[72.2-77.3]
N	4565	3456	4114	4246

AC. Percentage of Adults Who Have Seen Antismoking Advertising on Television, ATS 2003-2006.

Year	2003	2004	2005	2006
Estimate*	75.5%	70.9%	68.9%	79.4%
C.I.	[73.3-77.5]	[69.4-72.4]	[67.1-70.6]	[77.7-81.0]
N	3665	7507	7196	8011

AC. Percentage of Adults Who Have Seen Advertising About Family Members Losing a Loved One Due to Smoking-Related Illnesses, ATS 2003-2006.

Year	2003	2004	2005	2006
Estimate*	45.8%	47.6%	50.3%	55.3%
C.I.	[43.4-48.2]	[46.0-49.2]	[48.5-52.2]	[53.3-57.3]
N	3918	8150	7826	8613

AC. Percentage of Adult Smokers Who Have Seen Advertising About Family Members Losing a Loved One Due to Smoking-Related Illnesses, ATS 2003-2006.

Year	2003	2004	2005	2006
Estimate*	45.5%	49.4%	55.1%	58.0%
C.I.	[41.1-50.1]	[46.1-52.8]	[50.7-59.3]	[53.0-62.8]
N	975	1786	1261	1315

AC. Percentage of Adult Smokers Who Have Noticed Advertising About the Dangers of Children Being Exposed to Cigarette Smoke, ATS 2003-2006.

Year	2003	2004	2005	2006
Estimate	64.1%	67.5%	65.3%	76.8%
C.I.	[59.5-68.4]	[64.3-70.5]	[61.1-69.2]	[72.6-80.5]
N	973	1798	1252	1312

AC. 3-11a Percentage of Adults Who Have Noticed Advertisements About Calling a Quitline, ATS 2003-2006.

Year	2003	2004	2005	2006
Estimate*	49.4%	50.3%	49.7%	57.9%
C.I.	[47.0-51.8]	[48.7-51.9]	[47.8-51.5]	[55.8-59.9]
N	3893	8103	7827	8598

AC. 3-11b Percentage of Adult Nonsmokers Who Have Noticed Advertisements About Calling a Quitline, ATS 2003-2006.

Year	2003	2004	2005	2006
Estimate*	47.9%	49.0%	48.7%	56.3%
C.I.	[45.2-50.7]	[47.2-50.8]	[46.7-50.7]	[54.1-58.6]
N	2918	6275	6519	7235

AC. 3-11c Percentage of Adult Smokers Who Have Noticed Advertisements About Calling a Quitline, ATS 2003-2006.

Year	2003	2004	2005	2006
Estimate*	55.4%	56.3%	56.0%	66.5%
C.I.	[50.8-59.9]	[53.0-59.6]	[51.6-60.2]	[61.6-71.0]
N	970	1797	1254	1311

AC. 3-3a Percentage of Adults Who Reported Confirmed Awareness of NYTCP Media Campaign Advertisements (Statewide and Local), ATS 2003-2006.

Year	2003	2004	2005	2006
Estimate*	6.3%	18.6%	29.7%	30.9%
C.I.	[5.0-8.0]	[17.3-20.1]	[28.1-31.4]	[29.0-32.8]
N	1894	6418	7975	8747

AC. 3-3b Percentage of Adult Nonsmokers Who Reported Confirmed Awareness of NYTCP Media Campaign Advertisements (Statewide and Local), ATS 2003-2006.

Year	2003	2004	2005	2006
Estimate*	6.4%	18.4%	28.5%	29.8%
C.I.	[4.9-8.4]	[16.9-20.1]	[26.7-30.3]	[27.8-31.9]
N	1440	5050	6648	7373

AC. 3-3c Percentage of Adult Smokers Who Reported Confirmed Awareness of NYTCP Media Campaign Advertisements (Statewide and Local), ATS 2003-2006.

Year	2003	2004	2005	2006
Estimate*	5.9%	20.1%	38.8%	36.5%
C.I.	[3.8-8.9]	[17.1-23.4]	[34.6-43.1]	[31.6-41.7]
N	452	1342	1270	1317

AC. 3-7a1 Percentage of Adults Who Reported Confirmed Awareness of Media Campaign Advertisements and Said that the Ad Said Something Important to Them (Statewide and Local), ATS 2003-2006.

Year	2003	2004	2005	2006
Estimate *	74.4%	91.6%	90.7%	91.4%
C.I.	[64.2, 84.5]	[89.6, 93.6]	[88.8, 92.7]	[89.4, 93.4]
N	164	1111	2380	2438

AC. 3-7a1 Percentage of Adult Nonsmokers Who Reported Confirmed Awareness of Media Campaign Advertisements and Said that the Ad Said Something Important to Them (Statewide and Local), ATS 2003-2006.

Year	2003	2004	2005	2006
Estimate	84.1%	94.0%	92.6%	93.0%
C.I.	[73.9, 94.3]	[92.1, 95.8]	[90.5, 94.6]	[91.2, 94.8]
N	121	862	1898	1991

AC. 3-7a2 Percentage of Adult Smokers Who Reported Confirmed Awareness of Media Campaign Advertisements and Said that the Ad Said Something Important to Them (Statewide and Local), ATS 2003-2006.

Year	2003	2004	2005	2006

Estimate *	37.5%	81.2%	82.2%	84.9%
C.I.	[17.2, 57.8]	[74.6, 87.7]	[76.9, 87.5]	[78.0, 91.8]
N	43	248	473	437

AC. 3-7b1 Percentage of Adults Who Reported Confirmed Awareness of Media Campaign Advertisements and Said that they Had Talked to Someone About the Ad (Statewide and Local), ATS 2003-2006.

Year	2003	2004	2005	2006
Estimate	23.9%	24.4%	24.9%	29.3%
C.I.	[12.4, 35.5]	[20.7, 28.1]	[22.2, 27.6]	[25.9, 32.6]
N	170	1135	2414	2479

AC. 3-7b1 Percentage of Adult Nonsmokers Who Reported Confirmed Awareness of Media Campaign Advertisements and Said that they Had Talked to Someone About the Ad (Statewide and Local), ATS 2003-2006.

Year	2003	2004	2005	2006
Estimate	27.4%	25.1%	25.9%	28.5%
C.I.	[13.6, 41.2]	[21.0, 29.3]	[22.8, 29.0]	[25.0, 32.0]
N	127	881	1924	2021

AC. 3-7b2 Percentage of Adult Smokers Who Reported Confirmed Awareness of Media Campaign Advertisements and Said that they Had Talked to Someone About the Ad (Statewide and Local), ATS 2003-2006.

Year	2003	2004	2005	2006
Estimate *	10.5%	21.4%	20.0%	32.5%
C.I.	[-2.8, 23.8]	[13.7, 29.2]	[14.6, 25.5]	[23.4, 41.5]
N	43	252	481	448

AC. Percentage of Middle and High School Students Who Were Aware of Reality Check, YTS 2000-2006.

Year	2004	2006
Middle School		
Estimate	32.3%	39.7%
C.I.	[27.8-37.1]	[32.6-47.3]
N	2693	2776

High School		
Estimate	36.3%	43.5%
C.I.	[27.6-46.0]	[37.2-49.9]
N	3331	4289

AC. Percentage of Middle and High School Students Who Had Participated in Reality Check Events, YTS 2000-2006.

Year	2004	2006
Middle School		
Estimate	6.3%	5.8%
C.I.	[4.5-8.7]	[3.0-11.0]
N	2670	2770
High School		
Estimate	9.0%	4.7%
C.I.	[4.3-17.7]	[3.2-6.8]
N	3301	4293

AC. 3-14a Percentage of Adult Smokers Who Believed Smokers Have a Higher Risk of Heart Attack, ATS 2003-2006.

Year	2003	2004	2005	2006
Estimate	58.9%	62.2%	65.6%	60.9%
C.I.	[54.3-63.3]	[57.6-66.5]	[61.5-69.6]	[55.8-65.8]
N	951	961	1214	1281

AC. 3-14b Percentage of Adult Smokers Who Believed Smokers Have a Higher Risk of Lung Cancer, ATS 2003-2006.

Year	2003	2004	2005	2006
Estimate	74.3%	76.8%	77.7%	77.2%
C.I.	[70.2-78.1]	[73.0-80.3]	[74.1-81.0]	[72.9-81.1]
N	963	973	1231	1299

AC. Percentage of Adult Smokers Who Believed Smokers Have a Higher Risk of Cancers Other Than Lung Cancer, ATS 2003-2006.

Year	2003	2004	2005	2006
Estimate*	74.3%	76.8%	77.7%	77.2%
C.I.	[70.2-78.1]	[73.0-80.3]	[74.1-81.0]	[72.9-81.1]

N	963	973	1231	1299

AC. Percentage of Adult Smokers Who Think There Is Little Health Benefit To Quitting If a Person Has Smoked a Pack of Cigarettes a Day for More Than 20 Years, ATS 2003-2006.

Year	2003	2004	2005	2006
Estimate	32.1%	32.8%	32.2%	28.7%
C.I.	[27.8-36.8]	[28.6-37.4]	[28.0-36.6]	[24.1-33.7]
N	960	963	1231	1284

AC. Percentage of Adult Smokers Who Do Not Think That High-Tar Cigarettes Are At Least Twice As Likely To Cause Illness As Low-Tar Cigarettes, ATS 2003-2006.

Year	2003	2004	2005	2006
Estimate	38.9%	44.1%	48.0%	42.2%
C.I.	[34.4-43.6]	[39.4-48.9]	[43.4-52.7]	[37.1-47.5]
N	849	864	1078	1165

AC. 3-15a Percentage of Adults Who Believe the Harmful Effects of Cigarettes Have Not Been Exaggerated, ATS 2003-2006.

Year	2003	2004	2005	2006
Estimate*	NA	75.3%	80.6%	82.1%
C.I.	NA	[73.2-77.3]	[78.9-82.2]	[79.6-84.4]
N	NA	3917	7754	3586

AC. 3-15b Percentage of Adult Nonsmokers Who Believe the Harmful Effects of Cigarettes Have Not Been Exaggerated, ATS 2003-2006.

Year	2003	2004	2005	2006
Estimate*	NA	79.0%	83.2%	84.4%
C.I.	NA	[76.7-81.1]	[81.4-84.9]	[81.6-86.8]
N	NA	3111	6472	3014

AC. 3-15c Percentage of Adult Smokers Who Believe the Harmful Effects of Cigarettes Have Not Been Exaggerated, ATS 2003-2006.

Year	2003	2004	2005	2006
Estimate*	NA	56.9%	63.5%	70.7%

C.I.	NA	[51.9-61.7]	[59.0-67.8]	[63.5-77.0]
N	NA	788	1232	547

AC. 5-25a Percentage of Adults Who Agree That Movies Rated G, PG, and PG-13 Should Not Show Actors Smoking, ATS 2003-2006.

Year	2003	2004	2005	2006
Estimate*	68.3%	69.6%	78.7%	82.1%
C.I.	[65.2-71.3]	[68.1-71.1]	[77.1-80.2]	[80.4-83.7]
N	1987	7861	7706	8554

AC. 5-25b Percentage of Adult Nonsmokers Who Agree That Movies Rated G, PG, and PG-13 Should Not Show Actors Smoking, ATS 2003-2006.

Year	2003	2004	2005	2006
Estimate	71.6%	71.8%	80.2%	84.0%
C.I.	[68.0-75.0]	[70.1-73.4]	[78.5-81.9]	[82.1-85.6]
N	1465	6088	6434	7195

AC. 5-25c Percentage of Adult Smokers Who Agree That Movies Rated G, PG, and PG-13 Should Not Show Actors Smoking, ATS 2003-2006.

Year	2003	2004	2005	2006
Estimate	54.7%	59.7%	69.0%	73.9%
C.I.	[48.5-60.7]	[56.3-63.0]	[64.8-72.9]	[69.1-78.2]
N	519	1743	1216	1306

AC. 5-24a Percentage of Adults that Agree that Actors Smoking in the Movies Encourages Smoking among Teens, ATS 2003-2006.

Year	2003	2004	2005	2006
Estimate*	72.2%	68.0%	73.6%	77.1%
C.I.	[69.1-75.2]	[66.4-69.5]	[71.9-75.3]	[75.3-78.8]
N	1974	7834	7637	8469

AC. 5-24b Percentage of Adult Nonsmokers that Agree that Actors Smoking in the Movies Encourages Smoking among Teens, ATS 2003-2006.

Year	2003	2004	2005	2006
Estimate*	74.6%	70.8%	75.1%	78.1%
C.I.	[70.9-77.9]	[69.0-72.5]	[73.1-76.9]	[76.1-80.0]
N	1465	6079	6372	7136

AC. 5-24c Percentage of Adult Smokers that Agree that Actors Smoking in the Movies Encourages Smoking among Teens, ATS 2003-2006.

Year	2003	2004	2005	2006
Estimate*	63.1%	55.7%	63.3%	72.4%
C.I.	[57.0-68.7]	[52.2-59.1]	[58.9-67.5]	[67.8-76.6]
N	507	1728	1210	1282

AC. Percentage of Middle and High School Students Who Think Smoking Makes People Look Cool, YTS 2002-2006.

Year	2002	2004	2006
Middle School			
Estimate*	15.5%	11.2%	10.1%
C.I.	[13.0-18.4]	[10.0-12.4]	[8.6-11.9]
N	4199	3620	2744
High School			
Estimate*	14.8%	10.9%	10.4%
C.I.	[12.5-17.3]	[9.1-13.0]	[8.4-12.8]
N	3501	4141	4281

AC. Percentage of Middle and High School Students Who Think it is Safe to Smoke for Just a Year or Two, YTS 2002-2004.

Year	2002	2004	2006
Middle School			
Estimate*	10.1%	9.6%	6.2%
C.I.	[8.7-11.8]	[8.5-10.9]	[4.9-7.8]
N	4206	3665	2761
High School			
Estimate*	13.3%	10.4%	9.1%
C.I.	[11.8-14.9]	[8.8-12.2]	[7.9-10.4]
N	3504	4138	4280

AC. Percentage of Adult Smokers Who Visited a Doctor, Nurse, or Other Health Professional in the Past 12 Months, ATS 2003-2006.

Year	2003	2004	2005	2006
Estimate*	61.6%	63.7%	67.5%	74.4%
C.I.	[57.0-65.9]	[60.3-66.9]	[63.2-71.6]	[69.5-78.8]
N	985	1812	1269	1327

AC. 5-9 Percentage of Adult Smokers Who Were Asked If They Smoked When They Visited a Health Care Provider in the Past 12 Months, ATS 2003-2006.

Year	2003	2004	2005	2006
Estimate	91.9%	87.0%	89.1%	87.7%
C.I.	[88.2-94.6]	[83.6-89.8]	[85.3-92.1]	[84.0-90.6]
N	644	1216	894	1032

AC. 5-10 Percentage of Adult Smokers Who Were Advised to Quit Smoking When They Visited a Health Care Provider in the Past 12 Months, ATS 2003-2006.

Year	2003	2004	2005	2006
Estimate	74.7%	69.9%	77.0%	76.6%
C.I.	[69.3-79.5]	[65.8-73.7]	[72.4-81.0]	[71.8-80.7]
N	645	1219	896	1034

AC. 5-11 Percentage of Adult Smokers Who Report that their Health Care Provider Assisted Them with Smoking Cessation When They Visited a Health Care Provider in the Past 12 Months, ATS 2003-2006.

Year	2003	2004	2005	2006
Estimate	37.4%	38.0%	43.8%	44.6%
C.I.	[32.3-42.9]	[34.2-41.9]	[38.9-48.9]	[38.8-50.6]
N	642	1213	893	1031

AC. Percentage of Adult Smokers Who Have Heard of the New York State Smokers' Quitline, ATS 2003-2006.

Year	2003	2004	2005	2006
Estimate*	54.7%	57.0%	67.4%	69.7%
C.I.	[50.2-59.2]	[53.7-60.4]	[63.3-71.4]	[64.7-74.2]

N	978	1803	1266	1314

AC. Percentage of Adult Smokers Who Have Called the New York State Smokers'Quitline, ATS 2003-2006.

Year	2003	2004	2005	2006
Estimate	6.4%	6.7%	4.1%	9.6%
C.I.	[3.7-10.8]	[4.8-9.2]	[2.5-6.7]	[6.2-14.5]
N	534	1031	862	961

AC. Percentage of Adult Former Smokers or Current Smokers with A Quit Attempt in the Past 12 Months Who Have Used a Nicotine Patch or Nicotine Gum, ATS 2003-2006.

Year	2003	2004	2005	2006
Estimate	27.0%	22.6%	27.9%	25.8%
C.I.	[21.8-32.9]	[19.3-26.4]	[23.2-33.0]	[20.6-31.7]
N	545	1047	799	894

AC. 3-20 Percentage of Adult Smokers Who Were Planning to Stop Smoking in the Next 30 Days, ATS 2003-2006.

Year	2003	2004	2005	2006
Estimate	26.0%	24.3%	28.5%	32.3%
C.I.	[22.0-30.4]	[21.2-27.7]	[24.5-32.8]	[27.1-37.9]
N	901	1517	1127	1156

AC. 3-21 Percentage of Smokers Who Made a Quit Attempt in the Past 12 Months, ATS 2003-2006.

Year	2003	2004	2005	2006
Estimate*	46.3%	46.3%	49.4%	54.1%
C.I.	[41.9-50.9]	[43.0-49.6]	[45.1-53.7]	[49.0-59.1]
N	982	1810	1267	1322

AC. 3-22 Percentage of Smokers Who Made a Successful Quit Attempt in the Past 12 Months (Remained Quit for More Than 6 Months), ATS 2003-2006.

Year	2003	2004	2005	2006

Estimate*	14.9%	25.9%	24.9%	14.4%
C.I.	[10.7-20.5]	[22.1-30.0]	[20.8-29.5]	[11.6-17.7]
N	584	1288	963	1062

DT. Percentage of Tobacco Retailers with Any Interior or Exterior Cigarette Advertising, By Region, RATS 2004-2006

Year	2004	2005	2006
Estimate*	95.2%	96.3%	97.0%
C.I.	[94.3, 96.1]	[95.6, 97.1]	[96.4, 97.6]
N	2266	2374	2896

DT. Percentage of Tobacco Retailers with Any Exterior Cigarette Advertising,, RATS 2004-2006

Year	2004	2005	2006
Estimate*	53.2%	52.4%	59.2%
C.I.	[51.1, 55.2]	[50.4, 54.4]	[57.4, 61.0]
N	2266	2379	2896

DT. Percentage of Tobacco Retailers with Any Interior Cigarette Advertising,, RATS 2004-2006

Year	2004	2005	2006
Estimate*	94.4%	95.2%	96.8%
C.I.	[93.4, 95.3]	[94.3, 96.0]	[96.2, 97.5]
N	2266	2355	2893

DT. Percentage of New York Tobacco Retailers with Purchase Promotions,, RATS 2004-2006

Year	2004	2005	2006
Estimate*	17.2%	21.2%	13.8%
C.I.	[15.7, 18.8]	[19.6, 22.8]	[12.6, 15.1]
N	2266	2395	2897

DT.2-3 Percentage of Adults Who Currently Smoke Every Day or Some Days, ATS 2003-2006

Category	Estimate	C.I.	N
Age*			
18-24	22.9%	[20.3-25.8]	1540
25-34	20.6%	[18.7-22.6]	3614
35-44	19.6%	[18.1-21.2]	5368
45-54	19.0%	[17.5-20.6]	5887
55-64	14.8%	[13.3-16.4]	5159
65 + years	7.6%	[6.7-8.7]	6731
Race*			
White (non-Hispanic)	17.5%	[16.7-18.3]	22666
Black (non-Hispanic)	18.1%	[16.1-20.3]	2507
Hispanic	18.0%	[15.7-20.5]	2122
Other	12.3%	[10.3-14.6]	1564
Gender*			
Male	19.1%	[18.0-20.3]	10988
Female	15.6%	[14.8-16.4]	17863
Education*			
Less Than High School	28.3%	[25.2-31.7]	1958
High School	22.9%	[21.4-24.5]	7815
Some College	19.3%	[17.9-20.8]	6965
College Degree or More	10.1%	[9.3-11.0]	11990
Region*			
Western	20.1%	[18.6-21.6]	7236
Central	21.4%	[19.4-23.5]	3729
Capital	20.7%	[18.5-23.1]	3327
Metro	15.5%	[14.7-16.4]	14453
Insurance*			
Public	18.2%	[16.8-19.8]	7417
Private	14.6%	[13.8-15.5]	17855
None	26.8%	[24.5-29.3]	2946

DT.2-4 Average Number of Cigarette Packs Smoked by Current Smokers in the Past 30 Days, ATS 2003-2006.

Category	Estimate	C.I.	N
Age *			
18-24	18.0	[16.0, 20.1]	465
25-34	19.2	[17.5, 20.8]	875
35-44	23.5	[21.9, 25.1]	1201
45-54	24.5	[22.5, 26.6]	1292
55-64	24.2	[22.3, 26.0]	841
65 + years	24.1	[21.8, 26.5]	534
Race *			
White (non-Hispanic)	24.8	[23.9, 25.8]	4061
Black (non-Hispanic)	16.4	[14.4, 18.5]	534
Hispanic	16.4	[14.1, 18.7]	399
Other	19.6	[16.7, 22.5]	266
Gender *			
Male	23.7	[22.4, 24.9]	2207
Female	20.3	[19.4, 21.2]	3052
Education *			
Less Than High School	22.6	[20.0, 25.3]	543
High School	25.0	[23.6, 26.4]	1865
Some College	21.2	[19.9, 22.4]	1542
College Degree or More	18.3	[16.8, 19.8]	1297
Region *			
Western	24.4	[23.1, 25.6]	1428
Central	26.6	[24.0, 29.1]	808
Capital	25.5	[23.5, 27.5]	688
Metro	19.9	[18.8, 20.9]	2311
Insurance			
Public	22.2	[20.6, 23.9]	1281
Private	21.7	[20.7, 22.8]	2925
None	23.0	[21.0, 25.0]	944

DT. 2-5 Percentage of Middle School Students Who Currently Smoke, YTS 2000-2006

Category	Estimate	C.I.	N
Gender*			
Female	5.0%	[3.8-6.5]	1494
Male	3.2%	[2.3-4.4]	1183
Race			
White	3.8%	[2.7-5.3]	825
Black	4.3%	[2.2-8.3]	501
Hispanic	6.6%	[4.0-10.8]	994
Other	2.4%	[0.6-9.0]	214
Grade*			
6th	2.3%	[1.1-4.5]	774
7th	2.7%	[1.7-4.3]	866
8th	6.7%	[4.7-9.5]	1056
Region			
Rest of State	3.8%	[2.6-5.4]	1251
New York City	4.6%	[2.9-7.3]	1445

DT. 2-6 Percentage of High School Students Who Currently Smoke, YTS 2000-2006

Category	Estimate	C.I.	N
Gender			
Female	16.8%	[13.9-20.0]	2143
Male	15.9%	[13.1-19.1]	1973
Race*			
White	20.3%	[17.7-23.2]	1505
Black	8.0%	[5.2-12.2]	989
Hispanic	13.4%	[9.8-18.0]	1117
Other	9.0%	[6.9-11.6]	389
Grade			
9th	12.7%	[9.1-17.5]	906
10th	16.6%	[13.5-20.2]	1222
11th	18.4%	[15.0-22.5]	1087
12th	17.8%	[13.4-23.3]	928
Region			
Rest of State	17.2%	[14.7-20.1]	2100
New York City	14.5%	[11.0-18.9]	2043

DT. 2-7a Percentage of Adults Who Currently Use Any Tobacco Product Other than Cigarettes, ATS 2003-2006.

Category	Estimate	C.I.	N
Age*			
18-24	12.2%	[10.1-14.7]	1535
25-34	9.3%	[7.9-10.9]	3597
35-44	7.6%	[6.5-9.0]	5351
45-54	6.6%	[5.5-7.9]	5880
55-64	5.4%	[4.3-6.7]	5156
65 + years	3.2%	[2.4-4.2]	6718
Race			
White (non-Hispanic)	7.4%	[6.8-8.1]	22649
Black (non-Hispanic)	5.7%	[4.4-7.4]	2504
Hispanic	7.2%	[5.5-9.4]	2106
Other	8.0%	[5.9-10.7]	1540
Gender*			
Male	13.0%	[11.9-14.1]	10946
Female	2.0%	[1.6-2.4]	17845
Education			
Less Than High School	7.5%	[5.7-9.9]	1950
High School	6.8%	[5.9-7.9]	7793
Some College	7.8%	[6.7-9.1]	6955
College Degree or More	7.0%	[6.2-8.0]	11965
Region*			
Western	7.4%	[6.4-8.6]	7223
Central	8.6%	[7.1-10.3]	3727
Capital	9.7%	[7.8-11.9]	3316
Metro	6.6%	[6.0-7.4]	14419
Insurance*			
Public	5.0%	[4.2-6.0]	7387
Private	7.5%	[6.8-8.3]	17834
None	9.0%	[7.5-10.7]	2941

DT. 2-7b Percentage of Adults Who Currently Smoke Cigars, ATS 2003-2006.

Category	Estimate	C.I.	N
Age*			
18-24	7.8%	[6.2-9.7]	1540
25-34	6.8%	[5.6-8.3]	3620
35-44	5.4%	[4.4-6.6]	5375
45-54	5.4%	[4.5-6.6]	5897
55-64	4.8%	[3.7-6.1]	5180
65 + years	2.1%	[1.5-3.0]	6771
Race*			
White (non-Hispanic)	5.8%	[5.2-6.4]	22744
Black (non-Hispanic)	3.7%	[2.7-5.0]	2520
Hispanic	5.1%	[3.7-6.9]	2123
Other	4.2%	[2.8-6.2]	1562
Gender*			
Male	9.7%	[8.8-10.7]	11008
Female	1.2%	[0.9-1.5]	17933
Education			
Less Than High School	4.7%	[3.4-6.4]	1968
High School	4.4%	[3.7-5.2]	7843
Some College	5.5%	[4.6-6.6]	6982
College Degree or More	5.8%	[5.0-6.6]	12019
Region*			
Western	5.5%	[4.6-6.6]	7258
Central	6.0%	[4.7-7.6]	3736
Capital	7.0%	[5.5-9.0]	3332
Metro	4.8%	[4.3-5.5]	14509
Insurance*			
Public	3.7%	[2.9-4.6]	7444
Private	5.6%	[5.0-6.2]	17903
None	5.9%	[4.8-7.3]	2956

DT. 2-7c Percentage of Adults Who Currently Use Smokeless Tobacco, ATS 2003-2006.

Category	Estimate	C.I.	N
Age*			
18-24	2.2%	[1.3-3.7]	1537
25-34	1.6%	[1.1-2.3]	3616
35-44	1.4%	[0.9-2.1]	5373
45-54	0.5%	[0.3-0.8]	5904
55-64	0.2%	[0.1-0.3]	5188
65 + years	0.5%	[0.3-0.8]	6774
Race			
White (non-Hispanic)	1.0%	[0.8-1.2]	22762
Black (non-Hispanic)	0.9%	[0.4-1.6]	2520
Hispanic	1.1%	[0.5-2.5]	2120
Other	2.2%	[1.1-4.4]	1559
Gender*			
Male	2.0%	[1.6-2.5]	11017
Female	0.2%	[0.1-0.5]	17936
Education*			
Less Than High School	1.9%	[1.0-3.7]	1965
High School	1.2%	[0.9-1.6]	7840
Some College	1.6%	[1.1-2.4]	6986
College Degree or More	0.5%	[0.3-0.7]	12033
Region*			
Western	1.7%	[1.2-2.4]	7262
Central	1.6%	[1.1-2.3]	3739
Capital	1.7%	[1.2-2.4]	3333
Metro	0.8%	[0.5-1.1]	14513
Insurance*			
Public	0.7%	[0.5-1.1]	7454
Private	1.0%	[0.7-1.3]	17909
None	2.0%	[1.3-3.1]	2954

DT. 2-8 Percentage of Middle and High School Students Who Have Used Tobacco Products Other Than Cigarettes in the Past 30 Days, YTS 2000-2006.

Category	Estimate	C.I.	N
Middle School			
Gender*			
Female	2.6%	[1.8-3.8]	1524
Male	5.8%	[4.2-7.9]	1214
Race			
White	3.6%	[2.5-5.2]	835
Black	5.0%	[2.7-9.0]	507
Hispanic	6.6%	[4.4-9.9]	1038
Other	3.7%	[1.5-8.8]	210
Grade*			
6th	1.7%	[0.7-4.0]	783
7th	3.7%	[2.6-5.4]	898
8th	6.3%	[4.2-9.2]	1077
Region			
Rest of State	4.0%	[2.7-6.1]	1288
New York City	4.5%	[2.9-7.0]	1470
High School			
Gender*			
Female	6.3%	[4.7-8.4]	2214
Male	15.2%	[12.1-18.8]	2046
Race*			
White	13.6%	[11.1-16.5]	1553
Black	5.0%	[3.2-7.5]	1018
Hispanic	8.4%	[6.2-11.4]	1164
Other	5.7%	[3.0-10.6]	403
Grade*			
9th	7.4%	[4.8-11.1]	945
10th	10.4%	[7.6-14.0]	1264
11th	11.9%	[9.2-15.4]	1127
12th	14.3%	[10.2-19.8]	950
Region*			
Rest of State	13.0%	[10.4-16.3]	2176
New York City	6.4%	[4.5-8.9]	2110

DT. 2-9 Percentage of Middle and High School Students Who Have Smoked Cigars in the Past 30 Days, YTS 2000-2006.

Category	Estimate	C.I.	N
Middle School			
Gender*			
Female	1.8%	[1.1-2.8]	1558
Male	3.8%	[2.6-5.4]	1230
Race			
White	2.4%	[1.5-3.7]	840
Black	3.3%	[1.6-6.8]	518
Hispanic	4.3%	[2.6-7.1]	1063
Other	3.0%	[0.9-9.3]	214
Grade*			
6th	1.1%	[0.4-3.2]	801
7th	2.4%	[1.5-3.6]	912
8th	4.2%	[2.9-6.0]	1097
Region			
Rest of State	2.7%	[1.6-4.3]	1299
New York City	2.9%	[1.6-5.1]	1511
High School			
Gender*			
Female	4.6%	[3.0-6.9]	2219
Male	12.0%	[9.8-14.7]	2058
Race*			
White	10.9%	[9.0-13.2]	1552
Black	3.6%	[2.2-5.9]	1024
Hispanic	6.2%	[4.2-8.9]	1169
Other	3.4%	[1.6-7.2]	404
Grade*			
9th	5.2%	[3.2-8.3]	950
10th	8.4%	[6.1-11.5]	1272
11th	8.7%	[7.1-10.7]	1127
12th	12.0%	[7.9-17.8]	955
Region*			
Rest of State	10.4%	[8.4-12.7]	2174
New York City	4.5%	[3.1-6.7]	2130

DT. 2-10 Percentage of Middle and High School Students Who Have Used Smokeless Tobacco in the Past 30 Days, YTS 2000-2006

Category	Estimate	C.I.	N
Middle School			
Gender*			
Female	1.2%	[0.6-2.3]	1555
Male	2.2%	[1.3-3.7]	1231
Race			
White	1.5%	[0.7-2.9]	841
Black	1.7%	[0.4-6.3]	519
Hispanic	3.1%	[1.5-6.2]	1060
Other	2.0%	[0.6-6.7]	214
Grade			
6th	1.0%	[0.3-3.1]	798
7th	1.3%	[0.7-2.4]	914
8th	2.6%	[1.4-4.8]	1095
Region			
Rest of State	1.9%	[1.0-3.6]	1296
New York City	1.4%	[0.6-3.1]	1511
High School			
Gender*			
Female	1.0%	[0.6-1.8]	2222
Male	5.2%	[3.1-8.4]	2054
Race			
White	3.7%	[2.2-6.1]	1548
Black	1.6%	[0.7-3.9]	1024
Hispanic	2.7%	[1.7-4.3]	1177
Other	1.7%	[0.6-4.4]	401
Grade			
9th	2.3%	[1.3-4.2]	948
10th	3.7%	[2.3-6.0]	1273
11th	3.4%	[1.7-6.6]	1125
12th	3.1%	[1.8-5.3]	955
Region*			
Rest of State	3.9%	[2.3-6.6]	2164
New York City	1.6%	[1.0-2.6]	2137

DT. 2-19 Percentage of Smokers Who Purchased Cigarettes from Low- or Untaxed Sources, ATS 2003 – 2006.

Category	Estimate	C.I.	N
Age			
18-24	63.0%	[55.9-69.5]	420
25-34	57.5%	[52.2-62.6]	787
35-44	54.2%	[49.5-58.8]	1125
45-54	55.0%	[50.3-59.6]	1212
55-64	61.7%	[55.6-67.5]	786
65 + years	56.8%	[49.7-63.5]	504
Race*			
White (non-Hispanic)	63.2%	[60.7-65.7]	3774
Black (non-Hispanic)	40.8%	[34.7-47.3]	505
Hispanic	46.1%	[38.6-53.8]	354
Other	63.5%	[54.1-72.1]	249
Gender			
Male	58.1%	[54.6-61.5]	2042
Female	56.4%	[53.5-59.3]	2840
Education*			
Less Than High School	49.3%	[42.3-56.4]	491
High School	54.8%	[50.9-58.6]	1740
Some College	57.9%	[53.6-62.0]	1447
College Degree or More	65.2%	[60.9-69.4]	1194
Region*			
Western	75.1%	[70.9-78.9]	1340
Central	65.9%	[60.1-71.2]	751
Capital	52.7%	[46.2-59.1]	647
Metro	51.0%	[47.8-54.2]	2119
Insurance*			
Public	52.3%	[47.7-56.8]	1210
Private	61.2%	[58.1-64.3]	2702
None	55.4%	[50.3-60.5]	869

DT. 2-20a Percentage of Smokers Who Purchased Cigarettes from Indian Reservations, ATS 2003 - 2006

Category	Estimate	C.I.	N
Age*			
18-24	28.2%	[22.9-34.1]	419
25-34	25.3%	[21.4-29.6]	782
35-44	30.7%	[26.8-34.8]	1120
45-54	31.8%	[27.9-35.9]	1205
55-64	37.6%	[32.4-43.1]	780
65 + years	40.8%	[34.3-47.7]	502
Race*			
White (non-Hispanic)	40.1%	[37.8-42.5]	3749
Black (non-Hispanic)	15.2%	[10.9-20.7]	504
Hispanic	8.7%	[5.6-13.3]	353
Other	24.3%	[18.1-32.0]	248
Gender			
Male	30.1%	[27.3-33.1]	2034
Female	31.5%	[29.1-34.0]	2820
Education*			
Less Than High School	28.7%	[23.4-34.7]	489
High School	34.4%	[31.0-37.9]	1730
Some College	32.1%	[28.6-35.8]	1433
College Degree or More	25.2%	[21.8-28.9]	1192
Region*			
Western	69.6%	[65.4-73.6]	1330
Central	51.2%	[45.6-56.8]	747
Capital	27.9%	[23.0-33.4]	644
Metro	16.8%	[14.6-19.2]	2108
Insurance			
Public	30.7%	[27.1-34.7]	1204
Private	32.3%	[29.6-35.1]	2686
None	29.5%	[25.6-33.8]	863

DT. 2-20b Percentage of Smokers Who Purchased "All the Time" or "Sometimes" from Indian Reservations, ATS 2003 - 2006

Category	Estimate	C.I.	N
Age*			
18-24	17.9%	[13.8-23.0]	419
25-34	17.6%	[14.5-21.3]	782
35-44	24.6%	[21.0-28.6]	1116
45-54	24.7%	[21.2-28.6]	1201
55-64	30.9%	[26.2-36.0]	779
65 + years	32.9%	[26.9-39.4]	501
Race*			
White (non-Hispanic)	30.7%	[28.6-32.8]	3740
Black (non-Hispanic)	11.6%	[7.8-17.1]	504
Hispanic	7.0%	[4.2-11.4]	353
Other	15.2%	[10.5-21.6]	247
Gender			
Male	22.5%	[20.1-25.2]	2032
Female	24.4%	[22.2-26.6]	2812
Education*			
Less Than High School	22.0%	[17.4-27.4]	488
High School	28.1%	[24.9-31.4]	1729
Some College	23.5%	[20.5-26.8]	1428
College Degree or More	17.0%	[14.4-20.1]	1189
Region*			
Western	62.4%	[58.1-66.5]	1324
Central	36.2%	[31.0-41.7]	746
Capital	19.8%	[15.6-24.8]	643
Metro	10.8%	[9.0-12.9]	2106
Insurance			
Public	24.8%	[21.5-28.4]	1201
Private	24.1%	[21.7-26.6]	2680
None	21.6%	[18.2-25.3]	863

DT. 2-21a Percentage of Smokers Who Purchased Cigarettes Over the Internet, ATS 2003 - 2006

Category	Estimate	C.I.	N
Age			
18-24	5.6%	[3.5-9.0]	420
25-34	8.6%	[6.0-12.1]	786
35-44	5.6%	[4.1-7.6]	1121
45-54	8.8%	[6.4-12.1]	1210
55-64	7.8%	[5.3-11.3]	782
65 + years	3.7%	[1.6-8.2]	500
Race*			
White (non-Hispanic)	7.9%	[6.7-9.4]	3760
Black (non-Hispanic)	3.6%	[1.8-7.0]	505
Hispanic	3.5%	[1.7-7.0]	353
Other	13.1%	[7.7-21.3]	248
Gender			
Male	6.8%	[5.4-8.6]	2030
Female	7.0%	[5.7-8.6]	2836
Education*			
Less Than High School	3.7%	[1.9-7.0]	489
High School	6.6%	[5.1-8.6]	1735
Some College	6.4%	[4.7-8.8]	1443
College Degree or More	9.8%	[7.5-12.7]	1189
Region*			
Western	2.4%	[1.5-3.8]	1336
Central	9.1%	[6.2-13.2]	749
Capital	9.3%	[6.2-13.6]	646
Metro	7.3%	[5.9-8.9]	2110
Insurance*			
Public	5.7%	[3.9-8.2]	1206
Private	8.4%	[6.9-10.2]	2696
None	5.3%	[3.7-7.7]	865

DT. 2-21b Percentage of Smokers Who Purchased "All the Time" or "Sometimes" Over the Internet, ATS 2003 - 2006

Category	Estimate	C.I.	N
Age			
18-24	4.2%	[2.3-7.5]	420
25-34	4.5%	[2.8-7.2]	785
35-44	3.4%	[2.3-4.9]	1121
45-54	6.1%	[4.1-9.1]	1208
55-64	5.5%	[3.5-8.6]	782
65 + years	3.7%	[1.6-8.2]	499
Race*			
White (non-Hispanic)	5.3%	[4.2-6.5]	3756
Black (non-Hispanic)	1.6%	[0.6-4.4]	505
Hispanic	3.2%	[1.5-6.7]	353
Other	7.6%	[3.9-14.4]	248
Gender			
Male	4.6%	[3.4-6.2]	2028
Female	4.4%	[3.4-5.7]	2834
Education*			
Less Than High School	1.0%	[0.4-2.9]	488
High School	4.7%	[3.3-6.5]	1735
Some College	4.5%	[3.0-6.7]	1442
College Degree or More	6.3%	[4.6-8.6]	1187
Region*			
Western	1.8%	[1.0-3.1]	1335
Central	5.7%	[3.4-9.6]	748
Capital	7.4%	[4.7-11.6]	646
Metro	4.6%	[3.5-6.0]	2108
Insurance*			
Public	3.8%	[2.4-5.8]	1205
Private	5.7%	[4.5-7.3]	2694
None	3.1%	[1.9-5.1]	865

DT. 2-22 Average Price per Pack of Cigarettes Paid by Adult Smokers, ATS 2003 - 2006

Category	Estimate	C.I.	N
Age*			
18-24	5.1	[4.9, 5.3]	384
25-34	5.0	[4.9, 5.2]	717
35-44	4.7	[4.5, 4.8]	1007
45-54	4.6	[4.4, 4.8]	1088
55-64	4.4	[4.2, 4.6]	704
65 + years	4.2	[3.9, 4.4]	427
Race*			
White (non-Hispanic)	4.4	[4.3, 4.5]	3357
Black (non-Hispanic)	5.5	[5.3, 5.7]	454
Hispanic	5.4	[5.2, 5.7]	333
Other	5.1	[4.7, 5.5]	220
Gender			
Male	4.8	[4.6, 4.9]	1812
Female	4.7	[4.6, 4.8]	2551
Education*			
Less Than High School	5.0	[4.8, 5.3]	443
High School	4.5	[4.4, 4.6]	1576
Some College	4.7	[4.5, 4.8]	1283
College Degree or More	5.1	[4.9, 5.3]	1052
Region*			
Western	3.5	[3.3, 3.6]	1219
Central	3.9	[3.8, 4.1]	635
Capital	4.3	[4.1, 4.4]	565
Metro	5.4	[5.2, 5.5]	1936
Insurance			
Public	4.7	[4.5, 4.9]	1049
Private	4.7	[4.6, 4.9]	2469
None	4.8	[4.6, 4.9]	756

DT. 2-22 Average Price per Pack of Cigarettes Paid by Adult Smokers Who Engage in Tax Evasion, ATS 2003 - 2006

Category	Estimate	C.I.	N
Age*			
18-24	4.1	[3.7, 4.6]	129
25-34	4.3	[3.9, 4.6]	258
35-44	3.7	[3.5, 4.0]	394
45-54	3.6	[3.3, 3.9]	447
55-64	3.4	[3.1, 3.8]	327
65 + years	3.2	[2.9, 3.5]	189
Race*			
White (non-Hispanic)	3.5	[3.4, 3.7]	1493
Black (non-Hispanic)	5.0	[4.6, 5.5]	96
Hispanic	4.5	[4.0, 5.0]	81
Other	4.1	[3.6, 4.6]	87
Gender			
Male	3.9	[3.7, 4.1]	704
Female	3.6	[3.5, 3.8]	1053
Education*			
Less Than High School	3.4	[3.1, 3.8]	158
High School	3.5	[3.3, 3.7]	692
Some College	3.7	[3.4, 3.9]	502
College Degree or More	4.4	[4.1, 4.7]	404
Region*			
Western	2.9	[2.8, 3.1]	765
Central	3.3	[3.0, 3.6]	290
Capital	3.5	[3.1, 3.8]	187
Metro	4.6	[4.3, 4.8]	513
Insurance*			
Public	3.4	[3.2, 3.7]	412
Private	3.9	[3.7, 4.1]	1011
None	3.9	[3.6, 4.2]	312

DT. 2-22 Average Price per Pack of Cigarettes Paid by Adult Smokers Who Do Not Engage in Tax Evasion, ATS 2003 - 2006

Category	Estimate	C.I.	N
Age*			
18-24	5.5	[5.3, 5.8]	209
25-34	5.5	[5.3, 5.7]	370
35-44	5.2	[5.0, 5.4]	535
45-54	5.1	[4.9, 5.4]	558
55-64	5.2	[4.9, 5.5]	324
65 + years	5.0	[4.6, 5.4]	201
Race*			
White (non-Hispanic)	5.0	[4.9, 5.1]	1574
Black (non-Hispanic)	5.6	[5.4, 5.9]	322
Hispanic	5.7	[5.4, 6.0]	208
Other	5.8	[5.3, 6.2]	114
Gender			
Male	5.3	[5.2, 5.4]	940
Female	5.3	[5.2, 5.4]	1278
Education*			
Less Than High School	5.7	[5.4, 6.0]	232
High School	5.1	[5.0, 5.2]	745
Some College	5.2	[5.0, 5.4]	683
College Degree or More	5.5	[5.2, 5.7]	551
Region*			
Western	4.4	[4.2, 4.6]	368
Central	4.4	[4.3, 4.6]	287
Capital	4.6	[4.5, 4.7]	338
Metro	5.7	[5.5, 5.8]	1218
Insurance			
Public	5.4	[5.2, 5.6]	556
Private	5.3	[5.1, 5.4]	1234
None	5.2	[5.0, 5.5]	371

DT. 2-22a1 Percentage of Smokers Who Purchased Cigarettes from Neighboring States, ATS 2003 - 2006

Category	Estimate	C.I.	N
Age*			
18-24	40.9%	[34.4-47.8]	420
25-34	37.0%	[31.9-42.4]	785
35-44	30.5%	[26.3-35.1]	1122
45-54	28.8%	[24.6-33.4]	1211
55-64	30.9%	[25.5-36.9]	780
65 + years	21.0%	[15.7-27.4]	503
Race*			
White (non-Hispanic)	30.8%	[28.4-33.3]	3762
Black (non-Hispanic)	30.1%	[24.4-36.5]	505
Hispanic	37.3%	[30.1-45.1]	354
Other	44.9%	[35.8-54.4]	248
Gender			
Male	34.3%	[31.0-37.7]	2035
Female	30.5%	[27.8-33.3]	2834
Education*			
Less Than High School	24.3%	[18.5-31.1]	488
High School	25.8%	[22.4-29.5]	1736
Some College	31.3%	[27.2-35.6]	1444
College Degree or More	48.8%	[44.4-53.4]	1191
Region*			
Western	15.9%	[13.2-19.1]	1339
Central	25.1%	[20.8-29.9]	747
Capital	30.3%	[24.3-37.2]	645
Metro	38.4%	[35.2-41.6]	2113
Insurance*			
Public	26.4%	[22.3-30.9]	1205
Private	37.0%	[33.9-40.3]	2696
None	29.1%	[24.7-34.0]	869

DT. 2-22a2 Percentage of Smokers Who Purchased "All the Time" or "Sometimes" from Neighboring States, ATS 2003 - 2006

Category	Estimate	C.I.	N
Age			
18-24	11.6%	[8.1-16.4]	420
25-34	15.7%	[12.2-19.9]	785
35-44	14.8%	[11.4-19.0]	1122
45-54	12.3%	[9.5-15.7]	1208
55-64	12.5%	[9.1-17.0]	776
65 + years	13.2%	[8.7-19.4]	501
Race			
White (non-Hispanic)	12.6%	[11.0-14.5]	3752
Black (non-Hispanic)	14.2%	[9.8-20.0]	505
Hispanic	13.8%	[9.3-20.1]	354
Other	23.1%	[16.2-31.7]	248
Gender			
Male	14.9%	[12.5-17.7]	2032
Female	12.1%	[10.4-14.1]	2827
Education*			
Less Than High School	10.1%	[6.6-15.3]	487
High School	11.5%	[9.0-14.6]	1735
Some College	11.2%	[9.0-13.8]	1440
College Degree or More	21.7%	[17.9-26.0]	1187
Region*			
Western	5.7%	[4.1-7.7]	1336
Central	11.3%	[8.6-14.7]	746
Capital	10.2%	[7.0-14.6]	643
Metro	16.9%	[14.6-19.6]	2109
Insurance*			
Public	10.8%	[8.4-13.7]	1203
Private	16.0%	[13.6-18.7]	2688
None	12.2%	[9.3-15.7]	869

DT. 2-22b1 Percentage of Smokers Who Purchased Cigarettes from Duty-Free Sources, ATS 2003 – 2006.

Category	Estimate	C.I.	N
Age			
18-24	12.2%	[8.5-17.1]	412
25-34	16.0%	[12.4-20.5]	779
35-44	15.2%	[11.7-19.5]	1112
45-54	11.7%	[8.9-15.2]	1191
55-64	14.5%	[11.0-18.8]	775
65 + years	9.5%	[6.3-14.2]	495
Race*			
White (non-Hispanic)	13.8%	[12.0-15.7]	3717
Black (non-Hispanic)	10.0%	[6.5-15.3]	499
Hispanic	13.2%	[8.5-20.0]	349
Other	24.1%	[16.8-33.4]	247
Gender*			
Male	16.0%	[13.5-18.9]	2013
Female	11.1%	[9.5-13.0]	2799
Education*			
Less Than High School	6.5%	[4.3-9.6]	477
High School	9.7%	[7.6-12.4]	1708
Some College	13.4%	[10.6-16.7]	1429
College Degree or More	24.1%	[20.0-28.6]	1188
Region*			
Western	12.2%	[9.9-15.0]	1323
Central	8.6%	[6.2-11.7]	733
Capital	8.2%	[5.5-12.1]	638
Metro	15.6%	[13.3-18.2]	2093
Insurance*			
Public	8.1%	[6.1-10.7]	1187
Private	15.6%	[13.3-18.3]	2677
None	14.7%	[11.3-18.8]	848

DT. 2-22b2 Percentage of Smokers Who Purchased "All the Time" or "Sometimes" from Duty-Free Sources, ATS 2003 – 2006.

Category	Estimate	C.I.	N
Age*			
18-24	1.8%	[0.8-4.1]	412
25-34	6.4%	[4.3-9.4]	779
35-44	7.1%	[5.0-9.9]	1112
45-54	4.8%	[3.2-7.2]	1191
55-64	7.7%	[5.1-11.4]	774
65 + years	6.1%	[3.6-10.3]	495
Race*			
White (non-Hispanic)	6.0%	[4.9-7.3]	3715
Black (non-Hispanic)	3.4%	[1.9-5.8]	499
Hispanic	4.4%	[2.1-8.8]	349
Other	12.2%	[7.0-20.2]	247
Gender*			
Male	6.7%	[5.2-8.6]	2013
Female	4.6%	[3.6-5.8]	2797
Education			
Less Than High School	4.0%	[2.3-6.6]	477
High School	4.9%	[3.6-6.7]	1708
Some College	5.6%	[3.9-8.0]	1429
College Degree or More	8.0%	[5.8-10.9]	1186
Region*			
Western	7.2%	[5.4-9.5]	1323
Central	3.8%	[2.4-5.9]	733
Capital	2.9%	[1.5-5.5]	638
Metro	6.0%	[4.7-7.7]	2091
Insurance			
Public	3.9%	[2.7-5.7]	1186
Private	6.3%	[5.0-7.9]	2676
None	6.0%	[3.8-9.3]	848

DT. 2-22c1 Percentage of Smokers Who Purchased Cigarettes from Toll Free Numbers, ATS 2003 – 2006.

Category	Estimate	C.I.	N
Age*			
18-24	2.3%	[1.0-5.0]	419
25-34	3.3%	[1.8-5.8]	786
35-44	3.3%	[2.1-5.2]	1119
45-54	5.4%	[3.5-8.2]	1207
55-64	7.8%	[5.5-11.0]	781
65 + years	15.3%	[10.6-21.6]	500
Race*			
White (non-Hispanic)	6.1%	[5.0-7.4]	3754
Black (non-Hispanic)	4.1%	[2.2-7.5]	504
Hispanic	2.2%	[0.9-5.3]	353
Other	0.4%	[0.2-1.0]	248
Gender			
Male	4.5%	[3.4-6.1]	2033
Female	5.3%	[4.2-6.7]	2826
Education			
Less Than High School	4.8%	[2.8-8.2]	488
High School	5.3%	[3.9-7.2]	1733
Some College	4.0%	[2.7-6.0]	1440
College Degree or More	5.4%	[3.8-7.6]	1188
Region*			
Western	2.3%	[1.4-3.9]	1337
Central	4.9%	[3.0-8.1]	748
Capital	6.9%	[4.2-10.9]	645
Metro	5.3%	[4.2-6.8]	2104
Insurance			
Public	6.5%	[4.8-8.9]	1208
Private	5.0%	[3.8-6.5]	2688
None	3.3%	[2.0-5.4]	865

DT. 2-22c2 Percentage of Smokers Who Purchased "All the Time" or "Sometimes" from Toll Free Numbers, ATS 2003 – 2006.

Category	Estimate	C.I.	N
Age*			
18-24	1.3%	[0.5-3.7]	419
25-34	2.6%	[1.3-5.2]	786
35-44	2.6%	[1.5-4.4]	1119
45-54	4.5%	[2.8-7.3]	1205
55-64	5.4%	[3.7-7.9]	781
65 + years	12.8%	[8.6-18.6]	499
Race*			
White (non-Hispanic)	4.8%	[3.8-5.9]	3751
Black (non-Hispanic)	3.7%	[1.9-7.1]	504
Hispanic	1.2%	[0.3-4.7]	353
Other	0.3%	[0.1-1.0]	248
Gender			
Male	3.6%	[2.6-5.0]	2033
Female	4.1%	[3.1-5.3]	2823
Education			
Less Than High School	2.9%	[1.4-5.7]	488
High School	4.5%	[3.2-6.2]	1731
Some College	3.3%	[2.1-5.3]	1439
College Degree or More	4.0%	[2.6-5.9]	1188
Region*			
Western	1.9%	[1.0-3.4]	1337
Central	3.8%	[2.2-6.5]	747
Capital	6.6%	[4.0-10.6]	645
Metro	3.9%	[2.9-5.2]	2102
Insurance*			
Public	5.6%	[3.9-7.9]	1208
Private	3.8%	[2.8-5.2]	2685
None	2.4%	[1.3-4.3]	865

DT. 3-23a Percentage of Adults in Smoke-free Homes, ATS 2003-2006

Category	Estimate	C.I.	N
Age*			
18-24	71.4%	[68.1-74.5]	1540
25-34	72.9%	[70.5-75.2]	3622
35-44	73.8%	[71.9-75.7]	5375
45-54	70.6%	[68.7-72.5]	5897
55-64	70.6%	[68.5-72.6]	5172
65 + years	68.9%	[67.0-70.7]	6736
Race*			
White (non-Hispanic)	71.0%	[70.0-72.0]	22703
Black (non-Hispanic)	69.1%	[66.3-71.7]	2519
Hispanic	75.9%	[73.0-78.6]	2126
Other	73.6%	[69.8-77.0]	1561
Gender*			
Male	68.8%	[67.4-70.3]	11007
Female	74.2%	[73.1-75.2]	17894
Education*			
Less Than High School	62.5%	[58.8-66.1]	1966
High School	66.3%	[64.5-68.0]	7830
Some College	71.3%	[69.4-73.0]	6975
College Degree or More	77.2%	[76.0-78.4]	12003
Region*			
Western	68.4%	[66.6-70.2]	7253
Central	69.0%	[66.5-71.4]	3733
Capital	70.9%	[68.4-73.4]	3329
Metro	72.9%	[71.7-74.0]	14480
Insurance*			
Public	66.2%	[64.4-68.1]	7422
Private	75.3%	[74.3-76.4]	17892
None	65.1%	[62.3-67.8]	2950

DT. 3-23b Percentage of Adult Nonsmokers in Smoke-free Homes, ATS 2003-2006

Category	Estimate	C.I.	N
Age*			
18-24	78.6%	[74.9-82.0]	1061
25-34	82.5%	[79.8-84.8]	2725
35-44	84.6%	[82.7-86.3]	4133
45-54	81.3%	[79.4-83.1]	4546
55-64	79.0%	[76.8-80.9]	4282
65 + years	73.2%	[71.2-75.0]	6123
Race*			
White (non-Hispanic)	79.1%	[78.1-80.0]	18438
Black (non-Hispanic)	80.6%	[77.8-83.1]	1949
Hispanic	83.9%	[80.9-86.5]	1705
Other	80.9%	[76.7-84.4]	1280
Gender*			
Male	77.1%	[75.5-78.6]	8698
Female	82.7%	[81.7-83.7]	14667
Education*			
Less Than High School	78.2%	[74.1-81.9]	1392
High School	77.7%	[75.8-79.5]	5874
Some College	80.7%	[78.7-82.5]	5373
College Degree or More	81.5%	[80.2-82.7]	10618
Region			
Western	79.0%	[77.1-80.8]	5762
Central	80.1%	[77.4-82.5]	2899
Capital	81.6%	[79.0-83.9]	2614
Metro	80.2%	[79.0-81.3]	12011
Insurance*			
Public	75.3%	[73.3-77.2]	6047
Private	82.4%	[81.4-83.4]	14829
None	78.2%	[75.0-81.0]	1976

DT. 3-23c Percentage of Adult Smokers in Smoke-free Homes, ATS 2003-2006

Category	Estimate	C.I.	N
Age*			
18-24	47.1%	[40.7-53.6]	478
25-34	36.6%	[31.9-41.6]	887
35-44	29.5%	[25.6-33.6]	1226
45-54	25.6%	[21.9-29.8]	1326
55-64	21.9%	[17.6-26.9]	859
65 + years	15.2%	[11.1-20.5]	558
Race*			
White (non-Hispanic)	32.9%	[30.6-35.4]	4147
Black (non-Hispanic)	17.3%	[13.5-21.9]	554
Hispanic	39.3%	[32.4-46.7]	413
Other	23.9%	[17.3-31.9]	275
Gender*			
Male	33.9%	[30.7-37.1]	2255
Female	28.0%	[25.5-30.6]	3133
Education*			
Less Than High School	23.0%	[17.9-29.1]	560
High School	28.0%	[24.7-31.5]	1914
Some College	31.8%	[27.9-35.9]	1573
College Degree or More	39.3%	[35.1-43.7]	1329
Region*			
Western	26.2%	[22.9-29.7]	1458
Central	28.3%	[23.7-33.3]	820
Capital	31.0%	[25.0-37.7]	703
Metro	33.1%	[30.2-36.2]	2380
Insurance*			
Public	25.3%	[21.5-29.5]	1328
Private	34.0%	[31.1-36.9]	2982
None	29.7%	[25.3-34.6]	962

DT. Percentage of Adults in Smoke-free Cars, ATS 2003-2006

Category	Estimate	C.I.	N
Age*			
18-24	69.0%	[65.4-72.4]	1342
25-34	73.9%	[71.4-76.3]	3115
35-44	78.6%	[76.9-80.3]	4848
45-54	76.6%	[74.7-78.5]	5290
55-64	78.6%	[76.6-80.4]	4664
65 + years	83.4%	[81.8-84.9]	5748
Race*			
White (non-Hispanic)	74.8%	[73.8-75.7]	20664
Black (non-Hispanic)	82.7%	[80.1-85.0]	1906
Hispanic	82.0%	[78.7-84.8]	1609
Other	82.1%	[78.6-85.2]	1321
Gender*			
Male	73.2%	[71.7-74.6]	9803
Female	81.0%	[80.0-82.0]	15691
Education*			
Less Than High School	70.4%	[66.5-74.1]	1431
High School	71.7%	[69.8-73.4]	6892
Some College	74.2%	[72.3-76.0]	6293
College Degree or More	83.7%	[82.5-84.8]	10781
Region*			
Western	71.5%	[69.7-73.3]	6830
Central	70.7%	[68.3-73.1]	3515
Capital	72.4%	[69.7-74.9]	3150
Metro	80.4%	[79.2-81.5]	11929
Insurance*			
Public	77.8%	[76.0-79.6]	6030
Private	78.7%	[77.7-79.7]	16506
None	69.6%	[66.7-72.4]	2416

DT. Percentage of Adult Nonsmokers in Smoke-free Cars, ATS 2003-2006

Category	Estimate	C.I.	N
Age*			
18-24	80.7%	[76.7-84.1]	929
25-34	85.2%	[82.6-87.4]	2368
35-44	89.9%	[88.4-91.2]	3754
45-54	86.9%	[84.9-88.6]	4134
55-64	86.3%	[84.3-88.0]	3919
65 + years	87.4%	[85.8-88.8]	5252
Race*			
White (non-Hispanic)	85.3%	[84.4-86.2]	16874
Black (non-Hispanic)	90.4%	[88.1-92.3]	1516
Hispanic	89.0%	[85.9-91.6]	1308
Other	88.3%	[84.5-91.2]	1095
Gender*			
Male	83.3%	[81.8-84.6]	7846
Female	89.8%	[88.9-90.6]	12942
Education*			
Less Than High School	85.3%	[81.3-88.6]	997
High School	84.4%	[82.7-86.0]	5218
Some College	85.8%	[83.9-87.5]	4886
College Degree or More	88.6%	[87.5-89.7]	9604
Region*			
Western	83.8%	[81.9-85.4]	5480
Central	84.5%	[82.1-86.6]	2743
Capital	85.3%	[82.8-87.4]	2491
Metro	87.9%	[86.8-88.9]	10019
Insurance			
Public	85.6%	[83.7-87.4]	4999
Private	87.4%	[86.4-88.3]	13752
None	85.7%	[82.8-88.2]	1598

DT. Percentage of Adult Smokers in Smoke-free Cars, ATS 2003-2006

Category	Estimate	C.I.	N
Age			
18-24	28.8%	[22.9-35.5]	412
25-34	29.0%	[24.0-34.6]	739
35-44	29.6%	[25.6-34.0]	1079
45-54	29.2%	[24.8-34.0]	1136
55-64	29.0%	[23.4-35.4]	718
65 + years	30.9%	[24.6-38.0]	451
Race*			
White (non-Hispanic)	22.9%	[20.8-25.2]	3684
Black (non-Hispanic)	43.3%	[36.4-50.5]	377
Hispanic	47.1%	[38.7-55.6]	298
Other	32.5%	[23.7-42.7]	223
Gender			
Male	27.2%	[24.1-30.6]	1912
Female	31.5%	[28.6-34.4]	2669
Education*			
Less Than High School	35.2%	[28.3-42.7]	426
High School	27.0%	[23.5-30.9]	1636
Some College	23.6%	[20.1-27.5]	1384
College Degree or More	36.2%	[31.8-40.8]	1127
Region*			
Western	19.2%	[16.2-22.6]	1319
Central	18.1%	[14.6-22.2]	759
Capital	21.3%	[16.3-27.4]	648
Metro	36.4%	[33.1-39.8]	1840
Insurance*			
Public	37.8%	[32.9-43.0]	997
Private	26.1%	[23.5-28.9]	2681
None	27.5%	[22.8-32.7]	807

DT. Average Number of Hours in the Past 7 Days That Adults Spent in a Room Where Someone Was Smoking, ATS 2003-2006.

Category	Estimate	C.I.	N
Age *			
18-24	7.1	[5.2, 9.0]	727
25-34	4.4	[3.5, 5.4]	1581
35-44	5.0	[4.0, 6.0]	2111
45-54	4.5	[3.6, 5.5]	2187
55-64	5.0	[3.8, 6.1]	1789
65 + years	2.4	[1.8, 3.1]	2018
Race			
White (non-Hispanic)	4.8	[4.3, 5.4]	8023
Black (non-Hispanic)	4.3	[3.1, 5.5]	1035
Hispanic	3.9	[2.7, 5.1]	943
Other	5.1	[3.3, 6.9]	625
Gender *			
Male	5.2	[4.4, 5.9]	4252
Female	4.2	[3.6, 4.7]	6371
Education *			
Less Than High School	7.5	[5.1, 9.8]	806
High School	5.9	[5.0, 6.9]	2910
Some College	5.7	[4.7, 6.7]	2642
College Degree or More	2.4	[2.0, 2.7]	4220
Region *			
Western	7.0	[5.6, 8.4]	2469
Central	8.0	[6.1, 9.9]	1229
Capital	6.2	[4.2, 8.3]	1197
Metro	3.5	[3.0, 3.9]	5731
Insurance *			
Public	5.0	[4.0, 6.0]	2454
Private	3.7	[3.2, 4.2]	6707
None	7.6	[6.0, 9.2]	1229

DT. Average Number of Hours in the Past 7 Days That Adults Spent in a Vehicle Where Someone was Smoking, ATS 2003-2006.

Category	Estimate	C.I.	N
Age *			
18-24	3.8	[2.4, 5.1]	617
25-34	1.8	[1.4, 2.3]	1227
35-44	2.0	[1.5, 2.6]	1633
45-54	1.4	[1.1, 1.7]	1683
55-64	1.6	[1.1, 2.2]	1384
65 + years	0.7	[0.4, 1.0]	1461
Race *			
White (non-Hispanic)	2.2	[1.8, 2.6]	6173
Black (non-Hispanic)	1.7	[1.0, 2.4]	784
Hispanic	1.1	[0.7, 1.5]	716
Other	1.4	[0.8, 2.0]	484
Gender *			
Male	2.3	[1.9, 2.8]	3247
Female	1.5	[1.1, 1.8]	4907
Education *			
Less Than High School	2.9	[1.4, 4.4]	651
High School	2.4	[1.9, 3.0]	2335
Some College	2.3	[1.7, 2.8]	2077
College Degree or More	1.0	[0.7, 1.2]	3064
Region *			
Western	2.5	[1.9, 3.2]	1923
Central	3.2	[1.7, 4.7]	1012
Capital	3.5	[1.9, 5.2]	964
Metro	1.3	[1.1, 1.6]	4258
Insurance *			
Public	1.5	[1.1, 2.0]	1929
Private	1.7	[1.4, 1.9]	4970
None	3.3	[2.2, 4.4]	1058

DT. Average Number of Hours in the Past 7 Days That Adult Nonsmokers Spent in a Room Where Someone was Smoking, ATS 2003-2006.

Category	Estimate	C.I.	N
Age			
18-24	2.5	[1.5, 3.4]	471
25-34	2.2	[1.4, 3.0]	1161
35-44	1.5	[1.1, 1.9]	1549
45-54	1.8	[1.3, 2.3]	1632
55-64	2.4	[1.5, 3.3]	1446
65 + years	1.2	[0.7, 1.8]	1796
Race			
White (non-Hispanic)	1.7	[1.5, 2.0]	6265
Black (non-Hispanic)	1.9	[1.0, 2.8]	761
Hispanic	2.0	[1.0, 2.9]	728
Other	2.6	[1.6, 3.7]	486
Gender *			
Male	2.2	[1.7, 2.6]	3253
Female	1.6	[1.3, 1.9]	4985
Education			
Less Than High School	1.9	[1.0, 2.8]	542
High School	2.0	[1.5, 2.6]	2059
Some College	2.4	[1.6, 3.1]	1955
College Degree or More	1.4	[1.1, 1.8]	3642
Region			
Western	2.1	[1.6, 2.5]	1838
Central	2.4	[1.5, 3.4]	908
Capital	2.4	[1.2, 3.6]	895
Metro	1.7	[1.4, 2.0]	4599
Insurance			
Public	1.7	[1.2, 2.3]	1904
Private	1.9	[1.5, 2.2]	5348
None	1.9	[1.3, 2.5]	798

DT. Average Number of Hours in the Past 7 Days That Adult Smokers Spent in a Room Where Someone was Smoking, ATS 2003-2006.

Category	Estimate	C.I.	N
Age			
18-24	18.3	[12.7, 24.0]	256
25-34	12.6	[9.4, 15.8]	415
35-44	16.8	[12.8, 20.7]	557
45-54	15.6	[11.6, 19.6]	551
55-64	20.3	[14.6, 26.0]	334
65 + years	16.1	[11.9, 20.3]	210
Race *			
White (non-Hispanic)	17.9	[15.5, 20.3]	1729
Black (non-Hispanic)	13.1	[8.7, 17.6]	268
Hispanic	11.5	[7.1, 15.9]	214
Other	19.4	[10.0, 28.9]	137
Gender			
Male	16.4	[13.6, 19.3]	984
Female	16.0	[13.5, 18.5]	1363
Education *			
Less Than High School	20.8	[13.5, 28.0]	261
High School	17.0	[13.9, 20.0]	842
Some College	18.0	[14.3, 21.8]	681
College Degree or More	9.9	[7.6, 12.1]	559
Region *			
Western	23.2	[18.0, 28.4]	624
Central	25.6	[19.1, 32.0]	318
Capital	17.2	[10.4, 23.9]	298
Metro	12.0	[10.0, 14.1]	1108
Insurance *			
Public	16.9	[13.0, 20.8]	542
Private	13.1	[10.9, 15.3]	1336
None	22.2	[17.1, 27.3]	426

DT. Average Number of Hours in the Past 7 Days That Adult Nonsmokers Spent in a Vehicle Where Someone was Smoking, ATS 2003-2006.

Category	Estimate	C.I.	N
Age *			
18-24	1.8	[0.5, 3.1]	346
25-34	0.9	[0.5, 1.3]	794
35-44	0.5	[0.3, 0.7]	1028
45-54	0.4	[0.2, 0.7]	1059
55-64	0.3	[0.1, 0.5]	977
65 + years	0.3	[0.1, 0.5]	1234
Race			
White (non-Hispanic)	0.6	[0.4, 0.9]	4160
Black (non-Hispanic)	0.8	[0.4, 1.2]	538
Hispanic	0.6	[0.3, 0.8]	514
Other	0.8	[0.2, 1.4]	350
Gender			
Male	0.8	[0.6, 1.1]	2153
Female	0.5	[0.2, 0.8]	3407
Education *			
Less Than High School	0.4	[0.2, 0.5]	380
High School	1.1	[0.5, 1.8]	1411
Some College	0.8	[0.5, 1.2]	1296
College Degree or More	0.3	[0.2, 0.5]	2452
Region			
Western	0.4	[0.3, 0.5]	1179
Central	1.2	[-0.4, 2.9]	629
Capital	0.9	[0.3, 1.5]	621
Metro	0.6	[0.5, 0.8]	3133
Insurance			
Public	0.7	[0.4, 1.0]	1341
Private	0.5	[0.4, 0.6]	3503
None	1.4	[0.3, 2.5]	578

DT. Average Number of Hours in the Past 7 Days That Adult Smokers Spent in a Vehicle Where Someone was Smoking, ATS 2003-2006.

Category	Estimate	C.I.	N
Age			
18-24	7.0	[4.0, 9.9]	271
25-34	4.3	[3.2, 5.4]	430
35-44	5.4	[3.7, 7.2]	600
45-54	3.8	[2.9, 4.7]	621
55-64	6.7	[4.6, 8.8]	400
65 + years	3.8	[1.9, 5.8]	219
Race *			
White (non-Hispanic)	6.1	[5.0, 7.2]	1992
Black (non-Hispanic)	4.3	[2.0, 6.6]	240
Hispanic	2.6	[1.1, 4.2]	200
Other	3.9	[2.3, 5.5]	134
Gender *			
Male	6.1	[4.7, 7.5]	1081
Female	4.3	[3.5, 5.2]	1484
Education			
Less Than High School	7.0	[3.2, 10.8]	267
High School	5.1	[4.0, 6.1]	915
Some College	5.5	[4.0, 7.1]	778
College Degree or More	4.2	[2.8, 5.7]	600
Region *			
Western	6.6	[4.7, 8.5]	739
Central	7.0	[4.1, 9.9]	379
Capital	8.7	[4.0, 13.4]	341
Metro	3.7	[3.0, 4.4]	1107
Insurance			
Public	3.8	[2.4, 5.3]	582
Private	5.3	[4.3, 6.4]	1452
None	6.5	[4.2, 8.8]	475

DT. Number of Days in the Past Week Middle and High School Students Were in a Room with a Smoker, YTS 2003-2006.

Category	Estimate	C.I.	N
Middle School			
Gender *			
Female	1.9	[1.7, 2.1]	1538
Male	1.4	[1.1, 1.7]	1220
Race *			
White	1.9	[1.6, 2.2]	833
Black	1.1	[0.8, 1.4]	514
Hispanic	1.4	[1.2, 1.7]	1044
Other	1.4	[1, 1.7]	213
Grade			
6th	1.5	[1.1, 1.9]	794
7th	1.8	[1.4, 2.2]	897
8th	1.6	[1.3, 1.9]	1086
Region			
Rest of State	1.7	[1.4, 2]	1288
New York City	1.5	[1.2, 1.8]	1489
High School			
Gender			
Female	2.2	[2, 2.5]	2214
Male	2	[1.7, 2.3]	2053
Race *			
White	2.4	[2.1, 2.7]	1554
Black	1.6	[1.3, 1.8]	1019
Hispanic	1.8	[1.5, 2.1]	1169
Other	1.7	[1.2, 2.1]	404
Grade			
9th	2.1	[1.7, 2.5]	942
10th	2.1	[1.9, 2.4]	1269
11th	2.1	[1.8, 2.5]	1127
12th	2.2	[2, 2.5]	955
Region			
Rest of State	2.2	[1.9, 2.6]	2182
New York City	1.9	[1.6, 2.2]	2111

DT. Number of Days in the Past Week Middle and High School Students Were in a Car with a Smoker, YTS 2003-2006.

Category	Estimate	C.I.	N
Middle School			
Gender *			
Female	1.2	[1, 1.5]	1536
Male	0.9	[0.7, 1.1]	1222
Race *			
White	1.2	[1, 1.5]	835
Black	0.7	[0.5, 0.9]	513
Hispanic	0.9	[0.6, 1.1]	1045
Other	0.8	[0.6, 1]	214
Grade			
6th	1.0	[0.6, 1.4]	792
7th	1.1	[0.8, 1.4]	899
8th	1.1	[0.8, 1.3]	1087
Region *			
Rest of State	1.2	[0.9, 1.4]	1288
New York City	0.8	[0.6, 1.1]	1490
High School			
Gender			
Female	1.3	[1.1, 1.5]	2215
Male	1.3	[1.1, 1.6]	2056
Race *			
White	1.7	[1.4, 1.9]	1554
Black	0.7	[0.5, 0.9]	1022
Hispanic	0.9	[0.7, 1.2]	1171
Other	0.9	[0.5, 1.3]	404
Grade			
9th	1.3	[1, 1.6]	943
10th	1.3	[1.1, 1.5]	1269
11th	1.3	[1, 1.7]	1129
12th	1.3	[1.1, 1.6]	956
Region *			
Rest of State	1.6	[1.3, 1.8]	2182
New York City	0.9	[0.6, 1.2]	2115

DT. Number of Days in the Past Week Middle and High School Students Who Live With a Smoker Were in a Room with a Smoker, YTS 2003-2006.

Category	Estimate	C.I.	N
Middle School			
Gender *			
Female	3.6	[3.3, 3.9]	614
Male	2.7	[2.3, 3.2]	459
Race *			
White	3.6	[3.3, 3.9]	356
Black	2.3	[1.6, 3]	180
Hispanic	2.6	[2, 3.2]	405
Other	2.8	[1.9, 3.7]	79
Grade			
6th	2.7	[2, 3.4]	298
7th	3.6	[3.1, 4.2]	347
8th	3.0	[2.5, 3.5]	435
Region			
Rest of State	3.3	[3, 3.7]	510
New York City	3.0	[2.4, 3.6]	570
High School			
Gender			
Female	3.9	[3.6, 4.2]	844
Male	3.5	[3.1, 3.9]	742
Race *			
White	4.0	[3.7, 4.3]	678
Black	3.0	[2.5, 3.5]	328
Hispanic	3.0	[2.6, 3.4]	398
Other	3.2	[2.4, 4.1]	138
Grade			
9th	3.7	[3.3, 4.1]	365
10th	3.9	[3.6, 4.3]	467
11th	3.5	[3.1, 3.9]	415
12th	3.6	[3.2, 4.1]	348
Region			
Rest of State	3.8	[3.5, 4.1]	866
New York City	3.4	[2.9, 4]	729

DT. Number of Days in the Past Week Middle and High School Students Who Do Not Live With a Smoker Were in a Room with a Smoker, YTS 2003-2006.

Category	Estimate	C.I.	N
Middle School			
Gender			
Female	0.8	[0.7, 0.9]	902
Male	0.6	[0.4, 0.8]	744
Race *			
White	0.8	[0.6, 0.9]	473
Black	0.4	[0.3, 0.5]	322
Hispanic	0.7	[0.5, 0.9]	626
Other	0.6	[0.3, 0.8]	130
Grade			
6th	0.7	[0.5, 0.9]	485
7th	0.7	[0.5, 1]	538
8th	0.6	[0.5, 0.8]	633
Region			
Rest of State	0.7	[0.6, 0.8]	768
New York City	0.6	[0.5, 0.8]	888
High School			
Gender			
Female	1.1	[1, 1.3]	1362
Male	1.1	[0.9, 1.4]	1295
Race *			
White	1.3	[1, 1.5]	868
Black	0.9	[0.7, 1.1]	685
Hispanic	1.2	[0.9, 1.4]	764
Other	0.8	[0.5, 1]	266
Grade *			
9th	1	[0.8, 1.2]	573
10th	1	[0.8, 1.2]	793
11th	1.3	[1, 1.6]	707
12th	1.4	[1.1, 1.6]	601
Region			
Rest of State	1.2	[0.9, 1.4]	1306
New York City	1.1	[0.9, 1.3]	1368

DT. Number of Days in the Past Week Middle and High School Students Who Live With a Smoker Were in a Car With a Smoker, YTS 2003-2006.

Category	Estimate	C.I.	N
Middle School			
Gender *			
Female	2.6	[2.2, 2.9]	611
Male	2.0	[1.6, 2.4]	459
Race *			
White	2.7	[2.4, 3]	356
Black	1.4	[1.1, 1.8]	179
Hispanic	1.7	[1.2, 2.3]	404
Other	1.8	[1.2, 2.4]	78
Grade			
6th	2.1	[1.3, 2.9]	294
7th	2.6	[2.1, 3]	350
8th	2.1	[1.7, 2.5]	433
Region *			
Rest of State	2.6	[2.3, 2.9]	506
New York City	1.7	[1.1, 2.3]	571
High School			
Gender			
Female	2.5	[2.2, 2.9]	845
Male	2.5	[2.1, 2.8]	746
Race *			
White	3.0	[2.7, 3.3]	678
Black	1.4	[1.1, 1.8]	329
Hispanic	1.8	[1.4, 2.1]	401
Other	2.0	[1.1, 2.8]	138
Grade			
9th	2.5	[2.2, 2.9]	367
10th	2.7	[2.3, 3.1]	468
11th	2.5	[2, 3]	417
12th	2.2	[1.9, 2.6]	348
Region *			
Rest of State	2.8	[2.5, 3.1]	866
New York City	1.8	[1.3, 2.3]	734

DT. Number of Days in the Past Week Middle and High School Students Who Do Not Live With a Smoker Were in a Car With a Smoker, YTS 2003-2006.

Category	Estimate	C.I.	N
Middle School			
Gender			
Female	0.3	[0.2, 0.4]	903
Male	0.2	[0.2, 0.3]	746
Race			
White	0.3	[0.2, 0.4]	474
Black	0.2	[0.1, 0.3]	322
Hispanic	0.4	[0.3, 0.5]	628
Other	0.2	[0.1, 0.3]	132
Grade			
6th	0.3	[0.1, 0.4]	487
7th	0.2	[0.2, 0.3]	537
8th	0.4	[0.2, 0.5]	636
Region			
Rest of State	0.3	[0.2, 0.4]	771
New York City	0.2	[0.2, 0.3]	889
High School			
Gender			
Female	0.5	[0.4, 0.7]	1362
Male	0.6	[0.5, 0.8]	1295
Race *			
White	0.7	[0.5, 0.9]	868
Black	0.4	[0.3, 0.5]	687
Hispanic	0.5	[0.3, 0.6]	763
Other	0.3	[0.2, 0.5]	266
Grade			
9th	0.5	[0.3, 0.7]	572
10th	0.5	[0.4, 0.6]	792
11th	0.6	[0.4, 0.8]	708
12th	0.8	[0.6, 1]	602
Region *			
Rest of State	0.7	[0.5, 0.9]	1306
New York City	0.4	[0.3, 0.5]	1368

DT. Percentage of Indoor Workers Who Reported Seeing Smoking in their Work Area in the Past Week, ATS 2003-2006.

Category	Estimate	C.I.	N
Age*			
18-24	15.9%	[12.1-20.7]	634
25-34	10.9%	[8.7-13.6]	2093
35-44	8.3%	[6.7-10.2]	3215
45-54	8.2%	[6.5-10.2]	3486
55-64	6.0%	[4.4-8.3]	2057
65 + years	6.0%	[2.9-11.9]	510
Race*			
White (non-Hispanic)	7.0%	[6.1-8.0]	9575
Black (non-Hispanic)	10.3%	[7.9-13.4]	1072
Hispanic	17.8%	[13.9-22.4]	871
Other	12.3%	[8.7-17.2]	659
Gender*			
Male	13.0%	[11.4-14.9]	4483
Female	5.9%	[5.0-7.0]	7693
Education*			
Less Than High School	20.6%	[14.4-28.4]	362
High School	12.8%	[10.4-15.5]	2553
Some College	10.9%	[9.0-13.2]	2933
College Degree or More	6.2%	[5.2-7.5]	6297
Region*			
Western	7.0%	[5.5-8.9]	3123
Central	8.5%	[6.1-11.8]	1585
Capital	5.4%	[3.9-7.3]	1428
Metro	10.4%	[9.1-11.9]	6001
Insurance*			
Public	15.1%	[10.9-20.5]	767
Private	7.6%	[6.7-8.7]	10264
None	17.2%	[13.3-21.8]	954

DT. Percentage of Restaurant Patrons Who Saw Smoking Indoors in the Past 30 Days, ATS 2003-Q2, 2006.

Category	Estimate	C.I.	N
Age*			
18-24	8.7%	[6.7-11.4]	1065
25-34	5.7%	[4.5-7.3]	2545
35-44	5.3%	[4.3-6.6]	3663
45-54	4.5%	[3.6-5.6]	3841
55-64	5.3%	[4.0-7.0]	3304
65 + years	5.8%	[4.6-7.2]	3877
Race*			
White (non-Hispanic)	4.8%	[4.3-5.4]	15204
Black (non-Hispanic)	8.0%	[6.0-10.6]	1321
Hispanic	7.5%	[5.6-10.0]	1165
Other	7.8%	[5.4-11.0]	958
Gender*			
Male	6.5%	[5.7-7.5]	7272
Female	5.0%	[4.4-5.7]	11370
Education*			
Less Than High School	10.7%	[7.5-15.0]	828
High School	6.1%	[5.1-7.3]	4688
Some College	7.2%	[5.9-8.7]	4538
College Degree or More	4.2%	[3.6-4.9]	8534
Region			
Western	6.0%	[5.0-7.3]	4285
Central	6.2%	[5.0-7.6]	2578
Capital	6.1%	[4.6-8.1]	2264
Metro	5.5%	[4.8-6.3]	9437
Insurance*			
Public	7.9%	[6.5-9.5]	4126
Private	4.6%	[4.0-5.2]	12402
None	8.5%	[6.8-10.7]	1766

DT. Percentage of Bar Patrons Who Saw Smoking Indoors in the Past 30 Days, ATS 2003-2006.

Category	Estimate	C.I.	N
Age*			
18-24	33.8%	[27.9-40.3]	475
25-34	21.9%	[18.1-26.2]	1009
35-44	22.8%	[18.2-28.2]	931
45-54	23.3%	[18.9-28.5]	880
55-64	20.5%	[14.9-27.7]	554
65 + years	24.0%	[17.8-31.6]	365
Race			
White (non-Hispanic)	23.4%	[21.3-25.7]	3572
Black (non-Hispanic)	27.5%	[19.4-37.4]	224
Hispanic	28.9%	[20.1-39.5]	250
Other	28.8%	[21.0-38.2]	220
Gender*			
Male	27.1%	[24.2-30.3]	2261
Female	20.9%	[18.0-24.1]	2004
Education*			
Less Than High School	40.4%	[28.3-53.7]	137
High School	30.6%	[25.4-36.3]	932
Some College	26.1%	[21.9-30.9]	1069
College Degree or More	20.3%	[17.6-23.4]	2120
Region			
Western	24.3%	[20.7-28.4]	1071
Central	25.7%	[20.6-31.5]	621
Capital	29.5%	[23.6-36.3]	484
Metro	24.4%	[21.4-27.8]	2062
Insurance*			
Public	30.1%	[23.9-37.0]	539
Private	21.7%	[19.2-24.4]	3129
None	35.6%	[29.3-42.3]	513

DT. Percentage of Middle and High School Students Who Have Been Asked for Proof of Age When Purchasing Cigarettes, YTS 2000-2006

Category	Estimate	C.I.	N
Middle School			
Gender			
Female	29.0%	[13.8-51.1]	57
Male	28.9%	[16.0-46.3]	68
Race			
White	25.5%	[10.1-50.9]	22
Black	36.9%	[23.2-53.2]	21
Hispanic	25.1%	[14.7-39.3]	70
Other	29.3%	[3.6-82.2]	11
Grade			
6th	25.7%	[8.0-57.9]	19
7th	33.6%	[14.7-59.9]	33
8th	28.6%	[18.2-41.9]	74
Region			
Rest of State	33.5%	[20.7-49.4]	42
New York City	25.2%	[17.6-34.8]	84
High School			
Gender			
Female	55.6%	[43.5-67.1]	213
Male	54.0%	[44.4-63.4]	271
Race			
White	57.6%	[49.4-65.3]	241
Black	50.9%	[33.8-67.7]	57
Hispanic	44.5%	[32.3-57.5]	147
Other	49.2%	[35.9-62.6]	29
Grade*			
9th	37.9%	[27.1-50.0]	75
10th	55.2%	[41.7-67.9]	106
11th	49.6%	[37.2-62.0]	146
12th	65.3%	[54.5-74.8]	163
Region*			
Rest of State	60.6%	[51.5-68.9]	228
New York City	45.1%	[36.6-53.9]	262

DT. Percentage of Middle and High School Students Who Have Been Refused Sale of Cigarettes Because of Age, YTS 2000-2006

Category	Estimate	C.I.	N
Middle School			
Gender			
Female	39.9%	[29.8-50.9]	61
Male	45.1%	[33.3-57.4]	68
Race			
White	52.6%	[30.6-73.7]	20
Black	51.2%	[28.2-73.7]	23
Hispanic	41.9%	[27.0-58.4]	72
Other	5.8%	[0.6-39.5]	13
Grade			
6th	51.9%	[21.6-80.9]	19
7th	43.1%	[26.3-61.6]	38
8th	41.7%	[30.7-53.5]	74
Region*			
Rest of State	51.6%	[42.3-60.8]	46
New York City	35.0%	[23.8-48.2]	85
High School			
Gender			
Female	29.4%	[22.3-37.8]	210
Male	36.5%	[29.7-43.8]	252
Race			
White	35.0%	[26.6-44.5]	230
Black	38.0%	[23.9-54.6]	52
Hispanic	30.2%	[21.0-41.2]	142
Other	25.4%	[10.4-50.0]	27
Grade*			
9th	34.2%	[21.9-49.0]	63
10th	49.0%	[37.3-60.8]	116
11th	41.9%	[30.0-54.8]	135
12th	18.2%	[12.4-25.9]	150
Region			
Rest of State	34.2%	[26.0-43.4]	225
New York City	33.8%	[26.4-42.1]	239

DT. Percentage of Adults Who Favor the Clean Indoor Air Act, ATS 2003-2006.

Category	Estimate	C.I.	N
Age*			
18-24	68.5%	[65.0-71.8]	1516
25-34	74.2%	[71.9-76.4]	3577
35-44	76.0%	[74.2-77.7]	5309
45-54	73.0%	[71.0-74.8]	5834
55-64	76.4%	[74.5-78.2]	5122
65 + years	76.3%	[74.5-78.1]	6623
Race*			
White (non-Hispanic)	73.1%	[72.2-74.1]	22459
Black (non-Hispanic)	75.6%	[72.9-78.0]	2457
Hispanic	78.9%	[75.9-81.5]	2098
Other	75.2%	[71.5-78.6]	1520
Gender*			
Male	69.7%	[68.2-71.1]	10861
Female	78.8%	[77.8-79.8]	17665
Education*			
Less Than High School	70.6%	[67.2-73.9]	1899
High School	68.9%	[67.1-70.6]	7701
Some College	71.7%	[69.8-73.5]	6886
College Degree or More	80.6%	[79.4-81.8]	11917
Region*			
Western	69.5%	[67.7-71.2]	7165
Central	66.6%	[64.1-69.1]	3696
Capital	71.8%	[69.1-74.3]	3286
Metro	77.0%	[75.9-78.1]	14278
Insurance*			
Public	73.3%	[71.4-75.0]	7289
Private	77.2%	[76.2-78.2]	17723
None	66.3%	[63.4-69.0]	2894

DT. Percentage of Adult Nonsmokers Who Favor the Clean Indoor Air Act, ATS 2003-2006.

Category	Estimate	C.I.	N
Age*			
18-24	78.8%	[74.7-82.3]	1048
25-34	83.4%	[80.9-85.6]	2694
35-44	84.7%	[83.0-86.4]	4096
45-54	80.9%	[78.8-82.8]	4505
55-64	82.9%	[80.9-84.6]	4247
65 + years	80.0%	[78.1-81.7]	6022
Race			
White (non-Hispanic)	81.7%	[80.7-82.6]	18265
Black (non-Hispanic)	82.8%	[80.0-85.2]	1906
Hispanic	84.0%	[80.8-86.7]	1686
Other	80.7%	[76.7-84.2]	1246
Gender*			
Male	77.8%	[76.3-79.3]	8595
Female	85.8%	[84.8-86.7]	14501
Education*			
Less Than High School	79.0%	[75.1-82.5]	1348
High School	79.1%	[77.1-80.9]	5779
Some College	80.7%	[78.8-82.5]	5311
College Degree or More	85.1%	[83.8-86.2]	10552
Region*			
Western	79.5%	[77.7-81.3]	5700
Central	77.3%	[74.6-79.8]	2872
Capital	82.4%	[79.9-84.6]	2587
Metro	83.2%	[82.0-84.3]	11862
Insurance*			
Public	80.2%	[78.3-82.0]	5950
Private	84.0%	[82.9-84.9]	14708
None	78.1%	[74.8-81.0]	1938

DT. Percentage of Adult Smokers Who Favor the Clean Indoor Air Act, ATS 2003-2006.

Category	Estimate	C.I.	N
Age			
18-24	33.4%	[27.4-40.0]	468
25-34	39.1%	[34.2-44.3]	872
35-44	39.2%	[34.9-43.6]	1197
45-54	39.2%	[34.8-43.9]	1305
55-64	38.3%	[32.7-44.3]	844
65 + years	32.6%	[26.6-39.2]	548
Race*			
White (non-Hispanic)	32.5%	[30.3-34.9]	4078
Black (non-Hispanic)	42.3%	[36.2-48.7]	537
Hispanic	54.8%	[47.5-61.9]	404
Other	36.4%	[28.4-45.2]	268
Gender*			
Male	35.2%	[32.0-38.5]	2214
Female	40.2%	[37.4-43.1]	3072
Education*			
Less Than High School	49.4%	[42.6-56.2]	538
High School	34.6%	[31.1-38.3]	1881
Some College	33.6%	[29.8-37.5]	1547
College Degree or More	40.2%	[36.1-44.5]	1309
Region*			
Western	29.4%	[25.8-33.3]	1432
Central	27.3%	[22.5-32.6]	810
Capital	30.4%	[25.5-35.7]	687
Metro	43.2%	[40.1-46.3]	2331
Insurance			
Public	41.9%	[37.5-46.4]	1295
Private	37.3%	[34.4-40.3]	2934
None	34.3%	[29.7-39.3]	946

DT. 5-20a Percentage of Adults Who Would Be in Favor of a Law Banning Smoking in Outdoor Public Places Such as Beaches or Parks, ATS 2005-2006.

Category	Estimate	C.I.	N
Age*			
18-24	60.8%	[55.4-66.0]	688
25-34	62.6%	[58.8-66.1]	1779
35-44	59.5%	[56.7-62.3]	2948
45-54	51.5%	[48.7-54.4]	3468
55-64	50.7%	[47.7-53.6]	3214
65 + years	46.8%	[44.3-49.3]	4299
Race*			
White (non-Hispanic)	50.7%	[49.3-52.1]	13416
Black (non-Hispanic)	60.3%	[56.0-64.5]	1377
Hispanic	65.7%	[61.4-69.7]	1152
Other	64.8%	[59.0-70.2]	786
Gender*			
Male	51.1%	[48.9-53.3]	6296
Female	59.2%	[57.6-60.8]	10432
Education*			
Less Than High School	58.2%	[52.7-63.6]	1028
High School	50.5%	[47.8-53.2]	4513
Some College	53.7%	[50.9-56.5]	3980
College Degree or More	58.8%	[56.9-60.8]	7122
Region*			
Western	48.9%	[46.3-51.4]	4608
Central	50.7%	[47.0-54.4]	1926
Capital	50.2%	[46.3-54.0]	1800
Metro	58.0%	[56.2-59.8]	8397
Insurance*			
Public	52.1%	[49.5-54.7]	4522
Private	55.9%	[54.3-57.5]	10436
None	58.7%	[54.0-63.2]	1402

DT. 5-20b Percentage of Adults Who Would Be in Favor of a Law Banning Smoking in the Entranceways of Public Buildings and Workplaces, ATS 2005-2006.

Category	Estimate	C.I.	N
Age			
18-24	78.1%	[73.5-82.2]	688
25-34	79.4%	[76.0-82.5]	1778
35-44	77.9%	[75.4-80.1]	2946
45-54	75.7%	[73.2-78.1]	3465
55-64	75.2%	[72.4-77.9]	3212
65 + years	73.7%	[71.5-75.9]	4302
Race			
White (non-Hispanic)	75.4%	[74.1-76.7]	13415
Black (non-Hispanic)	79.5%	[75.7-82.9]	1377
Hispanic	79.1%	[75.2-82.5]	1150
Other	79.2%	[74.8-83.1]	784
Gender*			
Male	73.4%	[71.5-75.3]	6295
Female	79.9%	[78.6-81.2]	10428
Education*			
Less Than High School	74.1%	[68.9-78.7]	1025
High School	74.6%	[72.3-76.8]	4515
Some College	77.1%	[74.7-79.3]	3978
College Degree or More	78.7%	[77.0-80.4]	7121
Region			
Western	77.6%	[75.3-79.7]	4612
Central	78.3%	[75.0-81.3]	1927
Capital	78.9%	[75.6-81.9]	1800
Metro	76.2%	[74.7-77.7]	8387
Insurance*			
Public	74.3%	[72.0-76.5]	4522
Private	78.2%	[76.7-79.5]	10434
None	74.2%	[70.0-78.0]	1400

DT. 3-16a Percentage of Adults Who Believe Secondhand Smoke Causes Heart Disease, ATS 2003-2006.

Category	Estimate	C.I.	N
Age*			
18-24	75.6%	[72.4-78.6]	1540
25-34	74.3%	[72.0-76.5]	3613
35-44	75.1%	[73.2-76.8]	5369
45-54	72.0%	[70.1-73.9]	5897
55-64	69.2%	[67.1-71.3]	5177
65 + years	64.0%	[62.0-66.0]	6765
Race*			
White (non-Hispanic)	71.0%	[70.0-71.9]	22724
Black (non-Hispanic)	69.8%	[67.0-72.5]	2512
Hispanic	76.4%	[73.5-79.0]	2126
Other	72.2%	[68.7-75.4]	1567
Gender*			
Male	72.7%	[71.3-74.0]	11005
Female	70.8%	[69.7-71.9]	17916
Education*			
Less Than High School	70.1%	[66.7-73.3]	1962
High School	68.7%	[67.0-70.5]	7839
Some College	72.0%	[70.2-73.7]	6985
College Degree or More	74.0%	[72.7-75.3]	12006
Region*			
Western	74.0%	[72.4-75.6]	7260
Central	72.4%	[70.0-74.6]	3731
Capital	73.1%	[70.6-75.5]	3323
Metro	70.9%	[69.7-72.1]	14501
Insurance*			
Public	66.7%	[64.9-68.6]	7443
Private	73.2%	[72.1-74.3]	17900
None	73.6%	[71.0-76.0]	2939

DT. 3-16b Percentage of Adult Nonsmokers Who Believe Secondhand Smoke Causes Heart Disease, ATS 2003-2006

Category	Estimate	C.I.	N
Age*			
18-24	77.7%	[73.9-81.0]	1061
25-34	77.0%	[74.4-79.4]	2720
35-44	77.5%	[75.5-79.5]	4130
45-54	76.1%	[74.0-78.1]	4550
55-64	73.6%	[71.3-75.7]	4285
65 + years	66.6%	[64.5-68.6]	6149
Race*			
White (non-Hispanic)	73.9%	[72.9-75.0]	18460
Black (non-Hispanic)	72.1%	[68.9-75.0]	1944
Hispanic	78.8%	[75.7-81.7]	1706
Other	75.0%	[71.3-78.4]	1287
Gender*			
Male	75.7%	[74.2-77.1]	8695
Female	73.4%	[72.2-74.6]	14695
Education*			
Less Than High School	73.4%	[69.4-77.1]	1392
High School	72.2%	[70.2-74.2]	5886
Some College	75.3%	[73.3-77.2]	5382
College Degree or More	75.7%	[74.3-77.0]	10620
Region*			
Western	77.2%	[75.4-79.0]	5767
Central	75.7%	[73.1-78.1]	2902
Capital	76.5%	[73.9-79.0]	2610
Metro	73.4%	[72.1-74.7]	12032
Insurance*			
Public	69.2%	[67.2-71.2]	6067
Private	75.7%	[74.6-76.9]	14837
None	77.9%	[74.8-80.6]	1972

DT. 3-16c Percentage of Adult Smokers Who Believe Secondhand Smoke Causes Heart Disease, ATS 2003-2006

Category	Estimate	C.I.	N
Age*			
18-24	68.8%	[62.8-74.2]	478
25-34	63.8%	[58.7-68.6]	882
35-44	65.2%	[60.9-69.3]	1223
45-54	54.9%	[50.4-59.4]	1323
55-64	44.5%	[38.9-50.2]	862
65 + years	35.3%	[29.2-41.9]	559
Race			
White (non-Hispanic)	57.5%	[55.1-59.9]	4145
Black (non-Hispanic)	60.5%	[54.4-66.3]	552
Hispanic	65.0%	[57.7-71.6]	412
Other	51.0%	[42.1-59.8]	274
Gender			
Male	60.5%	[57.3-63.7]	2256
Female	56.8%	[54.0-59.5]	3126
Education			
Less Than High School	61.5%	[55.0-67.6]	557
High School	57.1%	[53.5-60.7]	1910
Some College	58.4%	[54.2-62.4]	1574
College Degree or More	59.8%	[55.7-63.9]	1329
Region			
Western	61.4%	[57.3-65.2]	1459
Central	60.0%	[54.8-65.0]	816
Capital	60.4%	[54.2-66.3]	702
Metro	57.7%	[54.6-60.7]	2378
Insurance			
Public	56.1%	[51.8-60.4]	1328
Private	58.7%	[55.8-61.6]	2983
None	61.7%	[56.9-66.4]	955

DT. 3-17a Percentage of Adults Who Believe Secondhand Smoke Causes Lung Cancer, ATS 2003-2006

Category	Estimate	C.I.	N
Age*			
18-24	89.5%	[87.2-91.5]	1541
25-34	86.4%	[84.6-88.1]	3619
35-44	86.2%	[84.7-87.5]	5372
45-54	81.3%	[79.6-82.9]	5902
55-64	78.2%	[76.2-80.0]	5177
65 + years	75.3%	[73.5-77.1]	6771
Race*			
White (non-Hispanic)	81.9%	[81.1-82.6]	22739
Black (non-Hispanic)	81.8%	[79.4-84.0]	2515
Hispanic	87.5%	[85.2-89.5]	2129
Other	83.1%	[80.1-85.8]	1565
Gender*			
Male	81.8%	[80.6-82.9]	11012
Female	83.7%	[82.8-84.5]	17928
Education*			
Less Than High School	80.1%	[77.3-82.6]	1964
High School	79.5%	[78.0-80.9]	7840
Some College	84.0%	[82.6-85.3]	6985
College Degree or More	84.9%	[83.8-85.9]	12021
Region			
Western	83.9%	[82.5-85.2]	7261
Central	82.6%	[80.8-84.3]	3737
Capital	84.2%	[82.3-85.9]	3331
Metro	82.4%	[81.4-83.3]	14505
Insurance*			
Public	78.4%	[76.8-79.9]	7450
Private	84.5%	[83.6-85.3]	17909
None	82.9%	[80.8-84.9]	2945

DT. 3-17b Percentage of Adult Nonsmokers Who Believe Secondhand Smoke Causes Lung Cancer, ATS 2003-2006

Category	Estimate	C.I.	N
Age*			
18-24	91.8%	[89.1-93.9]	1062
25-34	89.6%	[87.6-91.4]	2722
35-44	89.7%	[88.2-91.1]	4134
45-54	86.2%	[84.4-87.8]	4553
55-64	83.3%	[81.2-85.2]	4285
65 + years	78.5%	[76.7-80.2]	6156
Race*			
White (non-Hispanic)	85.7%	[84.8-86.5]	18471
Black (non-Hispanic)	85.4%	[82.8-87.7]	1947
Hispanic	89.7%	[87.2-91.7]	1709
Other	85.9%	[82.7-88.6]	1285
Gender*			
Male	85.2%	[83.9-86.3]	8700
Female	87.1%	[86.2-88.0]	14705
Education*			
Less Than High School	84.6%	[81.5-87.3]	1392
High School	83.7%	[82.0-85.2]	5886
Some College	87.9%	[86.5-89.3]	5383
College Degree or More	87.2%	[86.0-88.2]	10633
Region*			
Western	87.6%	[86.2-88.9]	5768
Central	87.5%	[85.6-89.1]	2904
Capital	88.3%	[86.4-89.9]	2618
Metro	85.4%	[84.4-86.4]	12036
Insurance*			
Public	81.5%	[79.7-83.1]	6075
Private	87.7%	[86.8-88.6]	14845
None	87.7%	[85.3-89.7]	1974

DT. 3-17c Percentage of Adult Smokers Who Believe Secondhand Smoke Causes Lung Cancer, ATS 2003-2006

Category	Estimate	C.I.	N
Age*			
18-24	81.9%	[76.6-86.2]	478
25-34	74.3%	[69.7-78.4]	886
35-44	71.7%	[67.6-75.6]	1222
45-54	61.3%	[56.9-65.6]	1325
55-64	49.1%	[43.4-54.7]	861
65 + years	38.1%	[31.7-44.9]	558
Race*			
White (non-Hispanic)	64.3%	[62.0-66.6]	4148
Black (non-Hispanic)	66.8%	[60.8-72.2]	552
Hispanic	77.4%	[70.8-82.9]	412
Other	64.1%	[55.1-72.2]	274
Gender			
Male	68.0%	[64.9-70.9]	2257
Female	65.2%	[62.5-67.8]	3128
Education			
Less Than High School	69.3%	[63.2-74.8]	559
High School	65.7%	[62.2-69.0]	1911
Some College	67.6%	[63.7-71.3]	1573
College Degree or More	65.3%	[61.2-69.1]	1330
Region			
Western	69.3%	[65.6-72.8]	1459
Central	64.7%	[59.5-69.5]	819
Capital	68.9%	[63.2-74.0]	702
Metro	66.1%	[63.2-68.9]	2378
Insurance			
Public	65.3%	[61.3-69.2]	1327
Private	65.8%	[63.0-68.6]	2983
None	70.0%	[65.4-74.2]	959

DT. 3-18a Percentage of Adults Who Believe Breathing Smoke From Other People's Cigarettes Causes Respiratory Problems in Children, ATS 2003-2006

Category	Estimate	C.I.	N
Age*			
18-24	95.6%	[93.8-97.0]	1541
25-34	94.6%	[93.1-95.8]	3622
35-44	95.2%	[94.3-96.0]	5375
45-54	92.9%	[91.7-93.9]	5907
55-64	90.5%	[89.0-91.9]	5185
65 + years	87.3%	[85.9-88.7]	6772
Race*			
White (non-Hispanic)	92.7%	[92.1-93.2]	22758
Black (non-Hispanic)	91.1%	[89.1-92.7]	2518
Hispanic	94.8%	[93.1-96.1]	2129
Other	92.3%	[89.9-94.2]	1567
Gender*			
Male	91.2%	[90.3-92.0]	11022
Female	94.1%	[93.5-94.6]	17942
Education*			
Less Than High School	88.6%	[86.1-90.6]	1967
High School	91.2%	[90.0-92.3]	7846
Some College	93.6%	[92.6-94.4]	6992
College Degree or More	94.2%	[93.4-94.8]	12029
Region*			
Western	93.3%	[92.3-94.2]	7268
Central	93.0%	[91.5-94.2]	3736
Capital	94.5%	[93.4-95.4]	3335
Metro	92.4%	[91.6-93.0]	14519
Insurance*			
Public	89.3%	[88.1-90.5]	7454
Private	94.2%	[93.6-94.7]	17919
None	92.6%	[91.0-93.9]	2951

DT. 3-18b Percentage of Adult Nonsmokers Who Believe Breathing Smoke From Other People's Cigarettes Causes Respiratory Problems in Children, ATS 2003-2006

Category	Estimate	C.I.	N
Age*			
18-24	95.7%	[93.3-97.2]	1062
25-34	96.0%	[94.2-97.2]	2726
35-44	96.5%	[95.4-97.3]	4136
45-54	95.4%	[94.2-96.3]	4556
55-64	93.4%	[91.9-94.7]	4293
65 + years	89.2%	[87.7-90.5]	6158
Race*			
White (non-Hispanic)	94.3%	[93.7-94.8]	18491
Black (non-Hispanic)	92.5%	[90.2-94.2]	1949
Hispanic	96.0%	[94.1-97.3]	1708
Other	94.2%	[91.6-96.0]	1287
Gender*			
Male	92.6%	[91.6-93.5]	8712
Female	95.7%	[95.1-96.2]	14716
Education*			
Less Than High School	90.6%	[87.8-92.9]	1394
High School	92.7%	[91.3-93.8]	5892
Some College	95.2%	[94.2-96.1]	5388
College Degree or More	95.3%	[94.6-95.9]	10643
Region*			
Western	94.9%	[93.9-95.8]	5774
Central	94.7%	[93.1-96.0]	2905
Capital	95.8%	[94.8-96.6]	2619
Metro	93.9%	[93.1-94.5]	12051
Insurance*			
Public	91.0%	[89.7-92.2]	6079
Private	95.5%	[94.9-96.1]	14855
None	94.4%	[92.5-95.8]	1979

DT. 3-18c Percentage of Adult Smokers Who Believe Breathing Smoke From Other People's Cigarettes Causes Respiratory Problems in Children, ATS 2003-2006

Category	Estimate	C.I.	N
Age*			
18-24	95.5%	[92.1-97.4]	478
25-34	89.4%	[85.6-92.2]	885
35-44	90.3%	[87.9-92.3]	1223
45-54	82.7%	[78.9-86.0]	1327
55-64	74.6%	[69.4-79.2]	861
65 + years	66.4%	[59.8-72.4]	557
Race			
White (non-Hispanic)	85.6%	[83.9-87.2]	4147
Black (non-Hispanic)	85.6%	[81.1-89.2]	553
Hispanic	89.2%	[84.1-92.8]	413
Other	79.1%	[70.7-85.6]	274
Gender			
Male	86.0%	[83.8-88.0]	2255
Female	85.6%	[83.5-87.4]	3131
Education			
Less Than High School	83.7%	[78.6-87.8]	559
High School	86.5%	[84.0-88.6]	1911
Some College	86.7%	[83.8-89.2]	1575
College Degree or More	84.9%	[81.8-87.6]	1329
Region			
Western	87.1%	[84.6-89.3]	1460
Central	86.7%	[83.1-89.7]	817
Capital	89.6%	[85.9-92.4]	704
Metro	84.6%	[82.4-86.6]	2378
Insurance*			
Public	82.6%	[79.3-85.5]	1327
Private	86.7%	[84.7-88.5]	2983
None	87.7%	[84.3-90.5]	960

DT. Percentage of Middle and High School Students Who Think Secondhand Smoke is Harmful, YTS 2000-2006

Category	Estimate	C.I.	N
Middle School			
Gender*			
Female	95.4%	[93.8-96.6]	1540
Male	92.5%	[90.2-94.4]	1221
Race*			
White	96.0%	[94.0-97.3]	836
Black	91.5%	[88.6-93.8]	513
Hispanic	90.2%	[86.7-92.8]	1056
Other	91.9%	[86.0-95.5]	210
Grade			
6th	91.5%	[87.9-94.2]	795
7th	95.5%	[92.8-97.2]	904
8th	93.7%	[90.7-95.7]	1083
Region			
Rest of State	94.9%	[92.6-96.5]	1288
New York City	92.1%	[89.0-94.4]	1494
High School			
Gender*			
Female	97.1%	[95.9-98.0]	2212
Male	93.7%	[91.7-95.3]	2054
Race*			
White	95.7%	[93.8-97.1]	1553
Black	97.0%	[95.7-97.9]	1018
Hispanic	92.6%	[90.0-94.5]	1168
Other	95.0%	[91.8-97.0]	404
Grade			
9th	94.2%	[91.6-96.0]	947
10th	96.0%	[94.3-97.2]	1266
11th	95.2%	[93.6-96.4]	1127
12th	96.2%	[92.5-98.1]	952
Region			
Rest of State	95.9%	[94.0-97.3]	2176
New York City	94.2%	[92.5-95.5]	2116

DT. Percentage of Adults Who Believe Tobacco-Related News Stories are Negatively Slanted in the Media, ATS 2003-2006

Category	Estimate	C.I.	N
Age*			
18-24	50.5%	[46.9-54.2]	1519
25-34	49.7%	[47.1-52.4]	3571
35-44	48.7%	[46.6-50.9]	5304
45-54	48.2%	[46.1-50.4]	5807
55-64	43.7%	[41.5-46.0]	5081
65 + years	36.1%	[34.2-38.1]	6482
Race*			
White (non-Hispanic)	50.4%	[49.3-51.5]	22251
Black (non-Hispanic)	38.8%	[35.9-41.8]	2465
Hispanic	40.2%	[36.9-43.6]	2075
Other	35.0%	[31.3-38.9]	1507
Gender*			
Male	49.2%	[47.6-50.8]	10814
Female	43.2%	[42.0-44.5]	17476
Education*			
Less Than High School	32.5%	[28.9-36.3]	1870
High School	40.5%	[38.6-42.4]	7625
Some College	45.8%	[43.7-47.8]	6848
College Degree or More	52.9%	[51.4-54.4]	11830
Region*			
Western	50.2%	[48.2-52.1]	7116
Central	48.7%	[46.2-51.3]	3639
Capital	50.7%	[47.8-53.5]	3254
Metro	44.4%	[43.1-45.7]	14182
Insurance*			
Public	37.7%	[35.8-39.7]	7184
Private	50.6%	[49.4-51.9]	17609
None	41.9%	[38.9-44.9]	2885

DT. Percentage of Tobacco Retailers with Any Interior or Exterior Cigarette Advertising, By Region, RATS 2004-2006

Category	Estimate	C.I.	N
Region*			
Western	95.8%	[94.8, 96.8]	1619
Central	98.2%	[97.5, 98.8]	1630
Capital	98.1%	[97.4, 98.7]	1642
Metro	94.3%	[93.4, 95.1]	2645
New York State	96.3%	[95.8, 96.7]	7536

DT. Percentage of Tobacco Retailers with Any Exterior Cigarette Advertising, By Region, RATS 2004-2006

Category	Estimate	C.I.	N
Region*			
Western	56.7%	[54.3, 59.2]	1623
Central	56.9%	[54.5, 59.3]	1631
Capital	56.8%	[54.4, 59.2]	1643
Metro	52.3%	[50.4, 54.2]	2644
New York State	55.2%	[54.1, 56.4]	7541

DT. Percentage of Tobacco Retailers with Any Interior Cigarette Advertising, By Region, RATS 2004-2006

Category	Estimate	C.I.	N
Region*			
Western	94.7%	[93.6, 95.8]	1612
Central	97.7%	[97.0, 98.4]	1625
Capital	97.6%	[96.8, 98.3]	1638
Metro	93.5%	[92.6, 94.5]	2639
New York State	95.6%	[95.1, 96.0]	7514

DT. Percentage of New York Tobacco Retailers with Purchase Promotions, By Region, RATS 2004-2006

Category	Estimate	C.I.	N
Region*			
Western	12.0%	[10.5, 13.6]	1629
Central	14.6%	[12.9, 16.3]	1636
Capital	21.1%	[19.2, 23.1]	1647
Metro	19.5%	[18.0, 21.0]	2646
New York State	17.2%	[16.3, 18.0]	7558

DT. Percentage of Middle and High School Students Who Would Wear Tobacco Branded Attire, YTS 2000-2006

Category	Estimate	C.I.	N
Middle School			
Gender*			
Female	14.8%	[11.9-18.2]	1525
Male	20.6%	[16.0-26.1]	1216
Race			
White	17.2%	[12.0-23.9]	836
Black	21.1%	[16.5-26.6]	508
Hispanic	18.8%	[14.7-23.7]	1044
Other	10.3%	[6.6-15.7]	208
Grade*			
6th	10.9%	[7.4-15.7]	788
7th	17.6%	[14.5-21.1]	902
8th	22.0%	[17.0-27.9]	1073
Region			
Rest of State	17.6%	[12.8-23.6]	1286
New York City	17.7%	[14.0-22.2]	1477
High School			
Gender*			
Female	22.8%	[19.4-26.5]	2207
Male	32.6%	[29.1-36.4]	2045
Race*			
White	30.9%	[27.8-34.2]	1554
Black	24.5%	[20.6-28.8]	1013
Hispanic	22.7%	[20.3-25.4]	1164
Other	18.1%	[14.7-22.0]	404
Grade			
9th	27.4%	[22.9-32.3]	946
10th	26.8%	[22.5-31.6]	1264
11th	28.7%	[24.6-33.1]	1119
12th	28.1%	[24.3-32.2]	948
Region*			
Rest of State	30.0%	[26.9-33.3]	2178
New York City	23.1%	[19.7-27.0]	2099

DT. Percentage of Middle and High School Students Who Have Seen Tobacco Advertising on the Internet, YTS 2000-2006

Category	Estimate	C.I.	N
Middle School			
Gender			
Female	69.6%	[65.6-73.3]	1524
Male	67.1%	[62.4-71.6]	1197
Race*			
White	74.5%	[70.5-78.1]	832
Black	59.7%	[51.6-67.4]	501
Hispanic	60.6%	[53.7-67.2]	1042
Other	62.4%	[55.2-69.1]	207
Grade*			
6th	56.1%	[51.8-60.2]	778
7th	71.0%	[66.3-75.3]	895
8th	73.0%	[66.8-78.4]	1069
Region			
Rest of State	70.3%	[65.1-75.1]	1273
New York City	64.4%	[58.6-69.9]	1469
High School			
Gender*			
Female	78.2%	[75.2-80.9]	2197
Male	73.5%	[70.3-76.5]	2039
Race*			
White	78.4%	[76.2-80.5]	1549
Black	70.8%	[66.2-75.1]	1007
Hispanic	69.7%	[64.0-74.9]	1155
Other	74.9%	[70.7-78.7]	403
Grade			
9th	72.4%	[67.1-77.2]	943
10th	77.8%	[73.2-81.9]	1253
11th	74.7%	[71.4-77.7]	1116
12th	78.3%	[73.4-82.5]	950
Region			
Rest of State	77.4%	[75.2-79.5]	2164
New York City	72.3%	[67.1-76.9]	2098

DT. Percentage of Middle and High School Students Who Have Seen Tobacco Advertising in Newspapers or Magazines, YTS 2000-2006

Category	Estimate	C.I.	N
Middle School			
Gender*			
Female	67.7%	[62.4-72.6]	1500
Male	54.3%	[48.6-59.9]	1183
Race*			
White	65.4%	[60.3-70.1]	824
Black	55.4%	[48.0-62.6]	495
Hispanic	56.8%	[50.8-62.7]	1027
Other	51.5%	[42.6-60.3]	201
Grade*			
6th	53.0%	[47.7-58.4]	772
7th	62.7%	[57.7-67.5]	883
8th	63.8%	[57.4-69.8]	1050
Region			
Rest of State	62.6%	[56.4-68.4]	1263
New York City	57.7%	[52.3-62.9]	1442
High School			
Gender*			
Female	81.5%	[78.3-84.3]	2195
Male	68.5%	[64.7-72.1]	2025
Race			
White	75.8%	[72.6-78.7]	1547
Black	78.4%	[75.0-81.4]	1004
Hispanic	70.5%	[62.9-77.2]	1151
Other	72.7%	[65.8-78.6]	398
Grade*			
9th	67.0%	[60.7-72.8]	940
10th	79.2%	[76.2-82.0]	1245
11th	75.7%	[72.6-78.5]	1112
12th	77.9%	[73.9-81.5]	949
Region			
Rest of State	74.7%	[71.3-77.9]	2161
New York City	75.1%	[70.3-79.4]	2085

DT. Percentage of Adults Who Have Seen Antismoking Advertising on Television, ATS 2003-2006

Category	Estimate	C.I.	N
Age*			
18-24	86.1%	[83.0-88.7]	1382
25-34	82.1%	[79.8-84.2]	3270
35-44	74.9%	[72.9-76.7]	4962
45-54	72.4%	[70.4-74.3]	5386
55-64	67.4%	[65.2-69.5]	4754
65 + years	61.5%	[59.4-63.5]	6142
Race*			
White (non-Hispanic)	73.3%	[72.3-74.2]	20790
Black (non-Hispanic)	77.3%	[74.8-79.7]	2272
Hispanic	75.5%	[72.4-78.4]	1928
Other	66.8%	[62.7-70.6]	1389
Gender*			
Male	76.2%	[74.8-77.6]	10105
Female	71.4%	[70.3-72.5]	16266
Education*			
Less Than High School	69.8%	[65.9-73.4]	1715
High School	73.1%	[71.3-74.8]	7180
Some College	76.2%	[74.5-77.9]	6463
College Degree or More	73.5%	[72.1-74.8]	10917
Region*			
Western	76.3%	[74.7-77.9]	6748
Central	76.2%	[73.9-78.3]	3416
Capital	78.1%	[75.9-80.2]	3035
Metro	72.3%	[71.1-73.5]	13079
Insurance*			
Public	69.0%	[67.1-70.8]	6696
Private	75.1%	[74.0-76.2]	16517
None	75.3%	[72.3-78.0]	2621

DT. Percentage of Adults Who Have Seen Advertising About Family Members Losing a Loved One Due to Smoking-Related Illnesses, ATS 2003-2006

Category	Estimate	C.I.	N
Age*			
18-24	54.3%	[50.6-58.0]	1529
25-34	52.3%	[49.7-55.0]	3592
35-44	50.1%	[48.0-52.3]	5314
45-54	50.7%	[48.5-52.8]	5805
55-64	50.9%	[48.6-53.2]	5115
65 + years	41.9%	[39.9-43.9]	6603
Race*			
White (non-Hispanic)	48.0%	[47.0-49.1]	22393
Black (non-Hispanic)	54.0%	[50.9-57.0]	2479
Hispanic	56.3%	[52.9-59.6]	2104
Other	43.8%	[39.9-47.8]	1531
Gender*			
Male	46.8%	[45.2-48.4]	10867
Female	52.5%	[51.2-53.7]	17632
Education*			
Less Than High School	53.5%	[49.7-57.3]	1927
High School	50.6%	[48.7-52.6]	7719
Some College	52.1%	[50.1-54.2]	6887
College Degree or More	47.1%	[45.7-48.6]	11840
Region			
Western	50.0%	[48.1-51.9]	7147
Central	49.5%	[46.9-52.1]	3682
Capital	53.0%	[50.1-55.8]	3289
Metro	49.4%	[48.1-50.7]	14276
Insurance			
Public	49.6%	[47.6-51.6]	7289
Private	49.9%	[48.7-51.2]	17669
None	49.9%	[46.9-53.0]	2917

DT. Percentage of Adult Smokers Who Have Seen Advertising About Family Members Losing a Loved One Due to Smoking-Related Illnesses, ATS 2003-2006

Category	Estimate	C.I.	N
Age*			
18-24	62.5%	[56.2-68.4]	474
25-34	51.2%	[46.1-56.3]	883
35-44	50.7%	[46.2-55.1]	1214
45-54	49.3%	[44.8-53.8]	1312
55-64	47.9%	[42.3-53.7]	848
65 + years	41.7%	[35.2-48.5]	551
Race*			
White (non-Hispanic)	48.9%	[46.4-51.4]	4108
Black (non-Hispanic)	60.1%	[54.0-65.9]	548
Hispanic	56.2%	[48.9-63.2]	409
Other	45.4%	[36.7-54.4]	272
Gender			
Male	50.6%	[47.2-53.9]	2235
Female	52.5%	[49.6-55.3]	3101
Education			
Less Than High School	55.6%	[48.9-62.1]	554
High School	52.5%	[48.8-56.2]	1890
Some College	51.9%	[47.7-56.0]	1560
College Degree or More	47.2%	[42.9-51.5]	1320
Region			
Western	46.6%	[42.5-50.8]	1442
Central	50.7%	[45.3-56.1]	815
Capital	52.6%	[46.3-58.8]	698
Metro	52.9%	[49.8-56.0]	2354
Insurance*			
Public	56.4%	[52.0-60.7]	1309
Private	48.4%	[45.4-51.5]	2954
None	52.9%	[48.0-57.8]	960

DT. Percentage of Adult Smokers Who Have Noticed Advertising About the Dangers of Children Being Exposed to Cigarette Smoke, ATS 2003-2006

Category	Estimate	C.I.	N
Age			
18-24	70.8%	[64.8-76.0]	476
25-34	64.4%	[59.3-69.2]	883
35-44	66.0%	[61.7-70.1]	1210
45-54	72.5%	[68.5-76.2]	1312
55-64	72.4%	[67.2-76.9]	852
65 + years	66.3%	[59.4-72.5]	547
Race*			
White (non-Hispanic)	65.7%	[63.3-68.0]	4105
Black (non-Hispanic)	76.6%	[70.9-81.5]	548
Hispanic	75.2%	[68.4-81.0]	408
Other	57.9%	[48.9-66.5]	274
Gender*			
Male	66.3%	[63.2-69.4]	2230
Female	70.6%	[67.9-73.1]	3104
Education*			
Less Than High School	75.4%	[69.3-80.6]	552
High School	69.4%	[65.8-72.7]	1893
Some College	69.4%	[65.4-73.1]	1561
College Degree or More	61.7%	[57.5-65.7]	1316
Region*			
Western	72.3%	[68.3-75.9]	1439
Central	72.7%	[67.9-77.0]	817
Capital	69.0%	[63.2-74.3]	698
Metro	66.5%	[63.5-69.3]	2353
Insurance			
Public	72.9%	[68.8-76.6]	1302
Private	67.2%	[64.3-70.0]	2958
None	67.2%	[62.5-71.6]	958

DT. 3-11a Percentage of Adults Who Have Noticed Advertisements About Calling a Quitline, ATS 2003-2006

Category	Estimate	C.I.	N
Age*			
18-24	55.8%	[52.1-59.4]	1531
25-34	55.1%	[52.4-57.7]	3578
35-44	51.0%	[48.9-53.2]	5319
45-54	52.3%	[50.2-54.4]	5800
55-64	49.8%	[47.5-52.1]	5063
65 + years	48.3%	[46.2-50.3]	6590
Race*			
White (non-Hispanic)	51.7%	[50.6-52.8]	22331
Black (non-Hispanic)	54.3%	[51.2-57.3]	2481
Hispanic	53.0%	[49.6-56.4]	2083
Other	46.0%	[42.0-50.0]	1526
Gender*			
Male	49.6%	[48.1-51.2]	10842
Female	53.8%	[52.6-55.0]	17571
Education*			
Less Than High School	46.9%	[43.1-50.7]	1919
High School	50.8%	[48.8-52.8]	7686
Some College	55.5%	[53.5-57.5]	6874
College Degree or More	51.4%	[49.9-52.9]	11811
Region*			
Western	55.8%	[53.8-57.7]	7137
Central	51.8%	[49.3-54.4]	3671
Capital	56.2%	[53.4-59.0]	3285
Metro	50.5%	[49.1-51.8]	14216
Insurance			
Public	52.1%	[50.1-54.1]	7275
Private	52.6%	[51.3-53.8]	17596
None	49.9%	[46.8-52.9]	2913

DT. 3-11b Percentage of Adult Nonsmokers Who Have Noticed Advertisements About Calling a Quitline, ATS 2003-2006

Category	Estimate	C.I.	N
Age*			
18-24	54.8%	[50.4-59.1]	1058
25-34	53.9%	[50.8-57.0]	2686
35-44	50.1%	[47.7-52.5]	4090
45-54	50.4%	[48.0-52.9]	4464
55-64	48.3%	[45.8-50.8]	4184
65 + years	47.5%	[45.3-49.6]	5989
Race			
White (non-Hispanic)	50.5%	[49.3-51.7]	18111
Black (non-Hispanic)	51.9%	[48.4-55.3]	1919
Hispanic	51.9%	[48.1-55.7]	1668
Other	45.6%	[41.3-50.0]	1249
Gender*			
Male	48.1%	[46.3-49.9]	8558
Female	52.6%	[51.3-54.0]	14382
Education*			
Less Than High School	45.4%	[40.9-50.0]	1354
High School	48.8%	[46.5-51.1]	5762
Some College	54.2%	[51.9-56.5]	5286
College Degree or More	50.4%	[48.8-52.0]	10432
Region*			
Western	54.4%	[52.3-56.6]	5662
Central	50.7%	[47.8-53.6]	2844
Capital	55.8%	[52.6-58.9]	2580
Metro	49.1%	[47.6-50.5]	11776
Insurance			
Public	51.0%	[48.8-53.2]	5918
Private	51.3%	[49.9-52.6]	14570
None	47.7%	[44.0-51.4]	1948

DT. 3-11c Percentage of Adult Smokers Who Have Noticed Advertisements About Calling a Quitline, ATS 2003-2006

Category	Estimate	C.I.	N
Age			
18-24	59.4%	[52.9-65.6]	472
25-34	59.5%	[54.4-64.4]	881
35-44	55.1%	[50.7-59.5]	1213
45-54	60.8%	[56.4-65.0]	1312
55-64	57.2%	[51.5-62.7]	850
65 + years	60.7%	[54.0-67.0]	550
Race*			
White (non-Hispanic)	57.8%	[55.3-60.2]	4107
Black (non-Hispanic)	65.5%	[59.2-71.2]	546
Hispanic	58.1%	[50.9-65.0]	408
Other	48.4%	[39.6-57.3]	271
Gender			
Male	56.7%	[53.4-60.0]	2231
Female	60.4%	[57.6-63.1]	3100
Education*			
Less Than High School	51.0%	[44.2-57.7]	551
High School	57.8%	[54.1-61.4]	1885
Some College	61.1%	[57.1-65.1]	1560
College Degree or More	60.4%	[56.2-64.5]	1323
Region			
Western	61.2%	[56.9-65.2]	1442
Central	56.0%	[50.6-61.3]	814
Capital	57.8%	[51.5-63.8]	694
Metro	58.5%	[55.4-61.5]	2355
Insurance			
Public	58.3%	[53.8-62.6]	1315
Private	60.3%	[57.3-63.2]	2947
None	56.2%	[51.3-61.0]	953

DT. 3-3a Percentage of Adults Who Reported Confirmed Awareness of NYTCP Media Campaign Advertisements (Statewide and Local), ATS 2003-2006

Category	Estimate	C.I.	N
Age*			
18-24	26.6%	[23.0-30.4]	1229
25-34	27.7%	[25.3-30.3]	3009
35-44	26.8%	[24.9-28.9]	4534
45-54	22.7%	[20.9-24.5]	5129
55-64	22.4%	[20.6-24.3]	4560
65 + years	18.9%	[17.4-20.5]	6066
Race*			
White (non-Hispanic)	25.2%	[24.2-26.2]	19827
Black (non-Hispanic)	24.3%	[21.6-27.3]	2090
Hispanic	23.9%	[21.1-27.0]	1834
Other	17.1%	[13.7-21.0]	1283
Gender*			
Male	22.3%	[20.9-23.7]	9486
Female	26.1%	[25.0-27.2]	15543
Education*			
Less Than High School	19.6%	[16.5-23.1]	1668
High School	25.2%	[23.5-27.0]	6766
Some College	28.3%	[26.3-30.3]	6001
College Degree or More	22.3%	[21.0-23.6]	10474
Region*			
Western	32.0%	[30.2-33.9]	6434
Central	32.3%	[29.8-35.0]	3116
Capital	31.9%	[29.2-34.6]	2819
Metro	20.7%	[19.6-21.9]	12610
Insurance*			
Public	22.1%	[20.5-23.8]	6539
Private	25.1%	[24.0-26.2]	15504
None	24.1%	[21.3-27.2]	2445

DT. 3-3b Percentage of Adult Nonsmokers Who Reported Confirmed Awareness of NYTCP Media Campaign Advertisements (Statewide and Local), ATS 2003-2006

Category	Estimate	C.I.	N
Age*			
18-24	25.4%	[21.4-29.9]	877
25-34	26.5%	[23.8-29.4]	2294
35-44	26.2%	[24.1-28.5]	3541
45-54	23.1%	[21.2-25.2]	4017
55-64	22.5%	[20.5-24.6]	3807
65 + years	18.6%	[17.0-20.2]	5529
Race*			
White (non-Hispanic)	24.6%	[23.5-25.6]	16302
Black (non-Hispanic)	22.7%	[19.7-25.9]	1644
Hispanic	24.6%	[21.4-28.1]	1496
Other	17.1%	[13.5-21.5]	1069
Gender*			
Male	21.4%	[19.9-23.0]	7601
Female	25.7%	[24.5-27.0]	12906
Education*			
Less Than High School	18.7%	[15.2-22.8]	1211
High School	23.9%	[22.0-26.0]	5163
Some College	28.4%	[26.2-30.7]	4695
College Degree or More	21.9%	[20.6-23.3]	9334
Region*			
Western	30.7%	[28.7-32.7]	5173
Central	33.6%	[30.6-36.7]	2449
Capital	30.1%	[27.3-32.9]	2256
Metro	20.4%	[19.1-21.7]	10593
Insurance*			
Public	21.4%	[19.7-23.3]	5398
Private	24.8%	[23.6-26.0]	12989
None	21.7%	[18.5-25.4]	1681

DT. 3-3c Percentage of Adult Smokers Who Reported Confirmed Awareness of NYTCP Media Campaign Advertisements (Statewide and Local), ATS 2003-2006

Category	Estimate	C.I.	N
Age*			
18-24	30.3%	[23.5-38.1]	351
25-34	33.3%	[28.0-39.0]	705
35-44	29.6%	[25.2-34.4]	977
45-54	20.5%	[17.1-24.4]	1088
55-64	22.5%	[17.9-27.8]	724
65 + years	23.9%	[18.6-30.0]	484
Race*			
White (non-Hispanic)	28.8%	[26.3-31.5]	3411
Black (non-Hispanic)	32.7%	[26.1-39.9]	432
Hispanic	20.6%	[14.6-28.3]	330
Other	17.2%	[11.5-24.9]	208
Gender			
Male	26.6%	[23.3-30.2]	1835
Female	28.5%	[25.8-31.4]	2545
Education			
Less Than High School	22.5%	[16.4-29.9]	443
High School	29.8%	[26.1-33.8]	1563
Some College	27.7%	[23.8-32.0]	1279
College Degree or More	26.5%	[22.3-31.3]	1085
Region*			
Western	38.4%	[34.1-42.9]	1228
Central	27.6%	[22.7-33.1]	655
Capital	39.2%	[32.1-46.9]	551
Metro	23.0%	[20.0-26.3]	1932
Insurance			
Public	25.8%	[21.8-30.3]	1097
Private	27.1%	[24.2-30.2]	2436
None	31.4%	[26.1-37.2]	754

DT. 3-7a1 Percentage of Adults Who Reported Confirmed Awareness of Media Campaign Advertisements and Said that the Ad Said Something Important to Them (Statewide and Local), ATS 2003-2006

Category	Estimate	C.I.	N
Age *			
18-24	90.9%	[86.8, 95.0]	319
25-34	89.2%	[85.8, 92.6]	843
35-44	91.1%	[88.7, 93.6]	1226
45-54	92.2%	[89.7, 94.7]	1310
55-64	92.5%	[90.5, 94.5]	1136
65 + years	86.6%	[83.5, 89.8]	1153
Race			
White (non-Hispanic)	90.5%	[89.2, 91.8]	4909
Black (non-Hispanic)	90.0%	[86.3, 93.7]	527
Hispanic	90.7%	[86.3, 95.2]	444
Other	92.8%	[88.8, 96.7]	213
Gender *			
Male	88.5%	[86.2, 90.8]	2021
Female	92.2%	[91.0, 93.4]	4071
Education *			
Less Than High School	81.8%	[74.4, 89.2]	330
High School	89.1%	[86.5, 91.6]	1709
Some College	91.7%	[89.9, 93.6]	1685
College Degree or More	92.4%	[90.6, 94.1]	2343
Region			
Western	88.8%	[86.4, 91.3]	1838
Central	87.8%	[84.7, 90.9]	974
Capital	91.3%	[88.8, 93.8]	899
Metro	91.7%	[89.9, 93.5]	2382
Insurance *			
Public	88.5%	[85.9, 91.1]	1450
Private	91.9%	[90.6, 93.3]	3970
None	87.5%	[82.8, 92.2]	554

DT. 3-7a1 Percentage of Adult Nonsmokers Who Reported Confirmed Awareness of Media Campaign Advertisements and Said that the Ad Said Something Important to Them (Statewide and Local), ATS 2003-2006

Category	Estimate	C.I.	N
Age *			
18-24	94.1%	[90.4, 97.7]	224
25-34	92.8%	[89.9, 95.7]	617
35-44	93.8%	[91.2, 96.5]	939
45-54	93.3%	[90.4, 96.1]	1022
55-64	94.1%	[92.1, 96.0]	941
65 + years	87.1%	[83.7, 90.4]	1036
Race			
White (non-Hispanic)	92.9%	[91.7, 94.1]	3931
Black (non-Hispanic)	89.8%	[85.2, 94.3]	389
Hispanic	93.0%	[89.1, 96.9]	380
Other	96.2%	[93.6, 98.8]	172
Gender			
Male	91.4%	[89.2, 93.6]	1579
Female	93.7%	[92.4, 94.9]	3292
Education *			
Less Than High School	80.0%	[70.4, 89.5]	230
High School	91.2%	[88.7, 93.8]	1253
Some College	94.6%	[92.9, 96.3]	1306
College Degree or More	94.0%	[92.5, 95.6]	2061
Region			
Western	91.9%	[89.2, 94.5]	1422
Central	89.6%	[86.3, 92.8]	781
Capital	92.9%	[90.3, 95.6]	695
Metro	93.6%	[92.0, 95.2]	1974
Insurance *			
Public	89.1%	[86.0, 92.1]	1153
Private	93.3%	[91.9, 94.8]	3281
None	94.8%	[91.9, 97.7]	348

DT. 3-7a2 Percentage of Adult Smokers Who Reported Confirmed Awareness of Media Campaign Advertisements and Said that the Ad Said Something Important to Them (Statewide and Local), ATS 2003-2006

Category	Estimate	C.I.	N
Age			
18-24	80.9%	[69.0, 92.8]	94
25-34	77.8%	[68.0, 87.6]	226
35-44	81.3%	[75.2, 87.3]	285
45-54	86.5%	[80.7, 92.4]	285
55-64	82.4%	[73.8, 90.9]	186
65 + years	81.8%	[73.2, 90.4]	113
Race *			
White (non-Hispanic)	80.7%	[76.5, 84.9]	961
Black (non-Hispanic)	90.5%	[85.2, 95.8]	136
Hispanic	77.0%	[58.3, 95.7]	63
Other	63.9%	[42.0, 85.8]	41
Gender			
Male	78.2%	[71.5, 84.8]	438
Female	84.8%	[81.3, 88.3]	763
Education			
Less Than High School	86.1%	[76.8, 95.4]	99
High School	82.6%	[76.0, 89.3]	449
Some College	79.3%	[72.8, 85.8]	372
College Degree or More	80.0%	[71.3, 88.7]	277
Region			
Western	78.8%	[73.2, 84.4]	411
Central	79.3%	[70.7, 87.9]	190
Capital	86.2%	[79.9, 92.5]	201
Metro	81.9%	[75.3, 88.5]	399
Insurance			
Public	86.3%	[81.5, 91.1]	295
Private	84.1%	[80.0, 88.1]	674
None	71.7%	[60.1, 83.3]	204

DT. 3-7b1 Percentage of Adults Who Reported Confirmed Awareness of Media Campaign Advertisements and Said that they Had Talked to Someone About the Ad (Statewide and Local), ATS 2003-2006

Category	Estimate	C.I.	N
Age *			
18-24	25.8%	[18.6, 33.0]	326
25-34	30.3%	[25.5, 35.2]	856
35-44	28.6%	[24.8, 32.4]	1242
45-54	25.1%	[21.4, 28.8]	1330
55-64	27.9%	[23.9, 32.0]	1151
65 + years	19.8%	[16.0, 23.5]	1184
Race *			
White (non-Hispanic)	21.8%	[20.0, 23.6]	4994
Black (non-Hispanic)	34.8%	[28.2, 41.4]	537
Hispanic	38.4%	[31.7, 45.1]	449
Other	31.2%	[21.5, 40.9]	218
Gender *			
Male	21.9%	[19.0, 24.8]	2063
Female	30.1%	[27.7, 32.5]	4134
Education			
Less Than High School	33.3%	[24.4, 42.2]	342
High School	28.0%	[24.3, 31.6]	1737
Some College	26.8%	[23.2, 30.4]	1709
College Degree or More	23.9%	[21.2, 26.7]	2384
Region *			
Western	25.2%	[22.3, 28.1]	1866
Central	17.7%	[14.3, 21.1]	985
Capital	19.6%	[16.1, 23.0]	920
Metro	30.2%	[27.3, 33.1]	2427
Insurance *			
Public	32.2%	[27.9, 36.5]	1480
Private	24.4%	[22.4, 26.5]	4029
None	29.1%	[22.5, 35.7]	565

DT. 3-7b1 Percentage of Adult Nonsmokers Who Reported Confirmed Awareness of Media Campaign Advertisements and Said that they Had Talked to Someone About the Ad (Statewide and Local), ATS 2003-2006

Category	Estimate	C.I.	N
Age *			
18-24	25.2%	[16.8, 33.6]	227
25-34	29.4%	[24.0, 34.8]	629
35-44	29.7%	[25.5, 33.9]	949
45-54	27.2%	[23.0, 31.4]	1038
55-64	28.4%	[24.1, 32.8]	951
65 + years	19.9%	[16.0, 23.8]	1063
Race *			
White (non-Hispanic)	22.2%	[20.3, 24.1]	3998
Black (non-Hispanic)	34.8%	[27.3, 42.2]	396
Hispanic	37.3%	[30.2, 44.4]	384
Other	33.6%	[22.6, 44.6]	175
Gender *			
Male	21.7%	[18.5, 24.8]	1608
Female	30.5%	[27.9, 33.1]	3344
Education			
Less Than High School	31.4%	[21.5, 41.4]	236
High School	27.4%	[23.4, 31.3]	1271
Some College	28.3%	[24.1, 32.5]	1325
College Degree or More	24.6%	[21.6, 27.6]	2099
Region *			
Western	26.8%	[23.5, 30.1]	1440
Central	19.1%	[15.2, 22.9]	790
Capital	20.9%	[17.1, 24.7]	711
Metro	29.5%	[26.3, 32.6]	2012
Insurance			
Public	30.7%	[26.1, 35.4]	1175
Private	25.2%	[23.0, 27.5]	3332
None	31.9%	[23.5, 40.2]	352

DT. 3-7b2 Percentage of Adult Smokers Who Reported Confirmed Awareness of Media Campaign Advertisements and Said that they Had Talked to Someone About the Ad (Statewide and Local), ATS 2003-2006

Category	Estimate	C.I.	N
Age *			
18-24	28.1%	[14.1, 42.2]	98
25-34	33.3%	[22.7, 43.9]	227
35-44	24.7%	[15.8, 33.7]	290
45-54	14.1%	[8.6, 19.6]	289
55-64	22.7%	[11.6, 33.7]	191
65 + years	19.2%	[6.4, 32.1]	117
Race *			
White (non-Hispanic)	19.8%	[15.3, 24.4]	978
Black (non-Hispanic)	35.4%	[21.2, 49.6]	139
Hispanic	45.9%	[27.2, 64.5]	64
Other	11.9%	[3.3, 20.6]	43
Gender			
Male	22.6%	[15.5, 29.7]	450
Female	27.9%	[21.8, 33.9]	774
Education			
Less Than High School	37.7%	[19.6, 55.8]	104
High School	29.5%	[21.1, 37.9]	459
Some College	20.4%	[14.0, 26.8]	377
College Degree or More	18.2%	[10.4, 26.0]	280
Region *			
Western	19.7%	[13.5, 25.8]	421
Central	11.0%	[4.6, 17.3]	192
Capital	14.3%	[7.0, 21.6]	206
Metro	34.1%	[26.1, 42.2]	405
Insurance *			
Public	37.9%	[27.6, 48.1]	303
Private	19.6%	[14.2, 25.1]	681
None	23.6%	[12.7, 34.4]	211

DT. Percentage of Middle and High School Students Who Were Aware of Reality Check, YTS 2000-2006

Category	Estimate	C.I.	N
Middle School			
Gender			
Female	36.8%	[28.7-45.7]	1537
Male	42.6%	[34.6-51.0]	1217
Race*			
White	44.5%	[34.9-54.6]	840
Black	38.8%	[31.7-46.3]	513
Hispanic	30.7%	[26.0-35.8]	1050
Other	26.4%	[19.9-34.1]	208
Grade			
6th	32.7%	[27.8-38.0]	793
7th	42.7%	[31.0-55.3]	898
8th	40.9%	[33.1-49.3]	1085
Region*			
Rest of State	44.5%	[34.3-55.1]	1287
New York City	30.9%	[28.0-33.9]	1489
High School			
Gender			
Female	43.6%	[37.1-50.4]	2213
Male	43.3%	[37.1-49.9]	2050
Race*			
White	48.5%	[39.7-57.3]	1551
Black	36.1%	[31.7-40.7]	1015
Hispanic	34.6%	[30.5-38.9]	1168
Other	30.9%	[24.5-38.2]	405
Grade			
9th	43.3%	[36.7-50.3]	948
10th	43.9%	[36.9-51.2]	1264
11th	45.6%	[38.1-53.2]	1123
12th	40.6%	[31.3-50.7]	954
Region*			
Rest of State	50.2%	[41.5-58.9]	2173
New York City	29.9%	[26.7-33.3]	2116

DT. Percentage of Middle and High School Students Who Had Participated in Reality Check Events, YTS 2000-2006

Category	Estimate	C.I.	N
Middle School			
Gender			
Female	5.4%	[1.9-14.6]	1538
Male	6.4%	[3.8-10.4]	1211
Race			
White	6.7%	[2.9-14.8]	840
Black	5.8%	[3.0-10.9]	511
Hispanic	3.5%	[2.1-5.8]	1046
Other	2.7%	[1.0-7.4]	209
Grade			
6th	2.4%	[1.3-4.4]	793
7th	6.4%	[2.9-13.5]	896
8th	7.4%	[3.1-16.7]	1081
Region*			
Rest of State	7.5%	[3.5-15.5]	1285
New York City	2.7%	[1.7-4.3]	1485
High School			
Gender			
Female	4.1%	[2.5-6.5]	2215
Male	5.3%	[3.6-7.7]	2053
Race			
White	5.1%	[3.3-8.0]	1556
Black	3.5%	[2.0-6.0]	1018
Hispanic	3.8%	[2.2-6.5]	1166
Other	2.3%	[1.3-4.3]	405
Grade			
9th	4.1%	[2.5-6.6]	947
10th	4.5%	[2.3-8.5]	1267
11th	5.9%	[3.9-8.9]	1124
12th	4.2%	[2.4-7.1]	955
Region*			
Rest of State	5.5%	[3.5-8.7]	2176
New York City	3.0%	[2.0-4.4]	2117

DT. 3-14a Percentage of Adult Smokers Who Believed Smokers Have a Higher Risk of Heart Attack, ATS 2003 - 2006

Category	Estimate	C.I.	N
Age*			
18-24	64.5%	[57.6-70.9]	391
25-34	64.1%	[58.5-69.4]	703
35-44	64.4%	[59.6-68.9]	1022
45-54	61.6%	[56.7-66.2]	1100
55-64	57.7%	[51.5-63.7]	701
65 + years	42.3%	[35.1-49.8]	446
Race			
White (non-Hispanic)	60.3%	[57.6-63.0]	3408
Black (non-Hispanic)	60.5%	[53.7-66.9]	462
Hispanic	68.8%	[61.0-75.7]	315
Other	58.7%	[49.0-67.8]	222
Gender			
Male	61.9%	[58.2-65.4]	1828
Female	61.1%	[58.1-64.1]	2579
Education			
Less Than High School	61.4%	[53.9-68.3]	437
High School	61.3%	[57.3-65.1]	1553
Some College	61.5%	[57.0-65.9]	1312
College Degree or More	61.9%	[57.2-66.3]	1094
Region			
Western	62.1%	[57.4-66.6]	1227
Central	57.2%	[51.2-63.0]	674
Capital	60.7%	[53.8-67.1]	586
Metro	62.1%	[58.8-65.3]	1896
Insurance			
Public	59.3%	[54.5-63.9]	1090
Private	62.6%	[59.3-65.7]	2445
None	61.7%	[56.3-66.8]	775

DT 3-14b Percentage of Adult Smokers Who Believed Smokers Have a Higher Risk of Lung Cancer, ATS 2003 -2006

Category	Estimate	C.I.	N
Age*			
18-24	84.7%	[79.6-88.7]	394
25-34	80.5%	[75.3-84.8]	713
35-44	78.0%	[73.8-81.7]	1034
45-54	76.9%	[72.7-80.7]	1114
55-64	61.5%	[55.1-67.5]	714
65 + years	60.5%	[53.2-67.4]	454
Race			
White (non-Hispanic)	76.8%	[74.5-79.0]	3458
Black (non-Hispanic)	69.9%	[63.7-75.6]	463
Hispanic	80.9%	[74.0-86.4]	328
Other	74.9%	[65.7-82.3]	217
Gender			
Male	77.0%	[73.8-79.9]	1854
Female	75.6%	[72.9-78.0]	2612
Education*			
Less Than High School	68.9%	[61.9-75.1]	440
High School	75.6%	[72.0-78.8]	1575
Some College	79.4%	[75.7-82.6]	1332
College Degree or More	78.0%	[73.9-81.6]	1108
Region			
Western	74.9%	[70.5-78.9]	1243
Central	74.7%	[69.5-79.2]	678
Capital	80.0%	[74.8-84.4]	592
Metro	76.0%	[73.1-78.7]	1928
Insurance*			
Public	69.6%	[65.2-73.6]	1118
Private	78.7%	[75.9-81.2]	2469
None	78.5%	[73.7-82.7]	783

DT Percentage of Adult Smokers Who Believed Smokers Have a Higher Risk of Cancers Other Than Lung Cancer, ATS 2003-2006

Category	Estimate	C.I.	N
Age*			
18-24	65.2%	[58.5-71.5]	386
25-34	55.7%	[50.0-61.3]	697
35-44	55.6%	[50.6-60.4]	1018
45-54	46.7%	[41.8-51.6]	1083
55-64	35.8%	[29.9-42.2]	686
65 + years	30.1%	[23.4-37.8]	429
Race			
White (non-Hispanic)	51.6%	[48.8-54.3]	3345
Black (non-Hispanic)	44.9%	[38.2-51.7]	455
Hispanic	56.8%	[48.7-64.5]	325
Other	56.0%	[46.0-65.4]	215
Gender*			
Male	54.0%	[50.3-57.7]	1796
Female	48.9%	[45.8-52.0]	2544
Education			
Less Than High School	47.3%	[39.8-55.0]	427
High School	51.8%	[47.7-55.9]	1539
Some College	52.6%	[48.1-57.1]	1289
College Degree or More	52.3%	[47.5-57.0]	1074
Region			
Western	49.9%	[45.3-54.5]	1206
Central	51.9%	[45.8-57.9]	659
Capital	60.5%	[54.0-66.7]	576
Metro	50.5%	[47.1-54.0]	1875
Insurance			
Public	46.7%	[41.9-51.6]	1071
Private	53.2%	[49.8-56.5]	2403
None	53.4%	[48.0-58.8]	775

DT Percentage of Adult Smokers Who Think There Is Little Health Benefit To Quitting If a Person Has Smoked a Pack of Cigarettes a Day for More Than 20 Years, ATS 2003-2006

Category	Estimate	C.I.	N
Age*			
18-24	35.8%	[29.2-42.9]	391
25-34	30.2%	[25.0-35.9]	708
35-44	29.3%	[24.9-34.2]	1027
45-54	26.2%	[22.0-30.9]	1114
55-64	34.1%	[28.3-40.5]	714
65 + years	41.4%	[34.2-48.9]	441
Race*			
White (non-Hispanic)	24.0%	[21.8-26.3]	3425
Black (non-Hispanic)	41.2%	[34.5-48.2]	462
Hispanic	47.2%	[39.5-55.1]	332
Other	45.5%	[36.0-55.4]	219
Gender*			
Male	33.8%	[30.4-37.5]	1839
Female	28.6%	[25.7-31.6]	2599
Education*			
Less Than High School	54.3%	[46.9-61.6]	438
High School	34.8%	[30.9-38.8]	1558
Some College	26.9%	[23.0-31.3]	1322
College Degree or More	18.6%	[15.2-22.7]	1110
Region*			
Western	33.2%	[28.7-38.0]	1229
Central	25.5%	[20.6-31.2]	661
Capital	23.9%	[18.6-30.1]	596
Metro	32.4%	[29.2-35.7]	1924
Insurance*			
Public	40.3%	[35.6-45.2]	1096
Private	24.0%	[21.1-27.1]	2464
None	37.5%	[32.3-42.9]	784

DT Percentage of Adult Smokers Who Do Not Think That High-Tar Cigarettes Are At Least Twice As Likely To Cause Illness As Low-Tar Cigarettes, ATS 2003-2006

Category	Estimate	C.I.	N
Age			
18-24	42.5%	[35.6-49.8]	362
25-34	44.5%	[38.8-50.3]	636
35-44	46.3%	[41.2-51.4]	921
45-54	41.2%	[36.3-46.3]	1001
55-64	38.6%	[32.6-45.0]	622
65 + years	32.4%	[25.9-39.7]	377
Race*			
White (non-Hispanic)	48.3%	[45.4-51.2]	3038
Black (non-Hispanic)	27.8%	[22.2-34.2]	418
Hispanic	33.0%	[25.7-41.2]	295
Other	46.3%	[36.6-56.4]	205
Gender			
Male	41.4%	[37.8-45.2]	1671
Female	44.2%	[41.0-47.5]	2285
Education*			
Less Than High School	27.7%	[21.7-34.6]	408
High School	45.1%	[40.9-49.4]	1406
Some College	43.0%	[38.4-47.7]	1165
College Degree or More	47.5%	[42.5-52.5]	969
Region*			
Western	48.5%	[43.7-53.4]	1107
Central	48.9%	[42.6-55.3]	594
Capital	40.6%	[33.9-47.6]	531
Metro	40.2%	[36.8-43.7]	1702
Insurance*			
Public	37.4%	[32.7-42.3]	982
Private	45.1%	[41.6-48.6]	2173
None	44.8%	[39.3-50.3]	722

DT. 3-15a Percentage of Adults Who Believe the Harmful Effects of Cigarettes Have Not Been Exaggerated, ATS 2003-2006

Category	Estimate	C.I.	N
Age*			
18-24	75.3%	[70.3-79.7]	743
25-34	79.0%	[75.7-81.9]	1870
35-44	82.0%	[79.4-84.2]	2822
45-54	81.5%	[79.0-83.7]	3184
55-64	80.3%	[77.8-82.6]	2807
65 + years	78.7%	[76.3-80.9]	3487
Race*			
White (non-Hispanic)	85.7%	[84.6-86.7]	12059
Black (non-Hispanic)	75.5%	[71.5-79.1]	1270
Hispanic	62.5%	[58.0-66.7]	1144
Other	70.4%	[64.9-75.4]	784
Gender*			
Male	77.6%	[75.7-79.5]	5823
Female	81.8%	[80.4-83.1]	9431
Education*			
Less Than High School	51.9%	[46.3-57.5]	918
High School	74.5%	[72.1-76.8]	4061
Some College	80.6%	[78.1-82.9]	3592
College Degree or More	88.2%	[86.8-89.4]	6608
Region*			
Western	83.0%	[80.9-84.9]	3365
Central	80.7%	[77.2-83.7]	1868
Capital	83.1%	[79.5-86.1]	1730
Metro	78.6%	[77.1-80.1]	8294
Insurance*			
Public	73.5%	[70.8-76.0]	3781
Private	85.4%	[84.1-86.6]	9740
None	65.5%	[61.0-69.6]	1378

DT. 3-15b Percentage of Adult Nonsmokers Who Believe the Harmful Effects of Cigarettes Have Not Been Exaggerated, ATS 2003-2006

Category	Estimate	C.I.	N
Age*			
18-24	75.6%	[69.6-80.7]	541
25-34	81.5%	[77.9-84.6]	1456
35-44	85.5%	[82.8-87.8]	2240
45-54	85.5%	[82.9-87.8]	2523
55-64	84.1%	[81.5-86.3]	2355
65 + years	80.4%	[77.9-82.7]	3173
Race*			
White (non-Hispanic)	89.0%	[88.0-90.0]	9991
Black (non-Hispanic)	77.2%	[72.6-81.2]	1004
Hispanic	64.5%	[59.8-69.0]	939
Other	72.4%	[66.5-77.6]	663
Gender*			
Male	81.3%	[79.2-83.2]	4719
Female	83.8%	[82.2-85.2]	7876
Education*			
Less Than High School	53.9%	[47.2-60.4]	668
High School	77.5%	[74.8-80.0]	3112
Some College	83.5%	[80.7-86.0]	2843
College Degree or More	89.8%	[88.4-91.0]	5905
Region*			
Western	87.1%	[84.8-89.1]	2701
Central	84.0%	[80.0-87.4]	1485
Capital	88.0%	[84.2-91.0]	1387
Metro	80.9%	[79.2-82.5]	7024
Insurance*			
Public	75.4%	[72.4-78.1]	3123
Private	87.9%	[86.6-89.1]	8225
None	68.7%	[63.5-73.5]	960

DT. 3-15c Percentage of Adult Smokers Who Believe the Harmful Effects of Cigarettes Have Not Been Exaggerated, ATS 2003-2006

Category	Estimate	C.I.	N
Age*			
18-24	74.3%	[65.4-81.5]	202
25-34	67.7%	[59.8-74.7]	405
35-44	65.0%	[58.1-71.3]	572
45-54	60.3%	[53.7-66.5]	648
55-64	53.2%	[45.8-60.5]	429
65 + years	52.5%	[44.4-60.5]	283
Race*			
White (non-Hispanic)	67.7%	[64.4-70.9]	1991
Black (non-Hispanic)	66.1%	[57.2-74.0]	258
Hispanic	49.4%	[38.3-60.5]	200
Other	49.5%	[36.3-62.7]	118
Gender*			
Male	59.4%	[54.4-64.3]	1071
Female	69.0%	[65.3-72.5]	1495
Education*			
Less Than High School	44.2%	[33.9-55.0]	241
High School	63.6%	[58.2-68.7]	924
Some College	66.8%	[60.9-72.2]	734
College Degree or More	70.9%	[65.0-76.1]	662
Region			
Western	65.0%	[59.3-70.2]	645
Central	66.2%	[59.1-72.7]	374
Capital	63.8%	[54.0-72.6]	334
Metro	63.4%	[58.8-67.7]	1214
Insurance*			
Public	62.7%	[56.4-68.6]	629
Private	68.6%	[64.6-72.4]	1464
None	55.3%	[47.1-63.2]	412

DT. 5-25a Percentage of Adults Who Agree That Movies Rated G, PG, and PG-13 Should Not Show Actors Smoking, ATS 2003-2006

Category	Estimate	C.I.	N
Age*			
18-24	66.6%	[62.9-70.1]	1371
25-34	72.1%	[69.5-74.6]	3276
35-44	77.1%	[75.2-78.9]	4888
45-54	75.0%	[73.1-76.9]	5382
55-64	79.2%	[77.1-81.1]	4716
65 + years	81.4%	[79.6-83.1]	5964
Race			
White (non-Hispanic)	75.1%	[74.1-76.1]	20518
Black (non-Hispanic)	77.7%	[74.9-80.3]	2279
Hispanic	75.1%	[71.9-78.0]	1945
Other	76.1%	[72.4-79.6]	1366
Gender*			
Male	68.5%	[67.0-70.0]	9887
Female	81.8%	[80.8-82.8]	16213
Education			
Less Than High School	73.7%	[70.0-77.1]	1687
High School	75.5%	[73.6-77.3]	7037
Some College	77.0%	[75.1-78.7]	6272
College Degree or More	75.0%	[73.6-76.4]	10991
Region			
Western	77.9%	[76.1-79.7]	6580
Central	75.5%	[73.1-77.8]	3187
Capital	74.2%	[71.4-76.8]	2966
Metro	75.2%	[74.0-76.4]	13318
Insurance*			
Public	79.0%	[77.2-80.7]	6604
Private	75.6%	[74.5-76.7]	16382
None	71.0%	[68.0-73.9]	2537

DT. 5-25b Percentage of Adult Nonsmokers Who Agree That Movies Rated G, PG, and PG-13 Should Not Show Actors Smoking, ATS 2003-2006

Category	Estimate	C.I.	N
Age*			
18-24	67.9%	[63.5-72.0]	940
25-34	73.8%	[70.8-76.6]	2486
35-44	79.4%	[77.3-81.3]	3782
45-54	78.1%	[75.9-80.0]	4170
55-64	80.8%	[78.5-82.9]	3921
65 + years	82.9%	[81.0-84.6]	5430
Race			
White (non-Hispanic)	77.7%	[76.6-78.8]	16723
Black (non-Hispanic)	78.7%	[75.5-81.6]	1762
Hispanic	76.5%	[73.0-79.7]	1566
Other	77.9%	[73.8-81.5]	1131
Gender*			
Male	70.8%	[69.0-72.4]	7844
Female	83.7%	[82.5-84.7]	13331
Education			
Less Than High School	76.0%	[71.6-80.0]	1191
High School	78.7%	[76.5-80.7]	5287
Some College	79.4%	[77.3-81.4]	4850
College Degree or More	76.5%	[75.0-77.9]	9750
Region*			
Western	80.5%	[78.4-82.4]	5227
Central	78.1%	[75.4-80.6]	2489
Capital	77.8%	[74.8-80.6]	2338
Metro	77.0%	[75.7-78.3]	11084
Insurance*			
Public	81.0%	[79.0-82.9]	5383
Private	77.5%	[76.2-78.7]	13637
None	73.7%	[70.0-77.1]	1689

DT. 5-25c Percentage of Adult Smokers Who Agree That Movies Rated G, PG, and PG-13 Should Not Show Actors Smoking, ATS 2003-2006

Category	Estimate	C.I.	N
Age			
18-24	62.3%	[55.5-68.7]	430
25-34	65.4%	[60.2-70.3]	779
35-44	67.3%	[62.7-71.6]	1090
45-54	62.5%	[57.6-67.2]	1190
55-64	69.5%	[64.0-74.5]	766
65 + years	61.4%	[54.3-68.0]	481
Race*			
White (non-Hispanic)	62.3%	[59.7-64.9]	3680
Black (non-Hispanic)	73.7%	[67.8-78.9]	504
Hispanic	67.5%	[60.0-74.1]	371
Other	63.5%	[53.9-72.2]	229
Gender*			
Male	59.1%	[55.6-62.6]	1989
Female	71.4%	[68.6-74.1]	2794
Education			
Less Than High School	68.5%	[61.5-74.8]	483
High School	65.1%	[61.3-68.7]	1711
Some College	66.5%	[62.3-70.4]	1394
College Degree or More	60.9%	[56.2-65.4]	1185
Region			
Western	67.9%	[63.5-71.9]	1322
Central	66.5%	[60.9-71.6]	685
Capital	60.2%	[53.5-66.5]	616
Metro	64.8%	[61.6-67.9]	2148
Insurance			
Public	70.1%	[65.8-74.1]	1177
Private	64.2%	[61.1-67.2]	2666
None	63.8%	[58.5-68.8]	838

DT. 5-24a Percentage of Adults that Agree that Actors Smoking in the Movies Encourages Smoking among Teens, ATS 2004-2006

Category	Estimate	C.I.	N
Age*			
18-24	69.4%	[65.7-72.9]	1368
25-34	69.7%	[67.0-72.3]	3267
35-44	74.7%	[72.7-76.7]	4858
45-54	74.2%	[72.2-76.2]	5340
55-64	74.5%	[72.1-76.6]	4680
65 + years	72.5%	[70.5-74.4]	5898
Race*			
White (non-Hispanic)	76.4%	[75.5-77.4]	20306
Black (non-Hispanic)	68.5%	[65.5-71.4]	2284
Hispanic	66.1%	[62.7-69.3]	1957
Other	63.8%	[59.5-67.9]	1367
Gender*			
Male	69.1%	[67.5-70.7]	9841
Female	76.1%	[75.0-77.3]	16066
Education*			
Less Than High School	59.9%	[55.9-63.8]	1702
High School	68.1%	[66.1-70.0]	7008
Some College	73.7%	[71.7-75.6]	6232
College Degree or More	78.1%	[76.7-79.4]	10854
Region*			
Western	75.1%	[73.2-76.9]	6518
Central	74.6%	[72.1-76.9]	3181
Capital	74.7%	[71.9-77.2]	2930
Metro	71.8%	[70.6-73.1]	13227
Insurance*			
Public	70.2%	[68.2-72.1]	6559
Private	76.0%	[74.8-77.1]	16265
None	64.0%	[60.8-67.1]	2510

DT. 5-24b Percentage of Adult Nonsmokers that Agree that Actors Smoking in the Movies Encourages Smoking among Teens, ATS 2004-2006

Category	Estimate	C.I.	N
Age*			
18-24	71.0%	[66.5-75.1]	942
25-34	71.7%	[68.6-74.6]	2479
35-44	76.7%	[74.4-78.9]	3755
45-54	77.1%	[74.8-79.2]	4153
55-64	75.7%	[73.1-78.1]	3904
65 + years	73.3%	[71.2-75.3]	5376
Race*			
White (non-Hispanic)	79.1%	[78.1-80.2]	16574
Black (non-Hispanic)	70.2%	[66.8-73.5]	1773
Hispanic	65.7%	[61.9-69.3]	1577
Other	63.9%	[59.1-68.4]	1128
Gender*			
Male	71.1%	[69.3-72.8]	7830
Female	77.8%	[76.6-79.0]	13216
Education*			
Less Than High School	62.6%	[57.7-67.2]	1216
High School	70.2%	[67.9-72.4]	5271
Some College	75.2%	[72.9-77.3]	4831
College Degree or More	79.0%	[77.5-80.4]	9633
Region*			
Western	77.9%	[75.8-79.8]	5180
Central	78.7%	[76.0-81.2]	2494
Capital	78.3%	[75.3-81.0]	2327
Metro	73.1%	[71.7-74.5]	11006
Insurance*			
Public	71.9%	[69.7-74.0]	5346
Private	77.5%	[76.2-78.7]	13558
None	67.1%	[63.1-70.8]	1680

DT. 5-24c Percentage of Adult Smokers that Agree that Actors Smoking in the Movies Encourages Smoking among Teens, ATS 2004-2006

Category	Estimate	C.I.	N
Age			
18-24	64.1%	[57.6-70.2]	426
25-34	62.1%	[56.7-67.2]	778
35-44	66.3%	[61.7-70.5]	1088
45-54	61.5%	[56.6-66.2]	1163
55-64	66.3%	[60.5-71.7]	746
65 + years	60.8%	[53.7-67.4]	476
Race			
White (non-Hispanic)	63.4%	[60.9-65.9]	3622
Black (non-Hispanic)	60.2%	[53.7-66.4]	498
Hispanic	67.1%	[59.7-73.8]	372
Other	65.2%	[55.5-73.7]	235
Gender*			
Male	60.9%	[57.4-64.3]	1962
Female	66.5%	[63.7-69.3]	2764
Education*			
Less Than High School	53.4%	[46.1-60.6]	473
High School	60.7%	[56.8-64.5]	1699
Some College	67.4%	[63.3-71.2]	1374
College Degree or More	69.4%	[65.3-73.3]	1169
Region			
Western	63.5%	[59.1-67.7]	1306
Central	59.7%	[53.8-65.3]	675
Capital	60.0%	[53.1-66.5]	591
Metro	64.8%	[61.6-67.9]	2142
Insurance*			
Public	62.8%	[58.3-67.1]	1173
Private	67.1%	[64.2-69.9]	2630
None	55.7%	[50.2-61.0]	821

DT. Percentage of Middle and High School Students Who Think Smoking Makes People Look Cool, YTS 2000-2006

Category	Estimate	C.I.	N
Middle School			
Gender			
Female	10.0%	[7.6-13.0]	1516
Male	10.4%	[8.1-13.1]	1207
Race			
White	9.0%	[6.8-11.8]	835
Black	14.3%	[9.2-21.4]	504
Hispanic	12.4%	[10.2-15.1]	1035
Other	8.3%	[4.7-14.2]	206
Grade*			
6th	8.1%	[5.7-11.4]	777
7th	9.3%	[7.5-11.5]	895
8th	12.2%	[9.6-15.4]	1072
Region			
Rest of State	9.8%	[7.7-12.4]	1274
New York City	10.7%	[8.2-13.8]	1470
High School			
Gender*			
Female	6.9%	[5.2-9.1]	2210
Male	13.8%	[11.0-17.2]	2045
Race			
White	10.5%	[7.7-14.1]	1550
Black	8.5%	[6.5-10.9]	1016
Hispanic	11.0%	[8.1-14.8]	1168
Other	11.1%	[7.0-17.1]	402
Grade			
9th	10.4%	[6.8-15.5]	946
10th	10.4%	[8.3-12.9]	1267
11th	11.6%	[8.3-16.1]	1119
12th	9.0%	[6.6-12.2]	949
Region			
Rest of State	10.0%	[7.3-13.5]	2176
New York City	11.2%	[8.5-14.5]	2105

DT. Percentage of Middle and High School Students Who Think it is Safe to Smoke for Just a Year or Two, YTS 2000-2006

Category	Estimate	C.I.	N
Middle School			
Gender			
Female	6.9%	[5.0-9.4]	1530
Male	5.4%	[4.0-7.3]	1210
Race			
White	5.1%	[3.2-7.8]	833
Black	8.4%	[5.0-13.7]	511
Hispanic	9.0%	[6.4-12.6]	1044
Other	5.9%	[3.6-9.4]	210
Grade			
6th	7.4%	[5.3-10.3]	789
7th	4.6%	[3.1-6.7]	897
8th	7.0%	[4.9-10.0]	1075
Region			
Rest of State	5.2%	[3.5-7.6]	1282
New York City	7.9%	[5.7-10.9]	1479
High School			
Gender*			
Female	6.2%	[4.9-7.9]	2210
Male	11.7%	[9.9-13.8]	2044
Race			
White	9.4%	[8.2-10.8]	1551
Black	6.5%	[4.5-9.4]	1015
Hispanic	8.7%	[6.9-11.1]	1166
Other	10.9%	[8.2-14.4]	402
Grade			
9th	8.3%	[5.9-11.7]	943
10th	8.7%	[7.0-10.9]	1268
11th	8.6%	[7.0-10.5]	1120
12th	10.9%	[8.4-13.9]	949
Region			
Rest of State	8.9%	[7.6-10.5]	2178
New York City	9.3%	[7.1-12.2]	2102

DT. Percentage of Adult Smokers Who Visited a Doctor, Nurse, or Other Health Professional in the Past 12 Months, ATS 2003-2006

Category	Estimate	C.I.	N
Age*			
18-24	50.5%	[44.1-57.0]	478
25-34	60.1%	[54.8-65.1]	886
35-44	66.8%	[62.4-70.8]	1225
45-54	73.1%	[68.9-76.9]	1329
55-64	79.4%	[74.2-83.8]	859
65 + years	80.0%	[74.1-84.9]	561
Race*			
White (non-Hispanic)	67.6%	[65.2-69.9]	4150
Black (non-Hispanic)	72.0%	[66.1-77.2]	555
Hispanic	58.8%	[51.4-65.8]	413
Other	58.6%	[49.4-67.2]	275
Gender*			
Male	58.0%	[54.7-61.3]	2259
Female	75.7%	[73.1-78.1]	3133
Education*			
Less Than High School	55.1%	[48.4-61.7]	561
High School	61.0%	[57.2-64.6]	1914
Some College	71.4%	[67.4-75.1]	1576
College Degree or More	75.3%	[71.3-78.9]	1330
Region*			
Western	64.5%	[60.2-68.5]	1459
Central	62.8%	[57.2-68.1]	819
Capital	60.3%	[54.0-66.3]	705
Metro	68.8%	[65.7-71.7]	2382
Insurance*			
Public	76.9%	[72.8-80.6]	1329
Private	72.8%	[69.9-75.4]	2985
None	42.3%	[37.7-47.2]	964

DT. 5-9 Percentage of Adult Smokers Who Were Asked If They Smoked When They Visited a Health Care Provider in the Past 12 Months, ATS 2003-2006

Category	Estimate	C.I.	N
Age			
18-24	92.4%	[86.3-95.9]	237
25-34	87.6%	[83.0-91.1]	575
35-44	88.4%	[84.6-91.4]	841
45-54	91.1%	[87.5-93.7]	977
55-64	86.9%	[81.8-90.7]	672
65 + years	85.7%	[79.6-90.2]	443
Race			
White (non-Hispanic)	89.3%	[87.3-91.0]	2946
Black (non-Hispanic)	88.8%	[83.9-92.4]	409
Hispanic	91.0%	[84.7-94.8]	255
Other	79.7%	[67.8-88.0]	176
Gender*			
Male	87.1%	[84.2-89.6]	1390
Female	90.5%	[88.4-92.3]	2396
Education*			
Less Than High School	89.6%	[82.4-94.1]	327
High School	90.7%	[87.8-92.9]	1263
Some College	90.6%	[87.8-92.8]	1169
College Degree or More	84.8%	[80.8-88.0]	1020
Region			
Western	89.8%	[86.0-92.6]	1037
Central	92.6%	[89.0-95.1]	552
Capital	90.3%	[85.7-93.5]	471
Metro	88.0%	[85.5-90.1]	1708
Insurance			
Public	87.0%	[83.2-90.0]	1049
Private	89.8%	[87.6-91.7]	2210
None	90.1%	[85.6-93.4]	454

DT. 5-10 Percentage of Adult Smokers Who Were Advised to Quit Smoking When They Visited a Health Care Provider in the Past 12 Months, ATS 2003-2006

Category	Estimate	C.I.	N
Age*			
18-24	70.5%	[61.8-77.9]	239
25-34	66.2%	[59.8-72.1]	578
35-44	73.3%	[68.4-77.6]	838
45-54	81.7%	[77.5-85.3]	980
55-64	76.8%	[71.0-81.8]	672
65 + years	78.6%	[72.1-84.0]	444
Race*			
White (non-Hispanic)	77.1%	[74.6-79.4]	2955
Black (non-Hispanic)	71.7%	[65.1-77.6]	408
Hispanic	68.1%	[58.7-76.2]	255
Other	66.2%	[55.1-75.8]	176
Gender			
Male	73.1%	[69.2-76.6]	1404
Female	75.7%	[72.7-78.4]	2390
Education			
Less Than High School	74.7%	[66.1-81.7]	328
High School	73.8%	[69.5-77.7]	1266
Some College	77.3%	[73.2-81.0]	1173
College Degree or More	72.2%	[67.7-76.3]	1019
Region			
Western	76.5%	[72.1-80.3]	1040
Central	77.0%	[71.3-81.8]	555
Capital	75.3%	[68.6-81.0]	473
Metro	73.1%	[69.8-76.3]	1708
Insurance*			
Public	75.5%	[70.9-79.6]	1050
Private	76.0%	[72.9-78.8]	2216
None	67.5%	[60.4-73.8]	455

DT. 5-11 Percentage of Adult Smokers Who Report that their Health Care Provider Assisted Them with Smoking Cessation When They Visited a Health Care Provider in the Past 12 Months, ATS 2003-2006

Category	Estimate	C.I.	N
Age*			
18-24	39.8%	[30.8-49.6]	237
25-34	31.9%	[26.8-37.5]	577
35-44	43.8%	[38.4-49.5]	836
45-54	45.5%	[40.3-50.8]	979
55-64	44.9%	[38.8-51.2]	669
65 + years	35.3%	[28.6-42.6]	438
Race			
White (non-Hispanic)	40.6%	[37.7-43.5]	2941
Black (non-Hispanic)	44.3%	[37.0-51.8]	408
Hispanic	40.8%	[32.1-50.1]	255
Other	32.6%	[23.4-43.2]	175
Gender			
Male	41.5%	[37.2-45.8]	1398
Female	40.3%	[37.2-43.5]	2381
Education			
Less Than High School	36.6%	[28.4-45.7]	326
High School	43.0%	[38.6-47.6]	1262
Some College	43.2%	[38.5-48.2]	1166
College Degree or More	37.2%	[32.5-42.1]	1017
Region*			
Western	46.8%	[42.0-51.8]	1037
Central	44.6%	[38.3-51.0]	552
Capital	51.4%	[43.5-59.3]	470
Metro	36.9%	[33.4-40.6]	1702
Insurance*			
Public	44.3%	[39.4-49.3]	1046
Private	42.0%	[38.5-45.5]	2208
None	32.0%	[25.9-38.8]	454

DT. Percentage of Adult Smokers Who Have Heard of the New York State Smokers' Quitline, ATS 2003-2006

Category	Estimate	C.I.	N
Age			
18-24	62.7%	[56.3-68.7]	476
25-34	65.2%	[60.1-70.0]	880
35-44	60.7%	[56.3-65.0]	1221
45-54	58.6%	[54.1-63.0]	1315
55-64	61.7%	[56.1-67.0]	861
65 + years	58.7%	[52.1-65.1]	553
Race			
White (non-Hispanic)	61.8%	[59.4-64.2]	4125
Black (non-Hispanic)	60.4%	[54.0-66.5]	551
Hispanic	62.6%	[55.5-69.2]	411
Other	57.4%	[48.4-65.8]	274
Gender			
Male	62.5%	[59.3-65.7]	2239
Female	60.3%	[57.5-63.1]	3121
Education*			
Less Than High School	52.9%	[46.1-59.6]	553
High School	59.4%	[55.7-62.9]	1907
Some College	67.7%	[63.7-71.4]	1565
College Degree or More	62.3%	[58.1-66.4]	1323
Region*			
Western	67.8%	[63.8-71.6]	1450
Central	55.6%	[50.2-60.9]	814
Capital	74.0%	[68.7-78.8]	700
Metro	59.7%	[56.7-62.7]	2369
Insurance*			
Public	56.0%	[51.5-60.3]	1320
Private	65.7%	[62.8-68.5]	2971
None	60.3%	[55.3-65.0]	955

DT. Percentage of Adult Smokers Who Have Called the New York State Smokers' Quitline, ATS 2003-2006

Category	Estimate	C.I.	N
Age*			
18-24	3.9%	[1.7-8.6]	292
25-34	6.4%	[4.0-10.2]	600
35-44	12.5%	[8.3-18.5]	774
45-54	5.4%	[3.8-7.8]	824
55-64	4.4%	[2.7-7.2]	552
65 + years	3.2%	[1.5-6.7]	314
Race			
White (non-Hispanic)	5.1%	[3.9-6.6]	2643
Black (non-Hispanic)	11.1%	[6.9-17.4]	335
Hispanic	9.3%	[4.4-18.6]	252
Other	8.9%	[3.5-20.9]	158
Gender			
Male	6.3%	[4.2-9.4]	1423
Female	7.4%	[5.8-9.6]	1964
Education			
Less Than High School	3.5%	[1.4-8.6]	289
High School	5.6%	[3.6-8.6]	1175
Some College	8.8%	[6.0-12.6]	1052
College Degree or More	7.9%	[4.8-12.6]	863
Region			
Western	4.6%	[3.2-6.6]	1013
Central	4.8%	[2.3-9.8]	466
Capital	4.9%	[2.4-9.7]	508
Metro	8.1%	[5.9-11.1]	1392
Insurance			
Public	7.8%	[5.3-11.4]	762
Private	6.7%	[4.7-9.4]	1985
None	6.7%	[3.8-11.4]	587

DT. Percentage of Adult Former Smokers or Current Smokers with A Quit Attempt in the Past 12 Months Who Have Used a Nicotine Patch or Nicotine Gum, ATS 2003-2006

Category	Estimate	C.I.	N
Age*			
18-24	15.3%	[9.3-24.2]	297
25-34	25.0%	[20.1-30.7]	593
35-44	26.1%	[21.2-31.8]	736
45-54	34.3%	[29.1-39.9]	801
55-64	31.7%	[25.4-38.7]	486
65 + years	24.0%	[17.4-32.0]	334
Race			
White (non-Hispanic)	28.5%	[25.6-31.6]	2454
Black (non-Hispanic)	24.8%	[18.8-32.1]	367
Hispanic	18.6%	[12.3-27.2]	285
Other	18.9%	[11.0-30.7]	179
Gender			
Male	24.5%	[20.7-28.7]	1342
Female	27.2%	[24.2-30.4]	1942
Education			
Less Than High School	18.9%	[13.4-25.9]	315
High School	25.7%	[21.6-30.2]	1087
Some College	26.3%	[21.8-31.4]	963
College Degree or More	28.3%	[23.4-33.8]	914
Region			
Western	24.8%	[20.3-29.9]	815
Central	26.7%	[20.6-33.8]	426
Capital	32.0%	[23.6-41.8]	420
Metro	24.8%	[21.6-28.3]	1604
Insurance			
Public	24.9%	[20.4-29.9]	801
Private	28.3%	[24.8-32.0]	1906
None	21.7%	[16.6-28.0]	513

DT. 3-20 Percentage of Adult Smokers Who Were Planning to Stop Smoking in the Next 30 Days, ATS 2003-2006

Category	Estimate	C.I.	N
Age*			
18-24	27.4%	[21.2-34.5]	406
25-34	28.1%	[23.6-33.0]	795
35-44	32.8%	[28.2-37.7]	1069
45-54	28.1%	[24.0-32.7]	1173
55-64	20.2%	[16.0-25.1]	736
65 + years	19.5%	[14.7-25.5]	477
Race*			
White (non-Hispanic)	24.2%	[22.0-26.6]	3612
Black (non-Hispanic)	38.6%	[32.2-45.5]	485
Hispanic	32.3%	[25.6-39.9]	356
Other	23.0%	[16.0-31.8]	248
Gender			
Male	27.6%	[24.4-30.9]	1974
Female	27.6%	[24.8-30.5]	2726
Education			
Less Than High School	34.9%	[28.1-42.4]	482
High School	26.0%	[22.5-29.8]	1649
Some College	27.4%	[23.7-31.4]	1377
College Degree or More	26.1%	[22.0-30.5]	1182
Region*			
Western	23.7%	[20.1-27.7]	1289
Central	23.0%	[18.4-28.3]	720
Capital	23.3%	[18.2-29.3]	600
Metro	30.4%	[27.4-33.7]	2066
Insurance*			
Public	32.6%	[28.1-37.4]	1162
Private	24.9%	[22.2-27.8]	2631
None	27.2%	[22.6-32.4]	813

DT. 3-21 Percentage of Smokers Who Made a Quit Attempt in the Past 12 Months, ATS 2003-2006

Category	Estimate	C.I.	N
Age			
18-24	52.9%	[46.5-59.3]	476
25-34	49.5%	[44.4-54.6]	887
35-44	50.7%	[46.3-55.1]	1220
45-54	47.5%	[43.0-52.0]	1327
55-64	45.1%	[39.5-50.8]	859
65 + years	39.4%	[33.2-45.9]	557
Race*			
White (non-Hispanic)	45.4%	[42.9-47.8]	4145
Black (non-Hispanic)	57.7%	[51.5-63.6]	551
Hispanic	55.0%	[47.8-62.1]	412
Other	47.8%	[39.1-56.7]	273
Gender			
Male	47.8%	[44.5-51.2]	2254
Female	49.9%	[47.1-52.7]	3126
Education			
Less Than High School	49.6%	[43.0-56.3]	560
High School	48.3%	[44.6-52.1]	1912
Some College	49.4%	[45.3-53.5]	1569
College Degree or More	48.4%	[44.1-52.7]	1327
Region			
Western	44.2%	[40.2-48.4]	1455
Central	49.0%	[43.7-54.4]	818
Capital	45.8%	[39.6-52.1]	703
Metro	50.5%	[47.4-53.6]	2377
Insurance*			
Public	53.3%	[48.9-57.6]	1324
Private	48.9%	[45.9-51.9]	2979
None	44.0%	[39.2-48.9]	962

DT. 3-22 Percentage of Smokers Who Made a Successful Quit Attempt in the Past 12 Months (Remained Quit for More Than 6 Months), ATS 2003-2006

Category	Estimate	C.I.	N
Age*			
18-24	11.7%	[6.8-19.3]	311
25-34	17.0%	[12.7-22.3]	662
35-44	16.4%	[13.1-20.4]	845
45-54	20.0%	[15.8-25.1]	921
55-64	27.9%	[22.4-34.1]	616
65 + years	40.1%	[33.3-47.3]	492
Race*			
White (non-Hispanic)	21.9%	[19.6-24.4]	2960
Black (non-Hispanic)	12.2%	[8.0-18.3]	402
Hispanic	19.5%	[13.6-27.3]	331
Other	13.6%	[7.0-24.6]	204
Gender			
Male	18.6%	[15.7-21.9]	1582
Female	20.8%	[18.1-23.7]	2313
Education*			
Less Than High School	13.9%	[9.3-20.3]	354
High School	16.2%	[12.9-20.1]	1251
Some College	18.6%	[14.9-23.0]	1101
College Degree or More	26.5%	[22.5-30.8]	1180
Region			
Western	17.7%	[13.9-22.2]	962
Central	15.7%	[11.5-21.2]	495
Capital	20.9%	[15.8-27.2]	501
Metro	20.8%	[18.0-23.8]	1915
Insurance			
Public	19.8%	[16.0-24.3]	975
Private	21.4%	[18.7-24.3]	2282
None	14.9%	[10.1-21.5]	555