STATE OF MAINE
GOVERNOR'S COMMISSION ON SMOKING OR HEALTH

FINAL REPORT AND RECOMMENDATIONS
JANUARY 1990
AUGUSTA, MAINE

January 22, 1990

The Honorable John R. McKernan, Jr.
Governor of Maine
State House
Augusta, Maine 04333

Dear Governor McKernan:

I am pleased to be able to present to you the attached final report of the Governor's Commission on Smoking OR Health. Since receiving your charge back in January of 1989, the Committee has met monthly and heard testimony regarding the issues set forth by you in your Executive Order establishing the Commission. After completion of a draft report, the Commission held seven public hearings to receive the input of Maine citizens on the draft recommendations. As a result of comment heard at these hearings, several important changes have been made in the final report.

I know I speak for all the members of the Commission in thanking you for issuing the Executive Order and requesting us to review the status of this important public health issue and to make recommendations to you. I have also enclosed a minority report, representing the views of three members of the Commission. While we were unable to agree on several of the recommendations regarding protection of non-smokers from the health risks associated with environmental tobacco smoke, the recommendations regarding education and cessation were generally unanimous.

The Commission looks forward to meeting with you and discussing with you further the recommendations in our report.

Respectfully submitted,

Gordon H. Smith
Chairperson
Governor's Commission on Smoking OR Health

GHS:pp

Enclosures

REPORT OF THE

GOVERNOR'S COMMISSION ON SMOKING OR HEALTH

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GOVERNOR'S COMMISSION ON SMOKING OR HEALTH

EXECUTIVE SUMMARY

Tobacco use is the leading preventable cause of death and disease in Maine and the United States. The Governor's Commission on Smoking OR Health was charged with developing a statewide plan to prevent tobacco use among young people, protect the health of nonsmokers and reduce the health and economic impact of smoking on Maine people.

The Commission met through 1989 and issued recommendations in several areas: prevention and youth, cessation resources, protection of the non-smoker's health and others.

The following is a summary of the salient recommendations. The full report and set of recommendations follows.

PREVENTION AND YOUTH

- All public and private school systems (elementary and secondary) in Maine should be tobacco free by the year 1992 (50% by 1990, remaining 50% by school year 1990-91).

- Programs should be available for employees and students who wish to quit smoking or control their addiction.

- The Department of Educational and Cultural Services should promote effective smoking prevention curricula as part of comprehensive health education and comprehensive alcohol/drug use prevention programs using established standards for prevention and curriculum guidelines.

- Smoking prevention should begin in the primary grades.

- The Department of Human Services should lend its active support to methods to strengthen enforcement of laws restricting tobacco sale to minors. The state, county and local law enforcement community should vigorously enforce violations of the sales of tobacco products to minors.

- Should illegal sales to minors remain a problem by January 1991 additional efforts should be made to license tobacco vendors and treat tobacco sales in the same manner as alcohol sales are now treated.

SMOKING CESSATION RESOURCES

- A statewide network of cessation services should be developed.

- Insurance companies should be encouraged to offer coverage to individuals and groups for smoking cessation. Insurance coverage for smoking cessation should be regarded as nicotine addiction treatment and treated as any other substance abuse treatment.

- Cessation programs should be directed to specifically targeted high risk groups - women, blue collar workers, those with lower educational attainment.

- A comprehensive plan to educate health professionals in Maine about smoking cessation methods and techniques should be developed.

- A comprehensive Tobacco Use Prevention and Control Education Program should be developed and located in the Bureau of Health.

PROTECTION OF THE NONSMOKER'S HEALTH

- Since involuntary smoking has been established to be a cause of lung cancer in healthy nonsmokers, with no safe threshold for exposure and because of the acute, severe effects of environmental tobacco smoke on Maine's 86,000 citizens with lung disease, a Comprehensive Smoke-Free Environment Act is recommended. This legislation would prohibit smoking in any indoor area used by the general public. Designated smoking areas may be permitted so long as there is no impact on the nonsmoker.

- A mass media and targeted education program on the detrimental health effects of involuntary smoking, particularly on children should be implemented.

OFFICE OF
THE GOVERNOR

NO. 3 FY 88-89

DATE January 11, 1989

AN ORDER

CREATING THE GOVERNOR'S

COMMISSION ON SMOKING OR HEALTH

WHEREAS, cigarette smoking is the chief, single preventable cause of death, illness and disability in the United States and in Maine; and

WHEREAS, nearly 2,000 Maine citizens die each year from the consequences of smoking; and

WHEREAS, smoking costs the citizens and taxpayers of Maine an estimated $250,000,000 each year, including

Direct medical costs	$124,659,230
Indirect mortality costs	86,412,140
Indirect morbidity costs	46,353,442
Total	$257,424,812

and,

WHEREAS, over 6,000 Maine children under age 18 begin to smoke each year and 95% of all new smokers become addicted before it is legal for them to purchase cigarettes; and

WHEREAS, a recent survey of over 28,000 students in Maine indicated that about one-fourth of high school seniors are current smokers and that nearly 30% of ninth graders are smokers in some rural counties; and

WHEREAS, a broad-based partnership between the public and private sectors is needed to mount a serious and effective effort to reduce the adverse health and economic consequences caused by cigarette smoking and the use of smokeless tobacco in Maine;

NOW THEREFORE, I, John R. McKernan, Jr., Governor of the State of Maine, do hereby establish the Governor's Commission on Smoking OR Health, the organization and function of which shall be as follows:

Purpose

The Governor's Commission on Smoking or Health is charged with developing a statewide plan to prevent tobacco use among young people, protect the health of non-smokers and reduce the health and economic impact of smoking on Maine people. This plan will identify the current status and future direction of the following:

- Prevention strategies for reaching young people through schools and other youth-serving organizations.

- The role of the media in information and education.

- Public and private regulatory and policy issues concerning the sale of tobacco, the protection of non-smokers health, and economic incentives for non-smoking.

- Funding for prevention efforts.

- Design of a statewide system to assist those smokers who want to quit.

Membership

The Commission shall be comprised of not more than 30 members, to be appointed by the Governor and to serve at his pleasure. The Commission shall include representatives from the following areas:

1. Health education
2. Medicine
3. Public health
4. Law
5. Business
6. Labor
7. Insurance
8. Advertising
9. Education
10. Legislators
11. Parents
12. School administration
13. Students
14. Representatives of tobacco interests

Officers

The Governor shall appoint an Honorary Chair and a Chair to serve during the duration of the Commission.

Administration

The Department of Human Services, the Department of Educational & Cultural Services and the Division of Drug and Alcohol Education shall be responsible for providing staff support to the Commission.

Meetings

The Commission will convene by March 1, 1989 and shall issue its report by January 1, 1990.

Compensation

Members of the Commission shall serve without compensation. Necessary expenditures incurred by members in the performance of their duties which are allowed by State Law shall be borne by their parent organizations.

The effective date of this Order is January 11, 1989.

John R. McKernan, Jr.
Governor

GOVERNOR'S COMMISSION ON SMOKING OR HEALTH

MEMBERS

Gordon Smith, Esq.
Chairperson
Governor's Commission on Smoking OR Health
East Winthrop, ME
Subcommittee on Protection of the Nonsmoker's Health

Robert McAfee, M.D.
Honorary Chairperson
Governor's Commission on Smoking OR Health
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Subcommittee on Prevention and Youth

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Representing: State Legislature
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INTRODUCTION

Governor John R. McKernan, Jr. issued an Executive Order on January 11, 1989 (the release date of the 25th Anniversary Surgeon General's Report) establishing the Governor's Commission on Smoking OR Health, which was charged with: **"developing a statewide plan to prevent tobacco use among young people, protect the health of nonsmokers and reduce the health and economic impact of smoking on Maine people. This plan will identify the current status and future direction of the following:**

- **Prevention strategies for reaching young people through schools and other youth-serving organizations.**
- **The role of the media in information and education.**
- **Public and private regulatory and policy issues concerning the sale of tobacco, the protection of nonsmokers' health, and economic incentives for nonsmoking.**
- **Funding for prevention efforts.**
- **Design of a statewide system to assist those smokers who want to quit."**

The Commission first met on January 19, 1989 at which time three subcommittees were established: Prevention and Youth; Cessation Resources; and Protection of the Nonsmokers' Health. The Commission and Subcommittees met at least monthly through 1989 reviewing scientific evidence and approaches to public policy regarding various smoking or health issues.

Recommendations from each of the subcommittees and other recommendations from the full Commission follow.

BACKGROUND

National Findings

Research into the detrimental effects of tobacco use has been ongoing since the early part of this century. The past twenty-five years have seen an increased pace in this research, marked by the publication of a series of Surgeon General's reports on tobacco use and health.

Smoking has been identified as the single largest source of preventable morbidity and premature mortality in each of the reports of the U.S. Surgeon General produced since 1964.

The Surgeon General's Report on the Health Consequences of Smoking: Cancer[1] stated:

(a) An estimated 85-90% of all lung cancers are caused by cigarete smoking.

(b) Tobacco contributes to 30% of all cancer deaths each year. Cigarette smoking is a major cause of cancers of the lung, larynx, oral cavity, and esophagus, and contributes to cancers of the bladder, pancreas and kidney.

(c) Overall cancer death rates of men who smoke are double those of nonsmokers.

(d) Overall cancer death rates of women who smoke are 30% higher than those for nonsmokers and are increasing.

(e) The lung cancer death rate for women has begun to surpass the breast cancer death rate for women.

(f) The five-year survival rate for lung cancer is only 12%.

Tobacco contributes significantly to a variety of cancers. Lung cancer mortality in the United States has risen sharply from 18,300 in 1950 to 131,000 in 1984. Lung cancer accounts for 25 percent of cancer mortality and 5 percent of all deaths in the United States. Since 85-90% of deaths from lung cancer are directly attributable to smoking, tobacco use is the leading cause of cancer mortality in the United States. As stated by Cullen, "the link between smoking and cancer is firmly established. The weight of the evidence, both epidemiologic and experimental, is so convincing that virtually all but the minions of the tobacco industry acknowledge that smoking and tobacco use constitute the single most serious public health problem in our society today[2]."

Smokeless tobacco use is rising and is expected to contribute to increased rates of oral disease in the future.

However, the health and economic burden of smoking can be reduced. According to the National Cancer Institute (NCI), "all major studies in which the relationship between cessation of smoking and lung cancer was examined, report a decrease in risk; smokers who have quit for 15 or more years have lung cancer mortality rates between one and two times that of nonsmokers (3, pg. 18)." The rationale for prevention is provided in the NCI Objectives for the Nation as well, "In addition to the emphasis on smoking cessation, efforts must also be undertaken for prevention of smoking. Although the effect of these efforts will not be realized until after the year 2000, the mortality reduction goal (to reduce cancer mortality by 50%) can only be achieved through the elimination of tobacco use in each age group."[3, pg. 18]

Previous Surgeon General's Reports on Smoking and Health have stated:

- It has been estimated that among the 565,000 annual deaths from coronary heart disease in the United States, 30 percent or 170,000 deaths are attributable to smoking [4];

- Thirty percent of the 412,000 annual cancer deaths, about 125,000, are attributable to smoking, with 80 percent resulting from carcinoma of the lung[5];

- Between 80 and 90 percent of deaths due to chronic obstructive lung disease are attributable to smoking - over 60,000 deaths annually[6].

The most recent report, published in 1989, Reducing the Health Consequences of Smoking: 25 Years of Progress [7], commemorates the 25th anniversary of the first Surgeon General's report on smoking. The 25th Anniversary Surgeon General's Report on the Health Consequences of Smoking documented that, despite significant progress, smoking remains the single most preventable cause of death and disease in our society. The report provides a retrospective view of important gains over the last twenty-five years in preventing smoking and smoking-related disease in the United States as well as sources of continuing concern and major challenges.

1. The prevalence of smoking among adults decreased from 40 percent in 1965 to 29 percent in 1987. Nearly half of all living adults who ever smoked have quit.

2. Between 1964 and 1985, approximately three quarters of a million smoking-related deaths were avoided or postponed as a result of decisions to quit smoking or not to start. Each of these avoided or postponed deaths represented an average gain in life expectancy of two decades.

3. The prevalence of smoking remains higher among blacks, blue-collar workers, and less educated persons than in the overall population. The decline in smoking has been substantially slower among women than among men.

4. Smoking begins primarily during childhood and adolescence. The age of initiation has fallen over time, particularly among females. Smoking among high school seniors leveled off from the 1980 through 1987 after previous years of decline.

5. Smoking is responsible for more than one of every six deaths in the United States. Smoking remains the single most important preventable cause of death in our society.

The report identified that "to maintain momentum, we need to direct special attention to the following groups within our society:

- Children and Adolescents
- Women
- Minorities
- Blue Collar Workers"

Key (selected) new findings of the 25th Anniversary Surgeon General's Report include:

- Cigarette smoking is a major cause of cerebrovascular disease (stroke), the third leading cause of death in the United States;

- By 1986, lung cancer caught up with breast cancer as the leading cause of cancer death in women. Women smokers' relative risk of lung cancer has increased by a factor of more than four since the early 1960s and is now comparable to the relative risk identified for men in that earlier period. Gender differences in smoking behavior are disappearing; consistent with this, gender differences in the relative risks of and mortality from smoking-related diseases are narrowing.

- Disparities in smoking prevalence, quitting, and initiation between groups with the highest and lowest levels of educational attainment are substantial and have been increasing. Educatonal attainment appears to be the best single sociodemographic predictor of smoking.

- There is growing recognition that prevention and cessation interventions need to target specific populations with high smoking prevalence or at high risk for smoking-related disease. These populations include minority groups, pregnant women, military personnel, high school dropouts, blue collar workers, unemployed persons and heavy smokers.

- Whereas past smoking control efforts targeting children and adolescents focused exclusively on prevention of smoking, the smoking control community has identified the need to develop cessation programs for children and adolescents addicted to nicotine.

INVOLUNTARY SMOKING (ETS)

Recently, increased emphasis has been placed on the detrimental effects of exposure to environmental tobacco smoke (also known as involuntary smoking). Both the National Academy of Sciences and the Surgeon General published reports in 1986 that discussed the health effects of involuntary smoking.[8,9] The Surgeon General's Report listed three major conclusions:

1. Involuntary smoking is a cause of disease, including lung cancer, in healthy nonsmokers.

2. The children of parents who smoke compared with the children of nonsmoking parents have an increased frequency of respiratory infections, increased respiratory symptoms, and slightly smaller rates of increase in lung function as the lung matures.

3. The simple separation of smokers and nonsmokers within the same air space may reduce, but not eliminate, the exposure of nonsmokers to environmental tobacco smoke.

The report further stated:

> "Of the epidemiologic studies reviewed in this Report that have examined the question of involuntary smoking's association with lung cancer, most (11 of 13) have shown a positive association with exposure, and in 6 the associations reached statistical significance. In general, those studies with large population sizes, more carefully validated diagnosis of lung cancer, and more careful assessment of ETS exposure status have shown statically significant associations. A number of these studies have demonstrated a dose-response relationship between the level of ETS exposure and lung cancer risk... In examining a low-dose exposure to a known carcinogen, it is rare to have such an abundance of evidence on which to make a judgment, and given this abundance of evidence, a clear judgment can be made: exposure to ETS is a cause of lung cancer." The Report further stated, "It is not surprising that some studies failed to achieve statistical significance (those with small sample size) but the lack of statistical significance in all studies should not invalidate the positive significant associations for involuntary smoking that have been observed."

The National Academy of Sciences supported each of the above findings. It stated:

> "The weight of evidence derived from epidemiologic studies shows an association between ETS exposure of nonsmokers and lung cancer that, taken as a whole, is unlikely to be due to chance or systematic bias... The finding of such an increased risk is biologically plausible, because nonsmokers inhale other people's smoke and, as a result, absorb smoke components containing carcinogens[9]."

The Environmental Protection Agency (EPA) published a fact sheet about environmental tobacco smoker (ETS) in June, 1989[10] and a subsequent Report to Congress on Indoor Air Quality[11]. The EPA states "Environmental Tobacco Smoke is one of the most widespread and harmful indoor air pollutants." In addition to the three findings listed above, EPA concluded that "the effects of ETS on the heart may be of even greater concern than its cancer-causing effects on the lungs." The general recommendation of the Environmental Protection Agency is:

> "Published risk estimates place ETS among the most harmful indoor air pollutants, and higher in risk than many environmental pollutants currently regulated by EPA." It recommends, "Environmental tobacco smoke can be totally removed from the indoor air only by removing the source (cigarette smoking). Separating smokers and nonsmokers in the same room may reduce, but will not eliminate, nonsmokers exposure to tobacco smoke. Placing smokers and nonsmokers in separate rooms that are on the same ventilation system also may reduce nonsmokers' exposure to tobacco smoke; this approach, however, will probably not eliminate exposure to tobacco smoke since most pollutants readily dispense through a common air space and since in public or commercial buildings most HVAC systems re-circulate much of the contaminated indoor air." It further states, "Research indicates that total removal of tobacco smoke through ventilation is both technically and economically impractical... Since there is no established, health-based threshold for exposure to environmental tobacco smoke and since EPA generally does not recognize a no-effect or safe level for cancer causing agents, the Agency recommends that exposure to environmental tobacco smoke be minimized whenever possible. The most effective way to minimize exposure is to restrict smoking to smoking areas that are separately ventilated and directly exhausted to the outside or by eliminating smoking in the building entirely[11]."

Against this background of general national recommendations, the Commission reviewed in depth prevalence, morbidity, mortality, and cost data unique to Maine.

Smoking and Tobacco Use Data in Maine

The State of Maine has several excellent data sources on the prevalence for all age groups, morbidity, mortality, and economic costs of tobacco use in the state:

1. **"Smoking in Maine: A Report on the Health and Economic Consequences of Cigarette Smoking in Maine"(12)**, 1983, which was derived from the 1980 Maine Baseline Hypertension Household Survey. As one of seven states funded by the National Heart, Lung and Blood Institute for "The Development and Evaluation of a Coordination System for Hypertension Control Activities" a sample of households throughout the state was interviewed.

2. **The Maine Behavioral Risk Factor Survey and Surveillance System Report(13)** - Since December, 1986, the Bureau of Health's Division of Health Promotion and Education has participated with the federal Centers for Disease Control in the implementation of a random-digit dialed telephone survey to determine the prevalence of major behavioral risk factors for premature mortality in Maine.

3. **The Maine Youth Tobacco Use Survey(14)**, by the Tri-Agency Tobacco Free Project - In 1987 and 1989, the American Cancer Society, Maine Division Inc.; American Heart Association, Maine Affiliate, Inc. and the American Lung Association of Maine conducted the nation's largest, most comprehensive survey on teen tobacco use. Twenty-eight thousand (28,000) 5th, 7th, 9th, and 12th grade students from 72% of Maine's public and private schools responded to the survey in 1987 and 22,194 students responded in 1989.

4. **Annual Economic Costs and Deaths Attributable to Cigarette Smoking in Maine (1987)(15)**. A report based on the Smoking Attributable Morbidity, Mortality Economic Costs (SAMMEC) software package developed by the Minnesota Department of Health(9) which identifies, through the most up-to-date epidemiologic and economic formulas the death, disease and economic burden attributable to cigarette smoking in Maine.

TOBACCO USE IN MAINE:

The reports mentioned above provide data on various aspects of tobacco use in 1980, 1985, 1986 and 1987. Prevalence can be examined for 1980, 1986, and in addition is monitored on an ongoing basis through the Behavioral Risk Factor Surveillance System.

1. Prevalence Data

Tobacco use prevalence in Maine is estimated from several sources. The first comprehensive source of tobacco use data in Maine was from the 1980 Maine Baseline Hypertension Survey[10]. A random sample of 1,253 individuals 18 years old and over was constructed in such a way that it yielded valid information for the State as a whole and for eleven State planning regions.

The survey estimated that 34% of Maine residents 18 and over were current smokers. The percentages of smokers were 37% for men and 33% for women (a high proportion of women compared to the U.S.). Among men, the cohort of 25-34 year olds had the highest smoking prevalence at over 50%, with 18-24 year olds having the next highest rate. Fewer than one in five men over 65 were current smokers[12].

The consistency of the smoking habit across age groups for Maine's women was a troubling finding. The prevalence of smoking in Maine women in the 1980 survey was higher at every age (in Maine) than the national averages for women. The proportion of those women who have ever smoked, who were not current smokers - the quitting rate was lower than that of their male counterparts' rates at every age from 35 onward, although Maine women followed the national trend of increasing percentages of quitters with increasing age[12].

Formal educational level was indicated to be fairly directly related to cigarette smoking. The greater the level of education, the lower the percentage of men or women who were current smokers. Regarding occupational groups, rates were especially high for blue collar workers and those in the farming, fishing and forestry trades. The lowest rates of smoking for both men and women were found in the relatively high income households.

The study documented the impact of parents' smoking habits on those of their children. Children of nonsmoking parents were more likely never to take up smoking themselves. Parental smoking was also associated with earlier onset of smoking.

Maine Behavioral Risk Factor Survey Data, 1986 and 1988:

The Maine Behavioral Risk Factor Survey (BRFS) was initiated in December, 1986, and is currently utilized as an ongoing health risk factor surveillance system.

The BRFS questions are derived from previous National Health Interview Survey questions thus permitting comparison to national data. Comparison to other states utilizing the BRFS is available as well. The BRFS provides data on the smoking patterns of Maine citizens by age, sex, income and education level. Data on smokeless tobacco is provided as well. Excerpts from the BRFS are presented below.

In contrast with the 1980 survey, the BRFS does not provide breakdowns by occupation or geographic region (county information has recently been added to the surveillance system).

The 1986 BRFS indicates 27.8% of Maine adults, 18 and over, are current smokers. This is compared to the 34% prevalence of current smokers in the 1980 Maine Hypertension Household Survey. Thus, a decline is seen from 34% in 1980 to 27.8% in 1986, although caution should be used when comparing the surveys as the methodologies differed.

The 1988 BRFS data on tobacco use showed a slight decrease in the overall tobacco use from 27.8% in 1986 to 26.4% in 1988. Smoking among males showed a decline from 29% to 25.4%, females showed a slight increase in smoking prevalence from 26.8% in 1986 to 27.2% in 1988. Smoking prevalence increased in the 18-24 age group and 25-34 age group, but declined in all age groups greater than 34.

BEHAVIORAL RISK FACTOR SURVEY

MAINE

SMOKING PREVALENCE BY SEX

	1986 PERCENT AT RISK	1987 PERCENT AT RISK	1988 PERCENT AT RISK
FEMALE	26.8	27.4	27.2
MALE	29.0	27.9	25.4
TOTAL	27.8	27.7	26.4

The 1988 Behavioral Risk Factor Survey indicates that 37.6% of current smokers stopped smoking for a week or more over the past year (preceding the survey).

Teen and Youth Tobacco Use Prevalence:

The Maine Youth Tobacco Use Survey, a joint smoking prevention effort of the American Cancer Society, Maine Division, Inc., American Heart Association, Maine Affiliate. Inc. and the American Lung Association of Maine, was designed to obtain current Maine specific data on the prevalence of tobacco use among teens. Twenty-eight thousand fifth, seventh, ninth and twelfth grade students from 72% of all Maine's public and private schools responded to the survey[7] in 1987 and 22,174 students responded in 1989.

In 1987, smoking rates for boys and girls were found to be the same, with 12.6% of all students responding as current smokers. A large jump in smoking rates occurs between grades seven and nine, from 8.6% to 17.7%. As might be expected, fewer grade five students smoke (3.1%), and rates increase in grade twelve to 23.2%. Nearly 30% who have tried smoking have quit. Smokeless tobacco use was reported by 7.8% of ninth grade boys, and increased to 8.3% of twelfth grade boys. Of those who use smokeless tobacco, 45% also smoke cigarettes.[7]

TOBACCO USE BY GRADE BY COUNTY
1987

County	Smoking				Chewing			
GRADE	5	7	9	12	5	7	9	12
Androscoggin	4.4	6.0	15.6	24	1.4	1.9	3.4	5.5
Aroostook	4.1	7.9	15.0	28	.7	1.5	5.8	3.3
Cumberland	2.0	8.4	18.4	25	.8	1.9	2.9	3.3
Franklin	5.6	9.6	22.7	23.3	2.8	3.8	7.4	15.0
Hancock	5.5	11.1	19.9	23.6	1.4	.5	3.8	5.0
Kennebec	1.7	8.0	15.6	24.1	.5	1.7	2.7	4.9
Knox	6.5	7.2	15.0	23.3	1.5	2.4	3.1	8.6
Lincoln	6.0	10.1	11.0	26.6	2.3	.6	1.9	2.3
Oxford	2.0	6.7	18.8	19.8	2.5	2.6	7.7	5.8
Penobscot	2.2	7.7	18.2	20.4	1.3	2.0	6.5	5.7
Piscataquis	3.8	6.9	19.7	20.2	1.9	2.5	2.2	6.7
Sagadahoc	2.4	12.6	18.3	15.1	1.2	5.4	5.6	8.3
Somerset	3.2	5.8	15.8	24.7	1.6	1.2	5.3	5.0
Waldo	4.5	12.1	20.5	22.4	1.2	2.4	4.5	Under 1.0
Washington	4.9	16.4	28.3	27.8	.5	5.1	6.3	1.3
York	2.4	10.6	19.7	21.9	.9	2.4	2.4	2.3
State Average	3.1	8.6	17.7	23.2	1.1	2.1	4.2	4.6

Source: Maine Youth Tobacco Survey

The survey was repeated in 1989. In that survey, in all four grades together, some 11.2% (12.6% in 1987) of students are now smokers. Smoking occurs among 2.6% (3.1% in 1987) of 5th grade students, 9.7% (8.6% in 1987) of 7th grade students, 16.9% (17.7% in 1987) of 9th grade students, and 23.1 (23.2% in 1987) of 12th grade students. Thus, by the last year of school almost one-quarter of all students are smokers. Since this is only the second survey, no trend analysis is possible. Plans call for repeating this survey every two years in order for trends to be identified.

Statewide, the combined four grades showed 10.2% of females (12.7% in 1987) and 12.0% of males (12.5% in 1987) smoke. Significant differences, however, were found in smoking rates among the 16 counties of the state.

2.3% of current smokers have not yet smoked 100 cigarettes. Seventy-one percent of all students reported being bothered by smoke.

Results were also obtained on smokeless tobacco use, indicating that some 2.6% of the total survey population use these products. Findings reveal that 6.0% of 9th grade boys and 8.7% of 12th grade boys use smokeless tobacco at least once a week. As with smoking, the percentage of chew/snuff users is higher in the upper grades. Smokeless tobacco use does not necessarily replace smoking. Forty-seven percent of youngsters using smokeless tobacco also smoke cigarettes.

Use of smokeless tobacco use was also found to vary widely among counties, with higher rates more common for seniors in Franklin, Oxford and Washington counties. Furthermore, in some parts of the state smokeless tobacco use begins at an earlier age, i.e., 4.5% of 5th graders in Somerset County report weekly use as compared to less than 1% use reported in four other counties.

TOBACCO USE BY GRADE & COUNTY
1989

County	Smoking			
GRADE	5	7	9	12
Androscoggin	2.1	11.4	13.7	18.0
Aroostook	2.7	11.3	13.6	24.8
Cumberland	2.5	7.6	23.5	26.1
Franklin	2.3	13.3	15.9	*
Hancock	4.3	6.5	11.7	16.9
Kennebec	2.6	9.0	18.3	22.7
Knox	3.6	12.2	10.2	19.0
Lincoln	2.9	6.5	16.5	23.3
Oxford	3.5	9.3	22.8	26.7
Penobscot	2.2	6.2	15.6	24.3
Piscataquis	1.6	10.0	19.0	*
Sagadahoc	4.2	18.6	21.4	*
Somerset	2.4	15.7	19.9	22.1
Waldo	1.0	2.3	24.6	22.6
Washington	6.1	15.6	19.2	16.3
York	1.4	7.4	15.5	21.9
STATE	2.6	9.7	16.9	23.1

* INSUFFICIENT DATA

Source: Maine Youth Tobacco Survey

2. Tobacco Mortality, Morbidity and Economic Cost Data:

Data on tobacco mortality, morbidity and economic costs is available from the 1987 SAMMEC Report, Annual Economic Costs and Deaths Attributable to Cigarette Smoking in Maine.

The SAMMEC (Smoking Attributable Mortality, Morbidity, and Economic Cost) software package was developed by the Minnesota Department of Health. It was designed to permit rapid calculation of the disease impact of cigarette smoking. "SAMMEC Software incorporates the most advanced methodologies available from the fields of epidemiology and health economics to estimate smoking-attributable mortality, years of potential life lost, direct health care costs, indirect mortality costs and indirect morbidity costs[16]".

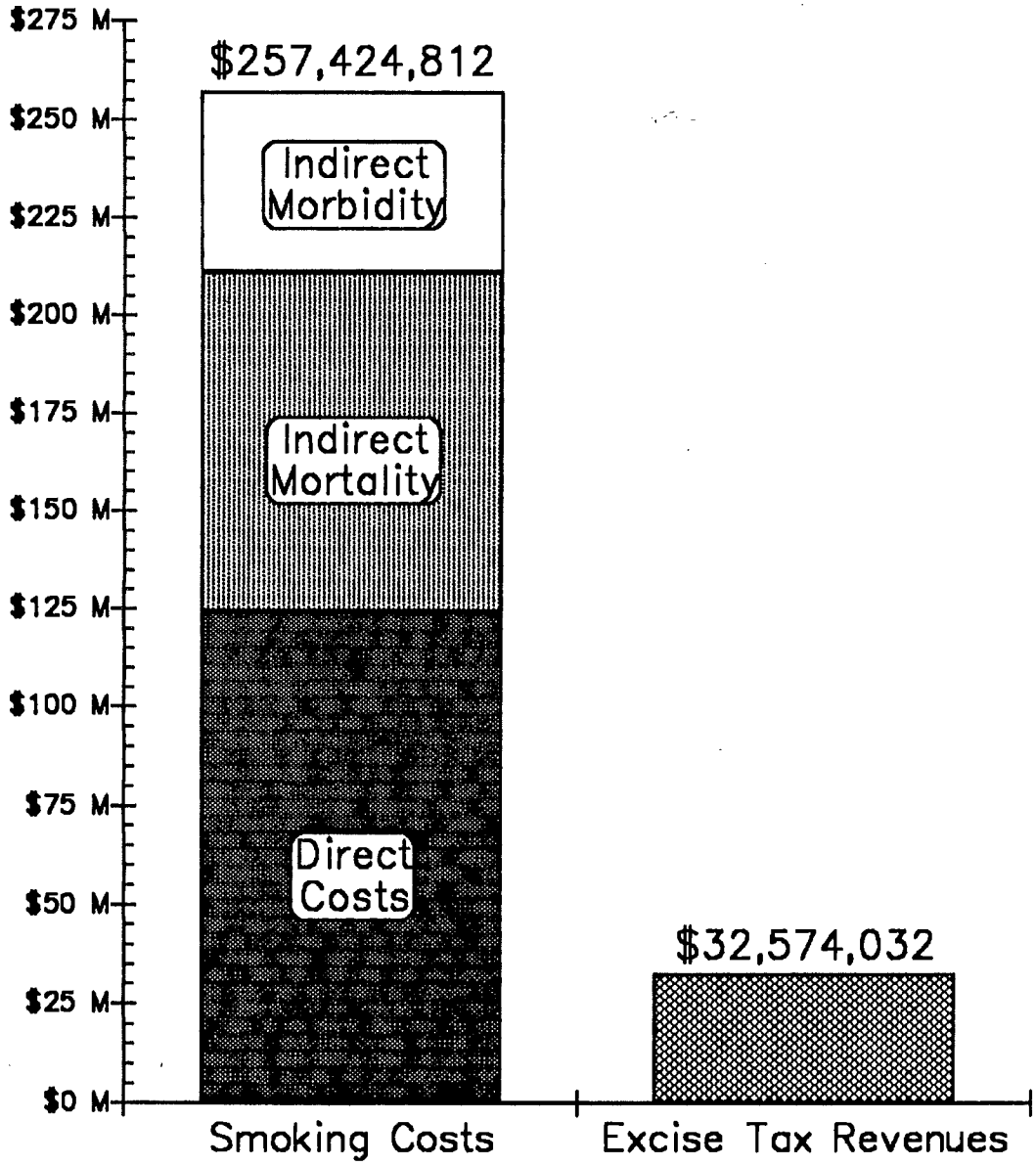
Health Care Financing Administration health care expenditure data and smoking prevalence data from the 1985 current population survey smoking supplement were used. The SAMMEC Report indicated that at least 1,846 deaths annually were attributable to smoking in Maine, representing sixteen percent of total deaths in 1985[8].

Of the smoking attributable deaths, 40% of the deaths are due to cardiovascular disease, 33.6% are due to cancer and 25% are due to respiratory disease.

Smoking attributable costs in Maine were estimated at over $257 million per year. Direct health care costs (reflecting expenditures for prevention, and diagnosis and treatment of smoking-related diseases and medical conditions) attributable to smoking were estimated at $124,659,230 which is $107 per person in the state, or $520 per smoker age 20+. Indirect Costs (costs resulting from lost output due to cessation or reduction of productivity due to smoking-related death or disability, typically calculated using lost income) attributable to smoking were estimated at $132,765,582, which is $114 per person, or $554 per smoker age 20+.[15]

Cost Burden of Smoking in Maine, 1985

Smoking Costs compared with State Excise Tax Revenues



Source of Data: State of Maine Bureau of Taxation for calendar year revenues; fiscal year tax figures differ.

DHS ODRVS 1/22/90
CBOSM85 03-058 SG

While smoking cost the state over $257 million in 1985, only $32.5 million was collected that year in cigarette sales excise taxes. Thus, the cost deficit was $224,850,780.

Of the $124,659,230 of smoking attributable personal health care expenditures, $55,283,667, or 44%, was covered by public funds. Smoking attributable health care costs represent 9% of total health care expenditures.

One portion of the smoking attributable costs to the State is caused by health benefit payments to current and former state employees. For the twelve months ending September 30, 1988, lifestyle attributable heart, circulatory, and lung disease caused $1.4 million in benefits to be paid. The active state employees represented just under one million dollars of this figure.

TOBACCO USE AND MORTALITY IN MAINE COMPARED TO THE UNITED STATES

When data on tobacco use and mortality in Maine is compared to other states and the United States, the findings are alarming.

A study published by the Centers for Disease Control of the U.S. Public Health Service in the Morbidity and Mortality Weekly Report (MMWR) on November 18, 1988, "State-specific Estimates of Smoking Attributable Mortality and Years of Potential Life Lost - United States, 1985" indicates that Maine ranks sixth highest in the U.S. in smoking-attributable mortality.

The prevalence of current smokers aged 18-34 in Maine, 32.8%, ranks third highest in the nation, surpassed only by Tennessee and Kentucky. The proportion of persons aged 18-34 in Maine who ever smoked, 53.1%, ranks highest in the U.S. This data indicates the large number of smokers who began smoking when teenagers over the past two decades who are new adult smokers. This is supported by data from the 1980 Household Survey which indicates that 96% of male smokers age 18-24 and 93% of female smokers in the youngest age group began smoking in their teen years.

MAINE LAWS ON TOBACCO USE

A number of laws regulating tobacco sales and smoking have been enacted in Maine in recent years, and as early as 1848. A list of these laws, as well as those that were passed in the most recent legislative session follows:

25 M.R.S.A. §2433 Safety
Prohibits smoking in mills, mill-yards, passenger buses, shipyards, factories, covered bridges, or stables if notice of no smoking is posted near the principal entrance. Enacted (originally) in 1848.

17-A M.R.S.A. §554 Endangering Welfare of a Child
It is a class D. crime (up to 1 year in jail) to furnish or give away tobacco or cigarettes to a child under the age of 16. (Endangering the Welfare of a Child). Enacted 1975.

22 M.R.S.A. 1578 Public Meetings
Prohibits smoking at indoor meetings of any public board, commission, agency or authority. Exception: only if all in attendance give their consent for others to smoke. Enacted 1981.

22 M.R.S.A. §1825 Nursing Homes
Restricts smoking in nursing homes by residents, visitors, and personnel to designated areas. Enacted 1983.

22 M.R.S.A. §1580: Prohibits smoking in jury rooms. Exceptions: only if all have given their consent to smoke. Enacted 1983.

22 M.R.S.A. §1580-A Workplace
Each employer shall establish, or may negotiate through the collective bargaining process, a written policy to protect the employer and employees from the detrimental effects of smoking by others. The policy must be posted and supervised by the employer and prohibit smoking except in designated areas. The law does not prohibit employers from establishing policies for members of the public using the facility, nor does it prohibit the employer from banning smoking entirely. Violation: Not more than $100. Enforcement authority: Bureau of Health, Department of Human Services. Enacted 1985.

22 M.R.S.A. §1622 Retail Stores
Prohibits smoking in all sections of retail stores over 4,000 square feet open to the public. Enacted 1985.

22 M.R.S.A. §1578-A Public Areas
Prohibits smoking in any public area of any publicly owned building. Exceptions: when leased by private groups; indoor restaurants subject to State's restaurant law (22 M.R.S.A. §1579-A); civic auditoriums may provide a smoking area but not in the main entrance area. Enacted 1987.

22 M.R.S.A. §1578-B Schools

Prohibits tobacco use by students in school buildings or on school property. Employees and the public are governed by sections 1580-A and 1578-A, respectively. Any designated smoking area for school employees shall be located away from areas frequented by students. Enacted 1988.

22 M.R.S.A. §1579 Sales to Minors

No one may sell, furnish, give away or offer to sell, furnish or give away cigarettes or tobacco to any child under the age of 18. It shall be unlawful for any person under the age of 18 years to purchase cigarettes or any other tobacco product. Amended 1989. Fine: Clerk - not less than $10 nor more than $100, Owner - Not less than $100 nor more than $1,000, Minors Purchasing - Not less than $10 nor more than $50.

22 M.R.S.A. §1579-A Restaurants

Restaurants shall provide a no-smoking area to meet the needs of the non-smoking public. Notice of the section will be by sign or verbal announcement. The Department of Human Services shall enforce this law and define the size of the non-smoking area. Violation by a restaurant will result in a fine of not less than $100 nor more than $500. Amended 1989.

22 M.R.S.A. §1580-B Ferries

Prohibits smoking in enclosed areas on ferries. Exception: Any area used as a restaurant is governed by the Restaurant Law. Penalities: $100 fine for failure to post a notice; $100 fine for any smoking in a prohibited area. Enacted 1989.

22 M.R.S.A. §1580-B Hospitals

Beginning November 16, 1989, no person may smoke tobacco or any other substance in any enclosed area of any hospital. Exception: A physician may write an order permitting a patient to smoke in a designated area. Enacted 1989.

22 M.R.S.A. §1628 Vending Machines

Restricts vending machines sales of cigarettes to locations that are at all times under direct supervision by an adult during the hours the machine is accessible. Amended 1989.

22 M.R.S.A. §1672-A Shopping Malls

Smoking in common areas of malls is prohibited except in designated areas. Designated smoking areas shall be in locations designed to minimize the effects of environmental tobacco smoke. Smoking in food or beverage service areas is governed by the Restaurant Law. Enacted 1989.

22 M.R.S.A. §1629 Packaging

No person may sell cigarettes except in the original sealed package which they are placed by the manufacturer. Nor may any person sell cigarettes in smaller quantities than placed by the manufacturer. Fine: Clerk - not less than $10 nor more than $50, Employer - not less than $100 nor more than $1,000. Enacted 1989.

TAXES

The current state excise tax on cigarettes is 31¢ per pack, federal 16¢. The excise tax on tobacco was increased in 1989 as follows: for cigarettes, a 9¢ total increase from 28¢ in 1989, - an additional 3¢ on October 1, 1989, an additional 2¢ on January 1, 1991 and an additional 4¢ on July 1, 1991. For smokeless tobacco, the tax increased from 45% of total sale to 50% on October 1, 1989, 55% on January 1, 1991, 62% on July 1, 1991. For pipe tobacco and cigars, the tax increased from 12% to 13% on October 1, 1989, 14% on January 1, 1991 and 17% on July 1, 1991. Since 1984 cigarettes have been subject to the state's 5% sales tax.

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GOVERNOR'S COMMISSION ON SMOKING OR HEALTH

Recommendations

I. Prevention and Youth

II. Cessation Resources

III. Protection of Nonsmokers'Health

IV. Other

DATE: February 20, 1990 - EMBARGOED UNTIL 2:30 p.m.

SUBJECT: Governor's Commission on Smoking OR Health Presents Final Report and Recommendations to Governor McKernan

CONTACT: Gordon Smith
Chairperson, Governor's Commission on Smoking OR Health
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Department of Human Services
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AUGUSTA -- The Governor's Commission on Smoking OR Health presented its final report and recommendations to Governor John R. McKernan, Jr. today after a year of deliberations. The Commission was established by Executive Order in January, 1989 and charged with "developing a statewide plan to prevent tobacco use among young people, protect the health of nonsmokers and reduce the health economic impact of smoking on Maine people. This plan will identify the current status and future direction of the following:

- Prevention strategies for reaching young people through schools and other youth-serving organizations.
- The role of the media in information and education.
- Public and private regulatory and policy issues concerning the sale of tobacco, the protection of nonsmokers' health, and economic incentives for nonsmoking.
- Funding for prevention efforts.
- Design of a statewide system to assist those smokers who want to quit."

The Commission met monthly and after completion of a draft report, a series of seven public hearings was held. These hearings provided input from nonsmokers and smokers alike and resulted in a number of important changes in the draft recommendations. The report presents recommendations in the following areas: prevention and youth, smoking cessation resources and protection of the non-smoker's health. A minority report was also presented.

2581H

Governor's Commission on Smoking OR Health

Smoking Prevention Recommendations

SCHOOL ENVIRONMENT

Background

It is illegal for any student to smoke on school property in Maine. It is also against the law for anyone to smoke in a public area of a public building. This only leaves two areas of our schools where smoking is permitted by adults - in "non public areas" of school buildings and outdoors on school campuses. School personnel's "right to smoke" is based on the concept of "past precedent, i.e. this activity has been allowed as a working condition in the past and any changes must be negotiated through collective bargaining. At the present time, at least 54 Maine school systems are smoke-free where no tobacco use is allowed by anyone during school hours. Some school systems like SAD 52 have taken a different approach. It is generally accepted that athletes should not use tobacco anytime or anywhere. Violation of this rule usually results in suspension from the team. SAD 52 expanded on this concept and prohibits smoking at any time by students involved in extra curricula activities, whether or not they involve athletics. In some school systems, the road to a smoke-free environment has been filled with grievances and arbitration. In other locations, like Fort Kent, the process was carefully negotiated each step of the way. Most schools have made provisions to assist their employees who wish to quit smoking. Some also provide help to those who simply need to get through the school day without a cigarette.

A healthy school environment is fundamental to learning. Schools are unique institutions where formal and informal learning occurs. Children quickly learn both from what is taught in the classroom and what they observe being practiced by their teachers and other role models in the school setting. Allowing smoking on school campuses sends a message that is contradictory to the educational efforts of classroom teachers and most parents who feel strongly that tobacco use is dangerous to health.

Recommendations

- All public and private school systems (elementary and secondary) in Maine should be tobacco free by the year 1992 (50% by 1990, remaining 50% by school year 1990-91).

- In those school districts in which employees are presently permitted to smoke in designated smoking areas by virtue of a negotiated labor contract, school administrators and labor groups should make the goal of smoke-free environments part of their contract bargaining process. If it is not currently part of a contract, the school environment should be smoke-free through policy and it should not be part of collective bargaining.

- Employee and student programs with the school dealing with substance abuse (EAPs, education programs, etc.) should be expanded to include nicotine as an addictive substance and these programs need to provide a variety of services including help to those employees and students who wish to quit smoking or control their smoking addiction.

- Policies and administrative procedures need to be updated to include prohibition of, or restrictions on, the use of tobacco products and prohibition of possession of tobacco products by students. These should be monitored periodically by administration and the school board.

- The above four recommendations should be communicated to organizations such as the Maine Teachers' Association, The Maine School Management Association and the State Principals' Association. These organizations should be encouraged to make the above goals part of their objectives.

SCHOOL CURRICULUM

Background

Maine law requires that all school systems teach at least 10 content areas of health education. While tobacco use prevention is not a separate topic, it is generally considered to be included in the substance abuse content area. The National Cancer Institute has conducted extensive research on the most effective methods for preventing tobacco use. It has distilled the results of their research into a few simple findings. It was encouraging to find that school-based smoking prevention programs have had a consistently positive effect although the outcomes have been modest and limited in scope. The major findings of the NCI research are as follows:

- Programs may focus on tobacco only or include tobacco use prevention as a significant part of other drug abuse prevention efforts.

- The content of the program should focus on short term physiological effects of tobacco use, the role of social influences in promoting tobacco use especially by peers, parents and the media; information about and training in refusal skills.

- Smoking prevention need not be limited to the health or science sections of the curriculum to be effective.

- The minimum length of school-based tobacco use prevention programs should be two five session blocks delivered in separate school years between grades 6 and 9 (10 hours). It is preferred that up to 10 tobacco focused sessions per year actually be taught in each year between grades 6 and 9 (30 hours).

- Specific attention should be focused on those transition years from elementary to middle or junior high school and from junior to senior high school. It is critical that tobacco use prevention efforts be boosted during these years.

- Peer involvement in the delivery of school-based smoking prevention programs has been shown to enhance effectiveness.

- Teacher training for the implementation of any tobacco use prevention program is an essential element.

The degree to which tobacco use prevention education in Maine schools meets or exceeds the standards presented above is unknown.

Recommendations

- The Department of Educational and Cultural Services should develop mechanisms to assess the degree to which Maine schools are meeting the minimum standards established for school-based smoking prevention by the National Cancer Institute.

- The Department should promote effective smoking prevention curricula as part of comprehensive health education and comprehensive alcohol/drug use prevention programs using the Minnesota/Maine curriculum guidelines which are based on the NCI recommendations as the minimum standard. The Department also should incorporate smoking prevention and smoking cessation in all of their "wellness activities."

- Smoking prevention needs to start in the primary grades and be part of a more comprehensive health and drug/alcohol prevention program.

- The Department should work with other health education organizations to develop methods to reach those students at highest risk for beginning to smoke.

- The Maine School Nurses Association should be asked to support and promote smoking prevention and smoking cessation program through the efforts of school nurses.

- The Maine Medical Association, Maine Dental Association, Maine Osteopathic Association, the Maine Academy of Family Practice, and the Maine Chapter of the American Academy of Pediatrics should be asked to encourage all physicians and dentists to work with the schools to promote smoking prevention and cessation programs.

- The school physicians committee of the Maine Medical Association should be encouraged to take a strong stand toward assuring that quality smoking prevention curricula and smoking cessation treatment services are available to students and faculty.

- The evolving model in Franklin County which links the tobacco use prevention efforts of the local school, university, hospital and health agencies should be evaluated and used, if appropriate, as a model for other communities.

- School personnel should be trained to recognize nicotine addiction and make appropriate referrals as early as possible.

SALES TO MINORS

Background

An integral part of any tobacco use prevention strategy is making the product less accessible to minors. State law provides that it is illegal to sell or give away tobacco to anyone under age 18. In fact, such conduct constitutes a criminal offense if the child is under age 16. Yet each day in our state, this law is violated without consequence. Over 5,000 children begin to smoke each year. Ninety-five percent of our new smokers are under age 18, the legal age for purchase.

Recognizing the problems with the existing law, the Maine Coalition on Smoking OR Health* worked with the Legislature in 1989 to propose sweeping new laws to address this important issue. It was proposed that the state treat tobacco sales in precisely the same way that alcohol sales are regulated. That is, anyone wishing to sell tobacco would need a license and this license would be revoked if they abused their responsibility by selling to minors.

Through the legislative process, this proposal was modified. As a result, new language was added to the law which now requires all tobacco vendors to post a sign stating that tobacco sales to minors are illegal. Attempting to purchase tobacco products by minors was made illegal and vending machines now must be located in areas that are under constant visual supervision by an adult. In addition, a joint resolution of the House and Senate was passed which called attention to the problem of illegal tobacco sales to minors and urged all law enforcement agencies throughout the state to enforce the current law.

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*The Maine Coalition on Smoking OR Health is a coalition of 23 health-related organizations formed to advocate for state legislation restricting smoking and promoting public health. The organization was formed in 1983 and has been the moving force behind the twelve tobacco-related laws enacted since that time.

The Maine Coalition on Smoking OR Health and many of the member organizations will be continuing efforts to monitor tobacco sales to minors.

Recommendations

- The Department of Human Services should lend its active support to methods to strengthen enforcement of laws restricting tobacco sales to minors. The state, county and local law enforcement community should vigorously enforce violations of the sales of tobacco products to minors laws.

- Should illegal sales to minors remain a problem by January 1991, additional efforts should be made to license tobacco vendors and treat tobacco sales in the same manner as alcohol sales are now treated.

- Maine law should be amended to make possession of tobacco products by a minor a civil violation.

- A study should be conducted to determine how frequently minors are able to purchase cigarettes from vending machines through a scientifically valid monitoring program with the results reported to the Governor and Legislature within a year. If vending machines remain widely accessible to minors as points to purchase cigarettes, the sale of tobacco through vending machines should be prohibited as recommended by the Surgeon General.

Goal

The strategies recommended above should lead to a decrease in the prevalence of smoking in youth (age 5-18) by 25% in 1992 and toward the goal of a smoke-free Maine youth by the year 2000.

SMOKING CESSATION SUBCOMMITTEE

SMOKING CESSATION

Background

The 1988 Surgeon General's Report entitled, "The Health Consequences of Smoking: Nicotine Addiction" drew the following conclusions:

- Cigarettes and other forms of tobacco are addictive.
- Nicotine is the drug in tobacco that causes addiction.
- The pharmacologic and behavioral processes that determine tobacco addiction are similar to drugs such as heroin and cocaine.

A number of studies indicate that up to 90% of smokers want to quit. Although the majority of those who do quit do so on their own, many smokers seek some structured assistance. The method used depends on the needs of the individual smoker and access to available programs.

There are many types of programs available such as, self help (manuals, videotapes), group and multimedia programs. In addition, there are many items and services available as adjuncts to program or non-program cessation attempts (pharmacological, hypnosis, acupuncture, over-the-counter devices). Currently, few consumers are aware of options regarding smoking cessation or the need to assess the effectiveness of programs offered.

Recommendations

- The basis of all smoking cessation programs should be treatment of nicotine addiction, using both physiological and behavioral approaches.

- A statewide network of cessation services should be developed. The network should be based on existing services of all types and should include multi-media approaches.

- Group clinic programs should adhere to the Code of Practice for Smoking Cessation Programs developed by the Peer Review Committee on National Smoking Cessation Programs.

- A statewide multi-media effort should be launched to educate the consumer about the benefits of quitting and of the smoking cessation options available and how to choose which would be best.

- Insurance coverage for smoking cessation should be regarded as nicotine addiction treatment and treated as any other substance abuse addiction.

- Insurance companies should be encouraged to offer coverage to individuals and groups for smoking cessation through the vehicle of a mandated option that could be purchased.

- The State's Medicaid Program and the Maine Health Program should consider paying for smoking cessation programs for participants. This is especially important considering the current demographics of smoking in Maine.

CESSATION AT THE WORKSITE

Background

Many employees do not currently have smoking cessation programs available. Business and labor leaders are not well informed regarding the importance of offering smoking cessation assistance when implementing a change to a more restrictive smoking policy or when a company decides to become totally smoke-free. The lack of programs during work hours and/or payment for these programs may also act as a deterrent.

Smoking rates approach 50% among blue-collar workers in Maine. Because of the likelihood that these same workers may be exposed to other occupational hazards, it is particularly important to target this group for smoking cessation activities.

Recommendations

By July 1, 1991, the Bureau of Health should have developed a plan to address smoking cessation for Maine worksites and have obtained the resources to implement the plan. At a minimum, the plan should contain provisions to:

- Heighten awareness of the recently enacted Rules regarding the Workplace Smoking Act of 1985 and assure compliance with these Rules through the Bureau of Health.

- Inform and educate business leaders through the Maine Chamber of Commerce and Industry and other professional organizations about options for smoking cessation.

- Special emphasis should be placed on educational programs and services for blue-collar workers.

SELECTED HIGH-RISK TARGET GROUPS

Background

Data available from the Division of Health Promotion and Education establishes that women and other high risk groups in Maine smoke at higher rates than the national average. This population is more difficult to reach than others but is significantly at higher risk. Lung cancer rates among women have been rising dramatically; women need to be alerted to their increased risk of cancer from voluntary or involuntary smoking. Women who smoke and are currently using oral contraceptives must be alerted to the increased risk of stroke.

Data from initial WIC (Women, Infant and Children's Program) eligibility screenings performed between August 1987 and December 1988 indicate smoking prevalence of 41% to 43% in the WIC participant population. This rate is much higher than for the population of all Maine women of childbearing age (prevalence = 27% to 32%) and for all U.S. women of childbearing age (prevalence = 23% to 28%).

Recommendations

- Voluntary health agencies and the Bureau of Health should develop educational programs directed to specifically targeted women's groups regarding health risks associated with voluntary and involuntary smoking.

- Lung cancer rates among women have been rising dramatically; women should be alerted to their increased risk of cancer from voluntary or involuntary smoking.

- Other high risk groups in Maine should be identified. Educational programs should be developed specifically targeted to those groups and should be culturally appropriate when used with such groups as Native American, Franco Americans and other ethnic/cultural groups.

SMOKING CESSATION FOR THE COMMUNITY

Background

Local hospitals/rural health clinics are common locations that individuals consult when they are interested in smoking cessation.

Recommendations

- Use existing hospital/rural health center-based smoking cessation programs as the basis for further community efforts.

- Establish a state-wide multi-media approach with public and private funds to reach greater numbers of people with a smoking cessation message.

  - Use all media for reinforcement.
  - Develop smoking cessation videotapes for free rental in all Maine video stores and public libraries.

- Encourage established programs to train more than one facilitator/volunteer in their agency, to allow for job changes or other day to day issues which can affect availability of resources.

SMOKING CESSATION TRAINING FOR HEALTH PROFESSIONALS

Background

Several national surveys indicate that physicians have great credibility in talking with patients about the risks associated with smoking. While professional associations such as the American Medical Association make cessation kits available to their members, there is no coordinated effort to train all Maine's health professionals to provide effective smoking cessation counseling to their patients.

Recommendations

By July 1, 1991, the Bureau of Health shall have developed and implemented a comprehensive plan to educate health professionals in Maine about smoking cessation methods and techniques.

Delivery Sites:

- Residency programs
- Professional training, schools (medical schools, other professional schools)
- Hospital Grand Rounds
- Office based training

The following is a list of health professionals to consider for training:

- Physicians - M.D. and D.O.
- Chiropractors
- Physician Assistant
- Nurses - R.N./L.P.N.
- Certified Nursing Assistants
- School Nurses
- Dentists
- Dental Hygienists
- Dental Assistants
- Pharmacists
- Respiratory Therapists
- Physical Therapists
- Medical Assistants
- Psychologists
- Social Workers
- Substance abuse counselors
- Other mental health professionals
- Counselors

COMPREHENSIVE PROGRAM

Background

Currently there are no resources in the state budget committed exclusively to tobacco prevention and control.

Recommendations

A recommended Tobacco Use Prevention and Control Education Program should be located in the Bureau of Health to do the following:

- Provide technical assistance, including design and evaluation methods, materials, and training to agencies, communities, and other organizations that undertake community programs for the promotion of nonsmoking.

- Collect and disseminate information and materials for smoking prevention.

- Provide assistance to workplaces to develop policies that promote nonsmoking and are consistent with the Workplace Smoking Act of 1985.

- Evaluate new and existing nonsmoking programs on a statewide and regional basis using scientific evaluation methods.

- Conduct surveys regarding the epidemiology of smoking, and the penetration of statewide smoking control programs.

- Conduct a long-term, coordinated public information program that includes public service announcements, public education forums/programs, mass media and written materials to promote nonsmoking.

- Award special grants to local agencies to conduct community-wide pilot programs for the promotion of nonsmoking.

- Provide bi-annual reports on activities undertaken, smoking rates in the population and subgroups of the total population, evaluation activities and results of those activities and recommendations for further action.

The program should include appropriate and adequate funding for necessary staff, administrative and program costs, media and community grants. (Depending on community grants, the budget may total from $328,500 to $778,500.)

Protection of Nonsmoker Subcommittee

RECOMMENDATION FOR THE CREATION OF
A SMOKE FREE ENVIRONMENT ACT

Background

Maine is a leading state in this nation in legislative efforts to protect the nonsmoker from exposure to environmental tobacco smoke. The basis for such legislation is the conclusion outlined in both the Surgeon General's report and the National Academy of Science's report that involuntary smoking is a cause of lung cancer in healthy adults, with no known safe threshold for exposure. As with any known carcinogen in our environment, protection of the public from the risks of environmental tobacco smoke has become a priority. We have therefore witnessed a flurry of legislative activity around the issue of smoking in the past few years.

However, the approach followed by Maine has been piecemeal: nearly 20 different laws regulate smoking in a wide array of settings. This trend promises to continue, as evidenced by the numerous proposals submitted to the Legislature and specific subcommittee recommendations reported in the later section of this report.

Clearly, there is a need for establishing a simple and comprehensive policy prohibiting smoking in all areas accessible to the public or where the public must conduct its business. Such a policy would be easily understood by the public, as few exceptions would likely exist. It would obviate the need for the legislature to consider the countless number of smoking-related bills likely to arise in upcoming legislative sessions.

Such legislation should be introduced in January 1991 and become effective in January 1992. Enforcement efforts will be delayed until January 1, 1993.

Drawbacks to this approach are evident. Obviously, enforcement is difficult, as with any of the current laws regulating smoking in public places. Resistance may emerge from some public groups,

merchants, businesses, or facility operators. Some exceptions will likely be needed. Local preemption will probably be an issue. However, these are the same issues that are dealt with repeatedly with most new pieces of smoking legislation proposed. In recent years, the societal ethic has moved so clearly in the direction of prohibition of smoking, that there may well be a surprisingly widespread acceptance of such a comprehensive law, particularly given the evidence regarding the health risks of ETS to the nonsmoker.

In 1989, the U.S. Environmental Protection Agency issued the Report to Congress on Indoor Air Quality and a fact sheet Indoor Air Facts, Environmental Tobacco Smoke. The EPA stated, "environmental tobacco smoke is one of the most widespread and harmful indoor air pollutants." The EPA further states, "Published risk estimates place ETS among the most harmful indoor air pollutants, and higher in risk than many environmental pollutants currently regulated by EPA." They recommend, "Environmental tobacco smoke can be totally removed from the indoor air only by removing the source (cigarette smoking). Separating smokers and nonsmokers in the same room may reduce, but will not eliminate, nonsmokers exposure to tobacco smoke. Placing smokers and nonsmokers in separate rooms that are on the same ventilation system also may reduce nonsmokers' exposure to tobacco smoke; this approach, however, will probably not eliminate exposure to tobacco smoke since most pollutants readily dispense through a common air space and since in public or commercial buildings most HVAC systems re-circulate much of the contaminated indoor air." It further states, "Research indicates that total removal of tobacco smoke through ventilation is both technically and economically impractical... Since there is no established, health-based threshold for exposure to environmental tobacco smoke and since EPA generally does not recognize a no-effect or safe level for cancer causing agents, the Agency recommends that exposure to environmental tobacco smoke be minimized whenever possible. The most effective way to minimize exposure is to restrict smoking to smoking areas that are separately ventilated and directly exhausted to the outside or by eliminating smoking in the building entirely."

Recommendations

Implement by legislation a Smoke-free Environment Act. Language for a Smoke Free Environment would include the following:

- Smoking will be prohibited in any indoor area used by the general public including, but not limited to, public elevators, supermarkets or food outlets, shopping malls, public conveyances, service facilities (such as hair dressers or laundromats), educational facilities, health and medical care facilities (unless the patient obtains permission from the physician), professional offices (such as lawyers and accountants), auditoriums, arenas, gymnasiums, courtrooms, meeting rooms. This prohibition does not apply in cases where an entire room or hall is used for a private social function, nor does this prohibition apply to bars or cocktail lounges. the prohibition excludes offices located in private homes. If it is the policy of the facility, there may be a designated smoking area as long as there is no impact on the nonsmoker. This does not mean that a business must have a designated smoking area, rather it means they may have one, so long as it is entirely physically separated from any area in which the public must conduct business.

  Any state level legislation to protect the health of nonsmokers should be considered as minimum standards which can only be exceeded by local ordinances. The Smoke-free Environment legislation should become effective in 1992 with enforcement beginning on January 1, 1993.

- Except in designated smoking areas located in a manner consistent with proposed rules covering the Workplace Smoking Act, no person shall smoke in any place of work. Smoking policies must be developed in a manner consistent with those rules.

- Except in an area specifically designated as a smoking area, no person shall smoke in any restaurant. When smoking and nonsmoking areas are designated, the nonsmoking area must be reasonably calculated to address the needs of the nonsmoking public.

- Regulations regarding sign posting and violations would be included, as well as sufficient funding for adequate enforcement.

- Designated smoking areas may be permitted so long as they were located and constituted in such a way as to eliminate exposure of ETS to nonsmokers.

- The Governor should issue a directive to all Department and Agency heads assuring that the Worksite Smoking Act and its accompanying rules be adhered to by all units of State Government.

- Municipalities should follow the lead of the Governor and require that all municipal agencies be in compliance with the Worksite Smoking Act.

INVOLUNTARY SMOKING AND CHILDREN: EDUCATION

Background

Children of smokers are "at risk" for development of respiratory infections and reduced lung function.

Recommendation

Educate parents regarding the hazards of environmental tobacco smoke to the fetus, the infant, and the child. Educational messages should be directed to parents through:

- Mass media (enlisting the help of newspaper writers and science writers, as well as the Maine Association of Broadcasters).

- Direct educational programs through the Bureau of Health and the voluntary health agencies.

- Education of the helping professions dealing with families and children to counsel parents regarding the health risks of environmental tobacco smoke for their children. INclude such groups as: obstetricians, family physicians, pediatricians, family planning providers, WIC Program staff, health centers, Cooperative Extension agents and teachers. The voluntary health agencies and the Bureau of Health have primary responsibility for this activity.

INVOLUNTARY SMOKING AND CHILDREN: PROTECTION

Background

Children should be cared for and taught in smoke-free environments; any event organized for the enjoyment or education of children should be smokefree. Current regulations governing smoking in child-related settings include: prohibition of smoking at licensed day care centers but not in licensed or certified day care homes or in licensed nursery schools; prohibition of smoking on school grounds by students; nursery schools; prohibition of smoking on school grounds by students; prohibition of smoking in public areas of public buildings (including schools); restriction of smoking by employees to designated areas only.

Recommendation

- By 1992, any facility licensed or certified by the state to provide day care or early education for children will be smokefree. If a survey of such sites by the Department of Human Services reveals poor compliance with voluntary measures, then a legislative approach or regulation will be pursued in 1993. Cooperation by the statewide association of day care providers should be sought.

- Provisions of the Workplace Smoking Act should be extended to college and university settings in order to protect nonsmoking students and visitors. Adequate separation of smoking and nonsmoking students in residences should be considered, including separate floors for smokers, separate dormitories, and separate apartment buildings.

HEALTH CARE FACILITIES

Background

Any facility where the public seeks health care services should be a smoke-free environment. Currently, smoking is prohibited in any enclosed area of any hospital and is restricted in nursing homes to designated areas.

Recommendation

- By 1993, the sale of tobacco in all pharmacies should be banned.

- The Governor should communicate with Maine's federal delegation to recommend that State laws protecting nonsmokers apply to all federal health facilities in Maine.

ADDITIONAL ISSUES

The Commission has considered a number of issues which do not fall neatly into the scope of any one of the Subcommittees. These issues, along with recommendations, are as follows:

1. Due to the impact of tobacco-related advertising and sponsorship on smoking prevalence, particularly on youth, the Commission recommends that the Governor and Legislature communicate with the Congressional delegation to request the repeal of federal pre-emption laws, and to support the Tobacco Product Education and Health Protection Act of 1990 sponsored by Senator Edward Kennedy (D-MA).

2. The Commission recognizes that there is evidence available suggesting that increases in cigarette excise taxes decrease the purchase of cigarettes by youth. However, because of the 9¢ increase enacted in 1988, and given the significant level of the tax in Maine presently, the Commission makes no recommendations in this area.

3. The Commission recommends prohibition of sale of such items as tobacco "look-alike" imitation products such as candy cigarettes and "snuff" packages containing shredded bubble gum due to potential impact on the acquisition of the smoking habit by youth. Legislation should be introduced by January 1, 1991, to be effective January 1, 1992.

4. The Commission recommends that the Governor consider and advocate a challenge to fellow New England Governors through the Regional Health Committee of the New England Governor's Conference, or through the National Governor's Association regarding which state can proceed most quickly to be smoke free, as has been done in the western states.

MINORITY REPORT

Three members of the Commission have chosen to write a minority report dissenting from portions of the Commission's report. It is fair to say that the major difference of opinion relates to whether ETS poses such a health risk to nonsmokers that further efforts need to be made to protect them. The majority of the Commission chooses to believe the evidence cited in the Surgeon General's 1986 report and the report of the EPA and the National Academy of Sciences. The minority chooses to believe that secondhand smoke is an annoyance only, and not a health risk to the nonsmoker. It is this basic difference that leads to our disagreement. There is widespread agreement on those portions of the Report dealing with youth education and cessation. Copies of the Minority report are available from the Bureau of Health.

COMMISSION MEETINGS

The Governor's Commission on Smoking OR Health met throughout 1989 reviewing scientific and policy issues regarding smoking or health. Guest speakers and expert consultants made presentations at a number of Commission meetings. A list of the meetings and guest speakers follows:

Date of Commission Meeting	Guest Speaker
February 9, 1989	Karen Deasy, Special Assistant to the Director, United States Office on Smoking and Health. A letter from Surgeon General C. Everett Koop was presented to Governor McKernan applauding the formation of the Commission.
March 13, 1989	Jan Hitchcock, PhD, Associate Director, Institute on Smoking Behavior and Policy; Research Associate, Human Services Development Institute, University of Southern Maine. Presentation on Prevention and Youth.
May 8, 1989	Gary Giovino, PhD, U.S. Office on Smoking and Health; Larry Holcomb, PhD, Consultant to the Tobacco Institute; presentations on Environmental Tobacco Smoke and Involuntary Smoking.
June 12, 1989	
July 20, 1989	Frank Johnson, Director, Bureau of State Employee Health, Department of Administration presentation on smoking cessation activities for State Employees.
August 23, 1989	Diane Parotte, M.D., Occupational Health Physician, Bath Iron Works, presentation on Smoking in the Worksite.
November 14, 1989	Richard Silkman, PhD, Director, State Planning Office, presentation on cigarette excise taxes.
September 15, 1989	Dr. Jacobsen, Medical Director, Augusta Mental Health Institute, discussion on smoking in mental health facilities.
December 22, 1989	Deliberations on final report

PUBLIC HEARINGS

The Governor's Commission on Smoking OR Health held seven public hearings to receive comment on draft recommendations issued in October, 1989. The public hearing dates and locations were as follows:

October 18, 1989:

Shaw School, Gorham (to review recommendations of the Prevention and Youth Subcommittee)

Portland City Hall

November 2, 1989:

Eastern Maine Medical Center, Bangor

November 14, 1989:

State Office Building, Augusta

November 16, 1989:

Presque Isle High School (afternoon hearing to review recommendations of the Prevention and Youth Subcommittee); and Presque Isle High School, evening hearing

December 13, 1989:

St. Mary's Hospital, Lewiston

Funded by Appropriation 3310-2017