

A Pilot Study to Evaluate a Tobacco Diversion Program

DeAnn Lazovich, PhD, Janet Ford, MPH, Jean Forster, PhD, MPH, and Brigid Riley, MPH

By 1998, 42 states had implemented legislation to prohibit the purchase, possession, or use of tobacco by minors, a 24% increase since 1995.^{1,2} In response, communities have developed tobacco education classes, known as tobacco diversion programs, offered in lieu of, or in addition to, other penalties for youths cited for tobacco use. Despite the proliferation of these programs, little is known about their effect on youths' tobacco use.

Since September 1998, adolescents who are cited for a first or second tobacco violation in Hennepin County, Minn, have the option of paying a fine (\$50 for the first offense, \$75 for the second offense), attending a tobacco diversion program (\$25 fee), or scheduling a court hearing. Youths who attend the tobacco diversion program satisfy the conditions of the citation and the misdemeanor is removed from their record. The tobacco diversion program consists of a single 2½-hour class to teach youths about the realities of tobacco use and to encourage them to think about their smoking behavior and quitting. The program uses open discussions, visual aids, and participatory exercises and provides resources for smoking cessation.

From January to July 1999, we completed interviews with 112 adolescents (74.7% of those whose parents granted permission and 33.2% of all those cited during the period). Interviews were completed after the citation but before the youths participated in the tobacco diversion class. Follow-up interviews were completed with 95 of them 3 months later. In Table 1, we report the baseline demographic characteristics and the knowledge, attitudes, and behavior related to tobacco use among adolescents who attended the tobacco diversion program compared with those who paid the fine. We observed only minor differences between the 2 groups in tobacco use

and readiness to quit at 3 months (data not shown).

The limitations of our study included its small sample size, self-selection of adolescents for either the class or the fine, and lack of a nonintervention comparison group. Nevertheless, our results raise important questions regarding tobacco diversion programs as a public health strategy for reducing smoking among youths. The active enforcement of laws aimed at youths' possession of tobacco and incentives associated with diversion to a tobacco education program have the potential for reaching large numbers of smoking youths, especially those who might not otherwise volunteer. Yet we found that only about 35% of those in our sample elected that op-

tion. If youths view attendance in a tobacco diversion program as punishment or coercive, they may be less willing to participate or to be receptive to the program's messages. Other factors limiting the program's potential impact include its short duration and lack of effective smoking cessation strategies designed for adolescents.³

Adolescents who receive a citation for smoking experience immediate significant consequences. Thus, tobacco diversion programs may do no better than the citation in changing smoking behavior and may be a questionable use of resources. Although we interviewed youths within 30 days of their citation, 23.3% of those who paid the fine reported no smoking in the past month com-

TABLE 1—Characteristics of Youths Who Attended Tobacco Diversion Class Compared With Those Who Elected to Pay Citation Fine

Characteristic	Attended Class (n = 39)	Paid Fine (n = 73)	P
Demographic			
White, %	89.7	79.5	.17
Female, %	41.0	32.9	.39
Mean age, y (SE)	15.7 (0.2)	15.6 (0.1)	.54
Enrolled in school, %	94.9	95.9	.80
Received mostly A's and B's, %	35.9	48.0	.22
Personal, social, and environmental			
Reported that >40% of high school students smoked, %	74.4	80.8	.43
Reported that >40% of good friends smoked, %	89.7	61.6	<.01
Reported that >40% of adults smoked, %	82.1	67.1	.09
Father smokes, %	53.9	41.1	.20
Mother smokes, %	46.2	43.8	.81
Mean no. of known smokers (SE)	3.2 (0.2)	2.9 (0.2)	.20
Tobacco use			
Mean age at first cigarette, y (SE)	11.4 (0.4)	12.4 (0.2)	.30
Mean Fagerstrom score (SE)	4.1 (0.3)	3.4 (0.2)	.03
Mean no. of physical effects reported (SE)	2.6 (0.2)	1.8 (0.2)	.01
Smoking status, %			
Less than monthly	5.1	23.3	
Monthly	2.6	6.9	
Weekly	10.3	12.3	
Daily, ≤½ pack	48.7	35.6	
Daily, >½ pack	33.3	21.9	.08
Stage of change among 93 youths who smoked in past 30 days, %			
Precontemplation	35.9	19.2	
Contemplation	38.5	31.5	
Action	25.6	49.3	.04

pared with 5.1% of those who attended the class. They may have quit or underreported smoking to avoid further consequences. Youths attending the class were more likely than those paying the fine to report indicators of addiction (e.g., earlier age at first cigarette, higher mean Fagerstrom score,⁴ more physical effects from smoking). While they may have participated in the class for help with smoking, the lower financial consequences of diversion could also have enabled their purchase of needed tobacco.

The effect of laws aimed at youths' possession of tobacco and associated penalties for adolescent smoking has not been studied. Before there is further implementation, we urge researchers to address the concerns raised here—that is, program reach, inappropriate financial incentives for smoking, and the effect of receiving a citation on smoking—in addition to conducting much-needed research on the efficacy of tobacco diversion programs to reduce smoking among adolescents. ■

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Providing Hepatitis B Vaccination to Injection Drug Users: Referral to Health Clinics vs On-Site Vaccination at a Syringe Exchange Program

Don C. Des Jarlais, PhD, Dennis G. Fisher, PhD, Jessica Clark Newman, MPH, Beth N. Trubatch, BA, Molly Yancovitz, BA, Denise Paone, EdD, and David Periman, MD

Injection drug users (IDUs) are at very high risk for infection with hepatitis B virus (HBV) through multiperson use of injection equipment and through unprotected sexual contact. Although a safe and efficacious vaccine exists for hepatitis B, there are multiple problems in vaccinating IDUs in the United States, including (1) discrimination against drug users by health care providers, (2) the need to reach IDUs before they are exposed to HBV, (3) paying for the vaccinations, and (4) difficulties in completing the 3-injection vaccination series.

We compared 2 methods for delivering free hepatitis B vaccination to IDUs: (1) referral by research staff to local health care providers and (2) on-site vaccination at a syringe exchange program.

METHODS

Longitudinal Cohort Study

Funding was obtained to provide hepatitis B vaccination to IDUs in a cohort study con-

ducted in Anchorage, Alaska. Subjects in the study were given counseling and testing for HIV, HBV, and hepatitis C virus. Subjects eligible for hepatitis B vaccination were referred for free vaccinations to 1 of 2 local clinics or to their Medicaid provider. The local clinics instituted a policy of taking study participants before other patients to minimize waiting time.

The research study visits were scheduled for every 6 months and were conducted at a field site in the community. Participants were paid \$25 for each interview session and \$30 for each session in which testing results were provided. Initial referrals led to a very modest 7% of subjects receiving a first vaccination.¹ Additional efforts were then made to increase vaccination. Free transportation was provided from the research site to the local clinics. After November 3, 1997, subjects were paid \$10 when they provided proof of each individual vaccination. On March 18, 1999, the monetary incentive for the second and third vaccinations was increased to \$20. On April 7, 2000, the incentive was increased to \$50 for each vaccination.

Syringe Exchange On-Site Services

Pilot research funding was obtained to study the administration of hepatitis B vaccination at the Positive Health Project, a multi-service syringe exchange program in New York City.

From September 1998 through January 1999, 2 research associates were stationed at the syringe exchange program for 12 hours per week to recruit subjects for the hepatitis B vaccination study. Criteria for participation in the study were (a) having been a participant in the Positive Health Project for at least 1 month and (b) having injected drugs for no longer than 10 years. Informed consent was obtained, a short questionnaire was administered, and a blood sample for HBV testing was taken at the first visit. Subjects received \$5 at the first study visit. They returned 1 week later to receive their HBV test results and, if they were eligible for hepatitis B vaccination, to receive their first vaccination; they received \$5 at this second study visit. Subjects receiving the vaccine were asked to return 1 month later and 4 months later to receive the second and third injections and for

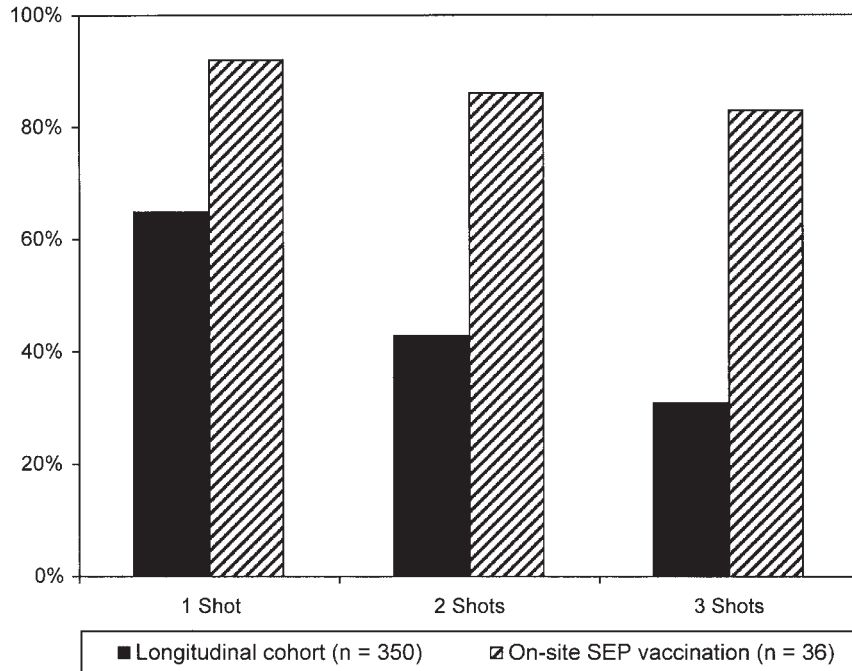


FIGURE 1—Hepatitis B vaccination adherence among injection drug users: research longitudinal cohort (n = 350) and syringe exchange program (SEP) site subjects (n = 36).

the administration of short follow-up questionnaires. They received \$10 at each of these follow-up visits.

Over a 6-month period from September 1998 to February 1999, a physician's assistant or a nurse was available to administer hepatitis B vaccine on 2 days per week for a total of 7 hours. From March 1999 to June 1999, vaccine administration was available for 5 hours on 1 day per week.

RESULTS

In the cohort study, 350 of 652 subjects had no evidence of previous HBV infection or hepatitis B vaccination and were eligible for vaccination within the study. Figure 1 shows the final vaccination results after transportation and incentives were implemented—31% of the subjects received 3 shots.

In the syringe exchange study, 97 persons attending the exchange were asked to participate in the study, of whom 74 (76%) agreed to participate; 36 subjects were HBV negative and in need of vaccination. Figure 1 also shows the final vaccination outcomes for

these 36 subjects—30 of them (83%) received all 3 shots, an adherence comparable to hepatitis B vaccination of IDUs in a study conducted within drug treatment programs² and to influenza vaccination³ and tuberculosis services⁴ provided at syringe exchange programs.

These 2 studies suggest that both modest financial incentives and convenient location greatly increase adherence to hepatitis B vaccination among IDUs.

We believe that researchers working with marginalized populations have an ethical obligation to identify better methods for providing health care to those populations, and research funding agencies have an ethical obligation to provide the extra resources required to ensure that research subjects receive the needed health care services. ■

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A Comparison of State-Specific All-Terrain Vehicle–Related Death Rates, 1990–1999

James C. Helmkamp, PhD

The US Consumer Product Safety Commission estimated that an average of 254 all-terrain vehicle (ATV)–related deaths occurred annually in the 1990s.^{1,2} Despite widespread

TABLE 1—State-Specific All-Terrain Vehicle–Related Death Rates, 1990–1999

State	(No. of Deaths) Rate per 100 000								Total
	Female				Male				
	1–16	17–49	50–64	65–84	1–16	17–49	50–64	65–84	
Helmet and Other Safety Equipment Required^a									
California	(8) 0.02	(6) 0.01	...	...	(23) 0.06	(67) 0.08	...	(7) 0.05	(117) 0.04
Delaware	(4)
Florida	...	(11) 0.03	...	...	(28) 0.19	(44) 0.14	...	...	(91) 0.07
Kentucky	...	(6) 0.06	...	...	(27) 0.61	(44) 0.47	...	...	(85) 0.23
Maine	(5) 0.36	(21) 0.69	...	...	(40) 0.33
Massachusetts	(8) 0.05	...	...	(14) 0.02
Michigan	...	(5) 0.02	...	...	(31) 0.27	(45) 0.19	(6) 0.10	...	(90) 0.10
Minnesota	...	(5) 0.04	...	...	(24) 0.43	(21) 0.18	...	...	(61) 0.14
Missouri	(18) 0.29	(24) 0.19	...	...	(53) 0.10
New Hampshire	(8) 0.27	...	...	(12) 0.11
New Jersey	(10) 0.05	...	...	(11) 0.01
New York	(21) 0.10	(49) 0.11	...	...	(79) 0.04
North Dakota	(5) 0.32	...	...	(11) 0.18
Oregon	(8) 0.22	(20) 0.26	...	...	(40) 0.13
Pennsylvania	(8) 0.06	(6) 0.02	...	...	(39) 0.30	(72) 0.26	(6) 0.07	(5) 0.07	(137) 0.12
Rhode Island	(1)
Tennessee	(6) 0.11	...	...	...	(30) 0.51	(50) 0.39	...	...	(94) 0.19
Texas	(7) 0.03	(12) 0.03	...	...	(30) 0.12	(33) 0.07	(8) 0.07	...	(94) 0.05
Utah	(6) 0.21	...	...	...	(18) 0.59	(15) 0.32	...	...	(46) 0.24
Virginia	(11) 0.15	(19) 0.11	...	...	(41) 0.06
Wisconsin	(19) 0.31	(33) 0.27	...	...	(59) 0.12
Machine-Related Requirements^b									
Alaska	(7) 0.81	(16) 0.94	...	...	(37) 0.55
Arizona	...	(6) 0.56	...	...	(12) 0.23	(36) 0.35	(6) 0.23	...	(62) 0.15
Arkansas	(6) 2.11	...	...	...	(18) 0.61	(34) 0.61	(7) 0.42	(5) 0.37	(75) 0.31
Colorado	(5) 0.11	(9) 0.09	...	...	(20) 0.06
Connecticut	(7) 0.02
Georgia	(9) 0.11	(5) 0.03	...	...	(22) 0.25	(22) 0.12	...	...	(61) 0.09
Idaho	(5) 0.34	...	...	...	(6) 0.39	(9) 0.33	...	...	(27) 0.24
Illinois	(21) 0.15	(23) 0.08	...	...	(53) 0.05
Indiana	(13) 0.19	(16) 0.11	...	...	(40) 0.07
Iowa	(7) 0.21	(15) 0.23	(5) 0.26	...	(33) 0.12
Kansas	(12) 0.38	(11) 0.18	...	...	(29) 0.12
Louisiana	(17) 0.31	(19) 0.18	...	...	(44) 0.10
Maryland	(9) 0.02
Montana	(12) 0.14
Nebraska	(8) 0.40	...	...	...	(18) 0.11
Nevada	(13) 0.09
New Mexico	(5) 0.23	(6) 0.15	...	...	(18) 0.11
Ohio	(17) 0.13	(22) 0.08	...	...	(51) 0.05
Oklahoma	(15) 0.38	(7) 0.09	...	...	(28) 0.09
South Dakota	(5) 0.30	...	...	(14) 0.20
Vermont	(5) 0.75	(11) 0.74	...	...	(19) 0.34
Washington	(7) 0.05	...	...	(14) 0.03
Wyoming	(10) 0.22

Continued

TABLE 1—Continued

										No Safety Legislation ^c	
Alabama	...	...	...	...	(17) 0.35	(22) 0.22	...	...	(49) 0.12		
Hawaii	...	...	...	...	...	...	...	...	(2)		
Mississippi	(7) 0.22	...	...	...	(30) 0.88	(20) 0.32	...	...	(65) 0.25		
North Carolina	...	...	...	...	(28) 0.35	(56) 0.31	...	...	(94) 0.13		
South Carolina	...	...	...	...	(6) 0.14	(5) 0.06	...	...	(16) 0.04		
Washington, DC	...	...	...	...	...	...	...	...	(2)		
West Virginia	(10) 0.55	(10) 0.23	...	...	(20) 1.04	(64) 1.51	(9) 0.67	(10) 0.98	(124) 0.70		
										Totals	
United States	(138) 0.05	(133) 0.02	(11) 0.01	(9) 0.01	(657) 0.21	(1052) 0.16	(126) 0.07	(100) 0.80	(2226) 0.09		
Sex		(291) 0.02					(1935) 0.16				

^aRate for 1180 deaths=0.08.

^bRate for 694 deaths=0.09.

^cRate for 352 deaths =0.17.

education and training efforts by the Consumer Product Safety Commission and major ATV manufacturers,³ average annual deaths have risen to 267 since 1995.¹ Renewed efforts are directed at adolescents younger than 17 years, among whom more than one third of ATV-related deaths have occurred.⁴

The Specialty Vehicle Institute of America's annual list⁵ of state-specific ATV safety requirements for 2000 can be viewed as 3 mutually exclusive groups: (1) helmet and other safety equipment requirements (21 states), (2) machine-related safety but no helmet requirement (23 states), and (3) no safety legislation (6 states and the District of Columbia). Death data, obtained from the Consumer Product Safety Commission, were divided into 4 age groups: 1–16 years, 17–49 years, 50–64 years, and 65–84 years. The few deaths in persons older than 84 years were not included. Although the Consumer Product Safety Commission has estimated death rates based on national ATV user information to identify broad populations at risk,⁶ reliable and accurate state-specific user information is not consistently available from ATV distributors. Therefore, population-based rates were calculated on the basis of US Census Bureau state-, age-, and sex-specific population estimates.⁷ Rates were based on 10-year composites of numerator and denominator data for 1990 to 1999 and were not calculated for any cell with fewer than 5 deaths.

States without safety legislation had a collective death rate twice that of the other 2

groups—0.17 deaths per 100 000 vs 0.08 and 0.09, respectively (see Table 1). Pennsylvania led all states with 137 deaths, and West Virginia had the highest fatality rate among all states: 0.70 (7.8 times the overall national rate). The 124 deaths in West Virginia ranked second among all states. Arkansas had the highest rate (2.11) among female adolescents aged 1 to 16, and Arizona had the highest rate (0.56) among women aged 17 to 49; both of these rates were based on 6 fatalities. No state had more than 5 deaths in either of the 2 oldest female age groups. Among male deaths, West Virginia had the highest rates in each of the 4 age groups: 1–16 (1.04), 17–49 (1.51), 50–64 (0.67), and 65–84 (0.98). Across the entire United States, 87% of all deaths related to ATVs were in males, with a death rate 8 times that of females (0.16 vs 0.02).

Rates based on few events are often subject to large fluctuations. This phenomenon is likely at play with the crude rates presented here. Accepting that limitation and the notion that these rates are not the most valid assessment of risk in terms of ATV user populations, these rates do provide a broad state-by-state population-based risk comparison. To my knowledge, this report is the first comprehensive state listing of sex- and age-specific ATV-related fatality rates. These results also show clearly that states with some level of safety legislation, be it mandated helmet use or machine-related requirements, have substantially fewer deaths

and lower fatality rates than do states that have no ATV safety laws. ■

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Buckling Up America: Making a Difference at the Local Level

Al Golden, MPH, and Barbara J. Hatcher, PhD, MPH, RN

Deaths and injuries from traffic accidents continue to be major public health problems. From 1994 to 1998, more than 208 000 traffic fatalities and more than 16.7 million nonfatal injuries occurred in the United States, with more than 2500 of these fatalities among children aged 4 to 8 years.^{1,2} In 1994, 27% of the drivers reported that their use of seat belts had increased over the prior 12 months, whereas this percentage dropped to 15% in 1998.³ Substantial evidence indicates that using seat belts and other restraint systems saves lives and reduces injuries.⁴⁻⁶ Robertson⁴ reported that increased seat belt use was positively correlated with a reduction in occupant fatalities per mile traveled. Wageenaar and Webster⁵ found a 25% reduction in the number of children 3 years or younger injured in automobile crashes after a Michigan law was implemented requiring all young children in automobiles to be restrained. Similar findings were reported in a 1997 study by Niemcryk et al.⁶ of children 4 years or younger in Nevada.

The American Public Health Association (APHA), under a cooperative agreement with the National Highway Traffic Safety Administration and in collaboration with several state affiliates, educated the general public and policymakers about crucial traffic safety issues, particularly the use of seat belts and restraints.

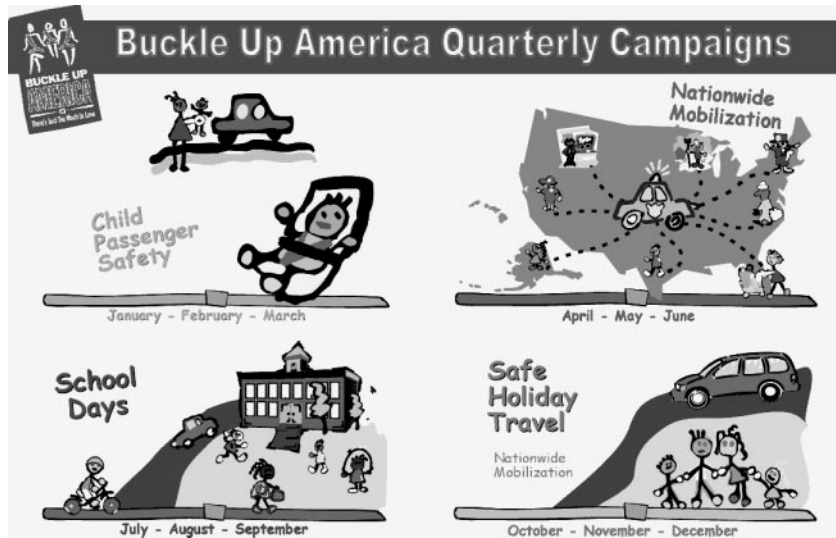


FIGURE 1—American Public Health Association (APHA)—National Highway Traffic Safety Administration safety campaign poster.

APHA designed a portable “Buckle Up, America” traffic safety display depicting the 4 major “Buckle Up, America” emphasis themes (Figure 1). Seventeen APHA affiliates used this display from January 2000 to January 2001 as part of their respective traffic safety advocacy programs. APHA also created fax-on-demand documents and a how-to manual on its Web site to assist local affiliates in developing effective traffic safety campaigns.

Six affiliates received funding to support local collaborative traffic safety initiatives as part of their respective annual meetings:

1. The *Alabama Public Health Association* emphasized supporting the training of technicians to operate car seat “checkup” events around the state. Videotapes and other educational materials also were distributed.

2. The *Illinois Public Health Association* disseminated traffic safety materials and presented a lifetime achievement award to Senator John Cullerton for his commitment to traffic safety legislation.

3. The *Missouri Public Health Association* educated its statewide membership about traffic safety as a major public health issue, highlighted model community traffic safety programs, and advocated for traffic safety resolutions.

4. The *Montana Public Health Association* produced a display board to be used in traffic safety programs throughout the state, created a pamphlet on traffic safety, and is developing a program to implement a graduated drivers’ license program for adolescents.

5. The *Metropolitan Washington Public Health Association* disseminated traffic safety information, mailed a local traffic safety resource list to individuals and organizations, and posted traffic safety resource information on their Web site.

6. The *South Carolina Public Health Association* inspected 20 child safety seats and replaced 7, distributed National Highway Traffic Safety Administration traffic safety information, and provided information about law enforcement participation in increasing seat belt use and proper child passenger restraints.

In summary, local collaborative efforts to publicize the importance of seat belt and restraint system use to the general public and to policymakers are essential to positively affect traffic fatalities and injuries. ■

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AMERICAN JOURNAL OF PUBLIC HEALTH

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Original unpublished research is urgently needed to advance understanding of CAM and its potential to further public health. Research addressing indigenous health systems, special populations, or underrepresented groups is especially encouraged. **The deadline for all research submissions for the CAM special issue is February 1, 2002.**

Papers that report the results of original quantitative or qualitative public health research are published as Articles (up to 3500 words and 4 tables or figures, with a structured abstract of 120 words). Preliminary or novel findings may be reported as Briefs (up to 800 words and 2 tables or figures, with no abstract). Further information on the publication requirements for AJPH may be found on-line at <http://www.ajph.org/misc/ifora.shtml>.

Informal inquiries. The editors cannot respond to individual queries regarding the appropriateness of planned contributions. Formal submissions gain our full attention. Please note that we are not requesting editorials or commentaries. Unsolicited submissions on CAM other than Articles or Briefs will not be peer reviewed.

Special Instructions. Please submit all papers, along with a list of 6 suitable and willing peer reviewers, directly to **AJPH Submissions, 800 I St NW, Washington, DC 20001-3710**. Please be sure to state in your cover letter that your research paper is intended for the CAM special issue, in order to assure timely routing for review.

Vincent M. B. Silenzio, MD, MPH
 Guest Editor

in close collaboration with the Journal's editorial staff,
 the Harlem Health Promotion Center of Columbia University,
 and the Centers for Disease Control and Prevention

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