

Correlates of Daily Smoking Among Female Arrestees in New York City and Los Angeles, 1997

Tracy L. Durrah, DrPH

Smoking is the most common, and most preventable, cause of death in America. In 1997, approximately 165 000 women in the United States died prematurely as a result of smoking-related diseases, and since 1980, nearly 3 million US women have died prematurely from such diseases.¹ Smoking-related diseases account for more premature mortality than alcohol use, use of other drugs, car accidents, murders, suicides, fires, and HIV/AIDS combined.² The negative outcomes of smoking are even more severe for women living in impoverished communities.³ Therefore, many researchers and policymakers have come to accept the belief that high rates of illicit drug use always indicate high rates of daily smoking.

The prevalence of tobacco use among women in the United States dropped from 35% to 23% between 1965 and 1990, but the rate of smoking among women who are illicit drug users is much higher.^{1,4,5} The purpose of this study was to determine correlates of daily smoking among recently arrested women participating in the Drug Use Forecasting Program (DUF), many of whom were illicit drug users. Also, smoking rates among DUF women were compared with rates among women taking part in the population-based Behavioral Risk Factor Surveillance System (BRFSS) survey. Because general population surveys such as the BRFSS do not include as many illicit drug users, this comparison might highlight disparities in tobacco use and the social and political environments that affect health behaviors and outcomes.

Also, I hoped that a DUF–BRFSS comparison would contribute to an increased understanding of tobacco use prevalence and trends among women who are illicit drug users and women in the general population, and how these trends are influenced by statewide tobacco control policies. In addition, because of the significant contribution of tobacco-related morbidity and mortality to health disparities, results from the current

Objectives. I sought to determine correlates of daily smoking among recently arrested women involved in the Drug Use Forecasting Program (DUF), many of whom are illicit drug users. Also, I compared smoking rates among DUF women, who were illicit drug users, with rates among women taking part in the Behavioral Risk Factor Surveillance System (BRFSS) survey, who do not have high levels of drug use, to determine if drug use accounts for heavy smoking.

Methods. I compared daily smoking, illicit drug use, and selected demographic characteristics in 2 DUF cities: New York, with the highest rate of smoking among DUF cities in 1997, and Los Angeles, with the lowest. I also compared DUF and BRFSS daily smoking rates.

Results: Although rates of illicit drug use were similar in New York and Los Angeles (69.7% and 61.8%, respectively), the daily smoking rate was higher in New York (90.9% vs 41.7%). DUF smoking rates were higher than BRFSS rates; both rates were higher than the general population (23%).

Conclusions. Illicit drug use does not, in all cases, explain high rates of daily smoking. Future efforts to shape tobacco-related public health policies in New York and elsewhere should involve collaboration with criminal justice transitional health programs. (*Am J Public Health.* 2005;95:1788–1792. doi:10.2105/AJPH.2004.056457)

study should help to promote successful collaboration of prevention and intervention efforts among tobacco cessation programs, drug treatment programs, and other social services focusing on decreasing or eliminating tobacco and illicit drug use and implementing other *Healthy People 2010* initiatives.^{4,6–9}

METHODS

DUF Design and Study Sample

Since 1987, the DUF, funded by the National Institute of Justice, conducted face-to-face interviews at quarterly intervals in 24 cities with men and women who were recently arrested. A core questionnaire was used to obtain detailed information on the use of licit and illicit drugs. All of the participants provided a urine sample that was subsequently tested, via enzyme-multiplied immunoassay technique (EMIT) analysis, for the presence of 10 drugs: opiates, cocaine, phencyclidine (PCP), marijuana, amphetamines, methadone, propoxyphene, barbiturates, methaqualon, and benzodiazepines. In the case of all drugs except marijuana, which can be detected in urine for up to 30 days, testing within approximately

72 hours of drug use allowed a determination of the reliability of reports of drug use. Because EMIT analysis does not distinguish between powder cocaine and crack cocaine, the use of crack was self-reported.

Although all have been recently arrested (and detained for processing for 24 to 48 hours), most DUF participants will not be convicted. More often they are detained, regardless of whether they are convicted, because they are unable to pay fines or court costs. Most such detainees are released in 7 to 10 days, and the majority of those who are convicted serve sentences of less than 1 year.

The DUF sample of women who are illicit drug users are at high risk for mortality and morbidity associated with tobacco use. I compared rates of daily smoking and illicit drug use and selected demographic characteristics in 2 DUF cities: New York, with the highest smoking rate of DUF cities in 1997 (the year of data collection), and Los Angeles, with the lowest rate. In 1998, the DUF program was transitioned to a new instrument and sampling plan of the Arrestee Drug Abuse Monitoring (ADAM) program, and questions on smoking were not asked. I included in my analyses

women aged 18 years or older who were interviewed in 1 of 21 cities included in the DUF study in 1997 (n=7457). Additional analyses focused on women in New York and Los Angeles.

Current daily smokers in the DUF sample were defined as women who reported smoking cigarettes every day of the past 30 days. Non-daily smokers were defined as women who had smoked on 29 or fewer days in the past month. In addition to nonsmokers, this conservative definition included regular but nondaily smokers; however, it also allowed a focus on the heaviest, most persistent smokers.

Current drug users were defined as those who, according to positive EMIT urine analyses, had used at least 1 illicit drug in the past 72 hours. Because these analyses did not distinguish between powder cocaine and crack, current crack users were defined as women who reported having used crack in the past 72 hours. All of these women tested positive for cocaine. Current injection drug users were categorized as those who reported having injected any drug in the past 30 days.

BRFSS Design and Study Sample

The BRFSS, established by the Centers for Disease Control and Prevention in the early 1980s, is a telephone survey of approximately 2000 adults aged 18 years or older in each state that monitors state-level prevalence rates of major behavioral risks associated with preventable chronic diseases, injuries, and infectious diseases.¹⁰ Many public health researchers and policymakers believed that collecting information on actual behaviors rather than attitudes or knowledge would be useful in planning, initiating, supporting, and evaluating health promotion and disease prevention programs.¹⁰

The initial surveys were conducted in 15 and then 29 states on a monthly basis. Since 1994, all states, the District of Columbia, and 3 territories have participated in the BRFSS. The sample for analyses in this study was composed of women who completed the BRFSS survey in 1997. In the BRFSS, “current daily smokers” are defined as women providing an affirmative response to the question “Do you smoke cigarettes now?”

Rates of daily smoking in 3 DUF 1997 samples (the national sample and the New

York City and Los Angeles samples) were compared with rates in 3 1997 BRFSS samples (the national sample and the New York and California samples). Although the DUF involved citywide face-to-face interviews and the BRFSS involved statewide telephone surveys (the BRFSS initiated city-level data collection in 2002), comparisons between them proved useful for understanding differences in both smoking rates and the effects of statewide tobacco control policies.

RESULTS

The median age of the national DUF sample (n=7457) was 31 years (range: 18–71 years). The sample included 422 women in New

York and 503 women in Los Angeles. Selected characteristics of the study participants are shown in Table 1; characteristics of the national sample are provided for informational purposes. Women in New York and Los Angeles were compared on daily smoking and selected demographic characteristics.

The national, New York, and Los Angeles participants were similar in terms of age and marital status. Most women reported being single and younger than 45 years. Women in New York were more likely than women in Los Angeles to report Black ethnicity (61.6% vs 49.1%, respectively). Percentages of women who used at least 1 illicit drug (i.e., cocaine, crack, or heroin) were high in both cities, 69.7% in New York and 61.8% in Los

TABLE 1—Characteristics of Drug Use Forecasting Program Participants: National Sample, New York, and Los Angeles, 1997

| | National Sample (n = 7457), No. (%) | New York (n = 422), No. (%) | Los Angeles (n = 503), No. (%) |
|---|--|--------------------------------|-----------------------------------|
| Age, y | | | |
| 18–29 | 3277 (43.9) | 146 (34.6) | 184 (36.6) |
| 30–44 | 3695 (49.6) | 240 (56.9) | 275 (54.7) |
| 45–65 | 476 (6.4) | 35 (8.3) | 44 (8.7) |
| ≥ 65 | 9 (0.1) | 1 (0.2) | 0 (0.0) |
| Race/ethnicity | | | |
| Black, non-Hispanic | 3836 (51.4) | 260 (61.6) | 247 (49.1) |
| White, non-Hispanic | 2388 (32.0) | 77 (18.2) | 101 (20.1) |
| Hispanic | 1005 (13.5) | 76 (18.0) | 140 (27.8) |
| Other | 228 (3.0) | 9 (2.2) | 15 (3.0) |
| Education | | | |
| High school or equivalent | 4678 (63) | 267 (64) | 270 (54) |
| Some college (1–8 years) ^a | 1407 (19) | 89 (21) | 86 (17) |
| Marital status | | | |
| Single | 3310 (44.4) | 207 (49.1) | 231 (45.9) |
| Living with partner | 1673 (23.0) | 121 (28.7) | 121 (24.1) |
| Married | 1038 (13.9) | 51 (12.1) | 65 (12.9) |
| Divorced/widowed | 1431 (20.0) | 43 (10.1) | 86 (17.1) |
| Housing (past 30 days) | | | |
| Private housing (e.g., apartment) | 6928 (92.9) | 377 (89.4) | 454 (90.3) |
| Shelter | 68 (0.9) | 12 (2.8) | 2 (0.4) |
| Jail/prison | 39 (0.5) | 3 (0.7) | 3 (0.6) |
| Halfway house | 27 (0.4) | 4 (0.9) | 1 (0.2) |
| Drug/alcohol treatment facility | 42 (0.6) | 0 (0.0) | 2 (0.4) |
| On street | 281 (3.8) | 26 (0.7) | 32 (6.4) |
| Positive urine test (any illicit drug) | 4686 (63.0) | 343 (82.0) | 351 (70.0) |
| Positive urine test (excluding marijuana) | 3960 (53.1) | 294 (69.7) | 311 (61.8) |

Note. Missing values are excluded.

^a Respondents reporting “some college” may also be included in the high school or equivalent group.

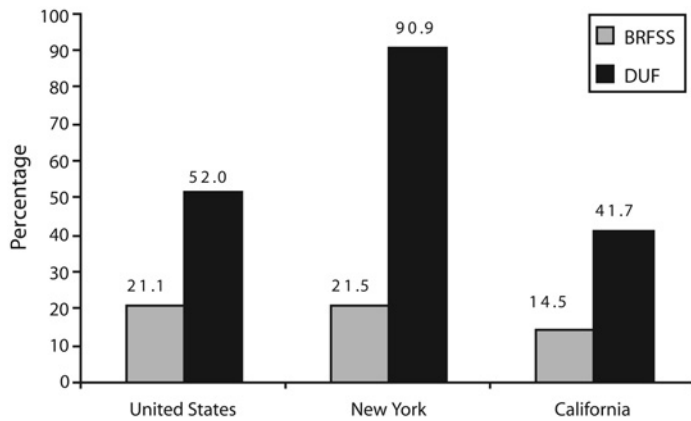


FIGURE 1—Rates of daily smoking among women in the Behavioral Risk Factor Surveillance System (BRFSS) and the Drug Use Forecasting (DUF) program: 1997.

Angeles, and each of these percentages was higher than the national DUF average (52.6%). Although women in New York and Los Angeles exhibited similar rates of drug use, tobacco use rates were very different. The rate of daily smoking (i.e., smoking every day in the past 30 days) was much higher in New York (90.9%) than in Los Angeles (41.7%).

DUF-BRFSS Comparison

Smoking rates of women in the DUF cities with the lowest and highest rates of daily smoking (i.e., Los Angeles and New York) were compared with state and national rates of smoking among BRFSS participants from the general population. In all cases, rates of daily smoking among female arrestees were higher than state and national rates of smoking among women in the general population (Figure 1).

The 1997 BRFSS data revealed that the rate of current smoking (14.5%) among women in California was low in comparison with rates in other BRFSS states (the highest rate was observed in Kentucky [28.7%], and the lowest was observed in Utah [11.5%]).¹⁰ The BRFSS smoking rate in New York State (21.5%) was close to the nationwide average of 23.2%.¹⁰

Demographic and Drug Use Correlates of Daily Smoking

Women who participated in the DUF provided self-reported drug use information as well as a urine sample (“recent drug use”).

Selected demographic and drug use characteristics associated with daily smoking among DUF women are shown in Tables 2 and 3. Although data on the DUF national sample were included in the analyses, χ^2 tests of sig-

nificance focused only on comparisons of the New York and Los Angeles samples.

Daily smokers and non-daily smokers were compared in each city. Because “non-daily smokers” included women who had smoked on 29 or fewer days in the past month, this group was composed of smokers as well as nonsmokers. Daily smokers in New York were significantly more likely than those in Los Angeles to report having a high school or general equivalency diploma; women in Los Angeles were significantly more likely than those in New York to report being single.

Differences were observed in patterns of daily smoking and drug use between New York and Los Angeles. Among daily smokers, patterns of recent use of cocaine, heroin, amphetamines, and methamphetamines were significantly different in the 2 cities (Table 3). Rates of recent cocaine (73.0% vs. 63.0%, respectively) and heroin (26.4% vs. 13.0%, respectively) use were significantly higher among daily smokers in New York than among daily smokers in Los Angeles. Higher percentages of

TABLE 2—Percentages of Daily Smoking, by Selected Demographic Characteristics: Drug Use Forecasting Program Participants, 1997

| | National Sample (n = 3871), No. (%) | New York (n = 296), No. (%) | Los Angeles (n = 146), No. (%) |
|---------------------------------------|--|--------------------------------|-----------------------------------|
| Age, y | | | |
| 18–29 | 1492 (38.5) | 93 (31.4) | 49 (33.6) |
| 30–44 | 2148 (55.5) | 176 (59.5) | 87 (59.6) |
| 45–65 | 226 (5.8) | 26 (8.8) | 10 (6.8) |
| ≥ 65 | 5 (0.1) | 1 (0.3) | 0 (0.0) |
| Race/ethnicity | | | |
| Black, non-Hispanic | 1854 (48.2) | 187 (63.4) | 68 (46.9) |
| White, non Hispanic | 1557 (40.5) | 54 (18.3) | 39 (26.9) |
| Hispanic | 374 (9.7) | 49 (16.6) | 33 (22.4) |
| Other | 86 (1.6) | 6 (1.7) | 6 (3.8) |
| Education | | | |
| High school or equivalent | 2373 (61.7) | 178 (60.3) | 77 (52.8)* |
| Some college (1–8 years) ^a | 761 (20.0) | 48 (17.0) | 26 (18.0) |
| Marital status | | | |
| Single | 1617 (41.8) | 133 (44.9) | 65 (45.0) |
| Living with partner | 944 (24.4) | 93 (31.4) | 43 (29.5) |
| Married | 497 (12.8) | 43 (14.5) | 16 (11.0) |
| Divorced/widowed | 810 (21.0) | 27 (9.2) | 22 (14.5) |

Note. National sample smoking rates are included for informational purposes only. Chi-square comparisons involved New York and Los Angeles only.

^a Respondents reporting “some college” may also be included in the high school or equivalent group.

* $P < .05$ (χ^2).

TABLE 3—Percentages of Daily Smoking, by Drug Use Characteristics: Drug Use Forecasting Program Participants, 1997

| | New York | | Los Angeles | |
|--|-------------------------------|--------------------------------------|-------------------------------|--------------------------------------|
| | Daily Smokers (n = 296), % | Non-daily smokers (n = 126), % | Daily Smokers (n = 146), % | Non-daily smokers (n = 357), % |
| Positive urine test (any illicit drug) | 91.2 | 8.8 | 94.5 | 5.5 |
| Positive urine test (excluding marijuana) | 80.1 | 19.9 | 80.3 | 19.7 |
| Recent cocaine use | 73.0* | 27.0 | 63.0 | 37.0 |
| Recent crack use (self-report only) | 39.9 | 60.1 | 45.9 | 54.1 |
| Recent heroin use | 26.4** | 73.6 | 13.0 | 87.0 |
| Recent injection drug use (self-report, 30 days) | 10.1 | 89.9 | 11.6 | 88.4 |
| Recent marijuana use | 25.7 | 74.3 | 21.2 | 78.8 |
| Recent amphetamine use | 0.0 | 0.0 | 87.5** | 12.5 |
| Recent methamphetamine use | 0.0 | 0.0 | 95.8** | 4.2 |

Note. Non-daily smokers included women who smoked on 29 days or fewer in the past month. All "recent" use refers to the 72 hours before arrest, confirmed by enzyme-multiplied immunoassay technique analysis except where indicated. All χ^2 tests of significance compared daily smokers in New York with daily smokers in Los Angeles.

* $P < 0.05$ (χ^2); ** $P < .001$ (χ^2).

cocaine and heroin users in New York than in Los Angeles were daily smokers. No significant differences were observed in crack use (self-reported), current injection drug use, or marijuana use. Recent amphetamine and methamphetamine use was not self-reported by or detected in the urine of DUF women in New York City; historically, these drugs have been more popular in the western United States.

These dramatic findings suggest that high rates of illicit drug use do not in themselves account for high rates of daily smoking among women. Divergent tobacco control policies in New York and California may have contributed to the differences observed.

DISCUSSION

DUF women in New York and Los Angeles were compared because, despite their similar rates of drug use, they exhibited very different rates of daily smoking (90.9% and 41.7%, respectively). In 1997, New York City had the highest rate of daily smoking among DUF women, and more than 60% tested positive for use of at least 1 illicit drug. A higher proportion of women in New York who used cocaine and heroin were daily smokers. No significant differences were found in self-reported crack use, current injection drug use, or marijuana use.

Although patterns of drug use and types of drugs used were different in New York and Los Angeles, further analysis and understanding would require more detailed information on market trends, policing patterns, and the social and structural environment in the 2 cities. Divergent tobacco control policies in New York and California may have contributed significantly to the results observed in this study.

My findings are further supported by the results of the DUF–BRFSS comparisons; however, conclusions based on these 1997 comparisons are limited. The DUF involves a face-to-face interview of illicit drug using women who are unlikely to be included in a population-based study. The BRFSS, in contrast, is a population-based telephone survey. However, the comparison does highlight the variability in rates of smoking between women in the general population and women who are illicit drug users, whether or not they were currently in jail or living in the community. The comparisons of the DUF and BRFSS samples showed that higher percentages of women in New York City and New York State than in Los Angeles and California were daily smokers, regardless of drug use patterns.

Several factors may account for the difference in the rates of daily smoking among il-

licit drug using women in New York City and Los Angeles. In 1988, California was the first US state to launch a comprehensive tobacco control program. Through the efforts of local health departments, community-based organizations, a statewide media campaign, and other statewide support systems (e.g., a toll-free telephone service to assist smokers and their families and friends), California has continued to make significant progress toward eliminating tobacco use. A smoke-free workplace law and increased state cigarette excise tax have contributed to tobacco use reduction. Between 1990 and 2000, per capita cigarette consumption in California declined by 51%, and had the lowest per capita cigarette consumption of any state in 2000 and 2001.¹⁰

Researchers have documented the wide-reaching impact of California's tobacco control policies. Since 1990, when most existing tobacco control programs were initiated in California, data from the California Tobacco Survey and the California Youth Tobacco Survey have shown increases in the proportion of youths aged 12 years or younger who reported never having smoked. In addition, through strategies aimed at protecting non-smokers from environmental tobacco smoke, California's tobacco policies have been successful in reducing cigarette consumption among adults who continue to smoke. Research has shown that knowledge about the dangers of environmental tobacco smoke, employment in a smoke-free workplace, and residence in a smoke-free home are inversely related to self-reported cigarette consumption.¹²

The California policies also have been linked to declines in lung cancer incidence and heart disease death rates.^{13–17} My DUF–BRFSS comparisons suggest that the success of these policies extends to all segments of the population, including illicit drug using women who are more likely to be daily smokers and are most vulnerable to smoking-related negative health consequences than women in the general population. Since initiating its comprehensive tobacco control program in 1988, California has become a role model for tobacco control programs in the United States.

Although the tobacco control policies of New York State and New York City are

similar to those of California, they are more recent in origin. However, having modeled its policies after the successful California tobacco control efforts, New York City became the first community in the United States to meet the *Healthy People 2010* objective of increasing the cigarette excise tax to \$2 per pack. In 2003, New York City passed legislation increasing taxes on tobacco products as well as eliminating tobacco use in all public areas.^{4,10}

These efforts, although recent, are proving to be quite effective. Rates of smoking in New York City's general population have declined rapidly in the brief time these policies have been in place.¹⁸ A recent study sponsored by the New York City Department of Health indicated an 11% decrease in smoking among noninstitutionalized adult residents of New York City; findings from this study will be used to guide additional tobacco control measures in the city, including targeting neighborhoods at high risk for smoking and asthma.^{18,19}

The DUF data for women in New York City did not reflect the success of these tobacco control efforts in 1997. No studies have been conducted to measure potential changes in tobacco use among illicit drug users in New York City since 1999, when the DUF program eliminated all questions on tobacco use. New York has instituted some effective tobacco control policies, but these policies have not been in place long enough, nor has enough research been conducted, to determine their impact or to compare their success to that of California in reaching all segments of the population.

It is likely that other policy, regional, and ethnic differences exist in rates and patterns of tobacco use, but such potential differences were beyond the scope of this study.^{6,20} My findings highlight the crucial need for cessation programs targeted to women who use illicit drugs. Because drug use is the most common reason for arrest among women, arrest and incarceration may be an important intervention point for women at high risk of poor health outcomes.^{8,20,21} Understanding tobacco use trends and patterns will lead to successful prevention and intervention collaborations between social programs and medical services designed to decrease tobacco and illicit drug use as well as the

mortality and morbidity associated with tobacco-related chronic diseases.^{1,4,10,22,23}

In summary, my findings highlight the fact that illicit drug use does not account for high rates of daily smoking among women in all cases. My findings further emphasize the far-reaching policy implications of effective tobacco control policies. Future smoking prevention and cessation efforts should seek additional nontraditional points of intervention, such as criminal justice settings, and transitional health care programs should be developed for women returning to the community from such settings. Researchers, social service providers, and criminal justice policymakers should also continue in their efforts to shape tobacco-related public health policies. ■

About the Author

Tracy L. Durrah is with the Department of Sociomedical Sciences, Mailman School of Public Health, Columbia University, New York City.

Requests for reprints should be sent to Tracy L. Durrah, DrPH, Department of Sociomedical Sciences, Mailman School of Public Health, Columbia University, 600 West 168th St, 4th Floor, New York, NY 10032 (e-mail: tld5@columbia.edu).

This article was accepted March 23, 2005.

Acknowledgments

Funding for the preparation of this article was provided by the Calderone Research Prize for Junior Faculty.

I am extremely grateful to Patricia Thompson-Reid, MAT, MPH, for assistance with conceptualization of the article. I would like to thank Hannah Frisch for her careful review and comments on the article. Thanks also to Bernard Moore for administrative assistance in preparing the article. I would especially like to thank the many women who were willing to share their experiences.

Human Participant Protection

No protocol approval was needed for this study.

References

1. *Women and Smoking: A Report of the Surgeon General*. Rockville, Md: US Public Health Service; 2001.
2. Fullilove RE, Fullilove MT, Northridge ME, et al. Risk factors for excess mortality in Harlem: findings from the Harlem Household Survey. *Am J Prev Med*. 1999;16(suppl 3):22–28.
3. Northridge ME, Morabia A, Ganz ML, et al. Contribution of smoking to excess mortality in Harlem. *Am J Epidemiol*. 1998;147:250–258.
4. Durrah TL, Rosenberg TJ. Smoking among female arrestees: prevalence of daily smoking and smoking cessation efforts. *Addict Behav*. 2004;29:1015–1019.
5. Tomar SL. Trends and patterns of tobacco use in the United States. *Am J Med Sci*. 2003;326:248–254.

6. Fagan P, King G, Lawrence D, et al. Eliminating tobacco-related health disparities: directions for future research. *Am J Public Health*. 2004;94:211–217.
7. Henderson LA, Vlahov D, Celentano DD, Strathdee SA. Readiness for cessation of drug use among recent attenders and nonattenders of a needle exchange program. *J Acquir Immune Defic Syndr*. 2003;32:229–237.
8. Wong MD, Shapiro MF, Boscardin WJ, Ettner S. Contribution of major diseases to disparities in mortality. *N Engl J Med*. 2002;347:1585–1592.
9. *Healthy People 2010: Understanding and Improving Health*. Washington, DC: US Dept of Health and Human Services; 2001.
10. Behavioral Risk Factor Surveillance System: 1997. Available at: <http://www.cdc.gov/brfss>. Accessed September 30, 2004.
11. Chen X, Li G, Unger JB, Liu X, Johnson CA. Secular trends in adolescent never smoking from 1990 to 1999 in California: an age-period-cohort analysis. *Am J Public Health*. 2003;93:2099–2104.
12. Gilpin EA, Pierce JP. The California Tobacco Control Program and potential harm reduction through reduced cigarette consumption in continuing smokers. *Nicotine Tob Res*. 2002;4(suppl 2):S157–S166.
13. Barnoya J, Glantz S. Association of the California Tobacco Control Program with declines in lung cancer incidence. *Cancer Causes Control*. 2004;15:689–695.
14. Centers for Disease Control and Prevention. Declines in lung cancer rates—California, 1988–1997. *MMWR Morb Mortal Wkly Rep*. 2000;49:1066–1069.
15. Fichtenberg CM, Glantz SA. Association of the California Tobacco Control Program with declines in cigarette consumption and mortality from heart disease. *N Engl J Med*. 2000;343:1772–1777.
16. Jemal A, Cokkinides VE, Shafey O, Thun MJ. Lung cancer trends in young adults: an early indicator of progress in tobacco control (United States). *Cancer Causes Control*. 2003;14:579–585.
17. Siegel M, Mowery PD, Peckacek TP, et al. Trends in adult cigarette smoking in California compared with the rest of the United States, 1978–1994. *Am J Public Health*. 2000;90:372–379.
18. Frieden TR. New York City's smoking rate declines rapidly from 2002 to 2003, the most significant one-year drop ever recorded. Available at: <http://www.nyc.gov>. Accessed May 12, 2004.
19. Mostashari F, Kerker BD, Hajat A, Miller N, Frieden TR. Smoking practices in New York City: the use of a population-based survey to guide policy-making and programming. *J Urban Health*. 2005;82:58–70.
20. King G, Polednak AP, Bendel R. Regional variation in smoking among African Americans. *Prev Med*. 1999;29:126–132.
21. Fullilove RE. Substance abuse and public policy in the United States: a war on drugs or managed care for treatment. *Curr Issues Public Health*. 1996;2:68–73.
22. Weissman G, Brown V. Drug-using women and HIV: risk-reduction and prevention issues. In: O'Leary A, Jemott LS, eds. *Women at Risk: Issues in the Primary Prevention of AIDS*. New York, NY: Plenum Press; 1995:175–193.
23. Sullivan MA, Covey LS. Current perspectives on smoking cessation among substance abusers. *Curr Psychiatry Rep*. 2002;4:388–396.