UCSF Smoking Cessation Leadership Center
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15 Years Went By Fast

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On January 15, 2003, the Smoking Cessation Leadership Center at UCSF officially began, thanks to a five-year grant from The Robert Wood Johnson Foundation, and later supplemented by support from the then American Legacy Foundation, now Truth Initiative.

When I arrived at UCSF that day, I had no idea of the journey ahead. All I had was an office and the opportunity to hire staff and to develop mechanisms that would help organizations do a better job supporting quit attempts by smokers. What was known was the large gap between what clinicians should do and what they actually did. SCLC?s focus over the last 15 years has been how to narrow the gap among clinicians and within other relevant organizations. What evolved over the years was our strategic approach and the partners we engaged. I also did not foresee the longevity of our Center, nor the multiple other sources of support we were fortunate to secure. Looking back, here are some of the highlights of those past 15 years. *

Getting to work with wonderful people. A special bonus has been the quality and dedication of the people we encountered, both within our partner organizations and among the SCLC staff. In retrospect, this should not have been a surprise. The kinds of people who choose to work in public health are mission-driven and inspired to help others. That may be especially true in the case of tobacco control, because the problem is so serious, there are evidence-based strategies that can make a difference, and the tobacco industry has such a notorious history of duplicity. At a time when so many problems seem impossible to resolve and are fraught with controversy, smoking cessation is a refreshingly clear way to do the right

thing. I want to acknowledge my colleagues at SCLC and our dedicated partners. It continues to be an honor to work with you.

Overcoming barriers. It came as a surprise that despite widespread knowledge about the dangers of smoking and the benefits of quitting, smoking cessation was a low priority for many organizations and professionals. As we explored the reasons for this and developed ways of overcoming those barriers, we evolved two parallel strategies. In the case of organizations representing the bulk of clinicians, the major barriers were time pressures, reluctance to tackle the seemingly hopeless challenge of overcoming nicotine addiction, the stigma attached to smoking, and lack of skills to help smokers quit [1]. For many of these organizations, a two-part message proved helpful. Part one was that smoking cessation was so beneficial that not to help was an abandonment of professional responsibilities. Part two consisted of providing several different ways to help smokers quit. As regards those not able or willing to become smoking cessation experts, they could refer to a telephone quitline or?for some?to dedicated centers within their own health systems. Most clinical organizations were receptive to these arguments and worked with us to promote smoking cessation by their members. Paradoxically, one group of clinicians that were not as responsive were the internal medicine subspecialties most concerned with diseases caused by smoking: cardiology, pulmonology, and oncology, although the American College of Cardiology is now embarking on a promising program.

Overcoming barriers for organizations dealing with--or representing--behavioral health clients suffering with mental illness and/or substance use disorders, presented different challenges. Smoking has become increasingly concentrated within these populations. Yet a set of myths had prevented action to help clients quit. These myths included beliefs that they did not want to quit, could not quit, or that their underlying conditions would worsen as a result of quitting [2]. Three strategies proved helpful in securing buy-in: awareness of the huge toll smoking exerts, explaining the harm from second hand smoke exposure, and showing evidence that stopping smoking was not only feasible but also beneficial for their underlying conditions.

Continued progress brings new challenges. One of the great triumphs of the past half century has been the steady decline in smoking rates, which are now at modern lows for adults and youth [3]. In addition, smoking profiles have changed from being fairly evenly distributed across our population to becoming concentrated among vulnerable segments, mainly the ?have nots.? As a result, many well educated persons seldom have contact with a smoker beyond encounters in the street. So, despite the facts that there remain 37 million smokers and about 500,000 deaths annually from smoking [4], there is disproportionately little support for tobacco control. Most of the ?leaders? in our country feel that the problem has been solved, there is a notable absence of advocacy efforts compared with issues such as breast cancer or autism, and the topic suffers from stigma. For these reasons, SCLC has been trying to frame smoking cessation as a social justice issue.

An unanticipated benefit from the debate about electronic nicotine delivery devices (ENDS). The popularity and novelty of ENDS have sparked widespread interest, and polarized the tobacco control community. Do ENDS help or hinder smoking cessation efforts? Are they a gateway for youth to regular tobacco use or other substances? How harmful are they? SCLC has taken a ?wait and see? posture on ENDS, choosing to maintain our focus on the deadly combustible cigarette, although I have composed some thoughts on ENDS [5]. The positive benefit from the controversy is that it made smoking newsworthy; responsible reporting has to include the stark realities about combustible tobacco use. Thus, the dangers from smoking have received renewed attention. I would argue that as a society we are moving

toward a tobacco tipping point, although that movement is more evident in states like California, New York and Massachusetts than the ?Tobacco Nation? of the southeast [6] part of the country.

Looking ahead.

For my part, I intend to focus on two major activities for the near future. One is to sustain our efforts, relying on the energy and commitment of SCLC staff and our amazing partners. A special target will continue to be the behavioral health population, and we have high hopes for the effort we launched with the American Cancer Society: The National Partnership on Behavioral Health and Tobacco Use [7]. The other activity is to secure resources so that the SCLC can continue to help smokers quit. We have already made progress in that regard, and are optimistic about our future. During my long career, I have been fortunate to have had many wonderful jobs that provided opportunities to improve health and health care. In many ways, working at the SCLC has been the most gratifying, and for that I am very thankful. Our work continues to be informed by those working in the field, and we will continue to welcome your suggestions about directions our Center should take.

My hope is that someday smoking cessation efforts will be seen as archaic as iron lungs to treat polio patients. But there are still 37 million smokers, and what we do will continue to be an important component of public health for the foreseeable future.

*For those who would like more details, please refer to a two part series about the SCLC in the Journal of Psychoactive Drugs (Part 1 [8], Part 2 [9]).

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