YOUTH SMOKING IN CALIFORNIA A CONFLICT ASSESSMENT FOR
COLLABORATION

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B.A., California Polytechnic State University, 2007

THESIS

Submitted in partial satisfaction of
the requirements for the degree of

MASTER OF PUBLIC POLICY AND ADMINISTRATION

at

CALIFORNIA STATE UNIVERSITY, SACRAMENTO

SPRING
2011

YOUTH SMOKING IN CALIFORNIA A CONFLICT ASSESSMENT FOR
COLLABORATION

A Thesis

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Abstract

of

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Many organizations and public agencies in California invest in efforts to reduce

youth smoking. Collaborations across these organizations do exist, however, there is no

formal partnership that involves all relevant and powerful stakeholders, including those

that realize an economic gain from smoking. Excluding these stakeholders from

collaborative efforts neglects best practices established for successful collaborations and

policy solutions. This project conducts a conflict assessment to determine whether a

formal collaboration is appropriate to address youth smoking in California. By

interviewing many stakeholders, including those who profit from tobacco consumption,

the project identifies areas of common ground and assesses the likelihood of

stakeholders' willingness to work together. While substantial areas of common ground

exist, a collaborative process would not be appropriate at the current time because

primary stakeholders are unavailable or unwilling to participate in such a process. The

project concludes with recommendations to address some barriers that exist. This

includes workshops between stakeholders of similar interests to begin discussing the

importance of interest-based negotiation and collaboration. Until all primary stakeholders

are willing to engage, a collaboration is not feasible, however such workshops could

assist stakeholders in preparing for the potential of collaboration.

_____ , Committee Chair
William D. Leach, Ph.D.

_____
Date

DEDICATION

I would like to dedicate this thesis to my husband, who demonstrated extreme patience, support and love throughout this process, to my mother, who forced me to go to graduate school kicking and screaming. Thanks mom, for always pushing me to be better. I would also like to thank the faculty in the MPPA program, in particular William Leach and David Booher. Your guidance was so helpful, and I would not have been able to complete this without your assistance. Here is to the MPPA class of 2011! It has been quite a ride, but we made it!

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Chapter 1

INTRODUCTION AND BACKGROUND

As the problem of youth smoking continues to be a concern for Californians, this project seeks to assess the appropriateness of collaboration to engage all stakeholders and design effective intervention strategies. The project consists of a review of the literature on public health collaboratives, a description of the methods used for conducting a conflict assessment, and a detailed assessment of various stakeholder interests and readiness for collaboration. For the purposes of this project, the term "youth" refers to those under the age of 18.

The majority of data available regarding youth smoking is from public health departments and non-profit health organizations. It should be noted that stakeholder interviews identified discrepancies with certain aspects of this data. The purpose of this section is to identify available information on smoking prevalence in California; however, it is not intended to substantiate the validity of this information. The necessity of joint fact-finding to establish common agreement on facts is a pivotal recommendation from this project and is discussed in following sections.

Tobacco control has a broad history in California. Since its inception in 1988, the California Tobacco Control Program (CTCP) has documented a decrease in overall tobacco consumption. According to CTCP, the prevalence of adult smoking has declined by 35% and per-capita consumption of cigarettes declined by 60.8%. These declines are varied, however, and fluctuations in cigarette consumption continue to occur. CTCP

identified an increase from 13.2% in 2004 to 15.4% in 2006 for 30-day smoking

prevalence among California high school students (CTCP, 2009, p. 1).

In 2010, the American Lung Association (ALA) found that 14.6% of California

high school students smoke (an estimated 2% higher than adult smoking prevalence), and

6% of California middle school students smoke. The national average of high school

smokers is 19.5%, middle school 5.2%. ALA estimates that the costs of healthcare

services related to smoking in California is $18.1 billion, based on health care

expenditure figures from 2004 and productivity losses from 2000-2004 (ALA, 2010, pp.

45, 55).

California was one of the first states to pass legislation aimed to limit the amount

of youth and adult smoking. However, it was not until 1986 when the Surgeon General of

the United States officially recognized cigarette smoke as a significant health risk

(Gilpin, Farkas, Emery, Ake, & Pierce, 2002, p. 1). As the next section highlights,

California's cigarette tax remains at the 1999 level of $.87 per pack and stakeholders

differ widely on the importance of excise taxes.

To address the lack of tax increases, the American Cancer Society, the American

Lung Association, the American Heart Association and other partners recently worked to

create an initiative. In the next election, California voters will voice their opinion on the

California Cancer Research Act. This act proposes a $1 per pack increase in California's

cigarette tax to raise funds for cancer research and prevention programs. This measure is

also designed to increase funding for research on heart disease, emphysema and a variety of other tobacco-related diseases (California Healthline, 2010, p. 1).

The potential passage of the California Cancer Research Act would influence the implementation efforts of a potential collaboration and could further polarize health advocates from industries. Passage is not a determinant factor of collaborative success or failure, but could put up a substantial hurdle to reaching common ground.

Regardless of current and future disagreement between stakeholders, the purpose of this project is to include the voices of all stakeholders to assess their approaches in reducing youth smoking. Collaboration in the public health field is a common approach to reduce smoking and other health concerns, but such collaborations usually lack input from all stakeholders. Without including necessary representation, policy decisions risk failure and can create further divisiveness between stakeholder groups (Ansell & Gash, 2008, p. 556).

While the tobacco industry is often portrayed in a negative light, certain companies focus a great deal of resources to reduce youth smoking and are active in youth prevention. For example, Philip Morris established a Youth Smoking Prevention department that performs research on youth consumption and designs strategies for reduction. Philip Morris is also responsible for the "We Card" campaign, which notifies consumers that retailers require identification. In addition, Philip Morris launched the "Talk. They'll Listen" campaign to encourage parents to talk about the dangers of smoking with their kids (Philip Morris, n.d.). Criticisms of such campaigns include the

targeting of parent responsibility and legality of underage smoking, without accurately portraying the health risks associated with smoking (Landman, Ling, & Glantz, 2002, p. 917). Health representatives also criticize such programs as efforts by the tobacco industry to avoid future legislation (Ling, Landman, & Glantz, 2002, p. 4).

The tobacco industry has approached health and youth organizations, such as 4-H clubs and the Boys and Girls Club, requesting partnerships and offering funding. For example, in 1998, Philip Morris approached representatives from 4-H and offered a grant to fund a youth smoking prevention program, which 4-H accepted. Following the announcement of this partnership, 4-H received an influx of protests from the American Lung Association, the American Heart Association, the American Cancer Society, Americans for Nonsmokers Rights, the American Medical Association, and the National Center for Tobacco Free Kids. In response, 4-H clubs in 27 out of 50 states rejected participation. The National 4-H organization, however, continues its partnership with Philip Morris (Landman, 2002, p. 921).

In response to additional partnership requests to public agencies, the Centers for Disease Control (CDC) released guidelines for collaborating with tobacco companies and other private entities. These guidelines ultimately urged the need to review each partnership request at the level it is made. The recommendations are quite general, but they do place a large emphasis on evaluating how collaborations with private industries impact the mission and the values of the particular public agency (Centers for Disease Control, n.d. p. 1).

The relationship between stakeholders regarding youth smoking is complex. This is largely related to the divisiveness between health organizations and the tobacco industry and the disagreement on smoking policies. Additionally, these relationships emerged through a robust history of tobacco control in California. A chronological discussion of legislation and tax increases beginning in 1988 is provided below.

History of Tobacco Regulation in California, 1988-2011

In 1988, through a citizen-led effort, The California Tobacco Tax and Health Promotion Act (Proposition 99) was placed on the ballot and approved by voters (California Tobacco Control Program [CTCP], 2009, p. 1). During this time, smoking was popular and widespread. For example: health care providers were permitted to smoke while in emergency rooms and while conducting patient exams; teachers were permitted to smoke in hallways between classes; students were provided smoking areas; and smoking was legal in all public locations (California Department of Public Health, 2009, p. 1).

Proposition 99 increased the cigarette tax from $.10 to $.35 per pack. This was the first comprehensive tobacco legislation passed in the United States. The legislation also placed a tax of $.42 on non-cigarette tobacco products. Twenty percent of the revenue from these taxes was dedicated to tobacco reduction efforts (Bal, Lloyd, Roeseler, & Shimizu, 2001, p. 69). Proposition 99 also created the California Tobacco Control Program (CTCP) under the California Department of Public Health (CDPH).

CTCP's ultimate goal is to reduce the occurrence of smoking-related deaths in California (CTCP, 2009, p. 1). The initial focus of CTCP only included smokers, not those affected by second-hand smoke. This changed following the 1992 release of the United States Environmental Protection Agency's (EPA) report on second-hand smoke and the dangers of inhalation.

The Legislature passed the California Breast Cancer Act in 1993, which raised the cigarette tax by an additional $.02 per pack to $.37 effective January 1, 1994. Funds generated by the Act were intended to fund breast cancer research and early breast cancer detection services for uninsured and underinsured women (Taylor, 2006). The Legislature also passed Assembly Bill 13 in 1994, which mandated clean air in workplaces. This was expanded to include restaurants, clubs, and bars in 1998 (Gilpin et al., 2002, p. 1).

An additional report, published by the EPA and circulated by the National Cancer Institute (NCI) in 1995, contained the first indication that second-hand smoke caused cancer and heart disease and contributed to respiratory and morbidity in youth (Gilpin et al., 2002, p. 1).

On November 23, 1998, the attorneys general and the four major tobacco companies agreed to a Master Settlement Agreement (MSA). The MSA required the companies to provide funding to 46 states and the District of Columbia to offset health costs related to smoking. The MSA required the tobacco companies to pay states $206 billion over a 25-year period (Sung, Hu, Ong, Keeler, & Sheu, 2005, p. 1030). While the MSA was designed to reduce the burden of health costs on states, the Agreement did not

require states to spend the money on smoking prevention and control. In fact, states could spend this money in any way they desired, including purchasing tobacco securitization bonds and offsetting state budgetary debts (Johnson, 2004, pp. 113-121). Philip Morris, however, maintains that the funds should be directed at smoking reduction efforts (Philip Morris, n.d.).

Following the MSA, California voters passed Proposition 10, the California Children and Families First Act, in 1999. Proposition 10 increased the state excise tax on cigarettes from $.37 to $.87 per pack. Revenues raised from this tax were earmarked for early childhood development programs (Taylor, 2006).

As California entered the new millennium, it rivaled as one of the most aggressive states in challenging smoking. While disagreement is clear on the necessity to change this, California is one of only six states that has not increased its cigarette tax since 1999. Again, the next election holds the potential to alter this with the California Cancer Research Act. According to the American Lung Association (ALA), California's national ranking for comprehensive tobacco control declined substantially in the past decade. The data cited in the following section admittedly lacks appropriate representation from industry. Again, the need for further research in this area will be addressed in the following sections. The information provides a particular stakeholder view on how California compares to other states.

How California Compares to Other States

Each year, the ALA releases an annual Tobacco Control Report which grades states on smoke-free air laws, cigarette tax rates, funding for tobacco prevention, and control and access to cessation treatments and services for those who want to quit smoking. During stakeholder interviews, some concern was expressed that the report card did not capture much of the work being done in California to address youth smoking. The report does, however, provide an interesting look at comparable ratings between California and other states.

In the 2010 report, California scored a D for cigarette tax, an A for smoke-free air, and Fs for both program spending and cessation coverage. The discussion below identifies how California compares to other states in the nation according to this report.

Smoke-free air laws represent a common policy choice in the nation. The grading system used by the ALA reflected criteria developed by the National Cancer Institute, with additional modifications, to reflect political changes and the current environment. As discussed, California does not permit smoking in public restaurants and workplaces and it received an A for this category. Twenty-five other states received an A, seven states received a B, five states received a C, two states received a D, and 12 states received an F.

Regarding cigarette taxes per pack, states with cigarette excise taxes above $2.90 received an A (five states), $2.899-$2.175 received a B (five states), $2.1749-$1.45 received a C (13 states), $1.449-$0.725 received a D (13 states), and states with taxes

below $0.725 received an F (15 states). At $0.87 per pack, California ranks 33rd in the United States. New York charges $4.35 in excise tax for a pack of 20 cigarettes, the highest in the nation. Missouri ranks the lowest, charging only $.17 (p. 55).

The ALA based grades for tobacco control funding on the Centers for Disease Control's 2007 version of Best Practices for Comprehensive Tobacco Control Programs. The CDC recommends that comprehensive state programs maintain five components: State and Community Interventions, Health Communication Interventions, Cessation Interventions, Surveillance and Evaluation, and Administration and Management. In addition, the CDC recommends appropriate funding levels to sustain a comprehensive program. This funding level accounts for numerous state factors such as prevalence of tobacco use, the cost and complexity of conducting mass media outreach and the amount of the population that is insured (p. 35). States received an A if their funding was 80% or higher than CDC recommended levels (two states), a B for 79-70% (two states), a C for 69-60% (three states), a D for 59-50% (three states), and an F for under 50% (41 states). The CDC recommended funding level for California is $441,900,000, and with a fiscal year 2010/2011 allocation of $89,695,605, California is at 20% of the recommended level and therefore received an F (p. 55).

Grades for cessation coverage included the categories of Medicaid coverage of cessation treatments, state employee health plan coverage of cessation services, and the investment per smoker for the "quitline." "Quitlines" are toll free phone numbers available for smokers to receive cessation services that were a new addition to the 2010

ALA report. They are especially important to smokers in rural areas who do not have access to other cessation programs (pp. 11, 39). There were not any states that received an A in this area, one state received a B, five states received a C, eight states received a D and 37 states received an F. California received an F in this category, primarily based on the variability of health plan coverage for cessation services and the low amount of investment per individual ($.87 versus the CDC recommended level of $10.53).

The history of California tobacco control provides insight on the varying levels of action in the state. However, legislation is not the only tool utilized to address youth smoking. As discussed, community-based collaborations are often initiated to engage stakeholders with common goals. The following section provides a literature review on varying collaborative approaches to address youth smoking and other risky behaviors.

Chapter 2

REVIEW OF LITERATURE

Many agencies in the United States apply collaborative methods to address public health concerns. Literary discussions on collaborative practices on the subject matter focus on three themes: examples of collaboratives established to address public health concerns, the measurement techniques used to evaluate the success of the collaboratives, and theories used to justify the utilization of collaboration and measure network strength. A network is a group of individuals or organizations engaging or interacting with each other. Network Analysis collects and analyzes data on these networks to determine strength and common characteristics (Provan, Veazie, Staten, & Teifel-Shone, 2005, p. 605).

The following review provides details of these emerging themes. The first section presents a short summary of best practices for collaboration and conflict assessment. The second section focuses on various collaboratives and coalitions aimed at reducing tobacco consumption and other behaviors that contribute to chronic health conditions or overall public health concerns. The third section reviews measurement tools researchers have identified to understand how the success and failure of collaboratives emerge. The fourth section provides a detailed theoretical understanding of why daunting and pervasive health problems often are well suited for a collaborative or network approach.

Best Practices in Collaboration and Conflict Assessment

Collaboration is an emerging technique to address problems deeply entrenched

and highly complex. These problems are often termed wicked problems, as a consensus

on even the nature of the problem does not exist. Objectivity is typically absent from

these problems and it is almost impossible for an expert to know what a good decision

entails (Innes & Booher, 2010, p.1). When facing wicked problems, collaboration offers a

venue to begin dialogue that previously remained siloed.

An essential element in collaboration is authentic dialogue. Stakeholders are often

accustomed to concealing their interests and stand-by positions. Authentic dialogue

entails creating an open space where stakeholders may express their true interests without

feeling the need to stand by ritualized positions (Inness & Booher, 2003, p. 37).

The prerequisite for authentic dialogue is coupled with the importance of

inclusiveness needed for collaboration. To secure a balance of power and representation,

advocates for all relevant stakeholders must be present. Such advocates must also have

the ability and knowledge to accurately represent the views of their constituencies

(Firehock, 2011, p. 7).

Another common element that emerges in both the assessment and collaboration

processes is the need for joint fact-finding. Often, stakeholders stand by facts assumed to

be accurate based on their involvement with an organization or personal views and

experiences. Knowledge is commonly considered scientific expertise in Western

societies. Collaboration expands this to include knowledge that is interpretative and based

on individual experiences (Innes & Booher, 2010, p. 17). Early stages of collaboration include education exercises aimed at creating common knowledge for the group. This may consist of bringing in outside experts and listening to each stakeholder to identify discrepancies in knowledge (Firehock, 2011, p. 7).

Another key element to collaborative governance is interdependence between stakeholders. When stakeholders must rely and depend on each other to attain a common goal, collaboration achieves higher effectiveness (Ansell & Gash, 2008, p. 560). Interdependence also speaks to the motivation stakeholders need to engage with each other. If the stakeholders are not interdependent, they may see little opportunity to collaborate (Innes & Booher, 2010, p. 7).

The purpose of a conflict assessment is to uncover the aspects just identified. Susskind, McKearnans, and Thomas-Larmer (1999) explain the necessity and best practices of a conflict assessment in detail. The process is typically conducted by a neutral assessor and seeks to identify key stakeholder issues and potential areas for common ground (p. 68). During this process, the assessor has the ability to explain the collaboration process to stakeholders and respond to questions privately (p. 104).

Engaging in collaboration without a conflict assessment has inherent risks of failure with perhaps the largest risk in neglecting to include all stakeholders. If a collaboration convenes without full representation, the entire legitimacy and success of the collaboration could be undermined (Susskind et al., 1999, p. 105). This refers back to

the notion of excluding powerful stakeholders with the ability to make or break a policy decision.

The assessment process also allows the assessor to identify the issues where conflict exists. Without this process, the collaboration might not address the correct issues and, therefore, will not alleviate conflict. Collaboration is not always an appropriate venue to address policy concerns, and the conflict assessment makes this determination (Susskind et al., 1999, p. 105). Chapter 3 outlines the steps utilized in this conflict assessment based on established best practices.

Examples of Public Health Collaboration

Collaboration is a common tool for addressing public health concerns, such as youth smoking, because the effects are often widespread and involve many stakeholders. The problems are complex and cannot solely be solved by one organization; they instead require a diversity of participation and research (Lasker & Weiss, 2003, p. 15). Some examples of collaborative efforts throughout the country aimed to alter public health are identified in this section.

Wandersman and Florin (2003) identified two forms of collaboratives in their work, research-driven and community-driven. Research-driven collaboratives are typically funded by federal agencies or national non-profit health organizations and are highly scientific and expensive. The more common form of collaboratives is community-driven. Community-driven prevention is operated at a local level and involves a large portion of the community including schools, businesses, and churches (p. 442).

Wandersman and Florin (2003) provided examples of both prevention strategies. The Midwestern Prevention Project is an example of research-driven collaboration, as it was a six-year study that incorporated several components (media influence, school-based social skills training for youth, programs for parents, and changing local ordinances). These strategies were aimed at reducing youth access to tobacco, marijuana, and alcohol (Wandersman & Florin, 2003, p. 443). Results indicated that the rates of alcohol, cigarette, and marijuana use for adolescents were lower when tested after one year. After three years, effects were found for high- and low-risk adolescents on 30-day prevalence rates for cigarette and marijuana use, but not alcohol (Wandersman & Florin, 2003, p. 444)

In addition, Project Northland and the Prevention of Alcohol Trauma were both research-based collaborative efforts. Project Northland created a community-wide task force aimed at changing school curriculum to reduce alcohol use. The Prevention of Alcohol and Trauma was a five-year community trial that sought to mobilize the community, provide education and training of bar staff to increase responsible serving, and enhance the use of local laws to reduce intoxicated driving. The analysis demonstrated that the change in social behavior and acceptability resulted in less support for alcohol use (Wandersman & Florin, 2003, p. 444).

Examples of community-driven prevention include the Hampton Healthy Families Partnership, which included public libraries, public schools, the United Way, and neighborhood organizations to increase the safety and health of youth pregnancies. In

addition, the Saving Lives Program implemented in Massachusetts united community coalitions, multiple city departments, and private citizens to engage in activities to reduce drunk driving and speeding. This coalition also reviewed patterns in youth tobacco consumption by different age groups (Wandersman & Florin, 2003, p. 445). The results of this coalition included reduced pregnancy risk and birth complications. Tobacco consumption results were not reported.

The overall results reported by Wandersman and Florin (2003) included many successful community-level interventions. Unfortunately, more inclusive reviews of community-level interventions did not demonstrate the same level of success. To increase achievement, the authors recommend a greater focus on prevention science and the use of different models focused on accountability and technical assistance (Wandersman & Florin, 2003, p. 1). They reinforce the necessity to bridge the current gap between science and prevention and make this information more accessible and useful to communities (p. 9). The examples of research-driven prevention did result in positive outcomes; however, these interventions are very expensive and rare (Wandersman & Florin, 2003, p. 2). The authors focused on strategies communities are able to utilize to keep costs manageable yet still achieve favorable results.

Narrowing the focus to a specific health behavior, Carver et al. (2003) explored the relationship between government and non-profit organizations in reducing tobacco consumption. They reviewed a case study of the Partnership for a Healthy Mississippi (PHM). This partnership was formed in 1997 following a court hearing that ordered the

tobacco industry to provide $62 million for a comprehensive pilot project designed to reduce youth tobacco consumption. Mississippi's Attorney General at the time, Mike Moore, spearheaded the coalition. Moore invited a variety of stakeholders including health non-profits, physicians and nurses, law enforcement, youth groups, and local businesses.

Four meetings were hosted and an estimated 75 citizens formed four committees to develop goals and recommendations. The committees identified the following areas of focus: education, raising awareness, advocacy, service, enforcement, and research (Carver et al., 2003, pp. 187-191). Overall, the actions by the committees resulted in a reduction of tobacco use. In a nationwide survey, Mississippi was below the national average for current cigarette smokers and had a lower count of smokers than several neighboring states. From 1999-2000, 12,235 fewer students between grades 6 and 12 used tobacco (Carver et al., 2003, p. 191).

Broadening the research to include multiple communities addressing a variety public health concerns, Schulz et al. (2001) performed a case study of the East Side Village Health Worker Partnership in Detroit, Michigan. This was a community-based research effort to identify social determinants of health in Detroit's east side (p. 549). Funded by the Center for Disease Control and the Detroit Community-Academic Urban Research Center, the project included over 40 community residents and a steering committee compiled of representatives from a variety of community-based organizations, health agencies, and academic institutions.

The partnership aimed to address many levels of public health in the community including issuance of information, providing referrals and assistance for the promotion of positive health behavior, conducting activities that created constructive and supportive relationships, advocating for organizational changes to allow more health services, increasing accessibility to health services, and working toward community-wide change (Schulz et al., 2001, p. 550).

The authors reported several improvements in research methods including the development of a context-specific stress practice-model, the implementation of a community survey, and the interpretation and dissemination of these results. Additional improvements included practice activities such as integrating social context and health and improving community relationships through strengthening networks between health workers, the community, and the steering committee (Schulz et al., 2001, p. 552). The purpose of this study was to measure the effectiveness of these improvement areas; however, it did not discuss the overall effects of the partnership on the community. It is unclear if this partnership improved health in Detroit.

On a federal level, calls for collaboration are also emerging. Following the passage of the Patient Protection and Affordable Care Act (PPACA), Kathleen Sebelius, Secretary of the Department of Health and Human Services (HHS), called for a comprehensive strategic plan to address tobacco consumption at the federal, state, and local levels. In 2010, HHS released a report titled: *Ending the Tobacco Epidemic: A Tobacco Control Strategic Action Plan* for the U.S. Department of Health and Human

Services. By convening 20 federal agencies and offices, HSS created a working group with four subcommittees focused on tobacco-use cessation and treatment, prevention policies, education and communication, surveillance and monitoring, and tobacco regulation (p. 8).

The working group agreed that its plan should accelerate progress in reducing tobacco use; be bold and innovative; be evidence-based and achieve a large-scale public health impact; engage all HHS agencies in a collaborative, department-wide strategy; be operationally feasible; start immediately; and bolster and support tobacco-control plans at the local, state, federal, and international levels (HHS, 2010, p. 8). The plan calls on action, not only by HHS, but encourages collaboration at the state and local levels, as well, with both public and non-profit partners (HHS, 2010, pp. 5, 20). Results of this plan will emerge in subsequent years as communities begin implementation.

At a local level, the California Tobacco Control Program provides funding and oversight for collaborative efforts. The Tobacco-Use Prevention Education (TUPE) program provides funding for 6-12 grades for student education, activities designed for positive reinforcement, and smoking cessation and intervention activities. The goal of TUPE is to reduce youth tobacco use by providing resources to make healthy decisions. TUPE relies on collaboration with community-based tobacco control programs and works with parents, schools, and the community to form a comprehensive and cohesive network (California Department of Education, 2010, p. 1).

Every two years, TUPE is evaluated to determine its level of effectiveness in reducing youth tobacco use. Park, Dent, Abramsohn, Dietsch, and McCarthy (2006) performed a study to test overall effectiveness from 2003-2006. The study reviewed the motivations for students who smoke and the relationship between a student's desire to smoke and the number of his or her friends that smoke (both actual and perceived). These factors appear to increase as students transition from grade nine to grade 12. TUPE activities did reduce the rate of student tobacco use, while taking into account a variety of other variables including the school's socioeconomic status and other content-specific factors (p. 43).

Finally, some collaborative research has been dedicated to incorporating more diverse stakeholders from tobacco interests. In 1994, Reeve, Collins, Dukes, and Lynott discussed The Virginia Tobacco Communities Project. This project addressed the often-overlooked economic effects of tobacco policies on growers in states such as Virginia. The reliance of these communities on tobacco growing is staggering and changes in consumption carry very real threats to the livelihood of these communities (p. 1). The initial meeting for the project occurred in 1994 and included more than 40 participants. The topics discussed included prospects for tobacco, the importance and the need for agricultural diversification, and economic development. The following meeting addressed the level of support for economic diversification, identified both agricultural and community needs for diversification and economic development, and assessed the level of resources both individually and institutionally to develop greater leadership (pp. 4-5).

Two more meetings occurred and a set of recommendations were developed by four working groups and were presented to the Joint Legislative Study Committee on Alternative Strategies for Tobacco Farmers in 1995. The recommendations from the report included the need to improve both marketing and production of tobacco, accessibility to information on supplemental on-farm enterprises, the need for financing in small business developments, and the importance of education in targeted work sectors (Reeve et al., 1994, p. 9). While the recommendations were well received and endorsed by those at the town meeting, the project overall received very little attention from manufacturers and manufacturing unions (Reeve et al., 1994, pp. 9-12). The authors indicate that the need for non-traditional allies such as health organizations are essential to health promotions and warn against health organizations that maintain a single-minded approach against anything tobacco related (Reeve et al., 1994, p. 14).

As a fellow researcher in The Virginia Tobacco Communities Project, Franklin Dukes published a helpful manual for tobacco collaborations with his colleague, Madeleine Soloman (2004). This manual identifies the complexities and ongoing changes within tobacco coalitions, and offers guidance to leaders of tobacco coalitions on ways to productively engage conflict (p. 9).

<div align="center">Measuring Collaborative Efforts</div>

As a somewhat popular means to address public health concerns, the question of effectiveness and measurement for collaboration provides a challenge to researchers and communities alike. Investment in collaboration is often expensive and time-intensive. It

is important to identify whether the investments are warranted and how they should be implemented to maximize results (Lasker, Weiss, & Miller, 2001, p. 181; Pentz, 2000, p. 259).

Additionally, behavior modifications within a community often take time and are not quickly measurable following the completion of a collaborative process. With the growing popularity of collaboration to address public health concerns, the necessity to measure its effectiveness with empirical evidence grows as well (Roussos & Fawcett, 2000, pp. 370-374). The discussion below is intended to provide examples of research conducted to assess the effect of collaborative approaches in public health. It is not intended to provide an overall justification for collaboration, but rather to focus on the methods used and the current research to measure success.

Focusing on the necessity of leadership in collaborative partnerships, Alexander, Comfort, Weiner, and Bogue (2001) reviewed four health partnerships to identify themes in effective leadership. Four cases selected by the researchers participated in the Community Care Network (CNC), a non-profit organization that promotes collaboration and community participation to address public health concerns (CNC, 2011, para. 1). Conducting 115 interviews, the researchers identified five leadership themes that predicted successful collaborations:

- Theme One: Systems Thinking is the ability of a leader to understand that public health programs require comprehensive approaches. This often includes social, economic, cultural and environmental factors (p. 163).

- Theme Two: Vision-Based Leadership argues that, in order for a leader to be effective, he or she must have a strong vision that is communicable to participants. Given that participation in collaboration is often voluntary, a strong vision assists participants in staying focused on the purpose (p. 165).

- Theme Three: Collateral Leadership is ensuring that leadership is broad. The sources of collateral leadership include partnership staff, organizational representatives, and community advocates (p. 166).

- Theme Four: Power Sharing is forming joint responsibility and empowerment. Again, due the voluntary nature of collaboration and the common absence of a legislative mandate, personal investment is necessary and must be facilitated by a leader (p. 168).

- Theme Five: Process-Based Leadership provides information on how a leader pursues his or her goal. Respondents indicated that a leader's ability to listen and communicate in the collaborative process is fundamental to achieve success (pp. 169-170).

Additional research on the success of collaborative efforts focuses on the changes in smoking behaviors in communities. A variety of community participation programs provide incentives for states to participate in prevention efforts. A common way to measure the effectiveness of these efforts is through interviews with community leaders and collaborative participants (Brown, Hawkins, Arthur, Abbott, & Van Horn, 2008; Francisco, Paine, & Fawcett, 1993; Lezi & Young, 2000; Snell-Johns, Imm,

Wandersman, & Claypoole, 2003). To assess the effectiveness of Alcohol, Tobacco and Other Drug (ADOT) prevention programs in South Carolina, Snell-Johns et al. (2003) reviewed meeting minutes from the Alcohol Abuse Coalition and interviewed staff and coalition members (p. 63).

Results from the ADOT study were not reported because it was premature to assess the environmental change. Initial positive outcomes did emerge including smoking reductions in schools with no-smoking policies and lower recidivism rates of students attending university-sanctioned events under the influence of drugs or alcohol. Following the implementation of the "Safe on the Lake Campaign," accidents and fatalities also declined and the occurrence of illegal purchases of tobacco products were reduced (Snell-Johns et al., 2003, p. 668).

An additional way to assess success is through surveys to determine the effect of a collaborative's implementation strategy on a particular community (Butterfoss, Goodman, & Wandersman, 1996; Provan et al., 2004; Robins & Krakow, 2000; Taylor et al., 1998; Yin, Kaftarian, Yu, & Jansesn, 1997). Yin et al. (1997) reviewed the outcomes of the Center for Substance Abuse Prevention's (CSAP) Community Partnership. The researchers studied 24 participating communities and compared them to similar or partner communities that were not participating in CSAP. Surveys were utilized to assess the behavior of adults, 8th-graders and 10th-graders (p. 345). While the results were weak, some statistically significant indicators emerged that communities participating in CSAP presented lower prevalence of substance abuse.

Furlong, Casas, and Corral (1997) conducted a similar study to identify substance abuse changes in communities participating in the Substance Abuse Prevention Community Partnership Project. The study focused on adolescents in Santa Barbara County from 1991-1995 (p. 300). The North Santa Barbara County Prevention Coalition and the Multicultural Community Partnership administered the aforementioned CSAP prevention program in the county. By conducting both pre- and post-intervention surveys, the researchers found a decrease in the use of alcohol and a lower incidence of substance abuse. There was not, however, an indication of reduced tobacco consumption (p. 304).

Other studies utilize a broad approach to measure collaborative success. Lezin and Young (2000) took issue with the lack of studies on the implementation efforts of collaborations (p. 50). They reviewed the literature of coalition stages that determine success and identified two key stages. The first stage is pre-formation, or the initial starting point of a coalition. While they note that pre-planning is often not an option due to funding restrictions, it may enhance a coalition's ability to thrive during its first year. They suggest interviews to assess stakeholder availability and to identify potential barriers (p. 52).

The second stage, identified by Lezin and Young (2000), is formation. Recruiting members; setting formal rules and procedures; and defining roles, goals, and expectations were all noted as contributing to a collaborative's success. Forming a clear mission and having adequate community representation were also highlighted as necessities in the formation stage (Lezin & Young, 2000, p. 54).

Taking a more theoretical approach to measurement, an article by Goodman et al. (1998) sought to understand community capacity as a basis for measurement. They defined community capacity as characteristics of a community that influence its ability to identify, mobilize, and address social and public health problems. Community capacity also encompasses the use and communication of transferable knowledge, skills, systems and resources that have an affect on a community (p. 259). The article focused on a Centers for Disease Control-sponsored symposium aimed to understand how a community can build its capacity to address public health concerns. The symposium identified citizen participation, leadership, skills to engage productively, resource availability, social and interorganizational networks, sense of community, understanding of community history, community power, community values, and critical reflection as essential elements in community capacity-building (pp. 261-262). These provide measurement categories to determine a community's readiness for collaboration.

An additional article by Goodman, Wandersman, Dhinman, Imm, and Morrisey (1996) expanded on the notion of community readiness by proposing an ecological measurement approach. Since issues such as tobacco and alcohol consumption are complex, it is important to understand that multiple levels of intervention are often necessary. The authors identify a strategy called triangulation to determine if a community is moving forward effectively to address public health concerns. This strategy utilized three stages recommended for proposed collaboratives. Phase one is formation, phase two is plan implementation, and phase three is impact or durability. Each phase

includes measurement techniques geared to encompass a multifaceted approach to

understanding the complexity of changing individual behavior (pp. 40-53).

<div align="center">Theories of Collaboration Applied to Public Health</div>

As mentioned, the complexity of public health concerns often requires a broad

approach. The following section delves into the theoretical basis of network analysis

commonly used when justifying the use of collaboration. This section also provides

suggestions for measuring the strength and durability of a network.

Collaboration across networks is common for addressing tobacco control, as

organized networks often exist across state, national, and sometimes international

boundaries (Luke et al., 2010, p. 1290). Many researchers justify the use of collaboration

for public health concerns based on theories related to network analysis (Krauss et al.,

2004; Provan et al., 2004; Provan et al., 2005). Provan et al. (2005) defines network

analysis as a method for analyzing and collecting data from many different organizations

or individuals that interact (p. 605). Research on network analysis often focuses on the

strength of the networks by identifying the number of organizations involved and the

forms of communication utilized by the networks (Kraus, Mueller, & Luke, 2004; Provan

et al., 2004). This is also commonly referred to as a transdisciplinary approach, denoting

that network participants represent a variety of disciplines and backgrounds (Leischow et

al., 2008, p. 196).

Kraus et al. (2004) used a social network analysis to examine the tobacco control

efforts of five states. They were most interested in the frequency of contact with network

partners, flow of money, the productivity of relationships, and effectiveness of the network and improvement methods.

By conducting interviews with network participants and utilizing quantitative data collection (i.e., measuring the frequency of meetings or contact with other organizations), Kraus et al. (2004) identified patterns in the five observed networks. In most cases, the lead agency had the most control over communication flow and the network structure was hierarchical (Kraus et al., 2004, p. 6). Additionally, lead agencies had the greatest control over flow of money and finances. The researchers also uncovered a link between higher productivity and open communication (Kraus et al., 2004, pp. 8-9). Somewhat surprisingly, their research did not find a strong relationship between network funding and success. It appears that other factors, such as frequent and open communication and geographical closeness, were more direct determinants of accomplishment in this particular case (Kraus et al., 2004, p. 9).

Provan et al. (2005) also used a network analysis to identify methods to strengthen community partnerships. Utilizing research conducted at the University of Arizona's Southwest Center for Community Health Promotion on U.S.-Mexico border concerns, the authors compiled a list of eight questions to assist communities in building network strength with community partnerships (p. 606). The questions focused on the centrality of network participants, core organizations involved, personal relationships between network participants, strength of relationships, progress within communities, levels of trust, and benefits and drawbacks of collaboration (pp. 607-610).

In an effort to address fragmentation and the lack of empirical evidence supporting collaboration, Lasker and Weiss (2003) proposed a model of community health governance. The model argues that focusing on individual empowerment, bridging social ties, and creating synergy are all necessary outcomes needed to strengthen community problem-solving. Additionally, they argued that leadership and management are required to achieve community success (pp. 17-18). To increase individual empowerment, the model called for individuals within a community to be directly and actively involved in addressing problems that affect their lives. Bridging social ties involves breaking down previous community barriers to create a greater sense of community and build trust and support. Creating synergy relies on designing a collaborative process that combines the diverse forms of knowledge and skills needed to achieve success (p. 21).

This review of literature provides an overview of current research on the occurrence of collaboration to address public health concerns, measurements available to gauge success, and theoretical justifications of a network approach. While collaboration appears to be widespread, a gap exists between the engagement of the tobacco industry and others that directly profit from tobacco consumption as participants. Based on best practices, the exclusion is a significant area of research that deserves expansion. Noting the necessity to include all stakeholders to achieve durable results, this project aims to fill the current gap. The following proposal provides an outlined conflict assessment to

determine whether or not collaboration is an appropriate approach to address youth smoking in California.

Chapter 3

PROJECT METHODS

To address youth smoking in California and to identify policy options for future success, this section discusses the methods of this project and the conflict assessment performed to understand the possible effectiveness of collaboration. Collaborative governance offers the unique opportunity to design and implement effective policy. By working around traditional power structures of policymaking, collaboration offers an opportunity for solutions by including a group of diverse stakeholders committed to achieving a common goal (Firehock, 2011, p. 7). To establish and achieve this objective, a structured forum is utilized. This forum is typically initiated by public agencies and includes a wide range of non-state actors. The discussion is intended to empower stakeholders to create policy and consensus (Ansell & Gash, 2008, pp. 544-545).

To determine the appropriateness of a formal collaboration for the incidence of youth smoking in California, this section discusses the six phases used in this conflict assessment: identifying stakeholders, outlining interviews, arranging and conducting the interviews, reporting findings, proposing recommendations, and distributing the final assessment (Susskind et al., 1999). The detailed findings for each phase are discussed in Chapter 4 of this report.

Stakeholders handled the interview questions very differently. Some answered questions individually and gave succinct responses. Others explained a variety of other issues and details surrounding the question itself. Seven interviews were conducted via

telephone, two were conducted in person, and two stakeholders opted to complete the questions via e-mail. In-person interviews were the preferable option; however, many stakeholders were in other areas of the state or country.

Phase One

Based on research and informal stakeholder discussions, an initial list was prepared to identify specific stakeholders to contact for interviews. While this originally began with a preliminary list, other relevant stakeholders were identified in the interview process (Susskind et al., 1999, p. 108). Due to confidentiality, the names of organizations and individuals interviewed for this project are not disclosed. The four categories of initial stakeholder interviews included representatives from: health organizations, public health, the tobacco industry, and the education field.

Following a selection of the stakeholders, an invitation letter was sent to all potential interviewees **(**see Appendix A**)** explaining the request and the process (Susskind et al., 1999, p. 108). To ensure both smooth operation and content coverage, a protocol for the interviews was designed. This protocol included a list of questions for all stakeholders (see Appendix B). Each stakeholder to be interviewed signed a consent form for participating in research (see Appendix C).

The selection of stakeholders is a difficult process; however, it is essential that all deal-breakers are included at the table. The exclusion of powerful stakeholders risks the destruction of any agreement (Innes & Booher, 2003, p. 40). Unfortunately, certain powerful stakeholders were not available for interviews in this process. This inhibited the

ability to gather necessary input and generate a comprehensive understanding of
stakeholder interests.

Phase Two

In this phase of the conflict assessment, each stakeholder was interviewed. The
interviews began with the key stakeholders central to the collaboration and expanded to
include additional potential stakeholders. It was important for the interview to maintain
structure, but also to allow the interviewee flexibility with the discussion. Following each
interview, a written summary was provided to the interviewee to ensure that all topics
were understood correctly (Susskind et al., 1999, p. 115).

Phase Three

After completing stakeholder interviews, the findings were analyzed by reviewing
all the interview summaries and identifying each stakeholder's interests and concerns
(Susskind et al., 1999, p. 116). In this process, the stakeholders' positions were separated
from their interests. Oftentimes, stakeholders feel they must conceal their interests and
instead stand by positions, while avoiding an authentic dialogue on why they felt a
particular way (Inness & Booher, 2003, p. 37). By uncovering stakeholder interests,
potential areas for common ground were identified. To assist in outlining these common
areas of agreement and disagreement, a matrix was utilized (Susskind et al., 1999, p.
117). This matrix is provided in Appendix D and discussed in Chapter 4.

After mapping the interests from stakeholder interviews and identifying areas of
mutual gain, a conclusion was reached on the appropriateness of the collaboration for the

concerns of youth smoking in California. For this decision, the Center for Collaborative Policy's (CCP) *Conditions Favorable to Initiate a Collaborative Process* were utilized (CCP, n.d.). Each condition is described below in the context of its use for this assessment:

A. Issues Do Not Focus on Constitutional Rights Or Very Basic Societal Values: If stakeholders were focused on rights or values, such as the morality of youth smoking or the constitutionality of interventions, collaboration would likely not be an appropriate venue.

B. Potential Areas for Agreement: Multiple Issues for Trade-Offs: The assessment uncovers areas where common ground might exist. This is important to know for a collaboration.

C. Primary Parties are Identifiable and Will Participate: The issue of youth tobacco consumption includes highly adversarial stakeholders, such as health organizations and the tobacco industry. If these parties were not willing to participate and work together, collaboration would not be appropriate.

D. Each Party Has a Legitimate Spokesperson: Each group must be fairly represented at the table. It was essential that less representative groups have an appropriate representative who could accurately communicate the concerns of their constituency.

E. Potential Deal-Breakers are at the Table: If health organizations and the tobacco industry were not included in the collaboration, these powerful groups could limit the success of implementation.

F. No Party Has Assurance of a Much Better Deal Elsewhere: Other areas, such as legislation, were identified that could provide a remedy or opportunity for success outside of collaboration. If there was a better deal for stakeholders, collaboration would not be worth the time and resources.

G. Parties Anticipate Future Dealings With Each Other: Once a collaboration is completed, stakeholders would need to work together in the future to ensure successful implementation. Assessing the likelihood of this was a necessary element in the process.

H. Relative Balance of Power Among the Parties: Ensuring that each stakeholder had legitimate and accurate representation was essential to this assessment. It is necessary there be a level playing field where no one entity dominates the discussion.

I. External Pressures to Reach Agreement: It was necessary to identify whether stakeholders faced pressure to reach consensus. Ideally, a common interest for all stakeholders would be to decrease youth smoking; however, the assessment sought to identify what pressures were exerted on stakeholders to reach a common approach.

J. Realistic Timeline for Completion: The stakeholders must be realistic in their efforts. It has taken almost two decades for tobacco-control to reach current levels, and stakeholders must understand that a solution will not occur overnight, but will instead require continued efforts.

K. Adequate Resources/Funding to Support Negotiations: If a collaboration convened, it would be necessary to identify a convener and a funding source.

Phase Four

It is not necessary for every condition to be entirely met; however, if a substantial hurdle is identified, it must be addressed in order to move forward. Pre-collaborative workshops have the potential to provide an opportunity to educate stakeholders on the process and to address any deficit conditions (CCP, 2004, p. 4.12). Examples of this include workshops on interest-based negotiations (Fisher & Ury, 1981, p. 10-11), the importance of representativeness and power balance, and education on how the collaborative process is preferable to other outlets, such as legislative or judicial. The assessment report identified necessary pre-collaborative efforts needed in order for the collaborative to occur.

Because this assessment does not recommend moving forward with a recommendation, Chapter 5 provides suggestions for potential workshops that could be useful for stakeholders in the future. Substantial barriers were uncovered that limit the possibility of collaboration and these must be addressed for any future hope that a collaboration could occur.

Chapter 4

RESULTS

This chapter reports the results garnered from stakeholder interviews. A total of

11 interviews were conducted with diverse stakeholders. Two individuals were

interviewed from one organization and are thus represented as one stakeholder. The

inability to interview a small selection of powerful stakeholders from tobacco companies

and certain large health organizations, which were either unavailable or unwilling to

participate, resulted in a limitation of the research. To protect confidentiality, the

identities of the stakeholders who did not contribute, as well as those interviewed, are

excluded from the report.

A significant number of stakeholders were available for interviews, and they

provided noteworthy information to assess the conflict and the appropriateness of

collaboration. To identify themes and the areas of common ground, interview responses

were coded. Based on themes that emerged from this coding, a matrix was utilized to

chart the results (Appendix D). A stakeholder's interest in a particular issue is designated

by an "X" in the matrix. After all stakeholder interviews were coded and their interests

were marked, areas of common ground were identified.

The major areas of common ground are discussed below. This is followed by a

review of the conditions outlined in Chapter 3 and an assessment on the appropriateness

of collaboration for this issue, based on the conditions and the areas of common ground.

Areas of Common Ground

Focus on Youth Early

Several stakeholders across the board expressed the need to focus on youth prevention at a young age. In one stakeholder's experience, many youth state they plan on quitting by the time they are 18 or 20 and do not seem to understand the difficulty in this. Other stakeholders discussed the difficulty of quitting later in life and emphasized the need to catch smokers before they become addicted.

Some stakeholders work with youth over a three-year period and their progress is monitored throughout high school. Others suggested raising the minimum age for sales or increasing the tobacco tax. While the approaches were quite different, this area did receive common interest from a diverse group of stakeholders.

Youth Education

Some stakeholders expressed a common focus of the need for smoking education in schools. This included certain public health organizations working with schools to ensure that tobacco education is a component of curriculum. Other stakeholders expressed their efforts to intervene early and track the progress of youth.

One stakeholder discussed efforts to ensure smoking bans on public school grounds. This stakeholder also highlighted schools as the ideal place to reach youth in large quantities to educate them and prevent them from smoking.

Changing Culture and Norms

Several stakeholders discussed elements of cultural norms that contribute to youth smoking. This was expressed in different ways, including home, school, and community. Regarding the culture at home, some stakeholders mentioned the power of emulation. One stakeholder stated,

> If positive examples are set by adults, there is less likelihood that younger people will smoke. The desire to be accepted by the peer group is also an important factor as to why young people smoke along with the desire to be rebellious – move against social norms.

Other stakeholders mentioned cultural barriers that create difficulties in reducing youth smoking. This included disparities within different cultural groups and challenges in accessing and educating diverse populations.

An additional element some stakeholders discussed was the need to align cultures in both schools and communities. This involves changing the norms as to what is considered acceptable, both within and outside school. One stakeholder commented,

> It is not just about education or community. It is also about school and community norms. These do not always match. Sometimes the norm in a school is that smoking is bad – however the norm in the community might not match (or vice-versa). Norms need to be aligned and consistent.

Other stakeholders expressed the difficulties in working within a community that does not have a culture focused on reducing youth smoking. It can be difficult when a

community does not think youth smoking should be something that deserves focus and resources.

Need for Research

Several stakeholders expressed the importance of the inclusion of science and research in the collaborative process. One stakeholder stated that in order to join a collaboration, they would want there to be an honest scientific discussion of the issues and not just emotion. Another stakeholder discussed the need for more accurate statistics on smoking patterns and the concern that current numbers are out of date.

Some stakeholders made reference to harm reduction alternatives as another area of research. For these stakeholders, harm reduction included smoking alternatives, such as electronic cigarettes and other smokeless tobacco products. They were concerned with the dismissal of scientific evidence in support of these alternatives and felt this was a disservice to the public. One stakeholder pointed to federal regulations that restrict tobacco manufacturers from saying that these alternatives are safer than smoking and felt that this action restricted the expression of accurate public health research.

Another group of stakeholders discussed the importance of current research such as surveys distributed to local youth to obtain information on their smoking habits. Based on the results of the surveys, certain stakeholders are able to focus their efforts on areas where a higher level of need has been identified. Stakeholders expressed the difficulties in measuring the effectiveness of school-based programs. There are many factors and

variables that affect a youth's decision to smoke; thus, it is difficult to isolate the results from a specific school-based program.

Allocation of Tobacco Revenue

Several stakeholders mentioned concerns with state reliance on tobacco revenue, as well as the tension between successful prevention programs decreasing funding for those very programs due to a reduction in smoking. Essentially, if these programs are successful at helping people quit smoking, revenue for the programs will decline.

Some stakeholders addressed the direction of funding from the Master Settlement Agreement specifically, and felt that this agreement had been abused. These stakeholders were also concerned that funding from prior legislation was not being directed at the intended population group initially targeted by the legislation. Concern was also discussed with the inconsistency of relying on tax revenue from smokers to support programs.

Other stakeholders involved in public health also recognized the dilemma in services being funded through tobacco revenue. In reality, if these stakeholders do their jobs to prevent smoking, they will lose revenue. Others did express the importance to focus the funding on prevention programs, as opposed to on unrelated issues such as the general fund.

Reduce Youth Smoking

Perhaps the most significant area of agreement discussed by all stakeholders was the importance of eliminating youth smoking. Stakeholders expressed this in various

ways. One stakeholder took a strong stand that smoking is an adult activity and their

organization does not condone anything illegal. Several other stakeholders took a more

active stance against youth smoking and discussed many ways their organizations work

to prevent and stop youth from smoking.

The specific strategies highlighted by stakeholders in this area are discussed in

other sections of this chapter, but it is important to note that all stakeholders expressed at

least some interest in eliminating youth smoking.

Focusing on Licensing and Sales

Some stakeholders focused on concerns with licensing and sales of tobacco

products to youth. One stakeholder stated that the dramatic reduction of smoking was

primarily a result of licensing requirements and the Stop Tobacco Access to Kids

Enforcement (STAKE Act). Representing tobacco interests, this stakeholder was

supportive and involved with the licensing act and said we are just now starting to see the

effectiveness of this law. The stakeholder continued to say that sometimes people do not

realize it takes years for laws to fully show their effectiveness.

Another stakeholder discussed varying levels of policies to reduce sales to minors.

This stakeholder was in favor of banning children from stores where tobacco is sold, but

thought that proposals to hide tobacco products completely in stores were overkill.

Other stakeholders discussed the importance of retail licensing laws that further

prohibit sales at certain distances from schools, which would include strengthening

current restrictions. Budget reductions for licensing programs were also mentioned as causing a reduction in staffing that has directly impacted enforcement of the STAKE Act.

One stakeholder discussed the need to reduce the amount of sales that occur through social sources. This includes family members purchasing cigarettes for their children. In certain communities, cultural barriers exist that create confusion in knowledge of the law. This particular stakeholder group works within their diverse community to educate families on the legality of selling.

Increased Cigarette Taxes

Many stakeholders from the health-related organizations expressed their support for further increases in tobacco taxes. These stakeholders maintain that tax increases are the single most effective way to decrease youth smoking. Many of those in support of tax increases specifically discussed the California Cancer Research Act and their hope that it passes. One stakeholder highlighted that much of the revenue from the new tax would go to research on prevention and funding for smoking cessation. This stakeholder emphasized the importance of this, as there has been earlier criticism that these taxes do not go to prevention.

One stakeholder stated that the tax in a state should be high enough only to reimburse the costs the state has to pay for the health affects of smoking. This stakeholder also stated that some states have gone overboard with their tax rates, and another stakeholder discussed concerns that higher tobacco tax rates create black markets for cigarettes, which typically have unregulated tobacco.

Youth Cessation Programs

Some stakeholders discussed the need for cessation programs especially designed for youth. One stakeholder brought up the necessity for cessation programs to be voluntary, as people must want to quit on their own. Unfortunately, not one youth that participated in the cessation program operated by this stakeholder has finished the program. Young people may state they want to quit, but the failure to complete the program may be an indicator otherwise.

Other stakeholders have initiated cessation programs where students may elect to participate, as opposed to suspension when they are caught smoking. The curriculum in this program is specifically designed for youth. These stakeholders often expressed the difficulties in promoting cessation for youth and for youth to understand the long-term impacts of smoking.

Evaluate the Fiscal Impacts of Policy Proposals

Some stakeholders expressed the need to discuss the fiscal impacts of policy proposals. One stakeholder organization stated they worked with policymakers to provide information on what the impacts and costs will be of a particular proposal. This stakeholder said costs are always more than what bureaucrats expect. To implement policies, it is costly to hire the people to act and enforce.

Other stakeholders mentioned unintended consequences of policy decisions. This includes the fiscal impacts of increases in tobacco taxes, as an increase in excise taxes

will result in less consumption. This could also affect the vendors that sell the products, and in some communities, this could create a problem for small businesses.

Address Disparities

Some stakeholders from diverse backgrounds discussed particular communities affected by smoking. Based on results from a survey, one stakeholder mentioned a shockingly high level of increased smoking in non-traditional schools in their area.

Others discussed the need for programs to focus on cultural diversity and linguistic appropriateness for each school and community. Many of the stakeholders interviewed resided in diverse areas and mentioned the cultural challenges in reaching residents to ensure they have accurate information and resources. Other stakeholders referred to the issue of menthol cigarettes and the disproportionate affect these have been said to have on African American communities.

Address Limited Resources

Some stakeholders referred to challenges they faced based on limited resources. The main resource issue discussed was that of budgets and financial restraints. One stakeholder explained that, due to limited resources, they focused their efforts on schools with higher incidents of youth smoking. This did not mean they were ignoring other schools with lower levels, but they needed to focus their resources.

Resources were also discussed as the reason for disagreement between stakeholders with similar goals. Budgetary cuts in California have generated concerns among these stakeholders on how to select what programs are going to be reduced or

eliminated. Inter-stakeholder conflict over the distribution of cigarette tax money was also mentioned as a previous resource concern.

Other Areas

Several other areas of interest were mentioned by stakeholders that would arise as areas of discussion in a collaborative process. Some of these areas would likely be a source of conflict; however, others might generate common ground. Below are some of the areas that emerged with a brief description of varying viewpoints expressed in stakeholder interviews.

The issue of smoking alternatives, such as electronic cigarettes and other smokeless tobacco products, is highly contentious among stakeholders. Some stakeholders maintain that the smoke in tobacco contains harmful components. They are interested in initiating the discussion of smoking alternatives and the scientific backing available for the products. These stakeholders maintain it would be better for the public to encourage and educate smokers that smoke-free tobacco provides a better alternative. One stakeholder stated,

> For the first time ever, the Industry is on the "right side of the public health movement." This is important for the industry; true also for larger commercial reasons. No one wants to put companies out of business if they have a product that benefits the public health community. If there is a safer alternative to smoking and if the industry is providing these products, adhering to established standards and protocols, they should be available.

Others are strongly opposed to any smoking alternatives. As one stakeholder discussed, there are a variety of other nicotine products such as candy-flavored orbs, discs, and strips. Speaking about these products in particular, this stakeholder stated that

the introduction of a new wave of tobacco delivery devices that do not look or function like cigarettes promote the perception, particularly among young people, that using such devices is socially acceptable because they do not emit tobacco smoke, and are not addictive and – probably the most damning claim – that they are safer than traditional cigarettes.

They find these products as an emerging area of concern.

It is important to note that both stakeholders above are discussing very different products. The take-away from this is that the topic of cigarette alternatives would almost certainly emerge in a collaborative discussion. Each alternative mentioned above would need to be discussed separately, as the products are extremely different.

Other areas of discussion that could potentially generate agreement among stakeholders include: the need for fairness, setting clear goals, concerns with unregulated tobacco, concerns with the creation of black markets, need for more grassroots advocacy, and the need to build partnerships and trust. While stakeholder interviews did not generate sufficient responses in these areas to definitively identify them as areas of common ground, they also do not preclude each other.

Conditions for Collaboration

Based on the results from stakeholder interviews, this section utilizes the criteria listed in Chapter 3 to analyze the appropriateness of collaboration. Below is a discussion of each condition with examples from stakeholder interviews.

Issues Do Not Focus on Constitutional Rights or Very Basic Societal Values

Overall, stakeholder interests regarding youth smoking in particular did not focus on constitutional rights or values. All stakeholders agreed that youth smoking should be prevented.

The purpose of this assessment was youth smoking; however, the general issue of smoking did emerge in several interviews and would arise in a collaborative setting. Those representing tobacco interests repeatedly explained their frustration with health advocates and the government focusing on eliminating smoking entirely. Some of these stakeholders did refer to an adult's right and choice to smoke. Health interests, however, did not dispute an adult's legal right to smoke, but did repeatedly emphasize the high prevalence of adults who begin smoking as youth.

While not a reason to abandon hopes of collaboration, it should be expected that a general discussion of the constitutional right of adults to smoke would arise. Stakeholders would need to discuss this and come to some form or agreement on the issue.

Potential Areas for Agreement: Multiple Issues for Trade-Offs

As demonstrated by the matrix and the above discussion, potential areas for agreement were uncovered in the assessment interviews. The most significant area of agreement is the necessity to prevent youth smoking.

The other areas which generated the most amount of agreement across stakeholders was the need for science as research, concerns with tobacco revenue spending on unrelated issues, reaching youth while they are young, the focus on licensing and sales, the need to change social and cultural norms, and the willingness to collaborate if certain conditions were met. Based on the diversity of stakeholders interviewed, these multiple areas of common ground offer hope for collaboration.

Primary Parties are Identifiable and Will Participate

The primary parties in this assessment were identifiable. Unfortunately, many primary parties were not willing to participate in the assessment, were unreachable, or were not available in the interview timeframe. Willingness and ability to participate is an essential condition for collaboration and, therefore, determines that, at the current time, a collaboration will not move forward.

This assessment found that public education stakeholders and the tobacco companies would not be engaged in a collaboration. While public education may one day be able to consider collaboration with representatives from the tobacco industry, it is not a feasible option at this time. Public education stakeholders maintain strict standards on not accepting tobacco funds and not supporting tobacco company youth education

programs. Collaborating with tobacco companies does not work well with these standards. These two stakeholders are considered primary parties, and without their participation, a collaboration would not be effective.

It is important to note that this assessment did not reveal that tobacco companies would not be willing to participate. Instead, the assessment found that most companies could not respond to unsolicited requests for interviews. Some company websites specifically indicate that student requests for interviews will not be granted. There is a possibility that if a request were to be made from a formal organization, these companies would be more willing to respond.

Additionally, some stakeholders did not participate in interviews because of concerns of confidentiality. This does not preclude future participation in a formal assessment process. Others were simply unavailable due to time constraints. The timing of this report coincided with intense budget discussions in the state capitol and, therefore, many were regrettably unavailable to participate.

Each Party Has a Legitimate Spokesperson

Based on stakeholder interviews in this assessment, it would appear that the parties have legitimate spokespersons. The representatives interviewed from all stakeholder groups were very informed on their particular stakeholder histories and had many years of experience.

The challenge with this particular issue is the vast diversity of stakeholders. It would not be sufficient, for example, to have one stakeholder present to address local

health concerns. Because California has many urban and rural localities, stakeholders would need to be present that could accurately reflect these nuances. Selecting who would actually be at the table would be a challenging process.

Potential Deal Breakers are at the Table

Similar to the primary parties not being able or willing to participate, this condition was not met in the assessment. As previously discussed, excluding powerful stakeholders risks the failure of a collaborative. Several stakeholders representing health organizations spoke about their struggles in countering the power and financial abilities of tobacco companies. Convening a collaboration without such deal breakers would be problematic.

If recommendations were established through the process, the tobacco companies and public education entities could exercise their power in the implementation phase. If this occurred and the collaborative's recommendations were not successful, this would likely result in frustration at the wasting of time and resources, and could further increase stakeholder conflict.

No Party Has Assurance of a Much Better Deal Elsewhere

Many stakeholders interviewed discussed the California Cancer Research Act or excise tax initiatives in general. This assessment cannot conclude whether this would be a better deal for some stakeholder health advocates, but it does offer that possibility.

This initiative will be in the next election and holds the potential to be a big win for health advocates. These stakeholders did not seem reliant on the success or failure of the Act as a determinant of their participation in the collaborative.

When asked about other external factors that would promise a better deal, one stakeholder indicated that litigation had occurred due to the FDA's desire to treat and regulate smokeless tobacco products as drugs. The FDA did lose in this challenge; however, the stakeholder indicated that further litigation would likely continue on this issue. It is not clear if this litigation will provide a better alternative for advocates of these products, but that is a possibility.

Parties Anticipate Future Dealings With Each Other

The stakeholders interviewed for this assessment were very versatile and highly independent. Certain groups, such as local public health and public education, as well as the variety of non-profit health organizations, do anticipate dealing with each other in the future. Their interests are quite intertwined and this interaction is unavoidable and often preferred.

Other stakeholders from tobacco caucuses also expressed reliance on their relationships and future dealings. The interdependence between all stakeholder groups is not clear from the assessment. Many stakeholders from both sides expressed their desire to work together one day in the future in an effort to mitigate the occurrence of youth smoking, but the disputes between stakeholder groups are deep. Thus, it seems that this possibility is far from reality.

A handful of tobacco stakeholders did express previous relationships with health organizations; however, in every instance of this, the relationships dissolved in an unsatisfactory way. This mitigates the possibility of desire to work together in the future.

Relative Balance of Power Among the Parties

The group of stakeholders interviewed represented many powerful groups. However, there were some substantial gaps that emerged in the balance of the parties. Some of these imbalances were based on financial means and decision-making authorities. Local public health for example does not have the monetary capabilities or the decision-making authority to implement policies. They are reliant on funding and direction from elected entities above them.

Many stakeholders expressed concerns in their interviews on the financial support from external industries such as pharmaceutical companies. On several occasions, health groups referenced the strong financial capabilities of the tobacco industry, whereas tobacco groups referenced bias they experienced from academic journals refusing to publish their research and the demonization they feel distracts from many of the positive actions they have taken.

External Pressures to Reach Agreement

If a collaborative process were to convene, it is not clear from this assessment what forms of external pressures would be present to push toward consensus. Stakeholder interviews revealed the potential for external pressures to criticize the process instead of encouraging it. In other words, many were skeptical that national health organizations,

for example, would support a collaboration with the tobacco industry. This would seem to work against the mission of such organizations.

To achieve a necessary amount of external pressure, leadership at all levels of stakeholder organizations would likely need to be on board. If the collaboration were to fail, this could affect the image of the stakeholders involved, and, therefore, leadership could potentially place external pressure for success.

Realistic Timeline for Completion

When asked about the collaborative process, stakeholders did not express concerns with the timeline for completion. This condition would need to be addressed following a proposal for the collaborative process moving forward. Because this assessment does not make that recommendation, the timeline is not currently relevant.

Adequate Resources/Funding to Support Negotiations

Because the collaboration is not recommended for this issue at the particular time, funding was not addressed. This assessment, however, does propose workshops to increase stakeholder understanding regarding the potential for collaboration and the importance of interest-based negotiation. A funding source would be needed to arrange for these workshops and was not identified in the assessment process.

Chapter 5

CONCLUSION

The purpose of this project was to assess the appropriateness of collaboration for the issue of youth smoking in California. Collaboration is not suited for every problem, and a conflict assessment is intended to ensure that a collaborative process should move forward or if it would be ineffective at addressing a particular problem. This assessment found that, at this time, collaboration is not a recommended step for stakeholders. The main reason for this recommendation is the inability or unwillingness of primary stakeholders to participate at this point in time. This section provides an expanded discussion on this issue, the limitations in this project and recommendations of potential actions that could move stakeholders in the direction of collaboration.

Stakeholder Participation

Often with problems as deeply rooted as youth smoking, stakeholders are hesitant to enter a collaborative process. This emerged in the assessment, as some stakeholders were not able or willing to even be interviewed. This occurred for a variety of reasons. The large tobacco companies were simply unreachable and could not respond to an unsolicited request for an interview. Some stakeholders speculated that these companies are extremely hesitant to speak about their policies, as they are concerned about previous experiences and being portrayed in a negative light.

Other stakeholders did not have the time to be interviewed for this assessment. A limitation to this research was the short time allocated for interviews. This timeframe

coincided with intense budget negotiations in California. Many of the stakeholders

approached for interview requests represented their organizations in a government

relations context and were very focused on legislation and budgetary cuts to their

constituencies. Given a longer timeframe and a less chaotic political environment, it is

very likely more stakeholders would have agreed to interviews.

Limitations

Many stakeholders did not respond to interview requests for undisclosed reasons.

Perhaps they were concerned about expressing their interests, or did not feel that the

assessment would provide useful information to their organization. Regardless of their

reasoning, additional time and an interview request from an established assessor might

have increased response rates. In some cases, an interview request from a student was

met with excitement from stakeholders. In other cases, the researcher's student status

may have discouraged some stakeholders from participating.

Another limitation to this project was the small sample of 11 stakeholder

interviews. These interviews did provide a diverse perspective of interests surrounding

youth smoking; however, a larger number of interviews would have expanded the

generalizability of these study results. It is important to note that a collaboration is not

recommended for the particular stakeholders interviewed for this assessment; however,

this recommendation cannot be applied to national or international concerns about youth

smoking. Perhaps if the interviews were expanded to include more individuals from

public education, and tobacco companies agreed to participate, a collaboration could be considered.

Recommendations

This assessment does not recommend a collaboration; however, that does not mean all hopes are lost for this process. Stakeholder interviews did highlight substantial areas of common ground. Of utmost importance, all stakeholders stated in some way that youth smoking should not occur. While stakeholders certainly differed in their approaches to achieve this and their level of interest in taking action, this area of common ground provides a strong beginning for collaboration.

For this process to begin, it appears that one stakeholder would need to take a leadership role. This project differed from traditional assessments in that it was initiated by a student, rather than a stakeholder. A leader would need to take initiative to engage other stakeholders in designing the process (Innes & Booher, 2010, p. 92). Typically, a stakeholder involved in the problem will recognize that previous efforts to reach consensus have failed and litigation has not assisted in creating solutions. Therefore, they explore the possibility of collaboration. What is needed in further discussions of collaboration for youth smoking in California is a leader. If a particular stakeholder decided that this process might offer some potential for success, they could champion the process and request a more formal and reliable assessment.

Based on the results from this assessment, it is clear that if the process were to begin, there is a need for extensive education on the collaborative process. As is common

with such complex problems, a high level of conflict is present between stakeholders. There would need to be a series of workshops with these stakeholders to discuss the ability of collaboration to use this previous conflict to generate creative and useful approaches that may not have been considered before. The workshops would initially need to occur within caucuses, where stakeholders are grouped by interest in a comfortable environment. This would allow them to have an honest discussion with a neutral facilitator to explain their concerns with the process. The workshops would need to continue until the stakeholders felt confident in the process and their ability to engage in interest-based negotiation with other stakeholders (Fisher & Ury, 1981, p. 10-11).

Another area that emerged strongly in the assessment is the need for joint fact-finding. There is clear disagreement among stakeholders on data both surrounding youth smoking patterns and smoking alternatives. Joint fact-finding in these areas, however, would likely generate a great deal of conflict. To reiterate, joint fact-finding allows stakeholders to evaluate information collaboratively. This involves many forms of knowledge, including science and local knowledge. It also can include reframing a discussion to think about it in a different context or frame (Inness & Booher, 2010, p. 160).

Tobacco interest groups and one public health stakeholder expressed many times that they feel current published data is biased and will not include reliable studies performed by tobacco companies. This distrust highlights the importance of joint fact-finding.

Research on smoking alternatives would certainly cause concern for many public health interest groups. Many health organizations take strong stances against these alternatives, and even the concept of researching their potential for safety could create uproar from their constituencies. This area is also restricted by FDA regulations that prohibit the marketing of these products as safer alternatives. Such challenges would need to be considered with creating a plan for joint fact-finding. Agreeing to joint fact-finding in these two areas could create a challenge in and of itself, and would require an extremely skilled facilitator and strong buy-in by stakeholders in the collaborative process.

Final Thoughts

As Californians continue to focus on concerns of health care costs and the occurrence of chronic diseases, the issue of youth smoking will remain prevalent. Stakeholders in this assessment expressed different opinions on trends and causes of youth smoking; however, most agreed that further work is needed to decrease this occurrence.

This assessment offers the building blocks to begin engaging a variety of stakeholders in the potential for collaboration. While the process is not currently suitable for the stakeholders included in this assessment, collaboration may be a potential venue for stakeholders in the future. If current trends of youth smoking continue and stakeholders discover that traditional forums of legislation and litigation are not offering solutions, stakeholders may be ready to consider collaborating.

This report is intended to provide all stakeholders with the tools to consider varying views and approaches to preventing youth smoking. If stakeholders review this report objectively, and they begin to understand the interests of other stakeholders and potential areas of common ground, then this project was a success.

APPENDICES

APPENDIX A

Stakeholder Invitation Letter
(Susskind et al., 1999)

Dear (Stakeholder Name):

I am writing to request your participation in an important project to address youth smoking in California. To complete my Master's in Public Policy and Administration from California State University, Sacramento, I am interested in crafting solutions for this problem as a thesis project. While the prevalence of youth smoking has substantially declined due to the hard work of many organizations, our youth continue to smoke at higher than desired levels. To identify new ways to address this challenge and to combine local efforts, my project performs a conflict assessment to explore the option of collaboration.

It is clear that there are many concerns and approaches within stakeholder groups and I would like to request your input. With your help and the skills I have gained in my program, I will design a consensus-building process to ensure that your concerns are adequately addressed.

I am currently conducting a series of confidential interviews with affected stakeholders. I invite you to speak with me to contribute valuable data during this phase of the conflict assessment. From the results of the interviews, I will:

> Identify all relevant stakeholders and concerns
> Highlight points of agreement and disagreement
> Identify the key issues with youth tobacco-control that must be addressed
> Assess the willingness of key stakeholders to work collaboratively, despite the differences, to achieve consensus
> Suggest ground rules for consensus-building
> Identify any joint fact-finding procedures we ought to follow
> Propose a work plan for proceeding with a consensus-building process

It should be noted that this is solely an exercise to apply my acquired skills in assessing the appropriateness of a collaborative process. I will distribute the final assessment to all participating stakeholders and hope that it will provide some insight on the various stakeholder positions and interests. I will truly value your participation in this process and plan to begin interviews as soon as possible. I will contact you shortly to propose potential days and times to fit with your schedule.

If you have any questions in the interim, please do not hesitate to contact me at 530-448-4951 or kristyoriol@gmail.com.

Sincerely, Kristy Oriol

APPENDIX B

Guide for Interview Questions

Conflict History

- What is the current focus of your organization regarding the occurrence of youth smoking in California?
- How do you feel about the current trends of youth smoking?

Goals, Issues and Interests

- What are the key issues of your organization as it relates to youth smoking?
- How would your organization benefit or be harmed by decreasing youth smoking?
- What are the central issues that must be addressed in order to accurately address this problem?
- What issues are of greater or lesser importance?
- Are there any other issues related to youth smoking that you would like to discuss?

Other Stakeholders

- Who are the other major stakeholders who should be involved in a process to develop recommendations for addressing youth smoking?
- Which of these stakeholders should directly participate in a decision-making process, along with other stakeholders, to decide on recommendations and help implement decisions?
- Which stakeholders need to be consulted and kept informed, but not necessarily as decision-making participants?
- Can you tell me the key areas where you agree and/or disagree with any of these Stakeholders?
- Do you have any suggestions for how stakeholders, not participating directly in a decision-making process to formulate recommendations, should be involved?

About the Process

- Would a collaborative process to develop recommendations for addressing youth smoking be effective? Why or why not?
- If a collaborative process were convened to develop recommendations, would your organization be willing to participate?
- Are there any conditions related to such a collaborative process itself that would be important to address, in order for you to participate?
- What types of information should be available for the participants in a collaborative

process to do their work?
- Are you aware of any other activities related to youth smoking, such as legislation or litigation, which might affect a collaborative process?
- If a collaborative process developed reform recommendations that your organization agrees with, would you be willing to help implement those reforms?

(Booher & Folk-Williams, 2006)

APPENDIX C

Consent Form

Consent Form

Youth Smoking in California
A Conflict Assessment for Collaboration

You are being invited to participate in a research project to assess whether or not a formal collaboration is an appropriate venue for the issue of youth smoking in California. This research is being conducted by Kristy Oriol, with faculty advisement from California State University, Sacramento. This research will be used for Kristy Oriol's thesis in obtaining a Masters Degree in Public Policy and Administration.

The information I obtain from this interview will remain confidential if you so desire. Following our interview I will summarize our discussion for my records. I will then send you a copy of this summary to ensure I have fully captured your answers. This summary will not be included in my final document, however with your consent I will likely refer to specific quotes from our discussion.

There are no anticipated risks to you from participating in this research. However, should you prefer your identity be withheld in the completed report, please make that request known at the start of the interview and check the appropriate box below. The researcher will then make a good faith effort to conceal your identity as the source of any information or ideas reported in the thesis. However, given the small number of people being interviewed, it may be possible for readers of the thesis to infer your identity even if you are not identified by name.

☐ I wish to be identified by name in the written research report.

☐ I request that my name not be disclosed. I acknowledge that given the small number of people being interviewed, it may be possible for readers of the report to infer my identity even if I am not identified by name. I consent to particular quotes from the interview to be anonymously referenced.

Your participation is completely voluntary and you may decline to participate in this research without consequences. You also understand that if you participate in this research you are not obligated to answer any questions that you do not want to answer. Your signature below indicates that you have read this page and agree to participate in the study.

_____ _____
Name   Organization

_____
Date

APPENDIX D

Matrix of Common Ground

	Need for Fairness	Focus on Potential Alternatives to Smoking	Set Clear Goals	Focus on Smoking Related Diseases	Need for Science and Research
Stakeholder 1	X				X
Stakeholder 2		X			X
Stakeholder 3					X
Stakeholder 4	X	X			X
Stakeholder 5				X	
Stakeholder 6			X	X	
Stakeholder 7			X		
Stakeholder 8					X
Stakeholder 9					
Stakeholder 10					X

	Concern with Tobacco Revenue being Spent on Unrelated Issues	Reaching Youth while Young Including Youth/Peer Advocates	Reduce Youth Smoking	Focus on Licensing and Sales	Ban Smoking in Schools
Stakeholder 1	X		X	X	
Stakeholder 2	X	X	X		
Stakeholder 3			X		
Stakeholder 4			X	X	
Stakeholder 5	X		X	X	
Stakeholder 6		X	X	X	
Stakeholder 7	X	X	X	X	
Stakeholder 8		X	X		X
Stakeholder 9		X	X		
Stakeholder 10			X	X	

	Education within Schools	Support for CCRA and Increased Taxes	Concern with Effects of Increased Excise Taxes	Setting Realistic Goals for Smoking Reduction	Concern with Imported, Unregulated Tobacco
Stakeholder 1			X		
Stakeholder 2					
Stakeholder 3			X	X	X
Stakeholder 4		X		X	
Stakeholder 5	X	X			
Stakeholder 6	X				
Stakeholder 7		X			
Stakeholder 8	X				
Stakeholder 9	X				
Stakeholder 10	X	X			

	Advertising Concerns	Concerns with Smoking Alternatives	Need to Change Social and Cultural Norms	Need Youth Smoking Cessation Opportunities	Address Concerns with Black Markets and Smuggling
Stakeholder 1					X
Stakeholder 2			X		
Stakeholder 3					X
Stakeholder 4			X		
Stakeholder 5			X	X	
Stakeholder 6	X	X	X		
Stakeholder 7			X	X	
Stakeholder 8			X		
Stakeholder 9	X		X	X	
Stakeholder 10	X	X	X	X	

	Evaluate Fiscal Impacts of Policy Proposals	Discuss Impacts and Need for Regulation	Need for More Grassroots Advocacy	Address Disparities	Address Limited Resources
Stakeholder 1	X	X			
Stakeholder 2			X	X	
Stakeholder 3	X	X			
Stakeholder 4			X		
Stakeholder 5					
Stakeholder 6					X
Stakeholder 7				X	X
Stakeholder 8					X
Stakeholder 9	X				
Stakeholder 10	X			X	X

	Concerns with Reliance on Tobacco Revenue	Need to Build Partnerships and Trust	Need for Litigation	Willing to Consider Collaboration with Conditions	Address Smoking in Movies/Entertainment
Stakeholder 1	X				
Stakeholder 2			X		X
Stakeholder 3				X	
Stakeholder 4				X	
Stakeholder 5				X	
Stakeholder 6				X	X
Stakeholder 7	X			X	X
Stakeholder 8	X	X			
Stakeholder 9				X	
Stakeholder 10				X	X

WORKS CITED

Alexander, J., Comfort, M., Weiner, B., & Bogue, R. (2001). Leadership in collaborative community health partnerships. *Nonprofit Management Leadership, 12,* 159-175.

American Lung Association. (2010). *State of tobacco control*. Retrieved from http://www.stateoftobaccocontrol.org/ala-sotc2010.pdf and http://www.stateoftobaccocontrol.org/2010-key-findings/prevention-and-wellness/

Ansell, C., & Gash, A. (2008). Collaborative governance in theory and practice. *Journal of Public Administration Research and Theory,18,* 543-571.

Bal, D., Lloyd, J., Roeseler, A., Shimizu, R. (2001). California as a model. *Journal of Clinical Oncology, 19*, 69-73.

Booher, D., & Folk-Williams, J. (2006). *Assessment report reforming the mandate reimbursement process*. Center for Collaborative Policy, California State University, Sacramento. Retrieved from http://www.csus.edu/ccp/publications/CCP_CSM_Final_Assessment_Report.pdf

Brown, E., Hawkins, D., Arthur, M., Abbott, R., & Van Horn, L. (2008). Multilevel analysis of a measure of community prevention collaboration. *American Journal of Community Psychology, 41,* 115-126.

Butterfoss, F., Goodman, R., & Wandersman, A. (1996). Community coalitions for prevention and health promotion: Factors predicting satisfaction, participation, and planning. *Health Education Quarterly, 23,* 65-79.

California Department of Education. (2010). *Tobacco-use prevention education program overview.* Retrieved from http://www.cde.ca.gov/ls/he/at/tupeoverview.asp

California Department of Public Health. (2009). *California's award winning tobacco control program*. Retrieved from http://www.cdph.ca.gov/Pages/NR2009-25.aspx

California Healthline. (2010). *Signatures for tobacco tax increase submitted for spot on 2012 ballot.* Retrieved from http://www.californiahealthline.org/articles/2010/7/1/signatures-for-tobacco-tax-increase-submitted-for-spot-on-2012-ballot.aspx

California Tobacco Control Program. (2009). *California tobacco control update 2009.* Retrieved from http://www.cdph.ca.gov/programs/tobacco/Documents/CTCPUpdate2009.pdf

Carver, V., Bonita, R., Range, L., Campbell, C., & Boyd, N. (2003). Nonprofit organizations versus government agencies to reduce tobacco use. *Journal of Public Health Policy, 24,* 181-194.

Center for Collaborative Policy (n.d.). *Conditions favorable to initiate a collaborative process.* Retrieved from http://www.csus.edu/ccp/collaborative/initiate.stm

Center for Collaborative Policy. (2004). *Stakeholder collaborative process feasibility assessment report Lake Tahoe Basin California and Nevada.* Retrieved from http://www.csus.edu/ccp/Lake_Tahoe/Final%20P7%20Assessment%20Report%209-24-04%20v6.pdf

Centers for Disease Control (CDC). (November, 2010). *CDC guidance for collaboration with the private sector*. Retrieved from http://www.cdc.gov/tobacco/tobacco_control_programs/program_development/accepting_funds/index.htm

Community Care Network. (2011). *Mission statement.* Retrieved from http://www.ccnworks.org/index/mission

Dukes, F., & Soloman, M. (2004). *Reaching higher ground: A guide for preventing, preparing for, and transforming conflict for tobacco control coalitions.* Tobacco Technical Assistance Consortium, Emory University, Atlanta. Retrieved from https://docs.google.com/viewer?a=v&pid=gmail&attid=0.1&thid=12f4159e95a358ef&mt=application/pdf&url=https://mail.google.com/mail/?ui%3D2%26ik%3D47d0b31108%26view%3Datt%26th%3D12f4159e95a358ef%26attid%3D0.1%26disp%3Dattd%26zw&sig=AHIEtbSJAEBaowpGrTuUA7XVPcMPNTxHeg

Firehock, K. (2011). An overview of the community based-collaborative movement in the United States. In K. Firehock, *Community-based collaboration* (Chapter 1).

Fisher, R., & Ury, W. (1981). *Getting to yes negotiating agreement without giving in.* Boston: Houghton Mifflin.

Francisco, V., Paine, A., & Fawcett, S. (1993). A methodology of monitoring and evaluating community health coalitions. *Health and Education Research, 8,* 403-416.

Furlong, M., Casas, M., & Corral, C. (1997). Changes in substance use patterns associated with the development of a community partnership project. *Evaluation adn Program Planning, 20,* 299-305.

Gilpin, E., Farkas, A., Emery, S., Ake, C., & Pierce, J. (2002). Research and practice clean indoor air: Advan clean indoor air: Advances in California. *American Journal of Public Health*, *92*, 785-791.

Goodman, R., Speers, M., McLeroy, K., Fawcett, S., Kegler, M., Parker, E., Smith, S.,…Wallerstein, N. (1998). Identifying the dimensions of community capacity to provide a basis for measurement. *Health Education and Behavior, 25,* 258-278.

Goodman, R., Wandersman, A., Chinman, M., Imm, P., & Morrissey, E. (1996). An ecological assessment of community-based interventions for prevention and health promotion: Approaches to measuring community coalitions. *American Journal of Community Psychology, 24,* 33-61.

Innes, B., & Booher, D. (2010). *Planning with complexity an introduction to collaborative rationality for public policy.* New York: Routledge.

Innes, J. E., & Booher, D. E. (2003). Collaborative policy making: Governance through dialogue. In M. A. Hajer & H. Wagenaar (Eds.), *Deliberative policy analysis: Understanding governance in the Network Society.* Boston, MA: Cambridge University Press.

Johnson, C. (2004). The state of tobacco settlement: Are settlement funds being used to finance state government budget deficits? A research note. *GAO, 851,* 113-125.

Krauss, M., Mueller, N., & Luke, D. (2004). Interorganizational relationships within state tobacco control networks: A social network analysis. *Public Health Research, Practice and Policy, 1,* 1-25.

Landman, A., Ling P., & Glantz, A. (2002). Tobacco industry youth smoking prevention programs: Protecting the industry and hurting tobacco control. *American Journal of Public Health, 6,* 917-930.

Lasker, R., & Weiss, E. (2003). Broadening participation in community problem Solving: a multidisciplinary model to support collaborative practice and research. *Journal of Urban Health, 80,* 14-60.

Lasker, R., Weiss, E., & Miller, R. (2001). Partnership synergy: A practical gramework for studying and strengthening the collaborative advantage. *The Milbank Quarterly, 79,* 179-205.

Leischow, S., Best, A., Trochim, W., Clark, P., Gallagher, R., Marcus, S., & Matthews, E. (2008). Systems thinking to improve the public's health. *American Journal at Preventive Medicine, 25,* 196-203.

Ling, P., Landman, A., & Glantz, S. (2002). Is it time to abandon youth tobacco programmes. *Tobacco Control, 11*, 3-6.

Luke, D., Harris, J., Shelton, S., Allen, P., Carothers, B., & Mueller, N. (2010). Systems analysis of collaboration in 5 tobacco control networks. *American Journal of Public Health*, *100,* 1290-1297.

Park, H., Dent, C., Abramsohn, E., Dietsch, B., & McCarthy, W. (2010). Evaluation of

    California's in-school tobacco use prevention education (TUPE) activities using a

    nested school-longitudinal design, 2003-2004 and 2005-2006 (2010). *Tobacco*

    Control, 19, 43-50.

Pentz, M. (2000). Institutionalizing community-based prevention through policy change.

    Journal of Community Psychology, 28, 257-270.

Philip Morris. (n.d.). *Helping reduce underage tobacco use.* Retrieved from

    http://www.philipmorrisusa.com/en/cms/Responsibility/Helping_Nav/Helping_Re

    duce_Underage_Tobacco_Use/Select_Historical_Programs/default.aspx

Provan, K., Staten, M., Teufel-Shone, N., & Huddleston, C. (2004). Network analysis as

    a tool for assessing and building community capacity for provision of chronic

    disease services. *Health Promotion Practice, 5,* 174-181.

Provan, K., Veazie, M., Staten, L., & Teufel-Shone, N. (2005). The use of network

    analysis to strengthen community partnerships. *Public Administration Review, 65,*

    603-613.

Reeve, R., Collins, R., Dukes, F., & Lynott, J. (1994). *Virginia tobacco communities*

    project: A search for common ground. Retrieved from

    http://www.virginia.edu/ien/tobacco/casestudy.html

Robbins, H., & Krakow, M. (2000). Evolution of a comprehensive tobacco control

    programme: Building system capacity and strategic partnerships – Lessons from

    Massachusetts. *Tobacco Control, 9,* 423-430.

Roussos, S., & Fawcett, S. (2000). A review of collaborative partnerships as a strategy for improving community health. *Annual Review of Public Health, 21,* 369-402.

Schulz, A., Israel, B., Parker, E., Lockett, M., Hill, Y., & Wills, R. (2001). The East Side Village health worker partnership: Integrating research with action to reduce health disparities. *Public Health Reports, 116,* 548-194.

Snell-Johns, J., Imm, P., Wandersman, A., & Claypoole, J. (2003). Roles assumed by a community coalition when creating environmental and policy-level changes. *Journal of Community Psychology, 31,* 661-670.

Sung, H., Hu, T., Ong, M., Keeler, T., & Sheu, M. (2005). A major state tobacco tax increase, the master settlement agreement, and cigarette consumption: The California experience. *American Journal of Public Health, 95,* 1030-1035.

Susskind, L., McKearnan, S., & Thomas-Larmer, J. (1999). *The consensus building handbook.* London: SAGE Publications.

Taylor, M. (2006). Casting votes on healthcare. Midterm election referendums bring big money, potential impact on healthcare-mostly with anti-smoking proposals. *Modern Healthcare, 36,* 6-7.

Taylor, M., Ross, N., Cummings, M., Glasgow, R., Goldsmith, C., Zanna, M., & Corle, D. (1998). Community intervention trial for smoking cessation (COMMIT): Changes in community attitudes toward cigarette smoking. *Health Education Research, 13,* 109-122.

United States Department of Health and Human Services (HHS). (2010) *Ending the*

tobacco epidemic: A tobacco control strategic action plan for the U.S.

Department of Health and Human Services. Retrieved from

http://www.hhs.gov/ash/initiatives/tobacco/tobaccostrategicplan2010.pdf

Wandersman, A., & Folrin, P. (2003). Community interventions and effective prevention.

American Psychologist, 58, 441-448.

Yin, R., Kaftarian, S., Yu, P., & Jansesn, M. (1997). Outcomes from CSAP's community

partnership program: Findings from the national cross-site evaluation. *Evaluation*

and Program Planning, 20, 345-355.