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ALA's Not-On-Tobacco school quit smoking program not effective

by John R. Polito, founder of [WhyQuit](#) and author of [Freedom from Nicotine - The Journey Home](#)

The American Lung Association's (ALA's) Not-On-Tobacco (N-O-T) [web site](#) asserts that its school-based teen stop smoking program "really works" and has "a 21% quit rate." These statements are contrary to findings from two recent independent studies. But try telling that to U.S. health officials.

**N-O-T
NOT
Effective**

[According to the Centers for Disease Control](#) (CDC), the ALA's N-O-T program is the only smoking cessation program it rates as a "model program." In fact, the CDC does not list any other smoking cessation program as [effective, promising or notable](#). The bottom of each N-O-T web page displays the U.S. government's seal of approval. Each declares that, "Initial funds for this web site were provided by the Centers for Disease Control and Prevention."

Visitors to the Not-On-Tobacco site, established in [February 2009](#), are told it's a "voluntary program for teens who want to quit smoking," is presented during normal school hours, and lasts for ten weeks. The site boasts that its 21% success rate is "higher than the success rate of any other program to help teens stop smoking," and that N-O-T is "the most researched, most widely used and most successful such program in the United States."

But a careful reading of that research leaves you wondering, in how many other areas is the American Lung Association misrepresenting the facts, what possible motive could it have for claiming an ineffective program is highly effective, and how the CDC could read the same studies and yet hold N-O-T up as a "model program."

Maryland High School N-O-T Findings

According to the [U.S. Tobacco Treatment Guideline](#), the research standard for contrasting the efficacy and effectiveness of quit smoking interventions is to compare six-month

quitting rates. It states that, "research indicates that a high percentage of those who ultimately return to smoking will do so by 6 months." [1]

A study published in the [July 27, 2009](#) online version of [Pediatrics](#) involved establishing and evaluating the Not-On-Tobacco (N-O-T) program in 8 Maryland high schools. [2] The study was designed to compare N-O-T program stop smoking rates to those generated by control groups in which students were simply handed standard quitting brochures and encouraged to quit.

Normally the N-O-T program involves students attending 10 weekly sessions that last 50 minutes each. But finding an extra 50 minutes of school teaching time each week proved difficult. The study addressed the issue by modifying the ALA's program to a bi-weekly lunchtime format that resulted in 20 lunch sessions of 25 to 30 minutes each.

The study found that at six months after program completion that the N-O-T program was no more effective than quitting rates generated by the control group. Researchers collected and compared N-O-T and control group rates at the end of the ten-week program, and at 1 month, 3 months, 6 months and 1 year after program completion. According to the study, "there were no statistically significant differences for the NOT program at any follow-up point."

After applying a rigorous intent to treat analysis, and validating student quit smoking claims by having them undergo saliva cotinine testing (cotinine is a nicotine metabolite), the study found that only 5% of N-O-T participants were not smoking at six months versus 9% among students in the control group. That's not only contrary to the ALA's assertion that it "really works" but four times lower than the ALA's 21% success rate assertion.

Alabama High School N-O-T Findings

The only other truly independent evaluation of the N-O-T program was an effectiveness study that followed the program in 44 Alabama high schools. This time the control group wasn't even offered encouragement to quit, just brochures. Published in the [July 2008](#) edition of the [American Journal of Health Behavior](#), it found no statistically significant differences in quitting rates between N-O-T and control group participants at 6 months. [3]

The study's authors fired a misrepresentation warning shot across the ALA's bow. "It would be seriously misleading to report that the N-O-T program resulted in a 20.4% quit rate at 12 months, when at the end of the program the quit rate was 10.2% and at 6 months it was 12.7%," they wrote.

And it isn't as though the ALA could have missed their warning. The ALA's "[Why Use N-O-T](#)" web page asserts that the program's 21% success rate is "based on more than [10 years of research and evaluation](#)." Clicking the link to the "10 years of research" actually lists the 2008 American Journal of Health Behavior study, implying to readers that it too supports the 21% assertion. You'll also note that the 2009 Pediatrics paper hasn't yet been listed.

What quickly becomes evident when examining the list of papers supposedly supporting the 21% success rate is that nearly all involved Dino and Horn as co-authors. The West Virginia University [profile page](#) of Geri Dino, PhD states that Dr. Dino "co-authored the American Lung Association's national and international teen smoking cessation program, Not-On-Tobacco (N-O-T)." The West Virginia University [profile page](#) of Kim Horn, EdD, MSW states that "one of the programs Dr. Horn developed, Not On Tobacco, was adopted by the American Lung Association in 1998 and is used across the US and in Europe to help teens stop smoking. The program has reached thousands of teens with 1 in 5 quitting smoking."

N-O-T Program Creators Resort to Funny Quitting Math

So how is the American Lung Association able to claim on its website that the N-O-T program "really works" and that "it has a 21% quit rate"? Dino and Horn were lead authors of a study of the N-O-T program in 10 Florida schools in 1999 and another 10 in 2000. Their study compared quitting rates generated by N-O-T's ten 50-minute sessions to quitting rates of 20 comparison schools where students received what's commonly available to high school students, brief quitting advice (less than 10 minutes) and quitting handouts.

Published in the December 2001 edition of [Preventive Medicine](#), the study's free [summary](#) asserts that "NOT smoking cessation outcomes were significantly better than those of the brief intervention [BI]," and that "overall, more NOT youth quit ... than did BI youth." The authors conclude that "NOT is an effective teen smoking cessation option." [4] But the study summary stands in stark contrast to the known facts presented in the paper's [\\$31.50 full-text version](#).

Dino and Horn put a total of 313 students through the 10-week N-O-T program. Follow-up to determine smoking status for both groups was done 7.2 months after the N-O-T program started (5.2 months after it ended). But only 127 of the 313 students who went through the N-O-T program (just 41%) returned for follow-up at 5.2 months and had their breath's carbon monoxide level tested to determine if they had recently smoked. According to the paper, only 20 of the original 313 students who went through the N-O-T program were confirmed to have not smoked within the prior 24 hours, a horrible rate of just 6%. Among the 147 of the 253 students in the control group who returned for follow-up (58%), Dino and Horn confirmed that 20 were non-smokers, a stop smoking rate of 8%.

An identical 20 confirmed quitters in each group, Dino and Horn's study summary assertion that "overall, more NOT youth quit than did BI youth" doesn't square with the facts. In that N-O-T participants actually did slightly worse than students receiving brief intervention (6% vs. 8%), the summary assertion that "N-O-T smoking cessation outcomes were significantly better than those of the brief intervention" is also troubling. So how were the co-creators of the N-O-T program able to pluck victory from the jaws of defeat?

Instead of counting and treating all students in both groups who failed to return for follow-up as having relapsed to smoking, Dino and Horn decided to pretend the fiction that all who didn't return had the exact same quitting status of those within each group who had returned

and been tested. Since a significantly greater percentage of the N-O-T group failed to show-up for breath tests than in the control group (59% vs. 42%), instead of the two groups having an identical number of proven quitters, 20, Dino and Horn mathematically invented an additional 47 N-O-T victories (giving N-O-T a **21.7%** total quitting rate), while only awarding the BI group 12 additional successful quitters (an overall BI quitting rate of 12.6%).

Researcher N-O-T program bias is also suggested in how they portray male quitting rates. Even after their above magic math, as shown by study Table 2, the success rate for male N-O-T program participants was 14% as compared to 16% for male students in the BI group. Instead of simply telling readers that the N-O-T program had proven ineffective for male participants, the study's summary was written to state, "males showed successful quit attempts in both intervention groups."

What could possibly have motivated Dino and Horn to portray a clearly ineffective program as highly effective? We don't know. None of the studies disclose any financial conflict of interest.

N-O-T's Chilling Effect

Taken as a whole, ALA and CDC representations regarding N-O-T falsely suggest that the program is highly effective at transforming smoking students into long-term successful ex-smokers. The effect of painting N-O-T as a "model program" chills and delays the research quest and urgency to create and deploy a school-based cessation program that truly is effective.

My investigation of this topic wasn't my chance. After having presented bi-monthly [College of Charleston](#) quitting programs for three years, I'd developed my own ideas, backed by my own empirical evidence, about what works and what doesn't. But I'd become rather disheartened after a decade of failure in convincing U.S. health officials that it was wrong to allow [pharmaceutical industry influence](#) to re-write U.S. cessation policy in June 2000, effectively outlawing government support for all forms of non-pharmacology cessation.

[Battling health officials](#) for ignoring the cessation education and support needs of the roughly [80 to 90%](#) of quitters who each year trust their natural instincts and attempt quitting without pharmacology left little time to reflect on the one area where pharmacology had consistently proven [totally ineffective](#), youth cessation. But after recently reviewing N-O-T program studies and marketing it has become apparent that the ALA's influence and lock on youth cessation is nearly as strong as the pharmaceutical industry's is on adults (including [our President](#)).

Why N-O-T Is Not Effective

The reason that most N-O-T programs will be a waste of student and facilitator time and energy likely has little to do with program content. Although the ALA treats facilitator guides as if "top secret," program outlines suggest that N-O-T covers key topics such as

nicotine dependency, withdrawal management, crave coping, weight and stress management, peer pressure and relapse prevention. Program failure is likely the result of two factors, extremely weak facilitator training and program isolation.

The ALA's [one day training sessions](#) - for which participants are charged \$200 - are a joke. We can no more create a skilled drug addiction counselor in one day than we can an algebra teacher, principal or school nurse. While written lesson guides provide a format, schedule, discussion topics, exercises and facilitator confidence, a single erroneous facilitator response to a student [smoking rationalization](#) can fuel and trigger fatal junkie relapse thinking for the entire group.

Just as critical is the obvious shortfall that N-O-T can only educate and influence students who attend. The program does nothing to change smoking perceptions of the great majority of smoking students who don't. Nor is N-O-T's scope as broad as its name, as student addiction to oral tobacco is apparently ignored. Any program success is quickly consumed by tobacco and nicotine's predominant image within the school. If students generally see tobacco use as cool, a means to rebel against authority or a way to imitate an adult activity, then what happens once the facilitator's weekly contact ends?

Create Your Own School-Wide Program

If I were a teacher, school nurse, principal or administrator in search of an effective school-based program, I'd create my own. I'd be driven by a single objective, to totally [demolish tobacco's image](#) within our school. I'd hit tobacco [so hard](#) that never-users would fear experimentation and those hooked would be scrambling for freedom. In creating such a program there'd be absolutely no need to exaggerate, as [the truth](#) itself is scary enough.

The program would have three key elements: (1) an ongoing, rotating hall poster education campaign; (2) formation of a new student organization or club devoted to nicotine dependency prevention and cessation; and (3) free weekly peer cessation support meetings facilitated by students for students.

The School's Hall Education Campaign

Envision a hall poster education campaign that utilizes high visibility locations in two of the school's busiest areas. Imagine rotating [high quality poster messages](#) weekly, eventually having enough for the entire school year. Picture roughly half of the program's posters focusing on various aspects of [chemical dependency](#), while the other half share [tobacco's harms](#), with strong emphasis on immediate harms (loss of self esteem, the stink, cost, battling craves and urges during class, an inability to engage in prolonged vigorous physical activity, premature skin aging, nicotine picking your friends, diminished impulse control in males, destruction of brain gray matter, air sacs and ongoing damage to blood circulation, slow wound and fracture healing, and gum disease).

During 2005, I handed college students who admitted being hooked a blackboard and marker. I asked them to imagine standing on a stage in front of 500 students who were

thinking about experimenting with smoking. "What would you tell them," I asked? I then photographed each student holding their message.

You can feel [chemical dependency](#) in 18-year-old [Rachel's](#) face and message, and see your school's #1 reason for student experimentation in 19-year-old [Brittany's](#) message. Students are given a sense of just how challenging quitting can be in the messages of 19-year-old [Reggie](#) and 18-year-old [Kathryn](#). Eighteen-year-old [Katie](#) tells how the stink sticks to you, 17-year-old [Krystal](#) tells how disgusting it is, [Rick](#) calculates how much money he's spent, and 20-year-old [Katie](#) says that "true friends wouldn't let you start."

Although all of [WhyQuit's](#) stories and photographs are free and available for student education, imagine the power of inviting your school's hooked students to share their own messages. A [2005 youth study](#) found that 86% of students who smoked nicotine at least once daily were already chemically dependent using DSM-IV nicotine dependency standards. A [2007 study](#) found that students can begin experiencing powerful desires for more nicotine within two days of first smoking it. While negative peer pressure is the most common trigger for youth experimentation, positive peer pressure can be equally persuasive in preventing experimenting but only if put to work.

Sadly, school nurses, teachers, principals and administrators have been reluctant to teach students the truth about nicotine, that whether smoked or taken orally, it's [highly addictive](#) and enslaves the same brain dopamine pathways as [heroin](#), [methamphetamine](#) or [crack cocaine](#). What they fail to appreciate is that while nicotine's dopamine high is accompanied by alertness instead of drunkenness, numbness, euphoria or a sense of speed or acceleration, that addiction to smoking nicotine will this year claim 24 times as many lives [as all illegal drugs combined](#).

What our schools fail to comprehend is that nicotine is "the" [gateway drug](#), that once addicted to using an external chemical to steal brain dopamine "aaah" sensations, that using other chemicals to add drunkenness, numbness, euphoria or acceleration to the experience is a normal and logical progression. What educators are missing is smoking isn't an "adult activity," that up to 90% of adult smokers became hooked as teens. What they're missing is a golden opportunity to educate the entire student, to awaken them to nicotine's truths before getting hooked.

According to the Surgeon General, smoking claims roughly half of adult smokers, each an average of 13 to 14 years early. But in the minds of teen smokers the risk of lung cancer, emphysema, or a smoking induced heart attack or stroke is decades away, giving them plenty of time to quit. Imagine large wall posters sharing tragic stories such as how smoking killed 34-year-old [Bryan Lee Curtis](#), 33-year-old [Noni Glykos](#) or how oral tobacco claimed 19-year-old [Sean Marsee](#). Imagine being 17-years-old, a smoker, and being forced to confront the possibility that your life may already be half over.

We should teach youth the truth, that once enslaved that success at quitting will likely be the greatest challenge they've ever confronted. Youth deserve to know that nicotine patch and gum commercials vastly exaggerate success rates. For example, a hall poster could

alert them to the fact that a [major study](#) found that only 7% of smokers who try quitting with the nicotine patch or gum were still not smoking within six months, a 93% product failure rate.

A rotating hall poster program could be used to counter tobacco industry marketing messages bombarding students in local stores. For instance, the large yellow "We Card" signs are not to alert students that the store checks I.D.'s. Once [secret tobacco industry documents](#) suggest that they were put there by the tobacco industry as a constant reminder to children and teens that smoking is a rite of passage into adulthood. Hall posters can be used to make convenience store flavor and taste cigarette marketing laughable, as there are zero taste buds inside human lungs. It's each school's opportunity to substantially diminish a school smoking rate that's probably in the neighborhood of [22%](#).

Starting a Student Dependency Prevention & Cessation Group

Imagine a student group or club dedicated to the dual cause of countering peer and community pressures upon students to experiment with nicotine, and helping hooked students break free. Such a group could become a magnet for students who've lost friends and loved ones to tobacco. It could become the school's cessation knowledge base, home to students [proud](#) about having successfully quit and wanting to support others in doing the same.

Imagine this student group handing out [quitting tips](#) during the annual Great American Smoke or on World No Tobacco Day. Imagine them becoming caretakers of the school's hall education campaign. Imagine them being allowed one assembly per year, 50 minutes in the gym or auditorium, in which to drive home their message. Imagine the community impact of media coverage of students protesting on the sidewalk in front of the [convenience store](#) nearest the school, which had the most tobacco use marketing signs inviting youth to experiment.

Imagination is the only limit on such a student group's potential. Imagine them making your entire school fully aware that nicotine is highly addictive, that it can happen fast, and that quitting is so challenging that each year more than 400,000 smokers smoke themselves to death.

Creating In-School Peer Cessation Support

Understanding and ongoing support are key to dramatic increases in youth cessation. The dependency understanding portion is the easy part. While the ALA may treat N-O-T program lesson guides as "top secret," the Internet is loaded with free high quality [quitting books and guides](#). "[Never Take Another Puff](#)" by Joel Spitzer and my book, "[Freedom from Nicotine - The Journey Home](#)," offer hooked students the ability to quickly understand where things stand and how to break free. Also, Joel has recorded [64 free video quitting lessons](#) on almost every topic imaginable.

Imagine reserving a cafeteria table or lunchtime classroom for the school's cessation

support group. Imagine the positive bonds that can develop when users and ex-users are brought together to support and encourage each other in remaining nicotine-free today.

Picture the group welcoming visitors, providing them [quitting tips](#), and letting them know that they're not alone in their quest. Imagine each student being granted time to share their latest victory, newest concern or favorite quitting tip article. Consider the impact upon the rest of the student body of seeing nicotine dependency recovery openly treated as any other chemical addiction.

Contrary to ALA and CDC assertions, this nation does not yet have an effective school-based smoking cessation program. Hopefully, readers of this article are now thinking in terms broader than simply cessation of a single form of nicotine delivery. It's my dream that you're an educator who will soon be as convinced as I am in the power of positive [peer messages](#) and [peer support](#) to dramatically diminish both experimentation and dependency.

References:

- [1] Clinical practice guideline for treating tobacco use and dependence: 2008 update. A U.S. Public Health Service report, [National Library of Medicine](#) Chapter 1, Methods and Overview, Outcome Data
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- [3] Kohler, CL et al, [Effectiveness Evaluation of the N-O-T Smoking Cessation Program for Adolescents](#), *American Journal of Health Behavior*, July-August 2008; Volume 32(4), Pages 368-379
- [4] Dino G, et al, [A 2-Year Efficacy Study of Not On Tobacco in Florida: An Overview of Program Successes in Changing Teen Smoking Behavior](#), *Preventive Medicine*, December, Volume 33, Issue 6, Pages 600-605

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