

# **School-based, youth-centred smoking intervention programmes: ... to be or not to be?**

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- Summary
- Why school-based, youth-centred interventions have little effect on smoking behaviour
- What can be done to make school-based approaches more effective (if they are to be used at all)
- Conclusion and final comments

## **Summary**

### **Why do school-based, youth-centred smoking interventions have little effect on behaviour?**

- Smokers and potential smokers are most likely to be absent from school
- Many smokers reject school values
- Children learn remarkably little from school lessons
- Those who learn best are academic and least likely to smoke
- The needs of small specific groups are not met in a general classroom context
- Social influences are very strong
- Children are not considered mature enough to make serious decisions in other contexts
- Warnings of risk and also sales restrictions can make smoking seem even more attractive
- Smoking education is affective and does not fit an examination-oriented curriculum
- Teachers are often unfamiliar with the theories and methods needed
- Teachers modify the programmes

### **How can school-based interventions, if they are used at all, be made more effective?**

- Involve the young people in planning by using focus groups
- Target small specific groups with the same needs on the basis of focus group findings
- Use social reinforcement approaches
- If information on physical effects is included they should be immediate ones, not long-term
- Train teachers in theory and methods needed
- Involve parents for younger children
- Involve peers
- Develop school 'no-smoking' policy for staff and students
- Target at age of onset for prevention
- Devote sufficient time to the subject (10 sessions is suggested)
- Provide cessation help when seriously requested by older students

### **Conclusions**

- The best that can be hoped for with school-based, youth-centred interventions is a modest short-term delay in onset of smoking.
- Some countries with the best, most wide-spread, school-based programmes have very high smoking prevalence among their youth
- School-based and other youth-centred programmes should only be used as a small part of a holistic national and community approach
- The tobacco industry is very supportive of youth-centred approaches and prevention of sales to minors.

# Why school-based, youth-centred interventions have little effect on smoking behaviour

## ***Absence from school***

On a randomly selected day, a hierarchy of absence can be observed, with smokers who have a smoking parent most likely to be absent from school and nonsmokers whose parents do not smoke being least likely to be absent.<sup>1</sup> Whatever the young person's current smoking status, parental smoking is associated with an increased risk of absence and of becoming a smoker.

## ***Rejection of school***

The reasons for this increased absence from school are both physical, at least in part related to active or passive smoking, and social.<sup>2</sup> The social reasons are indicative of rejection of school values. They include a high rate of truancy and suspension for antisocial behaviour. Smokers are likely to say they are *fed up* with school.<sup>3</sup>

## ***Amount learned***

Students learn remarkably little from lessons, especially health education lessons it seems. Taking the results of a randomly-selected Examination Board, it was seen that 13.3% of the entrants did not score highly enough to be given a grade at all in Human Physiology and Health. Only 3.6% scored A and 8% scored B.<sup>4</sup> These young people who scored highest were likely to be academically inclined who are least likely to smoke. Research has consistently shown that smokers have low self-perception with regard to scholastic achievement<sup>5</sup> and place little value on it.

## ***Maturity***

School students are not considered to be old enough to vote or to take legal responsibilities. How can it be assumed that a lesson in school will give them sufficient maturity to make a reasoned decision on smoking? Even adults find this difficult.

## ***Reaching the smokers***

Numerous reviews of school-based programmes have shown that they consistently fail to reach the 'drop outs'.<sup>6,7</sup> One of the main reasons for this is that the needs of small, specific groups cannot be met in a general classroom context. To be practicable in the school setting, classes must be taught as a whole, but they do not present a homogeneous target group. The majority will never smoke anyway. Groups of children even within the same class have different backgrounds, subcultures, social groups, needs and values. General programmes risk having the opposite effect from the one intended, especially if they are designed by well-meaning adults without reference to the specific young people. For example, teaching about risks and emphasising that cigarettes are only to be sold to adults, can make smoking all the more attractive to certain groups of young people. Likewise, a programme designed for a particular country, which has met with some success there can be totally inappropriate in another setting.

## ***Social influence***

These are the strongest and most widely varied factors involved in a young person's decision to smoke.<sup>7</sup> Macrofactors such as availability, price, advertising and restrictions on sales to minors; mesofactors including friends, parents, teachers and role-models smoking and school policy; microfactors such as image, self-perception, beliefs and subjective norms, present a complex framework.<sup>8</sup> Unless these influences are removed or reduced, mere lessons in school cannot be

realistically hoped to affect behaviour.

***Teaching***

Many teachers are unfamiliar with the theoretical underpinning of education for behavioural change and are not comfortable with the student-involvement methods needed. There is still a general belief that school is for teaching facts. There is little place for affective education in an examination-oriented school curriculum. Thus, teachers sometimes adapt the programme as they feel to be appropriate.<sup>7</sup> In doing this, they risk losing the very elements which might be effective.

## **What can be done to make school-based approaches more effective (if they are to be used at all)**

### ***Involve the specific target group***

Rogers and Shoemaker demonstrated the need for action to be generated and carried out by the community or group itself if it is to be effective.<sup>9</sup> Actions initiated and imposed from outside are generally rejected. Adults perceive young people=s needs differently and programmes generated by them can fall into serious traps in the young people=s subcultures. Focus groups conducted with the young people before planning enables their needs to be identified, small homogeneous target groups to be segmented and ownership of the programme to be given to the group.

### ***Target small specific groups with similar needs and values***

Advertisers segment their audience,<sup>10</sup> health educators rarely if ever do, but must in the future if they are to be more successful. For example, 11 to 15 year olds as a whole are not a target group. Even all 11 year old boys are not a target group. It is not a waste of money and effort to tailor a very specific package on the basis of the focus group findings. A programme should never be used with a group other than the one for which it was prepared.

### ***Lesson content***

Social reinforcement taught by student-involvement methods has consistently been shown to be most effective. Information delivered in the form of lectures and demonstrations has little or no effect on behaviour.<sup>11</sup> Some of the most effective programmes have involved the building of refusal skills and self-efficacy,<sup>12</sup> e.g. those by Evans *et al.*,<sup>13</sup> and McAlister *et al.*<sup>14</sup> However, if the young person actually wants to smoke, he or she will never put these taught skills into action. Knowledge of health risks is not an important element in a young person=s decision on smoking, but information about immediate effects is more meaningful to them than long-term risks. Such information could be included as part of the programme.

### ***The best time to intervene***

The age of onset appears to be best for prevention.<sup>6</sup> The stage at which the older students seriously request cessation help is best for that type of intervention. These stages vary from country to country and group to group. They need to be identified.

### ***How much intervention is needed***

Research in the USA suggests that at least 10 sessions are needed, either as a single block in the main year of onset, or as a block of five lessons in each of the first two years.<sup>6</sup>

### ***Peer involvement***

Peer-bonding is probably the most important reason why young people take up smoking.<sup>8</sup> It seems reasonable, therefore, that anti-smoking education by peers might be effective. However, evaluation findings are equivocal with regard to this.<sup>7</sup> Research in communications suggests that the message is best given first by someone different from the receivers e.g. an adult, and then disseminated by people who are similar to the receivers e.g. peers.<sup>9</sup>

### ***Parental involvement***

Smoking can be part of a 'family circle' both because of the health problems and the increased risk of the children becoming smokers.<sup>15</sup> Children of smokers are twice as likely to take up smoking.<sup>16</sup>

Children who perceive that their parents disapprove of their smoking are about seven times less likely to be smokers than those who think they approve. The influence of parents is strongest in younger children and the evaluation of a family-linked programme for 9 and 10 year olds showed a lower onset rate in the taught children and a decrease in smoking prevalence among their parents.<sup>17</sup>

### ***Teacher training***

This is vital.<sup>6,7</sup> Teachers need to understand the theories and methods involved in behaviour-oriented education.

### ***School policy***

A 'health-promoting school' is needed to support classroom teaching. One study found that in colleges with a no-smoking policy for both staff and students, smoking prevalence among students was half that in colleges where smoking was allowed.<sup>18</sup> The smokers also smoked fewer cigarettes both within and outwith the college.

## **Conclusion and final comments**

- Research indicates that the best we can hope for with school-based interventions is a moderate, short-term delay in smoking onset.<sup>6</sup>
- school-based intervention programmes should only be used as one small element in a holistic national and community policy.<sup>19</sup>
- Some countries with the best-developed and most widespread school-based and youth-centred programmes have very high smoking prevalence among their youth, even when they incorporate most or all of the principles mentioned here.

The tobacco industry, more specifically Philip Morris, is very supportive of youth-centred education to prevent young people from taking up smoking and also strongly support the prevention of sales to minors.<sup>20, 21</sup> Their very attractive "Think. Don't smoke" commercials appeared on television in the USA and their 1997 and 1998 Annual Reports affirm these two aims as part of their major public policy initiatives. We appear to have support from an unexpected source.

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