CALIFORNIA healthy kids SURVEY

TOBACCO
MODULE D

CALIFORNIA Safe and Healthy Kids PROGRAM OFFICE

WestEd

CONTENTS

TABLES

PREFACE

This report provides the detailed results from the district's administration of the California Healthy Kids Survey (CHKS) supplementary Tobacco Module D. It is designed to be used in conjunction with the findings on tobacco from the main report on CHKS Core Module A. The report is divided into two sections: (a) a discussion of the items by topic; and (b) the results for each item presented by grade in tables. In both sections, users are provided references to questionnaire items by number, as well as the actual item wording. An index at the beginning of the tables refers users from survey item numbers and variables to the table number in which the results are provided. The index also provides references to the relevant Core tables.

Users should also consult CDE's new *Getting Results* volume (Part II): *California Action Guide to Tobacco Use Prevention Education*. It provides research-based strategies for program implementation.

ACKNOWLEDGEMENTS

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TOBACCO USE

SMOKING FREQUENCY AND PATTERNS

REGULAR SMOKING AND NUMBER OF CIGARETTES SMOKED PER DAY

Question D1: Have you ever smoked cigarettes daily, that is, at least one cigarette every day for 30 days?
Question D3: During the past 30 days, on the days you smoked, how many cigarettes did you smoke per day?
Question D4: Have you smoked 100 cigarettes in your life?

Table D1 provides the number of cigarettes students smoked per day, on the days they smoked, in the past 30 days. These data give an indication of how much cigarette users consume on the days that they choose to smoke.

Table D2 reports the proportion of respondents who *ever* smoked daily, defined as at least one cigarette every day for 30 days. Comparing these results with the proportion of current regular smokers in Table A4.3 provides an indication of the proportion of smokers who may have succeeded in stopping smoking, or at least reducing use from a daily habit.

Table D3 reports the proportion of respondents who smoked 100 cigarettes in their life. This item is an indication of established smoking amongst youth.[1]

CIGARS

Question D6: During the past 30 days, on how many days did you smoke any cigars, cigarillos or little cigars?

Table D4 reports the rate of any current (past 30 days) smoking of cigars, cigarillos or little cigars. Cigars recently have become popular among young adults and teenagers.[2] In the mid- to late-1990s, cigar bars and lounges began to appear and several prominent actors were photographed smoking cigars. Cigar smoking appeared to be trendy and associated with wealth and enjoyment of life. Many people believe that cigars are less dangerous than cigarettes; they think that the tobacco in cigars is more pure or natural; and they believe that cigar smokers inhale less than cigarette smokers do. However, studies have shown that cigar smoking is associated with an increased risk of cancer, just like cigarette smoking.[3]

SMOKING TO CONTROL WEIGHT

Question D2: Did you ever smoke to control your weight?

Why youth say they smoke is important to know when developing intervention programs. The proportion of students reporting that they ever smoked to control their weight is found in **Table D5.** Weight control is an important issue for young females in particular. Information about smoking and weight control should be included in prevention and cessation classes. The social influences model encourages students to discuss the reasons they smoke or why they think their peers smoke. Table D7 further provides the percent of students who believe smoking helps control weight.

ATTITUDES AND OPINIONS

INTENTIONS TO SMOKE

Question D15: How likely do you think it is that you will smoke one or more cigarettes in the next year?

Table D6 provides the proportion of respondents who indicated a likelihood that they might smoke within the next year. In determining program needs, it is important to take into consideration not only the proportion of students who report that they smoke, but also the proportion who indicate future intent to smoke. This is one of the most powerful predictors of smoking.[4] Students who acknowledge any possibility of future intent to smoke should be considered at increased risk of smoking compared to those who say "I am sure it won't happen." If students have not made a firm commitment not to smoke in the future, encourage them to do so and to make their commitment formal by putting it in writing or stating it in front of their classmates.

REASONS TO USE/NOT USE

Questions D17-24: Please indicate whether or not you agree with the following statements: Smoking makes kids look grown up…Smoking makes your teeth yellow…Smoking is cool…Smoking makes you smell bad…Smoking helps you make friends…Smoking is bad for your health…Smoking helps you relax…Smoking helps control your weight.

Respondents were given eight statements about smoking and asked to indicate how much they agreed or disagreed with each. **Table D7** provides the proportion of students who reported that they agreed or very much agreed with each statement. The statements include both positive reasons for use (e.g., "Smoking is cool") and adverse effects that might deter use ("Smoking makes your teeth yellow"). These are reasons why teens say they smoke and consequences that are typically discussed in smoking prevention programs. As such, this item is useful in helping assess the effectiveness of tobacco curriculum on youth attitudes. The adverse consequences that seem to be the most powerful in influencing nonsmoking are those most immediately relevant to youth, such as those that affect appearance and social relationships, rather than those related to long-term health.[5]

The proportion of youth that agreed that smoking is bad for health or dangerous can be compared with the proportion that perceived smoking as harmful in Table A4.6 in the main report.

PEER AND ADULT NORMS

PEER ATTITUDES AND BEHAVIOR

Adolescents tend to overestimate the actual prevalence of smoking among their peers. For example, in the 1996 Independent Evaluation of the California Tobacco Control, Prevention, and Education Program, only 17% of the 8th graders reported smoking in the past month, but the 8th graders estimated that 43% of their peers smoked. Similarly, only 27% of the 10th-grade students reported smoking in the past month, whereas 10th graders estimated that 51% of their 10th-grade peers smoked.[6]

Because of the overestimation of peer substance use, students may smoke in an effort to imitate these peers, when in reality most of the peers are not smokers. Therefore, prevention programs focusing on normative expectations designed to counter these misperceptions have been found to be an effective prevention strategy.[78] If local youth are significantly overestimating peer smoking behavior, use the CHKS results to counter this. You can monitor the effectiveness of this strategy by follow-up administrations of the survey to determine if student estimates of peer smoking

become more realistic over time, as would be expected. Theoretically, this should be accompanied by a reduction in overall smoking rates.

ADULT SMOKING

Question D16: About how many adults you know smoke cigarettes?

In **Table D8**, youth estimates of the proportion of adults they know who smoke at least once a month are presented (none, some, many, most, or all). Adult behavior provides a model for youth. The results for this item can be used in parent education efforts to demonstrate how students' perception of adult use might influence their decisions to use or not to use. (If the supplementary Module C was also administered, these findings can be compared with their estimates of adult use of marijuana.)

ACCESS TO CIGARETTES

Question D5: If you smoked cigarettes during the past 30 days, how did you usually get them?

The Core module asks students to identify how easy it is to obtain cigarettes (see Table A4.7). To shed further light on cigarette availability, **Table D9** provides data on where students obtain cigarettes.

Recent laws have attempted to make it more difficult for underage youth to obtain cigarettes. Store employees are instructed to ask people for proof of age when they attempt to purchase cigarettes. Many stores keep their cigarette displays locked so adolescents cannot steal cigarettes. Cigarette vending machines have been removed from many places where adolescents could access them. However, these policies are effective only if enforced.[9] It is important to determine whether these policies have indeed made it more difficult for adolescents to obtain cigarettes from retail sources.

What percent of students reported purchasing cigarettes from retail sources and were not asked to show proof of age? The 2001 YRBS reported that 19% of the high school students who had smoked in the past month had purchased cigarettes at a store or gas station in the past month. Among the underage students who had purchased cigarettes at a store or gas station, 67% reported that they were not asked to show proof of age.[10] If students are getting cigarettes from retail sources, policies restricting youth access are not being enforced.

What percent of students reported stealing cigarettes from people or stores? What percent of students reported getting their cigarettes from friends or family members? If they are getting cigarettes from social sources, older relatives and friends may need to be educated about the importance of not giving cigarettes to minors. Now that it is more difficult for adolescents to obtain cigarettes from retail sources, some researchers have speculated that they may rely more heavily on social sources (friends and relatives) or illegal channels to obtain their cigarettes.

SMOKING CESSATION

Question D7: If you now smoke cigarettes, would you like to quit smoking?
Question D8: How many times have you tried to quit smoking cigarettes?
Question D9-11: If you used tobacco during the past 12 months, did you do any of the following things at school to get help to quit using? ...go to a special group or class? ...talk to an adult at your school about how to quit? ...talk to a peer helper about how to quit?

The CHKS asks youth five cessation-related questions: whether they desired to quit, the frequency of cessation attempts, and whether they ever sought help to quit at the school from an adult or peer helper or from a special group or class. Providing encouragement and support for youth cessation efforts is extremely important, because the process of quitting smoking is extremely difficult.[11] People who try to quit smoking often have intense negative physical and psychological reactions that make them extremely likely to relapse. They typically attempt to quit smoking several times before they quit successfully.[12] In this process, they typically progress through stages of change, of which five have been identified:

- not wanting to quit,
- contemplating it,
- taking action,
- a risk relapse stage, and
- finally, a maintenance stage in which the smoker has abstained from smoking for a long period of time, such as six months, and has a high probability of success.

This Transtheoretical Model of Change (TMC), also referred to as the Stages of Change Theory, maintains that the way to help people quit smoking is to develop programs that address the participant's readiness to change. Unlike some stage models, it recognizes that subjects can move back and forth between stages or recycle several times through the stages. Unfortunately, a major controlled scientific trial failed to support the utility of the Stages of Change Theory for increasing effectiveness of tobacco control efforts targeted to British school children.[13] However, that is not to say that programs using this approach should not be included in your district's cessation efforts.

Table D10 provides the proportion of students who have a desire to quit. If only a few smokers express a desire to quit, then efforts may need to be focused on demonstrating why they should stop. If a large proportion wish to quit, it may be a good idea to establish a school-based smoking cessation clinic or class, or at least a referral process for referral to a community-based program. This is particularly important if a high proportion indicate a desire to quit but relatively few have ever tried, as indicated in Table D11. Students may be more likely to quit successfully if they have support from other students who wish to quit, school staff, and trained health educators.

Table D11 reports the frequency that smokers have attempted to quit smoking. The CSS has shown consistently that just under half of the 9th- and 11th-grade smokers (40% and 48% respectively) try to stop the habit at least once. This is a higher cessation-attempt rate than found for illicit drugs and over twice as high as found for alcohol.

Table D12 reports the proportion of students who ever went to a special group or class at school or who ever talked with an adult or peer helper at school about quitting. If these services are available but students are not using them, greater outreach efforts are clearly needed. Consideration should be given to assessing the adequacy of the school TUPE program in promoting the benefits of quitting. This is particularly important if students express a high desire to quit and/or frequency of quit attempts.

PREVENTION PROGRAM EXPOSURE

Module D has been designed especially with the needs of TUPE program development in mind. Table D7 reports student agreement with eight statements about smoking and its effects that are typically covered by prevention curricula. Tables D13 through D15 below help assess exposure to any tobacco lessons and to refusal skills training, one of the most common tobacco education strategies.

EXPOSURE TO ANY LESSONS

Question D13: During the past 12 months, did you do any of these things at school? ...have lessons about tobacco and its effects on the body?

The CHKS asks respondents about whether they had any lessons in school about tobacco and its effects on the body in the past year. The results are reported in **Table D13**. If a high proportion report "yes," you might compare the curriculum content with the strategies assessed by other items in the survey—such as adverse consequences, refusal skills, and normative education—to determine how well the intended messages have been learned. If a high proportion of students say "no" or "don't know," the adequacy of current prevention efforts needs to be examined.

REFUSAL SKILLS TRAINING (SELF-EFFICACY)

Question D12: How hard would it be for you to refuse or say "no" to a friend who offered you a cigarette to smoke?
Question D14: During the past 12 months, did you do any of these things at school? ...practice different ways to refuse or say "no" to tobacco offers?

In **Tables D14** and **D15** students report on whether they had any *practice* saying "no" to tobacco offers in the past year and on their ability to refuse a friend's offer of a cigarette to smoke. Confidence in one's ability to perform an action successfully is called self-efficacy. People tend to perform the actions that they think they can perform well, and they tend to avoid actions that they think they are unable to perform.[14] Some students are not confident that they could successfully resist a cigarette offer from a peer; they may not even try to say "no."

It is not easy for students to tell their friends that they do not want to engage in behavior that their friends think is acceptable.[15] Prevention research has shown that it is not enough to just tell youth to "just say no." Self-efficacy develops through successful performance of the behavior. They need to engage in role-playing and practice. These skills must be reinforced with regular booster sessions and practiced each year until students feel confident in their ability to refuse tobacco. Students who have practiced saying "no" and have been successful will have increased confidence and be more likely to say "no" in the future.

Most tobacco prevention curricula that have shown effectiveness incorporate refusal skills training.[16] Typically students do role-plays in which one student offers a cigarette and another student practices saying "no." If the student says "no" assertively and firmly, compliment the student. If the student seems uncertain, brainstorm ways that the student can say "no" more assertively, without being bullied, ridiculed, or pressured into trying the cigarette. Of course, students will say "no" to a cigarette offer only if they truly do not want to smoke. Therefore, it is not enough to teach students how to say "no." Students must be convinced that smoking is not attractive or cool.

If respondents report that they haven't received any resistance training in the past year, or students have had training but report little confidence in refusal skills, the value of current anti-tobacco curricula needs to be assessed.[17] Even if the curriculum being used does have regular refusal skills training, the teachers may not be implementing the program appropriately.[18]

You might want to further analyze your results to determine if the percentage of students who feel that they would be unable to say "no" differs by grade level, gender, or ethnicity. Some researchers have speculated that adolescents from certain cultural backgrounds (such as Asian Americans or Hispanic/Latinos) may have difficulty saying "no" because their cultural norms and values emphasize harmonious relationships with other people.

Research also suggests that the assertiveness skills and negotiation skills used to refuse cigarette offers are also useful in helping adolescents to avoid other undesirable behaviors, such as drug use, unsafe sex, fighting, and gangs.[19] Thus if students report lacking these skills it may be a good idea to implement a school-wide generic program to teach assertiveness skills, conflict resolution skills, and negotiation skills.

Endnotes

1 Choi et al. (1997).
2 Centers for Disease Control. (1997).
3 Wald, N. J., & Watt, H. C. (1997).
4 For example, Kaplan et al. (2001).
5 Hurd et al. (1980).
6 Independent Evaluation Consortium. (1998).
7 Hansen, W. B., & Graham, J. W. (1991).
8 Flay, Petraitis, & Hu. (1999).
9 Jones et al. (2002).
10 Grunbaum et al. (2002).
11 Fiore et al. (1990).
12 Pallonen et al. (1998).
13 Aveyard et al. (1999).
14 Bandura, A. (1986).
15 Friedman, Lichtenstein, & Biglan. (1985).
16 Ellickson & Hays. (1990).
17 Centers for Disease Control. (1994). Guidelines for school health programs to prevent tobacco use and addiction.
18 Botvin et al. (1990).
19 Charlton, Minagawa, & While. (1999).

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TOBACCO MODULE D

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