

## **Best Practices in Local Tobacco Use Prevention Programs Final Report 1/2006**

### **Overview of the Present Report**

Previous analyses conducted by Dr. Carlo C. DiClemente and his team at the University of Maryland, Baltimore County (UMBC) found that the prevalence of cigarette smoking among underage adolescents in Maryland decreased from 2000 to 2002 (c.f. DiClemente, Pitts, Delahanty, Gmyrek, Malson, & Fiedler, 2004: Adolescent smoking in Maryland 2000-2002: An analysis of the stages of smoking initiation by county with suggestions for prevention strategies). Similarly, significant shifts were found in the Stages of Smoking Initiation from the Transtheoretical Model of Intentional Behavior Change (TTM) from 2000 to 2002, with statewide decreases in the percentage of adolescents in Preparation, Action, and Maintenance (i.e., current smokers) and increases in the percentage of adolescents in Precontemplation (i.e., adolescents who are not thinking about smoking). Appendices A and B provide detailed information on the Transtheoretical Model of Intentional Behavior Change (TTM)'s Stages of Smoking Initiation. One of the key findings of the previous report was that differential changes were present in Stage of Smoking Initiation distributions in Middle and High School youth by county. Consideration of these differences allows individual counties to see where shifts in the Stages of Smoking Initiation have occurred as well as to determine which existing prevention efforts were the most and least effective.

Based on these previous findings, we conducted an examination of county-level practices and smoking prevention programming designed to reduce adolescent smoking to assess whether successful program components could be determined. Phase I of the present study identified 8 Maryland jurisdictions (i.e., counties), 4 of which evidenced more disruption of the process of smoking initiation over time in terms of increases in the commitment of not smoking and decreases in smoking experimentation and regular smoking (from 2000 to 2002) and 4 of which that evidenced less disruption of the process of smoking initiation over time among Middle and High school youth. Phase II of the present study sought to determine successful programming components specific to each of the selected counties. To analyze this, data were abstracted from each of the chosen counties' grants, quarterly progress reports and end of year reports for the Fiscal Years of 2001, 2002 and 2003. This present report will provide a description of how the target jurisdictions were selected (Phase I), followed by the assessment plan and process review (Phase II), results from the data abstraction (Phase III) and finally recommendations and future directions.

### **Phase I: Selection of Target Jurisdictions**

**Goal:** Analyze the Maryland Youth Tobacco Survey (MYTS) data for each jurisdiction to identify those jurisdictions with the highest and lowest rates of tobacco use in 2000 and 2002 (separate analyses conducted for middle and high schools). Use this data to select jurisdictions for participation in this study, "Best Practices in Local Tobacco Use Prevention Programs". The jurisdictions selected shall include those with relatively low rates of tobacco use as well as some with relatively high rates of tobacco use for comparative study.

**Rationale:** Most jurisdictions exhibited positive changes (e.g., decreases in the percentage of youth in the Action / Maintenance Stages of Smoking Initiation) in both Middle School and High School. Given these overall positive changes in the prevention of smoking initiation, the purpose of this study is to highlight specific jurisdictions with prevention programming that is most

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effective. To do this, we examined change over time and shifts in Stages of Smoking Initiation as well as prevalence rates for both middle and high school youth in the 8 selected jurisdictions.

**Methodology:** Maryland has 24 jurisdictions (i.e., counties): Allegany, Anne Arundel, Baltimore City, Baltimore County, Calvert, Caroline, Carroll, Cecil, Charles, Dorchester, Frederick, Garrett, Harford, Howard, Kent, Montgomery, Prince George's, Queen Anne's, St. Mary's, Somerset, Talbot, Washington, Wicomico, and Worcester.

Criteria used to evaluate jurisdictions for participation in this study were: absolute changes in Centers for Disease Control and Prevention (CDC) prevalence rates and in distributions of the Stages of Smoking Initiation in 2000 and 2002 (for more information see *Adolescent Smoking in Maryland 2000-2002: An Analysis of the Stages of Smoking Initiation by County with Suggestions for Prevention Strategies*). Demographic variables (i.e., ethnicity, poverty, population density, percentage of high school graduates, and geographic location) were also examined to avoid any potential confounding effects based on these factors. Jurisdictions were selected for inclusion in this study based on an examination of regression graphic software (ARC) as well as on rank order patterns of data.

Of the 24 jurisdictions, 8 were selected for inclusion in this study based on the absolute changes in CDC prevalence rates and in the distributions of the Stages of Smoking Initiation in 2000 and 2002: Allegany, Calvert, Harford, Howard, Kent, Queen Anne's, St. Mary's, and Somerset. Four jurisdictions were chosen because they exhibited less smoking initiation disruption (LSID): Allegany, Calvert, Kent, and St. Mary's. These jurisdictions will subsequently be identified using the label "LSID". Four other jurisdictions were selected because they showed more smoking initiation disruption (MSID): Harford, Howard, Queen Anne's, and Somerset. These jurisdictions will subsequently be labeled "MSID". The remaining 16 jurisdictions were excluded from this study, with two jurisdictions being used to pilot assessments.

### **Reasons for Inclusion**

#### **Less Smoking Initiation Disruption "LSID" Counties:**

##### **Allegany: LSID County**

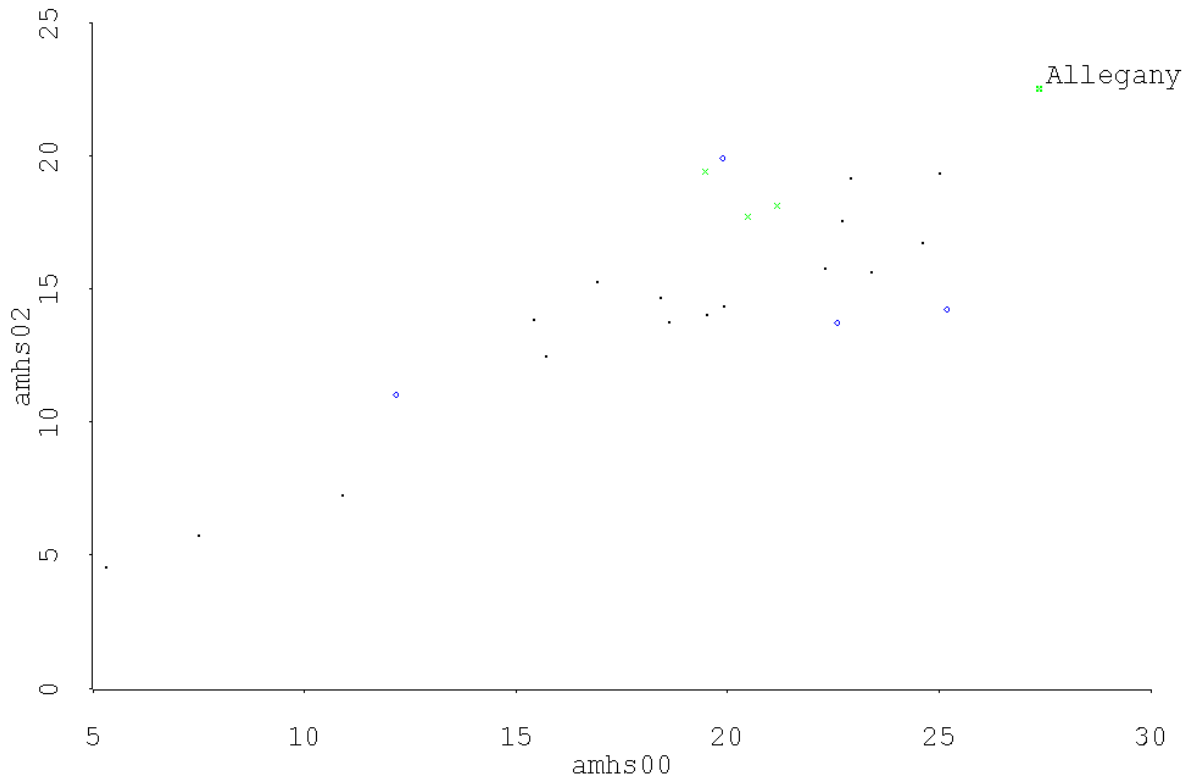
Allegany County was considered to be a 'LSID' because this county had one of the lowest rates of youth in precontemplation among *high school students* in 2000 and evidenced only a slight decrease over time (i.e., from 2000 to 2002) in youth in Action / Maintenance among *middle school youth*. There was a moderate decrease of youth in Action / Maintenance among *high school youth*; however among the chosen 8 counties, Allegany reported the highest rate in CDC prevalence (i.e., past month cigarette smoking) in 2002.

The figure below shows the 8 selected counties (4 **LSID** in **green** and 4 **MSID** in **blue**) and where they were in terms of the percentage of youth in high school who reported being in the Action / Maintenance stage (i.e., current regular smokers) in 2000 (horizontal, x-axis) and the percentage of youth in high school who reported being in the Action / Maintenance stage in 2002 (vertical, y-axis).

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Figure 1 illustrates how Allegany county (upper right-hand corner of figure), while showing a decrease among youth in high school in Action / Maintenance from 2000 to 2002, still reported one of the highest levels of current smoking (i.e., youth in Action / Maintenance) in 2002.

Figure 1. Percentage of High School Youth in Action / Maintenance in 2000 (amhs00) with the percentage of High School Youth in Action / Maintenance in 2002 (amhs02) by Selected Counties



**Calvert: LSID County (High School ONLY)**

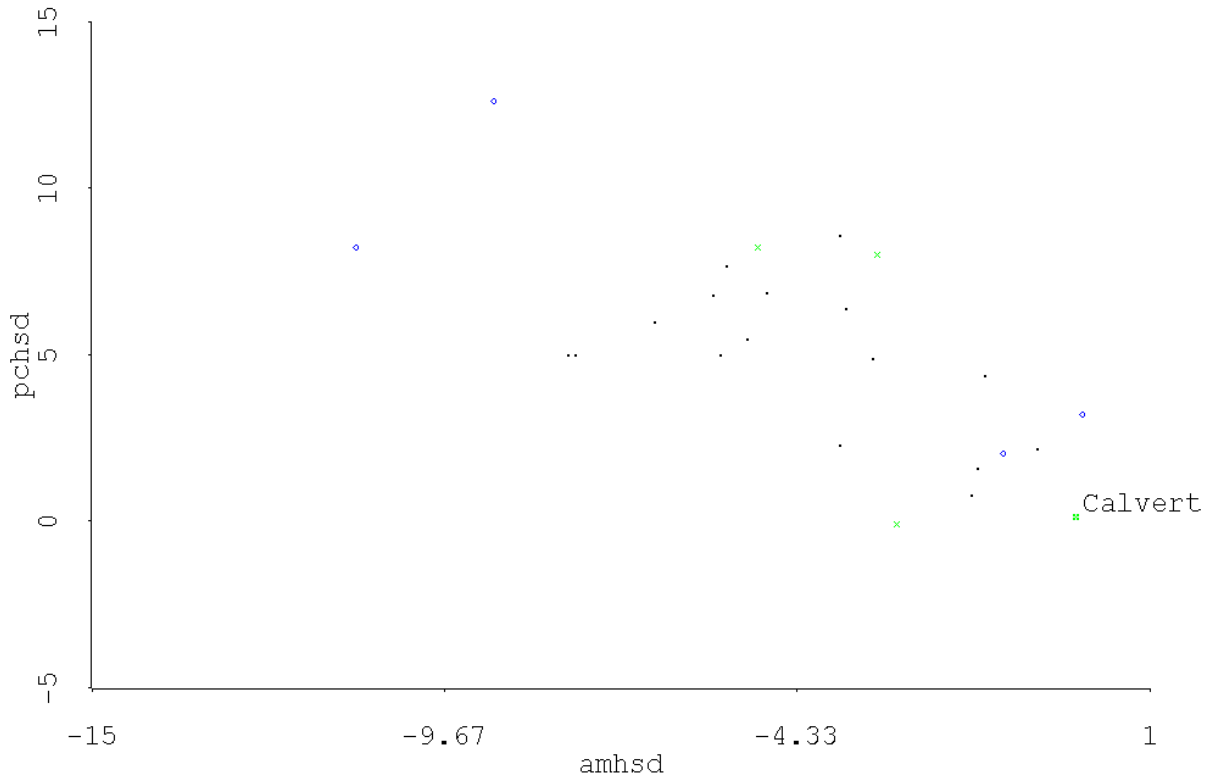
Calvert County was considered to have had less smoking initiation disruption (LSID) because this county had evidenced virtually no change over time in the percentage of youth in precontemplation (i.e., youth with a firm commitment not to smoke in the future) among *high school students*. Among *middle school youth*, there was a moderate decrease of the percentage of youth in Action / Maintenance over time; however there was only a slight decrease among high school youth. Thus, Calvert County was chosen as a LSID County based on their *high school youth* only.

Figure 2 depicts the difference in youth in Action / Maintenance in high school (% of youth in Action / Maintenance in 2002 - % of youth in Action / Maintenance in 2000) on the X-axis (horizontal) and the difference in youth in Precontemplation in high school (% of youth in Precontemplation in 2002 - % of youth in Precontemplation in 2000) on the Y-axis (vertical).

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Calvert County (lower right hand corner) evidenced only a small decrease in youth in Action / Maintenance over time and a minimal increase in the number of youth in Precontemplation over time, relative to the other counties.

Figure 2. Differences in the Percentage of High School Youth in Action / Maintenance (amhsd) with the difference in the percentage of High School Youth in Precontemplation (pchsd) by Selected Counties

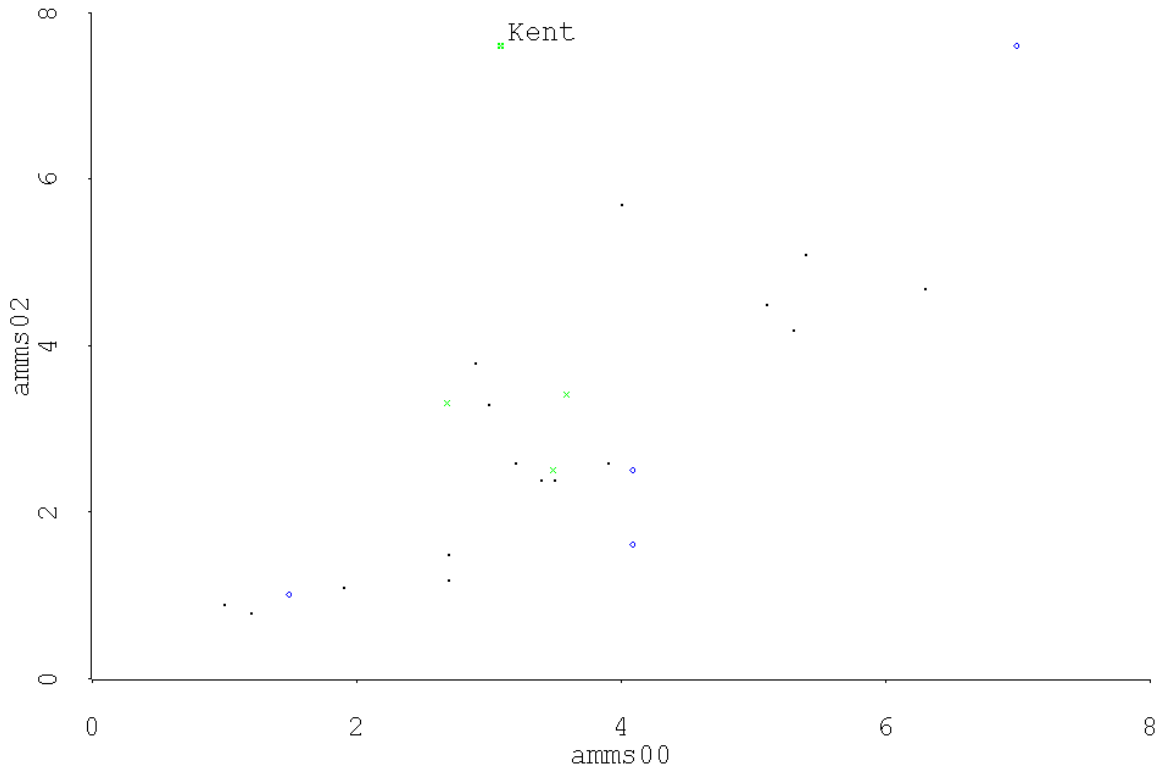


**Kent: LSID County**

Kent County was considered to have had less smoking initiation disruption (LSID) because this county was the only county to decrease the percentage of *middle school youth* in precontemplation over time. Similarly, this county evidenced the highest increase in Action / Maintenance among *middle school students*. Kent County did show increases in youth in precontemplation among *high school youth*, but in 2000 had one of the lowest percentages of *high school youth* in precontemplation. Kent County did show decreased CDC prevalence for *high school youth*; however 25% of high school student were still smoking in 2002. Figure 3 compares the percentage of *middle school youth* in Action / Maintenance in 2000 to the percentage of middle school youth in Action / Maintenance in 2002. This figure shows how the percentage of middle school youth who are smoking (Action / Maintenance) in Kent County increased over time (from 2000 to 2002). Kent County was also chosen because it is geographically adjacent to a MSID county, Queen Anne’s county.

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Figure 3. Percentage of Middle School Youth in Action / Maintenance in 2000 (amms00) with the percentage of Middle School Youth in Action / Maintenance in 2002 (amms02) by Selected Counties

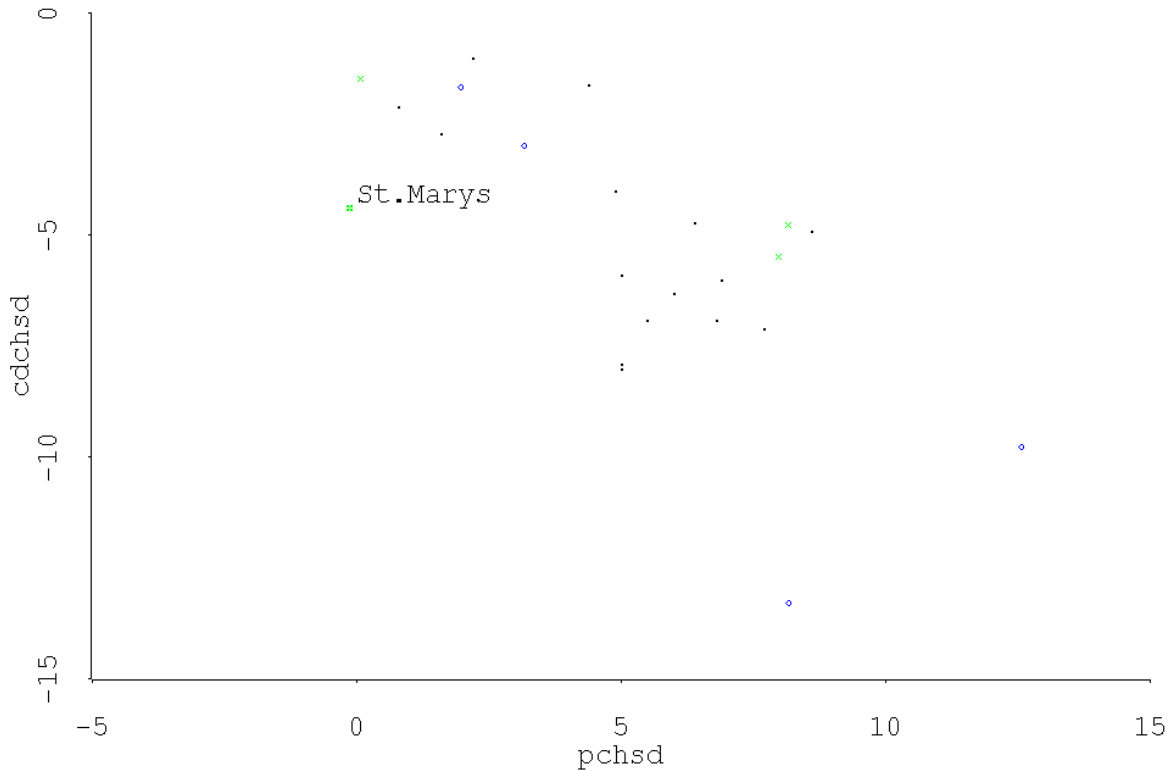


**St. Mary's: LSID County**

St. Mary's County was considered to have had less smoking initiation disruption (LSID) because this county was the only county to decrease the percentage of *high school youth* in precontemplation over time. Similarly, there was an increase in the percentage of youth in Action / Maintenance over time among *middle school youth*. Similar to Kent County, there were decreases over time in CDC overall prevalence of smoking among *high school youth*; however a high percentage of *high school students* were still smoking in 2002. Figure 4 shows that while decreasing the percentage of High School youth who smoked according to CDC criteria (i.e., smoked a cigarette on one or more days during the past 30 days), this county was the only county to decrease the percentage of *high school youth* in precontemplation over time.

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Figure 4. Difference in percentage of High School youth in Precontemplation (% of High School youth in Precontemplation in 2002 - % of High School youth in Precontemplation in 2000: pchsd) with the difference in the percentage of High School youth reporting past month smoking according to CDC prevalence (2002 - 2000: cdchsd) by Selected Counties.



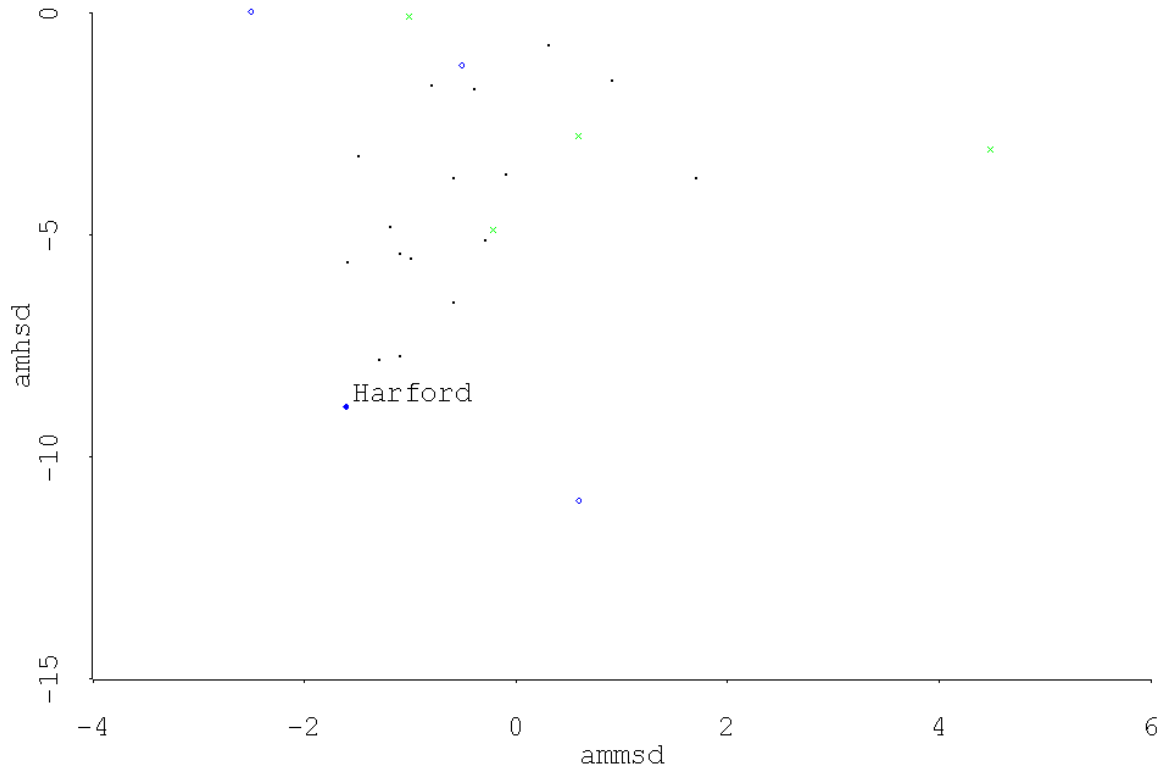
**More Smoking Initiation Disruption “MSID” Counties:**

**Harford: MSID County**

Harford County was considered to have had more smoking initiation disruption (MSID) because this county had one of the largest decreases in rates of youth in Action / Maintenance among both *middle and high school students* over time (see Figure 5). Figure 5 presents the difference in percentage of Middle School youth in Action / Maintenance (% of Middle School youth in Action / Maintenance in 2002 - % of Middle School youth in Action / Maintenance in 2000) with the difference in percentage of High School youth in Action / Maintenance (% of High School youth in Action / Maintenance in 2002 - % of High School youth in Action / Maintenance in 2000). Harford County also evidenced the greatest increase in youth in precontemplation among *high school youth* from 2000 to 2002. There also were significant decreases in CDC prevalence among both middle school (highest decrease) and high school youth (2<sup>nd</sup> highest decrease) over time.

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Figure 5. Difference in percentage of Middle School youth in Action / Maintenance (ammsd) with the difference in percentage of High School youth in Action / Maintenance (amhsd) by Selected Counties.

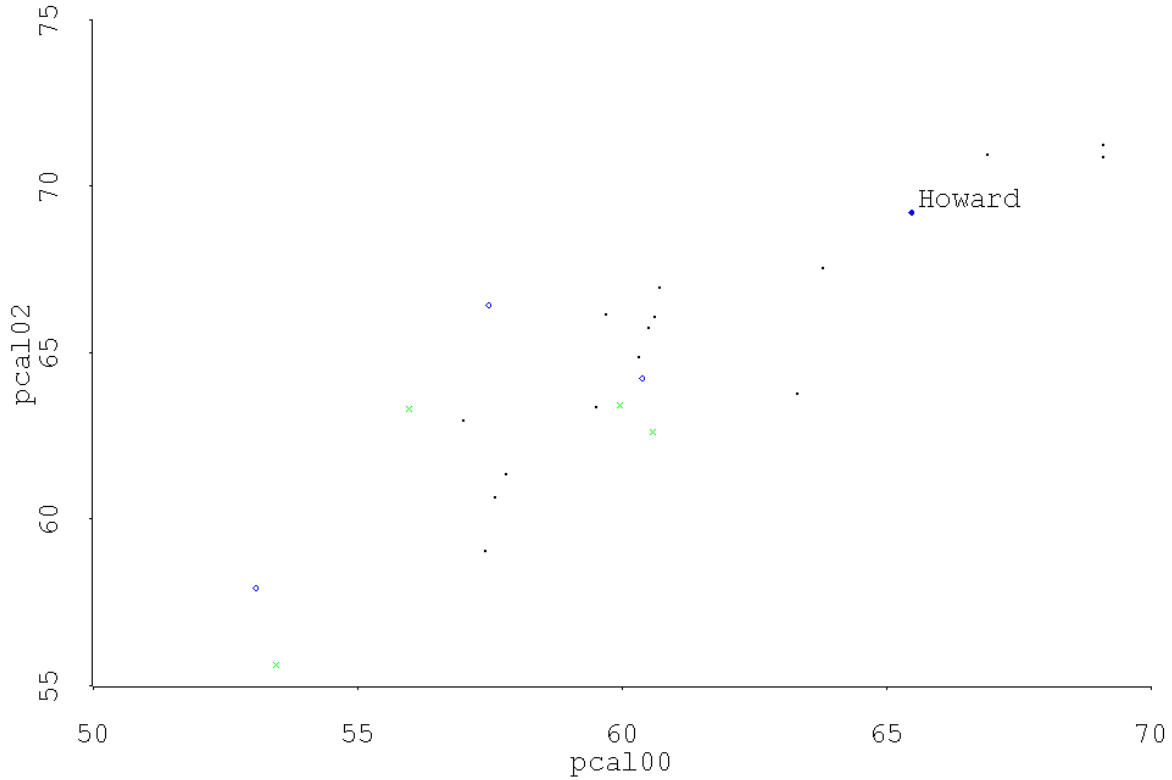


**Howard: MSID County**

Howard County was considered to have had more smoking initiation disruption (MSID) because this county had one of the largest decreases in rates of youth currently smoking, i.e. in Action / Maintenance, among both Middle and High school students over time. Similarly, as Figure 6 shows, Howard county also demonstrated the largest increase in the percentage of youth in Precontemplation (Middle school and High school combined) over time (from 2000 to 2002).

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Figure 6. Comparison of percentage of youth in Precontemplation in 2000 (pca100) with the percentage of youth in Precontemplation in 2002 (pca102) by Selected Counties



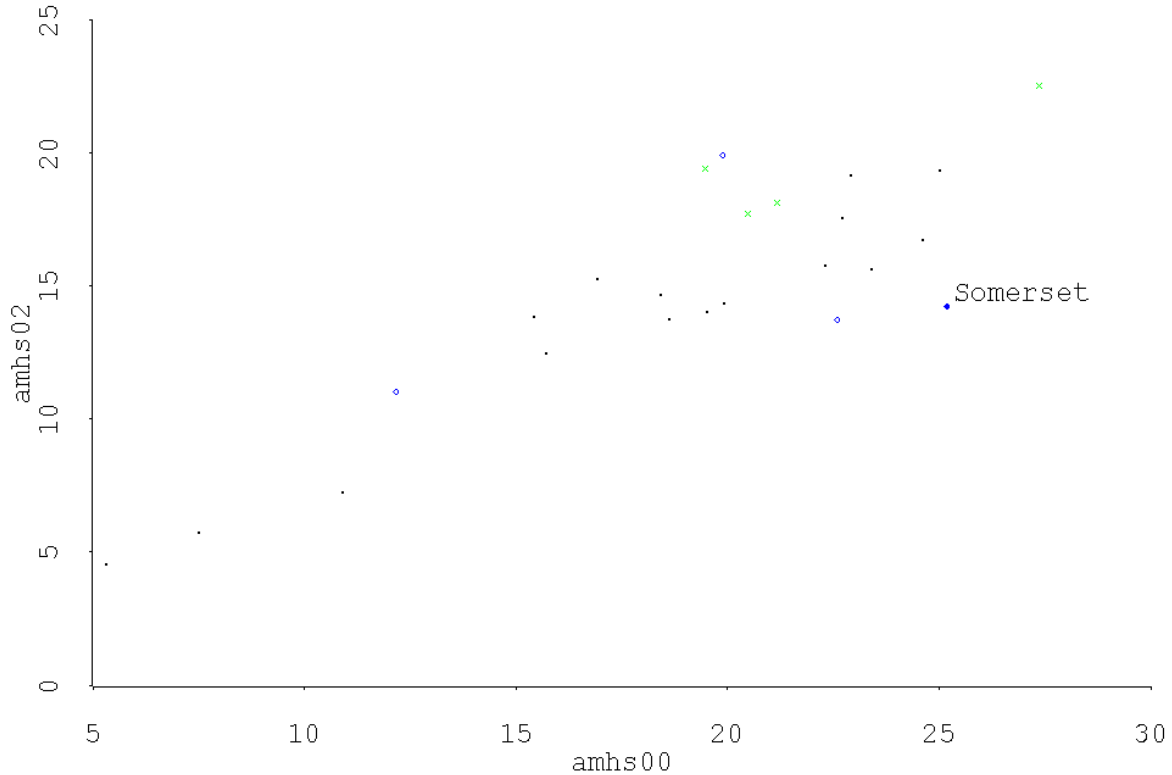
**Somerset: MSID County (High School ONLY)**

Somerset County was considered to have had more smoking initiation disruption (MSID) because this county had the largest decrease of youth in Action / Maintenance among *high school* youth from 2000 to 2002 (see Figure 7). Somerset County evidenced a slight increase in the percentage of youth in Action / Maintenance among *middle school* youth over time (from 2000 to 2002). Thus, Somerset County was considered a MSID county based on their high school youth only.



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Figure 7. Percentage of High School youth in Action / Maintenance in 2000 (amhs00) compared with the percentage of High School youth in Action / Maintenance in 2002 (amhs02) by Selected Counties

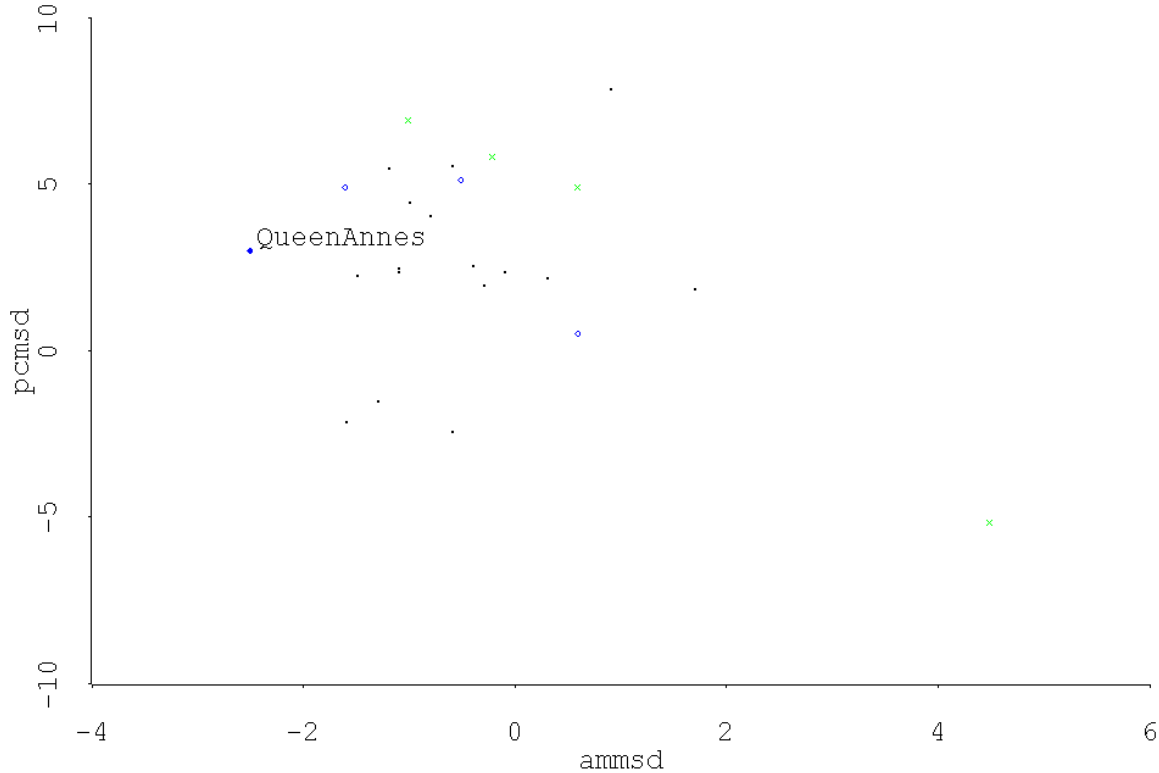


**Queen Anne’s: MSID (Middle School ONLY)**

Queen Anne’s County was considered to have had more smoking initiation disruption because this county had the highest decrease of youth in Action / Maintenance among *middle school* youth from 2000 to 2002 while showing moderate increases in the percentage of youth in precontemplation. Figure 8 presents the differences in the percentage of Middle School youth in Action / Maintenance (% of Middle School youth in Action / Maintenance in 2002 - % of Middle School youth in Action / Maintenance in 2000) compared with differences in the percentage of Middle School youth in Precontemplation (% of Middle School youth in Precontemplation in 2002 - % of Middle School youth in Precontemplation in 2000). Queen Anne’s County evidenced virtually no change in the percentage of youth in Action / Maintenance among *high school* youth over time (from 2000 to 2002). Thus, Queen Anne’s County was considered an MSID county based on *middle school* youth only.

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Figure 8. Differences in the percentage of Middle School youth in Action / Maintenance (ammsd) compared with differences in the percentage of Middle School youth in Precontemplation (pcmsd) by Selected Counties.



**Reasons for Exclusion:**

Based on a preliminary assessment of the MYTS data, Anne Arundel and Cecil were chosen to be used as pilot jurisdictions for “Phase II – Assessment Plan and Process Review” because they demonstrated minimal changes over time and neither large positive or negative changes in adolescent cigarette smoking initiation.

Baltimore City and Baltimore County were considered to be jurisdictions with more smoking initiation disruption (MSID) because they exhibited high rates of youth in *Precontemplation* and lower rates of youth in *Action / Maintenance* in both middle and high school. These jurisdictions were excluded from this study because it was believed that due to their profile on demographic variables it would be difficult to use them for comparison with other Maryland jurisdictions.

Allegany, Garrett and Washington counties were considered jurisdictions with less smoking initiation disruption (LSID) because all 3 counties reported high rates of youth currently smoking, i.e. in *Action / Maintenance*, in both middle school and high school. Of these three jurisdictions, Allegany was selected because it had the highest rates of smoking among high school students in both 2000 and 2002. Garrett and Washington were excluded from this study because of their similarity to Allegany, which was selected for inclusion.

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Howard, Montgomery, and Prince George's counties were considered to be MSID jurisdictions. All three jurisdictions reported high percentages of youth in *Precontemplation* and low percentages of youth in *Action / Maintenance* in both middle and high school. Of these three jurisdictions, Howard was selected because it had the one of the highest percentages of students in the Precontemplation Stage of Smoking Initiation in both 2000 and 2002. Montgomery and Prince George's were excluded from this study because of their similarity to Howard, which was selected for inclusion.

Because Kent, Queen Anne's, and Somerset were selected for inclusion in this study, other Eastern Shore jurisdictions (i.e., Caroline, Dorchester, Talbot, Wicomico, and Worcester) were excluded to avoid similarities due to location.

To avoid similarities due to location and because they did not show large positive or negative changes in terms of increases in youth commitment not to smoke in the next year (*Precontemplation*) nor decreases in smoking experimentation and regular smoking (*Action / Maintenance*) in adolescent cigarette smoking (from 2000 to 2002), Frederick and Carroll were also excluded from this study.

### **Demographic Characteristics and Chosen Jurisdictions**

The State of Maryland is very diverse, including geographic composition, ethnic distribution, distribution of poverty, and educational attainment. Since smoking prevalence has been shown to be related to socio-demographic characteristics (e.g., poverty level and ethnicity), care was taken to avoid having all of the 'LSID' or all of the 'MSID' jurisdictions being too similar on demographic characteristics. For example, we took care to avoid having all of the MSID jurisdictions all being from low poverty counties or having all of the LSID jurisdictions all being from Eastern Shore counties. Thus, analyses also were conducted to ensure that the chosen jurisdictions were not confounded by demographic characteristics.

Figures 9, 10, and 11 demonstrate that the selection of the **MSID** and **LSID** counties was not confounded by demographic variables. Figure 9 shows the percentage of high school graduates in each of the selected counties. The **MSID** counties had both the highest and lowest percent of high school graduates. However, overall there did not appear to be differences in terms of percent of high school graduates and county type (**MSID** or **LSID**). Figures 10 and 11 show the percentage of persons who are white<sup>1</sup> by the county types (**MSID** or **LSID**) and the percentage of persons who are living in poverty<sup>2</sup> by the county types (**MSID** or **LSID**). Both of these figures show that the distribution of ethnicity and poverty is equally spread across the 2 types of smoking initiation disruption.

Appendix C presents an examination of the county type (**MSID** or **LSID**) and the sample demographic characteristics and other smoking-related characteristics derived from the 2000 and 2002 MYTS surveys.

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<sup>1</sup> The demographic characteristics of the State of Maryland were derived from the Maryland Quick Facts from the U.S. Census Bureau website (<http://quickfacts.census.gov/qfd/states/24000.html>)

<sup>2</sup> From 1999 estimate, also derived from the State of Maryland Quick Facts website

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Figure 9. Histogram of percent of High School Graduates (hsgrad) by County Type (**MSID** or **LSID**).

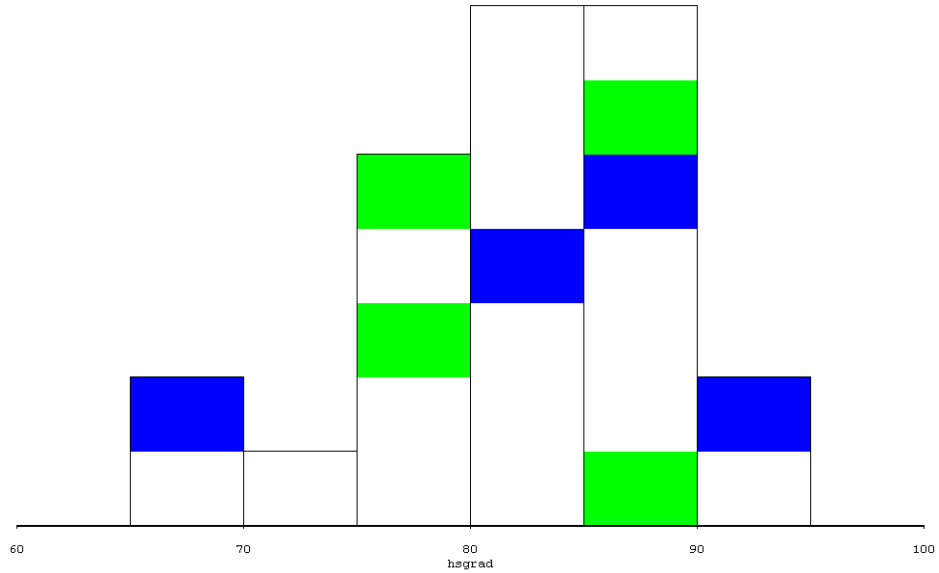
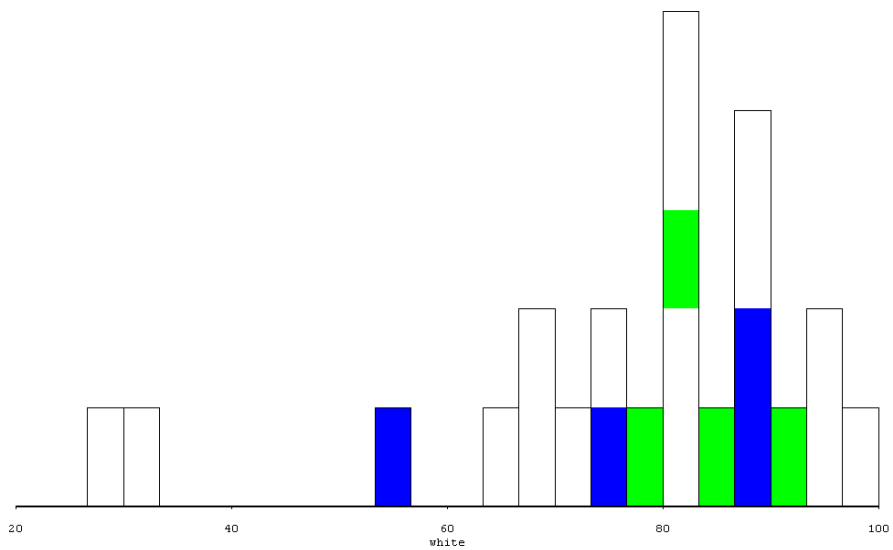
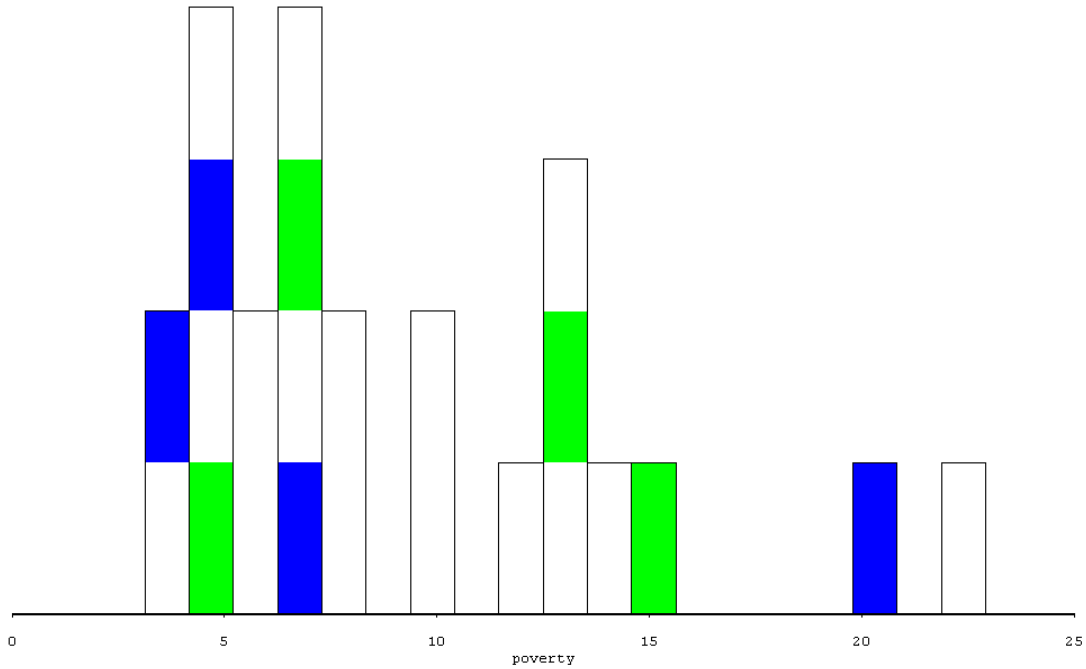


Figure 10. Histogram of percent of Persons who are White by County Type (**MSID** or **LSID**).



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Figure 11. Histogram of percent of persons who are living in Poverty by County Type (**MSID** or **LSID**).



**Summary:** The vast majority of jurisdictions showed positive changes (i.e., decreases in the percentage of youth in the Action / Maintenance Stages of Smoking Initiation) in both middle school and high school. Very few counties were best or worst across the board. Care was taken to make sure these comparisons of smoking rates in the chosen jurisdictions were not confounded with demographic variables (i.e., ethnicity, poverty, population density, geographic location).

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### **Phase II: Assessment Plan and Process Review**

**Goal:** Develop a plan for reviewing the available process data, acquiring any additional data, and mapping this data against relevant aspects of the CDC Evaluation Framework, Stages of Initiation Model, and the analytical framework being used to assess ‘best practices.’

**Rationale:** In Phase I of this study, eight Maryland jurisdictions were selected for inclusion based on absolute changes in CDC prevalence rates and in distributions of the Stages of Smoking Initiation. Four jurisdictions were chosen because they less smoking initiation disruption (LSID): Allegany, Calvert, Kent, and St. Mary’s. Four other jurisdictions were selected because they demonstrated more smoking initiation disruption (MSID): Harford, Howard, Queen Anne’s, and Somerset. The remaining 16 jurisdictions were excluded from this study. The purpose of this phase of the study was to establish a strategy for reviewing and acquiring data from the grant applications from FY 2001 – FY 2003 for each of the eight chosen jurisdictions as well as from interviews with key personnel in these jurisdictions.

**Methodology:** Based on a preliminary assessment of the MYTS data, Anne Arundel and Cecil were chosen as pilot jurisdictions for this phase of the study because they did not show large positive or negative shifts in adolescent cigarette smoking. All available grant applications and quarterly progress reports from FY 2001 – FY 2003 were reviewed for these jurisdictions. Data for each jurisdiction were independently reviewed by two raters.

Based on this examination of the data as well as on literature regarding existing school-based tobacco programs, a template was compiled that detailed commonly occurring smoking cessation and prevention efforts (see Appendix D). However, because jurisdictions also conduct tobacco programs outside of the schools, a separate template was created to specify smoking cessation and prevention efforts including community-based, enforcement, and cessation initiatives (see Appendix E). Another template was created for use in mapping the jurisdictions’ school-based tobacco programs against CDC’s *Recommendations for School Health Programs to Prevent Tobacco Use and Addiction* (see Appendix F).

**Summary:** This plan for reviewing the available data and acquiring additional data facilitated our assessment of the ‘best practices’ for producing behavioral change with respect to the prevention of underage tobacco use in Maryland.

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### Phase III: Data Collection from Target Jurisdictions

**Goal:** Using the templates derived from the examination of the Pilot Counties (Anne Arundel and Cecil counties; see Appendices D through F) from Phase II, we conducted reviews of the selected 4 **MSID** and 4 **LSID** jurisdictions' grants, quarterly and end of year reports for Fiscal Year (FY) '01, FY '02, and FY '03.

**Rationale:** The purpose of this phase of the study was to quantify the tobacco-related activities conducted in each of the jurisdictions acquired from the grant applications, quarterly and end of year reports from FY 2001 – FY 2003 for each of the eight chosen jurisdictions.

**Methodology:** In order to determine which activities or components were most related to changes in tobacco use initiation among middle and high school students, we reviewed all available grant applications and quarterly progress reports from FY 2001 – FY 2003. Data for each jurisdiction were independently reviewed by two raters. Data were abstracted from the county reports using the templates created in Phase II (see Appendices D through F) and targeted primarily 4 Domains of Influence. The domains identified were School-Based, Community-Based, Cessation, and Enforcement Initiatives, which are reflective of the types of areas that utilized funding from the Cigarette Restitution Fund (CRF) to develop tobacco prevention and intervention programming.

**School-based initiatives and activities** are believed to be integral to decreasing tobacco use in middle and high school students because it is in this environment that the largest number of school-aged individuals can be reached. Thus, the first domain of intervention examined was in-school activities. The counties in the state of Maryland used several methods to attempt to decrease tobacco use in school-aged children.

Although we are primarily interested in activities in middle and high schools because we are measuring adolescent tobacco use, in some instances we were unable to differentiate whether activities in the county reports were completed in elementary schools or in secondary schools. Thus, the information on school-based initiatives may also include some activities that occurred in elementary schools. Whether or not and the degree to which schools instituted school-based initiatives varies.

Components of the school-based domain include formal and informal prevention curricula. "Formal prevention curricula" refers only to the tobacco prevention curricula reported as effective by the Center for Disease Control (CDC). This includes Life Skills Training (LST) and Towards No Tobacco (TNT). Informal curricula refers to all other curricula implemented in schools with tobacco components, including, but not limited to, Not on Tobacco (NOT), Tobacco Awareness Program (TAP), Tobacco Education Program (TEP), Tobacco Education Group (TEG), Kids Against Tobacco Use (KATU), Here's Looking at You, Tobacco 101, the Growing Healthy Curriculum, and Stay Smart.

Schools also promoted tobacco prevention and cessation by providing students with educational information (brochures, pamphlets). School assemblies and presentations addressed the negative consequences of tobacco use, and contests that focused on anti-tobacco messages (e.g. poster and billboard design) raised awareness about the dangers of smoking. Additionally, some schools posted tobacco-related messages in school (e.g. posters, billboards) and held special awareness events on campus (World No Tobacco Day, Health & Wellness Fairs). In

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some instances student and teacher cessation classes were offered and peer-groups to address tobacco issues were organized.

The second domain of interest was **Community-Based initiatives**. While some activities in this sector included or focused on the population of interest (i.e. adolescents), others did not. The degree to which community initiatives were implemented varies by county. However, initiatives were designed to meet particular goals, and were targeted towards various groups. Some community interventions targeted specific populations (e.g. pregnant women, minority groups, faith-based groups, daycare centers) while others were not specific to any particular demographic. On the most basic level, educational materials about tobacco use and second-hand smoke (e.g. brochures, pamphlets, referral cards) and anti-tobacco merchandise (mugs, mini-footballs, etc.) were distributed to community members or organizations. Self-help materials and Nicotine Replacement Therapy were also provided in some counties. Mini-grants were awarded, which allowed for the implementation of anti-tobacco initiatives by faith-based and other community groups.

Other initiatives focused on building collaborations between the community and institutions in the form of coalitions, committees, and task forces. Coalitions made efforts to affect local policy, specifically by promoting “smoke-free environments.” Community funds were also used to train individuals in how to provide tobacco prevention and cessation classes. Some counties worked to educate physicians and other health care providers about how to implement tobacco education during patient visits. Special awareness events, generally in the form of health and wellness fairs, and events held on nationally recognized anti-tobacco days (i.e. Great American Smokeout, World No Tobacco Day) were also held. Some counties intervened in workplaces, and several disseminated information through the media (e.g. newspaper articles and billboard, radio, and television ads).

The third group of initiatives focused on **Tobacco Cessation**. The most commonly used initiative was cessation counseling, which was generally targeted toward the adult segment of the population. Counseling efforts were implemented in workplace environments and in peer led community groups. Cessation was also encouraged during special anti-tobacco events such as World No Tobacco Day. Additionally, funds for the cessation initiatives were used to provide pharmacotherapy for smokers in the form of quit aids, such as Zyban or Nicorette. Finally, general educational materials, self-help/“Quit” kits, and incentives and promotional items (e.g. stickers, pens, etc.) were distributed.

The fourth and final domain was **Enforcement**, which focused on the enforcement of laws regarding tobacco use. Counties provided vendor education, which included the provision of information about product placement and youth access. Youth volunteers were recruited to conduct compliance checks at tobacco vendors; citations were given to vendors who were found in violation. In some counties, youth also received violation notices if they were using tobacco illegally. Training for officers was provided in some counties and educational programs for youth were held. One county reported the use of a police tip-line.

The school-based initiatives were also analyzed with regard to the *seven recommendations set forth by the Center for Disease Control (CDC) for school health programs to prevent tobacco use and addiction*. The recommendations are as follows (also see Appendix F):

- 1) Develop and enforce a school policy on tobacco use;



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- 2) Provide instruction about the short- and long-term negative physiologic and social consequences of tobacco use, social influences on tobacco use, peer norms regarding tobacco use, and refusal skills;
- 3) Provide tobacco-use prevention education in K-12; this instruction should be especially intensive in junior high or middle school and should be reinforced in high school;
- 4) Provide program-specific training for teachers;
- 5) Involve parents or families in support of school based programs to prevent tobacco use;
- 6) Support cessation efforts among students and all school staff who use tobacco;
- 7) Assess the tobacco-use prevention program at regular intervals.

Abbreviated details of what each county did to meet each recommendation were then entered into Appendix F.

All of the counties and their schools, prior to receipt of the Tobacco Grant, had tobacco policies in place. No significant changes in these policies were reported in the grants, therefore, school districts have met Recommendation 1. Due to the limited information regarding the content of formal and informal prevention programs, compliance with Recommendation 2 could not be accurately assessed. Presumably, counties who used CDC approved tobacco programming (i.e. Life-Skills Training (LST) and Towards No Tobacco (TNT)) did comply. Counties did not mention whether the parents or families of children in the schools were informed of or participated in the tobacco prevention and cessation programs implemented in the schools. Therefore, Recommendation 5 could not be appropriately assessed. Finally, detailed information regarding how tobacco-use programs were regularly assessed was not consistently provided within the reports; therefore compliance with Recommendation 7 could not be determined.

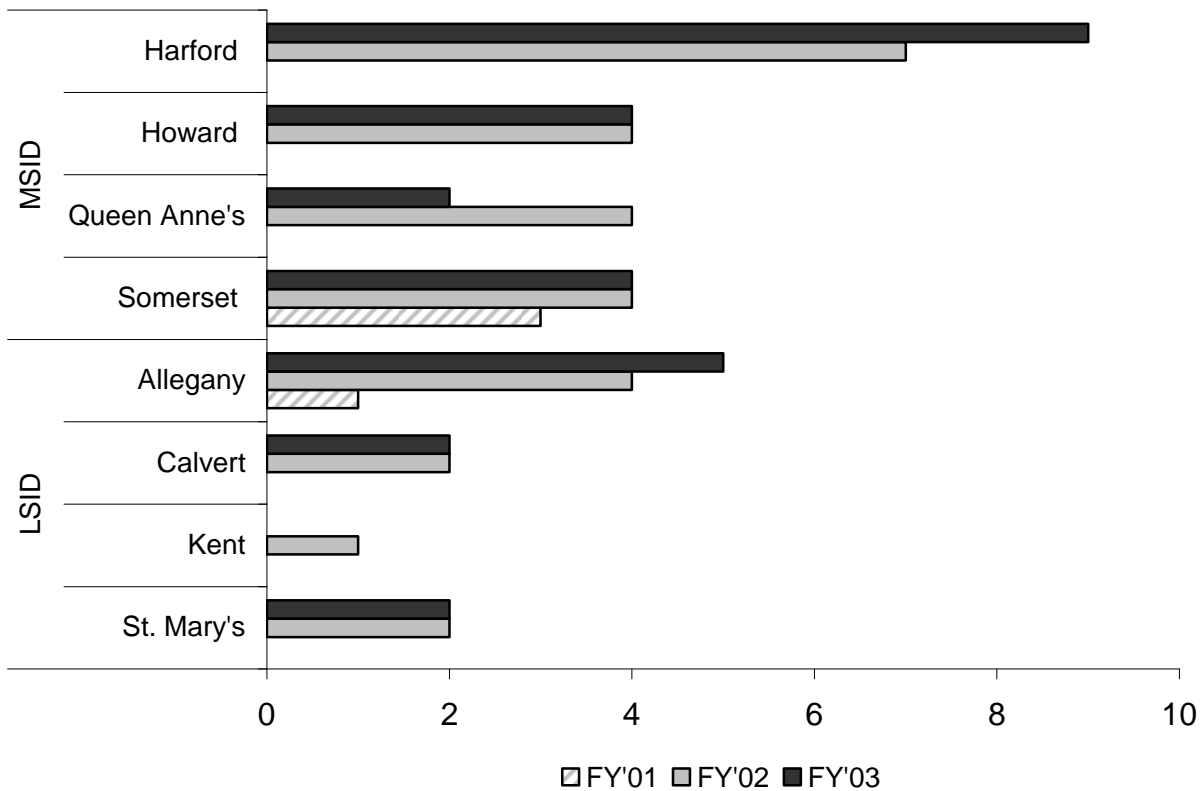
**Data Analysis:** Overall, jurisdictions differed dramatically in the manner in which they recorded their county's tobacco-related activities. In some cases, jurisdictions reported detailed information about a smoking-related activity (e.g., the number of youth who received the intervention, the target grade level, the number of sessions) and in other cases, jurisdictions just recorded that the activity occurred. However, due to each jurisdiction not having a standardized way to report their tobacco-related activities (i.e., different formats for quarterly and end of year reports); it was often the case that we could only determine whether an activity was conducted or not conducted. Thus, we ultimately were only able to record when an activity was conducted, allowing for comparison of the jurisdictions that had better record keeping with jurisdictions with less optimal record keeping. Using the templates in Appendices D through F, each independent rater would give credit if an activity was reported to be conducted in the county during a Fiscal Year. Counts of activities were calculated across Fiscal Years for each Domain (i.e., number of school-based activities in FY'01 + number of activities in FY'02 + number of activities in FY'03) and within a domain and Fiscal Year (i.e., the number of school-based activities conducted in FY'01 only). The number of CDC recommendations that were reported for each of the jurisdictions was also tabulated. As noted in the methodology, only three of the seven CDC recommendations could be evaluated from the quarterly and end of year reports, thus the count ranges from 0 to 3, with 0 representing no activities conducted and 3 representing all activities conducted.

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**Results:**

Figure 15 shows the count of School-Based Activities by Fiscal Year (FY '01, FY '02, and FY '03) by County and County Type (**more smoking initiation disruption [MSID]** vs. **less smoking initiation disruption [LSID]**). Not surprisingly, in FY'01, prior to the institution of Cigarette Restitution Funds, very few of the counties (only Somerset and Allegany) were recording school-based activities. Across the board, the number of activities reported by each of the jurisdictions increased in FY '02 and FY '03. As this figure demonstrates, overall it appears that the **MSID** counties reported more School-Based activities relative to the **LSID** counties, with the exception of Queen Anne's and Allegany counties.

Figure 15. Count of School-Based Activities by Fiscal Year ('01 – '03) by County and County Type (MSID vs. LSID)



Tables 1 and 2 examine the rank-order of the counties by the number of activities by domain. These tables demonstrate that the three of the four top ranked counties were **MSID** counties; one was a **LSID** county (Allegany).

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Table 1. Total Count of Activities (Across Fiscal Years) by Domain of Influence by County and County Type (**MSID** vs. **LSID**)

County	Type	School-Based	Cessation	Community	Enforcement
Harford	<b>MSID</b>	16	18	17	9
Somerset	<b>MSID</b>	11	13	15	10
Allegany	<b>LSID</b>	10	10	18	10
Howard	<b>MSID</b>	8	7	14	5
Queen Anne's	<b>MSID</b>	6	7	7	10
Calvert	<b>LSID</b>	4	3	14	6
St. Mary's	<b>LSID</b>	4	8	23	9
Kent	<b>LSID</b>	1	6	12	3

Table 2. Rank-Order of 4 Domains of Influence by County Type (**MSID** vs. **LSID**)

**MSID Counties**

- Harford County:
  - 1st in School-Based
  - 1st in Cessation
  - 3rd in Community
  - Tied for 4th Enforcement
- Howard
  - 4th in School-Based
  - Tied for 5th Cessation
  - Tied for 5th Community
  - 7th for Enforcement
- Somerset
  - 2nd in School-Based
  - 2nd in Cessation
  - 4th in Community
  - Tied for 1st for Enforcement
- Queen Anne's
  - 5th in School-Based
  - Tied for 5th Cessation
  - 8th Community
  - Tied for 1st for Enforcement

**LSID Counties**

- Allegany
  - 3rd in School-Based
  - 3rd in Cessation
  - 2nd in Community
  - Tied for 1st in Enforcement
- St. Mary's
  - Tied 6th in School-Based
  - 4th Cessation
  - 1st in Community
  - Tied for 4th in Enforcement
- Kent
  - 8th in School-Based
  - 7th Cessation
  - 7th in Community
  - 8th in Enforcement
- Calvert
  - Tied 6th School-Based
  - 8th in Cessation
  - Tied for 5th in Community
  - 6th in Enforcement

Table 3 and Figure 16 show the number of CDC recommendations that each of the jurisdictions conducted according to Fiscal Years. The 01, 02 and 03 in the columns under each county name in Table 3 refer to the Fiscal Years.

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Table 3. CDC Recommendations by County and Fiscal Year

CDC Recommendations	More Smoking Initiation Disruption (MSID)									Less Smoking Initiation Disruption														
	Harford			Howard			Somerset			Queen Anne's			Allegany			Calvert			Kent			St Mary's		
	01	02	03	01	02	03	01	02	03	01	02	03	01	02	03	01	02	03	01	02	03	01	02	03
Rec #1: Develop and enforce a school policy on tobacco use	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Rec #2: Provide instruction about the short- and long-term negative physiologic and social consequences of use, social influences, peer norms and refusal skills *	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--
Rec #3: Provide tobacco-use prevention education in kindergarten through 12th grade; Intensive in Middle School, reinforced in High School	●	●	●			●		●	●					●	●		●	●			●		●	●
Rec #4: Provide program-specific training for teachers		●				●	●	●		●			●	●	●	●	●							●
Rec #5: Involve parents or families in support of school-based programs to prevent tobacco use *	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--
Rec #6: Support cessation efforts among students and all school staff who use tobacco		●	●			●	●						●	●	●								●	
Rec #7: Assess the tobacco use prevention program at regular intervals *	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

✓ indicates that this recommendation was already in place

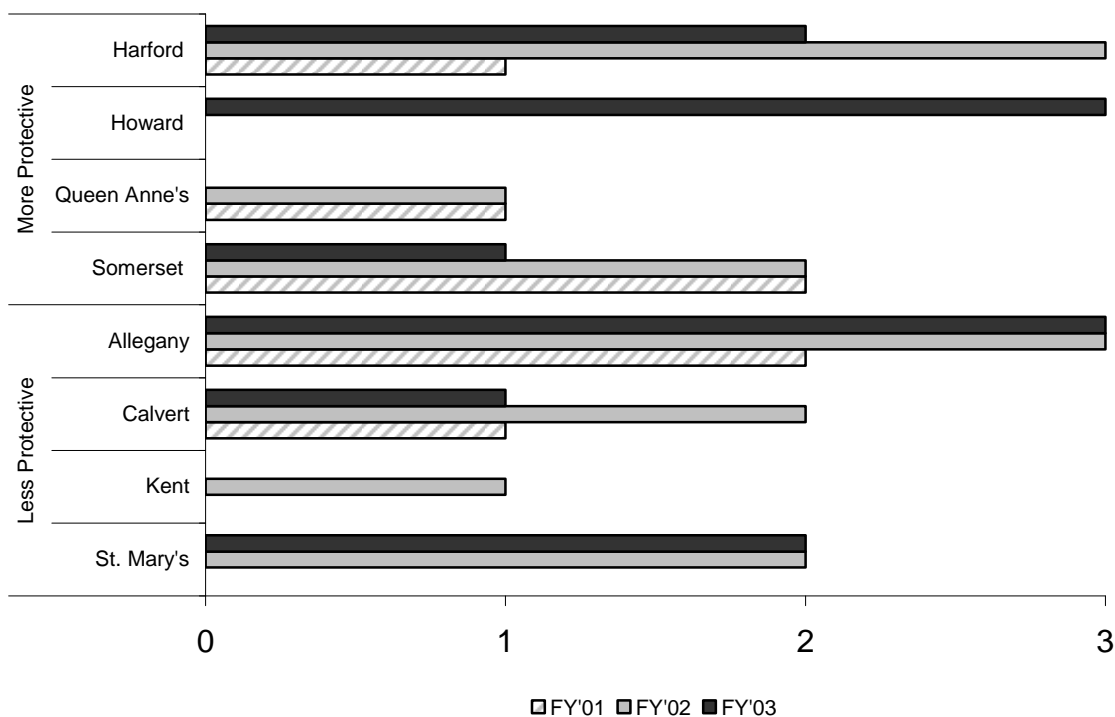
● indicates that this recommendation was met for the Fiscal Year

-- indicates that it could not be determined from the reports whether or not this activity was conducted

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Figure 16 shows the count of the 3 CDC Recommendations computed over the 3 Fiscal Years. Only 3 of the 7 recommendations for could be determined from the data abstraction of the county's reports. Thus Figure 13 depicts the number of recommendations that each jurisdiction reported doing for each Fiscal Year. Two of the 8 counties (1 MSID [Howard] and 1 LSID [Allegany]) were doing all 3 of the recommended activities in Fiscal Year '03.

Figure 16. CDC Recommendations by County Type (Less vs. More) and Fiscal Year (FY'01 - FY'03)



### Summary of Results

Due to differential reporting of activities conducted in the 8 jurisdictions, only a count of activities conducted could be obtained from the chart abstractions. However, despite this, clear patterns by county type (**MSID** vs. **LSID**) do emerge:

Overall, **MSID** counties appear to be more active in smoking prevention and cessation among school-aged youth relative to **LSID** counties:

1. 3 of the 4 top ranked counties for School-Based Initiatives were **MSID** counties and these **MSID** counties conducted more school-based activities relative to **LSID** counties
2. 2 of the **LSID** counties conducted a great number of activities yet were considered **LSID** counties, thus a finer detailed examination of the activities conducted in these counties is warranted to determine why this level of activities did not influence smoking initiation as well as in other counties.
3. Harford and Somerset counties appear to have conducted the most activities across the board (across all 4 Domains: School-Based, Cessation, Community and Enforcement). Somerset

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was chosen as a MSID county because it had the highest decrease in the percent of High School youth in Action / Maintenance over time (from 2000 to 2002). It may be critical to examine more in-depth what activities were conducted in that county's schools that led to these significant changes. Similarly, it may be helpful to compare Somerset's school-based activities with the school-based activities conducted by Harford, who demonstrated reductions for **both** Middle and High School youth, to find commonalities and/or differences.

### **Recommendations**

Based on the evaluation of the county reports, there are several recommendations that may ease the difficult task of collecting complete and comprehensive data across all domains of intervention.

1. A standard template for the documentation of all initiatives should be developed to be used in every county so that there is greater comparability of reporting. This template should outline all information pertinent to the smoking related initiatives and activities that are completed. Only activities that are funded by the monies distributed as part of the grant should be documented on one sheet with possibly additional sheets available to report other activities regardless of source of funding. Reports of activities not funded by the grant or of activities that were in place prior to receipt of grant funds should be kept and clearly marked.
2. The template should include a detailed description of each initiative, the date(s) on which it took place and where it was held, the name and contact information for the event coordinator, the number of individuals present for the event and demographic information for those in attendance. Additionally, information about the perceived effectiveness or overall support for the initiative should be provided.
3. A summary table, which provides a simplified list of activities and the number of individuals reached, maybe helpful in providing a quick glance at the scope of the initiatives.
4. During large events, such as health and wellness fairs, it is difficult to track the number of individuals who are reached by promotional information. Therefore, during these events, planners should have a system in place to count the number of individuals who interact with the display and/or request information regarding tobacco use. If possible, demographic information about those reached should be collected as well.
5. When promotional items are distributed during initiatives, a description of what the items were (e.g. pamphlets, Quit Kits, promotional items such as pens) and how many of each was distributed should be kept as well.

Recommendations regarding school-based initiatives:

1. Based on the evaluation of the county reports, it seems as though school-based initiatives are most successful when an individual is appointed to oversee or manage the implementation of initiatives.
2. For school-based initiatives, the standard template for data collection should include the number of students exposed to the initiatives by grade level. The context in which the initiative was presented (e.g. health class, science class, during an assembly, for a

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- sports team) should be reported, along with a detailed description of the content and length of the presentation. The CDC recommends that tobacco programming in schools emphasize 1) the short- and long-term negative physiologic and social consequences of tobacco use, 2) social influences on tobacco use, 3) peer norms regarding tobacco use, and 4) refusal skills. Thus, the presence, or lack of, these components should be recorded.
3. A summary of each initiative with information about the presenter's satisfaction with the event, a description of how well the event was received by students, school faculty, administrators, staff, and parents, and what the program presenter might do differently in future semesters would also be helpful in determining what portions of the initiative were most beneficial.
  4. Barriers to school-based initiatives need to be critically analyzed and solutions to these barriers need to be discussed and implemented.
  5. Conversation between counties can promote the exchange of information about successful initiatives and implementation techniques. This exchange will be beneficial for planners looking to increase success in school-based initiatives.

County program planners should use the information provided in the present report to:

- Examine county-specific data regarding the number of school-based initiatives were reported in the End-of-Year and Quarterly reports.
  - Please note that the data is based only on activities that were clearly identified within the reports submitted to DHMH. Any activities that were not formally submitted are, therefore, not included.
  - A survey that will allow each county to further explicate school-based activities during the Fiscal Years '01-'03 will be distributed to county contacts, providing an opportunity to report information that may have been inadvertently excluded from the reports.
  - Meetings with county contacts may also be held to gain more insight into the school-based initiatives in the counties.

### **Future Directions**

In order to gain a more complete picture of the school-based tobacco prevention and cessation programs during the Fiscal Years of 2001-2003, we would like to create and distribute a survey. The survey would request supplementary information about the in-school tobacco policies, parental involvement in tobacco programming, the number of hours students were exposed to each type of program, and in-school cessation programs. This additional information may help create a more clear distinction between what initiatives were more and less effective in reducing tobacco use among Maryland Youth. This may also help distinguish which activities were targeted towards Middle School students, and which were targeted towards High School students. This would help frame the process by which youth smoking decreased between 2000 and 2002.

Additionally, meetings with individuals who were involved with the implementation of school-based initiatives would be extremely helpful in attempts to outline the mechanisms that influenced decreases in youth smoking.

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The goals of further analyses include determining whether the process of change in tobacco use varies across demographics such as gender and race, identifying critical differences between types of smoking initiation disruption and levels and types of prevention activities that influence youth tobacco use, and understanding the relationship between smoking status and stage of smoking initiation by county.



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### Appendix A

#### Stages of Smoking Initiation

The Stages of Smoking Initiation use both experience with smoking and attitudes, cognitions, and intentions about smoking to create a measure more sensitive to initiation than simple prevalence rates. Unlike prevalence rates, these stages focus not only on the number of, and most recent smoking events, but also future intentions and behaviors. Data from the MYTS were classified into various stages of acquisition of cigarette smoking, consistent with the five stages proposed by the Transtheoretical Model. This classification resulted in five Stages of Smoking Initiation.

Three questions were used to stage smoking initiation in the present report. Survey questions are presented parenthetically for Wave 1 (2000) and Wave 2 (2002), respectively.

- **Prevalence:** About how many cigarettes have you smoked in your entire life (Q8 / Q12)?
- **Intention:** Do you think you will smoke a cigarette in the next year (Q45 / Q53)?
- **Rate of Current Smoking:** During the past 30 days, on how many days did you smoke (Q10 / Q15)?

Appendix B shows how these questions were used to create the algorithm that classified adolescents into the five Stages of Smoking Initiation. Initially, the classification consisted of 11 groups, which considered both Level of Experience with cigarette smoking (i.e., Inexperienced, Exposed, and Experienced) and Stage of Smoking Initiation (i.e., Precontemplation, Contemplation, Preparation, Action, and Maintenance). Consistent with the five stages proposed by the Transtheoretical Model, the groups were collapsed into five Stages of Smoking Initiation. Accordingly, all adolescents in the Precontemplation Stage of Smoking Initiation (i.e., Inexperienced, Exposed, and Experienced Precontemplators) were collapsed to form one group of Precontemplators. All other Stages of Smoking Initiation were collapsed in a similar fashion, producing the five Stages of Smoking Initiation: Precontemplation, Contemplation, Preparation, Action, and Maintenance.

Definition of Stages of Smoking Initiation:

- Precontemplation (PC) – Youth who are not currently smoking and have no thoughts of smoking a cigarette within the next year. This includes both youth who have never smoked a whole cigarette in their entire life and youth who have smoked less than 100 cigarettes in their entire life, but have not smoked in the past 30 days.
- Contemplation (C) – Youth who are not currently smoking but have some thoughts about smoking a cigarette within the next year. This includes both youth who have never smoked a whole cigarette in their entire life and youth who have smoked less than 100 cigarettes in their entire life, but have not smoked in the past 30 days.

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### Appendix A (*continued*)

- Preparation (P) – Youth who have tried more than one puff from a cigarette but have smoked less than 100 cigarettes in their lifetime, who may be currently smoking (5 days or less out of the past 30 days), and have expressed some thoughts of smoking a cigarette within the next year
- Action (A) - Youth who have smoked more than 6 cigarettes in their entire life, and have smoked for more than 6 but less than 20 days during the past 30 days, and have expressed some thoughts of smoking a cigarette within the next year
- Maintenance (M) - Youth who have smoked more than 100 cigarettes in their entire life, and have smoked on 20 or more days during the past 30 days, and have expressed some thoughts of smoking a cigarette within the next year

### **School Status**

In general, smoking prevalence rates have been found to differ between Middle School and High School students, such that the uptake of cigarette smoking is much greater in High School students. Accordingly, the present analyses considered the relation between smoking status (i.e., Stage of Smoking Initiation) and school status (i.e., Middle School vs. High School). Middle School (MS) status was defined as grades 6 through 8 while High School (HS) status was defined as grades 9 through 12.

#### *Survey Methodology – Wave 1(2000)*

The MYTS 2000, designated Wave 1, was a classroom-based survey, conducted in randomly selected public schools throughout the state of Maryland between October 2 and November 15, 2000. 55,967 Maryland students enrolled in grades 6 through 12 participated in the survey. 89.5% of eligible Middle School students and 84.8% eligible High School students chose to participate. See *Initial Findings from the Baseline Tobacco Study*<sup>2</sup> from DHMH for more information.

#### *Dropped – Wave 1(2000)*

The full sample was 55,967 Middle School and High School students. As this report focuses on underage tobacco use, individuals aged 18 years old or older were dropped ( $n = 1303$ ) and individuals missing age data were likewise dropped ( $n = 149$ ). An additional 3,867 cases were dropped from the analyses due to missing staging criteria data and 2,625 cases were dropped due to inconsistent data ( $n = 6,492$ ). This resulted in eliminating 11.9% of the full sample. The present analyses are based on a final sub-sample of 48,023 students. The students who were dropped from our analyses were less likely to be White (59.0%) than those students included in the analyses (70.2% White), chi-square = 327.81,  $p < .0001$ . Similarly, the students who were dropped from our analyses were less likely to be Male (43.5%) than those students included in the analyses (52.2% Male), chi-square = 168.64,  $p < .0001$ .

#### *Survey Methodology – Wave 2(2002)*

The second survey was the MYTS 2002. Because the survey was revised between the two data collections some of the survey questions were different. The MYTS 2002, designated Wave 2, was a classroom-based survey, conducted in randomly selected public schools throughout the

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state of Maryland between October 8 and November 26, 2002. 66,272 Maryland students enrolled in grades 6 through 12 participated in the survey. 89.9% of eligible Middle School students and 84.2% eligible High School students chose to participate. See *Monitoring Changing Tobacco Behaviors in Maryland: A Report on the fiscal year 2001 and 2003 Maryland Tobacco Surveys*<sup>37</sup> from DHMH for more information.

### *Dropped - Wave 2 (2002)*

The full sample was 66,272 of Middle School and High School students. Those aged 18 years and older were dropped from the analyses (n = 1,253) because the focus of the present report was on underage tobacco use and an additional (n = 131) were dropped due to missing data on age. An additional 5,719 cases were dropped from the analyses due to missing staging criteria data and 2,349 cases were dropped due to inconsistent data. This resulted in eliminating 12.4% of the full sample. The present analyses are based on a final sub-sample of 56,820. The students who were dropped from our analyses were less likely to be White (49.9%) than those students included in the analyses (66.0% White), chi-square = 767.32, p < .0001. Similarly, the students who were dropped from our analyses were less likely to be Male (42.7%) than those students included in the analyses (52.5% Male), chi-square = 266.52, p < .0001.

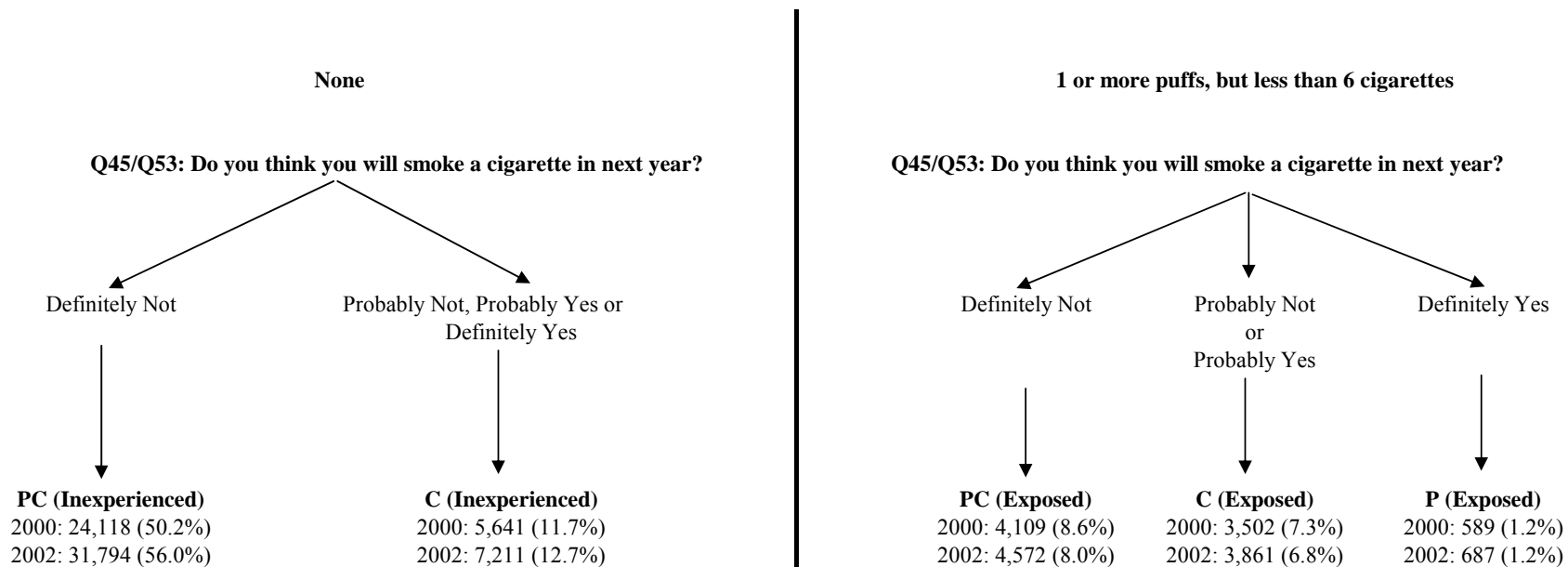
### *Limitations of the MYTS Surveys*

Because Wave 1 (2000) and Wave 2 (2002) of the MYTS were conducted in public schools, the results underrepresented individuals who do not attend school, those whose parents did not elect for them to participate in the survey, and those absent on the day of the survey administration. The survey also underrepresented those who attend special and private schools.

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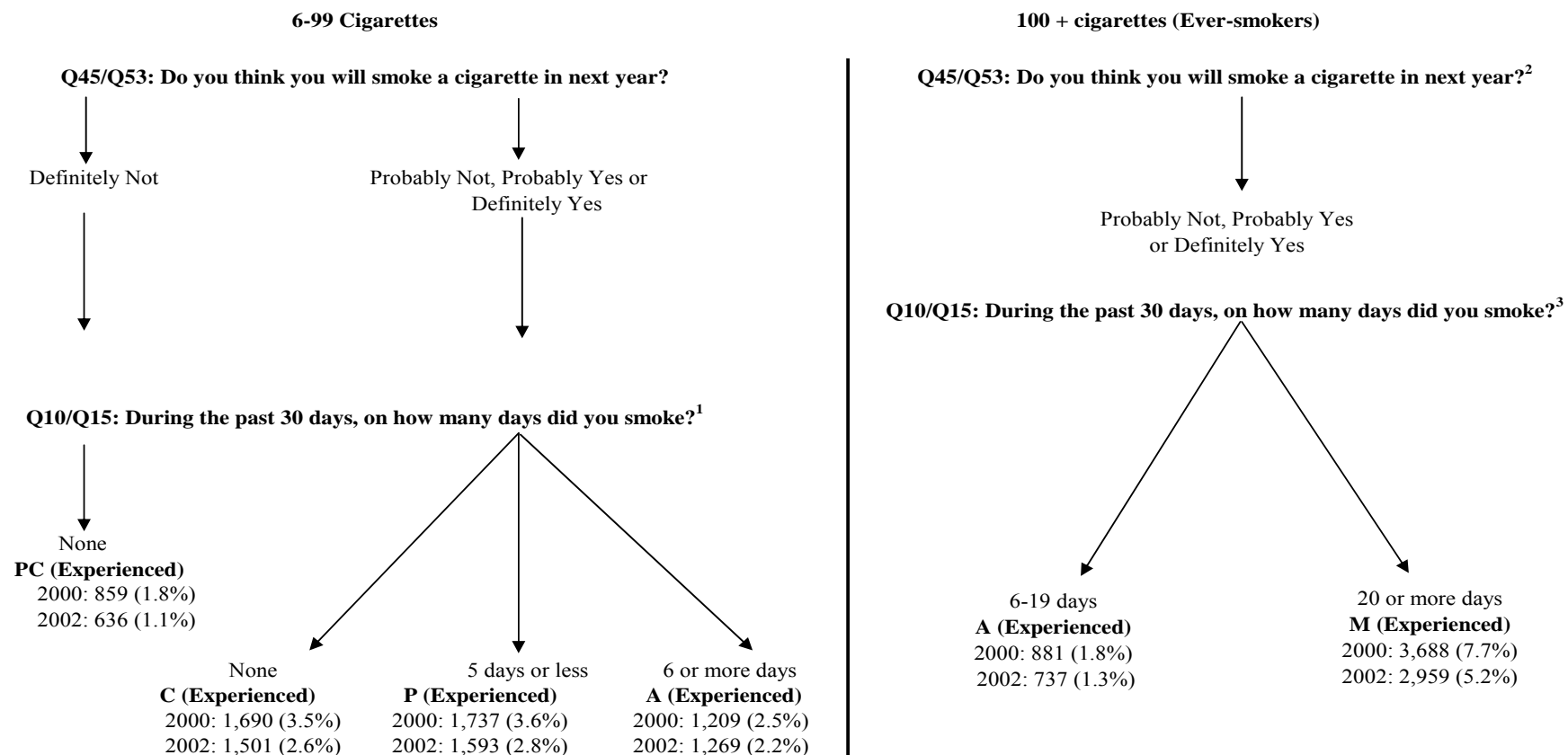
## Appendix B

About how many cigarettes have you smoked in your entire life? (Q8/Q12)



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About how many cigarettes have you smoked in your entire life? (Q8/Q12)



<sup>1</sup> n=193 (2000) and n=212 (2002) participants indicated cigarette smoking on one or more days of the past thirty, though indicated no intentions of smoking (definitely not) in the next year. These anomalous data points were omitted from analyses.

<sup>2</sup> n=373 (2000) and n=336 (2002) participants indicated no behavioral intentions (definitely not) of smoking within the next year, suggesting they may be in a stage of smoking cessation. These participants were omitted from analyses.

<sup>3</sup> n=855 (2000) and n=633 (2002) "Ever-smoking" participants, though indicating some level of behavioral intention for cigarette smoking, did not indicate cigarette smoking at frequencies great enough to warrant staging into either the Action or Maintenance stage for smoking initiation. These participants were omitted from analyses.

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### Appendix C

#### Examination of Differences by County Type (MSID or LSID)

Despite taking great care to ensure that the selection of jurisdictions was not confounded by demographic differences (e.g., ethnicity), there were some demographic differences found by county type (MSID or LSID). Using data derived from the 2000 and 2002 MYTS surveys, analyses were conducted to evaluate county type (i.e., MSID or LSID) differences on demographic and other smoking-related variables.

#### Demographic Characteristics:

Examination of the 2002 Maryland Youth Tobacco Survey (MYTS) data revealed that there were equal proportions of boys and girls represented in the LSID and MSID counties (50.3% vs. 50.6%, respectively). There were however more white youth in the LSID counties (79.0%) relative to the MSID counties (71.4%) in 2002,  $X^2 = 417.70$ ,  $df = 1$ ,  $p < .001$ . Age was significantly different by county type ( $M = 13.8$ ,  $SD = 1.9$  for the LSID vs.  $M = 13.7$ ,  $SD = 1.9$  for the MSID), however this comparison is most likely significantly different due to the large sample size. The LSID counties (53.8%) also reported significantly more youth in high school relative to the MSID (51.9%),  $X^2 = 20.88$ ,  $df = 1$ ,  $p < .001$ . However, again these significant results may be driven by large sample sizes.

#### Exposure to Anti-Tobacco Messaging

The 2002 MYTS survey included questions about exposure to anti-tobacco messaging in the media. Three questions assessed exposure to anti-tobacco messages: one for the Truth anti-smoking commercial (television) and 2 questions for Smoking Stops Here commercials (one for radio and one for television). Examination of the report of anti-tobacco messaging by county type (see Figure 12) revealed that youth in the LSID counties (31.5%) were significantly less likely to report always seeing Truth campaign commercials relative to the MSID counties (35.0%),  $X^2 = 60.09$ ,  $df = 1$ ,  $p < .001$ . Conversely, youth in the LSID counties (25.2%) were significantly more likely to report always seeing Smoking Stops Here commercials on television relative to the MSID counties (23.9%),  $X^2 = 10.12$ ,  $df = 1$ ,  $p < .001$ . Finally, the county types did not differ significantly in terms of the percentage of youth who reported hearing Smoking Stops Here radio commercials (15.2% vs. 14.8%). Approximately two-thirds of the youth reported seeing the Truth campaign commercials less than always (i.e., most of the time, some of the time, hardly ever or never) while approximately three-fourths of the youth reported seeing the Smoking Stops Here commercials less than always (i.e., most of the time, some of the time, hardly ever or never), see Figure 13. These significant differences should be interpreted with caution because they are based on both weighted and large sample sizes.

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Figure 12. Percentage of youth who reported 'Always' seeing / hearing anti-tobacco commercials by County Type

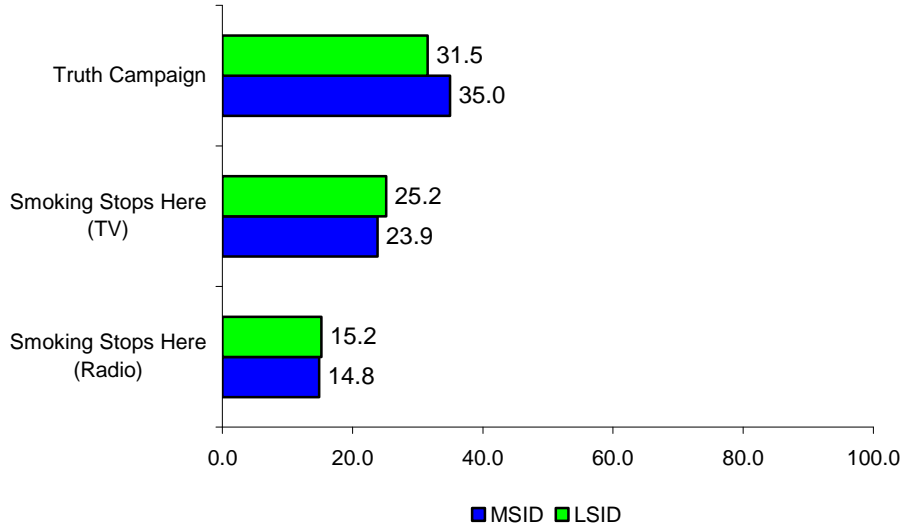
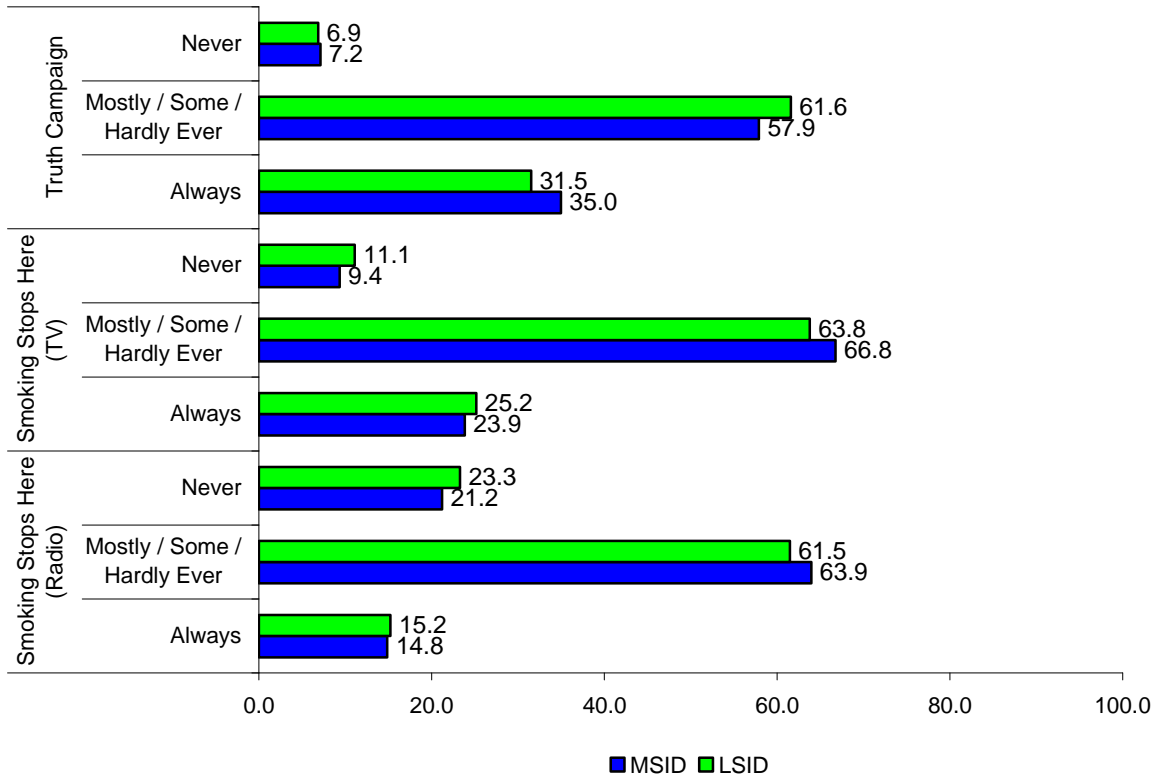


Figure 13. How Often Seen/Hear Anti-smoking Advertisements by County Type

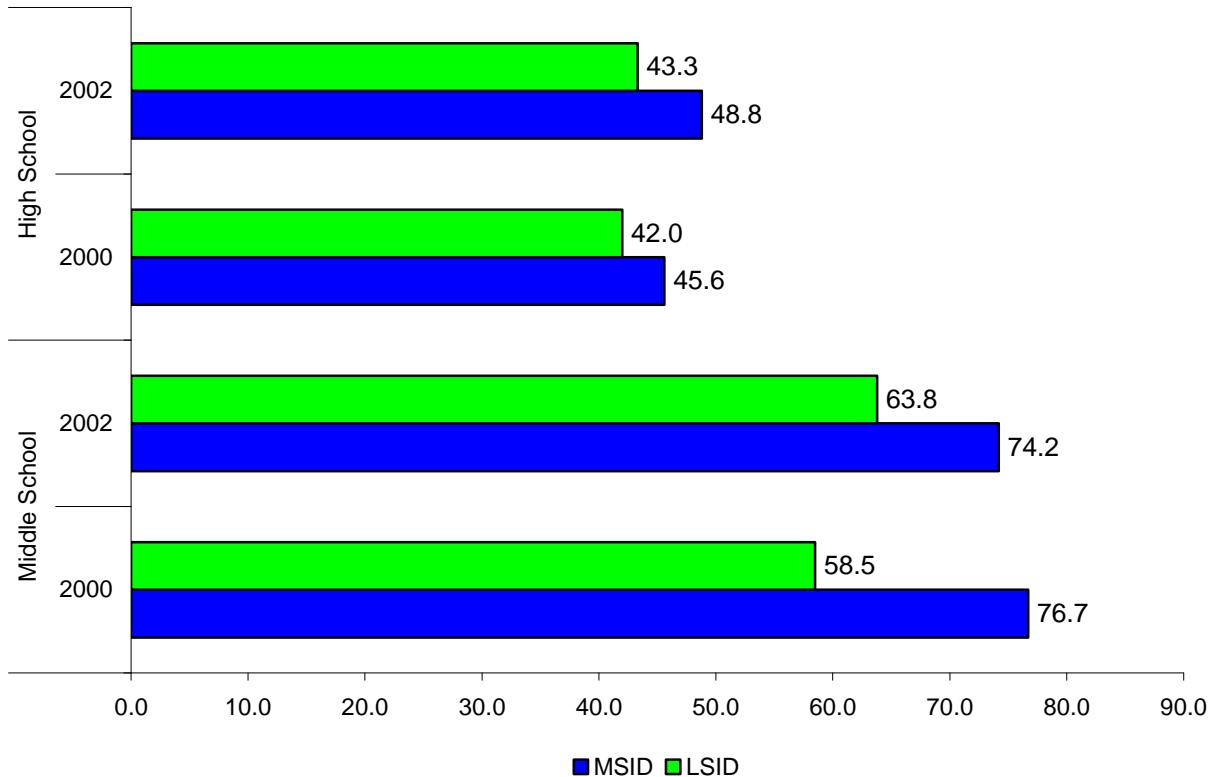


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### Exposure to Anti-Tobacco Messages in Classroom

The 2000 and 2002 MYTS surveys included a question about exposure to anti-tobacco messages being taught in the classroom. Figure 14 shows the percentage of youth who reported being taught about tobacco use in their classes by School status (Middle vs. High School), Wave (2000 MYTS vs. 2002 MYTS), and County Type (**LSID** vs. **MSID**). Among High School Students, in both 2000 and 2002, less than half reported being taught about tobacco use in their classes, irrespective of County type (**LSID** vs. **MSID**). Among Middle School students, approximately 75% of the youth in the **MSID** counties reported being taught about tobacco use compared to only approximately 60% of the youth in the **LSID** counties.

Figure 14. Percent who reported being taught about tobacco use in classes by School Status, Wave and County Type





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Appendix D. School-Based Initiatives

School-Based Initiatives K-12	County		
	FY'01	FY'02	FY'03
Formal Prevention Curricula			
Informal Prevention Curricula			
Educational Brochures / Pamphlets / Referral Cards			
School Assemblies			
Promotions (e.g., Contests)			
Merchandise (e.g., cups, mugs, mini-footballs)			
Tobacco-Related Messages in School Media (i.e. Newspaper articles, Billboards, Announcements, Television ads, Press releases)			
Internet Resources			
Special Awareness Events (e.g., Physician Training; Health Care Providers Workshop; Health & Wellness Fairs; World No Tobacco Day; Tobacco Awareness Conference)			
Guest Speakers			
Student Cessation Classes			
Teacher Training			
Peer Training			
Nurse Training			
Teacher/Staff Cessation Classes			
Youth Summit			
Peer Programs			

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### Appendix E. Other Domain Initiatives

Community	County		
	FY'01	FY'02	FY'03
Faith-based efforts			
Formal Prevention Curricula			
Educational Brochures / Pamphlets / Referral Cards			
Promotions (e.g., Contests)			
Policy Efforts (e.g., Smoke-free environments; NRT; NRT w/ Personal support (e.g., from health educator, R.N.))			
Merchandise (e.g., cups, mugs, mini-footballs)			
Self-Help Materials			
Empowerment: Mini-Grants (e.g., awareness and training)			
Training			
Tobacco-related Messages in Media (i.e., Newspaper Articles (i.e., local); Billboard Ads; Radio Ads; Television Ads; Press Releases); Awareness Campaigns			
Internet Resources (e.g., Web-sites)			
Employment / Workplace efforts			
Dissemination of Community Efforts (e.g., Letters to Politicians)			
Special Awareness Events (e.g., Physician Training; Health Care Providers Workshop; Health & Wellness Fairs; World No Tobacco Day; Tobacco Awareness Conference)			
Tobacco-related collaborations between Community and Institutions (e.g., creation of coalitions, committees, task forces, program coordinators hired to bridge gap)			
Population-specific efforts (e.g., day care providers)			
Second-hand smoke education			
Presentations			
Youth Involvement			

Cessation	County		
	FY'01	FY'02	FY'03
Cessation Counseling			
Pharmacotherapy			
Educational Brochures / Pamphlets / Referral Cards			
Self-Help Materials			
Internet (Web-sites)			
Special Events (e.g., World No Tobacco Day)			
Employment / Workplace Cessation Programs			

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Appendix E (cont'd)

<b>Cessation (continued)</b>	<b>County</b>		
	<b>FY'01</b>	<b>FY'02</b>	<b>FY'03</b>
Incentives (stickers, pins, etc.)			
Peer Led Groups			
Quit Kits			

<b>Enforcement</b>	<b>County</b>		
	<b>FY'01</b>	<b>FY'02</b>	<b>FY'03</b>
Vendor Education (e.g., product placement, youth access)			
Compliance Checks / "Stings"			
Tobacco Vendor Citations			
Tobacco Youth Citations			
Teen Court			
Police Tip-line			
Youth Volunteers			
Education for Youth			
Training for Officers			
Policing Community			

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Appendix F. CDC Recommendations

CDC Recommendations	County		
	FY'01	FY'02	FY'03
Rec #1: Develop and enforce a school policy on tobacco use			
Rec #2: Provide instruction about the short- and long-term negative physiologic and social consequences of use, social influences, peer norms and refusal skills *	--	--	--
Rec #3: Provide tobacco-use prevention education in kindergarten through 12th grade; Intensive in Middle School, reinforced in High School			
Rec #4: Provide program-specific training for teachers			
Rec #5: Involve parents or families in support of school-based programs to prevent tobacco use *	--	--	--
Rec #6: Support cessation efforts among students and all school staff who use tobacco			
Rec #7: Assess the tobacco use prevention program at regular intervals *	--	--	--

\* Whether these recommendations were or were not conducted could not be determined from our data abstraction