Guidelines for School Health Programs to Prevent Tobacco Use and Addiction

ABSTRACT: Tobacco use is the leading cause of preventable death in the U.S. Most daily smokers (82%) began smoking before age 18, and more than 3,000 young persons begin smoking each day. School programs designed to prevent tobacco use could become one of the most effective strategies available to reduce U.S. tobacco use. The following guidelines summarize school-based strategies most likely to be effective in preventing tobacco use among youth. They were developed by CDC in collaboration with experts from 29 national, federal, and voluntary agencies and with other leading tobacco-use prevention authorities to help school personnel implement effective tobacco-use prevention programs. These guidelines are based on an in-depth review of research, theory, and current practice in school-based tobacco-use prevention. The guidelines recommend that all schools: a) develop and enforce a school policy on tobacco use, b) provide instruction about the short-term and long-term negative physiologic and social consequences of tobacco use, social influences on tobacco use, peer norms regarding tobacco use, and refusal skills, c) provide K-12 tobacco-use prevention education, d) provide program-specific training for teachers, e) involve parents or families in support of school-based programs to prevent tobacco use, f) support cessation efforts among students and all school staff who use tobacco, and g) assess the tobacco-use prevention program at regular intervals. (J Sch Health. 1994;64(9):353-360)

Tobacco use is the single most preventable cause of death in the U.S. Illnesses caused by tobacco use increase demands on the U.S. health-care system; lost productivity amounts to billions of dollars annually.²,³

Because four of every five persons who use tobacco begin before they reach adulthood,¹ tobacco-prevention activities should focus on school-age children and adolescents. Evidence suggests school health programs can prevent tobacco use among youth.⁴,⁵ These guidelines have been developed to help school personnel plan, implement, and assess educational programs and school policies to prevent tobacco use and the unnecessary addiction, disease, and death tobacco use causes. Although these guidelines address K-12 school programs, persons working with youth in other settings also may find the guidelines useful.

The guidelines are based on a synthesis of results of research, theory, and current practice in tobacco-use prevention. To develop these guidelines, CDC staff convened meetings of experts in tobacco-use prevention and education, reviewed published research, and considered the conclusions of the National Cancer Institute Expert Advisory Panel on School-Based Smoking Prevention Programs,⁶ and findings of the 1994 Surgeon General’s report, Preventing Tobacco Use Among Young People.⁷ CDC developed these guidelines in consultation with experts from the American Academy of Pediatrics, American Association of School Administrators, American Cancer Society, American Federation of Teachers, American Heart Association, American Lung Association, American Medical Association, Association of State and Territorial Directors of Public Health Education, Association of State and Territorial Health Officials, Council of Chief State School Officers, Health Resources and Services Administration, Indian Health Service, National Association of School Nurses, National Association of Secondary School Principals, National Association of State Boards of Education, National Cancer Institute, National Center for Nursing Research, National Congress of Parents and Teachers, National Education Association, National Heart, Lung, and Blood Institute, National Institute of Child Health and Human Development, National School Boards Association, National School Health Education Coalition, Office of Disease Prevention and Health Promotion, Office of Minority Health, Substance Abuse and Mental Health Services Administration, The Society of State Directors of Health, Physical Education, and Recreation, U.S. Dept. of Education, and the Western Consortium for Public Health.

BACKGROUND

School-based programs to prevent tobacco use can make a substantial contribution to the health of the next generation. This report defines “tobacco use” as the use of any nicotine-containing tobacco product, such as cigarettes, cigars, and smokeless tobacco. These products often contain additional substances such as benzo(a)pyrene, vinyl chloride, and polonium 210 that cause cancer in animals and humans.¹ Recent estimates suggest that cigarette smoking annually causes more than 400,000 premature deaths and 5 million years of potential life lost.² The 1990 estimated direct and indirect costs associated with smoking in the U.S. totalled $68 billion.²

In 1964, the U.S. Surgeon General’s first report on smoking and health documented that cigarette smoking causes chronic bronchitis and lung and laryngeal cancer in men.⁶ Subsequent reports from the Surgeon General’s office have documented that smoking causes coronary heart disease,⁸ atherosclerotic peripheral vascular disease,⁹ cerebrovascular disease,¹⁰ chronic obstructive pulmonary disease including emphysema,¹¹ intracranial growth retardation,¹² lung and laryngeal cancers in women,¹³ oral cancer,¹⁴ esophageal cancer,¹⁵ and cancer of the urinary bladder.¹⁶ Cigarette smoking also contributes to cancers of the pancreas, kidney, and cervix.¹⁷ Further, low birth weight and approximately 10% of infant mortality have been attributed to tobacco use by pregnant mothers.¹ Eighty-one percent of U.S. adults who smoke have tried to quit at least once in the last 12 months.¹² The 1994 Surgeon General’s report on smoking and health describes numerous adverse health conditions caused by tobacco use among adolescents, including reductions in the rate of lung growth and in the level of maximum lung function, increases in the number and severity of respiratory illnesses, and unfavorable effects on blood lipid levels, which may accelerate development of cardiovascular diseases.⁸
Breathing environmental tobacco smoke — including sidestream and exhaled smoke from cigarettes, cigars, and pipes — also causes serious health problems. For example, exposure to environmental tobacco smoke increases the risk for lung cancer and respiratory infections among nonsmokers and may inhibit the development of optimal lung function among children of smokers. Exposure to environmental tobacco smoke also may increase the risk for heart disease among nonsmokers. The Environmental Protection Agency recently classified environmental tobacco smoke as a Group A carcinogen, a category that includes asbestos, benzene, and arsenic.

Smokeless tobacco use, including chewing tobacco and snuff, also can be harmful to health. A report of the Advisory Committee to the Surgeon General indicated that using smokeless tobacco causes oral cancer and leukoplakia. Early signs of these diseases, particularly periodontal degeneration and soft tissue lesions, are found among young people who use smokeless tobacco.

Tobacco use is addictive and is responsible for more than one of every five U.S. deaths. However, many children and adolescents do not understand the nature of tobacco addiction and are unaware of, or underestimate, the important health consequences of tobacco use. On average, more than 3,000 young persons, most of them children and teen-agers, begin smoking each day in the U.S. Approximately 82% of adults ages 30-39 who ever smoked daily tried their first cigarette when younger than age 18. National surveys indicate 70% of high school students have tried cigarette smoking and more than one-fourth (28%) reported having smoked cigarettes during the past 30 days.

THE NEED FOR SCHOOL HEALTH PROGRAMS TO PREVENT TOBACCO USE AND ADDICTION

The challenge to provide effective tobacco-use prevention programs to all young persons is an ethical imperative. Schools are ideal settings in which to provide such programs to all children and adolescents. School-based tobacco prevention education programs that focus on skills-training approaches have proven effective in reducing the onset of smoking, according to numerous independent studies. A summary of findings from these studies demonstrates positive outcomes across programs that vary in format, scope, and delivery method.

To be most effective, school-based programs must target young persons before they initiate tobacco use or drop out of school. In 1992, 18% of surveyed U.S. high school seniors reported smoking their first cigarette in elementary school, and 30% started in grades seven to nine. Among persons ages 17-18 surveyed in 1989, substantially more high school dropouts (43%) than high school attendees or graduates (17%) had smoked cigarettes during the week preceding the survey.

Because considerable numbers of students begin using tobacco at or after age 15, tobacco-prevention education must be continued throughout high school. Among high school seniors surveyed in 1991 who had ever smoked a whole cigarette, 37% initiated smoking at age 15 or older (grades 10-12).

School-based programs offer an opportunity to prevent tobacco use initiation and therefore help persons avoid the difficulties of trying to stop after they are addicted to nicotine. Most current smokers (83%) wish they had never started smoking, and nearly one-third of all smokers quit for at least a day each year. Most smokers (93%) who try to quit resume regular smoking within one year. Of those persons who successfully quit smoking for one year or longer, one-third eventually relapse.

By experimenting with tobacco, young persons place themselves at risk for nicotine addiction. Persons who start smoking early have more difficulty quitting, are more likely to become heavy smokers, and are more likely to develop a smoking-related disease. Between 1975 and 1985, approximately 75% of persons who had smoked daily during high school were daily smokers seven to nine years later; however, only 5% of those persons had predicted as high school students that they would “definitely” smoke five years later. Smoking is addictive; three of four teen-agers who smoke have made at least one serious, yet unsuccessful, effort to quit. The 1994 Surgeon General’s report on smoking and health concludes that the probability of becoming addicted to nicotine after any exposure is higher than that for other addictive substances such as heroin, cocaine, or alcohol. Further, nicotine addiction in young people follows fundamentally the same process as in adults, resulting in withdrawal symptoms and failed attempts to quit. Thus, cessation programs are needed to help young persons who already use tobacco.

School-based tobacco-use prevention programs should be provided for students of all ethnic/racial groups. In high school, more White (31%) and Hispanic (25%) students than Black students (13%) are current smokers. Although ages and rates of initiation vary by race and ethnicity, tobacco use is a problem for all ethnic/racial groups. Given the diversity of cultures represented in many schools, it is important to tailor prevention programs for particular ethnic/racial subgroups of students. However, programs should be sensitive to, and representative of, a student population that is multicultural, multietnic, and socio-economically diverse.

Effective school-based tobacco-use prevention programs are equally important for both male and female students. From 1975 to 1987, daily smoking rates among 12th-grade females were as high or higher than males. Since 1988, smoking rates for males and females have been nearly identical. However, rates of smokeless tobacco use differ by sex: in 1991, 19% of male high school students and only 1% of females reported use during the past 30 days. Given the growing popularity of smokeless tobacco use, particularly among males, and given the prevalent misconception that smokeless tobacco is safe, school-based tobacco-use prevention programs must pointedly discourage the use of smokeless tobacco.

Despite gains made in the 1970s, progress in reducing smoking prevalence among adolescents slowed dramatically in the 1980s. For example, the percentage of seniors who report they smoked on one or more days during the past month has remained unchanged since 1980 — approximately 29%. Further, despite negative publicity and restrictive legislation regarding tobacco use, the proportion of high school seniors who perceive that cigarette users are at great risk for physical or other harm from smoking a pack a day or more has increased only minimally — from 64% in 1980 to 69% in 1992. Thus,
efforts to prevent tobacco use initiation among children and adolescents must be intensified.

School-based tobacco-use prevention programs also can contribute to illicit drug use prevention, such as marijuana and cocaine, especially if such programs also are designed to prevent the use of these substances. Tobacco is one of the most commonly available and widely used drugs, and its use results in the most widespread drug dependency. Use of other drugs, such as marijuana and cocaine, often is preceded by tobacco or alcohol use. Although most young persons who use tobacco do not use illicit drugs, when further drug involvement does occur, it is typically sequential — from use of tobacco or alcohol to use of marijuana, and from marijuana to other illicit drugs or prescription psychoactive drugs. This sequence may reflect, in part, the widespread availability, acceptability, and tobacco and alcohol use, as well as common underlying causes of drug use, such as risk-seeking patterns of behavior and deficits in communication and refusal skills. Recent reports on preventing drug abuse suggest that approaches effective in preventing tobacco use can also help prevent alcohol use and other drugs.

PURPOSES OF SCHOOL HEALTH PROGRAMS TO PREVENT TOBACCO USE AND ADDICTION

School-based health programs should enable and encourage children and adolescents who have not experimented with tobacco to continue to abstain from any use. For young persons who have experimented with tobacco use, or who are regular tobacco users, school health programs should enable and encourage them to immediately stop all use. For those young persons who are unable to stop using tobacco, school programs should help them seek additional assistance to successfully quit tobacco use.

NATIONAL HEALTH OBJECTIVES, NATIONAL EDUCATION GOALS, AND THE YOUTH RISK BEHAVIOR SURVEILLANCE SYSTEM

CDC's Guidelines for School Health Programs to Prevent Tobacco Use and Addiction were designed in part to help attain published national health objectives and education goals. In September 1990, 300 national health objectives were released by the Secretary, U.S. Dept. of Health and Human Services, as part of Healthy People 2000: National Health Promotion and Disease Prevention Objectives. The objectives were designed to guide health promotion and disease prevention policy and programs at the federal, state, and local levels throughout the 1990s. School-based programs to prevent tobacco use can help accomplish the following objectives from Healthy People 2000:

3.4 Reduce cigarette smoking to a prevalence of no more than 15% among people ages 20 and older. (Baseline: 29% in 1987).

3.5 Reduce the initiation of cigarette smoking by children and youth so no more than 15% have become regular cigarette smokers by age 20. (Baseline: 30% in 1987).

3.7 Increase smoking cessation during pregnancy so at least 60% of women who are cigarette smokers at the time they become smoking early in pregnancy and maintain abstinence for the remainder of their pregnancy. (Baseline: 39% in 1985).

3.8 Reduce to no more than 20% the proportion of children age six and younger who are regularly exposed to tobacco smoke at home (Baseline: 39% in 1986).

3.9 Reduce smokeless tobacco use by males ages 12-24 to a prevalence of no more than 4%. (Baseline: 6.6% for age 12-17 in 1988).

3.10 Establish tobacco-free environments and include tobacco-use prevention in the curricula of all elementary, middle, and secondary schools, preferably as part of quality [comprehensive] school health education. (Baseline: 17% of school districts were smoke-free, and 75% to 81% of school districts offered anti-smoking education in 1988).

3.11 Increase to at least 75% the proportion of worksites [such as schools] with a formal smoking policy that prohibits or severely restricts smoking at the workplace. (Baseline: 54% of medium and large companies in 1987).

3.12 Enact in 50 states comprehensive laws on clean indoor air that prohibit or strictly limit smoking in the workplace and enclosed public places [such as schools]. (Baseline: 13 states in 1988).

School-based programs to prevent tobacco use also can help accomplish one of the six National Education Goals: By the year 2000, every school in America will be free of drugs and violence and will offer a disciplined environment conducive to learning (Goal 6).

In 1990, CDC established the Youth Risk Behavior Surveillance System to help monitor progress toward attaining national health and education objectives by periodically measuring the prevalence of six categories of health risk behaviors usually established during youth that contribute to the leading causes of death and disease; tobacco use is one of the six categories. CDC conducts a biennial Youth Risk Behavior Survey (YRBS) of a national probability sample of high school students and also enables interested state and local education agencies to conduct the YRBS with comparable probability samples of high school students in those states and cities. The specific tobacco-use behaviors monitored by the YRBS include: ever tried cigarette smoking, age when first smoked a whole cigarette, ever smoked cigarettes regularly (one cigarette every day for 30 days), age when first smoked regularly, number of days during past month that cigarettes were smoked, number of cigarettes smoked per day during past month, number of days during past month that cigarettes were smoked on school property, ever tried to quit smoking cigarettes during past six months, any use of chewing tobacco or snuff during past month, and any use of chewing tobacco or snuff during past month on school property.

States and large cities are encouraged to use the YRBS periodically to monitor the comparative prevalence of tobacco use among students in their jurisdictions, and school officials are encouraged to implement programs specifically designed to reduce these behaviors. National, state, and local data are being used to monitor progress in reducing tobacco use among youth and to monitor relevant national health objectives and education goals.
RECOMMENDATIONS FOR SCHOOL
HEALTH PROGRAMS TO PREVENT
TOBACCO USE AND ADDICTION

The following seven recommendations summarize strategies effective in tobacco-use prevention among youth. To ensure the greatest affect, schools should implement all seven recommendations.

1. Develop and enforce a school policy on tobacco use.
2. Provide instruction about the short-term 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 K-12 tobacco-use prevention education; 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.

Discussion of Recommendations

Recommendation 1: Develop and enforce a school policy on tobacco use. A school tobacco use policy must be consistent with state and local laws and should include the following elements:

- An explanation of the rationale for preventing tobacco use such as tobacco is the leading cause of death, disease, and disability,
- Prohibitions against tobacco use by students, all school staff, parents, and visitors on school property, in school vehicles, and at school-sponsored functions away from school property,
- Prohibitions against tobacco advertising in school buildings, at school functions, and in school publications,
- A requirement that all students receive instruction on avoiding tobacco use,
- Provisions for students and all school staff to have access to programs to help them quit using tobacco,
- Procedures for communicating the policy to students, all school staff, parents or families, visitors, and the community, and
- Provisions for enforcing the policy.

To ensure broad support for school policies on tobacco use, representatives of relevant groups, such as students, parents, school staff and their unions, and school board members, should participate in developing and implementing the policy. Examples of policies have been published, and additional samples can be obtained from state and local boards of education.

Clearly articulated school policies, applied fairly and consistently, can help students decide not to use tobacco. Policies that prohibit tobacco use on school property, require prevention education, and provide access to cessation programs rather than solely instituting punitive measures are most effective in reducing tobacco use among students.

A tobacco-free school environment can provide health, social, and economic benefits for students, staff, the school, and the district. These benefits include decreased fires and discipline problems related to student smoking, improved compliance with local and state smoking ordinances, and easier upkeep and maintenance of school facilities and grounds.

Recommendation 2: Provide instruction about the short-term and long-term negative physiologic and social consequences of tobacco use, social influences on tobacco use, peer norms regarding tobacco use, and refusal skills. Some tobacco-use prevention programs have been limited to providing only factual information about tobacco use’s harmful effects. Other programs have attempted to induce fear in young persons about the consequences of use. However, these strategies alone do not prevent tobacco use, may stimulate curiosity about tobacco use, and may prompt some students to believe the health hazards of tobacco use are exaggerated.

Successful tobacco-use prevention programs address multiple psychosocial factors related to tobacco use among children and adolescents. These factors include:

- Immediate and long-term undesirable physiologic, cosmetic, and social consequences of tobacco use. Programs should help students understand that tobacco use can result in decreased stamina, stained teeth, foul-smelling breath and clothes, exacerbation of asthma, and ostracism by nonsmoking peers.
- Social norms regarding tobacco use. Programs should use a variety of educational techniques to decrease the social acceptability of tobacco use, highlight existing antitobacco norms, and help students understand that most adolescents do not smoke.
- Reasons why adolescents say they smoke. Programs should help students understand that some adolescents smoke because they believe it will help them be accepted by peers, appear mature, or cope with stress. Programs should help students develop other more positive means to attain such goals.
- Social influences that promote tobacco use. Programs should help students develop skills in recognizing and refuting tobacco-promotion messages from the media, adults, and peers.
- Behavioral skills to resist social influences promoting tobacco use. Programs should help students develop refusal skills through direct instruction, modeling, rehearsal, and reinforcement, and should coach them to help others develop these skills.
- General personal and social skills. Programs should help students develop necessary assertiveness, communication, goal-setting, and problem-solving skills that may enable them to avoid both tobacco use and other health risk behaviors.

School-based programs should systematically address these psychosocial factors at developmentally appropriate ages. Particular instructional concepts should be provided for students in early elementary school, later elementary school, junior high or middle school, and senior high school (Table 1). Local school districts and schools should review these concepts in accordance with student needs and educational policies to determine in which grades students should receive particular instruction.
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school-based tobacco-use prevention is derived from studies of schools in which classroom curricula focused exclusively on tobacco use. Other evidence suggests that tobacco-use prevention also can be effective when appropriately embedded within broader curricula for preventing drug and alcohol use or within comprehensive curricula for school health education. The effectiveness of school-based efforts to prevent tobacco use appears to be enhanced by the addition of targeted community-wide programs that address the role of families, community organizations, tobacco-related policies, anti-tobacco advertising, and other elements of adolescents' social environment.

Because tobacco use is one of several interrelated health risk behaviors addressed by schools, CDC recommends that tobacco-use prevention programs be integrated as part of comprehensive school health education within the broader school health program.

**Recommendation 4: Provide program-specific training for teachers.** Adequate curriculum implementation and overall program effectiveness are enhanced when teachers are trained to deliver the program as planned. Teachers should be trained to recognize the importance of carefully and completely implementing the selected program. Teachers also should become familiar with the underlying theory and conceptual framework of the program as well as with the content of these guidelines. Training should include a program content review and modeling of program activities by skilled trainers. Teachers should be given opportunity to practice implementing program activities. Studies indicate in-person training and review of curriculum-specific activities contribute to greater compliance with prescribed program components.

Some programs may elect to include peer leaders as part of the instructional strategy. By modeling social skills and leading role rehearsals, peer leaders can help counteract social pressures on youth to use tobacco. These students must receive training to ensure accurate presentation of skills and information. Although peer-leader programs can offer an important adjunct to teacher-led instruction, such programs require additional time and effort to initiate and maintain.

**Recommendation 5: Involve parents or families in support of school-based tobacco-use prevention programs.** Parents or families can play an important role in providing social and environmental support for nonsmoking. Schools can capitalize on this influence by involving parents or families in program planning, in soliciting community support for programs, and in reinforcing educational messages at home. Homework assignments involving parents or families increase the likelihood that smoking is discussed at home and motivate adult smokers to consider cessation.

**Recommendation 6: Support cessation efforts among students and all school staff who use tobacco.** Potential practices to help children and adolescents quit using tobacco include self-help, peer support, and community cessation programs. In practice, however, these alternatives rarely are available within a school system or community. Although the options often are limited, schools must support student efforts to quit using tobacco, especially when tobacco use is disallowed by school policy.

Effective cessation programs for adolescents focus on immediate consequences of tobacco use, have specific attainable goals, and use contracts that include rewards. These programs provide social support and teach avoidance, stress management, and refusal skills. Further, students need opportunities to practice skills and strategies that will help them remain nonsmokers.

Cessation programs with these characteristics already may be available in the community through the local health department or voluntary health agency such as American Cancer Society, American Heart Association, and the American Lung Association. Schools should identify available resources in the community and provide referral and follow-up services to students. If cessation programs for youth are not available, such programs might be jointly sponsored by the school and the local health department, voluntary health agency, other community health providers, or interested organizations such as churches.

More is known about successful cessation strategies for adults. School staff are more likely than students to find existing cessation options in the community. Most adults who quit tobacco use do so without formal assistance. Nevertheless, cessation programs that include a combination of behavioral approaches such as group support, individual counseling, skills-training, family interventions, and interventions that can be supplemented with pharmacologic treatments, have demonstrated effectiveness. For all school staff, health promotion activities and employee assistance programs that include cessation programs might help reduce burnout, lower staff absenteeism, decrease health insurance premiums, and increase commitment to overall school health goals.

**Recommendation 7: Assess the tobacco-use prevention program at regular intervals.** Local school boards and administrators can use the following evaluation questions to assess whether their programs are consistent with CDC’s Guidelines for School Health Programs to Prevent Tobacco Use and Addiction. Federal, state, and local education and health agency personnel also can use these questions to a) assess whether schools in their jurisdiction are providing effective tobacco-use prevention education, and b) identify schools that would benefit from additional training, resources, or technical assistance. The following questions can serve as a guide for assessing program effectiveness:

1. Do schools have a comprehensive policy on tobacco use, and is it implemented and enforced as written?
2. Does the tobacco education program foster the necessary knowledge, attitudes, and skills to prevent tobacco use?
3. Is tobacco-use prevention education provided, as planned, in K-12, with special emphasis during junior high or middle school?
4. Is in-service training provided, as planned, for educators responsible for implementing tobacco-use prevention?
5. Are parents or families, teachers, students, school health personnel, school administrators, and appropriate community representatives involved in planning, imple-
menting, and assessing programs and policies to prevent tobacco use?
6. Does the tobacco-use prevention program encourage and support cessation efforts by students and all school staff who use tobacco?

CONCLUSION
In 1964, the first Surgeon General’s report on smoking and health warned that tobacco use causes serious health problems. Thirty years later, in 1994, the Surgeon General reports that tobacco use still presents a key threat to the well-being of children. School health programs to prevent tobacco use could become one of the most effective national strategies to reduce the burden of physical, emotional, and monetary expense incurred by tobacco use.

To achieve maximum effectiveness, school health programs to prevent tobacco use must be carefully planned and systematically implemented. Research and experience acquired since the first Surgeon General’s report on smoking and health have helped in understanding how to produce school policies on tobacco use and how to plan school-based programs to prevent tobacco use so they are most effective. Carefully planned school programs can be effective in reducing tobacco use among students if school and community leaders make the commitment to implement and sustain such programs.

References


Teaching Strategies Directory — The Health Studies Dept., Texas Woman’s University, is compiling a nonprofit directory on “Teaching Strategies for Cultural Diversity in Health Education.” The directory will contain specific classroom activities used by identified health educators to foster cultural awareness and sensitivity. Contact: Eva Doyle, Health Studies, P.O. Box 22808, Texas Woman’s University, Denton, TX 76204-0808; 817/898-2860, FAX 817/898-3198.

Strategies must be no longer than two pages, typed, double-spaced, and have to include a title, author’s complete address, learning objectives, needed materials and preparation, methods and implementation tips, and related handouts. Submissions must be received by February 6, 1995.