may arise, they are empowered to make the decision they want to make, and not just what their friends suggest.

For the last group, it is important to help them examine what has influenced their decisions so far. Are they happy with their decisions? How do they view the drug situation in our society? Is it what they want to be a part of, and can they do anything to change the situation?

Each mobile classroom can see up to 1.3 million children each year, as well as parents, teachers, and community members. No other drug education programme directly works with children and young people using the type of specialist, stimulating, and logically-progressing programmes that Life Education Centres are able to provide.

A positive impact

People often ask: “Does it work in preventing drug use?” Unfortunately this is very difficult to prove; however, we can say that the children enjoy the sessions, and that each year they learn different aspects about looking after themselves. If young people have an enjoyable time and remember it so well, it has to go a long way towards influencing their thoughts and decision-making skills in a positive way.

In a National Evaluation of Life Education Centres, 99% of teachers said that Life Education had a positive impact on children, and 93% of children gave Life Education the highest rating possible.

Fig. 1. Smoking levels, 1985–1988, for boys in Year 7–11. This data, which shows the percentage that smoked at least one cigarette during the previous week, is taken from annual Health Related Behaviour Questionnaire survey summaries.

John Balding

10 years of surveys of young smokers

After ten years of supporting hundreds of surveys of young people, and with responses from a third of a million of them recorded in our data bank, we feel entitled to take a longer view than is possible from a single year’s data.

We carried out a shorter-term exercise in 1988, based on about 70,000 responses received since 1983, and published the results under the heading Teenage smoking: are the levels falling at last? (Balding 1988).

This observation was based on the steady overall fall in the percentage of young people between the ages of 11 and 16 that could be described as ‘smokers’ according to their answers to three separate questions contained in early versions 8–11 of the Health Related Behaviour Questionnaire.

In Figure 1, below, we display results from four successive years of cumulative data (1985–1988) from surveys of different parts of the UK in each year. The results displayed are for boys, where the change is most marked; it is less clear in the data for girls. These same four rows are presented again in Figure 2.

It should be noted that each successive year’s accumulated data is derived from a different population and is ‘accidental’, in that it is outside the control of the Schools Health Education Unit. Recent discoveries from a planned cohort study in process in Yorkshire indicate that, for many behaviours at least, results in one region are a good predictor of results elsewhere in the country (Balding 1994, Balding 1995).

Two of the questions from versions 8–11, slightly modified, have been retained through subsequent updates up to the current 17th version, and a 10-year analysis of one of them, How many cigarettes have you smoked in the last 7 days?, is presented in Figure 2. This gives ‘3D’ plots for every available year group from 7 to 11, over the decade 1985–1994, that responded that they had smoked at least one cigarette in the last 7 days. It represents the results of well over a thousand surveys.

These series of columns tell a different story according to the way they are ‘read’.

1. Reading across. Going from left to right, the changing heights of the columns show how the percentage of smokers in each year group survey sample has changed from one year to the next.

2. Reading up. This shows the changing smoking levels from one year group to the next within each calendar year of the decade sur-
Fig. 2. Smoking levels, 1983–1994, for boys and girls in Years 7 to 11. This data, which shows the percentage that smoked at least one cigarette during the previous week, is taken from annual Health Related Behaviour Questionnaire survey summaries.

Fig. 3. The percentage of "non-smokers" in the 1994 data, from Years 7 to 11.

Table 1. 1994 responses to the question 'How many cigarettes have you smoked in the last 7 days?'

<table>
<thead>
<tr>
<th>Year</th>
<th>Boys</th>
<th>Girls</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>B</td>
<td>G</td>
</tr>
<tr>
<td></td>
<td>G</td>
<td>B</td>
</tr>
</tbody>
</table>

Table 2. 1994 responses to a question about smoking intentions.

<table>
<thead>
<tr>
<th>Year</th>
<th>Boys</th>
<th>Girls</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>B</td>
<td>G</td>
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<tr>
<td></td>
<td>G</td>
<td>B</td>
</tr>
</tbody>
</table>

3. Reading along the diagonals. For example, proceeding from Year 7 in 1985 to Year 8 in 1986, ending with Year 11 in 1989, will track the growing percentage of smokers among young people born in the same year (in this example, 1974). The higher percentages of smoking girls than boys in the older age groups are obvious when the two diagrams are compared. The decline in smoking between 1985 and 1988, indicated by the boys' data in Figure 1, is less clear for the girls. Year 11 girls do not show such a decline, and the low Year 7 smoking levels make observation difficult. A calculation of average percentage of smokers, 1985-1988 and 1989-1994, produces the following figures.

Consumption of cigarettes

In every case, the percentage of young smokers in surveys supported by the Unit has been higher in the post-1988 period.
We calculate that the Year 10 sample of 7534 girls included 2034 that smoked, and between these smokers the intake of smoke from 56,550 cigarettes in one week (and doubtless shared the opportunity with many others).

'The thin black line'

Although smokers are always in the minority, it is usual to have at least tried smoking by Year 11.

We regard those who say that they smoke occasionally or regularly as 'smokers'. In Table 1 we have accumulated the total of 'smokers' in italics.

We have chosen to display (see Figure 3) the complementary percentages to the 'smokers'. This shows that the great majority of young people do not smoke, including sixth-formers in other data collected by us.

Turning now to Table 2, we see that an ever-decreasing number across the year groups declare that they don't smoke and never will. Good intentions are seen to be not enough!

However, the groups signalling that they would like to give up present a challenge, as do those who say they might smoke in the future.

Most 'smokers' declare that they would like to give up, and we need to consider what would help them do this, assuming that this really does express their desire.

To put the situation in perspective, Figure 4 shows how each sex and year group in the 1994 sample can be divided into non-smokers, smokers that would like to give up, and smokers that do not want to give up.

Determined smokers usually form a tiny minority. Their largest contribution amounts to only 7% of the year group. They form a 'thin black line' in Figure 4.

What makes smokers smoke?

It would appear from Figure 5 that:

(a) If either mother or father smokes, similar and enhanced percentages of sons smoke.

(b) More daughters smoke if mother is the only parental smoker than if father is (mother smoking has more effect on girls than father smoking, and there is effectively no difference for boys).

(c) Where both mother and father smoke, even more daughters smoke. To a lesser extent, sons do so too.

(d) A brother or a sister smoking is related to a very large difference in percentages — approximately a doubling is noted.

The influence of a close friend shows some huge differences. We hear so much about peer pressure, and we note immediately the large percentages of boys and girls that smoke if a close friend smokes. However, we also note that these large percentages are actually smaller than those for boys when a brother smokes, and girls when a sister smokes.

What causes these differences between smoking or not smoking according to whether close friends do or do not smoke? Two alternative explanations are offered. The peer-pressure model. You do what your close friends do. If they happen to smoke, you join in.

The environment model. You seek the company of those people with behaviour that make you feel comfortable. Smokers seek out other smokers; non-smokers select other non-smokers.

Figure 6 shows the number of Year 10 smokers' households with people that smoke at home.

Table 3 shows the total number of people smoking in the home. This information is of interest to doctors, who may be concerned about passive smoking. The top line shows that there are no smokers in about half the homes. The increase in the number of smokers in the homes of older children would be consistent with some of them being smokers too and being included in this total.

Figure 7 shows the number of people that smoke in the homes of Year 10 smokers. There is a very clear trend for young smokers to come from smoky households — 70% of the Year 10 girls in households where three or more people smoke are themselves smokers, and will be included in the total.

Teachers, who may be interested to know about family models, also need to be sensitive to the necessity of avoiding creating conflict through 'smoking' lessons.

Smoking and newspaper readership group

We have referred elsewhere to the fact that different groups of newspapers tend to be read...
Internet: Go ask Alice

A freelance writer recently rang us up and asked: Do you know what sort of information is available on the Internet on, say, drug use? Are you worried?

The answer to the first question was Don't know, so the second answer was Not yet! Since then we've had a root around, and could now reply Some and Moderately.

The Internet has two main branches that can be easily accessed: the 'newsgroups' (bulletin boards) where people post messages on different topics, and the World Wide Web, where static documents are placed for general reading via the networks, but each document has links that you can follow to other documents.

There are lots of drug-related newsgroups. Many newsgroups maintain a list of Frequently Asked Questions or FAQs (with answers) for new readers; for example, an alt.hemp FAQ asks Doesn't marijuana cause brain damage?

The short answer is No.

The long answer is The reason why you ask this is because you probably heard or read some drivel about marijuana damaging brain cells, or makes you stupid. These claims are untrue.

The answer goes into further detail and quotes research (but compare Mary Trent’s article in Education and Health Vol 11 No 5). There are lots of other health-related bits of information on the Web, and you might say that because there is a mixture of 'pro' and 'anti' information, then there's a balance and browsers can make their own minds up. However, I don't think that's necessary true. Firstly, 'pro' pages have links to other 'pro' pages, and the same goes for the 'anti'. Secondly, not all of the information is equally accessible: when I searched for 'cannabis' and 'marijuana' at the National Clearinghouse for Alcohol and Drug Information (NCADI) database, which claims to be the world's largest resource for current information and materials, it required quite a bit of network awareness even to get started.

I have heard of a product called NET NANNY, which conjures up a charming image of a kind but firm restraining hand being placed on the keyboard when particular words appear. But would it pick up everything you wanted, since drug users employ such a rich variety of terms when discussing their hobby?

One of the best-known of all Web sites is the Healthwise page at the University of Columbia — one of the top 5% of most-visited Web sites. [URL=http://www.columbia.edu/healthwise/] Here you will find ALICE, a team of professional and peer educators who will answer questions submitted to their computer. Essentially, it's an electronic problem page. Answers are listed and indexed. Currently there are 43 files under Drug and alcohol concerns. For example:

Crystal meth
Dear Alice,
A few of my friends are becoming dependent on crystal meth. I am concerned about the health effects. Please give me information on what kinds of symptoms they might have on the body.

Thank Alice for a friend.

Dear Friend,
Crystal meth or methamphetamine hydrochloride is an amphetamine-like stimulant. The effect of small to moderate doses of crystal meth is increased heart rate and blood pressure, central nervous system stimulation, increased body temperature, and appetite suppression. Large or repeated doses may cause you to be concerned about your friends. What may have started as an all-nighter has the potential to turn into a nightmare.

I find Alice's style and popularity very welcome, and I think that health educators have here an approach that is accessible and frequently accessed.

There is probably no information on Internet that is not available elsewhere, in libraries, on television, or in magazines. I would not feel happy if youngsters had unrestricted access to it upstairs alone in their bedrooms; if parents abandon responsibility for their children's diet of information, then this is as potentially damaging with respect to Internet as anything else. However, if parents do abandon responsibility in this way, then Internet is the least of that family's problems. — David Regis.