

# EVALUATION OF THE *SURROUND* PILOT PROJECT: SCHOOL-BASED PROGRAMS FOR TOBACCO USE PREVENTION AT THE MIDDLE SCHOOL LEVEL IN MINNESOTA

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## Introduction

Youth tobacco use continues to be a major health problem. Of 50,000 9<sup>th</sup> grade students who participated in the Minnesota Student Survey in 2001, 19% smoked. Some smoked only occasionally but 4.5% reported smoking heavily (1/2 a pack to 2 packs per day). Among 12<sup>th</sup> grade students, 36% reported smoking and 13% were heavy smokers. Even among 6<sup>th</sup> grade students, 4% reported some tobacco use. (Minnesota Department of Children, Families & Learning and Minnesota Department of Human Services (2001). Minnesota Student Survey. Roseville, MN.)

In 2000, the Minnesota Department Education (MDE), formerly known as the Minnesota Department of Children, Families & Learning created a model for the implementation of a comprehensive, school-based tobacco use prevention program. This model was based on recommended school strategies published by the Centers for Disease Control (CDC) in the *Guidelines for School Health Programs to Prevent Tobacco Use and Addiction* (Centers for Disease Control and Prevention. Guidelines for School Health Programs to Prevent Tobacco Use and Addiction. MMWR 1994; 43 (No. RR-2): [inclusive page numbers]) and other factors identified by the Minnesota Department of Health (MDH). The MDE tobacco use prevention model was developed and implemented through two interrelated grants: *Surround* and *Health Skills for Life*. This five-year pilot program was supported by the Minnesota Department of Health, which managed the Minnesota Youth Tobacco Prevention Initiative funded by the Youth Tobacco Endowment. The Minnesota Legislature established the Youth Tobacco Endowment in 1999 with the goal of reducing youth tobacco use by 30% by 2005.

The MDE contracted with Minnesota Institute of Public Health (MIPH) to evaluate both the *Surround* and *Health Skills for Life* components. The focus of this article will be on the evaluation of the implementation of the *Surround* portion of this two-pronged initiative.

## Background

The objective of the *Surround* pilot project was to support comprehensive, school-based tobacco use prevention programs in middle schools following the CDC guidelines for school health programs. These guidelines focus on policy, curriculum/instruction, student services and parent/family involvement. In addition, the MDH Youth Tobacco Prevention Initiative required all grantees to include a youth engagement component. The MDE made assessment of school programs and linking school-based efforts with local public health, community coalitions

and statewide media or educational campaigns a priority. The project included implementation of comprehensive programs at five pilot sites and establishment of three task forces to develop implementation strategies and resources for the student services, policy and parent/family involvement components.

Each school selected to participate in the pilot project received ongoing technical assistance from a MDE contractor and employed an educator (Envoy) who worked on the project for one to four days per week, depending upon the school's enrollment. Staffing at each of the sites varied greatly. Three of the five sites employed a classroom educator as the Envoy. The fourth site contracted with a county public health educator to coordinate the program, and site five used a member of the student services team. Staff turnover among the Envoys occurred in two of the five sites. The Envoys had three roles:

1. Engage youth in the assessment and planning components of a comprehensive tobacco-use prevention program and work with youth to help them develop leadership roles in the school and/or community.
2. Assess the extent to which the school implemented CDC components in the areas of policy, family/parent involvement, student services, curriculum and community linkages. Based on the results of the assessment, each Envoy selected a component to work on initially and then branched out to other components as needed or as resources dictated. Use of the *Assessing Schools Tool* (available online at <[www.mnschoolhealth.com](http://www.mnschoolhealth.com)>) was strongly encouraged.
3. Act as a broker for new information, opportunities, and resources from the Youth Tobacco Endowment public information campaign, youth leadership initiative, other statewide and local initiatives, and research on tobacco use prevention.

Originally, five middle school sites were selected to implement this school-based tobacco use prevention program. Four of the sites remained with the project through the initial three years of implementation. The fifth site dropped out at the end of year one. Following is a brief description of the schools that participated in the pilot project:

- Site one was located in a northern suburb of the Minneapolis/St. Paul area. The school had approximately 1,500 students in grades six through eight. This site focused on curriculum selection and implementation during year one, on parent/family involvement in year two, and on awareness of the dangers of secondhand smoke in year three. This site placed a lot of effort on increasing awareness about the dangers of tobacco use among its large student body. Youth driven activities included a "rip it out campaign," no tobacco addiction essay contest, and a school-wide tobacco-free themed volleyball tournament.
- Site two was also located in a northern suburb of the Minneapolis/St. Paul area. The school had approximately 1,200 students in grades six through eight. Policy and procedures were the main focus of year one efforts with additional emphasis placed on curriculum implementation. In year two, the focus shifted to parent and community involvement. Finally, in year three a two-pronged focus was used to increase tobacco-free signage and provide students with general information on the dangers of using tobacco. As part of the year two focus on parent and community involvement, the students at this site built a tobacco-free community using paper bricks. The "bricks" were commitment cards to a smoke-free environment that families were encouraged to sign and return to school. The signed bricks were used to build a school display of a smoke-free community.
- Site three was located in rural central Minnesota. The school had approximately 500 students in grades five through eight. This site selected curriculum implementation for its year one focus. This focus continued into year two with additional effort placed on parent and community involvement. During year three, the focus shifted to raising awareness of the dangers of secondhand smoke. It should be noted that this site's efforts were closely coordinated with county public health efforts and this collaboration led to a major effort during year three that culminated in a citywide smoke-free restaurant night.
- Site four was located in rural northwestern Minnesota. The school had approximately 600 students in grades five through eight. Curriculum implementation and policy were the focus of year one. In year two, parent and community involvement became the focus and this carried over into year three. Over the course of the project, this site's youth group was comprised of nearly the entire student body. The youth

group became an advocacy team, stressing the dangers of tobacco use and secondhand smoke in both the school and in the community.

- Site five was located in the city of St. Paul, Minnesota. This open enrollment school had approximately 770 students in grades six through eight. The school has a technology focus and the school's student body was comprised of a high percentage of Somali, Hispanic, Hmong, and African American students. There was also a high poverty rate among the students. It should also be noted that unlike the other schools, staff from this site did not apply to participate in this pilot project. MDE recruited their participation. The Envoy at this location left the position before the beginning of year two. Unfortunately a replacement was not found and project implementation at this site was discontinued.

Various contextual issues occurred during the first three years of the program that had an impact on project implementation. First, in 2001, the Minnesota State Legislature considered using the Tobacco Endowment funds in a different manner than originally agreed. This would have completely taken away the funding for *Surround and Health Skills for Life*. Staff of both initiatives were forced to wait until the Legislature determined what would happen to these funds before they could make plans for the 2001-2002 school year. The funding was left in place, and despite the waiting period, all sites proceeded as planned for year two. Second, in 2002, a possible Minnesota government shutdown forced the funding agency (MDH) and the implementation agency (MDE) to make contingency plans for keeping program staff informed should shutdown occur. In the end, there was a two-week state workers strike, which caused a delay in funding for year two. Due to complications in the funding stream, the sites also suffered a reduction in funding and a six-month lag in year three. Ultimately, the Minnesota Legislature completely eliminated the Youth Tobacco Endowment beginning in the 2003-2004 school year.

## Evaluation Plan

The purpose of the evaluation was to follow the implementation process of a comprehensive, school-based tobacco use prevention program in five Minnesota middle schools. The project's original logic model was reviewed in conjunction with MDE staff and enhancements were made to the logic model during the first month of the project. The project's theory of change was based on the belief that a middle school staff person, dedicated at least part-time to tobacco use prevention and education, will have a greater likelihood of success when compared to many staff members working on small portions of a comprehensive model. Further, if a comprehensive, school-based approach becomes well established and supported by administration and other staff, then the likelihood is greater that the CDC components will be implemented successfully. Also, tobacco use prevention and control will be seen as an integral part of community-wide strategies that address the overall social context of tobacco use. This will lead to reduced tobacco use rates among students.

Two short-term outcomes and one long-term outcome were identified:

1. Establish and support comprehensive school-based tobacco prevention programming in the selected middle schools.
2. In each school, at least one of the following will occur: Increased policy establishment and/or enforcement; greater fidelity in curriculum implementation; establishment or increased coordination of student services; and/or increased parent/family involvement.
3. Tobacco use prevention and control viewed as an integral part of community-wide strategies that address the overall social context of tobacco use, leading to reduced tobacco use rates among students in the selected schools.

The process evaluation questions addressed during the evaluation included:

1. How were resources used to plan and implement the school-based tobacco use prevention programming in each target location?
2. How consistently and comprehensively was the program implemented in each target location?
3. What obstacles or barriers were encountered as each location implemented the program?
4. How was the *Assessing Schools Tool* used?

5. What connections were made internally (with other school staff) and externally (with local public health and law enforcement)?
6. How did any broad changes at the locations change the context in which the program was implemented?
7. How will evaluation findings be used to improve program implementation throughout the duration of the project?

The outcome evaluation questions addressed during the evaluation included:

1. To what extent did teacher training and support programs encourage fidelity to curricula implementation and goals?
2. To what extent did the school-based prevention programs affect administrators' leadership roles in reducing youth tobacco use?
3. To what extent did a comprehensive, school-based prevention program impact the student service team's awareness of early identification and awareness of available resources?
4. To what extent did the school-based prevention programs result in more consistent enforcement of tobacco-free school policies?
5. To what extent did the school-based prevention programs lead to a decrease in the number of youth who believe that smoking is the norm?
6. To what extent did the school-based prevention programs change student norms regarding tobacco use?
7. To what extent did the comprehensive, school-based prevention program impact students' knowledge, skills and attitudes regarding tobacco use?
8. To what extent did the school-based prevention programs lead to reduced youth tobacco use?

The original evaluation design assumed full implementation of the comprehensive program. Evaluators did not anticipate gaps in funding, nor was the premature cutoff of funding anticipated.

## **Evaluation Methodology**

A mixed-method, case study design was employed for this evaluation. This method was chosen for the evaluation because it works well to describe current events from a variety of perspectives. In addition, this approach allowed evaluators to adjust the evaluation plan based on evaluation findings and contextual changes that were beyond the scope of the project. Finally, this method allowed for a blend of qualitative and quantitative evaluation strategies for a more comprehensive understanding of the project. Data collection strategies used in this evaluation included:

1. A series of key informant interviews conducted with various school staff and community members. They included the Envoys, principals, teachers, student service team members, county public health representatives, and police liaison officers. The purpose of the interviews was to gain an in-depth understanding of how the *Surround* pilot project operated at each site. Youth involvement, principal support, student services team involvement and barriers to program implementation were discussed.
2. The *Tobacco and Health Survey* was created by MIPH to measure student knowledge, use and perceptions about tobacco use. Additional items in the survey included questions about alcohol and marijuana use, the practice of refusal skills, feelings of sadness or hopelessness and perception of weight status. The items on the survey were taken, with permission, from the *Minnesota Youth Tobacco Survey* (Minnesota Department of Health, Center for Health Statistics (2000). *Minnesota Youth Tobacco Survey*. St. Paul, MN.) and the *Minnesota Student Survey* (Minnesota Department of Children, Families & Learning and Minnesota Department of Human Services (2001). *Minnesota Student Survey*. Roseville, MN.). Using items from existing surveys provided a baseline to which results of this survey were compared.

3. A *Parent Awareness Tool* that was created to survey parent knowledge of the *Surround* pilot project, knowledge of tobacco and alcohol use consequences and communication with children about substance use.
4. The *Curriculum Fidelity Tool* was created to measure instructor fidelity to curriculum implementation and goals. This tool asked instructors about number of lessons taught, order of lessons, use of particular implementation strategies and satisfaction with curriculum effectiveness. Instructors were also asked about the level of training they had received, perception of reduced student tobacco use and student response to the curriculum. Questions on this survey were adapted, with permission, from the University of Minnesota's Program Evaluation Assistance Center (PEAC) *Curriculum Implementation Survey*.
5. Field observations were conducted at all sites during each year of implementation. These observations included the monitoring of classroom curriculum implementation and observation of various *Surround* pilot project activities.

Findings discussed in this article are based on data from the key informant interviews, curriculum fidelity tool and observations.

### ***Surround* Pilot Project Progress in Years 1, 2 and 3**

The comprehensive model developed by MDE was comprised of several components:

1. The CDC *Guidelines for School Health Programs to Prevent Tobacco Use and Addiction* (Centers for Disease Control and Prevention. Guidelines for School Health Programs to Prevent Tobacco Use and Addiction. MMWR 1994; 43 (No. RR-2): [inclusive page numbers]) that included policy, student services, curriculum/instruction and parent/family involvement.
2. A youth engagement focus as directed by the MDH.
3. An assessment of school programs in the areas of policy, curriculum/instruction, student services, parent/family involvement, and community linkages.
4. Creation of links between school-based efforts and local public health, community coalitions and statewide media or educational campaigns.

The following descriptions give an overview of the progress made in each area during the three years of implementation and the table that follows provides a snapshot of progress made at each site.

#### Progress Made In Year One

*Policy*—All schools reviewed their tobacco-free school policies to ensure that consistent implementation by school administration and staff was occurring.

*Curriculum and Instruction*—All schools selected an evidence-based curriculum and ensured adoption of the curriculum prior to or beginning in the fall of year two.

*Youth Involvement*—Youth tobacco advocacy groups were formed at each site. This youth-led adult guided group planned and implemented activities at each school.

*School Assessment*—Envoys convened representatives from various sectors (administration, educators, student support services, youth, community) and completed the *Assessing Schools Tool* to plan programs for the year.

*Collaboration Within the School*—Teachers provided some assistance to the Envoys. Each principal supported of the project, but his or her level of involvement remained disciplinary and managerial.

*Collaboration Within the Community*—Contact was made with local businesses and service organizations such as rotary clubs and the American Cancer Society.

### Progress Made In Year Two

*Policy*—All schools again ensured consistent enforcement of tobacco-free school policies with an added educational component.

*Curriculum and Instruction*—All schools either continued or began to implement an evidence-based curriculum.

*Parent/Family Involvement*—Year two activities were targeted to parents and families in order to increase awareness of the dangers of secondhand smoke.

*Youth Involvement*—Youth groups were well established at each site. Students continued to plan and implement activities at school and in the community.

*School Assessment*—Envoys again convened representatives from various sectors and completed the *Assessing Schools Tool* to plan programs for the year.

*Community Involvement*—Two sites had significant levels of community involvement (developed an adult tobacco coalition, partnered with an existing coalition).

*Collaboration Within the School*—Teacher involvement at two of the schools gained strength, while teacher support at the other sites remained stable. The principals' role shifted from involvement at a managerial level to that of eager participant at three sites. Principals had moved beyond disciplinary action to investment in the prevention curricula.

*Collaboration Within the Community*—Strong collaboration with local businesses and service organizations continued, while contact with local public health varied from minimal to great, depending upon site. Connections with law enforcement were present at two sites.

### Progress Made in Year Three

*Policy*—All schools ensured consistent enforcement of tobacco-free school policies.

*Curriculum and Instruction*—All schools continued to implement an evidence-based curriculum.

*Parent/Family Involvement*—Although activities were not specifically targeted toward parents and families at three of the sites, all four sites involved them in some student take home activities.

*Youth Involvement*—Youth groups were institutionalized at three of the four sites and continued, at all of the sites, to plan and implement activities.

*School Assessment*—Due to the six-month lag in funding, none of the sites implemented the assessment in its entirety. Despite this, CDC's components were used as the foundation for deciding which activities to pursue during the grant period.

*Community Involvement*—There was moderate community involvement during this contract period. One site involved restaurants, parks and recreation, and the city council in a citywide smoke-free night. In addition to local businesses, the American Cancer Society and the American Lung Association were involved in activities at two of the sites.

*Collaboration Within the School*—Teacher, principal and student services staff involvement remained stable at all sites.

*Collaboration Within the Community*—Collaboration with local businesses and service organizations were the strongest external link. Contact with local public health varied depending upon site. At a minimum each site participated in tobacco coalition meetings. County public health agencies provided materials for school activities at two of the four sites. Connections with law enforcement were present at two sites.

## Summary of School Progress To Date

	Site One	Site Two	Site Three	Site Four
Assessment	Conducted Annually	Conducted Annually	Conducted Annually	Conducted Annually
Curriculum/Instruction:				
Evidence-based curriculum	Implemented	Implemented	Implemented	Implemented
Curriculum reevaluated	Implemented	Implemented	Future	Future
Parent/Family Involvement	Initiated	Implemented	Implemented	Implemented
Policy	Implemented	Implemented	Implemented	Implemented
Student Services	Future	Future	Future	Future
Youth Involvement	Implemented	Institutionalized	Institutionalized	Institutionalized
Internal Collaboration:				
Principal	Initiated	Implemented	Implemented	Implemented
Teachers	Initiated	Implemented	Initiated	Implemented
External Collaboration:				
Community Involvement	Future	Future	Implemented	Implemented
Law Enforcement	Future	Future	Initiated	Initiated
Public Health	Initiated	Initiated	Implemented	Implemented

## Findings

1. Envoys that have established relationships in the school and community reported a greater ability to build infrastructure for tobacco use prevention and control.

Being part of a larger community increased the likelihood for successful program implementation. Having established relationships allowed the Envoy to receive feedback on an ongoing basis as well as have a support network when things were not progressing as planned. Community connections were also beneficial because they allowed the Envoy to leverage resources and build infrastructure that would last beyond the pilot effort.

2. Local public health agencies and schools can partner to better leverage resources to prevent tobacco use.

Public health departments want to decrease youth tobacco use and schools have a captive audience comprised of this population. Working to combine both monetary and time resources would work to each other's advantage.

3. Youth were the driving force behind this project and, according to many adult participants, that involvement was critical.

By the end of year three, the youth component of the project had been institutionalized at two of the four sites. A youth-led and adult guided approach was important because it allowed students to brainstorm and implement activities, while the Envoy acted as a sounding board and provided support and coordination. This approach also gave students a chance to be in the spotlight, develop programs, and stand up against tobacco industry manipulation.

4. The Envoys ranked youth development as the role where they had the greatest involvement.

The Envoys had three roles in this project: youth development, information broker, and targeted assessment. Youth involvement was embedded into many of the components of the *Surround* project and

continued to be the driving force behind most of the activities at each school. Engaging youth in student groups became a key component of the *Surround* pilot project early in the first year of the program. When the project started, the Envoys began working with youth in earnest. The influence of that involvement became increasingly apparent during the duration of the project.

5. Envoys believed that the project had an impact on student attitudes toward tobacco use.

Because many students were involved in the project at each school, Envoys believed this involvement contributed to students' attitude change toward tobacco use. At the two smaller sites, a majority of students participated in the youth groups. The other two sites, with larger student populations, had a core group of students target activities to the entire student body. The use of anti-tobacco industry messages was effective as was the consistency with which the messages were presented to the students.

6. As a result of project implementation, principals and student service team members became more aware of tobacco use prevention and they gave greater support for tobacco prevention programming.

Over the course of the three years, principals shifted their focus from disciplinary action to investment in prevention curricula. School counselors, social workers and psychologists began responding to students who were using tobacco by discussing the facts and consequences of tobacco use. Despite this positive shift in awareness, only one school formally tracked tobacco use referrals.

7. The amount of time needed to carry out project activities was consistently cited as the most significant obstacle to implementation.

Envoys found it challenging to balance implementation of the comprehensive model with their work with youth. They wanted to spend time working directly with youth groups, but realized the importance of assessing and planning for a school-wide comprehensive model and documenting project activities. While this obstacle was overcome at two of the sites by having someone in a non-teaching position implement the program, all of the Envoys still expressed concerns about the number of hours they dedicated to this project.

8. The Minnesota version of the CDC four-component model was not fully implemented at the *Surround* sites before funding was discontinued.

The *Surround* model became a hybrid of the CDC model with inclusion of the youth component, program assessment, and community collaboration. The student services, policy, and parent components were developed concurrently with the *Surround* implementation and the youth component took more time than anticipated. Necessarily, the inclusion of these components may have deflected energy from the CDC model. In addition, implementation was uneven due to school interest, Envoy experience, administrative buy-in, and time constraints.

9. Envoys suggested that a staff person who does not regularly teach in the classroom would be a better choice for guiding the youth and implementing this project.

Because of their part-time classroom teacher and part-time Envoy status, leading this project often caused over-commitment both in terms of workload and time availability. The Envoys asserted that it makes more sense to use someone outside of the teaching staff in the Envoy role because non-classroom teachers' time is more flexible. Social workers and chemical dependency counselors were among the options suggested.

10. Project staff believed that tobacco-use prevention programs are not a stand-alone activity and are best incorporated into comprehensive school health programs.

Pilot projects, such as *Surround*, provide staff at the local and state levels with information that can be used to inform programming for other health risk behaviors. Program components, barriers to implementation, and the effects of contextual issues warrant particular attention.

## Lessons Learned

1. Partnerships between schools and public health are feasible and can enhance each system's ability to implement tobacco prevention and control initiatives.

There is a creative tension between schools and public health. School systems are student achievement focused. Public health is interested in changing student health behaviors, but may not be formally trained in school programming. One of the goals of this project, for both sectors, was to empower youth with skills and education that will serve them into adulthood. Learning to partner and leverage resources is necessary to meet this goal.

2. Schools operate within a broader community context.

Schools are one of many sectors working to prevent tobacco use and they must work with others to accomplish this goal. Local norms and values about tobacco use influence school-based programs. In addition, local public health and tobacco advocacy organizations also influence school-based efforts. Schools cannot operate in a vacuum, nor can community organizations expect schools to comply with all of their requests.

3. Implementing the CDC recommendations for comprehensive, school-based tobacco prevention in phases is logical and will likely be more manageable for schools than attempting to implement all elements concurrently.

The school environment dictates that academic efforts must be the priority, making curriculum and instruction the logical starting point for this program. In addition, policies must be in place and enforced in order to assure that the learning environment is consistent with the curriculum taught. Student services and parent/family involvement are important as well, but until the education and policy components are in place, school staff will be hard pressed to understand how or why to take advantage of services or engage family members.

4. Substantial changes in policy and programming, such as those recommended by CDC, require a multi-year implementation period and a continuous funding commitment.

These projects were in year three of a proposed five-year grant cycle. Due to various contextual issues, which were beyond the control of project funders and grantees, these grants ended prematurely. In addition, these contextual issues caused a six-month lag in funding during year three.

5. It was challenging to implement a comprehensive program with fidelity.

The model program that MDE sought to implement involved curriculum/instruction, student services, policy, parent/family involvement, youth engagement, assessment, and community connections. Coordination of a multi-pronged program that also required connections with school staff and community members is a time consuming task for even the most seasoned educators.

6. Staff retention played a significant role in how these grants proceeded.

These projects saw a large amount of staff turnover, which for most schools is simply a reality that must be dealt with. Ways to overcome this obstacle, such as written records, training, direct communication, and/or obtaining buy-in from new staff will help offset issues related to staff turnover.

## Evaluation Limitations

This evaluation included qualitative data, which limits generalizability. Because of significant interactions between the evaluator and project staff, the evaluator may become a biased observer due to close relationships that are developed with the program participants during the evaluation process. Efforts were made to manage potential bias through regular meetings of members of the evaluation team.

From the start of the *Surround* pilot project, the five sites were considered individual locations. The intention was to monitor processes and outcomes at each location based on the activities, successes, and obstacles that were encountered at each site. In addition, the selected pilot schools were not matched with control schools. All of the

sites have different capacities and significant variability, constituting an important factor when interpreting evaluation findings.

## **Summary**

Full implementation of this comprehensive, school-based tobacco use prevention program was impeded by a variety of contextual changes that occurred during program implementation. Legislative action resulted in a six-month gap in funding and ultimately eliminated the grant supporting this initiative prior to full implementation. These factors had an impact on consistency of staffing, program implementation, and coordination of efforts with community-based partners.

Another factor that may have slowed full implementation of the original program design and theory of action was the requirement by the funding source that a youth involvement component be added to the CDC's recommended strategies. The Envoys responsible for implementing the program reported spending more time on this strategy than on the CDC's recommended strategies. Thus, the program that was actually implemented was markedly different from the model that was originally designed.

Short-term outcomes of this initiative include improved coordination of tobacco prevention efforts between local public health and schools in the pilot phase of the project, increased skills and capacity of school staff involved in implementing the program, and a better understanding by state education agency staff about the complexities of implementing school-based tobacco use prevention programs.

Future efforts to implement a comprehensive, school-based tobacco use prevention program can benefit from lessons learned in this initiative and working to secure ongoing, uninterrupted funding for three or more years, monitoring program implementation to ensure that all program elements are implemented with fidelity, and continuing to coordinate school-based activities with community-based tobacco prevention and control efforts.