LETTER TO THE EDITOR

Letters intended for publication should be a maximum of 500 words, 10 references, and one table or figure, and should be sent to the editor at the address given on the inside front cover. Those responding to articles or correspondence published in the journal should be received within six weeks of publication.

The centenary of the enactment of the law for prohibiting minors from smoking in Japan

EDITOR,—This year is the centenary of the enactment of the law for prohibiting smoking in Japan (Act on the Prohibition of Minors’ Smoking, 1900). As the law consists of only four articles, we have translated the full text of the law in English as shown below.

Article 1: Persons below the age of 20 years are prohibited from smoking.

Article 2: Any person, who commits an offence under Article 1, will have their tobacco products and instruments for smoking confiscated by the authority.

Article 3: Any parent or person in parental authority, who intends not to prevent his/her child from smoking, shall be punished with a fine not exceeding ¥10,000. Any person who supervises minors instead of their parents, shall be also punished by the former section of this Article.

Article 4: Any person, who sells tobacco products or instruments for smoking to a person below the age of 20 years for his/her own use, shall be punished with a fine not exceeding ¥20,000.

The fines shown (in yen) are the amounts now in force. We sent a questionnaire to 125 foreign embassies and 22 consulates located in Japan requesting information on the presence and contents of laws on minors’ smoking, and on the observance of these laws. Responses were obtained from 64 embassies and consulates (recovery rate: 43.5%) (table 1).

<table>
<thead>
<tr>
<th>Minors</th>
<th>Parents/guardians</th>
<th>Tobacco retailers</th>
<th>Number of countries</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>4</td>
</tr>
<tr>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>4</td>
</tr>
<tr>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>1</td>
</tr>
<tr>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>5</td>
</tr>
<tr>
<td>No</td>
<td>No</td>
<td>No</td>
<td>2</td>
</tr>
</tbody>
</table>

5. Observance of the law (n=20)

- Mostly: 3 countries
- Usually: 7 countries
- Occasionally: 3 countries
- Seldom: 5 countries
- Never: 2 countries

*(Japan: 1900)*

prosecuted since 1980. Furthermore, smoke free provisions have not been introduced in any national law, presumably because of the political environment, administrative inadequacy, and an inactive medical community in Japan. Our survey suggests that an unimplemented law prohibiting minors from smoking appears not to have sufficient effect on reducing their smoking prevalence in Japan. Other policies and laws such as the introduction of smoke free environments may be more effective.

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Book reviews and books of interest to "Tobacco Control" should be sent to the editor at the address given on the inside cover.

Changing people's behaviour


“...you cannot get people to change in five minutes.” "Doctors do not feel that they have the expertise or training to help people change behaviours." "Getting diabetics (smokers, drinkers, heart patients . . .) to change their diets (smoking, drinking, exercise . . .) is difficult if not practically impossible.” These statements represent typical comments from third year medical students in a class on behaviour modification that I teach at the medical school. I have often encountered these negative views of health behaviour change among health practitioners. In response I contend as cogently as I can that medical professionals can be taught about the process of change and trained to help individual patients make positive movement toward change in a brief period of time. I now have help. This practitioner guide by Rollnick, Mason, and Butler does a wonderful job of making these points in an elegant, convincing, and motivationally enhancing manner. This small, easy to read volume is filled with practical insights and strategies that would be useful and valuable for both the busy health practitioner and the

Table 1 Results of a survey of laws on tobacco control

<table>
<thead>
<tr>
<th>Presence of direct provision prohibiting minors from smoking in a law</th>
<th>Yes: 26 countries</th>
<th>No: 38 countries</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year of enactment (n=11)</td>
<td>Oldest: 1934*</td>
<td>Newest: 1999</td>
</tr>
<tr>
<td>Age restriction (n=24)</td>
<td>Youngest: 15 years</td>
<td>Eldest: 20 years</td>
</tr>
<tr>
<td>Punishment (n=18)</td>
<td>Eldest: 20 years</td>
<td>Median: 18 years</td>
</tr>
</tbody>
</table>

- Yes
- No


practitioners to do in order to develop rapport, to set agendas, and to negotiate change. The scripted dialogues between patient and provider throughout the book are one of the most useful aspects of the book. The authors provide many interesting examples both of what to do and of what not to do to prevent the patient from disengaging, and to foster meaningful dialogue about change.

Many practitioners will see themselves in some of the “not so good” approaches. I could picture myself doing some of the not so good engagement strategies and that gave me a better sense of the style and content of this behaviour change method. The authors illustrate well the dangers of forcing a premature focus on active problem solving or not listening well, and giving prescriptions and advice unsolicited or in a condescending manner. Immediately following the not so good are brief, interactive vignettes that highlight one or more ways to meet the patient and address the issue of change more effectively. These vignettes are a wonderful teaching tool that engage the reader, and are a very effective method for giving the reader a real feel for what a behaviour change negotiation would look like from beginning to end.

The second very useful contribution to the practitioner lies in the brief assessment tools that the authors use to facilitate the conversation and the change. There has been some controversy about whether the stages of change represent distinct categories and how to assess them in day to day practice. The authors acknowledge the heuristic value of the stage model and find a unique way of getting clients to discuss where they are in the process of change. The assessment is elegant in its simplicity. The recommended procedure is simply to use a numbered line, a sort of ruler, that can be shown to the patient so that he or she can mark where they see themselves with respect to the dimension in question. The problem I have always had with these single ladder or ruler assessments is that they try to put too many dimensions into a single assessment. These authors have avoided this dilemma by suggesting that there are several dimensions that need to be evaluated. They ask about the importance of the proposed behaviour to the patient, the confidence that the patient could accomplish the behaviour change, and finally the readiness of the patient to change the behaviour. By having the trainees mark themselves on a scale from 1 to 10 on these three dimensions, the practitioner gets a view of how each patient evaluates this particular health behaviour and their location in the process of change. This is a brilliant resolution to the assessment dilemma and offers the practitioner multiple avenues to begin a conversation with the patient about the needed behaviour change. I have already incorporated some of these suggested assessments in training practitioners for a brief motivational intervention in one of our research protocols at the University of Maryland. The trainees have found the exercises and the assessments to be very helpful in this situation and it is in this case my highest form of praise.

Helping people change is a thoughtful, practical guide for practitioners that deserves to be read by a whole host of health practitioners. Some may be able to adopt the entire method. Others may only be able to change their approach to giving advice to patients modestly. However, few will remain untouched by the examples offered by these authors. They clearly have experience with a variety of problems and patients. It is as much their experience as their thoughts that makes this a very useful guide. I am recommending it to my colleagues and students interested in health behaviour change as required reading.

Why Joe Camel is still smiling

**Smoked: why Joe Camel is still smiling.**


This provocative book is a critique of the anti-tobacco campaign in the USA in the 1990s. At the beginning of the book, the industry was in retreat. After several years of dealing with C Everett Koop, the most effective Surgeon General in history, the industry was faced with the prospect of a smoke-free society by the year 2000. According to Males, smoking rates among adults and young people were declining. But by decade’s end, available data showed that adult prevalence had not changed since 1990. Prevalence in adolescents was at least as measured by school surveys, was higher in 1997 than in 1992. Further, in 1998 the industry had negotiated a settlement that was, quoting Stan Glantz, “one of the biggest coups in the history of the world” (page 2). Worse yet, Males’ laments, the drives to decrease the social acceptability of smoking and provide increasingly more smoke-free indoor environments that highlighted the Koop era were replaced by efforts to reduce the initiation of smoking by young people.

Males writes that the industry’s role in the turnaround of its fortunes was “merely opportunistic” and was aimed to protect the forces for the unfavourable developments of the 1990s. He first chides the Clinton administration for backing off strategies to raise taxes on tobacco products and promote smoke-free policies aimed at “poll-drugs such as beer, marijuana, and tobacco in reaction against the depletion of the adults around them” (page 4).

I found this book to contain several insightful observations. Most in the tobacco control movement would agree with Males that the youth only focus is too limited, that President Clinton’s cigar smoking set a poor example, and that politicians who kept saying that “kids shouldn’t smoke because smoking is for adults” likely provided young people with incentive to smoke and adult smokers with reasons to continue. Such messages were probably equal in worth to millions of dollars of tobacco advertising. Males also
does a fine job of outlining the points of victory attained by the industry. Additionally, his concerns about policies that blame and punish teenagers are noteworthy. Finally, Males’ call for parents to set a better example by not smoking and his suggestion that the quality of the parent–child relationship plays a role are right on target.

However, this book misinterprets several key phenomena. It is overly simplistic in its description of trends from the Monitoring the Future surveys. Males’ reliance on data from the National Household Survey on Drug Abuse ignores the methodological concerns raised about the lack of respondent privacy afforded by the interview method. Males’ argument that marketing does not contribute to teen smoking is fraught with error. For example, he describes how increased marketing expenditures during the 1970s and 1980s were associated with decreased smoking rates among high school seniors. Males ignores the likely influence of other forces on smoking prevalence, such as concurrent increases in the real price of cigarettes. He also ignores the possibility that some of the additional advertising expenditures were not youth focused. The Camel campaign, with novel advertising and promotional strategies, was clearly youth focused and was associated with a sharp increase in smoking among young white males—the real target of Joe’s attention.

The suggestion that the Clinton administration’s actions on teenage smoking was a major cause for prevalence increasing is ludicrous. First, the surgeon general’s report, Preventing tobacco use among young people, was released in February 1994. The major story on tobacco for that day was not the release of the report, but that many McDonald’s restaurants were going smoke-free. Second, the proposed Food and Drug Administration (FDA) rule was not formally announced until August 1995. The rise in smoking among eighth, 10th, and 12th grade students began well before these events. I find it naive to think that the industry was minimally involved in the rise in teen smoking in the 1990s.

Males’ discussion of minors’ access restrictions are also off target. For example, he includes a brief description of the FDA regulations in a section entitled, “Criminalizing teen smoking,” when the FDA provisions penalise only the vendors. He frequently states that Montana has a reasonable approach to minors’ access legislation and the lowest prevalence of tobacco use in the nation, when Youth Risk Behavior Survey data indicate that Montana does not have the lowest rate of cigarette smoking and has nearly the highest rate of smokeless tobacco use. Males’ implies that Rigotti’s data show an increase in smoking in the group that received the minors’ access intervention, when the changes were not statistically significant. Additionally, he ignores the findings of Forster and others on the affects of minors’ access on smoking prevalence. It is simply wrong to imply that minors’ access legislation is iatrogenic, when studies to date are essentially equivocal.

Lastly, I found Males’ discussions of harm reduction strategies for illicit drugs to be only weakly relevant, and his suggestion that smoking rates went up in the 1990s because of the presence of a group of high risk children of parents with drug problems to be, at most, a hypothesis in need of investigation. Monitoring the Future data do not support the emergence of a high risk group in the 1990s.

Despite the many analytic errors, Males closes the book with some important recommendations (for example, renewed emphasis on denormalising smoking and protecting people from environmental tobacco smoke). All in all, this book is probably worth a look, but please make it a very careful one.

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