Multiple Perspectives on Tobacco Use Among Youth With Mental Health Disorders and Addictions

Chad D. Morris, PhD; Mandy G. May, MPH; Karen Devine, MSW; Shawn Smith, MA, MBA; Tamara DeHay, PhD; John Mahalik, PhD, MPA

Abstract

Purpose. Youth and young adults with mental health disorders and addictions are at a high risk of becoming nicotine dependent, and at least half will die of tobacco-related diseases. In comparison to the general population, this population also faces neurobiological and psychosocial vulnerabilities. There is a critical need for community services and research targeting tobacco interventions for these individuals.

Methods. A concurrent mixed methods study was conducted by collecting data from in-depth key informant interviews, focus groups, and a survey. Qualitative key informant interviews with healthcare professionals (n = 11) and youth focus groups (n = 32) were conducted by using semi-structured questioning regarding barriers and facilitators to tobacco interventions. Content analysis was used to code transcripts and categorize themes. Survey data were also collected from 230 smokers ages 13 to 17 years (n = 62) and young adults ages 18 to 25 years (n = 40) at three community mental health centers. The survey inquired about tobacco use, motivation to quit, history of quit attempts, and treatment preferences.

Results. Five thematic categories were identified in both the adult key informant interviews and the focus groups with youth: (1) motivation to quit, (2) cessation treatment needs, (3) social influence, (4) barriers to treatment, and (5) tobacco-free policy. Among those surveyed, 44% currently smoked. Youth and young adult survey respondents who smoked were often motivated to quit, few had used proven tobacco cessation aids, but there was interest in access to nicotine replacement therapy.

Conclusion. Merged qualitative and quantitative findings support past literature regarding youth in the general population but also expand upon our knowledge of issues specific to youth and young adults with mental health disorders and addictions. Findings suggest interventions warranting further attention in community treatment settings. (Am J Health Promot 2011;25[5 Supplement]:S31–S37.)

Key Words: Tobacco Cessation, Youth, Mental Health, Addictions, Community Treatment, Prevention Research. Manuscript format: research; Research purpose: descriptive; Study design: survey, content analysis; Outcome measure: behavioral; Setting: clinical/healthcare; Health focus: smoking control; Strategy: education, skill building/behavior change; Target population age: youth; Target population circumstances: all education levels, all income levels, all US locations, all races/ethnicities

INTRODUCTION

Tobacco use represents a significant risk factor affecting persons with mental health disorders and addictions. These individuals die up to 25 years earlier and experience increased medical comorbidity compared with the general population. Although there is mounting interest in addressing the tobacco cessation needs of these individuals, the focus has been on adults. Whereas the neurobiological, psychological, social, and systemic variables associated with high tobacco use among adults with mental health disorders and addictions have been well documented, there has been little study of smoking among youth and young adults with these same disorders. This younger population is a critical target for tobacco control. These individuals initiate smoking at early ages, inaccurately believe that they will soon stop smoking, and may not consider the later harmful effects of tobacco use.

Approximately 21% of U.S. children ages 9 to 17 years have diagnosable mental health disorders or addictions, and 5% of these have severe functional impairments related to psychiatric disorders. Anxiety disorders are the most common psychiatric diagnoses, followed by disruptive disorders and mood disorders. Addictions, including tobacco use, are also very prevalent among youth. Smoking in the prior 30 days is reported to be 7%, 14%, and 19% by 8th, 10th, and 12th graders, respectively.

Tobacco use prevalence among youth with mental health disorders and addictions is at a much higher rate...
than seen in the general population, with prevalence ranging from 20% to 59%. Smoking among youth has been found to cause recurrent behavioral problems and is related to an increased risk of lifetime depression. Among youth with major depressive disorder, 75% smoke. There is also high prevalence of tobacco use among youth with conduct disorder (90%), attention deficit/ hyperactivity disorder (50%), and other addictions (85%).

Although the intentions to quit smoking among youth and young adults with mental disorders and addictions are unknown, as many as 65% of youth in the general population report a desire to quit, and even more report an actual quit attempt. For the general youth population, a number of smoking prevention and cessation programs exist, but effectiveness has been mixed. Post-treatment abstinence declines rapidly, resulting in 12-month abstinence rates as low as 4%. The most successful programs are voluntary, school-based prevention programs, as well as those that focus on motivational enhancement, the immediate consequences of smoking, and building healthy coping strategies. Also, employing coordinated multi-component (e.g., school, media, and homework) interventions has been more successful than single-component strategies.

Tobacco cessation interventions specifically targeting youth with mental health disorders and addictions have been extremely limited, and it remains unclear if existing programs are appropriate for this population. The purpose of this study was to gather multiple perspectives on smoking behaviors and potential tobacco control strategies for youth and young adults with mental health disorders and addictions.

METHODS

Design

A concurrent mixed-methods study was conducted by collecting data from survey, key informant interviews, and focus groups. We chose complementary qualitative and quantitative methods to triangulate data and investigate convergence of findings. The study was conducted within public health systems. Study protocols were approved by the university institutional review board. Providers consented to interviews and parental consents and youth assents were obtained for focus groups and surveys.

Key Informant Interviews and Focus Groups. Sample. Utilizing a convenience sample of healthcare professionals, key informant interviews were completed regarding facilitators and barriers to tobacco cessation. Snowball sampling was employed to identify healthcare professionals with expertise in youth tobacco cessation, community-based treatment, and tobacco control policy. The study team interviewed 11 professionals over 2 months; five youth providers, two behavioral managed care administrators, two youth experts from the state behavioral health authority, and two administrators from the state health department. Through initial coding of interview transcripts, the five researchers agreed that the professionals interviewed were reporting overlapping issues and that theoretical saturation had been achieved.

Trained university research staff also conducted 10 focus groups with 32 participants over 3 months using a convenience sample of youth (ages 13–17 years) and young adults (ages 18–25 years). Participants were receiving treatment at five rural and urban community mental health centers. Advertisements posted at the treatment centers were used to recruit participants. To attract the greatest number of youth, discloser of tobacco use was not required. Focus groups participants received a $10 gift card. If the ideal size for focus groups was not achieved, additional focus groups were held.

Participants (N = 32) included youth willing to report current tobacco use (n = 6), ex-users (n = 3), and non-users or those who did not wish to disclose use (n = 23); 65.6% were ages 13 to 17 years, 28.1% were ages 18 to 20 years, and 6.3% did not report their age. Participants were 59.4% male and race/ethnicity was as follows: white, 50%; Hispanic/Latino, 46.9%; African-American, 9.4%; and Native American, 6.3%.

Measures. The questions used for interviews with professionals and focus groups were based on literature review and previous qualitative studies and used concepts from social learning, addictions treatment, and systems theories (Table 1). Interviews and focus groups were digitally recorded and transcribed verbatim.

Analysis. Transcripts were imported into NVIVO 8 qualitative data analysis software (QSR International, Cambridge, Massachusetts) for coding. We used an editing process of analysis, which encourages interpretation of the data using a team approach. Interview and focus group transcripts were first reviewed independently by several team members to extract themes. A codebook of themes and definitions was then developed through consensus meetings. By using an iterative process, the codebook guided further transcript analysis. Audits were completed, and any coding discrepancies were brought to the study team for final interpretation.

Tobacco Use Survey. Sample. Three rural and urban community mental health centers agreed to conduct a tobacco use survey with youth (ages 13–17 years) and young adults (18–25 years) who were receiving treatment for mental health disorders and addictions. Surveys were collected over 4 weeks. After completing a primary diagnosis field, providers disseminated surveys to clients, which asked brief questions regarding smoking. To ensure anonymity, respondents completed surveys after regular clinic visits and left these in sealed envelopes at the centers’ reception desks.

Measures. Survey questions were based on review of the literature. The survey collected tobacco use status, general demographic data, and diagnostic information. For respondents who were current smokers, additional questions asked about consumption, motivation to quit, history of quit attempts, and cessation aid preferences.

Analysis. Survey data was entered into Microsoft Excel version 2003 and was analyzed by using SPSS 18 (IBM, Somers, New York). Descriptive analyses and frequencies were conducted, and Pearson χ-square tests...
were run to determine differences in survey responses by age group.

RESULTS

Key Informant Interviews and Focus Groups

**Emergent Themes.** Five thematic categories (Table 2) emerged during the analyses of both the professional interviews and the youth focus groups transcripts: (1) motivation to quit, (2) cessation treatment needs, (3) social influence, (4) barriers to treatment, and (5) tobacco-free policy. **Motivation to Quit.** Professionals were much more likely than youth respondents to report that motivation for quitting tobacco was low among youth/young adults with mental health disorders and addictions. Professionals reported that the majority of youth did not intend to change their smoking behaviors and do not view themselves as being addicted to tobacco. Many youth (25%) reported that it was up to each individual to take the necessary

<table>
<thead>
<tr>
<th>Table 1</th>
<th>Key Informant and Focus Group Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Key Informant Interviews</strong></td>
<td><strong>Focus Group Questions</strong></td>
</tr>
<tr>
<td><strong>General Infrastructure and Dissemination Questions</strong></td>
<td></td>
</tr>
<tr>
<td>1. Is smoking cessation and prevention compatible with you/your organization’s values, norms, and perceived needs?</td>
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<tr>
<td>2. What are the possible benefits of offering smoking cessation and prevention services?</td>
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<tr>
<td>3. What support would you/your organization need to implement and sustain smoking cessation strategies? (initially and long term)</td>
<td></td>
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<tr>
<td>4. What are the perceived hurdles and potential implications of providing smoking cessation services?</td>
<td></td>
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<tr>
<td>5. What is the best means of creating buy-in at provider and organizational levels?</td>
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<tr>
<td>6. What prevention and strategies do you think we should promote?</td>
<td></td>
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<tr>
<td>7. What do you think would be best means of integrating tobacco prevention and cessation strategies within your organization?</td>
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**Questions for Professionals Regarding Youth Cessation**

1. What do you see as the unique smoking prevention and cessation needs for youth with mental illnesses and addictions?
2. Do you or your organization address youth tobacco prevention and cessation? If so, how?
3. What are the opportunities and hurdles for youth smoking prevention and cessation services for persons with mental health disorders and addictions in your organization?
4. What is your perception of the readiness of youth with mental health disorders and addictions to engage in cessation services?
5. Can you suggest individuals, providers, and/or organizations we should include in a future statewide survey?

**Youth and Young Adult Focus Groups**

1. Why do you/your friends smoke? What is the benefit of smoking? What are the costs of smoking?
2. What information and resources do you or others you know need to stop smoking?
3. How can mental health or addictions providers be of most help in assisting individuals to quit smoking?
4. What has prevented you or others from quitting in the past? What has worked?
5. How have your friends or family influenced your smoking or your desire to quit?

<table>
<thead>
<tr>
<th>Table 2</th>
<th>Qualitative Themes by Professionals and Youth/Young Adults</th>
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<tbody>
<tr>
<td><strong>Emergent Themes</strong></td>
<td><strong>Professionals (n = 11)</strong></td>
</tr>
<tr>
<td><strong>No. (%)</strong></td>
<td><strong>No. of References</strong></td>
</tr>
<tr>
<td>Motivation to quit</td>
<td>7 (63.6)</td>
</tr>
<tr>
<td>Cessation treatment</td>
<td>10 (91)</td>
</tr>
<tr>
<td>Education</td>
<td>8 (72.7)</td>
</tr>
<tr>
<td>Counseling</td>
<td>5 (45.4)</td>
</tr>
<tr>
<td>NRT*</td>
<td>6 (54.5)</td>
</tr>
<tr>
<td>Pharmacotherapy</td>
<td>1 (9)</td>
</tr>
<tr>
<td>Self guided</td>
<td>0 (0)</td>
</tr>
<tr>
<td>Colorado quitline</td>
<td>3 (27.3)</td>
</tr>
<tr>
<td>Social influence</td>
<td>6 (54.5)</td>
</tr>
<tr>
<td>Peers</td>
<td>3 (27.3)</td>
</tr>
<tr>
<td>Family</td>
<td>3 (27.3)</td>
</tr>
<tr>
<td>Media</td>
<td>4 (36.4)</td>
</tr>
<tr>
<td>Technology</td>
<td>3 (27.3)</td>
</tr>
<tr>
<td>Barriers to treatment</td>
<td>9 (81.8)</td>
</tr>
<tr>
<td>Provider</td>
<td>8 (72.7)</td>
</tr>
<tr>
<td>Organizational</td>
<td>7 (63.6)</td>
</tr>
<tr>
<td>Policy</td>
<td>5 (45.4)</td>
</tr>
</tbody>
</table>

* NRT indicates nicotine replacement therapy.
actions towards quitting and stressed that tobacco users will not quit until ready. Both professionals and youth further asserted that youth/young adults are not concerned about the serious health consequences resulting from tobacco use. Youth and young adults generally described themselves as healthy and far too young to be concerned about their own mortality. One professional noted that even youth who are already facing significant physical illness, such as heart conditions, seem to understand the dangers of tobacco yet continue to smoke. As one young adult stated, “I think that it all falls down to a choice. Cause you can give them all the information that you want, but just like any other thing, it’s all up to the person to change.”

Conversely, both professionals and youth reported that, although many youth and young adults are not ready to quit smoking, cessation education and interventions might rapidly move many of these individuals toward healthy behavioral change. As one professional stated, “They are probably more ready than people think.” Additionally, 37.5% of youth participants reported that maintaining or regaining good physical health is a motivator to quit smoking. One young adult reported, “I would like to quit. I would be more active and would not smoke cigarettes all the time... I mean it’s our health, it’s all we have.”

Cessation Treatment Needs. Identified cessation treatment needs fell into five subcategories: education, counseling, nicotine replacement therapy (NRT) and other pharmacotherapy, self-guided treatment, and quitline services. In general, professionals and youth/young adults agreed that available cessation treatments were geared toward adults. Youth also noted the lack of tobacco programs outside the school system. Professionals, as well as youth, stated that interventions tailored to individuals with mental health disorders and addictions would be helpful. For example, youth reported a need for interventions that specifically addressed the social pressures they face. Many professionals interviewed (45%) stated that one-on-one interventions were necessary to assist youth clients replace smoking with healthy coping skills. Professionals and youth concurred that educational programs focusing on the health consequences of tobacco and using scare tactics are necessary. Youth further stated that cessation programs should include visual aids, such as photos of a cancerous lung and/or handouts listing the thousands of chemicals found in cigarettes. Although professionals reported directing young clients to the state quitline for assistance, youth participants were generally unaware of a quitline or any other community resources existed. Youth, on the other hand, described the necessity for self-guided resources that did not require direct professional intervention (e.g., internet-based services).

Views among professionals were split regarding use of NRT or other cessation medications, with half of professionals viewing medications as inappropriate for youth, whereas the other half asserted that these cessation aids were not utilized enough. One professional stated, “People [providers] are just now realizing that NRT can help with smoking cessation without exposing youth to the harmful substances cigarettes contain.” All youth participants who reported smoking desired the opportunity to use NRT and pharmacotherapy.

Social Influence. Identified social influences relating to tobacco cessation efforts fell into four subcategories: peers, family, media, and technology. Peers and family were reported to have the most influence on youth and young adults. Peers were viewed as highly influential in tobacco use initiation but were also viewed as impacting cessation efforts positively. A large number of youth (53%) reported they would like friends to help them quit smoking and, in turn, voiced a willingness to help their peers quit. Professionals also supported the idea of peer strategies but to a much lesser extent. As expressed by one professional, “I would like to see groups use more peer leaders. The peers are more effective than adults could ever be.”

Family was also seen as highly influential. Youth reported beginning tobacco use because their parents smoked. Half of the youth who smoked obtained cigarettes from their parents and smoked with their parents in the home. On the contrary, others reported refraining from tobacco use because of their families. As one youth stated, “I rely on my family to help me and my siblings.”

Media and technology were seen as key culprits in promoting tobacco use and thwarting quit attempts. Respondents agreed that the tobacco industry targets youth through its advertising. Youth and young adults further reported that the movie industry’s portrayal of smoking as sexy or cool led to smoking. Others spoke to the potential positive influence of media. One youth reported, “I saw a movie on chewing tobacco. It scared me so much I decided never to do it.”

Barriers to Treatment. Only professionals reported barriers to treatment. Providers’ competing demands were seen as key impediments to prevention and cessation services. Professionals shared that they have limited time to address clients’ primary mental health disorders and addictions. Tobacco use was seen as a secondary concern, with some providers viewing tobacco use as a bad habit rather than an addiction. Professionals were also concerned that quit attempts would exacerbate their clients’ behavioral issues. They reported that there was a common perception that smoking is a necessary evil that helps individuals to manage their psychiatric symptoms.

At an organizational level, professionals reported that community treatment centers lacked awareness of tobacco cessation resources. Generally, tobacco use among young clients was not viewed as a leadership priority, and organizations did not provide staff training regarding this issue. Even when educational efforts were implemented, one provider aptly noted, “You can provide in-depth trainings, but you want to make sure the organization is incorporating treatment into daily practice.”

Although youth and young adults did not directly discuss treatment barriers, focus group participants did voice a desire for schools and providers to discuss treatment options.
One youth reported, "... even a teacher could help me quit smoking if they would just talk to me about how bad it is for me."

**Tobacco-Free Policy.** Both professionals and youth asserted that tobacco-free policies would decrease smoking. Nearly half of professionals (45%) shared that tobacco-free policies at their treatment agencies were effective, though improved enforcement of existing tobacco-free policies was necessary. Youth and young adults also supported tobacco-free campus policies, and 19% shared that they would like to see tobacco products become illegal, making them more difficult to obtain.

**Tobacco Use Survey**

Surveys were collected from 230 youth; 68.7% were ages 13 to 17 years, and 31.3% were ages 18 to 25 years. Participants were 55.2% male. Primary diagnoses from treatment records were as follows: 53.2% had internalizing disorders (e.g., anxiety, depression), 21.6% had addictions, 19.4% had disruptive behavior disorders (e.g., attention deficit/hyperactivity disorder, oppositional defiant disorder), 2.7% had relational disorders (e.g., reactive attachment disorder), and 2.3% had psychotic disorders (e.g., schizophrenia).

Table 3 presents survey findings. Point prevalence for smoking was 44.3%. Young adults ages 18 to 25 years had a significantly higher prevalence of tobacco use than youth ages 13 to 17 years (c2 [1, n = 228] = 5.61; p = .02), with prevalence rates at 55.6% and 39.2%, respectively. Only the 102 respondents who responded yes to current smoking answered the remaining survey questions. Analyzing results by diagnostic categories, rates were 61.5%, 44.2%, and 34.7% for disruptive behavior disorders, addictions, and internalizing disorders, respectively. Other disorders were not represented among smokers. Most commonly smokers consumed between one and 10 cigarettes per day. Many youth and young adults reported wanting to quit (44.1%), and many of these (40.5%) were pretty motivated, very motivated, or extremely motivated to do so. However, the majority of tobacco users did not want help quitting (61.8%).

### Table 3

**Tobacco Use Survey Results for Current Tobacco Users***

<table>
<thead>
<tr>
<th>Question</th>
<th>Patients Age 13–17 Years (N = 62), No. (%)</th>
<th>Patients Age 18–25 Years (N = 40), No. (%)</th>
<th>Total Patients (N = 102), No. (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>How many cigarettes do you smoke per day?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>7 (11.3)</td>
<td>1 (2.5)</td>
<td>8 (7.6)</td>
</tr>
<tr>
<td>1–10</td>
<td>41 (66.1)</td>
<td>25 (62.5)</td>
<td>66 (64.7)</td>
</tr>
<tr>
<td>11–20</td>
<td>7 (11.3)</td>
<td>9 (22.5)</td>
<td>16 (15.7)</td>
</tr>
<tr>
<td>21–30</td>
<td>3 (4.8)</td>
<td>4 (10)</td>
<td>7 (6.9)</td>
</tr>
<tr>
<td>≥ 31</td>
<td>0 (0)</td>
<td>1 (2.5)</td>
<td>1 (1.0)</td>
</tr>
<tr>
<td>Do you want to quit?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>26 (41.9)</td>
<td>19 (47.5)</td>
<td>45 (44.1)</td>
</tr>
<tr>
<td>No</td>
<td>13 (21.0)</td>
<td>9 (12.5)</td>
<td>22 (21.6)</td>
</tr>
<tr>
<td>Not sure</td>
<td>19 (30.6)</td>
<td>12 (16.7)</td>
<td>31 (30.4)</td>
</tr>
<tr>
<td>How motivated are you to quit?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not at all</td>
<td>4 (6.5)</td>
<td>4 (10)</td>
<td>8 (7.8)</td>
</tr>
<tr>
<td>A little motivated</td>
<td>12 (19.4)</td>
<td>12 (30)</td>
<td>24 (23.5)</td>
</tr>
<tr>
<td>Pretty motivated</td>
<td>16 (25.8)</td>
<td>8 (20)</td>
<td>24 (23.5)</td>
</tr>
<tr>
<td>Very motivated</td>
<td>5 (8.1)</td>
<td>2 (5)</td>
<td>7 (6.9)</td>
</tr>
<tr>
<td>Extremely motivated</td>
<td>6 (9.7)</td>
<td>5 (12.5)</td>
<td>11 (10.1)</td>
</tr>
<tr>
<td>Have you tried to quit before?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>41 (66.1)</td>
<td>21 (52.5)</td>
<td>62 (60.8)</td>
</tr>
<tr>
<td>No</td>
<td>17 (27.4)</td>
<td>18 (45)</td>
<td>35 (34.3)</td>
</tr>
<tr>
<td>If yes, what kind of help did you get?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>29 (70.7)</td>
<td>16 (76.2)</td>
<td>45 (72.6)</td>
</tr>
<tr>
<td>NRT†</td>
<td>8 (19.5)</td>
<td>4 (19.0)</td>
<td>12 (19.4)</td>
</tr>
<tr>
<td>Counseling</td>
<td>0 (0.0)</td>
<td>1 (4.8)</td>
<td>1 (1.6)</td>
</tr>
<tr>
<td>Help from others</td>
<td>5 (12.2)</td>
<td>3 (14.3)</td>
<td>8 (12.9)</td>
</tr>
<tr>
<td>Do you want help quitting?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>17 (27.1)</td>
<td>14 (35)</td>
<td>31 (30.4)</td>
</tr>
<tr>
<td>No</td>
<td>38 (61.3)</td>
<td>25 (62.5)</td>
<td>63 (61.8)</td>
</tr>
<tr>
<td>What would help you quit?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NRT†</td>
<td>19 (30.6)</td>
<td>18 (45)</td>
<td>37 (36.3)</td>
</tr>
<tr>
<td>Counseling</td>
<td>3 (4.8)</td>
<td>3 (7.5)</td>
<td>6 (5.9)</td>
</tr>
<tr>
<td>Help from others</td>
<td>9 (14.5)</td>
<td>3 (7.5)</td>
<td>12 (11.8)</td>
</tr>
</tbody>
</table>

* Some item percentages do not add up to 100% because of missing data.
† NRT indicates nicotine replacement therapy.

The majority of smokers reported a history of lifetime quit attempts (and 67.8% reported two or more past quit attempts), but most of those making a quit attempt did not receive any cessation assistance (72.6%). When used, NRT was the most common strategy. Very few received cessation counseling (1.6%). When asked what would help them quit, the most frequent answer was NRT (36.3%). In comparing the two age groups of smokers (ages 13–17 years and 18–25 years) across all survey questions, there were no significant differences.

**DISCUSSION**

Addressing the smoking cessation needs of persons with mental illnesses and addictions is essential to achieving desired gains in population health. However, past research for this population has focused on adults. This was one of the few studies, to our knowledge, that explored the smoking characteristics of youth and young adults with mental illnesses and addictions. Qualitative and quantitative findings were integrated into the below convergent themes to increase the validity of results.
Consistent with current evidence for the general population, results suggest that age-appropriate tobacco cessation strategies should be integrated into school settings.66–27 However, the findings of this study further suggest that mental health and addictions providers are positioned, as behavioral change agents, to offer tobacco cessation treatments. To successfully intervene with youth and young adults, though, several barriers need to be addressed. Just as with adults, the culture of addictions and mental health treatment has historically reinforced tobacco use.36–39 Professionals working with youth and young adults with mental health disorders and addictions need continuing education regarding the growing evidence that tobacco cessation does not exacerbate psychiatric symptoms or threaten sobriety, that these individuals can successfully quit smoking, and that tobacco-free treatment milieus reduce clients’ behavioral problems and increase staff satisfaction.6–40–43

The survey found that 44% of respondents currently used tobacco, which is consistent with the few studies reporting prevalence for this population.12–17 Findings regarding the intention to quit were mixed. Although rates were lower than the general population,44 many current tobacco users were motivated to quit (41%), and the majority of smokers had tried to quit previously. However, most did not receive any aid in prior quit attempts, did not want counseling or help from others in future quit attempts, and had little knowledge of available cessation resources. It was striking that none of the youth smokers had received cessation counseling during quit attempts. These results are aligned with national findings that only 4% of youth/young adult smokers successfully quit smoking each year23,45 and are less successful than adults in their quit attempts.46 Although combined counseling and pharmacotherapy significantly improves the odds of quitting,46,47 both quantitative and qualitative results reinforce that much more work is necessary to motivate youth to utilize proven cessation aids.

Both professionals and youth indicated that tobacco cessation programming must be tailored to persons with behavioral disorders. Smokers most often had disruptive disorders, other addictions, and internalizing disorders, such as anxiety and depression. Providers might consider how to integrate tobacco prevention and cessation strategies into treatment modalities for these conditions. Results also point to several means of engaging and maintaining youth in treatment. Focus groups and survey suggested that youth and young adults were most interested in NRT as a cessation aid. NRT has not been shown effective for youth generally,48,49 and professionals, unlike youth respondents, were mixed on use of any pharmacotherapy. Even so, attention to this clear preference might engender therapeutic alliances that facilitate cessation counseling or entry into other services youth identified as desirable, such as Web-based or self-guided programs.

Our findings, along with past studies, support that peers, families, and tobacco-free policy are integral components of intervening.50–52 Youth stressed that peer leaders who have quit smoking themselves would be effective advocates for tobacco cessation. Findings from both professionals and youth also supported the importance of family messaging, which included restrictive home smoking rules and parental modeling of nonsmoking behaviors. Additionally, youth reported they would be less likely to use tobacco if these products were less readily available. Tobacco-free policies are one means of supporting this suggestion. Treatment agencies might enact and enforce policies to curtail second-hand smoke exposure for both staff and clients.

Professionals and youth focus group participants were in agreement that scare tactics should be used as an educational approach. In contrast, past study suggests that successful cessation programming includes teaching coping skills, motivational enhancement, and provision of healthy alternatives to tobacco use rather than fear tactics.53 It is unclear if such educational strategies for persons with mental health disorders and addictions would be of value.

There were several limitations to this study. Focus group and interview transcripts were not independently coded and audited by all research team members. Rather, a consensus approach was utilized with coding and auditing conducted by multiple team members, and final decisions were made by the team as a whole. Because focus group participation was not restricted to youth admitting to smoking, nonsmoking participants may have had differing perspectives than known tobacco users. Given this limitation, additional research with known youth tobacco users is recommended. The study used convenience sampling and had small sample sizes, restricting the generalizability of findings. Also, the survey was self-report, which may have led to under-reporting of tobacco use.

Input from professionals, youth, and young adults suggest challenges and opportunities to promoting tobacco control initiatives for individuals with mental health disorders and addictions.

SO WHAT? Implications for Health Promotion Practitioners and Researchers

What is already known on this topic?

Persons with mental health disorders and addictions have a higher smoking prevalence in comparison to the general population and suffer significant death and disability as a consequence. Past studies have focused on adults. Little is known regarding the smoking prevalence and cessation needs of youth with behavioral health conditions.

What does this article add?

This study explored the smoking characteristics of youth with mental illnesses and addictions. The perspectives of behavioral health providers and youth suggest opportunities for and barriers to tobacco control efforts. We found that many youth with behavioral health conditions were motivated to quit, but few utilized proven treatments, and common perceptions that youth do not desire to quit and are unable to stop smoking persist.

What are the implications for health promotion practice or research?

Community mental health and addictions treatment settings are an ideal point of intervention for smoking cessation among youth clients. These agencies’ providers have the behavioral change skills necessary to create evidence-based, age-appropriate tobacco cessation programming.
tions. Youth and young adults have a tremendous need for services, and community mental health and addiction treatment settings are an important point of intervention. Contrary to common perceptions, many youth with mental disorders and addictions are motivated to quit smoking, and most have tried to quit. However, youth are not utilizing provider-driven treatments or quitlines. Although professionals tend to recommend individual, clinic-based interventions, youth desire peer advocacy, technology-based interventions, and NRT or pharmacotherapy. Youth and professionals further agree that tobacco-free policies for treatment clinics and households are critical. These findings add to the existing literature in suggesting the roles community treatment settings might play in not only raising awareness regarding the high rates of smoking among youth clients but also the types of treatments that youth desire and that must be integrated into standard practice.

References
Definition of Health Promotion

“Health Promotion is the art and science of helping people discover the synergies between their core passions and optimal health, enhancing their motivation to strive for optimal health, and supporting them in changing their lifestyle to move toward a state of optimal health. Optimal health is a dynamic balance of physical, emotional, social, spiritual, and intellectual health. Lifestyle change can be facilitated through a combination of learning experiences that enhance awareness, increase motivation, and build skills and, most important, through the creation of opportunities that open access to environments that make positive health practices the easiest choice.”

(O’Donnell, American Journal of Health Promotion, 2009, 24, 1, iv)

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