Public Health Law Center
AT WILLIAM MITCHELL COLLEGE OF LAW

Tobacco and Juvenile Offenders:

Breaking the Cycle

A Policy Options Brief
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Table of Contents

Executive Summary

Many youth underestimate the addictiveness of nicotine and discount the health effect of tobacco use. Yet almost a third of all young people who become new smokers each year will ultimately die of tobacco-related disease. Like many adolescents, juvenile offenders – youth detained or incarcerated in the juvenile justice system – experiment with tobacco use. Unfortunately, many of these youth are particularly susceptible to nicotine addiction. Compared to the general adolescent population, juvenile offenders suffer many more physical, mental health and cognitive challenges, as well as substance abuse disorders – all of which have proven links with the use of nicotine. Moreover, juvenile offenders often come from troubled socioeconomic backgrounds, with limited, inconsistent or nonexistent health care, and little or no substance abuse treatment, including tobacco cessation. Many of these high-risk youth live in environments where the use of tobacco by families and peers is a social norm. Given the appeal and prevalence of tobacco use among high-risk adolescents, the juvenile justice system appears to be a natural venue where youth could receive the tobacco prevention and cessation aid and support they need.

Unfortunately, this is not always possible. Juvenile courts in the U.S. process close to one and a half million youth each year for a vast number of offenses. Given the size and complexity of the juvenile justice system, the broad range of offenders, the transitory nature of placements, and the variability between state and local juvenile facilities, providing youth with tobacco cessation services is often difficult.

This policy brief examines the current state of tobacco control policies in juvenile residential correctional facilities and detention centers, the health impact of tobacco use on juvenile offenders, challenges with tobacco cessation services in the juvenile justice system, and policy options and opportunities. The purpose of this brief is to highlight effective policies to address the problem of tobacco use among juvenile offenders – youth who tend to have a disproportionate number of emotional, mental and substance abuse challenges.

Introduction

Adolescence is a difficult time, and for some teenagers, particularly those who begin using addictive substances, it can be a time when impulsive decisions and choices can have serious, even fatal consequences. A high number of adolescents in U.S. correctional facilities, for example, have substance abuse problems prior to entering custody, and continue to have them once they are released.[1] An even higher number of these youth use tobacco products.[2] In fact, studies often find links between tobacco use by juvenile offenders and alcohol and illegal drug use.[3] Tobacco use is a "priority high risk behavior," established during childhood and adolescence, which extends into adulthood and contributes to the leading causes of morbidity and mortality among youth and adults.[4] The prevalence of tobacco use among youth who also use alcohol and illegal drugs is troubling – particularly since these young people are often housed in correctional facilities that have limited means to treat their interrelated emotional, behavioral, and chronic health care problems. Many juvenile detention or correctional facilities vary widely in terms of purpose and services, and while some community-based programs (such as group homes and day reporting centers) focus largely on a youth's immediate medical or safety needs, others (such as residential treatment facilities) focus on more long-range problems, such as tobacco use.[5]

Although juvenile offenders are often struggling with more mental, psychological, and socioeconomic challenges than their peers outside the justice system, they are also youngsters coping with the difficulties of adolescence. Understanding why so many young people experiment with tobacco can shed light on why juvenile offenders, who are prone to engage in high-risk behavior, are so susceptible to tobacco use.

Overview of Tobacco Problem Among Juvenile Offenders

Adolescence is a time of turbulent transitions. It is a time when youngsters are forming a sense of self, establishing an identity, exploring who they are – a time when social relationships grow and change daily. It is also a time when, as a group, adolescents exhibit a disproportionate amount of reckless behavior, seeking sensations and taking risks.[6] In fact, one psychologist who studies antisocial behavior in adolescents concluded that "actual rates of illegal behavior soar so high during adolescence that participation in delinquency appears to be a normal part of teen life."[7]

Behavioral scientists, pediatricians, and other scientists have advanced countless theories on why adolescents exhibit such high risk behavior.[8] One plausible explanation may simply be that an adolescent's brain is not yet fully developed.[9] The last part of the brain to develop is the frontal cortex, which controls decision making and impulse control.[10] As a result, many teens make decisions quickly and impulsively, without a great deal of critical thought. Their susceptibility to influence by peers, perspectives on time, and perceptions of the likelihood of risky outcomes are still in formation. Adolescents are clearly not the decision makers they will be as adults.

And yet the decisions adolescents make, and the habits and behaviors they adopt, during these formative years can have a lasting and devastating impact on their lives. This is why what happens in adolescence is so important, and why it is so critical to prevent tobacco use at a young age. While tobacco use is prevalent among juvenile offenders, it also continues to be a common rite of passage among many adolescents in general.

Tobacco Use and Adolescents

Nearly 90 percent of all U.S. adults who smoke started in their teens and half of them started by their eighteenth birthday.[11] Significantly, 37 percent of all smokers were under the age of eighteen when they first started smoking daily.[12] Today, trends in smoking behavior among youth have not paralleled the recent decline among adult smokers.[13] Despite the prevalence of traditional school-based programs that educate students on the harm of tobacco use, approximately 19.5 percent of all U.S. high school students (grades 9 to 12) still smoke cigarettes.[14]

Moreover, as the result of record tobacco marketing efforts and the entry of major cigarette companies R.J. Reynolds and Philip Morris into the smokeless tobacco arena, youth use of novel non-cigarette tobacco products is on the rise.[15] These smokeless tobacco products include snuff, chewing tobacco, and dissolvables – all of which come in various sweet flavors and handy discrete forms, which make them particularly appealing to young people.[16] Among new smokeless tobacco users, almost half (46.1 percent) began using before they were eighteen years old.[17] Some research indicates that smokeless tobacco use could be an important predictor of smoking among high school males.[18] Thus, in addition to the health risks posed by that smokeless tobacco, the use of these products may serve as a gateway to cigarette smoking.[18]

Youth Access to Tobacco. For many young people, tobacco is a popular drug of choice.[20] Youth are often prone to experimentation and susceptible to peer pressure, as well as the influence and norms exhibited by family members and the home environment.[21] They are also vulnerable to targeted marketing by tobacco manufacturers.[22] Unfortunately, some adults tacitly condone smoking by the young, since tobacco use remains socially acceptable among certain segments of the U.S. adult population.[23] Although laws have reduced youth access to tobacco products in retail establishments, minors are still often able to purchase these products[24] or obtain them through other non-retail sources, such as social channels, including parents and friends.[25] For many youth, particularly those who tend to engage in high risk behavior already, tobacco products have a "forbidden fruit" allure.

Health Impact. Of all priority health-risk behaviors, tobacco use is the single largest preventable cause of death and disease in the United States.[26] The adverse health effects of tobacco products have been known for decades and chronicled in Surgeon General's reports since 1964. In 2010, the Surgeon General released a definitive report with findings based on a formidable compilation of scientific studies – all of which provided irrefutable proof of the health hazards of tobacco use and secondhand smoke exposure.[27] Tobacco smoke causes significant health problems, including cardiovascular disease (such as heart attacks and strokes), cancer, chronic obstructive pulmonary disorders, respiratory symptoms such as coughing, phlegm and wheezing, asthma-related symptoms, atherosclerosis, even low bone density.[28] It can cause lung function to begin to decline even in late adolescence and early adulthood.[29] Smokeless tobacco use can lead to cardiovascular disease, oral cancer and gum disease.[30]

All too often, nicotine addiction leads to a lifetime of tobacco use and nicotine dependency. And those particularly vulnerable to addiction are those who experiment with tobacco at an early age. Studies show that every day more than 3,500 U.S. youth under eighteen try smoking for the first time, and of that group, approximately 1,000 become new daily smokers.[31] Because tobacco use is illegal for minors, it can be just another way for youth to confirm their credentials as members of an outside (often described by psychologists as "anti-social" or "deviant") peer network.[32]

Tobacco Use and Juvenile Offenders

Sooner or later, most youth who engage in high risk behaviors on a regular basis end up in the juvenile justice system. A disproportionate number of juveniles in the justice system use tobacco products. Generalizations about this population are difficult, since juvenile courts process close to one and a half million juveniles each year for a vast number of diverse offenses.[33] Juvenile arrests range from violent crimes (such as murder, rape or aggravated assault) and property crimes (such as burglary, larceny-theft and arson)[34] to "status offenses" – such as chronic or persistent truancy, running away, being ungovernable or incorrigible, violating curfew laws, or possessing alcohol or tobacco.[35]

Still, a few patterns emerge from juvenile justice data – population demographics that may help explain the prevalence of tobacco use among these young people. Many juvenile offenders struggle with mental illness, substance abuse, and learning disabilities. These problems, along with the tendency of many of these adolescents to come from troubled socioeconomic backgrounds, make them far more likely to engage in high risk behaviors than their peers outside the juvenile justice system.

Low Socioeconomic Status and Health Disparities. Although professionals differ on the many root causes of delinquent behavior, the factor most influencing trends in juvenile crime is low socioeconomic status.[36] Poorer health is related to lower socioeconomic status, which is in turn more likely to be found among minority youth.[37] While minority youth represent roughly a third of the youth population, they constitute between 61 and 65 percent of detained youth.[38] This statistic is important when considering the unmet health needs of detained youth, since youth in the juvenile correctional system typically have more physical, developmental, mental health, and substance abuse challenges than the general adolescent population.[39] Hence, health disparities in the juvenile justice system reflect larger socioeconomic and racial/ethnic inequities in the outside world.

In addition, juvenile offenders often have had limited, inconsistent, or nonexistent health care before they are admitted to a juvenile custodial facility.[40] The sad truth is that for some juvenile offenders, the first time they receive medical care or treatment is when they enter the juvenile justice system. At that time, tobacco cessation treatment is often provided in conjunction with other substance abuse interventions.[41]

Finally, one recent study found that youth involved with the child welfare system have significantly higher rates of lifetime smoking and current smoking than do youths outside the system.[42] Although it is important to distinguish juvenile offenders from youth in the child welfare system, who generally enter the system because of parental behavior rather than their own, and whose lives are often characterized by child abuse, neglect, poverty, domestic violence and parental substance abuse, it is still interesting to note the high prevalence of smoking in this group. Significantly, of youth in child welfare, the primary factor associated with lifetime and current smoking is delinquency.[43]

Mental Illness. Studies indicate that nearly two-thirds of youth in detention centers could meet diagnostic criteria for having a mental disorder and a little more than a third need ongoing clinical care – a figure twice the rate of the general adolescent population.[44] Although researchers may define mental disorders differently, most agree that youth in the justice system manifest a substantially greater prevalence of mental disorders than U.S. youths on average.[45] In fact, half of all lifetime cases of mental and substance use disorders begin by age fourteen.[46] Researchers have found that individuals with mental illness in the U.S. are nearly twice as likely to smoke cigarettes as those with no mental illness.[47]

Substance Abuse. In addition, adolescent offenders often show high rates of substance abuse.[48] For instance, 44 percent of youth in custody say they were under the influence of alcohol or drugs at the time of one or more of the offenses that led to their being placed in custody.[49] Teen smoking is often linked to substance abuse problems, and can indicate a tendency toward later addictive behavior. One Minnesota study, for example, found that among youth who used both cigarettes and marijuana by the twelfth grade, 65 percent smoked cigarettes before using marijuana, and youth who smoke are more than eleven times as likely to use illicit drugs and sixteen times as likely to drink heavily as youths who do not smoke.[50] And a study of California and Oregon adolescents found that early-onset smokers are three times more likely by grade twelve to use tobacco and marijuana regularly, use hard drugs, sell drugs, have multiple drug problems, drop out of school, and engage in stealing and other delinquent behaviors.[51] Although national studies on smoking and tobacco use among juvenile offenders often combine data on other substance use, the prevalence of tobacco use in this priority population is clear.

Also, evidence has repeatedly shown a high correlation of heavy drinking and alcohol dependence with tobacco use among adolescents.[52] Tobacco use is, in fact, endemic among individuals with alcohol disorders.[53] Moreover, researchers have found that the "concurrent use of tobacco and alcohol represents a significant and preventable risk factor for disease and early death, particularly given the evidence that the risks of combined use are multiplicative instead of merely additive in the case of cancers of the esophagus, larynx, and liver."[54]

Because so many juvenile offenders tend to use tobacco and alcohol, as well as illegal drugs, treating their substance abuse often means addressing many related medical and mental health problems.[55] This presents an assortment of cessation and treatment challenges in the juvenile justice system, where opportunities to engage in long-term treatment are often limited.[56]

Learning Disabilities. In addition to mental illness and substance use disorders, delinquent behavior often is an indication of other problems that may make juvenile offenders more prone to tobacco use – learning disabilities. Researchers have often documented educational deficiencies among delinquent youth, including poor school attendance, greater rates of grade retention, and higher suspension rates due to more disciplinary problems.[57] A national survey of youth in

custody reports that 30 percent of youth in custody have been diagnosed with a learning disability, compared with 5 percent of youth between the ages of 10 and 20 in the general population.[58] Some educational researchers report that as many as 40 percent of incarcerated youth may have a learning disability – a rate up to seven times higher than that of the general population.[59] Teens with learning disabilities are often wrestling with cognitive or psychological challenges that make it difficult for them to perceive or appreciate the risk of substance abuse, including nicotine use.[60]

Pregnancy. Given the many health, socioeconomic, and related challenges facing young offenders, medical, public health, and related professionals are keenly aware of the need for interventions. One statistic brings home the increasing need to break the cycle of substance abuse and tobacco use in the juvenile justice system: A startling 20 percent of youth in custody already have children or are pregnant.[61] In comparison, approximately 10 percent of all children in the U.S. are born to mothers under the age of nineteen, and this number is continuing to decline.[62]

For youth in the juvenile justice system, pregnancy can complicate an already challenging situation. To begin with, studies have shown that girls in the juvenile justice system tend to engage in sexual activity at an earlier age than other girls, placing them at greater risk for unintended pregnancy[63] and at a substantially higher risk for reproductive health problems compared to girls outside the system.[64] In addition, teens with unplanned pregnancies may continue substance use – particularly if they are unaware of their pregnancy, or unwilling to seek medical attention. Unfortunately, not all juvenile facilities offer incarcerated girls access to prenatal or obstetric services.[65]

Pregnant teens who smoke are not only endangering their health and lives, but the health and lives of their unborn children. Smoking when pregnant increases the risk of spontaneous abortions and stillbirths.[66] Moreover, prenatal exposure to tobacco in utero has been linked to psychological, cognitive, and physical problems in children.[67] And other health-related problems often follow after birth. According to the U.S. Surgeon General, a pregnant woman who smokes is 1.5 to 3.5 times more likely than a non-smoker to have a low-birth weight baby, which can lead to complicating heath issues.[68] Infants whose mothers smoked while pregnant, as well as infants exposed to secondhand smoke, are more likely to die from sudden infant death syndrome (SIDS). In fact, almost one quarter of all SIDS deaths have been attributed to prenatal maternal smoking.[69]

Significantly, prenatal smoking cessation programs have been shown to have a protective effect on intrauterine growth retardation.[70] Also, for those women who quit smoking by the first trimester, their infants tend to have weight and body measurements comparable to those of nonsmokers.[71]

As a side note: If, upon release from a juvenile facility, young parents retain custody of their children and allow them to be exposed to tobacco smoke – either their own smoking or that of others in their home or social setting – these children can suffer an assortment of tobacco-related health problems, including chronic respiratory disorders, increased eye and ear infections, and eventually other medical issues related to cardiovascular disease and cancer.[72] Quitting smoking and the use of tobacco products thus protects the health of both young parents and their children, and breaks the cycle of nicotine addiction and adverse health effects.

Health Care Cost Impact

Cigarette smoking and exposure to secondhand smoke results in approximately 443,000 premature deaths a year in the U.S., as well as $96 billion in health care costs and an additional $97 billion a year in lost productivity losses.[73] Tobacco-related health care costs are particularly high for the young, ranging from the cost of health and developmental problems of infants and children caused by parental smoking or secondhand smoke exposure[74] to the disproportionately high neonatal health care costs of pregnant smokers on Medicaid.[75] One of the most striking indications of tobacco's devastating toll on juveniles: Of all young people who become new smokers each year, almost a third will ultimately die of tobacco-related disease.[76]

Research shows that treatment, even treatment for relapses into substance abuse, is less expensive than untreated addiction.[77] For instance, a recent study shows that for every dollar a state spends on tobacco cessation treatments, it saves an average of $1.26 – a 26 percent return on investment.[78] Given the appeal of tobacco among many high risk adolescents, the juvenile justice system would appear to be one venue where youth could receive the tobacco cessation aid and support they need.

Overview of Juvenile Justice Facilities

Unfortunately, providing juvenile offenders with tobacco cessation services is not as simple as it might seem. Part of the problem is the overall complexity of the juvenile justice system. How juvenile offenders are processed and where they are eventually placed varies greatly from state to state and often from community to community. As a result, once youth enter the juvenile justice system, their access to substance abuse services, such as tobacco cessation treatment, depends largely on where they are detained or incarcerated, state and local funding, administrative logistics, and the type of treatment resources available.

Although states may differ in how they handle juvenile offenders, most take active measures to ensure that juvenile offenders remain out of correctional facilities (often described as "secure detention") and have access to effective detention alternatives.[79] These alternatives include residential treatment facilities, group homes, camp programs, house arrest, or other non-secure community based programs.[80]

The transitory nature of juvenile placements makes it challenging to provide tobacco cessation programs over any extended period. The length of time youth offenders spend in a facility varies, depending on their time in detention prior to adjudication, the nature and severity of their offense(s), and their commitment status.[81] The median stay for youth placed by the juvenile justice system is approximately four months.[82] Approximately one-third resides in a facility for 60 days or less, another one-third resides in a facility between 61 and 180 days. Only about one in ten juveniles is in custody for more than a year.[83]

Figure 1 illustrates the complexity of the juvenile justice process, as well as a few key stages in the process where a juvenile's substance abuse needs are generally assessed.

Figure 1. Overview of Juvenile Justice Process[84]

Juvenile enters the system (usually through law enforcement)	**Detention Decision** ▪ Released? ▪ Sent to day/evening reporting center? ▪ Supervised release? ▪ Electronic monitoring? ▪ Home detention?
Juvenile's case is heard (adjudicated)	**Dispositional Decision** ▪ Put on probation? ▪ Sent to day/evening reporting center? ▪ Sent to residential placement? ▪ Sent to secure facility?
Juvenile is committed to a secure facility	**Initial Assessment** ▪ Custody assessment ▪ Preliminary program needs assessment (where substance abuse and tobacco-related needs are typically first identified) ▪ Sent to appropriate facility.
Juvenile is transferred to appropriate facility	**Internal Classification** ▪ More in-depth needs assessment to determine appropriate housing and program assignment (including tobacco cessation aid)
Juvenile is transferred to a designated housing unit and program	**Reclassification** Juvenile's initial classification reassessed after review of conduct during stay in facility. Assigned to housing unit and program: ▪ Group home? ▪ Residential treatment center? ▪ Wilderness camp? ▪ Boot camp? ▪ Community-based program? ▪ Etc.
Juvenile is paroled, released, or reenters system	**Final disposition**

In 2008 (the most recent year such census findings are available) approximately 2,860 residential juvenile justice facilities in the U.S. housed slightly more than 81,000 juvenile offenders.[85] These facilities include:

- **Non-residential or community based placements**, such as day/evening reporting centers and skill training programs

- **Non-secure or staff-secured residential placements**, such as home/community detention; foster care homes; group homes; shelters; halfway houses; and residential treatment centers
- **Secure placements**, such as detention centers, reception/diagnostic centers; ranches/wilderness camps, boot camps, and training schools/long-term secure facilities.[86]

The most common juvenile placements are in residential treatment centers (34 percent); group homes/halfway houses (27 percent); and detention centers (30 percent).[87] Youth who have committed the most serious career offenses, such as murder, rape, or kidnapping, are typically placed in correctional facilities, residential treatment, or community-based programs.[88] Youth who commit property offenses are often placed in camp programs, while juvenile drug and public order offenders are frequently placed in detention and camp programs.[89] Yet even these generalizations depend upon the way in which juveniles are classified and proceed through the justice system, as well as the availability of facilities and programs, and alternative detention and confinement options. Needless to say, tobacco control policies and cessation interventions and programs also depend on the setting in which a juvenile is placed.

Tobacco Cessation in Juvenile Facilities

Given the range of juvenile correctional and detention facilities in the U.S., it is not surprising that facility standards of substance abuse treatment or counseling should vary.[90] Still, the extent to which these standards diverge is significant. For instance, despite the prevalence of substance abuse and nicotine addiction among juvenile offenders, nearly one-fifth (19 percent) of juveniles in custody are in facilities that do not screen youth for substance use problems and more than one-third (36 percent) are in facilities that screen some, but not all, juveniles.[91] Unless a juvenile's tobacco addiction is identified and assessed, cessation aid and support may not be made available.

Overview of Juvenile Placements and Tobacco Cessation Services

Some correctional or detention facilities are simply not set up to provide tobacco cessation programs or services. [92] For example, the juvenile justice system typically cannot require those in pretrial detention centers to participate in treatment activities.[93] The state does not have unlimited authority to intervene clinically in youth's lives, especially at certain stages of juvenile justice processing.[94]

Nevertheless, many residential juvenile facilities do offer tobacco cessation services, such as counseling, resources, aids, and other evidence-based interventions. The U.S. Public Health Service's 2009 Clinical Practice Guideline, Treating Tobacco Use and Dependence recommends seven medications and three types of counseling (individual, group, and by phone) to help smokers quit.[95] Cessation services for young people often include cognitive-behavioral components and content specific to adolescents – and typically focus on counseling and group programs.[96]

Appendix A provides brief descriptions of a few common juvenile justice placements in the U.S., opportunities for tobacco cessation services, and tobacco use and cessation initiatives in each facility.[97] Although staff and treatment professionals in juvenile placements may vary in the way they approach substance abuse, this table provides a general overview of basic complications that may arise in specific programs, and considerations that may need to be taken into account. For example, short-term emergency-basis shelters or detention centers are generally not designed to provide tobacco use interventions, while residential treatment centers may have the staff and time to provide effective

cessation aid. Also, home or community-based detention could provide important support from family members as youth attempt to quit tobacco use, yet this placement could also prove counterproductive if family and friends continue to use tobacco and tobacco use is seen as a social norm in the environment.

Problems and Obstacles

In addition to the facility-specific challenges identified in Appendix A, public health professionals, juvenile justice staff, and others concerned with addressing tobacco use by juvenile offenders face other obstacles, such as –

Lack of Motivation. With most juveniles, but high-risk youth in particular, nicotine addiction is not perceived to be a problem or at least a health care concern meriting special treatment or attention.[98] Motivating these young people to participate in cessation treatment and, significantly, follow through once they are released from custody, is likely to continue to be a challenge.

"Lower" Priority Issue. Most juveniles in custody need some type of rehabilitative assistance. And juvenile facilities must often stretch resources in addressing a host of psychosocial, behavioral, educational, and mental health problems of young offenders. As a result, many facilities have a difficult time providing evidence-based substance abuse treatment – particularly tobacco cessation services – that high-risk adolescents need.[99] What makes this troubling is that despite decades of medical evidence on the health risks of tobacco use, many treatment counselors continue to view tobacco addiction as a less urgent substance abuse issue than more "problematic" alcohol and drug addictions.[100] It is thus a sad irony that people who receive treatment for substance use disorders die as a result of their tobacco use more often than as a result of the other chemical dependencies for which they were treated.[101] In fact, one study describes the situation as "a major health disparity with respect to tobacco and tobacco-related disease among individuals with [substance abuse disorders]."[102]

Belief that Tobacco Cessation Jeopardizes Other Addiction Treatments. In the past, many treatment professionals believed that treating tobacco cessation at the same time as other substance abuse problems (or mental health disorders) was likely to jeopardize or undermine recovery or stability.[103] Some professionals continue to believe that tobacco cessation is too challenging for patients in early sobriety or drug withdrawal, and that it should be treated separately at a later time.[104] Recent research, however, has shown that when substance abusers are also treated for tobacco dependence, the treatment is effective, and many patients actually show improved recovery outcomes.[105] Juvenile offenders, who are often struggling with more than one substance abuse disorder, may find themselves cycling through treatment programs that fail to address the parallel problems of nicotine addiction.

Length of Placement and Personnel. Because most juvenile placements are intended to be short-term, and because youth often transition quickly from one program or housing situation to another, many facilities do not offer long-term tobacco cessation services. Moreover, in some placements, such as community-based skills training programs, tobacco use may be common, even among staff and counselors. Thus, the transitory nature of the placement, and the type of environment and personnel, often make it difficult to provide effective tobacco cessation treatment.

Lack of Family / Social Support. Upon release, juvenile offenders struggling with substance abuse disorders often find themselves back in difficult environments where they receive little or no positive support from parents or other adults, and where their abstinence may set them apart from their peers. Without opportunities for ongoing cessation services upon release and limited after care monitoring, many juveniles are likely to resume tobacco use when they return to their old neighborhoods.[106]

Limited Funding or Resources. Positive tobacco cessation outcomes for juvenile offenders may depend on the quality and availability of resources in the facility or program in which the youth are placed, or the community where they reside. Some treatment professionals with expertise in tobacco cessation may lack experience working with high-risk adolescents, and others with a background in the juvenile justice system may be unfamiliar with tobacco and nicotine addiction. Also, given limited access to health care dollars for youth in detention, procuring funding for community-based tobacco cessation programs and personnel may be difficult.[107]

Lack of Follow-up Quit Information. One of the biggest challenges in researching the effectiveness of tobacco cessation treatment in certain "captive" audiences, such as correctional and juvenile offender populations, is the lack of data once offenders are released. Tracking juveniles after they have been released from custody, when little funding is available for such efforts, is rarely possible. Moreover, without the cooperation of the patient, limited or no information on the long-term effectiveness of the cessation intervention can be obtained. Although young smokers are often motivated to quit, quit rates among youth are low.[108] In the juvenile offender population, given the higher prevalence of tobacco use, these rates tend to be even lower.[109]

Select Initiatives

Despite the challenges in reducing the use of tobacco among juvenile offenders, some communities have taken innovative measures to address this problem. In August 2005, the Health Education Council (HEC) received a 3-year grant from the County of Sacramento Health and Human Services Department to decrease tobacco use among at-risk youth and young adults by institutionalizing tobacco cessation programs in youth work programs and juvenile justice facilities.[110] The Sacramento Job Corps in California was recruited as one of the first pilot sites for an HEC tobacco cessation intervention. Also involved were the Sacramento Conservation Corps, the Warren E. Thornton Youth Center, and the Sacramento County Youth Detention Facility.

Over the three-year period, the project implemented several education and policy initiatives:

- **Initiative 1:** A comprehensive tobacco-free policy
- **Initiative 2:** A targeted tobacco-cessation curriculum
  - Taught in 2 to 4 one-hour sessions (compared with traditional cessation programs that can last 6 to 8 weeks)

- Designed for facilitators with limited health education or tobacco cessation experience

- **Initiative 3:** Integrated tobacco cessation services
  - Promotional strategies included flyers, sign-up sheets, and announcements at student and staff meetings
  - Incentives to encourage participation, such as "quit kits," gum, and an opportunity for free nicotine replacement therapy (NRT) through an onsite Wellness Center
- **Initiative 4:** Sustained tobacco cessation services
  - High staff involvement
  - Peer-led cessation classes

The project successfully met its goal of fully institutionalizing a tobacco cessation program for at-risk youth in a workforce setting and adapting the program to neighboring juvenile detention facilities. Despite some challenges, the program remains an effective model for cessation efforts directed at young offenders and at-risk youth.

The Health Education Council's recommendations for similar cessation programs highlight the importance of targeting tobacco policy initiatives to the needs of at-risk populations. The Council recommends integrating tobacco control policies (such as tobacco-free measures) with tobacco cessation programs; engaging staff throughout the process, particularly during the initial and implementation stages; and providing short and simple cessation programs and participant incentives. Finally, the Council encourages short follow-up efforts in tracking cessation success, since the longer the time frame, the harder it becomes to obtain long-term follow up data on quit rates.

Tobacco Policy Considerations for Juvenile Offenders

Tobacco use by juvenile offenders is a complicated problem, which is not made easier by the complexities of the juvenile justice system and its many different residential, community-based, and home-based detention and correctional placements. For those concerned about this vulnerable and troubled population, the breadth and complexity of the justice system may seem daunting. Yet different cessation options and initiatives continue to emerge in juvenile facilities across the U.S. And given the tremendous financial toll of tobacco-related illness, preventive measures for reducing tobacco use continue to be explored and promoted at all levels of government.

Below are a few policy options and considerations that juvenile justice professionals might keep in mind when addressing the problem of tobacco use by juvenile offenders.

Programs and Services

- Comprehensive tobacco-free policies that prohibit the possession, use, sale or trade of tobacco products both indoors and on the outside grounds of a facility are the most effective way to protect youth and staff from the adverse health risks of tobacco use and secondhand smoke exposure. When tobacco policies contain exemptions, such as permitting smoking in designated areas, or allowing staff or visitors to use tobacco products in certain areas, difficulties can arise, and the policy can be more difficult to interpret, implement and enforce.

- Effective initial assessment of substance abuse, as well as tobacco dependency, is an essential first step in any juvenile treatment program. Even in short-term facilities that may not offer tobacco cessation services, assessing a youth's tobacco dependency and habits can help with placement decisions. Also, when assigning youth to specific housing units and programs, staff might want to consider integrating tobacco cessation services with other substance abuse programs, since studies have shown that combining these interventions is often more effective than addressing them individually.[111]

- Some research has found that adolescent substance abuse can be exceptionally resistant to change when accompanied by a host of medical and mental health problems. In addition to direct negative health outcomes, increased substance use appears to set the stage for future victimization or revictimization, which in turn increases the risk of additional substance abuse.[112] In some cases, cessation experts might find it helpful to draw on the expertise of other professionals in the health field.

- Programs that address the specific tobacco cessation needs of youth who are parents or expectant parents may enhance their ability to parent their children safely in the future. These materials could focus on the health risks of smoking and tobacco use on fetal development, as well as the adverse health effects of secondhand smoke exposure on their infants and children.

- Cessation materials should be written clearly and simply in a style and language that captures the attention of the juvenile justice population and that presents accurate and complete information about the adverse health effects of tobacco use. Materials should also include information about the health risks of the newest types of non-cigarette tobacco products, and other nicotine-delivery devices.

Counseling

- Peer counseling and peer-led classes can help engage youth and encourage them to seek advice and support from positive peer models.

Pre-Release Planning

- When former tobacco users are about to be released from a juvenile facility, they need to be prepared for the challenges they may face in returning to homes or communities where smoking or tobacco use is the social norm. Facilities can help ease the reentry transition by helping them focus on ways to avoid common triggers that may prompt them to resume tobacco use, including intense peer pressure.

Conclusion

Of the close to one and a half million youth that enter the U.S. juvenile justice system each year, a disproportionate number use tobacco. Because these high-risk adolescents typically struggle with a host of other socioeconomic, psychological, and mental issues – including high substance abuse – their nicotine addiction may be viewed as less a priority than other more immediate challenges. Moreover, the juvenile justice system's breadth and complexity, its broad range of placements and the variability among programs and facilities across the country, all make the provision of tobacco cessation services difficult at times and impossible at others. Yet given the devastating health care impact of tobacco-related illness, effective policies that focus on tobacco prevention and cessation in juvenile placements could help many of these adolescents break the cycle of nicotine addiction and, in turn, save their lives.

Appendix A
Juvenile Justice Placements & Tobacco Policy Implications

Placement	Description
Day/evening reporting centers	▪ A highly-structured, community-based placement option requiring youth to report daily activities to case managers. ▪ Typically, youth are required to report to a facility at scheduled times 5-7 days/week.
Skills training programs	▪ A community-based placement option that provides a setting for youth to gain hands-on training and education, while partially insulating them from the triggers and environments that led them to offend. ▪ May also be structured as a non-secure residential facility.
Non-secure or Staff-secured Residential Placements	
Home/community detention	▪ A placement option for youth who can safely reside in their own homes or with relatives. ▪ Often combined with intensive supervision (involving frequent, random, unannounced staff visits, face-to-face community supervision and telephone contacts to minimize the chances that youth are engaged in ongoing delinquent behavior and to ensure court appearances are made) or electronic monitoring.
Foster care	▪ A placement option for youth who are at a lower risk to re-offend criminally, but for various reasons are not yet able to return to their families' homes or are not yet ready to live independently. ▪ Although there are typically differences between correctional foster placements and child welfare foster placements, both systems require foster parents to meet certain requirements and complete initial and ongoing training.
Group home	▪ A broad class of residential placements, involving the supervision of a relatively small number of youth in a house or house-like setting. ▪ Group homes are considered staff-secured, rather than locked. ▪ Group homes generally do not provide academic instruction and residents typically attend local public schools.

Implications for Youth Tobacco Use and Cessation

- Services commonly provided include support, treatment, or treatment referral for problems with addiction, as well as tobacco cessation services.

BUT

- Because youth report to these facilities at scheduled intervals, tobacco use could occur between check-ins if supervisory staff do not monitor for evidence of tobacco use.

- Tobacco cessation assistance in this setting, accompanied by a tobacco-free policy, could help decrease youth tobacco use.

BUT

- Tobacco use may be common among staff and participants.
- Tobacco-free policies may not be in place.

- Family can be critically important in affecting adolescent tobacco use – either positive or negative.
- Research suggests that adolescent tobacco cessation often depends upon family involvement for success.

BUT

- Youth who are placed in their own homes may continue to use tobacco or struggle with cessation efforts if their parents or other family members use tobacco.

- Providers are increasingly subject to smoke-free foster home policies.
- Where these policies are in place, no smoking is permitted within the foster home and, increasingly, outside the immediate vicinity of the home, and in vehicles when foster children or youth are present.

BUT

- Where such policies have not been implemented, tobacco cessation efforts by youthful offenders may be undermined by exposure and access to tobacco.

- Group homes are a likely source of peer influence, either positive or negative. Peer contagion is a form of peer influence involving a feedback loop in which adolescents influence one another to become more delinquent than they otherwise would have been in the absence of the program.
- Since youth may be affected differently by peer contagion effects depending on their age, gender, kinds of behaviors, temperament, maturity, and significant relationships with other adults, the group home option has clear implications for both tobacco use and cessation.

BUT

- Youth housed with other youth who use tobacco, and who are susceptible to the effects of peer contagion, are more likely to have continued access to tobacco and to continue tobacco use.

Appendix A Juvenile Justice Placements & Tobacco Policy Implications (continued)	
Placement	**Description**
Shelter	▪ Often characterized as a type of group home, this placement is most frequently used in an emergency or time-sensitive situation.
Halfway house	▪ Another type of group home, typically used as a transitional placement for youth who have spent time in confinement at a secure facility, before they return home.
Residential treatment center	▪ A placement option for youth with significant psychiatric or substance abuse problems who have proved unsuitable for foster care, day treatment programs, and other nonsecure environments but who do not yet merit commitment to a psychiatric hospital or secure correctional facility. ▪ These placements frequently offer a combination of substance abuse and mental health treatment programs and 24-hour supervision in a highly structured environment.
Secure Placements	
Detention center	▪ A youth may be placed in a detention facility at different points as a case progresses through the juvenile justice system. ▪ These facilities provide secure confinement and care for juveniles pursuant to a secure custody order or pending a court hearing or placement in a long-term secure facility.
Reception/ diagnostic center	▪ These facilities serve as a point of entry for youth with mental health, substance abuse, and other treatment needs who are referred by a juvenile court to a secure placement. ▪ Comprehensive screening, assessment, and evaluation services are provided, enabling authorities to determine the level and type of rehabilitative treatment needed and the most appropriate facility or program placement within the system.

Implications for Youth Tobacco Use and Cessation

- Typically used on a short-term, emergency basis, this placement is less likely to foster new/continued tobacco use or to undermine an ongoing tobacco cessation effort.

BUT

- The short-term nature of the placement means that it is unlikely to provide tobacco cessation services (although referrals may be available).

- Tobacco cessation assistance is more likely to be provided compared to other types of group homes because aftercare plans initiated during a youth's incarceration will be in full effect, allowing the youth to benefit from pre-arranged services and support.

BUT

- This placement also offers opportunities for peer contagion.

- The serious negative health consequences of cigarette smoking are well-known, and adolescents' decreased smoking after substance use treatment has actually been associated with decreases in other forms of substance use.
- If residential treatment centers addressed youth tobacco use more comprehensively, they could be some of the juvenile corrections system's most effective providers of tobacco cessation services, given the characteristically supportive environment and availability of staff with addiction training.

BUT

- Tobacco use is often overlooked as a substance use treatment problem because of the mistaken belief that attempts at smoking cessation will undermine sobriety.

- Very likely to have a tobacco-free policy in place, including characterization of tobacco as contraband.

BUT

- Due to the typically short stay of youth, there may be limited opportunities for meaningful tobacco use interventions.
- If multi-session tobacco cessation courses are offered, youth would be unlikely to be able to attend most or all sessions, and thus not derive the intended benefit.

- With an orientation toward youth substance abuse treatment and mental health care, tobacco-free policies are common in these facilities and support for tobacco cessation efforts already underway would likely be available.

BUT

- As in the detention center environment, placements are typically brief, meaning the initiation of a new tobacco cessation effort would likely be deferred until the longer-term placement was decided upon.

Appendix A
Juvenile Justice Placements & Tobacco Policy Implications (continued)

Placement	Description
Ranch/ wilderness camp	■ These placement options provide participants with a series of physically challenging outdoor activities designed to prevent or reduce delinquent behavior and recidivism; they serve as alternatives to traditional detention. ■ Placements within this category vary widely in terms of settings, eligibility criteria, types of activities, duration, involvement of family members, and therapeutic goals.
Boot camp	■ Boot camps are military-style correctional programs that emphasize discipline and physical conditioning. They are typically developed as a rigorous alternative to longer terms of confinement in juvenile correctional facilities. ■ These placements have become somewhat disfavored because of data reflecting that they do not reduce recidivism.
Training school/long-term secure facility	■ Secure placements generally reserved for delinquent juveniles who are a danger to persons or property in the community and for whom no less restrictive placement is available or appropriate.

Implications for Youth Tobacco Use and Cessation

- Offers the advantage of comparatively remote locations, making contraband control more effective and access to tobacco products correspondingly more difficult.

  BUT

- One potential concern about youth tobacco cessation in the ranch or wilderness environment is the comparative infrequency with which youth interact with their families. Youth in this setting are twice as likely to have a low rate of family contact as youth in facilities other than training schools. This may present problems for tobacco cessation because of the demonstrated importance of family involvement in lasting tobacco cessation efforts for youthful offenders.

- Tobacco-free policies are likely to be strictly enforced.

  BUT

- Limited data are available regarding whether boot camps offer tobacco cessation assistance, and if so, how effective it may be.

- Tobacco-free policies are likely to be in place.
- Access to tobacco is likely to be precluded by search and contraband policies.

  BUT

- Although tobacco cessation services might be available, they are more likely to be offered only upon request and less likely to be screened for and automatically treated.

Appendix B

Glossary

Adjudicate: To remove a case through judicial decision. Many juvenile justice cases are heard without the assistance of a jury. In such cases the judge will hear the case and prescribe the best course of action, thus "removing" it from the court.

Adjudicated: The court finds a youth guilty of committing a delinquent act. The court can commit the youth or place the youth on community supervision.

Adjudication Withheld: The court finds that a youth committed a delinquent act, but withholds an adjudication of delinquency. The court places the youth on community supervision.

Aftercare: The probationary period following a youth's release from a juvenile facility. During this time the youth's behavior will be followed by the juvenile court, and he or she may be required to meet specific probationary obligations.

CHIPS: Stands for Children in Need of Protection. There are several case types under the heading of CHIPS, including child protection, termination of parental rights, truancy, runaway, delinquencies under the age of 10 years old, and voluntary placement cases.

Commitment: A youth is placed in a program for delinquent youth defined by state statute. These programs range from low to maximum restrictive levels.

Confidentiality protection: A youth's records may be made available to schools, youth agencies, law enforcement officials, prosecutors, victims, and the public only under certain, specified circumstances. Juvenile confidentiality is guarded by each state's provisions.

Consent decree: A youth who has admitted to committing delinquent acts may have his case dismissed by fulfilling obligations to the court and the injured party. These obligations are set out in a consent decree and often include restitution, mandatory curfew, increased school attendance, and rehabilitation.

Cost of Care: Parents or guardians may be billed a nominal charge for the services delivered to their child.

Delinquent act: Any act committed by a youth that would be a criminal violation if committed by an adult.

Delinquent juvenile: A youth who has been found responsible for having committed a delinquent act – the equivalent of being found guilty of a criminal offense.

Detention: In custody (secure, non-secure, or home confinement) while awaiting an adjudication hearing, disposition, or commitment placement.

Detention Center: A facility where youth are securely held pending court hearings, for contempt of court, or while awaiting placement in a commitment program.

Detention hearing: A judicial hearing generally required to be held within 72 hours of a youth being taken into custody, at which point the court determines whether (1) there is probable cause to believe that the youth has committed a delinquent act or a court order exists that requires the continued detention of the youth, and (2) continued detention is required pending an adjudicatory hearing.

Disposition hearing: Scheduled if a youth has been found delinquent by the juvenile court. The probation officer, prosecutor, and juvenile are permitted to propose disposition strategies. Recommendations frequently include drug rehabilitation, limited (weekend) confinement, restitution, and residential placement.

Intake: The process used for every youth referred to juvenile court. Intake involves screening each youth to determine the appropriateness for release or referral to a diversionary program or agency for nonofficial or nonjudicial handling. This screening also identifies the presence of medical, psychiatric, psychological, substance abuse, and educational problems or other conditions that may have caused the youth to come to the attention of law enforcement or intake. Intake includes initial screening of a status offender to determine the recommended action to be taken in the best interests of the youth, the family, and the community.

Manner of handling: A general classification of case processing within the juvenile court system.

- Petitioned (formally handled) – Cases that appear on the official court calendar in response to the filing of a petition or other legal instrument requesting the court to adjudicate the youth delinquent or to waive the youth to criminal court for processing as an adult.
- Nonpetitioned (informally handled) – Cases that duly authorized court personnel screen for adjustment without the filing of a formal petition. Such personnel include judges, referees, probation officers, other officers of the court, and/or an agency statutorily designated to conduct petition screening for the juvenile court.

Parens patriae: Translates roughly to "state as parent." This is the idea that the state has a responsibility to play a parental role to youths who have been neglected by their parents.

Placement facility type: Identifies whether a juvenile placement facility is publicly or privately owned/operated.

- Public facilities – Facilities operated by state or local government agencies in which the employees working daily in the facilities and directly with the residents are state or local government employees.
- Private facilities – Facilities operated by private nonprofit or for-profit corporations or organizations in which the employees working daily in the facilities and directly with the residents are employees of the private corporation or organization.

Placement status: Identifies categories of juveniles held in residential placement facilities.

- Committed – Includes juveniles in placement in the facility as part of a court-ordered disposition. Committed juveniles include those whose cases have been adjudicated and disposed in juvenile court and those who have been convicted and sentenced in criminal court.

- Detained – Includes juveniles held prior to adjudication while awaiting an adjudication hearing in juvenile court, as well as juveniles held after adjudication while awaiting disposition or awaiting placement elsewhere. Also includes juveniles awaiting transfer to adult criminal court, or awaiting a hearing or trial in adult criminal court.
- Diversion – Includes juveniles sent to the facility in lieu of adjudication as part of a diversion agreement.

Probation: The status of a delinquent youth placed on community supervision. Youth are supervised by a Juvenile Probation Officer based on the order of the court.

Status offender: A youth who has committed an act that is only considered a law violation because of his or her status as a juvenile. Some examples of status offenses are underage tobacco consumption, truancy from school, general "ungovernability," violation of curfew, and running away from home.

Youthful offender: "Youthful offender" status may be given to a juvenile being tried in the criminal justice system. The status usually guarantees that the proceedings will not be open to the public and that after turning 21 the youth's criminal record will be cleared, provided court requirements have been met.

Sources

http://www.lawyershop.com/practice-areas/criminal-law/juvenile-law/glossary

http://www.djj.state.fl.us/parents/glossary.html

http://www.behavioralinstitute.org/FreeDownloads/TIPS/Juvenile%20Justice%20Terms-MN.pdf

http://www.family-court.org/Documents/What%20are%20the%20definitions.pdf

http://www.ojjdp.gov/ojstatbb/glossary.html

Appendix C

Tobacco Cessation in Juvenile Justice Settings: Selected Resources

American Academy of Pediatrics (AAP): The American Academy of Pediatrics is committed to the attainment of optimal physical, mental, and social health and well being for all infants, children, adolescents, and young adults. The website includes instructions for tobacco counseling and media education in the practice setting (i.e., understanding and confronting how images and messages in the mass media affect the health and well being of children and adolescents), as well as educational materials for parents and teenagers on the risks of tobacco use.
http://www.aap.org/en-us/advocacy-and-policy/Pages/Advocacy-and-Policy.aspx

American Cancer Society (ACS): The American Cancer Society is a nationwide, community-based voluntary health organization dedicated to eliminating cancer as a major health problem.
http://www.cancer.org/Cancer/CancerCauses/TobaccoCancer/tobacco-related-cancer-fact-sheet

American Heart Association (AHA): The American Heart Association is a national voluntary health agency that helps reduce disability and death from cardiovascular diseases and stroke.
http://www.heart.org/HEARTORG/

American Lung Association (ALA): The American Lung Association is a leading organization working to save lives by improving lung health and preventing lung disease through education, advocacy and research.
http://www.lungusa.org/

American Medical Association (AMA): The American Medical Association strives to promote the art and science of medicine and the betterment of public health. The AMA participates in the development of tobacco cessation guidelines and provides tools for physicians assisting patients with tobacco use cessation, as well as providing information and tools for use by patients.
http://www.ama-assn.org/

Annie E. Casey Foundation Juvenile Detention Alternatives Initiative (JDAI): The Annie E. Casey Foundation believes that all youth involved in the juvenile justice system should have opportunities to develop into healthy, productive adults as a result of policies, practices, and programs that maximize their chances for personal transformation, protect their legal rights, reduce their likelihood of unnecessary or inappropriate incarceration, and minimize the risks they pose to their communities. The Foundation's Juvenile Detention Alternatives Initiative was launched in 1992 and focuses on juvenile detention as a direct entry point for reform, given the numerous ways it shapes juvenile justice systems and the communities they impact.
http://www.aecf.org/MajorInitiatives/JuvenileDetentionAlternativesInitiative/AboutJDAI.aspx

Break Free Alliance: The mission of Break Free Alliance is to reduce tobacco use among populations of low socioeconomic status. Break Free Alliance is a program of the Health Education Council and was formerly known as the National Network on Tobacco Prevention and Poverty.
http://www.breakfreeallince.org

Campaign for TobaccoFree Kids: This campaign is one of the nation's largest nongovernmental initiatives ever launched to protect children from tobacco addiction and exposure to secondhand smoke. The Campaign's goals are to deglamorize tobacco use through countermarketing, change public policies to protect children from tobacco use, and increase the number of organizations and individuals working to reduce tobacco use.
http://www.tobaccofreekids.org

Health Education Council (HEC): The Health Education Council is a nonprofit agency focused primarily on eliminating preventable causes of death resulting from the use of tobacco, poor nutrition, and lack of physical activity. HEC operates more than 25 public health programs nationwide to meet the needs of diverse communities by increasing access to health-related knowledge and information.
http://healthedcouncil.org/index.html

North American Quitline Consortium (NAQC): The North American Quitline Consortium (NAQC) is an international, non-profit membership organization that seeks to promote evidence-based quitline services (telephone-based tobacco cessation services that help tobacco users quit) across diverse communities in North America.
http://www.naquitline.org/

Office of Smoking and Health (OSH) – Centers for Disease Control and Prevention (CDC): The Centers for Disease Control and Prevention, through its Office on Smoking and Health, is the lead federal agency for comprehensive tobacco prevention and control. OSH is dedicated to reducing the death and disease caused by tobacco use and exposure to secondhand smoke. Through OSH's National Tobacco Control Program, programs relating to tobacco use prevention, cessation, smoke-free environments, and tobacco-related disparities are funded.
http://www.cdc.gov/tobacco/index.htm

Office of the Surgeon General (OSG): The Surgeon General serves as America's Doctor by providing Americans the best scientific information available on how to improve their health and reduce the risk of illness and injury. The OSG provides a tobacco cessation resource webpage with links for clients and clinicians, including supportive materials, pocket cards, fact sheets, and clinical guidelines for treating tobacco dependence. Materials are also in Spanish.
www.surgeongeneral.gov/tobacco/

Tobacco Cessation Leadership Network (TCLN): The mission of the Tobacco Cessation Leadership Network is to help increase the capacity in every state to establish effective, sustainable, and affordable cessation services to help tobacco users quit and stay quit. TCLN provides online resources, links, and roundtable discussions on tobacco treatment.
www.tcln.org

Tobacco Control Legal Consortium (TCLC): The Tobacco Control Legal Consortium's team of legal and policy specialists works to assist communities with tobacco-law related issues by providing legislative drafting and policy assistance to community leaders and public health organizations. The Consortium, a program of the Public Health Law Center, provides a wealth of tobacco law and public health law-related publications and resources online.
http://publichealthlawcenter.org/programs/tobacco-control-legal-consortium

Tobacco Technical Assistance Consortium (TTAC): The Tobacco Technical Assistance Consortium is dedicated to assisting organizations in building and developing highly effective tobacco control programs. TTAC provides products, tools and an extensive pool of tobacco control resources through its website.
http://www.ttac.org/

Endnotes

[1] Andrea J. Sedlak & Karla S. McPherson, Office of Juvenile Justice and Delinquency Prevention, *Youth's Needs and Services: Findings from the Survey of Youth in Residential Placement*, Juvenile Justice Bulletin 4 (2010) [hereinafter *Youth's Needs and Services*] (reporting a significant relationship between drug use and serious delinquent behavior), *available at* https://www.ncjrs.gov/pdffiles1/ojjdp/227728.pdf. For purposes of this paper, the terms "youth" or "juvenile" refer to a person from the age of 12 through 18, and the term "juvenile offender" refers to youths in the juvenile justice system.

[2] *See, e.g.,* Laurie Chassin et al., *Substance Use Treatment Outcomes in a Sample of Male Serious Juvenile Offenders*, 36 J. Substance Abuse Treatment 183, at *1-3 (2009), *available at* http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2652415/pdf/nihms93942.pdf; Mark Myers et al., *Is Cigarette Smoking Related to Alcohol Use During the 8 Years Following Treatment for Adolescent Alcohol and Other Drug Abuse?*, 42 Alcohol & Alcoholism 226, 226-7 (2007), *available at* http://alcalc.oxfordjournals.org/content/42/3/226.full.pdf+html.

[3] Mark Myers et al., *supra* note 2, at 226.

[4] Ctrs. for Disease Control & Prevention, *Youth Risk Behavior Surveillance, United States, 2009*, 59 Morbidity & Mortality Wkly Rep. SS-5, 2 (2010) [hereinafter *Youth Risk Behavior Surveillance*], *available at* http://www.cdc.gov/mmwr/pdf/ss/ss5905.pdf.

[5] *See generally* James Austin et al., Office of Juvenile Justice and Delinquency Prevention, *Alternatives to the Secure Detention and Confinement of Juvenile Offenders*, Juvenile Justice Bulletin (2005) [hereinafter *Alternatives to Secure Confinement*], *available at* https://www.ncjrs.gov/pdffiles1/ojjdp/208804.pdf.

[6] Linda Spear, *The Adolescent Brain and Age-Related Behavioral Manifestations*, 24 Neuroscience & Biobehavioral Reviews 417, 421 (2000), *available at* http://faculty.weber.edu/eamsel/Classes/Adolescent%20Risk%20taking/Lectures/3-4%20Biological/Spear%20LV%20%20(2000).pdf.

[7] Terrie Moffitt, *Adolescence-Limited and Life-Course-Persistent Antisocial Behavior: A Developmental Taxonomy*, 100 Psychol. Rev. 674, 675 (1993), *available at* http://www.psychology.sunysb.edu/ewaters/552-04/slide%20sets/brian_mcfarland_aggression/moffitt_aggression.pdf.

[8] *See, e.g.,* Linda Spear, *supra* note 6; Thomas Grisso, Double Jeopardy: Adolescent Offenders with Mental Disorders, 100-07 (2004).

[9] Grisso, *supra* note 8, at 105.

[10] Grisso, *supra* note 8, at 105-06.

[11] Karen B. Friend et al., *The Impact of Local U.S. Tobacco Policies on Youth Tobacco Use: A Critical Review*, 1 J. Preventive Med. 34, 34 (2011), *available at* http://www.scirp.org/Journal/PaperInformation.aspx?paperID=6940.

[12] *Id.*

[13] David Nelson et al., *Long-term Trends in Adolescent and Young Adult Smoking in the United States: Metapatterns and Implications*, 98 Am. J. Public Health 905, 911-13 (2008), *available at* http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2374818/pdf/0980905.pdf (finding that recent declines in adolescent and young adult cigarette smoking have been "decidedly nonlinear" and that to ensure ongoing reduction in smoking among this population, a long-term societal commitment to tobacco use prevention is needed).

[14] *Id.*; *see Youth Risk Behavior Surveillance*, *supra* note 4, at 12-13.

[15] Campaign for Tobacco-Free Kids, *The Danger from Dissolvable Tobacco and Other Smokeless Tobacco Products* (2011), *available at* http://www.tobaccofreekids.org/research/factsheets/pdf/0363.pdf. *See generally* the Campaign for Tobacco-Free Kids website at http://www.tobaccofreekids.org/facts_issues/fact_sheets/toll/products/smokeless/ (presenting resources on smokeless tobacco products and health effects).

[16] *See* Tobacco Control Legal Consortium, *Novel Non-Cigarette Tobacco Products: An Overview of Regulatory Options* (2011) (presenting policy options that communities might consider in regulating the sale and marketing of non-cigarette tobacco products), *available at* http://publichealthlawcenter.org/sites/default/files/resources/tclc-fs-novelotps-2011.pdf.

[17] *See* U.S. Dep't of Health & Human Servs., Substance Abuse and Mental Health Services Admin., *Results from the 2010 National Survey on Drug Use and Health: Summary of National Findings* 56 (2011) [hereinafter *Results from 2010 Nat'l Survey on Drug Use and Health*], *available at* http://www.samhsa.gov/data/NSDUH/2k10NSDUH/2k10Results.pdf.

[18] *See Youth Risk Behavior Surveillance*, *supra* note 4, at 12; *see also* Nat'l Survey on Drug Use and Health, *Smokeless Tobacco Use, Initiation, and Relationship to Cigarette Smoking: 2002 to 2007*, The NSUDH Report (2009), *available at* http://www.oas.samhsa.gov/2k9/smokelessTobacco/smokelessTobacco.pdf.

[19] *See, e.g.,* Scott Tomar et al., *Patterns of Dual Use of Cigarettes and Smokeless Tobacco Among U.S. Males: Findings from National Surveys*, 19 Tobacco Control 104 (2010), *available at* http://tobaccocontrol.bmj.com/content/19/2/104.full.pdf+html.

[20] Gus Martin, Juvenile Justice: Process and Systems 65 (2005).

[21] Martin, *supra* note 20, at 65.

[22] *See, e.g.,* Campaign for Tobacco-Free Kids website at http://www.tobaccofreekids.org/facts_issues/fact_sheets/industry/marketing/ (containing fact sheets and other resources on tobacco industry marketing to children and adolescents).

[23] Martin, *supra* note 20, at 64.

[24] *See Youth Risk Behavior Surveillance-U.S. 2009*, *supra* note 4, at 11.

[25] Friend, *supra* note 11, at 35; *see also* Jean Forster et al., *Social Exchange of Cigarettes by Youth*, 12 Tobacco Control 148, 153 (2003).

[26] Ctrs. for Disease Control & Prevention, *Vital Signs: Current Smoking Among Adults Aged ≥ 18 Years – U.S., 2005-2010*, 60 Morbidity & Mortality Wkly Rpt. 1207, 1207 (2011), *available at* http://www.cdc.gov/mmwr/PDF/wk/mm6035.pdf.

[27] U.S. Dep't of Health & Human Servs., How Tobacco Smoke Causes Disease: The Biology and Behavioral Basis for Smoking-Attributable Disease: A Report of the Surgeon General (2010) [hereinafter 2010 Surgeon General's Report], *available at* http://www.surgeongeneral.gov/library/tobaccosmoke/; *see also* U.S. Dep't of Health & Human Servs., The Health Consequences of Involuntary Exposure to Tobacco Smoke: A Report of the Surgeon General (2006) [hereinafter 2006 Surgeon General's Report] *available at* http://www.surgeongeneral.gov/library/secondhandsmoke/.

[28] U.S. Dep't of Health & Human Servs., The Health Consequences of Smoking: Surgeon General's Report (2004) [hereinafter 2004 Surgeon General's Report], *available at* http://www.surgeongeneral.gov/library/smokingconsequences/.

[29] *See* Cecilie Svanes et al., *Parental Smoking in Childhood and Adult Obstructive Lung Disease: Results from the European Community Respiratory Health Survey*, 59 Thorax 295, 301 (2004), *available at* http://thorax.bmj.com/content/59/4/295.full.pdf+html.

[30] *See, e.g.,* Campaign for Tobacco-Free Kids, *Health Harms from Smokeless Tobacco Use* (2011), *available at* http://www.tobaccofreekids.org/research/factsheets/pdf/0319.pdf.

[31] *See Results from 2010 Nat'l Survey on Drug Use and Health*, *supra* note 17, at 55-6; *see also* Campaign for Tobacco-Free Kids, *The Path to Smoking Addiction Starts at Very Young Ages* (2009), *available at* http://www.tobaccofreekids.org/research/factsheets/pdf/0127.pdf.

[32] *See* Chassin, *supra* note 2 at 183; *see also* Barry Holman & Jason Ziedenberg, Justice Policy Inst., The Dangers of Detention: The Impact of Incarcerating Youth in Detention and Other Secure Facilities 5 (2006), *available at* http://www.justicepolicy.org/research/1978.

[33] U.S. Census Bureau, *Arrests by Sex and Age: 2009*, Statistical Abstract of the U.S.: 2012 (2012), *available at* http://www.census.gov/compendia/statab/2012/tables/12s0324.pdf; Scott W. Henggeler & Sonja K. Schoenwald, *Evidence-based Interventions for Juvenile Offenders and Juvenile Justice Policies that Support Them*, 25 Social Policy Report 3, 3 (2011), *available at* http://207.235.77.113/files/SPR.pdf. *See also* Robert Brame et al., *Cumulative Prevalence of Arrest from Ages 8 to 23 in a National Sample*, 129 Pediatrics 21, 25 (2012) (finding that by age 23, approximately one of every three U.S. youths is arrested at least once for something more serious than a traffic violation).

[34] *See, e.g.,* Charles Puzzanchera, Office of Juvenile Justice & Delinquency Prevention, *Juvenile Arrests* 2008, Juvenile Justice Bulletin 3 (2008), *available at* https://www.ncjrs.gov/pdffiles1/ojjdp/228479.pdf.

[35] Am. Bar Ass'n Ctr. Children & Law, Juvenile Justice Act 4, *Juvenile Status Offenses (Fact Sheet)* (last visited Feb. 21, 2012), *available at* http://act4jj.org/media/factsheets/factsheet_17.pdf. A "status offense" is conduct that would not be considered a crime if committed by an adult under the law of the jurisdiction in which the offense was committed. *Id.* at 1.

[36] Am. Acad Pediatrics, *Health Care for Youth in the Juvenile Justice System*, 128 Pediatrics 1219, 1220 (2011), *available at* http://pediatrics.aappublications.org/content/early/2011/11/22/peds.2011-1757.full.pdf+html; *see also* Michael Shader, U.S. Dep't of Justice, *Risk Factors for Delinquency: An Overview* 8 (2001), *available at* https://www.ncjrs.gov/pdffiles1/ojjdp/frd030127.pdf.

[37] *See* Am. Acad. Pediatrics, *supra* note 36, at 1220.

[38] *See* Am. Acad. Pediatrics, *supra* note 36, at 1220.

[39] *Id.*; *see* Grisso, *supra* note 8, at 6–13.

[40] *See* Am. Acad. Pediatrics, *supra* note 36, at 1219.

[41] Jaimee L. Heffner et al., *Predicting Alcohol Misusers' Readiness and Ability to Quit Smoking: A Critical Review*, 42 Alcohol & Alcoholism 186, 190-1 (2007), *available at* http://alcalc.oxfordjournals.org/content/42/3/186.full.pdf+html.

[42] Danielle L. Fettes & Gregory A. Aarons, *Smoking Behavior of U.S. Youths: A Comparison Between Child Welfare System and Community Populations*, 101 Am. J. of Public Health 2342, 2346 (2011).

[43] *Id.* at 2346.

[44] *See* Linda Teplin et al., *Psychiatric Disorders of Youth in Detention*, Juvenile Justice Bulletin (2006), *available at* https://www.ncjrs.gov/pdffiles1/ojjdp/210331.pdf; *see generally* Grisso, *supra* note 8.

[45] Grisso, *supra* note 8, at 13.

[46] Ronald Kessler et al., *Lifetime Prevalence and Age-of-Onset Distributions of DSM-IV Disorders in the National Comorbidity Survey Replication*, 62 Archives of General Psychiatry 593, 601, *available at* http://clclinic.cos.ucf.edu/Documents%20and%20Files/Kessler,%20Berglund,%202005.pdf.

[47] Karen Lasser et al., *Smoking and Mental Illness: A Population-Based Prevalence Study*, 284 J. Am. Med. Assoc. 2606, 2610 (2000), *available at* http://jama.ama-assn.org/content/284/20/2606.full.pdf.

[48] Chassin et al., *supra* note 2, at 182.

[49] *See* Andrea J. Sedlak & Carol Bruce, Office of Juvenile Justice & Delinquency Prevention, *Youth's Characteristics and Backgrounds*, Juvenile Justice Bulletin 4 (2010), [hereinafter *Youth's Characteristics and Backgrounds*], *available at* https://www.ncjrs.gov/pdffiles1/ojjdp/227730.pdf.

[50] Dep't of Public Safety, Office of Justice Programs, Youth in Minnesota Correctional Facilities: Responses to the 2007 Minnesota Student Survey (2009), *available at* https://dps.mn.gov/divisions/ojp/forms-documents/Documents/!2010%20Youth%20Corrections%20Report.pdf.

[51] Phyllis L. Ellickson et al., *High-Risk Behaviors Associated with Early Smoking: Results from a 5-Year Follow-Up*, 28 J. Adolescent Health 465, 471, *available at* http://dionysus.psych.wisc.edu/lit/articles/EllicksonP2001a.pdf.

[52] *See* Mark Myers et al., *supra* note 2, at 226.

[53] *See* Myers et al., *supra* note 2, at 226.

[54] *See* Heffner et al., *supra* note 41, at 186.

[55] *See* Myers et al., *supra* note 2, at 226; Ellickson et al., *supra* note 51, at 465-6.

[56] *See* Myers et al., *supra* note 2, at 226.

[57] *See Youth's Characteristics and Backgrounds*, *supra* note 49, at 7.

[58] *See id.*

[59] *See, e.g.,* Holman & Ziedenberg, *supra* note 32, at 2; Am. Acad. Pediatrics, *supra* note 36, at 1229.

[60] Grisso, *supra* note 8, at 134-5.

[61] *See Youth's Characteristics and Backgrounds*, *supra* note 49, at 9.

[62] Joyce Martin et al., U.S. Dep't of Health & Human Servs., *Births: Final Data for 2009*, 60 Nat'l Vital Statistics Rpts 2, *available at* http://www.cdc.gov/nchs/data/nvsr/nvsr60/nvsr60_01.pdf.

[63] *See* Am. Acad. Pediatrics, *supra* note 36, at 1222-3.

[64] Catherine Gallagher et al., *A National Overview of Reproductive Health Care Services for Girls in Juvenile Justice Residential Facilities*, 17 Women's Health Issues 217, 217 (2007).

[65] *See* Am. Acad. Pediatrics, *supra* note 36, at 1223 (finding in one 2004 study that one-quarter of juvenile facilities lacked obstetric services and in another study that one third lacked prenatal services).

[66] *See, e.g.,* Campaign for Tobacco-Free Kids, *Smoking and Pregnancy: The Harms of Continued Smoking and the Benefits of Quitting*1 (2008) (compiling numerous studies on health risks of smoking for pregnant women), *available at* http://www.tobaccofreekids.org/research/factsheets/pdf/0288.pdf.

[67] *See id.* at 3.

[68] U.S. Dep't of Health & Human Servs, Women and Smoking: A Report of the Surgeon General (2001) [hereinafter 2001 Surgeon General's Report], *available at* http://www.ncbi.nlm.nih.gov/books/NBK44303/.

[69] Harold Pollack, *Sudden Infant Death Syndrome, Maternal Smoking During Pregnancy, and the Cost-Effectiveness of Smoking Cessation Intervention*, 91 Am. J. Public Health 432, 432 (2001).

[70] Jennifer Prah Ruger & Karen M. Emmons, *Economic Evaluations of Smoking Cessation and Relapse Prevention Programs for Pregnant Women: A Systematic Review*, 11 Value in Health 180, 180–81 (2008).

[71] *Id.* at 188.

[72] *See, e.g.,* 2006 Surgeon General's Report, *supra* note 27, at 13-19.

[73] Ctrs. for Disease Control & Prevention, *Quitting Smoking Among Adults – U.S., 2001-2010*, 60 Morbidity and Mortality Wkly Rep. 1513, 1517 (2011), *available at* http://www.cdc.gov/mmwr/PDF/wk/mm6044.pdf.

[74] *See* Paul Frijters et al., *Quantifying the Cost of Passive Smoking on Child Health: Evidence from Children's Cotinine Samples*, 174 J. Royal Statistical Soc'y 195, 211 (2011).

[75] E. Kathleen Adams et al., *Smoking Among Medicaid Insured Mothers: What are the Neonatal Expenses?* 26 Health Care Financing Review 105, 105 (2005), *available at* http://www.cmms.hhs.gov/HealthCareFinancingReview/downloads/04-05winterpg105.pdf. Pregnant women on Medicaid are more than twice as likely to smoke as pregnant women not on Medicaid. *Id. See generally* Campaign for Tobacco-Free Kids, *Toll of Tobacco in the United States of America* (2011), *available at* http://www.tobaccofreekids.org/research/factsheets/pdf/0072.pdf. Moreover, annual expenditures through Social Security Survivors Insurance for the more than 300,000 children who have lost at least one parent from a smoking-caused death are approximately $2.6 billion a year. *Id.*

[76] *See* 2010 Surgeon General's Report, *supra* note 27, at iii.

[77] U.S. Dep't of Justice, *Substance Abuse: The Nation's Number One Health Problem*, 17 OJJDP Fact Sheet 2 (2001), *available at* https://www.ncjrs.gov/pdffiles1/ojjdp/fs200117.pdf

[78] Am. Lung Ass'n, *Helping Smokers Quit: Tobacco Cessation Coverage 2011* 4 (2011), *available at* http://www.lung.org/assets/documents/publications/smoking-cessation/helping-smokers-quit-2011.pdf (based on analysis of data from Am. Lung Ass'n & Pa. State Univ., *Smoking Cessation: The Economic Benefits* (2010)).

[79] Am. Bar Ass'n 3, *supra* note 35, at 2.

[80] Nat'l Juvenile Defender Ctr., *The Use and Abuse of Juvenile Detention: Understanding Detention and Its Uses* (2004), *available at* http://www.njdc.info/pdf/factsheetdetention.pdf.

[81] *See Youth's Characteristics and Backgrounds*, *supra* note 49, at 6.

[82] U.S. Dep't of Justice, *Juvenile Offenders and Victims: 2006 National Report* (2006), *available at* http://www.ojjdp.gov/ojstatbb/nr2006/.

[83] *See Youth's Characteristics and Backgrounds*, *supra* note 49, at 6.

[84] This graphic is adapted from "Risk Assessment and Classification at Various Decision Points,"*Alternatives to Secure Confinement*, *supra* note 5, at 7.

[85] Sarah Hockenberry et al., Office of Juvenile Justice and Delinquency Prevention, *Juvenile Residential Facility Census, 2008: Selected Findings*, Juvenile Offenders and Victims: Nat'l Report Series Bulletin 2 (2011), *available at* https://www.ncjrs.gov/pdffiles1/ojjdp/231683.pdf.

[86] *See* Appendix A. *Juvenile Justice Placements and Tobacco Policy Implications*.

[87] Hockenberry et al., *supra* note 85, at 3. Respondents to the Juvenile Residential Facility Census were allowed to select more than one facility type category. Approximately 15 percent identified themselves as group homes/residential treatment centers, group homes/halfway houses, or similar combinations. *Id.*

[88] Andrea J. Sedlak & Karla S. McPherson, Office of Juvenile Justice and Delinquency Prevention, *Conditions of Confinement: Findings from the Survey of Youth in Residential Placement*, Juvenile Justice Bulletin 3 (2010), *available at* https://www.ncjrs.gov/pdffiles1/ojjdp/227729.pdf.

[89] *Id.*

[90] *See Youth's Needs and Services*, *supra* note 1, at 5.

[91] *Id.* at 4.

[92] Grisso, *supra* note 8, at 130-31.

[93] *Id.* at 131.

[94] *Id.*

[95] Michael Fiore et al., U.S. Dep't Health & Human Servs., *Treating Tobacco Use and Dependence: A Clinical Practice Guideline Update* (2008), *available at* http://www.ncbi.nlm.nih.gov/books/NBK63952/.

[96] Susan Curry et al., *A National Survey of Tobacco Cessation Programs for Youth*, 97 Am. J. Public Health 171, 175 (2007), *available at* http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1716253/.

[97] *See* Appendix A. *Juvenile Justice Placements and Tobacco Policy Implications*.

[98] Susan Curry et al., *supra* note 96, at 176.

[99] Scott Henggeler & Sonja Schoenwald, *supra* note 33, at 4.

[100] Laurie Chassin et al., *supra* note 2, at *3.

[101] Edward Perka, Jr., *Culture Change in Addictions Treatment: A Targeted Training and Technical Assistance Initiative Affects Tobacco-Related Attitudes and Beliefs in Addiction Treatment Settings*, 12 Health Promotion Practice 159S, 161S (2012), *available at* http://hpp.sagepub.com/content/12/6_suppl_2/159S.full.pdf.

[102] *See id.*

[103] *See* Perka, *supra* note 101, at 162S.

[104] *Id.*

[105] *Id.*

[106] *See* Shader, *supra* note 36, at 6–7.

[107] *See* Am. Acad. Pediatrics, *supra* note 36, at 1230.

[108] Chad D. Morris et al., *Multiple Perspectives on Tobacco Use Among Youth With Mental Health Disorders and Addictions*, 25 Am. J. Health Promotion S31, S32 (2011); *see also* Tyree Oredein et al, Motivating Adolescent Smokers to Quit Through a School-Based Program: The Development of Youth Quit2Win 172 (2008), *available at* http://www.tobaccoprogram.org/pdf/Adolescent-Smoking&Health-08.pdf

[109] *See generally* Amy Helstrom et al., *Motivational Enhancement Therapy for High-risk Adolescent Smokers*, 32 Addictive Behaviors 2404, 2405 (2007).

[110] *See* Health Education Council, Case Study: *Tobacco Cessation and Policy in the Workforce Development Setting*, 1-20 (2008) [hereinafter HEC Case Study], *available at* http://healthedcouncil.org/docs/tobacco_casestudy-12-9-08.pdf. The following text summarizes key points in the HEC case study.

[111] *See* Perka, *supra* note 101, at 162S.

[112] Dean G. Kilpatrick et al., *Risk Factors for Adolescent Substance Abuse and Dependence: Data from a National Sample*, 68 J. Consulting & Clinical Psychology 19, *8–10 (2000) (finding from a study of 4,023 adolescents aged 12 to 17 years old that adolescents who had been physically assaulted, sexually assaulted, witnessed violence or who had family members with alcohol or drug use problems had increased risk for current substance abuse/dependence).

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