Recommendations and Guidance for Practice in Youth Tobacco Cessation

Micah H. Milton, MPH; Catherine O. Maule, BA; Cathy L. Backinger, PhD, MPH
Dena M. Gregory, MPH

***Objective*: To summarize recommendations from *Youth Tobacco Cessation: A Guide for Making Informed Decisions* for careful consideration, selection, implementation, and evaluation of youth cessation interventions. *Methods*: Recommendations were developed from an evidence review and consensus from a multidisciplinary advisory panel. *Results*: Identified essential elements for selecting, planning, delivering, and evaluating youth cessation interventions. *Conclusions*: Until there is more evidence for effectiveness of youth specific cessation interventions, clinicians and practitoners should adopt treatments that use cognitive-behavioral approaches for youth cessation interventions that require careful planning and rigorous evaluation.**

***Key words*: tobacco cessation, youth/adolescent, cognitive behavioral, tobacco control**

***Am J Health Behav*. 2003;27(Suppl 2):S159-S169**

The US Healthy People 2010 objectives include the following targets for reducing tobacco use by youths: (a) To reduce the use of tobacco products (past month) by youths from 40% to 21%, (b) to reduce cigarette smoking (past month) by youths from 35% to 16%, and (c) to increase the proportion of ever-daily smokers who attempted to quit from 76% to 84%.[1] To achieve these goals, the Centers for Disease Control and Prevention (CDC) recommends that a major goal of any tobacco control program should be to promote quitting among young people and adults.[2]

Youth smoking prevalence is unacceptably high. According to the Youth Risk Behavior Surveillance System (YRBSS) in 2001, 28.5% of youths in grades 9 to 12 are current smokers (defined as having smoked on one or more of the preceding 30 days). The good news is that, among current young smokers, 61% report wanting to quit tobacco use completely, and 59% report trying to quit in the preceding 12 months.[3] Additionally, nearly 64% of middle and high schools report providing tobacco-use cessation services.[4] The bad news is that most attempts are unsuccessful. Contributing to this is the relative paucity of evidence-based treatments for youth cessation. This is in stark contrast to treatments for

Micah H. Milton, Health Scientist, National Center for Birth Defects and Development Disabilities, Centers for Disease Control and Prevention, Atlanta, GA. Catherine O. Maule, Manager, Canadian Tobacco Control Research Initiative, CCS/NCIC National Office, Toronto, ON Canada. Cathy L. Backinger, Health Scientist, Tobacco Control Research Branch, Behavioral Research Program, Division of Cancer Control and Population Sciences, National Cancer Institute, Bethesda, MD. Dena M. Gregory, Community Outreach/Website Manager, Maryland Action Partnership, GKV Communications, Baltimore MD.

Address correspondence to Ms. Milton, National Center for Birth Defects and Development Disabilities, Health, Centers for Disease Control and Prevention, 1600 Clifton Road, MS E-87, Atlanta, GA 30333. E-mail: mmilton@cdc.gov

Table 1
Public Health Service Clinical Practice Guideline Recommendations for Youth Cessation

The Public Health Service's Clinical Practice Guideline for Treating Tobacco Use and Dependence advises that for youth cessation:

1. Clinicians should screen pediatric and adolescent patients and their parents for tobacco use and provide a strong message regarding the importance of totally abstaining from tobacco use.
2. Counseling and behavioral intervention shown to be effective with adults should be considered for use with children and adolescents. The content of these interventions should be modified to be developmentally appropriate.
3. When treating adolescents, clinicians may consider prescriptions for buproprion SR[a] or NRT[b] when there is evidence of nicotine dependence and desire to quit tobacco use.
4. Clinicians in a pediatric setting should offer smoking cessation advice and interventions to parents to limit children's exposure to secondhand smoke.

a Sustained release
b Nicotine replacement therapy

Fiore MC, Bailey WC, Cohen SJ, et al. Treating Tobacco Use and Dependence: Clinical Practice Guideline. Rockville, MD: U.S. Department of Health and Human Services, Public Health Service, 2000.

adult tobacco use and dependence. The recently updated Public Health Service (PHS) clinical practice guideline identified approximately 6000 published studies and based recommendations on 180 studies that focused on adult cessation.[5] In the case of youth tobacco cessation, fewer than 80 studies on the subject had been published in scientific journals as of spring 2001, or just over 1% of the volume of adult cessation research.[6]

With regard to adult tobacco use and cessation, the PHS guideline panel reached several conclusions: Tobacco dependence is a chronic condition that often requires repeated intervention; if willing to quit, tobacco users should have access to effective treatments; if unwilling, tobacco users should be provided with brief interventions to increase their motivation to quit; there is a strong dose-response relationship between the intensity of tobacco cessation counseling and its effectiveness; social support (within or outside the treatment setting) and teaching problem-solving skills both help tobacco users quit; pharmacotherapies are available and should be used in the absence of contraindications for persons experiencing symptoms of nicotine withdrawal; and cessation is clinically proven and cost-effective in relation to other medical and disease-prevention strategies.[5]

The panel drew on these conclusions and their expert opinions to offer recommendations (Table 1) for health care providers to address youth cessation. In essence, the recommendations state that, until there is more evidence for the effectiveness of youth-specific cessation interventions, clinicians should consider adapting for youths the behavioral and pharmacological treatments that have proven effective with adults. Other such recommendations promote the use of anticipatory guidance by clinicians and define the role of the clinician as a role model and advocate.[7]

The few clinical trials among youths, however, suggest that adapting adult strategies may not be effective for youth tobacco-use treatment, for example, pharmacologic treatments. Existing guidelines thus provide little guidance for individuals in community-based settings and organizations (eg, schools, youth organizations) that are motivated to provide cessation services for the youths who wish to quit. To fill this gap, the Youth Tobacco Cessation Collaborative convened advisory panels that synthesized evidence and their expert opinions to develop practical guidelines for informed decision making about youth cessation

Table 2
Components of a Comprehensive Tobacco Control Program

- Tobacco use prevention efforts involving education and countermarketing.
- Legislative and policy efforts to limit tobacco use, stop tobacco advertising and promotions, promote clean indoor air, restrict youth access to tobacco, and increase the cost of tobacco through taxation.
- Enforcement of existing laws and policies.
- Cessation interventions, for adults and youths.
- Interventions to prevent and/or reduce the burden of chronic diseases related to tobacco use.
- Surveillance and evaluation to improve knowledge about best practices in tobacco control.
- Administration and management activities that can coordinate tobacco control efforts at both the community level and at the level of the state, province, or other larger jurisdiction.
- Tobacco control efforts that operate at multiple levels (ie, state or province, community, and school).

Centers for Disease Control and Prevention. Best Practices for Comprehensive Tobacco Control Programs. Atlanta, GA: Centers for Disease Control and Prevention 1999:3.

U.S. Department of Health and Human Services. Reducing Tobacco Use: A Report of the Surgeon General. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health 2000.

programming. A product of this effort, *Youth Tobacco Cessation: A Guide for Making Informed Decisions*,[8] was developed to orient users to the comprehensive tobacco control perspective, highlight important considerations in developing an implementation plan for cessation interventions, present the most promising types of interventions for youth tobacco cessation, and describe critical evaluation issues. The remainder of this article summarizes major conclusions and recommendations for each topic.

Youth Tobacco Cessation as a Component of Comprehensive Tobacco Control

Comprehensive tobacco control efforts that include clean indoor air, minor access policies, price increases, mass media campaigns, and availability treatment services create a supportive environment for tobacco-use cessation. Table 2 summarizes components that make a tobacco control program comprehensive, according to CDC.[2] Clearly, no one organization or community entity will be able to implement every component of a comprehensive program; however, there are synergistic advantages to coordinating the tobacco control efforts of different organizations to ensure that all components are implemented.

For example, strong regulatory policies to deter tobacco use among youths can provide the impetus for developing community-based resources for youth tobacco cessation. In one state, the passage and enforcement of legislation that provided penalties for youth tobacco possession created a demand for youth cessation interventions as diversion for youths who were cited for underage possession. The state developed a short series of cessation classes that, although helping participants quit smoking, had limited reach into the general population of young smokers. However, this modest initial effort was leveraged with tobacco settlement funding to establish a statewide youth cessation quitline.

Counteradvertising can play a significant role in reducing youth tobacco use. Mass media campaigns that counter tobacco industry advertisements can help create an environment in which it is less acceptable to use tobacco and potentially increase motivation to quit. Counteradvertising aimed at preventing tobacco use among youths can increase demand for youth cessation services.

Increasing the unit price of tobacco products is an effective way to increase cessation among youths and adults, and prevent tobacco use initiation. In 2002, 20 states increased the unit price of tobacco products by raising excise taxes.[9] Every 10% increase in the price of tobacco

Table 3
Community Needs and Organizational Assessment: Constructs and Examples of Information to Obtain

Profile of Target Population
- Number of youths expected to participate in the cessation intervention.
- Age(s) or grade level(s) of youths who are being served.
- Types and amounts of tobacco used by those youths.
- Emotional or psychological factors that may influence tobacco use and cessation (eg, depression, social anxiety, violence and other risk-taking behavior).
- Other substance use/abuse common among the target population.
- Cultural factors that might affect tobacco use and cessation.
- Apparent level of interest in or motivation for quitting among youths, and their willingness to participate in supportive interventions or services.
- Youth participation in extracurricular school activities or other organized leisure activities.
- Segments of the target population that may be difficult to reach (eg, high-school dropouts, youths living in rural areas).

Community Context/Environmental Factors
- Level of support or demand among community members (eg, parents, school administrators, health care providers) for tobacco cessation services for young people.
- Community activities and interventions that reinforce tobacco cessation messages (eg, tobacco-use, prevention programs, mass media campaigns, tobacco product price increases).
- Tobacco control policies in place in the community, and the degree to which they are enforced.
- Social acceptability of tobacco use in the community, and factors that may lead to community resistance to cessation activities (eg, local economic dependence on tobacco production, cultural norms involving tobacco use).

Sponsoring Agency/Organization Profile
- Level of priority placed on tobacco control within the mandate, and activities of the sponsoring agency or organization.
- Organizational leaders who have indicated support for youth cessation activities.
- Programs sponsored by the organization that may compete with or reinforce the cessation intervention's messages about tobacco use.
- Ways to support the intervention with funds, services, or materials (eg, new revenue sources, partnerships, reallocation of funds).
- Estimates of potential costs to the organization, including the costs of human and material resources, and of adequately recruiting and encouraging youths to fully use the services.
- Credibility of the agency or organization as a source of information among youths and in the community at large.
- Organizational goal for the intervention (eg, to ensure that youths in the community have access to effective cessation programs, and to provide a program that will help 20% of young smokers quit over the next year).

products results in an estimated 3.7% decrease in the number of youths who use tobacco.[10]

Planning for a Youth Tobacco Cessation Intervention

It is important to invest time and energy in strategic planning and needs assessment prior to selecting and implementing a youth tobacco-use cessation program. Planning activities include assessing the organization, developing an implementation plan, setting realistic goals, and determining a marketing strategy.

Community and organizational assessment. The planning process should begin with an assessment of organizational capabilities and an understanding of the basic characteristics of youths to be served by a cessation intervention. Table 3 illustrates categories and types of questions that can guide this assessment. With regard to the target population, significant information includes ages, major types of

Table 4
Key Elements of an Intervention Plan

Information needed to develop an intervention plan includes:

- Number of youths who could benefit from cessation interventions or services, and the number who have expressed interest in the service or a willingness to participate.
- Expected quit rate and other potential benefits (eg, reductions in tobacco use, improvements in general health) of the intervention.
- Time available to select and implement an intervention, and the time period over which it can be delivered.
- Available budget for the cessation intervention.
- Settings in which (eg, high school classrooms) or channels through which (eg, telephone lines) interventions may be delivered.
- Ways in which youths can learn about the availability of the intervention.
- Costs associated with the settings or channels through which the intervention will be delivered and advertised (eg, renting space, paying for phone service, purchasing media coverage).
- Ways to enable youth access to the intervention, such as release time from class or transportation to venues outside school.
- Sources of referral to cessation intervention (eg, physicians, teachers), and reason for enrollment (ie, mandatory or voluntary).
- Persons who can support youths in their attempts to quit (eg, peers, family members, community leaders).
- Strategies in place to reengage youths who withdraw from the intervention (eg, referral to a more suitable intervention, a reenrollment strategy so that the youth can complete the intervention).
- Sources through which facilitators or counselors can be located and recruited (if not already present in the organization).
- Sources of funding, and/or resources for and estimated time needed for sufficient training to ensure that facilitators or counselors are competent in the intervention content and in general issues of youth development and behavior.
- Payroll costs for staff.
- Indicators of facilitators' credibility with the target population (eg, certification, previous experience).
- Means by which ongoing supervision can be provided for the interventions (including peer support, if relevant).
- Print materials (eg, worksheets, games, brochures) needed, and means of obtaining or developing them.
- Other materials needed and sources for obtaining them.
- Costs associated with materials and equipment.
- Ways in which costs may be kept down without compromising the integrity or effectiveness of the intervention (eg, checking for the availability of donated materials or services).
- Ways in which the intervention will be monitored to determine if it is implemented and delivered as intended.

tobacco products used, and the presence of other problems such as psychological disorders or other substance use. Community-context factors relate to the priority given tobacco cessation services among community members, other tobacco control policies, and the availability of supportive community leaders. A profile of the sponsoring agency's or organization's capacity focuses on leadership support, logistic and financial feasibility, and the consistency of tobacco-use cessation programming with the organization's mission. Community and organizational assessment does not need to be expensive or involve formal data collection. Some information will be available from local health departments and state-level summaries that are available online at the CDC web site (www.cdc.gov). Much information can be found in the collective experience and knowledge of program staff.

Implementation plan. Assuming that the community and organizational assessment supports the importance and feasibility of implementing an intervention, the next step in the process involves developing an implementation plan. Table 4 summarizes key elements of an intervention plan. At this point, it is important

Table 5
Basic Elements of a Cognitive-Behavioral Intervention

Establish Self-awareness of Tobacco Use
- Record tobacco use behaviors.
- Discuss thoughts, beliefs, and reasons for using and not using tobacco.
- Learn about the physical and psychological effects of tobacco use.

Prepare to Quit
- Set a specific and reasonable quit date.
- Choose a quit method (eg, cold turkey, gradual reduction), and set short- and long-term goals appropriate to quit method.
- Learn about the physical and psychological symptoms of withdrawal.

Provide Strategies to Maintain Abstinence
- Use problem-solving techniques to minimize effects of situational triggers.
- Develop coping skills (thoughts and actions).
- Seek social support from family and peers.
- Develop strategies to monitor and reinforce progress.

to set realistic goals for staffing, delivery method, participant recruitment and retention, and anticipated tobacco cessation rates. Each of these elements can and likely will be modified with experience.

Setting realistic goals. Perhaps most important is setting realistic goals for youth participation and cessation rates. A study published in this issue by McDonald et al found that quit rates for those who received cessation intervention compared to a control group were 8 percentage points on average and ranged from 5 to 20 percentage points. In selecting and planning an intervention, its reach can be balanced (ie, the number of youths who will receive the program) with its intensity (ie, the amount of time spent in treatment and supporting services). Interventions that are lower in intensity but reach thousands of youths may experience quit rates as low as 1% or 2%. Such an intervention could have a significant public health impact, however, if it reached 100,000 youths (1% equals 1000 quitters). This would be a much greater impact than an intervention with a 20% quit rate that reached only 50 youths. Thus, the goal is to optimize these factors to provide the most intensive intervention possible to the greatest number of youths.

Selecting a Youth Cessation Intervention

Format selection. Selecting a cessation intervention involves decisions about program format and content. Cessation intervention formats include brief interventions, noninteractive self-help, computer-based programs, telephone counseling, group counseling, and individual counseling. Brief interventions are delivered individually, in-person, by a health care provider or other trained professional (eg, teacher, youth group leader). They typically last 5 to10 minutes and involve an assessment of motivation to quit, advice on benefits and methods of quitting, and assistance with quitting, including referral to other treatment. Noninteractive self-help interventions are delivered via written materials (eg, self-help booklets) or audiovisually (eg, videotapes). Expert consensus and research with adults indicate that these are best used in conjunction with other formats (eg, brief counseling, telephone counseling, or group interventions).[5] Computer-based interventions use information technology to tailor youth counseling and feedback based on information they provide about their tobacco use and motivation to quit. Telephone interventions can offer support of varying intensity while reducing barriers to treatment participation (eg, the need for transportation, scheduling conflicts, confidentiality concerns). Telephone counseling may be initiated by the tobacco user, but this is typically followed by proactive, outreach counseling and support calls. Group counseling

involves the planned and structured delivery of behavior-change strategies through a series of sessions delivered to a group of youths. Groups often make use of mutual support as well as counseling by trained facilitators or therapists. Individual counseling is delivered in person by a trained counselor or therapist using any of various behavior-change strategies and therapies. This is generally the most intensive way to deliver an intervention, but it typically requires a substantial investment of resources. Programs must have sufficient capacity to recruit, train, and supervise facilitators to use this one-on-one approach.

Factors to consider in choosing an intervention format include intervention costs, the need for ancillary services, and characteristics of the target population. Though there is a lack of evidence about the effectiveness of these approaches for youths, some recommendations have been based on adult interventions, expert opinions, and experience. For example, telephone counseling (shown to be effective for adults) is likely to be most appropriate for reaching geographically isolated youths in rural areas or serving youths who want anonymity when seeking assistance. Face-to-face counseling (shown to be effective for adults) would be more appropriate for youths who have psychological and/or physical comorbidities (eg, depression, other substance use disorders). As noted earlier, format selections need to balance intervention reach and intensity.

Content selection. The better-practices evidence review concluded that the most promising interventions for youth tobacco cessation employ principles of cognitive-behavioral approaches to behavior change.[11-14] Such approaches work to identify and change thought processes that maintain tobacco use and teach skills or strategies that can help stop tobacco use and maintain cessation. Elements of a cognitive-behavioral intervention include establishing awareness of tobacco use, providing motivations for cessation, preparing to quit, and providing strategies for coping with challenges to maintaining abstinence after cessation.

The cornerstone of cognitive-behavioral approaches has been skill training for alternative behaviors to tobacco use. For youths who may turn to tobacco use because they lack healthier ways to respond to problems such as resisting peer pressure or coping with anger, skill training is an important part of cessation interventions. A variety of skills may be taught as part of tobacco-use cessation interventions including: (a) assertiveness training for youths who have difficulty expressing views or making decisions when pressured; (b) social skills training for youths who have more general difficulties in interpersonal situations (this often includes teaching effective communication — listening and speaking — skills); (c) anger control for youths who have difficulty controlling anger, or who exhibit inappropriate anger and whose anger may lead to tobacco use; (d) social-support-seeking skills to teach youths how to ask for help; (e) relaxation training (including physical relaxation skills such as yoga, and cognitive methods such as meditation) for youths who have difficulty relaxing and may use tobacco to help themselves relax; and (f) problem solving to enable youths to identify and cope with high-risk situations that could lead to a return to tobacco use.

Pharmacotherapy. In addition to behavioral counseling programs delivered in a variety of formats, there may be interest in or demand for pharmacotherapies to help with quitting. The US Food and Drug Administration (FDA) has approved for adults over-the-counter use of nicotine gum, patches and lozenges, and prescription use of the nicotine inhaler, nicotine nasal spray and bupropion SR (sustained release), sold as Zyban®. There are important considerations regarding the use of medications with youths. First, no over-the-counter or prescription products have been approved by the FDA for use by individuals under age 18. Second, although shown to be effective with adults, none of the youth clinical trials that used pharmacotherapy for cessation have shown effectiveness.[15,16] The PHS clinical practice guideline notes that health care providers may decide to use pharmacotherapies with youths if they determine that the risks associated with their use are lower than those associated with continued tobacco use. Any program that considers the use of pharmacotherapy as an intervention should provide it only upon proper medical assessment, recommendation, and supervision by a medical health care

Table 6
Key Questions for Process Evaluation

Questions and Examples	Sources of Information	How to Use the Information
How many participants were present at the initial session?	·Phone logs (for interventions delivered via phone). ·Records of meeting attendance.	Determine the relative success of your recruitment methods.
How did participants hear about the intervention?	·Entrance or pre-entrance questionnaires.	Determine the success of marketing efforts, and adjust recruitment methods for future activities.
How many participants completed the intervention?	·Exit or postintervention surveys. ·Attendance records.	Determine the retention rate.
How satisfied were the participants with the quality of the services?	·Exit or postintervention surveys of focus groups. ·Follow-up surveys or focus groups with youth who dropped out of the intervention.	Understand reasons for participant retention, and identify areas for improvement.
How many participants were chemically validated, if chemical validation was used?	·Records of chemical validation tests (eg, expired carbon monoxide or saliva cotinine testing).	Confirm reports of quitting.
What types of activities, and how many of each type occurred during the intervention implementation?	·Logs of intervention activities that were actually implemented.	Document how closely the intervention plan was followed.
What amount of time spent with participants?	·Logs of session length and frequency.	Document intervention fidelity, and determine the allocation of resources (financial or otherwise).
What aspects of the intervention deviated from the protocol?	·Logs of intervention activities that were actually implemented and exceptions that were made.	Document intervention fidelity.
What staffing was required to implement the intervention?	·Staff logs that note the number of hours worked and hourly pay rate.	Determine the allocation of human resources and costs.
How many staff training workshops were conducted? What evidence was there that training helped staff deliver the intervention?	·Logs of staff training hours. ·Staff surveys.	Determine the extent of staff training needed for a given level of effectiveness, and how much training improved staff effectiveness.
What money, services, and materials were used to provide the intervention?	·Logs of program expenditures and donations of services and materials.	Determine if the intervention is cost effective.

provider.[5]

Selecting prepackaged interventions. Although the research base for effective tobacco-use cessation interventions for youths is meager, prepackaged interventions are available. Some interventions may be available at minimal cost; others may be offered for purchase. Selection should be based on a clear and thorough description of the entire intervention. Important information to ask for includes: (a) program goals, objectives, and desired outcomes; (b) intervention content, including a curriculum if applicable; (c) an implementation protocol; (d) recruitment strategies; (e) training manuals; (f) examples of materials for participants; and (g) evaluation tools. Before purchasing an intervention, ask to see evidence of its effectiveness, including detailed information on how and with whom the intervention was evaluated. It is recommended that quit rates 6 months after the end of the intervention be used to evaluate intervention effectiveness. Preferable are interventions that have been developed for and tested with youths from similar cultural, developmental, and educational backgrounds as those in the target population. If a program has not been tested with a similar target population, find out if the developers provide technical assistance for adapting the intervention to other populations. Also important is the clarity of instructions provided for implementation, and the degree of flexibility in the implementation protocol. Steps needed to provide the intervention effectively should be clearly understood.

Monitoring Progress: Process and Outcome Evaluation

Evaluation should be an integral part of any youth tobacco-use cessation intervention. Evaluation data can be used to adjust an intervention and increase its effectiveness and impact over time. *Process evaluation* focuses on a program's operation and implementation. *Outcome evaluation* focuses on changes in youth tobacco-use behavior associated with intervention participation. Detailed coverage of program evaluation is beyond the scope of this summary, but can be found in a recent CDC publication, *Introduction to Program Evaluation for Comprehensive Tobacco Control Programs.*[17]

Process evaluation. Because a process evaluation compares what is actually done to implement an intervention compared to the ideal implementation, it begins with a detailed description of implementation plans, intended participants, location, length, content, and costs of the program. Table 6 summarizes key questions for a thorough process evaluation, sources of information, and how the process evaluation information may be used. A fair amount of process evaluation is based on information recorded during program implementation in attendance logs, surveys completed by program participants, bookkeeping records, and staff logs. Maintaining and reviewing such information can help a program determine the success of its recruitment methods, how well participants are retained in the program, how closely the intervention followed the original treatment plan, how well staff were trained, and how much it actually costs to deliver.

Outcome evaluation. Key questions for outcome evaluation are summarized in Table 7. The major outcome (tobacco-use cessation) is the rate of abstinence from tobacco at the end of treatment and at one or more follow-up points (preferably at least 6 months postintervention). Secondary outcomes may include the number of serious attempts to quit smoking over time, longest periods of abstinence from tobacco achieved during and after the intervention, motivation to quit among participants who do not quit tobacco use, and amount of tobacco use among nonquitters.

It is important to calculate quit rates and other outcomes by including all tobacco users who enrolled in the program in the denominator, not just those who could be reached at follow-up. This is necessary because intervention effectiveness must account for all factors that influence intervention participation and completion (eg, attrition). Attrition and loss to follow-up must be taken into account when calculating intervention outcomes to produce results that reflect the general population of young tobacco users rather than only those who were retained in the intervention and those who could be reached postintervention. Though this method is likely to produce more conservative quitting estimates, it is the most appropriate way to determine the quit rate. It cannot be assumed that those who did not complete the intervention or who could not be reached during follow-up actually quit. Further analysis would be

Table 7
Key Questions for Outcome Evaluation

Questions and Examples	Sources of Information	How to Use the Information
How many tobacco users who started the intervention were no longer using tobacco: ·At the end of the intervention? ·At 6 months postintervention? ·At 12 months postintervention?	· Exit and postintervention client surveys conducted at conclusion of intervention and regularly thereafter (6 and 12 months preferred).	To determine the effectiveness of the intervention.
What was the number of serious quit attempts (eg, 24 hours or more of nonuse with the intention of quitting) by each smoker: ·At the end of the intervention? ·At 6 months postintervention? ·At 12 months postintervention?	· Exit and postintervention client surveys conducted at conclusion of intervention and regularly thereafter (6 and 12 months preferred).	To compare the number of youths who attempt to quit to the number who successfully quit.
Do individuals use other types of tobacco besides cigarettes (eg, chew, dip, biddies, cigars, pipes)?	· Initial surveys and exit interviews.	Document all tobacco use, and, in particular, determine if smokers are switching to other tobacco products in their attempts to quit.
What was each individual's longest period of abstinence: ·At the end of the intervention? ·At 30 days postintervention? ·At 6 months postintervention?	· Exit and postintervention client surveys conducted at conclusion of intervention and regularly thereafter (6 and 12 months preferred).	Provides another outcome measure for youths who did not quit for good (ie, did not meet the primary goal of the intervention).
How motivated and prepared for and/or confident about quitting were participants: ·At the beginning of the intervention? ·At the end of the intervention? ·At 6 months postintervention? ·At 12 months postintervention?	· Entrance or pre-entrance surveys and interviews. · Exit and postintervention client surveys conducted at the conclusion of intervention and regularly thereafter (6 and 12 months preferred).	To determine how motivation was influenced by the intervention, and how motivation influenced quitting.
If smokers, how many cigarettes do participants smoke (eg, each day, week, month)? How much of a cigarette do they smoke? What quantity of other forms of tobacco do participants use?	· Entrance and postintervention client surveys.	To track changes in consumption for youths who did not quit or remain abstinent.

required to determine if those who did not complete the intervention and/or were unable to be contacted were similar to youths who completed the intervention and who were contacted at follow-up.

CONCLUSION

The lack of convincing evidence on which to base recommendations for best practices in youth tobacco cessation is frustrating to the many dedicated individuals who wish to provide effective resources for youths who wish to quit using tobacco. As research to evaluate innovative treatment approaches continues, we can be encouraged by the fact that the

most promising methods to emerge from 2 reviews[6] of existing evidence are cognitive-behavioral treatments, which form the foundation for state-of-the-art behavioral treatments that are proven effective for adult cessation. What should be clear from the guideline recommendations summarized in this paper is that an effective cessation program involves much more than having the right "content." Also important are the community context, organizational capacities and support, careful planning for program selection and implementation, and commitment to careful record keeping and tracking of program participants for process and outcome evaluation. We encourage those with interest in and the ability to provide youth tobacco-use cessation resources to obtain a full copy of *Youth Tobacco Cessation: A Guide for Making Informed Decisions*,[8] and we wish them success in their efforts. ■

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