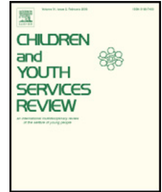
Children and Youth Services Review 58 (2015) 142–145

Contents lists available at ScienceDirect

Children and Youth Services Review

journal homepage: www.elsevier.com/locate/childyouth



# Tobacco use among foster youth: Evidence of health disparities

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ARTICLE INFO

*Article history:*
Received 30 July 2015
Received in revised form 19 September 2015
Accepted 19 September 2015
Available online 25 September 2015

*Keywords:*
Foster care
Tobacco use
Aging out
Substance use

ABSTRACT

Youth aging out of foster care face a challenging road to independence. Following exposure to myriad risk factors such as abuse, neglect, parental substance use, and severe housing mobility, supportive services decrease upon exit from care, often increasing risk for substance use, homelessness, and unemployment. Although tobacco use is also highly prevalent, little attention has been paid to screening, assessment, and treatment of tobacco use in this vulnerable group. The current study ($N = 116$) reports on tobacco use prevalence, consequences, and co-occurrence with other substances in a sample of youth (ages 18 to 19) exiting the foster care system. In the face of an overall decrease in tobacco use among general population adolescents and young adults, results suggest disproportionate levels of lifetime, recent, and daily use among foster youth. Prevalence of recent tobacco use (46%) is nearly triple national rates, while daily smoking (32%) is almost four times that of general population young adults. Tobacco users were more likely than non-users to drink (70% vs. 40%) and to smoke marijuana (72% vs. 25%). We strongly encourage researchers and practitioners to increase attention to this tobacco-related health disparity.
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## 1. Introduction

Tobacco use is the single most preventable cause of morbidity and premature mortality in the United States, accounting for nearly 480,000 annual deaths (U.S. Department of Health and Human Services, 2014). While the last 20 years have seen a substantial decline in the prevalence of U.S. adolescent and young adult cigarette smoking (Johnston, O'Malley, Miech, Bachman, & Schulenberg, 2015), many vulnerable subpopulations (e.g., LGBT, those living with a disability, individuals experiencing homelessness) have not experienced these changes (Baggett & Rigotti, 2010; Green et al., 2007; Lee, Griffin, & Melvin, 2009; Schroeder & Morris, 2010). Foster youth are one such at-risk group, as maltreatment and neglect are strongly related to smoking behavior. For example, maltreatment and other adverse childhood experiences (ACEs) such as childhood abuse, substance use in the home, mental illness in the home, and parental separation predict early initiation of tobacco use, lifetime use, current use, and heavy smoking (Anda et al., 1999; Ford et al., 2011; Mills, Alati, Strathearn, & Najman, 2014), independent of other known risk factors such as parental smoking and household substance abuse. While a graded relationship exists between ACEs and smoking (Anda et al., 1999; Ford et al., 2011), maltreatment is particularly harmful, prospectively predicting nicotine dependence above and beyond other ACEs (Elliott et al., 2014). Given their disproportionate exposure to ACEs, foster youth are at extreme risk for developing harmful tobacco use behaviors.

Indeed, the National Study on Child and Adolescent Well Being – a nationally representative study of youth in the U.S. child welfare system – indicated that nearly half (48%) of youth (aged 11–15) in out-of-home care situations (i.e., traditional foster care, kinship foster care, and group care, $n = 331$) were lifetime cigarette smokers; over one-third (37.4%) of these lifetime smokers reported current cigarette smoking (U.S. Department of Health and Human Services, 2005). Nearly identical rates were reported among adolescents in Missouri foster care, with 38.1% identifying as current smokers (Scott, Munson, McMillen, & Ollie, 2006). Looking outside the United States, smoking prevalence within foster care populations is comparable, if not higher. For example, among 58 foster youth in Serbia and Montenegro, 79.3% reported lifetime cigarette use and over half (55.2%) were current smokers (Backović, Marinković, Grujlčić-Šipetić, & Maksimović, 2006). Of the 32 current smokers in that study, over 4 in 5 (81.3%) smoked 5–7 days per week. Among three independent samples of Turkish youth residing in social service settings (e.g., orphanages, foster care), current smoking rates ranged from 19.7% to 32.2% (Caman & Ozcebe, 2011; Erguder et al., 2009; Erol, Simsek, & Münir, 2010).

The remainder of available data on the high prevalence of tobacco use among foster youth, however, comes from U.S. studies of other at-risk or general populations in which former foster care placement is ancillary. For example, within the AddHealth sample (a nationally representative sample of general U.S. adolescents), 45% of participants with a history of foster care acknowledged being a current smoker (Snyder & Medeiros, 2013). In a study involving substance-using homeless youth aged 15–25, 98% of those who had been in foster care ($n =$

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http://dx.doi.org/10.1016/j.childyouth.2015.09.017
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44) reported lifetime tobacco use (Hudson & Nandy, 2012). Similarly, in a sample of chronically delinquent boys in foster care (aged 12–17, $n = 79$), 78% reported tobacco use in the past 6 months (Smith, Chamberlain, & Eddy, 2010). In a sample of adolescents receiving substance use treatment (aged 12–17), 60% of those who had a foster care placement in the last year ($n = 366$) were weekly tobacco users, which was significantly greater than those without such a history (48%; Coleman-Cowger, Green, & Clark, 2011). Among newly homeless young adults aged 18–21, those with a history of foster care ($n = 147$) were three times more likely to be current smokers (Thompson & Hasin, 2011). A limitation of the extant literature is that this selection of samples involves current substance use, homelessness, and/or delinquency, all of which are also associated with risk for tobacco use. However, even among these high-risk populations, a history of foster care is associated with even greater tobacco use prevalence.

Among foster youth, moreover, those exiting or "aging out" of the system are a group at particular risk. Although the transition to adulthood is difficult for many in the general population, the path out of foster care and into independence presents additional challenges (Masten, Obradovic, & Burt, 2006; Osgood, Foster, Flanagan, & Ruth, 2005; U.S. Department of Health and Human Services, 2007). In addition to the ACEs noted above, youth experience significant home and school instability while in the foster care system, both of which negatively impact the scaffolding from which adolescents build a successful path to adulthood (Geenen & Powers, 2007; McCoy, McMillen, & Spitznagel, 2008). Upon exit, these youth experience alarmingly high rates of substance use, unemployment, unstable housing, and both psychiatric and physical health issues (Courtney & Dworsky, 2006; Courtney et al., 2005; Courtney, Piliavin, Grogan-Kaylor, & Nesmith, 2001; Pecora et al., 2006). In fact, almost half of aged out youth report housing instability, and one in five report chronic homelessness within two years of leaving foster care (Fowler, Toro, & Miles, 2009). Combined with decreasing access to health services (Casanueva, Stambaugh, Urato, Fraser, & Williams, 2011; McCarthy, Van Buren, & Irvine, 2007), aging out youth may find themselves surrounded by factors that augment their already increased likelihood of tobacco use and tobacco dependence.

Such data, however, are sparse, with only one study of tobacco use among former foster youth, who were also homeless (Thompson & Hasin, 2011). The current study fills this gap in the literature by reporting the prevalence of tobacco use among a general sample of youth aging out of foster care. Additionally, this report moves the field forward by being the first to examine prevalence of tobacco dependence symptoms and co-occurrence of other substance use in this population.

## 2. Material and methods

### 2.1. Procedures

Young adults aging out of foster care were recruited from a large New England agency serving individuals receiving transitional foster care services. Data for the current study were derived from the screening measures for a larger intervention development project (Braciszewski et al., in press). Young people were identified through flyers and referral by agency staff, and were then invited to be screened for the larger study. Specifically, flyers advertised a general health study for former foster youth aged 18 or 19. Agency staff referred all program youth to study interviewers using the same criteria (i.e., they asked any 18 or 19 year old in the program if they were interested in hearing more about a health study). For screening, youth also needed to have left child welfare custody within the past 2 years. Given the focus of the program from which individuals were being recruited, all 18 and 19 year olds met this criterion. Once the referral criteria were met, youth were then asked a series of questions to determine eligibility for the parent study. Only 1 young person who met the referral criteria declined to complete the screening measures. Full screening took no more than 10 min and participants did not receive a monetary incentive.

### 2.2. Participants

In total, 116 young people completed the screening procedure for the larger study. On average, participants were just over 19 years old ($M = 19.04$ years, $SD = 0.60$) and had been removed from foster care for an average of 9.84 months ($SD = 7.75$). Cell phone ownership was nearly ubiquitous (98%), with all owners using text messaging as a form of communication.

### 2.3. Measures

History of substance use was collected using the Alcohol, Smoking, and Substance Involvement Screening Test (ASSIST; WHO ASSIST Working Group, 2002). The ASSIST evaluates frequency and consequences of use for a variety of substances, separately. For this study, we assessed use of tobacco ("tobacco products (cigarettes, chewing tobacco, cigars, etc.)"), alcohol, marijuana, cocaine, amphetamines, inhalants, sedatives, hallucinogens, opioids, prescription opioids, bath salts, and synthetic cannabinoids. Weighted scores are assigned and summed for a total score, which can be used to categorize risk level (i.e., low, moderate, and high). Moderate and high risk scores are strongly predictive of interview-based determinations of substance use disorders (Humeniuk et al., 2008). Descriptive statistics on tobacco use are presented, as well as on co-occurring tobacco, alcohol, and marijuana use.[1]

## 3. Results

Table 1 illustrates prevalence of tobacco and other substance use among the full sample, recent tobacco users (i.e., past 3 months), and those who have not recently or ever used tobacco. With regard to overall frequency, 62% ($n = 72$) reported lifetime tobacco use and nearly half (46%) indicated recent use ($n = 53$), defined as at least one day in the last three months. About one-third (32%) of the full sample identified as "daily or almost daily" tobacco users; such individuals represented almost 70% of recent users. Nearly all recent tobacco users endorsed symptoms of tobacco dependence, with 87% reporting recent (i.e., past 3 months) cravings and one-third experiencing psychosocial problems (e.g., social, health, financial) due to tobacco use. Almost half (46%) had unsuccessfully attempted to quit or cut down at some time in the past. Among the full sample, 57% were categorized as low risk (or had never used), 32% were moderate, and 11% were high risk.

Co-occurrence of alcohol and marijuana use was very common (see Table 1). Among individuals endorsing recent tobacco use, 70% reported concurrent alcohol use, significantly more than those who were not recent tobacco users (40%). Co-occurring marijuana use rates were even higher, with 72% of recent tobacco users endorsing marijuana use compared to just 25% of non-tobacco users. Correspondingly, likely rates of both alcohol and marijuana use disorder (i.e., scoring at moderate or high risk) were significantly higher among recent tobacco users. In addition to nearly ubiquitous co-occurrence of tobacco and marijuana use, such use was generally at high levels. Specifically, 89% of recent co-users of tobacco and marijuana would likely meet criteria for a marijuana use disorder. Finally, over one-quarter (26%) of recent tobacco users reported daily use of both tobacco and marijuana.

## 4. Discussion

Youth exiting foster care evidence high rates of tobacco use and co-occurrence with alcohol and marijuana, putting many of these vulnerable youth at risk of continuing their use of tobacco into adulthood. Lifetime tobacco use rates found here mirror that of other child welfare and foster care samples (Coleman-Cowger et al., 2011; Hudson & Nandy, 2012; Smith et al., 2010; Thompson & Hasin, 2011). Best comparisons with

[1] Endorsement of using other substances was so low as to preclude presentation.

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