



Awareness and intervention approaches related to smoking addiction among child and adolescent psychiatrists

Çocuk ve ergen psikiyatristlerinin sigara bağımlılığı ile ilgili farkındalıkları ve müdahale yaklaşımları

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The known about this topic

Smoking is a public health problem with gradually increasing importance that also affects children and adolescents. Child and adolescent psychiatrists should intervene with their patients in this area to protect physical and mental health.

Contribution of the study

Although most physicians (52.5%) asked about smoking status, which is included in the first step in the 5As approach used in smoking cessation, it was observed that they implemented further steps of the 5As with gradually decreasing rates in our study. It was found that physicians working with pediatric and adolescent patients in Turkey had low levels of awareness about smoking addiction, and they did not feel competent in this area. Considering that tobacco and related addictions are gradually increasing in children and adolescents, physicians must receive training in the area of smoking cessation methods and start practicing these methods.

Abstract

Aim: To determine the attitudes of child and adolescent psychiatrists working in different institutions throughout Turkey towards smoking addiction and intervention steps.

Material and Methods: An information form assessing physicians' 5As approach was established considering the studies included in the literature, and this form was applied to physicians working in the area of child psychiatry by way of e-mail and phone.

Results: Although most physicians (52.5%) asked about smoking status, which is included in the first step in the 5As approach used in smoking cessation, it was observed that they implemented further steps of the 5As with gradually decreasing rates in our study. Only 15% of the physicians performed follow-up in smoking cessation treatment.

Öz

Amaç: Bu çalışmanın amacı, Türkiye genelinde farklı kurumlarda görev yapan çocuk ve ergen psikiyatristlerinin sigara bağımlılığı ve müdahale basamaklarıyla ilgili tutumlarını belirlemektir.

Gereç ve Yöntemler: Yazındaki çalışmalar dikkate alınarak hekimlerin 5A uygulamasını değerlendiren bilgi formu oluşturulmuş ve çocuk ruh sağlığı alanında çalışan hekimlere mail ve telefon aracılığıyla uygulanmıştır.

Bulgular: Çalışmamızda sigara bırakmada kullanılan 5A yönteminde ilk basamakta yer alan sigara içme durumunu sormayı hekimlerin çoğunluğu (%52,5) uygulamasına rağmen 5A'nın ileriki basamaklarını gittikçe azalan oranda uyguladıkları görülmüştür. Hekimlerin yalnızca %15'i sigara bırakma tedavisinde izlem yapmaktadır.

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Conclusion: Physicians who work with pediatric and adolescent patients in Turkey have low levels of awareness about smoking addiction and they do not feel competent. Considering that tobacco and related addictions are gradually increasing in children and adolescents, physicians must receive training in the area of smoking cessation methods and start practicing these methods. It was thought that organizing smoking cessation training for physicians would contribute positively to the treatment of patients.

Keywords: Child psychiatry, smoking cessation, 5As method

Çıkarımlar: Türkiye’de çocuk ve ergen hasta grubuyla çalışan hekimlerin sigara bağımlılığı ile ilgili farkındalığının düşük olduğu ve kendilerini yetkin hissetmedikleri gözlenmiştir. Tütün ve ilişkili bağımlılıkların çocuk ve ergenlerde gittikçe arttığı düşünüldüğünde hekimlerin sigara bırakma yöntemleri konusunda eğitim almaları, uygulamaya geçmeleri önemlidir. Hekimlere yönelik sigara bırakma eğitimlerinin düzenlenmesinin hastaların tedavisinde olumlu katkılar sağlayacağı düşünülmüştür.

Anahtar sözcükler: Çocuk psikiyatrisi, sigara bırakma, 5A yöntemi

Introduction

Smoking is a health problem in children and adolescents, and the importance of this issue is gradually increasing. The Global Youth Tobacco Survey (GYTS), which is conducted throughout the world, is also being applied in our country. As a result of a study conducted with students aged between 13 and 15 years in 2017, it was found that 17.9% of the adolescent population consumed a tobacco product, 7.7% were smokers, and 28% had tried cigarettes at least once (1).

In a study conducted by the United States Centers for Disease Control and Prevention, it was reported that the prevalence of smoking was higher (36%) in individuals who had mental health problems compared with the normal population (2). In these patients, the prevalence of tobacco addiction was 2–4-fold higher compared with the general population (3). It was found that smoking had a negative effect on life expectancy and quality of life in individuals with mental illness (4). Studies reported that tobacco-related cardiac and pulmonary diseases and cancer were more prevalent in individuals with mental illness and life expectancy was reduced due to chronic diseases related to tobacco use (5). Among adolescents who smoke, the risk of tobacco addiction in adulthood is higher in individuals with psychiatric disorders compared with those without psychiatric disorders. These individuals start smoking at a younger age, smoke more intensively and have a higher risk for smoking-related medical comorbidities (6). Adolescents who smoke have a higher risk in terms of alcohol and substance use compared with their non-smoking peers (7). Even when the diagnosis of mental illness was controlled in adolescents who had mental illness and smoked, smoking was found to be associated with suicide attempts and self-harm (8). Polycyclic aromatic hydrocarbons found in tobacco smoke increase the metabolism of many psychotropic drugs and reduce their blood levels by inducing the cytochrome P450 system, especially the CYP 1A2 enzyme, and may disrupt treatment response (9). Considering all these factors, physicians working in the area of mental health are important for the organization of smoking addiction treatment in children and adolescents.

According to the results of GYTS conducted in 2017, 56.4% of adolescents who used tobacco products had tried cessation in the last 12 months and 53.2% wished to quit at present (1). In a study conducted by Minami et al. (10) with adolescent patients who smoked, it was found that adolescents had the intention to quit smoking independent of psychiatric diagnosis and disease severity. In a study conducted by Bancej et al. (11) in 2007, it was reported that cessation success was higher if interventions were made before the diagnosis of addiction in adolescents who smoked.

Although it is known that adolescents rarely plan tobacco cessation initiations and tend to choose unassisted cessation methods, it was found that adolescents who participated in tobacco cessation programs had a higher probability of success in cessation initiations compared with adolescents who did not receive assistance. It has been reported that cessation initiations should be started at the earliest period possible independent of tobacco consumption level in all adolescents who smoke (6). The strategies recommended for this objective were specified with the ‘5As’ method. The 5As method consists of the following five steps: Ask, Advice, Assess, Assist, Arrange. The 5A steps were translated into Turkish as Ö (Öğren, Öner, Ölç, Önderlik et, Örgüt) (12, 13). Interrogating and recording if the individual smokes (A1), giving recommendations on the issue of smoking cessation to each individual smoker with a clear, strong and personal message (A2), specifying if the individual is willing to quit smoking (A3), supporting cessation initiative and establishing a plan (A4), and performing follow-up to prevent relapse (A5) constitute the steps of this application.

The aim of this study was to determine the attitudes of child and adolescent psychiatrists working in different institutions throughout Turkey towards smoking addiction and intervention steps.

Material and Methods

The population of this study involved academics, specialist physicians, and residents working in the area of psychiatry. There are 850 physicians registered in the Turkish Association of Child and Adolescent Psychiatry. The information form established was sent to the Association’s

joint e-mail group and joint phone groups. One hundred seventy-six physicians participated in the study.

Information Form: This form was prepared by the research team considering the studies in the literature (14, 15). It consists of four parts and 40 questions.

The first part includes questions related to the physicians' sociodemographic data (sex, age, city of work, institution), whether they received training related to smoking cessation, the information source of the physicians who received training, and the reasons for not having received training for physicians who did not receive training.

The second part included the physicians' knowledge related to the 5As method and questions related to their applications. There are five questions related to the 5As method, and these questions were arranged in accordance with a 5-point Likert scale (1= always, 2= most of the time, 3= occasionally, 4= rarely, 5= never). The physicians were asked how often they specified and documented smoking status in children and adolescents who presented for an interview, how often they gave a clear, strong, and personal message encouraging smoking cessation to children and adolescents, how often they assessed if children and adolescents were willing to quit smoking at the time of the interview, how often they gave a consultancy service to assist smoking cessation to children and adolescent who were willing to quit, and if they planned an interview in the first week in the treatment process for children and adolescents who attempted to quit smoking. This part also involves a question related to the purpose of determining the smoking status of patients and the usage of this information about the patients and a question related to the obstacles to questioning and recording the smoking status of children and adolescents. The participants could mark more than one option for these two questions.

The third part involves 11 5-point Likert-type questions related to the resources and techniques used by physicians to help patients quit smoking. The Likert scale was arranged as follows: 1= always, 2= most of the time, 3= occasionally, 4= rarely, and 5= never.

The fourth part involves 10 3-point Likert-type questions related to ideas preventing smoking cessation therapy applications and social and economic obstacles. The Likert scale was arranged as follows: 1= I agree, 2= I am uncertain, and 3= I disagree.

Approval was obtained for this study from Manisa Celal Bayar University clinical research ethics committee (Approval date and number: 19.06.2019/20.478.486). The study

Table 1. The participants' characteristics, demographic data and training related to smoking

Sociodemographic data	n	%
Sex		
Male	42	24
Age range		
20–30	88	50
30–40	73	41.5
40–50	10	5.7
50 and above	5	2.8
Working institution		
University hospital	84	47.7
Education and research hospital	54	30.7
Private practice	5	2.8
Public/city hospital	29	16.5
Estimation of smoking percentage in child-ren/adolescents in Turkey		
Less than 10%	27	15.4
10–30%	114	65.1
30–50%	32	18.3
50–70%	1	0.6
More than 70%	1	0.6
Estimation of smoking percentage in child-ren /adolescents with mental illness in Turkey		
Less than 10%	3	1.7
10–30%	35	20
30–50%	87	49.7
50–70%	44	25.1
More than 70%	6	3.4
Smoking status in physicians		
I have a smoking habit	13	7.4
I smoke occasionally	27	15.4
I was smoking, I quit	14	8
I have never smoked	121	69.1

was conducted in accordance with the principles of the Helsinki Declaration.

Results

The participants' characteristics, demographic data and training related to smoking

For this study, 850 physicians who were affiliated with the Turkish Association of Child and Adolescent Psychiatry, were reached by way of e-mail and common phone groups; 176 physicians participated in the study. Twenty-four percent of the physicians were male, and the majority were aged between 20 and 40 years (91.5%) (Table 1).

Table 2. Use of the 5As method for smoking cessation

Components/stages of 5A	Always/most of the time (%)	Sometimes /rarely (%)	Never (%)
How often do you specify and document the smoking status of pediatric and adolescent patients who present for interview? (Ask)	52.5	44	3.4
How often do you give a clear, strong and personal message encouraging smoking cessation to pediatric and adolescent patients? (Advice)	30.9	66.3	2.9
How often do you assess if children and adolescents who smoke are willing to quit smoking at the time of interview? (Assess)	31.4	64	4.6
How often do you provide consultancy service to assist children and adolescents who are willing to quit smoking? (Assist)	30.9	57.8	11.4
Do you plan an interview in the first week during the treatment process for children and adolescents who attempt to quit smoking? (Arrange)	15	33.5	51.4

Among the participants, 77.7% did not receive any training related to smoking cessation and only 22.3% received training. Among the physicians who received training, about half (57.4%) reported that they received this training while studying at medical school and 31.9% reported that they received this training at congresses and conferences. Among the physicians who did not receive training related to smoking cessation, 79.1% reported that unawareness of appropriate training courses was the major obstacle in this respect, and 35.1% reported that having less interest in this issue compared to other issues in clinical practice was one of the obstacles.

Use of the 5As approach for smoking cessation

Each stage of the 5As method used in smoking cessation was asked to physicians separately and they were asked to report to what extent they used these stages. In terms of the data belonging to questioning and specification of smoking status, about half of the physicians (52.5%) reported that they always or mostly implemented this stage. Only 30.9% of the physicians always or mostly implemented the second stage, which consists of giving a clear and strong message directed to smoking cessation. The third stage, which consisted of assessing if children and adolescents were willing to quit smoking at the time of the interview, was always or mostly implemented by 31.4% of the physicians. When the physicians were questioned as to whether they gave a consultancy service to assist smoking cessation to children and adolescents who were willing to quit smoking, which was the fourth stage, only 30.9% reported that they always or mostly gave this service. The final stage, which consisted of planning an interview in the first week in the treatment process of children and adolescents who attempted to quit smoking, was always or mostly implemented by 15% of the physicians. Eighty-five percent of the physicians reported that they did not implement this planning (Table 2).

When the physicians were asked about which objective they used the information obtained about their patients' smoking status, 60.1% reported that they used this information to refer to during clinical consultations as a part of medical history and 53.2% reported that they used this information to initiate talking about smoking cessation during clinical interviews.

When the physicians were asked about the obstacles to questioning and the recording smoking status of pediatric and adolescent patients, 58.8% reported that they did not have sufficient time to question smoking status during interviews, 41.3% reported that there was no routine system for recording smoking status, and 5.6% reported that they were uncomfortable with questioning smoking status.

Techniques used in smoking cessation

Only 6.9% of the child and adolescents psychiatrists used self-help materials such as brochures to help smoking cessation. The percentage of physicians who referred their patients to technology-based sources (e.g. website, cellular phone applications) was 12%. Fifteen point four percent of the physicians referred their patients to a smoking cessation hotline. Thirty-five point eight percent of the physicians reported that they always or mostly performed motivational interviewing with their patients about smoking cessation. Among the participating physicians, 16.6% referred their pediatric and adolescent patients to face-to-face consultancy services (group or individual). Twenty-eight point six percent of the physicians reported that they discussed with their pediatric and adolescent patients how to avoid restarting smoking (Table 3).

Barriers to smoking cessation activities

Sixty-one point three percent of the physicians reported that they considered smoking an important health problem that should be addressed during their interviews with their patients.

Table 3. Sources and techniques used by physicians to assist patients to quit smoking

	Always/most of the time (%)	Sometimes /rarely (%)	Never (%)
Providing published self-help materials related to smoking cessation for children and adolescents	6.9	14.2	78.9
Discussing how to overcome obstacles in smoking cessation with children and adolescents	22.9	58.2	18.9
Directing children and adolescents to technology-based sources for smoking cessation	12	22.9	65.1
Encouraging children and adolescent to call smoking cessation hotline	15.4	32	52.6
Sending an application to smoking cessation hot-line to arrange an appointment for children and adolescents	6.9	10.3	82.8
Performing a motivational interview to assist children and adolescent to quit smoking	35.8	50	14.2
Referring children and adolescents to face-to-face consultancy services to assist them to quit smoking	16.6	36.5	46.9
Applying a standard smoking cessation pharmacotherapy algorithm for children and adolescents	8	27.4	64.6
Where appropriate, prescribing nicotine replacement therapy for children and adolescents	8	11.5	80.5
Where appropriate, prescribing varenicline, bupropion treatment for children and adolescents	8.6	13.2	78.2
Discussing how to avoid starting smoking again with children and adolescents	28.6	46.3	25.1

When the barriers to smoking cessation therapy applications were evaluated, it was found that 74.6% of the physicians reported that they thought adolescents did not behave willingly about this issue. Sixty-one point eight percent of the physicians reported that they did not have sufficient time to spare for this issue during their interviews, 49.1% reported they were not competent in this area, 62.4% reported that they did not have sufficient experience and self-confidence, and 66.5% reported that outpatient clinic conditions were not sufficient in terms of smoking cessation. One-third of the physicians thought that initiating smoking cessation therapy would disincline patients to present at an outpatient clinic, and one-third disagreed. Six point nine percent of the physicians thought that quitting smoking would worsen the symptoms of the pediatric and adolescent patients' present illnesses, but 68.2% disagreed with this idea. The majority of the physicians (80.1%) agreed that preventive medicine measures would be more beneficial compared with smoking cessation therapy in the area of children and adolescents' smoking cessation (Table 4).

Discussion

There are limited data about smoking cessation initiations in the young population with mental health problems. Although 62.3% of the physicians in our study reported that they considered smoking an important

health problem that should be addressed during their interviews, they also reported that they had no experience in this area, they were not competent in this regard, and outpatient clinic conditions were not appropriate. It was found that they did not use all stages of the 5As intervention method used in smoking cessation at a sufficient level. Only 22.3% of the participants received training about smoking cessation. Considering that the frequency of tobacco and related habits is gradually increasing in children and adolescents in our country, future studies in this area are gaining importance. As far as we know, our study is the first related to 5A smoking cessation interventions in the pediatric and adolescent population with mental illness in our country.

Although most physicians (52.5%) questioned and recorded smoking status, which comprises the first step in the 5As approach used in smoking cessation, it was observed that they implemented further steps of the 5A method with gradually decreasing rates in our study. The literature contains some studies evaluating the attitudes of healthcare workers working in the area of child and adult psychiatry towards this issue (14, 15). A study was conducted with healthcare workers working in mental health in an adult psychiatry clinic in 2018 in Australia. The study showed that most practitioners regularly implemented at least one stage of the 5As method, but less than one-third

Table 4. Obstacles in smoking cessation activities

Obstacles in smoking cessation activities	I agree (%)	I am uncertain (%)	I disagree (%)
I do not consider this issue as an important health problem which I should address during my inter-views.	17.9	20.8	61.3
Adolescents are generally not willing to quit smoking.	74.6	15	10.4
I do not have enough time to spare for this issue during my interviews.	61.8	21.4	16.8
I am not competent in this area.	49.1	30.6	20.2%
I do not have sufficient experience in this area and I have no self-confidence.	62.4	24.9	12.7
As my previous applications were unsuccessful, I do not wish to perform applications again	5.8	23.1	71.1
Outpatient clinic conditions are not sufficient in the issue of smoking cessation	66.5	17.9	15.6
I fear discouraging patients from presenting at out-patient clinics for follow-up	32.6	32	35.5
I think that smoking cessation will aggravate the symptoms of present disease in children and adolescents	6.9	24.9	68.2

implemented all stages. The majority of the participating physicians (73.8%) reported that they questioned their patients' smoking status. However, only 44.9% recommended smoking cessation, 49% gave a consultancy service for smoking cessation, and 50.6% arranged follow-up interviews (14). In the United States of America, only 14% of physicians who participated in a study conducted in a clinic that worked with children and adolescents reported that they specified and documented their patients' smoking status, 30% reported that they gave a clear, strong and personal message for smoking cessation to each smoker, 18.5% reported that they assessed if the adolescent smoker was willing to attempt to quit smoking at the time of the interview, 33% reported that they assisted their patients who were willing to quit smoking with various methods, and 8.2% reported that they interviewed adolescent patients in the first week after smoking cessation. Twenty-five percent of the physicians reported that they did not perform any intervention for their adolescent patients who smoked (15). Our results are similar to the literature. It is known that adolescents who participate in a tobacco cessation program have a higher probability of success in terms of cessation initiations compared with adolescents who do not receive assistance (6). Therefore, it is important to implement all stages.

Seventy-seven point seven percent of the physicians reported that they did not receive any training about smoking cessation, and thus they did not have sufficient experience and self-confidence in terms of smoking cessation therapy. In a study conducted by Sharma et al. (14) in 2018, only 50% of the participating physicians reported that they received smoking cessation training. In this study, it was reported that having received training was an im-

portant predictor for implementing the 5A stages, and the physicians who received training had a higher probability of advising smoking cessation. In a study conducted by Hartmann et al. (16), it was reported that the physicians who received training related to smoking cessation implemented this therapy with a 2-fold higher rate, and the ideal time for training was the residency period. In the European Psychiatry Association guideline, it was reported that psychiatrists should be given training about tobacco addiction, and smoking addiction should be included among the disorders that should be examined during psychiatry residency (5). We think that successful implementations will increase in our country with the organization of training about smoking cessation.

In our study, 74.6% of the physicians reported that they thought adolescents did not behave willingly in terms of smoking cessation and 32.6% reported that they thought advising patients to quit smoking would dis-incline patients to present to outpatient clinics. The GYTS performed in 2012 in Turkey reported that 53.2% of the adolescents who smoked were willing to quit at the present time and 56.4% had attempted to quit in the last 12 months (1). In a study conducted by Prochaska et al. (17) in 2004, similar results were obtained; it was reported that 82% of the adolescents aged between 11 and 19 years who smoked thought of quitting smoking, and 77% had seriously attempted to quit in the last one year. In addition, studies showed that individuals with mental illness showed a willingness to quit smoking with similar frequencies to the general population (5). Studies have shown that adolescents are willing to quit smoking and they attempt to quit smoking (1, 6). They should receive a structured therapy for smoking cessation.

In our study, 6.9% of the physicians reported that they thought smoking cessation would worsen the symptoms related to the present disease in children and adolescents. Seventeen point nine percent of the physicians reported that they did not consider smoking cessation initiations an important health problem that should be addressed during their interviews, and 20.8% reported that they were uncertain in this respect. About half of the physicians who participated in our study (49.1%) thought that they were not competent in the area of smoking cessation interventions. In a study conducted by Mendelsohn et al. (9), it was reported that quitting smoking did not worsen present mental health problems, and rather contributed in improvement of mental health. In a study conducted by Ragg et al. (18), it was reported that no deterioration was found in mental health problems after quitting smoking. Studies have shown that smoking negatively affects mental health, and quitting has positive contributions to the prognosis in many mental diseases (19). In a meta-analysis conducted by Taylor et al. (19), it was found that depression and anxiety symptoms decreased, and mental well-being and quality of life increased when individuals with mental health problems quit smoking. In addition, it was found that the effect of smoking cessation on mood and anxiety disorders was equal to antidepressant treatment. Physicians must address smoking in their interviews, because smoking may lead to problems in mental illnesses by affecting nicotinic pathways in the brain, causing a difference in the release of neurotransmitters and interacting with medications used in treatment (5, 9, 20). In a study conducted by Price et al. (15), the strong relationship between adolescent mental health and smoking was emphasized, and the importance of regularly addressing smoking cessation by child psychiatrists during interviews was noted. Smoking addiction is an important health problem in both physical and mental aspects and should be addressed during interviews.

Sixty-one point eight percent of the physicians who participated in our study reported that they did not have sufficient time to spare for the issue of smoking cessation during their interviews. Similar to our country, Price et al. (15) showed that psychiatrists regarded shortage of time as an obstacle to smoking cessation attempts. Studies have reported that the counseling phase of 5A interventions takes approximately 7 minutes, and the implementation of all stages takes approximately 10–12 minutes (15, 21). It is thought that structured arrangements may contribute to improving the negative results of a shortage of time.

Our results suggested that psychiatrists working with pediatric and adolescent patient groups should be supported with training in smoking cessation, and more studies should be conducted in this area.

There were limitations in two areas in the present study. The sample did not fully reflect the study population because all physicians targeted could not be reached, and all physicians who were reached did not participate in the survey. Another limitation was the probability that some psychiatrists might have responded to some survey questions in the socially desired manner because of the awareness that the 5A method is a basic evidence-based protocol in the area of smoking cessation. If this is correct, it would be a threat to the internal consistency of the results. However, the fact that we do not know the personal information such as name and surname of the psychiatrists who completed the questionnaire, increases the probability of receiving objective responses.

Ethics Committee Approval: Approval was obtained from Manisa Celal Bayar University clinical researches ethics committee for this study (approval date and number 19.06.2019/ 20.478.486).

Informed Consent: Informed consent was obtained from the participants for the study.

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