UCSF Smoking Cessation Leadership Center
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Smoking and Behavioral Health: Is there a national strategy?

During a recent phone call, the leader of one of our partner organizations asked Catherine Saucedo and me if there exists a national strategy to reduce smoking rates within the behavioral health population. It was a great question, and the short answer was ?not yet, but one is evolving.? Because this is such an important issue, I want to provide a longer response.

The disproportionate burden that smoking exerts on the behavioral health population has been known for several decades[1,2]. Smoking prevalence among the one fifth or so of the population with either mental health conditions, substance use disorders, or both, is double or triple the 17.8% adult smoking rate of the general population. And, of course, that 17.8% baseline figure would be even lower if it excluded the one fifth or so of the population with a behavioral health condition. Persons with such conditions die much earlier, and many of their fatal diseases are caused by smoking. When the CDC?s estimated number of annual deaths from tobacco use was 435,000 per year, several tobacco control experts estimated that about 200,000 of those premature deaths occurred among persons with behavioral health conditions. Subsequently a Surgeon General?s Report raised the number of annual deaths to 480,000, and just this year data from the American Cancer Society increased that estimate to at least 540,000 annual smoking-related deaths[3]. Accordingly, it is reasonable to raise that earlier 200,000 estimate proportionately to about 250,000 annual deaths from smoking. In addition, about 40% of all cigarettes consumed in the United States are by persons with behavioral health conditions. On a personal level, we at SCLC hear far too many stories from

drug and alcohol counselors about patients who achieve sobriety, only to die a premature and painful death from such conditions as lung cancer, COPD, or heart disease.

Yet, despite these facts, smoking cessation has not been an important goal among health professionals responsible for treating behavioral health clients--psychiatrists, psychologists, psychiatric nurses, and social workers. Furthermore, the issue of smoking was essentially ignored by such relevant federal agencies as the Substance Abuse and Mental Health Services Administration and the Centers for Disease Control, as well as by advocacy organizations such as the National Alliance on Mental Illness. Not surprisingly, there are many explanations for this neglect. Some were longstanding myths: ?smoking treats mental health symptoms; it is their only consolation; they don?t want to quit; they are unable to quit; and smoking is a less important part of their medical condition and doesn?t merit a treatment plan.?[4] In addition, many substance abuse treatment counselors, themselves former addicts, had been able to quit their substance use habits but not tobacco, and therefore felt unable or unwilling to promote smoking cessation. The federal agencies may have narrowly construed their mission, and may also have been intimidated by the potential threat of tobacco industry lobbying. As a result of this collective inaction, persons with mental illness (and presumably substance use disorders as well) did not benefit as much from the overall declines in smoking prevalence over the past several decades[5].

We are now in the midst of a culture change in which these long held attitudes are changing. Here are a few examples. The American Psychiatric Nurses Association has called for its members to be active smoking cessation champions, both in their clinical settings and as policy advocates. The CDC is preparing to air a *Tips From Former Smokers* campaign that features a former smoker with mental illness. Psychiatric hospitals, which had long condoned and even encouraged smoking, are increasingly becoming smoke-free, both indoors and on the external grounds. And a recent NAMI video on healthy hearts begins with instructions on how to stop smoking, a stark contrast from an earlier version, which studiously ignored smoking as a contributor to heart disease. Yet, social change comes hard, and there is still much inertia and many pockets of resistance. We have a long way to go before smoking cessation is mainstreamed into behavioral health treatment.

So let?s return to the original question-- what would be a national strategy to reduce smoking in the behavioral health population? First, it would be based on a foundation of basic public health tobacco control measures such as clean indoor air policies, raising tobacco taxes at federal, state, and local levels, counter-marketing, getting smoking out of the movies, and in general furthering the social denormalization of smoking. Second, it would build on smoking cessation interventions, which though admittedly imperfect still increase the odds of quitting. This means continuing education and motivation of all clinicians, assuring health insurance coverage for smoking cessation treatments, and achieving greater use of toll-free telephone quitlines. Third, it would accelerate the cultural change currently just beginning, so that smoking cessation is viewed as an integral part of the responsibility of clinicians and agencies caring for clients with behavioral health conditions. That is not only the right thing to do, it is essential to realizing our national goals for tobacco control and health. For its part, the Smoking Cessation Leadership Center commits to working with our partners to make that happen.

References

1. Williams JM, Willett JG, Miller G. Partnership between tobacco control programs and offices of mental health needed to reduce smoking rates in the United States. JAMA Psychiatry 2013; 70:1261-62 [1]
2. Schroeder SA, Morris CD. Confronting a neglected epidemic: tobacco cessation for persons with mental illness and substance abuse problems. Ann Rev Public Health 2010; 31:297-314 [2]
3. Carter BD, Abnet CC, Feskanich DF et al. Smoking andmortality?beyond established causes. New Engl J Med 2015;372:631-640 [3]
4. Prochaska JJ. Smoking and mental illness?breaking the link. New Engl J Med. 2011;365:196-198 [4]
5. Cook BL, Wayne GF, Kafali N et al. Trends in smoking among adults with mental illness and association between mental health treatment and smoking cessation. JAMA 2014;311:172-182 [5]

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Smoking Cessation Leadership Center
University of California, San Francisco

3333 California Street, Suite 430, San Francisco, CA 94143, Phone: (877) 509-3786
https://smokingcessationleadership.ucsf.edu

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