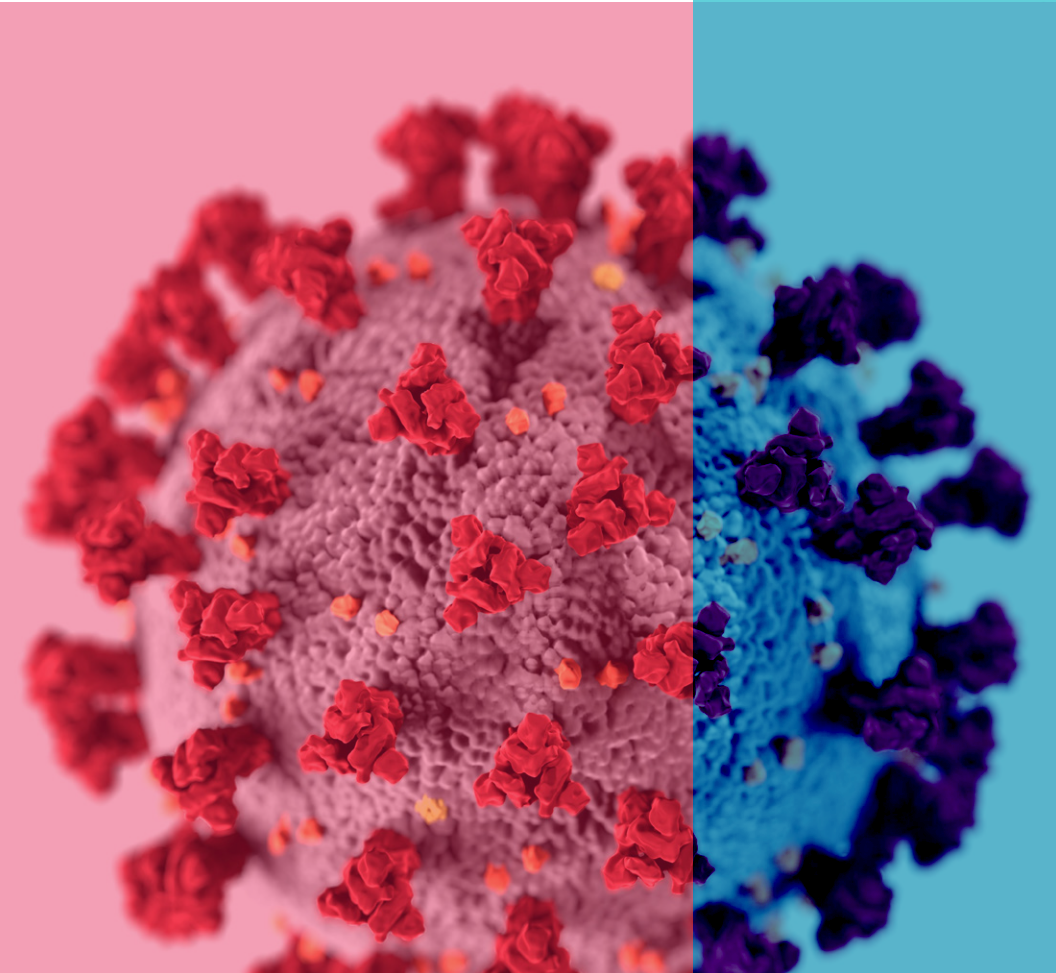


Smoking and Behavioral Health in the Time of COVID-19

EXECUTIVE SUMMARY



UCSF Smoking Cessation Leadership Center
(877) 509-3786
www.smokingcessationleadership.ucsf.edu



The COVID-19-Tobacco Connection

Strictly speaking, COVID-19 and smoking are unrelated catastrophes—one is a highly contagious viral disease, the other a deadly, preventable, human-caused drug affliction. And yet, for the Smoking Cessation Leadership Center, these two global social plagues are utterly and dangerously intertwined. They have *everything* to do with each other.

Most obviously—and this became clear as soon as the pandemic first hit in early 2020—COVID-19 and smoking are both equity issues. The pandemic heightened the urgency of addressing smoking, especially among those with behavioral-health problems, because more people than ever fit that definition. They were depressed, anxious, struggling, both with and because of COVID-19.

Since 2003, SCLC, a program of the University of California, San Francisco, has worked with health professional organizations and institutions to increase their motivation and ability to help smokers quit. Once SCLC realized that COVID-19 disproportionately attacked, sickened, and killed the same people we were trying to rescue from tobacco addictions, we knew we should confront the disease in our work.

As society groped toward a solution to limit the damage of the pandemic, we wanted to show the world that tobacco was an essential part of the COVID-19 story, as was behavioral health. The deathly grip of a smoking addiction—and the prevalence of smoking among those with mental illnesses and substance-abuse disorders—has always required SCLC to be tenacious and creative when working in the field of behavioral health.¹ Smoking is at least twice as common among people with behavioral health conditions, and people with these disorders are more likely to die from smoking than from any other affliction.

The Cessation Message

We knew that COVID-19 was taking a deadly toll on smokers. We didn't realize just how much it was affecting their desire to quit until our partners at the North American Quitline Consortium (NAQC) released a report that showed a 30% decline in calls to the quitline that followed the trajectory of the pandemic. We put together a press briefing based on their report with representatives from additional partners at the American Lung Association, National Alliance on Mental Illness, American Society of Addiction Medicine and the Robert Wood Johnson Foundation. The briefing resulted in substantial media coverage in both print and broadcast media, including on local news programs across the country. It was big news that spoke to the increased anxiety people were feeling that was driving them to cope somehow—even if it was, unknowingly, making them feel worse.

Even though studies have shown that stopping smoking can improve mental well-being by reducing anxiety and depression, and improve outcomes for substance use disorders, smoking cessation has not been integrated into the treatment of behavioral health conditions. On the contrary, the culture of treatment in behavioral health is often a culture of smoking, where patients are not only allowed to light up, but encouraged to do so.

The pandemic added new urgency to a battle we have been fighting for well over a decade. Since 2007, SCLC has been working with agencies, advocacy organizations and clinical groups, like the federal Substance Abuse and Mental Health Services Administration, to bring about culture change within behavioral health. It has worked, for example, to get state mental health hospitals to limit or ban smoking—a much-needed and long-overdue development, since more than 44 percent of adults with serious mental illness are smokers, compared with about 20 percent of the general population. Studies have shown that people with serious mental illness die 25 years before the general population, often from smoking-related diseases.

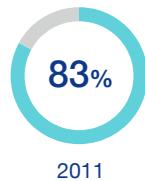
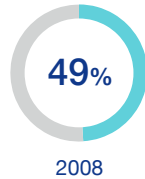
When the pandemic hit, the public-health response was chaotic, full of confusing mixed messages, amid a political environment of demagoguery and seemingly willful ignorance. Tackling smoking and behavioral health together in the time of COVID-19 was a challenge. It seemed nearly impossible to put out any public health message that wasn't about COVID. Smoking was relegated to a “lesser problem,” even though tobacco kills so many hundreds of thousands of people each year.

Our work during the pandemic was laid on a foundation that we had begun to build several years earlier—our goal of creating tobacco-free spaces, in the public realm and in the behavioral-health sector. Professionals working in mental health were among the toughest to persuade about the importance of smoking cessation. Many people struggling with mental illness and substance abuse regard cigarettes as one of their last freedoms. And health providers have long used cigarettes for behavior modification: Quite often, clients who do well get cigarettes; those who don't, don't.



But over the years SCLC has made inroads with the mental health and substance abuse community. We've worked to convince state mental health directors of the importance of banning smoking at state mental health hospitals. In 2007, we launched the Behavioral Health Partnership for Wellness and Smoking Cessation to legitimize the idea of smoke-free mental-health facilities. This gathering was followed up in 2016 by the creation of the National Partnership on Behavioral Health and Tobacco Use, a group which involves the Centers for Disease Control and other federal entities. By 2020, a National Research Institute (NRI) study found that some 96 percent of state mental health facilities were now smoke-free.

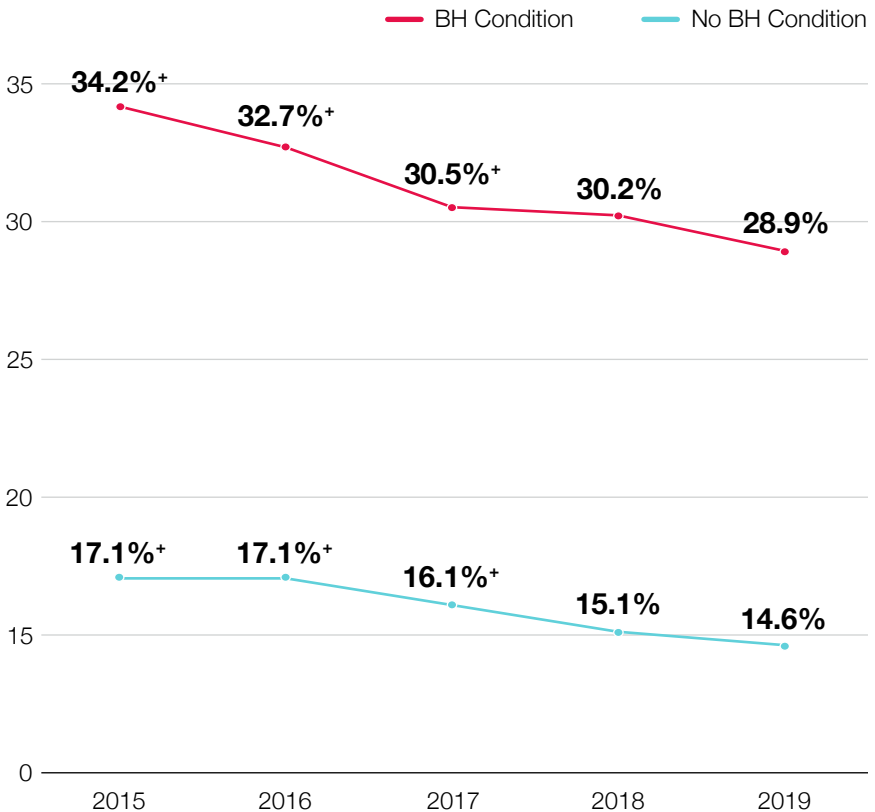
Percent of Smoke Free* State Psychiatric Hospitals in the U.S.



*Response rates: 2005 - 55%, 2006 - 82%, 2008 - 75%, 2011 - 80%, 2020 - 42%
 Source: Ortiz G, Schacht L, Lane M. Smoking Cessation Care in State-Operated or State-Supported Psychiatric Hospitals: From Policy to Practice, *Psychiatr Serv.* 2013 Jul 1;64(7):666-71.
 Ortiz G, Randi M, Schacht L, "Improving Tobacco Cessation with Adult Inpatient Psychiatric Clients." SCLC Webinar Series, May 2021.

We also worked with multiple public and private partners to put smoking cessation on the front burner for people with substance use disorders. Our challenge was to convince leaders in the behavioral health field that people with mental illness or substance abuse could and wanted to quit smoking, and that quitting wasn't going to upset a person's recovery. We had the data—and we showed it wherever we could. We knew there had been a steady decline in smoking among adults with behavioral health conditions from 2008 to 2019—just before COVID-19 hit.

Current Smoking among Adults (Age ≥ 18) with a Past Year Behavioral Health (BH) Condition: NSDUH, 2015-2019



Current Smoking is defined as any cigarette use in the 30 days prior to the interview date.
Behavioral Health Condition includes Any Mental Illness (AMI) and/or Substance Use Disorder (SUD).
⁺ Difference between this estimate and the 2019 estimate is statistically significant at the .05 level.



The Equity Problem

Our work raising awareness of tobacco's toll in specific populations—Native American, Latino, Asian American and Pacific Islander, and African American—was important during the early months of the pandemic. We conducted media briefings and developed op-ed articles from experts in community-specific smoking-cessation work.

In December 2021, we hosted a webinar on “Stress and Cigarette Smoking Among Black and Latinx Adults with Psychiatric Disorders,” with data that exposed the inequity problem in stark detail. We shared the results of a study that sought to examine the relationship between psychosocial stressors and both smoking status and nicotine dependence among Black and Latinx adults with mental illness.

We highlighted research showing that the coronavirus was especially dangerous for people with conditions² that using tobacco causes or worsens. We were concurrently focused on circumstances where the virus disproportionately attacks communities of color, such as with lung and heart disease, high blood pressure, diabetes, and cancer. We showed how COVID-19 worsened gaps in health care, with deadly results.³ Anxiety and depression have run rampant, racist violence has spiked⁴ in Asian-American communities, and many people have started or resumed smoking to manage their stress.⁵

And in December 2021, SCLC conducted a briefing for the media on COVID-19's effect on smoking in Native American, Asian, Black and Latino populations. The briefing led to four commentaries exploring the pandemic's effects in each of these communities, and what makes each community's experience distinct. For example, the history of racist marketing, particularly of menthol cigarettes, to Black Americans. The particular stress effects and cultural and familial conditions affecting smoking among Asian and immigrant subgroups. And the striking developments involving smoking on Indian reservations and in Indian casinos.

I COVID QUIT

Since I quit smoking my depression and anxiety have improved

—Katie, ex-smoker



Outreach and Testimonials

A key part of SCLC's work before and during the pandemic was partnership with and outreach to the states. One example was a series of webinars beginning in May 2022 offering what we called "the Great State Update," a refresher on the state partnerships we had been building for years to treat tobacco addiction in behavioral health settings. In California, where the smoking rate is 8.9%—and the smoking rate among adults with frequent poor mental health is 15%, nearly double the rate of the general population—our California Behavioral Health and Wellness Initiative is meant for all smokers who are in residential treatment programs. The goal is to support access to cessation services as part of an emphasis on overall wellness. The success of this program was one reason California has adopted Assembly Bill 541, signed into law by Governor Gavin Newsom in August of 2021, that requires treatment facilities to screen for tobacco use disorder upon intake and provide treatment if the disorder is identified.

On a wider scale, SCLC conducted a national social media marketing campaign called "I COVID Quit"⁶—a project to promote smoking cessation among people with behavioral health conditions. Through posters, streaming videos⁷ and other media materials, social-media hashtags and personal testimonials, the campaign took a positive approach to confronting the pandemic tragedy and generated nearly five million impressions across all channels. The campaign capitalized on the dire urgency of the public-health crisis to help thousands of people to finally break the grip of smoking and improve their mental health.



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One of our most moving and effective testimonials came from our ally Katie Rodgers, a teacher in Oakland, Calif., who spoke at a national press event announcing the declining number of smokers seeking cessation help during the COVID-19 pandemic. A former smoker, she quit for the third time in July of 2020 as the pandemic worsened and is still smoke-free. Rodgers has been the “peer speaker” at a few events for SCLC, in-person in Idaho and as the peer/former smoker for a State of Washington virtual summit. In an article published in *The Hill* on May 17, 2021, she wrote: “I’ve been in a personal battle with both smoking and depression for years, and I know I’m not alone in this struggle.”

She continued: “Today, I don’t go through the cycles of self-hating and depression that I did when I was smoking. ‘What now’ for me has so much potential. Today, as I consider post-pandemic life, I feel better, my mood is better, and my outlook is much more positive. I am working hard to be the person that I want to be. And that ideal version of myself is smoke-free.”

The Opportunities Ahead

The pandemic has exposed the cracks through which too many people keep falling—smokers, people with behavioral-health problems and other debilitating conditions, and those in underserved communities. But it has also deepened our understanding of the work that lies ahead of us. We have learned of people in underserved populations—particularly those with behavioral-health issues—who we thought had better access to quality health care than they actually do.

It's clearer now that we need more and better data. We need crossover data to illuminate where various groups and issues intersect. To direct help toward those who need it, it will be necessary to continue to do groundbreaking research to deepen our understanding of various communities, using survey and clinical data that the pandemic will augment. Knowing how the coronavirus ravaged certain populations will help us better understand what made so many people so vulnerable to serious illness and death. This understanding will help galvanize efforts to start tackling these underlying problems.

Starting, of course, with smoking. We will need to keep smoking cessation at the forefront of public-health discussions. Cessation is too often treated as secondary to whatever is considered the public-health topic of the moment. There is too little understanding that smoking causes a lot of the problems that we think of as primary ill effects of COVID-19. That thinking needs to change. Smoking is still, discouragingly, not considered a primary diagnosis or something to be treated concurrently with substance-use or mental-health disorders, when we know that quitting smoking drastically improves things for patients with those conditions.

The people most harmed by tobacco live in marginalized communities where disparities in education and income are prevalent, and where the tobacco industry's power is strongest. Big Tobacco always stands ready to use its marketing machinery to ensnare new customers with its lethal products. We need to be there to counter their deadly tactics—with a message of hope, healing and possibility.

The last three years have brought hard-earned wisdom, amid unspeakable grief and loss. In the future, given all we have learned, we will have the capacity to act differently if a public health emergency arises.


Stock photo posed by models



UCSF Smoking Cessation
Leadership Center

20
YEARS

There is so much more to do. Now moving into our 20th year at SCLC, we hope to continue making headway with our national partnership group. There are so many potentially effective innovations and policy prescriptions that can be scaled up with broad and lasting impact. As our work continues, the core motivation behind it, the force that guides our best efforts in policymaking and public health, can be summed up in one word: equity.



Under the leadership of our new director, Dr. Maya Vijayaraghavan as of January 2023, four overarching opportunities will direct SCLC's work in the future:

1

To promote equity, the SCLC will continue to work with state and national partners to promote policies that combine tobacco-free grounds with coordinated access to tobacco treatment in multi-unit housing, behavioral health clinics, and substance use treatment facilities. The SCLC will also expand focus on populations with very high rates of tobacco use – people experiencing homelessness and justice-involved populations – to reach and engage these populations and their service providers to integrate tobacco treatment as part of housing and re-entry services. We will develop cessation toolkits that address the intersectional nature of tobacco risk in priority populations using collaborative community-based approaches with impacted populations and their service providers.

2

Our work will contribute evidence to support legislation that promotes tobacco-free grounds and tobacco treatment where, historically, there have been none. In correctional systems where there is a national smoke-free policy, the policy is not accompanied by tobacco treatment. The lack of access to tobacco treatment in jails and prisons contributes to periods of forced quitting, with high rates of relapse after release, which negates the potential positive effects of a smoke-free policy.



Dr. Maya Vijayaraghavan

3

The SCLC will continue to highlight ways in which tobacco treatment can be included in states' tobacco endgame plans and prioritized with federal tobacco control policy. Other policies like the flavor ban on tobacco products also have implications for tobacco cessation, and SCLC's work will help provide a framework for integrating tobacco treatment with this and similar tobacco control policies.

4

The SCLC's activities of capacity building, training, and service delivery naturally lend themselves to training the next generation of public health practitioners. So, we'd like to take advantage of being embedded within an academic health center to identify opportunities for trainees in different disciplines (e.g., medical, dental, nursing, pharmacy) at the graduate and post-doctoral levels. These opportunities might include field work with our team through engaging with state and national partners at summits or at service sites like substance use treatment facilities, and/or data analysis opportunities with national data sets of tobacco prevalence, cessation or services, or tobacco policy-level data among impacted populations. We plan to partner internally with the Center for Tobacco Control Research and Education and others at UCSF, and externally through our state and national partners to increase training opportunities in cessation research and practice.

Acknowledgements

The I COVID Quit campaign, this report and other critical components of SCLC's work have been made possible thanks to the generous support of the Robert Wood Johnson Foundation.

The National Partnership on Behavioral Health and Tobacco Use Participating organizations:

American Academy of Family Physicians (AAFP)

American Cancer Society (ACS)

American Cancer Society Cancer Action Network (ACS CAN)

American Lung Association (ALA)

American Psychiatric Association (APA)

American Psychiatric Nurses Association (APNA)

American Psychological Association

American Society of Addiction Medicine (ASAM)

Association of State and Territorial Health Officials (ASTHO)

Centers for Disease Control and Prevention, Office on Smoking and Health (CDC, OSH)

GlaxoSmithKline plc. (GSK)

National Association of Community Health Centers (NACHC)

National Alliance on Mental Illness (NAMI)

National Association of Social Workers (NASW)

National Association of State Mental Health Program Directors (NASMHPD)

National Council for Mental Wellbeing

North American Quitline Consortium (NAQC)

Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS)

RVO Health

Public Health Law Center

Robert Wood Johnson Foundation (RWJF)

Smoking Cessation Leadership Center (SCLC)

Substance Abuse and Mental Health Services Administration (SAMHSA)

Truth Initiative

UnitedHealth Group

University of Wisconsin—Center for Tobacco Research and Intervention

Veterans Health Administration (VHA)

Endnotes

- 1 <https://www.tandfonline.com/doi/full/10.1080/02791072.2017.1412547?src=recsys>
- 2 <https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-with-medical-conditions.html>
- 3 <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8335981/>
- 4 <https://www.kff.org/coronavirus-covid-19/issue-brief/asian-immigrant-experiences-with-racism-immigration-related-fears-and-the-covid-19-pandemic/>

- 5 <https://smokefree.gov/quit-smoking/smoking-and-covid19>
- 6 <https://smokingcessationleadership.ucsf.edu/campaigns/covidquit-campaign>
- 7 https://www.youtube.com/channel/UCZJkYd7njqOYoFz_VyUa9Q


A positive note to end on

COVID-19 has galvanized and, in many respects, unified those working in the public health sphere. The realities of our systems' failures is now common knowledge—as is the sincere desire to do better.

We'd like to thank all of our partners for their continued dedication. Together, we have made a difference, and, together, we will continue to positively change lives and minds.

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