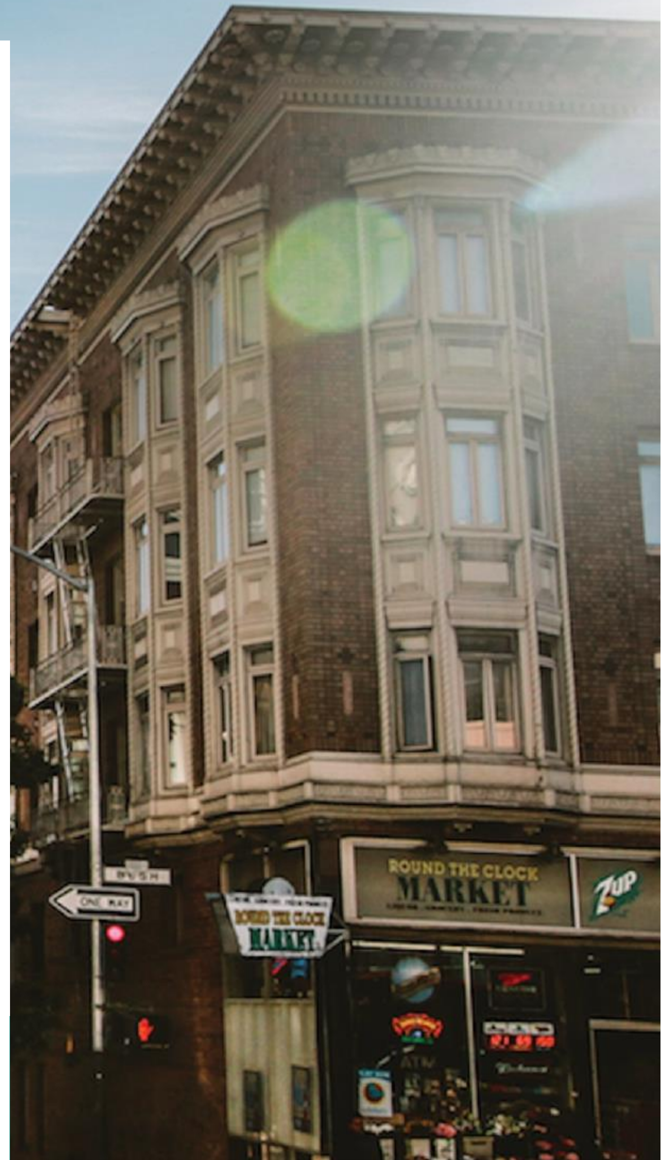
Smoking and Behavioral Health in the Time of COVID-19



June 2023

UCSF Smoking Cessation Leadership Center | National Center of Excellence for Tobacco-Free Recovery

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Preface: A letter from Deputy Director, Catherine Bonniot

The Smoking Cessation Leadership Center has worked for nearly two decades to help more people quit smoking and to increase the number of health professionals who help smokers end their addiction.[i, ii] It is a monumental task — anyone involved in this struggle has their hands full. But when the pandemic struck in early 2020, our mission suddenly took on a vast new dimension, and a new urgency.

COVID-19 was an acute emergency laid tragically atop the chronic crisis of tobacco use. Smoking is an old enemy. It has been the leading cause of preventable death and disability for many years. COVID-19 was a brand-new sickness. But its deadly effects were grimly familiar. Like so many tobacco-related respiratory diseases, it attacks the lungs and cruelly robs its victims of breath.

We took it on ourselves to understand and confront the COVID-19 disaster head-on. The pandemic almost instantly made the smoking calamity worse — of the many people who were falling sick and dying, many of the most vulnerable were those weakened by chronic conditions tied to commercial tobacco use. Countless smokers were felled by the virus. And when the deaths, lockdowns, deep uncertainty and political ugliness sent the country's levels of stress, anxiety and depression through the roof, many people turned to smoking, that old, familiar, lethal coping mechanism.

Our involvement with smokers struggling to escape addiction, and the many other harmful effects of tobacco, led us into the realm of behavioral health. We have long known that smoking and behavioral health problems go hand in hand. Individuals with mental illness and/or substance use disorders represent 25% of the nation's population, and consume 40% of all cigarettes sold in the United States.[iii] Over half a million Americans die each year due to tobacco use, and over 200,000 of those deaths are among those with a mental illness.[iv]

The coronavirus, meanwhile, is especially dangerous for people with conditions like lung and heart disease, high blood pressure, diabetes, cancer — sicknesses that using tobacco causes or worsens, and that disproportionately attack communities of color.

Emotional pain, suffering, addiction, and more — COVID-19's effects on behavioral health are going to be a lingering disaster of this pandemic. And the smoking epidemic will only make the damage worse. The connection is clear, though it is not always well understood. Smoking steals years from a smoker's life.

And yet, not many people—not even healthcare professionals--know the good news. Quitting can not only give some of those years back, but it can also lift the gloom of a smoker's depression and anxiety. As shown in a study by Dr. Gemma Taylor, Research Director of the Addiction and Mental Health Group at the University of Bath, quitting smoking can help to ease mood and anxiety disorders as well as or even better than anti-depressants.[v] There has never been a better time for smokers and those who want to help them, to learn this — and get motivated to quit!

Because of our work among smokers with behavioral health issues, we were well-positioned to see—quite early in the pandemic— how the coronavirus was compounding the smoking problem, by disproportionately afflicting those in vulnerable and marginalized groups. The people who smoked and the people who got the worst of COVID-19 — tragically, these groups were one and the same.

It became clear early on that COVID-19 and smoking were both equity issues. The pandemic heightened the urgency of addressing smoking—especially among those with behavioral-health struggles, because more people than ever fit that definition: depressed, anxious, addicted — with and because of COVID-19. This made us feel compelled to share what we knew about what works.

Because COVID-19, smoking and behavioral health are so interconnected, we knew that if we tackled these issues together, we could help to improve the lives of many in our community. We wanted to be deeply engaged in the pandemic response, to learn and spread the public-health lessons so they could be put into practice for the inevitable next time a pandemic or similar crisis hits. We couldn't look the other way, and so we undertook an array of efforts and initiatives, which we relate in this report.

What follows lays out what we have learned and done during the time of COVID-19, and what we make of it all.

Background: Before the Pandemic

The Smoking Cessation Leadership Center, housed at the University of California, San Francisco, was established in 2003 to work with health professional organizations and institutions to increase their motivation and ability to help smokers quit.

Nearly 70 percent of adults who smoke say they would like to quit, but only about 3-5 percent are able to do so without help.[vi] The advice of a health professional by itself can increase the chance of a quit attempt, yet only 69.5% percent of adult smokers who saw a physician in the last year said they were advised to quit.[xvi]

Statistics like these illustrate a startling truth—health professionals have an opportunity to make a big difference in helping their patients quit smoking, but too many do not take advantage of it. Neither do the many clinical organizations, governmental agencies, and advocacy groups that decry the ill effects of smoking but put little effort into smoking cessation.

SCLC's efforts began with primary care physicians but have since expanded to include many other medical and non-physician disciplines, ultimately engaging 21 separate specialties. SCLC also stimulated smoking cessation projects in governmental, not-for-profit, and industry groups, including the federal Veterans Affairs Department and the Health Resources Services Administration of Los Angeles County. Because clinicians and their organizations are often daunted by the challenge of becoming cessation experts, SCLC began a program called "Ask, Advise, Refer," to promote referrals to telephone quitlines, which are highly effective at helping people to escape their tobacco habits.

The deathly grip of a smoking addiction — and the deep-seated prevalence of smoking among those with mental illnesses and substance-abuse disorders — has required SCLC to be tenacious and creative when working in the field of behavioral health. Smoking is much more common among persons with behavioral health conditions, and people with these disorders are more likely to die from smoking than from any other affliction.

But smoking cessation has not been integrated into the treatment of behavioral health conditions, even though studies have shown that stopping smoking can improve mental well-being and improve outcomes for substance use disorders. 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.

Since 2007, SCLC has been working with agencies, advocacy organizations and clinical groups, like the federal Substance Abuse and Mental Health Services Administration, the National Alliance on Mental Illness and Community Anti-Drug Coalitions of America, and the American Psychiatric Association, 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 nearly 27 percent of adults with serious mental illness are individuals who smoke,[vii] compared with 11.5 percent of the general population.[viii] Studies have shown that people with serious mental illness die 25 years before the general population, often from smoking-related diseases.[ix]

Nearly 20 years later, the work goes on. You can say it has barely begun. Smoking still kills 520,000 people a year in the United States.

March 2020: When Everything Changed

When the pandemic hit, it swept in on a flood tide of anxiety, uncertainty and fear. The public-health response was chaotic, full of confusing mixed messages, amid a political environment of demagoguery and seemingly willful ignorance.

As hospitals, nursing homes and other institutions became overwhelmed, public-health organizations at the local, state and regional levels did their best to mobilize.

Academic institutions like SCLC worked hard to fulfill their mission during the COVID-19 storm. Tackling smoking and behavioral health together in the time of COVID-19 was a challenge, to say the least. We often heard from our constituents that the pandemic had made it nearly impossible to put out any public health message that wasn't about COVID. And so, as it is often the case in substance abuse and behavioral health treatment, smoking was relegated to a "lesser problem" even though the death toll from commercial tobacco use is so vast (imagine if COVID-19 happened every other year — that's how many people tobacco kills).

An important point: What you're reading about here we didn't do alone. We have had partners, we've been facilitators, all this work has been in deep collaboration with others.

Our work during the pandemic was laid on a foundation that we had begun to build several years earlier. It had become clear by about 2005 that the goal of creating tobacco-free spaces was going to be especially difficult in the worlds of behavioral health and substance abuse. Professionals working in those sectors 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: Patients who do well get cigarettes; those who don't, don't.

But several studies appeared that shocked these communities into re-evaluating their common practices. We learned that more than 44 percent of adults with serious mental illness were smokers, compared with about 20 percent of the general population at the time. Studies also showed that people with serious mental illness died 25 years before the general population, often from smoking-related diseases.

This was about the same time, the SCLC was beginning to make inroads with the mental health and substance abuse community. Robert Glover, PhD, executive director of the National Association of State Mental Health Program Directors, asked for help in persuading state mental health directors of the importance of banning smoking at state mental health hospitals, almost all of which at that time allowed it. We provided Glover's group with a $30,000 study grant in 2005 to find out how many of the state mental health hospitals were tobacco-free. The study found that just 20 percent banned smoking.

At annual meetings of the state mental health directors, Schroeder and other center staff members used this data to help catalyze the field to do something, Glover said.

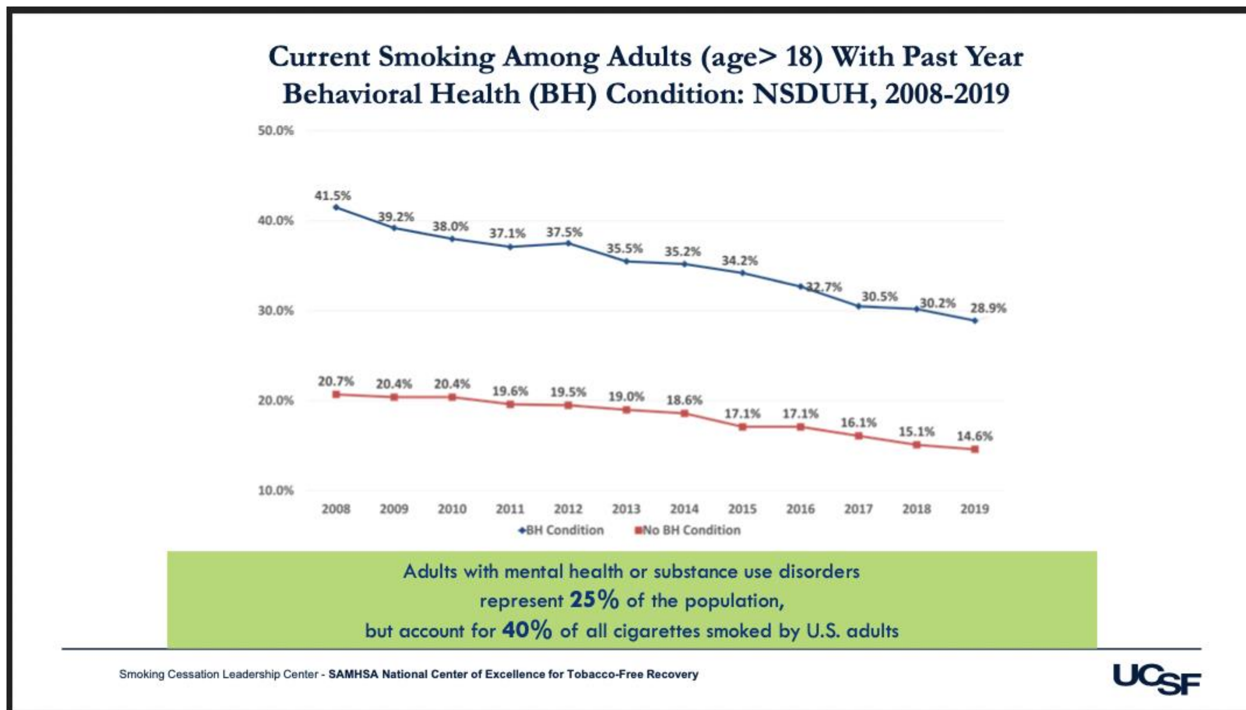
In July 2006, NASMHPD approved a goal of making all state mental health hospitals smoke-free. Then, with the center's support, the association developed a toolkit for hospitals to do just that.

In 2007, the center launched the Behavioral Health Partnership for Wellness and Smoking Cessation to legitimize the idea of smoke-free mental-health facilities. Partners included the Depression and Bipolar Support Alliance, the American Psychiatric Nurses Association and the National Alliance on Mental Illness. It worked: By 2011, our follow-up study found that some 79 percent of state mental health facilities were now tobacco-free.[x]

SCLC also worked with multiple public and private partners, including the federal Substance Abuse and Mental Health Services Administration and the Community Anti-Drug Coalitions of America, to put smoking cessation on the

front burner for people with substance use disorders. In 2011, the center organized five SAMHSA state health summits that brought together heads of various agencies in each state (tobacco control, mental health, substance abuse, alcohol, public health, and the state quitline and clinical leaders) to agree on a common goal of reducing smoking prevalence by a defined amount within a specified period. The summit members have created a set of strategies that they pledge to execute. Two more summits were added in 2012, in Texas and North Carolina.

The 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 needed to go on one-on-one meetings with all the national leaders and convince them with the data," Catherine Saucedo said. "And we did."



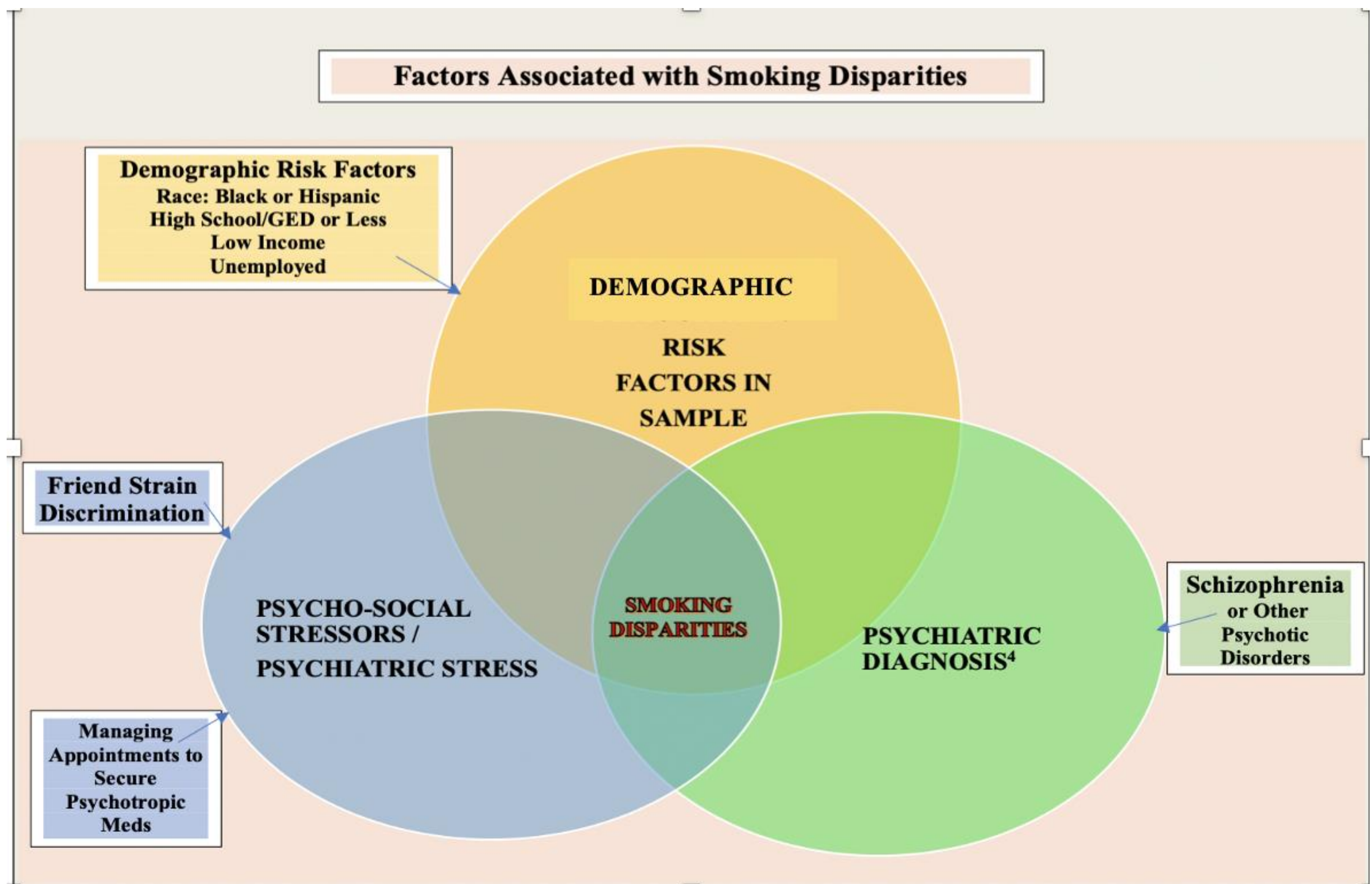
So by the time the pandemic hit, we knew what worked. That, in fact, was the title of a webinar we sponsored in September 2021. The graphic above shows the good news of a steady decline in smoking among adults with behavioral health conditions from 2008 to 2019 — just before COVID-19!

The smoking rates in that population were still bad, but slowly getting better. And then the pandemic hit.

COVID-19 in Communities of Color

As part of SCLC's work raising awareness of tobacco's toll in specific populations — Native American, Latino, Asian American and Pacific Islander, and African American — we conducted media briefings and developed op-ed articles from experts in community-specific smoking-cessation work.

In December 2021, a webinar we hosted on "Stress and Cigarette Smoking Among Black and Latinx Adults with Psychiatric Disorders" showed 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.[xi] The study also measured psychiatric related stress to examine the relationship between such stress and smoking status and nicotine dependence.



The 2013 study found, among other things, that participants who reported high stress related to relationships, finances, work, perceived inequality, past-year family problems, and high summary scores were more likely to be persistent smokers. It also found that high relationship stress, perceived inequality, and past-year family problems were associated with almost double the odds of failure to quit.

Seven years later, COVID-19 exploded on the scene and made difficult situations for this population far worse.

The coronavirus is especially dangerous for people with conditions like lung and heart disease, high blood pressure, diabetes, cancer — sicknesses that using tobacco causes or worsens, and that disproportionately attack communities of color. As Dr. Janice Tsoh of the University of California, San Francisco, has written, COVID-19 has exacerbated the gaps of health care, with deadly results. Anxiety and depression have run rampant, racist violence has spiked in Asian-American communities, and many people have started or resumed smoking to manage their stress.

Also in December 2021, SCLC conducted a briefing for the media: "An Issue of Health Equity: How COVID-19 Is Impacting Smoking Prevalence for Minority Populations." Researchers who shared findings on prospects for smoking cessation were: Delmonte Jefferson, Executive Director, The Center for Black Health & Equity; Janice Tsoh, Practicing Clinical Psychologist and Professor of Psychiatry and Behavioral Sciences at the University of California San Francisco; Marcel de Dios, Assistant Professor in the Department of Psychological, Health, and Learning Sciences at the University of Houston; and Patricia Nez Henderson, MD, MPH, a member of the Dine' (Navajo) tribe and a leading authority on tobacco control in American Indian communities.

The panelists explained how people with underlying medical conditions, particularly cigarette smokers, experienced disproportionate health consequences with COVID -- some due to vaccine hesitancy, and others because of the mental health impact of the pandemic. This was made worse by the Delta variant. Spotlighting these challenges specifically among minority populations, the panelists said, reveals inequities fueled by racism and cultural norms that continue to contribute to negative health outcomes from smoking.

The condensed text of the four op-eds exploring the pandemic's effects in 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. The striking developments involving smoking on Indian reservations and in Indian casinos.

What Happened When Smoking Was Banned in Indian Casinos

By Patricia Nez Henderson and Catherine Saucedo

Patricia Nez Henderson, M.D., MPH, vice president of the Black Hills Center for American Indian Health, is Diné (citizen of the Navajo Nation) and an expert on commercial tobacco control in American Indian communities.

Catherine Saucedo is deputy director of the Smoking Cessation Leadership Center at the University of California, San Francisco.

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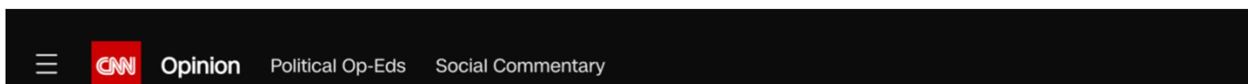


What happened when smoking was banned in American Indian casinos

Opinion by Patricia Nez Henderson and Catherine Saucedo
Updated 2:39 PM EST, Sat March 12, 2022

It took more than a decade to achieve. The final push to victory resulted from -- of all things -- a global pandemic. But anyone who cares about health in Indian country will gladly take the win. American Indian tribes are banning smoking in casinos and other public places -- permanently, in the case of the Navajo Nation, the Eastern Band of Cherokee Indians and others.

This development may have once seemed unthinkable in communities where consuming tobacco is both a sacred ritual and a heavily entrenched public-health burden. But it's happening. It is a striking reversal for the tobacco industry, which has pushed its toxic products on American Indian lands for a century or more, and the gambling industry, which has argued against smoking bans since Indian casinos first emerged in the 1980s.

Advocates for preventing and treating addictions now need to learn from and consolidate this victory. We should fight hard to persuade our nations with only temporary smoking restrictions to make them permanent.

Traditional healers have taken care to explain and preserve the crucial distinction between ceremonial tobacco, which has an old and rightful place in religious observances, and commercial tobacco products, whose only sacrament is pursuit of the sacred dollar. This distinction has been blurred over many years, to the great detriment of American Indian health and well-being. Federal policies enacted in the 1800s banned American Indians' cultural and religious practices, curtailing the ritual use of traditional plants like tobacco Not long after, the tobacco industry made its move and began injecting its poison -- commercial products far different from the plants used in religious rites -- into American Indian communities. American Indian iconography and imagery have been used to sell cigars, cigarettes, chewing tobacco and a false history in which Indian culture and nicotine were indelibly linked.

It has taken a lot of effort and education to turn that story around. Casinos worried that going smoke-free would cost them customers and precious revenue. American Indian communities which used commercial tobacco sometimes conflated tradition with addiction. Public-health advocates had their hands full fighting against a range of scourges -- not just commercial tobacco but also other addictive drugs -- and for essentials sorely lacking on reservations, like clean water and air, with little money or support.

Then, two years ago, Covid-19 hit and casino profits plunged. Advocates used the opportunity to present options to industry executives. Many of the casinos reopened with new policies designed to allow customers to breathe easier and not get sick. These included previously unheard-of smoking restrictions -- it's hard to smoke with a mask on. But much to everyone’s surprise, it seems that going smoke-free could be good for business.

For much of our country, it took a lethal pandemic to bring forth such simple, common-sense health measures, but that is the situation the tobacco industry has left us in, not only in Indian country but in marginalized communities everywhere.

Covid and smoking are parallel disasters. The pandemic has killed more than 950,000 people in the United States in the last two years. Use of commercial tobacco products kills about 500,000 people a year. Many of these deaths result from illness laid atop injustice. Indian reservations and other communities of color have long been afflicted by poverty, ill health and inadequate health care. For generations they have also been targets of the tobacco industry's aggressive, predatory marketing. No wonder they suffer disproportionately from lung and heart disease, high blood pressure, diabetes, cancer and other conditions linked to tobacco use. The industry's deadly products create many opportunities for an opportunistic virus to sweep in and cut down those whom tobacco has left vulnerable.

These are the challenges that confront those trying to improve public health in Indian country. Commercial tobacco is a powerfully addictive drug, and Covid-19 is ruthless. Saving lives often starts with getting people to break their smoking habits. This can be difficult, but here is the good news: Smokers can free themselves, through proven

interventions like counseling, peer and family outreach, and medications like nicotine gum, patches and other pharmacotherapies. Telephone quit lines can double their chances of success.

And yet, on Tribal reservations, where many homes lack electricity and running water, calling a quit line or attending an anti-smoking webinar are not always realistic options for smokers.

But smoke-free casinos are feasible. And American Indians seeking to quit can benefit from the role of traditional healers and techniques like mindfulness training, which was a fact of American Indian life centuries before it became a contemporary buzzword. And, as Dr. Nez Henderson has often said, American Indians can decolonize tobacco in every setting. American Indians themselves can debunk the notion that commercial tobacco is somehow an integral part of Indigenous culture. It's not. The casinos are a fine place to start, but this isn't over. We are continuing to fight to change the system to deliver health equity – and we need help with basic resources to make cessation possible as we continue the decolonization struggle. The sooner commercial tobacco addiction begins disappearing from Indian country, the better we are as tribal nations.

Racism, COVID-19 and the Battle Against Menthol Cigarettes

By Delmonte Jefferson and Catherine Saucedo

[Delmonte Jefferson](#) is executive director of the Center for Black Health & Equity, a national organization that facilitates public health programs to benefit communities and people of African descent.

The Food and Drug Administration this week proposed banning menthol cigarettes, long popular among Black smokers. It's an overdue move that will save many lives — the tobacco industry's targeted marketing to African-American consumers, particularly with menthols, is a major reason that this community suffers disproportionately from tobacco-related diseases and death.

We anti-smoking advocates are now bracing for a long and bitter public-relations and legal battle, as the tobacco industry fights to hold onto menthols — the only flavored cigarettes still being sold in the United States — so it can prolong its deadly grip on a community that it has already done so much to sicken and kill.

Big Tobacco has worked devilishly hard to hold onto its black smokers, and to replace those who die. For many decades it has enlisted black sports and entertainment icons as spokespeople and pushed its products heavily in publications like Jet and Ebony. It has promoted cultural events like the Kool Jazz Festival, which is as much a celebration of cigarettes as it is of music.

Behind all these efforts is the addictive treachery of menthols. They mask the bitterness of burning cigarettes, making the habit easier to start and just as hard, if not harder, to quit. The industry has worked tirelessly to establish menthols in the Black community, with help from the inside. As The Los Angeles Times reported on Monday, Big Tobacco has systematically bought off Black lawmakers, civil-rights leaders, law-enforcement officials and others to help it defend menthols. These hired shills spread the industry's ridiculous lie that menthol crackdowns are somehow motivated by racism and will pose a new policing danger to Black smokers, particularly young men.

It is maddening to see people like the Rev. Al Sharpton and members of the Congressional Black Caucus speaking out of both sides of their mouths — denouncing police violence against African Americans while defending menthol cigarettes. They parrot the false argument that banning menthols will somehow make African Americans more vulnerable to unjust arrests — as if racist cops need any new excuses to oppress. The murders of young black men by the police are a brutal injustice. But so are the preventable deaths, in vastly greater numbers, of their ailing black sisters and brothers at the hands of the tobacco dealers.

As the researchers Valerie Yerger and Ruth Malone, of the University of California, San Francisco, have put it, the industry's African American allies are smoking with the enemy. The tobacco industry, they write, "established relationships with virtually every African American leadership organization and built longstanding social connections with the community, for three specific business reasons: to increase African American tobacco use, to use African Americans as a frontline force to defend industry policy positions, and to defuse tobacco control efforts."

Thankfully, not all community leaders are willing to blowing smoke for the industry. Derrick Johnson, president and chief executive of NAACP, called the FDA's decision "a huge win for equity, justice, and public health concerns." He

said in a statement that “the targeting and marketing of menthol flavoring by the tobacco industry have had a devastating impact on our community."

Racist, brutal policing is a deadly fact. But so are these facts: Heart disease, cancer and stroke, all tobacco-related diseases, are the leading causes of death among African Americans. Blacks get lung cancer at higher rates than Whites. And African American children and adults are more likely to be exposed to secondhand smoke than any other racial or ethnic group. Compared with regular cigarettes, menthol cigarettes have higher carbon monoxide concentrations and may increase the risk of lung and bronchial cancer.

Although Blacks as a group tend to be lighter smokers than other Americans, they have more difficulty quitting. While 74 percent of African American smokers say they want to quit, and about 60 percent of them try each year, only 3.3 percent succeed, compared with 6.6 percent of Whites.

These truths are difficult to hear. But here is the good news. There are ways of escape, even in these trying times. Smokers can quit, and they do. The Smoking Cessation Leadership Center has worked with health practitioners around the country to help smokers to break their shackles, through counseling, social support, and medication like nicotine patches. Smokers' quitlines double the chances of quitting. And these methods work better if they are delivered in culturally appropriate ways and with serious follow-through. The Center for Black Health & Equity has pioneered such efforts, with events like No-Menthol Sunday, a day to help black churchgoers better understand the industry's tactics.

But all this work is undermined when some of Black America's most respected leaders and elected representatives are working with the industry — and, shockingly, using the righteous power of the anti-racist and Black Lives Matter movements to sell more cigarettes.

The most effective call to action in recent memory, heard around the world, was uttered by Eric Garner in New York and George Floyd in Minneapolis: "I can't breathe!" Those very dying words may have been uttered, too, by the untold thousands of other Black men and women whose tobacco use led to deathly illnesses, including the coronavirus. When we debate what to do about menthol cigarettes, let's remember them as well.

On May 25, 2022, The Los Angeles Times published a letter to the editor from Jefferson and Saucedo about this subject. It was headlined: "Big Tobacco's exploitation of George Floyd and Eric Garner is next-level evil."

LETTERS TO THE EDITOR

Letters to the Editor: Big Tobacco's exploitation of George Floyd and Eric Garner is next-level evil

To the editor: Only a truly bleak satirist could dream up a scheme as cynical as the tobacco industry hiring Black civil-rights advocates to help sell products that kill Black people. And with this repulsive twist: using George Floyd and Eric Garner to falsely suggest that cigarettes — particularly menthols — go well with anti-racism and Black Lives Matter.

That's deep, in-the-gutter evil. But it's real.

As The Times' investigation reveals, the industry has put Black leaders on its payroll for years to block efforts to keep menthol cigarettes out of Black neighborhoods. They help to push the lie that menthol bans are motivated by racism and pose a police danger for young Black smokers.

Making menthols the favorite among African American smokers is one of Big Tobacco's oldest and greatest marketing triumphs. Easier to smoke and very hard to quit, menthols are a main reason that tobacco-related illnesses kill a disproportionately high number of Black Americans.

It is not lost on many anti-smoking advocates that addiction is akin to enslavement — that African Americans long ago went from picking tobacco to smoking and dying from it.

Your article could have mentioned one more bitter dimension to this story. Everyone who was moved to grief and action by the shocking murders of Floyd and Garner remembers their dying words: "I can't breathe!" Now think of the many African Americans, sickened to death by their addiction to menthol cigarettes or felled by the coronavirus because of smoking-related respiratory problems, who died with those very words on their lips.

That is the tobacco industry's murderous gift to us, with help from its many shills in the Black community.

Delmonte Jefferson, Durham, N.C.
Catherine Saucedo, San Francisco

COVID-19 and the Smoking Burden in Communities of Color

By Janice Tsoh and Catherine Saucedo

Janice Tsoh *is Practicing Clinical Psychologist and Professor of Psychiatry and Behavioral Sciences at the University of California, San Francisco.*

We need to talk about smoking. Yes, there is another public-health emergency still dominating the news and occupying our minds. The pandemic has been devastating. But it helps to remember that diseases caused by tobacco have not eased their deadly grip — particularly in communities of color.

That is why the Food and Drug Administration this week proposed banning menthol cigarettes, the type that the tobacco industry has long marketed to African-American consumers. Menthols are favored by a wide margin among Black smokers, and they are a major reason that this group suffers disproportionately from tobacco-related diseases and death.

The FDA's decision stems from its realization that illness and injustice have long been intertwined. This truth has been cruelly laid bare in the last two and a half years. For generations — with lethal effectiveness — the tobacco industry has pushed its poison into communities of color. Among many individuals who are dependent on — and weakened by — smoking cigarettes or using tobacco, COVID has been finishing the job.

The coronavirus is especially dangerous for people with conditions like lung and heart disease, high blood pressure, diabetes, cancer — sicknesses that using tobacco causes or worsens, and that disproportionately attack communities of color. In the underserved Asian American and Pacific Islander communities where Dr. Tsoh conducts research, COVID-19 has exacerbated the gaps of health care, with deadly results. Meanwhile, as anxiety and depression have run rampant in these COVID times, and racist violence has spiked in Asian-American communities, many people choose smoking to manage their stress. Mood is one of the biggest triggers for continuing or increasing tobacco use, or for ex-smokers to relapse.

COVID and smoking are interconnected problems, and if we think about them together, this awareness can improve the public-health response — and the lives of many in our community.

Our research and advocacy involve trying to understand why people smoke and how to help them quit. The Smoking Cessation Leadership Center, working with health practitioners around the country, has highlighted the principles and methods that help people to break their nicotine shackles. Dr. Tsoh's research mission has been to bring to underserved populations the information and skills that will help them abandon tobacco in favor of better health.

The good news is that despite the many social and health inequities that COVID has brought to light, and addiction's powerful grip, there are interventions that work. People can break the habit, through counseling, peer and family outreach, and medications like nicotine gum or patches or inhalers. Smokers' quitlines (1-800-QUIT-NOW) work, too, free telephone counseling services available in multiple Asian languages through the Asian Smokers' Quitline — in fact, they double the chances of quitting. And these and other methods are even more effective if they are delivered in culturally appropriate and sensitive ways, with well-targeted messages and serious follow-through. This is absolutely essential for engaging with Asian Americans and Pacific Islanders.

But here is the rub: Shaping the right approaches and messages for different communities requires information that is often unavailable. One of the greatest challenges in working with the Asian American and Pacific Islander population, for example, is the lack of detailed survey data that accounts for the vast diversity of nationalities, ethnicities, social groups and languages within those broad demographic categories.

Surveys have shown that overall, people in Asian and Pacific Islander communities use tobacco less than other groups. But generalized statistics like these don't account for the significant variations between and among communities — not to mention between women and men, immigrants and the native-born, and those who speak English and those who don't. Smoking is disproportionately high in some groups, particularly among Asian men with limited English proficiency. Cigarette use tends to be higher among those of Korean and Vietnamese ancestry than among those of, say, Asian India or Chinese descent.

Better data would help us to understand and explain these disparities. We know that mental illness and substance-use disorders disproportionately affect underserved groups and racial minorities. But language barriers and social isolation can hamper surveys measuring things like tobacco use and mental health. Fortunately, hard work on the ground can overcome gaps in the data. Dr. Tsoh and her research team have been conducting several community-based projects among Asian American smokers and their families, with lay health workers reaching out to promote quitting and healthy lifestyle changes.

We don't know all we want to know about the long-term consequences in the many communities harmed by smoking, just as we don't yet know when and how COVID will end. We do know that the journey out of addiction is often a long one, with frequent relapses. And yet we also have a very good idea of what works to reduce the damage that tobacco does to families and communities.

We know that — as with raising children — healing someone's smoking addiction takes a village, through education and a lot of compassionate support from peers and family members. As we continue to battle a virus that has ended and ravaged so many lives, let's apply some of that same urgency — along with hope and determination — in renewing our fight against tobacco, and getting smokers and their loved ones who are affected by secondhand smoke exposure to breathe freely again.

Smoking Worsens COVID-19's Toll in the Latino Community

By Marcel de Dios and Catherine Saucedo

Marcel de Dios is an assistant professor in the Department of Psychological, Health, and Learning Sciences at the University of Houston.

In less than two years, the pandemic has killed more than 850,000 people in the United States. Smoking kills about 500,000 every year. That is a devastating toll of sickness and misery, but we should not let ourselves be numbed by the numbers. We should all be working at saving lives — taking all the steps we can to prevent what deaths we can.

We can start by acknowledging that these disasters are related. Covid and smoking are like deadly partners in crime, and not just because they leave people gasping for breath, in terrible suffering. These afflictions are working together in attacking the Latino and immigrant communities and other communities marginalized by poverty and isolation, where poor health and uneven health care leave millions with underlying conditions that increase their risk of severe illness.

Covid is dangerous for those who have tobacco-related ailments like lung and heart disease, high blood pressure, diabetes and cancer — sicknesses that disproportionately attack communities of color. Stress, anxiety and depression, meanwhile, are causing many Covid-weary people to light up. Mood can be one of the strongest impulses for starting (or falling back into) a smoking habit.

Fighting back against Covid is relatively straightforward, a matter of vaccines and masks. But the battle against tobacco is another story. In the Latino community as much as any other, a nicotine addiction is powerful and relentless — and so is the tobacco industry, which has pushed its poisons on its victims for generations.

The good news is that people can break the habit. Years of research have given us an array of interventions that work, including counseling, peer and family outreach, and medications like nicotine gum, patches and inhalers. Telephone quit lines have been shown to double a smoker's chances of escaping an addiction. And if these methods are delivered in culturally appropriate ways, they are even more effective.

The Smoking Cessation Leadership Center works with health practitioners around the country to highlight the principles and methods that help smokers quit. Its mission has been to pass on the information and skills that help people in underserved communities overcome their addictions and improve their health.

One example of a culturally tailored approach is a study now being conducted by Professor de Dios at the University of Houston's Health Research Institute. It aims to test various ways to help Latino smokers who have been trying to quit smoking through counseling and nicotine-replacement therapy. Professor de Dios hopes the findings will give clinical practitioners better tools to make their anti-smoking interventions more effective in the Latino community.

This work could potentially do a lot of people good — there are about 60 million Latinos live in the United States, and about 6.2 million are smokers.

Research shows that Latinos and Asian and Pacific Islanders generally use tobacco less than members of other groups. But we need better data to understand the facts beneath those generalized statistics. Broad demographic terms fail to capture the vast diversity and differences among nationalities, ethnicities, social groups and languages, not to mention the varying ways different people may use tobacco — women and men, immigrants and the native-born, and those who speak English and those who don't.

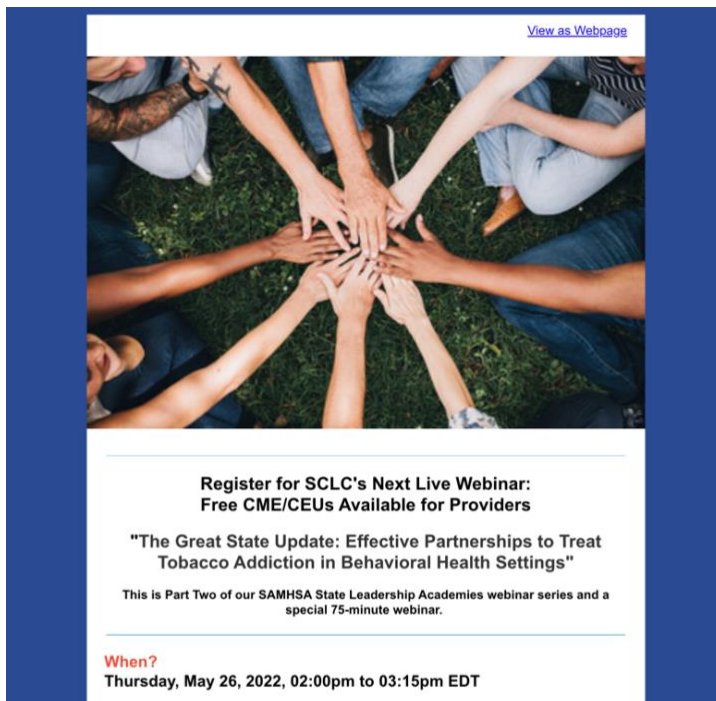
Smoking can be disproportionately high in certain subgroups. According to the Centers for Disease Control and Prevention, Puerto Ricans smoke cigarettes considerably more than other Latinos — about 28.5 percent, compared with 19.1 percent for Mexicans and 15.6 percent for Central and South Americans. Among people who smoke every day, Cubans light up most often, with 50% of male daily smokers and more than 35% of female daily smokers report smoking 20 or more cigarettes per day.

Language barriers and social isolation are among the reasons surveys measuring tobacco use and mental health tend to miss certain groups. But gaps in the data can be overcome by on-the-ground legwork that meets smokers where they live, in their own languages.

We don't want to suggest that quitting smoking is easy. It's not. The journey out of addiction can be very long and slow, and is often stalled by relapses. But years of study have given researchers a good idea of what helps smokers to quit. We need to use all the tools available to undo the damage that tobacco does to smokers and their families and communities.

The battle against the coronavirus has shown us the priceless importance of education and persistence — how the effects and spread of a lethal respiratory disease can be blunted if people have good information and the steady support of peers and family members. It's the same with smoking. If we apply the same fierce urgency to fighting tobacco — while holding on to hope and determination — we will save many, many lives.

Technical Assistance to the States



In May 2022, another SCLC webinar offered what we called "the Great State Update," a refresher on the partnerships we had been building for years to treat tobacco addiction in behavioral health settings.

One example of SCLC's outreach can be seen in California, where the smoking rate is 6.2%[xii] — and the smoking rate among adults with frequent poor mental health is 14.1%,[xiii] over double the rate of the general population.

The California Behavioral Health and Wellness Initiative (CABHWI, pronounced "cabby") will help create equal access to cessation services for all smokers in the state, specifically those with a behavioral health condition, such as a mental health diagnosis or substance use disorder.

Through this initiative, UCSF's Smoking Cessation Leadership Center provides customized, technical assistance, and social marketing for behavioral health agencies, providers, and the clients they serve throughout California. In part because of the success of CABHWI, Assembly Bill 541 is now in effect, which requires substance-use treatment facilities to screen for tobacco use on intake and offer treatment if an incoming patient is determined to have Tobacco Use Disorder. Michael Freeman, who is in charge of the group evaluating these facilities for the state, was on the advisory board for CABHWI. Also, in April 2022, the Journal of Substance Abuse Treatment published one of the few studies about the initiative that shows a positive association between tobacco-free grounds and cessation. It concluded: "An intervention to promote tobacco-free grounds implemented in residential SUD (substance-use disorder) treatment programs was associated with a significant reduction in client smoking and an increase in NRT/pharmacotherapy. These associations were observed both before the COVID-19 pandemic and in the early stages of the pandemic, suggesting that they may be due to the intervention rather than to the pandemic."

Covid-quitting

"I COVID Quit" is our national social media marketing campaign, begun in March 2021, to promote smoking cessation among people with behavioral health conditions. The campaign utilizes the pandemic as a motivating force to give up smoking. It is funded by the Robert Wood Johnson Foundation for "Sustaining and Expanding the National Partnership on Behavioral Health and Tobacco Use."

Through posters, streaming videos and other media materials, social-media hashtags and personal testimonials, the I COVID Quit campaign took a positive approach to confronting the pandemic tragedy, enlisting the dire urgency of the public-health crisis to help thousands of people to finally break the grip of smoking.

Below are some of the comments we received on the I COVID Quit page of our website where we asked people to tell us how they "COVID quit." This new feature was accessed through clicking on social media ads or visiting icovidquit.org or navigating from the "Campaigns" section of our website. The social media toolkit as well as all the assets—still ads and videos—were available at no cost on the page.

"I quit smoking 20 days ago. It was my fifth attempt. It feels good to have done something positive for my health. I think I've quit for good this time. Wellbutrin helped. Having a dedicated support person helped."

—Amanda C., Michigan

“I never thought I had a problem smoking, but I smoked when I drank beers with my friends after my shift at the restaurant where I worked. I'm trying to start over now, and it feels good to choose the things that are good for me. Even though it’s really hard, and COVID added a lot of stress, I’m always fighting to be healthy.”

—José, New Jersey

"I started at only 12 years old from being peer pressured into it by some bad kids. I smoked half a pack a day for 20 years. When COVID hit, the fear of catching it led me to my decision to quit. While there have been some slip-ups, I'm determined to quit for good."

—Josh, shared on Instagram @tobaccofreerecovery

"I started smoking cigarettes at age 12. I started abusing substances at age 13. I began my recovery from substances July 25, 2014. I quit smoking cigarettes in May of 2017 but began vaping then and continued to vape for 3 years after I quit smoking. When the pandemic began I actually got really sick at the end of March into the beginning of April. My area didn’t have Covid tests to know whether that was what was happening but I thought, 'If this isn’t Covid, I don’t want to know what it is like to vape if I do have it, because this is bad.' So, I ordered nicotine gum online and started using that while vaping here and there and finally quit vaping April 11, 2020."

—Ana Woodburn, Health Educator, Hutchinson, Kansas

Katie Rodgers's Story

Katie Rodgers is 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. This article was published in The Hill on May 17, 2021, and is reprinted here with permission.

How the Pandemic Helped Me Quit Smoking

By Katie Rodgers

As we look with hope for the end of the COVID-19 pandemic, "what now?" is the big scary question. We all know that the pandemic has made things worse in so many ways, and cigarette smoking is one of those things that has gotten worse.

I see people smoking more, fewer quitting, and with all the challenges we have, too little attention to how smoking hurts our mental health. This is a big deal, because hundreds of thousands of people will die from smoking this year — just like every other year. I know all this firsthand, because I've been in a personal battle with both smoking and depression for years, and I know I'm not alone in this struggle.

I started smoking at the age of 15. I was a rule follower back then. I don't think I ever skipped class, but after school I did all sorts of things that I probably shouldn't have. I smoked with my friends and I smoked at parties and I smoked in coffee shops. I continued to smoke in college and kept on smoking afterwards.

Today, if I could talk to my 15-year-old self — I don't know if I would have actually listened — I would point out that this thing that seems fun will actually lead you down a path of self-hatred. The times that smoking makes you feel good will be heavily outweighed by the times that you feel physically sick or sad. And I see that now, after a year of this pandemic, more than ever.

The nicotine that you inhale from smoking cigarettes not only makes you addicted, I've learned from a friend who is researching addiction, but your brain actually gets anxious until you light the next cigarette. No one should be hooked on that when all of us are struggling in one way or another with everything that has been dumped on us.

The first time I tried to quit, I was in my 20s. My partner at the time helped me quit, and that was great. Those were good years. But, after a while, I moved to Chicago without him, for my first teaching job. The stress of that job and the transition drove me to start smoking again.

After a few years, I moved back home with my parents, who don't tolerate smoking, so I quit again. They had good reasons: My father's parents were heavy smokers and both passed away from their addictions. For me, I knew cigarettes were bad, and they weren't helping my mental health at all. I still felt depressed and anxious.

So I quit, got my act together, moved out again, but then I ended up in a toxic relationship. Again, I secretly started smoking, because I couldn't figure out how to handle the stress of not knowing what to do with my life. I think that's the really evil part of cigarettes. You get so addicted, and cigarettes become your outlet for coping. For some people in certain circumstances, lighting up is one of the few parts of the day where they might get alone time.

Last year, I married someone healthy for me, got a great teaching job, but I had started smoking again. And then, when the COVID cases started piling up, I decided it was past time to stop. While other smokers kept puffing, I just became sick of my own patterns and behavior. I saw images and videos of young people on ventilators and read about hospitals that didn't have beds, with lines of people waiting outside on gurneys. I knew then that I had to quit. I don't want to die, alone in a hospital in California, without my husband or family around.

Fewer people are trying to quit smoking these days and it's because of COVID, of course. Quitline calls have dropped 27 percent, and cigarette sales are up. It's crazy. But now, as we start to climb out of this pandemic, there's no better time to quit. The resources are out there, free and available, but it's up to each one of us whether to take that first step.

Everyone defines "freedom" for themselves and sees that word very differently. But, if you are addicted to something, are you really free? When something is so overpowering that you can't say no to it? I have made a choice, to be done with cigarettes, because this brings me closer to what freedom now means to me.

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.

National Partnership on Behavioral Health and Tobacco Use

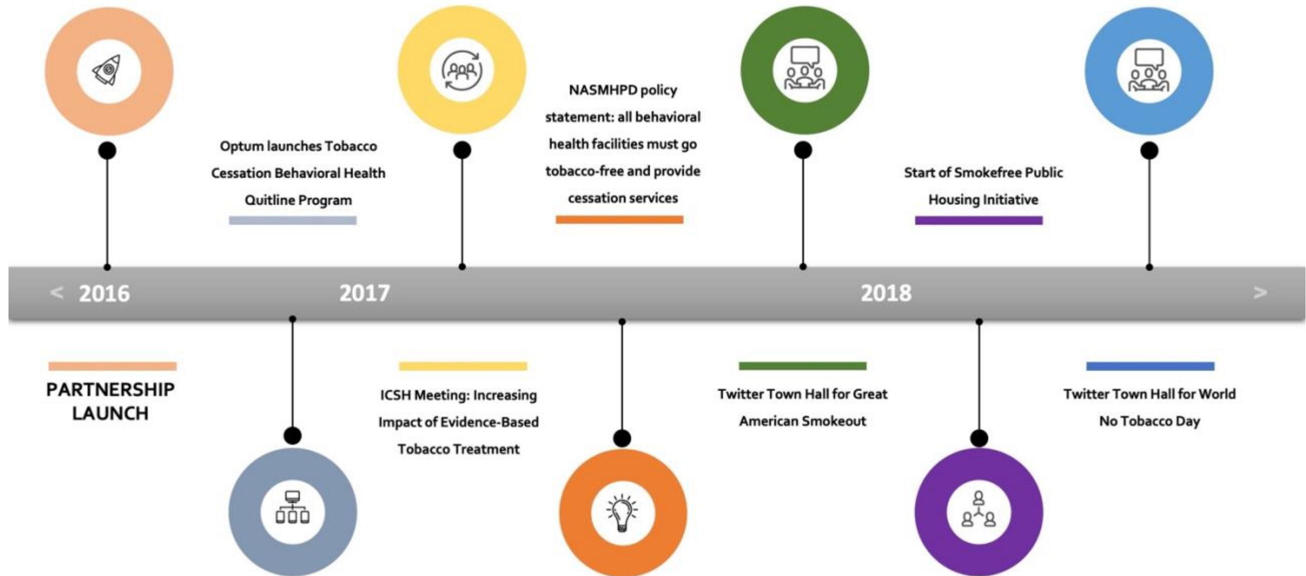
In 2016, SCLC and the American Cancer Society founded the National Partnership on Behavioral Health and Tobacco Use in response to the ongoing challenge of reducing smoking-related morbidity and mortality in this population. We convened leaders from the tobacco control/public health and behavioral health sectors to collaborate on the development of a comprehensive plan to combat disparities in smoking prevalence and treatment for those with mental health and substance use challenges.

Adults with mental health and/or substance use challenges (collectively referred to as behavioral health conditions) represent about 25% of the population, but account for about 40% of all cigarettes smoked in the United States. Half a million Americans die each year due to smoking, approximately half of whom are individuals living with behavioral health conditions. Indeed, a 2016 study found that the life expectancy difference between people who currently smoke with serious psychological distress (SPD) and those who never smoke without SPD is primarily due to smoking,[xiv] concluding that aiding individuals with serious mental illness to avoid smoking will translate into sizable gains in life expectancy.

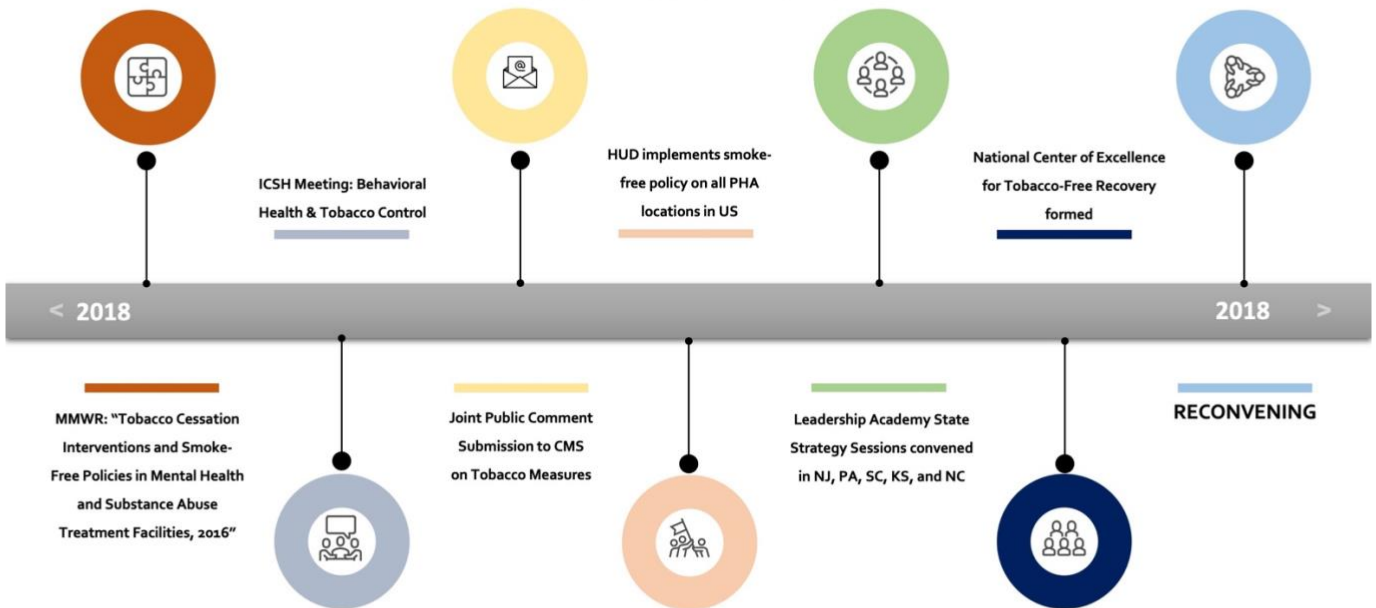
The partnership's member organizations and agencies set an original target to reduce smoking prevalence among adults with behavioral health conditions to 30% by 2020. We met this target more quickly than anticipated, in early 2018. By 2019, National Survey on Drug Use and Health data, on which these figures are based, showed that smoking prevalence among individuals with behavioral health conditions had fallen to 28.9%.[xv] So the National Partnership set a new and more ambitious target, to reduce smoking prevalence among those with behavioral health conditions to 20% by 2022 (#20by22).

In 2021, the most recent NSDUH data showed, quite encouragingly, that smoking prevalence was 26.8% among adults with any behavioral health condition.1Due to multi-mode data collection and a change in defining substance use disorder (using DSM-V definition), the 2021 data is not directly comparable to previous years. However, the National Partnership acknowledges this lower prevalence as movement in the right direction.

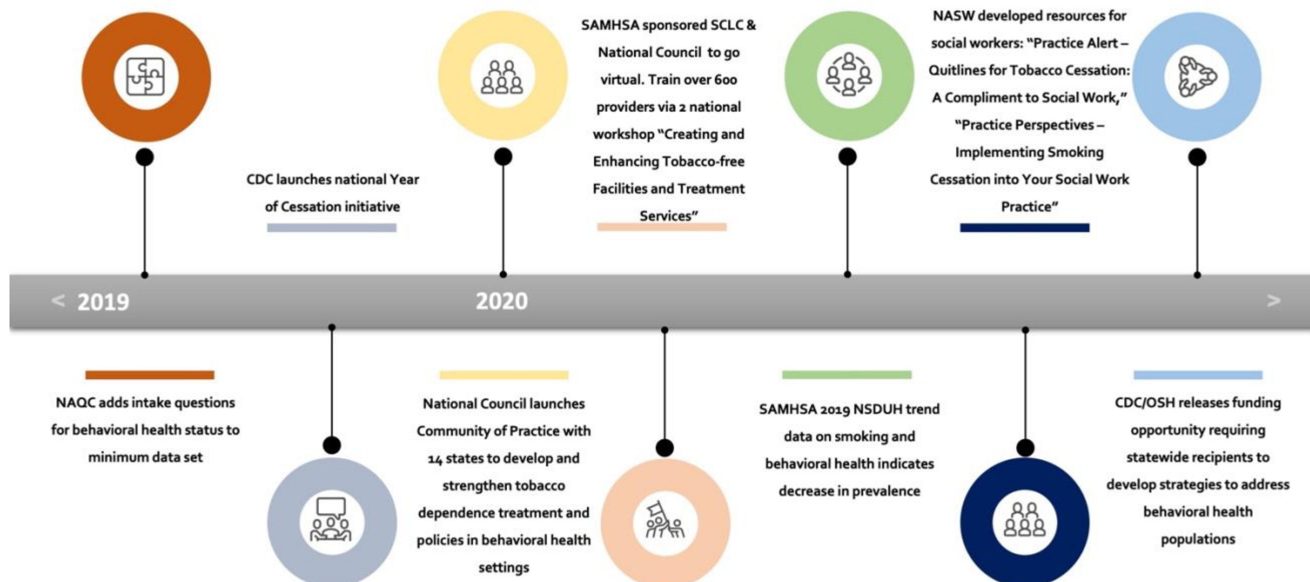
Since launching the National Partnership on Behavioral Health and Tobacco Use, smoking prevalence in the behavioral health population has dropped substantially since 2015. While there are certainly multiple societal and policy influences at work, there is clear evidence that the efforts of this first-of-its kind national collaboration has had, and continues to have a significant impact.

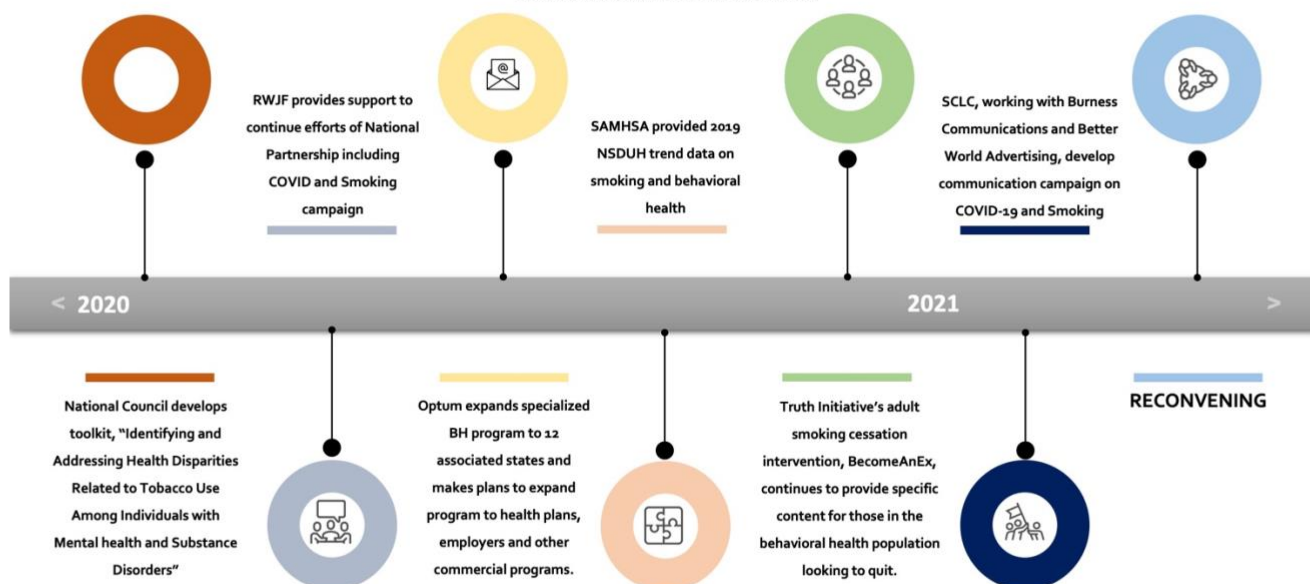


The National Partnership on Behavioral Health and Tobacco Use
Collaborative Timeline
2016
2017
2018
PARTNERSHIP LAUNCH
Optum launches Tobacco Cessation Behavioral Health Quitline Program
ICSH Meeting: Increasing Impact of Evidence-Based Tobacco Treatment
NASMHPD policy statement: all behavioral health facilities must go tobacco-free and provide cessation services
Twitter Town Hall for Great American Smokeout
Start of Smokefree Public Housing Initiative
Twitter Town Hall for World No Tobacco Day



The National Partnership on Behavioral Health and Tobacco Use
Collaborative Timeline
2018
2018
MMWR: "Tobacco Cessation Interventions and Smoke-Free Policies in Mental Health and Substance Abuse Treatment Facilities, 2016"
ICSH Meeting: Behavioral Health & Tobacco Control
Joint Public Comment Submission to CMS on Tobacco Measures
HUD implements smoke-free policy on all PHA locations in US
Leadership Academy State Strategy Sessions convened in NJ, PA, SC, KS, and NC
National Center of Excellence for Tobacco-Free Recovery formed
RECONVENING


The National Partnership on Behavioral Health and Tobacco Use
Collaborative Timeline
2019
2020
CDC launches national Year of Cessation initiative
SAMHSA sponsored SCLC & National Council to go virtual. Train over 600 providers via 2 national workshop "Creating and Enhancing Tobacco-free Facilities and Treatment Services"
NASW developed resources for social workers: "Practice Alert – Quitlines for Tobacco Cessation: A Compliment to Social Work," "Practice Perspectives – Implementing Smoking Cessation into Your Social Work Practice"
NAQC adds intake questions for behavioral health status to minimum data set
National Council launches Community of Practice with 14 states to develop and strengthen tobacco dependence treatment and policies in behavioral health settings
SAMHSA 2019 NSDUH trend data on smoking and behavioral health indicates decrease in prevalence
CDC/OSH releases funding opportunity requiring statewide recipients to develop strategies to address behavioral health populations


The National Partnership on Behavioral Health and Tobacco Use
Collaborative Timeline
2020
2021
RWJF provides support to continue efforts of National Partnership including COVID and Smoking campaign
SAMHSA provided 2019 NSDUH trend data on smoking and behavioral health
SCLC, working with Burness Communications and Better World Advertising, develop communication campaign on COVID-19 and Smoking
National Council develops toolkit, "Identifying and Addressing Health Disparities Related to Tobacco Use Among Individuals with Mental health and Substance Disorders"
Optum expands specialized BH program to 12 associated states and makes plans to expand program to health plans, employers and other commercial programs.
Truth Initiative's adult smoking cessation intervention, BecomeAnEx, continues to provide specific content for those in the behavioral health population looking to quit.
RECONVENING

Conclusion: Survey of the Work Ahead

The pandemic has shone a harsh light on the fragility of our society's systems of care. It 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 here is the unexpected opportunity that lies buried within the tragedy of COVID-19: The pandemic has introduced us to problems many of us weren't aware of and thus weren't addressing. It has 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. For example, there are not a lot of studies with statistics that reveal, say, how many Asian-Americans smoke while also experiencing behavioral-health disorders. Nor is there an abundance of data on how many African-Americans are smokers who are recovering from substance-use disorders.

To direct help toward those who need it, it will be necessary to get more and better information, to continue to do groundbreaking research to deepen our understanding of various communities, using troves of survey and clinical data that the global crisis of COVID-19 will surely 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, because so much misery starts with and flows out from a lighted cigarette.

Too often cessation is treated as secondary to whatever is considered the public-health topic of the moment. There are so many ways that well-meaning interventions keep missing the point. For example, it was often very difficult to introduce smoking cessation into a larger conversation about COVID-19. From the beginning of the pandemic, the discussion centered on taking specific actions related to this specific virus: Wash your hands. Wear a mask. Keep your distance. Get the vaccine and booster shot. It wasn't also — quit smoking now, so you have a better chance of surviving this deadly disease.

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.

There is so much more to do. 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. One promising idea is to establish a national standard for reimbursing social workers who are involved in behavioral-health programs that address smoking. Tackling smoking addictions in such settings can be extremely difficult. Progress takes considerable effort and time, and those who undertake this vital work deserve support

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. The people in our communities who are most affected and afflicted by tobacco are those living on the wrong side of the equity ledger. These are the people whose communities have long been under-resourced, undervalued and 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 life-affirming message: If you want to quit, you can. And we are here to help.

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