From the Sidelines to the Front Line

From the Sidelines to the Frontline: How the Substance Abuse and Mental Health Services Administration Embraced Smoking Cessation

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Smoking is a major contributor to premature mortality among people with mental illness and substance abuse. Historically, the Substance Abuse and Mental Health Services Administration (SAMHSA) did not include smoking cessation in its mission.

We describe the development of a unique partnership between SAMHSA and the University of California, San Francisco's Smoking Cessation Leadership Center. Starting with an educational summit in Virginia in 2007, it progressed to a jointly sponsored "100 Pioneers for Smoking Cessation" campaign that provided grants and technical assistance to organizations promoting cessation. By 2013, the partnership established 7 "Leadership Academies," state-level multidisciplinary collaboratives of organizations focused on cessation.

This academic–public partnership increased tobacco quit attempts, improved collaboration across multiple agencies, and raised awareness about tobacco use in vulnerable populations. (*Am J Public Health.* 2014; 104:796–802. doi:10.2105/AJPH.2013.301852)

SMOKING RATES ARE MUCH higher among those with mental illnesses, substance abuse disorders, or both. In 2000, this population accounted for 44% of all cigarettes sold in the United States, despite constituting only 22% of the general population.[1] A 2013 report revealed that this population, which represented 24.8% of adults in the United States, consumed nearly 40% of all cigarettes.[2] This is in contrast to recent US Centers for Disease Control and Prevention (CDC) reports of a record-low adult smoking prevalence of 18% in the overall population (45.3 million smokers).[3]

Not only are behavioral health patients twice as likely to smoke as the general population, they also smoke more heavily because of a complex interplay of biological, social, and psychological factors.[4,5] Recent data from the National Surveys on Drug Use and Health further corroborate the strong association among cigarette use, mental illness, and substance abuse across gender and age.[6] Smoking contributes to premature death and disability in all populations, and those with mental illness and substance abuse disorders are at particular risk.[7,8] Williams et al. argue that these populations should be designated a "tobacco use disparity group" to garner more national resources to address the longstanding disproportionate impact of smoking.[5]

The Substance Abuse and Mental Health Services Administration (SAMHSA), a Department of Health and Human Services agency, is the principal federal agency charged with safeguarding the health of people with mental illness and substance abuse disorders. However, despite the disproportionate prevalence of tobacco use in the population it serves, SAMHSA did not include smoking cessation as part of its mission; its tobacco control activities were limited to the 1992 Synar Amendment, which stated that states could not receive SAMHSA block grants unless they enforced laws prohibiting cigarette sales to minors. Recently, SAMHSA has leveraged activities to help smokers quit, aided by a partnership with the Smoking Cessation Leadership Center (SCLC) at the University of California, San Francisco.

THE ORIGIN OF THE SAMHSA–SCLC PARTNERSHIP

SAMHSA's mission is to "reduce the impact of substance abuse and mental illness on America's communities."[9] In 2012, SAMHSA had a budget of $3.39 billion,[10] used predominantly to fund service programs. Prior to 2008, other than overseeing the implementation of the Synar Amendment, SAMHSA did not support any formal smoking cessation programs.[11] In conversations with past and present SAMHSA leaders, we learned that this omission was multifactorial, reflecting a lack of awareness of tobacco use as a significant problem in the behavioral health community at that time, as well as a lack of motivation to address the issue.

The SCLC was established at the University of California, San Francisco in 2003 as a national program office of the Robert Wood Johnson Foundation. In 2006, the SCLC received additional funding from The American Legacy Foundation to promote smoking cessation among those with mental illness or substance

abuse disorders. Prior to the SAMHSA–SCLC collaboration, the agency had no other private–public partnerships focused on tobacco cessation.

In 2007, the SCLC partnered with Gail Hutchings, former chief of staff at SAMHSA, to organize a series of meetings for the behavioral health community to increase the importance of smoking cessation in mental health care. The SAMHSA Administrator, Terry Cline, PhD, decided to establish grassroots initiatives dedicated to smoking cessation. These meetings led to a historic National Summit on Smoking Cessation and Wellness at Lansdowne, Virginia, where the SCLC hosted 24 public and private agencies, including SAMHSA. That summit resulted in a national partnership emphasizing smoking cessation in mental health and substance abuse treatment settings and paved the way for further SAMHSA-SCLC collaboration.

In July 2008, the SCLC sponsored an in-service educational training session on tobacco dependence and behavioral health at SAMHSA headquarters in Rockville, Maryland. Cline and several speakers, including one of the authors (S. A. S.), educated SAMHSA staff about the prevalence of smoking among patients with mental illness and substance abuse, as well as how to implement effective treatments and interventions. A month later, with its increased focus on tobacco, SAMHSA adopted a smoke-free conference policy, requiring smoke-free enclosed workplaces and public places (including restaurants and meeting facilities) for SAMHSA-sponsored conferences.

"100 PIONEERS FOR SMOKING CESSATION"

In 2009, SAMHSA and the SCLC began an evolving partnership to promote tobacco cessation in patients with mental illness and substance abuse disorders. In the first phase of the collaboration, they jointly sponsored a campaign called "100 Pioneers for Smoking Cessation." Through a competitive application process, 96 organizations were selected from the 1400 existing SAMHSA grantees, including health care providers, rehabilitation centers, consumer groups, community centers, mental health treatment centers, youth service providers, and other local stakeholders committed to smoking cessation. The box on pages e2 and e3 lists the states and the types of organizations involved. Although only 96 pioneers were selected, the term "100 Pioneers" was retained for naming purposes.

SAMHSA awarded each organization a $1000 grant and the SCLC provided free technical assistance, including toolkits to train mental health professionals, smoking cessation curricula for peer counselors, guides to promote tobacco quitlines, and tips to make psychiatric facilities smoke-free. In addition, in 2009, the SCLC began a free comprehensive webinar series highlighting discussions by national experts on a variety of smoking cessation topics. The first 10 of the 36 webinars to date involved only the 100 Pioneers, but they have since expanded to a broader audience. Registration for webinars 11 through 31 ranged from 190 to 861 persons (mean = 429; median = 368). These numbers may understate the actual number of participants, since multiple persons often connected at an individual site.

In spring 2011, SCLC conducted a study to determine whether the 100 Pioneers campaign increased the number of tobacco interventions aimed at clients who smoked. We sent a short, anonymous evaluation survey, comprising 16 questions, to the SAMHSA grantees representing 96 agencies that participated in the 100 Pioneers campaign. The SCLC administered this survey through Zoomerang, an online survey tool. We sent an e-mail reminder 2 weeks after the initial e-mail; 3 weeks were allotted for survey completion. We provided no monetary or gift rewards for completing the survey. Twenty-six of the 96 agencies completed the survey (response rate = 27%). Each agency was asked to give the approximate percentage of clients whom it provided with tobacco dependence interventions (1) before the agency participated in the 100 Pioneers campaign and (2) currently. An independent sample *t* test was used to analyze the statistical relationship between the 2 samples (n = 25).[12] The 100 Pioneers campaign more than doubled the rate of provider intervention to behavioral health clients who smoked, from approximately 20% to just more than 50% in the first 18 months of the program.[12]

Organizations and Interventions in the "100 Pioneers for Smoking Cessation" Campaign: SAMHSA–SCLC Partnership, 2009–2012

States and jurisdictions (n = 38)

Alabama
Alaska
Arizona
Arkansas
California
Connecticut
District of Columbia
Delaware
Florida
Georgia
Illinois
Indiana
Iowa
Kansas
Kentucky
Louisiana
Maine
Maryland
Massachusetts
Michigan
Minnesota
Missouri
Nebraska
New Jersey
New Mexico
New York
North Carolina
Ohio
Pennsylvania
Puerto Rico
Tennessee
Texas
Utah
Vermont
Virginia
Washington
West Virginia
Wisconsin

Continued

Continued

Types of organizations

Youth drug prevention programs (n = 22)
Community advocacy groups (n = 20)
Outpatient mental health multidisciplinary recovery centers (n = 17)
Departments of Mental Health (n = 11)
Outpatient substance abuse treatment networks (n = 10)
Mental health care providers (n = 7)
Peer counseling groups (n = 3)
Community hospitals or clinics (n = 3)
Research institutes (n = 2)

Interventions

Grants
Honoraria
Toolkits
Quitlines
Cessation curricula
Seminars
Webinars
Smoke-free workplace kits
Informational resources

Note. SAMHSA = Substance Abuse and Mental Health Services Administration; SCLC = Smoking Cessation Leadership Center.

A second phase of the 100 Pioneers initiative was launched in 2010, when 25 of the pioneers received an additional $2000 each to expand their preexisting tobacco cessation projects, categorized within 7 overarching goals:

1. Provide provider training and education,
2. Create and sustain partnerships,
3. Implement smoke-free policies,
4. Strengthen and support smoking cessation groups,
5. Strengthen youth-focused education and cessation treatment,
6. Generate staff buy-in, and
7. Bolster consumer-focused education and treatment.

STATE-LEVEL LEADERSHIP ACADEMIES

In 2010, SAMHSA and the SCLC launched state-level leadership academies. SAMHSA had previously conducted a series of policy academies to help state, local, and federal entities improve services for people with substance abuse and mental health disorders. The SCLC had also conducted summits that taught health professional organizations how to effectively help their smoking patients to quit. Combining these 2 approaches led to the development of state-level Leadership Academies for Wellness and Smoking Cessation. The Leadership Academies served as multidisciplinary statewide collaborations of organizations focused on tobacco cessation; surprisingly, many of these state agencies had rarely worked together before meeting at these sessions. Invitees included state departments of public health tobacco control, mental health, and substance abuse, as well as the state telephone quitlines. Many of the academies included additional relevant organizations, such as the local chapters of the National Alliance on Mental Illness, CDC regional offices, and regional behavioral health care delivery organizations.

SCLC staff worked with SAMHSA to select 7 states to hold Leadership Academies: New York, Arizona, Oklahoma, Maryland, North Carolina, Texas, and Arkansas. We selected these states for their geographic diversity, readiness to participate in interdisciplinary partnerships, and potential to benefit from in-depth technical assistance. The Leadership Academies were funded by SAMHSA to host 2-day Leadership Academy Summits in each state, with the goal of systematically developing statewide comprehensive tobacco cessation action plans. The number of participants at these meetings ranged from 20 to 30, representing a variety of organizations: state departments of mental health, state tobacco control and substance abuse agencies, consumer organizations, hospitals, Veterans Health Administration officials, academic medical centers, state branches of national patient and community advocacy groups, insurance companies, and youth organizations, plus SCLC leadership and staff.

The Leadership Academy Summits followed the Performance Partnership Model, which encourages groups to develop "low-cost, no cost" strategies. The model asked states to establish baseline smoking prevalence, set specific measurable targets, develop multiple strategies to achieve those goals, and identify methods to maintain the goals.[13] Measuring baseline values of tobacco consumption was a critical first step motivating states to confront the problem of tobacco use, and comparing interstate baseline data often spurred competition.

Throughout this process, SAMHSA entrusted the SCLC to serve as coordinator, trainer, recorder, and facilitator for the summits. SCLC staff worked with SAMHSA to lead the states' pre–Leadership Academy training sessions; SCLC also provided detailed in-person, on-the-phone, and online technical assistance as well as skilled facilitators, summit recorders, and event planners. After the summit, the SCLC provided ongoing technical assistance, and all participating states submitted 6-month progress reports collecting data demonstrating progress toward specified targets. SAMHSA paid for travel and conference expenses of all participants. At each step, the SCLC clearly delineated the responsibilities of state representatives, the SCLC, SAMHSA, and the logistics vendor, thus fostering collaboration, accountability, and clear division of labor. Initially, the SCLC volunteered its services, but in 2011, it received a SAMHSA contract to continue its technical assistance activities. This process was replicated successfully across all 7 states. An eighth state, Mississippi, held a self-funded and SAMHSA-endorsed Leadership Academy in May 2013.

Before the summits, each state submitted estimates of baseline data for smoking prevalence (among the mentally ill and substance users as well as the general population). The states' final baseline data and desired targets are shown in Table 1. For example, New York used the 2011 New York State Office of Mental Health's Patient Characteristic Survey[14] to estimate that 30% of

TABLE 1—Baseline Tobacco Use and Reduction Targets in States With Leadership Academies: SAMHSA–SCLC Partnership, 2010–2012

State	Baseline Tobacco Use: Serious Mental Illness, %	Baseline Tobacco Use: Substance Use Disorder, %	Reduction Target, %	Target Year	Source Estimate
New York	30	50	–10	2015	Patient Characteristic Survey conducted by NYS Office of Mental Health
Arizona	30–50	30–50	–40	2016	Approximation by Arizona Leadership Academy
Oklahoma	62	74	–14	2015	Oklahoma Department of Mental Health & Substance Abuse Services Reports
Maryland	47.80	71.80	–20	2014	Maryland Alcohol and Drug Abuse Administration, Maryland Public Mental Health System
North Carolina	49	63	–16	2016	North Carolina Treatment and Outcomes Performance System
Texas	33.70	39.70	–10	2017	Texas Behavioral Risk Factor Surveillance System
Arkansas	22.9 (all adults)	22.9 (all adults)	–3	2017	Arkansas Behavioral Risk Factor Surveillance System

Note. NYS = New York State; SAMHSA = Substance Abuse and Mental Health Services Administration; SCLC = Smoking Cessation Leadership Center.

patients with serious mental illness were smokers and 50% of patients with mental illness or substance abuse disorders were smokers; New York set a target of reducing each group's smoking prevalence by 10% by 2015. The goals and strategies to achieve these targets are shown in Table 2.

Six months after each state's summit, surveys assessed progress. The designated contact person from each Leadership Academy state completed the survey. We calculated means, medians, standard deviations, and 95% confidence intervals for each answer, but because of the small sample size, no inferential statistical analyses were performed. The survey, shown in the box on page e6, was an 11-item assessment including 4- and 5-point Likert scales, short-answer questions, and yes–no questions.

Survey data showed that most states had made concrete improvements 6 months after the summit; 6 of 7 states reported increased quit attempts by behavioral health clients. All states reported concrete, measurable improvements on their action plans, and 5 of 7 states reported that the action plan was mostly being implemented. No state reported little or no progress on the action plan. Five states reported that new partners had joined statewide efforts since the Leadership Academy—mostly statewide public organizations or community groups. All states reported that they somewhat or strongly agreed that the summit increased the importance of tobacco dependence treatment among providers of behavioral health treatment (mean score = 4.71 out of 5). All states were strongly interested in partnering with other Leadership Academy states. Similarly, all states agreed that over the prior 6 months the Leadership Academy committees leveraged existing efforts in tobacco prevention and cessation (mean score = 4.57 out of 5).

The survey identified multiple factors that could help states continue ongoing improvement; 6 states cited strengthened tobacco-free policies (such as in restaurants, workplaces, or housing units) as a condition that would facilitate progress over the next 6 months, and 5 states cited other conditions such as increased smoking cessation reimbursement coverage, increased state funding for tobacco control, additional public-sector partners to help with implementation, and support from additional consumer organizations.

Qualitative data from the survey showed that most states focused on increasing provider education, improving quitlines, advocating for state-level policy changes, improving behavioral health facilities, and focusing on community. Each state provided concrete examples of how to advocate for cessation. For example, Oklahoma funded a full-time staffer to help implement its Leadership Academy action plan, New York created a Listserv to share information and resources among all partners, and Arizona aimed to increase referral to tobacco quitlines. States also reported that "having this team in place encourages collaboration and will enable us to garner needed support for state-level policy changes." They also emphasized the "platform for introducing and implementing cessation initiatives" and noted that the "Academy generated much collaboration across agencies that was previously not happening."

Barriers to implementation included funding cuts, personnel changes, reorganization, and fatigue. One state reported that personnel changes from state budget cuts hampered longitudinal progress on postsummit tobacco cessation efforts. Even when employees did stay on the job, numerous states found it challenging to maintain momentum; ongoing "day jobs" made it difficult to organize follow-up meetings and plans. Two states held "reunion" summits to continue the work that had been started. Another practical challenge was that smoking cessation billing codes needed to be created and used to efficiently track cessation initiatives.

TABLE 2—Leadership Academies' Action Plan Strategies to Achieve Smoking Reduction Targets: SAMHSA–SCLC Partnership, 2010–2012

Strategy Group	Specific Aims
Policy	Require mental health and substance abuse treatment plans to address smoking.
	Change state-level reimbursement for smoking cessation counseling.
	Advocate for legislation targeting Clean Indoor Air Act and legislation of tobacco-free campuses.
	Identify best practices in tobacco cessation nationwide.
	Align tobacco-free policies between different organizations in the state.
Education	Identify and dedicate facility-specific local champions.
	Train pharmacists with Rx for Change, educate providers about available cessation resources.
	Devise curriculum to educate physicians, substance abuse counselors, newsletters, community training.
	Integrate cessation into existing training for mental health and substance abuse.
	Promote and fund quitline.
	Promote youth cessation.
	Assess preexisting knowledge on cessation before educating providers.
Peers and community	Train peer cessation specialists across facilities including in faith-based organizations.
	Offer peer-to-peer education and consumer-driven campaign on cessation.
	Expand marketing to social media and youth-focused groups, implement a speakers bureau.
	Sponsor cessation poster contest and incentives for staff who refer most to quitline.
	Collaborate with other stakeholders such as researchers, advocacy groups, local Veterans Administration hospitals.
Data	Calculate tobacco use prevalence among staff and clients, integrate interagency data.
	Obtain and analyze data from mental health departments and youth data, and construct surveys.
Tobacco-free facilities	Focus on decreasing tobacco use among providers and staff via culture change, incentives, and P4P.
	Prohibit tobacco as patient reward in mental health facilities and implement tobacco-free campus.
	Implement human resources policies regarding tobacco cessation, incentivize early adopters who go smoke-free.
Treatment and nicotine replacement	Increase referrals to cessation treatment and increase access to cessation kits.
	Expand Medicaid coverage of and education about NRT, consider free NRT for mental health patients.
	Promote quitline heavily in substance abuse treatment facilities.

Note. NRT = nicotine replacement therapy; P4P = pay for performance; SAMHSA = Substance Abuse and Mental Health Services Administration; SCLC = Smoking Cessation Leadership Center. The 8 Leadership Academy states were New York, Arizona, Oklahoma, Maryland, North Carolina, Texas, Arkansas, and Mississippi.

SAMHSA and the SCLC are currently working with leaders from the Leadership Academy states to connect and refine strategies, sustain momentum, and offer an ongoing problem-solving platform. The state leaders are participating in a series of calls to explore opportunities for collaboration with each other as well as to increase direct communication with SAMHSA. In addition, under the leadership of current SAMHSA Administrator Pamela Hyde, JD, new language was added to SAMHSA requests for proposals that encourages applicants to have smoke-free workplaces and to provide cessation services. Grantees are also encouraged to use a 30-day abstinence period as a target to help smokers quit. New York created online training modules; the Oklahoma governor created a statewide policy banning tobacco use on state-owned property (including, but not limited to, psychiatric and substance abuse treatment facilities); Maryland and North Carolina each received $100 000 Pfizer Medical Education Group smoking cessation grants in 2013 for the strategies proposed at their summits.

On February 5, 2013, the CDC and SAMHSA held a joint press conference highlighting tobacco use among adults with mental illness.[15] On the same day, the lead article of the CDC's *Morbidity and Mortality Weekly Report* focused on SAMHSA's recent report, *Smoking and Mental Illness*,[6] which analyzed 3 years of survey data that further confirmed the relationship between smoking and mental illness. At this press conference, CDC Director Tom Frieden, MD, and Public Health Advisor for SAMHSA Doug Tipperman reviewed evidence for the higher prevalence of tobacco use among people with mental illness. It was the first time that the CDC gave significant public attention to the link between smoking and mental illness. Furthermore, SAMHSA emphasized its collaboration with the SCLC, describing the 100 Pioneers campaign and the Leadership Academies. Subsequently, SAMHSA issued 2 additional reports featuring the high prevalence of smoking among persons with mental illness and substance use disorders.[2,16] To ensure that tobacco remains a sustainable core of its platform, SAMHSA incorporated tobacco cessation into its Strategic Initiatives,[17] which cover long-term strategy for the years 2011 through 2014.

A September 2013 SCLC webinar delineated specific progress

Postsummit Survey Assessments: SAMHSA–SCLC Partnership, 2012–2013

Qualitative questions
Since the summit, how many new partners (organizations and individuals) have joined the initiative?
Please list the names of any new organizations and individuals who joined the initiative following the summit.
Briefly describe benchmarks reached by the strategy committees to date.
Briefly describe up to 3 challenges that emerged and how they were addressed.
What opportunities have supported the work of the Leadership Academy?
What conditions would improve implementation efforts of the Leadership Academy in the next 6 months?
May partners from other Academy States contact you with questions?
Briefly describe the effectiveness of the communications among the Leadership Academy committees and partners as a whole.
Likert-style questions
To what extent is the Leadership Academy Action Plan being implemented?
Did the Academy help increase quit attempts among clients with mental illnesses and addictions who smoke?
Did the awareness of the importance of tobacco dependence treatment increase among behavioral health treatment providers across the state?
Did more behavioral health providers refer clients to the quitline?
Is data development in progress and on schedule?
Over the last 6 months, did the Leadership Academy committees leverage existing efforts in tobacco prevention and cessation?
Was the technical assistance offered by SCLC helpful?

Note. SAMHSA = Substance Abuse and Mental Health Services Administration; SCLC = Smoking Cessation Leadership Center.

made by each SAMHSA state since the Leadership Academies.[18] Arizona conducted extensive behavioral health provider trainings focusing on tobacco cessation counseling and tried to incorporate cessation into its electronic health records. North Carolina collaborated across different agencies to develop a comprehensive 15-week program focused on wellness and smoking cessation titled "Breathe Easy, Live Well." Mississippi developed and distributed a 1-page fact sheet of local tobacco cessation resources. Oklahoma worked with multiple organizations targeting Native American smokers. Arkansas integrated tobacco cessation counseling and behavioral health counseling across multiple sites. Texas focused extensively on cessation of staff working in treatment facilities and conducted training around the 5 A's model of tobacco intervention.[19] The Austin, Texas, site showed a 10-fold increase in calls to the state quitline. Maryland launched a system to carefully document statistics on tobacco cessation; it found that 40% of mental health providers reported having tobacco cessation programs. New York discussed its latest Medicaid approaches to funding nicotine replacement therapy.

CONCLUSIONS

This report describes how collaboration between a government agency and an academic medical center resulted in policy changes regarding the importance of smoking cessation for a segment of the population with significantly higher smoking prevalence and heavy disease burden from tobacco use.

Although the data so far focus mostly on process measures rather than outcomes (change in smoking prevalence), they provide information on the daunting challenge of tobacco cessation among the mentally ill.[20] Collaboration between the SCLC and SAMHSA was successful in raising awareness, encouraging quit attempts, and making concrete progress toward tobacco cessation at the state level. Moreover, it served as a model of public–academic cross-agency interdisciplinary collaboration.

In an era of state budget cuts and limited funding for mental health and substance use, harnessing the power of multiple, often-overlapping state-level agencies is crucial. Forming networks of key stakeholders and effectively uniting them to achieve a common goal can spur ongoing collaboration and innovation. The Performance Partnership Model used during the state summits helped state leaders work toward the shared goal of improving cessation while connecting across state agencies. Each state expressed interest in partnering with other states to collaborate on smoking cessation. This could serve as a model to promote healthy interstate competition for funding, share best practices, and mentor new Leadership Academy states.

The SAMHSA-SCLC collaboration demonstrates how a federal agency tasked to improve the health of people with mental health and substance abuse issues came to collaborate with an academic tobacco cessation center. Prior to this effort, SAMHSA did not have any private–public partnerships focused on tobacco cessation. Yet significant financial and structural barriers to ongoing progress remain. However helpful the SAMHSA–SCLC collaboration may be, structural changes at the state and national level—such as increased tobacco taxation, increased funding for tobacco control, and stronger tobacco-free policies in businesses and residences—are still necessary to make a significant dent in the high prevalence of tobacco use. States need to increase funding for

tobacco control; a report from the Campaign for Tobacco-Free Kids showed that in 2012, 20 states collected $25.7 billion from tobacco settlements and taxes but spent only 1.8% of it ($459.5 million) on smoking prevention and cessation programs, amounting to less than 2 cents for every dollar.[21] For the United States to have significant declines in smoking prevalence and its attendant harms, it will be essential to address the huge burden that falls on those with mental illness or substance abuse disorders. Greater involvement and aggressive leadership from SAMHSA are essential for achieving this goal. ■

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This article was accepted December 13, 2013.

Contributors

L. Santhosh prepared the first draft of the article and edited revised drafts. S. A. Schroeder forged the initial liaison with SAMHSA, reviewed the article drafts, and participated in the composition of the article. M. Meriwether, C. Saucedo, R. Reyes, C. Cheng, B. Clark, and D. Tipperman reviewed the article drafts and edited revised drafts.

Acknowledgments

This work was supported by grants from the Robert Wood Johnson Foundation and American Legacy Foundation.

Human Participant Protection

Institutional review board approval was not needed for this publication because no experimentation was involved and the data were summaries of public meetings and other public activities.

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