TOBACCO USE and BEHAVIORAL HEALTH: A STATE APPROACH

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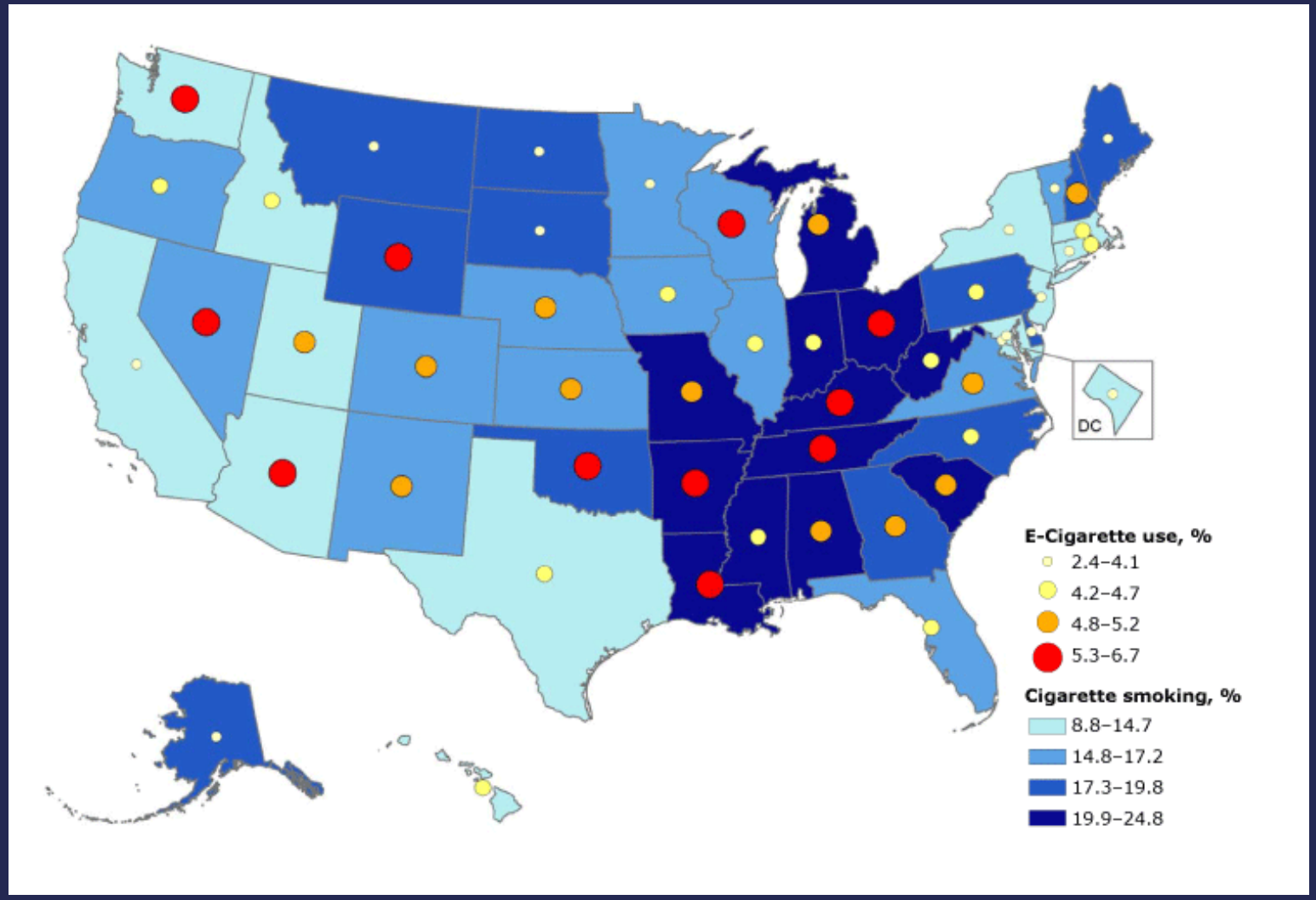
Financial Disclosures

- Jill Williams has no current relationships with pharmaceutical companies

The people I treat have more serious problems to address than tobacco use.

- Strongly agree
- Somewhat agree
- Neutral, neither agree nor disagree
- Somewhat disagree
- Strongly disagree

What is the smoking rate in US?

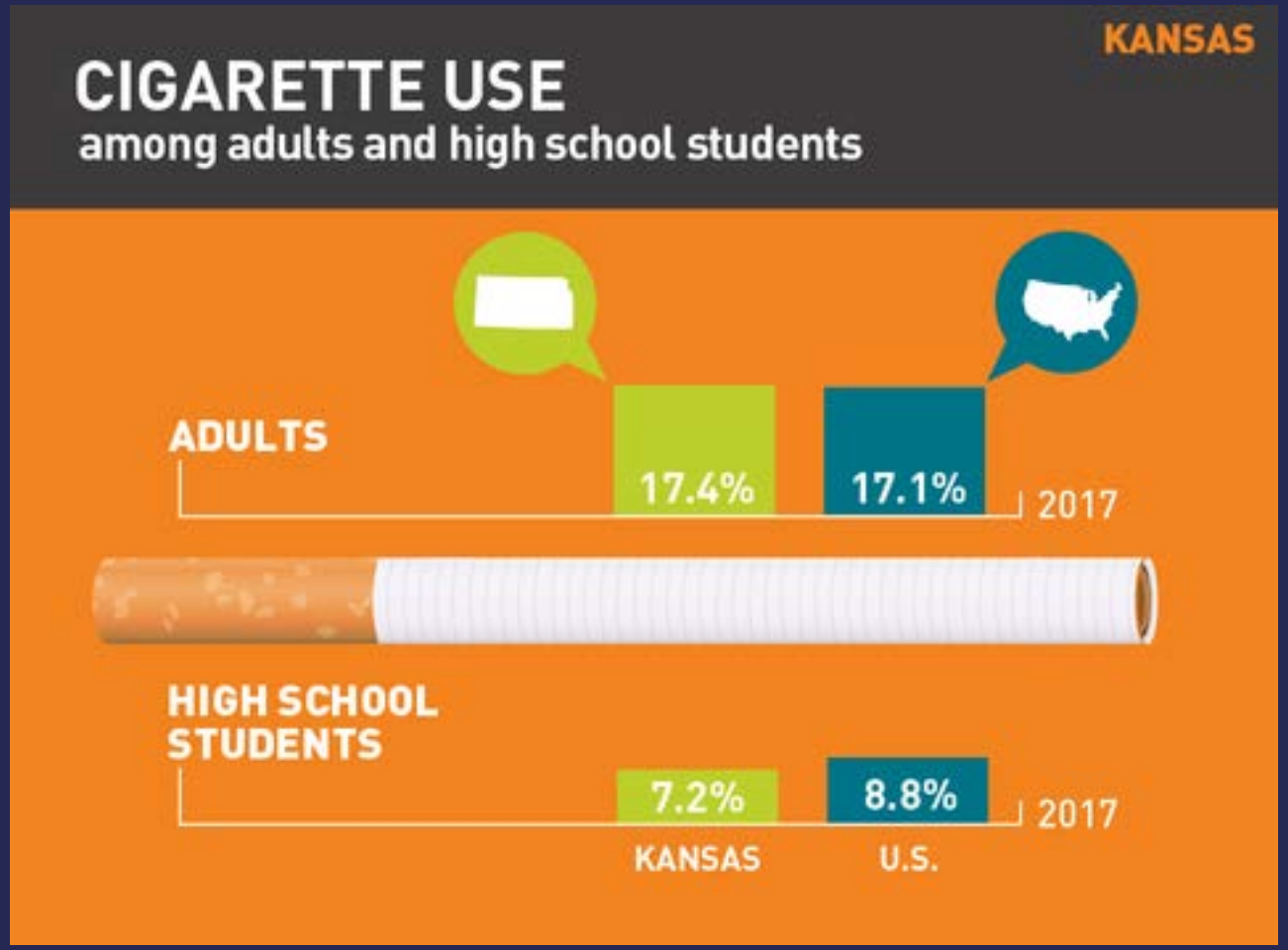


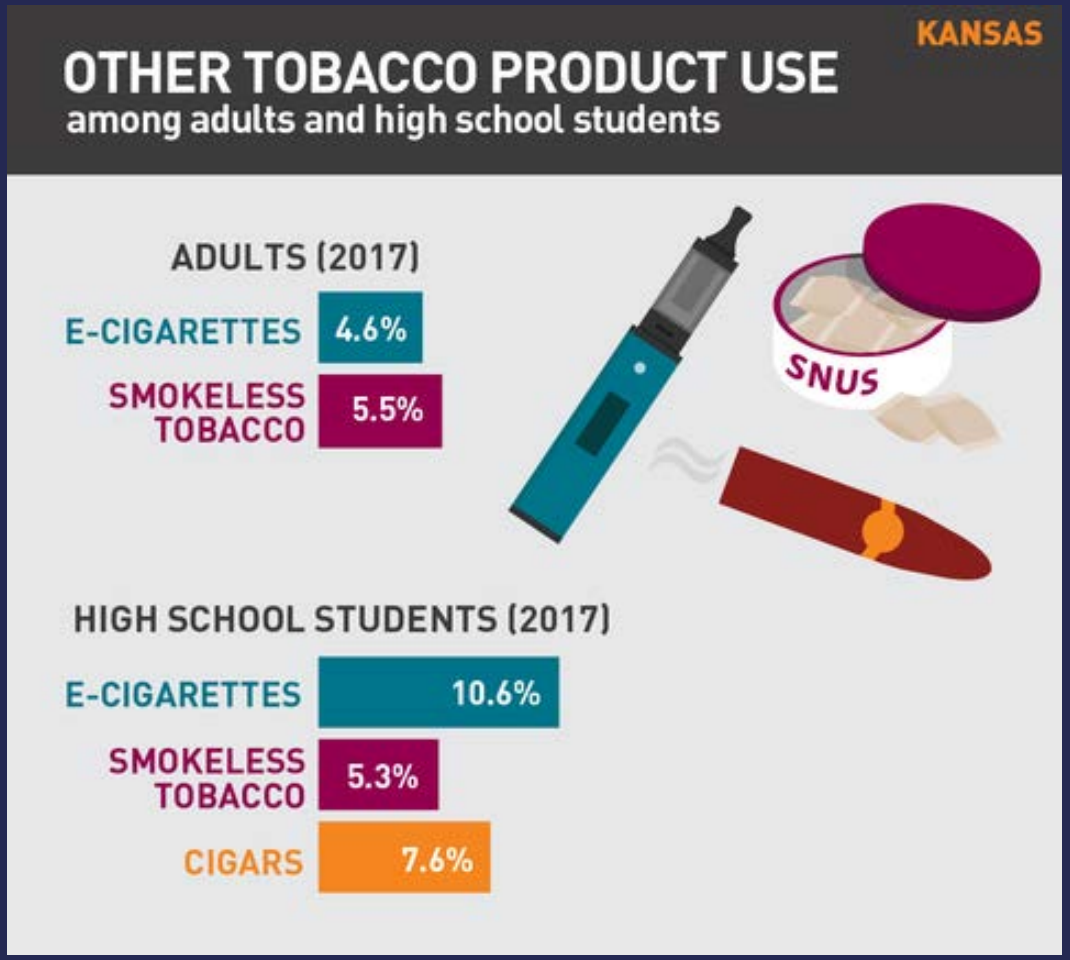
US 13.7%

in 2018

US Adults, BRFSS, Centers for Disease Control and Prevention, 2016

Smoking in Kansas





Truthinitiative.org

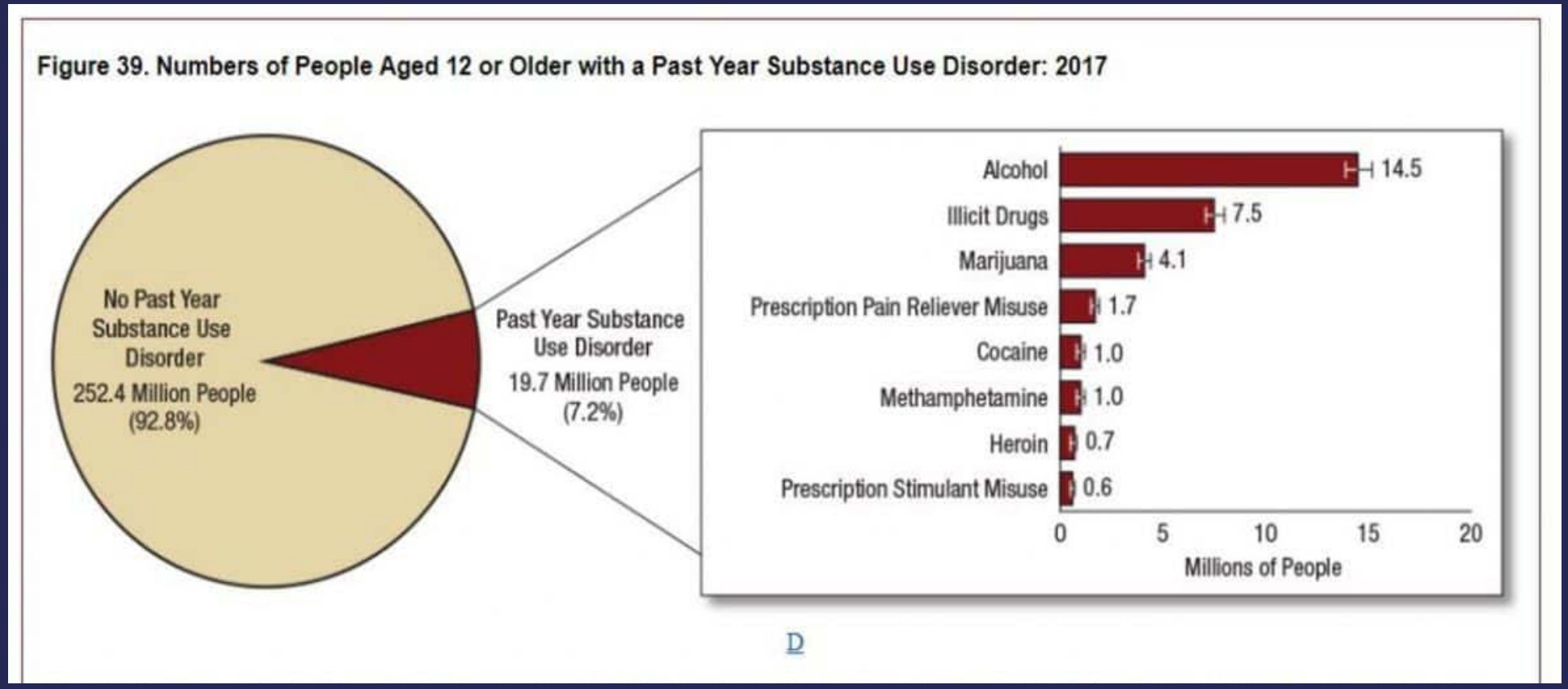
Smoking is a Social Justice Issue

www.thetruth.com

Epidemiology of Tobacco-US

- Prevalence has declined in the US from 42% in 1965 to 14% in 2017
- Men are more likely to be smokers than women (15.8% vs 12.2%)
- > 16 million Americans have smoking-related disease
- Accounts for 20% of deaths in the US

Alcohol and Tobacco Still the Most Widely Used Substances and the Most Deadly



People with a Past Year SUD 12 or older: 2017

https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHFFR2017/NSDUHFFR2017.htm

Annual U.S. deaths attributable to:

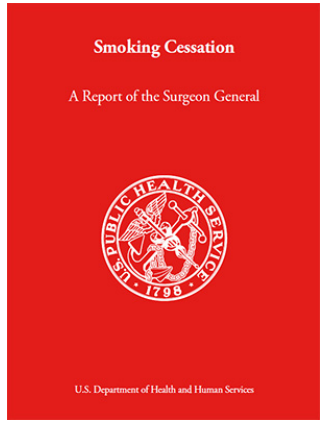
- Opioid overdose – 48,000 (drug overdose – 68,000)[1]
- Motor vehicles – 37,000[2]
- Homicide – 17,000[3]
- Suicide – 47,000[4]
- Vietnam War – 10,513[5]
- U.S. Civil War – 150,000[6]
- Cigarettes – 480,000[7]

1 2017 for opioids; 2018 for drug (Opioids: Gladden RM, O'Donnell J, Mattson CL, Seth P. Changes in Opioid-Involved Overdose Deaths by Opioid Type and Presence of Benzodiazepines, Cocaine, and Methamphetamine — 25 States, July–December 2017 to January–June 2018. MMWR 2019;68:737–744.) (Drug: Ahmad FB, Escobedo LA, Rossen LM, Spencer MR, Warner M, Sutton P. Provisional drug overdose death counts. National Center for Health Statistics. 2019.) 2 2017 ("Quick Facts 2017," National Center for Statistics and Analysis, NHTSA, US DOT, July 2019.) 3 2017 ("Crime in the U.S. 2017," Table 1, Uniform Crime Report, Federal Bureau of Investigation, September 2018.) 4 2017 (Kochanek KD, Murphy SL, Xu JQ, Arias E. Deaths: Final data for 2017. National Vital Statistics Reports; vol 68 no 9. Hyattsville, MD: National Center for Health Statistics. 2019.) 5 1966-1970 (Vietnam Conflict Extract Data File of the Defense Casualty Analysis System, U.S. National Archives and Records Administration, April 28, 2008; accessed November 27, 2017.) 6 1960-1965 (J David Hacker, "A Census-Based Count of the Civil War Dead," *Civil War History*, 37:4: pp 307-348, Dec 2011.) 7 2005-2009 annual rate ("The Health Consequences of Smoking: A Report of the Surgeon General - Executive Summary," U.S. Department of Health and Human Services, 2014.)

Health Consequences

- Smokers die 10 years earlier than non smokers on average
- Cancer: oral cavity, pharynx, larynx, bladder, esophagus, cervix, kidney, lung, pancreas, stomach, liver, bowel, acute myeloid leukemia
- Cardiovascular disease, DM type II
- COPD, Asthma
- Osteoporosis, cataracts and macular degeneration, early menopause, erectile dysfunction, gastric and duodenal ulcer disease, skin aging, periodontal disease

The Evidence is Sufficient…



CANCER

1. The evidence is sufficient to infer that smoking cessation reduces the risk of **lung cancer**.
2. The evidence is sufficient to infer that smoking cessation reduces the risk of **laryngeal cancer**.
3. The evidence is sufficient to infer that smoking cessation reduces the risk of **cancers of the oral cavity and pharynx**
4. The evidence is sufficient to infer that smoking cessation reduces the risk of **esophageal cancer**.
5. The evidence is sufficient to infer that smoking cessation reduces the risk of **pancreatic cancer**.
6. The evidence is sufficient to infer that smoking cessation reduces the risk of **bladder cancer**.
7. The evidence is sufficient to infer that smoking cessation reduces the risk of **stomach cancer**.
8. The evidence is sufficient to infer that smoking cessation reduces the risk of **colorectal cancer**.
9. The evidence is sufficient to infer that smoking cessation reduces the risk of **liver cancer**.
10. The evidence is sufficient to infer that smoking cessation reduces the risk of **cervical cancer**.
11. The evidence is sufficient to infer that smoking cessation reduces the risk of **kidney cancer**.
12. The evidence is sufficient to infer that smoking cessation reduces the risk of **acute myeloid leukemia**.

CARDIOVASCULAR DISEASE

1.The evidence is sufficient to infer that smoking cessation. **reduces levels of markers of inflammation and hypercoagulability and leads to rapid improvement in the level of high-density lipoprotein cholesterol**
2.The evidence is sufficient to infer that smoking cessation leads to a reduction in the development of subclinical **atherosclerosis**, and that progression slows as time since cessation lengthens.
3.The evidence is sufficient to infer that smoking cessation reduces the risk of **cardiovascular morbidity and mortality** and the burden of disease from cardiovascular disease.
4.The evidence is sufficient to infer that the relative risk of coronary heart disease among former smokers compared with never smokers falls rapidly after cessation and then declines more slowly.
5.The evidence is sufficient to infer that smoking cessation reduces the risk of **stroke** morbidity and mortality.
6.The evidence is sufficient to infer that, after smoking cessation, the risk of stroke approaches that of never smokers.

Jerome M. Adams, M.D., M.P.H;
Surgeon General Report on Cessation 2020

Compounds in Tobacco Smoke

An estimated 4,800 compounds in tobacco smoke,
including 11 proven human carcinogens

Gases

- Carbon monoxide
- Hydrogen cyanide
- Ammonia
- Benzene
- Formaldehyde

Particles

- Nicotine
- Nitrosamines
- Lead
- Cadmium
- Polonium-210

Nicotine is the addictive component of tobacco products,
but it does NOT cause the ill health effects of tobacco use.

Sources of Tobacco Toxins

Nicotine; nitrosamines

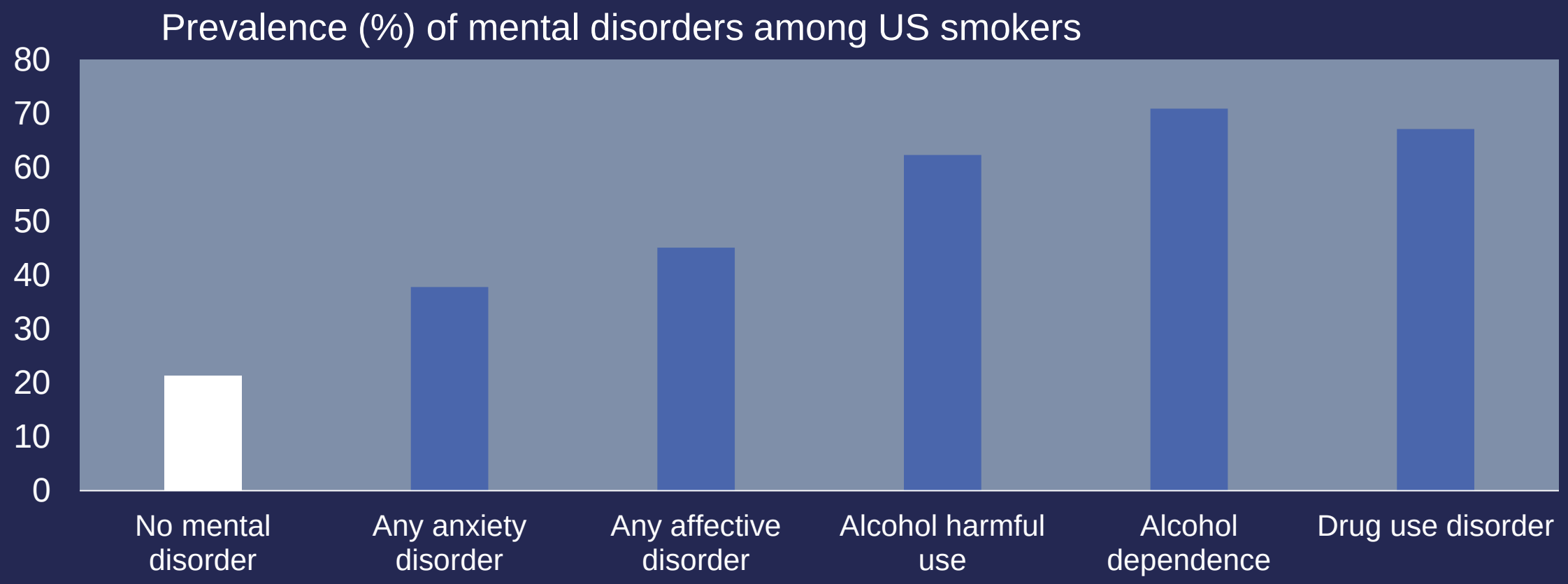
More than 600; Ammonia, cellulose acetate; flavors

Thousands; carbon monoxide; formaldehyde; benzene; arsenic, lead; polycyclic aromatic hydrocarbons

CDC 2014

Smokers with Behavioral Health Comorbidity (Mental Illness and Addiction) are a Sizeable Percentage of Smokers Left in the US

Epidemiology

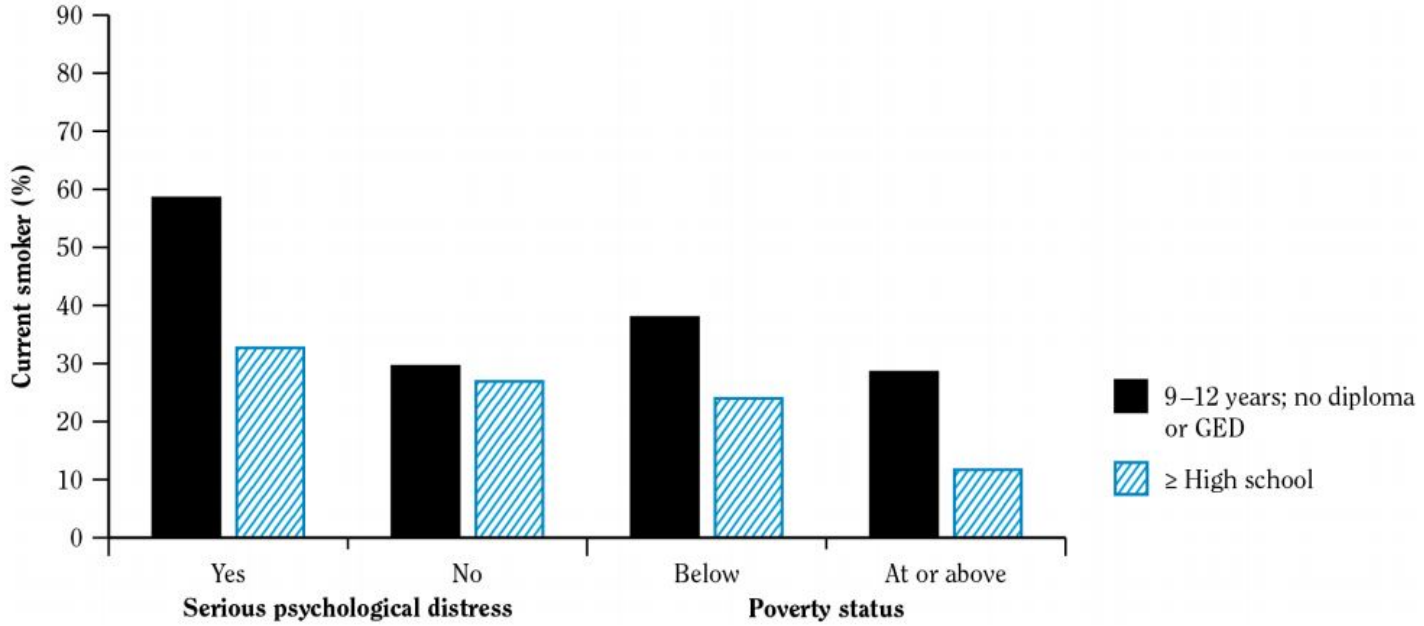


Lawrence et al BMC Pub Health 2009; 9:285.

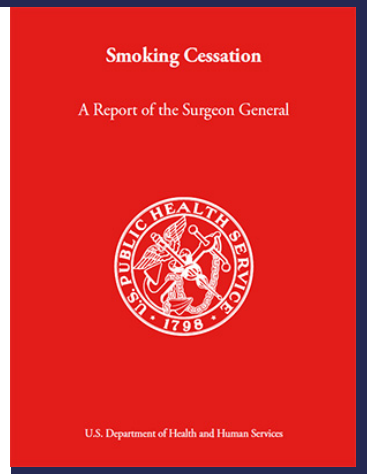
Smoking is Much More Common in Adults with Mental Illness than Other Adults

A Report of the Surgeon General

Figure 2.7a **Prevalence of current cigarette smoking by level of education and presence or absence of serious psychological distress and poverty status among adults 25 years of age and older: National Health Interview Survey (NHIS) 2017; United States**



Source: NHIS, National Center for Health Statistics, public use data, 2017.
Note: **GED** = General Educational Development.

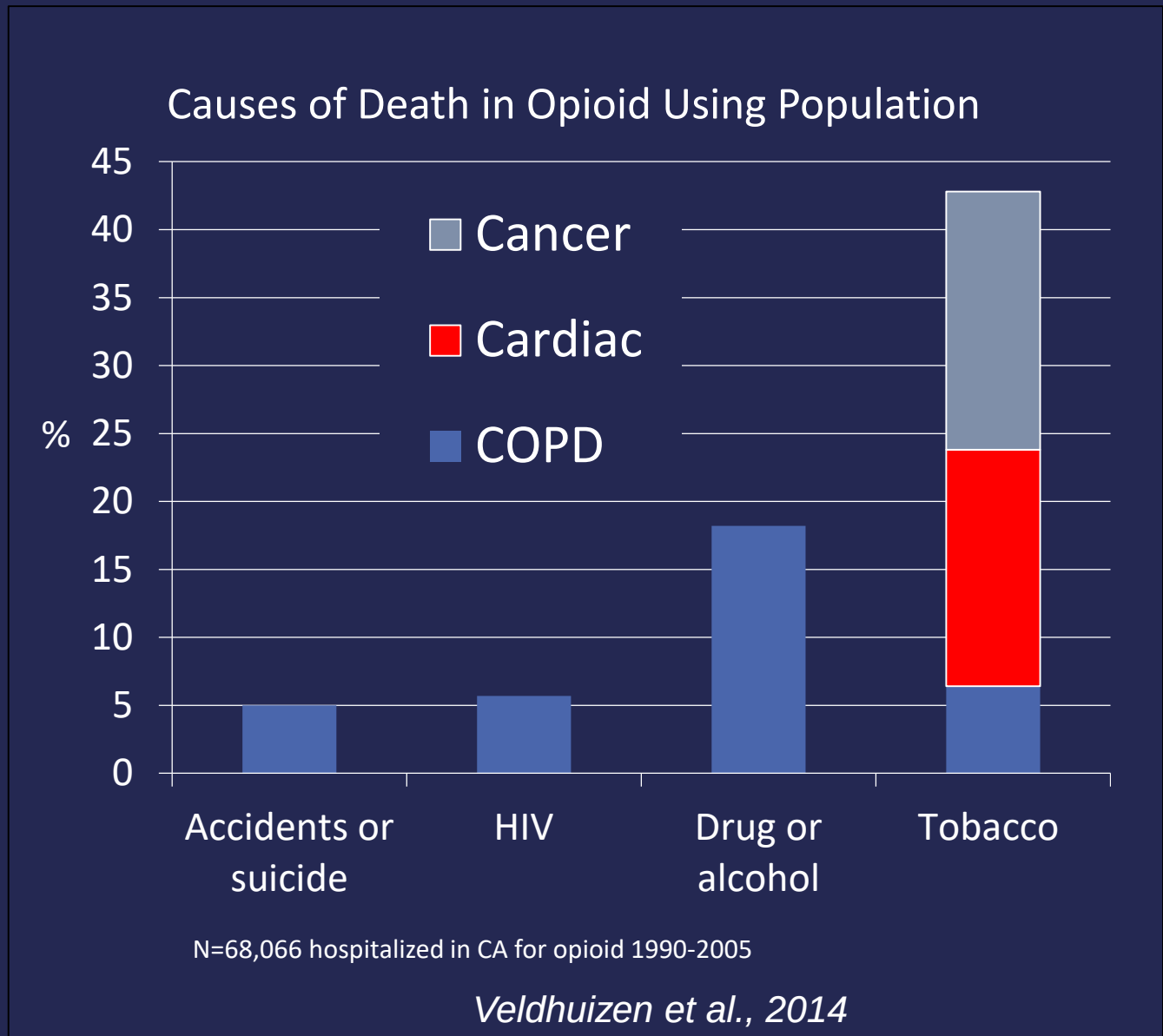


Jerome M. Adams, M.D., M.P.H;
Surgeon General Report on Cessation 2020

Tobacco Causes More Deaths in Patients with SUD than their Primary Substance

More alcoholics die of smoking caused diseases than die of alcohol caused disease

Hurt et al., 1996



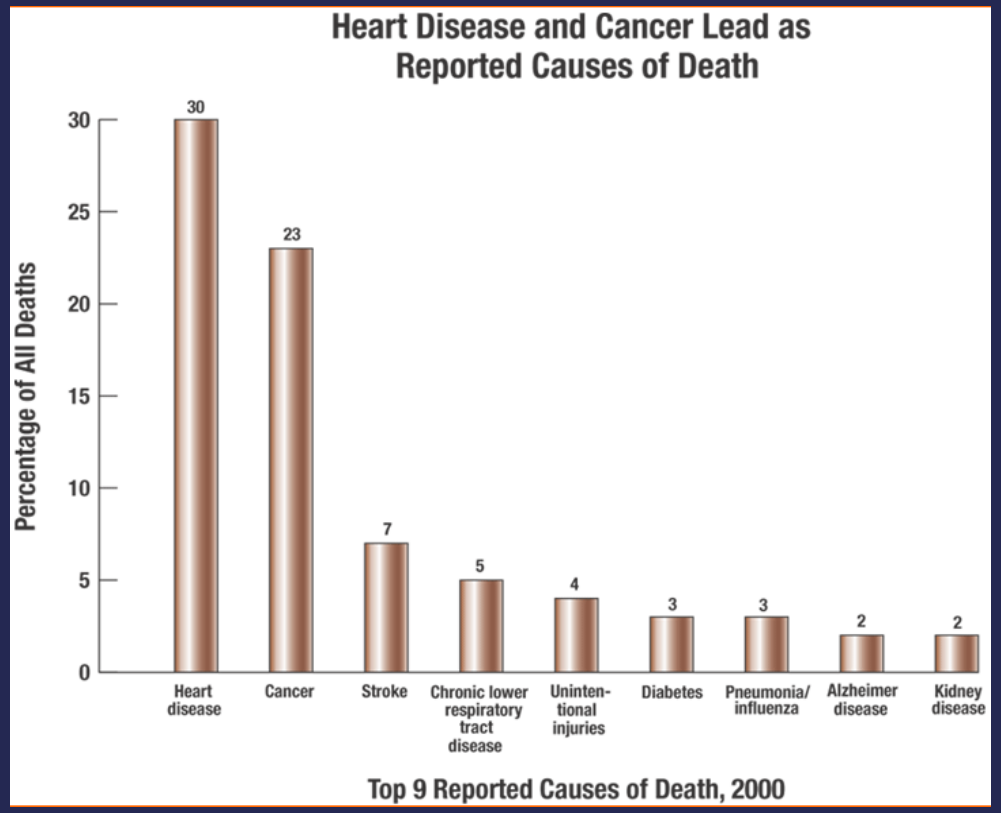
Tobacco is Number One Cause of Death

- Schizophrenia
- Depression
- Bipolar Disorder

- Accountable for 50% of all deaths

Top Causes of Death= Tobacco

General US population



Minino AM et al. Natl Vital Stat Rep. 2002

Public mental health clients

Heart Disease
Cancer
Suicide
COPD
Accidents
Stroke

https://www.cdc.gov/pcd/issues/2006/apr/05_0180.htm

Tobacco Associated Problems

- Barrier to Recovery
- Financial Hardships
- More Employment Difficulties
- More Housing Difficulties
- Poorer Mental Health
- More Relapse to Drugs and Alcohol
- Social Stigma
- Poorer Appearance
- More Fires in Home

Public Health Interventions

- Anti-smoking advertisements
- Increasing taxes
- Age-restrictions
- Tobacco-free laws and policies
- Support for cessation

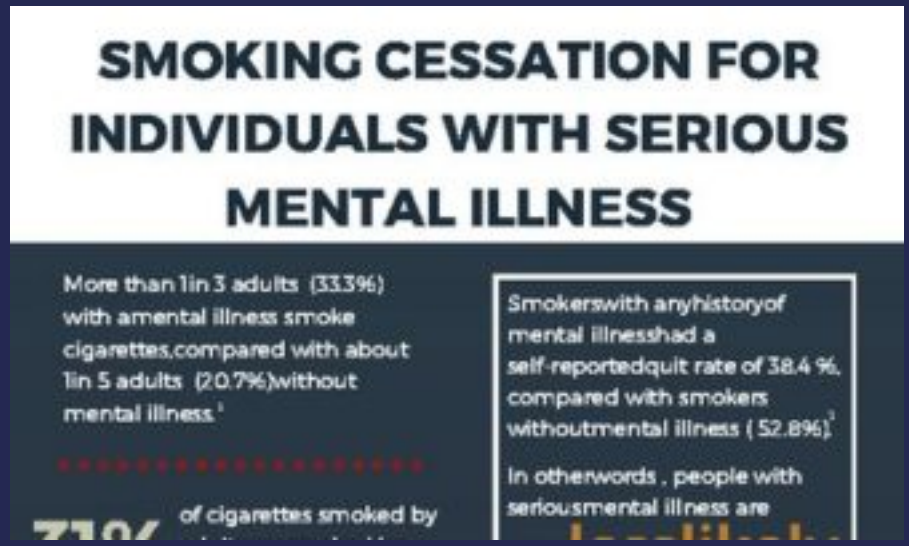
Have We Made Progress on This Issue?

Increased Recognition

- **Smoking and Mental Illness: A Bibliometric Analysis of Research Output Over Time.**
  - 547 articles
    - 1993-1995 (n = 65)
    - 2003-2005 (n = 153)
    - 2013-2015 (n = 329)
- The number and proportion of data-based publications significantly increased over time, although their **focus remained predominantly descriptive** (≥83%); less than 14% of publications in any period had an intervention focus

Metse et al., NTR 2017

Federal Level



NYC Tobacco Cessation Training & Technical Assistance Center

Website: www.nyctcttac.org

New SAMHSA Grant Language

- **Other Expectations:**

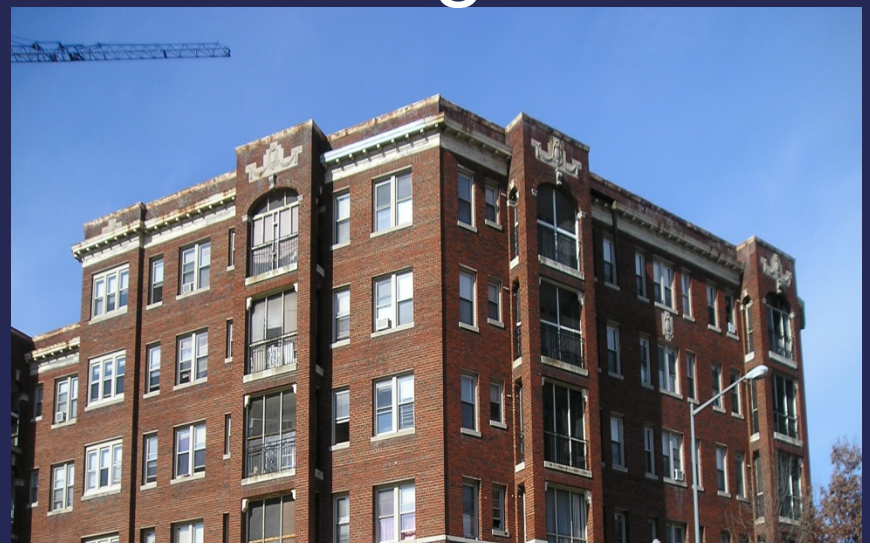
- SAMHSA strongly encourages all recipients to adopt a tobacco-free facility/grounds policy and to promote abstinence from all tobacco products (except in regard to accepted tribal traditions and practices).

Smoke Free Housing

As much as 60% of airflow in multi-unit housing can come from other units

SHS infiltrates through air ducts, cracks, stairwells, hallways, elevators, plumbing, electrical line

SHS is Class 1A carcinogen, in the same class as **asbestos**



All U.S. Public Housing Will Go Smoke-Free by 2018

HUD Issues Final Smoke-Free Rule

WASHINGTON, D.C. – November 30, 2016 – The U.S. Department of Housing and Urban Development (HUD) today announced its final rule to require more than 3,100 public housing agencies across the country to implement smoke-free policies in their developments. The rule, which gives public housing agencies 18 months to comply, will prohibit lit tobacco products, including cigarettes, cigars, pi[illegible] units, indoor common areas, administrative offices and all [illegible] housing and administrative office buildings.

FINAL

A statement from Chris Hansen, president of the American Cancer Society Cancer Action Network (ACS CAN), follows: "By eliminating secondhand smoke exposure in public housing units,more than 2 million U.S. residents living in public housing will breathe clean, smoke-free air where they live, improving the health of an estimated 760,000 children and more than 300,000 senior citizens.

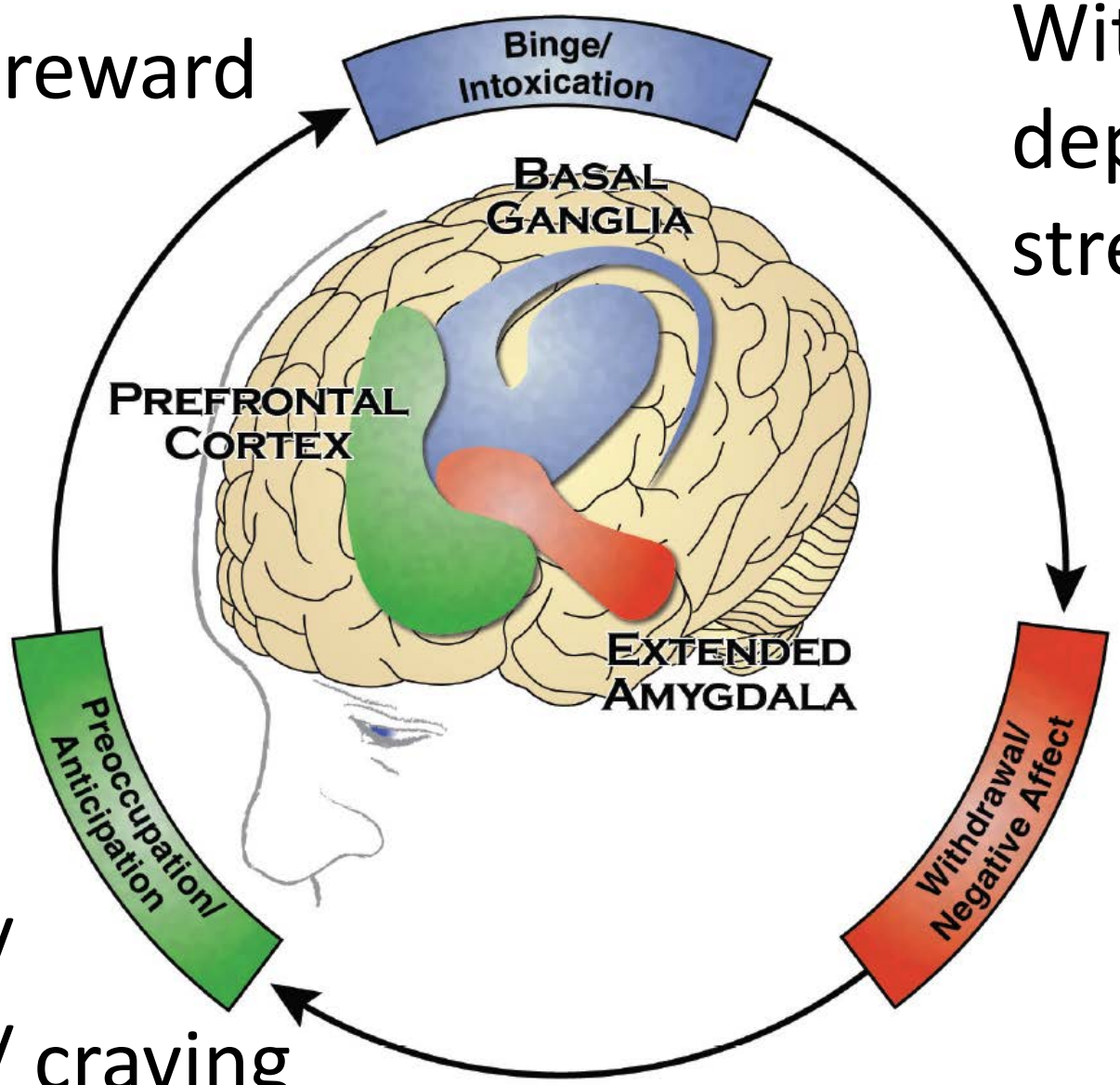
"In addition to giving everyone the right to smoke-free air, smoke-free public housing will also encourage resident cigarette smokers to quit, which is why it's essential such residents have access to affordable and comprehensive cessation services through private insurance, Medicaid or Medicare.

http://www.cdc.gov/healthyhomes/healthy_homes_manual_web.pdf

Figure 2.3: The Three Stages of the Addiction Cycle and the Brain Regions Associated with Them

Seeking/ reward

Withdrawal/ depression/ stress



Consequences/ Preoccupation/ craving

Tobacco Use Worsens Behavioral Health Outcomes and Quitting Smoking Improves Anxiety and Depression

Suicide and Smoking

Daily smoking →

predicts suicidal thoughts or attempt

(adjusted for prior depression, SUD, prior attempts; OR 1.82)

Breslau et al., 2005; Ostacher et al., 2006; Altamura et al., 2006; Iancu et al., 2006; Cho et al., 2007; Oquendo et al., 2007; Riala et al., 2006; Moriya et al., 2006

?? Benefits of Smoking

Cognition

Nicotine/ Nicotinic Receptors

- ✓ Alzheimer's disease
- ✓ Attention deficit disorder
- ✓ Autism
- ✓ Schizophrenia

- Tobacco ≠ pharmacological treatment
- Not a rationale for smoking

Depression

MAO Inhibitor Like Substance

Improved Mental Health with Quitting Smoking

Meta-analysis 26 studies (gen pop and mental health)

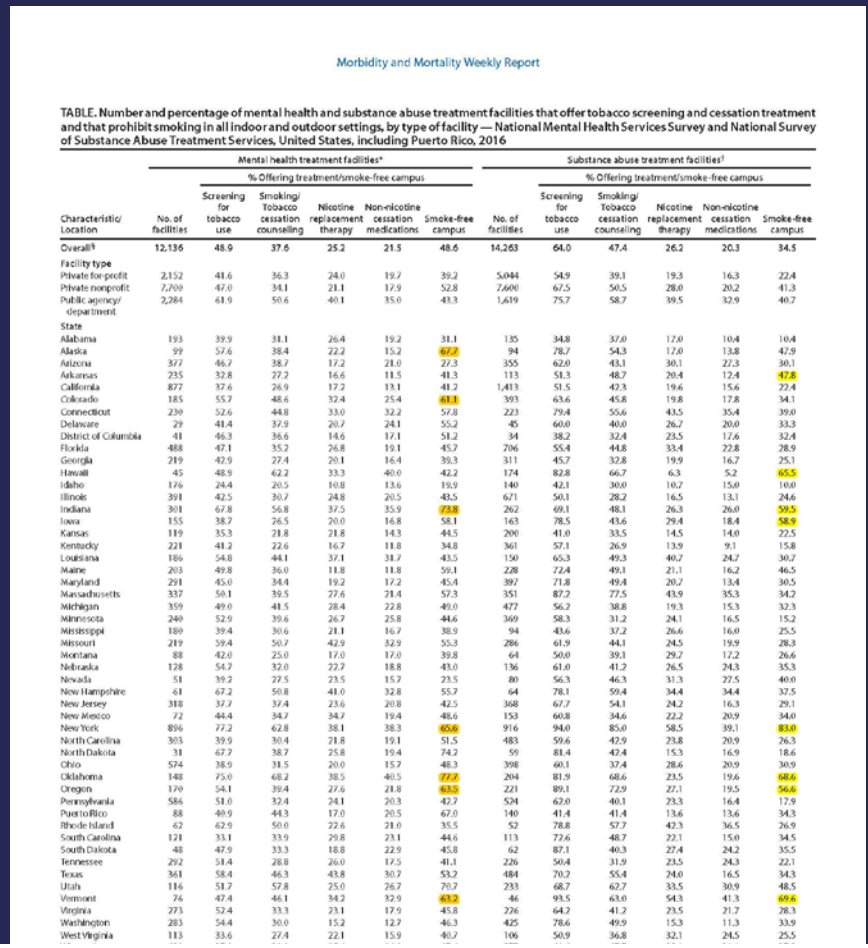
Table 1| **Effect of smoking cessation on mental health. Sensitivity analysis after removal of studies of low quality (mec Newcastle-Ottawa scale)**

Outcome	No of studies included	No of studies excluded	Standardised mean difference (95% CI)	
			Effect estimate	Original effect estimate
Anxiety	4	0	−0.37 (−0.70 to −0.03)	−0.37 (−0.70 to −0.03)
Depression	9	1	−0.29 (−0.42 to −0.15)	−0.25 (−0.37 to −0.12)
Mixed anxiety and depression	4	1	−0.36 (−0.58 to −0.14)	−0.31 (−0.47 to −0.14)
Psychological quality of life	4	4	0.17 (−0.02 to 0.35)	0.22 (0.09 to 0.36)
Positive affect	1	2	0.68 (0.24 to 1.12)	0.40 (0.09 to 0.71)
Stress	2	1	−0.23 (−0.39 to −0.07)	−0.27 (−0.40 to −0.13)

Taylor et al, 2014

Tobacco Free Behavioral Health

- NY
- Arkansas
- Hawaii
- Oklahoma
- Oregon
- Vermont
- Indiana
- Texas**
- Philadelphia



Morbidity and Mortality Weekly Report

TABLE. Number and percentage of mental health and substance abuse treatment facilities that offer tobacco screening and cessation treatment and that prohibit smoking in all indoor and outdoor settings, by type of facility — National Mental Health Services Survey and National Survey of Substance Abuse Treatment Services, United States, including Puerto Rico, 2016

	Mental health treatment facilities*						Substance abuse treatment facilities†					
		% Offering treatment/smoke-free campus						% Offering treatment/smoke-free campus				
Characteristic/ Location	No. of facilities	Screening for tobacco use	Smoking/ Tobacco cessation counseling	Nicotine replacement therapy	Non-nicotine cessation medications	Smoke-free campus	No. of facilities	Screening for tobacco use	Smoking/ Tobacco cessation counseling	Nicotine replacement therapy	Non-nicotine cessation medications	Smoke-free campus
Overall§	12,136	48.9	37.6	25.2	21.5	48.6	14,263	64.0	47.4	26.2	20.3	34.5
Facility type												
Private for-profit	2,152	41.6	36.3	24.0	19.7	39.2	5,044	54.9	39.1	19.3	16.3	22.4
Private nonprofit	7,709	47.0	34.1	21.1	17.9	52.8	7,600	67.5	50.5	28.0	20.2	41.3
Public agency/ department	2,284	61.9	50.6	40.1	35.0	43.3	1,619	75.7	58.7	39.5	32.9	40.7
State												
Alabama	193	39.9	31.1	26.4	19.2	31.1	135	34.8	37.0	17.0	10.4	10.4
Alaska	99	57.6	38.4	22.2	15.2	67.7	94	78.7	54.3	17.0	13.8	47.9
Arizona	377	46.7	38.7	17.2	21.0	27.3	355	62.0	43.1	30.1	27.3	30.1
Arkansas	235	32.8	27.2	16.6	11.5	41.3	113	51.3	48.7	20.4	12.4	47.8
California	877	37.6	26.9	17.2	13.1	41.2	1,413	51.5	42.3	19.6	15.6	22.4
Colorado	185	55.7	48.6	32.4	25.4	61.1	393	63.6	45.8	19.8	17.8	34.1
Connecticut	239	52.6	44.8	33.0	32.2	57.8	223	79.4	55.6	43.5	35.4	39.0
Delaware	29	41.4	37.9	20.7	24.1	55.2	45	60.0	40.0	26.7	20.0	33.3
District of Columbia	41	46.3	36.6	14.6	17.1	51.2	34	38.2	32.4	23.5	17.6	32.4
Florida	488	47.1	35.2	26.8	19.1	45.7	706	55.4	44.8	33.4	22.8	28.9
Georgia	219	42.9	27.4	20.1	16.4	39.3	311	45.7	32.8	19.9	16.7	25.1
Hawaii	45	48.9	62.2	33.3	40.0	42.2	174	82.8	66.7	6.3	5.2	65.5
Idaho	176	24.4	20.5	10.8	13.6	19.9	140	42.1	30.0	10.7	15.0	10.0
Illinois	391	42.5	30.7	24.8	20.5	43.5	671	50.1	28.2	16.5	13.1	24.6
Indiana	301	67.8	56.8	37.5	35.9	73.8	262	69.1	48.1	26.3	26.0	59.5
Iowa	155	38.7	26.5	20.0	16.8	58.1	163	78.5	43.6	29.4	18.4	58.9
Kansas	119	35.3	21.8	21.8	14.3	44.5	200	41.0	33.5	14.5	14.0	22.5
Kentucky	221	41.2	22.6	16.7	11.8	34.8	361	57.1	26.9	13.9	9.1	15.8
Louisiana	186	54.8	44.1	37.1	31.7	43.5	150	65.3	49.3	40.7	24.7	30.7
Maine	203	49.8	36.0	11.8	11.8	59.1	228	72.4	49.1	21.1	16.2	46.5
Maryland	291	45.0	34.4	19.2	17.2	45.4	397	71.8	49.4	20.7	13.4	30.5
Massachusetts	337	59.1	39.5	27.6	21.4	57.3	351	87.2	77.5	43.9	35.3	34.2
Michigan	359	49.0	41.5	28.4	22.8	49.0	477	56.2	38.8	19.3	15.3	32.3
Minnesota	249	52.9	39.6	26.7	25.8	44.6	369	58.3	31.2	24.1	16.5	15.2
Mississippi	189	39.4	30.6	21.1	16.7	38.9	94	43.6	37.2	26.6	16.0	25.5
Missouri	219	59.4	50.7	42.9	32.9	55.3	286	61.9	44.1	24.5	19.9	28.3
Montana	88	42.0	25.0	17.0	17.0	39.8	64	50.0	39.1	29.7	17.2	26.6
Nebraska	128	54.7	32.0	22.7	18.8	43.0	136	61.0	41.2	26.5	24.3	35.3
Nevada	51	39.2	27.5	23.5	15.7	23.5	80	56.3	46.3	31.3	27.5	40.0
New Hampshire	61	67.2	50.8	41.0	32.8	55.7	64	78.1	59.4	34.4	34.4	37.5
New Jersey	318	37.7	37.4	23.6	20.8	42.5	368	67.7	54.1	24.2	16.3	29.1
New Mexico	72	44.4	34.7	34.7	19.4	48.6	153	60.8	34.6	22.2	20.9	34.0
New York	896	77.2	62.8	38.1	38.3	65.6	916	94.0	85.0	58.5	39.1	83.0
North Carolina	303	39.9	30.4	21.8	19.1	51.5	483	59.6	42.9	23.8	20.9	26.3
North Dakota	31	67.7	38.7	25.8	19.4	74.2	59	81.4	42.4	15.3	16.9	18.6
Ohio	574	38.9	31.5	20.0	15.7	48.3	398	60.1	37.4	28.6	20.9	30.9
Oklahoma	148	75.0	68.2	38.5	40.5	77.7	204	81.9	68.6	23.5	19.6	68.6
Oregon	179	54.1	39.4	27.6	21.8	63.0	221	89.1	72.9	27.1	19.5	56.6
Pennsylvania	586	51.0	32.4	24.1	20.3	42.7	524	62.0	40.1	23.3	16.4	17.9
Puerto Rico	88	40.9	44.3	17.0	20.5	67.0	140	41.4	41.4	13.6	13.6	34.3
Rhode Island	62	62.9	50.0	22.6	21.0	35.5	52	78.8	57.7	42.3	36.5	26.9
South Carolina	121	33.1	33.9	29.8	23.1	44.6	113	72.6	48.7	22.1	15.0	34.5
South Dakota	48	47.9	33.3	18.8	22.9	45.8	62	87.1	40.3	27.4	24.2	35.5
Tennessee	292	51.4	28.8	26.0	17.5	41.1	226	50.4	31.9	23.5	24.3	22.1
Texas	361	58.4	46.3	43.8	30.7	53.2	484	70.2	55.4	24.0	16.5	34.3
Utah	116	51.7	57.8	25.0	26.7	70.7	233	68.7	62.7	33.5	30.9	48.5
Vermont	76	47.4	46.1	34.2	32.9	63.2	46	93.5	63.0	54.3	41.3	69.6
Virginia	273	52.4	33.3	23.1	17.9	45.8	226	64.2	41.2	23.5	21.7	28.3
Washington	283	54.4	30.0	15.2	12.7	46.3	425	78.6	49.9	15.3	11.3	33.9
West Virginia	113	33.6	27.4	22.1	15.9	40.7	106	50.9	36.8	32.1	24.5	25.5

Morbidity and Mortality Weekly Report

Tobacco Cessation Interventions and Smoke-Free Policies in Mental Health and Substance Abuse Treatment Facilities — United States, 2016

Kristy Marynak, MPP[1]; Brenna VanFrank, MD[1]; Sonia Tetlow, MPH[1]; Margaret Mahoney, JD[1]; Elyse Phillips, MPH[1]; Ahmed Jamal, MBBS[1]; Anna Schecter, MPH[1]; Doug Tipperman, MSW[2]; Stephen Babb, MPH[1]

New Approaches to Counseling

- Messaging
  - “Treatment” not “Cessation”
- Alternatives to Quitting
  - Quit for a Day
  - Reduce to Quit
- Modified Quitline
- Opt-Out Services

Why Not Quit for One Day?

- Or Six Hours?

- Save money
- Try free NRT
- Feel better
- Master a new skill
- Try other coping
- Not go outside in bad weather

Tobacco Use is a Co-Occurring Disorder

Treatment, not Cessation

Why do you have to quit tobacco forever (cessation) but you can quit alcohol one day at a time?

“Opt-Out" Tobacco Treatment

- Hospital, cancer, prenatal
- All tobacco users : bedside consult and phone follow-up 3, 14, and 30 days after hospital discharge
  - 15% refused counseling
  - ↑ use of stop smoking medications and abstinence after DC
- Call the quitline from the bedside and hand the phone to participants for enrollment/ counseling.
  - Enrollment RR 1.67 warm vs FAX referral
- Those counselled in the hospital 2x likely (RR 1.98, CI 1.04-3.78) to be abstinent from smoking at any time 30 days post-discharge.

Nahhas et al., 2017; Buchanan et al., 2017; Richter 2015

National Certificate in Tobacco Treatment Practice (NCTTP)

- ATTUD and NAADAC
- Standardize and unify tobacco competencies, knowledge, and skills
- National, unified recognition of professionals
- Demonstrating to employers, third-party payers, and clients
- Tobacco Treatment Specialist Training Program + 240 hours of experience

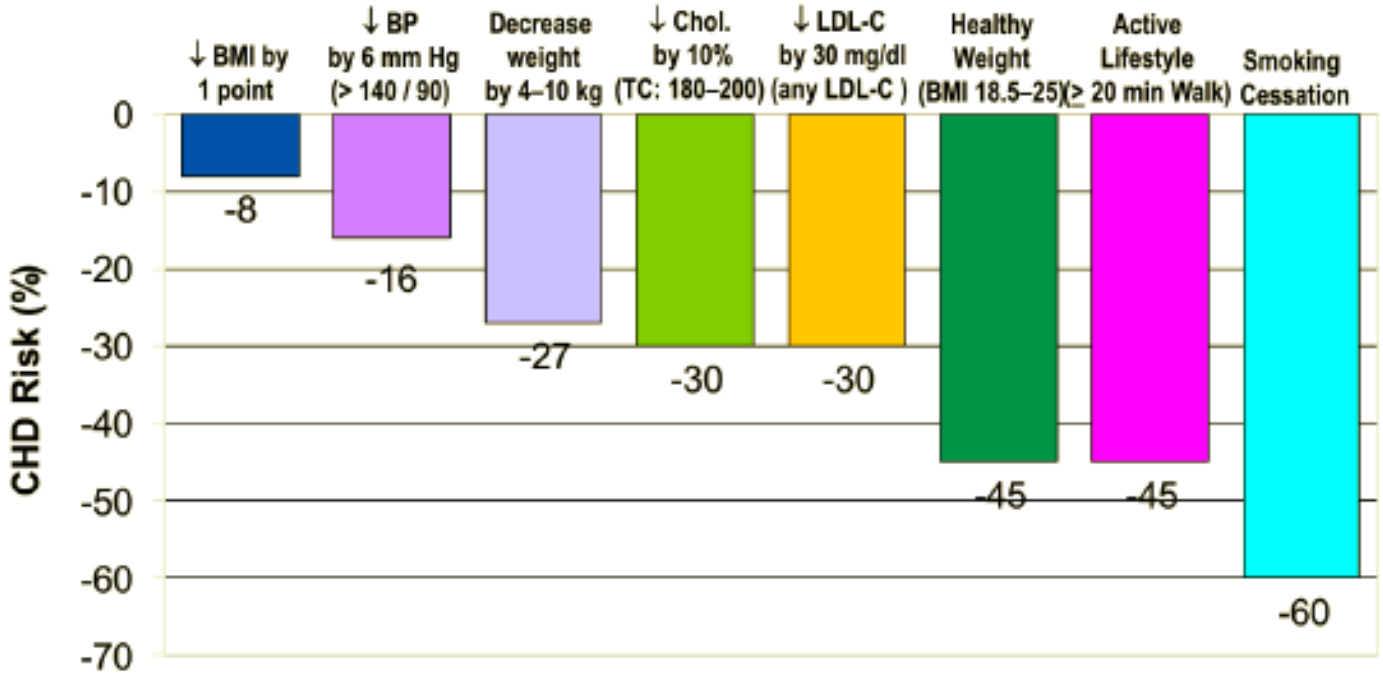
Where Have We Still Not Done Enough?

Mortality in Schizophrenia

- Mortality risk at 20 years is 30%
- White and male are highest risk
- Top causes of death: CV, cancer, infection, respiratory, stroke
- **Cigarette smoking increased CV mortality rate by 86% over a 20 year period**
- Clozapine did not increase mortality risk

Stolz et al., 2019

Not Smoking is the Single Most Important Risk Factor in Preventing CVD/ Metabolic Syndrome



Correll CU. *CNS Spectr*. 2007;12(10 Suppl 17):12-20, 35.

COVID

JAMA Network Open

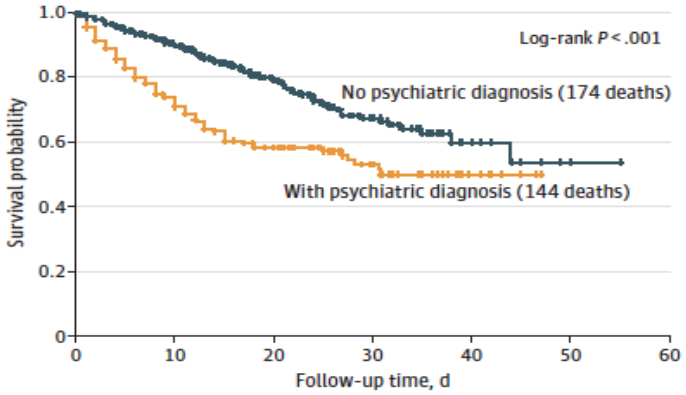
Research Letter | Psychiatry

Association of a Prior Psychiatric Diagnosis With Mortality Among Hospitalized Patients With Coronavirus Disease 2019 (COVID-19) Infection

Luming Li, MD; Fangyong Li, MHS, MS; Frank Fortunati, JD, MD; John H. Krystal, MD

The risk for COVID-19–related hospital death was greater for those with any psychiatric diagnosis.

Figure 1. Kaplan-Meier Survival Curves for Hospitalized Patients With Coronavirus Disease 2019, With or Without a Psychiatric Diagnosis



No. at risk

No psychiatric diagnosis	1212	548	255	79	15	3
With psychiatric diagnosis	473	197	74	36	14	0

Tobacco Cessation Interventions and Smoke-Free Policies in Mental Health and Substance Abuse Treatment Facilities — United States, 2016

Kristy Marynak, MPP[1]; Brenna VanFrank, MD[1]; Sonia Tetlow, MPH[1]; Margaret Mahoney, JD[1]; Elyse Phillips, MPH[1]; Ahmed Jamal, MBBS[1]; Anna Schecter, MPH[1]; Doug Tipperman, MSW[2]; Stephen Babb, MPH[1]

Persons with mental or substance use disorders or both are more than twice as likely to smoke cigarettes as persons without such disorders and are more likely to die from smoking-related illness than from their behavioral health conditions (*1,2*). However, many persons with behavioral health conditions want to and are able to quit smoking, although they might require more intensive treatment (*2,3*). Smoking cessation reduces smoking-related disease risk and could improve mental health and drug and alcohol recovery outcomes (*1,3,4*). To assess tobacco-related policies and practices in mental health and substance abuse treatment facilities (i.e., behavioral health treatment facilities) in the United States (including Puerto Rico), CDC and the Substance Abuse and Mental Health Services Administration (SAMHSA) analyzed data from the 2016 National Mental Health Services Survey (N-MHSS) and the 2016 National Survey of Substance Abuse Treatment Services (N-SSATS). In 2016, among mental health treatment facilities, 48.9% reported screening patients for tobacco use, 37.6% offered tobacco cessation counseling, 25.2% offered nicotine replacement therapy (NRT), 21.5% offered non-nicotine tobacco cessation medications, and 48.6% prohibited smoking in all indoor and outdoor locations (i.e., smoke-free campus). In 2016, among substance abuse treatment facilities, 64.0% reported screening patients for tobacco use, 47.4% offered tobacco cessation counseling, 26.2% offered NRT, 20.3% offered non-nicotine tobacco cessation medications, and 34.5% had smoke-free campuses. Full integration of tobacco cessation interventions into behavioral health treatment, coupled with implementation of tobacco-free campus policies in behavioral health treatment settings, could decrease tobacco use and tobacco-related disease and could improve behavioral health outcomes among persons with mental and substance use disorders (*1–4*).

SAMHSA conducts N-MHSS and N-SSATS annually among all known public and private facilities in the United States that provide mental health or substance abuse treatment services.* Survey respondents are typically facility administrators or others knowledgeable about facility operations; web-based and paper options for completion are available. In 2016, 12,745 eligible mental health treatment facilities responded to N-MHSS (response rate = 91.1%) and 14,632 eligible substance abuse treatment facilities responded to N-SSATS (91.4%). Facilities in U.S. territories, except Puerto Rico, and facilities that did not respond to one or more tobacco-related questions assessed in this report were excluded, yielding a total of 12,136 mental health and 14,263 substance abuse treatment facilities.† Descriptive statistics were assessed nationally and by state.

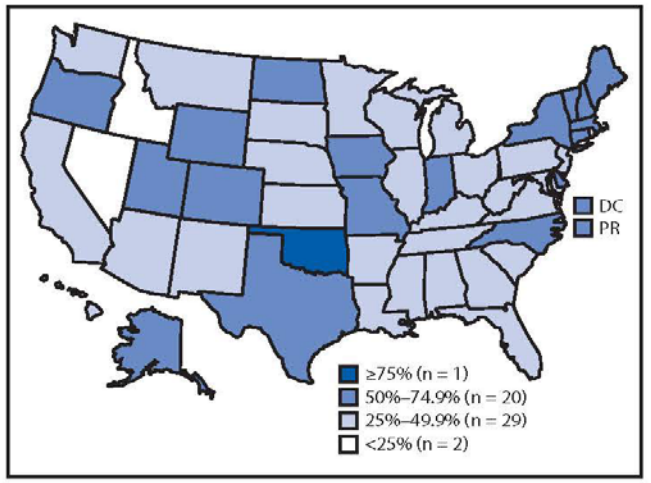
In 2016, tobacco screening was the most commonly implemented tobacco-related practice in mental health (48.9%) and substance abuse (64.0%) treatment facilities (Table). Cessation counseling was the most commonly offered tobacco dependence treatment in mental health (37.6%) and substance abuse (47.4%) treatment facilities. Approximately one fourth of all mental health (25.2%) and substance abuse (26.2%) treatment facilities offered NRT, and approximately one fifth of mental health (21.5%) and substance abuse (20.3%) treatment facilities offered non-nicotine medications. Approximately half of mental health (48.6%) and one third of substance abuse treatment facilities (34.5%) reported having smoke-free campuses. Among facilities with smoke-free campuses, 57.3% of mental health and 39.4% of substance abuse treatment facilities did not report offering counseling, 67.6% of mental health and 65.7% of substance abuse treatment facilities did not report offering NRT, and 74.6% and 75.8% did not report offering non-nicotine medications.

By state, the percentage of facilities offering tobacco cessation counseling ranged from 20.5% (Idaho) to 68.2% (Oklahoma) among mental health facilities and from 26.9% (Kentucky) to 85.0% (New York) among substance abuse treatment facilities. The percentage of facilities with smoke-free campus policies ranged from 19.9% (Idaho) to 77.7% (Oklahoma) among mental health treatment facilities and from 10.0% (Idaho) to 83.0% (New York) among substance abuse treatment facilities. In 31 states, fewer than half of mental health facilities

*N-MHSS: https://www.samhsa.gov/data/sites/default/files/2016_National_Mental_Health_Services_Survey.pdf. N-SATSS: https://www.samhsa.gov/data/sites/default/files/2016_NSSATS.pdf. Excluded for N-MHSS were facilities whose client counts were included in other facilities' counts and whose facility characteristics were not reported separately and facilities that provided administrative services only. Excluded for N-SSATS were nontreatment halfway houses, solo practices not approved by the state agency for inclusion, and facilities that treated incarcerated clients only.

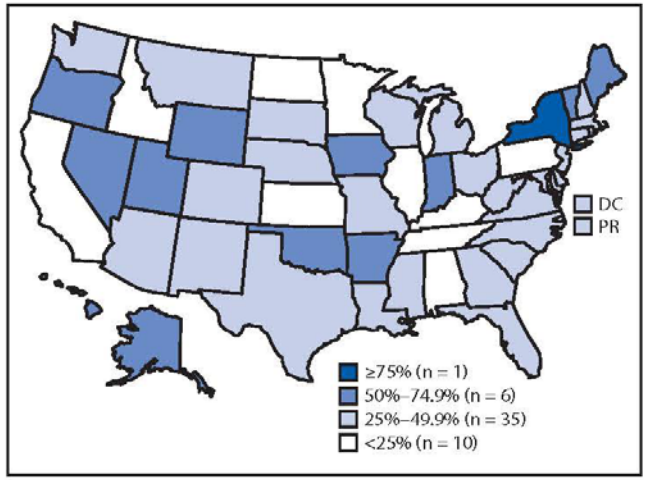
†This report does not include data collected from the Commonwealth of the Northern Mariana Islands, the Federated States of Micronesia, Guam, the Republic of Palau, or the U.S. Virgin Islands because they are not reported separately by N-MHSS and N-SSATS.

FIGURE 1. Percentage of mental health treatment facilities that prohibit smoking in all indoor and outdoor locations — National Mental Health Services Survey, United States, 2016



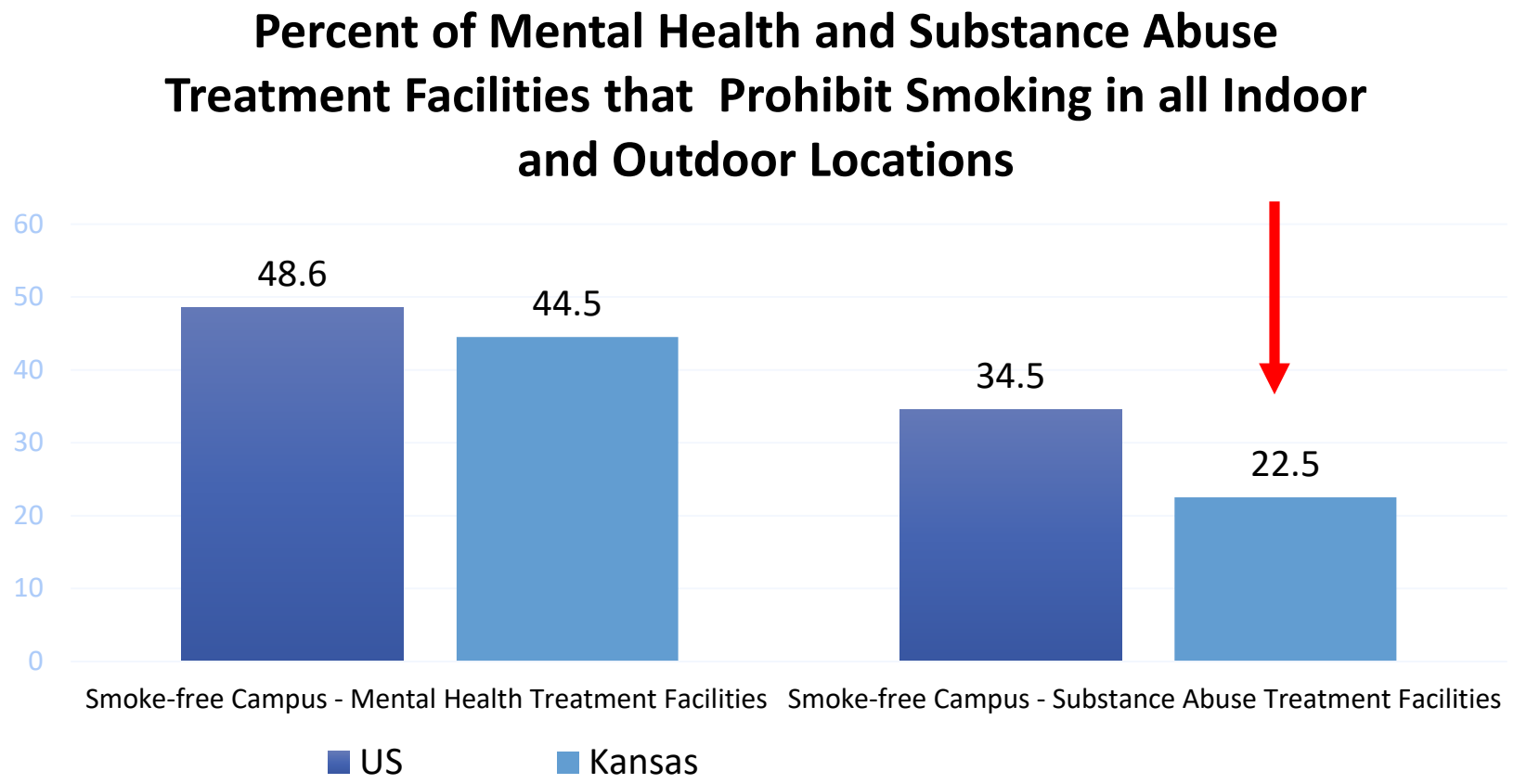
Abbreviations: DC = District of Columbia; PR = Puerto Rico.

FIGURE 2. Percentage of substance abuse treatment facilities that prohibit smoking in all indoor and outdoor locations — National Survey of Substance Abuse Treatment Services, United States, 2016



Abbreviations: DC = District of Columbia; PR = Puerto Rico.

CDC *MMWR* Tobacco-Related Polices in Mental Health and Substance Abuse Treatment Facilities



Buy-In is Still Low

Rates of tobacco screening and treatment by psychiatrists have *gone down* since the 1990s (NACS)

- Psychiatrists prescribed NRT to < 1% of smokers
- Screen 77% (93-96), 69% (01-05), 60 %(06-10)

VA Study (2018) : Five "barriers" themes emerged:

- competing priorities
- patient challenges/resistance
- complex staffing/challenging cross-discipline coordination
- mixed perceptions about whether tobacco is a mental health care responsibility
- limited staff training/comfort in treating tobacco.

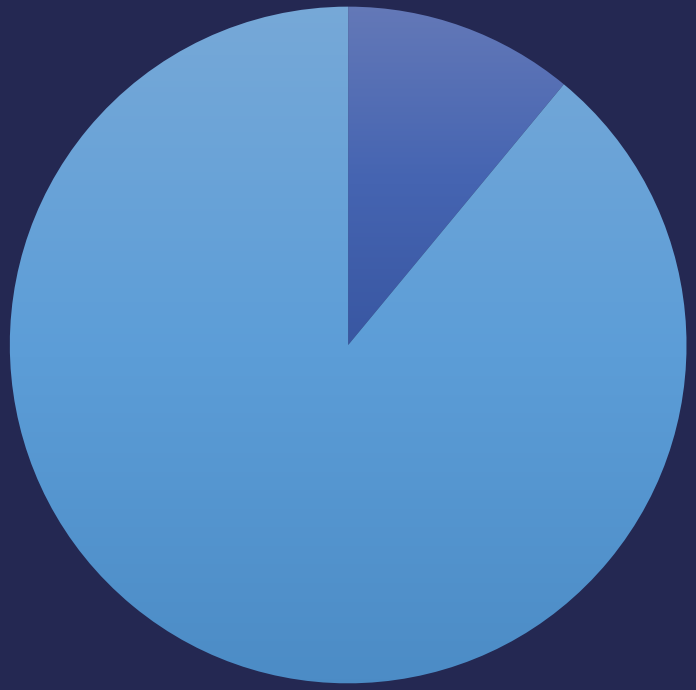
Rogers & Sherman 2014

Reduced Access to Specialty Tobacco Treatment

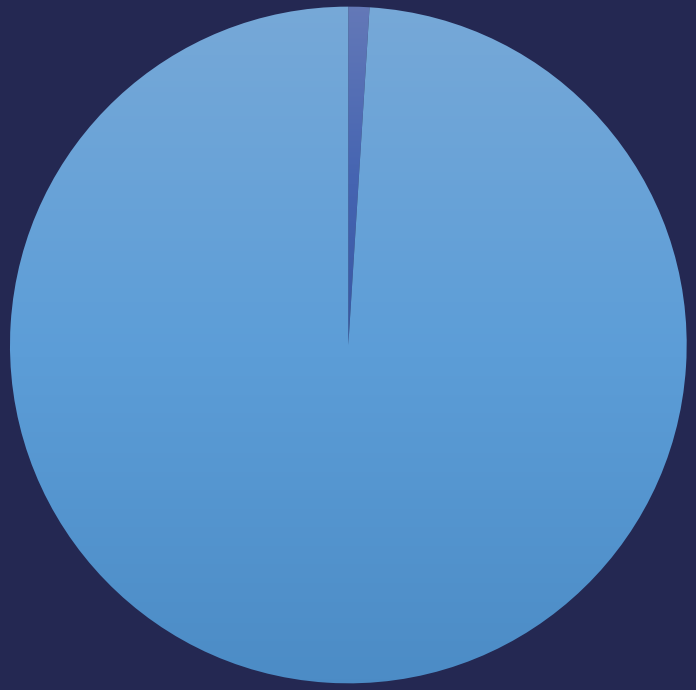
51 million use cigarettes

23 million individuals need treatment for an drug or alcohol use problem

11% Access



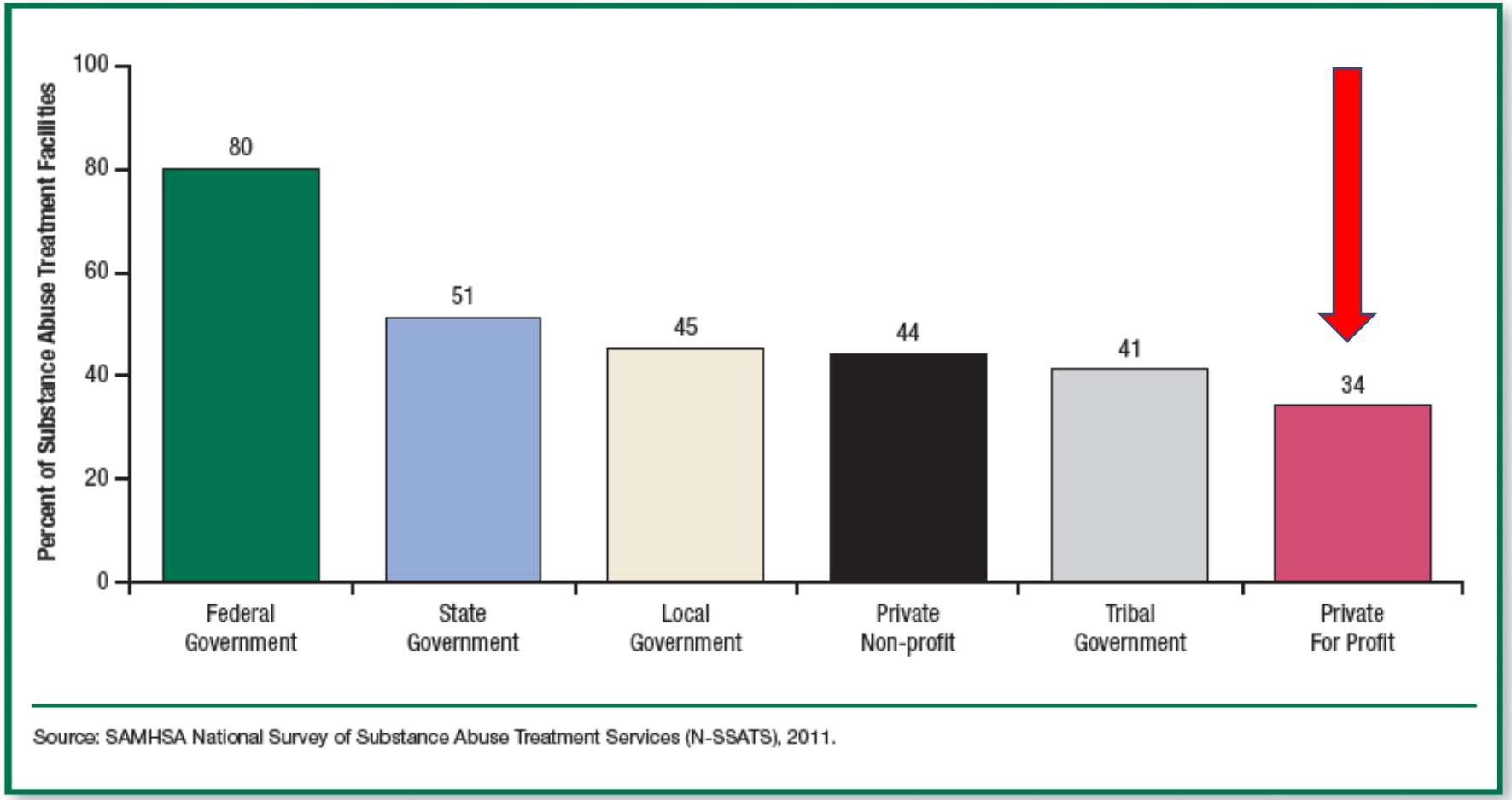
1% Use Quitlines



12% received intensive outpatient (IOP)

Least Tobacco Treatment in Private SATP

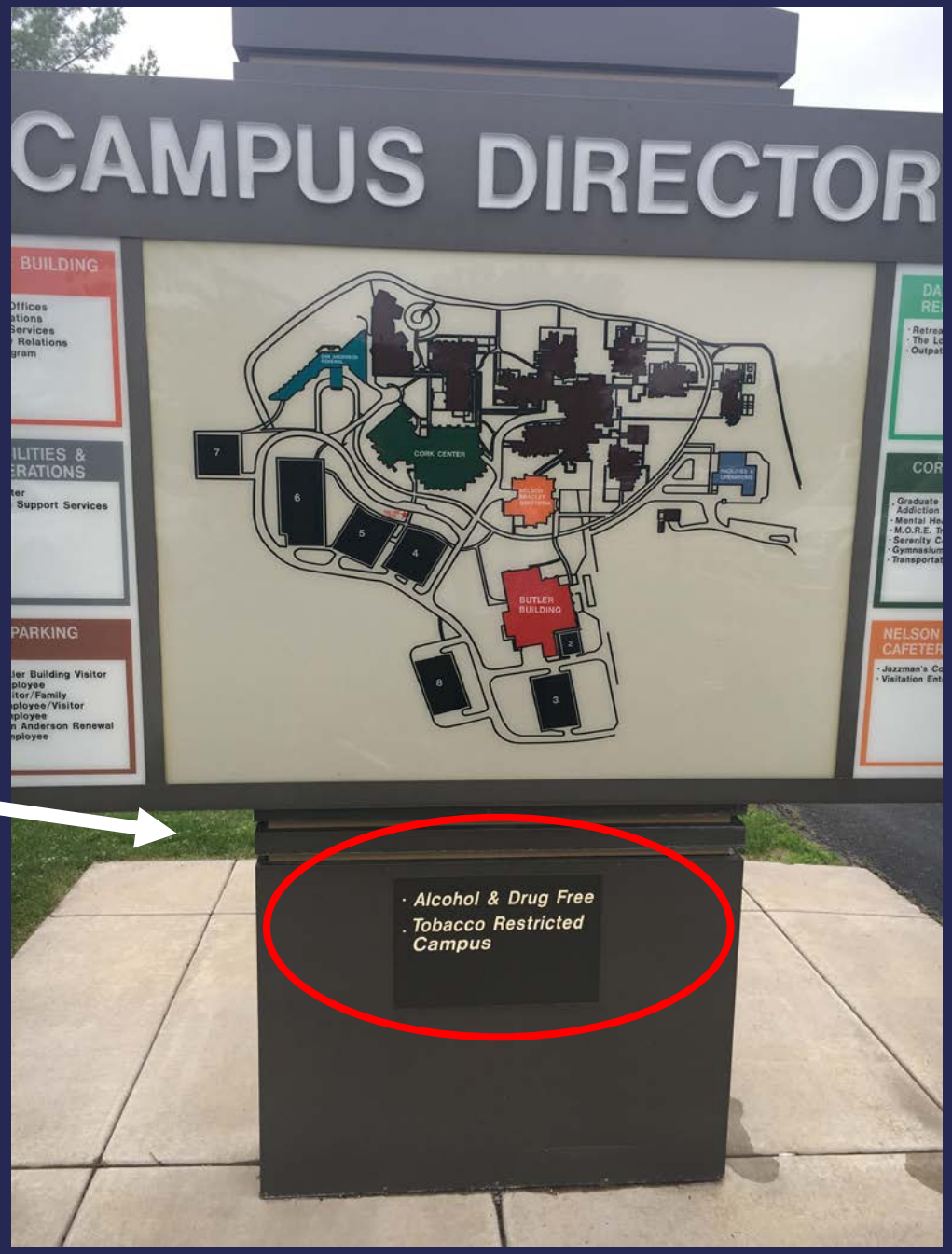
Figure 3. Substance Abuse Treatment Facilities Offering Tobacco Cessation Services, by Facility Operation: 2011



Source: SAMHSA National Survey of Substance Abuse Treatment Services (N-SSATS), 2011.

Alcohol Free
Drug Free

Not
Tobacco Free



Behavioral Health Should Take a Lead in Tobacco Treatment

YES

- High prevalence of tobacco use/ patient need
- Tobacco Dependence in DSM-V
- Trained in addictions
- Tobacco interactions with psych meds
- Longer and more treatment sessions
- Experts in counseling
- Relationship to mental symptoms and other addictions

BUT

- Undervalue tobacco use as a problem
- Poor reimbursement
- Consumers/ families minimize the health risks of tobacco
- Professionals/ systems have been slow to change in addressing tobacco
- Lack the knowledge about effectiveness of treatment
- Lack of advocating for treatment
- Higher smoking among staff

Addressing Tobacco Requires Attention to Multiple Domains

- Neurobiological
- Psychological
- Social & Environmental
- Spiritual & Advocacy
- Treatment System & Institutional

- Greater dependence
- Poor coping; low confidence
- Live with smokers
- Seeing peers succeed; having hope
- Provider bias; No access to help

Call it Treatment not Cessation

Tobacco Use is a Co-Occurring Disorder

Treatment Planning in the Behavioral Health Setting

- Add Tobacco Use Disorder to Problem List and Treatment Plan
- Complete Assessment – Identify level of dependence and motivation to change
- Identify measurable long-term and short-term goals

Conclusions

- It’s the smoke that kills
- Numerous consequences from tobacco for individuals with mental illness
- Mental health professionals MORE involved in tobacco treatment
- Treat it like a co-occurring disorder

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