

HealthAffairs **Blog**

Making Smoking Cessation Work For People With Mental Illnesses And Other Vulnerable Populations

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The prevalence of cigarette smoking among adults is now at a modern low of 15 percent, and youth rates are also down for high school seniors, with only 3.4 percent smoking daily. Yet this is not a time to become complacent and move on to other public health problems. As many as 40 million people still smoke, and half of them will die prematurely as a result. Furthermore, smoking rates remain high among the most vulnerable populations, such as people with mental illnesses or substance use disorders, necessitating policies and strategies targeted specifically at them, as well as support for tobacco control at the federal, state, and local levels.

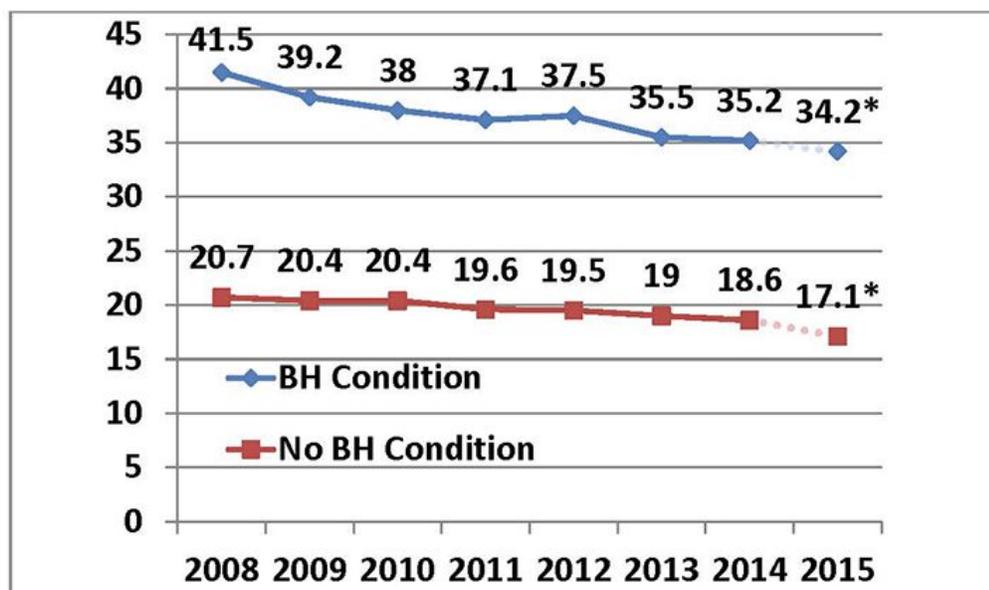
Smoking rates have declined much faster among prosperous, well-educated people than they have among the less fortunate. As a result, smoking is now concentrated among special populations: People with mental illnesses have smoking rates that range from 30 percent to more than 50 percent, depending on the specific diagnosis. People with substance use disorders have even higher rates—from about 50 percent for those who abuse alcohol to more than 77 percent for those who abuse heroin. The LGBTQ populations, people with less education, prisoners, and homeless people also have smoking rates that are higher, sometimes much higher, than the overall population's rate. Yet these special populations are a part of that general population. Excluding them would bring the population smoking rate closer to 10 percent.

How Do We Reach These Smokers?

Addressing smoking among vulnerable populations requires motivating and engaging the clinical, governmental, and advocacy organizations that serve those clients. This involves challenging several erroneous but deeply ingrained myths, such as the beliefs that individuals with a chronic mental illness do not want to quit smoking, are unable to, rely on smoking to treat their underlying disease, or do not suffer much damage from smoking. The Smoking Cessation Leadership Center at the University of California, San Francisco, has been working collaboratively with the Substance Abuse and Mental Health Services Administration (SAMHSA) to hold leadership academies in 15 different states to create a plan to drive down smoking rates among people with mental illnesses or substance use disorders. In addition, the center has worked with clinical organizations such as the American Psychiatric Nurses Association, the American Psychiatric Association, and the American Psychological Association, advocacy groups such as the National Alliance on Mental Illness, and consortiums such as the National Council for Behavioral Health to accomplish those goals. A recent collaboration with the American Cancer Society has engaged multiple organizations to create a national roundtable on behavioral health and tobacco use.

Although it is premature to assess the effectiveness of these efforts, over the past few years smoking among people with behavioral health conditions has declined at a faster rate than for the general population, although it is still at a much higher level (Exhibit 1). Strategies that may have contributed to this progress include motivating behavioral health clinicians and mental health advocacy groups to promote smoking cessation, mandating smoke-free grounds at behavioral health treatment settings, educating state quitlines about how to respond to callers with behavioral health problems, helping staff at behavioral health facilities (many of whom are smokers) to quit, and creating partnerships among different behavioral health entities.

Exhibit 1: Current Smoking Among Adults (Ages ≥ 18) With Past-Year Behavioral Health (BH) Condition, 2008–15



Source: National Survey on Drug Use and Health, 2008–15. Notes: Behavioral health condition includes any mental illness and/or substance use disorder. Due to changes in survey questions regarding substance use disorders in 2015, including new questions on meth and prescription drug misuse, these data are not comparable to prior years.

Other strategies that have been instrumental in driving down tobacco use to the current low level in the general population also work for vulnerable populations. These include raising tobacco taxes at the state and federal level; enacting clean indoor air laws that prohibit smoking in public places; deploying counter-marketing campaigns such as the recent ones by the Food and Drug Administration, the Centers for Disease Control and Prevention (CDC), and the Truth Initiative;

sending smokers to toll-free telephone quitlines (1-800-QUITNOW); and providing health insurance coverage for counseling and the seven medications that can increase the odds of quitting. A new—and controversial—strategy involves motivating smokers who are unable or unwilling to quit with traditional smoking cessation interventions to do so by switching to electronic nicotine devices, such as e-cigarettes. While the efficacy of using e-cigarettes to stop smoking is yet unproven, since their introduction smoking rates have declined at a faster rate than before they were available.

Challenges Under The Trump Administration

Although President Donald Trump has not yet directly addressed the issue of tobacco control, his pledge to replace the Affordable Care Act (ACA) and the priorities reflected in his recent budget proposal would dismantle most federally supported tobacco control elements. In fiscal year 2016, the Prevention and Public Health Fund created by the ACA provided \$126 million for the CDC's Office on Smoking and Health plus \$160 million for state block grants that focus on preventing or treating the most common causes of disability, of which tobacco is number one. Those funds helped maintain many state quitlines and also supported the CDC's successful Tips From Former Smokers campaign featuring smokers who managed to quit (including one with bipolar disorder). That campaign is credited with stimulating hundreds of thousands of people to stop smoking. Repeal of the ACA would terminate that fund. And even if the ACA remains untouched, the proposed Trump budget would zero out these programs. Other tobacco-related benefits of the ACA disappear if the 20 million Americans newly covered under the act lose their health insurance, and thus access to smoking cessation treatments. In addition, ACA-mandated health insurance coverage of smoking cessation services would vanish.

If federal support for tobacco-control measures does erode, state support would become even more important, especially under block grant dynamics wherein tobacco control competes directly with other projects that enjoy a more powerful constituency. As smoking becomes more concentrated among the most vulnerable, the already precarious support for tobacco control could erode further.

Next Steps, Sustaining Momentum

Due to current political challenges, there is certainly cause for pessimism regarding sustained federal action for smoking cessation, but there is still ample opportunity for state and private-sector involvement. At the state level, tobacco excise tax increases likely will continue. In the 2016 election, California—the state with the second-lowest smoking prevalence but the largest number of smokers (three million, reflecting the state's huge population)—voted to raise its state tobacco tax by \$2 per pack, taking that tax from the thirty-seventh highest in the nation to the eighth. If the past is any guide to the future, other states will continue the trend of raising tobacco taxes, which reliably translates into reduced tobacco consumption. A comparable trend has occurred with clean indoor air laws—although in some areas of the country, virtually all people are now covered by a clean indoor air law, meaning much of the potential progress in this area has already been made.

State Medicaid programs looking to reduce their expenditures could promote an economic case to state government for more smoking cessation services. Less smoking means less medical care. In addition, health professional associations, as well as organizations focused on heart and lung disease and cancer, must counter the erroneous myths about smoking cessation and behavioral health. They should emphasize that stopping smoking not only improves physical health but increases mental health, as well as the odds of successful substance use disorder treatment. There is much to learn about best practices to help vulnerable smokers quit, including the potential role of electronic cigarettes and comparable devices, and the National Institutes of Health should encourage research in these areas.

The work of the Smoking Cessation Leadership Center has spanned red states and blue states, some with high smoking rates and some with lower rates. But in every instance there exist dedicated state and private-sector employees who are committed to improving the health of the public by reducing the harm from tobacco. Tobacco control should not be a partisan issue. Indeed,

in this time of intense partisan divide, reducing death and disability—especially among the most vulnerable—is one of only a few potential bridges. As we celebrate the remarkable progress in tobacco control of the past several decades, let us not forget that there is still much more to do.

HEALTH EQUITY

ASSOCIATED TOPICS: POPULATION HEALTH, PUBLIC HEALTH

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