BEHAVIORAL HEALTH & TOBACCO DEPENDENCY

Integrating Treatment into Behavioral Health Facilities

Commercial tobacco use[1] among adults with behavioral health issues such as mental health or substance use disorders[2] has been described as "a neglected epidemic."[3] Although only 25 percent of the U.S. adult population have behavioral health issues, individuals with mental health or substance use disorders consume approximately 40 percent of the cigarettes sold in the U.S.[4]

The numbers are striking. Almost three in ten U.S. adults with mental illness and four in ten adults with serious mental illness smoke, and anywhere from 49 to 98 percent of adults with various substance use disorders smoke.[5] As a result, the nicotine dependency rate for individuals with behavioral health disorders is two to three times higher than that of the general population, which is approximately 14 percent of all U.S. adults.[6] To reduce tobacco use and the disproportionate

tobacco-related illnesses among those experiencing behavioral health issues, members of this population need ongoing help to address their nicotine addiction.

This guide provides local communities, administrators, and treatment professionals in mental health and substance abuse facilities ("behavioral health facilities") with tools and resources to fold tobacco dependency treatment into existing services. It describes obstacles to incorporating tobacco treatment in behavioral health facilities, identifies basic elements of tobacco cessation policies or programs, and lists several provider and client resources.

Overview

Commercial tobacco use kills one in two lifetime users.[7] Tobacco users who do not die directly or indirectly of tobacco-related illness such as cancer, cardiovascular problems, respiratory disease, and diabetes, often witness their friends and family, who may not use tobacco, suffer compromised health due to secondhand smoke exposure.[8] In addition to increased susceptibility to major tobacco-related diseases, users often experience other adverse health impacts, such as dulled smell and taste,[9] premature aging of skin, scarred lungs, and gum and tooth disease.[10]

As harmful as tobacco use is to the general population, the consequences of tobacco use are particularly detrimental for those with behavioral health challenges. Along with the well-documented health risks of commercial tobacco use, smoking can trigger cravings for other addictive substances, exacerbate long-term symptoms of anxiety and depression, and prolong and complicate recovery from behavioral health conditions.[11] In the behavioral health population, death from tobacco-linked causes has historically occurred at higher rates[12] and at earlier ages than among smokers in the general population.[13] Moreover, smoking in this population also causes economic and social hardship. Persons with mental illnesses and substance use disorders are more likely to live in stressful conditions; lack access to health insurance, health care, and help in quitting; and have low annual household incomes. Cigarettes often consume a significant fraction of their monthly expenditures.[14]

Despite common beliefs, many individuals who experience behavioral health challenges want to quit using tobacco.[15] For instance, in one survey, more than 90 percent of psychiatrists at four community mental health centers said their smoking patients were not interested in quitting.[16] However, four in five of their patients stated that they, in fact, were either interested in curbing their smoking or quitting altogether.[17] Indeed, research suggests that general interest among this population in quitting may be rising as a result of the health dangers and financial challenges brought on by COVID-19.[18] Quitting tobacco improves mental and overall wellbeing,[19] reduces long-term anxiety, stress, and depression, and enables addiction-free

living.[20] In fact, studies have shown that when tobacco treatment is provided with addiction treatment, there is a 25 percent increased likelihood of long-term abstinence from alcohol and other drugs.[21] Given growing awareness of the increased health risk that tobacco use poses for these priority populations, it is more important than ever for behavioral health facilities to foster environments that support tobacco dependency treatment.

Unfortunately, despite long-standing evidence of the adverse impact of tobacco use on the behavioral health population, fewer than two-thirds of behavioral health facilities screen for tobacco use and fewer than half have smoke-free policies or incorporate tobacco cessation counseling into their work.[22] As of March 2020, only eleven state laws required that mental health facilities have tobacco-free grounds and only five state laws required that substance use treatment programs have tobacco-free grounds.[23] The lack of tobacco-free grounds policies is particularly significant because if a smoking culture exists in a treatment facility, it's more challenging for clients to quit.

Obstacles to Tobacco-Free Policies & Interventions

Why, despite the evidence of the harm of tobacco use and nicotine addiction in the behavioral health population, have so few mental health and substance use treatment facilities adopted tobacco-free grounds policies or integrated tobacco dependency treatment into their clinical practices and programs?

Behavioral health facilities vary in their administrative structures, clinical approaches, and capacity. As a result, facilities and jurisdictions face a variety of challenges in adopting comprehensive smoke-free policies and integrating tobacco treatment services into their clinical practices and programs. Among these challenges are systemic, organizational, and staff obstacles.

Systemic Barriers

Often a key obstacle to tobacco treatment in both mental health and addiction treatment facilities is the lack of funding for treatment or resources. Many key providers are ineligible for tobacco treatment reimbursement, and facilities that are reimbursed typically do not receive rates that cover the costs associated with delivering treatment.[24] Also, access to medication and services can be difficult. Tobacco treatment requires an MD order or sign-off, and medications have quantity/duration limits, prior authorization requirements, and other barriers to access, which can prolong or complicate access.[25] In addition, treatment resources such as free over-the-counter nicotine replacement therapy (NRT) products are often not readily available on site.

Organizational Barriers

Another barrier to implementing tobacco use interventions may be an institutional tolerance of tobacco use, given a facility's mission or culture. Facility leadership or clinicians may maintain that tobacco dependency treatment is a low priority compared to their organization's more pressing need to treat mental illness or addiction to other drugs.[26] Facilities may also contend that attempting to quit will overburden patients or staff or compromise treatment or that they lack the trained staff available to provide extra time with clients.[27] Administrators may fear potential loss of clients or staff if they are no longer permitted to use tobacco on the premises.

Finally, some clinicians may believe that since clients will only relapse and smoke again once they're released, it's futile to focus on tobacco cessation in the first place.[28] This is a particularly concerning belief because even if many clients do relapse eventually, medical professionals do not refuse treatment for other addictions, even when they believe the patient is not motivated to remain abstinent. The major goal of behavioral health facilities is to provide clients with the opportunity to stabilize and to detoxify while in treatment with the hope that they will choose a substance-free life. Quitting is hard, especially in environments where

tobacco use is acceptable. By incorporating tobacco dependency treatment in a recovery plan, staff can help clients learn how to identify triggers and regain control if they relapse.

Staff Barriers

Additional barriers at the staff level include limited staff training related to tobacco dependency treatment, a lack of up-to-date knowledge about the relationship between tobacco use and mental health/substance use disorder recovery, and staff smoking. Some staff feel inadequate to help clients quit smoking, particularly when they may be smokers themselves.[29] Also, staff may hold common fixed attitudes and historical preconceptions about tobacco use among this population, including notions that clients lack the desire or motivation to quit, that smoking is an individual right;[30] and that quitting tobacco may interfere with a client's overall recovery.[31]

Myths About Tobacco Use & Behavioral Health

Below are just a few common myths surrounding tobacco use and behavioral health, along with sample responses to debunk these statements.

1 ***"My clients have enough on their plate without having to tackle tobacco cessation."*** Quitting tobacco is hard, but it should be viewed as part of behavioral health treatment — not as an option. Tobacco cessation supports lasting recovery from substance abuse and mental illness. It improves overall wellbeing,[32] reduces anxiety, stress, and depression,[33] and has not been shown to worsen serious mental illnesses like major depression and schizophrenia.[34] Moreover, non-smokers are less likely to relapse from other addictions than smokers.[35]

2 ***"Tobacco use is not a priority compared to the other conditions my client has or the other drugs my client is using."*** While tobacco use may not have the acute, immediate impact on physical health and well-being that severe mental illness and substance abuse can have, the long-term effects of tobacco use are devastating and life-threatening. Tobacco is the number one cause of preventable death in the United States, and tobacco users are likely to experience at least one of many debilitating diseases, such as cancer, heart disease, COPD, diabetes, or emphysema.[36] Clients who receive treatment for major drug addiction or mental illness will never adequately recover their health until they also quit tobacco.

3 ***"Smoking is an important way for my client to deal with the stress of recovering from substance abuse or mental illness."*** The belief that smoking is a necessary form of self-medication is a myth long perpetuated by the tobacco industry.[37] While smoking decreases short-term anxiety, it increases long-term anxiety and worsens an individual's social acceptability, finances, and physical health.[38]

4 ***"Quitting smoking might compromise or worsen psychiatric symptoms."*** Research does not suggest that quitting will harm those who suffer from major mental illnesses like schizophrenia and major depression and may instead improve overall health and wellbeing.[39] Moreover, non-smokers are less likely to relapse from other addictions than smokers.[40]

5 ***"It will be too hard for our facility to support tobacco treatment on top of what we already do."*** Facilities can incorporate tobacco dependency treatment into clinical programs and practices in a variety of ways, depending on the organization. Some basic tobacco cessation counseling can take as little as a few minutes, while other types of interventions can provide more comprehensive support for treatment professionals and clients.[41]

Basics of Integrating Cessation into Clinical Programs

The resources listed below describe a variety of different strategies that can support tobacco cessation in behavioral health facilities. Some of the most common policy options that behavioral health facilities can take to reduce tobacco use among this population include (1) ensure that clients are treated in a tobacco-free setting, (2) provide individualized tobacco dependency treatment and resources, and (3) work with staff to create a campus culture that supports and promotes tobacco-free living.

Element 1: Ensure That Clients Are Treated in a Tobacco-Free Setting

A tobacco-free policy not only prevents the use of tobacco products on facility property, but it demonstrates the facility's commitment and support to those with nicotine dependency — clients, staff, visitors, contractors, and anyone else on the premises. Because e-cigarettes and similar products produce an aerosol of undetermined and harmful substances, both to users and nonusers, and because these devices typically contain tobacco-derived nicotine, which is a highly addictive substance, tobacco-free restrictions in behavioral health facilities should include e-cigarettes. The use of e-cigarette devices in locations where smoking is prohibited re-normalizes commercial tobacco use, creates concern and confusion, and makes enforcement of smoke-free and tobacco-free restrictions more difficult.

Also, comprehensive tobacco-free policies commonly apply to both indoor areas and the adjacent grounds, including vehicles owned, leased, used, or otherwise controlled by the facility. Before implementing any policy like this, facilities need to take time to educate staff, clients, and the adjacent community, and prepare to offer tobacco treatment services and resources as much as possible.

Element 2: Provide Individualized Tobacco Dependency Treatment and Resources

Supporting tobacco dependency treatment in a behavioral health facility may require staff and clients to change their perceptions about the usefulness and benefits of quitting tobacco. Creating a campus culture that is optimistic and excited about tobacco cessation efforts can make a huge difference in the effectiveness of an overall program or policy.

Incorporating tobacco treatment into a clinical plan involves coordinating the whole health needs of an individual — including primary care, mental health care, and addiction treatment. Common approaches for integrating tobacco treatment into clinical practices include 1) Screening every patient for tobacco use; 2) Advising every patient who uses tobacco to quit; and 3) Connecting every patient to appropriate resources, including treatment.[42]

Screening & Advising. One frequently used and flexible approach, called the "5 A's," only takes a few minutes to include in a pre-counseling interview or counseling session.[43] Counselors simply:

1 **"Ask"** patients if they smoke and, if so, how much

   Example: *"Do you smoke?" "How many times per day do you smoke?"*

2 **"Advise"** them to quit smoking

   Example: *"I believe that quitting smoking is one of the most important things you can do for your recovery and your health."*

3 **"Assess"** whether or not they are ready to quit

   Example: *"Are you willing to quit smoking in the next 30 days?"*

4 **"Assist"** patients to quit smoking by encouraging them to quit, developing a quit plan, counseling, and/or providing medication

   Example: (for patients who say "no") *"I encourage you to think about quitting smoking before our next visit and the benefits that it will give you."*

   Example: (for patients who say "yes") *"Let's develop a plan to cut down on your smoking together."*

5 **"Arrange"** for a follow-up appointment and other referrals to assist with cessation. A list of patient resources is available at the end of this guide.

   Example: *"At our next session, I will ask you about...."*[44]

For situations in which a full five-step counseling process may be impractical, practitioners may want to consider using an abbreviated three-step process "Ask, Advise, Refer."[45] With this approach, counselors complete the first two steps of the above process and then refer patients directly to quit support services.[46] However, this method may be less effective than the full five-step process.[47] Brief, free trainings are available on the 5 A's: (CF-5A's Tour).[48]

Connecting with Treatment. The heart of tobacco treatment in behavioral health facilities is effective individual counseling. The length, scope, and type of counseling a facility can provide depends largely on its resources. Pharmacology intervention (that is, medication taken in tandem with coaching) is key to helping behavioral health clients manage symptoms of nicotine withdrawal and support quit attempts.

The U.S. Food and Drug Administration currently approves seven first-line medications for tobacco dependency treatment: five nicotine replacement therapy (NRT) products (nicotine patch, nicotine gum, nicotine lozenge, nicotine nasal spray, and nicotine oral inhaler) and two prescription medications (Varenicline, known as Chantix, and Bupropion SR, known as Zyban). Each of these medications has been tested for safety and effectiveness, and studies have shown that people with mental illness who take these medications have a greater chance of quitting successfully.[49] Often these medications are more effective in this population when they are used in combination or for extended periods of time. Also, any medications need to be coordinated with other treatment plans and clinicians need to closely monitor medication levels and side-effects of clients making quit attempts.

Unfortunately, despite strong evidence of the efficacy of tobacco cessation medication, access often is limited for people with mental illness and substance use disorders who are interested in quitting. One way to increase access is to make sure that providers, pharmacists, and clients all understand the available treatment options and if these options are covered by insurance. Coverage will vary depending on the client's insurance — whether it is provided by the government (e.g., Medicaid, Medicare, VA benefits), by an employer, or purchased through the individual marketplace. Providers also need to address lack of coverage when clients are uninsured.

Element 3: Work with Staff to Create a Campus Culture that Supports and Promotes Tobacco-free Living

Staff who use tobacco also need help to quit. Offering tobacco treatment services to staff is cost-effective for employers and helps promote a healthy tobacco-free setting throughout the facility. Employees who see the benefits of quitting firsthand can more effectively help others quit and can play a big role in supporting and promoting tobacco-free policies.

Multi-Disciplinary Collaborations

States, local communities, social services, clinicians, mental health providers, and substance use treatment providers can all benefit when pooling their expertise with policymakers and public health professionals to address the problem of tobacco use — particularly as it affects the most susceptible members of our community. Larger level policy changes regarding the way in which tobacco products are marketed and targeted to certain populations can have an impact on reducing tobacco use in these populations. Such policy changes can include tobacco retail licensing, restrictions on sales of certain products (such as flavored products), and smoke-free laws and policies at the state or local level. Not only can these policies benefit people with behavioral health issues, but the providers that serve them. Also, behavioral

health facilities, where possible, can build support networks by connecting with local nicotine addiction quit groups, charitable organizations, local tobacco cessation programming, and grant providers to help clients quit for good.

Several states and organizations collaborate with experts in different fields and professionals at the federal, state, and local levels, to develop plans and implement policies to address this problem. For instance, the National Partnership on Behavioral Health and Tobacco Use, established in 2016, works to develop national strategies to expand and accelerate efforts to combat disparities in smoking prevalence and tobacco treatment for those with mental health and substance use disorders.[50] The Partnership draws on expertise and insights from clinicians, leaders of health professional organizations, federal agencies, nonprofit health organizations, managed health care companies, experts in behavioral health and tobacco prevention and cessation, and other stakeholders.

Another national organization, the Smoking Cessation Leadership Center (SCLC), located at the University of California San Francisco, supports tobacco dependency treatment efforts throughout the U.S., including among behavioral health populations.[51] SCLC organizes statewide collaborations, called State Leadership Academies, that convene 1.5 day summits with mental health, substance use treatment, tobacco control, and public health experts, all dedicated to fostering tobacco-free living among the behavioral health population in their states.

Resources

Below are select resources and organizations that focus on addressing tobacco use among the behavioral health population.

Select Toolkit Resources

Several states and organizations have developed materials, including toolkits, for behavioral health and addiction treatment specialists interested in integrating tobacco dependency treatment and policies into their clinical practice. The following select resources can all be adapted for different jurisdictions.

- **Million Hearts Tobacco Cessation Change Package:** Tobacco dependency treatment toolkit for behavioral health centers, physicians, and partners developed by the Centers for Disease Control and Prevention.
- **California Behavioral Health & Wellness Initiative's** Tobacco-free Toolkit for Behavioral Health Agencies. A tobacco dependency treatment toolkit for behavioral health agencies with a focus on policy development. Provides California-specific resources and creative tips for building a wellness culture on campus.
- **University of Colorado Anschutz Medical Campus School of Medicine Behavioral Health & Wellness Program's** DIMENSIONS: Tobacco-Free Policy Toolkit. Resource for healthcare providers, including hospitals, behavioral health facilities, and other entities, interested in developing tobacco-free policies. Includes Colorado-specific information on health insurance coverage for tobacco cessation.
- **Kansas NAMI and Public Health Law Center's** Kansas Tobacco Guideline for Behavioral Health Care: An Implementation Toolkit (2018). A toolkit for behavioral healthcare centers that walks through twelve strategies for supporting tobacco cessation. Provides resources, case studies, health insurance, and other information specific to Kansas.
- **Legacy (now Truth Initiative)'s** A Hidden Epidemic: Tobacco Use and Mental Illness: An older toolkit (June 2011) for healthcare organizations with case studies of organizations that have implemented tobacco cessation-related interventions.
- **American Lung Association in Minnesota,** A Toolkit to Address Tobacco Use in Behavioral Health Settings
- **American Lung Association,** Public Health Roadmap to Coaching a Clinical Team to use the Million Hearts® Tobacco Cessation Change Package (2020)

Select Patient Resources

- **Quit groups**
  - Nicotine Anonymous: Uses the outline of the Alcoholics Anonymous twelve-step program for nicotine addiction. Group settings vary; some are face-to-face, while others meet online or by phone.
- **Smoking quitlines**
  - State Quitline Directory (1-800-QUIT-NOW): Connects callers to state quitline services.
  - National Cancer Institute Quitline (877-44U-QUIT): Provides tobacco cessation help. Available in English and Spanish, M–F, 9 a.m. to 9 p.m. ET.
- **Online chat**
  - National Cancer Institute LiveHelp: Provides tobacco cessation help. Available in English and Spanish, M-F, 9 a.m. to 9 p.m. ET.
- **Text messaging and social media**
  - Smokefree text services: Users can sign up for one or more free text messaging services that provide smokers trying to quit with supportive texts 3–5 times per day for 6–8 weeks. Programs are available for general smoking cessation and for specific populations, including moms, teens, veterans, and Spanish speakers.
  - Smokefree apps: Smokefree's QuitGuide and quitSTART cellphone apps provide personalized quitting support.
  - Smokefree on social media: Smokefree can provide quit support on most major social media feeds, including Facebook, Twitter, Pinterest, and Instagram.
- **Websites**
  - "Quitting Smoking" from Kaiser Permanente: Provides information about quitting, motivational stories, and interactive tools to help people quit.
  - Smokefree.gov: Provides smokers at each stage of the quitting process find tools and resources to assist them in their quitting goals.

Conclusion

Smoking rates among individuals who face mental health or substance abuse challenges far exceed those among the general population. Many of these individuals are interested in quitting tobacco use, and providers increasingly recognize the important impact that tobacco cessation can have on client recovery efforts and overall wellbeing. The strategies and resources described in this guide can help behavioral health facilities create a culture that includes tobacco dependency support and treatment in clinical practice. For more information about policy approaches and strategies to reduce tobacco use in the behavioral health population, please contact the Public Health Law Center.

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Endnotes

1 The Public Health Law Center recognizes that traditional and commercial tobacco are different in the ways they are planted, grown, harvested, and used. Traditional tobacco is and has been used in sacred ways by Indigenous communities and tribes for centuries. Comparatively, commercial tobacco is manufactured with chemical additives for recreational use and profit, resulting in disease and death. For more information, visit http://www.keepitsacred.itcmi.org. When the word "tobacco" is used throughout this guide, a commercial context is implied and intended.

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