Smoking Cessation Leadership Center

University of California San Francisco

Blame and shame are killing our clients: How behavioral health stigma biases providers and undermines smoking cessation

co-hosted by NBHN

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A National Center of Excellence for Tobacco-Free Recovery

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Smoking Cessation:
A Report of the Surgeon General

The first report focused solely on smoking cessation in 30 years

2020 Surgeon General's Report
on Smoking Cessation

Quitting smoking is beneficial at any age.

Learn more about this report:
CDC.gov/CessationSGR

Executive Summary

Key Findings Factsheet

Consumer Guide

Free 1-800 QUIT NOW cards

Take Control
1-800-QUIT-NOW
Call. It's free. It works.
1-800-784-8669
For details on your state services, go to: http://map.naquitline.org

✓ Refer your clients to cessation services

National Behavioral Health Network

For Tobacco & Cancer Control

- Jointly funded by CDC's *Office on Smoking & Health & Division of Cancer Prevention & Control*
- Provides resources and tools to help organizations reduce tobacco use and cancer among people with mental illness and addictions
- 1 of 8 CDC National Networks to eliminate cancer and tobacco disparities in priority populations

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Today's Presenter

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Blame and Shame are Killing Our Clients: How Behavioral Health Stigma Biases Providers and Undermines Smoking Cessation

Jason M. Satterfield, PhD

Professor of Medicine

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SAMHSA National Center of Excellence for Tobacco-Free Recovery

Objectives

1. Define and describe stigma as it relates to behavioral health disorders, smoking, and substance use.

2. Describe the social and psychological processes that create stigma and cause it to be internalized.

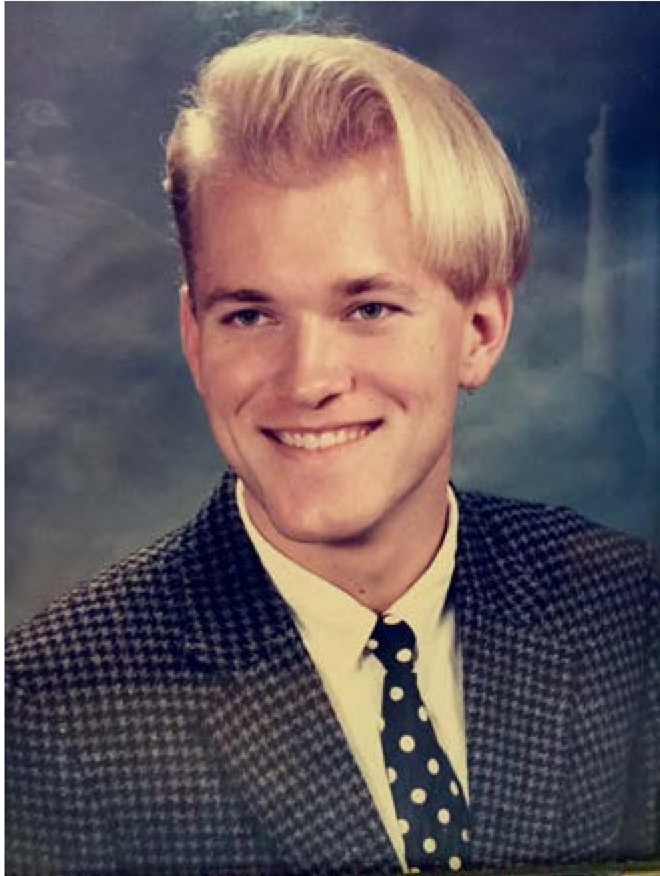
3. Summarize how stigma affects both client and provider behavior and contributes to health and health care disparities.

4. Compare and contrast two interventions intended to reduce stigma, expand access to treatment, and improve outcomes for smoking and other behavioral health disorders.

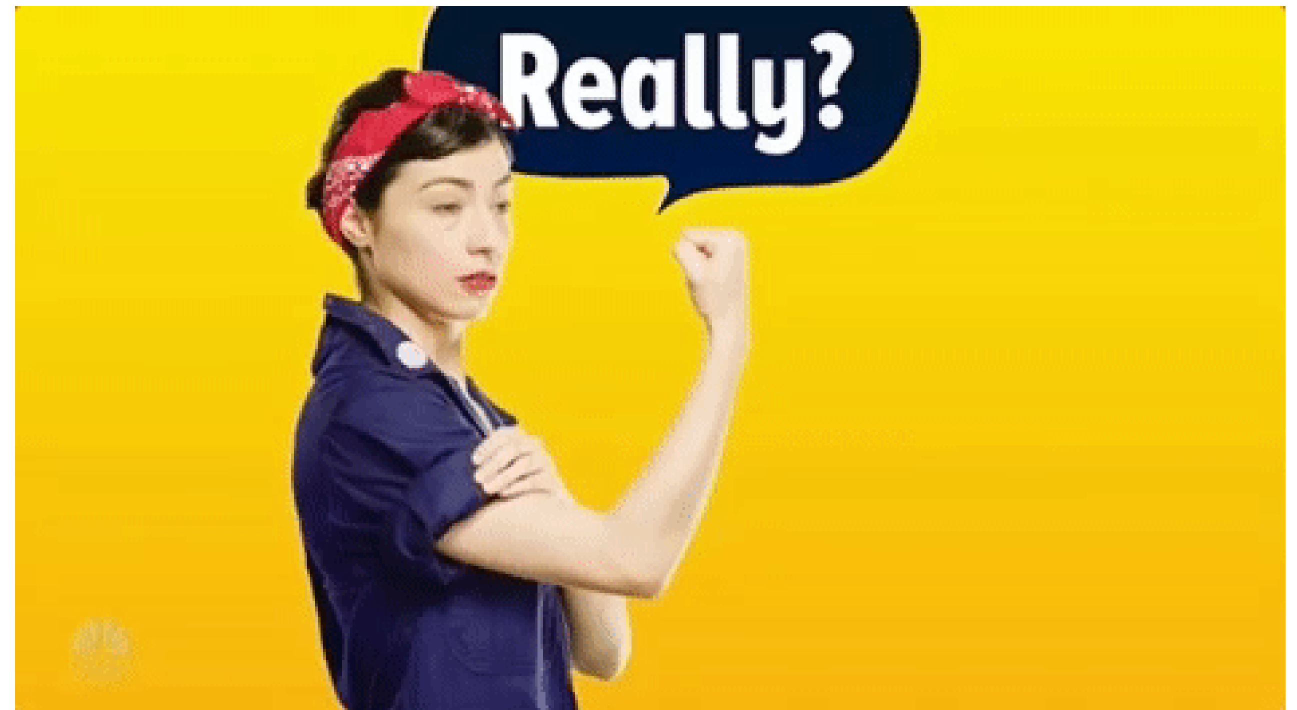
Roadmap

- Smoking and behavioral health disorders
- Smoking cessation in patients with BH disorders
- Stigma, bias, prejudice and discrimination – “shame, and blame”
- Addressing stigma and promoting smoking cessation

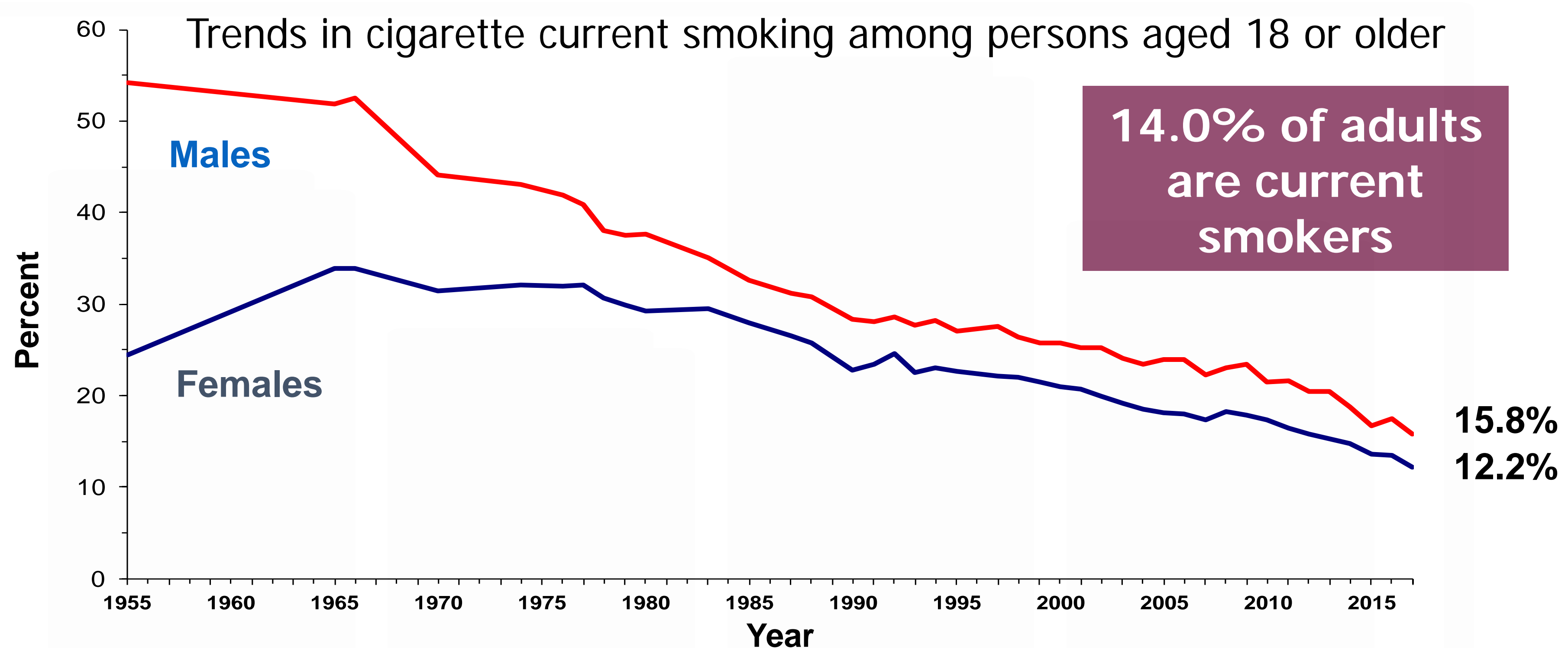
The year is 1994….



We’ve come a long way baby – have we?



TRENDS in ADULT SMOKING, by SEX—U.S., 1955–2017



68% want to quit
55% tried to quit in the past year

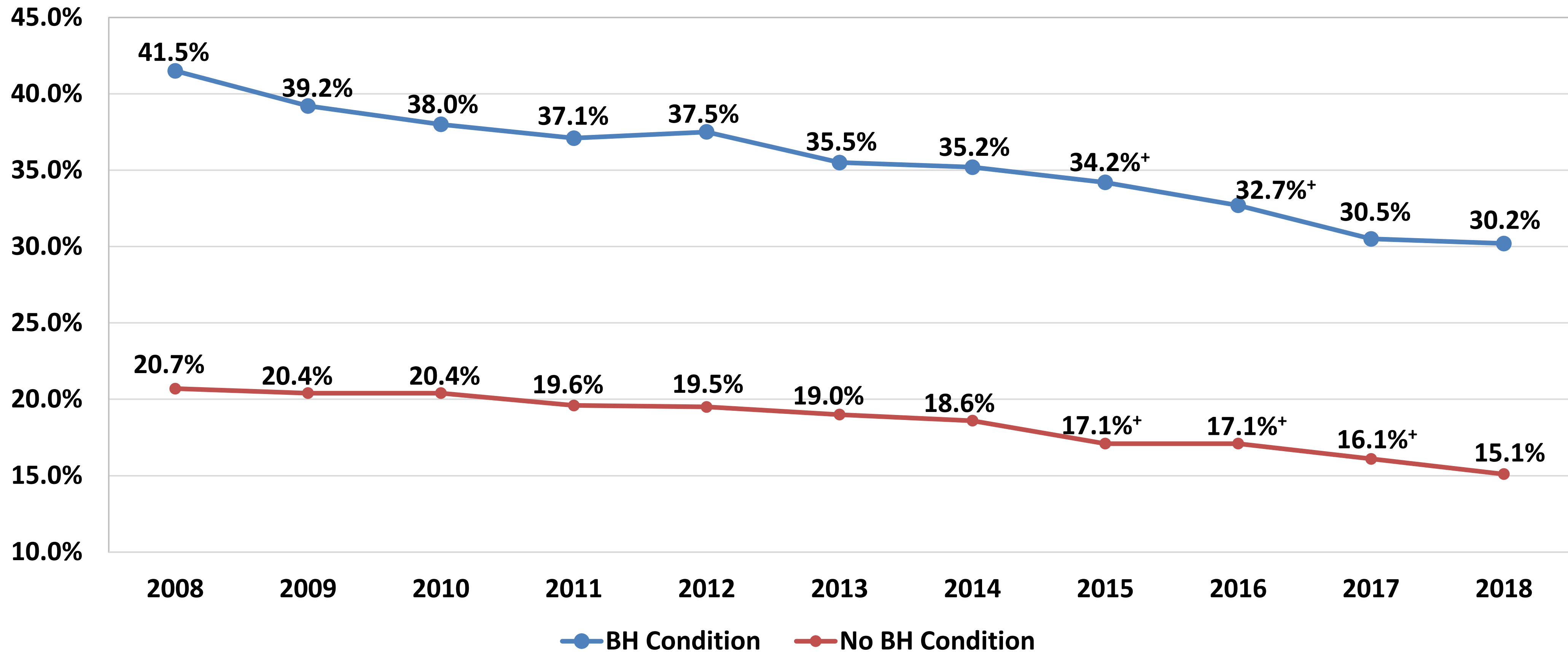
Graph provided by the Centers for Disease Control and Prevention. 1955 Current Population Survey; 1965–2017 NHIS. Estimates since 1992 include some-day smoking.

CDC
CENTERS FOR DISEASE CONTROL AND PREVENTION

Smoking and Special Populations

- Smoking prevalence is 50% higher among LGBT Americans compared with straight Americans.
- In 2013, smoking prevalence was significantly higher among persons living below poverty (29.9%) than those living at or above poverty (20.6%).
- Among adults under age 65, 30 % of Medicaid enrollees and 30% of uninsured individuals smoke, compared to 15 % with private insurance coverage.
- People living at or below the poverty line are less likely to successfully quit smoking (5.1%) than those living at or above poverty (6.5%).
- Those groups most impacted by the tobacco epidemic have consistently been targets of marketing by the tobacco industry.

Current Smoking Among Adults (age> 18) With Past Year Behavioral Health (BH) Condition: NSDUH, 2008-2018



Adults with mental health or substance use disorders represent **25%** of the population, but account for **40%** of all cigarettes smoked by U.S. adults

Behavioral Health Condition includes AMI and/or SUD

Due to changes in survey questions regarding substance use disorders in 2015, including new questions on meth and prescription drug misuse, this data is not comparable to prior years

*Difference between this estimate and the 2018 estimate is statistically significant at the .05 level

UCSF

Smoking Prevalence and Co-morbid SUD

- 53-91% of people in addiction treatment settings use tobacco[1]
- Tobacco use causes more deaths than the alcohol or drug use bringing clients to treatment: death rates among tobacco users is nearly 1.5 times the rate of death from other addiction-related causes
- In 2016, < half (47.4%) of U.S. substance abuse treatment facilities —offered tobacco cessation services

[1]Guydish J, Passalacqua E, Tajima B, et al. Smoking Prevalence in Addition Treatment: A Review. *Nicotine Tob Res*. 2011;13(6):401-11.
[2]Substance Abuse and Mental Health Services Administration, *National Survey of Substance Abuse Treatment Services (N-SSATS): 2013. Data on Substance Abuse Treatment Facilities.* BHSIS Series S-73, HHS Publication No. (SMA) 14-489. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014.
[3] Marynak K, VanFrank B, Tetlow S, et al. Tobacco Cessation Interventions and Smoke-Free Policies in Mental Health and Substance Abuse Treatment Facilities —

Smoking and Behavioral Health: The Heavy Burden

- 240,000 annual deaths from smoking occur among patients with chronic mental illness and/or substance use disorders
- This population consumes 40% of all cigarettes sold in the United States

  -- higher prevalence, smoke more, smoke down to the butt
- People with serious mental illnesses die earlier than others, and smoking is a large contributor to that early mortality
- Greater risk for nicotine withdrawal
- Social isolation from smoking compounds the social stigma

Why DO INDIVIDUALS WITH MENTAL ILLNESS SMOKE?

Smoking in adolescence is associated with psychiatric disorders in adulthood, including: panic disorder, GAD and agoraphobia, depression and suicidal behavior, substance use disorders, and schizophrenia (Breslau et al., 2004; Weiser et al., 2004; Goodman, 2000; Johnson et al., 2000)

SMOKING

MENTAL ILLNESS

Active psychiatric disorders are associated with daily smoking and progression to nicotine dependence (Breslau et al., 2004).

WHY is SMOKING COMMON AMONG PEOPLE with MENTAL ILLNESSES?

- **Culture:** Smoking has historically been used in psychiatric facilities as a reward; many staff members themselves smoke, making quitting more challenging
- **Lack of attention:** People with substance use diagnoses are often not advised to quit smoking by their providers
  - One study showed that psychiatrists offered nicotine addiction recovery counseling to only 12% of clients who smoked
  - There appears to be little expectation for recovery
  - Clinicians often focus on health problems other than smoking

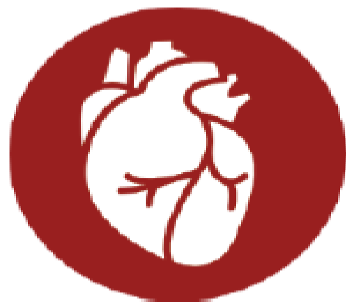
Many people with mental illnesses who smoke say they have never been advised to quit smoking by a mental healthcare professional.

It Didn't Happen by Accident....

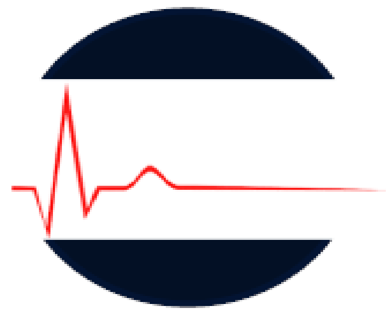
- The tobacco industry has a well-documented history of marketing to vulnerable groups and there is evidence to show that it has specifically targeted people with mental health conditions.
- In the United States there was a long standing practice of providing cigarettes to psychiatric hospitals, supporting efforts to block hospital smoking bans and engaging in a variety of activities that slowed development of treatment for nicotine dependence treatment for this population group.
- A study of tobacco industry documents found industry-funded research supporting the idea that individuals with schizophrenia were less susceptible to the harms of tobacco and that they needed tobacco as self-medication.
- The idea that tobacco is a useful tool for self-medicating has been widely supported by tobacco companies.

Adverse Health Effects of Tobacco Use

People with mental illness or substance use disorders die about 5 years earlier than those without these disorders; many of these deaths are caused by smoking cigarettes.

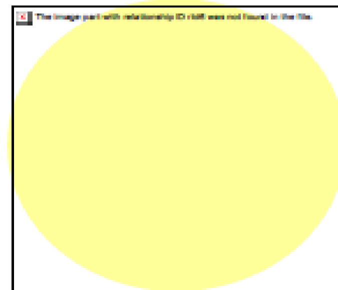


The most common causes of death among people with mental illness are heart disease, cancer, and lung disease, which can all be caused by smoking.



Drug users who smoke cigarettes are four times more likely to die prematurely than those who do not smoke.

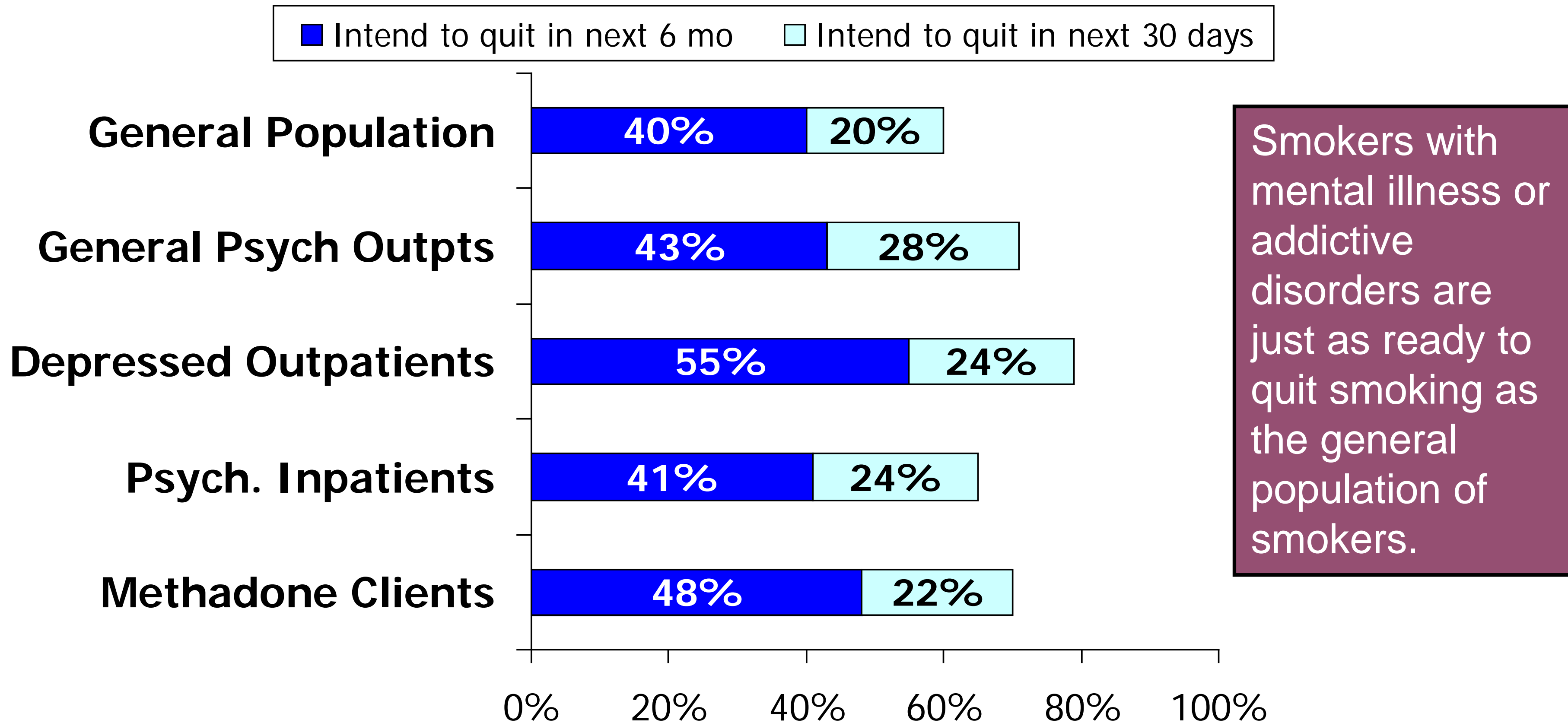
Nicotine has mood-altering effects that can temporarily mask the negative symptoms of mental illness, putting people with mental illness at higher risk for cigarette use and nicotine addiction.



Tobacco smoke can interact with and inhibit the effectiveness of certain medications taken by mental health and substance abuse patients.

Sources: CDC. Vital Signs: Current Cigarette Smoking Among Adults Aged ≥18 Years With Mental Illness—United States, 2009–2011. MMWR 2013;62(05):81-87; Druss BG, Zhao L, Von Esenwein S, Morrato EH, Marcus SC. Understanding Excess Mortality in Persons With Mental Illness: 17-Year Follow Up of a Nationally Representative US Survey. Medical Care 2011;49(6):599–604; CDC. Vital Signs Fact Sheet: Adult Smoking Focusing on People With Mental Illness, February 2013. NCCDPHP, Office on Smoking and Health, 2013; Smoking Cessation Leadership Center. Fact Sheet: The Tobacco Epidemic Among People With Behavioral Health Disorders. San Francisco: SCLC, University of California, 2015; Smoking Cessation Leadership Center. Fact Sheet: Drug Interactions With Tobacco Smoke. San Francisco: SCLC, University of California, 2015.

READINESS to QUIT in SPECIAL POPULATIONS*



Smokers with mental illness or addictive disorders are just as ready to quit smoking as the general population of smokers.

*** No relationship between psychiatric symptom severity and readiness to quit**

Traditional Methods for Cessation

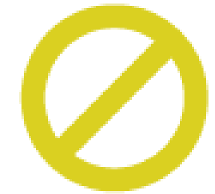
- Clinical Counseling Interventions
  - Brief Advice
  - Motivational interviewing
  - USPHS 5 Rs
  - Telephone quit lines
- Medications
  - NRT products
  - Rx: bupropion, varenicline

- Patient with BH Conditions:
  - May require more quit attempts and more support BUT can still be successful

Evidence Review Shows Stopping Smoking <u>Improves</u> BH

- Cochrane Collaborative meta-analysis of 26 papers
- Smoking cessation leads to: ↓ depression, anxiety, stress and ↑ mood and quality of life
- Effect sizes of smoking cessation > or = anti-depressive drugs for mood or anxiety disorders
- Among smokers with pre-existing alcohol use disorder, smoking cessation leads to ↓ likelihood of recurrence or continuation of their alcohol use disorder
- Smoking cessation interventions during addictions treatment has been associated with a 25% ↑ likelihood of long-term abstinence from alcohol and illicit drugs

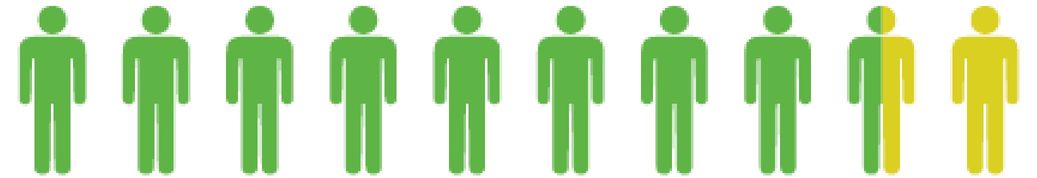
Smoking Cessation for Patients with SUD



Studies have shown that as many as **80% of clients** in substance use disorder treatment have **expressed an interest in tobacco cessation**.[8]

Quitting tobacco use during drug addiction treatment is linked to a **25% increase in long-term sobriety**.[8]

Research has shown **substance use disorder treatment attendance did not differ** between the groups receiving smoking cessation treatment and those receiving treatment as usual.



In fact, **85% of participants completed the 10-week active treatment period** concurrent with smoking cessation treatment.[9]

Room for Improvement….But Why?

Intervention	Mental Health Tx Facilities	Substance Abuse Tx Facilities
	2017	2017
Tobacco Use Screening	51.5%	66.0%
Cessation Counseling	39.1%	49.5%
Nicotine Replacement Therapy	25.6%	27.1%
Non-nicotine Cessation Medications	22.8%	21.3%
Smokefree Building/ Grounds	49.9%	34.8%

Sources: National Mental Health Services Survey (N-MHSS): 2017. Data on Mental Health Treatment Facilities; National Survey of Substance Abuse Treatment Services (N-SSATS): 2017. Data on Substance Abuse Treatment Facilities.

Blame and Shame Are Killing our Clients….

- Both PC and BH Providers are less likely to offer smoking cessation services to patients with BH conditions – despite having access to effective interventions
- Hypothesis: The stigma of having a BH condition biases providers who think cessation will not be wanted, will not be effective, and/or will exacerbate the BH condition.
  - In a sense, these clients are **blamed** for smoking/continuing to smoke
- Hypothesis: Clients who smoke and have a BH condition are **shamed** for having a mental illness and for being a smoker.
  - This lowers self-esteem and self-efficacy and raises stress

What Internalized Stigma Feels Like…

“I’m ashamed to walk down the street. It’s like I have a foul odor coming off of me, like I’m subjecting other people to see something ugly – me, a bipolar lunatic that should probably never leave the house….”

“I don’t wish I was dead. That would be too easy. I just wish I could wake up in someone else’s skin, with someone else’s life. I’m too broken to be fixed, too messed up to ever be a contributing member of society. I can’t work and I hurt the people I love. I should just go live in a cave and stay high all the time.”

Provider Bias

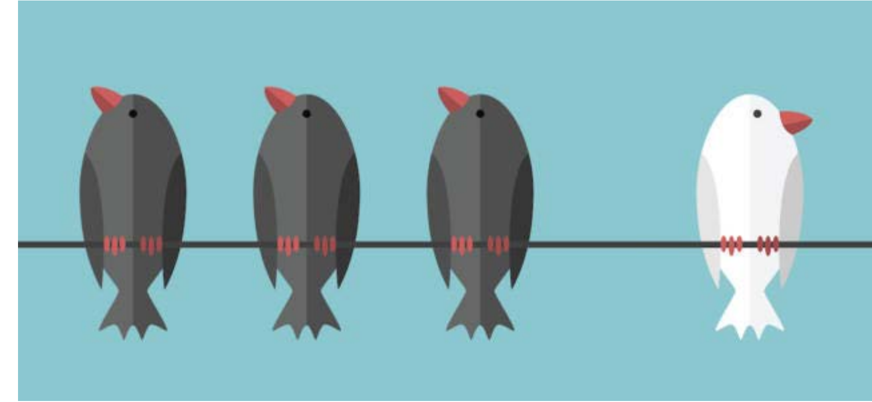
[From a PCP] “I saw him on my schedule and my heart sank. There’s really nothing I can do to help him. He won’t see a psychiatrist and he won’t take his antipsychotics. He lives in an SRO and gets robbed like every other week. Am I really supposed to talk about healthy behaviors?”

“Yeah, this guy reeks of cigarettes but, you know, he’s marginally housed, depressed, and has HIV. I’m not going to rock the boat and take his cigarettes away. Smoking is his only joy in life.”

Why should we care?

- Research has shown health providers are less likely to refer patients with mental illness for mammography (Koroukian et al., 2012), inpatient hospitalization after diabetic crisis (Sullivan et al., 2006), cardiac catheterization (Druss et al., 2000), or even to treat pain (Corrigan et al, 2014).
- Research suggests mental health providers may endorse stigma equal to or greater than many other professions (Lauber et al., 2006; Schulze, 2007).
- Psychiatrists are less likely to provide smoking cessation services than other specialists and the majority say they do not feel prepared to counsel for cessation effectively. Smoking cessation is not a requirement for psych residencies.

Why does it matter?



- Employers are less likely to hire a person with a BH condition
- Landlords are less likely to rent an apartment
- People are more likely to falsely accuse of a crime/violent act
- Segregation – mental health carve outs, separate tx buildings, less access to tx, concentration of SRO's
- Even "supportive" individuals avoid people with BH conditions, often promote NIMBY policies

What are Stigma, Prejudice, and Discrimination?

- Erving Goffman (1963) in his seminal work: Stigma: Notes on the Management of Spoiled Identity, states that stigma is “an attribute that is deeply discrediting” that reduces someone “from a whole and usual person to a tainted, discounted one”
  - Stigma – negative attitudes, beliefs, stereotypes, biases/prejudices, and discriminatory behavior
  - in ancient Greece, a “stigma” was a brand to mark slaves or criminals.
- Prejudice: emotional reactions to a stereotype or a stereotyped person
- Discrimination – unjust or prejudicial behavior; may be explicit or implicit; individual, institutional, or structural

Stigma, Structural Discrimination, and Health

- Structural discrimination refers to societal conditions that constrain an individual's opportunities, resources, and wellbeing
- Structural discrimination of those with mental illness is still pervasive, whether in legislation limiting rights, insurance coverage, research funding, public health attention, or media representation.
- Stigma can be conceptualized as a social determinant of health – a source of chronic stress and social disadvantage. Mental illness still carries one of the strongest, negative social stigmas.

Stereotypes About People with BH Conditions

- They are dangerous and often perpetrators of violence
- They are unreliable employees/family members/friends
- They are a burden on society
- They are unable to live “normal” healthy lives
- Lazy, antisocial, entitled, childlike
- Wild, rebellious and artistic
- Morally weak, flawed character

- Held by both the general public and health professionals (Keane, 1990; Lyons & Ziviani, 1995; Mirabi, Weinman, Magnetti, & Keppler, 1985; Page, 1980; Scott & Philip, 1985).

Provider Beliefs about Tobacco and BH

- Tobacco is necessary self-medication
- BH consumers are not interested in quitting
- They are unable to quit
- Quitting worsens recovery
- Smoking is a low priority problem
- THESE ARE MYTHS

Self-Stigma: A progressive model

Aware -> agree -> apply -> harm (Corrigan and Watson 2002)

- A person is first aware of prevalent negative stereotypes and,
- Second, the person agrees to some extent with the negative stereotypes.
- Third, the person self-identifies with the stigmatized group and may apply negative stereotypes to himself/herself,
- This lastly results in negative consequences that cause harm such as loss of self-esteem and reduced self-efficacy

Emotional, Cognitive, and Behavioral Responses from People with BH

- Guilt – "I've done something bad or wrong…"
- Shame – "I am something bad or wrong…"
- Hopelessness – "Nothing I do will make a difference…there's no way out…."
- Distrust – "Medical people don't respect me and won't help me…."
- Avoidance; other forms of maladaptive coping (e.g. smoking, drinking)
- Stigma yields 3 kinds of harm that may impede treatment participation:
  - It diminishes self-esteem, lowers self-efficacy and robs people of social opportunities.

Smoking-related Stigma

- Boon or bust?
- Social acceptability has dramatically decreased but more so for white people with higher education and higher incomes.
- Smoking-related stigma promotes shame and embarrassment which can reduce smoking behaviors and/or push smoking into the closet or move smokers to vaping.
- Structural changes: smoke-free spaces, no smoking at work, taxes
- Is using stigma for good ok? Non-normative=stigma?

Intersectionality of Stigma

- Smoking is a stigmatized behavior; people who smoke are stigmatized people
- Substance use is a stigmatized behavior; people who use substances are stigmatized people
- BH conditions are stigmatized disorders; people who have BH conditions are stigmatized people
- POSSIBLE DOUBLE or TRIPLE STIGMA

How this plays out

- Provider-held stigma: BH patients are difficult, non-adherent, can’t change
  - Why should I refer them? Divert resources to more hopeful cases

- Client-held stigma: I’m a BH patient so I must be difficult, hopeless, and discard-able. I’m weak and incompetent. Why should I even try to quit smoking?
  - Self-prejudice -> low self-esteem, low self-efficacy -> shame
  - Research participants who expressed a sense of shame from personal experiences with mental illness were less likely to be involved in treatment.

What to do about stigma and discrimination

Change strategies for mental illness stigma into three approaches:

- Protest inaccurate and hostile representations of mental illness as a way to challenge the stigmas they represent. These efforts send two messages. To the media: stop reporting inaccurate representations of mental illness. To the public: stop believing negative views about mental illness.
  - This challenges negatives but doesn't really promote any positives.
- Education – about the presence/effects of stigma, correcting misinformation about the stigmatized group. The "messenger" matters!
- Contact – direct contact with members can dramatically change opinions but requires member to "come out" and risk negative consequences

Reducing Provider Bias and Stigma

- Protest, Educate, Contact
- Structural changes
  - Data, data, data – use data to drive decision making. Consider audits and performance reports
  - Adapt workflows to include smoking status and cessation
  - Smokefree workplaces and clinics
    - Assistance for staff who smoke and/or have BH dx
  - Designate people with BH conditions as underserved to increase research, education, and clinical funds/innovations

Program Examples

- UCSF Smoking Cessation Leadership Center and the SAMHSA Center of Excellence for Tobacco Free Recovery
- NAMI –National Alliance on Mental Illness [Peer, family, and provider programs]
  - www.nami.org
- Time to Change (UK); Opening Minds (Canada); Beyondblue (Australia)
- VAMC – Make the Connection, Real Warriors campaigns

Time to Change (UK) - $60 million investment www.time-to-change.org.uk

- Social marketing and mass media activity; library of stories
- Local community events to bring people with and without mental health problems together (“hubs” and “time to talk” events)
- A grant scheme to fund grassroots projects led by people with mental health problems
- A program to empower a network of people with experience of mental health problems to challenge discrimination
- Targeted work with stakeholders to improve practice and policy
- Research and evaluation

Best Practices

- Adopting and implementing a tobacco-free facility/grounds policy.
- Behavioral health providers routinely asking their clients if they use tobacco and providing evidence-based cessation treatment.
- The effectiveness of tobacco cessation treatment is significantly increased by integrating cessation services/initiatives into the mental health or addiction treatment program.
- Many may benefit from additional counseling and longer use of cessation medications.
- Peer-driven approaches such as peer specialists trained in smoking cessation.

"Mental illness is nothing to be ashamed of, but stigma and bias shame us all."

Bill Clinton

References and Recommended Readings

- National Academies of Sciences, Engineering, and Medicine (2016). Ending Discrimination Against People with Mental and Substance Use Disorders: The Evidence for Stigma Change. Washington, DC: The National Academies Press. doi: 10.17226/23442.
- R.J. Evans-Polce et al. The downside of tobacco control? Smoking and self-stigma: A systematic review. Social Science & Medicine 145 (2015) 26e34
- J. Stuber et al. Stigma, prejudice, discrimination and health. Social Science & Medicine 67 (2008) 351–357

Q&A

- Submit questions via the **'Ask a Question' box**

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Respiratory Therapists: This program has been approved for a maximum of 1.0 contact hour Continuing Respiratory Care Education (CRCE) credit by the American Association for Respiratory Care, 9425 N. MacArthur Blvd. Suite 100 Irving TX 75063, Course # 182749000.

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American Association for Respiratory Care (AARC)

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- Instructions on how to claim credit will be included in our post-webinar email

Behavioral Health Accreditation

California Association of Marriage and Family Therapists (CAMFT)

This webinar is accredited through the CAMFT for up to 1.0 CEU for the following eligible California providers:

- Licensed Marriage and Family Therapists (LMFTs)
- Licensed Clinical Social Workers (LCSWs)
- Licensed Professional Clinical Counselors (LPCCs)
- Licensed Educational Psychologists (LEPs)

- For our California residents, SCLC offers regional trainings, online education opportunities, and technical assistance for behavioral health agencies, providers, and the clients they serve throughout the state of California.
- For technical assistance please contact (877) 509-3786 or Jessica.Safier@ucsf.edu.
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- You will receive the following in our post webinar email:
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    - PDF of the presentation slides
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