Debunking Myths About Smokers with Behavioral Health Conditions

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People with mental illness and substance use disorders want to quit smoking and can quit successfully. And mental health professionals can help. Until a few years ago, it was not common for people with mental illness or substance use disorders to be treated for their tobacco dependence. People with behavioral health conditions have only recently been identified by tobacco control and cessation professionals as a priority, even though their smoking rates are 2-4 times higher than in the general population (Lasser et al., 2000).

The 2006 Morbidity and Mortality in People with Serious Mental Illness report issued by the National Association of State Mental Health Program Directors, found that persons with serious mental illness die, on average, **25 years** earlier and suffer increased medical co-morbidity. They often die from tobacco related diseases and are more likely to die from these diseases than from alcohol use.

The need to help this clientele quit tobacco is clear. Some strongly held myths have stood in the way of progress in this area. Fortunately, a growing body of research is debunking these myths, making way for new interventions.

The first myth is that persons with mental illness and substance use disorders do not want to quit. Research argues that the majority of persons with mental illness and substance use disorders want to quit smoking and want information on cessation services and resources. For example, one study examined depressed smokers' readiness to quit and the applicability of the Stages of Change framework to a psychiatric sample. The majority (79%) reported intention to quit smoking with 24% ready to take action in the next 30 days (compared to 16% in the general smoking population) (Prochaska et al., 2004). Among hospitalize psychiatric patients who smoke, another study found that 79% were not only interested in quitting, but agreed to participate in a clinical study to help them quit (Prochaska, Hall, & Hall, 2009). And for smokers in substance use facilities, a review of clinical trials found that 50 to 77% of smokers in substance use facilities were interested in quitting (Joseph, Willenbring, & Nugent, 2004).

Myth number two is that persons with mental illness and substance use disorders are unable to quit smoking. In a review of 24 studies, the recorded quit rates of patients with mental illness or addictive disorders were similar to those of the general population (el-Guebaly, Cathcart, Currie, Brown, & Gloster, 2002). For depressed smokers, a stepped-care intervention tailored to their readiness to quit had a 25% abstinent rate at 18-month follow-up (Prochaska, Hall & Hall, 2009). Another example is among smokers with schizophrenia, a meta-analysis of several randomized trials using bupropion for smokers with schizophrenia had a 3-fold increase in abstinence rates 6 months after treatment. (Tsoi, Porwal, Webster, 2010).

The third myth is that smoking cessation worsens psychiatric symptoms. On the contrary, smoking cessation can actually improve psychiatric symptoms. This myth has historical ties to the tobacco industry, which has directly funded, or monitored, research supporting the idea that individuals with schizophrenia were less susceptible to the harms of tobacco and that they needed tobacco as self-medication. Unfortunately the bias behind the research was not commonly known, and therefore was believed for years (Prochaska, Hall, & Bero, 2008). Fortunately new research is emerging to debunk this myth. In a study with smokers with schizophrenia who quit, there was no worsening of attention, verbal learning or memory, working memory, executive function or inhibition, or clinical symptoms of schizophrenia (Evins et al., 2005). Another randomized trial found that actively depressed smokers who

quit reported a significant decline in depression symptoms and a reduction in alcohol use compared with participants who continued smoking (Prochaska et al., 2008).

Finally, there are often questions about whether smoking cessation threatens recovery for persons with substance use disorders. Not only is this a myth, but smoking cessation can actually enhance long-term recovery for persons with substance use disorders. A systematic review of 17 studies found that concurrent tobacco cessation treatment with individuals in addictions treatment was associated with 25% increased abstinence from alcohol and illicit drugs six months or longer after treatment (Prochaska, Delucchi, & Hall, 2004). There is one caveat. One study looked at concurrent vs. delayed tobacco cessation treatment and found comparable quit rates at 18 months, but there were lower prolonged alcohol abstinence rates for the concurrent treatment group at 6 months.[4] This simply means concurrent treatment is not right for everyone, but it does open the door for discussion.

Persons with serious mental illnesses die up to 25 years earlier, often from tobacco related diseases. Their desire to quit and ability to do so may be stronger than you may think. Clinicians are encouraged to talk with their patients and offer them assistance in quitting. Many of the treatment strategies that work for smokers without behavioral health issues (e.g., cessation pharmacotherapy and behavioral counseling) can work for this clientele as well.

For additional assistance, patients may be referred to the California Smokers' Helpline, 1-800-NO-BUTTS. For a free Smoking Cessation Toolkit for Health Care Providers, please visit info.nobutts.org/mh17.

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