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Helping Smokers Quit: The Smoking Cessation Leadership Center Engages Behavioral Health by Challenging Old Myths and Traditions

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ABSTRACT

Smoking is much more common among persons with behavioral health conditions (mental illnesses and/or substance use disorders). Persons with these disorders are more likely to die from smoking-related causes than any other reason. Studies have shown that stopping smoking can improve mental health function, as well as improve outcomes for substance use disorders. Yet, for a variety of reasons, smoking cessation has not been integrated into the treatment of behavioral health conditions, and in many instances tobacco use was not only condoned but encouraged. Beginning in 2007, the Smoking Cessation Leadership Center (SCLC) began engaging relevant agencies in an attempt to stimulate more vigorous smoking cessation activities. Partners included the federal Substance Abuse and Mental Health Services Administration, advocacy organizations such as the National Alliance on Mental Illness and Community Anti-Drug Coalitions of America, and clinical groups such as the American Psychiatric Nurses Association, the American Psychiatric Association, American Psychological Association, National Council on Behavioral Health, and National Association of State Mental Health Program Directors. A signature program featured 16 individual state summits involving agencies and groups from multiple sectors, all aiming to lower smoking rates in behavioral health populations. These activities mark an evolving culture change within behavioral health.

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Behavioral health; mental illness; public health; smoking cessation; substance use disorders; vulnerable populations

Background

Notably lacking in the University of California, San Francisco Smoking Cessation Leadership Center's (SCLC) early years was involvement with those behavioral medicine specialties responsible for treating patients with mental illnesses and substance use disorders, despite the very high rates of smoking among these populations (Schroeder et al. 2017). This avoidance of behavioral health reflected advice SCLC received from national smoking cessation experts, who counseled that patients with these disorders were not interested in quitting and were not able to even if they tried. Furthermore—they warned—there was little interest in cessation among behavioral health clinicians, and smoking was engrained in the behavioral health treatment culture. Many staff members smoked, especially those who were themselves in recovery, and it was routine in psychiatric hospitals for staff to join patients during smoke breaks.

Thus, SCLC reluctantly heeded that advice, despite awareness of the immense burden that smoking exerted upon people with behavioral health disorders (Lasser et al. 2000), and the fact that several psychiatrists and psychologists were well-recognized as smoking cessation experts (Guydish et al. 2007; Hall et al. 1983; Hughes et al. 1984; Prochaska, Gill, and Hall 2004; Williams and Ziedonis 2004; Ziedonis et al. 1994). Given the crisis-driven nature of much mental health and substance use treatment, including non-predictable psychotic episodes, overdoses, and the threat of suicide, it is not surprising that smoking usually takes a therapeutic back seat. After all, the serious consequences of smoking generally occur several decades after a person begins to smoke, and in health care the acute can overwhelm the chronic. In addition, several studies, some sponsored by the tobacco industry, alleged that smoking alleviated mental health symptoms, and that smoking cessation might exacerbate underlying psychiatric symptoms (Schroeder and Morris 2010). But many clinicians and patients were mislabeling the symptoms of nicotine withdrawal as worsening of psychiatric symptoms or substance use disorders. In reality, as shown by a recent meta-analysis, stopping smoking can improve mental health outcomes, with an effect larger than antidepressive therapy (Taylor et al. 2014), and stopping smoking can improve the chances of recovery from alcohol or drug abuse (Prochaska, Delucchi, and Hall 2004; Tsoh et al. 2011).

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Color versions of one or more of the figures in the article can be found online at www.tandfonline.com/UJPD.

SCLC accepts the behavioral health challenge

Early steps

SCLC became involved in behavioral health in 2007, when the American Legacy Foundation (now Truth Initiative) urged SCLC to work with behavioral health clinicians to address this issue and provided additional funds for that effort. This new assignment required greater SCLC familiarity with the organizations and key leaders in behavioral health. Two individuals were instrumental in helping SCLC navigate this new terrain: Bob Glover, then executive director of the National Association of State Mental Health Program Directors (NASMHPD), and Gail Hutchings, an independent consultant who had previously held senior positions at both NASMHPD and the federal Substance Abuse and Mental Health Services Administration (SAMHSA), whose $3.5 billion annual budget funds most public mental health and substance use treatment centers. With their help, SCLC assembled a group of 24 leaders of public and not-for-profit behavioral health organizations for a first-of-its-kind summit on smoking and behavioral health at Lansdowne, VA, in 2007. A crucial preliminary meeting was held with the executive leadership of the National Alliance on Mental Illness (NAMI), a powerful organization advocating for patients and families with mental illness. Since a pervasive strategy of the tobacco industry emphasizes a smoker's right to smoke, and since so many families of persons with mental illness were genuinely concerned about the consequences of their loved ones stopping smoking, NAMI and its constituency represented a potential obstacle to the desired outcome of the Lansdowne summit. At that NAMI meeting, the SCLC director shared evidence about the harm from smoking, the dangers associated with exposing loved ones and employees to secondhand smoke, the greatly shortened life expectancy of smokers with mental illnesses (Colton and Manderscheid 2006), and the role of the tobacco industry in promoting smoking among this population (Appolonio and Malone 2005). The NAMI leaders confided that its constituency was conflicted on this topic. A compromise resulted. NAMI would attend the Lansdowne conference and not boycott it. It would not block a cessation movement, but—for the time being—would not embrace it either. Over time, NAMI leadership became more supportive of smoking cessation efforts, as illustrated by two outcomes. First, NAMI featured smoking cessation sessions for the first time at its 2009 annual meetings. Second, in 2010, when it redid its signature "Hearts and Minds" video aimed at preventing heart disease among persons with mental illness, the video (partly funded by an SCLC grant) began with a segment on smoking cessation. By contrast, the original 1999 video was not permitted to mention smoking.

Next steps, including a breakthrough partnership with the Substance Abuse and Mental Health Services Administration

The 2007 Lansdowne summit marked the beginning of formal engagements between SCLC and virtually all of the organizations that attended. The summit forged a general consensus that more smoking cessation activities were not only needed, but should be supported. A notable partnership began with SAMHSA, which had previously been uninvolved in smoking cessation efforts, except for monitoring underage tobacco sales as mandated by the Synar amendment (Substance Abuse and Mental Health Services Administration 2016). A pre-summit private meeting in 2007 with then SAMHSA Director Terry Cline resulted in his commitment to put SAMHSA's weight behind smoking cessation initiatives. The initial step was a July 2008 in-service program for SAMHSA employees. SCLC staff assembled the program speakers, one of which was the SCLC director. Two resultant SAMHSA/SCLC partnerships emerged. One was the 100 Pioneers Project, in which SCLC administered the awarding of small ($1,000) grants to 100 of the 1,400 existing SAMHSA grantees to become more involved in smoking cessation efforts and to take their facilities smoke-free, followed by additional $2,000 awards to 25 of those pioneers. SAMHSA delegated this grants program to SCLC, which organized the process, notified SAMHSA to whom to pay the awards, and monitored post-grant efforts. The grantees were able to use these small grants to produce relatively large impacts at their locations, with activities that include increasing availability of smoking cessation resources to consumers (i.e., quitline cards and cessation workbooks), adoption of non-smoking policies on the facility's campus, partnering with larger organizations to host robust smoking cessation courses, and pre-post surveys of consumers to track changes in views, utilization of cessation resources, quit attempts, and successful quits. A second—and more ambitious—SAMHSA/SCLC partnership was the selection of (to date) 16 states to hold individual summits bringing together multiple state agencies, health insurers, clinicians, and not-for-profit groups to set a target of reduced smoking prevalence among the state's behavioral health population by a designated date, agree upon a set of strategies to achieve that goal, and then monitor progress, as described in the performance partnership model (Revell and Meriwether 2011; Santhosh et al. 2014). Many of these states have high smoking rates (e.g.,

Oklahoma, North Carolina, Kentucky, Mississippi, and Arkansas). Although SAMHSA ultimately stopped funding these summits, SCLC was able to continue them through the National Behavioral Health Network, a CDC-funded program awarded to the National Council on Behavioral Health, which then subcontracted with SCLC. Additionally, some states hosted summits using internal funds. Another outgrowth of the SAMHSA/SCLC partnership was development of a webinar series, originally open only to behavioral health practitioners, but then available to all interested parties. Since the series began in 2009, there have been 70 separate webinars focusing on various populations, health professional types, and other themes that involve tobacco; continuing education credits are offered. Webinar registration numbers have steadily increased, with the most recent offerings attracting about 1,000 persons.

Results are still pending for most of the SAMHSA/SCLC state summits, but some changes have already been documented. In one state—Oklahoma—smoking prevalence declined between 2009 and 2015 from 62% to 54% for those with mental illness and from 74% to 48% for those with substance use disorders. Many process measures were initiated by the participating states. For example, in Texas, New York, and Oklahoma, most behavioral health treatment facilities became smoke-free, with the numbers varying by state and category of behavioral health treatment. In Oklahoma, the number of calls to the state quitline increased 10-fold between 2012 (380 calls) and 2015 (4070 calls). In Maryland, the smoking prevalence among persons with behavioral health conditions fell from 71.8% in 2010 to 56.5% in 2014, and there was a 9% increase in calls to the state quitline.

Working with other governmental and non-governmental organizations

SCLC began collaborating with another federal agency, the CDC's Office on Smoking and Health (OSH), following a presentation there by the SCLC director. OSH subsequently created eight national networks to focus on tobacco and cancer control, one of which concentrated on behavioral health. Establishing this network marked CDC's first formal smoking cessation activity targeted at people with mental health or substance abuse problems. OSH followed by introducing a patient with chronic depression as part of its *Tips from Former Smokers* media campaign, the first time a public service announcement linked smoking and mental health.

Introducing smoking cessation activities into relevant organizations was not limited to governmental agencies. The Community Anti-Drug Coalition of America (CADCA), founded in 1992, supports over 5,000 community anti-drug coalitions. Until it began working with SCLC in 2008, however, it had not viewed tobacco control as part of its mission. Since then, it has secured multiple smoking cessation grants. CADCA has also become the lead CDC network for geographic health equity and tobacco control.

Similar to CADCA, the National Council on Behavioral Health, an organization representing 2900 membership groups and serving 10 million clients, had not been involved with tobacco until contacted by SCLC. Like CADCA, it now runs one of the eight CDC networks, focusing on behavioral health. The National Council chose SCLC to be one of three strategic national partners for its network.

SCLC worked with NASMHPD to reduce the number of state mental health facilities allowing smoking. Between 2005 and 2013, the proportion of smoke-free state mental health hospitals nationally rose from 20% to 83% (Ortiz, Schacht, and Lane 2013; Schacht, Ortiz, and Lane 2012). In addition, in August 2017, NASMHPD adopted a policy to make all clinics smoke-free. SCLC also sponsored a survey, provided educational content including presentations at NASMHPD annual meetings, and helped create the tobacco-free toolkit that was used to guide psychiatric facility administrators through the process of creating tobacco-free grounds.

Working with health professional societies

Behavior health clinicians represent a key potential group of smoking cessation actors. However, as mentioned, there was a long tradition of either ignoring or minimizing smoking as a relevant problem. The first change in that posture occurred after a task force meeting in October 2008 with the American Psychiatric Nurses Association (APNA). The meeting, which addressed whether APNA should become active in smoking cessation, resulted in the creation of a smoking cessation task force, as well as a set of resolutions from the APNA Board of Directors. Those resolutions advocated that all nurses who work with individuals with mental health or substance use disorders should: demonstrate smoking cessation competencies; intervene to help smokers quit; work to improve access to smoking cessation interventions; engage in state-focused tobacco control efforts; become tobacco control advocates; work to increase tobacco education content in nursing curricula, including continuing education material; and create a smoking cessation task force for actions to increase by 5% each year the number of psychiatric nurses who report referring smokers to treatment, as well as the number who themselves provide best smoking cessation practices (Naegle, Baird, and Stein 2009). This call to action was featured in a 2009 special

issue of the *Journal of the American Psychiatric Nurses Association* devoted entirely to helping individuals with behavioral health conditions stop smoking. A guest editorial saluted APNA for being ahead of the curve and setting an example for other clinicians who work with persons with behavioral health conditions (Schroeder 2009). A 2012 follow-up survey showed small increases in proportions who asked, advised, and assisted, and a larger (27%) increase in psychiatric nurses reporting intensive interventions.

Another example grew from the observation that many callers to state quitlines self-identified as having behavioral health conditions. In order to increase the effectiveness of interactions between those callers and quitline operators, SCLC retained Chad Morris, PhD, Professor of Psychiatry at the University of Colorado Medical School and smoking cessation expert, to lead the Behavioral Health Quitline Advisory Council, consisting of quitline clinical directors from a suite of vendors and state quitlines. The focus of that organization's technical assistance was how best to serve callers with behavioral health conditions. The recommendation prompted revising the North American Quitline Consortium minimum data set to include optional question regarding behavioral health status.

As the overall smoking prevalence in the US declined to a modern low of 15% by 2015, it became obvious that smoking was becoming concentrated among vulnerable populations, especially those with behavioral health conditions. Smoking had become a social justice issue, not just a medical issue, and behavioral health clinicians needed to become more involved. After years of preliminary discussions, SCLC entered into formal agreements with the American Psychiatric and American Psychological Associations. Both organizations received SCLC grants to create task forces addressing smoking cessation activities by their members. In addition, a few joint educational efforts have occurred with another major clinical organization that serves behavioral health populations, the National Association of Social Workers.

The National Partnership on Behavoral Health and Tobacco Use

A major initiative was recently launched with the American Cancer Society (ACS), whose new Vice President for Prevention and Early Intervention, Rosemary Henson, had become familiar with SCLC's work when she was principal deputy to President Obama's Assistant Secretary of Health, Howard Koh. Henson and her ACS colleague, Cliff Douglas, understood that reducing the national burden of cancer caused by smoking required reducing smoking rates among persons with behavioral health conditions. Accordingly, she approached SCLC to create The National Partnership on Behavioral Health and Tobacco Use. The effort began with a summit at ACS Atlanta headquarters in September 2016. Representatives from 19 organizations attended, including mental health clinical associations, tobacco control organizations, federal agencies, advocacy groups, the pharmaceutical and health insurance industries, and voluntary agencies. Attendees agreed on a target to reduce the prevalence of smokers with behavioral health conditions from 34% to 30% by the year 2020 ("30 by 20") through a set of strategies that included educating clinicians and peers, policy change, systems change, and data/research. Each organization pledged its own action steps. Other groups will be invited to join this movement, which will be hosted by the American Cancer Society in conjunction with SCLC. Reaching the 30 by 20 target could save an estimated one million premature deaths, based on the following calculations:

> There are approximately 57.7 million adult Americans with chronic mental illness, plus 23.5 million with substance use disorders. Assuming that 65 million people have one or more of these two conditions and that their smoking prevalence is 34%, that translates to about 22 million smokers in the behavioral health population. Those 22 million smokers amount to more than half the population of adult smokers in the United States. Reducing the prevalence to 30%—or 19.5 million smokers—would result in 2.5 million fewer smokers. Given that one half of all long-term smokers die prematurely from smoking-induced illnesses, that would translate to more than a million premature deaths averted, not to mention avoiding needless suffering and economic costs, including major healthcare expenditures and lost productivity. It would also prevent many millions more from suffering from chronic tobacco-induced diseases.

Although it is premature to judge the results of this ACS/SCLC partnership, the fact that an organization with the prestige and power of the ACS has put its organizational heft behind reducing smoking in behavioral health populations sends an important national signal.

Lessons learned from working in behavioral health

Promoting smoking cessation in the behavioral health field presented extra challenges compared with traditional medical care, where the damage from smoking was acknowledged and the barriers to smoking cessation activity related more to work load, motivation, and stigma than to uncertainty about benefits of cessation. Penetrating behavioral health required countering longstanding beliefs about the benefits of smoking and the fears that stopping smoking

would exacerbate the underlying behavioral health condition, as well as addressing the degree to which smoking had penetrated the behavioral health culture. Five factors proved helpful in changing attitudes and behaviors. Most important was the science showing not only the devastation caused by smoking, but also the dangers of secondhand smoke exposure, the reality that smoking cessation is not only possible but beneficial, and that old fears—such as the worry that creating smoke-free hospitals would create disciplinary issues—are unfounded (Schacht, Ortiz, and Lane 2012). A second factor was the presence of courageous leaders who created the research to slay the myths or who led organizations such as NASMHPD (Bob Glover), SAMHSA (Terry Cline), APNA (Daryl Sharp), and NAMI (Ken Duckworth) and were willing to try to change organizational culture. Third was the growing stigma attached to smoking that resulted from the migration of the population who smoked from a cross-section of America in the 1940s, 1950s, and 1960s into the most vulnerable segments of society. Since a major goal of behavioral health treatment is reintegration of clients into mainstream culture, the stigma accompanied by smoking presents a barrier to that goal. Fourth was the science showing that smokers need to take higher doses of many psychotherapeutic medications, since the ingredients in tobacco smoke catalyze faster degradation of these compounds. Because the side-effects of these drugs are both so bothersome and dose-related, stopping smoking brings the opportunity for better medication adherence and reduced side-effects. Finally, the 2009 passage of the Affordable Care Act expanded access to health care (including smoking cessation services) for many previously uninsured smokers with behavioral health conditions, as well as mandating coverage for FDA-approved smoking cessation interventions. These five factors, in combination with recruiting key organizational leaders, identifying leverage mechanisms within the organizations, and providing small convening grants, were the ingredients that led to success.

Major accomplishments of SCLS's behavioral health work

Mainstreaming smoking cessation into the behavioral health culture and treatment settings

Although it was long recognized that smoking and behavioral health were intertwined, that situation was chronically tolerated, and in some instances even enabled. By confronting relevant organizations with the reality of the problem, SCLC helped to catalyze a growing movement that represents a major behavioral health culture change. Today, almost every organization that serves behavioral health populations either embraces smoking cessation or at least acknowledges its importance. A helpful prerequisite for this transition is that, in general, the same treatment regimens to help non-behavioral health patients stop smoking work for behavioral health patients. One minor modification is that initial doses of cessation drugs might be lower, and duration of treatment a bit longer (Schroeder and Morris 2010). Admittedly, this is still a work in progress. For SCLC, there are 34 states plus the District of Columbia that have yet to hold behavioral health summits, the American Cancer Society/SCLC partnership is just beginning, and far too many behavioral health clinicians still remain either ambivalent about or opposed to helping smokers quit. Nevertheless, there has been much accomplished in less than a decade.

Launching multiple state summits to create and execute action plans to reduce smoking in behavioral health populations

To date, 16 states have participated in these summits, and have produced a set of activities to reduce smoking among persons with behavioral health conditions. The popularity of behavioral health smoking cessation summits is attested by the fact that several states came forward with their own funding strategy to host them, and many others have requested funds for that purpose.

Declines in smoking prevalence

The proportion of persons with behavioral health conditions who smoke—after having been stable for several decades at 40% or greater—declined from 2009 to 2015 at a faster rate than the general population (Figure 1; Substance Abuse and Mental Health Services

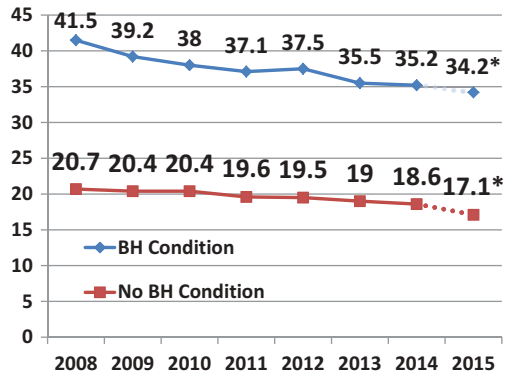

Figure 1. Current smoking among adults (age ≥18) with past year behavioral health (BH) condition: NSDUH, 2008–2015.

[a]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, these data are not comparable to prior years.

Administration 2016). This trend coincided with the period that SCLC began to focus on behavioral health. The extent to which SCLC contributed to this progress is speculative.

Unfinished business

SCLC has long wished to work with certain constituencies that interact with many persons with behavioral health conditions who smoke. A prime example is Alcoholics Anonymous (AA), a storied American institution currently serving an estimated 1.2 million persons at 55,000 meeting places scattered throughout the country. AA is a major force among organizations representing persons with behavioral health issues. Yet, AA remains steadfast in resisting any efforts that it interprets as potential mission creep, and hews to its single (and laudable) goal of providing a resource where persons with alcohol issues can find support and comfort. It is likely that as many as 500,000 AA members continue to smoke, even those who have overcome their alcoholism. Thus, they may face the same fate as AA founders, Bill Wilson and Dr. Bob Smith, both of whom died of smoking-related illnesses. Involvement of AA with smoking cessation could be non-intrusive. Local groups could display posters that contains the blue Quit Now cards, providing instructions as to how to call a toll-free quitline (Schroeder et al. 2017). Such callers have about a 30% chance of quitting smoking. But absent national guidance, making this resource available will proceed very slowly.

Greater engagement with other behavioral health clinicians, most notably social workers, is a continuing SCLC priority. Social work, psychology, and psychiatry are the three health professions with the most intimate contact with behavioral health conditions, and thus present major opportunities for smoking cessation interventions. Hence, the need to pursue a more active social work engagement. In addition, changing the long-entrenched attitudes of other behavioral health clinicians about smoking cessation remains an enduring challenge that will likely proceed slowly, even with support from the relevant professional societies.

The 16 state summits mobilized a group of state actors around smoking cessation in behavior health populations in ways that had not previously occurred. Five additional states have requested their own summit. It is anticipated that at least three more will be held each year. Ideally, not only will each state host a summit, but many will seek a refresher experience to revisit the progress of the initial set of strategies and to consider new ones.

Discussion of SCLC efforts in smoking cessation (both general and behavioral health)

Convincing organizations to take on smoking cessation is challenging. Although the ability to give small grants as inducement helped, the presence of internal champions—both on the administrative staff and within the membership—was even more critical. These champions, who had already identified smoking cessation as an important facet of their work, were able to persuade colleagues to commit to activity and to sustain it after funding ceased. A corollary lesson is that small grants may be more effective than large ones. Often, an organization that was ready for action would ask for a small boost to get started, while organizations that stipulated very large grants as the price of engagement were less likely to be in for the long haul. Working to establish and sustain organizational change depends on initiating and then maintaining relationships. In all organizations—but especially political ones, such as state government—change is constant, and is accompanied not only by personnel turnover but by budgetary and programmatic shifts. A final organizational lesson came from the experience of courting potential partners. With some, the ingredients were present from the start, while others took up to a decade before committing to work with SCLC. Had SCLC not been able to sustain its efforts over time, the late-blooming relationships, some of which represented a large potential smoking cessation reach, would never have developed.

A crucial factor in engaging organizations was the strong evidence base of the harm from smoking and secondhand smoke exposure, as well as the benefits from the several components of smoking cessation activities. In particular, evidence that quitlines work was instrumental in persuading clinical organizations that meaningful smoking cessation activity could be accomplished during a brief clinical encounter.

As smoking has evolved from a commonplace activity to one relegated to marginalized and vulnerable populations, such as those with behavioral health conditions, it risks becoming a hidden epidemic (Schroeder 2007). Because those who make public opinion and determine budgetary priorities are increasingly distanced from people who smoke, they harbor the erroneous notion that the problem has been solved. Thus, it is crucial that organizations exist that advocate for activities and policies that reduce the burden of smoking that falls so disproportionately on vulnerable populations.

Finally, the unique nature of SCLC must be acknowledged. Because tobacco control is generally viewed as a public health activity, the bulk of its funding, whether

from federal organizations such as the CDC or philanthropic sources such as the Bloomberg or Gates Foundations, focuses on population-wide strategies, especially clean indoor air laws and taxing tobacco products. These are, indeed, effective strategies, both to prevent initiating tobacco use and to stimulate smoking cessation. But working with clinicians and other relevant entities, while also effective, remains a funding orphan (Gollust, Schroeder, and Warner 2008). A large proportion of SCLC effort was devoted to connecting various persons and organizations who had common interests but had not previously interacted, or in providing technical assistance to partners and others who needed information or contacts. This is unglamorous work that helps to build a field, but for which the outcomes do not lend themselves to assessment. Were the SCLC to disappear, no other entity stands ready to assume its functions.

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