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Reducing Tobacco-Related Health Disparities among Individuals with Psychiatric and Substance Use Disorders: Opportunities for Social Work

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ABSTRACT: *While there has been a significant reduction in the general incidence and prevalence of smoking and smoking-related problems, these gains have not been observed in individuals with mental health problems. In spite of a number of improvements in the content, promotion, availability, and delivery of smoking cessation programs, people with mental illness continue to smoke at high rates and experience negative health consequences. Social workers are strategically located within the mental health and healthcare delivery systems, and can play an important role in reducing smoking-related health disparities among individuals with these challenges. Here, we present the epidemiology of smoking and related health problems among individuals with psychiatric and substance use disorders, and provide recommendations regarding the potential contributions of social workers toward decreasing smoking-related health disparities in this population.*

Keywords: *Social work practice, Smoking cessation, Cancer, Health disparities*

The year 2014 marked the 50th anniversary of the release of Surgeon General Luther Terry's report on smoking and health. In the intervening fifty years, the per-capita consumption of cigarettes has declined by 72%, the prevalence of smoking among adults has decreased by more than 50%, eight million preventable deaths have been avoided, and the lifespan has been extended (Holford et al., 2014; Lushniak, 2014). Unfortunately, individuals with mental illnesses and/or substance abuse disorders have not experienced these improved health outcomes (Cook et al., 2014; Schroeder & Koh, 2014). Approximately 200,000 of the 440,000 deaths that are caused by smoking-related problems each year occur in this population (Mauer, 2006; Schroeder & Morris 2009). In this group, some estimate the rate of smoking to be as high as 70% (De Leon & Diaz, 2005; Grant, 2004; Krejci, Steinberg, & Ziedonis, 2003). These individuals also die 25 years earlier than the general population (Colton & Manderscheid, 2006; Joukamaa et al., 2001a; Mauer, 2006).

The 2011 Legacy report, *A Hidden Epidemic: Tobacco Use and Mental Illness*, notes that individuals with psychiatric and substance use disorders have a much higher incidence of smoking and related cancers (Bagnardi, Vecchia, & Corrao, 2001; Drobes, 2002; Grant, 2004; Kalman, Morissette, & George, 2005; Legacy, 2011). This population smokes at a rate twice that of the general population, and consumes nearly half of all cigarettes smoked in the United States (Cook, 2014; Grant, 2004; Kalman, Morissette, & George, 2005; Lasser et al., 2000). Some studies have reported as many as 80% of individuals with substance use disorders smoke (Bierut, Schuckit, Hesselbrock, & Reich, 2000; Drobes, 2002; Grant, 2004; Joseph, Willenbring, Nugent, & Nelson, 2004). High rates of lung, oral, esophageal, and other cancers with smoking as a known contributing factor have been documented among patients with alcoholism, people who abuse drugs, and those with psychiatric disorders (Bagnardi, Vecchia, & Corrao, 2001; Drobes, 2002). Unfortunately, these individuals are caught between mental health and substance abuse treatment professionals who do not address smoking and nicotine addiction, and cancer treatment providers and researchers who are unprepared to address this population's unique treatment needs. This produces tobacco-related disparities for individuals with psychiatric disorders and/or substance use disorders (Hunt et al., 2012; Joseph, Nelson, Nugent, & Willenbring, 2003; Legacy, 2011).

Numerous effective smoking cessation programs have been developed and tested (Stead & Lancaster, 2012). These programs include intensive individual and group counseling approaches, manual-based self-help methods, nicotine replacement programs and Quitline programs (Joseph, Nelson, Nugent, & Willenbring, 2003; Joseph, Willenbring, Nugent, & Nelson, 2004). Many of these approaches have undergone clinical trials and have been demonstrated to be effective in the general population, as reported in *Treating Tobacco Use and Dependence: 2008 Update* (Fiore, Jaen & Baker, 2008). Unfortunately, "treatment as usual" appears to be less effective for individuals experiencing psychiatric and/or substance use disorders (Legacy, 2011; Ziedonis et al., 2008). This apparent reduction in effectiveness could be due to genetic, biological, psychological, or social factors (Breslau, Novak, & Kessler, 2004; Legacy, 2011; Ziedonis et al., 2008).

Few researchers have investigated potential interactions between predisposing, mediating, moderating, or maintaining factors in smoking and nicotine dependence in this population (Kalman, Morissette, & George, 2005; Legacy, 2011; Ziedonis et al., 2008). Some suggest that smoking cessation programs should be modified to address co-occurring psychiatric and substance use disorders, while others recommend that substance abuse and psychiatric programs incorporate psychological and pharmacological treatments for smoking (Clancy, Zwar, & Richmond, 2013; Ziedonis et al., 2011; Kalman, Morissette, & George, 2005).

Further adding to this conundrum are common misconceptions about smoking among individuals with psychiatric disorders. Prochaska (2011) identifies the following five myths. First, nicotine is misperceived as a necessary self-medication for many dealing with

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mental illness. Individuals with mental health problems may also be incorrectly categorized as lacking interest in quitting smoking. Further, those with mental illness may be viewed as unable to quit smoking. Some erroneously believe that quitting smoking will interfere with recovery from mental illness. Finally, for persons with mental illness, stopping smoking is mistakenly considered a low priority. Unfortunately, most of these myths are perpetuated by treatment providers and treatment programs. Thus, changing provider attitudes and behaviors is a key factor in facilitating the delivery of smoking cessation treatments to patients with mental illness.

In an attempt to address these misperceptions, numerous agencies and individual researchers have made the following recommendations: 1) improving screening methodology, 2) changing providers' existing beliefs, 3) providing tailored treatment services, 4) examining the manner in which psychiatric disorders interact with nicotine, 5) modifying existing smoking cessation programs for individuals with psychiatric and substance use disorders, 6) increasing the use of pharmacotherapy for smoking while monitoring psychiatric medications, 7) adjusting current behavioral therapies, and 8) providing training and supervision to existing counseling staff (Hunt et al., 2012; Banham, 2010; Legacy, 2011; Ziedonis et al., 2008; Fiore , Jaen, & Baker, 2008; Kalman, Morissette, & George, 2005). Since social workers are primary mental health services providers and work in various medical settings, they are in a unique position to address the tobacco-related health disparities that individuals with psychiatric and substance use disorders face.

Social workers can take action to help individuals with psychiatric and substance use disorders receive desperately-needed smoking cessation treatment. From a clinical perspective, social workers should routinely ask individuals with substance use and mental health problems about smoking behavior. If the person self-reports smoking, the social worker should then ask if the patient would like to quit smoking, and include quitting in the treatment plan. Several studies have found that those with substance use and psychiatric problems often want to quit smoking, and can successfully quit with a tailored program (Prochaska et al., 2007; Siru, Hulse, & Tait, 2009).

In addition, social workers should further understand the pharmacology of nicotine and the signs and symptoms of nicotine dependence and withdrawal, and be able to provide education about these dynamics. With a thorough working knowledge of the available smoking cessation treatments, providers can then incorporate these approaches into their work. To that end, social workers should investigate local and state-supported Quitline services in their areas, and work directly with Quitlines to incorporate these services into existing treatment programs for individuals with substance use and psychiatric problems. Further, social workers must educate themselves about evidence-based pharmacological treatments (varenicline and bupropion) that can be safely used with this population, and interface with medical providers who are willing to prescribe these medications (Banham, 2010; Fiore, 2008).

Social workers can also contribute to the body of research in this area and devote efforts toward a better understanding of the comorbid nature of nicotine dependence, psychiatric disorders, and substance use disorders through qualitative and quantitative studies that identify psychosocial factors that predispose, mediate, moderate, or maintain smoking in this population. Additional research would help to identify critical pathways or treatment packages that simultaneously address emotional, psychological, alcohol and drug use problems, and nicotine dependence. Moreover, there is a need for community-based research and advocacy that focuses on helping mental health and substance abuse treatment agencies to incorporate smoking cessation into their existing programs and to develop nonsmoking policies and procedures.

Furthermore, social workers are in an excellent position to advocate for smokers with psychiatric and/or substance use disorders. Tobacco companies that target marketing toward individuals with psychiatric and/or substance use disorders should be held accountable for their business practices. Moreover, social workers should work to help educate agency administrators and managers that individuals with psychiatric and substance use disorders want to and can quit smoking. Many treatment facilities harbor a significant degree of stigma about smoking, substance use, and psychiatric disorders. Social workers can dispel myths about smoking and encourage administrators to enforce institutional no-smoking policies (Gleason et al., 2012). Traditionally, substance abuse treatment agencies, psychiatric facilities, and residential living and supportive housing arrangements have not actively supported smoking cessation (Naegle, Baird, & Stein, 2009; Solway, 2009).

Social workers are uniquely positioned to impact the tobacco-related health disparities of individuals with mental health and substance use disorders. Through increased awareness and flexibility, these providers can improve the overall health and well-being of their clients by directly addressing smoking in their clinical work. By working with existing community resources, conducting clinical research, and advocating for smoking cessation resources, social workers can improve and increase the treatment options that are available to these individuals.

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