



Behavioral Health & Nicotine

BURDEN FACTS

Disparities among people with behavioral health conditions

- Persons with mental illness or substance use disorder represent **25%** of the adult population yet consume **40%** of all cigarettes.⁴
- **51%** of deaths among clients in substance use treatment were the result of tobacco related causes, which is more than **2X** the percentage found in the general population.⁵
- **31%** of Montanans who use tobacco report binge drinking compared to **16%** of non-tobacco users.⁶
- **18%** of Montanans who use tobacco report having poor mental health compared to **9%** of non-tobacco users.⁶

Patients are 25% more likely to maintain long term abstinence from alcohol and illicit drugs if they also quit nicotine.¹

Common Myths⁷

Myth #1: Tobacco is a necessary self-medication for people with mental illness.

Fact: Not only is tobacco ineffective as a treatment for mental disorders, but psychiatric disease makes the brain more susceptible to addiction.

Myth #2: People with mental illness are not interested in quitting smoking.

Fact: Patients in outpatient and inpatient psychiatric settings are about as likely as the general population to want to quit smoking.

Myth #3: People with mental illness cannot quit smoking.

Fact: Randomized treatment trials and systematic reviews involving smokers with mental illness document that success is possible.

Myth #4: Smoking is a coping strategy. Quitting interferes with recovery from mental illness and leads to decompensation.

Fact: Smoking cessation does not exacerbate depression or PTSD symptoms or lead to psychiatric hospitalization or increased use of alcohol or illicit drugs.

Myth #5: Smoking is the lowest priority concern for patients with acute psychiatric symptoms.

Fact: People with psychiatric disorders are far more likely to die from tobacco-related disease than from mental illness.

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SOURCES

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3. Taylor, G., McNeill, A., Girling, A., Farley, A., Lindson-Hawley, N., & Aveyard, P. (2014). Change in mental health after smoking cessation: Systematic review and meta-analysis. *BMJ*, 348, g1151. Retrieved October 29, 2015, from <https://www.bmj.com/content/348/bmj.g1151>
4. Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. (March 20, 2013). *The NSDUH Report: Data Spotlight: Adults with Mental Illness or Substance Use Disorder Account for 40 Percent of All Cigarettes Smoked*. Rockville, MD.
5. Hurt et al. (1996), a seminal 11-year retrospective cohort study of 845 people who had been in addictions treatment (described in SAMHSA, [2011])
6. Behavioral Risk Factor Surveillance System, 2017
7. SAMHSA (2016). Enhance your states tobacco cessation efforts among the behavioral health population: A behavioral health resource.

When compared with smoking, smoking cessation was associated with reduced depression, anxiety, and stress—and it improved mood and quality of life.^{2,3}

How the Montana Tobacco Use Prevention Program can help:

- Model tobacco-free campus policy language
- Provide a “Toolkit to Integrate Tobacco Treatment and Policies into Montana’s Behavioral Health System” which providers information on:
 - Understanding the Toll of Tobacco
 - Implementing Organizational Change
 - Integrating Tobacco Dependence Treatment for clients into Routine Systems of Care
 - Enhancing Employee Knowledge and Offering Cessation Assistance
 - Creating a Tobacco-Free Policy to Support Tobacco-Free Living
- Free or reduced cost cessation medications and free individual counseling from the Montana Tobacco Quit Line.
- Trainings on brief cessation intervention and referral mechanisms to the Quit Line
- Free Tobacco-Free signage and Quit Line materials specific to addiction and mental health located on our on-line store <http://mtupp.allegrahelena.com/>

