TOBACCO USE AND MENTAL HEALTH

Despite reductions in smoking prevalence achieved since the first Surgeon General's report on the consequences of smoking in 1964, smoking remains the leading cause of preventable death in the United States.[1] Smoking accounts for more than 490,000 deaths in the United States each year, and is a major risk factor for the four leading causes of death: heart disease, cancer, chronic obstructive pulmonary disease, and stroke.[2] Many subpopulations, including those with mental illness, continue to suffer from disproportionately high tobacco use and its associated health consequences.

Tobacco Use Among Persons with Mental Illness

Adults

National surveys continue to show high rates of current cigarette smoking among people with mental health conditions, including generalized anxiety and/or depression. According to the 2022 National Health Interview Survey (NHIS), 27.2 percent of adults with severe generalized anxiety disorder (GAD) were current smokers, compared to 10.1 percent of adults without or with minimal GAD.[3] Similarly, 27.1 percent of adults with severe depression were current smokers.

Data from another national survey, the 2024 National Survey on Drug Use and Health (NSDUH), found that 25.1% of adults with any mental illness[*] were current (past month) smokers, compared to 17.7% of adults without any mental illness.[4] Among those with mental illness, current smoking is even higher among men, and those living below the federal poverty line. More than a third (36.7%) of adults with mental illness living at or below the poverty line are current smokers.[5] In addition to having higher smoking rates, adults with mental illness also tend to be heavier smokers.[6] According to NSDUH, nearly one-third (31%) of cigarettes smoked by adults are smoked by those with mental illness.[7] Data from NSDUH also show that from 2008 to 2016, the smoking rate among those with serious psychological distress declined slower and remained at least double the rate of those with no serious psychological distress.[8]

Smoking rates are even higher among those with mental illness who experience compounding health and socioeconomic disadvantages. According to a study of NHIS data from 2008 to 2017, the more disadvantages an individual had faced, the more likely they were to initiate smoking and the less likely they were to quit smoking. Disadvantages included current unemployment, poverty, low education, disability, serious psychological distress, and heavy drinking. With each additional disadvantage an individual faced, the probability of smoking increased.[9]

It is important to note that most data on the smoking prevalence of those with mental illness are limited by the exclusion of those who are institutionalized—either in treatment or incarcerated[†]—and those experiencing homelessness. Research estimates that between a quarter and a third of the chronically homeless are mentally ill.[10] Finally, given that NSDUH's definition of any mental illness excludes substance abuse, these rates likely underestimate smoking among the adult population with mental illness. Other data from NSDUH has indicated that those who have received treatment for a substance use disorder are three times more likely to be current smokers.[11]

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[*] NSDUH defines any mental illness as "having a diagnosable mental, behavioral, or emotional disorder, other than a developmental or substance use disorder." and defines current smoking as "smoking all or part of a cigarette within the 30 days preceding the interview."

[†] Tobacco sales have been banned in prison commissaries since 2006. In January 2015, the Federal Bureau of Prisons prohibited tobacco use in any form except as part of religious activity; however, staff and visitors may smoke in designated smoking areas except where prohibited by state or local law. While smoking cessation programs are sometimes available to prisoners, no financial support is provided to prisoners for nicotine replacement therapy. Further, contraband cigarettes continue to be a problem for US prisons. See http://www.no-smoke.org/pdf/100smokefreeprisons.pdf for more information.

Youth

Data on cigarette smoking rates among youth with mental illness is also very limited and is not reported in nationally representative datasets. Some research suggests that their smoking prevalence follows patterns similar to adults with mental illness.[12] According to the 2022 National Youth Tobacco Survey (NYTS), 18.3% of students reporting severe psychological distress use any tobacco product, compared to the 7.2% of students with no distress.[13] However, among youth, e-cigarettes have been the most commonly used tobacco product since 2014. In 2021, feelings of anxiety, stress, and depression was the most common reason for using e-cigarettes, with 43.4% of current youth e-cigarette users reporting these feelings as the reason for their current use.[14]

Health and Economic Consequences of Tobacco Use Among Persons with Mental Illness

Smoking accounts for more than 490,000 deaths in the United States each year, and is a major risk factor for the four leading causes of death: heart disease, cancer, chronic obstructive pulmonary disease, and stroke.[15] It is estimated that over 40 percent (around 200,000) of these deaths are among persons with mental illness or substance abuse.[16] According to one study, persons with serious mental illness die, on average, 25 years prematurely, primarily due to chronic illness, including tobacco-related disease.[17] In addition, smoking may interfere with many prescription medications commonly used to treat mental illness by reducing the therapeutic blood levels of certain psychotropic medications, thereby undermining their effectiveness.[18]

In addition to the tremendous burdens that persons with mental illness often face, such as higher rates of unemployment, victimization, homelessness, poverty, incarceration and social isolation, smoking adds a significant financial burden.[19] For example, persons with schizophrenia have been found to spend 27% of their income on cigarettes.[20] Similarly, these stressful conditions can also make it harder for persons with mental illness to quit smoking and limit their access to cessation services.

Tobacco Industry Targeting of Persons with Mental Illness

The tobacco industry is infamous for targeting its products to vulnerable populations, and the mentally ill are no exception. Examination of tobacco industry documents found that in the 1980s and 1990s, the tobacco industry targeted some psychiatric hospitals with sales promotions and giveaways of value brand cigarettes. There is also evidence of mental health institutions and treatment facilities soliciting financial donations and donation of cigarettes from the tobacco industry.[21] The tobacco industry has fought restrictions on smoking bans in hospitals and medical facilities—specifically psychiatric institutions.[22] Finally, the industry has funded a substantial body of research in its attempts to assert that smoking is both less harmful to those with schizophrenia and that it is a necessary self-medication tool.[23]

Industry targeting of the homeless population—who are disproportionately burdened by mental illness—has been even more flagrant, including donation of cigarettes to homeless shelters by Lorillard and donation of blankets branded with Phillip Morris' Merit logo to homeless shelters. RJ Reynolds' urban marketing plan in the 1990s specifically focused on targeting value brands to "street people."[24]

Helping Persons with Mental Illness Quit Smoking

Given that one in five adults in the US—over 61 million people[25]—have some form of mental illness, addressing the disparately high smoking rate in this population is critical. About 70% of people diagnosed with anxiety or depression, respectively, want to quit and nearly 60% have tried to quit in the past year.[26] Unfortunately, only about 1 in 10 succeed. Services and policies to help people quit using tobacco consist of a variety of evidence-based, individual and population-level approaches aimed at reducing the toll of tobacco use by helping users quit. According to the U.S. Public Health Service Clinical Practice Guideline, tobacco cessation treatments are effective across a broad range of populations. It is critical that health care providers screen for tobacco use and provide advice to quit to tobacco users.[27] In 2022, less than 60% of adults diagnosed with anxiety or depression received advice to quit from a healthcare professional, and only about 50% utilized counseling or FDA-approved medications to help them quit.[28]

Myths abound that smoking is an important stress coping mechanism for those with mental illness, and therefore smoking cessation is often deprioritized by mental health providers.[29] While providers should closely monitor mental health patients pursuing smoking cessation, evidence does not point to smoking cessation as disruptive to mental health treatment.[30] Randomized controlled trials have shown that smoking cessation treatment among patients receiving mental health treatment is effective and does not exacerbate mental health symptoms or lead to increased use of alcohol or illicit drugs.[31] Further, studies have consistently found that smoking cessation is actually associated with reduced depression, anxiety and stress, as well as improved quality of life.[32] As such, both the CDC and the American Psychiatric Association (APA) encourage integration of cessation treatment with mental health services.[33] Unfortunately, a 2006 study of over 800 practicing psychiatrists found that only 23% recommended nicotine replacement therapy and even fewer (11%) provided referrals, despite self-reporting greater prevalence of smoking in their patient population than other practitioners. Only 62% of psychiatrists had advised smoking patients to quit, as compared to 93% of internal medicine providers.[34] Further, only a quarter (24.2%) of mental health centers and less than half (46%) of substance abuse treatment centers offer cessation services.[35]

In addition to individual level treatment, the adoption of consistent tobacco prevention policies across mental health and substance abuse treatment contexts can help encourage cessation among those with mental illness. Effective in 1993, the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) set smoke-free standards for hospitals; however, mental health advocacy organizations successfully fought for the exclusion of psychiatric inpatient units and substance use facilities from this standard.[36] Further, some outpatient mental health patients still use cigarette provision or cigarette breaks as incentives for treatment compliance.[37] While many mental health facilities have subsequently implemented smoke-free policies, there is still progress to be made. As of July 2024, 18 states and Washington, D.C. had enacted laws or regulations requiring mental health facilities to have tobacco-free grounds.[38] The 2014 Surgeon General's Report, *The Health Consequences of Smoking—50 Years of Progress*, concluded that smoke-free laws are proven to encourage smokers to quit.[39] Further, the 2024 Surgeon General's Report, *Eliminating Tobacco-Related Disease and Death: Addressing Disparities,* further affirms this conclusion and adds that in specific settings, including inpatient psychiatric facilities, smokefree policies protect patients and residents, staff, and visitors from exposure to secondhand tobacco smoke and can reduce smoking, especially when combined with tobacco cessation services.[40] Smoke-free policies should be coupled with the integration of smoking cessation services and mental health treatment to prevent relapse when patients leave care.

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Additional Sources of Information

- Smoking Cessation for Persons with Mental Illnesses: A Toolkit for Mental Health Providers, http://www.integration.samhsa.gov/Smoking_Cessation_for_Persons_with_MI.pdf
- Tobacco-Free Living in Psychiatric Settings: A Best Practices Toolkit Promoting Wellness and Recovery, http://www.integration.samhsa.gov/pbhci-learning-community/Tobacco-Free_Living_in_Psychiatric_Settings_Toolkit.pdf
- National Behavioral Health Network, http://bhthechange.org/
- Action to Quit: Behavioral Health, http://actiontoquit.org/populations/behavioral-health/

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[1] *Smoking and Health: Report of the Advisory Committee to the Surgeon General of the Public Health Service*, PHS publication 1103, 1964, http://www.cdc.gov/tobacco/sgr/sgr_1964/sgr64.htm. McGinnis, JM, et al., "Actual causes of death in the United States," *Journal of the American Medical Association (JAMA)* 270:2207-2212, 1993.

[2] HHS. Eliminating Tobacco-Related Disease and Death: Addressing Disparities—A Report of the Surgeon General. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2024. https://www.cdc.gov/tobacco-surgeon-general-reports/about/2024-end-tobacco-disparities.html.; Curtin SC, et al. Deaths: Leading causes for 2021. National Vital Statistics Reports; vol 73 no 4. Hyattsville, MD: National Center for Health Statistics. 2024. DOI: https://dx.doi.org/10.15620/cdc/147882. *See Table C. Deaths and percentage of total deaths for the 10 leading causes of death: United States, 2021 and 2020.*

[3] CDC. Tobacco Product Use Among Adults – United States, 2022. 2022 National Health Interview Survey (NHIS) Highlights. Accessed from https://www.cdc.gov/tobacco/media/pdfs/2024/09/cdc-osh-ncis-data-report-508.pdf.

[4] Substance Abuse and Mental Health Services (SAMHSA), HHS, *Results from the 2023 National Survey on Drug Use and Health, NSDUH: Detailed Tables*, 2024, https://www.samhsa.gov/data/report/2023-nsduh-detailed-tables; Pulled from *Table 6.50B – Substance Use in Past Year: Among People Aged 18 or Older; by Past Year Level of Mental Illness, Percentages, 2023 and 2024*. NSDUH defines any mental illness as "having a mental, behavioral, or emotional disorder, excluding developmental and substance use disorders, in the past 12 months" and defines current smoking as "smoking all or part of a cigarette within the 30 days preceding the interview."

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[10] SAMHSA, "Current Statistics on the Prevalence and Characteristics of People Experiencing Homelessness in the United States," July 2011, http://homeless.samhsa.gov/ResourceFiles/hrc_factsheet.pdf.
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