

# REVIEW OF THE LITERATURE ON TOBACCO USE AND CONSUMERS OF MENTAL HEALTH SERVICES

## Tobacco Use and Consumers

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The results from the 2006 National Survey on Drug Use and Health (NSDUH) estimated that 72.9 million Americans (29.6% of population) 12 and older were current users of a tobacco product in the past month. The rates of tobacco use were unchanged from 2005 to 2006 and the highest rate (43.9%) of current tobacco use was among young adults 18 to 25. The survey also indicated that in 2006 current cigarette smoking was highest in the Midwest (27.4%) among persons 12 and older. In 2006, 23.2% of Missouri adults were current smokers, one of the highest rates in the Nation (BRFFS, 2006).

The NSDUH also assess the age of first use of tobacco. The average age of first use for individuals 12 to 49 was 17.1 years which was similar to 2005 data. According to the Missouri 2007 Youth Tobacco Survey, 13% of high school students and 26.5% of middle school students in Missouri who had smoked a whole cigarette in their lifetime that they had started smoking before the age of 11.

The prevalence of tobacco use is considerably higher among persons with mental illness when compared to the general population. According to Grant (2004) only 7.1% of the U.S. population has a psychiatric illness but those individuals consume over 34% of the all cigarettes. Persons with mental illness are twice as likely to smoke as other persons (Lasser, 2008). The results from the 2006 NSDUH also indicated that cigarette use among adults with serious psychological distress (SPD) was 44.2% compared to those individuals without SPD (24.5%). According to Glassman (1993), rates of smoking among persons with schizophrenia may be as high as 90% and Poirier (2002) suggests 50% of persons with major depressive disorder smoke. Another study indicated that the prevalence of cigarette smoking among patients with mild retardation was 30% and borderline retardation was about 37% (Hymowitz, 1997). According to Falkowski (2006) nicotine is often the first drug used and last one stopped by individuals with substance use problems and Hughes (1996) suggests that 80% of alcoholics currently smoke. See tables below for more detailed smoking status among various psychiatric diagnoses.

**Smoking Prevalence Among People with Mental Illness**

Disorder	% smoke
Major depression	50-60%
Anxiety disorder	45-60%
Bipolar disorder	55-70%
Schizophrenia	65-85%

**Source: DMH Technical Report on Smoking Policy and Treatment in State Operated  
Psychiatric Facilities (2006)**

**Table 3. Smoking Status Among Respondents According to Psychiatric Diagnosis at Any Time in Their Life\***

Lifetime Diagnosis	US Population, %	Current Smoker, %	Lifetime Smoker, %	Quit Rate, %
No mental illness	50.7	22.5	39.1	42.5
Social phobia	12.5	35.9†	54.0†	33.4‡
Agoraphobia	5.4	38.4†	58.9†	34.5
Panic disorder	3.4	35.9§	61.3†	41.4
Major depression	16.9	36.6†	59.0†	38.1
Dysthymia	6.8	37.8†	60.0†	37.0
Panic attacks	6.5	38.1†	60.4†	36.9
Simple phobia	11.0	40.3†	57.8†	30.3
Nonaffective psychosis	0.6	49.4§	67.9‡	27.2
Alcohol abuse or dependence	21.5	43.5†	65.9†	34.0‡
Antisocial personality, antisocial behavior, or conduct disorder	14.6	45.1†	62.5†	27.8†
Posttraumatic stress disorder	6.4	45.3†	63.3†	28.4§
Generalized anxiety disorder	4.8	46.0†	68.4†	32.7
Drug abuse or dependence	11.4	49.0†	72.2†	32.1§
Biopolar disorder	1.6	68.8†	82.5†	16.6†

\*Percentages of the National Comorbidity Study sample of 4411 persons are weighted to approximate the US population as determined from the 1989 US National Health Interview Survey.

†Significantly different from respondents without mental illness,  $\chi^2$ ,  $P \leq .0001$ .

‡Significantly different from respondents without mental illness,  $\chi^2$ ,  $P \leq .01$ .

§Significantly different from respondents without mental illness,  $\chi^2$ ,  $P < .001$ .

||Significantly different from respondents without mental illness,  $\chi^2$ ,  $P < .05$ .

**Source: Lasser, et al, 2000**

**Smoking Prevalence Among Addiction Patients**

Addiction	% smoke
Alcohol inpatient	85%
Alcohol outpatients	71-93%
Former problem drinkers	41%
Crack cocaine	88%
Cocaine outpatients	75%
Cocaine inpatients	85-90%
Methadone maintained	95%

**Source: DMH Technical Report on Smoking Policy and Treatment in State Operated  
Psychiatric Facilities (2006)**

Many individuals die each year due from tobacco-related diseases (i.e., cancer, cardiovascular, respiratory diseases, etc.). According to the Center for Disease Control an estimated 438,000 people in the U. S. die prematurely from smoking or exposure to secondhand smoke, and another 8.6 million have a serious illness caused by smoking. The Missouri Department of Health and Senior Services indicated that that 9,607 Missourian's died from tobacco related disease during 2003-2004. Often persons with mental illness experience greater physical health consequences and deaths related to tobacco use compared to the general population because their tobacco rates are higher. Williams (2004) suggests that the leading cause of premature death for people with mental illness or addiction is tobacco use.

Smoking cessation for persons with mental illness can dramatically reduce the physical health consequence of smoking, relieve the financial burden of buying tobacco products, improve the individual's economic status, lead to a sense of personal accomplishment, and reduce feelings of stigma (Johnson, 2006). Currently there is a National quit line available for individuals to call 365 days a year and 24-hours a day, 1-800-QUIT-OUT. The National line will link callers in fifty states to local quit lines.

Other initiatives have been put forth making recommendations for interventions to reduce tobacco use among general population. Hopkins et al., (2001) made the following recommendations: "(1) Increase the unit price for tobacco products; (2) Mass media campaigns (when combined with other interventions such as tobacco product excise tax, school-based education or other community programs); (3) Multicomponent patient telephone support (Quitlines), when combined with other interventions such as education, and/or therapies; (4) Health care system interventions to prompt health care providers to assess for tobacco use and counseling to patients; (5) Provider counseling to patients, including brief advice; and (6) Pharmacologic treatment of nicotine addiction (including use of nicotine patch and gum, and bupropion)."

Recommendations have also been made specifically for reducing tobacco use in persons with mental illness. Johnson et al., (2006) suggested these recommendations: "(1) Tobacco treatment for persons with mental illness or addictions should be integrated into existing mental health and addiction services; (2) Counselors and health care providers need support and training to incorporate brief interventions into their practices; (3) Nicotine replacement therapy should be provided to all individuals with mental illness or addictions who are willing to quit or reduce their smoking; (4) Individuals who are taking anti-psychotic medications and quit smoking should have their medication dosages monitored in the first months following cessations; and (5) smoke free spaces support and encourage individuals with mental illness and addictions to remain smoke free."