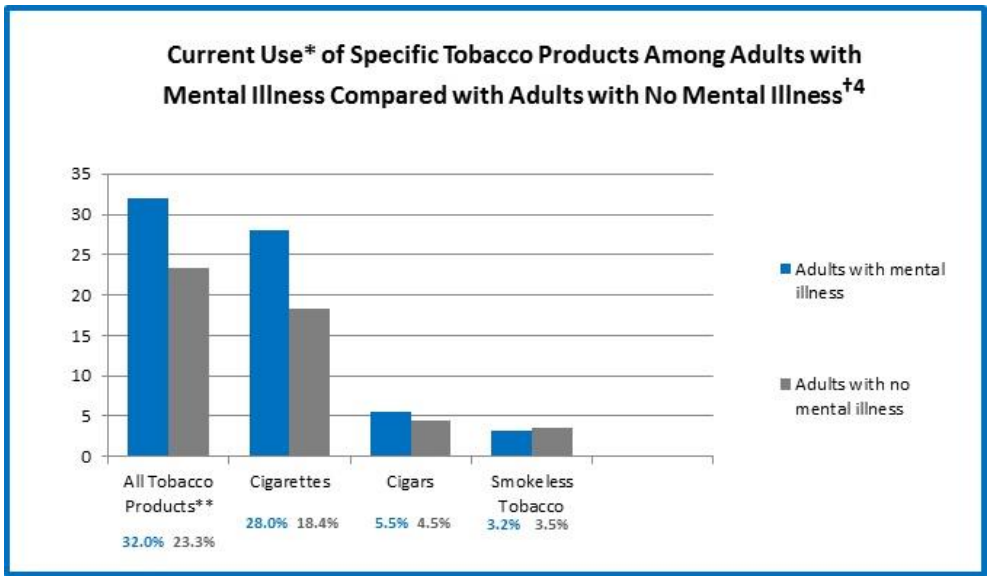
# Burden of Tobacco Use in Maine: Behavioral Health

MPHA
Maine Public Health Association

## Smoking Is Higher Among Persons with Mental Illness[1]




***32.0% of adults with any mental illness reported current use* of tobacco, compared to 23.3% of adults with no mental illness***

* "Current Use" is defined as self-reported consumption of cigarettes, cigars, and smokeless tobacco in the past month (at the time of survey). **All Tobacco Products includes cigarettes, smokeless tobacco (i.e., snuff, dip, chewing tobacco, or "snus"), cigars, and pipe tobacco. †Data taken from the National Survey on Drug Use and Health, 2016, and refer to adults aged 18 years and older self-reporting any mental illness in the past year, excluding serious mental illness.


## Industry Marketing & Targeting

The tobacco industry uses multiple marketing strategies to target populations with mental illnesses:

- Making financial contributions to organizations that work with mentally ill patients.[2]
- Funding research to foster the myth that cessation would be too stressful because persons with mental illness use nicotine to alleviate negative mood.[2,3]
- Providing free or cheap cigarettes to psychiatric facilities.[3]
- Supporting efforts to block smoke-free psychiatric hospital policies.[3]
- Creating marketing plans that target marginalized populations (*Project SCUM*: Sub Culture Urban Marketing).[2]

## Health Effects

- The most common causes of death among people with mental illness are heart disease, cancer, and lung disease, which can all be caused by smoking.[4]
- Tobacco smoke can interact with and inhibit the effectiveness of certain medications used to treat mental health and substance abuse patients.[5]

# Quitting Behavior Disparities

- People with mental illness are less likely to stop smoking than those without mental illness; however, many smokers with mental illness want to quit.[3]
- People with mental illness are more likely to have stressful living conditions, have low annual household income, and lack access to health insurance, health care, and help quitting. All of these factors make it more challenging to quit.[3,6]
- Fewer than 50% of U.S. mental health and substance use treatment facilities offer evidence-based tobacco treatment.[7,8]

# Myths

- People with mental illness or Substance Use Disorders are not interested in or cannot quit.[9]
- Quitting interferes with recovery from mental illness or addictions.[9]
- Tobacco is not as harmful as other substances.[2]
- Tobacco is necessary for self-medication,[9] and cessation would be too stressful.[2]
- Tobacco cessation efforts might prevent treatment of other addictions.[2] (However, with careful monitoring, delivering smoking cessation interventions does not interfere with treatments for mental illness and can actually be part of the treatment.[10])

# Policy Actions to Take

Evidence-based tobacco prevention and treatment strategies, including culturally appropriate media campaigns and CDC-recommended tobacco prevention and control programs and policies, will reduce the burden of disease among persons with mental illness and substance use disorders. Specific policy actions to take include:

1. Increase the price of **all** tobacco products, including e-cigarettes, through regular and significant tax increases.
2. Implement and enforce comprehensive smoke-free and tobacco-free laws. These policies support cessation, reinforce tobacco-free norms, and eliminate exposure to secondhand smoke.[7]
3. Fully fund and sustain evidence-based, statewide tobacco use prevention and treatment programs. **Maine's program is funded at approximately 30% of the U.S. CDC recommended level of $15.9 million**:
    a. Aggressive, directed counter-marketing and education campaigns
    b. Investments in surveillance and evaluation to build data specific to behavioral health
    c. Increase the reach of effective tobacco treatment programs, such as the Maine Tobacco HelpLine

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[2] Centers for Disease Control and Prevention. Best Practices User Guide: Health Equity in Tobacco Prevention and Control. Atlanta: U.S. DHHS, CDC, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2015
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[4] Druss BG, Zhao L, Von Esenwein S, Morrato EH, Marcus SC. Understanding Excess Mortality in Persons With Mental Illness: 17-Year Follow Up of a Nationally Representative US Survey. *Medical Care* 2011;49(6):599–604
[5] Smoking Cessation Leadership Center. Fact Sheet: Drug Interactions With Tobacco Smoke. San Francisco: Smoking Cessation Leadership Center, University of California, 2015
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[7] Marynak K, Vanfrank B, Tetlow S, et al. Tobacco Cessation Interventions and Smoke-Free Policies in Mental Health and Substance Abuse Treatment Facilities—United States, 2016. MMWR, 2018;67(18):519-23
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[9] Prochaska JJ. Smoking and Mental Illness—Breaking the Link. *New England Journal of Medicine*, 2011;365:196-8
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