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## Commentary on Szatkowski & McNeill: Where the smokers are

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Szatkowski and McNeill (1) have given us a gem, not only for its elegant simplicity and findings, but also for what it reveals about treatment of tobacco dependence among those with mental health disorders. My research focuses on smoking and other addictions, so my comments are framed in those terms. Dreher and Fraser reported, in 1967, elevated rates of smoking among persons in alcohol treatment (2). When we reviewed the literature on smoking in addiction treatment samples, from 1987–2009, we found over 40 papers reporting smoking prevalence from 47% to 94%. National Survey on Drug Use and Health data yielded annual smoking prevalence, for persons receiving addiction treatment, from 67–69% (3). In 1986, Kozlowski and colleagues called smoking in addiction treatment a “neglected problem” (4). In 2010, Schroeder and Morris called it a “neglected epidemic” (5).

From a public health perspective, we cannot further reduce national smoking prevalence unless we treat smoking in substance abuse and mental health populations. Yet in the U.S. we generally fail to do so. We have clinical guidelines (6), policy statements (7), and a Health and Human Services working group strategic plan (8), all supporting the provision of tobacco cessation services in addiction and mental health treatment. Yet, studies conclude that tobacco dependence is not addressed in most addiction treatment programs (9–10). There are important exceptions: The Smoking Cessation Leadership Center’s work with state and national organizations (11), the mandate for provision of cessation services to all Veterans Administration patients, including those with mental health and substance use disorders (12), and the New York mandate for tobacco-free grounds and cessation services in all publicly-supported addiction treatment programs statewide (13). However, considering that tobacco-related burden of illness, mortality, and economic costs are borne disproportionately in these populations, our response is weak. It is weak from a public health perspective, from a tobacco control perspective, and from behavioral health and general health perspectives. I do not understand why my colleagues in tobacco control, following stunning successes in reducing smoking in the general population, show a paucity of interest in substance abuse and mental health populations. This is, in 2013, where the smokers are.

In contrast to the U.S., it is a surprising and positive finding that smokers with a mental health diagnosis in the UK are more likely to receive cessation counseling (50.6%) and medication (11.2%) as compared to the general population (33.4%, 6.7% respectively) (1). In the U.S., physicians provide cessation counseling to psychiatric patients on about 38% of visits (14).

Szatkowski and McNeill found a 30.3% smoking prevalence among persons with a mental health condition compared to 19.7% among those without. In the U.S. comparable numbers are 36.1% and 21.4%, respectively (15). There the similarity ends, and potential lessons for

the U.S. begin. Most important is access to care. In 2011, about 16% of Americans (48 million) were uninsured (16). This is expected to decrease to 8% under the Affordable Care Act (ACA) in 2014 (17), accompanied by a doubling of the number of adults in Medicaid with behavioral health disorders, and many of those patients will receive primary care in our federally qualified health centers (18). Under the ACA, primary care providers will have increased opportunity to treat smoking among persons with substance abuse and mental health diagnoses. In the UK, cessation medications are available and the Quality Outcome Framework offers provider incentives to address smoking in some clinical populations. Beginning in 2014, Medicaid mandates coverage of tobacco cessation prescription drugs (19). This will increase access to tobacco cessation medications among persons with behavioral health disorders, although coverage for other tobacco cessation services will be left to States. No provider incentives for cessation services are contemplated as part of the ACA, but they should be, as Szatkowski and McNeill suggest such incentives increase cessation services.

If I go to my primary care clinic 3 times in a year, and if no provider there mentioned or treated my hypertension, then my medical care is poor. What is different about smoking? And what is different about smoking among those with mental health or substance abuse diagnoses? Cessation services, in both primary care and specialty care, should be available to everyone who uses tobacco products. Providers, whether in primary care, mental health or substance abuse, should have the training and tools to intervene on smoking, and incentives to support those efforts. Tobacco control should bring its policy expertise to where it is needed most. And our national leadership, now embodied in the HHS Tobacco Control Working Group, should reach beyond education and awareness, to policies that denormalize smoking in substance abuse and mental health, and ensure cessation medication and services for those receptive to quitting. Winston Churchill is famously credited with: “We can always count on the Americans to do the right thing, after they have exhausted all the other possibilities.” To address smoking in substance abuse and mental health in the U.S., we must now do the right thing. Szatkowski and McNeill have shown the way.

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