Center of Excellence for Cultural Competence
New York State Psychiatric Institute
Cultural Competence Matters

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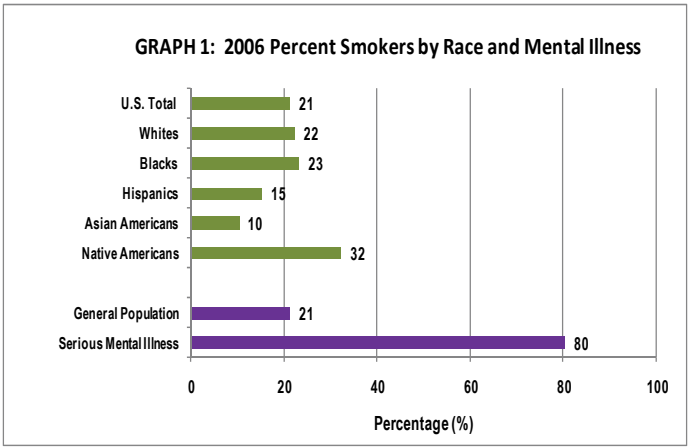
Culturally Competent Smoking Cessation Interventions for People with Serious Mental Illness

Problem: Cigarette smoking is the leading cause of preventable illness and death in the U.S. and can be blamed for 1 out of every 5 deaths each year, totaling 438,000 people. In 2006, about 21% of Americans were smokers, though this rate varies across racial groups, as shown in **Graph 1**. Underserved racial and ethnic groups face disparities in accessing smoking cessation care. Compared to White smokers, Black and Hispanic smokers are less frequently asked about their tobacco use or advised to quit by a healthcare provider, and less likely to use tobacco-cessation aids to help them quit. As a result, minorities who smoke have even worse health problems and higher rates of smoking-related illnesses than Whites.



Individuals with mental health problems consume nearly half of all cigarettes sold in the U.S. Among people with Serious Mental Illness (SMI, e.g., schizophrenia and bipolar disorder), about 80% use tobacco products. Mental healthcare providers do not usually ask patients about their smoking habits and rarely include smoking cessation in patients' treatment plans. In fact, smoking is often seen as a form of self-medication, and a difficult habit to break in psychiatric populations.

Findings: The gold standard of smoking cessation treatment includes the use of nicotine replacement therapy (NRT) combined with behavioral counseling, and sometimes the use of antidepressants to relieve symptoms of quitting. Very little research has been done to determine the best ways to engage diverse cultural groups in treatment. And while some studies have been conducted in psychiatric populations, we know of none that has examined the combined influence that race/ethnicity and mental illness may have on treatment success. Overall, compared to Whites, non-White smokers report less use of NRT, less participation in smoking cessation programs, less advice from healthcare providers on how to quit, and more unsuccessful quit attempts. Smoking cessation interventions must take these factors into account when designing programs for these underserved populations.

Similarly, smoking cessation programs for people with mental illness must pay close attention to special concerns in this population. Doses of psychiatric medication may need to be adjusted during smoking cessation, since tobacco affects the breakdown of many medications, particularly antipsychotics. In addition, some smokers experience increased depression when they quit and should be monitored closely. These issues have to be considered when developing programs to engage mental health consumers in care. Although quit rates for people with mental illness are slightly lower than for the general population, the long-terms success is high enough to greatly improve health in this population.

Implications: There are substantial disparities in access to smoking cessation programs among racial and ethnic minorities, and people with SMI. Barriers to engagement of these populations by service providers play a role in this process. Mental healthcare providers should receive training on smoking cessation interventions, and the special biological and psycho-social needs of this population. In addition, interventions need to be linguistically and culturally tailored to engage and meet the needs of diverse populations. The Center of Excellence for Cultural Competence at the New York State Psychiatric Institute is partnering with community agencies and mental health clinics to develop culturally and linguistically appropriate approaches to engage SMI consumers in smoking cessation programs. Through this partnership with consumers and service providers, we hope to help people quit for good and to improve the health of this doubly-burdened population of racial and ethnic minorities with psychiatric illness.

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