Proposal for a Tobacco Subcommittee of the Governor's Behavioral Health Services Planning Council

Tobacco is considered the leading behavioral risk factor for chronic disease morbidity and mortality, and there is a well-known correlation between tobacco use and behavioral health disorders. According to the CDC, people with mental illnesses and addictions comprise about 25% of the population, but they smoke almost 40% of all cigarettes produced and smoke cigarettes down to the filter more than other smokers.

Data from the 2020 Kansas Behavioral Risk Factor Surveillance System (BRFSS) suggests several notable disparities around tobacco and behavioral health. For example, 10.5% of Kansas adults have mild to moderate mental illness as measured by the Kessler 6 psychological distress scale, but 18.1% of current smokers have mild to moderate mental illness. Similarly, an estimated 5% of adult Kansans have substantial mental illness, but this group comprises 11.6% of adult Kansans who currently use tobacco. The prevalence of tobacco use is 2.1 times higher among Kansans who have experienced poor mental health compared to those who did not experience poor mental health; and the prevalence of Kansas adults who reported their mental health was not good was 2.2 times higher among smokers compared to nonsmokers (2020 BRFSS). The patterns are similar for those who use substances such as alcohol as well. For example, the prevalence of binge drinking is 1.6 times higher among Kansans who smoke compared to those who do not smoke. And the prevalence of binge drinking is 1.4% higher among those with poor mental health compared to those who did not experience poor mental health.

Tobacco also kills a disproportionate number of people with behavioral health disorders. People with any type of mental illness or substance use disorders die about 5 years earlier than those without these disorders (CDC) and people with serious mental illness die 25 years younger than the general population. These disparities in life expectancy are largely due to conditions caused or worsened by smoking such as are heart disease, cancer, and lung disease – the most common causes of death for people with mental illness. Despite all this, until recently, anti-smoking efforts have not been directed consistently toward people with mental illnesses. While nicotine can temporarily mask the negative symptoms of mental illness, many people with mental illness still want to quit, but may not be offered support from their therapist. Common beliefs such as 1) people with mental illness need tobacco to cope with symptoms and stress, 2) quitting interferes with recovery from addictions or mental illness, and 3) tobacco is less harmful than other products are now being challenged. Moreover, the process of quitting is often made more difficult in behavioral health care facilities that still allow smoking.

The Kansas Health Foundation provided funding from 2016-2022 for a Tobacco Recovery Initiative to increase evidence-base tobacco treatment for people with behavioral health conditions in Kansas. Some of the accomplishments of this grant include:

1. Developing the Kansas Guideline for Behavioral Health Care, its companion document the online Self-Assessment tool that is now hosted on the KDADS website, and an 80-page Implementation Toolkit detailing resources related to each of the 12 Guideline strategies. These documents outline what evidence-base tobacco treatment looks like and how to implement these strategies.

2. Supporting the Tobacco Treatment Specialist training at KU Med in Kansas City. This nationally accredited training program has and continues to address workforce development issues in the State.
3. Commissioning the 2018 and 2020 studies that demonstrated a positive return on investment for expanding tobacco benefits, first in KanCare and subsequently in the Kansas Employee Health Plan and private insurance plans. The 2018 study successfully made the case to the legislature to substantially expand tobacco treatment benefits in KanCare.
4. Hosting a Strategy Session in December 2021 for forty-five stakeholders, including several KDHE and KDADS employees. At this virtual event, the participants developed an action plan to address the sustainability and continuity of the work related to the Kansas Health Foundation's Tobacco Recovery Initiative. As part of the Action Plan, four strategy Teams were formed:
    a. Education
    b. Data
    c. Systems Change, and
    d. Policy.

    This subcommittee will serve to elevate key recommendations to the Council for state agencies to consider from not only these **tobacco strategy teams**, but also other key stakeholders such as the **Tobacco Free Kansas Coalition**, a statewide advocacy organization which has been a champion for critical public policy changes in support of goals to reduce tobacco use. This includes being the lead organization for implementing the objectives in the Kansas Tobacco Control Strategic Plan. The **Community of Practice**, located in WSU's Community Engagement Institute, has facilitated meetings of providers interested in expanding their skill sets for treating tobacco dependence. And KDHE through its CDRR (Chronic Disease Risk Reduction Grant Program) is currently implementing strategies in communities around the State in several tobacco-goal areas.

Vision: To help Kansans in the behavioral health population improve their quality of life by achieving a tobacco free lifestyle.

Mission: To maintain a committed focus on reducing and preventing tobacco use in the behavioral health population and increasing the number of participants in tobacco cessation treatment who experience success in quitting.

Tobacco Subcommittee Charter Objectives:

1. Increase access to evidence-based treatment for individuals with mental illness and substance use disorders, especially for Medicaid beneficiaries.
2. Expand insurance coverage and increase utilization of insurance for tobacco dependence treatment.
3. Create statewide policy and culture change to support tobacco prevention and treatment in substance use, mental health, and primary care settings.

4. Support behavioral health and primary care providers in adopting and implementing the Kansas Tobacco Guideline for Behavioral Health Care.
5. Increase the number of behavioral health and primary care providers who are actively engaged in providing tobacco cessation treatment.

Membership: The Tobacco Subcommittee will assess our membership each year and add additional members including those with lived experience to ensure that all voices are represented.

_____, KDADS, Liaison to GBHSPC
Babalola Faseru, University of Kansas School of Medicine
Chad Childs, Wichita State University Community Engagement Institute
Daniel Craig, Kansas Public Health Association
Sara Prem, American Lung Association
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