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Tobacco Use among Kansans with Mental Illness

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Executive Summary

Tobacco use is the leading preventable cause of death and disease in the United States, and new evidence of harmful health effects continues to emerge. Although substantial progress has been made in the prevention and control of tobacco use, and smoking prevalence among the general population has decreased over the past several decades, the smoking rate among adults with mental illness has not decreased.

Adults with mental illness are significantly more likely to smoke than the general U.S. population, and rates are highest among those with serious mental illness, multiple disorders, and substance use disorders. People with mental illness are at elevated risk of negative health, financial, and social outcomes associated with their tobacco use.

This report explores the rates of mental illness among adults and youth in Kansas and tobacco use prevalence among those with mental illness.

- In 2012, 10.2% of Kansas adults reported experiencing mental illness, and 3.4% of adults reported experiencing serious mental illness.
- The smoking rate among Kansas adults with mental illness (37.8%) was more than twice the smoking rate among adults without mental illness (17.3%). Kansas adults who experienced serious mental illness in the past 30 days had an even higher smoking rate (45.7%).
- Smoking rates are also high among Kansas adults with mental illness and low income (40.1%).
- Smoking rates were much higher among Kansas adults who binge drink and receive mental health treatment (58.9%) than among those who binge drink but do not receive mental health treatment (30.7%).
- Mental illness is significantly associated with poor physical health, including health problems exacerbated by smoking.

- Adult smokers with mental illness were more likely to have tried to quit (64.7%) than those without mental illness (55.3%).
- More than one-fifth of Kansas youth in grades 9 through 12 have experienced mental illness in the past year. Among youth with mental illness, 61.8% had ever tried cigarette smoking, even one or two puffs. By comparison, 35.5% of youth without mental illness had ever tried smoking cigarettes.
- Youth who reported mental illness were more than twice as likely to be current smokers (26.8%) as youth without mental illness (10.9%).

Results in this report are consistent with national trends, reinforcing the importance of addressing these issues within the state of Kansas. The findings in this report can clarify the scope of the problem and inform future efforts.

Introduction

Tobacco use is the leading preventable cause of death and disease in the United States (Mokdad et al., 2004). Fifty years after the first report on smoking and health, the U.S. Surgeon General described progress made in tobacco control and highlighted the ongoing problem of tobacco use in the United States (USDHHS, 2014). The Surgeon General's report details the grave and wide-ranging effects of tobacco use on the human body. It also summarizes new evidence of harm from tobacco use, including adding two types of cancer to the long list of cancers that are caused by smoking and establishing smoking as a cause of diabetes and rheumatoid arthritis. The Centers for Disease Control and Prevention (CDC) reports that 18.1% of U.S. adults smoke cigarettes (CDC, 2014); however, smoking rates are disproportionately higher among some populations. In particular, studies have found that people with mental illness in the United States have disproportionately high smoking rates.

In the United States, approximately 43.7 million adults and 2.2 million youth experienced mental illness in 2012.

In 2012, approximately 43.7 million U.S. adults (18.6%) had any mental illness in the past year (SAMHSA, 2013). Approximately 9.6 million adults (4.1%) experienced serious mental illness in the past year (SAMHSA, 2013). Nationally, more than 34 million adults (14.5%) received any mental health treatment or counseling services during the past year (SAMHSA, 2013). Among youth, the most common reason for receiving mental health services was feeling depressed (SAMHSA, 2013). In 2012, approximately 2.2 million youth aged 12 to 17 (9.1%) had a major depressive episode during the past year (SAMHSA, 2013). Approximately 89,000 Kansans received mental health services in 2012, and there were 13,900 admissions to publicly funded substance use disorder treatment programs (Governor's Mental Health Task Force, 2013).

People with mental illness are significantly more likely to smoke than the general population. Although precise smoking rates vary by how mental illness is measured and by study setting, smoking rates are consistently higher among adults with mental illness than among adults without mental illness (Grant et al., 2004; Hall & Prochaska, 2009; Hartz et al., 2014; Lasser et al., 2000; McClave et al.,

Smoking rates are highest among those with serious mental illness, multiple disorders, and substance use disorders.

2010). Moreover, rates are highest among those with serious mental illness, multiple disorders, and substance use disorders (Hall & Prochaska, 2009; Lasser et al., 2000; McClave et al., 2010). One recent study found that 38.1% of people with serious psychological distress were current smokers (McClave et al., 2010). A review of multiple studies similarly noted that people with mental illness smoke at double the rate of the general population (Hall & Prochaska, 2009). Another study reported that smoking rates by psychological diagnosis during the past month were highest among those with drug abuse or dependence (67.9%), bipolar disorder (60.6%), alcohol abuse or dependence (56.1%), and generalized anxiety disorder (54.6%) (Lasser et al., 2000). Furthermore, smoking prevalence among people with mental illness increases with the number of mental illnesses an individual experiences (Hall & Prochaska, 2009; Lasser et al., 2000; McClave et al., 2010). McClave et al. (2010) calculated that 18.3% of adults with no lifetime mental illness smoked, compared with 31.9% of people with one mental illness, 41.8% of people with two mental illnesses, and 61.4% of people with three or more mental illnesses.

Adults with mental illness are also more likely to be heavy smokers than the general population. One study estimated that adults with mental illness make up 28.3% of the population but consume approximately 44% of the cigarettes smoked in the United States (Lasser et al., 2000). Tobacco consumption also increases concomitantly with the number of lifetime psychiatric diagnoses (Lasser et al., 2000).

Although people with mental illness have comparatively higher smoking rates, those with mental illness want to quit and try to quit at rates similar to those among the general population (Lawrence, Mitrou, & Zubrick, 2011; McClave et al., 2010; Schroeder & Morris, 2010; Smith et al., 2014a, 2014b). Studies indicate that those with mental illness have lower success in quitting, which may be due at least in part to the higher smoking intensity and nicotine dependence among this population. One study found that more severe nicotine withdrawal among those with mental illness accounted for the lower likelihood of quit success (Smith et al., 2014a).

Smoking rates have decreased among the general population, but not among individuals with mental illness.

Although smoking prevalence among adults in the United States has decreased over the past few decades (USDHHS, 2014), smoking rates have not decreased among adults with mental illness (Gfroerer et al., 2013; Hartz et al., 2014; Le Cook et al., 2014). As a result, this population is disproportionately and severely affected by the negative effects of tobacco use. Approximately 200,000 of the 443,000 Americans who die each year from smoking have mental illness and substance use disorders (Schroeder & Morris, 2010). Adults with mental illness and substance use disorders die 25 years earlier than the general population, with major causes of death being related to smoking (Callaghan et al., 2014; Colton & Manderscheid, 2006; Schroeder & Morris, 2010). Alcoholics are more likely to die from smoking-related disease than from alcohol-related disease (Hurt et al., 1996). Further, adults aged 35 to 54 with psychotic disorders are 12 times more likely to have cardiac-related deaths compared with nonsmokers with psychotic disorders; the risk is even greater as the number of cigarettes smoked increases (Kelly et al., 2011).

Tobacco use among adults with mental illness raises additional health and social concerns. Tobacco use changes the effectiveness of medications used to treat mental illness, including reducing the blood levels of certain psychiatric medications (Hall & Prochaska, 2009; Williams & Ziedonis, 2004; Zevin & Benowitz, 1999). The economic burden imposed by tobacco dependence is also a significant challenge. Adults with mental illness are more likely to be below the poverty level, and many spend more than one-quarter of their income on tobacco products (Steinberg, Williams, & Ziedonis, 2004). In an era of social norm change supporting smoke-free environments, the stigma attached to smoking is another challenge for adults with mental illness, which can compromise their integration into the community (Schroeder & Morris, 2010).

Youth with mental illness are also more likely to be smokers (DeHay et al., 2011; Williams & Ziedonis, 2004). Youth tobacco use often precedes other substance use and mental illness, including depressive symptoms (Goodman & Capitman, 2000; Williams & Ziedonis, 2004). Youth with mental illness are likely to continue using tobacco and

experience negative health, financial, and social outcomes as they move into adulthood.

The Kansas Health Foundation (KHF) is implementing a Fellows Program to address the challenge of tobacco use among Kansans with mental illness. Although one national survey estimates that 37.5% of Kansas adults with any mental illness smoke cigarettes (Gfroerer et al., 2013), it is important to explore available data in more detail to understand the scope of the problem in Kansas more thoroughly. This report examines rates of mental illness among adults and youth in Kansas and tobacco use prevalence among those with mental illness. This report also describes some key associations between mental illness, tobacco use, and demographic characteristics and health outcomes in Kansas. By clarifying the scope of the problem, this report will help the KHF Fellows Program consider the policy and practice options for addressing this issue in Kansas.

Methods

This report estimates tobacco use among adults and youth with mental illness using national survey data that allow for state-level analysis. Table 1 describes the data used to measure each construct. We used adult-level data from the 2012 Kansas Behavioral Risk Factor Surveillance System (BRFSS), which assesses risk factors and health behaviors and includes questions regarding tobacco use and mental health. For youth, we used survey data from the 2011 Kansas Youth Risk Behavior Surveillance System (YRBSS) for high school students. Questions related to mental illness in YRBSS are specific to depressive disorders, which are the most common type of mental illness among youth.

This report shows tobacco use associated with these mental illness measures. We report prevalence rates by type of tobacco product and by use of multiple tobacco products. However, our findings primarily focus on cigarette smoking, which is the most common form of tobacco use.

Table 1. Data Sources and Mental Health Status Measures Used in This Report

Age Group	Data Source	Construct	Measures
Adults	BRFSS	Mental illness	Respondents reported the number of days out of the past 30 days that their mental health was not good. This includes stress, depression, and problems with emotions. Those with 14 days or more in which their mental health was not good were considered to experience mental illness.
		Serious mental illness	This report uses serious psychological distress (SPD) as a measure of serious mental illness. SPD is determined based on respondents' reports of how frequently they experienced the following depressive and anxiety-related symptoms: <ul style="list-style-type: none"> ▪ Nervousness ▪ Hopelessness ▪ Feeling restless or fidgety ▪ Feeling so depressed that nothing could cheer them up ▪ Feeling that everything was an effort ▪ Feeling worthless Responses were scored by how frequently symptoms were experienced and summed for a score from 0 to 24. On this validated scale, scores of 13 or higher indicate SPD (Kessler et al., 2002).
		Received mental health treatment	Respondents reported whether they are currently taking medicine or receiving treatment from a doctor or other health professional for any type of mental health condition or emotional problem.
Youth	YRBSS	Mental illness	Respondents reported whether in the past 12 months they <ul style="list-style-type: none"> ▪ felt so sad or hopeless almost every day for two weeks or more in a row that they stopped doing some usual activities, ▪ seriously considered attempting suicide, ▪ made a plan about how you would attempt suicide, or ▪ actually attempted suicide.

Note: BRFSS = Behavioral Risk Factor Surveillance System; YRBSS = Youth Risk Behavior Surveillance System

We summarize the prevalence of tobacco use, particularly cigarette smoking, among adults and youth with mental illness in Kansas. In addition, we present several key characteristics associated with mental illness and tobacco use to provide additional context. This report also displays regional and county-level prevalence estimates.

We used chi-squared tests to understand the association between tobacco use outcomes and mental illness measures, and we conducted *t* tests to determine statistically significant differences. We note within the report text and in footnotes where differences are statistically significant (at $p < 0.05$).

Results

Mental Illness among Kansas Adults

In 2012, 10.2% of Kansas adults reported experiencing mental illness, and 3.4% of adults reported experiencing serious mental illness. Similarly, 12.1% of Kansas adults reported receiving treatment for a mental health condition or emotional problem.

Mental illness affects people across all segments of the population, but some groups are more likely to experience mental illness than others. For example, women are more likely to report mental illness and treatment for mental illness than men. Women make up 50.9% of the adult population in Kansas, but they make up 59.9% of the adult population with mental illness. Individuals below the poverty level make up 9.8% of the adult population in the state, but they make up 24.0% of the adult population with mental illness. Individuals with mental illness are more likely to have poor physical health and tobacco-related health problems than individuals without mental illness.

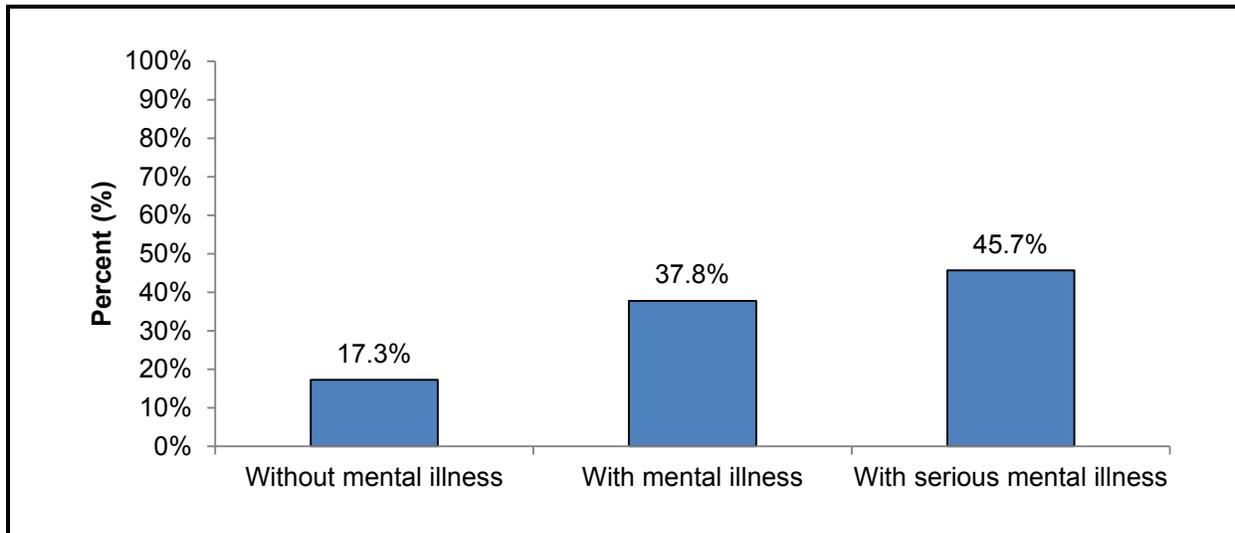
Tobacco Use among Kansas Adults with Mental Illness

The smoking rate among Kansas adults with mental illness is more than double the smoking rate among Kansas adults without mental illness.

The smoking rate in Kansas was 19.4% among the general adult population in 2012. However, Kansas adults with mental illness were much more likely to be current smokers than Kansas adults without mental illness. The smoking rate among adults with mental illness was 37.8%, more than double the smoking rate among Kansas adults without mental illness (17.3%) (Figure 1). Kansas adults who experienced serious mental illness during the past 30 days had an even higher smoking rate (45.7%).

Kansas adults with mental illness are more likely to use any tobacco product (cigarettes, chewing tobacco, snuff, or snus) (40.1%) than adults without mental illness (21.7%). Dual use – current cigarette smoking and current use of chewing tobacco, snuff, or snus – among Kansas adults is 1.3%. The rate of dual tobacco use does not differ by mental health status.

Figure 1. Current Smoking among Kansas Adults, by Mental Health Status



Note: Current smoking among Kansas adults with mental illness is significantly higher than current smoking among Kansas adults without mental illness. Current smoking among Kansas adults with serious mental illness is significantly higher than current smoking among Kansas adults without mental illness.

Smoking rates among Kansas adults vary by level of psychological distress. Scores on this scale range from 0 (no psychological distress) to 24 (severe psychological distress). Serious psychological distress is indicated by a score of 13 or higher (Kessler et al., 2003; McClave et al., 2010). Serious psychological distress is described in this report as serious mental illness (see Table 1). Nearly 60% of Kansas adults have a very low score on this scale (0 to 2), and the smoking prevalence for this group is 12.9% (Table 2). Kansas adults with higher scores on the scale have notably higher smoking rates; those with serious mental illness have a smoking rate of 46.6%.

Table 2. Distribution of Kansas Adult Population and Smoking Prevalence, by Level of Psychological Distress

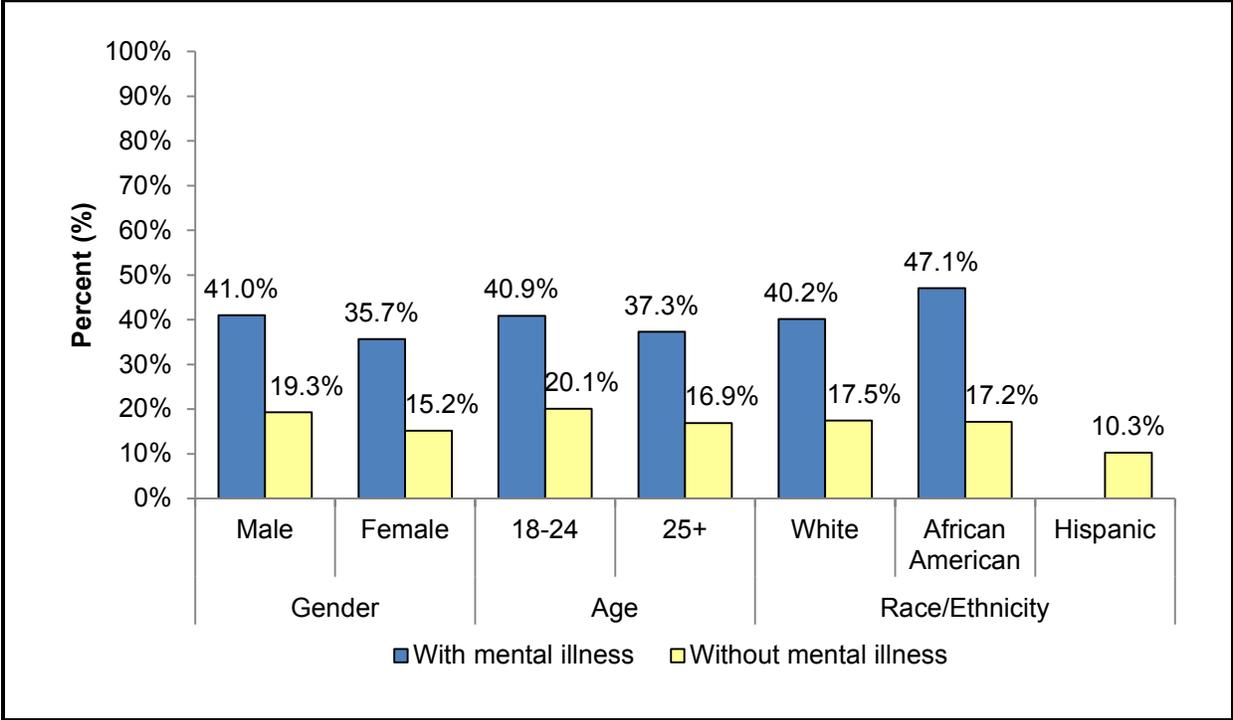
Score on Psychological Distress Scale	Distribution of Population	Smoking Prevalence
0–2	59.4%	12.9%
3–7	30.5%	21.9%
8–12	7.4%	36.3%
13–24	2.7%	46.6%

Note: Thirteen or higher indicates serious psychological distress.

Smoking among Kansas Adults with Mental Illness: Key Demographics and Health Outcomes

Smoking rates among those with mental illness show similar patterns by demographic characteristics, including gender, age, and race/ethnicity (Figure 2). For males and females, the smoking rate among adults with mental illness is more than double the rate among those without mental illness. Similarly, both young adults and adults aged 25 or older with mental illness smoke at twice the rate of those without mental illness. Both white and African American Kansas adults with mental illness smoke at more than twice the rate of those without mental illness.

Figure 2. Current Smoking among Kansas Adults, by Mental Health Status and by Gender, Age, and Race/Ethnicity

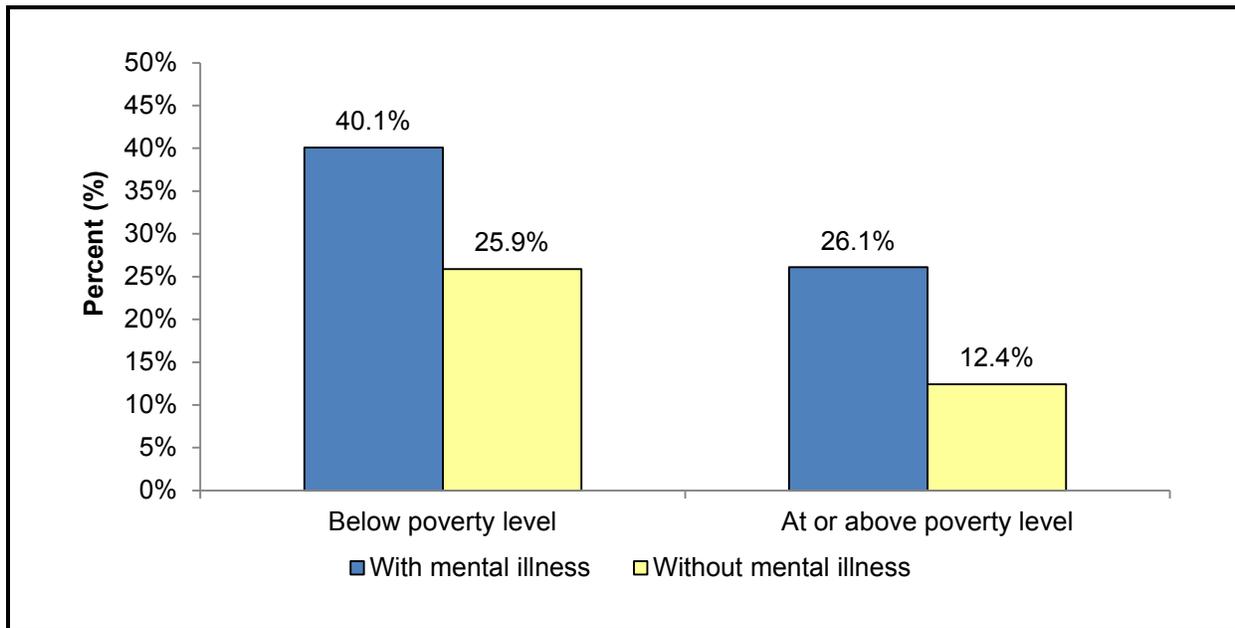


Note: Current smoking among Kansas adults with mental illness is significantly higher than among Kansas adults without mental illness by gender, age, and race/ethnicity measures. The smoking rate for Hispanics with mental illness is not shown because there were too few cases to provide a reliable estimate.

Kansans with mental illness and low income are even more likely to be smokers.

Kansas adults with mental illness and low income are even more likely to be smokers (Figure 3). The smoking rate among Kansas adults with mental illness who are below the poverty level is 40.1%, much higher than the rate among those with either mental illness or low income, both at about 26%. Kansas adults with neither mental illness nor low income have a smoking rate of 12.4%, half that of adults with either risk factor alone and less than one-third that of adults with both risk factors.

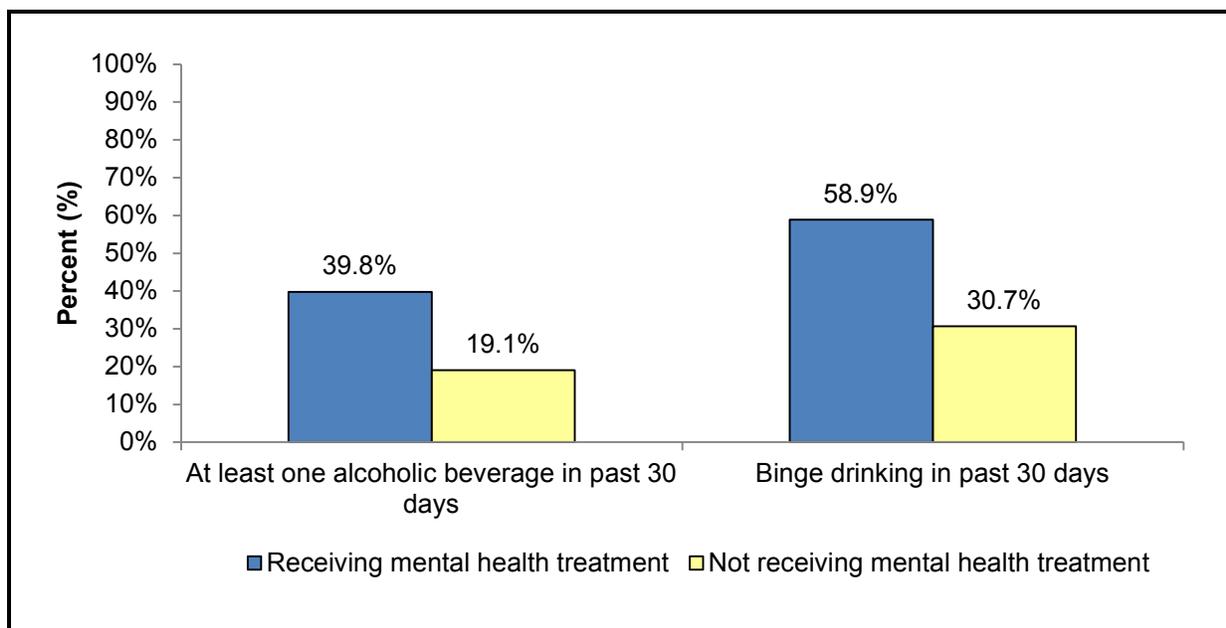
Figure 3. Current Smoking among Kansas Adults, by Mental Health Status and Poverty Status



Note: Current smoking among Kansas adults with mental illness is significantly higher than current smoking among Kansas adults without mental illness, both for those at or above the poverty level and those below the poverty level.

Among Kansas adults who drink alcohol, those who receive mental health treatment were more likely to be smokers than those who do not receive mental health treatment (Figure 4). Smoking rates were much higher among Kansas adults who binge drink and receive mental health treatment (58.9%) than among those who binge drink but do not receive mental health treatment (30.7%). More than twice as many adults in Kansas who had at least one alcoholic beverage in the past 30 days and receive mental health treatment were smokers (39.8%) as those not receiving mental health treatment (19.1%).

Figure 4. Current Smoking among Kansas Adults, by Mental Health Treatment and Alcohol Use

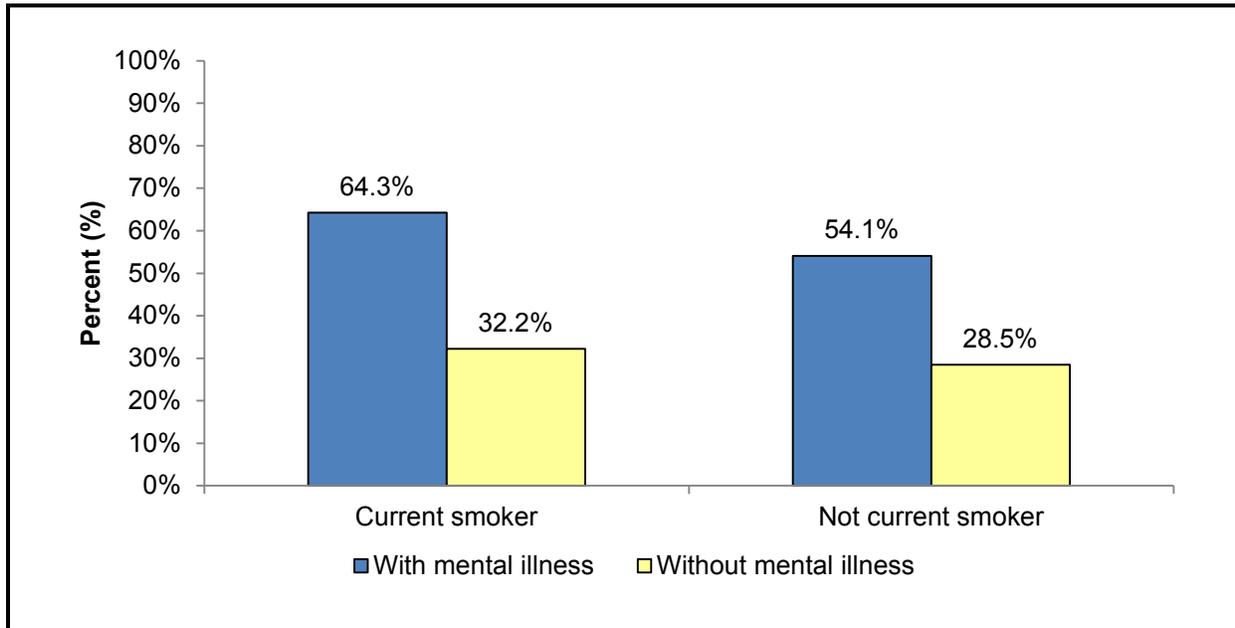


Note: Current smoking among Kansas adults receiving mental health treatment is significantly higher than current smoking among Kansas adults not receiving mental health treatment, both among those who had at least one alcoholic beverage in the past 30 days and among those who reported binge drinking in the past 30 days.

Mental illness is significantly associated with having had poor physical health at least 1 day in the past 30 days (Figure 5). Notably, although smokers – with or without mental illness – were more likely to report poor physical health in the past month than nonsmokers, poor physical health was more strongly associated with mental illness than with smoking status. More than 64% of smokers with mental illness reported poor physical health, compared with 32.2% of smokers without mental illness. More than 54% of nonsmokers with mental illness reported poor physical health, compared with 28.5% of nonsmokers without mental illness.

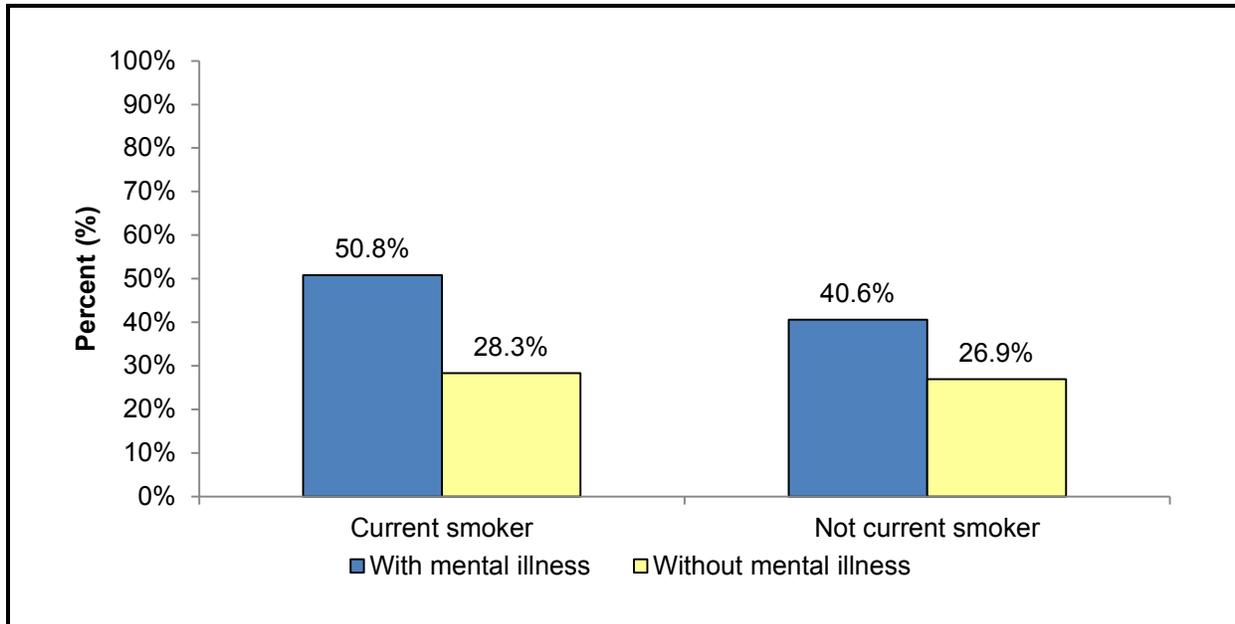
Among Kansas adults without mental illness, smoking status was not associated with reports of having had health problems that are often associated with tobacco use, specifically heart attack, coronary heart disease, stroke, chronic obstructive pulmonary disease, emphysema, chronic bronchitis, asthma, or cancer (Figure 6). Adults with mental illness were more likely to report having these health problems, particularly those who are mentally ill and current smokers.

Figure 5. Percentage of Kansas Adults Reporting Poor Physical Health, by Mental Health Status and Smoking Status



Note: The percentage of Kansas adults reporting poor physical health is significantly higher among those with mental illness than among those without mental illness, both among current smokers and nonsmokers.

Figure 6. Percentage of Kansas Adults Reporting Health Problems That Are Often Associated with Tobacco Use, by Mental Health Status and Smoking Status



Note: Health problems often associated with tobacco use that were used in this analysis include heart attack, coronary heart disease, stroke, chronic obstructive pulmonary disease, emphysema, chronic bronchitis, asthma, or cancer.

The percentage of Kansas adults reporting health problems that are often associated with tobacco use was significantly higher among those with mental illness than those without mental illness, both among current smokers and nonsmokers.

Regional and County-level Estimates of Mental Illness and Smoking among Kansas Adults

Estimates for the four most populous counties in Kansas show that smoking is slightly lower in Johnson County (15.0%) than statewide (19.4%) but that Sedgwick, Shawnee, and Wyandotte Counties' smoking rates are close to the statewide rate (Table 3). In these four counties, smoking rates are significantly higher among adults with mental illness than among adults without mental illness.

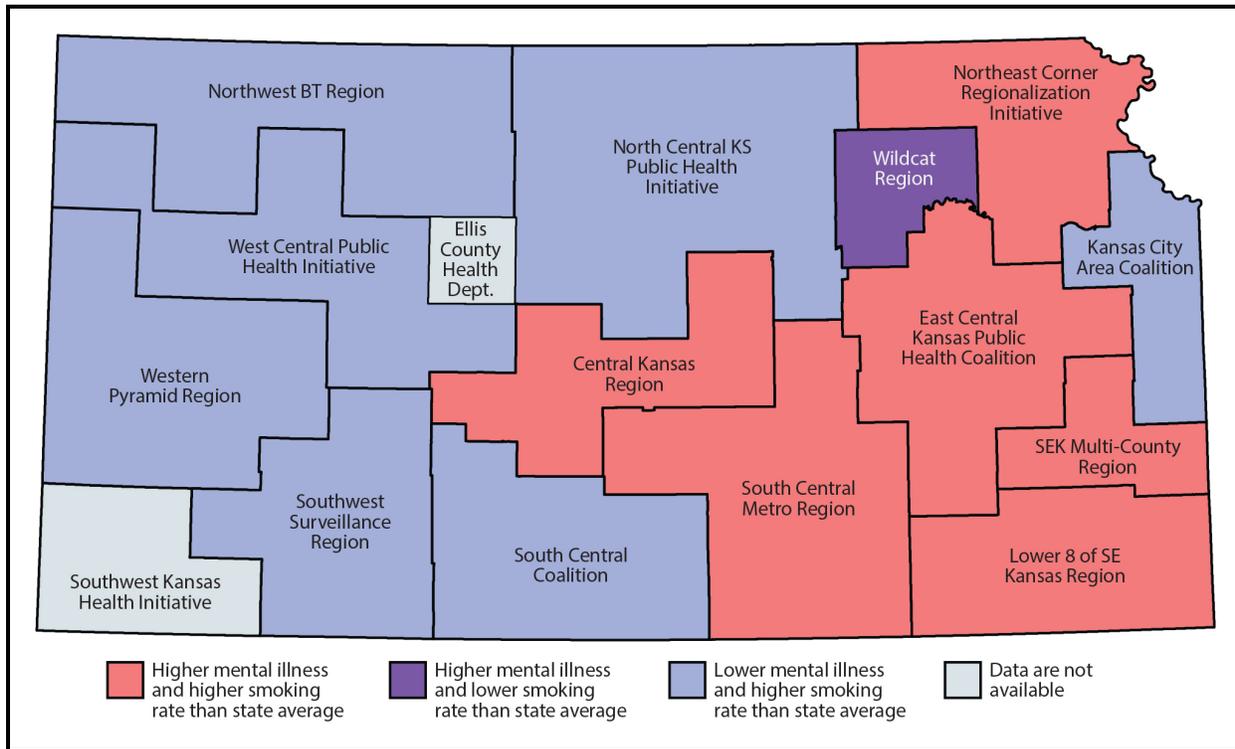
Table 3. Smoking Rates for Kansas and Selected Counties, Overall and by Mental Health Status

	Current Smoking (Overall)	Current Smoking by Mental Health Status	
		Without Mental Illness	With Mental Illness
Kansas (statewide)	19.4%	17.3%	37.8%
Johnson County	15.0%	13.7%	31.3%
Sedgwick County	19.3%	17.5%	35.8%
Shawnee County	20.7%	17.3%	41.9%
Wyandotte County	19.9%	18.3%	32.4%

Note: Smoking rates were significantly higher among Kansas adults with mental illness than among Kansas adults without mental illness statewide and for each of the four selected counties.

To further consider how mental illness and smoking among adults are distributed across Kansas, Figure 7 shows how each region compares with the state averages of mental illness and smoking prevalence. Western regions were more likely to have mental illness rates lower than the state average and smoking rates higher than the state average. Many of the central and eastern regions had higher rates of mental illness and current smoking. Regional adult smoking rates range from 18.7% to 26.5%; regional rates of mental illness range from 6.4% to 12.8%.

Figure 7. Rates of Mental Illness and Current Smoking among Kansas Adults, by Region



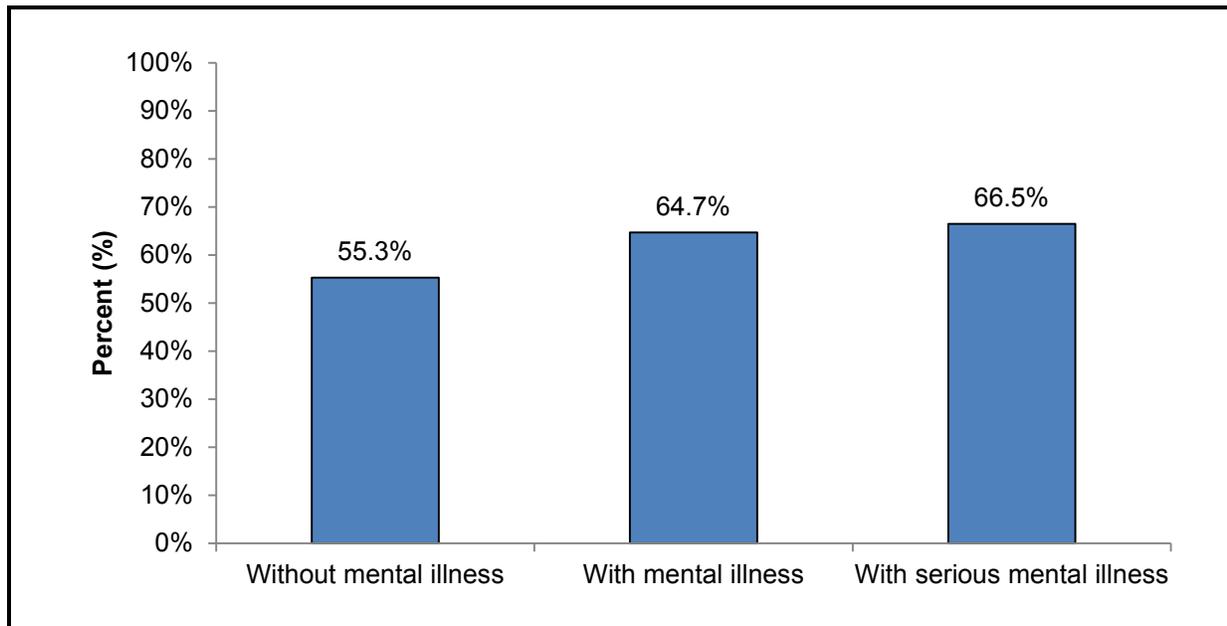
Quitting Behaviors among Kansas Adults with Mental Illness

Kansas adults with mental illness are more likely to have tried to quit smoking than those without mental illness.

Among smokers, adults with mental illness were more likely to have tried to quit in the past 12 months than those without mental illness (Figure 8). Among Kansas smokers, 55.3% without mental illness made a quit attempt, compared with 64.7% of Kansas smokers with mental illness and 66.5% of Kansas smokers with serious mental illness in the past 30 days.

A total of 3.2% of Kansas adults were recent quitters, meaning that they do not currently smoke but have smoked cigarettes within the past year and have smoked more than 100 cigarettes in their lifetime. Adults with mental illness were more likely to be recent quitters; 5.2% of Kansas adults with mental illness were recent quitters, compared with 2.9% of those without mental illness.

Figure 8. Percentage of Kansas Adult Smokers Who Made a Quit Attempt in the Past 12 Months, by Mental Health Status



Note: Percentages of Kansas adults with mental illness and serious mental illness who made a quit attempt in the past 12 months were each significantly higher than the percentage among Kansas adults without mental illness.

Mental Illness among Kansas Youth

More than one-fifth of Kansas youth in grades 9 through 12 have experienced mental illness in the past year. Among Kansas youth, 21.9% felt so sad or hopeless for 2 weeks or more in a row during the past 12 months that they stopped doing some usual activities (Table 4). Approximately 11.8% of Kansas youth seriously considered suicide in the past 12 months, 9.9% made a plan about how to attempt suicide, and 5.9% had at least one suicide attempt in the past 12 months. In this report, youth who reported feeling sad or hopeless for 2 weeks or more in a row were defined as having mental illness.

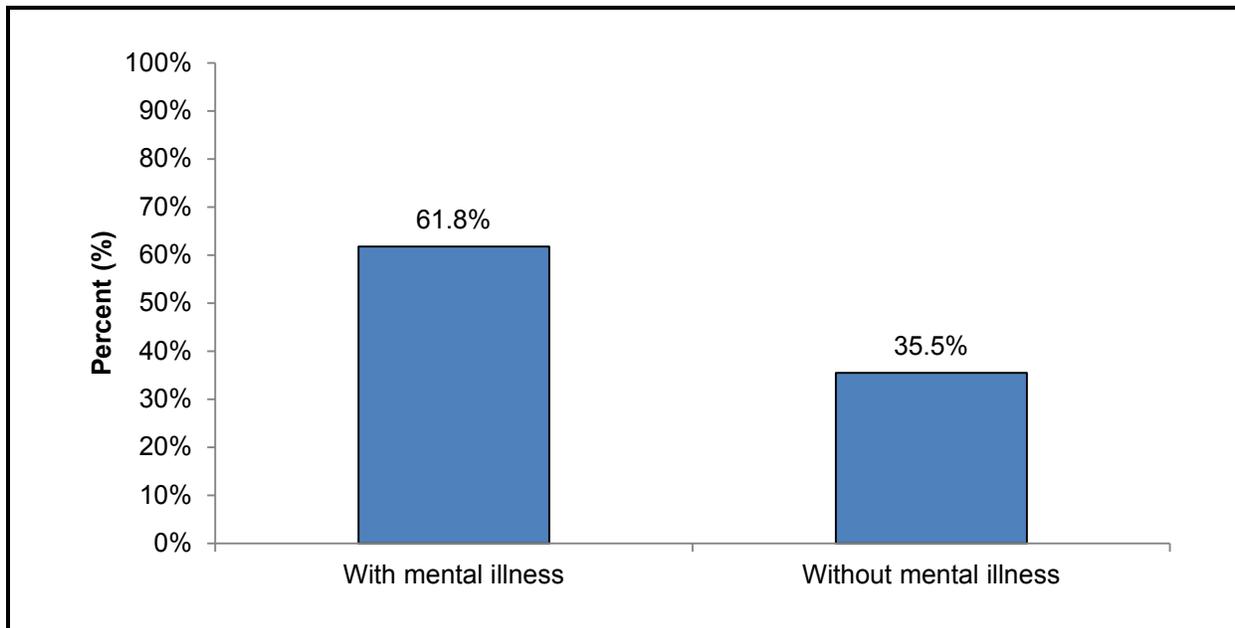
Table 4. Percentage of Kansas Youth Reporting Mental Illness in the Past 12 Months

Mental Illness Measure	Percentage
Felt sad or hopeless for 2 weeks or more in a row	21.9%
Seriously considered attempting suicide	11.8%
Made a plan about attempting suicide	9.9%
Actually attempted suicide	5.9%

Tobacco Use among Kansas Youth with Mental Illness

Tobacco use among high school youth in Kansas statewide is 14.4%. A total of 3.6% of Kansas youth currently smoke cigarettes and use chewing tobacco, snuff, or dip. Further, 1.6% of Kansas youth currently smoke cigarettes and use chewing tobacco, snuff, or dip as well as smoke cigars. Among youth with mental illness, 61.8% had ever tried cigarette smoking, even one or two puffs (Figure 9). By comparison, 35.5% of those without mental illness had ever tried smoking cigarettes.

Figure 9. Percentage of Kansas Youth Who Ever Tried Cigarette Smoking, by Mental Health Status

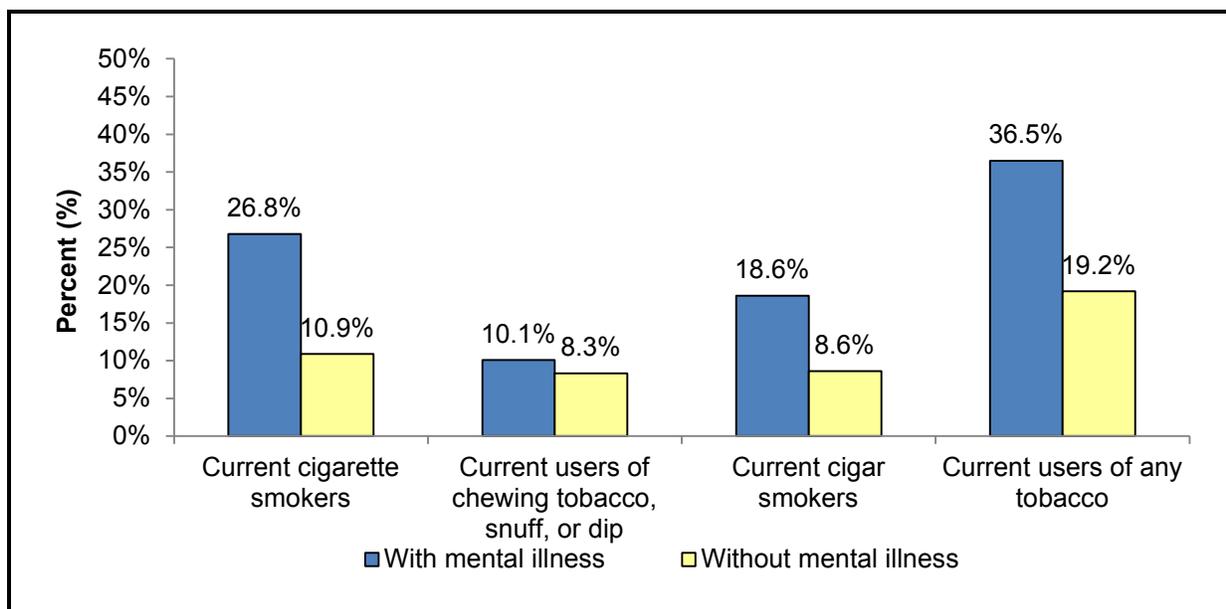


Note: The percentage of Kansas youth who ever tried cigarette smoking was significantly higher among youth with mental illness than among youth without mental illness.

Youth with mental illness are more than twice as likely to be current smokers as youth without mental illness.

Youth who reported mental illness were more than twice as likely to be current smokers (26.8%) as youth without mental illness (10.9%) (Figure 10). Use of chewing tobacco, snuff, or dip was similar between the two groups, but youth with mental illness were more likely to smoke cigars than those without mental illness.

Figure 10. Percentage of Kansas Youth Reporting Tobacco Use, by Mental Health Status



Note: The percentage of Kansas youth reporting current use of cigarettes, cigars, or any tobacco was significantly higher among youth with mental illness than among youth without mental illness.

Conclusion

Kansas adults and youth who experience mental illness smoke at higher rates than the general population. Those with serious mental illness are at significantly increased risk of smoking. Smoking rates are especially high among Kansas adults with mental illness living in poverty and those who report recent binge drinking. Youth with depressive symptoms are more likely to try smoking and twice as likely to be current smokers as youth without mental illness. These findings are consistent with national trends, reinforcing the importance of addressing these issues within the state of Kansas.

Kansas adults with mental illness, even those with serious mental illness, try to quit at rates even higher than those without mental illness. Tobacco products are highly addictive, but resources to assist people in quitting are effective and available. The fact that Kansans with mental illness are at even greater risk for health problems, above and beyond the health problems experienced by smokers without mental illness, makes addressing tobacco use even more important. High smoking rates among youth with mental illness further highlight the need to change current

trends, or else the next generation of young people experiencing mental illness will face the same smoking-related health, financial, and social problems as adults.

Several limitations to these analyses should be noted. First, available data from surveys with the most appropriate measures use methods that may underrepresent those with severe and persistent mental illness, including those who are homeless or institutionalized. Second, BRFSS and YRBSS data do not contain measures of substance use disorder, which is associated with some of the highest documented smoking rates. Third, although these surveys contain questions related to mental illness, they are not specific enough to allow for analyses by mental illness diagnosis. Fourth, data used in these analyses are cross-sectional rather than longitudinal. Despite these limitations, this report strategically informs the scope and nature of the problem of tobacco use among Kansans with mental illness.

Improved surveillance and outcome measures would offer better data to inform future efforts for tobacco control and mental health programs (Williams, Willett, & Miller, 2013). Stronger collaboration between these two fields could ensure that key tobacco-related measures are included in mental health studies and that key mental health measures are assessed in tobacco-related surveys. For example, tobacco surveys could incorporate additional questions or scales to document mental health more accurately, or these surveys could better capture substance use and mental health disorders. Efficiently and effectively changing existing surveillance systems will be challenging, but improvements will allow for more informed interventions and more meaningful monitoring of trends among populations disproportionately affected by tobacco use.

The KHF Fellows Program soon will launch initiatives to address tobacco use among Kansans with mental illness. Understanding the prevalence of tobacco use among adults and youth in Kansas is a crucial step in the process of addressing the problem. Sustained implementation of evidence-based, comprehensive, integrated interventions built on this understanding can help Kansans with mental illness live tobacco-free lifestyles.

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