RESEARCH ARTICLE

Tobacco Screening and Treatment of Patients With a Psychiatric Diagnosis, 2012−2015

Erin S. Rogers, DrPH,[1,2] Christina N. Wysota, MPH[1]

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Introduction: Smoking disproportionately affects individuals with psychiatric diagnoses. Providers can play a role in reducing tobacco-related morbidity among people with a psychiatric diagnosis by routinely screening and treating all patients for tobacco use. This study seeks to identify rates of tobacco screening, counseling, and medication orders during outpatient visits with adults who have a psychiatric diagnosis.

Methods: Data from the 2012−2015 National Ambulatory Medical Care Survey were examined to calculate the proportion of visits with people who have a psychiatric diagnosis that included tobacco screening, counseling, or smoking-cessation medications. Logistic regression was used to identify patient and visit factors associated with tobacco screening and treatment. All analyses were conducted in 2018.

Results: Seventy-two percent of visits included tobacco screening, 23% of visits with tobacco users included cessation counseling, and 4% of visits with tobacco users included a cessation medication order. Visits were more likely to include tobacco screening if they were for a nonpsychiatric condition, were >30 minutes, or were with a primary care physician ($p<0.05$). Visits were less likely to include tobacco screening if they were with a black, non-Hispanic patient or patient with Medicaid ($p<0.05$). Visits were more likely to include cessation counseling if they were for a nonpsychiatric condition ($p<0.05$), and were less likely to include counseling if they were with a Hispanic or self-pay patient ($p<0.05$).

Conclusions: There is still room for improvement in providing equitable treatment for people with psychiatric conditions for smoking, particularly in nonprimary settings.
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INTRODUCTION

Tobacco use is the leading preventable cause of death in the U.S.[1] Although the overall percentage of people who use any form of tobacco has declined to 19%, people with mental illness have experienced little reductions in the prevalence of smoking over time.[2] Treatments are available to help people with psychiatric diagnoses quit, including bupropion, varenicline, nicotine replacement therapy (NRT), and behavioral counseling.[3−7]

In 1996, the Agency for Health Care Policy and Research (now the Agency for Health Care Research and Quality)[8] and the American Psychiatric Association[9] released clinical practice guidelines recommending that all patients, including those with psychiatric diagnoses, should be screened for tobacco use at each visit and provided with evidence-based treatment. In 2000 and 2008, the U.S. Public Health Service updated the Agency for Health Care Research and Quality guidelines, continuing

From the [1]Department of Population Health, New York University Langone Health, New York, New York; and [2]Research Service, VA NY Harbor Healthcare System, New York, New York

Address correspondence to: Erin S. Rogers, Dr, PH, Department of Population Health, New York University Langone Health, 180 Madison Avenue, New York NY 10016. E-mail: erin.rogers@nyulangone.org.

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to stress the need to screen and treat tobacco users who have psychiatric comorbidities with medications, behavioral counseling, or both.[10,11] Several federal policies were then initiated from 2009 to 2010 to further motivate and enable systems-level tobacco use treatment. The Recovery and Reinvestment Act of 2009 established meaningful use, which incentivized healthcare professionals to adopt electronic health record systems that met quality objectives, including tobacco screening and treatment. The Affordable Care Act[12] of 2009 was also designed to increase patient access to preventive services, including those for tobacco cessation, particularly through Medicaid expansion and the creation of health insurance marketplaces requiring preventive service coverage. In 2010, *Healthy People 2020* established objectives to increase tobacco screening and counseling in healthcare settings.

The last national-level, healthcare-based assessment of the rates at which U.S. physicians screen and treat patients with psychiatric diagnoses for tobacco use was published in 2001. Using data from 1991 to 1996, that study showed that physicians conducted tobacco screening during 76% of visits with patients who had a psychiatric diagnosis but counseled only 23% of tobacco users to quit.[13] A more recent study of national visits with psychiatrists specifically found that, in 2006−2010, psychiatrists screened for tobacco use during only 60% of visits, counseled during only 22% of visits with tobacco users, and provided NRT to <1% of tobacco users.[14] Most recently, in a population-based study conducted outside of the healthcare delivery system, in 2013−2016, people with mental health problems or combined mental health−substance abuse problems were more likely than people without mental health problems to report being screened for tobacco use and advised to quit.[15] However, that study was limited by its reliance on participant report of physician behavior during the prior 12 months, which may be subject to recall error. The study also measured mental health problems using a combination of participants' self-reported psychological distress and functional impairment and, therefore, was unable to evaluate participants' psychiatric diagnoses.

In summary, though there has been a large amount of literature on the prevalence of tobacco use among people with psychiatric diagnoses and on the development of treatments to help them quit, there has been limited investigation into how the U.S. healthcare system is addressing tobacco use in people with psychiatric diagnoses. This lack of knowledge limits the field's ability to identify the need for policies and interventions that leverage the healthcare system to reduce tobacco use and related morbidity in this high-priority population. To help target policy and systems interventions, the objective of the current study is to estimate the recent rates at which people with a psychiatric diagnosis are screened and treated for tobacco use by their physician, as well as factors associated with the odds of being screened and treated for tobacco use.

METHODS

Study Sample
The data source for the study was the National Ambulatory Medical Care Survey (NAMCS), a nationally representative survey of outpatient physician visits conducted annually by the National Center for Health Statistics. NAMCS samples visits with office-based medical doctors and Doctors of Osteopathy in the U.S.[16] Participating physicians are randomly assigned to a 1-week reporting period. A systematic random sample of each physician's office visits during the reporting period is selected, and interviewers record data for each visit using an automated patient record form. Recorded data include physician specialty, patient demographic characteristics, symptoms and diagnoses, medications ordered, and services provided.

Participating physicians recorded all patient diagnoses associated with the visit using ICD-9 codes on the NAMCS forms. The first-listed diagnosis in the record was the primary diagnosis associated with the visit. For example, if a patient with schizophrenia was seen for diabetes, diabetes would be the first-listed diagnosis and schizophrenia would have been listed in a subsequent diagnosis field. If a psychiatric diagnosis (ICD-9 codes 290−319) was reported in any of the NAMCS record's diagnosis fields, the visit was coded as having occurred with a patient who had a psychiatric diagnosis. For the current study, records from the 2012−2015 NAMCS public data files for all visits involving individuals aged ≥18 years with a psychiatric diagnosis were selected for analysis.

Measures
To assess the rate of screening for tobacco use, providers were asked: *Does the patient use tobacco?* Response options were the following: *current*, *not current*, and *unknown*. If the provider checked *current* or *not current*, the patient was coded as having been screened for tobacco use. For each visit with a current tobacco user, the visit was coded as having included counseling or referral to counseling if the physician checked a box indicating that they provided counseling, education, or referral to counseling and education on "tobacco/use." Lastly, the NAMCS forms included 10 fields for listing any medications prescribed during a visit. If Zyban, varenicline, or any form of NRT (e.g., patch, lozenge, inhaler, nasal spray, gum) were in the list of medications, the visit was coded as having included a cessation medication prescription.

Several variables were assessed for their potential associations with the odds of tobacco use screening and treatment. The first variable examined was the main diagnosis associated with the visit. As described in the Study Sample section, even though all patients in the sample had a psychiatric diagnosis in the record, some may have been seen during the visit primarily for a nonpsychiatric condition (e.g., diabetes). For this analysis, the first-listed diagnosis was recoded as follows: nonpsychiatric, schizophrenia, affective, anxiety, posttraumatic stress disorder, alcohol or substance abuse−related (not including tobacco use disorder), or other (personality disorders, attention-deficit disorder, and organic and non-organic psychoses).

Additional independent variables assessed included patient age, sex, and expected source of payment (private insurance, Medicaid, Medicare, self-pay, or other sources, including worker's compensation, no-charge charity care, and insurance not listed). Patient race and ethnicity were assessed as white, non-Hispanic white; black, non-Hispanic; Hispanic; or other, non-Hispanic. Additional visit factors assessed included the time spent with the physician in minutes, whether the patient had been seen by the provider before, and the physician specialty. To ensure adequate sample sizes in the physician specialty group analyses, physician specialties were recoded into 3 broad categories: (1) primary care, including general and family practice and internal medicine; (2) psychiatry; or (3) other, including gynecology and obstetrics, general or orthopedic surgery, dermatology, cardiology, urology, neurology, ophthalmology, otolaryngology, and an "other" category capturing all other specialties.

Statistical Analysis

Analyses were conducted in 2018−2019 using SAS, version 9.4. The percentage of visits during which tobacco screening was completed was first calculated, followed by the percentage of visits with a tobacco user during which cessation counseling was provided, and the percentage of visits with a tobacco user that included a cessation medication prescription. To generate national estimates, analyses were weighted using the national Patient Visit Weight variable included in the NAMCS file, and physician clustering was accounted for using a physician code for each visit. SEs of the estimates were calculated. To assess the reliability of all estimates, relative SEs were calculated as an estimate's SE divided by the estimate (a relative SE<30% was considered reliable).

Weighted bivariable logistic regression models were used to estimate the association between each independent variable and the 3 dependent variables. When examining the associations between patient diagnoses and the odds of tobacco screening and treatment, the recoded primary visit diagnosis variable was used in the analysis (with "nonpsychiatric diagnosis" as the reference group). Weighted multivariable logistic regression models that included all independent variables were then used to estimate the independent associations between the patient and visit factors with tobacco screening and treatments.

RESULTS

There were 169,658 adult outpatient visits in the data files, 9.1% of which (15,410 visits) were with a patient who had a psychiatric diagnosis, which comprised the study sample. Table 1 shows key patient and visit characteristics of the sample.

Overall, 72.4% (SE=1.6%) of visits with a patient who had a psychiatric diagnosis included tobacco use screening. Table 2 shows tobacco screening rates by patient and visit characteristics. Factors independently associated with odds of tobacco screening were patient diagnosis, race and ethnicity, expected source of payment, time spent with the physician, and physician type. Compared with visits that were primarily for a nonpsychiatric condition, visits were less likely to include tobacco screening if

they were primarily for an affective disorder (AOR=0.58, 95% CI=0.44, 0.77), an alcohol- or drug-related disorder (AOR=0.43, 95% CI=0.27, 0.67), or a psychiatric condition falling into the "other" category (AOR=0.50, 95% CI=0.367, 0.69). Visits with black, non-Hispanic patients were less likely to include tobacco screening than visits with white, non-Hispanic patients (AOR=0.60, 95% CI=0.44, 0.82), and Medicaid patients were less likely to be screened for tobacco use than patients with private insurance (AOR=0.71, 95% CI=0.52, 0.97). Visits lasting >30 minutes were more likely to include tobacco screening than visits lasting ≤15 minutes (AOR=1.72, 95% CI=1.19, 2.49). Visits with a psychiatrist or with a physician whose specialty was in the "other" category were less likely to include tobacco screening than visits with primary care physicians (AOR=0.27, 95% CI=0.19, 0.40 and AOR=0.53, 95% CI=0.37, 0.76, respectively).

Overall, 22.9% (SE=1.8%) of visits with a tobacco user included tobacco-cessation counseling. Patient diagnosis, race and ethnicity, expected source of payment, and whether the patient had been seen before were independently associated with odds of being counseled (Table 2). Compared with visits that were primarily for a nonpsychiatric condition, visits were less likely to include counseling if they were for schizophrenia (AOR=0.23, 95% CI=0.06, 0.96), an affective disorder (AOR=0.27, 95% CI=0.15, 0.49), an anxiety disorder (AOR=0.39, 95% CI=0.22, 0.70), or a diagnosis falling into the "other" category (AOR=0.21, 95% CI=0.08, 0.55). Hispanic patients were less likely to be counseled than white, non-Hispanic patients (AOR=0.48, 95% CI=0.26, 0.89), and visits with a patient expected to pay on their own were less likely to include counseling than visits with patients with private insurance (AOR=0.41, 95% CI=0.20, 0.82). Return patients were less likely to be counseled than new patients (AOR=0.48, 95% CI=0.33, 0.70).

Overall, the percentage of visits with tobacco users in which a cessation medication was ordered was 4.4% (SE=0.7%). The percentage reached a high of 7.8% during visits with patients seen for an alcohol or drug use disorder, and a low of 0% during visits with patients seen for schizophrenia (Table 2). Because of the low prescribing rates, some subgroups' estimates had a relative SE>30%; thus, estimates may be unreliable and regression models could not generate stable estimates of the relationships between independent variables and the odds of receiving a prescription.

DISCUSSION

This study evaluated the national rates of tobacco use screening and treatment provided to people with a psychiatric diagnosis during U.S. ambulatory care visits

Table 1. Patient and Visit Characteristics[a]

Measure	*n*	%
Patient characteristics		
Primary visit diagnosis		
Nonpsychiatric	5,108	33.2
Hypertension	547	10.7
General medical symptoms or general medical exam	493	9.7
Chronic airway obstruction or other respiratory symptoms	247	4.8
Diabetes mellitus	175	3.4
Other nonpsychiatric	3,646	71.4
Schizophrenia	522	3.4
Affective	4,582	29.7
Anxiety	2,760	17.9
Alcohol or drug-related	1,002	6.5
Other psychiatric[b]	1,436	9.3
Age, years		
18−25	1,694	11.0
26−35	2,506	16.3
36−55	5,845	37.9
>55	5,365	34.8
Sex		
Female	9,339	60.9
Male	6,071	39.4
Race		
White, non-Hispanic	12,716	82.5
Black, non-Hispanic	1,055	6.9
Hispanic	1,047	6.8
Other, non-Hispanic	592	3.8
Expected payment source		
Private insurance	6,975	45.3
Medicaid or other state-based	1,724	11.2
Medicare	3,289	21.3
Self-pay	2,043	13.3
Other[c]	466	3.0
Unknown or missing	913	5.9
Patient type		
New patient	1,638	10.6
Patient seen before	13,772	89.4
Visit characteristics		
Visit duration, minutes		
0−15	5,283	34.3
16−30	6,208	40.3
>30	3,919	25.4
Physician specialty		
Primary care	5,592	36.3
Psychiatry	7,115	46.2
Other[d]	2,703	17.5

[a]*n*=15,410 visits.
[b]Other psychiatric diagnoses included personality disorders, attention-deficit disorder, and organic and non-organic psychoses.
[c]Other sources of payment included workers' compensation, no-charge charity care, and other sources of insurance not listed.
[d]Other physician specialties included gynecology and obstetrics, general or orthopedic surgery, dermatology, cardiology, urology, neurology, ophthalmology, otolaryngology, and other specialties not otherwise listed.

Table 2. Rates of Tobacco Use Screening and Treatment During Outpatient Visits[a] With Adults With a Psychiatric Diagnosis: National Ambulatory Medical Care Survey, 2012−2015

Characteristics	Visits that included tobacco use screening			Visits with tobacco users that included tobacco-cessation counseling or referral to counseling			Visits with tobacco users that included a cessation medication[b]
	% (SE)	OR (95% CI)	AOR (95% CI)	% (SE)	OR (95% CI)	AOR (95% CI)	% (SE)
Total	72.4 (1.6)	—	—	22.9 (1.8)	—	—	4.4 (0.7)
Primary visit diagnosis							
Nonpsychiatric	85.5 (1.3)	ref	ref	32.7 (2.9)	ref	ref	5.6 (1.2)
Schizophrenia	59.6 (4.5)	**0.27 (0.18, 0.41)**	0.73 (0.48, 1.13)	8.0[c] (4.5)	**0.18 (0.05, 0.60)**	**0.23 (0.06, 0.96)**	0.0 (0.0)
Affective	61.4 (2.5)	**0.29 (0.22, 0.38)**	**0.58 (0.44, 0.77)**	10.2 (2.3)	**0.24 (0.14, 0.41)**	**0.27 (0.15, 0.49)**	2.0[c] (1.0)
Anxiety	73.6 (2.2)	**0.51 (0.39, 0.67)**	0.76 (0.58, 1.00)	14.2 (3.9)	**0.34 (0.17, 0.67)**	**0.39 (0.22, 0.70)**	1.6[c] (0.8)
Alcohol or drug-related	66.8 (5.1)	**0.37 (0.23, 0.59)**	**0.43 (0.27, 0.67)**	19.8 (3.8)	**0.51 (0.30, 0.86)**	0.66 (0.38, 1.16)	7.8 (2.3)
Other psychiatric[d]	62.3 (3.6)	**0.30 (0.21, 0.43)**	**0.50 (0.367, 0.69)**	7.2[c] (3.0)	**0.16 (0.07, 0.39)**	0.21 (0.08, 0.55)	1.7[c] (1.1)
Race and ethnicity							
White, non-Hispanic	73.4 (1.5)	ref	ref	23.8 (1.9)	ref	ref	4.8 (0.8)
Black, non-Hispanic	65.3 (3.4)	**0.68 (0.51, 0.91)**	**0.60 (0.44, 0.82)**	23.6 (6.7)	0.99 (0.47, 2.07)	0.80 (0.36, 1.80)	1.4[c] (0.8)
Hispanic	70.8 (3.2)	0.88 (0.67, 1.16)	0.86 (0.65, 1.13)	14.3 (3.5)	**0.53 (0.30, 0.94)**	0.48 (0.26, 0.89)	4.7[c] (2.0)
Other, non-Hispanic	71.4 (5.6)	0.91 (0.54, 1.52)	1.01 (0.69, 1.46)	18.6 (5.2)	0.73 (0.37, 1.44)	0.63 (0.31, 1.29)	3.3[c] (2.0)
Sex							
Women	73.6 (1.7)	ref	ref	23.8 (2.3)	ref	ref	4.6 (1.1)
Men	70.6 (1.8)	**0.86 (0.75, 0.99)**	0.90 (0.78, 1.04)	21.8 (2.2)	0.90 (0.66, 1.21)	0.93 (0.67, 1.29)	4.2 (0.9)
Age, years							
18−25	71.2 (2.3)	ref	ref	14.9 (3.0)	ref	ref	0.5[c] (0.3)
26−35	71.2 (2.3)	1.00 (0.81, 1.25)	1.00 (0.80, 1.25)	18.6 (2.9)	1.31 (0.78, 2.20)	1.19 (0.70, 2.03)	5.5 (1.4)
36−55	70.9 (1.8)	0.99 (0.81, 1.21)	0.93 (0.75, 1.14)	23.0 (2.8)	1.72 (0.05, 2.81)	1.52 (0.93, 2.48)	5.9 (1.4)
>55	74.9 (1.9)	1.21 (0.95, 1.55)	0.93 (0.73, 1.18)	28.5 (2.6)	**2.28 (1.35, 3.86)**	1.61 (0.89, 2.92)	2.7[c] (0.7)
Expected payment source							
Private insurance	74.1 (2.2)	ref	ref	27.8 (2.8)	ref	ref	5.9 (1.1)
Medicaid	65.4 (3.6)	**0.66 (0.47, 0.93)**	**0.71 (0.52, 0.97)**	19.3 (3.6)	0.62 (0.38, 1.03)	0.67 (0.40, 1.12)	2.4[c] (0.8)
Medicare	75.1 (2.2)	1.05 (0.81, 1.37)	0.96 (0.76, 1.23)	28.8 (2.9)	1.05 (0.74, 1.49)	0.93 (0.60, 1.44)	6.1[c] (2.9)
Self-pay	71.7 (3.4)	0.89 (0.61, 1.30)	1.32 (0.91, 1.93)	9.4 (2.4)	**0.27 (0.15, 0.48)**	**0.41 (0.20, 0.82)**	0.5[c] (0.4)
Other[e]	71.3 (4.4)	0.87 (0.55, 1.38)	1.04 (0.65, 1.66)	12.2 (3.7)	**0.36 (0.18, 0.75)**	0.50 (0.25, 1.00)	5.2[c] (3.0)
Time with physician, minutes							
0−15	73.8 (2.3)	ref	ref	23.2 (3.4)	ref	ref	6.0 (1.5)
16−30	70.4 (2.1)	0.84 (0.64, 1.11)	0.93 (0.70, 1.22)	24.1 (2.4)	1.05 (0.68, 1.63)	1.09 (0.70, 1.71)	3.9 (0.8)
>30	74.0 (2.6)	1.01 (0.72, 1.42)	**1.72 (1.19, 2.49)**	19.2 (2.5)	0.78 (0.49, 1.26)	1.06 (0.61, 1.85)	2.1 (0.6)

Table 2. Rates of Tobacco Use Screening and Treatment During Outpatient Visits[a] With Adults With a Psychiatric Diagnosis: National Ambulatory Medical Care Survey, 2012−2015 (continued)

Characteristics	Visits that included tobacco use screening			Visits with tobacco users that included tobacco-cessation counseling or referral to counseling			Visits with tobacco users that included a cessation medication[b]
	% (SE)	OR (95% CI)	AOR (95% CI)	% (SE)	OR (95% CI)	AOR (95% CI)	% (SE)
Patient seen before							
No	77.0 (2.9)	ref	ref	35.5 (4.1)	ref	ref	4.3 (0.8)
Yes	71.9 (1.6)	0.76 (0.55, 1.05)	0.83 (0.62, 1.12)	21.8 (1.8)	**0.48 (0.34, 0.69)**	**0.48 (0.33, 0.70)**	5.3 (1.5)
Physician specialty							
Primary care	83.4 (1.4)	ref	ref	26.0 (2.7)	ref	ref	5.5 (1.1)
Psychiatry	58.9 (2.9)	**0.28 (0.21, 0.39)**	**0.27 (0.19, 0.40)**	10.2[c] (3.4)	**0.32 (0.15, 0.71)**	0.92 (0.36, 2.34)	2.6[c] (1.2)
Other[f]	75.8 (2.7)	**0.62 (0.44, 0.88)**	**0.53 (0.37, 0.76)**	28.9 (3.3)	1.16 (0.77, 1.75)	0.96 (0.64, 1.44)	3.2 (0.9)

Note: Boldface indicates statistical significance ($p<0.05$). Visits could have included both cessation counseling and a cessation medication prescription.
[a] n=15,410 visits.
[b] Cessation medications included nicotine replacement therapy (patch, lozenge, gum, inhaler, nasal spray), Zyban, or varenicline.
[c] Relative SE of the estimate (SE/estimate) is >30%.
[d] Other psychiatric diagnoses included personality disorders, attention-deficit disorder, and organic and non-organic psychoses.
[e] Other sources of payment included worker's compensation, no-charge charity care, and other sources of insurance not listed.
[f] Other physician specialties included gynecology and obstetrics, general or orthopedic surgery, dermatology, cardiology, urology, neurology, ophthalmology, otolaryngology, and other specialties not otherwise listed.

occurring since the enactment of several tobacco-related federal policies from 2009 to 2010. Results showed that from 2012 to 2015, >27% of visits with a patient who had a psychiatric diagnosis did not include tobacco screening. This represents a small decline in screening compared with Thorndike et al.,[13] who reported that from 1991 to 1996, among outpatient physician visits with a patient who had a psychiatric diagnosis, 24% did not include tobacco screening. Moreover, this study found that only 23% of visits with tobacco users included tobacco-cessation counseling, which is a small decline in the 27% counseling rate identified by Thorndike and colleagues. Cessation medication prescription rates showed an improvement in the rate reported by Thorndike et al. (2%) yet remained very low overall at 4%. NRT became available over the counter in 1996 and, thus, physicians may not have prescribed it during this study's years. However, as out-of-pocket costs can be a barrier to accessing NRT, prescribing NRT may improve patient access to treatment.[17,18] Of note, there was sufficient evidence of Zyban's or varenicline's effectiveness with tobacco users who have a psychiatric condition during this study's years, but these medications were also rarely prescribed.

The low rates of counseling and medication prescriptions found here are consistent with the low rates found in other high-priority populations, such as patients with chronic obstructive pulmonary disease or hyperlipidemia.[19,20] Therefore, the undertreatment of tobacco use found in this study is not unique to patients with psychiatric conditions. However, results highlight that there are still significant missed opportunities to address tobacco use in a population with disproportionately high rates of tobacco use and related mortality.

This study also found disparities in tobacco use screening and counseling. Patients who had Medicaid insurance or were black, non-Hispanic appeared to be especially vulnerable to low tobacco screening, as well as those seen by a psychiatrist. This is concerning, as African-Americans are more likely to die from tobacco-related illness than whites.[21] Tobacco use continues to be high among low-SES groups, and the Affordable Care Act was expected to increase access to preventive services through Medicaid expansion.[22] Providers and patients may be unaware of Medicaid's cessation treatment benefits, which has been cited as a barrier to cessation medication utilization in Medicaid patients.[17,18] Because screening is the first step to initiating treatment, future work is needed to reduce the screening disparities identified here. With respect to tobacco counseling, Hispanic and self-paying patients were most vulnerable to not being counseled about quitting. The disparities identified here are largely consistent with prior research. In psychiatric and nonpsychiatric studies, nonwhite patients are less likely to be

asked about tobacco use, and longer visits are associated with increased cessation counseling.[14,23−25] The low rates of tobacco screening by psychiatrists in particular are consistent with prior findings and may be because of lack of a defined role for psychiatrists in addressing tobacco, perceived resistance from patients, perceptions that quitting is not a priority or may harm patients, low confidence or skills in effectively addressing tobacco use, and limited time.[26,27] However, this study found that few patients seen in primary care (where tobacco use is traditionally addressed) were provided with tobacco treatment—showing that persistent barriers to tobacco treatment access for people with psychiatric diagnosis exist even within primary care settings.

Diagnosis-driven disparities in tobacco use screening and treatment were also identified. When a patient with a psychiatric diagnosis was seen primarily for a nonpsychiatric condition, the rates of tobacco screening were quite high (86%) and one third of tobacco users were counseled to quit. However, when a patient was being seen primarily for their psychiatric condition, tobacco screening and treatment rates were much lower. This suggests that whether a person has a psychiatric condition may not be the primary driver of tobacco screenings and treatment, but rather whether the visit is for their psychiatric condition. This may reflect attention biases on the part of providers or the relative prioritization of tobacco use in the context of the visit needs. If the visit is for a medical, potentially tobacco-related condition (e.g., hypertension), physicians may prioritize tobacco use. If the visit is for a psychiatric condition, there may be more urgent needs to address, such as acute psychosis.[27]

Tobacco users with psychiatric diagnoses report that perceived lack of support from healthcare providers is a major barrier to quitting.[28] This study's results support this perception by showing that most of tobacco users with a psychiatric diagnosis are still not receiving evidence-based tobacco treatment from their physicians, despite recommendations and policy incentives to do so. These findings highlight a continued need to invest resources in implementing tobacco treatment for people with psychiatric diagnoses. Because healthcare providers often report that they do not feel quitting is a priority for their patients with psychiatric conditions, educating providers on the immediate consequences of tobacco use for their patients (e.g., financial strain and deprivation[29,30]) may activate more providers to address tobacco use in this vulnerable population. Additionally, healthcare systems may need to move toward models of care that do not rely on physician orders and that address the needs of patients being seen for a nontobacco-related psychiatric problem. These models may include proactive treatment, wherein tobacco users are identified via the electronic health record and proactively contacted by nonphysicians for tobacco treatment offers, which have been shown to be effective in primary care and mental healthcare settings yet are not widely disseminated.[31,32]

Limitations

The NAMCS relies on self-reported physician behavior, and there is a risk of misreporting. Although physician reporting on the NAMCS forms has performed well when compared with direct observation, behavioral counseling is often under-reported by physicians.[33] Thus, the cessation counseling rates identified here may be underestimated.[33] Another limitation is in the evaluation of cessation medication prescriptions. Though the NAMCS data set allowed for the analysis of Zyban, which is prescribed specifically for tobacco cessation, it was not possible to assess prescriptions of bupropion for tobacco use cessation, as bupropion is also prescribed for depression. Therefore, the cessation medication prescription rate may be underestimated. Lastly, this analysis did not include patients without a psychiatric diagnosis, so it is not possible to determine the extent to which the mental health−related tobacco use disparities reported in prior literature are driven by disparities in screening and treatment by providers.

CONCLUSIONS

Despite the emphasis in the past 30 years on the need to identify and treat tobacco users with psychiatric diagnoses, most tobacco users with psychiatric diagnoses are not treated routinely for tobacco use by their physicians. Moreover, there are persistent tobacco use screening and treatment disparities within psychiatric populations, leaving subgroups of patients (e.g., black Medicaid patients seen for a psychiatric condition) with especially high vulnerability to being underscreened and undertreated. There is an urgent need to expand equitable healthcare system−based tobacco control efforts for people who have a psychiatric diagnosis.

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