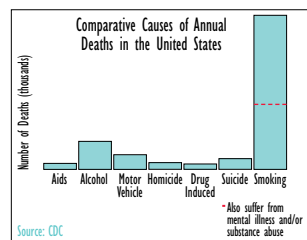


Smoking

Cessation in Psychiatric Facilities

Smoking in mental health facilities does not make sense. On the one hand, Americans pump millions of dollars into mental health systems to treat people with mental illnesses and assist with their recovery. Yet at the same time, mental health systems have not only granted people with mental illnesses the “right” to smoke in psychiatric treatment facilities, but for decades it has been actively encouraged. When developing treatment plans, mental health systems have overlooked the fact that mental health consumers smoke, believing they do not want to stop smoking and cannot handle the stress of quitting. Despite good intentions, mental health systems have unwittingly played a role in the number one contributor to death among psychiatric patients: cigarette smoking.

That has been the history, but it does not have to be the future. Mental health systems are now armed with new information from the National Association of State Mental Health Program Directors (NASMHPD) that people with serious mental illnesses die an average of 25 years earlier than their non-mentally ill peers (2006). And, most of these deaths are due to preventable diseases linked to smoking including heart disease and cancers. From a behavioral health perspective, there is emerging interest in bringing the issue and consequences of smoking to much greater light in the substance abuse field and there have been isolated pockets of some great strides in doing so (in New York State, for example).



The American public knows that smoking kills. However, the Centers for Disease Control and Prevention released data that few people are aware of. The new data shows that up to 75 percent of individuals with serious mental illnesses or addictions smoke cigarettes compared with 21 percent of the general population (2007). And, this issue impacts staff as well — 30 percent to 35 percent of behavioral health treatment staff smoke, again much higher than the rate of the general population. Alarming, people with mental illnesses and substance abuse disorders smoke 44 percent of all cigarettes consumed in the U.S. (Lasser, et al., 2000). Few of us are aware that half of all deaths due to smoking in the U.S. occur among individuals with mental illnesses (Lasser, et al., 2000).

In addition to early, preventable death — the ultimate price to pay — there are other serious clinical consequences to smoking. Smokers with schizophrenia experience increased psychiatric symptoms, more hospitalizations and a need for higher medication doses. In fact, smoking increases the metabolism of some psychiatric medications (e.g., Haldol, Prolixin, Olanzapine, Clozapine, Mellaril, and Thorazine) to such an extent that smokers need almost double the regular dose (el Guebaly, et al., 2002). This interaction is

particularly problematic when people leave those inpatient care settings where smoking was prohibited or curtailed and resume their pack-a-day habit upon returning to their community. This change in smoking pattern may cause medication blood levels to drop, resulting in a psychiatric relapse.

An estimated 37 percent of psychiatric hospitals still allow smoking inside their facilities (Monihan, Schacht & Parks, 2006). Until recently many mental health systems allowed smoking to continue for a number of reasons. They used smoke breaks as a reward or incentive for patient compliance, relied upon tobacco use to decrease agitation in patients, believed that most smokers cannot or will not quit, feared the reaction of patients and advocates if a ban was instituted and depended on revenue from tobacco sales as discretionary income for facilities (Monihan, Schacht & Parks, 2006).

Another hurdle preventing mental health systems from tackling this issue is the tension around consumers’ “right” to smoke. Decisions about when, what, and how much to smoke are among the few choices consumers are allowed to make in many systems of care. Historically, smoking has been viewed by many as a “normalizing” activity that is common among consumers, staff members and people outside of the mental health system; some consumers view smoking prohibitions as a violation of their autonomy and privacy rights. Many staff members share a resistance to smoking cessation efforts; staff who smoke fear they will lose their jobs if they cannot quit.

In other instances, mental health systems feel free to prohibit or restrict patients’ legal choices (e.g., consumption of alcohol) based upon concerns about individual health effects and potential harm to others. Similarly, mental health professionals should address the health hazards posed by smoking. In addition to the health risks faced by smokers and those exposed to second-hand smoke, smoking has a negative effect on the therapeutic environment. Mental health administrators report that smoking-related issues are a precursor to events that lead to patients’ seclusion or restraint; result in threats and coercion between patients; cause environmental health problems in the milieu; contribute to elopement during smoke breaks; and lead to fires related to smoking materials (Monihan, Schacht & Parks, 2006).

However, the most compelling impetus to act revolves around the fundamental reason mental health systems exist: *to treat people with mental illnesses and facilitate their recovery*. The mental health system is responsible for teaching, facilitating and supporting consumers’ decision making and for providing an environment that fosters this process. Smoking creates insurmountable health hurdles that derail patients’ efforts to recover and lead healthy, productive lives; it also interferes with their right to a safe, healthy and effective treatment environment.

Psychiatric facilities that went smoke free found these advantages: improved health of patients, cleaner grounds/environment, and more time for treatments. After implementing no smoking policies, they also found a decrease in behavioral problems related to smoking habits, less violence and increased staff satisfaction after implementing no smoking policies (Monihan, Schacht & Parks, 2006). Staff in inpatient psychiatric settings worry because they believe that smoking-related problems will erupt if a smoking ban is instituted. However, a review of findings from 26 international studies found there was no increase in aggression, use of seclusion, discharge against medical advice or increased use of as-needed medication following the ban (Lawn & Pols, 2005).

In addition to helping patients and staff, smoking cessation activities improve the health of the smokers' family and friends by reducing their exposure to secondhand smoke. In inpatient settings that still permit smoking, fellow patients and staff are subjected to secondhand smoke from primary smokers. Almost half (48 percent) of non-smoking patients indicated they were bothered by other patients smoking, with 30 percent of those saying they were too intimidated to ask that the smokers stop. Similarly, 30 percent of non-smoking patients were uncomfortable with staff smoking, with 22 percent of them uncomfortable with asking staff to stop.

However, simply banning smoking in mental health settings is not the answer. Mental health professionals must actively support consumers' and staffs' efforts to quit smoking.

National Leadership Emerges

It's in recognition of these alarming outcomes and systems failures that the National Association of State Mental Health Program Directors recently issued a strong position statement stating, "Silently and insidiously tobacco sales and tobacco smoking became an accepted way of life not only in our society, but also in our public mental health treatment facilities... As individuals committed to supporting health, wellness and recovery, and entrusted with the care and management of consumers and staff in our facilities and of limited public funds, we must act on what we know. Therefore, NASMHPD stands against tobacco and will take assertive steps to stop its use in the public mental health system" (2006, July).

NASMHPD has indeed undertaken several important activities to honor its position: its Medical Director's Council issued a technical report on smoking policy and treatment in public psychiatric hospitals (2006); NASMHPD relied on a diverse group of stakeholders to develop and publish a technical assistance tool kit designed to assist psychiatric hospitals become smoke-free (2007); and it is one of the founding organizations in the new National Mental Health Partnership on Wellness and Smoking Cessation, a consortium of more than 25 national mental health and tobacco cessation organizations convened by the Smoking Cessation Leadership Center at the University of California, San Francisco. In recognition of the huge toll that smoking exacts on people with addictions, and on people with co-occurring mental illnesses and substance use disorders, there is growing interest and commitment to expanding the focus of the National Partnership to include addiction-focused organizations.

Smoking Cessation Interventions Work

Up to 70 percent of smokers, including those with mental illnesses, want to quit (Prochaska, et al., 2004). For many consumers, they want to quit smoking due to the cost of cigarettes and health concerns. While some have attempted to quit, few consumers successfully

quit on their own. The good news is that there are effective smoking cessation interventions that can help.

Clinicians can and should incorporate cessation interventions into treatment plans. A physician asking his/her client about tobacco use has shown to impact the client's attempts to quit, but only 50 percent of smokers report having received smoking cessation advice from their doctors in the past year; 25 percent of those sought and received further counseling and assistance. With help from a clinician, the number of patients who quit smoking doubles (Fiore, et al., 2000).

In both community and inpatient settings, mental health professionals can provide information, offer counseling and evaluate (or make referrals) for nicotine replacement therapy and/or other drugs. These approaches are useful for staff members who smoke as well. 1(800) QUIT-NOW is a national quitline number that offers free, telephone guidance 24/7 by trained tobacco cessation counselors. Evidence suggests use of a quitline can more than triple success in quitting. Almost a quarter of patients in one study who had multiple quitline sessions were abstinent after 12 months (Zhu, 2002). It is quick and easy for health professionals to refer patients to quitlines.

All people — consumers, staff members, friends and family — deserve a life that is healthy, both mentally and physically. If mental health systems are to help consumers achieve this goal, we must open our eyes to the ravages caused by smoking and act with purpose to change. ▼

Gail P. Hutchings is President and CEO of the Behavioral Health Policy Collaborative, LLC in Alexandria, VA. She is the lead mental health consultant to the Smoking Cessation Leadership Center at the University of California, San Francisco and is the former Chief of Staff of the Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services. She may be contacted by email at GHutchings@BehavioralHealthPolicy.com.

References

- Centers for Disease Control and Prevention. (2007). Cigarette Smoking Among Adults—United States, 2006. *Morbidity and Mortality Weekly Report* [serial online], 56(44), 1157-1161. Retrieved March 2, 2008 from: <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5644a2.htm>.
- el-Guebaly, N., Cathcart, J., Currie, S., Brown, D. & Gloster, S. (2002) Public Health and Therapeutic Aspects of Smoking Bans in Mental Health and Addiction Settings. *Psychiatric Services*, Vol. 53, No. 12, 1617-1622.
- Fiore, M.C., Bailey, W.C. & Cohen, S.J., et al. (2000). Tobacco Use and Dependence Clinical Practice Guideline Panel, Staff, and Consortium Representatives. A clinical practice guideline for treating tobacco use and dependence: a U.S. Public Health Service report. *Journal of the American Medical Association*, 283, 3244-3254.
- Lasser, K. et al. (2000). Smoking and mental illness: A population-based prevalence study. *JAMA*, 284(20), 2606-2610.
- Lawn, S. & Pols, R. (2005). Smoking Bans In Psychiatric Inpatient Settings? A Review of the Research. *Australian and New Zealand Journal of Psychiatry*, 39:866-885.
- Monihan, K.M., Schacht, L.M. & Parks, J. (2006, June). A comparative analysis of smoking policies and practices among state psychiatric hospitals. Alexandria, Virginia: National Association of State Mental Health Program Directors Research Institute, Inc.
- National Association of State Mental Health Program Directors Medical Directors Council (2006). *Morbidity and mortality in people with serious mental illness*. Alexandria, Virginia: National Association of State Mental Health Program Directors. Retrieved from http://www.nasmhpd.org/general_files/publications/med_directors_pubs/Oct2006%20Final%20Report%20on%20Smoking%20Policy%20and%20Treatment%20atState%20Operate d%20Psychiatric%20Facilities.pdf.
- National Association of State Mental Health Program Directors. (2006, July 10) *Position Statement on Smoking Policy and Treatment at State Operated Psychiatric Hospitals*. Alexandria, Virginia: National Association of State Mental Health Program Directors. Retrieved from http://www.nasmhpd.org/general_files/publications/med_directors_pubs/Oct2006%20Final%20Report%20on%20Smoking%20Policy%20and%20Treatment%20atState%20Operated%20Psychiatric%20Facilities.pdf.
- National Association of State Mental Health Program Directors Medical Directors Council. (2006). *Technical Report on Smoking Policy and Treatment in State Operated Psychiatric Facilities*. Alexandria, Virginia: National Association of State Mental Health Program Directors. Retrieved from http://www.nasmhpd.org/general_files/publications/med_directors_pubs/Oct2006%20Final%20Report%20on%20Smoking%20Policy%20and%20Treatment%20atState%20Operated%20Psychiatric%20Facilities.pdf.
- National Association of State Mental Health Program Directors. (2007). *Tobacco-Free Living in Psychiatric Settings: A Best-Practices Toolkit Promoting Wellness and Recovery*. Alexandria, Virginia: National Association of State Mental Health Program Directors. Retrieved from http://www.nasmhpd.org/general_files/publications/NASMHPD_toolkitfinalupdated90707.pdf.
- Prochaska, J.J. et al. (2004). Depressed smokers and stage of change: implications for treatment interventions. *Drug Alcohol Dependence*, 76, 143-151.
- Zhu, S.H., Anderson, C.M. & Tedeschi, G.J. et al. (2002). Evidence of real-world effectiveness of a telephone quitline for smokers. *N Engl J Med*. 347: 1087-1093.