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Smoke-free policies in the psychiatric population on the ward and beyond: A discussion paper

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Abstract

Healthcare facilities from a number of countries have or are in the process of implementing smoke-free policies as part of their public health agenda and tobacco control strategy. Their main intent is to prevent the harmful effects of environmental tobacco smoke on employees and patients. However, these protection policies are often implemented before taking into account the specific needs of patients in psychiatric facilities and are clouded by a lack of knowledge, myths and misconceptions held by a variety of stakeholders. Consequently, the implementation of smoke-free policies tends to result in unintended and unfavourable consequences for this aggregate. Patients are forced to abstain from tobacco use during their hospitalization but have few options to address their dependence upon discharge. The development and implementation of such policies should not occur in isolation. It requires thoughtful consideration of the needs of the affected population. Recommendations are presented on the role of nurses in lobbying for policy changes. As well as strategies for policy makers and administrators that should accompany such a policy in psychiatry.

Keywords: Smoke-free policies in psychiatry; Smoking and mental illness; Tobacco dependency; Tobacco use in psychiatry

What is already known about the topic?

- There is a growing awareness and concern about the high rates of tobacco use among people with mental illness compared to the general population and the concomitant impact on the physical, psychological and financial health of this population. Smoking prevalence rates have been cited as high as 88% for people with mental illness. An increasing number of health care facilities around the world have or are in the process of implementing smoke-free policies as part of their tobacco control strategies. Psychiatric units pose a particular challenge given the historical use of tobacco as a therapeutic intervention and the neurobiological, psychological, behavioral and social factors that contribute to the complex relationship between nicotine and mental illness.

What this paper adds

- This paper summarizes and synthesizes the literature regarding tobacco use in individuals with mental illness and smoke-free policies in psychiatry.
- It questions the development of smoke-free policies in psychiatric facilities and the lack of attention to the needs of individuals with mental illness with respect to the narrowness of the policy. This type of policy focuses on the protection of staff and the general population from environmental tobacco smoke as opposed to developing smoking cessation strategies for those most affected by such a policy; the patients.
- It provides recommendations on the role of the psychiatric nurse in addressing tobacco use in individuals with mental illness that range from micro to macro level interventions.

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1. Introduction

Health care facilities in a number of developed countries are in the process of implementing smoke-free policies which are framed within a larger tobacco control strategy. The main purpose of the policy is to protect individuals in these facilities including patients, residents, staff, contractors, students/trainees, volunteers and the general public from the harmful effects of exposure to second-hand smoke (Parle et al., 2005; Winnipeg Regional Health Authority, 2004).

While implementation of such policies on most inpatient units occurs with minimal concern, there is an ongoing debate about whether or not to exempt psychiatric inpatient units. In the United States all hospital buildings were to become smoke-free in 1992, including psychiatric inpatient units (Prochaska et al., 2004), although a recent US survey indicated that many psychiatric hospitals still allow patients to smoke (Matthews et al., 2005). The United Kingdom is currently in the process of implementing smoke-free environments in public and work places in England and Wales (Campion et al., 2006; McNally et al., 2006). The smoking ban came into force on 1 July 2007 (Wilkinson, 2007), however, its application in psychiatric settings is still a matter of debate amongst some clinicians who argue that it might not be entirely beneficial and that some patients in psychiatry should be exempt (Arnone and Simmons, 2007). The trend towards 100% smoke-free health care facilities began in Canada in 2003 and continues to spread across the country (Parle et al., 2005).

There is an increased interest in addressing tobacco use among the psychiatric population, which is encouraging. However, there is a reluctance to implement a smoke-free policy in psychiatric inpatient units. Concerns regarding a rise in behavioral disruptions and greater mental stress by patients are raised as reasons for maintaining a smoking policy. Further, where smoke-free policies exist, there tends to be little or no implementation of smoking cessation strategies that enable the patient to remain a non-smoker for longer than their brief hospital stay (el-Guebaly et al., 2002). Rather, the primary goal of a smoke-free policy is the protection of individuals in that institution from second-hand smoke.

The purpose of this paper is to discuss the insights obtained as a result of the decision to implement a smoke-free policy in psychiatry at a tertiary care facility in Canada. The factors that influence the reluctance to implement a smoke-free policy for psychiatric inpatients and the lack of a holistic view of their health needs when such a policy is implemented will be discussed. The myths and misconceptions held by the various stakeholders, policy makers and employees that play a role in the development and implementation of such a policy will be highlighted. A discussion of the factors that should influence the development of a smoke-free policy and the role of the psychiatric nurse is provided with recommendations for a more comprehensive approach (the term psychiatric nurse refers to nurses working with individuals who have a serious and persistent mental illness in either an inpatient, outpatient or community setting).

Finally, the authors hope to encourage more dialogue between the world of tobacco control, the mental health, addictions and self-help/advocacy communities. Interaction between these communities with respect to tobacco control is in its infancy. However, such interaction is critical if successful strategies are to be developed and implemented to decrease tobacco use among individuals with serious and persistent mental illness.

2. Tobacco use in the psychiatric population

In the last decade, published literature demonstrates a growing awareness and concern about the high rates of tobacco use among individuals with mental illness as compared to the general population. A United States population-based study that examined associations between type and the likelihood of smoking concluded that individuals with mental illness were about twice as likely to smoke as other persons (Lasser et al., 2000). Based on American and Australian studies, smoking prevalence rates have been cited as high as 88% for individuals with mental illness (Lawn and Pols, 2005) with similar rates reported in several other countries, such as Spain, Japan, Taiwan and India (Ziedonis and Williams, 2003). Additionally, between 50 and 70% of cigarettes consumed in the United States are likely smoked by individuals with psychiatric disorders (Ziedonis and Williams, 2003). Consequently, this population has two to three times the risk of developing tobacco-related medical illness as the general population (Ziedonis and Williams, 2003).

Biological, psychological and social factors have all been cited in the literature as playing a role in smoking and mental illness (Ziedonis and Williams, 2003). However, the marketing of cigarettes by the tobacco industry to this special population is also a factor. In an attempt to target and exploit the unique psychological/psychosocial needs of smokers, industry documents from The R.J. Reynolds Tobacco Company revealed that social interaction, mood enhancement, positive stimulation and anxiety relief were examined as part of their marketing strategy (Reynolds, 1981; LeCook et al., 2003). The tobacco companies have identified the mentally ill (in the same way they have identified other marginalized groups such as minorities) as part of their ‘‘downscale market’’, i.e. less-educated than others, more literal, usually not in college and into escapism (Reynolds, 1989). Researchers analyzed approximately 400 tobacco industry documents from 1977 to 2000 made available from legal settlements in the United States between the state attorney general and tobacco industry companies. They concluded that the industry tried to gain positive media coverage and political support through philanthropy and outreach cam-

paigns to the homeless and seriously mentally ill (Appollonia and Malone, 2005).

Financially, the consequences of tobacco use for this population are significant in that many people with mental illness are often on limited incomes. An American study ($N = 78$) on motivational interviewing in smokers with schizophrenia or schizoaffective disorder reported that 87.2% of participants were receiving public assistance and the median percentage of income spent on cigarettes per month was 27.36% (Steinberg et al., 2004).

Tobacco use is a serious problem for individuals with mental illness. Various societal myths and misperceptions exist during the formulation and implementation of smoke-free policies and the unique challenges faced by the psychiatric population in abstaining and quitting smoking are often not taken into account.

3. Myths and misperceptions of smoke-free policies and the psychiatric population

The perception that smoking is an acceptable cultural norm for individuals with mental illness has been a long held belief by society and health care providers. Smoking has been a part of the psychiatric culture for many years with providers often joining patients to smoke as a way to establish a therapeutic relationship or to reward desired behavior (Dickens et al., 2004). Consequently, both patients and staff developed a very convoluted relationship with tobacco. The idea of imposing smoking bans in psychiatric settings is thought to be a recent phenomenon (Lawn and Condon, 2006).

The challenges discussed in the literature concerning implementation of a smoking ban in psychiatry are many. Psychiatric nurses frequently express concern that conflict over a no smoking policy will harm their therapeutic relationship with their patients. Doubt is often expressed that the effort required to implement a smoke-free policy given the high rates of smoking in those with mental illness is not worth the attempt or that patients will discharge themselves against medical advice (Bloor et al., 2006; Matthews et al., 2005). A common belief of psychiatric nurses is that patients will find it difficult if not impossible to quit given their high rates of smoking and will become aggressive if not allowed to smoke.

Research suggests that psychiatric nurses who smoke often have more negative attitudes towards smoking bans and believe tobacco use is therapeutic for their patients (Bloor et al., 2006; Dickens et al., 2004). Canadian, Australian and American researchers report aggression does not increase with the implementation of smoking bans in psychiatric facilities (el-Guebaly et al., 2002; Lawn and Pols, 2005; Matthews et al., 2005). A total of 48 studies were examined as part of a literature review by Canadian and Australian researchers. The importance of prescribing nicotine replacement therapy once a ban is implemented to ameliorate any deleterious effects from abstinence was highlighted by American researchers. In an analysis of 250 medical records, Prochaska et al. (2004) concluded that smokers who were not given a prescription for nicotine replacement therapy were more than twice as likely as non-smokers and smokers who received a prescription to be discharged from hospital against medical advice. Lastly, research studies indicate that individuals with serious mental illness are interested in quitting smoking (Addington et al., 1998; Green and Clarke, 2005; Van Dongen et al., 1999).

4. Development of smoke-free policies

In Canada, smoke-free policies were developed after a decision in 2002 by the Ontario Workers' Compensation Board in Ontario to accept a claim by a hospitality employee who developed and subsequently died of lung cancer (despite never being a smoker). Consequently, other provincial governments made amendments to their Health Protection Acts out of concern that they may be liable for future claims if legislation to protect workers from the effects of tobacco smoke were not implemented (Province of Manitoba, 2003, 2004).

The main problem with most smoke-free policies with respect to individuals with mental illness in Canada and the United States is that they were not developed to address the issue of smoking in this special population. Instead, they are often a byproduct of broader policies on tobacco control that have arisen out of legislative changes at the local level spurred on by various interest groups; to being part of the larger national and international debate on the dangers of environmental tobacco smoke. The focus is on the protection of workers, workplace safety and industrial hygiene (for example, prevention of product contamination) (Farkas et al., 1999).

While workplace bans are critical to tobacco control, they have very little impact on reducing smoking in the psychiatric population. A literature review by a team of Canadian researchers on smoking bans found that the policies did not produce behavioral indicators of unrest or non-compliance as are often feared. However, neither did the policies have any significant effect on smoking cessation. Consequently, they concluded that smoking cessation strategies need to be an inherent component of smoke-free policies, i.e. nicotine dependence treatment needs to be more fully integrated into most programs (el-Guebaly et al., 2002).

5. Implementation of smoke-free policies

Several factors need to be taken into account by policy makers and psychiatric nurses when considering the implementation of smoke-free policies in psychiatry. A review of 26 international studies on smoking bans in psychiatric inpatient settings concluded a number of measures need

to be considered in order to introduce effective smoking bans. A multi-level, multidisciplinary approach was recommended. It included significant consultation and collaboration with all stakeholders, developing alternative activities to smoking, introducing dietary changes, providing clear guidelines for staff and patients, and involving family members (Lawn and Pols, 2005).

Smoking often provides structure and facilitates socialization for psychiatric patients in the hospital and at home. Their ability to socialize may be compromised due to their illness or because they lack sufficient funds for leisure activities. When smoking bans are implemented the individual may lose their ability to connect to other patients, particularly if the unit does not offer sufficient activities or groups (el-Guebaly et al., 2002; Forchuk et al., 2002). Alternative activities and dietary changes within a facility need to be created by psychiatric nurses as a means of socialization and to promote a healthy lifestyle. For example, psychiatric nurses on inpatient units may have to consider offering relaxation, social skills and fitness groups. Nutritious snacks should be offered frequently to assist patients with abstinence. Smoking rooms need to be renovated to ensure there is no incentive to re-open them for smokers as the smoke-free policy is being implemented. Nicotine replacement therapy may have to be added to the hospital formulary to address nicotine withdrawal in patients and staff may need to be trained on how to administer it (Lawn and Condon, 2006).

There may also be an issue of how patients will afford nicotine replacement therapy (NRT) upon discharge as income security programs may not cover it once a patient is out of hospital. Implementing a smoke-free policy that is holistic will require additional expenditures that need to be taken into consideration. Psychiatric nurses can remind policy makers that these types of expenditures need to be taken into account. It is important to ensure funds are in place to address the consequences of the smoke-free policy in this population.

Policy makers need to assess the impact of the ban within the facility. However, they also must consider what supports are available to patients once they leave the hospital. Smoke-free policies force patients to abstain while they are admitted to a facility but make no provision to assist them with long-term smoking cessation upon discharge. Debates between the community and hospital administrators can result in a lack of smoking cessation programs to the detriment of patients. However, it is the responsibility of all programs regardless of location to work together to address the high rates of smoking in their patients.

There is greater recognition that co-occurring disorders (i.e. the existence of both mental illness and substance use disorders) are quite prevalent among the psychiatric population. In both the United States and Canada, initiatives are underway to create linkages between service providers in both systems to improve treatment of all existing disorders simultaneously (rather than separately as has been the practice in the past) (Health Canada, 2003; Minkoff, 2004). For example, service providers in both systems attend the same training sessions on addictions. Unfortunately, these initiatives often do not include tobacco use.

Finally, self-help/advocacy groups were visibly absent during the implementation of smoke-free policies in our area. A search of Pub Med did not produce any significant results on mental health self-help groups and tobacco use. None of the self-help groups in Canada (Schizophrenia Society of Canada, Mood Disorders Society of Canada) have policy statements on tobacco use and mental illness. The national website for the Canadian Mental Health Association did have ''Stop Smoking website links''. A policy statement on tobacco use and mental illness from the schizophrenia self-help organization in England was located on the web (Rethink Policy Statement, 2003).

6. Recommendations

The literature on smoking cessation in the psychiatric population is increasingly calling for those in the mental health and addiction communities and we would add the tobacco control and self-help/advocacy communities, to address the issue of tobacco use in individuals with mental illness (el-Guebaly et al., 2002; Parle et al., 2005; Ziedonis and Williams, 2003).

Australian researchers argue that imposing bans on inpatient units is only part of a larger strategy needed to address the high rates of smoking in individuals with mental illness (Lawn and Pols, 2005). Smoke-free policies need to move beyond forced abstinence, to a coordinated response among all programs to assist individuals with mental illness to reduce their high rates of tobacco use. The following is a list of recommendations for policy makers and psychiatric nurses (ranging from the individual, program and systems level) to address the issue of tobacco use in the psychiatric population in a more substantive manner.

1. Systemically and programmatically, tobacco use needs to be viewed as an addiction and part of the co-occurring disorders or poly-drug use spectrum just like any other substance, so that the treatment cultures of the psychiatric and addictions settings will treat it in earnest. Traditionally, smoking has not been discussed or treated like drug or alcohol addictions, yet it is a substance psychiatric patients commonly abuse (Ziedonis and Williams, 2003). It is the clinical experience of one of the authors that patients and service providers rarely view smoking in the same light as other addictions, despite the fact that nicotine is a drug and nicotine dependence and nicotine withdrawal is listed in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) (American Psychiatric Association, 1994).
2. Departments of Health need to liaise with those departments responsible for income security to have the cost of

nicotine replacement therapy covered once patients leave hospital. Many patients are on a limited income or are supported by income security programs that may not cover this cost once patients are discharged from hospital.

3. More comprehensive tobacco dependence assessments and training needs to be developed for psychiatric nurses. There are numerous medications for nicotine dependence treatment and psychosocial treatments discussed in the literature to assist patients with smoking cessation but they are not commonly known or used (Kalman et al., 2005; Prochaska et al., 2005; Ziedonis and Williams, 2003). It is important that resources be made available to develop and offer smoking cessation interventions specifically for individuals with mental illness when they are hospitalized (and are forced to abstain from tobacco use due to smoking bans), in the outpatient department or in the community.
4. Programs may need to be modified to accommodate decreased concentration and deficits with information processing (Addington et al., 1998; George et al., 2000). It is the lead authors' clinical experience that generic programs such as telephone help lines, self-help materials, online help and individual counselling may not be well suited to the psychiatric population. They are often costly, held in inaccessible locations, are difficult for those with cognitive deficits to follow and tend to cater to a more upscale demographic than that of most individuals with mental illness. The lead author discovered that when a smoking cessation group was offered to women with schizophrenia that participants did not want an abundance of written material and that the relaxation component of the program was rated as the most helpful with cessation efforts.
5. Clinicians may need to take into account the unique needs of individuals with psychiatric conditions who are trying to quit smoking. Tobacco use and abstinence can affect blood levels of psychiatric medications, with implications for mental and physical status. For example, plasma levels of clozapine and olanzapine can increase with smoking cessation (Zullino et al., 2002; Evins, 2007).
6. The US Clinical Practice Guidelines (American Medical Association, 2000) and the American Psychiatric Associations' (APA) Nicotine Dependence Treatment Guidelines (American Psychiatric Association, 1996) are useful resources to access for those wishing to help people with mental illness quit smoking. The practice guidelines recommend first-line medications such as sustained-release buproprion hydrochloride, nicotine gum, nicotine inhaler, nicotine nasal spray and the nicotine patch. However, they have limited information on behavioral therapies for smokers with psychiatric disorders. The APA provides information on psychosocial treatments such as motivational enhancement therapy, cognitive behavioral therapy and other behavioral therapies. However, their guidelines are outdated with respect to the latest FDA approved medications (Ziedonis and Williams, 2003). A review article by Kalman et al. (2005), the APA Practice Guidelines for the Treatment of Patients with Substance Use Disorders (2005) and the APA Guideline Watch (2007) provides more up to date information in this area. A recent review of developments in pharmacotherapy for tobacco dependence concluded that continued research is still required in individuals with mental illness given their unique needs (Foulds et al., 2006).
7. Motivation and timing of the quit attempt may also be an issue in the psychiatric population. There is often a debate among clinicians that patients should not quit during recovery from an episode while in hospital or while trying to quit other addictions. Clinicians may wonder if an individual should simultaneously quit all substances? Or, at what stage in recovery from the psychiatric disorder should treatment of nicotine dependence occur? (Ziedonis and Williams, 2003). Currently, there is a move in the addictions field to address all addictions simultaneously, including smoking (Fuller et al., 2007; Fogg and Borody, 2001). However, there is conflicting evidence in the literature regarding timing of the quit attempt with some researchers recommending sequential treatment of the psychiatric disorder and or substance disorder first and then treatment of nicotine dependence (Kalman et al., 2005). Assessing readiness to change and the level of motivation to quit is essential to determine the type of intervention required (Cataldo, 2001; Synder, 2006)
8. Finally, psychiatric nurses can offer alternative health care treatments such as meditation, massage, yoga and guided imagery in addition to support groups, exercise and pharmacologic interventions as additional avenues for treatment of tobacco use (Synder, 2006).

All health care professionals have a responsibility to address tobacco use in their patients including psychiatric nurses. Nurses in this area have frequent contact and are often addressing other types of addictions with their patients. In addition, their counselling skills make them well suited to incorporate this issue into their role (Cataldo, 2001). Opportunities to address such use can begin on the ward and continue in the outpatient or community setting once patients leave the hospital. Research indicates that nurses in psychiatry require institutional support to incorporate this issue within their clinical role since they may have relied on the use of cigarettes to facilitate patient interaction and reduce role conflicts (Lawn and Condon, 2006).

7. Conclusion

Over the last decade the international community has come to accept the dangers of second-hand smoke and has passed legislation to ban smoking in public places indoors (including workplaces) due to pressure from special interest

groups and the general public. Unfortunately, individuals with mental illness have only partially benefited from this movement, although this is understandable given the long history of tobacco use in the psychiatric population.

Few recognize how ignoring tobacco perpetuates the stigma associated with mental illness and addiction when some ask 'why should tobacco be addressed in mental health or addiction settings? (...) These questions reflect stigma towards this specific population, as we do not ask this question of the general population (Ziedonis and Williams, 2003, p. 306).

It behooves those in the psychiatric, addictions, tobacco control and self-help/advocacy communities to move beyond protecting individuals from the harmful effects of second-hand smoke to assisting individuals with severe and persistent mental illness (who have one of the highest rates of smoking and one of the worst financial and health consequences) to address their tobacco use. Smoke-free policies need to be revised to include a more holistic interdisciplinary, cross-agency/community approach that includes strategies to help individuals with mental illness (who are forced to stop smoking when institutionalized) to remain smoke-free after discharge.

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