

Commentary | February 6, 2008

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The US public mental health system must address the issue of tobacco use in psychiatric hospitals. Programs that treat behavioral health problems such as depression or schizophrenia are the only remaining sector of health care that fail to systematically help patients quit smoking. At state-funded psychiatric hospitals, medical directors and administrators are attempting to enact policies that restrict tobacco use in these facilities—not only in buildings but on all adjacent outdoor areas or grounds. Some advocates for the mentally ill are opposing these policy changes, using legal means to stall or overturn them. A lawsuit was filed in September 2007 by 6 patients against the largest state hospital in Connecticut, claiming a violation of their civil rights by the restriction of smoking at the facility.¹ Other psychiatric hospitals have faced similar cases and opposition from local disability rights groups.²⁻⁴ The mere threat of legal or political action has been effective in getting states to rescind or exempt psychiatric or addictions treatment facilities from tobacco-free policies.^{3,5}

Tobacco-free hospital policies are intended to create a healthy environment for everyone who receives care, visits a patient, or works in these facilities. The state psychiatric hospitals of several states including New Jersey, Connecticut, and the Commonwealth of Virginia are in the early stages of becoming tobacco free and need the help and support of mental health advocates. As mental health systems move toward addressing tobacco use, advocates can provide an important role in demanding increased access to tobacco dependence treatment and increasing staff education on the evidence-based treatments. Only then can more individuals with mental illness successfully overcome nicotine addiction and strive toward full mental health recovery.

✓ In 2006, a report from the National Association of State Mental Health Program Directors showed that individuals with serious mental illness die, on average, at least 25 years earlier than the general population.⁶ Cardiovascular or heart disease is the leading cause of death among patients with serious mental illnesses, resulting in more deaths than from injuries or obesity-related diseases such as diabetes.⁷ A survey of 222 state-operated psychiatric facilities in the United States found that the majority of hospitals had begun the process of becoming tobacco-free facilities or were planning to do so in the subsequent year.³ Facilities that had undergone these changes indicated improved patient health, cleaner indoor environments and hospital grounds, increases in staff satisfaction, and more time to provide treatment. These findings are consistent with national trends calling for a transformation of US mental health care to be more oriented toward wellness and recovery.⁸

State psychiatric hospitals are faced with the daunting task of treating society's most fragile members and out of compassion there are calls to "let them smoke." Smoking is an accepted part of the culture of care in some psychiatric hospitals in which staff (often those who smoke themselves) take patients outdoors to smoking shelters at several times during the day. These smoke breaks can serve both as fillers of time and as a reward activity for patients who have been cooperative with the day's events. For example, a patient newly admitted to a hospital might be under observation and not allowed to leave the ward. However, with improvement in behavior and symptoms, patients are granted privileges to go outside to smoke. Facilities often allow only a certain number of smoking breaks per day (eg, 1 per 8-hour staff shift) or restrict the number of cigarettes allowed to be smoked in a day to less than 10. The National Association of State Mental Health Program Directors survey of state-operated psychiatric facilities indicated that on average both short- and long-term hospitals provided 5 smoke breaks per

day³. These well-meaning practices that allow smoking might put smokers at risk for experiencing significant nicotine withdrawal symptoms throughout the day if they smoked much more before coming to the hospital.

Since patients are rarely allowed to have possession of tobacco products and lighters, staff (usually nursing or rehabilitation assistants) must alternatively distribute and gather tobacco paraphernalia at times of smoking breaks. Much time is spent in the bartering and control of tobacco products between staff and patients and this can be the source of conflicts and incident reports. Not surprisingly, studies of psychiatric hospitals becoming tobacco free report fewer behavioral problems and less violence after policies take effect.²⁻¹⁰

✓ Tobacco use should be characterized as an addiction and not merely a habit.¹¹ In fact, most individuals who use tobacco meet criteria for addiction.¹² There is also evidence that individuals who have mental illness smoke at higher rates, consume more tobacco, and have greater difficulty in quitting smoking.¹³⁻¹⁵ These trends are particularly true for individuals with the most severe forms of mental illnesses, who often are disabled from their illness and who use the services of the state psychiatric hospital. While nicotine may provide temporary benefit for schizophrenia¹⁶ and perhaps other illnesses,¹⁷ this benefit should not be a rationale for continued smoking. Until better treatments are available, individuals should not be subjected to a lifetime of exposure to tobacco smoke toxins and carcinogens when safe US Food and Drug Administration–approved treatments, including nicotine replacement medications, are readily available.

In the hospital setting, all patients should be given access to a safe and comfortable detoxification from tobacco, as is done with other addicting substances, to prevent the emergence of nicotine withdrawal symptoms. Pharmacotherapy may be particularly important for smokers with serious mental illness who have high levels of nicotine dependence.¹⁸⁻¹⁹ Psychiatric inpatients who were not given a prescription for nicotine replacement therapy were more than twice as likely to be discharged from the hospital against medical advice.²⁰ Moreover, patients with schizophrenia have not shown worsening of symptoms during a period of tobacco abstinence.²¹

Why then is there continued resistance and slow movement toward making all psychiatric hospitals tobacco free? The most frequently cited obstacles to change involve the professional staff and not the patients. Staff are often opposed to such policies for a variety of reasons including fear that patients will become violent, despite evidence to the contrary.^{3,9} After these changes are in place, staff typically report that they anticipated more smoking-related problems than actually occurred.^{3,9} Hospitals providing general medical care have made numerous strides becoming tobacco free. General hospitals are also a successful example of a nationwide smoke-free workplace that in addition to helping patients, improves employee health, and reduces employer costs including health care costs.²²

Exempting mental health hospitals from smoke-free laws aimed at protecting the public also has the potential to worsen health inequalities for people with mental illness and further their stigmatization. When certain groups are outside the protection of public policies or laws, that is often perceived as a form of stigma. Stigma is a resonating issue as the mental health community collectively and individually strives for greater community acceptance and integration of individuals with mental illnesses. Smokers increasingly face stigma as tobacco use rates decline and smoking is further marginalized from general society. Thus, advocacy that aims to protect smoking can further marginalize and stigmatize smokers with mental illness who are looking to succeed in securing housing and employment.

Lawsuits made on behalf of mental health patients or patient advocacy groups have almost all been in

the name of smokers' rights despite the fact that the legal precedent for support of smokers' rights has been almost nonexistent.²³ Legally, tobacco use has been deemed in courts throughout the United States to not be a right but a privilege that can be restricted when it is detrimental to others.²⁴ Organizations like the National Disability Rights Network²⁵ that form a network of congressionally mandated, legally based agencies for the protection and advocacy of individuals with disabilities should be leading tobacco-free initiatives and disseminating this information to local and state constituents. There is little legal support for the continued use of addicting substances in a supervised treatment setting that is being supported by public funds. Patients with mental illnesses deserve the same protection from tobacco exposure that benefits the rest of the public.

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Financial Disclosure: Dr Williams has reported serving on the speakers bureau for Pfizer.

Funding/Support: Dr Williams is supported in part by grants from the National Institute on Mental Health R01-MH076672-01A1; the New Jersey Department of Human Services, Division of Mental Health Services, as a consultant to the New Jersey State Psychiatric Hospitals on Addressing Tobacco; and the New Jersey Department of Health and Senior Services, Office of the State Epidemiologist, through funds from the New Jersey Comprehensive Tobacco Control Program.

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