Smoking Cessation and Mental Health Facilities

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The Problem of Smoking Cessation from a State Hospital Viewpoint

- We need to stabilize patients so they can succeed in society
- We need to get people off the substances that prevent them from functioning, such as heroin or methamphetamines
- People with mental illness and substance abuse have trouble without the added stress of tobacco cessation
- We have limited resources and need to set sensible priorities; this isn't one of them

State Hospital View (2)

- Cigarettes have a positive side; they help calm and stabilize patients and help staff manage large caseloads
- Cigarettes can motivate patients as well
- Bottom line– this just isn't a priority for us

Counterarguments

- Tobacco is the leading cause of death for patients previously treated for alcohol and other non-nicotine drugs of abuse
- Smoking exacerbates mental illness symptoms, HIV/AIDS symptoms, hepatitis C and other conditions
- Impact of exposure to secondhand smoke among nonsmoking clients and staff as well as family members (including children) is a very serious issue

Counterarguments (2)

- The real bottom line is that with evidence pouring in on the harm caused by secondhand smoke, facilities are being mandated to go smoke free; there will be no choice

And Patients Want to Quit

- Documented interest in quitting among clients across all treatment modalities
- Standard treatment approaches work with these patients (NRT plus behavioral counseling and bupropion)
- Promise of emerging new drugs
- Patients are already in a secure, supportive environment ideal for nicotine cessation

Barriers

- Staff smoke in large numbers
- Staff lacks information and training on nicotine cessation
- Tobacco use is not viewed as substance abuse
- Staff and clients smoking together is seen as informal counseling opportunity rather than a boundary or therapeutic issue

Barriers (cont.)

- Smoking viewed as a privilege and reward; programming is built around smoking breaks
- Staff give inconsistent messages about smoking in treatment settings and about stopping smoking in recovery

Misconceptions

- One drug at a time
- Quitting smoking will jeopardize sobriety
- Clients don’t want to quit
- Treatment doesn’t work
- Too much too soon
- Client is not focusing on recovery
- Will make staff unhappy

What Are the Facts About Smoking and Comorbidities?

Background

- 44% of cigarettes smoked in the U.S. are consumed by individuals with a psychiatric or substance abuse disorder.

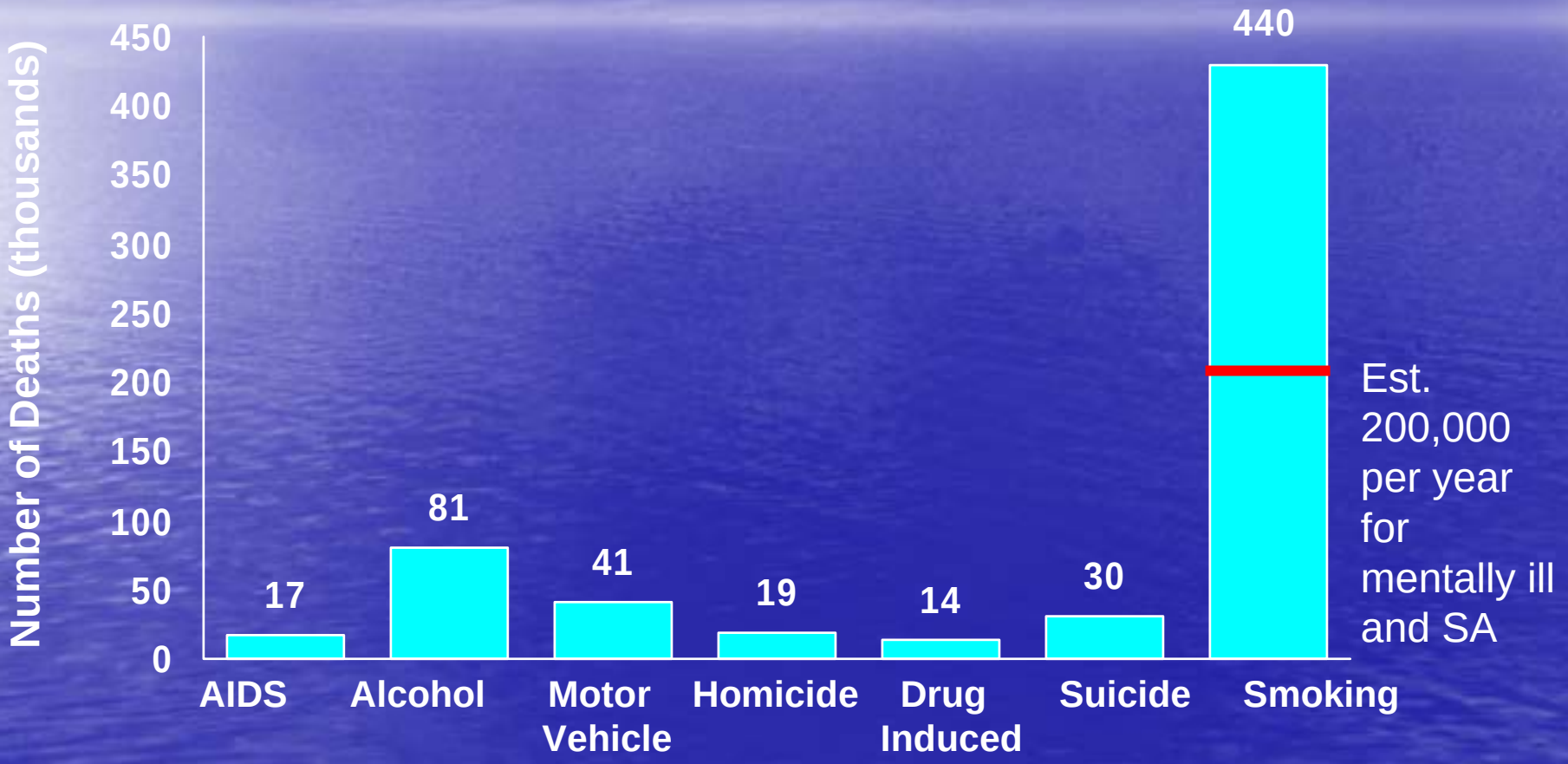
Background (2)

- Persons with mental illness are more than twice as likely to smoke as others.
- Roughly 60-95% of patients in addiction treatment are tobacco dependent.
- Of those individuals, roughly half smoke more than 25 cigarettes per day.

Background (3)

- Cigarette smoking appears consistently highest among people with psychotic disorders, but remains high also for depression, anxiety, substance abuse, and personality disorders.
- An estimated 200,000 smokers with mental illness or addiction die each year due to smoking, a figure highly disproportionate to the number of those with mental disorders in the general population.

Comparative Causes of Annual Deaths in the United States



Source: CDC

Smoking and Depression

- Rates of smoking are estimated at 50-60% in patients with a clinical diagnosis of depression.
- 25-40% of psychiatric patients seeking smoking cessation treatment have a past history of major depression or minor dysthymic disorder.

Smoking and Schizophrenia

- Patients with schizophrenia smoke at three times the rate of the general population.
- Some studies show prevalence rates as high as 90%.

Smoking and Schizophrenia (2)

- Smokers with schizophrenia experience increased psychiatric symptoms, number of hospitalizations, and need for higher medication doses.
- The metabolism of tobacco (not nicotine) can dramatically affect psychiatric medication dosing requirements and blood levels by affecting the P450 liver cytochrome enzymes.
- Often smoking requires a ***doubling*** of medication dosage.

Anxiety Disorders and Tobacco

- The presence of an anxiety disorder with or without concurrent depression is associated with an increased likelihood of smoking.

Anxiety Disorders and Tobacco (2)

- Smoking has been found to be a risk factor for the onset of panic disorder; elevated smoking rates are observed in patients with chronic panic disorder.
- Despite patients' subjective reports that smoking reduces anxiety, chronic nicotine use in animals is related to increased anxiety.

Smoking and Alcohol Dependence

- Smokers have a 2-3 times greater risk for alcohol dependence than nonsmokers.
- An estimated 80% of alcoholics currently smoke.

Smoking and Alcohol Dependence (2)

- More alcoholics die from smoking-related diseases than from alcohol- related ones.
- Both founders of Alcoholics Anonymous died from their tobacco addictions.

Smoking and Other Substance Abuse

- Smoking rates are 2-3 times higher among drug addicts than the general population .
- Surveys have reported 85-98% smoking prevalence rates in methadone maintenance program patients.

A Targeted Population

- As smoking prevalence declines, a greater proportion of smokers are in this population
- Tobacco companies actively target the mentally ill and substance abusers
- This is proven through tobacco papers (Project SCUM)

What Is Desperately Needed

- More research on tobacco cessation in this population
- Evidence that links cessation and smoke-free environments to improved quality of life and longevity for these patients
- Proof of efficacy of these measures

Secondhand Smoke

- Secondhand smoke contains 4000 chemicals, 50 of which are known carcinogens, and 6 that negatively impact childhood development and reduce fertility in both sexes.
- More non-smokers will die from exposure to secondhand smoke than from any other air pollutant.

Secondhand Smoke (2)

- Children of parents who smoke are at a higher risk for developing chronic coughing, wheezing, and sputum production; middle ear infections; and asthma.
- Infants are three times as likely to die from SIDS if their mothers smoked during and after pregnancy, and twice as likely if their mothers stop smoking during pregnancy but resume again following birth.

What Can Be Done?

- Current situation is unacceptable
- Cessation will reduce, not increase, suffering
- Secondhand smoke rules will force change
- Starting now to help staff and patients quit is vital

Facing the Challenge

- Importance of top-down support and leadership
- Acceptance that it has to be done, and there is a right way to go about it
- Waivers for mental health facilities on the way out
- It won’t be easy, but it’s the right thing to do

How Can We Help Make Facilities Smoke Free in the Most Humane Way Possible?

- Some states have done a much better job than others in complying with mandates
- New Jersey succeeded on first attempt, Massachusetts on second
- Draconian mandates implemented overnight will fail
- Lessons learned in Massachusetts

Lessons Learned

- Accept that change will occur in stages
- Decision makers need educating and need a PROCESS or systematic design for moving toward smoke-free environments

Lessons Learned (2)

- Involve staff at all levels and clients in developing a blueprint for going smoke free
- Implementation starts with rewards, incentives and support for staff tobacco treatment

Next Steps For Us

- 1. Develop and implement a cessation program for staff
- 2. Form a committee of staff, patients, family members and administrators to develop a step-by-step blueprint for going smoke free
- 3. SCLC can provide technical assistance in developing the blueprint

http://smokingcessationleadership.ucsf.edu

A Chance to Make a Real Difference

- Highest prevalence and toughest issues in this population
- Most to gain by breakthroughs
- Move toward mandates makes the issue unavoidable
- If done right, this could be a tremendous success story someday