

## Guest editorial

# A smoking ban in psychiatric units: threat or opportunity?

Lindsay Banham

Research Fellow in Health Sciences and Foundation Year 2 Doctor, Department of Health Sciences, University of York, UK

Simon Gilbody

Professor of Psychological Medicine and Health Services, Department of Health Sciences, University of York, UK

Helen Lester

Professor of Primary Care, NPCRDC, University of Manchester, UK

### ABSTRACT

People with severe mental illness (SMI) experience some of the worst physical health and die younger than almost any section of the population. Mental health professionals have seemed strangely indifferent to this inequality, which in other areas of health would be a national scandal. In this editorial we discuss the recently introduced smoking ban in inpatient mental health service settings, which will offer mental health services an opportunity to implement creative, evidence-based strategies to help people with SMI address smoking and nicotine addiction. In doing

this, we refer to National Institute for Health and Clinical Excellence (NICE) guidance. This guidance forms the basis of national smoking policies for the general population and forms a starting point for those with SMI. Such a strategy will necessarily involve close collaboration with primary care, and we specifically examine how this might be achieved.

**Keywords:** physical health inequalities, severe mental illness, smoking cessation

People with severe mental ill-health are the latest section of society to be targeted in the national smoking strategy. This is long overdue. People with a serious mental illness die approximately 25 years earlier than members of the general population,<sup>1,2</sup> and a large proportion of the health inequality can be attributed to smoking-related causes.<sup>3,4</sup> Mental health professionals and policy makers have seemed strangely indifferent to this inequality, which in other areas of health would be a national scandal. In fact, smoking has always been an integral element of the 'culture' within psychiatric services – and particularly inpatient psychiatric units. This culture will be challenged by the ban on smoking in inpatient psychiatric units, which came into force in July 2008 in England, Wales, and Northern Ireland. At the time of writing, this ban is causing much consternation within mental health services. A

cultural shift will soon be forced upon psychiatric services, and like all cultural shifts, this represents both a threat and an opportunity. Here we argue that the 'smoking ban' could offer mental health services an opportunity to implement creative, evidence-based strategies to help people with severe mental illness (SMI) address smoking and nicotine addiction.

### Smoking, severe mental ill-health and the 'smoking ban'

The 2000 UK Office for National Statistics survey found that 44% of those with psychotic disorders living in community settings were smokers, and

27% were heavy smokers.<sup>5</sup> Among those with SMI who use inpatient services, studies show that up to 70% smoke, and around 50% are heavy smokers.<sup>6,7</sup> Smoking-related illness occurs within a background of general ill-health – an unhealthy lifestyle and poor physical health provision for many with SMI.<sup>8</sup>

A ban on smoking in public places was introduced in England on 1 July 2007, in recognition of the dangerous effects of secondhand smoke, and with the hope of reducing smoking rates.<sup>9</sup> Initially, both acute and long-stay psychiatric inpatient units were exempt from the ban, with smoking being permitted in designated rooms.<sup>10</sup> However, from 1 July 2008, the law has required psychiatric residential units in England, Wales and Northern Ireland to enforce a complete indoor non-smoking policy.<sup>11</sup>

Advocates of smoking-cessation efforts for those with SMI feel that, as many spend time as inpatients, not only would the introduction of smoking cessation interventions help to make a smoke-free hospital policy workable, but that the reverse would also apply. Furthermore, psychiatric staff could benefit from a smoke-free environment. Detractors have been keen to emphasise the ethical difficulties in imposing a ban upon those who are compulsorily 'resident' in psychiatric units,<sup>12</sup> and for whom the place of care becomes 'home' (where smoking is permitted for the general public). The right of those with SMI to exercise choice over whether or not to smoke is also an argument put forward by mental health patients and professionals alike.<sup>13</sup> However, the possible benefits to the physical, and possibly mental health of the individual with SMI are great, and an extension to the smoking ban complements the strategy of the National Institute for Health and Clinical Excellence,<sup>12</sup> which states that reducing rates of smoking among those from less-privileged groups, 'will help reduce health inequalities more than any other public health measure'.

## Barriers to smoking cessation for those with severe mental illness

Before considering what might be offered to those with SMI who smoke, it is important to consider just why smoking is so prevalent in this group. Explanations involve neurochemical, psychological and cultural factors. Pomerleau and colleagues suggest that nicotine may ameliorate symptoms of SMI, the 'self-medication' theory;<sup>14</sup> and Patkar and colleagues support this assertion by reporting that nicotine may improve some of the negative symptoms of

schizophrenia, i.e. poor concentration.<sup>15</sup> Levin *et al* also suggest that nicotine may alleviate some of the side-effects of the anti-psychotic medications that are used to treat SMI.<sup>16</sup> However, these theories remain unproven, and a 2006 Cochrane review on nicotine use for the symptoms of schizophrenia found no relevant randomised controlled trials in the literature.<sup>17</sup> Others suggest that typical anti-psychotic medications can predispose to nicotine addiction and make smoking cessation difficult.<sup>18</sup> Psychological and neurochemical explanations for smoking and SMI are only part of the picture. Smoking is largely culturally reinforced within inpatient settings. The most useful insights in this respect were drawn together in the *Clearing the Air* report commissioned by the UK King's Fund, which highlights the 'culture' of smoking in psychiatric care settings,<sup>13</sup> where high smoking rates exist among staff as well as patients. Staff themselves are generally resistant to smoking bans – where as few as 6% favour of a ban on smoking.<sup>19</sup> Commentators suggest that staff believe patients will not be able to quit smoking,<sup>20</sup> that quit attempts may result in increased behaviour problems among inpatients,<sup>21</sup> or that stopping smoking may precipitate a deterioration in mental state.<sup>13</sup> These concerns have no basis in neurochemical research. West, an expert on nicotine addiction and smoking, disagrees with these hypotheses, suggesting that smoking itself is anxiogenic, and the apparent relief experienced with smoking is due to satiation of nicotine cravings.<sup>22</sup> West also contends that after one week of nicotine abstinence, anxiety related to withdrawal abates.

The main reasons for smoking therefore seem to be cultural. Mental health staff perceive that smoking is pleasurable<sup>13</sup> and relieves boredom for inpatients in psychiatric units<sup>23</sup> so may be reluctant to encourage cessation. Furthermore, staff in inpatient units may use cigarettes as a tool to persuade patients to behave well.<sup>24</sup> The UK Health Development Agency provides clarity on this issue by stating that 'tobacco should not be used as a reward or incentive for long-stay or mental health service users'.<sup>9</sup> Loss of control of cigarette use for staff may make them more wary of challenging patients and also lead to the development of alternative, less unhealthy, behavioural strategies.

## Helping people with SMI to quit smoking: what works?

The ban on smoking in mental health settings should be viewed as an opportunity to reduce the harm done by nicotine addiction. Clearly, effective

approaches must utilise the best of the available evidence, and prioritise further experimental research. At present, guidance for health professionals supporting smoking cessation in the general population is based upon Cochrane systematic reviews,<sup>25-32</sup> and evidence-supported guidance from NICE.<sup>33,34</sup> Nicotine replacement therapy (NRT), bupropion, and individual, group or telephone behavioural support have all been shown to improve the efficacy of quit attempts in the general population; however, it is uncertain whether these interventions are equally efficacious in those with SMI. Jochelson and Majrowski suggest that 50% of those with mental health problems want to quit,<sup>13</sup> but smoking prevalence in this group is not declining in the UK or elsewhere.<sup>35,36</sup> Specialist smoking-cessation interventions tailored to the needs of those with SMI have been described, and often combine interventions such as contingent monetary reinforcement,<sup>37</sup> NRT,<sup>38-40</sup> bupropion,<sup>40-44</sup> clozapine,<sup>45,46</sup> and cognitive behavioural therapy (CBT).<sup>47</sup> However, considering the number of smokers with SMI who may wish to quit, bespoke programmes are sparse and seldom detail user involvement in their design or implementation.

The paucity of interventions may be because programmes operate at the interface of psychiatric and physical health services where conflicts may arise over roles and responsibilities in delivering physical health interventions to patients with SMI. Mirza and Phelan suggest that psychiatric staff should deliver advice on healthier lifestyle;<sup>4</sup> however, staff may not feel it is within their capability to do this.<sup>13</sup> From a primary care perspective, Lester comments that many primary care staff still feel that, in contrast to patients with complex diabetes or heart failure for example, holistic care of patients with SMI is beyond their remit.<sup>48</sup>

## Primary care-led smoking-cessation services

Delivery of effective combined physical and mental health care is essential for successful smoking cessation and requires close working, excellent communication, and defined roles and responsibilities between mental health services and primary care.<sup>48</sup> If smoking cessation is to be started in the community or maintained when inpatients are discharged home, support in the community is crucial. Until recently, this would have seemed even more of an uphill task. However, the advent of the pay for performance scheme, the Quality and Outcomes Framework (QOF), as part of the new general medical

services contract (nGMS), from April 2004 has increased general practitioners' willingness to be more involved in the holistic care of people with SMI.<sup>49</sup> Indeed, from April 2008 practice teams have been specifically incentivised to record smoking status and give smoking-cessation advice or referral to a specialist service for all patients with a diagnosis of schizophrenia, bipolar affective disorder or other psychoses. However, if programmes are to truly be 'tailored' to service users' needs, the involvement of those with SMI is required at every stage: policy making, innovation, planning, and delivery. To our knowledge this has not yet become a reality in most areas.<sup>50</sup>

## Conclusion

The ban on smoking in hospital settings has now arrived and is unlikely to be reversed. The inequalities in health experienced by those with SMI remain a national scandal. Major improvements in public health usually only follow on from difficult social and legislative changes, and the smoking ban in psychiatric inpatient units should be seen in this context. The inpatient smoking ban should be seen to be a catalyst for efforts to do something serious about the national scandal of poor health and early death that all too often accompanies SMI. General health professionals and mental health specialists must show commitment to improving the health of those with SMI. The extension of the national smoking ban should be welcomed as an opportunity to launch a new phase of innovation and collaboration between mental health professionals, physical health specialists and service users themselves.

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#### CONFLICTS OF INTEREST

None.

#### ADDRESS FOR CORRESPONDENCE

Dr Lindsay Banham, Department of Health Sciences, Seebohm Rowntree Building, University of York, YO10 5DD, UK. Email: [lindsaybanham@gmail.com](mailto:lindsaybanham@gmail.com)

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