Smoking and mental health

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Smoking affects everyone. It is a major cause of death and disability, with five million worldwide dying prematurely each year as a result of smoking. For those who live with smokers, there is a significantly higher risk of developing heart disease or lung cancer. The economic costs are high, too, and billions of pounds are spent each year from National Health Service budgets on treating diseases caused by smoking.

On the face of it, it is difficult to understand why so many people do smoke. Given all the evidence, why don't they just stop? A full answer to this apparently simple question would involve a complex exploration of pharmacology and an understanding of psychological dependence, but the simple answer is that people smoke because it is extremely difficult to quit. However, quitting is not impossible, and this is borne out by the thousands of smokers who do manage to quit each year, often making use of whatever stop-smoking services are available to them.

It is widely acknowledged that smoking is a preventable cause of death and disability. This is reflected in the very large number of signatories to the World Health Organization (WHO) Framework Convention on Tobacco Control, which came into force on 27 February 2005. This is the only convention to have received more than 170 national signatories. It expresses concern about the devastating worldwide health, social, economic and environmental consequences of tobacco consumption and exposure to tobacco smoke, and recognises that the spread of the tobacco epidemic is a global problem with serious consequences for public health. It emphasises the burden being placed on families, on the poor and on national health systems, particularly in low- and middle-income countries, by the increased consumption of tobacco products and it calls for the widest possible international cooperation and the participation of all countries in an effective, appropriate and comprehensive international response (see http://www.who.int/tobacco/framework/en/).

This excellent initiative of the WHO, supported by the international community, has moved the issue of smoking cessation up the agenda of health services in many countries, although in some this has been with more urgency than in others. Within this context, there are important and specific implications for those with mental illness, who are a particularly vulnerable group in terms of the effects of smoking. Smoking rates are at least twice as high among people with mental health problems as in the general population (Meltzer *et al*, 1995), with nearly 45% of all cigarettes consumed being smoked by individuals with a psychiatric disorder (Lasser *et al*, 2000). One possible explanation is that many mental health patients effectively self-medicate with tobacco, using nicotine to alleviate their symptoms. For example, nicotine has been found to stimulate neurotransmitters (such as dopamine) in the same way that many antidepressant medications do (Le Houezec, 1998). Another theory is that the propensity to smoke among these patients is mediated by their social circumstances. Smoking has been found to be strongly associated with social deprivation in terms of low income, poor accommodation, unemployment and so on (Jarvis & Wardle, 1999), and deprivation, in turn, is related to the presence of psychiatric disorder (Rasul *et al*, 2001).

Contrary to common assumptions, recent surveys in the UK have reported that around half of smokers with mental health problems are concerned about their smoking and want to stop (McNeill, 2001). However, they have expressed dissatisfaction with the support they receive from mental health professionals in relation to quitting. It has been claimed that psychiatrists rarely discuss patients' smoking and that local services rarely support smoking cessation, for example by offering nicotine replacement therapy. Historically, too, little attention has been paid to the psychiatric patient group in smoking cessation research. In a recent review of the literature on hospital-based smoking cessation (Rigotti *et al*, 2003), a wide range of healthcare areas were considered but studies of patients admitted with psychiatric disorders were excluded.

However, patients with mental health problems have as much right to be helped to overcome their addiction to tobacco as any other individuals and there is, indeed, some evidence to suggest that smoking cessation interventions can be as useful for people with mental health problems as for the rest of the population (El-Guebuly *et al*, 2002). It is interesting that researchers have reported a sense of exclusion from mainstream cessation programmes among mental health patients (Lawn *et al*, 2002). Psychiatrists and other members of mental health teams therefore have a particular responsibility to establish policies that will help their patients to quit and to provide individuals with assistance whenever this is needed.

The issue of prohibiting smoking in public places has been widely discussed in many countries – and has been implemented in some. Although the adoption of smoke-free policies in healthcare settings is generally a popular move, it is often suggested that psychiatric hospitals should be exempted. This appears to be based on a perception that psychiatric settings are difficult places within which to implement smoking restrictions. This may be related to the unique place occupied by smoking within the practice and culture of psychiatric care. For example, smoking is often a major source of structure and activity to the patient's day and may also feature strongly in the social club of mental health units (Lawn & Pols, 2005). Studies have also reported that mental health staff often use cigarettes to appease or engage patients (Mester *et al*, 1993). The arguments for exempting mental health units from smoke-free policies also make reference to human rights, in the context that many patients are

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resident in hospitals for extended periods and often against their will.

Clearly, these are thorny issues. However, mental health patients have the same right as any other patients to access to health promotion and to protection from the harmful effects of smoking. In this complex environment, the attitude of mental health professionals is likely to be of great importance and a recent survey revealed that mental health staff have significantly less positive attitudes towards providing smoking-related intervention to their service users than general medical staff (McNally *et al*, 2006). There is also some evidence that smoking-related attitudes differ across professional groups. For example, in one study doctors ranked smoking cessation as more important than nurses did (Braun *et al*, 2004). However, it appears that once smoke-free policies have been in place for some time, staff develop much more positive attitudes towards smoking cessation. This shift in opinion may flow from the fact that smoking bans have rarely been found to lead to increased aggression and adverse incidents and, in fact, have even had a positive effect on ward functioning in many cases (Lawn & Pols, 2005).

It is clearly important that patients with psychiatric disorders are not deprived of their right to a smoke-free environment because of unwarranted assumptions about what can and cannot be implemented within a hospital setting. Also, many mental health patients are now cared for in the community, where these arguments are irrelevant. It is therefore essential that psychiatrists exercise their duty of care and leadership in promoting smoking cessation at both individual patient level and within their institutions, to protect their patients from the serious consequences of smoking.

References

Braun, B. L., Fowles, J. B., Solberg, L. I., *et al* (2004) Smoking-related attitudes and clinical practices of medical personnel in Minnesota. *American Journal of Preventive Medicine*, **27**, 316–322.

El-Guebuly, N., Cathcart, J., Currie, S., *et al* (2002) Smoking cessation approaches for persons with mental illness or addictive disorders. *Psychiatric Services*, **53**, 1166–1170.

Jarvis, M. & Wardle, J. (1999) Social patterning of individual health behaviours: the case of smoking. In *The Social Determinants of Health* (eds M. Marmot & J. Wilkinson), pp. 240–255. Oxford University Press.

Lasser, K., Boyd, J. W., Woodhandler, S., *et al* (2000) Smoking and mental illness: a population-based prevalence study. *JAMA*, **284**, 2606–2610.

Lawn, S. J. & Pols, R. G. (2005) Smoking bans in psychiatric inpatient settings? A review of the research. *Australian and New Zealand Journal of Psychiatry*, **39**, 874–893.

Lawn, S. J., Pols, R. G. & Barber, J. G. (2002) Smoking and quitting: a qualitative study with community-living psychiatric clients. *Social Science and Medicine*, **54**, 93–104.

Le Houezec, J. L. (1998) Nicotine: abused substance and therapeutic agent. *Journal of Psychiatry and Neuroscience*, **23**, 95–108.

McNally, L., Oyefeso, A., Annan, J., *et al* (2006) A survey of staff attitudes to smoking-related policy and intervention in psychiatric and general health care settings. *Journal of Public Health*, **28**, 192–196.

McNeill, A. (2001) *Smoking and Mental Health – A Review of the Literature*. Action on Smoking and Health.

Meltzer, H., Gill, B., Petticrew, M., *et al* (1995) *The Prevalence of Psychiatric Morbidity Among Adults Living in Private Households*. TSO (The Stationery Office).

Mester, R., Toren, P., Ben-Moshe, Y., *et al* (1993) Survey of smoking habits and attitudes of patients and staff in psychiatric hospitals. *Psychopathology*, **26**, 69–75.

Rasul, F., Stansfeld, S. A., Davey-Smith, G., *et al* (2001) Sociodemographic factors, smoking and common mental disorder in the Renfrew and Paisley (MIDSPAN) study. *Journal of Health Psychology*, **6**, 149–158.

Rigotti, N. A., Munafon, M. R., Murphy, M. F. G., *et al* (2003) Interventions for smoking cessation in hospitalised patients. *Cochrane Database of Systemic Reviews*, issue 2. Update Software.

THEMATIC PAPERS – INTRODUCTION

The mental health of refugees

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Concerns about the fate of refugees, displaced because of war or famine and in some cases by genocide, are now expressed almost daily in news broadcasts and other media. This is a global problem, but currently there is a particular focus on the needs of Africa, and the terrible internal conflicts that are occurring in countries such as Sudan and Somalia. In our thematic section for this issue, we present three papers that express concern about the mental health of refugees.

In a series of polemical statements, Dr Njenga sets out the urgent challenges facing the international community. He discusses the former genocide in Rwanda and the scale of the conflict in Somalia, from which thousands of refugees are fleeing to Kenya, to escape a civil war between Islamists and warlords, thereby putting pressure on the fragile mental health infrastructure of that country. He mentions the high rates of post-traumatic stress disorder among refugees in Sudan. The failure of the world to take action to prevent the incipient genocide of the displaced peoples in Darfur has been described by President George Bush as putting the credibility of the United Nations at stake.

The suffering of the people of Sudan is the subject of the article by Drs Loza and Hasan, from Egypt. The south of Egypt borders Sudan, and many refugees have moved north. The number of displaced persons is so large that pressure is being put on the reception facilities in Egypt that are endeavouring to cope with them. Drs Loza and Hasan point out that not only do refugees have experiences of murder, rape and torture to come to terms with, psychologically, but also, in the foreign country to which they have escaped, they are likely to face racial discrimination and invariably