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Editorial

# The smoking culture in psychiatry: time for change

Elena Ratschen, John Britton and Ann McNeill

**Summary**
Smoking is closely linked to severe mental illness and has a major detrimental impact on individuals' lives. Despite this and the recent societal 'de-normalisation' of smoking, the historic 'smoking culture' still prevails within mental health settings. Change is urgently required to prevent a widening of existing health gaps.

**Declaration of interest**
None.

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## A matter of concern

The link between tobacco smoking and mental illness is strong – so strong that it is tempting to assume the two were inextricably interwoven. Smoking rates among people with mental health diagnoses are disproportionately high, ranging from 40 to 50% for diagnoses of depressive and anxiety disorders to around and above 70% among people with schizophrenia,[1] irrespective of other contributing factors such as age or socioeconomic status. Tobacco smoking constitutes a considerable cause of morbidity and excess mortality in the severely mentally ill; it has indeed been suggested that most of the excess mortality observed in schizophrenia is related to smoking.[2] People with severe mental illness are two to three times more likely to suffer from smoking-related illnesses such as cardiovascular disease and cancers.[3]

Many mental health professionals regard smoking as a phenomenon that belongs, somehow, to the 'other side', namely the area of physical health, occupying a space outside the direct spectrum of their influence and responsibility. However, it is important to recognise that tobacco smoking fulfils the physiological, behavioural and social characteristics of a dependence syndrome, with related morbidity and mortality exceeding the effects of any other drug, or any other single behaviour, at a population level.[4] Smoking also deserves attention in relation to treatment for mental illness. Due to the shared metabolism of some antipsychotic drugs and hydrocarbon agents in tobacco smoke, smokers require generally higher doses of antipsychotic drugs. Furthermore, nicotine, as the main psychoactive component in tobacco smoke, has direct effects on cognition, mood and attention, and its effects are therefore interwoven with common symptoms of many psychiatric illnesses.[5] Despite all this, many mental health professionals regard smoking as an important coping mechanism and means of self-medication for individuals.[6] It remains a frequently used means of reward or punishment for adherence to treatment, playing an important part in the context of social interaction between patients and staff in treatment settings.

## Stepping forward (and back)

Some recent developments have however been heartening. Recent systematic reviews confirm that treatment interventions based on behavioural support and pharmacotherapy that work in the general population are also (and approximately equally) effective in smokers with mental illness and do not appear to worsen psychiatric symptoms.[7,8] Guidelines, toolkits and training programmes to support appropriate treatment of smokers with mental illness are being developed, and the legal obligation to create smoke-free environments in mental health settings in England from July 2008 was a welcome move.

We designed a research programme to explore smoke-free policy implementation in mental health in-patient units in our local National Health Service (NHS) mental health trust, one of the largest in the country, which introduced a comprehensive smoke-free policy a year in advance of the required date.[9,10] Briefly, we found that, on the adult mental health acute wards studied, the smoke-free policy, which was intended to cover buildings and grounds comprehensively, was only partially implemented, allowing for blanket exemptions in courtyards, in front of ward entrances and elsewhere on the premises. This meant that smoking outdoors remained the norm. Adverse effects, such as a drain on staff resources when facilitating smoking breaks or escorting formal patients, and patients' fixation on these regular breaks to the detriment of other therapeutic activities, were reported. Staff knowledge with regard to tobacco dependence, its treatment and links with mental illness was poor across all staff groups working across the trust. Patients expressed general agreement with the policy, as long as they were able to smoke outside, and reported a lack of structured support in smoking cessation from staff.

In the light of the deficiencies discovered, we developed a pilot intervention that included tailored staff training and an evidence-based smoking cessation/reduction programme in collaboration with the local NHS stop smoking service, to engage and train staff to support smoke-free policies, and to offer nicotine dependence treatment to acute patients. Recruitment of staff and patients proved extremely difficult, reflecting both illness-related and systemic factors such as staff attitudes and a prevailing smoking norm; as a result, the programme failed to deliver measurable positive results.

Our findings indicating challenges are not isolated,[11] and any form of complacency with regard to the promotion of smoke-free living in mental health settings would be misplaced. The reasons for the persistence of smoking as an accepted (maybe even

expected) phenomenon are complex, but we believe are strongly related to the reluctance among mental health professionals to acknowledge the importance and feasibility of addressing smoking and to adopt the anti-smoking agenda. This reluctance may be rooted in the misconception that people with severe mental illness generally do not want to quit smoking, an assumption that is not borne out by the evidence,[12] and which appears to be specific to the mental health sector.[13] Considerable efforts therefore lie ahead to ensure people with severe mental illness are not excluded from progress made in combating the effects of tobacco smoking.

## The path ahead

Greater awareness needs to be raised among clinicians, for example through mandatory professional training at all levels, and further research conducted to identify and improve tailored and effective means to support smokers with severe mental illness. Smoking should be acknowledged as a vital sign in mental as in all other aspects of healthcare provision. Indeed the thorough integration of smoking-related issues in care pathways appears paramount. Further political and economic changes could include the introduction of strong financial incentives for clinicians to address smoking among their patients, for example within the quality of outcome framework in the case of general practitioners, or within an adequate alternative reward and incentive programme for primary and secondary care mental health settings, which would include smoking as one of the parameters by which clinicians' performance is evaluated.

The NHS stop smoking services were set up to provide accessible support to smokers across the country. People with severe mental health illness and high levels of nicotine dependence should be a prime target for such services, but often seem to be left out.[14] Four-week quit targets are less meaningful or even meaningless in the context of attempting to tailor service provision to the needs of highly dependent smokers with mental illness, who often require intense support to make even the first steps towards quitting, and for many of whom even cutting down is a difficult aim to achieve. When stop smoking services invest resources in the care of hard-to-reach groups, they currently have to do so at the expense of working towards targets against which they are monitored. Changes to short-term quit targets, which are a major driver of cessation service planning and delivery, a focus on quit targets related to smokers vulnerable to other health inequalities and appropriate training of stop smoking advisors to ensure adequate treatment of smokers with mental health problems are urgently needed if stop smoking treatment is to be provided on a standard basis in mental health settings. Furthermore, attention needs to be paid to improve collaboration between mental health and stop smoking service providers.[14]

Currently, continued heavy smoking among people with mental health problems is threatening to widen existing health gaps and to increase stigma that interest groups are so fiercely battling against. We believe that taking the measures above will ensure people with mental illness are not left behind.

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