



Smoking and Mental Health

The Department of Health will be smokefree from 1 January 2008.

Why Smoke Free?

The purpose of implementing the *Smokefree* policy in health services is to improve the health of all Western Australians by preventing exposure to passive smoking.

This fact sheet, informed by mental health consumers and health professionals, addresses a range of common concerns and myths about smoking.

Myth: People with a mental illness do not smoke any more than the general population.

Fact: In Australia, the prevalence of smoking amongst people with a mental illness is reported to be as high as 88%, compared with only 25% for the general population. A 2005 audit of public mental health inpatient services revealed that over 67% of mental health inpatients smoked compared with 15.5 % of Western Australians aged 14 years and over.¹

Myth: Australia is the only country where smoking in mental health services is banned.

Fact: A number of countries with comparable health systems, including Canada, the United Kingdom and the United States have introduced successful smoking bans.

Smoke free mental health services have been successfully implemented in Australia and Canada.

Kunyk, Els, Predy and Haase (2007) report that “*no behaviour indicators of unrest or violence and noticeable changes in the levels of psychopathology occurred among patients*” after the implementation of Canada’s smoke free policy.²

Lawn and Pols (2005) review of 26 international studies, including Australia, on the effectiveness of smoke free policies in inpatient psychiatric settings identified that there was “no increase in aggression, use of seclusion, discharge against medical advice or increased use of as-needed medication” following smoke free implementation.³

Myth: People with a mental illness have a right to smoke.

Fact: Although smoking is legal, health workers, mental health consumers and visitors are entitled to an environment where they are not exposed to passive smoking.

Myth: Smoke free environments will increase distress in mental health in-patient environments.

Fact: A recent systematic review of relevant American, Canadian and Australian research illustrates that the frequency of aggression, use of seclusion, discharge against medical advice or use of as-needed medication (to calm) did not increase in a smoke free environment. An important component to the success of any smoke free policy is the availability of nicotine replacement therapy for both staff and mental health consumers.⁴

Myth: Designated smoking areas will stop the effects of passive smoking and protect staff and non-smokers.

Fact: There is no such thing as safe levels of exposure to secondhand cigarette smoke.

Myth: Nicotine is the most harmful ingredient in cigarettes.

Fact: Cigarette smoke contains over 4000 toxic compounds. It is the toxins in the other compounds that are responsible for tobacco-related diseases, not nicotine.



<p>Myth: Combining use of nicotine replacement therapy with smoking increases the risk of heart attack.</p>	<p>Fact: Smoking and the use of nicotine replacement therapy does not increase the risk of a heart attack or related cardiovascular events.⁵</p>
<p>Myth: Using more than one form of nicotine replacement is unsafe.</p>	<p>Fact: Combinations of more than one form of nicotine replacement therapy can be used safely to assist people to quit smoking. Clinical trials demonstrate that there is no significant increase in adverse events when more than one form of nicotine replacement therapies are combined.⁶ In fact, evidence indicates that combined nicotine therapies are more effective as they can complement each other, providing a better outcome for consumers.⁷</p>
<p>Myth: Nicotine replacement therapy is as addictive as cigarettes.</p>	<p>Fact: The nicotine in cigarettes is addictive because it is delivered rapidly into the body. All forms of nicotine replacement therapy deliver nicotine more slowly and have low or no abuse potential.⁸</p>
<p>Myth: Mental health consumers who smoke are being forced to quit.</p>	<p>Fact: Research indicates that, when asked, the majority of mental health consumers appreciate help to stop smoking.⁹</p>
<p>Myth: Nicotine replacement therapy will effect psychotropic medication.</p>	<p>Fact: Chronic smoking increases the body’s metabolic rate and can impact on the effectiveness of medication. NRT does not adversely affect the metabolic rate. However, any sudden cessation of cigarette smoking will require clinicians to monitor the levels of medication, as it often results in the patient requiring less medication, including less psychotropic medications.¹⁰</p>

¹ Department of Health public mental health inpatient service audit conducted 2005 that included smoking prevalence.
² Konyk, D., Els, C., Predy, G., & Haase, M. (2007) Development and Introduction of a Comprehensive Tobacco Control Policy in a Canadian Regional Health Authority, Preventing Chronic Disease, vol 4, p 1-8.
³ Lawn, S. & Pols, R. (2005) Smoking bans in psychiatric inpatient settings? A review of the research. Australian and New Zealand Journal of Psychiatry, vol 39, p 866-885.
⁴ Royal College of Psychiatrists Psychiatric Bulletin (2006) 30: 241-242 Smoke-free psychiatric services.
⁵ Nicotine and nicotine replacement therapy - the facts Prof Nick Zwar, John Bell, Prof Mathew Peters, Prof Christie MacDonald, Colin Mendelson, Australian Pharmacist, Volume 25, Number 12 Dec 2006 pp 969-973.
⁶ Number 3
⁷ Number 3
⁸ Number 3
⁹ Treatment of Tobacco Use in an Inpatient Psychiatric Setting (J, Prochaska, et al, 2004) Nov 2004 Vol. 55 No. 11.
¹⁰ The British Journal of Forensic Practice May 2005, Issues in running smoking cessation groups with forensic psychiatric inpatients: results of a pilot study and lessons learnt. Long, Clive g, Jones, Kelly.

