

Mental Health Network

Findings from the literature and stakeholder consultations pertaining to the cessation of smoking within psychiatric inpatient settings

In December 2006 and January 2007 the Mental Health Network sought stakeholder feedback about the following objective:

Implement a phased in total ban on smoking by staff and consumers in all public mental health services including hospital grounds by mid 2009

The purpose of the email was to seek views and suggestions from consumers and staff on the following:

1. Do you support the objective outlined above?
2. What key strategies would you suggest to achieve this objective?
3. What do you identify as the key risks associated with implementing this objective?
4. What risk management strategies would you use to mitigate against the key risks?

The feed back from consultant psychiatrists, other public mental health service clinicians, non-government mental health services, Council of Official Visitors, and mental health consumers and advocates indicated they while they supported a smoking reduction strategy they were generally opposed to the plan for total cessation of smoking within psychiatric settings citing the following reason.

- Impact on consumers and the community of consumers who are stressed by the ban and may not seek the treatment they require because of the smoking ban;
- Possibility of increased consumer aggression and escalating mental health symptoms as an outcome of forced nicotine withdrawal and the interaction of the loss of nicotine and its impact on the effectiveness of the consumer's psychotropic medication;
- Negative impact on the working environment from consumer non-compliance with treatment and ban;
- Exacerbation for some of their mental health symptoms as an outcome of taking Nicotine Replacement Therapies medication;
- Capacity (legal and practical) of the Department of Health to implement and ensure compliance with the policy if the patient fails to agree to the ban, particularly patients on involuntary orders;
- Enforcement and policing by staff considered a role counter to the therapeutic process requiring clear delineation of who is to police the ban;
- Clandestine smoking could create a fire risk from consumers defying the ban;
- Prohibition may create an underground market further complicating compliance;

- The legal ramification of banning the consumption of a product that is not considered illegal and the ethical considerations of enforced withdrawal considered as 'cruel' for people suffering from chronic mental health issues and a violation of mental health consumer rights, particularly as nicotine is not an illegal substance; and
- The need for support for patients who relapse post discharge from psychiatric services and Quit programs been made available to consumers who are not inpatient clients.

Some of the literature addresses these concerns and provide some considerations when operationalising a plan of total cessation of smoking within psychiatric settings.

In relation to increased aggression and staff perceptions of poor take up from consumers, the Royal College of Psychiatrists Psychiatric Bulletin (2006) 30: 241-241 entitled *Smoke-free psychiatric services* states;

¹Despite these concerns, the evidence to date for the success of smoking bans in psychiatric settings is far from negative and suggests that staff members anticipated more difficulties than actually occur. In a recent systemic review of relevant American, Canadian and Australian data, the frequency of aggression, use of seclusion, discharge against medical advice or use of as-needed medication did not increase following a ban (Lawn & Pols, 2005). It is also notable that previous imposed bans in psychiatric wards had some positive effects on patients, such as an increased sense of self-esteem and mastery (Cooke, 1991). However, they had little effect on smoking in the longer term (El Guebaly et al, 2002; Lawn & Pols, 2005). This was not the case for the staff, however, who were more likely to use the opportunity to cease smoking (Borland et al, 1990; Chapman et al, 1999)

Other studies have shown that success to promoting ongoing cessation of smoking with consumers requires a management plan that is made available not only to in-patient clients, but also within the residential and community settings. This would address issue of relapse of consumers re-entering the community and to provide continuity of care. The South London and Maudsley NHS Trust plans to introduce a ban on smoking on all sites by July 2006, using a phased introduction and after wide ranging local consultations the South London and Maudley NHS Trust Smoke –free policy states;

²As part of the policy, smoking cessation will be a consideration in every patient's management plan from the point of admission to the service, be that community, in-patient or residential setting. To assist in longer-term cessation, plans for continued support should be part of the patient's care plan as they move from one part of the service to

¹Royal College of Psychiatrists Psychiatric Bulletin (2006) 30: 241-241 *Smoke-free psychiatric services*

²Royal College of Psychiatrists Psychiatric Bulletin (2006) 30: 241-241 *Smoke-free psychiatric services*

another. This indicates the need for more coordination between inpatient and community-based staff.

In relation to compliance to participating in nicotine replacement therapy a study conducted by (J, Prochaska, et al, 2004) *Treatment of Tobacco Use in an Inpatient Psychiatric Setting* suggests:

³Just over half the current smokers were given a prescription for nicotine replacement therapy, and nearly all these patients used the therapy for most of their hospital stay, which suggests that patients use nicotine replacement therapy when its is prescribed. This finding is far more hopeful than previous case reports from inpatient psychiatric units that suggested nicotine replacement therapy was helpful for few patients and was often rejected or discontinued.

This also supports the assertion that successful treatment will require a combination of use of nicotine replacement therapy , support and counselling. The same article supports the prescription of nicotine replacement therapy to all smokers on admission and concludes:

Our study identified differences inpatient outcomes based on the prescription of nicotine replacement therapy. Notably, smokers who were given a prescription for this therapy had outcomes that were similar to those of non-smokers. These findings suggest that the prescription of nicotine replacement therapy may be a simple intervention with clinically significant implications.

A paper produced by VicHealth entitled Background Brief, *Mental Illness and smoking cessation an urgent public health issue* (2003) recognized the reluctance of staff in implementing total ban that identified resistance from staff who were smokers themselves.

⁴Research indicates that smoking staff tend to expect and experience more problems with implementing smoking bans than non-smoking staff. While hospitals have introduced smoke free policies, smoking remains a problem for staff and management. Reports include staff time required to monitor patients who try to smoke indoors; fire risk of clandestine smoking; and the requirement to build balconies so that inpatients could smoke at night and yet not be at risk of suicide.

It is clear that consideration will need to be given to staff who themselves require support in quitting smoking and the transitioning of the culture of inpatient settings from allowing patient to smoke, to one of monitoring the risk associated with clandestine smoking. A total ban is likely to gain most resistance from smoking staff and any attempt to enforce changes will require commitment from all staff.

³ *Treatment of Tobacco Use in an Inpatient Psychiatric Setting* (J, Prochaska, et al, 2004)
<http://ps.psychiatryonline.org> November 2004 Vol. 55 No. 11

⁴ VicHealth, Background Brief, *Mental Illness and smoking cessation an urgent public health issue* (2003)

Patients with chronic mental illness such as schizophrenia tend to smoke more than others who have acute mental illness, as they derive a therapeutic effect from smoking. Any nicotine replacement therapy will need to take into consideration the effects on medication. The British Journal of Forensic Practice, *Issues in running smoking cessation groups with forensic psychiatric inpatients: results of a pilot study and lessons learnt* (Long G, Jones, K, 2005) recognizes greater difficulty with forensic patients as boredom and lack of motivation impacts on the consumer's ability to manage the complete cessation of smoking.

⁵Other barriers to quitting smoking among psychiatric populations are motivational; patients may have few alternative reinforcers and may suffer from an increase in negative symptoms, decreased attention and lowered concentration. Cognitive limitations may inhibit the learning of self-management skills (Mc Ghargue et al, 2002)

Evidence suggests that psychiatric illness bolsters vulnerability to nicotine dependence; for example, smokers with schizophrenia may experience relief from negative symptoms, schizophrenia-related cognitive dysfunction and medication side effects (Dalack et al, 1998). Perhaps not surprisingly, patients with schizophrenia are often not interested in stopping and long-term abstinence is rare (Ziedonis et al, 2004)

Some of the evidence within the literature supports concerns from workers who suggest smoking for clients with chronic mental illness is both self-medication and relieves boredom associated with being an inpatient.

Conclusion

The literature search revealed that the cessation of smoking within psychiatric settings is a relatively new area of research, with a majority of papers suggesting more substantial research is required on the subject⁶. The literature also reveals the complex interrelated nature of addiction, agency, self-medication and the cost benefits associated with enforced cessation of smoking on those suffering chronic mental health conditions⁷. Some research revealed that generally good will and agreement in the benefits of not smoking from both staff and consumers existed but the actual practical implications of implementing a program was contested⁸.

Some of the fears proposed by staff, consumers and advocates such as the complication of administering total cessation and increased aggression was not supported by research, however, other concerns relating to nicotine

⁵ 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

⁶ VicHealth, Background Brief, *Mental Illness and smoking cessation an urgent public health issue* (2003)

⁷ Effectiveness of Hospital-Based Smoking Cessation American College of Chest Physicians (2005, Fung, P et. al)

⁸ Royal College of Psychiatrists Psychiatric Bulletin (2006) 30: 241-241 *Smoke-free psychiatric services*

withdrawal interacting with medications were mentioned as areas of consideration, particularly in relation to nicotine replacement therapy⁹.

The literature search did not find any mention of the cessation of smoking giving rise to a 'black market' or clandestine smoking in inpatient settings; however, this is an inconclusive finding due to the relative newness of the research not containing any significant evaluations of existing programs.

What is clear from the research is that if a total ban of smoking is to occur, then comprehensive support in terms of pharmacotherapy, counseling and education is required for both staff and patients. This includes such support being offered to those clients who are not inpatients and those who return to community, as relapse after leaving a hospital is extremely high. It is considered prudent to implement the Smoke free Policy in stages, progressing from quarantine areas of smoking to complete cessation over time, allowing for monitoring of integration and participation. Some research suggested a project officer maybe required to ensure program constancy and to provide support in evaluation.

April 2007 Update

Since the above consultation and literature were undertaken, the Minister for Health has refined his intentions. The Department of Health will be implementing a smoke free health facilities and grounds policy from 1 January 2008. This will mean all health services will be smoke free.

⁹ 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