

Mental Health Foundation of New Zealand

Tobacco Smoking and Mental Health

Smoking cessation, and strategies which promote becoming and remaining smokefree, work to improve mental health

Being smokefree helps people to flourish, and smoking cessation works to improve mental health and wellbeing in the long term (Ziedonis et al., 2008; Kaplan et al., 2007; Parrott 2006).

There is strong evidence that smoking increases stress and anxiety, particularly in the long term, and the chances of developing depression, anxiety disorders (particularly panic disorder, agoraphobia and post-traumatic stress disorder), and other mental illness, and are associated with increases in the likelihood of suicidal ideation and suicide related acts (Cosci et al, 2009; Ziedonis et al., 2008; Morissette et al., 2007; Parrott, 2006; Zvolensky et al., 2005; Breslau et al., 2005; Upadhyaya et al., 2002; Fergusson et al., 2003). There is also strong evidence that smoking contributes to intellectual and cognitive decline, and increases the probability of developing dementia and Alzheimers (Anstey et al., 2007; Swan et al., 2007; Peters et al., 2008; Durazzo et al., 2010).

Research shows that smoking cessation diminishes stress and anxiety; smoking cessation has also been associated with reduced rates of panic attacks, suicidal ideation, and suicide related acts (Breslau et al., 2005; Parrott 2006). Smoking cessation reduces vulnerability to intellectual and cognitive decline, as well as dementias and Alzheimers (Anstey et al, 2007; Peters et al, 2008). Improvements in physical health that follow smoking cessation lead to greater vitality, make it easier to be active, and improve happiness. Collectively, these benefits mark the improvement in well-being that being and remaining smokefree offers.

Smoking is not simply a personal choice. Research suggests that smokers share a nearly-universal regret at the decision to smoke, and a desire to quit (Fong et al., 2004). Research also shows that concerns about smoking and the desire to quit extend to people who are experiencing mental illness (Siru et al., 2009; Solty et al., 2009; Olivier et al., 2007). In New Zealand, tobacco smokers generally support smokefree policy measures, including the extension of smokefree areas, tobacco marketing bans, and tax increases for tobacco products, where the proceeds are committed to smoking cessation and public health (Wilson et al., 2010; Wilson et al., 2010a).

Addiction to nicotine is a medical condition, and needs to be treated as such (American Psychiatric Association, 2000). Nicotine dependence can be usefully conceptualised as a loss of autonomy (DiFranza et al., 2009). In this sense, smoking cessation represents a movement towards autonomy. There is evidence that smoking cessation may improve resilience, and operates as a source of self-esteem (Lawn et al., 2010; Ward et al., 2011).

Policy

The Mental Health Foundation supports measures which will serve to reduce the prevalence of smoking in New Zealand, and eliminate smoking by 2025

Current policies have improved wellbeing by helping and encouraging people to become smokefree, but further legislation which restricts the marketing, sale and distribution of tobacco products, increases the cost of tobacco products, and increases the range and kind of smokefree environments, will function to further dis-incentivise and de-normalise smoking. Along with these restrictions and price increases, further smokefree marketing and education will help to diminish the prevalence of smoking in New Zealand. Support for evidence-based smoking cessation therapies, including counselling, nicotine replacement, and drug therapies, will help to improve wellbeing, as these therapies both increase quit rates and diminish the acute side-effects of smoking cessation (Koh et al., 2012; Wilson et al., 2012; Wilson et al., 2008).

Smokefree policies need to continue developing in conjunction with Maori and Pasifika communities

The prevalence of smoking amongst Maori and Pasifika remains very high. In particular, Maori have the highest rates of smoking of any ethnic group in New Zealand. (Ministry of Health, 2011) This has a considerable impact on the wellbeing of these communities, and is an impediment for the flourishing of Maori and Pasifika people. There is strong support for smokefree and smoking cessation policies amongst these communities, particularly amongst community and political leaders. Addressing smoking cessation will be most effective if implemented in consultation with these communities (Salmond et al., 2012). These communities should have access to evidence-based, culturally appropriate smoking cessation advice and support (McRobbie et al., 2008).

Healthcare services, particularly Primary Healthcare Organisations and Mental Health Services, have a responsibility to support all clients, including people with experience of mental illness, in smoking cessation and being smokefree.

Smoking cessation should be considered as part of the treatment of people experiencing mental illness. In New Zealand, as overseas, despite success in reducing the prevalence of smoking generally, people with experience of mental illness continue to smoke at high rates; as with all clients of health services, they should be offered effective advice and support for smoking cessation (McRobbie et al, 2008; Tobias et al., 2008). Research suggests that supporting people with experience of mental illness in becoming and remaining smokefree will help their physical and mental health, helping them to flourish (Lawrence et al, 2009; Moss et al, 2010). Smokers with experience of mental illness generally want to cease smoking (Soltz et al., 2009; Lucksted et al., 2004; Morris et al., 2009).

Research shows that smoking is a critical factor in the poor mortality and morbidity that people with experience of mental illness experience (Lawrence et al., 2009; Banham et al., 2010; Moss et al., 2010). There is no evidence that people with experience of mental illness will not experience the considerable benefits to mental and physical health that smoking cessation offers (Ragg et al, 2008).

Despite this, tobacco smoking has played a key part in the institutional life of MHS in-patient units; tobacco products have been used as positive reinforcers for behaviour management and therapeutic purposes, as part of a token economy, and non-smoking in-patients appeared to have been at risk of taking up smoking (Olivier et al., 2007).

Medical support significantly improves smoking cessation rates for people diagnosed with mental illness, as it does for people without diagnosed mental illness. Smoking cessation treatments are most effective when supported with consideration of clients' experiences of mental distress. Tobacco smoking has variable effects on psychotropic medications, and smoking cessation may alter both their effectiveness and side effects. In particular, evidence suggests that the hydrocarbons in tobacco smoke (rather than nicotine) impact on the liver's metabolism of psychotropics. (Moss et al., 2010; Schaffer et al., 2009; Lawrence et al., 2009; Morris et al., 2009; Hitsman et al., 2009; Ziedonis et al., 2008; Olivier et al., 2007; El-Guebaly., 2002).

Support in smoking cessation for people with experience of mental illness needs to happen both through mental health services, and through general health services. Because many people with experience of mental illness do not utilise mental health services, but have contact with PHOs and other health providers, these health providers have an important role to play in supporting people with experience of mental illness in smoking cessation. Similarly, many clients of mental health services have limited contact with other health services, so these services also need to support smoking cessation (Lawrence et al., 2009; McRobbie, 2008).

The understanding that smoking cessation is achievable for people with mental illness needs to be promoted

Smoking cessation is achievable for people with experience of mental illness, as it is in the rest of the population, particularly with the support of health services (Banham et al, 2010; Hitsman et al, 2009; Ziedonis et al, 2008). The acceptance of tobacco smoking as being normal, untreatable, or of minor importance for people with experience of mental illness is discriminatory, given that it works to deprive them of the standard of care that other clients of health services benefit from.

The evidence does not support the assumption that smoking is simply a symptom of mental illness. There is strong evidence both that mental illness makes people more likely to smoke, and that smoking makes people more vulnerable to mental illness. Smoking amongst people with experience of mental illness may also be attributable in large part to social and environmental factors, which correlate with both smoking and mental illness, such as peer smoking, poverty, or homelessness, and the culture of mental health in-patient units (Lawrence et al., 2009; Chaiton et al., 2009; Morrisette et al., 2007; Olivier et al., 2007; Zvolensky et al., 2005; Parrott, 2003).

In line with the best evidence, health services need to promote the understanding that tobacco smoking is not an effective medication for mental illnesses

Given the clear and abundant evidence that smoking is an impediment to health and well-being, there would need to be strong evidence that smoking has therapeutic value before smoking could be countenanced or condoned as a treatment. The evidence that tobacco smoking has any therapeutic value in the treatment of mental illnesses is, at best, equivocal, and is not supported by longitudinal and prospective studies (Winterer, 2010; Lawrence et al., 2009; Parrott, 2003).

In cases where smoking appears beneficial, this generally appears to be a result of nicotine dependence reversal—that is, smoking temporarily alleviates the symptoms of withdrawal from nicotine. These benefits are best garnered through nicotine replacement therapy and smoking cessation. Research supporting the therapeutic value of nicotine is frequently confounded by the failure to address the effects of withdrawal (Lawrence et al., 2009; Parrott, 2003).

Smoking may offer benefits in the alleviation of some symptoms of schizophrenia, but the evidence for these benefits tends to be insignificant; smoking may also exacerbate other symptoms of mental illness, and/or militate against the efficacy of prescribed medications (Ziedonis et al., 2008; Swan et al., 2007; Ragg et al., 2008). Research producing evidence supporting tobacco's therapeutic value in treating mental illness, particularly schizophrenia, is severely compromised; investigations have revealed that the tobacco industry kept secret its role in funding, promoting and silencing much of the research in this area (Prochaska et al., 2008). In this context, such research lacks validity, and should be disregarded in favour of research that has not been tainted by these processes; this evidence generally suggests that smoking is not an effective treatment for schizophrenia.

In careful consultation with people with experience of mental illness, and their whanau, Mental Health Services should work to make all facilities smokefree.

Smokefree environments serve to prevent cultures of smoking which may foster tobacco smoking amongst clients and staff (Lawrence et al., 2009). Clients of the mental health system frequently increase the rates at which they smoke, or take up smoking, which can exacerbate conditions and interfere with the effects of medications (Olivier et al., 2007). Family and whanau of clients of mental health services may well be more supportive of services which are smokefree, and protect their family members from smoking.

Research shows maintaining smokefree mental health facilities generally improves management outcomes, with fewer violent incidents, incidences of self-harm and suicide related acts, and discharges against medical advice (Moss et al, 2010; Olivier et al, 2007). This results from having effective, evidence-based programmes and processes to support clients in being smokefree, including appropriate therapies (such as motivational interviewing, counselling and cognitive behavioural therapy, as well as nicotine replacement therapy and drug-therapy where appropriate). Smokefree environments are most effective where facilities are totally smokefree (including staff and visitors); partial bans are less effective in achieving smoking cessation, and more disruptive to patients and staff (Moss et al, 2010; Olivier et al, 2007).

Patients who stop smoking are relieved of the process of regular withdrawal, a source of stress and anxiety, where appropriate therapies are in place (particularly nicotine replacement therapy). Use of cigarettes as a reward, as part of a “token economy”, for instance, reinforces smoking as a practice amongst clients. Smoking privileges and intermittent curtailment of smoking rights reinforce the sense that mental health facilities work as a regime (Moss et al, 2010; Olivier et al, 2007).

Clients of the mental health system frequently cite boredom as a reason for smoking while in mental health facilities. Ensuring that there are a broad range of physical, social, cultural and educational activities, suitable for clients, may serve to alleviate boredom and the stresses that go with it (Moss et al, 2010).

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