the Clearinghouse

The Key ASSISTANCE REPORT

Focus on SMOKING CESSATION

National Mental Health Consumers' Self-Help Clearinghouse

IN THIS ISSUE

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A CRITICAL WELLNESS ISSUE

When it comes to quitting smoking, people with mental illness face a significant challenge, as smoking and mental illness are often unhealthily intertwined. Forty-five percent of the cigarettes smoked in the United States are consumed by individuals with a psychiatric or substance abuse disorder, and consumers are twice as likely to smoke as others. Smokers with mental illness also tend to smoke more heavily than other smokers.

There are a number of theories — ranging from biochemical to environmental — as to why so many people with mental illness smoke, according to Dr. Steven Schroeder, director of the Smoking Cessation Leadership Center at the University of California in San Francisco. "Early on, people with mental illness may find that smoking can alleviate their symptoms, so it becomes a form of self-treatment," Schroeder said. "Another major factor is exposure to smoking in mental health institutions, clinics and substance abuse treatment centers. Sometimes nonsmokers have even become smokers after living in these settings."

These days, the dangerous effects of smoking are well documented. The toxic chemical compounds in cigarettes have been linked to multiple cancers — among them cancers of the lung, larynx, pharynx, esophagus, and gastric system, and some forms of leukemia — as well as reduced fertility, poor pregnancy outcomes, heart disease, stroke, respiratory disease and many other chronic health problems. In 2004, the National Health Interview Survey (NHIS) found that there were 44.5 million smokers in the United States, and it is estimated that one third to one half will ultimately die from the habit.

Because people with mental illness are both more likely to smoke and smoke greater numbers of cigarettes, their chances of encountering serious health problems are even greater. Since consumers also face higher premature death rates than the general population — mainly due to cardiovascular and respiratory disease — smoking cessation has become a critical wellness issue in the mental health community.

OBSTACLES TO QUITTING

Smoking was not always demonized in the mental health arena, however. In fact, it has long been tolerated. Even as general practitioners urged their patients to quit, mental health clinicians seemed to deliberately overlook the problem. "For too long, the mental health treatment community has been isolated from the rest of health care on this issue," said Schroeder. "I don't think it was understood or acknowledged until recently just how adverse the effects of smoking are on people with mental illness."

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A longstanding culture of smoking in mental health institutions has made them the last holdovers among public spaces that allow smoking. According to the Smoking Cessation Leadership Center, 37 percent of psychiatric hospitals still allow smoking inside their facilities.

Another reason mental health counselors have not encouraged smoking cessation is that many are smokers themselves and feel it is hypocritical to ask others to change if they are not willing to drop the habit. Smoking has become deeply entrenched in institutional life. For staff and patients, smoke breaks can be a time to socialize and a way to structure the day. With so many consumers coming into hospitals already addicted to smoking, cigarettes are sometimes used by staff as behavioral incentives. "There is a fear in these institutions that if cigarettes are taken away, the patient won't be as easy to manage," said Schroeder.

Indeed, the mood-enhancing effect of smoking may be one reason it is such a difficult habit to break. Smoking is most prevalent among people with psychotic disorders, depression, anxiety, substance abuse and personality disorders. It is thought that nicotine can increase alertness, concentration and thinking as well as stimulate relaxation and engender a sense of calm. Because smoking is often a form of self-medication, and cigarettes are easily acquired, it is one of the most accessible over-the-counter forms of "treatment."

Wayne Holland, an advocate with CHOICES (Consumers Helping Others Improve their Condition by Ending Smoking) in Piscataway, N.J. (www.njchoices.org), began a 20-year two-pack-a-day smoking habit as a teenager. Holland has schizoaffective disorder and he found that cigarettes helped him concentrate and quell anxiety. Smoking also gave him a sense of social wellbeing, an automatic membership in what he calls "the smokers' clique" wherever he went.

Smokers have reported that cigarettes can help with unpleasant medication side effects, particularly those caused by antipsychotic drugs, such as stiffness and tremors. Some have also said that smoking helps slow the increased appetite and weight gain associated with some drugs.

In addition to helping relieve psychiatric symptoms or drug side effects, smoking is often permitted as a crutch for people trying to rid themselves of other chemical dependencies. Between 60 percent and 95 percent of people in addiction treatment smoke, and half of these smoke more than 25 cigarettes a day.

Quitting smoking raises the possibility of added stress and nicotine withdrawal, which includes symptoms such as

HOW TO QUIT

There is no one best approach to smoking cessation. Many people use a combination of medication, education and counseling. While quitting smoking can be expensive, most of the costs of smoking cessation – medication as well as counseling – are usually covered by Medicaid for Medicaid-eligible people.

The Food and Drug Administration has approved three classes of drugs for cessation:

- **Nicotine replacement therapy** (NRT) products take the place of cigarettes and help relieve withdrawal symptoms. These include over-the-counter products such as gum, patches and lozenges, as well as prescription products such as nasal sprays and inhalers. Most NRTs can only be used for three to 12 months.
- **Nicotine agonists**, the most common of which is Varenicline, work by acting on the acetylcholine brain receptors in the same manner as nicotine. Varenicline is a prescription medication that reduces cravings for tobacco products and can be used for 12 weeks.
- Some **psychotropic drugs**, used to treat mental illnesses, help with withdrawal and lessen the urge to smoke.

Counseling — either alone or in conjunction with medications — is another option for quitters.

- **Individual counseling** is a one-on-one arrangement with a psychologist or smoking cessation coach.
- **Group counseling** programs are available in hospitals and other health centers.
- **Telephone counseling** at 1-800-QUIT-NOW allows quitters to talk to a trained smoking cessation expert about an individually tailored quitting plan.

insomnia, irritability and increased appetite. Clinicians have worried about this effect on consumers, Schroeder said. "There's been a feeling that smoking is the only pleasure some of these people have, so why make them feel worse? But many people do want to quit — it's just that they are not being encouraged to quit."

REASONS FOR QUITTING

The perceived benefits of smoking are outweighed by its far more certain dangers. Contrary to the idea that smoking can ease psychiatric symptoms, research has found that smoking can actually trigger illness in some cases. Smoking has been identified as a risk factor for the onset of panic disorder, and nicotine use in animals is related to increased anxiety. Smokers with schizophrenia endure more psychiatric symptoms and more hospitalizations than nonsmokers with schizophrenia.

There has also been evidence that smoking may make medications less effective. The ingredients in cigarette smoke affect the metabolic breakdown of psychoactive drugs, which means that people who are prescribed medications when they are not smoking may end up under-treated if they take up the habit. Smokers often have to increase their medication dosage over time.

'Each pack of cigarettes you don't smoke can buy you more food, more clothes and even better living conditions.'

Holland, for one, noticed that smoking decreased the effectiveness of his medication. "The more I smoked, the less the medication worked. I didn't like it because my doctors weren't always going to give me more, and I didn't necessarily want to be taking any more medication than I had to. But I would notice increased symptoms like anxiety, agitation and depression," he said.

Quitting smoking is difficult — nicotine dependence is comparable to heroin, cocaine and alcohol addiction — but the majority of smokers want to quit. A 2005 study found that of 45.1 million smokers in the United States, 70 percent said they hoped to stop smoking.

The health benefits of quitting smoking are remarkably immediate. Within 48 hours after an individual quits smoking, blood pressure drops and the chance of a heart attack decreases. Within a year, circulation and lung function increase while shortness of breath and coughing decrease.

Holland points out that quitting smoking can relieve an enormous financial burden on the smoker. Since people with severe mental illness are likely to have lower incomes, smoking cessation can mean greater financial freedom and flexibility. "Each pack of cigarettes you don't smoke can buy you more food, more clothes and even better living conditions," Holland said. What's more, it is not, as has been suspected, more difficult for people with mental illness to quit smoking. People with mental illness who don't use drugs and alcohol have smoking cessation rates equal to people without mental illness. Some recent evidence suggests that people with substance addiction are less likely to relapse over the long term if they quit smoking. Like many people, Holland had to quit a number of times before he was able to quit for good. He realized he had to make a serious change once and for all when his mother died of emphysema from smoking. A combination of therapy, the patch and karate helped him though withdrawal, and he has been smoke-free for five years.

'Many people do want to quit — it's just that they are not being encouraged to quit.'

A CHANGE IN THINKING

In the population at large, cigarette bans and antismoking campaigns have led to a wider cultural intolerance of smoking. That sentiment has trickled down to the mental health community, where smoking is no longer being overlooked. "Now that we know the real dangers of secondhand smoke and we've seen that smokers with mental illness fare so much worse, things have changed," Schroeder said. "Up until now it's been a hands-off approach, but now there's a realization that we need a different kind of policy."

Efforts to encourage smoking cessation specifically within the mental health community are under way. At this writing, the Smoking Cessation Leadership Center is planning a conference in Lansdowne, Va., in March 2007, to focus on improving smoking cessation resources in mental health communities.

With the CHOICES program, Holland visits mental health centers, health fairs and other venues to educate people about smoking and provide resources for people looking to quit. Holland said it is important to see smoking cessation as part of an overall wellness and recovery strategy. "One of the things I tell people trying to quit is not to get discouraged if it takes several tries, because that's often the case," he said. "The key part of it is to keep trying — no matter what." ■

RESOURCES FOR SMOKING CESSATION

National Center for Chronic Disease Prevention and Health Promotion Tobacco Information and Prevention Source (TIPS)
www.cdc.gov/tobacco/index.htm

Nicotine Anonymous
www.nicotine-anonymous.org

Online Guide to Quitting
http://www.smokefree.gov/

Smoking Cessation Leadership Center
http://smokingcessationleadership.ucsf.edu/

National Network of Tobacco Cessation Quitlines
1-800-QUIT-NOW

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The Clearinghouse welcomes all programs in which consumers play a significant role in leadership and operation to apply for inclusion in its Directory of Consumer-Driven Services. The directory, accessible at http://www.cdsdirectory.org, is searchable by location, type of organization, and targeted clientele, and serves as a free resource for consumers, program administrators and researchers.

Apply online at www.cdsdirectory.org/contact, via fax at 215-636-6312, or by phone at 800-553-4KEY (4539). To receive an application by mail, write to info@cdsdirectory.org or NMHCSH Clearinghouse 1211 Chestnut Street, Suite 1100, Philadelphia, PA 19107.

The Key ASSISTANCE REPORT

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funded by U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Mental Health Services www.samhsa.gov

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