

Smoking and Mental Illness (2006)

Smoking and Mental Illness
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Smoking kills people. It kills people with mental illness more often and at an earlier age than other smokers. The newest data reveals that persons with serious and persistent mental illnesses have a 25-year lower life expectancy than the general population. More than half of that difference is related to conditions caused or worsened by smoking cigarettes.

So why address smoking in persons with mental illness? Because smoking inhibits psychiatric recovery in many ways, including leading to the ultimate barrier, death.

Recovery from the affects of psychiatric illness is a complex and expansive issue, which is not so much about “curing” as it is about living. Unlike getting a wart removed, recovery from persistent illnesses like diabetes, high blood pressure, or lower back pain, mental illness is an ongoing process of life adjustment and adaptation. Persistent conditions require a holistic approach to recovery. Focusing on a single characteristic of life without the consideration of the whole person is ineffective.

Recovery is about creating a life expression that is not dependent or defined by illness or sickness. Smoking addictions are in direct opposition to recovery.

Let’s review the facts. Although the overall prevalence of smoking has been decreasing in the general public since the early 70s, those with psychiatric disorders continue to have significantly higher rates of smoking. These rates have gone largely unchanged over that time span. It has been estimated that patients with mental illness consume roughly half of all cigarettes in the United States. Research has shown that persons who smoke and are experiencing a serious and persistent mental illness start smoking at an earlier age, smoke more cigarettes and extract more tar and nicotine from each cigarette than the average smoker. It comes as no surprise that they also suffer health consequences at a higher rate.

In addition, smokers with psychiatric illnesses are less likely to attempt quitting without direct support and are less likely to be involved in a smoking cessation group than other smokers. The United States' Centers for Disease Control and Prevention describes tobacco use as "the single most important preventable risk to human health and an important cause of premature death worldwide".

At Riverview Psychiatric Center, on the day this was written, 68 percent of those being served smoke. Additionally, 72 percent have a metabolic condition, (diabetes or obesity) compounding the negative consequences of smoking.

Historically, the issue of mental illness and smoking has been ignored almost entirely. In the not too distant past it was not unusual to “reward” patients with cigarettes. Riverview and the former Augusta Mental Health Institute allowed and even supported smoking by clients. Many people with serious and persistent mental illness never experience living in a smoke-free and health-supportive environment. Although persons with mental illness are less likely to be engaged in a smoking cessation program, research also suggests they are just as likely to benefit as persons without mental illness.

What about the argument that taking away smoking will make the psychiatric illness worse? There is no evidence that patients relapse while making a quit attempt. In fact, evidence suggests that abstinence results in little adverse impact. A national survey recently demonstrated that smoke-free psychiatric hospitals have less violence, less injuries and less use of restraint and seclusion.

A visitor to Riverview asked “Why take away the one thing the client enjoys?” Is reducing the experience of joy down to the practice of a deadly addiction and protecting that “joy” really a social good? Those addicted to nicotine and cigarettes no more choose to smoke than any other addict who makes a choice.

Mental illness creates a vulnerability to smoking addiction. Brief symptom reductions related to immediate nicotine absorption (during smoking and for a few minutes afterward) is experienced by persons with psychiatric symptoms. Disruptions in thinking and coping, related to the mental illness, add to the vulnerability. Refusing to address addiction is in essence refusing to address the mental illness. Until the addictive behavior is interrupted, no real progress can be made at expanding autonomy and the practice of choice.

Addiction, diabetes, high blood pressure, finding work, maintaining social relationships and obtaining basic supports are the type of challenges many face in recovery from mental illness. Care services to support persons facing these challenges are needed. These services must be provided in a safe care environment. You would not find drinking alcohol, using recreational drugs, or smoking at any hospital in Maine. This is not because “treatment” is being forced. It is because observing the practice of an addiction is a trigger to those who are engaging in treatment. Through the providing of safe therapeutic care environments, the process of life adjustment and adaptation can begin.

Programs and services designed to promote recovery of individuals with persistent mental illness necessitates offering services addressing a wide range of human conditions. Recovery supportive care is care which helps widen the scope of joy and life that each person experiences. Reducing the burden some will have in battling multiple health issues while in the midst of personal recovery from mental illness is a goal all mental health services should set.