

## **Why Mental Health settings should be included in smoke free workplace legislation?**

### **Why?**

- 5 million deaths worldwide will occur from tobacco consumption in 2006, projected to reach 10 million deaths annually by 2020<sup>1</sup>.
- Smoking remains the largest single cause of preventable illness and premature death in the UK with 106,000 people dying of smoking caused diseases in 2002<sup>2</sup> and more than 10,000 deaths each year attributable to passive smoking<sup>3</sup>. Heavy passive smoking is associated with a 50 to 60% increased risk of coronary heart disease<sup>13</sup>.
- The effects of environmental tobacco smoke on health are now accepted and under the Health and Safety at Work Act, employers have a legal duty to protect both patients and staff from environmental tobacco smoke.

### **Legislation**

- The Health Act 2006 will make all enclosed public and work places smoke-free environments but may exclude some mental health settings.
- The Health Select Committee<sup>4</sup> proposed that psychiatric institutions should not be exempt from the law.
- A consultation regarding exemptions<sup>2</sup> takes place until October 2006. Amongst proposed exclusions are mental health units that provide long-term accommodation (defined as not less than six months) as well as prisons, care homes and hospices.
- The proposal to exempt those units where patients remain for more than six months will create difficulty with enforcement and exempt most units since 46% of psychiatric inpatients in 2006 were inpatients for longer than 6 months<sup>5</sup>.
- Exemption from the Act will exclude mental health patients from mainstream health improvement strategy and further exacerbate inequality.
- The Human Rights Act only allows an individual freedom of choice to act when their actions do not endanger others. Mental Health patients are not allowed to drink alcohol or use illicit drugs in mental health units so why should smoking be allowed?

### **Mental Health and Smoking.**

- Nicotine dependence fulfils the core criteria for mental disorder. It is therefore the most prevalent and deadly of all psychiatric disorders but is frequently overlooked by psychiatric professions.
- High levels of smoking are found among people with mental health problems; nearly three quarters of people with schizophrenia, affective psychosis and neurotic disorders living in mental health settings are smokers<sup>6</sup> and they are more likely to be heavier and more dependent smokers<sup>7</sup>.
- Smoking tobacco is significantly associated with increased prevalence of all major psychiatric disorders and a clear relationship exists between smoking and number of depressive or anxiety symptoms<sup>8</sup>. Anxiety decreases following

first week of abstinence<sup>22</sup> and smoking appears to be chronically anxiogenic rather than anxiolytic. Smokers have been found to have higher rates, experience more severe depression, are more likely to think about suicide and have higher suicide rates<sup>23</sup>.

- Psychological problems have been shown to decline significantly in smokers who stopped smoking for six months<sup>9</sup>.
- Those with schizophrenia have almost ten times higher risk of death from respiratory disease than the general population<sup>10</sup>.
- Nicotine may be particularly reinforcing in schizophrenia because it stimulates the subcortical reward system and the prefrontal cortex which both appear to be hypofunctional in schizophrenia<sup>15</sup>. Nicotine's ability to trigger dopamine release in mesolimbic reward centres might render smoking one of the few reinforcers able to overcome the anhedonia that characterizes schizophrenia and depression<sup>16</sup>.
- Cigarette smokers are generally prescribed higher doses of antipsychotic medication due to smoking increasing the metabolism of antipsychotic medication<sup>17</sup> through induction of liver enzyme P450-1A2.
- There is a suggestion that psychiatric hospitalization can lead non-smokers to become smokers since they are vulnerable to the constant smoking stimuli<sup>14</sup>. The smoking culture in mental health units was recently demonstrated in a survey showing that 54% of mental health staff believed that staff smoking with patients was of value creating therapeutic relationships<sup>19</sup>.
- Given the very high levels of smoking among those with serious mental illness and the fact that approximately one in two smokers die prematurely<sup>11</sup>, the death toll from smoking far outweighs the 10% lifetime risk of suicide.

### **Policy and Support**

- In a systematic review of twenty-six international studies examining the impact of smoke-free policies in mental health settings, there was no increase in aggression, discharge against medical advice or increased use of as-needed medication following the ban in 90% of sites imposing total bans<sup>12</sup>. Simple smoking policies applied in a consistent way to all patients were more effective than selective or gradually introduced bans. Complaints and verbal aggression were associated with selective bans.
- Smoke-free policies can also be successfully implemented in maximum security psychiatric settings and apprehensions of staff and patients to dissipate with time after the smoking ban was implemented<sup>20</sup>.
- Smoke-free policy in mental health settings will significantly improve health and well-being in populations with disproportionate levels of inequality and is a key part of addressing the physical health needs of those with mental health problems.
- There is no clear evidence that stopping smoking exacerbates psychotic illness<sup>21</sup> and there are no consistent reports that after smoking cessation, there is an increase in depression or anxiety.
- Smoking cessation treatments are extremely cost effective at reducing ill health and prolonging life<sup>18</sup>.
- These effective treatments to help smokers quit are not being offered routinely to people with mental health problems.

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