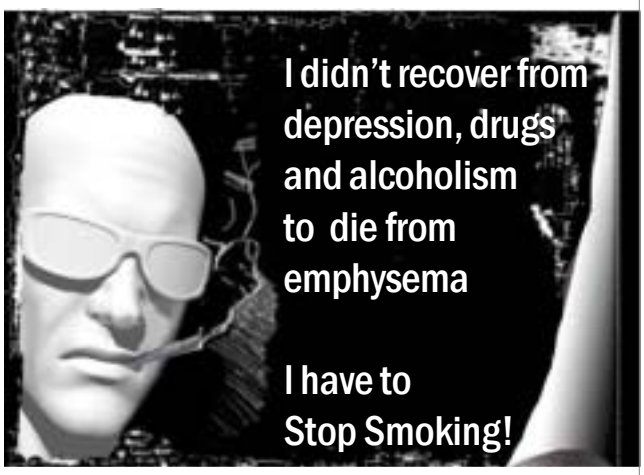
Mental health, Recovery, and Quitting Smoking

County of San Diego Health and Human Services

Mental health, Recovery, and Quitting Smoking

Smoking among patients with mental illness and addictions is a major and underappreciated public health problem. This has been a “silent” epidemic facing the challenges of the stigma associated with mental illness and addictive disease.

New explanations for the link between cigarette smoking and mental illness are emerging. A research found that forty-one percent of current smokers report having a mental health diagnosis in the past month, 60% report a mental health diagnosis at some point in their lifetime, and among current smokers, the most common mental health diagnoses are alcohol abuse, major depressive disorder, anxiety disorders, and illicit drug use or dependence.The more severe the psychiatric symptoms, the more likely the patient is to be a smoker, and quitting cigarettes requires long-term planning, impulse control and the ability to personalize risk -- all that much harder to do when one's thinking is impaired by mental illness.



Smoking by teens may well signal the fire of alcohol and other drug abuse and mental illnesses such as depression and anxiety disorders. Teens who start smoking early are more likely to report symptoms of mental illness such as hopelessness, depression and worthlessness.

According to research by The National Center on Addiction and Substance Abuse (CASA) at Columbia University, because nicotine significantly affects the structural and chemical changes in the developing brains of adolescents, smoking cigarettes makes teens more vulnerable to alcohol and drug addiction and to mental illness. Analyzing data from the National Survey on Drug Use and Health (NSDUH), CASA researchers found that teens who smoke are nine times more likely to meet the medical criteria of alcohol abuse or dependence, and 13 times more likely for abuse and dependence on an illegal drug, compared with teens who don't smoke. The report is titled, Tobacco: The Smoking Gun.

"These findings sound an alarm for parents, teachers, pediatricians and others responsible for children's health that smoking by teens may well signal the fire of alcohol and other drug abuse and mental illnesses such as depression and anxiety disorders," said Joseph A. Califano, Jr., chairman and president of CASA in a news release. "We have known for a long time that smoking causes deadly and crippling cancers and cardiovascular and respiratory diseases. Now we see the devastating effects that nicotine can have on the developing brains of our children and teens." “This report underscores what we know about the developing brains of teens who are highly vulnerable to personal, social and media influences to begin smoking and why it is so vital to reach them with information and education about tobacco before they start to smoke.”

Recent studies suggest that quitting is possible for this population with combination treatments, including use of motivational techniques as well as combinations of medications and behavioral therapy.

Mental health clinicians have tended not to address smoking cessation with their patients, but increasing evidence suggests that such reticence is unwarranted, as smoking cessation in this population is feasible. The approach to cessation should include standard interventions of counseling and pharmacotherapy, for which substantial evidence of efficacy exists in patients with and without mental illness. If patients with mental illness are to achieve wellness, smoking cessation must be an integral component of their treatment regimen. Counseling should emphasize the continuing benefits of quitting as well as devise behavioral strategies to combat the urge to smoke.

Psychiatric hospitals are now becoming smoke free, despite initial resistance from staff as well as from the patients and their families, and from the tobacco industry. The tobacco industry has been implicated in sponsoring studies that claim that nicotine helps psychiatric symptoms and in opposing smoking bans in institutions. Some staff had warned that removing tobacco privileges would lead to increased violence, disciplinary actions, and exacerbations of psychiatric symptoms. In fact, the opposit occurred, with less violence, fewer disciplinary actions, and more staff contact time with patients in therapeutic settings being reported.

About 70% of smokers with mental illness want to quit, similar to the general population and there is abundant evidence that smokers with mental illness are able to quit.

Tobacco use counseling treatment may be delivered in a variety of formats, including proactive telephone counseling or contact (quit lines and callback counseling), individual counseling, and group counseling/

contact. Toll-free telephone quit lines such as 1-800-NO-BUTTS increase quit rates in a range comparable with drug trials. This Toll-free system offers counseling and refers callers to their local community resources. All forms of intervention increase abstinence rates compared with no intervention.

Smoking harms nearly every organ of the body, reducing the health of smokers, and often leading to incurable disease and death. In the United States, cigarette smoking is responsible for about one in five deaths annually. Although exact numbers are unknown, probably as many as 200 000 of the 435 000 annual deaths from smoking occur among persons with mental illness and/or substance abuse. People with chronic mental illness die, on average, 25 years earlier than the general population, largely from cardiovascular disease and diabetes mellitus, and smoking is a major contributor to these premature deaths.

In a 20-year follow-up study of 845 patients hospitalized for addiction to alcohol or illicit drugs, the observed mortality was 48% vs. an expected rate of 18%; half the deaths were attributable to smoking. According to The Mental Health and Substance Abuse Corporations of Massachusetts, Inc. (MHSACM), individuals with serious and chronic mental illness are more likely to have co-morbid chronic medical conditions including diabetes, cardiovascular disease, chronic obstructive pulmonary disease, and obesity. Among those with substance use disorders, individuals are more likely to have chronic liver disease, hepatitis C, human immunodeficiency virus/AIDS, and other chronic illness. The reasons for the high co-morbid medical illness in individuals with serious behavioral health conditions and addictive disease have become well known: lifestyle habits of smoking, drug & alcohol use, including IV drug use and other high risk behaviors, poor nutrition, lack of exercise, obesity, the weight gain caused by psychotropic medication, homelessness, transience, patients' fears and lack of motivation to access medical services, strong residual stigma concerning mental illness and substance use disorders, frequent discomfort with and unwillingness by physicians to serve individuals with serious mental illness addictive disease, and inadequate rates to provide the extent of medical care needed by the population.

Tobacco addiction kills more Americans than suicide, homicide, AIDS, and most other known illnesses.

We need to educate patients and their families about the benefits of treatment and considerable risks of smoking. All patients deserve access to effective smoking treatments. Research reveals that even a small reduction in smoking in this population will demonstrate favorable health outcomes as well as a cost-savings to State Medicaid expenditures.

Tobacco control efforts, like policy formation, increased taxation, and antismoking media campaigns, are effective strategies that reduce cigarette smoking and sales.

Groups with excess tobacco use or special needs, like pregnant women and adolescents, are identified for aggressive interventions, which address prevention, education, and treatment. Despite the fact that persons with a mental illness or addiction account for nearly half of the U.S. tobacco market, there have been virtually no specific tobacco control activities directed towards reducing tobacco use in these groups. Stigma and lack of advocacy for these populations may contribute to this effect. Families and treatment providers have been ambivalent about tobacco and have not demanded tobacco control efforts on behalf of their loved ones and clients. Tobacco addiction in individuals with mental illness or an addiction can no longer be ignored. We cannot allow stigma to block our efforts to apply effective public health and clinical treatment approaches to the leading cause of death and morbidity for this population.

As desirable as it might be to transform primary care specialists into smoking cessation experts, it is an unrealistic goal. The achievable alternative is to develop systems and resources to marshal essential nicotine cessation services. At a minimum, this should include referring the smoker to a quit line.

No smoker should leave a physician's office without an offer of help to stop smoking.

REFERENCES: This article was written for community education purposes with part of the information excerpted from an article written by Steven A. Schroeder, MD, titled "A 51-year-old woman with bipolar disorder who wants to quit smoking" published by the Journal of the American Medical Association, JAMA. Vol.301 No 5, Feb.2009. available at http://jama.ama-assn.org/cgi/content/full/301/5/522 and with information excerpted from the report titled, Tobacco: The Smoking Gun. Report made by The National Center on Addiction and Substance Abuse at Columbia University. www.casacolumbia.org. The article information also includes information from the Mental Health and Substance Abuse Corporations of Massachusetts, Inc. (MHSACM) report, and recommendations from the report "Addressing tobacco among individuals with a mental illness or an addiction" written by Jill M. Williams and Douglas Ziedonis. A document supported in part by a grant from the National Institute on Drug Abuse (NIDA K-DA14009-01 for J.W.). Dr. Ziedonis is receiving research grant support from Janssen, Bristol-Myers Squibb, Astra-Zeneca, and Lilly