Breaking Barriers and Implementing Changes

The Significance of Tobacco Dependence in Persons with Mental Illness

Part 1 in a 3-Part Series
Counseling Points™

Breaking Barriers and Implementing Changes

The Significance of Tobacco Dependence in Persons with Mental Illness

Continuing Education Information

Target Audience
This educational activity is designed to meet the needs of psychiatric nurses with an interest in providing quality care to patients with mental illness who smoke.

Learning Objectives
Upon completion of this educational activity, the participant should be able to:

• Understand that tobacco dependence is a significant problem in persons with mental illness

• Describe the factors that are believed to be responsible for increased tobacco use in persons with mental illness

• Understand that tobacco dependence can be successfully reduced or eliminated in persons with mental illness

Continuing Education Credit
The American Psychiatric Nurses Association is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center’s Commission on Accreditation.

1.0 CNE contact hours may be earned for successful completion of this activity.

This program expires: July 15, 2012.

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Disclaimer
Participants have an implied responsibility to use the newly acquired information to enhance patient outcomes and their own professional development. The information presented in this activity is not meant to serve as a guideline for patient management. Any medications, diagnostic procedures, or treatments discussed in this publication should not be used by clinicians or other healthcare professionals without first evaluating their patients’ conditions, considering possible contraindications or risks, reviewing any applicable manufacturer’s product information, and comparing any therapeutic approach with the recommendations of other authorities.
Dear Colleague,

Welcome to this new series of Psychiatric Nurse Counseling Points™, an official publication of the American Psychiatric Nurses Association (APNA), on tobacco cessation for persons with mental illnesses and/or substance abuse addictions. We would like to thank Pfizer, Inc. for providing an educational grant for the series of three issues.

Tobacco use has often been ignored, or even tolerated or encouraged, in patients with mental illness. Given what we now know about the toll that smoking takes on the overall health and lifespan of patients and the fact that available interventions can successfully help these patients to quit, tobacco cessation is an issue whose time has come for psychiatric nurses.

APNA has formed a Tobacco Dependence Council and partnered with the Smoking Cessation Leadership Center at UCSF, led by Dr. Steven Schroeder, to educate our membership about smoking interventions and strategies. Currently, survey data suggest that 61% of psychiatric nurses refer or assist smokers with quitting interventions and 29% provide intensive reduction interventions. The Council has set a goal of increasing the percentage of psychiatric nurses intervening by 5% each year—which is where you, the reader, come in.

We have been lucky enough to benefit from the efforts of several energized leaders in this field in meeting this goal, most notably the chair for this series, Daryl Sharp, PHD, PMHCNS-BC, NPP, of the University of Rochester School of Nursing. Along with faculty member Susan Blaakman, MS, RN, NPP-BC, Daryl is co-author of Intensive Tobacco Dependence Intervention with Persons Challenged by Mental Illness: Manual for Nurses, which is available on the Tobacco Dependence Information Center section of the APNA website at www.apna.org/TDInfoCenter. We encourage you to take advantage of the many resources available on the website, as well as in this issue and the two to come over the next few months. The time to act is now!

Best regards,

Mary D. Moller, DNP, APRN, PMHCNS-BC, CPRP, FAAN
President, APNA
The Significance of Tobacco Dependence in Persons with Mental Illness

Introduction

It is well established that people with mental illnesses and/or addictive disorders are dying, on average, at significantly younger ages than found in the general population. In large part, the 25-year shorter life expectancy of the psychiatrically ill can be explained by their exceptionally high rates of tobacco dependence. It is estimated that those with mental illnesses and/or addictive disorders account for approximately 200,000 of the 443,000 annual deaths from tobacco-related illnesses in the United States, with another 8.6 million suffering from tobacco-related disabilities. Sadly, many smokers with mental illness do not reach their 50th birthday. Furthermore, living with the co-morbid illnesses caused by tobacco use (including cardiovascular disease, cancer, and respiratory illnesses) negatively impacts quality of life and prevents many people from working toward their recovery goals.

Given the widespread incidence of smoking in this population, a significant disease burden is also borne by others due to exposure to the negative health effects of second-hand smoke, which contains at least 250 chemicals known to be toxins.

Despite the scope of this epidemic, nurses and other clinicians have typically failed to intervene with their patients who smoke even though efficacious interventions exist to treat tobacco dependence. In light of the increasingly stigmatizing nature of tobacco dependence, it is particularly disconcerting that treatment is withheld from a vulnerable population that is often already stigmatized by the nature of their diseases and by the educational, social, and economic disadvantages that may accompany them.

General Factors Linked with High Smoking Rates

Although smoking in the general population has significantly declined over the past several decades, tobacco use prevalence rates among those with psychiatric and/or addictive disorders (other than tobacco dependence) remain more than twice that of the general population (Table 1). Tobacco dependence experts agree that nicotine addiction results from a complex interplay of genetic, neurobiological, psychological, social, economic, and cultural factors. There is strong genetic evidence linking smoking and depression, as well as smoking and alcohol use. Nicotine binds to several neurotransmitters that underlie mental illness, including dopamine, norepinephrine, acetylcholine, glutamate, serotonin, β-endorphin, and GABA. Some have postulated that nicotine is used as a form of self-medication among those with mental illnesses because it tends to help people calm down and concentrate better, thereby ameliorating some psychiatric symptoms and improving cognition (Table 2). Nicotine also elicits a pleasure response, which may be difficult for some with mental illnesses to experience via other routes, such as typically experienced through relationships, work, and play. Boredom is a widely reported problem in this population, and many report reliance on smoking as a key coping strategy for combating monotony in their daily lives. Furthermore, nicotine’s dopaminergic effects may improve some of the negative symptoms associated with psychotic disorders as well as some medication side effects from the use of traditional antipsychotic agents.

Given the psychoneurobiological underpinnings of psychiatric illnesses, patients with serious mental illness (SMI) may be particularly sensitive to withdrawal effects, which only heighten the challenges posed by reducing or stopping smoking. Beyond these genetic, neurobiological, and psychological factors, social support is often lacking among clients with SMI; they frequently live in community residences where smoking is not only permitted but is part of

<table>
<thead>
<tr>
<th>Table 1. Smoking Prevalence Rates Among Persons with Mental Illness</th>
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<tbody>
<tr>
<td>Schizophrenia</td>
</tr>
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<td>Major depression</td>
</tr>
<tr>
<td>Anxiety disorder</td>
</tr>
<tr>
<td>Bipolar disorder</td>
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<td>Substance abuse disorders</td>
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</tbody>
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Table 2. Factors Linked to High Smoking Rates in the Psychiatrically Ill Population

- Genetic predisposition
- Effects of nicotine (calming, pleasurable, and improves concentration)
- Boredom
- Smoking is part of the culture and used as a reward or behavioral tool in some psychiatric settings
- May negate some antipsychotic agents’ side effects
- Increased sensitivity to nicotine withdrawal
- Lack of social support
- High unemployment rates and poverty
- Relatively low education levels

the normative culture. Although researchers have demonstrated through social network analyses that smoking in the general population has become progressively marginalized, high smoking rates among those with mental illnesses and/or substance use disorders have persisted, thereby reinforcing smoking in these subpopulations.\(^\text{11,20}\) Added to these factors, high unemployment rates, poverty, and relatively low education levels among the psychiatrically ill increase the likelihood of tobacco dependence and contribute to the smoking epidemic in this population.\(^\text{7,17,21}\)

Nicotine Dependence and Specific Psychiatric Disorders

Nicotine Dependence and Schizophrenia

Smoking rates among people with schizophrenia are estimated to be 75%-85%, with higher rates among males than females.\(^\text{22}\) Approximately half of smokers with schizophrenia consume more than 25 cigarettes daily.\(^\text{1,13,23}\) Researchers conducting smoking topography studies have found that people with schizophrenia puff their cigarettes more frequently, extract more nicotine from them, and experience a greater carbon monoxide boost than those without the disease.\(^\text{24-26}\) Although researchers agree that a complex interplay of genetic, biological, psychological, and social factors underlie schizophrenia and nicotine dependence, studies regarding causal mechanisms are limited. Nicotine improves sensory gating (a largely automatic process by which the brain is able to adaptively adjust so it can attend to stimuli) and may improve visuospatial working memory, both of which are negatively affected by schizophrenia.\(^\text{27}\)

Smoking may be a form of self-medication, but Ziedonis and colleagues emphasize that it is important for both clinicians and researchers to stay open to other explanations such as addiction, dependence, tolerance, or nicotine withdrawal effects as reasons for why patients continue to use tobacco products.\(^\text{1}\)

Smoking outcomes also may be affected by psychiatric treatment medications.\(^\text{28-29}\) For instance, people taking atypical antipsychotic medications have demonstrated better smoking outcomes (number of cigarettes smoked daily and/or quit rates) than those taking typical antipsychotic medications.\(^\text{18,29}\)

Nicotine Dependence and Depression

People who smoke have significantly higher rates of lifetime depression in comparison to nonsmokers.\(^\text{1,30,31}\) Recent estimates from cross-sectional surveys indicate that approximately 30% of those with depression smoke.\(^\text{12,32}\) Consistent evidence also exists supporting the strong relationship between smoking and bipolar disorder with reported prevalence rates as high as 68.8%.\(^\text{13,18}\) The Substance Abuse and Mental Health Services Administration (SAMHSA) reported findings from the 2006 National Survey on Drug Use and Health (NSDUH) in which those aged 18 or older who were nicotine dependent in the past month were more than twice as likely as those who were not dependent on nicotine to have experienced serious psychological distress in the past year.\(^\text{33}\) The survey also revealed that youths aged 12-17 who were nicotine dependent in the past month were over twice as likely to have met the criteria for major depressive disorder; a similar pattern was noted among adults aged 18 or older.

Such findings have led clinicians and researchers to hypothesize that depression may cause smoking. Youths or young adults may start smoking because they experience relief from depressive symptoms when they do so.\(^\text{1}\) Indeed nicotine may ameliorate depressive symptoms, which perpetuates smoking.\(^\text{34}\) Researchers also hypothesize that the strong relationship between depression and nicotine dependence may be due to genetic vulnerability to both illnesses.\(^\text{35,36}\) There also is some evidence that smoking may cause depression due to compensatory neurophysiological changes catalyzed by prolonged smoking. Ziedonis and colleagues conclude that the causal relationship between depression and smoking is likely to be bidirectional.\(^\text{1}\) Although there is debate about whether a history of major depression is an independent risk factor for cessation failure, smokers with
a past history of major depressive disorder are more likely than those without such a history to experience the disorder after they stop smoking.\textsuperscript{24,34,37-39} This has led to the development and testing of interventions in which both depressive symptoms and nicotine withdrawal are treated concurrently. Investigators have concluded that adding cognitive-behavioral treatments (CBT) targeting depression to tobacco dependence interventions yields better quit rates than standard cessation interventions for those with a history of recurrent depression (two or more episodes).\textsuperscript{1,40,41} Bupropion SR and nortriptyline are the most effective pharmacotherapy options to aid cessation in this population, yet their mechanism of action does not appear to be a decrease in depressive symptoms.\textsuperscript{1,42,43} In general, selective serotonin reuptake inhibitors (SSRIs), which are widely used to treat depression, have not been demonstrated to be effective cessation medications.\textsuperscript{21}

**Nicotine Dependence and Anxiety**

Anxiety disorders comprise the largest single group of psychiatric disorders in the United States and commonly occur with other mental and physical disorders.\textsuperscript{1,44} Although estimates vary by anxiety disorder diagnosis and the selected sample population, prevalence estimates of smoking among those with anxiety disorders is significantly greater in comparison to those in the general population.\textsuperscript{45} Highest prevalence estimates across studies are reported for those with panic disorder (with or without agoraphobia, 19%-47%) and those with posttraumatic stress disorder (44-66%).\textsuperscript{45}

Similar to the research regarding the association between smoking and depression, the underlying causal relationships have not been clearly established with respect to anxiety disorders and smoking. Researchers hypothesize that while the presence of an anxiety disorder may increase one’s risk for nicotine dependence, the reverse process may be true for some anxiety disorders (i.e., smoking may cause the disorder).\textsuperscript{1} For example, nicotine-dependent young adults are at higher risk for developing anxiety disorders.\textsuperscript{31,45}

Evidence suggests that nicotine may be anxiolytic, yet such anxiety relief is likely to be quite variable depending on administration route (i.e., inhaled versus transdermal), as well as administration timing and severity of anxiety.\textsuperscript{45} It also is possible that for some anxiety disorders, nicotine could be anxiogenic, although current research in this area is limited to animal models.\textsuperscript{45}

The relationship between smoking and anxiety is particularly important because smokers often report stress as a cue for smoking, and those who are trying to quit typically report negative affect as a primary reason for relapsing.\textsuperscript{46,47} Poor tolerance of the distressing symptoms associated with withdrawal from nicotine may also impede cessation efforts.\textsuperscript{1} Additionally, “anxiety sensitivity” (fear of the sensations accompanying fear, dread, or panic) predisposes people to developing some anxiety disorders (e.g., panic and posttraumatic stress disorder), and has been associated with more intense nicotine withdrawal symptoms, more perceived difficulty quitting, and early relapse.\textsuperscript{48-50} Although effect sizes were small and primarily linked to panic disorder, Morissette and colleagues found that smokers with anxiety disorders experienced greater anxiety sensitivity, anxiety symptoms, agoraphobic avoidance, depressed mood, negative affect, stress, and life interference in comparison with nonsmokers.\textsuperscript{51} Further research exploring mediators and moderators of the relationship between anxiety and nicotine dependence are needed so that more targeted interventions can be developed to aid cessation efforts among those with anxiety disorders.

**Nicotine Dependence and Substance Use Disorders**

Epidemiological evidence indicates that the prevalence of smoking among those who are alcohol dependent is as high as 75%.\textsuperscript{52} Smoking rates among those using cocaine are estimated to be approximately 80%, with prevalence estimates of 90% among those who are opioid-dependent.\textsuperscript{18,53,54} Findings from the 2006 NSDUH survey revealed that those aged 12 or older who were nicotine dependent in the past month were more likely to have engaged in alcohol use, binge alcohol abuse, and heavy alcohol abuse in the past month.\textsuperscript{33} They also were over 3 times more likely to have engaged in illicit drug use within the past month. Although the findings from one study support delaying smoking cessation until after alcohol treatment to maximize the effectiveness of anti-drinking interventions, researchers have generally concluded that stopping smoking does not interfere with recovery from other drug use.\textsuperscript{21,55} Smoking abstinence also has been correlated with reductions in
illicit substance use, which underscores the importance of integrated treatment approaches that target all substances of abuse, including tobacco.\textsuperscript{56}

**How Providers Contribute to the Epidemic**

Unfortunately, provider reticence to intervene contributes to continued high smoking prevalence rates among the mentally ill and those with addictive disorders. Despite the fact that tobacco dependence has strong neurobiological and psychological underpinnings, and the high likelihood that there cannot be recovery from mental illness or substance use disorders without physical wellness, many psychiatric clinicians express disinterest and discomfort in treating tobacco dependence, some even claiming that such treatment exceeds the limits of their practice responsibilities.\textsuperscript{7,57} Prochaska and colleagues found that only 1\% of psychiatric inpatients were assessed for smoking status during hospitalization, with smoking status largely absent from treatment planning.\textsuperscript{58} Thorndike and colleagues reported only 38\% of outpatients with psychiatric illnesses received tobacco dependence counseling from their primary care physicians and only 12\% from their psychiatrists.\textsuperscript{59}

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Lack of provider intervention is likely a function of the decades-long practice of using cigarettes as behavioral reinforcement and even viewing smoking with patients as therapeutic.\textsuperscript{60} Despite providing care in “smoke-free” treatment facilities, staff members (who frequently are smokers) may still escort patients for smoking breaks (i.e., “privileges”) outdoors.\textsuperscript{61} Clinicians, erroneously, have described smoking as the “least of their patients’ problems” and may try to preserve one of the few “pleasures” enjoyed by these already burdened individuals.\textsuperscript{62} Clinicians have also reported concern that psychiatric symptoms will worsen when smoking is discontinued, that quitting or decreasing smoking is not realistic for those with mental illness, and/or that persons with mental illness/addictive disorders are not invested in smoking cessation.\textsuperscript{10,17,63} Research, however, does not support any of these conclusions.

The current literature shows that persons with mental illness often wish to quit, look for resources to assist their efforts, and can be successful at decreasing and/or quitting smoking.\textsuperscript{7,64,65} Research regarding smoke-free policies in psychiatric hospitals has revealed that persons with mental illness are able to quit smoking and that cessation may be linked to decreases in violence and the need for disciplinary action in addition to increases in staff satisfaction and time spent with patients.\textsuperscript{54,66,67}

Especially as smoking prevalence decreases in the general population, continued high rates of smoking contribute to the stigma of mental illness and the marginalization of this vulnerable population, and interfere with the ability of many with mental illnesses to lead healthy, productive lives.\textsuperscript{6} For these reasons, researchers, clinical leaders, and policy experts are urging psychiatric clinicians to overcome their reluctance to intervene with their patients who smoke.\textsuperscript{21,68}

**Tobacco Dependence Treatment Efficacy**

**Individual Level Interventions**

Across psychiatric and substance use disorders, persuasive evidence exists that smokers can be helped to stop smoking with intensive interventions.\textsuperscript{1,20,69} The expert panel behind the *Clinical Practice Guideline for Treating Tobacco Use and Dependence* identifies several interventions that are effective in the general population—and that can also be used effectively for those with psychiatric and/or substance use disorders.\textsuperscript{21} Although smokers with these disorders are at higher risk for relapse than those without mental illness and/or addictive disorders, convincing evidence exists to support the efficacy and effectiveness of pharmacotherapy and psychosocial tobacco dependence counseling in predicting cessation outcomes among the mentally ill.\textsuperscript{1,21,70}

A critical review of the literature comprised of 24 studies with samples that included persons with a variety of psychiatric disorders and a meta-analysis of 15 studies focused on participants with depressive disorders found comparable quit rates to those in the general population.\textsuperscript{24,64} Most interventions in these studies combined medications and tobacco dependence counseling.
Although both individual and group formats have been found to be effective, brief interventions and self-help approaches are not likely to provide sufficient intervention doses to help patients with psychiatric illnesses and/or substance use disorders to stop smoking. Thus, intensive integrated interventions (7 to 10 sessions) are recommended in this population.\textsuperscript{21,35,66} Investigators in clinical settings have reported results similar to those obtained in efficacy trials.\textsuperscript{67,71} Cessation outcomes among 79 subjects with mental illnesses receiving group-based cessation treatment in a community mental health clinic in Canada were comparable to those reported following group-based cessation treatment for those without mental illnesses.\textsuperscript{72} Foulds and colleagues concluded from a large cohort study (N=1021) in a free tobacco clinic in New Jersey that smokers who were highly nicotine-dependent and of lower socioeconomic status (as are many smokers with mental illness and/or substance use disorders) required more support to maintain treatment adherence, which predicted greater success in stopping smoking.\textsuperscript{73}

**Systems Level Interventions**

In addition to providing access to evidence-based individual treatments, the Practice Guideline expert panel recommends systems intervention strategies, including:

- establishing a tobacco user identification system to ensure comprehensive screening;
- providing adequate training, resources, and feedback to all clinicians;
- dedicating staff to provide tobacco dependence treatments (and evaluating their performance in this role);
- promoting hospital policies (e.g., tobacco-free campuses) that support and provide tobacco dependence services; and
- expanding clinic formularies to include FDA-approved pharmacotherapies to aid in cessation efforts.\textsuperscript{21}

Creating treatment settings that honor the central mission of health care (to heal and comfort) begins with not permitting smoking on clinic grounds while providing evidence-based cessation treatments for patients and staff. One of the effective strategies for reducing tobacco use in the general population has been the “person-to-person spread of smoking cessation,” which has resulted in the progressive denormalization of tobacco use and the marginalization of those who smoke.\textsuperscript{11,19} This process has not been realized to the same extent within the subculture of those with mental illnesses and/or other addictive disorders. When clinicians advocate for smoke-free health care facilities and provide clients with evidence-based treatments, smoking cessation can potentially spread person-to-person, which can denormalize tobacco use, and by extension, reduce stigma for those with mental illnesses and/or substance use disorders who are able to quit smoking when these supports are in place.\textsuperscript{62}

Given that tobacco dependence is the most common co-occurring disorder for the SMI population, some mental health leaders have advocated the use of a co-occurring mental illness and addiction paradigm in conceptualizing tobacco dependence treatment.\textsuperscript{17} Integrated treatment requires that the mental health system eliminate any practices that support tobacco use (e.g., smoking breaks with staff).

Although considerable concern has been raised regarding the potential negative impact of smoke-free treatment setting policies on patients with psychiatric illnesses who are heavily addicted to nicotine, achieving such policies has not resulted in negative outcomes and, in fact, has had beneficial effects.\textsuperscript{64,74,75} The positive impact of these policies, however, can be undermined by a lack of sustained investment in staff training, as well as a lack of available comprehensive cessation treatments.\textsuperscript{66}

**Treatment Cost Considerations**

The CDC estimates that tobacco dependence costs the United States nearly $96 billion per year in direct medical costs and more than $97 billion in lost productivity.\textsuperscript{21,76} The health benefits and cost savings of quitting smoking are substantive: Those who quit by age 30 eliminate nearly all excess risk associated with smoking.\textsuperscript{77} Even when people quit later in life, they experience considerable health gains. Those quitting by age 50 cut their risk of dying in half within the next 15 years.\textsuperscript{78} Tobacco dependence interventions are highly cost-effective in relation to other reimbursed interventions such as mammography, hypertension screening for men ages 45-54, and high cholesterol treatment.\textsuperscript{21,79} Health care costs also are realized when chronic diseases such as heart and pulmonary diseases as well as cancer are prevented by smoking cessation.\textsuperscript{21}

Tobacco dependence interventions have actually been referred to as the “gold standard” of health care cost-effectiveness.\textsuperscript{80} Because the economic burden caused by the morbidities associated with continued smoking is so great,
tobacco dependence interventions are cost-effective even when a single application of an effective treatment results in modest quit rates or sustained abstinence in only a minority of smokers.\textsuperscript{21}

**A Challenge to Nurses**

Nurses possess a long track record of advocating for patients and of creating health care and social reform in the most challenging of circumstances. From our earliest history, Dorothea Dix (1802–1887) spoke out for prisoners and persons with mental illness who were inhumanely treated and otherwise did not have a voice.\textsuperscript{81} Florence Nightingale (1820–1910) fought fiercely to develop nursing into a science through which holistic care could be delivered and evaluated.\textsuperscript{82} Her perseverance decreased patient mortality, improved quality of life, and led to policy changes that have shaped nursing and environmental practices both then and now.\textsuperscript{82,83}

Additional nurse activists have included Lillian D. Wald (1867–1940) who changed the health and functioning of entire communities; Margaret Sanger (1879–1966) who gave marginalized women access to reproductive health options; Florence Wald (1917–2008) who prioritized care at the end of life; and, among contemporary nurse leaders, Margo McCaffery, who has altered how patient pain is assessed and managed.\textsuperscript{84–88}

For these nurses, a keen moral obligation accompanied their professional drive to help those in need. Nurses, including psychiatric-mental health and addiction specialists, are guided in practice by standards for ethical and quality care. It is the responsibility of nurses to promote, and not compromise, patients’ health and well-being.\textsuperscript{89–91} Sally Gadow describes the ideal philosophical foundation of nursing in terms of “existential advocacy” or the moral commitment of nurses to authentically understand the experiences of patients, as well as their own, through the caring relationship.\textsuperscript{92} From this perspective, nurses cannot undervalue the needs and desires of their patients.\textsuperscript{93} Coupled with the view that nursing involves “the protection, promotion, and optimization of health and abilities, prevention of illness and injury, alleviation of suffering through the diagnosis and treatment of human response, and advocacy in the care of individuals, families, communities, and populations,” it is unimaginable that nurses can wait any longer to fully intervene on behalf of those who disproportionately bear the burdens of tobacco dependence.\textsuperscript{90,91}

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**Smoking Cessation Resources**

- **Agency for Healthcare Research and Quality**
  - Treating Tobacco Use and Dependence: 2008 Update
  - [www.ahrq.gov/path/tobacco.htm](http://www.ahrq.gov/path/tobacco.htm)

- **American Psychiatric Association**
  - Treatment of Patients with Substance Use Disorders, Second Edition
  - [www.psych.org/MainMenu/PsychiatricPractice/AddictionPsychiatry/ClinicalPracticeGuidelinesandOther.aspx](http://www.psych.org/MainMenu/PsychiatricPractice/AddictionPsychiatry/ClinicalPracticeGuidelinesandOther.aspx)

- **American Psychiatric Nurses Association**
  - Tobacco Dependence Information Center
  - [www.apna.org/TDInfoCenter](http://www.apna.org/TDInfoCenter)

- **American Psychiatric Nurses Association**
  - Intensive Tobacco Dependence Intervention with Persons Challenged by Mental Illness: Manual for Nurses
  - [www.apna.org/i4a/pages/index.cfm?pageid=3643](http://www.apna.org/i4a/pages/index.cfm?pageid=3643)

- **Centers for Disease Control and Prevention**
  - Office on Smoking and Health
  - [www.cdc.gov/tobacco/](http://www.cdc.gov/tobacco/)

- **Mayo Clinic Nicotine Dependence Center**
  - [www.mayoclinic.org/ndc-rst/](http://www.mayoclinic.org/ndc-rst/)

- **New York State Tobacco Control Program**

- **Rx for Change**
  - Clinician-assisted Tobacco Cessation
  - [www.rxforchange.ucsf.edu](http://www.rxforchange.ucsf.edu)

- **Smoking Cessation Leadership Center**
  - [http://smokingcessationleadership.ucsf.edu/](http://smokingcessationleadership.ucsf.edu/)

- **Society for Research on Nicotine and Tobacco**
  - [www.srnt.org/](http://www.srnt.org/)

- **Tobacco Disparities Initiatives of the State Tobacco Education and Prevention Partnership Colorado Department of Public Health and Environment**
  - Smoking Cessation for Persons with Mental Illnesses: A Toolkit for Mental Health Providers.
  - [http://smokingcessationleadership.ucsf.edu/Resources.htm](http://smokingcessationleadership.ucsf.edu/Resources.htm)
  - #Toolkits

- **Tobacco Free Nurses**
  - [www.tobaccofreenurses.org](http://www.tobaccofreenurses.org)

- **University of Medicine and Dentistry of New Jersey Tobacco Dependence Program**
  - [www.tobaccoprogram.org/index.htm](http://www.tobaccoprogram.org/index.htm)

- **University of Wisconsin Center for Tobacco Research and Intervention**
  - [www.ctri.wisc.edu/About.CTRI/About.CTRI](http://www.ctri.wisc.edu/About.CTRI/About.CTRI)
What prompted your interest in tobacco dependence?
One reason is my history as a clinician. I am a general internist and I’ve seen a number of patients who became ill from smoking, including some who really wanted to quit, and couldn’t. Another reason was that I became knowledgeable about the public health toll of smoking. The third was that I found that tobacco cessation efforts were largely ignored: Here was this huge problem causing so much misery, yet very few people seemed interested in trying to combat it.

Why have you focused most recently on helping people with psychiatric and addictive disorders to stop smoking?
I became interested in psychiatric populations just as a function of the greater number of patients with mental illness who smoke—the rates are much higher than in the general population—and how much damage it causes.

Tell us about the Smoking Cessation Leadership Center—when was it established and what is its mission?
The Center was established by the Robert Wood Johnson Foundation in the beginning of 2003, with subsequent support from the Veterans Health Administration and the American Legacy Foundation. It is currently supported by the Foundation at the University of California at San Francisco, and its intent is to help health professionals and other groups do a better job of helping smokers quit.

How do you think the Smoking Cessation Leadership Center can be helpful in supporting psychiatric nurses’ efforts to provide cessation interventions for those with mental illnesses?
As we’ve done with other health professionals, we’d like to help psychiatric nurses give voice to the importance of this issue within their specialty. We also want to help them identify champions within their midst—for example, Daryl Sharp, the chair for this APNA series of publications. Our goal is to educate these thought leaders so they, in turn, can educate their colleagues.

How do you envision psychiatric nurses interfacing with nurses from other specialties to help more people (with and without mental or addictive illnesses) to stop smoking?
There are a couple of interesting things about nursing in general: One is that it is the largest health profession. Two, for the longest time, nurses smoked more than other health professionals. Smoking among nurses is down to 13%, and the rate in the general population is 20%, but contrast that to what it is for doctors (1%) or pharmacists, dental hygienists or dentists, who have much lower rates.93

Any conjecture as to why that is—for instance, are nurses more stressed out due to the intense work pressures they face?
It’s part of the culture in many hospitals. Nurses take smoking breaks, and in mental health fields, many of them smoke at higher rates than the general population. I’m not sure I fully understand why.

Nurses, like most health professionals, have underperformed as smoking cessation champions. But psychiatric nurses have taken a leadership role in this area and there is an opportunity for them to help their colleagues in other nursing specialties to do this, leading by example. Nurses as individuals can also stimulate their colleagues to get interested in smoking cessation efforts.

Why do some mental health providers believe that smoking cessation is an unrealistic goal for their clients?
They think (A) patients are not interested in stopping smoking, (B) even if they are, they’re not able to stop smoking, and (C) their clinical conditions might get worse if they stop. It turns out all three are misconceptions. A fourth reason is they say, “We’re dealing with very disruptive patterns of personal behavior—suicidal tendencies, maybe psychosis—and cigarette smoking is pretty trivial in comparison to these other issues.” One of the things that’s helped to dissuade that viewpoint is the recent knowledge that people with chronic mental illness die so much earlier, 25 years earlier than the general population, and a large part of that is due to smoking.

How can mental health professionals become more proactive in promoting smoking cessation and counseling among those with mental illnesses?
First of all they can say “It is part of my job to find out which of my patients smoke. It’s also part of my job to keep them healthy—and the most important thing I can do to keep them healthy is to get them to stop smoking.” Clinicians need to engage the patient in a discussion about stopping smoking and figure out how best to do that—either counseling the patient herself or referring her elsewhere.

But it has to be part of every initial encounter with a client?
Yes, it has to be part of every encounter period. You can’t have healthy patients if they keep smoking.
This educational series is designed to better equip psychiatric-mental health nurses to grapple with the challenges of tobacco dependence among persons with mental illness and/or addictive disorders. Informed, skilled, and motivated nurses can facilitate transformation in tobacco dependence treatment at all levels of practice, education, research, administration, and policy implementation. The American Psychiatric Nurses Association (APNA) has issued a policy statement asserting that now is the time to act on tobacco dependence and failure to do so is harmful. The call to action is for each of us: How will you choose to answer?

References


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The Significance of Tobacco Dependence in Persons with Mental Illness

- People with mental illnesses and/or addictive disorders die at significantly younger ages than people in the general population, largely due to use of tobacco.
- Approximately 200,000 of the 443,000 annual deaths from tobacco-related illnesses in the United States occur among people who are mentally ill or who have addictive disorders.
- Co-morbid illnesses caused by tobacco use (including cardiovascular disease, cancer, and respiratory illnesses) negatively impact quality of life and prevent people from working toward their recovery goals.
- Tobacco dependence experts agree that nicotine addiction results from a complex interplay of genetic, neurobiological, psychological, social, economic, and cultural factors.
- According to Dr. Steven Schroeder, mental health clinicians may not encourage smoking cessation for patients with mental illnesses and addiction disorders because they mistakenly believe these patients are not interested in stopping smoking, are not able to stop smoking, and that their clinical condition might worsen if they stop smoking.
- Intensive integrated interventions are likely to be most effective in this population compared to brief and self-help interventions.
- Psychiatric nurses can impact smoking rates in their patients by intervening both on the individual level, and on a system-wide level.


18. McCaffrey, M., & Robinson, E.S. (2002). Your patient is in pain: Here’s how to talk with the Humanities.
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