

Psychiatric patients given smoking-cessation treatment less likely to be rehospitalized

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Patients who participated in a smoking-cessation program during hospitalization for mental illness were able to quit smoking and were less likely to be hospitalized again for their psychiatric conditions, according to a new study led by a Stanford University School of Medicine scientist.

The findings counter a longstanding assumption, held by many mental-health experts, that smoking serves as a useful tool in treating some psychiatric patients.

Smoking among such patients has been embedded in the culture for decades, with cigarettes used as part of a [reward system](#). Indeed, clinicians sometimes smoke alongside patients as a way of creating a rapport with them, said Judith Prochaska, PhD, MPH, associate professor of medicine at the Stanford Prevention Research Center and lead author of the study.

The result is that psychiatric patients are among the country's most prolific smokers and among those most likely to die of smoking-related ailments, Prochaska said. Nearly half of the cigarettes sold in the United States are to people with psychiatric or addictive disorders, according to data from the U.S. Centers for Disease Control and Prevention. The [average life expectancy](#) for people with severe mental illness is 25 years less than that of the general population, and their leading cause of death is chronic illness, mostly tobacco-related.

Prochaska said it has long been thought that if these patients quit

smoking, it would be detrimental to their recovery—that they would lose a critical crutch for coping with stress. However, she pointed out that the daily cycle of [nicotine withdrawal](#) a smoker experiences creates a great deal of stress, and that mental-health providers are well-equipped to assist patients with developing healthier forms of coping.

The new study showed that a simple intervention that included periodic contact with a counselor, written and computerized materials, and the use of nicotine patches could support, rather than harm, the patients' mental health, she said.

"This is a very low-cost, brief intervention that helped patients quit smoking and offers evidence that it may have helped their mental health recovery," said Prochaska, who focuses on developing interventions to treat tobacco dependence in people with mental illness or [addictive disorders](#).

She said the study, done in collaboration with researchers at UC-San Francisco, is the first to examine the impact of a stop-smoking intervention in adult psychiatric patients. It will be published online Aug. 15 in the *American Journal of Public Health*.

Michael Fiore, MD, MPH, director of the University of Wisconsin Center for Tobacco Research and Intervention and a leader in national policy for tobacco treatment who was not involved in the study, said the paper "provides powerful evidence that evidence-based tobacco dependence treatments can substantially increase quit rates among psychiatric inpatients. We know that psychiatric patients smoke at very high rates and are at tremendous risk from their smoking. Thus, the findings hold promise to make an important, real-world contribution to the health of these patients."

Since 1993, tobacco use in U.S. hospitals has been banned, with the

exception of inpatient psychiatry units, which can and often do permit smoking, and where staff may smoke with patients. Prochaska regularly gives talks in which she documents the long history of tobacco in psychiatry, sharing excerpts from a 1951 psychotherapy handbook that encourages practitioners to smoke during treatment sessions. Her work also has highlighted how the tobacco industry has sponsored research to promote the self-medication hypothesis—that patients with psychiatric disorders need to smoke to function—and marketed their products to patients with psychiatric disorders.

Tobacco use has been thought to help calm patients and enable them to focus in therapy, she said. Certainly, a cigarette will calm someone who is in a state of nicotine withdrawal, and in hospitals that structure smoking breaks every four hours, the patients are being thrown into repeated withdrawal states that are uncomfortable and stressful. When hospitals adopt smoke-free policies, along with using nicotine-replacement products, the therapeutic environment is more balanced, she said. The challenges mental health clinicians have feared when banning smoking have not been borne out by studies.

Smoking also can interfere with treatment, affecting the metabolism of some psychiatric medications, Prochaska said. For instance, it increases the body's elimination of olanzepine, a drug used for psychosis or psychotic depression, by more than 90 percent, and of Haldol, a common schizophrenia drug, by 44 percent. Some patients may appear more alert and attentive simply because the tobacco smoke is reducing the sedating side effects of their psychiatric medications, she said.

To test the effects of treating tobacco use among hospitalized [psychiatric patients](#), the researchers initiated an intervention among 224 patients at the Langley Porter Psychiatric Institute, a smoke-free, locked mental hospital for acute care at UCSF. All patients who smoked at least five cigarettes daily prior to hospitalization were invited to participate. Few

were ready to quit smoking, yet 79 percent agreed to participate. The patients had a range of psychiatric diagnoses, including depression, bipolar disorder and schizophrenia; three in four were actively suicidal. Half were randomly assigned to a treatment group, and the other half received the usual care.

All patients were offered nicotine patches or gum during their smoke-free hospitalization. Patients in the control group received a pamphlet about the hazards of smoking, with information on how to quit.

Participants in the treatment group completed a computer-assisted program with tailored feedback, received a print manual, met for 15-30 minutes with a counselor, and were offered a 10-week supply of [nicotine patches](#), available when the participant became ready to quit. All of the materials were tailored to patients' readiness to quit, and the computer-assisted intervention was repeated at three and six months post-hospitalization to support participants through the process of quitting smoking. A copy of the computer printout was mailed to patients' outpatient providers.

"A key aspect of the intervention is that we did not assume all patients were ready to quit," Prochaska said. "We met them where they were at and worked with them over time. When they became ready to quit, we were there for them, and they could get the patches to help with withdrawals."

Only a small number of patients—16 percent—initially said they were prepared to quit when they enrolled in the study, though over time they became progressively more committed to the process, which is typical in these types of interventions, Prochaska said.

The participants all were contacted following hospital discharge at one week and at three-, six-, 12- and 18-month follow-ups. Quit rates were

confirmed with breath samples or by a third party who knew the participant.

At the end of the 18 months, 20 percent of those in the treatment group had quit smoking, compared to just 7.7 percent in the control group, the researchers found. Moreover, there were fewer hospital readmissions among those in the treatment group—44 percent, compared to 56 percent in the control group.

This is the first finding of its kind, and Prochaska said it needs to be replicated. But at a minimum, she added, treating patients' smoking did not harm their mental health recovery and may have even enhanced it.

"I think some of the therapeutic contact that addressed participants' tobacco dependence, and supported them with this major health goal, may have generalized to them feeling better about their mental health condition," she said.

The patients' diagnoses and the severity of their symptoms had no impact on intervention outcomes, the researchers found. "Assumptions we have made in the field—that these patients don't want to quit, are too ill to quit or that quitting will hurt their [mental health](#) recovery—none of that held up," she said.

What did influence outcomes were patients' perceptions at the study start of how successful they would be with quitting and how difficult it would be to not relapse, as well as their level of nicotine dependence—the same factors that affect smoking-cessation results in the general population.

Prochaska said reaction from the psychiatric community thus far has been positive. "I received a call from a clinician asking to make a referral—saying this is a great program. She then asked, 'Should we stop giving out cigarettes at our clinic?' I thanked her for the call and

encouraged, 'Yes, please do.' The work is raising consciousness and has the potential to change practices. If we wonder in our field why our patients smoke at such high rates, we have to start by looking at how we've addressed tobacco. This is the one group that has been encouraged to smoke and discouraged from quitting by their providers. The tide is changing, and this is a very exciting time for the field."

Prochaska and her colleagues are now following up with a larger trial involving more than 900 [patients](#) at Stanford Hospital & Clinics, Alta Bates Summit Medical Center in Berkeley, and UCSF's Langley Porter.

Provided by Stanford University Medical Center

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