Smoking and Mental Health

Mental Health Foundation of New Zealand

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Introduction

The Mental Health Foundation's mission is to improve the mental health of all people and communities in New Zealand. Mental health is a positive sense of emotional, psychological and spiritual wellbeing. We define mental health as being the capacity to feel, think and act in ways that enhance our ability to enjoy life and deal with the challenges we face.

People who have information can make informed choices. It is up to each person to decide what mental health is and what it means for them. We believe that providing accurate and helpful information is vital to the process of enabling people to gain control over and enhance their mental health and wellbeing. This includes considering factors that determine our mental health status such as age, gender, ethnicity, income, education, housing, sense of control over life circumstances and access to health services.

We have developed this resource as part of our Mental Health Information New Zealand (MHINZ) series which aims to provide people with a range of information that can be a starting point for ongoing learning and personal development. The series is primarily designed to meet the needs of people working with the discovery that they or those close to them may have a mental health problem sufficiently distressing to warrant medical intervention.

Smoking rates among those with a mental illness are much higher than those in the general population. Smokers with a mental illness have higher rates of smoking-related diseases. Smoking also contributes to a significantly lowered life expectancy for this group. There are many reasons for these high rates, a major one being the historical 'culture of smoking' that has existed in mental health inpatient units. With many hospitals becoming smokefree, a resource such as this booklet is timely.

The resource is primarily for people who have a mental illness, are smokers and who are contemplating giving up or reducing their smoking. We have included information on smoking which may also be helpful to the general reader as well as service users, their families and whanau and support workers.

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Smoking and Mental Health

Figures from the United States, the United Kingdom and Australia show that the rates of smoking amongst people with mental health problems are significantly higher than those among the general population. This means that these people are at risk of developing tobacco-related medical illnesses at a much higher rate. While there are no firm statistics on smoking among people with mental health problems in New Zealand, according to the New Zealand Schizophrenia Society "Smoking has become part of the life of many people who experience schizophrenia, bipolar disorder or depression. They smoke at a rate far in excess of the general population." (Newsletter December 2000)

Suggested reasons for a high rate of smoking include the stress of coping with a diagnosis of mental illness and in some cases, enforced unemployment. Some people smoke to control weight gain caused by their medication, or to self-medicate. Others believe that smoking will prevent relapse or reduce symptoms such as depression, anxiety or poor concentration. In inpatient units the lack of meaningful activity may be a reason that people smoke.

Studies of smoking patterns and attitudes among people with a mental illness indicate that tobacco plays a very important role in their lives. Cigarettes are rated as a 'core need' – often rated as being more important than food.

A recent study by the mental health charity Mentality in the United Kingdom found that although around half of people with a diagnosis wanted to quit smoking, smoking is often condoned by the mental health system. Mentality reported a general failure by health authorities to support service users who wanted to quit. Smoking has traditionally been used as a 'pacifier' in psychiatric settings where many of the staff smoke as well. (Friedli, 2001)

Why People Smoke

The tobacco plant, nicotiana, was introduced into France by Jean Nicot in 1556. Christopher Columbus had observed its use by Native Americans who smoked it for ceremonial and medicinal properties. During the seventeenth century, religious leaders and statesmen in many countries condemned the use of tobacco. The Catholic Church excommunicated smokers with some allegedly condemned to death and executed. Despite all this, the tobacco smoking habit spread rapidly all over the world. Captain Cook is credited with its introduction into New Zealand.

In the 21st Century, with indisputable evidence that smoking can kill, people continue to smoke. Although worldwide trends show a decrease in the number of adults smoking, smoking rates amongst adolescents have increased in recent years. In New Zealand in 2003, the ASH survey of Year 10, 14-15 year old, students bucked that trend by showing a slight decrease in youth smoking. Overall, an estimated 25 percent of the New Zealand population smokes.

Many and various reasons for smoking have been recorded. These include:

- To relieve stress
- To celebrate
- To relax, calm down
- To stay awake
- To get to sleep
- To look sexy
- To be 'cool'
- To be seen as 'adult' or mature
- To get energy
- To concentrate
- To think better
- To 'reward' themselves for doing something
- To be sociable
- To feel confident
- To stay thin
- To accompany food, drink, fun, games, sex
- In response to advertising that promotes smoking as glamorous, cool and sophisticated
- To emulate a role model – an admired teacher, pop star, sporting hero or a television character who smokes can influence others to smoke
- Because they feel unhappy, bored, lonely, anxious, tired or frustrated
- Because their parent/parents or siblings smoke
- Because of peer pressure – wanting to fit in with group
- Because they have low self-esteem
- Because of social and economic deprivation – social deprivation is linked to smoking levels
- Because of major problems like unemployment, breakup of a relationship, financial pressure or illness
- Because it's a habit - an almost unconscious act
- Because they feel indestructible or immortal – some people, especially young people, do not think smoking will affect their health despite knowing the risks
- Because they know its dangerous, but feel it is too late as the damage has already been done.
- Because smoking is still acceptable in many public places

For people with a mental illness, starting to smoke can sometimes be directly related to their contact with mental health services or welfare organisations

> "I did not smoke at school. I became a state ward and lived in a girls' home. Everyone smoked. A packet of smokes was given to all the girls by social workers on our 15th birthdays."

"When I lived in the psychiatric hospital I worked on the grounds and we were paid in cigarettes."

"Peer pressure in hospital. When I was in hospital I felt stressed and anxious and felt a sense of hopelessness. There was nothing to do… all I could do was smoke."

(Quotes from Kites focus group research, 2004)

"In New Zealand's past inpatient service users were rewarded or "paid" with a daily quota of cigarettes. Cigarettes are used as prizes during organised games in some supported accommodation. In the current inpatient environment the room that is warmest and friendliest, a gathering point, is the smoking room, a fact that helps foster addiction."

(Handisides, 2004)

Regular smokers get used to a certain level of nicotine in their system and only feel better by lighting another cigarette. For most people, the reason they continue to smoke is because they are addicted to nicotine.

How Nicotine Works

Nicotine is one of more than 4,000 chemicals found in the smoke from tobacco products such as cigarettes, cigars and pipes. Smokeless tobacco products such as snuff and chewing tobacco also contain high levels of nicotine. Recognised as one of the most frequently used addictive drugs, nicotine is a naturally occurring colorless liquid that turns brown when burned.

Cigarette smoking is the most common form of nicotine intake. Through inhaling smoke, the average smoker takes in one to two milligrams of nicotine per cigarette.

Nicotine is absorbed through the skin and mucosal lining of the mouth and nose, or by inhalation in the lungs. Depending on how tobacco is taken, nicotine can reach peak levels in the bloodstream and brain rapidly. Cigarette smoking results in rapid distribution of nicotine throughout the body, reaching the brain within 10 seconds of inhalation. Cigar and pipe smokers, on the other hand, typically do not inhale the smoke, so nicotine is absorbed more slowly through the mucosal membranes of their mouths. Nicotine from smokeless tobacco also is absorbed through the mucosal membranes.

Once nicotine reaches the brain it begins to act on specific neurons or working cells. Each neuron has receptors to which brain chemicals called neurotransmitters can attach themselves. Nicotine fits into one of the receptors acted upon by a neurotransmitter called acetylcholine and causes the brain to release two other brain chemicals - noradrenaline and dopamine. These act as stimulants.

Although nicotine is a stimulant, paradoxically, the smoker may feel either stimulated or relaxed. This depends on their mental and physical state and the situation in which smoking happens. An after-dinner cigarette is likely to be experienced as more relaxing than one smoked prior to sitting a university exam.

Nicotine's addictive effect is linked to its capacity to trigger the release of dopamine – a brain chemical that is associated with feelings of pleasure. Nicotine has been shown to have effects on brain dopamine systems similar to the effects of drugs such as heroin or cocaine. Recent research has suggested that in the long term, nicotine actually depresses the brain's ability to experience pleasure and that smokers therefore need greater amounts of nicotine to achieve their former levels of satisfaction. Smoking is therefore a form of self-medication. Further smoking alleviates the withdrawal symptoms, which set in soon after the effects of nicotine wear off.

Withdrawal effects of nicotine

Typical physical symptoms following cessation or reduction of nicotine intake include craving for nicotine, irritability, anxiety, difficulty concentrating, restlessness, sleep disturbances, decreased heart rate, and increased appetite or weight gain. The fact that these symptoms can be attributed to nicotine, rather than behavioural aspects of tobacco use is shown by the finding that withdrawal symptoms are relieved by nicotine replacement therapy such as gum and patches, but not by placebo – i.e. products that do not contain nicotine.

Stress

Many smokers say they smoke to relieve feelings of anxiety and stress. The stress-reducing properties of nicotine may however be more illusory than real. As mentioned in the previous section, nicotine stimulates the release of dopamine in the brain. Smokers quickly develop regular smoking patterns and eventually need increased levels of nicotine to feel 'normal'. As the nicotine level in their blood drops, they begin to crave a smoke and feel 'stressed' until the craving is relieved. The relief of this craving by replenishing the nicotine supply is what makes the smoker feel 'relaxed'. They are in fact merely ending the withdrawal. One physiological consequence of stress is that it makes the urine acidic. This makes the smoker's body excrete nicotine at an accelerated rate, so when the smoker encounters a stressful situation he/she loses nicotine and goes into drug withdrawal.

Genetic influence

Certain smokers may be predisposed to nicotine addiction through the effects of a gene responsible for metabolising nicotine. Scientists have found that non-smokers are twice as likely as smokers to carry a mutation in a gene that helps to rid the body of nicotine. Smokers who carry this mutation are likely to smoke less because nicotine is not rapidly removed from their brain and bloodstream. In contrast, smokers with an efficient version

of the gene (known as CYP2A6) will tend to smoke more heavily to compensate for nicotine being removed more rapidly.

Defining addiction

In 1988 the US Surgeon General published a landmark review that concluded that cigarettes and other forms of tobacco are addicting and that nicotine is the drug in tobacco that causes addiction. In February 2000 the British Royal College of Physicians published a report on nicotine addiction with the conclusion that: "Cigarettes are highly efficient nicotine delivery devices and are as addictive as drugs such as heroin or cocaine."

Despite the weight of such authoritative research, there has been some debate about the extent to which the smoking habit is controlled by physiological addiction. The debate has arisen because there is no universally accepted definition of addiction. The World Health Organisation's definition of addiction is:

> "A state, psychic and sometimes also physical, resulting in the interaction between a living organism and a drug, characterized by the behavioural and other responses that always include a compulsion to take the drug on a continuous or periodic basis in order to experience its psychic effects, and sometimes to avoid the discomfort of its absences. Tolerance may or may not be present."

On the basis of this definition, it is possible to demonstrate a scientific basis for defining nicotine as an addictive substance.

The Effects of Smoking on Mental Health

The effects of cigarette smoking on physical health such as cancers, cardiovascular and respiratory diseases are widely reported. Researchers are now beginning to look at the effects of smoking on mental health. Nicotine dependence itself has been classed as a psychiatric disorder, although it should be stated that not all smokers are nicotine dependent. Nicotine dependence is said by some to be the most prevalent, the most costly, the most deadly but the most treatable of all the disorders. Health professionals, particularly in the mental health sector where there has been a strong culture of smoking among professionals and clients alike, often overlook it.

Cigarette smoking is linked with a wide range of psychiatric diagnoses including depression, anxiety, panic disorder, post-traumatic stress disorder, and illnesses such as schizophrenia and bipolar affective disorder where psychosis is part of the condition. Researchers don't yet understand what these links are. They don't know whether tobacco smoking directly causes any of the mental illnesses or whether having a mental illness makes people more likely to smoke. There is however, some evidence that smoking may increase vulnerability to some mental conditions. In general a greater severity of mental illness seems to be associated with higher rates of smoking. **Prenatal exposure to**

nicotine or cigarette smoke may be a causal factor in mental health problems later in life.

While the literature on smoking and mental health is comparatively new, it is important as it conveys information that is pertinent to helping smokers with a mental health problem to quit or cut down their smoking should they chose to do so. Conversely, in assisting people to give up smoking, GPs or those conducting smoking cessation programmes need to be aware that some people may have underlying mental health problems that need attention and may be in the way of successful quitting

Studies on smoking and mental health tend to focus on diagnostic categories with most of the information to date on depression and schizophrenia. Below is a sample of what the literature says on links between smoking and some common diagnoses.

Anxiety and panic disorder

Many people smoke in the belief that it lessens anxiety but there is some evidence that smoking can cause anxiety. Smoking may be a risk factor for developing panic disorder and it may also be a contributing factor to higher cardiovascular risk in people with panic disorder. A gender effect that links smoking behaviour with higher levels of panic disorder in women has also been found.

Post-traumatic stress disorder

Studies of Vietnam veterans who smoke show that they are more likely than non-smoking veterans to report higher levels of PTSD symptoms, depression and anxiety.

Depression

Many studies have linked smoking to depression and vice versa. Some have concluded that the effects on the brain of poverty, deprivation, childhood trauma, personality, low self-esteem, poor coping strategies and genetic factors may predispose a person to both smoke and to develop major depression. There are a number of studies which link regular smoking with an increased risk of either depressive symptoms or major depression. Just to complicate matters, for some smokers nicotine seems to act as an antidepressant, which may help to explain why some individuals with a history of depression use smoking as a form of self-medication.

Schizophrenia

People with schizophrenia are estimated to have twice the mortality rate from smoking-related diseases than the general population. Smoking behaviour in schizophrenia is a complex process. It may be that the release of dopamine caused by nicotine alleviates some symptoms of schizophrenia. People with schizophrenia are thought to have a lower number of nicotinic receptors than others and this makes them more vulnerable to

becoming heavy smokers should they begin smoking. In addition they may consume higher doses of nicotine from their cigarettes.

There is evidence too, that people with schizophrenia who live in institutions including boarding or 'halfway' houses or are homeless, have a higher rate of smoking than the general population. This could be attributed to social or environmental factors such as poverty or unemployment rather than to their particular brain chemistry.

Nicotine interacts with the drugs commonly used to treat schizophrenia by reducing the levels of such drugs in the person's blood. This may lead to the need for higher doses of anti-psychotic medications, which in turn, can lead to increased side effects. One study has shown that people smoke more when treated with the antipsychotic drug Haliperidol than during a medication-free state. In some instances smoking may reduce side effects of medication though evidence for this is not conclusive. The use of the newer 'atypical' antipsychotic drugs has been reported to reduce heavy smoking as well as improve outcomes in tobacco addiction treatment programmes.

Bipolar affective disorder

Data about smoking and bipolar disorder (manic depression) is limited but seems to show that as for schizophrenia, heavy smoking is associated with a history of psychosis. Once again, smoking may be related to dopamine transmission.

Alzheimer's disease

Studies done in the early 1990s suggested that smoking had a protective effect against Alzheimer's disease. It was hypothesised that nicotine may compensate for the loss of nicotinic brain receptors in Alzheimer's disease and therefore postpone its onset.
Recently that theory has been challenged. Even if smoking were 'protective' against Alzheimer's, it could never be advocated for this purpose. This is because the known health risks of smoking far outweigh any possible reduction in risk of getting Alzheimer's disease in later life.

(Sources for studies quoted in this section: Ziedonis, Douglas M. & Williams, Jill M. (2003). Management of Smoking in People with a Psychiatric Disorder.
McNeill, Dr Ann (2001) Smoking and Mental Health - a review of the Literature).

Living with Nicotine Dependence

Kites - a mental health consultancy group, supplied information for the following two sections. Researchers conducted focus groups on the issue of mental health and smoking – one with people who experience mental illness and have been, or currently are, smokers - another with family and whanau of people with experience of mental illness.

Consumer views

Connections between smoking and mental illness

Some participants felt there was a connection between their illness and their smoking. Some started smoking in hospital, and others felt that they were encouraged to keep smoking by mental health workers. "Being a smoker is part of the regime".

A sample of illness-related reasons given for smoking includes:

Symptom relief

"I get tired –smoking keeps me awake."

Alleviating side effects of psychiatric medication

"I definitely smoke more when I am taking medication for my mental illness."

Inpatient hospital stays

"In the intensive care unit (psychiatric hospital) I am deprived of cigarettes. Get only one on the hour. I get moody, then deprived again, then locked up."

"The withholding of cigarettes is another form of control."

"Smoking gives me comfort in a very hostile environment – it is the only positive thing."

"The staff will have a smoke whenever they like. They shouldn't smoke in front of us when we can't."

"Smoking helps calm me down."

Relief of boredom, both in hospital and out

"Need something meaningful to do in hospital when confined – there is nothing to do."

"Smoking relieves inactivity – as mental health consumers we have been done out of meaningful roles. This is something to do."

"It helps when I am bored – it is something to do."

Day-to-day effects of smoking

Participants spoke about the effects that smoking has on their lives. People identified expense of smoking as a major negative factor, especially as many of them were on a low income and struggling to buy food. Others identified health and safety hazards:

"I get short of breath."

"Poor circulation."

"The time factor – the shortening of one's life."

"Stops you from being fit."

"It is a diet suppressant – I don't eat so much."

"Risk of fires."

One person commented on a social hazard of being a smoker: "It gives fascists a chance to have a go. People think they have a right (to criticise)."

A number of people felt that smoking had a negative impact on their self-esteem:

"It controls me – the over-dependency."

"It affects my self-esteem – makes me angry with myself."

"Feel guilty."

"I worry about passive smokers."

Family/Whanau Views

Families worried about the 'culture of smoking' associated with in-patient units and echoed many of the concerns expressed by service users.

One participant's child started smoking at the age of 15, when admitted to a psychiatric hospital. That person felt that staff provided cigarettes, "to shut up the patients."

Parents whose children more recently came in contact with in-patient facilities feared the child would start smoking as it seemed that smoking areas were places where people congregated and instant bonds were made. Even though there were designated smoking areas, ventilation was poor and cigarette smoke circulated into corridors. They also stated that the designated smoking areas tended to look awful – for example, ashtrays were not emptied.

Participants felt strongly that mental health workers should not encourage people to smoke and had observed situations of staff telling 'patients' not to smoke and then observed staff members smoking.

Some participants expressed concern toward the staff, for example: "How stressed are they? What support do they get?" "Many mental health workers seem to smoke." One person had had to ask a staff member not to smoke in their house.

Asked if they felt mental health services should have a role in supporting people to give up smoking participants felt caution was needed:

> "All health workers should be concerned about physical health but experiencing mental illness is stressful enough without adding more stress by telling people to stop smoking."

> "Maybe support could be offered once the person has recovered from an acute episode".

In relation to designated smoking areas within hospitals, participants felt care was needed to ensure the same practices were adopted as within the rest of the hospital.

Families also feared the effects smoking was having on their family member in terms of their physical health and the fact that smoking may shorten life.

They felt the reason for smoking was largely based on addiction. They felt the connection with mental illness was more associated with boredom and the side effects of medication than the idea that mental illness could be a cause of smoking. One person wondered if there was a connection between ECT (electro-convulsive therapy) and smoking.

They acknowledged that people needed to seek out activities that made them feel better and expressed the view that smoking can make people feel calm, avoid weight gain and provide peer support.

Owing to the cost of cigarettes, many end up financially supporting their family member as cigarettes often take priority over food and paying the power bill.

Harm Reduction

Programmes that target smokers in the general population are aimed at helping them to quit. Quitting is also the most desirable outcome for smokers with mental health problems. But given the high rates of smoking in this group a 'harm reduction' approach in parallel with encouraging people to eventually stop smoking, may be more pragmatic in some instances. If some cigarettes were replaced with less harmful forms of nicotine delivery such as nicotine patches or gum, there might be an overall benefit to the person's health. Using a less harmful form of nicotine delivery may in turn encourage the smoker to quit. There is an argument too that smokers who are unwilling or unable to quit should at least be given the choice of which form of nicotine delivery to use.

Clinicians in the United States have been concerned about whether tobacco abstinence will worsen mental illness or jeopardize recovery from other substance abuse. Although this area has received limited study, reports to date indicate that nicotine dependence treatment for people with a mental illness is safe and usually well tolerated. However there have been reports of some increases in mental illness symptoms during the acute detoxification phase.

Inpatient treatment units and other mental health settings are increasingly required to be smoke free. Nicotine replacement medications can be helpful in these settings in preventing nicotine withdrawal during periods of forced or temporary abstinence.
 International studies tracking the process of treatment units becoming tobacco-free have been positive. They report no significant increases in the rates of disruptive behaviour, 'Against Medical Advice' discharges, additional seclusion and restraints, or the use of 'as needed' or emergency medications when tobacco use is prohibited.

Quitting

Why quit?

A healthier and longer life

Quitting smoking gives people the possibility of a healthier and longer life.
Because of their smoking habits deaths from respiratory disorders are 60 percent more likely amongst people with a mental illness compared with the general population, and deaths from heart diseases are 30 percent more likely. Chronic illnesses such as strokes and the drawn-out suffering of emphysema severely affect the quality of a person's life.

Lower doses of antipsychotic medication

Quitting is likely to reduce the levels of antipsychotic medication needed to be effective
People with schizophrenia who smoke tend to require larger doses of antipsychotic medication to gain a therapeutic effect than their non-smoking counterparts. Smokers tend to have lower plasma concentration and clear their antipsychotics from the body at faster rates than non-smokers. There is some research to show that people on newer antipsychotic medications (such as clozapine) may smoke less than those taking the more traditional antipsychotics.

A sense of achievement

Even small steps towards quitting raise self-esteem. Self-confidence can soar as people realise they can take control over their lives.

Improved income

Quitting can help to achieve or restore financial independence.
It has been estimated that smokers with mental illness spend an average of 30 – 50 percent of their income on cigarettes and tobacco products. This can have an enormous impact on the person's finances and their overall quality of life.

Breaking down the barriers to socializing or getting work

Heavy smoking may affect socializing or getting work. (For example, there are now fewer places where smoking is socially acceptable).

Increased opportunities to develop effective coping strategies

Quitting provides an opportunity to develop new and effective coping strategies.
While people use smoking as a coping strategy to deal with stress, they miss the opportunity to develop more effective coping strategies. Some people with a mental illness have had limited opportunities to develop positive coping strategies because they

developed the illness early in adult life. This can be made worse by the amount of time and money they must devote to smoking, creating a vicious cycle.

Enjoying ordinary smokefree activities

Cutting down or quitting promotes access to ordinary community activities.
Many heavy smokers cannot take part in community activities because of smoking bans at many public venues.

Reducing fire hazards

There is a real risk of accidental fire caused by cigarettes. Smoking less and quitting reduces fire dangers.

(Above section adapted with permission from the SANE SmokeFree Kit)

- Within one day of quitting, the chance of a heart attack decreases
- Within two days of quitting, smell and taste are enhanced.
- Within two weeks to three months of quitting, circulation improves and lung function increases by up to 30 percent
- Former smokers live longer: after 10-15 years' abstinence, the risk of dying almost returns that of people who have never smoked
- Women who stop smoking before or during the first trimester of pregnancy reduce risks to their baby to a level comparable to that of women who have never smoked

National Health Committee Revised Guidelines for Smoking Cessation, 2002)

What helps?

Quitting smoking is a big challenge. Some people can go 'cold turkey' and never smoke again. For most smokers, quitting is a process. No one should feel discouraged if they have to make several attempts. Smokers cycle through the stages of contemplating quitting, actually quitting and relapsing on an average of three to four times before achieving permanent success. The message is, "don't quit trying to quit". There is good evidence that the following options for quitting are effective:

- Brief advice from health professionals (personal, non-judgmental advice on quitting to smokers repeated in different forms from different sources. Frequent and consistent interventions over time are more important than the type of intervention).

- All forms of nicotine replacement therapy (NRT). NRT products include patches, gum, nicotine nasal spray and nicotine inhaler. A doctor's prescription is needed for the nasal spray and the inhaler is available only from a pharmacist. Subsidised nicotine patches and gum are available in New Zealand for people smoking more

than 10-15 cigarettes a day through the national Quitline (0800 778 778), smoking cessation providers who are part of the Quit Cards programme and Aukati Kai Paipa providers.

- Self-help materials (e.g. books, pamphlets); adding follow-up telephone calls from a health professional improves effectiveness.

- Organised group programmes. These are better than self-help materials but no better than intensive health professional advice.

- Counselling and self-help materials for pregnant women who smoke.

- Specific counseling for men at risk of ischaemic heart disease.

- Some interventions provided in specialist smoking cessation clinics. (The mental health consumer organisation SANE Australia, has produced a SmokeFree Kit containing a quit programme designed to meet the needs of people with a mental illness. Often consumers/tangata whaiora do not wish to reveal their illness in more general groups or may prefer facilitators who understand mental illness.)

- The use of antidepressants nortriptyline or bupropion (Zyban) as second-line pharmacotherapy. (n.b.bupropion is not publicly subsidised in New Zealand and the Medical Adverse Reactions Committee has recommended that it should only be considered as a second-line intervention after unsuccessful trial with other smoking cessation treatments, including nicotine replacement therapy.)

The national Freephone Quitline 0800 778 778 offers confidential support and advice for people wanting to quit smoking. Quit advisors are expertly trained to help smokers gain the required skills to address problems with quitting. Maori and Pacific quit advisors are also available.

Aukati Kai Paipa is one of the services of Te Hotu Manawa Maori. The focus of the service is to provide quality training, support and advice to kaimahi Maori who will then provide free smoking cessation services and support using Nicotine Replacement Therapy, Cognitive Behavioural Therapy and support over a period of 8 weeks to twelve months

Medications and quitting

Nicotine, hydrocarbons and tar-like substances in tobacco products can alter the way drugs are metabolized in the body. When a person no longer inhales hydrocarbons, the liver enzymes take about a month to return to normal levels. During this time the body may build up increased concentrations of a particular medication.

If you are on medication and decide to stop smoking, **it is extremely important that you tell your doctor**. Your medication needs to be monitored and the dosage may need to be reduced. This is particularly important if you are taking medications used to treat mental illness (also for heart or diabetes medications).

(Source: National Health Committee Revised Guidelines for Smoking Cessation, 2002)

Smoking and caffeine

Nicotine masks the effects of caffeine so that coffee, tea and cola drinks can make you feel jittery and irritable. Reduce or monitor your caffeine intake to minimize these effects. Do not drink acidic liquids such as coffee, orange juice or Coke before chewing or during the use of nicotine chewing gum.

Consumer experiences of quitting

A number of participants in the *Kites* consumer focus group had either given up or attempted to give up smoking. Some went 'cold turkey,' used their determination and "just did it." Others used help such as the Quitline, patches and gum. A number of people found these aids either made them feel sick or that withdrawal was too painful. A number said they'd made the first call to Quitline, but had not made a second call. People also spoke of starting again as they either became depressed or experienced panic attacks after stopping smoking.

Asked what helps when giving up, participants had the following answers:

- Asking God for help
- Encouragement from family not to smoke
- Family pressure
- Having a bet with a friend
- Going for lots of walks and keeping busy knitting etc,
- Not associating with smokers
- Gradual reduction
- Separate areas for smoking
- Replacing negative thoughts with positive ones
- Being strong and committed
- Savings plan with a goal, like buying a car

One success story illustrates the need for determination:

"I gave up for six months and got depressed then hospitalized. Did crime etc to get smokes, then gave up while in prison. I weaned off after three days. That was six-and-a –half years ago and I gave up cigs, drugs and alcohol."

What doesn't help?

A number of the consumer focus group members found that having smoking made an issue for them was not helpful.

> "If people hassle me or intimidate me I feel more resolve not to give up."

> "The horrific experiences of anti-smoking people – their cynicism, unscientific information and rubbish."

> "Having to think about the nicotine-medication interface. I think it is quackery."

> "If smoking is made an issue. I feel venomous toward people who produce information about not smoking."

Is there a role for mental health services in helping people to quit?

While some people in the Kites consumer focus group felt there was no role for mental health services in helping people to quit smoking, others did. They made the following suggestions:

> "Have residential services like they have for other addictions like drugs and alcohol. Giving up cigarettes can be harder than giving up other drugs."

> "Counselling services like Alcoholics Anonymous or Odyssey House."

> "Introduce ways to give up, helpful tools."

> "Provide assistance to get patches, Nicorette etc."

> "Get rid of the smokers rooms in hospitals. At least that might help people who are new to mental health services not to start."

Dealing with obstacles to quitting

Withdrawal

The body reacts when it stops getting nicotine and all the other chemicals in tobacco smoke. For some people this can produce withdrawal symptoms and sensations that can feel unpleasant. However unpleasant, they are actually positive signs that the smoker's body is recovering.

Emotional symptoms such as anxiety or irritability can be closely related to the physical reaction of the body as nicotine leaves the system. Some symptoms such as upset digestion, constipation and sore throat last only for a few days, while others, such as coughing and sleep disturbances, last longer. However most symptoms become less intense or completely disappear within two to three weeks.
Common signs of withdrawal include:

- **Cravings for tobacco** - these usually last less than five minutes. Initially they can be very strong, but with time they become less frequent and less intense.

- **Feelings of irritation, anxiety or depression** – these should lessen over one to three weeks. The may be a result of chemical changes in the body, inadequate means of coping with these feelings without cigarettes or a grief reaction to losing cigarettes**.**

- **Tingling sensation in the fingers or toes** – this is due to an improvement in blood circulation.

- **Coughing or tightness in the throat** - coughing means that the cilia (the small hair-like structures that line the lungs) are working again and are sweeping out the tar and mucus. This should be a temporary effect.

- **Change in sleep patterns** - some people complain about unusual or strong dreams while others find they sleep better. The use of nicotine patches can sometimes lead to very vivid dreams or nightmares. These should pass with time. Use of 16–hour patches (instead of 24-hour patches) may be more appropriate to lessen this effect.

- **Difficulty concentrating** – use lists or other methods to help. Reduce the demands you make on yourself as you readjust.

- **Occasional headaches or dizziness** - this is a sign that the brain is receiving more oxygen. These feelings should pass. Consult your doctor if they persist**.**

- **Changes in appetite** - there is often a temporary increase in appetite because nicotine in the cigarettes can suppress appetite. In addition, within a couple of days of quitting, the taste buds become more sensitive and people can taste things better. Be prepared by keeping healthy foods at hand. (See section below on weight gain.)

Weight gain

Weight gain is a side effect of some antipsychotic medications, so concerns about putting on more weight are especially valid. Not everyone who quits smoking puts on weight, but for those who do, the average weight gain is about two kilograms, which people usually lose within a couple of months. The health benefits of quitting are much greater

than the effects of gaining this amount of weight. Weight gain can be minimized with very little exercise (for example, 20 minutes of brisk walking, three times a week). There is also some evidence that using nicotine gum can delay weight gain.

Some people put on weight because they eat more when they quit. Some have an increased appetite and a preference for sugar when they quit. Other people eat more as a replacement strategy for cigarettes or to comfort themselves. Eating can be associated with pleasure, relaxation or dealing with different emotions. Try sugar-free sweets and healthy snacks, or use non-food rewards such as buying flowers, having a bath or telephoning a friend.

Depression

It is common for anyone who quits smoking to feel down at some stage of an attempt to quit. Coping strategies such as positive self-talk, phoning a friend, doing favourite activities, exercising, meditating or having a massage can be effective in lifting a depressed mood.

People with a history of depression are more likely to be smokers than those who don't have such a history. They are also more likely to experience a relapse of depression when they quit smoking. It is important that such people feel reassured and supported in their efforts to stop smoking. If you have experienced depression and want to quit smoking, talk to your doctor and work out ways of managing quitting that will minimise any chance of relapse.

Changing your thoughts and beliefs about quitting smoking

Your style of thinking may get in the way of successfully quitting smoking. Challenging negative thought patterns and replacing them with positive ones can be powerful. On the following page are some common examples of 'faulty' thinking and some suggestions for countering them:

Style of thinking	Negative thought	Suggestions for countering
Black and white thinking You look at things in absolute, all-or-nothing terms	"If I don't quit now, I never will."	"I will give it a go. I know a lot of people don't succeed the first time they try – quitting successfully might take some hard work but I can do it."
Overgeneralisation You view each negative event as a never-ending pattern of defeat	"Every time I try to stop smoking I fail."	" I haven't managed to quit so far, but that doesn't mean I never will."
Selective thinking You dwell on the negatives and ignore the positive	"Quitting is too hard. You get crabby, eat too much and then fail."	Quitting is hard, but you have more money, better health and a sense of achievement."
Fortune telling You predict that things will turn out badly	"I know I won't be able to quit no matter how hard I try."	Where's the evidence for this prediction?
Magnification or minimisation You blow things up out of proportion or you shrink their importance inappropriately	"Quitting is the hardest thing in the world," OR "I only quit for three hours, that's pathetic."	"Quitting is tough, but it's not impossible. I could start by challenging myself to quit for half a day."
Personalisation You blame yourself for something you are not responsible for	"I shouldn't nave gone to that smoker's house"	How were you to know that person was a smoker?

Complementary Therapies

Health, healing and healing practices are varied and differ according to how people view illness. Any health-related practice that increases an individual's sense of wellbeing or wellness is likely to be of benefit. Talking things over with people you feel comfortable with can be useful and may help to define a problem and ways to begin to tackle it.

The term complementary therapy is generally used to indicate therapies and treatments which differ from conventional western medicine and which may be used to complement, support and sometimes replace it. There is an ever-growing awareness that it is vital to treat the whole person and assist them to find ways to address the causes of mental health problems rather than merely alleviating the symptoms. This is often referred to as an holistic approach. Complementary therapies often support an holistic approach and are seen as a way to address physical, nutritional, environmental, emotional, spiritual and lifestyle needs.

Many cultures have their own treatment and care practices which many people find helpful and which can often provide additional benefits to health and wellbeing. Rongoa Maori is the indigenous health and healing practice of New Zealand. Tohunga Puna Ora is a traditional healing practitioner. Traditional healing for many Pacific Islands' people involves massage, herbal remedies and spiritual healers.

In general, meditation, hypnotherapy, yoga, exercise, relaxation, massage, mirimiri and aromatherapy have all been shown to have some effect in alleviating mental distress. Complementary therapies can include using a number of herbal and other medicinal preparations to treat particular conditions. It is recommended that care is taken as prescription medicines, herbal and medicinal preparations can interact with each other.

When considering taking any supplement, herbal or medicinal preparation we recommend that you consult a doctor to make sure it is safe and will not harm your health.

Women who may be pregnant or breastfeeding are advised to take extra care and to consult a doctor about any supplements, herbal or medicinal preparation they are considering using, to make sure they are safe and that they will not harm their own or their baby's health.

For more information see the MHINZ booklet *Complementary and Alternative Therapies and Mental Health.*

Legislation

Smoking endangers health, but secondhand smoke is also a significant health risk. Exposure is linked to heart disease, lung cancer and other cancers, strokes, asthma induction and aggravation, and many illnesses. An estimated one life is lost every day (over 350 a year) as a result of exposure to secondhand smoke, with a further 3,700 hospital admissions for heart attacks, strokes and other illnesses, 27,000 GP consultations and 14,000 episodes of childhood asthma. The realisation of the seriousness of the health effects of secondhand smoke led to the enactment of the Smokefree Environments Act 1990, and the awareness that secondhand smoke is a health and safety hazard under the Health and Safety in Employment Act.

(Source: Woodward A and Laugesen M, *Deaths in New Zealand attributable to second hand cigarette smoke: A report to the New Zealand Ministry of Health*, September 2000)

The Smoke-free Environments Act 1990

The Act aims to 'prevent the detrimental effect of other people's smoking on the health of people in workplaces, or in certain public enclosed areas, who do not smoke or do not wish to smoke there'. The Smoke-free Environments Act (as amended by the Smoke-free Environments Amendment Act 2003) requires employers to take all reasonably practicable steps to ensure that no person (including employees, patients, residents, volunteers, contractors, and visitors) smokes at any time in the internal areas of a workplace, including a cafeteria, corridor, lift, lobby, stairwell, toilet, washroom, or other common internal area of the workplace. The definition of "workplace" covers mental health facilities with employees or volunteers and also includes employer-provided vehicles that are normally used by employees or volunteers.

Hospital care institutions, residential disability care institutions and rest homes are workplaces and must comply with the Smoke-free Environments Act. However patients and residents may smoke in these workplaces if, according to section 6 of the Act:

    (a)   the smoking takes place only in one or more dedicated smoking rooms; and

    (b)   each dedicated smoking room is equipped with or connected to a mechanical ventilation system that takes air from the room to a place outside the workplace; and

    (c)   all reasonably practicable steps are taken to minimise the escape of smoke from the dedicated smoking rooms into any part of the workplace that is not a dedicated smoking room; and

    (d)   for each dedicated smoking room, there is available for patients or residents who wish to socialise in a smokefree atmosphere an adequate equivalent room.

Therefore, hospitals, rest homes and residential care institutions may ban smoking, but where they choose to allow smoking, only patients or residents (not staff, volunteers, or members of the public) may smoke in a dedicated smoking room. In addition, the fact that section 20A emphasises that the Health and Safety in Employment Act 1992 is paramount legislation and must be complied with over and above the Smoke-free

Environments Act may mean that managers of these facilities must take steps to ensure that patients and residents do not smoke in areas where it may pose a health and safety hazard to themselves and to others.

The Health and Safety in Employment Act 1992

The Health and Safety in Employment Act applies to workplaces including mental health facilities. The Department of Labour's Occupational Health and Safety Service views secondhand smoke as a *significant hazard capable of causing serious harm and death* (OSH *Policy and Procedure Manual* 2001). The Health and Safety in Employment Act requires employers to:

- identify "significant hazards" in or near the workplace (including vehicles); and
- "take all practicable steps to eliminate" such hazards; and
  - "ensure that no action or inaction" harms employees and volunteers and "any other person" (patients, residents, contractors, and visitors) in or near the workplace; and
  - monitor staff health using an appropriate test, such as a "cotinine test" which indicates exposure to secondhand smoke.

The Act does not permit employees and others (including patients, residents, volunteers, contractors and visitors) to consent to being exposed to hazards such as secondhand smoke. As medical and scientific evidence shows that ventilation is not able to "isolate and minimise" the hazard of secondhand smoke, the only solution may be to ban smoking.

(Source: Repace J (2000) *Can ventilation control secondhand smoke in the hospitality industry?* (www.repace.com); Environment Australia, *Indoor Air Quality Report* 1997)

Cigarettes may also be viewed as a hazard under the Health and Safety in Employment Act due to their flammability, and the addition of accelerant (potassium citrate) to keep cigarettes burning. Cigarettes burn at 700 degrees centigrade and are linked to 600 fires, injuries and deaths annually.

(Source: A. MacGuire, *How the Tobacco Industry Continues to Keep the Home Fires Burning;* Tobacco Control 1999; 8: 67-69.)

There are other health and safety considerations associated with smoking, as smoking around food is considered a hygiene risk (Food Hygiene Regulations 1974), and the health risks associated with tobacco use are enhanced by co-exposure to numerous chemical, biological and physical agents commonly found in the workplace.

(Source: World Health Organisation *Environmental Health Criteria* No 211, 1999).

Employment Relations Act 2000

Employers have a duty to be a "good employer" under the Employment Relations Act 2000 and provide a safe and healthy workplace. Where secondhand smoke is present in the workplace, an employee may seek a compliance order, or injunction, or bring a personal grievance case, or even strike to force an employer to provide a healthy and smokefree workplace. Workers also have a right to a safe and smokefree workplace under United Nations Conventions, including ILO Convention 155 and ILO Convention 148 on the Working Environment, and WHO Framework Convention on Tobacco Control.

Negligence

Accident compensation is available for employees who suffer illness or injury attributable to exposure to secondhand smoke in the workplace under the Injury Prevention Rehabilitation and Compensation Act 2001. Those employees who do not qualify for ACC (for example, where their work-related illness or injury was diagnosed before 1 April 2002) can seek redress from their employers through the courts (see *Marlene Sharp v Port Kembla RSL*, NSW Supreme Court, May 2001). Employers could also be sued for breaching the duty of care owed to the patients, residents, visitors, volunteers, contractors and the public if they allow smoking.

Human Rights Act 1993

A person who finds it difficult or impossible to tolerate second-hand smoke could lodge a complaint with the Human Rights Commission where they feel that they have suffered direct or indirect discrimination because of their disability, and where, for example, they feel that they have not been able to access a public facility (sections 21 and Section 65 Human Rights Act). There may also be a breach of the Human Rights Act where employees and those seeking employment believe that they have been discriminated against on the grounds of a disability that makes it difficult or impossible for them to tolerate the presence of second-hand smoke in the workplace (sections 22 and 29(2) Human Rights Act).

The Health and Disability Commissioner Act 1994

Those providing health and disability services must take "reasonable actions in the circumstances to give effect to the rights and comply with the duties" in the Code of Health and Disability Services Consumers' Rights. Consumers have the right to have services provided in a manner consistent with his or her needs (Right 4(3) and Right 4(4)) and the right not to be discriminated against on the grounds of a disability (Right 2) that makes it difficult or impossible for them to tolerate the presence of secondhand smoke. Consumers also have the right to services that comply with legal, professional, ethical and other relevant standards including the Smoke-free Environments Act and other laws relating to secondhand smoke (Right 4(2)).

Health and disability services consumer advocates may act on complaints from consumers who believe that they have suffered harm after being exposed to secondhand smoke while resident in healthcare facilities or while being provided with services. Advocates may also assist those who wish to pursue a complaint and make a representation to the Health and Disability Commissioner, who may in turn refer the matter on to the Human Rights Commission or other agency to be dealt with where appropriate (sections 54 and 57 Health and Disability Commissioner Act 1994).

Summary

Secondhand smoke is a "significant hazard capable of causing serious harm and death". In terms of the Health and Safety in Employment Act, significant hazards must be eliminated or banned. To avoid any confusion, the Smoke-free Environments Amendment Act 2003 specifically refers to the Health and Safety in Employment Act and consequently the duty to protect workers and everyone in or near a workplace. Failure to protect everyone might lead to a prosecution under the Health and Safety in Employment Act or other legislation including the Employment Relations Act, the Human Rights Act and claims for compensation for negligence where workers or patients, residents and others have not been protected from the hazard of secondhand smoke. As the health effects of inhaling secondhand smoke become more widely know, it is predicted that New Zealand will see an increase in the number of cases before the courts on this issue. Given that the majority of New Zealanders are non-smokers, it is only logical that they would want to work in smokefree workplaces and will insist on smokefree mental health facilities.

This is a brief guide to the law on secondhand smoke in workplaces. It is not intended to give you legal advice on a particular problem or situation. You may need to consult a lawyer.

Sources and References

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Further Information

Groups and organisations

Thinking about quitting? Phone the Quitline - 0800 778 778

For general enquiries
The Quit Group
PO Box 12-605 Wellington
Phone 04 915 9899   Fax 04 470 7632

ASH New Zealand
Level 2, 27 Gillies Ave
Box 99 126, Newmarket
Auckland
Phone: 64 9 520 4866 Fax: 64 9 520 4891
Email: ashnz@ash.org.nz

Te Hotu Manawa Maori
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Ellerslie, Auckland
PO Box 17160, Greenlane, Auckland
Phone: 09 571 9018   Fax: 09 571 9019
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Websites
www.ash.org.nz
http://www.quit.org.nz/
http://www.auahikore.co.nz/static
http://www.nhf.org.nz/index.asp?pageID=2145822181
http://www.healthnz.co.nz/
http://www.ndp.govt.nz/tobacco/tobacco01.html
http://www.nzdf.org.nz/smokefree_amendment_bill.html
www.ash.org.uk
http://www.ash.org.uk/html/factsheets/html/fact15.html
http://www.mindbodylife.com.au/sections/default.asp?s=358
This site is a resource for mental health professional and consumers of mental health services that promotes quitting smoking.

Books
The Quit Book
A booklet designed to assist smokers in their quit attempts from planning through to successful maintenance. Developed by The Quit Group and available free from Health Education Resource Providers associated with regional Public Health Units.

SANE SmokeFree Zone (Guides to giving up smoking for consumers and supporters)
Includes guides for the person quitting and for a supporter, 4Ds card and stickers.
ISBN 1 875 182 29 2
SANE Australia

SANE SmokeFree Kit (Manual for mental health workers)
Workers' manual on running SANE's smoking cessation program for people with a mental illness. ISBN 1 875182 42 X
SANE Australia

Mental Health Foundation Resource & Information Centre

The Mental Health Foundation Resource and Information Centre is at the Foundation's Auckland offices and is open to the public. Information and resources are available in a range of formats including pamphlets, books, journals videos, research papers and directories.   Anyone living in Auckland may borrow books and videos are lent throughout New Zealand. The extensive collection includes resources on

· Mental Health ·	· Mental Illness ·	· Mental Health Services ·
· Depression ·	· Discrimination ·	· Workplace Wellbeing ·
· Stress ·	· Maori Mental Health ·	· Support Groups ·
· Recovery ·	· Relaxation ·	· Self-Help ·
· Older People's Mental Health ·	· Young People's Mental Health ·	

The centre is open Monday to Friday, 9am to 4.30pm.

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Titles in the MHINZ series of booklets

Attention Deficit / Hyperactivity Disorder	*Dementia*
Alcohol Problems	*Depression*
Anorexia Nervosa	*Depression in Children and Young Adults*
Attachment Disorder	*Obsessive-Compulsive Disorder*
Autism	*Panic Disorder*
Bipolar Affective Disorder	*Personality Disorders*
Brief Psychotic Disorder	*Phobias*
Bulimia Nervosa	*Postnatal Depression & Psychosis*
Cannabis Problems	*Problems with Tranquilliser Use*
Conduct Disorders	*Schizophrenia*
Complementary Therapies in Mental Health	*Separation Anxiety Disorder*
Delusional Disorders	*Solvent and Inhalant Problems*
	Tourette Disorder