Psychiatric Hospitals and Workplace Smoking Bans: A Biological and Sociological Commentary

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Smoking is widely known as an architect of well-documented, negative health outcomes. The advent of legislated actions to ban work- and public-place smoking has reduced the overall smoking prevalence in Canada and around the world. However, what is often overlooked are patients with psychiatric illness who are confined in psychiatric institutions and are not able to take advantage of designated smoking areas. The aim of this commentary is to raise awareness of potential inequitable conditions that are inherent in workplace smoking restrictions particularly for psychiatric patients. A biological and social equity perspective will frame the discourse of the issue.

Keywords: workplace smoking restrictions, psychiatric patients, inequitable

Smoking is widely known as an architect of well-documented, negative health outcomes. With the advent of legislated policies to ban work and public place smoking has helped reduce the overall smoking prevalence in Canada and around the world. However, the effects of these smoking bans have on patients with psychiatric illness who are institutionalised in long-term psychiatric facilities are often overlooked.

It is estimated that compared to the general population, individuals suffering from a mental illness use tobacco two- to threefolds higher (Hughes, 1993). This rate also varies with mental illness. According to Ziedonis and George (1997) it is estimated that a 40-50% increase in cigarette use can be observed with individuals with depressive and anxiety disorders compared to that of the general population. This stark difference is more pronounced in patients with chronic schizophrenia. These patients tend to use tobacco 70–90% higher in comparison to the general population (Ziedonis & George, 1997). These numbers speak volumes in regards to the necessity of smoking cessation interventions in psychiatric long-term facilities; however, at what cost? But more importantly, what is the cost to the patient? The aim of this commentary is to raise awareness of potential inequitable conditions for patients in long-term psychiatric facilities as a result of workplace smoking bans. The question of how smoking bans in psychiatric facilities may result in inequitable conditions for individuals living in psychiatric long-term care facilities will be raised. A biological and sociological context will be the focus of the following discourse.

Biological Context

An important clinical factor in smoking cessation with psychiatric populations is the metabolising effect of hydrocarbons in tobacco smoke on psychotropic medications (Desai, Seabolt, & Jann, 2003). Due to this metabolising effect, blood levels of numerous psychotropic medications are altered if smoking behaviour is changed (Van der Weide, Steijns, & Van Weelden, 2003). For example, in a study by Van der Weide and associates (2003), they found that clozapine clearance and maintenance was strongly correlated with smoking behaviour. Smokers tend to require more clozapine due
to the increase activity of cytochrome P450 enzyme CYP1A2 and are susceptible to intoxication once smoking is stopped (Van der Weide, Steijns, Van Weelden, 2003). Adverse reactions have been documented in several case studies due to the elevated metabolized concentrations of clozapine or olanzapine (Greenwood-Smith, Lubman, & Castle, 2003).

It is well cited in the literature that the degree of success in the cessation of tobacco use is elevated by the use of pharmacotherapies, such as nicotine replacement therapies, Buproprion and Varenicline. However, what is not well advertised is that many of these therapies, like any other medications, often carry side effects that are intensified in psychiatric patients. Varenicline, in particular, has shown an array of problems when given to this population. Case studies have revealed that the use of Varenicline has led to psychotic breakdowns (Freedman, 2007) and even suicide ideations (McIntyre, 2008).

Sociological Context

Smoking restrictions in psychiatric settings may also affect the social interactions of smoking patients and staff. Cigarettes seem to be a social driver between these key players; a sort of social currency. Lawn and Pols (2003) conducted interviews with patients and staff in a stand-alone psychiatric hospital. These interviews revealed that staff used cigarettes and smoking privileges as a form of control against negative behaviours and compliance to medications.

From a sociological perspective, smoking bans in hospital settings seem to create an environment that results in social inequity. Hospital smoking restrictions seem to limit psychiatric patient’s use of a social currency that is relied upon by the staff to manage them on a daily basis.

One might argue that many patients are able to congregate outside for a cigarette; however, there are many more patients who cannot. Marcus (2008) eloquently queries and centralises the dilemma with smoking bans in psychiatric facilities. In his letter to the editor he puts the question: ‘Why is it that I can smoke in my home, you can smoke in your home, but long-term residents of psychiatric institutions cannot smoke in their homes? If self-determination, equity, and respect are core principles of recovery, what justifies this selective suspension?’ (Marcus, 2008, p. 330). Similarly, Lavin (1990) argues that when patients are detained in hospital settings against their will or are living in long-term facilities, forced abstinence becomes more important. In these cases, it is not justifiable to place restrictions on patients’ autonomy and liberty to smoke (Lavin, 1990).

Conclusion

The previous discourse raised the possible inequitable outcomes for psychiatric patients in smoke-free psychiatric hospitals from a biological and sociological context. The point here is not to advocate that patients be allowed to smoke when and where they want, as that would be counter-productive to our goals as health professionals. But as health care professionals, we have to advocate for people who cannot advocate for themselves. It is imperative to realise that special considerations are necessary for this population. The point rather is to make available to these patients resources like precise medical monitoring during the cessation attempt, safe pharmacotherapies and counselling support through a comprehensive institutional policy. Also, all staff should be educated in smoking cessation protocols to aid the cessation process of patients. As Lavin (1990) said, entire smoking restrictions are morally indefensible. Implemented restrictions on patient smoking should be mindful of the special circumstances psychiatric patients may face and the potential harms they may endure as a result.

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