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Smoking in Psychiatric Hospitals: What is the Role of Nursing Staff?

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Abstract:- Smoking is the leading cause of preventable death in the world. Studies have shown that the frequency of its use in schizophrenic patients is significantly higher than in the general population, or in other psychiatric disorders, which hinders both treatment strategies and the efficacy of antipsychotics.

Various hypotheses have been proposed to explain the high level of tobacco dependence in schizophrenic patients, which it seems important to address. However, caregivers working in psychiatric wards reportedly trivialize smoking in schizophrenic patients and resist the implementation of specific care, although treatments are available in most institutions.

In order to have an overview of the situation of psychiatric services concerning tobacco, we carried out the survey "smoking and psychiatry" in the form of a questionnaire addressed to professionals working in Moroccan psychiatric services.

It emerged that the caregivers, although concerned by this smoking problem, do not make it their priority. Nevertheless, it was found that the presence of addictologists/tacologists would positively influence the attitude of caregivers regarding the management of smoking in patients with psychiatric conditions, especially with the provision of nicotine substitutes.

Providing training in addictology/tobacco would encourage caregivers to better manage patients with psychiatric conditions who smoke.

I. INTRODUCTION

The tobacco epidemic is one of the most serious threats ever to global public health. It kills more than 8 million people worldwide every year [1]. According to the WHO, all forms of tobacco are harmful, and there is no safe level of exposure. Tobacco therefore remains the leading preventable cause of mortality and morbidity in North America and worldwide [2].

In the United States, it is estimated that almost half the cigarettes consumed in this country were consumed by people suffering from a mental illness. Schizophrenia remains the psychiatric disorder with the highest proportion of smokers, with a smoking-related mortality rate five times higher than that normally expected in the general population [3].

Smokers with schizophrenia not only consume more cigarettes, but also extract more nicotine per cigarette. They experience greater smoking reinforcement effects and more severe withdrawal symptoms during abstinence than non-schizophrenic smokers. These subjects are therefore more likely to develop nicotine dependence, and smoking cessation in them remains very difficult [4].

Various hypotheses have been put forward to explain schizophrenic patients' heavy dependence on tobacco, and it seems important to remedy this. However, caregivers working in psychiatric wards are said to trivialize inpatient smoking and resist the implementation of cessation strategies, even though treatments are available in most establishments [5].

We have little data on the Moroccan situation regarding the attitude of health-care teams towards smoking, its consequences and the implementation of specific cessation strategies for patients with psychiatric conditions. The aim of this study is to remedy this situation.

II. MATERIALS AND METHODS

In order to obtain an overview of the situation of psychiatric services concerning tobacco, we carried out the "smoking and psychiatry" survey in the form of a questionnaire addressed to professionals working in Moroccan psychiatric services.

We conducted a cross-sectional study, the aim of which was to assess smoking prevention and management in several Moroccan psychiatric facilities. The questionnaire was developed on Google forms and then shared among groups of Moroccan psychiatric professionals.

The study's target population consisted of healthcare professionals who had been working in psychiatric settings for at least 06 months (doctors, nurses, orderlies, etc.).

The variables in our study were organized into three groups: The professional's socio-demographic data, data related to the care structure, then the professional's degree of training in tobacco control.

Data collection and statistical processing of the questionnaire were carried out using "Epi-info" and "Excel" software.

III. RESULTS

The total number of patients responding to the questionnaire was 40. 80% were female, and their ages ranged from 24 to 50, with an average of 30 (Graph I). 62.5% were doctors, while 37.5% were nurses (GraphII).

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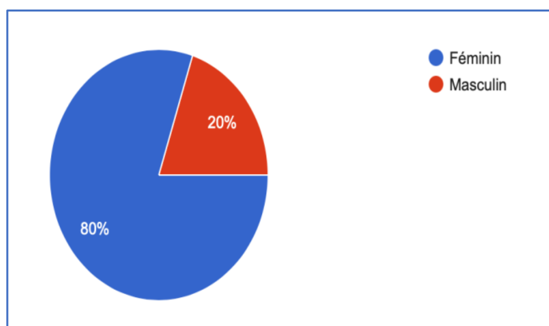
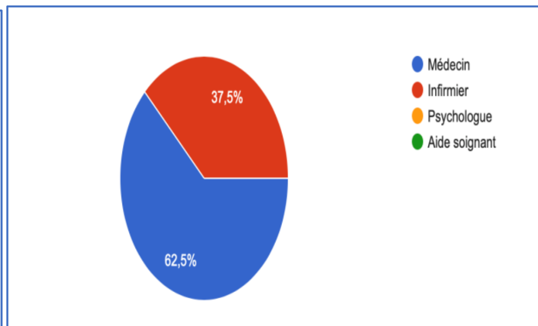
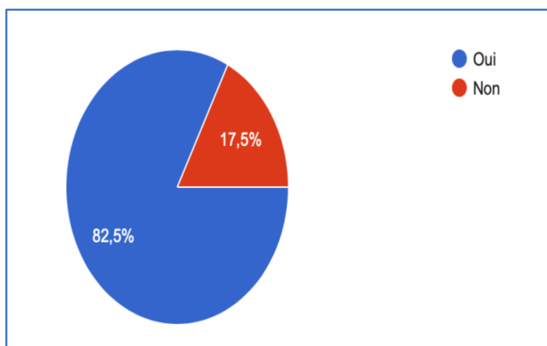


Graph I: Gender

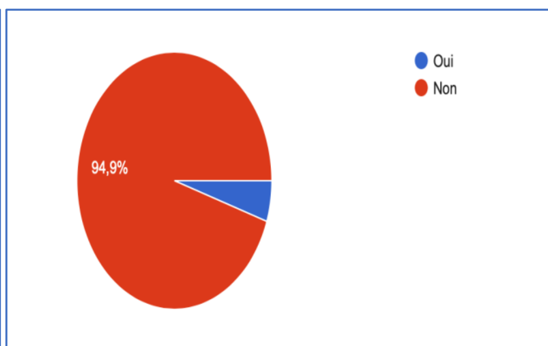


Graph II: Profession

87.25% worked at the university hospital, with length of service ranging from 06 months to 30 years. 82.5% had an addictology service at their place of work (Graph III), and only 5.1% were smokers, with a number of cigarettes ranging from 4 to 10 per day (Graph IV).

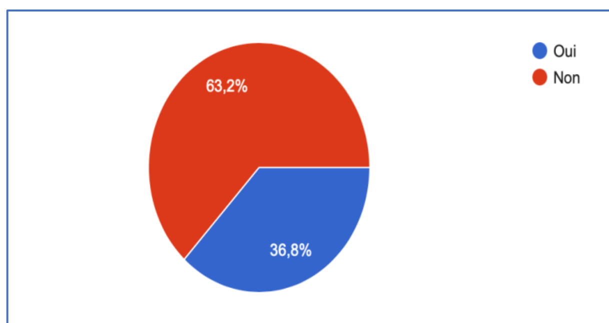


Graph III: Addictology service.

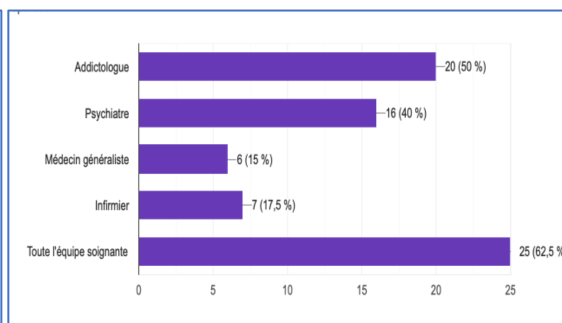


Graph IV: Smokers caregivers.

Only 36.8% were trained in smoking management (Graph V), 25% said that smoking management was the responsibility of the entire health care team (Graph VI), and only 30% of participants systematically offered smoking cessation to their patients.

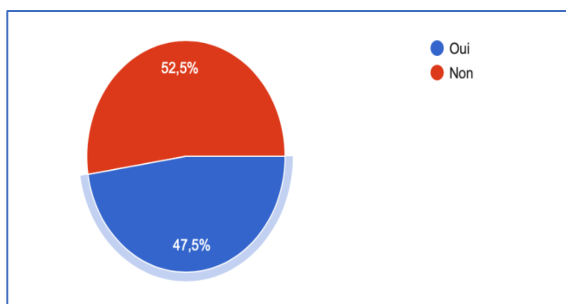


Graph V: Addictology training .

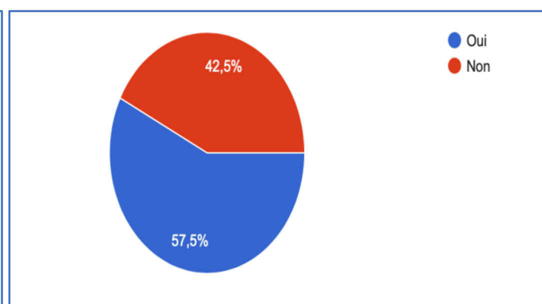


Graph VI: Smoking management responsibility

52.5% were against banning smoking in psychiatric facilities (Graph VII), and 57.7% mobilized a member of the team to fetch cigarettes for patients (Graph IIX).



Graph VII: Banning smoking.



Graph IIX: fetching cigarettes for patients.

Unfortunately, no smoking cessation treatment was available in Morocco.

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IV. DISCUSSION

A. *Discussion of our results:*

The results obtained provide an overview of the situation in psychiatric wards with regard to smoking. They show that, although concerned by the problem of smoking, carers do not make it their priority. It also shows the importance of smoking in psychiatric wards, due to its high estimated prevalence, and the mobilization of caregivers to go out and buy cigarettes for patients.

These results effectively demonstrate the importance of tobacco in psychiatry. Contrary to what the authors have expressed in their studies [6], the ban on smoking in psychiatry would be rather badly perceived by caregivers working in psychiatry who, according to the survey results, would tend to smoke less in their workplace. The majority of professionals responding to the survey also considered the smoking ban to be a bad thing in psychiatric wards. Few professionals offered smoking management to smokers with psychiatric conditions, which is in line with the literature. According to the same results, caregivers do not feel concerned by patients' smoking habits in the context of their profession.

According to various authors, the high prevalence of smoking among schizophrenic patients makes it very difficult for them to stop [7]. However, the results of the "smoking and psychiatry" survey showed that no cessation treatment was available in Moroccan establishments.

All professionals feel that it is up to all doctors and healthcare staff to provide this care. Most professionals feel concerned by the care of smokers within the framework of their profession, but only 60% are directly involved in the care of smoking patients. The results show that the best results are obtained in establishments with the presence of tobaccologists/addictologists or an addictology liaison team.

The literature shows that requests for smoking consultations more often come from patients themselves, rather than from doctors [8]. When an addictologist/tabacologist or liaison team is present, all doctors are more involved in the tobacco management of patients with psychiatric conditions [9][10].

Better tobacco prevention when a tobaccologist/addictologist or liaison team is present in psychiatry [11]. In these cases, weaning is more often undertaken, as is tobacco management [12]. With regard to nicotine substitutes, the results show that they are available from the hospital pharmacy in 80% of French establishments, particularly in the case of patches [13]. The majority of facilities offer several types of nicotine substitutes, which are accessible to psychiatric patients [14]. Some establishments even have a specific protocol for the use of nicotine substitutes in hospitals [15].

Raising caregivers' awareness of tobaccology would therefore appear to be a sensible way of reducing the prevalence of smoking among patients with psychiatric disorders [16]. It would be worthwhile offering regular, comprehensive training courses on tobacco dependence and its treatment to caregivers working in psychiatry [17]. It is important that such training should focus on the prevention and management of smoking, to enable caregivers to take action both upstream and downstream.

Such training would, on the one hand, dispel the preconceived notion that patients with psychiatric disorders do not want to stop smoking, and on the other hand, ensure quality smoking management for patients with psychiatric disorders [18].

B. *Management of nicotine dependence :*

➢ Pharmacological treatments :

- Nicotine substitutes:

Available in the form of transdermal devices (patches) or chewing gums, they consist of daily nicotine intake in progressively decreasing doses over several weeks.

However, abstinence rates at 12 weeks after substitution with transdermal systems are lower in schizophrenic patients (36-42%) than in the general population (50-70%) [17].

- *Bupropion :*

Mixed antide pressant, norepinephrine and dopamine reuptake inhibitor, amphetamine structure. It acts via two neuronal pathways, dopaminergic and serotonergic.

This product has proved to be a suitable therapy for smoking cessation, but its benefit-risk balance is unfavorable in smoking cessation.

Subjects motivated to cut down but not to stop smoking were given bupropion (300 mg/d) and ST support sessions for 14 weeks, but none of them stopped smoking [18].

- Varenicline :

A partial nicotinic receptor agonist, this drug is said to be significantly more effective than bupropion in aiding smoking cessation, in terms of complete abstention between the 9th and 12th week of treatment and reduction in craving. It has not been studied in a psychotic patient population and has not been reported [18].

In several studies, men unmotivated to quit smoking were given varenicline (2 mg/d) for 9 weeks. At the end of the study, a reduction in daily cigarette consumption and a decrease in plasma cotinine concentration were observed. The point prevalence of abstinence at the end of treatment was 16.6%.

Administration of varenicline (2 mg/d) combined with cognitive-behavioural therapy sessions for 12 weeks, with a point prevalence at the end of treatment of between 47.3 and 60.4% [19].

- Combined therapies:

Subjects motivated to quit smoking received a 3-month ST combination of bupropion (300 mg/d), 21 mg/24-hour patches, nicotine gum or tablets, and behavioral and cognitive therapy sessions.

Point prevalence of abstinence at the end of month 15 was 64.7%. The rates of continuous abstinence (4 weeks before the end of the study) and prolonged abstinence from months 6 to 12 were 58.8% and 23.5% respectively.

The choice of medication (SN, bupropion or varenicline) and duration of treatment depend on patient and physician preference [19].

➢ *Supportive psychotherapy and other support modalities :*

- Cognitive and behavioural therapies:

Combined with ST medications, they have been shown to be effective in smokers without psychiatric pathology, but also in patients with schizophrenia, with improved compliance with antipsychotics, increased social skills and easier management of stressful situations. The combination of pharmacological treatment and cognitive-behavioural therapy is predictive of smoking abstinence [18, 20].

- Strengthening social skills and psychosocial management:

An enhanced program tailored to schizophrenia (with motivational enhancement, mental health education, social skills training and relapse prevention), combined with nicotine patches and group cessation support sessions, resulted in a significantly higher point prevalence of abstinence, as well as a significant reduction in positive and negative symptoms of schizophrenia through improved psychosocial skills, including feelings of self-efficacy and social skills in patients with schizophrenia [20, 21].

V. SMOKING CESSATION DIFFICULTIES IN PATIENTS WITH SCHIZOPHRENIA

Smoking cessation rates are about half as low in patients with schizophrenia as in the general population. Between 20% and 40% of schizophrenics say they want to stop smoking, but are unable to do so. These difficulties in quitting smoking may in fact be linked to the cognitive impairments of schizophrenia, as mentioned above. Re-learning to live smoke-free may also take longer in schizophrenic patients than in subjects without psychotic pathology [22,23].

The period of stabilization of psychiatric disorders is therefore an opportune time to consider weaning. Doses of antipsychotics should be systematically reassessed after weaning, as it is common to observe an increase in plasma levels of these drugs after smoking cessation, due to the suppression of tobacco's interaction with cytochrome P450 CYP1A2 [23].

VI. CONCLUSION

Schizophrenia patients form a population that is not only predominantly smokers, but also more addicted than the average general population. Smoking, long tolerated and unfortunately underestimated, is under-treated by caregivers.

Providing training in addictology/tobacology would encourage caregivers to take better care of smoking patients with psychiatric conditions.

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