Few would argue that smoking is a significant issue for people with mental illness. Prevalence is approximately two to four times that of the general population and there is growing evidence that it contributes significantly to increased mortality in this group. Data from the UK, for example, identifies that while people with serious mental illness represent five per cent of the population, they account for 18 per cent of deaths, and almost half of the excess mortality is due to cardiovascular disease, respiratory disease and cancer. More recently, a large Canadian study found tobacco-related conditions comprised approximately 53 per cent of total deaths in schizophrenia, 48 per cent in bipolar disorder and 50 per cent depression cohorts.

In light of this evidence, there is a growing push to redress the limited attention given to smoking in psychiatric populations and for mental health services to adopt a systematic and integrated approach to managing smoking as part of routine care. A recent Victorian coronial enquiry has included specific recommendations in this regard and various legal opinions have failed to uphold claims of discrimination against health services banning smoking in mental health facilities.

Assisting health services to step up to the challenge, a recent workshop conducted by the Victorian Network of Smokefree Healthcare Services provided an opportunity for mental health clinicians and service managers to discuss the issues and share strategies and resources.

Some of the key challenges identified included:

- the need to manage the attitudes and expectations of both consumers and staff, including the need to turn around a culture in which patients (and staff) expect to be able to smoke;
- the need to focus on ‘care’ of the nicotine dependent patient rather than the smoking ban – if appropriate assessment and treatment is provided, compliance with a ban will be less of an issue;
- the need to ensure staff are well educated and have access to appropriate expertise with respect to smoking and mental health, including motivational interviewing. The issues and management considerations are complex and there needs to be a distinction between managing nicotine withdrawal in the acute situation versus supporting an attempt to quit as part of ongoing care;
- the need to ensure appropriate pharmacotherapy is available, including managing acute withdrawal with fast acting nicotine replacement therapy (NRT), and being alert to the impact of smoking on the metabolism of psychotropic drugs;
- the need for appropriate monitoring and continuity of care, including engagement of the multidisciplinary team (medical, nursing, pharmacy and others) – consider using carbon monoxide monitoring to demonstrate and motivate progress;
- the need to address broader issues such as boredom and social isolation;
- the need to ensure consistency and compliance with a health service smoke-free policy – a total ban is more likely to achieve the goals of protecting staff and patients and providing consistent clinical care.

One of the hot topics was the place of electronic cigarettes in supporting smoking cessation or as a strategy for harm minimisation. This is clearly an evolving area and regular updates are included on the Victorian Network of Smokefree Health Care Services website: smokefreevictoria.com.au.

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1Mental Health Bulletin (Health and Social Care Information Centre, 2013
2Callaghan RC et al. Patterns of tobacco-related mortality among individuals diagnosed with schizophrenia, bipolar disorder or depression. Journal of Psychiatric Research, 2014;102-110
3Coroner’s Court of Victoria. Inquest into the death of Renee Treen, October 2013