Editorial

Smoking and mental illness

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Possibility of causality

This year new meta-analyses show that smoking is associated with increased risk of psychosis and with earlier onset of psychotic illness (1). The results indicate that smoking could be a causal factor for development of psychotic illness, thus adding mental illness to the long list of harmful injuries from smoking. However, the evidence of a causal link between smoking and psychosis requires more investigation to establish, including genetics, social conditions and other influencing factors.

No scientific support of smoking as self-medication for mental ill patients

Overall, psychiatric patients have a very high frequency of smoking. An old but still thriving theory states that smoking is used by patients with a mental diagnosis for self-medication of their mental illness. This should then counteract the health risk related to smoking to a degree, as many patients with a psychiatric diagnosis have been encouraged to continue to smoke by psychiatric wards establishing indoor smoking rooms/boxes and routines with free cigarettes. Surprisingly, this takes place in countries with highly developed psychiatry.

Patients with a mental diagnosis have a rather poor health with a huge potential for improvement. A potential, which is often not utilised in the health care settings – despite that many patients have a long continuity in the staff. A few years ago, a large Scandinavian registry study showed that patients with a psychiatric diagnosis pass away about 15-20 years before the background population, mainly because of medical diseases that are potentially preventable (2).

There are no scientific arguments supporting the old theory of self-medication. In contrast, growing evidence shows that quitting smoking is associated with better mental health status; depression, anxiety and stress are reduced, while the psychological quality of life and positive mood is increased significantly after the tobacco withdrawal period has finished. The improved mental status is common for both psychiatric smokers and other smokers (3).

A pre-understanding of continuous smoking being good for the mental ill patients is probably strange for the younger generations, while the senior generations have experienced similar examples before within internal medicine and surgery.

Internal Medicine

In the nineteen-fifties, the strong association between smoking and throat problems was used to advertise specific cigarettes as being “good for your T-zone”; i.e. the throat and mouth. Doll and Hill famously demonstrated the danger of smoking back in 1956 (4), and built a solid platform of knowledge that has expanded ever since. Today, everybody knows smoking is a cause of development of diseases in the so-called “T-zone” as well as in many other organ systems. Even second-hand smoking has severe consequences. Today, the evidence of smoking-ban and quit-smoking interventions is strong; both regarding effect and cost-effectiveness.

Surgery

Also in the middle of last century, another strong association was identified between smoking and complications after surgery for the first time. This association has since then been re-evaluated in over 300 studies (5). A quite new aspect of the danger of smoking was introduced through a demonstration of direct relation between smoking and the outcome of treatment. Though many conditions are not caused by smoking directly, are however aggravated by smoking. In addition to surgical

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interventions this is the case for a general condition like pregnancy, and illnesses like asthma and diabetes – amongst others. In the nineteen-eighties an observational study was published, and based on extrapolation, the authors considered it dangerous to quit smoking less than 8 weeks before surgery (6). This has since then been contradicted by several other and more solid studies as shown in a systematic review from 2009 (7).

It took about fifty years from the association was identified until the first randomised study on smoking cessation intervention in the preoperative period took place (8). Today, smoke-free operations, where the patients are offered smoking cessation interventions prior to the operation, are implemented all over the world to improve the surgical outcome.

Psychiatry

Patients with a psychiatric diagnosis should have relevant treatment that includes both their mental and physical health - in line with all other patient groups.

Often heavy smoking is followed by severe addiction and development of strong withdrawal symptoms requiring pharmaceutical treatment in combination with motivational counselling, other psychological support and patient education. This is also effective for psychiatric patients (9). The process towards successfully quitting smoking is improved by smoke-free surroundings. In a busy clinical environment, it may seem convenient to avoid withdrawal symptoms by establishing smoke-rooms and offering free cigarettes; an approach which would then counteract any efforts towards introducing smoking cessation interventions. It corresponds to having a bar with free beers when treating alcohol addicted patients. Nevertheless, the free beers scenario seems too obscure to be the case within psychiatric clinics and hospitals, where a “zero alcohol tolerance” is the general policy, and where alcohol withdrawal symptoms are handled carefully. So why is tobacco not seen in the same way?

Smoke-free psychiatry is a must in line with the above-mentioned smoke-free operation or in the area of cardiology and pulmonology.

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