

## **NASMHPD POSITION STATEMENT ON SMOKING POLICY AND TREATMENT AT STATE OPERATED PSYCHIATRIC HOSPITALS**

Silently and insidiously tobacco sales and tobacco smoking became an accepted way of life not only in our society, but also in our public mental health treatment facilities.

Revenue from sales of tobacco provides discretionary income for facilities. Smoke breaks became an ‘entitlement’, deserved and protected, and are one of the only times consumers can practice relating to each other and staff in a ‘normalized’ way. When, what, and how much to smoke are often the only choices consumers make as inpatients, reinforcing cigarette use by virtue of the autonomy it appears to allow. More troubling, cigarettes used as positive/negative reinforcement by staff to control consumer behavior. While taking seriously and treating illicit drug use by those with mental illness for some time, a substance far more deadly and pervasive, and used disproportionately by this population, has largely been ignored.

And now, a few words about tobacco. It Kills. And, it kills those with mental illness disproportionately and earlier, as the leading contributor of disease and early death in this population.

A preponderance of evidence has clearly established the deleterious health effects of tobacco smoking and second hand or environmental tobacco smoke. Science as well as experiences in mental health facilities have also shown that tobacco smoking leads to negative outcomes for mental health treatment, the treatment milieu, overall wellness and, ultimately, recovery.

Smoking promotes coercion and violence in facilities among patients and between patients and staff. It occupies a surprising amount of staff and patient’s time that could be better used for more productive activities. It is a poor substitute for practice in decision-making and relationship building and is inappropriate as a means to manage behavior within the treatment milieu. And, while smoking can be framed as the one ‘choice’ consumers get to make while inpatients, and a personal ‘choice’ for staff, it is critical to realize that *addiction is not a choice*.

*But, quitting smoking is.* While smoking has become more socially unacceptable and prevalence has decreased in the general population, much needs to be done to assist those with mental illness to quit. Currently, 59% of public mental health facilities allow smoking. If we agree that the goal shared by consumer and physician for mental health is recovery and that health and wellness is an integral part of that recovery, the issue of tobacco use in our facilities cannot be ignored.

As individuals committed to supporting health, wellness and recovery, and entrusted with the care and management of consumers and staff in our facilities and of limited public funds, we must act on what we know. Therefore, NASMHPD stands against tobacco and will take assertive steps to stop its use in the public mental health system.

As physicians, we commit to educating individuals about the effects of tobacco and facilitating and supporting their ability to manage their own physical wellness. We will practice the 5 A's; ASKING individuals about tobacco use, ADVISING users to quit, ASSESSING their readiness to make a quit attempt, ASSISTING with that attempt and ARRANGING follow-up care.

As administrators, we will commit the leadership and resources necessary to create smoke free systems of care, provide adequate planning, time and training for staff to implement new policies and procedures, and ensure access to adequate and appropriate medical and psychosocial cessation treatment for consumers and staff alike.

As partners in the recovery process, we will work with national organizations and decision makers, public and private service providers, and other support systems to ensure that those who want to be tobacco free have access to continued cessation treatment and support in the community. Health and wellness is a shared responsibility. NASMHPD is committed to doing their part to assist individuals in going tobacco free and will continue to advocate for those with mental illness in their right and hope to be well in recovery.

***Approved by the NASMHPD membership on July 10, 2006.***