

Myths and Facts of Tobacco and Mental Illness

1. Myth: Persons with mental illness and substance use disorders can't quit smoking.

Fact: Persons with mental illness and substance use disorders can successfully quit using tobacco at rates similar to the general population.¹

2. Myth: Persons with mental illness and substance use disorders don't want to quit.

Fact: The majority of persons with mental illness and substance use disorders want to quit smoking and want information on cessation services and resources.^{2,3} Smokers are more than twice as likely to quit for good when they quit with the help of stop smoking medications and extra coaching and support.⁴

3. Myth: Consumers will just start smoking again once they are discharged.

Fact: Many of consumers *will* smoke again. We don't refuse treatment for other addictions, even when we believe the client is not motivated to remain abstinent. We give everyone the opportunity to detoxify while in treatment with the hope that they will choose a substance-free life. Quitting is hard, especially in environments where tobacco use is acceptable. By incorporating tobacco cessation in our recovery philosophy, we can help clients learn refusal skills, identify triggers, and regain control if they relapse to open new doors to wellness and recovery.

4. Myth: Quitting smoking is a low priority problem; patients and medical providers have more important things to worry about.

Fact: Smoking is a leading cause of death and disability in behavioral health populations. Rates of smoking can be as high as 90% for behavioral health populations compared to 23% in the general population.⁵ Mental health consumers can have a 25 year shorter life expectancy; a big reason for this is smoking.⁶ Tobacco use and its effects limit employment, housing and economic opportunities for consumers.⁷

5. Myth: Smoking calms down consumers. Without smoking, facilities will be complete mayhem

Fact: Banning smoking in psychiatric hospitals actually *reduces* mayhem. Facilities that do *not* allow smoking report fewer incidents of seclusion and restraint and a reduction in coercion and threats among patients and staff.^{8,9}

6. Myth: Smoke breaks are one of the few opportunities that consumers have to relate to other consumers and staff as peers.

Fact: Smoking is an addiction. Treatment facilities can no longer support addiction by condoning smoking by consumers or staff. Furthermore, consumers and staff can work together to create new activity choices and opportunities that are both fun *and* healthy.

7. Myth: Tobacco is necessary for self-medication. Consumers need to smoke to manage their mental illness

Fact: The Tobacco industry has spread this myth. The Tobacco Industry has a long history of targeting vulnerable populations, including those with mental illness. Nicotine has powerful mood-altering effects that can change how people living with mental illness think and feel. Tobacco use can worsen mental illness. Behavioral health populations who smoke can have more severe symptoms, poorer well-being and functioning, increased hospitalizations and are at greater risk of suicide.¹⁰

8. Myth: Smoking cessation will threaten recovery for persons with substance use disorders.

Fact: Smoking cessation can enhance long-term recovery for persons with substance use disorders. For example, if someone quit smoking at the same time they are quitting drinking, they can have a 25% greater chance of staying clean and sober.¹¹

9. Myth: We have no time to offer tobacco treatment to consumers

Fact: When smoking is allowed openly on psychiatric units, nursing staff spend an average of 15 minutes per shift managing patient smoking.¹² For units that continue to allow smoke breaks, staff may spend up to 4 hours a day managing patient's off-unit smoking behavior.¹³ This time can be redirected for tobacco treatment and wellness oriented programming.

10. Myth: Tobacco treatment is the consumer's primary care provider's responsibility.

Fact: There is evidence that those with mental illness experience barriers in accessing health care, including primary care settings. Behavioral health professionals have experience and training in the treatment of other addictions and are skilled to deliver behavioral therapies, and even group therapy for treating tobacco.¹⁴ Moreover, consumers look to their mental health provider to help them quit smoking.¹⁵ That being said, numerous studies support that a multi-disciplinary approach of providers to help more people quit.¹⁶

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