OPINION

PSYCHIATRY AND WORLD NO TOBACCO DAY

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Abstract

Objective: Smoking is a prevalent problem globally but more so among most ASEAN countries. Worldwide, six million lives are lost annually and this number is expected to grow. In light of this, the World Health Organization recognises the 31st of May to be World No Tobacco Day. For 2013, the theme is “Ban Tobacco Advertising, Promotion and Sponsorship”. This article aims to increase awareness among mental health workers, in particular psychiatrists, on the dangers of smoking, the tactics of the tobacco industry, and simple measures to address these problems within their daily activities. Method: A brief review of recent relevant literature in the field and actual experience from the field were highlighted in this opinion section. Results and Conclusion: Mental health workers are at an advantage as they have training in both psychological treatments such as brief intervention, cognitive behavioural therapy or counselling skills and for some others, pharmacological treatments. It is timely that health workers in the region take up this challenging but meaningful opportunity to help those with mental illness to stop their dependence for tobacco.

Introduction

Each year since 1987, the World Health Organization (WHO) commemorates World No Tobacco Day (WNTD) to highlight the dangers of tobacco. Smoking is the commonest form of tobacco ingestion with dangerous consequences. It is reported there are 7000 toxins within the tobacco smoke of which 69 of them are carcinogenic [1]. Annually, six million lives are lost due to this addiction and within the next decade this number is expected to grow to ten million as early as 2030 (1). For 2013, the WHO has decided the WNTD theme to be “Ban Tobacco Advertising, Promotion and Sponsorship”. This is in keeping with Article 13 within the Framework Convention for Tobacco Control (FCTC), which many in ASEAN have ratified [2]. The FCTC is a legal treaty initiated by the WHO to assist member countries to reduce smoking prevalence through a number of strategies [2].

ASEAN, having a number of countries within the group, are categorised as lower middle income and is at risk of the tobacco industry’s marketing campaigns due to their cumulative growth and large population base. As developed nations “roll out” more and more aggressive tobacco control initiatives, countries such as ASEAN appear more and more attractive as a result. Many countries in ASEAN still do not have well organized tobacco control strategies. Consequently smoking prevalence in adults is high, especially among men. As a direct result of this, many lives are lost annually due to smoking; 22% of male deaths in Malaysia and Philippines, 20% in Indonesia, 19% in Myanmar, 17% in Cambodia and 16% in Thailand [1]. Many more suffer from health
related morbidities due to smoking such as cardiac ailments, respiratory diseases and various cancers.

The limited tobacco control activities available to us in the region are oftentimes concentrated to the general population. There is however usually minimal input for minority populations. This includes those with comorbid health or substance abuse, indigenous population and especially important in our profession; the mentally ill. Experiences from developed nations have shown that when tobacco control activities mature and the prevalence of smoking for the general population reduced, a plateau may be seen [3]. This ‘stabilisation’ despite increasing resources is thought to be due to residual smokers who made up the minority population, sometimes known as ‘special’, or more recently increasingly known as ‘underserved’ [4]. Those within this population are thought to be ‘hardened’, meaning they are less influenced by cessation activities [5]. Those with mental illness, as mentioned, are thought to belong in this group.

A recent editorial by the Lancet highlighted this phenomenon [3]. Those with mental illness are often reported having higher smoking prevalence compared to the general population. Two to three times more is the ‘rule of thumb’, but for those with schizophrenia this number can be as high as 90%. Often they are also reported to smoke more cigarettes, are often more addicted to nicotine and are believed to consume a disproportionate number of cigarettes compared to the general population. In spite of this, they are usually neglected from treatment due to a number of reasons (for more see review by Prochaska(6)) or excluded from treatment trials. As the editorial stated, “caring for the patient’s mental health need and neglecting his or her physical health is not acceptable” [3].

In response to this year’s theme for WNTD, let us reflect that it was not that long ago when psychiatry endorsed smoking to our patients as a form of ‘self-medication’ [7]. Even now, there are those that believe that having a cigarette with a patient is a way to engage or develop rapport [6]. Both ideas of which should be unacceptable considering the dangers of smoking to both the health giver and the patient. One way for us to do right to the follies of the past is to endorse an environment which is free of tobacco promotion through increasing our efforts to make our psychiatric facilities (be it clinics, wards, hospital or institutions) smoke free. There are those among us who may still disagree despite the benefits that a smoke free environment may generate [8].

Another way to reduce tobacco promotion and indirect advertising is to ensure that we, in mental health care provision, are also smoke free. A study by Morris et al., [9], using a qualitative design, found that the role of health care providers was important in influencing psychiatric patients to quit smoking. The study also reported, that patients who were interviewed found it difficult to quit if their carer was also smoking at the time of their quit attempt.

As a profession, those in psychiatry are ideally placed to provide the best level of care as a result of their training in both physical and also psychological health. For psychiatrists, this includes training in both pharmacological and a variety of behavioural treatments. For the rest, training may include strategies to address unmotivated clients and also basic counselling skills. Despite this, not many of us take tobacco dependence treatment seriously. We had recently reviewed all published articles looking at psychiatrist and tobacco dependence treatment and found that oftentimes our medical colleagues do much better in both documenting diagnosis, treating or referring to relevant services. Considering the difficulties that our patients already experience in accessing existing services, having a familiar health care provider who has expertise in tobacco dependence treatment will be important [9]. As ‘champions’ of mental health care, our involvement should encompass both governmental and non-governmental aligned groups and associations involved in tobacco control activities.

To conclude, it is hoped that this opinion piece will create discussion and fruitful debate within the ASEAN mental health community so we
may be able to provide the best level of care to our patients. It is time we took up the challenge in pushing for this agenda in our respective countries. It is only a matter of time before our countries are exposed to marketing campaigns of the tobacco industry if not already. By being active now, we will be in better position to align tobacco control activities for the mentally ill together with the general population. This task is indeed a challenge but it holds much promise for the future.

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References


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