

Tobacco, Co-morbidity and Stigma

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Stigma is an important factor to consider in the area of tobacco use in the mentally ill. Smoking itself is clearly stigmatized as evidenced by the fact that people label “smoking” and associate it with a negative stereotype. Although there is evidence that smokers are stigmatized and perhaps even discriminated against in some situations, it is the positive effects of stigma and not the negative ones that get more attention in the smoking cessa-

tion literature. Stigmatizing smokers may help increase the motivation for smokers to quit in order to remove the effects of stigma. Societal effects which stigmatize smokers are also positive since these help to change the culture towards quitting and healthier living.

There is abundant evidence that people suffering from a mental illness are victims of stigma which results in many negative effects including shame, mistrust of others, discrimination and further difficulty integrating into society. What is not known are the effects of being both a smoker and having a mental illness. It is

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possible that there is an additive effect of increased stigma leading to further marginalization from society. Alternatively, it is possible that the stigma from smoking is perceived as less important than the stigma of having a mental illness and these are difficult research questions to assess. It is curious, though, that people with a serious mental illness cite that their greatest priority is securing housing and employment, yet the evidence supports that smokers are greatly stigmatized in access to both.

In addition to the stigma experienced by an individual, there are also the effects of societal stigma: the US vs THEM mentality that keeps groups apart. When considering how societal stigma may affect smokers with mentally illness, 3 groups emerge as important. These include the Mental Health System, the Tobacco Control Community and Mental Health Advocacy Groups. The effects of potential societal stigma may emerge in the form of discrimination, neglect or so called, “counter-advocacy”.

Do smokers with mental illness suffer discrimination? They are not considered a priority group within tobacco control, despite high smoking prevalence, low quit rates and the tremendous health burden they incur as a consequence of tobacco use. They suffer reduced access to tobacco cessation services, as there is both a lack of specialized treatment and little evidence-based research to direct treatment. Surveillance of tobacco use patterns in this group is lacking. Virtually none of the Master Settlement Funds were directed towards this group of smokers. This trend continues as new data collection systems for Quitlines and other national resources omit questions on mental health indicators.

Some of the measures used effectively by Tobacco Control to reduce tobacco use in other populations include prevention, treatment, advocating for and allocating resources, surveillance and research on tobacco use trends, and litigation against the tobacco industry. Despite research indicating that people with a mental illness smoke at increased rates and consume a disproportionately high amount of tobacco product in the US, little of these efforts have been directed towards helping this group. The controversial theory that smokers in the US are “hardening” and becoming more difficult to treat is highly suggestive of a changing smoking population that is mostly co-morbid for mental illness or other addiction.

Is the paucity of attention and resources merely an issue of neglect? Nearly 10 years ago, the American Psychiatric Association (APA) recommended that psychiatrists should treat tobacco dependence in all patients being seen for a psychiatric disorder who smoke. Yet we know that most mental health services lack tobacco dependence treatment. Psychiatrists continue to play a small role and tobacco dependence remains under-diagnosed and under-treated in mental health settings.

Smoking remains fairly entrenched within many mental health treatment systems as an accepted part of the treatment culture. Smoking is still the norm in group homes and residences for the mentally ill and outpatient treatment programs almost universally have designated outdoor smoking shelters on their grounds. State psychiatric hospitals in New Jersey still sell tobacco products in the stores. Perhaps most importantly, mental health staff frequently do

not believe that it is possible for individuals with mental illness to quit smoking.

In addition to discrimination and neglect, there may be opposing forces which are actually preventing or slowing movement in this area. We refer to this as “counter-advocacy” since it represents advocacy in the wrong direction, usually by mental health advocates. Tobacco use is devalued as a problem for people with mental illness. Since its effects are not acute, it remains a low priority. Both family members and professionals remain uneducated about the risks of smoking and benefits of quitting, with unfounded concerns of violence or other untoward effects that could result. These family and other advocates have been protecting the use of tobacco instead of advocating for increased access to tobacco treatment.

One national mental health advocacy organization has a public policy statement stating

“We **encourage** all state psychiatric hospitals... to provide...a designated smoking area for consumers to smoke. We recognize

the need that many consumers have to smoke. “Mental health advocates have successfully lobbied for exemptions to strict clean indoor air regulations for facilities for the treatment of mental disorders in several states.

Despite these difficulties there is evidence that mental

health consumers do want to address their smoking and are receptive to beginning this discussion. A leader in this area has been the Mental Health Association in New Jersey (MHANJ), the state branch of a national advocacy organization of mental health consumers. MHANJ has become interested in helping its constituency address tobacco use and in November 2004 adopted a Public Policy Statement of 11 recommendations entitled, “Regarding the Use of Tobacco among Mental Health Consumers” (http://www.mhanj.org/tobacco_policy_paper_nov_2004.pdf).

CHOICES (Consumers Helping Others Improve their Condition by Ending Smoking) is an innovative program targeting smokers with mental illness in New Jersey. The project employs mental health peer counselors to communicate the important message to smokers with mental illness that addressing tobacco is important. Consumer Tobacco Advocates to visit mental health centers, self-help centers and health fairs and also provide resources about places in New Jersey where smokers with mental illness can receive tobacco dependence treatment. Peer driven efforts which educate mental health consumers about the risks of smoking and benefits of quitting, are vital to increase consumer demand for tobacco treatment services.

In conclusion, the effects of individual stigma on smokers with mental illness are unknown. It is unclear how this additional stigma will be perceived although there is concern that it could have negative effects, which further marginalize this group and keep them from accessing treatment. To address societal stigma, concentrated efforts by the mental health, tobacco control and advocacy organizations will be needed to bring greater attention and resources to this vast problem. The population urgently needs increased access to treatment. Increasing consumer demand for services may be an important step in effecting change.

