Smoking is the first cause of morbidity and death in psychiatric settings

Gatov and colleagues' concern for the dramatic premature death of patients with schizophrenia "8 years younger than those without schizophrenia" was a missed opportunity to call a spade a spade.[1]

The issue is not new: adults with schizophrenia are 3.5 times more likely to die than the general population, mainly because of lung cancer, and chronic obstructive pulmonary and cardiovascular diseases; standardized mortality ratios are 52/100 000 person-years for suicide versus 75 for lung cancer in this group.[2]

Knudsen's enduring crusade against smoking showed sad evidence that the problem remains unchanged.[3]

Why are specific benefits of smoking cessation in the psychiatric setting almost ignored? In a randomized controlled trial, nicotine replacement therapy prevented agitation and neuroleptics use in smokers with schizophrenia admitted to the emergency department.[4] Whatever immediate effects smoking may have on perceived stress (decreasing pain caused by withdrawal syndrome), overall smoking generates or aggravates negative emotional states.[5] A time-series analysis showed that smoke-free policy reduced the incidence of physical assaults in psychiatric settings.[6] Robust evidence has been available since 2004 showing that tobacco cessation treatment improves other outcomes for substance use (alcohol and illicit drugs) and predicts more favourable long-term outcomes.[3] Last, treatments are safe and effective.[7]

However, it is most depressing that a recent article called for "resources" in implementing smoke-free policies and concluded that "research into the effect of smoking cessation on mental illnesses should also be a priority."[8]

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References

1. Gatov E, Rosella L, Chiu M, et al. Trends in standardized mortality among individuals with schizophrenia, 1993–2012: a population- based, repeated cross-sectional study. *CMAJ* 2017;189:E1177-87.
2. Olfson M, Gerhard T, Huang C, et al. Premature mortality among adults with schizophrenia in the United States. *JAMA Psychiatry* 2015;72:1172-81.
3. Knudsen HK. Implementation of smoking cessation treatment in substance use disorder treatment settings: a review. *Am J Drug Alcohol Abuse* 2017;43:215-25.
4. Allen MH, Debanné M, Lazignac C, et al. Effect of nicotine replacement therapy on agitation in smokers with schizophrenia: a double-blind, randomized, placebo-controlled study. *Am J Psychiatry* 2011;168:395-9.
5. Hajek P, Taylor T, McRobbie H. The effect of stopping smoking on perceived stress levels. *Addiction* 2010;105:1466-71.
6. Robson D, Spaducci G, McNeill A, et al. Effect of implementation of a smoke-free policy on physical violence in a psychiatric inpatient setting: an interrupted time series analysis. *Lancet Psychiatry* 2017;4:540-6.
7. Anthenelli RM, Benowitz NL, West R, et al. Neuropsychiatric safety and efficacy of varenicline, bupropion, and nicotine patch in smokers with and without psychiatric disorders (EAGLES): a double-blind, randomised, placebo-controlled clinical trial. *Lancet* 2016;387:2507-20.
8. Gage SH, Maynard OM. Smoke-free policies in psychiatric hospitals need resources. *Lancet Psychiatry* 2017;4:509-10.

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