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Original Article

Tobacco use among users of Psychosocial Care Centers and Residential Therapeutic Services

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People with psychic disorders tend to be most vulnerable to smoking. Because of the relation between smoking and the occurrence of mental illness, came to light the interest to check the consumption of tobacco among users of Psychosocial Care Centers and Residential Therapeutic Services. This is a descriptive and quantitative study conducted with 392 users of mental health services through questionnaires. The main data showed the influence of smoking with the person with psychic disorder and the diagnosis, since these people show behavioral patterns which justify smoking. Therefore, we should think on harm reduction and prevention as care strategies for these people.

Descriptors: Rehabilitation Centers; Mental Disorders; Smoking.

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O uso de tabaco entre usuários de Centros de Atenção Psicossocial e Serviços Residenciais Terapêuticos

Pessoas portadoras de transtornos psíquicos tendem a ser um grupo mais vulnerável ao hábito de fumar. Ante a relação existente entre tabagismo e a ocorrência da doença mental, surgiu o interesse de se verificar o consumo de tabaco em usuários de Centros de Atenção Psicossocial e Serviços Residenciais Terapêuticos. Trata-se de estudo descritivo e quantitativo, realizado com 392 usuários de serviços de saúde mental, mediante aplicação de questionários. Os principais dados revelados foram a prevalência do fumo entre essa população e a relação com o diagnóstico, pois essas pessoas apresentavam padrões comportamentais somados ao tratamento farmacológico, que justificam o gosto pelo hábito de fumar. Portanto, deve-se pensar na redução de danos e prevenção como estratégias de cuidado a essas pessoas.

Descritores: Centros de Reabilitação; Transtornos Mentais; Hábito de Fumar.

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Personas portadoras de trastornos psíquicos tienden a ser un grupo más vulnerable al hábito de fumar. Frente la relación existente entre tabaquismo y la ocurrencia de la enfermedad mental, surgió el interés de verificar el consumo de tabaco en usuarios de Centros de Atención Psicosocial y Servicios Habitacionales Terapéuticos. Se trata de un estudio descriptivo y cuantitativo realizado con 392 usuarios de servicios de salud mental, mediante aplicación de cuestionarios. Los principales datos revelados fueron la superioridad del humo entre esta población y la relación con el diagnóstico, pues estas personas presentan calidades comportamentales sumado al tratamiento farmacológico que justifican lo gusto por el hábito de fumar. Por tanto, se debe pensar en la reducción de daños y prevención como estrategias de cuidado a estas personas.

Descriptores: Centros de Rehabilitación; Trastornos Mentales; Hábito de Fumar.

Introduction

Smoking, a cultural practice among indigenous groups and disseminated worldwide by the tobacco industry, is a epidemic related to various diseases, directly or indirectly[1].

Regardless of creed, race or social class, the use of psychoactive substances has always been present in our culture[2]. The reasons for the use of these substances are cults, rituals, commemorative events, pleasure feelings, pain relief, among others[3].

However, smoking is responsible for an average of 200,000 deaths each year in Brazil and exceeds the deaths due to alcoholism, AIDS, traffic accidents, homicides and suicides[4].

Due to the attention to mental disorders, the Brazilian psychiatric reform movement is been developing since the late of the 1970 decade. The main goal of this movement is replacing the psychiatric hospital as treatment space, in favor of other therapeutic practices that recover citizenship and autonomy of the mentally ill patients across the country[5].

Thus, places such as the Psychosocial Care Centers (PCC) provide mental health care with the objective to provide service to users, perform clinical monitoring and encourage social reintegration, creating the possibility to substitute the psychiatric hospital[6-7].

Also in this context, Residential Therapeutic Services (RTS) strengthen the hospital-centered model substitution. These services are alternatives of assisted living for people who experience psychiatric hospitalization for a long period and are deprived of family care. It can also be considered as a support to other mental health services and support to ensure the permanence of users outside asylums[8-9].

Psychological disorders people tend to be a vulnerable group to smoking. For many years, the impact of smoking in this population has been neglected due to failure to recognize that smoking is an addiction. Studies show that smoking in people suffering from mental disorders is higher than in the general population, including higher levels of tolerance and dependence[10].

Studies indicate close relationship between smoking and psychopathological features, in which stand out schizophrenia and depression[11].

Because of this relationship between smoking and the occurrence of mental illness the interest to verify the consumption of tobacco in PCC and RTS users was created. This is a study that enables greater knowledge about tobacco consumption in people with mental disorders.

Methods

The presentation of this study belongs to the research entitled "Rehabilitate networks – Evaluating innovative experiences in the composition of networks of psychosocial care" (REDESUL) with a quantitative, descriptive and transversal approach. However, this paper presents a descriptive analysis.

PCC users and residents of the RTS from Brazilian southern (Alegrete, Bagé, Caxias do Sul, Porto Alegre and Viamão) were interviewed and selected for the sample from 07 to 10 September 2009. Questionnaires were given to users and their companions. A nominal variable (smoking) was used to identify the existence of smokers, ex-smokers and non-smokers in health services. There were no specific and validated questionnaires regarding tobacco use. There were three empirical issues related to tobacco use, period of use and number of cigarettes consumed in a day.

To calculate the sample an alpha value equal to 5% and a power of 80% was used, and the calculation was performed on Epi-info 6.04 through different measures and indicators of variability found in the literature.

The study included 392 users in the quantitative stage. From the five cities selected for the sample we interviewed 143 users from Residential Therapeutic Services and 249 interviewees in PCCs, among users of semi-intensive care and intensive care. Children, alcohol and drugs from PCCs were not sampled, given their specificities. As the criterion for identifying was defined from a Residential Therapeutic Services, the services were identified in the five cities in Rio Grande do Sul with RTS.

To test the tools and enable them to the needs, a pilot project was created. It was performed in a PCC in Pelotas/RS, a city which has not been selected in the sample, after training of interviewees and development of instruments.

The REDESUL research was approved by the Ethics Committee of the School of Dentistry, Federal University of Pelotas – UFPel, No. 073/2009. All participants signed an informed consent.

Results

Table 1 - Smoking prevalence among users of Mental Health Care in the state of Rio Grande do Sul, Brazil

Variable	N	Frequency %
Smoker	163	41.58
Non-smoker	197	50.25
Former smoker	29	07.39
Did not inform	03	00.76
Smoker		
From PCC	91	55.82
From RTS	72	44.17

Table 2 - Distribution of period of use and number of cigarettes smoked per day by users of Mental Health Care in the state of Rio Grande do Sul, Brazil (N=163)

Variable	n	Frequency %
Period of use*		
0-2 years	09	05.52
3-5 years	11	06.74
6-10 years	18	11.04
11-20 years	45	26.60
21-30 years	30	18.40
31-40 years	26	15.95
41-50 years	07	04.29
51-60 years	04	02.45
Over 60 years	01	00.61
Did not inform	12	07.36
Cigarettes/day†		
1-5 cigarettes	35	21.47
6-10 cigarettes	26	15.95
11-20 cigarettes	58	35.58
21-30 cigarettes	10	06.13
31-40 cigarettes	22	13.49
41-50 cigarettes	02	01.22
51-60 cigarettes	05	03.06
Over 60 cigarettes	03	01.84
Did not inform	02	01.22

* Regarding period of use, average: 21.93 years (SD=13.98), minimum of 0 and maximum of 64 years

† As the number of cigarettes per day, average: 20.46 cigarettes (SD = 16.44), minimum of 2 and maximum of 80 cigarettes

Table 3 - Tobacco use as first self-reported diagnosis

Tobacco	Diagnosis	N	%
Non-smoker	Schizophrenia	31	43.0
Smoker		32	44.4
Former smoker		09	12.5

(continue...)

Table 3 - (continuation)

Tobacco	Diagnosis	N	%
Non-smoker	Major depressive disorder	35	54.7
Smoker		24	37.5
Former smoker		05	07.8
Non-smoker	Bipolar disorder	25	64.1
Smoker		11	28.2
Former smoker		03	07.7
Non-smoker	Epilepsy/seizure	08	61.5
Smoker		04	30.7
Former smoker		01	07.2
Non-smoker	Other disorders	12	57.1
Smoker		08	31.1
Former smoker		01	04.7
Did not inform*		183	46.6

* In this Table there are 183 users who did not answer the question about tobacco (smoking/non-smoking/former smoker) or were unable to inform the diagnosis

Discussion

This study presents 41.58% of smokers in health care service with an average time of use of 21.93 years and average consumption of 20.46 cigarettes per day. Given these results, it can be stated that Brazil, for its great cultural, social and economic diversity, can directly influence smoking habits. The literature shows that the prevalence of daily smoking, pointed out in a study conducted in Southern Brazil[12], was higher in the South and Southeast regions. This study shows findings that corroborate with the results found in searches of the Protective and Risk Factors for Chronic Diseases by Telephone Survey (VIGITEL – in Portuguese), which has been monitoring, among others, smoking in the adult population of 26 state capitals and the Federal District[12].

Smoking is caused by several factors, including individual characteristics of human being and also the strong influence of the family and the social group. Adolescence is characterized as the period when the person is more likely to adopt behavior changes, and this may reflect initial actions and behaviors to acquire habits like smoking and alcohol[13].

Strengthening the idea of the role of the family against smoking, there is a study that reported exposure to tobacco influenced by cultural behavior in society and family. In large urban centers, such as São Paulo-SP, there are families that support and consent smoking, particularly in psychiatric patients, with the intention that this habit provides "welfare" and keep the patient calm and the mental disorder "under control". This practice is also accepted in psychiatric hospitals under the same conditions[12]. In countries where smoking is prohibited by the family and those with mental illness live and rely on their families for their care, the prevalence and exposure to alcohol and tobacco decrease[14].

Smoking is directly harmful to health. Smokers can be considered chronic ill and patients susceptible to multiple health problems had higher chances of developing lung cancer or other in organs, chronic obstructive pulmonary disease (COPD), heart and circulatory complications, skin problems and oral cavity, among others[15]. Tobacco consumption causes not only proven health risks, it is characterized as a legal drug, unlike other drugs, which causes the greatest challenges to promote its control as its consumption is tolerated in the society[16].

Given this reality of non-restraint tobacco consumption, it is thought, as a control strategy, prevention, reduction and harm reduction for those who already have the habit[16].

This study shows smoking prevalence of 41.58%, a rate below the average reported by other studies, which justifies its contents by the connection between nicotine dependence and psychiatric disorders, as the prevalence of tobacco use is higher among people with mental disorders (50 to 84%) compared to the general population (27 to 58%)[17].

Patients with mental disorders have higher tendency to acquire the habit of smoking, because the action of nicotine in the body causes a positive effect on mood and cognition of the individual[18].

Thus, it is believed that smoking is common among schizophrenics. Based on the analysis of table 3 we noticed that, in this study, 44.4% people with this diagnosis are smokers.

In other studies high prevalence of smokers (80%) with schizophrenia was observed, surpassing what was found in this study[17]. Studies in other countries also state these findings presenting a prevalence of 64% of smoking in schizophrenics, in a survey carried out in Spain[19].

Smoking is more severe when associated with factors such as young age, early onset of mental disorders, higher number of hospitalizations and high doses of antipsychotic medications[20].

The literature discusses tobacco use among schizophrenic patients as a reflection of the institutionalization process, boredom and low impulse control of individuals with this disease. Reports of patients claim that smoking is relaxing, reduces anxiety and side effects of medications. It can also improve concentration and reduce unpleasant arousal experienced by some schizophrenics[11].

Another relevant fact pointed out by this study refers to the prevalence of smoking among patients with depression. However, the results indicated in this study (54.7% of patients with depression do not smoke) contradict the findings of other studies. This disparity of results can be understood due to the limitations of the study because the diagnoses were self-referenced by respondents and also by the possible reduction in the number of smokers in the Brazilian general population which dropped in 65% from 1980 to 2010. In 2010 there was the slightest record of cigarette consumption per capita (682 units) throughout this period[21]. A study made in 2010 revealed that the occurrence of depression was higher in smokers than in people who never smoked[18].

A study that brings a non-systematic review of literature of the relationship between smoking and psychiatric disorders states that the act of quitting smoking is reduced in patients with depression. And yet, when

this practice is left behind, such action may contribute to worsening of symptoms evolving, possibly, for the occurrence of new depressive episode[11].

One acceptable explanation to justify the relationship between smoking and depressive disorders is that tobacco use can cause a relief feeling from sadness and negative mood, assuming the role of "self-medication". There is even scientific evidence that nicotine acts on the neurotransmitter system reflecting in mood regulation[11]. Another determinant factor of this connection between smoking and depression is because of the unidirectional relation, where the occurrence of one substance influences directly on the other. People who smoke and are depressed use this habit in an attempt to relieve negative feelings, smoking becomes reinforcing and stimulating[11].

In discussions about smoking it is very clear the search and desire for abstinence, so it is worth reflecting on the care approach to patients dependent on licit or illicit substances. Nowadays, there is the understanding for care and expanded clinic, whose practice is the transformation of the biological and individual attention given to the patient as a whole, being understood on all aspects[22]. In relation to tobacco dependence, it can be considered as an alternative to reducing damage to the patient, seeking the possibility of reducing consumption in order to minimize damage to health, respecting the uniqueness and the free will of each individual. This dependency can involve strong psychological factors that should not be disregarded from care plan and attention, valuing the person and his/her experience in every aspect of his/her life[15-16].

Final consideration

This study provided a better understanding of the connection between tobacco consumption and the occurrence of mental illness. Relevant data were revealed regarding the practice of smoking and the care services that these people attend. The diagnosis was a relevant explanation for this connection, because for people with these diagnoses have behavioral patterns linked to pharmacologic treatment to justify smoking.

It should be thought on tobacco and smoking from the idea that tobacco is considered a legal drug without any legal restriction and the practice of smoking as culturally accepted in our society, however, very harmful to health. Therefore, abstinence during healthcare practice is to be considered, since it is the patient's will.

Currently, there is the concept of expanded health care, which in practice reflects respect for the individual and complete view of the subject. Thus, it should be based on the concept of harm reduction to these people who opt for smoking and still invest in prevention, because a country with fewer cases of smoking means less spending on health and fewer cases of associated diseases, resulting from tobacco, with the possibility of investing in other sectors.

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