Quit Victoria: Safe smoking cessation and mental illness

The impact of tobacco use for people with many of the major psychiatric disorders is a serious health issue. As well, smokers with mental illness who are trying to quit, have special needs in the area of smoking cessation.

It is clear from the literature that tobacco-smoking rates in people with schizophrenia, bipolar disorder, personality disorder, anxiety and depression continue to remain extremely high. Consumption has been estimated between two and three times that of the average Australian smoker, smoking more, and often brands with higher tar and nicotine levels.

On average, smoking is three times more prevalent among people with schizophrenia, than the general population. Very little research has been done in Australia but what there is indicates that smoking rates among the mentally ill are not declining commensurate with the general population. One study conducted at the Centre for Young People’s Mental Health in Parkville, Victoria, found that 75% of their sample were smokers. Other research conducted in an outpatient setting in Melbourne reported that 76% of those surveyed were smokers. This compares to a smoking rate of approximately 20% in the general adult population in Australia.

A number of studies found that people with schizophrenia report smoking because it relieves boredom and offers opportunities to socialise when 88% of them are unemployed and isolated.

Smoking is severely damaging the health of people with mental illness. Deaths from respiratory and heart disorders are 60% and 30% more likely among people with mental illness compared to the general population. Smoking also has financial and social implications, especially when there are increasing restrictions on where people can smoke.

Quitting gives people with a mental illness not only the possibility of a healthier and longer life, but a better quality of life, freeing finances previously allocated to tobacco use, for food, accommodation, recreation, and better self-care and presentation.

However there is a complex interaction between tobacco smoking, symptoms of a mental health condition and some medications used to treat these conditions, that needs to be considered when supporting safe smoking cessation within this group.
Smokers with mental health conditions tend to develop a more complicated dependence than the general community. This is best described as a complex interaction between nicotine and other components of tobacco, which can affect the course of psychiatric disorders, the modification of psychoticviii and other psychiatric symptoms,ix and increase some and reduce other side-effects of particular medications. x,xii

In addition, because nicotine temporarily increases the activity of brain chemistry, providing some short-term beneficial effects, some smokers may use cigarettes to self-medicate symptomsxii or to alleviate the side effects of prescribed medications, xiii or as some evidence suggests, for an anti-depressant effect.xiv

Therefore any withdrawal of tobacco smoking may be complicated. Various published guidelines for medical management of cessation in smokers with mental illness advise close monitoring for effects on psychiatric illness including depression and anxiety; consideration of pharmacotherapies and other treatments to assist withdrawal; and the management of medications, their side-effects and levels, during and following smoking cessation. xv,xvi,xvii,xviii

Smoking can directly impact clinical care by altering medication blood levels. Smokers require prescription of higher doses of neuroleptics than nonsmokers to gain a therapeutic effect.xix Accordingly, smoking can interfere with the benefits of some medications and increase related side effects. At the same time, smoking can be a means of reducing some side effects, particularly in relation to antipsychotic drugs. Thus, medication blood levels may be substantially altered during changes in smoking patterns, and medication dosage may need adjusting following reduction in smoking.xx

Fluctuations in smoking levels may precipitate or exacerbate psychiatric symptoms; abrupt cessation may lead to hospitalisation. Withdrawal can be confused with, or may exacerbate, symptoms of schizophrenia. In Victoria there are specific guidelines for general practitioners that advise and detail a program of management and monitoring of quitters with schizophrenia, for the effects of reduction in smoking on their psychiatric illness and medication.

The link between tobacco use and depression is such that people with a history of depression are generally described in the literature as more likely to smoke, more likely to find it difficult to quit and at increased risk of suffering significant mood disturbance or full blown depression following cessation. xxi,xxii Not every smoker with a history of major depression, who successfully quits, relapses to major depression. However, studies report a significantly increased risk of developing a new episode of major depression, which remains high for at least 6 months following cessation. xxiii,xxiv,xxv Monitoring for depression is advised for at least 6 months following quitting.

Given the possibility of such interactions, a person’s presentation may vary over time. Therefore, ongoing face-to-face monitoring of withdrawal by their treating
doctor will provide the best opportunity for people with mental health conditions to cut down or quit smoking with reduced risk of precipitation or exacerbation of symptoms or side effects and to ensure any necessary adjustment to prescribed medication(s).

1 Mental illness and smoking cessation: an urgent public issue. Forum proceedings, 19 November 1996, compiled by Quit Victoria.


7 Polgar S, McGartland M, Borlongan CV, Shytle RD, & Sanberg PR. Smoking cessation programmes are neglecting the needs of persons with neuropsychiatric disorders. Aust NZ Journal of Medicine, 1996;26, 572.


22 Covey LS. Tobacco cessation among patients with depression. Prim Care 1999;26(3):691-706.
