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Moving Towards Personalized Nursing in Mental Health

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I believe it was 2 years ago, in one of my home visits that I did within community psychiatric treatment in our Psychiatric Clinic. I remember that a patient said to me: "It is the only thing I have in this life – the cigarettes and coffee". I felt sorry for him and his "voices" "stood out" more than his "smokers cough". I just said to him "try to reduce a bit" (he was smoking 3 package of cigarettes per day!) and then put my efforts in explaining how important is for him to take his medication regularly, about schizophrenia symptoms and so on.

However later, he made me contemplate the status quo of mental health. It seems that with in mental health, professionals tend to see just one side of the coin. We are quite satisfied with our work when patients are calm, do not have delusions, are not suicidal et cetera. We don't care about their smoking.

However, the major cause of death in patients with schizophrenia is cardiovascular disease (CVD). Therefore, do we pay enough attention to the risk factors for CVD like tobacco consumption, the use of alcohol, poor diet, and lack of exercise among patients with schizophrenia? Let us take smoking as an example, which is known to be the leading preventable cause of death in patients' with psychiatric illnesses [1].

Can you imagine not asking patient with lung cancer, if he smokes and not to put every effort into helping him to stop smoking? Yes, we always take into a consideration the smoking status when dealing with patients with somatic problems like diabetes, cardiac and pulmonary illnesses. However, when treating patients with mental health problems like schizophrenia, we often overlook and/or even tolerate this addictive behavior.

Studies have shown that patients with schizophrenia have at least two to three times higher smoking rates than that of the general population [2]. The fact is that patients with schizophrenia who smoke have an increased risk for suicide [3], and moreover their life expectancy is reduced by about 25 years in comparison to a general population of smokers where life expectancy is reduced by approximately 10 years [4].

Furthermore their bad social status gets even worse when smoking. For example public assistance in Slovenia is 269, 20 euros, and a smoker with schizophrenia spends about 133.13 euros on average on cigarettes instead of on healthy food for example.

However, what is less known among healthcare workers is that smoking decreases plasma levels of many typical and atypical antipsychotics, so patients who smoke heavily may thus be easily undertreated with antipsychotic medication [5]. This may in part explain the observation that smokers tend to have higher numbers of hospitalizations, have more pronounced schizophrenia symptoms and are less adherent to their antipsychotic medication [6].

I asked my coworkers (doctors and nurses) at the Clinic where I work if they pay any attention to smoking cessation among their patients with schizophrenia? I did not get the answer I wanted to hear, most of them gave such answers as "it didn't cross my mind", or "I don't have time for this", "it is useless", or "we in psychiatry are treating just their brain, not body..." I have to mention that most of my coworkers smoke at their workplace, even though smoking is forbidden at the premises.

So let's face it, for those who are digging just their own garden, smoking affects the patients physically, mentally, and socially. If we ignore the problem this does not mean it does not exist.

And, yes it is sometimes easier and less time consuming to dress a wound or to give a prescribed medication, than to convince patients to be active, get out of bed or to stop smoking.

We all know that the smoking cessation rates among patients with schizophrenia are very low, however the question is can we do something to increase these numbers? When I asked patients with schizophrenia in one of my smoking cessation groups why they smoke, the majority of them said the following: to calm myself down (16%), to feel better (13%), to reduce tension (10 %), to redirect attention from symptoms (8%), because I am bored (8%), I am more relaxed (8%), to feel self-confident (8%), I like the taste (8%), to overcome sadness (5%), and to reward myself (5%). So it appears that the reason for patients with schizophrenia to smoke varies greatly.

It seems that the "one size fits all" model does not work with all nursing interventions. We need to move forward to "personalized nursing", that takes into a consideration that people are unique, and everyone needs their own unique nursing approach. For example if the patient says I smoke because I am bored, we should ask him what would you like to do when you are bored instead of lighting a cigarette. If patient smoke due to tension, we should reconsider the causes, advise him to go walking, adjust the medication therapy, and so on. Individual plan for smoking cessation is necessary for every patient.

To make a long story short as the Hippocrates said, "It's far more important to know what person has the disease than what disease the person has. " The take home message of this editorial would be: "be aware, speak to the patient and take the action."

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