Revista Brasileira de Enfermagem
REBEn

RESEARCH

The decreasing number of cigarettes during psychiatric hospitalization: intervention or punishment?

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Submitted: 04-11-2014 **Approved:** 12-12-2014

ABSTRACT

The smoking ban during psychiatric hospitalization provokes personal and institutional changes. **Objective:** To identify the mental disorders carriers' perception, the smokers ones, about the decreasing number of cigarettes during psychiatric hospitalization. **Method:** Exploratory study with 96 hospitalized carriers of mental disorders who are smokers: G1 (34 subjects hospitalized when was allowed one cigarette by hour) and G2 (62 subjects hospitalized when it was reduced to eight cigarette by day). Semi-structured questionnaire. Thematic content analysis. **Results:** The G1 admitted satisfaction with the restriction – smoking during hospitalization as entitlement. The G2 resists the restriction change occurred without dialogue or support. In spite of the difficulties, some attitude changes about the cigarette were noticed such as increase of the responsibility, discovery of the ability to reduce smoking and the meaning of its role. **Conclusion:** Some subjects understand the smoking health policy change as punishment, while others as opportunity to think about the role of cigarette in their life.

Key words: Smoking; Health Policy; Psychiatric Department, Hospital; Non-smoking Areas; Psychiatric Nursing.

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INTRODUCTION

There are about 1.3 billion smokers worldwide, and each year more than six million people die because of this practice, which is one person every five seconds. Approximately one third of smokers die due to use of cigarettes and if control measures are not implemented continuously and effectively, tobacco-related deaths will increase to eight million a year in 2030[1].

Among patients with severe mental disorders, this picture is particularly concerning. Due to the high frequency of smokers and a higher degree of nicotine dependence among them, tobacco is one of the major factors responsible for somatic complications and decrease in life expectancy. People with severe mental disorders are expected to live 10-30 years less than people in general[2-3].

In 2008, the World Health Organization (WHO) established the MPOWER, an anti-smoking policy to assist countries in tobacco control consisting on the following actions: 1) Monitor tobacco use; 2) Protect the population from tobacco smoke; 3) Offer help to quit smoking; 4) Warn about the dangers of tobacco; 5) Enforce bans on advertising, promotion and sponsorship, and 6) Raise taxes on tobacco[1].

The actions to protect the population against tobacco smoke resulted in a smoking ban in enclosed public premises, supported in Brazil by law 12.546/2011[4]. This ban has interfered in the care provided in psychiatric services, especially those intended for hospitalization. The use of cigarettes in these services used to be encouraged to control the behavior of patients and facilitate interaction. However, the new measure imposes a change of behavior of nurses and other professionals, with the discovery of new resources to deal with the conflicts of hospitalization.

The first studies on smoking restrictions in psychiatric inpatient units were carried out in the United States and Canada in the late 1980s. They emerged from the need to investigate the impact of the smoking ban provided in the legislation of these countries, within the context of care. Until then, smoking was conceived as a cultural identity of psychiatric hospitals and cigarette sales were common in these services[5-7].

As the legal smoking ban in collective environments is recent in Brazil, the reduction in number of cigarettes during psychiatric hospitalization and its impact in the context of care are still poorly investigated. Therefore, this study aims to provide an understanding of the smoking limitation during psychiatric hospitalization from the perspective of patients with mental disorders, contributing to knowledge of aspects to help implementing nursing care and other health technical procedures. For nurses, the knowledge on these issues is essential to understand what psychiatric patients think about the smoking ban in hospitalization, to helping them go through this period in the healthiest way possible.

Therefore, the aim of this study was to identify the perceptions of smoker patients with mental disorders about the reduction in number of cigarettes during psychiatric hospitalization.

METHOD

This is an exploratory study carried out in the psychiatric ward of a general and public university hospital located in the countryside of the state of São Paulo. The unit has 18 hospital beds for patients with mental and behavioral disorder in acute condition. All were referred for hospitalization after evaluation of the Emergency Unit staff of the hospital complex.

Inclusion criteria to participate in the study were the diagnosis of mental and behavioral disorder and current use of tobacco. Individuals aged under 15 years were excluded, as well as subjects with diagnosis of mental retardation, users of alcohol and other drugs without psychiatric comorbidities, people unable to communicate during the hospitalization period and those without preservation of basic mental functions (cognition, thought and perception).

Considering the average flow of admissions to the psychiatric unit is 15 patients per day, hospital stay is 16 days, occupancy percentage of the 18 beds is 83.3% and that preliminary surveys with inpatients in this unit have estimated one-third of subjects as smokers, we selected a simple random probability sample (precision of 95%; maximum error of 10%) made up of 270 patients with mental disorders in the unit. Of the 270 subjects, 96 stated to be smokers, comprising this study sample. As the 174 subjects who reported no use of tobacco were not investigated regarding their perception on the smoking restriction, their responses were not included in this study.

During the data collection period (August 2010 to February 2012), the multidisciplinary team of this psychiatric unit decided to change the access rule of patients to cigarettes. This interfered with the distribution of subjects because the 96 smoker patients with mental disorders who had been previously estimated by the sample calculation were naturally divided into two groups (group 1 and group 2). The hospitalization period and current constraint rule determined the distribution of subjects in each group: G1 and G2.

G1 – group 1 consisted of 34 patients with mental disorders, smokers, admitted at the beginning of this study, when a cigarette every hour was allowed in the period from 8 to 22 hours, as long as patients smoked in the bathroom of their rooms.

G2 – group 2 consisted of 62 patients with mental disorders, smokers, admitted when the restriction rule was modified. They were allowed to smoke in the area outside the ward only at six predetermined times (7.30, 9.30, 12h, 14.30, 16.30 and 18.30). Two cigarettes were permitted in the first and last times and a cigarette in the other times, i.e., eight cigarettes a day.

This study was approved by the Research Ethics Committee (EERP/USP 1173/2010). Data collection was authorized by the board of the Hospital das Clínicas of Marília. All subjects signed two copies of the Informed Consent Form (ICF).

The instrument called "Instrument for Identification of Smokers in the Psychiatric Unit of a general hospital – ITUP" (Instrumento de Identificação de Tabagistas em Unidade Psiquiátrica de hospital geral) was used. It was prepared for this study and consisted of structured and semi-structured questions. In order to meet the objectives of the study, an excerpt of the instrument

data was used, including objective questions about the clinical identification and information of individuals, and semi-structured questions addressing their perception on the reduction in number of cigarettes in hospitalization.

The interviews were recorded and transcribed, the contents were organized into thematic categories and discussed based on the scientific literature. For each statement was assigned a code to ensure the anonymity of subjects.

RESULTS

The interviews with 96 smoker patients with mental disorders lasted 44.8 minutes on average (22-120 minutes, standard deviation of 17.3 minutes). The results were organized in two topics: A) Identification of subjects and B) Thematic analysis of the content expressed by smokers.

A) Identification of subjects

Most study subjects were female and had a diagnosis of severe mental illness (schizophrenia, mood and personality disorders). Table 1 shows the sociodemographic and clinical information of the subjects.

Table 1 – Presentation of smoker patients with mental disorders, hospitalized in the psychiatric unit, according to sociodemographic and clinical identification

Identificação sociodemográficas		***n***	**%**
Gender	Female	59	61.5
	Male	37	38.5
Gender	Up to 29 years	26	27.1
	30 to 49 years	49	51
	50 years and over	21	21.9
Education	Primary	51	53.1
	Secondary	33	34.4
	Tertiary	12	12.5
Marital status	Single	42	43.8
	Married	32	33.3
	Separated/divorced	17	17.7
	Widowed	5	5.2
Income	R$ 600	28	29.2
	R$ 1,000	23	24
	R$ 1,800	27	28.1
	> R$ 1,800	18	18.8
Clinical identification		***n***	**%**
(Medical diagnosis (IDC-10)	F20 – F29*	32	33.3
	F30 – F39**	33	34.4
	F60 – F69***	12	12.5
	Others	19	19.8
Time since diagnosis	Up to 12 months	22	22.9
	1 to 4 years	27	28.1
	5 to 10 years	23	24
	11 years and more	24	25
Locations of previous psychiatric hospitalizations	General Hospital (GH)	12	12.5
	Psychiatric Hospital (PH)	11	11.5
	GH and PH	13	13.5
	GH, PH and Emergency	5	5.2
	Other combinations	15	15.6
	Not applicable	40	41.7
Total		**96**	**100**

**Schizophrenia, schizotypal and delusional disorders*
***Mood disorders (affective)*
****Disorders of adult personality and behavior*

B) Thematic analysis of the content expressed by smokers

The reports of 96 smoker patients with mental disorders were identified by code and organized into three themes: 1) The view of smoker patients with mental disorders about the permission to smoke a cigarette every hour; 2) Impact and limitations of reducing the number of cigarettes smoked during hospitalization; 3) Partial restriction as an opportunity to rethink the role of smoking.

1) The view of smoker patients with mental disorders about the permission to smoke a cigarette every hour

The reports of hospitalized subjects when they were allowed a cigarette every hour show they were in favor of this rule.

We have to smoke in the bathroom. It is our right, better than smoke in the hallway. (T4, G1)

Being able to smoke every hour is already a help, you know why? Because if it weren't at every hour I'd have no more cigarettes. (T16, G1)

The permission to smoke in the bathroom of the bedrooms seems to bother some smokers who feel the need for an airy place to smoke. There is concern in relation to other non-smoker patients.

I disagree [smoking within the ward]. I'd agree if at every hour the door was opened for the smoker patients smoking outside. Why keep a cigarette in the bathroom? It is dangerous, people with mental problems can set fire to a mattress like this. (T14, G1)

I found it odd [smoking in the hospital], and even more inside the bedroom. It's bothering me. (T25, G1)

I don't think it's right to smoke in the ward. [...] I'm thinking of others [nonsmokers]. (T21, G1)

Some patients with mental disorders realized the need for a stricter measure in the ward.

Here, there is the rule of one every hour, but it is liberal. It is the only place where you can smoke in peace even though there are rules [smoking ban laws]. It should be more strict. (T9, G1)

I think it's wrong [smoking in the hospital]. Since we are hospitalized, we should also stop smoking. There should

be no smoking at all here. [...] Smoking should be prohibited. (T10, G1)

2) Impact and limitations of reducing the number of cigarettes during hospitalization

The change of restriction rule on smoking for six predetermined times occurred from a decision of the unit multidisciplinary team, without planning actions of support and preparation of patients to face it. Since patients have not participated in the decision, the change came with resistance from some of them, who perceived it as an imposition.

[The change of restriction] was a shock! It was imposed, there was no dialogue, it seems a punishment. This is hindering my treatment, bringing me agony, sadness, despair! If I need to be admitted again, I won't accept it. I'll go to the Parque das Orquídeas [cemetery] at peace, but I don't come back here. (T39, G2)

Here, there are many rules and little explanation. They [professionals] simply cut you off. It's awful [change of restriction rule]. (T46, G2)

Here you have to quit smoking by force. This is torture, not support. (T67, G2)

The reduction in the number of cigarettes without accompaniment of nicotine replacement therapy (NRT) came with the identification of withdrawal symptoms and craving.

I smoke one already thinking about the time of the other. (T56, G2)

They control the cigarette time strictly. Then, this brings me other causes, such as nervousness. It's interfering with my recovery. [Cigarette restriction] makes me more desperate! (T72, G2)

I'm already in agony. I smoke one after the other, you know? I start to get anxious, nervous. Wow, I'm already going crazy [without cigarettes]. (T95, G2)

The discomfort brought by the new restriction rule has made individuals rethink their psychiatric hospitalization and consider the possibility of anticipating hospital discharge.

If I were at home, I'd have smoked a pack and a half because there it used to be one butt after the other. So far, I've smoked three cigarettes. It seems like there's something missing. If I knew [of the rule change], I wouldn't even have stayed here. (T54, G2)

It's been really tough! I told the doctor I'll be an inpatient only another two or three days and I'll leave 'cause otherwise I'll go crazy. I'll just wait to correct the medication. (T66, G2)

As it is, I can even request my hospital discharge. (T72, G2)

Geez! I'm here, but I'm dying to get out of this hospital. Before, it was less time, it used to be at every hour, but now it takes longer. Wow! It's hard for me. (T94, G2)

The rule change to six fixed times brought some limitations. The smokers reported concern about losing some of these times.

At the smoking time, sometimes the person is not in the mood. I feel obliged to smoke because if I miss that time it'll be just at the other. I could stay longer without smoking, but as there is a set time, I have to guarantee that cigarette. (T61, G2)

The permission to smoke two cigarettes in the first and last times (at 7.30 and 18.30) that occurred after the change of restriction rule is questioned by the subjects.

I prefer this rule [six predetermined times], but the last [cigarette] shouldn't be at six-thirty [18:30], but a little later. For example, instead of two cigarettes at 18.30, I'd rather one at 18.30 and one at 21.30. It'd be the same quantity, but with time in between. (T44, G2)

In the morning, you are entitled to take two cigarettes. I'm not able to smoke two cigarettes in a row ... If this persists for a long time, the person will start to smoke two cigarettes every hour because smoking is addictive, it will aggravate the addiction for sure. (T61, G2)

With the establishment of timetables to smoke, smokers have earned a little more freedom than other patients because at these times they are allowed to smoke in the area outside the ward. Due to the freedom brought by this measure, patients determined to quit smoking go back on their decision.

We smokers have more freedom here, our freedom is to go out for a smoke. (T63, G2)

Imagine I would be hospitalized here without smoking! Even more because smokers are the only ones who go out [external area of the ward]. Staying inside all day is hell! (T74, G2)

Smokers can get out more. At that time, F. [smoker patient] did not want to smoke, but he wanted to go out [of the ward]. He said he would quit, but he chose to smoke to be able to get out, to have more air. (T48, G2)

Despite recognizing the limitations of increasing severity in the restriction rule, a smoker stated to be in favor of completely withdrawing the permission of smoking in the hospital. He believes if doing so, new possibilities of interacting with other patients would arise.

If there were no cigarettes, I would deal with the anxiety in some other way, leaving [the room], talking to people,

distracting myself with games. If I didn't have the cigarettes to find refuge, I could [get closer to people], this would be the only alternative. (T57, G2)

3) Partial restriction as an opportunity to rethink the role of smoking

Regardless of the current restriction rule, in some cases the smoking restriction in hospitalization helps patients to develop self-control, because they discover to be able to smoke less. The restriction is seen as an opportunity to reflect on the true role of cigarettes in their lives.

Sometimes I say: I'm nervous, I'll smoke a cigarette. I think I'm fooling myself. How come I'm like that here [with reduced number of cigarettes] and I am not anxious? They've cut [number of cigarettes] in half, more than half! The nervousness, this anxiety is not caused by the cigarette, if it was, I'd already be worse [here, hospitalized], wouldn't I? (T8, G1)

Due to the restriction, I felt more responsible in relation to smoking. (T27, G1)

I see the other side, you know? If I can hold myself for an hour to smoke a cigarette, I can do even more. Do you know what I mean? I think it's an incentive. (T30, G1)

Here, I've reduced by 75% of what I was smoking outside. [The restriction] helps you put in your mind that you don't need it. Couldn't I say to you: Will you excuse me, I'm going there to get a cigarette? I can go there to get a cigarette, but I don't want to. (T33, G1)

I am in favor of the times, it made me think that I am able to quit [smoking]. For example, yesterday I did not smoke. Did I die? I didn't die. Before, I didn't know I could do without it [smoking], I thought cigarettes were in the foreground of my life. Here I found out that it's not so. (T60, G2)

Some patients feel motivated to continue following the restriction of hours after hospital discharge. In this sense, the restriction can be seen as re-education opportunity. However, patients recognize that restricting the number of cigarettes outside the hospital is more difficult.

I'll keep these times at home. Is it one every hour? So it's one every hour. I'll follow the clock. It was good, at least we re-educated ourselves because if we get a cigarette all the time, we lose track. (T8, G1)

Who knows, maybe when I leave here I can continue with this habit, smoking only eight cigarettes and decreasing? It's just that I don't know what I'll find out there, right! I'm afraid to leave here. [...] It's easier to be without smoking here than outside, because here it's as if I were in a bubble, there are no problems. (T69, G2)

[When I was admitted and found I could not smoke freely] I thought it wasn't going to pull it off. I was surprised, I did it [smoke less]. [...] At home I'd put one out and light another. I intend to continue to follow this rule when I leave here. [...] It is a path, it'll help me. (T78, G2)

The partial restriction may help patients in the decision-making process to quit smoking.

The decrease in number of cigarettes in the hospital played an important role. I used to smoke a lot and suddenly I began to smoke less. It was a barrier I had to overcome, you know? I'm even thinking about quitting, a sign that I was able to overcome the barrier of addiction. (T49, G2)

DISCUSSION

When investigating the perception of smoker patients with mental disorders on the restriction to smoking in psychiatric hospitalization, differing opinions are found. In general, the subjects in group 1 (hospitalized when a cigarette every hour was allowed) were satisfied with this rule for considering smoking in hospital as a right to be respected. However, the others stated to feel the need for more strict restrictions on the use of cigarettes.

In a recent review of the scientific literature is questioned whether the smoking ban in mental health services is a violation of patients' rights or simply a restriction of privilege[8]. In the United States, advocate of the smoking ban for some time, lawsuits filed by patients against the smoking restriction in health services are common. In such cases, the prohibition of tobacco use is presented as a violation of the subjects' civil rights[9].

Some of these lawsuits have been successful in the US courts, which is a regression for the psychiatric care. Exempting psychiatric institutions of the smoking ban is likely to increase the stigma among patients with mental disorders. Continuous use of cigarettes by these subjects (encouraged on admission) can be understood as an additional disadvantage (reinforcing the stigma), since smoking has become less and less common in other population groups. In order to get a job for example, not only the fact of having a psychiatric diagnosis weighs against the mentally ill, but also the fact of being a smoker, because smoking has been increasingly rejected in healthy environments[9-10].

As the smoke-free law in collective environments is recent in Brazil, little is known about lawsuits against this measure in Brazilian health institutions. At this point, the delay in implementing the legal ban on tobacco use can be perceived as a positive aspect for managers and professionals working in Brazilian public healthcare. The knowledge of experiences in other countries can help them to plan the implementation of restrictions and empower themselves to deal with the resulting situations (for example, lawsuits).

Although most patients with mental disorders in group 1 recognize the permission to use cigarettes as a right to be respected, some subjects admit the need to increase the rigor of the restriction rule that is related to identifying the true role

of the hospital institution (healthcare). Similarly, a study carried out with 82 patients admitted in different wards of two Canadian hospitals showed that regardless of being smokers or nonsmokers, the patients believe that smoking counteracts the hospital principle of health promotion[11].

In addition to awareness of the controversies between the permission to smoke during hospitalization and recognition of the role of hospital health institution, the concern about exposure of nonsmoker subjects to smoke contributes to the perceived need to increase the rigor of the restriction rule, which shows respect and social awareness with nonsmokers. In this sense, hospitalized subjects who were allowed a cigarette every hour recognized smoking inside the ward as a major limitation of this rule, requiring an airy place to smoke.

A study was carried out with 134 smokers hospitalized at a psychiatric ward of a hospital in Switzerland. It showed patients spontaneously reduced the number of cigarettes smoked during hospitalization after implementation of the partial restriction on smoking, even though they were allowed to smoke the desired amount in a specific room. For 18% of these subjects, the concern with nonsmoker people was a major reason to reduce the amount of cigarettes during hospitalization[12].

Conciousness of nonsmokers' exposure to tobacco smoke is a major concern of the World Health Organization (WHO), and over the years, they have been trying to raise awareness of the population about this issue. An aggravating factor of smoke is that its substances remain on the furniture, clothes, food, walls and curtains for weeks or even months after an individual has smoked, regardless if the environment had the windows open or air filters. Therefore, even without the presence of a smoker in the place, nonsmokers are exposed to these substances[13].

The need for an airy place to smoke was contemplated with the change of restriction rule for six predetermined times and permission to smoke only in the outer area of the ward. However, this rule has created a dilemma: the permission to smoke outdoors provided more freedom for smokers than nonsmokers. While the other patients leave the ward to sunbathe only twice a day, smokers are guaranteed to leave six times throughout the day, which is a privilege. In an opinion piece, a researcher at the University of New Jersey (United States)[9] suggests that smoke breaks are used by professionals to make up (boost) good behaviors and by patients to pass the time.

The recognition of smoking outdoors as a privilege interferes with the motivation of mental patients to quit smoking. Patients motivated to abandon smoking went back on their decision or declared themselves as occasional smokers, even without will, to avoid losing the opportunity to leave the ward.

Unlike what happens with the mentally ill, a Canadian study with 82 clinical patients admitted in different wards of two general hospitals found different results. As smoking was allowed only in the outer area, the subjects were reluctant to smoke and admitted they would consume more cigarettes if smoking were permitted inside the ward[11].

The difference of expectations between patients with mental disorders and clinical patients in relation to smoking outside the ward reveals a characteristic condition of psychiatric hospitalization: the generation of anxiety because of the many restrictions/rules imposed by these services (lack of activities, time to eat, time to sleep). Thus, a report produced by the *National Association of State Mental Health Program Directors*[2] recommends the planning of activities to help patients with mental disorders be distracted and reduce anxiety during hospitalization, in order that going out for a smoke become less and less necessary.

Patients with mental disorders in group 2 have reported that one of the major limitations of the restriction rule change was imposing it as just another rule in the ward routine. The main terms used by these subjects to refer to the reduction in number of cigarettes were the following: punishment, torture, rule, shock, little explanation, lack of dialogue, agony, despair and lack of support.

According to a study carried out with 100 patients hospitalized in a psychiatric unit in California (United States), the perceived lack of support to face the difficulties of limiting cigarette use is concerning because the smoking restriction does not reach the expected effects unless it is accompanied by actions of support and motivation[14].

The resistance of subjects in group 2 in terms of reducing the number of cigarettes is increased with the experience of nicotine withdrawal symptoms during hospitalization. This resistance is also reported by some subjects who complained about the time of the last cigarette of the day (18.30), since they need to wait more than 12 hours until the next day cigarette (7:30). This complaint is consistent with the physiological changes occurring after tobacco withdrawal. The symptoms of nicotine withdrawal (tension, irritability, poor concentration, decreased heart rate/blood pressure) begin to appear after a two-hour period without tobacco use[15-16].

The lack of support and the experience of nicotine withdrawal symptoms perceived after the restriction rule change instigate the question: Is reducing the number of cigarettes in the psychiatric hospital a therapeutic intervention or a punishment? Unless the reduction in number of cigarettes is accompanied by support measures, the line separating its interventionist and punitive character is tenuous. The understanding of restriction as a punishment induces some patients to rethink psychiatric hospitalization, thereby disturbing its therapeutic aspect.

Some smokers in this study thought about the possibility of an early discharge (request for discharge) because they saw the smoking restriction as punishment. This information is consistent with the results of another study conducted in this unit. It showed subjects who use cigarettes are those with shorter hospital stay[17].

Nicotine replacement therapy (NRT) is a resource capable of reducing the perception of restriction as punishment. A study carried out in a teaching hospital of San Francisco (United States) investigated the medical records of 250 psychiatric inpatients from 1998 to 2001. When comparing the requests for hospital discharge with tobacco use and prescription for NRT, smokers who were not using NRT had twice the frequency of requests for discharge than the subjects using NRT and nonsmokers[18].

Despite the difficulties faced due to smoking restrictions, some subjects from both Groups 1 and 2 have recognized some benefits, such as developing self-control and the discovery of their ability to quit smoking. The restriction allowed smokers to realize their responsibility in relation to smoking, since they had the opportunity to rethink the meaning of smoking in their lives. For some patients, smoking was in the foreground and with restriction on admission, they discovered new possibilities. Although the restriction is a policy requirement imposed on health services, it can be used as a therapeutic tool by professionals, as long as carefully planned and respecting the needs of each subject. In this sense, it is relevant to have this discussion in the therapeutic singular project[19].

The changes in attitudes of some study subjects, with increased responsibility about cigarettes, development of self-control, reframing of the role of cigarettes in their lives, and intention to continue with the smoking times after hospital discharge can be considered an achievement, revealing the effectiveness of restrictive measures during hospitalization. Therefore, reducing the amount of cigarettes on admission, coupled with actions of support and motivation can be the first step towards smoking cessation in the psychiatric population. For their proximity to care, nursing professionals are essential in this process.

After the health policy change in relation to the smoking restriction during hospitalization, the differences of opinion require that nurses look at each smoker patient with mental disorder individually, investigating the meaning of the cigarette reduction for each subject. Accordingly, although the restriction rule is generalized for all people benefitting from hospitalization, the nurses should be concerned about the impact of this restriction in each individual.

The perception of the nursing staff and other members of the multidisciplinary team about the change in the rule of access to cigarettes during psychiatric hospitalization can be investigated in future studies.

Study limitations: The qualitative approach did not allow to evaluate if the perception of individuals about the change of smoking restriction rule is associated with the degree of nicotine dependence, the number of cigarettes smoked before hospital admission and with the duration of the subjects' smoking habit. In addition, the lack of studies on smoking restriction in Brazilian psychiatric services did not allow to compare the results of this study with other realities in Brazil.

CONCLUSION

The mentally ill patients understood the reduction in number of cigarettes during psychiatric hospitalization as punishment, since it occurred without dialogue and support to face the nicotine withdrawal symptoms.

Despite this difficulty, some subjects recognized the reduction in number of cigarettes as an opportunity to rethink the role of cigarettes in their lives, showing that the restriction affects each individual differently.

Although the restriction is a change required by the health policy that directs services, it can be used as a therapeutic tool by nurses, as long as carefully planned, respecting the needs of each subject and their participation in the decision-making process.

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