

Research article

Perceptions and attitudes of people with severe mental disorders towards smoking in Greece

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ABSTRACT

Despite its significant decline in the general population, smoking remains endemic and highly prevalent among people with mental disorders. The impact of smoking-attributable morbidity on life expectancy is significant since, in comparison to the general population, people with severe mental disorders have a 15–20-year reduction in life expectancy. A cross-sectional study was conducted among 1015 people with mental disorders through personal interviews. The questionnaire was designed to examine these patients' knowledge, perceptions, and attitudes towards smoking. Individuals were recruited from the mental health residential community services, the outpatient department, and the inpatient facilities of the Psychiatric Hospital of Attica. Statistical analysis was performed using SPSS 26.0. In the sample analyzed, the current smoking prevalence stood at 68.4% (n=643), while 12.3% reported being former smokers. A staggering 86.3% smoked their first cigarette within 30 minutes of waking up, indicating a high level of dependence. Most of the former smokers (83.6%) reported that their main reason for quitting smoking was to improve their health, and the overwhelming majority (97.4%) had done so using no smoking cessation aid. Although slightly over half of the participants (53.7%) believed that health professionals adequately inform smokers about the harmful health effects of tobacco products, the information provided by health professionals on smoking cessation programs and tobacco harm reduction alternatives was considered sufficient by a mere 11.2%. Multiple logistic regression analysis demonstrated that outpatients tended to have a greater likelihood of being current smokers as compared to inpatients (OR=1.45), while users of mental health residential community services showed a significantly lower likelihood of being current smokers in comparison to inpatients (OR=0.49). Additionally, it was found that women had a lower likelihood of being current smokers compared to men (OR=0.51), while divorced/ widowed participants had a greater likelihood of being current smokers compared to single ones (OR=1.93). Finally, multiple regression analysis indicated that participants with psychotic disorders displayed a 2.39 times greater likelihood of being current smokers compared to those with mood disorders (OR=2.39). Understanding the knowledge, beliefs, and attitudes of people with mental disorders towards tobacco is an essential first step to confronting this neglected epidemic.

KEYWORDS: Smoking cessation, mental disorder, smoking, mental health, schizophrenia, mood disorders.

Introduction

Although smoking's prevalence is reduced among the general population, it remains endemic among people with mental disorders, with its prevalence in this group being two- to three-fold higher.¹ It is a hidden, neglected epidemic with profound consequences for both physical and mental health, as well as a heavy financial burden on this vulnerable population.^{2,3} Cook et al⁴ studied the proportion of self-reported smokers among those with and without mental disorders between 2004 and 2011. The study revealed that the proportion of smokers without mental disorders declined from approximately 20% to slightly over 15% while remaining constant at about 28–29% in those with probable mental disorders. Compared to the general population, life expectancy for people with severe mental disorders is also 15–20 years shorter possibly due to increased mortality from cardiovascular diseases, strokes, and respiratory cancer.^{1,5,6} Tobacco use is a major preventable cause of cardiovascular and respiratory diseases, cancer, and low quality of life.^{7–9} According to the Institute for Health Metrics and Evaluation,⁸ tobacco remained the leading risk factor for increased mortality and morbidity in Greece from 2009 to 2019.

There are many hypotheses about the high prevalence of smoking and the possible relationship between smoking and mental disorders. The self-medication hypothesis regards tobacco use as a means of relieving schizophrenia symptoms, negative ones in particular, as well as antipsychotic-induced extrapyramidal side effects.^{9–12} Yet the findings of several studies are inconsistent with the widespread self-medication hypothesis.^{13,14} To evaluate said hypothesis, the consequences of smoking cessation and reinitiation in smokers with schizophrenia were studied. When compared to those showing no change in smoking behavior, patients who started smoking during follow-up displayed a substantial increase in self-reported symptoms, specifically positive ones, whereas smoking cessation was neither linked with changes in symptoms nor quality of life.¹⁴ Furthermore, during smoking cessation, there were no significant changes in cognitive performance.¹³ Smoking has been reported as a possible indicator for the development of serious mental illness (including psychosis) and related health problems, especially in young people.¹⁵ Additionally, it is considered both a predisposing and a risk factor for the development of depressive symptoms; indicatively, depression can occur twice as often in smokers as in non-smokers.¹⁶ Lastly, it is also regarded as a risk factor for the onset of schizophrenia.^{16,17} In fact, many studies show a shared

genetic basis contributing to the comorbidity between smoking and schizophrenia.^{18,19}

However widely recognized the importance of treating smoking in people with mental disorders, limited evidence exists on the use of smoking cessation services by people with a history of mental illness, as this history is rarely recorded in smoking cessation services. There is also a lack of data regarding the quality of life of smokers with mental disorders, as well as the research, development, and implementation of effective anti-smoking interventions for people using mental health services.²⁰ In Greece, by Ministerial Decision No. 88202/2009, psychiatric institutions were exempted from the implementation of the smoke-free law. More specifically, "patients were allowed to smoke with the written consent of the attending psychiatrist for therapeutic purposes". However, one year later, the Ministerial Decision was revoked, and now smoking has been universally banned. Nevertheless, to the best of our knowledge, the smoking ban has never been implemented in inpatient and outpatient mental health services in Greece.

To examine the perceptions and attitudes of people with mental health disorders towards smoking and nicotine products, we conducted a cross-sectional study to address the gaps in current research, also considering the fact that, in Greece, smoking remains a public health issue among people with mental disorders.

Material and Method

Participants and procedures

The study population included adult mental health service users from the Psychiatric Hospital of Attica. Both inpatients and outpatients residing at mental health residential community services or living at home were eligible to participate. Data collection was conducted in eight Psychiatric Wards, thirty mental health residential community services, and the outpatient department and day care units of the Psychiatric Hospital of Attica.

The inclusion criteria were an age of between 18–75 years, a diagnosis of a mental disorder, a mental disorder in remission, the ability to read and understand Greek, and legal competency. The exclusion criteria concerned cognitive deficits inhibiting the understanding of the questionnaire. The initial number of prospective participants was 1526; however, 218 of them did not meet the criteria, while 293 refused to participate (77.59% response rate). A total of 1015 patients were included in this study: 318 hospitalized in the psychiatric wards of the Psychiatric Hospital of Attica, 320 users of mental health residential community services, and 377

living at home and receiving services from the outpatient department of the Psychiatric Hospital of Attica.

The participants were classified according to, firstly, the type of mental care being received at the time of study recruitment (inpatients, users of mental health residential community services, and outpatients living at home) and, secondly, their psychiatric diagnosis. The diagnosis was documented using the participants' medical records and confirmed by the treating psychiatrists. Their smoking status was recorded as current smokers, former smokers, and never smokers.

Written informed consent was obtained from all individuals included in the study. All procedures performed in studies involving human participants were by the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki Declaration and its later amendments or comparable ethical standards.²¹ The study protocol was approved by the Ethics Committee, the Scientific Committee, and the Management Board of the Psychiatric Hospital of Attica and by the Research Ethics Committee of the University of West Attica.

Measures

The survey was performed through a personal interview with each participant, and a researcher-constructed questionnaire was administered. The questionnaire recorded the following: socio-demographic data, psychiatric diagnosis, smoking status, onset of smoking age, tobacco product use, intention to quit smoking, attempts to quit smoking, smoking abstinence duration and smoking cessation intervention (for former smokers), perceptions about health damage from tobacco products, passive smoking, referral to smoking cessation programs by health professionals, and whether smoking bans in public places or the financial crisis have reduced tobacco product use. The questionnaire was assessed by experts for content validity.

Initially, the questionnaire was designed to be self-administered; however, after performing a pilot study, it was decided to administer it through a personal interview, which was perceived as more confidence-inspiring by the study participants. In the pilot study, the method of cognitive interviewing was utilized to validate the questionnaire, using 30 psychiatric patients who did not participate in the final study sample.²²

Statistical analysis

Variables were first tested for normality using the Kolmogorov-Smirnov criterion. Quantitative variables were expressed as mean (Standard Deviation) or me-

dian (interquartile range). Qualitative variables were expressed as absolute and relative frequencies. For the comparison of proportions, chi-square, and Fisher's exact tests were used. If the normality assumption was satisfied for the comparison of means between three or more groups, analysis of variance (ANOVA) was used. The Kruskal-Wallis test was used for the comparison of continuous variables between three or more groups when the distribution was not normal. The Bonferroni correction was used to control for type I errors. Logistic regression analysis in a stepwise method (p for entry 0.05, p for removal 0.10) was used to find independent factors associated with being a current smoker. Adjusted odds ratios (OR) with 95% confidence intervals (95% CI) were computed from the results of the logistic regression analyses. All reported p values are two-tailed. Statistical significance was set at $p < 0.05$ and analyses were conducted using SPSS statistical software (version 26.0).

Results

Most of the participants (66.2%) were diagnosed with schizophrenia, schizotypal, and delusional disorders (F20-F29); 26.4% of the participants were diagnosed with mood (affective) disorders (F30-F39); 6.3% with neurotic, stress-related, and somatoform disorders (F40-F48); finally, 1.1% had other diagnoses (F10-F19, F60-F69, F91). Statistical analysis was performed between the two groups (F20-F29) and (F30-F39), with under-represented groups excluded from the analyzed sample.

The socio-demographic characteristics and psychiatric conditions of the study sample are presented in table 1. The mean participants' age was 50.7 years, 59.3% being males. Participant recruitment was well balanced between outpatients (33.9%), users of mental health residential community services (33.7%), and inpatients (32.3%). Most of the participants (71.5%) were diagnosed with psychotic disorders (F20-F29), with the remaining (28.5%) diagnosed with mood disorders (F30-F39).

The participants' smoking status and behavior are presented in table 2. Current smoking was reported by 68.4% ($n=643$), while 12.3% reported being former smokers. The mean age of cigarette smoking initiation among current smokers was 17.7 years. Approximately 60% consumed more than 20 cigarettes a day, and almost 80% had been smoking for over 20 years. Most of them (60.2%) used boxed cigarettes. The vast majority (86.3%) smoked their first cigarette within 30 minutes of waking up, indicating a high level of dependence. However, only 64.5% self-re-

Table 1. Participants' sociodemographic characteristics and diagnoses (n=940).

		N	%
Sex	Male	557	59.3
	Female	383	40.7
Age, mean (SD)		50.7 (12.8)	
Education	Classes of Primary school	29	3.1
	Primary Education	157	16.7
	Lower Secondary Education	165	17.6
	Upper Secondary Education	316	33.6
	Post-secondary non-Tertiary Education	88	9.4
	Bachelor's degree or equivalent tertiary education level	172	18.3
	Master's degree or Doctoral degree	13	1.4
Marital status	Single	609	64.8
	Married	125	13.3
	Separated	26	2.8
	Divorced	160	17.0
	Widowed	20	2.1
Do you have children?	No	687	73.2
	Yes	252	26.8
If so, how many children do you have? Median (IQR)		2 (1–2)	
Do you live	Alone	224	23.9
	With family members	374	39.8
	With roommates	19	2.0
	In mental health residential community services	322	34.3
Are you employed?	No	778	82.8
	Yes	162	17.2
What is your personal monthly income?	0–400 euros	556	59.1
	401–600 euros	169	18.0
	601–800 euros	106	11.3
	801–1000 euros	80	8.5
	More than 1001 euros	29	3.1
Groups	Inpatients	304	32.3
	Outpatients	319	33.9
	Users of mental health residential community services	317	33.7
Diagnosis	Mood (affective) disorders (F30-F39)	268	28.5
	Schizophrenia schizotypal and delusional disorders (F20-F29)	672	71.5

ported that they were highly addicted to smoking (high/very high). The majority of former smokers (83.6%) reported that their main reason for quitting smoking was to improve their health, and a notable 97.4% had done so using no smoking cessation aid.

The participants' risk perceptions about smoking are presented in table 3. Illicit cigarettes and illicit roll-your-own (RYO) cigarettes were perceived to be associated with higher health risks. Over 90% of the participants reported that smoking was linked to high, very high, or extremely high health risks. A similar proportion regarded passive smoking as equally harmful and the banning of smoking in public places as beneficial to public

health. Although slightly over half of the participants (53.7%) believed that health professionals adequately inform smokers about the harmful health effects of tobacco products, only 11.2% believed that health professionals adequately inform smokers about smoking cessation programs, tobacco harm reduction alternatives, and related products.

Findings according to participants' diagnoses

Smoking rates varied significantly by diagnosis, recorded significantly lower in participants with mood disorders as compared to participants with psychotic disorders [$\chi^2(2)=18.03$; $p<.001$]. Additionally, smokers

Table 2. Smoking attitudes of participants toward tobacco and related products.

		N	%
Smoking status	No	181	19.3
	Yes	643	68.4
	Former smoker	116	12.3
At what age did you start smoking?	mean (SD)	17.7	(6.0)
How many cigarettes do you smoke each day?	Up to 10	54	8.4
	11–20	177	27.5
	21–40	282	43.9
	more than 40	130	20.2
How long have you been smoking?	Up to 5	12	1.9
	5–10	22	3.4
	10–20	103	16.0
	more than 20	506	78.7
How soon after you wake up do you smoke your first cigarette?	Within 30 minutes	555	86.3
	Later	88	13.7
Do you find it difficult to refrain from smoking in places where it is forbidden?	No	255	39.7
	Yes	388	60.3
How Strong is Your Nicotine Addiction?	Very Low	7	1.1
	Low	49	7.6
	Moderate	172	26.7
	High	281	43.7
	Very high	134	20.8
What type of tobacco product do you use? (Multiple answers)	Boxed cigarettes	387	60.2
	Hand Rolled cigarettes	133	20.7
	Hand Rolled cigarettes (Illicit tobacco)	33	5.1
	Cigarillos	85	13.2
	Boxed cigarettes (smuggled)	135	21.0
Are you planning to quit smoking in the future?	No, I do not intend to quit smoking	280	43.5
	Yes, I intend to quit smoking within a month	17	2.6
	Yes, I intend to quit smoking within the next 6 months	99	15.4
	Yes, I intend to quit smoking this year	60	9.3
	Yes, but not this year	187	29.1
Have you tried to quit smoking in the past?	No	314	48.9
	Yes	328	51.1
If so, what is the longest time you have quit smoking?	2 to 3 weeks	31	9.5
	1 month to 3 months	94	28.7
	4 months to 9 months	76	23.2
	10 months to 12 months	7	2.1
	more than 1 year	120	36.6
Reason to quit smoking	Health effects	425	66.1
	Financial cost	218	33.9
What was the reason to quit smoking? Multiple answers	Health	97	83.6
	Financial cost	31	26.7
	Other reasons	9	7.8
Other reasons	Social Reasons	5	0.5
	Children	4	0.4
Did you use any of the following smoking cessation methods? Multiple answers	Nicotine Replacement Therapy (Patch. Gum, etc.)	2	1.7
	Alternative therapies (Acupuncture, etc.)	0	0.0
Other methods	Medication	0	0.0
	Support of health professional or smoking cessation clinic	0	0.0
	Alone	113	97.4
	Other	7	6.0
	E-cigarette	6	0.6
	Heated Tobacco Product	1	0.1

Table 3. Participants' risk perceptions about tobacco.

		N	%
Rate the health risk caused by the following tobacco products. (score from 1 to 5), mean (SD)-median (IQR)	Boxed cigarettes	2.7 (1)	3 (2–3)
	Roll-your-own (RYO) cigarettes	3.3 (0.9)	3 (3–4)
	Illicit roll-your-own (RYO) cigarettes	4.7 (0.6)	5 (5–5)
	Cigarillos	3.2 (0.9)	3 (3–4)
	Illicit cigarettes (smuggled)	4.6 (0.7)	5 (4–5)
Rate the health risk from smoking	Minimal risk	7	0.7
	Moderate risk	75	8.0
	High risk	311	33.1
	Very high risk	237	25.2
	Extremely high risk	310	33.0
Do you think that passive/ secondhand smoking is harmful to health?	No	80	8.5
	Yes	860	91.5
Do you think that smoking bans in public places benefit public health?	No	114	12.1
	Yes	826	87.9
Do you think that health professionals inform patients about the harmful health effects of tobacco and related products?	No	435	46.3
	Yes	505	53.7
Do you think health professionals inform smokers about smoking cessation programs and alternatives to reduce harm from tobacco and related products?	No	835	88.8
	Yes	105	11.2
Do you think that smoking is a chronic disease and you should consult a health professional for smoking cessation?	No	186	19.8
	Yes	754	80.2
Do you think that banning smoking in public places has reduced smoking?	No	425	45.2
	Yes	515	54.8
Do you think that the economic crisis has led to a reduction in smoking?	No	552	58.7
	Yes	388	41.3

with psychotic disorders smoked significantly fewer cigarillos [$\chi^2(1)=9.97$; $p=.002$] and considered financial burden a motive to quit smoking [$\chi^2(1)=12.09$; $p=.001$] (Supplementary material table S1).

Concerning risk perceptions and beliefs as per diagnosis group, more smokers with psychotic disorders than patients with mood disorders believed that boxed cigarettes ($Z=-3.99$; $p<.001$), illicit roll-your-own tobacco ($Z=-2.84$; $p=.005$), cigarillos ($Z=-3.11$; $p=.002$) and smuggled cigarettes ($Z=-4.12$; $p<.001$) caused less harm. Also, smokers with psychotic disorders thought that they had significantly less health risk from smoking [$\chi^2(3)=22.38$; $p<.001$] (Supplementary material, table S2).

Findings according to received mental care at the time of study recruitment

Compared to inpatients and outpatients, users of mental health residential community services smoked at a significantly lower rate [$\chi^2(4)=29.64$; $p<.001$]. Other findings according to received mental care are presented in Supplementary material, table S3. The health benefits of smoking cessation are considered by the

majority of outpatients as the most important motivation to quit smoking in comparison to inpatients and users of mental health residential community services [$\chi^2(2)=72.29$; $p<.001$]. Regarding former smokers, the proportion of participants who quit smoking due to its financial cost was significantly higher among users of mental health residential community services and outpatients [$\chi^2(2)=10.77$; $p=.005$] (Supplementary material table S4).

When multiple logistic regression analysis was conducted in a stepwise method for being a current smoker (table 4), it was found that, compared to inpatients, outpatients tended to have a greater likelihood of being current smokers (OR=1.45; 95% CI: 0.99–2.12; $p=0.058$); again, compared to inpatients, users of mental health residential community services had a significantly lower likelihood of being current smokers (OR=0.49; 95% CI: 0.34–0.70; $p<0.001$). Moreover, it was found that women had a lower likelihood of being current smokers compared to men (OR=0.51; 95% CI: 0.38–0.70; $p<0.001$) and divorced/ widowed participants had a greater likelihood of being current smokers compared to singles (OR=1.93; 95% CI: 1.32–2.82; $p=0.001$). Furthermore,

Table 4. Results from multiple logistic regression analysis in a stepwise method with dependent variable being a current smoker.

		OR (95% CI)*	Wald test	p
Group	Inpatients (reference)			
	Outpatients	1.45 (0.99–2.12)	3.59	0.058
	Users of mental health residential community services	0.49 (0.34–0.70)	15.35	<0.001
Sex	Men(reference)			
	Women	0.51 (0.38–0.70)	18.27	<0.001
Family status	Single(reference)			
	Married	1.33 (0.84–2.12)	1.50	0.221
	Divorced/ Widowed	1.93 (1.32–2.82)	11.36	0.001
Diagnosis	Mood (affective) disorders(F30-F39) (reference)			
	Schizophrenia, schizotypal and delusional disorders (F20-F29)	2.39 (1.69–3.36)	24.72	<0.001

*Odds Ratio (95% Confidence Interval)

multiple analyses showed that patients with psychotic disorders had a 2.39 times greater likelihood of being current smokers compared to those with mood disorders (OR=2.39; 95% CI: 1.69–3.36; $p<0.001$).

Discussion

This study verifies the high smoking rate and heavy nicotine dependence in patients with mental health disorders, particularly those with schizophrenia.^{23,24} In essence, the smoking rate reported herein is more than 2-fold higher than that of the general population in Greece.²⁵ Studies have revealed that motivation to quit smoking among smokers with mental illness is similar to that of the general population.^{26,27} Having studied the smoking behavior and motivation to quit smoking by assessing “the stages of change” in smokers with psychosis compared to general population smokers, Etter et al²⁴ concluded that the allocation of these stages was similar in both samples. However, the findings of our study have shown different motivations between the groups. Patients with mood disorders are motivated by health effects to a greater extent than patients with schizophrenia. One possible explanation could be that people with schizophrenia are less aware of the smoking-associated health risks than people without mental health disorders.²⁸ This explanation is consistent with our findings that, compared to the other groups, smokers with schizophrenia believed that boxed cigarettes, cigarillos and smuggled cigarettes cause less harm. Moreover, compared to patients with mood disorders, people with schizophrenia also believed that illicit RYO cigarettes cause less harm. This finding is in agreement with a study by Spring et al²⁹ who assessed the reinforcing value of conventional cigarette smoking versus pleasant activities among heavy smokers with schizophrenia or depression and heavy smokers

without mental health disorders. According to their findings, all participants perceived the negative health effects of smoking equally. However, in the same study, when compared with smokers without mental health disorders, smokers with schizophrenia or depression perceived more smoking-related benefits and found smoking more attractive than alternative rewards.

The National Drug Strategy Household Survey³⁰ in Australia showed that the cost of smoking was the main factor prompting smokers to attempt to quit or cut back, while other studies mention cost and health concerns as important factors associated with the motivation to quit.^{31,32} Similarly, according to our findings, the financial burden was the key reason for users of mental health residential community services who had quit smoking, exhibiting a significant difference in comparison to the other groups. In fact, during the interview, many participants commented that they would like to save money to afford recreation and leisure activities or leave the mental health facility and move into their own homes.

In addition, according to our findings, outpatients were less likely to face difficulties in complying with smoke-free legislation than inpatients and users of mental health residential community services. One possible explanation is that they live in a community where they must conform to a complete ban on smoking in enclosed public places.

Our findings suggest that, compared to outpatients, users of mental health residential community services quit smoking for much longer periods, which may be attributed to the staff’s motivating and supportive interventions positively affecting the residents’ attempts.³³

Several studies have reported that smokers with mental disorders are rarely referred to smoking cessation

services by healthcare professionals.^{34,35} Our study also showed that a meager 11.2 % of the participants believe that health professionals adequately inform smokers about smoking cessation programs, tobacco harm reduction alternatives, and related products. This could have resulted from the many misconceptions among mental health professionals about the willingness and ability of smokers with mental disorders to quit.^{1,9,36}

The main limitation of this study is that its data were collected only from the Psychiatric Hospital of Attica and may not represent the entire population of patients with severe mental disorders. Individuals with mental health disorders receiving care from the psychiatric wards of general hospitals, community mental health centers, or private practice psychiatrists may have different knowledge, beliefs, and attitudes toward tobacco and related products. Despite current sectorization, the Psychiatric Hospital of Attica provides primary, secondary, and tertiary care services for people living in various districts of Greece, not limited to Attica, with various socio-demographic characteristics, regardless of their economic, social, or professional status. The second limitation concerns the fact that the findings are based on self-reported smoking status, meaning there is a possibility of recall bias among former smokers.

The consistently high prevalence of smoking among patients with severe mental disorders reflects not only that smoking is a highly addictive behavior, particularly for such patients, but that there is also a significant failure of public health and clinical services to address the specific needs of this vulnerable population. It is time for these challenges to be met by consistently implementing smoke-free legislation, training mental healthcare professionals in smoking cessation counseling, and implementing tailor-made health promotion interventions specifically targeting people with mental disorders.^{1,9,31}

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It has been shown that pharmacological treatments (varenicline, bupropion, and nicotine replacement therapy) as well as smoking cessation counseling or combination strategies are effective in smokers with mental illness.^{9,31,37–39}

Several studies suggest that harm reduction options such as e-cigarettes (either disposable or rechargeable) help smokers with mental illness who are unwilling or unable to quit.^{40–42} The use of e-cigarettes as an alternative to smoking is a common practice in mental health facilities in England⁴³ and Australia.⁴⁴ Furthermore, e-cigarettes seem an option appealing to smokers with mental disorders wishing to quit or cut down⁴⁵ since they reduce smoking and carbon monoxide without increasing nicotine dependence.^{46,47} In addition, tobacco smoke contains polycyclic aromatic hydrocarbons inducing P450 CYP1A2 activity; as a result, it increases the clearance of various psychiatric medications, thus requiring higher therapeutic doses. Nevertheless, polycyclic aromatic hydrocarbons are either absent or only appear in trace amounts in non-smoked nicotine products, so e-cigarette users usually need to reduce their medication dose after quitting regular cigarette smoking.^{42,47} Increased attention to and systematic monitoring of levels of psychotropic medications is required after the transition from smoking to e-cigarettes.^{48,49}

In conclusion, understanding the knowledge, beliefs, and attitudes of people with severe mental disorders towards tobacco is an essential first step to confronting this neglected epidemic, which perpetuates both health and socio-economic inequalities.

Supplementary materials

Supplementary material associated with this article can be found, in the online version, at doi:10.22365/jpsych.2023.022

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Ερευνητική εργασία

Πεποιθήσεις και στάσεις ατόμων με σοβαρές ψυχικές διαταραχές προς το κάπνισμα στην Ελλάδα

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ΠΕΡΙΛΗΨΗ

Το κάπνισμα ενδημεί στα άτομα με ψυχικές διαταραχές και ο επιπολασμός του παραμένει υψηλός παρά τη σημαντική μείωση στον γενικό πληθυσμό τα τελευταία χρόνια. Σκοπός της παρούσας συγχρονικής μελέτης είναι η διερεύνηση των γνώσεων, στάσεων και αντιλήψεων των ατόμων με ψυχική διαταραχή προς το κάπνισμα. Σχεδιάστηκε ερωτηματολόγιο για τον σκοπό της μελέτης και χορηγήθηκε σε 1015 άτομα με ψυχικές διαταραχές με προσωπική συνέντευξη στα Εξωτερικά Ιατρεία, σε Δομές Ψυχοκοινωνικής Αποκατάστασης και σε Ψυχιατρικά Τμήματα Εισαγωγών του Ψυχιατρικού Νοσοκομείου Αττικής. Η στατιστική ανάλυση πραγματοποιήθηκε με το SPSS 26.0. Ο επιπολασμός καπνίσματος στο αναλυθέν δείγμα ήταν 68,4% (n=643), ενώ 12,3 ήταν πρώην καπνιστές. Η πλειοψηφία (86,3%) κάπνιζαν το πρώτο τους τσιγάρο μέσα σε 30 λεπτά από το ξύπνημα, υποδηλώνοντας υψηλό επίπεδο εξάρτησης. Ο κίνδυνος για την υγεία ήταν το κύριο κίνητρο διακοπής καπνίσματος για την πλειοψηφία των πρώην καπνιστών (83,6%) και σχεδόν όλοι (97,4%) είχαν διακόψει το κάπνισμα χωρίς βοήθεια. Περίπου οι μισοί από τους συμμετέχοντες (53,7%) θεωρούν ότι οι επαγγελματίες υγείας ενημερώνουν επαρκώς τους καπνιστές για τις βλαβερές επιπτώσεις των προϊόντων καπνού στην υγεία, αλλά μόνο το 11,2% πίστευε ότι οι επαγγελματίες υγείας ενημερώνουν τους καπνιστές σχετικά με προγράμματα διακοπής του καπνίσματος και εναλλακτικές για τη μείωση της βλάβης από το κάπνισμα. Η ανάλυση πολλαπλής λογιστικής παλινδρόμησης κατέδειξε ότι οι εξωτερικοί ασθενείς έτειναν να έχουν μεγαλύτερη πιθανότητα να είναι καπνιστές σε σύγκριση με τους νοσηλεύόμενους (OR=1,45), ενώ οι ένοικοι Δομών Ψυχοκοινωνικής Αποκατάστασης είχαν σημαντικά χαμηλότερη πιθανότητα να είναι καπνιστές σε σύγκριση με τους νοσηλεύόμενους (OR=0,49). Επιπρόσθετα, διαπιστώθηκε ότι οι γυναίκες είχαν μικρότερη πιθανότητα να είναι καπνίστριες σε σύγκριση με τους άνδρες (OR=0,51) και οι διαζευγμένοι/χήροι συμμετέχοντες είχαν μεγαλύτερη πιθανότητα να είναι καπνιστές σε σύγκριση με τους άγαμους (OR=1,93). Πολλαπλή ανάλυση παλινδρόμησης κατέδειξε ότι οι συμμετέχοντες με ψυχωτικές διαταραχές είχαν 2,39 φορές μεγαλύτερη πιθανότητα να είναι καπνιστές σε σύγκριση με εκείνους με διαταραχές διάθεσης (OR=2,39). Η κατανόηση των γνώσεων, των πεποιθήσεων και των στάσεων των ατόμων με ψυχικές διαταραχές προς τα καπνικά και συναφή προϊόντα είναι ένα ουσιαστικό πρώτο βήμα για την αντιμετώπιση αυτής της παραμελημένης επιδημίας.

ΛΕΞΕΙΣ ΕΥΡΕΤΗΡΙΟΥ: Διακοπή καπνίσματος, ψυχική διαταραχή, κάπνισμα, ψυχική υγεία, σχιζοφρένεια, συναισθηματικές διαταραχές.