

# Eliminating Cigarette Restrictions in the Mental Health System is a Matter of Human Rights

*By The Council Against Institutional and Psychiatric Abuse (CAIPA), An Advisory Board to the Massachusetts Disability Law Center, July, 2021*

Over the last decade, hospitals in Massachusetts increasingly took action to restrict access to smoking. Not long after this shift began, all Massachusetts state hospital grounds (both indoor and outdoor) were declared “smoke free,” and – at the urging of the Joint Commission - private entities were steadily following suit. By 2018, the Commonwealth had enacted legislation mandating all healthcare facilities eliminate smoking.<sup>1</sup> The legislation offered an exception for facilities treating problems with substances as well as for nursing homes, but not for psychiatric institutions.<sup>1</sup> It is worth noting here that this is not the case in several other states (for example, Michigan and Maryland), where awareness of the implications of imposing abrupt smoking cessation on individuals held in psychiatric facilities seems to be much greater.<sup>2</sup> Nonetheless, efforts on the part of those who have sought to end smoking in psychiatric facilities were bolstered by citations of studies reporting that people with psychiatric diagnoses are not only more likely to smoke than the general population, but also consume more cigarettes than other smokers.<sup>3</sup> That was then tied to the growing mortality gap indicating that people with psychiatric diagnoses die 25 years younger on average.<sup>4</sup> And, once that happened, how could the mental health system not respond?

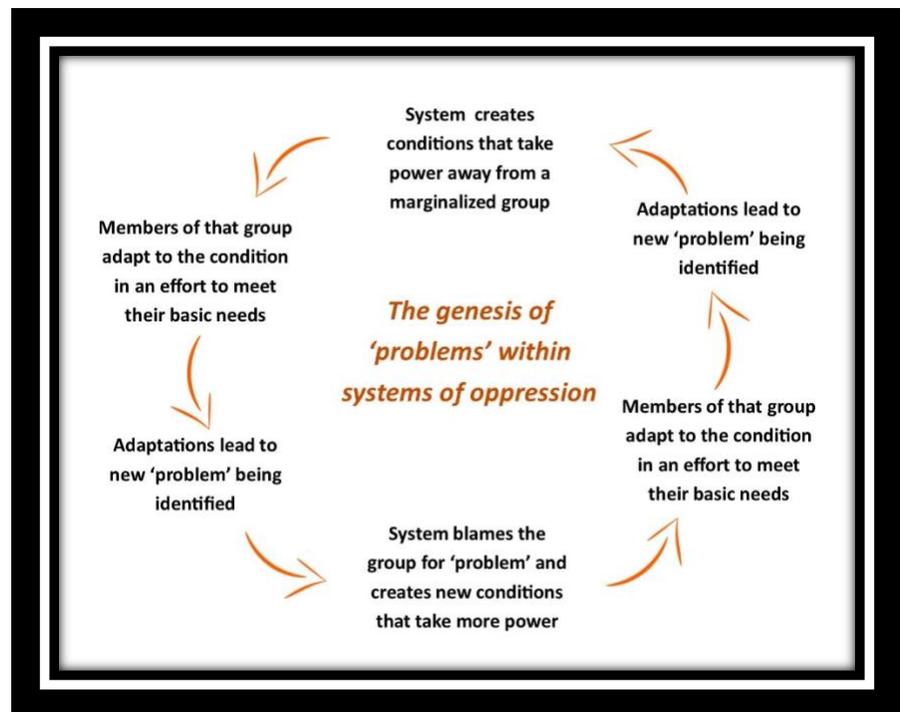
Yet, there’s at least one question that largely goes unanswered in regards to this topic: How did we get to this point? There are papers in circulation that attempt to tackle this question from an ethical standpoint. However, they generally neglect to seek input from individuals who’ve been held in psychiatric facilities, leading them to draw conclusions that fail to consider key points.<sup>5</sup> As such, their reviews don’t typically ask the right questions or consider the full picture. It’s impossible to understand what it is like to lose the level of power that gets lost when someone is forcibly committed to a psychiatric institution unless you’ve been through it yourself. However, imagine just for a moment that you have been pulled from your life without notice, and forcibly contained in a space where you will likely be required to sleep next to a stranger, have your words and actions watched, scrutinized, and documented throughout the day and night, be told what’s wrong with you, and then told what to do about it. Imagine that there is little else to do while you’re there, few people who even stop to talk to you, and that some of the groups you’ll be penalized for not attending include infantilizing exercise and art groups that might have you decorating a page out of a child’s coloring book. Now, also imagine that you’re going to be strongly encouraged (and sometimes forced) to take heavy doses of psychiatric drugs that may sap your energy, and leave you struggling to hold your thoughts together. Finally, imagine that one of the only ways you can access fresh air, assert yourself as an adult, and try to combat some of the negative effects of the psychiatric drugs is to become a smoker.

When people lose power, they try to adapt. The reality here is that one of the top reasons that so many people who’ve been in the psychiatric system smoke is because they’re adapting to conditions

that the system has created. But, of course, smoking is addictive, and so even when they are free of that environment, it is a habit that – once begun –is hard to break.

Yet the cycle doesn't stop there. Those who hold power in a particular system control countless factors. This includes what is and is not considered to be 'a problem.' So, the system that first set the conditions to start people smoking then decides that smoking must be stopped, and uses force once again as

their main means to accomplish that goal. This does not generally include recognizing their own role in having created the 'problem' in the first place. In the rare circumstances when it does, it still fails to acknowledge that loss of power was the main issue above all others. Unfortunately, all this means the mark is missed again. If so many people started smoking because of loss of power, then the answer certainly can't be to take more power away.



Turning adaptations individuals make to survive and get their needs met into 'the problem' is deeply embedded in the ways of the psychiatric system (as well as in all systems of oppression). Another example: The Adverse Childhood Experiences (ACE) study told us that people who score a seven or higher on the ACE scale that measures how much childhood trauma someone experienced are 500% more likely to hear voices.<sup>6</sup> Many who have that experience have cited how their voices helped them survive terrible situations or taught them important survival-oriented lessons, even if they are also a source of distress sometimes. Yet, few in the psychiatric system regard voice hearing as anything other than sign of disease within that individual who is hearing them, and sometimes will take forceful measures to try to make those voices go away.

One more example: Our medical systems have historically lied to black and brown people and subjected their bodies to painful and sometimes deadly procedures to preserve resources or conduct testing to benefit white people.<sup>7</sup> Yet, when the greater reluctance to access medical systems in black and brown communities is spoken of, few take responsibility for the conditions upon which mistrust was built. Instead we have a system that routinely assigns more severe diagnoses to non-white folks, and uses force to get them to comply with subsequent treatments with much greater regularity.<sup>8,9</sup> When it comes to cigarettes, black and brown communities have also been inequitably targeted, both in how they've been marketed and subsequent restrictions that have followed.<sup>10</sup>

Smoking may seem like a too-simple example of this phenomenon, or even misguided given the clear health risks related to cigarettes. However, it illustrates a common pattern of how ‘problems’ are identified in systems of oppression, and particularly those that target poor, disabled, and non-white communities. It clearly perpetuates serious harms across a large number of people who’ve already had so much taken from them. At present, there are only a very limited number of historically marginalized groups who can so easily be controlled and have their rights withdrawn due to a perceived “bad habit.” That makes these actions unquestionably discriminatory. And the failure on the system’s part to recognize themselves and the power they’ve taken away as the source of ‘the problem’ while continuing to take additional steps to withdraw more power makes their actions unquestionably abuse. Both the United Nations<sup>11</sup> and the World Health Organization<sup>12</sup> have recently released documents emphasizing the importance of mental health systems shifting to a right-based approach. It should be demanded that Massachusetts Officials heed that advisement and consider this issue through that lens.

**In regards to this matter, CAIPA advocates the following:**

- The state and other psychiatric facilities will immediately be required to reverse their decision to eliminate smoking, and create spaces away from non-smokers where smoking opportunities are reasonably accessible. Additionally, they will also prohibit any penalties for smoking when an individual being held on a psychiatric unit is off the unit on a pass.
- The mental health system will openly acknowledge and apologize for its role in creating a community of people who are disproportionately being impacted by the harms of smoking. As a part of this process, a committee will be formed to address reparations for harm caused.
- The state will hold all psychiatric facilities contracted, licensed, or operated by the Department of Mental Health accountable for creating consistent fresh air access, and eliminate loopholes that allow them to avoid doing so.
- The state will establish and implement penalties for failure to publicly post and adhere to the Six Fundamental Rights (including the right to fresh air) in all relevant institutions.
- The state will follow the lead of the most progressive, and rights-based programs and approaches across the world, and create well-funded and widely available alternatives to psychiatric drugs, as well as supports for people wishing to reduce or withdraw from the drugs they are taking.<sup>13</sup> For as long as in-patient facilities continue to exist, this will also include facilities of this nature that center drug-free approaches.<sup>14</sup>
- The state and other psychiatric facilities will routinely offer supports and aids to stop smoking for those who wish to do so voluntarily.
- The state will require all programs and facilities that it licenses, funds, or operates to train its employees in the use of power and strategies for minimizing power imbalances. These trainings will be designed and facilitated primarily by individuals who themselves have been diagnosed and held in facilities of that nature, though they may also choose to include disability rights attorneys and other relevant parties in those trainings as applicable.

***To reach CAIPA with any questions, feedback, or concerns, e-mail [CAIPA@dlc-ma.org](mailto:CAIPA@dlc-ma.org)***

## **Citations:**

- <sup>1</sup> Massachusetts General Law, Part IV, Chapter 27, Section 22 <http://tiny.cc/MAchap27section22>
- <sup>2</sup> US State Laws Requiring Tobacco-Free Grounds for Mental Health and Substance Use Facilities, <http://tiny.cc/NationalSmokingBansH>
- <sup>3</sup> Smoking and Mental Illness: A Prevalence-Based Study, JAMA, 2000. <http://tiny.cc/Smokingrates>
- <sup>4</sup> World Health Organization Information Sheet: Premature Death Among People with Severe Mental Disorders. <http://tiny.cc/WHO25>
- <sup>5</sup> Smoking Bans in Psychiatric Units: An Issue of Medical Ethics. Frontiers in Psychiatry, 2019. <http://tiny.cc/SmokingEthics>
- <sup>6</sup> Adverse Childhood Experiences and Hallucinations. Child Abuse & Neglect, 2005. <http://tiny.cc/VoicesACES>
- <sup>7</sup> More than Tuskegee: Understanding Mistrust About Research Participation. Journal of Healthcare for the Poor and Underserved, 2015. <http://tiny.cc/MedicalExpBB>
- <sup>8</sup> African-Americans More Likely to be Misdiagnoses with Schizophrenia, Study Finds. ScienceDaily, 2019. <http://tiny.cc/BBseverediagnoses>
- <sup>9</sup> Why Race Matters When It Comes to Mental Health. BBC, 2020. <http://tiny.cc/RaceMattersBBC>
- <sup>10</sup> With Menthol Cigarettes, Big Tobacco Targets Black Lives. USA Today, 2021. <http://tiny.cc/TobaccoBlackLives>
- <sup>11</sup> UN Rights Expert Urges Shift Away from Drugs in Addressing Depression. United Nations, 2017. <http://tiny.cc/UNspecialrap>
- <sup>12</sup> Guidance and Technical Packages on Community Mental Health Services. World Health Organization, 2021. <http://tiny.cc/WHOGuidance21>
- <sup>13</sup> International Institute for IIPDW Psychiatric Drug Withdrawal. <https://iipdw.org/>
- <sup>14</sup> How Norway is Offering Drug-Free Treatment to People with Psychosis. BBC, 2021. <http://tiny.cc/BBCdrugfree>