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Systematic Literature Review

Impact and Barriers for the Restriction of Smoking During Psychiatric Hospitalization: An Integrative Review[1]

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Abstract: The aim was to identify the barriers for implementing the restriction on smoking in psychiatric hospitalization services, its impact on the hospitalized smokers, and the positioning of the professionals. Integrative review of 19 articles published (1989-2011) in MEDLINE and SCOPUS. Descriptive analysis was carried out. The studies revealed that the main barriers for the implementation of the restriction were: beliefs in the patients' increased aggressiveness, damage to the professional-patient relationship, and lack of preparation to address the theme. After the implementation, the restrictions showed a positive impact: reduction of cigarettes smoked, increased motivation to quit smoking, and more attempts to stop smoking. The professionals who smoked and those who did not believe that quitting smoking benefits mental health patients were those that least supported the implementation of the restrictions. In conclusion, the restriction on smoking is effective in psychiatric hospitalization, as it provokes an attitude of change in mental health patients.

Keywords: mental disorders, psychiatric patients, smoking, mental health services, nursing

Impacto e Barreiras da Restrição ao Tabagismo na Internação Psiquiátrica: Revisão Integrativa

Resumo: Objetivou-se identificar as barreiras para a implantação da restrição ao tabagismo nos serviços de internação psiquiátrica, seu impacto nos tabagistas internados e o posicionamento dos profissionais. Revisão integrativa de 19 artigos publicados (1989-2011) no MEDLINE e na SCOPUS. Foi realizada análise descritiva. Os estudos revelam as principais barreiras para a implantação da restrição: crenças sobre o aumento da agressividade dos pacientes, prejuízo da relação profissional-paciente e falta de preparo para abordar o assunto. Após implantação, a restrição apresenta impacto positivo: redução do número de cigarros fumados, aumento da motivação para deixar de fumar e do número de tentativas de parar de fumar. Os profissionais tabagistas e aqueles que não acreditam que o abandono do tabagismo traga benefícios ao portador de transtorno mental são os que menos apoiam a implantação das restrições. Conclui-se que a restrição ao tabagismo é eficaz na internação psiquiátrica, pois provoca mudanças de atitudes nos portadores de transtornos mentais.

Palavras-chave: distúrbios mentais, pacientes psiquiátricos, tabagismo, serviços de saúde mental, enfermagem

Impacto y Barreras de la Restricción al Tabaquismo en la Internación Psiquiátrica: Revisión Integradora

Resumen: Se objetivó identificar las barreras para la implantación de la restricción al tabaquismo en los servicios de internación psiquiátrica, su impacto en los tabaquistas internados y el posicionamiento de los profesionales. Revisión integradora de 19 artículos publicados (1989-2011) en MEDLINE y SCOPUS. Análisis descriptivo. Los estudios muestran las principales barreras para la implantación de la restricción: creencia sobre aumento de la agresividad del paciente, perjuicio de la relación profesional–paciente y falta de preparo para discutir el asunto. Después de la implantación, la restricción presenta impacto positivo: reducción de cigarrillos fumados, aumento de la motivación para dejar de fumar. Los profesionales tabaquistas y aquellos que no creen que dejar de fumar puede traer beneficios al portador de trastorno mental son los que menos apoyan la implantación de las restricciones. Se concluye que la restricción al tabaquismo es eficaz en la internación psiquiátrica, pues provoca cambios de actitudes en los portadores de trastornos mentales.

Palabras clave: trastornos mentales, pacientes psiquiátricos, tabaquismo, servicios de salud mental, enfermería

Worldwide, there are approximately 1.3 billion smokers and it is estimated that, each year, around six million people die as a result of tobacco use. These rates have stimulated the recognition of smoking as a serious public health problem and the responsibility of governments, contributing to the strengthening of intervention measures (World Health Organization [WHO], 2011).

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With the strengthening of these measures and reduction in the number of smokers in the general population in some countries, from the 1980s, the higher frequency of tobacco use in patients with mental disorders became evident, as well as a greater severity of nicotine dependence and greater difficulty in quitting smoking (Aubin, Rollema, Svensson, & Winterer, 2012; Johnson et al., 2010; Lasser et al., 2000; Ma et al., 2010; Morrison & Naegle, 2010; Peuker, Rosemberg, Cunha, & Araújo, 2010).

One of the actions to combat smoking, suggested by the World Health Organization and adopted as legislation in many countries, including Brazil, is the prohibition of smoking in public environments, which has led to a cultural change in the world (Pan American Health Organization, 2013; WHO, 2011).

Previously, smoking was accepted by society and was a status symbol. Today, it is a reason for discrimination. Those who can not stop smoking, even for brief periods, shy away from social interaction. Accordingly, the restriction of smoking in psychiatric hospitalization contexts is an opportunity for people with mental disorders to re-educate themselves and discover resources to help them to smoke less. With the support of the team, during the hospitalization they experience a replica of what happens in society.

Despite the restriction during hospitalization being an opportunity for the individual with mental disorders to experience abstinence, the majority of professionals do not believe that the hospitalization period is the best time to stop smoking (Keizer, Gex-Fabry, Bruegger, Croquette, & Khan, 2014). This impasse has provoked reactions in people with mental disorders and in the professionals involved in the care.

The main difficulty faced with the restriction of smoking in the hospital is the resistance of the psychiatric patients to limiting the amount of cigarettes, related to the following motivations for smoking: relief of tension and anxiety; escape from problems arising from living with the mental disorder; alternative to fill the idle time; feeling of pleasure; facilitation of social interactions; reduction in the side effects of the medication; improvement of cognitive impairments; relief of some psychiatric symptoms (negative symptoms of schizophrenia) and support to feel part of the world (Barr, Procyshyn, Hui, Johnson, & Honer, 2008; Galazyn, Steinberg, Gandhi, Piper, & Williams, 2010; Johnson et al., 2010; Ma et al., 2010).

The restriction of smoking in psychiatric hospitalization contexts needs to be discussed because it means facing not only the difficulty and resistance of individuals with mental disorders to remain abstinent, but also the cultural heritage of the psychiatric services that, for many years, used the cigarette as a care instrument, a bargaining chip to control the behavior of the patients and encourage adherence to the pharmacological treatment (Green, 2010; McCloughen, 2003).

This integrative review aims to answer the following questions: (a) what are the main barriers for the implementation of restrictions on smoking in psychiatric hospitalization services?, (b) what is the impact of the restriction on hospitalized smokers?, and (c) how are the professionals positioning themselves regarding this issue in the quotidian practice of health services?

This study aimed to identify, in the scientific literature, the barriers for the implementation of the restriction of smoking in psychiatric hospitalization services, its impact on the hospitalized smokers and the positioning of the professional regarding this issue.

Method

The integrative review is a research method that seeks to synthesize the knowledge produced about a certain reality in a comprehensive and in-depth way, allowing professionals, inserted in the everyday practices of health services, a critical look at the situations experienced and more safety in the decision making process in order to improve care practices (Mendes, Silveira, & Galvão, 2008; Whittemore & Knafl, 2005).

Procedure

This integrative review followed six steps: (a) defining of the guiding questions; (b) sampling process with the establishment of the inclusion and exclusion criteria of the studies; (c) definition of the data to be obtained from the selected studies; (d) assessment of the studies included; (e) interpretation of the results, and (f) presentation of the review (Mendes et al., 2008; Whittemore & Knafl, 2005).

Data collection. The articles were selected from the MEDLINE (Medical Literature Analysis and Retrieval System Online), SCOPUS, and the CAPES Journal Portal databases, using the combination of descriptors: smoking ban, psychiatric inpatient, psychiatric unit, psychiatric hospitalization, and psychiatric hospital.

The following inclusion criteria were used: original articles, published in full, in Portuguese, English or Spanish, regardless of the year of publication, aiming to include both the first articles published on the subject up to the most recent articles (up to September 2012).

The exclusion criteria used were: (a) studies conducted in prison psychiatric services, (b) studies that investigated other types of drugs in the psychiatric hospitalization services, and (c) studies with the same sample, in which case the most recent article was considered.

The inclusion and exclusion criteria were initially applied by one of the researchers, from reading the abstracts of all the articles found in the databases. In the case of excluded articles, the justification for their exclusion was recorded. Following this, a second researcher was provided with access to the abstracts and exclusion justifications for a second opinion. For the items in which there was disagreement between the researchers, the opinion of the more experienced researcher was considered.

The articles selected in the final sample were read in full and the information tabulated as an *Excel* spreadsheet, according to the following: year, authors,

title, aim, methodology, results/conclusion, country in which the study was conducted, place where the study was conducted (psychiatric hospital or general hospital), language, and journal.

Data analysis. The articles were analyzed descriptively, highlighting the similarities. The results were discussed based on the literature on the theme.

Results

A total of 57 articles were found in the SCOPUS and 28 in MEDLINE databases, totaling 85 items. Of this total, 26 articles were found in both databases, therefore, a total of 59 articles were retrieved.

After reading the abstracts of the 59 articles, 40 (67.8%) were excluded, with 11 found and deleted in both databases. The items were excluded due to the following reasons: six (15%) addressed the restrictions on smoking in prison psychiatric services; four (10%) did not cover the objectives of this study; one (2.5%) dealt with the use of other drugs; one (2.5%) was written in Norwegian; 10 (25%) were theoretical articles, and 18 (45%) were not available in their entirety in the databases consulted.

Of the 19 articles selected (32.2% of the initial sample), four were found only in the SCOPUS database and 15 in the SCOPUS and MEDLINE databases. Only abstracts were available for two of these articles, with the entire text found in the CAPES Journal Portal database.

The results of this integrative review are organized into: (a) characterization of the selected studies and (b) thematic categories.

Characterization of the Selected Studies

The 19 studies analyzed in this integrative review span a publication period of 22 years (1989 to 2011). They are presented in Table 1, according to their code number, title, and year of publication.

Ten of the 19 studies analyzed were longitudinal (comparison between the periods before and after the implementation of the smoking restriction) and nine cross-sectional. The studies were conducted in nine countries, with the United States (n = 6), England (n = 3) and Switzerland (n = 3) being the most frequent.

Eight studies were conducted in psychiatric hospitals (PH), eight in psychiatric wards of general hospitals (GH), two in both services (PH and GH), and one in a psychiatric hospital and community mental health care service.

The studies were published in 13 journals, with the *General Hospital Psychiatry* journal presenting the highest number of publications (n = 3). All the studies were published in English.

Regarding the type of smoking restriction, nine addressed total restriction, four partial restriction, two addressed the two types of restriction, and four did not specify this. The majority of the studies (n = 11) mentioned nicotine replacement therapy in the subjects investigated.

Table 1
List of Articles Selected

Code	Title (year)
1	Nicotine replacement prescribing trends in a large psychiatric hospital, before and after implementation of a hospital-wide smoking ban (Scharf, Fabian, Fichter-DeSando, & Douaihy, 2011).
2	Total smoking ban in psychiatric inpatient service: a survey of perceived benefits, barriers and support among staff (Wye et al., 2010).
3	The impact of opening a smoking room on psychiatric inpatient behavior following implementation of a hospital-wide smoking ban (Crockford, Kerfoot, & Currie, 2009).
4	Smoking bans in a psychiatry department: are nonsmoking employees less exposed to environmental tobacco smoke? (Vorspan et al., 2009).
5	Smoking prevalence among qualified nurses in the Republic of Ireland and their role in smoking cessation (O'Donovan, 2009).
6	Variations in smoke after admission to psychiatric inpatients units and impact of a partial smoking ban on smoking and on smoking related perceptions (Keizer et al., 2009).
7	Changes in psychiatric patients' thoughts about quitting smoking during a smoke-free hospitalization (Shmueli, Fletcher, Hall, Hall, & Prochaska, 2008).
8	Acceptability and impact of a partial smoking ban followed by a total smoking ban in a psychiatric hospital (Etter, Khan, & Etter, 2008).
9	Exploration of inpatient attitudes towards smoking within a large mental health trust (Smith & O'Callaghan, 2008).
10	Acceptability and impact of a partial smoking ban in a psychiatric hospital (Etter & Etter, 2007).
11	A survey of staff attitudes to smoking-related policy and intervention in psychiatric and general health care settings (McNally et al., 2006).
12	The effects of a non-smoking policy on nursing staff smoking behavior and attitudes in a psychiatric hospital (Bloor, Meeson, & Crome, 2006).
13	Exposure to environmental tobacco smoke (ETS) and determinants of support for complete smoking bans in psychiatric settings (Willemsen, Gorts, Van Soelen, Jonkers, & Hilberink, 2004).
14	Survey of staff attitudes to smoking in a large psychiatric hospital (Stubbs, Haw, & Garner, 2004).
15	Obligatory cessation of smoking by psychiatric inpatients (Smith, Pristach, & Cartagena, 1999).
16	Implementing smoking bans in American hospitals: results of a national survey (Longo et al., 1998).
17	Implementation of a smoking ban on a locked psychiatric unit (Ryabik, Lippmann, & Mount, 1994).
18	The feasibility of smoking bans on psychiatric units (Taylor et al., 1993).
19	Effects of a smoking ban on a general hospital psychiatric unit (Thorward & Birnbaum, 1989).

Thematic Categories

The main results of the studies analyzed are presented in three thematic categories: (a) impact of the restriction on the hospitalized smokers, (b) barriers for the implementation of the smoking restriction, and (c) positioning of the professionals.

Impact of the restriction on the hospitalized smokers. Of the 19 articles analyzed, nine contemplate the impact of the smoking restriction on the hospitalized smokers. One study, conducted in a psychiatric hospital in Switzerland,

shows that two months after the implantation of partial restriction, through a specific smoking room without limiting the cigarettes/day, 45% of the smokers spontaneously reduced the number of cigarettes smoked, compared to the period that preceded the hospitalization (Etter & Etter, 2007).

The authors conducted a second study in the same hospital, three years after the implementation of the partial restriction, and found that after the partial restriction there were no changes in the prevalence of smoking or its severity. However, there was a change in the attitudes of the smokers who were considered to be in the smoking cessation process. The stages of change contemplation and preparation/action increased among the smokers after the implementation of the restriction (Keizer, Descloux, & Eytan, 2009).

From the two studies, the authors concluded that partial restriction encourages a reduction in the number of cigarettes smoked during the hospitalization (Etter & Etter, 2007; Keizer et al., 2009). Through a qualitative approach, some reasons reported by the patients for reducing the number of cigarettes were identified: lessening of tension, effect of the treatment, need to smoke in a closed room, the perceived need to respect the other patients, the place to smoke being uncomfortable, and lack of activities commonly associated with smoking (alcohol, walks).

Total restriction seems to encounter more resistance in the deployment process, both from the patients and the professionals. A study in a psychiatric hospital in Switzerland showed that 80.6% of the subjects (professionals and patients) were in favor of the implementation of partial restriction, however, 87% were against the possibility of implementing total restriction (Etter & Etter, 2007).

Despite the initial resistance toward the possibility of implementing total restriction, a third study by these authors showed that after the implementation of total restriction (smoking permitted only outside the hospital), 71 (52.8%) participants (professionals and patients) were satisfied with this measure. One positive outcome for total restriction, shown in the study, was the increase in the number of attempts to quit smoking during the hospitalization (18% of the subjects compared to 2% when there was only partial restriction) (Etter et al., 2008).

It was concluded that the efficacy of total restriction, as evidenced by the increased number of individuals attempting to quit smoking, is associated with nicotine replacement therapy implemented with total restriction in those patients motivated to quit smoking (Etter et al., 2008). The efficacy of nicotine replacement therapy was also found in another study (Shmueli et al., 2008).

A study in a general hospital in the United States, in which there was a total smoking restriction, showed that, at the time of admission until the discharge, there was an increase in patients' expectations regarding success in quitting smoking and a reduction in the expectations of difficulties in maintaining the abstinence. Although 100% of the subjects returned to smoking after the hospitalization, there was a reduction in the mean number of cigarettes/day three months after the discharge, compared to the amount smoked prior to hospitalization, and 48% tried to quit smoking after the discharge. It was concluded that total restriction, when the patients are monitored and protected, helps smokers to realize that they are able to quit smoking (Shmueli et al., 2008).

Barriers for the implementation of the smoking restriction. The studies analyzed revealed that the main barriers for the implementation of the smoking restrictions in inpatient psychiatric services were: fear of increased aggressiveness in the patients, fear of damaging the doctor-patient relationship, and lack of training of the professionals to address patients who are smokers.

The myth of increased aggressiveness of patients with the implementation of the restriction is one of the main barriers that limit the actions of psychiatric professionals. A study in a psychiatric hospital in Australia revealed that 89% of the professionals believed that the implementation of a smoking restriction in the hospitalization service can increase the aggressiveness of the smokers (Wye et al., 2010). A study showed that the professionals that had less fear regarding problems arising from the restriction, such as aggressiveness, were the ones that supported the implementation of this measure (Willemsen et al., 2004).

The apprehension of the professionals related to increased aggressiveness is disputed in some studies. A Canadian study investigated the aggressive behavior of patients at two moments: before the implementation of partial restriction and one year after the implantation. The authors concluded that there was no difference in the aggressive behavior of patients before and after the implementation of partial restriction (Crockford et al., 2009). Similar results were found in studies conducted in the United States and Canada (Ryabik et al., 1994; Smith et al., 1999; Taylor et al., 1993; Thorward & Birnbaum, 1989).

Another barrier relates to the belief that smoking promotes the professional-patient relationship. The perception of the influence of smoking in the professional-patient relationship seems to alter according to the habits of the professional. One study showed that 78.9% of the professionals who were smokers believed that smoking can help in establishing the professional-patient relationship, compared to 47.2% of the nonsmoking professional (Stubbs et al., 2004).

The lack of training of the professionals to address psychiatric patient smokers, during the hospitalization, is also considered a barrier for the implementation of the smoking restriction. A study with professionals in a psychiatric hospital in Australia showed that 52% of the professionals indicated the lack of training for this type of approach as one of the main barriers for the process of implementation of the restrictions (Wye et al., 2010). Similar results were found in another study, in which 74% of the nursing professionals did not address smoking cessation with patients due to lack of time, and 65% due to lack of preparation (O'Donovan, 2009).

For the patients, the main reasons that encourage smoking during the hospitalization, which may be considered barriers, were: idle time; lack of activities; nervousness; stress; desire to increase social contact; influence of other smokers, and the issue of habit (Keizer et al., 2009).

Positioning of the professionals. Professionals working in the psychiatric area seem to be the least supportive of restrictions on smoking. The perception of the professionals regarding this measure influences the support provided throughout the process (Longo et al., 1998; McNally et al., 2006).

A study conducted in Australia shows that professionals who believed that a smoking restriction can help psychiatric patients stop smoking were 23 times more likely to support its implementation in the workplace. In the same study, the authors show that the professionals believed little in the benefits of smoking cessation for psychiatric patients: 71% did not believe or were unsure as to the contribution in improving the mental health of psychiatric patients, and 62% did not believe that the restriction could help the patient quit smoking (Wye et al., 2010).

Among the professionals, there seemed to be greater acceptance of partial restriction. In a study performed in a general hospital in Canada, 86% of the professionals were in favor of partial restriction by creating a specific room for smokers: 81% said they felt safer to work and had more time to establish a bond with the patients after the implementation of this room (Crockford et al., 2009). In a study conducted in France, the professionals were investigated after the implantation of partial restriction, and 100% said they were satisfied with its implementation (Vorspan et al., 2009).

Total restriction encountered more resistance from the professionals, especially from the professionals who smoked. A study with nursing professionals in a psychiatric hospital in England revealed that 53% of nonsmoking professionals supported total restriction, compared to 6.3% of the smoking professional (Bloor et al., 2006).

A study conducted in a general hospital in Ireland showed that 89% of the nonsmoking nurses believed that smoking harms psychiatric patients, compared to 65% of the smoking nurses; 65% of the nonsmoking nurses were in favor of the implementation of the restriction during hospitalization, compared to 25% of the smoking nurses. In the same study, it was found that 72.6% of the nurses believed that the main help for psychiatric patients to stop smoking is nicotine replacement therapy and not their professional practice (O'Donovan, 2009).

A study in a psychiatric hospital in the United States revealed that after the implementation of total restriction, accompanied by training of the team to identify the symptoms of withdrawal, nicotine replacement therapy began to be prescribed more frequently, suggesting that the training of professionals favors better positioning in relation to the interventions necessary to help the patient deal with the limitation in the number of cigarettes (Scharf et al., 2011).

Discussion

From this integrative review, the complexity of the smoking restriction in inpatient psychiatric services was confirmed. Because it is a subject that has recently been gaining attention, there are not a significant number of publications, nor a consensus regarding the best alternatives to overcome the difficulties and limitations of this practice. Currently, there are reports of some successful experiences and clarification of the main myths involved.

One of the main discussions related to the subject is related to the ethical implications of smoking restrictions in the psychiatric hospitalization period. Authors question the effectiveness of the restriction in the long term, its relevance at the time of hospitalization, and the right of choice of the patients (Shattell & Andes, 2008).

If, on one hand, there is the question regarding the right of the patient to adhere to the smoking restrictions and its relevance at the time of hospitalization, conversely, there should be a discussion regarding the omission of care, revealed by the permission and support for smoking in inpatient psychiatric settings in the absence of educational and therapeutic alternatives, such as prevention and treatment for those who want to quit, despite the recognition of the impairments caused. It is important that these two extremes are part of the discussions of the professionals involved in the psychiatric services, as restricting smoking during the hospitalization may involve the revision of a culture of care.

One point that needs to be discussed relates to the difference between the restriction of smoking for psychiatric patients and for non-psychiatric patients. Why is it obligatory, in the services, for non-psychiatric patients to comply with smoking restrictions, while in some psychiatric services this habit is still allowed?

In the scientific literature it is accepted that to allow smoking only for psychiatric patients increases the inequality between them and society (Campion, McNeill, & Checinski, 2006). However, the authors of a theoretical discussion refute this statement, as they understand that the responsibility for the decline in the differences can not be transferred to the smoking restriction measures (Shattell & Andes, 2008).

Despite the divergence of opinion among the authors, the understanding of permission to smoke during psychiatric hospitalization is reiterated as a sign of distinction, since this practice is based on myths about smoking cessation in these individuals (apprehension regarding increased aggressiveness, impaired professional-patient relationship), as well as the lack of confidence in their ability to quit smoking (Praveen, Kudlur, Hanabe, & Egbewunmi, 2009; Wye et al., 2010).

Regarding smoking as a marker of difference, it is considered that permission to smoke in psychiatric services is inconsistent with the current moment that psychiatry is experiencing in relation to changing the concepts and practices of social reinsertion of individual with mental disorders and the decrease in the differences (Law No. 10.216, 2001).

Allowing smoking in the psychiatric hospitalization context is also inconsistent with the proposal of returning to society in a short period of time. A study examined in this review shows that the length of hospitalization of smokers is higher when smoking is allowed than when hospitalized in a tobacco-free environment (Crockford et al., 2009). By recognizing the impairments of smoking, at the time of exacerbation of the mental disorder, increasing the time required for recovery, it is difficult to reconcile the care practices with this habit.

The permissive attitude toward smoking in the psychiatric hospital, may be related to other factors in addition to those already mentioned, such as increased stress and exacerbation of psychiatric symptoms with the removal of the tobacco, low motivation of the team in planning strategies to recognize the high rates of relapse, and the belief that smoking is not among the priority concerns during the hospitalization process. Furthermore, some psychiatric patients in the acute phase present difficulties to adhere to social norms due to lack of impulse control or contact with the social reality, as well as cognitive impairment, which may make a change in attitude difficult (Keizer et al., 2009; Keizer & Eytan, 2005).

Increased stress as a result of tobacco withdrawal is something that can happen due to the withdrawal syndrome. However, the belief of an increase in the aggressiveness of psychiatric patients due to withdrawal from tobacco was challenged in several studies (Crockford et al., 2009; Longo et al., 1998; Ryabik et al., 1994; Smith et al., 1999; Taylor et al., 1993; Thorward & Birnbaum, 1989). The belief in the increased aggressiveness of psychiatric patients, with the removal of the tobacco, can involve the insecurity of the professional and the lack of a scientific basis for dealing with the issue.

Regarding the discussion about the best time to initiate smoking reduction strategies, it is believed that psychiatric hospitalization should be seen by professionals as an appropriate and ideal time for this practice, as the restriction combined with the support of the team can assist in increasing awareness and motivation to quit the habit. It must also be considered that many psychiatric patients will never spontaneously seek help to stop smoking, with the time of hospitalization being a moment of opportunities (Etter et al., 2008; Keizer et al., 2009).

The results of the smoking restrictions in the studies analyzed in this review may at first seem discouraging, when noting that all the patients returned to smoking after they were discharged. However, when analyzing other aspects of these studies positive changes can be observed, such as a reduction in the number of cigarettes smoked during the hospitalization and after discharge, an increase in attempts to quit smoking, increased expectations of success, and a change in attitudes, with many patients passing to the stages of contemplation and preparation for action (Etter & Etter, 2007; Etter et al., 2008; Keizer et al., 2009; Shmueli et al., 2008).

To consider the results of smoking restrictions discouraging due to no change in the prevalence of smoking after discharge is to look at the problem in a reductionist manner, revealing a biased view of the professionals, believing that smoking in patients with mental disorders is not something possible to overcome.

It is worth considering that in smoking cessation relapses are not seen as failures, but as part of a process of change. Therefore, the changes of attitudes in the psychiatric patients, shown from the implementation of the restrictions, as well as the reduction in the number of cigarettes and increase in the attempts to quit smoking, can be considered achievements, revealing the efficacy of the restriction measures during the hospitalization.

Although the professionals recognized the difficulties that people with mental disorders have to quit smoking, it is essential that they review their positions, because the impairments to the individual with mental disorders outweigh the initial difficulties. In the scientific literature, it is accepted that smoking interferes with the pharmacological therapy, exacerbates the mental disorder symptoms, increases the occurrence of psychotic episodes, increases the risk for tardive dyskinesia, makes the individual with mental disorders more vulnerable to chronic diseases and mental disorders, and may increase the distress and limitations (Diehl, Reinhard, Schmitt, Mann, & Gattaz, 2009; Kotov, Guey, Bromet, & Schwartz, 2010).

A key point in the implementation of a smoking restriction is the training of the team to deal with these issues, because, although in the first moment the professionals presented resistance to this measure, after its deployment they were able to perceive the benefits, both in the workplace and in the care of the psychiatric patients, when they found new possibilities to approach the issue (Wye et al., 2010).

It was evident in this review that the professionals that smoked perceived smoking in the psychiatric patients differently to the nonsmoking professionals, supporting the continuation of this culture in inpatient services (O'Donovan, 2009; Praveen et al., 2009). Because of this, the importance can be recognized of educating professionals about the various aspects of smoking in their own lives and the lives of the patients who receive their care.

The importance of education of the professionals may be based on the results of some studies that show that the attitude of the team, regarding issues related to smoking in inpatient psychiatric services, influences the perceptions of patients regarding this habit and their motivations for abandoning it (Bloor et al., 2006; Keizer et al., 2009). When the professionals do not accept and will not participate in the process of implementation of the restrictions, the results are unsatisfactory (Bloor et al., 2006; Stubbs et al., 2004).

Although the number of studies on the restriction of smoking in psychiatric inpatient services has increased, it can be observed that they are limited to the time of hospitalization without planning for the continuity of this

care after discharge. This limitation raises a question that can be answered in future studies: is the restriction of smoking, limited to the time of psychiatric hospitalization, an intervention or a punishment?

This study provides important contributions, as it presents healthcare professionals with a systematic view of a topic that, although not new, has been little studied. The low number of studies available on the subject in the scientific literature is highlighted as a limitation of this study.

Final Considerations

The total smoking restriction is that which presents more resistance for its implementation in inpatient psychiatric services. However, after the implementation of total or partial restriction, these contribute to the psychiatric patient decreasing the amount of cigarettes and feeling more motivated to quit smoking, with increased attempts to stop.

The main barriers for the implementation of the restriction are associated with the beliefs of the professionals about the increased aggressiveness of the patient with the removal of the cigarette, damage to the established relationship, and lack of preparation to address the issue. The myth of increased aggression and damage to the professional-patient relationship was challenged in the studies analyzed.

The way the professionals position themselves faced with restrictions is associated with their own habits and their perceptions about the benefits of the removal of tobacco in psychiatric patients. The professionals who smoke and those who do not believe that smoking cessation can benefit patients with mental disorders are the least supportive of the implementation of the restrictions.

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