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Original Article

View of hospitalized psychiatric patients on the smoking habit[1]

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This is an exploratory descriptive study with quantitative and qualitative approach, which aims to know the opinion of patients about smoking in the hospital and the degree of dependence on smoking. We used a semi-structured interview and Fagerström questionnaire on smokers. We observed 25 patients: 44.0% with mood disorder, schizophrenia 28.0%, 52.0% 10 or more years of disease, 64.0% 1-5 hospitalizations. Of these, 24.0% were smokers, 83.3% had a high degree of dependence. Most nonsmokers agreed to ban smoking in collective environments, without privileges for the mentally ill. Smokers were shown to be opposed to smoke-free policies, but in favor of nicotine replacement therapy during hospitalization. It is expected the investment of the team in tobacco-free environment, health services and raise awareness of smokers to seek smoking cessation treatment.

Descriptors: Smoking; Mentally Ill Persons; Hospitalization; Psychiatry; Mental Health.

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Opinião de pacientes psiquiátricos internados sobre o hábito de fumar

Este é um estudo exploratório-descritivo com abordagem quantitativa e qualitativa, cujo objetivo foi conhecer a opinião dos pacientes acerca do fumar na internação e o grau de dependência dos fumantes. Utilizou-se a entrevista semiestruturada e questionário de Fagerström nos fumantes. Foram observados 25 pacientes: 44,0% com transtorno de humor, 28,0% esquizofrenia; 52,0% 10 ou mais anos de doença; 64,0% 1 a 5 internações. Desses, 24,0% eram fumantes, 83,3% apresentavam grau elevado de dependência. A maioria dos não fumantes concordou em proibir o fumo em ambientes coletivos, sem privilégios para doentes mentais. Os fumantes mostraram-se contrários a políticas antifumo, mas favoráveis à terapêutica de reposição de nicotina na internação. É esperado o investimento da equipe no ambiente livre de cigarros, nos serviços de saúde e na conscientização do fumante, para buscar tratamento antitabágico.

Descritores: Tabagismo; Pessoas Mentalmente Doentes; Hospitalização; Psiquiatria; Saúde Mental.

Opinión de pacientes psiquiátricos internados sobre el hábito de fumar

Éste es un estudio exploratorio-descriptivo con abordaje cuantitativo y cualitativo, cuyo objetivo fue conocer la opinión de los pacientes acerca del fumar en la internación y el grado de dependencia de los fumadores. Se utilizó la entrevista semi-estructurada y cuestionario de Fagerström en los fumadores. Fueron observados 25 pacientes: 44,0% con trastorno de humor, 28,0% esquizofrenia; 52,0% 10 o más años de enfermedad; 64,0% 1 a 5 internaciones. De eses, 24,0% eran fumadores, 83,3% presentaban grado elevado de dependencia. La mayoría de los no fumadores concordó en prohibir el humo en ambientes colectivos, sin privilegios para enfermos mentales. Los fumadores se mostraron contrarios a políticas antitabaquismo, pero favorables a la terapéutica de reposición de nicotina en la internación. Es esperado la inversión del equipo en el ambiente libre de cigarrillos, en los servicios de salud y en la concienciación del fumador, para que busquen tratamiento antitabaquismo.

Descriptores: Tabaquismo; Enfermos Mentales; Hospitalización; Psiquiatría; Salud Mental.

Introduction

The mentally ill constitute a group more vulnerable to smoking. The impact of smoking in this population was, for many years, neglected, due to failure to recognize that smoking is a form of dependency, the lack of awareness of medical complications that habit and limited knowledge about the association between smoking and psychiatric disorders [1]. Studies show that smoking prevalence in people with psychiatric disorders is higher than in the general population, including higher levels of tolerance and dependence [1-4]. In the specific situation of psychiatric hospitals, the results of research conducted in three hospitals in Israel have shown high rates of smoking

among both health professionals (48.1%) and among inpatients (76.0%) (5). These authors concluded that a person admitted under these circumstances is significantly exposed to the "pro-smoking atmosphere" and the consequences of smoking on his health.

Smoking can take a significant role in the lives of the mentally ill, because cigarette smoking can bring a sense of relief from side effects of certain medications and even some disease symptoms. The feeling of helplessness of the person with mental illness, coupled with his despair about the chances of recovery and the need to control, tend to facilitate the search for relief in tobacco use. Idleness, in turn, common in psychiatric institutions, can contribute to the patient's smoking habit [3,6].

Difficulties in controlling tobacco use during psychiatric hospitalization are due in part to the non-integration strategies to smoke free service routines. The distrust of health professionals and patients who smoke, compared to treatments for nicotine dependence may lead them to interfere in such approaches [1]. Moreover, many health professionals believe that the patient shall have the right to smoke, even indoors, as in the ward (matter of legal right). The release of the use of the cigarette may, in turn, be used as a guarantee for patients to follow the recommendations of treatment and therapeutic activities of the various participating provided. Smoking passes, therefore, to be seen as an instrument that soothes and eases social interaction of patients [7]. The team tends to believe that the prohibition of smoking increase the aggressiveness of the patients [4].

For some individuals, hospitals appear as a way to reduce or even temporarily stop using tobacco, which is no guarantee of termination of this habit. Strategies for smoking cessation that are based on that level of motivation and preparation to change may, however, not be appropriate to the mentally ill [3]. In this case, there are psychoeducational programs that provide detailed information about addiction and its potential harm, techniques and strategies for controlling anxiety and stress management as muscle relaxation and meditation, combined with pharmacological interventions for nicotine withdrawal, as indicated [1.6].

Motivated therefore by these considerations, it was resolved here to hear the opinion of patients about tobacco use in the hospital environment and the degree of dependence of smokers belonging to that group.

Method

Descriptive exploratory study of quantitative and qualitative nature (8), held in Psychiatric Nursing (EPQU), Hospital das Clinicas, School of Medicine of Ribeirao Preto, University of São Paulo (HCRP), with 25 hospitalized patients.

The HCRP-EPQU aims to provide full hospitalization to 15 psychotic patients in acute crisis, and offer rapid reintegration of the patient to his family and society. It prioritizes work performed by a fixed interdisciplinary team (psychiatrist, nurse, nurse assistant, psychologist, social agent, occupational therapist and administrative officer) and other rotating team (psychiatry residents; students of psychology, social work and occupational therapy). Patients participate in a treatment program that consists of pharmacotherapy, operative groups and occupational therapy, physical activity and leisure, individual psychotherapy sessions and family gatherings.

Patients could smoke at this service, given some determinations regarding location and time. Since June 2009, smoking was banned on the premises of the HCRP, including EPQU, given the State Law 13.541/2009. This law prohibits throughout the territory of the State of São Paulo, the use of cigarettes, cigars or any other smoking product, whether or not derived from tobacco, in an environment of collective use, public or private, wholly or partially closed, including the health institutions.

In the EPQU-HCRP, similar to what occurs in the rest of the institution, is offered to smokers admitted, a policy of restriction on smoking, use of nicotine patches (nicotine replacement therapy - NRT), through their voluntary membership. NRT aims to reduce discomfort, maximize the smoke free policy submission to the hospital, and minimize some of the adrenergic side effects associated with nicotine withdrawal [2,9-10]. This usage follows regimen recommended for the cessation of smoking during their stay in service.

Data collection was conducted through semi-structured interview technique. The issues contained data previously developed for the identification of participants and their opinion on smoking, including the following sub-items: reserve areas for smokers in public places, judgment on smoking among the mentally ill, opinion about smoking in EPQU -HCRP, and a question to identify which group the respondent falls in relation to tobacco use or not (never smoker, former smoker and smoker). This question selects smokers who answered the Fagerström questionnaire [11], which assesses the degree of dependence on tobacco smoking.

The hospitalized patients were interviewed in the individual and group waiting room of the EPQU-HCRP, throughout their stay in the unit, at times which did not affect their participation in activities provided for in their treatment.

For quantitative analysis, we built a database using Microsoft Excel software. Later, they were compiled using SPSS software. Qualitative data were subjected to the technique of thematic content analysis [8].

The study was approved by the ethics committee of HCRP (Process HCRP No. 3504/2009), meeting the guidelines related to the research protocol contained in Resolution 196/96, CNS.

Results

The results for the sociodemographic characteristics of patients are presented in Table 1.

Table 1 - Sociodemographic characteristics of the study population. Ribeirão Preto, Brazil, 2010

Variables	Patients	
	f	%
Age		
12 - 20	5	20,0
20 - 30	1	4,0
30 - 40	7	28,0
40 - 50	2	8,0
50 - 60	5	20,0
60 or more	5	20,0
Gender		
Male	12	48,0
Female	13	52,0
Marital status		
Married	7	28,0
Single	13	52,0
Consensual union	1	4,0
Divorced	2	8,0
Widowed	2	8,0
Education		
Primary Education incomplete	8	32,0
High School Complete	3	12,0
High School Incomplete	2	8,0
High School Incomplete	7	28,0
College incomplete	3	12,0
College complete	2	8,0
Religion		
Without religion	3	12,0
Catholic	15	60,0
Pentecostal	4	16,0
Protestant	1	4,0
Spiritualist	2	8,0
Occupation*		
Group 2	1	4,0
Group 3	2	8,0
Group 5	12	48,0
Group 7	3	12,0
Group 9	1	4,0
Retired	1	4,0
student	4	16,0
Unemployed	1	4,0

* Occupation / profession as Major Occupational Groups of Brazilian Classification of Occupations (CBO - Ministry of Labor and Employment): Group 2 - professionals in the arts and sciences, Group 3 - mid-level and Group 5 - service workers, vendors trade in shops and markets, Group 7 - production workers in goods and industrial services, Group 9 - maintenance and repair workers.

We interviewed 25 patients, 12 (48%) were male. Most were adults, ranging from 20 to 59 years (60.0%). As for marriage, 17 (68.0%) had no nuptial bond (single, widowed or divorced) and 8 (32.0%) had (married or consensual union). Of the total 25 patients, eight (32.0%) had incomplete Primary Education, 5 (20.0%) completed Elementary School or High School; 10 (40.0%) reported having completed high school or College incomplete and 2 (8.0%) University degree. With regard to occupations, 12 (48.0%) patients had activities related to the occupational group of workers in services (homemaker, housekeeper, salesman, clerk, general services), 3 (12.0%) of the production of industrial goods and services (driver, builder, marketer of industrial equipment), 2 (8.0%) to mid-level (bank, nursing assistant) and 1 (4.0%) for professionals in science and arts (journalist), 1 (4.0%) for maintenance workers (road construction), 1 (4.0%) reported being unemployed, 1 (4.0%) retired and four (16.0%) were students. Of the 25 patients, 15 (60.0%) were Catholic, 4 (16.0%), Pentecostal, one (4.0%) Protestant, two (8.0%) and 3 spirit (12.0%) without religion.

Table 2 presents information on the clinical characteristics of patients consisting of the diagnosis group, duration of illness and hospitalization status, number of hospitalizations, use of tobacco and smokers' degree of dependence (assessed by the Fagerström questionnaire).

Table 2 - Diagnosis, duration of illness and hospitalization status, number of hospitalizations, use of tobacco and the study of patients degree of dependence on smoking. Ribeirão Preto, Brazil, 2010

Characteristics	Patients	
	f	%
Diagnosis group- CID-10†		
F00 – F09	1	4,0
F10 – F19	1	4,0
F20 – F29	7	28,0
F30 – F39	11	44,0
F40 – F48	1	4,0
F50 – F59	1	4,0
F60 – F69	3	12,0
Time of illness (years)		
0 - 1	4	16,0
1 - 5	6	24,0
5 - 10	2	8,0
10 - 20	10	40,0
20 or more	3	12,0
Time of admission (days)		
0 - 30	14	56,0
30 - 60	5	20,0
60 - 90	2	8,0
90 - 120	3	12,0
120 or more	1	4,0
Number of admissions		
1	8	32,0
2 - 5	8	32,0
6 or more	9	36,0
Ueo of tobacco		
Smoker	6	24,0
Never a smoker	17	68,0
Ex-smoker	2	8,0

(continue...)

Table 2 - *(continuation)*

Characteristics	Patients	
	f	%
Degree of addiction†		
Very low	0	00,0
Low	1	16,7
Moderate	0	00,0
High	4	66,6
Very high	1	16,7

† Main diagnosis group of ICD-10 which led to hospitalization of the patient. Classification: F00 - F09 organic mental disorders, including symptomatic, F10-F19 mental and behavioral disorders due to psychoactive substance use; F20 - F29 Schizophrenia, schizotypal and delusional disorders, F30 - F39 mood disorders, F40 - F48 Neurotic disorders disorders, stress related and somatoform disorders, F50 - F59 behavioral syndromes associated with physiological dysfunctions and physical factors; F60 - F69 disorders of personality and adult behavior.
‡ Results of application of the Fagerström questionnaire in subjects who reported being smokers.

In this study, nearly three quarters of inpatients received a diagnosis of mood disorder (44.0%) or schizophrenia (28.0%). Also observed was a lower proportion of disorders related to substance abuse (4.0% vs. 7.3%) and psycho-organic disorders (4.0% vs. 9.3%). Of the patients who participated in the study, 13 (52.0%) had a history of 10 or more years of disease evolution, 8 (32.0%) had 1-9 years of evolution and four (16.0%) less one year since the beginning of his suffering. As the number of hospitalizations, 16 (64.0%) had a history 1-5 hospitalizations and 9 (36.0%) of 6 or more. Regarding the duration of current hospitalization, the average was 46.3 days, median 30 days, ranging from 3-240 days.

Of the total 25 patients who responded to this survey, 17 (68.0%) never smoked, or smoked less than five packs of cigarettes (100 cigarettes or less) throughout life, 2 (8.0%) were former smokers, therefore, smoked five or more packs of cigarettes (100 cigarettes or more) throughout life, and currently do not smoke anymore. The six (24.0%) patients were smokers, characterized as those who smoked five packs of cigarettes or more (100 or more cigarettes) throughout life, and currently smoke cigarettes or products (pipes, cigars, snuff or chewing tobacco).

Table 3 shows the results about the opinion of the study participants on the reservation of areas for smoking and its prohibition.

Table 3 - Opinion of patients on reserved areas for smoking and its prohibition. Ribeirão Preto, Brazil, 2010

Variables	Patients	
	f	%
Reserved areas for smoking		
No	2	8,0
Yes	23	92,0
Banning smoking at airports		
No	2	8,0
Yes	23	92,0
Banning smoking in churches		
No	2	8,0
Yes	23	92,0

(continue...)

Table 3 - *(continuation)*

Variables	Patients	
	f	%
Banning smoking in public transportion		
No	2	8,0
Yes	23	92,0
Banning smoking in commercial centers		
No	4	16,0
Yes	21	84,0
Banning smoking in hospitals		
No	2	8,0
Yes	23	92,0

In the opinion of the majority of the respondents (92.0%), specific areas should be reserved for smokers and be forbidden to use tobacco in places where there is some concentration of people. Twenty-three patients (92.0%) agree with the banning on smoking in airports, churches, public transportation, hospitals, and 21 (84.0%) in shopping centers. All patients showed smokers to be favorable to the reservation of areas for smokers in public places. *Must have a smoking area* (P5). *Do not smoke in a forbidden place, must go elsewhere* (P8). *Having a private place is better* (P19).

Table 4 shows the findings about the opinion of interviewees about the use of cigarettes by the mentally ill in different locations.

Table 4 - Review of the individuals on the use of cigarettes by the mentally ill in different locations. Ribeirão Preto, Brazil, 2010

Variables	Patients	
	f	%
Allow the mentally ill to smoke in a public place where smoking is prohibited		
No	22	88,0
Yes	2	8,0
Don't know	1	4,0
Allow mentally ill smoking in DH§		
No	15	60,0
Yes	9	36,0
Don't know	1	4,0
Allow mentally ill smoking in clinics		
No	22	88,0
Yes	3	12,0
Allow mentally ill smoking in CAPS‖		
No	15	60,0
Yes	9	36,0
Don't know	1	4,0
Allow the mentally ill smoking in wards of general hospitals		
No	19	76,0
Yes	6	24,0
Finds it difficult or uncomfortable with smoking during EPQU**		
No	9	36,0
Yes	16	64,0
Prohibit smoking in EPQU		
No	8	32,0
Yes	17	68,0

(continue...)

Table 4 - *(continuation)*

Variables	Patients	
	f	%
Replace smoking by nicotine patch in EPQU		
No	2	8,0
Yes	22	88,0
Don't know	1	4,0

§DH – day-hospitals; ||CAPS – Psychosocial Care Centers.; **The patients could smoke in EPQU until June 2009, when smoking was banned throughout the HCRP.

Patients agree in number of 22 (88.0%), among which four smokers (66.7% of these), with the mentally ill not being allowed to smoke in public places where smoking is prohibited. Among the reasons, they cite the dangers of smoking, the damage to the treatment and for people who are not smokers. *If it is forbidden it's because it is harmful, otherwise it would not be prohibited* (P2). *It is part of the treatment quitting smoking. Smoking is veryt harmful to the brain* (P25). *Even if you have mental problems,it impairs the health of patients* (P7). *Because it is better for the patients treatment and for those who do not smoke* (P8).

The 2 (33.3%) smokers who are in favor for the mentally ill to smoke in public places where it is forbidden used as an argument the citizen's right to free will and the notion that smoking relieves anxiety. *Everyone does as they please* (P6). *Smoking relieves anxiety* (P21).

Asked about allowing smoking for the mentally ill in specialized care, most respondents are against the use in outpatient clinics (88.0%), even among smokers (83.3%). Regarding EPQUs, most studied also agrees to not allow smoking by the inpatients (76.0%). *Because it harms those who do not smoke, non-smokers receives the highest load* (P12). *Banning while they are here, they can consider quitting when they are out there* (P24).

When questioned, however, about the ban of tobacco use in EPQU-HCRP, although most subjects agree, the findings were in lower percentages (68.0%). The group of smokers was found to be divided: 3 (50.0%) in favor and 3 (50.0%) against the ban in EPQUs and mostly (66.6%), contrary to prohibit the use of cigarettes by patients during hospitalization in EPQU-HCRP. What was expected is that the answers to these questions were similar. *There must be an area for smokers (P5). Because I will not go there when they are smoking (P1). I tolerate it no to be antisocial (P10).*

When asked if they found some difficulty or felt some discomfort caused by tobacco use in internal EPQU-HCRP, 64.0% of patients responded affirmatively. All subjects smokers responded negatively to this question. *The smell bothers people* (P1). *I feel nausea and headache* (P8). *Because it's too bad because the smell is bad, uncomfortable* (P9). *No, because I also smoke and I'm used to the smell* (P21).

Study subjects, in majority (88.0%) agree with the conduct of offering the use of nicotine patches (NRT) to smokers admitted to the EPQU-HCRP, a policy of restriction on smoking. Of the smokers, 4 (66.6%) were positioned favorably to NRT. *One must stop at once* (P4). *Because I'm using it, it is helpful, I do not feel an urge to smoke* (P7). *Decreases addiction gradually , if tehre is strict abstinence, a person smokes twice as much* (P10). *Thus, one does not remember about cigarettes* (P18).

Discussion

The Ministry of Health conducted between 2002 and 2003, the "household survey on risk behaviors and morbidity of noncommunicable diseases and injuries," 15 Brazilian capitals and the Federal District. In this investigation, it was shown that the overall prevalence of smoking in the population above 15 years was about 19%, with higher incidence among men (12-13). Recent findings of the "Surveillance System Risk and Protective Factors for Chronic Non Communicable by the Telephone - VIGITEL", implemented by the Ministry of Health, pointed, in 2006, its first year of survey, percentage of 16.2% smokers in Brazil, more widespread habit among men [14].

In this study, the percentage of smokers was 24.0%, higher than the population studies. The prevalence of smoking in patients in hospitals tends to be larger (15). Research conducted at University Hospital of São Paulo, in 1995, identified 21% of smokers in different specialized hospital units that institution (16). Patients admitted to a psychiatric ward of a university hospital in Porto Alegre underwent three consecutive censuses in range that attended the turnover of hospital, having been found the percentages of 46.7, 54.3 and 38.9% of patients smoking at all times (17). Regarding gender, 53.3% of women were smokers at the time of the first census, in the second, 57.9% were men, and in the third, the ratio between men and women were identical. The results presented here, the overall number of smokers, were closer to the study hospital in Sao Paulo (21%), with percentage of 24.0% of patients hospitalized smokers. The prevalence of smoking in relation to gender, in total there were 4 (66.6%) women and 2 (33.3%) male smokers, a finding different from that found in population studies.

Comparing the diagnostic distribution of this study with data from another study (18), it was found a greater proportion of mood disorder (in this study: 44.0%, as the other survey: 30.0%) and schizophrenia (here : 28.0%, as the other survey: 19.1%). Regarding the diagnosis of neurotic or personality disorders, the results were similar (this study: 16.0%; as the other survey: 15.0%). There were also these findings, 1 (4%) patient with behavioral syndrome associated with physiological dysfunctions and physical factors.

The degree of dependence, assessed by the Fagerström questionnaire application was considered high (score ≥ 6) to 5 (83.3%) of smokers. This finding corroborates the literature suggests that psychiatric patients have more severe dependence than those who smoke and have no comorbid diagnosis of mental illness [17].

Regarding smoking in public places, or where there is some concentration of people, 92.0% of respondents agree to ban smoking. These findings were similar to those of Italy and Ireland, respectively, 90.0 and 83.0% of the population were in favor of smoke-free public areas [19].

The smokers in general tend not to agree to rules that interfere with their right to smoke in enclosed public places such as hospitals and other health care services [20]. Likewise, in this study, all smokers were in favor of

reservation areas for smokers in public places.

According to the literature [21], the use of tobacco adversely affects the physical and psychological integrity of the individual. Nicotine induces dependence, and the individual, social and environmental conditions are important for the development of this addition [21]. In this study, most patients (22 to 88.0%) agreed not to allow mentally ill people use tobacco in public places, where it is prohibited. Presented as a justification for this stance your knowledge about the hazardous effects of smoking, the damage to the treatment and for people who are not smokers.

Tobacco smoking can act as an emotional buffer, because smokers tend to believe that by smoking, can control their anxiety, anger, sadness, becoming more calm (6.21). In the present study, the smokers in favor of the mentally ill from smoking in public places, where it is forbidden, used as an argument the right of every citizen to free will and the notion that smoking relieves anxiety. The smoking contributes, however, for the development of anxiety disorders (agoraphobia, panic disorder and generalized anxiety disorder) [22]. This would be related, inter alia, the apparent anxiogenic effects of nicotine. Furthermore, cessation of smoking is followed by reduction of anxiety, withdrawal after 4 weeks [22]. The question regards the right to smoke (free will) not be addressed in this study had a contentious issue, and flee the proposed objectives.

The question regarding the permition of smoking for the mentally ill, in mental health care services has shown conflicting results. Although the majority of nonsmokers agrees to disallow the use of cigarettes by CAPS and DH patients, the percentages were lower in relation to its ban in the clinics. This difference can be explained by the fact that patients usually stay for a longer period of time in DH and CAPS than in clinics. In these, patients attend for care and at the end of it, return to their homes. Another possible explanation may be greater on the physical space of the DH and CAPS, which, in turn, would set aside areas for smoking.

Smokers in this study, the majority would allow smoking in DH and CAPS. In addition to the reasons given above, another motivation may be found in the study [23] conducted in a CAPSad (CAPS alcohol and drugs), in which patients, before attending the treatment, did not consider the cigarette as an illicit drug. They believed they could smoke freely and that smoking does not cause damage to health.

In the specific situation of permitting smoking in hospital in EPQUs, most subjects were nonsmokers in this study agreed with the smoking ban. Smokers, in turn, were divided, with half agreeing and half disagreeing that prohibition. When asked specifically about the EPQU-HCRP, there was a decrease in the overall number of favorable responses to the smoking ban. Most non-smokers and only a third of smokers agreed with the prohibition of cigarette use during hospitalization in EPQU-HCRP. As explained previously, the patients could smoke in EPQU-HCRP until June 2009 when it was given its ban. Therefore, patients were already accustomed to a ward where he was allowed the use of cigarettes, ie, there was a certain "pro-smoking culture of patients" [5]. This could explain the differences in the responses of these groups as to permit smoking in EPQUs and service where this study was conducted.

Most non-smokers reported feeling uncomfortable or uneasy in hospital environments where smoking is permitted. There were expressions of dissatisfaction with the fact that they are exposed to secondhand smoke, the effort to tolerate smoking in such environments, uncomfortable with the smell of cigarettes, complaints about feeling sick and headache. On the other hand, smokers, due to the habit itself, denied any difficulty or discomfort and suggested the reserved area for smokers in the wards. Nonsmokers, on the other hand, expressed the idea that smoking cessation in hospital could serve as a stimulus for smoking cessation after hospital discharge.

Despite the differences observed between smokers and nonsmokers, most subjects of both groups agreed with the current approach of HCRP-EPQU the use of NRT as a nicotine patch, ensuring a smoke-free atmosphere in the service.

Final Considerations

Knowing the opinion of people who will be under the care of a health team, especially in situations of hospitalization, facilitates the approach of situations that may raise issues or even conflict, as is the restriction or prohibition on the use of some substance by the individual. In this study, it was revealed differences of opinion in smokers and nonsmokers about the mentally ill to prohibit smoking in psychiatric care services. Despite these differences, there was agreement from respondents about the voluntary use of NRT by smokers throughout their stay in EPQU-HCRP, given that recommended by state law that banned smoking in indoor environments.

The care team has an active role in the inclusion of patients in the different services available in the network of health care. In this sense, needs to provide conditions so that patients get along with each other and with professionals in an environment of harmony. Work behavior in relation to tobacco use among smokers and nonsmokers implies improve their interaction and help them to adopt a healthy lifestyle, enhancing the protective factors of individual and collective health. The care team must be aware of the fact that offer smoke-free environment in the health services may be the beginning of a therapeutic process to encourage the cessation of smoking. It is hoped, therefore, that professionals address the issue of smoking in its entirety, i.e., not only regarding its prohibition, and the introduction of NRT in treatment, but investing in prevention and awareness of the smoker to seek smoking cessation treatment.

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