Published in final edited form as:

J Dual Diagn. 2014 ; 10(4): 204–211. doi:10.1080/15504263.2014.961883.

Public Commenting on Inpatient Psychiatry Smoking Ban Media Coverage

Cati Brown-Johnson, PhD [Postdoctoral Fellow],

Stanford Prevention Research Center, Department of Medicine | Stanford University, Medical School Office Building, X316, 1265 Welch Road, Stanford, CA 94305-5411, USA, catibj@stanford.edu

Ashley Sanders-Jackson, PhD [Postdoctoral Fellow], and

Stanford Prevention Research Center, Stanford University School of Medicine, 1070 Arastradero Road, Suites 100 and 300, Palo Alto, CA 94304-1334, USA, asnsande@stanford.edu

Judith J. Prochaska, PhD, MPH [Associate Professor of Medicine]

Stanford Prevention Research Center, Department of Medicine | Stanford University, Medical School Office Building, X316, 1265 Welch Road, Stanford, CA 94305-5411, USA, T 650-724-3608, F 650-725-6247, jpro@stanford.edu

Abstract

Objective—Individuals with mental health concerns are disproportionately affected by, and suffer the negative consequences of, tobacco use disorder, perhaps because smoking has historically been part of psychiatry’s culture. In the early 1990s, psychiatric inpatient facilities were exempted from US hospital smoking bans, in response to public outcries with national media attention. Almost two decades later, the current study characterizes online conversation about psychiatric hospital smoking bans. Previous commenting studies have demonstrated commenting’s negativity, documenting the “nasty effect” wherein negative comments color perceptions of neutral articles. Thus, we focused particular attention on cited barriers to implementing health-positive smokefree policies.

Methods—We collected online comments ($N=261$) responding to popular media articles on smoking bans in inpatient psychiatry between 2013 and 2014, and conducted an inductive and exploratory qualitative content analysis.

Results—Verifying previous studies documenting the prevalence of negative commenting, of the comments explicitly supporting or refuting psychiatry smoking bans, there were over twice as many con comments (44) than pro (18). Many commenters argued for access to outdoor smoking areas and warned of patient agitation and risk posed to care workers. Identified content themes included psychiatric medication and negative side effects, broken mental health systems and institutions, denigration of the health risks of tobacco in the context of mental illness, typical pro-smoking arguments about “smokers’ rights” and alternatives (including e-cigarettes), addiction, and stigma.

Conclusions—The current findings provide a platform to begin to understand how people talk about mental health issues and smoking. Our analysis also raised complex issues concerning forces that impact US patients with serious mental illness, but over which they have little control, including medication, the US health system, stigma, perceptions that life with chronic serious mental illness is not worth living, and psychological and physical pain of coping with mental illness. In consideration of identified barriers raised in opposition to smoking bans in inpatient psychiatry, efforts should emphasize patient stakeholder involvement; patient, visitor, and staff protection from smoke exposure; the effectiveness of nicotine replacement for managing withdrawal; and the lack of evidence that cigarettes are therapeutic.

Keywords

smoking ban; psychiatric inpatient; schizophrenia; stigma

Tobacco is a major problem for individuals with mental health concerns, who are at greater risk of heart and lung disease and shortened life expectancy (Centers for Disease Control and Prevention, 2013; New York State Department of Health, 2012). People diagnosed with schizophrenia have a smoking prevalence of 62% in the US, triple that of the general population (Chapman, Ragg, & McGeechan, 2009).

Smoking has been part of psychiatry's culture -- normalized in mental health institutions by clinicians smoking with patients (Dickens, Stubbs, & Haw, 2004; Lawn, 2004), and providing cigarettes to assuage patient agitation (Lawn, 2004) or increase treatment compliance (Wye et al., 2009). Historically, the tobacco industry has attempted to link tobacco use and psychiatric symptom mitigation, funding research in the 1980s to investigate tobacco as "an efficient form of 'self-medication' ...this would be significant bonus for the tobacco industry" (Knott & Royal Ottawa Hospital, 1983). This particular researcher (Knott) continues to study smoking effects on mental health (see Fisher et al., 2012). Despite steady population declines in smoking, tobacco use has remained high among those with mental illness or addictive disorders, a group estimated to consume half the cigarettes sold in the US (Centers for Disease Control and Prevention, 2013; New York State Department of Health, 2012).

Individuals with mental illness have not been afforded equal protections from tobacco exposure. In 1992, The Joint Commission, which accredits and certifies US health care organizations, mandated hospitals to ban smoking nationally. In response to patient advocacy groups and media attention that emphasized patients' needs and rights to smoke (Miller, 1995), the Commission exempted psychiatry units (Beemer, 1993; Taylor et al., 1993). More than 20 years later, The Joint Commission's smoking bans still do not apply to psychiatry.

Growing recognition of the negative health consequences of secondhand smoke exposure to patients, visitors, and staff (U.S. Department of Health and Human Services, 2004; Wye et al., 2010) has led to voluntary adoption of smoking bans in inpatient psychiatric facilities, which has been less difficult than anticipated (Lawn & Pols, 2005). Among US state-run inpatient psychiatric facilities, the proportion with complete smoking bans has increased

from 20% in 2005 to 79% in 2011 (Schacht, Ortiz, & Lane, 2012), despite tobacco industry work to overturn hospital smoking bans (Offen, Smith, & Malone, 2013).

The news media has infrequently covered the tension around tobacco use in inpatient psychiatry. A search for “smoking ban” AND “mental health” or “psychiatric inpatient” AND “hospital” or “facility” and their plurals in the Lexis Nexis media database identified only one US article published between 2003 and 2013. Appearing February 7, 2013 on the front page of the *New York Times*, the headline read, “Smoking, once used to reward, faces a ban in mental hospitals” (Belluck, 2013). The article, nearly two years in the making, quoted patients, researchers, and clinicians, and drew from material in a study of the tobacco industry’s efforts to promote tobacco use among those with serious mental illness (Prochaska, Hall, & Bero, 2008). The *New York Times* article generated a good deal of online public comment in response. Using Google news alerts, to follow additional print and online media coverage on the topic subsequent to the *New York Times* article, we discovered eleven related articles appearing between 2/7/13 and 6/1/14, two of which also had online comments.

Since The Joint Commission’s 1992 exemption of inpatient facilities, little effort has been made to revisit public opinion vis-à-vis psychiatric inpatient smoking bans, and the way people talk about smoking bans is poorly understood. Attending to that gap, our goal was to characterize the conversation about smoking and smoking bans for individuals with serious mental illness as a first step towards understanding public sentiment on this topic. Though the comments analyzed in this study are modest in number ($N=261$), they represent a snapshot of reactions and provide initial data on the landscape of online discussion surrounding this issue. In particular, we wanted to use the opportunity of the *New York Times* article and subsequent news coverage of the topic to describe perceived barriers to and benefits of smoking bans in inpatient psychiatry.

As more readers access newspapers digitally (Moos, 2012), commenting and social media recommendations (e.g. “likes”) are increasingly available and popular (Li, Wang, Chen, & Lin, 2010). One reason to investigate online comments in a high-profile media outlet like the front page of the *New York Times* is that exposure to online comments and information through social media may affect attitudes (Walther, DeAndrea, Kim, & Anthony, 2010) and behaviors. In online discussion of politics, “the nasty effect” of commenting has been observed: readers of neutral articles with nasty comments developed more negative opinions of article topics (Anderson, Brossard, Scheufele, Xenos, & Ladwig, 2013).

In 2011, 25% of American adults read online comments about individual experiences or medical issues. Few studies have investigated online commenting in the area of health promotion. One tobacco-related study of public commenting examined online postings regarding Australia’s plain cigarette packaging and found that while a minority of relevant articles had associated comments, those that were posted were primarily negative (Freeman, 2011). Research of online comments in health contexts on YouTube found that negative videos (on Tourette’s Syndrome) were associated with a larger volume of commenting (Fat, Sell, Barrowman, & Doja, 2012), while personal “real life” videos (on epilepsy) received the most favorable empathetic scoring and informative videos tended to be neutrally or

negatively received (Lo, Esser, & Gordon, 2010). Further, there is some evidence of the effect of comment emotionality. In a study of anti-marijuana public service announcements (PSAs) on YouTube, a higher degree of agreement with commenters made readers more vulnerable to being swayed in their attitudes toward marijuana by the emotionality (positive or negative) of comments (Walther et al., 2010).

Applying qualitative content analytic methods, the current study aimed to describe and characterize public commenting in the context of a high-profile publication on psychiatric inpatient smoking bans and subsequent news coverage on the topic in order to provide mental health administrators a comprehensive view of potential attitudes towards, and particularly continued resistance to, smoking bans in psychiatric inpatient facilities.

METHODS

Data

We gathered data from publicly available online sources beginning with the publication of the *New York Times* article on 2/7/13. The institutional review board of the University of California, San Francisco deemed this study exempt from review because it involved existing information that is publically available. The day after publication, 213 public comments had been posted to the *New York Times* online site in response to the article, totaling over 15,000 words. To provide a sense of the relative volume of interest in the topic, the median number of comments on front-page articles published in the *New York Times* on the Thursday before and after the inpatient psychiatry article was 134. We conducted ongoing Google searches through July 2014 for “smoking ban,” and “mental health” or “psychiatric inpatient”, and “hospital” or “facility” and their plurals, yielding 11 additional articles, of which 2 included comments (27 in *Time*; 21 in *Care to Share Magazine* blog), bringing the total comment dataset to 261.

Participants (Comment Characteristics)

Our 261 comments had a total of 20,234 words (15,895 *New York Times*, 1748 *Time*, and 2591 for *Care to Share*). *New York Times* commenters ($n=136$) reported their location: 27 states, the District of Columbia, and all regions of the continuous US were represented as well as international locations such as the UK (*Time* and *Care to Share* commenters did not indicate their location). Although identity of commenters could not be verified in this context, commenters from all three sources identified themselves as stakeholders invested in the area of mental health and smoking, including self-identified patients, family members, facilities staff, physicians, and taxpayers. Assuming no one reposted under alternative names or pseudonyms, most commenters posted one comment, median = 1, interquartile range (1, 1). The commenter with the largest number of posts (14) had three original comments; the rest were responses or clarifications.

Analyses

We conducted a qualitative content analysis of themes examining what was discussed. Themes were content coded in a qualitative, unstructured manner, per conventional qualitative content analysis in health contexts (Hsieh & Shannon, 2005). We emphasized an

inductive approach, which is an exploratory, a-theoretical approach best suited to topics or methods with few previous studies (Elo & Kyngäs, 2008). Our specific distributed, team-oriented method of analysis included: 1) independent close readings of comments by authors 1 & 2; 2) identification of potential themes distilled into a research note with quotes highlighting emerging themes reviewed and reworked conceptually by author 3; 3) further review and discussion in Dr. Prochaska's research team of two licensed psychologists; a practicing addiction psychiatrist; a psychiatry resident; and four postdoctoral fellows in public health, tobacco control, psychology, linguistics, and communications; 4) independent coding of comments for themes using the revised research note (authors 1 & 2); 5) conversations between authors 1 & 2 to reconcile differences in coding (3 hours total); and 6) additional review by author 3 and feedback from the research team in an iterative process incorporated into the final paper.

Issues of triangulation, credibility and trustworthiness are imperative to valid qualitative analysis. Triangulation in qualitative analysis lessens opportunities for individual bias (Patton, 1999) by using multiple coders to independently assess themes and by diversifying data sources. For coder triangulation, we employed a dual independent coder approach with feedback from a diverse expert team. To address source triangulation, we included comments from two subsequent news sources on the topic of smoking bans in psychiatric inpatient settings, in addition to the original article comments. Verifying consistent findings across sources also helped us establish that the original comments were representative of broader views, which speaks to credibility of data and analysis (Cutcliffe & McKenna, 1999). Finally, with respect to trustworthiness and the ability to reproduce results or have our findings challenged in an informed way, our data and final coding assessments are available upon request.

RESULTS

Nearly a quarter ($n = 62$, 23.8%) of the comments explicitly supported or refuted smoking bans, with more than twice as many con comments (44) than pro (18). Many argued for access to outdoor smoking areas, warning of agitation among patients unable to smoke and the risk they pose to care workers.

We identified six non-exclusive primary themes and numerous secondary themes summarized in Table 1 and discussed below. Thirteen non-categorized comments were non-content responses (e.g., "You're right") or concerned irrelevant side-discussions.

Theme 1: Psychiatric Medication and Side Effects discussed smoking and nicotine as a treatment for mental illness and represented 31.4% of all comments. Commenters mentioned a myriad of psychiatric medication side effects, such as "weight gain," "diabetes," and "metabolic syndrome", and medications were generally recognized as "awful," neither adequately addressing psychiatric needs, nor treating without detrimental side effects. Fervently cited reasons to oppose smoking bans in inpatient facilities were the "significant (mental) health benefits" of smoking and the challenges of living with serious mental illness. Commenters argued that the risks of smoking were "balanced" by positive management of mental health disorders including depression, schizophrenia, attention-deficit, and

Alzheimer's. Furthermore, commenters often presented smoking as a calming ritual. One commenter even asserted, "There is a biological basis for the need ... to smoke" in individuals diagnosed with schizophrenia. Infrequent opposition identified smoking as a complicating factor to treatment for people in psychiatric care. Separate from tobacco, after "eliminating smoke inhalation," comments presented nicotine as "relatively harmless" and potentially therapeutic.

Theme 2: Mental Health Systems and Institutions, described by some as a "home," were criticized by others, with specific instances of extreme patient abuse. Some commenters called for a "vast overhaul" of the mental health care system. Comments discussed smoking as a last "pleasure" for patients within environments that are "lousy." Further, bans were viewed as likely to cause aggression on the units and drive mentally unstable individuals out into the streets, but e-cigarettes were promoted as a viable substitute for cigarettes. Other commenters described institution successes with complete smoking bans that provided patient access to "real fresh air." Another argument in favor of smoking bans emphasized costs for treatment of patient tobacco-related illnesses: "...Who pays for the medical care and support of the patients... who die of smoking-related illnesses?"

Despite this call for bans, many commenters perceived inadequate support for cessation: "the system will come to the rescue if they struggle with food, rent, utilities, and so on - but not cigarettes." Another commenter highlighted inequalities in health protections afforded the general population (e.g., New York City's ban of trans fat) compared to the lack of health protections for psychiatric inpatient populations. Some commenters suggested starting small without mandates, "by just offering support and programs including alternatives to cigarettes (sic) for those who are willing to try to quit." Others opposed the ban because of it being a perceived barrier to care, and argued that individuals would not seek help in inpatient settings if smoking bans were in place.

Theme 3: Morbidity and Mortality of Tobacco vs. Mental Illness comments centered on discussion of psychiatric symptoms, quality of life, and premature mortality associated with tobacco use versus serious mental illness. One line of reasoning contrasted the risks from tobacco use with other risks specific to mental illness, such as suicide. A significant minority of commenters took the position that having a shorter life would be desirable compared to living with serious mental illness:

let's see: these people are in a sense terminally ill....they will not have enjoyable, productive, creative lives. so their cigarettes should be withheld so they can live LONGER? (emphasis in original)

Comments that advocated benefits of a shortened lifespan for people with serious mental illness underscored: 1) the extreme psychological pain of mental illness; 2) a potential lack of value placed on patients' lives; and 3) a nihilistic perspective of mental illness, which was construed as chronic and deadly (see Table 1 for examples). Notably, this line of reasoning – that death is preferable to mental illness – did not originate from commenters who identified as having a mental health diagnosis.

This position did not go unchallenged; some family members countered with personal perspectives positively equating non-smoking with longevity and one commenter likened smoking in psychiatric facilities to Nazi programs: “a modern-day, slow rolling version of the Nazi T-4 Program that euthanized mentally and physically disabled citizens.” Commenters described tobacco-related diseases as “a very painful way to die” and identified secondhand smoke as putting people nearby “at risk on a daily basis.”

Theme 4: Smokers’ Rights and Alternatives comments characterized tobacco control efforts as controlling and shaming: “nannying”, “micro-managing”, “draconian measures”, “puritanical.” A frequent rhetorical device used to justify delaying tobacco bans denigrated the proposal by noting all the other things that need prioritization to better the lives of people with mental illness and schizophrenia diagnoses, e.g., “rally for more research into schizophrenia and the development of new drugs.”

The comments emphasized the rights of smokers, including the legality of smoking. One commenter called with exasperation for the “right” of diagnosed individuals to smoke: “Let these poor souls smoke. My goodness.” Here, after establishing the legality of smoking, a commenter offered as a “sort of compromise” the use of e-cigarettes, which simulate the act of tobacco smoking and were presented as a no-risk way to smoke.

Theme 5: Addiction was discussed in relation to nicotine and other substances and struggles with quitting smoking. While commenters shared their own experiences (e.g., “God, I miss smoking”) and advocated not quitting because of the difficulty of overcoming addiction, some discussion highlighted how tobacco addiction affects psychiatric treatment and understanding of symptom sequelae:

.... Cigarettes are extremely (sic) addictive, they reduce the effectiveness of medications and cause people with mental illness to loose (sic) ability to control their symptoms. Once addicted, people will make excuses like it helps with anxiety or helps their symptoms...

Commenters emphasized the need for treatment in relation to addiction: “...we need to find improved methods for helping people break their addiction to nicotine.” Lastly, staff smoking affected by bans addressed addiction: “What about the NURSES at all hospitals who stand outside the hospitals during their breaks, in every kind of whether (sic) SMOKING to feed THEIR nicotine addiction?” (emphasis in original).

Theme 6: Stigma was the smallest of the thematic groups, yet the strongest affectively in content and tone. Stigma emerged in the comparison between psychiatric inpatient facilities, “mental institutions,” and prisons. Confinement references borrowed terminology from prisons: “for life,” “incarcerated,” “sequestered.” One comment blatantly summed up perceived connections between confinement scenarios and underscored stigma: “There is not much difference in the populations in those two types of institutions [jails and inpatient psychiatric facilities] anymore. Prisons are overflowing with mentally ill people.”

Some instances of stigma were subtler. The sibling of a patient simultaneously supported patients by explicitly delineating the impact of stigma (“they [people with schizophrenia

diagnoses] are treated as freaks by society in general”), while still echoing a critique of the value of a life lived as a person diagnosed with schizophrenia:

... I would find it worse to deprive her [commenter’s sister] of this small pleasure [cigarettes] when schizophrenics have so few pleasures... Life may be prolonged, but is the quality any better. It’s not an easy decision.

This comment posited a stigmatizing perspective that even minimal positive experience would be preferable for patients regardless of detrimental risk.

DISCUSSION

Content analysis of comments to a front-page *New York Times* article and two associated articles on smoking and psychiatric inpatient facilities provides mental health practitioners and tobacco control advocates with valuable information about the barriers to enacting smoking bans in psychiatric inpatient facilities. This analysis also raises complex issues concerning the forces that impact US patients with serious mental illness on a daily basis, but over which they have little control, including medication, the US health and mental health systems, public stigma toward mental illness and smoking, a public perception that life with chronic serious mental illness is not worth living, the psychological and physical pain of coping with mental illness, and the public cost and personal value of patients’ lives and well-being.

People with serious mental illness experience significant barriers to health beyond their disease. These *New York Times*, *Time*, and *Care to Share* comments highlight the perceived impact of system-wide policies on patient health, not just with respect to smoke-free hospitals, but also with regard to medication side effects, impoverished care facilities, and health care system changes. Findings indicated that certain topics and themes did not originate from patients themselves in this limited context. For instance, individuals identifying themselves as patients did not invoke the subtheme that life with serious mental illness might not be worth living. Hence, we argue that patients have a unique perspective on their experience in psychiatric inpatient facilities, and every effort should be made to include their voices in policy decision-making, both at a national level and at individual facilities. To that end, research has shown high levels of patient support for indoor smoking bans in psychiatry settings, even among current smokers (Wye et al., 2010).

Smoking bans are an important tool for smoking cessation (Borland, Chapman, Owen, & Hill, 1990; Mills, Messer, Gilpin, & Pierce, 2009) likely due to denormalization of smoking behavior (Brown, Moodie, & Hastings, 2009; Thrasher, Perez-Hernandez, Swayamkapala, Arillo-Santillan, & Bottai, 2010) and increased inconvenience to smoke (Borland et al., 1990). Facilities looking to reduce health risks to their patients and staff by instituting a smoking ban should consider their constituencies and form alliances prior to logistical ban discussions, as has been suggested for tobacco control efforts with other marginalized populations (Balbach & Campbell, 2009; Raebeck, Campbell, & Balbach, 2010). Cigarettes are highly addictive; hence, smoke-free inpatient psychiatric facilities must provide proper medical support and, as appropriate, equivalent or increased smoke-free time outdoors for patients. Reviews of units adopting smoking bans have identified greatest success with

100% smoking bans (indoor and out), supported by leadership, with cessation medications to manage withdrawal (Lawn, 2005; Lawn & Pols, 2005). Furthermore, tobacco smoking induces the metabolism of some psychiatric medications resulting in reduced therapeutic levels and higher doses being required; clinical attention to these medication interactions is needed along with patient education (Zevin & Benowitz, 1999). Despite limited data on their safety and efficacy as a cessation aid, e-cigarettes are gaining in public awareness and use (Pepper & Brewer, 2014), and commenters recommended e-cigarettes as a substitute option for the hospital setting. Research is needed on the impact of emitted e-cigarette ultra-fine particulates on indoor air.

Efforts to institute smoking bans in inpatient psychiatry may learn from the wide array of responses analyzed here, including those that seem the most extreme, which may provide insight into likely opposition arguments (Freeman, 2011). Our study findings corroborate results from an Australian study where public news comments about plain cigarette packaging included “nanny state” smokers’ rights arguments and assertions that other health issues are more important (Freeman, 2011). A pro-tobacco argument unique to our comment data posited shorter life expectancy being preferable for patients with mental illness. Awareness of highly emotional negative arguments such as this is important since hyperbolic negative comments have been shown elsewhere to impact public opinion (Anderson et al., 2013).

Study limitations included a small dataset; limited ability to identify the population expressing these ideas, and thus no way to ascertain who the sample is; and the possibility of intrusion of special interest agendas or inflammatory “trolls” who enjoy creating controversy. Further, these results may not be generalizable to places outside the United States, particularly those in the non-English language-speaking world, or in very different tobacco control contexts (e.g., New Zealand). Additionally, patients and their family members did not participate in data coding and interpretation, which in future research could contribute useful insights.

Public opinion on smoking bans in psychiatric inpatient settings is an underexplored area. We thoroughly searched news sources to find all articles related to inpatient psychiatric smoking bans between the time points of interest and synthesized information that may be helpful to administrators considering implementing smoking bans. Our study, however, is limited in that we characterized *communication* about smoking bans, which is related to, but not equivalent to, public opinion. Furthermore, it is likely that these commenters were not representative of the general public, since the readership of the *New York Times* is non-representative of people in the United States. Finally, previous research has found that negative comments affect reader perceptions. To guard against the possibility that coders were impacted by negative comments, they coded items in chunks, separated by at least two hours. Though the coders discussed the coding scheme, they coded items separately to avoid overlap simply due to agreement.

Despite limitations, this study provides initial insight into the current landscape of opinion on smoking in inpatient psychiatry settings. Content analysis of comments to a *New York Times* article on smoking bans for psychiatric inpatient facilities and two subsequent articles

on the same topic demonstrated: 1) the value of language data analysis in revealing rhetorical approaches to a polarized health issue; 2) the richness of comment data with respect to instances of mental health stigma; 3) the range of responses to smoking in the context of treatment for mental illness, and schizophrenia specifically; and 4) the potential pushback administrators and policy-makers may encounter when seeking to enact a smoking ban in psychiatric settings. At minimum, this analysis captured the extremes of reaction, which should be known and ideally addressed by officials attempting to enact smoking bans in psychiatric facilities. In this context, future smoking ban efforts in psychiatry may benefit from emphasizing the rights of patients to equal protection from secondhand smoke exposure, the effectiveness of nicotine replacement to treat tobacco withdrawal in-hospital, and the lack of evidence that smoking cigarettes is therapeutic.

ACKNOWLEDGMENTS

We wish to acknowledge Pam Belluck, the reporter of the original *New York Times* article of interest.

DISCLOSURES

Drs. Brown-Johnson and Sanders-Jackson report no financial relationships or receipt of compensation from commercial interests, including organizations, institutions, companies, individuals, and intermediaries such as sub-contractors or conference organizers, in any of the previous three years. Dr. Prochaska is Principal Investigator on an Investigator Initiated Research Award funded by Pfizer and has served as an ad hoc scientific advisor to the company.

FUNDING

This work was supported by grants from the National Institutes of Health including #T32 CA113710, #R01 MH083684, #P50 DA09253, and #CA-113710; and by the State of California Tobacco-Related Disease Research Program (#17RT-0077 and #22-FT-0081).

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Table 1

Identified Primary and Secondary Themes ($N = 261^*$)

Themes	Number of Comments n (%)	Quotes
<i>Theme 1 Psychiatric Medication and Side Effects</i> Discussion of medication, side effects, nicotine/cigarettes as medication, drugs, and nicotine (as a substance)	82 (31.4%)	"I see a widespread myth developing that psychiatric medications are doing more harm than good; even making people crazy." "If nicotine helps makes (sic) people feel better and reduces symptoms they ought to have access to it, preferably with the safety (sic) possible delivery method..."
<i>Theme 2 Mental Health Systems and Institutions</i> Discussions of abuse, patient care, standards for involuntary commitment, use of cigarettes as rewards, and mentions of mental health facilities	85 (32.6%)	"When the hospital moved into a brand new building, smoke breaks ceased, and patients were given the patch. A few complained, but most accepted it. Instead of euphemistically referring to smoke breaks as "fresh air" breaks, the patients actually got real fresh air..." "... New York City is so concerned about the health of the general population that it outlawed big, sugary soft drinks and trans fat. Yet psychiatric patients are permitted to smoke while in the hospital..."
<i>Theme 3 Morbidity and Mortality of Tobacco vs. Mental Illness</i> Mentions of death, quality of life, and symptoms having to do with tobacco or mental illness	67 (25.7%)	"I know my smoking will shorten my life, so will my suicide. As one who fights that every day, I say leave people alone. Sometimes smoking is the least of their worries." "the usual motive for not smoking – prolonging life – may be of dubious benefit to those confined..." "...Seem (sic) arrogant and cruel to take that [smoking breaks] away. If you were incarcerated in one of these institutions, you might not see it as a problem to shave 5–10 years off your sentence."
<i>Theme 4 Smokers' Rights and Alternatives</i> Perceived "right" of smoker to control the time, manner, and place of consumption e-cigarettes, discussed as alternatives to cigarettes Subthemes included: a) the legality of smoking; b) science deniers, who were also categorically resistant to the smoking ban; and c) rhetoric of smoking as a "choice," primarily included in comments that opposed smoking bans in psychiatric inpatient facilities	63 (24.1%)	"Let's not forget that most of these patients are legal adults and should be allowed to smoke outside if they wish." "They [patients with psychiatric disorders] are not in a prison and smoking is legal. They should not have to suffer more than their disease is causing them to. Perhaps e-cigarettes are some sort of compromise."
<i>Theme 5 Addiction</i> Addiction to any substance	37 (14.2%)	"I used to smoke years ago and realize that it is a strong addiction. It is something you always want to enjoy but rarely do." "Many people are missing the points here. Cigarettes are extremely addictive, they reduce the effectiveness of medications and cause people with mental illness to lose ability to control their symptoms. Once addicted people will make excuses like it helps with anxiety or helps their symptoms, but the cigarettes are just pushing back withdrawal symptoms that start up when they haven't had a smoke for an hour or so."
<i>Theme 6 Stigma</i> Explicit discussion of stigma as a factor with respect to smoking, schizophrenia or mental illness; negative portrayals or discussion of negative portrayals of smoking, schizophrenia or mental illness as dirty, wrong, or something to be ashamed of or to hide from others	23 (8.8%)	"Let me get this straight: you label a person as mentally ill, stigmatize him, medicate him, and now take his cigarettes away. So he will now need another drug to calm himself and curb his nicotine addiction. Who wins here? The pharmaceutical and medical industries." "Where did anyone say smoking is good and they are for it. I for one am definitely against it but I am against people being stigmatized because they are addicted to a legal substance. It's okay to do drugs, illegal, drink, legal, but smokers are ridiculed and harassed."

* 213 public comments were on the *New York Times* article, 27 on the *Time* article, and 21 on the *Care to Share Magazine* blog