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# A time to quit

Experiences of smoking cessation support  
among people with severe mental illness

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LGB&T Partnership

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## Contents

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	Acknowledgements	3
	Executive summary	4
1	Introduction	5
2	Why are people with severe mental illness less likely to quit?	7
3	What commitments have been made and what targets have been set?	9
4	What works for smoking cessation in people with severe mental illness?	13
5	How should services be organised and delivered?	19
6	How does this project fit into the picture?	23
7	The experiences of people with severe mental illness of smoking cessation	29
8	What do people with severe mental illness want from smoking cessation services?	30
9	What support do services currently provide, and what challenges and opportunities do they face?	19
10	Conclusions	22
	References	31
	Appendix	30

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## Executive summary

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The aim of this report is to introduce practitioners, commissioners and policymakers to some of the key themes and evidence around the needs of people with severe mental illness and what is known about successful approaches to smoking cessation.

Based on the first-hand experiences of service users and published research, it brings into focus some of the challenges and complexities of this subject, and it provides a starting point for those looking to provide more effective smoking cessation support to people with severe mental illness. The primary focus is on smoking cessation in the community, but inpatient and residential settings are also discussed.

People with severe mental illness have very much higher rates of smoking than the general population, and those who do smoke are more likely to be heavy smokers. An estimated 50% of deaths of people with severe mental illness are from smoking-related illnesses. Yet rates of wanting to quit are about the same as for the general population.

There are numerous barriers to people with severe mental illness quitting smoking. These include myths about the risks of giving up smoking to mental health and perceptions that it will be more difficult for someone with a mental illness. This sometimes stops health professionals from offering help to people who might want to quit smoking.

There is evidence from research that what helps people with severe mental illness to quit smoking is broadly similar to that for the general population, including behavioural techniques, medication and help from peers, families and friends.

People with severe mental illness would like more help to quit smoking, including help to find the right time for them, holistic and personalised support, access to the full range of effective therapies, support from social networks and incentives to reduce or quit smoking.

To help them to do this, it is important that health professionals are trained in how to support people with severe mental illness in smoking cessation techniques, for psychiatric medication to be adjusted when people stop smoking, and for ongoing help to be offered to sustain quit attempts.

# 1. Introduction

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People with severe mental illness have significantly poorer physical health than the general population. This includes a higher risk of cardiovascular disease, various cancers, metabolic conditions and, ultimately, reduced life expectancy (Chang *et al.*, 2011; Chesney, Goodwin & Fazel, 2014). Smoking contributes disproportionately to these health inequalities.

People with severe mental illness are more likely to smoke than the general population (RCP, 2013; Szatkowski & McNeill, 2015) and to smoke more heavily (Szatkowski & McNeill, 2015); and some people with severe mental illness may be at increased risk of smoking-related illness compared to the general population, even after adjusting for clinical and demographic factors (Krieger *et al.*, 2019).

However, people with severe mental illness are often found to be as motivated as the general population to stop smoking (Szatkowski & McNeill, 2015) but, historically, have not received the same benefits from smoking cessation programmes (Cook *et al.*, 2014). As a result, the prevalence of smoking in people with severe mental illness is falling at a slower rate than in the general population, leading to increasingly unequal health outcomes (Dickerson *et al.*, 2017; NHS Digital, 2018).

It has been estimated that 50% of deaths of people with severe mental illness are due to tobacco-related illnesses and that smoking may account for two-thirds of the difference

in life expectancy between current smokers with severe mental illness and never-smokers without severe mental illness (Tidey & Miller, 2015; Tam, Warner & Meza, 2016). There is widespread recognition that this inequality is unacceptable and must be addressed (RCP, 2013; Passey & Bonevski, 2014; ASH, 2016; Firth *et al.*, 2019).

## Definition of terms

### *Severe mental illness*

Severe mental illness refers to psychological problems that are often severe enough to seriously limit a person's ability to work and do day-to-day activities. It includes, but is not limited to, severe and enduring psychotic disorders, personality disorders and mood disorders.

Diagnosable eating disorders are also widely recognised as severe mental illnesses; however, owing to the special clinical considerations of weight management in these cases, they will not be included in this report.

### *Smoking cessation*

Of most interest to this literature review are interventions that result in an individual stopping smoking completely and permanently. However, harm reduction options, which lead to lower smoking rates, will also be considered, especially as a means to an end of abstinence.

## 2. Why are people with severe mental illness less likely to quit?

This section will focus on factors relating to the individual. External factors, such as the design and delivery of smoking cessation interventions and the attitudes of clinicians, will be discussed in a later section of this report.

### Level of addiction

There is evidence that some smokers with severe mental illness may be more dependent on nicotine compared to the general population. The evidence of this association comes mainly from people with schizophrenia diagnoses (Freeman *et al.*, 2014; Scott *et al.*, 2018). A UK population-based study found that quit attempts in people with common mental health conditions were less likely to be successful than those among the general population, but this association disappeared when adjusted for heavy smoking (Richardson, McNeill & Brose, 2019). This suggests that the more heavily a person smokes, the lower the likelihood that a quit attempt will be successful. However, in understanding this relationship, it may be important to note that a retrospective analysis of 1,604 smokers from the general population found that smoking intensity did not independently predict the likelihood of successful smoking cessation with a telephone-based intervention; instead, success was strongly associated with confidence in quitting (Ni *et al.*, 2018).

### Perception of quitting as difficult

Richardson *et al.* (2019) in a UK population-level study found that individuals with common mental health conditions were more likely than the general population to perceive giving up as difficult. A UK-based cohort study of 491 smokers with severe mental illness and those without found that the former experienced a greater increase in anxiety when they made an

unsuccessful quit attempt (McDermott *et al.*, 2013). Therefore, the relationship between perceived failure, relapse, anxiety, motivation, and a perception of quitting as difficult is complex.

### Impact of smoking on mental health

It is often believed that people with severe mental illness smoke because it helps them to manage their symptoms. The evidence supporting this hypothesis is weak (Smith, Homish, Giovino & Kozlowski, 2014; Sharma, Gartner & Hall, 2016; Prochaska, Das & Young-Wolff, 2017). It is possible that this belief, irrespective of the evidence, could affect the likelihood of an individual making a successful quit attempt via its effect on their confidence in their ability to stop smoking. Educational approaches that dispel misconceptions combined with nicotine replacement therapy (NRT) to reduce the effects of nicotine withdrawal may be helpful. Notably, smoking cessation has been shown to be associated with reduced depression, anxiety and stress, and improved positive mood and quality of life compared with continuing to smoke (e.g., Taylor *et al.*, 2014). However, this finding cannot be generalised to people with severe mental illness and highlights an area that requires further research. More specifically, the possible mental health benefits to people with severe mental illness when quitting smoking.

### Withdrawal symptoms

When making a quit attempt, smokers with severe mental illness experience more severe nicotine withdrawal symptoms than smokers in the general population (Smith *et al.*, 2014). One US-based study found that, among psychiatric inpatients, the following groups experienced the most severe withdrawal symptoms:

- Women
- African American participants
- Participants with polysubstance misuse
- Those with more severe mental illness
- Those with greater cigarette dependence (Soyster, Anzai, Fromont & Prochaska, 2016).

As a result, it may be that people with severe mental illness would benefit disproportionately from NRT and from education about nicotine and nicotine withdrawal (misconceptions about the safety of NRT are common [Bobak *et al.*, 2010]).

### Social networks and norms

Smoking spreads through social networks, as does quitting (Christakis & Fowler, 2008; Aschbrenner *et al.*, 2019). This literature review did not identify any UK data on whether people with severe mental illness had more smokers in their social networks than others; however, an Australia-based study did find that smokers with severe mental illness were more likely to live with another smoker (Metse *et al.*, 2019). Additionally, a US-based study of 124 smokers with severe mental illness found that uptake of smoking cessation medication and group therapy was influenced by perceived social norms, especially those of family and friends (Aschbrenner *et al.*, 2015).

### Boredom

There is evidence that people with severe mental illness smoke to help relieve boredom (Peckham *et al.*, 2016; Lum, Skelton, Wynne & Bonevski, 2018). Whether they do so at a higher rate than the general population is unclear. This finding has led to a recommendation that, as part of quit attempt, practitioners should help people with severe mental illness to identify meaningful activities to relieve boredom (Peckham *et al.*, 2016; Huddleston, Sohal, Paul & Ratschen, 2018).

### Compliance

In a cohort study based in Denmark, Rasmussen *et al.* (2018) compared the effectiveness of a smoking cessation intervention among smokers with and without severe mental illness (4,388 and 21,023 individuals, respectively). At 6-month follow-up, the overall quit rate in smokers with severe mental illness was 29% - significantly lower than the 38% in those without. The strongest predictor of success in quitting was compliance, defined as attending at least three-quarters of the planned meetings. However, because the study did not explore the reasons for the lower rates of compliance among smokers with severe mental illness, it is unclear what approach would successfully address this problem.

## 3. What commitments have been made and what targets have been set?

### Government

The UK Government has set out in its Tobacco Control Plan an ambition to make England smoke-free by 2030 (DHSC, 2017). This is defined as reducing smoking rates to less than 5% of the population. The plan includes pledges in relation to ‘parity of esteem’ for people with mental health conditions.

### NHS Long Term Plan

The NHS has made a commitment to improve physical health support for people with severe mental illness. The NHS Long Term Plan focuses on ensuring that all patients (in general acute, mental health trusts and both adults and teenagers) admitted overnight, pregnant mothers and higher risk outpatients (including those accessing specialist mental health and learning disability services) are offered access to tobacco dependence treatment and smoking cessation services (NHS England, 2019).

### Public Health England

The recent Public Health England five-year strategy commits to taking action to help to achieve the Government’s ambition for a smoke-free future. Its pledges include supporting the NHS’s plans for smoking cessation and advising local authorities on their stop smoking services, “including increasing targeting towards groups and local areas with the highest need” (PHE, 2019).

### NICE guidelines

#### ***Smoking: acute, maternity and mental health services [PH48]***

In brief, the guidance for inpatient services set out by NICE is:

- Identifying people who smoke and offering help to stop, including intensive support in acute and mental health services, and maternity services

- Providing information and advice for carers, family, other household members and hospital visitors
- Advising on and providing stop smoking pharmacotherapies, and making these available in hospital
- Adjusting drug dosages for people who have stopped smoking
- Putting referral systems in place for people who smoke
- Developing smoke-free policies and commissioning smoke-free secondary care services
- Supporting staff to stop smoking and providing stop smoking training for frontline staff.

There is also a NICE guideline for stop smoking services in communities and primary care, NG92 (NICE, 2018). It includes detailed recommendations for local authorities in commissioning and providing stop smoking services and lists people with mental health problems as a priority group for the provision of evidence-based interventions.

### CQC

The CQC have set out what evidence it would, ideally, like to see evidenced around implementation of smoke-free environments in mental health inpatient services. It notes that “... inspections should not challenge smoke-free policies... Instead, focus should be paid on whether such a ban is mitigated by adequate advice and support for smokers to stop or temporarily abstain from smoking with the assistance of behavioural support, and a range of stop smoking medicines and/or e-cigarettes. Inspections should also consider whether alternative activities are in place and promoted, including regular access to outside areas.”

## 4. What works for smoking cessation in people with severe mental illness?

There is evidence that what works for the general population also works for people with severe mental illness (Banham & Gilbody, 2010). The subsections below will focus on studies with people with severe mental illness wherever possible. However, where research is limited or unavailable, findings from research into the general population and people with common mental health conditions will be cited.

### Starting a conversation and providing advice

According to NICE guidelines, practitioners should ask all people accessing mental health services about their smoking status and encourage all smokers to stop completely (NICE, 2013a & 2014). Action on Smoking and Health (ASH) have published guidance for mental healthcare professionals to help them trigger an attempt to quit among the patients who smoke (ASH, 2019). Very Brief Advice (VBA), the model of support they recommend, is a three-step intervention designed to be delivered in as little as 30 seconds: ASK establishing and recording smoking status; ADVISE advising on the most effective way to stop; and ACT offering help by, for example, referral to a stop smoking service or prescribing medication.

### Behavioural interventions

The main psychosocial interventions used in smoking cessation are educational, motivational and cognitive-behavioural. The most commonly used delivery methods are one-to-one, group and via telephone. However, these interventions more often form the backdrop to studies of pharmacotherapy. As a result, for people with severe mental illness, the optimal frequency, duration and format of behavioural interventions and overall effectiveness has not been established (Evins, Cather & Laffer, 2015; Peckham *et al.*, 2017). There is also some evidence that contingent reinforcement, in the shape of cash incentives, can help to reduce smoking in people with schizophrenia (Tsoi, Porwal & Webster, 2013). Incentives have also

been successfully used to improve other health behaviours in the short term among people with severe mental illness (Tidey, 2012; Priebe *et al.*, 2013; Farholm & Sørensen, 2016). For the general population, Individual counselling (e.g., Lancaster & Stead, 2017), group therapy (e.g., Stead, Carroll & Lancaster, 2017), and telephone counselling (e.g., Matkin, Ordóñez-Mena & Hartmann-Boyce, 2019) have all been shown to be effective methods of offering behavioural support. Yet, the most effective and most widely recommended smoking cessation interventions are those that combine pharmacotherapy with behavioural support (Stead, Koilpillai, Fanshawe & Lancaster, 2016; NICE, 2017).

### Pharmacotherapy

There are three main pharmacotherapies prescribed for the treatment of smoking dependence in England: NRT, bupropion (Zyban) and varenicline (Champix) (NHS Digital, 2018). NRT is normally prescribed as a combination therapy, i.e. a long acting patch for slow release and then a quick acting gum/lozenge/spray for use when needed.

Research has shown that both on their own and in conjunction with other treatments, all three are efficacious and tolerable for smoking cessation in people with severe mental illness. In trials, bupropion and varenicline have been associated with higher levels of smoking cessation than NRT; and the efficacy of all three in people with severe mental illness is similar to that in the general population (Tsoi *et al.*, 2013; Anthenelli *et al.*, 2016; Roberts *et al.*, 2016; Peckham *et al.*, 2017). The large scale EAGLES trial (Anthenelli *et al.*, 2016) found that varenicline and bupropion were not associated with an increase in moderate-to-severe neuropsychiatric events relative to nicotine patch or placebo in those with psychiatric disorders or those without. The efficacy of the treatments did not differ by cohort, with varenicline being superior in efficacy to bupropion and nicotine patch.

In this context, maintenance treatment refers to continuing (and tapering) smoking cessation pharmacotherapy after the initial treatment period has ended. In trials, maintenance treatment has significantly reduced relapse rates in people with severe mental illness (Evins *et al.*, 2014; Evins *et al.*, 2017).

For the general population, the most effective and most widely recommended smoking cessation interventions are those that combine pharmacotherapy with behavioural support (Stead, Koilpillai, Fanshawe & Lancaster, 2016; NICE, 2017). The trial of SCIMITAR+, an intervention combining these techniques for people with severe mental illness, are summarised in Box 1.

### Box 1: SCIMITAR+ trial (Gilbody *et al.*, 2019)

#### What was the bespoke smoking cessation intervention?

- An intervention from the Manual for Smoking Cessation Training was adapted to cater for people with severe mental illness. The adaptations included:
  - Making several assessments before setting a quit date;
  - Offering NRT before setting a quit date ('cut down to quit');
  - Recognising the purpose of smoking in the context of a person's mental illness;
  - Providing individual house visits (up to 12 lasting approximately 30 minutes);
  - Providing additional face-to-face support after an unsuccessful quit attempt or relapse;
  - Informing a primary care physician or psychiatrist of a successful quit attempt so that medication can be adjusted accordingly.
- The intervention was delivered by a trained mental health smoking cessation practitioner who worked in conjunction with the participant and the participant's primary care physician or mental health specialist.
- Practitioners advised participants on the range of smoking cessation pharmacotherapies, but the final decision was based on participant preference.

#### Participants

- Participants were motivated-to-quit adults with an SMI diagnosis who smoked at least five cigarettes a day.
- Participants were randomised either to treatment as usual (statutory smoking cessation services available at no direct cost in the UK) or to the bespoke intervention.
- The most common diagnoses were schizophrenia (65%), bipolar disorder (22%) and schizoaffective disorder (13%).

#### Findings

- The chances of successful quitting at the six-month follow-up were more than twice as high in participants who received the bespoke intervention.
- At 12-month follow-up, the difference in the proportion of participants who had quit in the two conditions was not significant, but motivation to quit was higher in the intervention group.
- There was no evidence that either intervention was harmful to mental health.

## Peer support and social support

There is currently limited evidence in the use of peer support. A systematic review found only one study that met the inclusion criteria (Ford, Clifford Gussy & Gartner, 2013), which demonstrated a significant reduction in smoking at both the one- and six-month follow-ups. Additionally, there is some evidence that support will be more effective if it is provided by someone from the individual's existing social network (Aschbrenner *et al.*, 2015; Lawn, Bowman, Wye & Wiggers, 2017), and preliminary research has been carried out into the skills needed by family and friends to motivate smokers to seek treatment through a pilot called Care2Quit (Aschbrenner, Patten & Brunette, 2018; Brockman, Patten & Lukowski, 2018).

## Smoke-free policies

Five years after the policy of making mental health inpatient wards smoke-free was initiated, Cancer Research UK, the Mental Health and Smoking Partnership and ASH carried out research on its uptake and outcomes (CRUK/MHSP/ASH, 2019). They found that, by 2018, 79% of the 39 mental health trusts surveyed had implemented comprehensive smoke-free policies, and one of the benefits reported by staff was increased motivation among patients to stop smoking. Yet, the same study found that patients frequently found ways to smoke on hospital grounds, despite smoke-free policies being in place. This had limited the cultural change achieved by the smoking ban and, by making smoking more hidden, reduced the potential for conversations about behaviour change to take place. Finally, even if bans were to be successfully and universally enforced, the ethical issue around removing inpatients' right to choose remains controversial (Woodward & Richmond, 2019).

## Harm reduction

Harm reduction refers to interventions designed to lower the use of tobacco cigarettes, instead of stopping abruptly. Given that the health benefits of reduction are small compared to abstinence, it is only recommended as a means to an end of complete cessation (Begh, Lindson-Hawley & Aveyard, 2015). A Cochrane review of reduction-to-quit interventions in the general population found that people who cut down their smoking gradually were no less likely to quit than those who stopped abruptly (Lindson *et al.*, 2019). The SCIMITAR+ trial for people with severe mental illness included a 'cut down to quit' option as part of its smoking cessation intervention (see Box 1).

## E-cigarettes

Public Health England has endorsed e-cigarettes as a harm reduction smoking cessation aid for the general population (PHE, 2015). They are not, however, a licensed medication and are not completely harmless. A UK-based RCT with 886 participants (Hajek *et al.*, 2019) compared e-cigarettes accompanied by behavioural support (one-to-one sessions with a local clinician) to NRT accompanied by behavioural support. E-cigarettes were more effective than NRT for smoking cessation. However, because e-cigarettes are a relatively recent addition to the market, research is in its infancy. Reviews of the evidence note the need for more trials, especially as the technology continues to evolve (PHE, 2018a) and concerns about safety remain. In general, there is currently a paucity of rigorous research on the use of e-cigarettes by people with severe mental illness. The evidence available does provide some initial support around the use of e-cigarettes in reducing use of tobacco (Pratt *et al.*, 2016; Hickling *et al.*, 2018).

## Links with psychiatric medication

There is evidence that smoking reduces the impact of some psychiatric medications (RCP, 2013). This has important implications for the prescribing of those medications when someone stops smoking:

“Patients who smoke are therefore likely to need higher doses of these drugs to achieve similar blood levels to non-smokers, and in the event of stopping smoking need to reduce the doses used to compensate for this effect.

This applies in particular to clozapine and olanzapine, two commonly used antipsychotic medications... Adverse clinical outcomes arising from rapid increases in blood levels of these drugs after stopping smoking have been reported... Clinical guidelines recommend reducing doses of these drugs by around 25% during the first week after stopping smoking, and monitoring blood levels before and at weekly intervals after stopping smoking until levels have stabilised.” (RCP, 2013, p92)

## 5. How should services be organised and delivered?

It has been noted that the quit rates achieved by people with severe mental illness in clinical trials are often much higher than those observed in the real world (Cather, Pachas, Cieslak & Evins, 2017). This suggests that something about the way services are organised and delivered is undermining the potential effectiveness of smoking cessation interventions (Huddleston *et al.*, 2018).

### Concordance with guidelines

In the past, research has found low levels of compliance with guidelines among primary and secondary care, and stop smoking services (McNally & Ratschen, 2010; McDermott *et al.*, 2012; Szatkowski & McNeill, 2013). More recent research suggests that, although there have been improvements, typical practice is still falling short of best practice (Huddleston *et al.*, 2018). For example, the SCIMITAR+ trial found that few participants were prescribed varenicline by their primary care physician, despite evidence that it is the most effective form of pharmacotherapy and safe for use in people with severe mental illness. The survey of smoke-free policy and practice in mental health trusts in England found that, on a typical mental health ward, only half of trusts ask about smoking status. And when smokers are identified, only a third always give advice about abstaining from smoking (CRUK/MHSP/ASH, 2019; Gilbody *et al.*, 2019). This implies that policies and guidelines need to be clear, easy to follow and hard to ignore.

### Culture, norms and misconceptions

There is a widespread perception that smoking is the 'norm' among people with severe mental illness, and there are also common misconceptions about the relationship between smoking and mental health. For example, an Australian survey completed by 256 family members of individuals with severe mental illness who smoked found prevalent

misconceptions related to the benefits of smoking (e.g., quitting would worsen mental health symptoms).

Research has also explored the attitudes of staff working with smokers with severe mental illness (Sheals, Tombor, McNeill & Shahab, 2016; Simonavicius, Robson, McEwen & Brose, 2017). Mental health professionals have been found to hold negative and permissive attitudes toward smoking and smoking cessation among people with mental illnesses. Barriers to mental health professionals providing effective support for smoking cessation included their own smoking behaviour, viewing smoking as the 'norm' among people with severe mental illness, and believing that smoking acts as an important coping mechanism or helps the person feel better.

Cancer Research UK, Mental Health and Smoking Partnership and ASH (2019) found that one of the biggest barriers to implementing smoke-free policies in the UK was staff resistance to the cultural shift the policies required (e.g., a concern that the policy impinges on their therapeutic relationship with patients). It is therefore important that the concerns and views of mental health professionals are considered and addressed in the implementation of policies to support smoking cessation.

### Staff training

In 2013, the Royal College of Physicians recommended that all mental health professionals should receive mandatory training to understand smoking issues, deliver brief advice, and provide support or signposting to available cessation support (RCP, 2013). However, a recent survey of mental health trusts in England found that in only 16% were all staff trained in VBA for smoking cessation (CRUK/MHSP/ASH, 2019). Other research has found that only 58% of mental health nurses and

43% of psychiatrists in England had received smoking cessation training (ASH, 2019) and among stop smoking advisers, mental health training is relatively low (Simonavicius *et al.*, 2017; ASH, 2019). There is initial support from an 18-month UK-based pilot study to show the effectiveness of staff education, compared to baseline, in better capturing of smoking status, reducing smoking rates, and increased confidence among staff to initiate smoking cessation conversations (Rethink Mental Illness, 2016).

### Using technology

There is interest in using more recent technology to deliver smoking cessation interventions. Research focusing on people with severe mental illness is in its early stages (Naslund *et al.*, 2017; Vilardaga *et al.*, 2017; Klein, Lawn, Tsourtos & Agteren, 2019). It has been more extensively studied in the general population. A Cochrane review of mobile phone text messaging and app-based interventions found that they showed promise in increasing the quit rate, either delivered on their own or as an add-on to other treatments (Whittaker *et al.*, 2019). A systematic review of internet interventions found they were equivalent to telephone and face-to-face counselling, in terms of effectiveness (Graham *et al.*, 2016).

### Service co-ordination and integration

The majority of people with a severe mental illness receive community rather than hospital treatment for all or the majority of the time. It is therefore vital that smoking cessation support follows people who move between inpatient and community services (in both directions). A systematic review and meta-analysis of five RCTs found that patients who were provided with post-discharge smoking cessation support are able to maintain their abstinence, or reduce their cigarette use, for longer than those who were not provided with support (Brose, Simonavicius & McNeill, 2018).

However, historically, integration and co-ordination have not proved to be straightforward. One barrier is lack of agreement about who should be responsible for co-ordinating physical health care in mental health settings (Rodgers *et al.*, 2018). Another is the increasing diversity in the ways in which treatments are offered. A report jointly produced by Cancer Research UK, Mental Health and Smoking Partnership and ASH (2017; 2019) notes that, because some local Stop Smoking Services have been decommissioned or replaced with 'lifestyle' services, it is becoming more difficult for mental health services to put referral pathways in place.

## 6. How does this project fit into the picture?

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We collected data from two primary groups: people with lived experience and commissioners/practitioners. Separate surveys and interviews were conducted with each group, with questions focused on different aspects of smoking cessation. Focus groups were also conducted with service users to explore their experiences around past smoking cessation support. The commissioner/practitioner survey

was completed by 27 respondents, primarily working within NHS settings. The second survey was completed by 37 service users who self-reported as having a SMI and were either active or ex-smokers. Seven focus groups were carried out to explore the issues in greater depth than the surveys. Follow-up interviews were conducted with smaller numbers of service users and other stakeholders.

## 7. The experiences of people with severe mental illness of smoking cessation

This section will review the major themes that emerged from the lived experience participants, from the focus groups and completed surveys, related to their experiences of being offered or asking for support to quit smoking tobacco.

### Understanding the high rates of smoking

A range of views were provided by focus group attendees to explain the reasons for continuing to smoke. Smoking as a method to manage stress and emotions was a common response amongst participants but, also, for many the habit helped to alleviate boredom and provide opportunities for removing themselves from a situation:

*“Smoking is quite relaxing, and goes well with alcohol, it is a way to give yourself a break”.*

*“Cigarettes would calm me down, I’d experience stress and think: ‘I need a fag’, it was a way of coping with stress. I was smoking 60 a day and didn’t think it was possible for me to ever give up”.*

Social factors indicated the importance of smokers being part of their social network as a contributing factor for continuing to smoke. For instance, people felt that there would be less opportunities to socialise if they gave up smoking.

Many participants felt that smoking was a personal choice and were often more reluctant to discuss quitting in comparison to making changes to their diet to manage their weight.

### Confidence in ability to quit

Several participants said they did not have the confidence about their ability to stop smoking, with many indicating how difficult they found even contemplating it.

Generally, participants felt that services did not provide the right type of support, with many insisting that to stop smoking required a great deal of willpower and self-determination:

*“...you basically have to do it by yourself; there’s not really much out there. You’ve got to do it on your own”.*

For a small number of participants “fear of failing” and “past failures” further impacted on the person’s sense of self-efficacy around smoking cessation. It was also not uncommon for participants to indicate that smoking cessation was rarely brought up by healthcare professionals but rather instigated by the participant. The perception that quitting is too challenging for a person with severe mental illness is often expressed by mental health professionals, and this may, indirectly, affect the person’s own beliefs about the likelihood of success. In addition, for some participants, symptoms of severe mental illness, such as auditory hallucinations (i.e., voices commanding a person to smoke), seriously impacted on the person’s belief that even contemplating a quit attempt was unrealistic.

The survey data highlighted that respondents typically felt that their mental health affected their ability to stop smoking (33 of 37). The majority indicated that their mental health increases their dependence on tobacco (22 of 37). Conversely, only a minority of respondents indicated that their mental health affected their ability to engage in smoking cessation programmes (9 of 37) or made it harder to access support to stop smoking (3 of 37).

### Motivation to quit

The two main themes from the focus groups that typify the motivations for quitting related to cost and concerns for physical health. Interestingly, the smoke-free policy adopted by the NHS was only reported by one participant as being a motivating factor to quit. The general cost of smoking was highlighted by many as a significant factor in motivating them to quit: “When you think about losing that £10, it makes a big difference. You put that in your pocket and can save up for months”. However, it was suggested during one of the interviews that

it can be difficult to save “...in practice as it just gets swallowed up by something else for example food... but you always find money for fags”.

Concerns about physical health were commonly raised by participants as a reason to quit. Family were often cited in tandem to concerns about the impact of smoking on physical health, for instance, premature death and subsequently not being there to support their family: “It’s important to stay well for your family so you can be there if they need you”.

Health scares were often cited as being substantial motivating factors in determining to quit: “It took a heart attack to make me stop”. These physical health concerns might also be a source of worry that, for some, are an additional burden in the process of managing their mental health:

*“I like being healthy, and realised that smoking is actually and basically a health problem in the main...I didn’t want to be that person that deliberately messes up my health. I didn’t want to add that to my mental health concerns.”*

### Access to support

Several participants discussed a lack of access to a full range of options to support their quit attempt. For instance, NRT was often the only option made available to someone with severe mental illness. Many participants were either unaware of the full range of pharmacotherapy options (i.e., Bupropion, Varenicline), or they were never offered. There was some suggestion that these were being withheld from participants, and this could be related to the previous “black box warning” (i.e., communicate potential rare but dangerous side effects) designation for drugs such as Varenicline. Participants outlined several problems around the use of NRT (e.g., skin irritation, non-adherence, taste):

*“Some people say that patches make you itch; they’re uncomfortable and don’t really work”.*

A range of other service rationing issues was also cited as a significant barrier to stop smoking. These included funding cuts to local

stop smoking services, healthcare professionals being unaccountable (e.g., “Chemist and Doctor were both confused – passed from pillar to post”), or GPs not having enough resources available to support patients to stop smoking. In addition, substantial travel difficulties to the destination of a stop smoking service, for example, where the distance is considered too far, reduced the likelihood of engagement.

### Relapse in mental health

Smoking was described as a tool for stress management in the focus groups, and many participants talked about a fear that quitting smoking would bring about a relapse of mental illness. Some were apprehensive that drugs such as varenicline would directly affect the stability of their mental health. Conversely, during a mental health relapse some participants felt that there was little to no support in helping them to maintain smoking abstinence. Rather, it was felt to be almost inevitable that a person would begin smoking once more during a relapse.

### Poor knowledge among health professionals

Generally, participants expressed concern at the perceived lack of knowledge held by healthcare professionals (e.g., GPs, mental health practitioners, psychiatrists) about key factors in supporting or undermining smoking cessation for people with severe mental illness. There was a common perception that healthcare providers did not understand the specific needs of people with severe mental illness and their reasons for smoking. Consequently, for some participants, this lack of understanding was viewed as an impediment to engaging with professionals and the cessation programmes themselves. Timing was considered a pivotal factor in determining whether to engage smoking cessation services:

*“I think it has to be from health professionals at the right time. If you don’t want to give up then you are not going to listen. I didn’t find it helpful when health professionals just told me to give up, it is wrong and that doesn’t support you.”*

## 8. What do people with severe mental illness want from smoking cessation services?

This section explores the emergent themes from the focus groups and survey, outlining key aspects of service delivery that would better support a quit attempt. The themes to be discussed here are the need for a personalised and holistic approach, specialist advice and support, non-judgemental and emotional support, harm reduction, and incentivised interventions.

### Personalised and holistic approach

The majority of participants identified the need for a personalised approach to the design and implementation of a quit smoking plan. There was a consensus, in terms of the range of approaches expressed, that a ‘one size fits all’ approach was inadequate. This consensus included a range of approaches that some found helpful and others less so. What was clear was that overcoming the initial first steps of quitting often led to an increase in confidence to maintain abstinence:

*“I tried to wean myself off and this gave me the confidence that I could do it. I would recommend this for giving yourself confidence and allowing it to feel realistic”.*

Half of survey respondents indicated that personal characteristics (e.g., determination, willpower) were a factor in aiding a previous quit attempt. Therefore, any approach would benefit from drawing on or helping to enhance these personal qualities.

The range of interventions suggested by survey and focus group participants included one-to-one support, group sessions, psychological/behavioural interventions, NRT, medication, vaping, harm reduction, and advice/information. Many participants expressed a desire for services to become more holistic, by taking a whole person approach to supporting a quit attempt and better understanding a person’s present mental health:

*“Not making it taboo – realising that there are positives to smoking, and to stop vilifying it. This then doesn’t create a feeling of shame or stigma around accessing support”.*

Promoting a personalised and holistic approach to support would enable the opportunity for a ‘continued’ and ‘open’ dialogue around a person’s smoking habit. Furthermore, the ‘right time to quit’ could be identified together, with a third of survey respondents stating that timing was a reason for not accepting help.

### Specialist advice and support

Largely, it was felt that smoking cessation services should be provided by a specialist with knowledge of issues for specific client groups. This included not only severe mental illness but also issues faced by, for example, LGBTQ+ communities. A number of participants requested that prescription of pharmacotherapy, including NRT, should be undertaken by their mental health team (e.g. by a psychiatrist). The idea of a step-down service for people leaving hospital, where a smoke-free policy was enforced, would help to support a continued quit attempt once discharged.

Evidence from Friends, Family and Travellers’ focus group also emphasised the need for mainstream services to invest time in developing relationships and trust with Gypsy and Traveller communities. This will enable them to fulfil their responsibilities under Public Sector Equality Duty, including to:

- Eliminate unlawful discrimination
- Advance equality of opportunity between people who share a protected characteristic and those who don’t
- Foster or encourage good relations between people who share a protected characteristic and those who don’t.

Complementary to this, mainstream services should ensure they are compliant with the Accessible Information Standard and considerate of how they offer services in an inclusive and non-stigmatising way for people who have low literacy or are experiencing digital exclusion.

A key recommendation we received from participants was around the failure of services to provide accessible information regarding smoking cessation to people with low or no literacy. 45% of FFT's beneficiaries have low or no literacy, and are therefore often excluded from health messages around smoking.

### **Access to all smoking cessation interventions**

Typically, participants were either unaware or not offered the full range of pharmacotherapy that is widely available to the general population. It was evident that healthcare professionals were over reliant on offering NRT as the primary pharmacotherapy. Participants were generally open to the idea of medication, provided that this was supervised by staff with mental health expertise.

### **Support network**

Family was mentioned as a reason for wanting to quit smoking tobacco across the focus groups and survey. A participant from a Gypsy and Traveller community focus group noted the importance of their extended family:

*“Family are the most important thing in your life, and they can support and motivate you”.*

A quarter of survey respondents indicated that support from family and friends was a significant factor in supporting a previous quit attempt.

### **Incentivised interventions**

Rewards and incentives were identified as a useful smoking cessation aid. Goals and rewards for achievement were particularly important. It was felt that these types of intervention were currently lacking in services.

## 9. What support do services currently provide, and what challenges and opportunities do they face?

This section summarises the key themes from the stakeholder interviews and survey data. A range of stakeholders contributed to the interviews and surveys including staff from VCSE organisations, GPs, nurses, public health consultants, academics, commissioners, and mental health professionals. More generally, the stakeholder interviews provided further support to the extant literature on smoking cessation for people with severe mental illness. The emergent themes were resources, training, the smoke-free policy, uncertainty about what works, and vaping.

### Resources and pathways

A quarter of all survey respondents felt that inefficient referral pathways were one of the top three challenges to providing effective smoking cessation services. Several respondents identified the continually changing landscape, in terms of funding and commissioning, as also impeding the efforts of frontline staff:

*“Services constantly going out to tender every three years, causing staffing issues, constant changes to pathways and lack of national campaigns and awareness”.*

The discontinuation of stop smoking services by financially-challenged local authorities and disagreements around who should fund pharmacotherapy for smoking cessation for people with severe mental illness was also expressed as a concern. It was reported that the SCIMITAR+ study had garnered a great deal of interest from NHS trusts wanting to introduce a similar programme. However, the main barrier to uptake appeared to be the cost involved in providing the extra resources required to fulfil the programme requirements. Conversely, setting up a good nicotine replacement therapy programme is a relatively cheap way to improve service provision but cannot be viewed as a comparable substitute to providing the full SCIMITAR+ programme.

Some respondents identified that the NHS Long Term Plan (NHS England, 2019) was a

positive and encouraging sign that could enable specialist teams or staff to be embedded within mental health services.

### Training and knowledge

Interestingly, only a small number of professionals who were surveyed felt that lack of training was a challenge to offering smoking cessation services. Yet, when asked to offer an example of the challenges of commissioning or providing smoking cessation services to people with severe mental illness compared with the general population, 12 of 18 responses could be considered misconceptions (for example believing that it was “harder to quit”, “links between mood and smoking” and “patients suffering so much without it”). This suggests that gaps and misperceptions may be limiting professionals’ knowledge of this topic.

One respondent raised the potential benefits of Motivational Interviewing as a key skill that could be adopted by health professionals in relation to smoking cessation:

*“When I worked in Australia, we were trained in smoking cessation/motivational interviewing (all the nurses)”.*

Motivational interviewing is a therapeutic approach to support behavioural change and perhaps highlights the possibility that many mental health professionals currently possess the necessary skills to effectively support smoking cessation. In this case, the issue would be one of application rather than a lack of skill or knowledge. However, the experiences of service users would suggest that it is not being used in this context, potentially due to a lack of staff time.

### Smoke-free policy

There were two main areas identified by professionals concerning the smoke-free policy, suggesting that it has had mixed results so far in practice. First, it was felt that staff should set

a good example of not smoking in restricted areas. Second, there was a general sense that the smoke-free policy was helping to foster a gradual shift in cultural attitudes around smoking in mental health services (see Box 2

for an example of how the smoke-free policy is being rolled out in Greater Manchester as part of a comprehensive treatment programme offered across the NHS estate).

## Box 2: The CURE Project - Curing tobacco addiction in Greater Manchester

### About the CURE Project

The CURE project is a comprehensive secondary care treatment programme for tobacco addiction. At its heart is systematically identifying all active smokers admitted to secondary care and immediately offering nicotine replacement therapy and other medications, as well as specialist support, for the duration of the admission and after discharge.

The term 'CURE' has been specifically chosen to 'medicalise' tobacco addiction and move away from the stigma of a lifestyle choice to disease treatment. Treating tobacco addiction must become part of the core activity of all clinicians in every part of the hospital.

### CURE aims to implement and deliver the following:

- All patients who are admitted to hospital are asked whether they smoke and their response is recorded in the hospitals' electronic patients records (EPR).
- All smokers are offered immediate Nicotine Replacement Therapy (NRT) at the moment of admission to help alleviate the cravings for nicotine during that admission.
- All smokers are offered specialist support through motivational interviewing and behavioural change support as well as access to additional evidence-based pharmacotherapy treatments for tobacco addiction.
- All smokers are offered further appointments with a specialist team after discharge from hospital to continue their support.
- Hospitals and hospital grounds are to become completely Smoke-free environments for all, supporting smokers in their quest to stop smoking and protecting patients, public and staff from second-hand smoke.

### Implementation of CURE effectively across all areas of the hospital requires the following:

- Training the medical workforce to have the competence and confidence to discuss and initiate the treatment for tobacco addiction with smokers (mandatory training)
- A standardised assessment and treatment pathway for smokers admitted to secondary care, which has now been delivered and implemented at Wythenshawe
- An appropriately resourced Specialist Nurse team to see all smokers admitted to secondary care and design individualised treatment plans including beyond discharge
- Standardised and robust handover of treatment plan to primary care upon discharge
- Culture change within secondary care to embed the treatment of tobacco addiction into all medical teams' day-to-day practice
- IT systems to support the delivery of this programme

### Recent outcomes

- Overall 1 in 5 Smokers abstinent at 3 months post discharge
- Cost £183 per quit

## Fear of failure

Interviewees told us that when people feel like their mental health is precarious, they don't want to take the risk of undertaking a task that is likely to make them feel worse (to be 'set up to fail') or to add another worry when they are entirely focused on recovering. The fear of failure was discussed by a number of stakeholders, and formed part of the rationale for the 'cut down to quit' approach in the SCIMITAR study (i.e. using smaller, more achievable intermediate goals with less of a risk of failure attached).

## Physical health checks

Despite the 60% target in the NHS Five Year Forward View, the national average for physical health checks for people with severe mental illness is around 30%. The physical health check

is a natural setting for starting a conversation about stopping smoking and signposting to other services, especially as the check includes an assessment of smoking status. One stakeholder spoke about operating an incentive scheme for service users, which significantly increased uptake.

## E-cigarettes

For several stakeholders, there was acknowledgement that guidance and policy, both local and national, was somewhat contradictory on the use of e-cigarettes. For instance, while PHE have endorsed the use of e-cigarettes as a harm reduction smoking cessation aid, some NHS trusts do not allow them to be used within hospital grounds. Health and safety (e.g., charging of e-cigarette products) concerns were also raised by stakeholders.

### Box 3: Limitations of the presented evidence

- A majority of the findings have come from participants with schizophrenia. Care needs to be taken when generalising to other mental illnesses.
- A majority of the findings have come from participants who are connected with voluntary sector organisations, with stable mental health at the time of the research and motivated to quit.
- Few studies include long-term (more than 12 months) follow-up data and few have explored relapse prevention.
- The meta-analyses considered in this review often run together findings from inpatient and outpatient settings making it difficult to identify special considerations that apply to each.
- Few studies stratify their findings according to type or severity of severe mental illness; as a result, it is unclear whether all interventions are equally suitable for all people with severe mental illness.
- The needs of populations such as young people, and people who are homeless or have substance misuse disorders, are not well represented in the literature on smoking cessation and severe mental illness.
- A majority of the studies are descriptive rather than experimental.
- Few real-world interventions, as opposed to clinical trials, have been independently evaluated.
- Less is known about preventing uptake of smoking among never-smokers than about helping smokers to quit and not to relapse.
- There have been no placebo-controlled trials of NRT as a single therapy.
- The literature on behavioural interventions is insufficient to support conclusions about the characteristics of programmes that will be most successful.

## 10. Conclusion

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People with severe mental illness are more likely to smoke and to smoke more heavily than the general population. Although the prevalence of smoking is falling in both populations, it has fallen more slowly among people with severe mental illness, increasing further the gap with the general population. This in turn is contributing to the widening gap between the life expectancies of the two populations – an inequality that has been widely recognised as unacceptable and in urgent need of redress.

The reasons for higher smoking rates and lower quit rates are complex and not well understood. The themes that repeatedly emerge from the literature and from our research are:

- 1. Motivation and confidence in ability to quit:** A common misconception is that people with severe mental illness are less motivated to quit, but the evidence consistently says otherwise. However, there is evidence that people with severe mental illness have less confidence in their ability to quit, possibly owing to smoking intensity and misconceptions about the effects of smoking on mental health. Some of this may also be related to low expectations of mental health service staff about people's abilities to quit.
- 2. Smoking intensity:** Heavy smokers with and without severe mental illness have lower success rates when they attempt to quit, and one reason for this appears to be that they have lower confidence in their ability to stop smoking.
- 3. Beliefs about the relationship between smoking and mental health:** Another misconception that may affect quit attempts is that smoking helps to manage mental health symptoms. Evidence has refuted this; however, the belief persists among many people with severe mental illness, their family and friends and their clinicians. One of the factors sustaining this belief may be withdrawal symptoms: people with severe mental illness experience more severe nicotine withdrawal symptoms than the general population and these symptoms may be misattributed to worsening mental health. People on some psychiatric medications may also need lower doses of these drugs when they quit smoking.
- 4. Social networks and norms:** There is some evidence that people with severe mental illness are more likely to have smokers in their social networks. There is also evidence their family and friends and their clinicians are more likely to see smoking as the norm for people with severe mental illness (possibly owing in part to misconceptions about the relationship between smoking and mental health). These networks and norms may negatively affect the confidence that someone has in their own ability to quit; they may also affect the likelihood that smokers with severe mental illness, compared to those in the general population, will be offered any support with a quit attempt by someone who genuinely believes in their ability to quit.

**5. Compliance and relapse:** Quit rates achieved in the real world by people with severe mental illness are typically much lower than those achieved in clinical trials. Two factors that appear to contribute to this are lower rates of compliance with the treatment and higher rates of relapse after treatment compared to the general population. But it is also important to note that in the general population it takes a number of quit attempts for someone to give up smoking completely (Chaiton *et al.*, 2016).

**6. The implementation of interventions and organisation of services:** Another factor that appears to contribute to the lower success rate of smoking cessation in the real world, as compared to clinical trials, is the way in which interventions are implemented and organised. Staff often lack the knowledge and skills needed to effectively support smoking cessation in people with severe mental illness; compliance with guidelines is not high; and there is a lack of integration between mental and physical health care. As a result, typical practice often falls short of best practice.

Few of these factors, however, are set in stone. Evidence-based interventions have demonstrated that people with severe mental illness can successfully stop smoking when the right support is provided in the right way. The right support is pharmacotherapy combined with behavioural support. Varenicline appears to be the most effective stop-smoking medication, but the characteristics of the most effective form of behavioural support are unclear (See Appendix 1 for a more comprehensive list of recommendations adapted from a range of reports).

Key elements of effective practice, and adaptations to the specific needs and circumstances of smoking cessation for people with severe mental illness appear to include:

- Interventions delivered by staff who have been trained in helping people with mental health conditions to stop smoking
- A phased quit attempt instead of abrupt cessation ('cut down to quit')
- Higher than average levels of NRT
- Education about smoking cessation to counter misconceptions held by family, friends, and health professionals, especially around smoking and mental health
- Smoke-free policies in mental health services (implemented in ways that support individuals to quit, including adjustments in psychiatric medication where necessary)
- Involvement of the individual's family and friends to support the quit attempt
- Maintenance treatment to reduce the risk of relapse.

Many of the myths that, historically, have led to acceptance about the disproportionately high prevalence of smoking in people with severe mental illness have been dispelled. Research has demonstrated that people with severe mental illness are motivated to stop smoking, that interventions that work for the general population are both safe and effective, especially when tailored for this population, and that stopping smoking does not lead to a deterioration in mental health. However, misconceptions remain widespread, even among mental health staff and stop smoking practitioners reported in the literature and in the data collected for this report, and there are significant gaps between best practice and typical practice.

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## Appendix 1: Summary of recommendations for smoking cessation in people with severe mental illness

(adapted from ASH, 2016 & 2019, and Association of Medical Royal Colleges *et al.*, 2016)

### Making smoking cessation in people with severe mental illness a priority

- More resources – human and financial – to be made available.
- Ambitious national targets to be set by government, and NHS England, the Department of Health and Social Care and Public Health England to ensure these are prioritised and tied to specific funds.
- Local targets to be embedded in contracts for services working with people with severe mental illness (primary care, secondary care, social care, IAPT and specialist stop smoking services).
- Commitments to be made by the Department of Health Tobacco Control Plan.
- Research funders (such as NIHR, Public Health Research Programme, the Medical Research Council and DH Policy Research Programme) prioritise research into tackling smoking among people with a mental health condition.

### Ensuring best practice is standard practice

- Mental Health Trust Boards, Clinical Commissioning Groups and commissioners of mental health services to ensure that delivery of NICE standards in relation to smoking, specifically PH48 and PH45, is a pre-requisite of services being commissioned.
- The Care Quality Commission (CQC) to provide a short guidance for inspectors of inpatient and community mental health settings of what is needed, including adequate tobacco dependence treatment, access to pharmacotherapy, and appropriate implementation of a smoke-free policy.

- NHS England to develop an appropriate national CQUIN to promote and incentivise NICE recommended treatment for tobacco dependence among people with a mental health condition. (This was implemented subsequently by NHS England.)

### Taking an integrated approach

- Health and Wellbeing Boards to ensure there are co-ordinated local approaches.
- Post-discharge support to be provided to patients after an inpatient admission.
- Clear care pathways to be established.
- Systems to be put in place to ensure appropriate information can be shared between secondary mental health services, primary care, stop smoking services, IAPT and pharmacies.
- Stop smoking services to have clear protocols with local mental health services including development of in-reach and outreach models of support.

### Embedding smoking cessation in mental health services

#### *Mental health staff training*

- Health Education England to support training in the effects of smoking and its prevalence among those with a mental health condition, as well as methods of cessation and harm reduction in standard training for mental health nurses, clinical psychologists, psychiatrists, occupational therapists, psychological therapists and other allied health professionals.
- All staff to be trained in Very Brief Advice.
- All staff to be knowledgeable about the benefits of stopping smoking.
- Undergraduate training (nursing, medical and allied health professionals) to include tobacco dependence in the curriculum.

- Knowledge about evidence-based smoking cessation treatments to be a core competency for mental health staff.
- Education and training to include:
  - How to have conversations with smokers to increase their motivation to reduce/ stop smoking
  - How to assess the severity of tobacco dependence and expired-air carbon monoxide
  - Knowledge of how stop-smoking medicines work and skills to optimise adherence
  - What stop-smoking medication side-effects to expect and how to manage them
  - How to assess and minimise tobacco withdrawal symptoms
  - How to provide intensive behavioural support.

#### *Mental health staff involvement*

- A member of staff to be appointed as a stop smoking champion.
- Staff who smoke to be given support to stop.

### **Embedding mental health in smoking cessation services**

- All services should have a mental health champion.
- All services should routinely ask about mental health and record this information.
- Stop smoking practitioners should be trained in issues around smoking cessation and mental health.

### **Involving service users**

- Mental health settings to appoint service user ‘stop smoking’ champions.
- Service users to contribute to service development, design and evaluation.
- Engagement with service users to be made a priority, minimising the number of people who are lost to follow-up.

### **Involving service users’ support network**

- Carers, friends and family members to be provided with advice and information about how to support a quit attempt.
- Carers to be involved in service development, design and evaluation.

### **Interventions**

#### *Advice and education*

- All smokers to be given advice about the benefits of quitting to physical health.
- All smokers to be informed about evidence-based ways to stop smoking.
- All smokers should be informed about the relative safety of nicotine.

#### *Behaviour change initiatives*

- People to be helped to develop alternative activities to smoking.

#### *Pharmacotherapy*

- Policies to enable timely access to appropriate pharmacotherapy in all care settings.
- All patients to be given rapid access to sufficient NRT upon admission to a smoke-free inpatient facility.
- Combination NRT or varenicline should be seen as first line medications for those wishing to cut down or quit.
- NRT to be a standard part of support for anyone who smokes.
- Access to pharmacotherapy to be easy and affordable.

#### *Peer support*

- Peer support to be made available.

#### *Care plan*

- A plan for quitting, or reducing harm, should be drawn up in collaboration with the service user.

### *Harm reduction*

- Harm reduction to be made available.
- A specific harm reduction plan for those with a mental health condition who do not want to or are finding it difficult to quit.

### *E-cigarettes*

- More research to be carried out with people with SMI.

### *Smoke-free environments*

- All environments in which care is delivered to vulnerable people to be smoke-free.

## **Populations that may have special requirements**

- Provision to be made for:
  - Smokers who do not want to quit entirely
  - Ex-smokers at risk of relapse
  - People in inpatient/residential facilities
  - People leaving inpatient/residential facilities and returning to the community
  - Young people
  - People in prison
  - Women who are pregnant
  - People who misuse drugs and alcohol

## **Research and data**

### *Data collection*

- As part of their Joint Strategic Needs Assessment, Local Authorities to estimate the number of smokers with mental health conditions and the proportion using the available services.
- Commissioners of mental health services

should mandate that there is recording of smoking status at all assessments, including automatic referral to smoking cessation services and an assessment of severity of dependence including CO Monitoring.

- Tobacco use and severity of tobacco dependence to be routinely assessed and recorded for all patients receiving inpatient, community or primary care for a mental illness.
- The Adult Psychiatric Morbidity Survey and the Mental Health and Learning Disabilities Data Set to report detailed data on smoking in people with severe mental illness.
- Smoking status and mental health conditions to be recorded in primary care with data consolidated and shared with local strategic partners including local authority and CCG.
- Recording of smoking status to be built into existing systems and collated by commissioners across a locality.
- Peer researchers to be used wherever possible.

### *Areas in need of investigation*

- A systematic review to be carried out to identify gaps in the evidence.

### *Practice evaluations*

- Investment to be made in evaluating existing and innovative interventions.

### *Translating research into practice*

- Research organisations, health providers, PHE, NHS England, professional bodies and policy organisations to ensure that new research findings are translated into policy and practice.



## A time to quit

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