National Collaborative Commissioning Unit
& Royal College of Psychiatrists Wales

Dyfodol Programme

Smoking & Mental Health

A framework for action in Wales

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CB SEIC COLEG BRENHINOL Y SEICIATRYDDION

GIG CYMRU NHS WALES
Uned Gomisiynu Cydweithredol Cenedlaethol
National Collaborative Commissioning Unit

in collaboration with

RC PSYCH ROYAL COLLEGE OF PSYCHIATRISTS

Public Mental Health Implementation Centre

About this report

This report was commissioned by the Welsh Government as part of the Dyfodol Programme.

The Joint National Collaborative Commissioning Unit & Royal College of Psychiatrists Wales Dyfodol Programme supports the enhancement of secondary care mental health services and delivery of optimal care for those people in Wales with serious and enduring mental illness.

The Dyfodol Programme enables the Welsh Government and national partners to acquire valuable insights in order to plan and commission effectively.

This framework report identifies priority areas for action to help reduce smoking rates among people with mental health conditions in Wales.

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About the PMHIC

The Public Mental Health Implementation Centre (PMHIC) was launched by the RCPsych in 2022. The aim of the PMHIC is to support the improved implementation of evidence-based interventions to treat mental disorders, prevent associated impacts, prevent mental disorders and promote mental wellbeing and resilience. The PMHIC is supporting the Dyfodol programme, a partnership between RCPsych Wales and the NCCU, and collaborating to produce a series of reports on the shared causes of physical and mental ill health.

List of abbreviations

ACE	adverse childhood experience
ASH	Action on Smoking and Health
CMHT	community mental health team
DARE	Database of Abstracts of Reviews of Effects
MI	Motivational Interviewing
NRT	nicotine replacement therapy
PATH	Partnership Action on Tobacco and Health
SMI	severe mental illness

Executive Summary

Smoking contributes to poor mental health, and increases inequalities in physical health and premature mortality. Smoking is a leading contributor to the 7–23-year lower life expectancy among people with severe mental illness (SMI) compared to the general population.

Some mental health professionals feel that providing physical health care is not within their remit. However, providing quitting support in mental health services can be highly effective and can help patients recover from all health problems.

Priority areas for action

We have identified three priority areas for action to help reduce smoking rates among people with mental health conditions in Wales:

1. Address misperceptions about smoking in mental health settings

Staff in mental health settings sometimes feel that smoking is inevitable among patients, and any attempts to help patients stop would be futile. However, large-scale studies have shown that most people with mental health conditions who smoke want to quit and can be just as successful at quitting as people without mental health conditions.

Education and upskilling are needed to address misperceptions among staff.

Staff in mental health settings play an essential role in supporting patients to stop smoking.

This report outlines ways that staff can support smoking cessation, by:

- learning about effective smoking-cessation support
- learning about and practicing trauma-informed care
- completing training in motivational interviewing

2. Improve implementation of quitting strategies in mental health settings

Smoke-free policies in psychiatric settings support quitting, especially when implemented as part of a whole-system intervention approach (1,2). Improved implementation will lead to healthier patients who learn other ways to cope with stress and mental health problems, without smoking.

Upskilling staff to help give patients smoking-cessation support means providing them with accessible training. To achieve this, we need to develop tools and resources for educating staff about interventions and how to implement trauma-informed care.

3. Address the lack of data on smoking and quitting among people with SMI

To take action against smoking, we need to address the gaps in the data in Wales on smoking rates among people with mental health conditions, including SMI. To monitor the success of smoking-cessation programmes, information on the prevalence of smoking and the number of quit attempts needs to be collected. Special attention is needed to ensure that people from marginalised groups, including those who are homeless, immigrants or in prison, are supported to stop smoking. These groups also need to be included in data collection and monitoring.

View our framework for local action to reduce smoking and improve mental health in Wales in Section 3.

Recommendations

1. Provide training resources for upskilling people working in mental health to support smoking cessation, including to address misperceptions among staff.
2. Review and augment the implementation strategy for Help Me Quit and the Tobacco Control Delivery Plan to support people with mental health conditions. This should include co-production with service users.
3. Improve accessibility to nicotine replacement therapy (NRT) and other smoking-cessation medication. People wanting to quit should have access to more than one quitting aid, to improve their chance of success.
4. Address data gaps by collecting reporting information on rates of smoking, including among people with mental health conditions.

Next steps to reduce smoking among people with mental health conditions

1. Develop an implementation strategy for the Tobacco Control Delivery Plan to target people with mental health conditions including SMI.
2. National campaigns promoting positive mental health should include messages about the mental health harms of smoking and the benefits of not smoking. Similarly, national stop-smoking communications should include information on the benefits to mental health.
3. Major gaps in data on smoking and quitting must be addressed. Data is needed to monitor smoking rates across all populations with a mental health condition. Data collection to measure the provision of evidence-based support and the outcome of treatment is also needed.

Contents

1.
Smoking and poor mental health

Smoking and poor mental health

In the 14.1% of adults in Wales who still smoke (3), smoking contributes to poor mental health.

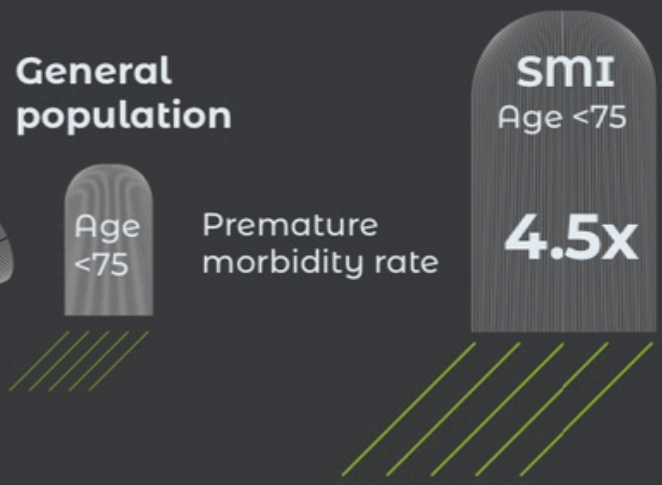
Smoking is more common among people with mental health conditions, and drives inequalities in physical health and premature mortality. We provide evidence that stopping smoking is critical to recovery from mental illness. We also refute common misconceptions about smoking during treatment and recovery.

The factsheet on the next page shows the evidence for smoking contributing to premature death among people with mental health conditions in Wales.

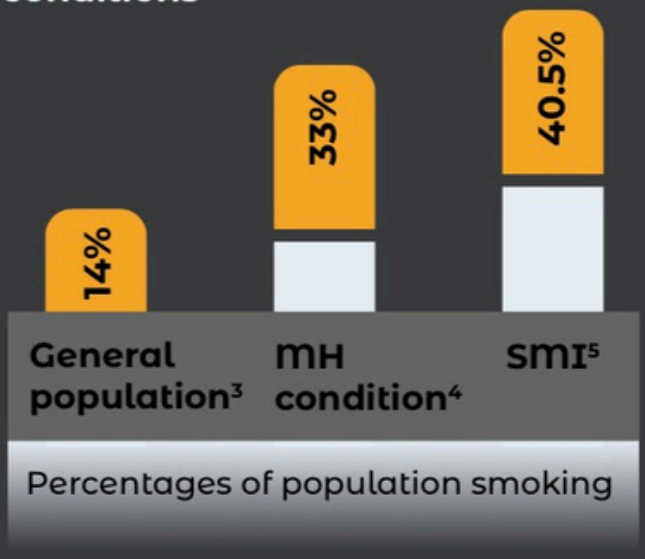
Smoking and premature death among people with mental health conditions: Wales Factsheet

People with serious mental illness (SMI) are 4.5 times more likely to die before age 75 than non-smokers in the general population[1]

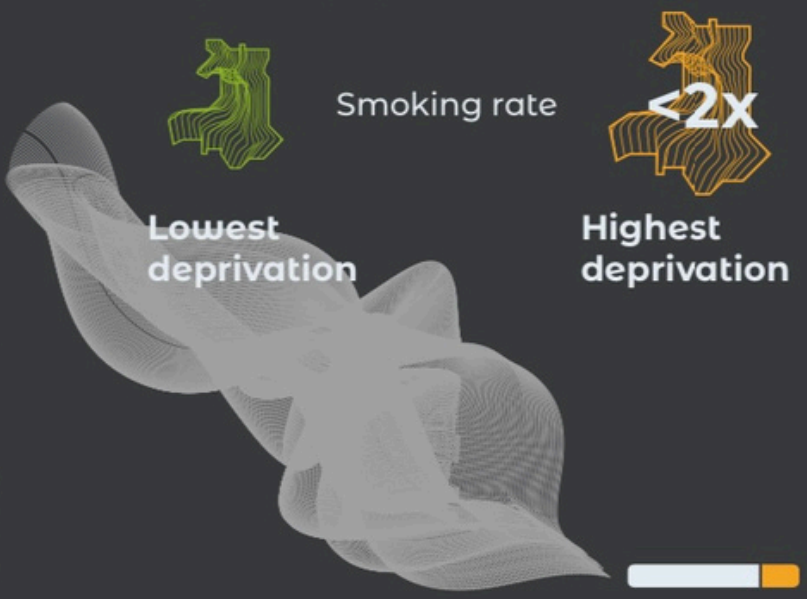
The largest preventable cause of premature mortality is smoking[x]



Smoking is more common among people with mental health (MH) conditions



Smoking rates are higher in more deprived populations in Wales[6]



more than half of current smokers want to quit[7]

Quitting smoking can help support recovery from mental illness

People with MH conditions are often motivated to quit smoking but interventions should be tailored and targeted to better support this group

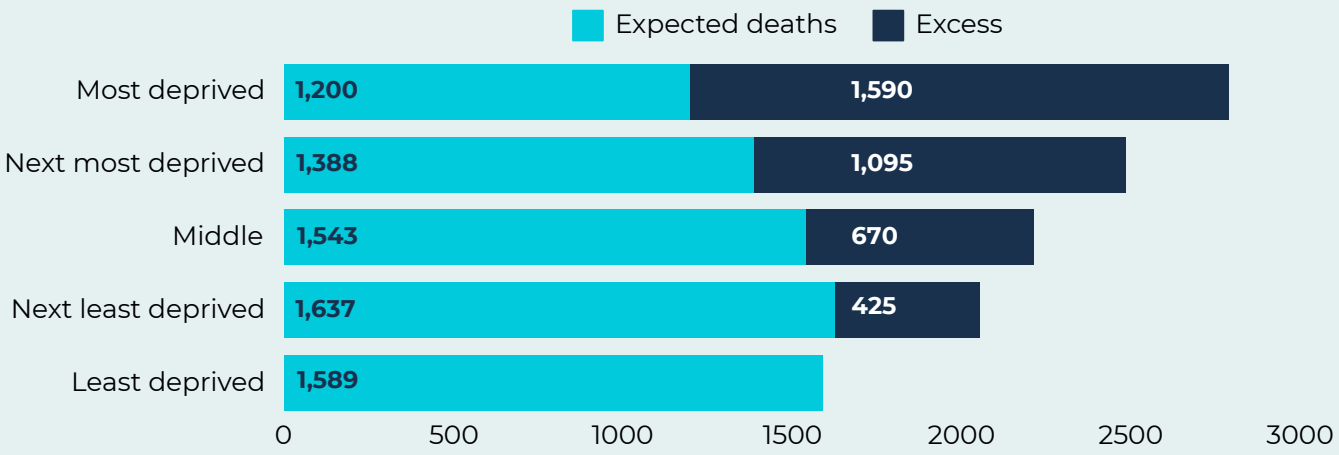
1 Office for Health Improvement and Disparities (2023)
2 NHS digital (2020)
3 Office of National Statistics (2022)
4 ASH Wales (accessed 2023)
5 Office for Health Improvement and Disparities (accessed 2023)
6 NHS Wales (2022)
7 Office of National Statistics (2020)

1.1 Smoking reduces life expectancy among people with mental health conditions and increases health inequalities

Smoking negatively affects both physical and mental health. It is a leading contributor to the 7–23-year lower life expectancy among people with SMI compared to the general population (4), which includes lifelong illnesses such as schizophrenia and bipolar disorder.

Premature mortality and years of life lost are also socioeconomically patterned, with those in the most deprived areas faring the worst. The large gap between expected and excess deaths in the most deprived areas of Wales contributes to 24,500 excess years of life lost (Figure 1). Every life lost early is someone's child, parent, partner or loved one

Premature mortality



Premature years of life lost (YLL)

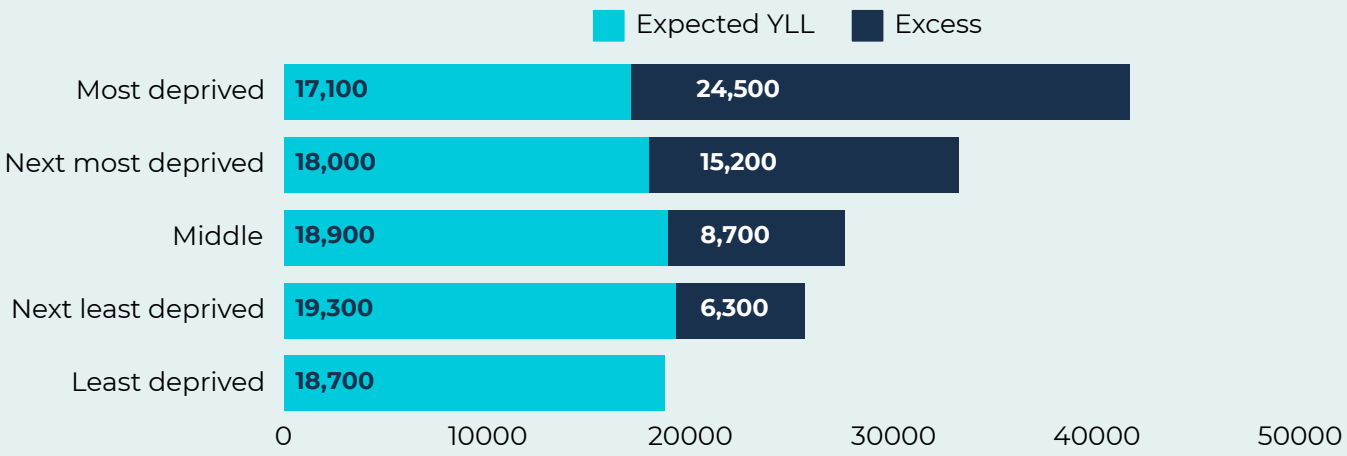


Figure 1: Premature mortality accounts for twice as many years of life lost in the most deprived areas, 2016–20. Source: Public Health Wales

Over 70 years since research proved the deadly impacts of smoking, it remains one of the leading causes of poor physical health and premature mortality. Smoking is, by far, the largest contributor to loss of healthy years of life in Wales (5). Smoking increases the risk of cancer, heart disease, stroke, diabetes, respiratory diseases, and dementia (6,7).

People from disadvantaged backgrounds are far more likely to smoke than better-off individuals. In Wales, the smoking rate among the 20% (quintile) of the population with highest deprivation is more than double the rate of smoking in the least deprived group. Smoking worsens the health inequalities that people with mental health conditions face, due to the impacts on physical health and mental wellbeing.

Therefore, reducing smoking rates among people with mental health conditions is a public health priority to improve their physical and mental health and reduce the premature mortality gap.

1.2 Prevalence of smoking among people with mental health conditions

Despite the robust evidence of a higher rate of smoking among people with mental health conditions compared with the general population, there is a lack of population-based data specific to Wales. Action on Smoking and Health (ASH) Wales and Public Health Wales reported that the smoking prevalence of people with 'mental illness' is estimated at 33% (8), compared with the general Welsh population estimate of 14% (3).

According to the Wales National Review of Patients Cared for in Secure Mental Health Hospitals, most patients in secure hospitals were smokers at the time of admission. The review conducted in 2022 in Wales found that 57.5% of patients were smokers (9).

In Wales, an estimated 14.1% of people are smokers (3). Smoking is much more common (33% prevalence) among people with mental health conditions (for example depression, anxiety) and is even higher among those with SMI (40.5% prevalence) (10–12) (see Figure 2). People with mental health conditions are also more likely to be heavy smokers, however they also report a higher interest in quitting than the general population (13).

Number and Prevalance of Smokers in Wales by Group

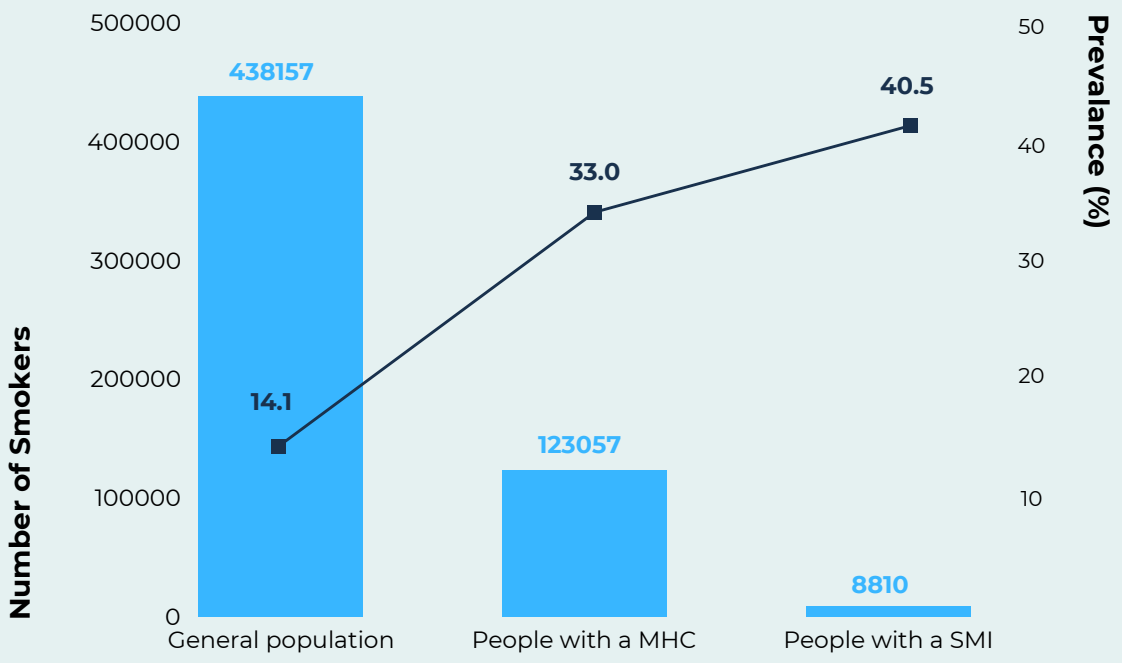


Figure 2: Smoking in Wales among the general population (Office of National Statistics, 2022) and among people with mental health conditions (ASH Wales, 2017)
MHC = mental health condition; SMI = severe mental illness

For Figure 2, note that data on smoking among people with an SMI are from UK data (Office for Health Improvement and Disparities, 2015). That the 2022 Wales National Review of Patients Cared for in Secure Mental Health Hospitals in 2022 identified that 57.5% of patients in secure hospitals were smokers.

Smoking is socioeconomically patterned. In 2022–23, people residing in the most deprived areas of Wales had a smoking rate of 22%, while those in the wealthiest areas reported only 8%(14) (see Figure 3).

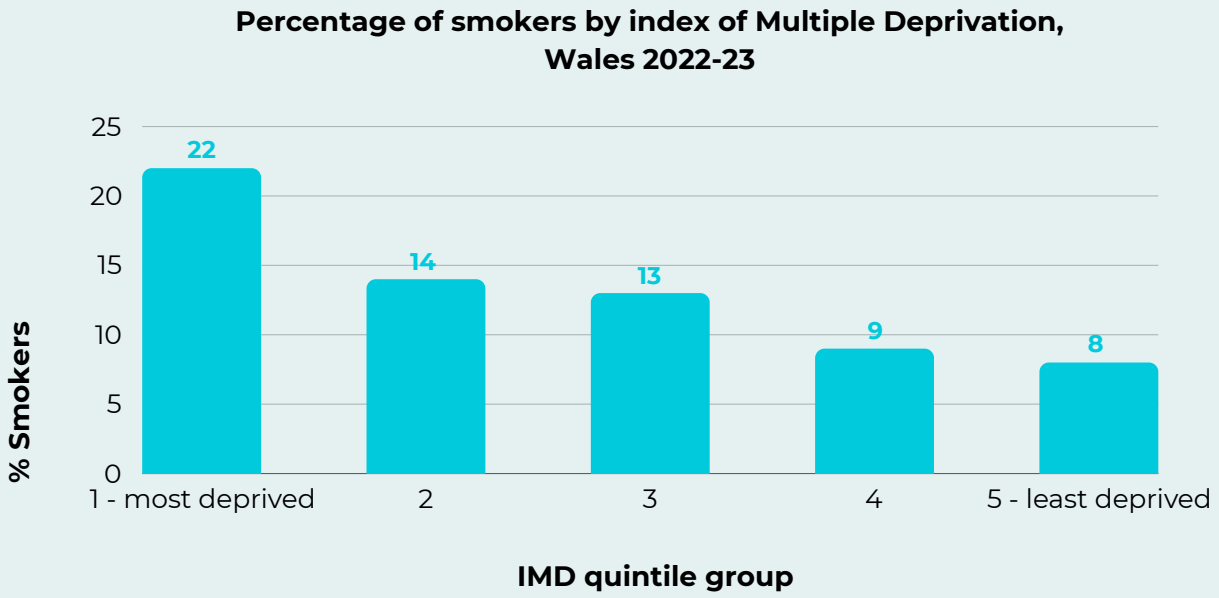


Figure 3: Percentage of smokers by Index of Multiple Deprivation, 2022–23. Smoking rates based on National Survey for Wales. IMD: Index of multiple deprivation

1.3 Prevalence of mental health conditions in Wales

Mental health conditions are increasing in prevalence in Wales. In 2016–17, 10% of people aged 16–44 in Wales reported having a mental health condition, which increased to 18% in 2023 (15).

In Wales, there are no population prevalence data on SMI, which is a barrier to understanding population needs and improving prevention. Instead, we can look to other databases in Wales to find this information. The SAIL (Secure Anonymised Information Linkage) databank provides population estimates of SMI prevalence. This is a population-based cohort with 3.9 million people aged 15 years and over, residing in Wales from 2004–15(16). The estimated 12-year-period prevalence for schizophrenia-related disorders was 0.4% and 0.3% for bipolar disorder using primary care data, and 0.4% and 0.2% for schizophrenia-related and bipolar disorder, respectively. However, people from the most deprived quintile had at least a twofold increase in having an SMI compared with those in the least deprived quintile.

The prevalence of mental health conditions in Wales varies by socioeconomic status (Figure 4). In 2022–23, people living in the most deprived areas of Wales were more than twice as likely to have reported a mental health condition than those living in the most affluent areas.

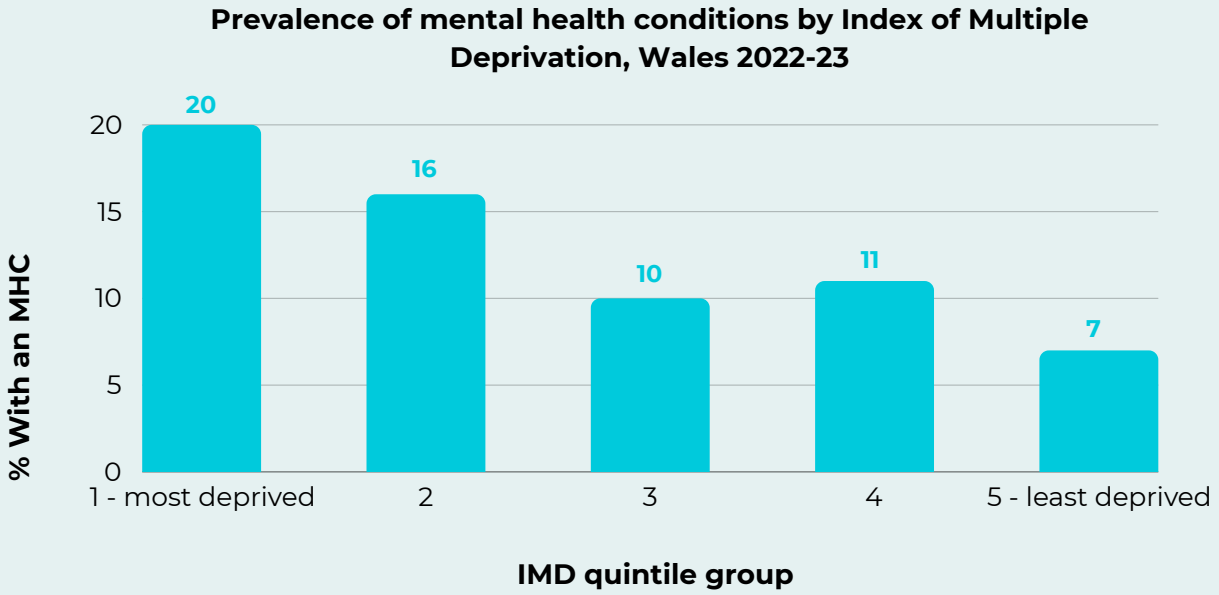


Figure 4: Percentage of people aged 16+ reporting a 'mental disorder' by deprivation quintile (National Survey for Wales). IMD = index of multiple deprivation; MHC = mental health condition

1.4 Why people with mental health conditions (including SMI) are more likely to smoke

1. Smoking and mental health: Shared causes and risk factors

Smoking and poor mental health share common risk factors, including genetic and environmental influences. Evidence suggests that shared genetic and environmental factors may predispose some people to both smoking and poor mental health (17). In the case of environmental influences, adverse childhood experiences (ACEs) lead to an increase in the uptake of smoking and the development of mental health conditions (18). Poverty and smoking have a bidirectional relationship: one leads to more of the other.

Within mental health services, smoking continues to be a part of the culture (2). The normalisation of smoking in this environment increases the likelihood of people using these services to adopt and sustain smoking habits.

2. Reduced access to and engagement with smoking-cessation services for people with mental health conditions

People with mental health conditions may face additional barriers to accessing smoking-cessation programmes. Contrary to the belief that people with mental health conditions can't quit smoking, there are proven methods to help them quit (19,20). However, these interventions are not widely implemented. Lack of support and resources can make it challenging for people with mental health conditions to quit smoking (21). Evidence from systematic reviews has also highlighted that people with a history of major depression have less success in smoking-cessation programmes than smokers without major depression (22).

People with mental health conditions encounter a double challenge when trying to quit smoking. First, they don't attend regular smoking-cessation services as much as those without mental health conditions (21). Second, even when they use these services, they have a lower success rate than the general population (23). This suggests that targeted interventions are needed to address the challenges faced by this population and effectively help them quit smoking.

3. Smoking as 'Self-Medication' and temporary relief from anxiety or low mood

Smokers with mental health conditions sometimes use smoking as a coping mechanism to manage their symptoms and medication side-effects (24–27). A common misperception is that smoking can relieve anxiety and improve mood. This perception contributes to the high prevalence of smoking among people with mental health conditions (28,29). This narrative has been fostered by the tobacco industry, through their funding of research that examines the self-medication hypothesis and by marketing cigarettes to people with mental health conditions (30). However, robust evidence indicates that quitting smoking leads to improvements in mental wellbeing (31) and supports recovery from mental illness. It is the responsibility of public health and mental health services to dispel the notion that smoking provides relief from mental health symptoms, and to educate staff and patients that quitting smoking supports recovery (20).

4. Evidence that smoking causes poor mental health

Research has established that smoking can contribute to the development of some mental health conditions, particularly depression and schizophrenia. Observational and Mendelian randomisation studies have reported an increase in the likelihood of developing these conditions among smokers compared with non-smokers (17). However, the possibility of symptoms of mental illness leading people to start smoking is also recognised.

There is also evidence of an association between smoking and increased likelihood of developing bipolar disorder (17). Moreover, smoking is causally linked to conditions that directly impair mental health, such as dementia(32–34). There is a degree of bidirectionality in these relationships. This bidirectionality suggests a potential vicious cycle, in which symptoms of mental health conditions lead people to smoke more, making them more susceptible to dependence. At the same time, smoking may increase the risk of developing mental health conditions and increase existing symptoms.

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1.5 Quitting supports mental wellbeing and recovery

Quitting smoking supports recovery from mental health conditions by improving the effectiveness of treatment and increasing mental wellbeing (10).

A Cochrane evidence review found that within 6 weeks of stopping smoking, ex-smokers saw an improvement in their mental health that was equivalent to the impact of taking antidepressants (31).

Smoking also impacts the metabolism of some antipsychotic medications, and therefore can affect recovery. Due to the metabolic impact of smoking, smokers can need higher doses of medication than non-smokers. That medication can be reduced when they stop smoking (35,36).

1.6 Physical health matters for mental health

The high prevalence for poor physical health, and behaviours associated with poor physical health, in people living with a mental illness highlights a need for greater physical health input within mental health services. As such a King's Fund report published in 2016 highlights this and proposes the need for a health care model that integrates physical, mental and social care services, to meet the complex and multidimensional needs of patients. Indeed, earlier legislation has also highlighted the need: the Health and Social Care Act 2012 (37) outlined the importance of parity of esteem – tackling physical and mental health issues with the same energy and priority as each other. Several initiatives have followed this legislation, however, there is still a lack of effective implementation of integrative health care, particularly for people with a mental illness.

2.

Approaches to reduce smoking in people with mental health conditions and SMI

Approaches to reduce smoking in people with mental health conditions and SMI

2.1 Overview of strategies to reduce smoking

There have been several strategies implemented by the Welsh Government to reduce smoking rates, and subsequent health complications. The most recent of these, the Tobacco Control Delivery Plan 2022–2024 (38), is the first of three delivery plans that aim towards a smoke-free Wales to be achieved by 2030.

Smoke-free Wales: a multi-level population based approach to reduce smoking

The smoke-free Wales policy was established to help support achieving the well-being goals from the Well-being of Future Generations (Wales) Act 2015. The smoke-free Wales policy emphasises a whole-system approach to smoking prevention, with implementation across multiple sectors.

The smoke-free Wales policy has a focus on reducing inequalities. It recognises the major inequalities in smoking and tobacco product use in Wales. The focus on reducing inequalities is particularly relevant to the epidemic of smoking in people with mental health conditions.

Case study for population-based strategies implemented under the smoke-free Wales policy

The Smoke-free Premises etc. (Wales) Regulations 2007 ended smoking in workplaces and enclosed public places. In March 2021, Chapter 1 of Part 3 of the Public Health (Wales) Act 2017 and the Smoke-free Premises and Vehicles (Wales) Regulations 2020 came into force, extending the smoke-free requirements in Wales.

Under the new legislation, hospital grounds, school grounds, public playgrounds, and outdoor nursery and childminding settings are designated as smoke-free.

Designating these spaces as smoke-free is critical for reducing secondhand smoke exposure, supporting people to quit smoking, and to avoid normalising smoking behaviours for children and young people.

The Tobacco Control Delivery Plans' actions are categorised under five areas:

1. Smoke-free environments
2. Continuous improvement and supporting innovation
3. Priority groups
4. Tackling illegal tobacco and the tobacco control legal framework
5. Working across the UK

The third area (priority groups) is particularly important, because it includes people engaged in mental health services. Current smoking-cessation strategies and interventions in Wales have not been specified for use with people living with mental illnesses. Despite this, the Welsh Government recognises the need for effective smoking-cessation support for people with a mental illness, and the importance of providing tailored support to reduce smoking prevalence. The strategies that are in place in Wales are outlined below.

2.1.1 Current evidence-based strategies in Wales

Help Me Quit

The most widely utilised smoking-cessation strategy in Wales is the Help Me Quit service; a coherent stop-smoking service for Wales. It is designed to give the largest number of smokers in Wales the best chance of quitting by referring people to the local stop-smoking service that best fits their needs. Help Me Quit comprises a bi-lingual website and contact centre. As an all-Wales brand, it replaces local smoking-cessation campaigns and is utilised across all seven health boards. The types of services in Wales that are offered through Help Me Quit include:

- face-to-face support, either one-to-one or in a group
- telephone support
- pharmacotherapy (for example, NRT, varenicline and bupropion, which are taken for short periods and reduce nicotine cravings (39)
- self-help resources such as mobile digital applications or electronic cigarettes
- a combination of the above

In terms of pharmacological support, the All-Wales Medicines Strategy Group (40) provided guidance on delivery of pharmacotherapy and (regulated) e-cigarettes as a form of abstinence-contingent treatment. The guidance offers advice on the clinical suitability, adverse effects, dosage and duration of pharmacological treatment for smoking cessation.

Besides Help Me Quit, some health boards in Wales also offer in-house smoking-cessation support, particularly in secondary care. For example, Cardiff and Vale University Health Board offer their smoking-cessation service, a hospital-based service that offers one-to-one, long-term, intensive behaviour support. Hywel Dda University Health Board have a specialist smoking and wellbeing team that offers free support by trained smoking and wellbeing practitioners within the health board, providing one-to-one or group support and access to pharmacological interventions.

Efficacy of stop smoking strategies

The inclusion of smoking-cessation strategies in Help Me Quit is largely based on the efficacy of treatment outlined in a publication by Public Health England (2017), and later reported in an independent review of smoking-cessation services in Wales (41). The Public Health England (2017) report (42) provides an overview of the efficacy of interventions in the general population, based on data and guidance from the Cochrane Collaboration, NICE guidance, and the National Centre for Smoking Cessation and Training. The interventions have been ranked from most to least effective and are outlined in the table below.

Table 1: Effectiveness of smoking-cessation interventions, from most effective (1) to least effective (7)

Ranked (1-7) interventions	Effective implementation boosts quit rate by:
1. Face-to-face group support with pharmacotherapy: Weekly group sessions facilitated by one or more specialist stop-smoking practitioners with a number of smokers at a specified time and place. Each session lasts around 1 hour, for 6 –12 weeks. All smokers have access to their choice of pharmacotherapy, and smoking status is verified by carbon monoxide (CO) monitoring at each session.	300%
2. Face-to-face individual support with pharmacotherapy: Weekly sessions for an individual smoker with a specialist stop-smoking practitioner, at a specified time and place. Sessions are each around 30–45 minutes long, over a 6–12-week period. All smokers have access to their choice of pharmacotherapy and smoking status is verified by CO monitoring at each session.	200-300%
3. Supported use of pharmacotherapy: Smokers are provided with stop-smoking medication(s) (NRT, varenicline, bupropion) of their choice, and given appropriate information and support to use it in a way that will maximise effectiveness.	50-100%
4. Telephone support: Sessions of proactive telephone support provided by a trained advisor for 6–12 weeks. Average call time is 15–30 minutes. This treatment works best when multiple sessions are delivered in the first week.	50-100%
5. Text message support: Evidence on text message support is limited, but some improvements have been shown when compared with no treatment or support.	40-80%
6. Online information: There is some evidence to suggest that online information can be effective in supporting smokers to stop, but no websites have been evaluated in randomised trials.	Unknown
7. Mobile digital applications: While there are a number of digital applications for smoking cessation, there is very limited evidence of their efficacy.	Unknown

Vaping and e-cigarettes

Using an alternative form of nicotine can help dependent smokers succeed in quitting or reducing overall smoking (43). E-cigarettes are the most popular aid to quitting in England and are more effective than using NRT (44). However, availability can be an issue for people on low incomes due to initial costs of e-cigarettes. Smokers with a mental health condition are twice as likely than those without to give cost as the reason why they stopped using an e-cigarette. This indicates that cost plays an important role in people's decision-making when choosing nicotine products (10). Smokers with poor mental health may also need more targeted support and encouragement to start using e-cigarettes.

We must also acknowledge the current epidemic of e-cigarette use by non-smokers. In the past decade, e-cigarette and vape use has increased enormously among non-smokers, including children, despite safety risks (45) and apparent harms (46). The rise in popularity has been fuelled by children and young peoples' rampant exposure to e-cigarette marketing and advertisements (47). While e-cigarettes can be a useful tool to help quit smoking, appropriate regulation is required to ensure that e-cigarettes are used primarily as smoking-cessation tools rather than a new gateway to nicotine addiction.

Specific strategies for people living with SMI

There are no specific interventions or guidance on smoking-cessation support for people living with SMI in Wales. However, there is empirical evidence that supports the efficacy of the interventions available in Wales through Help Me Quit, as outlined above. For example, the use of pharmacotherapy (that is, NRT, varenicline and bupropion) has been shown to be an effective means of smoking-cessation treatment for people with SMI (1,48). Providing at least two options of NRT and pharmacotherapy can be more effective in supporting successful quitting in people with SMI than only offering one choice (20). A review by Wilson et al. (2017) found that behavioural interventions were also effective (49). They found that single strategies and multi-component interventions were effective in supporting people with a mental illness, including SMI, to stop smoking. Single strategies include enhanced telephone counselling and motivational interviewing. Multi-component interventions include online programmes, smoking-cessation advice and telephone counselling, motivational interviewing, printed materials, pharmacotherapy, and contingency management.

2.1.2 Scaling evidence-based interventions for smokers with mental health conditions and SMI

Interventions to prevent the use and support cessation of tobacco products can be tailored to people with mental health conditions, to improve access and uptake (50).

The Adult Mental Health Community Mental Health Team (CMHT) report on Enabling Environments highlights the steps taken to support smoking cessation by community mental health services. The report notes the large gaps in implementation of smoking-cessation support – less than half (44%) of CMHT offices had information on smoking-cessation resources. Only around half (53%) of the CMHT offices actively navigated service users to smoking-cessation resources. The community mental health teams present an excellent opportunity for improving the reach and success of stop-smoking interventions. However, implementation needs to be improved so that people with mental health conditions can have better access to these resources.

Key difficulties in the implementation of physical health care in mental health services are related to the knowledge and attitudes of mental health professionals. Many mental health professionals, in different types of mental health services, recognise the need for physical health initiatives and the integration of physical health care into mental health care, particularly with regard to smoking (51–54). However, there is a disconnect between the recognition of this need and the skills and confidence required to fulfil it. For example, many mental health professionals feel that they do not have the skills or resources to provide effective physical health care and that a lack of managerial support hinders their ability to take part in physical health training (55).

In their systematic review of the literature about barriers to effective smoking-cessation support, Huddlestone et al. (2022) highlighted that:

- some staff members feel that they have limited time to support patients
- there is a lack of clear policy and information on smoking-cessation pathways
- staff don't have the confidence to deliver smoking-cessation support
- staff don't have enough knowledge about smoking cessation, which sometimes leads to misinformation.

The review also highlighted that a lack of intention to deliver smoking-cessation support from staff was a barrier. For example, some mental health professionals working in psychiatric inpatient units feel that providing physical health care is not within their remit (56).

This attitude is likely the result of a lack of understanding about the bidirectional relationship between poor physical and mental health. Some staff members feel that attempts to implement physical health care is pointless, particularly when it comes to smoking. Mwebe (2016) explored mental health nurses' views about their role in implementing physical health care (54). In this study, staff expressed that smoking was an inevitability and any attempts to help patients stop would be futile. In reality, smoke-free policies in psychiatric settings can be effective, especially when implemented as part of a whole-system intervention approach (2).

2.1.3 Addressing misperceptions among smokers and health professionals

Improving public and professional views on smoking can help improve the implementation and effectiveness of stop-smoking approaches. This requires addressing harmful misperceptions in mental health staff, such as the view that smoking may be therapeutic to patients (57). Another common misperception is that smokers with mental health conditions are unmotivated or unable to stop smoking.

However, evidence clearly disproves these misperceptions (10). A large population-based survey in England has demonstrated that smokers with mental health problems were more likely to report being motivated to quit smoking (58) and to have tried reducing their smoking, or using prescribed medication or behavioural support, than smokers without mental health problems (58,59). A survey of 10,000 smokers with SMI found that 56.7% wanted to reduce their smoking or quit (60). Smokers with mental health problems were also more likely to have made at least one attempt to quit in the past year than smokers without mental illness (58). There was also no difference in quit success between smokers with and without mental health problems (58). Mental health professionals should remain openminded to the likelihood that many of their patients may be interested in quitting and can be just as successful at quitting as other smokers.

Improving access to information can help reduce misperceptions. For example, information about the benefits of stopping smoking for mental health is now provided on the NHS Better Health webpages (61). These approaches can be integrated into local communications programmes.

2.1.4 Upskilling mental health professionals to enable them to motivate and support quit attempts

Upskilling will enable staff to provide better quitting support. Staff working in secondary mental health services have variable levels of skills in and knowledge of smoking cessation. In a survey by ASH England, around half of mental health nurses and the majority of psychiatrists had no training in delivering behavioural support to help smokers stop smoking (57).

Addressing gaps in training is an important way to ensure that staff have accurate knowledge and the skills to engage with smokers. However, if it is to lead to behaviour change, training must be supported by cultural changes and the ability to refer patients to dedicated quit support.

Staff members also need to have appropriate support in place to facilitate their education, as well as the support and resources necessary to upskill them so that they have the knowledge and confidence to implement good, effective physical health care to their patients. The upskilling of mental health professionals in the United Kingdom has been a target in recent years. For example, in 2013 the Department of Health published the 'No Health Without Mental Health' strategy which proposes that need to provide nurses with 'specialist knowledge and skills to interact with patients in a therapeutic and purposeful manner to aid their recovery and quality of life'.

Strategies for upskilling mental health professionals to support smoking cessation

There are several evidence-based strategies to upskill mental health professionals to implement support for smoking cessation. The challenges are complex (for example, maintaining a quit) and require sustained multilevel interventions.

Supporting smoking cessation requires culture changes, shifts in knowledge and attitudes, and new skills (by upskilling staff; see Training support for staff knowledge enhancement, below). We can then reinforce better practice over time, including by evaluating quality improvement outcomes.

1. Knowledge enhancement

- A focus for upskilling mental health staff members should be the enhancement of knowledge around effective smoking-cessation support. This is particularly important given that many members of staff working in mental health services feel that they lack the skills, knowledge and confidence to provide smoking-cessation support.

- Educate staff on the bi-directional relationship between smoking and poor mental health (62). This is important for understanding that poor physical health contributes to complexity of their care needs (63)

- NHS England (2020) have published the Physical Health Competency Framework for Mental Health and Learning Disability Settings, which sets out the knowledge base and skills required for staff members to obtain to support mental health patients with smoking cessation.

- The framework suggests that staff should be able to demonstrate skills that serve to:
  - sensitively raise issues of smoking with patients who smoke
  - explain the risks of smoking while taking certain medications (that is, antipsychotics, antidepressants, and benzodiazepines), and
  - articulate the benefits of smoking cessation.
- The framework also suggests that staff should be able to carry out nicotine-dependence assessments and know how to make referrals to smoking-cessation services. Staff must be trained and have the confidence to effectively implement this.

Resources

R Wootton, H Sallis, M Munafò. Is there a causal effect of smoking on mental health? A summary of the evidence. Bristol: University of Bristol, 2022. Available from: Attoe et al. (2016) developed a training programme for mental health professionals, to promote physical health care support skills for SMI patients.

Training support for staff knowledge enhancement

Attoe et al. (2016) developed a training programme for mental health professionals, to promote physical health care support skills for SMI patients. The programme included three courses aimed at increasing staff's awareness of physical health, enhancing physical health skills and refining skills in having health-related conversations with patients. These findings are consistent with earlier research on implementing physical health education for mental health professionals (52,64). The National Centre for Smoking Cessation and Training have developed a suite of resources, the NHS Community Mental Health Tobacco Treatment Training Resources, for the delivery of smoking-cessation support to people in inpatient and community mental health settings.

2. Trauma-informed care

Early traumatic experiences (ACEs) heavily influence engagement in health-harming behaviours (65–68). ACEs are also implicated in the development of SMI (69). Given the relationship between early psychological trauma and poor physical health, and between poor physical health and SMI, it would be prudent to upskill mental health staff members so that they are able to implement a trauma-informed approach to care. Supporting someone in a crisis to quit smoking is never coercion.

Trauma-informed approaches help to mitigate the adverse effects of traumatic experiences and promote positive mental and physical health outcomes.

The framework Trauma-Informed Wales (70) sets out four defined principles of practice that describe the different roles and approaches needed in a range of health and social care contexts to effectively implement trauma-informed care: 1) trauma-aware, 2) trauma-skilled, 3) trauma-enhanced and 4) specialist interventions. The framework document provides significant detail on each of these principles, including who each level is aimed at and what 'good' looks like.

Extensive guidance on the implementation of trauma-informed approaches within a health and social care context has also been provided by the National Trauma Transformation Programme (2023) in Scotland.

Ultimately, upskilling staff to work in a trauma-informed way requires a system-level change and a shift in care culture, as opposed to relying on addressing changes in individual practice. If staff members are educated on the impact of trauma and how that can influence patients' behaviours, then trauma-informed practice will follow (71). See also Table 2.

Table 2: Implementing trauma-informed care (based on a resource from the Centre for Disease Control, '6 Guiding Principles to a Trauma-Informed Approach')

Principle	Implementing the principle
Safety	This is about creating the physical and emotional space where people can disclose difficult personal information
Trustworthiness and transparency	People need to know they can trust the recipient of this information. Make clear from the onset that there may be circumstances when you will need to disclose some information to others, e.g. to protect children
Peer support	This may come late after disclosure: knowing that others have had similar experiences and good outcomes
Collaboration and mutuality	We cannot normalise traumatic experiences but we can explain how common they have become, that many groups and institutions (schools, prisons) want to learn how to support people better than they have done
Empowerment and choice	Almost universally, traumatised people have had their choice taken away during the traumatic event. So, even small choices here (e.g. asking for a female clinician) are important
Cultural, historical and gender issues	There are wider societal forces here, and these change over time: xenophobia, racism, homophobia, sexism and #MeToo are all culturally determined

3. Motivational interviewing

Another possible avenue of upskilling mental health staff is to train them in Motivational Interviewing (MI). MI is a widely used therapeutic modality that is client-centred and collaborative, designed to help people resolve ambivalence and make positive changes in their behaviour (72). The key principles that underpin MI include:

- expression of empathy
- development of discrepancy
- rolling with resistance
- supporting self-efficacy
- avoiding direct confrontation

MI has been used in a variety of healthcare settings for the improvement of physical health (73–75). More specifically, MI has been employed in smoking cessation for a diverse range of people, and with good efficacy (76,77).

In the context of SMI, Steinberg et al. (2016) found that MI was an effective tool for supporting people living with SMI to quit smoking. Given the low level of engagement in smoking cessation for people with SMI (78), upskilling staff with MI training in mental health services could be an effective way of promoting adherence to smoking cessation in their patients. Skills taught in MI may guide staff members, particularly nursing staff, in how to operationalise a person-centred approach to physical health care in everyday interactions (79–81).

Bunyan et al. (2017) conducted research to assess the feasibility of training mental health nurses MI skills in inpatient services (79). In their pilot study, they found that training MI was, in fact, feasible: that nurses felt that it was highly relevant to their work, and that patients had a more positive view of the ward they were on after nurses had MI training. However, they acknowledged that this latter effect had diminished after 6 months' follow-up. Given the feasibility of MI training for nursing staff, and the positive impact it can have on patient care, the authors suggested that MI principles should be incorporated into pre-registration training for nurses. The same process underlies NHS England's Very Brief Advice smoking-cessation support.

2.2 Improving data and monitoring

Monitoring outcome data at the population level – such as smoking rates in people with mental health conditions – is essential to evaluate whether smoking-cessation interventions are working.

Up-to-date information on rates of smoking, quit attempts and quitting success in people with mental health conditions is critical to providing the right resources and care. Public Health Wales publishes data on smoking rates in the general population, but information on smoking by people with mental health conditions is not consistently collected.

The CMHT report showed that just 18% of CMHT offices had a process in place to regularly monitor the smoking status of service users.

Useful data resources

- Public Health Wales smoking data tool
- StatsWales – Mental health data sources
- National Survey for Wales – Mental wellbeing in Wales
- Datamind mental health data resource

3.

A framework for local and community-led action

A framework for local and community-led action

There is a need for further development of resources for training, and other accessible support for addressing smoking in mental health settings.

Specific tools and resources need to be developed for:

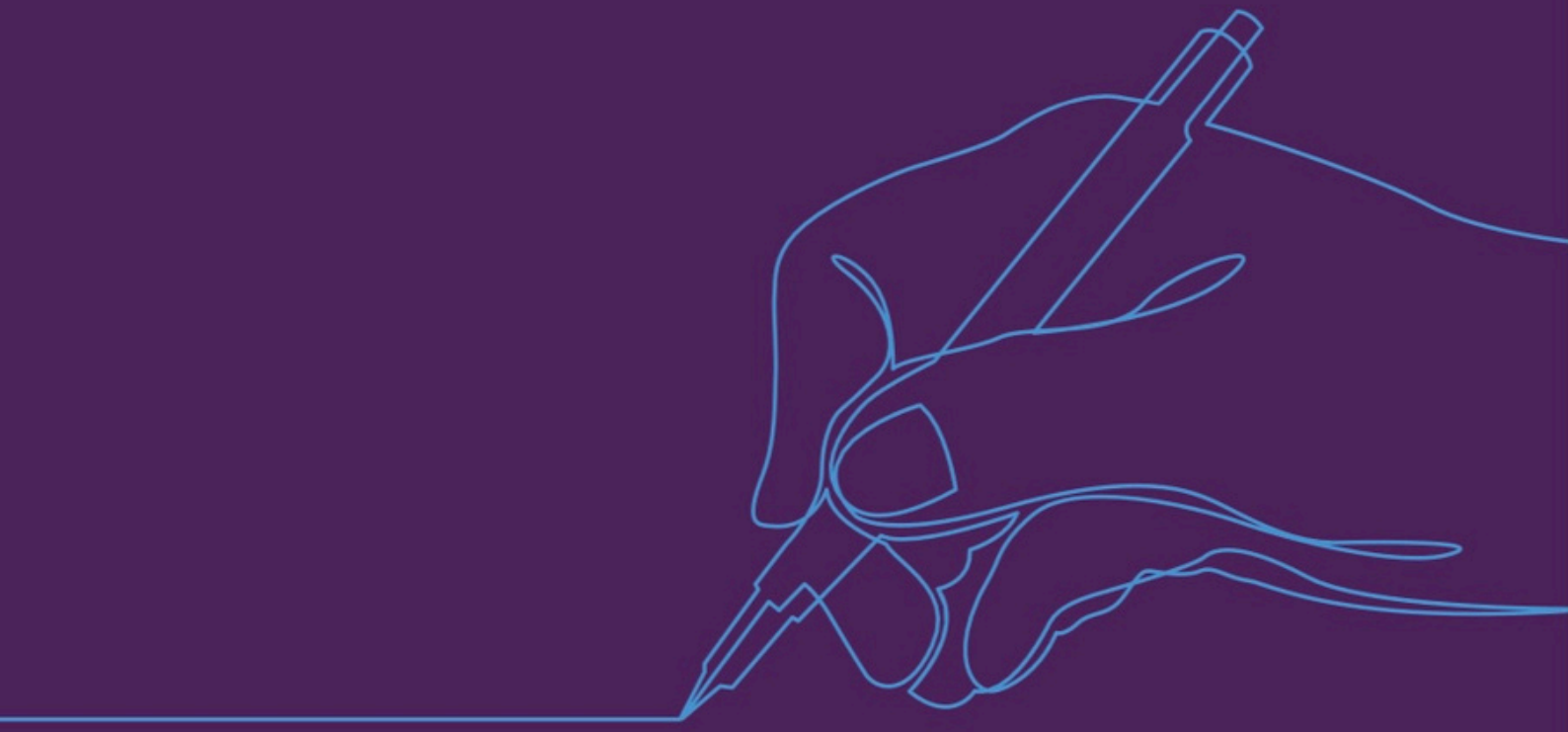
1. educating staff members on smoking cessation, the importance of addressing poor physical health in mental health settings and so on, and
2. how to implement trauma-informed care.

In this report, we have identified the gap in resources to support smoking cessation, and we have highlighted the next steps for taking action.

Table 3 presents a framework that outlines how local health systems and government strategies on smoking and on mental health can work together to reduce smoking rates and improve mental health in Wales. The framework was adapted from the framework for reducing smoking and improving population mental health, developed by ASH and the PMHIC (10).

Table 3: Framework for local action to reduce smoking rates and improve mental health in Wales

Area of action	Actions
Understanding local needs and assets	• Collect and publish national data on smoking rates, including from people with mental health conditions • Link with data from primary care, secondary mental health services and acute care, to better understand the population needs • Identify and quantify population needs through a strategic needs assessment
Working together	• Ensure that the Tobacco Control Delivery Plans' implementation strategy to address priority groups includes targeting of people with mental health conditions • Link local tobacco control strategies with community mental health teams, through staff training and upskilling • Involve people with mental health conditions in local decision-making, to better meet their needs
Taking action for prevention of smoking, mental health promotion, and reducing inequalities	• Increase onsite targeted support to stop smoking in mental health services and other local services that have a high rate of access by people with mental health conditions • Increase direct referral pathways to local support in services that have a high rate of access by people with mental health conditions. • Implement Help Me Quit resources into community-based mental health support • Create positive smoke-free environments in all mental health settings • Provide readily accessible NRT and other smoking-cessation medication • Identify and utilise opportunities to expand access to alternative nicotine-containing products for people who have or are vulnerable to poor mental health • Link communications messages together about mental wellbeing and quitting smoking • Develop approaches to support that engage smokers who have mental health conditions in peer support and other models that put smokers at the centre of delivery
Evaluation and measuring outcomes	• Standardise data collection on smoking in people with mental health conditions, in primary, secondary and tertiary care and in community settings • Standardise the measurement of quit attempts and quit success in people using mental health services • Evaluate targeted and population-based strategies for smoking cessation, including by collecting data on smoking rates and quit attempts • Seek qualitative feedback from smokers with mental health conditions, to understand how programmes can be improved
Leadership and direction	• Create a leadership structure: Identify smoking-cessation champions across mental health and public health provision • Have leadership at local levels (this is critical)



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