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Cessation support for smokers with mental health problems: a survey of resources and training needs

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ABSTRACT

Aims: Around thirty percent of smokers have a mental health problem. Smoking cessation has been associated with mental health benefits, but smoking prevalence remains high in populations with mental health problems. This study aimed to assess mental health related knowledge, practice, and training needs of practitioners supporting smoking cessation.

Methods: UK stop smoking practitioners ($n = 717$) recruited via a database of a national provider of smoking cessation training in June 2016 sufficiently completed an online survey about available resources, knowledge, confidence, and training needs related to smoking cessation and mental health. Responses were described and compared between practitioners with a mental health lead and those without such a lead in their service using chi-square statistics and *t*-tests.

Results: A considerable proportion agreed (37%) or were undecided (28.9%) that smoking helped people with mental health problems feel better and agreed (17.2%) or were undecided (30.2%) that cessation would exacerbate mental health symptoms. Only 11.6% said their service had designated funding for smokers with mental health problems and 26.5% were or had a staff member who was a dedicated lead practitioner for mental health work. Practitioners from services that had a dedicated mental health lead were more confident in supporting smokers with different mental health problems and using different pharmacotherapies (all $p < 0.001$) and were more likely to disagree that cessation was detrimental ($p = 0.001$). A majority of practitioners were interested in training, particularly about smoking cessation effects on psychiatric medication (84.3% of $n = 632$) and how to tailor stop smoking support to clients with mental health problems (82.4%).

Conclusion: Practitioners who support smoking cessation have limited knowledge about mental health and smoking but are willing to learn and improve. However, they are hindered by a lack of resources.

1. Introduction

Smoking prevalence in England has declined from 27% in 2000 to 16% in 2016 (Office for National Statictics, 2017). The improvement, however, has excluded people with mental health problems, where smoking rates have not significantly changed since the early 1990s (Szatkowski & McNeill, 2015) and remain twice as high as in the general population (Royal College of Physicians & Royal College of Psychiatrists, 2013). Among mental health patients, smoking contributes to reduced life expectancy (Royal College of Physicians & Royal College of Psychiatrists, 2013) and interferes with the metabolism of pharmacotherapy: smokers require higher doses of some psychiatric medication, which potentially increases medication side effects (Aguilar, Gurpegui, Diaz, & De Leon, 2005). Nevertheless, smokers with mental health problems are motivated to quit (Lukowski, Morris, Young, & Tinkelman, 2015; Morris, Waxmonsky, May, & Giese, 2009; Siru, Hulse, & Tait, 2009; Szatkowski & McNeill, 2015), willing to do so with specialist support (Kerr, Woods, Knussen, Watson, & Hunter, 2013), and quitting may improve their mental health (Banham & Gilbody, 2010; Campion, Checinski, Nurse, & McNeill, 2008; Stepankova et al., 2016; Taylor et al., 2014).

The need to focus on smoking alongside mental health treatment has been highlighted in national guidelines (Fiore et al., 2008; Hall & Prochaska, 2009; NICE, 2013) and covered by training programmes (Hiscock & Bauld, 2013; NCSCT, 2014b), but these smokers still encounter multiple barriers towards cessation. People with mental health problems smoke more intensely and are more nicotine dependent (McClave, McKnight-Eily, Davis, & Dube, 2010) which, along with the burden of ill health, makes quitting particularly challenging (Twyman,

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Bonevski, Paul, & Bryant, 2014). In psychiatry, where smoking was long considered a norm (Ratschen, Britton, & McNeill, 2011), patient smoking is usually overlooked by staff (Ratschen, Britton, Doody, Leonardi-Bee, & McNeill, 2009) or even facilitated during organised smoking breaks despite smoke-free legislation in mental health settings (Department of Health, 2006; Robson, Yates, Craig, Healey, & McNeill, 2016). Smokers with mental health problems also encounter difficulties in approaching specialist smoking cessation services. Mental health trusts rarely refer their patients to smoking cessation services (McNally & Ratschen, 2010; Parker, McNeill, & Ratschen, 2012), and in primary care these smokers are less frequently advised to quit than smokers without mental health problems (Szatkowski & McNeill, 2013). These disadvantages could stem from common misconceptions among healthcare professionals that smoking cessation aggravates mental health or that smokers with mental health problems lack confidence and motivation to quit (Kerr et al., 2013; Sheals, Tombor, McNeill, & Shahab, 2016).

In 1999 England established comprehensive smoking cessation services to support quitting, including among 'the most disadvantaged smokers who want to quit' (Department of Health, 1998, p. 28). The services support several hundred thousand stop smoking attempts every year (West, May, West, Croghan, & McEwen, 2013) with evidence-based pharmacological and behavioural interventions (NICE, 2008). In the services an array of professionals support smoking cessation, including but not limited to health and social care workers. Stop smoking practitioners are classified into 'specialist' and 'community': the former support smoking cessation as their main work role, and the latter provide smoking cessation support as a part of their job alongside their main role (e.g. practice nurses and pharmacists).

Cessation services consider smokers with mental health problems a targeted priority group (ASH, 2016; NCSCT, 2014a). To accommodate their needs, some services have a specific team member designated as a lead for smokers with mental health problems. Although the role is not standardised across all services, the designated leads within a smoking cessation service dedicate part of their time to supporting smokers with mental health problems, liaising with local mental health services, and providing training. In a survey of 27 Stop Smoking Services in London, half of services had a nominated lead for mental health work, but these practitioners on average spent only a quarter of their work time on supporting smokers with mental health problems (McNally & Ratschen, 2010). Also, there is little evidence about how well prepared practitioners are to support smokers who have mental health problems and how cessation support is tailored for these smokers (Gilbody et al., 2015). Therefore, this study aimed to:

1) Assess available resources for stop smoking practitioners to identify and support smokers with mental health problems.
2) Assess and compare practitioners' practice, attitudes, and confidence between those who have and do not have a staff member leading on mental health work.
3) Identify practitioners' knowledge and training needs.

2. Methods

2.1. Sample

The target population was all those who supported smoking cessation attempts as part of their professional role. As there is no central record of this group, a national training provider database was used to contact potential participants. In June 2016, an email invitation to complete an online questionnaire survey was sent to 22,214 email addresses, some outdated, of practitioners who at some point registered for recommended training at a UK national smoking cessation training provider database. Of those sent out, 4724 invitation emails were opened. Everyone who was sent an invitation to complete the survey had opted in to receive communications from the national smoking cessation training provider. Invitations were also distributed using newsletters of UK charity organisations focusing on smoking and public health. In total, 1056 respondents started the survey, of which 717 (67.9% of surveys started) sufficiently complete questionnaires (respondents were exposed to all survey items and answered >80%) were used in the analyses. Completion of individual items was not mandatory, therefore, sample sizes range from 632 to 695 respondents due to missing data. Respondents in any sample were from the main study sample of N = 717.

2.2. Study design

The survey took approximately 10 to 15 min to complete. The survey was online for four weeks, two email reminders were sent two weeks and three days prior to its closure. Before starting a questionnaire, all participants were introduced to the research aims and assured of the anonymity and confidentiality of their responses. Participants could also choose to participate in a prize draw to win one of ten High Street vouchers, each worth £50, by providing contact details at the end of a questionnaire. Participants were ensured that their contact information will be kept and treated separately from the rest of survey data. Winners were randomly drawn from the 1056 who started the survey and provided their contact details.

2.3. Measures

The questionnaire was developed by the study authors based on the available guidelines and training on smoking cessation for smokers with mental health problems (Hiscock & Bauld, 2013; NCSCT, 2014b; NICE, 2013). The questionnaire was revised by a group of practitioners supporting smokers with mental health problems and an additional pilot survey was conducted with 11 practitioners.

The questionnaire consisted of 23 questions (some with several sub-questions) assessing four main areas:

1) Practitioners' demographic and professional characteristics (gender, age, country of residence, professional role, employment);
2) Services' resources and current practice supporting smokers with mental health problems (availability of funding and treatment manual for work with smokers who have mental health problems, and availability of a designated member of staff who leads work with this group of smokers);
3) Current support for smokers with mental health problems. This included i) current practice (how often practitioners ask clients about mental health, record mental health medication they are taking, and contact General Practitioners or mental health services when supporting a smoker with mental health problems), ii) practitioners' attitudes towards smokers with mental health problems assessed in comparison with smokers who do not have mental health problems (interest in smoking cessation, chances to quit smoking, dependence on nicotine, willingness to use smoking cessation medication, need to cut down smoking before quitting, and whether 4-week quit outcomes are equally appropriate for both groups) and iii) confidence in supporting these clients having different diagnoses (depression or anxiety, bipolar disorder, eating disorder, schizophrenia, other substance use disorder) or providing them different support (NRT, bupropion, varenicline, electronic cigarettes);
4) Practitioners' knowledge (proportion of smokers with mental health problems, interaction between smoking and psychiatric medication, knowledge about cessation support medication) and training needs when supporting smokers with mental health problems.

Survey items required a single answer or asked to indicate the level of agreement with a statement using a 5-point Likert scale. A list of all survey questions and answers is outlined in the appendix Table A1.