



**Bournemouth**  
Teaching Primary Care Trust



## **"Wasting time?"**

A review of 2½ years experience of helping people with diagnoses of mental illness and/or learning disability to stop smoking

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## 1 Summary

Over the past 2½ years, Bournemouth SmokeStop have attempted smoking cessation interventions with people who have had diagnoses applied to them of mental illness and/or learning disability. The purpose of this review is to document what has happened; to state our learning from the experience and to say what policy questions arise.

People who have a mental illness and/or a learning disability seem to experience greater difficulty than most people when they attempt to stop smoking. The extra difficulty arises from impaired capacities to do the tasks that lead to the required outcome; having stopped smoking. Capacities like the ability to plan, to remain focussed, to gather support, to organise time and activity. People with mental illness and/or learning disability also more often live in social contexts which are boring and where smoking is more prevalent as a means of passing time, relating and managing emotions. It is also sometimes used to manage thoughts, feelings and behaviours arising from their psychopathologies or to moderate the side effects of medications being used to treat and manage these.

The availability of the smoking cessation service to people with mental illness and/or learning disability has been advertised around Bournemouth and to some extent in Poole. Over the 2½ years covered by this review clients have been referred or have self presented to the service explicitly as people needing more than usual support to stop smoking because of the mental illness and/or learning disability. Within that number is included a few people who were in formal treatment for recovery from drug or alcohol dependency. Many more people with mental illnesses, learning disability and in recovery present as ordinary clients to the service offered to the general population and these are not included in this review.

Several modes of intervention have been attempted involving different levels of cost and complexity including special groups, intensive 1:1 interventions and training of staff in supported accommodation. Working with clients has been difficult and there are also special difficulties working in this field where professionals and lay supporters are under much pressure and have complex working lives. In the first year our success in terms of outcomes was extremely poor. Over time we have developed what seems to be a more successful approach and in the past year outcomes have significantly improved. In the whole period covered by this review we have engaged about 55 clients in about 80 'treatment episodes' to support them to stop smoking. Of those, 23 remained abstinent at four weeks after quit date which is the point of initial measurement. Longer term quit rates are still being captured but seem so far to be holding up similarly to those in the general population.

The title of this paper is posed as a challenging question. The cost of each treatment episode and for each successful cessation for the people covered by this review has been much higher than for the general population. This raises questions for policy makers about the best allocation of resources. However, mentally ill and/or learning disabled clients who do succeed in stopping smoking report improvements in other areas of their lives including better mental health, improved finances, social life, diet and fitness. Reported improvements in physical health are similar to those reported by the general population.

The current direction of the Bournemouth smoking cessation service for populations with mental illness and/or learning disability is to offer special group or 1:1 support leading to individual planning and support. This direction has evolved from experience and resource limits.

## 2 Background

Over the past 2½ years, Bournemouth SmokeStop have attempted smoking cessation interventions with people who have had diagnoses applied to them of mental illness and/or learning disability. In a few cases, the diagnosis has been applied by the client themselves. The usual political and philosophical difficulties have arisen and professionals and clients in this field will already be aware of these. Questions about how to describe people and conditions; questions like:

- what is mental illness and mental health?
- is someone learning disabled; or do they have learning difficulties; or do they have impaired learning; or is it 'us', who have the problem?
- is there anything homogenous about these populations other than diagnostic labels?
- who decides if someone is mentally well, ill or has a learning disability?
- what are the power relationships between the diagnosed and those making the diagnoses or offering treatment and other forms of support?
- ... and so on.

The field is descriptively difficult even before we get to deal with the problems of supporting people to achieve the change they want: to stop smoking. Can anything consistent be said about smoking cessation in these populations if there is so little that is homogenous about them?

People who have a mental illness and/or a learning disability do seem to have some homogeneity that is relevant to smoking cessation other than diagnostic labels. For instance, people with these diagnoses often have more difficulties than the wider population in:

- exchanging information / expressing themselves accurately;
- understanding and assimilating information;
- planning and adhering to plans;
- making and adhering to agreements;
- maintaining attention on an issue of interest;
- making choices and accurately locating responsibility for these;
- managing their time, relationships and other resources.

Having said that, most people have difficulties in these areas. It's perhaps a matter of degree and duration.

There are thought to be about 1,300 people registered with GPs in Bournemouth who have "severe and enduring mental illness". About the same number are served through the integrated care programme approach by CMHT's. This is about 0.8% of the GP practice population: this is the highest prevalence in Dorset and Somerset.

There are about 600 people in Bournemouth who have sufficiently severe learning difficulties that they need continuing support from formal services.

There are about 100 people in Bournemouth in early stages of recovery from addictions receiving formal treatment services [primary and secondary treatment].

In the 2½ years covered by this review, 55 clients presenting explicitly with mental illness and/or learning disability engaged with the smoking cessation service. This number includes some people in early recovery from addictions other than to nicotine who specifically presented themselves in those terms.

### **3 Activity targeted at people with mental illness and/or learning disability**

In the 2½ years covered by this review we have intervened specifically with people who have a mental illness and/or learning disability.

#### **3.1 Promoting the service**

The availability of the service has been promoted by:

- promoting the smoking cessation service at institutions and supported accommodation where people with mental illness and/or learning disabilities live;
- promoting the smoking cessation service at places where people with mental illness and/or learning disabilities regularly spend time;
- promoting the smoking cessation service at places used by other populations that contain a higher than usual proportion of people with mental health and learning difficulties (e.g.: places supporting people recovering from other addictions; supporting street dwellers etc.);
- running five smoking cessation groups at Peer House, a resource centre operated by Rethink for people with mental illness. This has become a continuing open group where clients engage with the service and get some support in a group context but are worked with individually;
- running one long term smoking cessation group and a further more mixed intervention at 2 Care, a private residential institution for people with mental illness and/or learning disability;
- offering one to one support for people unable or unwilling to attend public groups because of mental illness and/or learning disability;
- offering groups at the Winton Centre and at Hahnemann House which became 1:1 interventions;
- accepting referrals from professionals and carers in mental health and/or learning disability settings;
- engaging separately with clients who have mental illness and/or learning disability who have presented at open groups and drop-ins.

### 3.2 Modes of intervention in detail

Over the 2½ years of experience, several modes of intervention have been attempted. These, roughly in ascending order of cost and complexity, have been:

Mode	Brief description and considerations
<b>Open public groups</b>  <b>Cost model A</b>	<p>Open public groups are run continuously and access to these is not limited in terms of mental capacities. The only entry criteria are that the participants are adults who are ready to attempt to stop smoking and who are generally able to attend the meetings of the group.</p> <p>People with various forms and degrees of mental illness and/or learning disability do join these open groups.</p> <ul style="list-style-type: none"><li>- <i>Clients with mental illness and/or learning disability are accessing a mainstream service and joining other 'mentally well' people in an ordinary way which may enhance their integration into their wider community.</i></li><li>- <i>Attention in the group may be skewed towards people with more needs which may deprive others of the attention they need.</i></li><li>- <i>People in the group may not be used to relating to others who are mentally unwell and/or learning disabled and may inadvertently cause offence or otherwise respond in ways that trigger pathological responses .</i></li><li>- <i>Marginal costs only.</i></li></ul>
<b>Drop-in services</b>  <b>Cost model B</b>	<p>Drop-in services are run continuously and access to these is not limited in terms of mental capacities. Services are used by the general population but are also used by people who for various social, logistical or psychological reasons cannot commit to attending groups or who are uncomfortable in group settings.</p> <p>People with various forms and degrees of mental illness and/or learning disability use the drop-in services.</p> <ul style="list-style-type: none"><li>- <i>Clients with mental illness and/or learning disability are accessing a mainstream service which may enhance their integration into a wider community.</i></li><li>- <i>More time may be needed to work with someone who has a mental illness and/or learning disability than is available.</i></li><li>- <i>Drop in services are offered on a 'no appointment necessary' basis and so someone with a mental illness and/or learning disability may not initially get to see an advisor with relevant experience.</i></li><li>- <i>Marginal costs only.</i></li><li>- <i>May be engaged into a longer term 1:1 arrangement.</i></li></ul>

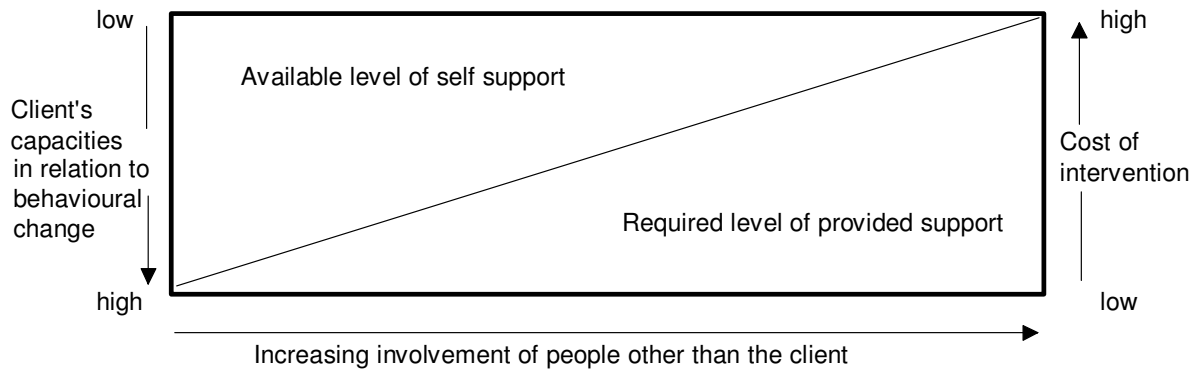
Mode	Brief description and considerations
<p><b>Training staff who work with potential clients to undertake smoking cessation interventions</b></p> <p><b>Cost model C</b></p>	<p>Staff are trained to undertake smoking cessation interventions with continuing support from the specialist service.</p> <p>Clients are supported to stop smoking by people they know and in settings they are familiar with and so change may be more easily integrated into everyday life.</p> <ul style="list-style-type: none"> <li>- <i>People who have a more detailed knowledge of their clients may be more effective at aligning smoking cessation interventions with other client therapeutic, learning and development needs.</i></li> <li>- <i>Staff may practise and develop their skills in behaviour change within their wider therapeutic or caring role.</i></li> <li>- <i>Staff may be enthusiastic about undertaking smoking cessation interventions but may not have the time to do this properly in addition to their other roles.</i></li> <li>- <i>Investment in training may or may not be recovered .</i></li> </ul>
<p><b>Special group for those with mental illness and/or learning disabilities</b></p> <p><b>Cost model D</b></p>	<p>Groups have been organised at places where people with mental illness and/or learning disability spend time. These groups have been co-facilitated by the smoking cessation advisor and one of the staff of the organisation concerned so as to combine specialist and local knowledge. The groups have been designed to be about ten weeks in duration - one hour per week.</p> <ul style="list-style-type: none"> <li>- <i>Clients have been able to work in a context specifically supportive of those with mental health and/or learning disability needs.</i></li> <li>- <i>Clients have had the security of working in a place and mostly with people that they know.</i></li> <li>- <i>The "cost per client" is relatively low though higher than for open groups. Clients usually need substantial one to one support in addition to the work done in the group and this increases the overall cost on intervention.</i></li> <li>- <i>Clients with very varying diagnoses and presentations may not be able to work cohesively as a group.</i></li> <li>- <i>The group may be relatively homogenous in the dimension of mental well-being but may be very varied in all other ways, and whatever the design it may support some but not others.</i></li> <li>- <i>Groups have been co-facilitated by a smoking cessation advisor and a member of staff from the institution where the group has met and this has extended smoking cessation skills and knowledge as well as promoting smoke free policy.</i></li> </ul>

Mode	Brief description and considerations
<p><b>Limited 1:1 support for those with mental illness and/or learning disabilities</b></p>	<p>The client is given brief advice and support to plan an attempt to stop smoking. NRT is organised and limited support is maintained through occasional meetings or by telephone.</p> <ul style="list-style-type: none"> <li>- <i>The client's abilities and independence are honoured and used to develop and fulfil their own plan.</i></li> <li>- <i>Relatively low cost of intervention.</i></li> </ul>
<p><b>Cost model E</b></p>	<ul style="list-style-type: none"> <li>- <i>The client may not be able to follow through on their plans or get sufficient support from their own social and caring networks.</i></li> </ul>
<p><b>Intensive 1:1 support for those with mental illness and/or learning disabilities</b></p>	<p>The client is given extensive 1:1 advice and support to plan an attempt to stop smoking. The client is also encouraged to organise additional support from their own social and caring network. NRT is planned and organised. Support is maintained through continuing meetings as well as telephone or written support between meetings.</p> <ul style="list-style-type: none"> <li>- <i>The gaps in the client's capacities are filled by the smoking cessation advisor who seeks to maintain the client's commitment to their plan through continuous support and monitoring.</i></li> </ul>
<p><b>Cost model F</b></p>	<ul style="list-style-type: none"> <li>- <i>The advisor may inadvertently create or amplify the idea that the client is incapable of succeeding on their own.</i></li> <li>- <i>The intensity of the intervention may amplify the transference and counter-transference processes between the client and advisor to an extent that distorts the therapeutic relationship.</i></li> <li>- <i>Relatively high costs.</i></li> </ul>

Mode	Brief description and considerations
<p><b>1:1 support with intensive intervention in the client's support network</b></p> <p><b>Cost model G</b></p>	<p>The client may not have the skills of planning, organising or maintaining their attention on the attempt to stop smoking. The smoking cessation advisor assesses that the client is not capable of managing an attempt without continuous and intensive support and encouragement from those around them. The advisor works mostly with the professional, caring and social networks surrounding the client. The advisor may train the client's support network; brief the clients social contacts; organise the use and supervision of NRT, maintain regular contact with the client and key people in their networks; and so on.</p> <ul style="list-style-type: none"> <li>- <i>Smoking is tackled in it's social context. As the client does not have the skills to change their behaviour in response to the smoking context, the context itself is reorganised. The client finds themselves moving through a world where whoever they encounter, they are encouraged to not smoke and any self efficacy is continuously encouraged and celebrated.</i></li> <li>- <i>The client is intensively supported in the areas where their capacities are lacking.</i></li> <li>- <i>This is an intervention which spreads awareness of smoking cessation beyond the individual client.</i></li> <li>- <i>It may seem that the advisor and others are "taking over" the client's way of life.</i></li> <li>- <i>The intensity of the intervention may amplify the transferential and counter-transferential processes between the client and advisor to an extent that distorts the therapeutic relationship.</i></li> <li>- <i>The costs are very high for the smoking cessation advisory service but may be less overall if the intervention into the client's social context is integrated into ordinary policy and behaviour. That is, the absence of smoking becomes the norm and smoking, should it happen, becomes an ordinary subject for challenge in the client's social context.</i></li> </ul>

## 4 Costs

The mode of intervention for a particular client or client group will be informed by the clients' capacities in relation to behavioural change. There is a spectrum of possibilities implying different levels of support and cost.



The title of this paper comes from a conversation that the author had with a consultant psychiatrist. The author asked the consultant what he thought about helping people with mental illness to stop smoking; "You'd be wasting your time", he said. The answer at first appears dismissive but in the light of experience it does raise some questions about supporting people in this area. Some observations from experience are that:

- helping people who are thought to be 'mentally healthy' to stop smoking is difficult. It is usually much more difficult supporting those who have a mental illness and/or a learning disability;
- the amount of work needed to support someone who has a mental illness and/or a learning disability is a function of their mental capacities and the degree of support available from others. Where the client's mental capacities are low and where they have little support; the costs are substantial. Estimates of the costs to the PCT are included in section 7 of this review and it is clear that overall, the 'cost per episode' and the 'cost per quitter' are much higher than for the general population;
- an extended network of professional and lay carers is often involved and unknown costs arise in various formal and informal service providers;
- additional costs arise from the need to keep professionals informed about work with a client;
- the success rate started very low but has improved significantly with learning. In the smoking cessation service, the initial measurement of 'success' is when the client has managed to remain completely abstinent from tobacco use for four weeks. Longer term success is measured by follow up telephone calls and questionnaires. Smoking cessation interventions in Bournemouth for the general population produce an initial success rate of about 75% and a three month success rate of about 60% of those engaging with the service [not including people who make contact but do not attend];
- as in other areas of mental health care, maintaining contact over time is sometimes difficult; in the 2½ years we have worked with about 55 people who presented to us as explicitly

mentally ill and/or suffering from learning disability. These clients have engaged in about 80 client episodes; that is, organised attempts at stopping smoking. Engagement with the service was sometimes sustained and sometimes sporadic. From the 80 client episodes 23 met the NHS criteria of remaining abstinent for four weeks from their quit date [about 28%].

We are still in the process of capturing longer term outcomes but from the little data we have we believe longer term abstinence rates will be similar to those in the general population;

- the clearly defined criteria for 'success' used in working with the wider population does not seem very relevant in this population where presenting pathology often confounds any system or process invented by service providers. Sometimes it is not entirely clear whether a person is smoking minimally or not at all; sometimes what the client reports cannot be relied upon to the same extent as with a 'mentally well' client; sometimes features of the smoking cessation process like 'assessment', 'planning', 'support', the use of NRT, group work and so on, have meanings that spring from psychopathologies or social needs independent of the expressed desire to stop smoking;
- the relatively lower success rate has financial and other resource implications for service providers. It also raises questions about staff and carer motivation and morale. Working in an area where 'success' in reporting terms is so poor can be demotivating, though this may also be the case for staff working in any area of enduring illness or disability;
- 'success' in other terms such as process and relationships with clients may be higher and smoking cessation interventions may have incidental outcomes in other areas of the client's life, like mental health, self esteem, diet, exercise, social contact, personal development and so on.

## 5 Benefits

To weigh against the difficulties and costs, service providers may consider that:

- people with mental illness and/or learning disability have an equal right to treatment;
- people with mental illness and/or learning disability diagnoses may have higher rates of morbidity associated with smoking than the general population;
- smoking meets all the criteria for substance dependence; a recognised psychiatric disorder;
- people in these populations may be less able to afford to smoke;
- lack of money due to financially prioritising smoking may lead to social isolation, boredom, excessive introspection and the exacerbation of mental illness;
- the fact of their smoking and the spending involved may give rise to consequential public costs; for instance, dealing with the health effects of poor diet and fitness levels;
- those clients who have successfully stopped smoking report improvements in many areas of their life including physical health, fitness, diet, social activity, self esteem and their mental health.

## 6 Working with clients

Smoking cessation groups that are run for the general population last for seven weeks [one hour per week] although the requirement for nicotine replacement therapy [NRT], when used, often lasts for 8-12 weeks. With groups who are mentally ill and/or learning disabled, the client's need for support has proven to be longer than seven weeks; typically 10-12 week programmes have been offered. More time is needed to inform clients about the options open to them, help clients plan and involve others, keep other professionals and carers informed, build the client's motivation, deal with social, medication and relapse problems as they arise and so on.

Work with individual clients has developed into the following pattern:

*Orientation and information giving*



*Seeking the client's consent*



*Assessment*



*Planning and contracting*



*Working through the period where smoking cessation is attempted*



*Celebration, measurement and review*

### 6.1 Orientation and information giving

The initial meeting with the client will usually involve:

- establishing a working relationship with the client and often their principal carer if they have one;
- discussing in general terms why they want to stop smoking and what they hope to gain by doing so;
- giving information about smoking, approaches to stopping and NRT;
- managing expectations about time scales and the likelihood of success;
- promoting planning and support as means of increasing the likelihood of success.

### 6.2 Consent

Helping someone to stop smoking, especially when NRT or other medications are being used, will constitute a treatment and so it is essential that the client gives their consent. Adults are always assumed to have the capacity to consent to treatment unless the opposite has been demonstrated. If there is any doubt about a client's capacity to consent, an appropriately qualified colleague would be called upon to assess the capacity of the client to take the relevant decisions.

Consent with regard to the Mental Health Act is unlikely to be an issue as compulsory treatment is limited to the condition that led to admission under the Act.

Consent in a wider sense may be an issue especially as many institutions are progressively limiting opportunities to smoke for reasons of communal health, safety and insurance. Carers are influenced by public health messages about smoking and in anticipation of the Health Act 2006.

People with mental illness and/or learning disabilities may be encouraged to stop smoking as part of an institution's smoking policy but such 'encouragement' for vulnerable people could also be understood as pressure. Even mentally healthy people need to be ready to stop smoking and prepared to make some effort to accomplish the change if they are to have a good chance of success. It will be more difficult for the person with mental illness and/or learning disability, and so for ethical and practical reasons the decision to attempt to stop smoking must be entirely that of the smoker who is not simply responding to pressure from others.

Mentally ill and/or learning disabled people often find it more difficult than the general population to implement plans and may need support from professionals and people in their daily lives. Often, formal and informal carers will need to be engaged in helping the client to implement their plan. This engagement may involve sharing information that would usually be confidential. Carers may need to be briefed about:

- the client's reasons for wanting to stop smoking;
- what difficulties the client has now and may face as they make their attempt at stopping smoking;
- what the client's smoking cessation plan is;
- what support the client needs to implement their plan;
- the use and management of NRT.
- how to respond to lapses and to relapse;
- where to seek help if anything goes wrong;

and so on.

It is important where other people are involved that the client's informed and written consent is obtained to the sharing of information that is relevant to their attempt to stop smoking. As well as meeting the requirement to respect the client and their right to confidentiality, the process of seeking consent can also be a sign to the client of how seriously the work of supporting them to stop smoking is being taken. Especially when supporting clients with mental illness and/or learning disability, the seeking of consent should be a process rather than a single event. People may want to change their mind about the sharing of information or withdraw specific aspects of their earlier consent.

### **6.3 Assessment**

Like other substance dependencies, the use of tobacco has biological, psychological and sociological aspects to its continuance and to its cessation. Assessment of the client and of their choice to attempt to stop smoking needs to address all of these if a plan with a chance of success is to be established.

Over the 2½ years of working with people who have presented specifically as mentally ill and/or learning disabled, we believe assessment may include:

- |                                       |   |
|---------------------------------------|---|
| <b><i>Mental health diagnosis</i></b> | <ul style="list-style-type: none"><li>- <i>Does the client have a current diagnosis and if so, what is it?</i></li><li>- <i>What purpose is served by smoking with regard to the client's mental illness and/or learning disability?</i></li><li>- <i>What impact might stopping smoking have on their mental illness and/or learning disability?</i></li></ul> |
|---------------------------------------|---|

- Relevant physical health diagnosis**
- *Does the client have any physical illnesses likely to be a result of, or affected by, smoking and if so, what are they?*
  - *If the client does have physical health problems, are these being treated?*
  - *Does the client have any physical conditions that might contraindicate the use of NRT?*
- Medication**
- *What medication is the client using?*
  - *If prescribed, who is the prescriber?*
  - *What degree of concordance is there with prescribed medication?*
  - *What role, if any, does smoking play in the client's management of side effects associated with medication?*
  - *What impact could stopping smoking have on medication?*
  - *Who manages the client's use of medication?*
  - *If the client uses NRT or Bupropion as an aid to smoking cessation, does this need to be supervised, and if so, by whom?*
- Skills and understanding**
- *How well is the client able to understand what giving up smoking means and entails?*
  - *How well is the client able to understand treatment options?*
  - *To what extent is the client able to plan and keep to plans?*
  - *To what extent is the client able to make agreements and keep to these?*
- Motivation**
- *What does the client hope to gain by stopping smoking?*
  - *Are the client's reasons sufficient to outweigh the benefits they perceive of continuing to smoke?*
  - *Does the client genuinely want to stop smoking or are they responding passively to pressure from others?*
  - *Where is the client in the cycle of change?*

**Smoking**

- *What does the client smoke (or what tobacco do they use)?*
- *What is the client's pattern of smoking (or tobacco use)?*
- *How much does the client smoke?*
- *What does the client spend on smoking?*
- *How and where does the client obtain tobacco products?*
- *What activities, locations, situations, thoughts or feelings lead the client to smoke?*
- *How addicted to nicotine is the client? (Fagerstromm Test for Nicotine Dependence).*
- *Does the client use other substances in combination or in association with smoking?*
- *How is the client affected by their smoking? (Health, fitness, financial, social etc.).*
- *Has the client attempted to stop smoking before; how and with what success?*

**Professional care network**

- *What other professionals are involved in the client's treatment and care?*
- *What capacity do they have to support the client in the attempt to stop smoking?*

**Informal care and social network**

- *Who else is involved in the client's treatment and care?*
- *Who does the client usually spend time with?*
- *How and where does the client spend their time?*
- *What support can the client expect from carers, friends and relatives?*
- *Does anyone in the client's social network encourage or facilitate their smoking?*
- *Who else in the client's social situation smokes and how will this effect the client's attempt to stop smoking?*
- *What support do informal carers need from professionals if they are to successfully help the client stop smoking?*

**Social context**

- *Does the client's social situation support or impede their attempt to stop smoking?*
- *Is there sufficient support available in the client's social context?*

Gathering information from mentally ill and/or learning disabled clients can present special problems. Clients are sometimes not able to communicate well; they sometimes say what they imagine the practitioner wants to hear or what others have taught them to say. At the other end of the spectrum, clients can be directly or subtly aggressive.

With clients who have mental illness and/or learning disability, the task of assessment is continuous. For instance, if the client relapses after their initial attempt at stopping smoking, and if the relapse is sufficiently severe or enduring, it may be necessary to cease the use of NRT and inform others involved in care and prescribing so that medications and other therapeutic interventions can be reassessed.

## **6.4 Planning and contracting**

Following assessment a decision will have to be taken about whether to continue with a smoking cessation intervention with the client.

### **6.4.1 The decision to support a quit attempt**

There may be several reasons why the intervention might not go ahead. For instance:

- the client may not be sufficiently motivated to change;
- the client may not have sufficient support available to give their attempt a reasonable chance of success;
- the level of support available to the client may be insufficient to outweigh impediments arising from their mental illness and/or learning disability;
- it may be the wrong time; other factors in the client's illness or condition; or in their life in general, may significantly impede their chances of success at this time.

### **6.4.2 The risks of supporting a failed attempt**

Attempting to support the client when the chances of success are low carries the risk of diminishing the client's self esteem through perceived 'failure', using the time of professionals and carers ineffectively; and creating or confirming negative beliefs about the possibility of giving up smoking and maybe about change in general. Such outcomes may impact negatively on the client's mental health.

### **6.4.3 Environmental factors**

If environmental factors are likely to impede the client's success, for instance, if smoking is a normal and significant activity in an institutional place they live, then consideration may be given to making another type of intervention, say promoting smoking cessation at the institution first before intervening with the individual client.

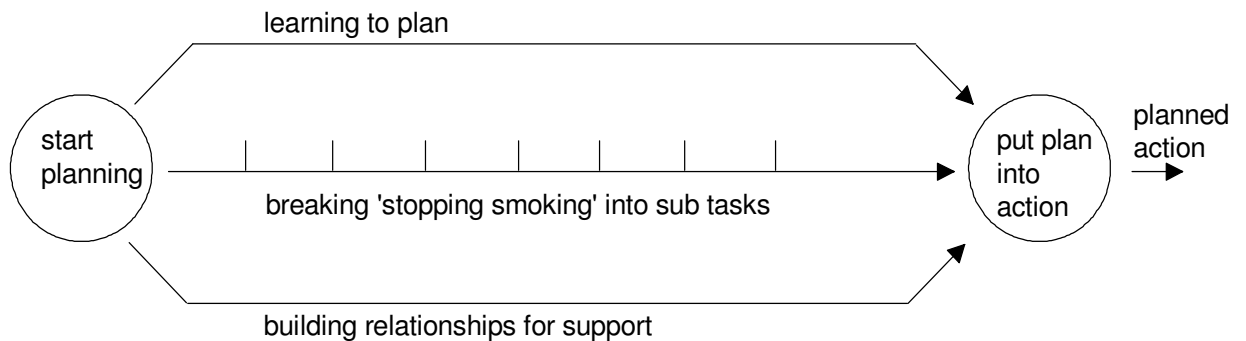
## 6.4.4 Formulating a plan

If the decision is to go ahead, then a plan will be formulated in discussion with the client and probably with others. This plan will certainly involve contracts between the client and others. The questions here are:

- what will the client have to do to give their attempt at stopping smoking the best chance of success?
- what skills and other resources can they deploy in their attempt?
- what support will they need from others?

The process of planning itself appears to be part of the engagement and learning needed to help clients make a good attempt at stopping smoking. Planning itself requires certain tasks to be done, for instance:

- meeting, conversing about specific subjects, recording views and decisions;
- breaking a large task [stopping smoking] down into a number of smaller tasks [asking for support, not buying tobacco, using and managing NRT, recording savings, generating ideas to address difficulties, making new rules etc.];
- informing others and making agreements for the support required.



Many of the skills involved in the task of planning are also required in the wider task of 'stopping smoking' and in this sense the planning phase is also a learning phase in preparation for the actions required.

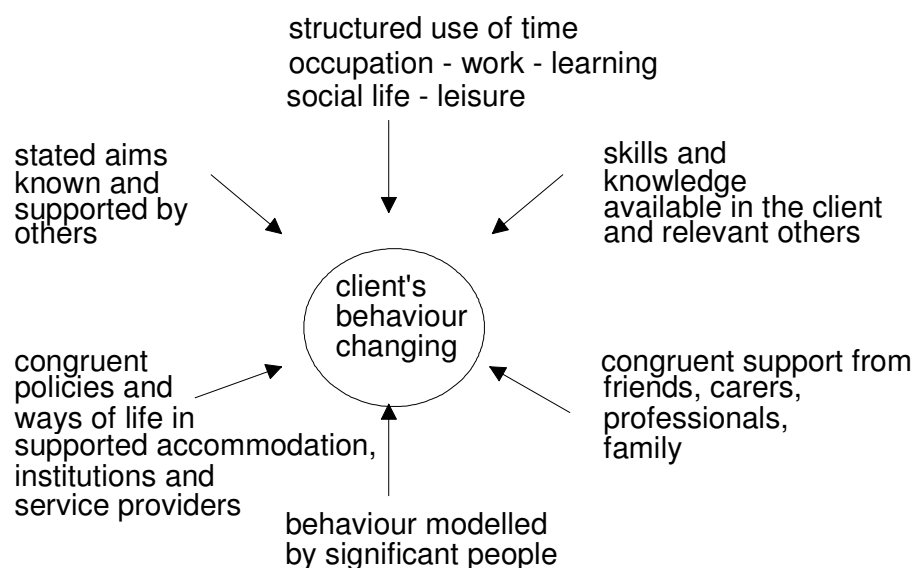
## 6.4.5 The contents of the plan

The plan developed with the client and others involved needs to address issues that have arisen in the assessment. There are many such issues but a few of the most common are:

- What purpose does smoking serve for the client in the context of their mental illness and/or learning disability? For instance, if the client uses smoking to deflect their attention from distressing 'voices' arising from schizophrenia how will they manage voices when they stop smoking? What other professionals need to be involved?

- How does the client spend their time? Many clients living in the community in supported accommodation have very inactive lives and use smoking to cope with feeling bored or simply to fill time. How can their activity level be increased?
- Smoking is often a normal or normalising behaviour in their social context. How will they manage relationships with friends without smoking?
- Smoking is often used to deflect from thoughts and feelings they are not able to tolerate. How can their management of feelings be improved? If the feelings are dangerous, for instance - feelings towards self harm, how can this be managed?
- What medications are they using? Many medications used in the treatment of mental illness are metabolised at different rates when smoking ceases. Who needs to be informed so that medication can be reviewed in the light of the attempt to stop smoking?
- What social support does the client need? Who will remind them to use their NRT? Who will encourage and praise them between group meetings or 1:1 sessions with the smoking cessation advisor? Who will remind them not to buy tobacco? Who will ensure they are not offered tobacco?

Changing behaviours which are reinforced by addiction, social norms and habits; and which serve the person in transiently useful ways is difficult. Success depends upon the desired change being supported by the social context within which the person moves. Interventions will have to be made into that social context to a degree informed by the level of support needed.



An example of the type of plan we are developing with clients is at appendix B.

## 6.4.6 Documenting and distributing the plan

Plans must be documented to provide a consistent record of what decisions have been taken that can be communicated to the various professional and lay carers as well as involved friends and relative. The documentation of the plan also helps to prevent the advisor getting caught up in chaotic or overly rigid thinking and behaviour that can often accompany mental illness. We have found that clients with mental illness and/or learning disabilities are very poor at documenting their plans and we have substantially undertaken the task for them.

## 6.4.7 Avoiding planning

Many clients and carers want to avoid or greatly hasten the planning phase of the attempt. Often, a client says they feel motivated to stop smoking immediately. Often, they have already stopped smoking before any engagement with the smoking cessation service and say that all they need is NRT. Carers often support this position. In this situation it is very difficult for smoking cessation advisors to resist the desire for immediate action, particularly to arrange for the prescription of NRT. However, it has been our experience in almost all cases that giving in to the desire to act without planning does not lead to a successful cessation. The client's apparent motivation is often nothing more than a strong idea picked up from someone else and amplified; their desire to act without planning is often part of their psychopathology. The enthusiastic carer often sees an opportunity for a quick success which is not moderated by an understanding of the difficulties involved in changing an addictive behaviour. The client may get angry or dispirited if they are discouraged from acting immediately or denied NRT until sufficient planning is done, but although it seems perverse to impede someone who wants to give up smoking at once, so far that has turned out to be the more successful choice.

## 6.5 Gathering support

The client's needs for support will be determined by the gap between what skills and other resources they are able to deploy and views about what is needed to give the attempt a good chance of success. These views may come from many people. Clearly the client themselves and the smoking cessation advisor, but also other professionals, formal and informal carers, relatives and friends. Clients with mental illness and/or learning disability, usually have an extensive network of professional, formal and informal carers.

### 6.5.1 The support community

The client's relevant networks and sources of support may include some or all of the following:

Medical community	GP; Consultant psychiatrist / psychologist; CPN and the Community Mental Health Team; OT; dietician; midwife.
Other professionals	Social worker; addiction key worker; ancillary staff in psychiatric hospitals; staff in other institutional settings: exercise or fitness advisor.
Housing community	Accommodation providers; housing or tenancy support key workers.
Formal and informal carers	Immediate and more distant family members; friends; day care or day centre workers; daily service providers [people who prepare food, clean etc].

## 6.5.2 Engaging support

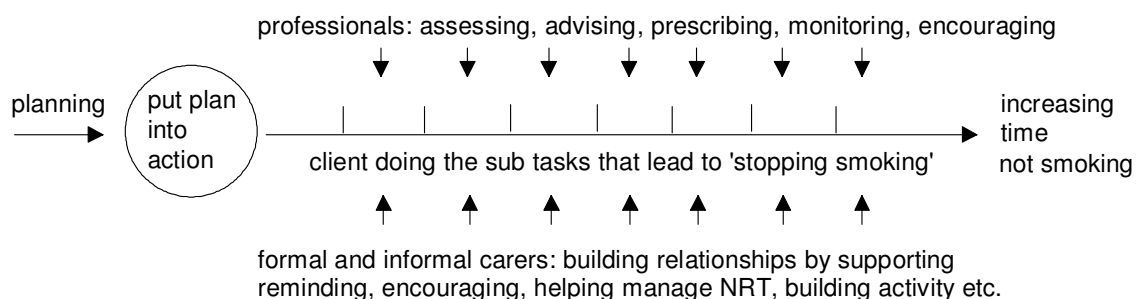
Engaging these various carers in the process of planning and managing the clients attempt to stop smoking is extremely difficult, especially within the medical and professional mental health communities.

The documented plan produced and agreed with the client, is copied to the relevant people in the client's network of supporters. 'Relevant' means the person has some agreed or professional part to play in the implementation of the plan. For instance:

- a review of medication may be necessary by the consultant psychiatrist;
- the assessment for and the prescription of NRT may be necessary by the GP;
- encouragement may be needed from the CPN;
- the management of NRT medication may be needed from staff in supported accommodation;
- increased activity and the avoidance of tobacco may depend on action by key workers;
- encouragement, reminding and praise will be needed from everyone.

## 6.5.3 The roles of supporters

Smoking has been a normal everyday activity for clients. Their reasons for smoking are complex and, as for any other smokers, usually include addiction to nicotine, habits arising from repeated daily smoking and managing feelings. They will be cued to smoke by habitual links between a normal daily action and smoking, by distressing or even positive feelings, by social interactions, and of course, by nicotine withdrawal symptoms. The purpose of involving so many people in the client's plan is that clients with mental illness and/or learning disability usually have difficulty maintaining focus on a task. They need to be repeatedly reminded and encouraged along the course of their plan. This can only be done sufficiently if the people they encounter in everyday life are engaged in the work of supporting the client in operating their plan.



## 6.5.4 Keeping professionals informed

Though it is difficult to engage many people, especially professionals in the planning process, once the plan is created and the client makes their attempt to stop smoking, keeping this network informed becomes a significant time cost for the smoking cessation advisor. Professionals, who are engaged much of their working day with many clients, sometimes at different locations, are often difficult to contact informally; for instance, by telephone. This combined with the need to communicate information precisely often means that communication is by letter. Our experience over the two years has been that it is often not possible to keep everyone who is involved informed to an ideal degree.

## 6.6 NRT and Bupropion

Most clients choose to use some form of NRT although a few have managed their attempt to stop smoking without any pharmacological support. Clients who are mentally ill and/or learning disabled are often strongly influenced by what they've heard from others and sometimes by irrational ideas arising from their psychopathology.

It is sometimes useful to try out a type of NRT during the planning phase to find out if it is acceptable to the client and has no unexpected aspects. This means asking the client's GP to prescribe an NRT option minimally as a trial.

Some clients with mental illness and/or learning disability are not capable of managing the use of NRT. Whether the client manages the use of NRT is informed mostly by whether they manage other medications.

Where others are involved in the management of NRT they will have to be briefed about how to do this and where to get information quickly if any problems arise.

There have been a few cases, especially where the client has been in recovery from substance dependence, where suspicion has arisen that NRT was being misused as:

- a stimulant in place of or in addition to smoking;
- a tradable commodity;
- a means to acquire medication of any type to satisfy a pathological need arising from a mental illness.

Bupropion has only been prescribed once for a client engaged within the scope of this review. The client did not have a clear mental health or learning disability diagnosis but was clearly not mentally well. Bupropion was prescribed after several forms of NRT and intensive support had proven ineffective. Bupropion in turn also proved to be ineffective with this particular client.

Caution is needed in the use of Bupropion as the product characteristics cite many contraindications and possible drug interactions, many relevant to the treatment of mental illness.

## 6.7 Working with clients - special features

In the smoking cessation service 1:1, group and organisational interventions are offered. Where the service is working directly with clients a variety of counselling modes and styles are used informed by the particular client or group, the context and the practitioner's training.

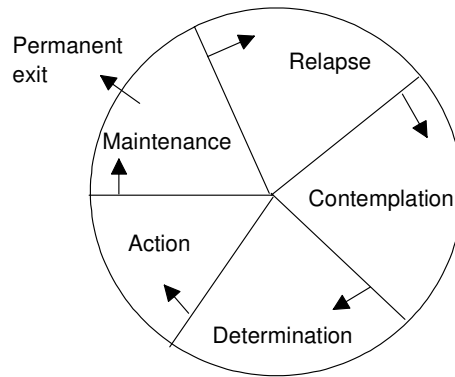
### 6.7.1 Motivational interviewing

Most of the work done directly with 'mentally well' clients can be described in terms of motivational interviewing, a mode of counselling and a body of counselling techniques aimed at helping people to change addictive behaviours.

The mode recognises several stages of behavioural change and values different interventions and styles in response to where the client is in the 'cycle of change' although there is no evidence that this model is better than any other in terms of informing the practitioner's interventions. What is necessary is that the practitioner is sensitive to the client's capabilities and situation when making an intervention or proposing actions.

It is not clear how useful the techniques of motivational interviewing are when working with people who are mentally ill and/or learning disabled. Clients are often very poorly motivated and unused to managing change in their own lives.

Motivational interviewing as a body of techniques relies upon clients having sufficient cognitive abilities. The ability to weigh up costs and benefits, to set goals, to plan and so on. With mentally ill and/or learning disabled clients it's these very capacities that are often impaired. Different meanings and priorities are attributed to various aspects of life which make understanding and communication difficult. Clients are often unused to planning and keeping to agreements: they sometimes understand and value these activities differently from the 'mentally well'.



Stages of change

### 6.7.2 Interruptions and ambivalence

Work that is attempted is often interrupted by thoughts, feelings and behaviours arising from the client's mental illness and/or learning disability. These interrupting features are different depending on the client's diagnosis and presentation and how severe the mental illness and/or learning disability is. Information that may be intended to inform the client may instead cause them alarm; suggestions may be understood as instructions, medications may be understood as poisons, and so on. Also, sometimes, the severity and presentation of the illness or disability are themselves dynamic and the practitioner may be responding to what sometimes seems to be a different person at each meeting.

Ambivalence is normal. Clients want to stop smoking *and* to continue. The struggle between these poles is mostly the work in the maintenance phase. Ambivalence often arises in carers too who may want the client to stop smoking but remain the same in all other respects. For instance, how can the client be easily calmed down or rewarded if the mechanism in the past has been a cigarette?

There is almost never an absolutely 'right' intervention. Anything the practitioner does will have positive and negative possibilities associated with it. What works one day may not work the next; in this sense, the work is always experimental.

### 6.7.3 Transference

As in all helping professions, practitioners need to beware of transference and counter transference in their relationship with the client and their carers. The client may begin to rely to an unreasonable degree on a practitioner or alternatively experience the practitioner as oppressive. The harder the practitioner works, the more the client may locate responsibility for change in the practitioner. The practitioner in turn may take increasing responsibility for supporting their client who may indeed need a lot of support. The practitioner may become critical in response to a 'difficult' or 'unsuccessful' client. They may also get drawn into aspects of the client's life that are connected with smoking and smoking cessation like diet, fitness, spending, accommodation and so on. This is especially a difficulty where the client has high support needs which require relatively intensive intervention. It is also a difficulty because as in so many health matters, smoking is a bio-psych-social activity and the boundaries of the problem and for intervention are far wider than first appear.

### 6.8 Celebration, measurement and review

As the amount of time that the client has managed to not smoke increases, the question arises about how to withdraw from the relationship.

Celebration is a key element in this. Ideally, celebration would be happening anyway as the client manages to implement different aspects of their plan, but it can also be used as a way of signalling the end of part of the supporting relationship.

Celebration is usually about more than just having stopped smoking. If the client is to maintain their abstinence then establishing in their mind the continuing benefits they have gained is crucial. The client may also have achieved successes in areas linked to smoking cessation and reminding them of this increases their capacity to remain abstinent.

The client might want to celebrate by:

- talking about health or fitness improvements;
- expressing feelings associated with becoming a non smoker;
- talking about what they've learnt in the process of stopping;
- talking about what they've gained financially and what their plans are in this respect;
- praising themselves;

and so on.

In general, what is being celebrated is the achievement, to whatever degree, of the client's criteria for success. This may be less specific than the NHS criteria. The smoking cessation service will only engage with people who want to stop smoking completely. The client may have had this initial aim but have come to accept a significant reduction in smoking as the best they can manage or, they may have stopped smoking in readiness for a specific event like a surgical procedure or other in-patient episode and having achieved that may want to take up smoking again. For many clients, simply having made an organised attempt to change something may be a significant achievement.

It will be useful to remember that the client has already lost what they experienced as a means of support, i.e. smoking. They are now also about to lose their relationship with the smoking cessation advisor and their position as the focal point of attention from various people who have been supporting them. Ideally, some of those supportive relationships will continue without the 'giving up smoking' focus, but a paradox of working hard to support someone to change is that rather than experience the loss of support, the client may relapse as an aware or unaware strategy for keeping it.

The smoking cessation advisor will need to brief the client and often their carers about what to do in the event of lapses or of a full relapse. This would also have been done earlier as part of planning but would probably have been forgotten by now. Reassurance about the availability of support may be needed. Depending on the length of the engagement with the client, there may still be issues about the continuing use of NRT and approaches to reduction to be discussed and agreed.

## 7 Outcomes

In the 2½ years covered by this paper, 55 clients have presented to the smoking cessation service explicitly as mentally ill and/or learning disabled and needing advice and support beyond what is usual for the general population of smokers. These clients collectively engaged in about 80 client episodes; that is, clients often needed more than one attempt to stop smoking.

### 7.1 Reported diagnoses

Diagnoses for 55 clients as reported by the clients themselves, by carers or by physicians have been:

Primary reported diagnosis <sup>1</sup>	Number
Schizophrenia	21
Recovering from substance dependence [other than nicotine]	7
Learning disability	6
Personality disorders	6
Depression and other affective disorders	6
Brain damage and neurological disorders	2
Not known	7

Note:

<sup>1</sup> Many clients have more than one diagnosis.

## 7.2 Interventions and cost<sup>8</sup> models

Cost model <sup>1</sup>	Intervention	Number of clients <sup>7</sup>
A	<i>Open public group<sup>2</sup></i>	1
B	<i>Drop in services<sup>2</sup></i>	1
C	<i>Training staff who work with specific and potential clients to undertake smoking cessation interventions in their institutional setting<sup>5</sup></i>	2
D	<i>Special group for those with mental illness and/or learning disabilities<sup>3</sup></i>	36
E	<i>Limited 1:1 support for those with mental illness and/or learning disabilities</i>	11
F	<i>Intensive 1:1 support for those with mental illness and/or learning disabilities<sup>4</sup></i>	7
G	<i>1:1 support with intensive intervention in the client's support network<sup>6</sup></i>	4

### Notes:

1. Cost models are broadly in ascending order of cost per client episode.
2. Many more people who are clearly mentally ill or have learning disability attend open groups and drop-in sessions but do not explicitly present as such.
3. Most clients who start out in a special group move on to receive support in a 1:1 context - cost models E, F and G.
4. In most cases this has also involved training client support staff - cost model C.
5. Training for staff has been explicitly undertaken at two institutions and less explicitly, through repeated contacts, briefings and co-working at a further four. There are probably some unrecorded outcomes leading from these interventions.
6. All four clients started out in special or open groups - cost models D and A.
7. There is some double counting where clients engaged in different cost models in the same quit attempt.
8. It is not possible to link costs directly to each cost model as clients usually move between models in a single episode of treatment.

### 7.3 Location of costs

The PCT costs associated with particular modes of intervention arise mostly from staff time. Other costs are involved and are located across several types of organisation. Costs arise in:

Costs of:	Costs accrue to:
SmokeStop advisor time	PCT.
Medication and prescribing	PCT and GPs.
Mental health services	Dorset Healthcare NHS Trust / Not for profit organisations; eg 'Together' , 'Rethink' <sup>1</sup> and 2Care.
Care, support and management	NHS Trusts; Bournemouth Social Services; Not for profit sector; Private sector [mostly housing].

Note:

1. Rethink, through their Peer House Resource Centre have been a particularly helpful partner in the work covered by this review. They have made premises available for special groups, helped substantially with promoting the service and made co-facilitators available. They have also been an easy to access source of expertise concerning mental illness.

### 7.4 Smoking cessation outcomes

Outcomes to date for 80 client episodes<sup>1</sup> have been:

Outcomes	Number
Waiting to set a quit date	3
Did not set quit date or quickly lost contact with the service:	10
Set a quit date but did not quit:	33
Set a quit date and still quit at 4 weeks:	23 <sup>2</sup>
Set a quit date and still quit at 3 months:	11 [reported so far]
Set a quit date and still quit at 6 months:	5 [reported so far]

Notes:

1. An "episode" is taken to be an organised and supported attempt to stop smoking. Many clients have chaotic presentations which resist precise definition and categorisation.
2. Successful quit outcomes are not distributed evenly over the period covered by this review; they are disproportionately represented in the last year.

## 7.5 Cost of outcomes

Comparative costs estimated for client episodes and quitters are:

<b>Estimated outcome costs February 2004 - August 2006</b>		
	General population <sup>1</sup>	Mentally ill and/or learning disabled population covered by this review <sup>2</sup>
	£	£
<b>Cost per episode</b>		
Estimated cost per episode excluding NRT/Bupropion	102	154
Estimated cost per episode including NRT/Bupropion <sup>3</sup>	132	184
<b>Cost per quitter</b>		
Estimated cost per quitter excluding NRT/Bupropion	155	536
Estimated cost per quitter including NRT/Bupropion <sup>4</sup>	225	636

Notes:

1. Costs for the general population have been estimated by dividing the entire service budget for the period by total client episodes and quitters respectively.
2. Costs for the mentally ill and/or learning disabled clients covered by this review have been estimated by dividing the gross manpower costs of delivering the service to this client population by episodes and quitters respectively. 'On costs' of employment and costs arising in other services, other than for NRT, have not been included.
3. Average NRT/Bupropion costs per episode have been estimated at £30.
4. Average NRT/Bupropion costs per quitter have been estimated at £70 for the general population and £100 for the population covered by this review.

## **8 Learning**

- Helping people with mental illness and/or learning disability requires different tactics and strategies than those required for the general population.
- It is not helpful to assume that clients can deploy the life skills often available to the 'mentally well'.
- When working with a client who has a severe mental illness or who has a significant learning disability, it is necessary to engage mostly with the people who surround them in their daily lives.
- Thorough assessment is essential to ensure a relevant plan is made and to ensure that stopping smoking does not have unintended pathological consequences.
- Planning and documenting the plan is essential both to establish repeatedly in the client's mind what needs to be done but also as a means of engaging others, signalling to the client and others that a serious intervention is being undertaken, creating a consistent record of what has been said and agreed, distributing relevant information to professionals and building skills and awareness in the client through the planning process.
- Special groups for people with mental illness and/or learning disability are useful for promoting various forms of support and giving information. Detailed work with individuals is more likely to be successful in 1:1 meetings. The combination of group and 1:1 work is the client contact strategy we believe has worked best so far.
- Where people live in supported or institutional accommodation, interventions involving the staff at those places and the development of smoke free policies there, are helpful strategically and tactically.
- Clients presenting to the service who are in early recovery from drug and/or alcohol addiction are more likely to succeed if similar approaches are taken as for those who present with explicit mental illness.

## **9 Policy implications**

- The costs of offering the smoking cessation service to people with mental illness and/or learning disability are significantly higher than for the general population.
- Different practices and procedures are required when working in this field.
- Formal definitions of success and failure may not capture wider health and social gains.
- There may be a prize to be won by succeeding with smoking cessation in this field in terms of better mental health, diet, physical health, social well-being, fitness, financial well-being, occupation and so on.

## **Appendices following:**

A - Illustrative case studies

B - Typical smoking cessation plan for a mentally ill client

C - Medications affected by smoking and smoking cessation

## **Appendix A - Illustrative case studies [anonymised]**

### **Dan**

*Dan is a young man living alone who has a diagnosis of learning disability. He has spent much of his earlier life in institutions. His day to day life is chaotic with disrupted sleep patterns, late nights out, heavy drinking and the use of cannabis. He is socially isolated and spends most of his time playing video games and watching television and violent videos. He lives in private sector supported accommodation. He smokes anything from 20 to 60 cigarettes each day though he says he smokes more. He is sometimes prone to the use of violent language and may have been actually violent in the past; though this is not certain.*

*Dan does not want to attend groups feeling that he might disrupt these. He is also scared of groups. On seeking help from the SmokeStop team he is engaged on a one to one basis. He wants to start using NRT at once at high doses but the advisor holds him back insisting on several assessment and planning sessions. Though Dan goes through the motions of planning he does not seem committed, continually wanting to start now rather than prepare. Eventually, the advisor visits his GP with him to get NRT prescribed.*

*Immediately, Dan disengages with the service, failing to attend agreed meetings or responding to telephone calls. Only by visiting the client at his home is it discovered that Dan is using NRT as well as cigarettes.*

### **Ben**

*Ben is a married man in his 30s with schizophrenia which is controlled. He says he is scared of groups and is often very sleepy especially after his regular administration of depot medication. He smokes quite heavily to modify the side effects of his medication. He spends a lot of time watching television and drinks alcohol daily through boredom.*

*Ben engages in a one to one relationship with the smoking cessation advisor with whom he develops a plan. The plan includes involving his CPN and consultant in a review of medication, getting his bike repaired so that he can occupy his time more and get some exercise. He is encouraged and supported by the smoking cessation advisor and his CPN to apply for work on a local garden project.*

*NRT is prescribed. The initial product used produces uncomfortable side effects and has to be changed. From then on Ben manages well but needs regular contact in the maintenance phase. Ben struggles with cravings and for a while speaks with the smoking cessation advisor by telephone almost daily. At one point Ben uses herbal cigarettes to moderate cravings and nearly relapses. Ben manages to remain abstinent and 1:1 meetings are progressively replaced by telephone calls and the occasional text message as the relationship is ended.*

## **Mary**

*Mary is a woman in her 50s with schizophrenia and living in supported accommodation. Her ability to communicate is very poor, largely echoing very loudly what others say. What she does communicate often does not accord with direct observation and cannot be relied upon. She smokes very heavily and, contrary to the rules where she lives, she also smokes secretly in her bedroom. She reports not liking smoking but smokes 20-40 cigarettes a day. Her continued secret smoking will lead to her having to be re-accommodated; something she does not want. She uses a wide variety of medications which are managed by the staff at her supported accommodation and receives depot medication from her CPN. She had previously managed to stop smoking for a while and the staff reported that her mental health presentation had much improved at that time. Most of the residents where she lives smoke and they occasionally offer her cigarettes.*

*Because of Mary's very limited ability to remain focussed on a subject, to communicate accurately or to adhere to agreements, the smoking cessation advisor intervenes mostly with the staff at her supported accommodation. While Mary continues to attend a smoking cessation group for general support, the smoking cessation plan is mostly worked out with the staff. The plan is also reviewed several times with Mary as it develops. The plan includes training the staff about smoking cessation generally and how to support Mary's attempt to quit specifically. Training the staff is difficult as most speak English as their second language. The plan involves all the staff, Mary's co-residents and one relative. The plan includes how to increase Mary's activity in the weeks after stopping; how to modify the structure of her day so that she eats more regularly; how to impede the purchase of tobacco as well as reward strategies for keeping to the plan.*

*Mary manages to stop smoking for about eight weeks and is now smoking occasionally. The staff are still working with her towards full cessation.*

## **Jim**

*Jim lives in very poorly supported accommodation. He has schizophrenia and wants to stop smoking because he experiences 'voices' which tell him to. He has a very poor diet, often missing meals. He gets £50 per week 'pocket money' and spends £35 of this on cigarettes. He has virtually no social life or meaningful occupation, spending most of his time watching television or sitting on a bench in the park. He has made several attempts to stop smoking using all forms of NRT over the years. His attempts have been unorganised responding immediately to a desire to stop initiated by his 'voices'. Sometimes he has been supplied with NRT lozenges by a well meaning friend who is also mentally ill. The smoking cessation advisor has some suspicion that Jim uses NRT as a stimulant as well as a genuine support to stop smoking. Jim has weekly depot medication administered by his CPN.*

*The smoking cessation advisor develops a plan with Jim and a day centre worker who has frequent contact with him. The plan involves an organised and monitored use of NRT, attendance by Jim at a 'voices management' group and a self esteem group run by a local mental health day centre. He is also involved in a gardening project to occupy some time. The advisor also visits the manager of his supported accommodation to engage the staff in the plan especially with regard to encouraging Jim to eat regularly. Jim manages to stop smoking for three weeks and relapses. With the agreement of his GP He then makes a further supported attempt and manages to quit.*

## Appendix B - Typical client smoking cessation plan [anonymised]



Anny Smith [Dob: 3.7.48]  
86 Blantyre Road  
Bournemouth BH1 6T

### People supporting the client

Supported accommodation owner / manager	Jenny Stokes 86 Blantyre Road, Bournemouth BH1 6TT Tel: 01202 ***** Mobile: 07785 *****
Key worker	Anna Carer [as above]
Consultant	Dr G Skullen Kings Park Hospital, Gloucester Road Bournemouth BH7 6JE Tel: 01202 *****
CPN	Martha Nurse Dorset Healthcare NHS Trust Bournemouth CMHT Kings Park Hospital, Gloucester Road Bournemouth BH7 6JE Tel: 01020 *****
GP	Dr B Healthy Ratcliffe Surgery, 14 Seafront Crescent Bournemouth BH1 4RR Tel: 01202 *****
SmokeStop advisor	Peter Keene Bournemouth Primary Care NHS Trust SmokeStop Team Littledown Centre, Chaseside Bournemouth BH7 7DX Tel: 01202 436868 Mobile: 07810 835181
Day Centre	Sally French Rossen House, 42 Orsett Road, Bournemouth BH1 5TT 01202 *****
Sister	Helen Runciman 26 Arcadia Road, Scunthorpe PE21 9BU 01457 *****

## **Information from meetings with Anny, and her key worker and other carers is that:**

### **Smoking pattern and costs**

- probably smokes about 20 manufactured cigarettes a day, sometimes more;
- sometimes exchanges cigarettes with co-resident [Bill];
- smokes "Sterling" and "Red Band" at about £4 per pack of 20: about £28 per week;
- smokes until money all gone;
- mostly buys cigarettes from shop in Palmerston Road;
- smokes fairly continuously during the day and may smoke sometimes at night;
- sometimes denies smoking when she is.

### **Health**

- she is ill with schizophrenia;
- mental health seemed to improve when not smoking five years ago;
- she has stomach discomfort and says she has a hiatus hernia;
- she has had a hip replacement operation about 6 years ago;
- sometimes feels sick and vomits;
- she uses a variety of medication supervised by the staff at 86 Blantyre Road;
- she more often than not, misses breakfast.

### **Reasons for smoking**

- nicotine dependency;
- feels anxious when not smoking;
- smokes to "contradict self image";
- smokes to occupy time, hands and mouth.

### **Reasons for stopping smoking**

- health;
- money - has arranged to visit sister in Scunthorpe in May;
- may stop if smoking is positioned as a lower class' activity;
- improve self image.

### **Quit date**

- quit date: Monday 6 March.

## Nicotine replacement plan

Anny tried to stop smoking in 2005 using 24 hour 21mg NRT patches. She had a little success with this but started using herbal cigarettes and then increased use of tobacco based cigarettes to her current level of about 20 pd.

On 17 February 2006, Anny tried using an NRT inhalator and seemed comfortable with this. It has the advantage of being a smoking substitute as well as a nicotine replacement therapy. The occupation of her hands and mouth seemed to be useful to her. It may be that if she can be persuaded to use an NRT inhalator for a substantial time, say 3 months, she will be able to recover from some of the debilitating effects of smoking sufficiently to give her the energy and insight to progressively stop 'smoking like' activity (ie. using the inhalator).

Anny has been shown how to use the inhalator. The use of the NRT capsules will be managed by the staff at her supported accommodation. The plan is that Anny will use the NRT inhalator for 12 weeks. Over time, the aim should be to habituate Anny to use no more than 6 capsules pd and to start cutting down after about 3 months by slowly reducing the number of capsules pd.

The pattern of use to aim for is:

Weeks 1 - 8 6 March - 30 April	Anny will be given one strip of six NRT capsules per day. If she uses these and asks for more, she will be given a maximum of one further strip per day; a maximum of 12 capsules per day.
Weeks 9 - 10 1 May - 14 May	Anny will be given a maximum of one strip of six cartridges per day.
Weeks 11 - 12 15 May - 28 May	Anny will be progressively weaned off the use of cartridges by slow reduction.

It is important, especially in the early weeks, that Anny uses sufficient NRT. The staff at her supported accommodation should encourage her not to scrimp on NRT use and also check that unused capsules are not being built up [hoarded].

The inhalator mouthpiece must be cleaned by rinsing in water at least twice a week. Each pack of cartridges will contain a new inhalator.

## Reviewing this plan

The plan will be reviewed weekly during the smoking cessation group meetings at Rossen House while that group meets and at least fortnightly at her supported accommodation.

## Activity

When Anny attempts to stop smoking she will need more activity, especially in the early weeks. Increased activity will help by:

- keeping her busy and reducing the opportunity to think about and acquire cigarettes;
- use up the extra energy she will probably experience from having less CO and more oxygen in her blood as well as improving lung capacity;
- increasing her appetite so that she eats more rather than responding to hunger by smoking;
- reducing the possibility of boredom which is a common cause of relapse.

## Social support plan

Aim	Who	... will do what
Brief staff on smoking cessation and how to support AS	PK	Briefing session at Blantyre Road on 2 March.
Impede purchase of cigarettes particularly from shop in Palmerston Road.	AC JT	Agree spending money and monitor amounts so as to reduce the possibility of buying cigarettes. Encourage AS frequently to not buy cigarettes but to use the inhalator instead.
Impede co-residents as far as possible from giving cigarettes to Anny or buying them for her.	AS JT	Make agreements as far as possible. Remind residents through poster campaign and in current affairs sessions.
Frequent praise for decision to not smoke and achievements so far.	AC JT	Congratulate Anny on each successful day.
	PK SF	Weekly praise for not smoking at Rossen House.
Help Anny understand and make real the benefits of not smoking.	PK	Prepare savings record for money saved.
	AC	Keep and update record for money saved.
	AC	Help Anny to keep a record for money saved.
	AC	Organise and manage shopping trip for Anny with spending linked to savings record.
	AS JT AC	Frequent reminders about savings in relation to Scunthorpe trip.
Increase Anny's activity.	AS JT SF	Encourage joining more activities at Rossen House.
Encourage breakfasting.	AC etc	In the early weeks to encourage Anny to eat some breakfast; initially in her room and progressively in the dining room.
Encourage concordance with NRT plan.	All	Daily reminders from staff at supported accommodation and at all meetings with other people involved in her care.
Inhibit secret smoking in bedroom.	JT	Installation of smoke alarm sensitive to tobacco smoke.

## Appendix C - Medications affected by smoking and smoking cessation

Drugs affected by Tobacco Smoking: Compiled for Smoking Cessation Service for  
Mental Health Units

### ***Mental Health Drugs***

<b><i>Drug</i></b>	<b><i>Interaction with smoking</i></b>	<b><i>Clinically significant?</i></b>	<b><i>Nicotine or polycarbons in smoke</i></b>	<b><i>Management in smoking cessation</i></b>	<b><i>References</i></b>
Benzodiazepines e.g. diazepam, lorazepam, chlordiazepoxide	Smoking causes lower plasma levels	Unclear	Polycarb	May need lower doses on conversion to NRT	Stockley Bazire
Zolpidem	Smoking may cause lower plasma levels	Probably minimal	Polycarb	May need lower doses on conversion to NRT	Stockley Bazire SPC
Propranolol	Smoking causes lower plasma levels	<b>Yes</b> – smokers may need higher doses	Polycarb	May need lower doses on conversion to NRT	Stockley
Beta-blockers – general	Effects on heart rate and blood pressure from smoking may negate effect of beta-blockers	<b>Yes</b> – smokers may need higher doses	Nicotine	May need lower doses as nicotine levels reduced with NRT	Stockley
Chlorpromazine	Smoking may cause lower plasma levels	Unclear	Polycarb	May need lower doses on conversion to NRT	Stockley Bazire
Clozapine	Smoking causes lower plasma levels	<b>Yes</b> – smokers may need higher doses	Polycarb	May need lower doses on conversion to NRT – can be huge difference. Take trough plasma level before conversion to NRT and after 2 weeks, or sooner if side effects develop.	Stockley Bazire SPC CPMS
Haloperidol	Smoking causes lower plasma levels	<b>Yes</b> – smokers may need higher doses	Polycarb	May need lower doses on conversion to NRT	Stockley Bazire
Olanzapine	Smoking causes lower plasma levels	<b>Yes</b> – smokers may need higher doses	Polycarb	May need lower doses on conversion to NRT	Stockley Bazire
Fluphenazine	Smoking causes lower plasma levels	Unclear	Polycarb	May need lower doses on conversion to NRT	Stockley
Antidepressants – tricyclics e.g. amitriptyline, imipramine, clomipramine	Serum levels fall but free levels rise, minimising the clinical significance*	Minimal	Both	Not significant	Stockley *Bazire
Fluvoxamine	Smoking causes lower plasma levels	<b>Yes</b> – smokers may need higher doses	Polycarb	May need lower doses on conversion to NRT	Stockley Bazire SPC
Mirtazapine	Possible decrease in plasma level	Not clinically significant	Polycarb	Probably no dose adjustment needed	Bazire SPC Organon

<b>Drug</b>	<b>Interaction with smoking</b>	<b>Clinically significant?</b>	<b>Nicotine or polycarbons in smoke</b>	<b>Management in smoking cessation</b>	<b>References</b>
Lithium	Smoking may reduce xanthine levels which would decrease lithium excretion	<b>Yes</b> – smokers may need lower doses	Polycarb	Conversion to NRT could increase lithium excretion, lowering levels	Stockley Bazire
Memantine	Smoking may increase plasma levels	<b>Yes</b> – smokers may need lower doses	Nicotine – theoretical interaction via competition for cationic transport system	May need higher doses as level of nicotine reduced	Bazire SPC

### **Others**

<b>Drug</b>	<b>Interaction with smoking</b>	<b>Clinically significant?</b>	<b>Nicotine or polycarbons in smoke</b>	<b>Management in smoking cessation</b>	<b>References</b>
Anticonvulsants: carbamazepine, phenytoin, phenobarbitone	Smoking has been shown to cause lower plasma levels	Not clinically significant	Polycarb	Not significant	Stockley SPC's
Flecainide	Smoking causes lower plasma levels	<b>Yes</b> – smokers may need lower doses	Both	May need lower doses on conversion to NRT and as nicotine levels reduced	Stockley
Insulin	Smoking causes increase in levels of hormones that oppose actions of insulin	Yes – smokers require 15-30% more insulin than on non-smokers		Insulin dose may need to be reduced as nicotine levels reduced	Stockley
Theophylline	Smoking causes lower plasma levels	<b>Yes</b> – smokers may need lower doses	Polycarb	May need lower doses on conversion to NRT	Stockley
Verapamil	Smoking may cause lower plasma levels	Unclear	Polycarb	May need lower doses on conversion to NRT	Stockley
Warfarin	Smoking may cause lower plasma levels	Unclear	Polycarb	May need lower doses on conversion to NRT	Stockley

This list is not exhaustive. It has been compiled to aid medication management in mental health clients who stop smoking and does not include those drugs not felt to pose a practical problem in this situation.

#### **References:**

Stockley, IH. Drug Interactions. The Pharmaceutical Press, London. 6<sup>th</sup> edition, 2002  
 Bazire, S. Psychotropic Drug Directory, Fivepin Publishing, Salisbury. 2003  
 SPC. Summary of Product Characteristics – for individual drugs  
 CPMS – Clozaril; Patient Monitoring Service

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