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AUDIT OF SMOKING CESSATION IN A COMMUNITY SECONDARY MENTAL HEALTH SERVICE

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INTRODUCTION

Smoking remains the single largest cause of preventable death. (1) Smoking prevalence is higher in people with mental disorder, who experience disproportionate associated harm to their physical and mental health. Smoking also reduces the bioavailability of several psychotropic medications. Evidence-based interventions exist to support smoking cessation/reduction in people with mental disorder, although evidence suggests less provision compared to the general population. Evidence-based interventions include behavioural support, medication, combined Nicotine Replacement Therapy (NRT) and nicotine-containing e-cigarettes (EC). (2, 3)

AIM

We aim to determine the unmet smoking cessation (SC) needs and associated causes for people attending a community secondary mental health service (CMHT), in order to advise appropriate service response.

METHOD

1. Analysis of information on smoking from 91 randomly selected patient electronic case notes.
2. Patient survey taken from 32 smokers and 11 ex-smokers within the caseload to identify barriers and facilitators in SC as well as attitude on e-cigarettes and referral to specialised SC services (SSCS).
3. Staff survey of 14 staff members of the CMHT to identify barriers and enablers in recording and offering of SC interventions.
4. Establish contact and coordination with GP's and SSCS.

RESULTS

Case note data

Smoking rates within the CMHT caseload were 44% compared to 12.4% in the general UK population. (4) Though 72% of smokers were recorded as being offered advice on SC, only a minority was offered NRT or referred to SSCS. Only 5% was recorded to agree to SC.

Patient survey

Patient surveys of 32 current smokers indicated 63% wished to quit or reduce smoking and that 88% had past failed SC attempts. Furthermore, 38% reported having received SC advice and 47% reported having NRT prescribed in the past. None of the 43 surveyed (ex-)smokers reported being prescribed medication such as bupropion or varenicline to support SC.

There was a discrepancy between case notes and reports by patients since only a fraction of smokers was offered NRT or referred to SSCS (see Figure 1).

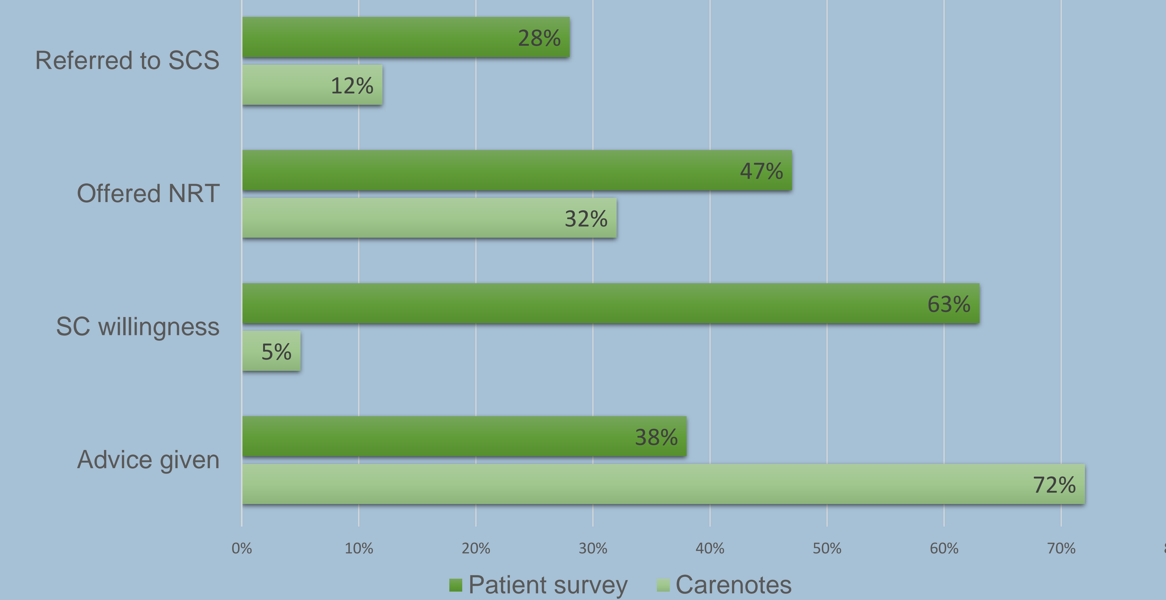

Figure 1: Comparison of reported advice on SC, willingness to quit or reduce smoking, NRT offered and referral to SCS between case notes and patient survey.

While using nicotine-containing EC supports SC and is likely to be substantially less harmful than tobacco cigarettes (2, 5), only 25% of surveyed current smokers thought EC were much less harmful than tobacco cigarettes, illustrating the patients' poor understanding of the relative harms of EC. 13% of smokers used EC, while 50% of ex-smokers reported using EC supported them to quit smoking.

The most frequently reported barriers in SC were habit, poor mental state and lack of daily activities. NRT, SSCS with follow-up and family support were the most mentioned facilitators in SC. Regarding barriers to SC, 32% mentioned social factors such as social isolation, lack of daily occupation and peers smoking. 41% mentioned social factors such as family support, social contact and daily occupation as facilitators in SC. This indicates that social context is perceived as an important factor in supporting SC.

4 of 5 ex-smokers that made use of SSCS experienced this as useful. In contrast, current smokers reported poor engagement with SSCS and SSCS refusal to support SC as they perceived the patients' mental disorder as the main cause of smoking behaviour in our surveyed smokers. CMHT was the preferred location to receive help with SC as reported by patients, although they thought access to SC advice in all public health services was important. This suggests that place-based care could include co-location of SSCS with mental health services, which could simultaneously improve coordination of required medication changes after SC.

Staff survey

71% of staff reported regularly giving advice on SC, yet only 43% routinely referred to SSCS. 57% reported having low expectations from patients with regards to SC. Nearly all staff suggested that training, routine referral to SCS, allocated time and staff to offer SC advice and coordination with GP's would increase SC rates. Training on required medication dose reductions after SC was a priority for medical staff. A clear referral pathway, practical training in brief advice and accessibility of NRT and e-cigarettes as well as NRT prescribers were also considered important in improving SC rates.

Coordination with other services

There was only one SSCS in the area which did not accommodate the needs of people with mental disorder. Furthermore, they did not collect data on mental disorder or dropout rate. The waiting time for treatment was 12 weeks in March 2022. GP's in the area did not prescribe NRT for people with mental disorders.

CONCLUSIONS

Smoking rates in this CMHT were 3.5 times higher than in the general population. 63% of current smokers wished to reduce or quit smoking. Only a minority of smokers used NRT, e-cigarettes or SSCS. Barriers in SC as reported by smokers were related to social factors, poor mental state or habit. Facilitators were reported as NRT, SSCS with follow-up and social support. Staff reported routinely offering SC advice, but rarely referred to SSCS, which in turn had limited capacity and did not accommodate the needs of people with mental disorder. Local GP's did not prescribe NRT. Primary care prescribing of NRT, improved coordination with GP's and SSCS and appropriate training for community mental health staff is necessary to support the required scale of implementation of SC interventions for people with mental disorder.

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LIMITATIONS

Only one person collected and interpreted all data for this audit, which was limited to just one CMHT. No contact was established with the local CCG, causing the reasons for GP's not prescribing NRT to remain unknown.

CONTACT INFORMATION

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