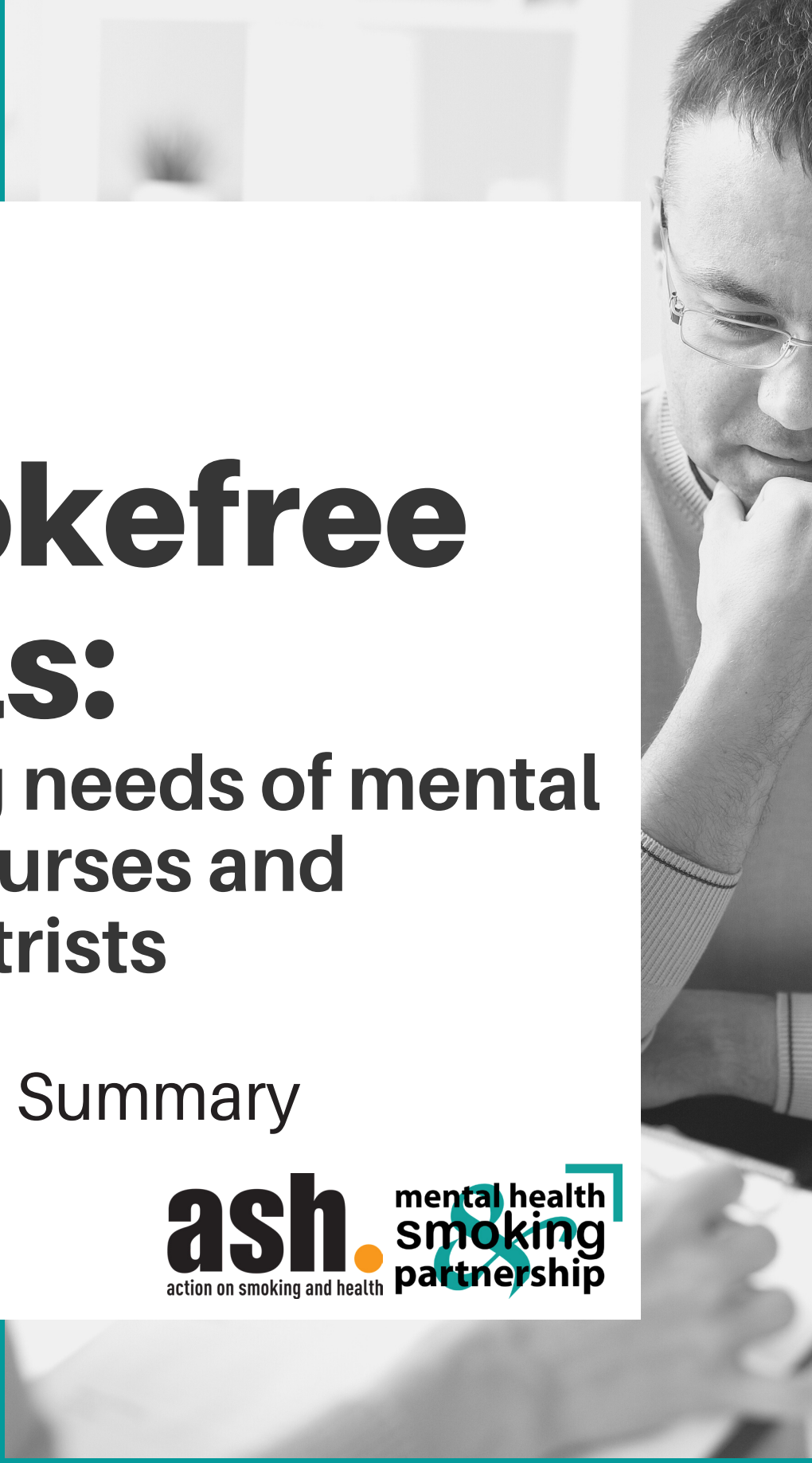
DECEMBER 2020

Smokefree Skills:

Training needs of mental health nurses and psychiatrists

Executive Summary



ash. action on smoking and health

mental health & smoking partnership

Foreword to the report

People with serious mental illness die 15-20 years before the rest of the population and smoking is one of the leading causes of this disparity. Smoking shortens peoples' lives, erodes their good health while they live, reduces their wealth and impacts negatively on their mental health. It is profoundly damaging to the wellbeing of an already vulnerable population.

Our respective organisations have long been concerned about the need to improve the physical health of people with mental health conditions. In 2013 the Royal College of Psychiatrists' joint report with the Royal College of Physicians described the burden of disease caused by smoking among people with mental illness and called for change.[1]

In 2016 the Academy of Medical Royal Colleges built on this work in their landmark report: *Improving the physical health of adults with severe mental illnesses*.[2] The AoMRC report included important recommendations about how health professionals should address this serious issue of health inequity, including making tobacco dependence treatment a 'core competency' for mental health professionals.

More recently Royal College of Nursing set out the case for addressing physical health needs of people with mental illness in their 2019 report: *Parity of Esteem – Delivering Physical Health Equality for those with Serious Mental Health Needs*.[3] This report reflected the concerns of the RCN members who felt more action was needed to address the current mortality gap for those with a serious mental illness. It particularly noted that lack of training and education for mental health nurses was a barrier to improving treatment for this population.

Seven years on from the initial Royal College of Psychiatrists and Royal College of Physicians report some things have changed, others have not. Most mental health trusts have now become smokefree, though the degree and effectiveness of implementation varies.[4] We are pleased that NHS England have recognised the need for action and have made a commitment that tobacco dependence treatment will be provided to all patients in mental health settings as part of the NHS Long Term Plan. This is all important progress and represents a real opportunity for change.

But change is never easy, and can only be achieved by engaging the hearts and minds of those on the front line. This report shows that gaps in training are contributing to an enduring culture which sees smoking for patients as inevitable and something to be contained rather than treated. Too many professionals wrongly believe that their patients don't want to quit or aren't able to, when we know the reverse is true.

This is not a criticism of staff. The lack of systematic training and education for health professionals on tobacco dependence treatment throughout their careers leaves them ill-equipped to address smoking in their patients. This must change. Nurses are often left to lead the day -to-day management of smoking cessation in mental health services and while training is important, support for co-creating environments conducive to smoking cessation also needs to be provided. The Action on Smoking and Health report calls for a national plan to roll out training on smoking for mental health staff and raise up the level of knowledge and understanding across the system. This is very much in line with the Royal College of Physicians and the Royal College of Psychiatrists report, the AoMRC report and the RCN report and we strongly support this recommendation.

Training will not solve all the organisational and cultural problems which make it difficult for staff to address their patient's tobacco dependency effectively, but it is an important tool for securing better practice. If we don't act now to skill up our workforce, the opportunity provided by the NHS Long Term Plan to implement new services and investment in tobacco dependence treatment will be missed.

We should not be disheartened. The report also demonstrates that staff are keen to learn more and be able to support their patients better, with the majority stating training on smoking should be mandatory. There is no doubt that training can be transformative for both staff and patients as testified by a clinician from one of the focus groups that informed this report. The clinician's trust had invested in staff training and rolling out policies to support its smokers and the impact this had was profound:

> ***"...I have seen patients who have massively benefitted physically and mentally and those were people I didn't, I didn't believe... could change... and they managed to do it. And you know... their physical health was like a time bomb, I felt, but they were also really mentally unwell and there was a lot of nihilism about it. But then they managed to stop and wow, it was a huge huge change. I have a few cases like that in my mind who sort of changed my, maybe my nihilism..."***

Professor Helen Stokes-Lampard
Chair of the Academy of Medical Royal Colleges

Dr Adrian James
President of the Royal College of Psychiatrists

Professor Dame Anne Marie Rafferty
President of the Royal College of Nursing

Introduction

This report has been part-funded through a Department of Health and Social Care grant to Action on Smoking and Health (ASH) and supported by the Mental Health and Smoking Partnership (MHSP).

Action on Smoking and Health (ASH) is a public health charity that works to eliminate the harm caused by tobacco. ASH was established in January 1971 by the Royal College of Physicians and works to support and inform Government policy and campaign for policy change to secure reductions in smoking and address the inequalities caused by smoking.

The MHSP was established in 2016 and is co-ordinated by ASH. It is chaired by Professor Ann McNeill, King's College London and Professor Paul Burstow, Chair of Tavistock and Portman Mental Health Trust. The ambition of the partnership, as set out in the Stolen Years report, is to reduce smoking rates among people with mental health conditions to 35% by 2020 and to 5% by 2025. Rates of smoking among people with mental health conditions are significantly higher than in the general population and are higher still among those accessing psychiatric care.

Purpose of the report

This report aims to identify areas for improvement in training for mental health professionals in relation to smoking and makes relevant targeted recommendations based on survey and focus group data. This research has been carried out in response to previous studies which identified gaps in the training provided to mental health professionals and concluded that training is key to improving the support given to smokers with mental health conditions.[5] It further aims to build on recommendations published in key reports by Royal Colleges that call for professionals working with people with mental health problems to be trained in awareness of smoking as an issue and training in how to support quit attempts.[1 2]

The impact of smoking on the lives of people with mental health conditions is profound. Smoking damages the health of all smokers but because rates are so much higher among people with a mental health condition it has a bigger impact on this population than it does on the population as a whole and is a major reason why people with a mental health condition have poorer physical health and die younger. In addition, smoking has a detrimental impact on mental health. Emerging research points to smoking as a contributing factor in the development of some psychiatric conditions, while quitting has been shown to equal the impact of anti-depressants. Dependency, the impact of smoking on health, and the financial burden of smoking all have further implications for people's wellbeing.

The wide-ranging impact of smoking on people with mental health conditions, the high rate of smoking and the massive inequalities this causes creates a pressing need to improve the knowledge, understanding and skills of staff to address smoking among people with mental health conditions.

This report focuses on psychiatrists and mental health nurses currently practicing in community or inpatient adult mental health settings in NHS organisations in England. There are many other

workforce groups that play important roles in smoking cessation support for people with mental health conditions. There are also many settings outside of psychiatric care where smokers with mental health conditions come into contact with services. While these are outside the scope of this report, some of the report's findings will have resonance for other professionals and other settings. ASH and the Mental Health and Smoking Partnership hope to be able to revisit the wider training context at a future date.

Evidence informing findings

Two new pieces of research have been carried out as part of this report's development:

- Qualitative research using focus groups to understand barriers that prevent mental health nurses (MHN) and psychiatrists from addressing smoking with patients, and to understand their views on training related to mental health, smoking and smoking cessation. The focus groups were held in November and December 2019.
- Quantitative research using a national online survey to assess perceived levels of confidence in delivering smoking cessation support, training provision and training needs among 427 MHN and psychiatrists. The survey was carried out in November 2019.

In addition to the new research, this report has been informed by:

- Findings from previous ASH reports and surveys, including *A Change in The Air*,[6] *Progress towards smokefree mental health services*,[4] *Smokefree skills: Community mental health*,[7] and the Mental Health and Smoking Partnership guide on the use of electronic cigarettes.[8]
- A review of current evidence and other existing literature.

The full findings and methodologies are available in the full report: [link].

Impact of COVID-19

It should be noted that this research was completed ahead of the global pandemic which has so profoundly disrupted all of our lives and the delivery of many aspects of health services. Insights from YouGov COVID Tracker have indicated that smokers with a mental health condition were more likely to have successfully quit during the lockdown period than other smokers, indicating that the pandemic was a 'teachable moment' for this population. However, smokers with mental health conditions who did not quit were more likely to have increased the number of cigarettes smoked and were more likely to be smoking indoors.[9]

Findings from a survey conducted by Rethink Mental Illness's Recovery and Outcome programme of 368 service users in secure settings in England noted that smoke free policies across inpatient settings were highly variable during lockdown. For more information, go to page 29 of their final report here.

Further insights are needed to understand what impact the pandemic may have on the training needs of mental health staff. It also remains to be seen whether changes such as an increase in remote appointments are maintained long term and, if so, whether this creates additional training needs for staff seeking to address smoking in their patients.

Key findings

In 2016 the Academy of Medical Royal Colleges (AoMRC) published: Improving the physical health of adults with severe mental illness: essential actions. This important report made significant recommendations on tackling smoking including the standards of care that should be met in mental health settings. The report stated that: "*It should be a core competency for mental healthcare staff to know about the evidence-based treatments available to support a quit attempt, how to make a referral to a specialist smoking cessation adviser and how to manage temporary abstinence from tobacco smoking.*"

It is evident from the findings presented below that this goal is still a long way off from being realised. While there has been real progress since the AoMRC report in recognising that more needs to be done in mental health settings to reduce rates of smoking, the capabilities of staff to deliver this remains lacking. One of the most important areas of progress is the commitment in the NHS Long Term Plan to: "*a new universal smoking cessation offer will also be available as part of specialist mental health services for long-term users of specialist mental health, and in learning disability services*". Despite the impact of COVID-19 on the NHS this programme is being rolled out across the country. However, this report's findings raise real concerns about whether the ambition of this commitment can truly be delivered given the baseline skills, knowledge and engagement of staff.

The recommendations in this report seek to provide a more detailed blueprint for how change can be achieved in terms of the content, level and reach of training among nurses and psychiatrists. However, there is also an urgent need for strategic leadership to secure change, particular to maximise the opportunity of greater investment to tackle smoking in mental health settings.

In this context we have two overarching recommendations:

Overarching recommendations

1. A plan must be developed and implemented by NHSE to ensure training meets the requirements of implementing NICE guidance on smoking in both inpatient and community mental health settings.
2. As the NHS Long Term Plan commitments are rolled out in mental health settings gaps in training must be addressed in line with the detailed findings in this report.

Current training

> ***"There's a complete blind spot about the destruction that tobacco dependence does. To not have that embedded in all healthcare professionals training is just daft, and it has to change... it's mental that we all have to put so much energy then in to trying to get people to recognise that this is an urgent clinical condition, this is the thing that's going to kill our patients, so you gotta teach people all about that when they are in their undergraduate training."*** — Mental Health Nurse

Training programmes for healthcare professions improve the delivery of smoking cessation interventions and lead to reductions in smoking prevalence among patients.[10] A lack of training during undergraduate and postgraduate education or within the workplace leaves staff ill

equipped to implement smoking cessation strategies.[11]

Despite the established link between training and the increased capacity of the workforce to address smoking in mental health patients, survey and focus group data suggest that training for professionals remains inadequate, from undergraduate level through to the workplace. This is in line with findings from a 2018 report from Royal College of Physicians.[12]

Training experiences vary a great deal between professionals, which suggests a lack of consistency in undergraduate, postgraduate and workplace training, while the majority of staff report inadequate training in all three settings. Gaps in training were reported more frequently by community-based staff than inpatient staff.

Despite relevant competencies in current curriculums,[13 14] only 17% of mental health nurses (MHN) and 13% of psychiatrists surveyed felt their undergraduate training on the links between smoking and mental health had been adequate while 28% of MHN who had completed a postgraduate course felt it had been. One third (33%) of psychiatrists felt their speciality training had been adequate.

Relevant training experiences were found to occur more frequently in workplaces than in undergraduate and postgraduate settings, though large numbers of MHN and psychiatrists still reported gaps in training in relation to key aspects of national guidance. Fifty-nine percent of psychiatrists and 33% of MHN said they had not received any training on National Institute for Health and Care Excellence (NICE) guidance *PH48 Smoking: Acute, Maternity and Mental health services* – the key national guidance in this area.[15]

Large proportions of MHN and psychiatrists reported having not received training, or could not recall if they had received training, on key aspects of the NICE guidance, including:

- Giving very brief advice: 18% MHN, 34% psychiatrists
- Behavioural support for smoking cessation: 47% MHN, 76% psychiatrists
- How to refer to smoking cessation support: 33% MHN, 50% psychiatrists
- Use of Nicotine Replacement Therapy: 35% MHN, 49% psychiatrists
- Other smoking cessation medications: 64% MHN, 63% psychiatrists
- Use of e-cigarettes: 51% MHN, 76% psychiatrists

There is a clear appetite amongst psychiatrists and MHN for more training to address smoking in people with mental health conditions across a wide range of topics with over half of respondents saying they would like more training on all topics asked about.

Employers should not assume that staff have sufficient training to deliver NICE PH48 guidance. Standards for training staff at undergraduate and postgraduate level do not appear to be leading to adequate training on key topics related to smoking and smoking cessation. If the workforce is to be equipped to better enable patients to quit smoking, then this must be addressed.

Recommendations: Improving existing training provision nationally

3. Standard setting institutions including the Nursing and Midwifery Council and the Royal College of Psychiatrists, should identify how they can best support academic institutions to include appropriate content on smoking in their curricula. This needs to deliver adequate levels of knowledge and skills at undergraduate and postgraduate level.
4. Health Education England and NHSE should ensure that standard training formats are developed and updated for NHS trusts to use for staff education and training purposes.
5. Any future training plans should set out how necessary training will be provided for community as well as inpatient mental health staff to enable more extensive support of patients outside of hospital admissions.

Existing knowledge and skills

> ***"The blindness that there is of actually seeing somebody who's in tobacco dependence withdrawal and not recognising it for what it is, is causing a lot of people to get bucket loads of medication they don't need, perphenazine and all the rest, and causing people to be on high doses of medication they don't need, so there's a big failure to treat tobacco dependence, failure to do the CO readings, failure to do the assessments in the community, failures to keep the treatments going after people have made improvements and left hospital, across the system there are plenty of opportunity for fixing these things, they are not difficult things to fix."***
> — Mental Health Nurse

There were high levels of reported confidence and knowledge on smoking and mental health topics in the quantitative survey but these were inconsistent with the low confidence and lack of knowledge demonstrated in focus groups and the low levels of training reported in the quantitative survey. This may be an indication that staff generally overestimate their knowledge and skills in relation to smoking cessation.

In particular, staff do not appear to fully understand how to deliver basic interventions such as Very Brief Advice (VBA) even though this is something they say they do regularly. While overall responses to the survey reported high confidence in delivery, when each stage was broken down (Ask, Advice, Act) a high proportion of staff had low confidence in delivering the 'act' stage with 37% of psychiatrists reporting low confidence in referring to cessation services and 26% of MHN. Notably, confidence was lowest among those working in the community.

With regards to clinical skills, knowledge and training, there was a notable lack of knowledge among staff on stop smoking medications and particularly the use of varenicline. This is despite a recent policy position published by the Royal College of Psychiatrists[16] and active communications work by the College on this issue. Again, staff working in the community had lowest levels of confidence.

There is also evidence that both nurses and psychiatrists lack knowledge about e-cigarettes and how to utilise these as an effective quitting aid despite clear policy positions of many leading institutions that these are an effective way to help smokers, are safer than continuing to smoke[17] and are currently the most popular aid to quitting.[18]

Recommendations: Improving knowledge and skills in current staff

6. NHS Trusts, as part of implementing NICE PH48, must train staff to deliver each part of Very Brief Advice. This training should be for staff in both inpatient and community settings and include information about local pathways.
7. NHS Trusts should ensure that training on stop smoking medications is regularly updated for all mental health prescribers to ensure they can safely support smokers.
8. NHS Trusts should ensure staff have the knowledge around e-cigarettes and stop smoking medications in order to confidently support patients to make positive choices.

Staff attitudes and beliefs

> *"I mean this notion of the poor mental health patient who you know, doesn't have much going for them and can only you know, the only joy in their life is their packet of cigarettes, it's like, and who am I to take that away from them, it's I think it would be worth having some kind of training to challenge your own beliefs of people's potential, and yeah, I don't know... I don't know what the next step away from that... it's just like a biased and slightly patronising view point but at the same time it kind of represents the model of care that we're giving people, that the only solace they have is in a cigarette, which doesn't really reflect well on us."*

Staff beliefs about patients and their capacities to quit smoking do not always align with reality. A third of survey respondents agreed that patients with mental health conditions are not motivated to quit smoking, though in reality, this group are just as motivated as other smokers to quit.[19 20] A third of respondents also admitted to discouraging quit attempts among their when they judged the patient's mental health to be too poor, despite evidence that poor mental health is not a barrier to quitting.[21 22]

While the importance of smoking as a risk factor for poor health is widely appreciated amongst staff, certain prominently held attitudes and beliefs are likely to create significant barriers to addressing smoking. These include beliefs that:

- quitting can be detrimental to mental health;
- smoking plays a positive role in the culture of mental health settings;
- smokefree policies are unethical, and;
- addressing smoking is not the role of mental health professionals.

These findings mirror that of a systematic review and meta-analysis which found that a significant proportion of mental health professionals held negative attitudes towards smoking cessation and permissive attitudes towards smoking.[23] It also corroborates the findings of previous ASH surveys of mental health trusts, which found that staff attitudes were the biggest barrier to successful implementation of smokefree policies.

Staff understanding of the harms of smoking and the inequalities it drives in their client group appear detached from their understanding of the purpose of local smokefree policies. The health promotion and harm reduction intentions of smokefree policies were rarely acknowledged in the focus groups, in which participants instead discussed the perceived negative impacts of the policies. The failure of the policy to be perceived as supportive of health appears to be inhibiting wider staff engagement.

Staff attitudes towards smoking appear to contrast with their attitudes towards other substances such as alcohol and illicit drugs, towards which staff are less lenient and are better trained to manage abuse.

Staff do not necessarily have an accurate perception of the specific nature of their role, the contribution that effective delivery of VBA can play in reducing smoking, and the limited amount of time needed to deliver an effective intervention. These misconceptions may be inhibiting staff from engaging patients in conversations about smoking.

Training is required to dispel misconceptions and address negative attitudes and beliefs. Training can also build resilience by making staff less susceptible to the influence of colleagues who hold such negative attitudes and beliefs.

Staff attitudes and beliefs are consistently found in the literature to be a major barrier to change. While they can be addressed to some extent through training, they are also underpinned by organisational culture. Change will not, therefore, be achieved through training alone.

Recommendations: Addressing staff attitudes and beliefs

9. Those developing training programmes should ensure that programmes include information on the role of different staff in tackling smoking and information to improve awareness that very brief advice can take as little as 30 seconds to deliver.
10. Training programmes should also seek to improve staff attitudes, gaps in knowledge and prevailing culture. As such they need to:
    - Provide information on smoking that is tailored to mental health settings and reflects the core values of mental health professionals
    - Ensure training formats promote reflective practice: e.g. including peer led sessions on myths and culture, using mentorship to support reflection and learning
    - Involve service users and their stories about smoking and quitting

Organisational barriers

> ***"it's interesting to ask patients... their view [in terms of smoking cessation] and... a few patients were telling me that it's very difficult to survive without a cigarette because it brings structure to their environment, it creates a timetable in their day and perhaps there should be thought for the inpatient teams... [about] what to do instead..."*** — Psychiatrist

There are a number of organisational barriers to effectively addressing smoking in mental health settings. These include:

- Failure to fully implement NICE guidance PH48 resulting in gaps in quit support and access to medications in both inpatient and community settings.
- Inconsistency between mental health settings; particularly between inpatient and community.
- Lack of resources in community mental health settings compared with inpatient environments which reduces the capacity within the community to address smoking and contributes to a view among community professionals that it is not their role to do so.
- Lack of visible leadership to ensure addressing smoking is a priority and address problems with smokefree policy implementation
- Lack of positive communication about the importance of addressing smoking among patients and the role of mental health professionals in doing so.

If these barriers are not addressed, then the efficacy of improved training will be limited.

Current training also needs to be sufficiently tailored to address the organisational constraints that people are working within.

Those working in community settings also note that mental health specific training is often focused on inpatient context and does not, therefore, address the particular barriers those working in the community may encounter.

Survey and focus group participants reported that staff training does not always include an overview of the entire tobacco dependence treatment pathway a patient can access, the role their mental health setting plays within that pathway, and how it impacts on the patient and other services.

In inpatient settings, consideration in training is not always given to the fact that breaches to existing smokefree policies are commonplace. Helping staff to understand why breaches occur and how they can be managed when they do occur can support positive outcomes.

Recommendations: Tackling organisational barriers

11. NHS Trusts must ensure that training reflect the organisational realities for professionals and equip them to understand their local policies and services and manage organisational barriers. Specifically, training should:
    - Be tailored for staff in community settings covering the specific issues which they might face in addition to local pathways and smokefree policies
    - Include content on how inpatient smokefree policies operate and how to learn from breaches of the policy to improve outcomes for patients
12. Leaders and frontline staff should receive training relevant to their role on the impact of smoking and actions needed to support quitting.
13. NHS Trusts need to enable a supportive organisational culture through consistent implementation of NICE PH48 and their corresponding smokefree policies. Clear communication is needed of these policies to all staff members and their role within this policy. This must include bank and agency staff and be reinforced through senior leadership

Addressing the gaps in training

> ***"So you know about training and it not being focused on [individuals] but actually you know, training for the system, not just training for staff nurses working on the wards, but a whole system response and that kind of leadership and have, you know, together manage part of the policies and procedures, so many things really, it's not just one thing is it. It's not just about the people training. It's about it being joined up isn't it, between the ward and the community and so on, so many angles to it really. Housing, all the rest of it."*** — Mental Health Nurse

Most psychiatrists (81%) and mental health nurses (91%) felt training should be compulsory in mental health academic programmes. The majority of respondents felt that it would be beneficial to them to receive refresher training at every stage of their career, so skills and knowledge are maintained and reflect the latest evidence.

Half of respondents said training should be included at induction and a majority said they would prefer to receive multi-disciplinary training. Training that involves multidisciplinary teams could help address the issue highlighted previously concerning lack of consistent quitting support across pathways that damages a patient's quit attempt.

The most popular methods for training were e-learning and face to face teaching, with a range of other methods deemed acceptable. A variety of formats should therefore be available.

Barriers to training include:

- staff being unaware of the training that is available to them
- lack of time/intensity of workload
- training not being provided in the workplace.

Recommendations: Ensuring good practice is sustained over time

14. CQC should review their guidance to inspectors to emphasise the importance of staff training and ensure greater consistency in both inpatient and community settings.
15. NHS Trusts must ensure that training is repeated regularly throughout the career of mental health professionals through a combination of e-learning and face to face methods. Core training should be face to face (including via online classroom formats where necessary) with knowledge and skills maintained through e-learning platforms.
16. NHS Trusts should ensure that workplace training is multidisciplinary where possible and includes an understanding of the different roles difference health professionals should play in addressing a patient's smoking.
17. National investment should be secured to ensure that trusts and academic institutions have appropriate evidence-based, consistent training accessible for all professionals.

Conclusion

As the AoMRC noted in 2016 addressing smoking in their patients should be a core competency for all mental health nurses and psychiatrists. However, many mental health nurses and psychiatrists still do not feel adequately trained to do this, and there are clear gaps in knowledge amongst staff that prevent the provision of appropriate advice and support to patients who smoke.

Our research shows that well over 10 years after smoke-free legislation was implemented in mental health settings, although improvements have been made in some areas, the culture of smoking persists and the implementation of evidence-based interventions is poor in some trusts. Lack of knowledge and skills about the use of varenicline, the most effective licensed smoking cessation aid, needs urgently addressing. Some mental health professions lack knowledge, skills, motivation and the mindset to address smoking among patients and work in environments that do not support good practice. Encouragingly, our research shows that there is a clear appetite for training and evident understanding of the harm that smoking is doing to patients.

The years to come will see welcome investment in mental health services to tackle smoking through the NHS Long Term Plan. It will be a major missed opportunity if this is not complemented with significant improvements in training.

We are entering a key decade in the battle against smoking. If we do not secure rapid change among professionals, we will leave behind a highly vulnerable group of smokers and risk failing to achieve the Government's ambition of a smokefree England by 2030. If, in 10 years' time, we have made no further progress for people with mental health conditions, we will have increased the already vast levels of inequality in smoking rates. We must not forget that smoking is a key driver of the excess mortality for those with mental health conditions. and parity of esteem cannot be achieved until that is addressed.

Authors

Lucy Furby, Public Health Specialty Registrar
Hazel Cheeseman, Director of Policy, Action on Smoking and Health
With support from **Vicky Salt**, Policy Manager, Action on Smoking and Health
Report design: **Sarah Power**, Communications Lead, Action on Smoking and Health

We would also like to thank all those who helped organise or participated in:

- Psychiatrist and Mental Health Nurse focus groups
- The smokefree skills psychiatrist and mental health nurse training survey
- Mental Health and Smoking Partnership

Please cite as: Action on Smoking and Health (ASH) and the Mental Health and Smoking Partnership. Executive Summary from *Smokefree Skills: Training Needs of Mental Health Nurses and Psychiatrists*. December 2020.

References

1. Royal College of Physicians, Royal College of Psychiatrists. Smoking and mental health. London: RCP, 2013.
2. Working Group for Improving the Physical Health of People with SMI (2016). Improving the physical health of adults with severe mental illness: essential actions (OP100). Royal College of Psychiatrists.
3. Royal College of Nursing. Parity of Esteem – Delivering Physical Health Equality for those with Serious Mental Health Needs. 2019.
4. Action on Smoking and Health (ASH). Progress towards smokefree mental health services. 2019.
5. Action on Smoking and Health (ASH). The Stolen Years. 2016.
6. Action on Smoking and Health (ASH). A Change in the Air. 2018.
7. Action on Smoking and Health & Cancer Research UK. Smokefree skills: Community mental health training. 2019.
8. Mental Health and Smoking Partnership. Use of electronic cigarettes by people with mental health problems: A guide for health professionals. 2020.
9. ASH. Supporting smokers to quit can help tackle surge in poor mental health. August 2020.
10. Carson KV, Verbiest ME, Crone MR, Brinn MP, Esterman AJ, Assendelft WJ, Smith BJ. Training health professionals in smoking cessation. *Cochrane Database of Systematic Reviews*, 2012(5).
11. Leonardi-Bee J, Jayes L, O'Mara-Eves A, Stansfield C, Gibson K, Ratschen E, McNeil A. Review 5: Barriers to and facilitators for smoking cessation interventions in mental health services. NICE Evidence Reviews: Smoking Cessation Acute, Maternity and Mental Health Services. Draft. 2012;3.
12. Royal College of Physicians. Hiding in Plain Sight. 2018.
13. Nursing and Midwifery Council (NMC). Standards for competence for registered nurses. 2010.
14. Royal College of Psychiatry. CORE TRAINING IN PSYCHIATRY CT1 – CT3. 2013.
15. National Institute for Health Care and Excellence (NICE). Smoking: acute, maternity and mental health services. Public health guideline [PH48]. 2013.
16. Royal College of Psychiatrists. Position Statement: The prescribing of varenicline and vaping (electronic cigarettes) to patients with severe mental illness [PS05/18]. December 2018.
17. Hartmann-Boyce J, McRobbie H, Lindson N, Bullen C, Begh R, Theodoulou A, Notley C, Rigotti NA, Turner T, Butler AR, Hajek P. Electronic cigarettes for smoking cessation. *Cochrane Database of Systematic Reviews 2020*, Issue 10. Art. No.: CD010216. DOI: 10.1002/14651858.CD010216.pub4.
18. Smoking Toolkit Study. Electronic cigarettes in England – latest trends. 2019. [Accessed March 2020]

19. NHS Digital. Health Survey for England 2010. 2011.
20. ASH. Smoking and Mental Health survey 2016: An analysis of the views of people with a mental health condition and staff working in mental health services. 2016.
21. Banham L, Gilbody S. Smoking cessation in severe mental illness: what works? *Addiction*. 2010 Jul;105(7):1176-89.
22. Gilbody S, Peckham E, Bailey D, Arundel C, Heron P, Crosland S, Fairhurst C, Hewitt C, Li J, Parrott S, Bradshaw T. Smoking cessation for people with severe mental illness (SCIMITAR+): a pragmatic randomised controlled trial. *The Lancet Psychiatry*. 2019 May 1;6(5):379-90.
23. Sheals K, Tombor I, McNeill A, Shahab L. A mixed-method systematic review and meta-analysis of mental health professionals' attitudes toward smoking and smoking cessation among people with mental illnesses. *Addiction.* 2016;111(9):1536- 1553. doi:10.1111/add.13387.

Action on Smoking and Health
6th Floor, Suites 59-63
New House
67-68 Hatton Garden
London, EC1N 8JY

tel: 020 7404 0242
fax: 020 7404 0850
e-mail: enquiries@ash.org.uk

Visit our website **www.ash.org.uk** for more information.

ISBN: 978-1-913448-08-0