DECEMBER 2020

Smokefree Skills:

Training needs of mental health nurses and psychiatrists

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 of 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

Overview

This report has been funded through a Department of Health and Social Care grant to Action on Smoking and Health (ASH) and is 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 campaign for policy change to secure reductions in smoking and address the inequalities caused by smoking.

The MHSP was established in 2016 it is co-ordinated by ASH and is chaired by Professor Ann McNeill, King's College London and the Professor Paul Burstow Chair of Tavistock and Portman Mental Health Trust. The ambition of the Partnership is to reduce smoking rates among people with a mental health condition to 5% by 2035, with an interim target of 35% by 2020.[5]

Scale of the problem

Smoking is the world's leading cause of preventable morbidity and mortality.[6] The prevalence of adult smoking in England has been decreasing steadily since the 1970s and currently stands at around 13.9% among the general population.[7] Smoking rates among people with common mental health conditions are around 50% higher than among the wider population,[8] while among people with serious mental illness smoking rates remain above 40%.[9] Life expectancy among people with mental health conditions is 15-20 years lower than in the general population.[10 11] Smokers with severe mental illness usually begin smoking at an earlier age and smoke more cigarettes a day than people without a severe mental illness.[1] High smoking rates are the largest contributing factor to this difference in life expectancy.

The current policy landscape

Preventing physical ill health among people with mental health conditions has been a growing public policy priority in recent years. In 2016, **The NHS Five Year Forward View for Mental Health**[12] was published, and recommended that Public Health England (PHE) give people with mental health problems – who are at greater risk of poor physical health – priority access to prevention and screening programmes, including access to 'stop smoking' services. It also recommended that NHS England and PHE should support all mental health inpatient units and facilities (for adults, children, and young people) to be smoke-free by 2018.

Then, in 2017, the publication of the **Tobacco Control Plan for England**[13] committed Government to implementing comprehensive smoke-free policies in all mental health services by 2018. It also made a commitment to provide access to training for all health professionals on smoking cessation, particularly mental health professionals. The plan also committed the Department of Health and Social Care (DHSC) and PHE to review data on smoking among people with a mental health condition and develop a better understanding of the needs in this population.

More recently, the **NHS Long Term Plan (2019)**[14] set out the NHS priorities for healthcare for the next 10 years, ensuring the NHS is fit for the future. It promises that: "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."

In the same year the Government announced its ambition for England to be smoke-free by 2030.[15] The Government admits this will be "extremely challenging", particularly in areas of deprivation and among people living with mental health conditions, and will require "bold action to both discourage people from starting in the first place, and to support smokers to quit." ASH, British Heart Foundation, Cancer Research UK, Royal College of Physicians, the British Medical Association, the British Lung Foundation, the Royal Society for Public Health and many others are calling on the Government to commit to this ambition and adopt our **Roadmap to a Smokefree 2030**.[16] The roadmap sets out what the UK Government must do to deliver on its **Smokefree 2030** ambition and includes a call to ensure the NHS Long Term Plan commitments to provide smoking cessation in the NHS in England are delivered.

Alongside the NHS, leading third sector organisations are increasingly prioritising action to address the 15-20-year life expectancy deficit that exists for people with mental health conditions. In 2016, the Academy of Medical Royal Colleges (AoMRC) published the report: *Improving the physical health of adults with severe mental illness: essential actions*, setting out a programme of interventions which were needed to help reduce this deficit.[2] This report laid the foundations for Equally Well UK,[17] the nationwide collaborative for equal health for people with long-term mental health conditions. In 2019 it announced that one of its two major work streams was focusing on tobacco smoking.[18]

NICE PH48 guidance aims to support smoking cessation, temporary abstinence from smoking and smoke-free policies in all acute, maternity and mental health settings.[19] It makes several targeted recommendations. Recommendation one indicates that health and social care practitioners should provide information to smokers who have a planned, or anticipated use of secondary care. Recommendation two calls for all health professionals to identify people who smoke and offer them help to stop, with recommendation three specifically calling for intensive support, including use of intensive behavioural support and pharmacotherapies, to be given to those using mental health services. With regards to training, recommendation 14 calls for all frontline staff to be trained to support people to stop smoking while using secondary care services. Specific actions under this recommendation include:

- Ensure relevant curricula for frontline staff include the range of interventions and practice to help people stop smoking, as outlined in this guidance.
- Ensure all frontline staff are trained to deliver advice around stopping smoking and referral to intensive support, in line with recommendations 1 and 2. They should know what local and hospital-based stop smoking services offer and how to refer people to them.
- Ensure online training can be completed and updated annually as part of NHS mandatory training (for example, training provided by the NCSCT).
- Ensure all frontline staff are trained to talk to people in a sensitive manner about the risks of smoking and benefits of stopping.
- Ensure all staff who deliver intensive stop smoking support are trained to the minimum standard described by the NCSCT (or its equivalent), with additional training that is relevant to their clinical specialism.
- Ensure all staff are provided with information about smokefree policies and instructions about their roles and responsibilities in maintaining a smokefree work environment. They should be advised on what action to take in the event of negative responses to smoking restrictions.

Smoking and mental health

There is growing evidence that smoking is a causal factor in the development of some mental health conditions.[20] Whereas cannabis use has long been understood by mental health professionals as contributing to the development of mental health conditions, few understand that smoking appears to have a similar and possibly stronger impact on the development of symptoms such as depression and psychosis. It is therefore unsurprising that smoking cessation is associated with improvements to mental health. Research has shown that quitting smoking is associated with reduced depression, anxiety and stress, as well as improved positive mood and quality of life, compared with continued smoking.[21] The impact of smoking cessation on anxiety and depression appears to be at least as large as antidepressants.[20] Smokers with mental health conditions are as motivated to quit as other smokers, with over 6 in 10 reporting that they want to quit.[22 23] However, smokers with mental health conditions are less likely to receive help to quit than other smokers.[24 25]

To reduce smoking rates among people with mental health conditions this lack of support to quit must be addressed. In 2019, ASH was commissioned by PHE to survey mental health trusts' implementation of NICE guidance, to assess the extent to which trusts were meeting the Government's ambition for them to be smokefree.[4] There were significant gaps in the implementation of NICE guidance in many trusts, which undermine the delivery of cessation support. These include:

- 1 in 5 mental health trusts still did not have a comprehensive smokefree policy in place
- Staff behaviour often enables smoking, with staff accompanying patients on smoking breaks every day in 57% of trusts
- In 55% of trusts, patients were not always asked if they smoked on admission
- Only 47% of trusts reported offering combination nicotine replacement therapy (NRT) or varenicline (Champix) to help patients quit.[4]

A survey of community mental health staff, also carried out by ASH in 2019, found additional gaps in the implementation of evidence-based support to quit in community settings.[26] It found just 15% of community mental health practitioners always, usually or sometimes prescribed stop smoking pharmacotherapies. While it did find high levels of staff asking and recording smoking status, around half of staff surveyed had not received appropriate training on smoking cessation.

Gaps in support are also evident in primary care.[24] Research suggests that smokers with mental health conditions are a third less likely to be prescribed varenicline in primary care compared to smokers without a mental health diagnosis, despite evidence that varenicline is a more effective quit aid and is not associated with adverse mental health outcomes.[27]

Why training is important

Evidence has found that training interventions not only improved the performance of smoking related tasks among professionals, but also improved reductions in smoking prevalence.[28] Evidence also suggests that a lack of training (during their education and whilst in post) was directly responsible for the lack of preparedness that clinical and non-clinical staff from inpatient and outpatient settings felt towards implementing smoking cessation strategies.[29]

Another ASH survey found that staff who had received smoking cessation training were more than twice as likely to report discussing quitting smoking with their patients, compared with staff who had received no training. They were also more likely to think that hospitalisation could provide a good opportunity to address smoking behaviour. Lastly, they were less likely to think that quitting smoking could have a negative impact on patient recovery and therapeutic relationships.[23]

Further, we know that mental health service users are more likely to respond positively to smoking cessation support provided by a mental health professional than by other health professionals,[30]

meaning it is essential these staff are given proper training in smoking cessation.

Smoking and Mental Health, a joint report by the Royal College of Physicians and the Royal College of Psychiatrists in 2013, recommended that: *All professionals working with or caring for people with mental problems should be trained in awareness of smoking as an issue, to deliver brief cessation advice, to provide or arrange further support for those who want help to quit and to provide positive (i.e. non-smoking) role models. Such training should be mandatory.*[1]

The AoMRC's 2016 report reiterated this call to action, making 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.*"[2]

Also in 2016, Action on Smoking and Health produced the **Stolen Years** report. This report, endorsed by 27 health and mental health organisations, sets out recommendations for how smoking rates for people with mental health conditions could be dramatically reduced. The report identified staff working in mental health settings seeing smoking cessation as a core part of their role, as a key ambition for improving practice. Specific actions identified, included mental health care settings ensuring their staff are trained in very brief advice (VBA) and that those assisting patients to temporarily abstain or quit smoking are trained to a minimum standard as described by the NCSCT.[31]

However, progress around adequately training the workforce has been slow. ASH's subsequent survey work of trusts' implementation of NICE guidance PH48 found that unmet training needs were a threat to maintaining momentum and embedding smoke-free practice in mental health services. It also found that Making Every Contact Count, VBA, and Level 2 training were enablers of smoke-free policy implementation in trusts.[4]

Findings from ASH's 2019 survey of community mental health nurses and psychiatrists indicated that the skills deficit around treating smoking dependence in patients should be a major area for future focus.[25]

Despite the impact of COVID-19 on the NHS, the NHS Long Term Plan commitments are still being rolled out across the country. However, this report's findings set out below 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.

Training and behaviour change theory

The Capability, Opportunity, Motivation, Behaviour (COM-B) model is a theory of behaviour that is primarily used to inform the design and delivery of interventions.[32]

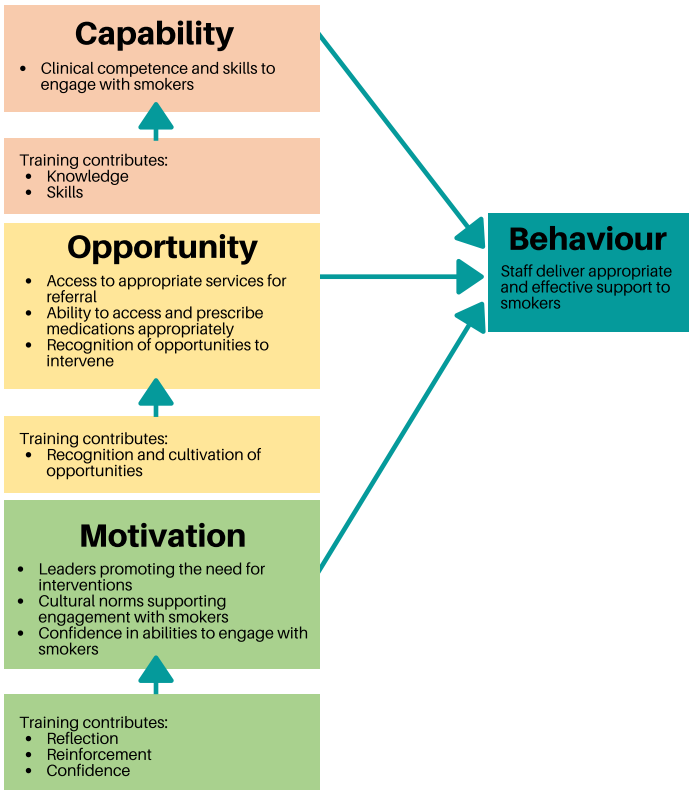
The COM-B framework posits that behaviour (B) is the result of interactions between three components: capability (C), opportunity (O), and motivation (M). Capability can be psychological or physical (knowledge and skills); opportunity can be social (social influence) or physical (environmental resources); motivation can be automatic (emotional responding) or reflective (beliefs) (See figure 1).

The model has been applied more recently to understand health professionals' current practice around addressing smoking in patients.33 This study found multiple barriers across the behaviour change framework that undermine the smoking cessation practice of mental health professionals.

The role of training in the COM-B model is evident, as it aims to equip staff with the skills and knowledge – in other words the capability – to support a patient to quit smoking. However, the model also helps us understand that that training alone will not change the behaviour of health professionals.

Components such as leadership, environment, culture, beliefs and attitudes (opportunity and motivation) can either act as barriers or facilitators to staff action to address patients' smoking. Whilst these components ostensibly seem outside the remit of smoking cessation training, it is plausible that training can play a part in changing these factors from barriers to facilitators.

Figure 1: The Capability Opportunity Motivation - Behaviour (COMB-B) model[32]



Scope and aim of report

This report has been written in response to the gaps in training identified by other research and the assessment that training is a key factor in securing lasting change in the smoking cessation support provided to smokers with mental health conditions. The aim of the report is to make recommendations to secure improvements in training for mental health professionals, in order for smokers with mental health conditions to receive more effective support and ultimately, quit smoking. Key objectives include:

- To explore, qualitatively, existing barriers that may be preventing mental health nurses and psychiatrists from addressing smoking with their patients.
- To assess the training needs of mental health nurses and psychiatrists as key members of the mental health workforce
- Identify levers for improving training for mental health nurses and psychiatrists related to addressing their patients' smoking
- Make recommendations to key organisations to address the smoking-related training needs of mental health nurses and psychiatrists

This report focuses on NHS psychiatrists and mental health nurses currently practicing in NHS community or inpatient adult mental health settings in England. We acknowledge that there are many other workforce groups that play important roles in smoking cessation support for people with mental health conditions and review of their role and training will be an important area for continuing research. ASH will engage with partners and other key organisations to scope this work.

Methods

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 and psychiatrists from addressing smoking with patients, and to understand their views on training related to mental health, smoking and smoking cessation
- quantitative research using a national online survey to assess perceived levels of confidence in delivering smoking cessation support, training provision and training needs.

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,[34] Progress towards smokefree mental health services,[4] Smokefree skills: Community mental health,[25] and the Mental Health and Smoking Partnership guide on the use of electronic cigarettes.[35]
- A review of current evidence and other existing literature.

Focus groups

Focus groups were undertaken with inpatient and community mental health nurses and psychiatrists (consultant and trainees) using a purposive sampling strategy. Key contacts in several NHS mental health trusts were briefed on the study aims and asked to participate and/or recommend other participants.

Eligible staff were those who were currently working in inpatient or community mental health nursing or psychiatry in an NHS trust. For one focus group - hosted as part of a wider meeting - the eligibility criteria was extended to include two additional participants who were currently lecturing in mental health nursing at an RCN recognised university but who had a background in mental health nursing, and one mental health nurse representative who had a background in health visiting. After discussions with the wider team at ASH, we agreed to include these participants for two reasons: firstly, the majority of participants in this focus group were mental health nurses who provided representation from trusts across England, and secondly the lecturers would have valuable insight in to key themes explored in the topic guides, from both a mental health nurse perspective and a training perspective.

An incentive of £50, or provision of lunch and refreshments, was offered to the participants at the discretion of the manager or lead staff member assisting in organising each focus group.

The mental health nurse focus groups consisted of participants from different trusts across England. One of the psychiatry focus groups comprised participants from a single London mental health trust, while trainees and consultants from various trusts within a single region (London) were represented in the other.

Psychiatrists:

- Focus group 1 – 10 participants, including 8 trainees and 2 consultants
- Focus group 2 – 12 participants, all consultants

Mental health nurses:

- Focus group 1 – 8 participants, all mental health nurses
- Focus group 2 - 7 participants, including 2 mental health nursing lecturers with backgrounds in mental health nursing, one mental health nurse representative from a union, and 4 mental health nurses.

Data collection and analysis

In total four focus groups with a total of 37 participants were conducted in November and December 2019. The research took place at different sites in London and were run at a time convenient to participants.

Primarily, the research sought to identify and describe key issues of concern relating to mental health, smoking and smoking cessation. Semi-structured focus groups were used to ensure the questions related to training were addressed whilst allowing new ideas and concepts to be explored.

Participant information sheets were given to participants before each focus group, along with a consent form. Both were read and signed by participants, who thereby agreed to the use of information and quotes in the reporting of the project. Confidentiality was assured from the outset and names of NHS trusts, locations and job titles have been anonymised.

A thematic content analysis was undertaken. This allowed for a combined deductive and inductive approach relevant to the project aims, whilst allowing for the emergence of other concepts based on participants' experience. Notes were made directly after each interview to capture initial thoughts around themes. The initial focus group recording was examined, and the topic guide was refined for subsequent focus groups using an iterative approach. Each focus group was transcribed verbatim by either the lead author or an ASH policy officer.

National survey of mental health nurses and psychiatrists

The survey was developed in November 2019 using SurveyMonkey. It was designed to assess current perceptions of staff confidence regarding their knowledge of smoking and smoking cessation topics and tools, and their delivery of certain interventions including giving very brief advice, advising patients on the use of nicotine replacement therapy and other medications such as varenicline, and for prescribers, confidence in prescribing NRT and varenicline. It was also designed to capture experiences around training, gaps in training, and demand for training.

Survey design was guided by findings from previous ASH surveys and from the preliminary results of the focus groups. Because of time constraints, the survey was designed and sent out before the final analysis of focus group data could take place. It was open from 22 December and closed on 11th February 2020. All eligible respondents had the option of entering a £150 prize draw. The survey was sent out to various relevant organisations and individuals including all the members of the Mental Health and Smoking Partnership, to college members of the Royal College of Psychiatrists, and to members of the Mental Health Nurses Association. All recipients were asked to promote the survey through relevant channels

Summary data for each question was exported from SurveyMonkey to Microsoft Excel for analysis. Data from open questions was subject to content analysis.

Characteristics of respondents

In total, 640 health professionals attempted the survey. Of these, 111 were not mental health nurses or psychiatrists and so were excluded from the analysis, though their responses will be reviewed at a later date. Mental health nurses and psychiatrists who worked solely with dementia patients or patients with learning difficulties were excluded because of the scarcity of literature on these populations regarding mental health, smoking and smoking interventions and the subsequent uncertainty around generalizability of recommendations that would arise from the analysis. Those working in child and adolescent mental health services were also excluded. Overall, 265 mental health nurses and 162 psychiatrists were included in the analysis.

Limitations

Survey respondents were self-selecting and may therefore reflect views of professionals who have an existing interest in smoking and mental health. There may be bias in the way respondents answer certain questions. Surveys can be susceptible to social desirability bias and this may have caused participants to over-report confidence in their skills and knowledge. Questions were optional and response rates to each question varied. These results should be considered indicative and should not be considered representative of all psychiatrists and mental health nurses working for the NHS in England.

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's COVID-19 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.[36]

Findings from a survey conducted by Rethink Mental Illness of service users in secure settings found notable variation in the implementation of smokefree policies in inpatient settings during lockdown. Some survey respondents said that smoking was being permitted in people's rooms (which breaches both policy and legislation) while, conversely, in other settings adherence to smokefree policies was reportedly stronger than usual during lockdown.

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.

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)*

What is currently included in standards of education?

Mental health nurses

To become a mental health nurse you need to train and study at a degree level and be registered with the Nursing and Midwifery Council (NMC).

All nurses working in the UK must complete a degree in nursing approved by the NMC and be registered with them. The NMC sets standards of proficiency that apply to all NMC registered nurses with new standards introduced in 2018.[37]

The NMC do not set curricula. Rather, curricula set by approved education institutions (AEIs), though education institutions must comply with the NMC standards in order to offer NMC approved programmes.

There are two relevant references to smoking in the standards which require all nurses to be able to: "discuss the impact of smoking... on mental, physical and behavioural health and wellbeing" and "assess motivation and capacity for behaviour change and clearly explain cause and effect relationships related to common health risk behaviours including smoking."[37]

To work at an advanced level of practice nurses must be educated to Masters level (this education will include the core areas of public health, epidemiology, health education and promotion), be an independent prescriber, and have met NMC revalidation standards.

Mental health nurse standards also include specific relevant competencies:[38]

- "Mental health nurses must work to promote mental health, help prevent mental health problems in at risk groups, and enhance the health and wellbeing of people with mental health problems."
- "Discusses sensitive issues in relation to public health and provides appropriate and guidance to individuals, communities and populations in health promoting behaviours such as ... cessation of smoking"
- "Understands the concept of public health and the benefits of healthy lifestyles and the potential risks involved with various lifestyles or behaviours, for example... smoking."

Psychiatrists

There are four key stages to becoming a consultant psychiatrist:

1. Obtaining a medical degree
2. Undertaking foundation training
3. Core training
4. Higher psychiatry training.

Royal College of Psychiatry has a curriculum for specialists in general psychiatry[39] and a curriculum for core training in psychiatry.[40]

Mentions of smoking in the **core training** curriculum are:

- "*Demonstrate the ability to recommend relevant investigation and treatment in the context of the clinical management plan…* Mini-ACE or ACE of giving brief advice concerning the effects of alcohol, tobacco…"
- "*To ensure that the doctor is able to inform and educate patients effectively…* so the patient may be more able to participate in their treatment and the ability to advise patients about environmental and lifestyle factors and the adverse effects of alcohol, tobacco and illicit drugs"

What are the current training recommendations for trusts?

NICE PH48 guidance aims to support smoking cessation, temporary abstinence from smoking and smoke-free policies in all acute, maternity and mental health settings. It has several recommendations and identifies who needs to take action.

With regards to training, recommendation 14 calls for all frontline staff to be trained to support people to stop smoking while using secondary care services. Specific actions under this recommendation include:

- Ensure relevant curricula for frontline staff include the range of interventions and practice to help people stop smoking.
- Ensure all frontline staff are trained to deliver advice around stopping smoking and referral to intensive support, in line with recommendations 1 and 2. They should know what local and hospital-based stop smoking services offer and how to refer people to them.
- Ensure online training can be completed and updated annually as part of NHS mandatory training (for example, training provided by the NCSCT).
- Ensure all frontline staff are trained to talk to people in a sensitive manner about the risks of smoking and benefits of stopping.
- Ensure all staff who deliver intensive stop smoking support are trained to the minimum standard described by the NCSCT (or its equivalent), with additional training that is relevant to their clinical specialism.
- Ensure all staff are provided with information about smokefree policies and instructions about their roles and responsibilities in maintaining a smokefree work environment. They should be advised on what action to take in the event of negative responses to smoking restrictions.

What we found out: Current levels of training

Smoking and mental health topics

Respondents were asked if they had received any training on particular topics related to smoking and mental health. These included the following:

- Prevalence of smoking among people with a mental health condition compared to general population

- Smoking as a cause of morbidity in people with a mental health condition
- Smoking as cause of mortality in people with a mental health condition
- Smoking and its associations with mental health conditions
- Quitting smoking and improvements in mental health
- Motivation to quit amongst smokers with mental health conditions
- Interaction of smoking with anti-psychotic medications
- NICE guidance PH48, including smoke free trust policies.

For almost every smoking and mental health topic presented, 22-26% of mental health nurses reported they had not received any training, and over a third had not received any training or teaching on NICE guidance PH48 and smoke-free trust policies. The workplace was the setting in which most MHNs had received training on smoking and mental health topics, with between 40-47% of respondents reporting having received workplace training on nearly all the given topics, apart from PH48 and smoke free trust policies where only 32% had reportedly received workplace training.

Psychiatrists were most likely to have received training on:

- prevalence of smoking among people with a mental health condition compared to the general population
- smoking as a cause of mortality and morbidity
- associations with mental health conditions

However large proportions said they had not received training on:

- quitting smoking and improvements in mental health
- motivation to quit amongst smokers with mental health conditions
- NICE guidance PH48, including smoke free trust policies

MHNs were more likely than psychiatrists to have received training in these areas (see figure 2 and 3).

Figure 2: The proportion of MHNs that have never had training on the following topics.

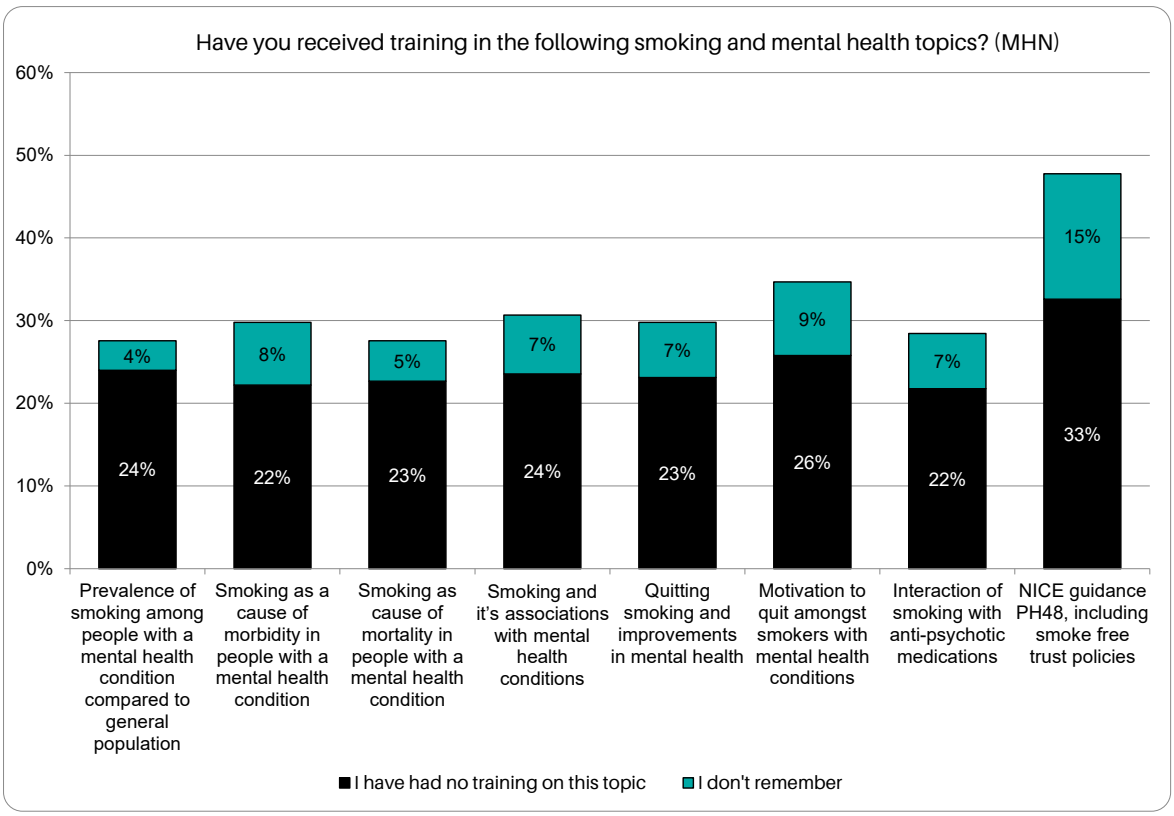
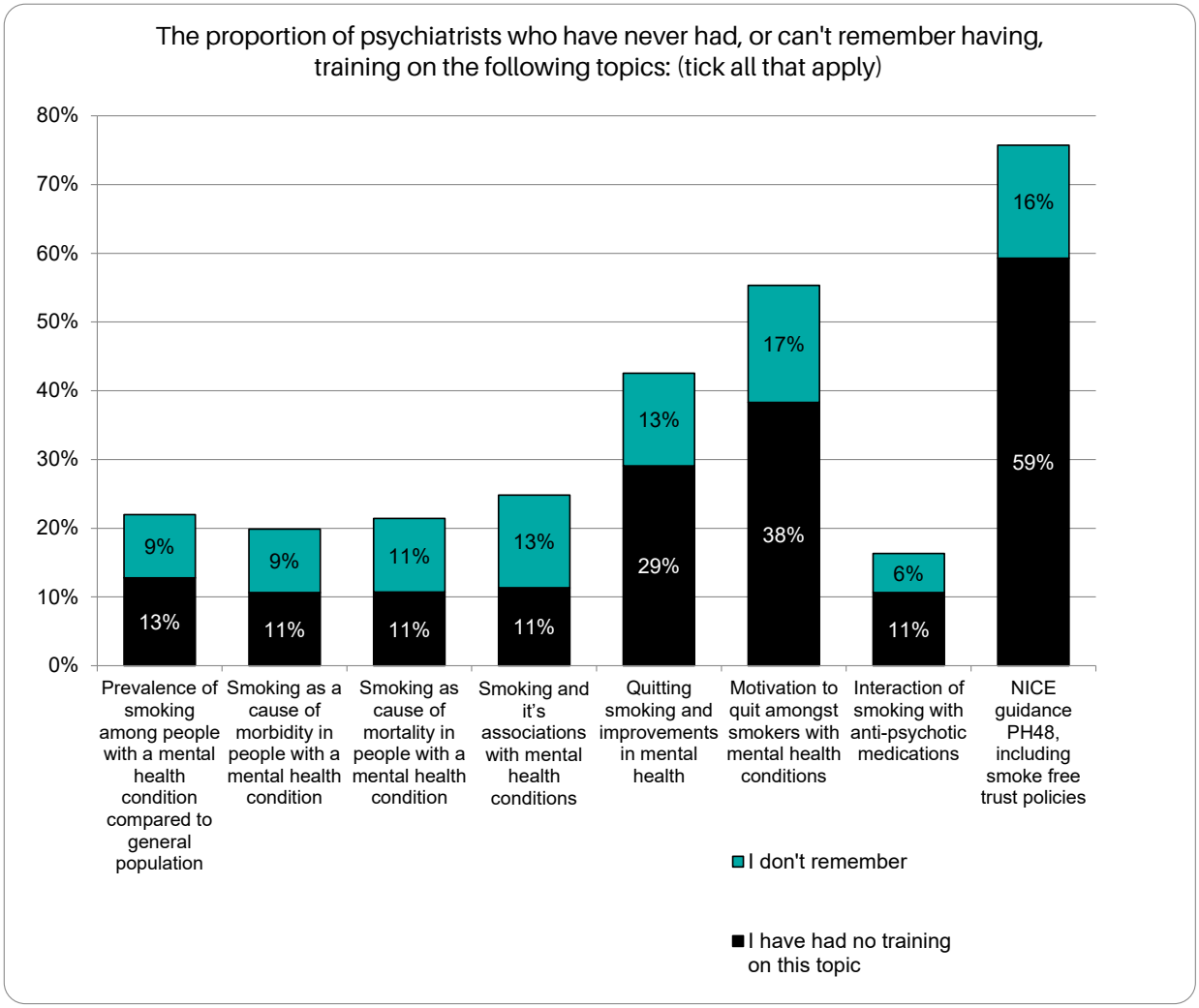


Figure 3: The proportion of psychiatrists who have never had, or cannot remember having training on the following topics



In general, most participants in the focus groups could not remember whether or not they had been taught about smoking specifically in relation to mental health settings and mental health patients as part of their undergraduate or postgraduate training. Some thought they had been taught about smoking and that it had been included as a topic in their exams, but they couldn't recall the content:

> ***"I think all of these facts do come into our exams in psychiatry training, and are taught at med school, is that right? (asks other participants, some shake their heads). I mean I was definitely taught all of this at med school, whether I can remember it..." (Psy1 252)***

When participants did recall being taught about smoking, they remembered it being taught as part of more general teaching on smoking or on smoking and physical health:

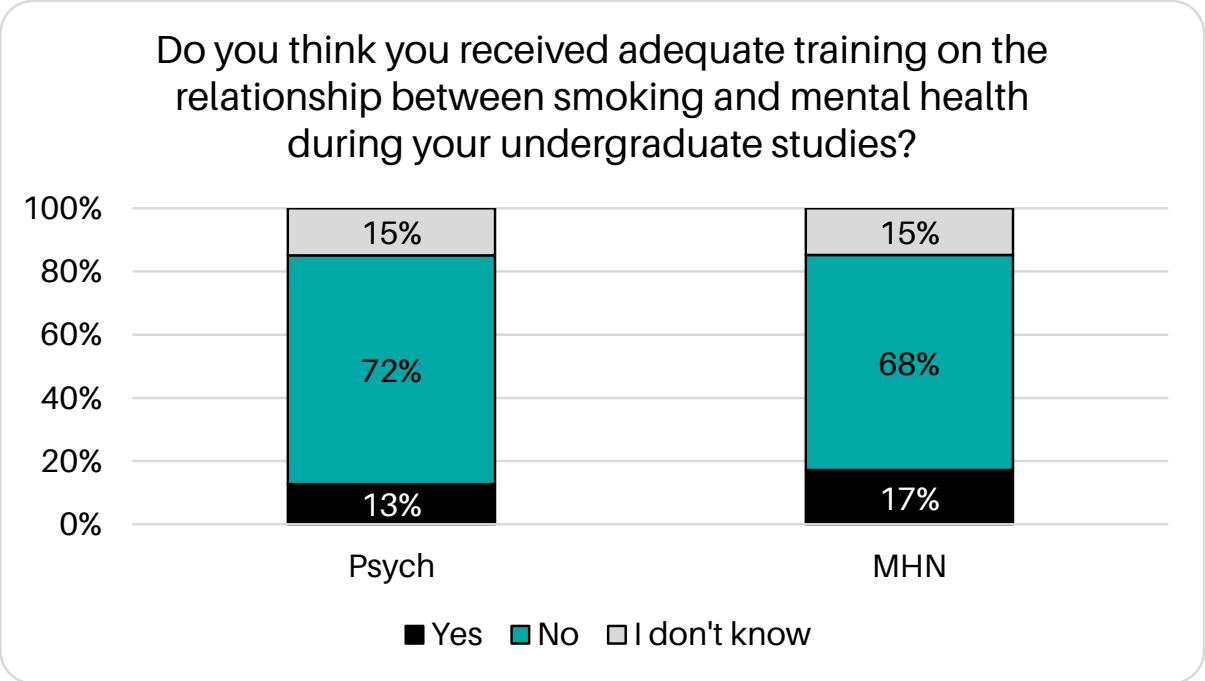
> ***"It was more smoking in general one than specific to mental health" (Psy1 277)***
>
> ***"I think if it has come up it's been more of a general sense rather than kind of a smoking and mental health topic" (Psy1 290)***
>
> ***"I don't think it's included. I think on the health society kind of stuff. Well, there is health - and physical health is addressed. And the problems with smoking." (MHN2 430)***

A minority of participants reported that they had received some training specific to smoking and mental health during their undergraduate training, primarily in relation to higher prevalence, pharmacology and interactions with medications:

> ***"When I was in med school, we got training in... like kind of more sort of pharmacological sense I guess exams have taught us about, interactions with medications and things like that" (Psy1 217)***
>
> ***"We had...in the postgraduate training... psychopharmacology, and when we did addictions, so how cigarettes can mitigate against certain medications, like antipsychotics, and also how in dual-diagnosis, smoking is very prevalent in that population. So it did come up." (MHN 516)***
>
> ***"Yeah it wasn't mentioned during my psychiatry placement at medical school, smoking specifically, not in terms of quitting behaviours, it was generally mentioned that people with mental health conditions are more likely to smoke and have greater physical [health issues] but not sort of quitting behaviours or what perpetuates smoking or anything like that." (Psy1 284)***

A substantial proportion of survey respondents further reported they did not receive adequate training on the relationship between smoking and mental health during their undergraduate studies. Only 13% of psychiatrists and 17% of MNH felt training on the relationship between smoking and mental health was adequate during their undergraduate studies. (See figure 4).

Figure 4: Survey response to adequate training on the relationship between smoking and mental health during undergraduate studies

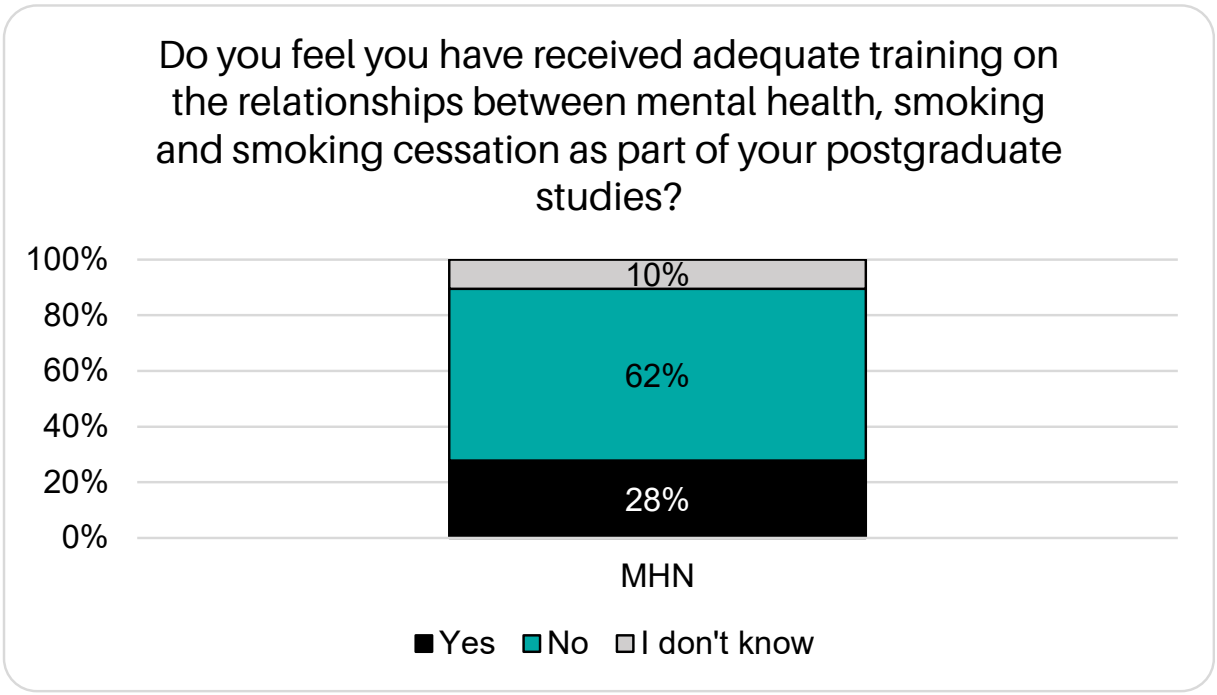


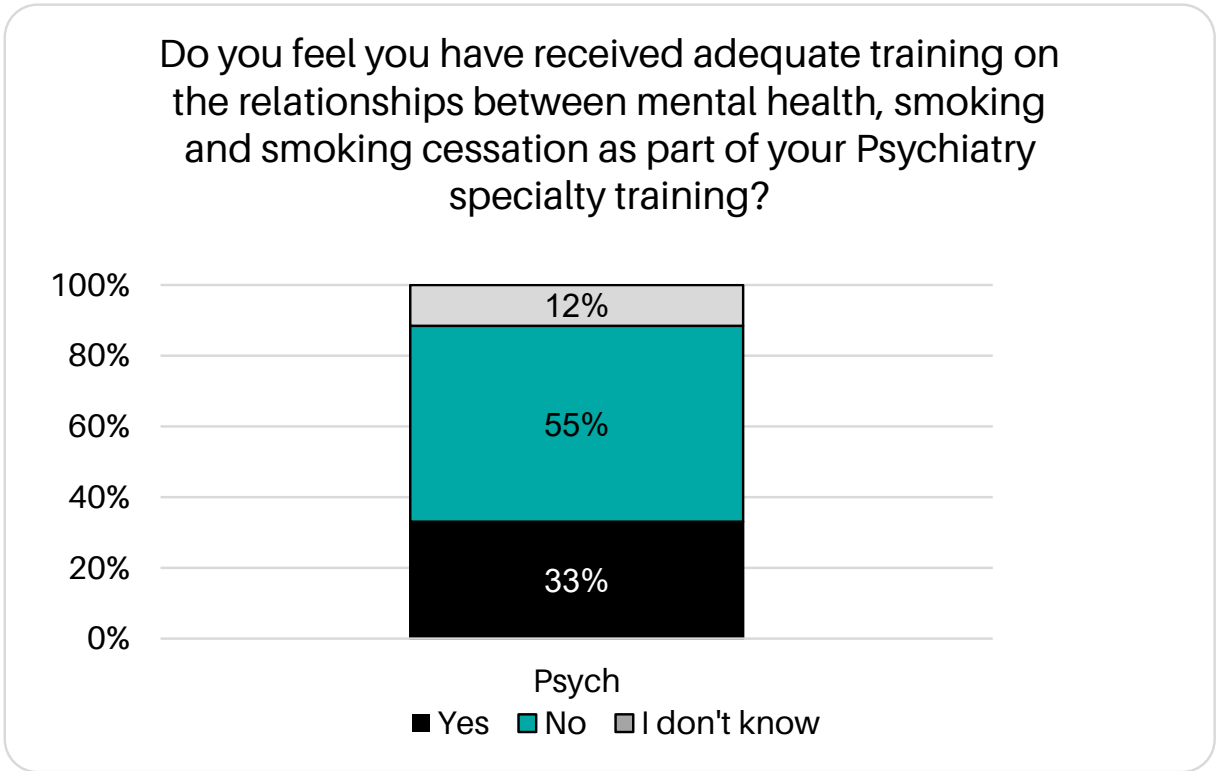
The same question was asked regarding postgraduate training. Two separate questions were asked because the training pathways for MHN and psychiatrists are different. Some but not all MHN may complete a postgraduate course, where as all psychiatrists will continue their postgraduate training and specialty training⁎ (see figure 5 on the next page).

⁎ We excluded answers from psychiatrists if they answered the postgraduate training question, as postgraduate training for this cohort is captured in the specialty training question, and we excluded answers from MHN about specialty training as this question referred to psychiatry specialty training.

- Only 28% of MNH who completed postgraduate courses felt they received adequate training on the relationships between mental health, smoking and smoking cessation as part of their postgraduate studies.
- Approximately 33% of psychiatrists felt they received adequate training in the relationships between mental health, smoking and smoking cessation as part of their specialty training.

Figure 5: Survey response to adequate training on the relationship between smoking and mental health during postgraduate studies





Smoking cessation training

Respondents were asked if they had received training in the following individual smoking cessation interventions or components of smoking cessation support:

- Giving very brief advice (or ask, advice and act)
- Behavioural support for smoking cessation
- How to refer to smoking cessation services, or relevant smoking cessation lead
- Use of Nicotine Replacement Therapy
- Other smoking cessation medications i.e. Varenicline and Bupropion
- Use of e-cigarettes

Figure 6: The proportion of MHNs who have never had, or who cannot remember having, training in the following smoking cessation support/interventions

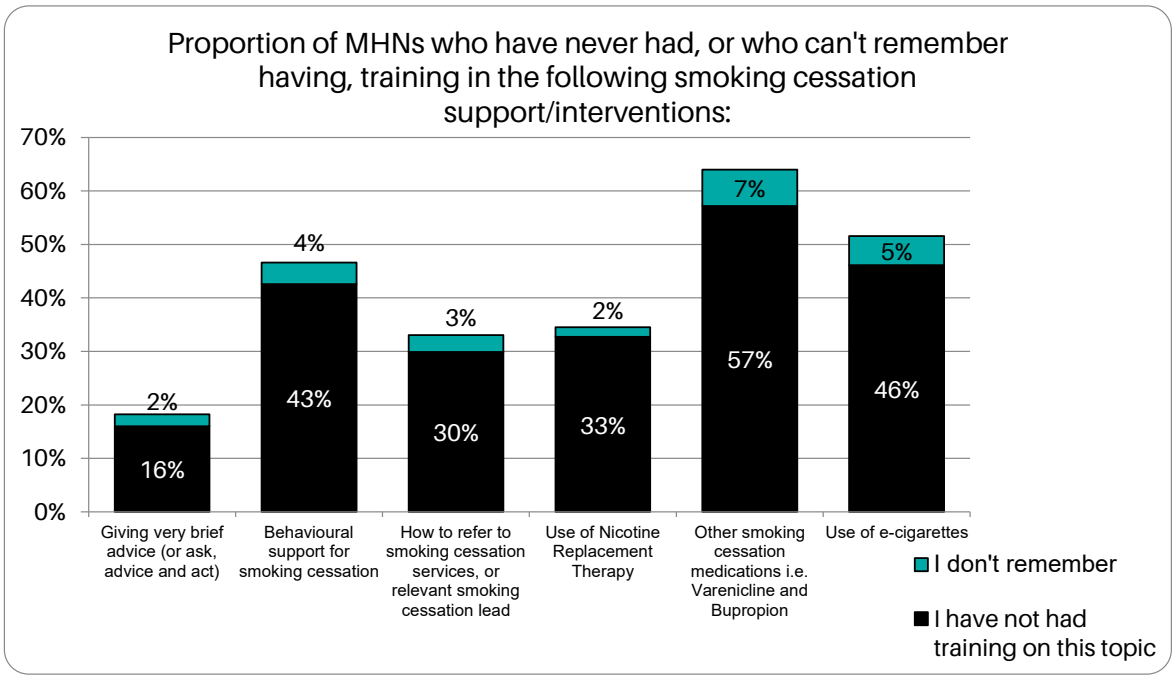
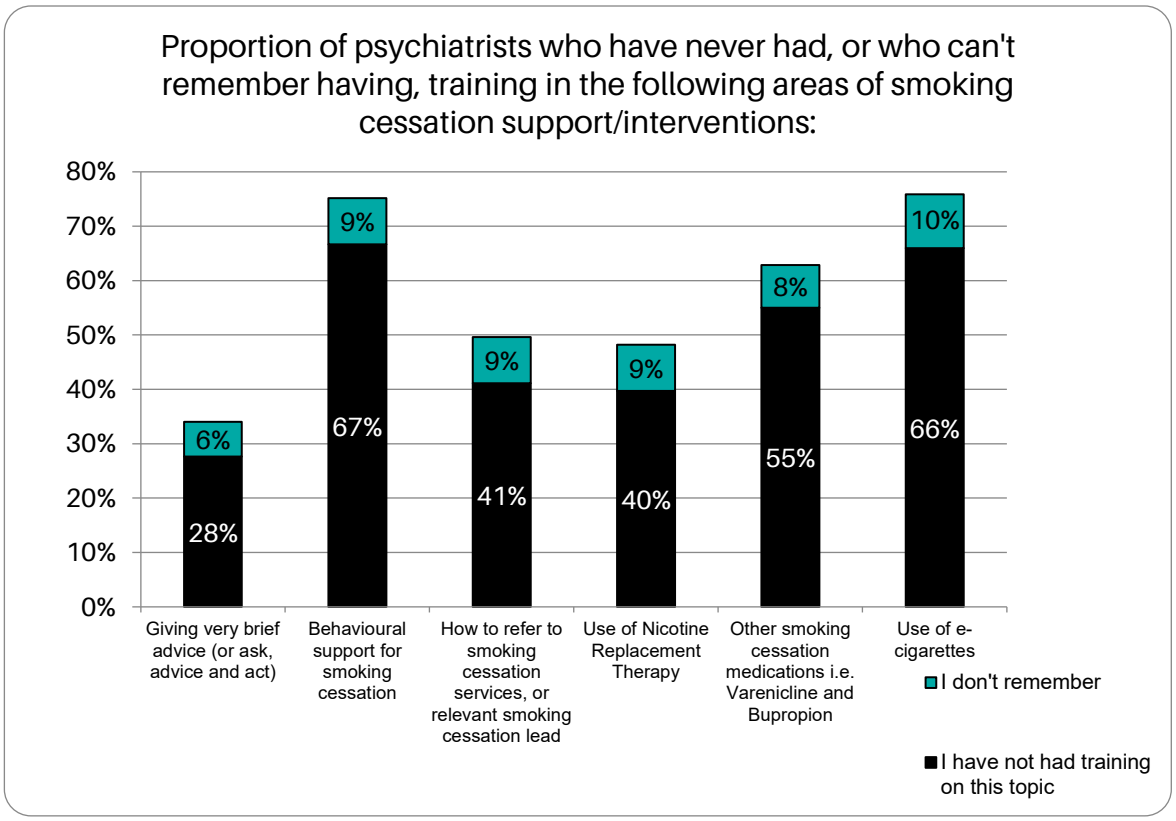


Figure 7: The proportion of Psychiatrists who have never had, or who cannot remember having, training in the following smoking cessation support/interventions



Very Brief Advice, behavioural support and referring to smoking cessation services or lead

Eighteen percent of mental health nurse respondents and 34% of psychiatrists reported they had never received training on how to deliver very brief advice (VBA), or could not remember doing so, which implies that most mental health nurse respondents (82%) and psychiatrist respondents (66%) have received some training in delivering VBA at some point in their careers (see figures 6 and 7). The workplace was the most common choice amongst MHN and psychiatrists when reporting when and where they had received training on delivering VBA (60% and 32% respectively). Only 4% of MHN and 12% of psychiatrists reported receiving any training on VBA as part of their undergraduate studies. The survey also found that 30% of MHN and 40% of psychiatrists had not received any training on how to refer a patient to smoking cessation services or a relevant smoking cessation lead.

In contrast, nearly all the psychiatrist participants in the focus groups reported that they did not have any training in giving VBA, though some indicated that they understood what it entailed:

> ***"I mean you might have been told this is what you should do but not like a specific formal training." (Psy1 313)***

> ***"I don't remember anything formal on that, it was kind of implicit in you know when a patient tells you, when they answer your question about smoking... I mean I think it would be difficult to say we've had absolutely no suggestions made to us that we should ask, advice or act but you know whether there's formal training on it is another issue." (Psy2 414)***

Some psychiatrists mentioned that they had received training on motivational interviewing, but that it was not specific to smoking and mental health:

> ***"When I was in med school we got training in motivational interviewing, and that was like often the example of smoking." (Psy1 217)***

> ***"We had the training, you know, in motivational interviewing didn't we, that's part of our training in general so, you know, it links together with training on alcohol dependency and drug dependencies and substances and substance misuse in general" (Psy 2 423)***

Prescribing stop smoking medications and use of e-cigarettes

The survey found that 33% of MHN and 40% of psychiatrists had not received any training in the use of nicotine replacement therapy (see figures 6 and 7). Over half of both MHN (57%) and psychiatrists (55%) reported they had not received training in the use of medication such as Varenicline and Bupropion as an aid to quitting, and 46% of MNH and 66% of psychiatrists reported they had not received any training in the use of e-cigarettes.

It was clear from discussions that there was a lack of knowledge around prescribing varenicline. Whilst some participants remembered recent learning opportunities from peers on the subject, most did not recall prescribing forming part of formal training when presented with a list of possible smoking cessation tools and interventions:

> ***"I've never been told by anyone exactly what's the best option or how I should be prescribing these things as far as I can remember, and, and if I've forgotten it's because it was so long ago that it's not, you know, it's not in the forefront of my mind anymore" (Psy2 712)***

Participation in smoking cessation training courses and modules

The survey asked respondents if they had participated in specific training courses or modules that covered the topic of managing patients' tobacco dependence, including online modules and face to face training delivered by the National Centre for Smoking Cessation and Training (NCSCT), or any other online or face to face courses, for example, ones developed by a Trust.

A substantial proportion of both psychiatrists (38%) and mental health nurses (19%) reported that they had not undertaken any training, with an additional 11% of psychiatrists and 9% of MHN reporting they did not remember undertaking any of the training. Among MHNs, there was a significant difference between the proportion of community nurses and inpatient nurses who reported not receiving training, with 24% of community nurses reporting no training compared to 13% of inpatient nurses. (See figures 8 and 9).

Among those respondents who had undertaken training, most reported taking an 'other' onlincourse (e.g. online teaching modules provided by your trust), followed by approximately a quarter of MHN reporting they had completed local stop smoking service training (25% of inpatient MHN and 26% of community MHN) and National Centre for Smoking Cessation Training (NCSCT) level one online training (26% inpatient MHN and 23% of community MHN). One fifth of inpatient psychiatrists could not remember completing any training courses (21%)

Figure 8: Training courses that psychiatrists participated in to aid the management of patients' tobacco dependence

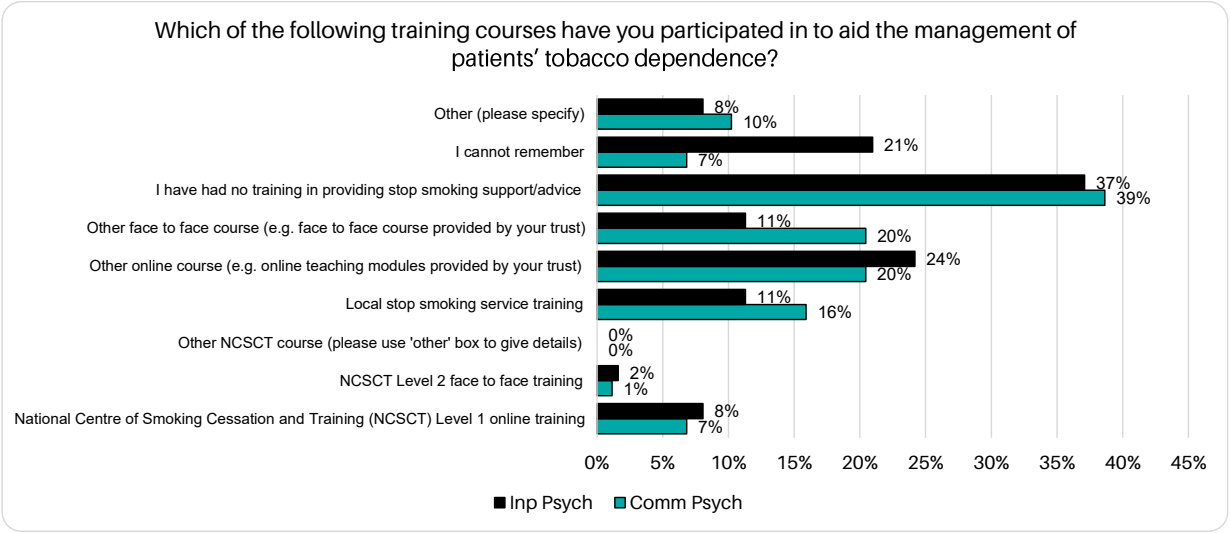
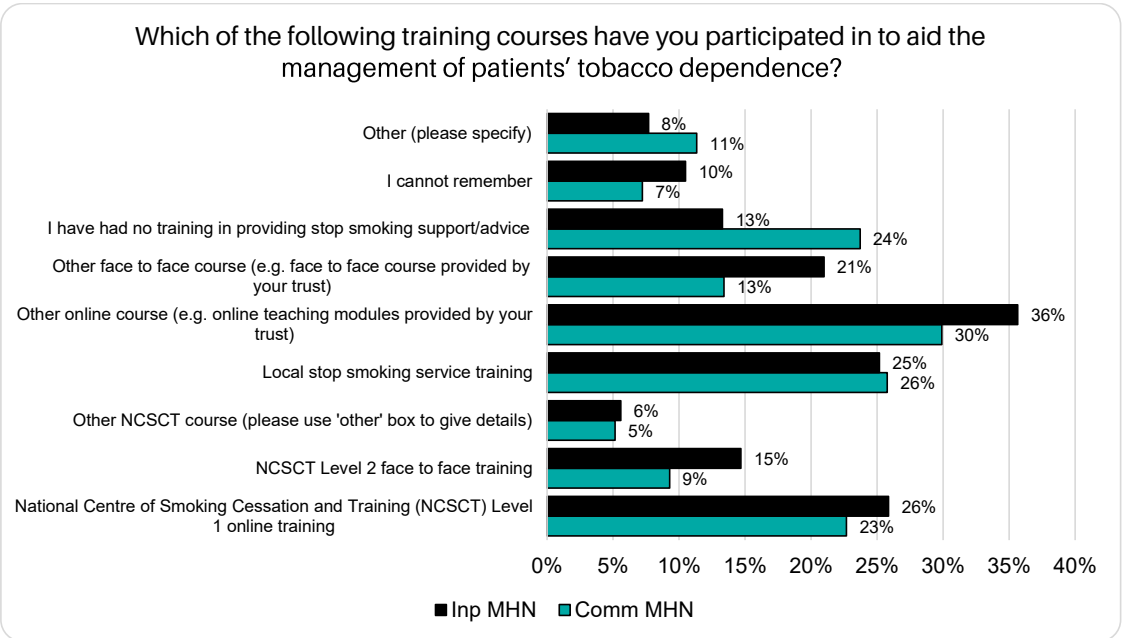


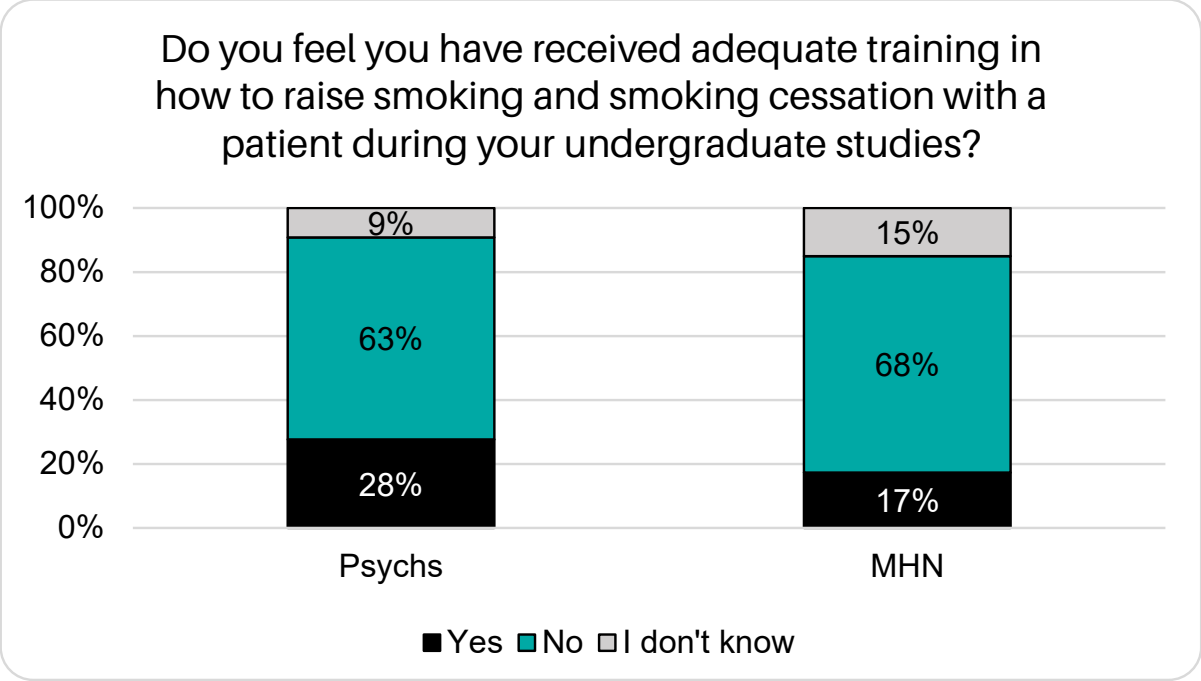
Figure 9: Training courses that MHNs participated in to aid the management of patients' tobacco dependence



Perceived adequacy of smoking cessation training in undergraduate and postgraduate studies

A substantial proportion of respondents felt that they did not receive adequate training on how to discuss smoking and smoking cessation with patients during their undergraduate studies. Only 28% of psychiatrists and 17% of MNH felt that the training they received during their undergraduate studies on how to raise smoking and smoking cessation with patients was adequate. (See figure 10).

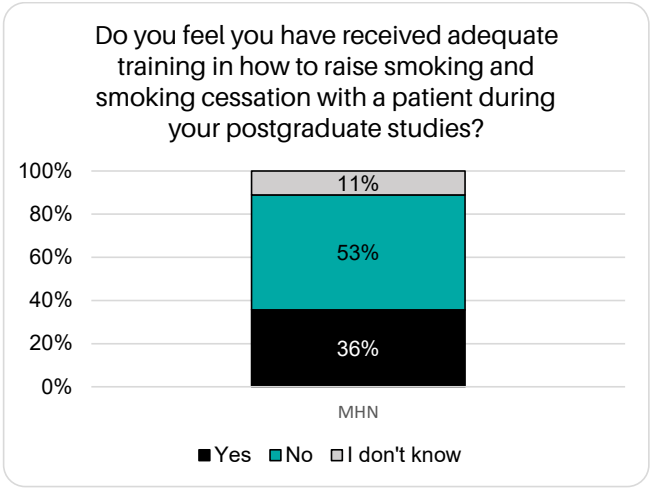
Figure 10: Perceived adequacy of smoking cessation training in undergraduate studies

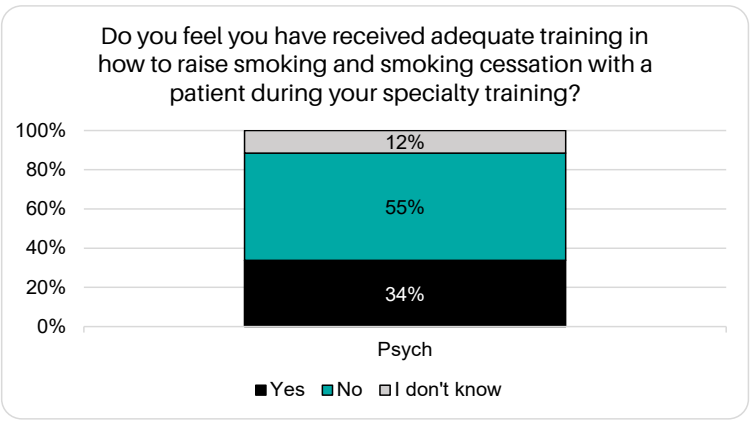


The same question was asked regarding postgraduate training:

- Only 36% of MNH who completed postgraduate courses felt they received adequate training on how to raise smoking and smoking cessation with a patient.
- Approximately 34% of psychiatrists felt they received adequate training on how to raise the subject with patients during their specialty training. (See figure 11).

Figure 11: Perceived adequacy of smoking cessation training in postgraduate studies





Respondents were asked to provide more detail in a free text box. Some free text respondents noted difficulties in remembering their training – especially if it was a long time ago – and discussed difference in attitudes that existed before the implementation of smokefree legislation:

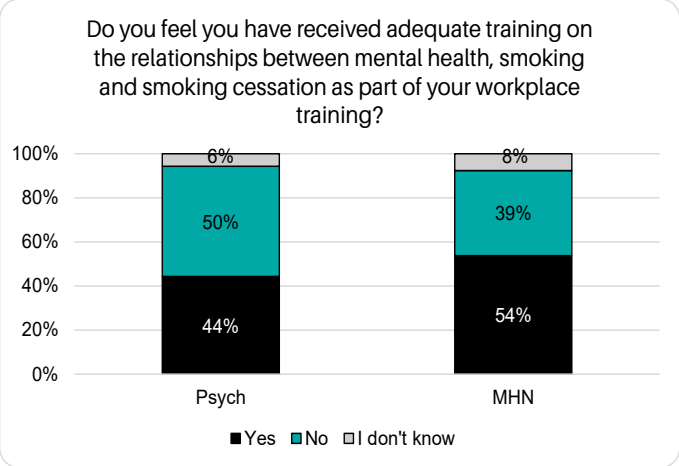
> ***"This wasn't an issue in the 1970s when I trained."***
>
> ***"That was a very long time ago! Life, science, and public attitudes have moved on."***
>
> ***"My undergraduate training was 30+ years ago - smoking was not considered an issue then. Consideration must be given to changing the current undergraduate programme but also providing postgraduate courses for staff like me who have been around a long time."***
>
> ***"in 1980s staff were 20-30 a day smokers. I was advised to give up nursing due to breathing problems in my environment at work."***

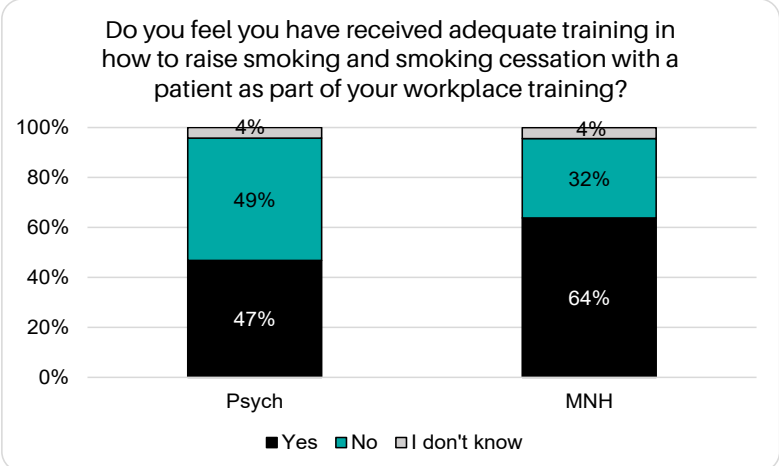
Adequacy of smoking cessation training in the workplace

Respondents were asked about their experiences of workplace training. A larger proportion felt they had received adequate training on both the relationship between smoking, smoking cessation and mental health and on how to raise the issue with a patient as part of workplace training. Specifically:

- 44% of psychiatrists and 54% of MHN felt their workplace training on the relationships between mental health, smoking and smoking cessation was adequate
- 47% of psychiatrists and 64% of MHN felt their workplace training on how to raise smoking and smoking cessation with a patient was adequate. (See figure 12).

Figure 12: Perceived adequacy of smoking cessation training in the workplace





There were noticeable differences among MHNs in the reported adequacy of training, depending on the setting in which the respondent worked. 59% of inpatient MHNs felt that they received adequate training on the relationship between mental health, smoking and smoking cessation, compared with 49% of community MHNs. 70% of inpatient MHNs also reported receiving adequate training on raising the issue of smoking and smoking cessation with patients, compared with 59% of community MHNs.

These survey findings were complemented by focus groups findings, in which most participants

indicated that they had not received any training on providing smoking cessation support during their undergraduate courses. Rather, most knowledge reportedly came from on-the-job and/or mandatory training:

> ***"Smoking cessation isn't actually a single thing that will happen [during undergraduate teaching]. It may come up, but it won't be taught directly. You only tend to teach things that are on the curriculum." (MHN Lecturer and former MHN 2 430)***
>
> ***"I would say for me it's been mainly on the job really, my level 3 [smoking cessation training] is too long ago. I suppose if we go to the annual updates, err there's a bit of training information as well, but mainly in house on an ongoing basis. A lot of it when we went smoke free five years ago, and err, more as we go along really." (MHN1 431)***

Psychiatrists were particularly likely to report that they had not received formal training on smoking in mental health settings, and that their knowledge had instead been picked up indirectly through other means, such as on-the-job training or through continual professional development groups:

> ***"Can I say, I'm new to this Trust, and I've never come across any teaching or training on this subject so what I've picked up, you know, I've picked up along the way, all by myself." (Psy2 364)***
>
> ***"We have a continued professional development group; I'm fortunate to have a very eminent psychiatrist in my group and lectures from him or discussion from him... were remarkable and this is what I remember about smoking cessation". (Psy2 398)***

In general, MHNs in the focus groups were more likely to have received some sort of formal training on smoking cessation, mainly via training provided by their trusts:

> ***MHN1: Just before the launch of going smoke free, it's an online training course, yeah, it's an inhouse online training course, to be completed, so yeah that's the basis of what we use to screen people [for smoking], when they come.***
>
> ***MHN2: Yeah, it wouldn't be part of the corporate induction, it would be something depending on your clinical area then your manager would then book you on to do the bit around policy and using a breathalyser.***

Perceived gaps in training

Focus Group participants were asked whether they felt they would benefit from more training around smoking and mental health, and if so, in what areas. Most participants reflected that they would like more teaching and training on smoking – not only regarding its implications for physical health, but specifically regarding how it relates to mental health.

> ***"Will it help if [training is] specifically linked to mental health? I think it will because when I'm seeing somebody I always make it a point to ask about alcohol because in my mind it's related, it's more related than smoking - I know slightly better now but I think if we had training with focus on smoking linked to mental health then I think it will make a difference and will you know you see people back to back and as everyone says it's not your first priority to check about everything else but if you see it as a part of your job you're more likely to do it." (Psy2 825)***

The focus group discussions also highlighted a collective desire for more training in other areas: E-cigarettes were discussed in almost all of the focus groups and most participants expressed a desire to have more standardised training on their use in mental health settings:

> ***"I still think we have more training to do standardised particularly around e-cigarettes, we haven't done that yet. I run vaping workshops now but they're pretty much what I've made up myself to be honest because there isn't' a nationally recognised programme of teaching people all about vaping. It hasn't been done anywhere yet that I'm aware of. Um, and I think that needs to be done." (MHN1)***

,

How to broach smoking and smoking cessation with the patient also emerged as a common theme when discussing training needs:

> ***"I think what we are hearing is the difficulty is having those conversations with patients and knowing how to approach it, so something in the motivational interviewing, brief intervention or whatever it is might be quite (...) might be quite useful." (Psy1 656)***
>
> ***"I think parts of the training is thinking about you know mental health nurses are really skilled at very difficult conversations, very skilled around managing symptoms, but actually sometimes they kind of, we get a bit stumped when this whole presentation is around a cigarette... I think there's something about um dealing with those kind of levels of conversations, that consistency." (MHN1 314)***
>
> ***"Even in the community setting at times, smoking becomes a difficult topic to preach [broach], so I think that kind of training as to how to deal with this topic, you know, that would have been more beneficial I would feel." (when asked about her VBA training) (Psy1 324)***
>
> ***"I sometimes think we sometimes feel at a bit of loss it's a losing battle, it's trying to find a way in, so we I think I often find waiting to let people ask rather than doing it as a norm..."(Psy1 338)***

Psychiatrists mainly expressed a desire to learn more about prescribing medications, in particular varenicline:

> ***"It would be nice to have more skill in prescribing the you know the varenicline, and bupropion, I don't think we have enough awareness or competence, I don't feel I [know] enough really to sell it to people." (Psy1 536)***
>
> ***"Something about when we're being asked for advice on these things, having information as a specialist or psychiatric service on what should be prescribed and what is best in patients who is suicidal or bipolar or suffering from mental illness." (Psy2 719)***
>
> ***"So maybe something that would help us be more confident about these drugs, that would be helpful" (Psy2 810)***

Understanding local referral pathways was also an area in which participants felt that they would benefit from more training:

> ***"I think probably better awareness of the referral pathways or resources because like I don't, I'm not aware of someone specific to our ward to go to for smoking, whereas we have the dual diagnosis worker for sort of alcohol or other substance misuse... if there was a smoking cessation service that was more readily available and we knew where that was and how to access it, that would be helpful." (Psy1 724)***

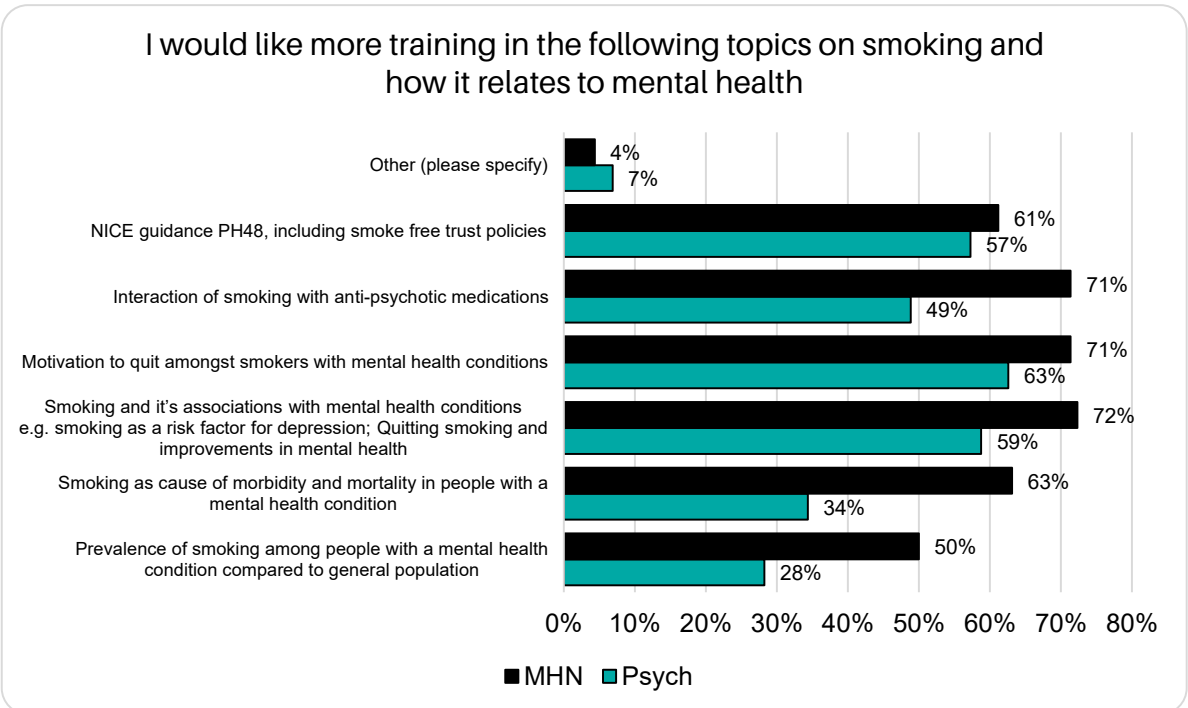
This was corroborated by findings from the survey. For each specific topic on smoking and mental health, 50% or more MHNs wanted more training on all topics presented to them with:

- Over 70% wanting more training on smoking and its associations with mental health conditions e.g. smoking as a risk factor for depression; Quitting smoking and improvements in mental health; motivation to quit amongst smokers with mental health conditions; and on the interaction of smoking with anti-psychotic medications.
- Over 60% wanting more training on NICE guidance PH48, including smoke free trust policies and smoking as cause of morbidity and mortality in people with a mental health condition. (See figure 13).

Psychiatrists who responded were most likely to want additional training in:

- Smoking and its associations with mental health conditions e.g. smoking as a risk factor for depression (59%)
- Quitting smoking and improvements in mental health (59%);
- NICE guidance PH48, including smoke free trust policies (57%),
- Motivation to quit amongst smokers with a mental health condition (63%).
- Interaction of smoking with anti-psychotic medications (49%) and over a third wanted more training on smoking as a cause of morbidity and mortality in people with a mental health condition. (See figure 13).

Figure 13: MHNs and Psychiatrists wanting more training in the following topics on smoking and how it relates to mental health



For practical smoking cessation tools and topics, 77% of psychiatrists reported they would like more training in prescribing NRT, varenicline and bupropion, followed by 59% who wanted more training in e-cigarettes and their use as a smoking cessation tool. The majority of psychiatrist respondents also reported they would like more training on advising on NRT, varenicline and bupropion (56%), and how to refer to smoking cessation services, or a relevant smoking cessation lead (55%). Almost half (48%) reported they wanted more training on VBA and how to deliver it. (See figure 14).

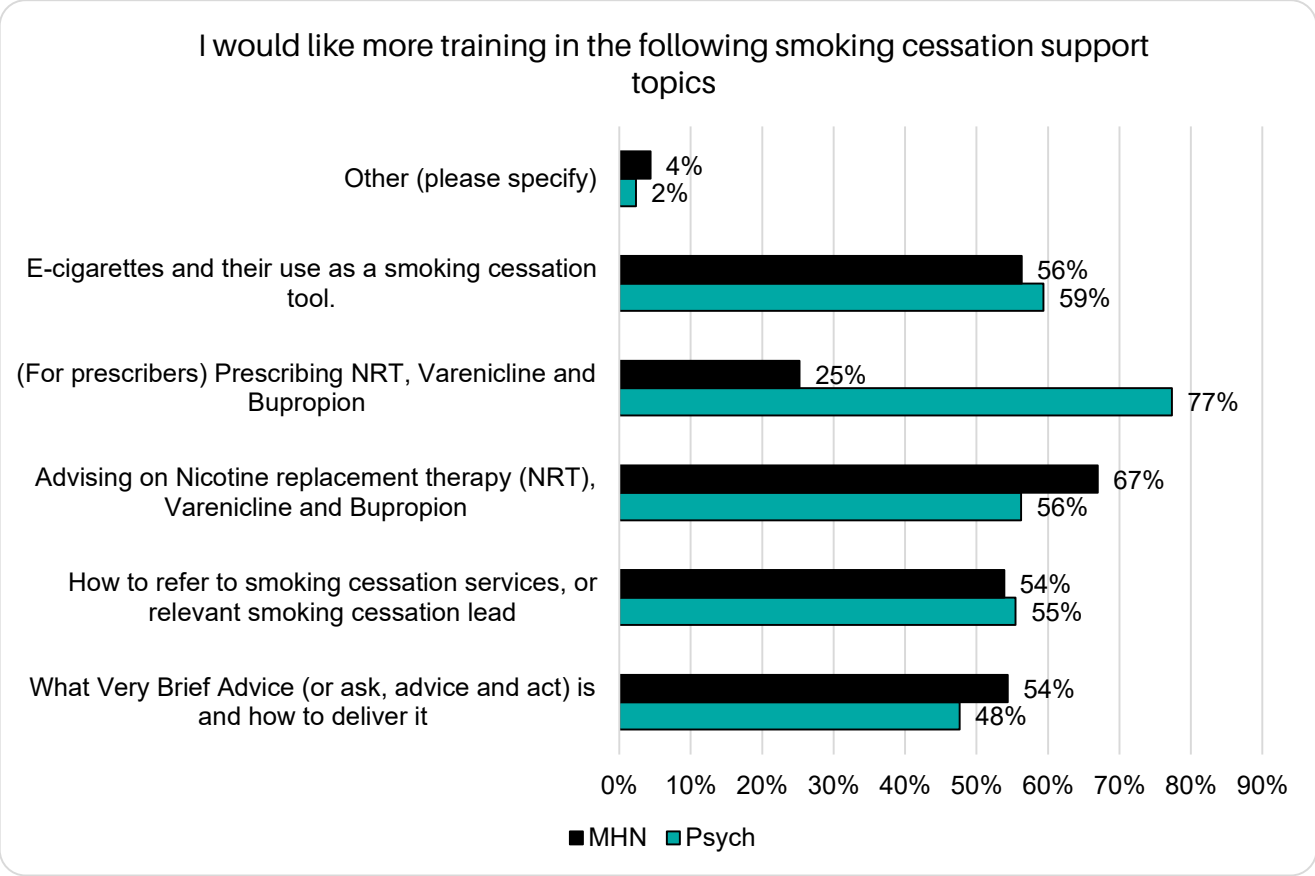
Large proportions of MHNs also said they would like more training in practical smoking cessation tools and topics, with the most popular areas being advising on NRT, varenicline and bupropion (67%), e-cigarettes and their use as a smoking cessation tool (56%), VBA and how to deliver it (54%) and how to refer to smoking cessation services, or a relevant smoking cessation lead (54%). (See figure 14).

Very few selected 'other', but those who did were asked to give more detail in a free text box. Responses included:

- "how to prevent violence and aggression from patients who have had to stop smoking enforced by the smoking ban", and
- "how to use VBA in my clinical situation."

One respondent wrote: "I think more training is needed for ALL (especially doctors and pharmacists) on Varenicline. Despite more recent evidence about its safety, there are still massive concerns and a lot of caution about using it in mental health."

Figure 14: MHNs and Psychiatrists wanting more training in the following smoking cessation support topics



Key findings and conclusions

Training programmes for healthcare professions improve the delivery of smoking cessation interventions and lead to reductions in smoking prevalence among patients.[41] A lack of training during undergraduate and postgraduate education or within the workplace leaves staff ill equipped to implement smoking cessation strategies.[28]

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.[42]

Training experiences vary a great deal between professionals, which suggests a lack of consistency in undergraduate, postgraduate and workplace training, while a 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,[39 42] only 17% of 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 NICE guidance PH48 Smoking: Acute, Maternity and Mental health services[19]– the key national guidance in this area.

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" (MHN)*

What knowledge and skills should health professionals have?

Healthcare professionals should be knowledgeable and adequately trained if they are to deliver successful interventions.[43] Lack of knowledge on key aspects of smoking and mental health can be a barrier to addressing smoking in patients with a mental health condition. The NICE PH48 evidence review in 2013 found evidence from one large UK survey to suggest that clinical mental health professionals from an inpatient setting lacked knowledge regarding the prevalence of smoking and tobacco addiction in patients with mental illness.[44] Although knowledge itself is not enough to engender behaviour change in health professionals, it can be considered a component of behaviour change modelling. In the COM-B model of behaviour change, for instance, knowledge can be considered as part of the capability component, and along with the other components of opportunity and motivation, can influence staff to address smoking cessation in a patient.

The NCSCT training standards outlines the knowledge competences that would make a significant difference (add value) to the quit attempt that practitioners were assisting with. If we apply these to the mental health setting, a successful practitioner will need to have knowledge on the following:

- Smoking topics including:
    - o Smoking in the (mental health) population.
    - o Smoking and health (including mental health)
    - o Why stopping smoking can be difficult
- Smoking cessation treatments
- The wider context (including the contribution smoking cessation has in reducing health inequalities)

Knowledge: current levels and gaps - topics related to smoking, smoking cessation and mental health

Respondents were asked to rate how confident they felt in their knowledge of various smoking and mental health topics, including:

- Prevalence of smoking among people with a mental health condition compared to general population
- Smoking as cause of morbidity in people with a mental health condition
- Smoking as cause of mortality in people with a mental health condition
- Smoking and its associations with mental health conditions
- Quitting smoking and improvements in mental health
- Motivation to quit amongst smokers with mental health conditions

- Interaction of smoking with anti-psychotic medications
- Your trust's smoke free policy.

While the survey findings suggest that confidence is high overall, a notable proportion of respondents still felt underconfident in their knowledge of key smoking and mental health topics, which further suggests that training is neither consistent nor adequate. For instance, nearly a quarter of respondents (25%) were 'not confident' in their knowledge of the mental health benefits associated with quitting smoking, while over a third (32%) of MHNs were not very or not at all confident in their knowledge of motivation to quit amongst smokers with mental health conditions. Mental health nurses felt most confident in their knowledge of their trust's smoke free policy, with only 6% reporting that they felt 'not very' or 'not at all' confident. (See figure 15).

Figure 15: MHNs response to how confident are they in their knowledge on topics related to smoking, smoking cessation and mental health

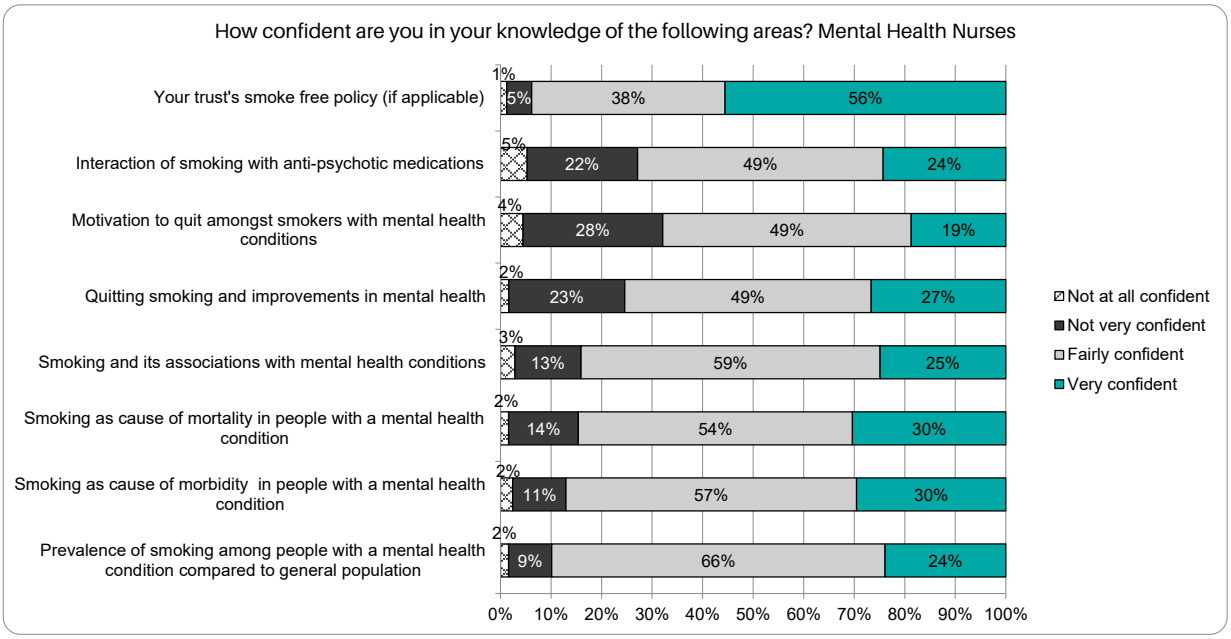
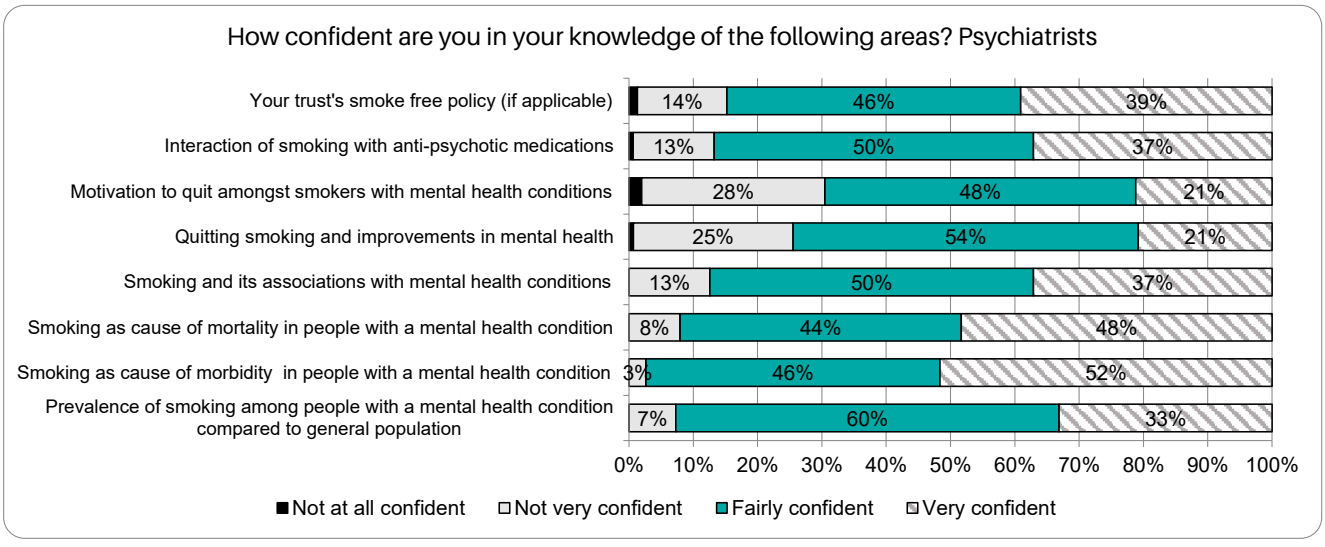


Figure 16: Psychiatrists response to how confident are they in their knowledge on topics related to smoking, smoking cessation and mental health



As with mental health nurses, a third of psychiatrist respondents were not confident in their knowledge regarding mental health patients' motivation to quit smoking, and a quarter were not confident in their knowledge on improvements to mental health related to quitting. The most

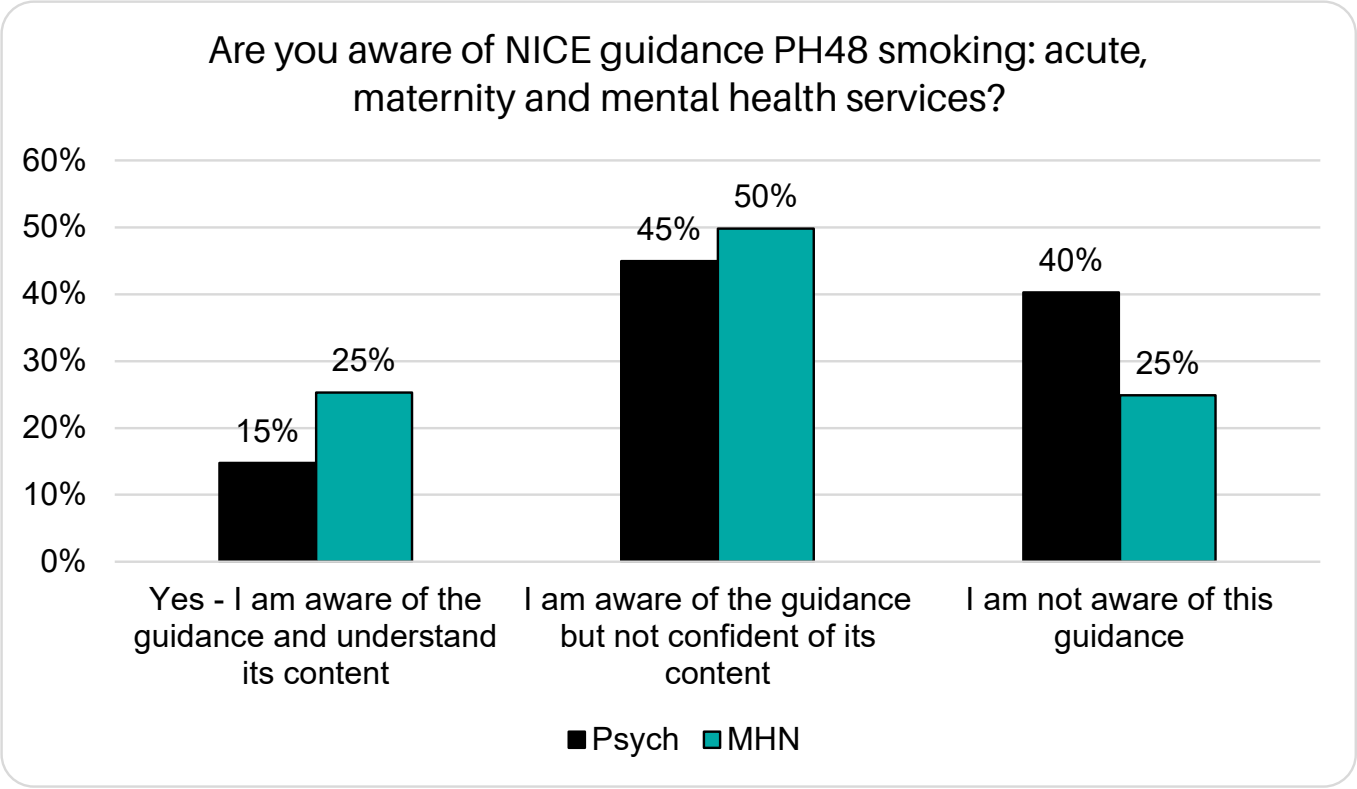
popular answer for psychiatrists was 'fairly' confident when asked how confident they were in the same areas. The area where psychiatrists felt fairly or very confident regarding their knowledge was smoking as a cause of morbidity in people with a mental health condition, with over 50% feeling very confident. (See figure 16).

Although the survey indicated high levels of confidence in knowledge of smoking and mental health topics, this wasn't always reflected in the focus group discussions. Participants in the focus groups were aware that people with mental health conditions smoked more than the general population, but there were gaps in knowledge around how smoking effects mental health, how long it would take someone to quit, and how nicotine withdrawal symptoms can be confused with symptoms of mental health issues:

> ***"I can't remember anything about quitting smoking and improvement in mental health, I don't think that's been a particular focus... whether their [mental] health improves when they stop smoking well that, that would be an interesting topic, I've not heard that at all to be honest actually .***
>
> ***"Maybe also I don't know enough about how long does it take for someone to give up smoking? How long is a course? And would that continue after someone's discharge?" (Psy2 346)***

With regards to knowledge on NICE guidance PH48, the majority of both psychiatrists and mental health nurses were either not aware of the guidance or aware of it but unsure of its content (85% of psychiatrists and 75% of mental health nurses) (See figure 17). Respondents working in inpatient settings were more likely to be aware of the guidance and understand its content compared to those working in community settings, and conversely those working in community settings more likely to not be at all aware of the guidance.

Figure 17: MHNs' and Psychiatrists' knowledge on NICE guidance PH48.



Knowledge: current levels and gaps - smoking cessation and treatments

Respondents were asked if they felt confident broaching the subject of smoking and smoking cessation when speaking with patients. Overall, 93% of mental health nurses and 88% of psychiatrists said they agreed or strongly agreed that they felt confident in doing so.
When asked about how confident they felt in their ability to give Very Brief Advice, or Ask, Advise and Act, the largest share of respondents said they agreed, followed by those who strongly agreed. Community based professionals were more likely to disagree or strongly disagree with this statement than inpatient professionals. (Figures 18 and 19).

Figure 18: MHNs' confidence level in their ability to give very brief advice

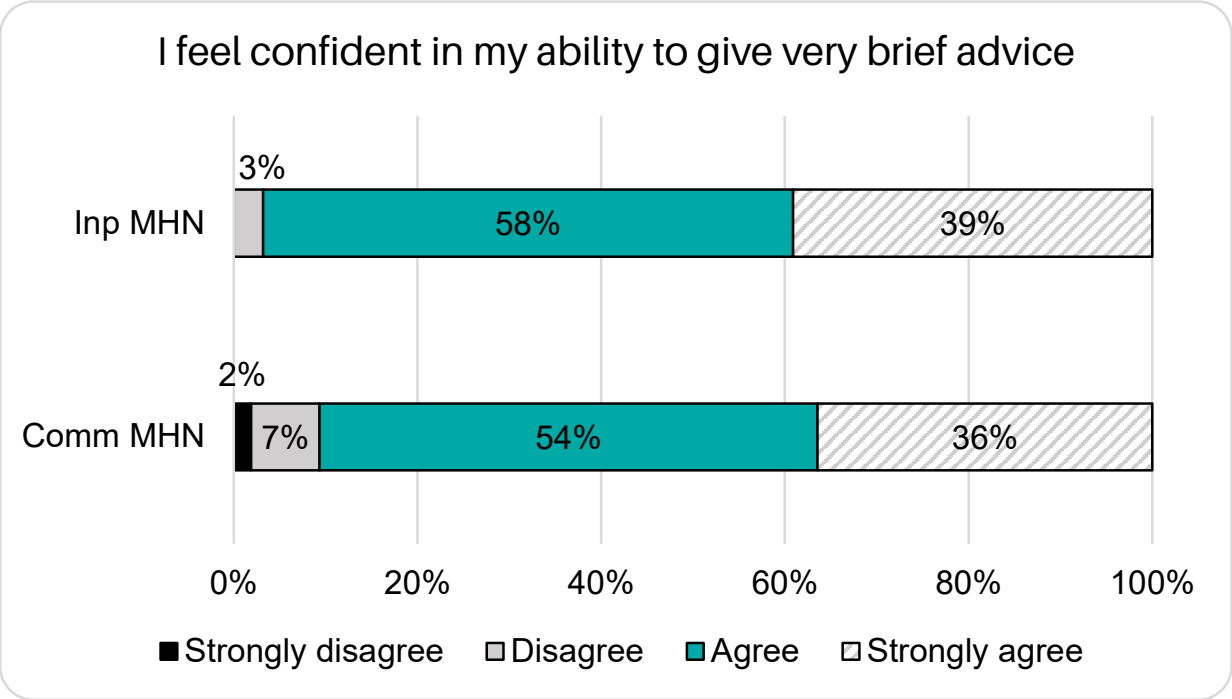
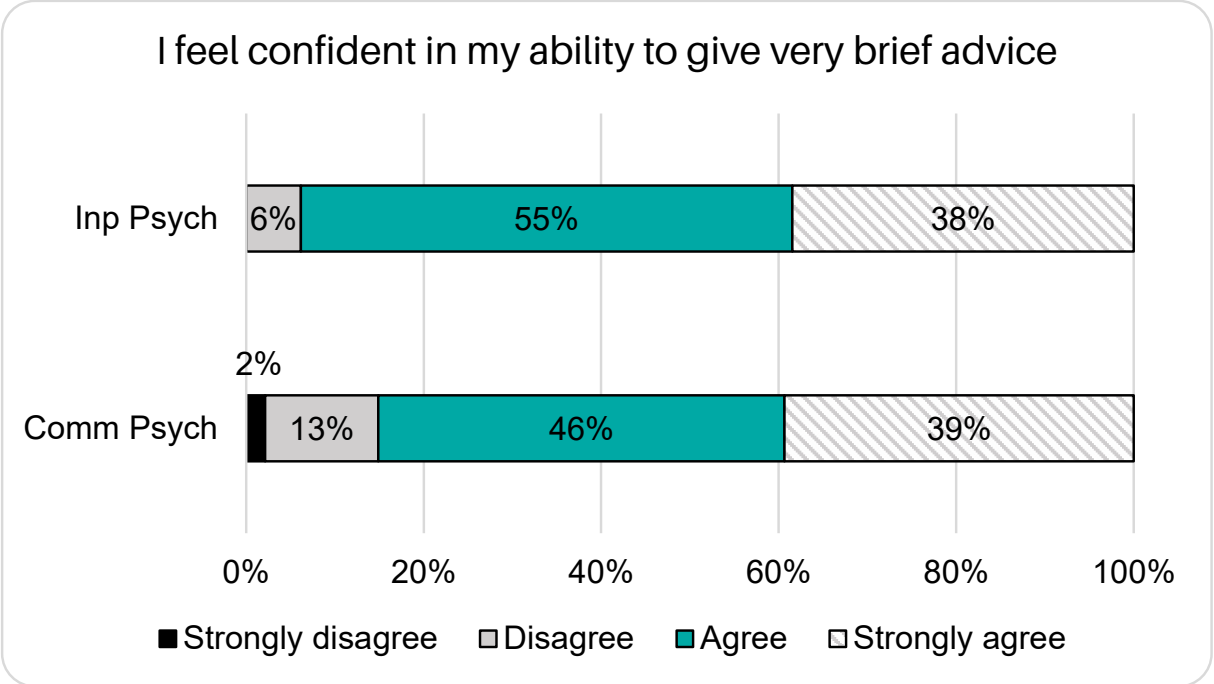


Figure 19: Psychiatrists' confidence level in their ability to give very brief advice



In contrast to this reported level of confidence, the focus groups revealed that addressing smoking with a patient was not commonplace, especially amongst psychiatrists:

> ***"We often record it and I might try to say oh have you thought about you know, do you need help trying to cut down, but I wouldn't force it." (Psych1 07)***
>
> ***"I wouldn't routinely offer people smoking cessation because most of the time we get people they are too di... (unfinished word) it wouldn't be appropriate to have that conversation in that state." (Psych1 60)***
>
> ***"So when someone comes to you and says 'I'm thinking of stopping smoking', you have NRT on the wards, e cigarettes are available and you can make specialist referral to a nurse who can come and see other patients, but it doesn't really form part of daily practice." (MHN2 148)***
>
> ***"I've only ever raised it if it's in relation to specific fear or concern that the patient has." (Psych1)***

When asked about delivering components that commonly make up VBA, survey respondents were less confident. When asked if they agreed with the statement 'I feel confident referring a patient to a stop smoking service or smoking adviser' 37% of psychiatrists disagreed or strongly disagreed and over a quarter (26%) of mental health nurses also disagreed or strongly disagreed (see figure 19). This lack of confidence was most prevalent in community settings for psychiatrists, with just over 40% of not confident referring, and 27% of inpatient mental health nurses indicating the same.

Similarly, over a third of psychiatrists and a fifth of mental health nurses did not feel confident advising patients on the use of NRT to help stop smoking, with community psychiatrists the least likely to feel confident (41% 'not confident'). The majority of both psychiatrists and mental health nurses (just over 70%) did not feel confident in advising patients on the use of varenicline.

While the majority of psychiatrists felt confident prescribing NRT, over a third indicated they were not confident. For most nurses, the question of prescribing NRT was not applicable. Among those for which it was applicable, nearly half indicated they were not confident in prescribing NRT (excluding the 'not applicable' respondents from the denominator, and assuming those who responded are nurse prescribers).

Figure 20: Psychiatrists confidence level in their ability to prescribe smoking cessation treatment

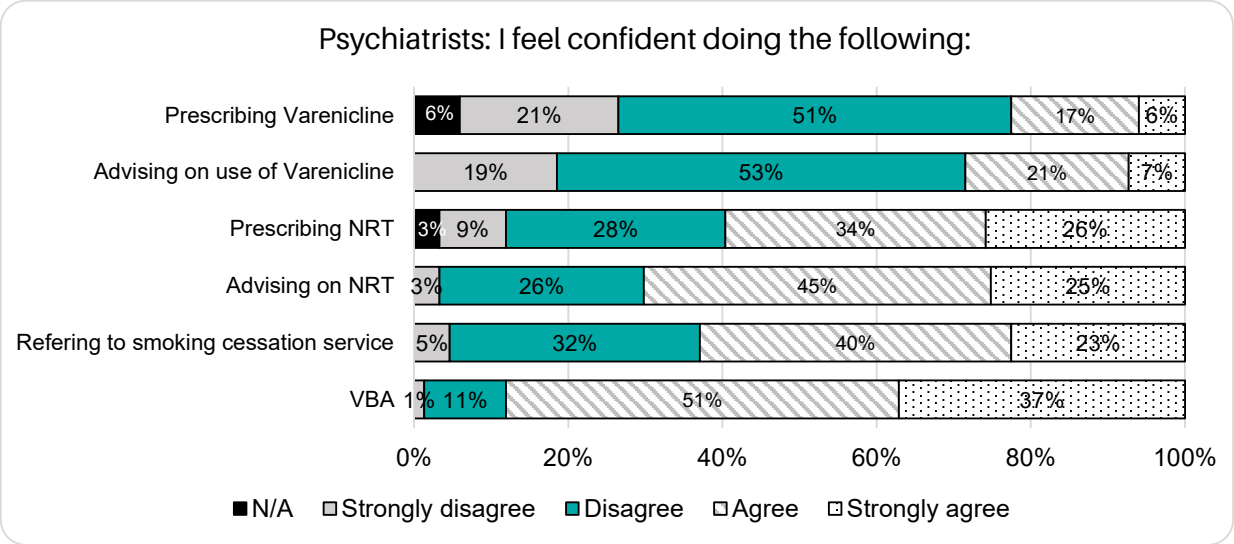
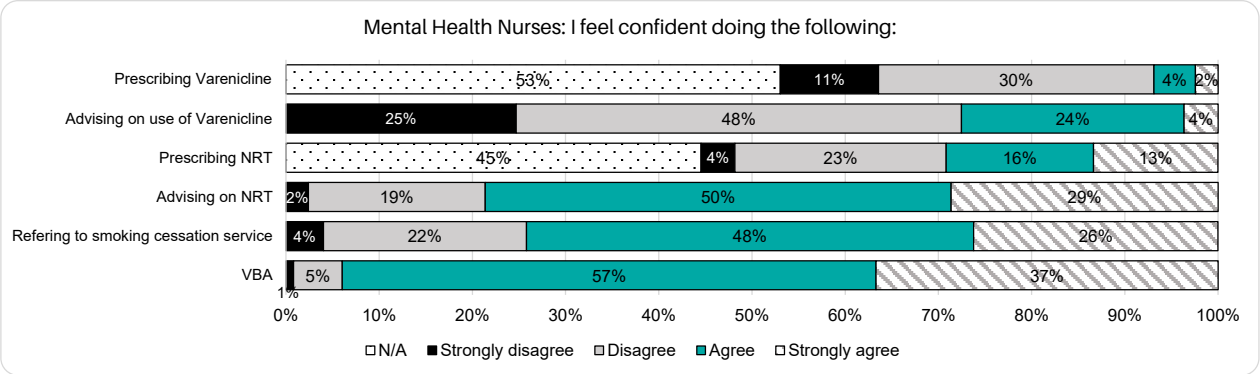


Figure 21: MHNs' confidence level in their ability to prescribe smoking cessation treatments



One mental health nurse consultant who leads on smoking cessation and mental health noted that in her trust there was an issue around the lack of knowledge on nicotine withdrawal symptoms, and that they were confusing it for symptoms of a patient's mental health condition:

> ***"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" (MHN 990)***

There was also uncertainty around how, and to whom, staff should refer patients who want support with smoking cessation:

> ***"I work out in the community and I don't know how to refer any one to a smoking cessation service." (Psy1 81)***
>
> ***"I work in the crisis team, we don't have a physical health lead or smoking cessation nurse, we don't have any resources like that, so I think we'd have to look externally if we were to refer a patient ."(Psy1 173)***

E-cigarettes

60% of all respondents agreed or strongly agreed that they feel confident recommending the use of e-cigarettes, 26% disagreed or strongly disagreed that they feel confident recommending the use of e-cigarettes, and 14% said they would not recommend the use of e-cigarettes. Those who said they would not recommend e-cigarettes to patients who smoked were asked to give a reason in a free text box. Reasons given for not recommending included concerns around health risks and media coverage suggesting harms, risk of fire in mental health settings and lack of knowledge.

Reasons given for not recommending e-cigarettes to patients:

- "Due to health risks related to e cigarette use"
- "Reports of adverse outcome in using it"
- "Because of recent press coverage suggesting other health hazards"
- "Feel there are health risks... which have been highlighted in news of late".
- "Recent concerns re lung damage"
- "Safety concerns re health effects and fire risk"
- "I don't know enough about the risks involved or the research with them being a relatively new product."

These findings on e-cigarettes corroborated what was indicated in the focus groups. Whilst some participants were well informed and discussed e-cigarettes in the context of latest evidence and UK guidelines, others displayed a lack of knowledge either through acknowledging they were unaware of the current evidence:

> *"I couldn't safely say I know enough about them to prescribe them to somebody or to tell them." (Psy1 755)*

Or indirectly by making statements about their safety based on recent media reports largely originating from the US, for situations which aren't translatable to the UK due to differing regulations.

> *"I think it leads to heart disease doesn't it?" (Psy1 774)*
>
> *"There are lots of recent reports with people serious lung injury." (Psy1 774)*
>
> *"Because recently, I heard something else about the vaping, about...cancer... They're still doing the research, but the preliminary findings shows that it doesn't really reduce the cancer rates because the ingredients in vaping can be equally carcinogenic as tobacco in the cigarettes." (Psy2 858)*

Key findings

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[45] 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,[46] and are currently the most popular aid to quitting.[47]

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 viewpoint 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."*

What we already know

Unsupportive staff attitudes present a major barrier to supporting patients to quit smoking and are important determinants and perpetuators of a smoking culture.[1] A systematic review found that commonly held beliefs amongst mental health care professionals include that patients are not interested in quitting (51.4%) and that quitting smoking is too much for patients to take on (38%) . Evidence contradicts these beliefs with studies showing that people with mental health conditions are just as motivated to want to quit[49] and that quitting smoking does not worsen and can even improve mental health.[20]

However, people with mental health problems are less likely to successfully quit smoking when they try. They are also less likely to receive help to quit smoking,[50] or to be prescribed varenicline or NRT.[26]

This contributes to smoking rates among people with mental health problems which are much higher than in the general population.

Beliefs in patient appetite and ability to quit

Overall a third of survey respondents agreed or strongly agreed with the statement 'patients with mental health conditions are not motivated to quit', with those working in inpatient settings more likely to agree or strongly agree compared to their community colleagues. (38% v 29% for MHN, and 37% v 21% for Psychiatrists) (see figures 22 and 23).

Figure 22: Psychiatrists' response to patients with mental health conditions are not motivated to quit

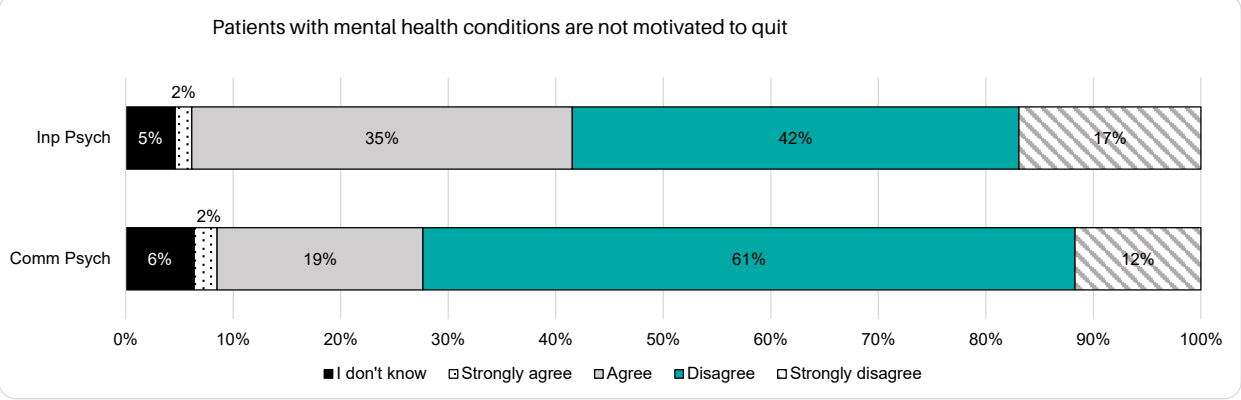
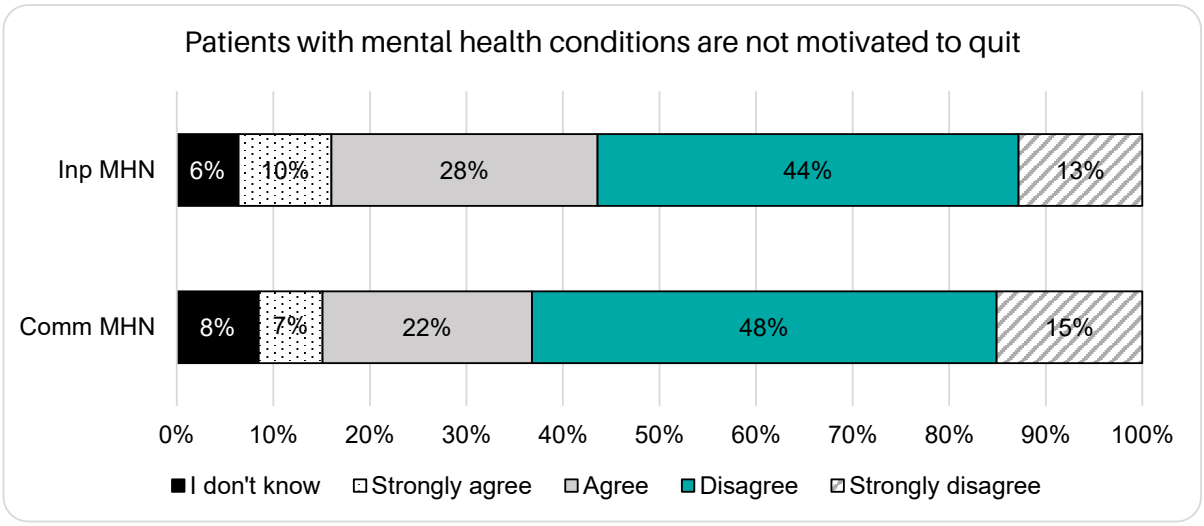
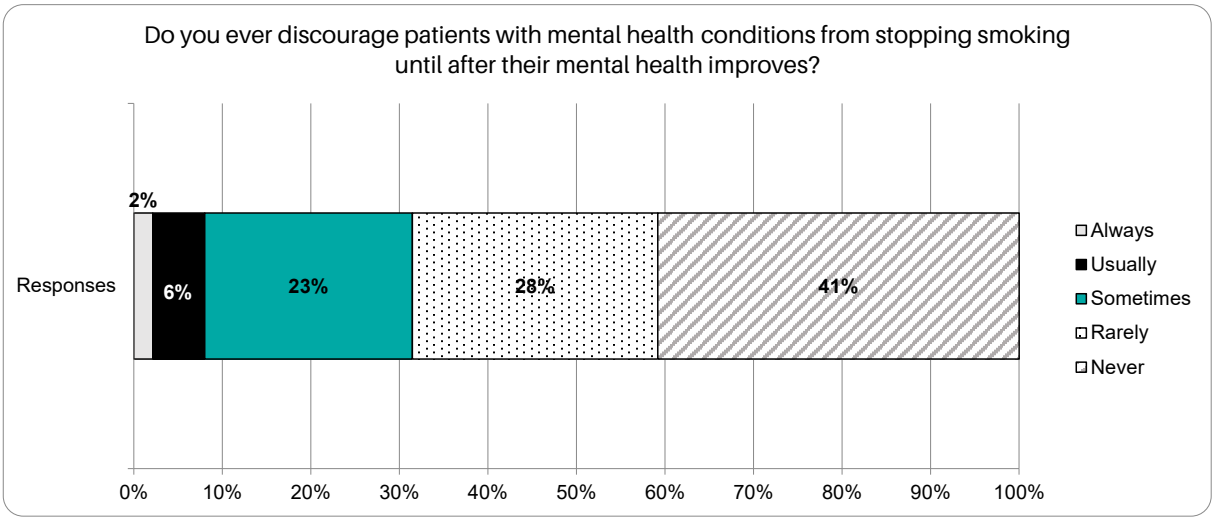


Figure 23: MHNs' response to patients with mental health conditions are not motivated to quit



Although the majority of mental health nurses and psychiatrists who responded to the survey said they agreed or strongly agreed with the statement 'stopping smoking has mental health benefits', around a third of respondents still sometimes, usually or always discouraged patients with a mental health condition from stopping smoking until after their mental health improves. (see figure 24).

Figure 24: MHNs' and Psychiatrists' response to whether they ever discourage patients with mental health conditions from stopping smoking until after their mental health improves



Role of smoking in a mental health setting

Results from the focus groups gave some further insights into beliefs and attitudes of mental health nurses and psychiatrists with regards to smoking and mental health, in particular the role they perceived smoking to play in mental health settings. Firstly, participants indicated that smoking played a social role, in that it brought people together helping to create bonds between patients:

> ***"Cigarettes are almost like a currency on the ward, like a social fabric of the ward, people socialise over, so it's part of their, their culture almost, getting to know one another, forming groups." (Psy1 consultant)***

Participants also indicated that it was still felt that smoking played a key role in the therapeutic relationship between patient and health care professional:

> ***"There is a lot of cynicism about smoking cessation among staff in those areas because they actually see some therapeutic benefits those cigarette breaks in terms of their therapeutic relationships to the patients." (MHN2 131)***

Lastly, it was felt that a smoking ban in hospitals increased violence and aggression, and therefore allowing someone to smoke played a role in preventing such incidents, and that historically smoking formed part of managing a patient's routine:

> *"There was a reliance historically in my area in the hospitals of relying on cigarettes for assuaging irritations and smoothing out crumples in the daily routine around making sure nicotine was available." (MNH2 865)*

Perceived conflict between smoking policy and inpatient staff values

Despite the health promotion rationale for smokefree policy being clearly outlined in NICE guidance, many participants felt that smokefree policy had undermined the 'role' cigarettes played, negatively impacting on patient experience, the patient/staff therapeutic relationship and increasing the incidence of violent and aggressive behaviour.

Furthermore, 'Some participants felt that smoke-free policy encroached on patients' already limited personal freedoms – and that smoking was one of the only things left for patients to 'enjoy':

> *"I mean at the same time it's when... all of someone's liberty is taken away and the ability to go and smoke might be the one thing that that they still have some control or choice over." (Psy1 consultant)*
>
> *"I also find that if they're stuck under section stuck in hospital... smoking might be the only thing that they enjoy or that they find relaxing so there's a balance to be struck." (Psy2 105 consultant)*

It was also felt that smoke free policy impacted negatively on day to day management of the ward:

> *"I work in the locked ward, the intensive care ward, and for me this is actually probably the top priority, you know when you say how important is it to you, to me this is, if someone is a smoker, this is probably the most important and pressing bit of their whole management before you start even thinking about prescription for psychosis or calming them down. What they're interested in is why they're being deprived of nicotine and the fact that NRT, generally, isn't working and they're very angry about it and as a staff you're alienated by this and it can become a matter of severe violence." (Psy2 115)*

It was apparent that there were conflicting views amongst psychiatrists and mental health nurses as to whether it is morally 'right' to address smoking with a patient who had a mental health disorder, particularly those with an acute episode.

There was a cohort of mainly MHNs in the focus groups who talked passionately about the importance of the health-promoting rationale of smoke free policy. However, most other participants used language that carried negative connotations when referring to smoke free policy, such as 'sanction' and 'prohibition'. Some even felt that a new culture had emerged that was focused on confiscating and policing.

> *"It's just becoming like another sanction in this system and, you know, I really don't agree with that sort of thing." (MHN2 218)*
>
> *"When I started my training, [it was] quite therapeutic to smoke with inpatients and you know [it] deescalated quite a lot of incidents [laughs] and we've gone to kind of the other end of the spectrum of kind of policing people smoking, which is for me, kind of unhelpful...it's kind of making it seem negative, rather than supporting somebody to stop." (MHN2 218)*
>
> *"You end up with the nurses and doctors becoming police for a smoking policy which they didn't subscribe to begin with." (Psych consultant 2)*

Free text answers from an option in the survey that allowed respondents to add any other comments or opinions highlighted strong opinions on both sides:

- "I think this is very important subject which improves clients' quality of life and their health." (MHN)
- "The impacts of health complications or smoking are causing high rates of morbidity and mortality in this group. This is avoidable and we should be tackling it." (Psych)
- "Whilst completely supporting training for staff and all assertive supportive measures to help patients stop smoking, I believe that the Smoking Ban in hospitals is immoral, overly authoritarian and deeply damaging to the engagement and therapeutic care of many patients. I wholeheartedly oppose it." (Psych)
- "I have very strong views about inpatient mental health units adopting smoke free policies. It is not the time to force patients to stop smoking and these policies must change." (MHN)

Perceived responsibilities around patient smoking status

The majority of MHN and psychiatrist focus group participants reportedly record their patient's smoking status, but while the MHNs also reportedly follow up with more thorough assessments, psychiatrists' are less consistent in the actions they take, largely due to varying perceptions of professional responsibilities. Some psychiatrists perceived smoking to be an issue related to physical, rather than mental health, for example, and therefore saw it as outside of their professional remit.

> ***"I think the issue is partly that there's been a culture in psychiatry which means that we're not responsible or we don't deal with physical health and that we will do some aspects of it but not, not very much." (Psy2 599)***
>
> ***"Do we ask about what their physical health conditions are in quite the same way, and the answer seems to be evidentially anecdotally, no, we don't ask as well, or as frequently as we ought to." (MHN2 676)***

Survey respondents were asked to provide any final thoughts or additional detail relating to this topic in a free text box. One survey respondent – a psychiatrist – simply felt that it wasn't their role to discuss smoking or smoking cessation with patients: "As a specialist community doctor, I expect smoking cessation conversations and advice to be delivered in primary care."

Related to this, some psychiatrists don't discuss smoking or smoking cessation with patients because they do not recognise the link between smoking and mental health to the same extent as they do with other substances, such as alcohol or cannabis, which have a much more widely accepted impact among psychiatrists. Psychiatrists therefore tend to prioritise holding conversations around other substances.

> ***"I think there's a slightly different attitude from like other substances, for example if someone in a clinic who told me they were drinking excessively I wouldn't just say 'that's interesting' and move on I would discuss it with them and 'so ok, how long has this been going on for? Why? You know have you thought about stopping?' or if they were talking about cannabis or anything else you would definitely explore that further but normally with smoking just say 'ok 20 cigarettes a day, has it ever been higher or lower?' and then you just sort of move on, so I think it's generally an attitude not just in mental health but generally speaking." (Psy1 456)***
>
> ***"I mean I think probably 60% of our inpatients are problematic cannabis users and so we have dual diagnosis workers on the ward we're much more focussed on cannabis reduction than smoking reduction" (Psy1 475)***

A survey respondent also commented: "I struggle with motivation as not many people are interested, also often trying to motivate patients to reduce/ stop illicit substances can trump this issue."

Key findings and conclusions

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.[22 23] 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.[51 52]

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[50] which found that a significant proportion of mental health professionals held negative attitudes towards smoking cessation and permissive attitudes towards smoking. 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:

- o Provide information on smoking that is tailored to mental health settings and reflects the core values of mental health professionals
- o Ensure training formats promote reflective practice: e.g. including peer led sessions on myths and culture, using mentorship to support reflection and learning
- o 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..."*

What we already know

This report draws on existing survey work carried out by ASH and others which assesses the extent to which mental health trusts are delivering for their smoking patients, within both community and inpatient environments. While progress has clearly been made in the last decade, barriers remain.

Organisational barriers to effective support of smokers in mental health settings include:

- Gaps in availability of quit support
- Lack of access to medications
- Inconsistent approaches across different settings
- Inconsistent or lack of leadership
- Prevailing culture and understanding (discussed in the previous section)

Lack of consistent support across settings and services

A lack of consistent support across pathways and services can undermine a patient's quit attempt and this appeared to be an issue for the focus group participants and their patients. Inpatient staff felt there was lack of smoking cessation support from community service colleagues, both in preparing a patient for an inpatient stay, and for maintaining quit attempts after they are discharged from inpatient stays. Some inpatient MHNs found that they were the first people to do an assessment of a patient's smoking status, even though the patient had previously engaged with community mental health teams.

> *"For a lot of patients it was a surprise when they got to hospital that they weren't allowed to smoke, and I think those clinicians that were working in the community or gatekeeping beds and treatments etc, I think they can sometimes choose not to share that information to make that pathway in easier for them and the individual, and then you know, it sits with us on the wards" (MHN1 664)*
>
> *"For our trust I think what is, we've noticed now 18 months in, desperately lacking is that community-based support is missing from the programme" (MHN1 685)*

Furthermore, it was felt there was a lack of consistent support from other services such as GPs. A reluctance to prescribe varenicline among GPs meant that some patients went back to smoking after they had undertaken a successful quit attempt on the ward.

> *"We've had a patient that we've prescribed this medication in one of our hospitals last month, he did really well on it whilst he was in the ward, we discharged him with his week's supply of medication including the varenicline, as we should have done, and as soon as he went to his GP for his repeat prescription the GP decided he wasn't going to give him the Varenicline" (MHN1 491)*

Some focus group participants highlighted the specific challenges that community services also face, including a lack of clear guidelines that specifically relate smoke-free policies to community mental health settings, and practical challenges around arranging medications:

> *"We throw all sorts at people when they're in hospital... the vapes, the NRT, and then once they're stepping back out of hospital it's like where's that going to come from where do they get it? who owns it? For that person? I've asked them you know, for the individual... trying to sort out their NRT or vaping is tricky." (MHN1 689)*

It was felt that smoke free guidance was less relevant in the community setting, and that there had not been adequate focus on community teams when a trust was preparing to go smoke free. As a result, community staff were less aware of what their role was when it came to providing smoking cessation support, and were less aware of how to refer patients to smoking cessation services.

> *"I have no idea what I'm expected to do other than ask someone whether they're smoking or not. I just ask them would you like support with quitting because that's what I might do in an appointment, but I don't do it in every appointment and I don't even know if it's my role or if it's the person who did the initial assessment role or if I'm seeing someone 6 months down the line am I supposed to ask them again - there's no clear definition of what mental health services are meant to be doing or inputting into this movement to help people to stop smoking, at least in the community." (Psy2 736)*

Lack of alternative activities

The lack of alternative activities offered to smokers to replace their regular cigarette breaks may be a barrier to effective policy implementation in acute settings. One focus group participant mentioned that patients used cigarette smoking to create structure and routine, often to relieve boredom, but that nothing was offered to take its place:

> *"It's interesting to ask patients themselves in terms of smoking cessation and their view and I know that we, err, 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 for how to - what to do instead how to work with this." (Psy2 212)*

One participant reported patients who didn't smoke began smoking as a way deal with being on a ward or in order to get leave:

> *"I've seen patients who've come into hospital under section who were not smoking take up smoking as a relief against being on the ward." (Psy2 194)*
>
> *"That becomes frustrating for clinicians doesn't it that all of your conversations with leave are to do with 'can I have a cigarette' rather than you know are you well enough and how are you going to use your leave and, um, you know people begin smoking when they come in to hospital because they want an excuse to go and ask for leave."*

Policy compliance

Policy breaches were discussed in the focus groups. Some participants indicated there was a more formal arrangement within the trust to go against policy as a response to what they deemed as risks and adverse consequences of the policy itself. This included the risk to patients from smoking in certain areas outside the hospital, risks to others from increased violence and aggression and perceived risk of damage to therapeutic relationships.

A related issue that was commonly discussed was how breaches of policy and lack of consistency in policy implementation undermined efforts of staff who complied with policy. It was felt that some staff allowed patients to smoke to make their lives easier, without consideration of efforts of staff who tried to comply to smoke free policy:

> ***"What makes it slip is the 'heroes' who say [to patients who smoke] 'look just go out there and have a cigarette, I'm not going to say anything to anyone'... they undermine it for absolutely everyone else." (MHN1 279)***
>
> ***"If you go to another ward and say, how on earth did you manage this patient's smoking, the response I got from the ward manager was to pull a packet of cigarettes out his pocket and say to me "this is what I do" and I said "can I have two please, I'm taking them back." (Psy2 157)***

Key Findings

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.

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:
    - o Be tailored for staff in community settings covering the specific issues which they might face in addition to local pathways and smokefree policies
    - o 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

> *"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." (MHN2 823)*

Stage of training

The vast majority of both psychiatrists (81%) and MHNs (91%) (Figure 25) thought that smoking and mental health education should be compulsory in mental health academic programmes, and the majority of respondents felt that refresher training related to mental health and smoking would be beneficial at every stage of their career (with the exception of consultant level, where just under 50% of MHNs thought it would be beneficial). (See figure 26).

- 93% of psychiatrists felt training would be beneficial during specialty training
- 74% of psychiatrists felt it would also be beneficial at undergraduate and foundation years
- 64% felt it would be beneficial at consultant level
- 85% of MHN felt training would be beneficial at undergraduate level
- 81% of MHN felt training would be beneficial during preceptorship for newly qualified nurses
- 72% felt it would be beneficial after preceptorship for practicing nurses

Figure 25: Psychiatrists' and MHNs' response to making smoking and mental health compulsory in mental health academic programmes

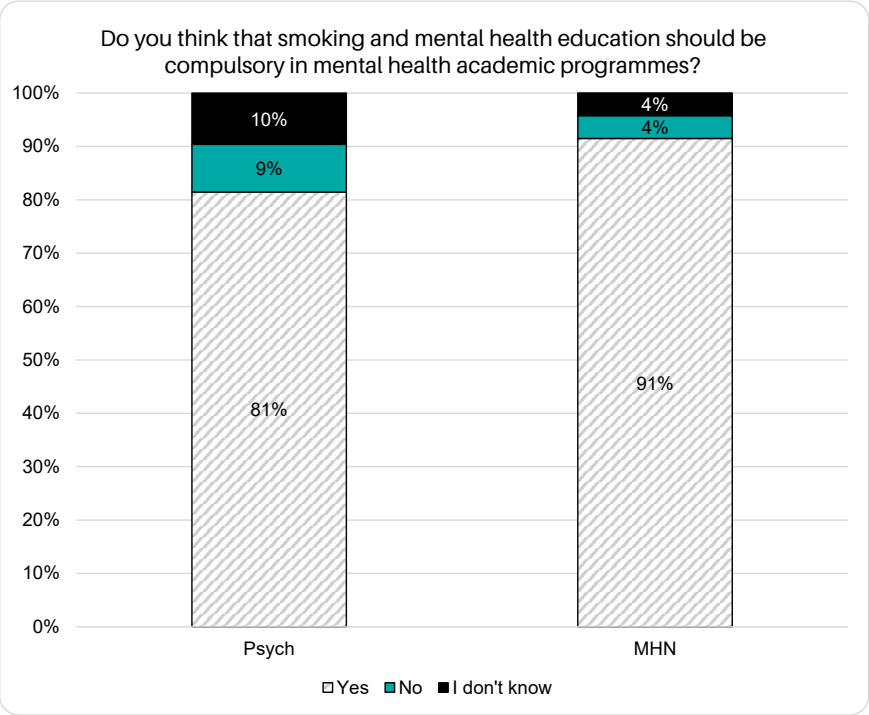
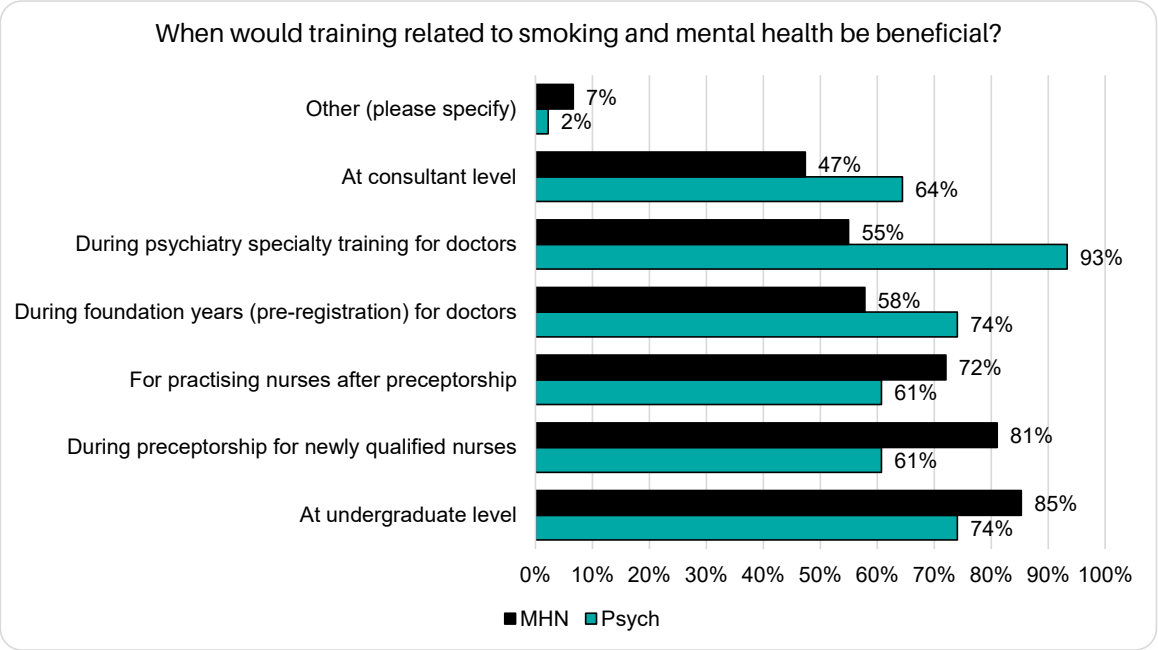


Figure 26: Psychiatrists' and MHNs' response to when would training related to smoking and mental health be beneficial



Provision of training

The majority of both MHN and psychiatrists felt training on mental health, smoking and smoking cessation should be mandatory. The majority of psychiatrists felt it should be delivered as part of a multi-disciplinary departmental training approach and should be taught at undergraduate level, with just over 50% selecting 'by hospital/department as part of the induction', and 'as part of regional teaching sessions for doctors in training'. Almost half also felt it would be best provided as part of specialty training and e-portfolio competencies. The least popular response was 'as an optional choice for continuing professional development' (28%). (Figure 27)

Large proportions of MHN also felt it should be provided by hospital trusts or departments as part of induction (69%), and as part of an undergraduate course (67%). 44% felt it would be best delivered through multidisciplinary departmental training and, as with psychiatrists, the least popular response was as an optional choice for continuing professional development (30%). (Figure 27)

Figure 27: Psychiatrists' and MHNs' response on the best way for training on mental health, smoking and smoking cessation to be provided

In the focus groups, participants argued that training needs be bespoke, with its content and delivery tailored to each specific trust, depending on a how a trust records information and what local smoking cessation services they access, if any. Focus group participants also felt that training should be delivered holistically across community and inpatient services:

> ***"For me personally I think it needs to be localised to fit in with the electronic patients record system, with the local, you know whether there is a local stop smoking service or not, it's all going to be tailored." (MHN1 007)***
>
> ***"I mean probably I want something like when we do the training is that we combine it with community colleagues which we have not done before. So that would be a good start where you could hear the opinions of the community mental health teams and the acute mental health teams and how they could work better together." (MHN1 968)***
>
> ***"We shouldn't try and compartmentalise into boxes and just say this is inpatient, this is community, that doesn't make any sense to patients, because our duty of care does not stop at the hospital gates, we have to think about the holistic view, the patients care should be seamlessly followed through, so I 100% agree, and also think there's, for me there's a different kind of training that need to be given to, if we are just talking about nurses, I think to nurse managers." (MHN1 974)***

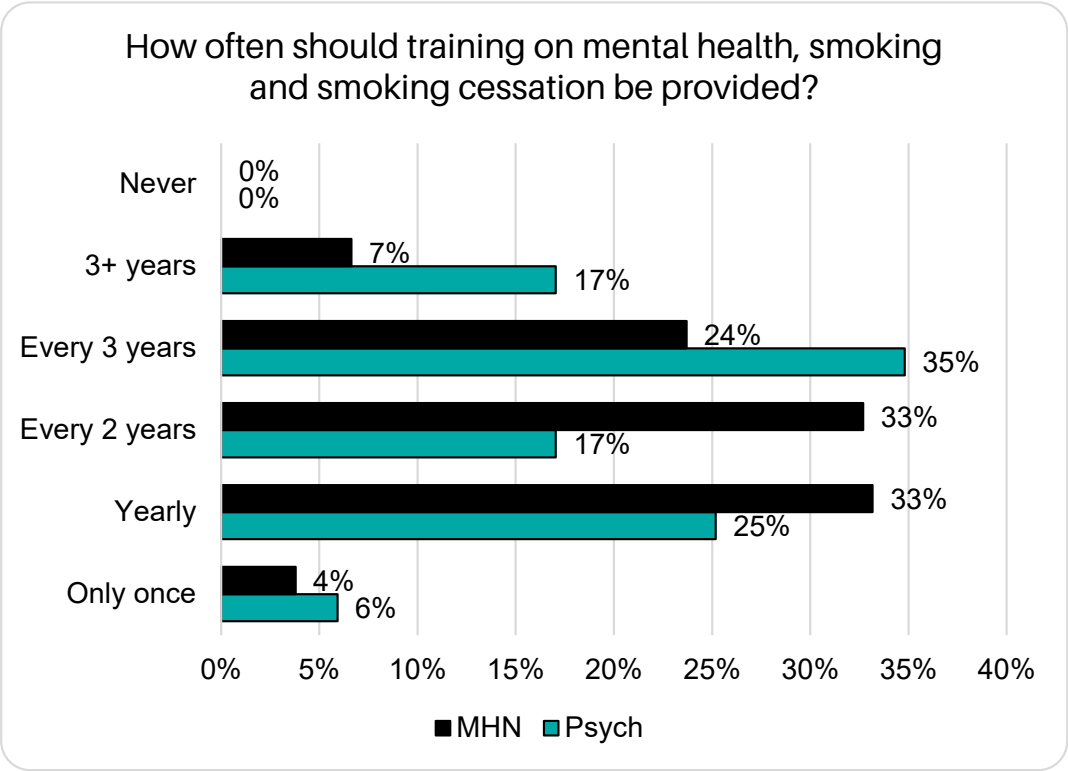
It was also felt that training should not be directed at single workforce groups, and that efforts on smoking and smoking cessation support were inextricably linked to pathways within and across services. One participant put it thus:

> ***"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." (MHN2 823)***

Regularity of training

Survey respondents were asked how frequently they felt training on mental health, smoking, and smoking cessation should be provided. Both psychiatrists and mental health nurses saw the need for regular training, though preferences differed with regards to length and timing. Over a third (35%) of psychiatrists would prefer to receive training every three years, followed by a quarter (25%) who were in favour of annual training. The largest proportion of MHNs (33%) said that training should be delivered on a yearly basis, and a similar proportion (33%) would prefer to receive training every two years. Just 6% of psychiatrists and 4% of MHNs agree that training should only take place once throughout their career. (Figure 28).

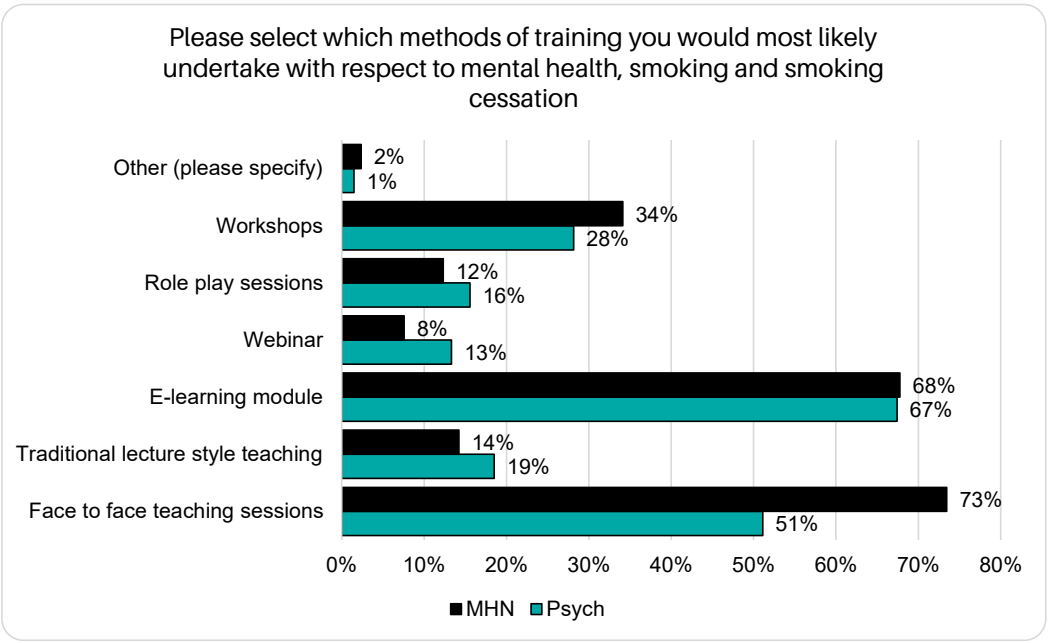
Figure 28: Psychiatrists and MHNs response to how often should training on mental health, smoking and smoking cessation be provided



Format of training

When asked which methods of training they would most likely undertake, the most popular choice for psychiatrists was e-learning modules (67%), followed by face to face sessions (51%). Conversely, face to face was the preferred method for MHNs (73%) followed by e-learning module (68%). Over a third of MHNs (34%) and over a quarter of psychiatrists (28%) selected workshops as the method they would most likely undertake. The least popular choice was webinars. (Figure 29).

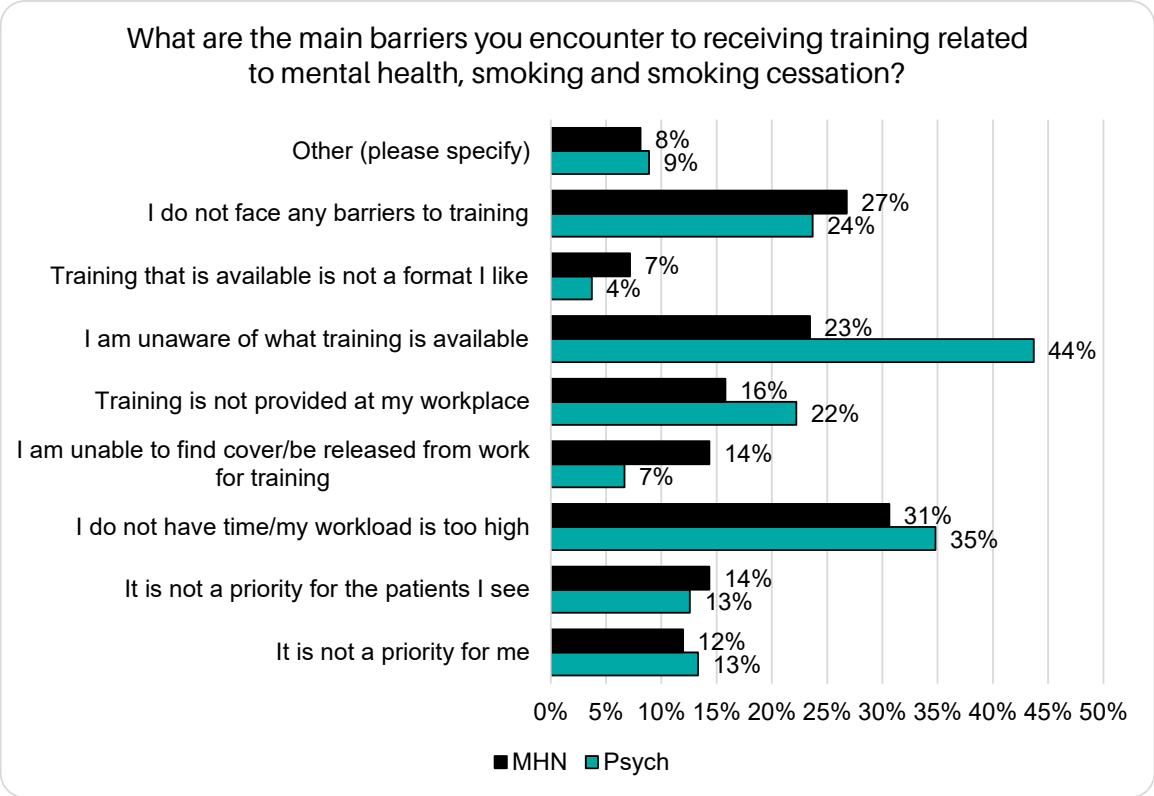
Figure 29: MHNs and Psychiatrists response to methods of training they would most likely undertake with respect to mental health, smoking and smoking cessation



Barriers to training

Respondents were asked to identify what, if any, barriers they encountered that limited their uptake of training related to mental health, smoking and smoking cessation. Similar proportions of psychiatrists and MHNs reported they did not face any barriers to training (24% and 27%). The top barrier for psychiatrists was a lack of awareness as to what training is available (44%), followed by a high workload and lack of time to devote to training (35%). For MHNs, the top barrier was a lack of time/ the intensity of their workload (31%) followed by a lack of awareness of the available training (23%). (Figure 30).

Figure 30: MHNs and Psychiatrists response to main barriers they encountered that limited their uptake of training related to mental health, smoking and smoking cessation



Uptake of training

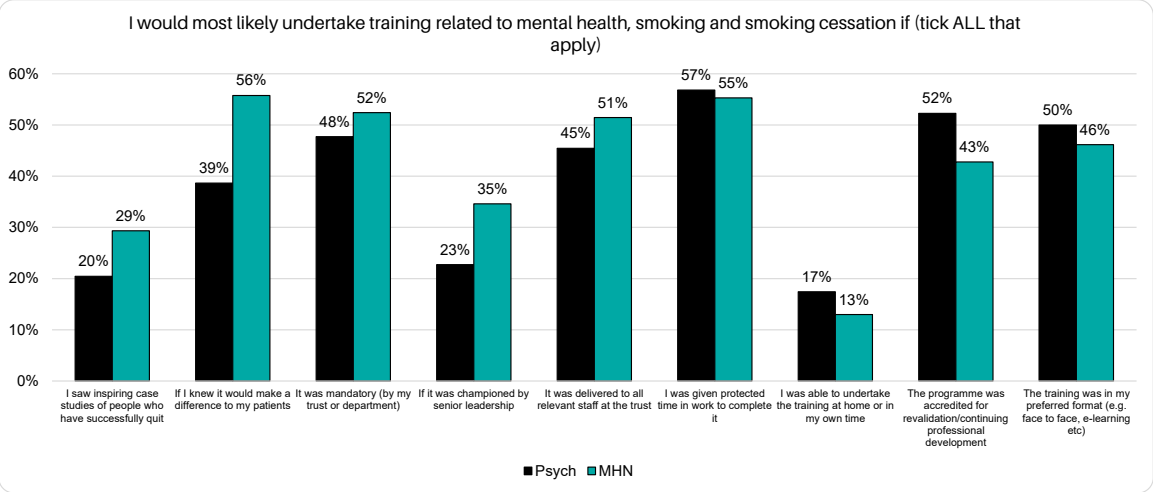
Respondents were asked which of the following would influence their uptake of training:

- I saw inspiring case studies of people who have successfully quit
- If I knew it would make a difference to my patients
- It was mandatory (by my trust or department)
- If it was championed by senior leadership
- It was delivered to all relevant staff at the trust
- I was given protected time in work to complete it
- I was able to undertake the training at home or in my own time
- The programme was accredited for revalidation/continuing professional development
- The training was in my preferred format (e.g. face to face, e-learning etc)

While psychiatrists are clearly hindered by a lack of free time and the intensity of their workload, over half (57%) said they would undertake training if they were given protected time within which to complete it. Similarly, a large proportion (52%) would be incentivised to complete training if they were to receive relevant accreditation, for example if the programmes was accredited for revalidation/ continuing professional development.(See figure 31). Uptake could also be encouraged by adapting

the format to suit attendees learning preferences, with half of psychiatrists saying that they would be likely to undertake training if it was in their preferred format. For MHNs, clearly communicating the potential health benefits for patients would have the largest impact on uptake, with over half of MHNs reporting that they would undertake training if they 'knew it would make a difference' to their patients.

Figure 31: Uptake of training related to mental health, smoking and smoking cessation



Other influencing factors

Focus group discussions highlighted other factors that can positively influence peoples experience of training. These included learning from peers and learning about real life success stories:

> ***"We have a continued professional development group I'm fortunate to have a very eminent psychiatrist in my group and lectures from him or discussions from him... were remarkable and this is what I remember about smoking cessation." (Psy2 398)***
>
> ***"I also, I want to, you know since we started to focus on them I have seen patients who have massively benefitted physically and mentally and those were people I didn't, I didn't believe nothing could change... and they managed to do it. And you know they were sort of, 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, you know, about how it is very difficult for people with mental illness, very ill people to change this." (Psy2 20)***

Key findings

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; and
- 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.

Conclusions and full recommendations

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.

Full 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.

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.

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.

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:

- o Provide information on smoking that is tailored to mental health settings and reflects the core values of mental health professionals
- o Ensure training formats promote reflective practice: e.g. including peer led sessions on myths and culture, using mentorship to support reflection and learning
- o Involve service users and their stories about smoking and quitting

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:

- o Be tailored for staff in community settings covering the specific issues which they might face in addition to local pathways and smokefree policies
- o 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.

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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

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- Mental Health and Smoking Partnership

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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.

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