WHY DO WE IGNORE SMOKING AND WHAT WORKS IN HELPING PEOPLE TO QUIT?:

REFLECTIONS ON THE SCIMITAR TRIAL

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On behalf of the SCIMITAR collaborative

Things I will talk about today

- Smoking and severe mental ill health (SMI): what we know?
- SCIMITAR+: the largest trial of a behavioural & pharma intervention for people who smoke use mental health services
  - History
  - Findings
  - Implications for services and policy

Public Health England

Protecting and improving the nation's health

Health Matters

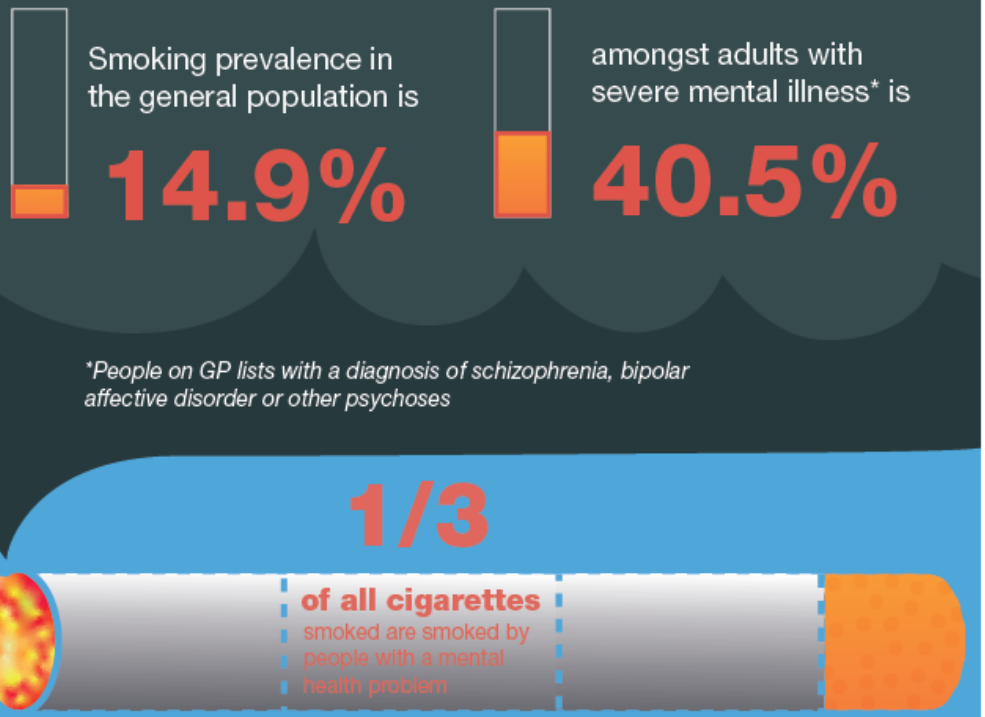
Reducing health inequalities in mental illness

4. Behavioural health risk factors

Smoking remains the largest single cause of preventable death in England. Whilst smoking prevalence in the general population is at an all-time low at 14.9%, amongst people with SMI registered with a GP, it is almost three times that at 40.5%. Research suggests that smoking rates may be even higher depending on the severity of the mental health problem.

The Tobacco Control Plan for England recognises the need for urgent action in inpatient and community mental health settings to reduce the stark difference in smoking rates, and ensure people with a mental health condition are not left behind as we move towards a smokefree generation.

Death by suicide is also a major risk, with a history of alcohol and/or drug use being recorded in 54% of all suicides in people experiencing mental health problems.



The smoking culture in mental health services

- Anthropological research demonstrates:
  - Staff accept smoking as routine and offer cigarettes
  - Staff smoke with users of services
  - Means of pacifying distressed people in inpatient settings
  - Source of relief from boredom in inpatient units
  - The 'cigarette economy of institutions'
  - Non-smokers initiated into the social rituals of smoking on first admission

Lawn 2004; Hempel et al 2000

Consequences of smoking for those with SMI

- Poor physical health
- Early death 20 – 25 years
- Tobacco poverty
- Increasing health inequalities
- Stigma

Smoking is the single most important modifiable risk factor in SMI

Mythbusting

People who use mental health services just aren't interested in quitting

No point asking, since nothing works

Therapeutic nihilism

SCIMITAR+

A pragmatic randomised trial design

The largest trial ever undertaken to address smoking in mental health services

SCIMITAR+ built on strong foundations

Addiction

REVIEW

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Smoking cessation in severe mental illness: what works?

Lindsay Banham[1,2] & Simon Gilbody[2]

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ABSTRACT

Aims The physical health of people with severe mental illness (SMI) is poor. Smoking-related illnesses are a major contributor to excess mortality and morbidity. An up-to-date review of the evidence for smoking cessation interventions in SMI is needed to inform clinical guidelines. **Methods** We searched bibliographic databases for relevant studies and independently extracted data. Included studies were randomized controlled trials (RCTs) of smoking cessation or reduction conducted in adult smokers with SMI. Interventions were compared to usual care or placebo. The primary outcome was smoking cessation and secondary outcomes were smoking reduction, change in weight, change in psychiatric symptoms and adverse events. **Results** We included eight RCTs of pharmacological and/or psychological interventions. Most cessation interventions showed moderate positive results, some reaching statistical significance. One study compared behavioural support and nicotine replacement therapy (NRT) to usual care and showed a risk ratio (RR) of 2.74 (95% CI 1.10–6.81) for short-term smoking cessation, which was not significant at longer follow-up. We pooled five trials that effectively compared bupropion to placebo giving an RR of 2.77 (95% CI 1.48–5.16), which was comparable to Hughes *et al.*'s 2009 figures for general population data; RR = 1.69 (95% CI 1.53–1.85). Smoking reduction data were too heterogeneous for meta-analysis, but results were generally positive. Trials suggest few adverse events. All trials recorded psychiatric symptoms and the most significant changes favoured the intervention groups over the control groups. **Conclusions** Treating tobacco dependence is effective in patients with SMI. Treatments that work in the general population work for those with severe mental illness and appear approximately equally effective. Treating tobacco dependence in patients with stable psychiatric conditions does not worsen mental state.

Keywords Health inequalities, severe mental illness, smoking, smoking cessation, systematic review, UK smoking ban.

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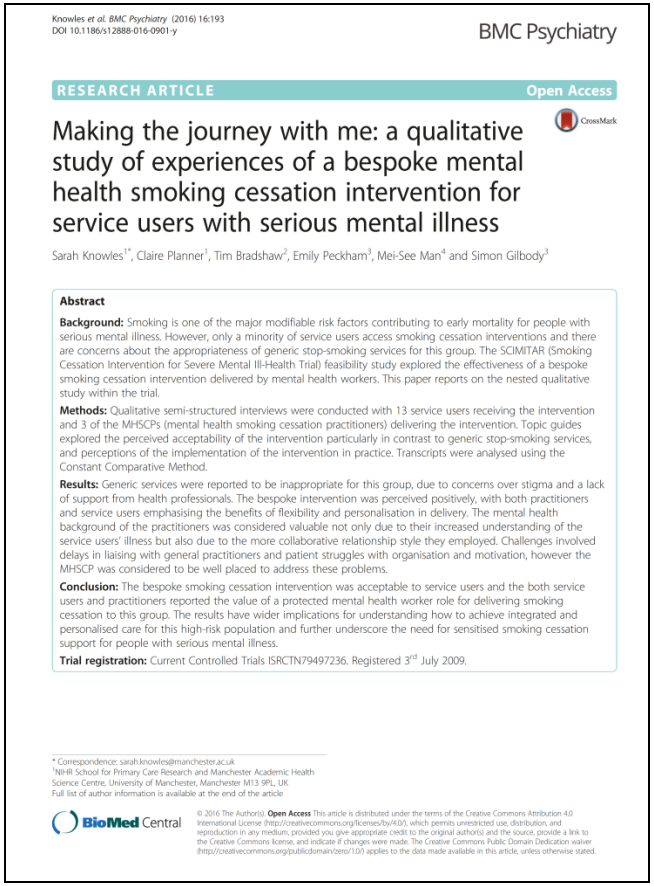
INTRODUCTION

People with severe mental illnesses (SMIs), such as schizophrenia and bipolar disorder, experience much poorer physical health and die much earlier than the rest of the population [1]. In the developed world, we know that those with schizophrenia are at 1.5 times greater risk of death compared with those in the general population, and people with any form of serious mental illness die approximately 2.5 years earlier than the general population [2,3]. The causes of these health inequalities are multi-factorial, but smoking-related illnesses are a major contributor to excess mortality and morbidity. Those with SMI are two to three times more likely to smoke than the general population [4]. Studies show that up to 70% smoke, and around 50% are heavy smokers [5,6]. Nicotine addiction and cigarette consumption have implications beyond their effects on physical health. Cigarettes are expensive, and those with SMI often survive on state benefits and may sacrifice a healthier diet or social activities in order to smoke [7].

In the United Kingdom, a number of public health interventions have been introduced to address nicotine addiction within the population in general, including a ban on smoking in public places. Initially, both acute and long-stay psychiatric in-patient units were exempt from the ban [8]; however, from 1 July 2008, psychiatric residential units in England enforced a complete indoor



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RESEARCH ARTICLE Open Access

Making the journey with me: a qualitative study of experiences of a bespoke mental health smoking cessation intervention for service users with serious mental illness

Sarah Knowles[1*], Claire Planner[1], Tim Bradshaw[2], Emily Peckham[3], Mei-See Man[4] and Simon Gilbody[3]

Abstract

Background: Smoking is one of the major modifiable risk factors contributing to early mortality for people with serious mental illness. However, only a minority of service users access smoking cessation interventions and there are concerns about the appropriateness of generic stop-smoking services for this group. The SCIMITAR (Smoking Cessation Intervention for Severe Mental Ill-Health Trial) feasibility study explored the effectiveness of a bespoke smoking cessation intervention delivered by mental health workers. This paper reports on the nested qualitative study within the trial.

Methods: Qualitative semi-structured interviews were conducted with 13 service users receiving the intervention and 3 of the MHSCPs (mental health smoking cessation practitioners) delivering the intervention. Topic guides explored the perceived acceptability of the intervention particularly in contrast to generic stop-smoking services, and perceptions of the implementation of the intervention in practice. Transcripts were analysed using the Constant Comparative Method.

Results: Generic services were reported to be inappropriate for this group, due to concerns over stigma and a lack of support from health professionals. The bespoke intervention was perceived positively, with both practitioners and service users emphasising the benefits of flexibility and personalisation in delivery. The mental health background of the practitioners was considered valuable not only due to their increased understanding of the service users' illness but also due to the more collaborative relationship style they employed. Challenges involved delays in liaising with general practitioners and patient struggles with organisation and motivation, however the MHSCP was considered to be well placed to address these problems.

Conclusion: The bespoke smoking cessation intervention was acceptable to service users and the both service users and practitioners reported the value of a protected mental health worker role for delivering smoking cessation to this group. The results have wider implications for understanding how to achieve integrated and personalised care for this high-risk population and further underscore the need for sensitised smoking cessation support for people with serious mental illness.

Trial registration: Current Controlled Trials ISRCTN79497236. Registered 3rd July 2009.

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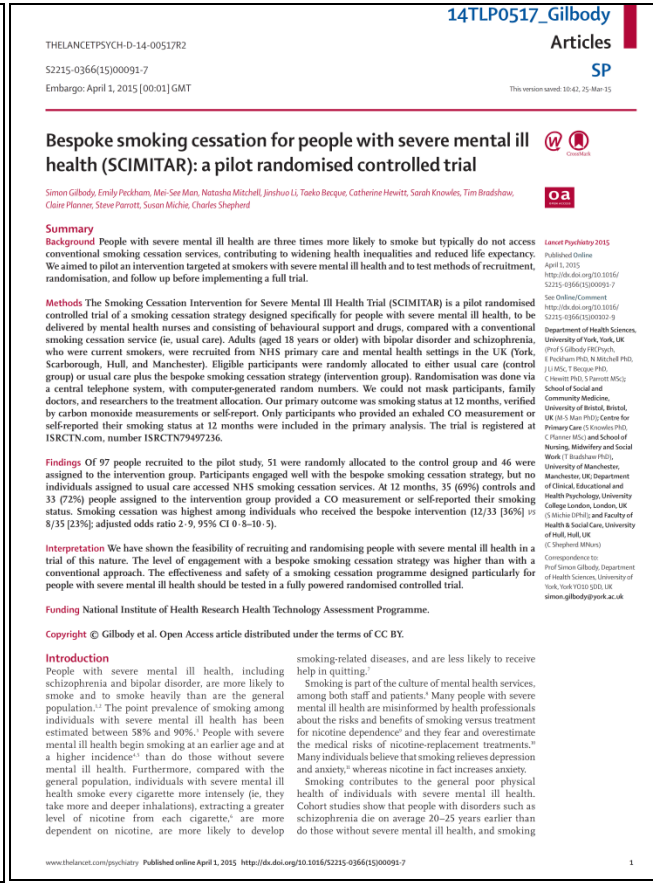

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Articles

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Bespoke smoking cessation for people with severe mental ill health (SCIMITAR): a pilot randomised controlled trial

Simon Gilbody, Emily Peckham, Mei-See Man, Natasha Mitchell, Jinshuo Li, Taeko Becque, Catherine Hewitt, Sarah Knowles, Tim Bradshaw, Claire Planner, Steve Parrott, Susan Michie, Charles Shepherd

Summary

Background People with severe mental ill health are three times more likely to smoke but typically do not access conventional smoking cessation services, contributing to widening health inequalities and reduced life expectancy. We aimed to pilot an intervention targeted at smokers with severe mental ill health and to test methods of recruitment, randomisation, and follow up before implementing a full trial.

Methods The Smoking Cessation Intervention for Severe Mental Ill Health Trial (SCIMITAR) is a pilot randomised controlled trial of a smoking cessation strategy designed specifically for people with severe mental ill health, to be delivered by mental health nurses and consisting of behavioural support and drugs, compared with a conventional smoking cessation service (ie, usual care). Adults (aged 18 years or older) with bipolar disorder and schizophrenia, who were current smokers, were recruited from NHS primary care and mental health settings in the UK (York, Scarborough, Hull, and Manchester). Eligible participants were randomly allocated to either usual care (control group) or usual care plus the bespoke smoking cessation strategy (intervention group). Randomisation was done via a central telephone system, with computer-generated random numbers. We could not mask participants, family doctors, and researchers to the treatment allocation. Our primary outcome was smoking status at 12 months, verified by carbon monoxide measurements or self-report. Only participants who provided an exhaled CO measurement or self-reported their smoking status at 12 months were included in the primary analysis. The trial is registered at ISRCTN.com, number ISRCTN79497236.

Findings Of 97 people recruited to the pilot study, 51 were randomly allocated to the control group and 46 were assigned to the intervention group. Participants engaged well with the bespoke smoking cessation strategy, but no individuals assigned to usual care accessed NHS smoking cessation services. At 12 months, 35 (69%) controls and 33 (72%) people assigned to the intervention group provided a CO measurement or self-reported their smoking status. Smoking cessation was highest among individuals who received the bespoke intervention (12/33 [36%] *vs* 8/35 [23%]; adjusted odds ratio 2·9, 95% CI 0·8–10·5).

Interpretation We have shown the feasibility of recruiting and randomising people with severe mental ill health in a trial of this nature. The level of engagement with a bespoke smoking cessation strategy was higher than with a conventional approach. The effectiveness and safety of a smoking cessation programme designed particularly for people with severe mental ill health should be tested in a fully powered randomised controlled trial.

Funding National Institute of Health Research Health Technology Assessment Programme.

Introduction

People with severe mental ill health, including schizophrenia and bipolar disorder, are more likely to smoke and to smoke heavily than are the general population.[1,2] The point prevalence of smoking among individuals with severe mental ill health has been estimated between 58% and 90%.[3] People with severe mental ill health begin smoking at an earlier age and at a higher incidence[4,5] than do those without severe mental ill health. Furthermore, compared with the general population, individuals with severe mental ill health smoke every cigarette more intensely (ie, they take more and deeper inhalations), extracting a greater level of nicotine from each cigarette,[3] are more dependent on nicotine, are more likely to develop smoking-related diseases, and are less likely to receive help in quitting.[1]

Smoking is part of the culture of mental health services, among both staff and patients.[6] Many people with severe mental ill health are misinformed by health professionals about the risks and benefits of smoking versus treatment for nicotine dependence[6] and they fear and overestimate the medical risks of nicotine-replacement treatments.[6] Many individuals believe that smoking relieves depression and anxiety,[6] whereas nicotine in fact increases anxiety.

Smoking contributes to the general poor physical health of individuals with severe mental ill health. Cohort studies show that people with disorders such as schizophrenia die on average 20–25 years earlier than do those without severe mental ill health, and smoking

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‘she understood my mental health’

- ‘she understood my mental health problems…….if you go to a normal stop smoking thing and they know you’ve got mental health problems……there’s the stigma’

SCIMITAR+ Bespoke Smoking Cessation

The intervention

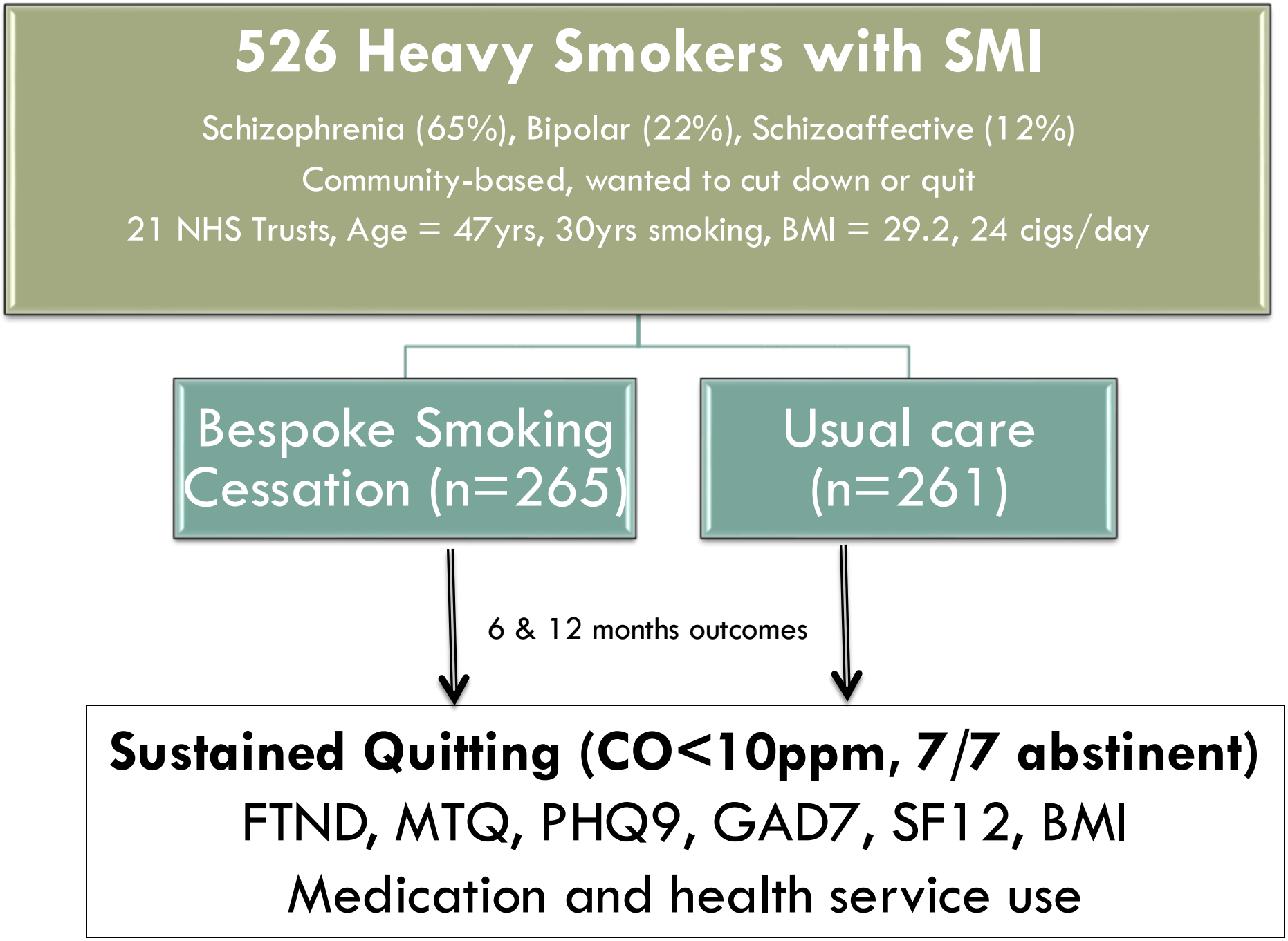
NHS
Centre for Smoking Cessation and Training

Standard Treatment Programme

Face to face individual smoking cessation interventions

Building on the NHS STP for mental health services

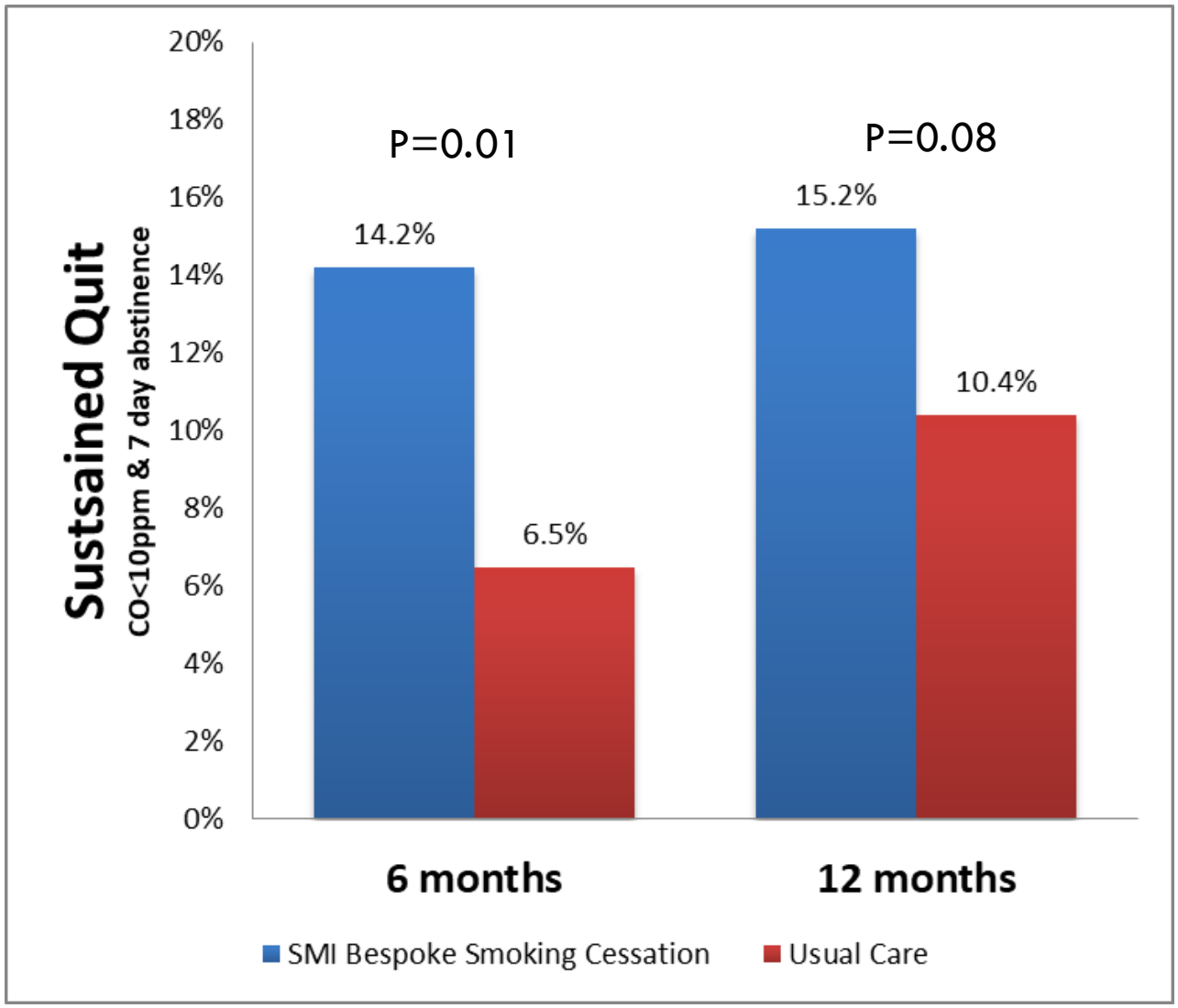
- Delivered by a mental health professional
- Nicotine pre-loading & 'cut down to quit'
- More intensive and more personalised
- Special attention to medication management
- Planning for quit attempt. What to do in place of smoking


526 Heavy Smokers with SMI
Schizophrenia (65%), Bipolar (22%), Schizoaffective (12%)
Community-based, wanted to cut down or quit
21 NHS Trusts, Age = 47yrs, 30yrs smoking, BMI = 29.2, 24 cigs/day
Bespoke Smoking Cessation (n=265)
Usual care (n=261)
6 & 12 months outcomes
Sustained Quitting (CO<10ppm, 7/7 abstinent)
FTND, MTQ, PHQ9, GAD7, SF12, BMI
Medication and health service use

SCIMITAR+

What were the results?

Did people with SMI quit?



Some reflections

WWW (What went well?)

- We have addressed the Q
- Big trial, generalisable
- Good long-term follow up
- Fed directly into NICE Guidelines in this area
- Has become the service model for NCSCT in mental health services

EBI (Even better if……)

- Take charge of the medication supply
- Varenicline
- Embrace e-cigarettes
- Longer-term support
- Younger people FEP

2.11. **Third, 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.** On the advice of PHE, this will include the option to switch to e-cigarettes while in inpatient settings.

Messages for mental health services

- Make every encounter count
- Be prepared to challenge common misperceptions
- Challenge therapeutic nihilism
- Challenge services to be responsive to the needs of people who use services
- Know how to manage medications when people quit
- Challenge the smoking culture
- Smokefree is a journey

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ash. action on smoking and health

NCSCT

NHS National Institute for Health Research