NATIONAL INSTITUTE FOR HEALTH AND CLINICAL EXCELLENCE

PUBLIC HEALTH GUIDANCE

DRAFT SCOPE

1 Guidance title

Smoking cessation in secondary care: mental health services

1.1 Short title

Smoking cessation: mental health services

2 Background

a) The National Institute for Health and Clinical Excellence (NICE) has been asked by the Department of Health (DH) to develop public health guidance on smoking cessation in secondary care. The referral has been divided into two separate pieces of complementary guidance.

b) This guidance will address smokefree policies and smoking cessation in mental healthcare settings. It will cover assessment, care and treatment for people with severe mental illness in hospitals, outpatient clinics and the community, as well as intensive services in psychiatric units and secure hospitals. The other guidance ('Smoking cessation in secondary care: acute and obstetric services') will address smokefree policies and smoking cessation in hospitals and other acute or obstetric care settings. It will cover emergency care, planned specialist medical care or surgery, and obstetric care provided in hospitals, maternity units, outpatient clinics and in the community (http://guidance.nice.org.uk/PHG/Wave23/22).

c) This guidance will support a number of related policy documents including:

- 'Fair society, healthy lives' (Marmot Review 2010)
- ‘Healthy lives, healthy people: a tobacco control plan for England’ (DH 2011a)
- ‘Healthy lives, healthy people: our strategy for public health in England’ (DH 2010)
- 'Improving outcomes: a strategy for cancer' (DH 2011b)
- 'No health without mental health: a cross-government mental health strategy for people of all ages' (DH 2011c)
- ‘Securing good health for the whole population’ (Wanless 2004)
- ‘The operating framework for the NHS in England 2011/12’ (DH 2011d).

d) This guidance will provide recommendations for good practice, based on the best available evidence of effectiveness, including cost effectiveness. It is aimed at professionals and managers with mental healthcare or public health as part of their remit. It is particularly aimed at commissioners and providers of evidence-based stop-smoking services and doctors, nurses, social workers and estates managers working in mental healthcare. In addition, it will be of interest to all mental health and other secondary care staff, patients, carers, and service users who smoke and other members of the public.

e) The guidance will complement other NICE guidance on stopping smoking. For further details, see section 6.

This guidance will be developed using the NICE public health programme process. (For details see www.nice.org.uk/aboutnice/howwework/developingnicepublichealthguidance/developing_nice_public_health_guidance.jsp).

3 The need for guidance

a) Tobacco smoking is the main cause of preventable morbidity and premature death in England. Smoking causes a wide range of diseases, including cancers, cardiovascular diseases, respiratory diseases and osteoporosis. It also causes complications of pregnancy and low birthweight. In England in 2009, it was estimated that 81,400 deaths among adults aged 35 and over were caused by smoking. The same study estimated that more than 462,000 hospital admissions in this age group were attributable to smoking, accounting for 5% of all admissions (NHS Information Centre 2010).

b) Breathing secondhand smoke can have both immediate and long-term health consequences. In the short term, it can exacerbate respiratory symptoms and trigger asthma attacks. In the longer term, there is an increased risk of smoking-related diseases (Royal College of Physicians 2005; Scientific Committee on Tobacco and Health 2004). Scientific evidence suggests that there is no risk-free level of exposure to secondhand smoke (US Surgeon General 2006).

c) Smoking rates are much higher among people with mental health problems than in the general population; thus people with mental health problems are at greater risk of smoking-related disease. A third (33%) of people with mental health problems (McManus et al. 2010) and more than two-thirds (70%) of patients in psychiatric units smoke tobacco (Jochelson and Majrowski 2006), compared with about one in five adults (21%) in the general population (NHS Information Centre 2010).

d) There are several possible explanations for the high rates of smoking among people with mental health problems, including a greater susceptibility to addiction or the belief that tobacco helps to

alleviate mental health symptoms. Smoking may be used to self-medicate for anxiety or depression (Olivier et al. 2007). However, there is evidence suggesting a negative impact of long-term smoking on mental health and illness severity (Olivier et al. 2007). Interactions between nicotine and some psychiatric medications make the medications less effective so that a higher dose is needed. In some instances there is a need for a planned reduction of doses of medications during a quit attempt (Campion et al. 2010).

e) Although people with mental health problems are more likely to smoke, recent studies show that they have a similar level of motivation to quit as the general population, and are able to quit when offered evidence-based support (Jochelson and Majrowski 2006; Siru et al. 2009). Review-level evidence has confirmed the effectiveness of smoking cessation interventions delivered to people with mental health problems (Campion et al. 2008; Tsoi et al. 2010); however, evidence also shows that effective treatment is not routinely offered to people with mental health problems (McNeill 2004; McNally et al. 2006).

f) Under the smokefree legislation that was introduced in England in July 2007, anyone who smokes in any enclosed or substantially enclosed public place or workplace commits an offence. A temporary 1-year exemption until July 2008 was applied for mental health units (HM Government 2006). Most NHS secondary care settings have smokefree policies that apply to their grounds (as well as enclosed areas), although there have been problems with compliance and enforcement (Ratschen et al. 2009; Shipley and Allcock 2008).

4 The guidance

Public health guidance will be developed according to NICE processes and methods. For details see section 5.

This document defines exactly what this guidance will (and will not) examine, and what the guidance developers will consider. The scope is based on a referral from the DH (see appendix A).

4.1 Who is the focus?

4.1.1 Groups that will be covered

The guidance will cover people who smoke from the following groups:

- Patients, outpatients and all users of secondary care mental health services, including those who are in the process of being referred to, or have recently been discharged from:
  - child, adolescent, adult and older people mental health services
  - inpatient, residential and long-term care for severe mental illness in hospitals, psychiatric and specialist units and secure hospitals.
- People living in the same household as a mental health service user, such as partners, parents, other family members and carers.
- Visitors to secondary care mental health settings who are not receiving treatment or care, such as relatives or friends of patients.
- Staff working in secondary care mental health settings, in particular those who have direct contact with patients and service users.

4.1.2 Groups that will not be covered

- People who have quit smoking for at least 12 months.

- People who have never smoked.
- Users of secondary care services other than mental health services, and their parents, carers and other family members
- Staff working in, and visitors to, secondary care services other than mental health.

4.2 Activities

4.2.1 Activities/measures that will be covered

The guidance will focus on:

a) Smoking cessation and temporary abstinence interventions to help people from the groups listed in 4.1.1. This will include:

- offering smoking cessation information, advice and support integrated within care pathways
- identifying and referring people to stop-smoking services or mental healthcare-based stop-smoking services
- sharing information about quit attempts between clinicians and prescribers, and coordinating the use of pharmacotherapies for smoking cessation with other medications.

b) Smokefree strategies and interventions in secondary care mental health settings – whether or not they are supported by the smokefree legislation (HM Government 2006). Examples include restrictions to eliminate smoking (including signage and enforcement) in the grounds, staff residencies and inside the hospital, and restrictions on staff smoking breaks. The strategies and interventions will also cover visits by mental healthcare professionals to community settings, including private residences.

The guidance will also focus on links between these activities and, where possible, will identify ineffective measures and approaches.

4.2.2 Activities/measures that will not be covered

- Smoking cessation interventions in primary care, medical and surgical acute care and obstetric care.
- Smokefree strategies and interventions in secondary care settings that are not providing mental health services.
- Programmes or interventions aimed at preventing the uptake of tobacco use.

4.3 Key questions and outcomes

Below are the overarching questions that will be addressed along with some of the outcomes that would be considered as evidence of effectiveness:

Smoking cessation interventions

Question 1a: How effective and cost effective are smoking cessation interventions in helping people from the groups listed in 4.1.1 to quit?

Question 1b: How effective and cost effective are interventions for temporary abstinence from smoking in secondary care mental health settings?

Subsidiary questions may include:

- How do the effectiveness and cost effectiveness vary for different population groups or speciality care services?
- Are certain interventions more effective and cost effective when used in combination?
- What impact do the following have on effectiveness, cost effectiveness and acceptability of different interventions: deliverer, setting, timing (or point in the care pathway), frequency, duration, severity of dependence?

Question 2a: How effective and cost effective are the current approaches used by secondary care mental health services to identify and refer people from the groups listed in 4.1.1 to stop-smoking services?

Question 2b: How effective and cost effective are the current approaches used by mental healthcare services to identify and provide patients with smoking cessation information, advice and support?

Question 3: What approaches are an effective and cost effective way to encourage secondary care mental health professionals to record the smoking status of the groups listed in 4.1.1, to offer them smoking cessation information, advice and support or to refer them to stop-smoking services?

Question 4: How can community, primary and secondary care mental health service providers collaborate more effectively to provide seamless smoking cessation services?

Question 5: What barriers and facilitators affect the delivery of effective interventions?

Question 6: What are the effects of nicotine intake, or changes in levels of nicotine intake, on the mental and physical health of patients and service users who are on medication and receiving support from mental health services?

Question 7: What are the effects of nicotine intake, or changes in levels of nicotine intake, on the mental and physical health of patients and users of mental health services?

Expected outcomes:

- Successful quit attempts, defined as follows (where abstinence from smoking is biochemically validated or self-reported):
    - temporary: during a stay or visit at a secondary care mental health setting
    - short term: at least 1 month after a quit attempt

  - medium term: at least 6 months after a quit attempt
  - long term: at least 12 months after a quit attempt.

- Increase in the number of referrals to and contacts with stop-smoking services.

- Increase in the number of people provided with smoking cessation support by mental healthcare services.

- Increase in the number of smoking cessation referrals between secondary care mental health and other settings.

- Health improvement, such as better recovery rates from illness or treatment.

- Positive changes in smoking-related knowledge, attitudes and behaviour.

Smoke-free strategies and interventions

Question 8: How effective and cost effective are strategies and interventions for ensuring compliance with smokefree legislation and local smokefree policies in secondary care mental health settings?

Question 9: Are there any unintended consequences from adopting smokefree approaches in secondary care mental health settings?

Question 10: What are the barriers and facilitators affecting compliance with smokefree policies in secondary care mental health settings? What are the views, perceptions and beliefs of mental healthcare staff, patients, service users and visitors?

Expected outcomes:

Compliance with smokefree policies.

4.4 Status of this document

This is the draft scope, released for consultation on 1-29 September 2011 to be discussed at a public meeting on 15 September 2011. Following consultation, the final version of the scope will be available at the NICE website in November 2011.

5 Further information

The public health guidance development process and methods are described in 'The NICE public health guidance development process: An overview for stakeholders including public health practitioners, policy makers and the public (second edition, 2009)' available at www.nice.org.uk/phprocess and 'Methods for development of NICE public health guidance (second edition, 2009)' available at www.nice.org.uk/phmethods

6 Related NICE guidance

Published

Quitting smoking in pregnancy and following childbirth. NICE public health guidance 26 (2010). Available from www.nice.org.uk/guidance/PH26

School-based interventions to prevent smoking. NICE public health guidance 23 (2010). Available from www.nice.org.uk/guidance/PH23

Preventing the uptake of smoking by children and young people. NICE public health guidance 14 (2008). Available from www.nice.org.uk/guidance/PH14

Smoking cessation services. NICE public health guidance 10 (2008). Available from www.nice.org.uk/guidance/PH10

Varenicline for smoking cessation. NICE technology appraisal 123 (2007). Available from www.nice.org.uk/guidance/TA123

Workplace interventions to promote smoking cessation. NICE public health guidance 5 (2007). Available from www.nice.org.uk/guidance/PH5

Brief interventions and referral for smoking cessation. NICE public health guidance 1 (2006). Available from www.nice.org.uk/guidance/PH1

Under development

Smokeless tobacco: South Asians. NICE public health guidance (publication expected September 2012).

Tobacco: harm reduction. NICE public health guidance (publication expected May 2013).

Smoking cessation: acute and obstetric services. NICE public health guidance (publication date to be confirmed).

Appendix A Referral from the Department of Health

The Department of Health asked NICE to focus on:

'… how routine identification and referral [of smokers] can be embedded in clinical care … (this would cover all secondary care services, including mental health and obstetrics where identification and referral of smokers is often poor)

… what infrastructure and systems are needed to support tobacco control activity (ie smokefree grounds, how to make nicotine replacement therapy for temporary abstinence available to patients, staff and visitors)…'

Appendix B Potential considerations

It is anticipated that the Programme Development Group (PDG) will consider the following issues:

- Do individual factors such as gender, sexual orientation, age, ethnicity, religion or disability influence the effectiveness, cost effectiveness and acceptability of interventions?
- How do effectiveness and cost effectiveness vary in different settings?
- Are tailored services or interventions more effective and cost effective than generic offerings?
- What impact do interventions have on inequalities in health?
- Is the intervention based on an underlying theory or conceptual model?
- How do smoking cessation interventions interact with other types of secondary care services?
- What knowledge and skills do practitioners need to deliver interventions effectively? Do requirements vary for the different groups?
- Are the interventions available and accessible to different groups?
- How do patients and the public view local smokefree policies?
- Are there any factors that prevent, or support, effective implementation?
- Are there any unintended (positive or negative) consequences of interventions, such as effects on the clinician–patient relationship?

Appendix C References

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Department of Health (2011c) No health without mental health: a cross-government mental health strategy for people of all ages. London: Department of Health

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