

2.5

Smoking & Mental Health

Can People with Mental Health Conditions Stop Smoking?

Background

Surveys have suggested that mental healthcare staff are significantly less positive about taking a role in supporting service users to quit smoking than their general healthcare colleagues (McNally et al., 2006). This may, at least in part, be a result of a number of assumptions. First, staff may believe that that smoking is beneficial to mental health. Second, they may fear that smoking cessation would have adverse effects on mental health. Third, they may be skeptical as to whether people with mental health problems can successfully quit smoking.

The evidence relating to the first two assumptions is discussed in Sections 2.3 and 2.4. From this it seems unlikely that either is true. Rather than being of benefit, smoking is likely to have adverse effects on mental health, particularly in relation to depression and anxiety. Furthermore, stopping smoking has been associated with a significantly lower risk of negative mental health outcomes.

However, this leaves the issue of whether attempts to support mental health service users to stop smoking will be effective. Evidence relating to this important question is discussed below.

The General Efficacy of Stop Smoking Treatment

As discussed in Section 1.4, the average quit rate for NHS Stop Smoking Services in England is around 50% (as assessed at four weeks post quit) and these services have been evaluated as cost-effective (Godfrey et al. 2005). Stop smoking services utilise evidence based methods in order to maximise their effects. For example, both group-based and individual support are employed for smoking cessation, which are more effective than self help (Lancaster & Stead, 2005, Stead & Lancaster, 2005). Adding pharmacotherapy (such as Nicotine Replacement Therapy, Burpopion or Varenicline) to interventions significantly increases success (Stead et al., 2008; Hughes et al., 2007; Cahill et al., 2008).

However, while the NHS has made excellent progress in developing and delivering effective smoking cessation treatments, interventions aimed at certain sub-groups in society have not been delivered extensively or effectively. Young people, for example, make up around only 3% of those treated by NHS Stop Smoking Services and only 2% of successful quits (HSCIC, 2009). The situation is likely to be the same in relation to mental health service users. Indeed, at the time of writing, mental health settings are not even included as an 'intervention setting' category in official Stop Smoking Service data publications, while other 'minority' settings such as military bases and prisons are included. Given the extremely high smoking rates among mental health service users this may be seen as a salient omission.

Stop Smoking Interventions for People with Mental Health Problems

There has been significant success reported relating to the delivery of stop smoking interventions aimed at people with mental health problems. In their review of 24 studies of interventions, el Guebaly et al (2002) reported that quit rates among this group were comparable to that found within the general population. Other writers have been less optimistic, however, estimating that quit rates are half that found in the general population (Williams & Foulds, 2007).

The reality is, however, that while there are sufficient studies to suggest that that smoking cessation interventions have significant efficacy within mental health service users, the size of the effects compared to non-mental health service users can not be reliably established at this point in time. This is because there is simply not enough high quality, randomized trials in this area from which a general meta-analysis could be performed and an overall effect size estimated.

Despite this, some suggestions relating to certain sub-groups or contexts have emerged from the available literature. For example, review level evidence suggests that, despite common assumptions, a history of major depression does not represent a risk factor for failure in smoking cessation treatments. Hitsman et al (2003), in an examination of 15 studies, reported no differences in either short-term (3 months) or longer-term abstinence rates (6 months) between smokers positive versus negative for history of depression.

What also seems clear is that a smoking cessation intervention is more likely to result in successful quits if it is geared not just towards smoking abstinence, but also towards preventing deterioration in mental health condition. For example, among patients with a history of depression attempting to quit smoking, that those patients experiencing these increases in depressive symptoms during the quit attempt are far more likely to return to smoking (Burgess et al, 2002).

Other studies suggest that the reason for the lower quit rates among mental health service may be a function of poor treatment adherence rather effectiveness per se. A recent example of a study examining a quit support programme aimed at mental health service users came from Baker et al. (2006). In this intervention, which was aimed at smokers with a psychotic disorder residing in the community, only one-half (47.6%) of the treatment group attended all eight treatment sessions, while one-quarter (23.8%) attended less than five sessions.

In this study, an 'intention-to-treat' analysis (which assumes that the participants who did not complete their follow-up assessment within the designated time period had relapsed back into smoking) found no significant overall effect of the programme on smoking abstinence. However, relative to the comparison group, participants who completed all treatment sessions were significantly more likely to be abstinent at the 6- and 12-month follow up.

Finally, it may be that smoking cessation interventions delivered with mental health service users observe greater efficacy if they are actually tailored to meet the needs of people with mental health problems rather than simply replications of programmes delivered in the general population. As Williams & Foulds (2007) point out, interventions provided in the general healthcare settings are often brief and may lack the intensity or specialization needed for mental health patients to stop smoking. They rely upon "a highly motivated and organized client who is ready to quit".

In line with this view, specialist services for smokers with schizophrenia and other mental illnesses that use a combination of medication and counselling have achieved abstinence rates as high as those for people without a history of mental illness. These services did not limit the number of contacts, and employed professionals who were qualified in both mental healthcare and smoking cessation support (Campion et al., 2008)

In conclusion, treatments to help people stop smoking are effective when aimed at mental health service users. While the success rates are often lower than those reported among non-mental health service users, the high rate of smoking among this group and the consequential impacts on physical, mental and social well-being, makes even relatively reduced success rates clinically significant.

Stop smoking programmes that focus on retaining service users in active treatment, incorporate treatment elements aimed at maintaining psychological well being, and offer other interventions specific to mental health are likely to be observe greater efficacy.

Promoting Smoking Cessation in Mental Health Settings

If, as suggested in the previous section, there is value to be gained from tailoring stop smoking interventions to the needs of mental health service users, then it follows that there is also some value in tailoring the promotion of smoking cessation in the same way.

It may well be that certain 'promotional messages' will be more influential among mental health service users than others. In a study of young people admitted to a psychiatric hospital, Apodaca et al (2007) examined the predictors of service users' readiness to quit smoking. The factors assessed included the confidence to quit smoking (self-efficacy), the perceived cons of smoking, peer and family attitudes, pros of smoking, current and future health concerns, and life goals. By far the most predictive factor of readiness to quit was self-efficacy. The only other predictive factor was the perceived cons of smoking (related to it causing bad breath and being a 'messy habit'). There was no relationship between readiness to quit and health concerns or peer and family attitudes.

The results of this study suggest that future promotional efforts aimed at attracting smokers with mental health problems into smoking cessation treatments should go beyond traditional health messages and address self-efficacy. The role of self-efficacy in smoking cessation and ways in which it can be promoted is addressed in detail in a later section.

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