Opinion

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# Assisting People with Severe Mental Illness to Reduce Smoking in the United Kingdom: The Need for Proactive Initiatives to Become Standard Practice in Primary Care

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**ABSTRACT**

People with severe mental illness die early due to diseases related to smoking. Healthcare professionals in primary care in the United Kingdom are responsible for ensuring that this group are supported with changing any unhealthy behaviors. Though there are some good innovative projects in primary care which promote smoking cessation for people with severe mental illness, these are ad hoc and often short lived. There is a need for proactive initiatives to support people with severe mental illness to stop or reduce smoking to become standard practice in primary care.

## Introduction

There is a mortality gap between people with Severe Mental Illness (SMI) and the general population of up to 25 years [1,2]. Seventy-five percent of this excess mortality is likely to be caused by smoking-related deaths such as respiratory disease, diabetes and cardiovascular disease [3,4]. Globally, smoking rates are high in people with SMI [5,6]. A study in the United Kingdom of people with SMI [7] found that approximately half smoked, which compares to 14.1% of the general population [8]. Some individual studies have shown the number of smokers in each disease population to be much higher, for example 82% of people with bipolar disorder [9] and up to 88% in schizophrenia [10]. Smoking is also associated with many other physical conditions which are more prevalent in people with SMI, for example Chronic Obstructive Airways Disease, dental problems, erectile dysfunction and osteoporosis [11]. People with SMI who smoke have a tendency to be strongly addicted to smoking and be part of peer groups where smoking is common [12]. Some people with SMI use smoking as a way to self-medicate as it improves some of their symptoms (Johnson et al. 2010) This may be due to an increased dopamine release in the pre-frontal cortex that alleviates positive and negative symptoms [13]. Smoking may reduce the side effects of antipsychotic medication because it enhances the metabolism of these drugs [14]. Historically, mental health services in England have encouraged a smoking culture, with staff smoking with patients socially and cigarettes being used as a reward [15]. Even now, health professionals do not always encourage people with SMI to quit smoking because they have low expectations about behaviour change, seeing it as too difficult an

issue to challenge [12]. Conversely, an online survey of 685 smokers with bipolar disorder found that 74% of them were interested in quitting smoking [16] and a study of 100 smokers diagnosed with schizophrenia found that most of them wanted to stop smoking [17].

A review of the literature in 2010 determined that treating tobacco dependence is effective in people with SMI [18]. The authors reported that treatments that work in the general population work for those with SMI and appear approximately equally effective; and that treating tobacco dependence in patients with stable psychiatric conditions does not worsen mental state. As smoking increases the metabolism of some medications including antidepressants, antipsychotics, benzodiazepines and opiates, the doses of these medications need to be reduced when smoking is reduced to prevent toxicity [19]. Further dose reductions may be required with continued cessation, although original doses need to be reinstated if smoking is resumed. Therefore, the dose of medication should be continually reviewed by their prescribing clinician during the period of smoking cessation and/or reduction. It is recommended by the writers of National Institute for Health and Care Excellence (NICE) guidance for psychosis and schizophrenia and bipolar disorder that GPs and other primary healthcare professionals in England monitor the physical health of people with SMI and offer appropriate lifestyle advice and support [20,21].

The physical health check should be carried out annually when responsibility for monitoring is transferred from secondary care. However, healthcare professionals in primary care are often unaware of the effect of smoking on psychiatric medication. They are also unclear of how they can ensure that the medication is continually reviewed in practice. It is therefore not surprising that there is evidence to suggest that primary care professionals are significantly less likely to intervene with smokers with a mental health condition than with those without [22]. In the United Kingdom, smoking cessation is carried out by healthcare professionals (referred to as smoking cessation advisors) who have completed training which equips them with the skills and knowledge needed to provide intensive stop smoking advice to those who would like to stop smoking. The healthcare professionals learn about evidence-based treatment that combines the use of pharmaceutical treatments with behavioural support. However, this training does not teach them about the special considerations they need to employ when supporting people with a SMI, and structured group education alone is not clinically effective in this group [23]. Additionally, there is often an assumption by those offering smoking cessation advice, that the people they are supporting are at the 'preparation' or 'action' stage [24] and are therefore able to take on board all the recommendations given. If people are referred to smoking cessation services when they are at the 'precontemplation' or 'contemplation' stage, then they are likely to fail. A mental health and smoking action report endorsed by 27 different organizations challenged defeatist assumptions that addiction to smoking amongst people with mental health conditions is either inevitable or intractable [12].

It sets out ambitions and specific actions for a whole care environment including primary care. In order to meet some of these ambitions, there is a need for proactive initiatives which support people with SMI to stop or reduce their smoking to become standard practice in primary care in the UK, such as:

1. Educating healthcare professionals who support people with SMI to stop or reduce smoking by teaching them
    - How severe mental illness affects a person and how best to manage consultations with this group
    - Why more people with SMI smoke than the general population
    - The different considerations needed when a person with SMI wants to cut down or stop smoking.
    - How to recognize relapse in mental health.
    - How to employ a motivational interviewing approach
2. Giving healthcare professionals in primary care the time to provide one to one support for people they have referred to smoking cessation services.
3. Developing peer led courses where people with SMI (who have stopped or reduced smoking) can coproduce and co-deliver them with smoking cessation advisors. The course could be used as an intervention for people with SMI who are at the precontemplation or contemplation stage of readiness to change. This would also create opportunities for people with SMI to learn from each other's experiences of attempting to stop or reduce smoking.

## Conclusion

There is an urgent need for action to confront the increasing health inequality of people with SMI. They need extra support to reduce or stop smoking. Doing this successfully will decrease their mortality and physical illness. Standard practice should include providing the right education and time for healthcare professionals to support people with SMI who want to reduce or stop smoking. Creating opportunities for people with SMI to learn about smoking and explore how they feel about it will increase their motivation

and ability to stop smoking.

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