

Stop-smoking support in mental healthcare settings: case studies

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Background

For several years the Smoking and Mental Health Working Group (SMHWG) of the Scottish Tobacco Control Alliance (STCA) has met to discuss issues relating to the provision of stop-smoking support to smokers who experience varying degrees of mental ill health.

Stop-smoking practitioners have related the challenges of providing cessation support to people with mental ill health at SMHWG meetings and have discussed the low mood described by particularly heavily addicted smokers who attempt to quit.

In addition, psychiatric and community mental health nurses are being trained to provide cessation support or to refer patients to stop-smoking services and in these and other situations there is an expressed need for trainers to be able to provide insights into the barriers to quitting and how support can be provided to overcome these. Indeed, those involved in providing stop-smoking training said they would value being able to illustrate that helping people with differing levels of depression and anxiety and mental ill health is both possible and transformative.

As part of the on-going effort of the STCA to ensure clearer communication of the issues around smoking cessation in mental healthcare settings several short case studies were collected from stop-smoking practitioners who were members of the SMHWG.

These are stop-smoking interventions which illustrate the huge benefits of stopping smoking for those who may also be coping with mental ill-health.

The aims of the case study collection

Case studies of stop-smoking interventions were collected in order to:

- identify and articulate some of the challenges in providing stop-smoking advice to individuals who may be experiencing mental ill health
- highlight the benefits of providing cessation support perceived by the practitioner and expressed to them by the client
- make available a number of readable, interesting and insightful cessation experiences to stimulate discussion amongst cessation practitioners and those whom they train, of their role in supporting clients with mental ill health.

These case studies can be downloaded from the ASH Scotland website.

The primary use of the case studies is to inform health care professionals but at their discretion they may be used with clients or support groups where deemed appropriate.

Methodology

The case studies were recorded from one hour interviews with stop-smoking practitioners.

There were a number of core questions around which the case study was built but the intention was to avoid setting too rigid a structure, so that each story stands alone and has an individual style, dominant theme or emphasis.

The stories were suitably altered to ensure anonymity, for use by stop-smoking practitioners and trainers.

Case studies were collected in February 2010, reviewed by the stop-smoking practitioners and completed in March 2010.

Additional case studies

Colin represents a case study collected previously by a member of ASH Scotland staff.

In December 2006 the STCA in partnership with UK Public Health Association (UKPHA) and Community Health Exchange (CHEX), organised a story dialogue-style event focusing on smoking and mental health.

The report from this event, Smoking, mental health and well-being, *'Be happy, don't worry and stop smoking'*, January 2007, is still a useful source of information and insight into smoking and mental health related issues. Dee's story has been reproduced within this document. The event report is on the ASH Scotland website: www.ashscotland.org.uk/ash/4145.html

Case study: Colin quitting in the community

Colin is 47 and had been smoking for about 20 years. Although he has a long history of schizophrenic illness, Colin has not required hospital treatment for over seven years. He attends a mental health day centre one day each week and he is a respected volunteer with the mental health advocacy team. Colin enjoys the advocacy work and finds it interesting and rewarding.

He started smoking after he was admitted to hospital to receive treatment for a schizophrenic illness. When asked why he started smoking he said it was to alleviate the boredom of being in hospital and to fit in and bond with the other patients. His mental health may also have been a contributing factor. A heavy smoker, Colin smoked at least 20 cigarettes a day which he bought without paying tax or duty. Despite not paying the full price for a packet of cigarettes, he would have smoked a lot more if he had the money.

Colin was diagnosed with severe angina and was awaiting a bypass but the surgeon had warned him that the operation might not go ahead unless he stopped smoking. Colin was very worried about the angina attacks and was keen to stop smoking. He approached the local stop-smoking service for help in his quit attempt. His parents were supportive of his quit attempts but they were worried about the effect on his mental health should he stop smoking. They were also worried about the effect that failed stop attempts would have on him, both on his physical and mental health.

Although keen to stop smoking, Colin had thought enough about the quit attempt to make him concerned about whether or not he could achieve it. He had considered the triggers and risky situations that could cause a lapse and when he would find it hardest not to smoke.

Stop smoking services became involved and offered intensive one-to-one support. Colin's surgeon encouraged the quit attempt and, along with the stop-smoking service and the other services involved in his care, carried out a risk assessment that allowed Colin to use NRT patches for long-acting relief and an inhalator for short-term relief. Colin was involved at all stages in the decision-making process and was aware of the contraindications.

Colin's operation was a success. He stopped using NRT after 12 weeks and three weeks after that the continued support he was getting from the stop-smoking team came to an end. With the operation and a successful quit attempt behind him his physical health has improved, his mental health is stable and his medication is unchanged.

Colin stopped smoking two years ago and he is still tobacco-free. His family, his friends and the care team are full of praise for his successful quit attempt. With a lot more disposable income he has bought himself a bicycle; this was something that he had always fancied trying but never got round to.

Case study: Sandy quitting in hospital

Sandy is a 47 year old patient being treated for schizophrenia in the closed psychiatric unit of a large hospital. Sandy has had long spells living in the community but at this time has been hospitalised for a number of months. Sandy smoked up to 30 per day; both filter and roll-ups.

Sandy's main motivation to stop smoking was to regain some control in his life. As a smoker in a psychiatric unit he must ask for permission to smoke, he was unwell around this time but still felt a need to try and quit. There was also a sense that people were using his smoking need as a way of rewarding him and encouraging co-operation and he was feeling quite rebellious about this.

In fact several members of the medical staff were uneasy that, in his mental state, he should be supported in a cessation attempt at all.

Sandy was being prescribed clozapine to counter his psychotic behaviour and the dosage would need to be monitored because reduced tobacco consumption could increase his clozapine blood plasma levels.

Nevertheless an agreed plan of support was put in place to aid his quit attempt. He was prescribed a 24hr patch and allowed access to an inhalator on request (eventually being allowed to retain the inhalator with a replacement cartridge).

After 10 weeks the patches were reduced to 14mg with 7mg at 14 weeks for a further 4 weeks.

During this time the hospital pharmacy monitored his clozapine plasma level along with his white blood cell count (which clozapine can sometimes affect). Clozapine dosage did required to be lowered during the first two weeks of his quit attempt. Also during part of this period Sandy's mood and psychotic symptoms did fluctuate, though they had done so in previous months whilst smoking, and despite this he maintained abstinence.

As well as support from the stop-smoking service on the ward, medical staff, nurses, pharmacy and the visiting GP all made supportive contributions.

The physiotherapy department helped develop his exercise regime to counter weight gain and occupational therapy worked to create interesting activities to counter boredom and find new outlets for new-found energy and concentration levels.

Sandy seemed to really benefit from this quit. He dressed more smartly and his appearance improved. He had something in common with staff that were quitting and found it really motivating to give other people support and advice for a change. Indeed several staff decided that if he could do it, with all that he was struggling with, they could too!

The stop-smoking practitioner thought that *'The medication issue, if properly handled, doesn't seem to be the problem I thought it would be. Really heartening to see anti-psychotic medication come down, it helped to reduce side-effects. It was really important to gain the trust and support of observing staff.'*

I felt that some staff were anxious that the quit attempt might be affecting Sandy's mental health, but in the end what difference does it really make if the person is unwell or stable while they try to improve a different aspect of health. Can we really be certain that quitting is causing a fluctuation in mental state when this has proved volatile across months in any case?'

Case study: Norman quitting in the community

Norman is a 37 year old life-long smoker with a heavy use and a past history of cannabis use. He has a bipolar disorder and has been in and out of residential care for many years.

When referred by his GP to the community stop-smoking service he had experienced a four month period of stable mood.

Part of Norman's motivation for quitting was that in a previous period of in-patient care his smoking had risen from 20 to 40 per day and he felt it had really been dominating his life. There were also health issues and strong encouragement from his mother, to whom he is very close.

Norman's stop-smoking practitioner, Jim, liaised with his GP and agreed a course of 4mg NRT gum. Norman had used gum on a quit attempt that had gone quite well in the past and was concerned at risking what he perceived to be more addictive products such as an inhalator or micro tabs.

Norman was prescribed gum for 13 weeks and has remained abstinent at three months; he was still using the gum occasionally.

Norman felt that his main barrier to staying quit had been his mood. He did find smoking a relief when in a low mood and knew he would need help and support should he relapse.

Jim's major concern was that the GP would monitor and adjust Norman's medication. He knew that Norman was prescribed diazepam, venlafaxine, sodium valproate, olanzapine and lithium but Jim was not qualified to be able to judge the potential interactions in such a complex mix of medications. There had been problems in the past with prescribing by medical staff in other interventions involving psychiatric patients.

In fact Jim had been concerned for some time that co-operation between the stop-smoking service based in the community, and acute psychiatric services had not been effectively established. The reasons were complex and partly due to resistance on the part of the service to get too involved for fear of eating into staff time and undermining efforts to reach Health Improvement Efficiency Access Targets (HEAT).

On the positive side Jim could see a marked change in Norman's self-confidence and in his appearance; his eyes were brighter, complexion healthier and he declared his energy levels had improved.

Jim learned from this case and others that people with mental health problems being used to keeping mood diaries are often happy to maintain a smoking pattern and quit-thoughts diary. Norman also responded to the idea of putting little motivational stickers around the house as an abstinence reminder.

Jim gained a lot of satisfaction from seeing Norman improve in so many ways week on week. The intervention was longer than with most clients and extra support might be needed in the future to prevent relapse.

For Norman it's great to now have a bit more money for treats such as a meal out or a visit to the beach and having given up smoking he feels he has one less worry and more to look forward to.

Case study: Ian quitting in the community

Janice is a stop-smoking practitioner working across a number of hospital catchments in support of people with mental health issues who wish to stop smoking.

Ian was one of her first clients when she began to specialise and he exemplifies many of the challenges faced in everyday practise in providing cessation advice in a mental healthcare setting.

As a 47 year old heavily addicted life-long smoker Ian has a number of problems which have conspired to complicate his quit attempts. Ian has epilepsy and suffers (often severe) depression, especially after episodes of grand mal seizure.

Anxiety manifested itself in psychosomatic symptoms and he was generally anxious and shaky at appointments. He was and is obsessive about his physical health.

Having made several attempts over the years to quit, Ian was further motivated following admission to hospital with chest pains and shortness of breath and a recommendation by medical staff to quit.

His wife, who also has a history of depression and anxiety, was very supportive. However, she believed from past attempts that quitting appeared to worsen episodes of epilepsy and that following seizures Ian's craving for a smoke was heightened and he could become physically aggressive when she tried to deny him cigarettes.

Ian was referred to the service by his Community Psychiatric Nurse (CPN). He missed several initial appointments but working with the CPN, Janice arranged to meet Ian and his wife at home. Ian was very anxious about the potential impact of quitting on his epilepsy but was sufficiently motivated by the impact of smoking on his general health to engage in several quit attempts.

Because he was assessed as heavily addicted, Janice in consultation with his GP prescribed 21mg, 24hr patch and use of an inhalator to break through cravings.

In the initial period of support, epilepsy and low mood meant a lack of success for Ian. He decided to wait a few weeks before considering another attempt during which time he cut his smoking to 20 per day with the help of the inhalator. Also, during this time Ian reduced his sleep medication.

The successful quit took place two months after Janice's initial interviewing. The quit required utilising the 24hr patch over double the suggested time course – 24 weeks and with moderate use of the inhalator.

Ian's epilepsy did not worsen as a result of his quitting smoking and his mood improved. Ian's wife was pleased that she could offer the inhalator at times of extreme anxiety for Ian and they were both pleased to have extra money to save towards a holiday.

Case study: Gabby quitting cannabis

Gabby was Colleen's biggest challenge to date in her role as a smoking cessation and addictions counsellor. Not only did Gabby have issues around self-esteem and a history of self-harm, she was heavily dependent on cannabis and tobacco.

Gabby was 17 when her GP referred her to the service. She had a troubled history and was a heavy user of alcohol and cannabis, which she had turned to because of sexual abuse as a child, her dyslexia and bullying at school. In fighting back against people, due to her insecurities, she had developed aggressive tendencies and had become isolated and withdrawn.

She was however, motivated to work on improving her health and lifestyle and in particular her cannabis dependency. Colleen visited her every week for a year, then over six months, fortnightly, then three weekly as a contributor to her care in cooperation with her GP.

Gabby was used to counselling and took well to keeping a record of her cannabis and tobacco use and the cognitive behavioural therapy (CBT) approach adopted by Colleen. Alcohol, tobacco and cannabis as well as long bouts on her PlayStation were part of Gabby's coping strategy but she acknowledged that these needed to be tackled.

Gabby's main concerns were over sleep. Cannabis was used as an aid to sleep and to relax and she wondered if less cannabis might result in heavier drinking or insomnia. These issues were addressed by introducing exercise, proper eating, work-related activities and by careful monitoring and motivational support.

Improvement came about very gradually; getting out for exercise by walking the dog (a gym trial did not go well), taking on some outside interests through the local college and obtaining a free bus pass to widen her access to activities. There was a steady reduction in cannabis use. Instead of a morning joint and very little breakfast, she took a proper breakfast and gradually improved her diet and eating patterns. She had been underweight and very malnourished and by putting on weight and eating more healthy foods she felt she had more energy.

More interaction with family and support workers followed and after a year Gabby enrolled at college full-time and now has only very occasional cannabis use, little alcohol use but still has a 30 a day cigarette dependence (actually a reduction of around half of her previous tobacco use). However, she has also been making attempts to quit smoking, has tried patches, as yet unsuccessfully but shows a commitment to reduce her smoking further. She now goes into schools regularly to talk to children about self-harm, is a student representative and feels good about this aspect of her new life without cannabis.

Colleen felt that a huge transformation had been achieved in Gabby's life. A very withdrawn and uncommunicative young woman had become vastly more confident and sociable and an asset to the community. Whereas before, Gabby had hid her face

under a baseball hat and spoke very quietly and with no great coherence, she was now able to engage in friendly conversation, make eye contact and speak with great confidence and clarity.

Colleen felt that the key in this case was the gradual approach which saw small changes to lifestyle being introduced on a monthly basis. A team of people contributed to the intervention; GP, stop-smoking practitioner, college staff and the local service that provides vocational tasters and advice for vulnerable young adults.

Case study: Julie the nurse

Julie is a 49yr old psychiatric nurse working in the forensic unit of a large hospital. Having smoked over twenty per day since her teens she had developed a smoking routine that included regular trips to the smoking shelter with colleagues.

She had thought about quitting for some time for there was conflict between her smoking self and the part that played health promoter and role model on the ward. Shortness of breath, a cough, smoker's voice and the unsightly stains from hand-rolled tobacco provided further motivation to seek support.

The smoking cessation service had been active in the hospital for over a year and Julie had seen both patients and staff visibly benefit for their supported quit attempts. The stop-smoking advisor proved to be easily accessible and weekly one-to-one sessions were arranged. Drop-in visits could also be made when times were difficult and motivation waned.

On the stop-smoking practitioner's advice varenicline was prescribed by Julie's GP and a successful quit attempt followed.

Julie found that friends and even staff who still smoked were supportive. It wasn't all plain sailing; it was difficult to overcome habits such as fitting in a cigarette before being scheduled to supervise a patient, patients would walk past with lit cigarettes from the nurses' station on their way to the smoking room, colleagues would 'hang out' and chat up at the smoking shelter and smoking was very evident during her working day.

Her quit attempt coincided with a few weeks of ill health that kept her off the ward. She said that this really helped her in those crucial first weeks and she felt strongly that she might not have managed without that break from old habits. The service has seen a great change in her life. She took up badminton and now has a new strand to her social life.

With more money in her pocket Julie treated herself to new clothes and found that her sleep patterns, complexion and voice all improved, helping to boost her mood and self-esteem. Issues that she had attributed to menopause were relieved.

Julie is now an inspiration to others on the ward. She feels more comfortable in offering others advice and support and regularly refers patients to the stop-smoking service. She has challenged the practice of allowing passive exposure of staff during supervision and the practice of allowing cigarettes to be lit outside the smoking room.

Her stop-smoking support practitioner said '*I was amazed considering the problems Julie faced in her personal life that she was able to cope with the quit attempt!*

'It is clearly very hard for clients to stop smoking in an environment where cigarettes are so evident and where smoking is sometimes actively encouraged as a coping mechanism.'

Dee's story – 'It takes as long as it takes – one-to-one support for a long-term smoker with a psychiatric history'

Dee had a long-term mental health problem. She wanted to quit smoking and has required a long time to stop (eight months with the current quit attempt). The focus has been on breaking the link between smoking and stress and providing support when there is a need to be calm.

Dee is in her early sixties and was diagnosed with schizophrenia in her twenties. She also suffers from diabetes and heart disease. Her physical health problems, including major heart surgery, prompted her to quit several years ago but she found it very difficult to do so.

Dee was a heavy smoker, 60 a day. When one cigarette was over she would light another if the situation allowed. All her family and many friends smoke and therefore there was little support in those quarters for her to remain tobacco-free.

Support from a cessation service and regular phone calls for reassurance and encouragement, along with continued use of NRT gum and inhalators, has allowed her to remain abstinent for eight months, her longest quit period.

At the beginning of her quit attempt Dee rated her confidence in being able to succeed as 0 out of 10 and has found that her belief in her ability to quit has increased simply by doing it.

In the past when Dee has lapsed she would leave the house to smoke without the family being aware that she had started smoking again; she was afraid to admit her failure. She feels that the smoke-free public places law has definitely helped to reduce her exposure to other people's smoking and hence to the pressure to resume smoking.

Although Dee has been using an inhalator, she often sucks on the plastic mouth piece when there is no NRT left; it gives a degree of comfort. Although NRT has been on-going she feels the benefits outweigh any possible disadvantages and believes that she will eventually quit using this support. She feels proud of her achievement and has been saving a considerable amount of money that has been used to buy clothes and trips away.

In the absence of smoking Dee has recognised that smoking contributed a lot to her anxiety. Now she realises that anxious moments are not because she needs a cigarette, or, that it would help to have one, but that the way she feels happens sometimes and she can use other ways to calm herself, for example, seeking support from her counsellor and friends.