

## Best practices

### Tobacco dependence treatment in people with SMI

#### 1. Offer quitting in one step (abrupt quit) as the first line option with flexibility to offer Cut Down to Stop (CDTS) for those not interested or able to stop in one step.

- Assess patients' readiness and ability to stop smoking. If they are ready to stop in one step, progress to the abrupt quit treatment programme. Extended support prior to setting a quit date may be required. Quitting will often occur at a slower pace.
- While the first choice for quitting should be abrupt quitting some patients with SMI benefit from the option to start by cutting down on their smoking in a first step before they set a quit date. If the patient is not ready to stop in one step, discuss structured CDTS approaches. The CDTS option should be a standard offer for patients with SMI who don't feel that they can quit in one go.

#### 2. Facilitate access to combination nicotine replacement therapy (NRT) and/or nicotine containing vapes or other pharmacotherapy prior to quitting and for extended periods after quitting to prevent relapse.

- Patients with SMI are more likely to be highly dependent on tobacco. Higher dose combination nicotine replacement therapy (nicotine patch + one or more faster acting NRT products) and/or nicotine vapes should be standard treatment.
- NRT products can be used in combination with nicotine containing vapes.
- Access to NRT and vapes should be provided free of charge.
- Policies should facilitate people with SMI having access to NRT and/or nicotine containing vapes for abrupt quit and CDTS for extended periods after quitting (6-12 months).
- Ensure the patients optimise their stop smoking medication by advising and coaching on correct technique and dispel any myths about nicotine
- People with SMI are more likely to use a vape than those without SMI. People with SMI generally find vaping more acceptable than NRT..

### 3. Provide patient centred support that is tailored to the individual, including flexible appointment venue, more frequent contact, and tailored duration of support.

- Offer flexibility on where appointments are delivered including home visits or outreach into mental health facilities. Home visits can increase engagement and assist with engaging family and friends with the patient's quit attempt, providing an opportunity to offer suggestions about modifying the patient's home environment and to allay fears among family members that quitting will make the patient worse.
- Patients with SMI will often require more frequent contact during quit attempts as well as extended duration of treatment for relapse prevention (minimum of 12 sessions or 3 months) with the opportunity to receive extended relapse prevention support.
- Weekly appointments are recommended for at least the first 4 weeks and based on patient need thereafter.
- Consider time of appointment; people with SMI may find morning appointments difficult due to symptoms and mental health medication side effects.
- Breaks during appointments may be required or breaking appointments up over a few weeks.
- Provide quiet waiting areas or organise appointments at a time of day that is not too busy.
- Deliver stop smoking support with people with mental health history in mind to enhance engagement and treatment success. This includes having good understanding of the patient's mental health diagnosis and how treatment and your own approach may need to be tailored to best meet the needs of patients.

### 4. Address common barriers to quitting and facilitate alternative activities.

- Address common barriers to quitting (boredom, stress, smoking in family and social networks, cannabis use) and facilitate alternative activities.
- Address the myth that smoking helps with stress with all patients. Smoking does not alleviate stress, it alleviates withdrawal symptoms: the irritability, the restlessness the low mood that falling nicotine levels cause.

- Support patients to consider ways of coping with stress, as well as planning ahead for times in their life where they may experience higher levels of stress.
- Work with patients to address boredom. Facilitating alternative activities is important, activities that offer the opportunity to stay busy, exercise, socialise and be active without smoking.
- Encourage patients to identify valued activities. If patients find it difficult to identify activities, provide a menu of options, two or three things that other patients have found helpful, and ask if they would be interested in trying any of them.
- Link patients with other health professionals e.g., occupational therapy or organisations that can provide activities and social opportunities.

## 5. Offer support with quitting to family / care givers

- Offer family/care givers access to stop smoking aids and behavioural support to stop smoking.
- Encourage the creation of a supportive smokefree environment which will reduce smoking cues and assist SMI patients with their quit attempt. Explain that this is the best way of supporting their relative through a challenging time.

## 6. Be ready for setbacks and build these into the treatment plan.

- Establish whether patients are ready and willing to make a plan for staying on track, even if that means taking some time to get through a difficult period. Provide positive reinforcement for any success achieved either now or previously (whether it's a few days or a few hours, or just effort).
- Understand that there may be breaks in quit attempts or between quit attempts and don't let the patient see this as a failure. Agree regular follow-ups to reassess interest in quitting and ability to easily reengage with support.
- Offer additional contact after unsuccessful quit attempts to support harm reduction and preparations for future quit attempt

## 7. Ensure good communication with the care team and those doing the mental health medication review.

- Review the individual's current risk assessment and medication regime before treatment commences.
- Establish communication with the patient's care team before starting to embark on a quit plan or a CDTs plan.
- For patients with current use of [medication that interacts with smoking](#), a quit/CDTS attempt should not commence unless the patient's responsible clinician (GP, psychiatrist or other) has been informed about the plan and has agreed to monitor/review the individual's medication more carefully throughout the treatment programme.
- The current use of psychotropic medication that interacts with smoking should not be a reason for an individual to not engage in a quit attempt. The quit attempt should be prioritised, and the care team engaged in appropriate monitoring of medications, before and during the quitting process. NB It is the smoke, not the nicotine, that affects medication levels.
- There should be mechanisms to ensure the clinical team are updated on quit attempts (starts and stops) and other information that may impact on the need for a medicines review.
- This is particularly important for patients who take clozapine. Ensure blood tests are arranged for the individual. Changes to plasma levels can happen very quickly (sometimes within one week); blood tests need to be done at baseline before any changes are made to the smoking routine and after one week following making the changes to the smoking routine. All patients who are taking clozapine must remain under the care of a psychiatrist and have regular follow-up in clozapine clinics.
- Educate the patient and family / carers if appropriate about what to look out for in terms of side effects associated with psychotropic medication overdose and the appropriate action to take.
- Any concerns regarding the patient's mental health or mental health medication should be discussed with the care team.