

Correspondence

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The case of Stop Smoking Services in England

A recent editorial in *Nature* concerning therapy deficit and the urgent need to invest in research to enhance the effectiveness of psychological treatment is timely and may prove influential for our field.¹ The piece used the example of the Improving Access to Psychological Therapies (IAPT) programme and the lack of resources to establish the causes of variation in outcome across a service that provides access to support to more than 600 000 people. We wish to alert interested researchers to a slightly more positive example: the Stop Smoking Services in England. These were established in 1998 to help address the single largest preventable cause of premature death in the country and now treat 800 000 smokers each year. Research has begun on establishing the aspects of support that account for the very large variation that exists between local services² and specialist practitioners within services.³ The research has found, for example, that group-based treatment is linked to higher success rates than one-to-one treatment or drop-in clinics, and that services which use particular 'behaviour change techniques', such as showing smokers their expired-air carbon monoxide readings to boost motivation to stop, have higher success rates.⁴ This work has led to the development of competence assessment and training programmes (e.g. www.ncsct.co.uk),⁵ but it is only a beginning. Because it can make use of routinely collected, national data, this kind of research can continue to be carried out extremely cost-effectively and save many thousands of lives. However, significant additional funding is required to evaluate improved treatment programmes, based on findings such as these, by means of randomised controlled trials. We hope researchers who are interested in enhancing the psychological treatment provided by IAPT and similar programmes can learn from the early progress made on optimising the Stop Smoking Services.

Declaration of interest

R.W. undertakes research and consultancy and receives fees for speaking from companies that develop and manufacture smoking cessation medications (Pfizer, Johnson & Johnson, McNeil, GlaxoSmithKline, Nabi, Novartis, and Sanofi-Aventis). He also has a share of a patent for a novel nicotine delivery device.

- 1 Therapy deficit. *Nature* 2012; **489**: 473–4.
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Nicotine dependence in patients with schizophrenia

We read with interest the important and clinically relevant study by Krishnadas *et al.*¹ Patients with severe nicotine dependence had greater scores on the positive subscale of the Positive and Negative Syndrome Scale (PANSS) and patients with mild–moderate dependence had greater scores on the PANSS negative subscale compared with non-smokers. As rightly pointed out by the authors, this finding is in contrast to a previous study² carried out in the same area and to other similar studies.³ The reason appears to be the use of the Fagerström Test for Nicotine Dependence (FTND), which has limited psychometric properties in patients with schizophrenia. The authors argue for the validity of the FTND in schizophrenia, by citing the article by Weiberger *et al.*⁴ Notwithstanding the methodological superiority of the study in terms of presence of a proper control group, the difficulty of using FTND in people with schizophrenia cannot be denied on a pragmatic basis. It has been widely accepted over the past few decades that dependence is a more holistic concept and cannot be attributed only to the amount or duration of smoking. However, Steinberg *et al.*⁵ has questioned the relevance of the items of the FTND – such as time to first smoking, difficulty abstaining in forbidden places and frequency of smoking in the first hours after waking up – by means of a factor analysis study in patients with schizophrenia. In fact, modification of the FTND for the serious mentally ill population has been suggested in view of individuals' frequent impairment in judgement and insight. Such a scale was also useful in Krishnadas *et al.*'s study because all the patients were residents of supported accommodation and there was lack of any objective assessment of nicotine use. Moreover, the emphasis on the amount smoked even in a cross-sectional study like this would have better helped to verify the authors' statement that 'those with severe dependence have successfully overcome negative symptoms by increasing their level of nicotine dependence' (pp. 309–310), although a longitudinal study is essential in settling this issue. We advocate the concept of pack-years in this regard.

The authors adjusted the results for many covariants but left out several important variables which may act as important confounders, such as use of smokeless nicotine, other substance use, presence of physical disorders, type of antipsychotics and other psychotropic medications. They have also not mentioned whether the consent from participants was taken or not. The fact that daily dose of medication was greater in the severely dependent group raises the possibility of a pharmacokinetic interaction or indicates the presence of a poor prognosis subtype with neurobiological underpinnings, which should be clarified in future studies. In Krishnadas *et al.*'s study, the majority of patients were smoking to relax, to socialise better or to alleviate their loneliness, anxiety and depressive symptoms. This makes a strong case for a holistic treatment approach, rather than just prescribing anti-psychotic medication, as many of the mentioned attributing factors can be addressed with a multimodal treatment approach.