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'Clients are the problem owners': a qualitative study into professionals' and clients' perceptions of smoking cessation care for smokers with mental illness

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ABSTRACT

Objective: To understand mental healthcare professionals' and clients' needs and preferences regarding smoking cessation care in mental healthcare settings.

Method: Individual semi-structured interviews conducted in the Netherlands between March and July 2021, with 18 mental healthcare professionals and 16 people with a DSM 5 diagnosis who smoked. Qualitative analysis followed the framework approach.

Results: Both professionals and clients reported that successful smoking cessation would benefit client's health, but was difficult to achieve. There were different views on who was responsible for smoking cessation care. Clients do not often initiate or bring up smoking cessation, although they often want to quit smoking to improve their overall (mental) health. Most clients stressed the need for support in quitting smoking, provided by an active, experienced professional who takes the initiative to discuss cessation. Conversely, professionals indicated that they rarely initiate this discussion, because they believe that clients should decide the focus of treatment, and that addressing smoking cessation may harm the therapeutic relationship. Professionals perceived clients as carrying the ultimate responsibility for smoking cessation.

Discussion: Professionals and clients agree that smoking cessation care should be tailored to the client's needs. However, as both clients and professionals wait for the other party to initiate a discussion about cessation, the issue often remains unaddressed. To increase chances of successful smoking cessation, clearly defined responsibilities regarding initiation and provision of smoking cessation care are required.

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Chronic tobacco use has a well-documented negative impact on physical health, including cardiovascular disease, respiratory disease, and numerous types of cancer (Conti et al., 2019). Furthermore, prolonged smoking is associated with an increased risk of depression, anxiety and cognitive impairment (Campos et al., 2017; Fluharty et al., 2017; World Health Organization, 2017). It appears that smoking causes subsequent depression and anxiety, and vice versa, although research findings on the direction of this relationship are inconsistent (Fluharty et al., 2017). Importantly, smoking is associated with adverse psychological outcomes in addition to the more widely known physical consequences of smoking.

Compared to the general population, individuals with mental health problems are two to three times more likely to smoke (Asharani et al., 2020; Lawrence et al., 2009; Smith et al., 2014) and often less successful at smoking cessation (Cook et al., 2014; Fagerström & Aubin, 2009), which contributes to lower quality of life and life expectancy within this group (Krebs et al., 2018). Importantly, many smokers with mental health problems want to quit smoking (Asharani et al., 2020; Fagerström & Aubin, 2009; Stockings et al., 2013; Zhou et al., 2009). However, most do not set specific behaviour change goals to facilitate success nor initiate a quit attempt (Fagerström & Aubin, 2009; Zhou et al., 2009).

Smokers often indicate that smoking relieves emotional stress and therefore helps them to stabilise their mood and feel relaxed (West et al., 2001), and some mental healthcare professionals (MHCPs) likewise believe that smoking helps their clients cope with problems (Sheals et al., 2016). However, this perception results from the fact that smoking relieves recurrent nicotine withdrawal symptoms (e.g., heightened anxiety and depression), and quitting smoking improves rather than deteriorates mental health in the short and long term (Taylor et al., 2021). Also, among people with mental health problems, successful smoking cessation improves both physical and mental functioning (Krebs et al., 2018). Furthermore, certain types of medication (e.g., some antipsychotics) are more quickly metabolised in smokers and are overall less effective, so a higher dosage is required and a quit attempt should be carefully monitored (Lucas & Martin, 2013; Matthews et al., 2011).

Importantly, people with mental health problems can benefit from intensive smoking cessation care (SCC) and adequate guidance from MHCPs (Fagerström & Aubin, 2009). However, interventions for smoking cessation do not always satisfy the needs of smokers with mental illnesses. This might explain why those suffering from mental illness have a much lower chance of successful smoking cessation (Smith et al., 2014). Moreover, the mental healthcare system remains hesitant about implementing SCC as a part, let alone a prioritisation, of psychological treatment (Johnson et al., 2010). MHCPs experience difficulties in providing SCC, with a lack of time, training, and confidence being reported as the key barriers to addressing smoking in their clients (Sheals et al., 2016). MHCPs often believe that clients do not want to quit smoking and that quitting smoking is too difficult for them to handle, demonstrating a smoking culture that is 'the norm' and a view of cigarettes as a valuable tool for both clients and employees (Sheals et al., 2016). In addition, MHCPs avoid addressing smoking behaviours and SCC, as they are afraid of harming the therapeutic relationship that is required to work on initial therapeutic goals (Smith et al., 2019). Similar findings in the medical domain show that physicians feel less responsible for addressing smoking and are less likely to provide SCC if they perceive smoking as a habit or lifestyle choice, rather than an

addiction with serious health implications (Meijer & Chavannes, 2021; Meijer et al., 2018, 2019; Pipe et al., 2009). Although perceptions of MHCPs have been studied in the past, little research simultaneously investigated how smokers with mental problems perceive their own role and responsibilities in SCC. This complicates an understanding of whether perceived barriers forwarded by MHCPs (e.g., clients being unmotivated to quit) correspond with the views of clients who smoke. Understanding the perspectives on SCC of both MHCPs and smokers with mental problems is crucial. Within mental healthcare, non-specific aspects of treatments such as the therapeutic relationship between MHCPs and client account for a large part of treatment success (Gelso et al., 2018). The therapeutic relationship appears relevant to SCC as well, since MHCPs are hesitant about SCC as they believe that it might harm the therapeutic relationship, whereas a good therapeutic relationship might facilitate successful smoking cessation and vice versa. The current study aims to investigate perceptions, needs and preferences regarding SCC of both MHCPs and clients.

Methods

Design, participants and recruitment

This qualitative study was part of a larger study into SCC in mental healthcare that employed a cross-sectional survey among MHCPs. Survey participants were recruited primarily through their professional associations, social media and via colleagues, and MHCPs were recruited for the interviews through this survey. Survey participants (n = 295) who indicated interest in being interviewed were invited via e-mail between January 2021 and May 2021. A reminder was sent by e-mail if no response was received within 10 days. From the MHCPs who agreed to participate, 18 MHCPs were selected to be interviewed, based on reply date (e.g., those who responded first were scheduled to be interviewed) and representation of different specialisations. Interview participants included five psychologists, four psychiatrists or psychiatrists in postgraduate training, six nurses working in mental healthcare, one child psychologist ('orthopedagoog' in Dutch[1]), one family coach, and one smoking cessation coach (N = 18). Participants were a mixture of MHCPs working in inpatient and outpatient mental healthcare facilities. Professionals had to be involved in the diagnostic process and/or treatment of people with mental health issues to be considered eligible for taking part in the interviews. The mean age was 41 (ranging from 23 to 69 years of age), and twelve and six identified as of male and female gender, respectively (N = 18). One of the interviewed MHCPs smoked occasionally, five had smoked in the past and twelve had never smoked consistently.

Clients were recruited via their therapist (for clients recruited at Stichting VALK, an outpatient mental healthcare facility) or counsellor (for clients recruited at a supported living facility, part of GGZ Rivierduinen), and via the social network of students working on the project. Clients had to be in treatment for a DSM 5 classified mental health disorder (self-reported), other than tobacco use disorder. In addition, they had to smoke daily, or had quit smoking no longer than half a year before the interview. All participants had to be fluent in Dutch. After informed consent (see procedure), clients were invited via e-mail for the semi-structured interviews. These were conducted between March and July 2021. Sixteen clients participated in the semi-structured interviews. The mean age

was 46 (ranging from 21 to 71 years of age). Twelve and four identified as of female and male gender, respectively ($N = 16$). Two clients had quit smoking a few months before the interview took place, and 14 clients smoked daily (12 of tried to quit smoking in the past; two wanted to quit smoking immediately and eight wanted to quit sometime in the future, and one did not want to quit), and two stopped smoking a few months prior to the interview. Clients often reported multiple diagnoses, which included ADHD, schizophrenia, generalised anxiety disorder (three clients each), depression and borderline personality disorder (two clients each), and PTSD, paranoid schizophrenia, schizophrenic anxiety disorder, social phobia, specific phobia (i.e., fear of flying), otherwise specified personality disorder, 'prone to addiction', and 'difficulty being alone' (one client each), and one client did not want to share their diagnosis.

Procedure

Data were collected between January and July 2021 in the Netherlands. Potential participants were given information about the study before deciding to participate, including information that participation was voluntary and could be terminated at any time, that the interview would be audio-recorded, and that data would be used confidentially and anonymously for research purposes only. For participating MHCPs, verbal informed consent was audio-recorded in a separate file, before the start of the interview. For participating clients, informed consent was written as well as shortly discussed and audio-recorded at the start of each interview. All interviews were semi-structured, followed the interview protocol (see Supplementary Materials), and were conducted via Microsoft Teams (seven MHCPs and three clients), telephone (11 MHCPs and five clients), or face-to-face (all eight clients recruited through a supported living facility). Only the interviewer and interviewee were present during the interviews. The interviews were conducted by Psychology bachelor students (AD, JJ, LG, and a fourth student) trained by their supervisor (EM) to ensure quality of data collection, except for the eight face-to-face client interviews which were conducted by a psychologist who had formally worked at the facility but did not have a current therapeutic relationship with these clients (EK). Individual interviews lasted 23 min on average excluding informed consent (ranging from 9 to 42 min). Participants received a € 20 – gift coupon for participation. Interviews were recorded, transcribed verbatim and coded with the assistance of AtlasTi. After the interviews were transcribed, the audio-recordings were deleted from the recording device, but audio-recordings and transcriptions of the interviews were kept on a secure internal drive. Audio-recordings were removed from the internal drive upon completion of the analysis. The procedure was cleared for ethics by the Leiden Den Haag Delft Medical Ethical Committee (N20.165).

Analysis

The analysis followed the Framework approach, which combines inductive and deductive analysis (Smith & Firth, 2011). Coders familiarised themselves with the data by reading transcripts and listening to the audio files if necessary. Most interviews were conducted by the coders themselves. Transcripts were separately coded by AD, JJ, LG, and a fourth student, using an initial coding scheme developed based on the literature (Meijer

et al., 2018). After the initial analysis, all coders independently came up with new items for the coding scheme in order to capture all relevant data. The coding scheme was discussed among the team and finalised. The interviews were subsequently coded with the assistance of AtlasTi. To establish inter-coder reliability, six interviews were double coded by two independent coders each, and discussed. In general, transcripts were coded reliably, and any discrepancies were solved through discussions among the team. Data for each participant were then clustered in tables based on codes. Finally, all participants' data were merged and analysed to identify themes and trends in the data that related to the research question. Final interpretations made by AZ were checked with the data and discussed among the author team.

Results

Analysis resulted in four themes: (1) Motivation and expectancies, (2) Desired care, (3) Responsibility for SCC, and (4) Client characteristics. Each theme is described below, discussing both the perspectives of MHCPs and clients for themes 1–3. Theme 4 only emerged from the MHCPs' interviews.

Motivation and expectancies

MHCPs

The professional's smoking status appeared to have an impact on provision of SCC. Several professionals who were smokers or ex-smokers themselves stated that they are aware that smoking is pleasurable or rewarding. They also acknowledged the difficulties of quitting smoking. Ex-smokers, however, seemed more likely than smokers or non-smokers to strongly advise clients to quit smoking. Professionals who currently smoked admitted to being more lenient with their clients' smoking habits than non-smoking and ex-smoking professionals. For example, a nurse who worked in crisis services and as case-manager, and who smoked sporadically, described the impact of her own smoking status on her attitude towards a client's smoking behaviour as follows:

> Yes, that surely has an impact on my attitude. Just the fact that I can understand why someone is smoking or can explain the function of tobacco use, makes me … err yeah more lenient than people or colleagues that don't smoke. (P1)

The motivation to implement SCC was greater among MHCPs if they had stronger beliefs that clients could successfully quit smoking. They believed it critical for the provision of SCC that the client is motivated to quit smoking. According to the following comment from a psychiatrist, forcing a client to quit smoking would be counterproductive:

> That makes it so much harder to motivate people because you feel that you are taking something away, what they actually don't want. (P2)

Outcome expectancies also affected a child psychologist's decision on bringing up smoking cessation. In addition, she judged whether the therapeutic relationship was sufficiently strong to do so:

> I decide to take action when I think I am able to accomplish something without harming the therapeutic relationship, so … I have to know if I, yes … Have a connection that allows me to say things. (P3)

In sum, MHCPs motivation to provide SCC seemed to be related to their own smoking status and outcome expectations.

Clients

Most clients indicated that they wanted to quit using tobacco. Even though several clients were strongly motivated to quit, they remained unclear and indecisive about the timing of actual smoking cessation. For example, one client (C4) stated 'I want to quit smoking cigarettes, but not yet, I am not ready now'. Clients mentioned being in an enduring 'never ending' state of preparation of quitting smoking. Initiating a quit attempt, by for example not buying new cigarettes seemed too scary:

> Every time I say things like; 'this is my last pack of cigarettes and then I will stop smoking. Well … but then it does not work and I panic when there's only little left, and then I've already bought a new one [pack of cigarettes]'. (C1)

When asked why they were afraid to quit smoking, clients often discussed the role that smoking fulfils in their lives. Smoking is often a large part of daytime activities, but also functions as a distraction from their (mental health) problems, a form of social interaction and gathering, or a moment to relax and just be. As such, the meaning of smoking was evident. About half of the clients also indicated that smoking fitted with who they are. It appeared that smoking had become part of their identity as a consequence of smoking frequently or smoking for a longer period of time. Having mental problems also seemed to contribute to smoker identity. One client (C8) stated that 'It sort of fitted with me, it made me like, a little more tough toward the world outside', suggesting that smoking gave a sense of protection. Another client (C6) stated that 'I used to be very much anti-smoking. But now it does fit, I've become psychiatric'. However, the other half of clients did not see smoking as fitting with their identity, mostly because smoking conflicted with their otherwise healthy lifestyle, or because smoking had become stigmatised in society due to tobacco control policies.

Clients had mixed expectations of what it would be like to quit smoking. Expectations of smoking cessation varied, including both negative (e.g., headaches) and positive (e.g., relief) consequences. Most clients named long term physiological improvements after successful smoking cessation (e.g., better overall condition), but stressed short term psychological barriers (e.g., becoming more dependent on other substances, and increasing feelings of stress). For example. C3 expected to feel 'stress, grumpy, restless'. Sometimes these expectations were based on previous quit attempts:

> Physically you will feel err … less comfortable, I know that from previous times. The largest part is just mentally, that I will be less patient at work, and with my colleagues. And of course yes. I know that stress in general will increase somewhat, if you quit, because you do not have that emotional outlet anymore. (C2)

In sum, most clients were motivated to quit smoking, but they seemed to be held back by the important role that smoking had in their daily lives and sometimes their identity, and mixed expectations of quitting.

Desired care

MHCPs

Professionals described their relationships with clients using terms like 'warm-hearted' or 'welcoming attitudes and non-judgmental environments', also when it comes to discussing smoking cessation. MHCPs repeatedly stated that they should be encouraging, curious, interested, and informed regarding smoking cessation, but should avoid at all costs to be pedantic or judgmental. Despite these attitudes, several MHCPs said that smoking cessation is not the main goal or focus within mental healthcare. Professionals were willing to assist in smoking cessation, but the client should take initiative and express concerns about smoking or ask for assistance in quitting first (see also Responsibility). MHCPs mentioned several factors that they believed were important in providing SCC. For example, a child and adolescent psychologist mentioned that adjusting her own behaviour to the client's developmental phase helped to build and keep a therapeutic relation:

> Well, the problem with my client population is that they are in a phase where smoking is a bit of a secret. So, part of my clients will smoke without telling me, and if you want to connect with the client you cannot directly disprove of their behaviours, because this age group is very sensitive to that. So … yes, you need to be somewhere in the middle. (P4)

In addition, professionals mentioned the importance of 'timing' when it comes to advising clients on smoking cessation. For example, some professionals advise clients to postpone smoking cessation:

> Well, I know that some clients want to quit smoking, but then I help them, you know, if I see that they are also getting off their antidepressant or something else that's difficult, then yeah I might tell them 'just wait one month and then start it right'. (P5)

Most MHCPs mentioned that support for smoking cessation itself was typically provided by general practitioners, and that clients were often referred to their general practitioner when they asked for help with quitting smoking. Several MHCPs did see SCC as a good fit with their other priorities and responsibilities. To illustrate, a psychologist stated the following on incorporating SCC into a client's treatment:

> In treatment I would of course really like to add that [smoking cessation care] because I do think, of course, it makes someone healthier in itself, but it is also … hmm, a way to strengthen healthy coping mechanisms, isn't it? If you quit smoking, something healthy needs to replace it. (P6)

In sum, most MHCPs seemed to perceive SCC as a sensitive subject that required a careful approach, and should preferably be provided by general practitioners.

Clients

Almost all clients had tried to quit smoking in the past, but relapsed. Almost all clients indicated that they would need support and information from their MHCPs for quitting smoking, whereas only one indicated that he could quit without help. Some clients specifically indicated that MHCPs should take the initiative, and should motivate and support them throughout the smoking cessation process. When asked how she would feel if her therapist would advise her to quit, C1 stated that:

> Yeah, I would be fine with that, but there should be something in return … That I … That she helps me you know. Support. (C1)

Whereas some clients indicated the wish for MHCPs to start the conversation regarding smoking cessation, other clients indicated that MHCPs would be perceived as interfering with their personal lives and should not comment on clients' health behaviours.

The majority of clients who wanted support preferred a person to talk to, rather than medication to support smoking cessation. Their own MHCPs were perceived as helpful, especially their treating psychologist because they know the client's history and preferences. Clients also believed that 'talking' therapy could help them to continue their smoking cessation process when experiencing barriers. For example, C4 stated that she needed 'a lot of talking. Talking and err … because, it is severely psychological that I smoke'. Importantly, clients stressed that SCC had to be intensive, with multiple session over an extended period of time, such that they could practice quitting and discuss and resolve barriers that might arise. Furthermore, the MHCP supporting them in quitting had to have expertise on smoking cessation in people with mental health problems, and support had to be structured to be experienced as helpful. None of the interviewed clients thought that concise sessions within a general practitioner's office or over the phone would be helpful, and clients mentioned that the general practitioner would not be available when needed. One client recalled an experience that she had had when discussing smoking with her general practitioner:

> My general practitioner said that the only benefit of smoking is that, yeah, in a sense it makes you a little bit happier. (…) I would not say he was cheering it [smoking] on, but he indicated the severity of my problems and that it would not be something we would look at right away. (C8)

Clients did perceive group therapy as potentially beneficial, provided that groups included smokers dealing with mental health issues. They expected that groups could facilitate sharing experiences and receiving encouragement from companions in a similar situation, help to build motivation to quit, and serve as distraction.

Many clients had used nicotine replacement therapy, but to no effect. Importantly, many indicated that they did not use them as intended, and they were aware that this had contributed to their quit attempts being unsuccessful. In addition, many clients mentioned practical challenges or barriers when it came to smoking cessation. For example, there was a lack of knowledge on how to get access to compensation measures or insurance coverage. Overall, most clients believed that they would need specialised and intensive 'talking' support to quit smoking, which they would prefer to receive from their MHCP.

Responsibility for SCC

MHCPs

MHCPs largely agreed that clients need to be motivated and take initiative for SCC, such as explained by this psychologist:

> Clients are … err, the problem owners and they propose the complaints they want to change. And if they don't err yeah, I shouldn't impose a new problem on them. I think, if someone asks for help, you have a certain responsibility to help them. (…) But if a client does not initiate this (…), I do not really see it as the psychologist' responsibility to

> start that conversation. This ultimate responsibility not only applies to smoking cessation, but to any type of dysfunctional behaviour someone performs. (…) eventually it is a client who has to do it and can do it. (P6)

Only after a client has taken initiative, MHCPs perceive SCC as part of their professional responsibility. They stated that for SCC to be successful, both MHCPs and clients have to invest in it, such that responsibility is shared from then on:

> Smoking cessation, well … that is not achieved with only one intervention … If you really want to quit smoking with people, it means you will have to use a number of follow-up appointments and that means that you will need to put time and effort in it from both sides [MHCP and client]. (P7)

MHCPs felt responsible for helping clients to reach treatment goals, but also mentioned that smoking cessation is not the main goal in a therapeutic setting. Instead, MHCPs considered it their responsibility to monitor and adjust for the influence of smoking on the effectiveness of medication or psychotherapeutic interventions. As such, it appears that MHCPs ultimately leave decisions concerning smoking cessation with the client, as explained by the following psychologist:

> Sometimes smoking cessation is part of the conversation when for example EMDR is indicated within the treatment plan, and if someone smokes so much that you think it might hamper you know … if smoking might reduce the therapy's effectiveness I will explain briefly, but then I of course leave it with the client, whether he wants to do something with it. (P6)

In sum, results suggested that MHCPs typically find supporting smoking cessation irrelevant to the treatment that they provide. They perceive clients as responsible for initiating the discussion about smoking cessation, which seems to be perceived as indicative of clients' motivation to quit, after which responsibility is shared.

Clients

Perceptions of responsibility for smoking varied among clients. About two-third of the interviewed clients indicated that smoking is their own choice, such as C5:

> It is completely own choice. Smoking is my own choice and quitting would also be own choice.

The others experienced their smoking behaviour as an addiction that they could not conquer, as illustrated by C6:

> Well, smoking is not own choice anymore, of course. Yes, it is an addiction. If you would quit, it could be your own choice, but it would be about one of the most important choices of your life. Well, that sounds a bit dramatic but … yeah.

Clients seemed to agree that smoking cessation did not receive much attention in psychological and psychiatric care, and that mental healthcare did not take much responsibility. For example, C5 stated that 'well in psychiatry, smoking is more common you know? So often, you see people sit, and think. Some rumination and so on. Then they quickly smoke' (C5). When asked whether smoking should receive more attention, C5 answered 'yes, that could be, that they specifically name it'. For many smokers, seeing others smoke was a trigger to smoke as well, as was explained by this client:

> (…) in psychiatry smoking is very common and I also have the tendency too, err, and that is something I might unlearn, that if someone else rolls tobacco that I also roll tobacco (…) I personally think that I do that a bit too much. (C9)

Clients who lived in supported living facilities pointed out that most people receiving psychological care are smokers, as they barely knew anyone who is not smoking. For them, this was a barrier to quit smoking. Clients also stated that staff members often join when clients go outside to smoke a cigarette, often lighting one up themselves. Clients appears to enjoy the company of staff members that smoked, such that smoking created a social gathering of clients and MHCPs. Importantly, clients viewed MHCPs who smoke as incapable of helping them to quit. However, MHCPs who are ex-smokers were viewed as being more suitable than others in guiding them through smoking cessation. In addition, clients who lived in supported living facilities reported a more passive, wait-and-see mentality when it comes to SCC. More than other clients, they wanted the MHCPs to start a conversation about SCC, instead of discussing the topic on their own initiative.

In sum, clients perceived that smoking cessation was not prioritised in mental healthcare. Smoking seemed to be normative behaviour in supported living facilities in particular, with clients being unlikely to initiate a discussion about SCC.

Client characteristics

MHCPs

Many MHCPs stated that smokers with mental illness generally need more support in order to quit smoking successfully than those without psychological problems. Multiple factors were mentioned that can influence quit success, such as clients' vulnerabilities, personalities and coping strategies, their diagnosis and medication, and demographic characteristics such as socioeconomic position and age. For example, a social psychological nurse who worked with homeless people said the following concerning the function of cigarette use, suggesting that smoking facilitated quality of life:

> I think that our target group is err, on the fringe of society, at the lowest edge of society, that maybe, quality of life gets a different meaning than with someone else, or with other types of clients. (P8)

Some MHCPs mentioned the need for a coping mechanism while working on mental health problems, even if this was smoking, suggesting that smoking was sometimes perceived as a positive coping mechanism. Similarly, a child psychologist considered smoking as a sign of autonomy in her adolescent clients.

MHCPs were more willing to provide SCC if they thought that smoking cessation was feasible and manageable for clients given type and severity of the client's psychological problems and complaints. They also stated that clients should not feel over-asked or overcharged, which they expected could lead to crisis or the termination of treatment in the worst case. In addition, the therapeutic relationship should be sufficiently developed such that discussing smoking cessation would not damage the relationship. This was explained by a child psychologist as follows:

> I let the approach depend on the client's problems. Especially, the therapeutic relationship, I think. If you know that people are willing to, or capable of hearing hard things, or they are not yet. It all comes down to the relationship between me and the client, and type of problems and whether I think that smoking has a negative influence on the client. The most important thing is that those people remain in care (…) So, then the first thing you'll say won't be 'Quit smoking'. (P3)

MHCPs appeared less likely to provide SCC to clients who experience acute psychological crisis. Smoking seemed to be a minor problem compared to the psychological problems that brought the client into treatment, such as explained by this nurse who worked at an acute psychiatric ward:

> We are working on averting the psychological crisis and stabilising clients as much as possible, to put it bluntly. Yeah, to focus so much on a habit, an addiction, like smoking, which is actually very common, that is just useless and does not have high priority. (P9)

As such, stabilisation was prioritised for clients with severe psychiatric complaints. MHCPs working with these clients indicated that it might be more achievable for SCC to effectuate in environments with clients who are less sensitive to crisis, for example in outpatient care.

> The patients that are with us, they are so ill, psychiatrically, that it [quitting smoking] does not have so much priority to be honest. You mostly first have to make sure that someone stabilises … so I think that, in settings where clients are more stable, err, it is more likely to be addressed. (P2)

Overall, MHPCs were reluctant to provide SCC for clients with more severe problems, as they were pessimistic about the outcomes and believed that other problems should be addressed first.

Discussion

This qualitative study provides in-depth insight into MHCPs' and clients' perspectives on smoking cessation in mental healthcare. All interviewed MHCPs perceived clients as carrying the ultimate responsibility for quitting smoking, and typically waited for clients to ask for help with quitting. However, clients were reluctant to initiate the discussion of smoking cessation, although they expressed a desire to quit or at least reduce smoking. Although MHCPs and clients seemed to agree that SCC should be tailored to the client's needs and possibilities, they also expressed different views on SCC.

MHCPs stressed that smoking cessation should – at the most – be suggested, but they did not want to be judgmental or pedantic, suggesting that they perceived SCC as potentially harmful for the therapeutic relationship. In line with earlier research, MHCPs' perceptions of smoking itself seemed important for how they viewed responsibility for smoking cessation (Meijer et al., 2018). MHCPs reported that they focus on other goals than smoking cessation, even more so when clients experience severe psychiatric illness or crisis and stabilisation is prioritised. Thus, groups in which smoking and its associated negative health consequences are most prevalent (e.g., people diagnosed with schizophrenia) receive the least support for quitting smoking. Importantly, the finding that most clients wanted to quit or reduce smoking is in line with previous findings (Asharani et al., 2020; Fagerström & Aubin, 2009; Stockings et al., 2013; Zhou

et al., 2009). It is questionable whether clients will actively ask for help quitting smoking, as many smokers are ambivalent towards quitting given their addiction to smoking, and smoking is still quite common in society in general, and among both staff and clients in inpatient mental healthcare in particular. This is even more important as MHCPs indicated that they do not start a conversation about smoking behaviours as they do not want the client to have to work on 'problems' that are not experienced as such, and they do not want to start a treatment by confronting them with certain behaviours, with a possibility of harming the therapeutic relationship. Hence, MHCPs seem to interpret clients' lack of initiative to discuss smoking as low motivation to quit, whereas it could also or instead result from low self-efficacy. In that case, asking clients who smoke whether they would want to know which treatment and referral options exist seems much better than leaving the subject unaddressed, both for the client's health and the therapeutic relationship. This seems to be especially relevant in inpatient or supported living mental health care facilities, as these clients, compared to other clients, report a more wait-and-see mentality when it comes to SCC. MHCPs even mentioned the need for a coping mechanism, even when they consist of smoking behaviours in the short term, while working on mental health problems. This is also often stressed by clients, as they indicate that smoking cigarettes for example relieves stress. Besides, clients often do not look forward to smoking cessation, partly because of losing coping mechanisms in the short term. MHCPs should therefore explain the benefits of smoking cessation, including the relevance for smoking cessation within the experienced mental healthcare problems. Taken together, it appears likely that smoking cessation often remains unaddressed in mental healthcare.

Some clients perceived their smoking behaviours as lifestyle and free choice, while others experienced smoking as an addiction. In line with this, needs and preferences for SCC differed among clients; some verbalised the need for (psychological) support, ranging from individual sessions to group therapy, while others preferred to quit smoking on their own. The majority of the interviewed clients would like a more active role of their MHCP, for example by asking questions about the clients' smoking behaviours and the role this behaviour fulfils, as well as some explanation of the consequences that smoking and smoking cessation could have for their treatment and mental health. Several clients stated that they had used nicotine replacement to no effect, since they did not manage to use it correctly. Such experiences likely decrease their self-efficacy to quit, whereas adequate support for quitting is likely to increase successful quit rates. Remarkably, most clients preferred their psychologist to be in charge of SCC, and stressed that MHCPs helping them had to be experienced in helping smokers with mental problems quit smoking. This poses a potential problem, as many MHCPs lack training in SCC and do not feel capable of helping smokers quit (Smith et al., 2019). Most MHCPs mentioned that SCC is based at the general practitioner's office, and clients are often referred to their general practitioner when they verbalise their wish to quit, whereas clients did not feel that this would be helpful and required more intensive support. It appears useful to explore other referral options for intensive support for this group, such as smoking cessation provided within addiction care, or group therapy for smoking cessation within a mental healthcare setting – similar to groups that address other transdiagnostic issues such as inadequate coping or low self-esteem. Given differences in clients' preferences, personalised care seems optimal, which fits perfectly with

the current objectives of mental healthcare. However, this has not yet been sufficiently mapped out with regard to SCC. Further research into individual preferences and the type of care seems of added value.

Results from both MHCPs and clients highlight the importance of open communication about smoking and smoking cessation within mental healthcare. MHCPs and clients both indicated the importance of discussing 'needs and preferences', and clients stressed the need for clarity about expectations and responsibilities when it comes to SCC. This finding emphasises the importance of the therapeutic relationship in SCC, where there is a safe (working) environment for the client to be honest about unhealthy behaviours that they themselves often are unhappy with, while MHCPs articulated the need for being empathic and understanding when discussing smoking and smoking cessation. As this allows MHCPs and clients to work together on improving health, we believe that this will optimise rather than harm therapeutic relationships.

This study has limitations. First, it is possible that MHCPs who were interested in SCC were more likely to respond to the invitation and therefore, be selected to take part in the interview. Interview participants were recruited through a large-scale online survey for which we approached MHCPs regardless of their experience with SCC in order to reduce bias. However, generalisation is not the aim of qualitative research, and more qualitative as well as quantitative studies are needed to ascertain whether current study findings are representative, if they differ amongst different types of MHCPs, and which characteristics (e.g., organisations, type of clients, familiarity with treatment types) are linked to MHCPs' perceptions of SCC. Relatedly, the current study did not allow for comparisons between subgroups of clients (e.g., based on diagnosis), but results suggest potential differences between clients who receive outpatient treatment versus people living in supported living facilities. Future research among different subgroups is needed to further examine this. Second, participants may have given socially acceptable answers despite assurances that data would be anonymously evaluated and reported. Given that some participants stated potentially divisive opinions, we do not think that social desirability played a significant role. Third, in order to include a sufficient number of participants, we used two techniques to gather data, which may have resulted in somewhat different participant responses. Face-to-face interviews were chosen for people living in supported living facilities, as this made communication easier for them. Individual telephonic interviews are relatively anonymous and prevent non-verbal communication such as facial expressions to be conveyed, whereas face-to-face interviews are more personal and allow for more participant–interviewer interaction, and video calls are somewhere in between. Several studies show that the quality of interviews performed through video calls is comparable to face-to-face interviews (Estévez-Carrillo et al., 2022; Rowen et al., 2022).

Conclusion

Given smokers' ambiguity towards quitting smoking, inherent to the addictive nature of smoking, most clients are unlikely to take the initiative to seek help. MHCPs often let clients decide on the treatment focus instead of actively supporting smoking cessation, which is often perceived by MHCPs as less of a priority. Clearly defined responsibilities

regarding initiation and provision of SCC seem necessary in order to improve the health of people with mental illness who smoke.

Note

1. In the Netherlands 'orthopedagoog' stands for a MHCP who has specialised in a systemic approach to guidance and treatment of developmental-, learning-, behavioural and emotional problems in children, adolescents and their contexts.

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Disclosure statement

No potential conflict of interest was reported by the author(s).

Ethics approval

The procedure was cleared for ethics by Leiden University Medical Center's Medical Ethical Committee (N20.165). The study was performed in accordance with the 1964 Helsinki Declaration.

Consent

All participants provided informed consent before study participation.

Data availability statement

Pseudonymized data are available from the corresponding author upon reasonable request.

Authors' contribution

Conceptualisation: EM; Methodology: AZ, JJ, LG, EK, EM; Investigation: AZ, JJ, LG, EK, EM; Formal analysis: AZ, JJ, LG, EM; Writing – original draft preparation: AZ, EM; Writing – review and editing: JJ, LG, EK, EM; Supervision: EM.

The COREQ and STROBE guidelines for reporting qualitative and observational studies were followed in preparing the manuscript.

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