In Wales, an estimated 14.1% of people are smokers. Smoking is much more common (33% prevalence) among people with mental health conditions and is even higher among those with SMI (40.5% prevalence).

Welsh Government commissioned NHS Wales' Joint Commissioning Committee and RCPsych Wales to develop a framework to help reduce smoking rates among people with mental health conditions in Wales.

The framework sought to address three priority areas for action:

Address misperceptions about smoking in mental health settings.

Improve implementation of quitting strategies in mental health settings.

Address the lack of data on smoking and quitting among people with SMI.

**Methods:** In partnership with the Public Mental Health Implementation Centre; a review of data, current interventions, policy and strategy across Wales was undertaken.

This was complemented by consideration of:

Overview of current evidence-based strategies in Wales.

Scaling evidence-based interventions for smokers with mental health conditions and SMI.

Addressing misperceptions among smokers and health professionals.

Upskilling mental health professionals to enable them to motivate and support quit attempts.

**Results:** In addressing the three priority areas for action, the framework focused upon:

Understanding local needs and assets.

Working Together.

Taking action for prevention of smoking, mental health promotion, and reducing inequalities.

Evaluation and measuring outcomes.

Additionally, a deficit in the following areas, led to several recommendations:

Provide training resources for upskilling people working in mental health to support smoking cessation.

Review and augment the implementation strategy for Help Me Quit and the Tobacco Control Delivery Plan to support people with mental health conditions.

Improve accessibility to nicotine replacement therapy (NRT) and other smoking cessation medication. People wanting to quit should have access to more than one quitting aid.

Address data gaps by collecting reporting information on rates of smoking, including among people with mental health conditions.

**Conclusion:** Several next steps are necessary to reduce smoking among people with mental health conditions in Wales:

Develop an implementation strategy for the Tobacco Control Delivery Plan to target people with mental health conditions including SMI.

National campaigns promoting positive mental health should include messages about the mental health harms of smoking.

Major gaps in data on smoking and quitting must be addressed.



## Service Evaluation of Transition Pathway and Audit of National Institute of Clinical Excellence (NICE) Guidelines Compliance

Dr Umama Khan[1], Dr Basanta Sapkota[1], Dr Parvathy Suresh[1], Dr Amaia Del-Pozo-Ugalde[1] and Professor Jeremy Turk[1]

[1]Hampshire and Isle of Wight NHS Foundation Trust, Isle of Wight, United Kingdom

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**Aims:** This project aimed to evaluate our transition service for young people, from Child & Adolescent Service (CAMHS) to Adult Mental Health Services (AMHS), and to audit NICE transition guidelines compliance.

**Methods:** A retrospective case note survey of complex patients who had transitioned between January 2021 and September 2024 was undertaken. NICE Guideline standards on transition were compared with current practices.

**Results:** All individuals had been seen by a consultant psychiatrist prior to transitioning, usually with diagnoses confirmed, and medications stabilized.

37 participants were female and 7 male. 38 were transferred to community mental health team (CMHT), 3 to a learning disability team and 3 to early intervention in psychosis service.

13 participants had a diagnosis of bipolar affective disorder. 21 had a diagnosis of autism spectrum disorder (ASD) and 5 had attention deficit hyperactivity disorder (ADHD). A few awaited diagnoses confirmation. Emotionally unstable personality disorder was the second most common diagnosis, seen in 8 cases.

Individuals with severe anorexia nervosa and possible autism proved the most difficult to engage in treatment following transition. Most individuals continued to be managed in the community. Only 3 required brief admission to hospital for a maximum stay of 3 days.

Only one had contact with the criminal justice system.

Two continued to receive care from CAMHS post 18th birthday, as they didn`t meet the adult service eligibility criteria.

We compared our current practices with NICE standards. There was good compliance with most, other than Standard 1, regarding age at transition planning. Adult service policy was to identify a named worker only a month before the young persons` 18th birthday. Hence, most individuals transitioned aged 17 years and 11 months.

There was NICE compliance for having a coordinated transition plan, a named worker to coordinate transition care and support before, during and after transition., and a patient meeting practitioner from each anticipated adult service.

**Conclusion:** This review has helped us in confirming that our transition pathway is largely effective in transitioning complex and enduring cases to adult services and has identified gaps which require attention. We believe that having a dedicated consultant psychiatrist providing continuity of care, pre and post transfer has been pivotal in reaching these goals.

Additionally, good and early patient preparation, and focused, prioritised, multidisciplinary support for complex cases has been crucial.

Abstracts were reviewed by the RCPsych Academic Faculty rather than by the standard *BJPsych Open* peer review process and should not be quoted as peer-reviewed by *BJPsych Open* in any subsequent publication.