

Priority Groups:

Good practice for targeting
and tailoring tobacco
dependence treatment



NCSCT

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Priority Groups:

Good practice for targeting and tailoring tobacco dependence treatment

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Introduction

While population smoking prevalence has dropped to an all-time low, tobacco use remains disproportionately concentrated within disadvantaged groups and is a key driver of **health inequalities**.

A number of national priority groups have been identified (see Box 1). These priority groups have higher rates of smoking and greater barriers to stopping than the general population of people who smoke (see Table 1). **Addressing high rates of tobacco use among priority groups is an important target for achieving the smoke-free goal.**

National guidance recommends that stop smoking services identify local priority groups and focus targeted action to reduce rates of smoking among those communities.

Box 1: National Priority Groups

This is a list of previously identified priority groups, but it is not intended to be exhaustive. Priority groups should be identified on a local basis and may include people who are:

- Socio-economically disadvantaged and/or those living in social housing
- Experiencing mental health conditions
- Living with substance use disorders
- Suffering from health conditions caused or made worse by smoking
- Experiencing multiple or complex needs (e.g. unemployed, homelessness, in contact with the criminal justice system, ethnic minorities, travellers, LGBTQI+)

This briefing consolidates current knowledge regarding key considerations, principles and good practices for tailoring stop smoking support to meet the needs of national priority groups to increase engagement (reach) and rates of successful quitting (effectiveness).

The briefing was informed by a rapid review of available evidence. The full report with sources is available in the Training and Resources section at end of this document.

Table 1: Rates of smoking in the population and for priority groups

Population group	Smoking rate	People who smoke
General population	12.7%	1 in 10
C2DE (Manual occupation)	22.5%	2 in 10
People living in social housing	25 – 33%	3 in 10
People with severe mental illness	40%	4 in 10
People in treatment at drug and alcohol addiction centres	53%	5 in 10
People within the judicial system	80%	8 in 10
People experiencing homelessness	76 – 85%	8 in 10

What we know about why smoking remains high among priority groups

In many priority groups we have not seen the same rate of decline in smoking rates as we have for the wider population who smoke. We now recognise that tobacco dependence is not a ‘bad habit’ or a ‘lifestyle choice’ but a chronic, relapsing condition that requires evidence based treatment and sustained support.

Individuals from priority groups are often facing **complex life challenges** including chronic stress, and trauma. Many live and work in **environments where smoking is the norm**. We know that individuals from some priority groups can be **more tobacco dependant** than the general population of people who smoke. All of which increase the challenges they face when stopping smoking (see Box 2).

Box 2: Important considerations for priority groups

- Greater tobacco dependence and daily tobacco consumption, more severe withdrawal symptoms and urges to smoke
- Greater enjoyment and perceived relaxation from smoking (lack of enjoyment/pleasure from other sources)
- Daily routines that are associated with smoking
- More frequent social triggers to continue smoking
- More stress, distress and symptoms of mental illness and co-addictions
- Socio-economic stressors and higher rates of unemployment
- Increased likelihood of past or present trauma
- Poorer cognitive function and greater likelihood of learning disabilities and mental illness
- Boredom, loneliness and social isolation play a role in smoking behaviours
- Less likely to receive stop smoking support
- More likely to have stopping smoking deprioritised against perceived more pressing needs

Considerations for tailoring treatment to priority groups

Several factors are common among members of priority groups and/or play an important role in tobacco dependence.

Greater tobacco dependence, severity of withdrawal symptoms and urges to smoke

We know that individuals from some priority groups, including people with severe mental illness, people with other addictions, people experiencing homelessness, and people living in social housing have significantly greater tobacco dependence, and therefore greater severity of tobacco withdrawal symptoms and urges to smoke. In addition, people with schizophrenia experience greater severity of withdrawal symptoms and this increased severity occurs independently of their level of tobacco dependence.

Stress, distress and mental illness

Individuals from priority groups report high levels of stress and distress and are more likely to be diagnosed with mental illness. This includes socio-economic stressors such as higher rates of unemployment, limited ability to work and challenging family circumstances. Smoking is frequently used as a coping mechanism by individuals facing these challenges.

Enjoyment and perceived relaxation from smoking

There is strong association between smoking and feelings of enjoyment and relaxation. This may play a larger role in sustaining smoking behaviour among priority groups when compared to the general population of people who smoke.

Smoking promoting environments

Individuals from priority groups are often surrounded by social and other environments that normalise, promote and reinforce smoking. Hence they have a greater number of people who smoke in their social networks and more contact with people who have positive smoking identities, both of which make smoking more visible, accepted and harder to change.

Boredom and loneliness

People in priority groups are more likely to use smoking to cope with boredom, loneliness and social isolation, and they also have reduced access to alternative activities.

Other addictions and dual diagnosis

There is a greater likelihood of co-addictions and dual diagnosis (e.g. mental illness and alcohol dependence) occurring amongst those in priority groups.

Reduced confidence, greater ambivalence

Those in priority groups often have a reduced confidence in their ability to stop smoking, and a greater ambivalence about stopping smoking.

More time building trust with service providers

Some individuals who are part of priority groups require longer to build trusted relationships due to a history of trauma, mental illness or other factors.

Guiding Principles

It has been well documented that rates of successful quitting are lower, both with and without treatment, among individuals in priority groups.

Evidence shows that **tailored or bespoke interventions**, shaped around the specific characteristics and contexts of groups or individuals, can significantly improve engagement, increase cessation attempts, and boost cessation success across most priority groups.

Addressing tobacco use among priority groups requires more than a standardised approach – **it requires targeted and tailored approaches and new ways of working that reflect the realities of people's lives** (see Box 3).

Box 3: Targeting and tailoring

- **Targeted:** Stop smoking support designed in a way that meets the needs of, and increases service access to, specific groups of people with high smoking prevalence.
- **Tailored:** Adapting stop smoking support to the needs of individuals who smoke.

Some individuals will require more flexibility, time and support than the usual protocols suggest – this requires new ways of working. This represents an important step change; attempting to use pre-existing treatment protocols, which increasingly are not evidence-based, will not be sufficient. **More intensive support and a variety of approaches are needed** (see Box 4).

These person-centred approaches to service delivery allow us to ensure the multi-faceted needs of individuals are considered in the treatment plan.

Box 4: Key principles for working with priority groups

These involve offering a more person-centred service, including flexible levels of behavioural support and the use of stop smoking aids. This often means embedding services in settings where there is direct contact with priority groups, with flexible hours and locations. Priority groups often benefit from more lead-in time before stopping as well as engaging in support over extended time periods to reduce the risk of relapse.

Considerations for those responsible for planning and commissioning services

National guidance recommends that stop smoking services:

- identify local priority groups
- work to reduce rates of smoking among locally established priority groups
- record and monitor access and outcomes for priority groups

Ensure the latest evidence is reflected in commissioning and service delivery

Changes to service specifications for stop smoking services are necessary to support the tailoring of interventions. This includes ensuring the latest evidence and good practice for targeting and tailoring treatment to priority groups is reflected in service specification and service delivery.

Successful outcomes among priority groups should be prioritised

Achieving and sustaining smoking abstinence in this population often requires considerable time and resources. Given the importance of focusing on reducing rates of smoking among priority groups it is essential that services be appropriately credited for these efforts. This includes monitoring service reach and outcomes among priority groups and giving greater weight to successful abstinence among them. It also means planning for a higher cost per quit that can be offset by ensuring all clients receive the services they need **(the right service, from the right person, at the right time)**.

Success may be measured differently for some priority groups

For some client cohorts, such as people experiencing homelessness, smoking abstinence remains challenging. In these contexts we have primarily seen success with increasing rates of engaging with treatment and reducing daily consumption, with long-term abstinence being harder to achieve. For groups with multiple overlapping challenges, it can be more effective to shift from a narrow focus on measuring a 4-week outcome to recognising meaningful achievements for this cohort. This includes a focus on increasing partnerships with services, engagement from priority groups, and harm reduction (reducing tobacco consumption but not necessarily stopping).

Below are ten principles that aim to provide practical recommendations for the delivery of services for priority groups.

Principles for delivering services

Below are ten principles that aim to provide practical recommendations for the delivery of services for priority groups.

1

Principle 1: Targeted outreach and embedding support in settings in which people from priority groups spend time

It is important that effort be made to reach out to populations who are experiencing inequalities. This includes being present in settings where we can reach priority groups and overcoming barriers to accessing services by these groups.

2

Principle 2: Make the offer welcoming and appealing

It is important that individuals from priority groups feel comfortable engaging with support. Priority groups can often feel judged by mainstream services and feel the service is not suitable to their needs.

3

Principle 3: An increased focus on building rapport and the client-practitioner relationship

The client-practitioner relationship has been shown to play a key role in effective stop smoking support. While this is the case for all individuals, it appears to be particularly important among members of priority groups.

4

Principle 4: Person-centred tailored support that addresses barriers known to affect priority groups

Person-centred services should include comprehensive assessment and individual tailoring of support and treatment to address the specific barriers to stopping smoking that clients are experiencing, particularly those which address psychosocial factors such as stress, social norms, identity and other daily pressures.

5

Principle 5: Address and treat higher rates of tobacco dependence (pre-treatment, higher doses and combining stop smoking aids)

It is important to anticipate when working with priority groups that treatment will need to focus on coping with withdrawal and urges to smoke. As well as advice and support this will include the advanced use of stop smoking aids.

6

Principle 6: Direct supply of stop smoking aids

The direct supply of stop smoking aids has been identified as particularly important for clients from priority groups. Removing barriers to access increases uptake and use of treatment.

7

Principle 7: Extended duration and intensity of behavioural support

A variety of more intensive support is often needed to help people maintain abstinence from smoking. People from priority groups experience higher rates of relapse following stopping. Extending behavioural support and stop smoking aids are two methods for reducing the risk of relapse.

8

Principle 8: Anticipate setbacks and build these into the treatment plan

High rates of relapse should be expected among clients from priority groups and having methods to normalise setbacks and re-engage clients in support is recommended. Small goals and small wins should be celebrated.

9

Principle 9: A well-trained, well-led workforce that reflects the needs of priority groups

Practitioners delivering specialist support to priority groups should receive additional training to ensure they have the knowledge, skills and confidence to do so.

10

Principle 10: Good communication with the client's care team and community services

Members of the health and social care team should at minimum be made aware of, and ideally be part of, the plan for stopping and/or reducing smoking, and have a formal role in supporting the client's quit attempt.

Good practice

The good practice section aims to provide practical recommendations for the delivery of each of the principles for working with priority groups. Table 2 provides a summary of established and emerging evidence for good practice by priority group.

Evidence and best practice on adapting and tailoring stop smoking services is more robust for some priority groups than others. Specifically, there is a larger evidence base for tailoring stop smoking support for people with severe mental illness (SMI) and those receiving treatment in drug and alcohol services. For others there has been, until recently, only limited research but emerging good practice (e.g. homelessness, social housing, prisons, LGBTQI+). It is fair to say we are still building our understanding of what good practice looks like for some priority groups.

Table 2: Summary of established and emerging evidence for good practice by priority group

Good practices	LGBTQI+	Common Mental Illness	SMI	Addiction Services	Prisons	Social Housing	Homeless Services	Pregnant Women
Engaging in treatment								
Tailor language		•					•	•
Group-based services	•							
Embed support into settings in which priority groups visit, live and/or spend time	•		•	•	•	•	•	•
Cut Down to Stop (CDTS)			•	•			•	
Incentives			•			•	•	
Targeted advertising	•		•					•
Behavioural support								
Extended duration or intensity of behavioural support			•	•	•	•	•	•
Flexible service delivery models			•	•	•	•	•	
Recognise the potential effects of mental and physical conditions and adapt support		•	•	•	•	•	•	•
Peer support	•					•		
Address barriers (stress, enjoyment, social networks, smokers in home, boredom)	•	•	•	•	•	•	•	•
Trauma informed approaches	•		•	•	•	•	•	
Non-smoker identity	•	•	•	•	•	•	•	•
Staff are prepared for setbacks and build these into the treatment plan			•	•			•	
Stop smoking aids								
Pre-treatment with stop smoking aids		•	•	•		•	•	
Nicotine vapes			•	•			•	•
Higher doses of replacement nicotine			•	•	•	•	•	
Nicotine analogues		•	•	•	•	•	•	
Direct supply of stop smoking aids			•	•	•	•	•	•
Extended use of stop smoking aids (4–12 months)			•	•	•	•	•	
Staff training								
Formal training and experience working in priority groups		•	•	•			•	•
CPD Training in working with priority groups	•	•	•	•	•	•	•	•

Reaching priority groups requires moving beyond traditional stop smoking services and taking support to where people already are. This means both **outreach** (e.g. actively going into community settings such as hostels and faith centres) to reach people who are unlikely to self-refer, and **inreach** (e.g. embedding stop smoking support within settings such as prisons, mental health units, and drug and alcohol services, where practitioners can deliver sustained support to people over time).

1.1 Embed support into settings in which priority groups live and/or spend time

There is evidence that embedding stop smoking support in familiar settings where individuals already have established relationships increases the likelihood of them engaging in support. It is recommended that in planning place-based service delivery, both service users and staff from service settings who work with priority groups are involved in the co-design and delivery of stop smoking support.

1.2 Offer flexibility on where appointments are delivered

Offer flexible client-centered service delivery models including outreach into community settings (e.g. homeless services, social housing) and treatment services and facilities (e.g. addiction services, clozapine clinics). Home visits can increase engagement as well as involving family and friends with the stop smoking programme. They also help allay fears among family and friends that stopping smoking will negatively impact the individual's mental health.

1.3 Staff in health and community settings who have direct contact with priority groups should be trained in VBA+ tailored for people in priority groups

Social and healthcare professionals in contact with people experiencing health inequalities should be trained in delivering VBA+ that is tailored to the populations they work with to increase receptivity. This training should focus on the importance of using non-intimidating language, normalising concerns, communicating about support known to appeal to people experiencing barriers to stopping (e.g. vape starter kits, Cut Down to Stop, incentive programmes) and addressing common barriers and myths.

1.4 Recognise the potential effects of mental and physical conditions and adapt support

Recognise that symptoms of mental illness, drug or alcohol use, learning disabilities and/or the effects of medications may affect the ability of individuals to engage in traditional forms of support. These can include social anxiety, difficulty concentrating, and difficulty with waking and functioning in the morning.

It is important that individuals from priority groups feel comfortable engaging with support. Priority groups can often feel stigmatised in mainstream services or feel the service is not suitable to their needs.

2.1 Tailor language

Communicate using language that is tailored to increase acceptability among members of priority groups. Use of lay, non-intimidating language that builds rapport is critical. Tailor communication materials to increase engagement by ensuring they resonate with and reflect priority groups. In addition, using person first language (e.g. 'people who smoke' rather than 'smoker') avoids labelling and shows respect.

2.2 Nicotine-containing vapes

There is strong evidence that nicotine vapes are effective in increasing rates of smoking abstinence and are well accepted as an aid for stopping smoking by people in priority groups. Providing **nicotine vape starter kits and supplies** can assist with engaging individuals in treatment and remove initial financial barriers to vape use. The provision of e-liquid supplies over an extended period (e.g. 12 weeks or longer) may enhance outcomes among priority groups who have socio-economic barriers. Assisting clients to develop knowledge and confidence with using vapes and addressing any concerns about their role as a harm reduction strategy can be important.

2.3 Financial incentives

There is high-quality evidence that financial incentives increase engagement and rates of smoking abstinence, and emerging evidence that this may be especially effective for people from disadvantaged socio-economic backgrounds. These incentives appear particularly beneficial for those who are pregnant or recently post-partum, have a high threshold for behaviour change, or respond well to external rewards. There is also growing evidence that incentives can be beneficial for people with mental illness and people experiencing homelessness. Economic evaluations have shown that financial incentives are cost-effective, particularly for pregnant women where direct effects on reductions in pregnancy complications and healthcare costs are seen in a short timeframe.

2.4 Cut Down to Stop (CDTS) is offered for those unable to stop abruptly

Individuals who feel unable to commit to stop smoking abruptly can be supported to cut down the amount that they smoke prior to a planned quit date. CDTS can appeal to people who lack confidence in their ability to stop abruptly, are more tobacco dependent and have greater barriers to stopping. CDTS is particularly useful for engaging people with severe mental illness and people experiencing homelessness.

Support for CDTS should include both structured multi-session support from a trained stop smoking practitioner and treatment with a first choice stop smoking aid (NRT, nicotine vapes, or varenicline). There are [CDTS resources](#) on the NCSCT website.

When evidence-based approaches are used, CDTS will often have a greater average cost per case relative to abrupt stopping. However, CDTS remains a cost-effective approach to stopping because the relatively small incremental cost is offset by the significant benefits to clients who are successful. This is particularly true for people who might not otherwise engage in, or be successful with, abrupt approaches to stopping smoking. This additional cost should be viewed as part of equity-based approaches to the delivery of stop smoking support.

3

Principle 3: An increased focus on building rapport and the client-practitioner relationship

The client-practitioner relationship has been shown to play a key role in effective stop smoking support. While this is the case for all individuals, it appears to be particularly important among members of priority groups.

3.1 Anticipate more time may be required to build rapport with clients

There is some evidence that building rapport with clients from priority groups is especially important in influencing treatment outcomes. Building rapport can often take more time among priority groups, where there is frequently a lack of trust. Practitioner-led behaviours for building rapport include building from prior interactions, using empathy, normalising challenges, reframing and summarising, validating achievements and the appropriate use of humour.

3.2 Trauma informed approaches (TIA)

TIA are a new area for stop smoking services. TIA have been widely used outside stop smoking services to tailor treatment and offer person-centred support. As there is a greater likelihood of past or present trauma for people in priority groups, TIA appear to be relevant for effectively engaging people in stop smoking support. As such, training practitioners working with priority groups to incorporate these approaches into the delivery of support is good practice.

4

Principle 4: Person-centred tailored support that addresses barriers known to affect priority groups

4.1 Address beliefs about smoking and stress

Address in a sensitive manner the myth that smoking helps to manage stress. It is important to acknowledge that the stress people are experiencing is real and that life circumstances can make smoking abstinence challenging. Help to clarify that smoking does not alleviate stress, it alleviates withdrawal symptoms: the irritability, restlessness and low mood that falling nicotine levels cause. Increase the client's confidence that with support it will become easier to stop, and stopping will result in lower levels of stress and improved mental health.

4.2 Address concerns that stopping may worsen symptoms of mental illness

Evaluations of targeted smoking cessation interventions have shown that clients do not experience a worsening of mental health symptoms after they stop smoking.

4.3 Support clients with social contacts who smoke

For many people in priority groups, smoking is deeply embedded in social relationships and daily routines, and for those who are isolated and lonely these connections may be particularly precious. Practitioners should be sensitive to the fact that staying smokefree can feel like losing a social world as well as a cigarette. In some situations, rather than advising clients to avoid people who smoke, support should focus on exploring what smoking means socially for each individual and collaboratively developing realistic strategies for managing smoking situations within existing relationships, building new social connections, and identifying alternatives to smoking in moments of social pressure.

4.4 Peer-to-peer and group-based support

There is some emerging experience that peer support has been shown to increase the acceptability of stop smoking support in social housing, homeless and mental health settings. Using peer exchange, buddy systems or group-based treatment modalities to connect peers is recommended. The use of trained peer mentors to deliver cessation support to social housing residents has been identified as a promising strategy but additional research is needed to inform practice.

Available research indicates that LGBTQI+ youth and young adults prefer smoking cessation and prevention interventions to: be LGBTQI+ specific; be accessible; be inclusive, relatable and highlight diversity; and incorporate LGBTQI+ peer support and counselling services.

4.5 Facilitate alternative activities

Help people to find activities that could be used in place of smoking, and which offer the opportunity to stay busy, socialise and be active without smoking. Encourage clients to identify activities they would find enjoyable or helpful. If clients find it difficult to identify activities, provide a menu of options – two or three things that other clients have found helpful – and ask if they would be interested in trying any of them.

4.6 Smokefree social care environments and role modelling

Smokefree health and social care environments are essential: reducing smoking cues and triggers will make stopping smoking easier to achieve. Creating and maintaining smokefree spaces is not just good practice, it is a core component of effective treatment for tobacco dependence. Working closely with health and social care providers to establish and uphold smokefree policies helps protect clients from constant exposure to smoke, reinforces their efforts to stay abstinent and promotes overall health and wellbeing. Ensuring staff working in community settings role model smokefree behaviours can be important (e.g. switching from smoking to vaping).

It is important to anticipate when working with priority groups that treatment will need to focus on coping with withdrawal and urges to smoke. As well as advice and support this will include the advanced use of stop smoking aids.

People with greater tobacco dependence are more likely to need stop-smoking aids – both before and after quitting. These aids may be required at higher doses to ease withdrawal symptoms and urges, and for extended periods to help prevent relapse.

5.1 Pre-treatment (pre-loading)

Pre-treatment involves the use of NRT or another aid before stopping smoking, generally one to a few weeks prior to the client's quit date. Nicotine pre-treatment appears to facilitate smoking abstinence by reducing urges to smoke and tobacco intake before stopping and urges to smoke after stopping. Pre-treatment with NRT and varenicline has been shown to result in a small but significant increase in success with stopping smoking. Pre-treatment may be particularly relevant to tailoring support to people with multiple barriers to stopping and/or low confidence in their ability to stop. Some evidence suggests that there is an increase in nicotine withdrawal symptoms prior to an individual's quit date which may be associated with the anticipation of stopping smoking and may occur in greater frequency among individuals in some priority groups (e.g. people experiencing homelessness). It may also be associated with not stopping on the scheduled quit date. Pre-treatment may be particularly useful for tailoring treatment to individuals with significant past experience of withdrawal symptoms and urges to smoke.

5.2 Higher doses of nicotine replacement

To increase rates of stopping and reduce relapse, stop smoking aids should be provided at sufficient doses to minimise withdrawal symptoms and urges to smoke. Higher doses (>42mg) of NRT are established as safe. There is good evidence that higher doses are more effective in addressing nicotine withdrawal in people who smoke more heavily or have greater tobacco dependence. Evidence demonstrates that people with SMI, and in particular people with schizophrenia, experience more pronounced withdrawal symptoms and urges to smoke, and poorer responses to standard treatment doses.

5.3 Behavioural strategies for coping with urges to smoke and withdrawal symptoms

Given the increased likelihood of more frequent and severe urges to smoke, behavioural support should include strategies for coping with this including both the use of stop smoking aids, and distraction and deep breathing techniques.

5.4 Extended use of stop smoking aids

There is good evidence that extended use of stop smoking aids can reduce the risk of relapse and this has been shown to be particularly true among people from priority groups, in particular people with SMI and people with co-addictions or complex needs. This can include the use of aids for 6 to 12 months.

5.5 Combination of two stop smoking aids

There is good evidence that combining varenicline and NRT increases success with stopping when compared to either medication alone. The addition of a second stop smoking aid is recommended for people with a high level of dependence, with past failed quit attempts with monotherapy, experiencing significant urges to smoke and withdrawal symptoms with a single treatment, or who have reduced but been unable to stop smoking completely. There is some limited evidence indicating combining varenicline with nicotine vapes as being superior to using vapes alone, however it is reasonable that combining either vapes or NRT with varenicline would produce similar effects, as both products deliver nicotine. Nicotine vapes and NRT can be safely and effectively combined to support more heavily dependent individuals.

6

Principle 6: Direct supply of stop smoking aids

The direct supply of stop smoking aids has been identified as particularly important in supporting clients from priority groups. NRT and nicotine vapes should be provided free of charge with minimal barriers to access to support temporary abstinence (not smoking for a specific period such as when admitted to hospital), harm reduction, abrupt stopping and CDTS. Provision of free stop smoking aids increases compliance and improves stop smoking outcomes and has been shown to be highly cost-effective. Research and insights work suggests the provision of cost-free stop smoking aids and direct supply may be particularly important for increasing the use of treatment among priority groups where multiple economic and other barriers exist.

7

Principle 7: Extended duration and intensity of behavioural support

People from priority groups experience higher rates of relapse following stopping. Extending behavioural support and stop smoking aids are two methods for reducing the risk of relapse.

7.1 Intensive support and extended treatment

Anticipate the need to provide more intensive stop smoking support (frequency of contacts) and for an extended duration of treatment (12 weeks or longer). This is particularly true for people with anxiety and schizophrenia spectrum disorder, other addictions and those facing multiple challenges.

7.2 Additional components of support

Be prepared to add additional components to the treatment plan over time as needed. This may include adding a second stop smoking aid, extending treatment support, adding digital support or more frequent contacts based on the patient's response to treatment.

High rates of relapse should be expected among clients from priority groups and having methods to normalise setbacks and re-engage clients in support is recommended. Policies and practices that allow clients to continue to access support over extended periods (12 weeks or longer) is good practice, as is allowing clients who do relapse to easily re-engage with support. Enabling clients to take a “break” from treatment and attempt to re-engage when they are ready can be useful for those with unstable life circumstances, or those who are experiencing a difficult period or have had a relapse: this should be viewed as part of the journey in helping people with complex needs to stop smoking.

8.1 Allow for a break in quit attempts

Understand that breaks within or between quit attempts are a normal part of the process and ensure clients don't see this as a failure. Agreeing to regular follow-ups keeps the door open, to reassess a client's interest in stopping smoking and to enable clients to re-engage with support quickly and easily whenever they feel ready.

8.2 Have methods to easily re-engage clients in support

Following relapse, establish whether the client is ready and willing to 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 is a few days, a few hours, or just general effort.

9.1 Advanced practice training

Practitioners delivering specialist support to priority groups should receive additional training to ensure they have the knowledge, skills and confidence to do so. Training should enhance practitioner confidence and competence in delivering behaviour change techniques (BCTs), particularly those related to motivation and ambivalence, as well as the advanced use of stop smoking aids, strategies for addressing urges to smoke, coping with stress, fostering a non-smoking identity and complex client needs. See Training and Resources section of this document.

9.2 Awareness training

In addition to training specific to stop smoking support, those designing and delivering services and support should also seek out local training/learning in awareness of working with different groups.

9.3 Recruiting from priority groups

When recruiting stop smoking advisors to work with priority groups it can be helpful – and is recommended good practice – to hire staff, when possible, with a background in working with people from priority groups including people with mental illness and people with drug and alcohol addictions.

10.1 Shared care

Members of the health and social care team should at minimum be made aware of, and ideally be actively involved in, the client's plan for stopping and/or reducing smoking. Having a formal shared role in supporting the client's plan helps boost consistency and reinforces progress across different care pathways. Social care staff can play an important day to day role in supporting individuals to adhere to treatment. They can do this by advising on the use of stop smoking aids and by offering encouragement.

10.2 Medications affected by smoking

Since clients in priority groups are more likely to use medications that are affected by smoking, a protocol for identifying smoking status, screening for potential interactions with medications and involving the appropriate prescriber is essential. Robust processes to ensure timely clinical review and medication adjustments when needed are vital to ensure client safety. A coordinated approach prevents adverse effects, helps stabilize symptoms and reinforces the importance of integrated care.

Training and Resources

Training

Tobacco Dependence Treatment: Advanced training course

Our NEW two-day Tobacco Dependence Treatment: Advanced Training Course provides training for stop smoking practitioners in tailoring tobacco dependence treatment for people who smoke, particularly people in priority groups.

www.ncsct.co.uk/publications/advanced-training-course

Tobacco Leads and Commissioners training course

This course for local authority tobacco leads and commissioners will increase participants' knowledge, skills and confidence in the organisation and commissioning of stop smoking services and aims to drive quality improvement, maximise service impact and contribute to reducing the rates of tobacco use, particularly among people in priority groups.

www.ncsct.co.uk/publications/tobacco-leads

Service Managers training course

This course provides local authority stop smoking service managers with the latest evidence and best practice for the targeting and tailoring of stop smoking service support to meet the specific needs of people who smoke, particularly those in priority groups.

www.ncsct.co.uk/publications/service-managers-course

Pregnancy and smoking cessation (eLearning)

This specialty course provides knowledge and skills training in tailoring stop smoking support to pregnant women.

https://elearning.ncsct.co.uk/pregnancy_specialty_module-registration

Mental health and smoking cessation (eLearning)

This specialty course provides knowledge and skills training in working with clients with mental illness.

https://elearning.ncsct.co.uk/mental_health_specialty_module-registration

Resources

Cut Down to Stop

As Cut Down to Stop (CDTS) becomes a first-choice treatment option for smoking cessation within local stop smoking services, the NCSCT will develop more resources to support this intervention. This page hosts resources to support local stop smoking services, practitioners and their clients with CDTS.

www.ncsct.co.uk/index.php/publications/cut-down-to-stop

Targeting and tailoring stop smoking interventions to priority groups: A rapid evidence summary

This briefing was informed by a rapid review of available evidence on targeting and tailoring stop smoking interventions/tobacco dependence treatment with a focus on national priority groups. The full report can be accessed here:

www.ncsct.co.uk/library/view/pdf/rapid-evidence-review-summary.pdf

Local Stop Smoking Services and support: commissioning, delivery and monitoring guidance

This document provides clear steps for commissioning, delivering and monitoring effective, evidence-based stop smoking support.

www.ncsct.co.uk/publications/commissioning-delivery-monitoring

Competency Framework for stop smoking practitioners

The National Training Standard was replaced with this competency framework in 2025 to reflect new evidence on tailoring treatment to people experiencing health inequalities. It identifies the knowledge and skills required by the tobacco dependence workforce to address the needs of priority groups and includes core and advanced competences.

www.ncsct.co.uk/library/view/pdf/competency-framework-for-stop-smoking-practitioners.pdf

Template protocol: Supply of Nicotine Replacement Therapy (NRT) for the treatment of tobacco dependence

The protocol outlines the use of NRT for the treatment of tobacco dependence and reflects latest evidence-based practice and national guidance. This template document can be downloaded below and modified by LSSS to reflect local service provision.

www.ncsct.co.uk/publications/template-NRT-protocol

