# *The Stolen Years*

## THE MENTAL HEALTH AND SMOKING ACTION REPORT

# Organisations endorsing this report

Action on Smoking and Health
Association of Directors of Public Health
British Heart Foundation
Cancer Research UK
Centre for Mental Health
Chartered Institute of Environmental Health
College of Mental Health Pharmacy
College of Occupational Therapists
Faculty of Public Health
Fresh North East
Healthier Futures
Mental Health Foundation
Mental Health Nurses Association
Mental Health Providers Forum
National Centre for Smoking Cessation and Training (NCSCT)
Primary Care Respiratory Society UK
Public Health Action
Rethink Mental Illness
Royal College of General Practitioners
Royal College of Nursing
Royal College of Physicians
Royal College of Psychiatrists
Smokefree Yorkshire & Humber
Tobacco Control Collaborating Centre
UK Centre for Tobacco and Alcohol Studies (UKCTAS)
Unite in Health
York Mental Health & Addictions Research Group

# *The Stolen Years*

The mental health and smoking action report

April 2016

www.ash.org.uk

# Foreword

This report is a call to action. It challenges defeatist assumptions that addiction to smoking amongst people with mental health conditions is either inevitable or intractable: it is not.

While smoking rates amongst the general population have fallen dramatically in the past few decades they have remained stubbornly high amongst people with mental health conditions. Seventy percent of those discharged from a psychiatric hospital are smokers. The result is lives cut short and in their final years lives blighted by heart and lung diseases, stroke and cancer. These are *the stolen years* - of life, of health and of wealth.

There is an urgent need for action to tackle this growing health inequality. A third of all tobacco now smoked in England is by someone with a mental health condition. Yet the desire to quit is just as strong as for the average smoker. These smokers do not lack motivation to quit but are more likely to be highly addicted and heavily dependent on tobacco, and therefore need more help.

When ASH asked smokers with a mental health condition if anyone providing inpatient care had offered them help to stop smoking two thirds told us no one had. Even among those who had been asked, few had been offered real support. Harm can occur not just when something happens, acts of omission cause harm too. For the goal of "parity of esteem" to be meaningful, people with mental health conditions need help to quit smoking.

Change can happen. This report documents what works to help people with mental health conditions quit. But to reverse the trends and return those stolen years leaders and professionals in every part of the health and social care system must act. Reversing decades of inaction requires a social movement across the whole system which hard wires service user and carer voice and experience into a common endeavour to support more people with a mental health condition become smokefree.

This is not a quick fix, nor will it be easy, but without a collective effort we will continue to condemn millions of the most vulnerable people in our society to needless death and disease.

**PAUL BURSTOW**

*Paul Burstow is a former MP and Health Minister. He is now Chair of the Tavistock and Portman Mental Health Trust and trustee of Action on Smoking and Health.*

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# Executive summary

Mental health conditions affect almost a quarter of the population who die on average 10-20 years earlier than the general population.

Smoking is the single largest cause of this gap in life expectancy.

People with mental health conditions smoke at higher rates and are more heavily addicted - around one third of adult tobacco consumption is by people with a mental health condition. As such they experience much greater smoking related harm.

Smoking rates among people with mental health conditions have barely changed at all over the last 20 years during a time when rates have been steadily falling in the general population.

People with a mental health condition are just as likely to want to stop smoking as other smokers but they face more barriers to quitting and are more likely to be dependant and therefore need more support.

Quitting smoking does not exacerbate poor mental health; in fact the positive impact of smoking cessation on anxiety and depression appears to be at least as large as antidepressants.

Action is needed to address the growing difference in smoking rates among those with a mental health condition compared to the general population. There is no single measure that will transform outcomes but a whole systems approach is needed that involves staff across mental health, physical health and social care, and empowers individuals to realise their goals of being smokefree.

Below we outline the high level ambitions that must be realised to drive down smoking rates. Each ambition is supported through a set of specific actions – these are listed on page 39.

# Ambition of this report

**Smoking among people with a mental health condition declines to be less than 5% by 2035, with an interim target of 35% by 2020.**

To be achieved by:

**AMBITION 1**: National and local leadership drives forward action that reduces smoking among those with a mental health condition.

**AMBITION 2**: People with a mental health condition are empowered to take action to reduce their smoking.

**AMBITION 3**: Staff working in all mental health settings see reducing smoking among service users as part of their core role.

**AMBITION 4**: Services for people with mental health conditions provide effective advice and support to quit smoking and access to appropriate specialist stop smoking models.

**AMBITION 5**: Local Authority funded stop smoking services (SSS) effectively support those with a mental health condition to quit smoking.

**AMBITION 6**: People with mental health conditions who access mainstream physical health services are routinely advised to quit smoking and sign-posted to effective support.

**AMBITION 7**: People with mental health conditions who are not yet ready or willing to quit are supported through harm reduction strategies.

**AMBITION 8**: All inpatient and community mental health sites are smokefree by 2018, through full implementation of NICE PH48 guidance and embedding support for service users who smoke.

**AMBITION 9**: Support to quit smoking for those with complex multiple needs and across different settings is appropriate and consistent.

**AMBITION 10**: Data regarding smoking status and progress towards quitting are collected in a timely and appropriate way in all settings and appropriately shared.
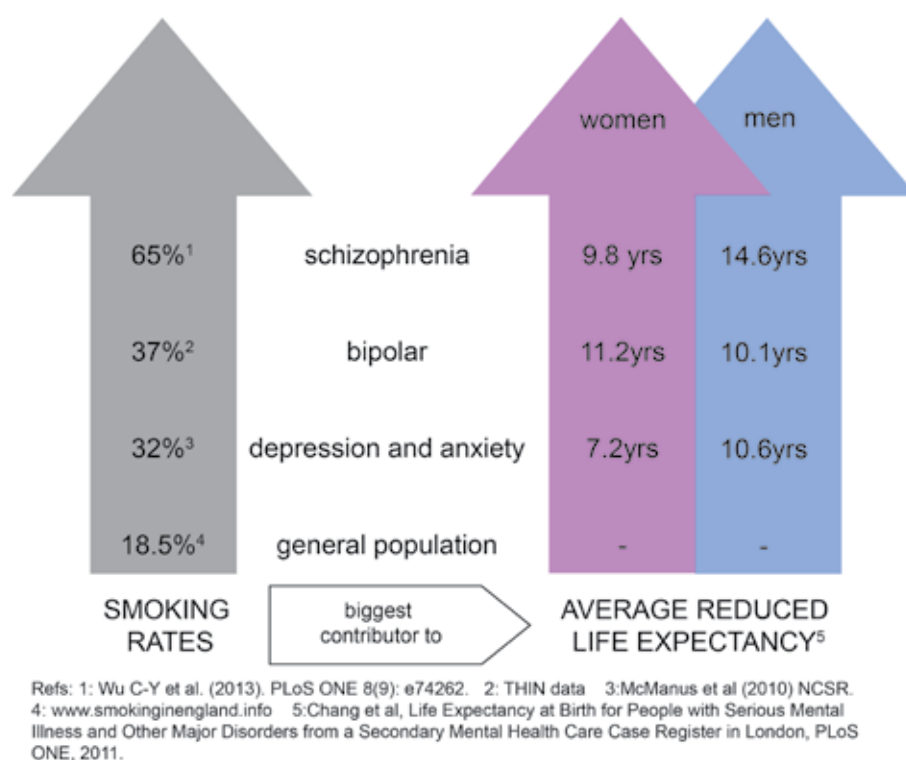
**AMBITION 11**: Populations at risk of developing mental health conditions are identified and appropriate interventions put in place to prevent uptake of smoking.

**AMBITION 12**: Robust evidence into the most effective means to sustainably reduce smoking rates among those with a mental health condition is available.

# Introduction

Smoking is the largest cause of preventable death in England. In 2013, smoking was responsible for over 78,000 deaths, 17% of all deaths in adults aged 35 and over that year.[1] Around one in four people in England experience a mental health condition in any one year, most commonly anxiety and depression.[2] Although mental health conditions vary widely, there is long-standing evidence that smoking prevalence is substantially higher among most mental health conditions, and increases with the severity of the condition.[3] Smoking rates are around 60% in those with probable psychosis,[2,4] and up to 70% for people in psychiatric units.[5] It has been clear for many years that people with mental health conditions die on average 10-20 years earlier than those without.[6,7,8] It is now clear that increased suicide rates are not responsible for this discrepancy but in fact it is due to socioeconomic, healthcare, and clinical risk factors[9,10] with smoking the single largest contributor to reduced life expectancy[11] (Figure1).

Figure 1: Smoking rates and average reduced life expectancy by mental health condition.



| SMOKING RATES | | AVERAGE REDUCED LIFE EXPECTANCY[5] | |
|---|---|---|---|
| | | women | men |
| 65%[1] | schizophrenia | 9.8 yrs | 14.6yrs |
| 37%[2] | bipolar | 11.2yrs | 10.1yrs |
| 32%[3] | depression and anxiety | 7.2yrs | 10.6yrs |
| 18.5%[4] | general population | - | - |

biggest contributor to

Refs: 1: Wu C-Y et al. (2013). PLoS ONE 8(9): e74262.   2: THIN data   3:McManus et al (2010) NCSR. 4: www.smokinginengland.info   5:Chang et al, Life Expectancy at Birth for People with Serious Mental Illness and Other Major Disorders from a Secondary Mental Health Care Case Register in London, PLoS ONE, 2011.

The 2011 cross Government strategy, 'No Health without Mental Health'[12] stated that: '*we are clear that we expect parity of esteem between mental and physical health services*'. In practice, this means that mental health should have the same value as physical health, and specifically that there should be equal access to the most effective and safest care and treatment and equally high aspirations for service users.[13]

In the last 20 years smoking rates for the general population have fallen significantly from around 27% in the mid-90s to 19% by 2014.[14] During this time however, rates among those with a mental health condition have not fallen, with smoking rates estimated to be at 40% throughout the last 20 years (figure 2). Successive comprehensive tobacco control strategies have made a real difference to smoking rates in the general population but have had limited impact on this group, and it is clear that a more targeted approach is needed. Compared with the general population, those with a mental health condition are more likely

to smoke and more likely to be heavily dependent. Even using a restricted definition of a mental health condition around one third of all tobacco smoked in the UK is consumed by those with a mental health condition.[11]

Reasons for the high rate of smoking in this population are complex, involving biological, environmental and social factors.[15] People with a mental health condition who smoke tend to be more heavily addicted to smoking, be part of peer groups where smoking is common and may not receive the same prompts and encouragement from health professionals to quit smoking.

Figure 2: Smoking prevalence in England, 1993-2013
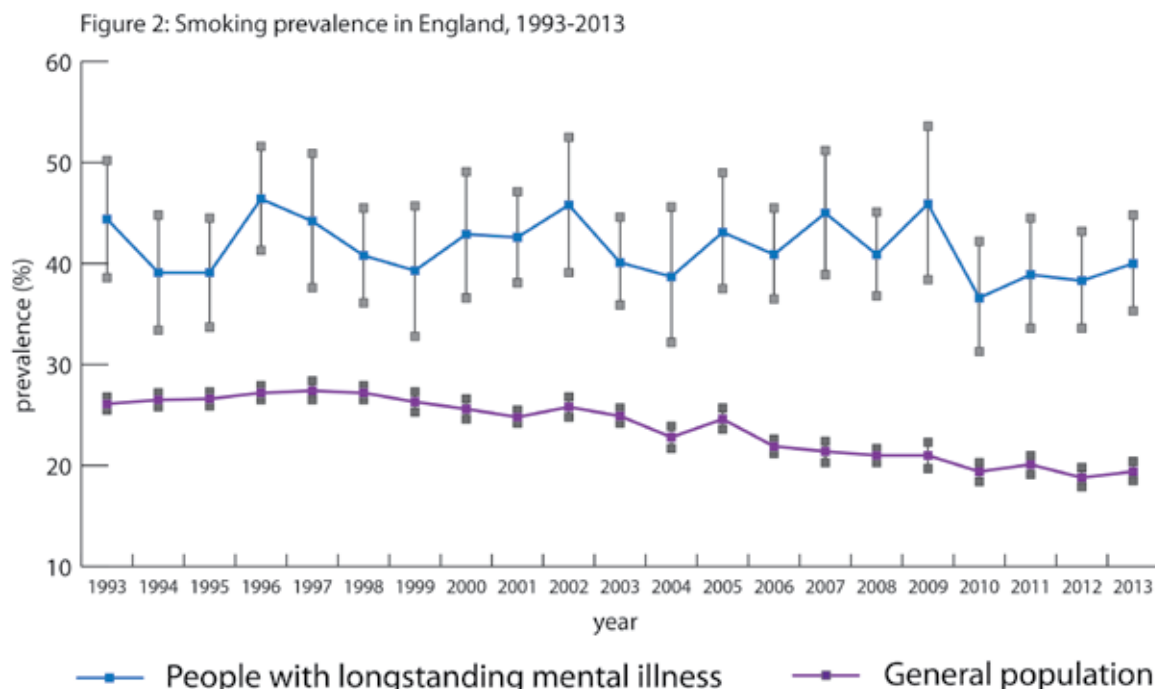
Adapted from: Szatkowski & McNeill. Diverging trends in smoking behaviours according to mental health status. Nicotine & Tobacco Research, 2015;3:356-60. http://ntr.oxfordjournals.org/content/17/3/356

Despite high rates of smoking and levels of addiction in this population, people with mental health conditions are no less likely to want to quit smoking but they expect to find it more difficult than the general population.[16] Health professionals can have low expectations about behaviour change among people with a mental health condition, seeing it as too difficult an issue to tackle. This lack of ambition among the workforce for the physical healthcare of those with a mental health condition is likely to have an impact, as prompts from health professionals have been shown to be an important driver in quit attempts among all smokers.[17] There is evidence that on a per consultation basis, primary care professionals are significantly less likely to intervene with smokers with a mental health condition than with those without.[18]

The higher levels of addiction among those with a mental health condition can mean that the fears people have they will not be successful at quitting are more likely to be realised. Access to appropriate medication and alternative sources of nicotine (such as electronic cigarettes) is therefore important in managing the physical symptoms of nicotine addiction. Too few people are using adequate levels of nicotine and more needs to be done to improve access to combat false perceptions of harm from nicotine held by both professionals and smokers.

For those who are moving in and out of mental health services where smoking rates are very high it can be the norm that people around you smoke. This can undermine attempts to quit but where peer groups quit together success rates can improve. There is a major opportunity to make better use of peer support models in smoking cessation support. While these models are increasingly a mainstream part of mental health provision they remain rare in supporting people to quit smoking.

For some with mental health symptoms smoking can feel like 'self-medicating' and people will say that it is an important way for them to deal with stress. However, this relief is temporary, linked to relieving withdrawal from nicotine, and in the long run can exacerbate symptoms.[19,20] As well as the extensive benefits from physical health of quitting smoking, there is also evidence showing benefits to mental health. Smoking cessation is associated with reduced depression, anxiety and stress as well as improved

positive mood and quality of life compared with continuing to smoke. The impact of smoking cessation on anxiety and depression appears to be at least as large as antidepressants.[17] Evidence also suggests an association between tobacco use and an increased risk of a number of other mental health conditions including psychosis,[21] Alzheimer's and dementia,[22] while smoking during pregnancy is associated with increased risk of conduct disorder[23] and ADHD symptoms[24] in children.

Smoking also places a significant financial burden on smokers with low incomes. While taxation is one of the most effective measures to reduce the level of smoking in the population, if individuals do not quit then the cost of continuing to smoke can significantly reduce household income. New research for this report shows high levels of smoking among those who have a mental health condition and are in poverty. In addition, around 130,000 people with a 'common mental health condition' are pushed into poverty as a result of smoking if their expenditure on tobacco is taken into account. For more information see page 32.

Tackling smoking among people with a mental health condition can also have a benefit to the overall health system. Mental health services are currently under great financial pressure. Around 40% of mental health trusts experienced reductions in income in 2013/14 and 2014/15, and only 14% of patients say that they received appropriate care in a crisis.[25] Smoking-related disease among those with a mental health condition cost the NHS an estimated £719 million in 2009/2010 (figure 3), and a recent study estimated the cost of facilitating smoking in four mental health wards as over £130,000 in six months.[26] This money could be put to better use in providing care for people with mental health conditions.



Figure 3: Costs due to smoking-related diseases among people with mental health conditions, 2009-10
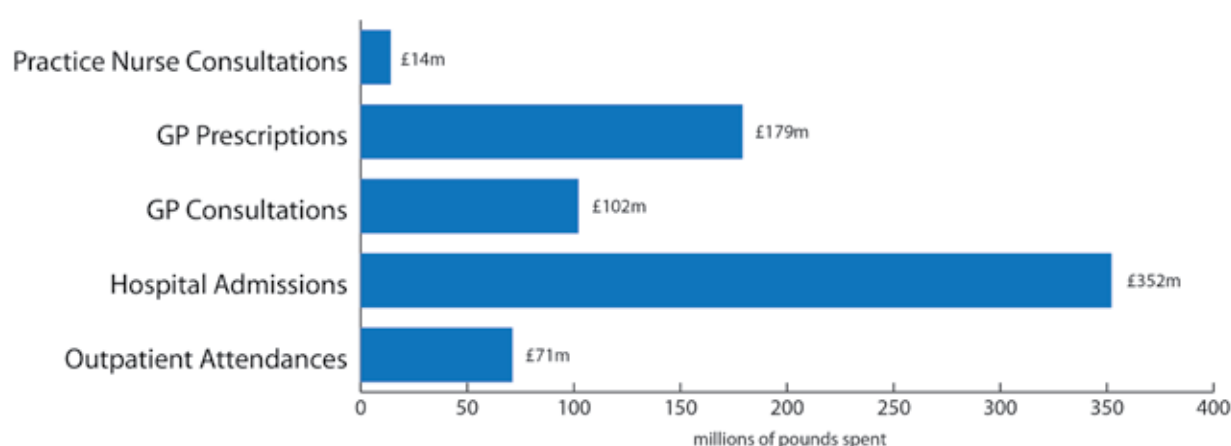
source: Royal College of Physicians and Royal College of Psychiatrists Smoking and Mental Health Report

## QUITTING SMOKING ASSOCIATED WITH IMPROVED MENTAL HEALTH
**Background**
A systematic review and meta-analysis was conducted to investigate change in mental health after smoking cessation compared with continuing to smoke.

**Results and conclusions**
Smoking cessation was associated with reduced depression, anxiety and stress, and improved positive mood and quality of life compared with continuing to smoke. The effect size was as large for those with psychiatric disorders as those without. The effect sizes were equal or larger than those of antidepressant treatment for mood and anxiety disorders.

**Implications for policy and practice**
Smoking cessation should be included as part of the standard treatment for mental health conditions. More research should be conducted into this association.

For more information please see:  Taylor G et al. Change in mental health after smoking cessation: systematic review and meta-analysis BMJ 2014; 348: g1151

# Background to the report

## Scope
Around one quarter of people with a mental health condition seek treatment for their condition, most frequently through primary care. However, among those with more severe conditions, up to 80% seek treatment2. People with mental health conditions will receive care and support in a range of settings, for example from their GP, Improving Access to Psychological Therapies (IAPT), Child and Adolescent Mental Health Services (CAMHS), community-based services, early intervention teams, crisis resolution, home treatment teams, outreach teams, forensic mental health services, inpatients services, secondary care for other conditions and through a social worker or a psychiatric liaison service. It is our belief that change is needed in all these settings to support people who smoke and have a mental health condition. The much higher rates of smoking in this population and the challenges they face in quitting smoking calls for a more targeted response. This report will, therefore, include all those in touch with any service a person with a mental health condition may come into contact with, including mainstream services, but with a greater focus on those with the highest level of need. Those with learning difficulties and those with dementia are not specifically referenced in this report and smoking rates are generally believed to be lower than among those with mental health conditions, although the evidence in this area is poor. However, there are different challenges to tackling smoking in these populations, and following this report ASH, the Royal College of Psychiatrists and others will work together to further consider this issue.

## Development
This report has been informed by the input of a wide range of experts and professionals from across public health, mental health and the wider NHS. This included an expert roundtable, workshops with front line staff, meetings with service user groups and collaboration with Public Health England's (PHE's) Mental Health and Smoking and Academic Network. A full list of endorsing organisations can be found at the front of this report.

The report has also been informed by surveys of staff working in mental health settings and people with a mental health condition. These surveys included questions about smoking behaviour and attitudes. The surveys were distributed through mental health charities and staff networks; 355 people with a mental health condition and 147 staff gave their opinions. While this is not a representative sample it does provide some interesting insights for this report and areas where more research may be required. For a full set of findings see the survey report at www.ash.org.uk/ashmentalhealth

ASH, with funding from Public Health England also commissioned new research looking at the relationship between poverty and smoking in this population. Researchers at Nottingham University have undertaken this unique piece of work using existing data sources to estimate the proportion of adults in the UK with a recognised mental illness who are living in poverty, and whose financial deprivation is exacerbated by expenditure on tobacco. The full report is available at www.ash.org.uk/povmentalhealth and results are reported on page 32.

This report also builds on important work that has been undertaken by others in recent years including:
- The Royal College of Physicians and Royal College of Psychiatrists 2013 report, Smoking and Mental Health[11]
- The Five Year Forward View for Mental Health, by the Mental Health Taskforce[27]
- The Mental Health Network's briefing on the importance of addressing smoking in the mental health population[28]
- Public Health England's work to support mental health units going smokefree[29,30]
- NICE guidance PH48 which sets standards for the delivery of stop smoking support in mental health settings[31]
- NICE guidance PH45, which sets standards for tobacco harm reduction approaches, for those who are likely to find it difficult to give up completely[32]
- The learning from Mental Health Trusts which have implemented fully smokefree sites

## Aim
This report sets out ambitions and specific actions for a whole care environment. This includes any setting in which someone with a mental health condition receives care whether for their mental health, physical health or social care needs.

# Strategic activity

**AMBITION OF THIS REPORT: Smoking among people with a mental health condition declines to be less than 5% by 2035, with an interim target of 35% by 2020.**

In 2013 the rate of smoking according to the Health Survey for England (HSE) was 21% for the general population and 40% for those with a long standing mental health condition. The evidence from the HSE indicates that smoking rates among those with a mental health condition have gone unchanged since the 1990s, while smoking among the general population has declined significantly. As a consequence the health inequalities faced by those with a mental health condition have grown over the last 20 years.

Action on Smoking and Health's 2015 report, *Smoking Still Kills*, called for ambitious national targets for different parts of the population to ensure that by 2035 smoking rates are no higher than 5% for all socio-economic groups. In seeking parity of esteem, this target should be the same for those with a mental health condition. Achieving this goal for the routine and manual group in the general population is extremely ambitious and requires a 0.8 percentage point decline every year. To achieve the same goal for the population with a mental health condition would require an almost 2 percentage point decline annually. Given the lack of progress of the last few decades such a change would be a remarkable achievement but if we are to make real progress to close the gap in smoking prevalence then it is a goal we must aim for.

The 12 ambitions of this report will feed into our overarching ambition to combat this growing inequality. Figure 4 shows what would happen: if there is no change in the current rate of smoking amongst those with a mental health condition; if there is a decline at the same rate as the ambition for the routine and manual population; and if the rate of decline is at the level necessary to reach less than 5% by 2035.

Figure 4: Trajectory of reduction in smoking rates in those with a mental health condition.
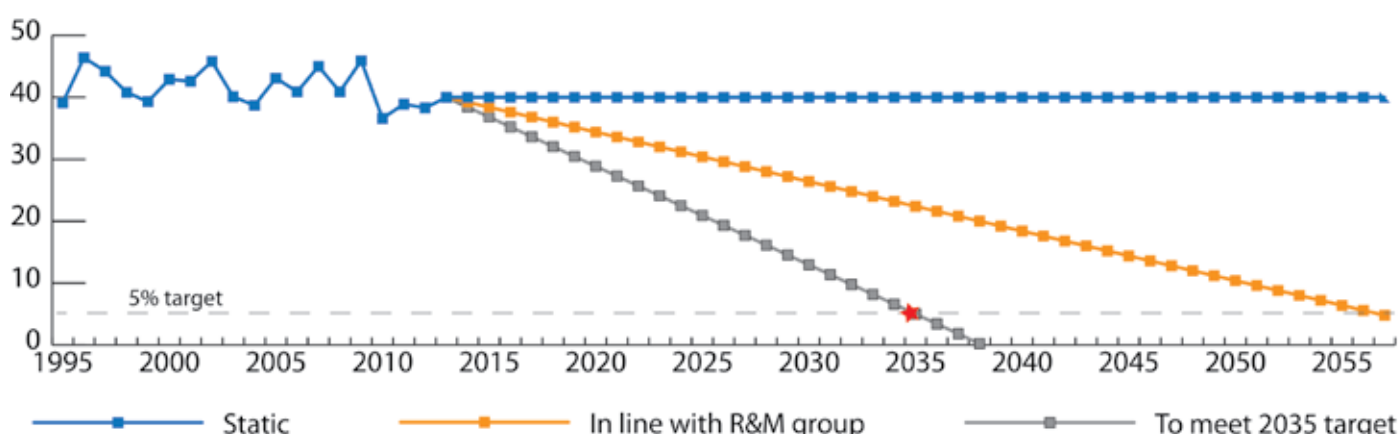


**Given the substantial challenge of achieving any rate of decline we propose a strong ambitious interim national target of less than 35% by 2020 to set a clear goal for the health and social care system and drive action. Progress towards this target should be reviewed in 2020, when we will need to build on this success and review how progress can be sped up in order to reach 5% by 2035.**

The HSE data shown above is currently the best measure available of the rate of smoking in the population with a mental health condition. However there are problems with these data. Due to small samples, the confidence intervals are wide and many of those with the highest levels of need are not included, in particular those currently admitted as inpatients, as HSE is a household survey. As such better measures should be identified and any target reviewed as a result. One possible route to achieving a more robust measure of smoking is the Mental Health and Learning Disabilities Data Set (MHLDDS), which could improve the accuracy of this measure and ensure those with more severe conditions are included.

To support a national target, local commissioners should also seek to set appropriate local measures of success as part of driving change.

A more detailed discussion around data needs is on page 34.

*Specific actions*
- *Ambitious national targets to reduce smoking among people with a mental health condition should be set by national Government, using the Health Survey for England to measure progress. An interim target of 35% by 2020 is set from the current level of 40%. A separate target for inpatient settings should also be considered, recognising the specific challenges in this setting.*
- *Local Authority and Health Commissioners should develop local measures of success that will contribute to reduce smoking rates among those with mental health conditions and build these into contracts for primary care, secondary care, secondary mental health care, IAPT, social care, and specialist stop smoking services.*

**AMBITION 1: National and local leadership drives forward action that reduces smoking among those with a mental health condition.**

Steadily reducing smoking rates among people with a mental health condition requires a joined up approach across primary care, secondary mental health care, IAPT, social care, pharmacies and the third sector  which may not currently operate in a co-ordinated way at a local or national level. As such leadership at every level will be crucial to ensure that progress is made.

In line with government strategy,[12] a national level strategic commitment to addressing smoking among people with a mental health condition is needed which is underpinned by high level actions, investment and incentives for systems to change. Many agencies have a role in this including NHS England, the Department of Health and Public Health England.

Voluntary sector providers who are already supporting those with a mental health condition to stop smoking and demonstrating leadership in this area should continue to do so.  In addition, the wider non-governmental sector, including voluntary sector organisations working in mental health, public health and the academic community, should continue to drive this agenda forward working with Government organisations to ensure the ambitions of this report are realised.

At a local level Health and Wellbeing Boards are the strategic and co-ordinating hub of local health and social care systems. They have a unique opportunity to work together with local Directors of Public Health to exploit their strategic and operational overview of activity across the system. They should inform their work using high quality Joint Strategic Needs Assessments, and ensure incentives are aligned and organisations supported to achieve change.  All these organisations listed above must work together to develop this agenda.

*Specific actions*
- *Strong commitments to reducing tobacco dependence among those with a mental health condition must be included in the next Department of Health Tobacco Control Strategy.*
- *National leadership from NHS England, the Department of Health and Public Health England is needed to ensure treating tobacco dependence in this population is a priority area for action.*
- *Organisations across public and non-governmental sectors should work together to reduce smoking.*
- *Primary care, specialist stop smoking services, IAPT, secondary care, social care, voluntary and community services should lead by example in supporting those with a mental health condition to quit or reduce smoking.*
- *Health and Wellbeing Boards must ensure there are co-ordinated local approaches to reducing smoking among people with a mental health condition.*
- *Local Authorities should estimate the number of smokers with mental health conditions and the proportion receiving cessation interventions in primary care, specialist stop smoking services, IAPT, social care and secondary care as part of their Joint Strategic Needs Assessment, as recommended by NICE (2013) to inform commissioners about the size of unmet need locally.*

# Culture, workforce and training

**AMBITION 2: People with a mental health condition are empowered to take action to reduce their smoking.**

Most people who smoke say they want to quit at some point and are concerned about the impact smoking might be having on their health.[33] People with a mental health condition are no different from the general population. Although not representative, the survey of 355 people with a mental health condition conducted for this report found the desire to quit was high, with 55% wanting to quit, and a quarter of these within the next three months.[34] This is similar to the finding from the Health Survey for England, which found 66% of those with a mental health condition wanted to quit.[16] People were also concerned about the impact of smoking on their health with 64% agreeing that this worried them.[34]

Despite their concerns about smoking and desire to change future behaviour, respondents to the ASH survey reported that smoking was not being routinely discussed with them in health and social care settings. Of those who smoked, 43% said they had not been spoken to by any health professional about their smoking in the past year. Of those who had been asked, 23% said they were not always advised to stop while 37% said they were advised to stop but not always offered any help to do so.

> *"[It was] suggested I wait until my mental health problems and stressors have eased before giving up smoking"*

The survey found that 83% of those who smoked had made a quit attempt in the past and 30% of respondents described themselves as ex-smokers. People with a mental health condition both want to quit smoking and can do so. However, many people spending time in mental health services are likely to be surrounded by others who smoke which undermines people's attempts to quit. Conversely we know that when people quit with their peer group the likelihood of success increases.[35]

There is a key role for peer support workers (PSWs) in improving outcomes around smoking.[36,37] A research project by the East London Foundation Trust is examining the role of PSWs in empowering service users to quit tobacco, and Rethink Mental Illness's innovation network has been gathering evidence that shows the benefits of peer support (see box).

There are many untapped opportunities to empower smokers with a mental health condition. As part of continuing our commitment to realising the ambitions of this report ASH undertakes to work with service users to better understand those opportunities and make recommendations for how they could be delivered.

*Specific actions*
- *Mental health settings should identify service user 'stop smoking champions' to work with staff and service users to support more people to move away from smoking.*
- *All smokers with a mental health condition should be provided with clear, evidence based information about different options to quit or reduce the harm from smoking by primary care, social care, IAPT, specialist stop smoking services, secondary care services and pharmacists in a coordinated way.*
- *Carers, friends and family members should be provided with advice and information about how best to support those with a mental health condition to address, reduce and stop their smoking.*
- *Service users are included in the development of services designed to support people to quit or reduce the harm from smoking.*
- *People with a mental health condition should be supported to develop alternative occupations to smoking, to help establish new healthier routines.*
- *ASH in partnership with service user groups will produce a report on further opportunities to empower those with a mental health condition who smoke to become smokefree.*

## SMOKING CESSATION ADVICE THROUGH PEER SUPPORT

Through Rethinks' Innovation Network, evidence has been gathered from five mental healthcare providers regarding different approaches to smoking cessation in a range of service types. An area of particular impact from within this evaluation is the added value of training peer supporters to deliver advice about the range of NRT available and signposting others towards stop smoking support, particularly within inpatient settings.

An individual's lived experience of going smoke-free can provide a powerful narrative and inspiration to others within the same service. The ability of a peer supporter to be available on an ad hoc basis can add to the level of support provided by staff. Skilling peer supporters with additional training can empower the individual, and providing peer support for others has been seen to have a positive impact on an individual's mental health.

There are many benefits of utilising existing peer support systems to deliver smoking cessation advice within inpatient settings. Peer support is often a key part of an individual's induction to a new ward or unit, which is likely to coincide with a change in their smoking status on a smoke-free site. We know this is a challenging time, and additional support from peers can connect with an individual on a different level to a staff member.

The lived experience of a peer supporter can also add value to the support that they are giving. This may include familiarity with the available smoking support services, and experiences of different types of NRT. We know that the evidence behind individualised support demonstrates it leads to better outcomes, and peer support can play a key role in this.

**AMBITION 3: Staff working in all mental health settings see reducing smoking among service users as part of their core role.**

Continuing the change of culture in mental health organisations is vital to successfully reduce smoking in this group. Treating smoking in mental health populations has previously been neglected in these settings[38] and smoking related interventions and policy have been less popular among mental health staff than other health care professionals.[39] There is evidence that cigarettes have even been used as a patient management tool by staff.[31,40]

More recently, this culture does seem to be changing.[41] A recent study found that 89% of mental healthcare staff felt that addressing patients' smoking would not have an adverse impact on the therapeutic relationship and that 81% did not think that quitting smoking during treatment would have a negative impact on their recovery.[42] However, this study also showed that only 48% of the respondents felt that addressing smoking was within their remit of responsibility as a mental health professional.

There are limited data on rates of smoking among mental health nurses, with prevalence estimated at between 17% and 40%.[11] However, there is evidence that nursing staff have begun smoking as a result of exposure to the smoking culture in mental health settings.[34] Helping staff to quit smoking is not only beneficial for their own health but allows them to be a role model for their patients. A number of studies have found that staff who are current smokers are more likely to hold negative beliefs about smokefree policies.[43]

The ASH survey of 147 staff working in mental health and related occupations revealed a number of positive findings:

- 76% agreed that patients using mental health services should be encouraged to quit smoking
- 93% believed that staff should be trained to offer advice and support, and
- 59% felt that encouraging patients to quit was part of their role.

However, views varied between smokers and non-smokers. Of the respondents 18% smoked and they tended to be more negative about the opportunities to quit smoking and less likely to routinely raise the issue with patients.

A quarter (26%) of staff respondents felt that addressing smoking would have an adverse effect on their therapeutic relationship, and 23% felt that quitting smoking during treatment for a mental health condition would have a negative impact on recovery. This differed by smoking status, for example 62% of respondents who smoked thought that addressing smoking would have a negative effect on the therapeutic relationship, compared with 19% of ex and never smokers. Training also impacted on responses. Where staff had received smoking cessation training they were more likely to be positive about the opportunity to help people quit, to raise smoking with patients and are less concerned about the impact on therapeutic relationships. This indicates that there is still work to do and specific training on these issues would be beneficial.

Staff groups in both inpatient and community settings will benefit from a better understanding of the negative impact smoking has on people with a mental health condition and the action they can take to best support them to change their behaviour. There is a role for all professionals including doctors, nurses, care workers, pharmacists, social workers, occupational therapists, counsellors, psychologists and others.

Staff have an important role to play in setting the culture of mental health services and prompting the opportunity of quitting, particularly in a context where most smokers want to quit. Staff working with this group can help people to develop alternative activities to smoking, to break their dependence and establish new healthy routines.

### *Specific actions*

- *In all environments in which care and support is provided to people with a mental health condition there should be a dedicated senior staff member who is the 'stop smoking champion', supported by a cross-disciplinary committee where appropriate. They should have responsibility for ensuring smoking is being addressed among service users.*
- *Mental health care settings should ensure all staff working with those with a mental health condition are trained in very brief advice (VBA), and those who are assisting patients to temporarily abstain or quit smoking are trained to a minimum standard described by the NCSCT. This should include communicating the relative safety of alternative sources of nicotine, prescribing medications, behavioural support and referring for further support where appropriate.*
- *There should be a good understanding among staff in all mental health settings about the benefits to service users of quitting smoking including improved physical and mental health, reduced need for antipsychotic medication and greater disposable income.*
- *The NCSCT should be funded to develop an enhanced VBA training module for mental health staff that serves as a bridge between the short VBA module and the full NCSCT training and assessment programme.*
- *Health Education England should support training in the effects of smoking and its prevalence among those with a mental health condition, as well as methods of cessation and harm reduction in standard training for mental health nurses, clinical psychologists, psychiatrists, occupational therapists, psychological therapists and other allied health professionals.*
- *Strategies should be in place to support staff in all mental health settings to quit smoking.*

# Service delivery

**AMBITION 4: Services for people with mental health conditions provide effective advice and support to quit smoking and access to appropriate specialist stop smoking models.**

The Adult Psychiatric Morbidity survey shows that most people who have a mental health condition will not go into a hospital setting and will never have an inpatient stay.[2] While many people who would benefit from treatment for their mental health condition still do not receive it those who do will access a range of support delivered in different settings by a wide range of providers. All services which provide support to people with the most acute mental health problems are likely to see the highest levels of smoking.

It is therefore appropriate that all services for those with a mental health condition are aware of the smoking status of their service users and seek to ensure their staff are trained to treat tobacco dependence including understanding pharmacotherapy and evidence based behaviour change interventions. This is in line with the Mental Health Taskforce Report's recommendation that services should be integrated. It states that: '*physical health checks and smoking cessation programmes should be made available for everyone with a severe mental illness*'.

There are many services which support people with mental health conditions that need to take concerted action to support their service users who smoke. These include primary care, IAPT, social care, community-based services, early intervention teams, crisis resolution and home treatment teams, outreach teams, forensic mental health services, inpatients services and psychiatry liaison services.

Treatments to help people quit smoking that work in the general population work for those with a mental illness regardless of the severity of the illness.[32] They are equally effective, and do not worsen mental state.[44,45] In fact, evidence suggests they may have a positive impact on mental wellbeing.[46] However, people with a mental health condition face significant barriers to quitting, in particular higher than average levels of addiction and being part of peer groups where smoking rates are high. As such, they are likely to need more intensive support to quit smoking and will benefit from programmes tailored to their needs. Of particular importance for this group is access to stop smoking medications in a timely way and in sufficient quantity.

Another effective means of supporting individuals to reduce or quit smoking is providing access to peer support which has been shown to be effective in this group.[47,48] It should be routinely facilitated for those with a mental health condition to increase their chances of a successful quit attempt.

The environment in which an individual with a mental health condition receives care includes many diverse and fragmented services. There is a real challenge to ensuring continuity of care across the different parts of the system including the provision of support to smokers to quit. For example, a person who quits smoking during an inpatient stay is likely to benefit from some support to prevent them from relapse when they are discharged. However, existing contracts and service configuration make it unlikely they would be routinely offered this support.

What is needed are clear, joined up treatment pathways across a locality that are ambitious about reducing harm from tobacco for the whole mental health population. In-reach by stop smoking services into mental health services could help to ensure continuity of care. However, there must also be links with other services that a person with a mental health condition may come in to contact with, for example GPs, acute services, voluntary sector services and social workers. Relapse prevention is vital in this group and must form part of the care pathway, and special attention must be paid to individuals following discharge from an inpatient unit by linking them in with community services and their GP.

The quality of support to service users must be driven by commissioning and reinforced through the inspection process. Local and national drivers are needed to incentives change in all mental health care settings.

When developing services for those with mental health conditions, the vison of the National Survivors User Network (NSUN) is that there should be service user involvement embedded at all stages of the decision-making process. They have developed the National Involvement Standards,[49] with the aim to 'hard wire' the

service user and carer voice and experience into the planning, delivery and evaluation of health and care services. They are inspired by the motto, "Nothing about us, without us". This document and its principles need to be taken into account by all those developing services and support and conducting research.

### *Specific actions*

- *All residential and community mental health settings should support quitting smoking by providing brief advice, in-house specialist tailored stop-smoking support or referral to appropriate stop smoking services. For hospital settings, on-site tobacco dependence treatment services should be established.*
- *Local Authority commissioned stop smoking services should be funded to support community and in-house mental health staff with appropriate training and mentoring to deliver to the necessary levels of intervention, as detailed above.*
- *Mental Health Trust Boards, Clinical Commissioning Groups and commissioners of mental health services should ensure that delivery of NICE standards in relation to smoking, specifically PH48 and PH45, is a pre-requisite of services being commissioned.*
- *Stop smoking support and appropriate signposting should be embedded in mainstream and community based mental health services.*
- *There should be clear policies which enable timely access to appropriate pharmacotherapy in all care settings for people with mental health conditions, including:*
  - *easy and affordable access to pharmacotherapy in the community for both quitting and cutting down*
  - *on arrival at an inpatient ward, patients should have access to nicotine replacement therapy (NRT) within 30 minutes (see box for possible arrangements to do this).*
  - *NRT should be available for as long as it is needed at a sufficient dose and frequency*
  - *combination NRT or varenicline should be seen as first line medications for those wishing to cut down or quit*
- *An agreed tobacco dependence treatment plan should be included in the collaborative care plan of all service users who smoke.*
- *Access to peer support should be available for people with mental health conditions attempting to quit smoking.*
- *The Care Quality Commission (CQC) should provide a short guidance for inspectors of inpatient and community mental health settings of what is needed, including adequate tobacco dependence treatment, access to pharmacotherapy, and appropriate implementation of a smokefree policy.*
- *NHS England should develop an appropriate national CQUIN to promote and incentivise NICE recommended treatment for tobacco dependence among people with a mental health condition.*
- *Service users and carers are included at all stages during the planning, delivery and evaluation of health and care services designed for those with mental health conditions.*

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### STOP SMOKING MEDICINES ARE EFFECTIVE TO HELP PEOPLE WITH SEVERE MENTAL ILLNESS (SMI) TO QUIT SMOKING

**The study:** A systematic review and network meta-analysis of the efficacy and tolerability of medicines to help people with SMI stop smoking.

**What did it find?** 17 randomised controlled trials included 356 smokers in the efficacy analysis and 423 participants in the tolerability analysis. Both bupropion and varenicline were more effective than placebo [odds (OR) = 4.51, 95% credible interval (CrI) = 1.45–14.04 and OR = 5.17, 95% CrI = 1.78–15.06, respectively]. There were no significant differences in tolerability.

**Implications for policy and practice**: bupropion and varenicline are effective and tolerable for smoking cessation in adults with serious mental illnesses; however there is a need to maximize the provision of these effective smoking cessation therapies on a much broader scale than is currently practised.

Roberts, E., Evins, E., McNeill, A. & Robson, D. (2016) Efficacy and tolerability of pharmacotherapy for smoking cessation in adults with serious mental illness: a systematic review and network meta-analysis. Addiction 111 (4) 599–612.
www.ncbi.nlm.nih.gov/pubmed/26594837

## MIND ABERYSTWYTH AND MIND PEMBROKESHIRE: QUIT SMOKING PROGRAMME FOR MENTAL HEALTH & USE OF CARBON MONOXIDE (CO) MONITORS.

**Background**

Mind Aberystwyth and Mind Pembrokeshire partnered to deliver a smoking cessation service for anyone with a mental health condition.

**Stop smoking workers provide:**
- An initial no-commitment educational session
- Weekly one-to-one sessions with the same person, as well as ongoing phone support
- Nicotine Replacement Therapy (NRT) meaning people do not need to visit their GP
- Access to other Mind services, such as drop in sessions or art groups
- CO monitors which they found to be highly effective at motivating and evidencing results for clients.

**Results**
- 40 smokers used the service between April 2014 and April 2015 and 24 (60%) of those successfully achieved a four week quit
- The staff have also successfully quit smoking
- All staff have been trained in delivering brief interventions.

**Staff feedback:**

*"As advisors we are always asked – can I do the machine today?...We have often found that those who tested their CO reading have in a few weeks returned and asked for a service, where in the past they declined…Seeing somebody achieve their 3rd or 4th low CO reading is amazing."*

**Service user feedback:**

*"I used to smoke 40 a day, I was so addicted, I used to wake up in the middle of the night to have a smoke....giving up was easier than I thought with Mind, I've got more money to buy the things I want"*

*"I've tried on numerous occasions before to give up smoking, but it's never lasted more than a few weeks.....since the support I've had here, I've gone the distance and it's been months now, it's been brilliant!"*

**Lessons for policy and practice**

The whole-team approach works – cravings and tough moments can come at any time. Our success has been that a client can access the drop-in centre, go to any of the sessions on offer through our service, even phone our receptionist and have a brief conversation about their quit attempt.

For this client group an isolated one-to-one visit with a smoking cessation practitioner doesn't work as well.

**AMBITION 5: Local Authority funded stop smoking services (SSS) effectively support those with a mental health condition to quit smoking.**

Only around one quarter of people with a mental health condition seek treatment for their condition, and most frequently in primary care.[2] For this reason local stop smoking services may well be treating people with a mental health condition who have not sought treatment for their mental health condition.

From the ASH survey of 355 people with a mental health condition who responded to the survey of the 83% of smokers and ex-smokers who had attempted to or successfully quit, 54% had used will power alone (compared with around 50% in the general population), 33% had tried NRT (compared with 30%) and 28% had used electronic cigarettes (respondents could choose more than one option). The survey also found that 16% of those who attempted to quit had used local stop smoking services.[33]

While not all smokers, including those with a mental health condition, will need a treatment service in order to quit smoking, for most smokers it will significantly improve their chances of quitting successfully. Research shows that smokers can improve their chance of quitting by up to four times compared to quitting unaided.[50]

Access to effective treatment services is particularly important for people with a high level of tobacco dependence who may find it more difficult to quit. Currently access to specialist support is being eroded in England[51] and access for those with a mental health condition is therefore variable. Locally public health commissioners, CCGs and Trusts must seek to ensure that those with the highest level of need have access to specialist support.

In addition stop smoking services are not always configured in a way that best meets the needs of people with mental health conditions both in terms of where they are delivered, their measures of success and the extent to which they meet the needs of smokers who may face additional barriers to quitting. Using learning gained from the experience of service users can reveal new ways of working which address some of these challenges. Developing these approaches requires both commissioners and service providers to adapt their current approaches.

An area of treatment services which is not currently well established or understood is that of relapse prevention. People with the highest level of addiction are more likely to relapse to smoking. Specialist support at times when relapse might be more common, for example when transferring between inpatient and community settings, may play an important role in addressing smoking long term in this population.

*Specific actions*

- *Stop smoking practitioners should be trained on the specific issues around mental health and smoking including the importance of liaising with primary and secondary care staff about the impact of quitting and relapse on anti-psychotic medication dosage.*
- *Stop smoking services should routinely ask about mental health conditions and record this information.*
- *Stop smoking services should have a "mental health champion" to ensure that those with mental health conditions receive appropriate treatment and support.*
- *Stop smoking services should have clear protocols with local mental health services including development of in-reach and outreach models of support.*
- *Greater attention should be paid to models of relapse prevention, especially for those identified at high risk of relapse.*
- *There should be a specific harm reduction plan for those with a mental health condition who do not want to or are finding it difficult to quit.*
- *Commissioners of stop smoking services should identify appropriate measures of success and appropriately incentivise services aimed at those with mental health conditions, for whom four-week quits may not be appropriate.*
- *Barriers to engagement with cessation services of those with mental health conditions should be identified and addressed.*

## THE LONDON CLINICAL SENATE CO4 CAMPAIGN

The vision of The London Clinical Senate is that every London clinician knows the smoking status of each patient they care for and has the competence and the commitment to encourage and support that patient to quit or reduce their consumption through direct action or referral. They are asking all London's health organisations to commit to CO4:

- The 'right' COnversation for every patient and staff member who smokes that gives him or her a chance to quit, referring if necessary.
- Make routine desktop exhaled carbon monoxide (CO) monitoring by clinicians possible: "Would you like to know your level?"
- COde the intervention so we can evaluate effectiveness – including death certification.
- COmmission the system to do this right: so right behaviours incentivised systematically.

For more information see: www.londonsenate.nhs.uk/helping-smokers-quit/

**AMBITION 6: People with mental health conditions who access mainstream physical health services are routinely advised to quit smoking and sign-posted to effective support.**

For a number of years there has been growing concern about the inequalities in death and disease experienced by those who have mental health conditions. Life expectancy and healthy life expectancy is lower than in the general population. Cancer, diabetes, respiratory and cardiovascular conditions, are all more common among those with a mental health condition.[52,53] All these conditions are caused by and exacerbated by smoking. Since smoking is the largest single cause of preventable death for people with mental health conditions, tackling smoking can, in many, prevent conditions from ever developing. But even once people have become ill, treating tobacco dependence is a highly clinically effective and cost effective measure and improves the likelihood of recovery.

Not everyone with a mental health condition will access mental health services but many will routinely access healthcare through primary and secondary care. For most people with a mental health condition, primary care is the first place they will seek treatment, and is the place they will be seen most often. From the Adult Psychiatric Morbidity Survey, 38% of those with a common mental health condition and 67% of those with a psychotic disorder had spoken to their GP in the last year.[2] The 2014 document, 'Primary Care Guidance on Smoking and Mental Disorders', sets out the key role of primary care in this population and provides treatment guidelines.[54] There is evidence that on a per consultation basis, primary care professionals are significantly less likely to intervene with smokers with a mental health condition than with those without.[18]

Systematic provision of evidence based support to all smokers in these settings could help to improve outcomes for those with a mental health condition but particular attention should be paid by services where smokers have an identified health condition.  Opportunities exist during these contacts to promote the benefits of quitting smoking by engaging individuals in conversations which support them. This includes provision of information, signposting or referral for specialised support, and encouragement to make healthy behaviour change. Supporting ex-smokers towards exercise and healthy diet is also central to maintaining abstinence from tobacco particularly given the increased risk of short term weight gain from quitting smoking.

There is an opportunity to improve provision of information to those with a mental health condition through ensuring that all professionals 'Make Every Contact Count' with all patients including those with a mental health condition.[55]

The London Clinical Senate recommends that every clinician knows the smoking status of each of their patients and uses carbon monoxide monitors as a way of motivating patients to take action (see box above).

*Specific actions*
- *Stop smoking support and appropriate signposting for those with mental health conditions should be embedded in primary care: Tobacco dependence treatment should be offered to everyone with a mental health condition accessing primary care services.*
- *Care should be provided in the community in a holistic way - mental and physical health needs are addressed, and each person receiving care should have access to a selection of health care professionals treating all of their health care needs.*
- *People with a mental health condition who develop a physical health condition should be provided with targeted support to quit in primary and secondary care.*
- *The use of CO monitors as a motivational tool is trialled.*
- *Health Education England should ensure that all professionals seek to Make Every Contact Count among those with a mental health condition in relation to smoking and other harmful behaviours.*

**AMBITION 7: People with mental health conditions who are not yet ready or willing to quit are supported through harm reduction strategies.**

The best way to reduce harm from tobacco smoke is to stop smoking altogether. However, for some smokers, especially those highly dependent on tobacco, it may be difficult to quit smoking in one step. While there is no safe level of smoking there are a number of ways in which people can be moved closer to quitting or to replace their smoking with alternative sources of nicotine for the short or long term[56] which also increases the chance of successfully stopping smoking altogether.

Around a third of all the cigarettes smoked in England are smoked by people with mental health conditions, and these people are more likely to be heavily addicted to cigarettes than other smokers[11] (Figure 5). Initiatives like 'cut down to quit', supplying sufficient NRT and supporting temporary abstinence can help people to move away from smoking in accordance with the NICE harm reduction guidance (PH45).[37]

One of the major barriers, both to people quitting and switching to safer forms of nicotine, is the lack of understanding of the relative safety of nicotine compared with other components of tobacco smoke. While people are addicted to nicotine it is the smoke and other chemicals in tobacco smoke which cause death and disease: as Professor Michael Russell said in 1976, people "*smoke for the nicotine but they die from the tar*".[57] There is widespread misunderstanding about this both among smokers and health professionals. More needs to be done to better communicate the relative safety of alternative sources of nicotine to staff and smokers.

The prolonged use of safer alternatives to tobacco has been shown to increase success at stopping smoking in the future[37] and where people continue to use alternative sources of nicotine rather than smoke this will substantially reduce the harm they are exposed to.[58,59] From the ASH survey around one third of respondents who were current of ex-smokers had used NRT; 28% had used an electronic cigarette in an attempt to quit; and 67% were in agreement that e-cigarettes should be available for use in mental health services as an alternative to smoking.[33]

Many smokers are already engaged in some kind of harm reduction activity, for example, trying to cut down or abstain from smoking inside. They can be supported to make this activity more successfully by encouragement to combine this with using another source of nicotine and, ultimately, to stop using tobacco altogether.

Figure: 5 The proportion of smokers heavily addicted to cigarettes according to mental health diagnosis.
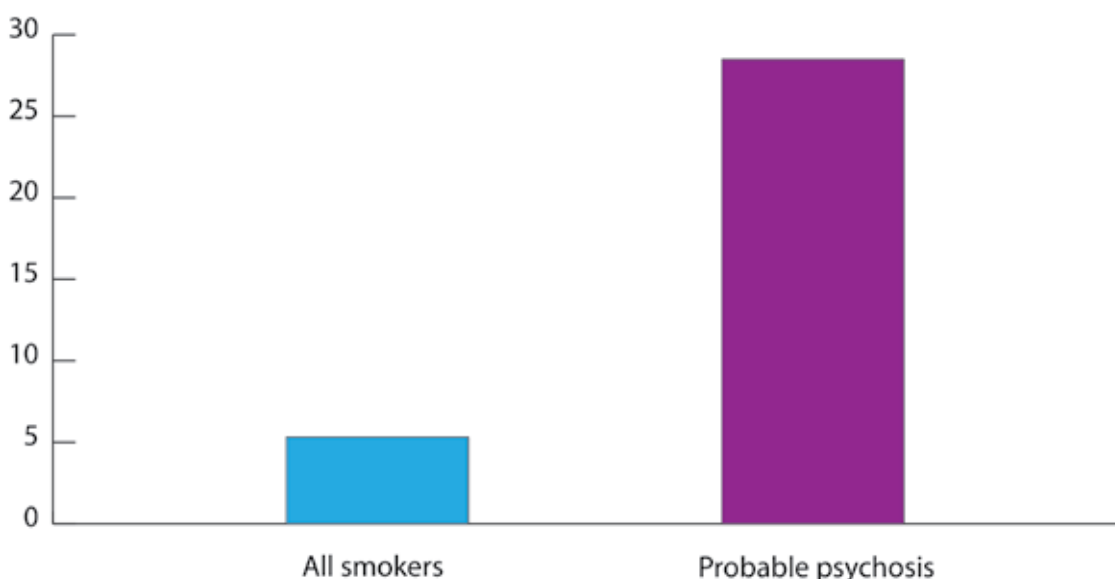


Ref: Adult Psychiatric Morbidity Survey 2007 & RCP & RCPSYCH Smoking & Mental Health report 2013.

*Specific actions*

- *The methods outlined in NICE PH45, 'Smoking: Harm reduction', should be implemented for all those with a mental health condition who are unwilling or unable to stop smoking completely.*
- *Evidence based information should be available to all those with a mental health condition about a range of alternative nicotine containing products including electronic cigarettes.*
- *Staff across mental health and physical health services should be trained and provided with information to enable them to discuss safer alternatives to smoking.*
- *Public Health England should continue to promote the importance of implementing NICE PH45 for all smokers who are unwilling or unable to stop in one step, especially for people with a mental health condition.*
- *NHS England should reaffirm their commitment to supporting alternative sources of nicotine and harm reduction, and have a clear communication strategy on the issue.*
- *Commissioners and providers should:*
  - *ensure all services include training on behavioural support, harm reduction and NRT*
  - *have good communication to all smokers on the relative safety of nicotine*
  - *make provision of NRT a normal part of care management for anyone who smokes*
  - *have performance management measures in place to monitor activity around harm reduction/ nicotine management activity.*

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### ELECTRONIC CIGARETTES – THE EVIDENCE

In 2015 Public Health England commissioned an expert review of the evidence around electronic cigarettes. This review concluded that:
- Electronic cigarettes are substantially safer than smoking.
- Recent studies support the Cochrane Review findings that electronic cigarettes can help people to quit smoking and reduce their cigarette consumption. There is also evidence that electronic cigarettes can encourage quitting or cigarette consumption reduction even among those not intending to quit or rejecting other support. More research is needed in this area.
- When used as intended, electronic cigarettes pose no risk of nicotine poisoning to users.
- The public and smokers have false perceptions of the relative safety of electronic cigarettes and these may be growing.

McNeill A et al . E-cigarettes: an evidence update. A report commissioned by Public Health England

As a result PHE made a number of recommendations:
- Smokers who have tried other methods of quitting without success could be encouraged to try electronic cigarettes to stop smoking.
- Stop smoking services should support smokers using electronic cigarettes to quit by offering them behavioural support.
- All health and social care professionals should provide accurate advice on the relative risks of smoking and e-cigarette use, and provide effective referral routes into stop smoking services

**Encouraging smokers who cannot or do not want to stop smoking to switch to electronic cigarettes could help reduce smoking related disease, death and related health inequalities.**

Public Health England. E-cigarettes: a new foundation for evidence-based policy and practice.

Both available at: www.gov.uk/government/publications/e-cigarettes-an-evidence-update

**AMBITION 8: All inpatient and community mental health sites are smokefree by 2018, through full implementation of NICE PH48 guidance and embedding support for service users who smoke.**

In many mental health settings, smoking had become engrained in the culture and routine. Smoking rates in inpatient settings can be as high as 70%.[5] Following the implementation of smokefree legislation in 2008, which meant that it was no longer legal to smoke inside, "smoking breaks" became routine in many care settings, with days becoming structured around the facilitation of smoking. This facilitation often dominates therapeutic activities and takes up valuable staff time. A recent study found that in four UK mental health wards, over 6000 staff hours were spent facilitating smoking in a six month period.[26,29] The environment is such that people can even feel pressured to start smoking on arrival.[31]

According to the ASH survey of people with a mental health condition,[34] 30% of the 127 people who had stayed in an inpatient unit reported that smoking was still going on inside the premises after the 2008 smokefree legislation. In addition, two thirds (67%) of patients who responded to the survey reported that they were not offered any kind of stop smoking advice or support during their inpatient stay, with 10% reporting that they started smoking while in an inpatient unit and 26% that they had increased their smoking with only 9% saying they had reduced or quit smoking during an inpatient stay. While this survey is not a representative sample, it does indicate ongoing issues which need to be addressed.

While the culture of smoking breaks, the use of qualified health professionals to facilitate smoking and the second-hand smoke exposure (where smoking is still taking place inside) are all far from desirable, implementing further restrictions on smoking is both complex and controversial.

Though highly hazardous to health, smoking is a legal activity and policies which prevent people from undertaking an activity they would otherwise wish to do must be well founded and appropriately implemented. Where smokefree policies are not implemented well they risk marginalising individuals and inhibiting their desire to quit smoking in the future.
The human rights aspect of smokefree legislation was tested in court in 2008, when three patients from the high security forensic facility at Rampton Hospital took Nottinghamshire Healthcare to judicial review, in response to the Trust's decision to go smokefree. The patients' lawyers argued that the smoking ban breached the European Convention on Human Rights, which guarantees respect for private life. However, the High Court ruled in favour of the Trust, finding that patients should not be allowed to endanger their own and others' health by smoking at the hospital. The judgement said: "*There is, in our view, powerful evidence that, in the interests of public health, strict limitations upon smoking, and a complete ban in appropriate circumstances, are justified.*" This was then taken to the court of appeal, which again ruled in favour of the Trust. The decision also stated that the Trust owes a duty of care to patients, "*which covers both their physical and their psychological health and which includes a duty to take reasonable steps to prevent patients from causing themselves self-harm*", going on to say that "*it may be necessary to take long term decisions for the benefit of patients and staff even though to do so would cause short term problems, provided that careful management was employed in their implementation.*"

NICE Guidance PH48[31] states that all secondary care services, including for mental health, should "*Develop a policy for smokefree grounds in collaboration with staff and people who use secondary care services, or their representatives*", and the 2016 Mental Health Task Force Report[25] stated that "*Mental health inpatient services should be smoke free by 2018*". This is an important step in changing culture and encouraging people to move away from harmful behaviours. However, it is imperative that the move to smokefree settings be done in a considered way, acknowledging that many service users will be highly dependent.

Sufficient time and planning must go into the process: a minimum of one year is recommended. Any smokefree policy must be implemented alongside the right support including providing access to alternative sources of nicotine that are of appropriate strength and are acceptable to smokers. No nicotine products shown to be substantially safer than smoking should be restricted unless there are clear health and safety reasons why they cannot be made available. Alternative forms of meaningful occupation, fresh air and social contact should be provided.

Service users should be included in the development of smokefree policies, and this should be an ongoing process even once a smokefree unit is established. Any policy needs to look at a service user's journey, including before and after being admitted to an inpatient setting, especially given the particular stress that is associated with entry into and discharge from hospital.

The ASH survey of people with a mental health condition[33] found that that support for smokefree mental health grounds was polarised between those who smoke and those who do not. Among those with an inpatient experience who smoked every day, 94% opposed and 4% supported smokefree grounds. However, among those who had never smoked 46% opposed and 46% supported smokefree grounds. Concerns expressed by service users included risk on conflict and the difficulty of coping without being able to smoke. Those sites which have implemented Smokefree grounds following NICE guidance to ensure the right support is in place have not found that these concerns have been born out.

Staff smoking is also important to address. A national audit of managers of mental health units in England found that non-smoker managers were more likely to adopt complete bans than unit managers who smoked, while unit managers' knowledge, attitude and practice also varied by their smoking status.[60]

Consideration needs to be given to how to meet the needs and concerns of service users and staff in developing and delivering any policy. However, an audit of secondary mental health settings in England showed that 96% of unit managers found that smoke-free policy had achieved positive outcomes of staff, patients, services and care. The importance of greater consultation and collaboration, as well as ongoing staff education, was highlighted.[61] In order to achieve the support of staff and service users, full consideration needs to be given to the development of a comprehensive and supportive smokefree policy, including a full consultation with those it will affect.[30]

*Specific actions*
- *All providers should implement a process of moving to a fully smokefree service by 2018 in line with NICE guidance PH48 and best evidence of what works, including their guidance on taking the needs of the patients into consideration and including provision of adequate NRT, pharmacotherapy and behavioural support.*
- *All providers moving towards being smokefree should have a nicotine dependence treatment strategy that includes access to a wide range of alternative sources of nicotine, alternative forms of meaningful occupation and social contact.*
- *Mental Health Trust Boards and commissioners of mental health care should require premises they oversee/commission to move towards being completely smokefree through full implementation of NICE PH48 and ensuring service users have appropriate tobacco dependence treatment and access to alternative sources of nicotine.*
- *The CQC should ensure services are meeting the needs of all service users (smokers and non-smokers) as they move to be smokefree and as smokefree services are established.*
- *Community based services should identify those at risk of inpatient admission and help them to make adequate preparation for their stay in a smokefree environment while they are still in the community. This plan should be documented in their care plan and communicated to staff if they are admitted.*
- *Commissioners should ensure that upon discharge from secondary care, appropriate smoking cessation or reduction support is available from primary care and other sectors.*

## KEY ELEMENTS OF SUCCESSFUL SMOKEFREE IMPLEMENTATION

1. Strong involvement of service users in all stages of planning and implementation.

2. A named lead for policy implementation, provided with adequate support.

3. The development of an infrastructure which ensures that all smokers and recent ex-smokers are routinely asked about their smoking and offered support.

4. The development of a nicotine dependence treatment strategy for the setting including:
   a) widely accessible and available behavioural and pharmacotherapy support, including appropriate management of medication interactions

   b) on-site , fully-trained, behavioural support

   c) staff training programme

5. Consultation with and involvement of staff at all levels, including support staff and relevant staff from other locations, for example, primary care, public health and commissioners. A point of contact for staff/patient concerns and queries.

6. A long lead in time of at least one year to plan and prepare appropriate policies, train necessary staff groups and to consult with the full range of stakeholders, including service users.

7. A communication plan to ensure everyone has clear, consistent and positive verbal and written information and advice about the smokefree policy. This should include community services so that service users most likely to use the service are aware of the policy.

8. Specific training for staff on how to support patients who smoke on admission.

9. A strategy for alternative occupations such as ward activity programmes and for gardens and patios to be used for fresh air, social contact and therapeutic activities.

10. A process for monitoring, review and updating the policy.

11. A plan for breaches of the policy and consistency in implementing it.

12. Addressing staff smoking, and providing support for staff who wish to quit.

References: Public Health England. Smokefree mental health services in England Implementation document for providers of mental health services. March 2016. https://www.gov.uk/government/publications/smoking-cessation-in-secondary-care-mental-health-settings,  Lawn & Campion, 'Achieving Smoke-Free Mental Health Services: Lessons from the Past Decade of Implementation Research'. 2013. Int J Environ Res Public Health. www.ncbi.nlm.nih.gov/pmc/articles/PMC3799524/, with additional input from experts.

## IMPLEMENTING NICE GUIDANCE PH48

The South London and Maudsley (SLaM) NHS Trust provides inpatient care for approximately 5,300 people and treats more than 45,000 patients in the community every year.

The Trust went completely Smokefree on 1 October 2014 in line with NICE Guidance.

**Why did SLaM go smokefree?**
- A desire to reduce the unacceptable inequality in life expectancy between those with mental health problems and the general population.

- To claim back time spent facilitating smoking for treatment. Before SLaM went Smokefree, inpatient services spent approximately two and a half hours a day facilitating smoking

- A pilot smoke-free policy in our forensic services resulted in improved engagement in therapy, 50% reduction in GP contacts, reduction in use of cannabis, improved sleep and a decrease in physical assaults on staff and patients.

**How did SLaM implement a smokefree policy?**
A long lead in time to allow patients and staff to prepare for smokefree was essential. SLaM also created a new tobacco dependence treatment pathway and created new posts. Every hospital in the Trust has a lead tobacco dependence treatment adviser who provides a bridging service between the wards and community specialist stop smoking services.

Over 100 ward staff were trained to provide intensive tobacco dependence treatment and a new electronic screening and referral system was created.

**How does SLaM support patients who smoke?**
Following assessment, all patients who smoke are provided with support to temporarily abstain from smoking and those who want to quit are supported to make a quit attempt. Coordinated rapid access to NRT on admission for inpatients ensures that no one is forced to experience the effects of nicotine withdrawal. If a patient struggles to stay smokefree, staff review their care plan with a view to adjusting their NRT and increasing behavioural support. Disposable e-cigarettes can be purchased by patients or brought into services by visitors and used in designated areas.

The tobacco dependence treatment pathway is underpinned by a staff training pathway, which includes mandatory online education and face to face advanced skills training
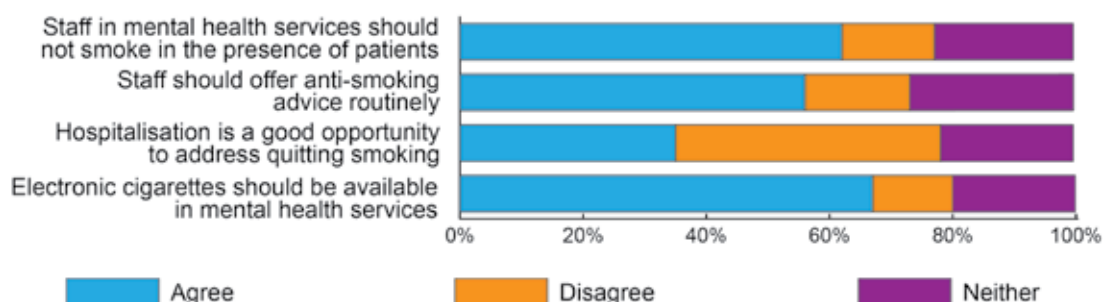
**What are the effects of the smoke-free policy?**
There has been an increase in the provision of very brief advice, including the identification of smoking status and referral to specialist stop smoking services. The provision of NRT has also improved. Staff were concerned that a smokefree policy would increase the risk of violence and fires.
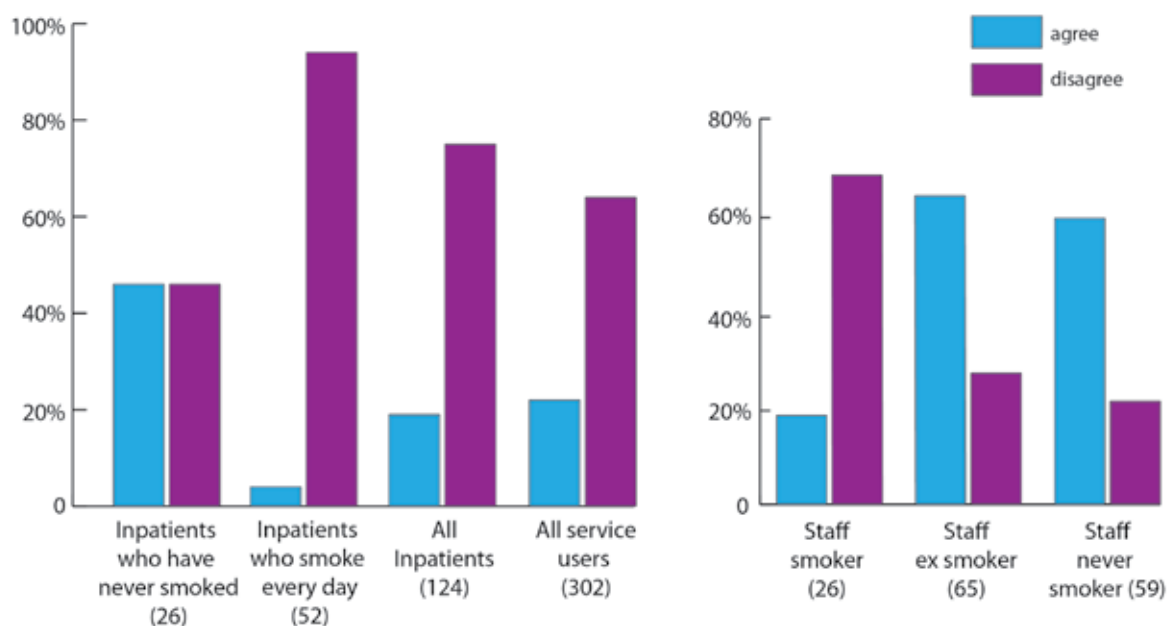
Researchers have carefully evaluated this and are reassured that neither violence nor fires increased post policy implementation (paper in preparation).

## Views on inpatient settings and smoking among those with a mental health condition



Staff in mental health services should not smoke in the presence of patients
Staff should offer anti-smoking advice routinely
Hospitalisation is a good opportunity to address quitting smoking
Electronic cigarettes should be available in mental health services

Agree  Disagree  Neither

## Smoking should be banned in the grounds of mental health hospitals



agree
disagree

Inpatients who have never smoked (26)
Inpatients who smoke every day (52)
All Inpatients (124)
All service users (302)

Staff smoker (26)
Staff ex smoker (65)
Staff never smoker (59)

## Quotes from respondents with a mental health condition

"People go into hospital as non-smokers and come out as smokers. Those people are harmed by their hospitalisation."

Male, 45-54, non-smoker

"…this is not a good time to force people to quit. There should never be a blanket ban without nicotine substitutes available"

Female, 55-64, non-smoker

"I was in an institution for years on a ward and my smoking increased as a result. It was hard to quit despite support offered because patients and staff around me were still smoking."

Female, 25-34, smoker

"It is a crutch in difficult times"

Male, 55-64, smoker

"I have asthma so I can't be around people smoking. Last time I was in, the only way to get outside for fresh air was smoking breaks. I asked if I could have fresh air breaks but wasn't allowed. I feel very isolated…I would have taken it up by now if it didn't stop me breathing."

Female, 25-34, non-smoker

"It would have been counterproductive to my mental health to quit smoking when I was inpatient, I was ill and stressed and bored and smoking…was a social thing with staff and other patients, and let me keep some control over my life…"

Female, 18-24, smoker

## IMPLEMENTING NICE GUIDANCE PH48

A Smokefree Policy was implemented within Oxleas' Bracton Centre and Challenging Behaviour Service on 5 September 2013

**The Process**
The smokefree policy was introduced following a year-long programme to prepare service users and staff in the two settings to become smokefree.

**Challenges and keys to success**
- While the policy was working well for those who could not leave the facility, for those who were allowed out on community leave, relapse was a problem. They combated this by allowing care-planned use of disposable non-rechargeable electronic cigarettes, which were very popular.
- A service user runs the on-site e-cigarette shop 7 days a week on a one in-one out basis. This works very well.
- Local stop smoking services facilitated a clinic in the facility once a week – which was so popular that it had to extend the time it was there to 2.5 hours per week.
- Some service users were trained to be stop smoking champions and this proved one of the most effective means of support.
- Staff smoking – staff were banned from smoking on and off site during working hours and on their lunch breaks to prevent them coming back smelling of smoke. They had access to the same stop smoking support that the service users had, but preferred to use services away from the unit, such as the local supermarket 'quit busses' , so appropriate signposting was provided

**Results**
Since the introduction of the smokefree policy two years ago:
- They have had excellent service user engagement in smoking cessation training.
- Service user smoking rates have reduced from 85% to less than 50%.
- Positive feedback was received by service users and staff in the one year report, supporting the smoking ban.

## CANNABIS, SMOKING AND MENTAL HEALTH

Mental health conditions are associated with higher levels of alcohol and drug misuse, including cannabis. Up to half of all people with psychosis report cannabis use[a] and tobacco smoking is highly associated with cannabis smoking.[b] Smoking cannabis carries similar risks to health as smoking tobacco, particularly as it is usually rolled with tobacco, and stronger varieties have also been linked to psychosis.[c]

If service users attempting to stop smoking are still using cannabis or trying to abstain from cannabis use, it may hamper quit attempts. This should be taken into consideration when treating for tobacco dependency and supporting quit attempts. More research is needed to ensure treatment models are effective in supporting cannabis users to quit smoking.

a) Barnett JH et al. Substance use in a population-based clinic sample of people with first-episode psychosis. Br J Psychiatry 2007 Jun;190:515-20. www.ncbi.nlm.nih.gov/pubmed/17541112
b) Hindocha C et al. Associations between cigarette smoking and cannabis dependence: A longitudinal study of young cannabis users in the United Kingdom. Drug Alcohol Depend. 2015; 148: 165–171. www.ncbi.nlm.nih.gov/pubmed/25622777
c) Arseneault L et al. Causal association between cannabis and psychosis: examination of the evidence. Br J Psychiatry 2004; 184 (2): 110-117 bjp.rcpsych.org/content/184/2/110

**AMBITION 9: Support to quit smoking for those with complex multiple needs and across different settings is appropriate and consistent.**

A person with complex or multiple needs has two or more needs affecting their physical, mental, social or financial wellbeing. These needs typically interact with and exacerbate one another leading to individuals experiencing several problems simultaneously.[62]

A 2002 study revealed that up to 75% of users of drug services and 85% of users of alcohol services were experiencing mental health problems, and that 44% of mental health service users had used drugs or reported hazardous use of alcohol in the previous year.[63] One study found that 'dual diagnosis' (someone receiving treatment for both a mental health condition and alcohol and/or drug dependence) was present in 20% of community mental health clients, 43% of psychiatric in-patients, and 56% of people in secure services.[64]

In England 46% of adults dependent on alcohol and 69% dependent on drugs, also smoke, often heavily.[3] In order to effectively support this group to quit smoking their multiple needs must be taken into consideration, along with the likelihood that people will be accessing different services and move between services for their different needs.

Smoking, substance use and mental health are also linked to other issues such as homelessness and offending, and this can lead to a cycle of inequality.[65] Providing smoking cessation support for people with complex needs enables them to use skills developed in quitting smoking to address other issues.

Other services that people with multiple or complex needs might come in contact with, such as housing services, debt advice and the job centre, also present opportunities to provide effective advice and signposting to help stop or reduce smoking. This highlights the importance of providing appropriate training about smoking cessation to workers in such settings. As well as the normal barriers to quitting, people with multiple needs may face more barriers to quitting as a result of high levels of addiction and complex lives.

Smoking during pregnancy increases the risk of mental health conditions in children.[23] Pregnant women with a mental health condition who also smoke may require specialised support to overcome barriers to smoking cessation. A study by Kings College London found that women with mental health conditions were more willing to accept referrals to smoking cessation services compared to those women who did not. However, the women with mental health conditions were more likely to still be smoking by the time of delivery (80% vs 60% for women with no mental health condition).[66]

*Specific actions*
- *Appropriate evidence-based interventions should be provided to all smokers receiving treatment for alcohol/drug use, to help them stop or reduce their smoking.*
- *Those in prisons, homelessness services and other settings with a high prevalence of mental health conditions should be offered advice and then evidence based interventions to stop or reduce their smoking.*
- *All pregnant smokers including those with mental health conditions should be offered advice and then evidence based interventions to stop or reduce their smoking.*
- *taff in other services accessed by people with mental health conditions such as social services, debt advice, job centre and probation should receive training so that they are able to offer very brief advice (VBA) and signpost for services which are able to offer evidence based interventions to stop or reduce their smoking.*

## POVERTY, SMOKING AND MENTAL HEALTH

Tobacco dependence is often described as a condition that starts in childhood. Most people start smoking in their teens and those from disadvantaged backgrounds are more likely to start younger and become more heavily addicted. Smokers with mental health conditions tend to have higher levels of dependency than the general population and as such face more barriers to quitting.

People with mental health conditions are also more likely to have low incomes and experience economic disadvantage. New research funded by Action on Smoking and Health and Public Health England from the University of Nottingham shows for the first time the extent to which those with a mental health condition are further economically disadvantaged as a result of smoking.

The research explored smoking and poverty rates[1] among people with a mental health condition using data from the Adult Psychiatric Morbidity Survey (2007) and the Health Survey for England (2013). Higher rates of smoking were found among those with a mental health condition who are below the poverty line:

| Type of disorder reported | Smoking prevalence in whole population | Smoking prevalence among those in poverty |
|---|---|---|
| Common mental disorder | 34% | 46% |
| Currently taking psychoactive medication | 34% | 46% |
| Longstanding mental disorder | 40% | 52% |

Looking at the number of cigarettes smoked and taking into account purchases of illicit and cheap tobacco it was estimated that smokers in poverty spend an average of around £1200 a year on smoking. However, adjusting for under reporting of the amount of tobacco smoked, smokers with a mental health condition below the poverty line could be spending over £2200 a year. The impact of this cost on people's lives was also shown in the ASH online survey of people with mental health conditions. This asked people how they coped if they didn't have enough money to buy tobacco. The survey found that 63% of respondents who smoked sometimes struggled to have enough money for cigarettes and resorted to other means. Respondents also report having to make difficult choices about how they spent their money with some reporting that they purchased tobacco instead of food.

**Actions taken when smokers have not had enough money to buy tobacco**
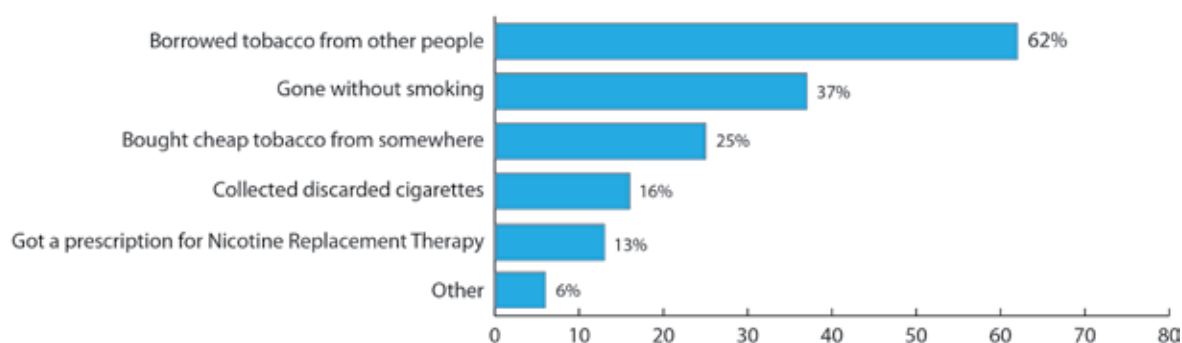


The University of Nottingham research also looked at how many people in the UK might be drawn into poverty if spending on smoking was taken into account. Using the conservative spend of £1200 a year the research found that many more people would be in poverty if tobacco expenditure is included as a cost:
- 135,300 people with a common mental disorder (6% of all those in poverty)
- 55,300 people currently taking psychoactive medication (6% of all those in poverty)
- 100,000 people with a long standing mental health disorder (11% of all those in poverty)

This new research illustrates the urgent need to invest in support to help people to quit not only to end the burden of death and disease but also to address the economic burden of smoking.

The full University of Nottingham Report is available at www.ash.org.uk/povmentalhealth

# Data collection

**AMBITION 10: Data regarding smoking status and progress towards quitting are collected in a timely and appropriate way in all settings and appropriately shared.**

To achieve change across the system we need much better data at a local and national level about smoking and quitting behaviour among people with a mental health condition. Currently national measures are possible through data captured by the Health Survey for England. While there are wide confidence intervals within the data it has the benefit of being consistently captured over a number of years and as such provides a good picture over time. It is vital this source is maintained and where possible improved to provide greater confidence in the national data. In addition, the Mental Health and Learning Disabilities dataset could be better utilised to provide local and national measures of smoking status among those with a mental health condition.

Local measures present particular challenges, and it is vital that these are addressed if accurate assessment of need and impact of interventions are to be made. The opportunity to improve the recording and sharing of information for those in contact with mental health and stop smoking services should be seen in the light of a better understanding of activity across the whole local population. To these ends primary care data could be a very important source of currently underutilised information. It is also essential that data are routinely shared with those who need it, for example, mental health trust boards, commissioners and public health professionals.

Capturing data is also an important way of prompting activity in services such as a referral to specialist support. At South London and Maudsley NHS Foundation Trust, a new electronic referral system was introduced in which the recording of smoking status is mandatory and if patients consent to having specialist support a referral is generated automatically. An assessment of severity of dependence and their CO level is also recorded at this point. This generated 519 referrals in the first year since the smokefree policy was implemented. Such prompts need to be built into systems as standard and effectively audited.

*Specific actions*
- *National data sets should be maintained and developed to ensure there is a clear picture of smoking rates in this population.*
- *Recording of smoking status should be built into existing systems and collated by commissioners across a locality. In particular, smoking status should be recorded:*
  - *for all people on the primary care depression register and SMI register which is available at local authority and practice level*
  - *on entry and discharge from IAPT services and be made available at local authority level*
  - *in secondary mental health care settings at admission and discharge and be available at local authority and trust level*
- *Recording of smoking status in mental health and other settings should prompt action, including referrals.*
- *Effective recording of smoking status and mental health conditions in primary care with data consolidated and shared with local strategic partners including local authority and CCG.*
- *Systems should be put in place to ensure appropriate information can be shared between secondary mental health services, primary care, stop smoking services, IAPT and pharmacies.*
- *Commissioners of mental health services should mandate that there is recording of smoking status at all assessments, including automatic referral to smoking cessation services and an assessment of severity of dependence including CO Monitoring.*
- *Data are effectively communicated to those who can use it to influence policy and commissioning.*
- *The Adult Psychiatric Morbidity Survey and the Mental Health and Learning Disabilities Data Set should report detailed data on smoking in this population as routine.*

# Prevention

**AMBITION 11: Populations at risk of developing mental health conditions are identified and appropriate interventions put in place to prevent uptake of smoking.**

Among smokers in the general population, about two-thirds report that they took up smoking before the age of 18 and over 80% before the age of 20.[67] This is likely to be similar in those who go on to develop a mental health condition. According to the World Health Organisation (WHO) certain groups in society may be particularly susceptible to experiencing mental health problems, including households living in poverty, people with chronic health conditions, minority groups and those who experience family conflict or neglect.[68]

According to a recent review, smoking prevalence among young people at their first presentation for treatment of psychosis is around 60% – six times higher than in those of a similar age without psychosis,[69] and the rate of smoking among 11-16 year olds with conduct disorder is around six times higher than that of children the same age in the general population.[70] In addition, a recent study found that there is a need to improve clinicians' knowledge, capacity and confidence in effectively identifying, motivating, supporting and treating young smokers in the context of treatment for mental health conditions.[35] Therefore, in order to prevent uptake and discourage first use of tobacco it is necessary to provide extra support, information, training of health professionals and non-smoking role-models.  While there is limited evidence in this area, we feel it is an important area for future research and for these recommendations to develop.

*Specific actions*
- *All environments in which care is delivered to vulnerable people should be smokefree.*
- *Populations identified as at risk of developing a mental health condition should receive targeted stop smoking support.*
- *Looked after children should be provided with smokefree role models and a smokefree environment.*
- *Clinicians working in CAMHS should have effective training in identifying and treating young smokers.*
- *All staff working in services where social care is provided should have basic knowledge and understanding of tobacco dependence and know how to seek specialist support as required.*

# Research agenda

**AMBITION 12: Robust evidence into the most effective means to sustainably reduce smoking rates among those with a mental health condition is available.**

Comprehensive literature reviews have been conducted in this area, for example for the 2013 Royal College of Physicians & Royal College of Psychiatrists report, "Smoking and Mental Health"[11] and for the NICE guidance, PH48.[52] In 2015, ASH Scotland also provided a comprehensive review of the literature on this topic.[71] Since the Royal College of Physicians and Royal College of Psychiatrists report in 2013, more evidence has emerged that quitting smoking can have a positive effect on depression, anxiety, stress and psychological quality of life compared with continuing to smoke. However, what works best to support those with mental health conditions to quit smoking still needs extensive research.

A recent Cochrane review assessed the evidence for smoking cessation advice for people with serious mental illness and concluded that they "could not find any high quality evidence to guide the smoking cessation advice healthcare professionals pass onto service users. This is an area where trials are possible and needed".[15] Having said this, much research in this area is underway, for example the SCIMITAR trial into smoking cessation in mental health (see box).

## Areas for further research
The following section highlights areas for further research. It is not an exhaustive list and further work is needed to systematically review the gaps in the evidence.

### 1. Mapping the population

- Identifying consistent means of tracking smoking rates among those with a mental health condition, and of linking datasets to better understand smoking behaviour in this population.
- Identifying and understanding different rates of smoking among people with different types of mental health conditions
- Understanding the relationship between smoking and mental health and why rates are higher

### 2. Treatment

- Barriers this population face to quitting smoking
- Treatment to prevent relapse to smoking with a special focus on support after discharge from smokefree inpatient settings
- The role of e-cigarettes in supporting more people to be smokefree.
- Using smoking cessation as adjunct treatment for depression and anxiety.
- Effective models to support cessation/abstinence in this population, including peer and family support, group support and special populations such as CAMHS/older people with mental health condition.
- Role of VBA – what it should contain, who is best to deliver it, when and how?
- Impact of rehospitalisation on smoking, especially in the context of smokefree environments.
- Integration of support to quit smoking into substance use treatment
- Integration of smoking cessation support with other lifestyle interventions to address high cardiovascular risks in this population

### 3. Service design and delivery

- Development of effective cessation and harm reduction interventions in mental health settings, including in the community, inpatient settings and primary and secondary care, and to maximise access to and delivery of evidence-based support
- The frequency of use of NRT, varenicline and bupropion in those with a mental health condition and barriers to wider uptake
- The barriers people with a mental health condition experience that can prevent them from accessing stop smoking services, and how these can be overcome
- Safe, feasible and effective models of delivery for groups with specific and complex needs, for example, those who are homeless, those with dementia, young people, older people, and pregnant women

## 4. Impact of wider tobacco control policies

- Impact of smokefree secondary care environments on long-term levels of smoking among patients
- Impact of comprehensive tobacco control policy on rates of smoking among those with a mental health condition
- Price responsiveness of smokers with a mental health condition
- Smoking initiation among those with a mental health condition and identifying opportunities for prevention

## 5. Outcomes for people with a mental health condition who smoke

- Neuro-psychiatric consequences of tobacco and nicotine for different conditions
- Impact of quitting and smoking on mental health: outcomes for different conditions
- Impact of quitting and smoking on poverty and income
- Impact of quitting and smoking on medication levels, with the aim of supporting clinicians
- Impact of quitting on markers of cardiovascular risk

### *Specific actions for researchers and funders*
- *Full systematic review is undertaken to establish gaps in the evidence and priority areas for action.*
- *Researchers should seek to involve smokers with mental health conditions in the development of research projects as far as possible.*
- *Research funders (such as NIHR, Public Health Research Programme, the Medical Research Council and DH Policy Research Programme) prioritise research into tackling smoking among people with a mental health condition with a strong focus on the priority areas for research identified in this document.*
- *Investment is made in evaluating existing and innovative practice in supporting people with a mental health condition to quit or abstain from smoking or reduce their consumption.*
- *Research organisations, health providers, PHE, NHS England, professional bodies and policy organisations ensure that new research findings are translated into policy and practice.*

# SCIMITAR: SMOKING CESSATION INTERVENTION FOR SEVERE MENTAL ILL HEALTH TRIAL

**Background**

The Smoking Cessation Intervention for Severe Mental Ill Health Trial (SCIMITAR) is a pilot randomised controlled trial of a smoking cessation strategy designed specifically for people with severe mental ill health.

The trial recruited adult smokers with bipolar disorder or schizophrenia from NHS primary care and mental health settings in the UK. Participants were randomly allocated to either usual care or usual care plus the bespoke smoking cessation strategy.

**Key features of the SCIMITAR intervention**

- Delivered by a mental health professional

- NRT as a mainstay of treatment

- Nicotine pre-loading & 'cut down to quit'

- Special attention to psychotropic medication management

- Planning for quit attempt - what to do in place of smoking

- Behaviour Change Techniques

**Findings**

- The level of engagement with a bespoke smoking cessation strategy was higher than with a conventional approach.

- At 12 months, 35 (69%) controls and 33 (72%) people assigned to the intervention group provided a CO measurement or self-reported their smoking status.

- Smoking cessation was highest among individuals who received the bespoke intervention (36% vs. 23%).

**Next steps**

Having shown the feasibility of recruiting and randomising people with severe mental ill health in a trial of this nature, the effectiveness and safety of a smoking cessation programme designed particularly for people with severe mental ill health will be tested in a fully powered randomised controlled trial.

For more information, see:
- Smoking cessation for people with severe mental illness: a pilot study and definitive randomised evaluation of a bespoke service (SCIMITAR). www.york.ac.uk/healthsciences/research/mental-health/projects/archive/scimitar/

- Gilbody S, Peckham E, Man M-S, Mitchell N, Li J, Becque T, et al. Bespoke smoking cessation for people with severe mental ill health (SCIMITAR): a pilot randomised controlled trial. The Lancet Psychiatry 2015; 2(5): 395-402

# Full list of ambitions and actions

## AMBITION OF THIS REPORT: Smoking among people with a mental health condition declines to be less than 5% by 2035.

*Specific actions*
- *Ambitious national targets to reduce smoking among people with a mental health condition should be set by national Government, using the Health Survey for England to measure progress. An interim target of 35% by 2020 is set from the current level of 40%. A separate target for inpatient settings should also be considered, recognising the specific challenges in this setting.*
- *Local Authority and Health Commissioners should develop local measures of success that will contribute to reduce smoking rates among those with mental health conditions and build these into contracts for primary care, secondary care, secondary mental health care, IAPT, social care, and specialist stop smoking services.*

To be achieved by:

## AMBITION 1: National and local leadership drives forward action which reduces smoking among those with a mental health condition.

*Specific actions*
- *Strong commitments to reducing tobacco dependence among those with a mental health condition must be included in the next Department of Health Tobacco Control Strategy.*
- *National leadership from NHS England, the Department of Health and Public Health England is needed to ensure treating tobacco dependence in this population is a priority area for action.*
- *Organisations across public and non-governmental sectors should work together to reduce smoking.*
- *Primary care, specialist stop smoking services, IAPT, secondary care, social care, voluntary and community services should lead by example in supporting those with a mental health condition to quit or reduce smoking.*
- *Health and Wellbeing Boards must ensure there are co-ordinated local approaches to reducing smoking among people with a mental health condition.*
- *Local Authorities should estimate the number of smokers with mental health conditions and the proportion receiving cessation interventions in primary care, specialist stop smoking services, IAPT, social care and secondary care as part of their Joint Strategic Needs Assessment, as recommended by NICE (2013) to inform commissioners about the size of unmet need locally.*

## AMBITION 2: People with a mental health condition are empowered to take action to reduce their smoking.

*Specific actions*
- *Mental health settings should identify service user 'stop smoking champions' to work with staff and service users to support more people to move away from smoking.*
- *All smokers with a mental health condition should be provided with clear, evidence based information about different options to quit or reduce the harm from smoking by primary care, social care, IAPT, specialist stop smoking services, secondary care services and pharmacists in a coordinated way.*
- *Carers, friends and family members should be provided with advice and information about how best to support those with a mental health condition to address, reduce and stop their smoking.*
- *Service users are included in the development of services designed to support people to quit or reduce the harm from smoking.*
- *People with a mental health condition should be supported to develop alternative occupations to smoking, to help establish new healthier routines.*
- *ASH in partnership with service user groups will produce a report on further opportunities to empower those with a mental health condition who smoke to become smokefree.*

**AMBITION 3: Staff working in all mental health settings see reducing smoking among service users as part of their core role.**

*Specific actions*
- *In all environments in which care and support is provided to people with a mental health condition there should be a dedicated senior staff member who is the 'stop smoking champion', supported by a cross-disciplinary committee where appropriate. They should have responsibility for ensuring smoking is being addressed among service users.*
- *Mental health care settings should ensure all staff working with those with a mental health condition are trained in very brief advice (VBA), and those who are assisting patients to temporarily abstain or quit smoking are trained to a minimum standard described by the NCSCT. This should include communicating the relative safety of alternative sources of nicotine, prescribing medications, behavioural support and referring for further support where appropriate.*
- *There should be a good understanding among staff in all mental health settings about the benefits to service users of quitting smoking including improved physical and mental health, reduced need for antipsychotic medication and greater disposable income.*
- *The NCSCT should be funded to develop an enhanced VBA training module for mental health staff that serves as a bridge between the short VBA module and the full NCSCT training and assessment programme.*
- *Health Education England should support training in the effects of smoking and its prevalence among those with a mental health condition, as well as methods of cessation and harm reduction in standard training for mental health nurses, clinical psychologists, psychiatrists, occupational therapists, psychological therapists and other allied health professionals.*
- *Strategies should be in place to support staff in all mental health settings to quit smoking.*

**AMBITION 4: Services for people with mental health conditions provide effective advice and support to quit smoking and access to appropriate specialist stop smoking models.**

*Specific actions*
- *All residential and community mental health settings should support quitting smoking by providing brief advice, in-house specialist tailored stop-smoking support or referral to appropriate stop smoking services. For hospital settings, on-site tobacco dependence treatment services should be established.*
- *Local Authority commissioned stop smoking services should be funded to support community and in-house mental health staff with appropriate training and mentoring to deliver to the necessary levels of intervention, as detailed above.*
- *Mental Health Trust Boards, Clinical Commissioning Groups and commissioners of mental health services should ensure that delivery of NICE standards in relation to smoking, specifically PH48 and PH45, is a pre-requisite of services being commissioned.*
- *Stop smoking support and appropriate signposting should be embedded in mainstream and community based mental health services.*
- *There should be clear policies which enable timely access to appropriate pharmacotherapy in all care settings for people with mental health conditions, including:*
  - *easy and affordable access to pharmacotherapy in the community for both quitting and cutting down*
  - *on arrival at an inpatient ward, patients should have access to nicotine replacement therapy (NRT) within 30 minutes (see box for possible arrangements to do this).*
  - *NRT should be available for as long as it is needed at a sufficient dose and frequency*
  - *combination NRT or varenicline should be seen as first line medications for those wishing to cut down or quit*
- *An agreed tobacco dependence treatment plan should be included in the collaborative care plan of all service users who smoke.*
- *Access to peer support should be available for people with mental health conditions attempting to quit smoking.*
- *The Care Quality Commission (CQC) should provide a short guidance for inspectors of inpatient and community mental health settings of what is needed, including adequate tobacco dependence treatment, access to pharmacotherapy, and appropriate implementation of a smokefree policy.*

- *NHS England should develop an appropriate national CQUIN to promote and incentivise NICE recommended treatment for tobacco dependence among people with a mental health condition.*
- *Clear pathways should be developed between mental health and other services to ensure support to quit smoking is maintained as people move through the system.*
- *Service users and carers are included at all stages during the planning, delivery and evaluation of health and care services designed for those with mental health conditions.*

**AMBITION 5: Local Authority funded stop smoking services (SSS) effectively support those with a mental health condition to quit smoking.**

*Specific actions*
- *Stop smoking practitioners should be trained on the specific issues around mental health and smoking including the importance of liaising with primary and secondary care staff about the impact of quitting and relapse on anti-psychotic medication dosage.*
- *Stop smoking services should routinely ask about mental health conditions and record this information.*
- *Stop smoking services should have a "mental health champion" to ensure that those with mental health conditions receive appropriate treatment and support.*
- *Stop smoking services should have clear protocols with local mental health services including development of in-reach and outreach models of support.*
- *Greater attention should be paid to models of relapse prevention, especially for those identified at high risk of relapse.*
- *There should be a specific harm reduction plan for those with a mental health condition who do not want to or are finding it difficult to quit.*
- *Commissioners of stop smoking services should identify appropriate measures of success and appropriately incentivise services aimed at those with mental health conditions, for whom four-week quits may not be appropriate.*
- *Barriers to engagement with cessation services of those with mental health conditions should be identified and addressed.*

**AMBITION 6: People with mental health conditions who access mainstream physical health services are routinely advised to quit smoking and sign-posted to effective support.**

*Specific actions*
- *Stop smoking support and appropriate signposting for those with mental health conditions should be embedded in primary care: Tobacco dependence treatment should be offered to everyone with a mental health condition accessing primary care services.*
- *Care should be provided in the community in a holistic way - mental and physical health needs are addressed, and each person receiving care should have access to a selection of health care professionals treating all of their health care needs.*
- *People with a mental health condition who develop a physical health condition should be provided with targeted support to quit in primary and secondary care.*
- *The use of CO monitors as a motivational tool is trialled.*
- *Health Education England should ensure that all professionals seek to Make Every Contact Count among those with a mental health condition in relation to smoking and other harmful behaviours.*

**AMBITION 7: People with mental health conditions who are not yet ready or willing to quit are supported through harm reduction strategies.**

*Specific actions*
- *The methods outlined in NICE PH45, 'Smoking: Harm reduction', should be implemented for all those with a mental health condition who are unwilling or unable to stop smoking completely.*
- *Evidence based information should be available to all those with a mental health condition about a range of alternative nicotine containing products including electronic cigarettes.*
- *Staff across mental health and physical health services should be trained and provided with information to enable them to discuss safer alternatives to smoking.*
- *Public Health England should continue to promote the importance of implementing NICE PH45 for all smokers who are unwilling or unable to stop in one step, especially for people with a mental health condition.*

- *NHS England should reaffirm their commitment to supporting alternative sources of nicotine and harm reduction, and have a clear communication strategy on the issue.*
- *Commissioners and providers should:*
  - *ensure all services include training on behavioural support, harm reduction and NRT*
  - *have good communication to all smokers on the relative safety of nicotine*
  - *make provision of NRT a normal part of care management for anyone who smokes*
  - *have performance management measures in place to monitor activity around harm reduction/ nicotine management activity.*

**AMBITION 8: All inpatient and community mental health sites to be smokefree by 2018, through full implementation of NICE PH48 guidance and embedding support for service users who smoke.**

*Specific actions*
- *All providers should implement a process of moving to a fully smokefree service by 2018 in line with NICE guidance PH48 and best evidence of what works, including their guidance on taking the needs of the patients into consideration and including provision of adequate NRT, pharmacotherapy and behavioural support.*
- *All providers moving towards being smokefree should have a nicotine dependence treatment strategy that includes access to a wide range of alternative sources of nicotine, alternative forms of meaningful occupation and social contact.*
- *Mental Health Trust Boards and commissioners of mental health care should require premises they oversee/commission to move towards being completely smokefree through full implementation of NICE PH48 and ensuring service users have appropriate tobacco dependence treatment and access to alternative sources of nicotine.*
- *The CQC should ensure services are meeting the needs of all service users (smokers and non-smokers) as they move to be smokefree and as smokefree services are established.*
- *Community based services should identify those at risk of inpatient admission and help them to make adequate preparation for their stay in a smokefree environment while they are still in the community. This plan should be documented in their care plan and communicated to staff if they are admitted.*
- *Commissioners should ensure that upon discharge from secondary care, appropriate smoking cessation or reduction support is available from primary care and other sectors.*

**AMBITION 9: Support to quit smoking for those with complex multiple needs and across different settings is appropriate and consistent.**

*Specific actions*
- *Appropriate evidence-based interventions should be provided to all smokers receiving treatment for alcohol/drug use, to help them stop or reduce their smoking.*
- *Those in prisons, homelessness services and other settings with a high prevalence of mental health conditions should be offered advice and then evidence based interventions to stop or reduce their smoking.*
- *All pregnant smokers including those with mental health conditions should be offered advice and then evidence based interventions to stop or reduce their smoking.*
- *Staff in other services accessed by people with mental health conditions such as social services, debt advice, job centre and probation should receive training so that they are able to offer very brief advice (VBA) and signpost for services which are able to offer evidence based interventions to stop or reduce their smoking.*

**AMBITION 10: Data regarding smoking status and progress towards quitting are collected in a timely and appropriate way in all settings and appropriately shared.**

*Specific actions*
- *National data sets should be maintained and developed to ensure there is a clear picture of smoking rates in this population.*
- *Recording of smoking status should be built into existing systems and collated by commissioners across a locality. In particular, smoking status should be recorded:*
  - *for all people on the primary care depression register and SMI register which is available at local authority and practice level*
  - *entry and discharge from IAPT services and be made available at local authority level*
  - *in secondary mental health care settings at admission and discharge and be available at local authority and trust level*
- *Recording of smoking status in mental health and other settings should prompt action, including referrals.*
- *Effective recording of smoking status and mental health conditions in primary care with data consolidated and shared with local strategic partners including local authority and CCG.*
- *Systems should be put in place to ensure appropriate information can be shared between secondary mental health services, primary care, stop smoking services, IAPT and pharmacies.*
- *Commissioners of mental health services should mandate that there is recording of smoking status at all assessments, including automatic referral to smoking cessation services and an assessment of severity of dependence including CO Monitoring.*
- *Data are effectively communicated to those who can use it to influence policy and commissioning.*
- *The Adult Psychiatric Morbidity Survey and the Mental Health and Learning Disabilities Data Set should report detailed data on smoking in this population as routine*

**AMBITION 11: Populations at risk of developing mental health conditions are identified and appropriate interventions put in place to prevent uptake of smoking.**

*Specific actions*
- *All environments in which care is delivered to vulnerable people should be smokefree.*
- *Populations identified as at risk of developing a mental health condition should receive targeted stop smoking support.*
- *Looked after children should be provided with smokefree role models and a smokefree environment.*
- *Clinicians working in CAMHS should have effective training in identifying and treating young smokers.*
- *All staff working in services where social care is provided should have basic knowledge and understanding of tobacco dependence and know how to seek specialist support as required*

**AMBITION 12: Robust evidence into the most effective means to sustainably reduce smoking rates among those with mental health condition is available.**

*Specific actions for researchers and funders*
- *Full systematic review is undertaken to establish gaps in the evidence and priority areas for action.*
- *Researchers should seek to involve smokers with mental health conditions in the development of research projects as far as possible.*
- *Research funders (such as NIHR, Public Health Research Programme, the Medical Research Council and DH Policy Research Programme) prioritise research into tackling smoking among people with a mental health condition with a strong focus on the priority areas for research identified in this document.*
- *Investment is made in evaluating existing and innovative practice in supporting people with a mental health condition to quit or abstain from smoking or reduce their consumption.*
- *Research organisations, health providers, PHE, NHS England, professional bodies and policy organisations ensure that new research findings are translated into policy and practice.*

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