Smoking cessation and smokefree policies:

Good practice for mental health services

NCSCT

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This document has been produced for Public Health England with the support of the CLAHRC South London, Action on Smoking and Health (ASH) and the Mental Health and Smoking Partnership.

Contents

Introduction

Smoking disproportionately affects the health and wellbeing of people with mental health conditions. People who use mental health services, who smoke, often want to quit but historically have not been offered a way out of tobacco dependence that is genuinely helpful to them.

The aim of this briefing is to guide staff working with mental health service users to:

- Minimise discomfort and anxiety to service users who are admitted to smokefree premises and maximise the likelihood of long-term cessation
- Support service users to temporarily abstain from smoking and/or to stop smoking during an admission to smokefree premises
- Support people in the community and help to prepare service users for admission to a smokefree setting
- Support people to co-operate with smokefree policies

Box 1: What is a smokefree NHS?

- Every frontline healthcare professional discussing smoking with their patients
- All smokers offered on-site stop smoking support or referral to local stop smoking services
- Completely smokefree buildings and grounds

This can be achieved through the full implementation of NICE guidance PH48.[1]

Background

Tobacco dependence in people with mental health disorders

Tobacco dependence is a chronic, relapsing clinical condition that prematurely kills at least half of people who smoke.

The 2016 Annual Population Survey showed that around 16% (15.5%) of adults in England smoke cigarettes.[2] However, **smoking rates among adults with a common mental health disorder such as depression or anxiety are almost twice as high when compared to those who are mentally well.**[3] Smoking rates are three times greater for those with schizophrenia or bipolar disorder[4] and four times greater for people receiving treatment for a substance use disorder.[5]

The prevalence of smoking is consistently higher among people who use mental health services compared to those who do not, including services for perinatal psychiatry, child and adolescent mental health, learning disability and older adults.[3]

Impact of smoking on mental health recovery

People with a mental health condition smoke heavily and intensely. Their health is disproportionally affected compared to smokers without a mental health condition, due to the greater exposure to carbon monoxide and other toxins present in tobacco smoke.

Smoking is associated with reduced life expectancy and an increased risk of developing cancer, heart and respiratory diseases.

What is often overlooked is how smoking also exacerbates other health and wellbeing problems experienced by people with a mental health condition and how it prevents or delays recovery.

People with a mental health condition who smoke:

- Experience more severe symptoms of psychosis,[6] depression and anxiety[7]
- Have an increased risk of the onset of panic attacks[8]
- Have an increased risk of dementia[9]
- Spend longer time in hospital and less time out of hospital[6,10]
- Require higher doses of some psychotropic medicines (see Box 2)

Box 2: Effect of smoking upon some psychotropic medicines

Polycyclic hydrocarbons from the tar in cigarette smoke (and **not nicotine**) increases the rate of metabolism of some antipsychotics and antidepressants; this can lead to lower blood concentrations of haloperidol, clozapine, olanzapine, and several antidepressants for some service users who smoke. A consequence of this is that smokers need higher doses of some psychotropic medicines compared to non-smokers.[11]

See Box 4 on page 19 and Appendix for medications whose plasma levels need to be monitored during smoking and smoking cessation.

The benefits of stopping smoking for people with a mental health condition

People with a mental health condition who smoke want to quit as much as smokers in the general population, but often lack confidence in their ability to do so.[12,13] They may therefore be less likely to make a quit attempt compared to smokers in the general population.

In addition to the well-established benefits of increased life expectancy and improved physical health, stopping smoking is associated with:

- Reduced depression,[7,14] anxiety,[15] and stress[7]
- Improved positive mood and quality of life[7]
- More disposable income[16]

Doses of some medicines such as clozapine and olanzapine can be reduced up to 25% in the first week after stopping smoking (see Box 4).

The benefits of smokefree policies for mental health recovery

The introduction of comprehensive smokefree polices in health care settings challenges a longstanding smoking culture.

Smokefree policies are an essential part of the wider framework of tobacco control and need to be implemented alongside integrated tobacco dependence treatment pathways and staff training. Receiving care in a smokefree setting can support mental health recovery (see Box 3).

Box 3: Ways that smokefree settings support mental health recovery

1. Smokefree settings help to protect people who are non-smokers from secondhand smoke and from initiation into smoking; for ex-smokers, smokefree settings can help to protect them from relapse.
2. The provision of tobacco dependence treatment, during an admission to a smokefree hospital, increases the chances of quitting. The longer the admission in smokefree settings, the higher the quit rate.[10,17]
3. The service user is less likely to be readmitted if provided with tobacco dependence treatment and follow-up support.[10]
4. If the service user does not quit during the current admission, there is an increased chance they will make a subsequent quit attempt following discharge.[10,18]
5. Smokefree inpatient settings, if implemented properly, increase the likelihood that the ward environment will be less disruptive and, when accompanied by staff training, is associated with a significant decrease in physical violence.[19,20]
6. Smokefree settings also mean that clinical time, previously spent on facilitating smoking, can be used to focus on promoting health and wellbeing.[21]

Tobacco withdrawal symptoms and cravings to smoke

People start smoking for various reasons but generally continue to smoke, even when they want to quit, because of nicotine. Nicotine is highly addictive when delivered to the body via inhaled tobacco smoke.

Cigarettes are engineered to deliver nicotine to the brain as fast as possible, including adding other substances to tobacco such as ammonia, sugars and flavourings. However, the **harm from smoking comes from the toxins, particularly tar and carbon monoxide, in tobacco smoke and not from nicotine.** Nicotine in tobacco smoke results in slight acute increase in heart rate and blood pressure, and is an irritant,[22] but is known to not cause cancer, heart and respiratory disease, or other smoking-related diseases.

Nicotine does not stay in the body for very long, so withdrawal symptoms can start very soon after smoking a cigarette. Withdrawal symptoms primarily occur because the body has become used to receiving regular doses of nicotine. A bit like food, the body then becomes *hungry* for nicotine if it is not regularly satisfied.

Some smokers will experience more severe withdrawal symptoms than others due to a variety of genetic, physiological, and environmental factors. People with schizophrenia may be more sensitive to the effects of acute tobacco abstinence and experience tobacco withdrawal symptoms earlier and more intensely than those without a mental illness.[23,24]

The good news is that most withdrawal signs and symptoms are temporary (see Tables 1 and 2). Providing a person does not have a puff on a cigarette, most symptoms peak about 48 hours after stopping smoking and subside over the next 2 to 4 weeks. If a person continues to smoke, even intermittently (just a couple of times a week) withdrawal symptoms will persist.

Cravings for cigarettes, or urges to smoke, can persist for much longer, even after many weeks or possibly months of abstinence – although they become far less frequent. Cravings for cigarettes manifests in two ways:

1. **Background or general cravings to smoke:** These usually fluctuate over the course of the day, depending on how tobacco dependent the smoker is. If a person completely abstains from smoking, then these cravings will gradually disappear.

2. **Cue-specific cravings or triggers to smoke:** These arise in response to being exposed to stimuli that may have become associated with smoking (e.g. certain places, seeing another person smoke, seeing a packet of cigarettes/tobacco pouch, talking about cigarettes, after a meal or with alcohol). These tend to have a fast onset, feel intense and are more short-lived than general cravings.

Nicotine replacement therapy (NRT), varenicline (Champix), bupropion (Zyban) and electronic cigarettes (e-cigarettes) can help alleviate withdrawal symptoms and reduce cravings to smoke.

Table 1: Tobacco withdrawal symptoms

Effect	Prevalence	Average Duration
Irritability or aggression	> 25%	< 4 weeks
Increased appetite	> 25%	> 10 weeks
Difficulty concentrating	> 25%	< 4 weeks
Restlessness	> 25%	< 4 weeks
Depressed mood	< 25%	< 4 weeks
Sleep disturbance	< 25%	< 4 weeks
Urges to smoke	> 25%	> 10 weeks but declining over time

Table 2: Signs of tobacco withdrawal

Effect	Prevalence	Average Duration
Cough/sore throat	< 25%	< 4 weeks
Mouth ulcers	< 25%	> 2 weeks
Constipation	< 25%	> 2 weeks
Weight gain	> 25%	enduring
Reduced heart rate	> 25%	permanent
Increased skin temperature	> 25%	permanent
Reduced tremor	> 25%	permanent

Supporting people in the community and preparing for an admission to a smokefree setting

Community staff have an important role to play in the management of tobacco dependence during an episode of community treatment. This role includes supporting quitting (as stopping smoking is one of the best things that smokers can do to improve their mental and physical health) and harm reduction for those service users who feel unable to quit at present (including the use of e-cigarettes).

Community staff also have a crucial role in supporting the implementation of smokefree polices, both before and after a service user is admitted to hospital.

When service users first come into contact with community services, and at every Care Programme Approach review, they should be provided with very brief advice on smoking (VBA):

ASK: Establish and record smoking status.

ADVISE: Advise that the best way of stopping smoking is with a combination of medication and support. That this is available from an on-site stop smoking support and/or local stop smoking service and that many of your patients have found them friendly and helpful. Offer a referral if the service user is interested.

ACT: Act on the service user's response and refer for on-site stop smoking support and/or to a local stop smoking service.

A short, free online *VBA on smoking* training module is available: https://tinyurl.com/NCSCT-VBA-course

Not offering support to patients to quit smoking (especially if other behaviours such as diet, alcohol and physical activity are raised) can encourage the patient to believe that their smoking is not a priority for the health professionals involved in their care.

The offer of help to quit (including medication and support) leads to more people making a quit attempt, compared with simply advising smokers to quit.[25] It can be helpful to explain what to expect from a local stop smoking service and how service users are up to four times more likely to quit successfully with support and medication than without help.[26]

If the service user wishes, community staff can advocate on their behalf to facilitate the delivery of behavioural support from a trained practitioner from their local stop smoking service, as well as, the most effective pharmacological treatment: varenicline (Champix) or combination NRT (e.g. nicotine patch plus one of the faster acting products).

Smokers should also be offered the choice of stopping in one go or gradually cutting down and then stopping.[27]

Community teams can often predict which service users are likely to require a future admission, based on their previous history. Advance plans (or statements) are commonly used in mental health care to collaboratively decide on treatment preferences in the event of a future admission. Developing an advance plan for tobacco dependence treatment is recommended for service users who smoke (see Table 3).

Table 3: Guide to developing an advance plan for tobacco dependence treatment

Actions	Details
Inform the service user and family that the local hospital buildings and grounds are completely smokefree, that support is available to abstain temporarily from smoking and that there are advantages of deciding about treatment in advance of admission	It is helpful to explain to service users what you cando to support them, rather than simply tell them what they are not allowed to do. It might be helpful to say something like: *"Our hospital wards and grounds are now completely smokefree. There is lots of support we can give people who smoke to make them comfortable during their stay. When you're well, it's often helpful to plan ahead in case you ever need to be treated in hospital for a physical or mental health condition in the future. This avoids you having to make decisions about your smoking when you may be unwell. Is it OK to have a chat about all the different support options that are available?"*
Establish service users experience with past quit attempts and knowledge about treatment options	Drawing on previous successes (even for short periods) can help guide treatment options. Dispelling misconceptions about stop smoking treatment and cessation can also be helpful. *"Have you ever tried to stop smoking in the past, what helped, what didn't help?"* *"What do you know about nicotine replacement therapy and other stop smoking aids? What would you like to know?"*
Provide information about stop smoking aids	Service users should have access to the full range of stop smoking medications (varenicline, NRT products, and bupropion) whilst in hospital. The hospital pharmacy may be able to give you a demonstration pack of NRT products, as it is helpful for people to see and possibly try the products. It will also be important to understand your hospital's policy on e-cigarette use as e-cigarettes can have an important role to play in both cessation and harm reduction.

Actions	Details
Establish what coping techniques they find useful	Encourage the service user to practice extending time between cigarettes and to try out smokefree coping techniques. *"It is helpful to use tried and tested techniques rather than introducing new ones when you are experiencing withdrawal symptoms; what things do you usually find calming?"*
Agree to a tobacco dependence treatment preference plan and record in clinical notes	Help the service user to anticipate, plan and rehearse dealing with any issues related to their smoking prior to admission. Ensure that the service user (and a family member if they wish) has a copy of their tobacco dependence treatment preferences (what they like/don't like, what they would prefer in the event of an admission). A copy should be included in the community and inpatient records and could simply be a statement of the service users wishes in the event of an admission.
Review	Revisit and update the advance plan regularly.
In the event of an admission	Work with inpatient colleagues to honour the advance plan, whilst explaining to the service user that some flexibility may be required depending on their mental state.

Supporting people in a smokefree hospital

When admitted to a smokefree hospital, people who smoke lose control over administering their regular dose of nicotine. People who smoke generally have the following choices when admitted to a smokefree hospital:

1. Abstain temporarily when in hospital buildings and grounds (with or without nicotine replacement and/or behavioural support).
2. Take the opportunity to quit completely with medication and/or behavioural support.

Offering immediate support for temporary abstinence on admission, rather than asking the service user if they are interested in quitting or telling them they need to quit, avoids getting into lengthy conversations whilst they may be feeling distressed and overwhelmed. At the earliest opportunity, ensure that the management of the service user's tobacco use is included within their care plan.

It is inevitable that some service users who smoke will experience a period of enforced abstinence during their admission; this period of abstinence will depend upon the length of their hospital stay. However, **service users should never be forced to experience withdrawal symptoms – these symptoms are predictable, preventable and treatable.**

The most effective and comfortable way to support temporary abstinence and manage withdrawal symptoms is with NRT, plus behavioural support, for the duration of the admission. E-cigarettes are also a popular and potentially effective option.

NRT needs to be promptly offered (ideally within 30 minutes of arrival on the ward) as service users are likely to be in nicotine withdrawal by the time they arrive on the ward.

Service users can choose not to have any support to manage their tobacco dependence during admission. However, this is likely to make their stay more physically and psychologically uncomfortable; this is especially so during the first few days when withdrawal symptoms are at their most intense, but it may continue for three or four weeks. Regular assessment of withdrawal symptoms is necessary, particularly as withdrawal symptoms may be confused with mental health symptoms by both staff and service users. It is also vital that staff repeatedly offer support to manage withdrawal symptoms, just as we would with any medication intended to reduce discomfort and distress.

A hospital admission can serve as an opportunity for service users to have a supported period of time being smokefree and may be a springboard for future health behaviour change. Every person who smokes should be offered the opportunity to transition from temporarily abstaining, to making a supported quit attempt. Exposure to a smokefree setting as well as the experience of using NRT may increase a service user's confidence in their ability to quit and make them more likely to take the opportunity to quit whilst they have access to 24-hour support.

Stop smoking interventions that are effective for the general population are effective for people with mental health conditions. Stopping in one step (known as abrupt quitting or abrupt cessation) with at least 8 to 12 weeks of medication such as NRT or varenicline, combined with behavioural support from a trained stop smoking practitioner, gives the best chance of success.[14] Some service users may require medication and support for longer periods of time (3 to 12 months).[28] E-cigarettes combined with behavioural support can also help people to quit.[29]

Supporting service users following discharge from a smokefree hospital

Service users who receive follow-up support for at least four weeks after admission to a smokefree hospital are more likely to quit smoking for good compared to those who receive support for a shorter time.[30] Even if they relapse back to smoking following discharge, a stay in a smokefree hospital and the experience of using NRT increases their chance of making a successful future quit attempt.[10,18]

Inpatient and community staff can support service users upon discharge in the following ways:

- Review experience of admission to a smokefree ward during discharge care planning.
- If service users wish to maintain the abstinence, or reduction in cigarette use, that they achieved during admission, ensure that they are provided with a sufficient amount of their stop smoking medication to take home.
- Ensure that service users know how to access future supplies of NRT/ medication either through their GP or local specialist stop smoking service, or know where to get an e-cigarette/e-liquid.
- During community appointments, check that they are using sufficient NRT/ other stop smoking medication/e-cigarettes and in the correct way.
- Ensure plasma levels of medication affected by smoking/stopping smoking are checked soon after discharge (see Box 4 and Appendix). A return to smoking, or an increase in cigarette use, may reduce plasma levels within 1 to 2 weeks of discharge from a smokefree environment and medication dosage may need to be altered accordingly.[11]

Box 4: Medications for which plasma levels need to be monitored during smoking cessation

Antidepressants: duloxetine, fluvoxamine, mirtazapine, tricyclic antidepressants

Antipsychotics: chlorpromazine, clozapine, fluphenazine, haloperidol, olanzapine

Other medicines: carbamazepine, methadone, insulin, heparin, warfarin

See Appendix for a comprehensive list of medications

Stop smoking medications and aids

It is important that service users are given a realistic expectation of what stop smoking medications can do for them. They will not completely remove the urge to smoke but they can reduce these urges, alleviate most withdrawal symptoms and make temporary abstinence and quitting easier.

As with all medications, their effectiveness partly depends on them being used as recommended and in the case of nicotine replacement therapy (NRT) administering them using specific techniques.

A free online training module on stop smoking medications is available here: https://tinyurl.com/NCSCT-medications

Nicotine replacement therapy (NRT)

All forms of NRT can be used for temporary abstinence, smoking reduction, and to help those who want to quit or to reduce smoking prior to quitting.

NRT is safe and effective for people with mental health problems who smoke; and is licensed for young people aged 12 and over, and for pregnant and breastfeeding women making a quit attempt.

There are eight different products to choose from:

- Transdermal patch
- Gum
- Lozenge
- Inhalator
- Microtabs
- Nasal spray
- Mouth spray
- Mouth strips

Many of the NRT products come in different doses and flavours. A summary of product characteristics of all the proprietary brands can be accessed here: https://tinyurl.com/NCSCT-NRT

There is no evidence that one product is more effective than another, therefore the choice of products should be guided by any contraindications and service user preference; taking into account restrictions imposed in some settings (e.g. gum is contraband in some secure settings and the mouth spray contains a tiny amount of alcohol).

Typically, use of a single NRT product delivers about half as much nicotine as smokers obtain from their cigarettes. **Combining two NRT products (usually a nicotine patch plus one of the faster-acting products such as gum or mouth spray) is more effective than use of one product alone.**[28]

There is also evidence that NRT added to varenicline or NRT added to bupropion is effective in helping people with psychosis stop smoking.[31] **There are no safety concerns with combining two NRT products, combining NRT with varenicline or bupropion, or combining NRT with an e-cigarette.**[28]

If a service user has to abstain from smoking for a short period of time (a few hours), a single oral product is usually suitable. NRT should be used regularly between smoking episodes to provide comfort and to prolong smokefree intervals. To prevent withdrawal symptoms, regular use (at least hourly) of NRT is more helpful than waiting for the service user to ask for NRT or, more likely feel the need to smoke. The mouth spray, nasal spray and 4 mg lozenge tend to act faster than other products and can be particularly helpful in addressing acute cravings.

Familiarity with the summary of product characteristics for each of the available NRT products, plus specific stop smoking medication training, will ensure that you are able to give service users the best possible advice and support.

Some inpatient mental health services find it challenging to frequently administer oral NRT. However, this can be overcome by working with pharmacy colleagues to adapt medicine charts and allow service users (following a risk assessment) to keep hold of a morning/daily supply of NRT so that they have control over their dose of NRT.

Service users should be regularly offered the opportunity to transition to using NRT to completely quit.

Varenicline (Champix)

Varenicline is a prescription only medicine licensed for smokers over the age of 18. It is more effective than a single NRT product or bupropion for helping people with a mental health condition to stop smoking.[32]

Several trials have been conducted in service users with psychosis and, when the results are pooled together, varenicline improves the odds of quitting by five times compared to placebo.[31]

Up until 2016, varenicline carried a black triangle symbol, indicating additional safety monitoring was required for people with a mental health condition. However, this was removed by the European Medicines Agency following the publication of the largest randomized controlled trial (RCT) to compare varenicline, NRT patch, bupropion or placebo in people with and without a psychiatric disorder (see Box 5).[32]

Treatment should be started whilst the service user is still smoking and a quit date is usually set within the first two weeks of starting varenicline. Service users, who are unwilling or unable to set a target quit date within two weeks, can start treatment and then choose their own quit date within five weeks of commencing varenicline. The dose is titrated using the following schedule: 0.5 mgs daily for the first three days, 0.5 mgs twice a day from days 4 to 7, and then 1 mg twice a day until week 12. For service users who have successfully stopped smoking at the end of 12 weeks, an additional course of 12 weeks of treatment at 1 mg twice daily may be considered for the maintenance of abstinence.

Common side effects include nausea, strange dreams and sleep disturbance. It has no known interactions with psychotropic medications.

Box 5: Evaluating Adverse Events in a Global Smoking Cessation Study (EAGLES)

The study included 8,144 smokers with and without a history of psychiatric disorders. Participants were randomised to receive either varenicline, bupropion, nicotine patch or placebo for 12 weeks and were followed for 24 weeks. The results found that varenicline was the most effective treatment for helping people with and without psychiatric disorders to quit. It also found that varenicline and bupropion did not significantly increase the risk of neuropsychiatric adverse events (including anxiety, depression, aggression, psychosis and suicidal behaviour) when compared to placebo or nicotine patch in patients with or without a history of psychiatric disorders.[33]

A summary of the product characteristics for varenicline can be accessed here: https://tinyurl.com/NCSCT-varenicline

Bupropion (Zyban)

Bupropion is a prescription only medicine licensed for smokers over the age of 18. It is the least frequently used licensed stop smoking medication, possibly because of its side effect profile, contraindications and cautions (refer to the summary of product characteristics for details).

However, there are several trials that have found it effective for helping people with psychosis stop smoking in the short-term. In smokers with serious mental illness, bupropion improves the odds of quitting by four times compared to placebo.[31] In the EAGLES study (see Box 5) it was found to be similarly effective to NRT patch for helping people with mental health problems stop smoking, but less effective than varenicline.[32]

Bupropion should be started at least one week before the quit date and taken for 8 to 12 weeks. For the first six days, the smoker is prescribed 150mg daily; 150mg twice daily on days 7 to 49 (leave an interval of at least 8 hours between doses). On days 50 to 63, if the service user has stopped smoking, continue with 150mg twice daily; but discontinue if abstinence is not achieved.

Bupropion is contraindicated in those with seizure disorders, eating disorders, and alcohol dependence. Common side effects include dry mouth, insomnia, and headache. It has the potential to interact with several psychotropic medications, including monoamine oxidase inhibitors (MAOIs) and antipsychotics.

A summary of the product characteristics for bupropion can be accessed here: https://tinyurl.com/NCSCT-bupropion

Electronic cigarettes

Electronic cigarettes (e-cigarettes) are devices that deliver nicotine within an inhalable aerosol by heating a solution that typically contains nicotine, propylene glycol and/or glycerol, plus flavours.

This aerosol is commonly referred to as vapour and so the use of an e-cigarette is described as vaping. Unlike cigarettes, there is no combustion (burning) involved in e-cigarettes so there is no smoke and no other harmful products of combustion, such as tar and carbon monoxide.

In the UK e-cigarettes are subject to minimum quality and safety standards, packaging and labelling requirements, and tight restrictions on advertising. These regulations also cover ingredients in the solutions used in them (often called e-liquid or e-juice), limits on nicotine concentration and on the size of tanks and refills, and child and tamper proof containers.[33]

There is growing evidence that e-cigarettes are effective in helping people quit smoking, reduce cigarette consumption and relieve withdrawal symptoms.[29]

E-cigarettes are used almost exclusively by smokers and ex-smokers.[34] E-cigarettes are not risk free but, based on the available evidence, are at least 95% less harmful than cigarettes.[22,29,35]

Any conversation with service users about e-cigarettes needs to include an acknowledgement that **e-cigarettes are far less harmful than cigarettes, are popular with smokers and that they have a role to play in helping smokers to quit, reducing the harm of continued smoking and managing temporary abstinence.**

A free online training module, *E-cigarettes: a guide for healthcare professionals* is available here: https://tinyurl.com/NCSCT-e-cig-course

In the interests of public health, the use of e-cigarettes, NRT and other non-tobacco nicotine products should be promoted as widely as possible as a substitute for smoking.[22]

Public Health England and the Care Quality Commission (CQC) support the use of e-cigarettes in mental health in-patient settings as an alternative to smoking. The CQC recently highlighted the role of e-cigarettes in supporting smokefree policies and advised that within in-patient settings, a blanket ban on e-cigarettes is not justified (secondhand vapour poses no identified risk to bystanders), unless there are specific and rational reasons for doing so.[36] When developing and implementing smokefree polices, smoking and vaping should be considered separately as recommended in Public Health England's advice on e-cigarette use in public places and workplaces.[37]

A summary of the evidence and recommendations for clinical practice is available here: https://tinyurl.com/NCSCT-e-cigarettes

The 2016 Royal College of Physicians report on harm reduction (including e-cigarettes) can be found here: https://tinyurl.com/2016-RCP-report

A comprehensive review of the evidence in 2015 by Public Health England can be accessed here: https://tinyurl.com/2015-PHE-review

A comprehensive review of the evidence in 2018 by Public Health England can be accessed here: https://tinyurl.com/2018-PHE-review

Preparation, implementation and maintenance of smokefree policies

Smoking has been embedded in the culture of psychiatry[3] and cigarettes have historically been used to manage service users' behaviour.[38,39] There is an opportunity for inpatient mental health staff to move away from the time-consuming activity of facilitating smoking and reclaim this clinical time to promote and support temporary or permanent abstinence.

The effective implementation of a smokefree policy can be helped by the following factors:

Visible leadership, cohesive clinical team work (including co-production of policies and resources with service users) and communicating clearly with service users, carers and families, staff and other stakeholders to encourage engagement.

Consistency in applying the policy between members of staff and across wards and community services.

An information technology (IT) system that supports the identification and recording of smoking status, prompts clinicians to provide very brief advice (VBA) and supports clinicians to make a referral to a trained tobacco dependence treatment advisor.

Written protocols for offering NRT to service users on admission, consistency in the approach for the use of NRT, persistence and diligence by staff in offering NRT.

Written protocols and guidance on the prescribing of varenicline to service users in hospital and in the community.

Clear and integrated tobacco dependence treatment care pathways from community to inpatient and back to community services.

Therapeutic activity programmes that fit around the management of tobacco dependence rather than fit around smoking.
Education programmes for service users to promote the use of stress management skills.
Guidance for staff about how to help service users stay smokefree during periods of leave.
Guidance on how to manage service users who find it difficult not to smoke whilst on the ward and grounds.
Allow the use of electronic cigarettes, supported by guidance for staff and service users.
Support for staff who smoke, to quit.

Staff education and training about smoking and mental illness is crucial and should include:

- understanding the difference between nicotine and tobacco smoke
- how to deliver very brief advice (VBA) on smoking
- how to communicate the risks and benefits of smoking and quitting on mental health
- the benefits of smokefree settings
- how to prevent and manage withdrawal symptoms
- how to motivate a service user to move from abstaining temporarily to permanently quitting
- the use of carbon monoxide monitoring
- how to improve adherence with stop smoking medicines and/or e-cigarettes

Storage of tobacco

The storage of tobacco and smoking paraphernalia has become a source of contention since Mental Health Trusts have started to go completely smokefree. Trusts may need to review and revise their existing policies on the management of personal belongings and what property is considered appropriate during an inpatient stay and what is considered contraband.

Trusts will already have in place polices on managing the possession and storage of alcohol and other contraband items. These policies can be adapted to include tobacco, matches and lighters. This needs to be clearly and widely communicated to every service user in receipt of community and inpatient services, preferably in advance of an inpatient admission.

The storage of tobacco is a clinical issue. If a smoker keeps tobacco on their person, in a bedroom, in a locked but accessible clinical area or with staff then it can be a cue to smoke and may cause them to experience additional strong urges for a cigarette. Facilitation of smoking takes up valuable clinical time and undermines attempts by service users who are taking the opportunity to quit smoking during an inpatient admission, and those who are trying hard to co-operate with the policy.

Therapeutic response to breaches of a smokefree policy

It is likely that some service users (and staff) will find it difficult to adhere to a smokefree policy and smoke in areas where it is not allowed. Initially, when smokefree polices are implemented, staff may see an increase of smoking in wards, as smokers struggle to adjust to the physical, psychological and environmental changes. When this occurs, it is helpful if staff respond in a supportive and consistent manner. The goal is to ensure safety, maximise engagement and create an environment that is conducive to recovery.

Staff who continue to smoke during working hours seriously undermine the implementation of smokefree policies and they could potentially trigger cravings to smoke in service users if they smell of tobacco smoke. It is important for Mental Health Trusts to support staff who smoke to make a quit attempt and/or manage temporary abstinence whilst at work. In-house stop smoking support or access to a local stop smoking service during working hours, without loss of pay, should be made available.[1]

If a service user is observed smoking on the ward, staff should ensure the area is safe. If there is an imminent risk then support should be enlisted. Where there is no immediate risk the staff should discuss the breach with colleagues and agree the most appropriate time and place to meet with the service user to review the care plan. People who are struggling to co-operate with the smokefree policy should have their care plan reviewed, particularly the dose and frequency of NRT, the service user's adherence with NRT and their access to behavioural support.

An example of a smokefree policy can be found here:
https://tinyurl.com/SLAM-smokefree

One of the main barriers to the implementation of smokefree policies is staff concerns that violence, absconding and fires will increase. Although understandable, the majority of research from the UK and other countries suggest that these untoward effects do not occur.[20] A Mental Health Trust in South London found there was a 47% decrease in physical assaults in the 12 months after they went smokefree compared to the 32 months prior to the introduction of the policy.[19]

Therapeutic management of leave

NICE Guidelines for smoking in acute, maternity and mental health settings recommend there should be no staff-facilitated smoking or smoking breaks.[1] This poses unique challenges for service users, especially for those who are detained under the Mental Health Act and for clinicians who have to deliver care in the least restrictive environment. Since many Mental Health Trusts have gone completely smokefree there is anecdotal evidence that service users are escorted, or leave unescorted, to smoke outside the hospital boundaries several times a day.

According to the Mental Health Act 1983 Code of Practice, the Responsible Clinician needs to consider a number of things when granting Section 17 leave, regardless how short the time period is, including:

1. the interests of the service user
2. the benefits and any risks to the service user's health and safety
3. the benefits to facilitating recovery
4. what support the service user needs during their period of leave
5. an assessment of risk

Whilst leave conditions should be personal to each individual service user, the use of Section 17 leave, in order for service users to smoke does not facilitate recovery, rather it impairs recovery. Cancelling leave as a punishment for breaching smokefree policies is also poor practice. Instead, leave should be planned with the service user in advance and a leave care plan developed. The preparation of leave should include a plan of when and how to use NRT or e-cigarettes and how to avoid and deal with smoking cues.

Changing the smoking culture

Smoking is often perceived to fill time in the absence of alternative activities for people on mental health wards, and for those living in the community. It often becomes a major part of a service user's daily routine, providing structure and a means of breaking up the day. It is often viewed as a shared experience, providing opportunities to make friends, interact and connect with others. Service users may be afraid of losing these perceived benefits despite the negative impact of smoking and they may see it as one of the few things they can control in their lives. With good mental health care, there should be alternative and healthier solutions offered to people to gain a sense of control in their lives.

Staff and service users need to work together to develop new ward routines (and community routines) to replace smoking and develop distraction techniques that help to avoid or manage cravings to smoke. The therapeutic management of boredom requires creativity and imagination, facilitating smoking requires neither. Smokefree policies, including treatment for tobacco dependence, have the potential to transform the culture of mental health organisations, and assist with ensuring the poor physical health of service users is prevented rather than expected.

Conclusion

The health and wellbeing of people who use mental health services is greatly affected by high rates of smoking. Treating tobacco dependence is integral to addressing the disproportionate poor physical health and premature mortality in people with a mental health condition.

Adequately resourced smokefree policies that include the full range of licenced stop smoking medicines plus e-cigarettes, alongside behavioural support from trained community and inpatient staff, will maximise the likelihood of long-term smoking cessation and improve the physical and mental health of service users.

Resources

Smoking Cessation and Mental Health: A briefing for front-line staff. An NCSCT briefing aimed at those who work in mental health settings and giving expert, concise guidance on how to deliver Very Brief Advice (VBA) on smoking to service users who smoke: https://tinyurl.com/NCSCT-mental-health

Improving the physical health of people with mental health problems: Actions for mental health nurses. A Department of Health resource for mental health nurses, wherever they work, to take positive action to improve the physical health of people living with mental health problems: https://tinyurl.com/DH-mental-health-nurses

Smoking and your mental health. A short film for service users about the links between smoking and mental health, and about the opportunities of mental health services going smokefree. Produced by the Harrow Mental Health OT service, with the support of the Chelsea and North West London Recovery College: https://tinyurl.com/smoking-and-mental-health

Improving the physical health of adults with severe mental illness: essential actions. A report of the Academy of Medical Royal Colleges and the Royal Colleges of General Practitioners, Nursing, Pathologists, Psychiatrists, Physicians, the Royal Pharmaceutical Society and Public Health England: https://tinyurl.com/RCPSYCH-report

Smoking cessation in secondary care: mental health settings. Guidance and self-assessment framework for NHS mental health trusts to develop local action to reduce smoking prevalence and the use of tobacco: https://tinyurl.com/secondary-care

Guidance from the National Institute for Health and Care Excellence.
Smoking: acute, maternity and mental health services:
https://tinyurl.com/NICE-PH48

Smoking: harm reduction: https://tinyurl.com/NICE-PH45

The Stolen Years. A 2016 publication by Action on Smoking and Health (ASH) which highlights the disproportionately high rates of smoking among people with a mental health condition: https://tinyurl.com/the-stolen-years

The Mental Health and Smoking Partnership. The Mental Health and Smoking Partnership was established in 2016 following the publication of The Stolen Years report, to bring together organisations committed to improving the health and lives of people with a mental health condition through achieving the ambitions set out in the report: https://tinyurl.com/MHSP-report

Smokefree policies in mental health inpatient services.
A brief guide from the Care Quality Commission: https://tinyurl.com/CQC-smokefree

Towards a smokefree generation: a tobacco control plan for England.
The 2017 policy paper from the Department of Health and Social Care outlining plans to reduce smoking in England, with the aim of creating a smokefree generation:
https://tinyurl.com/GOV-UK-smokefree

Smoking and tobacco: applying All Our Health.
https://tinyurl.com/all-our-health

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Appendix:

Medications for which plasma levels need to be monitored during smoking cessation

Tobacco smoke interacts with medicines commonly prescribed for people with mental health problems. These interactions are caused by the components in the tar within the tobacco smoke (i.e. polycyclic aromatic hydrocarbons) and not nicotine. The tar in the smoke speeds up the metabolism and clearance of some medicines. In order to have the desired therapeutic effect, smokers often need higher doses of some psychotropic medicines compared with non-smokers. One benefit of stopping smoking is the dose of some medicines can possibly be reduced.

The levels of medication in the blood can vary if a person starts, stops or changes the way they smoke (such as temporarily abstaining from smoking). Generally speaking, for a person who stops smoking, either planned or due to enforced abstinence, prescribers should consider a dosage reduction of drugs that are metabolised by the liver enzyme CYP1A2. Conversely, if a person resumes smoking following discharge, or even after a period of leave, their dose of medication may need to be increased. Evidence of the effect of brief periods of smoking abstinence on blood levels of medication is lacking. Close monitoring and good communication between the patient, their carer and the prescribing doctor is essential.

The table below is not an exhaustive list and new interactions are continually being discovered. Staff are encouraged to refer to the Maudsley Prescribing Guidelines for an up-to-date list of psychotropic drugs that are affected by tobacco smoke.[11]

Psychiatric medicines that may be affected by smoking status
(adapted from Maudsley Prescribing Guidelines) [11]

Actions	Effect of smoking	Action to be taken on stopping smoking	Action to be taken on resuming smoking
Antipsychotics			
Clozapine	Reduces plasma levels by up to 50%. May be a greater reduction in people taking Valproate.	If possible, take plasma level before stopping. On stopping, reduce dose gradually (over a week) by 25%. Repeat plasma levels one week after stopping. Continue to review dose.	Anticipate this may happen very soon after discharge, take plasma levels in anticipation. Increase dose to previous dose whilst smoking over one week. Repeat plasma levels.
Fluphenazine	Reduces plasma levels by up to 50%	On stopping, reduce dose by 25%. Monitor for up to eight weeks. Consider further dose reductions.	Increase dose to previous dose whilst smoking. Monitor closely.
Haloperidol	Reduces plasma levels by around 20%	Reduce dose by around 10% and continue to monitor. Consider further dose reductions.	Increase dose to previous dose whilst smoking. Monitor closely.
Olanzapine	Reduces plasma levels by up to 50%	Take plasma level before stopping. On stopping, reduce dose by 25%. After one week, repeat plasma level and consider further reductions.	Increase dose to previous dose whilst smoking. Repeat plasma levels.

Actions	Effect of smoking	Action to be taken on stopping smoking	Action to be taken on resuming smoking
Antidepressants and benzodiazepines			
Duloxetine	Plasma levels may be reduced by up to 50%	Monitor closely. Dose may be reduced.	Consider re-starting previous 'smoking' dose.
Tricyclic anti-depressants	Plasma levels reduced by 20–50%	Monitor closely. Consider reducing dose by 10–25% over one week. Consider further dose reductions.	Monitor closely. Consider restarting previous dose whilst smoking.
Benzo-diazepines	Plasma levels reduced by 0–50%	Monitor closely. Consider reducing dose by up to 25% over one week.	Monitor closely. Consider re-starting previous dose whilst smoking.