Smoking and mental health

Key points

• Smoking prevalence among people with mental illness is substantially higher than the general population.
• In mental health units, up to 70 per cent of patients smoke.
• Understanding the physical and psychological impact of quitting smoking for mental health service users is an important part of a harm reduction strategy.
• Smoking affects the way some psychiatric drugs are metabolised, with more medication needed than for non-smokers.
• Reducing smoking among mental health service users can make an important contribution to the public health agenda.
• Key questions for boards to consider are on page 6.

Tobacco smoking is the main cause of preventable and premature deaths in the UK. People with mental illness are more likely to smoke heavily than the general population. Those with severe mental illness live 16 to 25 years less than the general population, have a reduced life expectancy, and are at significantly greater risk of smoking-related illnesses. The national mental health strategy, No health without mental health, and the Public Health Outcomes Framework, Healthy lives, healthy people, are drivers for change to reduce such health inequalities.

The implementation of smoke-free legislation in 2008 saw mental health service providers adapt to a new way of providing services, placing greater limits on smoking provision for service users, introducing more ‘quit smoking’ support and, in some cases, establishing premises that were entirely smoke free.

This Briefing provides the background to smoking prevalence and the consequences for people with mental illness. It examines the evidence of what works to reduce harm from smoking for this group, and how providers are implementing the smoking ban in practice.

Reducing smoking among mental health service users can make an important contribution to improving public health and can improve the longer-term health and wellbeing of people living with mental health problems.

Prevalence

Smoking prevalence among people with mental illness is substantially higher than the general population. Around 22 per cent of the English population in private households are regular smokers, smoking seven or more cigarettes a week. However, among people with mental health problems, the figure is 33 per cent and up to 40 per cent among people with probable psychosis. The strength of association tends...
Higher smoking rates among people with mental illness result in increased levels of morbidity and premature death. The highest prevalence of smoking is found among psychiatric inpatients. In mental health units, it is estimated that 70 per cent of patients smoke, with 50 per cent of patients described as heavy smokers.

Higher rates of smoking are also believed to be a major factor in the ten-fold increase in deaths from respiratory disease for people with schizophrenia, compared to the general population. Smoking also contributes to a significant proportion of deaths caused by cancer and circulatory disease, with people who smoke heavily being more prone to smoking-related illnesses.

### Policy context

One of the objectives of the national mental health strategy, *No health without mental health*, is that more people with mental health problems should have good physical health. The strategy recognises that smoking is responsible for most of the excess mortality of people with severe mental health problems and points to the Public Health Outcomes Framework as a mechanism for measuring change. *Healthy lives, healthy people* includes a measure relating to excess mortality in adults under the age of 75 with a serious mental illness. Although the indicator does not specifically refer to smoking, it is known to be a significant contributing factor towards early death within this group.

There are several smoking-related indicators within the framework. Reducing the amount that mental health service users smoke can contribute to progress against these indicators and so reduce health inequalities.

The National Institute for Health and Care Excellence (NICE) intends to publish new guidance on smoking cessation in mental health services at the end of 2013. Guidance published by the Health Development Agency in 2005 recommended a series of steps for implementing a smoke-free policy within inpatient settings (see ‘Key questions for boards’ box on page 6).

Public Health England, in their work to reduce health inequalities, will be supporting the development of intelligence, including appropriate guidance and advice on smoking cessation for people with mental health problems.

### The economic cost of smoking

*Smoking and mental health*, a report published by the Royal College of Physicians and the Royal College of Psychiatrists, indicated that the NHS spends approximately £720 million a year in primary and secondary care treating smoking-related disease in people with mental health disorders. It also states that smoking increases psychotropic drug costs in the UK by up to £40 million a year. Addressing the high prevalence of smoking in people with mental health disorders offers the potential to realise substantial cost savings to the NHS, as well as benefits in quality, and length, of life.

To achieve this, the report recommends that health professionals and commissioners require mental health service settings to be smoke free, and prioritise providing support for cessation, abstinence and harm reduction for people with mental disorders.

### Smoking cessation for mental health service users

Compared to the reduction in smoking prevalence in the general population, smoking among people with mental health problems has remained largely unchanged over the past 20 years. Yet many mental health service users wish to stop and can do so with support.

### What works?

Smoking cessation interventions include brief advice, a range of group or individual talking therapy sessions and/or cessation medications. They can be accessed through general practice, local pharmacies, services provided by mental health trusts and by self-enrolment with a local NHS Stop Smoking Service (NHS SSS).
Case study: Smoking cessation success in south west London

In 2010, South West London and St George’s Mental Health NHS Trust established a smoking cessation project to support delivery of its commissioning for quality and innovation (CQUIN) targets. The targets aimed to improve access to smoking cessation information, advice and support for mental health service users, and recorded smoking status; the number of referrals to the smoking cessation service; the number of smokers referred who set a ‘quit date’; and a service feedback after 12 weeks into the support package.

The project has seen smoking cessation training introduced into the trust’s mandatory induction programme. So far, 90 per cent of all relevant clinics have received smoking cessation brief intervention training, enabling them to deliver brief interventions for identified smokers. Smoking status is noted at initial assessment and recorded on RIO, the trust’s reporting system, with 85 per cent of the trust’s current caseload registered. If service users indicate they would like to change their smoking habits, a referral is made to the largely community-based cessation clinics. Support to inpatient units is also offered. Service users can also self-refer for support.

The smoking cessation clinics offer a 12-week programme of weekly sessions (individual or group), regular carbon monoxide monitoring, pharmacological therapy advice and behavioural change therapy sessions. Close liaison with medical teams ensures medication dosage is monitored. The programme content is tailored to the specific needs of mental health service users and is run by a dedicated team of NHS-accredited smoking cessation practitioners with a range of therapeutic skills and qualifications, including cognitive behavioural therapy, counselling and health promotion interventions. Having additional mental health experience and skills enables smoking advisers to deal with the complex issues they may come across.

Over 700 smokers have been referred to the smoking cessation clinics, and more than 30 per cent have either quit or significantly reduced their cigarette intake. While some smokers have been unable to stop completely, their smoking reduction offers immediate health benefits and may give them the confidence to give up at a later date.

A dedicated project board team brings together senior staff, clinicians, technicians and specialists from key areas of the trust and drives the programme throughout the organisation.

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The vast majority of people with mental health problems receive treatment and support in primary care, making the role of GPs in providing smoking cessation treatment crucial. The recent introduction of mental health specific smoking-related outcomes in the Quality and Outcomes Framework (QOF) recognises this and rewards GPs for documenting smoking status in patients with schizophrenia, bipolar disorder and other psychoses, and for providing smoking cessation advice or referral to an NHS SSS. 22

NHS SSSs can involve weekly behavioural support sessions with a trained practitioner, alongside nicotine replacement therapy (NRT) or other pharmacological interventions. They have been shown to be highly cost effective. 23 However, it has been argued that the demands of the traditional ‘four-week’ quit targets have inhibited the full potential of these services to reduce health inequalities for people who are disadvantaged and may require enhanced support. 24

A review of the evidence 25 found that a combination of talking therapies and pharmacological interventions is beneficial in helping people with mental illness to stop smoking, in some cases achieving abstinence rates comparable to those among people without a history of mental illness. These services did not limit the number of contacts and employed professionals who were qualified in both mental health and cessation support. 26
‘Understanding the biological, psychological and social factors that contribute to people smoking can help those who want to stop’

Tailoring treatments to meet the specific demands of this group is a common theme in the literature. This has more recently been acknowledged and is reflected in recent national guidance aimed at NHS SSSs, and in training modules for smoking cessation advisers.  

**Staff awareness and training**

Understanding the biological, psychological and social factors that contribute to people smoking can help those who want to stop. Healthcare professionals will need to be aware of the psychological and physical effects that quitting can have on people with mental illness, and be able to understand the symptoms of nicotine withdrawal. Training may be required to increase staff knowledge as well as challenge any misconceptions they may have about entrenched smoking cultures among service users.

Closer working between primary and secondary care staff can facilitate greater integration. This can help staff feel confident to identify and know how best to intervene in adverse health behaviours, such as smoking.

Smoking can affect the way some psychiatric drugs are metabolised, so those who smoke may require more medication than non-smokers. Individuals who quit smoking while taking medication should be closely monitored so that medication levels can be adjusted, if required.

**Harm reduction**

Draft NICE guidelines endorse the use of harm reduction strategies, by which people who are otherwise unlikely to quit, or do not want to, are encouraged to substitute smoking tobacco with alternative sources of nicotine for long-term use. Nicotine substitutes offer the potential to prevent harm from smoking, by directly reducing the amount of smoke inhaled. Harm reduction is recommended as a means to promote smoking cessation, and support smoke-free policies, in mental health settings.

**Implementing a smoke-free mental health service**

In 2007, it became an offence to smoke within any public building or space in England. Mental health units were given an additional 12 months to comply with the law. The Department of Health commissioned a review in 2010 to gauge how mental health providers were adapting to the legislation. The review comprised a survey of 220 mental health units, including acute units and low, medium and high secure facilities, and follow-up visits with 28 providers. The review found that the majority of units were complying with the legislation, either in the form of a total ban encompassing both premises and grounds, or as a partial ban just within the premises.

**Full versus partial smoking bans**

There continues to be debate on whether full or partial bans should be the preferred option. In support of full bans, some argue that total bans are simpler to implement, and carry less risk of passive smoking. Advocates for partial bans argue that this allows service users to exercise their choice to continue to smoke or not. A summary of the benefits and limitations of full and partial bans is considered in Cormac and McNally’s 2008 paper on how to implement a smoke-free policy.

The review commissioned by the Department of Health found that those units that had implemented a complete ban were largely medium to high secure units. Many of the providers that allowed smoking outdoors at any time had designated enclosed areas. This resulted in outdoor areas effectively becoming smoking areas, which can be unpleasant for others to occupy.

The review highlighted the cost to mental health providers of providing supervised breaks, estimating that it took one whole-time equivalent member of staff per unit to supervise smoking activity each day. Smoking breaks were also noted to interrupt therapeutic programmes.
Case study: Smoking cessation at a medium secure facility

When St Andrew’s Healthcare opened William Wake House – a medium secure facility – in Northampton in 2010, they made it a non-smoking environment in order to improve the physical and mental health of service users.

Two established units, Hawkins and Robinson, moved from existing accommodation to new smoke-free facilities. Hawkins’ service users with a learning disability and detained under the Mental Health Act were offered more intensive support. They were offered a 12-week smoking reduction programme prior to the move, which included information about the link between smoking and poor physical health, nicotine replacement therapy and psychological support via the nursing staff and primary care practice nurse. However, only three of the 13 smokers on the ward took up the programme and they quickly reverted to smoking again. Subsequently, a six-week programme of reduced smoking was implemented. Each week the number of allocated smoking times was reduced. Prior to the move, Hawkins’ service users were only smoking up to three cigarettes a day, which made the transition to the smoke-free facility easier, especially as it was a ‘whole-ward’ approach.

Service users on the Robinson ward were offered nicotine replacement and psychological support at the time of the move. Those without access to escorted leave within the grounds had to give up smoking completely, while those with the right to leave the building with an escort were encouraged to reduce the number or cigarettes they smoked, or quit.

On each ward, a health promotion link nurse and a service user representative coordinated healthier living activities, including an increase in physical activity and healthier eating. The facility reports no rise in incidents of aggression and has not had any formal complaints since implementing the policy.

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Case study: Human rights versus a right to health – the Rampton Hospital judgement

In 2008, three patients from the high secure, forensic facility at Rampton Hospital took Nottinghamshire Healthcare to judicial review, in response to the trust’s decision to introduce a total smoking ban throughout the hospital’s buildings and grounds. The patients’ lawyers argued that the smoking ban breached Article 8 of the European Convention on Human Rights, which guarantees respect for private life. They argued that the hospital was their home and to prevent them smoking when they were not free to go elsewhere breached their rights.

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.”

The patients appealed the decision, taking it to the Court of Appeal, but again courts ruled in favour of the trust. The court noted that the trust owed a duty of care to staff to protect them from second-hand smoke and that it was legitimate to restrain a person’s Article 8 rights for the protection of health. According to the legal firm which represented the trust, the ruling means that it is unlikely that any patient detained under the Mental Health Act in any psychiatric hospital in the country has a legal right to smoke, unless there are exceptional circumstances in their case.

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Mental Health Network viewpoint

People with mental illness are at a substantially increased risk of an early death, often as a result of smoking. However, the evidence demonstrates that many service users want to stop, and can with tailored interventions and enhanced support.

The vast majority of people with a mental health problem are treated and supported in primary care. This means that GPs have a crucial role to support and refer people with mental health problems to smoking cessation services.

However, the rates of smoking among people with severe and enduring mental illness is very high; this group is more likely to be in touch with secondary mental health providers. For that reason, there is a clear role for mental health providers, and commissioners, to focus on smoking cessation as one of the key ways in which to improve the physical health of service users.

For more information on the issues covered in this Briefing, please email claire.mallett@nhsconfed.org

Key questions for boards to consider

- **Service user support**: Does your organisation have support mechanisms in place to help service users to quit smoking, including access to nicotine replacement therapy, signposting to NHS stop smoking services, educational information and counselling?

- **Service user monitoring and support**: Is the smoking status of service users routinely recorded and smoking cessation offered? Are new interventions offered to service users who relapse?

- **Staff awareness and training**: Are your clinical staff sufficiently trained in providing brief smoking cessation interventions to service users? Are staff aware of the physical and mental side effects of smoking cessation and how to support service users going through withdrawal?

- **Engagement**: Do you have mechanisms for engaging service users and staff in your organisation’s smoking policy?

- **Communications**: Do you have a communications strategy to support the organisation’s efforts to support smoking cessation? This could include face-to-face engagement through staff meetings and service user forums, posters, intranet resources on smoke-free information, and support and information packs for clinical staff.

- **Policy breaches**: Does your smoking reduction policy make clear what action will be taken around breaches? Different procedures should be considered to manage breaches by staff, patients and visitors.

- **Evaluation and review**: Do you regularly evaluate how successful your organisation has been in supporting service users to stop smoking? Monitoring quit rates, service user feedback and incident levels can assist evaluation.
References

8. ibid.
20. ibid.
23. ibid.
24. ibid.
26. ibid.
29. ibid.
32. ibid.
The Mental Health Network

The NHS Confederation’s Mental Health Network (MHN) is the voice for mental health and learning disability service providers to the NHS in England. It represents providers from across the statutory, for-profit and voluntary sectors.

The MHN works with Government, NHS bodies, parliamentarians, opinion formers and the media to promote the views and interests of its members and to influence policy on their behalf.

For further details about the work of the MHN, visit [www.nhsconfed.org/mhn](http://www.nhsconfed.org/mhn) or email [mentalhealthnetwork@nhsconfed.org](mailto:mentalhealthnetwork@nhsconfed.org)

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