Public mental health and smoking

A framework for action

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Public Mental Health Implementation Centre

RC PSYCH ROYAL COLLEGE OF PSYCHIATRISTS

ash. action on smoking and health

Contents

1. Introduction

Smoking is a leading cause of the 7–25 year reduced life expectancy among people with mental health conditions (Walker et al., 2015). It makes people poorer and less likely to be employed, which increases the likelihood of poor mental health (ASH, 2020b).

By meeting the UK government's ambition of a smokefree country by 2030, we will not only reduce physical health inequalities but also reduce the burden of mental ill health.

This report is a practical document, designed to drive action locally, regionally and nationally across sectors. It is for people and organisations developing plans and strategies to improve mental and physical health in our communities, particularly those working to implement public mental health approaches to prevent poor mental health in society.

Section 2: Smoking and poor mental health: a cycle of dependence

Section 2 provides evidence that people with poor mental health are more likely to smoke and that smoking can damage people's mental health.

We also examine the impact of the bi-directional relationship between smoking and poor mental health on health inequality, including increased mortality and loss of healthy years.

Section 3: Approaches to reduce smoking

Section 3 sets out evidence-based strategies for reducing smoking at population level, and targeted approaches for those with mental health conditions.

Section 4: National and local action needed to secure change

Section 4 contains a framework (Table 3) for scaling-up action, in line with the Prevention Concordat for Better Mental Health, to secure the Government's ambition for England to be smokefree by 2030.

How this report was developed

This report has been produced collaboratively by the Mental Health and Smoking Partnership (coordinated by Action on Smoking and Health [ASH]) with the Royal College of Psychiatrist's Public Mental Health Implementation Centre. It has been produced with expert input from researchers within the SPECTRUM academic consortium (Spectrum Consortium, 2022).

1.1. Summary and recommendations

Public mental health aims to reduce the burden of poor mental health on society by taking preventative measures to reduce harm (Public Mental Health Implementation Centre, 2022). This can occur both by reducing the incidence of poor mental health and by reducing the broader harmful impacts when poor mental health occurs.

Smoking is a causal factor in poor mental health and leads to worse outcomes. It is therefore an important target area for public mental health. This report sets out how a joined-up approach across tobacco control and public mental health can secure wider benefits to society than taking a siloed approach to each.

1.1.1. Key findings in this report

- Smoking is a leading cause in the gap in life expectancy between people with mental health conditions and those without. The inequalities in health caused by smoking are greatest among those with severe mental illness (SMI), with smoking contributing up to two-thirds of the reduced life expectancy of this population. However, the numbers of people affected by smoking and poor mental health are greatest among those with common mental health conditions such as depression and anxiety, with over a million people living with these conditions and smoking.
- Smoking is a cause of poor mental health across the whole population. Indirectly, through its impact on physical health, income and employment, and directly, by increasing the risk of some mental health conditions (such as depression and schizophrenia) and through the creation of addiction, which inhibits people's mental wellbeing.
- Stopping smoking improves symptoms of depression and anxiety, equivalent to the impact of taking antidepressants, for all smokers (G. Taylor et al., 2014; G. M. Taylor et al., 2021). For people taking certain antipsychotic medications, stopping smoking can mean that lower doses are needed. All smokers benefit from increased income, improved employment prospects and short- and long-term gains to physical health.
- There is a major challenge in changing the perceptions of both smokers and healthcare professionals about the impact of smoking on mental health. There are widespread misperceptions that smoking helps manage stress, while the evidence demonstrates that smoking is a causal factor in mental health conditions and can exacerbate rather than reduce stress.
- The interventions needed to reduce smoking for the whole population and for those with a mental health condition are known. However, despite a government pledge to make smoking obsolete there are significant gaps in implementation, in terms of national action and delivery in the NHS and local government public health programmes for those with a mental health condition. To break the cycle of dependence between smoking and mental health, concerted action is needed nationally and locally.

1.1.2. National recommendations

1. A new Tobacco Control Plan is required, with a strong focus on tackling smoking in all people with a mental health condition, through targeted investment and

effective data monitoring systems, underpinned by targets for reduced smoking prevalence in this population (Mental Health and Smoking Partnership, 2021).

2. Nationally, Improving Access to Psychological Therapies (IAPT) services should include support for smokers to quit, to improve both mental and physical health outcomes.
3. National communications activity on promoting positive mental health should include messages about the benefits of stopping smoking and avoiding starting. Similarly, national 'stop smoking' communications should include information on the benefits to mental health.
4. Coproduction with service users locally should be supported to resource peer support workers using QI (quality improvement) methodology, to maximise signposting to help and quit rates.
5. Major gaps in the data must be addressed. Data is needed to monitor smoking rates across all populations with a mental health condition, to measure the provision of evidence-based support and the outcome of treatment.

1.1.3. Framework for local action

Strategies to reduce smoking and improve mental health

Table 3, found in Section 4, is a key component of this report.

This utilises the Prevention Concordat Framework (Public Health England, 2020) to describe how local NHS and local government strategies can develop stronger, more coherent approaches to secure the twin objectives of reducing rates of smoking and improving population mental health.

2. Smoking and poor mental health: a cycle of dependence

This section describes the complex interactions between smoking and poor mental health, and the extent to which one feeds into the other.

It shows how smoking increases the risk of development of some mental health conditions, how smokers with poorer mental health have higher levels of dependence and face more barriers to quitting, and how the impact of smoking on health and wealth is a further driver of poor mental health in the population.

Breaking this cycle of dependence (Figure 1) will help address inequalities by securing improvements to physical and mental health.

Figure 1. Cycle of Dependence

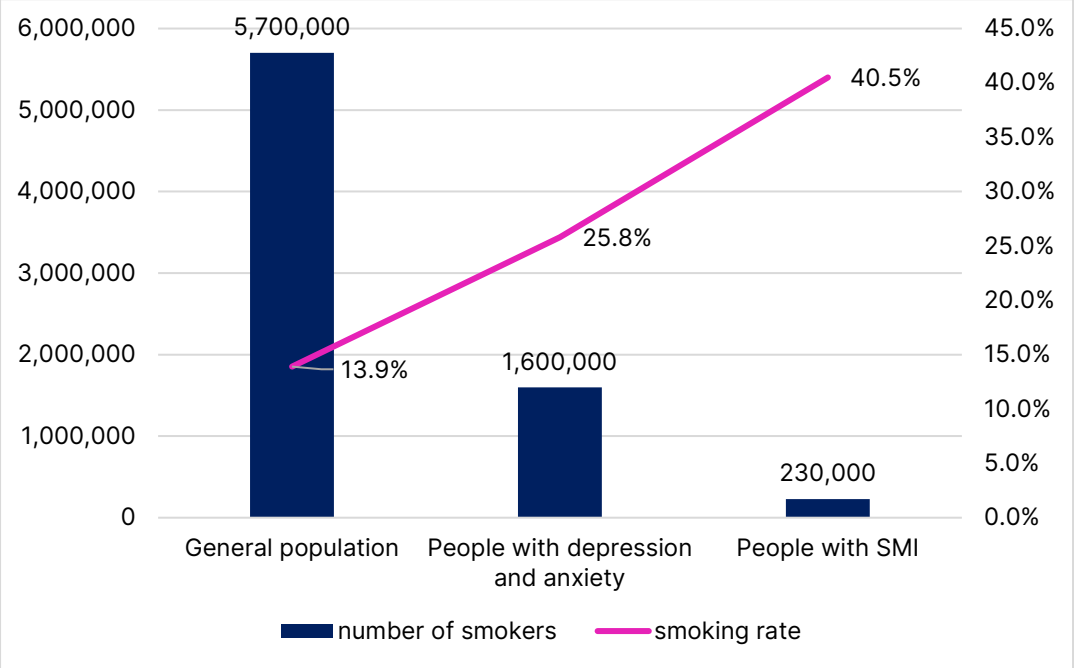
2.1. High rates of smoking drive health inequalities among people with mental health conditions

Higher smoking rates lead to poorer long-term health outcomes and reduced life expectancy in people with mental health conditions (Chesney et al., 2014, 2021; Lawrence et al., 2013; Tam et al., 2016; Wahlbeck et al., 2011). Smoking contributes two thirds of the reduced life expectancy of people with SMI (Tam et al., 2016)

Smokers with schizophrenia, schizoaffective disorder and bipolar disorder are reported to have a reduced life expectancy of 6.2 years compared with those who are non-smokers (Chesney et al., 2021).

Smoking rates are higher in most groups of people with mental health conditions compared to the general population (Figure 1). The Royal College of Physicians meta-analysis found people with depression were 1.7 times more likely to smoke while those with schizophrenia were more than twice as likely to smoke compared to people without a mental health condition (Tobacco Advisory Group of the Royal College of Physicians, 2018). People with a mental health condition are also more likely to be heavy smokers, despite a more frequent desire to quit compared to the general population (Richardson et al., 2019).

Figure 2 Prevalence of smoking among adults with and without mental health conditions, England[1]



Most smoking starts before adulthood. As with adults, smoking is several times more common in children and young people with mental health conditions and behavioural disorders. In 2017, children and young people in England aged 11–16 identified as having a probable mental disorder were 10 times more likely to smoke regularly than those without (Marcheselli et al., 2018). An estimated 19.3% of young people aged 17–22 with a probable mental disorder (based on the Strengths and Difficulties Questionnaire (Youth In Mind, n.d.)) had smoked one or more cigarettes in 2020, compared to only 5.4% of young people unlikely to have a mental disorder (Vizard et al., 2020). Young smokers are more susceptible to the harms of tobacco on physical

[1] Data sources: prevalence of current smoking among the total adult (18+) population of England taken from the 2019 Annual Population Survey (ONS, 2021); prevalence of current smoking among adults in England with a long-term mental health condition.

health and show increased likelihood of smoking heavily in adulthood (Grana et al., 2012; Hegmann et al., 1993; McCarron, 2001). Preliminary evidence suggests that children and young people with mental health conditions understand the harms of smoking but lack motivation and confidence to quit (Day et al., 2016).

There are overlaps between some groups in Table 1 – people with depression and anxiety and SMI will also be represented in the long-term mental health condition group. Similarly, substance misuse and harmful drinking may also overlap with other groups.

Table 1. Smoking rates and numbers of smokers with different mental health conditions in England

Population	Smoking rate	Estimated population size
Adults 18+ in England	13.9% smoking rate (ONS, 2020)	~ 5.7 million people. This includes: • ~ 52,000 pregnant smokers (NHS Digital, 2022) • ~ 1.2 million households living in poverty (Reed, 2021) • ~ 1.4 million people in social housing[a] (ASH, 2019b) There are also: • ~ 250,000 people economically inactive due to smoking (ASH, 2020b) • ~ 1.5 million people with social care needs due to smoking (ASH, 2021)
Adults with depression and anxiety	25.8% smoking rate	~1.6 million people[b]
Adults with a long-term mental health condition	26.3% smoking rate (Office for Health Improvements and Disparities, 2022)	~ 1.28 million people[c]
Adults on GP SMI register who smoke	40.5% (14/15 GP data)(Health and Social Care Information Centre, 2015)	~ 230,000 (this does not include adults with SMI who are not on GP register)[d] (NHS England and NHS Improvement, n.d.)
Adults who drink harmfully (more than 15 units a week)	20% smoking rate Among those in treatment for alcohol dependence, smoking rate is 43% (Office for Health Improvements and Disparities, 2022)	• ~ 1.2 million smokers who also drink harmfully • 15,300 smokers also in treatment for alcohol dependence

Adults in treatment for opioid dependency	70% smoking rate (Office for Health Improvements and Disparities, 2019)	~ 19,700 smokers who are also in treatment for opioid dependency
Adolescents and young smokers aged 17–22 identified as having a probable mental disorder	19.3% smoking rate (Vizard et al., 2020).	• ~51k 17–22-year-old men with probable mental disorder who smoke • ~99k 17–22-year-old women with probable mental disorder who smoke

[a] This was calculated applying the proportion the people living in social housing in the ASH/YouGov survey (12%) to the ONS mid-year population estimates 2020 for 18+ population and the ASH/YouGov rates of smoking among those living in social housing (26%).

[b] This estimate was calculated applying the rate of people with depression and anxiety in the GPPS (13.7%) to the ONS mid-year population estimates 2020 for 18+ population and the GPPS rate of smoking among people with depression and anxiety (25.8%).

[c] Calculated by applying the rate of LT MH condition in the GPPS (11%) to the ONS mid-year population estimates 2020 for 18+ population and the smoking prevalence for people with LT MH condition in the GPPS (26.3%)

[d] Calculated by applying the 2014/15 smoking rate among people on the GP SMI register (40.5%) to the number of people on the 2021/22 GP SMI register (526, 443)

[e] This is calculated by applying the level of drinking above 15 units found in the ASH/ YouGov survey (13.5%) to the ONS mid-year population estimates 2020 for 18+ population and the smoking prevalence for this population from the ASH/YouGov survey (19.9%)

[f] Calculated by applying the rate of probable mental disorder in Mental Health of Children and Young People in England, 2020 for men (13.3%) and women (27.2) the ONS mid-year population estimates 2020 for 17–22-year-olds in England and the smoking prevalence rate for all 17–22-year-olds with a probable mental disorder (19.3%)

2.2. Poor mental health among those with poor physical health

Smoking is a leading cause of preventable death in the UK and is responsible for just under 500,000 hospital bed days each year (Office for Health Improvement and Disparities, n.d.). Smokers need help with everyday activities such as washing and shopping a decade earlier than non-smokers. These additional health needs result in an additional £1.2 billion social care costs for local authority, and mean that friends and family provide informal care to more than 1 million people (ASH, 2021). In a survey of carers, 30% reported that their mental health is bad or very bad (Carers UK, 2021).

People with poor physical health often also suffer from poor mental health. The King's Fund estimate that around 4.6 million people are living with long-term physical health conditions and poor mental health. The incidence of poor mental health among those with long-term conditions is believed to account for 12–18% of all NHS expenditure on long-term physical conditions (Naylor et al., 2012).

Reducing smoking rates could reduce the incidence of poor physical health and subsequently reduce the incidence of common mental health conditions such as depression and anxiety.

2.3. Why people with mental health conditions are more likely to smoke

There are three main hypotheses as to why smoking is more common in the population of people with a mental health condition:

1. Smoking is used as self-medication for people with poor mental health to manage their symptoms
2. Smoking and poor mental health share common risk factors
3. Smoking plays a causal role in poor mental health

The most recent evidence indicates that all these factors are at play in driving high rates of smoking (Wootton et al., 2022).

Self-medication

Smokers often believe that the symptoms of mental illness or side effects of psychiatric medications are alleviated by the chemical properties of tobacco (Desai et al., 2001; Khantzian, 1997; Lerman et al., 1996; Levin, 1996). It is common for smokers to experience their smoking as helping them to temporarily relieve anxiety or improve mood. This is a factor in the increased uptake, and perpetuation, of smoking among individuals with poor mental health.

However, there is now strong evidence that stopping smoking improves mental wellbeing once withdrawal has past (G. M. Taylor et al., 2021).

> *"It's like an old friend, isn't it? I mean, you know, it's bad for you. But it's, it's like something that becomes your friend over the years. It feels like it's one of your best friends. And when it's taken away, you know, you just kind of don't feel right. Yeah. You really miss it."*
> — MH sufferer, 35-44, North/NW

Common liability

Shared genetic and environmental factors could predispose people to smoking and to having poorer mental health. For example, environmental factors might include trauma in childhood, which could drive smoking initiation as well as the development of mental health conditions. There is limited evidence in this area and further research is needed.

Two studies used a co-twin control design to explore the genetic associations between smoking and schizophrenia (Kendler et al., 2015) and depression (Kendler, 1993). This method compares rates of mental illness diagnoses in pairs of twins, where one twin smokes and one doesn't. The twins who smoked were found to have

significantly higher risk for both schizophrenia and depression (Kendler, 1993; Kendler et al., 2015)

Studies comparing identical and non-identical twins showed an association between smoking and depression due to genes that predispose to both smoking and depression. However, Mendelian randomisation studies, summarised below, suggest that shared genes may not fully account for this relationship. In the case of schizophrenia, it has been found that the association is only partially explained by shared genes.

Smoking is causal in developing mental health conditions

Evidence from observational and Mendelian randomisation studies suggest smoking has a causal effect on both depression and schizophrenia (Wootton et al., 2022). Estimates of the size of this effect vary. Based on the results of the Mendelian randomisation studies, smokers appear to have an increased likelihood of developing schizophrenia of between 53% and 127%. The effect of smoking on the increased likelihood of developing depression is estimated to range from 54% to 132%.

There is little evidence for a causal effect of smoking on other mental health conditions (for example attention deficit hyperactivity disorder [ADHD], anorexia nervosa, suicidal ideation, psychological distress) and further research is needed. However, studies have indicated that smoking could be associated with an increased likelihood of developing bipolar disorder (Wootton et al., 2022). Smoking is causal in the development of conditions that directly impair mental health such as dementia (Durazzo et al., 2014; Livingston et al., 2017; Zhong et al., 2015).

Because smoking contributes to the risk of developing a mental health condition as well as exacerbating mental health conditions, it can create a vicious cycle of dependence. (see Figure 1).

2.4. Stopping smoking improves mental health and treatment of mental health conditions

There is strong evidence to show that people who stop smoking improve their mental wellbeing. The most recent Cochrane evidence review found that within 6 weeks of stopping smoking, people saw an improvement in their mental health (G. M. Taylor et al., 2021) an effect equivalent to the impact of taking antidepressants (G. M. Taylor et al., 2014) . This effect endured across follow-up in all the included studies and across all social groups. This effect is likely linked to the negative mental health impact of nicotine withdrawal, whereby smokers are locked in a cycle of cravings.

Smoking also increases the metabolism of some anti-depressants, antipsychotic medications and benzodiazepines. This means that smokers can need higher doses of medication compared to non-smokers, and that medication can be reduced when they stop smoking (Jones et al., 2007; Knox et al., 2006). It is important to note that the changes in levels of medication needed are due to the metabolic impact of smoking, not due to changes in mental health conditions.

There is also evidence that stopping smoking improves outcomes for individuals receiving treatment for drug and alcohol dependency. Smoking is associated with higher consumption of some drugs such as cocaine (Kohut, 2017). Furthermore, continuing to smoke during treatment for drug use impairs outcomes (Weinberger et al., 2017). Stopping smoking during treatment increases the chances of successful outcome by 25% (Prochaska et al., 2004).

2.5. Interaction with the wider determinants of health

Smoking and poor mental health are both associated with socioeconomic disadvantage. Smoking rates among those with mental health conditions increase with increasing socioeconomic disadvantage; 16.4% of people who report being treated for a mental health condition smoke in the least deprived populations (compared to 8.3% of those who have not been treated for a mental health condition), whereas 24.3% of people who have been treated for a mental health condition smoke in the most deprived populations (vs 16.4% in those who have not been treated for mental health condition) (ASH, 2022a). The proportion of smoking in unemployed people was 26.8% compared to employed (14.5%) and economically inactive (12.8%) (Office for National Statistics, 2020). Each indicator of disadvantage increases an individual's risk of smoking.

> *"Some days I really do hate it. Both pregnancies I gave up and another time I gave up for two years, so I can do it. And I think just where I'm constantly worried about the increase in prices and, you know, everything like that, gets on top of you, and I think 'Oh I know, I'll have a fag, that'll make me feel better.' Sort of goes hand in hand: stress and a fag."*
> — MH sufferer, 22-34, southern coastal town

Difficult circumstances not only lead to both poorer mental health and higher probability of starting smoking, but smoking and poor mental health also both reinforce and compound difficult life circumstances. Poor mental health can lead to 'social drift', where a person moves down the social ladder due to lower employment and economic status, limited housing options and increased social stigma. Similarly, smoking is not only a cause of poor health and early death; it is also a driver of poverty, underemployment and lower productivity. The average smoker spends just under £2,000 per year on tobacco (equating to £17 billion a year in England) (ASH Action on Smoking and Health, 2022), faces lower rates of employment and earns less than the wider population as a result of ill health (ASH, 2020b). The cost of smoking pushes over a million additional households into poverty in England each year (Reed, 2021).

To see the impact on inequality in your area see the ASH Inequalities Dashboard (ASH, 2019b). This provides data at local authority, regional and combined authority level on a range of inequality and economic metrics. Information at Integrated Care System (ICS) level can be found in ASH ICS briefings (SmokefreeAction, 2022).

2.6. Impact of the COVID-19 pandemic

> *"I used to be quite a heavy smoker until COVID. Got furloughed and can't afford 12 pounds per packet for Marlboro lights. So actually switched things...made the switch to roll ups. Yeah. And can't smoke another cigarette. Now it has to be roll ups. But it saves me, I used to spend probably £140 a week on six packets."* — MH sufferer, 35-44, North/NW

The pandemic and associated lockdowns impacted on smoking behaviour. During the pandemic, smoking rates declined somewhat universally (Kock et al., 2021; Seiler et al., 2020), including among people with SMI (Peckham et al., 2021). Interest in quitting smoking also increased during the pandemic, even more so for people with mental health conditions. During the pandemic, 27.6% of smokers with mental health conditions reported an intention to quit, compared to 22.6% of smokers without mental health conditions (YouGov, 2020), and 9.2% were successful in quitting compared to 5.6% in the general population of England. In part, this may have been due to more frequent belief among those with mental health conditions that smoking increases risk of COVID-19 (48.8% vs 44.0%)(YouGov, 2020). Among those who continued to smoke, however, more than half reported smoking more (Peckham et al., 2021).

The disparity in smoking prevalence between people with and without mental health conditions persists and contributes to disparities in wellbeing. During the pandemic, people with mental health conditions who smoke reported substantially poorer wellbeing and lower happiness, self-worth and life satisfaction compared to the general population (Peckham et al., 2021). Comparing pre-pandemic (2016/2017) with post-pandemic (2020) data, distress increased among smokers, with more severe stress among smokers from disadvantaged groups and among women (Kock et al., 2021). This disparity highlights the impact of the pandemic on the health and wellbeing of both smokers and disadvantaged groups, such as those with mental health conditions.

3. Approaches to reducing smoking

This section explores the evidence-based approaches to reducing smoking for the whole population and targeted for smokers with mental health conditions. Reducing smoking has benefits for mental health at population level:

- Smoking is causal in the development of some conditions such as schizophrenia, depression and dementia (Wootton et al., 2022).
- Stopping smoking improves the mental health of all smokers equivalent to the impact of taking antidepressants (G. Taylor et al., 2014).
- Smoking causes significant physical health problems, which are associated with increased risk of mental health conditions (Moussavi et al., 2007; Ronaldson et al., 2021). Additional ill health of smokers creates a need for more unpaid carers who have poorer mental health.
- Smoking is associated with poverty and reduced employment opportunities, which has negative consequences for wellbeing (ASH, 2020b).

3.1. Strategy for the whole population

The Government goal of reducing population prevalence to less than 5% by 2030 ('Smokefree 2030') requires action by national government as well as local government and the NHS. At the same time as expanding the treatment available to all smokers. investment is needed in regulatory, communication and strategic approaches that will promote quitting and reduce uptake.

Current provision of smoking cessation support is described in Table 2, and guidance on effective interventions is set out in the NICE guideline (NICE, 2021) Appendix 1 links provides further detail on approaches to support quitting. However, cessation support is only one aspect of a comprehensive approach to reduce smoking. The most effective strategies to reduce smoking address both the demand and the supply of tobacco through a range of measures. The World Health Organisation have set out six strands for effective tobacco control strategies (World Health Organization, 2021). These six strands are designed to both encourage smokers to stop and dissuade young people from taking up smoking. The most effective ways to prevent uptake among young people is to change the world they are growing up in, to reduce their exposure to tobacco smoke, imagery and products.

ASH has produced a guide for local implementation around the 10 High Impact Actions a local area can take and further guidance for Integrated Care Systems (ASH, 2022b). National level action is also important to reduce smoking across the population. Further information about a recommended national strategic approach has been developed by the All Party Parliamentary Group on Smoking and Health (APPG on Smoking and Health, 2021).

3.2. Addressing misperceptions among smokers and health professionals

> *"And yes, a lot going on at the moment. It's just I can't see it happening [quitting]. I'd love to, you know, and, uh, yeah..."*
> — MH sufferer, southern coastal town, 22-35

In taking a whole of population approach, improving public and professional understanding of the impact of smoking on poor mental health is an important lever. The evidence that stopping smoking can improve your mental health is well substantiated, although this remains poorly understood by the public with less than a third (30%) identifying smoking as a cause of depression and anxiety (ASH, 2022a). This approach has been used in public health campaigns nationally, such as the 2021 No Smoking Day campaign (ASH, 2022d), and information about the benefits of stopping smoking for mental health is now provided on the NHS Better Health webpages (NHS, 2021). These approaches can be integrated into local communications programmes.

There is also work to be done to address poor knowledge and understanding among all healthcare professionals and those working in mental health specifically. Staff in mental health settings often still see smoking as to some extent facilitating therapeutic relationships (ASH, 2020a).

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

While reducing smoking for the whole population has benefits for everyone's mental health, it needs to be combined with additional support for smokers with mental health conditions if inequalities are to be reduced. A large proportion of overall tobacco consumption is by people with mental health conditions who therefore experience disproportionate smoking associated harm (McManus et al., 2010; Royal College of Physicians & Royal College of Psychiatrists, 2013).

There are two ways to reduce inequalities in smoking rates among those with and without mental health conditions: you can make each attempt more likely to succeed (for example by connecting people to support), or you can increase the number of times a person tries to stop. Both are needed. Priority areas for action which either enhance quit success or quit frequency include:

- Maximise existing professional contacts to motivate more quit attempts.
- Connect people to dedicated support, to improve quit success.
- Maximise the uptake of alternative sources of nicotine, to increase quit success.
- Improve skills and knowledge of mental health professionals, to enable them to motivate and support quit attempts.
- Promote smokefree environments, to aid motivation and prevent relapse.

- Improve data and monitoring, to understand impact.

Across all this activity, smokers with a mental health condition need to be engaged and involved. Interventions will be more effective if their perspectives are at the heart of approaches. ASH has recently undertaken insights work with smokers with mental health conditions (quotes from this are throughout this report). Approaches like this are needed across the system.

3.4. Maximise existing contacts to motivate more quit attempts

> *"I enjoy smoking. I really do. But, you know, it's gonna kill me one day. And I've got two young kids. I need to start. I need to try."*
> — MH sufferer, 35-44, North

People with mental health conditions are just as interested, if not more, in quitting as other smokers, and often have numerous existing contacts with NHS and other services. that provide opportunities for to prompt and support encouragement to quit attempts. The Very Brief Advice model is an evidence-based framework for opportunistic smoking cessation advice which requires professionals to:

- **A**sk about smoking
- **A**dvise people on how best to stop
- **A**ct to connect them to support
  (National Centre for Smoking Cessation and Training, 2021).

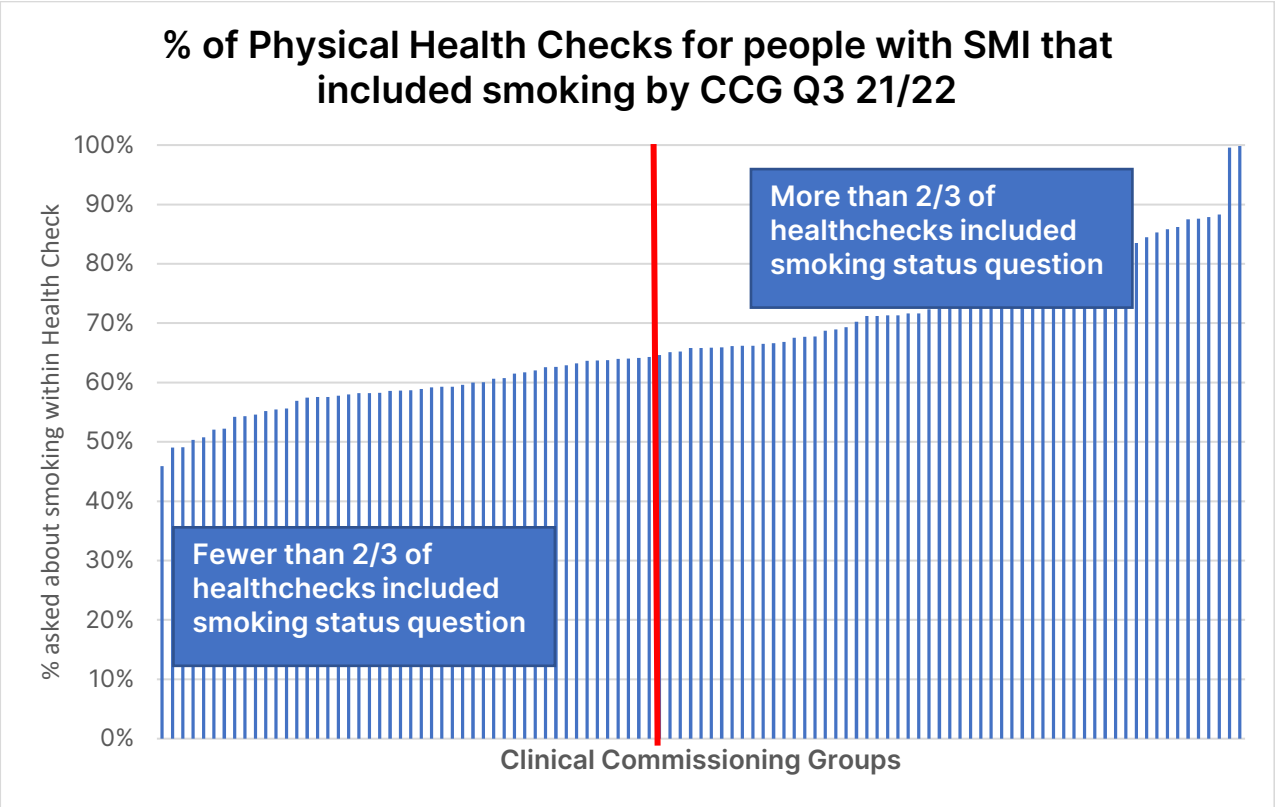
The Very Brief Advice model could have a big population level effect if implemented consistently and at scale. Important contacts where this opportunity can be maximised are described below.

Health checks

One of the flagship models for improving the physical health of people with SMI has been the roll out of physical health checks. These are delivered in primary care and additional investment has been made through the NHS Long Term Plan to expand their reach (NHS, 2019). There is currently big variation in whether smoking status questions are being asked as part of the health check.

Figure *1* shows the percentage of people with SMI who were asked about smoking in their physical health check in 2021/22 (NHS England and NHS Improvement, n.d.). While two CCGs managed to ask about smoking in all of their health checks, more than half of CCGs did not ask about smoking in a third or more of their health checks. To be a meaningful intervention, however, health checks also need to connect smokers to support. Evidence shows this is most effective when done as an opt out referral (Tobacco Advisory Group of the Royal College of Physicians, 2018).

Figure 1: Percentage of people with SMI whose health checks by CCGs included physical health checks



Primary care contact with those who have common mental health conditions

Most people with common mental health conditions seek support through primary care from their GP and through the Improving Access to Psychological Therapies (IAPT) programme.

GP prompted quit attempts have been in decline for the whole population since 2010. Although smokers with common mental health conditions, and those with SMI, are more likely to get an offer of cessation support from their GP, this is also in decline and is still a minority of smokers (Monthly Tracking KPI - Graphs - Smoking in England, n.d.).

The IAPT programme has around 1.69 million referrals a year. Given the rates of smoking among people with common mental health conditions, it is likely that around one in four people accessing the service are smokers (APPG on Smoking and Health, 2021). Smoking status, however, is not routinely gathered for clients of IAPT services.

Settings where smoking and poor mental health are overrepresented

Smokers and people with mental health conditions are overrepresented in settings such as social housing. It's estimated that people living in social housing make up 27% of all smokers with a mental health condition. Targeted approaches in social housing could, therefore, make a substantial contribution to reducing smoking rates among

people with a mental health condition as well as addressing wider inequalities. Other important settings where smokers with poor mental health are over-represented include addiction services, homelessness services, and debt advice services.

3.5. Connect people to dedicated support to improve quit success

> *"I think it's a really good idea... We work on sleeping. We work on eating. We work on exercise. We work on caffeine. We work on all the elements of somebody's wellbeing and the only thing we don't really touch is smoking, which is – we even work on alcohol use so to have treatment with us, you have to be below the alcohol limits... Smoking seems to be the only one we don't really touch, so that's – I think it would sit really nicely in the IAPT service."* — IAPT Counsellor

Improving people's chances of quitting successfully means connecting them to evidence-based support. The NICE guideline recommends that smokers with mental health conditions receive similar support to all smokers, but note that this may need to be tailored (NICE, 2021). Recommendations for tailoring include varying the duration and frequency of support, increasing access to medication or nicotine alternatives, and integrating harm reduction approaches such as cutting down to quit. Table 2 provides a summary of current provision for different groups in the population.

Table 2. Current level of smoking cessation provision in England

Populations	Current provision	Gaps in current provision

General population	• Smoking cessation support:
	  ○ Just over 50% of quit attempts use no support
	  ○ Around 20% use an e-cigarette
	  ○ Around 10% use nicotine replacement therapy bought from a shop
	  ○ just under 10% use prescribed medications (*Monthly Tracking KPI - Graphs - Smoking in England*, n.d.). .
	• Since 2013, public health responsibilities have sat with local authorities and they commission quit services in the community. These have been in decline following cuts to the public health grant. Some local authorities now restrict access to support to priority groups, and a couple have cut all support other than for pregnant women. In 2020/21, 178,815 people set a quit date with local
		• Although quit success with local authority services has grown, quit attempts have been in decline for a decade. Access to support varies depending on where people live.
		• The use of prescribed medications declined by 77% between 2010/11 and 2020/21 (NHS Digital, 2021). GP prompted quit attempts have been in decline for a decade. There are no national programmes of support for NHS outpatients, a particular missed opportunity for those with respiratory conditions, a cancer diagnosis or on surgical waiting lists.

	authority-funded stop-smoking services (NHS Digital, 2021). • New NHS investment means that all smokers having an inpatient stay in hospital or accessing maternity services will get additional support to stop. These services should be fully rolled out by 23/24.	
People with common mental health conditions	• Access to mainstream services. • Pilot studies have been commenced to look at the effectiveness of addressing smoking in IAPT services. An initial feasibility study found that counsellors were well equipped to deliver support and amenable to doing so, and that clients also valued the integration of smoking cessation support.	• NRT prescribing for smokers with mental health conditions fell from 14.4% in 2007 to 3.9% in 2015 (G. M. Taylor et al., 2021). • At system level, there is no targeted access to treatment above what's generally available for all smokers.
People accessing secondary care mental health services	• Dedicated quit support for smokers in secondary mental health services is being established through new NHS investment, although this has been delayed due to the pandemic. Inpatient services are expected to have 48 new smoking cessation services to treat people during inpatient stays and following discharge. In addition, NHSE is introducing early implementer sites in community mental health settings through 2021/22 with a view to rolling out a national programme. It is important that these services are scaled up rapidly, given that most smokers with SMI will have far greater contact with community services. • In a 2021 ASH survey, 77% of local authorities said they provided targeted support to people with mental health conditions (ASH, 2022c). The majority of activity involved tailoring mainstream services for populations with mental health conditions, for example establishing direct referral pathways. Around a third of local authorities were also engaged in improvement activity with mental health trusts, such as supporting staff training or implementing smokefree policies. A minority were providing dedicated support within mental health settings.	• The timeline for rollout of NHS services is variable and community access uncertain. • Engagement of local government is variable and needs further strategic thought in the context of embedding more cessation services in secondary mental health services. • Gaps in training: Only 58% of mental health nurses and 43% of psychiatrists in England had received smoking cessation training (ASH, 2020a). • NICE guidance is inconsistently implemented across settings (ASH, 2019a). • An English longitudinal primary care cohort study between 2007 and 2014, found the proportion of smokers receiving NRT was only 10.1% for SMI and while this is greater than for smoker's without SMI where 5.9% received NRT it is a downward trend (Falcaro et al., 2021). Bupropion and varenicline prescribing was very low and lower for those with SMI. Less than 5% of smokers were referred to stop smoking services.

No specific additional support for people with mental health conditions is available for the following populations, beyond what individual service settings may have developed locally:

- People with drug and alcohol dependence

- People with PTSD
- People with ADHD
- Adolescent smokers with mental health conditions
- Populations vulnerable to poor MH and smoking e.g. people living in social housing.

> *"I always wanted to. But I think at the time I was trying to better myself, so at the time I thought we'll give it a go at the same time, why not sort of thing."* — IAPT client who quit through IAPT service

3.6. Maximising the uptake of alternative sources of nicotine to increase quit success

3.6.1. E-cigarette use (vaping)

> *"I've also discovered vaping as well. So I've been able to cut down on cigarettes a bit. And I'm trying to get use of vaping and sometimes it's alright and sometimes I don't really manage it, but I've definitely managed to cut down by using a vape."* — MH sufferer, 35-44, North

Smokers with mental health conditions are observed to be more dependent than those without mental health conditions, consuming more tobacco and smoking earlier in the day. Using an alternative form of nicotine can help dependent smokers succeed in quitting and reduce harm if not making a quit attempt. E-cigarettes are the most popular aid to quitting in England and are more effective than using NRT (Hartmann-Boyce et al., 2021). For smokers with a high level of dependency, they offer an acceptable alternative to continuing to use smoked tobacco and can substantially reduce harm. Recent surveys have found that smokers with a mental health condition are as likely as other smokers to use e-cigarettes as a quitting aid, and more likely to have used prescribed NRT (Brose, Brown, & McNeill, 2020).

There are widespread misperceptions about the harms from e-cigarettes. Over a third of smokers with a mental health condition wrongly believe that e-cigarettes are more or as harmful as smoking cigarettes (ASH, 2022a). Effective communication and education strategies can be used to address this (Mental Health Smoking Partnership, 2020). The Mental Health and Smoking Partnership Guide to e-cigarettes can support communications and there are further myth-busting resources on the Partnership website (Mental Health Smoking Partnership, 2020).

Accessibility can also be an issue for those on low incomes due to initial start-up costs, although vaping is cheaper in the long run. Smokers with a mental health condition are twice as likely than those without to state cost as the reason they stopped using an e-cigarette indicating that cost plays an important role in people's decision making around products. Programmes which provide e-cigarette starter kits

have been shown to deliver impressive outcomes. Smokers with poor mental health may also require more targeted support and encouragement to initiate e-cigarette use.

3.6.2. Prescription medicinal nicotine replacement

Access to medicinal nicotine on prescription has declined over the last decade due to reductions in local authority funded services and a decline in GP prescribing. While NRT bought over the counter does not substantially improve likelihood of success, NRT prescribed to smokers does. Addressing the reversal of access within primary care can play a role in boosting quit success.

3.7. Improve the skills and knowledge of professionals to enable them to motivate and support quit attempts

There are misperceptions among staff working in mental health settings that smokers with mental health conditions are unmotivated or unable to stop smoking but the evidence tells a different story:

- Quit Interest: Smokers with mental health problems were more likely to report motivation to stop smoking for the next three months than those without mental health problems (Brose, Brown, Robson, et al., 2020)
- Quitting Behaviours: Smokers with mental health problems were more likely to show harm reduction behaviours including cutting down, using e-cigarettes, and using NRT (Brose, Brown, Robson, et al., 2020)
- Quitting Attempts: Smokers with mental health problems were more likely to have made at least one quit attempt in the past year (Brose, Brown, Robson, et al., 2020). Quitting attempts were more frequently triggered by current health problems (Brose, Brown, & McNeill, 2020). Smokers with mental health problems were more likely to have used prescribed medication or behavioural support and less likely to have used over the counter NRT(Brose, Brown, & McNeill, 2020)
- Quit Success: No difference between smokers with and without mental health problems in having achieved short-term abstinence in the past year (Brose, Brown, Robson, et al., 2020).

Research conducted by ASH in 2019 demonstrated that staff working in secondary mental health services have variable levels of skills and knowledge relating to smoking cessation (ASH, 2020a):

- Around half of mental health nurses and a majority of psychiatrists had no training in delivering behavioural support to help smokers stop smoking
- Staff report they deliver Very Brief Advice (VBA)regularly but do not report accurate understanding of all the parts of VBA.
- Misperceptions about smoking, quitting and mental health were common among nurses and psychiatrists.

- Organisational structures and norms were inhibiting uptake and implementation of training.

Addressing gaps in training, starting with undergraduates right through to induction and continuing professional development in the workplace, is crucial to ensure that staff have accurate knowledge and the skills to engage with smokers. However, training must be supported by cultural changes and access to dedicated quit support if it is to lead to behaviour change.

3.8. Promote smokefree environments

Creating services and environments that promote quitting rather than smoking is an important step in changing the norms for people with mental health conditions. Specific NICE guidance for addressing smoking among people in secondary mental health care has been in place since 2013, and states that environments should be smokefree. However, ASH survey work in 2019 found variable implementation of this guidance (ASH, 2019a). In a survey covering 72% of mental health trusts:

- 82% of trusts who responded to the survey had a fully comprehensive smokefree policy in operation by April 2019.
- Less than half of trusts (44%) employed dedicated smoking cessation staff with only 29% having a dedicated service for patients.
- All trusts offered NRT to their patients but only 47% offered the choice of combination NRT or varenicline.
- 91% of trusts permitted the use of e-cigarettes by some or all patients – but with significant variability in how access was facilitated and use enabled
- Significant staff time was spent supporting smoking: staff accompanied patients on smoking breaks every day in 57% of surveyed trusts.

Staff and patients need support to maintain smokefree hospital environments, signage alone is not sufficient. This work should not be restricted to inpatient settings.

3.9. Improve data and monitoring

One of the national commitments in the 2017 Tobacco Control Plan was to improve data on mental health and smoking. The Local Tobacco Control Profiles provide local level data largely using the GP Patient Survey, a regular survey sent to those on GP patient lists which is used to better understand primary care delivery and needs. The profiles report smoking rates at local level for smokers with depression and anxiety (2016/17 data) and for people with a long-term mental health conditions (2020/21 data).

However, the data are not regularly updated, and there remain big gaps in our understanding of smoking and access to support in this population. While there has been bespoke data analysis of smoking rates of those on GP SMI registers, the last time this occurred was 2016. The best survey for understanding rates among people with common mental health conditions is from 2014. Mental health status is not

captured in nationally reported data for local authority funded stop smoking services. While GPs are incentivised to ask about smoking in the SMI health checks through the Quality and Outcomes Framework (QOF) the data are not aggregated and reported nationally. These data could and should be made available for every local authority or ICS in the country.

Furthermore, there are some populations for which we have even less knowledge about the scale of the challenge. Smoking rates among people with PTSD were noted to be 37% in 2007 and for people with ADHD 31%. Despite these very high rates we have no more recent national survey data to identify whether progress has been made or not.

Data on provision in mainstream local authority funded services is also hard to interpret. While 'setting' can be reported no other information is available. In 2021/22 local authorities reported that 0.04% of all quit dates set were in community or inpatient psychiatric settings, despite 77% of local authorities reporting they provide some kind of targeted supported for smokers with mental health conditions. Either the level of reported quits represent a very major gap between ambition to engage mental health populations and the reality, or the data are not of sufficient quality to identify the level of support being provided to people with a mental health condition.

The lack of accurate data on smoking and access to quit services among those with poor mental health inhibits service improvement. National, local and ICS level targets are also difficult to establish and monitor without improved data collection.

4. National and local action needed to secure change

National action on smoking from a mental health perspective has grown over the last decade (see Appendix 1 for a full timeline), but we need to do more if the inequalities which still exist are to be addressed:

- A new Tobacco Control Plan is required, with a strong focus on tackling smoking in all people with a mental health condition, through c targeted investment and effective data monitoring systems, underpinned by targets for reduced smoking prevalence in this population (Mental Health and Smoking Partnership, 2021).
- Nationally, Improving Access to Psychological Therapies (IAPT) services should include support for smokers to quit, to improve both mental and physical health outcomes.
- National communications activity on promoting positive mental health should include messages about the benefits of stopping smoking and avoiding starting. Similarly, national 'stop smoking' communications should include information on the benefits to mental health.
- Coproduction with service users locally should be supported to resource peer support workers using QI (quality improvement) methodology, to maximise signposting to help and quit rates.
- Major gaps in the data must be addressed. Data is needed to monitor smoking rates across all populations with a mental health condition, to measure the provision of evidence-based support and the outcome of treatment.

4.1. Framework for local action

The framework in Table 3 utilises the Prevention Concordat Framework to describe how local NHS and local government strategies on both smoking and mental health can develop stronger more coherent approaches to secure twin objectives of reducing rates of smoking and improving population mental health.

Table 3. Framework of strategies to develop approaches for reducing smoking and improve mental health in the population

Understanding local needs and assets	• **Utilise national data on** populations with mental health conditions **through the Tobacco Control Profiles and triangulate with data from local sources including GP patient records and Trust records to ensure robust analysis of local need and gaps in support is included in local Joint Strategic Needs Assessments (JSNAs) and other planning documents.** • **Engage with organisations that work with populations where people with mental health conditions are over-represented to understand smoking behaviours e.g. social housing, homelessness, addiction services**

	• Work with **smokers who have mental health conditions to address misperceptions** and ensure services and approaches are co-produced **to meet their needs.** • **Join the Mental Health Information Network** to stay up-to-date with information on smoking and mental health
Working together	• Ensure mental health representation on local Tobacco Control Alliances where they exist (many local authorities have this forum for bringing partners together to address common issues). • Agree ICS level targets to reduce rates of smoking among people with a mental health condition and embed action to achieve targets within ICS prevention plans. • Link local Tobacco Control Strategies to local Public Mental Health Strategies where they exist to identify synergies and shared opportunities • Seek to collaborate with key stakeholders on a wider footprint such as ICS or region to undertake population level activity such as development and delivery of communications messages. • Ensure smokers with mental health conditions are involved in local decision making so approaches better meet their needs.
Taking action for prevention and promotion, including reducing health inequalities	• Increase onsite targeted support to stop smoking in local services with a high rate of access by people with mental health conditions. • Increase direct referral pathways to local support and the delivery of Very Brief Advice in services with high rate of access by people with mental health conditions. • Develop local approaches to integrating smoking cessation support into community based mental health support such as IAPT • Create positive smokefree environments in all settings linked to higher rates of mental health conditions • Identify and utilise opportunities to expand access to alternative nicotine containing products for those with or vulnerable to poor mental health • Link communications messages around mental wellbeing and quitting smoking • Develop approaches to support that engage smokers with mental health conditions in peer support and other models which put smokers at the centre of delivery.
Defining success and measuring outcomes	• Identify target populations within the community that include both those with pre-existing mental health conditions and those vulnerable to poor mental health. Track success of programmes in these communities • Elicit qualitative feedback from smokers with a mental health condition to understand the impact of delivery and identify opportunities for improvement.
Leadership and direction	• Identify senior champions for this agenda across mental health and public health provision – utilise them to deliver shared, visible communications messages. • Sign the Local Government Declaration on Tobacco Control and the NHS Smokefree Pledge

For more information about smoking and mental health, contact admin@smokefreeaction.org.uk

Appendix 1. Effective smoking cessation interventions

Evidence based smoking cessation interventions are effective for people with
- Mental disorder (Anthenelli et al., 2016; NICE, 2021)
- Depression (Secades-Villa et al., 2017, p.; van der Meer et al., 2013)
- Schizophrenia (Siskind et al., 2020; Tsoi et al., 2013)
- Serious mental illness (Pearsall et al., 2019; Peckham et al., 2017; Roberts et al., 2016)
- Substance use disorders (Apollonio et al., 2016)

Effective pharmacotherapy includes:
- NRT (Hartmann-Boyce et al., 2018) which is also effective for people with MHCs (Anthenelli et al., 2016)
- Buproprion (Hughes et al., 2014) which is also effective for people with mental disorder (Anthenelli et al., 2016) including SMI (Peckham et al., 2017)
- Varenicline (Cahill et al., 2016) which is also effective for people with mental disorder (Anthenelli et al., 2016) including SMI (Peckham et al., 2017; Tsoi et al., 2013)

The following non-pharmacological interventions for the general population are likely to be effective for people with mental disorder:
- Smoking cessation advice by doctors (Stead et al., 2013)
- Interventions by nurses (Rice et al., 2017)
- Individual behavioural counselling (Lancaster & Stead, 2017)
- Group behaviour therapy programmes (Stead et al., 2017)
- Telephone counselling (Matkin et al., 2019)
- Mobile phone support (Whittaker et al., 2016)
- Internet based interventions (G. M. J. Taylor et al., 2017)
- Print-based self-help materials (Livingstone-Banks et al., 2019)
- Mass media campaigns (Bala et al., 2017; Sims et al., 2014)
- Financial incentives (Notley et al., 2019)

Combined pharmacotherapy and non-pharmacotherapy improved smoking cessation rates for people with depression (van der Meer et al., 2013), SMI (Gilbody et al., 2019), and substance use disorders (Apollonio et al., 2016).

Appendix 2. Timeline of national action

Over the last decade there has been a growing effort to highlight the impact of smoking on people with mental health conditions and to advocate for policy action.

2013

- The Royal College of Psychiatrists and the Royal College of Physicians published Smoking and mental health (Royal College of Physicians & Royal College of Psychiatrists, 2013) which clearly described the scale of the problem and recommended targeted action.
- As the 2013 report was being developed NICE were also developing national guidelines for supporting smokers in a range of secondary care settings including mental health. NICE PH48 made comprehensive recommendations about how people with mental health conditions could best be supported to address smoking which included the implementation of smokefree hospital sites alongside treatment and the engagement of family and carers (NICE, 2013). This guideline was updated in 2021 as part of wider update of tobacco guidelines (NICE, 2021).

2016

- The ASH report The Stolen Years was published, widely endorsed by health organisations, setting out a programme for action to reduce rates of smoking (Harker & Cheeseman, 2016).
- Later in 2016 the Academy of Medical Royal Colleges published 'Improving the health of adults with SMI; essential action' (Working Group for Improving the Physical Health of People with SMI, 2016). This report led to the establishment of the Equally Well Coalition while The Stolen Years report led to the establishment of Mental Health and Smoking Partnership.
- The development of a national consensus on the need to address smoking in this population informed the recommendation made by the independent Mental Health Taskforce for NHSE in their report, the Five Year Forward View for Mental Health (Independent Mental Health Taskforce to the NHS in England, 2016): *"PHE should prioritise ensuring that people with mental health problems who are at greater risk of poor physical health get access to prevention and screening programmes. This includes primary and secondary prevention through screening and NHS Health Checks, as well as interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services. As part of this, NHS England and PHE should support all mental health inpatient units and facilities (for adults, children and young people) to be smoke-free by 2018."*

2017

- The Government's Tobacco Control Plan for England, (Department of Health and Social Care, 2017), for the first time in a national tobacco control strategy, included a chapter on addressing smoking among people with a mental health condition. Included were high level commitments to improve data collection, improve the training for staff in mental health settings and make all inpatient sites smokefree by 2018.

2018

- The Science and Technology Select Committee Inquiry into e-cigarettes took a particular interest in the role of e-cigarettes in supporting stakeholders with a mental health condition (Parliament.UK, 2018). The following recommendation was made:

"NHS England should set a clear central NHS policy on e-cigarettes in mental health facilities which establishes a default of allowing e-cigarette use by patients unless an NHS trust can show reasons for not doing so which are demonstrably evidence-based. NHS England should issue e-cigarette guidance to all NHS mental health trusts to ensure that they understand the physical and mental health benefits for their patients."

2019

- The NHS Long Term Plan made commitments for the NHS on smoking and mental health stating that: *"a new universal smoking cessation offer will also be available as part of specialist mental health services for long-term users of specialist mental health, and in learning disability services"* (NHS, 2019).

2020

- The Mental Health and Smoking Partnership published guidance to support mental health trusts to adopt a more consistent position on e-cigarettes (Mental Health Smoking Partnership, 2020).

2021

- No Smoking Day 2021 was themed around the mental health benefits of stopping smoking alongside the publication of the Cochrane Review documenting the evidence of this effect (ASH, 2022d).
- The Mental Health and Smoking Partnership published a set of recommendations for the next Tobacco Control Plan (Mental Health and Smoking Partnership, 2021).

2022

- The first of 48 new inpatient tobacco dependency treatment services was established. Full implementation anticipated by March 2024.
- New community models of support for people with SMI are piloted with a view to scale these up nationally.
- The Khan independent review into smoking for the Secretary of State recommended action to make smoking obsolete (Office for Health Improvement & Disparities, 2022). This included the recommendation: *"Tackle the issue of smoking and mental health. Disseminate accurate information that smoking does not reduce stress and anxiety, through public health campaigns and staff training. And make stopping smoking a key part of mental health treatment in acute and community mental health services and in primary care."*

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