So why don't psychiatrists prescribe varenicline or cytisine?

Peter Byrne,
Liaison psychiatrist, Royal London Hospital;
Director RCPsych Public mental health implementation centre

Context / declaration of interests

Pre 33 years Psychiatry, Cardiology + Chest Medicine

Wrote 2019 RCPsych Vaping + Varenicline Report

Strategic Director PMHIC

PMHIC overall aim

Improve implementation of evidence-based interventions to prevent mental disorders, their associated impacts (including through improved treatment coverage), and promote mental wellbeing and resilience

The mental health condition (MHC) TREATMENT GAP: **everyone's concern**

The PMH / Prevention **Implementation Gap**: PMHIC's primary aim: shared by few others

RC PSYCH ROYAL COLLEGE OF PSYCHIATRISTS

Public Mental Health Implementation Centre

Follow NICE guidelines on tobacco use https://www.nice.org.uk/ng209

Brief intervention / behavioural support

Offer combined NRT and/or varenicline

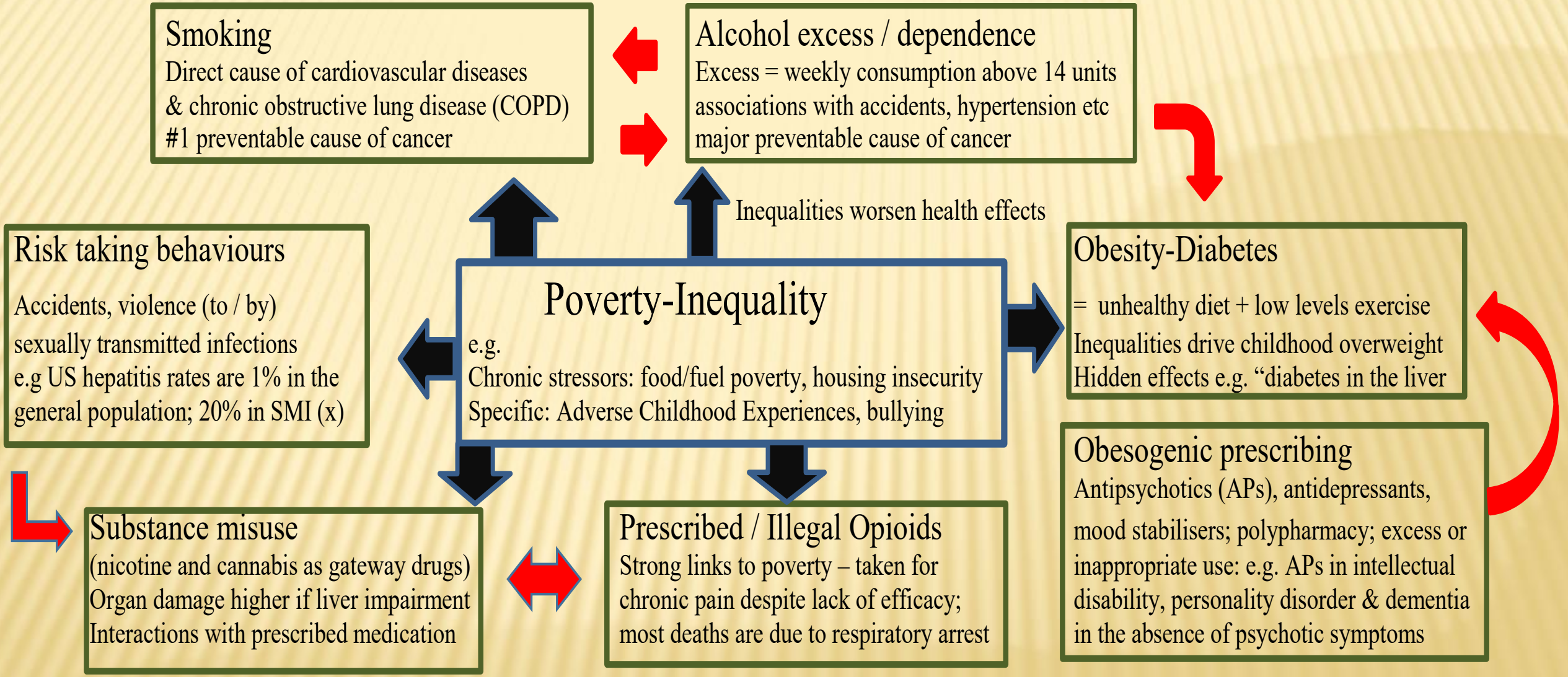
Referral to Smoking Cessation service

Stop smoking

Anticipate impact on antipsychotic drug metabolism; alter dose appropriately

The policy-practice gap (new Lester adaptation listed centrally)

Seven drivers of Premature Mortality in people with severe mental illness. (SMI)



Byrne, 2023: Irish J Psychol Med

VARENICLINE OR CYTISINE INCREASE SMOKING QUITS

"Tell people who smoke that a range of interventions is available to help them stop smoking. Explain how to access them and refer people to stop-smoking support if appropriate. [2021]"

- NICE Guidance, 2025 = **Ensure the following are accessible to adults who smoke:**

behavioural interventions:

- behavioural support (individual and group)
- very brief advice

medicinally licensed products:

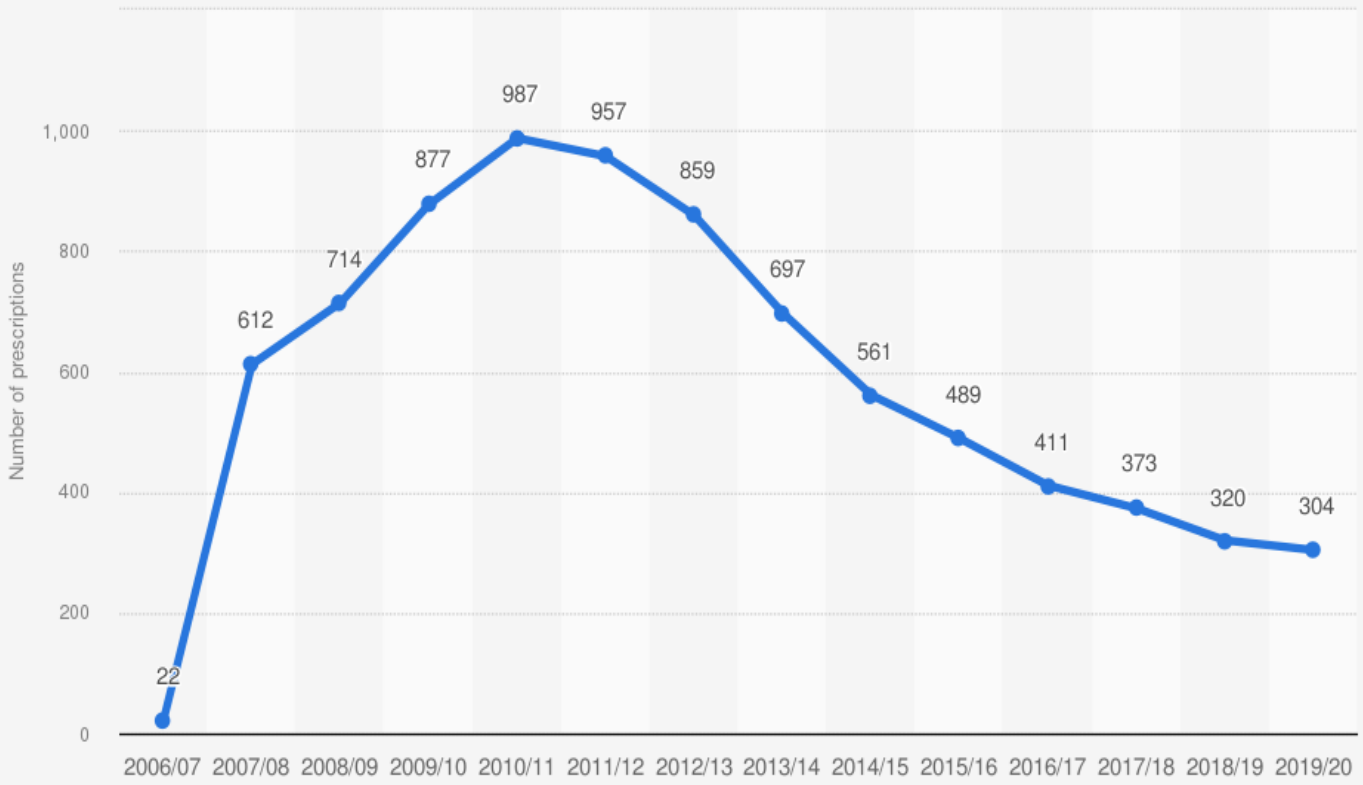
- cytisinicline **[2025] – (cytisine)**
- nicotine replacement therapy (NRT) – short and long acting
- varenicline
- bupropion
- nicotine-containing e-cigarettes
- Allen Carr's Easyway in-person group seminar.

12 WEEKS / 25 DAYS TOTAL TREATMENT PERIOD, AGED 18-65: NICOTINIC ACETYLCHOLINE PARTIAL AGONISTS

- Varenicline ⟶ α4β2 receptors
- Relieves withdrawals – start treatment **before** quit date
- Blocks cues / rewards to relapsing back to smoking
- Versus placebo: OR = 3.2
- Mild nausea most common S/E (< bupropion): take with food
- Systematic reviews: no increase in suicidal thoughts / behaviours

- Cytisine ⟶ α4β2 receptors
- Relieves nicotine withdrawals
- Competes with nicotine: Day5 stop
- ↑appetite, tho nausea up to 10%
- Sleep ↓↑, anxiety ↑, mood↓
- Dose dependent anticholinergic SE
- Cautions in stroke, heart or liver
- Both better tolerated than SSRIs
- Both have min drug interactions
- Local protocols: ↑start then ↓taper

Decline in scripts came BEFORE Covid-19 and before supply problems: number of prescriptions England in 2023/24 was 388,256, compared to 1.8 million in 2013/14



Varenicline prescriptions have significantly declined, especially in England, since a **supply disruption in 2021**. This decline is attributed to the recall of Pfizer's Champix due to nitrosamine impurities. Studies suggest this has led to thousands fewer people quitting smoking and potentially more avoidable deaths

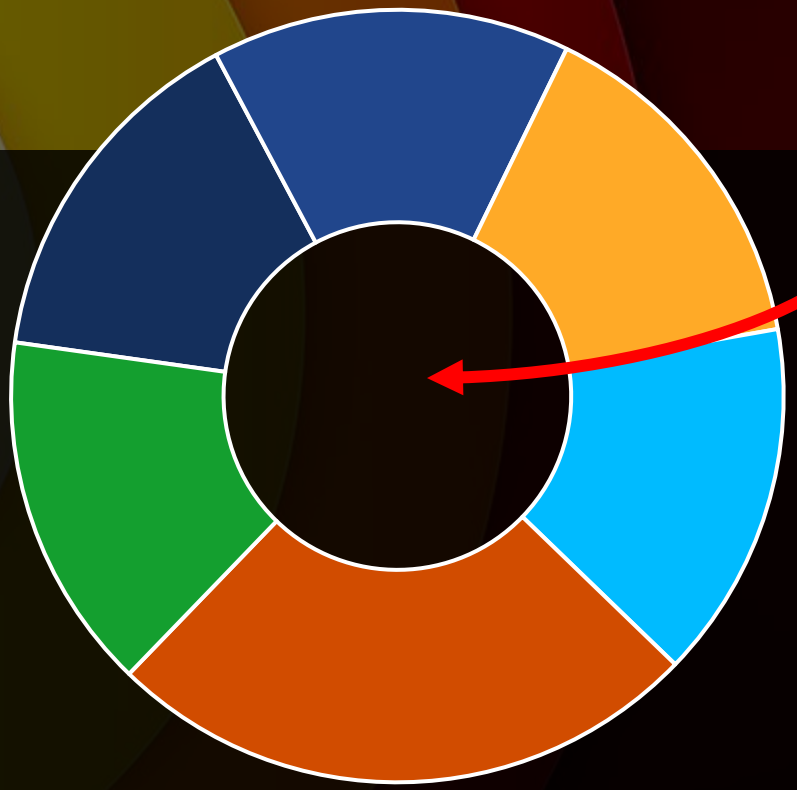
The number of cytisine prescriptions in England has decreased significantly, falling from 3.9% of all quit attempts in the second half of 2021 to 0% by the end of 2022. This decline was attributed to a disruption in the supply of varenicline (another smoking cessation medication) due to nitrosamine impurities. Cytisine, a nicotine receptor agonist, is an alternative to varenicline and is available on prescription in the UK

SO WHY DON'T PSYCHIATRISTS PRESCRIBE VAR / CYT?

- The "Can't someone else do it?" response – I have enough to worry about without adding a safe, short-term cheap medicine to their list of medications that will improve MH and physical health
- Caution: memories of the black box warning. A whiff of danger to varenicline prescription. Ask who benefits the most from >40% smoking rates in SMI (gen pop 14%) and eCigs, pouches. The answer to both Qs is Big Tobacco.
- Confidence = familiarity: psychiatrists have let this slip.

THEORY OF CHANGE IN ONE SLIDE: @ MANY LEVELS

Fragmented NHS, absent / inaccessible services



??Integrated Care Boards

Acute Trusts

Primary care

MH Trusts

Local Authorities

Commissioners

Vol sector: ASH, BHF, community etc

Solutions (after Teasdale et al, 2025)

Enabling environments: many competing priorities but SMOKING is a Life or Death issue. There are no downsides to quitting smoking – except if you work for / accept blood money from Big Tobacco. Nicotine addiction (NRT, e cigarettes, pouches) has cost implications for people with MHCs - outta frying pan into the air fryer

PROCESSES

Clear but flexible treatment pathways

Transparent funding, data on outcomes

CULTURE + SKILLS

Learning communities

Coproduction … task shifting

Leadership, local champions

Listen to the doubters, think about obstacles to quits

DELIVERY TOOLS

Integrate teams and their skill sets

Consistency across fragmented services and settings

Communicate success: data and narratives

Thank you!

Email:
peter.byrne@nhs.net

Website:
www.rcpsych.ac.uk