Tobacco Dependence and Mental Health:
A briefing for front-line staff



NCSCT

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Introduction

People who have a severe mental illness (SMI), such as schizophrenia or bipolar disorder, and those who have a common mental disorder, such as depression or anxiety, are **at greater risk of a range of medical conditions** compared to people without mental illness. They experience physical illnesses more frequently and in some cases more severely, and they also have a considerably shorter life expectancy compared to those without a mental illness. The reasons for this are multifaceted; however, it is the **high rates of smoking in this population that exacerbate these health inequalities**. We now know that in addition to physical health, smoking also affects mental health and recovery from mental illness. For people with mental illness who smoke, stopping smoking is among the most important changes that can be made to improve both physical and mental health.

Very brief advice to stop smoking, behavioural support and tobacco dependence aids are life-saving interventions that can significantly increase success with stopping smoking. When tailored to the needs of people with SMI, these interventions can be even more powerful.

In addition to primary care settings playing a central role in assessing and managing the physical health of people with serious and common mental disorders, **mental health inpatient and community staff have a critical role** in identifying people who smoke, advising on the most effective way of stopping smoking and providing, or referring people for, specialist support.

How to use this document

This briefing is an adaption of the NCSCT's online Mental Health Specialty Module and is aimed at those who work in a mental health setting. Its aim is to increase the delivery of opportunistic Very Brief Advice on Smoking (VBA+) to people with mental illness who smoke. See the **Training and resources** section of this document for further information.

The term **stop smoking practitioner** is used to refer to individuals who provide tobacco dependence treatment and/or stop smoking support. However, the content of this briefing is relevant to staff in all settings who work with people with mental illness.

Background information

Smoking prevalence

Approximately 12% of adults in the UK currently smoke. Smoking rates are **significantly higher among people with mental health conditions.** Among adults with common mental disorders, such as depression and anxiety, smoking prevalence is **nearly double** that of the wider general population. Rates are even higher among people with SMI, with **up to 70% of individuals with schizophrenia or those admitted to psychiatric inpatient settings** being reported to smoke. People with substance use disorders, with or without a co-morbid mental health problem, have among the highest rates of smoking. In every area of mental health, even child and adolescent mental health services, perinatal psychiatry and older adults care, **smoking rates are disproportionally high.**

It is estimated that people with a mental health or substance use problem purchase approximately 42% of the tobacco sold in the UK. People with a mental illness **tend to smoke more heavily** and **be more dependent on tobacco** than those without a mental illness. They are **just as likely to want to stop smoking** but often lack confidence in their ability to quit and historically have not routinely been offered specialist support to quit.

The NHS spends approximately £1.82 billion a year treating smoking-related diseases in people with mental illness and an additional £13.2 billion in social care costs; therefore, implementing strategies to reduce the high prevalence of smoking in this population will not only have a **positive impact on quality of life**, but also has the potential to **realise cost savings for the NHS.**

The impact of smoking on mental health

People who smoke tobacco have **more severe mental health symptoms**, require **higher doses of psychotropic medication** and spend **more time in hospital** compared to people with a mental illness who do not smoke. Smoking **exacerbates poverty** for a large proportion of adults with a mental disorder, many of whom prioritise smoking over food and leisure activities. Smoking is associated with an **increased risk of suicidal thoughts and behaviours**. It is not known if this relationship is causal or due to underlying factors such as mental illness or socio-economic disadvantage.

Traditionally, tobacco dependence has been viewed as 'a lifestyle choice', a 'bad habit' or a 'personal freedom'. However, **tobacco dependence is a chronic relapsing disease** for which we now have available clinically and cost-effective interventions. The NHS has established the identification and treatment of tobacco dependence as a **new standard of care**, urging all staff to embrace the opportunity to embed this **life-saving treatment** across all care pathways to achieve individual and population-level health benefits.

"Doesn't smoking help alleviate mental health problems?"

"Quite simply: No"

Many patients, carers and mental health clinicians often perceive smoking as beneficial. They often attribute improved mood and reduced anxiety to the effects of smoking rather than the reality: that smoking simply alleviates the effects of nicotine withdrawal that occur throughout the day. This 'self-medication' hypothesis is popular among clinicians but has little consistent empirical evidence to support it.

But it's also important to be careful how we talk about this. Telling someone ***"smoking doesn't really help your mental health"*** might be technically accurate but, if it's delivered too bluntly, it can feel dismissive or invalidating. Many people with mental health challenges experience smoking as one of the few things that helps them feel calm, regulated, or in control – even if only briefly. Instead of correcting or dismissing that belief, we need to acknowledge the meaning it holds. We might say: ***"It makes sense that smoking feels helpful. Let's explore why that is – and what else could give you the same relief without the harm."*** It's not just about presenting facts. It's about acknowledging the emotional logic behind dependence on smoking before offering an alternative.

The benefits of stopping smoking

In addition to the immediate and long-term physical health benefits that result from stopping smoking, such as improvement in cardiovascular and respiratory health, people's mental health improves. **People who stop smoking have better mental health** than those who continue to smoke and, the longer they manage to remain abstinent, the **likelihood of having symptoms of depression and anxiety reduce.** Depending on the type of medication prescribed, some patients may be able to have their dosage of psychotropic medication reduced (see **page 21**). A successful quit attempt can often be a catalyst for other positive behaviour change and the financial savings enable patients to participate more inclusively in society.

Benefits of stopping smoking include:

- better physical health in the short- and long-term
- reduced depression, anxiety and stress
- better mental health, including mood, self-confidence and self-esteem
- improved sleep over the long-term
- less time in hospital
- increased disposable income
- improved quality of life
- reduced stigma and exploitation
- potential to reduce doses of some medications

Very Brief Advice on Smoking (VBA+)

VBA+ follows three simple steps, with minor difference depending on where the intervention is taking place.

VBA+ in community settings

ASK and record smoking status

"Do you smoke?"

ADVISE on the most effective way of stopping

*"Stopping smoking is one of the **most important** things you can do to improve your mental **and** physical health."*

*"The **easiest** way to stop smoking is with regular use of **stop smoking aids** such as nicotine vapes, nicotine replacement therapy or nicotine analogue medicines alongside specialist support. Specialist support is **free** and many people I work with have found the support really helpful."*

Those who are not interested or confident they can stop abruptly at this time should be informed about Cut Down to Stop:

"I understand you may not be ready to stop smoking now, would you be willing to cut down on your smoking with a view to stopping completely in the future?"

ACT – refer patients to stop smoking support

Opt-out referral: Refer all patients for specialist support unless they specifically ask you not to.

Opt-in referral: Refer patients who are interested in stopping or making a quit attempt.

Refer to locally available stop smoking support:

"Someone from the stop smoking service will call you to discuss the options. Can I check I have the correct contact details for you?"

Follow-up on referral and provide encouragement.

If the patient says they do not want to be referred:

"It is your choice. Help will always be available. You can always return to see me or contact the smokefree helpline or your GP if you change your mind."

Ensure the patient understands where to find support.

Repeat VBA+ at future visits and at least once a year.

VBA+ in inpatient settings

ASK – identify and record smoking status

"Do you smoke?"

"Have you recently stopped smoking (in the last two weeks)?"

ADVISE on the most effective way of stopping and available support

*"Stopping smoking is one of the **most important** things you can do to improve your mental **and** physical health and can help with your recovery."*

"All NHS hospitals including this one are completely smoke free. Whilst you are in hospital it is important that we help you manage the withdrawal symptoms and urges to smoke you may experience. We can give you a vape or nicotine replacement therapy that will make it much easier for you to not smoke."

"A member of our Tobacco Dependence Team will come and see you to check how you're doing and provide additional support during your stay in hospital. They can also help you to stop smoking long-term or cut down on your smoking."

ACT – refer patients to tobacco dependence treatment

- **Treat** – Ensure tobacco dependence aids are initiated as soon as possible (ideally within 30 minutes of admission) to address withdrawal symptoms. Risk assessment should be completed to support the selection of a tobacco dependence aid.
- **Refer** – Complete opt-out referral to tobacco dependence service. Refer all patients for specialist support unless they specifically ask you not to.
- **Record** in admission diagnosis and disease care plan.

Follow-up on referral and provide encouragement.

Opportunities to intervene

It is essential that mental health staff use every contact as an opportunity to improve or maintain the mental and physical wellbeing of patients. Staff are well placed to provide VBA+, which can take **as little as 30 seconds** to deliver.

Providing VBA+ to every person who smokes is recommended by the Department of Health and Social Care, and is effective in general care and mental health settings. We now know that **tailoring this advice to increase receptivity among individuals with mental illness is important.** This may include highlighting the benefits to their mental health recovery and the offer of cutting down before stopping (Cut Down to Stop) if stopping in one go (abrupt cessation) is not possible or realistic for the individual.

Mental health staff already have the necessary therapeutic skills to engage patients in conversations about behaviour change and can easily adapt these to discuss smoking.

We know that offering support with stopping, rather than merely asking a person who smokes if they are interested in stopping or telling them they should stop, leads to more people making a quit attempt.

Minimising barriers to accessing this support (e.g. offering flexible appointment venues and times) and ensuring support is delivered by trained staff is also important.

Raising the issue of smoking can be done **opportunistically with patients during everyday interactions**, such as during protected engagement time, routine observations and whilst walking. These moments can feel more natural and **may be more effective when linked to something personally relevant**, like a patient's cough or shortness of breath.

Raising the issue at any appropriate opportunity ensures that stopping smoking is seen as an important part of holistic healthcare at any point in the patient's journey.

ASK

Identifying patients who smoke

"Do you smoke or use any other form of tobacco?"

"Have you recently stopped smoking?"

Improving the identification and assessment of people who smoke is an essential first step in encouraging people to quit. Asking **every mental health patient** if they smoke and documenting their smoking status should be part of **standard mental health care.**

It is just as important to know if a patient used to smoke. Not only is this an opportunity to provide positive feedback to the patient, it also recognises that an admission to hospital or a mental health relapse may precipitate a return to smoking and support to prevent this can be included in their care plan.

The identification and recording of each patient's smoking status needs to be completed regularly, such as on admission and discharge from hospital, on first contact with community services and at each Care Programme Approach (CPA) review.

Confirming if someone smokes should be followed up with advice on the most effective way of stopping.

The first-choice interventions for people who smoke are nicotine vapes, combination nicotine replacement therapy (NRT), varenicline or cytisinicline, provided with **12 sessions of group or individual behavioural support.** This level of support can be provided by an in-house tobacco dependence adviser or local stop smoking service. People who smoke are **three times more likely** to succeed in stopping with specialist support than if they try to stop unaided. In addition to the tobacco dependence service, mental health staff can be trained to deliver intensive support in mental health settings and can have a positive impact on quit rates.

Identifying patients who vape

"Do you currently vape (use an e-cigarette)?"

It is also recommended that we ask about the use of vapes. Ensuring people who use vapes are using them correctly, and alongside the support of a trained stop smoking practitioner, can help to increase their ability to remain smokefree long-term. People who smoke tobacco and vape (known as dual users) should be advised to switch completely to vaping.

Advise

Advise on the best way of quitting smoking

All patients who smoke who receive inpatient care, whether it is for a mental or physical health condition, will have restrictions placed on their smoking behaviour. **Mental health staff have an important role to play in providing advice and support throughout an inpatient stay regarding the management of tobacco withdrawal, and temporary or permanent abstinence.** Exchanging information with patients and carers about the most effective and comfortable way of managing withdrawal from tobacco and abstaining from smoking during an admission can help minimise any potential difficulties.

Examples of what to say to patients who smoke

Inpatient staff

"Did you know that stopping smoking is the best thing you can do for your overall health and wellbeing and can assist with your (mental health) recovery?"

"We can support you to temporarily or permanently stop smoking. The most effective and comfortable way to do this is by using tobacco dependence aids (such as a vape or nicotine replacement therapy) and receiving support from a tobacco dependence adviser."

"All NHS hospitals including this one are completely smokefree, in both the buildings and on the grounds. This is to protect the health and wellbeing of patients and staff."

"Because your body is used to getting regular doses of nicotine from cigarettes, it must now adjust to getting nicotine from another source."

"During your stay it is important for us to help you manage the withdrawal symptoms and urges to smoke that you may experience. We can give you a vape or a nicotine replacement therapy that will help with this and should make it much easier for you to not smoke."

Referral to specialist support should be a standard of care for all people in hospital

Community staff

"Did you know that stopping smoking is the best thing that you can do for your overall health and wellbeing?"

"Receiving specialist support and using tobacco dependence aids, such as vapes or nicotine patches and lozenges, really improves your chance of quitting and makes the whole process easier."

"Would you like me to arrange for you to meet a stop smoking specialist to have a chat about this?"

Referral pathways

Integrated referral and care pathways between local stop smoking services in primary care, community mental health and inpatient services are necessary to enable people to access support at any point in their patient journey. Commissioners of mental health services are being asked to ensure such systems are in place.

Act

Act on patient response

- Build confidence and self-efficacy
- Exchange information (e.g. about the benefits of stopping smoking or managing tobacco withdrawal)
- Refer to a stop smoking practitioner within the local stop smoking service or an in-house tobacco dependence adviser employed by the mental health trust or local authority
- Ensure the patient is assessed for, and has access to, a nicotine vape, NRT or other licensed medication for smoking cessation (see **page 15**) throughout an inpatient stay, regardless of intention to quit, and refer to the stop smoking service
- Be proactive rather than reactive regarding withdrawal symptoms during temporary or permanent abstinence
- Review dosage of tobacco dependence aids and, for people using a nicotine vape or NRT, ensure doses provided are appropriate to treat withdrawal symptoms and urges to smoke; address any side effects and prompt correct use at every contact
- Record actions

Most patients are interested in changing their smoking behaviour but lack the confidence to do anything about it. **Patients can be supported by encouraging them about the value and effectiveness of having specialist support.**

The role of mental health staff

Once a person who smokes is in contact with a stop smoking practitioner, mental health staff have an important role to play in providing ongoing support to patients who are making a quit attempt as well as those who are temporarily abstaining from smoking.

Staff and patients may misinterpret signs of nicotine withdrawal as a worsening of mental health symptoms and believe that the patient can only get relief by having a cigarette. Advising on the benefits of using NRT from the point of admission is important. Staff can give advice about the correct use of tobacco dependence aids and support strategies for dealing with urges to smoke.

Mental health staff must be aware that efforts to stop smoking or temporarily abstain can be easily undermined. For example:

- facilitating leave to smoke
- offering cigarettes
- smoking in front of patients
- agreeing to buy cigarettes on behalf of patients
- turning a blind eye to patients hiding their cigarettes in hospital grounds
- conveying a sense of pessimism about the ability of patients to stop smoking
- not having the right knowledge and skills to support patients' attempts to stop smoking

Tobacco dependence aids

Due to the very short half-life of nicotine, a person who smokes will start to experience withdrawal symptoms (e.g. irritability, low mood, poor concentration) within one to two hours of their last cigarette, plus strong urges to smoke.

People who use mental health services, particularly when on an inpatient unit, often have a low tolerance for stress, so having to cope with distressing mental health symptoms as well as tobacco withdrawal symptoms can be a challenge for the patient and the staff involved in their care.

Patients with mental illness experience more severe symptoms of tobacco withdrawal than those without mental illness. This is in part due to the higher rates of dependence but can also be related to some psychiatric conditions. This is particularly true among people with schizophrenia, who have been shown to have higher levels of tobacco dependence and more pronounced withdrawal symptoms and urges to smoke.

Tobacco dependence aids (also known as stop smoking aids) are effective at reducing nicotine withdrawal symptoms and have been shown to increase success with stopping smoking in the short- and long-term.

Nicotine vapes, combination nicotine replacement therapy (NRT), varenicline and cytisinicline are recommended as **first-choice tobacco dependence aids.** These products help reduce withdrawal symptoms and urges to smoke and should be offered to all people who smoke.

Single NRT and bupropion (Zyban) are considered **second-choice options**. All tobacco dependence aids are more effective when combined with behavioural support from a trained stop smoking practitioner.

Stopping in one step (known as abrupt quitting or abrupt cessation) with at least eight to 12 weeks of assistance, through the use of a first-choice stop smoking aid and behavioural support from a trained stop smoking practitioner, gives the best chance of success. Some people may require stop smoking aids and behavioural support for longer periods of time (three to 12 months).

Patients who are not able to commit to stopping abruptly

Quitting will often occur at a slower pace when compared to people without mental illness, in particular for those with SMI. While **abrupt quitting with support should be the first option, some patients benefit from cutting down on their smoking before they set a quit date.** Cut Down to Stop (CDTS) support should include both structured multi-session support and treatment with a first-choice stop smoking aid. While individuals will benefit from flexible and person-centred timeframes, it is **recommended that CDTS support focuses on setting realistic reduction targets, with the goal of stopping completely six weeks to six months** after the treatment start date.

For more information, see the Cut Down to Stop section of our website.

Tobacco dependence aids

First-choice

- Nicotine vapes (adults only)
- Combination NRT (age 12+)
- Varenicline (adults only)
- Cytisinicline (adults only)

Second-choice

- Single NRT product (age 12+)
- Bupropion (adults only)

Combining tobacco dependence aids with behavioural support further increases success with stopping

Nicotine vapes

Nicotine vapes (also known as electronic cigarettes or e-cigarettes) deliver an inhalable vapour to the user via a mouthpiece. There is **no tobacco or combustion involved in vaping and as such the vapour does not contain carbon monoxide and other dangerous chemicals associated with tobacco combustion.** Nicotine vapes are not risk free but, based on the available evidence, are **significantly less harmful than smoking tobacco.**

Nicotine vapes are recommended by NICE as a **first-choice stop smoking aid for adults**. They help manage withdrawal symptoms and urges to smoke – often more rapidly than faster-acting NRT products – by providing doses of nicotine. Clinical experience suggests that **people with mental illness may find vaping more acceptable compared to NRT**, leading to better adherence and higher quit rates. High-quality randomised controlled trials have found nicotine vapes are almost twice as effective as NRT.

The Care Quality Commission (CQC) support the use of nicotine vapes in mental health inpatient settings as a less harmful alternative to smoking. The CQC has emphasised that nicotine vapes can play a key role in supporting smokefree policies and advised that, within inpatient settings, **a blanket ban on nicotine vapes is not justified unless there are specific and rational reasons for doing so**, since short-term secondhand vapour poses no known risks to others.

When developing and implementing smokefree polices, **smoking and vaping should be considered separately** in line with the Office for Health Improvement and Disparities' advice on vape use in public places and workplaces. For example, while smoking is restricted in hospital buildings and grounds, **vaping could be permitted in private bedrooms or in specified indoor/outdoor areas**, subject to local risk assessments and patient needs.

For more information, see the vaping resources section of our website.

Combination nicotine replacement therapy (NRT)

NRT products contain lower levels of nicotine than tobacco and the way these products deliver nicotine means they **pose a very low risk of dependence to users.** They can be used as a substitute for smoking when people are cutting down or abstaining and are far safer than smoking. **NRT does not interact with any mental health medicines or affect the blood levels of medication**, though smoking and stopping smoking can affect medication levels.

Combination NRT (patch plus one of the faster-acting products) is effective at reducing nicotine withdrawal symptoms and should be offered to all people who smoke throughout the duration of an inpatient stay, even if they have no intention to quit or show no desire to stop smoking. **Combination NRT is more effective than a single NRT product.**

There are seven different NRT products to choose from:

- Transdermal patch
- Gum
- Lozenge
- Inhalator
- Microtab
- Nasal spray
- Mouth spray

A course of NRT **lasts for eight to 12 weeks**, though experts believe that a longer duration – **up to 12 months or beyond** – may be needed for mental health patients to prevent relapse.

Due to higher levels of tobacco dependence among people with a mental illness, **the amount of NRT required is likely to be higher** than for people with lower levels of tobacco dependence. Typically, people who smoke need to replace each cigarette with 1mg of NRT. However, since people with a mental illness typically smoke each cigarette longer and harder and are more dependent on tobacco, **the recommendation is to initially try substituting 2mg of NRT for each cigarette.** This can be further titrated upwards if the patient remains uncomfortable and withdrawal symptoms persist. As a general guide, the patch can be used to treat background urges to smoke and a faster-acting product can be used on the hour, every hour to deal with breakthrough urges. When possible, **self-administration of NRT is the preferred option**, as this allows patients to have fingertip control over their nicotine intake – just as they do when smoking – which can be empowering and reassuring.

It is safe to give NRT to patients with a mental illness, even those who receive high doses of psychotropic medication and those who continue to smoke.

Nicotine analogue medications

Nicotine analogues are medications that **mimic the effects of nicotine in the brain centres**. They do not contain nicotine but assist with reducing withdrawal symptoms and urges to smoke, as well as satisfaction from smoking. Nicotine analogues are **almost twice as effective as bupropion and more effective than combination NRT.** There are two nicotine analogues available – varenicline and cytisinicline – both of which are prescription-only medications.

Cytisinicline (cytisine)

Cytisinicline is a natural plant alkaloid that comes in the form of a tablet. In community settings, **patients are advised to stop smoking five days after they start taking the medicine**. In the smokefree inpatient setting, patients should use NRT in combination with cytisinicline during this initial period of treatment. **A course of cytisinicline treatment is 25 days.**

There is limited research on the use of cytisinicline among people with mental illness. For this reason, it should be used with caution in people with unstable SMI and those with schizophrenia.

For more information, see the cytisinicline section of our website.

Varenicline

Varenicline is a nicotinic acetylcholine receptor partial agonist. Like cytisinicline, it comes in the form of a tablet. In community settings, **patients are advised to stop smoking seven to 14 days after they start taking the medicine**. In the smokefree inpatient setting, patients should use NRT in combination with varenicline during this initial period of treatment. **A course of varenicline treatment is 12 weeks**, although this can be extended to 24 weeks for patients who would benefit. There is evidence to support use for up to 12 months to prevent a relapse to smoking.

There are no good grounds for excluding patients with mental illness from taking varenicline. Because of its high level of effectiveness, it may be their best chance of stopping smoking, especially given the generally high levels of tobacco dependence within this population.

There has been no suggestion in the published studies or case reports that people with pre-existing mental illness are more vulnerable to neuropsychiatric side effects than other patients.

In a study of over 500 patients followed up for 12 months, varenicline increased smoking cessation in people with stably treated current or past depression without exacerbating depression or anxiety. **A large review of the use of varenicline in patients with mental health problems has shown that there is no evidence of the link to suicide or cardiac events** and supports the use of varenicline for people with a mental illness.

For more information, see the varenicline section of our website.

Bupropion

Bupropion is licensed as an antidepressant and a smoking cessation medicine. It is only available on prescription. It is thought to work by blocking nicotine receptors, increasing dopamine and noradrenaline, and taking away the 'pleasurable' effects of nicotine. Although bupropion is considered a second-choice stop smoking aid, there have been more studies on its use than NRT or varenicline in people with SMI. **When combined with group therapy, it almost triples the chance of quitting in the short-term.**

Bupropion is not recommended for people with current or history of seizures, current or previous diagnosis of bulimia or anorexia nervosa, or a history of bipolar disorder, as it may precipitate a manic episode. There is the potential for interactions between bupropion and psychotropic medicines, such as some antipsychotics and antidepressants.

For all people using NRT, varenicline, cytisinicline or bupropion, there should be:

- cautious treatment initiation
- patient education
- close monitoring for mood and behaviour changes during therapy
- regular follow-up

Effects of smoking and smoking cessation on medication blood levels

Tobacco smoke – **not nicotine** – speeds up how the body breaks down certain psychotropic medications such as some antipsychotics, antidepressants and benzodiazepines. This happens because chemicals in tobacco smoke activate liver enzymes (especially CYP1A2), which leads to faster drug clearance. This effect is the same regardless of what stop smoking aid someone uses (including nicotine vapes).

A consequence of speeding up the metabolism of some medicines is that people who smoke need higher doses of some psychotropic medicines to achieve the same effect as someone who doesn't smoke. Once someone stops smoking, the liver enzyme activity drops off quickly – often within the first week of quitting – which can cause medication blood levels to rise significantly, increasing the risk of side effects or even toxicity.

Blood levels of medication will be affected by many things such as age, gender, ethnicity and how well people adhere to their prescribed treatment, but changes in smoking are especially important. When someone stops smoking, doses of affected medications may need to be reduced by 25–50%, usually within the first week.

Nicotine vapes and NRT on their own do not affect enzyme activity, but tobacco smoke does, even when someone smokes only occasionally, or is vaping and smoking at the same time (dual use) or smoking cannabis with tobacco (joints).

Blood levels, clinical symptoms and any changes in the frequency and severity of side effects all need to be closely monitored when cigarette smoking is reduced, stopped or restarted.

High-risk interactions: clozapine and olanzapine

Clozapine is an effective but potentially toxic drug and has a clinically significant interaction with tobacco smoking – from the tar in tobacco smoke, **not** the nicotine. It is a particular concern because, **when a patient stops or reduces their smoking, the metabolism of clozapine slows down and, in some people, the blood levels of clozapine can almost double within about a week.** This can lead to serious symptoms and, in very rare events, death from a seizure.

Because of this, we must give particular attention to clozapine and getting the dosage right when we support patients who have stopped smoking, are temporarily abstaining, or are reducing the amount they smoke whilst in hospital.

Patients taking clozapine should have their **daily dose reduced by 25% in the first week after stopping smoking**, then reassessed based on symptoms and plasma levels. Plasma level reduction may be greater in people who are also taking valproate. Plasma levels should be checked before and after changes, to guide safe dosing. If a patient starts smoking again, the dose will likely need to be increased. **Blood levels of clozapine may still be altered for up to six months after stopping smoking.**

At present, there are no clear guidelines about what happens when someone cuts down rather than stops smoking completely. However, new evidence suggests that **even smoking a few cigarettes a day (two or three for men and four or five for women) can almost fully activate the enzymes involved in clozapine metabolism.** Therefore, any reduction in smoking should still prompt clinical monitoring and, for medications like clozapine, plasma level testing may be needed to guide safe dosing.

Olanzapine is another medication with a known significant clinical interaction with smoking.

On stopping smoking, the dose may need to be reduced by 25%. Be alert for increased adverse effects of olanzapine such as dizziness, sedation and hypotension. If adverse effects occur, further reduction in dose may be required. If the patient begins smoking again, the dose should be increased to the previous dose over a period of one week.

Smokefree policies within mental health settings

Smoking is prohibited by law inside all hospital buildings across the UK. Additionally, national guidance from NICE recommends that all healthcare settings, including mental health and acute hospitals, implement comprehensive smokefree policies that extend to the entire hospital grounds. This approach aims to protect patients, staff and visitors from the harms of secondhand smoke and to promote healthier environments.

In addition to the physical aspects of smoking, the behavioural, psychological and social aspects greatly contribute to its addictiveness in mental health patients. Smoking is often viewed as a shared experience and perceived by patients and staff as a way to reduce the feeling of isolation. It provides opportunities to make friends, and interact and connect with others. Patients are often afraid of losing this perceived benefit despite the negative impact of smoking – they 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.

Mental health staff often express concern that stopping smoking will exacerbate mental health symptoms and increase aggressive behaviour. However, **evaluations of the implementation of comprehensive smokefree policies in mental health settings report no overall increase in the frequency of aggression, the use of seclusion, discharge against medical advice or the use of as required (PRN) medication.**

Studies of smoking cessation interventions for people with psychosis show that quitting smoking does not harm mental health and, with the right support, can be done safely. In fact, growing evidence suggests that stopping smoking may lead to improvements in mood, anxiety and overall wellbeing. The evidence points instead to tobacco withdrawal, not quitting itself, acting as a temporary stressor. Like any form of stress, withdrawal can briefly worsen mental health if not properly managed.

Where increased aggression has been reported in inpatient services when smoking is restricted, it is often linked to how smokefree policies are implemented rather than the restrictions themselves. Contributing factors can include unclear or inconsistently applied policies, limited access to tobacco dependence support, gaps in staff training or confidence and inconsistent staff responses. A lack of access to nicotine vapes, NRT or other tobacco dependence aids can also increase patient distress and frustration.

Although NICE clearly advises that staff should not facilitate 'smoking breaks', this practice remains common on many inpatient units. Time that could be spent using clinical skills to support temporary or permanent abstinence is instead used to supervise smoking – a non-therapeutic activity that reinforces dependence and undermines recovery.

While it is understandable that staff may feel conflicted about restricting smoking, particularly when caring for people who may lack capacity to fully understand the rationale, framing this as a matter of 'rights' risks overlooking deeper issues of equity and justice.

Supporting someone's continued access to a harmful, addictive product – rather than offering evidence-based treatment – would not be acceptable in other areas of healthcare. People with mental health conditions already face disproportionate tobacco-related harm, and continuing to facilitate smoking perpetuates this inequality.

Smokefree policies are not unique to mental health settings. They apply across all NHS hospital environments and all enclosed public spaces, including acute care settings. Failing to implement them consistently in mental health services reinforces a harmful double standard that leaves some of the most disadvantaged patients behind.

Staff and patients will need to keep in mind that tobacco dependence is a chronic relapsing condition and it might take several attempts to successfully stop smoking.

Following the provision of VBA+ and motivating the person to engage with a trained stop smoking practitioner, mental health staff continue to have a valuable role in helping patients make a successful quit attempt or manage temporary abstinence.

A trained practitioner has the knowledge and skills to tailor pharmacological and behavioural support to maximise success. Receiving specialist support from a trained stop smoking practitioner, such as those in local stop smoking services, significantly improves the chances of stopping smoking.

Mental health staff can acquire the skills to become competent in providing intensive smoking cessation support to patients who use mental health services.

A comprehensive, online, evidence-based training programme for mental health practitioners who want to assist people to stop smoking is available for those working in both community and inpatient mental health settings. Stop smoking practitioners who are NCSCT Certified can also access the **mental health specialty module**, which builds upon the information contained in this briefing. See the **Training and resources** section of this briefing to access these resources.

A Standard Treatment Plan (STP) for Inpatient Tobacco Dependence in Mental Health Hospitals was published in 2024 by NHS England and the NCSCT. The STP is designed to ensure patients receive consistent and evidence-based tobacco dependence support that provides them with the best possible chance of having a smokefree admission to a mental health hospital and a goal of long-term abstinence.

Training and Resources

Guidance

NHS Standard Treatment Plan (STP) for Inpatient Tobacco Dependence in Mental Health Hospitals

This STP provides guidance to support delivery of the Inpatient Tobacco Dependence Treatment Care Bundles.

Full document:
www.ncsct.co.uk/publications/STP-inpatient-mental-health

Admission Care Bundle:
www.ncsct.co.uk/library/view/pdf/NHS-STP-MH-v4-the-point-of-admission-care-bundle.pdf

NHS England competency framework for tobacco dependence treatment: mental health services

www.ncsct.co.uk/publications/NHSE-competency-framework-mental-health

Care Quality Commission (CQC): Smokefree policies for mental health inpatient services

www.cqc.org.uk/sites/default/files/2024-04/9002497_Brief_Guide_Smoke_Free_Policy_MH_inpatient_services.odt

eLearning

NHS England: Tobacco dependence in inpatient mental health hospitals
This training will enable the admitting team and front-line mental health staff to further their knowledge on the benefits of treating tobacco dependence as a new standard of care.

https://learninghub.nhs.uk/catalogue/tobaccodependenceinpatienttraining

NCSCT Mental health speciality module
This specialty module on mental health and smoking is recommended for practitioners working in both community and inpatient settings. Successful completion of the NCSCT Stop Smoking Practitioner Training Programme is required to access the module.

https://elearning.ncsct.co.uk/mental_health_specialty_module-launch

NCSCT Very Brief Advice on Smoking (VBA+) module
A free, open-access training module that focuses on delivering VBA+ to all people who smoke

https://elearning.ncsct.co.uk/vba-launch

Resources for local trainers

NHS Community mental health tobacco treatment training resources
This comprehensive suite of training materials provides trainers with high-quality, evidence-based resources to support local training delivery to NHS staff who will be providing specialist tobacco treatment in community mental health settings.

www.ncsct.co.uk/publications/category/NHSE-training-materials-SMI

NHS Mental health inpatient tobacco dependence adviser training resources
These materials provide trainers with high-quality, evidence-based training resources to support local training of tobacco dependence advisers who work with patients hospitalised in mental health trusts. The resources have been developed by national experts and cover the NHS-NCSCT core competencies for tobacco dependence advisers.

www.ncsct.co.uk/publications/category/inpatient-mental-health-training-resources

Psychotropic drugs affected by smoking status and action to take on stopping and starting smoking

Source: Taylor DM, Barnes TR, Young AH. Maudsley Prescribing Guidelines, 2025

Drug	Effect on smoking	Action to be taken on stopping smoking	Action to be taken on restarting smoking
Agomelatine	Plasma levels reduced.	Monitor closely. Dose may need to be reduced.	Consider reintroducing previous smoking dose.
Benzodiazepines	Plasma levels reduced by 0 – 50% (depends on drug and smoking status).	Monitor closely. Consider reducing dose by up to 25% over one week.	Monitor closely. Consider reintroducing previous smoking dose.
Carbamazepine	Unclear, but smoking may reduce carbamazepine plasma levels to a small extent.	Monitor for changes in severity of adverse effects.	Monitor plasma levels.
Chlorpromazine	Plasma levels reduced. Varied estimates of exact effect.	Monitor closely. Consider dose reduction	Monitor closely. Consider reintroducing previous smoking dose.
Clozapine	Reduces plasma levels by up to 50%. Effect may be maximal at as few as two or three cigarettes a day. Plasma level reduction may be greater in those receiving valproate. Effect is reversed by co-administration of fluvoxamine.	Take plasma level before stopping. On stopping, reduce dose gradually (over a week) until around 75% of original dose reached (i.e. reduce by 25%). Repeat plasma level one week after stopping. Anticipate further dose reductions.	Take plasma level before restarting. Increase dose to previous smoking dose over one week. Repeat plasma level. Deterioration is common if dose increases allow a fall in blood levels.
Duloxetine	Plasma levels may be reduced by up to 50%.	Monitor closely. Dose may need to be reduced.	Consider reintroducing previous smoking dose.
Escitalopram	In practice, people who smoke have lower blood levels despite being given higher doses. Reduction in levels may be up to 50% (possibly via induction of CYP2C19).	Monitor closely. Consider reducing dose by 25%.	Monitor closely. Increase dose to previous smoking dose.
Fluphenazine	Plasma levels reduced by up to 50%.	Reduce dose by 25%. Monitor carefully over following four to eight weeks. Consider further dose reductions.	Increase dose to previous smoking dose.

Drug	Effect on smoking	Action to be taken on stopping smoking	Action to be taken on restarting smoking
Fluvoxamine	Plasma levels reduced by around one third.	Monitor closely. Dose may need to be reduced.	Dose may need to be increased to previous smoking dose.
Haloperidol	Plasma levels reduced by around 25 – 50%.	Reduce dose by around 25%. Monitor carefully. Consider further dose reductions.	Increase dose to previous smoking dose.
Loxapine (inhaled)	Half-life reduced from 15.7 hours to 13.6 hours.	Monitor.	Monitor.
Mirtazapine	Unclear, but effect probably minimal.	Monitor.	Monitor.
Olanzapine	Plasma levels reduced by up to 50%.	Take plasma level before stopping. On stopping, reduce dose by 25%. After one week, repeat plasma level. Consider further dose reductions.	Take plasma level before restarting. Increase dose to previous smoking dose over one week. Repeat plasma level.
Risperidone / paliperidone	Active moiety concentrations probably lower in people who smoke. Minor effect (possibly via induction of CYP3A4). Smoking may not affect paliperidone concentrations	Monitor closely.	Monitor closely.
Trazodone	Around 25% reduction.	Monitor for increased sedation. Consider dose reduction.	Monitor closely. Consider increasing dose to previous smoking dose.
Tricyclic antidepressants	Plasma levels reduced by 25 – 50%. Some studies suggest more limited effect.	Monitor closely. Consider reducing dose by 10 – 25% over one week. Consider further dose reductions.	Monitor closely. Consider reintroducing previous smoking dose.
Zuclopenthixol	Unclear but likely minimal.	Monitor.	Monitor.

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