

Smoking Cessation and Mental Health:

A briefing for front-line staff



Smoking Cessation and Mental Health

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Introduction

People who have a serious mental illness, 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 the general population.**

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.** For people with mental illness who smoke, stopping smoking will have the greatest impact on their health.

Very brief advice to stop smoking, and behavioural support to assist quit attempts, are life saving interventions.

Whilst primary care settings play 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 window of opportunity to identify people who smoke, advise on the most effective way of stopping smoking and either provide, or refer people for, specialist support.**

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 (VBA) to patients who smoke.

A free open access training module for VBA (focussing on all people who smoke) is available on the NCSCT website: elearning.ncsct.co.uk/vba-launch

Background information

Smoking prevalence

Currently in the UK, approximately 20% of adults smoke. Smoking rates among adults with a common mental disorder such as depression and anxiety are almost twice as high compared to adults who are mentally well, and three times higher for those with schizophrenia or bipolar disorder. People with substance use disorders, with or without a co-morbid mental health problem, have 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 disproportionately high.

It is estimated that people with a mental health or substance use problem buy approximately 42% of the tobacco sold in the UK. People with a mental illness tend to smoke more heavily and be more dependent on nicotine 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 £720 million a year treating smoking related diseases in people with mental disorders; therefore implementing strategies to reduce the high prevalence of smoking in people with mental disorders will not only have a positive impact on quality of life, but also has the potential to realise cost savings for the NHS.

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The impact of smoking on mental health

People who smoke cigarettes 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. They spend more of their disposable income on cigarettes and prioritise cigarettes over food and leisure activities. Smokers are more likely to report having suicidal thoughts and have higher suicide rates.

“Doesn’t smoking help alleviate mental health problems?”

“Quite simply: No”

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.

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. Ex-smokers are happier 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 18). 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.

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Very Brief Advice

Very Brief Advice follows three simple steps:

ASK

AND RECORD SMOKING STATUS

Is the patient a smoker, ex-smoker or a non-smoker?

ADVISE

ON THE BEST WAY OF QUITTING

The best way of stopping smoking is with a combination of medication and specialist support.

ACT

ON PATIENT'S RESPONSE

Build confidence, give information, refer, prescribe.
They are up to four times more likely to quit successfully with support.

REFER THEM TO THEIR LOCAL STOP SMOKING SERVICE

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Ask

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 very brief advice (VBA), which can take as little as 30 seconds to deliver.

The NHS Future Forum emphasises the value of having brief opportunistic 'healthy lifestyle chats' including raising the issue of stopping smoking. Providing VBA to every smoker is recommended by the Department of Health, is effective in general care settings and can be adapted in mental health settings.

Mental health staff already have the necessary therapeutic skills to engage patients in conversations about behaviour change and can easily do it more often with regards to smoking.

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

Raising the issue of smoking can be done opportunistically with patients: such as during protected engagement time; at the end of a home visit or during clinical visits. It can be helpful to link these brief interventions to a current health problem such as a cough, breathlessness, or something that is of personal relevance to the patient.

Raising the issue at any appropriate opportunity ensures that stopping smoking is seen as important part of holistic health care at any point in the patient journey.

Ask and record

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Identifying patients who smoke

"Do you smoke?"

"Have you recently stopped smoking?"

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

It is just as important to know if a patient is an ex-smoker. 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, e.g. on admission and discharge from hospital, on first contact with community services and at each Care Programme Approach (CPA) review.

Confirming if someone is a smoker, should be followed up with advice on the most effective way of quitting.

The most effective treatment for smokers with a mental illness is a combination of medication (Bupropion [Zyban], nicotine replacement therapy [NRT], or varenicline [Champix]) and six to 12 sessions of intensive group or individual behavioural support. This level of support can be provided by a local stop smoking service. Smokers are up to four times more likely to succeed in quitting with a local stop smoking service than if they try to quit unaided. Alternatively, mental health staff can be trained to deliver intensive support in mental health settings and can have a positive impact on quit rates.

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Advise

Advise on the best way of quitting

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, 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.

Example of what to say to a patient who smokes

Inpatient staff

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

"During your stay, we can support you to temporarily or permanently stop smoking. The most effective and comfortable way to do this is by using stop smoking medication and having support from a stop smoking specialist."

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

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Community staff

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

"Having specialist support and stop smoking medication, such as 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?"

Record advice given and patient's response

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 a smoker to access stop smoking support at any point in their patient journey. Commissioners of mental health services are being asked to ensure such systems are in place. The NCSCT also provide a national system of referring patients on to local support. It results in a significantly greater number of staff being trained in the delivery of VBA on smoking, the routine identification of hospital patients who smoke and a dramatic increase in the number of smokers being referred into local support.

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Act

Act on patient response

- Build confidence and self-efficacy
- Exchange information (e.g. about the benefits of stopping, dealing with tobacco withdrawal)
- Refer to a stop smoking practitioner; to either the local stop smoking service or in-house specialist stop smoking practitioner employed by the mental health trust.
- Ensure patient is assessed for and has access to NRT or other licensed medication for smoking cessation (see page 11) 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 medication and systematically assess side effects
- Record actions

The majority of 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 of having specialist support.**

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The role of mental health staff

Once a smoker is in contact with a stop smoking specialist, mental health staff can easily support patients who are making a quit attempt who are temporarily abstaining from smoking. They can give reinforcing advice about the correct use of medicines such as NRT and support strategies for dealing with cravings. Mental health staff also have to be aware that efforts to stop smoking or temporarily abstain can be easily undermined. For example: offering cigarettes, smoking in front of patients, agreeing to buy cigarettes on their behalf, conveying a sense of pessimism about their ability to stop smoking, or not having the right knowledge and skills to support their attempt.

Stop smoking medications

Due to the very short half-life of nicotine, a smoker will start to experience withdrawal symptoms within one to two hours of their last cigarette (e.g. irritability, low mood, poor concentration) 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 and tobacco withdrawal symptoms can be a challenge for the smoker and the staff involved in their care.

Nicotine Replacement Therapy (NRT)

NRT is effective at reducing nicotine withdrawal symptoms and should be offered to all smokers throughout the duration of an inpatient stay even if they have no intention to quit or show no desire to stop 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. Therefore advising on the benefits of using NRT from the beginning of admission is important.

Smoking Cessation and Mental Health

NRT products (such as patches, gum, lozenges and the inhalator) are also licensed for use during smoking reduction and temporary abstinence. **Combination NRT (e.g. patches plus a faster acting oral product such as lozenges or the inhalator) are more effective than a single product.** A course of NRT lasts for 8 to 12 weeks, though experts believe that a longer duration may be needed for mental health patients.

Due to higher levels of nicotine dependence, the amount of NRT required by smokers with mental illness is likely to be higher than the rest of the population.

Licensed nicotine products contain lower levels of nicotine than tobacco and the way these products deliver nicotine makes them less addictive than smoking. They can be used as a substitute for smoking when people are cutting down 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 such levels.

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

Varenicline

Varenicline is a nicotinic acetylcholine receptor partial agonist. It is available on prescription only. It is almost twice as effective as bupropion and is almost certainly more effective than single forms of NRT. **There are no good grounds for excluding patients with mental health problems from taking varenicline and because of its high level of effectiveness it may be their best chance of stopping smoking,** especially given their generally high level of nicotine dependence.

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

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In a study of over 500 patients followed up for 12 months, varenicline increased smoking cessation in smokers with stably treated current or past depression without exacerbating depression or anxiety. A recent 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 all smokers who are using varenicline, there should be:

- Cautious treatment initiation
- Patient education
- Close monitoring for mood and behaviour changes during therapy
- Regular follow-up

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 the least used smoking cessation medicine, there have been more studies on it than NRT or varenicline in smokers with a serious mental illness. When combined with group therapy, it almost triples the chance of quitting in the short term.

Bupropion is not recommended for smokers with a current or past 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 smokers who are using bupropion, there should be:

- Cautious treatment initiation
- Patient education
- Close monitoring for mood and behaviour changes during therapy
- Regular follow-up

Smoking Cessation and Mental Health

Effect of smoking cessation on medication blood levels

Tobacco smoke speeds up the metabolism of some antipsychotic medications, as well as some antidepressants and benzodiazepines, by inducing certain liver enzymes (CYP450 1A2 isoenzyme). This effect is not caused by nicotine but is secondary to the polycyclic aromatic hydrocarbons from the tar in tobacco smoke.

A consequence of speeding up the metabolism of some medicines, is that smokers need higher doses of some psychotropic medicines compared to non-smokers.

Blood levels of medication will be affected by many things such as age, gender and how well they adhere to their prescribed treatment. Stopping smoking can result in an increase in blood levels of some medicines (see page 18); these are likely to increase within seven days of quitting. Because this could potentially led to toxicity, doses of affected psychotropic medicines may need to be reduced by 25–50% once someone stops smoking.

Blood levels, clinical symptoms and any changes in the frequency and severity of side effects all need to be closely monitored when cigarette consumption is reduced or stopped, but also for a few weeks after patients are discharged, as they may start smoking again. Blood levels of clozapine may still be altered for up to six months after stopping smoking.

Currently there are no published guidelines about the effect of cutting down the amount of cigarettes smoked on the metabolism of psychotropic medication, therefore it may be wise to be led by symptoms and side effects and still take plasma levels, particularly for clozapine.

See page 18 for an overview of the medicines that are likely to be affected by smoking and stopping smoking

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Smoke-Free policies within mental health settings

In addition to the physical aspects of smoking, the behavioural, psychological, and social aspects of smoking greatly contribute to its addictiveness in mental health patients. Smoking is often viewed as a shared experience and is often perceived by patients to reduce the feeling of isolation. It provides opportunities to make friends, interact and connect with others. Often patients are 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.

Evaluations of the implementation of smoking bans in mental health settings report no increase in the frequency of aggression, the use of seclusion, discharge against medical advice or the use of required medication.

Evaluations of targeted smoking cessation interventions for smokers with psychosis have also failed to find a worsening of mental health symptoms. The evidence points instead to tobacco withdrawal a potential stressor which, like any stressor, can temporarily exacerbate mental health symptoms if not treated appropriately.

Where staff have encountered increased aggression in inpatient services where smoking is restricted, it tends to be the way in which the legislation is implemented that increase the risk of aggression. Selective or partial bans, ambiguous policies, inconsistent application of a smoke-free policy, lack of stop smoking resources, poor knowledge and skills of staff, inconsistent behaviour of staff and lack of access to nicotine replacement therapy are all contributing factors.

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It is now recommended that mental health settings (and all general health care settings) become totally smokefree and that smoking is banned from both hospital/healthcare buildings and grounds.

There is an opportunity for inpatient mental health staff to move away from the time consuming activity of supervising 'smoking breaks' that has become dominant on inpatient units in recent years, and reclaim this clinical time to promote and support temporary or permanent abstinence.

Whilst we may acknowledge the public health implications of tobacco use, some of us may also be conflicted about the 'rights' of smokers who may not have the capacity to understand the rationale for prohibiting smoking during a hospital stay.

Total smoking bans are not simply restricted to mental health settings, but also general hospital settings and enclosed places where people work and/or the public (patients) have access to. To have special exemptions in place to allow smoking for mental health patients does little to support the argument for equality for people with mental health problems.

Smoking Cessation and Mental Health

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

Following the provision of VBA, and motivating the smoker 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 the pharmacological and behavioural support to maximise success. Having 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 health professionals who want to assist smokers to quit is available here: www.ncsct.co.uk

Stop smoking practitioners who are NCSCT certified can also access the mental health specialty module which builds upon the information contained in this briefing.

Smoking Cessation and Mental Health

Table 1: Effect of smoking cessation on certain drugs

Adapted from Taylor, D., Paton, C., Kapur, S. *Maudsley Prescribing Guidelines 11th Edition*.
West sussex: John Wiley & Sons; 2012

Drug	Effect on smoking	Action to be taken on stopping smoking	Action to be taken on (re)starting smoking
Benzodiazapines	Plasma levels reduced by 0–50%	Monitor closely. Consider reducing dose by up to 25% over one week	Monitor closely. Consider reintroducing previous smoking dose
Carbamazepine	Unclear	Monitor for changes in severity of side effects	Monitor plasma levels
Antidepressants			
Duloxetine	Plasma levels may be reduced by up to 50%	Monitor closely. Dose may be reduced	Consider re introducing previous smoking dose
Fluvoxamine	Plasma levels may be reduced by 30%	Monitor closely, dose may need to be reduced	Dose may need to be increased to previous smoking dose
Mirtazipine	Unclear but effect probably minimal	Monitor	Monitor
Tricyclic antidepressants	Plasma levels reduced by 20–50%	Monitor closely. Consider reducing dose by 10–25% over one week. Consider further dose reductions	Monitor closely. Consider restarting previous smoking dose
Chlorpromazine	Plasma levels reduced. Varied estimates of exact effect	Monitor closely, consider dose reduction	Monitor closely, consider restarting previous dose (when patient was a smoker)
Clozapine	Reduces plasma levels by up to 50%. May be a greater reduction in people taking Valproate	Take plasma level before stopping. On stopping, reduce dose gradually (over a week) by 25%. Repeat plasma level 1 week after stopping	Take plasma level before resuming smoking (anticipate this may happen soon after discharge). Increase dose to previous dose (when patient was a smoker)
Fluphenazine	Reduces plasma levels by up to 50%	On stopping, reduce dose by 25%. Monitor for up to 8 weeks.	On restarting, increase dose to previous level
Haloperidol	Reduces plasma levels by around 20%	Reduce dose by around 10% and continue to monitor	On restarting, increase dose to previous level
Olanzapine	Reduces plasma levels by up to 50%	Take plasma level before stopping. On stopping, reduce dose by 25%. After 1 week, repeat plasma level. consider further reductions	Take plasma level before resuming smoking (anticipate this may happen soon after discharge). Increase dose to previous dose (when patient was a smoker)