Mental Health and Smoking Partnership recommendations for the Tobacco Control Plan for England 2021

May 2021

mental health smoking partnership

These recommendations have been endorsed by the following members of the Mental Health and Smoking Partnership:

Action on Smoking and Health	Association of Directors of Public Health
Association of Mental Health Providers	Breathe 2025
Cancer Research UK	Centre for Mental Health
Equally Well	Fresh (Making Smoking History)
Mental Health Nurses Association	Mental Health Foundation
National Centre for Smoking Cessation & Training	Primary Care Respiratory Society
Rethink Mental Illness	Royal College of Nursing
Royal College of Occupational Therapists	Royal College of Psychiatrists
SPECTRUM Research Consortium	UCL Tobacco and Alcohol Research Group
Unite	

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Recommendations

See below for the full list of recommendations for the 2021 Tobacco Control Plan for England. Further detail on the rationale and potential costs associated with each recommendation is set out at the end of each section.
Target setting
1. Reduce smoking among people with a Long-Term Mental Health condition in primary care via the GP Survey data. The current rate of 25% needs to decline by 2.2 percentage points a year for the next 9 years to be at 5% by 2030. As such the Government should set a target of 14% smoking prevalence by 2026.
2. Reduce smoking among those receiving care from secondary care services. To track this NHS Digital need to make the Assist-Lite fields mandatory within the Mental Health services Data Set.
3. An additional measure of smoking among people with SMI would be to repeat the analysis done in 2016 with data extracted from primary care records via the GP Extraction service. This found smoking rates of 40.5% among people with SMI.
4. Reduce smoking among all people who report having a mental health condition. Government data sources currently appear inadequate for this. However, the Smoking Toolkit Study (STS) could be used to assess progress in this area.
Access to medication and other aids
5. Improving the competency of staff through training to facilitate evidence-based advice to smokers and increased prescribing of medications in both mental health and primary care settings.
6. Setting specific goals in mental health and primary care settings to maximise the uptake of stop smoking medications, other quitting aids and behavioural support.
7. Encourage dedicated stop smoking services to reach more smokers with a mental health condition to provide them with access to medications and e-cigarettes alongside quit support.
8. National funding to support access to e-cigarettes for disadvantaged smokers.
Community and inpatient mental health settings
9. Retain existing ambition for all MH trusts to be smokefree and extend to cover all aspects of PH48 not only whether sites permit smoking.
10. NHSE should ensure that smokers in touch with community mental health services, not only those in inpatient care, have access to tailored stop smoking support. This could be delivered through an extension of the NHSE Long Term Plan activity to include community support.
11. As part of a comprehensive strategy for improving the training of professionals in the NHS, all mental health staff should receive tailored training to enable them to deliver Very Brief Advice and create service environments that are pro-quitting not pro-smoking.
12. Communication tools for professionals to facilitate conversations about smoking in both hospital and community settings.
13. Clear opt out referral pathway to stop smoking support is needed as part of routine Health Check for people with serious mental illness. This must be measured and incentivised.

Improving support for smokers with common mental health conditions
14. Change the IAPT minimum dataset to include smoking status on admission. While this is being updated, Mayden Health (major provider of IAPT patient administration system) should be engaged to create a standard data entry field for recording smoking information.
15. Provide training for all IAPT counsellors to make a brief intervention offering support to quit and opt-out referral to the Stop Smoking Services, accompanied by a brief explanation of the benefits of quitting to mental health to all identified smokers.
16. Strengthen the referral pathways between existing stop smoking services and IAPT services. This could include opt-out referral, co-location of advisors in IAPT services and utilising IAPT text messaging to recruit smokers into stop smoking support.
17. Revise the national guidance in line with the evidence to ensure that smoking cessation is included as a mandatory component of IAPT services for all identified smokers.
Addressing smoking in high prevalence groups
18. Acknowledge these populations and the necessity of not leaving them behind as we move towards smokefree 2030 and the risk of compounding significant inequality and stigma these populations already face. Review opportunities to set specific targets to reach these disadvantaged populations.
19. Invest in embedded models of support within existing services working with these populations including homelessness and drug and alcohol services.
20. Invest in training at scale for services in touch with these groups to enable them to deliver VBA and support local smokefree policies.
Improving the mental health of all
21. Highlight the evidence that smoking cessation can contribute to the overall mental wellbeing of the population.
22. Embed these messages within routine advice on maintaining good mental wellbeing across NHS and public health.
23. Consider how messages on improved mental health can be integrated into broader public mental health strategies.

1. Introduction

1.1 In December 2020, the Government announced there would be a new Tobacco Control Plan for England published in July 2021. The strategy will set out how the Government will achieve their ambition of a smokefree country by 2030. Key for the Mental Health and Smoking Partnership is how this ambition can be achieved for people with a mental health condition and the contribution which tackling smoking among people with mental health conditions can make to this ambition.

1.2 On 29th March, the Government published a policy note announcing the creation of an Office for Health Promotion (OHP) to take on Public Health England's health improvement functions. The OHP is expected to have been established by October 2021 and will sit within the Department for Health and Social Care and report to both the Secretary of State for Health and Social Care and the Chief Medical Officer. The Mental Health and Smoking Partnership wants the new systems and structures to better address and prioritise issues like mental health and smoking that cut across two areas of Ministerial responsibility. Too often in the past, the shared responsibility means no single Minister takes responsibility for the underlying causes of poor health among people with a mental health condition, nor exploring the opportunity of improved mental health through addressing causes of poor physical health. The new system must ensure that it can maximise the opportunity to improve both the physical and mental health of the whole population.

1.3 This note sets out a series of recommendations for improving outcomes for people with a mental health condition who smoke. It has been endorsed by 19 members of the Mental Health and Smoking Partnership. A draft of the below suggestions was discussed at a meeting of the Partnership on 23rd February which PHE and DHSC attended as observers. Following the meeting we have updated the recommendations and set out where specific areas of additional funding might be needed.

1.4 This document should be read in conjunction the Roadmap to a Smokefree 2030. The Roadmap is backed by the Mental Health and Smoking Partnership and calls for a range of measures to secure overall reductions in smoking over time. Most notably the Roadmap calls for a '2030 Smokefree Fund' levied from a charge on the tobacco industry to fund the intensive work needed to bring about an equitable smokefree country by 2030. These resources should partly be used to meet the costs of increasing the support to smokers with a mental health condition.

1.5 Smokers with a mental health condition make up a significant proportion of all smokers. Findings from the Smoking Toolkit Study indicate that around 1 in 3 smokers has a diagnosable mental health condition and they are over-represented in other disadvantaged groups.[1] For example, the ASH YouGov survey findings indicate that around half of smokers in social housing have a mental health condition. This is a population who have been left behind as others have quit and risk being left further behind as we look towards a smokefree country by 2030.

1.6 To achieve a smokefree 2030 for all, the Partnership believes the Government must reduce smoking among people with a mental health condition by:

- Setting intermediate targets to reduce smoking prevalence among people with mental health conditions
- Expanding access to stop smoking medications and other aids to quitting
- Improving support in community and inpatient mental health settings
- Supporting smokers who access IAPT services to quit smoking
- Implementing a targeted approach to addressing smoking among vulnerable people with co-occurring high rates of smoking and poor mental health, such as smokers who misuse drugs or alcohol
- Reaching all smokers with messages that quitting can improve their mental health

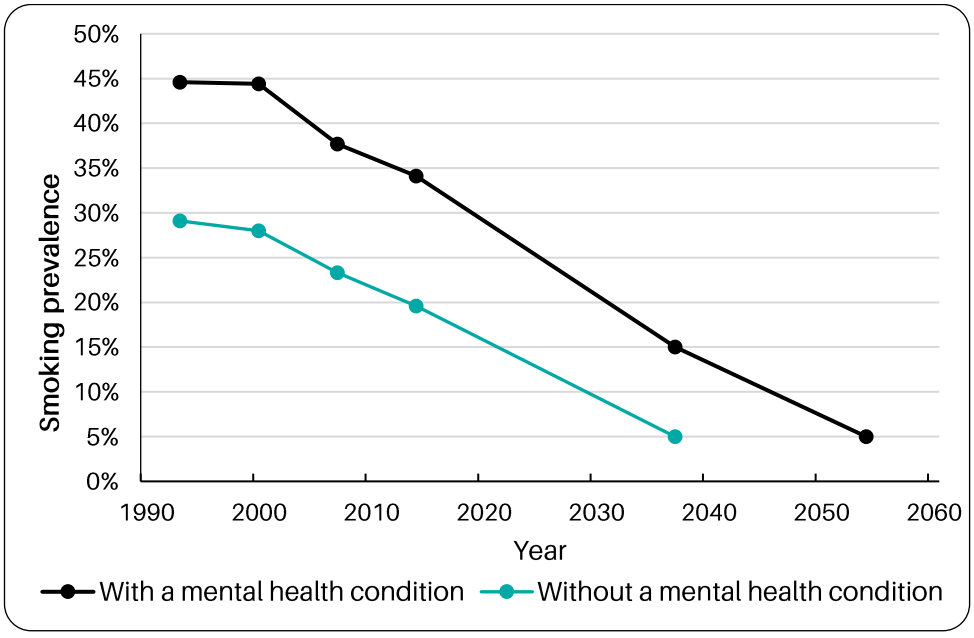
2. Targets needed to achieve a smokefree 2030 for all

2.1 Smoking among people with a mental health condition remains a major health inequality, with those experiencing more severe and complex conditions having very much higher rates of smoking than the general population.[2] This high prevalence of smoking is a key driver in the gap in life expectancy for people with and without a mental health condition.[2] To close the gap in life expectancy it is necessary to reduce rates of smoking among people with mental health conditions.

2.2 National datasets do not allow for an accurate estimate of the number of people in touch with secondary mental health services who smoke. The Adult Psychiatric Morbidity Survey (APMS) records that 45% of people with severe mental illnesses (SMI) smoke. However, the APMS was last carried out in 2014 so is quite out of date. The GP Patient Survey (GPPS) data shows that 25% of people with a long-term mental health condition smoke, although this is limited by relatively small sample sizes and responder bias. Applying these prevalence rates to the numbers accessing secondary mental health services each month somewhere between 250k to half a million smokers accessing secondary care services each month.[3] These estimates provide a sense of the scale of the challenge in mental health services, but they lack precision due to the poor quality of data in this area – something the Partnership recommends is addressed.

2.3 Using data from the APMS, Figure 1 on the next page[4] illustrates that it is highly unlikely that the population with a diagnosed common mental health condition will achieve a smoking rate of 5% or less by 2030, based on previous trends. It is estimated that this population may reach 5% more than 20 years later than those without a mental health condition.

Figure 1: Projected rate of decline among smokers with and without a mental health condition



Using trend data from the APMS for 2000-2014, for people with and without a mental health condition, weighted estimates of smoking prevalence in England were used to linearly extrapolate smoking prevalence after 2014. (Richardson & Robson, unpublished data)

2.4 It is also important to note that people with a mental health condition make up a large proportion of all smokers. Therefore, strategies to reduce smoking that do not take account of the population with mental health conditions will underdeliver, jeopardising the Government's overall vision for a smokefree country by 2030.

2.5 Given the significant inequalities and the large proportion of smokers with a mental health condition, it is vital that there are clear ambitions to reduce smoking rates in this population to both assess and drive progress. The last Tobacco Control Plan set out to improve the data around smoking and mental health. Although progress has been made, significant gaps remain, making target setting a challenge in some areas.

2.6 The only existing Government data source that would allow a target to be set are the data gathered through the GP Patient Survey. In 2020, this survey was sent to 2.3 million people and just under 30% responded. The survey is primarily designed to look at people's experience of their local GP services, but it also captures smoking status and whether people report having a long-term mental health condition.

2.7 Tracking progress in smoking rates among people in contact with secondary mental health services remains an issue that needs to be addressed. The Assist-Lite screening tool has been included in the Mental Health Services Dataset and therefore some fields on smoking can be populated by service providers. However, it does not form part of the minimum dataset meaning that there is no requirement on providers to populate it, and it is not collated nationally so that performance and trends can be monitored. This needs to be urgently addressed. Making the Assist-Lite screening tool mandatory would not only provide important information on smoking but would also provide national level data on alcohol and other substance use.

2.8 There are currently no robust national Government measures for the overall smoking rates among all people with mental health condition and mental distress. The Smoking Toolkit Study has been gathering this information and as such it would be possible to set a target and track progress using this data source. We anticipate that funding questions in this survey would be more efficient than using national surveys such as the Adult Population Survey to provide similar information.

Recommendations for target setting	Rationale	Potential costs
1. Reduce smoking among people with a Long-Term Mental Health condition in primary care via the GP Survey data. The current rate of 25% needs to decline by 2.2 percentage points a year for the next 9 years to be at 5% by 2030. As such the Government should set a target of 14% smoking prevalence by 2026.	While this data source has limitations, it is currently gathered and a trend can be tracked over time.	These data are already gathered and part of the Tobacco Control Profiles – no new costs

2. Reduce smoking among those receiving care from secondary care services. To track this NHS Digital need to make the Assist-Lite fields mandatory within the Mental Health services Data Set.	A measure is needed to assess progress among people accessing secondary MH services given that smoking prevalence in this population is more than double that of the general population. There is also extensive policy activity in these settings both through the NHS LTP and wider efforts to implement PH48. To both drive and assess progress a proper measure of performance within these services is needed.	Rates of smoking exist in both primary care and MH Services Dataset. There would be administrative costs associated with collating these data nationally and assessing and improving its quality.
3. An additional measure of smoking among people with SMI would be to repeat the analysis done in 2016 with data extracted from primary care records via the GP Extraction service. This found smoking rates of 40.5% among people with SMI.	Robust measure of smoking among people with SMI	There would be a cost to data extraction and the Partnership understands that was the reason the data have not been extracted since 2016.
4. Reduce smoking among all people who report having a mental health condition. Government data sources currently appear inadequate for this. However, the Smoking Toolkit Study (STS) could be used to assess progress in this area.	Not all people with poor mental health are in touch with services. To ensure populations are not being left behind a broad measure is needed of progress being made for all smokers with a MH condition.	To ask question on 'mental distress' and 'ever diagnosis of condition' would cost around £27k if included in 4 waves of the STS per year (about 7k adults).

2.9 We therefore recommend that progress must be maintained and built on in the new plan, with three new targets that will allow Government to effectively track rates of smoking in different populations of people with a mental health condition. The Partnership feels no single target will provide an adequate picture of smoking among these groups.

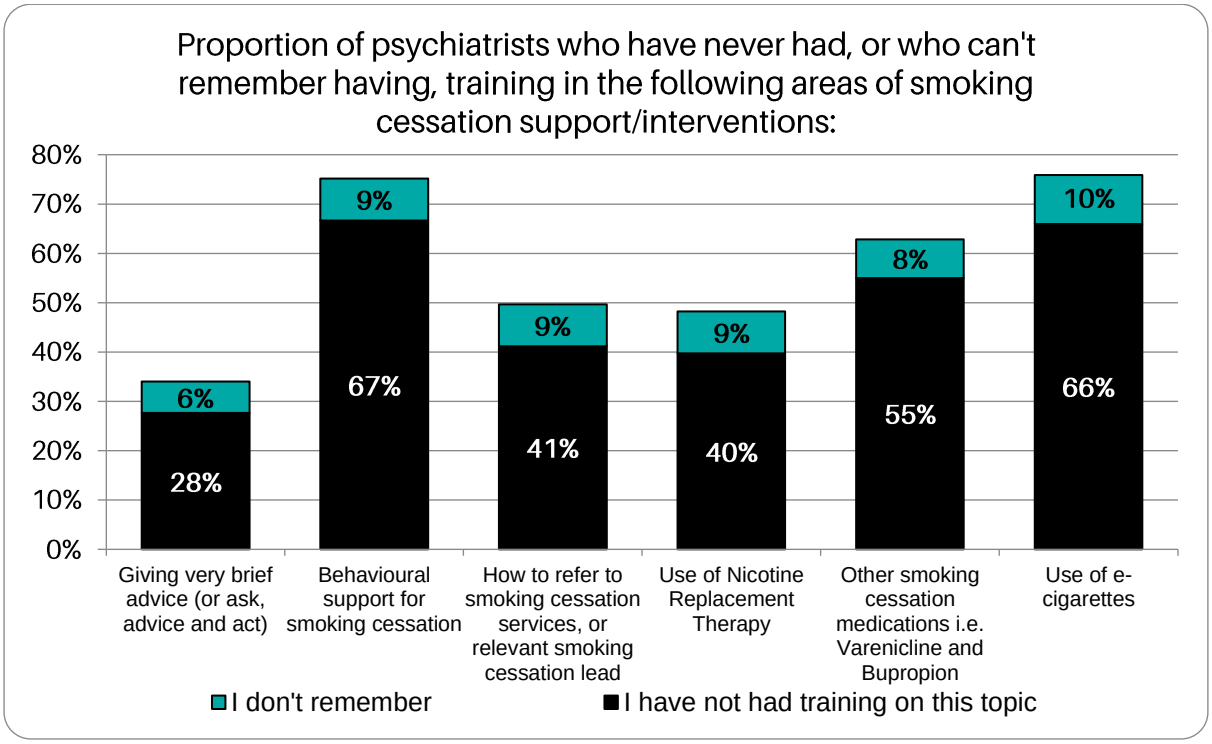
3. Improving access to medication and other aids to quitting such as e-cigarettes

3.1 Getting more people who currently smoke to stop is key to delivering a smokefree 2030. To do this we need to increase the rate at which people quit and the success of their quit attempts. In 2019, the rate at which people tried to stop smoking was at an all-time low according to the Smoking Toolkit Study, with 29% of smokers making a quit attempt. The pandemic has disrupted this trend, with 36% of smokers making a quit attempt in 2020, the highest proportion since 2014.[5] However, we cannot be complacent about the pandemic's impact, not least because there were also reasonably high rates of people relapsing to smoking. Boosting the number of quit attempts long term means investment in mass media campaigns, continued price increases and maximising smokers' contact with services through scaled up approaches to Very Brief Advice. These population level measures are likely to also impact on smokers with a mental health problem.

3.2 One of the most effective ways to boost quit success is to increase the rate at which stop smoking medications and other aids are accessed by smokers. This is particularly important for a population with high levels of addiction and barriers to quitting. Research shows that motivation to quit[6] is equally high among smokers with a mental health condition but success in quitting is lower.[2] Evidence suggests that this lower success rate is due to higher levels of nicotine dependency among smokers with mental health conditions, compared with smokers in general.[1]

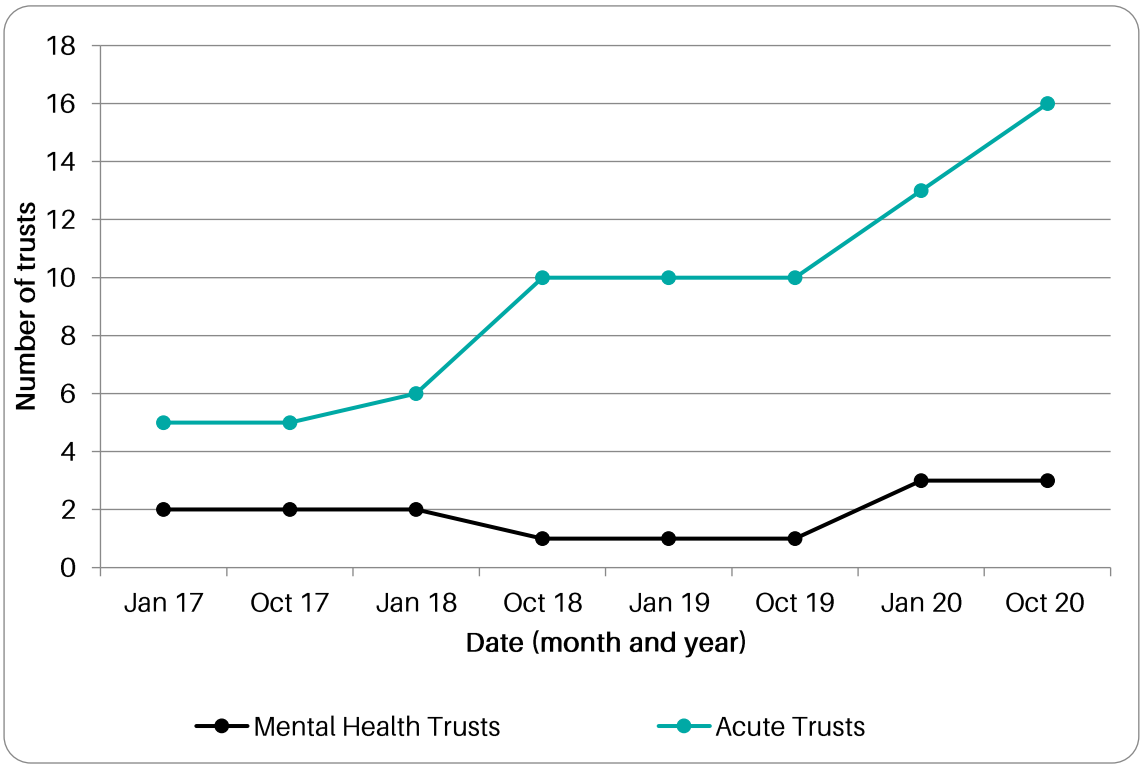
3.3 In this context, widening access to licenced stop smoking medications and other aids, such as e-cigarettes, is important to boost quit success rates and should be an important part of the overall strategy for the next Tobacco Control Plan. The Partnership has identified a lack of training among professionals as one of the key barriers to increasing rates of prescribing of smoking cessation medications and the delivery of very brief advice (VBA). A high proportion of psychiatrists surveyed for the DHSC-funded ASH report on their training needs, had not received or could not remember receiving training on nicotine replacement therapy (NRT), other stop smoking medications, or e-cigarettes, as Figure 2 illustrates.

Figure 2: Smokefree Skills: Training needs of mental health nurses and psychiatrists



3.4 There is also a growing inequality in prescribing between mental health and acute trusts. While more acute trusts are now prescribing smoking cessation medications than three years ago, the gap in prescribing between acute and mental health trusts is widening. Figure 3 is a snapshot of prescribing rates for Varenicline in acute and mental health trusts between 2017-2021.

Figure 3: Changes in the number of trusts prescribing Varenicline, 2017-2021



3.5 Prescribing in primary care has also declined in recent years. According to the UCL Smoking Toolkit Study quitters using prescriptions peaked at 25% in 2012 and is now at a low of around 5%. For many people with mental health conditions their primary medical contact will be with primary care services, so this drop, at a time when attendance to local authority funded stop smoking services is also in decline, is likely to be reducing their access to prescribed medications to support quit attempts.

3.6 Stop smoking medications are low cost and, where smokers quit, reduce the need for other more expensive medications resulting from development or exacerbation of illnesses. In the context of mental health, ex-smokers often need lower doses of anti-psychotic medications when they quit. This is beneficial in terms of both cost and health given the significant side-effects of these medications.

3.7 E-cigarettes have been shown to offer an effective and palatable alternative to smoking for many.[7] Given the higher levels of addiction in this population they can play an important harm reduction role in providing people with medium to long term replacement for the nicotine they get from smoking tobacco. Barriers to accessing e-cigarettes include poor understanding of the relative safety of e-cigarettes compared to smoking and, for those on low incomes, price can be a barrier with initial outlay for a starter kit being prohibitive for some smokers who may not be confident in their effectiveness. The Government can seek to address both of these barriers in the Tobacco Control Plan through schemes to specifically support this population to access e-cigarettes.

3.8 We estimate that between 250k and 500k smokers are in touch with secondary mental health services at any one time. To provide a basic e-cigarette starter kit at the top end of this estimate would cost around £6.3 million. Any scheme that sought to provide e-cigarette starter kits at scale to smokers in this population should also proactively offer behavioural support. In Salford, where such a scheme was rolled out to people living in social housing,[8] that support was largely provided by community pharmacy.

3.9 The Partnership sees merit in exploring this type of model for smokers in contact with secondary mental health services who face some of the highest barriers to quitting. It should be noted that this population overlaps significantly with other priority populations who might also be the target of such a scheme. For example, according to unpublished data from an ASH/YouGov survey around half of all smokers in social housing also have a mental health condition.

Recommendations for access to medication and other aids	Rationale	Potential costs
5. Improving the competency of staff through training to facilitate evidence-based advice to smokers and increased prescribing of medications in both mental health and primary care settings.	The gaps in staff training remain a major barrier to change. Skills and knowledge about many areas of smoking cessation remain low. All smokers should be able to receive evidence-based advice and, where appropriate, prescriptions of medications that can help them quit.	ASH is developing a separate proposal about how to scale up training across the NHS
6. Setting specific goals in mental health and primary care settings to maximise the uptake of stop smoking medications, other quitting aids and behavioural support.	Increased prescribing of these low-cost medications will boost quit success without the need to significantly change existing delivery	Any increased costs could be offset by reductions in more expensive medications such as anti-psychotics.
7. Encourage dedicated stop smoking services to reach more smokers with a mental health condition to provide them with access to medications and e-cigarettes alongside quit support.	Mainstream stop smoking services have a variable record in supporting smokers with mental health conditions and need to be better equipped to support their needs.	This could be done within existing LA budgets
8. National funding to support access to e-cigarettes for disadvantaged smokers.	These products have been shown to improve outcomes but low-income smokers may be wary of the initial outlay. A scheme can also give health professionals greater confidence in these products and improve their advice to patients.	The cost of providing starter kits half a million smokers within secondary MH services would cost around £6.3 million

4. Supporting smokers in community and inpatient mental health settings

4.1 It is likely that more than 250k smokers are in touch with secondary mental health services at any one time. Progress has been made on improving provision for smokers during their inpatient stay since the current Tobacco Control Plan was published, but delivery remains inconsistent, and it appears likely that the pandemic will have set progress back in some trusts.

4.2 The commitments in the NHS Long Term Plan[i] to support smokers are welcome but current funding will not support smokers outside of inpatient stay until the final year of the programme. While efforts are being made to consider how smoking cessation pathways can be maintained on discharge, most people in touch with secondary mental health services will not have an inpatient stay in any given year. As a result, this investment is unlikely to benefit the vast majority of smokers in contact with secondary mental health services until 2023/24 when some funding for outpatients will be released. This will mean that people continue to be admitted for inpatient stays without adequate preparation in the community for smokefree policies and is a massive missed opportunity in terms of reaching the population of smokers with a mental health condition.

4.3 Funding for support to smokers outside the inpatient environment should be brought forward with a further commitment to fund support past 2023/24. Given the very high levels of smoking in this population, addressing these inequalities will require significant investment over time. Failure to find effective solutions for this population will mean they are left behind as the country moves towards smokefree 2030, intensifying the disadvantages they experience.

4.4 Studies such as the SCIMITAR trial have demonstrated that services can be developed and embedded for smokers with SMI.[9] Recent meta-analysis submitted for publication and undertaken by the team behind the Mental Health and Addiction Research Group at York found that tailored support for people with a mental health condition produces better quit results than mainstream support.

4.5 The bespoke approach such as the SCIMITAR model are highly effective but costly interventions. The model in the trial cost in the region of £561 per person in the first year, falling to £371 in following years to provide. However, it is estimated that around a third of smokers would take up the offer if it were made showing the appetite among smokers in this population for high quality quit support. More work is needed to understand what models of support could work at scale for smokers in touch with secondary mental health services and who would benefit from the more intensive approach of something like SCIMITAR. There is an opportunity to build on the infrastructure that will be established through the Long Term Plan and ensure that smokers are not only supported during inpatient stays.

[i] The NHS Long Term Plan commits to implementing NHS-funded tobacco treatment services for all people admitted hospital who smoke by 2023/24. It also commits to introducing a new universal smoking cessation offer for long-term users of specialist mental health services, and in learning disability services.

4.6 Findings from the YouGov covid tracker indicate that smokers with a mental health condition have quit smoking with greater success during the pandemic. More worryingly however, many smokers with mental health conditions appear to be increasing their consumption of tobacco, with some relapsing and evidence that some may have taken up smoking for the first time[10]. The pandemic may therefore be contributing to the significant inequalities this group already face.

4.7 Smokers in contact with secondary mental health services make up a large proportion of all smokers and over time this is likely to grow. Now is the time to put the infrastructure in place to address the current inequality in smoking rates and avert even greater inequalities in the future.

4.8 The Partnership would also like to see the Government retain their ambition for all mental health trusts to be smokefree. In 2019, ASH conducted a survey of trusts funded by PHE which found 82% had a comprehensive smokefree policy but implementation was variable.[11] There have been reports that the COVID-19 has impacted on policy implementation in some areas, though the extent of this is unknown.

Recommendations for community and inpatient mental health settings	Rationale	Potential costs
9. Retain existing ambition for all MH trusts to be smokefree and extend to cover all aspects of PH48 not only whether sites permit smoking.	Important as part of driving cultural change needed in MH trusts. Currently unfinished business from the existing plan.	PHE commissioned a survey of MH trusts in 2019 for £30k to assess progress. Repeating this survey in 2021/22 and again later in the life of the Plan would provide a picture of progress.
10. NHSE should ensure that smokers in touch with community mental health services, not only those in inpatient care, have access to tailored stop smoking support. This could be delivered through an extension of the NHSE Long Term Plan activity to include community support.	Current LTP roll out will not deliver in community settings. This is a major missed opportunity with smokers in the community outnumbering those in hospital by around 10 to 1. Without tailored support it is likely the existing inequality in smoking rates will widen.	More work in needed to scope costs. Any programme of support is likely to be popular so a first step would also be to understand the likely demand for services through a proper estimate of the number of smokers in touch with secondary care.
11. As part of a comprehensive strategy for improving the training of professionals in the NHS, all mental health staff should receive tailored training to enable them to deliver Very Brief Advice and create service environments that are pro-quitting not pro-smoking.	Mental health services need to move from being indifferent (at best) about smoking to pro-quitting institutions. Training is a major gap in delivering this goal	ASH is developing a separate proposal about how to scale up training across the NHS

12. Communication tools for professionals to facilitate conversations about smoking in both hospital and community settings.	Simple leaflets have been a useful aid for practice in maternity settings, giving professionals something to help them structure their conversations with smokers. Such resources could also aid engagement in MH settings.	Based on the experience of the Smoking in Pregnancy Challenge Group two different types of resources could support effective conversations about smoking: • Hospital resource for smokers on admission or at risk of admission • Community resource to facilitate conversations and referral to support If 750k resources were produced this would cost approximately £45k
13. Clear opt out referral pathway to stop smoking support is needed as part of routine Health Check for people with serious mental illness. This must be measured and incentivised.	This existing opportunity to engage with people about their health appears underutilised to support quit attempts	Existing budgets should be able to facilitate improved VBA and referral pathway. Some additional project management resources may be needed

4.9 Retaining this ambition – for mental health settings to be smokefree – would support the roll out of the NHS Long Term Plan activity on smoking in inpatient mental health settings, as well as other activity to improve support for this population. However, the ambition in the current plan does not adequately capture the recommendations of NICE PH48, which are intended to create environments that fully facilitate and support quitting, not merely prohibit smoking. A revised ambition that sought to implement NICE PH48 in all mental health trusts would also be welcome.

5. Addressing smoking through IAPT services

5.1 The Improving Access to Psychological Therapies (IAPT) programme has around 1.69 million referrals a year. It supports people with common mental health conditions such as depression and anxiety. Smoking status is not routinely gathered for clients of IAPT services. However, it is likely that around 1 in 4 people accessing the service smoke, given the rates of smoking among people with common mental health conditions.

5.2 IAPT services were set up in part to support more people back into employment by widening access to therapies for mental health conditions including depression and anxiety, which are recognised as barriers to workforce participation.[12] [13] A similar rationale was behind the expansion of the service to support people with long term health problems.[14] People with less depression and anxiety are better equipped to self-manage their condition which reduces the overall cost to the NHS. Stopping smoking increase the likelihood of employment[15], improves mental health[16] and reduces risk of health conditions and/ or exacerbations. As such addressing smoking is a good fit for the overall objectives of these services.

5.3 Pilots have been commenced to look at the effectiveness of addressing smoking through IAPT services following an initial feasibility study which 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. The following quotes are from a qualitative University of Bath-led feasibility study of integrating smoking cessation in IAPT support:

"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

"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 in feasibility study

5.4 There is currently substantial investment from the voluntary sector in this area. In addition to the ongoing University of Bath pilot there is also a CRUK funded project to produce an online CBT module which would form part of the standard online IAPT offer, but could also be integrated into face-to-face treatment.[17]

5.5 There are also existing programmes in IAPT services which have co-located or integrated specific additional support such as employment advisors. Such activity serves to illustrate how smoking cessation models might also be better aligned with IAPT.

Recommendations to improve support for smokers with common mental health conditions	Rationale	Potential costs
14. Change the IAPT minimum dataset to include smoking status on admission. While this is being updated, Mayden Health (major provider of IAPT patient administration system) should be engaged to create a standard data entry field for recording smoking information.	This is necessary to facilitate better engagement on smoking from services.	There is no significant cost associated with this beyond business as usual
15. Provide training for all IAPT counsellors to make a brief intervention offering support to quit and opt-out referral to the Stop Smoking Services, accompanied by a brief explanation of the benefits of quitting to mental health to all identified smokers.	There is a good evidence base for VBA delivered by trained and trusted professionals it should form a routine part of training for staff.	Free online training via NCSCT available – staff time needed to complete training
16. Strengthen the referral pathways between existing stop smoking services and IAPT services. This could include opt-out referral, co-location of advisors in IAPT services and utilising IAPT text messaging to recruit smokers into stop smoking support.	A high number of smokers pass through IAPT services who are motivated to make changes in their life. Mutually beneficial for both services outcomes to have stronger links	Could be done within existing IAPT and LA budgets
17. Revise the national guidance in line with the evidence to ensure that smoking cessation is included as a mandatory component of IAPT services for all identified smokers.	Longer-term national change is best secured through updating the national guidance and providing some additional resources to widen access to cessation support through IAPT	Inclusion in the national guidance and national rollout would require additional funding depending on the model adopted.

6. Supporting groups with high co-occurring rates of smoking and poor mental health

6.1 There are several vulnerable populations where smoking rates and poor mental health are much higher than the general population. Notably people who are homeless, people who misuse substances, and people leaving prison. These are often populations already experiencing high levels of disadvantage and stigma. Smoking rates are estimated to be over 60% for these populations – many times that of the average rate of smoking.[2] Despite high smoking rates these groups are as motivated to quit as other smokers and try to quit just as often – however their quit success is lower.

6.2 Organisations working with these populations are not routinely addressing their client groups' smoking, although there is reason to believe that reducing smoking would support many of the recovery goals that homelessness, substance use and other services have for their client groups.

6.3 For example, substance use services routinely capture smoking status but there is limited evidence of systematic support to help their clients quit smoking. Continuing to smoke reduces the likelihood of positive treatment outcomes while quitting smoking reduces the likelihood of relapse post-treatment for those receiving treatment for drugs.[18] A meta-analysis of the evidence found that successful smoking cessation during treatment for illicit drug or alcohol consumption was associated with a 25% increase in likelihood of long-term abstinence.[19] Co-use of opioids and tobacco is associated with increased use of one or both substances, and increased tolerance and addiction, thus making abstinence from either substance more difficult. [20] Consequently, some experts have made a strong call for integrated approaches which facilitate co-treatment of opioid and tobacco dependency to meet patients' substance use recovery goals and improve population health.[20]

6.4 The section on smoking cessation in *Drug misuse and dependence: UK guidelines on clinical management*[21] is comprehensive and if implemented in full would be likely to have a beneficial impact on the population. There is reason to believe, however, that this guidance is not being effectively implemented. For example, data from services show that among those in treatment for opioids 70% were smoking at the start of treatment but only 2% accessed smoking cessation support.[22]

6.5 A survey of clients in addictions services in London found rates of smoking at 88% but 79% of these expressed a desire to quit and 46% were interested in receiving advice.[23] However, only 15% had been offered support to stop smoking during their current treatment episode, while 56% reported never having been offered support. This may in part be due to the lower priority which staff placed on smoking cessation compared to clients, with just under a third of staff saying it should be dealt with early in treatment, compared to just under half of clients. One of the major barriers, therefore, to implementing the high-quality existing guidance is a gap in practice, likely driven by a combination of organisational culture, staff training and levels of investment.

6.6 Evidence of models to support these client groups is growing. A particular focus of research has been the role of harm reduction and the use of e-cigarettes for this highly addicted population who have low quit success. A cluster feasibility study[24] offering e-cigarettes to smokers accessing homeless services showed high levels of uptake and good acceptability of e-cigarettes. This project has now been funded at scale by NIHR and would create a good foundation from which to build a more comprehensive approach to supporting smokers in homeless settings that we currently have.

6.7 It should also be noted that homelessness organisations and others are often open to playing a more proactive role in relation to their client group but lack the resources to do this. A recent national survey of smokefree policies in homeless settings, covering 118 charities, found that providers would like to offer more to their service users, but that there was no 'go to' resource which specifically addressed the needs of their service users. The Medical Research Council (MRC) is funding the development of a harm reduction toolkit for these services but more could and should be done to scale up action.

Recommendations to address smoking in high prevalence groups	Rationale	Possible costs
18. Acknowledge these populations and the necessity of not leaving them behind as we move towards smokefree 2030 and the risk of compounding significant inequality and stigma these populations already face. Review opportunities to set specific targets to reach these disadvantaged populations.	These populations already experience high levels of disadvantage and stigma. Achievement of the smokefree 2030 target should not leave them behind	Substance use services already track this information and it is published in the Tobacco Control Profiles – setting targets should not be complex. More investment would be needed to understand how other priority populations could be tracked.
19. Invest in embedded models of support within existing services working with these populations including homelessness and drug and alcohol services.	The evidence of what works is that services need to be located where people can easily access them and where they feel those services are free from stigma.	NIHR has recently funded a £1.6m trial into support for this population. This process could be used to scope and cost sustainable models of support
20. Invest in training at scale for services in touch with these groups to enable them to deliver VBA and support local smokefree policies.	Securing a step-change in organisations working with these vulnerable populations view and treat smoking is unlikely to be achieved without improved training. Many existing training resources are appropriate for these settings and further resources could be developed over time.	Existing VBA training is available through the NCSCT – however securing uptake of this and supporting organisations to develop and implement effective smokefree policies would be better delivered through a project lead for this work

7. Improving the mental health of all smokers

7.1 Stopping smoking potentially has benefits for the mental health of all smokers.[16] This information is not widely known or understood by professional groups. It has implications for practice and for the design of services which take a shared approach to smoking and mental health, particularly in light of the growing burden of poor mental health on the population as a whole as a result of the pandemic. The findings of the recent Cochrane review show that the benefits to the mental health of all smokers is similar to the impact of taking anti-depressants (for those for whom they are effective) and appears to endure for many years after a person has stopped smoking.

7.2 Addressing smoking should be a strategic goal within broader efforts to improve the mental health of the population as we emerge from the pandemic. This will require engagement from a wide group of stakeholders from primary care through to the voluntary sector.

Recommendations to improve the mental health of all	Rationale	Possible costs
21. Highlight the evidence that smoking cessation can contribute to the overall mental wellbeing of the population.	Framing in the Tobacco Control Plan can support a wider narrative in public health and elsewhere	None
22. Embed these messages within routine advice on maintaining good mental wellbeing across NHS and public health.	Given the contribution to improved mental wellbeing this should be routine advice alongside other evidence-based advice	Should be covered within existing budgets
23. Consider how messages on improved mental health can be integrated into broader public mental health strategies.	Large numbers of people stopping smoking could make a non-trivial contribution to improving overall wellbeing	No immediate costs

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