

## Myth Buster Smoking and Mental Health

- The smoking rate among people with a severe mental illness is 40.5% across England<sup>1</sup> more than double that of the general population.<sup>2</sup>
- Smoking is the main cause of illness and premature death among people with a mental health condition who die 10-20 years earlier than the general population.<sup>3</sup>
- Smokefree policies provide a key opportunity to address this health inequality.
- All inpatient mental health services should be smokefree by 2018 in accordance with the Five Year Forward View for Mental Health<sup>4</sup> and Tobacco Control Plan.<sup>5</sup>

### 1. Effects on mental health

**Myth: “Quitting smoking is bad for mental health and can trigger depressive episodes.”**

**Facts: Quitting smoking has been associated with better mental health.**

Quitting smoking may be challenging but smoking cessation has been associated with reduced levels of depression, stress and anxiety as well as improved positive mood compared with continuing to smoke.<sup>6</sup> Furthermore, the impact of quitting smoking on mood and anxiety disorders appears to be equal to or greater than that of antidepressants.<sup>6</sup> The experience of stress that comes from stopping smoking is a symptom of nicotine withdrawal and can be treated effectively with stop smoking medications or electronic cigarettes.

Evidence also suggests that quitting smoking can reduce the necessary dose of some anti-psychotic medicines<sup>6</sup> and reduce costs to mental health services.

**Myth: “Denying patients the ability to smoke will increase violent incidents.”**

**Facts: Trusts that have implemented smokefree policies have not seen an increase in violence.**

Evidence from services in the UK and abroad that adopted comprehensive smokefree policies suggests that levels of violence have actually decreased following the introduction of smoking bans. This was illustrated in a maximum security setting where overall incidence of disruptive behaviour and verbal aggression significantly decreased following implementation of smokefree policies.<sup>7</sup> This pattern has also been seen at South London and the Maudsley NHS Foundation Trust where there was a 39% reduction in the number of physical assaults per month after the introduction of the smokefree policy compared with beforehand.<sup>8</sup> This has been achieved through full implementation of NICE Guidance rather than selectively implementing policies. As part of the implementation process individual settings may want to consider how they would deal with incidents of violence that relate to smokefree policies.

### 2. Medications

**Myth: “Stop smoking medications don’t work for people with a mental health condition.”**

**Facts: Studies have found that medications are effective**

Treatments to help people quit smoking that work for the general population are also effective for those with a mental health condition, regardless of the severity of the illness<sup>9</sup> and do not have adverse effects on mental state.<sup>10,11,12</sup> Given these results, there is a need to maximise use of these effective therapies on a much broader scale than is currently the case.

**Myth: “I don’t want to prescribe varenicline while it says it can cause suicidal thoughts.”**

**Facts: This warning on varenicline has been removed following clinical trials.**

Varenicline, often marketed as Champix, has previously had a so-called ‘black box warning’. However, the US Food and Drug administration has recently removed this warning<sup>13</sup> following the results of a large clinical trial which showed adverse side-effects to be far lower than previously thought.<sup>14</sup> This study also showed varenicline was effective in supporting people to quit smoking whether or not they had a history of mental illness.<sup>14</sup>

### **3. Never a bad time to quit**

**Myth: “There’s too much else going on, we need to deal with other problems first.”**

**Facts: Even smokers facing multiple challenges want to quit**

Despite competing priorities even people facing multiple disadvantage want to quit, and quitting can lead to other benefits. If someone with drug and alcohol dependencies quits smoking their chance of long-term abstinence from alcohol or illicit drugs can increase up to 25%.<sup>15</sup> Quitting smoking increases disposable income and nationally half a million people could be lifted out of poverty through smoking cessation.<sup>16</sup> Improvements in health and positive sense of achievement from quitting smoking can also help people in facing other challenges.

### **4. Smokefree environments**

**Myth: “Inpatient stays are stressful enough without making people quit smoking”**

**Facts: Inpatient services can provide a supportive environment for quitting smoking.**

Inpatient settings that have gone smokefree should be free from the cues that make people want to smoke. Alongside effective treatment of nicotine withdrawal, through pharmacotherapy and behavioural support, this makes inpatient units suitable settings in which to discuss smoking. Staff who have received training on smoking cessation are more likely to believe that inpatient stays are appropriate times to address smoking behaviour.<sup>17</sup>

It is important that a supply of alternative nicotine products are available within half an hour of admitting a patient to a smokefree unit or ward. Nicotine withdrawal can be a source of stress for patients and mimic or exacerbate symptoms of mental health problems, this needs to be dealt with quickly.

**Myth: “All the staff smoke and we like going out for breaks, some people might not support the ban”**

**Facts: Staff are key to implementing effective policies and can improve their health.**

Full implementation of NICE PH48 includes supporting staff members to stop smoking. In addition NICE Guidance PH5 encourages promotion of smoking cessation within the workplace which Trusts have an obligation to comply with.

There is evidence that nursing staff have sometimes begun smoking as a result of exposure to the smoking culture within mental health settings.<sup>17</sup> Staff who smoke are less likely to discuss quitting smoking with patients than staff who don’t, which does not provide patients with the full support they should receive. Further, where staff continue to smoke during working hours this

can undermine the creation of an environment that fully supports quitting. It is not fair to service users experiencing cravings to smell smoke on staff.

Quitting smoking is still the single best thing staff could do for their health, as well as saving an average of £2000 per year.

**Myth: “Smokefree policies will be too expensive to implement”**

**Facts: Smokefree policies are actually more cost effective than allowing smoking in inpatient settings.**

A 2016 study estimated the cost of facilitating smoking in four mental health wards was over £130,000 in six months.<sup>18</sup> While smoking-related disease among people with a mental health condition cost the NHS an estimated £719 million in 2009/10.<sup>19</sup> Further, the same 2016 study estimated that the facilitation of smoking breaks cost 6000 hours of staff time across the 6 month period.<sup>18</sup> This gives an illustration of the costs that can be saved if services transition to becoming smokefree.

**Myth: “Smoking is a human right”**

**Facts: A court ruling has found that smoking is not protected under the Human Rights Act.**

The 1998 Human Rights Act allows individual choice only if this choice does not endanger others. A Court of Appeals ruling in 2009 upheld the right to impose smokefree policies in mental health settings. The judgement concluded that mental health inpatient units are public institutions and as such public places and therefore, cannot be considered a patient’s home meaning section 8 of the Human Rights Act 1998 – stating that everyone has the right to respect for his/her private and family life, home and correspondence – does not apply.<sup>20</sup>

Mental health inpatient settings have a duty of care to both service users and their staff. Implementing effective smokefree policies can be crucial in supporting individuals to quit smoking and thus reducing the gap in life expectancy between people with a mental health condition and the general population.

## **5. E-cigarettes**

**Myth: “E-cigarettes are just as harmful as tobacco”**

**Facts: E-cigarettes are significantly less harmful than tobacco**

E-cigarettes do not contain tobacco but heat a nicotine solution to deliver nicotine to users without the level of harmful carcinogens found in tobacco smoke. Public Health England’s review of e-cigarettes estimates that they’re around 95% safer than tobacco and there is no evidence of harm to bystanders.<sup>21</sup> These conclusions have been supported by further research including a report from the Royal College of Physicians which suggests switching to e-cigarettes could be an effective and safer option for smokers struggling to quit.<sup>22</sup>

**Myth: “E-cigarettes can’t help smokers quit”**

**Facts: Increasing evidence shows e-cigarettes are effectively helping people to quit.**

E-cigarettes are the most popular aid to quitting used in the UK and increasing evidence suggests they are effective at supporting people to quit smoking. A Cochrane Review found that compared to a placebo e-cigarettes containing nicotine increased chances of long term smoking cessation.<sup>23</sup> Further, a study published in the British Medical Journal (BMJ) suggests

that use of e-cigarettes led to an additional 54,000 short to medium term quits in 2015. Given that some of these individuals will relapse the researchers concluded that e-cigarettes may have led to an additional 18,000 long term ex-smokers in 2015.<sup>24</sup>

## 6. Desire to quit

**Myth: “Smokefree policies won’t work, smoking is too ingrained”**

**Facts: People with a mental health condition want to quit smoking.**

While smoking rates among people with a mental health condition are very high, 66% of these smokers report wanting to quit.<sup>25</sup> Further, a survey for ASH found that 83% of smokers with a mental health condition had made a quit attempt in the past and 30% of respondents described themselves as ex-smokers.<sup>17</sup> This illustrates that there is a strong desire to quit smoking among people with a mental health condition, and given the right support, people with a mental health condition are successful at quitting smoking.

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