Supporting Leicester residents with mental health conditions to quit smoking

For consideration by:
Health and Wellbeing Scrutiny Commission
Date: 22 March 2022
Lead Director: Ivan Browne

Useful information

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1. Summary

Prevalence of smoking in Leicester City has been declining year on year and is now at an all time low of 15.4%[1] (13.9% England average), in large part due to the provision of high-quality stop smoking support. However, the national data clearly shows that prevalence has remained much higher amongst those with a long term mental health condition (26.8%) and higher still amongst those with a severe mental illness (40.5%)[2], yet smokers with mental health conditions are no less likely to express desire to stop. There is therefore a case for identifying why this is the case, and what measures can be taken to better prevent people with mental ill-health from being disproportionately affected by smoking-related disease.

The links between smoking and mental health are complex, but the available evidence clearly outlines the wealth of benefits quitting brings to individuals with mental health conditions, as will be outlined in the supporting information section. People with mental health conditions have an equal right to be asked whether they smoke. It is vitally important to highlight that the evidence demonstrates that smokers with mental health issues are no less likely to want to quit smoking than other smokers, but that they anticipate that it will be more difficult and are less likely to receive help than other smokers.[3] Furthermore, despite overwhelming evidence about the dangers of tobacco use, many mental health professionals have reported feeling reluctant to engage with patients about smoking and/or having low expectations of patients' motivation or ability to stop smoking[4]. Staff who smoked were more likely to have reservations about the importance of the smoke free policy and the treatment of nicotine dependence among patients.[5]

Parity of esteem for those with mental health conditions was a key ambition set out in the 2017 Tobacco Control Plan for England, and the Public Health Team at Leicester City Council are committed to ensuring that people with mental health conditions have fair access to treatment and support which meets their needs.

[1] PHE fingertips

[2] PHE fingertips – 2019 (adult prevalence), 2018/19 (long term mental health conditions) and 2014/15 (SMI)

[3] NHS digital – Health Survey for England 2010 - 2011

[4] ASH-Factsheet_Mental-Health_v3-2019-27-August-1.pdf

[5] Ratschen E et al. Tobacco dependence, treatment and smoke-free policies: a survey of mental health professionals' knowledge and attitudes. Gen Hosp Psych 2009; 31(6): 576-82

Two small pilot schemes which were run with the homeless population and service users at Turning Point have demonstrated some success with engaging people who may not otherwise have accessed support, through the use of a different service delivery model.

It is important to note from the outset that the breadth of mental health conditions, the impact this has on the likelihood of smoking, the amount smoked, and the longer-term health implications is vast. The treatment provided for mental health conditions ranges from very intensive inpatient support to much lighter touch community support or self-management, and as such different levels of support options to help patients successfully quit smoking are likely to be necessary. Inpatient care is currently provided through Leicestershire Partnership Trust (LPT) which is currently developing a model of support for smokers as set out by the National Health Service (NHS) Long Term Plan. An interim project manager has been recruited by LPT to oversee this work, with plans to recruit a permanent smoke free lead. The role will primarily focus on delivery of the NHS long term plan ambitions but it is anticipated that the remit will also consider the necessity to ensure that those with mental health conditions in the community are able to receive the same high quality care as that which will be planned for those in inpatient settings. Consideration has also been given to the continuity of care between these services.

This report outlines the reasons why this group of smokers is so important to consider, the support which is currently available to all smokers, how the needs of smokers with mental health conditions may differ from 'standard care', and recommendations for how this programme could be shaped to tailor the support offer to better suit their needs.

2. Recommended actions/decision

The Health Scrutiny Commission is asked to:

- Endorse the proposed approach to supporting smokers with mental health conditions, specifically the proposed next steps outlined in section 5;
- Engage in the approach by identifying opportunities to support and advocate through stakeholders.

3. Scrutiny / stakeholder engagement

This report has been discussed at directorate management team and lead member briefings, and the recommendations have been supported.

As part of the recommendations outlined in section two, there is an intention to consult with both staff and potential service users to gain greater understanding from a 'lived in' perspective, and to shape the service delivery model to best meet the needs and capabilities of both staff and service users.
It is not anticipated that the proposals will have equalities impacts as the proposed changes are intended to reduce any equalities issues which are currently being faced by the target population. However, an equalities impact assessment has also been undertaken to ensure all equalities impacts have been fully considered.

4. Background and options with supporting evidence

4.1 Existing provision for smoking cessation (and considerations for those with mental health conditions)

Currently smoking cessation support is delivered via the Live Well service, which is an integrated lifestyle service within which a dedicated smoking cessation service operates. Smoking cessation support is available to any smoker who wishes to quit and smokers are offered 12 weeks evidence-based support comprising of a weekly contact with a trained smoking cessation advisor and access to an appropriate smoking cessation medication (if desired). The service delivery model was adapted during the COVID-19 pandemic to a telephone based service, and subsequent consultation work with service users highlighted that this had been a welcome option for many service users, and that a mixture of telephone and face-to-face was desired for the future. As such, a proportion of the available appointments offered are now face-to-face.
The needs of service users have been considered in a number of ways:

- Advisors have the discretion to extend the usual 12 weeks support for clients where there is an identified need.
- Clients have the option to access a smoke free app in addition to their usual care which, amongst other features, gives them access to a 24/7 'live chat' facility whereby they can have contact with a stop smoking advisor for advice and support. This is provided to them free of charge for 12 weeks.
- The service offers flexibility with appointment times so that there is a range of options to meet individual need, i.e. morning, afternoon, evening.
- There are a number of appointments blocked out as 'emergency' appointments which can be offered at short notice to priority client groups, which includes clients with mental health issues.
- During periods when COVID restrictions are sufficiently lifted clients are offered the option to have a carbon monoxide reading at 4 weeks post quit day to highlight the extent of their success and boost motivation to continue.

Options for addressing any remaining gaps for clients with mental health conditions:

- Consideration is being given to the feasibility of offering some drop-in sessions for clients who may find it more difficult to attend a more structured appointment routine.
- Evaluation of the smoke free app will give an indication of how useful clients have found it to have contact with a smoking cessation advisor between their usual appointments and, if indications are positive, consideration will be given to how this can continue.
- Total abstinence may not feel like an achievable starting point for some service users with mental health conditions. Shorter harm reduction based KPI's can be much more helpful for building confidence and motivation to quit completely, therefore consideration will be given to how alternative measures of success can be embedded, i.e. harm reduction.

Mental health conditions vary widely in their symptoms and presentation and accounting for this neurodiversity is essential in considering how future services should be shaped. It is likely that different approaches will need to be taken dependant on the type of mental health condition rather than developing a universal approach for 'people with mental health conditions' which may inadvertently widen the existing inequality gap, and evaluation will be imperative to ensure smoking rates are reducing equally across all of the relevant mental health groups.

4.2 History with Leicestershire Partnership Trust (LPT) and community mental health teams

Since 2018 national policy has required mental health inpatient units and facilities to become smoke free. Taking into account the wealth of evidence highlighting the disproportionate impact of smoking on those with severe mental illness (SMI), it has been important for staff working in this field to be clear that their primary concern is helping their patients to get better, and that quitting smoking is evidence-based to help with improvements in mood disorders, and therefore should be included routinely as part of an effective treatment plan. Furthermore smoking contributes to health inequalities which people with mental health conditions are already adversely affected by, so it is even more important that parity of esteem is at the forefront in ensuring they are given better chances of improving their outcomes by helping them to quit.

The previous iteration of the stop smoking service (now delivered via Live Well's integrated lifestyle service) worked with LPT to support the implementation of the nationally mandated smoke free mental health trusts. This included provision of 'brief intervention' training for staff working within the Trust to support conversations about smoking, and more in depth 'level 2' training to upskill staff and enable them to provide 1-1 support to smokers who wished to quit. The stop

smoking team also worked with the Trust to implement a system whereby all new inpatients had their smoking status recorded and were offered either nicotine replacement therapy or a vaping device to support the management of withdrawal symptoms during times when smoking could not be permitted. As a result of reduced capacity in the smoking service due to cost savings, it has not been possible to provide this support to LPT recently. As result of this reduced capacity and other covid-related issues some of the previous progress has been lost. This will form part of the remit of the new smoke free lead being recruited by LPT. LPT have highlighted the additional difficulties which have been experienced as a result of the COVID-19 pandemic in maintaining the smoke free progress which had been made, and are committed to addressing this.

4.3 Engaging with LPT

It is intended that LPT will recruit a 'smoke free lead' to sustain the programmes of training and support on an ongoing basis, and to support links between inpatient and community provision. LPT are also collaborating with the LLR Long Term Plan Tobacco Dependence Steering Group through which the CURE programme is being supported and part of a phased roll out of the CURE approach to maternity and mental health services.

A report published by Action on Smoking and Health in December 2020 – Smokefree Skills: Training needs of mental health nurses and psychiatrists – highlighted the wide discrepancy in smoking cessation training provision for practitioners working in mental health roles. Recommendations from this report include that as a minimum all frontline staff should be trained to deliver brief advice around stopping smoking and referral to intensive support. The intention is that this will be implemented as part of the CURE rollout, and it is imperative that community mental health teams are also provided with this training to ensure consistency across services.

4.4 Pilot schemes with Action Homeless and Turning Point

Two pilot schemes have been delivered in Leicester working with groups who experience additional complex needs, and both based on models of support which were designed to differ from 'standard care' provided via the Live Well stop smoking team.

<u>Action Homeless</u>

Service provision was delivered on-site by a smoking cessation specialist and adaptations were made to the usual service model to meet the unique needs of the client group. Specifically these included: drop-in sessions which allowed clients to attend ad hoc, shorter appointments to aide those with concentration and memory issues, extended time allowed to reach abstinence, training staff to continue conversations about smoking between appointments and build on successes, simple instructions to demonstrate the products available, and access to free immediate treatment, including vaping devices. Of the 82 clients who

attended the service during the 15 month period, 67% disclosed additional mental health conditions. 62 clients attended more than one appointment, 20% quit smoking altogether and 45% were able to significantly reduce their carbon monoxide result indicative of harm reduction.

Turning Point

The pilot scheme was initially targeted at alcohol users due to the evidence base highlighting that 70-80% of dependent drinkers smoke, and that smoking is a factor which significantly worsens the problems experienced by change resistant drinkers[6]. Turning Point staff volunteers who service users had already built rapport with were used to deliver a 6-session intervention, in-house and on a drop-in basis, offering service users a free vaping device to stop or significantly reduce their smoking. During the 6 month pilot period 10 clients accessed support: 20% successfully quit for at least four weeks and a further 30% were able to significantly reduce their carbon monoxide level.

It is important to highlight that both of these projects successfully engaged with smokers who would not otherwise have sought support for their smoking were in not for the availability of the service in a manner that suited their unique needs. The provision of a free vaping device was also a significant factor in the success of these projects, and the service users typically could not afford to purchase the device themselves (or were unwilling to invest an amount of money on something they were not yet confident would work for them).

5. Detailed report

5.1 Overview

In 2019 the Government laid out their ambition to achieve a smoke free generation (where prevalence of smoking is 5% or less) by 2030[7]. Smoking rates have been in decline both nationally and locally over the last 20 years and are currently at their lowest ever rates of 13.9% nationally, and 15.4% locally[8] (although Leicester's Health and Wellbeing survey data in 2018 would indicate that the Leicester rate is closer to 20%). However, this trend has not translated across all groups, particularly those with mental health issues, and smoking rates have remained unfairly high in this group.

When the national Tobacco Control Plan for England was published in 2017 it specifically cited the importance of parity of esteem in supporting people with

[6] Alcohol concern: Blue Light Bulletin 23 - Vaping and problem drinkers: A missed opportunity?

[7] Advancing our health: prevention in the 2020's - 2019

[8] PHE fingertips data

mental health issues to quit, recognising that this group of smokers may need access to a different, targeted approach to quitting than that which is used by the general population. Our local tobacco control strategy reiterates this, highlighting our commitment to reducing health inequalities in the city and supporting the most vulnerable in our society to make positive changes to their health and wellbeing.

5.2 Critical data

5.2.1 Smoking and it's primary impacts

The physical health implications of smoking are well documented and include[9], but are not limited to:

- Increased risk of at least 12 types of cancer, and in particular a 70% chance of lung cancer
- Coronary heart disease and heart attack
- Stroke, peripheral vascular disease and cerebrovascular disease
- Asthma, COPD and emphysema
- Reduced fertility and impotence

Approximately half of all lifelong smokers will die prematurely, losing on average 10 years of life[10].

By contrast, immediate benefits (within 20 minutes) can be brought about by quitting, including a return to normal blood pressure and improved circulation. Within a short space of time oxygen levels return to normal and breathing becomes easier, and on a longer-term quitters benefit from improved lung capacity and reductions in risks of heart attack, stroke and lung cancer.

In addition to the physical effects, smokers are more likely to experience poverty, using a significant percentage of their disposable income on tobacco[11], thus widening health inequalities.

5.2.2 Smoking prevalence, practice and outcomes in mental health compared to the general population

One third of all cigarettes smoked in the UK are smoked by people with a mental health problem[12] and smoking prevalence amongst those with poor mental health is significantly higher than those without. Whilst the smoking prevalence in England has dropped to 13.9% it is much higher amongst those with a long term mental health condition (26.8%) and higher still amongst those with a severe mental illness (40.5%)[13], yet smokers with mental health conditions are no

[9] https://www.nhs.uk/common-health-questions/lifestyle/what-are-the-health-risks-of-smoking/
[10] Mortality in relation to smoking: 50 years' observations on male British doctors | The BMJ
[11] https://ash.org.uk/wp-content/uploads/2019/10/191016-Smoking-and-Poverty-2019-FINAL.pdf
[12] The Royal College of Physicians and the Royal College of Psychiatrists, Smoking and mental health, 2013
[13] PHE fingertips – 2019 (adult prevalence), 2018/19 (long term mental health conditions) and 2014/15 (SMI)

less likely to express desire to stop. It is of great concern that people with poor mental health die on average 10-20 years earlier than the general population, and smoking is the single largest contributor to this life expectancy gap[14], highlighting that there is an urgent clinical need to ensure smokers are offered effective methods to quit smoking. Smokers with a mental health condition also smoke significantly more and have greater nicotine dependence than smokers without a mental health condition[15].

It is estimated that one in four adults in the UK experience a mental health condition in any given year[16], which highlights how widespread this issue is likely to be. The umbrella of 'mental health conditions' refers to a number of conditions which differ in both their symptoms and severity ranging from relatively common conditions such as low mood to more severe conditions such as schizophrenia. Prevalence of smoking differs between different mental health conditions with rates highest in those with severe mental illness (SMI). Both adults and children with ADHD are also significantly more likely to smoke than those without, and studies have highlighted nicotine as having a regulatory effect in terms of improving concentration and reducing hyperactivity amongst this group[1718].

Benefits of quitting specific to mental health conditions

As well as the well documented benefits to physical health of quitting smoking evidence has also demonstrated that there are significant benefits to mental health. In fact, recent research has shown that the benefits of quitting smoking can be equal to that of taking anti-depressant medication.[19]

Many smokers with stress and anxiety disorders smoke in the belief that smoking will help to relieve these symptoms, but a 2021 Cochrane review of the evidence for this found that quitting smoking did not lead to a worsening of mood long-term, and may lead to improvements in mental health, such as reductions in anxiety and depression symptoms.

Furthermore, patients who are reliant on antipsychotic medications often experience unpleasant side effects from these medications. As smoking increases the metabolism of drugs quitting means that the drug dose can often be reduced, thus reducing the unpleasant side-effects experienced by the patient[20].

Data provided from the Leicestershire Health Informatics Service (LHIS) team in May 2021 to provide a snapshot view of current smoking prevalence amongst patients accessing mental health services indicated that adult smoking rates

[14] The Royal College of Physicians and the Royal College of Psychiatrists, Smoking and mental health, 2013
[15] The Royal College of Physicians. Smoking and mental health London, RCP, March 2013
[16] https://www.england.nhs.uk/mental-health/adults/
[17] Fuemmeler BF, Kollins SH, McClernon FJ. Attention deficit hyperactivity disorder symptoms predict nicotine dependence and progression to regular smoking from adolescence to young adulthood. J Pediatr Psychol 2007; 32(10): 1203-13
[18] Wilens TE, et al. Cigarette smoking associated with attention deficit hyperactivity disorder. J Pediatr. 2008; 153(3): 414-19
[19] Taylor G et al. Change in mental health after smoking cessation: systematic review and meta-analysis. BMJ 2014; 348: g1151
[20] Taylor D, Paton C, Kapur S. Maudsley prescribing guidelines. 11th Ed. Informa Healthcare, 2012.

were above the national average across all of the listed groups (SMI, anxiety disorders, ADHD, personality disorders, trauma related disorders, eating disorders and mood disorders), and exceeded 30% prevalence across all groups, with the exception of eating disorders. A similar pattern was also noted in the under 18 groups, although numbers of patients were much lower. More detailed data can be found in appendix i.

Service access data from the Live Well stop smoking team indicated that for the January 2020-January 2021 period 15.7% of service users self-disclosed a mental health condition, which is significantly lower than the estimated 25% of the population who experience a mental health condition in any given year. Data collected from Live Well's patient management system does not specify the type or severity of mental health condition but there is an option to record detail in the 'free type' fields, and this has indicated that the vast majority of mental health conditions disclosed were anxiety and depression disorders (either with or without medical intervention) rather than illnesses classified as 'severe mental illness'. This is not necessarily reflective of the number in the local population who *want* to quit, only of those who have felt that the current service offer is useful to their needs.

There was no significant difference between the quit rates between those who disclosed a mental health condition and those who did not, but it should be noted that only those who are already motivated to quit, and have been supported to do so, are likely to have accessed the service.

5.2.3 National and local imperatives to reduce smoking within those with mental health conditions

In recent years there have been a number of key guidance documents, research and reports urging action in this area. These key documents are listed and their content briefly summarised in appendix ii, but highlight the vast difference in health outcomes between smokers with poor mental health compared to those with good mental health, and include recommendations to:

- Provide intensive support to people using acute and mental health settings (and ideally by those within those settings and for an extended period of time)
- Offer harm reduction options for scenarios when quitting isn't possible
- Ensuring that offering support to quit smoking is "everybody's business"
- Taking a holistic approach to physical and mental health
- Supporting switching to vaping

Providing meaningful training to enable health professionals to support smokers in the right way.

5.2.4 Proposed next steps

A. Staff working in mental health services are in an excellent position to be advocates for stop smoking support, particularly if they can share their own positive experiences, therefore staff should be encouraged and supported to quit or remain abstinent at work through widespread promotion and support of smoking cessation services for staff.

B. For Public Health to continue to work with the interim project manager for LPT, and to encourage LPT in their recruitment of a smoke free lead to retain oversight and provide capacity to support via all of our existing mechanisms, and also to enable the joined-up approach that will be critical to developing and maintaining links between primary and secondary care services so that patients are consistently supported whatever their setting of care provision.

C. For the tobacco control lead to work with the LPT project manager/smoke free lead on engagement work with: a) smokers with mental health issues to explore views on the type of support they would find beneficial, b) staff who work in community mental health services to explore how smoking cessation support could feasibly fit within their current roles, and c) other Trusts where smoke free work has already been embedded to explore models with proven success and consider what could be adopted in Leicester/Leicestershire.

D. Based on outcomes from engagement work, and in conjunction with the Live Well, Quit Ready and mental health services (staff and service users), develop a model of support, which adequately meets the unique needs of those with mental health issues. This may mean developing a range of different support options to meet the needs of differing mental health conditions. Learning from pilot schemes offering smoking cessation support to substance misusers and the homeless population in Leicester, who also often experience mental ill-health, could be taken to identify if/how those models could be applied to this group.

E. To consider options for including harm reduction in the Live Well service specification. Currently the stop smoking service is commissioned to deliver '4 week quits' but this may not be realistic (initially) for many smokers who are suffering with additional mental health issues[21]. A more flexible approach could be considered, with key performance indicators (KPI's) linked to periods of abstinence or reduced carbon monoxide (CO) readings initially.

F. To work with Quit Ready and LPT to identify how a programme of training can be rolled out to community mental health teams, in line with that

[21] https://www.nice.org.uk/guidance/ph45

which is planned for inpatient teams, to provide staff with a baseline level of knowledge which builds a foundation of understanding, and to increase their skills in engaging smokers and motivating quit attempts, with the overall aim of ensuring effective and consistent approaches to addressing smoking. This should include primary prevention information which can be shared with young people and their carers who are in contact with mental health services to minimise uptake of smoking amongst this group.

6. Financial, legal, equalities, climate emergency and other implications

6.1 Financial implications

The report is highlighting how various initiatives have been implemented in the past to look at smoking cessation and its success rate, except amongst smokers with Mental Health conditions. Therefore, new initiatives are proposed which will all be funded from the current EMCA (East Midlands Cancer Alliance) earmarked reserves parked within Public Health.
The EMCA funding has got around £94k earmarked for Tobacco Control and these initiatives will all be funded from that financial envelope, together with the CURE rollout programme.

Yogesh Patel -Accountant (ext 4011)

6.2 Legal implications

There is suggestion within the report to explore feasibility for the Public Health team to support Leicestershire Partnership Trust (LPT) ***in their recruitment*** of a smoke free lead to retain oversight and provide capacity to support via all of our existing mechanisms. I note that LPT are recruiting a 'smoke free lead' post using their own money, the support element would come from us in terms of subject expertise, i.e. supporting with job description writing, offering peer support etc. Further HR/employment legal advice should be sought depending on our level of support and involvement.

In terms of the delivery of training, we need to consider if as a Local authority we are in are able to deliver this as it may be classed as a 'commercial activity'. If a LA wishes to undertake a commercial activity, then they must be able to identify a specific power to do so under The Localism Act 2011. The act provides a power for local authorities to charge for the provision of services, however this comes with its limitations and restrictions. If relevant further advice should be sought.

In terms of the CURE project and model, I note that at this stage there are still some discussions to be had and agreements to be made about the service model. There is no intention that the current service model would change for the majority, rather that the engagement work might result in additional options

being made available to support the specific needs of those with mental health conditions.
However, should there be any amendments to the model, this will need to go out to public consultation.

Ongoing legal advice should be sought as and when necessary.

Meera Patel, Solicitor (Commercial) Ext. 37 4069

There are currently no employment law implications arising from this report.

The report has indicated that the LPT will recruit a “smoke free lead”. The recruitment process will be undertaken by the LPT and any new recruit will also be employed by them. As a result of this, Leicester City Council shall not be the employer and therefore there are no employment implications arising from this.

The Council currently provides smoking cessation support via its Live Well Service. No changes are envisaged which would change the terms and conditions of existing staff within the Live Well Service. Accordingly, there are no employment implications arising from this. If, however, there are any changes in the future of the service which may impact existing staff then further HR and legal advice should be sought at the time.

Suraiya Ziaullah, Employment & Education Solicitor 0116 454 1487

6.3 Equalities implications

Under the Equality Act 2010, public authorities have a Public Sector Equality Duty (PSED) which means that, in carrying out their functions, they have a statutory duty to pay due regard to the need to eliminate unlawful discrimination, harassment and victimisation, to advance equality of opportunity between people who share a protected characteristic and those who don’t and to foster good relations between people who share a protected characteristic and those who don’t. This includes where services are contracted out – the PSED cannot be delegated.

Protected Characteristics under the Equality Act 2010 are age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation.

The report looks at endorsing the proposed approach to supporting smokers with mental health conditions and the proposed next steps, if the proposal is agreed it should lead to positive outcomes for people from across a range of protected

characteristics. An Equality Impact Assessment has been drafted and is with the Corporate Equalities Team awaiting feedback/comments.

The equality impact assessment is an iterative process that should be revisited throughout the decision-making process and updated to reflect any feedback/changes due to consultation/engagement as appropriate.

Sukhi Biring, Equalities Officer, 454 4175

6.4 Climate Emergency implications

There are no significant climate emergency implications directly associated with this report.

Aidan Davis, Sustainability Officer, Ext 37 2284

Appendix i.

Table 1. Data provided by LHIS on the number of patients accessing mental health services in May 2021 who smoked compared to the number who did not smoke. N.B. numbers for under 18's are not representative of total population.

Mental health category	**Smoking prevalence (adults)**	**Smoking prevalence (young people under 18)**
SMI	**40%** Actual numbers: 1924 smokers 2890 non-smokers	**21%** Actual numbers: 5 smokers 19 non-smokers
ADHD	**34%** Actual numbers: 545 smokers 1048 non-smokers	**6%** Actual numbers: 27 smokers 388 non-smokers
Anxiety disorders	**36%** Actual numbers: 12282 smokers 26029 non-smokers	**9%** Actual numbers: 41 smokers 420 non-smokers
Personality disorders	**33%** Actual numbers: 698 smokers 1387 non-smokers	**10%** Actual numbers: 3 smokers 25 non-smokers
Trauma-related disorders	**35%** Actual numbers: 1435 smokers 2684 non-smokers	**17%** Actual numbers: 4 smokers 20 non-smokers
Eating disorders	**22%** Actual numbers: 52 smokers 186 non-smokers	**5%** Actual numbers: 3 smokers 60 non-smokers
Mood disorders	**34%** Actual numbers: 20881 smokers 40290 non-smokers	**17%** Actual numbers: 50 smokers 247 non-smokers

Appendix ii:
List of documents highlighting the need to address smoking in people with mental health conditions and a brief summary of content:

NICE guidance PH48[22] which includes a recommendation to "provide intensive support for people using acute and mental health settings" and outlines how this should be achieved, and **PH45**[23] which addresses the need to offer harm reduction from smoking in scenarios when quitting may not be possible, for example within secure mental health units.
The Stolen Years (2016)[24] which highlighted smoking as the single largest cause of the 10-20 year gap in life expectancy faced by those with mental health conditions, and set out 12 ambitions for reducing smoking prevalence amongst this group.
The Five Year Forward Plan for Mental Health (2016)[25] which set out an overview of what modern mental health services should be, highlighting that delivery of it's recommendations should be 'everybody's business'. Specific recommendations included preventing poor physical outcomes including providing access to smoking cessation services, and supporting mental health inpatient units and facilities to be smoke free by 2018.
Improving the physical health of people with mental health problems: Actions for mental health nurses (2016)[26] which reiterated that people with mental health problems have poorer physical health than the general population and are often unable to access the physical healthcare they needed, leading to health inequalities. The report recommends taking a holistic approach to physical and mental health, noting the inextricable links and the detrimental impact of regarding physical and mental health as separate entities. The report compels mental health nurses to take action to support mental health patients to quit smoking, highlighting that quitting does not have a negative impact on mental health, and outlining a series of activities to achieve this action.
The SCIMITAR trial (2019)[27] which was a randomised control trial assigning patients with SMI to either 'usual care' or a bespoke smoking cessation intervention which consisted of "behavioural support from a mental health smoking cessation practitioner and pharmacological aids for quitting, with adaptations for people with SMI such as extended pre-quit sessions, cut down to quit and home visits". The results from this trial showed that the bespoke intervention lead to greater incidences of quitting at 6 months, but that this effect waned by 12 months suggesting more effort is needed for sustained quitting.

[22] https://www.nice.org.uk/guidance/ph48
[23] https://www.nice.org.uk/guidance/ph45
[24] The Stolen Year: The mental health and smoking action report (2016) – Action on Smoking and Health
[25] The Five Year Forward Plan for Mental Health (2016) - A report from the independent Mental Health Taskforce to the NHS in England.
[26] Improving the physical health of people with mental health problems: Actions for mental health nurses (2016) – NHS England
[27] https://www.thelancet.com/journals/lanpsy/article/PIIS2215-0366(19)30047-1/fulltext

The NHS long term plan (2019)[28] which recognises the disparity in smoking rates between those with a mental health condition compared to those without, and outlines its intention to develop "a new universal smoking cessation offer" which will be "available as part of specialist mental health services for long-term users of specialist mental health, and in learning disability services," to include the option of switching to e-cigarettes whilst in inpatient settings.

Parity of Esteem – Delivering Physical Health Equality for those with Serious Mental Health Needs (2019[29]**)** which reiterates the importance of equating the importance pf physical health with mental health and places importance on mental health nurses being supported to develop the appropriate skills and knowledge to be able to provide this holistic care.

Smokefree Skills: Training needs of mental health nurses and psychiatrists (2020)[30] which addresses the wide gaps in training provision across mental health trusts, and the impact of this on supporting smokers to quit. The report outlines a series of recommendations for embedding training into mental health trusts to build a foundation of knowledge, improve confidence and ensure consistency across all services.

[28] The NHS long term plan. 2019. https://www.longtermplan.nhs.uk/

[29] Parity of Esteem – Delivering Physical Health Equality for those with Serious Mental Health Needs (2019) – Royal College of Nursing

[30] Smokefree Skills: Training needs of mental health nurses and psychiatrists (2020) – Action on Smoking and Health