

## Shared Key Messages

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### The Mental Health and Smoking Partnership

The Mental Health and Smoking Partnership was established in 2016 following the publication of [The Stolen Years: The Mental Health and Smoking Action Report](#), to bring together organisations committed to reducing smoking rates among people with a mental health condition. The Partnership brings together Royal Colleges, professional bodies, trade unions, voluntary sector organisations, academia and service users to review progress and highlight areas for further action.

### Purpose of this document

- **Why have we created this document?** To make sure that the Mental Health and Smoking Partnership delivers clear, consistent and accurate messages. This document provides key messages and the evidence to support them.
- **Who is this document for?** This document is for individuals and organisations who want to disseminate clear and accurate, myth-busting messages about smoking and mental health.
- **When should you use it?** This document is a reference source for speaking with the media or providing materials and resources about smoking and mental health.
- **How should you use it?** The key message is the top line for any communication. The evidence behind it is to add detail to different messages.

## Key messages

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### The challenge we face:

1. **High smoking rates:** Smoking rates are much higher among people with a mental health condition than the population as whole.
2. **Leading cause of premature death:** Smoking makes the largest contribution to premature death among people with a mental health condition.
3. **Barriers to quitting:** People with a mental health condition are similarly motivated to quit compared to the general population and with support of the right duration and quality can be equally successful.
4. **Wide impact of smoking:** Smoking impacts on mental and physical health and can push people into poverty.
5. **Deep inequalities:** People with experience of multiple disadvantage are even more likely to smoke. People with a mental health condition who also have an experience of homelessness or drug and alcohol problems, for example, have higher rates of smoking. Pregnant women with a mental health condition are also more likely to smoke than those without.
6. **Smoking myths:** A significant number of staff working with people who have a mental health condition believe that smoking can be helpful in alleviating anxiety and managing distress. Many also think that quitting can lead to violence and aggression. There is no evidence for these beliefs and in some cases the reverse is actually true. These are myths that need to be countered.

### The changes we need:

1. **National leadership:** Implementation of *Towards a Smokefree Generation: A Tobacco Control Plan for England*, alongside a specific target to reduce rates of smoking among people with a mental health condition.
2. **Local co-ordination:** Shared plans between local authorities and the NHS to reduce smoking among people with a mental health condition.
3. **Empowered and informed people:** Service users empowered by public health and mental health services to take control of their own smoking and be included in the development of relevant services.
4. **Trained staff:** Mental health staff to receive appropriate training in smoking cessation and smoking cessation specialists to be trained in mental health; this training needs to be maintained and updated.
5. **Environments that support quitting:** Full implementation of National Institute for Health and Care Excellence (NICE) Guidance PH48 in all mental health trusts to treat tobacco dependency, alongside implementing smokefree grounds.
6. **Alternatives for those who can't quit:** Information should be given to those who cannot quit about a range of alternative nicotine containing products including electronic cigarettes
7. **Better data and more research:** Improved official data on smoking rates and service provision for people with a mental health condition who smoke alongside encouraging research to fill current gaps in the evidence base.

### Further evidence: The challenge we face

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#### 1. High smoking rates

- Smoking prevalence among the general population was 15.5% in 2016<sup>1</sup> but was substantially higher among those with a mental health condition<sup>2</sup> and has remained consistent at around 40% over the last 20 years.<sup>3</sup>
- Smoking rates vary among people with a mental illness:
  - Among people with a common mental disorder (anxiety and/or depression) the smoking rate is 34%, however among those with a common mental disorder and living in poverty the smoking rate rises to up to 46%,<sup>4</sup>
  - Among people with a severe mental illness the smoking rate was around 40%,<sup>5</sup>
  - This rises to up to 60% for those with probable psychosis,<sup>2,6</sup>
  - And up to 70% among people in psychiatric units.<sup>7</sup>
- Today, a third of all tobacco smoked in the UK is smoked by someone with a mental health condition.<sup>8</sup>

#### 2. Leading cause of premature death

- People with a mental health condition die on average 10-20 years earlier than the general population<sup>9</sup> and high rates of smoking are the largest single reason for this gap in life expectancy.<sup>8</sup>
- Among people with schizophrenia, for example, smoking prevalence is approximately 65%. Women with schizophrenia die approximately 9.8 years earlier than average and men 14.6 years.<sup>9,10</sup>

#### 3. Barriers to quitting

- Motivation to quit:
  - The 2010 Health Survey for England found that 66% of smokers with a mental health condition wanted to quit.<sup>11</sup> These findings are supported

by a survey of 355 mental health service users commissioned by Action on Smoking and Health (ASH) which, whilst not representative, found 55% wanted to quit and a quarter of those wanted to do so in the next three months.<sup>12</sup> This shows that there is a clear desire to quit smoking among people with a mental health condition.

- People with a mental health condition are concerned about the impact smoking is having on their health, with 64% of people in the ASH survey reporting that that the health consequences of smoking tobacco worried them.<sup>12</sup>
- Barriers people face:
  - One of the primary barriers smokers with a mental health condition face is that they are likely to be more heavily addicted<sup>8</sup> and as such may need more support to quit and require higher dosages of stop smoking medications for longer periods.
  - There are also low expectations of smokers in mental health settings. Respondents to the ASH survey reported that smoking was not being routinely discussed with them in health and social care settings. Of those respondents who smoked, 43% said that in the past year they had not been spoken to about their smoking by a health professional. Further, of those who had been asked, 23% said they were not always advised to quit, and 37% said that while they had been advised to quit they were not always offered any help to do so.<sup>12</sup> This echoes previous research, which has found systemic barriers are in place in mental health settings, primary among which is the low expectation among healthcare professionals that service users will be able to quit.<sup>13,14</sup>
  - Furthermore, those spending time in mental health services are likely to be surrounded by others who smoke which can undermine individual quit attempts. In some inpatient settings smoking breaks are such a fundamental part of the routine that facilitating smoking can dominate therapeutic activities and pressure people to start smoking on arrival.<sup>15</sup> Comprehensive smokefree policies that include the grounds as well as inside buildings, alongside the provision of treatment and support for smokers to stop smoking, should change this.<sup>15</sup>
  - Although individuals with a mental health condition typically have frequent contact with primary care services, they are less likely to receive a smoking cessation intervention per consultation than those without a mental health condition.<sup>16</sup> This illustrates the need for all healthcare services to improve their treatment pathways for individuals with a mental health condition.

#### 4. Wide impact of smoking

- Impact on mental health and medications
  - Smoking cessation has been associated with reductions in depression, anxiety and stress as well as improved positive mood and quality of life compared with continuing to smoke.<sup>17</sup>
  - The impact of quitting smoking on mood and anxiety appears to be equal to or larger than that of antidepressant treatments.<sup>17</sup>
  - Quitting smoking can reduce the necessary dose of some antipsychotic medications, which can reduce the cost of mental health services to the public purse.<sup>17</sup>
- Impact on incomes
  - Higher rates of smoking are observed among those with a mental health condition who are below the poverty line.<sup>4</sup>

- Approximately 135,000 people with a common mental disorder are pushed into poverty if their spending on tobacco is taken into account.<sup>4</sup>
- This can lead to people engaging in risky behaviours such as collecting cigarette butts and purchasing illicit tobacco from criminal networks.<sup>4</sup>

## 5. Deep inequalities

- There are a number of groups who experience mental health problems where smoking rates are particularly high.
- People with an experience of **homelessness** are estimated to have very high rates of smoking, for example a survey by London charity St Mungo's found that 73% of their service users smoked.<sup>18</sup>
- **Prisoners** have very high rates of smoking. A 2007 Government survey of two English prisons found smoking prevalence of 78% and 88%.<sup>19</sup>
- **Looked-after children** in the care system are likely to have much higher rates of smoking than other children.<sup>20</sup> A 2003 study found that as many as two thirds of children in residential care smoke.<sup>21</sup>
- **Pregnant women with a mental health condition** are more likely to still be smoking at the time of delivery compared to women without a mental health condition, despite being more likely to accept referrals to smoking cessation services.<sup>22</sup> This has a lasting impact, as smoking during pregnancy increases the risk of physical and mental health conditions in children.<sup>23,24</sup>

## 6. Smoking Myths

- There is evidence that mental health professionals lack knowledge and skills to effectively address people's smoking behaviour and that this gap in training is impacting on their behaviour and willingness to raise smoking with service users.<sup>25,26</sup>
- Common myths and widespread misunderstandings around the effects of smoking and smoking cessation on people with a mental health condition can dissuade staff from encouraging smoking cessation. For example, the mistaken belief that people with a diagnosed condition cannot use some kinds of stop smoking medications.<sup>27</sup>
- It is important that these myths are addressed, and that staff are equipped with the information they need to support service users. This is particularly important as some medications such as varenicline and bupropion, which can be highly effective in supporting quit attempts, are not being utilised effectively due to these misunderstandings.<sup>28</sup>

## Further evidence: The changes we need

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### 1. National leadership

Full and effective implementation of: *Towards a Smokefree Generation: A Tobacco Control Plan for England*,<sup>29</sup> and a specific national target to reduce rates of smoking among people with a mental health condition.

- The most effective way to tackle smoking is through comprehensive strategy that seeks to tackle demand and supply for tobacco.<sup>30</sup> However, to date approaches that have been successful for the population as a whole have failed to deliver as well for those with a mental health condition.<sup>31</sup>
- The aims laid out in the new Tobacco Control Plan around implementation of smokefree policies, data collection and further integration of stop smoking services will be key to tackling these inequalities and ensuring no group is left behind as we move towards a smokefree future.

## 2. Local co-ordination

There need to be shared plans between local authorities and the NHS to reduce smoking among people with a mental health condition.

- Need for a joined up approach:
  - Local service delivery and pathways in and out of secondary care are vital to ensuring that people have access to the right quit support, whether they are in secondary care or in the community.<sup>8</sup>
  - It is estimated that only a quarter of people with a common mental disorder seek treatment for their condition, and most frequently in primary care.<sup>32</sup> Therefore, it is important that a strategic approach is taken to tackling smoking in primary as well as specialist mental health care.
  - The voluntary and community sector features clearly within planning for local health and wellbeing services, with the sector supporting between 5 and 8 million people every year. A collaborative approach involving these services is needed in order to provide the best support for individuals and communities.
  - While local commitments and responsibilities vary, a joined-up approach across local government, local voluntary sector organisations, and the NHS could help ensure that there is a single co-ordinated approach to providing support to smokers with a mental health condition.
- Provision of high quality cessation services:
  - While not all smokers will need a treatment service to help them quit smoking, research shows that smokers can improve their chances of quitting by up to four times with the support of a treatment service.<sup>33</sup> Access to specialist treatment is particularly important for people with a high level of tobacco dependence, something that is particularly prevalent amongst smokers with a mental health condition.<sup>8</sup>
  - Stop smoking services are not always structured in a way that best meets the needs of people with a mental health condition, in terms of the way they deliver services, measure success, and the extent to which they meet the needs of smokers with additional barriers to quitting.<sup>34,35</sup> Service user experiences need to be taken into account in development of local approaches.
  - Relapse prevention is especially important in those with the highest level of addiction.<sup>36</sup> Specialist support at times when relapse may be more common, for example, when transferring between inpatient and community settings, could be an important step forwards in supporting people with a mental health condition to quit.

## 3. Empowered and informed people

It is vital that service users are empowered by public health and mental health services to take control of their own smoking and are included in the development of services.

- A majority of smokers with a mental health condition report wanting to quit smoking.<sup>11</sup> Whilst people with mental health conditions often face more barriers to quitting, one method that is known to be effective is utilising peer support workers.<sup>37</sup>
- When smokers attempt to quit with their peer group the likelihood of success increases,<sup>38</sup> suggesting that there is a key role for peer support workers in improving outcomes around smoking.
- Through Rethink Mental Illness' Innovation Network, evidence has been gathered from five mental healthcare providers regarding different approaches to smoking cessation. Learning from these pilots illustrates the value of involving

individuals who use the services, through reductions in smoking rates alongside increased access to and awareness of support available.<sup>39</sup>

- An individual's lived experience of going smokefree can provide a powerful narrative and inspiration to others within the same service and this can add value to specialist smoking cessation support.<sup>39</sup> Peer support is often a key part of an individual's introduction to a new ward to unit, which is likely to coincide with a change in smoking status as individuals move into smokefree settings.

#### 4. **Trained staff**

Mental health staff need training in smoking cessation and smoking cessation staff need training in mental health; this training needs to be maintained and updated.

- Training mental health staff around smoking can improve their willingness to address smoking among service users.<sup>12</sup>
- In an ASH survey staff who received smoking cessation training were:
  - More than twice as likely to report discussing quitting smoking with their patients compared with staff who had received no training.
  - More likely to think that hospitalisation could provide a good opportunity to address smoking behaviour.
  - Less likely to think that quitting smoking could have a negative impact on patient recovery and therapeutic relationships.<sup>12</sup>
- Further, we know that mental health service users are more likely to respond positively to smoking cessation support provided by a mental health professional compared with other health professionals,<sup>40</sup> meaning it is essential these staff are given proper training in smoking cessation.
- However, given that many people with a mental health condition will not access formal mental health treatment services,<sup>6</sup> and many of those who do may be referred to mainstream stop smoking support, it is important that stop smoking service staff have appropriate training and skills to support people with a mental health condition.

#### 8. **Environments that support quitting**

There needs to be full implementation of NICE Guidance PH48 in all mental health trusts to treat tobacco dependency, alongside implementing smokefree grounds.

- NICE Guidance PH48:<sup>15</sup>
  - NICE PH48 was published in 2013 and sets out how smokers should be supported in acute, maternity and mental health services. It should be used in conjunction with NICE guidance on smoking cessation (PH10)<sup>41</sup> and NICE guidance on tobacco harm reduction (PH45).<sup>42</sup>
  - It is vital that trusts do not seek to pick and choose which parts of the NICE guidelines they implement. Implementation of smokefree policies in the absence of effective support for people's tobacco dependency misses the point of policies intended to create environments that enhance and support opportunities to quit. It is also likely to run counter to the advice provided by the Care Quality Commission to their inspectors regarding smokefree policies.<sup>43</sup>
  - Full implementation of NICE PH48 will include providing information to service users ahead of admission regarding the organisation's smokefree policy, identifying smokers on admission, providing access to stop smoking medications for quitting smoking or temporary abstinence, offering intensive support to quit, putting referral systems and follow-ups in place for when people return to the community, and developing smokefree policies.
  - Full implementation of NICE guidance also includes providing support for staff to quit. Where staff continue to smoke during working hours this

risks undermining the creation of an environment that fully supports quitting. It is also deeply unfair for service users experiencing cravings to have to smell smoke on staff members. In addition, staff who smoke themselves are less likely to discuss smoking with patients than staff who don't smoke.<sup>12</sup>

- Smokefree grounds:
  - The Mental Health Five Year Forward View contains the ambition for all mental health inpatient units to be smokefree by 2018, in line with NICE PH48 (see above).<sup>44</sup>
  - Smoking has been prohibited inside hospitals since 2008 however an unintended consequence of this has been that outside 'smoking breaks' have become a part of the routine in many inpatient settings.<sup>45</sup> This routine is so strongly ingrained that some people even feel pressured to start smoking on arrival at inpatient units.<sup>45</sup> Research has found that the facilitation of these smoking breaks in four mental health wards took up 6000 hours of staff time over a period of 6 months.<sup>46</sup>
  - To change this routine and ensure smoking is not prioritised over other activities trusts need to become smokefree; this means not only prohibiting smoking on trust sites but also supporting service users to quit or temporarily abstain from smoking whilst they are using trust services.
  - A 2016 study estimated the cost of facilitating smoking in four mental health wards was over £130,000 in six months.<sup>46</sup> Further research has shown smoking cessation could release hours of clinical time better used to provide therapeutic care.<sup>47</sup> This research estimated the opportunity cost of supervising smoking was between £50 to £238 per ward per day, or £18,250 to £86,870 per ward per year, depending on the seniority of the staff supervising smoking breaks. Smoking-related diseases among people with a mental health condition cost the NHS an estimated £719 million in 2009/10.<sup>47</sup> This gives an illustration of the costs that can be saved if services transition to becoming smokefree.
  - Trusts that have gone smokefree in line with the recommendations of NICE Guidance have seen benefits including, for example, a reduction in the number of violent incidents.<sup>48</sup> Trusts such as South London and Maudsley (SLaM)<sup>49</sup> or Tees Esk and Wear Valley (TEWV)<sup>50</sup> show that going smokefree is not only possible, but delivers benefits to Trusts as well as service users.

## 5. Alternatives for those who can't quit

Information should be given to those who cannot quit about a range of alternative nicotine containing products including electronic cigarettes.

- 'Substitution rather than 'quitting'
  - Smokers with a mental health condition are often more heavily addicted than other smokers, making quitting harder.<sup>8</sup>
  - As such, where smokers are struggling to stop smoking, harm reduction approaches should be discussed with them.<sup>42</sup>
  - Harm reduction in this context means switching to a non-combustible less harmful form of consuming nicotine such as nicotine replacement therapy (NRT).
  - Where people use alternative sources of nicotine rather than smoking tobacco, they substantially reduce the harm they are exposed to, and NRT can be used for as long as necessary to prevent relapse back to smoking.<sup>42</sup>
  - One likely barrier to a harm reduction approach is the lack of understanding about the relative safety of nicotine compared to other components of tobacco smoke. While nicotine is the addictive component, it is the other chemicals in

tobacco smoke that cause disease and death.<sup>51</sup> This widespread misunderstanding among health professionals and smokers needs to be addressed through better communication about the relative safety of alternative sources of nicotine.

- Implementation of NICE Guidance on Tobacco Harm Reduction is vital
  - Initiatives like 'cut down to quit', supplying sufficient NRT and stop smoking medications, and supporting temporary abstinence can help people to move away from smoking tobacco in accordance with NICE Guidance on Smoking: Harm reduction (PH45).<sup>42</sup>
  - Electronic cigarettes, also known as vapourisers, are nicotine delivery systems that do not contain or burn tobacco. As such they are significantly less harmful than tobacco cigarettes.<sup>52</sup>
  - A review of the evidence on electronic cigarettes conducted by Public Health England concluded that using an "electronic cigarette is around 95% safer than smoking" tobacco.<sup>52</sup> As a result of this, Public Health England made a series of recommendations, including that smokers who cannot or do not want to stop smoking are encouraged to switch to electronic cigarettes, and that stop smoking services should support smokers using electronic cigarettes to quit by offering them behavioural support.<sup>52</sup>
  - Surveys show electronic cigarettes have quickly become the most popular aid to quitting smoking in the UK,<sup>53</sup> and research suggests that they are increasingly being used in successful quit attempts.<sup>54.55</sup>
  - Public Health England states that encouraging smokers who cannot or do not want to stop smoking to switch to electronic cigarettes could help reduce the burden of preventable disease and death caused by smoking. Providers need to consider these recommendations when developing a policy on the use of electronic cigarettes.

## 6. **Better data and more research**

Improved official data on smoking rates and service provision for people with a mental health condition who smoke is needed.

- Currently there are few high quality measures of smoking rates among people with a mental health condition or of the services and support they receive.
- We need high quality measures both to ensure we have a full picture of the challenge we face and the progress we're making, but also to drive action in the system.
- The Mental Health Services Dataset must include smoking status as a mandatory field including the advice offered by staff to support a service user's tobacco dependency,
- The measure of smoking among Serious Mental Illness groups included in the CCG Outcomes Indicator Set must be updated annually and steps taken to improve the quality of this data to allow for local measures of prevalence.
- NHS England and Public Health England must monitor the implementation of PH48 in mental health settings.
- A well-resourced research programme is needed to fill gaps in our current evidence base.

**Endorsing organisations:**



The Department of Health Sciences



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- 1 ONS. [Annual Population Survey](#). 2016
  - 2 McManus S. Meltzer H. Campion J. [Cigarette smoking and mental health in England. Data from the Adult Psychiatric Morbidity Survey 2007](#). National Centre for Social Research, 2010.
  - 3 Szatkowski L. McNeill A. [Diverging trends in smoking behaviours according to mental health status](#). Nicotine & Tobacco Research, 2015.
  - 4 Langley T. [Mental Health Smoking and Poverty in the UK: A report commissioned by Action on Smoking and Health and Public Health England](#). 2016.
  - 5 Public Health England. [Local Tobacco Control Profiles](#). Original data from the Health and Social Care Information Centre: [Smoking rates in people with serious mental illness](#). (By Clinical Commissioning Group) (Dataset 1.23).
  - 6 Health and Social Care Information Centre. [Adult Psychiatric morbidity in England 2007: Results of a household survey](#). 2009.
  - 7 Jochelson, K. Majrowski W. [Clearing the Air: Debating Smokefree Policies in Psychiatric Units](#). King's Fund, 2006.
  - 8 Royal College of Physicians and Royal College of Psychiatrists. [Smoking and Mental Health](#). March 2013
  - 9 Chang CK. Hayes R. Broadbent M. Perera G. Fernandes A. Lee W. Stewart R. et al. [Life expectancy at birth for people with serious mental illness and other major disorders from a secondary mental health care case register in London](#). PLoS One. 2011; 6(5): e19590. 9.
  - 10 Wu C-Y. Chang CK. Robson D. Jackson R. Chen SJ. Hayes R. et al. [Evaluation of Smoking Status Identification Using Electronic Health Records and Open-Text Information in a Large Mental Health Case Register](#). PLoS ONE 2013, 8(9): e74262
  - 11 NHS Digital. [Health Survey for England 2010](#). 2011
  - 12 Action on Smoking and Health. [ASH smoking and mental health survey 2016: An analysis of the views of people with a mental health condition and staff working in mental health services](#). 2016
  - 13 Lawn S. [Systematic barriers to quitting smoking among institutionalised public mental health service populations: a comparison of two Australian sites](#). International Journal of Social Psychiatry 2004
  - 14 Lawn S. Condon J. [Psychiatric nurses' ethical stance on cigarette smoking by patients: Determinants and dilemmas in their role in supporting cessation](#). International Journal of Mental Health 2006;15(111):118.
  - 15 National Institute of Health and Care Excellence. [Smoking: acute, maternity and mental health services](#). Public Health Guidance PH48, 2013.
  - 16 Szatkowski L. McNeil A. [The delivery of smoking cessation interventions to primary care patients with mental health problems](#). Addiction, 2013, doi:10.1111/add.12163.
  - 17 Taylor G. McNeill A. Girling A. Farley A. Lindson-Hawley N. Aveyard P. [Change in mental health after smoking cessation: systematic review and meta-analysis](#). BMJ 2014; 348: g1151.
  - 18 St Mungo's Client Needs Survey 2013 (personal communication).
  - 19 Acquitted - Best practice guidance for developing smoking cessation services in prisons. Department of Health and HM Prison Service, 2007.
  - 20 Huddleston L. Pritchard C. Ratschen E. [Smoking and Looked-After Children: A Mixed-Methods Study of Policy, Practice, and Perceptions Relating to Tobacco Use in Residential Units](#). Int. J. Environ. Res. Public Health 2016, 13(6), 593; doi: 10.3390/ijerph13060593.
  - 21 [The mental health of young people looked after by local authorities in England](#). Office for National Statistics, 2002.
  - 22 Howard LM. Pickett KE. Green J. Wakschlag L. [Smoking cessation in pregnant women with mental disorders: a cohort and nested qualitative study](#). BJOG. An International Journal of Obstetrics and Gynaecology. 2013; 120(3): 362-70.
  - 23 Hutchinson J, Pickett KE, Green J, Wakschlag LS. [Smoking in pregnancy and disruptive behaviour in 3-year-old boys and girls: an analysis of the UK Millennium Cohort Study](#). J Epidemiol Community Health 2010; 64: 82-88.
  - 24 Button TM, Maughan B, McGuffin P. [The relationship of maternal smoking to psychological problems in the offspring](#). Early Hum Dev 2007; 83: 727–732.
  - 25 Sheals K. Tombor I. McNeill A. Shahab L. [A mixed-method systematic review and meta-analysis of mental health professionals' attitudes toward smoking and smoking cessation among people with mental illnesses](#). Addiction, 2016.
  - 26 Robson D. Haddad M. Gray R. Gournay K. [Mental health nursing and physical health care: A cross-sectional study of nurses' attitudes, practice, and perceived training needs for the physical health care of people with severe mental illness](#). International Journal of Mental Health Nursing (2013) 22, 409–417 doi: 10.1111/j.1447-0349.2012.00883.x
  - 27 Ratschen, E. Britton J. Doody GA. Leonardi-Bee J. McNeill A. [Tobacco dependence, treatment and smoke-free policies: a survey of mental health professionals' knowledge and attitudes](#). General Hospital Psychiatry, 2009, Volume 31, Issue 6 , 576 – 582.
  - 28 Action on Smoking and Health. [The Stolen Years: The mental health and smoking action report](#). 2016.
  - 29 Department of Health. [Towards a Smokefree Generation: A Tobacco Control Plan for England](#). 2017.
  - 30 The World Bank. [Tobacco Control](#). 2011.
  - 31 Szatkowski L. McNeill A. [Diverging trends in smoking behaviours according to mental health status](#). Nicotine & Tobacco Research, 2015;3:356-60
  - 32 The Health and Social Care Information Centre. [Adult psychiatric morbidity in England](#), 2007 Results of a household survey. 2009.
  - 33 West R. [Stop smoking services: increased chances of quitting](#). NCSCT Briefing. 2012
  - 34 Low A. Unsworth L. Low A. Miller I. [Avoiding the danger that stop smoking services may exacerbate health inequalities: building equity into performance assessment](#). BMC Public Health 2007;7(1):198.
  - 35 Parker C. McNeill A. Ratschen E. [Tailored tobacco dependence support for mental health patients: A model for inpatient and community services](#). Addiction 2012;107(suppl 2):18–25.
  - 36 Hiscock R. and Bauld L. [Stop Smoking Services and Health Inequalities](#), NCSCT Briefing, 2013.
  - 37 Ford P. Clifford A. Gussy K. Gartner C. [A systematic review of peer support programmes for smoking cessation in disadvantaged groups](#). International Journal of Environmental Research and Public Health 2013; 10(11): 5507– 5522.
  - 38 Christakis N. Fowler J. [The collective dynamics of smoking in a large social network](#). NEJM 2008; 358: 2249- 2258
  - 39 Rethink Innovation Network. [Making a difference: Smoking cessation in mental health settings](#). 2016.

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- 40 Gilbody S, Peckham E, Man MS, Mitchell N, Jinshou L, Becque T. et al. [Bespoke smoking cessation for people with severe mental ill health \(SCIMITAR\): a pilot randomised controlled trial](#). *Lancet Psychiatry* Volume 2, No. 5, p395–402. 2015.
- 41 National Institute of Health and Care Excellence. [Stop Smoking Services](#). Public Health Guidance PH10, 2013
- 42 National Institute for Health and Care Excellence. [Smoking: Harm reduction](#). Public Health Guidance PH45, 2013
- 43 Care Quality Commission. [Brief guide for inspection teams: Smokefree policies in mental health inpatient services](#). 2017.
- 44 NHS England. [Five Year Forward View for Mental Health](#), 2016.
- 45 Ratschen E., Britton J, Doody GA and McNeill A. [Smokefree policy in acute mental health wards: avoiding pitfalls](#). *General Hospital Psychiatry*. 2009 Mar-Apr;31(2):131-6. doi: 10.1016/j.genhosppsych.2008.
- 46 Sohal H, Huddleston L, Ratschen E. [Preparing for completely smoke-free mental health settings: Findings on patient smoking, resources spent facilitating smoking breaks, and the role of smoking in reported incidents from a large Mental Health Trust in England](#). *Int J Environ Res Public Health*. 2016. 25;13(3).
- 47 Wu Q, Szatkowski L, Britton J, Parrott S. [Economic cost of smoking in people with a mental health condition in the UK](#). *Tobacco Control* 2014. doi: 10.1136/tobaccocontrol-2013-051464
- 48 Robson D, Spaducci G, McNeill A, Stewart D, Craig T, Yates M. et al. [Effect of implementation of a smoke-free policy on physical violence in a psychiatric inpatient setting: an interrupted time series analysis](#). *Lancet Psychiatry*, 2017.
- 49 [Smokefree](#). [Internet] South London and Maudsley NHS Foundation Trust. 2016 [Accessed September 2017].
- 50 [Smokefree Trust](#). [Internet] Tees Esk and Wear Valley. 2016 [Accessed September 2017].
- 51 Royal College of Physicians. [Nicotine without smoke: Tobacco harm reduction](#). 2016.
- 52 McNeill, A, Brose L, Calder R, Hitchman S, Hayek P, McRobbie H. [Electronic Cigarettes: An evidence update](#), a report commissioned by Public Health England, 2015.
- 53 R. West. [Smoking Toolkit Study: Electronic Cigarettes in England – latest trends](#), 2017
- 54 Beard E, West R, Michie S, Brown J. [Association between electronic cigarette use and changes in quit attempts, success of quit attempts, use of smoking cessation pharmacotherapy, and use of stop smoking services in England: time series analysis of population trends](#). *BMJ* 2016;354:i4645
- 55 Cochrane Tobacco Addiction Group. [Electronic cigarettes for smoking cessation](#). 2016.