



SMOKING CESSATION AND MENTAL HEALTH

A briefing for front-line staff



Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive



HSE Mental Health Services



Commission
Mental Health
Meabhair-Shláinte
Commission



2016 HSE Tobacco Free Ireland Programme
National Centre for Smoking Cessation and Training UK (NCSCT) ©
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FOREWORD

Reducing the burden of disease and disability caused by tobacco use was identified as a priority for the health services in 2010 with the publication of the HSE's first framework for tobacco control. The approach we have taken to address this significant public health issue is aligned with the Healthy Ireland Framework (2013) and the Tobacco Free Ireland Policy (2013).

The leadership shown by the HSE over the past five years has seen great progress in the delivery of this comprehensive and challenging 61 point action plan. Key to this progress has been the determined efforts and leadership of the National Implementation Group, matched by the support and engagement of our highly committed staff working across our services. Significant achievements during this time include –

- development of policies for tobacco free campuses and protection of staff from exposure to second-hand smoke in domestic settings in 2012;
- an award winning and sustained QUIT social marketing campaign launched in 2011;
- significant numbers of frontline staff trained in our nationally accredited programme in brief intervention for smoking cessation;
- implementation of a standardised intensive cessation support programme in 2012 with in excess of 40,000 smokers receiving support to date;
- commissioning and publication of research to inform policy and practice;
- active enforcement of tobacco control legislation;
- the establishment of an engaged and supportive external stakeholder network.

The Tobacco Free Campus Policy (2012) is the cornerstone of the HSEs' Tobacco Free Ireland Programme. The policy contributes to changing social norms around tobacco use and ensures we treat tobacco addiction as a healthcare issue by systematically advising and supporting people to quit smoking.

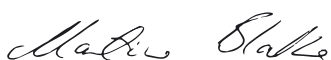
A phased approach has been taken for the roll-out of the policy across the health service. All acute hospitals, primary care sites and administrative sites are now tobacco free. Introduction of the policy has been supported by a suite of tools and resources developed for managers and staff, in addition to support and guidance from the National Tobacco Free Campus coordinator and Health Promotion and Improvement staff. Implementation is now underway across Social Care, Mental Health Services and TUSLA child and adolescent services.

This briefing document is a tailored resource produced for Mental Health Services in recognition of the unique challenges arising from established practices and misconceptions around mental health and smoking. It is a valuable reference for staff in these services to support and guide them in their day-to-day interactions with clients and service users. The resource challenges myths and emphasises the crucial role staff play in reducing tobacco prevalence. This resource works alongside The Tobacco Free Campus Implementation Guide, a comprehensive suite of additional generic tools and resources to support smooth implementation of the policy.

Reaching our goal of a Tobacco Free Ireland (smoking rates at less than 5%) by 2025 is an ambitious endeavour; however with a multi-pronged approach based on the World Health Organisation's MPOWER principles and a consistent approach to tobacco management across all health services we can undoubtedly make a huge contribution to this goal.

We now have compelling evidence that the comprehensive, multi-faceted and sustained efforts by the health service, by community and voluntary partners, by Government through fiscal policy and public health legislation is helping to reduce smoking rates in Ireland. The 2015 Healthy Ireland Survey reported daily smoking prevalence among adults at 19%, down from 24% in 2007. In addition youth rates have also dropped from 12% to 8% between 2010 and 2014 according to the latest Health Behaviour in School-Aged Children Survey.

The HSE is committed to playing its part and we look forward to working collaboratively with colleagues in the Mental Health Division, the Health and Wellbeing Division's Health Promotion and Improvement service, and in Community Healthcare Organisations and Hospital Groups to support delivery on this significant health agenda.



Martina Blake
National Lead Tobacco Free
Ireland Programme

Dr. Stephanie O'Keeffe
National Director
Health and Wellbeing Division

PREFACE

I am delighted to introduce *'Smoking Cessation and Mental Health - A briefing for front-line staff'*, which was developed in conjunction with the Health and Wellbeing Division and the Tobacco Control Programme.

The HSE's Healthy Ireland Implementation plan 2015-17 and the National Mental Health Policy A Vision for Change, 2006 have prioritised work which tackles inequality in health care. The introduction of tobacco dependence treatments into routine care is one of the many measures helping to address this health inequality.

As National Director of the HSE Mental Health Division, I am committed to the implementation of the National Tobacco Free Campus Policy across our Approved Units and Residential services. Mental health staff have an important role to play in the provision of advice, support and the prescription of tobacco dependence treatments for our service users in smoking cessation so that all of our mental health services are tobacco free by the end of 2016. It is acknowledged that implementation of the National Tobacco Free Campus Policy presents significant challenges within mental health services however with the concerted efforts of all our staff I believe it can be achieved.

This *Smoking Cessation and Mental Health briefing document* has been developed to provide front line staff with basic knowledge of current best practice in tobacco management. I would ask that all staff familiarise themselves with the content of this briefing document, avail of Brief Interventions for Smoking Cessation training where required and input into the development of on-site smoking cessation support for service users to support successful quitting. I would like to acknowledge all of the tremendous work being done across our services through the establishment of working groups, stakeholder consultation, provision of staff training, cessation support and instigating a phased approach to the roll out of the Tobacco Free Campus policy within their services.

I would like to thank the national HSE TFC Toolkit group collaborated with the Mental Health Commission and the Mental Health Division to develop this important resource for front line staff towards the successful implementation of the HSE Tobacco Free Campus Policy.



Anne O'Connor,
National Director
Mental Health Division



1. INTRODUCTION

People who have a serious mental illness, such as schizophrenia or bipolar disorder, and those who have a common mental disorder, such as depression or anxiety, are at greater risk of a range of medical conditions compared to the general population. They experience physical illnesses more frequently and in some cases more severely; and they also have a considerably shorter life expectancy compared to those without a mental illness. The reasons for this are multifaceted; however it is the high rates of smoking in this population that exacerbate these health inequalities. For people with mental illness who smoke, stopping smoking will have the greatest impact on their health.

Brief Interventions for smoking cessation and behavioural support to assist quit attempts, are life saving interventions. Whilst primary care settings play a central role in assessing and managing the physical health of people with serious and common mental disorders, mental health inpatient and community staff have a critical window of opportunity to identify people who smoke, advise on the most effective way of stopping smoking and either provide, or refer people for, specialist support.

This briefing is an adaptation of the HSE/NCSCCT's online Mental Health Specialty e learning Module www.hse.ie/eng/about/Who/TobaccoControl/intervention/National_Intensive_Tobacco_Cessation_Training.html and is aimed at those who work in a mental health setting. Its aim is to act as an easy to read resource for staff wishing to gather further insight into tobacco use/cessation in mental health settings. For further information on tobacco cessation training please *see page 22*.

2. BACKGROUND INFORMATION

Smoking Prevalence

Further analysis of the data is ongoing, to review smoking rates among those with mental health difficulties however in the UK smoking rates among adults with a common mental disorder such as depression and anxiety are almost twice as high compared to adults who are mentally well, and three times higher for those with schizophrenia or bipolar disorder. People with substance use disorders, with or without a co-morbid mental health problem, have the highest rates of smoking. In every area of mental health, even child and adolescent mental health services, perinatal psychiatry and older adults care, smoking rates are disproportionately high.

It is estimated that people with a mental health or substance use problem buy approximately 42% of the tobacco sold in the UK. People with a mental illness tend to smoke more heavily and be more dependent on nicotine than those without a mental illness. They are just as likely to want to stop smoking but often lack confidence in their ability to quit and historically have not routinely been offered specialist support to quit.

The HSE spends approximately €280 million a year treating tobacco related diseases ; therefore implementing strategies to reduce the high prevalence of smoking in people generally and more specifically for smokers with mental disorders will not only have a positive impact on quality of life, but also has the potential to realise cost savings for the Health Service.

The Impact Of Smoking On Mental Health

People who smoke cigarettes have more severe mental health symptoms, require higher doses of psychotropic medication and spend more time in hospital, compared to people with a mental illness who do not smoke. They spend more of their disposable income on cigarettes and prioritise cigarettes over food and leisure activities.



“DOESN'T SMOKING
HELP ALLEVIATE MENTAL
HEALTH PROBLEMS?”



“QUITE SIMPLY: NO”

Patients/Clients, carers and mental health clinicians often perceive smoking as beneficial. They often attribute improved mood and reduced anxiety to the effects of smoking rather than the reality that smoking simply alleviates the effects of nicotine withdrawal that occur throughout the day. This 'self-medication hypothesis' is often voiced among clinicians but has little consistent empirical evidence to support it.

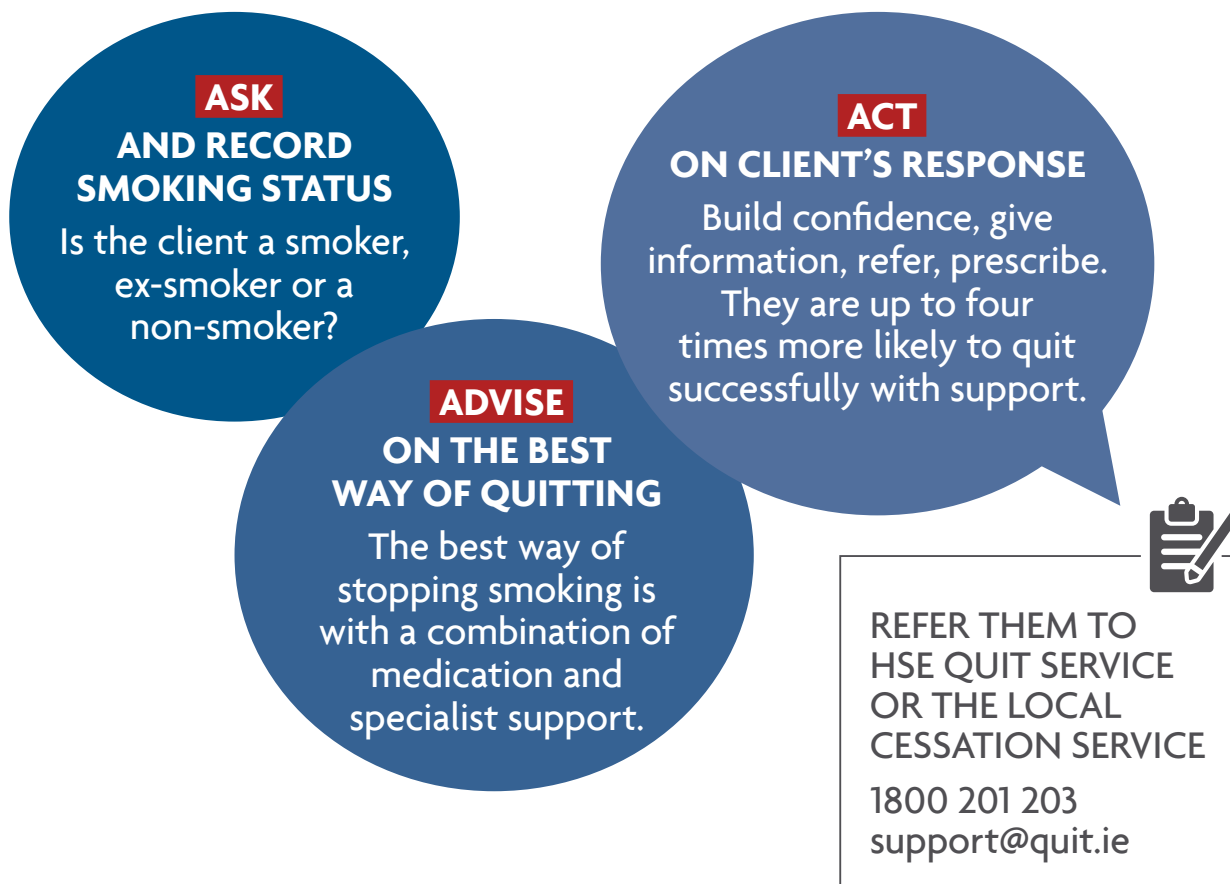
The Benefits Of Stopping Smoking

In addition to the immediate and long term physical health benefits that result from stopping smoking, such as improvement in cardiovascular and respiratory health, people's mental health improves. Ex-smokers are happier and, the longer they manage to remain abstinent, the likelihood of having symptoms of depression and anxiety reduce. Depending on the type of medication prescribed, some patients/clients may be able to have their dosage of psychotropic medication reduced (*see page 24*). A successful quit attempt can often be a catalyst for other positive behaviour change and the financial savings enable clients to participate more inclusively in society.

Very Brief Advice

The Tobacco Free Ireland Programme and the National Cancer Control Programme launched a 30 Second QUIT Smoking Guide for Health Professionals recently. The guide is a simple A4 card, for use by hospital and health care teams and community health professionals when they are caring for someone who is a smoker (*See page 11 and 12*). The aim is to ensure that all patients are asked if they smoke and if they do that they are offered support to quit and prescribed medication to help them. The 30 Second QUIT Guide is available to order on www.healthpromotion.ie.

VERY BRIEF ADVICE FOLLOWS THREE SIMPLE STEPS



3. ASK

Opportunities To Intervene

It is essential that mental health staff use every contact as an opportunity to improve or maintain the mental and physical wellbeing of clients. Staff are well placed to provide Very Brief Advice (VBA), which can take as little as 30 seconds to deliver. The HSE Healthy Ireland Implementation plan has identified a number of strategic priorities for the coming 10 years, one of which is to reduce the burden of chronic disease. One of the key actions is to train health professionals to incorporate prevention and support for behaviour change as a routine part of healthcare delivery with the aim of 'making every contact count'.

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

30 Second Stop Smoking Advice

When you only have 30 seconds the most effective thing you can do is ASK, ADVISE and ACT

ASK

ASK every patient about tobacco use at every healthcare contact, including on hospital admission and record smoking status.

ADVISE

"Quitting is the single best thing you can do to improve your health. We need to do two things – give you support and start you on medication. With medication and support you are up to **4 times** more likely to be successful."

Combined pharmacotherapy and behavioural support is 4 times more effective when compared with quitting unaided

KEY MESSAGES:

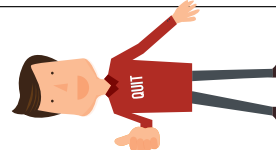
- Tobacco dependence is a chronic relapsing disease, WHO (ICD-F17.2) classification
- Smokers expect to be asked about smoking as it shows concern for their overall health
- Tobacco dependence treatments are both clinically effective and cost effective
- No other clinical intervention produces the same significant results for such a small investment in time

ACT

PRESCRIBE
"The first few days and weeks after you quit can be the hardest. Many people will go back to smoking unless they get extra help. You will now get the medication and support to help you." (see prescribing information on page 2).

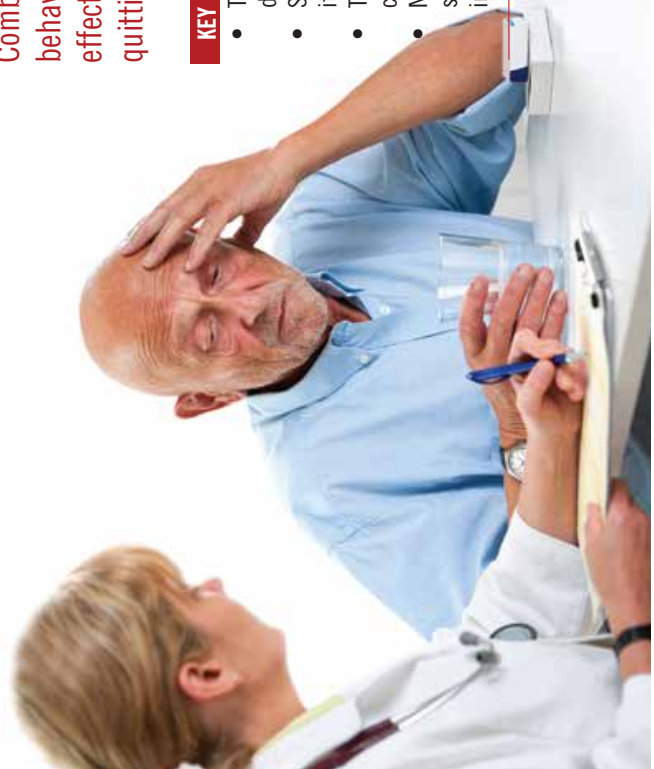
REFER

"I would also like you to call the **HSE Quit Team @ 1800 201 203** www.quit.ie*, which is a free service. They will give you tips on dealing with cravings, withdrawal symptoms, smoking medications and help in staying motivated. Are you happy to do that now?"



* as per local arrangements

Make every contact count



PRESCRIBING FOR TOBACCO DEPENDENCE

Tobacco use remains the leading preventable cause of illness and death in our society. Smokers who quit reduce their risk of many diseases, including cardiovascular disease, respiratory disease and cancer. Quitting increases life expectancy. Some smokers make many attempts to quit before they succeed.

TREATMENT

NICOTINE REPLACEMENT THERAPY (NRT)*

→ PATCH

→ GUM / LOZENGE

→ INHALER

→ MOUTH SPRAY

COMBINATION NRT
A combination of nicotine patch and a faster acting, intermittent form along with behavioural support is more effective than monotherapy and should be considered the standard treatment

→ PATCH + GUM

→ PATCH + LOZENGE

→ PATCH + INHALER

→ PATCH + MOUTH SPRAY

SET QUIT DATE: SAME DAY AS STARTING NRT

KEY MESSAGES:

- Quit rate is double placebo
- NRT is available to purchase over the counter
- NRT is available for medical card holders
- NRT should be prescribed to all patients ON ADMISSION to hospital, including day cases, to help them manage nicotine withdrawal symptoms

VARENICLINE (CHAMPIX)*

SET QUIT DATE: 7-14 DAYS AFTER STARTING VARENICLINE

KEY MESSAGES:

- This is the most effective medication; quit rate is triple placebo
- Available only on prescription
- There is no good evidence that combining NRT with Varenicline improves success rates



BUPROPION (ZYBAN)*

SET QUIT DATE: 7-10 DAYS AFTER STARTING BUPROPION

KEY MESSAGES:

- Quit rate is double placebo
- Available only on prescription
- There is no good evidence that combining NRT with Bupropion improves success rates

We're here to help!

FREEPHONE 1800 201 203
FREETEXT QUIT TO 50100
EMAIL US SUPPORT@QUIT.IE
TWEET US @HSEQUITTEAM
FACEBOOK US FACEBOOK.COM/HSEQUIT
GET STARTED ON WWW.QUIT.IE

* for comprehensive information on these medications consult your prescribing manual.

Acknowledgement: Developed with the assistance of Dr Andy McEwen, Executive Director, National Centre for Smoking Cessation and Training. www.ncsct.co.uk

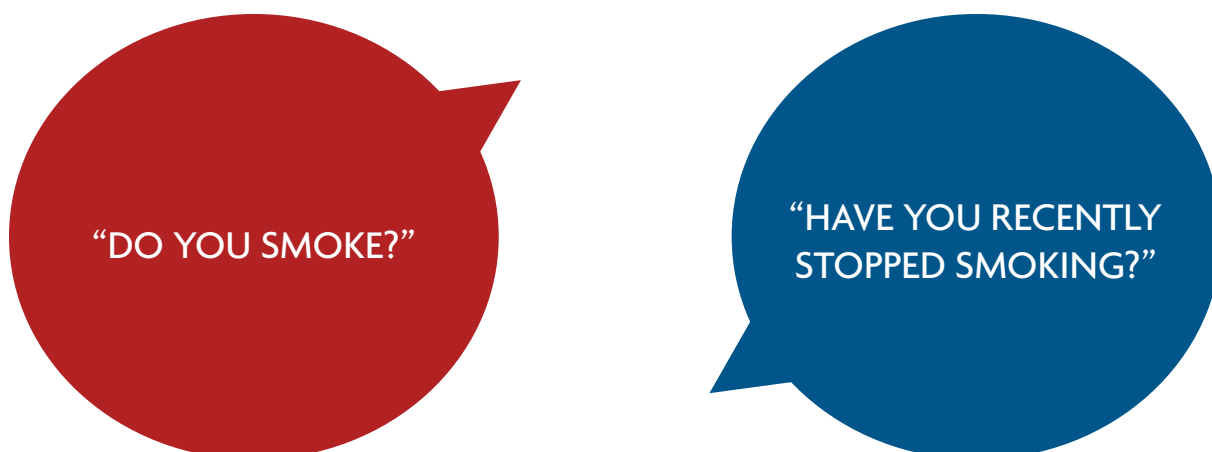
This guideline was developed in line with the evidence available. This guidance does not, however, override the individual responsibility of health professionals to make decisions appropriate to each patient. The guideline will be reviewed as new evidence emerges.

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

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

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

Identifying Clients Who Smoke



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

It is just as important to know if a client is an ex-smoker. Not only is this an opportunity to provide positive feedback to the client, it also recognises that an admission to hospital or a mental health relapse may precipitate a return to smoking and support to prevent this can be included in their care plan.

The identification and recording of each patient/client's smoking status needs to be completed regularly, e.g. on admission and discharge from hospital, on first contact with community services and at each individual care plan review.

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

The most effective treatment for smokers with a mental illness is:

- A combination of varenicline [Champix] and 6 to 12 sessions of intensive group or individual behavioural support
- or
- Bupropion [Zyban] and 6 to 12 sessions of intensive group or individual behavioural support
- or
- Combination nicotine replacement therapy (NRT) – a slow acting product e.g. patch in combination with a fast acting product e.g. lozenge/gum or mouth spray in addition to 6-12 sessions of intensive group or individual behavioural support

Intensive behavioural support can be provided by local intensive tobacco cessation services if these are available and/or more appropriately by the existing mental health service providing all other care to the client. Ideally these cessation services/clinics/groups should be established within existing mental health services and run by mental health professional staff who have completed specialist tobacco cessation training and have been allocated dedicated time to deliver this support to their clients. Smokers are up to four times more likely to succeed in quitting with specialist QUIT support than if they try to quit unaided.

4. ADVISE

Advise On The Best Way Of Quitting

The introduction of the National Tobacco Free Campus Policy requires a holistic approach to the management of smoking and tobacco addiction within each service. Mental health staff have a central role to play in providing advice and support throughout an inpatient stay regarding the management of tobacco withdrawal, whether this be temporary or permanent abstinence. Exchanging information with clients and carers about the most effective and comfortable way of managing withdrawal from tobacco and abstaining from smoking during an admission can help minimise any potential difficulties.

Example Of What To Say To A Patient/Client Who Smokes

INPATIENT STAFF

“Did you know that the Carbon Monoxide in cigarette smoke binds to your red blood cells and displaces the oxygen. This may be part of the reason you are finding it more difficult to catch your breath?”

“Would you like me to arrange for you to meet a tobacco cessation specialist to have a chat about this?”

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

RECORD ADVICE
GIVEN AND PATIENT/
CLIENT’S RESPONSE



“Can you tell me a little bit about your smoking?
We have a range of options to help support you to quit smoking?”

“Having specialist support and stop smoking medication, such as nicotine patches and lozenges really improves your chance of quitting and makes the whole process easier.”

“Would you like me to arrange for you to meet a tobacco cessation specialist to have a chat about this?”

COMMUNITY STAFF

Referral Pathways

The HSE is working on the development of an integrated referral and care pathway to intensive tobacco cessation services/QUIT services. A national electronic referral process will be in place supported by a national IT patient management system whereby Health professionals can refer to the national service and the client will be allocated to the most appropriate service suitable to their needs. In the interim your clients/smokers can self refer to to the on-site trained tobacco cessation Health Professional within your Mental Health Service (if this is available), or to their local face to face cessation support service or to the National QUIT service. See contact details below.

Freephone 1800 201 203 and visit www.quit.ie and www.facebook.com/HSEquit
EMAIL QUIT on support@quit.ie
FREE TEXT QUIT on 50100
TWEET QUIT on @HSEQuitTeam

5. ACT

Act On Patient/Client Response

- Build confidence and self-efficacy
- Exchange information (e.g. about the benefits of stopping, dealing with tobacco withdrawal)
- Refer to a tobacco cessation specialist; in-house tobacco cessation specialist employed by the mental health service, local cessation service or National QUIT Service
- Ensure patient/client is assessed for and has access to NRT or other licensed medication for smoking cessation (see page 12) throughout an inpatient stay, regardless of intention to quit and refer to the specialist cessation behavioural support service
- Be proactive rather than reactive regarding withdrawal symptoms, during temporary or permanent abstinence
- Review dosage of medication and systematically assess side effects
- Record actions

The majority of patient/clients are interested in changing their smoking behaviour but lack the confidence to do anything about it. Patient/Clients can be supported by encouraging them and informing them of the value and evidence base behind having specialist support to quit.

The Role Of Mental Health Staff

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

Stop Smoking Medications

Due to the very short half-life of nicotine, a smoker will start to experience withdrawal symptoms within one to two hours of their last cigarette (e.g. irritability, low mood, poor concentration) plus strong urges to smoke. People who use mental health services, particularly when on an inpatient unit often have a low tolerance for stress, so having to cope with distressing mental health symptoms and tobacco withdrawal symptoms can be a challenge for the smoker and the staff involved in their care.

Nicotine Replacement Therapy (NRT)

NRT is effective at reducing nicotine withdrawal symptoms and should be offered to all smokers throughout the duration of an inpatient stay even if they have no intention of quitting or show no desire to stop smoking.

Staff and patients/clients may misinterpret signs of nicotine withdrawal as a worsening of mental health symptoms and believe that the patient/client can only get relief by having a cigarette. Therefore advising on the benefits of using NRT from the beginning of admission is important.

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

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

Licensed nicotine products contain lower levels of nicotine than tobacco and the way these products deliver nicotine makes them less addictive than smoking. They can be used as a substitute for smoking when people are cutting down and are far safer than smoking. **NRT does not interact with any mental health medicines or affect the blood levels of medication, though smoking and stopping smoking can affect such levels.**

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

Varenicline

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

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

In a study of over 500 patients followed up for 12 months, varenicline increased smoking cessation in smokers with stably treated current or past depression without exacerbating depression or anxiety. A recent review of the use of varenicline in patients/clients with mental health problems has shown that there is no evidence of the link to suicide or cardiac events and supports the use of varenicline for people with a mental illness.

For All Smokers Who Are Using Varenicline, There Should Be:

- Cautious treatment initiation
- Close monitoring for mood and behaviour changes during therapy
- Patient/Client education
- Regular follow-up
- Regular plasma monitoring of therapeutic drugs

Bupropion

Bupropion is licensed as an antidepressant and a smoking cessation medicine. It is only available on prescription. It is thought to work by blocking nicotine receptors, increasing dopamine and noradrenaline and taking away the 'pleasurable' effects of nicotine. Although bupropion is the least used smoking cessation medicine, there have been more studies on it than NRT or varenicline in smokers with a serious mental illness. When combined with group therapy, it almost triples the chance of quitting in the short term.

Bupropion is not recommended for smokers with a current or past history of seizures, current or previous diagnosis of bulimia or anorexia nervosa, or a history of bipolar disorder as it may precipitate a manic episode. There is the potential for interactions between bupropion and psychotropic medicines (such as some antipsychotics and antidepressants).

For All Smokers Who Are Using Bupropion, There Should Be:

- Cautious treatment initiation
- Close monitoring for mood and behaviour changes during therapy
- Patient/Client education
- Regular follow-up
- Regular plasma monitoring of therapeutic drugs

Effect Of Smoking Cessation On Medication Blood Levels

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

A consequence of speeding up the metabolism of some medicines, is that smokers need higher doses of some psychotropic medicines compared to non-smokers. Blood levels of medication will be affected by many things such as age, gender and how well they adhere to their prescribed treatment. Stopping smoking can result in an increase in blood levels of some medicines (*see page 24*); these are likely to increase within seven days of quitting. Because this could potentially lead to toxicity, doses of affected psychotropic medicines may need to be reduced by 25 – 50% once someone stops smoking.

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

Currently there are no published guidelines about the effect of cutting down the amount of cigarettes smoked on the metabolism of psychotropic medication, therefore it may be wise to be led by symptoms and side effects and still take plasma levels, particularly for clozapine. *See page 24 for an overview of the medicines that are likely to be affected by smoking and stopping smoking.*

Tobacco - Free Policies Within Mental Health Settings

In addition to the physical aspects of smoking, the behavioural, psychological, and social aspects of smoking greatly contribute to its addictiveness in patients/clients with mental health conditions. Smoking is often viewed as a shared experience and is often perceived by patients/clients to reduce the feeling of isolation. It provides opportunities to make friends, interact and connect with others. Often patients/clients are afraid of losing this perceived benefit despite the negative impact of smoking. They see it as one of the few things they can control in their lives. With good mental health care, there should be alternative and healthier solutions offered to people to gain a sense of control in their lives.

Mental health staff often express concern that stopping smoking will exacerbate mental health symptoms and increase aggressive behaviour.

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

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

Where staff have encountered increased aggression in inpatient services where smoking is restricted, it tends to be the way in which the policy is implemented that increase the risk of aggression. Selective or partial bans, ambiguous policies, inconsistent application of a Tobacco - free policy, lack of stop smoking resources, poor knowledge and skills of staff, inconsistent behaviour of staff and lack of access to nicotine replacement therapy are all contributing factors. As per the **Tobacco Free Ireland Programme** action plan and HSE National Service Plan all HSE sites and services including mental health settings/services, are required to implement, the HSE Tobacco Free Campus policy whereby smoking is prohibited in all buildings and grounds and Tobacco dependence is treated as a healthcare issue.

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

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

Total smoking bans are not simply restricted to mental health settings, but also general hospital settings and enclosed places where people work and/or the public areas where (patient/clients) have access to Government policy encapsulated within 'Tobacco Free Ireland' is to further develop tobacco free environments across a wide variety of public spaces; including parks, beaches and playgrounds in order to denormalise tobacco use and protect children from the harmful effects of tobacco. Not to implement the Tobacco Free Campus policy in mental

health settings does little to support the argument for equality for people with mental health problems. Staff and patients/clients will need to keep in mind that tobacco dependence is a chronic relapsing condition and it might take a number of attempts to successfully stop smoking.

Following the provision of Very Brief Advice or brief intervention, and motivating the smoker to engage with a trained tobacco cessation specialist, mental health staff continue to have a valuable role in helping patients/clients make a successful quit attempt or manage temporary abstinence.

A trained practitioner has the knowledge and skills to tailor the pharmacological and behavioural support to maximise success. Having specialist support, significantly improves the chances of stopping smoking.

Mental health staff can acquire the skills to become competent in both brief and intensive smoking cessation support for patients/clients who use mental health services. See Levels of Training in Tobacco Cessation below.

Levels Of Training In Tobacco Cessation

Level 1 Training is the National Brief Intervention in Smoking Cessation training course (BISC). Applications for this training can be made on www.hse.ie/bisc

Brief Interventions are a range of effective behaviour change interventions that are client-centred, short in duration and provided in a variety of settings by healthcare professionals. They use an empathic approach, emphasising self efficacy, personal responsibility for change and information giving including details of resources available to support change. For smoking cessation, brief interventions involve opportunistic advice, discussion, negotiation and encouragement to quit smoking and typically take between 3 and 10 minutes.

It is currently delivered as a 1 day (6 hour) face to face training. (There are plans in progress to develop this training into a national generic brief intervention model which may involve online training)

Level 2 Training This training is an online training and assessment programme designed to develop the competencies (knowledge & skills) required by specialist tobacco cessation practitioners.

The training programme will provide staff with a good understanding of the factors involved in smoking and smoking cessation and will link this theoretical understanding to professional practice. The training programme includes the information required to pass the practitioner assessment and receive full HSE/NCSCCT certification as a tobacco cessation specialist practitioner.

Practitioners who have passed the practitioner assessment are able to access two further specialist training courses, one to develop skills to support smokers with mental health difficulties and another to support cessation among pregnant smokers. It involves completion of a 6-8 hour online training course (in as many sittings as desired) followed by an on-line assessment. www.hse.ie/eng/about/Who/TobaccoControl/intervention/BISC.html

Level 3 Training is a 2 day face to face training in behavioural support for smoking cessation which follows the HSE's National Standard for Tobacco Cessation Support Programmes. This training is a supplementary training offered to staff to further develop their learning and practice the skills they have developed through completion of the on-line training.

Staff who are new to intensive tobacco cessation support and considering establishing intensive behavioural support services would be advised to attend this training to develop behavioural support skills in this area. For further information on this please contact Geraldine Cully. Email: geraldine.cully@hse.ie

As outlined earlier an additional module on smoking cessation and mental health is available to staff who have completed and passed the on-line intensive tobacco cessation specialist training. http://elearning.ncsct.co.uk/practitioner_training_ireland-registration

Table: Effect Of Smoking Cessation On Certain Drugs

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

DRUG	EFFECT ON SMOKING	ACTION TO BE TAKEN ON STOPPING SMOKING	ACTION TO BE TAKEN ON (RE) STARTING SMOKING
BENZODIAZAPINES	Plasma levels reduced by 0 –50%	Monitor closely. Consider reducing dose by up to 25% over one week	Monitor closely. Consider reintroducing previous smoking dose
CARBAMAZIPINE	Unclear	Monitor for changes in severity of side effects	Monitor plasma levels
ANTIDEPRESSANTS			
DULOXETINE	Plasma levels may be reduced by up to 50%	Monitor closely. Dose may be reduced	Consider re introducing previous smoking dose
FLUVOXAMINE	Plasma levels may be reduced by 30%	Monitor closely, dose may need to be reduced	Dose may need to be increased to previous smoking dose
MIRTAZAPINE	Unclear but effect probably minimal	Monitor	Monitor
TRICYCLIC (antidepressants)	Plasma levels reduced by 20 – 50%	Monitor closely. Consider reducing dose by 10 –25% over one week. Consider further dose reductions	Monitor closely. Consider restarting previous smoking dose
CHLORPROMAZINE	Plasma levels reduced. Varied estimates of exact effect	Monitor closely, consider dose reduction	Monitor closely, consider restarting previous dose (when client was a smoker)
CLOZAPINE	Reduces plasma levels by up to 50%. May be a greater reduction in people taking Valproate	Take plasma level before stopping. On stopping, reduce dose gradually (over a week) by 25%. Repeat plasma level 1 week after stopping	Take plasma level before resuming smoking (anticipate this may happen soon after discharge). Increase dose to previous dose (when client was a smoker)
FLUPHENAZINE	Reduces plasma levels by up to 50%. May be a greater reduction in people taking Valproate	On stopping, reduce dose by 25%. Monitor for up to 8 weeks.	On restarting, increase dose to previous level
HALOPERIDOL	Reduces plasma levels by around 20%	Reduce dose by around 10% and continue to monitor	On restarting, increase dose to previous level
OLANZAPINE	Reduces plasma levels by up to 50%	Take plasma level before stopping. On stopping, reduce dose by 25%. After 1 week, repeat plasma level. consider further reductions	Take plasma level before resuming smoking (anticipate this may happen soon after discharge). Increase dose to previous dose (when client was a smoker)



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