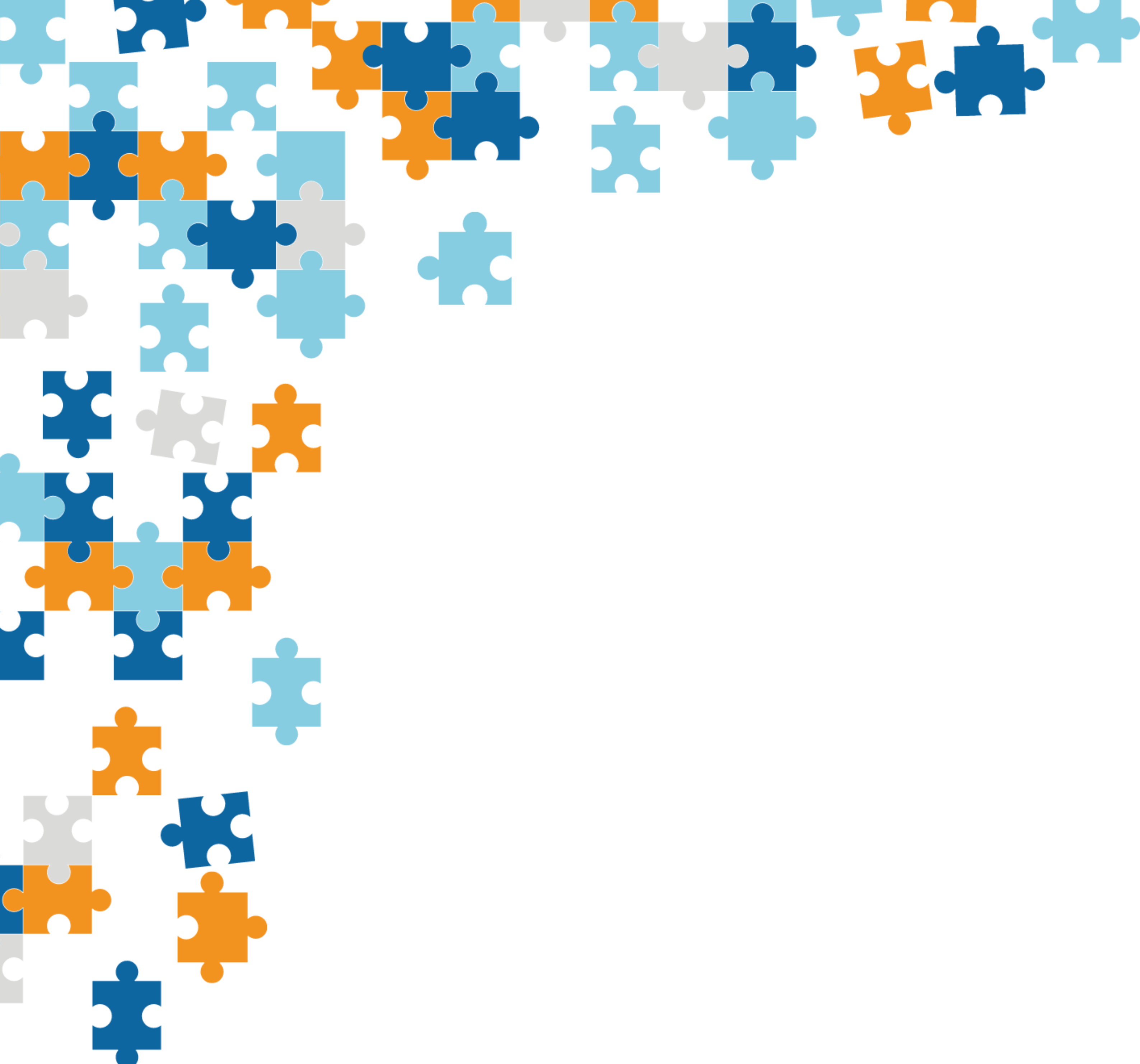

Closing the Inequality Gap: Smoking and Mental Health

ash scotland

Taking Action on Smoking and Health

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> I still worry that if I go back into hospital I will start smoking again, but really, I now mainly feel safe from that temptation. It shocks me how badly smoking affects our community's health. I know many of us insist on our right to smoke and of course we can smoke if we want to, but all those lives lost, all those years of illness and regrets too late, about not giving up. We are still a community where it is almost cool to smoke, where there is that touch of comfort and that wee element of rebellion.
>
> Having the conversation about smoking is important – but having a conversation that is not patronising, not directive, one that is free from that element of 'do this, do that' is even more important. Conversations that are about something that is, for some of us, the one pleasure we have in almost intolerable lives need to be sensitive, need to respect our world and need to offer some comfort and hope.

Graham Morgan MBE, Engagement and Participation Officer, Mental Welfare Commission for Scotland; Special Advisor HUG (Action for Mental Health)

Summary of key points and recommendations

The aim of this report is to provide an overview of smoking and mental health in Scotland; to share learnings from policy and practice; and to present recommendations which aim to close the inequality gap and build a tobacco-free generation by 2034.

Our approach to tackling the interplay of smoking and mental health must ensure those who are experiencing mental health issues[i] are protected and empowered to make informed decisions about their wellbeing. Their voices must be at the forefront of influencing policy decisions to improve Scotland's physical and mental health.

Key new evidence

One in three people with mental health issues in the UK smoke[1], compared with around one in six of the general population[2]. By our calculations[ii], this means that more than **230,000 people in Scotland are smokers with mental health issues**. People with mental health, substance misuse and addiction issues smoke more, tend to be more addicted to nicotine, and find it harder to quit[3,4,5]. This has created a serious health inequalities gap which must be addressed.

Although this gap has been evident for decades, a clear Scottish picture has been missing. To get a better understanding of the situation in Scotland, ASH Scotland has commissioned ScotCen to newly analyse data from the Scottish Health Survey.

On average, smoking prevalence among people with mental health issues is between **1.6 and 2 times** higher, than those without.

In addition, they smoke more, on average, per day.

67% of smokers with mental health issues say they would like to quit.

This is equal to, if not more, than the general population.

Our analysis of the Scottish Health Survey shows that on average **smoking prevalence** among people with mental health issues[iii] is between 1.6 and 2x higher, than those without, and that they smoke more cigarettes per day. Sixty-seven percent of smokers with mental health issues say they would like to quit[6], which is, equal to, if not more than the general population.

[i] Terminology is diverse within the field of mental health. This report has used the general term 'mental health issues', (or 'condition' when speaking of a specific diagnosis). When quoting external sources, the source term has been used.

[ii] With a 17% smoking prevalence there are 773,366 smokers in Scotland. 30% of these is 232,009

[iii] People with a probably psychiatric condition, those with moderate or severe anxiety or depression and those with a long-term mental health disorder - see detailed explanation in section 2

In the most deprived areas smoking prevalence among people with mental health issues is

40-50%

For comparison, the last time the Scottish smoking prevalence was 50%, was in 1974.

There is a clear link between smoking, mental health and deprivation. We have calculated that there are over 250,000 smokers living in Scotland's most deprived areas (SIMD1)[iv]. Our analysis shows that **in the most deprived areas smoking prevalence among people with mental health issues is 40-50%**, and likely substantially higher for those with severe conditions. Supporting cessation in this group would make a huge difference to overall prevalence rates. For comparison, the last time the Scottish smoking prevalence was at 50%, was in 1974. The smoking prevalence in people without mental health issues in the wealthiest communities is currently 4%.

Time trend analysis between 2003 and 2019 shows that the smoking prevalence gap between smoking with mental health issues and the population average has remained broadly the same.

Overall, our analysis reinforces existing research and presents us with a sobering but hopeful picture. With the right support and policies there is a real opportunity to improve the quality of many lives, physically, mentally and financially. Reducing this inequalities gap is key to supporting those living in the poorest communities and achieving the Scottish Government's 2034 Tobacco-free generation target.

Although limited good practice information is available, there is already existing research evidence and government policy which can be built on, if we have the will to tackle the gap. The issue is multi-faceted and requires an interconnected policy approach. Going forward, ASH Scotland is committed to building a better understanding of good practice in service delivery, and encouraging more ambitious government policy.

[iv] Based on 2020 National Records of Scotland population estimates by area of deprivation, there are 856,433 aged 16+ people living in SIMD1 (most deprived quintile). The smoking prevalence in SIMD1 is 32% (Scottish Health Survey 2019). 856,433x0.32=274,059

Recommendations

Our analysis leads us to call for the following key changes in policy and practice:

Specific recommendations for mental health and smoking	
1	The Scottish Government's forthcoming refreshed **Mental Health and Tobacco Control strategies must each prioritise the physical health of people with mental health issues**, by making connected commitments to supporting cessation and smoking prevention work among this priority group and then delivering on that commitment.
2	The Scottish Government must **set a specific Key Performance Indicator (KPI) to reduce smoking prevalence among people with mental health issues** and therefore to narrow the inequalities gap, aiming towards the much lower prevalence seen in the general population.
3	The Scottish Government and Public Health Scotland must **identify prevalence data to regularly report on progress against this KPI in strategy updates.** Data could come from available Scottish Health Survey statistics, as demonstrated here.
4	The Scottish Government must **ensure that all NHS Boards have up to date tobacco control strategies which prioritise cessation support for people with mental health issues**; and that they are resourced to offer specialist smoking cessation advice to this group.
5	NHS Boards should ensure that **all mental health patients admitted to acute or community settings are regularly asked if they smoke,** including on discharge, so they can be offered specialist cessation support during or after their treatment.
6	All bodies with an interest in tobacco control and health should **work in partnership to improve understanding of and share good practice** in what works to reduce smoking among people with mental health issues.

Recommendations for the whole population

These measures will make a difference for all smokers, including the 1/3 who have mental health issues, and help to deliver the Scottish Government's 2034 tobacco-free generation target.

7	The Scottish Government must **deliver on its existing commitment to implement regulations to make hospital perimeters smoke-free**. In addition, it should **encourage similar good practice** in all environments where people are receiving treatment and support.
8	The Scottish Government must **regulate all tobacco and related products consistently**, including novel tobacco products and e-cigarettes.
9	All bodies with an interest in tobacco control and health should **work in partnership to reduce the appeal and availability of tobacco products to young people.**
10	The Scottish Government should **lead regular mass media and targeted social media campaigns to encourage smokers to quit and to *Take it Right Outside*.** They should also raise awareness at all levels of Government and public office of the damage caused by health-harming industries and their products to population's health.

ASH Scotland will review and update these recommendations throughout 2022 as we build conversations on this important theme with policy makers and practitioners.

Section One – Current Situation

We all have mental health – but around one in four of us struggle with mental health issues[7]. These are diverse, spanning a range of symptoms from sub-clinical anxiety and depression, to the most severe clinically diagnosed mental illnesses.[8]

Individual, social and environmental factors all help to determine the quality of our mental health; in 2018/2019, the prevalence of depression, anxiety, suicide attempts and self-harm were highest amongst those living in the most deprived areas in Scotland[9]. From a policy perspective, when seeking to improve the mental health of Scotland's people, we must start from an understanding of the important interconnection with deprivation and poverty.

This report summarises available evidence on smoking and mental health; reports on a new analysis of existing Scottish data; reviews government policy and examples of practice, and makes recommendations to close the inequality gap.

Addiction, COVID-19 and mental health

Concerningly, reports have found that the pandemic has worsened the mental health of those most vulnerable within society[10,11]. One group found to be at particular risk due to the COVID-19 pandemic and lockdown are those who struggle with addiction and substance misuse.

A recent study by the Scottish Association for Mental Health (SAMH), which looked at the impact of the pandemic on mental healthcare and support, found that changes in treatment as well as the pandemic itself have *"contributed to feelings of disempowerment and isolation."*[12] One interviewee in the report, Gus, said the pandemic affecting his treatment made him feel left behind: *"You just feel like a forgotten child, you know? You're just like a lost child in the corner that somebody's forgot about"*[13]. The pandemic has left many who struggle with their mental health feeling alone and isolated.

Many people who experience mental health issues use various substances to cope, and this has been made worse by the impact of the pandemic. A large proportion of the population increased their alcohol consumption in the UK[14], and deaths from mental and behavioural disorders due to alcohol increased by 10.8%.[15] Some people with mental health issues reported using increased amounts of cannabis due to 'feeling more anxious/depressed' during lockdown.[16] Lockdown has had a negative impact on us all, but it has hit those with addiction and mental health issues significantly more.

Similarly, tobacco use has increased during lockdown, with 36% of smokers saying that they smoked more and only 8% reporting that they smoked less[17]. Statistics from the *Smoking in Scotland Toolkit* survey suggest that smoking prevalence may have increased in Scotland during 2020-2021[18]. Considering the reports of worsening mental health during the COVID-19 pandemic, and the strong link between stress and smoking, it comes

as no surprise that smoking has increased – especially amongst the poorest and most vulnerable in society.

Tobacco and health

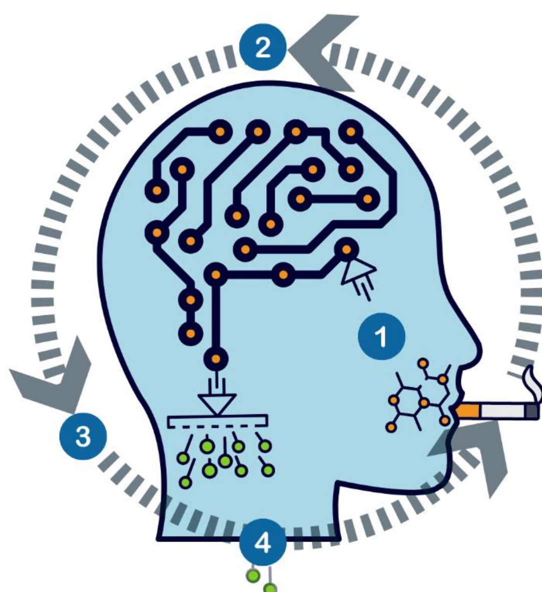
Smoking is the leading cause of preventable disease and death in Scotland. There are nearly 100,000 smoking-related hospital admissions[19] and over 9,000 smoking-related deaths every year[20]. In Scotland's most deprived areas (SIMD1), 35% of deaths were from smoking-attributable causes, compared with 8% of deaths in the least deprived SIMD quintile[21].

Smoking can increase the risk of developing non-communicable diseases such as lung cancer, cardiovascular disease, stroke, respiratory diseases and rheumatoid arthritis[22]. Furthermore, the risk of developing smoking-related diseases increases with how long and how much someone has smoked. In short, tobacco is one of the most dangerous substances to public health, contributing globally to the deaths of more than 8 million people each year[23].

Tobacco use as a risk factor for mental health issues

People with mental health issues are more likely to have physical health conditions[24] and to face structural inequality related to their gender, age and socioeconomic status[25], and may have their lives shortened significantly due to physical ill-health[26].

There is a common misconception that smoking is a relaxant and relieves feelings of stress and anxiety. It is true that the immediate effect of nicotine in the brain creates feelings of relaxation and relief, however, this feeling is temporary and soon after can give way to increased cravings and withdrawal symptoms such as anxiety, depression, brain fog and fatigue[27]. The main stress that ends up being relieved is that of nicotine dependence. So, smoking can worsen the mental health of people who are already struggling, meaning they can end up stuck in what can feel like a hopeless situation.



The development of nicotine dependence

1. Nicotine delivered by smoking and travels to the brain
2. Nicotine activates nicotinic receptors which stimulate the release of Dopamine
3. Dopamine released, leading to pleasant feelings of calmness and reward
4. Dopamine levels reduce, leading to withdrawal symptoms of stress and anxiety, which triggers the desire for another cigarette.

Source: ASH Scotland, IMPACT Guidance booklet, 2017

However, there is hope. The benefits of quitting smoking, particularly for someone with mental health issues, are considerable. Despite people with mental health issues smoking disproportionately more, they are just as likely to want to quit as the rest of the general population – and quitting can provide relief from their symptoms as well as better physical health. A recent Cochrane review of 102 studies found that people with mental health issues who quit, compared to those who continued to smoke, saw greater reductions in anxiety and depression and improvements in positive feelings and mental wellbeing[28]. A further meta-analysis showed that for many, the effect of quitting on mental health can be equal to or larger than that of anti-depression treatment[29]. While it cannot be said that quitting smoking will radically and suddenly improve mental health for all, the benefits are substantial.

Cost of high smoking rates among people with mental health issues

There is no recent data on the cost to the public purse of smoking in Scotland, either for the whole population or for people experiencing mental health issues. In January 2022, ASH in England released an updated economic analysis suggesting the cost of smoking in England is now £17 billion a year. With Scotland's population 10% the size of England's, this suggests the cost to Scotland could be about £1.7 billion.[30] As smoking prevalence is slightly higher in Scotland than England, this is potentially a low estimate.

Regarding the cost of smoking-related diseases among people with mental health issues, a 2013 report[31] from the Royal College of Physicians and the Royal College of Psychiatrists, looking at GP and practice nurse consultations, outpatient attendance, GP prescriptions and hospital attendance, estimated this to be around £719m for the UK. Based on population share, Scotland would therefore have faced costs of around £57.5m.

In addition to the cost to the public purse, smoking is a heavy financial burden for individual smokers as well as a health burden. A smoker in Scotland spends on average £1,875 per year, rising to more than £4,000 for people smoking a pack of factory-made cigarettes per day[32]. With an estimated 30% of smokers having a mental health issue[33], even a 1% reduction in the smoking prevalence in this group would release £43.5 million for people to spend in other ways[v].

Investment in smoking cessation for people with mental health issues will reduce ill health, improve lives and reduce future public spending needs.

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[v] With a 17% smoking prevalence there are 773,366 smokers in Scotland. 30% of these is 232,009. So a reduction of 1% smoking prevalence in this group would mean 23,200 fewer smokers. £1,875 is the average amount of money spent on tobacco per smoker annually (reference). 23,200 x £1,875 = £43.5million

Smoking, mental health and inequalities

While our mental health can impact all of us at some point in our lives, some groups in society are more likely to face mental health issues. We have already noted the important connection to deprivation. We have calculated that there are over 250,000 smokers living in Scotland's most deprived areas (SIMD1)[vi]. Our analysis shows that in the most deprived areas smoking prevalence among people with mental health issues is 40-50%, and likely substantially higher for those with severe conditions. Supporting cessation in this group would make a huge difference to overall prevalence rates. For comparison, the last time the Scottish smoking prevalence was at 50%, was in 1974. The smoking prevalence in people without mental health issues in the wealthiest communities is currently 4%.

Factors such as where we are born, our ethnicity, gender identity and sexual orientation hugely impact on how we experience daily life – and consequently, our mental health. The Scottish Health Survey notes that key social groups are at an increased risk of experiencing mental health issues, including disabled people, LGBTQIA+ communities, minority ethnic communities and carers[34]. These groups are also, on average, more likely to smoke; lesbian, gay and bisexual people are more likely to smoke than heterosexual people[35], and disabled people are more likely to smoke than non-disabled people[36].

Smoking, mental health and young people

> *"Adults should talk to young people to let them know it does affect your mental health, as I personally had no idea that smoking could make you depressed and affect your mental health, nobody ever told me about that."*[37]

Young people are particularly susceptible to the harm of tobacco; nearly two-thirds of smokers start before they are aged 18 – a fact which the tobacco industry exploits[38]. In Scotland, 2% of 13-year-olds and 7% of 15-year-olds are regular smokers (usually smoking one or more cigarettes a week)[39], and around 14% of 16 to 24-year-olds currently smoke[40]. Whilst it is encouraging that the vast majority of young people are now tobacco-free, those who do smoke may be more likely to experience mental health issues; given that their brains are still developing, nicotine can affect adolescents' brain development to sensitise the brain to future substance use, deficits in emotional regulation and increase risk of anxiety disorders[41,42,43]. According to SALSUS 2018, youth smokers were more likely to have lower mental wellbeing scores; those with below average mental wellbeing scores were more likely to be a regular smoker than those with an average or above average score[44].

[vi] Based on 2020 National Records of Scotland population estimates by area of deprivation, there are 856,433 aged 16+ people living in SIMD1 (most deprived quintile). The smoking prevalence in SIMD1 is 32% (Scottish Health Survey 2019). 856,433x0.32=274,059

The drastic difference in smoking prevalence between different levels of deprivation seen in adults, is not yet seen in young people. There are a range of predictive factors influencing the transition from youth experimentation to adult addiction. A number of these factors also increase the risk of developing lifelong mental health issues: the experience of adverse childhood experiences, being in care, or being a young carer as well as living in areas of high deprivation[45,46,47]. However, one of the largest factors is exposure to smoking, this includes parents or carers smoking[48,49]. Supporting parents and carers to quit smoking has a direct and positive impact on reducing up take for the next generation.

Smoking and psychiatric medication

Smoking is known to affect the metabolism and therefore the effectiveness of some commonly prescribed drugs including psychotropic medications. These include several antipsychotics, anxiolytics (benzodiazepines) and antidepressants[50]. Other commonly prescribed and used drugs such as warfarin, beta blockers, asthma inhalers, methadone and caffeine are affected in similar ways.

Tobacco smoke causes an increase in activity to an enzyme in the liver which can cause concentrations of medication in blood plasma to be reduced. This means that the medication can be up to 50% less effective, requiring higher doses to be prescribed, potentially with greater side-effects.

When smokers quit, enzyme activity reduces over a week or so. The reduced enzyme activity means that the concentration of medication in blood plasma increases over this time. This may require the dose to be reduced. Either way it is important that any attempt to stop smoking or restart smoking should be discussed with the prescriber.

Smoking cessation support for people with mental health conditions

Quitting smoking is associated with reduced depression, anxiety, and stress and improved positive mood and quality of life [51], and it is important that there is cessation support available for all. There are numerous methods proven to be effective in helping people quit tobacco; of these, a recent meta-analysis indicates varenicline and nicotine replacement therapy to be the most effective combination[52.] Adding behavioural support further increases quit success[53,54]. Specific to Scotland, data from the NHS smoking cessation services show that when compared to pharmacy-only support, specialist cessation support strongly increases quit success[55].

Our analysis (see Section Two) shows that people with mental health issues have more cessation attempts before successfully quitting. It is important that cessation methods account for the patient's mental health; studies conducted to date of varenicline, where some research participants had pre-existing psychiatric conditions, have found it to be effective and generally well-tolerated[56]. There are also models of support designed for medical staff to encourage quit attempts, such as 'brief interventions', which involve a

health worker taking brief opportunities to encourage a quit attempt either directly or working with a patient's family[57].

NHS Health Scotland's smoking cessation guidance has provided advice for services working with smokers with mental health issues. The guidance suggests the best approach is to provide tailored smoking cessation advice, with the discussion of current and past smoking behaviour, to build a personal smoking cessation plan (as a part of a wider review of their health)[58]. Indeed, there is no one way to quit smoking, and different methods work for different people.

However, research shows that many mental health professionals hold attitudes and misconceptions that may undermine the delivery of smoking cessation interventions[59]; in England a study showed that one in five mental health trusts do not have a sufficient smoke-free policy[60]. A 2019 study by BMC Psychiatry reported that mental health professionals often fail to encourage patients to quit smoking due to misunderstanding the potential benefits of cessation, and easy accessibility of tobacco by the patient within the community[61]. If clinicians feel they are unable to discuss smoking with their patients, we will **not** see smoking rates reduce among those with mental health issues. We need better support and training for health professionals to enable open and honest conversations about quitting smoking to improve mental health.

Section Two – Findings from the Scottish Health Survey

As is evidenced throughout this report, smoking prevalence among those with mental health issues is significantly higher than in the general population. However, until now, we have not been able to identify data to give a clear picture in Scotland.

For this report ASH Scotland has commissioned ScotCen[62] to analyse data from the Scottish Health Survey on various smoking and mental health measures. Although the annual Scottish Health Survey cannot tell us about specific disorders, it does collect data on smoking behaviours and mental health across the population, going back as far as 2003, until the most recent complete data set from 2019.

The Scottish Health Survey asks respondents to complete questionnaires which assess their likelihood to have a mental health issue as well as their level of mental wellbeing. The data published in this report cover the outcomes of the General Health Questionnaire-12 (GHQ-12), the Clinical Interview Schedule - Revised (CIS), and Mental Wellbeing, measured with the Warwick-Edinburgh Mental Wellbeing Survey (WEMWBS). In the GHQ a score of 4 or more (4+) is indicative of a probable/likely psychiatric condition. The CIS measures a range of mental health issues, where a score of 2 or more (2+) indicates a moderate or severe condition. This report covers CIS scores for anxiety and depression. Further, the survey asks respondents to report whether they have a 'long-term mental health disorder'. In the reporting, we have used these four (GHQ 4+, Anxiety 2+, Depression 2+ and Long-term mental health disorder) measures as proxy indicators to assess numbers of respondents with a mental health issue. These provide indications, not actual diagnoses. Figures reported are in line with other UK research[63,64,65,66]. Although the Scottish Health Survey does not identify specific disorders, research from England indicates that prevalence for certain conditions can be as high as 60%[67].

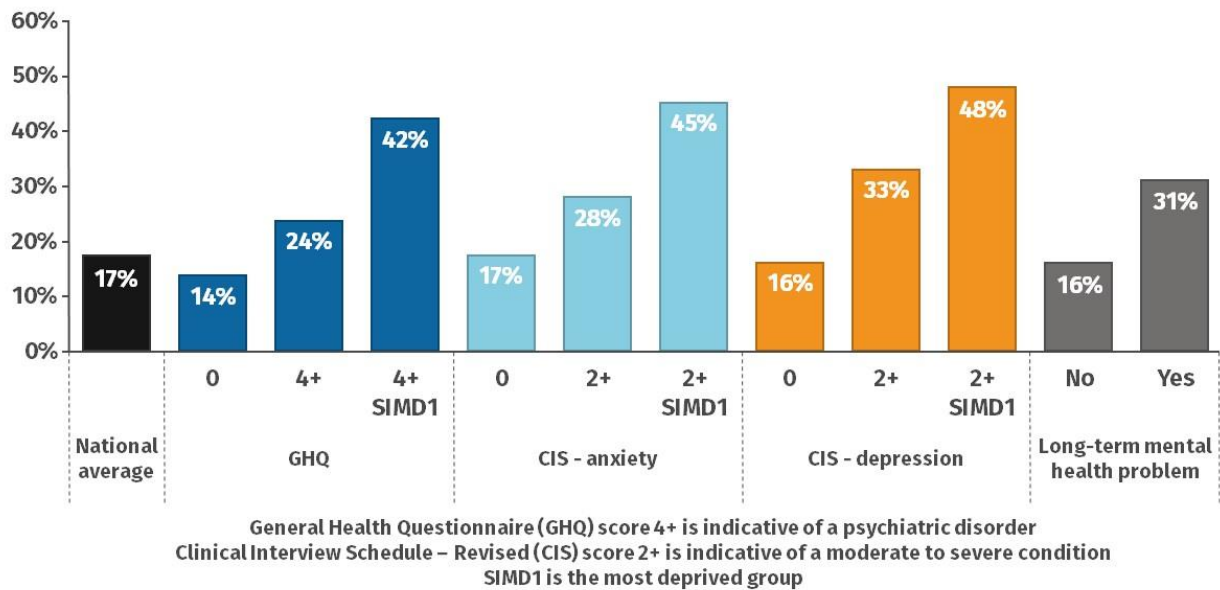
Finding 1: People with mental health issues are more likely to smoke, especially if they live in a deprived area

The graph below (Figure 1) shows (from left to right) the national smoking prevalence for Scotland in 2018/19 (17%), followed by prevalence for people with no psychiatric condition (GHQ 0), a likely psychiatric condition (GHQ 4+), and those with a likely psychiatric condition who live in the most deprived areas in Scotland (GHQ 4+ SIMD1). The same information is summarised for anxiety and depression and for those who respond that they do or do not have a long-term mental health problem.

It can be seen that for each group, people with a mental health issue are much more likely to smoke than those who do not have mental health issues, ranging between 1.6 to

2x higher[vii]. Almost half of those with a mental health issue in the most deprived areas are smokers.

Figure 1 – Smoking prevalence in people with mental health problems, including those in the most deprived areas - *Scottish Health Survey 2018/2019*



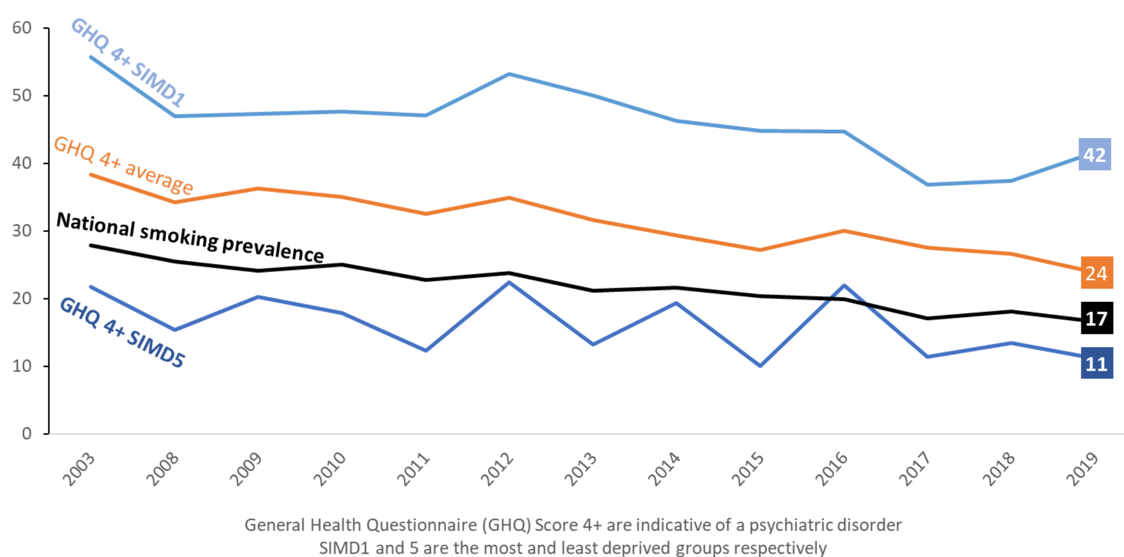
Further, our analysis shows that those without a mental health issue are more likely never to have smoked; 62% of those who do not have a long-term mental health problem and 42% of those who do, have never smoked.

Finding 2: Smoking rates in people with mental health issues have reduced to the same degree as the general population, but we are seeing an upward tick in the most deprived areas

The graph below (Figure 2) shows time trend analysis to indicate that smoking prevalence in people with mental health issues has been falling since 2003 at a similar rate compared with the national prevalence. For those with probable psychiatric conditions (GHQ 4+) it appears that since 2017 the gap between the most and least deprived quintiles is growing. This is concerning, although it is too early to conclude this to be a long-term trend. Based on the last two years, increased COVID-related mental health strain in society and the known association with smoking it seems reasonable to suspect that the trend is maintained in 2022.

[vii] Smoking prevalence for those with a possible psychiatric disorder (GHQ-12 4+) compared to those without (GHQ-12 score of 0) is 71.43% higher; for those with anxiety score 2+ compared to a score of 0 it is 64.7% higher; for people with depression score 2+ compared to a score of 0 it is 106.3% higher; for those with a long-term mental health problem compared to those without, prevalence is 106.7% higher

Figure 2 – Smoking and mental health prevalence – *Scottish Health Survey 2003 - 2019*

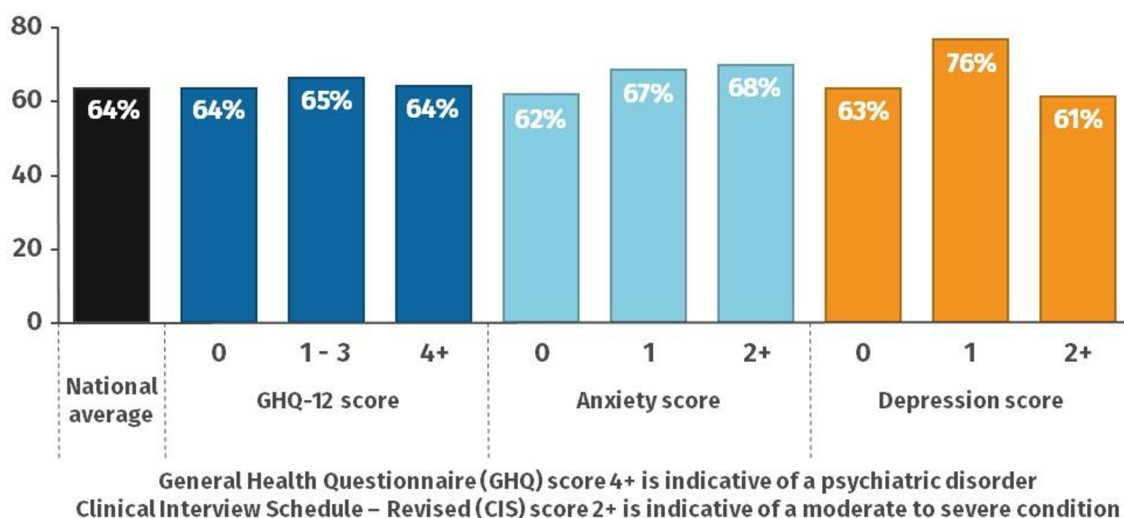


General Health Questionnaire (GHQ) Score 4+ are indicative of a psychiatric disorder
SIMD1 and 5 are the most and least deprived groups respectively

Finding 3: Over two thirds of smokers with mental health issues want to quit

Figure 3, below, combines data for smokers from the surveys of 2016-19 to analyse responses about desire to quit. Smokers with mental health issues are as likely, or more likely to want to quit, and this trend has been consistent since 2008 (data not shown). Differences in quit desire in each group are not statistically significant.

Figure 3 – People with mental health issues are equally likely to want to quit compared to those without. *Scottish Health Survey 2016 – 2019*



General Health Questionnaire (GHQ) score 4+ is indicative of a psychiatric disorder
Clinical Interview Schedule – Revised (CIS) score 2+ is indicative of a moderate to severe condition

People with a probable psychiatric condition (GHQ score of 4+) are more likely than those without a condition never to have tried to quit. They are also more likely to have tried to quit three or more times previously (27% compared with 20%). This indicates that people with mental health issues experience challenges which make them less likely to initiate a quit attempt. Those who do try are more likely to have to try multiple times.

Finding 4: Smokers with mental health issues are likely to smoke more

The table below sets out the number of cigarettes smokers report smoking daily, by number of symptoms of conditions. In many cases, smokers with mental health issues smoke more than the national average. The effect of deprivation on the number of cigarettes smoked per day by mental health conditions was not analysed for this report. However, in the general population, people from the most deprived quintile (SIMD1) smoke 13.2 and those from the least deprived (SIMD5) smoke 10.2 cigarettes per day.

Table 4 – Number of cigarettes smoked by mental health condition – Scottish Health Survey

CIS (Depression and Anxiety) scores 2016-2019:			
	0	**1**	**2+**
Depression	11.9	11.4	15.7
Anxiety	12.7	12.5	11.9
GHQ-12 (psychiatric condition) scores 2018-2019:			
	0	**1-3**	**4+**
	11.5	12.3	13.1
National average for all smokers 2019:			
	12.2		

** differences in cigarettes smoked per day between groups are not significant except for GHQ-12 4+ and depression 2+*

Finding 5: Smokers have lower mental wellbeing than those who have never smoked or quit

The Warwick and Edinburgh Mental Wellbeing Questionnaire (WEMWBS) is a well-established questionnaire which examines subjective mental wellbeing. It is scored on a low-high range of 14-70 and the Scottish average score in 2019 was 49.8. Breakdown by deprivation unsurprisingly shows a gradient in mental wellbeing, with 46.9 for the most deprived quintile (SIMD1) and 51.5 for the least deprived (SIMD5).

The effect of smoking on WEMWBS scores has not previously been analysed. Our analysis (see Table 5 below) shows that across the whole population, smokers experience reduced mental wellbeing (46.3) relative to those who have never smoked (50.9), and former regular smokers (48.9). The difference in scores between smokers and former smokers confirms that smoking cessation comes with improved mental wellbeing, for all smokers not just for those with mental health issues. This improved mental wellbeing is seen in every age group, showing that it is never too late to stop smoking.

When looking at the effects of smoking on wellbeing by deprivation we observe the familiar gradient, those from more deprived areas have lower wellbeing scores. Smokers from the two most deprived quintiles score 44.2 and 46.1, for SIMD1 and SIMD2, respectively. Importantly, stopping smoking brings mental wellbeing improvements across all groups (Table 5).

Table 5 - Mental wellbeing and smoking. Scottish Health Survey WEMWBS scores 2019

	Current smokers	Former regular smokers	Never regular smokers	All
Average	46.3	48.9	50.9	49.6
Most deprived	44.2	46.9	48.8	46.8
2nd	46.1	47.9	49.7	48.5
3rd	48.8	48.8	51.2	50.2
4th	47.3	50.4	51.5	50.7
Least deprived	47.6	50.1	51.9	51.3

Finding 6: E-cigarette users with a mental health issue are more likely also to smoke

Our data shows that 32% of e-cigarette users with no symptoms of a mental health issue are dual users of both tobacco and e-cigarettes. This is concerning enough, since dual use maintains the health harms of smoking while also introducing harms associated with e-cigarette use. E-cigarettes are useful for public health purposes only as a potential route towards stopping smoking. Anyone who is using both should be strongly encouraged to stop smoking tobacco as soon as they can[68].

However, almost half of those reporting symptoms of a likely psychiatric condition also reported dual use of e-cigarettes and tobacco. This potentially calls into question the value of e-cigarettes as a route to quitting tobacco for this group in the longer term.

Table 6 – Dual use of e-cigarettes and tobacco, 2018-19

GHQ score:	0	1-3	4+*
	32%	45%	48%

* A GHQ score of 4 or more is indicative of a psychiatric disorder

Section Three – Current Scottish Government Policy

The Scottish Government has developed detailed separate strategies to improve mental health and to address tobacco control. Both are under review during 2022, with a view to producing new strategies by 2023. The concerning prevalence of smoking among people with mental health issues shows that more must be done to close this inequality gap and improve people's mental and physical health by supporting smokers to quit and preventing new uptake. Both new strategies need to make interconnected commitments to improve the current picture.

Scottish Government's Mental Health Strategy 2017-2027

The *Mental Health Strategy* [69] outlines actions which seek to "*achieve parity between physical and mental health*". This strategy is being reviewed, and the main document currently driving progress in this space is the *Coronavirus: Mental Health - Transition and Recovery Plan*[70].

Importantly, the paused 2017 Strategy highlights that those who struggle with mental health issues are also likely to struggle with physical ill health. A key stated ambition is ensuring "*…that the rate of smoking amongst people with a diagnosed mental health problem should decline at the same rate as the rate for the general population*".[71] It is not clear what data was to be used to measure this decline, but our analysis of Scottish Health Survey data (see Section Two, Finding 2) indicates it has broadly been achieved, although without any narrowing of the inequalities gap (and a recent widening in the most deprived areas).

Following on from this ambition, **Action 29** of the strategy commits the Scottish Government to "*Work with partners who provide smoking cessation programmes to target those programmes towards people with mental health issues*"[72].

The 2019 progress report notes that "*IMPACT guidance has been rolled out to all NHS Boards. Quarterly training continues. Improvements in data are planned by end 2019. With these actions underway through joint working with partners, the action is now complete.*"[73]

Although the 2019 Report states that Action 29 is complete, it does not explain what the status is of '*improvements of data planned by end 2019*' or how smoking cessation programmes have in practice been successfully targeted towards people with mental health issues. ASH Scotland's IMPACT project mentioned here is discussed further in Section Four below.

Since the action was marked complete, no further mention of the above ambition or of smoking and mental health can be found in more recent Scottish Government progress reports. The new Mental Health strategy must re-establish the connection to physical health and include quality smoking cessation support for people with mental health

conditions, if the Scottish Government is to meet its 2034 target for tobacco control (see below).

Tobacco Control Action Plan 2018

The 2018 Tobacco Control Action Plan set ambitious actions in order to achieve the Scottish Government's goal (set in 2013) of a tobacco-free generation in Scotland by 2034. Some actions outlined include: creating smoke-free perimeters around hospital buildings and tobacco-free prison estates; promoting ASH Scotland's Charter for a Tobacco-Free Generation; and restricting the domestic advertising and promotion of e-cigarettes[74]. All the commitments within the Action Plan, if aimed at the whole population, will particularly support people with mental health issues as a key group of vulnerable smokers. In addition, the plan prioritises addressing the links between smoking and mental health as a key target group.

Specific to mental health, the Plan supports ASH Scotland's IMPACT training work[75], and notes that in terms of supporting the most vulnerable groups, the Scottish Government's greatest hope for improvement will be for smokers in mental health settings[76].

The NHS 24 national service, Quit Your Way Scotland, provides support and guidance on smoking cessation as well as referrals to local advisers, including mental health specialists. The Plan commits to building on Quit Your Way branding, in order to "*overcome barriers to access for priority groups*"[77]. Services have inevitably been impacted by the pandemic, and the new strategy will need to support their return to full delivery.

Some key policies, such as the ban on tobacco in prisons, have been successfully followed through. However, there are significant gaps in delivery which must now be addressed to reduce health harm. One such example is the lack of published Scottish data about smoking and mental health. The Plan states that there is a lack of data recording surrounding the smoking status of people who engage with mental health services[78]. The Plan commits to *"address the unequal harms of smoking associated with this patient group (by) encouraging better data collection and reporting."*[79] It is not clear what improvements in data collection and reporting have been delivered, and these are still urgently needed. Other delivery gaps which affect all smokers, and therefore disproportionately people with mental health issues, include the commitments to create smoke-free perimeters around hospital buildings, and to end the use of Heated Tobacco Products (HTP) in public places.

The new Tobacco Control strategy, currently under development, must make ambitious commitments to address whole population issues. These will particularly support people with mental health issues as a major group of smokers. In addition, it must make specific commitments to address the connections between mental health, deprivation and tobacco use. Section Four offers examples of specific good practice in reaching this target group which could be supported in the new strategy.

Section Four – Examples of good practice

Good practice on supporting smokers with mental health issues is not collated centrally or locally, nor is service data available for this user group, and examples have not been easy to source. Services remain challenged in the wake of the COVID-19 pandemic. Available examples are summarised here but more work is needed to support policy-makers and practitioners to share learnings and successes. Going forward, ASH Scotland remains committed to working with partners to collect and share examples of practice, and to encourage learning within services and beyond.

Training practitioners

Research shows a significant proportion of mental health professionals hold attitudes and misconceptions that may undermine smoking cessation interventions[80]. Many report a lack of time, training and confidence as the main barriers to addressing smoking amongst their patients.

ASH Scotland's IMPACT programme

ASH Scotland's IMPACT[81] project has provided up-to-date training and guidance on smoking and mental health to third sector, local authority and NHS services since 2017. Originally funded by the Edinburgh and Lothian Health Foundation (2015-17) and then by the Scottish Government (2017-21), it has reached 1,200 participants from all NHS Board areas, and demand for training remains high.

Training and guidance were based on a thorough ASH Scotland evidence review[82] and developed through practitioner and service user focus groups. Training has been consistently positively evaluated by participants and has been reported to make a difference to both knowledge and practice. Project funding for IMPACT ceased in March 2021.

A review of internal evaluations of the programme allows key conclusions to be drawn:

- IMPACT training and guidance is accessible and well evaluated. Participants report that their confidence increases after training, and that they are more likely

to initiate a conversation about smoking with someone they support, as well as more able to help them through a quit attempt

- Ongoing funding is necessary to roll out the programme further within NHS Boards and community-based services
- The AID framework used by IMPACT (Ask, Inform, Discuss) is a helpful means of starting conversations about smoking and mental health. It should act as a foundation for future programmes
- Practitioners are particularly interested in learning about the effect of smoking on mental health medications.

Connecting policy and practice in the NHS

Frontline medical staff can play a significant role in encouraging people with mental health issues to quit smoking. A Clinician Practice Review reported that the best quit outcomes involved intensive smoking cessation treatment delivered by clinicians who understood patients' health conditions[83]. Tailored approaches which understand the patient's needs are important to a successful quit attempt, and as the Review writes:

> Understanding whether the patient would prefer nicotine replacement therapy (NRT) or an e-cigarette as an alternative to smoking in an NHS smoke-free environment should be part of the person's care plan and will help with management of the patient's condition.

Conclusions

- Specialist mental health practitioners can provide support for cessation and work with generalist advisers who have received mental health training
- Multi-disciplinary engagement is necessary to deliver policy effectively
- Resources are needed to develop stronger mental health-related expertise within smoking cessation teams
- It is useful for practitioners to share with their peers emerging practice and learning.

NHS Lanarkshire Quit Your Way Mental Health Advisers

NHS Lanarkshire has a Tobacco Control Strategy (2018-23)[84] with the aim to protect children's health, tackle inequalities and reduce the prevalence of smoking in Lanarkshire from 21.8% to an overall 11% by 2022. People with mental health issues are listed as a priority group. There is a particular focus on reducing smoking in Lanarkshire's most deprived communities.

NHS Lanarkshire offers specialist support to anyone experiencing mental health issues who is ready to quit smoking. The health board has dedicated advisers trained through the IMPACT programme who are available to provide support and advice on

suitable nicotine replacement products. For people experiencing more severe mental health issues, a mental health nurse specialist is available, working to support smoking cessation in both community and acute settings. The model seems to show success - additional resources would allow more health boards to develop specialist cessation teams.

Between 2018 and 2021 the data from NHS Lanarkshire, for people referred to a mental health nurse specialist, indicated that the four week and 12 week quit rates are 49% and 31% respectively. Relative to figures for the whole population using specialist services (non-pharmacy), the quit rates are only around ten percentage points lower. Quit rates for pharmacy-only support are substantially lower[85]. Considering the substantial research showing that those with mental health issues have lower quit success, this data underlines the value of specialist cessation support, especially for those with mental health issues. Unfortunately, it is not known how many health boards have invested in this kind of specialist support. Cessation data by mental health diagnosis is not routinely recorded nor published.

Practitioner experience has shown that it is important that smoking is raised regularly at multi-disciplinary team meetings. Patients are often not aware that smoking can affect their medication levels. In many cases, patients can be on high doses because they smoke, which can have a significant impact on their daily functioning.

Community work with young people

"(It is) easier than going to a doctor to talk about stress and to get medication – cigarettes are easier to access as a coping mechanism"[86].

ASH Scotland's youth work partnerships

In late 2020, ASH Scotland commissioned YouthBorders and Lothian Association of Youth Clubs to conduct a consultation exploring smoking, young people and mental health[87]. The report made recommendations to support youth services in Scotland to enhance young people's health and wellbeing through addressing smoking. The report highlighted that the link between smoking and young people's mental health is not fully understood. Young people revealed that they choose to smoke as a coping mechanism for stress and anxiety. Additionally, feedback showed that young people are not fully aware of where to access stop smoking support.

Following on from our previous work[viii] in this space, ASH Scotland is now developing a holistic, inequalities-sensitive approach to smoking prevention and cessation, including building young people's resilience and positive ways to support physical, emotional, mental and social wellbeing. Over a three-year period we will build connections and key partnerships with Scotland's youth work sector to convey consistent messages on how remaining smoke-free or quitting smoking can benefit

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[viii] For example, https://www.befree.scot/

young people's mental health. We will pilot youth-led approaches learning from young peoples' voices and experiences about health behaviours and effects on wellbeing to trial new information and resources.

LANDED

LANDED Peer Education Service is a charity which provides harm reduction advice and information about alcohol, tobacco and drugs to young people. They deliver workshops, training and provide information about harm reduction to young people in Lanarkshire. Their tobacco and e-cigarettes workshop aims to raise awareness about tobacco-related harm and signpost young people to local stop smoking services.

LANDED received ASH Scotland's IMPACT training, with the aim of incorporating its messaging and findings into their tobacco and e-cigarettes workshop. Following the training session[88]:

- Staff immediately embedded the information into their informal workshop aimed at young people and their staff training course
- Staff now feel able to raise these issues with the young people they work with. This includes teaching them the ways in which mental health medication can be affected by smoking
- It has become apparent that when staff discuss tobacco-related harms and why people smoke, mental health is a common theme. Staff can signpost young people to the IMPACT website and ASH Scotland resources for further information. If the group is keen on learning more, handouts from the IMPACT training are available.

Testing bespoke cessation interventions

Current guidance tells us[89] that the best approach to cessation for people with mental health issues is to provide tailored smoking cessation advice, with the inclusion of discussion of current and past smoking behaviour, as a part of building a personal smoking cessation plan. There is no single best way to quit smoking, and different methods will work for different people.

Conclusions

- The 'Quit Your Way' approach of person-centred support may be helpful for people with mental health issues, as for all people, especially if advisers are trained and resourced to meet their needs
- Trials have not yet shown us the best way to support individuals. More practice-based learning and sharing of experience among practitioners may help us identify options.

Scimitar +

Scimitar Smoking Cessation Intervention for Severe Mental Ill Health Trial was a randomised controlled trial which aimed to test the effectiveness of a bespoke combined behavioural and pharmacological smoking cessation intervention to people with severe mental health issues. The trial included 536 participants, heavy smokers primarily with bipolar disorder or schizophrenia from 16 primary care and 21 community-based mental health sites in the UK.[90]

The bespoke intervention consisted of behavioural support from a mental health smoking cessation practitioner and pharmacological aids for smoking cessation, with adaptations for people with severe mental illness such as extended pre-quit sessions, cut down to quit, and home visits. Access to pharmacotherapy was via primary care after discussion with the smoking cessation specialist. The control group received usual care, which involved being offered access to local smoking cessation services not specifically designed for people with severe mental illnesses.

The bespoke intervention increased engagement and the chances of successful quitting. The quit rate at six months was more than twice those who received usual care, along with an improvement in short-term physical health and trend towards decreased numbers of cigarettes smoked per day at six months. Participants also reported increased motivation to quit at 12 months. However, the quit results at 12 months did not show any statistical difference between Scimitar's bespoke smoking cessation and usual care, emphasising how difficult it is for people to stay quit in the longer term.

Conclusion

This new analysis reinforces our understanding of this concerning health inequalities gap and presents us with a sobering but hopeful picture. With political will at national level and good implementation at local level, we can improve the lives of 230,000 people in Scotland.

There is already existing research evidence and good practice in service delivery which can be built on, if we have the will to tackle the gap. The issue is multi-faceted and requires an interconnected policy approach. We do not yet have enough examples of good practice, and practitioner experience is not widely shared.

Recommendations

Our analysis leads us to call for the following key changes in policy and practice:

Specific recommendations for mental health and smoking	
1	The Scottish Government's forthcoming refreshed **Mental Health and Tobacco Control strategies must each prioritise the physical health of people with mental health issues**, by making connected commitments to supporting cessation and smoking prevention work among this priority group and then delivering on that commitment.
2	The Scottish Government must **set a specific Key Performance Indicator (KPI) to reduce smoking prevalence among people with mental health issues** and therefore to narrow the inequalities gap, aiming towards the much lower prevalence seen in the general population.
3	The Scottish Government and Public Health Scotland **must identify prevalence data to regularly report on progress against this KPI in strategy updates.** Data could come from available Scottish Health Survey statistics, as demonstrated here.
4	The Scottish Government must ensure that **all NHS Boards have up to date tobacco control strategies which prioritise cessation support for people with mental health issues**; and that they are resourced to offer specialist smoking cessation advice to this group.

5	NHS Boards should ensure that **all mental health patients admitted to acute or community settings are regularly asked if they smoke, including on discharge,** so they can be offered specialist cessation support during or after their treatment.
6	All bodies with an interest in tobacco control and health should **work in partnership to improve understanding of and share good practice** in what works to reduce smoking among people with mental health issues.

Recommendations for the whole population

These measures will make a difference for all smokers, including the 1/3 who have mental health issues, and help to deliver the Scottish Government's 2034 tobacco-free generation target.

7	The Scottish Government must **deliver on its existing commitment to implement regulations to make hospital perimeters smoke-free**. In addition, it should **encourage similar good practice** in all environments where people are receiving treatment and support.
8	The Scottish Government must **regulate all tobacco and related products consistently,** including novel tobacco products and e-cigarettes.
9	All bodies with an interest in tobacco control and health should **work in partnership to reduce the appeal and availability of tobacco products to young people.**
10	The Scottish Government should **lead regular mass media and targeted social media campaigns to encourage smokers to quit and to** ***Take it Right Outside*****.** They should also raise awareness at all levels of Government and public office of the damage caused by health-harming industries and their products to population's health.

ASH Scotland will review and update these recommendations throughout 2022 as we build conversations on this important theme with policy makers and practitioners.

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