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NATIONAL CENTRE FOR SMOKING CESSATION AND TRAINING

NHS England

NHS Standard Treatment Plan for Inpatient Tobacco Dependence in Mental Health Hospitals

A guide to support delivery of the Inpatient Tobacco Dependence Treatment Care Bundles

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1.1 Admission to a mental health hospital: the importance of treating tobacco dependence

Treating tobacco dependence is among the **most important interventions** that can be provided to patients in mental health settings who smoke. **A patient's mental health condition should not be a barrier to providing effective tobacco dependence treatment.**

There is clear evidence that supporting patients to stop smoking significantly improves mental and physical health as well as quality of life.[1] Moreover, effective treatment of tobacco dependence can assist with decreasing patient agitation and discomfort, and improve recovery. **It can also mean reductions in psychotropic medication are possible for some patients.** For these reasons, treating tobacco dependence is now a standard of care in all NHS mental health hospitals, as well as acute and maternity services.

The NHS has committed to delivering tobacco dependence treatment to people admitted to mental health hospitals who smoke as a core component of their treatment. Furthermore, there is a pledge to provide care in completely smokefree hospitals, with all the cues to smoke removed, so that engagement with treatment is fostered.

This includes:

- **identifying the smoking status** of patients admitted to mental health hospitals;
- prompt and plentiful access to appropriate **licensed combination nicotine replacement therapy (NRT), vapes containing nicotine, nicotine analogues (cytisine, varenicline) or bupropion;**
- **opt-out referral (or notification) to** an appropriately trained in-house **Tobacco Dependence Adviser (TDA);**
- **a personalised tobacco dependence treatment plan** to support patients with a smokefree admission and **support with stopping long-term;** and
- referral to a specialist **stop smoking service following discharge from hospital** to provide ongoing support and supply of tobacco dependence aids.

1.2 The clinical case for treating tobacco dependence in patients admitted to a mental health hospital

Rates of smoking are much higher among people with mental illness than among the general population (40% among all people with mental illness, compared with 13% of the adult UK population).[1–3] Rates of tobacco smoking can be **as high as 70–80% in inpatient mental health hospitals.**[3–5]

People who have a severe mental illness (SMI) such as schizophrenia or bipolar disorder, and those who have a common mental disorder such as depression or anxiety, **are known to suffer disproportionately from multiple smoking-related illnesses** compared to the general population (see **Box 1**). They experience physical illnesses more frequently and in some cases more severely. They also have a considerably shorter life expectancy compared to those without a mental illness.[6,7] Available data indicates people with SMI **die on average 10 to 20 years earlier than members of the general population.**[6–9] The reasons for this are multifaceted. However, the high rates of smoking in this population exacerbate these health inequalities.[1,3,6–9]

We also know that smoking can adversely affect recovery from mental illness. 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.[1,3,8–11] Additionally, a significant number of staff hours are spent facilitating smoking in inpatient mental health wards and this can strain staff resources.[12]

Box 1: Facts about people with mental illness and smoking-related illness

When compared to the general population, people with mental illness are:

- at increased risk of heart disease and stroke
- 2–3 times more likely to have diabetes
- at 10 times greater risk of dying from a respiratory disease
- more likely to suffer from asthma, chronic bronchitis and emphysema
- tend to have poorer cancer survival rates
- at increased risk of osteoporosis and fractures

1.3 The benefits of stopping smoking for people with mental illness

Supporting people to manage their tobacco dependence offers huge benefits to physical and mental health, and to general wellbeing (see **Figure 1**).

Benefits of stopping smoking include:

- better physical health in the short- and long-term
- reduced depression, anxiety and stress
- better mental health, including mood, self-confidence and self-esteem
- improved sleep over the long-term
- less time in hospital
- increased disposable income
- improved quality of life
- reduced stigma and exploitation
- potential to reduce doses of some medications.

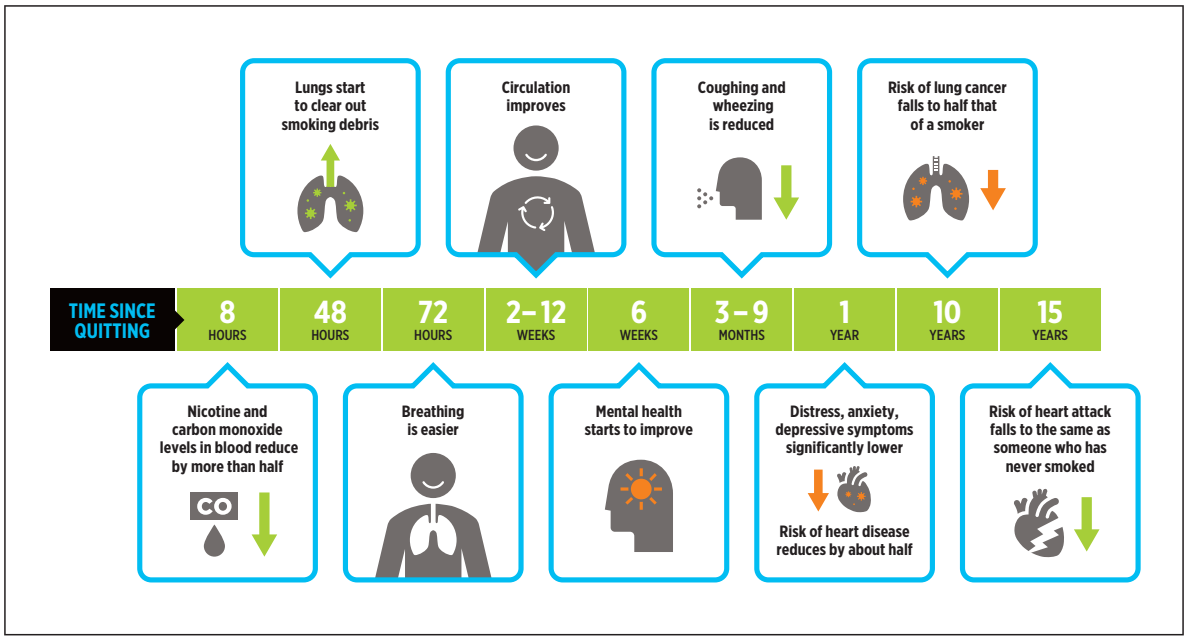
1.3.1 Physical health

Successfully stopping smoking will benefit a patient's long-term health by reducing the risk of developing smoking-related illnesses (e.g. cancers, heart disease, stroke, respiratory illness) that are the major cause of death and disability in people with SMI.[1,3,8,9] In the short to medium term, patients will experience improved breathing, circulation and energy levels.

1.3.2 Mental health

In addition to the benefits to physical health that result from stopping smoking, people's mental health improves and, importantly, their confidence and quality of life increases. Although the period immediately after stopping may be difficult, we know that stopping smoking **does not worsen the mental health of patients, particularly when tobacco dependence treatment is provided.**[13–15] In fact, **stopping smoking has been shown to improve mental health** (such as reduction in anxiety and depressive symptoms),[13–15] and the size of the effect can be the equivalent to taking antidepressants.[13]

Figure 1: The health benefits of stopping: physical and mental health



1.3.3 Increased disposable income

Smoking also impacts **socioeconomic wellbeing**, as people who smoke spend a considerable part of their income buying cigarettes. Studies have found that people with SMI spend on average around one third of their disposable income on smoking.[3]

1.3.4 Benefits to organisations: aggression and violence, quality of care

There are many benefits to treatment of tobacco smoking for trusts and NHS staff. There is a common concern among healthcare professionals that hospital smokefree policies and restricting patients from smoking leads to increased incidence of violence and aggression among patients. To the contrary, in English trusts that provide effective management of tobacco dependence, we have seen **a drop in the incidence of violence and aggressive patient behaviour** following the introduction of comprehensive smokefree policies.[16–18] Evaluations also document reductions in the use of seclusion and discharge against medical advice.[19]

Evidence to date shows that implementation of smokefree policies in mental health hospitals may also reduce fire risk.[20]

1.4 About this document

This **NHS Standard Treatment Plan (STP) for Inpatient Tobacco Dependence Treatment in Mental Health Hospitals** provides guidance on delivering tobacco dependence treatment to adult patients that smoke and are admitted to a mental health trust. The STP is designed to ensure patients receive consistent interventions grounded in evidence-based behaviour change techniques (BCTs) as part of specialist tobacco dependence support. The STP provides a guide on how these BCTs can be included in interactions with patients to ensure they have the best possible chance of having a smokefree hospital stay and a goal of long-term abstinence.

The STP is structured around the **Tobacco Dependence Treatment Care Bundles:**

- **Point of Admission Care Bundle**
- **Inpatient Care Bundle**
- **Post-Discharge Care Bundle**

Each section of the STP begins with a clinical checklist outlining what should be included in each bundle. This is followed by guidance on conducting an assessment and delivering specialist tobacco dependence support.

1.5 The NHS Inpatient Tobacco Dependence Treatment Care Bundles

Table 1 provides an overview of the NHS Inpatient Tobacco Dependence Treatment Care Bundles for Mental Health Hospitals. The three bundles are the:

- **Point of Admission Care Bundle:** Providing immediate brief advice, rapid management of tobacco withdrawal and opt-out automated referral (or notification) by ward staff to the in-house Tobacco Dependence Team at the point of admission.
- **Inpatient Care Bundle:** Providing personalised tobacco dependence support from a specialist TDA, including assessment and development of treatment plan.
- **Post-Discharge Care Bundle:** The offer of a post-discharge treatment and support package by specialist TDA, including the provision of tobacco dependence aids and referral to specialist support in the community.

1.6 The tobacco dependence treatment plan

Patients and staff should collaborate to develop an individualised treatment plan. TDAs should expect to see patients with a variety of mental health and physical symptoms. This will include patients who are coping well with not smoking and those that may be struggling with staying smokefree. While some patients will be interested in stopping smoking or reducing the number of cigarettes they smoke, others may be ambivalent or have no interest in stopping. Assessing the individual patient's needs and tailoring your support accordingly will be important. For those patients who have committed to temporary abstinence, effort should be made to regularly reassess and support them with harm reduction and steer them towards a goal of stopping long-term at a pace that is appropriate.

At the point of admission and during an inpatient stay a person who smokes has three options:

- **Smokefree admission without support:** to temporarily abstain from smoking whilst in buildings and on the hospital grounds, without using evidence-based tobacco dependence aids and/or behavioural support.
- **Smokefree admission with support:** to temporarily abstain from smoking whilst in buildings and on the hospital grounds, with evidence-based tobacco dependence aids and/or behavioural support.
- **Sustained abstinence:** to use the opportunity to make a sustained attempt to stop smoking, with evidence-based tobacco dependence aids and/or behavioural support.

Regardless of which option is chosen, every patient who smokes should be offered a nicotine vape or combination NRT to manage their tobacco dependence within 30 minutes of arrival at the hospital. This should be followed up by comprehensive tobacco dependence treatment and support as soon as the patient is able to engage with this.

Table 1: Overview of the NHS Inpatient Tobacco Dependence Treatment Care Bundles

Bundle	Responsible Team	Care Bundle Details
Point of Admission Care Bundle	**Admitting Team** (Target for completion: Ideally within 30 minutes of admission but always within two hours)	**Brief advice and acute management of tobacco withdrawal** **IDENTIFY** – Identify tobacco use and vaping status. Conduct carbon monoxide test. Any patient that actively smokes or has stopped within the **last two weeks** should be identified as meeting criteria for treatment. **ADVISE** – Provide brief advice and inform about available treatment and support. **TREAT** – Initiate treatment with a nicotine vape (for adults, if risk assessment permits) and/or combination NRT. **REFER** – Inform patient they will be referred to the in-house Tobacco Dependence Team and complete referral using local pathway. **RECORD** – Tobacco dependence diagnosis is recorded in patient medical record, ideally in the admission **diagnosis list and management plan.**
Inpatient Care Bundle	**Trust inpatient Tobacco Dependence Team** (Target for completion: Within 24 hours of admission)	**Initial assessment and treatment plan** ■ Complete assessment of severity of tobacco dependence ■ Titrate/adjust nicotine vape and NRT (as needed) ■ Advise on managing urges to smoke and coping strategies ■ Test carbon monoxide (CO) level and discuss result ■ Discuss patient's smokefree goal/plan ■ Provide brief motivational intervention (as appropriate)
	Trust inpatient Tobacco Dependence Team (Typically weekly and more frequently if needed)	**Follow-up consultations (whilst in hospital)** ■ Assess treatment response ■ Ensure correct use of vape/NRT ■ Repeat CO test and provide feedback ■ Review and revise treatment plan ■ Consider use of nicotine analogue medications where appropriate ■ Provide behavioural support
	Trust inpatient Tobacco Dependence Team	**Discharge planning and referral to community support** ■ Provide referral for ongoing support and to continue 12-week course of vape/NRT/nicotine analogue medication ■ On discharge, provide supply of combination NRT/other aids (minimum recommended supply is two weeks) ■ Ensure tobacco treatment plan is included in discharge summary and incorporates: behavioural support provided, treatment provided and details of referral to community stop smoking support
Post-Discharge Care Bundle	**Trust inpatient Tobacco Dependence Team or Community Stop Smoking Service (Transfer of Care)** (Target for completion: four weeks post-discharge)	**7 – 14 day post-discharge telephone contact** ■ Check smoking status, ongoing use of tobacco dependence treatment aids, check engagement with community-based tobacco dependence support, liaise with community support if appropriate. **Four week follow-up contact and outcome assessment** ■ Document smoking status, ongoing use of tobacco dependence treatment aids, check engagement with community-based tobacco dependence support, liaise with community support if appropriate.

1.7 Working with the patient's multi-professional care team

It is critical to have a trust-wide commitment to tobacco dependence treatment and a consistent approach among all members of the patient's care team, including psychiatrists, nurses, pharmacists, occupational therapists, psychologists, social workers, other allied health professionals and TDAs. Consistent, positive, and compassionate messages from healthcare staff across all contact points are invaluable.

Early and effective management of withdrawal symptoms is best practice and can play a key role in the patient's ability to remain smokefree at the point of admission, during their inpatient stay and beyond.

TDAs have a vital role to play in working with the patient's care team, family, and significant others. This includes regular communication about the patient's smoking and vaping status and response to treatment. TDAs are also ideally placed to reinforce and expand skills of frontline staff who are responsible for the Point of Admission Care Bundle, gaining confidence in initiating the rapid NRT protocol and initiating referrals to the Tobacco Dependence Team.

1.8 Working with Child and Adolescent Mental Health Services (CAMHS)

There is a higher prevalence of tobacco use among young people who use CAMHS. Admission to a smokefree hospital is a golden opportunity to intervene, with the potential to yield health and social gains. More than two thirds of people who try just one cigarette may go on to smoke regularly.[21] The younger a person starts smoking, the greater the likelihood of subsequent harm. Early uptake is associated with heavier smoking, higher levels of dependency, a lower chance of quitting and higher mortality.[22]

For CAMHS, the focus should be to prevent uptake of smoking, de-normalise tobacco use and support those who have started to stop.

Recommended best practice in CAMHS involves:

- early identification of tobacco dependence
- effective management of withdrawal symptoms (using NRT for those over 12 years of age)
- behavioural support to remain smokefree during their inpatient stay

NRT

NRT can be used by young people over the age of 12 to assist with management of withdrawal symptoms and support stopping. When compared to adults, pharmacotherapy has not shown to be as effective and behavioural support appears to play a larger role. Nevertheless, NRT remains a useful treatment for young people with moderate to high levels of dependence who may benefit from the relief from withdrawal symptoms it provides.

Vaping

It is likely that some young people admitted to CAMHS will be vaping. Whilst vaping is significantly less harmful than smoking, vapes are not recommended for use by people under the age of 18, or anyone who has never smoked, as vaping is not harmless. Vapes and vaping products which contain nicotine are age-restricted and should not be sold to, or bought for, under 18s. Therefore, vape use cannot be supported in CAMHS.

If a young person is admitted to CAMHS as a vaper, what can you do?

- Explain why vaping cannot be permitted in the hospital
- Support the young person to switch to NRT, if required, following assessment of need/risk
- Refer to the on-site TDA for behavioural support

Adults who live with young people

Children whose caregivers smoke are four times more likely to take up smoking themselves. Therefore, CAMHS have an important role to play regarding identification of people who smoke in the homes of young people, providing brief advice and signposting to local stop smoking support.

Advice for adults who smoke who live with young people: What can you say?

"Did you know that children who grow up in a home where their caregiver smokes are four times more likely to smoke themselves when they grow up?"

"The best way to stop is by using approved stop smoking aids together with support from a trained professional. This support is available free of charge. I will get the contact details and you can get in touch to find out how they can help."

> Signpost to Local Stop Smoking Service

2.0 The Essentials

A shared promise: We will never again refer to smoking as a 'lifestyle choice', 'bad habit' or 'personal freedom'.

Tobacco dependence is a **chronic relapsing clinical condition** for which we have **effective treatments.**

2.1 Tobacco dependence

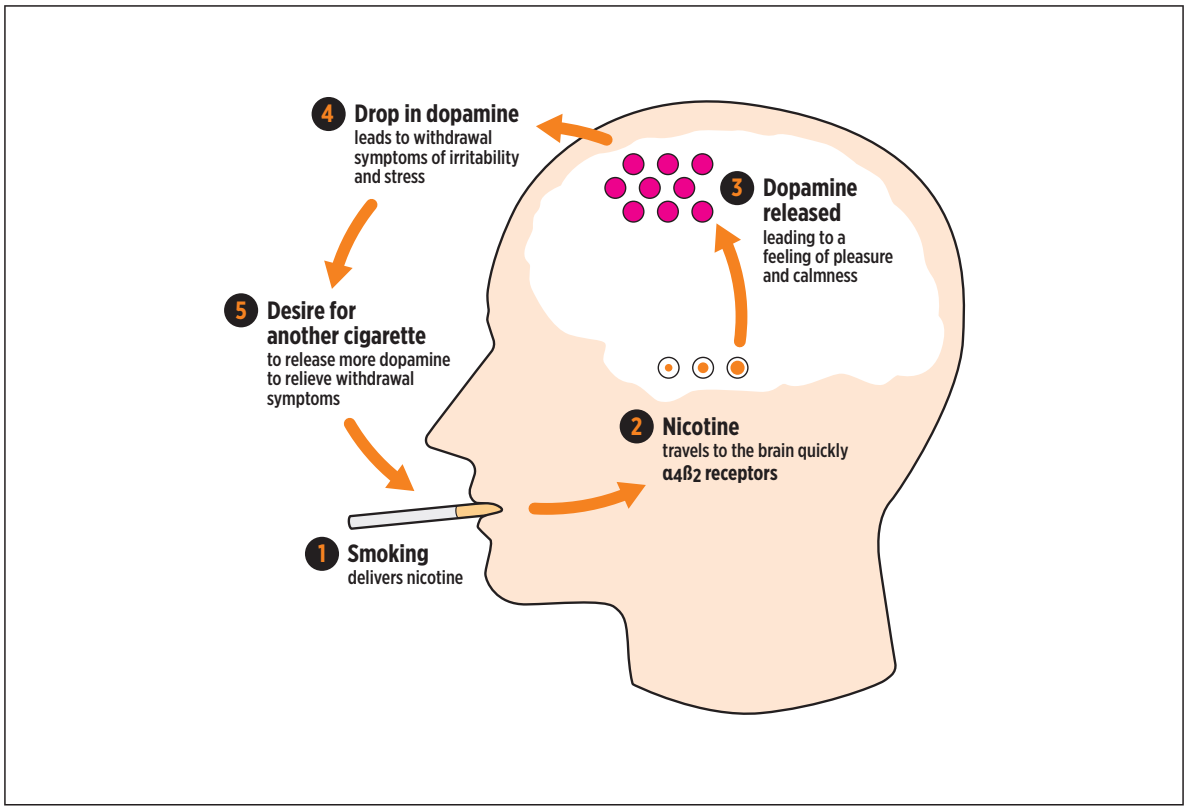
Why is it so difficult to stop smoking? Most people who smoke are dependent on tobacco. Having a good understanding of tobacco dependence is helpful when treating a patient and can assist practitioners in preparing for the challenges patients face.

Nicotine delivered by cigarette smoke is highly addictive and responsible for keeping people smoking.[21] However, it is not the cause of smoking-related illnesses such as cancer or lung diseases. The negative health effects of smoking instead come from the other parts of the tobacco plant and the chemicals that are produced during combustion of tobacco, including tar, carbon monoxide and carcinogens. There are over 5,000 hazardous chemicals and carcinogens in cigarette smoke that, when inhaled, lead to the diseases caused by smoking.

When a person inhales smoke from a cigarette, nicotine is rapidly delivered to the addiction centres of the brain. Nicotine creates positive feelings in the brain but results in dependence, meaning the absence of nicotine can lead to unpleasant withdrawal symptoms and urges to smoke (see **Figure 2**). When an individual smokes again, the cigarette relieves these withdrawal symptoms.

Nicotine delivered in cigarette smoke is particularly addictive because inhaled nicotine is delivered quickly to the brain. The speed of nicotine delivery is one of the key factors that leads to tobacco dependence. By comparison, NRT deliverers nicotine much more slowly to the addiction centres of the brain (over minutes rather than seconds) and as such has a very low risk of being addictive.

Figure 2: Tobacco dependence cycle



2.1.1 Withdrawal symptoms and urges to smoke

When someone stops smoking, they are likely to experience withdrawal symptoms and urges to smoke. These are the primary reasons individuals find it difficult to stop smoking in the early period after stopping. The severity of withdrawal symptoms and urges to smoke differ from person to person and from moment to moment, but they are known to be more severe in those who are more dependent on smoking and people with certain types of mental illness. They are at their most severe in the first few weeks of abstinence and most will typically subside within four weeks of stopping completely. However, the urge to smoke may persist long-term for some people, depending on the smoking cues they are exposed to and the availability of tobacco.

Withdrawal symptoms can have a rapid onset. At the point of admission, many patients may already be experiencing the effects of tobacco withdrawal if not treated promptly. The speed of onset can vary from person to person, but they typically begin to occur between 20 minutes to a few hours after the last cigarette.

Table 2 summarises the most common nicotine withdrawal symptoms. **Duration** is the average time people typically experience this side effect after they stop smoking. **Prevalence** indicates the percentage of people who stop smoking who experience this symptom. See **Appendix 1** for further information

Table 2: Nicotine withdrawal symptoms

Nicotine withdrawal symptoms	Duration	Prevalence
Urges to smoke	> 10 weeks	70%
Increased appetite	> 10 weeks	70%
Depression	< 4 weeks	60%
Restlessness	< 4 weeks	60%
Poor concentration	< 2 weeks	60%
Irritability / aggression	< 4 weeks	50%
Mouth ulcers	> 4 weeks	40%
Night-time awakenings	< 1 week	25%
Constipation	> 4 weeks	17%
Light-headedness	< 48 hours	10%

2.1.2 Presentation of withdrawal symptoms in people with mental illness

Compared to people in the general population who smoke, **patients with mental illness experience more severe symptoms of tobacco withdrawal.** This is in part due to the higher rates of dependence but can also be related to some psychiatric conditions. This is particularly true among people with schizophrenia, with research showing higher levels of nicotine, in addition to more pronounced withdrawal symptoms and urges to smoke, within this patient group.[23–26]

Furthermore, nicotine withdrawal can also mimic or exacerbate symptoms of mental illness and it is not uncommon for symptoms of untreated nicotine withdrawal to be confused with symptoms of mental illness.

It is therefore vital to mental health recovery that we ensure patients in inpatient mental health hospitals who smoke receive treatment with recommended tobacco dependence aids early in the admission process.

2.1.3 Effective management of withdrawal symptoms in the inpatient setting

Recognising, preventing and managing nicotine withdrawal among hospitalised patients who smoke should be a priority in all inpatient settings. Identifying the smoking status of all patients at the point of admission, followed by immediate management of acute nicotine withdrawal and urges to smoke, is essential.

To effectively treat withdrawal, nicotine vapes (for adults only, if risk assessment allows) or combination NRT should be initiated as soon as possible following admission, ideally within 30 minutes but always within two hours.

Withdrawal symptoms, including irritability, agitation and low mood, can affect the care of the patient and are commonly not recognised as being associated with tobacco withdrawal. Early and effective management of tobacco withdrawal and urges to smoke will increase the patient's confidence in their ability to stop smoking or abstain from smoking.

Patients will feel much less agitated and irritable if tobacco withdrawal is addressed and managed quickly, thus enabling effective treatment of tobacco dependence and improved overall patient care.

2.1.4 Smoking routines and triggers

In addition to being addictive, tobacco smoking is often integral to individuals' daily routines, social situations and relationships, and this further reinforces tobacco dependence. Smoking can often be perceived as a method of coping with stress or as a way of managing symptoms of mental illness.

In addition to addressing the tobacco dependence, support is necessary to change daily routines and behaviours that involve smoking. This is why creating a completely smokefree space in the hospital environment (both buildings and grounds) is so important because effective treatment of tobacco dependence is not just about providing access to 'clean' nicotine, but also about supporting individuals to establish new healthy routines and habits.

2.2 Tobacco dependence treatment

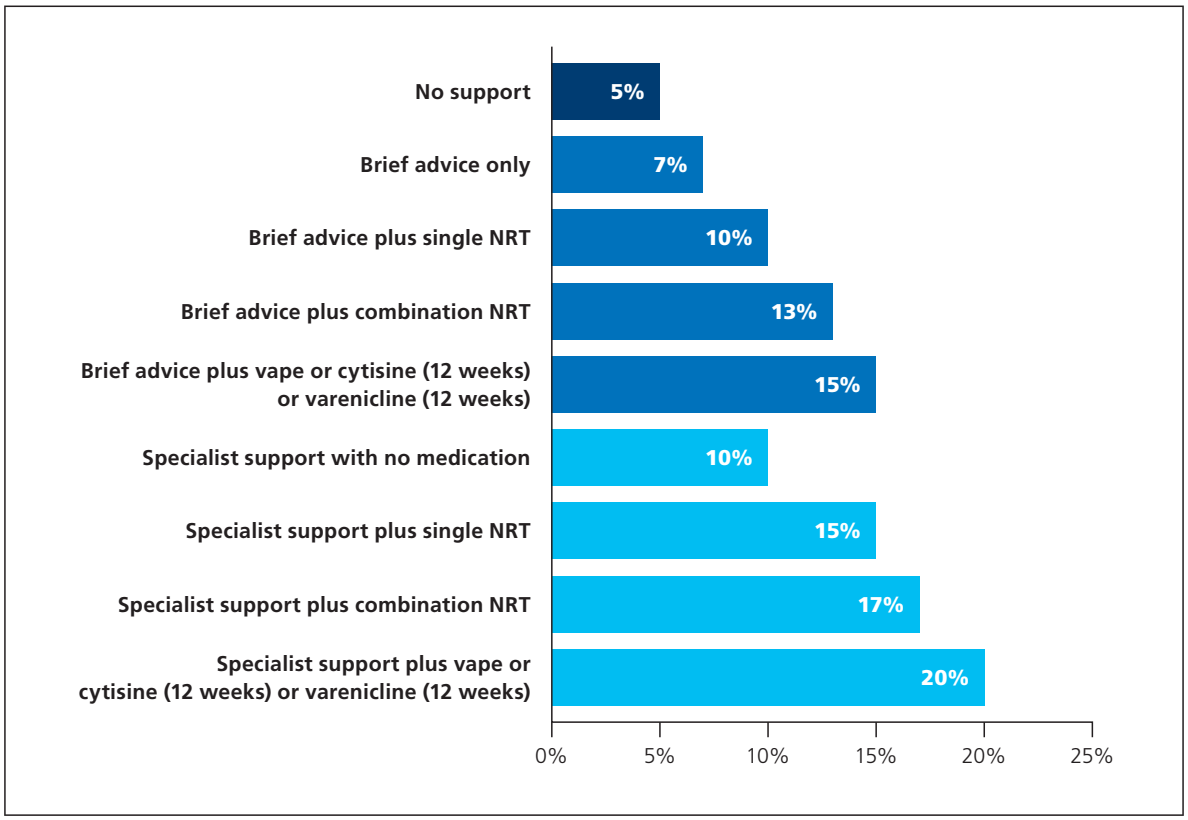
Contrary to common perception, people with mental illness who smoke are equally motivated to stop smoking as the general population, but are less confident about stopping and staying abstinent.[27] It is important to note that it is normal to be ambivalent about stopping and motivation to stop fluctuates – this happens to people with and without mental illness who embark on changing a behaviour. Treatments that work for people from the general population also work for those with mental illness, including SMI.[28–30]

People who smoke with mental illness can stop smoking, and they are more likely to stop successfully if they receive the appropriate support.[29,30] The most effective method of treating tobacco dependence is with nicotine vapes, combination NRT, or nicotine analogue medication, alongside behavioural support delivered by a trained adviser.

There is strong evidence that the combination of behavioural support and tobacco dependence aids is more effective than either alone (see **Figure 3**).[31,32] To give patients who smoke the best chance of achieving a goal of long-term abstinence, all individuals should be supported to use both behavioural support and a first-line tobacco dependence aid.

Support with temporary abstinence and treatment of acute withdrawal from smoking is recommended for all patients who smoke, even if they are not planning to stop smoking long-term.

Figure 3: Rates of smoking abstinence by treatment[32]



2.3 Behaviour change techniques

Behavioural interventions focus on the patient's thoughts, feelings, knowledge and actions relating to tobacco dependence. This includes: boosting confidence and motivation to stop, enhancing self-regulation, advising on use of and enhancing adherence to tobacco dependence aids, and improving the ability to cope with withdrawal symptoms, urges to smoke and high-risk situations that could undermine abstinence.

Evidence-based behaviour change techniques (BCTs) increase success rates and should be the focus of support provided.[33–35] The BCTs that have been shown to be the most important are:

- Establishing good rapport
- Increasing patient motivation and confidence in their ability to remain smokefree
- Making sure the patient has a realistic expectation of tobacco dependence medications and aids, uses these properly and is aware of any potential side effects
- Making sure the patient knows what to expect in terms of cravings and withdrawal symptoms
- Identifying barriers, smoking cues and triggers, and strategies to address these
- Using carbon monoxide testing as a motivational tool
- Stressing the importance of total abstinence as the ultimate goal, with options such as cutting down then stopping being available
- Prompting commitment from the patient to a treatment plan
- Supporting the patient to develop their identity as a person who does not smoke (i.e. non-smoker)

Effective communication and rapport building skills are key to forming a successful therapeutic relationship to help treat the patient's tobacco dependence.

2.4 Carbon monoxide testing

Carbon monoxide (CO) testing is a valuable tool for providing evidence of the risks to health that smoking poses. The test can detect exposure to tobacco smoke within the previous 24–48 hours and therefore helps patients understand the immediate benefits of stopping. The personalised nature of the test can be a great tool for engaging patients in treatment and providing positive reinforcement.

NICE recommends that exhaled CO levels be measured during each contact and these measurements used to provide feedback on progress and motivate patients to stop smoking.[36]

CO test results should be recorded in the patient's records in a way that allows changes to be observed over time, in the same way we record blood sugar levels, weight or blood pressure. This allows us, together with the patient, to reflect on patterns, identify challenging times and adjust the care plan to provide extra support when needed. See **Appendices 10 and 11** for more information on CO testing.

2.5 Tobacco dependence aids

Tobacco dependence (or stop smoking) aids are a fundamental element of providing evidence-based tobacco dependence treatment and can double or triple the chance of long-term abstinence.[32,36] Clinicians should encourage all patients, including those not intending to stop smoking long-term, to use effective tobacco dependence aids, except where contraindicated, to support a smokefree admission and potential long-term abstinence.

There are three recommended first-line tobacco dependence aids which have been shown to increase long-term success with smoking abstinence.[32,36] They are:

- **Nicotine vapes**
- **Combination nicotine replacement therapy (NRT)**
- **Nicotine analogue medications (varenicline, cytisine)**

All first-line tobacco dependence aids, including varenicline, can be used among patients with a mental illness, including SMI. Because of the greater severity of tobacco dependence among people with mental illness who smoke, they may need to:

- be given higher doses of NRT or nicotine vapes
- use vapes in combination with the nicotine patch
- be prescribed a nicotine analogue medication
- use these treatments for a longer period

2.5.1 Nicotine vapes (electronic cigarettes)

Vapes (also known as electronic cigarettes or e-cigarettes) deliver an inhalable aerosol vapour to the user via a mouthpiece. There is no tobacco and no combustion involved in vaping and as such the vapour does not contain carbon monoxide and other dangerous chemicals associated with tobacco combustion.[37] Nicotine vapes are recommended as **a first-line tobacco dependence aid for adults**.[36] Nicotine vapes assist with managing withdrawal and urges to smoke by providing doses of nicotine.

Clinical experience suggests that, among people with mental illness, vaping is more acceptable compared to NRT, with greater compliance among patients and higher rates of stopping. High-quality randomised controlled trials have found nicotine vapes to be an effective aid to stop smoking and are almost twice as effective as NRT.[32,37,38] Vapes can deliver nicotine more rapidly than fast-acting NRT products. The frequent use of nicotine containing vapes has been shown to be associated with greater success with stopping smoking.

There are a variety of nicotine vapes on the market. See **Appendix 4** for further information.

While vaping is not risk-free for people who have never smoked, the latest review of evidence concludes that vaping is significantly less harmful than smoking, posing a small fraction of the risks of smoking.[37]

In the UK, vapes are regulated under the Tobacco Products Directive. Importantly, UK regulations have, since 2016, prohibited the use of ingredients in nicotine-containing e-liquid that pose a risk to human health in heated or unheated form.

People who smoke cigarettes and vape (known as dual users) should be advised to switch completely to vaping.[37] People who have never smoked should not start vaping. It is important to note that it is illegal to supply nicotine vapes (or tobacco cigarettes) to people under the age of 18.

If newly admitted patients are established vapers, every effort should be made to ensure they are supported to continue using the vape of their choice.

The initial nicotine e-liquid dose should be selected based on the patient's level of tobacco dependence, in the same way we would with NRT. The initial dose for most patients who smoke regularly will be 18mg/ml or 20mg/ml. Patients who smoke heavily are likely to require two e-liquids daily and/or combination treatment with the NRT patch and a nicotine vape. See **Appendix 8** for more detailed dosing guidance.

It is best practice that mental health hospitals provide free vapes as a treatment option for adults, once a risk assessment has been completed (see **Appendix 7**). Mental health hospitals should have systems in place for the safe disposal of vapes. They should also ensure vapes are available for sale in hospital shops, where available.

Did you know?

The use of vapes as a tobacco dependence aid has been endorsed by leading health organisations, including the Royal College of Psychiatrists (RCPsych), the National Institute for Health and Care Excellence (NICE), the NCSCT, the British Medical Association (BMA), the Royal College of Nursing (RCN), the Royal College of General Practitioners (RCGP) and the Royal College of Physicians (RCP).

2.5.2 Combination NRT

NRT reduces withdrawal symptoms and urges to smoke. NRT provides a clean, therapeutic form of nicotine. It is **licensed and safe** to use by most people (12 years or older) and any side effects are usually mild.

Combination NRT (nicotine patch plus a fast-acting NRT product) is a first-line tobacco dependence treatment. Combination NRT gives superior relief of withdrawal symptoms and urges to smoke and increases long-term rates of smoking abstinence compared to single NRT.[32,36,39] Specifically, the patch provides a steady supply of nicotine throughout the day (helping with withdrawal symptoms and background urges to smoke) and the fast-acting NRT products can be used by patients in response to 'breakthrough' urges to smoke. NRT is well tolerated, with most side effects being mild and often the result of incorrect use (see **Appendix 3**).

NRT is typically used for eight to 12 weeks, when risk of relapse is at its highest; however, many patients with mental illness will benefit from extended use. See **Appendix 5** for further information on NRT.

Further information on combination NRT can be found here:
www.ncsct.co.uk/publications/combination_nrt_briefing

2.5.3 Nicotine analogue medications

Nicotine analogues are medications in tablet form that mimic the effects of nicotine in the brain centres. They do not contain nicotine but assist with reducing withdrawal symptoms and cravings to smoke as well as satisfaction from smoking. There are two nicotine analogues available: varenicline and cytisine.

Varenicline

Varenicline is not currently available in the UK.

Varenicline is a first-line tobacco dependence treatment that is twice as effective as single form NRT, and slightly more effective than combination NRT.[32,36,40] Varenicline is a prescription-only medicine. Varenicline reduces tobacco withdrawal symptoms and urges to smoke and blocks some of the rewarding effects of smoking.

Nausea is the most common side effect, occurring in 30% of users, with severe nausea in 3% of users. Vivid dreams are also a common side effect. Both nausea and vivid dreams typically resolve with continued use and small modifications to the way the medication is taken. See **Appendix 3** for a summary of these strategies. Large high-quality studies have found no statistically significant difference between people with and without mental health conditions taking varenicline and "neuropsychiatric adverse events" or suicidal ideation.[40–42]

Typically, patients who use varenicline are advised to continue with their usual smoking pattern for the first seven days of treatment. Since this is not possible in the smokefree hospital setting, it is recommended that patients use NRT during the first week of treatment whilst the varenicline is reaching full therapeutic level.

Varenicline is usually taken for 12 weeks. It has been shown to be safe and effective to extend treatment to 26 or 52 weeks in patients who may benefit. See **Appendix 6** for further information.

Cytisine

Cytisine is a natural plant alkaloid that comes in the form of a tablet. Like varenicline, cytisine acts to reduce withdrawal symptoms and cravings by stimulating nicotine receptors. It also reduces the reward and satisfaction associated with smoking. Cytisine is available as a prescription-only medication in the UK. A course of cytisine treatment is 25 days. When patients start taking cytisine in hospital, they should be given the remaining tablets in the pack at the point of discharge to ensure there is no interruption in the treatment.

Typically, patients who use cytisine are advised to stop smoking on the fifth day of treatment. Since this is not possible in the smokefree hospital setting, it is recommended that patients use NRT during the first five days of treatment whilst the cytisine is reaching full therapeutic level.

While there are a relatively small number of studies evaluating cytisine as a tobacco dependence aid, results have been promising and demonstrate effectiveness in increasing rates of smoking abstinence.[32] Cytisine has been shown to be significantly more effective than both placebo and single-form NRT in supporting smoking abstinence at six months.[32] The data comparing cytisine to varenicline suggests that it may not work quite as well as varenicline.[32] See **Appendix 6** for further information.

2.5.4 Additional considerations

Ensuring sufficient dose of replacement nicotine

It is important that a sufficient dose of nicotine is provided to patients to effectively prevent and treat symptoms of nicotine withdrawal and urges to smoke. One of the most common reasons for poor treatment response is the underdosing of replacement nicotine.

People who smoke who are more dependent on tobacco generally benefit from higher doses of NRT or nicotine vape, or the use of a nicotine analogue, to effectively manage withdrawal symptoms and urges to smoke.[43–48] Some heavily dependent patients will benefit from using both a nicotine vape and NRT patch concurrently.

It can be anticipated that people with mental illness who smoke more heavily may require higher doses of tobacco dependence aids. This is particularly true among people with schizophrenia or schizoaffective disorder who have been shown to have greater dependence, and more frequent and severe withdrawal symptoms and urges to smoke.[23–26] Research has shown that people with schizophrenia or schizoaffective disorder have higher nicotine levels per cigarette smoked, suggesting they extract more nicotine per cigarette.[23–26]

Patient response can be used to guide treatment. Further information on adjusting the doses of tobacco dependence aids for people who are more dependent is provided in the treatment bundles.

Appendix 7 provides guidelines for initial dosing of nicotine vapes and combination NRT for patients treated in mental health hospitals. **Appendix 8** provides guidelines for reducing the NRT dose.

Extended use of tobacco dependence aids

Some patients may benefit from the use of tobacco dependence aids for extended periods of time – even years. This is safe practice and recommended if there is a risk of relapse to smoking.[36,39] Extending use of tobacco dependence aids is recommended by NICE as a relapse prevention strategy.[36] Extended use of pharmacotherapy can be particularly useful in reducing rates of relapse among patients with mental illness.[28,36]

Combining first-line tobacco dependence aids

First-line tobacco dependence aids can be combined. Combining drugs with different mechanisms of action, such as varenicline and NRT, has increased rates of long-term smoking abstinence in some studies compared with use of a single product.[49]

Treatment of tobacco dependence in the inpatient setting provides a unique opportunity to use combination treatment. This is because all patients will be offered nicotine vapes or NRT upon admission, with the opportunity for a second treatment (e.g. nicotine analogues) to be added for patients who would benefit. In mental health services it is common practice to combine NRT patches with nicotine vapes.

The combination of varenicline and NRT has the strongest evidence of increased rates of smoking abstinence and as such may be the first choice for combination therapies.[49–55] The combination of varenicline and NRT has been used by people who are more dependent on tobacco, particularly those who continue to experience urges to smoke and/or withdrawal symptoms, and those who have reduced their cigarette consumption but not stopped completely when using a single product.

2.6 Considerations for people with mental illness

While we know that individuals with mental illness can successfully stop or reduce their smoking, we also know that they experience more challenges when stopping compared with the general population. We need to be aware of these challenges and how to adapt tobacco dependence treatment to facilitate stopping. These challenges include:

- **Greater tobacco dependence:** people with mental illness often smoke significantly more cigarettes per day and are more dependent on tobacco. The more severe the mental illness, the more the person smokes.
- **Perceived benefits:** People with mental illness and clinicians often wrongly believe that smoking is benefiting their mental health by, for example, helping them manage stress or anxiety and negative symptoms of mental illness.
- **Boredom:** people with mental illness may be socially isolated, unemployed and experience loneliness. It is not uncommon for patients to report an increase in their smoking during their stay in a mental health hospital as there are a lack of meaningful activities to engage with and because smoking breaks are typically part of the daily routine.
- **Socialising:** People with mental illness often have many peers who smoke within their social network and, as such, smoking can be triggered when spending time with them. Having alternative activities and ways of socialising that don't involve smoking is important, both while admitted to a mental health hospital and in the community.
- **Staff attitude and lack of training:** In the past, staff working in mental health hospitals had low expectations for patients in their care to successfully stop and they rarely offered tobacco dependence treatments. Furthermore, education and training for staff on the best way to treat tobacco dependence was not widely available.
- **Mental health hospital culture:** Traditionally, patients have been helped to smoke during hospital admissions. Established routines which involved storage of tobacco materials, facilitation of escorted smoking breaks and failure to provide sufficient meaningful alternatives to smoking resulted in people using these services to start smoking or smoking more during a hospital stay, rather than getting support to stop or reduce their smoking.

2.7 Psychotropic medications affected by smoking

Changes to smoking routine can influence the metabolism of some medications, both physical and psychotropic. **This is irrespective of the tobacco dependence aid used.**

Most interactions are not clinically significant but there are a few exceptions, including antipsychotic medications, in particular clozapine and olanzapine.

At the point of admission, a patient's medication should be reviewed. For patients identified as prescribed clozapine, olanzapine, or other medicines where metabolism is significantly affected by smoking, the clinical team should consider dose adjustment. **Clinicians are advised to follow local trust protocols or other evidence-based published guidelines such as the Maudsley Prescribing Guidelines.**[56] Always seek support from the local pharmacy team.

Refer to **Appendices 12 and 13** for further guidance and for medication management of smoking and other psychotropic medicines.

2.7.1 Clozapine

Clozapine is an effective but potentially toxic drug and has a **clinically significant interaction with tobacco smoking** (from the tar in tobacco smoke, **not** the nicotine).

It is a particular concern because, when a patient stops or reduces their smoking, the metabolism of clozapine slows down and, in some people, the blood levels of clozapine **can almost double within about a week. This can lead to serious symptoms and, in very rare events, death from a seizure.**

Because of this we must give particular attention to clozapine and getting the dosage right when we support patients who have stopped smoking, are temporarily abstaining, or reducing the amount they smoke whilst in hospital.

Patients taking clozapine should have the daily dose reduced by 25% in the first week after stopping, with subsequent reductions as needed.[56] Plasma level reduction may be greater in people who are also taking valproate. Blood plasma levels should be taken before and after to guide further dose reductions. Doses will need to be adjusted again should the patient return to smoking. The specialist TDA and the patient's prescriber should assess whether dose reduction is needed for short lengths of stay where the patient does not intend to remain smokefree long-term.

Trusts will have a clozapine management protocol in place. This typically includes:[50]

- taking clozapine plasma trough levels on admission to a smokefree hospital
- immediate stepwise reduction of clozapine after stopping smoking of about 10% daily for four days
- repeating plasma level one week after stopping smoking
- using blood levels to guide the ongoing dosing of clozapine
- blood and clinical monitoring for up to six months

Should smoking resume, the plasma trough level should be retaken and clozapine increased to the previous dose over a period of one week, and then the plasma trough level repeated.

2.7.2 Olanzapine

Olanzapine is another medication with a known **significant clinical interaction** with smoking. **On stopping smoking, the dose may need to be reduced by 25%**.[56] Be alert for increased adverse effects of olanzapine such as dizziness, sedation and hypotension. If adverse effects occur, further reduction in dose may be required. If the patient begins smoking again, the dose should be increased to the previous dose over a period of one week.

2.8 Storage of tobacco

In addition to removing smoking triggers (e.g. the smell of smoke, ashtrays, smoking shelters, the presence of discarded tobacco waste), it is now recommended best practice that smokefree hospitals do not facilitate storage of tobacco products. This is so that it becomes harder for patients to smoke, easier to comply with the smokefree policy, engage with tobacco dependence treatments and successfully quit.

Updated Care Quality Commission guidance for inspectors states that smokefree policies, including bans on tobacco smoking, should not be considered an unwarranted 'blanket restriction'.[57]

Reasonable efforts must be made to ensure patients are advised about the smokefree policy prior to admission. Patients who arrive to hospital with tobacco materials should be supported to return these items to their home/family for safekeeping. Patients who breach the policy by continuing to bring tobacco materials into the hospital during their admission should be supported to understand the policy and know that continued failure to comply may result in confiscation or destruction of those tobacco materials. By assisting patients with a smokefree admission, we are supporting their recovery.

2.9 Facilitating leave

It is recommended that TDAs and members of the care team work with patients to develop a collaborative plan for smokefree leave. Some patients may need assistance to explore and engage in alternative activities. They may also need support to establish new routines and find ways to manage their finances.

According to the Mental Health Act Code of Practice (2015), detained patients may have leave for specific occasions or for specific or indefinite periods of time. Leave is subject to conditions which the team consider necessary in the interests of patient safety or for the protection of others.

We know that, for people who smoke, being granted leave after a period in a smokefree hospital is a high-risk time for relapse back to smoking. It is vital that we strengthen the support at this time and discuss and agree how to manage this risk with the patient. By getting their full involvement in developing a smokefree leave plan, we can increase the chance of success.

It is sometimes the case that patients need help to think of alternative activities to do instead of smoking. We can say ***"another patient in a similar situation to you started to use leave to go to the outdoor gym / to go to the computer café / to walk in the park / to do some food shopping."***

Helping patients to recognise health gains achieved following a smokefree period can have a powerful impact on building their confidence and ability to remain smokefree outside of the ward. One way to achieve this is to regularly conduct CO tests, as this can help patients see the health improvements they have achieved.

2.10 Culture transformation

A culture of smoking by patients and staff in mental health hospitals has been embedded in the fabric of the NHS. Cigarettes have been used as a currency between patients and to manage patient behaviour by staff. A faulty set of assumptions about smoking among people with mental illness coupled with poor knowledge and skills about tobacco dependence treatment among staff contributed to a stalemate. Furthermore, evidence-based tobacco dependence treatments were not available in mental health hospitals.

This culture is somewhat responsible for perpetuating the detrimental physical, mental, social and economic impacts experienced by people who smoke and received care within mental health hospitals. It was not unusual for a patient to be admitted to a mental health hospital not smoking and be discharged smoking 20 cigarettes per day. In the past the belief that smoking was a 'lifestyle choice' or a 'bad habit' allowed staff to make it easy for patients to smoke, rather than easy to stop. This culture, which ignored the realities about the harmful impact of smoking on health, still persists in many areas.

Since 2018, mental health hospitals have been expected to have smokefree policies. There are three things that make a hospital smokefree:

- Every frontline professional discusses smoking with their patients.
- Smoking cessation support offered onsite or through referral to local services.
- No smoking anywhere in buildings or grounds.

Although considerable progress has been made, many issues remain unresolved for genuine smokefree policies in mental health hospitals to be realised.

The context into which we now implement smokefree policies must be understood if we are to enable these policies and TDAs to flourish. TDAs are likely to face challenging conversations about patient rights, choice and restrictive practice. Improvements require change, which inevitably creates varying degrees of anxiety and resistance. To prepare for this, TDAs need to generate enthusiasm among colleagues and seek to win over those opposed to the change.

Listening with empathy to staff and patient feedback, and collecting and reflecting on their opinions after implementing the policy, is important to foster ownership and engagement. However, no staff should face aggressive behaviour or abuse whilst undertaking their duties. TDAs and other staff should refer to local bullying and harassment policies, as well as 'Freedom to Speak Up' ambassadors and their line manager or supervisor for support.

Smokefree policies require significant shifts in culture. If new ways of working are to be embedded, it is vital to be clear about the new standards, regularly check they are being achieved and shine a light on success. When staff are recognised for their work, they will be more likely to repeat this. Competition between teams and services can help raise standards too. TDAs who work closely with quality improvement teams have extra support for facilitating change in practice.

Best practices for treating tobacco dependence in mental health hospitals	
1. Ensure hospital environments (buildings and grounds) are completely smokefree because removal of cues to smoke makes it easier for people to stop.	☐
2. Where possible, inform patients prior to admission about the smokefree policy and prepare a collaborative advance directive to outline how the patient would like their tobacco dependence needs to be met.	☐
3. Do not assist smoking by providing safe storage spaces for tobacco materials. If patients bring tobacco materials to hospital, these materials should be sent home. If patients continue to bring tobacco materials to smokefree hospitals, they should be advised these items may be destroyed.	☐
4. Do not facilitate leave from the hospital for smoking breaks, as this will undermine the patient's recovery.	☐
5. Identify tobacco use on arrival at hospital, ideally within 30 minutes.	☐
6. Identify vape use on admission and provide support to maintain vaping during admission where applicable, as this will reduce. the risk of relapse back to smoking.	☐
7. Conduct carbon monoxide testing at admission and then weekly during the admission.	☐
8. Record tobacco dependence in the admission diagnosis list of patient's medical record.	☐
9. Conduct medications review and adjust dose of medications with clinically significant interactions with smoke as per practice guidelines.	☐
10. Provide brief advice, whereby the patient is advised how to stop, rather than asked if they want to stop.	☐
11. Provide nicotine replacement (nicotine vapes/licensed NRT) at an appropriate dose to effectively manage withdrawal symptoms within 30 minutes of admission.	☐
12. Refer all patients who report current tobacco use (within the last 14 days) to the in-house Tobacco Dependence Team.	☐
13. Provide specialist support during admission, with initial contact ideally within 24 hours and follow-up support, based on patient need, typically weekly. This should include support with temporary abstinence, cutting down, and stopping long-term.	☐
14. Ensure there is an ongoing offer of first-line tobacco dependence aids during admission and upon discharge from hospital (minimum two-week supply).	☐
15. Ensure there is a pre-agreed discharge plan for tobacco dependence treatment following discharge.	☐
16. Provide follow-up support for 4–12 weeks post-discharge, and longer for those at risk of relapse, which includes provision of tobacco dependence aids and behavioural support from a trained adviser.[4]	☐
17. Extended use of tobacco dependence aids to prevent relapse.	☐

2.11 The importance of support following discharge

Tobacco dependence treatment initiated in hospital will be more successful when follow-up support is provided. It is best practice to provide a minimum of one-month post-discharge support and, for people with SMI, follow-up should ideally be for a **minimum of 12 weeks due to the high risk of relapse.** Some patients will need **more intensive and longer support to remain smokefree.**

The **risk of relapse** to smoking **is greatest in the first month after stopping,** when withdrawal symptoms and urges to smoke are at their peak.[58] **The early period post-discharge, when patients return to their regular routines and environments,** can add a further challenge. Stopping smoking is also more difficult for those who are more dependent on tobacco, those with mental ill health, co-addictions and those who live with other people that smoke.

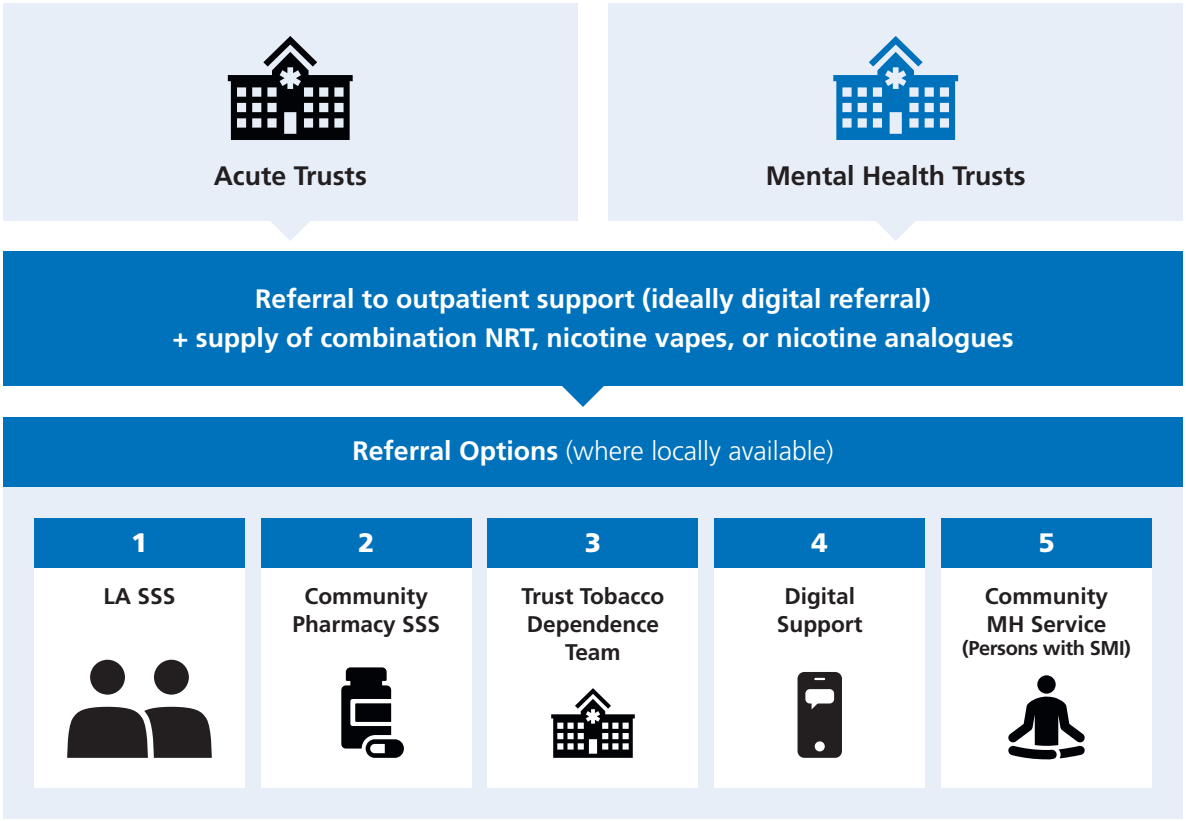
Everyone that stops smoking remains prone to relapse. Once patients are smokefree for two to three months, their risk of relapse is much lower – but by no means gone.

Trained community providers will provide follow-up support to patients following discharge from hospital. The follow-up support available differs across the country and it is important for TDAs to be aware of options available locally and have effective referral pathways and strong working relationships with community providers. **Figure 4** depicts the Transfer of Care to post-discharge follow-up support.

At present there are five options for patients to receive community-based support:

1. **Local Authority Stop Smoking Services (LA SSSs)** – LA SSSs should receive referrals and provide ongoing support post-discharge, including continued behavioural support via telephone or face-to-face contact and continued supply of tobacco dependence aids.
2. **NHS Community Pharmacy Smoking Cessation Service (SCS)** – The NHS Community Pharmacy SCS has been designed to enable NHS trusts to undertake a Transfer of Care upon patient discharge, referring patients, where they consent, to a participating community pharmacy of their choice. Importantly, the service specification for the Community Pharmacy SCS indicates that patients who relapse between weeks 4–12 will not be eligible to continue in the service and may be referred to a LA SSS.
3. **Trust Tobacco Dependence Teams** – Some trusts will have the capacity to offer patients post-discharge support from the trust Tobacco Dependence Team.
4. **Digital support** – Some localities offer digital post-discharge follow-up via a smartphone digital application. Check with your local service providers to find out the options available for patients with mental illness in your community.
5. **Community Mental Health (CMH) Tobacco Dependence Teams** – Some localities will have CMH Tobacco Dependence Teams that have received specialised training and will provide follow-up support to patients with mental illness in the community setting. A national training programme has been developed for CMH TDAs. See NHS Community Mental Health Tobacco Treatment Training Resources (**www.ncsct.co.uk/publications/category/NHSE-training-materials-SMI**)

Figure 4: Inpatient tobacco treatment pathway and referral options (where locally available)



2.12 Common misconceptions

Misconception 1: Stopping smoking may be too stressful and/or destabilise a patient's mental illness

Quitting smoking does not adversely affect mental health. Evaluations of targeted smoking cessation interventions for people who smoke with psychosis indicate patients do not experience a worsening of mental health symptoms.[29] The evidence points instead to tobacco withdrawal as a potential stressor which, like any stressor, **can temporarily exacerbate mental health symptoms if not treated appropriately.**

In the short-term after stopping, the patient may experience depressed/low mood and/or mental health difficulties. However, in the longer-term, evidence shows that people who succeed in stopping experience improved confidence, self-esteem and mood. In fact, stopping smoking has been shown to enhance mental health, including reduction in anxiety and depressive symptoms, and the size of the effect is the equivalent to taking antidepressants.[13–15]

Misconception 2: Smoking helps people cope with stress

Many people report that they smoke because it helps them cope with stress. It is important to recognise that, in fact, smoking does not help relieve stress. We know that, as early as six weeks after stopping, people report significantly less stress and anxiety, and improved mood. This can be one of the many benefits of stopping.[13–15]

Given coping with stress is a commonly reported barrier to stopping, it can be useful to understand why a person who smokes perceives their smoking to help with stress.

When a person smokes, dopamine is released in the brain, producing a relaxing effect. The relief however is temporary and, once the dopamine levels subside, withdrawal symptoms such as irritability, restlessness, low mood and poor concentration will emerge. People who smoke will have the need to smoke again to feel good. This relief of withdrawal symptoms is perceived by the person who smokes as being relaxing or helping to relieve stress.

In short, smoking does not alleviate stress, it alleviates withdrawal symptoms. The only way to break this cycle is to address the dependence on tobacco.

When speaking to a patient you could say:

"Most people who smoke say one of the main reasons they smoke is to help cope with stress. However, we know that people who stop smoking report less stress and improved mood."

"When you smoke, it tops up the level of nicotine in your body and relieves your withdrawal symptoms, making you feel more relaxed… but it's only temporary. Soon after you've finished smoking, your nicotine levels start to fall… leaving you craving another cigarette. When your nicotine levels are low you get withdrawal symptoms, making you feel tense, irritable, anxious… stressed. This is why you may feel like your cigarettes help relax you or calm your nerves. This will happen to you many times throughout the day and the only way to stop this from happening is to stop smoking. It takes a few weeks, but people who stop smoking report being a lot less stressed."

Misconception 3: Smoking is a 'lifestyle choice'

Smoking is not a 'lifestyle choice' or 'bad habit'. It is a powerful addiction and a chronic relapsing clinical condition that frequently starts in childhood. Healthcare professionals and patients benefit from reframing tobacco use as a disease rather than a lifestyle choice.

It is important to treat tobacco dependence as a clinical priority, using the same urgency you would when managing other life-threatening, but treatable, disease (e.g. management of depression, eating disorder, heart disease, COPD, diabetes, hypertension). This includes diagnosis, initiation of treatment and behaviour change support, with regular follow-up and adjustment of the treatment plan, until goals are met.

Misconception 4: Tobacco dependence medications should be used in the same way for all patients

This is false. Patients experience tobacco withdrawal and urges to smoke in different ways. While we may start all patients who report current tobacco use on the rapid NRT protocol, it is best practice to assess patient response and titrate the dose, duration and use of a combination of medications in order to manage the patient's response to treatment. Some patients may benefit from use of tobacco dependence aids for extended periods, even years – this is safe practice and recommended if there is a risk of relapse to smoking.

Misconception 5: Patients become addicted to NRT

It is very uncommon for patients to become addicted to vapes and NRT products. This is because nicotine is more addictive when it is delivered more rapidly to the centres of the brain, as is the case with combustible tobacco. Some patients use NRT products for extended periods and these tend to be individuals who smoked heavily for many years. These individuals are often using a fast-acting NRT product when they have urges to smoke.

It is safe to use NRT products for extended periods (even years) as it delivers a clean therapeutic form of nicotine without the 5,000+ harmful chemicals contained within tobacco smoke and so does not cause smoking-related illness to the individual or those in close proximity. When risk of relapse is low, patients can be supported with discontinuing NRT use. This is generally done slowly (a stepwise reduction) but can also be done in one step if deemed appropriate. See **Appendix 9** for more details.

Misconception 6: It is not safe to smoke while using first-line tobacco dependence medications and aids

All tobacco dependence medications and aids are safe to use while smoking and there is no contraindication. While smoking is not permitted on the grounds of smokefree NHS hospitals, if a patient reports or is observed smoking, they should be supported to continue to use vapes and/ or NRT. The fact that a patient is still smoking suggests the nicotine strength in the vape or NRT product might need to be increased and that additional support is needed.

3.0 The Point of Admission Care Bundle

Brief advice and acute management of nicotine withdrawal

Timeframe: Ideally within 30 minutes of admission but always within two hours of admission
Responsible Team: Admitting Team
Duration: 5–10 minutes

Brief clinical checklist

Done

1 **IDENTIFY current tobacco and vape use (last 14 days)** ☐

- ***"Do you currently smoke or use any other tobacco?"*** **> If yes,** complete checklist; **If no,** record
- ***"Do you currently vape?"*** **> If yes,** support with continued use and record
- **Measure and record carbon monoxide (CO) level** ☐

2 **ADVISE – Provide brief advice on:**

- **Hospital's smokefree policy:** ***"All NHS hospitals including this one are completely smokefree, both in the buildings and on the grounds. This is to protect the health and wellbeing of patients and staff."*** ☐
- **Available treatment and support:** ***"Whilst you are in hospital it is important that we help you manage the withdrawal symptoms and urges to smoke you may experience. We can give you a vape or nicotine replacement therapy that will make it much easier for you to not smoke."*** ☐

3 **TREAT – Initiate rapid treatment protocol with nicotine vape or combination NRT**

- **Complete risk assessment to ascertain if patient can safely use a vape / NRT** ☐
- **Assess tobacco dependence:** ***"On a typical day, how many cigarettes do you smoke?"*** ☐
  See dosing guidelines (on next page).
- **Provide instructions for use of selected vape / NRT products** ☐

  Nicotine vapes > ***"Use the vape regularly throughout the day and when urges to smoke occur. Take slow puffs on the vape to draw the vapour into your mouth and then inhale into your lungs."***

  Combination NRT > ***"Use a new patch every day and use the fast-acting NRT on the hour, every hour and as needed to manage urges to smoke and withdrawal symptoms."***

4 **REFER – Complete referral to the in-house Tobacco Dependence Team** ☐

- **Inform patient:** ***"A member of our Tobacco Dependence Team will come and see you to check how you're doing and provide additional support during your stay in hospital."***

5 **RECORD** tobacco dependence in **admission diagnosis** and treatment details in the **care plan** ☐

Dosing guidelines

Tobacco dependence	Initial dosing guidance
Low level dependence <10 cigarettes per day	■ 3–12 mg/ml **vape**; or ■ **Fast-acting** NRT product; or ■ 10–15 mg NRT **patch**
Moderate level dependence 10–19 cigarettes per day	■ 12–20 mg/ml **vape** (1 daily); or ■ 21 or 25 mg **patch + fast-acting** NRT product
High level dependence 20–29 cigarettes per day	■ 18–20 mg/ml **vape** (1–2 daily); or ■ 18–20 mg/ml **vape** (1 daily) + 21 or 25 mg NRT patch; or ■ 21 or 25 mg NRT **patch + fast-acting** NRT product
Very high level dependence >30 cigarettes per day	■ 18–20 mg/ml **vape** (2–3 daily); or ■ 18–20 mg/ml **vape** (1–2 daily) + 21 mg or 25 mg NRT patch; or ■ 2 x 21 or 25 mg NRT NRT **patch + fast-acting** NRT product

Prior to the consultation

- [ ] Check the patient's record for an advance agreement for tobacco treatment – if you find one, honour it
- [ ] Conduct medications review (See **Appendix 12** for interactions with smoking)

Following the consultation

- [ ] Record tobacco dependence in the admission diagnosis list
- [ ] Record details of treatment in care plan
- [ ] Arrange provision of nicotine vapes or NRT
- [ ] Complete referral to/notify in-house Tobacco Dependence Team using local protocol
- [ ] For patients taking clozapine or olanzapine, or other medication where smoking affects drug metabolism, consult with prescriber on dose adjustment as per local protocol (See **Appendix 12**)
- [ ] Record baseline carbon monoxide (CO) test result

Tips

- Tailor advice according to the patient's mental health status. Using your clinical judgement and the patient's presentation, decide how much detail you should go into regarding the tobacco dependence treatment options. For patients who are too ill, this information can be repeated when appropriate.
- On admission, the patient may be experiencing florid psychotic symptoms which can make them feel unsafe, confused, agitated, anxious and distressed. Feeling agitated and anxious are also symptoms of nicotine withdrawal. Prompt treatment to effectively manage the onset of nicotine withdrawal symptoms and minimise urges to smoke is crucial. Early intervention will help ensure mental health symptoms are better managed and not compounded by nicotine withdrawal.
- Check the patient's record to establish if there is an advance agreement in place which details how the patient would like their tobacco dependence to be managed – if you find one, honour it!
- The patient may be feeling anxious and reluctant or unable to engage in a conversation about their smoking, so your approach is key to providing reassurance. Communicating in a non-judgmental, empathetic manner is important to help patients feel more open and receptive to engage in support.
- Changes in smoking status can affect the metabolism of some medications. This is irrespective of the tobacco dependence medication or aid used. Most interactions are not clinically significant but there are a few exceptions, including antipsychotic medications, in particular clozapine and olanzapine. A medication review is recommended at the time of admission and whenever a patient's smoking status changes. For patients identified as using clozapine or olanzapine, or other medicines affected by smoking, support dose adjustment as per the trust protocol. See **Appendices 12 and 13** for more information.

The section below provides further detail on the admission care bundle.

1 Identify current tobacco and vape use

Ask all patients:

"Do you currently smoke or use any other tobacco?"

"Do you currently vape?"

If the patient reports being smokefree in the last two weeks > Record.

If the patient reports smoking in the last two weeks > Treat by completing the admission care bundle.

If the patient reports vape use > Record and support continued use.

Measure and record carbon monoxide (CO) level at point of admission (See **Box 2**).

2 Provide brief advice and details about available treatment and support

- **Inform the patient about the smokefree policy and the support available to cut down and stop smoking.**

  "All NHS hospitals including this one are completely smokefree, both in the buildings and on the grounds. This is to protect the health and wellbeing of patients and staff."

- **Advise on managing withdrawal symptoms, urges to smoke and the role of treatment.**

  "Whilst you are in hospital it is important that we help you manage the withdrawal symptoms and urges to smoke that you may experience. We can give you a vape or nicotine replacement therapy to make it much easier for you to not smoke."

  See **Box 3** for guidance on addressing patient concerns and providing reassurance.

3 Initiate treatment with a nicotine vape or combination NRT

To effectively treat withdrawal from nicotine, it is of critical importance that nicotine vapes or combination NRT (patch plus a fast-acting NRT product) be initiated as soon as possible following admission, ideally within 30 minutes and always within two hours.

- **Complete a risk assessment** (See **Appendix 7**)

  The risk assessment will be used to ascertain if, based on the available information and current presentation, the patient can safely use a vape or NRT products. Once this is completed the options can be offered, allowing the patient to choose their preferred option.

- **Assess tobacco dependence**

  Two questions are used to estimate the initial dose of nicotine vape or NRT the patient will require to manage nicotine withdrawal symptoms and urges to smoke. These are:

  "On a typical day, how many cigarettes do you smoke?"

  "On a typical day, how soon after waking up do you have your first cigarette of the day?"

  People who smoke within 30 minutes of waking have greater dependence.

- **Initiate rapid vape / NRT treatment protocol**

  Box 4 provides initial treatment guidance for nicotine vapes and/or combination NRT.

  If the patient is unable to provide you with information about their current smoking, but the patient record or an informant (family/escorting staff) indicates the patient currently smokes, treatment, with consent, can be initiated using the rapid vape/NRT protocol. The specialist team can adjust treatment upon further assessment.

- **Provide instructions for product use and support to use the products correctly**

  – Reassure the patient that these products are safe and any side effects are usually mild.

  "Vapes and NRT are a great option for people like you who are in a situation where they cannot smoke. Using either a vape or NRT will ensure any withdrawal symptoms you may get from not smoking are well managed and urges to smoke are reduced."

  – **Review and demonstrate correct use of vape / NRT products.**

  Nicotine vapes (See **Appendix 4** for vaping quick reference sheet).

  "Use the vape regularly throughout the day and when cravings/urges to smoke occur. Take slow puffs on the vape to draw the vapour into your mouth and then inhale into your lungs."

Combination NRT (See **Appendix 5** for NRT quick reference sheet).

- Emphasise the importance of using fast-acting NRT products ***"on the hour, every hour"*** and as needed to manage urges to smoke, in addition to a patch.

"I recommend you start using the NRT patch, which provides a steady level of nicotine throughout the day. I will also provide you with a fast-acting NRT, such as an inhalator or lozenge. These fast-acting NRT products can deliver nicotine quickly and help top up your nicotine throughout the day."

"It's important to use the [fast-acting NRT product, e.g. mouth spray, lozenge] throughout the day, on the hour, every hour before you get urges to smoke. In addition, it can be used when you have urges to smoke. If you are using the NRT correctly and still have urges to smoke, we can increase the dose of the patch or add another type of NRT."

If appropriate, a **nicotine analogue medication** may be considered (see **Appendix 6**).

Patients who do not report current smoking who request use of a vape or NRT

Inpatients who do not report smoking in last two weeks but who request use a vape or NRT during their inpatient admission should be referred to the Tobacco Dependence Team for assessment. These patients (who often used to smoke) may find they have difficulty remaining smokefree during their admission and treatment may be warranted to prevent relapse.

4 Complete referral and inform patient they will be referred to the in-house Tobacco Dependence Team

Advise the patient that:

"A member of our Tobacco Dependence Team will come and see you shortly to check how you're doing and provide additional support for you to stay smokefree during your admission."

Arrange referral to the Tobacco Dependence Team via the local referral pathway.

5 Record tobacco dependence in the admission diagnosis list and disease care plan

Tobacco dependence should be listed within the **admission diagnosis** list and its treatment described within the admission progress notes. The care plan should specifically record the actions that were agreed.

Box 2: Measure CO levels and explain results

Measure and record carbon monoxide (CO) at the point of admission and record in the patient record. Even if members of the admission team do not review results with the patient, having a CO measure at admission allows the Tobacco Dependence Team to have a baseline (admitting CO level) to reference. This can be done alongside all the other vital signs monitoring.

Explain to patients that CO is a toxic gas contained in tobacco smoke and that there is a simple test that can be carried out to determine CO levels:

"Carbon monoxide is a toxic gas inhaled when you smoke a cigarette. This machine measures the amount of carbon monoxide in your lungs."

Carry out the CO test (see **Appendix 10** for instructions).

- **If the reading was below 6 ppm:**

  "This reading is that of someone that no longer smokes and shows you are already benefiting from not smoking. Well done!"

- **If the reading was 6 ppm or above:**

  "The machine is showing a reading of ___ parts per million. The normal range for a person who doesn't smoke is between 1 and 5 ppm and so you can see your reading is (much) higher than the normal (healthy) range. The good news is that if you do not smoke at all you can get this down to the levels of someone who has not smoked."

Box 3: Providing reassurance and addressing patient concerns

The point of admission might not be the best time to explore concerns about being in a smokefree hospital. Use your clinical judgement to decide if you feel it is appropriate to discuss this issue further at this stage or return to it later. When you feel the time is right, here are some ideas about what to say to reassure patients:

"Being in hospital can be a worrying time and we appreciate that not smoking can sometimes be hard, but we will make sure that you receive the best treatment to ease any discomfort."

"By providing effective medication and support during your stay, you should find it much easier to not smoke."

"Withdrawal symptoms are normal – your body is anticipating the nicotine you used to get from your cigarettes. The good news is that this is temporary. Vapes and NRT help make withdrawal symptoms manageable."

"Most people feel concerned about stopping smoking abruptly, is there anything that you are particularly worried about?"

Box 4: Initial nicotine vape and combination NRT treatment guidance

People admitted to mental health hospitals who smoke generally need higher doses of NRT or nicotine vapes. We suggest an initial dose of 2 mg of nicotine from a vape or NRT for each cigarette smoked per day by the patient.

Table 1: Initial vape dosing

Treatment	<10 cigs/day	10–19 cigs/day	20–29 cigs/day	30–39 cigs/day	40+ cigs/day
Vape Single-use vape/pods (per 24hrs): Nicotine strength: % Nicotine:	 **1** **3–12 mg/ml** 0.3% or 1.2%	 **1** **12–20 mg/ml** 1.2% or 2%	 **1–2** **18–20 mg/ml** 1.8% or 2%	 **2–3** **18–20 mg/ml** 1.8% or 2%	 **2–3** **18–20 mg/ml** 1.8% or 2%
Combination treatment with NRT patch **Vape** Single-use vape/pods (per 24hrs): Nicotine strength: % Nicotine: **+** **Nicotine patch**			 **1** **18–20 mg/ml** 1.8% or 2%  **1 x 21/25 mg**	 **1–2** **18–20 mg/ml** 1.8% or 2%  **1 x 21/25 mg**	 **2** **18–20 mg/ml** 1.8% or 2%  **1 x 21/25 mg**

Table 2: Initial combination NRT dosing

Product	<10 cigs/day	10–19 cigs/day	20–29 cigs/day	30–39 cigs/day	40+ cigs/day
Transdermal NRT patch Every 24 hours	**15 mg (16hr) or 14 mg (24hr)**	**25 mg (16hr) or 21 mg (24hr)**	**25 mg (16hr) or 21 mg (24hr)** Option: 21/25 mg + 14/15 mg	**25 mg (16hr) / 21 mg (24hr) + 14/15 mg** Option: 2 x 21/25 mg	**2 x 25 mg (16hr) or 21 mg (24hr)**
Fast-acting Use on the hour, every hour and as needed	**AND** one of the available **fast-acting NRT products:** ■ Mouth spray (64 sprays/day) ■ Inhaler (up to 6 cartridges/day) ■ 4 mg Lozenge (up to 15/day) ■ 4 mg Gum (up to 15/day) ■ 2 mg Microtab (up to 40/day) ■ Nasal spray (64 sprays/day)				

Nicotine vapes

For treatment with vapes, the initial dose for most patients who smoke 20 cigarettes a day regularly will be 18 mg/ml or 20 mg/ml. This is sometimes described as 1.8% or 2% on vape packaging.

Patients who smoke more heavily (>20–30 cigarettes a day) are likely to require up to two or sometimes even three 18 mg/ml or 20 mg/ml e-liquids daily and/or combination treatment with the NRT patch to manage withdrawal symptoms.
See **Table 1** for guidance on initial vape dosing.

Combination NRT

High-dose (21 mg or 25 mg) patch **and** a fast-acting NRT product is recommended. Patients who are more heavily dependent will benefit from use of more than one NRT patch to deliver a higher steady state blood nicotine level. See **Table 2** for initial combination NRT dosing.

Top Tips for administration of NRT

Prompt administration	Plentiful supply	Practice use	Prolonged use
As soon as possible; ideally within 30 minutes	At least 2 NRT products combined	To get the correct technique	Extended use to prevent relapse

Assess response and adjust dose as indicated

Assess withdrawal symptoms (see below) daily and adjust NRT accordingly. If additional NRT is required, increase the patch strength initially as this will provide a stable level of additional nicotine. Self-administered fast-acting products are more effective if the patient's mental state and risk assessment allow. It is safe to use nicotine vapes with prescribed NRT.

If the dose is **too low**, the patient will experience the physical discomfort of withdrawal, including:

- irritability
- dysphoria
- restlessness
- anxiety
- insomnia
- headache
- myalgias
- decreased concentration
- strong urges to smoke (cravings)

If the dose is **too high**, the patient may present with the following and dose reduction of the fast-acting products can be considered to ensure the patient's comfort and safety:

- nausea (note: nausea is often due to incorrect product use)
- dizziness
- palpitations
- dysphoria

4.0 The Inpatient Care Bundle

4.1 Initial assessment and treatment plan

Timeframe: Within 24 hours of admission
Responsible Team: Hospital Tobacco Dependence Team
Duration: 15–45 minutes

Clinical checklist	Done
1 Establish rapport and learn about how the patient is managing their tobacco dependence	☐
2 Provide personalised advice and inform about available support	☐
3 Conduct assessment	
■ Assess patient's level of tobacco dependence	☐
■ Assess withdrawal symptoms and urges to smoke	☐
■ Assess current treatment use (frequency, correct technique, dose)	☐
4 Agree to treatment plan and provide specialist support during hospital stay	
■ Advise on importance of tobacco dependence aids and instructions for use	☐
■ Titrate/adjust nicotine vape or NRT (as needed) and/or consider use of nicotine analogue	☐
■ Advise on managing urges to smoke and planning personal coping strategies	☐
■ Explain and conduct carbon monoxide (CO) testing	☐
■ Discuss patient's smokefree goal/plan during and beyond hospital admission	☐
■ Provide motivational intervention (as appropriate)	☐
5 Provide summary, agree to next follow-up, and prompt commitment	
■ Provide summary and ask about any questions	☐
■ Prompt commitment from patient to treatment plan and staying smokefree or harm reduction goal	☐

Communication skills used

Build rapport	☐	Use reflective listening	☐
Boost motivation and self-efficacy	☐	Provide reassurance	☐

After the assessment

Record assessment and treatment plan, update disease management plan	☐
Arrange continued supply of nicotine vape, combination NRT or nicotine analogue	☐
Communicate with patient's treating team	☐

TDA Tips

- On arrival at the ward and prior to meeting the patient, check with the nurse in charge if it is OK to see the patient and get an update on current presentation. Ascertain how the patient is settling into the ward.
- Prior to seeing the patient, review the patient's notes to:
  - check for an advanced agreement for management of tobacco dependence.
  - gain information about the patient's current mental state and risk assessment.
  - review details about the patient's current medication.
- Communicate with ward staff about the location of the assessment.
- Follow ward protocols for managing personal safety, such as use of an alarm.
- When approaching the patient, conduct a visual assessment of their current physical and mental state and use this to guide your interaction.
- As you engage with the patient, assess their ability to interact with you. Factors such as auditory hallucinations, low mood, level of distress and cognitive impairment will all need to be considered.
- Patients often fear being judged by health professionals about their smoking and they may feel pressured to stop or lack confidence in their ability to abstain while in hospital. All these feelings may result in the patient being reluctant to engage with you.
- Communicating in a non-judgmental, empathetic manner is important in making patients feel more open to, and receptive of, treatment and support.

- Patients experiencing extreme tobacco withdrawal are unlikely to be able to discuss stopping smoking long-term with you. The best thing to do is to assist with effectively managing withdrawal symptoms and urges to smoke. Once they are feeling more comfortable, you can reassess their interest in a smokefree admission and a long-term goal of stopping. A positive experience with a smokefree admission can serve to boost their motivation and confidence with stopping smoking long-term.
- Be quick to address any issues the patient may be experiencing from the treatment methods being used to manage their withdrawal symptoms. This will help regain their confidence in your ability to treat their tobacco dependence.
- Before leaving the ward, provide a verbal update or feedback to the ward staff and ensure they are clear about the treatment plan agreed with the patient.
- Liaise with the ward doctor to ensure any medications are prescribed as agreed with the patient and discuss the need for a medication review, if indicated.
- Document the assessment and a brief summary of the key points of your discussion with the patient so that your colleagues can provide continuity of care.

1 Establish rapport and learn about how the patient is managing their tobacco dependence

Establishing and building rapport is crucial for effective interactions with patients who smoke and has been shown to be directly linked to more successful outcomes. This is the 'art' of tobacco dependence treatment that will allow you to deliver the 'science' – nicotine vapes, NRT, nicotine analogues and behavioural support, in combination – that will improve a patient's chances of stopping.

Spend the first few minutes of this visit assessing the patient's ability to speak with you and establish rapport.

Ensure that you are using their preferred name and remember to take a few minutes to learn about their experience in hospital and how they are feeling. This is a good way to start and can increase the likelihood of them remaining engaged in the consultation.

Use communication and motivational techniques to engage patients in discussion about their tobacco use and their interest in stopping smoking.

Your approach should be non-judgmental, unbiased, informative, personalised and supportive.

Introduce yourself to the patient:

"Hello, my name is _____ from the Tobacco Dependence Team here at the hospital/trust."

"How are you feeling today?"

Explain your role and the role of the Tobacco Dependence Team:

"My job is to meet with all patients who smoke to ensure they are comfortable during their stay."

Ask about how they have been doing with staying smokefree during their admission and discuss the response:

"How are you getting on, have you managed to stay smokefree since your admission to hospital?"

or

"How have you been getting on with not smoking since being admitted to hospital?"

or

"When did you last use any form of tobacco?"

If the patient has remained abstinent:

- Congratulate and provide praise

If the patient reports smoking since admission:

- It will not be uncommon for patients to have found a way to smoke during their stay. It can be helpful to understand the challenges of the smokefree environment and provide non-judgmental support and encouragement.
- You can acknowledge any effort made or small successes achieved, especially for those more dependent on smoking:

  "I understand how hard it is for you to stay smokefree right now and you made a good start, many other patients find it difficult too."

- You can explain that some people who smoke regularly find it hard to be smokefree during their admission to hospital and that you are there to make sure they have the support they need.
- Reinforce the rationale of complete abstinence, as having the occasional cigarette makes withdrawal worse and reduces the likelihood of stopping:

  "I know that it can be difficult to be completely smokefree and that you may still feel the urge to smoke, but having just one or two cigarettes can worsen your withdrawal symptoms and make it much harder to stay smokefree."

- Learn more about when, where and why they are smoking as this information can help inform the patient's tobacco treatment plan.

- Communicate your confidence that, with support, it will be easier to stay smokefree and that part of today's assessment will look at how you can best support them with staying smokefree while in hospital. Inform them that if they want to use this as an opportunity to aim for long-term abstinence, support is available to do so too:

  "Our Tobacco Dependence Team will support you to stay smokefree whilst you are here in hospital. We can also ensure you receive support following your discharge from hospital."

- For patients who say they intend to smoke during their admission, treatment should still be provided and tobacco dependence aids prescribed, with advice provided for replacing some cigarettes as part of a harm reduction approach.

2 Provide personalised advice and inform about available support

Provide personalised advice about the importance of being smokefree:

"Staying smokefree is so important for your recovery and keeping you healthy. We know stopping smoking isn't easy and we are here to help. Given your current mental health problems, it's important for your recovery that you stay smokefree."

Explain that treating tobacco dependence is a standard of care in the NHS and inform about available support:

"We treat all patients with tobacco dependence with nicotine vapes or NRT to make them more comfortable during their stay in all mental health hospitals. As the Tobacco Dependence Adviser at this hospital, I can support you with staying smokefree. We will also offer you support when you go home."

Explain how tobacco dependence develops

Explain how tobacco dependence develops, how assessing tobacco dependence can assist with the choice of tobacco dependence medication, and provide the patient with an understanding of what they need to overcome.

You could say:

"Most people who smoke are addicted. This means your brain has become used to getting regular doses of nicotine. When you don't get regular nicotine, you get unpleasant feelings. These are temporary withdrawal symptoms and can make it difficult to manage."

Reassure the patient that, with the use of proven medications and effective support, they will have a good chance of overcoming this.

3 Conduct assessment

Assess patient's level of tobacco dependence

To quickly assess tobacco dependence, ask the patient how many cigarettes per day they smoked, and how soon after waking they had their first cigarette of the day, prior to feeling unwell and being admitted to hospital. This is known as the Heaviness of Smoking Index (HSI). Alternatively, conduct the Fagerström Test for Nicotine Dependence (FTND).

Heaviness of Smoking Index (HSI)

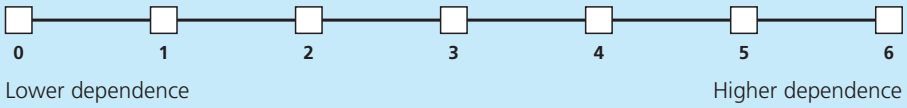
[adapted for inpatient setting]

1. **Before you were admitted to hospital, how soon after you woke up did you have your first cigarette of the day?**

- ☐ Within 5 minutes (3 points)
- ☐ 6–30 minutes (2 points)
- ☐ 31–60 minutes (1 point)
- ☐ After 60 minutes (0 points)

2. **Before you were admitted to hospital, how many cigarettes would you typically smoke per day?**

- ☐ 10 or fewer (0 points)
- ☐ 11–20 (1 point)
- ☐ 21–30 (2 points)
- ☐ 31 or more (3 points)



Explain to the patient their level of tobacco dependence and what it means in terms of their treatment plan.

Patients with greater dependence will often benefit from:

- higher doses of NRT or nicotine vapes
- more frequent use of fast-acting NRT
- extended behavioural support post-discharge
- extended use of tobacco dependence aids
- use of a nicotine analogue medication

If time permits, and the patient is able, you may wish to learn more about how smoking fits into the patient's life.

This can be useful in engaging patients in conversation, building rapport and gaining information that can be useful to inform the treatment plan.

You could ask:

"How old were you when you started smoking?"

"How did smoking fit into your life?"

"What did you like most about smoking? What did you like least?"

"Have you stopped smoking in the past? How did you feel when you stopped?"

"Do you have a spouse or partner? Does your spouse or partner smoke?"

"Do you have children or grandchildren? Do they smoke?"

Use reflective listening and summary statements to show your understanding of what the patient has shared.

Before moving on, verify that tobacco dependence has been recorded in the admission diagnosis list and disease management plan and update as appropriate.

Assess withdrawal symptoms and urges to smoke

Withdrawal symptoms are the body's response to being without nicotine and are common for patients to experience.

It is important for the patient to understand that these symptoms are normal and can be managed by using the recommended medication, alongside some specific coping strategies.

Withdrawal symptoms can include: urges to smoke, anger, irritability, frustration, anxiety, difficulty concentrating, restlessness, insomnia or awaking at night, constipation and increased appetite (See **Appendix 1**).

- Explain that many people that stop smoking experience a range of symptoms. You could ask the patient to describe symptoms they may have experienced during previous periods of abstinence, including how they managed them and how long they lasted:

  "Some people experience urges to smoke, anger, frustration, anxiety, increased appetite, restlessness, difficulty concentrating, headaches, insomnia, constipation, tiredness, low energy, or depressed mood."

- Ask the patient:
  "Have you been experiencing any withdrawal symptoms or urges to smoke?"

A helpful way of doing this part of the assessment is to show the patient the list of withdrawal symptoms and ask them to identify which ones they have experienced. You could also ask them to say how severe they are.

This can be a valuable tool for identifying patients who may benefit from treatment adjustment.

"On a scale from 0 (none at all) to 4 (severe), how severe is the _____ you're experiencing?"

"On a scale of 0 (none at all) to 4 (severe), how strong are the urges to smoke you are experiencing?"

"How frequently are you having urges to smoke?"

For any patient reporting withdrawal symptoms or urges to smoke that are a 3 or 4 in severity or frequency, treatment adjustment should be considered.

- Reassure the patient that withdrawal symptoms are normal when you first stop smoking.

  "Withdrawal symptoms are normal – your body is expecting the nicotine you used to get from your cigarettes. The good news is that this is temporary, and medications will help make withdrawal symptoms more manageable."

- Reassure the patient that most symptoms last, on average, between two and four weeks, and will become less severe and less frequent the longer they remain smokefree:

  "These symptoms usually last between two and four weeks – though they may last longer for some patients – and become less frequent over time. To get you through these first few weeks we will work together to give you strategies for dealing with any withdrawal symptoms or urges to smoke you may experience."

- Remind the patient to be prepared for the possible withdrawal symptoms and to ask ward staff for extra NRT if they feel uncomfortable. Using NRT or a vape regularly will help make the withdrawal symptoms easier to deal with.

Understanding tobacco dependence and withdrawal symptoms

- The severity of withdrawal symptoms and urges to smoke can differ from person to person and moment to moment.
- Withdrawal symptoms are known to be more severe in more dependent individuals and people with certain types of SMI.
- There is also a genetic component to tobacco dependence that may be useful to explain to the patient. This genetic component plays a role in how susceptible a person is to becoming dependent, how severely they experience withdrawal symptoms and how difficult they find it to stop.

Assess current treatment use (frequency, correct technique, dose)

Find out about how the patient is using their tobacco dependence aid, including how the product is being used and the frequency of use.

You could say:

"You were given NRT (or a vape) when you arrived yesterday, how have you been getting on with it?"

If the patient is using their aid, document dosage and ask:

"How frequently are you using the [fast-acting NRT product, e.g. nasal spray, lozenge, vape]?"

If the patient is not using any tobacco dependence medication or aids:

Enquire why they didn't start, or stopped using, their medication. Review the correct technique for their specific tobacco dependence aid.

If the patient was not taking it or was using it incorrectly, ask if they would like to try it again using the new information, or if they would be interested in trying a different aid.

For administration techniques for each medication see **Appendices 4–6**.

Enquire if they stopped taking it because of side effects (see below).

Assess any side effects

Assess any side effects the patient may be experiencing and help them to distinguish between medication side effects and withdrawal symptoms. Strategies for addressing side effects can be discussed to assist with alleviating these. Most side effects reduce with continued use.

Side effects are often the result of incorrect product use. Check on how the patient is using their product(s) and provide guidance and advice on correct use, if necessary.

Ask the patient:

"Have you had any difficulty/side effects with the vape/NRT/tobacco dependence medication?"

It can be useful to ask patients to rate the severity of any reported side effects.

- If the patient reports a side effect known to occur when taking the aid, review correct technique:

  "Sometimes side effects occur when NRT is not used correctly. Let me review correct use with you and we can see if that helps."

- If the patient has been using their medication correctly and is still experiencing side effects, discuss strategies for managing common side effects:

  "There are a few tips I can provide to help you manage better with some of the side effects you mentioned, such as sleep disturbance, skin irritation, coughing and throat irritation."

For patients experiencing side effects:

"It is unfortunate that you are experiencing side effects from the medication. Why don't we see how best we can address this together?"

- It is not uncommon for side effects such as nausea and mouth or throat irritation to be the result of incorrect use. Review the instructions for use with the patient (see **Appendices 4–6** for nicotine vape, NRT and nicotine analogue quick reference sheets).
- Many side effects will dissipate with continued use and patients and TDAs should be aware of this and reassess at a later date. It is important not to reduce dose or discontinue medication and risk the patient returning to smoking.
- Switching to a different fast-acting NRT product should be considered to reduce side effects and/or enhance compliance.
- If symptoms are severe (3 or 4 on severity scale) or the patient is not able to tolerate the side effects, consider decreasing the dosage of the medication and/or switching to another product (e.g. nicotine analogue).
- **Although not common, in the instance of an allergic reaction or severe side effects it may be necessary to discontinue the medication. Follow-up with the clinical lead or responsible team member is recommended. Patients who discontinue use should be offered alternative treatment.**

4 Agree to treatment plan and provide specialist support during hospital stay

Advise on importance of tobacco dependence aids and instructions for use

Reinforce the importance of using tobacco dependence medications or nicotine vapes.

Ensure the patient understands that using their medication regularly and correctly is highly recommended and will maximise its efficiency:

"Tobacco dependence aids help to significantly reduce withdrawal symptoms and urges to smoke. With these medications you are twice as likely to be successful staying smokefree than if you were to try to manage without them. They are safe and do not cause cancer, strokes, heart or lung disease. There are three main types of medication: nicotine replacement therapy, nicotine vapes and nicotine analogues (varenicline and cytisine)."

- Review correct use and technique with the patient (see **Appendices 4–6** for nicotine vape, NRT and nicotine analogue quick reference sheets).

Reinforce the need to use fast-acting NRT regularly throughout the day, on the hour, every hour and as required to help cope with urges to smoke:

"It's important to use the [fast-acting NRT product, e.g. mouth spray, lozenge, vape] throughout the day – use it on the hour, every hour before withdrawal symptoms emerge. In addition, it can be used when you have urges to smoke. If you find you are using a lot of the medication, we can increase the dose of the patch or add another medication."

"Make sure you take your NRT/vape with you wherever you go. Always keep a supply handy, perhaps where you used to keep your cigarettes."

- Offer the patient the opportunity to ask any questions or express any concerns about the tobacco dependence aid they are using:

  "Do you have any questions or concerns about using the [medication of choice]?"

  Respond to any questions that may arise. Reinforce the safety of these products and the important role they will play in helping the patient remain smokefree, and how this will improve their recovery and overall health.

  If the answer is *"I'm not planning on using any medication"*

  - Explore the reasons for this and encourage use of one of the medications. Spend a few minutes discussing why medications are recommended, that they are safe, and that multiple options are available to them, including: combination NRT, nicotine vapes and nicotine analogues.
  - Past experience with the use of medications can often affect a patient's beliefs about the value of using them. Medications such as NRT are often used incorrectly, and you can take a few minutes to explain that we now use two medications in combination (see sample text below), reinforcing that patients and research show us this is more effective for managing withdrawal symptoms and cravings and making it easier for people to manage without smoking.
  - Some patients believe they need to use willpower alone to stop smoking. Take a few minutes to ensure that patients understand that use of these medications is standard treatment for all patients with tobacco dependence. While willpower is helpful, many patients will benefit from using tobacco dependence aids.

Nicotine replacement therapy (NRT)

"Nicotine replacement therapies – shortened to NRT – are very effective aids to help you stop smoking. They contain a small amount of the nicotine that you are currently getting from cigarettes."

"It is important to remember that this is clean, safe nicotine, without the 5,000 other chemicals found in tobacco smoke."

Describe how NRT works and the different products available:

"NRT works by reducing urges to smoke and other withdrawal symptoms, thereby making stopping smoking easier. It is not a magic cure – but it will help."

"There are several different products to choose from and all are effective in helping you to stop: patches, nasal spray, gum, lozenge, inhalator, microtab and mouth spray. They differ in the amount of nicotine that they contain, how it is delivered and how quickly it acts."

Combination NRT (patch plus one other product) is the most effective medication option and is suitable for most patients (see below).

"Combination NRT means a combination of two NRT products, often the patch to deliver a background continuous dose and the nicotine inhalator or lozenge to provide quick extra help when needed. Do you have any thoughts about this?"

"Studies show that using two products together gives you an increased chance of success compared with using one product. Combining products is also safe: there is no need to worry about overdosing on nicotine. If you are unsure about using two products, you could start off with the patch and if you find you are having difficulty in dealing with your urges to smoke you can then try adding another product."

If patients are classed as more dependent, based on the HSI, a higher dose product such as the 25mg patch, 4mg lozenge or nicotine nasal spray will help them more.

Nicotine vapes (e-cigarettes)

Some patients will choose to use a nicotine-containing vaping device (vape) or may be already using one.

Unlike cigarettes, vapes do not burn or contain tobacco and do not produce tar or carbon monoxide. Vaping is very popular with people who smoke and the evidence to date indicates that they are significantly less harmful than smoking cigarettes.

"Many patients find nicotine vapes – sometimes called electronic cigarettes or e-cigarettes – helpful for stopping smoking and evidence shows that they can be effective. If you do choose to use a vape and that helps you to stop and stay smokefree, then it is significantly less harmful than continuing to smoke.

Importantly, vapes do not produce carbon monoxide, which is the poison produced when you smoke cigarettes. There is a wide range of vapes available and most people need to try various types and flavours to find the one they like. At our hospital we have [detail available devices]. I can get you started and we can see how you get on."

Where appropriate, explain the hospital policy on vaping during admission, including information on designated areas.

Provide guidance on how to use a vape and, if appropriate, discuss using one in combination with NRT.

Nicotine-containing e-liquids are a form of nicotine replacement and dosing guidelines follow the same principles as with NRT. The HSI can be used to select the initial dose of nicotine. Starting at a nicotine concentration that is at least equal to the number of cigarettes smoked is recommended and, in some cases, it will need to be higher. Patients can reduce the nicotine concentration over time.

Nicotine analogues (varenicline and cytisine)

Nicotine analogue medications (varenicline and cytisine) are effective treatments for tobacco dependence that can be discussed and prescribed during the admission.

Inform the patient about these medications and the instructions for their use.

Inform the patient about common side effects, including nausea, sleep disturbance and vivid or colourful dreams. These can be minimised by taking the medication with food and a glass of water, taking anti-sickness medications, taking the medication earlier in the evening and/or reducing the dose.

Titrate / adjust nicotine vape or NRT (as needed) and/or consider use of nicotine analogue

Monitoring patients in the initial period following smoking abstinence is important to ensure that the selected dose meets their needs.

The most common situation is that the patient does not receive sufficient NRT to effectively manage nicotine withdrawal symptoms and cravings to smoke. Some patients will require their dose of NRT or nicotine strength of the vape to be increased or nicotine analogue added to their treatment plan to effectively manage withdrawal and urges to smoke. Patient response as well as patient preference can be used to guide treatment.

As appropriate, discuss modifying the medication plan to manage cravings, withdrawal, and side effects. This includes increasing the nicotine dose and frequency of NRT product used (see NRT protocol).

Some patients may benefit from experimenting with different fast-acting NRT products. As appropriate, the patient can be supported by changing the fast-acting NRT product they were prescribed to one that may be more suitable to them.

Patient self-management

Patients should be supported to self-manage their use of NRT or nicotine vapes to optimally manage cravings and withdrawal symptoms, including increasing the frequency at which they use their fast-acting NRT product or increasing the dose of the NRT patch. This may not always be possible and will depend on current mental state and risk assessment. By the time a patient is considered ready to use leave periods outside the ward, they should be able to self-manage their NRT. Refer to your trust's medication management policy for guidance on how to facilitate this.

It should be noted that use of fast-acting NRT products beyond the maximum recommended frequency is associated with an increase in side effects, particularly nausea. It may therefore be preferrable to increase the amount of NRT delivered via the patch – this may include the use of more than one NRT patch.

Practice guidance for adjusting treatment plan

Indications:

- Currently smoking, including those who have reduced but not achieved complete cessation
- Experiencing significant withdrawal symptoms and/or urges to smoke
- There is risk of relapse to smoking

Action:

If withdrawal symptoms and urges to smoke persist after initiation of the rapid NRT protocol and/or the patient reports smoking or being at risk of relapse, increase dose of NRT and:

- consider addition of nicotine vape
- consider addition of nicotine analogue

Increasing NRT dose:

- Although the amount of nicotine a person absorbs from cigarette smoking is influenced by how a person smokes (e.g. intensity and frequency of puffing, time between cigarettes), as a general guide you can adjust dose so that the total dose is at least equal to the number of cigarettes per day smoked by the patient. Since people with mental illness tend to be more heavily dependent, and extract more nicotine from their cigarettes, we can expect that higher doses of nicotine may be needed to appropriately manage urges to smoke and withdrawal symptoms.
- NRT dose should seek to approximate nicotine delivered by cigarettes. As a general guideline, we attempt to deliver 2 mg of nicotine from NRT for each cigarette smoked per day by the patient. For patients who smoke within 30 minutes of waking, higher doses may be necessary, and this is safe practice.
- NRT dose (mg) = number of cigarettes per day

  Example: 30 cigarettes per day = 60 mg/day or 2 x 25 mg patch + fast-acting product
- After 24 hours, you may add a 7 mg nicotine patch
  (the general recommendation is to increase by 7 mg increments)

Managing expectations:

- When used correctly, NRT doubles the chance of stopping long-term compared to not using an aid. However, NRT supplies less nicotine less rapidly than cigarettes. Patients using NRT will not have the same satisfaction they get from smoking cigarettes. However, if used correctly, it will provide relief from withdrawal symptoms and urges to smoke and double their chance of stopping long-term.

For patients using nicotine vapes:

- Patients who are still struggling with urges to smoke despite vaping can be helped by increasing the nicotine strength to the maximum allowed, 20 mg/ml. Those who are already using 20 mg/ml e-liquid will benefit from adding an NRT product such as an NRT patch, which will provide a regular dose of background nicotine. Another option Is to add a nicotine analogue.

Advise on managing urges to smoke and planning personal coping strategies

Provide tailored guidance on managing any withdrawal symptoms or urges to smoke that the patient may be experiencing.

Urges to smoke

- Urges to smoke are common. The most important thing to remember is that these urges pass after a short time, often just three to five minutes, and the longer an individual goes without a single puff on a cigarette, the less frequent the cravings become.
- When a patient feels the urge to smoke, they should plan to do the following:
  - **Delay:** Cravings are at their worst for three to five minutes. Do your best to delay the temptation to smoke and the urge will pass.
  - **Exit:** Remove yourself from situations where you have the temptation to smoke.
  - **Avoid:** Avoid situations in which you may be tempted to smoke, particularly in the early period after stopping.
  - **Distract yourself:** Keep your mind off smoking by doing something else, such as phone a friend, take a shower, paint your nails, play a boardgame, do some pushups or exercise, watch TV, read a magazine, complete a crossword puzzle, make a snack, listen to music or try some meditation or mindfulness. If you can go outside, you could take part in other activities such as sports, visiting your preferred place of worship, doing some shopping, going to the barber/hairdresser, having a manicure or pedicure, going to a cafe, or going for a brisk walk or run.
  - **Deep breathing:** Deep belly breathing can help you to relax while cravings pass.
  - **Drink water:** Drink a glass of chilled water. This provides the hand to mouth action you miss from smoking.
- Patients should be advised to use fast-acting NRT (e.g. gum, inhaler, mouth spray) regularly, on the hour every hour, before the cravings arise so that the nicotine receptors are always saturated and there is no drop in nicotine level. In this way, they are getting ahead of the cravings rather than trying to manage them after they have presented. In addition, they can also top up the nicotine when they experience urges to smoke.
- Avoiding situations where the patient knows they might be tempted to smoke, at least temporarily at the start of the smokefree admission, is recommended.

Explain and conduct carbon monoxide (CO) testing

Carbon monoxide (CO) tests provide patients with feedback on the effects of being smokefree on their recovery and long-term health. Many patients find this feedback particularly motivating as evidence of the benefits they get from stopping smoking. Regular CO testing is recommended by NICE.[30] See **Appendix 10** for further information on conducting a CO test.

Explain to the patient that CO is a toxic, odourless, poisonous gas contained in cigarette smoke and that there is a simple test that can be carried out to determine CO levels. Explain that CO tests are carried out to show the patient objective proof of the immediate benefits of stopping for their recovery and improved long-term health from being smokefree. CO tests are also used to validate that they really have stopped smoking. The expected level for someone who doesn't smoke is below six parts per million (ppm). It is not typically zero due to environmental exposure to CO.

Note: a cut-off of 4ppm is used for pregnant women as part of the maternity care pathway.

"Carbon monoxide is a toxic gas inhaled when you smoke a cigarette. Carbon monoxide starves the heart and lungs of oxygen. This can affect healing and recovery, and causes heart disease and other illnesses. The good news is that shortly after stopping smoking the level of carbon monoxide in your body returns to that of someone who no longer smokes. This machine measures the amount of carbon monoxide in your lungs in parts per million and if you have not been smoking then we would expect it to be below six parts per million."

It is worth emphasising that patients will be required to hold their breath for a minimum of 15 seconds before blowing into the CO monitor. This allows the pressure in the lungs to equalise and for the CO in the blood to pass into the air in the lungs. It is this that is then measured by the monitor. It can be helpful to demonstrate the test by measuring your own CO level as this can reassure the patient.

"I am going to ask you to take a deep breath, hold your breath and then exhale into this machine. You will need to hold your breath for 15 seconds. After you have taken your breath, I will hand the machine to you and the machine will count down. Just before it's time to exhale, the machine will beep to count down 3, 2, 1 and I will then tell you to blow into this mouthpiece."

After the test:

- If the test wasn't completed adequately (i.e. the patient did not hold their breath for the required time or did not place their lips around the tube properly) then politely advise the patient that the test needs to be repeated. Allow them a couple of minutes to get their breath back before repeating the test.
- **If the reading was below 6ppm**

  "Congratulations! This reading is that of someone that no longer smokes; you are already benefiting from not smoking and you should be very proud of your achievement. This is because you haven't had a cigarette for X amount of time. We can help you to maintain low levels of carbon monoxide by using a nicotine vape or nicotine replacement therapy to manage your cravings and remain smokefree whilst you're in hospital."

  Use feedback to explain the support available. A CO chart can be a useful visual aid for providing feedback (see **Appendix 11**).

- **If the reading was 6ppm or above**

  If the patient indicates they have not smoked, it is important to remain non-judgmental and ask the person if they may have been exposed to CO somewhere else (e.g. being in close contact with other people that smoke).

  "The monitor is showing a reading of _____ parts per million which is what we expect to see for someone who is still smoking. The normal range for someone that does not smoke is between 1 and 5ppm and so you can see that your reading is higher than what we would expect. The good news is that if you do not smoke at all you can get this down to the levels of someone that does not smoke."

If the patient reports they have smoked in the past 24 hours:

"As we would expect, given you reported smoking in the last 24 hours, your carbon monoxide reading is high. Carbon monoxide levels reduce shortly after stopping smoking, so we can support you to reduce your carbon monoxide levels by supporting you to remain smokefree."

Our bodies produce small amounts of CO and it is also present in the atmosphere around us, so the reading will almost never be zero. It will also fluctuate slightly depending upon what air you have been exposed to. A reading of below 6ppm is considered to be that of someone that no longer smokes.

Readings above 6ppm are not normally caused by being in the company of other people who smoke; this can increase exposure to CO but does not normally push the reading above 6ppm. For patients who report that they are not smoking, it may be worth double checking and examining what other sources of CO may be affecting their reading.

Discuss patient's smokefree goal / plan during and beyond hospital admission

Ask the patient how they feel about not smoking:

"How do you feel about not smoking during your hospital stay?"

Or

"Are you ready to receive treatment and support to stay smokefree once you go home?"

If yes, ask about their reasons for wanting to stop:

"What has made you decide to go smokefree now?"

Ask about their confidence in staying smokefree while in hospital:

"On a scale of one to 10, if one is not very confident and 10 is very confident, how confident are you that you will be able to stay smokefree during your admission? What level would you rate your confidence today?"

For patients focusing on temporary abstinence:

Let them know that support with staying smokefree during their admission can be the focus, and reinforce the importance of support for a smokefree admission:

"If you feel you are not able to stop long-term now, that's OK, we are here to support you with staying comfortable and smokefree during your stay in hospital."

Explain that the offer of support is always open and provide information on how to access it if they change their mind:

"The offer of support with staying smokefree after you leave hospital is open. If you change your mind, I would be really pleased to provide the support you need. I think you will find that taking it day by day is sometimes the best way. See how you do over the next day or two."

"Either I or a member of the Tobacco Dependence Team will stop by in any case to see how you are doing tomorrow/another date, or you can ask the ward staff to get in touch with me."

Provide motivational intervention (as appropriate)

- Roll with resistance: back off and use reflection when the patient expresses resistance.

  e.g. ***"It sounds like you're feeling pressure about your smoking."***

- Express empathy.

  e.g. ***"I understand that you are worried about how to manage withdrawal symptoms."***

- Explore concerns and benefits.

  "What are some of the good things that smoking does for you?"

  "What are some of the not so good things?"

  "Looking ahead, what do you think would you like to do about your smoking?"

- Support self-efficacy: help the patient identify and build on past successes. How long did they stop for, how much better did they feel, what worked well, what did they learn?

  e.g. ***"I know that you have a lot on your plate right now, and I understand thinking about stopping smoking for good might be too much to commit to right now. I know you stopped in the past, could you tell me more about this?"***

- Ask permission to provide information.

  e.g. ***"Would you like to hear about some strategies that can help you address [concern identified by patient] when you stop smoking?"***

- Offer options for achievable small steps toward change (e.g. reading about the benefits of stopping smoking and strategies).

5 Provide summary, agree to next follow-up, and prompt commitment

Provide summary and ask about any questions

Provide the patient with a summary of the consultation and the treatment plan that you have agreed to and allow time for the patient, or family members and care providers, to ask questions.

It should include the following:

- Confirm choice of tobacco dependence aid, arrange supply and review instructions for use.
- Summarise what to do when they experience urges to smoke and withdrawal symptoms.
- Summarise the plan agreed for stop smoking support post-discharge.
- As appropriate (based on length of stay), schedule next follow-up appointment.
- Inform on how to contact you or a member of the Tobacco Dependence Team if they have any questions or concerns.
- Ask if they have any questions.

Prompt commitment from patient to treatment plan and staying smokefree or harm reduction goal

- Seek (ideally verbal) patient commitment to the treatment plan you have discussed.
- Reinforce the importance of a smokefree admission and boost patient confidence in their ability to remain smokefree.

4.2 Follow-up consultations (whilst in hospital)

Timeframe: Based on length of stay and patient complexity
Responsible Team: Hospital Tobacco Dependence Team
Duration: 10–15 minutes

Clinical checklist

Done

1 Check on patient progress ☐

- Provide positive reinforcement

2 Measure carbon monoxide (CO) ☐

3 Assess treatment response

- Assess withdrawal symptoms and urges to smoke and how they have dealt with them ☐
- Confirm correct use of treatment (frequency, technique); address any side effects ☐
- Discuss any difficult situations experienced and method of coping ☐

4 Review and revise treatment plan

- Adjust treatment plan as needed; advise on continued use of aids ☐
- Consider addition of second aid ☐
- Discuss strategies for coping with urges to smoke ☐
- Discuss personal smoking routines, triggers, high risk situations and coping strategies ☐
- Reassess patient's tobacco treatment goals and confidence in remaining smokefree ☐
- Provide information about community follow-up support (as appropriate) ☐

For patients focusing on temporary abstinence:

- Provide brief motivational intervention (as appropriate) ☐
- Assess interest in harm reduction ('Cut Down and Then Stop' with use of vape or NRT) ☐
- Keep door open and provide information on support should they change their mind ☐

5 Provide summary and prompt commitment for staying smokefree

- Address any questions or concerns ☐
- Prompt commitment from patient for staying smokefree or achieving harm reduction goals ☐

Communication skills used

Build rapport	☐	Use reflective listening	☐
Boost motivation and self-efficacy	☐	Provide reassurance	☐

After the consultation

Document consultation in patient record	☐
Coordinate NRT, vape or nicotine analogue	☐
Communicate with care team (as needed)	☐
Communicate with prescribers (as needed)	☐
Coordinate community referral (as needed)	☐

TDA Tips

- Before approaching the patient:
  - Report to the nurse in charge and check on the patient's current mental state and risk assessment. Follow the ward protocols for managing personal safety.
  - Check to see if the patient has an advanced agreement in place and then try to honour it.
  - Check what medications the patient is on as this will inform the ongoing care.
  - Learn from the care team about any important details that might inform your interactions with the patient.
- Ensure you have read your colleagues' documentation so that you can provide continuity of care and build on the Point of Admission Care Bundle.
- When approaching the patient, conduct a visual assessment of their current physical and mental state and use this to guide your interaction, in particular any changes that may have occurred since the last assessment.
- As you engage with the patient, reassess their ability to interact with you. Factors such as auditory hallucinations, low mood, level of distress and cognitive impairment will all need to be considered as these can change significantly and frequently during the hospital stay.

- Encourage the patient to talk openly about how they've been getting on with the tobacco dependence treatment and listen out for any concerns/ issues with the medications or in relation to remaining smokefree.
- Be mindful not to judge or criticise any lapses to smoking that may have occurred during the hospital stay. Reassess compliance with treatment, review medication and explore possible reasons for any lapse. Reiterate the importance of abstinence in relation to current health issues and the benefits of staying smokefree.
- If abstinence is reported, congratulate the patient on their commitment to remaining smokefree during their admission and gauge their willingness to extend this to a longer-term goal of abstinence.
- Reassure the patient that treatment and support will be provided during their stay and can be arranged to continue beyond discharge.
- Document the outcome of the consultation in the patient's notes.

Where appropriate, based on length of stay, weekly follow-up consultations with the TDA are recommended for up to 12 weeks with all inpatients who smoke to provide ongoing support, review response to treatment, provide behavioural support and revise the treatment plan as needed. For patients focused on a smokefree admission, this is an opportunity to revisit their commitment to making long-term abstinence their goal.

1 Check on patient progress and provide positive reinforcement

Check on patient progress and show genuine interest in how they are doing with their recovery and staying smokefree.

Reaffirm with the patient that you are here to support them to achieve a smokefree admission or smoking abstinence.

Let the patient know that you would like to learn how they have been doing with staying smokefree, make any necessary changes to their treatment plan and discuss some specific strategies to help them cope with staying smokefree. Keep the tone of the visit positive and non-judgmental.

"Hi _____ , how are you doing? I am so glad to see you, I'm interested to hear how you have been doing with staying smokefree? How have you been doing since I/my colleague last saw you?"

"Hi _____ , it's lovely to see you again, I'm looking forward to hearing how you have been managing to stay smokefree since I/my colleague last saw you."

As appropriate, learn about their hospital recovery generally, how they are feeling and plans for discharge. This is useful in building a relationship with the patient and can inform the treatment plan.

Ask about how they have been doing with staying smokefree during their admission and discuss the response.

"How are you getting on, have you managed to stay smokefree since your admission to hospital?"

or

"How have you been getting on with not smoking?"

or

"When did you last use tobacco?"

For patients who report being smokefree:

- Congratulate and provide positive reinforcement.
- Ask how they feel about being smokefree. Reflect on any positive feedback they provide.

  "How are you feeling about being smokefree these past few days/last week(s)?"

  "Have you noticed any positive changes now that you are not smoking? (e.g. to your breathing?)"

For patients who report smoking:

- Ensure you remain non-judgmental and supportive.
- As appropriate, provide positive feedback about any small successes they have been able to achieve, including reducing smoking.

  "It would be great for you to be completely smokefree, as that's the best thing you can do for your recovery. I know you have smoked for many years and would normally smoke _____ cigarettes in a day. You said you smoked _____ and in many ways that is a success/step in the right direction. No one said this would be easy so let's see if I can help with making it a little easier."

  "Ideally, we would like you to become totally smokefree from your arrival. However, we also understand how difficult it can be. It is brilliant that you have successfully managed to smoke less and, with a little more help and support, we can help you to maintain and build on this success."

- Find out more about circumstances including frequency of smoking.
- Show your confidence in their ability to get on track and that you can discuss making changes to their treatment plan to help make the urges to smoke easier to deal with.

Use of nicotine vapes, NRT and nicotine analogues for patients who report smoking

- Sometimes both patients and healthcare professionals will discontinue tobacco dependence treatment because they have returned to smoking or had a few cigarettes.
- It is safe to use these tobacco dependence aids whilst also continuing to smoke.
- For patients who report smoking, nicotine replacement (vapes and/or NRT) or analogues should be continued and patients assured of their safety.
- The fact the patient is smoking while taking the medication should signal the need to review appropriate dosing of NRT and/or add a nicotine analogue to the treatment plan.
- Learning about where, when, and why the patient is smoking can also be useful. This information can be used to inform strategies to address the circumstances that led to their smoking.

2 Measure carbon monoxide (CO)

See **section 4.1** for instructions.

Discuss the result with the patient and, as appropriate, use it to reinforce the benefits of staying smokefree or reinforce the health effects continued smoking is having on them.

If the reading is low (below 6 ppm):

- Congratulate the patient and use it as an opportunity to discuss the positive effects staying smokefree is having on their recovery and overall health.

If the reading is above 6 ppm:

- Use this as an opportunity to compare it with the previous reading (whether lower or higher) and discuss focusing on staying smokefree to get that number down and help ensure a healthy recovery.

3 Assess treatment response

- Assess withdrawal symptoms and urges to smoke and how they have dealt with them

  Ask the patient: ***"Have you been experiencing any withdrawal symptoms or urges to smoke?"***

  Asking patients to rate the severity of any withdrawal symptoms can be a valuable tool and assist with identifying patients who may benefit from treatment adjustment.

"On a scale from 0 (mild) to 4 (severe), how severe is the [withdrawal symptom] you're experiencing?"

For any patient reporting withdrawal symptoms that are a 3 or 4 in severity, treatment adjustment should be considered.

Ask about how they have dealt with urges to smoke and withdrawal symptoms and provide advice as appropriate.

- Confirm correct use of treatment (frequency, technique); address any side effects.

"Have you been using the medication/aid we recommended regularly (on the hour, every hour)?"

"How often have you used the NRT/vape during the day?"

Assess any side effects that may be experienced and address as appropriate.

"Have you had any problems with using your NRT/vape/medication?"

Assess severity on a scale of 0 to 4.

Review strategies for dealing with any reported side effects (see **Appendix 3**).

For patients reporting side effects or urges to smoke, review correct techniques. It can be helpful to have patients demonstrate or verbally explain how they are using the fast-acting NRT product so that you can offer guidance on correct technique. You can also demonstrate correct technique to the patient.

For patients using nicotine vapes:

- Reassure the patient it is safe to use their vape frequently, taking short shallow puffs throughout the day. This is often called "grazing". It can worry some patients when they are using the vape so much, as this is in contrast with less frequent "binges" on a cigarette.
- Patients who are still struggling with urges to smoke despite vaping can be helped by increasing the nicotine strength to the maximum allowed, 20 mg/ml. Those who are already using 20 mg/ml will benefit from adding an NRT product such as an NRT patch, which will provide a regular dose of background nicotine.

For patients using nicotine analogues who report nausea:

"Many patients report nausea when they first begin using varenicline/cytisine. This usually disappears within the first few weeks of using the medications. Since your nausea is not severe what I would recommend is ensuring that you always take the medication with a full glass of water and after food. We can also consider adding an anti-nausea medication. Would you like to try that for a few days and see if that addresses the nausea you are experiencing?"

For patients using a nicotine analogue who report sleep disturbance or night-time awakenings:

"This is one of the known side effects of the medication and it's also something experienced by patients who stop smoking. We find this tends to subside over time. Are you finding it difficult to manage? It can be helpful if you move your evening dose so that you take it earlier, a few hours before bedtime. That tends to improve sleep disturbances. You can try that but if you find it is not bearable then we can reduce your dose to half, which should help."

- **Discuss urges to smoke, any difficult situations experienced and method of coping**

  Learn about any difficult situations the patient has experienced with urges to smoke or withdrawal symptoms. Ask about how they dealt with them.

  "Have there been any difficult moments in terms of urges to smoke or withdrawal symptoms?"

  "I would like to hear about how you managed (what you did) when this happened/ when you get a strong urge to smoke."

4 Review and revise treatment plan

- Adjust treatment plan as needed and advise on continued use of aids.
- Consider addition of a second aid (NRT, nicotine analogue or nicotine vape) as needed.
- Reinforce importance of using treatment as recommended, and for full course.

  "Many people who use medications such as NRT to help them stop smoking do not use them for long enough. It is common to believe that, after a few weeks of not smoking, there is no longer a need to continue taking the medication. It is recommended that you use the medication for the amount of time that was prescribed but we can discuss reducing the medication once you feel that you are ready."

- **Confirm / reassess patient tobacco treatment goals.**

  "What are your thoughts about stopping smoking now?"

  Most patients are not admitted to a mental health hospital with the intention to stop smoking but, given the support provided and the need to remain smokefree whilst in the hospital, it is often the case that they recognise what an important opportunity this is.

- **Provide advice on coping with urges to smoke**

  "Stopping smoking is a process, and it takes time. Be patient with yourself. If you feel tempted again to smoke, try:

  - ***changing the situation – stop smoking immediately, leave the room, throw out your cigarettes … reach for your vape or NRT, and carry on.***
  - ***talking positively to yourself – remind yourself of how far you have come, encourage yourself to keep at it.***
  - ***taking action – find something else to do that makes it difficult to smoke (e.g. take a shower) or do physical activity.***
  - ***asking for help – talk to someone to distract or encourage you."***

- **Discuss personal smoking routines, triggers, high risk situations and coping strategies**

  Work with the patient to identify situations in which they may find it difficult not to return to smoking. It can be helpful to focus the discussion on a specific time frame like the upcoming week. In addition, a patient's past experience with stopping can be very useful in identifying situations in which they may have difficulty or that may place them at greatest risk for relapse.

  "When you have tried to stop smoking in the past, were there any situations or times of the day in which you found it particularly difficult not to smoke?"

  "Looking at the week ahead, are there any specific situations that are coming up that you feel you might find difficult?"

  "Remind yourself of something you are looking forward to experiencing this week, as now you are no longer smoking."

  "Have you thought about what you will do with the money you would usually spend on cigarettes/tobacco?"

  "Thinking about when you leave hospital and return back home, are there any specific things that you are worried about that might make staying smokefree a challenge?"

Discuss situations that could be considered challenging for the patient such as:

- being around people who are smoking
- when alcohol is involved as it lowers inhibitions
- when mental health symptoms are severe
- when leave from the ward is approved
- when having an argument with someone such as a family member, spouse or friend
- when experiencing work-related stress or feeling overwhelmed to meet deadlines or expectations

- evenings and weekends, when there are less staff around on the ward and fewer opportunities to engage in diversional activities
- celebrations and holidays
- when dealing with a bereavement or illness

Identify strategies for addressing challenging situations:

- Attempt to have the patient come up with strategies for dealing with challenging situations. Patients will be far better at understanding what strategies will work for them than anyone else.
- If they are unable to identify strategies, ask about past experience in addressing this situation. Ask: what worked last time? what could they have done differently?

"Imagine what you would do if you were not able to have a cigarette."

"What are some ways to help you cope with stress that don't involve cigarettes?"

"If you are used to smoking at specific times during the day, how can you change your routine?"

- If patients are stuck, offer examples of what other patients have done who were in a similar situation.

"Other patients who were struggling like you found that taking their leave at a different time than the group who smoke helped them to stay smokefree."

"Last week, a patient who was in a similar situation to you booked an appointment with the barber during his leave and this helped him stay smokefree."

"Another patient I supported requested a longer period off the ward so that she could go to the nail salon for a pedicure. Having one long leave period rather than several short periods helped her to stay smokefree."

Dispel myths surrounding smoking and stress

For patients who are feeling stressed, reinforce the fact that, while they may feel that smoking decreases stress, studies have shown that smoking causes long-term stress levels to rise. For those who are dependent on smoking, it may appear to relieve stress when in fact it will make it worse.

"Many patients say that one of the main reasons they have a slip up is to help them deal with stress. However, we know that, once people stop smoking, their stress levels are lower than when they smoked. Next time you feel stressed and want a cigarette, think to yourself, 'what would someone that doesn't smoke do?' Maybe it's taking long deep breaths, or going for a walk, or phoning a friend. Let's talk about what you think may work for you in those situations."

Address concerns about weight gain

For patients concerned about weight gain, a gain between 2.5–3 kg (5–7 lbs) during the first few months of stopping is normal. Reassure the patient and give them tips to help avoid gaining weight when stopping smoking.

"A common concern is gaining a little weight. You'll be less likely to gain weight if you make some small changes to your diet and increase your physical activity. You can manage this small gain with a brisk 30-minute walk daily. We have also found that making a small change to your diet (e.g. changing the type of snack you eat) and drinking cold water rather than sugary drinks can reduce any weight gain. Using NRT, varenicline or a nicotine vape may also slow weight gain."

Reinforce the 'smokefree promise' with patients:

"We have come up with a great plan to support you with stopping. The first few days and weeks of becoming smokefree can be the toughest but, once you get through this period, things should start to feel a little easier. You may find yourself in situations where you are tempted to smoke and think that having just one cigarette will be okay, but it will undo all the hard work you have just put in. Imagine how pleased you will be when you see your CO test results or see how much money you have saved after just one week – make a promise to yourself to stay smokefree."

- **Reassess patient's tobacco treatment goals and confidence in remaining smokefree**

  Assess confidence
  At each follow-up visit, reassess the patient's confidence in being able to remain smokefree.

  "On a scale of one to 10, with 10 being most confident, how confident are you that you will be able to remain smokefree?"

  If the patient's confidence level is greater than five, they are quite confident that they will be able to become/remain smokefree. Encourage them to ask staff to call you to return to see them if something changes.

  "That's great that you are feeling confident about stopping smoking. Be sure to ask ward staff to contact me if there are any changes in your confidence level so that we can figure out how to boost your confidence back up."

  If their confidence level is five or less, explore the reasons why they have low confidence and discuss strategies to help improve their confidence.

  "Ok, I hear that your confidence in becoming/remaining smokefree is low; can you tell me why you feel that way?"

  Discuss response and provide appropriate support.

Useful questions may be:

"Why are you a three and not a one?"

"What would need to happen for you to get from three to five?"

- **Provide information about community follow-up support (as appropriate)**

  Discuss importance of follow-up support once they leave hospital.

"We know working with a Tobacco Dependence Adviser for one to three months, either in-person or by phone, can double your success with stopping. It will be important that we arrange this for you after your discharge from hospital to support you with staying smokefree."

Review options and agree to a discharge plan with ongoing support and treatment that flexes to the needs of the patient.

"There are a few different methods of follow-up support that are available after you leave hospital. Let's review these and see which one will suit you best."

"These include (as locally available):

- ***follow-up by the local stop smoking team***
- ***follow-up by a local community pharmacy***
- ***follow-up by our team here at the trust***
- ***a digital app that provides support with staying smokefree."***

Patients have the option to opt out of community-based support. However, it is really important to leave the door open and, if length of stay permits, to reassess after the patient has been smokefree for an extended period.

5 Provide summary and prompt commitment to staying smokefree

Provide a summary:

- Confirm the plan for the use of tobacco dependence aids and how frequently they will be used.
- Have the patient describe what they will do if they experience cravings and ensure that they have some strategies in place if they are feeling like they want to smoke.
- Ensure the patient knows who to contact if they are having any difficulty.
- Address any questions or concerns.

Ask the patient:

"Do you have any questions for me?"

Remind the patient that it will continue to get easier over time. Encourage them to stay committed and to contact the Tobacco Dependence Team if they need support.

- Prompt commitment from the patient to staying smokefree or achieving harm reduction goals.

  Have the patient confirm, and ideally state aloud, their commitment to the treatment plan, whether this is to stay smokefree during their admission, to achieve long-term abstinence, or to reduce their smoking by an agreed amount.

4.3 Discharge planning

Timeframe: Prior to discharge based on length of stay
Responsible Team: Hospital Tobacco Dependence Team
Duration: 5–10 minutes

Clinical checklist

		Done
1	**Assess progress and any challenges experienced, provide positive reinforcement and reassess readiness to stop or reduce smoking**	☐
2	**Discuss continued use of treatment and provide supply of tobacco dependence aids**	☐
3	**Discuss importance of support following discharge from hospital**	
	■ Discuss importance and review plans for post-discharge support	☐
	■ Inform patient of post-discharge follow-up calls/contacts	☐
4	**Provide guidance on staying smokefree / reducing smoking following discharge**	
	■ Discuss plan/tips for staying smokefree following discharge	☐
	■ Discuss plan for dealing with urges to smoke	☐
	■ Reinforce the importance of abrupt cessation and dealing with any lapses	☐
	■ Identify support persons and plan ahead for patients with other people who smoke in the home	☐
	■ If relevant, remind the patient about the impact of smoking on the metabolism of their medication, and the need to inform their doctor if they start smoking again, so that medication can be adjusted	☐
5	**Provide a summary and address any questions or concerns**	☐
	■ Prompt commitment from patient to staying smokefree or achieving harm reduction goals	

Communication skills used

Build rapport	☐	Use reflective listening	☐
Boost motivation and self-efficacy	☐	Provide reassurance	☐

After the consultation

Document consultation in patient record	☐
Provide a supply of NRT and/or e-liquid/pods/nicotine analogues to be used post-discharge (minimum recommended supply is two weeks). If the patient is taking cytisine, provide the remaining tablets in the pack to reach the end of the 25-day treatment.	☐
Communicate with patient's care team (as needed)	☐
Communicate with prescribers (as needed)	☐
Coordinate community referral (as needed)	☐

TDA Tips

- Prior to meeting the patient, speak with the nurse in charge or appropriate ward staff to get an update on their progress, current mental state, and risk assessment. Ascertain plans for the patient's discharge.
- When approaching the patient, conduct a visual assessment of their current physical and mental state and use this to guide your interaction, taking particular note of any changes that may have occurred since the last assessment.
- As you engage with the patient, reassess their ability to interact with you. Factors such as auditory hallucinations, low mood, level of distress and cognitive impairment will need to be considered as these can change significantly during the hospital stay.
- Listen to any concerns and worries the patient may have concerning treatment or their ability to remain smokefree once they are discharged.
- For those that have achieved a successful smokefree admission, re-explore and encourage a longer-term goal of abstinence once they go home and the associated benefits to their health and finances this would have.
- Be open to the fact that even the most resistant patient may change their mind about stopping smoking and you will want to ensure they are linked with post-discharge support.
- Reassure the patient that treatment and support will still be provided during their stay and can continue beyond discharge to avoid relapse back to smoking.
- Always congratulate and praise the patient on how much they have achieved so far, remember that this is not easy for them.
- Summarise and reflect on any significant changes or achievements and discuss potential barriers and sources of support the patient may need to remain abstinent.

- Discuss the benefits of ongoing support as part of their continuing care plan and ensure an appointment has been arranged for ongoing specialist follow-up.
- Patients that have previously declined support during their admission may be more receptive post-discharge, so consider offering a referral as part of the routine follow-up call.
- If the patient has restarted smoking or states an intention to do so after leaving hospital, communicate the need to have medication levels monitored carefully (when applicable) to avoid unpleasant side-effects and toxicity. Ensure the patient understands this risk and is aware of how to seek support from community mental health services. Liaise with the responsible community mental health service to ensure appropriate monitoring of medication levels is maintained to ensure patient safety.
- Document the outcome of the consultation in the patient's notes.

1 Assess progress and any challenges experienced, provide positive reinforcement and reassess readiness to stop or reduce smoking

- Assess progress with staying smokefree and any challenges experienced
- Provide positive reinforcement for staying smokefree, including personal benefits
- Reassess readiness to stop or reduce smoking, as appropriate

2 Discuss continued use of treatment and provide supply of tobacco dependence aids

- Review instructions for use of tobacco dependence aids following discharge, including products, frequency of use and instructions for use

Reinforce the importance of using these aids for the full 10–12-week treatment course. Inform the patient that using vapes, and other aids, beyond 12 weeks might increase their chances of successfully remaining smokefree.

Provide a supply of NRT and/or e-liquid/pods/nicotine analogues to be used post-discharge and until the next consultation with the community-based stop smoking service. The minimum recommended supply is two weeks.

Inform patients that the service they have been referred to will be able to continue to supply them with tobacco dependence medications or aids for the full 10–12-week treatment period and beyond if required.

Ensuring adequate supply of nicotine vapes, NRT and nicotine analogues during Transfer of Care

While ideally the community-based stop smoking service will provide a continued supply of combination NRT, nicotine vapes, or other medication free of charge, there are often delays to carrying out the initial assessment.

Working with the local stop smoking and pharmacy services to ensure they promptly see patients discharged from hospital and that tobacco dependence aids are being provided is critical to preventing relapse. Some services arrange for pick up or drop off of tobacco dependence aids for patients with mobility issues or poor health. Working with local services to develop processes for supporting patients in the critical period following discharge from hospital with continued supply of tobacco dependence aids is recommended best practice.

3 Discuss importance of support following discharge from hospital

- Discuss the importance of referral to post-discharge follow-up support, where they will get expert support with staying smokefree

It will be important to schedule the first consultation **before the tobacco dependence aids supplied to the patient in hospital run out.**

Remind the patient of the agreed appointment date, time and location. Check that you have the correct contact number for the patient so that a text can be sent, or call made, to remind the patient the day before the appointment. This reduces the likelihood of missed appointments and is a better use of the service.

Provide a contact number for the service the patient has been referred to.

"We have coordinated a referral to the [community pharmacy/stop smoking service] to support you with staying smokefree when you return home. You can expect to receive a call from them to see how you are doing and also provide you with an additional supply of NRT/vape/nicotine analogue."

"If you have any questions or concerns before that time, you can always call [name] at _____. Likewise, if you can't keep your appointment please give them a call. Don't worry if you struggle at all with staying smokefree – the advisers at the service are friendly and I think you will find their support will be really helpful."

- Inform the patient about follow-up calls that will take place 7–14 days and one-month post-discharge.

"We follow up with all patients following discharge from hospital. We will plan to give you a quick check-in call next week or the following week. Can I just verify the number you would like us to use to reach you? We will also schedule a time to see you back here at the hospital or when you come for your mental health review."

4 Provide guidance on staying smokefree / reducing smoking following discharge

- **Review the plan / tips for staying smokefree following discharge from hospital.**

  Provide guidance to all patients:

  "There are a few things that other patients have found really helped to keep them stay smokefree, could I share some of these with you? They are:

  – ***to throw out all of your tobacco/cigarettes, lighters and ashtrays***

  – ***to make a conscious effort to avoid people who smoke, especially in the first few weeks***

  – ***to try to keep yourself busy during the times when you would normally smoke***

  – ***to establish new routines/habits for the times when you would usually smoke***

  If you do get the urge to smoke, use the [fast-acting NRT product/nicotine vape] to help the craving pass, or distract yourself until the urges to smoke pass. Remember, the urge will not usually last any longer than five minutes."

- Review the patient's plan for dealing with urges to smoke, withdrawal symptoms and triggers in this early period (over next week).
- Reinforce the importance of maintaining and building on the health gains achieved for their recovery.
- Reinforce the importance of dealing with any lapses promptly so that they don't become relapses.
- Ask about other people who smoke in the home and signpost to local stop smoking support, as appropriate.
- For those who live in shared accommodation (e.g. residential services with communal spaces), consider liaising with residential support workers about how they can help with smoking relapse prevention.
- Discuss with the patient who might be able to support them with staying smokefree (e.g. a good friend, spouse or partner, family member, co-worker, community psychiatric nurse, peer support worker, befriender, advocate).

  "Is there someone that will be able to support you with your goal to stop smoking/ remain smokefree? Someone who can lend you support and encouragement or be there for you in any difficult times as you make this important change?"

  Be prepared for situations in which there is no 'support person' and provide reassurance that this is OK.

5 Provide a summary and address any questions or concerns

Verbally, and ideally in written form, summarise the plan following discharge from hospital. Allow time for the patient to ask any questions.

Prompt commitment from the patient to staying smokefree or achieving harm reduction goals.

5.0 The Post-Discharge Care Bundle

5.1 7–14-day post-discharge contact

Timeframe: 7–14 days post-discharge
Responsible Team: Hospital Tobacco Dependence Team or Community Stop Smoking Service (Transfer of Care)
Duration: 5–10 minutes

Clinical checklist

		Done
1	**Establish rapport and explain the reason for the call**	☐
2	**Assess smoking status and reassess smokefree goals**	☐
3	**Assess medication / vape use and supply**	☐
4	**Confirm access to community-based support, briefly address barriers, review options and refer as appropriate**	☐
5	**Provide a summary and schedule 28-day follow-up**	☐
		☐

Communication skills used

Build rapport	☐	Use reflective listening	☐
Boost motivation and self-efficacy	☐	Provide reassurance	☐

After the consultation

Document consultation in patient record	☐
Coordinate community referral (as needed)	☐
Liaise with care team (mental health and GP) if the patient's smoking status has changed and the medication needs to be reviewed, according to local protocol	☐

Responsible team

There is flexibility in the model for post-discharge follow-up in which either the in-house Tobacco Dependence Team will be responsible for the post-discharge contacts or this responsibility will be transferred to a community-based stop smoking provider, referred to as the Transfer of Care.

TDA Tips

- Always greet the patient in a positive manner and remain positive about their progress so far.
- As you engage with the patient, reassess their ability to interact with you, either in-person or over the telephone.
- Check on treatment compliance: are they using the medication/vape and have they engaged with specialist support?
- If continual abstinence is reported, congratulate and praise the patient on how much they have achieved so far, remember that this is not easy for them.
- Remind the patient that their achievement of going smokefree will continue to have significant benefits to their physical and mental health.
- Discuss the benefits of ongoing specialist support as part of their continuing care plan and ensure a follow-up has been arranged.
- If continual abstinence is not reported, elicit examples of any success (e.g. not smoking for a day, reducing the number of cigarettes per day) and provide positive feedback. Ask what support they need to reduce their cigarettes per day further or increase the number of days they are smokefree.
- If the patient has returned to smoking, liaise with the responsible mental health/GP service to ensure a medication review takes place, if relevant.
- If the patient has returned to smoking, encourage them to reestablish contact with the local stop smoking service as soon as possible. Suggest dates: ***"maybe on your birthday, or perhaps you could re-join the programme for Stoptober/National No Smoking Day/World No Tobacco Day, or as part of your new year resolutions."***
- Document the outcome of the call in the patient's notes.

1 Establish rapport and explain the reason for the call

Returning home after a hospital stay can be challenging due to ongoing illness, recovery and stigma issues. Additionally, this can be a period in which there is an elevated risk of relapse to smoking, as patients return to their regular routines and the environments where they have smoked in the past. Furthermore, the stress of illness and hospitalisation may affect the patient's motivation to remain smokefree or be a trigger for smoking more.

Patients may be struggling with withdrawal symptoms or urges to smoke.

Let the patient know the Tobacco Dependence Team calls all patients they meet whilst in hospital to see how they are doing after they have returned home.

"Hi _____. It's _____ from the Tobacco Dependence Team at the _____ hospital. How are you? I am calling to see how you have been getting on since your return home. It's important for us to ensure you are getting on well and have the support you need to stop smoking or reduce your smoking."

2 Assess smoking status and reassess smokefree goals

Ask about smoking status and discuss the response.

For patients who were engaged in long-term abstinence attempts you can ask:

"How are you getting on, have you managed to stay smokefree since leaving hospital?"

or

"How have you been getting on with not smoking since being discharged from hospital?"

To get an accurate response it is often useful to clarify the patient's response by offering them the following options, or by asking them to confirm that they have not had even one puff on a cigarette:

- No, not even a puff.
- Yes, just a few puffs.
- Yes, between 1 and 5 cigarettes.
- Yes, more than 5 cigarettes.

If the patient has remained abstinent:

- Congratulate and praise them on their progress to date.
- Reinforce the importance of staying smokefree and not having even one puff on a cigarette. Advise the patient that most people who relapse go back to smoking in the first few weeks after stopping and that managing not to smoke at all makes their chances of becoming permanently smokefree much higher.

If the patient has had a slip(s) (had a few cigarettes but not returned to regular smoking):

- Acknowledge the effort made, especially for those more dependent on tobacco. However, also gently remind the patient about the rationale of complete abstinence, as having the occasional cigarette makes withdrawal worse and reduces the likelihood of stopping.
- Provide positive feedback on small successes (e.g. not smoking for a day, reducing the number of cigarettes per day).
- Learn about the details of the patient's smoking (when, where and why).
- Ask what support they need to reduce their cigarettes per day further or increase the number of days they are smokefree.
- Ensure they are seen by follow-up support.

If the patient has relapsed (returned to regular smoking):

- It will not be uncommon for patients who expressed an initial interest in quitting to change their mind or feel a lack of confidence in their ability to quit. It can be helpful to understand the challenges of stopping and provide non-judgmental support and encouragement. Often just a few minutes speaking to a trained practitioner can assist with boosting patient confidence and help them return to the plan for harm reduction or stopping.

For patients not engaged in becoming smokefree:

"How many cigarettes a day are you smoking at the moment?"

"Have you attempted to reduce your smoking at all?"

"What are you finding challenging?"

Provide advice and motivational intervention as appropriate.

Assess their readiness to go smokefree:

"Have you thought about getting support from the local stop smoking team/community pharmacist to support you with quitting?"

"Have you been able to look at the stop smoking app? Many people in your situation really find it helps to have access to support at their fingertips."

or

"I wanted to check to see how you are doing and let you know the offer of support is always here. We can provide medications without cost and specialist support."

Respond as appropriate.

Review options for follow-up support and initiate referral to locally available stop smoking support, as appropriate.

3 Assess medication / vape use and supply

- Assess patients use of tobacco dependence mediation and/or vape.

  "Have you been using the [medication/vape] that was provided to you?"

- Assess current supply levels.

  "How much medication/vape/pod supply do you have left?"

4 Confirm access to community-based support, briefly address barriers, review options and refer as appropriate

Confirm access to follow-up support (for patients who were referred to community-based follow-up support):

"I wanted to check to see if you met with the Tobacco Dependence Adviser at the [name of service to which patient was referred for stop smoking support]?"

If the patient is being actively followed by a community-based stop smoking service:

That's great, I am so glad you have been working with the service."

Learn more about their experience, where appropriate, and provide reinforcement:

"Are you finding you are getting the support you need?"

"You are the one doing all the work, but I am glad to know that, despite the fact that a visit to hospital is how we met, you have been able to use the opportunity to get expert support with stopping."

If the patient is not being followed by a community-based stop smoking service, briefly address any barriers, review options and refer as appropriate.

Whilst structured support from a specialist service will provide the best chance of stopping, consider alternative support mechanisms as part of addressing any reported barriers.

This might include a different service (for instance, if they were referred to a Community Pharmacy Smoking Cessation Service, a Local Stop Smoking Service, digital offer, self-help, support group, etc., might work better.).

Advise any patients not interested in formal support about the option to switch to vaping.

"I recall you decided not to use a vape when you were in hospital, as you chose the NRT option. Given that the NRT hasn't worked out this time, would you like to reconsider using a vape? It is the most popular way to stop smoking in the UK at this time and vapes are recommended by health organisations such as the Department of Health and Social Care."

If the community-based stop smoking service was not in touch:

- Let the patient know that you will be in touch with the service to see what may have happened.
- Provide any immediate support the patient may need, particularly with the supply of the tobacco dependence treatment that was prescribed in hospital.

If the patient has changed their mind:

- Review the reasons for this and encourage them to consider engaging in support, letting them know the door remains open.
- Consider other options for follow-up support, as appropriate.

If the patient has identified barriers to accessing the service, briefly address these barriers. Barriers may include: travel time, ability to devote time to visit, concerns about being pressured or not understood and having to engage with a new service.

5 Provide a summary and schedule 28-day follow-up

Provide patients with brief advice:

"Try to keep yourself busy during the times when you would normally smoke. If you do get the urge to smoke, use the NRT or vape to help the craving pass, or keep yourself busy for three to five minutes while the urge to smoke passes."

For patients experiencing moderate to severe withdrawal symptoms or urges to smoke, advice should be provided about increasing frequency of use, or dose of the NRT/vape.

Provide a summary

Summarise what was discussed as part of the call and any actions to be taken by the patient or yourself (e.g. initiate referral). Contact the community mental health team or GP to review medication, if indicated.

Ask the patient if they have any questions:

Do you have any questions or concerns that you want to talk about?"

If no, continue. **If yes,** answer the questions as best you can.

Schedule the 28-day follow-up

Schedule the 28-day follow-up. Confirm the best contact number.

If possible, arrange this follow-up to coincide with another appointment the patient may have (e.g. clozapine/olanzapine/depot clinic or outpatient follow-up).

Ensure the patient has a contact number for the service to which they are being referred and/or the trust Tobacco Dependence Team.

For trusts conducting face-to-face follow-up:

- Ensure the patient has details of location of their appointment.

5.2 Four-week follow-up contact and outcome assessment

Timeframe: 28 days post-discharge
Responsible Team: Hospital Tobacco Dependence Team or Community Stop Smoking Service (Transfer of Care)
Duration: 10 minutes
Format: By telephone or in-person

Clinical checklist

		Done
1	**Learn about progress and assess current smoking status, reassess smokefree goals**	☐
2	**Assess medication / vape use and supply**	☐
3	**Confirm access to community-based support, briefly address barriers, review options and refer as appropriate**	☐
4	**Provide a summary and positive reinforcement**	☐

Communication skills used

Build rapport	☐	Use reflective listening	☐
Boost motivation and self-efficacy	☐	Provide reassurance	☐

After the consultation

Document consultation in patient record	☐
Document 28-day smoking status in using locally established protocols for national dataset	☐
Coordinate community referral (as needed)	☐

Responsible team

There is flexibility in the model for post-discharge follow-up in which either the in-house Tobacco Dependence Team will be responsible for the post-discharge contacts or this responsibility will be transferred to a community-based stop smoking provider, known as the Transfer of Care.

Whilst the follow-up may in these circumstances be led by the community-based provider, there is still an onus on the NHS to work with that provider to collect and record the 28-day smoking status, which is the main outcome tracked in the national dataset. This may require data sharing agreements to be in place.

1 Learn about progress and assess current smoking status, reassess smokefree goals

Welcome the patient and ask about their health status. Show genuine interest in learning about how they have been doing in general and in staying smokefree.

For patients who were engaged in long-term abstinence:

"How are you getting on, have you managed to stay smokefree since leaving hospital?"

or

"How have you been getting on with not smoking since being discharged from hospital?"

To get an accurate response it is often useful to clarify the patient's response by offering them the following options, or by asking them to confirm that they have not had even one puff on a cigarette:

- No, not even a puff.
- Yes, just a few puffs.
- Yes, between 1 and 5 cigarettes.
- Yes, more than 5 cigarettes.

Record self-reported smoking status in the locally established tracking system. The 28-day quit rate is the main outcome indicator for the local and national monitoring dataset for the NHS tobacco dependence programme.

If the patient has remained abstinent:

- Congratulate and praise the patient on their progress to date.
- Reinforce the importance of staying smokefree and not having even one puff on a cigarette. Advise the patient that most people who relapse go back to smoking in the first few weeks after stopping and that managing not to smoke at all makes their chances of becoming permanently smokefree much higher.

If the patient has had a slip(s) (had a few cigarettes but not returned to regular smoking):

- Acknowledge and congratulate the effort made, especially for those more dependent on tobacco. However, also gently remind the patient about the rationale of complete abstinence, as having the occasional cigarette makes withdrawal worse and reduces the likelihood of stopping.
- Provide positive feedback on small successes (e.g. not smoking for a day, reducing the number of cigarettes per day).
- Learn about the details of the patient's smoking (when, where and why). Provide brief advice and ensure they are seen by follow-up support.
- Ask what support they need to reduce their cigarettes per day further or increase the number of days they are smokefree.

If the patient has relapsed (returned to regular smoking):

It will not be uncommon for patients who expressed initial interest in stopping to change their mind or feel a lack of confidence in their ability to stop. It can be helpful to understand the challenges of quitting and provide non-judgmental support and encouragement. Often just a few minutes speaking to a trained practitioner can assist with boosting patient confidence and help them stay on track with their plan for harm reduction or stopping

Medication and smoking interactions in line with local protocols
Check which medications the patient is using. Ask about any changes in side effects. Where appropriate, revisit the way tar in tobacco smoke speeds up the metabolism of some medications.

Advise the patient that you will contact their care team to ensure their medication is reviewed to ensure their safety.

For patients not engaged in becoming smokefree:

"How many cigarettes a day are you smoking at the moment?"

"Have you attempted to reduce your smoking at all?"

"What are you finding challenging?"

Provide advice and motivational intervention, as appropriate.

Assess their readiness to go smokefree:

"Have you thought about getting support from the local stop smoking team/ community pharmacist to support you with cutting down or quitting?"

"Have you been able to look at the stop smoking app? Many people in your situation really find it helps to have access to support at their fingertips."

or

"I wanted to check to see how you are doing and let you know the offer of support is always here. We can provide medications without cost and specialist support."

Respond as appropriate.

Review options for follow-up support and initiate referral to stop smoking support, as appropriate.

Good practice: CO verification of 28-day quit

For teams who will see patients in-person, it is a recommended good practice to conduct a CO test (**Appendix 9**) to verify self-reported smoking status. Advisers can briefly review results with patients which can serve as a motivational intervention.

Note: the cut-off for CO-verified 28-day quit is a CO reading of less than 10ppm. This cut-off is the national standard for all stop smoking services and is higher than the typical level for a person who doesn't smoke (0–6ppm). This is to reflect the fact that results of 7–9ppm are borderline values that may be found in both people who do and do not smoke, particularly in individuals that live in an area with high levels of air pollution.

2 Assess medication / vape use and supply

- Assess the patient's use of tobacco dependence medication and/or vape.

  "Have you been using the [medication/vape] that was provided to you?"

- Assess current supply levels.

  ""How much medication/vape/pod supply do you have left?"

3 Confirm access to community-based support, briefly address barriers, review options and refer as appropriate

For patients who were referred to community-based support:

"I'm interested in finding out if you met with the Tobacco Dependence Adviser at [name of service to which patient was referred for stop smoking support]?"

If the patient is being actively followed by a community-based stop smoking service:

"That's great, I am so glad you have been working with the service. Well done, this is such a great achievement."

Learn more about their experience, where appropriate, and provide reinforcement:

"Are you finding you are getting the support you need?"

"You are the one doing all the work, but I am glad to know that, despite the fact that a visit to hospital is how we met, you have been able to use the opportunity to get expert support with stopping."

If the community-based stop smoking service was not in touch:

- Let the patient know that you will be in touch with the service to see what may have happened.
- Provide any immediate support the patient may need, particularly with the supply of the tobacco dependence treatment that was prescribed in hospital.

If the patient has changed their mind:

- Review the reasons for this and encourage them to consider engaging in support, letting them know the door remains open.
- Consider other options for follow-up support, as appropriate.

If the patient has identified barriers to accessing the service, briefly address these barriers. Barriers may include: travel time, ability to devote time to visit, concerns about being pressured or not understood and having to engage with a new service.

4 Provide a summary and positive reinforcement

Provide a summary

Summarise what was discussed as part of the call and any actions to be taken by the patient or yourself (e.g. initiate referral). Contact the community mental health team or GP to review medication, if indicated.

Provide positive reinforcement

Provide positive reinforcement to the patient on the importance of staying smokefree to their health and financial situation. Where appropriate, link to the patient's personal reasons for stopping.

Acknowledge that stopping smoking can be difficult but that the support being provided shows how important we believe it is for their health.

If time permits, you can ask the patient about some of the good things that have come from stopping, encouraging them to describe these in their own words. You can also calculate the money saved by not buying cigarettes or provide information about benefits to their health in relation to their reason for hospitalisation or other health issues.

For some patients, exploring the benefits for family members, especially children, older people or pets, can be a driver for reconnecting and committing to a smokefree plan.

Ask the patient if they have any questions:

"Do you have any questions or concerns that you want to talk about?"

If no, continue. **If yes,** answer the questions as best you can.

Provide a summary and contact number

Provide a summary of what was discussed, thank the patient for their time and provide a contact number, as appropriate.

6.0 Clinical Considerations

Allergic reactions

Patients with any allergic reactions to a tobacco dependence aid should discontinue use and switch to another tobacco dependence aid. While allergic reactions are rare, they may present as a serious skin reaction, itching, burning, swelling (on the face, eyelids, lips, tongue, throat, hands, legs feet or genitals), trouble breathing or swallowing, chest tightness or convulsions.

Body weight

Patients with a high BMI, including overweight or large muscle mass, may benefit from higher doses of NRT and/or use of a nicotine analogue medication. Patients with low BMI, including the elderly, may need dose reductions, particularly when using varenicline, in order to manage side effects such as nausea. This does not seem to affect the efficacy of the medication.

Patients with cardiovascular disease

Cardiovascular diseases (CVD) are the most common cause of death in people with SMI.[59–61] Stopping smoking is one of the most important changes patients with SMI can make to improve their CVD health, and reduce their risk of future events, hospitalisation and death.[8,9,62–63]

All first-line tobacco dependence aids can be safely used in patients with CVD.[64–66] The one area where there has been less evidence to guide practice is patients with acute coronary syndrome (ACS). While there have been only a small number of studies to examine the use of NRT and varenicline among patients with ACS, those conducted to date show no adverse effects.[67–70] Any possible risks associated with NRT use in this population are considered to be far lower than the well-established risk of continued smoking.

Research has also shown that people who switch completely from smoking to vaping can see improvement in cardiovascular function after 30 days.[71] In the short-term, heart rate and blood pressure are lower among people who vape compared with those who smoke and similar or higher compared to people who do not smoke or vape.[71]

Cannabis smoking

Cannabis is the most widely used illicit substance worldwide, including the UK, where 12.3% of adults report using it in the past year.[72] The majority of cannabis users smoke it together with tobacco (i.e. in joints or spliffs). This is why it is relevant to tobacco dependence treatment.

Patients in smokefree mental health hospitals where cannabis and tobacco smoking are not permitted can struggle to cope with withdrawal from both substances. Screening at the point of admission should identify cannabis users.

TDAs should explore cannabis use as part of the initial assessment by asking:

"Do you ever use cannabis? How do you use it?"

"I am asking you this because it might affect your treatment and I want to give you the most relevant and helpful advice."

TDAs should explain that their priority is to ensure the patient can manage their tobacco dependence during their hospital stay. They can also help if the patient decides to take the opportunity to engage in a quit attempt.

TDAs should explain that they work closely with specialist addiction (dual diagnosis) services and can arrange for extra support with cannabis use if the patient agrees.

Patients should be advised that continued cannabis smoking may hamper their chance of successfully quitting because there is strong evidence that cannabis use is associated with an increased risk of starting smoking and a risk of relapse after quitting.

TDAs can say:

"The best thing for your quit attempt is to completely stop smoking both cannabis and tobacco. Even in the long-term, a return to using cannabis puts you at high risk of relapsing back to tobacco smoking."

or

"Completely stopping smoking cannabis with tobacco significantly improves your chance of staying smokefree."

TDAs should observe for cannabis withdrawal symptoms (see list below), which usually start between one to three days after cessation, peak at two to six days, and last for 14 days or more.

> Cannabis withdrawal symptoms include: restlessness, irritability, feeling anxious or worried, feeling depressed, trouble sleeping, nightmares/vivid dreams, feeling tired during the day, lack of appetite and weight loss, headaches, sweating, digestion problems, cramps, nausea, tremor, fever and chills.

Research suggests NRT may assist with cannabis withdrawal symptoms. A recent review found that varenicline was useful for treating withdrawal symptoms among people who used both tobacco and cannabis. Trials are ongoing to evaluate the use of nabilone (a THC analogue) for tobacco and cannabis cessation.

For more information, please see the NCSCT briefing: Smoking cessation and cannabis use – A guide for stop smoking practitioners: **www.ncsct.co.uk/publications/cannabis**.

In-house tobacco dependence services for staff

Many NHS trusts support employees who smoke by giving protected time to attend tobacco dependence treatment appointments or by offering free access to in-house tobacco dependence services.

Where TDAs facilitate access to tobacco dependence treatment for colleagues, the scope of this service must be clearly outlined. It is recommended to provide clarity about:

- how to contact the service
- the duration of the treatment available
- the treatment options provided
- the location of the service
- the option for virtual/online service
- what personal information will be collected
- how personal information will be stored
- what data will be shared, and in what format, about the service activity and outcomes

Whilst safeguarding confidentiality is important for all service users, it is of vital importance in a service for staff, where the lines can be blurred, and colleagues may find they are working alongside someone one day and providing direct care to the same person on another day.

Patients with diabetes

For patients who stop smoking, close monitoring of glycaemic control and adjustment of anti-diabetic medications, as needed, is recommended in the first year after stopping. Liaise with the clinical team administering anti-diabetic medication if the patient is being supported with smoking abstinence during their admission.

Patients with orthopaedic and musculoskeletal conditions

People who smoke will experience an increased risk of decreased bone mass and of developing osteoporosis. Men with SMI have an increased risk of osteoporosis and both men and women with SMI have an increased risk of fractures.[73]

The risk increases with the length and intensity of the patient's smoking history. People who smoke have an increased risk of fracture and a slower rate of fracture healing. There is mixed evidence as to whether nicotine affects bone health. However, nicotine delivered via NRT will not reach the same level in blood as nicotine delivered via a cigarette.

Pregnant women

Combination NRT can be used for pregnant women who smoke and might be particularly helpful to those who are more dependent or are struggling with withdrawal symptoms and/or urges to smoke. It is recommended that pregnant women use a 16-hour patch or remove the 24-hour patch overnight. Nicotine vapes are also an effective stop smoking option for use by pregnant women. Varenicline and cytisine are not licensed for pregnant and breastfeeding women.

Patients taking clozapine

Upon identification of clozapine use by patients, specialist advice should be sought.

Trusts will have a clozapine protocol in place for dose adjustment. The recommended dose adjustment is 25% over the first week, to 75% of original dose. Blood plasma levels are taken before and after to guide further dose reductions. Doses will need to be adjusted again should patients return to smoking. The specialist will assess whether dose reduction is needed for short lengths of stay where the patient does not intend to remain smokefree long-term.

Refer to **Appendices 12 and 13** for further guidance and for medication management of smoking and other psychotropic medicines.

Renal impairment

Schizophrenia and bipolar disorder are associated with an increased risk of chronic kidney disease.[74]

Patients with moderate to severe renal impairment may experience a 40–60% reduction in clearance of nicotine. Clinicians can contemplate a dose reduction based on patient response for less dependent patients. Patient risk of relapse and treatment response should guide practice.

Patients with severe renal impairment (creatine clearance < 30 ml/min) should reduce their dose of varenicline by half (0.5 mg twice daily). Patients with renal failure should not use varenicline.

No adjustments are needed for patients with mild to moderate renal impairment.

There is no clinical experience of cytisine in patients with renal or hepatic impairment, therefore the drug product is not recommended for use in those with any level of renal impairment.

7.0 References

1. RCP. Hiding in plain sight: Treating tobacco dependency in the NHS. London: The Royal College of Physicians; 2018.
2. NHS Information Centre: Health Survey for England. https://digital.nhs.uk/data-and-information/publications/statistical/health-survey-for-england#:~:text=The%20Health%20Survey%20for%20England,in%20private%20households%20in%20England
3. Action on Smoking and Health. *The Stolen Years.* ASH; 2016. Available from: https://ash.org.uk/uploads/MHreport29-07-16.pdf?v=1648129334
4. Jochelson, K. & Majrowski W. Clearing the Air: Debating Smokefree Policies in Psychiatric Units. London, King's Fund, 2006.
5. Richardson S, McNeill A, Brose LS. Smoking and quitting behaviours by mental health conditions in Great Britain (1993-2014). *Addict Behav* 2019;90:14–19.
6. Chesney E, Robson D, Patel R, Shetty H, Richardson S, Chang CK, McGuire P, McNeill A. The impact of cigarette smoking on life expectancy in schizophrenia, schizoaffective disorder and bipolar affective disorder: An electronic case register cohort study. *Schizophr Res.* 2021 Dec;238:29–35.
7. Chang CK, Hayes RD, Perera G, Broadbent MTM, Fernandes AC, et al. (2011) Life Expectancy at Birth for People with Serious Mental Illness and Other Major Disorders from a Secondary Mental Health Care Case Register in London. PLoS ONE 6(5): e19590.
8. Chesney, E et al. Risks of all-cause and suicide mortality in mental disorders: a meta-review. *World Psychiatry.* 2014; 3 (2): 153–160.
9. Smoking and Mental Health. A joint report by the Royal College of Physicians and the Royal College of Psychiatrists. 2013
10. Vermeulen J, Schirmbeck F, Blankers et al. Smoking, symptoms, and quality of life in patients with psychosis, siblings, and healthy controls: a prospective, longitudinal cohort study. *Lancet Psychiatry.* 2019 Jan;6(1):25–34.
11. NCSCT Smoking and mental health. A briefing for HCP. https://www.ncsct.co.uk/publications/Smoking_cessation_and_Mental_Health_briefing
12. Robson D, Yates M, Craig TJ, Healey A, McNeill A. Time to Smoke: Facilitating Smoking Breaks in Mental Health Inpatient Settings. *Nicotine Tob Res.* 2016 Aug;18(8):1794–7.
13. Taylor GMJ, et al. Smoking cessation for improving mental health. *Cochrane Database of Systematic Reviews* 2021, Issue 3. Art. No.: CD013522.
14. Wu AD, Gao M, Aveyard P, et al. Smoking Cessation and Changes in Anxiety and Depression in Adults With and Without Psychiatric Disorders. *JAMA* Netw Open 2023;6(5):e2316111.
15. Kock L, Brown J, Cox S et. Al. Association of psychological distress with smoking cessation, duration of abstinence from smoking, and use of non-combustible nicotine-containing products: A cross-sectional population survey in Great Britain. *Addict Behav.* 2023 Mar;138:107570.
16. Robson D, Spaducci G, McNeill A, Stewart D, Craig TJK, Yates M, Szatkowski L. Effect of implementation of a smoke-free policy on physical violence in a psychiatric inpatient setting: an interrupted time series analysis. *Lancet Psychiatry.* 2017 Jul;4(7):540–546.
17. Spaducci G, McNeill A, Hubbard K, Stewart D, Yates M, Robson D. Smoking-related violence in a mental health setting following the implementation of a comprehensive smoke-free policy: A content analysis of incident reports. *Int J Ment Health Nurs.* 2020 Apr;29(2):202-211.
18. Huddlestone, L., Sohal, H., Paul, C. et al. Complete smokefree policies in mental health inpatient settings: results from a mixed-methods evaluation before and after implementing national guidance. *BMC Health Serv Res.* 2018;18:542.
19. Lawn S, Campion J. Achieving smoke-free mental health services: lessons from the past decade of implementation research. *Int J Environ Res Public Health.* 2013 Sep 10;10(9):4224–44.

20. Robson D, Spaducci G, McNeill A, Yates M, Wood M, Richardson S. Fire Incidents in a Mental Health Setting: Effects of Implementing Smokefree Polices and Permitting the Use of Different Types of E-Cigarettes. *Int J Environ Res Public Health.* 2020 Dec 1;17(23):8951.
21. Birge M, Duffy S, Astrid Miler J, Hajek P. What Proportion of People Who Try One Cigarette Become Daily Smokers? A Meta-Analysis of Representative Surveys, *Nicotine & Tobacco Research* 2018;20(12):1427–1433.
22. Seddon C. Breaking the Breaking the cycle of children's exposure to tobacco smoke. *British Medical Association.* 2007.
23. Williams JM, Ziedonis DM, Abanyie F, Steinberg ML, Foulds J, Benowitz NL. Increased nicotine and cotinine levels in smokers with schizophrenia and schizoaffective disorder is not a metabolic effect. *Schizophr Res.* 2005;79(2-3):323–35.
24. Williams JM, Gandhi KK, Lu SE, Kumar S, Shen J, Foulds J, Kipen H, Benowitz NL. Higher nicotine levels in schizophrenia compared with controls after smoking a single cigarette. *Nicotine Tob Res.* 2010;12(8):855–9.
25. Tidey JW, Colby SM, Xavier EM. Effects of smoking abstinence on cigarette craving, nicotine withdrawal, and nicotine reinforcement in smokers with and without schizophrenia. *Nicotine Tob Res.* 2014;16(3):326–34. doi: 10.1093/nor/ntt152.
26. Lo S, Heishman SJ, Raley H, Wright K, Wehring HJ, Moolchan ET, Feldman S, Liu F, McMahon RP, Richardson CM, Kelly DL. Tobacco craving in smokers with and without schizophrenia. *Schizophr Res.* 2011;127(1-3):241–5. doi: 10.1016/j.schres.2010.06.017.
27. Richardson S, McNeill A, Brose LS. Smoking and quitting behaviours by mental health conditions in Great Britain (1993-2014). *Addict Behav* 2019;90:14–19.
28. Peckham E, Brabyn S, Cook L, Tew G, Gilbody S. Smoking cessation in severe mental ill health: what works? An updated systematic review and meta-analysis. *BMC Psychiatry.* 2017 Jul 14;17(1):252.
29. Gilbody S, Peckham E, Bailey D, Arundel C, Heron P, Crosland S, et al. Smoking cessation for people with severe mental illness (SCIMITAR+): a pragmatic randomised controlled trial. *Lancet Psychiatry.* 2019 May;6(5):379–390.
30. Spanakis P, Peckham E, Young B, Heron P, Bailey D, Gilbody S. A systematic review of behavioural smoking cessation interventions for people with severe mental ill health-what works? *Addiction.* 2022 Jun;117(6):1526–1542.
31. Hartmann-Boyce J, Hong B, Livingstone-Banks J, et al. Additional behavioural support as an adjunct to pharmacotherapy for smoking cessation. *Cochrane Database Syst Rev* 2019;6(6):CD009670.
32. Lindson N, Theodoulou A, Ordonez-Mena JM, et al. Pharmacological and electronic cigarette interventions for smoking cessation in adults: component network meta-analyses. *Cochrane Database Syst Rev* 2023;9(9):CD015226.
33. Michie S, Churchill S, West R. Identifying evidence-based competences required to deliver behavioural support for smoking cessation. *Ann Behav Med* 2011;41(1):59–70.
34. Michie S, Hyder N, Walia A, et al. Development of a taxonomy of behaviour change techniques used in individual behavioural support for smoking cessation. *Addict Behav* 2011;36(4):315–9.
35. Black N, Johnston M, Michie S, et al. Behaviour change techniques associated with smoking cessation in intervention and comparator groups of randomized controlled trials: a systematic review and meta-regression. *Addiction* 2020;115(11):2008–20.
36. NICE. Tobacco: Preventing uptake, promoting quitting and treating dependence. NICE Guideline [NG209]; 2021.
37. McNeil A, Simonavicius E, Brose L, Taylor E, East K, Zuikova E, Calder R, Robson D. Nicotine vaping in England: an evidence update including health risks and perceptions, 2022. A report commissioned by the Office for Health Improvement and Disparities; 202. https://assets.publishing.service.gov.uk/media/633469fc8fa8f5066d28e1a2/Nicotine-vaping-in-England-2022-report.pdf
38. Lindson N, Butler AR, McRobbie H, Bullen C, Hajek P, Begh R, et al. Electronic cigarettes for smoking cessation. *Cochrane Database Syst Rev* 2024: Issue 1: Art. No.: CD010216.

39. Theodoulou A, Chepkin SC, Ye W, et al. Different doses, durations and modes of delivery of nicotine replacement therapy for smoking cessation. *Cochrane Database Syst Rev* 2023;6(6):CD013308.
40. Livingstone-Banks J, Fanshawe TR, Thomas KH, et al. Nicotine receptor partial agonists for smoking cessation. *Cochrane Database Syst Rev* 2023;5(5):CD006103.
41. Anthenelli RM, Benowitz NL, West R, et al. Neuropsychiatric safety and efficacy of varenicline, bupropion, and nicotine patch in smokers with and without psychiatric disorders (EAGLES): a double-blind, randomised, placebo-controlled clinical trial. *Lancet* 2016;387(10037):2507–20.
42. Raich A, Ballbe M, Nieva G, et al. Safety of Varenicline for Smoking Cessation in Psychiatric and Addicts Patients. *Subst Use Misuse* 2016;51(5):649–57.
43. Mills EJ, Wu P, Lockhart I, et al. Comparisons of high-dose and combination nicotine replacement therapy, varenicline, and bupropion for smoking cessation: a systematic review and multiple treatment meta-analysis. *Ann Med* 2012;44(6):588–97.
44. Shiffman S, Ferguson SG, Gwaltney CJ, et al. Reduction of abstinence-induced withdrawal and craving using high-dose nicotine replacement therapy. *Psychopharmacology (Berl)* 2006;184(3–4):637–44.
45. Ferguson SG, Shiffman S, Gwaltney CJ. Does reducing withdrawal severity mediate nicotine patch efficacy? A randomized clinical trial. *J Consult Clin Psychol* 2006;74(6):1153–61.
46. Hatsukami D, Mooney M, Murphy S, et al. Effects of high dose transdermal nicotine replacement in cigarette smokers. *Pharmacol Biochem Behav* 2007;86(1):132–9.
47. Fredrickson PA, Hurt RD, Lee GM, et al. High dose transdermal nicotine therapy for heavy smokers: safety, tolerability and measurement of nicotine and cotinine levels. *Psychopharmacology (Berl)* 1995;122(3):215–22.
48. Dale LC, Hurt RD, Offord KP, et al. High-dose nicotine patch therapy. Percentage of replacement and smoking cessation. *JAMA* 1995;274(17):1353–8.
49. Thomas KH, Dalili MN, Lopez-Lopez JA, et al. Comparative clinical effectiveness and safety of tobacco cessation pharmacotherapies and electronic cigarettes: a systematic review and network meta-analysis of randomized controlled trials. *Addiction* 2022;117(4):861–76.
50. Hajek P, Smith KM, Dhanji AR, et al. Is a combination of varenicline and nicotine patch more effective in helping smokers quit than varenicline alone? A randomised controlled trial. *BMC Med* 2013;11:140.
51. Ramon JM, Morchon S, Baena A, et al. Combining varenicline and nicotine patches: a randomized controlled trial study in smoking cessation. *BMC Med* 2014;12:172.
52. Koegelenberg CF, Noor F, Bateman ED, et al. Efficacy of varenicline combined with nicotine replacement therapy vs varenicline alone for smoking cessation: a randomized clinical trial. *JAMA* 2014;312(2):155–61.
53. Ebbert JO, Hays JT, Hurt RD. Combination pharmacotherapy for stopping smoking: what advantages does it offer? *Drugs* 2010;70(6):643–50.
54. Chang PH, Chiang CH, Ho WC, et al. Combination therapy of varenicline with nicotine replacement therapy is better than varenicline alone: a systematic review and meta-analysis of randomized controlled trials. *BMC Public Health* 2015;15:689.
55. King A, Vena A, de Wit H, et al. Effect of Combination Treatment With Varenicline and Nicotine Patch on Smoking Cessation Among Smokers Who Drink Heavily: A Randomized Clinical Trial. *JAMA Netw Open* 2022;5(3):e220951.
56. Young AH, Taylor D, Barnes TRE. The Maudsley Prescribing Guidelines in Psychiatry. John Wiley & Sons, Ltd.; 2021. Print ISBN: 9781119772224 https://onlinelibrary.wiley.com/doi/book/10.1002/9781119870203
57. Care Quality Commission. CQC Brief Guide: Smokefree Policy in MH inpatient services. https://www.cqc.org.uk/search/site?fulltext=smoking
58. Hughes JR, Peters EN, Naud S. Relapse to smoking after 1 year of abstinence: a meta-analysis. *Addict Behav* 2008;33(12):1516–20.
59. Polcwiartek C, O'Gallagher K, Friedman DJ, Correll CU, Solmi M, Jensen SE, Nielsen RE. Severe mental illness: cardiovascular risk assessment and management, *European Heart Journal*, 2024;45(12):987–997.

60. Goldfarb M, De Hert M, Detraux J, Di Palo K, Munir H, Music S, Piña I, Ringen PA. Severe Mental Illness and Cardiovascular Disease: JACC State-of-the-Art Review. *J Am Coll Cardiol.* 2022 Aug 30;80(9):918–933.

61. De Hert M, Detraux J, Vancampfort D. The intriguing relationship between coronary heart disease and mental disorders. Dialogues Clin Neurosci. 2018 Mar;20(1):31–40.

62. National Center for Chronic Disease Prevention and Health Promotion (US) Office on Smoking and Health. The Health Consequences of Smoking – 50 Years of Progress: A Report of the Surgeon General. Atlanta (GA): Centers for Disease Control and Prevention (US); 2014. Available from: https://www.ncbi.nlm.nih.gov/books/ NBK179276/

63. Wu AD, Lindson N, Hartmann-Boyce J, et al. Smoking cessation for secondary prevention of cardiovascular disease. *Cochrane Database Syst Rev* 2022;8(8):CD014936. doi: 10.1002/14651858.CD014936.pub2.

64. Mills EJ, Thorlund K, Eapen S, et al. Cardiovascular events associated with smoking cessation pharmacotherapies: a network meta-analysis. *Circulation* 2014;129(1):28–41.

65. Sterling LH, Windle SB, Filion KB, et al. Varenicline and Adverse Cardiovascular Events: A Systematic Review and Meta-Analysis of Randomized Controlled Trials. *J Am Heart Assoc* 2016;5(2).

66. Benowitz NL, Pipe A, West R, et al. Cardiovascular Safety of Varenicline, Bupropion, and Nicotine Patch in Smokers: A Randomized Clinical Trial. *JAMA Intern Med* 2018;178(5):622–31. doi: 10.1001/jamainternmed.2018.0397 Franck C, Filion KB, Eisenberg MJ. Smoking Cessation in Patients With Acute Coronary Syndrome. *Am J Cardiol* 2018;121(9):1105–11.

67. Meine TJ, Patel MR, Washam JB, et al. Safety and effectiveness of transdermal nicotine patch in smokers admitted with acute coronary syndromes. *Am J Cardiol* 2005;95(8):976–8.

68. Woolf KJ, Zabad MN, Post JM, et al. Effect of nicotine replacement therapy on cardiovascular outcomes after acute coronary syndromes. *Am J Cardiol* 2012;110(7):968–70.

69. Pack QR, Priya A, Lagu TC, et al. Short-Term Safety of Nicotine Replacement in Smokers Hospitalized With Coronary Heart Disease. *J Am Heart Assoc* 2018;7(18):e009424.

70. Eisenberg MJ, Windle SB, Roy N, et al. Varenicline for Smoking Cessation in Hospitalized Patients With Acute Coronary Syndrome. *Circulation* 2016;133(1):21–30.

71. George J, Hussain M, Vadiveloo T, Ireland S, Hopkinson P, Struthers AD, Donnan PT, Khan F, Lang CC. Cardiovascular Effects of Switching From Tobacco Cigarettes to Electronic Cigarettes. *J Am Coll Cardiol*. 2019 Dec 24;74(25):3112–3120.

72. Hindocha C, Freeman TP, Ferris JA, Lynskey MT, Winstock AR. No Smoke without Tobacco: A Global Overview of Cannabis and Tobacco Routes of Administration and Their Association with Intention to Quit. *Front Psychiatry* 2016;7:104.

73. Avgerinou C, Walters K, Bazo-Alvarez JC, West RM, Osborn D, Clegg A, Petersen I. Association between severe mental illness and risk of osteoporosis and fragility fractures: analysis of UK primary care data, *Age and Ageing*, 2023;34(8):1411-27.

74. Tzeng NS, et al. Is schizophrenia associated with an increased risk of chronic kidney disease? A nationwide matched cohort study. *BMJ Open* 2015; 5:e006777.

8.0 Tobacco Dependence Adviser Training and Professional Development

TDA training

See NCSCT website for more information:
www.ncsct.co.uk/publications/topcategory/nhs

Training for admission team and other NHS staff

The NHSE-NCSCT eLearning for Admission Care Team and other NHS staff involved in the tobacco treatment programme includes five modules:

Module 1: Tobacco dependence treatment: a new standard or care

Module 2: The Admission Care Bundle

Module 2: Tobacco dependence in mental health hospitals

Module 3: Tobacco dependence aids

Module 4: Carbon monoxide testing

See eLFH: **https://portal.e-lfh.org.uk**

NCSCT website: **www.ncsct.co.uk/publications/topcategory/nhs**

Additional training resources

The NCSCT offers a suite of online training courses that can be accessed from our training home page (list of online courses below): **elearning.ncsct.co.uk/england**

- NCSCT Stop Smoking Practitioner Training and Assessment Programme
- Specialty course: Mental health and smoking cessation*
- Specialty course: Pregnancy and smoking cessation*
- Stop Smoking Medications
- Vaping: A guide for healthcare professionals
- Very Brief Advice on Smoking (VBA+)
- Very Brief Advice on Smoking for Pregnant Women
- Very Brief Advice on Secondhand Smoke

* Specialty courses are open to those who have passed the practitioner training

9.0 Resources for Tobacco Dependence Advisers

Reference material

Smoking Cessation and Mental Health: a briefing for front-line staff
This briefing is aimed at those who work in a mental health setting and gives expert, concise guidance on how to deliver Very Brief Advice (VBA+) to patients who smoke.

www.ncsct.co.uk/publications/Smoking_cessation_and_mental_health_briefing

CQC Brief Guide: Smokefree Policy in MH inpatient services

www.cqc.org.uk/search/site?fulltext=smoking

Tobacco: preventing uptake, promoting quitting and treating dependence
NICE Guidelines NG209

www.nice.org.uk/guidance/ng209

Hiding in plain sight: Treating tobacco dependency in the NHS
This key document addresses the harms and costs arising from smoking in the patients we see every day and argues for a new approach to treating their addiction.

www.rcp.ac.uk/improving-care/resources/hiding-in-plain-sight-treating-tobacco-dependency-in-the-nhs

NHS Tobacco Dependency Programme
This webpage provides a summary of the NHS tobacco dependency programme.

www.england.nhs.uk/ourwork/prevention/tobacco-dependency-programme

NHS Tobacco Dependence Competency Framework
The competency framework outlines the competencies (knowledge and skills) for both frontline staff who will deliver the initial assessment and staff delivering specialist tobacco dependence treatment within the NHS.

www.ncsct.co.uk/publications/category/NHSE-competency-frameworks

NHS Futures – Tobacco Dependence Forum

https://future.nhs.uk

Effects of smoking on health

ASH Factsheets
What's in a cigarette?

ash.org.uk/resources/view/whats-in-a-cigarette

Acute hospital admissions
This document is a bespoke Standard Treatment Plan for Inpatient Tobacco Dependence in acute trusts.

www.ncsct.co.uk/publications/STP-inpatient-acute

Maternity care pathway
This STP addresses tobacco dependence treatment in mental health hospitals. There are some differences between the tobacco dependence pathways for maternity care and mental health inpatients. It is acknowledged that there is potential crossover for pregnant women admitted to a mental health inpatient setting. As pregnant women may already be receiving support through a maternity TDA, a review of local pathways to ensure consistent advice and any variations to the STP in discharge planning is recommended.

Briefings and clinical tools

Tobacco dependence medications and aids

Stop smoking aids quick reference
This quick reference clinical tool has been written by experts in the field to support stop smoking practitioners with the task of helping patients to choose the best medication for them.

www.ncsct.co.uk/publications/stop-smoking-medications-quick-reference

Combination NRT briefing
Published in 2021, this NCSCT briefing on combination NRT summarises the latest research evidence and clinical good practice regarding the use of combination NRT:

www.ncsct.co.uk/publication_combination_nrt_briefing

Vaping (e-cigarettes)

Vaping: a briefing for health and social care professionals

www.ncsct.co.uk/publication_vaping_briefing

Smoking cessation and mental health: a briefing for frontline staff

www.ncsct.co.uk/publication_smoking_cessation_and_mental_health_briefing

Stopping smoking in pregnancy: a briefing for maternity care providers

www.ncsct.co.uk/publication_briefing_for_midwifery_staff

Supplying NRT to pregnant women

www.ncsct.co.uk/publications/nrt-supply-pregnancy

Medication interactions with smoking

www.sps.nhs.uk/articles/considering-drug-interactions-with-smoking

www.sps.nhs.uk/articles/managing-specific-interactions-with-smoking

10.0 Resources for Patients / Family / Carers / Significant others

NHS Smokefree
The NHS Smokefree website offers information and tips on stopping smoking, including information on accessing stop smoking support, daily email support, the free NHS Quit Smoking digital app and the online NHS Smokefree Quit Smoking Support Group.

www.nhs.uk/better-health/quit-smoking

Find your local Stop Smoking Service
Local Stop Smoking Services offer free stop smoking support from trained stop smoking practitioners, along with tobacco dependence medications.

www.nhs.uk/better-health/quit-smoking/find-your-local-stop-smoking-service

NHS Smokefree National Helpline: 0300 123 1044
The Smokefree National Helpline provides information and support with stopping smoking delivered by trained, expert advisers. All lines are open **Monday to Friday 9 am to 8 pm and Saturday and Sunday 11 am to 4 pm.**

Digital stop smoking apps

Below are two of the most popular smartphone apps.

NHS Quit Smoking app
The NHS Quit Smoking app is free and designed for those who want to stop smoking. The app provides a 4-week quit programme consisting of practical support, encouragement, and tailored advice. The support offered is evidence-based but not live. Users can track their progress, see how their health is improving, how much money they have saved and receive virtual badges to mark progress. Information on how to access the app, plus other NHS Stop Smoking resources, are available at Better Health.

iOS: apps.apple.com/gb/app/nhs-quit-smoking
Android: play.google.com/store/apps/details?id=com.doh.smokefree

Smoke Free app
The Smoke Free app is a comprehensive digital solution for people wanting to stop smoking. Live support is available 24 hours a day, every day of the year, and users can speak to an adviser as often as they like. The app also provides automated features such as daily stop smoking tasks, an AI QuitCoach, progress indicators such as time since the last cigarette, health improvements gained, and money saved.

smokefreeapp.com

Appendix 1
Nicotine withdrawal symptoms and management strategies

Duration is the average time period people typically experience this side effect after they stop smoking.

Prevalence indicates the percentage of people who stop who experience this symptom.

Symptom	Average duration	Prevalence	Mechanism	Patient strategies
Light-headedness	<48 hours	10%	Body is getting more oxygen than prior to stopping.	Get up slowly from a seated or lying down position.
Night-time awakenings	<1 week	25%	Nicotine is a stimulant; it affects brain and sleep patterns.	Reduce caffeine intake.
Urges to smoke	>2 weeks	70%	Your brain has nicotine receptors. When you stop smoking these nicotine receptors are deprived of nicotine and are expecting to be stimulated.	Your craving will only last a few minutes. Let it pass. Urges become less frequent and severe the longer it has been since the last cigarette. Use your fast-acting NRT product or vape to help with cravings. Develop strategies to deal with cravings. Remember the DEADDD strategies.
Poor concentration	<2 weeks	60%	Nicotine is a stimulant. The brain is getting used to staying alert without nicotine.	Be patient with yourself. Take breaks throughout your day.
Restlessness	<4 weeks	60%	Your brain has nicotine receptors. When you stop smoking these nicotine receptors are deprived of nicotine and are expecting to be stimulated.	Take time to relax.Take deep slow breaths in through your nose and out through your mouth. Develop new routines for distraction. Reduce caffeine intake.
Irritability / aggression	<4 weeks	50%	Your brain has nicotine receptors. When you stop smoking these nicotine receptors are deprived of nicotine and are expecting to be stimulated.	Inform friends and family of your goal for long-term abstinence so that they are aware of changes to your mood in this early period. Try to take it easy. Take a walk. Use relaxation techniques or a suitable exercise routine.

Symptom	Average duration	Prevalence	Mechanism	Patient strategies
Depressed mood	<4 weeks	60%	Changes to mood often occur in patients who stop smoking. Stopping smoking may unmask untreated depression.	Formal assessment of mood using validated scales should be used by health care professionals such as psychiatrists, nurses and psychologists. TDAs should conduct initial screen for possible depression, by asking the patient two depression identification questions: ■ During the last month, have you often been bothered by feeling down, depressed, or hopeless? ■ During the last month, have you often been bothered by having little interest or pleasure in doing things? If the patient answers 'yes' to either of these questions, the TDA should record this and ask relevant colleagues to carry out a formal assessment for depression.
Tired/low energy	2–4 weeks	–	Nicotine is a stimulant. It keeps body and brain alert.	Take a nap if you are tired. Don't push yourself. Your body is learning how to stay alert without nicotine.
Increased appetite/ weight gain	>10 weeks	70%	The brain can confuse nicotine craving with hunger. Taste buds return to normal and food begins to taste better. Nicotine is also associated with increased metabolism (approx. 150 calories/ day for regular smoking).	Choose healthy snacks, drink plenty of water and increase physical activity.
Constipation	>4 weeks	17%	Bowel movements may be less frequent.	Drink plenty of water, increase dietary fibre intake, move more. Consider use of over-the-counter or prescription medication.

Appendix 2
Heaviness of Smoking Index (HSI)

Heaviness of Smoking Index (HSI)

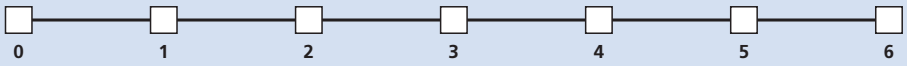
1. On the days that you smoke, how soon after you wake up do you have your first cigarette?

- ☐ Within 5 minutes (3 points)
- ☐ 6–30 minutes (2 points)
- ☐ 31–60 minutes (1 point)
- ☐ After 60 minutes (0 points)

2. How many cigarettes do you typically smoke per day?

- ☐ 10 or fewer (0 points)
- ☐ 11–20 (1 point)
- ☐ 21–30 (2 points)
- ☐ 31 or more (3 points)

Scoring



Lower dependence — Higher dependence

Appendix 3

Common side effects of tobacco dependence medications and management strategies

Product	What percent of patient experience this side effect	Strategies
Nicotine replacement therapy		
Skin irritation	35% (patch)	Rotate sites, use clear patch, or use cortisone cream.
Nausea	6% (patch) 18% (gum) 10% (spray)	Review instructions for use. Avoid swallowing for 15 seconds after use. Avoiding using more than recommended dose of fast-acting NRT (increase patch dose instead).
Dizziness	6% (patch)	Get up slowly.
Difficulty sleeping	7% (patch)	Remove patch at bedtime. Reapply 45–60 minutes before getting up (set alarm).
Mouth or throat irritation	17% (inhalator) 10% (mist)	Take slow puffs of inhalator to avoid throat burn. Avoid inhaling mist.
Headache	30% (patch) 10% (mist)	Use over-the-counter medication. Drink plenty of cold water.
Allergic reactions	2% (patch)	Discontinue medication and switch to another tobacco dependence aid.
Varenicline		
Nausea ■ Mild ■ Moderate ■ Severe	30% (breakdown below) 38.1% 71.4% 2%	■ Generally reduces on its own within two weeks of use ■ Take with full glass of water and meal ■ Take each tablet at least eight hours apart ■ Use over-the-counter anti-nauseant ■ Reduce dose by half (0.5 mg per day) if it is unresolved with the above ■ Discontinue if nausea is severe
Headache	15.5%	Use over the counter medication. Drink plenty of cold water.
Vivid/abnormal dreams	15%	Take dose earlier in the evening.

Appendix 4
Nicotine vapes quick reference

- Nicotine-containing vapes are a first-line tobacco dependence aid for adults who smoke and significantly less harmful than smoking.
- Vapes do not contain tobacco and there is no combustion, so they do not produce tar or carbon monoxide, two of the most damaging elements in tobacco smoke.
- Vapes are consumer products and are regulated for safety and quality by the Tobacco and Related Products Regulations 2016.

Guidelines for nicotine concentrations

- People who want to stop smoking should use a vape with nicotine-containing e-liquid or nicotine salts.
- E-liquid is typically available with nicotine concentrations of 0 mg/ml, 3 mg/ml, 6 mg/ml, 12 mg/ml, 18 mg/ml and 20 mg/ml.
- Most people who smoke regularly are likely to need 18 or 20 mg/ml e-liquid, at least to begin with. Those who are more dependent may initially benefit from vaping 18 or 20 mg/ml e-liquid and using a nicotine patch (NRT), with the vape acting as their fast-acting nicotine product.
- Experience can guide how much nicotine is required; the aim should be to use sufficient nicotine to significantly reduce or eliminate withdrawal symptoms and urges to smoke.

How it works

- Vaping devices heat a solution to create an aerosol that is inhaled. The solution typically contains nicotine, propylene glycol, vegetable glycerine and flavourings.
- Like NRT, the nicotine in a vape reduces the urge to smoke and is an effective substitute for smoking, delivering nicotine without harmful tobacco smoke.

Instructions

- Use regularly throughout the day and when cravings occur. Patients should be advised to use their vape as often as they need to in order to manage urges to smoke.
- The action of vaping is different to smoking. Patients new to vaping should inhale gently, drawing the vapour into the mouth and then inhaling into the lungs. Practice is often needed and patients should be supported to practice until they adjust their puffing technique.
- More frequent and consistent vaping ('grazing on nicotine') is typically needed to get sufficient nicotine, compared to smoking a cigarette every couple of hours ('bingeing on nicotine').
- Patients should be advised to always take their fully charged vape with them when they go out to avoid the risk of smoking when they haven't got their vape to hand.
- Advise patients not to leave their vape to charge overnight.
- Patients should be told that the benefits of vaping are greatest when they stop smoking tobacco completely.

Possible side effects

- The most common side effects of vaping tend to be a dry mouth and tickly cough.
- These can generally be remedied by drinking more water, as the vapour can have a drying effect on the mouth and throat.
- Any adverse side effects can be reported to the MHRA using the Yellow Card scheme: **https://yellowcard.mhra.gov.uk**

Main types of vaping devices

- There are many types of vapes on the market, with a wide variety in appearance, battery size and effectiveness. All devices deliver a flavoured aerosol, usually containing nicotine.
- Rechargeable devices with a refillable tank will deliver nicotine more effectively and quickly than a single-use device and for this reason may give patients a better chance of stopping smoking. In settings where only single-use devices are permitted, they are still good options.
- Mental health hospitals should provide recycling facilities for used vape materials.

Single-use (disposables) 	■ Newer to the market, they are compact, single-use and prefilled with flavoured e-liquid or nicotine salts. ■ They are most commonly pre-loaded with one strength of 20 mg/ml nicotine salt. ■ They are draw-activated and once the flavour/taste diminishes, they are designed to be disposed of and replaced with a new one. ■ They require no filling or practice to use and are relatively cheap. People not ready to commit to vaping may experiment with them. ■ The effectiveness of nicotine delivery is yet to be established, although reports from users are favourable.
Pods 	■ Compact rechargeable devices, some are shaped like a USB stick. ■ They use pods (small refills of e-liquid) made specifically for the device, often using nicotine salts. Pods are replaced when empty. ■ Most of these pods come pre-filled with a chosen flavour, although some newer models are refillable. Pods offer patients simplicity (you don't usually have to refill) and are more compact in size and appearance than tanks. ■ In the UK, the maximum strength of nicotine allowable for use in pod systems is 20 mg/ml. ■ There is the opportunity to gradually titrate down to 0 mg/ml e-liquid with some devices. ■ Due to their smaller battery and the limit on nicotine content, delivery of nicotine is currently not comparable to other devices (with the exception of JUUL).
Tanks 	■ Typically the size of a large pen, they have a more powerful battery than single-use devices and a 'tank' that the patient fills with their choice of e-liquid. ■ These devices can often be used with an interchangeable range of atomisers, cartomisers and tanks and may have adjustable power settings. ■ The patient can choose their own flavour and strength of e-liquid. With repeated use, experienced users can obtain blood nicotine levels comparable to that achieved from cigarettes. ■ It may not be possible for patients to use tank vapes inside hospital buildings because they are likely to activate fire alarm systems. However, they can be used outdoors.
Regulated mods 	■ These contain a chip that controls the power being delivered to the atomiser which prevents the device from short-circuiting. ■ Many devices allow the patient to adjust the voltage or wattage applied to the coil and some offer temperature control as well. ■ Some mods come with puff counters or downloadable software that allow patients to program their own voltage and wattage level and to monitor their patterns of use. ■ They come in a variety of shapes and sizes (from simple pen-style to larger box-shaped devices) and are designed to allow modifications and substitution of individual components according to patient preference and allow for more control over nicotine delivery. ■ The devices are generally recommended for more experienced vapers. It may not be possible for patients to use regulated mod vapes inside hospital buildings because they are likely to activate fire alarm systems. However, they can be used outdoors.

Appendix 5
Nicotine replacement therapy quick reference

Nicotine replacement therapy (NRT)

- NRT is both effective in increasing success with stopping smoking and safe.
- Most common side effects are mild.
- Combining the NRT patch with fast-acting NRT products (e.g. gum, lozenges, inhalator, mouth spray) has been shown to increase success with stopping long-term.
- NRT products are typically used for 8–12 weeks. It is important to use the full course of the medications to increase success with stopping long-term. The amount of NRT can be reduced over this time period or full dose can be maintained.
- Some patients will benefit from using NRT for extended periods of time (even years) to prevent relapse back to smoking, and this is safe practice.

Guidelines for individualised dosing of NRT:

- It is important for patients to use enough NRT.
- The initial dose of NRT can be determined based on **Heaviness of Smoking Index** (number of cigarettes and time to first cigarette in the morning).
- For patients who are heavily dependent, higher doses of NRT (>42 mg) have been shown to be more effective than standard doses (21 mg) in reducing withdrawal symptoms and cravings.
- Patient experience with withdrawal and cravings can be used to guide the need to adjust the initial dose. Both the dose of NRT patch and the frequency of fast-acting NRT use can be increased as needed to address withdrawal and cravings.

Patch

16-hour skin patch:

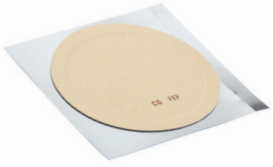
- 25 mg, 15 mg, 10 mg

24-hour skin patch:

- 21 mg, 14 mg and 7 mg

Products:

- Nicorette Invisi 25 mg, 15 mg, 10 mg
- Nicotinell 21 mg, 14 mg and 7 mg
- NiQuitin CQ 21 mg, 14 mg and 7 mg (Original and Clear)



How it works

- Delivers a steady dose of nicotine to the bloodstream via skin.
- Peak levels reached in 2 – 6 hours.
- Nicotine absorption: 0.6 to 1.6 mg per hour (depends on strength selected).

Prescribing guidelines

- Initial dose of nicotine based on heaviness of smoking index (number of cigarettes and time to first cigarette).
- Combining a patch with fast-acting NRT increases success with stopping.
- Use for 10 – 12 weeks or longer based on patient's needs.

Instructions

- Apply the patch to a clean, dry, non-hairy area.
- Replace the patch with a new one every 24 hours.
- Rotate site daily; rash from adhesive is common; topical creams may be applied.

Pregnant women

- 16-hour patch is recommended in pregnancy; remove patch at night.
- Pregnant women may experience increased skin sensitivity/rash.

Possible side effects: headache, dizziness, nausea, flushing, stomach upset, skin irritation, trouble sleeping (if patient has difficulty sleeping, use 16 hour patch or remove the 24 hour patch at bedtime).

Fast-acting NRT (oral and nasal)

Gum

Products:

- Fruit fusion, freshmint, icy white, or plain
- Nicorette 2 and 4 mg
- Nicotinell 2 and 4 mg
- NiQuitin CQ 2 and 4 mg

2 mg (smokes their first cigarette 30 or more minutes after waking up)

4 mg (smokes their first cigarette within 30 minutes of waking up)

How it works

- Delivers nicotine to bloodstream through buccal mucosa (lining of mouth and throat).
- Peak levels reached in about 30 minutes.
- Nicotine absorption: approx. 0.9 mg per 2 mg piece and 1.2 mg per 4 mg piece.
- The flavouring in Nicorette origional contains negligible amounts of medicinal alcohol and will not have any noticeable effects.*

Instructions

- Approx. one piece per hour every hour.
- Special chewing technique: chew and park.**
- Chew-park-chew for about 20 – 30 minutes. After 30 minutes gum is exhausted.
- Use up to 15 pieces. Using more than 20 pieces per day may cause nausea, consider increasing dose of patch if patient requires >20 pieces.
- Avoid acidic drinks (like fruit juice) for 15 minutes before or during use.
- Sticks to dentures; not appropriate for people with complicated dental work.
- Can be combined with NRT patch.
- Duration of treatment: 8 – 12 weeks; can be extended as required.

Possible side effects: nausea, headache, heartburn, coughing, hiccups, throat irritation.

* Although negligible, the presence of alcohol may be an issue for some people because of their cultural and religious beliefs, or because of issues with alcohol.

** ***Chew and park:*** Chew slowly until they can taste the nicotine or feel a slight tingling in their mouth, then stop chewing. Place the gum between the cheek and gums. After one minute, repeat the process until cravings are resolved.

Inhalator

Plastic holder containing cartridge with 15 mg of nicotine

How it works

- Puffing on inhalator draws nicotine vapour into the mouth: absorbed into bloodstream through buccal mucosa (lining of mouth and throat).
- Behavioural replacement for 'hand to mouth' action.
- Peak levels reached in 15 – 20 minutes.
- Nicotine absorption: 20 minutes puffing for 1 mg nicotine depending upon technique.

Instructions

- Line up ridges of plastic holder to open and insert cartridge (you will hear a click).
- Use every hour and puff for about 20 minutes or as needed to manage cravings.
- Special puffing technique: take slow shallow puffs to avoid throat burn.
- Each cartridge lasts for about 40 minutes of intense use.
- 6 cartridges per day.
- Avoid acidic drinks (like fruit juice) for 15 minutes before or during use.
- Can be combined with NRT patch.
- Duration of treatment: 8 – 12 weeks; can be extended as required.

Possible side effects: nausea, mouth/throat irritation.

Mouth spray

A 1 mg mouth spray:
Nicorette, brand name QuickMist

How it works

- Delivery through buccal mucosa (lining of mouth and throat), faster acting (about two minutes to reach bloodstream).
- Nicotine absorption: peak levels reached within 16 minutes of administration.
- Each spray contains 1 mg nicotine; bottle contains about 150 sprays.
- Contains negligible amounts of medicinal alcohol (7 mg / spray) and will not have any noticeable effects.*

Instructions

- 1 – 2 sprays every 30 minutes to an hour, as required throughout the day to minimise withdrawal symptoms and urges to smoke.
- Child-proof lock (push lever and slide up or down). First use: prime the pump (point away and spray).
- Open mouth wide; point inside mouth toward cheek and spray (press firmly); repeat on other side of mouth.
- Hold in mouth and refrain from swallowing for a few seconds immediately after spraying.
- Avoid acidic drinks (like fruit juice) for 15 minutes before or during use.
- Can be combined with NRT patch.
- Duration of treatment: 8 – 12 weeks; can be extended as required.

Possible side effects: headache, nausea, vomiting, changes in taste, tingling.

* Although negligible, the presence of alcohol in these products may be an issue for some people because of their cultural and religious beliefs, or because of issues with alcohol.

Nasal spray

Bottled nicotine solution:
10 mg/ml

How it works

- Delivers nicotine to bloodstream through nasal mucosa; faster acting (about two minutes to reach bloodstream).
- Peak levels reached in about 10 minutes.
- Nicotine absorption: approx. 0.5 mg nicotine each shot.
- Each bottle = 200 sprays = 6 days.

Instructions

- Remove the protective cap. Prime the spray by placing the nozzle between first and second finger with the thumb on the bottom of the bottle. Press firmly and quickly until a fine spray appears, this can take a few 'pumps'.
- Insert the spray tip into one nostril, pointing the top towards the side and back of the nose (45 degree angle). Press firmly and quickly. Give a spray into the other nostril.
- Warn patients that initial use may not be pleasant. Inform patients these adverse effects will pass with time (usually 2 days). Have a box of tissue on hand.
- 1 – 2 shots of spray in each nostril every hour.
- Initially at least 30 shots a day.
- Can be combined with NRT patch.
- Duration of treatment: 8 – 12 weeks; can be used longer as required.

Possible side effects: during the first 2 days of treatment, nasal irritation, sneezing, running nose, watering eyes, cough. Both the frequency and severity declines with continued use. Other possible side effects include nausea, headache.

Lozenge and mini lozenge

Sugar-free compressed tablet

- Nicotinell 1 mg and 2 mg (mint)
- NiQuitin CQ Original and Mini Lozenge 1.5 mg, 2 mg and 4 mg (Original, Mint)
- Nicorette Mini Lozenge 2 mg and 4 mg (mint)

How it works

- Delivers nicotine to bloodstream through buccal mucosa (lining of mouth and throat).
- Peak levels of 4 mg reached within 30 minutes.
- Nicotine absorption: approx. 1.5 mg per 4 mg lozenge.

Instructions

- Placed in mouth, allow to dissolve (20 – 30 minutes) by moving around mouth periodically; avoid crushing or chewing.
- 1 lozenge every 1 – 2 hours as required to minimise withdrawal symptoms and urges to smoke.
- Avoid acidic drinks (like fruit juice) for 15 minutes before or during use.
- Can be combined with NRT patch.
- Duration of treatment: 8 – 12 weeks; can be extended as required.

Prescribing guidelines

- Greater tobacco dependence (smokes within 30 mins of waking): use 4 mg.

Possible side effects: sore mouth or throat, throat irritation, jaw pain, hiccups, nausea, headache.

Microtabs

Nicorette: small white tablet 2 mg nicotine

How it works

- Each tablet delivers nicotine to bloodstream via buccal mucosa (lining of mouth and throat).
- Peak levels reached in about 30 minutes.
- Nicotine absorption: approx. 0.9 mg per tablet.

Instructions

- Used sub-lingually: placed under the tongue until dissolved (30 minutes); should not be chewed or swallowed.
- Use 1 – 2 per hour; 16 – 40 tablets a day.
- Avoid acidic drinks (like fruit juice) for 15 minutes before or during use.
- Can be combined with NRT patch.
- Duration of treatment: 8 – 12 weeks; can be used longer as required.
- 1 week s supply = 2 boxes of 100 each.

Possible side effects: throat irritation, hiccups, nausea, headache.

For more information

See Summary of Product Characteristics (SPC) where you can find all the information on effects, side effects, and drug interactions: **www.ncsct.co.uk/publications/topCategory/stop-smoking-aids** or **www.medicines.org.uk/emc**

Appendix 6
Nicotine analogue quick reference

Varenicline
(Champix)

How it works

Varenicline works directly at the level of the nicotine receptors in the brain. Partially alleviates craving and withdrawal symptoms by stimulating nicotine receptors and blocks the rewarding effects of nicotine if the patient smokes.

How it is used

- **Days 1 – 3:** 0.5 mg once daily
- **Day 4 – 7:** 0.5 mg twice daily (breakfast and dinner)
- **Weeks 2 – 12:** 1 mg twice daily (breakfast and dinner)

Instructions

- Set quit date and begin taking varenicline 7 – 14 days before quit date.
- In the inpatient setting, NRT may be used during this 7 – 14 day period, until the full therapeutic dose is reached or for longer periods.
- Swallow tablet whole; take with water and after a meal.
- Take tablets at least 8 hours apart.
- Take tablets well before bedtime to minimise sleep disturbance
- May have minor or moderate influence on the ability to drive and use machines. Make sure medication does not affect mental alertness before commencing these activities.
- Patients unable or unwilling to stop smoking after target quit date within 7 – 14 days of medication use may continue using the medication. It is recommended that they set a new quit date within 5 weeks of use.
- Varenicline is used for 12 weeks and patients should use full course of treatment. An additional course of 12 weeks treatment may be prescribed for those patients who think that they need it.

Contraindications

- Pregnant and breastfeeding women, adolescents.
- End stage renal failure.

Cautions

- Severe renal impairment (creatinine clearance <30 ml/min) reduce dose to 0.5 mg twice daily.

Possible side effects

Side effects generally resolve over time (first 2 weeks).

- Nausea (30%): mostly mild to moderate (3% severe).

  Verify patients are taking medication with/after a meal. Patients can be advised to lie down if this helps (the nausea will generally pass) and anti-emetics can be taken if persists.
- Headaches (15%)
- Insomnia (18%)*
- Abnormal (vivid) dreams (13%)*

*Option to take dose earlier in the evening.

The dose may be reduced to 0.5 mg twice daily as required to address side effects.

Extra care

- The use of varenicline among people with or without a history of psychiatric disorder has **NOT** been associated with an increased risk of serious neuropsychiatric adverse events compared with placebo.
- Formal monitoring of mood should be in place for all patients with history of mental illness whilst taking varenicline.

Cytisine

How it works

Cytisine is a naturally occurring plant-based substance that mimics the effect of nicotine in the brain. Like varenicline, cytisine acts to reduce withdrawal symptoms and urges to smoke; it also reduces the reward and satisfaction associated with smoking.

How it is used

Cytisine is started on a reducing dosing schedule over a 25 day course

- **Day 1 – 3:** 1 capsule every 2 hours (maximum 6 capsules/day)
- **Day 4 – 12:** 1 capsule every 2.5 hours (maximum 5 capsules/day)
- **Day 13 – 16:** 1 capsule every 3 hours (maximum 4 capsules/day)
- **Day 17 – 20:** 1 capsule every 5 hours (maximum 3 capsules/day)
- **Day 21 – 25:** 1 – 2 hours capsules/day

Instructions:

- Taken orally with water.
- The standard treatment course for cytisine is 25 days.
- Smoking should be stopped completely no later than the fifth day of treatment. Take NRT (patient's choice of product) during this five-day period, until the full therapeutic dose is reached.
- Cytisine is an effective treatment for tobacco dependence and can be added to all other treatments (e.g. NRT or nicotine vape).
- Cytisine cannot be prescribed but can be purchased from online retailers as a consumer product.
- Cytisine is more likely to be successful alongside behaviour change support provided by a TDA during and after hospital admission.

Contraindications:

- Patients with renal or hepatic impairment.
- Patients under 18 years or over 65 years of age.
- Pregnant and breastfeeding women.
- Patients with unstable angina, clinically significant arrythmias, recent stroke or myocardial infarction.
- Hypersensitivity to: mannitol, microcrystalline cellulose, magnesium stearate, glycerol dibehenate and hypromellose.

Cautions

Should be used with caution in case of ischemic heart disease, heart failure, hypertension, pheochromocytoma (a tumour of the adrenal gland), atherosclerosis (hardening of the arteries) and other peripheral vascular diseases, gastric and duodenal ulcer, gastroesophageal reflux disease, hyperthyroidism (overactive thyroid), diabetes, schizophrenia, kidney failure and liver failure.

Extra care:
Formal monitoring of mood should be in place for all patients with history of mental illness whilst taking cytisine.

This does not mean that cytisine should not be used.

Possible side effects

- Nausea (4 – 6.7%)
- Vomiting (2%)
- Insomnia (5.9%)
- Abnormal dreams (7.5%)
- Headache (2.5%)
- Dry mouth

Appendix 7

Risk assessment considerations for vape and NRT product use in mental health hospitals

All patients admitted to mental health hospitals are subject to a comprehensive risk assessment. For people who require access to vapes or NRT, assessment of the risks associated with these items will need to be considered. This document should be used in conjunction with local risk assessment protocols.

Risk	Examples of management strategies
Vape or NRT use can cause side-effects	Monitor for known side effects of NRT/vape use. Report suspected side-effects through the MHRA's Yellow Card scheme: **yellowcard.mhra.gov.uk**.
Environmental hazard	Provide hazardous waste stream for recycling used vape products.
Vapour can affect bystanders, (e.g. irritation of eyes, nose, throat)	Support vape use in single bedrooms or outdoor areas. Ensure vaping is not allowed in shared indoor spaces.
Unregulated vapes can be harmful to user's health	Only allow use of vapes notified to MHRA. The full notified product list can be accessed here: **vape-click.com**.
Plasma level changes may cause toxicity when people change smoking routines	Monitor plasma levels of indicated medications and adjust accordingly. Provide accessible information to educate patients and carers. See **Appendix 13** for further information.
Allergic reaction	Some e-liquids may contain traces of allergens, e.g. nuts. Screen for known allergies before issuing vapes or NRT
Vapes can be used as an ignition source if tampered with or, in rare cases, cause fires if not charged correctly	For people with a risk of arson, consider supervised use. For people with unstable mental state, consider single-use vapes. Follow manufacturing instructions for charging/using vapes.
Vapes can activate smoke alarms	Use vapes in a well-ventilated area. Only use single-use or pod vapes indoors.
Ingestion of battery or parts of a vape or NRT device	For people with a high risk of self-harm, confusion, or psychosis, consider supervised use of vape and NRT products. Seek immediate medical attention for suspected ingestion and contact the National Poisons Information Service for expert advice: **www.npis.org/healthcare**.

Risk	Examples of management strategies
Vapes or NRT inhalators may be misused to consume illicit substances	For people with a known recent history of using illicit substances, consider supervised use of approved vapes. Undertake tests for substance use. To guide practice, use clinical judgement and trust guidelines.
Vapes and NRT products may be misused to harm *others* (e.g. concealed weapon/sharing products)	For people with a known history of harming others, consider supervised use of approved items and undertake random checks. To control risk of infection, vapes and NRT products should not be shared.
Vapes and NRT products may be misused to harm *self* (e.g. broken to make a sharp object).	For people with a known history of self-harm, consider supervised use of approved items and undertake random checks.
Nicotine overdose	People who smoke are generally well able to self-manage their nicotine consumption, but those with unstable mental state may consume unsafe high levels of nicotine if unsupervised. High nicotine levels are indicated by nausea, palpitations, dizziness and dysphoria. Reduce nicotine intake to ensure relief and seek medical review if symptoms persist.

Appendix 8

Initial vape and NRT dosing guidance (for mental health hospitals)

People admitted to mental health hospitals who smoke generally need higher doses of NRT or nicotine vapes. We suggest an initial dose of 2mg of nicotine from a vape or NRT for each cigarette smoked per day by the patient.

Nicotine vapes

For treatment with vapes, the initial dose for most patients who smoke 20 cigarettes a day regularly will be 18mg/ml or 20mg/ml. This is sometimes described as 1.8% or 2% on vape packaging.

Patients who smoke more heavily (>20–30 cigarettes per day) are likely to require up to two or sometimes even three 18mg/ml or 20mg/ml e-liquids daily and/or combination treatment with the NRT patch to manage withdrawal symptoms. See Table 1 for guidance on initial vape dosing.

Table 1: Initial vape dosing (for mental health hospitals)

Treatment	<10 cigs/day	10–19 cigs/day	20–29 cigs/day	30–39 cigs/day	40+ cigs/day
Vape Single-use vape/pods (per 24hrs): Nicotine strength: % Nicotine:	 **1** **3–12mg/ml** 0.3% or 1.2%	 **1** **12–20mg/ml** 1.2% or 2%	 **1–2** **18–20mg/ml** 1.8% or 2%	 **2–3** **18–20mg/ml** 1.8% or 2%	 **2–3** **18–20mg/ml** 1.8% or 2%
Combination treatment with NRT patch **Vape** Single-use vape/pods (per 24hrs): Nicotine strength: % Nicotine:			 **1** **18–20mg/ml** 1.8% or 2%	 **1–2** **18–20mg/ml** 1.8% or 2%	 **2** **18–20mg/ml** 1.8% or 2%
+ **Nicotine patch**			 **1 x 21/25mg**	 **1 x 21/25mg**	 **1 x 21/25mg**

Combination NRT

High-dose (21 mg or 25 mg) patch **and** a fast-acting NRT product is recommended. Patients who are more heavily dependent will benefit from use of more than one NRT patch to deliver a higher steady state blood nicotine level. See **Table 2** for initial combination NRT dosing.

Table 2: Initial combination NRT dosing

Product	<10 cigs/day	10–19 cigs/day	20–29 cigs/day	30–39 cigs/day	40+ cigs/day
Transdermal NRT patch Every 24 hours	**15 mg (16hr) or 14 mg (24hr)**	**25 mg (16hr) or 21 mg (24hr)**	**25 mg (16hr) or 21 mg (24hr)** Option: 21/25 mg + 14/15 mg	**25 mg (16hr) / 21 mg (24hr) + 14/15 mg** Option: 2 x 21/25 mg	**2 x 25 mg (16hr) or 21 mg (24hr)**
Fast-acting Use on the hour, every hour and as needed	**AND** one of the available **fast-acting NRT products:** ■ Mouth spray (64 sprays/day) ■ Inhaler (up to 6 cartridges/day) ■ 4 mg Lozenge (up to 15/day) ■ 4 mg Gum (up to 15/day) ■ 2 mg Microtab (up to 40/day) ■ Nasal spray (64 sprays/day)				

Note: for patients who smoke heavily, higher doses (3mg of nicotine from NRT or a vape per cigarette smoked per day) may be necessary to manage withdrawal symptoms and urges to smoke. This is safe practice for patients with higher tobacco dependence.

Assess response and adjust dose as indicated

Assess withdrawal symptoms (see below) daily and adjust NRT accordingly. If additional NRT is required, increase the patch strength initially as this will provide a stable level of additional nicotine. Self-administered fast-acting products are more effective if the patient's mental state and risk assessment allow. It is safe to use nicotine vapes with prescribed NRT.

If the dose is **too low**, the patient will experience the physical discomfort of withdrawal, including:

- irritability
- dysphoria
- restlessness
- anxiety
- insomnia
- headache
- myalgias
- decreased concentration
- strong urges to smoke (cravings)

If the dose is **too high,** the patient may present with the following and dose reduction of the fast-acting products can be considered to ensure the patient's comfort and safety:

- nausea (note: nausea is often due to incorrect product use)
- dizziness
- palpitations
- dysphoria

Appendix 9
Guidelines for reducing NRT

Some patients may benefit from the use of NRT for extended periods – even years. This is safe practice and advised if there is a risk of relapse to smoking. Extending use of NRT is recommended by NICE as a relapse prevention strategy. When the patient is ready to commence a reduction of NRT, begin by getting an understanding of what the current use is, including details of when NRT is being used and in what circumstances.

Work with the patient to practice alternative coping strategies to manage cravings/urges to smoke. Remind the patient that these are usually short-lived and will subside quickly. Always reduce fast-acting products as a first step, then review and consider the next step after 6–8 weeks. Below are some examples.

Product	Step 1	Step 2	Step 3	Step 4	Step 5
NRT lozenge	From 4mg x 15 to 2mg x 15	From 2mg x 15 to 2mg x 10	From 2mg x10 to 2mg x 5	From 2mg x 5 to PRN	
NRT inhalator	From 15mg x 6 to 15mg x 5	From 15mg x 5 to 15mg x 4	From 15mg x 4 to 15mg x 3	From 15mg x 3 to 15mg x 2	From 15mg x 2 to 15mg x 1

When the patient is ready begin to reduce the nicotine strength of the patch, they can do so in the manner shown below.

Patch	Step 1	Step 2	Step 3	Step 4
NRT patch 21mg	From 21mg to 14mg	From 14mg to 10mg	From 10mg to 7mg	From 7mg to PRN

Be prepared to extend the review period if the patient's mental state or risk of relapse changes.

Regular carbon monoxide tests can reinforce the patient's motivation and commitment to staying smokefree. Continue to congratulate patients who have stopped smoking and reinforce support to stay smokefree.

Guidelines for reducing vape use

When supporting patients who want to stop vaping, our priority should always be to ensure that patients who stop vaping do not return to smoking cigarettes. For more information, see NCSCT guidance on stopping vaping: **www.ncsct.co.uk/publications/support_stop_vaping**

Appendix 10
Carbon monoxide (CO) testing Instructions

What is carbon monoxide?

Carbon monoxide (CO) is a colourless, odourless and tasteless poisonous gas.

You can't see it or smell it but it is in tobacco smoke.

It has a relatively short half-life (four hours), with elimination becoming slower as the concentration decreases. It is usually undetectable around 24 hours after the last cigarette. It is therefore a useful marker of regular smoking.

Tobacco Dependence Advisers can share CO readings with patients as proof of toxins leaving the body. This can be very motivational and provide an opportunity for behaviour change when used within the context of supportive and structured treatment during a hospital admission.

Health Issues

After CO is breathed in, it is absorbed into the bloodstream from the lungs and mixes with haemoglobin to form carboxyhaemoglobin (COHb). It binds to the haemoglobin within the red blood cells about 200 times as readily as oxygen. When this happens, the blood is no longer able to carry oxygen, and this lack of oxygen can cause the body's cells and tissue to fail and die.

People who smoke can have between 2% and 20% of their normal blood oxygen taken up by CO. To compensate for the shortage of oxygen the body must work harder with less fuel:

- The heart will need to beat faster as it tries to get enough oxygen to the body
- The heart itself gets less oxygen and this increases the risk of damage to the heart muscles and sudden death
- The patient will become more breathless as the body has little spare oxygen for any extra demands made by exertion
- The linings of the arteries are more permeable to cholesterol, causing a fatty build up and increasing the risk of circulation problems, heart attack and stroke
- The lack of oxygen can cause tiredness and affect the ability to concentrate
- COHb creates thicker blood

After stopping smoking, the level of CO falls almost immediately. It will be the same as a person who does not smoke within a couple of days. The blood will carry more oxygen, and circulation is improved along with increased concentration and energy levels.

Carbon monoxide poisoning

Raised CO readings usually indicate tobacco smoking. However, there are other reasons for a raised CO, such as secondhand smoke exposure, those living or working in urban areas, exposure to high levels of environmental pollution and inhalation of fumes from faulty exhausts or boilers. Lactose intolerance can also result in raised exhaled CO levels.

A patient may self-report that they are not smoking but, on testing, exhibit abnormally high expired CO levels. In such cases, they should be given advice about possible CO poisoning, which can be caused by the following:

- Faulty central heating systems, gas appliances and fires
- Car exhausts

Patients should be advised to:

- Have chimneys and flues checked
- Make sure gas appliances and heating systems are inspected
- Fit carbon monoxide alarms – available from DIY stores
- Never run cars, motorbikes or lawnmowers in a closed garage

Carbon monoxide testing

Exhaled CO is a readily available, simple and affordable marker that can be assessed using a non-invasive technique that produces immediate and reliable results.

How the CO test works:

- A CO monitor measures the CO levels in the blood and the lungs.
- You blow into a hand-held machine, called a CO monitor, which measures the level of CO parts per million (COppm) in your body. This can then be converted into COHb %.
- The more CO you have inhaled, the higher your CO reading will be. It's not always linked to the number of cigarettes smoked but the intensity of smoking.
- In other words, the more smoke you have inhaled, the more CO you will have in your body and the higher your health risks.
- Different types of tobacco produce different amounts of CO.
- It can also detect harmful secondhand tobacco smoke exposure.

How to carry out carbon monoxide testing

CO monitors measure the amount of **CO in expired breath,** displayed as parts per million (ppm).

CO monitors detect exposure to smoke in the previous **24 – 48 hours.**

Patients are required to hold their breath for **15 seconds** (minimum 10 seconds) to equalise pressure in the lungs and allow CO to transfer between blood and lungs

Evidence of smoking = reading above 6 ppm

A stricter cut-off of 4 ppm is used for pregnant women as part of the maternity pathway.

There are several models of CO monitors available and you should follow the instruction accompanying your model. However, the following procedure is common to all monitors:

1. Both the patient and the staff should wash their hands or use sanitiser gel (**non-alcohol**) on their hands before the test.
2. Attach a clean, disposable, mouthpiece (a fresh one for each patient) to the monitor.
3. Turn the monitor on.
4. Ask the patient to take a deep breath.
5. The monitor will count down 15 seconds and beep during the last 3 seconds.
6. The patient needs to blow slowly into the mouthpiece, aiming to empty their lungs completely.
7. The parts per million (ppm) of CO in the lungs will be displayed on the screen.
8. The mouthpiece should be removed by the patient (for infection control reasons) and disposed of in a refuse sack which is tied before being placed in another bag for collection (double bagging) to prevent domestic staff touching the mouth pieces.
9. The CO monitor should be cleaned between tests using a non-alcoholic wipe.

You should follow the instructions accompanying your monitor and local infection control procedures.

- Change 'D' piece as per instructions, usually once per month (this is the one-way bacteria filter).

Use recommended compatible wipes. Alcohol wipes can: affect the electrochemical sensors, cause permanent damage and affect reading and give false positive/negative readings.

Appendix 11
CO test chart

CO ppm	COHb(%)	
30	5.43	**10+ ppm** Typical levels for a person who smokes
29	5.27	
28	5.11	
27	4.95	
26	4.79	
25	4.63	
24	4.47	
23	4.31	
22	4.15	
21	3.99	
20	3.83	
19	3.67	
18	3.51	
17	3.35	
16	3.19	
15	3.03	
14	2.87	
13	2.71	
12	2.55	
11	2.39	
10	2.23	
09	2.07	**7 – 9 ppm** Borderline values that may be found in people who do and do not smoke
08	1.91	
07	1.75	
06	1.59	**0 – 6 ppm** Typical levels for a person who does not smoke, and should be your goal. It is normal to have some CO in your body.
05	1.43	
04	1.27	
03	1.11	
02	0.95	
01	0.79	

CO is a toxic, odourless, poisonous gas. CO deprives the body of oxygen which the body needs to survive.

To compensate for the shortage of oxygen, the body must work harder which puts a strain on the vital organs.

When you stop smoking the levels of CO in your blood begin to fall almost immediately.

They will return to normal levels within a couple of days. Your blood will carry more oxygen around the body, you will have more energy and better circulation.

Appendix 12
Clinically significant drug interactions with tobacco smoking

Key points

- Tobacco smoke stimulates a liver enzyme responsible for metabolising some drugs in the body, which means that the metabolism of some drugs increases.
- This effect is not caused by nicotine but rather by the tar in tobacco smoke.
- When treating tobacco dependence, be aware of a small number of drugs, in particular clozapine and olanzapine, which may require dose adjustment or increased monitoring when smoking status is altered.
- **This is irrespective of the tobacco dependence medication used.**

Managing interactions with smoking

- It is good practice to undertake a medication review or perform a medicines reconciliation when an individual's smoking status changes.
- Medical history and current medication use should be clarified at the initial assessment and pathways put in place for notifying prescribers, checking plasma levels and making dose adjustments as required.
- The dosage will need to be checked by the prescriber if it was worked out before the patient stopped smoking and then again if the patient relapses back to smoking.
- For most medicines, dose adjustment will not be required when a person stops smoking. However, it is helpful to be aware of relevant medicines and to counsel individuals to watch for signs of toxicity when stopping smoking.

Below we summarise those drug interactions with tobacco smoking that are considered to be most clinically important. It should not, however, be considered a comprehensive list.

Some antidepressants and anxiolytics:

- Amitriptyline
- Clomipramine
- Diazepam
- Duloxetine
- Tricyclic antidepressants

Some antipsychotics:

- Clozapine
- Olanzapine
- Chlorpromazine

Physical drugs:

- Aminophylline
- Caffeine
- Erlotinib
- Flecainide
- Insulin
- Methadone
- Propranolol
- Riociguat
- Theophylline
- Verapamil
- Warfarin

For patients taking clozapine

Hospital admissions

Review smoking status on and during admission. Arrange blood levels and dose reduction if smoking is significantly reduced or stopped.

Seek urgent specialist advice

Smoking status changes have a clinically important effect. Individuals stopping or reducing cigarette smoking are at risk of severe toxicity if blood levels and dose are not closely monitored. Those starting or resuming smoking may require dose titration.

Monitoring and dose adjustment

Dosage adjustment under specialist supervision will be needed.

If stopping smoking, take blood levels (in addition to any usual tests) and reduce dose as needed. Repeat blood levels after one week.

If starting (or restarting) smoking, take blood levels and titrate dose to maintain therapeutic effect. Repeat blood levels as needed.

Review changes if smoking is resumed.

Further Information

For more information see:

www.sps.nhs.uk/articles/considering-drug-interactions-with-smoking

www.sps.nhs.uk/articles/managing-specific-interactions-with-smoking

Appendix 13

Psychotropic drugs affected by smoking status and action to take on stopping and starting smoking

Drug	Effect of smoking	Action to be taken on stopping smoking	Action to be taken on restarting smoking
Agomelatine	Plasma levels reduced.	Monitor closely. Dose may need to be reduced.	Consider reintroducing previous smoking dose.
Benzodiazepines	Plasma levels reduced by 0–50% (depends on drug and smoking status).	Monitor closely. Consider reducing dose by up to 25% over one week.	Monitor closely. Consider reintroducing previous smoking dose.
Carbamazepine	Unclear, but smoking may reduce carbamazepine plasma levels to a small extent.	Monitor for changes in severity of adverse effects.	Monitor plasma levels.
Chlorpromazine	Plasma levels reduced. Varied estimates of exact effect.	Monitor closely. Consider dose reduction	Monitor closely. Consider reintroducing previous smoking dose.
Clozapine	Reduces plasma levels by up to 50%. Plasma level reduction may be greater in those receiving valproate. Effect is reversed by co-administration of fluvoxamine.	Take plasma level before stopping. On stopping, reduce dose gradually (over a week) until around 75% of original dose reached (i.e. reduce by 25%). Repeat plasma level one week after stopping. Anticipate further dose reductions.	Take plasma level before restarting. Increase dose to previous smoking dose over one week. Repeat plasma level. Deterioration is common if dose increases allow a fall in blood levels.
Doxepin	Plasma levels reduced by around 25% (levels of nordoxepin metabolite increased).	Monitor closely. Dose may need to be reduced.	Consider reintroducing previous smoking dose.
Duloxetine	Plasma levels may be reduced by up to 50%.	Monitor closely. Dose many need to be reduced.	Consider reintroducing previous smoking dose.

Drug	Effect of smoking	Action to be taken on stopping smoking	Action to be taken on restarting smoking
Escitalopram	In practice, people who smoke have lower blood levels despite being given higher doses. Reduction in levels may be up to 50% (possibly via induction of CYP2C19).	Monitor closely. Consider reducing dose by 25%.	Monitor closely. Increase dose to previous smoking dose.
Fluphenazine	Plasma levels reduced by up to 50%.	Reduce dose by 25%. Monitor carefully over following four to eight weeks. Consider further dose reductions.	Increase dose to previous smoking dose.
Fluvoxamine	Plasma levels reduced by around one third.	Monitor closely. Dose may need to be reduced.	Dose may need to be increased to previous smoking dose.
Haloperidol	Plasma levels reduced by around 25–50%.	Reduce dose by around 25%. Monitor carefully. Consider further dose reductions.	Increase dose to previous smoking dose.
Loxapine (inhaled)	Half-life reduced from 15.7 hours to 13.6 hours.	Monitor.	Monitor.
Mirtazapine	Unclear, but effect probably minimal.	Monitor.	Monitor.
Olanzapine	Plasma levels reduced by up to 50%.	Take plasma level before stopping. On stopping, reduce dose by 25%. After one week, repeat plasma level. Consider further dose reductions.	Take plasma level before restarting. Increase dose to previous smoking dose over one week. Repeat plasma level.

Drug	Effect of smoking	Action to be taken on stopping smoking	Action to be taken on restarting smoking
Risperidone / paliperidone	Active moiety concentrations probably lower in people who smoke. Minor effect (possibly via induction of CYP3A4).	Monitor closely.	Monitor closely.
Trazodone	Around 25% reduction.	Monitor for increased sedation. Consider dose reduction.	Monitor closely. Consider increasing dose to previous smoking dose.
Tricyclic antidepressants	Plasma levels reduced by 25–50%.	Monitor closely. Consider reducing dose by 10–25% over one week. Consider further dose reductions.	Monitor closely. Consider reintroducing previous smoking dose.
Zuclopenthixol	Unclear but likely minimal.	Monitor.	Monitor.

Source: Taylor DM, Barnes TR, Young AH. Maudsley Prescribing Guidelines, 2021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