

Mental Health and Smoking Partnership

Statement on Electronic Cigarettes

Why smoking and mental health matters

Smoking is around twice as common among people with mental health conditions as in the general population.¹ Over the last 20 years smoking rates among the general population have declined steadily but smoking rates have barely changed among people with a mental health condition.² People with mental health conditions die on average 10 to 20 years earlier than the general population³ and smoking is the single largest reason for this shocking difference.⁴

The aim of the Mental Health and Smoking Partnership is to reduce smoking rates among people with a mental health condition to 5% by 2035, with an interim target of 35% by 2020.⁵

Tackling high smoking rates among people with a mental health condition is a national priority and will significantly reduce the burden of preventable morbidity and mortality. The Five Year Forward View for Mental Health⁶ and new Tobacco Control Plan for England⁷ both emphasise the need for 'parity of esteem' in tackling rates of smoking.

People with mental health conditions are as likely to want to quit smoking as the general population of smokers.⁸ Most people with diagnosed mental health conditions receive care within the community, mainly by GPs, but also by specialist multidisciplinary teams. A minority of people with such conditions are managed in secondary care inpatient facilities. Cutting smoking rates among this group therefore requires action both in inpatient facilities and in the wider community, however smokers with mental health conditions can face barriers to engagement with cessation services.

Smoking cessation interventions combining behavioural support with cessation pharmacotherapy are known to be effective in the general population.⁹ When appropriately tailored these interventions are also effective for people with mental health conditions. Nicotine replacement therapy (NRT) is effective, but is likely to be required in high doses, for longer durations and with more intensive behavioural support than in the general population of smokers.¹⁰ Provision of the nicotine that smokers are addicted to without the harmful components of tobacco smoke can prevent most of the harm from smoking. Varenicline (Champix) is also a highly effective treatment and can be considered as an option provided mood monitoring is maintained.¹⁰

The evidence on e-cigarettes

Evidence on electronic cigarettes shows they are significantly safer than smoked tobacco.¹¹ Electronic cigarettes are marketed as consumer products, and are currently proving more popular than NRT as a quitting aid and a substitute for tobacco cigarettes.¹² While there are no medicinally licenced products available (one has received a licence but is not being manufactured) the evidence suggests that electronic cigarettes can help smokers to quit.¹³ Current evidence suggests that health risks arising from vapour inhalation from electronic cigarettes are unlikely to exceed 5% of the harm caused by smoking (and may be less).¹⁴ This remains an important area of research, and further evidence on the effects of long-term vapour inhalation will be important in informing policy positions.

Survey evidence suggests that public understanding of the relative harm of nicotine, e-cigarettes and smoked tobacco is relatively poor, and this is likely to be the case with people with mental health conditions. The latest ASH Smokefree GB survey (conducted by YouGov) found that only 13% of respondents recognised that electronic cigarettes are a lot less harmful than smoking, with 26% thinking they are more or equally harmful.¹⁵ This poor level of understanding could stop some smokers benefiting from switching to electronic cigarettes.

Principles for Health Professionals and Support Staff

1. Effective smoking cessation services and harm reduction support for people who smoke are vitally important to public health, and people with mental health conditions have an equal right of access to such services.
2. Smoking remains part of the culture in too many mental health settings, making cessation more difficult. Smokefree policies are a vital means of changing this culture and can be implemented successfully with the right leadership and support for patients and staff. Training for staff is essential for them to effectively support patients to quit or abstain from smoking.
3. Information on use of NRT, varenicline, bupropion and electronic cigarettes should form part of the care package for people with mental health conditions who smoke. Advice should be based on objective evidence of relative harm: it is better for health to use electronic cigarettes rather than smoke tobacco,¹⁴ and this advice should be given to smokers who find other aids to quitting unsatisfactory. Electronic cigarettes can also be used alongside other treatment options (NRT, varenicline, bupropion) for those who need additional support.¹⁰
4. Vaping is different to smoking. Electronic cigarette use does not meet either the legal or clinical definition of smoking. It is therefore a matter for employers (in partnership with their employees), managers and commissioners of health services to determine whether and where to permit electronic cigarette use in enclosed public places, including in-patient facilities for people with mental health conditions. It is also a matter for employers, managers and commissioners to determine whether to permit electronic cigarette use in grounds attached to such premises. There is no current evidence that secondary vapour from electronic cigarettes is a significant risk to non-users.¹¹
5. To help smokers to stop smoking and stay smokefree, a more enabling approach to vaping should be considered to make it an easier choice than smoking. Vapers should not be required to use the same space as smokers, as this could undermine their ability to quit and stay smokefree.
6. Policies on electronic cigarette use in medical and health premises should be clearly set out and communicated to all patients, staff and visitors. If possible this information should be provided in advance of any inpatient stays.
7. Where mental health service providers operate retail outlets, they should consider making NRT and electronic cigarettes available for sale to support accessibility.

8. Appropriate hazard waste disposal systems should be established for safe disposal of e-cigarettes, in line with existing policies for other products such as batteries or electronics.

Key documents

[Smoking and Mental Health](#). A joint report by the Royal College of Physicians and the Royal College of Psychiatrists, March 2013

[Nicotine without smoke: Tobacco harm reduction](#). Royal College of Physicians: working party report, April 2016

[RCGP Position Statement](#) on the use of non-combustible inhaled tobacco products, November 2016

[The Stolen Years: The Mental Health and Smoking Action Report](#). Action on Smoking and Health, April 2016

[E-cigarettes: a new foundation for evidence-based policy and practice](#): Public Health England, August 2015

[Use of electronic cigarettes \(vapourisers\) among adults in Great Britain](#), ASH, May 2017

[Brief Guide: Smokefree policies in mental health inpatient settings](#): Care Quality Commission, January 2017

[Smoking: Acute, maternity and mental health settings](#): National Institute for Health and Care Excellence, November 2013.

[Towards a Smokefree Generation: A Tobacco Control Plan for England](#), Department of Health, July 2017.

Questions

If you have further questions about the Statement, please email:

admin@smokefreeaction.org.uk or phone the ASH office on: 0207 404 0242

Endorsing Organisations





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- 1 Public Health England [Local Tobacco Control Profiles](#). Original data from the Health and Social Care Information Centre: [Smoking rates in people with serious mental illness](#). (By Clinical Commissioning Group) (Dataset 1.23)
 - 2 Szatkowski L. McNeill A. [Diverging trends in smoking behaviours according to mental health status](#). *Nicotine & Tobacco Research*, 2015;3:356-60
 - 3 Chang CK. Hayes R. Broadbent M. Perera G. Fernandes A. Lee W. Stewart R. [Life expectancy at birth for people with serious mental illness and other major disorders from a secondary mental health care case register in London](#). *PLoS One*. 2011; 6(5): e19590. 9.
 - 4 Royal College of Physicians and Royal College of Psychiatrists. [Smoking and Mental Health](#). 2013.
 - 5 Action on Smoking and Health, [The Stolen Years: The mental health and smoking action report](#), 2016.
 - 6 NHS England, [Five Year Forward View for Mental Health](#), 2016.
 - 7 Department of Health, [Towards a Smokefree Generation: A Tobacco Control Plan for England](#), 2017.
 - 8 NHS Digital, [Health Survey for England 2010](#), 2011.
 - 9 Stead LF. Kollipalli P. Fanshawe TR. Lancaster T. [Combined pharmacotherapy and behavioural interventions for smoking cessation](#). *Cochrane Database of Systematic Reviews* 2016, DOI: 10.1002/14651858.CD008286.pub3.
 - 10 Robson, D. Potts J. [Smoking Cessation and Mental Health: A briefing for frontline staff](#), NCSCT, 2014.
 - 11 Royal College of Physicians, [Nicotine without smoke: Tobacco harm reduction](#), 2016.
 - 12 West R. [Smoking Toolkit Study: Electronic Cigarettes in England – latest trends](#), 2017.
 - 13 Cochrane Tobacco Addiction Group. [Electronic cigarettes for smoking cessation](#), 2016.
 - 14 McNeill A. Brose L. Calder R. Hitchman S. Hayek P, McRobbie H. [E-cigarettes: An evidence update](#), 2015.
 - 15 Action on Smoking and Health. [Use of electronic cigarettes \(vapourisers\) among adults in Great Britain](#), 2017.