Smoking and Mental Health – An exploration of data in Northern Ireland and scan of policy approaches in the UK and Ireland

Institute of Public Health

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Developed by the Institute of Public Health in Ireland for the Department of Health in Northern Ireland

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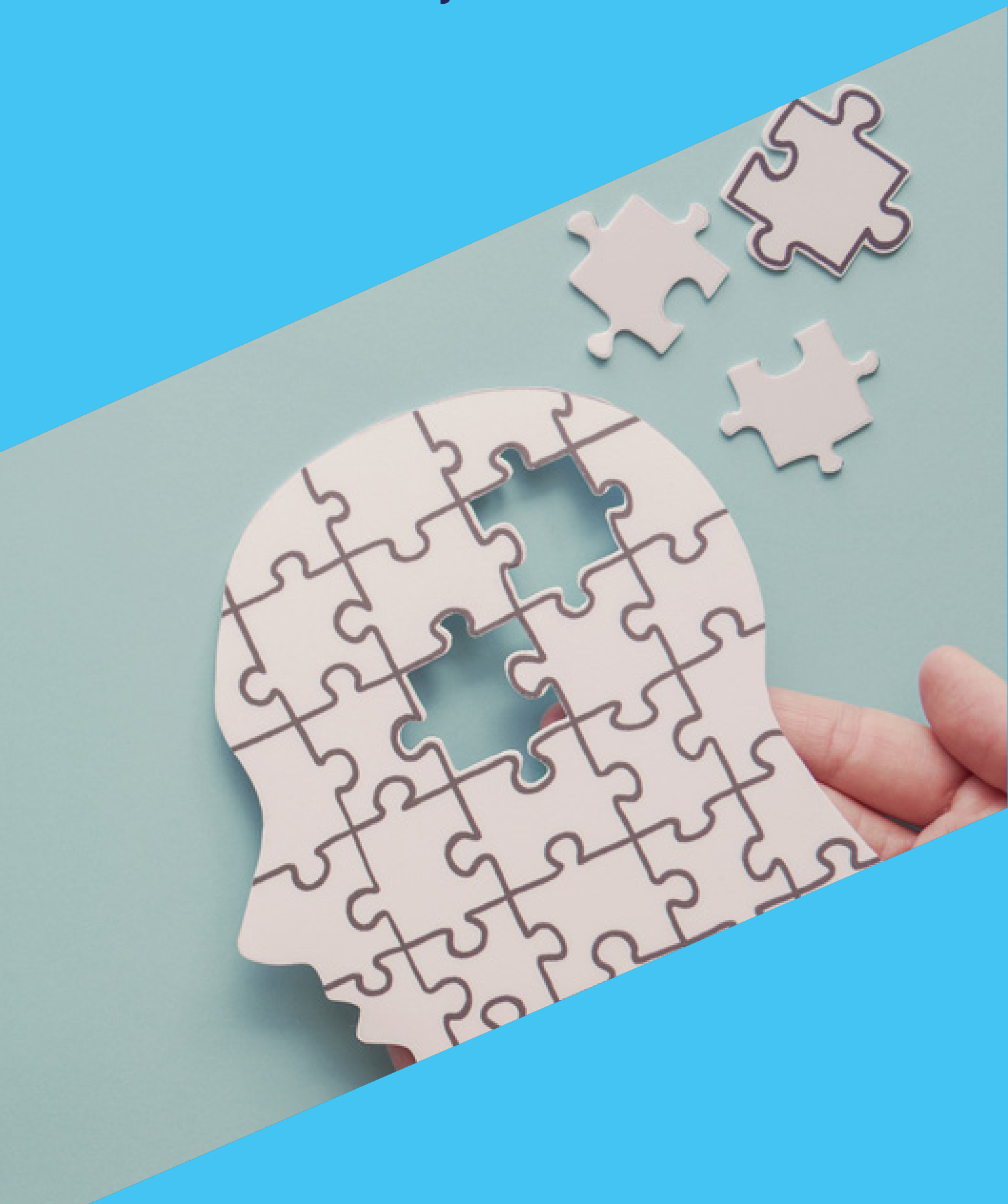


Executive Summary

This report was developed for the Department of Health as part of the end of term review of the Tobacco Control Strategy. It responds to the recommendations made in the mid-term review of the Tobacco Control Strategy to better understand the relationship between mental ill health and tobacco use and inform an appropriate policy response.

The report presents data from new analyses on mental ill health and tobacco use in Northern Ireland. It also presents insights from a document analysis of tobacco control policy documents in England, Scotland, Wales, Northern Ireland and Ireland.

Data for adults aged 16 years and older who took part in the Health Survey Northern Ireland 2018-2019 were analysed to assess the relationship between smoking status and mental ill-health. The analysis was conducted by the Public Health Information & Research Branch and included descriptive statistics. Z-scores were then calculated by the Institute of Public Health to compare the differences between two percentages. Variables included: currently smoking/never smoking/used to smoke, wanting to quit smoking, ever tried to quit smoking, General Health Questionnaire score, Warwick Edinburgh Mental Wellbeing Scale, self-reported levels of anxiety, and use of medications for stress, anxiety or depression. It should be noted that these groups are not mutually exclusive in the analysis.

The General Health Questionnaire (GHQ) is a screening tool designed to detect the possibility of psychiatric morbidity in the general population. The questionnaire contains 12 questions about recent general levels of happiness, depression, anxiety, and sleep disturbance. An overall score of between zero and twelve is constructed, with a score of 4 or more being classified as a respondent with a possible psychiatric disorder and referred to as a 'high GHQ12 score'.

The Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS) was developed to enable the monitoring of mental wellbeing in the general population. WEMWBS is calculated by totalling the scores for 14 statements. A score of 41-44 is indicative of possible/ mild depression and a score of <41 is indicative of probable clinical depression.

The key findings were:

- Possible psychiatric disorder was twice as common among those who currently smoke compared to those who never smoked (33% vs 14%, p<0.001) or those who used to smoke regularly (33% vs 15%, p<0.001).
- Probable clinical depression was twice as common among those who currently smoke than among those who used to smoke regularly (24% vs 12%, p<0.001).
- Probable clinical depression was four times more common among people who currently smoke than among people who have never smoked (24% vs 6%, p<0.001).
- The proportions of people who had ever tried to quit smoking were comparable between those with a possible psychiatric disorder, possible/mild, or probable clinical depression and those without (small numbers in analysis).
- The proportions of those wanting to quit smoking were also comparable between those with scores indicating a possible psychiatric disorder and those without a possible psychiatric disorder (small numbers noted in analysis).
- Fewer people with probable clinical depression who smoke want to quit smoking compared to those without probable clinical depression (57% vs 70%, p<0.01).

The READ approach (Dalglish et al, 2020) was applied to document analysis of current tobacco policy documents in the UK and Ireland. Official documents (policies/strategies), reviews of those policies and publicly available reports on implementation and/or policy evaluation were collated and are presented in the table overleaf.

Table 1. Tobacco policy documents for the UK and Ireland

Country	Strategy / Action Plan
England	Towards a Smokefree Generation A Tobacco Control Plan for England
England **(Khan Review)**	The Khan review. Making smoking obsolete Independent review into smokefree 2030 policies
Scotland	Raising Scotland's Tobacco-free Generation Our Tobacco-Control Action Plan 2018
Wales	A smoke-free Wales: Our long-term tobacco control strategy Our long-term plan towards a smoke-free Wales by 2030 A smoke-free Wales. Tobacco control delivery plan 2022-2024
Ireland	Tobacco Free Ireland Action Plan and annual reports HSE Tobacco Free Ireland Programme 2022-2025 The State of Tobacco Control in Ireland. HSE Tobacco Free Ireland Programme, 2018 The State of Tobacco Control in Ireland. HSE Tobacco Free Ireland Programme 2022
Northern Ireland	Ten Year Tobacco Control Strategy for Northern Ireland 2012-2022 Mid-term Review of the Ten Year Tobacco Control Strategy for Northern Ireland (2020)

Content was extracted based on pre-selected questions on elements of problem emergence, agenda setting, policy formulation, adoption and evaluation. A narrative of policy development for each jurisdiction was developed. Observations on the evolution of policy on tobacco and mental health are presented at the end of this report, followed by policy considerations for Northern Ireland.

England

English policy, launched in 2017, recognises higher smoking prevalence among people with mental health conditions. It frames an approach of 'parity of esteem' for addressing tobacco dependence for people with either physical or mental health conditions. The policy focuses on people with a serious mental illness and mental health service users with survey data used in indicators within area-based Tobacco Control Profiles. There is no specific policy target for reduction of smoking prevalence in this population group. The core policy commitments are that health and social care service commissioners and providers assess and address stop smoking support for people with mental health conditions and deliver targeted and effective interventions, including full implementation of NICE guidance in all

mental health services. This incorporated comprehensive smokefree policies in all mental health units by 2018. Evidence from scientific literature, professional bodies and statutory agencies features in the policy document, including evidence highlighting

- Equivalent aspirations to quit smoking among people with mental health conditions.
- Reluctance among healthcare professionals to offer stop smoking support.
- Misconceptions among healthcare professionals that stopping smoking could negatively affect patients' mental health.

The Department of Health, Public Health England, the Royal Colleges and NHS England are identified as key actors to address smoking among people with mental ill health. Actions to support the policy goal include:

- Develop and promote PHE and NHS England materials to support staff in mental health trusts to implement NICE Guidance PH451 and PH482.
- Guidance for commissioners in relation to smoking in secure mental health settings.
- Training of mental health professionals in stop smoking service delivery and bespoke training for people working with clients with mental health problems.
- Explore how to integrate further stop smoking support with addiction services and services for people with mental health conditions.
- Work with the Mental Health and Smoking Partnership of Royal Colleges, third sector organisations and academia to consider the evidence on how to reduce the prevalence of smoking among people with mental health conditions.
- Identify and rectify gaps in data on smoking and mental health which show prevalence, trends and the level of stop smoking support provided to have a comprehensive picture of the problem.

The Khan Review specifically recommends enhanced action on smoking and mental health and widens the 'policy lens' to include people with mental health conditions generally, as well as those with serious mental illness. The review cites evidence that around one third of adult tobacco consumption is by people with a current mental health condition, with smoking rates more than double that of the general population. Recommendation 13 relates specifically to mental health and adds the following recommendations:

- Disseminate accurate information that smoking does not reduce stress and anxiety, through public health campaigns and staff training.
- Make stopping smoking a key part of mental health treatment in acute and community mental health services and in primary care.

Scotland

Scottish policy, launched in 2018, acknowledges the relationship between smoking and mental health but does not present any survey data on the relationship, nor derive any indicator for use at national or local level. People with mental ill-health are not one of the five designated target groups nor is there any specific policy target for reducing smoking prevalence in this population group. Evidence presented in relation to smoking and mental health features significantly within the action plan, including:

- One third of all cigarettes sold in Scotland are bought by people with mental health problems and smoking rates amongst this group are significantly higher than the national average.

- Current evidence suggests that smoking reduces effectiveness of mental health medication by up to 50%.
- Smoking is known to have a significant impact on the effectiveness of medications, including those prescribed for mental health conditions.
- Smoking status information amongst people engaging with mental health services is one area where better data recording would be especially useful.
- The physical and mental health costs as well as the financial costs of smoking are well understood, but evidence suggests that this understanding is greater amongst better-off individuals and communities.

The policy commits to very specific actions relating to smoking and mental health, specifically:

- To support ASH Scotland in rolling out its effective IMPACT advice and training on the relationship between smoking and mental health care.
- To build on the Quit Your Way brand for specific stop–smoking initiatives and services such as for smoking in pregnancy and for smoking and mental health to build inclusivity and help overcome barriers to access for priority groups.

More broadly, the policy also commits to continue to support NHS Health Scotland in its research, guidance, training and advice on smoking prevention, protection, cessation, electronic cigarettes, and related health equalities. It also commits to address gaps in data and monitoring but these recommendations do not include any specific reference to mental health.

Wales

Welsh policy has been recently refreshed with the publication of 'A smoke-free Wales' in 2022, and the accompanying 'Tobacco control Delivery Plan 2022-2024'. The Welsh Government has stated that targeted and tailored support is crucial to ensure smoking prevalence is reduced for those with mental health conditions. Smoking and mental health features within *Theme 1 – reducing inequalities* where users of mental health services are identified as a 'priority group'. The document also refers variably to a broader group (people with mental health conditions) but the priority group specified within policy is mental health service users. There is no target specified in the final policy in terms of a reduction of smoking prevalence in this group. Evidence presented in relation to smoking and mental health within the policy includes:

- Smoking rates are much higher in people who have mental health conditions - it is estimated that 33% of people with mental ill health smoke.
- Smoking related diseases are a major contributory factor to reduced life expectancy for those with schizophrenia.
- Only a minority of people with mental health conditions receive effective smoking cessation interventions.
- At least 33% of tobacco consumed in the UK is used by people with mental health conditions, and 60% of people with a diagnosis of schizophrenia (ASH Wales 2017).

Mental health service users are identified as a 'priority group' for engagement and consultation in the development of the strategy and consultation reports provide perspectives from mental health service users on policy priorities and implementation opportunities and challenges. There are a number of actions which relate to tobacco and mental, namely:

- Enhance integration of service planning, delivery and monitoring with mental health and substance use services.
- Assess and respond to training needs for services used by priority groups (including mental health service users).

Performance management structures are identified as a domain of action with allied services, but while maternity services are mentioned, mental health services are not.

Ireland

Tobacco Free Ireland launched in 2013. Policy implementation is recorded through Departmental annual reports, periodic HSE implementation plans and the State of Tobacco Control (SOTC) in Ireland reports. There is no exploration of the mental ill health and smoking relationship in the original Tobacco Free Ireland policy. Creating tobacco free health services within the mental health service and enhancing compliance with smoke-free legislation is the sole policy action specific to mental health. However, tobacco and mental health are presented in the 2018 and 2022 SOTC reports. Evidence presented in these reports' highlights:

- The well-established relationship between smoking and mental health is complex, with evidence indicating that mental health increases the risk of becoming a person who smokes as well as confirming that smoking is injurious to mental health.
- Smoking explains much of the poor physical health experience of people with mental health problems.
- People with mental health problems who smoke express as much interest in quitting as the general population and can successfully quit.
- Users of mental health services continue to be excluded from the benefits of smoke-free legislation.
- Insights from implementation studies of tobacco-free campus approaches in mental health facilities in Ireland.
- Inclusion of mental health perspectives within the development of national clinical guidelines on smoking cessation.

SOTC states that the needs of people with mental health problems demand particular attention and recommends that this be informed by the needs of people with mental health problems as well as best international evidence. It repositions the issue from a health service compliance issue to a broader population health issue and presents indicators based on survey data using validated mental wellbeing scales. Policy implementation activities extended beyond the initial policy priority of smoke-free campus compliance in mental health service and included:

- Specific training in relation to smoking cessation and mental health and an online mental health and smoking module.
- Regular reporting on uptake of training and the level of tobacco free campus compliance within mental health acute and residential services.
- Resources to support mental health services to work towards tobacco free campus including toolkits, bursaries and awards.
- Research studies on implementation and evaluation in mental health service settings.
- partnership between TFIP and mental health leaders including a national 'conversation

café' on smoking and mental health and guidance on smoking, mental health and recovery colleges.

- Development of smoking and mental health section and resources on the HSE QUIT website.

Northern Ireland

Northern Ireland's tobacco control policy, which launched in 2012, recognised the link between smoking and mental ill-health but does not state any specific policy objective or target. Evidence presented within the policy includes:

- Smoking rates are much higher in people who have mental health conditions.
- Smoking related diseases contribute to excess mortality among people with mental illness.
- People with mental disorders are significantly over-represented among tobacco-related deaths.
- Smoking prevalence among inpatients in mental health services may be as high as 70%, and half of these are among those who smoke greater than or equal to 25 packs per day.
- Many people with mental ill health want to stop smoking.

A mid-term review of the strategy was published in 2020. Stakeholder engagement undertaken for the mid-term review highlighted the need for enhanced action on smoking among those experiencing mental ill health. The mid-term review proposed that people with mental ill health could be considered as a target group for the strategy going forward, alongside pregnant women, children and young people and routine/manual workers. The stakeholder engagement report presented an aspiration of additional resourcing, including specific service roles. It was also recommended that messaging on smoking be integrated into mental health supports, resources and community level actions for children and young people. The evidence review for the mid-term review also recommended a refresh of school-based programmes in light of the emerging interface with mental health issues and the importance of social competency elements with health education in school settings.

The Tobacco Strategy Implementation Steering Group lead by the Department of Health and Public Health Agency was tasked with formulating a plan for the development of actions and targets in relation to people with mental health issues who smoke.

Actions evident include:

- Public Health Agency funding to assist Health and Social Care Trusts to further develop stop smoking services within mental health services.
- Efforts to ensure compliance with NICE guidance for smoking cessation in mental health settings.
- An evidence review completed for mid-term review included evidence on smoking cessation and mental health. The review highlighted evidence on the effectiveness of both psychosocial and pharmacological supports for smoking cessation in people with current and past depression, and for people with schizophrenia. However, it noted that generic motivational interviewing and group counselling may need to be adapted to the needs of users with chronic mental health issues.

1 Background

1. Background

Smoking remains the most significant cause of ill health and early death in Northern Ireland and a major driver of health inequity. Government strategies have historically recognising that certain population groups carry an excess burden in terms of tobacco-related ill health, disability and shorter lives. People living in socio-economic disadvantage are identified as a target or priority group within most European strategies seeking to reduce tobacco use and tobacco-related harms. However, the relationship between tobacco and mental ill-health is emerging as a priority area for action.

This report was developed by the Institute of Public Health for the Department of Health. It provides insights on tobacco and mental health to inform the Department's end of term review of the *Ten Year Tobacco Control Strategy for Northern Ireland*. The insights in the report are also intended to inform a position on mental health and tobacco use in any future tobacco strategy in the region.

A Mid-term Review of the Tobacco Control Strategy was published in 2020 (Department of Health, 2020). This report included insights from implementation alongside findings from an evidence review (Purdy et al, 2020) and stakeholder engagement process (Rodriguez et al, 2020) to inform the remaining term of the strategy. The overall aim of the evidence review was to support evidence-informed decision-making to inform the mid-term review of the Tobacco Control Strategy and the direction of future implementation of the Strategy. The evidence review focused on exploring evidence to enhance the existing approaches set out in the Strategy and its action plans, as well as developing insights on innovative new approaches. Following a screening process, findings from 86 reviews were synthesised and presented according to the objectives of the Strategy. A series of policy considerations which included recommendations relating to smoking and mental health were developed (Purdy et al, 2020).

As part of the mid-term review of the Tobacco Control Strategy, the Institute of Public Health facilitated a stakeholder engagement process which comprised three parts:

1. A workshop with lead implementation stakeholders which included policy and programme leads from the Department of Health and the Public Health Agency (PHA) as well as those with lead roles in service commissioning, management and service provision as well as advocacy and research sectors.
2. An online survey of a wider group of implementation stakeholders.
3. An overview of stakeholder engagement reports developed by the Public Health Agency during the term of the Strategy.

The stakeholder engagement report presented views and experiences of implementation stakeholders and implications for future delivery of the Strategy. The stakeholder engagement yielded important insights on the potential reasons behind successes and challenges in implementation. This work sought to explore the 'black box' of implementation. Other components of the review looked at whether the strategy goals and actions were completed as planned and whether progress was achieved at population level in reducing smoking and exposure to second-hand smoke (Rodriguez et al, 2020).

The overall mid-term review report, published by the Department of Health, recommended that strategy in Northern Ireland would benefit from a better consideration of smoking among those living with mental ill health (Department of Health, 2020). The mid-term review report was published in February 2020, just prior to the outbreak of the COVID-19 pandemic. Subsequently, the implementation of the strategy and opportunity to take forward any recommendations was impacted by the COVID-19 pandemic and so progress on addressing the recommendations of the mid-term review were delayed. In order to progress this aspect of strategy implementation, the Department of Health requested that the Institute of Public Health provide additional insights on policy approaches to addressing smoking and mental health.

2 Aims and Methods

2. Aims and Methods

Note:
This report uses people first language throughout, for example 'people who smoke', 'people who used to smoke' etc. If people first language is not used (i.e. 'smokers', ex-smokers etc.) it is because we have quoted the language used in policy documents or survey data for accuracy.

The aims of this report were to:

- Describe the relationship between smoking and mental ill health in Northern Ireland based on representative government survey data.
- Explore policy development in relation to smoking and mental ill health in the UK and Ireland.
- Provide insights based on these analyses and propose considerations for policy on tobacco and mental health in Northern Ireland.

There were two approaches applied in this report.

1. Quantitative analyses on survey data mental ill health and tobacco use in Northern Ireland.
2. Document analysis of tobacco control policy documents in England, Scotland, Wales, Northern Ireland and Ireland.

1. Quantitative analyses of survey data on mental ill health and tobacco use in Northern Ireland

Sample

This approach included secondary analysis of data from the Health Survey Northern Ireland 2018-2019 dataset. This dataset was chosen as it contained the most recent and robust measures of mental health that were not impacted by COVID-19. This data includes all adults aged 16 years and over.

Analysis

A specification for analysis was sent by the Institute of Public Health to the data holders, the Public Health Information & Research Branch, in the Department of Health. The analysis was conducted by the Public Health Information & Research Branch. The analysis included descriptive statistics including frequencies and cross tabulations. Results were reported as case numbers and proportions. Z-scores were calculated by the Institute of Public Health to compare the differences between two percentages at the 95% level.

Measures

Smoking status and quitting status were recategorized for the purpose of the secondary analysis. Smoking status was categorised as: currently smokes cigarettes, used to smoke cigarettes regularly, used to smoke but not regularly, and never smoked. Quitting status was categorised as; ever tried to quit smoking and has not tried to quit smoking. Want to quit status was categorised as: wants to quit smoking (included the responses of I really

want to stop smoking and intend to do so in the next month, I really want to stop smoking and intend to do so in the next 3 months, I want to stop smoking and hope to do so soon, I really want to stop smoking but I don't know when I will, I want to stop smoking but haven't thought about when) and does not want to quit smoking (includes the responses of I know I should stop smoking but I don't really want to).

A number of mental health measures were used within the analysis including the General Health Questionnaire (GHQ), Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS), and taking any medicine or tablets for stress/anxiety or depression (Yes/No).

The GHQ is a screening tool designed to detect the possibility of psychiatric morbidity in the general population. The questionnaire contains 12 questions about recent general levels of happiness, depression, anxiety and sleep disturbance. An overall score of between zero and twelve is constructed, with a score of 4 or more being classified as a respondent with a possible psychiatric disorder, and referred to as a 'high GHQ12 score'. For the purpose of this analysis GHQ was categorised into scores of 0, 1-3, and 4+.

The Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS) was developed to enable the monitoring of mental wellbeing in the general population and the evaluation of projects, programmes and policies which aim to improve mental wellbeing. WEMWBS is calculated by totalling the scores for 14 statements. To calculate the score, all statements must have been scored. This results in an individual score between 14 and 70.

The WEMWBS has been benchmarked on CES-D with which it is highly correlated (.84). Using CES-D = 26 and CES-D = 16 as cut points, this analysis suggests that:

- a score of 41-44 is indicative of possible/ mild depression
- a score of <41 is indicative of probable clinical depression

For the purpose of this analysis WEMWBS was categorised into scores of <41, 41-44 and >44.

Where case numbers allowed, data were also analysed by gender, categorised as males and females, and deprivation, categorised as quintile 1 (most deprived), quintiles 2-4, quintile 5 (least deprived).

Strengths and limitations

This analysis is, to our knowledge, one of the first pieces of in depth analysis of mental health and smoking data in Northern Ireland using a large national dataset. The data is analysed by all measures of mental health available including reliable and validated scales as well as self-reported mental health information.

It should be noted that there will be some overlap in General Health Questionnaire score, Warwick Edinburgh Mental Wellbeing Scale, self- reported levels of anxiety and use of medications for stress, anxiety or depression. This means that some individuals will be counted in each of the selected measures. It should also be noted that taking medication may improve the GHQ12 score and the Warwick-Edinburgh score.

The data used in this analysis was based on self-report which could underestimate both the levels of smoking and the levels of mental ill health in the population. Furthermore, although the overall sample is large the subcategories were too small in some cases to analyse by gender and deprivation. Future analysis could look towards combining years of Health Survey Northern Ireland (HSNI) data to investigate the relationships between mental health and smoking further using multivariable regression models.

2. Document analysis of tobacco control policy documents in England, Scotland, Wales, Northern Ireland and Ireland.

A document analysis of tobacco control policies and action plans was undertaken to describe the state of policy development in relation to smoking and mental ill health in the UK and Ireland. This approach provided insights on these various policy analyses and set out a series of policy considerations to help address smoking and mental health in Northern Ireland.

The document analysis approach used in this report is based on that developed by Dalglish and colleagues (2020), known as the **READ** approach:

i. **R**eady your materials

ii. **E**xtract data

iii. **A**nalyse data

iv. **D**istil your findings

The READ approach is a systematic procedure for collecting documents and gaining information from them in the context of health policy at any level (global, national or local). It is an organised system of analysis which enhances procedural rigor and allows for a fuller understanding of the policy process and content. This section outlines the document analysis under the four headings above.

i. **Ready your materials.** This first stage involves setting parameters in terms of the nature and number of documents to be analysed, based on the research question. The authors note that consideration should also be given to the time available for the document analysis and scope of the research question. Criteria are then established around the topic (i.e. policy, programme or health issue), dates of inclusion, and where documents will be located.

   In this particular context, it was decided that the analysis would include tobacco control policy documents from the UK and Ireland. Some supplementary documents (such as policy and programme evaluations) were also reviewed to provide a comprehensive overview of the approaches taken and their effectiveness. All documents were current policy documents, identified from the relevant government or statutory agency websites and were read at least twice. This first stage in the process involves identifying the type of information to be extracted from the documents.

ii. **Extract data.** Data extraction can be conducted in a number of ways and the method chosen will depend on the research question and nature of the documents. Dalglish and colleagues suggest that one simple method is to use Excel to list each documents and category of information extracted. This was the method used by the Institute of Public Health. Alternative methods include using software for qualitative data analysis or creating a timeline of event to trace processes across a specified time period. For this document analysis an Excel file was created for each country based on the Stages Model of Policy Process (Peters, 2009), which is discussed in more detail later in this section.

iii. **Analyse data.** Data collection and analysis are iterative and characterised by emergent design, meaning that developing findings continually inform whether and how to interpret data (Creswell, 2013). This stage involves taking a holistic view of the document 'answers' to the questions or analysis categories applied during the data extraction stage.

iv. Distil your findings. Dalglish and colleagues note that results will often be grouped by theoretical or analytical category or presented as a policy narrative interweaving strands from other methods used. The findings of the distillation process will vary by research study (or in this case, policy document) and will allow the findings to be stated relative to the research question and policy-relevant conclusions stated.

Stages Model of Policy Process

At the Data Extraction Stage, the Stages Model of Policy Process (Peters, 2009) was applied to develop the excel file. The Stages Model is based on the Stage Heuristic Framework (Kulac and Özgür, 2017) used in policy studies to capture the learning from the different stages of policy development. The authors of this report have drawn on a number of policy process approaches to capture the learning on smoking and mental health from other jurisdictions. Table 2 describes the stages of policy development which were used to structure the findings from the document analysis.

Table 2. Stages Model of Policy Process

Stages of Policy Process	Specific actions
Issue emergence	Problem identified; policy response required (identify, describe and analyse the problem)
Agenda setting	This stage refers to the process through which a policy and the problem it is intended to address are acknowledged to be of public interest. Some authors differentiate among several types of agendas, including discussion agendas and decision agendas.
Policy formation	At this stage, the public administration concerned examines the various policy options it considers to be possible solutions. It should be noted that coalitions of actors strive, through the use of advocacy strategies, to gain priority for one specific interpretation of both the problem and its solution. It is at this stage that power relationships crystallize, determining the direction a policy will take.
Decision making/ policy adoption	Adoption is the stage during which decisions are made at the governmental level, resulting in a decision that favours one or more approaches to addressing a given problem.
Implementation	At this stage, the policy's implementation parameters are established, which can directly affect the eventual outcome of the policy. Several factors combine to determine the actual effects of a policy and how well it achieves its objectives. Factors noted by Sabatier and Mazmanian include: • The type and complexity of the problem addressed • The magnitude of the expected change and the groups targeted by the policy • The human and financial resources devoted to implementation • The administrative structures and regulations that will be put in place to support implementation of the policy (Sabatier & Mazmanian, 1995).
Evaluation	This is the stage during which a policy is evaluated, to verify whether its implementation and its effects are aligned with the objectives that were explicitly or implicitly set out. This evaluation can be carried out by the government apparatus, by consultants or by civil society (Howlett & Ramesh, 2003).

Adapted from: Benoit, F. (2013). Public Policy Models and Their Usefulness in Public Health: The Stages Model. Montréal, Québec: National Collaborating Centre for Healthy Public Policy.

Using the READ approach and Stages Model of Policy Process, the report authors collated all content relating to smoking and mental health in a excel file for England, Scotland, Wales, Ireland and Northern Ireland. The documents analysed are listed in Table 1 on page 7. The content from the excel file was then analysed and used to populate this report in two ways.

Firstly, a detailed narrative of each country's policy document was developed based on the structure of the Stages Model of Policy Process and is presented in Table 2. Secondly, a summary table has been developed (see appendix) which shows at a glance features of the policy in the context of smoking and mental health. Not all elements of the Stages Model of Policy Process were applicable to each policy document and there are various reasons for this. For example, the Khan Review and Mid-term Review of the Ten Year of Tobacco Control Strategy for Northern Ireland as the name suggests, are reviews of past or current policies, but nonetheless, these documents include important statements on smoking and mental health. Also, in the case of Ireland, the original policy was written in 2013 and since that time there have been a number of action plans, annual reports and government led evaluations of Tobacco Free Ireland which have encompassed developments around smoking and mental health which were not necessarily a focus in the original strategy document.

The policy document analysis has been used to develop a series of policy considerations to inform tobacco control measures in Northern Ireland in the context of smoking and mental health. The learning from policy approaches across the rest of the UK and Ireland will inform policy options on smoking and mental health for the Department of Health in Northern Ireland.

3 Analysis of mental health and smoking data in Northern Ireland

3. Analysis of mental health and smoking data in Northern Ireland

Results are presented in two sections:

- **Section 3.1** presents the findings from analysis of Health Survey Northern Ireland.
- **Section 3.2** presents the findings from document analysis of tobacco policies across the UK and Ireland.

Further detail on the methods are provided in section 2.

3.1 Data on smoking and mental health in Northern Ireland

3.1.1 Mental ill-health in Northern Ireland

In 2018/2019:

- 18% of the population reported currently smoking
- 31% used to smoke; 21% used to smoke regularly and 10% used to smoke but not regularly
- 51% had never smoked
- 18% had a GHQ score of 4 or more (possible psychiatric disorder)
- 9% had a WEMWBS of 41-44 indicating possible/mild depression
- 10% had a WEMWBS of <41 indicating probable clinical depression
- 14% reported taking medications for stress, anxiety or depression

Of those who take medications for stress, anxiety or depression:

- 46% have possible psychiatric disorder (GHQ score of ≥4)
- 39% have probable clinical depression (WEMWBS of 41-44)
- 16% have possible/mild depression

Of those with a GHQ score of 4 or more indicating a possible psychiatric disorder 41% take medications for stress, anxiety or depression.

Of those with WEMWBS scores indicating possible/mild depression or probable clinical depression, 30% and 55% take medications for stress, anxiety or depression respectively.

3.1.2 Smoking among people with 'mental ill health' in Northern Ireland

This section presents data on smoking behaviours among people with mental ill health, as determined by

- General Health Questionnaire (GHQ)
- Warwick Edinburgh Mental Wellbeing Scale (WEMWBS)
- Use of medications for stress, anxiety or depression

Figure 1 presents how smoking prevalence varies across three categories of GHQ score.

The data show that:

* Around one in three people with possible psychiatric disorder (GHQ score ≥4) smoke.
* Just over half of people (51%) with a possible psychiatric disorder (GHQ score ≥4) either currently smoke or used to smoke regularly compared to just over a third of people (34%) with a GHQ score of 0 ($p<0.001$).
* There was a 2.5 fold difference in the rate of those who had a score ≥4 and reported currently smoking in the most and least deprived areas (50% vs 20%, $p<0.001$, very small numbers in analysis, data not presented in figure).

Figure 1. Smoking status according to the General Health Questionnaire (GHQ) scores

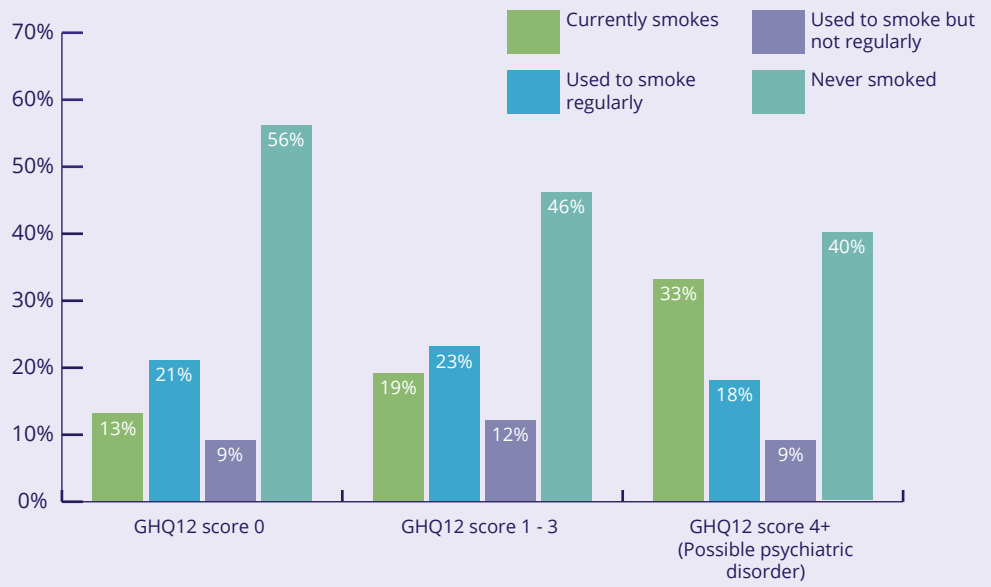


Figure 2 presents smoking status according to the Warwick Edinburgh Mental Wellbeing Scale. The data show that:

* Almost three times as many people meeting the criteria for probable clinical depression (WEMWBS <41) smoke than those with a WEMWBS score of >44 ($p<0.001$).
* Almost twice the proportion of people meeting the criteria with possible/mild depression (WEMWBS 41-44) smoke than those with a WEMWBS score of >44 ($p<0.001$).
* Two thirds of people with probable clinical depression (WEMWBS <41) either smoke or have smoked at some time in their lives.

Figure 2. Smoking status according to the Warwick Edinburgh Mental Wellbeing Scale scores

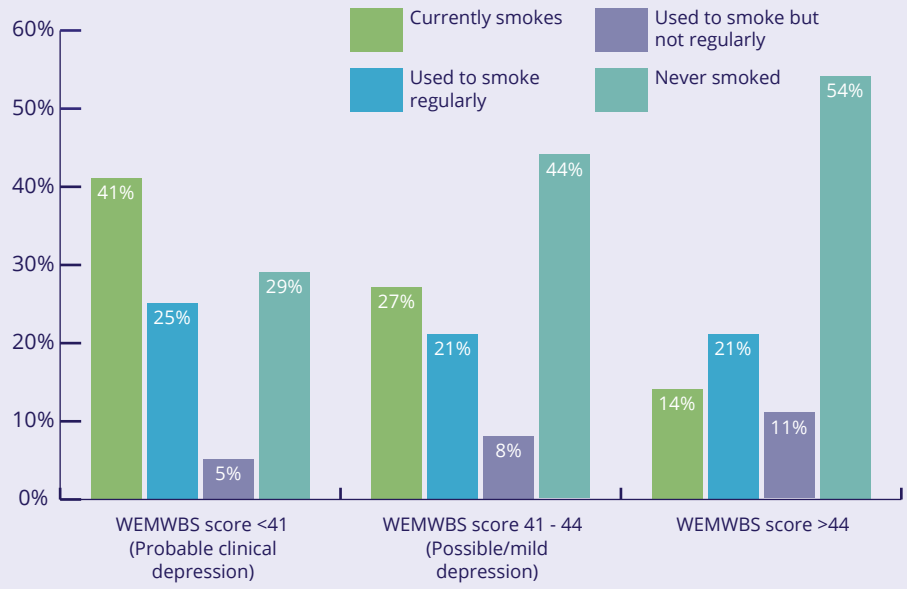
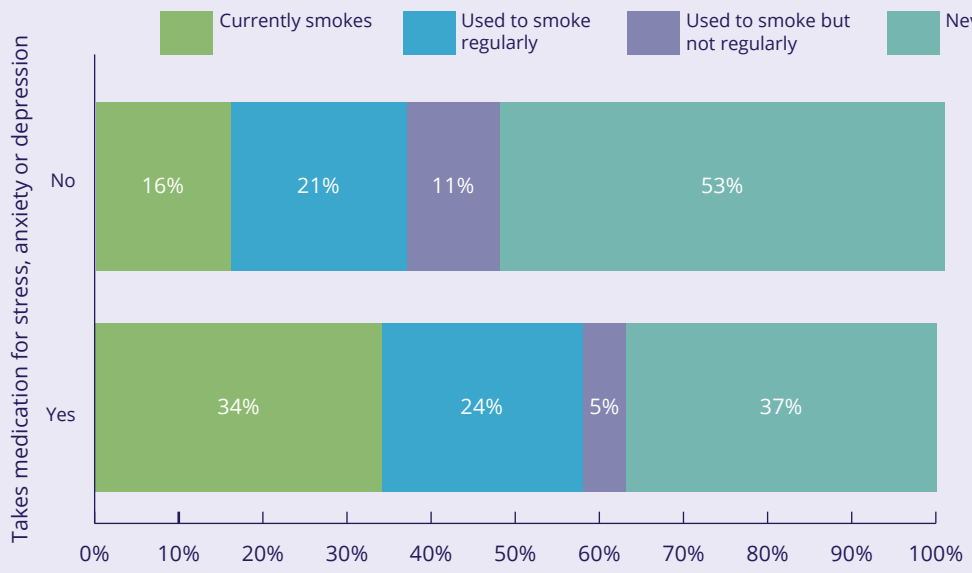


Figure 3 compares smoking among people who take medications for stress, anxiety or depression with those that do not. The data show that:

* Smoking prevalence among people who take medications for stress, anxiety or depression is double that of people who do not ($p<0.001$).
* Around one in three people who take medications for stress, anxiety or depression currently smoke.
* There is a lower proportion of people who never smoked among people who take medications for stress, anxiety or depression than among those who do not take medications for stress, anxiety or depression ($p<0.001$).
* There are similar proportions of people who used to smoke among people who take medications for stress, anxiety or depression and those that do not.
* There was an almost 2.5 fold difference in the rate of those who take medications for stress, anxiety or depression and report currently smoking in the most and least deprived areas (52% vs 21%, $p<0.001$, very small case numbers noted – data not presented in figure).

Figure 3. Smoking status of people who use medications for stress, anxiety or depression



3.1.3 Mental ill health among people who smoke in Northern Ireland

This section examines the relationship between smoking and mental ill health from the perspective of the total population of people who smoke rather than the total population with mental ill health. This perspective may be of particular interest to those involved in the design, delivery and evaluation of stop smoking services and campaigns.

Figure 4 presents smoking status by General Health Questionnaire (GHQ) scores, with a score of 4 or more considered to represent possible psychiatric disorder. The data show that:

* One in three people who smoke have a possible psychiatric disorder.
* The prevalence of possible psychiatric disorder among people who smoke is double that seen in those that used to smoke and never smoked (p<0.001).

Figure 4. General Health Questionnaire (GHQ) scores by smoking status

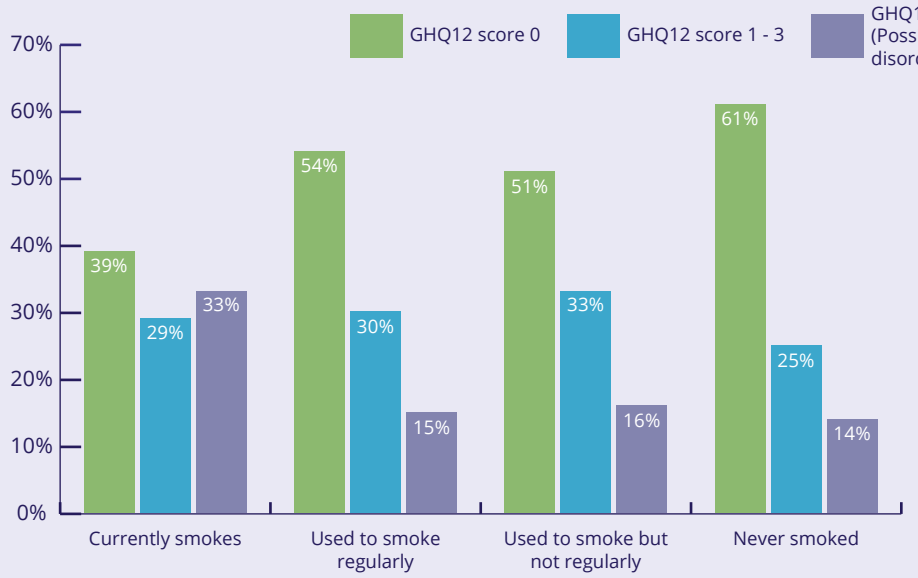


Figure 5 presents the picture using the Warwick Edinburgh Mental Wellbeing Scale (WEMWBS) scores, with lower score categories representing an increased probability of depression. These data show that:

* The proportion of those who smoke who have probable clinical depression is double that of those who used to smoke regularly (24% vs 12%, p<0.001).
* The proportion of those who smoke who have probable clinical depression is four times that of those who never smoked (24% vs 6%, p<0.001).
* Around one in four people who smoke have probable clinical depression.
* Around one in eight people who smoke have possible clinical depression.

Figure 5. Warwick Edinburgh Mental Wellbeing Scale scores by smoking status

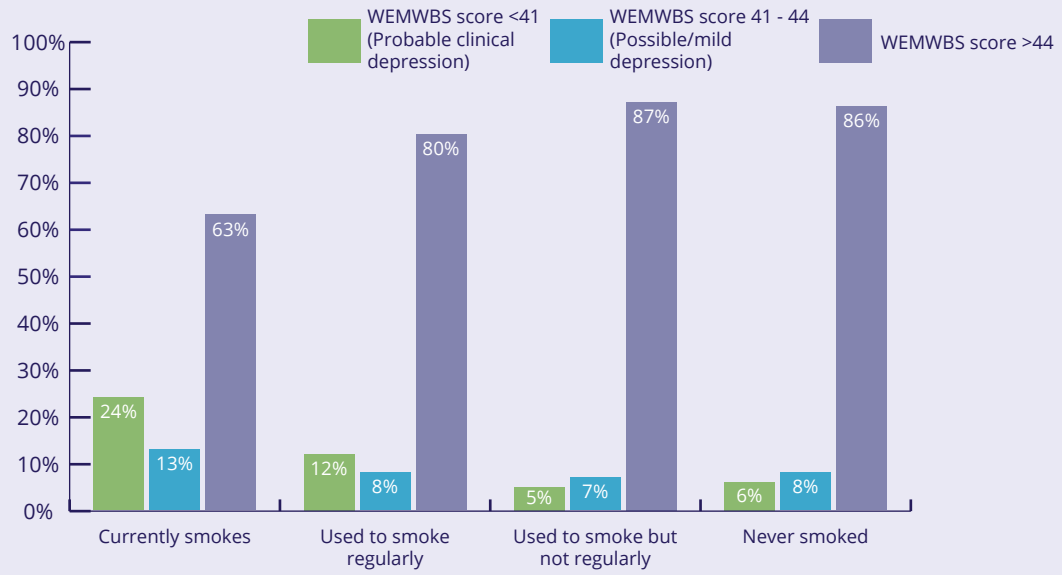
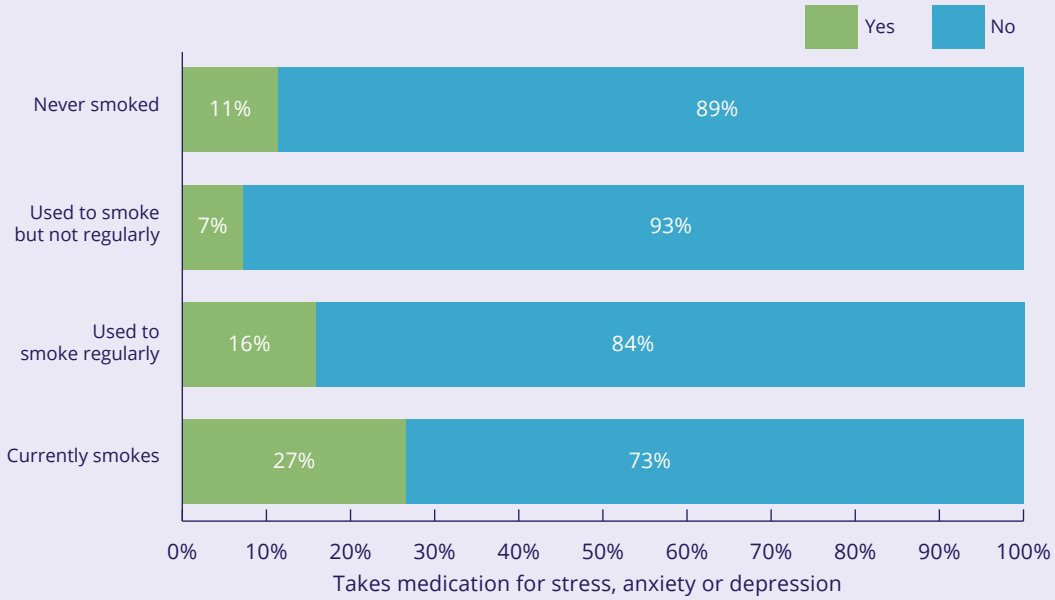


Figure 6 presents data on use of medications for stress, anxiety or depression among populations categorised by their smoking status. The data show that:

* A higher proportion of people who currently smoke use medications for stress, anxiety or depression than people who used to smoke or never smoked (both $p<0.001$).
* Around a quarter of people who currently smoke reported taking medications for stress, anxiety or depression.

Figure 6. Use of medications for stress, anxiety or depression by smoking status



3.1.4 Stopping smoking among people with mental ill health

The findings in this section represent a preliminary exploration of desire to quit smoking and previous quit attempts among people with mental ill health who smoke in Northern Ireland. They do not include any data on the nature of the quit attempt or whether a period of smoking cessation was achieved.

Exploring the relationship between 'wanting to quit' and mental health status

The two 'want to quit' groups reported in this section come from composites of the following responses to question 16 in the smoking section of the 2018/2019 Health Survey Northern Ireland questionnaire. The groups were categorised as following:

1. 'Want to quit' includes the responses 'I really want to stop smoking and intend to do so in the next month', 'I really want to stop smoking and intend to do so in the next 3 months', 'I want to stop smoking and hope to do so soon', 'I really want to stop smoking but I don't know when I will', 'I want to stop smoking but haven't thought about when'.
2. 'Do not want to quit' includes the responses 'I know I should stop smoking but I don't really want to' and 'I don't want to stop smoking'.

Figures 7 and 8 present data on 'wanting to quit' and smoking status using the General Health Questionnaire (GHQ) scores. The findings are presented from the perspective of two populations – the population with mental illness and the smoking population.

These data show that:

- Two thirds of people with possible psychiatric disorder who smoke want to stop smoking.
- The proportions wanting to stop smoking among people with possible psychiatric disorder are broadly similar to the proportions in the rest of the smoking population studied.
- Among the smoking population who want to quit, around one in three has a possible psychiatric disorder.

There were no significant differences between the proportions of those who want to quit and those who do not across all GHQ12 scores.

Figure 7. The General Health Questionnaire (GHQ) scores according to desire to quit smoking

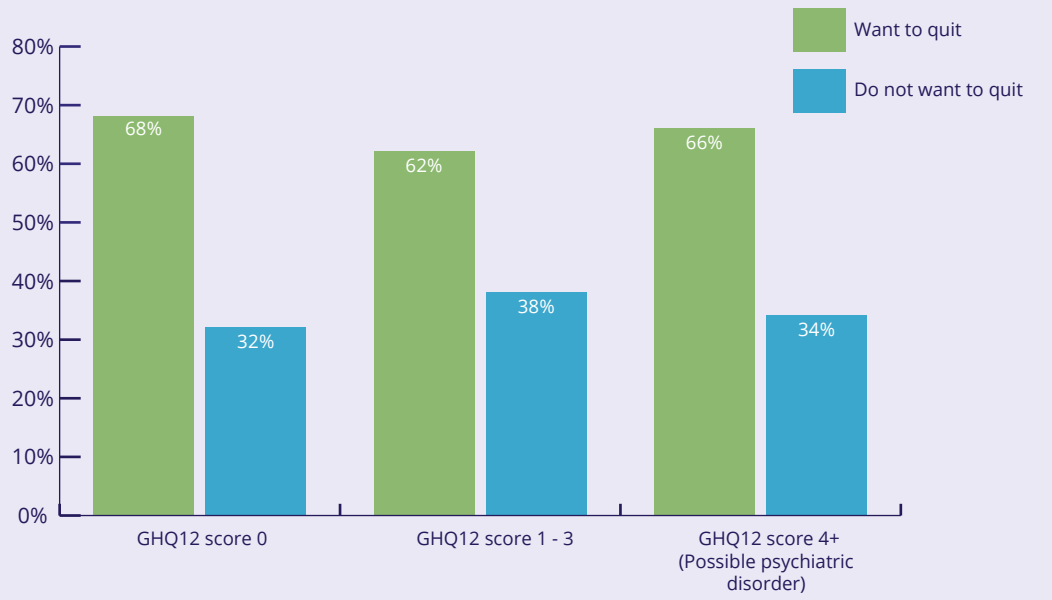


Figure 8. Desire to quit smoking according to the General Health Questionnaire (GHQ) scores

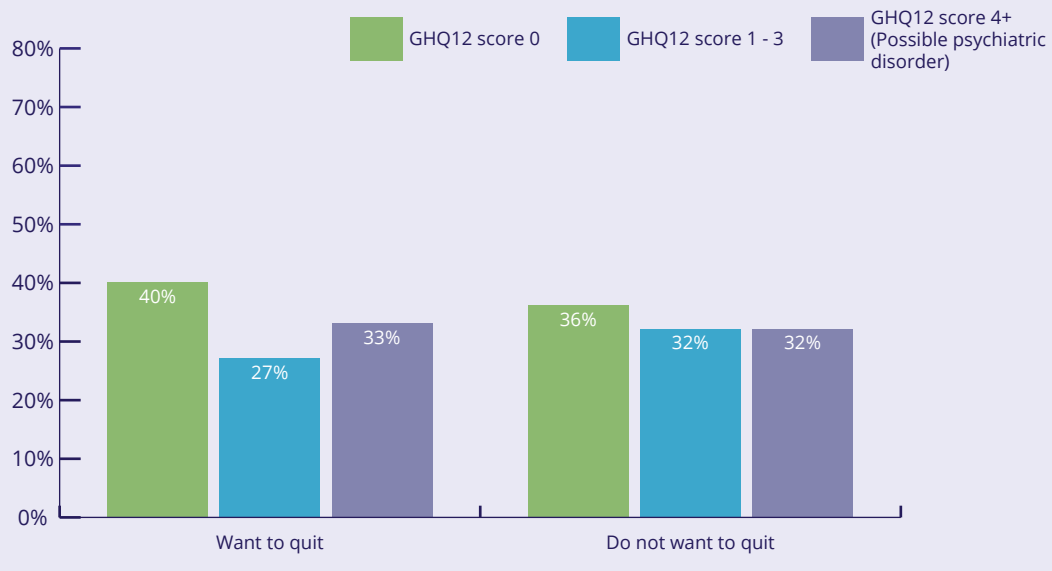


Figure 9 and 10 present data on 'wanting to quit' and smoking status using the Warwick Edinburgh Mental Wellbeing Scale (WEMWBS) scores.

The findings are presented from the perspective of two populations – the population with mental illness and the smoking population. These data show that:

* More than half of people with probable clinical depression want to stop smoking.
* Around two thirds of people with possible/mild depression want to stop smoking.
* Fewer people with probable clinical depression who smoke want to quit smoking than those with a score of >44 (57% vs 70%, p<0.01).
* Among those who want to stop smoking, around one in three may have some form of depression – with one in five experiencing probable clinical depression and around one in eight with possible clinical depression.

Figure 9. Warwick Edinburgh Mental Wellbeing Scale (WEMWBS) scores according to desire to quit smoking

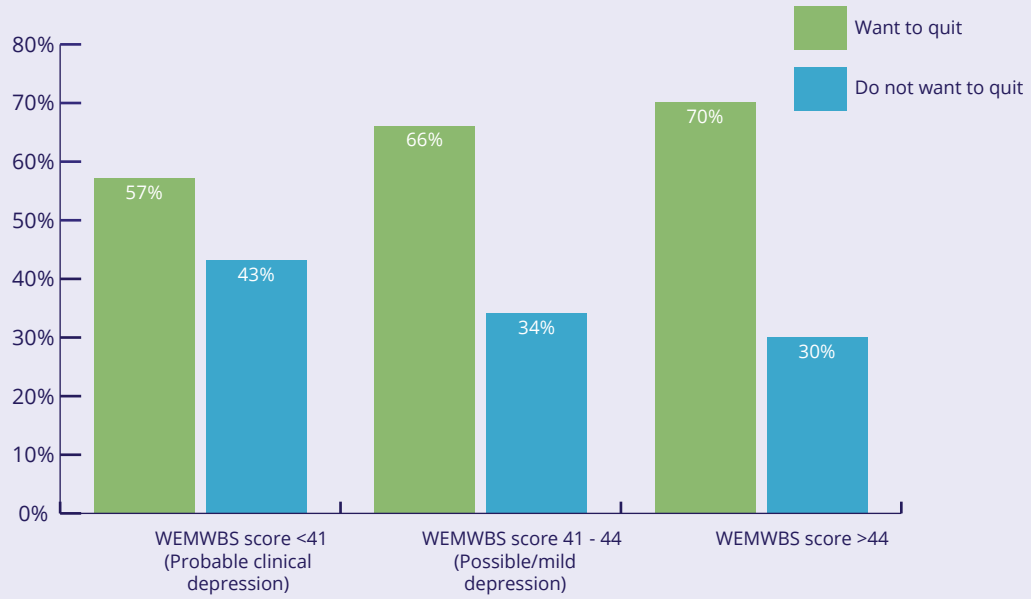
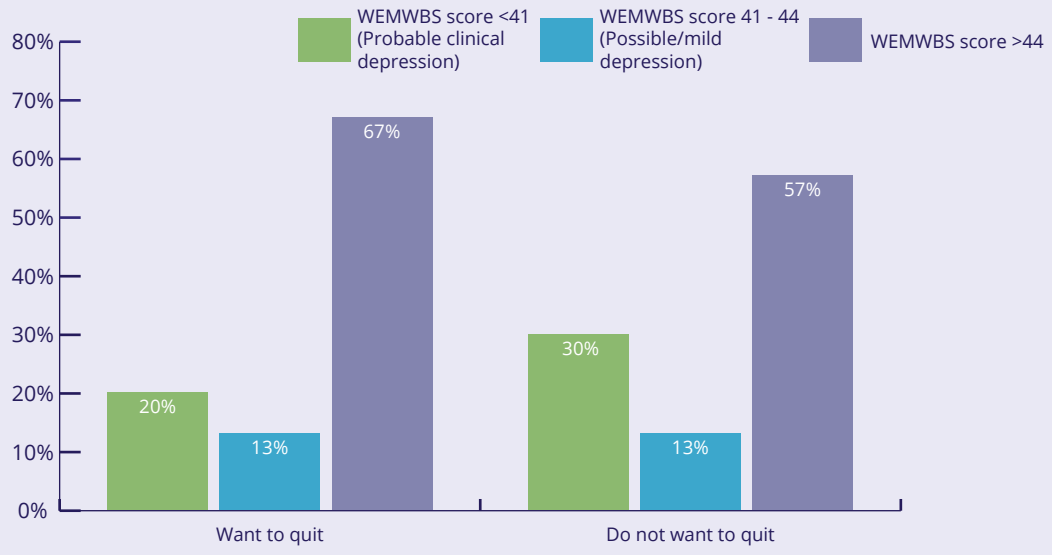


Figure 10. Desire to quit smoking according to the Warwick Edinburgh Mental Wellbeing Scale (WEMWBS) scores



Figures 11 and 12 present data on the relationship between use of medications for stress, anxiety or depression and wanting to stop smoking. These data show that:

* Among people who take medications for stress, anxiety or depression and smoke, 60% want to stop smoking.
* Among those that want to stop smoking, around one in four take medications for stress, anxiety or depression.
* Among those that do not want to stop smoking, around one in three take medications for stress, anxiety or depression.

Figure 11. Use of medications for stress, anxiety or depression according to desire to quit smoking

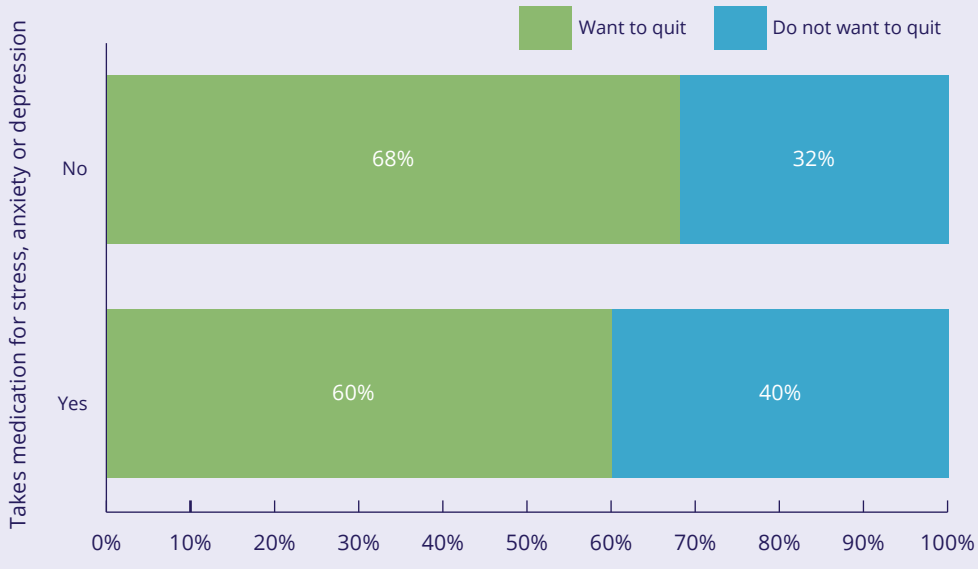


Figure 12. Desire to quit smoking according to use of medication for stress, anxiety or depression

Figures 13 and 14 present data on the relationship between 'ever tried to quit smoking' and mental health status using the General Health Questionnaire (GHQ) scores. These data show that:

* Over four out of five people with possible psychiatric disorder who smoke have tried to stop smoking.
* There was no difference in 'ever tried to quit smoking' across all GHQ12 scores.

Figure 13. The General Health Questionnaire (GHQ) scores according to ever tried to quit smoking

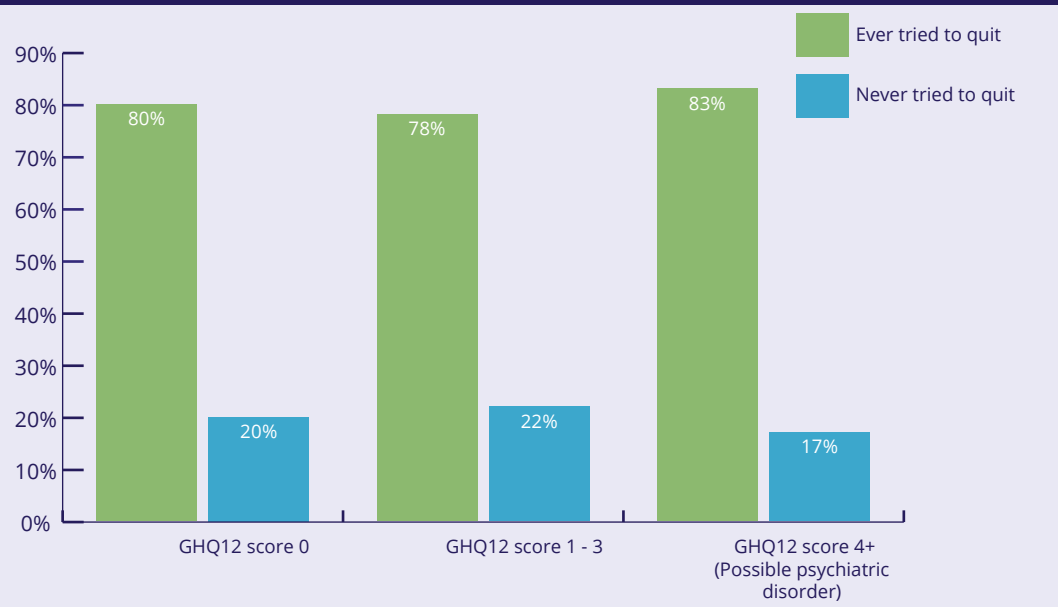
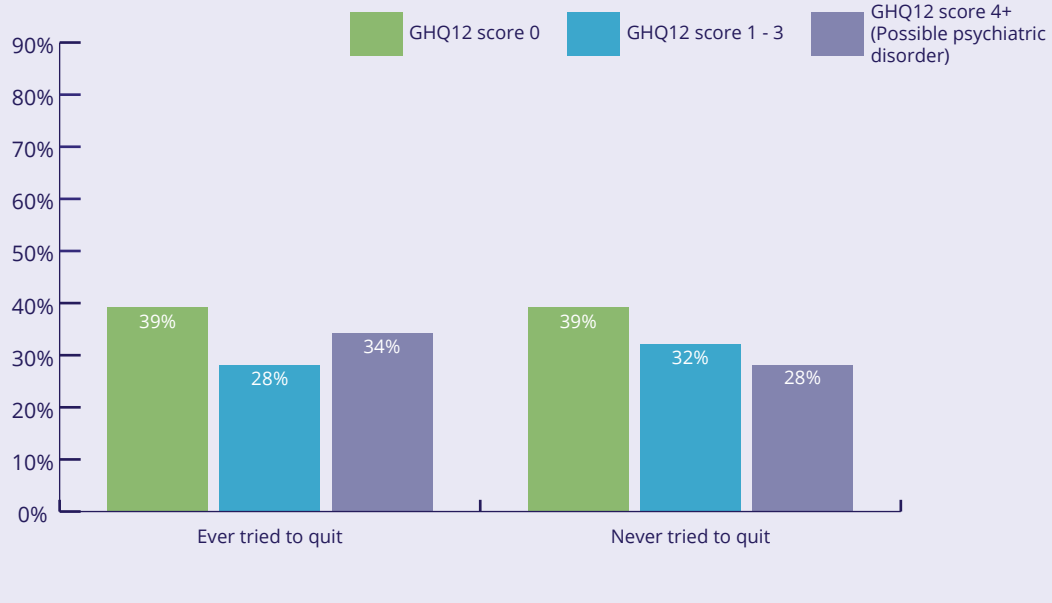


Figure 14. Ever tried to quit smoking according to General Health Questionnaire (GHQ) scores



Figures 15 and 16 present data on the relationship between 'ever tried to quit smoking' and mental health status using Warwick Edinburgh Mental Wellbeing Scale (WEMWBS) scores. These data show that:

* Over 7 in 10 and 4 in 5 people who have possible/mild or probable clinical depression and smoke have tried to quit.
* There were no significant differences in 'ever tried to stop smoking' by WEMWBS score categories.
* Among people who have ever tried to stop smoking, around a quarter have probable clinical depression and a further 12% have possible/mild depression.

Figure 15. The Warwick Edinburgh Mental Wellbeing Scale (WEMWBS) scores according to ever tried to quit smoking

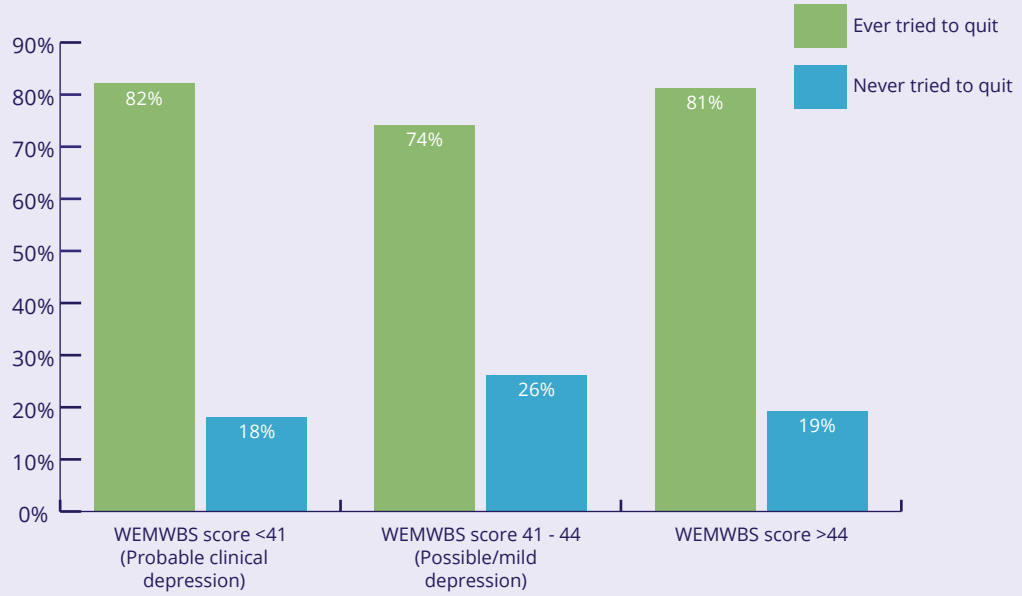
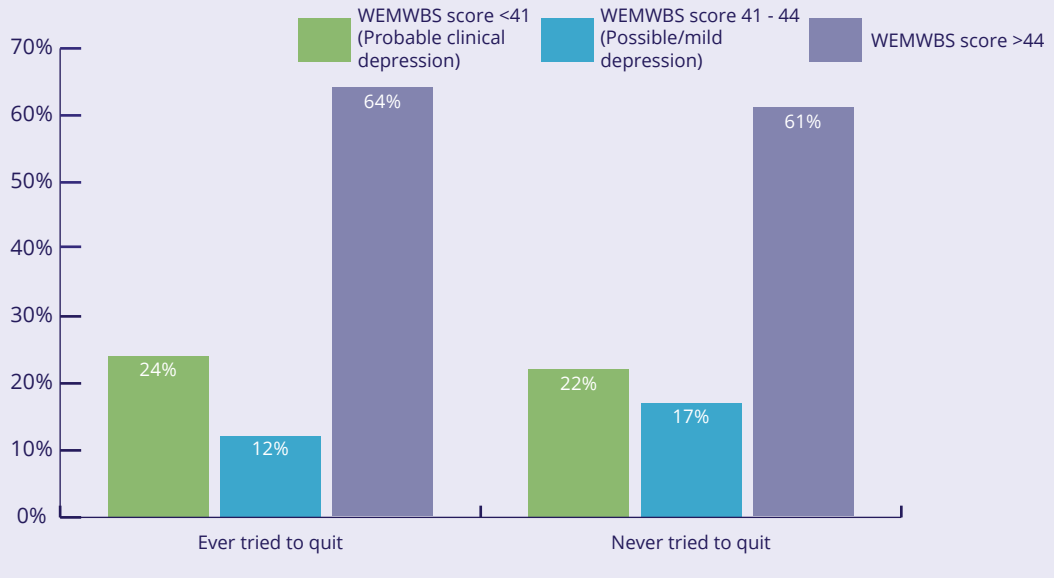


Figure 16. Ever tried to quit smoking according to Warwick Edinburgh Mental Wellbeing Scale (WEMWBS) scores



Figures 17 and 18 present data on the relationship between 'ever tried to quit smoking' and self- reported use of medications for stress, anxiety or depression. These data show that

* Around 80% of people who smoke have tried to stop smoking and there was no difference between the group who take medications for stress, anxiety or depression and the group that do not.

Figure 17. Use of medications for stress, anxiety or depression according to ever tried to quit smoking

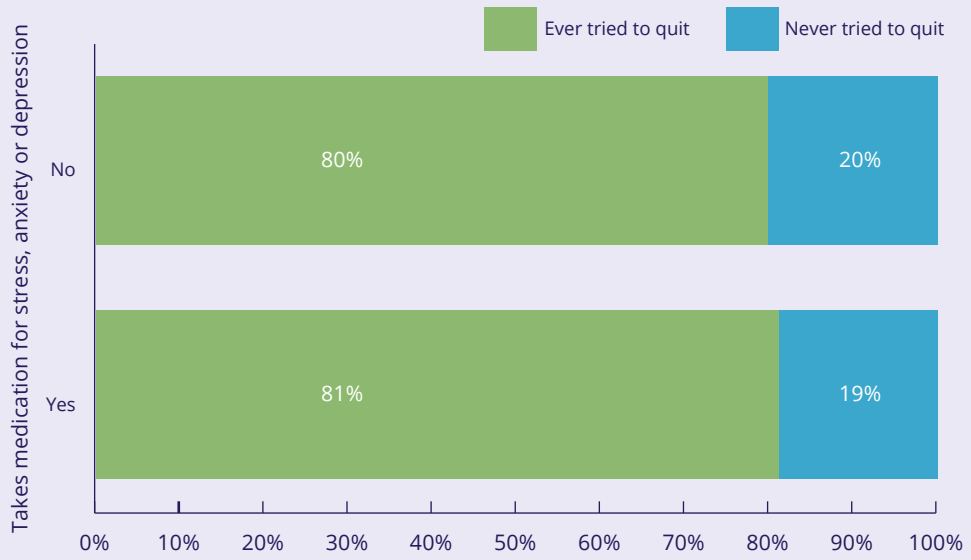


Figure 18. Ever tried to quit smoking according to use of medication for stress, anxiety or depression

Table 3. Smoking prevalence and smoking cessation among the general population in 2018-2019 - The policy target groups and people with mental illness

Population group	Smoking prevalence	% of those smoking that want to quit	% of those smoking that have ever tried to quit
General (age 16+)	18%	66%	80%
Routine manual workers*	27%	NA	NA
Most deprived quintile	29%	64%	81%
Pregnant women*	14%	NA	NA
Children (11-16 years)^	4%	63%	62%
People with possible psychiatric disorder (GHQ≥4)	33%	66%	83%
People with possible/mild depression (WEMWBS 41-44)	27%	66%	74%
People with probable clinical depression (WEMWBS <41)	41%	57%	82%
People who take medications for stress, anxiety or depression	34%	60%	81%

*Data from Mid Term Review of the Tobacco Control Strategy for Northern Ireland

^2019 data from the young persons behaviour and attitudes survey (YPBAS) of 11-16 year-olds

NA - Data not available

Table 4. Smoking status by mental health variables*

Population group	GHQ≥4 = possible psychiatric disorder	WEMWBS <41 = probable clinical depression	Takes medications for stress, anxiety or depression
General (age 16+)	18%	10%	14%
Currently smoke	33%	24%	27%
Used to smoke	NA	NA	NA
Used to smoke regularly	15%	12%	16%
Used to smoke but not regularly	16%	5%	7%
Never smoked	14%	6%	11%

*Mental health variables are not mutually exclusive groups

NA - data not available

3.2 Documentary analysis

Introduction

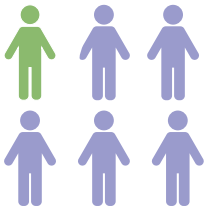
This chapter contains a summary of the state of policy development on tobacco and mental health within tobacco control strategy across the UK and Ireland. The methods applied in this work are detailed in the methods chapter.

The results are presented as follows

* A narrative summary of the current tobacco control policy documents in England, Wales, Scotland, Northern Ireland and Ireland are presented.
* A comparison of the commonalities and divergences in policy approach is presented.

Figure 19. Mental health and smoking in Northern Ireland

People who smoke in Northern Ireland

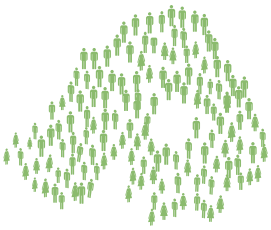


Around one in six people aged over 16 smoke

Among people who smoke, one in three has a possible psychiatric disorder*

People with mental ill health in Northern Ireland

Around one in six people have a possible psychiatric disorder*



In the general population there are more people who used to smoke than currently smoke, but among people with mental ill health there are still more people who currently smoke than used to smoke

Smoking was twice as common among people with a possible psychiatric disorder than those without**

Smoking was three times more common among people with probable clinical depression*** than among people without

Among people with a possible psychiatric disorder* in Northern Ireland:

*General Health Questionnaire score of 4 or more
**General Health Questionnaire score of 4 or more vs a score of 0
*** Warwick Edinburgh Mental Wellbeing Scale score of <41

Figure 20. Tobacco and Mental Health Policy

Ireland, Northern Ireland, Scotland, England and Wales each have their own policies to reduce smoking.

These policy documents were examined to see what they said about smoking and mental health and to learn what they are doing to protect people with mental ill health from being harmed by smoking.

Within the smoking policies from Ireland, Northern Ireland, Scotland, England and Wales:

Most recognised that there was a relationship between smoking and mental ill-health.

They used evidence to help understand the link between smoking and mental ill health.

This evidence showed that people with mental ill health were not always getting the same support to stop smoking.

None of the policies set a target for reducing smoking among people with mental ill-health.

Only some of these policies recognised that people with mental ill health need to receive additional priority.

4 Tobacco Control Policy England

4. Tobacco Control Policy England

Policy Overview

In July 2017 the Department of Health for England (2017) published Towards a Smokefree Generation A Tobacco Control Plan for England. The vision was to create a smokefree generation, which will be achieved when smoking prevalence is at 5% or below. To deliver this, the government set out the following **national ambitions** which will help focus tobacco control across the whole system:

1. **The first smokefree generation** - People should be supported not to start smoking
2. **A smokefree pregnancy for all** - Every child deserves the best start in life
3. **Parity of esteem for those with mental health conditions** - People with mental ill health should be given equal priority to those with physical ill health
4. **Backing evidence-based innovations to support quitting** - We are committed to evidence-based policy making

Approach

To achieve these ambitions, the Department of Health developed a tobacco control plan, targeted around four main themes, with a range of actions for each. These actions include:

1. **Prevention first. To achieve a smokefree generation we will:**
    * Ensure the effective operation of legislation such as proxy purchasing, and standardised packaging designed to reduce the uptake of smoking by young people.
    * Support pregnant people who smoke to quit. NICE has produced guidance on how to help pregnant people who smoke to quit. Public Health England and NHS England will work together on the implementation of this guidance.

2. **Supporting people who smoke to quit. To achieve a smokefree generation we will:**
    * Provide access to training for all health professionals on how to help patients - especially patients in mental health services - to quit smoking.
    * NHS Trusts will encourage people who use, visit and work in the NHS to quit, with the goal of creating a smokefree NHS by 2020 through the 5 Year Forward View mandate.

3. **Eliminating variations in smoking rates. To reduce the regional and socio-economic variations in smoking rates, we need to achieve system-wide change and target our actions at the right groups so we will:**
    * Promote links to “stop smoking” services across the health and care system and full implementation of all relevant NICE guidelines by 2022.
    * Support local councils to help people to quit by working with Directors of Public Health to identify local solutions, particularly where prevalence remains high.

4. **Effective enforcement. To reduce the demand for tobacco and continue to develop an environment that protects young people and others from the harms of smoking we will:**

    * Maintain high duty rates for tobacco products to make tobacco less affordable.
    * Ensure that sanctions in current legislation are effective and fit for purpose, using lessons from HMRC's work on sanctions to stop illicit tobacco.

The strategy term completed at the end of 2022.

Problem Emergence

How is the problem described?

Smoking prevalence remains even higher in people with mental health conditions (NHS Digital, 2016). 40.5% of adults with a serious mental illness smoke (NHS Digital, 2016) and people with a mental health condition die on average 10 to 20 years earlier than the general population (Chang et al, 2011 and Chesney et al, 2014). People with mental health conditions want to quit smoking as much as other people who smoke do (Royal College of Physicians and Royal College of Psychiatrists, 2013), yet health professionals can be reluctant to offer them stop smoking support (Public Health England, 2015). Some professionals mistakenly believe that stopping smoking could negatively affect their patients' mental health when it can actually reduce symptoms of anxiety and depression (Taylor et al, 2014).

How is the population (or populations) defined?

The population is described as those with mental health conditions and mental health patients.

What data are used to present the problem?

The following data sources have been used to describe the problem of smoking and mental health (data are summarised above):

- NHS Digital. 'Smoking rates in people with serious mental illness'. 2016. Available at Public Health England Tobacco Control Profiles.
- Chesney E, Goodwin GM, Fazel S. 'Risks of all-cause and suicide mortality in mental disorders: a meta-review.' World Psychiatry. June 2014. Jun;13(2):153-60. Doi: 10.1002/wps.20128.
- Chang CK and others. '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. 18 May 2011. 2011;6(5): e19590. Doi: 10.1371/journal.pone.0019590.
- Royal College of Physicians and Royal College of Psychiatrists. 'Smoking and Mental Health - A joint report by the Royal College of Physicians and the Royal College of Psychiatrists'. March 2013.
- Public Health England. 'Smoking cessation in secure mental health settings: Guidance for Commissioners'. April 2015.
- Taylor G, McNeill A, Girling A, Farley A, Lindson-Hawley N, Aveyard P. 'Change in mental health after smoking cessation: systematic review and meta-analysis.' 13 February 2014. British Medical Journal 2014;348: g1151.

What assessment is provided on the trend of the problem?

There is no assessment of smoking and mental health over time reported within the strategy.

What research is presented to describe the problem?

The following research sources set out the evidence in relation to aspirations to quit smoking among people with mental health conditions; reluctance among healthcare professionals to offer stop smoking; and misconceptions among healthcare professionals that stopping smoking could negatively affect patients' mental health, when symptoms of anxiety and depression can be reduced:

- Chesney E, Goodwin GM, Fazel S. 'Risks of all-cause and suicide mortality in mental disorders: a meta-review.' World Psychiatry. June 2014. Jun;13(2):153-60. Doi: 10.1002/wps.20128.
- Royal College of Physicians and Royal College of Psychiatrists. 'Smoking and Mental Health - A joint report by the Royal College of Physicians and the Royal College of Psychiatrists'. March 2013.
- Public Health England. 'Smoking cessation in secure mental health settings: Guidance for Commissioners'. April 2015.
- Taylor G, McNeill A, Girling A, Farley A, Lindson-Hawley N, Aveyard P. 'Change in mental health after smoking cessation: systematic review and meta-analysis.' 13 February 2014. British Medical Journal 2014;348:g1151.

Agenda Setting

Are costs of illness presented?

The strategy references cost of smoking related illness, but there are no specific costings in terms of mental health.

Who are identified as the problem owners?

The Department of Health, Public Health England, the Royal Colleges and NHS England are listed as the agencies which are required to act to smoking and mental health at a national level.

Is there evidence of advocacy, and who are the sources?

No

Has stakeholder analysis been undertaken?

There is no evidence of stakeholder analysis.

Policy Formulation

Have levers been identified which allow for intervention?

Public Health England and NHS England will develop and disseminate materials to support staff in mental health trusts to implement NICE Guidance PH451 and PH48, which outline

the recommendations for reducing the harm from smoking and for helping people stop smoking for people using maternity, mental health and acute services, respectively.

We want to see:

- Commissioners and providers of the local health and social care system assessing the need of stop smoking support for people with mental health conditions and delivering targeted and effective interventions.
- NICE guidance PH48 and PH45 fully implemented in all mental health contexts. This will mean the full roll out of comprehensive smokefree policies in all mental health units by 2018, as recommended in the 2016 Independent Mental Health Taskforce Report 'The Five Year Forward View for Mental Health'.

- Department of Health will explore how to integrate further stop smoking support with addiction services and services for people with mental health conditions.
- Public Health England will work with the Mental Health and Smoking Partnership of Royal Colleges, third sector organisations and academia to consider the evidence on how to reduce the prevalence of smoking among people with mental health conditions.
- Department of Health and Public Health England will identify and rectify gaps in data on smoking and mental health which show prevalence, trends and the level of stop smoking support provided to have a comprehensive picture of the problem.
- NHS England and Public Health England will support the implementation of commissioning levers associated with Commissioning for Quality and Innovation and Sustainability and Transformation Partnerships: the "preventing ill health by risky behaviours – alcohol and tobacco CQUIN", which includes a requirement for clinicians to undertake assessment and arrange for intervention where appropriate in relation to smoking status.

Have the impacts of different policy options been considered?

It is not clear if different policy options have been considered.

Has a logic model or theory of change been described?

The strategy does not include a logic model or theory of change approach.

Was feasibility of different approaches considered?

It is not clear if the feasibility of different policy approaches were considered.

Policy tools or instruments	
Training	Provide access to training for all health professionals on smoking cessation, particularly those working with mental health patients. Provide access to training for all health professionals on how to help patients - especially patients in mental health services - to quit smoking.
Guidance	PHE and NHS England will develop and disseminate materials to support staff in mental health trusts to implement NICE Guidance PH451 and PH48 2, which outline the recommendations for reducing the harm from smoking and for helping people stop smoking for people using maternity, mental health and acute services, respectively. Full implementation of NICE guidance PH48 and PH45 in all mental health contexts. PHE will provide evidence-based guidance for health professionals to support them in advising people who smoke and who want to use e-cigarettes or other nicotine delivery systems to quit. PHE will support NHS Trusts and secondary care units to implement NICE guidance PH48 on stopping smoking for people using maternity, mental health and acute services. At a national level DH and PHE will work with the Academy of Medical Royal Colleges, as well as charities and the research community, to develop guidance and messages for professionals across the health and care system on the delivery of stop smoking interventions. We want to see all NHS hospitals fully implementing NICE PH48 guidance supporting cessation in secondary care.
Information and awareness activities	PHE will continue to use mass media campaigns to promote smoking cessation and raise awareness of the harms of smoking. This will include the funding and delivery of Stoptober. PHE and DH will continue to review the effect of marketing campaigns in comprehensive action to reduce smoking and maintain an effective, evidence-based approach towards behaviour change marketing. We want to see local areas working together to explore if regional and cross-regional approaches could offer a greater return on investment for stop smoking campaigns.
Stakeholder forums	No
Political statement	Foreword by Steve Brine (Parliamentary Under Secretary of State for Public Health and Primary Care)

Leadership development	It is noted that the government will provide leadership and guidance on the most effective interventions, ensure that the new legislation is implemented well and that organisations with national responsibilities are joined up and effective. The strategy states that "It is through these dedicated joint partnerships that local areas can demonstrate real strategic leadership and champion the importance of a collaborative 'whole system approach' in working towards a common goal."
Champions/ dedicated roles	No
Service commissioning	Comprehensive and effective local tobacco control strategies require joined up working and integrated commissioning between local government and the NHS. NHS England and PHE will support the implementation of commissioning levers associated with Commissioning for Quality and Innovation and Sustainability and Transformation Partnerships: the "preventing ill health by risky behaviours – alcohol and tobacco CQUIN", which includes a requirement for clinicians to undertake assessment and arrange for intervention where appropriate in relation to smoking status. All commissioners taking up the 2017-19 Commissioning for Quality and Innovation framework which includes tobacco as a national indicator for clinicians to undertake assessment and arrange for intervention where appropriate in relation to smoking status. PHE will target support at those areas with high levels of people who smoke advising on commissioning and delivery of stop smoking services. Good quality local information is required to support effective local commissioning and target support to those who need it.
Regulations	Whilst there is no specific legislation relating to smoking and mental health within the strategy, the Department of Health has stated that it will continue to publish information on all meetings with the tobacco industry to further transparency. The exception is for commercially or operationally sensitive information. The Department of Health has stated that it will limit direct contact with the tobacco industry to that necessary to discuss the implementation of regulatory provisions or operational matters, and more broadly encourage tobacco companies to engage with the government in writing rather than face to face, email or phone communications so as to maximise transparency.
Voluntary approaches	No

Checklists	No
Integration	Comprehensive and effective local tobacco control strategies require joined up working and integrated commissioning between local government and the NHS. It is through these dedicated joint partnerships that local areas can demonstrate real strategic leadership and champion the importance of a collaborative 'whole system approach' in working towards a common goal. The Department of Health has outlined its commitment to implementing comprehensive smokefree policies, including integrated tobacco dependence treatment pathways, in all mental health services by 2018. For any hospital setting, becoming smokefree is more than simply telling patients, staff and visitors where they can and cannot smoke. It is about Trusts working to end cultures in which smoking is used to build relationships with patients or whereby cigarettes and smoking breaks are used as incentives or rewards. It also includes increasing the availability of a full range of evidence-based treatment options to support quitting or temporary abstinence for patients and staff and encouraging staff to act as role models. Most mental health provision takes place in the community. To achieve the ambition of a smoke-free society and to reduce inequalities, urgent action is needed in these settings. Primary care and community care providers are fundamental in delivering an integrated tobacco dependence treatment pathway. This includes the systematic identification of people who smoke, provision of advice and access to effective support to quit or reduce harm. Shared ownership and responsibility in the local health and social care system is essential to ensure the continuity of care between primary, community and inpatient settings. The Department of Health will explore how to integrate further stop smoking support with addiction services and services for people with mental health conditions.
Service level agreements	No
Service quality and performance	NHS England and PHE will support the implementation of commissioning levers associated with Commissioning for Quality and Innovation and Sustainability and Transformation Partnerships: the "preventing ill health by risky behaviours – alcohol and tobacco CQUIN", which includes a requirement for clinicians to undertake assessment and arrange for intervention where appropriate in relation to smoking status.

Goals and Targets

Have people with mental ill health been identified as a target group in the policy?

The strategy outlines the need for parity of esteem for those with mental health conditions.

What policy objective has been articulated?

The Department of Health has noted that people with mental ill health should be given equal priority to those with physical ill health. The Department will aim to:

- Improve data collected on smoking and mental health to help us to support people with mental health conditions to quit smoking.
- Make all mental health inpatient services sites smokefree by 2018.

The Department of Health want to see:

- Commissioners and providers of the local health and social care system assessing the need of stop smoking support for people with mental health conditions and delivering targeted and effective interventions.
- NICE guidance PH48 and PH45 fully implemented in all mental health contexts - this will mean the full roll out of comprehensive smoke-free policies in all mental health units by 2018, as recommended in the 2016 Independent Mental Health Taskforce Report 'The Five Year Forward View for Mental Health'.

What specific targets are proposed and in what timeline are they to be achieved?

The main target in terms of smoking and mental health is the roll-out of smoke-free policies in all mental health units by 2018.

Policy Adoption

What policy approach was decided?

The Department of Health has set out its commitment to implementing comprehensive smokefree policies, including integrated tobacco dependence treatment pathways, in all mental health services by 2018. It is expected that this will be achieved through primary care and community care providers delivering an integrated tobacco dependence treatment pathway. This includes the systematic identification of people who smoke, provision of advice and access to effective support to quit or reduce harm. Shared ownership and responsibility in the local health and social care system is essential to ensure the continuity of care between primary, community and inpatient settings.

Policy Implementation

What roles were described for programme and service leads?

At national level:

- Public Health England and NHS England will develop and disseminate materials to support staff in mental health trusts to implement NICE Guidance PH451 and PH48, which outline the recommendations for reducing the harm from smoking and for helping people stop smoking for people using maternity, mental health and acute services, respectively.
- The Department of Health will explore how to integrate further stop smoking support with addiction services and services for people with mental health conditions.

- Public Health England will work with the Mental Health and Smoking Partnership of Royal Colleges, third sector organisations and academia to consider the evidence on how to reduce the prevalence of smoking among people with mental health conditions.
- The Department of Health and PHE will identify and rectify gaps in data on smoking and mental health which show prevalence, trends and the level of stop smoking support provided to have a comprehensive picture of the problem.
- NHS England and PHE will support the implementation of commissioning levers associated with Commissioning for Quality and Innovation and Sustainability and Transformation Partnerships: the "preventing ill health by risky behaviours – alcohol and tobacco CQUIN", which includes a requirement for clinicians to undertake assessment and arrange for intervention where appropriate in relation to smoking status.
- Public Health England will support NHS Trusts and secondary care units to implement NICE guidance PH48 on stopping smoking for people using maternity, mental health and acute services.
- The Department of Health will explore how more frequent and reliable data could be collated to better inform tobacco control measures which aim to support people with mental health conditions.

Who were the identified implementation partners?

NHS England, PHE, and providers of local health and social care.

How is the policy translated into operational practice?

Most mental health provision takes place in the community. Primary care and community care providers are fundamental in delivering an integrated tobacco dependence treatment pathway. This includes the systematic identification of people who smoke, provision of advice and access to effective support to quit or reduce harm. Shared ownership and responsibility in the local health and social care system is essential to ensure the continuity of care between primary, community and inpatient settings.

How was the implementation co-ordinated?

This has not been reported.

How was capacity for implementation assessed/managed?

This has not been reported.

How was compliance with policy assessed?

It is not clear what the overall level of compliance was with the strategy. The Khan Review appears to be the only review of the strategy but is not an evaluation of the effectiveness of interventions.

Policy Evaluation

The strategy does not provide details of policy evaluation. To the best of our knowledge, we are not aware or have not been able to locate any formal evaluation of the strategy.

5 Tobacco Control Policy England (Khan Review)

5. Tobacco Control Policy England (Khan Review)

Policy Overview

Dr Khan was commissioned by Rt Hon Sajid Javid MP (Secretary of State for Health and Social Care) to carry out an independent review of 'smokefree 2030', the government ambition to get smoking rates down from 13.5% to 5%.

The Khan Review (Khan, 2022) looked at the current smokefree policy, along with very best practice from around the world. Dr Khan acknowledged that the UK has been a world leader in reducing smoking over the last few decades but are now at risk of stagnating. Dr Khan noted that the government needs to raise its ambition if it wants to continue leading the way.

Approach

The Khan Review set out 15 recommendations to achieve a smoke-free society. Recommendation 13 relates specifically to mental health, whilst two other recommendations (11 and 14) refer to prevention quitting and prioritisation of stop smoking interventions.

Recommendation 13 relates specifically to mental health:

- Tackle the issue of smoking and mental health.
- Disseminate accurate information that smoking does not reduce stress and anxiety, through public health campaigns and staff training.
- And make stopping smoking a key part of mental health treatment in acute and community mental health services and in primary care.

Recommendation 11 - The NHS needs to prioritise prevention, with further action to stop people smoking, providing support and treatment across all its services, including primary care (critical intervention). First and foremost, the NHS must meet its existing commitments in the NHS Long Term Plan. Healthcare professionals should use every 'teachable moment' to deliver very brief advice on quitting, and this should form part of revised core training curriculums. The NHS should invest to save, committing resource for this purpose and incentivise its services to implement the NICE guidance on stopping smoking. All hospitals must integrate 'opt-out' smoking cessation interventions into routine care. Hospital trusts should report on progress towards implementing these measures in their annual reports and have a named lead. The NHS must ramp up its messaging on stopping smoking.

Recommendation 14. Invest £8 million to ensure regional and local prioritisation of stop smoking interventions through ICS leadership. ICSs and directors of public health must set, and annually report against, clear targets to reduce smoking prevalence in their areas and commission services to allow that reduction to be achieved. The government should set up a support fund to which ICSs can bid for funding to support regional collaboration and partnership.

Problem Emergence

Is the problem noted in the policy document?

The review cites evidence from ASH in 2016 reporting that around one third of adult tobacco consumption is by people with a current mental health condition, with smoking rates more than double that of the general population. People with mental health conditions die 10 to 20 years earlier, and the biggest factor in this is smoking (ASH, 2016).

How is the problem described?

People with poor mental health are more likely to smoke, and people who smoke are more likely to have poor mental health. The more severe the mental health condition, the higher the rates of smoking, smoking dependence, and the chance of relapse. And on average, people with a pre-existing mental health condition were twice as likely to increase their smoking during the COVID-19 pandemic, compared to those not reporting one. People with mental health conditions die 10 to 20 years earlier, and the biggest preventable factor in this is smoking. People with long-term mental health conditions are much more likely to smoke at 26% (Office for Heaalth Improvement and Disparities, 2022).

How is the population (or populations) defined?

The Khan Review references people with common mental health problems (like anxiety and depression) as well as people severe mental health conditions.

What data are used to present the problem?

The Adult Psychiatric Morbidity Survey is used to present data on smoking and mental health. One in six people report experiencing a common mental health problem (like anxiety and depression) in any given week in England. One on four people who seek medicine to help them quit smoking are currently taking antidepressants (McManus et al, 2016) and half have a history of antidepressant prescription use (Taylor et al, 2020). Dr Khan notes that mental health should be valued equally to physical health (the parity of esteem), and so additional action is needed to support people with poor mental health.

What research is presented to describe the problem?

In addition to the Adult Psychiatric Morbidity Survey, only one research study is cited in the Khan Review. The study by Taylor et al (2020) estimate rates of varenicline and nicotine replacement therapy (NRT) prescribing and the relative effects on smoking cessation, and mental health. The authors concluded that smoking cessation medication prescribing may be declining in primary care. Varenicline was more effective than NRT for smoking cessation in patients with mental disorders and there is not clear consistent evidence that varenicline is adversely associated with poorer mental health outcomes.

Agenda Setting

Are costs of illness presented?

Costs associated with smoking and mental health are not presented in this report.

Who are identified as the problem owners?

The NHS is identified as the lead agency for taking forward the recommendations.

Is there evidence of advocacy, and who are the sources?

There is no evidence of advocacy in this report.

Has stakeholder analysis been undertaken?

Action on Smoking and Health (ASH) was commissioned to work with an expert team of qualitative researchers at Bluegrass to provide insights on attitude and behaviours to smoking. This work concentrated on seeking the views of people from more disadvantaged communities and included focus groups and in-depth interviews. Groups approached as part of the research included:

People who smoke:

- In social housing
- With common mental health conditions (anxiety or depression)
- Pregnant persons
- LGBTQ+ status

Other groups approached included:

- young adults who smoke
- People who used to smoke and those who have relapsed from disadvantaged communities
- healthcare professionals

Policy Formulation

Have levers been identified which allow for intervention?

As a review document, no specific levers haven been identified for intervention.

Have the impacts of different policy options been considered?

There has been no consideration of different policy options.

Has a logic model or theory of change been described?

A logic model has not been developed.

Was feasibility of different approaches considered?

There was no consideration of different approaches.

Policy tools or instruments	
Training	Staff training for all mental health care professionals to equip them with the capability, opportunity and motivation to provide very brief advice to all their patients who smoke.
Information and awareness activities	Public-facing campaigns that correct the myths and stress how people who smoke can improve their mental wellbeing as well as their physical health.
Stakeholder forums	Action on Smoking and health (ASH) was commissioned to work with an expert team of qualitative researchers at Bluegrass to provide insights on attitude and behaviours to smoking. This work concentrated on seeking the views of people from more disadvantaged communities and included focus groups and in-depth interviews.
Integration	Call for integrated care systems (ICS) across the country to lead on meeting smoking cessation targets. Integrated planning is essential to deliver an effective response to smoking.
Service level agreements	Addressing smoking should be standard care in mental health services.
Service quality and performance	We must offer effective smoking cessation treatment within acute and community mental health services and in primary care.

Within this review, Dr Khan has stated that government must do more to support the most deprived areas and groups who are disproportionately impacted by smoking, in particular, pregnant women and people with mental health conditions who show higher negative health impacts of smoking.

Dr Khan has called on integrated care systems (ICS) to lead on meeting smoking cessation targets, including tackling the sale of illicit tobacco. There are calls for government to invest in new research and data, including commissioning further research on smoking related health disparities.

It is proposed that mental health services should include measures to reduce improve compliance and enforcement with existing legislation, and support neighbours exposed to smoke drift.

Campaigns should focus on switching to vaping as a safer alternative. Campaigns also need to bust the myth that smoking relaxes you and reduces stress and anxiety. It should show how people who smoke can improve their mental wellbeing as well as their physical health by quitting.

Dentists, pharmacists, psychologists, psychiatrists, social workers, nurses, midwives, optometrists; therapeutic support staff and mental health workers should all direct people who smoke to stop smoking support and treatment.

All key training bodies should incorporate stop smoking and 'Very Brief Advice' training into their mandatory curricula for doctors, dentists, pharmacists, psychologists, psychiatrists, social workers, nurses, midwives, optometrists, therapeutic support staff and mental health workers should all direct people who smoke to stop smoking support and treatment.

Furthermore, an indicator in the NHS oversight framework should require ICSs to report on how many trust sites are offering cessation services, broken down by acute, maternity, and mental health services.

Every ICS is strongly recommended to adopt an approach that includes prioritising targeted interventions for specific target groups with high smoking prevalence rates (for example, people with mental health conditions; people living in social housing), setting clear targets for reduction from the best available baseline data.

Goals and Targets

Have people with mental ill health been identified as a target group in the policy?

Yes. Recommendation 13 specifically addresses tackling the prevalence of smoking among people with poor mental health.

What policy objective has been articulated?

A national target to be smokefree by 2030 was set in the 2017 strategy. No specific policy objective has been set within this review.

What specific targets are proposed and in what timeline are they to be achieved?

As a review, this is not applicable.

Policy Adoption

As a review, policy adoption was not applicable.

Policy Implementation

As a review, policy implementation was not applicable.

Policy Evaluation

This report was a high-level review which did not include evaluation of interventions.

6 Tobacco Control Policy Scotland

6. Tobacco Control Policy Scotland

Policy Overview

The Sottish Government (2018) published Raising Scotland's Tobacco-free Generation Our Tobacco-Control Action Plan 2018 following the publication of their strategy Creating a Tobacco-Free Generation – A Tobacco Control Strategy for Scotland in 2013.

In 2013 the Scottish Government set an ambitious target to create a tobacco-free generation by 2034. The aim was to protect children born since 2013 from tobacco so that when they turn 21 (from 2034) will live in a tobacco-free Scotland.

The 2018 Action Plan builds on effective practice in helping people understand the messages about ambition, success, and drivers for positive change as well as the evidence about risks, harms, and consequences.

Between 2018 and 2023 the Scottish Government aims to take action to raise awareness on:

- the harms and impacts of smoking
- the benefits of stopping smoking; the availability of free, local services which increase chances of successful quit attempts
- new legislation which restricts the type of place where smoking is allowed
- illicit and illegal tobacco trading
- proxy purchasing for underage children who smoke
- the relative risks of vaping compared to smoking.

Approach

The Action Plan sets out four categories of actions:

1. Informing and empowering through raising awareness	
National Campaign Action	• Have at least one truly national campaign each year throughout the life of the plan. • Seek every opportunity over the next five years to maximise any other opportunities to raise awareness further.
Prevention/ Protection Information and Training	• Co-fund ASH Scotland to provide valuable information, advice and training on smoking and health. • In mental health we will support ASH Scotland in rolling out its effective IMPACT advice and training on the relationship between smoking and mental health care. Continue to support NHS Health Scotland in its research, guidance, training and advice on smoking prevention, protection, cessation, electronic cigarettes, and related health equalities.

	• Ensure midwives and other carers are involved in the further development of I Quit in Pregnancy and the forthcoming advice to parents and practitioners in Ready Steady Baby! – which will be published by NHS Health Scotland in early 2019.
Research, evaluation, and monitoring	• Ensure the action plan is monitored by the Ministerial Working Group on Tobacco Control and is robustly evaluated. • The Ministerial Working Group's subgroup on Research and Evaluation will see an evaluation framework for this action plan developed and ensure that new and emerging evidence is summarised and made publicly available.
Enforcement and Compliance	• Ensure that all guidance published for enforcement of or compliance with regulations is developed with representatives of the non-tobacco industry groups affected. • Work with trading standards officers in Scotland and with retailers' organisations to make sure retailers are aware of the circumstances under which sponsorship activity is illegal
Charter for a Tobacco-free generation	• Continue to support ASH Scotland in promoting Scotland's Charter for a Tobacco-free Generation

2. Encouraging healthier behaviour	
Education	• Support the inclusion of more up-to-date advice on electronic cigarettes into the Health and Wellbeing strand of education in schools in Scotland through the Curriculum for Excellence. • Continue to support the call for schools to become Tobacco-free Schools and look for opportunities to encourage more to take part, especially in areas where there is high smoking prevalence and where teenagers are under most pressure to smoke. • Continue to support NUS Scotland to promote awareness and help with changes to make more campuses smoke-free.
Informal education and other settings	Facilitate a conference in 2019 to consider what more can be done to reach 16–24-year-olds more effectively either through youth engagement or employment

Workplace health improvement	Review the evidence on the impact of smoking and consequent employee health on business costs to help encourage employers to embrace initiatives such as the Health Working Lives programme.
Incentives	Analyse the evaluations of incentive pilot studies by NHS Greater Glasgow and Clyde, NHS Lanarkshire, and NHS Tayside to consider whether incentives schemes could be extended to other territories
Discouraging smoking in specific places	• Ban smoking around hospital buildings in 2018 – making it an offence to smoke within 15 metres of hospital buildings • Explore with local authorities and housing associations the idea of tobacco-free clauses in tenancy agreements and smoke-free housing alternatives being offered in social housing • The Prevention subgroup of the Ministerial Working Group will take work forward with practical help from NHS Health Scotland to provide support and guidance to boards and partnerships to ensure prevention initiatives are there for all children and young people.

3. Improving services	
Consistent services and identity	• Ensure this national Quit Your Way identify is embedded locally and nationally to help people who smoke know that there are free, local, and effective stop smoking services available to them • Bild on the Quit Your Way brand for specific stop–smoking initiatives and services such as for smoking in pregnancy and for smoking and mental health to build inclusivity and help overcome barriers to access for priority groups
Continued integration of services	• Reach out from tobacco control services to primary care to ensure GPs, dentists, mid wives, and other professionals are informed and connected. • The integration of health and social care should help increase the number of people who smoke to be directed to support through these professionals. • Boards and Partnerships already work well with Community Pharmacies to deliver stop-smoking services for the NHS. • Some boards or partnerships have adopted a shared- care approach where the pharmacological component of the specialist support is provided through community pharmacy. Integration such as

	this may help narrow the gap in terms of successful quitting between specialist services and pharmacy-only quit attempts.
Priority groups	Ensure the smoker's journey from cessation services provided for them in hospitals and prisons is as integrated as possible with the services they can expect in their own communities on their return.
Electronic cigarettes and stop-smoking services	• Work with health professionals, academics, representative groups, and others to develop guidance for health professionals and other relevant service providers so that they can offer basic advice on e-cigarette use as part of their support for people who smoke who choose to make quit attempts using e-cigarettes. • Work with health boards and integration boards to try to reach a consensus on whether vaping should or should not be allowed on hospital grounds through a consistent, national approach.
Refining stop-smoking data collection	• Ensure the data-recording process in stop-smoking services is fit-for-purpose.

4. Providing protection through regulations and restrictions	
Restricting Demand	• Smoke-free communal landings • Making cigarettes less attractive • Ban the use of Heated Tobacco Products (HTP) from public places • Ban on attractive flavourings in HTP • Introduce standardised packaging for HTP
Restricting Supply	• Further restrict availability of tobacco products • Consider additional price interventions for tobacco products • Conditional registration or licencing of retail or changes to planning guidance
Enforcement	• Rely on our enforcement authorities to help deliver change and improvement in tobacco control and in other public health policies and strategies. • Over the course of this action plan, it is likely that the markets for e-cigarettes and novel heated tobacco products will develop further. This could mean that the current focus of tobacco control enforcement changes over time to take account of these newer markets.

Problem Emergence

Is the problem noted in the policy document?

Data on smoking, vaping and cessation is presented in Annex 1 of the Action Plan (p39-47) but does not include a breakdown of statistics for those experiencing mental ill health.

Within the Action Plan, it is reported that one third of all cigarettes sold in Scotland are bought by people with mental health problems and smoking rates amongst this group are significantly higher than the national average. It is also noted that current evidence suggests that smoking reduces effectiveness of mental health medication by up to 50%.

How is the problem described?

There is no reporting of smoking prevalence among people who smoke with mental health problems.

How is the population (or populations) defined?

The population is defined as people who smoke in mental health settings and people with mental ill health.

What data are used to present the problem?

No data are used to present prevalence of smoking and mental ill health.

What research is presented to describe the problem?

There is no research presented to describe the issue of smoking and mental ill health.

A number of statements relating to smoking and mental are included within the action plan, but these are not referenced. The statements include:

- One third of all cigarettes sold in Scotland are bought by people with mental health problems and smoking rates amongst this group are significantly higher than the national average.
- Current evidence suggests that smoking reduces effectiveness of mental health medication by up to 50%.
- Smoking is known to have a significant impact on the effectiveness of medications, including those prescribed for mental health conditions.
- Smoking status information amongst people engaging with mental health services is one area where better data recording would be especially useful.
- The physical and mental health costs as well as the financial costs of smoking are well understood, but evidence suggests that this understanding is greater amongst better-off individuals and communities.

Agenda Setting

Are costs of illness presented?

There is no presentation of the economic impact of smoking for specific groups or indeed the whole population.

Who are identified as the problem owners

Public Health Scotland.

Has stakeholder analysis been undertaken?

The Scottish Government reported that during their engagement with representative bodies, health bodies, local authorities, third sector campaign groups, academics, and the public it was noted that restrictions would be most useful for limiting demand and supply of tobacco. The Sottish Government proposed to consider a number of regulations, but only with full consultation.

Policy Formulation

Have levers been identified which allow for intervention?

Yes. A series of actions have been identified under the headings (see section entitled 'Approach').

1. Informing and Empowering through raising awareness
2. Encouraging Healthier Behaviours
3. Improving Services
4. Providing Protection through regulation

Have the impacts of different policy options been considered?

There is no evidence of the impacts of different policy options having been considered.

Has a logic model or theory of change been described?

A logic model has not been developed.

Was feasibility of different approaches considered?

It is unclear as to whether the feasibility of different approaches was considered.

Policy tools or instruments	
Training	• Co-fund ASH Scotland to provide valuable information, advice and training on smoking and health. • Support ASH Scotland in rolling out its effective IMPACT advice and training on the relationship between smoking and mental health care. • Support NHS Health Scotland in its research, guidance, training and advice on smoking prevention, protection, cessation, electronic cigarettes, and related health inequalities.
Information and awareness raising activities	Raising awareness through support for national marketing campaigns; local advertising and promotion; improved training for care givers across a range of sectors; providing better guidance for traders and enforcers; supporting specific research; and regular evaluation of relevant research from Scotland and elsewhere.

Guidance	• Many community pharmacies sell those e-cigarettes to people who smoke seeking NHS support. Guidance for pharmacists about e-cigarettes would also be helpful. • Ensure that all guidance published for enforcement of or compliance with regulations is developed with representatives of the non-tobacco industry groups affected. • Work with health professionals, academics, representative groups, and others to develop guidance for health professionals and other relevant service providers so that they can offer basic advice on e-cigarette use as part of their support for people who smoke who choose to make quit attempts using e-cigarettes. • Continue to support NHS Health Scotland in its research, guidance, training and advice on smoking prevention, protection, cessation, electronic cigarettes, and related health equalities • Update training and guidance for health professionals in Scotland to ensure health professionals and other carers have a basic understanding of e-cigarettes and how to advise people who smoke about them. Advice on electronic cigarettes should be provided as just one aspect of stop-smoking service support. The strongest evidence from recognised studies is that people who smoke have the best chances of stopping by combining the behaviour support that stop-smoking services provide with the use of licensed products (i.e., varenicline and traditional NRT).
Political statement	Foreword by Aileen Campbell, MSP, Minister for Public Health, and Sport
Improving services	Build on the *Quit Your Way* brand for specific stop–smoking initiatives and services such as for smoking in pregnancy and for smoking and mental health to build inclusivity and help overcome barriers to access for priority groups.
Integration	• Integration or joining-up of services will be a theme for public health and for tobacco control services over the next five years • In many areas it is the partnership rather than the NHS which has responsibility for delivering stop-smoking services. The new public health priorities build on this integration theme, bringing local government activity and health activity together. • Need to reach out from tobacco control services to primary care to ensure GPs, dentists, mid wives, and other professionals are informed and connected. • With the integration of health and social care there are also a large group of specialists and professionals such as social workers and youth workers and other care givers who we need to reach out to.

- Boards and Partnerships already work well with Community Pharmacies to deliver stop-smoking services for the NHS. More than two-thirds of supported quit attempts are made through our Community Pharmacies rather than through specialist services provided directly by health boards. Some boards or partnerships have now adopted a shared-care approach where the pharmacological component of the specialist support is provided through community pharmacy. This sort of move will help integrate the support being made available. Integration such as this may help narrow the gap in terms of successful quitting between specialist services and pharmacy-only quit attempts. Currently a smoker is around twice as likely to succeed in a quit attempt through a specialist service than through pharmacy-only support. We will continue to work to close that outcome gap.
- The Scottish Government is working with boards now to develop a national formulary which will help ensure consistent access to products like this across all board areas.
- Ensure the smoker's journey from cessation services provided for them in hospitals and prisons is as integrated as possible with the services they can expect in their own communities on their return home.

Goals and Targets

Have people with mental ill health been identified as a target group in the policy?

Yes. There is a recognition that the Scottish Government need to increase efforts to raise awareness of the physical harm that tobacco is doing to people who already could be suffering mentally.

What policy objective has been articulated?

Achieving a reduction in smoking rates to five per cent or less by 2034 remains the key objective of the Scottish Government. There is no specific target for those experiencing mental ill health.

What specific targets are proposed and in what timeline are they to be achieved?

There are no specific targets in relation to smoking and mental health, but there are a number of population levels targets which are outlined below:

- By 2034 – smoking prevalence should be at 5% or lower.
- By 2021 – smoking prevalence for SIMD 1 and SIMD 2 (2 most deprived quintiles) combined should be 20% or lower.
- By 2022 – the proportion of those who reported regularly smoking among 13-15 years old combined should be 3% or less.
- By 2023 – smoking prevalence among people who smoke in the 20-24 years old age group should be 20% or less.

Policy Adoption

What policy approach was decided?

As highlighted earlier in this section, a number of actions relating to smoking and mental health have been outlined under these key themes:

1. Informing and Empowering through raising awareness
2. Encouraging Healthier Behaviours
3. Improving Services
4. Providing Protection through regulation

Policy Implementation

What roles were described for programme and service leads?

Various agencies are identified throughout the Action Plan as having responsibility for certain deliverables within the plan. Those most relevant to mental health are outlined below.

ASH Scotland

- Work with partners such as ASH Scotland's information service to ensure a wide range of evidence summaries are available.
- Support ASH Scotland in rolling out its effective IMPACT advice and training on the relationship between smoking and mental health care.
- Support ASH Scotland in promoting Scotland's Charter for a Tobacco-free Generation.
- Co-fund ASH Scotland to provide valuable information, advice and training on smoking and health.

Health Promoting Health Service

As part of the wider monitoring framework for the Health Promoting Health Service, the Scottish Government, NHS Health Scotland, NHS Boards, and Integration Boards will ensure progress in improving the level of support on managing temporary abstinence in acute settings across NHS Scotland. This will include offering specialist smoking cessation support and ensuring pre-admission and post-discharge care pathways.

Scottish Government

- The Scottish Government will continue to invest in tobacco control budgets across the 5-year lifetime of this Action Plan to help achieve improved health outcomes for people.
- Ensure progress in improving the level of support on managing temporary abstinence in acute settings across NHS Scotland. This will include offering specialist smoking cessation support and ensuring pre-admission and post-discharge care pathways.
- The Scottish Government is working with boards now to develop a national formulary which will help ensure consistent access to products like this across all board areas.

NHS Scotland

- Support NHS Health Scotland in its research, guidance, training and advice on smoking prevention, protection, cessation, electronic cigarettes, and related health inequalities.

- Updated guidance for professionals on e-cigarettes will be published by NHS Health Scotland.
- NHS Health Scotland will carry out an 'evaluability assessment' of the action plan. For those actions most readily evaluable health Scotland will then develop a robust evaluation framework. That will allow for meaningful evaluation of progress during and after the life of the action plan. Oversight for this could be through the Research and Evaluation sub-group of the Ministerial Working Group on Tobacco Control.

NHS Boards and Integration Boards

- Ensure progress in improving the level of support on managing temporary abstinence in acute settings across NHS Scotland. This will include offering specialist smoking cessation support and ensuring pre-admission and post-discharge care pathways.
- Boards and Integration Boards should reinforce their existing actions to ensure health professionals address smoking in all care settings and provide effective and person-centred referral pathways to appropriate smoking cessation support.
- Reach a consensus on whether vaping should or should not be allowed on hospital grounds through a consistent, national approach.

Who were the identified implementation partners?

1. ASH Scotland
2. Health Promoting Health Service, the Scottish Government
3. NHS Health Scotland
4. NHS Boards
5. Integration Boards
6. Health and Social Care partnerships
7. Local Government
8. Social Workers
9. Youth Workers
10. Community Pharmacies
11. Prevention subgroup of the Ministerial Working Group
12. Ministerial Working Group's sub-group on Research and Evaluation

How is the policy translated into operational practice?

Specific actions outlined are outlined in the 2018 Action Plan.

How was the implementation co-ordinated?

Implementation of the Action Plan has not been reported at this stage.

How was capacity for implementation assessed/managed?

Capacity for implementation of the Action Plan has not been assessed at this stage.

How was compliance with policy assessed?

Compliance with the Action Plan has not been assessed at this stage.

Policy Evaluation

Process

NHS Health Scotland will carry out an 'evaluability assessment' of the action plan. For those actions most readily evaluable, Health Scotland will then develop a robust evaluation framework. That will allow for meaningful evaluation of progress during and after the life of the action plan. Oversight for this could be through the Research and Evaluation sub-group of the Ministerial Working Group on Tobacco Control.

The Scottish Government will continue to monitor how the market for alternatives to cigarettes continues to develop. We will ensure evidence of the potential harms and benefits of electronic cigarettes is constantly monitored. They will also support the monitoring of any growth in the heated tobacco products (HTP) market, of other technological developments and any evaluation of evidence on HTP links to smoking. If this market grows there may be a need to consider regulating to bring the use of these products into line with existing laws on smoking in public places and the display of tobacco-related products.

The Scottish Government will continue to work with partners such as ASH Scotland's information service to ensure a wide range of evidence summaries are available.

The Ministerial Working Group's subgroup on Research and Evaluation will see an evaluation framework for this action plan developed and ensure that new and emerging evidence is summarised and made publicly available.

Outputs

Bi-annual evaluation will be undertaken with publications scheduled for 2020, 2022 and 2024. These evaluations of progress will allow Ministers to plan in more detail for the following two years.

Outcomes

The outcomes to be reported on include:

- Reducing levels proportionately of tobacco-related mortality/morbidity. Source: ScotPHO reports.
- Smoking prevalence declining, especially in priority groups (which may require better data collection to be in place). Source: Scottish Health Survey/Annual Population Survey/ Scottish Survey Core Questions.
- Continued reporting of low levels of exposure to second hand smoke (especially among young people and children). Source: Scottish Health Survey (Salcot sampling).
- Year-on-year growth in smoker numbers using NHS Scotland stop-smoking services Quit Your Way. Source: NHS National Services Scotland.
- Year-on-year growth in proportions of successful quits through services. Source: NHS National Services Scotland.
- Year-on-year drop in the average number of cigarettes smoked. Source: Scottish Health Survey.
- Year-on-year drop in the number of young people taking up smoking. Source SALSUS (young people's survey).

7 Tobacco Control Policy Wales

7. Tobacco Control Policy Wales

Policy Overview

In July 2022, the Welsh Government published A smoke-free Wales: Our long-term tobacco control strategy Our long-term plan towards a smoke-free Wales by 2030. In addition, the Welsh Government in conjunction with NHS Wales published A smoke-free Wales. Tobacco control Delivery Plan 2022-2024.

It is the ambition of the Welsh Government for Wales to be smoke-free by 2030 – this means achieving a smoking prevalence rate in adults (aged 16+) of 5% or less.

The strategy sets out how the Welsh Government will tackle all aspects of smoking to achieve this ambition. Work will be taken forward under 3 themes:

1. Reducing inequalities
2. Future generations
3. A whole-system approach for a smoke-free Wales

Delivery of the strategy will be supported by a series of two-year delivery plans commencing from 2022-2024 which will set out in detail the action to be undertaken.

Approach

The strategy does not set out a theoretical model underpinning the approach set out by Welsh Government. The approach to be taken is presented in the two-year delivery plan.

The 2022-2024 delivery plan will focus on the actions that support:

- the further denormalisation of smoking and making smoke-free the norm in Wales
- promotion of best practice
- integration of tobacco control across the whole system.

The strategy will continue to focus on the prevention of the uptake of smoking as well as smoking cessation. Action have been grouped into five priority action areas:

1. Smoke-free environments
2. Continuous improvement and supporting innovation
3. Priority groups
4. Tackle illegal tobacco and the tobacco control legal framework
5. Working across the UK

One of the key approaches set out by the Welsh Government is learning from the University of Ottawa Heart Institute. 2021. Ottawa Model for Smoking Cessation: Programme

What is the Ottawa Model for Smoking Cessation (OMSC)?

The Ottawa Model for Smoking Cessation (OMSC) is a validated, evidence-based process that combines knowledge translation and organizational change practices to identify, treat, and follow-up as part of routine care for people who smoke. It is cost-effective and adaptable to any type of healthcare setting and is currently being implemented in over 500 sites across Canada.

How is the OMSC implemented?

Expert OMSC Implementation Specialists work with partner sites to adapt their clinical practices to include smoking cessation treatment as part of their routine protocols. A detailed six-phase OMSC Implementation Workplan is used to facilitate this process. During the practice change process, an Evidence-Based Smoking Cessation Treatment Protocol is created specifically for each site. Once the smoking cessation program is launched, feedback and quality improvement processes allow the program to be refined and sustained over time.

How is its implementation monitored?

The University of Ottawa Heart Institute (UOHI) has developed "Centres of Excellence" in eastern and western Canada – outreach "hubs" – that provide outreach facilitation and implementation support to sites in other Canadian provinces.

In 2010, the Champlain Local Health Integration Network (LHIN) Hospital Service Accountability Agreements (HSAA) with 15 regional hospitals were amended to include a performance obligation stating that hospitals must expand their OMSC programs to reach (i.e., provide an OMSC smoking cessation consultation to) ≥ 80% of inpatient people who smoke each year. In 2013, 63% of expected people who smoke were reached by participating Champlain hospitals, compared to only 29% in 2010 – a relative improvement of more than 80%.

How is the OMSC evaluated?

To determine the impact of the Ottawa Model, all sites evaluate their patient smoking prevalence and 6 month quit rates before and after program implementation.

How effective is the OMSC?

The Ottawa Model for Smoking Cessation (OMSC) has been shown to change provider behaviour and is effective at increasing long-term quit rates.

A study by the University of Ottawa Heart Institute (UOHI) and the Institute for Clinical Evaluative Sciences (ICES) showed that:

- 35% of patients who received the OMSC were smoke-free at 6-months, compared to only 20% of the usual care participants.
- Patients who received the OMSC were 50% less likely to be re-admitted to the hospital for any cause, and 30% less likely to visit an emergency department within 30 days.
- People who smoke and received the OMSC were 21% less likely to be re-hospitalized and 9% less likely to visit an emergency department over 2 years.
- Most importantly, those who smoked and received the OMSC had a 40% reduction in risk of death over 2 years.

Problem Emergence

Is the problem noted in the policy document?

Within 'Theme 1 - Reducing Inequalities' there is specific mention that smoking rates are higher among certain population groups including people with mental health conditions.

How is the problem described?

It is noted that disparities in smoking rates are causing a greater burden of smoking related diseases among those with mental health conditions as well as other vulnerable groups such as people in routine and manual occupations, people who are unemployed, people from ethnic minority groups and people from the LGBTQ+ community.

How is the population (or populations) defined?

The population is described as people with mental health conditions or people engaged with mental health services.

What data are used to present the problem?

Two statutory data sources are used to:

- Welsh Government (2022) National Survey for Wales. Available at: https://gov.wales/national-survey-wales
- Welsh Government smoking cessation services. Available at: https://statswales.gov.wales/Catalogue/Health-and-Social-Care/NHS-Performance/smoking-cessation-services

What assessment is provided on the trend of the problem?

There is no assessment of trends in smoking among those with mental health conditions with the strategy or delivery plan

What research is presented to describe the problem?

There is evidence from a number of sources which describe the association between mental ill health and increased smoking prevalence. ASH Wales estimate that at least 33% of tobacco consumed in the UK is used by people with mental health conditions, and 60% of people with a diagnosis of schizophrenia (ASH Wales, 2017). The Royal College of Physicians and Royal College of Psychiatrists report that despite the persistent high prevalence of smoking amongst people with mental health conditions, only a minority of people with mental health conditions receive effective smoking cessation interventions (Royal College of Physicians and Royal College of Psychiatrists, 2013). It is reported that smoking rates are much higher in people who have mental health conditions - it is estimated that 33% of people with mental ill health smoke and smoking related diseases are a major contributory factor to reduced life expectancy for those with schizophrenia. It has been reported that despite the persistent high prevalence of smoking amongst people with mental health conditions, only a minority of people with mental health conditions receive effective smoking cessation interventions. The Welsh Government has stated that targeted and tailored support is therefore crucial to ensure smoking prevalence is reduced for those with mental health conditions.

Agenda Setting

Are costs of illness presented?

The costs associated with smoking among those living with mental ill health are not specifically reported. The strategy outlines the cost of treating smoking related diseases at a population level. It is estimated that smoking-related disease costs NHS Wales £302 million per year.

Who are identified as the problem owners

Delivery of the strategy and the delivery plans will be the responsibility of the Tobacco Control Strategic Board. The Strategic Board will include representation from key partners on tobacco control and provide leadership, assess evidence, and make decisions which influence the direction of travel for delivery of the strategy and delivery plans. The Board will also build in collaboration across the number of partners needed to make the systems changes that will support a smoke-free Wales. An implementation group will also be established with the remit of supporting, monitoring, and implementing delivery of the delivery plans, as well as undertaking the engagement and collaboration needed. This group will report to the Tobacco Control Strategic Board.

Is there evidence of advocacy, and who are the sources?

The consultation process included advocacy stakeholders. However, it is difficult to determine what the extent of their influence has been in the development of the strategy and delivery.

Has stakeholder analysis been undertaken?

A stakeholder consultation process was undertaken in March 2022 with 70 people representing stakeholders from across Wales. Participants included organisations from the NHS, local authorities, Public Health Wales, further and higher education, charities, organisations working with children and young people and trading standards.

The objectives of the consultation were to gather stakeholder views:

1. To explore the perceived benefits and drawbacks of the smoke-free Wales 2030 ambition.
2. To consider the strategic themes set out in the strategy and suggest alternatives.
3. To reflect on the 5 priority action areas and their actions which are in the first 2-year delivery plan.

The stakeholder report can be accessed here.

A second consultation exercise was undertaken with priority groups, known to have higher smoking prevalence. Fourteen interviews and four focus groups were held across Wales with people who had quit smoking and people who currently smoke. The objectives of this engagement were as follows:

1. To explore the perceived benefits and drawbacks of the smoke-free Wales 2030 ambition.
2. To focus on those strategic themes set out in the strategy that are important to the audience and suggest alternatives.

3. To share the 5 priority action areas and their actions which are in the first 2-year delivery plan and concentrate on those that are important to the audience.

Focus groups and interviews followed a format adapted from the topic guide used for the wider consultation to enable comparisons across each element of the consultation and ensure that priority groups had the opportunity to fully-contribute to the Tobacco Control Strategy for Wales, A Smoke-free Wales and the first draft Delivery Plan, Towards a Smoke-free Wales Delivery Plan 2022-2024.

The priority group report can be accessed here.

Policy Formulation

Have levers been identified which allow for intervention?

1. Smoke-free environments
2. Continuous improvement and supporting innovation
3. Priority groups
4. Tackle illegal tobacco and the tobacco control legal framework
5. Working across the UK

Have the impacts of different policy options been considered?

There has been no consideration of the impacts of different policy options within the strategy.

Has a logic model or theory of change been described?

A logic model has not been applied within the strategy.

Was feasibility of different approaches considered?

The feasibility of other approaches has not been considered.

Policy tools or instruments	
Training	Consider a more joined up approach to supporting people to quit by better integrating with those systems, services, and policies (including for example primary care, mental health, substance misuse) that are supporting those in our priority groups - including looking at training needs.
Guidance	The strategy references learning from successful international tobacco control interventions, such as The Ottawa Model for Smoking Cessation, which has been shown to increase long-term quit rates for people who smoke across Canada.
Information and awareness activities	Whilst the intervention is likely to be different depending on the group targeted, consideration will be given to interventions such as incentives, communication methods and messaging and digital technologies which could be effective in supporting more people to quit.

Stakeholder forums	Consultation with stakeholders and priority groups were conducted in March 2022 on the draft strategy and deliver plans. See previous section for more detail.
Political statement	Strategy foreword by Deputy Minister for Mental Health and Wellbeing.
Leadership development	Whilst there is no specific reference to leadership development in terms of smoking and mental health, the strategy states that Tobacco Control Strategic Board will have the right level of governance and challenge to provide leadership, assess evidence and make decisions which influence the direction of travel for delivery of the strategy and delivery plans.
Champions/ dedicated roles	No mention
Service commissioning	No mention
Regulations	The strategy outlines some regulatory measures, but not specific to mental health. There is a commitment to continue to work with the other UK Governments on a broad range of non-devolved tobacco control issues to support a strong tobacco control system, including: a. Age of sale. b. The environmental impact of smoking. c. Safety warnings on tobacco and nicotine products. d. Tobacco pricing, levy, and taxation
Voluntary approaches	No specific mention
Integration	Not specific to mental health - We will ensure that our work is integrated and has a whole of government approach and is strongly aligned with that of public bodies. In delivery of this strategy, we will support delivery of all 7 well-being goals as well as the government's policy goals on areas such as addressing health inequalities, climate change and the protection of the environment.
Service level agreements	No specific mention
Service quality and performance	It is proposed that the Welsh Government will use their performance management structures to ensure our delivery partners maintain their focus on reducing smoking prevalence, including within smoking cessation and maternal smoking (no specific mention of mental health in terms of service quality and performance).

Goals and Targets

Have people with mental ill health been identified as a target group in the policy?

People with mental health conditions or people engaged with mental health services have been identified as a priority group.

What policy objective has been articulated?

There is no specific policy objective in relation to smoking and mental health.

What specific targets are proposed and in what timeline are they to be achieved?

Although there are no specific targets in relation to smoking and mental health, it is noted that through undertaking the actions listed in the five priority action areas (see below), the Welsh Government will ensure that by March 2024 they have in place:

- An approach to continue to support denormalisation of smoking and making smoke-free the norm in Wales.
- A clear understanding of how to tackle smoking in priority groups.
- The systems in place that will support our smoke-free Wales strategy, building on our knowledge and experience of tobacco control in Wales.

Targets 2022-2024

1. Smoke-free environments

a. Monitor and support the implementation of all existing smoke-free spaces, including the recently introduced restriction in hospital grounds, public playgrounds, school grounds and outdoor areas of childcare settings, and holiday and temporary accommodation and mental health units.

b. Explore the establishment of additional smokefree spaces in Wales.

c. Advocate for publicly funded organisations to be smoke-free, including supporting more smoke-free spaces and embedding smoke-free principles.

d. Explore the role of environmental messages within tobacco control and work with the UK Government and other Devolved Administrations to support UK wide action to tackle the environmental impacts of smoking.

2. Continuous improvement and support for innovation

a. Implement a systematic Help Me Quit in Hospital smoking cessation service in Wales utilising learning from Canada's Ottawa Model for Smoking Cessation and adapting this for Wales with the additional inclusion of a prehospital stage in the programme.

b. Continually optimise smoking cessation and prevention of uptake provision. Explore innovative and digital methods to reduce smoking uptake and promote smoking cessation. Ensure a joined-up approach with consistent support for people who smoke to increase uptake of smoking cessation. Work with groups with the highest smoking prevalence or lowest uptake of smoking cessation services to understand barriers to smoking cessation and explore innovative solutions.

c. Explore the role of e-cigarettes and other nicotine products for smoking cessation.

3. Priority groups (including mental health)

a. Review the evidence and data around smoking cessation support for priority groups and identify where gaps exist, including where the greatest impact can be made.

b. Engage with people from priority groups and organisations representing priority groups to understand their reasons for smoking and barriers to smoking cessation, and work with them to develop tailored actions to support tobacco control.

c. Increase the percentage of smoke-free pregnancies by looking at initiatives to reduce smoking in pregnancy and optimise smoking cessation provision for all pregnant people across Wales. Work with maternity services to ensure that all pregnant women have their smoking status recorded and appropriate referrals made to smoking cessation services. We will also promote the importance of being smoke-free before pregnancy.

d. Ensure messaging is clear and consistent and is tailored to engage with our different priority groups.

e. Work to explore the evidence base, and working with partners, identify additional priority groups that we should work with to provide appropriate, additional support.

4. Tackle illegal tobacco and support the tobacco control legal framework

a. Review the evidence and data around the illegal tobacco landscape in Wales identify where gaps exist.

b. Raise awareness of the illegal tobacco and its impacts through communications materials and campaigns.

c. Develop a system to share information about illegal tobacco which supports effective enforcement across Wales.

d. Work with partners including the Police, HMRC and local authorities to explore innovative ideas to tackle illegal tobacco across Wales.

e. Undertake a review of the tobacco control enforcement tools available in Wales to understand if and where strengthening is required.

5. Working across the UK

a. Review tobacco control actions and policies that are implemented by other UK nations and share best practice on tobacco control actions and policies in Wales across the UK.

b. Continue to work with the other UK Governments on a broad range of non-devolved tobacco control issues to support a strong tobacco control system, including Age of sale; the environmental impact of smoking; safety warnings on tobacco and nicotine products; and tobacco pricing, levy, and taxation

Policy Adoption

What policy approach was decided?

The Welsh Government undertook a public consultation which ran from 8 November 2021 to 31 March 2022, including engagement with key stakeholders and priority groups (i.e., those with highest smoking prevalence).

Stakeholders were supportive of the Welsh Government's ambition for a smoke-free Wales (supported by the poll results). Health and financial savings were cited as the most obvious benefits while potential drawbacks highlighted included whether the ambition is realistic as well as the importance of taking regional differences and people's motivations to smoke, into account. Stakeholders supported the themes in the strategy as well as the priorities set out in the draft delivery plan, emphasising during discussions the need for resources, training, and strong local partnerships in order to succeed.

Based on interviews and focus groups with members of the priority groups identified, it was concluded that there was strong support overall for the ambition to achieve a smoke-free Wales by 2030. Participants agreed, with a few exceptions, with the three themes outlined in the draft strategy. Priorities set out in the 'Delivery Plan 2022-2024' also met with widespread support, though participants challenged each one based on their experience and knowledge. Participants showed concern for the most vulnerable and the need to understand and address the reasons behind smoking, the importance of a supportive tone of voice to avoid alienating people who smoke further, the potential of utilising relatable role models, and perhaps most of all the benefits of a smoke-free Wales.

Following the consultation, a Summary of Responses report was published followed by a report on next steps in terms of the strategy development. Based on the consultation, the strategy and delivery plan were amended to:

- Highlight the importance of communications campaigns and methods that engage with audiences in the appropriate way (including language).
- Make it clear that membership of the Tobacco Control Strategic Board and the Tobacco Control Delivery Plan Implementation Group are considered annually.
- Make it clear that the Tobacco Control Delivery Plan Implementation Group and the Tobacco Control Strategic Board will be transparent on progress with achieving the actions.
- Ensure the obligations to Article 5.3 of the WHO Framework Convention on Tobacco Control are appropriately reflected in the documents.

Policy Implementation

What roles were described for programme and service leads?

The Tobacco Control Strategic Board has overall responsibility for the implementation and delivery of the strategy and the delivery plans. This includes supporting the resourcing of the actions and ensuring our ambition remains achievable. The Board will be supported by the Tobacco Control Delivery Plan Implementation Group which will support, monitor, and implement the delivery plans, as well as undertaking the engagement and collaboration needed. The Implementation Group members will be appointed by the Tobacco Control Strategic Board and report directly to them and Welsh Ministers. The membership of both

the Board and the Implementation Group will be considered annually. Tobacco Control Strategic Board members are:

- Welsh Government (Chair)
- Public Health Wales
- Directors of Public Protection Wales
- Directors of Public Health
- Third Sector Representative
- Royal College of Physicians
- Royal Pharmaceutical Society

It was noted that the Welsh Government will also look at having a more joined up approach to supporting people to quit by better integrating with those systems, services, and policies (including for example primary care, mental health, substance misuse) that are supporting those in our priority groups - including looking at training needs. They will implement a systematic Help Me Quit in Hospital smoking cessation service in Wales utilising learning from Canada's Ottawa Model for Smoking Cessation and adapting this for Wales with the additional inclusion of a prehospital stage in the programme. They will also work with groups with the highest smoking prevalence or lowest uptake of smoking cessation services to understand barriers to smoking cessation and explore innovative solutions.

Who were the identified implementation partners?

The Tobacco Control Strategic Board has overall responsibility for the implementation and delivery of the strategy and the delivery plans. The Board will be supported by the Tobacco Control Delivery Plan Implementation Group which will support, monitor, and implement the delivery plans, as well as undertaking the engagement and collaboration needed. The Implementation Group members will be appointed by the Tobacco Control Strategic Board and report directly to them and Welsh Ministers. The membership of both the Board and the Implementation Group will be considered annually. The membership of the Implementation Group is not specified.

How is the policy translated into operational practice?

There is a commitment with the strategy to implement a systematic Help Me Quit in Hospital smoking cessation service in Wales utilising learning from Canada's Ottawa Model for Smoking Cessation and adapting this for Wales with the additional inclusion of a prehospital stage in the programme.

A series of actions have been identified under each priority area. These are presented below (not all priority areas are specifically related to smoking and mental health):

Priority action area 1 - Smoke-Free environments

1. Monitor the implementation of all existing smoke-free spaces, including the recently introduced restriction in hospital grounds, public playgrounds, school grounds and outdoor areas of childcare settings, and holiday and temporary accommodation and Mental Health Units.

2. Explore the establishment of additional smoke-free spaces in Wales.
3. Advocate for publicly funded organisations to be smoke-free, including supporting more smoke-free spaces and embedding smoke-free principles.
4. Explore the role of environmental messages within tobacco control and work with the UK Government and other Devolved Administrations to support UK wide action to tackle the environmental impacts of smoking.

Priority action area 2 - Continuous improvement and support for innovation

1. Implement a systematic secondary care smoking cessation service in Wales utilising learning from Canada's Ottawa Model for Smoking Cessation.
2. Continually optimise smoking cessation and prevention of uptake provision. Explore innovative and digital methods to reduce smoking uptake and promote smoking cessation. Ensure consistent support for people who smoke with the *Towards a Smoke-Free Wales Tobacco Control Delivery Plan 2022-2024* and increase uptake of smoking cessation. Work with groups with the highest smoking prevalence or lowest uptake of smoking cessation services to understand barriers to smoking cessation and explore innovative solutions.
3. Explore the role of e-cigarettes and other nicotine products for smoking cessation.

Priority action area 3 - Priority groups

1. Review the evidence and data around smoking cessation support for these priority groups and identify where gaps exist, including where the greatest impact can be made.
2. Engage with people from priority groups and organisations representing priority groups to understand their reasons for smoking and barriers to smoking cessation, and work with them to develop tailored actions to support tobacco control.
3. Increase the proportion of smoke-free pregnancies by looking at initiatives to reduce smoking in pregnancy and optimise smoking cessation provision for all pregnant people across Wales. Work with maternity services to ensure that all pregnant women have their smoking status recorded and appropriate referrals made to smoking cessation services.
4. Ensure messaging is clear and consistent and is tailored to different priority groups.
5. Work to explore the evidence base, and working with partners, identify additional priority groups that we should work with to provide appropriate, additional support.

Priority Action area 4 - Tackle illegal tobacco and support the tobacco control legal framework

1. Review the evidence and data around the illegal tobacco landscape in Wales identify where gaps exist.
2. Raise awareness of the illegal tobacco and its impacts through communications materials and campaigns.

3. Develop a system to share information about illegal tobacco which supports effective enforcement across Wales.
4. Work with partners including the Police, HMRC and Local Authorities to explore innovative ideas to tackle illegal tobacco across Wales.
5. Undertake a review of the tobacco control enforcement tools available in Wales to understand if and where strengthening is required.

Priority Action area 5 - Working across the UK

1. Review tobacco control actions and policies that are implemented by other UK nations and share best practice on tobacco control actions and policies in Wales across the UK.
2. Continue to work with the other UK Governments on a broad range of non-devolved tobacco control issues to support a strong tobacco control system, including:
   a. Age of sale
   b. The environmental impact of smoking
   c. Safety warnings on tobacco and nicotine products
   d. Tobacco pricing, levy, and taxation

How was the implementation co-ordinated?

There are no updates on implementation due to the early stage at which the delivery plan is currently at.

How was capacity for implementation assessed/managed?

There has been no reporting on capacity for implementation due to the early stage of strategy implementation.

How was compliance with policy assessed?

There has been no reporting on compliance with the strategy due to the early stage of strategy implementation.

Policy Evaluation

Progress reporting structure

There is a brief reference to reporting against plans in a timelier manner, but no clear outline of the reporting structure has been provided.

Inputs

The Welsh Government has stated that it will use performance management structures to ensure the delivery partners maintain their focus on reducing smoking prevalence, including within smoking cessation and maternal smoking. They have committed to using any other tools available to provide the best information to track progress, across the population and across priority groups, towards a smoke-free Wales.

Monitoring success of the actions in the delivery plan and progress towards a smoke-free Wales primarily will use the following data sources:

- National Survey for Wales which provides data on smoking tobacco in Wales and provides a smoking prevalence rate in adults age 16+.
- Student Health and Wellbeing in Wales survey for smoking and vaping behaviours in young people aged 11-16.
- Maternity and birth statistics3 for maternal smoking rates.

Outputs

The Welsh Government aims to develop data to demonstrate progress across different communities and demographics across Wales, allowing regular reporting against plans in a more timely way than is currently the practice

Outcomes

The aim is for a sustained decline in smoking prevalence across this and future delivery plans. The Welsh Government will work to ensure we continually look for opportunities to improve the data sources so that monitoring systems are in place to demonstrate this. They have committed to regularly reviewing data systems and making any changes necessary to support and maintain our focus on achieving the ambition of a smoke-free Wales by 2030.

8 Tobacco Control Policy Ireland

8. Tobacco Control Policy Ireland

Policy Overview

Tobacco Free Ireland (TFI) was published in October 2013 (Department of Health, 2013a). This tobacco control strategy was published under the aegis of the government's Healthy Ireland Strategic Framework (2013- 2025) (Department of Health, 2013b). The priorities of Healthy Ireland were reviewed and an action plan was then put in place for the last few years of the framework. The Healthy Ireland Strategic Action Plan 2021-2025 included a shift in priorities with a focus on health inequalities as well as revised structures for health improvement at local level (Government of Ireland, 2021).

Annual reports are published by the Department of Health providing transparency on progress with the commitments made in Tobacco Free Ireland, the most recent of which was published in October 2021 (Department of Health, 2021a). Implementation plans are also published periodically by the Health Service Executive Tobacco Free Ireland Programme (HSE-TFIP) (Health Service Executive, 2022a). HSE-TFIP implementation plans set out how a prioritised set of actions to be pursued by the HSE in line with the commitments made in TFI.

Approaches

Documentary analysis was undertaken on the original TFI policy document and on a collection of official reports on policy implementation and review. These include seven annual reports on implementation of TFI representing activity under the strategy covering the time period 2014 to 2022and the HSE State of Tobacco Control in Ireland (2018 and 2022 versions).

Problem Emergence

Is the problem noted in the policy document?

Yes, in the introduction section of Tobacco Free Ireland it refers briefly to mental health as follows:

> ***Health promotion and illness prevention are central to healthier lifestyles, resulting not only in the reduction of chronic diseases but also in the reduction of healthcare costs and the emergence of a healthier workforce, healthier children, positive ageing, and greater participation of those with disabilities and mental health issues in society.***
>
> Department of Health, 2013a p15

How is the problem described?

There is no description of the relationship between mental ill health and tobacco in the original Tobacco Free Ireland policy. However, creating tobacco free health services within the mental health service and enhancing compliance with the legislation is recognised as an action within the strategy.

The State of Tobacco Control (SOTC) in Ireland 2018 and 2022 feature specific sections on tobacco and mental health (Health Service Executive, 2018 & 2022b). The 2018 report states that the "*well-established relationship between smoking and mental health is complex, with evidence indicating that mental health increases the risk of becoming a person who smokes as well as confirming that smoking is injurious to mental health. Smoking explains much of the poor physical health experience of people with mental health problems, who on average die 10-20 years earlier than the general population; however, people with mental health problems who smoke express as much interest in quitting as the general population and can successfully quit, underlining the importance of mental health services and tobacco control working together with this population to address their needs. The needs of people with mental health problems also demand particular attention. Overall, considering the needs of different population groups must become central to tackling smoking in Ireland*" (Health Service Executive, 2018).

In this way, the first SOTC report repositions the issue from a health service compliance issue (as articulated in Tobacco Free Ireland) to a broader population health issue. The report further repositions the issue by signalling that responses should be informed by the needs of people with mental health problems and supported by national and international data and research. The report also recognises for the first time a bidirectional nature of tobacco dependence and poor mental health.

The second edition of SOTC published in 2022 continues to feature the issue of tobacco and mental health. It reframes the initial Tobacco Free Ireland policy narrative of enhancing compliance on smoke-free legislation in mental health service settings to a narrative that focusses on 'exclusion.' The 2022 report states that *"the benefits of smoke-free legislation more widely remains stalled, and some groups, such as people in prison settings and mental health care settings continue to be excluded...there is more to do in settings like secondary mental health care"* (Health Service Executive, 2022b).

How is the population (or populations) defined?

The population is not clearly described, only the setting of mental health services receives mention in Tobacco Free Ireland. It could be assumed that the population of interest is primarily people engaging with mental health services, particularly those who are inpatients or in residential settings. It could also be assumed that the population of interest is also mental health service management and staff.

The 2018 edition of State of Tobacco Control report signalled a shift in how the relationship between mental health and tobacco was understood. It includes a special section on tobacco and mental health and repositions the issue from a health service compliance issue to a broader population issue. Similarly, the Healthy Ireland Strategic Action Plan commits to enhance smoking cessation services for disadvantaged groups. It is not clear whether this provision extends to people with mental ill health or refers only to communities living in socio-economic disadvantage.

What data are used to present the problem?

No data are presented in the original TFI policy document. The first representative data on tobacco and mental health are presented in the 2018 State of Tobacco Control report based on analysis of Healthy Ireland Survey data from 2015.

Healthy Ireland 2015 measured mental health and wellbeing utilising the Mental Health Index-5 (MHI-5), which involved respondents indicating the extent to which they have experienced indicators of more negative aspects of mental health such as being "a very nervous person," feeling "downhearted and blue," "worn out," "tired" and "so down in the dumps that nothing cheers you up." Overall, approximately one-in-ten (9%) people reported psychological distress of an extent that indicated a probable mental health problem. The prevalence of smoking was greater among people reporting psychological distress. 35% of people with probable mental health problems were currently smoking, compared to 22% of those with no mental health problems ($p<0.0001$), a 1.6-fold difference.

Table 5. Prevalence of smoking status by probable mental health problems in Ireland (2015)

Mental Health Problems	Current smoker	Ex-smoker	Never Smoker
Probable mental health problem	35%	24%	41%
No mental health problems	22%	28%	50%

Source: Healthy Ireland 2015 Research Microfile

These data are updated and presented in SOTC 2022 as follows:

Overall, 15% of respondents to the Healthy Ireland survey 2021 had a score (56 or less) which indicates psychological distress of an extent that indicated a probable mental health problem; the corresponding figure in 2015 was 10%. This illustrates a significant variation in the prevalence of smoking by probable mental health problem status among adults, with greater prevalence of smoking among those with mental health problems (26% v 35%, $\chi 2 = 55.0$, $p<0.0001$).

No data are presented on the relationship between mental health and smoking in children or in specific subpopulations. Data are presented from a tobacco control perspective and therefore report on the prevalence of smoking among people experiencing psychological distress rather than the prevalence of psychological distress among people who smoke. No data are presented on smoking among people with life-limiting or chronic mental ill health or among people who are engaged or resident in mental health services.

What research is presented to describe the problem?

The joint report by the Royal College of Physicians and the Royal College of Psychiatrists on smoking and mental health is cited in both editions of the State of Tobacco Control report 2018. Academic papers published on the implementation of tobacco free campus in mental health services in Ireland are also quoted based on analysis completed by the Tobacco Free Research Institute.

Agenda Setting

Are costs of illness presented?

No estimate of cost of illness are presented. An economic assessment of the cost of tobacco to the State was published by the HSE in 2016 (ICF International, 2016). This does not include any reference to the economic cost specific to people with mental health difficulties.

Who are identified as the problem owners?

The problem is considered principally as a problem of ensuring mental health facilities are developed as smoke-free environments. Conceptualisation of the policy problem in this way means that the problem is co-owned by different parties. The Department of Health has responsibility for reporting to government on compliance with the law. The HSE environmental health workforce and the HSE Tobacco Free Campus programme leads are also identified as having roles in respect of compliance and development. Latterly, the problem is also 'owned' by the wider HSE Tobacco Free Ireland programme as an issue warranting attention through research, training, events, and the development of guidance.

The State of Tobacco Control report 2018 recommended that consideration be given to, 'How the HSE Tobacco Free Ireland Programme Plan can maximise the impact across the population with reference to health inequalities, people with mental health problems'.

Has stakeholder analysis been undertaken?

There was no stakeholder analysis evident in respect of mental health within the Tobacco Free Ireland Policy. However, this has been progressed in recent years through leadership by the HSE-Tobacco Free Ireland Programme (HSE-TFIP) in partnership with the Mental Health Commission.

Policy Formulation

Have levers been identified which allow for intervention?

Tobacco Free Ireland identifies only one interface point with mental health – an approach focussed on enhancing compliance in mental health services as smoke-free environments. However, several levers for intervention have been identified within the annual reports on progress with Tobacco Free Ireland.

Have the impacts of different policy options been considered?

No, only the original Tobacco Free Ireland Policy stands currently. There has been no policy position articulated since then. However, there are notable developments in implementation, which are detailed below under the policy implementation heading.

Goals and Targets

Have people with mental ill health been identified as a target group in the policy?

There is no target articulated to reduce smoking among people with mental ill health or reduce mental ill health among people who smoke. There is a goal to enhance the proportion of mental health facilities that comply with smoke-free legislation, but no SMART objective was applied.

Policy Implementation

What roles were described for programme and service leads?

See below detail provided in the section on policy tools and instruments

Who were the identified implementation partners?

See below detail provided in the section on policy tools and instruments

How is the policy translated into operational practice?

See below detail provided in the section on policy tools and instruments

Policy tools and instruments	
Training	
2014	Specific training in relation to mental health was launched in 2014. An on-line module on smoking and mental health were commissioned and launched in 2014. A report on the uptake of this specialist training is due at the end of April 2015.
2015	First report on numbers of mental health service staff trained as stop smoking specialists (n=14) First report on numbers of staff trained in mental health specialist training module (n=42)
2016	Second report on numbers trained in mental health specialist training module (n=16)
2019	Third report on numbers trained in mental health specialist module (n=27)
Tobacco-free campus	
2015	First report on mental health acute and residential services targeted for development as tobacco-free campuses and the level of compliance achieved.
2015	Development of a Tobacco-Free Campus toolkit and mental health briefing document.
2016	Publication, launch and dissemination of a Tobacco-Free Campus toolkit including workshops with mental health services.
2016	Second report on proportion of mental health units and residential services engaging with tobacco-free campus (70% and 45% respectively).
2016	Eve Holdings (Mental Health) implemented the HSE TFC policy within all their services and evaluated the use of the new revised smoking cessation group support resource?

2017	Third report on proportion of mental health units and residential services meeting criteria for tobacco-free campus. First report on engagement levels in mental health combined centres.
2018	Survey to assess stage of development with tobacco free campus policy. Survey results found that the policy was implemented in; 63% of Mental Health Approved Units 40% of Mental Health Residential Services.
2018	A research study examined implementation of the Tobacco Free Campus Policy at Galway Acute Mental Health Service to further inform a model of best practice in an acute mental health setting.
2018	The HSE Tobacco Free Ireland Programme engaged RCSI in a research evaluation of Tobacco Free Campus policy implementation in EVE services. EVE, a programme within the HSE provides a network of services for adults with mental health disabilities. In 2016, the Quit Smoking Programme (QSP) was implemented in sixteen of these centres. This study explores the implementation of this quit smoking programme in the EVE community setting. It aimed to provide qualitative data, integrating the views and experiences of both service users and facilitators in relation to this programme's implementation. This study therefore provides richer accounts of the experiences of both staff and service users than that reported in the previous literature, taking full account of the complex issues which can shape the process of implementation in real world mental health services.
2019	Mental Health Ireland and the TFI Programme partnered to host a national conversation cafe on Smoking, Mental Health, and Recovery. This was the first time that mental health services users, staff and policy makers had been brought together to examine the relationship between smoking and mental health and to have an open, honest, and direct conversation where all perspectives on this issue were articulated and recorded. More than seventy stakeholders from lived experience of mental health challenges, services providers, supporters, people who smoke, and people who have quit smoking came together on an equal footing, in the spirit of co-production, to tell the story of how things are now in terms of smoking and mental health and to contribute to a purposeful plan.
2019	The TFI Programme ran an incentivised Tobacco Free Campus quality improvement process for the first time in 2019. The programme awarded quality improvement bursaries to healthcare services who were able to demonstrate innovation, sustainability, and internal compliance building in Tobacco Free Campus Policy implementation. A total of twenty-one services (13 acute hospital and eight mental health services) participated in the bursary competition, with awards being made to 18 services.

Engagement and integration across service areas	
2017	The programme participated at the Mental Health Nurses conference in Dublin Castle in September, the MH Directors of Nursing conference in Mount Wolseley and the Nursing & Midwifery Research Conference in Tullamore (Oct 2017) and the Mental Health Summit in the Aviva (Nov 17) to showcase examples of good practice in TFC implementation in mental health and advocate for the treatment of tobacco addiction and consistent and improved TFC implementation in Mental Health services. The programme engaged with the Mayo Recovery College (Mental Health) to scope the potential to develop a 'Let's talk about smoking' module to be delivered by recovery colleges, followed up with a 1-day consultation workshop in Mayo Recovery College to co-produce the module. The programme did a site visit to Maudsley Hospital, South London where a number of local NHS health and tobacco specialists hosted a sharing and learning event for colleagues from Scotland, Finland, and Ireland. The Programme engaged with the Inspectorate division of the Mental Health Commission to advocate for the inclusion of Tobacco Free Campus policy implementation in future audits of mental health services.
2018	The programme engaged with the Mental Health Commission to advocate for inspection of TFC policy as part of routine audit and quality improvement across services - see action 7.5
2019	Mental Health Ireland and the TFI Programme partnered to host a national conversation cafe on "Smoking, Mental Health, and Recovery' ' in July 2019. This was the first time that mental health services users, staff and policy makers had been brought together to examine the relationship between smoking and mental health and to have an open, honest, and direct conversation where all perspectives on this issue were articulated and recorded. More than seventy stakeholders from lived experience of mental health challenges, services providers, supporters, people who smoke, and people who quit smoking came together on an equal footing, in the spirit of co-production, to tell the story of how things are now in terms of smoking and mental health and to contribute to a solution-focused plan for the future.
2020	Throughout 2020, the TFI Programme has worked in partnership with Mental Health Ireland to develop a guidance document on Smoking, Mental Health, and Recovery. This guidance document is being developed to support mental health services in the implementation of the National Framework for Recovery in Mental Health 2018-2020, to strengthen the delivery of a quality person-centred service and to provide mental health services with a practical guide on Smoking, Mental Health & Recovery. The document will support service providers already working with service users, families, supporters as well as the voluntary sector and those looking for more guidance to support their recovery practice. Recovery orientated services promote working in a holistic and respectful manner ensuring that everyone is valued and acknowledged for their unique experiences. This offers a way of working where the expertise of service users, family members and service providers is accepted equally and valued to ensure better recovery outcomes for all. This is relevant across all services; Child and Adolescent Mental Health Services, General Adult, Psychiatry of Later Life, Community and Voluntary sector services.

2017	DOH H&WB P engaging with Dept. of Education and Skills to ensure an effective approach to health and wellbeing. Also leading out on implementation of Outcome 1- Active and Healthy, Physical and Mental Wellbeing in Better Outcomes, Brighter Futures.
2018	Programme invested extensive time and support to the implementation of the Tobacco Free Campus Policy at Galway Acute Mental Health Service throughout 2018 to develop a model of best practice in an acute mental health setting. Various other sites and services were supported to commence and improve implementation of the HSE Tobacco Free Campus policy. Some were individual sites while others included a range of services with shared governance. Great progress was made in mental health services that engaged service user and family member groups from the outset addressing their concerns and reassuring them of the planned comprehensive approach.
2019	Smoking and mental health section on HSE QUIT website

Listed below (in no particular order) are the primary areas/topics, clients were given additional support on:

- Weight management
- Physical activity
- Stress management
- Mental health supports
- Cardiovascular health and risks
- Healthy eating and nutrition
- Smoking cessation group programmes
- Smoking cessation practitioners are ideally positioned to identify appropriate pathways and help signpost clients to local services and resources to meet their wider need.

Policy Evaluation

There has been no formal evaluation of the Tobacco Free Ireland policy in terms of its impact on reducing smoking among people with mental ill health.

9 Tobacco Control Policy Northern Ireland

9. Tobacco Control Policy Northern Ireland

Policy Overview

In 2012 the Department of Health published it's Ten Year Tobacco Control Strategy for Northern Ireland 2012-2022. The overall aim of the strategy was to create a tobacco-free society. The key objectives, which were carried forward from the Tobacco Action Plan 2003-2008, are:

- fewer people starting to smoke
- more smokers quitting
- protection for all from secondhand smoke.

The focus of the strategy was:

- Further development of legislative controls on advertising, marketing, and sale of tobacco products. Provision of public information, aimed at preventing and discouraging tobacco use (target group children and young people).
- Increasing the range of smoke-free locations not currently covered by the Smoking (Northern Ireland) Order 2006.
- Motivating and assisting people who smoke to quit.

A mid-term review of the strategy was commenced in 2018 and published in 2020. The review comprised:

- Progress on actions and key outcomes
- Evidence review
- Stakeholder engagement process.

The stakeholder engagement process highlighted the need to consider smoking among those experiencing mental ill health. Stakeholders highlighted the need for additional resourcing to support this group in terms of smoking cessation, for example, the creation of mental health nurse specialists. It was also noted that those with mental health issues should be a target group going forward.

Approach

An action plan to accompany the strategy was developed by the Public Health Agency which has responsibility for implementation, with the assistance of a multi-agency implementation group to oversee and drive forward the actions outlined in the plan. The group set intermediate targets in areas such as behavioural change following public information campaigns and uptake of smoking cessation services. Progress reports were presented to the Department annually.

Problem Emergence

Is the problem noted in the policy document?

Yes, the strategy notes a strong link between smoking and mental health disorders, with smoking being responsible for a considerable proportion of the excess mortality of people with mental illness (Brown et al, 2000). It was reported that smoking occurs at much higher rates in this population group, with almost half of total tobacco consumption and smoking-related deaths occurring in those who suffer from a mental disorder (Royal College of Psychiatrists, 2010). Studies conducted in the UK have shown smoking prevalence amongst inpatients in mental health units to be up to 70%, with around half of inpatients recorded as being people who heavily smoke (Jochelson and Majrowski 2006). Despite the very high smoking prevalence levels, large numbers of people with mental health conditions report that they would like to quit smoking (Doherty, 2006).

Agenda Setting

Are costs of illness presented?

The strategy does not specifically report on the cost of smoking in the context of mental ill health. At a population level it is reported that the hospital cost of treating smoking-related illnesses in Northern Ireland is in the region of £119m each year. In 2008/09 show that the annual hospital cost for treating people who smoke for the three main smoking related diseases - lung cancer, ischaemic heart disease and cerebrovascular disease - is approximately £50m. Whilst these three diseases are the ones most linked with smoking, there is evidence that smoking is a contributory factor in a range of other circulatory and respiratory diseases. The estimated hospital costs associated with these additional smoking-related diseases is approximately £69m. A study which looked at the hospital costs (2005 figures) of lung cancer patients, found them to be around £5,900 per patient over a 12-month period. These figures do not include the much higher economic cost to our society, because of lost productivity (through smoke breaks, or smoking-related sick leave), lost years of life, and fire damage caused by cigarettes.

Who are identified as the problem owners

The Department of Health is the policy owner, and the Public Health Agency has lead responsibility for implementation.

Has stakeholder analysis been undertaken?

At the time of the publication of the strategy it was noted that the Department was considering options around banning smoking in private vehicles and a public consultation on this issue will be launched in 2012. After this, legislation prohibiting smoking in private vehicles where children are present was introduced in February 2022.

In 2010, the Department of Health held a consultation on plans to introduce stronger sanctions against retailers who regularly flout the law with regards to underage sales. The consultation paper included proposals for a negative licensing scheme which would see repeat offenders losing their legal right to sell tobacco products for a period to be determined by the Northern Ireland Courts Service. The proposed measures will bring Northern Ireland into line with the rest of the UK. England, Wales, and Ireland introduced strengthened retailer sanctions from 2009 and Scotland introduced similar measures in April 2011 under the Tobacco and Primary Medical Services (Scotland) Act 2010. Legislation banning tobacco vending machines in Northern Ireland was introduced from 1 March 2012.

Policy Formulation

Have levers been identified which allow for intervention?

TSISG to formulate a plan for the development of actions and targets in relation to people with mental health issues who smoke. This should consider both short term actions and scope the inclusion of people with mental health issues as an additional priority group in any new strategy.

Have the impacts of different policy options been considered?

It is not clear if the impacts of different policy options have been considered.

Has a logic model or theory of change been described?

There is no evidence that a logic model or theory of change model has been applied.

Was feasibility of different approaches considered?

There is no evidence that the feasibility of different approached have been considered.

Policy tools or instruments	
Training	although there is no specific training referenced in relation to smoking and mental health, brief intervention training has been comprehensively rolled out across many disciplines, not only in the health service, but also among other groups involved in working with young people. Professions now routinely offered training include doctors, nurses, pharmacists, dentists, youth workers, and teachers. However, further work is required in terms of ensuring that the training is effectively applied and that the relevant professionals are taking advantage of opportunities when they are presented to them. The Training Framework for Smoking Cessation Services in Northern Ireland 2003 sets standards for Health and Social Care services in relation to service provision. The framework is also promoted as best practice among all individuals involved in developing and running smoking cessation services. While still a very relevant document, given new developments and guidance issued in this area in recent years, an updated framework is now required. Only services which comply with the standards in the Framework may be commissioned by the HSC and these services should be formally accredited.
Guidance	NICE has produced a number of public health guidance documents for professionals on smoking cessation services including guidance on smoking cessation services in mental health settings. The NHS produced its own service and monitoring guidance for 2010/1145. While this document offers best practice guidance relevant to the provision of all NHS stop smoking interventions, it is also a useful tool for all service providers in Northern Ireland.

Information and awareness activity	The two main forms of effective interventions available to support people to quit are brief opportunistic advice and specialist cessation interventions. These interventions are supported by public information campaigns which stimulate interest and signpost people to services. Online advice also has a valuable role to play.
Political statement	Foreword by Edwin Poots MLA, Minister for Health, Social Services and Public Safety
Service commissioning	The Department has recently developed a number of service delivery frameworks for the HSC sector to improve the way that health and social care is planned, commissioned, and delivered in Northern Ireland The Public Health Agency will commission public information campaigns, fund, and monitor enforcement of tobacco control legislation conducted by local District Councils, and commission smoking cessation services jointly with the Health and Social Care Board. The HSC commission specialist services which are evidence based and offer intensive treatment usually in the form of one-to-one or group support, over the course of up to 12 weeks. Clients attending the sessions can be offered additional support in the form of Nicotine Replacement Therapy and/or pharmacotherapy.

Goals and Targets

Have people with mental ill health been identified as a target group in the policy?

In the mid-term review there is a strategy priority to increase smoking cessation rates amongst manual workers and those with mental health issues, taking into consideration the needs of these group. It was noted that the Public Health Agency provide funding to assist Health and Social Care Trusts to further develop stop smoking services within maternity services, mental health services, for patients receiving treatment for long term conditions or cancer and preoperative patients.

It is also acknowledged within the mid-term review that the design and delivery of school-based programmes in Northern Ireland could be refreshed considering the significant contextual changes in the tobacco and e-cigarette retail environment, rising cannabis use and the changing landscape of youth mental health.

What policy objective has been articulated?

There was no specific policy objective in relation to smoking and mental health within the 2012 strategy. However, the mid-term review included the recommendation that the Tobacco Strategy Implementation Steering Group formulate a plan for the development of actions and targets in relation to people with mental health issues who smoke. This should consider both short term actions and scope the inclusion of people with mental health issues as an additional priority group in any new strategy.

What specific targets are proposed and in what timeline are they to be achieved?

There are no specific targets within the strategy

Policy Adoption

No specific policy approach to smoking and mental health was reported in the strategy or mid-term review.

Policy Implementation

No specific detail on policy implementation to smoking and mental health was reported in the strategy or mid-term review.

Policy Evaluation

Progress reporting structure

The 2012 strategy stated that an evaluation framework would be developed, against which the effectiveness of the action plan will be measured. In 2020 the Department of Health published a Mid-term Review report.

External review or internal review

The mid-term review was supported by the Institute of Public Health and the Public Health Agency and overseen by a review steering group.

Inputs

The mid-term review included progress in relation to smoking prevalence among the priority groups. Progress on the strategic priorities relating to each strategic objective was reported.

An evidence review was conducted to determine what changes had occurred in tobacco control since the strategy was published in terms of policy and research, and how any political or social changes in that time have changed the landscape in which the strategy is being delivered.

A stakeholder engagement workshop was held with lead implementation stakeholders which included policy and programme leads from the Department of Health and the Public Health Agency, as well as those with lead roles in service commissioning, management, and service provision as well as advocacy and research sectors.

Processes

The Department of Health and Public Health Agency presented data on relevant indictors to report on progress against the strategic objectives and for the priority groups.

At the request of the Department of Health, the Institute of Public Health undertook a review of the evidence published since the Strategy was launched in 2012. The overall aim of the evidence review was to support evidence-informed decision-making to inform the mid-term review of the Tobacco Control Strategy and the direction of future implementation of the Strategy. The specific research aims were:

1. To conduct a policy-focused rapid review which highlights significant high-level developments in evidence of effectiveness in defined elements of tobacco control policy addresses evidence emerging within the last 6 years.
2. To synthesise the review findings to propose strategic recommendations for consideration by the group overseeing the mid-term review.

The evidence review sought to address:

- What evidence informed approaches should be considered to further reduce the number of people in NI starting to smoke?
- What evidence informed approaches should be considered to further support engagement with stop smoking services delivered under the strategy?
- What evidence informed approaches should be considered to further reduce exposure to tobacco smoke in NI?

The Institute of Public Health undertook a stakeholder engagement process which took account of existing information from stakeholder engagement exercises which had recently been completed by the Public Health Agency. Further engagement included a facilitated workshop with the Strategy Steering Group members and its sub-groups. In addition, an on-line survey provided an opportunity to collate feedback from a wide range of stakeholders who had been involved in the delivery and implementation of the strategy as well as those stakeholders who were unable to attend the workshop.

Outputs

The Department of Health published the Mid-term Review of the Ten Year Tobacco Control Strategy for Northern Ireland, which included summaries of the work undertaken by IPH. The Institute of Public Health published the following separate reports:

- Mid-term Review of the Ten Year Tobacco Strategy for Northern Ireland Evidence Review
- Mid-term Review of the Ten Year Tobacco Strategy for Northern Ireland Stakeholder Engagement Report

Outcomes

The mid-term review included a series of recommendations including one related to smoking and mental ill health:

TSISG to formulate a plan for the development of actions and targets in relation to people with mental health issues who smoke. This should consider both short term actions and scope the inclusion of people with mental health issues as an additional priority group in any new strategy.

Evidence: Smoking prevalence is high in relation to people reporting a possible psychiatric disorder. Those with severe mental illness are more likely to die prematurely as a result of modifiable health risk behaviours such as tobacco smoking.

10 Observations

10. Observations

1. Current knowledge on mental ill health and smoking in Northern Ireland

In keeping with studies throughout the UK and Europe, there was evidence of a strong relationship between mental ill health and tobacco use in Northern Ireland. This relationship existed for self-reported symptoms of mental ill health using thresholds on validated scales and appears to be broadly similar to patterns observed in similar data in Ireland (Department of Health, 2021b).

Mental ill-health might be considered a valid target group or might be considered a cross-cutting issue in need of attention in order to better meet the needs of the existing policy target groups.

A lower proportion of 'never smokers' was observed among people with mental ill health across the variables studied. This could be interpreted as:

- Mental ill health being a pre-disposing or risk factor to being a smoker.
- Smoking being a pre-disposing or risk factor for development of mental illness.
- Common risk factors for the development of smoking and mental ill health.

In any case, the data on 'never smokers' has implications for how mental ill health might be understood in the context of efforts to prevent smoking as well as to respond to the needs of people with combined mental ill health and tobacco dependence.

2. Problem emergence – 'what's the problem?'

Higher smoking prevalence among people with mental ill-health is universally recognised in tobacco control policy across the UK. In general, more recent policy documents tend to afford a higher level of recognition and a broader understanding of the relationship - these frame the issue as a population health and health equity issue and not just an issue for attention within the health service. This is best evidenced in specific recommendations in the English Khan review, the Irish State of Tobacco Control 2022 report and the 2018 Mid-term Review of Tobacco Strategy in Northern Ireland. In general the core policy problem is understood as 'too many people with mental ill health smoke and this negatively affects their physical health'. However some 'unpacking' of components of the relationship, and its complexities, were evident including:

* Mental ill health as a risk factor for becoming a smoker.
* Smoking negatively affecting effectiveness of psychiatric medications.
* Misunderstandings about the likely mental health outcomes from smoking cessation.
* Barriers to inclusivity and accessibility of stop smoking support for people with mental ill health including in public messaging, campaigns, support materials and in terms of lower health literacy.
* Barriers to health service engagement with mental health service users on smoking cessation.

3. Agenda setting – evidence, advocacy and engagement with people experiencing mental ill health

The joint report of the Royal College of Physicians and the Royal College of Psychiatrists and reports by ASH appear particularly influential to policy development. Evidence reviews and high-quality intervention studies were also influential in challenging false assumptions about smoking cessation and mental health outcomes. NICE guidance specific to mental health services has also been significant in agenda setting within mental health services. Structured engagement with mental health service users within policy and programme development has grown but is not universally or consistently applied.

4. Engaging the health service with offering stop smoking support to people with mental ill health

A focus on training of mental health service providers in delivering best practice stop smoking support is evident across all jurisdictions. But beyond this, policy actions vary considerably. This is consistently presented as the 'solution' to the 'problem' (perceived or otherwise) of people with mental ill health not being engaged in stop smoking attempts. However, some jurisdictions adopt additional measures targeted to enhance stop smoking support in mental health services including financial incentives for service users and service level inducements such as funding/awards /bursaries for service development. There was some evidence of specific interventions seeking to decouple smoking and mental ill health. Ireland reported on the use of bespoke training and modules and Scottish policy endorsed the roll out of a specific IMPACT advice and training programme.

5. Addressing gaps in knowledge and understanding 'what works'

Identifying and addressing gaps in data and research on smoking and mental health emerges as a priority activity in English and Welsh policy, with England making specific reference to the value of qualitative research. However, none of the jurisdictions commit to a defined research programme or further development of indicator sets specific to tobacco and mental health nor any dedicated resource to support pilot/change management or feasibility testing of new programmes.

6. Priority groups, target populations and target setting

Neither Ireland nor any region in the UK has set a specific target to reduce smoking prevalence among people with mental ill health. Some jurisdictions report on relevant indicators, with the inclusion of mental illness within England's local tobacco profiles potentially being a highly significant development. Indicators used across the UK and Ireland are diverse and not comparable. They relate to both different populations and information systems (mental wellbeing scores, probable mental health conditions, disabling/serious mental illness and use of mental health services). Despite policy targets for full compliance with smoke-free mental health services, the true extent of compliance remains a little unclear. None of the jurisdictions appear to provide indicators on smoking and mental ill health among children or in relation to the policies priority/target groups (eg. pregnant women, lower socio-economic groups).

7. Integration in policy, across the health system and through intersectoral partnerships

There was no real evidence of integration between tobacco policy and mental health policy at national level in any jurisdiction with no shared policy agenda, common actions or joint priorities. However, reviewing tobacco issues within mental health policy was beyond the scope of this work. Integration and shifts to local planning and commissioning emerges as a significant theme in Wales, Scotland and England but it is not clear how addressing smoking and mental ill health will be enhanced within the new configurations. English policy commits to partnership approaches with ASH and the clinical/psychiatry bodies and Irish policy commits to partnership with the largest national mental health charity and recovery colleges.

8. Communication, messaging and literacy

The Khan review is the only policy document to make a specific recommendation on public communication and focusses on presenting accurate information that smoking does not relieve stress or anxiety and that smoking cessation does not cause a deterioration in mental health outcomes. Scottish policy acknowledges challenges in health literacy and the capacity of socially disadvantaged people to understand the harms caused by smoking. This policy seeks an improvement in the inclusivity and accessibility of stop smoking supports for mental health service users.

11 Policy considerations for Northern Ireland

11. Policy considerations for Northern Ireland

This section presents some options in terms of actions that could be taken in Northern Ireland to reduce the burden of tobacco-related harms on people with mental ill health.

Better understand the relationship between smoking and mental health

Address knowledge gaps through improved data collection in HSNI surveys or health information systems on:

* Smoking and chronic/life limiting mental illness.
* Smoking among mental health service users.
* Smoking among people with specific psychiatric diagnoses.
* Smoking and mental ill health in children including in the context of smoking initiation.
* The role of mental ill health in the context of the existing ' target groups' within the policy.
* E-cigarette use and level of uptake of behavioural support and approved pharmacological supports by people with mental ill health.

Invest in qualitative research with people with mental ill health in Northern Ireland to capture their understanding of smoking and their experiences of stopping smoking and engagement with awareness campaigns and services in the region.

Effectively focus attention and resource at policy level to reduce smoking related harms among people with mental ill health

Options in this regard could include:

* Designating people with mental ill health as a target group with a specific outcome for reduction in smoking prevalence within a set time period within any new tobacco control strategy.
* Committing to a multi-annual work programme to integrate mental health across the general strategy and within the existing target groups (people with social disadvantage, pregnant women and children).
* Agree a set of indicators relevant to smoking and mental ill-health to capture progress at population level but also within both mental health and stop smoking services.
* Exploring options a joint working mechanism (committee, programme or budget) for partnership work between the mental health strategy and tobacco control strategy.
* Integrating mental health policy and programme leads into the governance structures relevant to tobacco control
* Committing to report on progress on smoking and mental ill health within the policy reporting and review processes including level of compliance with NICE guidance.

Build partnerships with mental health advocacy organisations and professional organisations leading on delivering mental health services

Options in this regard include:

* Engagement of Northern Ireland's mental health champion.
* Forming an advisory group to oversee priority actions including how to best engage the views and experiences of people with mental ill health, their carers and service providers.

Assess 'best buys' for investment in training of service providers building on existing good practice

Training mental health service providers in delivering evidence-based stop smoking services is likely to remain a cornerstone in terms of a policy action. However, it would appear that training of individual service providers alone may be insufficient and that service- level change management may be required. Options that could be considered in this regard include:

* Incentivise and support staff working in mental health services to access stop smoking services.
* Enhanced training for stop smoking service providers in terms of recognising people with mental ill health and supporting, as well as training for mental health service providers.
* Service level change management programmes conceptualised as service quality development rather than individual behaviour change.
* Creating incentives for training through inclusion of service quality/performance indicators relating to the 5 As of stop smoking support.
* Explore the appropriateness and feasibility of replicating the ASH Scotland IMPACT advice and training programme.

Modify public awareness and messaging to engage people who smoke with mental ill health and facilitate access to support

Integrate clear consistent messaging on smoking and mental health within existing campaigns and promotional activities aimed at the general public on smoking.

Integrate clear consistent messaging on smoking and mental health within school-based health education relating to mental health and substance use.

Integrate clear consistent messaging on supports to stop smoking within mental health awareness campaigns aimed at destigmatising mental illness and empowering people with mental ill health to seek help.

Enhancing assessment of risk from tobacco-related harms among people with mental illness

Support compliance with the WHO Guidance on Management of Physical Health Conditions in adults with severe mental disorders.

Prioritise people with mental ill health within the design, delivery and evaluation of cancer awareness campaigns and cancer awareness training for mental health service staff.

Ensure that people who smoke and have chronic or life limiting mental illness, including those attending mental health services, are actively supported to access:

* vaccinations
* oral and dental health assessment
* clinically appropriate assessment of lung function and cardiovascular health
* smoke alarms and fire safety advice.

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Appendix

Tobacco Control Policies in the UK and Ireland

Country	Policy	Published	Author	Aim / Vision	Approach
England	Towards a Smokefree Generation A Tobacco Control Plan for England	July 2017	**Department of Health - Global and Public Health/ Population Health/HB/ cost centre**	**Our vision is to create a smokefree generation. To do this we need to shift emphasis from action at the national level - legislation and mandate of services to focused, local action, supporting people who smoke, particularly in disadvantaged groups, to quit.**	Developed a new tobacco control plan, targeted around four main themes, with a range of actions for each. 1.Prevention first 2.People who smoke to quit 3.Eliminating variations in smoking rates 4.Effective enforcement
England **(Khan Review)**	The Khan review Making smoking obsolete. Independent review into smokefree 2030 policies.	9 June 2022	Dr Javed Khan	Dr Khan was commissioned by Rt Hon Sajid Javid MP (Secretary of State for Health and Social Care) to carry out an independent review of 'smokefree 2030', the government ambition to get smoking rates down from 13.5% to 5%.	The review looked at the current smokefree policy, along with very best practice from around the world. Dr Khan acknowledged that the UK has been a world leader in reducing smoking over the last few decades but are now at risk of stagnating. The government needs to raise its ambition if it wants to continue leading the way.

Scotland	Raising Scotland's Tobacco-free Generation Our Tobacco-Control Action Plan 2018	**2018**	**Population Health Directorate, Scottish Government**	**Between 2018 and 2023 we will be taking action to raise awareness on: the harms and impacts of smoking; the benefits of stopping smoking; the availability of free, local services which increase chances of successful quit attempts; new legislation which restricts the type of place where smoking is allowed; illicit and illegal tobacco trading; proxy purchasing for underage people who smoke; and the relative risks of vaping compared to smoking.**	This tobacco control action plan builds on what we know works - in helping people understand the messages about ambition, success, and drivers for positive change as well as the evidence about risks, harms and consequences.
Wales	A smoke-free Wales: Our long-term tobacco control strategy Our long-term plan towards a smoke-free Wales by 2030. A smoke-free Wales. Tobacco control delivery plan 2022-2024	26 July 2022	Welsh Government	It is our ambition for Wales to become smoke-free by 2030. To meet this vision for a smoke-free Wales we will be driving forward work across our three key themes of Reducing Inequalities, Future Generations and a Whole-System Approach for a Smoke-Free Wales.	The two-year delivery plan will focus on the actions that support the further denormalisation of smoking and making smoke-free the norm in Wales, promotion of best practice and integration of tobacco control across the whole system. Actions have been grouped into five priority action areas: 1. Smoke-free environments 2. Continuous improvement and 3. supporting innovation 4. Priority groups 5. Tackle illegal tobacco and the tobacco control legal framework 6. Working across the UK

Ireland	Tobacco Free Ireland Action Plan HSE Tobacco Free Ireland Programme 2022-2025	**October 2013** **2022**	**Department of Health** **Health Service Executive**	**The overall aim of a tobacco control policy is to reduce and eliminate tobacco-related harm in the population and the unnecessary and preventable deaths and disability caused by tobacco use.** **A more concerted effort is now required to support the continued development of a tobacco free society by 2025 where people can live longer and healthier lives, free from the detrimental effects of tobacco.**	Actions are therefore required to: • prevent people who have never smoked including children and young people from starting to smoke • encourage, motivate and support people who currently smoke to quit • reduce recidivism rates among those who have quit • protect people who don't smoke, especially children, from the effects of second-hand smoke • limit the societal impacts of smoking and protect society, especially those under 18 years, from the marketing practices of the tobacco industry.
Northern Ireland	Ten Year Tobacco Control Strategy for Northern Ireland 2012-2022	2012	Department of Health	The overall aim of the Strategy is to create a tobacco-free society. The key objectives, which have been carried forward from the Tobacco Action Plan 2003-2008, are: • fewer people starting to smoke. • more smokers quitting; and • protecting people from tobacco smoke.	Objectives will only be achieved through a co-ordinated, multi-disciplinary approach is adopted across NI. Focus will remain on: • Further development of legislative controls • Provision of public information • Increasing the range of smoke-free locations • Motivating and assisting smokers who wish to quit.

Problem emergence

Problem identified; policy response required.

Problem Emergence	England	**England Khan Review**	Scotland	Wales	Ireland	Northern Ireland
Is the problem noted in the tobacco policy document?	Yes – set out in Foreword and National Ambitions	Presented as Recommendation 13: Tackle the prevalence of smoking among people with poor mental health.	Yes. Annex p39-46 sets out the smoking and vaping statistics 2018.	Yes - In 'Introduction' section, within 'Addressing Harms' and under 'Theme 1 - Reducing Inequalities'.	Yes – outlined in introduction section.	Yes – outlined in Chp 1 (p 15) of the strategy
How is the problem described?	Smoking prevalence remains even higher in people with mental health conditions. More than 40% of adults with a serious mental illness smoke.	People with poor mental health are more likely to smoke. People who smoke are more likely to have poor mental health. The more severe the mental health condition, the higher the rates of smoking, smoking dependence, and the chance of relapse.	There is no reporting of smoking prevalence among smokers with mental health problems.	Smoking rates are higher in some groups including people with mental health conditions.	No description provided in the original Tobacco Free Ireland Policy. However, creating tobacco free health services within the mental health service and enhancing compliance with the legislation is recognised as an action within the strategy.	Strong link between smoking and mental health disorders, with smoking being responsible for a large proportion of the excess mortality of people with mental illness. Higher smoking prevalence in this population, with almost half of total tobacco consumption and smoking-related deaths occurring in those who suffer from a mental disorder.

How is the population (or populations) defined?	People with mental health conditions and patients in mental health services.	People with common mental health problems (like anxiety and depression) as well as people severe mental health conditions.	Smokers in mental health settings; people with mental health problems.	People engaged with mental health services.	In terms of the setting in which mental health services are delivered. The population is not clearly described, only the setting of mental health services receives mention in Tobacco Free Ireland.	People suffering from mental illness.
What data are used to present the problem?	'Smoking rates in people with serious mental illness'. 2016. Available at Public Health England Tobacco Control Profiles.	Adult Psychiatric Morbidity Survey: Survey of Mental Health and Wellbeing, England, 2014.	Scottish Health Survey	National Survey for Wales Government smoking cessation services	No data are presented in the original TFI policy document. The first representative data on tobacco and mental health are presented in the 2018 State of Tobacco Control report based on analysis of Healthy Ireland Survey data from 2015.	None

What assessment is provided on the trend of the problem?	None	None	None	Smoking rates are much higher in people who have mental health conditions. Estimated that 33% of people with mental ill health smoke and smoking related diseases are a major contributory factor to reduced life expectancy for those with schizophrenia.	Data on trends are presented in the State of Tobacco Control in Ireland reports published in 2018 and 2022.	None
What assessment is provided on the scale of the problem?	None	None	None	Among people with mental health conditions, only a minority of people with mental health conditions receive effective smoking cessation interventions.		None

What research is presented to describe the problem?	Risks of all-cause and suicide mortality in mental disorders: a meta-review. Smoking and Mental Health - A joint report by the Royal College of Physicians and the Royal College of Psychiatrists Public Health England. Smoking cessation in secure mental health settings: Guidance for Commissioners Change in mental health after smoking cessation: systematic review and meta-analysis	Mental health in the pandemic: a repeated cross-sectional mixed-method study protocol to investigate the mental health impacts of the coronavirus pandemic in the UK Mental health and wellbeing in England: Adult psychiatric morbidity survey Prescribing Prevalence, Effectiveness, and Mental Health Safety of Smoking Cessation Medicines in Patients with Mental Disorders	None	ASH Wales. 2017. Smoking and mental health. Royal College of Physicians and Royal College of Psychiatrists. 2013. Smoking and Mental Health.	Joint report by the Royal College of Physicians and the Royal College of Psychiatrists on smoking and mental health. Academic papers published on the implementation of tobacco free campus in mental health services in Ireland are also quoted based on analysis completed by the Tobacco Free Research Institute.	Causes of the excess mortality of schizophrenia. Royal College of Psychiatrists – No health without public mental health – the case for action. Clearing the air. Debating smoke-free policies in psychiatric units.

How are concepts of emotional, mental and psychological wellbeing and illness presented?	Not described	Not described	Not described	Not described in detail.	These are not explored in any detail. However, these issues feature heavily in the public awareness information on the HSE QUIT website.	Not described
Is expert evidence used to identify the problem?	Yes. Evidence from scientific literature, professional bodies and statutory agencies is used to identify issues relating to smoking and mental health.	Yes - but in limited capacity	Yes, but in a limited capacity.	Yes	Yes, but in a limited capacity	Yes, but in limited capacity

Agenda Setting

- Agenda setting occurs when the key players focus on an issue or problem, which has been brought to attention through crisis, change in indicators, new evidence, media publicity or advocacy actions.
- The process by which a policy problem is acknowledged to be of public interest.

Agenda Setting	England	England Khan Review	Scotland	Wales	Ireland	Northern Ireland
Are costs of illness presented?	No	No	No	Not specifically for those living with mental ill health. It is estimated that treating smoking related diseases costs the NHS in Wales approximately £302 million per year.	No estimate of cost of illness are presented. An economic assessment of the cost of tobacco to the State was published by the HSE in 2016. This does not include any reference to the economic cost specific to people with mental health difficulties.	Not specifically for those living with mental ill health. The total Northern Ireland hospital costs of treating smoking related diseases is in the region of £119m per annum.
Who are identified as the problem owners	Department of Health	NHS	NHS Scotland	Tobacco Control Strategic Board and Tobacco Control Delivery Plan Implementation Group	The problem is considered principally as a problem of ensuring mental health facilities are developed as smoke-free environments.	Department of Health

Is there evidence of advocacy, and who are the sources?	No	No	Unclear	No	There is no evidence of advocacy from organisations representing people with mental ill health or from those involved in delivering health and social care services. However, this is likely to have occurred through informal channels and not being documented.	No
What solutions were proposed by external actors?	Unclear	Reach the communities where smoking is most prevalent. Make stop smoking a key part of mental health treatment.	Unclear	None proposed	There is no clear statement on addressing tobacco within the two mental health strategies published by the government.	None proposed

Has stakeholder analysis been undertaken?	No	ASH commissioned to provide insights on attitudes and behaviours to smoking. This work included focus groups and in-depth interviews. Groups approached as part of the research included smokers with common mental health conditions (anxiety or depression).	Engagement over the past two years with representative bodies, health bodies, local authorities, third sector campaign groups, academics and the public.	Stakeholder consultation undertaken in March 2022. Participants included organisations from the NHS, local authorities, Public Health Wales, further and higher education, charities, organisations working with children and young people and trading standards. Focus groups and interviews were held with those known to have higher smoking prevalence rates.	There was no stakeholder analysis evident in respect of mental health within the Tobacco Free Ireland Policy. However, this has been progressed in recent years through leadership by the HSE-TFIP in partnership with the Mental Health Commission.	Not on this specific strategy

Readiness for change assessment	No	No	No	No	No	No
What scenarios are discussed?	None	Reach the communities where smoking is most prevalent. Make stop smoking a key part of mental health treatment.	1. Informing and Empowering through raising awareness 2. Encouraging Healthier Behaviours 3. Improving Services 4. Providing Protection through regulation	3 themes and 5 priority action areas proposed. These were retained in the final strategy and delivery.	The removal of exemptions for the workplace smoking ban are proposed, alongside supports for development of smoke-free campuses in the main policy document Tobacco Free Ireland.	None
What disciplines of thought are included - human rights, psychiatry, neuroscience etc	None	None	None	None	The initial disciplines involved were those involved in creating smoke-free environments in the mental health service setting. These include the HSE Environmental Health Service and the HSE-TFIP project lead on tobacco free campus.	None

Policy Formulation

- The stage at which the public administration examines the policy options.
- The stage at which the extent to which the policy owners consider how to respond through formal mechanisms.

Policy Formulation	England	England Khan Review	Scotland	Wales	Ireland	Northern Ireland
Have levers been identified with allow for intervention?	Yes	As a review document, no specific levers haven been identified for intervention.	A series of actions have been identified under the following headings: Informing and empowering through raising awareness Encouraging healthier behaviours Improving Services Providing protection through regulation	Unclear	Tobacco Free Ireland identifies only one interface point with mental health – an approach focussed on enhancing compliance in mental health services as smoke-free environments. However, several levers for intervention have been identified within the annual reports on progress with Tobacco Free Ireland.	TSISG to formulate a plan for the development of actions and targets in relation to people with mental health issues who smoke. This should consider both short term actions and scope the inclusion of people with mental health issues as an additional priority group in any new strategy.

Have the impacts of different policy options been considered?	No	No	No	No	No, only the original Tobacco Free Ireland Policy stands currently. There has been no policy position articulated since then. However, there are notable developments in implementation, which are detailed below under the policy implementation heading.	No
Has a logic model or theory of change been described?	No	No	No	No	No	No
Was feasibility of different approaches considered?	No	No	No	No	No	No

Policy Instrument and Tools						
Training	Yes	Yes	Yes	Yes	No	Yes
Guidance	Yes	No	No	Yes	No	Yes
Information and awareness activities	Yes	Yes	Yes	Yes	Not specific to mental health	Yes
Stakeholder forums	No	Yes	Yes	Yes	Not specific to mental health	Unclear
Political statement	No	Yes	Yes	Yes	Not specific to mental health	No
Leadership development	Yes	No	No	Not specific to mental health	Not specific to mental health	No
Champions/ dedicated roles	No	No	No	No mention	Not specific to mental health	No
Service commissioning	Yes	No	No	No mention	Not specific to mental health	Not specific to mental health
Regulations	Yes	No	No	Yes	Yes	No
Voluntary approaches	No	No	No	No	Not specific to mental health	No
Checklists	No	No	No	No	Not specific to mental health	No
Integration	Yes	Yes	Yes	Not specific to mental health	Not specific to mental health	Not specific to mental health

Service level agreements	No	Yes	No	No	Not specific to mental health	No
Service quality and performance	Yes	Yes	Unclear	Yes	Not specific to mental health	No

Goals and Targets

Goals and Targets	England	England Khan Review	Scotland	Wales	Ireland	Northern Ireland
Have people with mental ill health been identified as a target group in the policy?	Yes	Yes	Yes	Yes	No	Yes – within Mid-term Review.
What policy objective has been articulated?	Parity of esteem for those with mental health conditions. People with mental ill health should be given equal priority to those with physical ill health.	None	No specific target for those experiencing mental ill health.	It is our ambition for Wales to become smoke-free by 2030. (Not specific to mental health)	Ensuring greater compliance with SHS ban. Not specific to mental health.	Not specific to mental health - The overall aim of the Strategy is to create a tobacco-free society.

What specific targets are proposed and in what timeline are they to be achieved?	Commissioners and providers of the local health and social care system assessing the need of stop smoking support for people with mental health conditions and delivering targeted and effective interventions. NICE guidance PH48 and PH45 fully implemented in all mental health contexts.	None	Not specific to mental health.	Targets 2022-2024 1. Smoke-free environments. 2. Continuous improvement and support for innovation. 3. Priority groups (including mental health). 4. Tackle illegal tobacco and support the tobacco control legal framework. 5. Working across the UK.	Unclear, but guidance and implementation of same.	Not specific to mental health.

Policy Adoption

The stage at which decisions are made at government level, resulting in a decision which favours one or more approaches to addressing the problem.

Policy Adoption	England	England Khan Review	Scotland	Wales	Ireland	Northern Ireland
What policy approach was decided?	Implementing comprehensive smokefree policies, including integrated tobacco dependence treatment pathways, in all mental health services by 2018.	No decision – recommendations only.	1. Informing and Empowering through raising awareness 2. Encouraging Healthier Behaviours 3. Improving Services 4. Providing Protection through regulation		Non policy approach in main TFI but evidence of progress in action plans.	None
How and where was this articulated?	Unclear	Not specified	Not reported		Action plans	Not specified

Policy Implementation

The stage at which the policy's implementation parameters are established.

Policy Implementation	England	England Khan Review	Scotland	Wales	Ireland	Northern Ireland
What roles were described for programme and service leads?	Support implementation of NICE Guidance. Integrate SSS with addiction services. PHE work with the Mental Health and Smoking Partnership of Royal Colleges. Identify gaps in data. Support implementation of commissioning levers.	None	See relevant section for full details.	Tobacco Control Strategic Board has overall responsibility for the implementation and delivery of the strategy and the delivery plans.	See Guidance document	None

Who were the identified implementation partners?	PHE, Dept of Health, NHS, Royal Colleges, third sector and academia.	NHS	ASH Scotland; Health Promoting Health Service, the Scottish Government, NHS Health Scotland, NHS Boards; Integration Boards; Health and Social Care partnerships; Local Government; Social Workers; Youth Workers; Community Pharmacies; Prevention subgroup of the Ministerial Working Group; Ministerial Working Group's sub-group on Research and Evaluation.	The Tobacco Control Delivery Plan Implementation Group will support the Board. Membership of Implementation Group is not specified.		PHA and Health and Social Care Trusts

How is the policy translated into operational practice?	Primary care and community care providers are fundamental in delivering an integrated tobacco dependence treatment pathway.	Unclear	Actions outlined in the strategy	Implement a systematic Help Me Quit in Hospital smoking cessation service in Wales utilising learning from Canada's Ottawa Model for Smoking Cessation.	Guidance document for SHS	Not specified
How was the implementation co-ordinated?	Not specified	Not specified	Not reported at this stage.	Too early to comment.	Not specified	Not specified
How was capacity for implementation assessed/ managed?	Not specified	Not specified	Not reported at this stage.	Too early to comment.	Not specified	Not specified
How was compliance with policy assessed?	Not specified	Not specified	Not reported at this stage.	Too early to comment.	Not specified	Not specified

Policy Evaluation

Policy Evaluation	England	England Khan Review	Scotland	Wales	Ireland	Northern Ireland
External review or internal review	Not reported	N/A (recommendations only)	NHS Health Scotland will carry out an "evaluability assessment" of the action plan.	Not specified - brief mention of reporting against plans in a more timely manner		An evaluation framework will also be developed, against which the effectiveness of the action plan will be measured. Mid-term review report.
Policy communication	Not reported	N/A	Unclear	Unclear		Unclear
Inputs	Not reported	N/A	Not reported	Use performance management structures		Indicator data
Processes	Not reported	N/A	Develop evaluation framework	Monitor the success of the actions in this delivery plan and our progress towards a smoke-free Wales		Evidence Review Stakeholder engagement workshop

Outputs	Not reported	N/A	Bi-annual evaluation – to be published in 2020, 2022 and 2024.	Develop data to demonstrate progress across different communities and demographics		Mid-term review report Evidence Review report Stakeholder engagement report
Outcomes	Not reported	N/A	Not specific to mental health.	Sustained decline in prevalence across this and future delivery plans.		Recommendations relating to mental health to TSISG.

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