Reviewed by Mental Health Support Experts

nicorette nicotine

Johnson & Johnson Limited have created and reviewed this factsheet in consultation with Mental Health UK (Charity number 1170815)

ONE STEP AT A TIME
HELP SMOKERS LIVING WITH MENTAL HEALTH CONDITIONS QUIT

This factsheet highlights smoking-related challenges in individuals who are living with a mental health condition.

THE CURRENT PICTURE OF SMOKING AMONG THOSE LIVING WITH MENTAL HEALTH CONDITIONS:

- The incidence of smoking among those living with mental illness is nearly double that of the general population, and is nearly triple in those with severe mental health conditions (such as schizophrenia and bipolar disorder)[1].
- Those with severe mental illness have a life expectancy 10-20 years less than the general population[1]. Smoking is a common risk factor among these individuals, also being one of the causes of cardiovascular disease, stroke and cancer[2].

QUITTING SMOKING IS BENEFICIAL FOR BOTH PHYSICAL AND MENTAL HEALTH:

- From 72 hours after quitting smoking, the respiratory function of a smoker may start to improve, which can help to increase their capacity for physical activity[3]. Longer term, quitting smoking reduces the risk of developing COPD, respiratory infections and can improve treatment outcomes in asthmatic and established COPD patients[4].
- The risk of diseases including coronary heart disease and stroke begins to decrease after only one to two years of quitting smoking, and can approach that of a non-smoker following 10-15 years of sustained abstinence[3,4].
- Studies have highlighted a potential link between quitting smoking and a reduction in levels of depression, anxiety and stress[5].

Please see page 5 for prescribing and adverse events reporting information.

EVIDENCE-BASED MYTH BUSTING

1

"SMOKERS LIVING WITH MENTAL HEALTH CONDITIONS HAVE TOO MUCH GOING ON TO THINK ABOUT QUITTING SMOKING"

Such beliefs may mean there are missed opportunities to initiate their quit journey – this is reflected in studies which show that smokers living with mental health conditions are less likely to be offered support to quit smoking[6].

Although variable from one mental health condition to another, evidence suggests that people living with a mental health disorder are as motivated to quit smoking as the general population[7].

2

"ATTEMPTS TO QUIT SMOKING WILL WORSEN THE STATE OF MY DEPRESSIVE OR ANXIOUS PATIENTS"

Systematic reviews and meta-analyses have shown that levels of anxiety, depression and stress did not worsen and psychological quality of life may help to improve in people who quit smoking compared to those who continued to smoke[5].

It is thought that this is due to the 'Nicotine dependency cycle', where withdrawal symptoms trigger such unpleasant anxiety or stress symptoms[8].

3

"SMOKING CESSATION INTERVENTIONS ARE NOT EFFECTIVE IN THOSE WITH SEVERE MENTAL ILLNESS"

Randomised controlled trials, such as the SCIMITAR+ trial, and systematic review evidence demonstrate that behavioural support, in combination with pharmacological aids, help with smoking cessation in those living with a mental health condition[9,10].

Data does indicate that long-term quit-rates may decline in individuals living with mental health conditions compared to the general population – as such, these individuals may need more support to adhere to their quit regime, and may relapse more frequently[11,12].

"ALL FRONTLINE PROFESSIONALS SHOULD BE ENCOURAGED TO DISCUSS SMOKING CESSATION WITH THEIR PATIENTS"

- Nearly **1/3** of mental health professionals state that they tend to discourage individuals with mental health conditions from quitting smoking until after their mental health has improved [7].
- Approximately **1/2** of psychiatrists and community mental health staff stated that they had not received appropriate training on guidance for smoking cessation in this population[7]– staff who received training were more than twice as likely to discuss smoking cessation with their patients, compared to those who had not received training[7].
- For pharmacists, while schools teach a wide range of smoking cessation interventional methods, studies report a lack of training in the management of smoking cessation in individuals living with a mental health condition[13].

YOUR CONVERSATION TOOLKIT

STEP 1: INITIATE THE CONVERSATION

Start with open questions

- Smokers need to feel that you are not going to scold them for their past or present health decisions – ensure to be non-judgemental and open to avoid discouraging them from disclosing important information to you
- Instead, bring up the concept of smoking cessation while discussing other health behaviours such as adherence to medication, exercise, healthy eating and social support[14]
- Discussing smoking cessation as part of their care plan allows the smoker to conceptualise smoking cessation as part of their holistic health journey

  - Examples:

    'How would you like to improve your general health?

    'I see that you are a smoker – how do you feel about smoking at the moment?'

General tip – 'Roll with resistance'

- Express your desire to help them quit smoking, but highlight that it is their decision to make and
  you are not forcing it upon them
- Avoid confronting or arguing with their beliefs about smoking; instead, 'roll with resistance', inviting the person to explore their own perspective

  - Example statements:

    'I can see that you don't feel you're in a position to quit smoking at the moment – would you like to discuss it for a little while to see if there's anything I can offer to help?'

    'I understand you feel that quitting smoking is impossible – shall we have a discussion about it further, so you know your options?'

STEP 2: EXPLORE MOTIVATIONS AND BARRIERS

Ask them whether they have ever attempted to quit before – if so, ask them what triggered them to try and quit

- Allow this flow of conversation to lead you to discuss their motivations to quit smoking

Assess their readiness to quit, and their confidence in their ability to do so, using a 1-10 scale for example

- From here, explore their barriers to quitting, and why their score is not 10/10

Throughout, use 'double-sided reflection' to show you are listening, but reframe any concerns

- For example, 'I understand that many of your friends smoke socially, and you would struggle to quit because of this, but on the other hand you worry about the effect of smoking on your children and family'

Utilise the Decision Table on the patient-facing leaflet to bring together the above discussion

- Ideally, the benefits of quitting smoking and the drawbacks of continuing to smoke outweigh the other sections in the table

STEP 3:
HIGHLIGHT CAPABILITY AND SUPPORT AVAILABLE TO QUIT SMOKING

Support

- Evidence suggests that behavioural support, including counselling and group support sessions, in combination with pharmacological support achieves the best quit outcomes[9,14]
- Advise the individual to bring the support of friends, family and carers into their quit journey – this will bring logistical as well as social support

Capability

- Discuss practical ways to avoid the social triggers to smoking
  - Find the smoker's common social and behavioural triggers – friends, stress, alcohol, food, time of the day
  - Offer practical tips:
    - Telling friends, family and colleagues that they are trying to quit
    - Reducing alcohol intake
    - Finding a replacement for a cigarette – chewing gum, a cup of tea
    - Distraction – exercise, calling a friend, colouring or drawing
    - Change of routine – brushing teeth after a meal, showering after waking up

STEP 4:
UNDERSTAND THAT SMOKING IS A PSYCHOSOCIAL AS WELL AS PHYSIOLOGICAL ADDICTION, WITH HIGH RELAPSE RATES

- While studies show that mental health conditions, such as depression, are not negative predictors of motivation to quit smoking, motivation is not a predictor of relapse[15].
- Individuals living with anxiety, depression and substance abuse show higher rates of smoking relapse than the general population and may need long-term support from you to maintain abstinence[11,12].
- It should be highlighted that relapse is not failure, but a step in the journey to quit for good
- If your patient does relapse, use this as a time to explore why, and highlight their initial motivations to quit
  - 'Talk to me about that first cigarette – what events lead up to it?'
- Revisit practical solutions to minimise the attractiveness of a cigarette in that moment and revisit motivations to quit smoking

REFERENCES

1. Public Health England. Health Matters: smoking and mental health (2020). Available at: https://www.gov.uk/government/publications/health-matters-smoking-and-mental-health/health-matters-smoking-and-mental-health [Accessed March 2022]
2. World Health Organisation. Tobacco use and mental health conditions: A policy brief (2020). Available at: https://www.euro.who.int/__data/assets/pdf_file/0009/429939/Tobacco-Mental-Health-Policy-Brief.pdf [Accessed March 2022]
3. NHS Better Health. Quit smoking (2019). Available at: https://www.nhs.uk/better-health/quit-smoking/?WT.mc_D=MarchQuitSmokingPPC&gclid=EAIaIQobChMIuqv2hNun9gIVgmDmCh2EW gZbEAAYASAAEgJ07fD_BwE&gclsrc=aw.ds [Accessed March 2022]
4. Centers for Disease Control and Prevention. Smoking and Tobacco Use: Benefits of Quitting (2020). Available at: https://www.cdc.gov/tobacco/quit_smoking/how_to_quit/benefits/index.htm [Accessed March 2022]
5. Taylor GM et al., Cochrane Database of Systematic Reviews (2021). https://doi.org/10.1002/14651858.CD013522.pub2
6. Siru R. et al., Addiction (2009);104(5):719-33
7. Action on smoking and health. Smokefree skills: Training needs of mental health nurses and psychiatrists (2020). Available at: https://ash.org.uk/wp-content/uploads/2020/12/MHTraining_FullReport.pdf [Accessed March 2022]
8. Prochaska J & Benowitz N., Science Advances (2019);5(10)
9. Gilbody S. et al., The Lancet Psychiatry (2019);6(5):379-90
10. Emily Stockings, Alexandra Metse & Gemma Taylor. ERS Monograph: Supporting Tobacco Cessation. Chapter 15; pg 248
11. Song F. et al., PLOS ONE (2018). https://doi.org/10.1371/journal.pone.0205992
12. Zyambo C. et al., BMC Public Health (2019);19(1409)
13. Hunter A. et al., Curr Pharm Teach Learn (2019);11(7):696-701
14. NICE Guidelines. Tobacco: preventing uptake, promoting quitting and treating dependence (2021). Available at: https://www.nice.org.uk/guidance/ng209/chapter/Recommendations-on-treating-tobacco-dependence#stop-smoking-interventions [Accessed March 2022]
15. Cooper J. et al., Addiction (2016);111(8):1438-47

ADVERSE EVENTS SHOULD BE REPORTED
Reporting forms and information can be found at https://yellowcard.mhra.gov.uk/
Adverse events should also be reported to McNeil Products Limited on 0808 238 9999

PRESCRIBING INFORMATION

Nicorette Invisi Patch (Nicotine) Prescribing Information

See SmPC for full information

Presentation: Transdermal delivery system available in 3 sizes (22.5, 13.5 and 9cm2) releasing 25mg, 15mg and 10mg of nicotine respectively over 16 hours.

Uses: Nicorette Invisi Patch relieves and/or prevents craving and nicotine withdrawal symptoms associated with tobacco dependence. It is indicated to aid smokers wishing to quit or reduce prior to quitting, to assist smokers who are unwilling or unable to smoke, and as a safer alternative to smoking for smokers and those around them. Nicorette Invisi Patch is indicated in pregnant and lactating women making a quit attempt. If possible, Nicorette Invisi Patch should be used in conjunction with a behavioural support programme.

Dosage: It is intended that the patch is worn through the waking hours (approximately 16 hours) being applied on waking and removed at bedtime. **Smoking Cessation: Adults (over 18 years of age):** For best results, most smokers are recommended to start on 25 mg / 16 hours patch (Step 1) and use one patch daily for 8 weeks. Gradual weaning from the patch should then be initiated. One 15 mg/16 hours patch (Step 2) should be used daily for 2 weeks followed by one 10 mg/16 hours patch (Step 3) daily for 2 weeks. Lighter smokers (i.e. those who smoke less than 10 cigarettes per day) are recommended to start at Step 2 (15 mg) for 8 weeks and decrease the dose to 10 mg for the final 4 weeks. Those who experience excessive side effects with the 25 mg patch (Step 1), which do not resolve within a few days, should change to a 15 mg patch (Step 2). This should be continued for the remainder of the 8week course, before stepping down to the 10 mg patch (Step 3) for 4 weeks. If symptoms persist the advice of a healthcare professional should be sought. **Adolescents (12 to 18 years):** Dose and method of use are as for adults however; recommended treatment duration is 12 weeks. If longer treatment is required, advice from a healthcare professional should be sought. **Smoking Reduction/Pre-Quit:** Smokers are recommended to use the patch to prolong smoke-free intervals and with the intention to reduce smoking as much as possible. Starting dose should follow the smoking cessation instructions above i.e. 25mg (Step 1) is suitable for those who smoke 10 or more cigarettes per day and for lighter smokers are recommended to start at Step 2 (15 mg). Smokers starting on 25mg patch should transfer to 15mg patch as soon as cigarette consumption reduces to less than 10 cigarettes per day. A quit attempt should be made as soon as the smoker feels ready. When making a quit attempt, smokers who have reduced to less than 10 cigarettes per day are recommended to continue at Step 2 (15 mg) for 8 weeks and decrease the dose to 10 mg (Step 3) for the final 4 weeks. **Temporary Abstinence:** Use a Nicorette Invisi Patch in those situations when you can't or do not want to smoke for prolonged periods (greater than 16 hours). For shorter periods then an alternative intermittent dose form would be more suitable (e.g. Nicorette inhalator or gum). Smokers of 10 or more cigarettes per day are recommended to use 25mg patch and lighter smokers are recommended to use 15mg patch.

Contraindications: Children under 12 years of age. Known hypersensitivity to nicotine or any component in the patch.

Precautions: Underlying cardiovascular disease, diabetes mellitus, renal or hepatic impairment, seizures, phaeochromocytoma or uncontrolled hyperthyroidism, generalized dermatological disorders, gastrointestinal disease. Angioedema and urticaria have been reported. Erythema may occur. If severe or persistent, discontinue treatment. Stopping smoking may alter the metabolism of certain drugs. Transferred dependence is rare and less harmful and easier to break than smoking dependence. May enhance the haemodynamic effects of, and pain response, to adenosine. Keep out of reach and sight of children and dispose of with care. Should be removed prior to undergoing MRI procedures.

Pregnancy and lactation: Smoking cessation during pregnancy should be achieved without NRT. However, for women unable to quit on their own, NRT may be recommended to assist a quit attempt after consulting a healthcare professional.

Side effects: Very common: pruritus. Common: headache, dizziness, nausea, rash, urticaria, vomiting. Uncommon: hypersensitivity, palpitations, paraesthesia, tachycardia, flushing, hypertension, hyperhidrosis, myalgia, application site reactions, asthenia, chest discomfort and pain, malaise, fatigue, dyspnoea. Rare: Anaphylactic reaction, GI discomfort, angioedema, erythema, pain in extremity. Very rare: reversible atrial fibrillation. Not known: seizures

NHS Cost: 25mg packs of 7: £11.43, 25mg packs of 14: £18.72, 15mg packs of 7: £11.43, 10mg packs of 7: £11.43

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