Health Needs Assessment: Southampton Community Mental Health Service Users Use of Tobacco and Alcohol

September 2021

Author: *Rebecca Perrin, Public Health Registrar*

Contributors: Charlotte Matthews, Adam Cox, Amanda Luker, all staff within Southern Health's Southampton community mental health services, and their partner organisations.

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1. Executive Summary

Life expectancy for people with severe mental illness is known to be shorter than for people without. This is primarily due to an increased likelihood of experiencing cardiovascular and respiratory conditions and at a younger age – smoking and alcohol use are major contributors to this. Smoking prevalence is higher amongst people with mental health conditions compared to the general population and is not reducing at the same rate; alcohol use amongst people who use mental health services has a similar prevalence. The city of Southampton has a growing population with higher than average prevalence of severe mental illness, smoking and harms from tobacco and alcohol consumption.

A health needs assessment of Southampton City Council residents who access Southern Health NHS Foundation Trust community mental health services relating to their tobacco and alcohol use was undertaken to inform efforts to address these health inequalities locally. Southern Health data was used to describe the needs of people who use the service in relation to smoking and drinking alcohol, and stakeholders internal and external to Southern Health were engaged. Themes regarding their experiences caring for people with mental ill-health, tobacco dependency and/or alcohol consumption were collated – this quantitative and qualitative data has been used to make recommendations for meeting their needs. An action plan with full oversight will be required to implement and monitor their effectiveness.

We found The data collected from stakeholders supports what has been published about culture and attitudes towards smoking in mental health services, as well as relationships between mental health and alcohol services. **We recommend** -Senior leaders within Southern Health are vocal and visible regarding the importance of tobacco and alcohol use by people with mental ill-health, and unrelenting. -An action plan to implement these recommendations is agreed and overseen by the Southampton Division Leadership Team. - Ambitions for addressing tobacco and alcohol use, as well as physical ill-health, are clearly articulated in divisional and organisational plans and priorities. - A communications strategy to support acceptable and effective messaging about tobacco and alcohol use for staff, people who use services and their carers.
We found Staff perceive most people with mental illness to smoke and drink alcohol, and health deterioration amongst them is seen as inevitable. **We recommend** -The culture of inevitability around smoking, alcohol use and declining physical health for people with mental illness is challenged and replaced with individualised and holistic care. -ambitious metrics are developed to drive forward improvements in quality and quantity of life for people who access community mental health services.

Data, Intelligence & Insight Team
Southampton City Council, Municipal Block – West,
Civic Centre, Southampton, SO14 7LT

E-mail: strategic.analysis@southampton.gov.uk
Website: https://data.southampton.gov.uk/

We found Physical and mental health are regarded separately, perpetuated by having separate 'physical health' clinics. Conversations about smoking and alcohol use are most likely to occur at these clinics but are unlikely to be followed up. **We recommend** How and when people are asked about their use of tobacco and alcohol and offered treatment should be influenced by what the person using the service requires, rather than how the service operates. These conversations must not be confined to physical health clinics, they must happen at any contact and they must include an intervention, however brief.
We found 52% of people accessing community mental health services had neither smoking nor alcohol status recorded, and 20% without a record of ethnicity. **We recommend** - an organisation-wide focus to help staff consistently record smoking and alcohol status and data on prevalence of tobacco and alcohol use communicated back to teams. - any changes to the recording of smoking and alcohol status and related interventions to be undertaken alongside the development of the care pathway or to support improvements in care, rather than as a focus for improvement in themselves.
We found Both mental health and alcohol services consider there to be a 'right time' to discuss smoking, which would not be until further into the person's care. **We recommend** - The concept of a right time to discuss tobacco and alcohol use is challenged. Opportunities can be taken at different times in a person's care, using different approaches according to what's appropriate at that moment. - Resources within Southern Health, such as the quality improvement programme, can release time to address tobacco and alcohol use alongside mental health priorities.
We found Smoking and alcohol use are more likely to be discussed when they are perceived to impact on a person's diagnosis or medication rather than solely as contributing factors to their mental ill-health. **We recommend** Discussions about tobacco and alcohol use are part of a holistic rather than medical model of care, recognising their impact on the whole person, the resulting reduction in quality of life and the perpetuating cycle of further deterioration in physical and mental health.
We found Smoking prevalence somewhere between 22%, and 46%, indicating between 600 and 1,200 people accessing community mental health services may require tobacco dependency treatment. **We recommend** - a comprehensive Smoke Free policy, meeting all the NICE guidance requirements that is widely communicated and implemented with formal mechanisms for monitoring, and delivered via a care pathway.

- an in-house model for tobacco dependency treatment, with all staff trained to deliver brief advice and some to offer extended interventions. - the full range of pharmacotherapy options to be available and promoted.
We found The Early Intervention Psychosis team had the highest smoking prevalence and the Acute Mental Health team the highest prevalence of dependent/harmful/hazardous drinking. **We recommend** Further work to better understand the role alcohol plays for people experiencing a mental health crisis and its impact on their need for acute or inpatient mental health services.
We found The highest percentages of smokers and people drinking at harmful/hazardous levels were male and younger, more smokers lived in the 30% most deprived areas, more men were drinking at dependent levels than women, as well as older age groups compared to younger. **We recommend** Considering a proportionate universalism approach to supporting people with tobacco and alcohol use.
We found 15% of smokers were drinking at dependent/harmful/hazardous levels and 53% of those drinking at these levels were smokers. In the alcohol service in the most recent year, 73% of people were receiving treatment from mental health services, 53% from their GP. **We recommend** - Viewing tobacco, alcohol and other substance use as addiction. - Including the interdependency of smoking, alcohol use and mental health in training and sharing this training with alcohol services.
We found Alcohol and mental health services do not share expertise and do not perceive or understand each other well. Any joint working that occurs is viewed as practitioner dependent leaving some people with no support for their alcohol use. **We recommend** - Collaborative working between alcohol and mental health services is robust and sustainable, rather than reliant on individuals. - Senior leaders lead by example by prioritising and visibly working with partners to address the complex needs of people who require tobacco and alcohol addiction as well as mental health services. - People with needs related to alcohol and mental health will benefit from services sharing their expertise and working in tandem not sequentially. - Reconvene the Southampton-wide co-occurring conditions strategic group to drive forward improvements in care for people with these complex needs.
We found Mental health staff are keen to undertake tobacco dependency treatment training.

We recommend - The willingness of staff to be trained in brief advice techniques and tobacco dependency behavioural support is capitalised upon and a strong and sustainable relationship built with stop smoking organisations, in particular Southampton Smoke Free Solutions. - Brief advice training should be delivered to address both smoking and alcohol use, and consideration given to how this aligns with Southern Health's Making Every Contact Count Strategy. - Any training offer needs to be continuous rather than one-off or adhoc. - Staff are empowered to use their existing skills, applied every day to address people's mental health needs, to help people replace smoking and alcohol with strategies that don't harm their long-term health.
We found It difficult to include contributions from people who use Southern Health community mental health services in this health needs assessment. **We recommend** Opportunities for everyone using community mental health services to be meaningfully involved in the development of services to better address tobacco and alcohol use – with thought to the barriers that different populations experience - the current mechanisms for engagement should be reviewed.

2. Glossary

Term	Definition
Adult Psychiatric Morbidity Survey	A series of surveys which provide data on the prevalence of both treated and untreated psychiatric disorders in the adult population (aged 16 and over), taking place in 1993, 2000, 2007 and 2014. The surveys capture information on: common mental disorders, mental health treatment and service use, post-traumatic stress disorder, psychotic disorder, autism, personality disorder, attention-deficit/hyperactivity disorder, bipolar disorder, alcohol, drugs, suicidal thoughts, suicide attempts, self-harm, and comorbidity.
Alcohol attributable conditions/mortality	The number of health outcomes or deaths in a population caused by alcohol use, calculated using the alcohol attributable fraction (AAF), which denotes the proportion of a health outcome that is caused by alcohol and would disappear if alcohol use was removed. AAF is calculated using the level of exposure to alcohol and the risk (and causal relationship) between it and the health outcome. Some will be wholly attributable and others partially attributable to alcohol.
Alcohol misuse	Drinking in a way that is harmful, or being dependent on alcohol
Alcohol-related mortality	Deaths from conditions which are wholly or partially caused by alcohol. For partially attributable conditions, a fraction of the deaths are included based on the latest academic evidence about the contribution alcohol makes to the condition (assigning an AAF).
Alcohol-specific mortality	Deaths from conditions wholly caused by alcohol
AUDIT	Alcohol use disorders identification test; a simple screening tool, of 10 questions, to pick up the early signs of hazardous and harmful drinking and identify mild dependence. AUDIT-C is a shortened version, only 3 questions. Answers are scored, with cut-offs to indicate harmful alcohol consumption.
Annual Population Survey	Continuous UK household survey over 12 months, total sample 320,000. Latest release 2020 (collection 2019)
Broad	total burden on community and health services (and narrow.. used to compare areas and over time
Chief Medical Officer's guideline for men and women	To keep health risks from alcohol to a low level it is safest not to drink more than 14 units a week on a regular basis. If you regularly drink as much as 14 units per week, it's best to spread your drinking evenly over three or more days, and to have 2 alcohol free days. If you have one or two heavy drinking episodes a week, you increase your risk of long-term illness and injury

Data, Intelligence & Insight Team
Southampton City Council, Municipal Block – West,
Civic Centre, Southampton, SO14 7LT

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Commissioning for Innovation and Quality (CQUIN)	The Commissioning for Quality and Innovation (CQUIN) payment framework enables commissioners to link a proportion of providers' income to the achievement of quality improvement goals. CQUIN schemes equate to 2.5% of the total contract value for providers. There are eight nationally set CQUIN schemes and all providers to which national CQUIN goals apply must work towards those that are applicable to them.
Common mental health conditions	Common mental health problems include depression and anxiety disorders, panic disorder, obsessive-compulsive disorder and post-traumatic stress disorder. Other common mental health problems include phobias about a specific thing or situations. These mental health problems are called 'common' because combined they affect more people than other mental health problems.
Co-occurring condition/dual diagnosis	Co-occurring disorders or conditions, also referred to as a dual diagnosis or comorbidity, is often used to describe a situation where an individual is diagnosed with more than one disorder at the same time, for example a mental health and substance use disorder.
Cross sectional study	Cross-sectional study design is a type of observational study design; the outcome and the exposures are measured in the study participants at the same time, and at one point in time. Cross-sectional designs are used for population-based surveys and to assess the prevalence of diseases.
Denominator	The total population, from which a subset (numerator) may be the subject of investigation or study. The number below the line in a fraction.
Dependent drinking	Characterised by craving, tolerance, a preoccupation with alcohol and continued drinking in spite of harmful consequences
DUDIT	Drug use disorders identification test. An 11-item self-administered screening tool for drug-related problems, giving information on the level of drug intake and selected criteria for substance abuse/harmful use and dependence
Electronic cigarette/vaping	An electronic cigarette is an electronic device that simulates tobacco smoking. It consists of an atomizer (a heating element that atomizes a liquid solution called e-liquid), a power source such as a battery, and a container such as a cartridge or tank. Instead of smoke, the user inhales vapor; using an e-cigarette is often called "vaping".
Excess under-75 mortality	a measure of the extent to which adults with a condition (i.e. severe mental illness) die younger than adults without it.
GP Patient Survey	An independent now annual survey run by Ipsos Mori on behalf of NHS England, sent out to over 2 million people across the UK, asking about their experiences of their GP practice. It includes questions about general health.

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Harm reduction	Harm reduction is a strategy or practice directed toward individuals or groups that aims to reduce the harms associated with certain behaviours, rather than to eliminate the behaviour altogether.
Harmful drinking	A pattern of alcohol consumption causing mental or physical health problems directly related to alcohol
Hazardous drinking	A non-diagnostic term for a pattern of alcohol consumption that increases someone's risk of harm. This can be mental and physical harm or social consequences
Healthy life expectancy	The number of years lived in self-assessed good health
Higher risk drinking	Drinking 35+ units (women) or 50+ units (men) of alcohol per week
Health Survey for England	Annual survey, sample of 8,000 adults. Those aged 25+ answer smoking and alcohol questions in face to face interviews, 16-17-year olds online and 18-24 have a choice of either. Latest release 2020 (collection 2019)
Increasing risk drinking	Drinking 15 – 35 units (women) or 15 – 50 units (men) of alcohol per week
Inequality	The uneven distribution of health or health resources as a result of genetic or other factors or the lack of resources. Inequity arises when these differences are unfair and avoidable.
Life expectancy	The average number of years a person can expect to live. Life expectancy at birth is defined as how long, on average, a new-born can expect to live, if current death rates do not change.
Lower risk drinking (termed by Southern Health as safe/sensible drinking)	Drinking up to 14 units of alcohol per week, for both men and women
Meta-analysis	The examination of data from a number of independent studies on the same subject, to determine overall trends. It involves a quantitative statistical analysis of the pooled data of several separate but similar experiments or studies.
Morbidity	The experience of a disease, illness or condition
Mortality	Death
Motivational interviewing	Motivational interviewing is a counselling method that involves enhancing a patient's motivation to change by means of four guiding principles, represented by the acronym RULE: Resist the righting reflex; Understand the patient's own motivations; Listen with empathy; and Empower the patient.
Nicotine replacement therapy	NRT is a medication that provides a low level of nicotine (the addictive element of cigarettes), without the tar, carbon monoxide and other poisonous chemicals present in tobacco smoke. It can help reduce unpleasant withdrawal effects, such as bad moods and cravings.

Opinions and Lifestyle Survey	Face to Face interviews with 7,100 people in Great Britain. (last collection including adult drinking habits was 2017, released 2018)
Premature mortality	Mortality rates for deaths under the age of 75
Prevalence	The proportion of a population who have a specific characteristic in a given time period. A representative sample of the population is usually used to estimate prevalence.
Prospective cohort study	a research study that over time follows a group of similar individuals (cohort) who differ with respect to certain factors, to determine how these factors affect rates of a certain outcome.
Quality outcomes framework (QoF)	The Quality and Outcomes Framework (QOF) is a system for performance management and payment, designed to remunerate general practices for providing good quality care to their patients, and to help fund work to further improve the quality of health care delivered. It was introduced in 2004 as part of the general medical services contract. Points are collected against a number of indicators.
(smoking) Quit rate	Of all those who attempt to quit smoking, the percentage who are abstinent from smoking at (usually) 4 weeks.
Severe mental illness	Refers to people with psychological problems that are often so debilitating that their ability to engage in functional and occupational activities is severely impaired. Schizophrenia and bipolar disorder are often referred to as an SMI.
Smoking attributable/conditions/ hospitalisations/ mortality	The ratio of the probability of the condition/hospitalisation/death occurring in the exposed group (smokers or ex-smokers) versus the probability of them occurring in the non-exposed group (never smoked), a relative risk, is combined with smoking prevalence information to create a smoking attributable fraction, which is the proportion of a disease that can be attributed to smoking.
Social gradient	A term used to describe the phenomenon whereby people who are less advantaged in terms of socioeconomic position have worse health (and shorter lives) than those who are more advantaged. A classic example of research on this subject is the Whitehall study of British civil servants.
Social norms	Rules and standards that are understood by members of a group, and that guide or constrain social behaviours; they often relate to a perceived social pressure to engage or not engage in specific behaviours.
Substance (mis)use	The use of alcohol, illegal drugs, or over-the-counter or prescription medications in a way that they are not meant to be used.
Systematic review	A research study that uses a clearly formulated question, systematic and reproducible methods to identify, select and critically appraise all relevant research, and collects and analyses the data from the studies

	that are included in the review so provide more robust evidence on the given topic.
Time series analysis	A time series is a number of data points ordered in time, tracking a sample over time. It can demonstrate what factors influence certain variables from during that time.
Very brief advice	Typically takes 30 seconds and follows the model Ask (for example, smoking or alcohol status), Advise (on quitting or reducing) and Act (build confidence, give information, refer). Brief advice takes slightly longer, 3 minutes or so, and includes more listening to the person's concerns and more open questions to explore the issues. Brief intervention can take up to 30 minutes and includes more specialist support.

3. Tables and Figures

Data, Intelligence & Insight Team
Southampton City Council, Municipal Block – West,
Civic Centre, Southampton, SO14 7LT

E-mail: strategic.analysis@southampton.gov.uk
Website: https://data.southampton.gov.uk/

4. Introduction

A decade has passed since life expectancy was found to be up to 17 years lower for a cohort of people with severe mental illness (SMI) in London[1]. There were similar findings for people with substance use disorders, particularly those drinking alcohol at dependent levels[2]. Excess premature mortality rates are more than three times higher amongst people with mental illness in England compared to the general population[3]. We also now know what people with mental illness are most likely to die from and at which ages; most notably circulatory and respiratory diseases under the age of 65[4]. People with SMI show a 78% higher risk for developing cardiovascular disease (CVD), 53% higher risk of having CVD, and an 85% higher risk of death from CVD compared to the general population[3].

The physical health conditions which contribute to premature death are 20-30% more likely for people with severe mental illness, in comparison to the whole population; that difference is even greater for people with two or more conditions (multi-morbidity), and those of a younger age[5]. People with severe mental illness can be five times more likely to have three or more physical health conditions aged 15-34, when compared with all those in this age group[5]. Some of the largest differences are seen for chronic obstructive pulmonary disease (COPD), heart failure and stroke[5]. People with severe mental illness living in the most deprived areas are even more likely to experience one or more physical health conditions, compared with people experiencing just one of these risk factors[5].

Smoking and alcohol are major contributors to circulatory and respiratory ill-health. Smoking is the second leading risk factor for all morbidity in England and alcohol the fifth[6]. For people aged 15 to 49 alcohol is the biggest risk factor for mortality, ill-health and disability[7]. Years of life lost in relation to smoking or alcohol are comparable, despite fewer alcohol-related deaths, as they tend to occur at a younger age than for smoking[7]. Smoking and drinking alcohol increase the risk of smoking-related cancer appreciably in comparison to people who do one or the other[7]. Obesity is now the leading risk factor for morbidity in England[6], and people with severe mental illness have 1.8 times the rate of obesity when compared to all those registered with a GP[5]; paired with alcohol at any level of consumption, the risk for liver disease doubles[7].

For people with severe mental illness, many years of taking antipsychotic medication is a factor in the higher prevalence of some cardiovascular, as well as metabolic, conditions, but does not account for all of the difference in risk[8,9]. It is of course harder to mitigate for the side effects of medication in the management of chronic and often enduring and complex severe mental illness, whereas other risk factors, like the physical health conditions they lead to, are wholly preventable.

Smoking prevalence has declined significantly in the general population over the last 10 years but has remained static for people with severe mental illness, at around 50% in Southampton[10]. It is estimated that a third of the cigarettes smoked in England are done so by people with mental health conditions[11]; smoking prevalence increases with severity of mental health experienced, as well as heavier smoking and higher levels of tobacco dependence[12]. A similar percentage of people open to mental health services use alcohol at harmful levels[13], an even higher percentage of people accessing drug and

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alcohol services report mental health needs[14] and also demonstrate a high prevalence of smoking. Not only is there an association between smoking and drinking alcohol, as well as with mental health, but people who do both are also more likely to experience the related harms; both contribute to risk from cardiovascular disease[15] as well as certain cancers[16]. Smoking and drinking alcohol impact on a person's mental as well as physical health.

The reasons for the high prevalence of smoking and alcohol consumption alongside severe mental illness are multifaceted; both can precede mental ill-health and be taken up following its development. The wider determinants of ill-health have a role to play and all three are linked to the experience of deprivation in some way – the prevalence of severe mental illness is higher in more deprived areas, as is smoking, and whilst overall alcohol consumption is often lower in comparison to less deprived areas, people in deprived areas are more likely to experience the harms from alcohol. Clustering of risk, and an accumulation of risk factors across the life course, will increase the likelihood of people experiencing ill-health and premature death. This is compounded by the inequality in experience and impact of mass media, social marketing and education programmes – these have contributed to the reduction in smoking prevalence for the general population whilst the prevalence amongst people with mental health conditions has remained high.

People who are supported by community mental health services have the potential to develop trusting and sometimes long-term relationships with healthcare workers, putting them in a unique position to help address risk factors such as tobacco and alcohol consumption. As well as improving life expectancy and healthy life expectancy, in the shorter term reducing the harm experienced from these addictions can improve a person's mental health as well as reduce the need for services. When people have poor mental health, it can be difficult to prioritise issues such as smoking and alcohol, but if we don't try, they will continue to die prematurely and disproportionately compared to those without mental health issues; this is a stark inequality.

A recent Kings Fund conference on improving the health and wellbeing of communities captured the essence of this - health makes a fundamental contribution to quality of life, the ability to live a fulfilled and enjoyable life, and impacts on the quality of life of those around us too[17].

4.1 Methodology

A health needs assessment is a systematic method of identifying the unmet health and health care needs of a group of people with a shared characteristic (which can be a shared geography, condition or use of service. The aim is to reduce those unmet needs and improve the health of the group, as well as contribute to a reduction in any health inequalities experienced by the group when compared to the general population.

Need is defined in several ways; normative, as defined by experts, felt, as perceived by individuals themselves, expressed in the form of help seeking and comparative, identified when there is a discrepancy between two similar groups. There is a difference between a need for health and a need

for healthcare; the latter is defined as having an illness or disability for which there is effective and acceptable care as well as a capacity to benefit from that care[18].

A health needs assessment can be epidemiological, comparative or corporate, or any combination of the three. This involves using quantitative data to describe the group of people and the characteristic of interest, comparing them to a similar group (for example in another geographical area) and seeking the views of stakeholders. This health needs assessment is a mixture of the epidemiological and corporate approach, described in table 1.

Table 1 Health Needs Assessment Methodology

Health needs assessment methodology includes	**In this instance included:**
Reviewing national and local policy	Relevant mental health, smoking and alcohol policy and strategy, as well as NICE guidance
Describing the population group, the issues it faces and existing services available to address those issues	Using Southern Health service data, with comparisons to the wider Southampton population as well as descriptions from published research and routinely available data Data from partner agencies was also utilised
Engaging all stakeholders for a richer understanding of what the quantitative data is telling us and including their views on required changes	From within Southern Health – frontline staff and divisional leaders Mental health and public health commissioners Voluntary sector partners
Searching the literature for evidence to support this local data as well as interventions that are effective in meeting the needs of the group.	Literature regarding smoking and alcohol prevalence amongst people with mental ill health, associations between smoking and alcohol use, as well as interventions that address smoking and alcohol use in this group of people

The findings of and recommendations from a health needs assessment must be presented back to the stakeholders and agreement secured for an action plan, its implementation and evaluation.

4.2 Aim and Objectives

The aim of this health needs assessment was to assess the current needs of Southampton City Council (SCC) residents who access Southern Health NHS Foundation Trust (SHFT) community mental health services, relating to their tobacco and alcohol use.
The specific objectives were to:

- Describe the epidemiology of Southampton City Council residents who access Southern Health NHS Foundation Trust community mental health services, and their use of tobacco and alcohol

- Describe the existing national and local tobacco control and drugs and alcohol policies
- Describe the current smoking cessation and alcohol support service provision for people who access Southern Health NHS Foundation Trust community mental health services and who use tobacco and alcohol, in Southampton, including any new developments
- Explore and present the range of stakeholder views on need and the current and potential for future service provision; providing a picture of what is working well and, where improvements are needed, what they might be
- Make recommendations based on this local intelligence as well as evidence-based interventions identified in the literature
- Develop an action plan and secure agreement for its implementation, monitoring and evaluation

4.3 Scope of the health needs assessment

Within the scope of this health needs assessment were the healthcare needs associated with use of tobacco and alcohol by Southampton City Council residents:

- who access Southern Health NHS Foundation Trust community mental health services
- are aged 18+

Despite the broadness of the approach, the following were outside the scope of this assessment:

- people admitted to inpatient services
- people accessing the eating disorder service
- Older People's Mental Health (OPMH) – staff were consulted but no data was included
- Southampton City Council residents with SMI who access services not delivered by Southern Health (i.e. primary care, voluntary sector)
- Hampshire County Council residents (and anyone else not resident within Southampton) who access Southern Health NHS Foundation Trust Mental Health Services
- The mental health needs of this group
- Future need – the focus of this health needs assessment was current unmet need

4.4 Limitations

There are a number of limitations associated with this heath needs assessment to be aware of. The main limitation, and of some significance, is the percentage of people using community mental health services in Southampton without a recorded smoking or alcohol status. Prevalence of smoking and alcohol use in this population has therefore been estimated using other sources of information. The accuracy of the data and what it tells us must be approached with caution; it reflects what is recorded, as well as how it is recorded, but not necessarily routine practice or the care that has been delivered. Data on diagnoses was not available; any differences in smoking and alcohol use by mental health condition could not be explored, which may have added some richness to the recommendations. In particular, the number and percentage of people in this group with co-occurring mental health and substance use conditions is not included.

Other data that are missing include from the Southern Health Older People's Mental Health service, as well as the drug and alcohol service for under 25-year olds in Southampton. The latter would have been helpful for a wider whole system perspective and to broaden the scope of any recommendations. The percentage of staff who are current smokers was not available for this health needs assessment, nor was levels of alcohol consumption; the former however is known to contribute to the culture in mental health services of acceptance of high smoking prevalence and would therefore have been useful to know. If this culture is to be addressed in the future, support for staff to stop smoking will need to be offered, and therefore the level of need estimated.

Where available, local service data has been compared to other mental health populations, to add to the narrative about how people with severe mental illness experience tobacco and alcohol use. However, these data were not always available particularly for people with severe mental ill-health as opposed to any mental health condition. In these circumstances, comparisons were made with either the general population or with people who have common mental health conditions. The views and experiences of people who use community mental health services are missing and this has limited the conclusions that can be drawn from the stakeholder engagement, instead they have been represented by reports and publications mainly from the voluntary sector. The alcohol care team at the local acute trust were not fully engaged, and their perspective may have been a useful addition. The cost implications of the recommendations have not been estimated but will need consideration.

Some of these omissions were as a result of the pragmatic approach taken during the Covid-19 pandemic. Despite these limitations, it is hoped that what is presented is sufficient to make meaningful recommendations and assist with service planning and workforce development.

Some of the topics touched on in this health needs assessment are addressed more fully in other recent Southampton health needs assessments as well as the single needs assessment for the city: https://data.southampton.gov.uk/data-and-resources/needs-assessments/

5. Background

The case for smoking and alcohol related ill-health and premature death and how this is experienced by people with severe mental illness was described in the introduction. Why this is a problem for Southampton, warranting the focus of a health needs assessment, will be explored in this section.

5.1 Southampton

Southampton has an estimated resident population of 256,459[19]. Between 1991 and 2018, the resident population rose by 23.5%, and is expected to rise a further 6.5% by 2025, to 273,020. Whilst the largest increases are predicted for the over 65 year olds, the 40-44 year old population is expected to increase by nearly 15%, with similar rises in older children and young people[19]; this could have an impact on mental health services as more than 75% of adults who access mental health services have a diagnosable disorder prior to the age of 18[20]. The absolute increase in population will also affect service capacity if the same percentage, or slightly higher, experience severe mental illness. The current prevalence of severe mental illness in Southampton is 1.1%, a slight decline in the latest year following an increasing trend for the past seven but remaining higher than the England average (0.93%)[21]. This prevalence is likely to differ across Southampton, with higher proportions of people with mental health conditions in the more deprived areas[5].

Life expectancy at birth in Southampton has stalled more recently for both men and women and has even fallen in some years. In 2015-17, it was 82.4 years for women and 78.3 for men, compared with 83.1 and 79.6 for England as a whole[22]. The difference in life expectancy between Southampton and England is mainly accounted for by deaths due to circulatory and respiratory conditions as well as cancer[22]. There is also inequality in life expectancy at a local level; the gap between those living in the least and most deprived areas is 6.6 years for men and 3.1 years for women. The single biggest contributors to this are lung cancer and respiratory diseases[22], reflective of the significance of the higher smoking prevalence in those more deprived parts of Southampton. The factors which contribute to people who live in more deprived areas being more likely to experience risk factors and conditions such as smoking, severe mental illness and reduced life expectancy include wider social factors - unemployment and poverty – and lack of support, stigma and isolation which act as barriers to accessing care[23].

Whilst deprivation contributes to the inequality experienced by people with severe mental illness, it does not fully explain it; even after controlling for this they are still more likely to have the physical health conditions that contribute to premature mortality and excess deaths[5]. Southampton experiences worse mortality and morbidity as a result of smoking, alcohol and severe mental illness than the average for England, as the following tables demonstrate. This is likely to be as a result of the higher smoking prevalence in Southampton overall as well as for people with severe mental illness specifically, the large percentage of people in Southampton who live in the 30% most deprived areas nationally, and for alcohol, the recording of information will also be influenced by the presence of an alcohol care team at the main hospital.

Table 2 Mortality indicators in adults for smoking, alcohol and severe mental illness, Southampton and England

	Southampton	England
Smoking attributable mortality, per 100,000 (2017-19)	261	202
Mortality rate from chronic obstructive pulmonary disease (COPD) per 100,000 (2017-19)	72	50
Alcohol related mortality per 100,000 (2018)	57	46
Alcohol specific mortality per 100,000 (2017-19)	17	11
Mortality from chronic liver disease per 100,000 (2017-19)	24	16
Premature mortality in adults with severe mental illness, per 100,000 (2016-18)	110	95
Premature mortality due to cardiovascular disease in adults with severe mental illness, per 100,000 (2016-18)	23	18
Excess under 75 mortality rate in adults with severe mental illness (%) (2016-18)	325	365
Excess under 75 mortality rate due to cardiovascular disease in adults with severe mental illness (%) (2016-18)	333	306
Excess under 75 mortality rate due to cancer in adults with severe mental illness (%) (2016-18)	92	113
Excess under 75 mortality rate due to liver disease in adults with severe mental illness (%) (2016-18)	333	541
Excess under 75 mortality rate due to respiratory disease in adults with severe mental illness (%) (2016-18)	406	520

Source: Public Health Profiles, 24.8.21

Compared with people who are not, those in Southampton who are in contact with mental health services are more than three times more likely to die prematurely from cardiovascular and liver disease, and more than four times from respiratory disease. Alcohol related and specific mortality for men in Southampton is even higher than for all (89 and 25 per 100,000), and the gap between the local and England rates wider (vs 67 and 15 per 100,000)[24]. The average age of death from mental and behavioural disorders due to use of alcohol in 2014 was 57.5 years[7]. Some excess death indicators are better for Southampton in comparison to England, which could be due to the higher underlying rate of deaths from these conditions for the general population in Southampton.

Table 3 Morbidity indicators in adults linked to smoking and alcohol, Southampton and England

	Southampton	England
Smoking attributable hospital admissions per 100,000 (2019/20)	1,901	1,398
Emergency hospital admissions for COPD per 100,000 (2019/20)	677	415
Admission episodes for alcohol related conditions per 100,000 (narrow) 2018/19	857	644
Admission episodes for alcohol related conditions per 100,000 (broad) 2018/19	4,022	2,367
Admission episodes for alcohol specific conditions per 100,000 (narrow) 2019/20	2,590	644

Source: Public Health Profiles, 24.8.21

Alcohol and mental illness have a significant impact on acute secondary care; hospital admissions in England for cardiovascular disease accounted for almost half of all alcohol related admissions in 2014/15, with mental and behavioural disorders being the second most common admission[7]. This will no doubt increase demand for psychiatric liaison services within acute trusts.

5.2 Costs of Smoking and Alcohol

The costs of smoking and alcohol are entirely preventable, unlike those attributable to mental ill-health[11]. The charity Action on Smoking and Health (ASH) has a tool for estimating the costs of smoking for local authorities. For Southampton, it estimates the annual cost of smoking to society as £56 million; £41 million lost from the local economy due to lack of productivity, and £10.8 million in costs to the NHS, as well as £3.2m for social care[25]. In its seminal report on smoking and mental health, the Royal College of Physicians estimated the total annual cost to the NHS from diseases caused by smoking in people with severe mental illness was £719m[11]. The economic costs for alcohol consumption are more difficult to estimate, although it has been attempted. One such estimate in 2016 suggested it was £47 million annually, including indirect costs such as loss of productivity and healthcare costs[7]. Other evaluations suggest the direct cost to the NHS as a result of alcohol attributable conditions in 2005/06 was £3 billion[7]. Whilst the healthcare costs relate mostly to acute secondary and primary care, the impact smoking and alcohol use has on the further deterioration of a person's mental health will bear a cost, however difficult to separate out. Wider harms as a result of alcohol consumption to society, such as crime, and to families and individuals such as financial instability, violence and the experience of anxiety are difficult to quantify[26].

5.3 Impact of Covid-19

The Covid-19 pandemic, specifically the restrictions in place since March 2020, is likely to have affected tobacco and alcohol use. Published in August 2020, the YouGov COVID-19 Tracker[27] found smokers with existing mental health problems were more likely to have quit successfully than other smokers (10% vs 7%). However, smokers with mental health problems were also more likely to report they were smoking more (40% vs 26%). Other evidence also indicates a reduction in smoking, but this

was most likely amongst younger people and those who were light smokers[28]. A number of studies investigated the potential for changes in alcohol use particularly during and after the periods of lockdown and most have found increases in alcohol consumption[28,29,30]. There is evidence to suggest that high risk drinking increased[31] particularly among people from disadvantaged social grades, and attempts to reduce the amount of alcohol being consumed only increased in those who are more advantaged[32]. Increases in alcohol use were also found to be associated with poor overall mental health, increased depressive symptoms and lower mental wellbeing[30].

5.4 Policy and Publications

There have been many policies and publications over the last two decades that have to a lesser or greater extent touched on mental health, smoking, alcohol use and physical ill-health disparities.

5.4.1 National

Dual Diagnosis Good Practice Guide, 2002[33]

This guide aimed to summarise policy at the time of publication and good practice in relation to providing services for people with both severe mental illness and substance use. It states, nearly 20 years ago, that substance use by people with mental health conditions is usual rather than exceptional, requiring high quality, patient focused and integrated care – delivered within mental health services, with substance use services providing treatment and advice. It states that integrated care, delivered by one team, produces better outcomes than sequential or parallel care, but recognises that parallel care may be a required stepping-stone to this model. It deems the necessary components for developing this to be input from all local stakeholders, a local strategy for service delivery and one for training.

No health without mental health, 2011[34]

One of the ambitions of this mental health strategy was for fewer people with mental health problems to die prematurely. It outlined the link between poor mental health and high rates of smoking and alcohol use, the need for access to support services, better coordination between mental health and drugs and alcohol services and fully integrated care when appropriate.

Alcohol Strategy, 2012[35]

Following the first national alcohol strategy in 2004, there have been updates in 2007 and 2012. In 2018, the Government committed to writing a new strategy, which is still pending. In this now 9-year-old strategy, there is some mention of the relationship between alcohol and mental ill-health but defers the detail to the coming implementation plan for the Mental Health Strategy.

The Mental Health Five Year Forward View, 2016[36]

This paper pledged to contribute to improving mental health care by levelling up physical and mental health. It introduced a number of ambitions for people with severe mental illness in terms of smoking, alcohol dependency and physical ill-health. It recognised the link between reduced life expectancy and avoidable physical illnesses, as well as risk factors such as smoking. A key deliverable for 280,000

people to have their physical health needs met was introduced, including an annual check but also interventions to address risks identified. It asked for extra efforts to reduce smoking in this population and for inpatient services to be smoke free by 2018. It recognised the challenges represented by separate services for mental and physical health as well as drug and alcohol use and the complexity that brings to patient pathways.

Tobacco Control Plan, 2017[37]

In this strategy the government set out commitments with regards smoking and mental, including:

- improving data collection
- making all mental health inpatient sites smoke free by 2018 (and outlined that this 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 as a way to build relationships with patients or used as an incentives) whilst noting the importance of community settings
- access to training for all health professionals
- parity of esteem in supporting people with mental health conditions
- reducing the prevalence of smoking in people with mental health conditions.

It highlighted that some staff mistakenly believe that stopping smoking could negatively affect their patients' mental health, when it can actually reduce symptoms of anxiety and depression, that people with mental health conditions have an equal right to be asked whether they smoke and to be offered effective methods to quit smoking or reduce harm (a full range of evidence-based treatment options) – it described an urgent clinical need to improve the support they receive.

Better Care for people with co-occurring mental health and alcohol/drug use conditions, a guide for commissioners and service providers, 2017[38]

This guide outlines two key principles for the care of people with co-occurring conditions, everyone's job (joint responsibility, working together to meet need) and no wrong door (all services have an open door, make every contact count, and offer treatment for any of the co-occurring conditions). It also states that smoking should be a routine part of care. It suggests this is achieved via a pathway of care and collaborative delivery, a named care coordinator overseeing care across agencies, and pathways for accessing other services. Shared ownership and leadership as well as a competent (knowledge, skills and values) workforce is required.

Commissioning for Quality and Innovation (CQUIN) 2017 – 2020[39]

CQUIN is a payment framework linking a proportion of a service providers income to the achievement of outcomes related to improving the quality of care. In 2017, the preventing ill-health by risk behaviours CQUIN encouraged providers to screen and offer brief advice for smoking and alcohol use for all those admitted as inpatients. The alcohol and tobacco screening and brief advice CQUIN followed on from this in 2019. Both required providers to screen and offer an intervention to a percentage of inpatients in order to receive the payment.

The NHS Long Term Plan, 2019[40]

The overall aim of the NHS Long Term Plan (LTP) is to achieve improvements in care over the next 10 years by overcoming the challenges faced by the NHS. Prevention is central to this by maximising the potential for reducing demand created by preventable illnesses. It introduced a universal stop smoking offer for long term users of specialist mental health services by 2023/24. More recently, the delivery model for this offer has been released and includes recording of smoking status for every person admitted to hospital, opt-out referral to an in-house specialist adviser, access to appropriate pharmacotherapy, and a plan to quit rather than abstain for the duration of their admission[41]. It emphasises that 'smoking cessation' isn't prevention, it's treatment[42]. The model for community mental health services is yet to be decided. The alcohol focus of the LTP is alcohol care teams in acute trusts. There are no other commitments in the plan related to alcohol, and there is no mention of alcohol identification and brief advice for the general population or those more at risk of drinking at increasing and higher risk levels. The LTP reaffirms the commitment to addressing the greater risk of poor physical health experienced by people with severe mental illness and the ambition to increase the numbers having an annual physical health check.

Green Paper on Prevention, 2019[43]

This paper reiterates the links between smoking and drinking alcohol, ill-health and inequalities, it recognises the work still required to reduce the numbers of people smoking and drinking as well as the harms experienced as a result, and the disproportionate burden on those in society with the least. There is a proposal for a smoke free England by 2030, and further support for the ambitions of the NHS Long Term Plan, as well as a new alcohol strategy.

The Community Mental Health Framework for Adults and Older Adults, 2019[44]

This framework sets out the vision for a new place-based community mental health model, driving forward the integration of mental and physical health and social care and modernising community mental health services to shift to whole person approach. Improving quality of life is one of the six aims of delivering good mental health support in the community, as is promoting mental and physical health and preventing ill health. There is a strong focus on people with co-existing mental and physical health problems, and the impact that has on the complexity of care required. There is no mention of smoking specifically but support for people with co-occurring mental health and substance use conditions is prominent, with suggestions for the establishment of formal links between services.

NHS Right Care[3]

This toolkit defines the core components of an optimal service for people with SMI who are at risk of developing cardiovascular disease, including early detection of CVD risk factors in people with SMI via screening, assessing and monitoring, a CVD prevention pathway and dedicated appointments with mental health trained staff to undertake checks, long term management of modifiable risk factors, personalised care planning, strong clinical leadership to champion physical healthcare of people with SMI and a proactive culture, as well as specifically stop smoking interventions and brief advice for alcohol use.

NICE

A number of National Institute for Health and Care Excellence (NICE) clinical guidelines are applicable to the management of tobacco and alcohol use in mental health services.

Psychosis and schizophrenia in adults: prevention and management [CG178][45]

This guidance contains recommendations pertaining to the physical health of people with psychosis or schizophrenia, and in particular their cardiovascular risk, including physical health checks, offering a combined healthy eating and physical activity programme, and help to stop smoking (even if previous attempts have been unsuccessful) using nicotine replacement therapy (NRT), bupropion (people with schizophrenia only) or varenicline.

This guidance is used to inform the physical health elements of *CG185 Bipolar disorder: assessment and management*.

Smoking: acute, maternity and mental health services Public health guideline [PH48][46]

This guidance sets out 16 recommendations for helping people stop smoking when in contact with one of these services, including offering information, identification, intensive support, involving family/carers, pharmacotherapies, referral systems, leadership and policies, supporting staff to quit and with training, inclusion in local strategies, and commissioning stop smoking services in secondary care. The Public Health England (PHE) self-assessment tool[47] is based on the recommendations in this guidance and provides a framework to help mental health trusts develop local action to reduce smoking prevalence and the use of tobacco within secondary care mental healthcare settings.

There are a further two guidelines regarding smoking – *NG92 Stop smoking interventions and services*[48] and *PH45 Tobacco: harm-reduction approaches to smoking*[49], which also advice on supporting people to stop smoking, and the extra input people who are highly dependent on nicotine may require, including harm reduction approaches such as long-term use of nicotine-containing products.

Cardiovascular disease: identifying and supporting people most at risk of dying early [PH15][50]

This guidance is not specific to mental health settings but relates to all smokers and therefore should be applied in the care of people with mental illness who consume tobacco. It covers the risk of early death from heart disease and other smoking-related illnesses, aiming to reduce the number of people who are dying prematurely through better access to treatment and support. It recommends actions for identifying adults at risk of premature death from cardiovascular disease, offering proactive support and easily accessible care that meets the specific needs of those most vulnerable. As with most guidance, it suggests staff must be appropriately trained to do so.

Coexisting severe mental illness (psychosis) and substance misuse: assessment and management in healthcare settings Clinical guideline [CG120][51]

This guideline covers assessing and managing people with coexisting severe mental illness (psychosis) and substance misuse - to improve treatment adherence, and to enhance their lives by stabilising, reducing or stopping their substance misuse. For secondary mental health services it makes recommendations regarding the competence of staff to recognise and care for adults with co-occurring conditions, accessing training from specialist services, offering treatment for both

Data, Intelligence & Insight Team
Southampton City Council, Municipal Block – West,
Civic Centre, Southampton, SO14 7LT

E-mail: strategic.analysis@southampton.gov.uk
Website: https://data.southampton.gov.uk/

conditions within the mental health service, and initiating joint working and/or seeking advice from specialist services, whilst maintaining responsibility for care coordination.

Coexisting severe mental illness and substance misuse: community health and social care services NICE guideline [NG58][52]

This guideline covers how to improve services for people who have been diagnosed as having coexisting severe mental illness and substance misuse, providing a range of coordinated services to address people's wider health and social care needs, as well as other issues such as employment and housing. It also identifies that people with co-occurring mental health and substance use conditions may have physical health conditions which need to be assessed, and interventions offered to address, such as diet, exercise and stop smoking. The guidance highlights that to achieve this, joint training between mental health and specialist substance use services should be considered, and leadership across all services is required.

Alcohol use disorders: prevention (PH24)[53] *(currently being updated)*

Regarding the assessment and offering interventions for alcohol use, this guidance recommends that NHS-commissioned services have an identified person providing strategic direction, governance structures and supervision to those providing screening and brief interventions, that staff have the resources to carry out screening and brief intervention work effectively and are sufficiently trained to do so (including extended interventions where the need demands it).

5.4.2 Local Policy

Southampton's last tobacco control plan ran from 2014 – 2016[54] smoking prevalence is highlighted in the Health and Wellbeing Strategy for the city (2017 – 2025)[55] and is a key measure for its success. Alcohol is a local priority, supported by the Southampton Alcohol Strategy (2017-2020)[56], Southampton 5-year Health & Care Strategy: Prevention & Health Inequalities Sub-Group (2019 to 2024)[57] and the Southampton Health and Wellbeing Strategy (2017-2025)[55]. Currently in development is a system wide self-assessment for co-occurring conditions, overseen by a multi-agency strategic steering group, to improve understanding of local need, develop shared vision and policy, and coordinated training and approach to assessment and interventions, with input from experts from experience.

6. Services

52% of people accessing community mental health services had neither smoking nor alcohol status recorded. It is therefore difficult to say anything about patterns of smoking and alcohol use amongst this group of people. This was particularly true for any differences by ethnicity.

Alcohol use is grossly underestimated in this data, recorded as being less than the general population, which is counter to what is known about mental ill-health and alcohol consumption.

Smoking prevalence including all those without a recorded status was 22% and excluding them was 46%. Between 600 and 1,200 people accessing community mental health services may require tobacco dependency treatment.

The Early Intervention Psychosis team had the highest smoking prevalence and highest percentage of recorded status for both smoking and alcohol.

The Acute Mental Health team had the highest percentage of smoking status unrecorded – 71% - and similarly for alcohol, but despite this had the highest prevalence of dependent/harmful/hazardous drinking.

For those with smoking status recorded, a higher percentage were younger and male, and the majority lived in the 30% most deprived areas.

When it has been recorded, a higher percentage of men drink at dependent/harmful/hazardous levels than women, older age groups at dependent levels and younger at harmful/hazardous.

15% of smokers were drinking at dependent/harmful/hazardous levels and 53% of those drinking at these levels were smokers.

In the alcohol service in the most recent year, 73%of people were receiving treatment from mental health services, 53% from their GP.

6.1 Community Adult Mental Health Services

Southern Health NHS Foundation Trust is an NHS organisation delivering community health, mental health and learning disability services across Hampshire and Southampton – it is structured through five divisions, one of which covers the Southampton area. Southern Health is commissioned by the Hampshire, Southampton and Isle of Wight Clinical Commissioning Group (CCG) to provide community and inpatient mental health services for the residents of Southampton. This is delivered via a number of different community teams, all with their own criteria for assessment following referral by a GP or other health professional.

Acute Mental Health Team (AMHT)

The Acute Mental Health (Crisis Resolution Home Treatment) Team support service users who require crisis support as a result of a relapse in their mental health, via assessment and short-term treatments. Among a number of aims for the service, they provide intensive support at home to avoid admission where possible, facilitate early discharge from hospital and also 48 hour and seven day follow up. Service users are referred from a range of primary and secondary services and discharged back to CMHTs, primary care, social care and other community services.

Community Mental Health Teams (CMHT)

Community Mental Health Teams provide a local single point of access for individuals who present with severe, complex and enduring mental health problems and offer community-based functions and interventions. All referrals are screened and categorised for response and assessment within at least 7 weeks. The criteria for acceptance into the service include a poor response to previous mental health treatment in primary care, history of violence or persistent offending, being at significant risk of persistent self-harm or neglect, dual diagnosis of severe mental illness and substance misuse, mental health illness which means that the individual is unable to carry on caring for a child or the child may be at risk of harm, neurodegenerative disease with associated mood or psychotic disorder where needs are best met by Adult Mental Health Services, assessed in Increasing Access to Psychological Therapy (IAPT) services as needing a specialist mental health treatment and military veterans with severe and persistent mental health difficulties which are likely to be related to their service in the armed forces.

There are three teams in Southampton covering the three geographical localities and the GP surgeries associated with them:

- East
- West
- Central

Early Intervention Psychosis Team (EIP)

A dedicated multidisciplinary team supporting individuals aged between 14-35 years old experiencing a first episode of psychosis (FEP) presenting for the first time to mental health services and who have either not yet received any antipsychotic treatment or have been treated for a psychotic episode for

less than one year within secondary mental health services, for the first three years of experiencing psychotic symptoms. Core clinical symptoms of FEP include hallucinations and delusions, often accompanied by 'negative symptoms' such as emotional apathy, lack of drive, poverty of speech, social withdrawal and self-neglect.

Assertive Outreach Team (AOT)

One team works across Southampton managing those with longstanding psychotic disorders and who haven't previously engaged with community mental health services – they are referred to the team by EIP and CMHT.

For context, different criteria are used in primary and secondary care when describing those who may require care for their mental health; severe mental illness, for inclusion on the primary care register, is based on the Quality and Outcomes Framework (QoF) definition – all individuals who have received a diagnosis of schizophrenia, bipolar affective disorder or who have experienced an episode of non-organic psychosis.

6.2 Other services that community mental health service users might access for smoking and alcohol needs

Stop smoking services were rolled out nationally in 2000. Historically, Southampton had a specialist stop smoking service, Southampton Quitters, which was funded by the public health grant and was commissioned to deliver a universal specialist stop smoking service. In April 2017 a new integrated health improvement and behaviour change service, Southampton Healthy Living, was commissioned to replace the Quitters service as well as other services; it was de-commissioned in March 2019 by mutual agreement.

Stop smoking support in Southampton is currently provided by a number of different services:

- 10 local pharmacies provide universal stop smoking support including free pharmacotherapy and behavioural support.
- Universal stop smoking support including free pharmacotherapy and behavioural support provided by maternity services
- GP practices have been encouraged to continue prescribing smoking cessation pharmacotherapy, with the medication costs funded by Southampton City Council with no time limit to the length of time patients can be prescribed these medications. Patients also pay prescription charges unless they are exempt. For behavioural support GPs would refer patients to local pharmacies or the national Smoke free website. People experiencing mental ill health would be asked their smoking status and offered an intervention as part of QoF, as well as the NHS Health Check and annual SMI check (that some people open to mental health services may have in primary rather than secondary care), depending on eligibility.
- A new service commissioned from 1st April 2021 - Southampton Smokefree Solutions - to build capacity, knowledge and skills by offering training, quality assurance, advice and support to providers and their front line staff with a particular emphasis on the more vulnerable groups, and providing an operational service to a small number of more complex individuals.

- Community Wellbeing Team, provided by Solent Medical Services; they work with GP surgeries to contact people on the SMI register and encourage them to attend for their physical health check, or go out to their home and undertake the check. This includes an assessment of smoking status, followed by brief advice, and the team also has their own smoking cessation service, with level 2 trained smoking cessation advisers, which they offer to all those recorded as a smoker on the systems of GPs signed up to this element of their service. This currently includes all surgeries in the West and one in the East localities. They are hoping to increase their knowledge and skills regarding working with people with SMI, by undertaking the specialist training modules and linking up more with the arm of the team that undertake the checks. The service has links with Southern Health and uses these to ensure people who are on the SMI register and open to secondary care have a check and that it is communicated with their GP.

Support for people living in Southampton and using alcohol above the recommended lower risk drinking guidelines is provided by:

- Change Grow Live (CGL), commissioned by Southampton City Council to provide drug and alcohol support services for people aged 25 and over. People can self-refer and will be offered different levels of support depending on the amount of alcohol being consumed and level of harm experienced. This includes a telephone helpline, one to one sessions and group work.
- No Limits, commissioned by SCC to provide drug and alcohol support services for people aged 24 years and under, operating in a similar way to CGL.
- GPs via alcohol screening and brief intervention; it is offered to all new patients when they register at the surgery as part of the GP contract, and ideally opportunistically to anyone attending for an appointment. It is also part of the NHS Health Check and the SMI annual health check.
- Community Wellbeing Team, provided by Solent Medical Services, as above; the physical health check includes an assessment of alcohol consumption using AUDIT-C, delivering brief advice, information on online resources and referral to CGL if required. They are also looking to increase their knowledge and skills around working with people who drink at increasing and higher risk levels.
- Alcoholics Anonymous; there are a number of meetings on different days in the area, the only requirement to be a member is a desire to stop drinking alcohol. People can be open to other services at the same time.

Other services not specifically commissioned/provided for smoking and alcohol, but people might access to support their mental health, which may also be able to offer initial support and signposting:

- Solent Mind offer a support line, peer support, community navigation and out of hours support for people with mental health issues and is self-referral.
- Southampton Mental Health Network led by Communicare in Southampton (who offer befriending, shopping, home maintenance and transport to those experiencing isolation and loneliness).

As far as can be determined, there is currently no 'pathway' for referral between secondary and primary or community services for smoking and alcohol, or within Southern Health from inpatients to community.

6.3 Southern Health Policy

Southern Health has four strategic priorities for 2021 through to 2023. The first priority is to improve health and wellbeing to enable more people to enjoy healthier lives, particularly the most vulnerable, contributing to a reduction in population levels of long-term conditions and their associated complications and an increase in life expectancy, with targeted support for inpatients and staff as well health checks in the community. Southampton Division's Plan for 2021/22 supports this strategic priority with a focus on improving physical health monitoring through increasing the number of staff trained to deliver it and linking in with GPs. Physical health checks and monitoring include asking and recording smoking and alcohol status.

Smoke Free Policy

Southern Health NHS foundation Trust became a smoke-free organisation on 1st May 2019; its smoke-free policy prohibits the use of all tobacco products on or in any Trust property. Southern Health also adopted the relevant national commissioning for quality and innovation (CQUIN) indicators including preventing ill health by risky behaviours – alcohol and tobacco (2017 – 19) and alcohol and tobacco screening and brief advice (2019 – 20)[39].

The aim of the policy is stated as providing a smoke-free environment and supporting health promotion (protect people from exposure to smoke, encourage and support people to become free of nicotine addiction). The stated purpose of the policy is to:

- Comply with smoke-free legislation.
- Ensure that all services are delivered from completely smoke-free environments.
- Identify the roles and responsibilities of staff and service areas.
- Clarify the rights and expectations of patients and visitors.
- Identify the support available to patients and staff.
- Embed care planning that supports smoking cessation.
- To aid the mitigation of unwanted fire or smoking related environmental events.
- Provide guidance on the management of any breach.

In the policy Southern Health recognises the legislation and what it signifies for organisations, but also that smoking is the single largest preventable cause of ill-health and premature death in England, smoking prevalence is high among people with mental health problems, especially those admitted to hospital, and states it is committed to improving the health and wellbeing of its patients, carers, staff and visitors. It also includes a desire to promote the NHS ambitions of a smoke-free generation, smoke-free environments as the social norm and to offer clear smoking cessation treatment pathways for patients and staff. It outlines the various roles and responsibilities for Executive Directors, managers, staff, clinical managers, patients and visitors, patients in the community, Human Resources and Facilities, covering inpatient and community care, including:

- Providing information on the harms from smoking
- Care plans for risks of smoking
- Offering effective psychological and behavioural advice to support quitting
- Training for staff
- Not facilitating patients smoking

- Supporting the use of e-cigarettes as a harm minimisation tool.

The policy does not go into operational detail about when, how and with what frequency service users should be asked their smoking status or offered interventions to stop smoking.
Southern Health also has NRT Treatment Guidelines – these are specifically for inpatients and therefore not within the scope of this health needs assessment.

Dual Diagnosis Policy (Substance Misuse and Mental Health Problems)

This policy is currently being reviewed by the Clinical Effectiveness Group, with plans to introduce a supporting procedural document which has been part of a pilot between some Hampshire based CMHTs and their local drug and alcohol teams.

The policy sets out how Adult Mental Health Services provide integrated services for individuals with a dual diagnosis of mental illness and substance misuse including arrangements for managing the risks associated with dual diagnosis in collaboration with Substance Misuse Services; service access, pathway arrangements and care responsibilities for both services. The policy recognises that 'dual diagnosis' covers a broad spectrum of mental health and substance use conditions, and the relationship between the two which may manifest as a primary psychiatric illness precipitating or leading to substance misuse, substance misuse worsening or altering the course of psychiatric illness and/or intoxication and/or substance dependence leading to psychiatric symptoms or illness.

The policy details the responsibilities for Executive and Divisional Directors, Leads, Area, Team and Ward Managers, Team Leads and Practitioners including:

- full assessment of both mental health and substance use needs, including risk assessments, to identify co-morbidity
- completion of AUDIT and DUDIT at initial assessment, discharge and in-between according to need (at least annually)
- Providing care, with appropriate allocation to staff, and referral to drug and alcohol services
- Access to training and clinical supervision for staff (dual diagnosis level 1 is specified within the policy, for Team Leads)
- Working collaboratively with substance misuse services, specifically 'Joint working may not be necessary in every case, particularly in cases where staff have the necessary skills to work with service users with co-existing mental health and substance misuse needs. However, in more complex cases where the service user is open to both services, joint working should occur'.
- Acting as a resource for Substance Misuse staff on mental health issues

Physical Assessment and Monitoring Policy & Physical Assessment and Monitoring Procedure for Mental Health and Learning Disability Services (including Older Person's Mental Health)

This policy is also being reviewed by the Clinical Effectiveness Group. It states the purpose of the policy is to provide minimum standards for physical health assessment, monitoring and management of identified physical health needs in both inpatient and community settings, and in relation to smoking and alcohol use covers:

- Initial and on-going examination and/or clinical risk assessment of existing and new patient/service user to ensure early identification of physical health problems
- Timely investigation, monitoring and follow-up of physical health problems, including appropriate referral to other health services as necessary
- Promotion of positive lifestyle change e.g. healthy eating, smoking cessation, where indicated
- Improve service users' awareness and adequate knowledge of the potential side effects of their medications and lifestyle behaviours which may affect their physical and mental health
- Being aware of previous use of alcohol, nicotine and other substances which could adversely affect management of both physical and mental wellbeing.
- Raising awareness of accessing health promotion/ screening/ primary and secondary physical health care.
- Offering education and training to ALL clinical staff in order to develop clinical decision-making skills in physical health assessment monitoring.
- It is the responsibility of all Southern Health NHS Foundation Trust staff to be actively involved in health promotion which should include open discussion and use of appropriate literature.

The procedure document is separated into inpatients and community assessment and monitoring, and describes an initial assessment including smoking and alcohol history but not the frequency at which they should be assessed thereafter; that issues should be communicated to the GP and/or psychiatrist, and training for staff, although doesn't specify smoking and alcohol interventions or training.

Making Every Contact Count (MECC)

Southern Health have a MECC strategy in which it states it is committed to embedding the principles of MECC across the organisation to enhance the quality of every discussion that is held with the people they support. MECC is an approach to behaviour change, via healthy conversations, that enables the opportunistic delivery of consistent and concise healthy lifestyle information and supports informed decision-making to enhance wellbeing. This would include discussions around healthy eating/healthy weight, physical activity, alcohol, smoking, and emotional wellbeing and mental health. Southern Health MECC accredited trainers and Learning and Development (LEaD) are coordinating a programme of training – paused during the first year of the pandemic but now restarting – which prioritises key staff groups (not including those working in mental health teams) but is open to all staff via the LEaD booking system.

6.4 Service Data

There are a number of nationally available indicators which suggest mental health services in Southampton are already busier each year. The rate of new referrals to secondary mental health services increased from just over 13,135 per 100,000 in 2017/18 to 14,620 per 100,000 in 2018/19[58]. The rate of attended contacts in community secondary mental health services also increased from 73,535 per 100,000 to 80,270 for the same time period[58]. Whilst a person could have more than one referral, and multiple contacts, and with only two data points it is difficult to predict a trend, this could indicate a growing need for secondary mental health care and people with increasingly complex needs.

6.4.1 Southern Health Data

All teams within Southern Health use the same electronic patient records system – Rio. The information entered into this system can be pulled through to the performance reporting system, Tableau. The current open caseload for adult mental health in Southampton Division was captured as of 30th April 2021 for further analysis. This total, 3,055, included 302 service users who were not residents within the Southampton local authority area (235 were from Hampshire, Isle of Wight and Portsmouth, the rest further afield); they have been excluded from this analysis. A caseload of 2,753 is in line with other data, for example prevalence of severe mental illness in Southampton and the number of people registered with a GP and noted as having a severe mental illness.

Table 4 Southampton Division Adult Mental Health open caseload, 30.4.21

Service	Number of service users	Percentage of total caseload
Community Mental Health Teams	2263	82%
Psychology	229	8%
Early Intervention Psychosis	87	3%
Assertive Outreach Team	79	3%
Acute Mental Health Team	38	1%
Mood Disorders	26	1%
Community Rehabilitation, homeless health, ECT and Hampshire liaison*	31	1%
Total (Southampton Local Authority)	2,753	

*combined due to small numbers
Source: Tableau

Profile of people open to Community Adult Mental Health Services, Southampton Division

In the following section, the demographics of people accessing Southampton community mental health services will be described, with comparisons to the overall population of Southampton. The resident rather than registered population has been used as the eligibility criterion for community mental health services is living within the team's catchment area, rather than being registered with a Southampton GP.

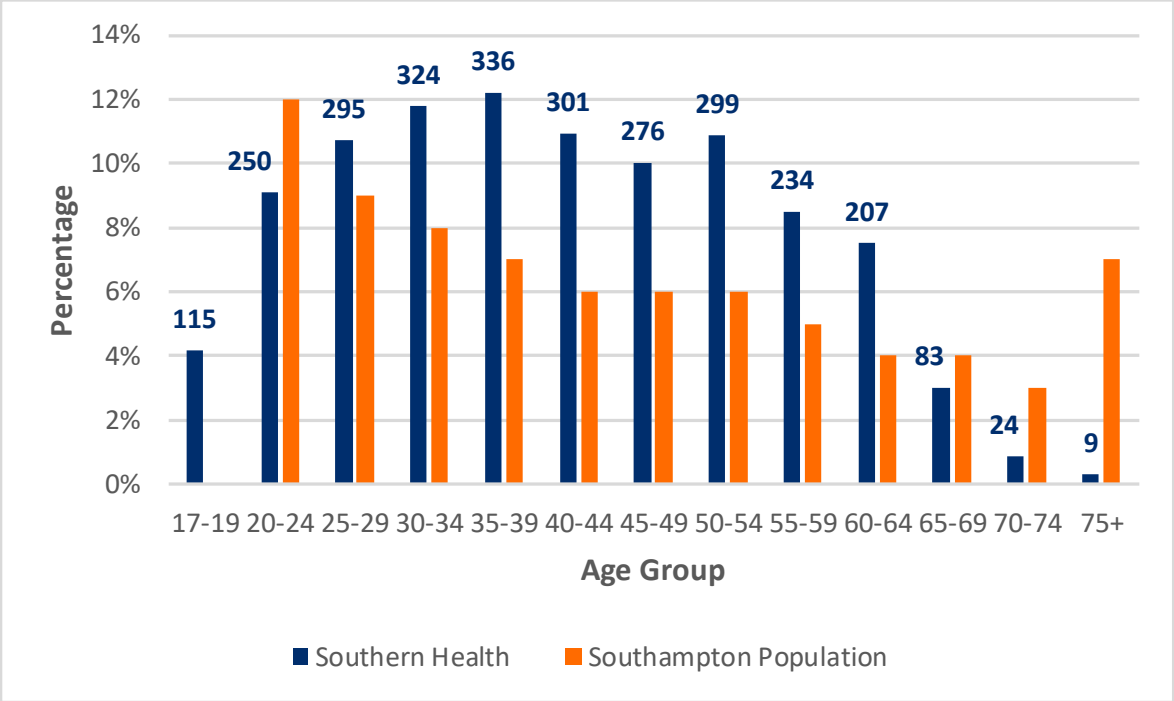
Gender

Of the 2,753 people, 53% were female and 47% male; this differs from the overall population of Southampton, of which 49% are female and 51% male[59]. There may be a number of reasons for this difference, including chance; this data captures one point in time rather than an average over a period of time. Whilst prevalence of SMI is known to be slightly higher in men than women[5] there are also differences in how men and women access health care; women have been shown to be up to 58% more likely to be in receipt of mental health treatment (from all services, not just secondary care)[60]. Men and women also differ in diagnoses, for example recording of schizophrenia is more common in men when compared with women, and vice versus for bipolar disorder[5]; this may impact on whether

they are cared for in primary or secondary care, or the length of time spent in secondary care. We did not have access to information on diagnoses in this data.

Age

Figure 1 Southampton Division Adult Mental Health open caseload and Southampton Population, by age



Source: Tableau, 30.4.21 and ONS Mid-Year estimates 2018, Southampton Data Observatory Population Pyramid tool (accessed 15.6.21)

The percentage of people within each age group being seen by the service increased with increasing age, peaking at 35 – 39 (12%), after which it decreased. 67% of all those within the service were aged 25 – 54 years.

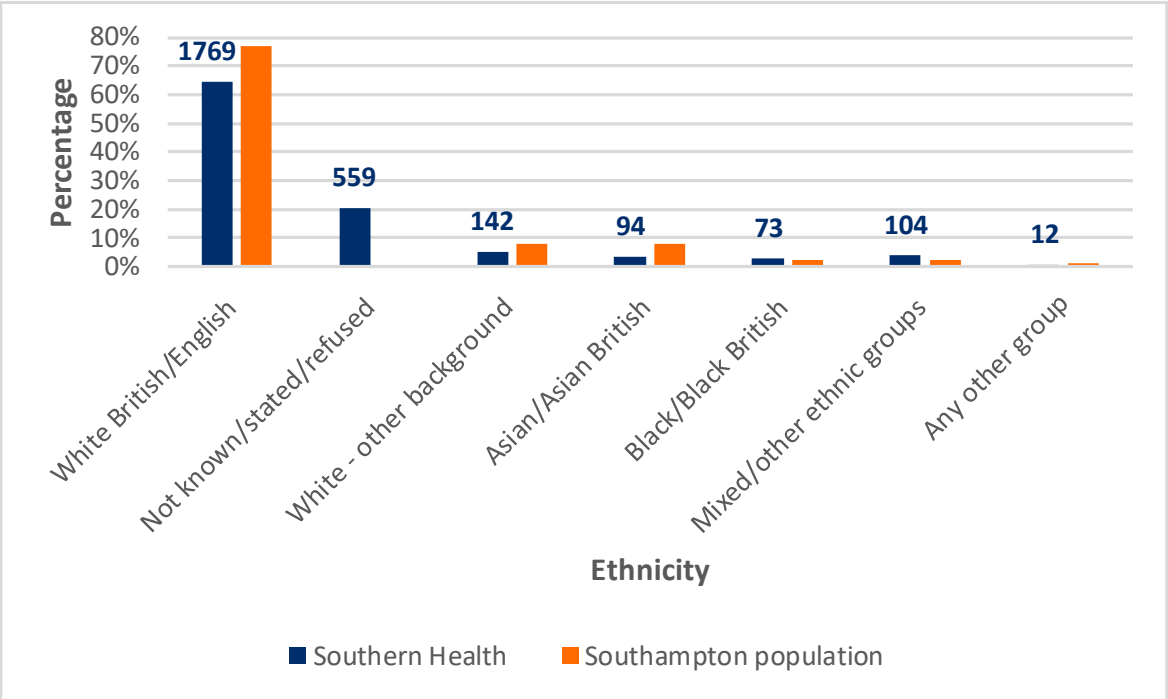
There are less people aged 20-24 within the service when compared to the population of Southampton (9% vs 12%), whereas age groups from 30 to 64 are overrepresented; the largest differences are seen in age groups 35 – 54, (all have a 5% difference between those in the service and the percentage in the population)[59]. This fits with what is known about both SMI prevalence and access to services:

- People aged 35 – 74 have a higher prevalence of SMI (1.1%) compared with those aged 15 – 34 (0.6%)[5], although this is based on a primary care cohort; differences in people being seen by secondary care could reflect access to the service as well as prevalence of mental ill health.
- People aged 35 – 54 are three times more likely to be in receipt of mental health treatment (from any service) when compared with people aged 16 – 24[60].

Ethnicity

Ethnicity was not known, not stated or refused for 559 service users, 20% of the open caseload. Ethnicity has been grouped from the original 53 options given to Southern Health service users into seven categories, to manage small numbers within some groups and to reflect the groups used in wider population data, for comparisons.

Figure 2 Southampton Division Adult Mental Health open caseload and Southampton Population by ethnicity



Source: Tableau, 30.4.21 and ONS 2011 Census, Southampton Data Observatory Population Data Compendium (accessed 15.6.21)

People from White British/English ethnicities were the largest group within Adult Mental Health services in Southampton. In comparison to Southampton's population, people from all White backgrounds (64% vs 77%) and Asian British ethnic groups (3% vs 8%) were under-represented, whereas people from Black/Black British (3% vs 2%) and Mixed/Other (4% vs 2%) ethnicities were over represented[59]. Due to the percentage of those with no ethnicity recorded, and the small numbers of people from ethnicities other than white, it isn't possible to say whether these differences are significant.

Experiences of common mental disorder have been demonstrated as more likely in black women when compared with their White counterparts (29% vs 21%) and Black men as more likely to experience a psychotic disorder when compared with White men (3% vs <0.3%). However the same data suggested that Black people are less likely to access treatment for a common mental disorder compared to white people (6% vs 14%); this is based on the general population rather than only those accessing secondary care services[60]. Data collected on use of mental health and learning disabilities services for 2019/20 showed the number of people using these NHS services, per 100,000, was highest for people of Mixed ethnicity (7,147) followed by Black people (5,098) compared with people from White backgrounds (4,180)[61].

Data, Intelligence & Insight Team
Southampton City Council, Municipal Block – West,
Civic Centre, Southampton, SO14 7LT

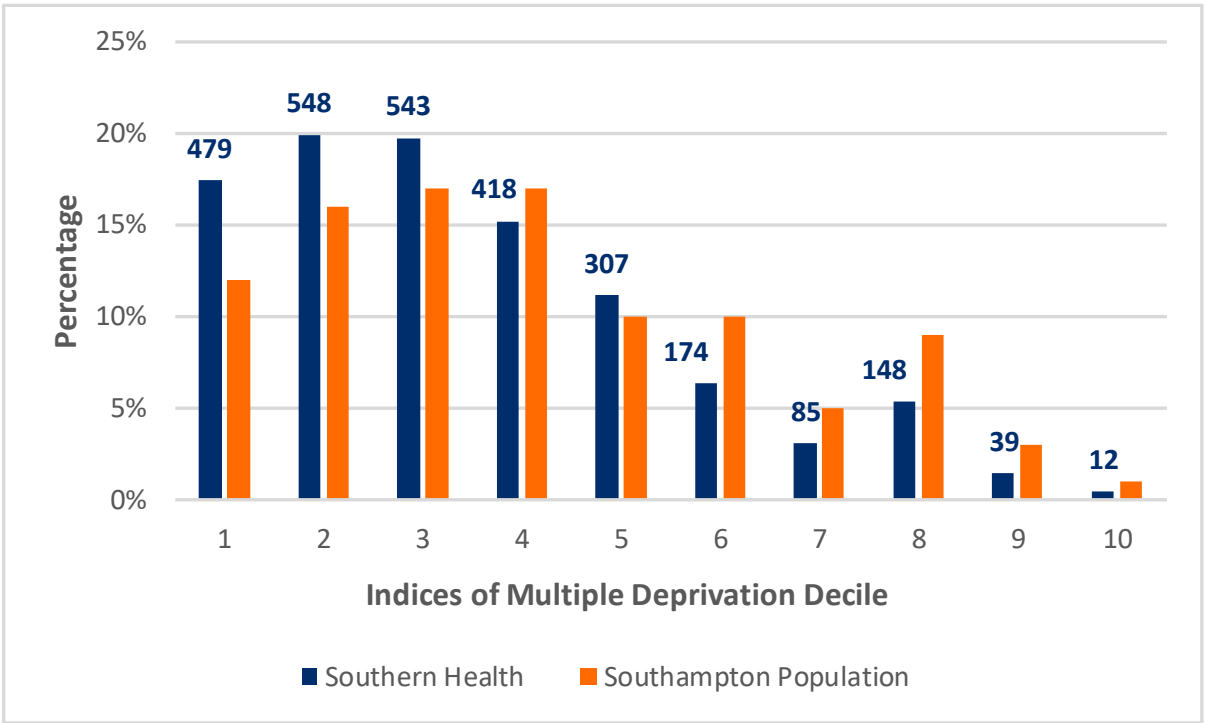
E-mail: strategic.analysis@southampton.gov.uk
Website: https://data.southampton.gov.uk/

Deprivation (with thanks to Southampton City Council Analyst team for this explanation of IMD)

The Index of Multiple Deprivation (IMD 2019) provides a relative ranking of areas across the country according to their level of deprivation and is the primary source of information on deprivation in England. The IMD measures deprivation at neighbourhood level known as Lower Super Output Areas (LSOAs), which contain approximately 1,500 people. Each of the 32,844 LSOAs in England is ranked by their level of deprivation and is then split into 10 equal groups known as deciles. It does not quantify how deprived an area is, only how deprived it is in relation to other areas, nor how deprived an individual is. The IMD brings together a range of indicators, which cover specific aspects of deprivation. These indicators are aggregated into seven domains, which are then weighted and combined to create the overall IMD; income, employment, education, skills and training, health, crime, barriers to housing and services and finally living environment.

- Of the 317 Local Authorities in England, Southampton is ranked 55th most deprived based on average rank of LSOAs
- Out of 146 of its LSOAs, Southampton has 19 LSOAs within the 10% most deprived and one in the 10% least deprived in England
- Around 12% of Southampton's population live in neighbourhoods within the 10% most deprived nationally and 45%, 117,000 people, in the 30% most deprived neighbourhoods nationally[62]

Figure 3 Southampton Division Adult Mental Health open caseload and Southampton Population by indices of multiple deprivation (1 = most deprived)



Source: Tableau, 30.4.21 and Index of Multiple Deprivation 2019, Southampton Data Observatory, Deprivation and poverty data compendium (accessed 15.6.21)

Data, Intelligence & Insight Team
Southampton City Council, Municipal Block – West,
Civic Centre, Southampton, SO14 7LT

E-mail: strategic.analysis@southampton.gov.uk
Website: https://data.southampton.gov.uk/

This overall picture for Southampton is reflected in the Southern Health service data; 57% of service users open to adult mental health teams resided in areas in the 30% most deprived neighbourhoods nationally - this is even higher than for the general population of Southampton.

This higher percentage likely reflects the higher prevalence of SMI in the most deprived communities compared with the least (1.8% vs 0.5%) and the contribution that deprivation makes to mental ill health as both a cause and consequence[5]. Compared with people living in the least deprived areas, those living in the most deprived are 39% more likely to be in receipt of some form of mental health treatment[60]. Based on survey data from the 2007 Adult Psychiatric Morbidity Survey (APMS) and the 2013 Health Survey for England (HSE), 25% of the general population were estimated to be living in poverty, in comparison to 43% of those with a longstanding mental health condition[63].

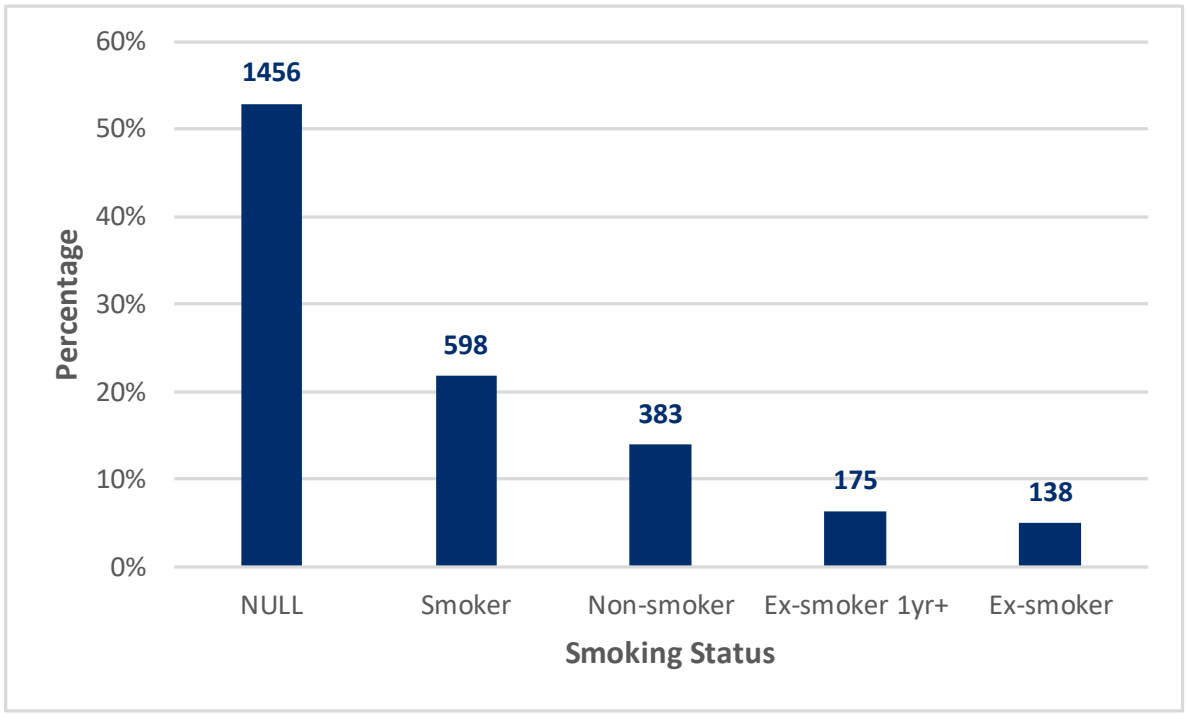
Smoking

Of the 2,753 people included in the analysis, 53% didn't have a smoking status recorded on Rio (represented as 'null' in all charts). The charts presented in this section must be seen within this context; the true prevalence of smoking amongst the adult mental health open caseload is not known.

There are two main sources of information about smoking prevalence in the general population, the Annual Population Survey (APS) and the HSE:

- The latest APS release suggests smoking prevalence amongst adults in England is 13.9% and in Southampton 16.8%[64].
- The HSE has prevalence for England higher at 16%[65]
- The trend across all surveys is a decreasing one; for example, in the APS from 21% in 2011[66].

Figure 4 Recorded smoking status, Southampton Division Adult Mental Health total open caseload, n = 2,753

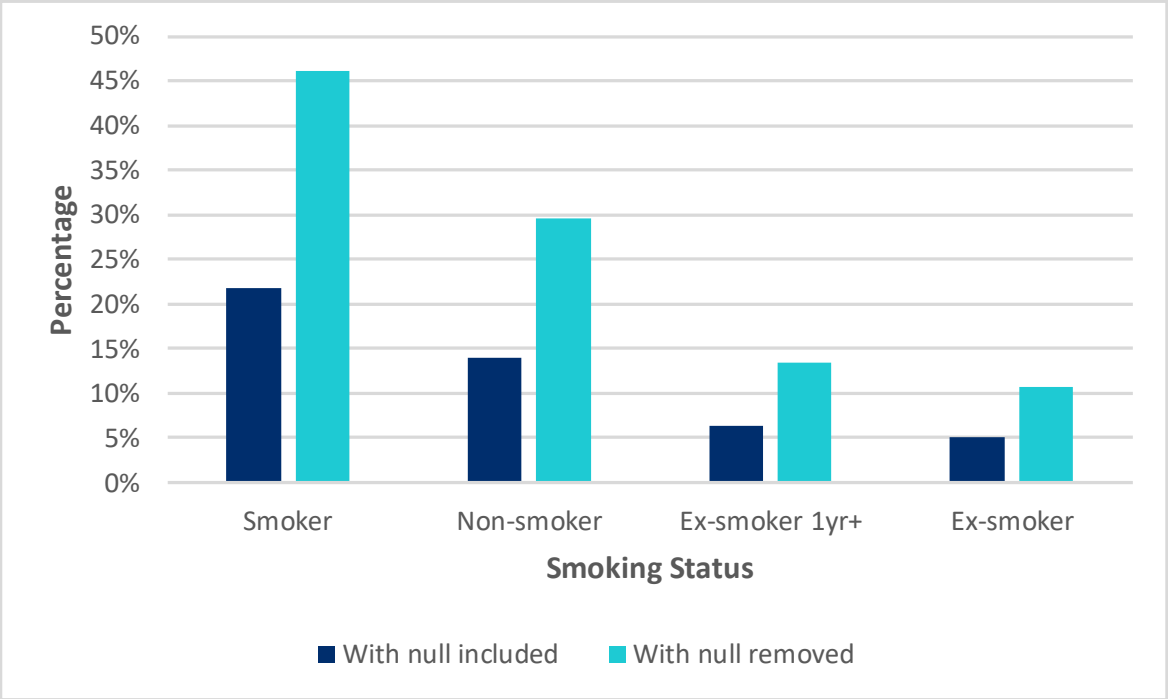


Source: Tableau, 30.4.21

Including the 53% of people (1,456) without a smoking status recorded, 22% were known to be smokers and 11% ex-smokers of some description.

This is in line with smoking prevalence in adults with a long-term mental health condition in Southampton as described by the self-reported GP Patient Survey (GPPS) in 2019/20 - 21% (25.8% in England)[67]. Based on this prevalence, it is estimated that the gap in smoking prevalence between the general population and those with a long-term mental health condition in Southampton is at an all-time low; the latter were three and a half times more likely to smoke in 2013/14, compared with 60% more likely in this most recent year[67].

Figure 5 Recorded smoking status, Southampton Division Adult Mental Health open caseload with null removed, n = 1,297



Source: Tableau, 30.4.21

If those people for whom smoking status is unknown are removed from the analysis, prevalence of smoking within adult mental health services is 46%, and 24% are ex-smokers.

This is more in line with smoking prevalence in adults with SMI, obtained via extracted GP data (GPES) – this includes people for whom both a diagnosis of SMI and status as a smoker is recorded and up to date on their GP notes; 51.3% for Southampton, compared with 40.5% for England and 38.5% for the South East[64]. This data is now 7 years old.

This higher prevalence is also supported by more recent data regarding physical health checks for people on a GP SMI register[68]. For Southampton, at the end of the period 1.10.20 – 31.12.20:

- there were 3,433 people on the register

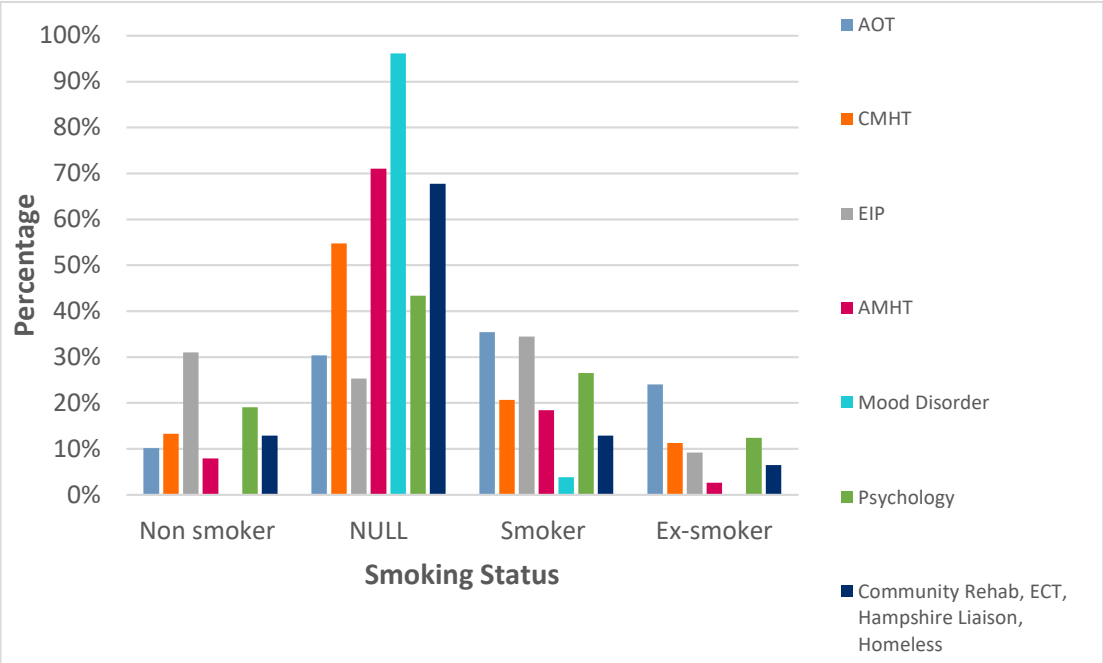
- 57% had an assessment of their smoking status in the previous 12 months (1,974)
- 1,105 required an intervention, such as brief advice or referral for further support, suggesting they were a current smoker. This is 32% of all those on the register, and 56% of only those with a smoking status assessment recorded.

A recent study involving people receiving inpatient mental health care demonstrated prevalence over 50%[69]; the APMS in 2014 found smoking prevalence amongst people with (any) mental health condition to be 34.1%[70].

If smoking prevalence for people accessing community mental health services in Southampton is somewhere in the region of 46%, applied to all those who are Southampton residents within the caseload (2,753), a further 668 would be smokers, giving a total of 1,266 people who should be offered information and support to consider stopping.

Smoking by team

Figure 6 Recorded smoking status by team, Southampton Division Adult Mental Health open caseload



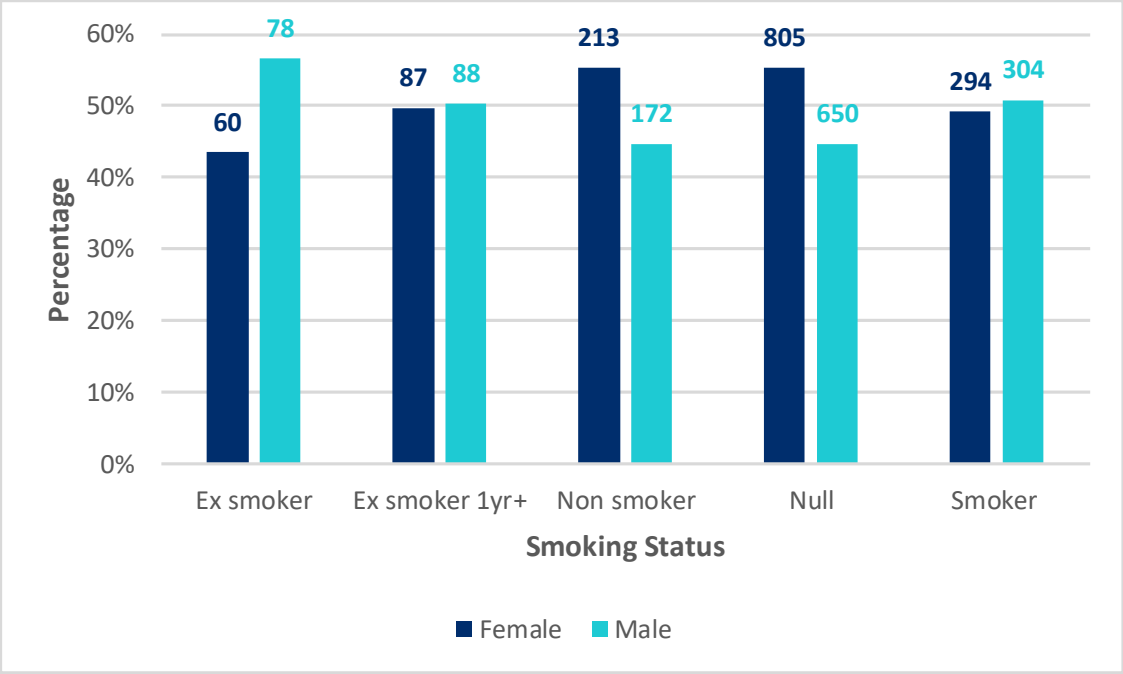
Source: Tableau, 30.4.21

Within the different community mental health teams in the Southampton Division, AOT and EIP have the highest prevalence of smoking – 35% and 34% respectively - whilst EIP has the lowest percentage of unrecorded smoking status (25%). This could therefore be a better reflection of the actual smoking prevalence, however EIP is a small team currently only open to people up to the age of 35, and therefore isn't representative of the whole service (smoking prevalence is higher in younger age groups, see section on age and smoking). With the largest share of service users, CMHT smoking prevalence reflects that of the service overall, 21%, with the caveat that 55% of people open to them did not have a smoking status recorded.

71% of people open to AMHT did not have a smoking status recorded; this is important if any future tobacco dependency pathway includes preparing people who are likely to be admitted to hospital for entering a smoke free environment. The Psychology service has the second largest caseload after CMHT, and a smoking prevalence of 27% despite 43% not having their status recorded – this team has not been consulted as part of the health needs assessment; based on this data their role in tackling tobacco dependency could warrant further consideration.

Smoking and gender

Figure 7 Recorded smoking status by gender, Southampton Division Adult Mental Health open caseload



Source: Tableau, 30.4.21

There is little difference between men and women in the service who were current or longer-term ex-smokers. More of the recent ex-smokers were men than women (57% vs 43%) and more of the non-smokers were women (55% vs 45%). Of those with no smoking status recorded, more were women than men (55% vs 45%).

There was a higher prevalence of smoking in men than women (24% vs 20%). Similar differences are seen in the general population between men and women; smoking prevalence has always been higher for men than women;

- current estimates from the HSE suggest prevalence is 18% for men and 15% for women[66]
- The APS gives a slightly lower prevalence at 15.8% for men and 12.1% for women in England, and in Southampton 17.8% for men and for women 15.8%[71]
- More men across the South East are ex-smokers when compared to women (31.3% vs 26%) and fewer are non-smokers (55% vs 63% for women)[71].

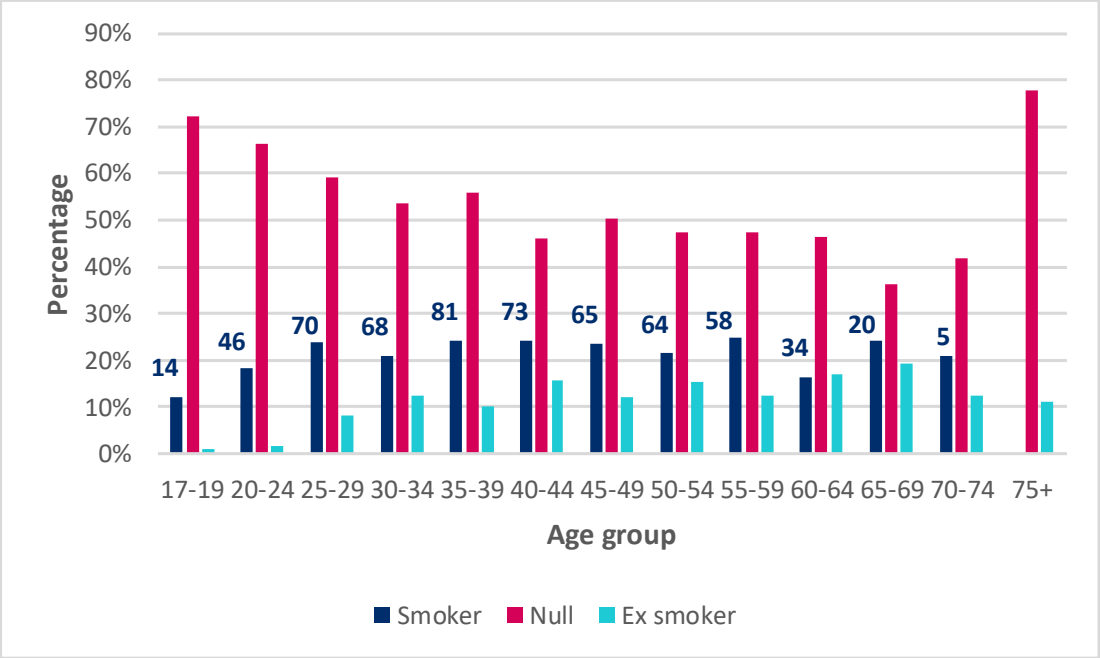
Ex-smokers of any duration have been presented as one group in the charts that follow to manage small numbers across the age bands.

Data, Intelligence & Insight Team
Southampton City Council, Municipal Block – West,
Civic Centre, Southampton, SO14 7LT

E-mail: strategic.analysis@southampton.gov.uk
Website: https://data.southampton.gov.uk/

Smoking and age

Figure 8 Recorded Smoking Status by age, Southampton Division Adult Mental Health open caseload



Source: Tableau, 30.4.21

Smoking prevalence increased with age and remained high across the lifespan, the highest being 25% for ages 55-59. However, as the percentage without smoking status recorded reduced with age (younger ages had a high percentage of smoking status not being recorded - 72% for 17-19-year-olds), it is possible that actual prevalence is higher in the younger age groups. People aged 25 – 44 years old accounted for 50% of all smokers within the service, and 14% of smokers were concentrated in the 35 – 39 age group.

The percentage of ex-smokers within each age band increased with age, the highest being 19% for those aged 65-69. This is reflected in general population data, with only 7% of those aged 18-24 being ex-smokers compared with nearly 42% of people who are 65+[71].

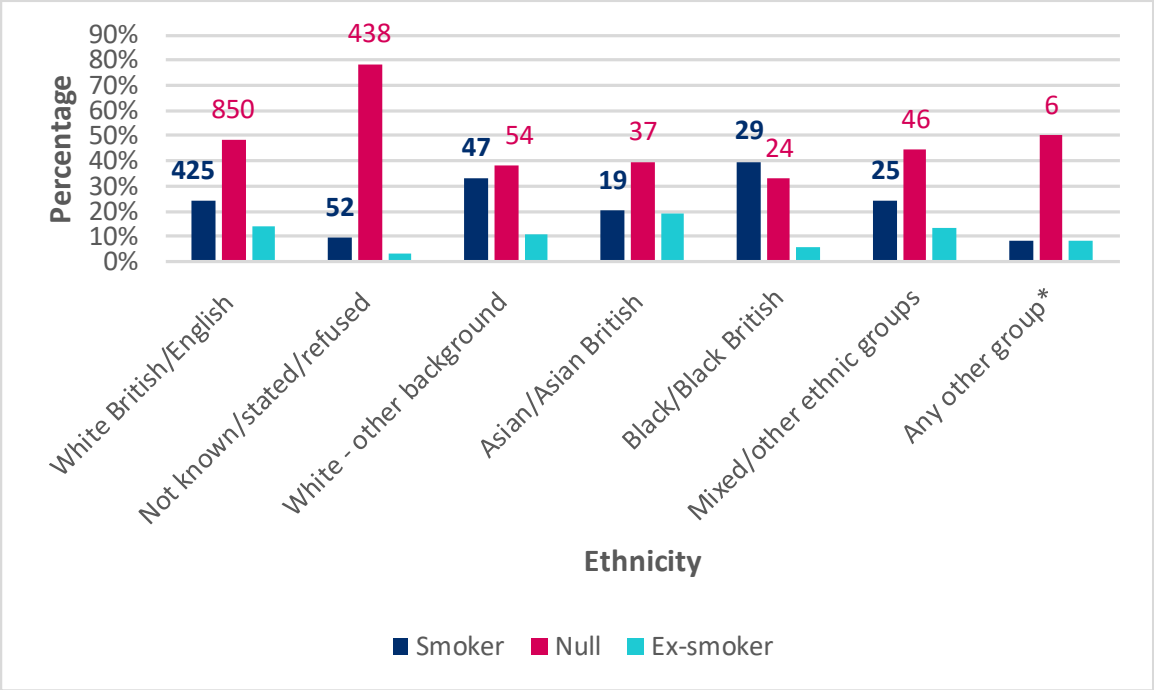
Prevalence across the age groups within adult mental health services in Southampton reflects what we know about smoking prevalence from national surveys of the general population:

- In England, prevalence for 18 – 24-year-olds is estimated at 16% and for 25 – 34-year-olds 18.9%[71]
- The HSE suggests higher prevalence for these age groups, and a greater difference between them; 21% for 16-24-year-olds and 25% for 25-34-year-olds[66]
- From this peak, smoking prevalence decreases with increasing age to 6% at age 65+[66]

A study in Australia found the prevalence of smoking amongst young people receiving mental health care to be 41% for those aged 20 - 30 (daily nicotine use)[72].

Smoking and ethnicity

Figure 9 Recorded Smoking Status by ethnicity, Southampton Division Adult Mental Health open caseload



*values <5 removed to preserve anonymity
Source: Tableau, 30.4.21

The highest smoking prevalence across adult mental health services was for people of Black/Black British ethnicity, at 40%. This is however based on a small number of people recorded as Black/Black British (73), and is not reflective of what is known about prevalence of smoking for people from Black, Asian and minority ethnic backgrounds – it could however be representative of a higher prevalence in people with severe mental illness.

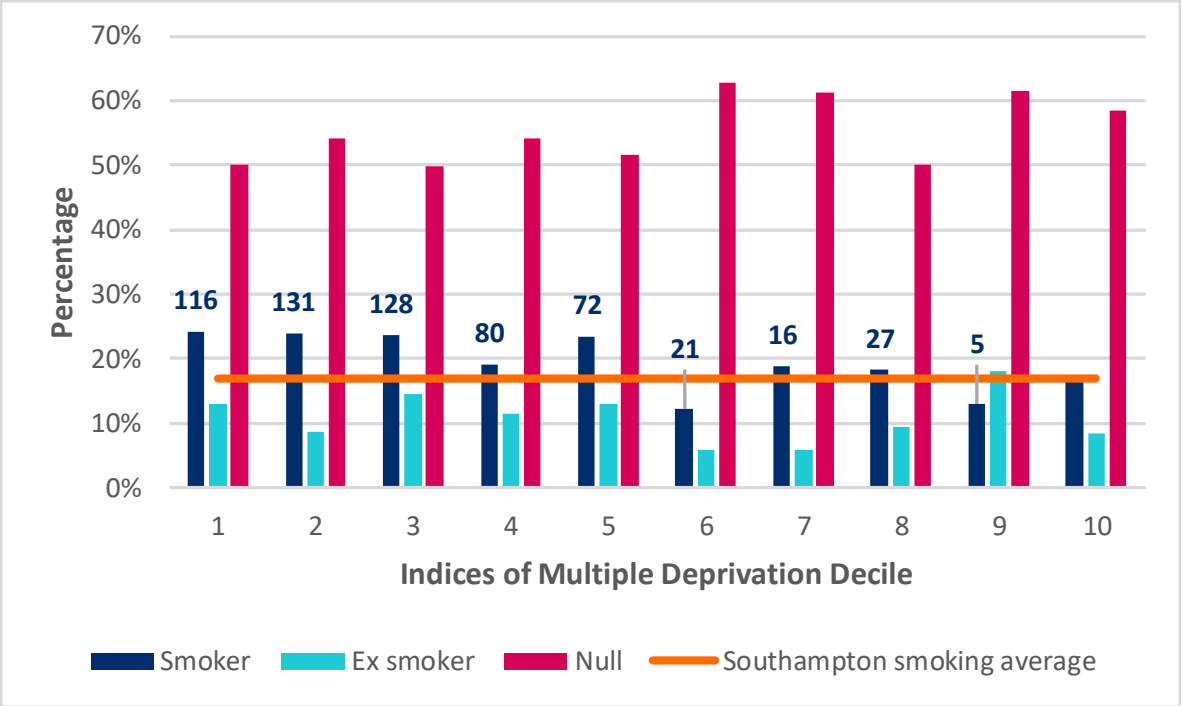
People of White Other ethnicity had the second highest prevalence – 33% - followed by White British/English and Mixed/Other ethnic groups both with 24%. People of Asian/Asian British ethnicity had the highest percentage of ex-smokers, 18%, which may be due to the small number of people recorded with this ethnicity (94). Of the people whose ethnicity wasn't known, 78% also didn't have their smoking status recorded; this will be explored later in the section.

In 2019 in the English general population, people of mixed ethnicity had the highest smoking prevalence – 19.5% - followed by Other ethnicities (15.6%) and White (14.4%)[71]. People of Asian and Black ethnicities had much lower prevalence of smoking, 8.3% and 9.7% respectively[71].

Data, Intelligence & Insight Team
Southampton City Council, Municipal Block – West,
Civic Centre, Southampton, SO14 7LT
E-mail: strategic.analysis@southampton.gov.uk
Website: https://data.southampton.gov.uk/

Smoking and IMD

Figure 10 Recorded Smoking Status by Indices of Multiple Deprivation, Southampton Division Adult Mental Health open caseload



Decile 10 - value <5 removed to preserve anonymity
Source: Tableau, 30.4.21

Describing smoking prevalence across the 10 IMD groupings is challenging because of the small numbers within the higher deciles (giving less confidence in the percentages seen) and the high percentage of nulls within all deciles.

This chart shows smoking prevalence is highest in deciles 1 – 5, the most deprived areas, and that prevalence is higher than the Southampton average (16.8%[61]) in all but 2 deciles. Deciles 1 – 3 have the highest prevalence, 24%, and 63% of all smokers reside there – these areas are in the 30% most deprived neighbourhoods nationally.

There is some indication that smoking status is more often recorded for people living in more deprived areas; the average for no status being recorded in deciles 1 – 5 is 52% vs 59% in deciles 6 – 10.
The most recent comparable national data for smoking prevalence by IMD comes from the APS in 2016[73], albeit for the general population;

- 27.2% of people living in the most deprived areas (decile 1) were smokers, compared with 7.9% in the least deprived (decile 10)
- 63% of smokers resided in areas in deciles 1-5
- People living in the most deprived areas were more than four times more likely to smoke vs those in the least deprived

Data, Intelligence & Insight Team
Southampton City Council, Municipal Block – West,
Civic Centre, Southampton, SO14 7LT
E-mail: strategic.analysis@southampton.gov.uk
Website: https://data.southampton.gov.uk/

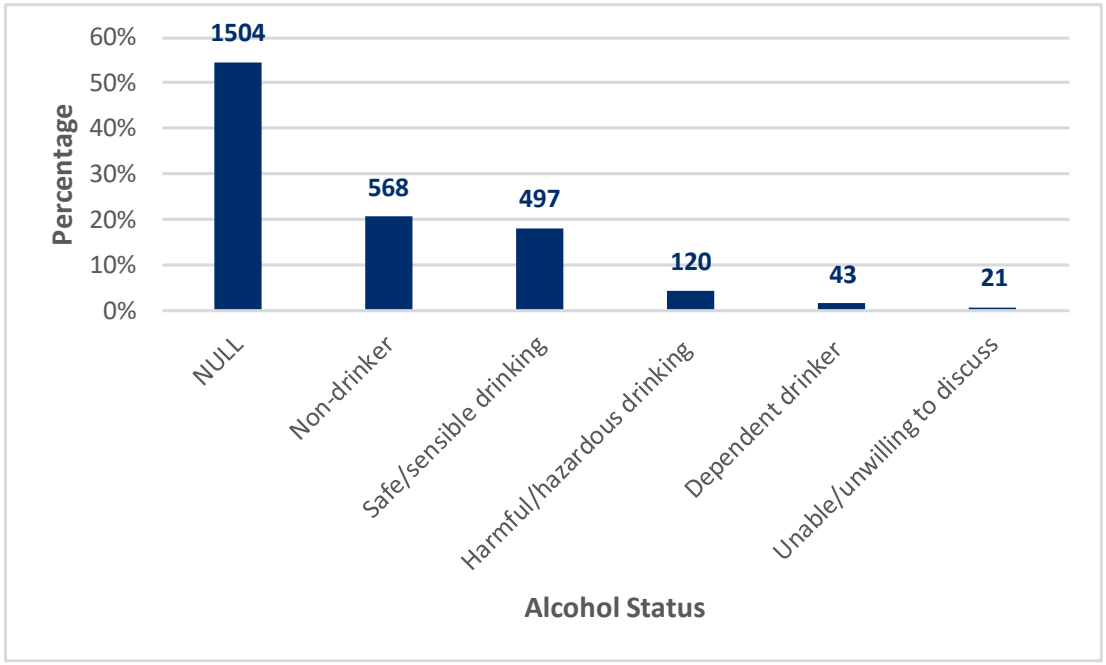
If smoking prevalence is 27% in the most deprived area amongst the general population, it is reasonable to expect the true prevalence amongst people living in those areas and who also experience mental ill health to be much higher than the 24% found in this caseload. In a report on mental health, smoking and poverty, which used data from the 2007 APMS and 2013 HSE, smoking prevalence was found to be higher for people with a longstanding mental health condition **and** who also live in poverty (53%), in comparison to people with either a mental health issue (40%) or who live in poverty (33%)[63].

A social gradient is not evident in the Southern Health data, which is likely to be because of the small number of people who live in the least deprived areas and the large percentage with no smoking status recorded. However, it is worth considering that smoking prevalence could be higher amongst people in those less deprived areas if they have a mental illness, and therefore wouldn't necessarily reflect the pattern seen in the general population.

Alcohol

Of the 2,753 people included in the analysis, 55% didn't have a smoking status recorded on Rio (represented as 'null' in the charts). The charts that are presented must be seen within this context; the true distribution of alcohol use in adult mental health services in Southampton is not known.

Figure 11 Recorded alcohol status, Southampton Division Adult Mental Health open caseload,



Source: Tableau, 30.4.21

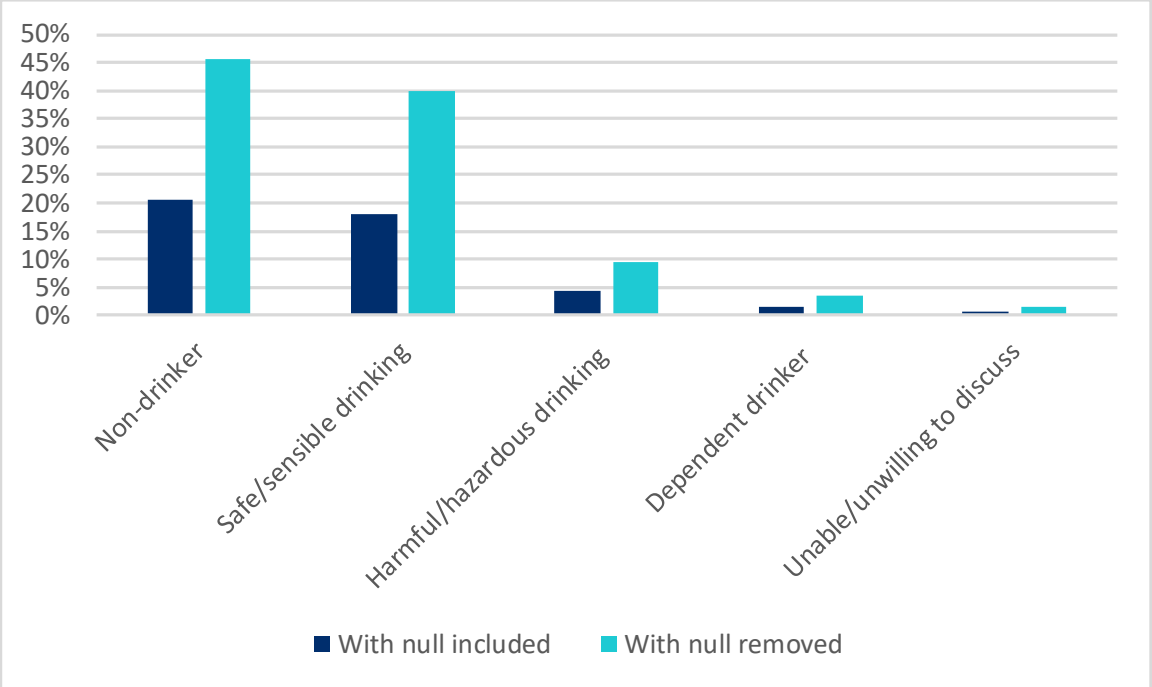
Including the 55% of people (1,504) without an alcohol status recorded, 2% were known to be drinking at dependent levels and 4% harmful/hazardous. 24% were recorded as drinking alcohol at some level. The largest proportion (other than nulls) were non-drinkers – 21%.

Data, Intelligence & Insight Team
Southampton City Council, Municipal Block – West,
Civic Centre, Southampton, SO14 7LT

E-mail: strategic.analysis@southampton.gov.uk
Website: https://data.southampton.gov.uk/

Data from the preventing ill-health by risky behaviours and tobacco and alcohol screening CQUINs showed that within mental health hospitals, 16% of inpatients screened were drinking at increasing or higher risk levels, and the rate of alcohol dependence was 8%[74].

Figure 12 Recorded alcohol status, Southampton Division Adult Mental Health open caseload with null removed, n = 1,249



Source: Tableau, 30.4.21

If those people for whom alcohol status is unknown are removed from the analysis, prevalence of drinking alcohol at levels that may cause dependency was 3%, and at harmful/hazardous levels 10%. 53% of people drank alcohol at some level and 45% were recorded as non-drinkers. This is more in line with data from the CQUINs (although the percentage of people without alcohol status recorded within that data is not known) but doesn't align with national surveys on alcohol use in the general population:

- 58% of people aged 16+ in England drank alcohol in last week, 20% reported they didn't drink alcohol at all[75]
- In the 2018 HSE[76], 80% of respondents reported drinking alcohol in the last year, and 48% at least once per week. Similarly, 20% had not drunk in the last year.
    - 57% of people drank 14 units or under (lower risk levels)
    - 19% drank at increasing risk levels and 4% at higher risk
    - Percentage abstaining from alcohol in Southampton was nearly 15%[77]
    - Percentage drinking more than 14 units per week in Southampton was 20.6%[77]

The lower prevalence of alcohol use at increasing and higher risk levels within Southampton's Adult Mental Health Services is likely to be as a result of such a large proportion with their alcohol status unrecorded. It is also well documented that when asked about alcohol people don't always estimate correctly, particularly those drinking at increasing and higher risk levels[78]; this could be even more

Data, Intelligence & Insight Team
Southampton City Council, Municipal Block – West,
Civic Centre, Southampton, SO14 7LT
E-mail: strategic.analysis@southampton.gov.uk
Website: https://data.southampton.gov.uk/

relevant if concerned it may affect the care received. A cross-sectional study in 4 UK centres demonstrated that 44% of people accessing community mental health services reported harmful drug or alcohol use in the past year[13].

Recent Southampton data[68] regarding physical health checks for people on a GP SMI register, at the end of the period 1.10.20 – 31.12.20 indicated that of the 3,433 people on the register:

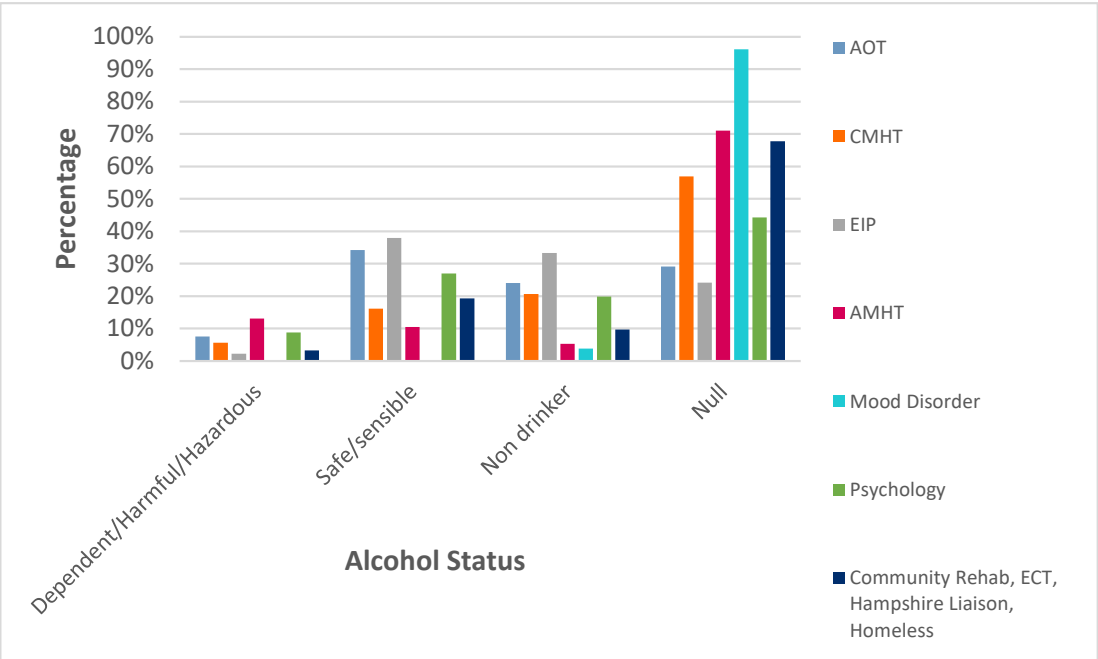
- 43% had an assessment of their alcohol consumption in the previous 12 months (1,466)
- 386 required an intervention, such as brief advice or referral for further support, suggesting 'alcohol misuse'. This is 11% of all those on the register, and 26% of only those with alcohol consumption assessment recorded.

A similar percentage (to secondary care) of people with SMI in primary care did not have their alcohol status recorded – 57%. If the prevalence of alcohol use at higher and increasing risk for people accessing community mental health services in Southampton is similar to the prevalence for people with alcohol consumption recorded in primary care (26%), a further 552 would be drinking at these levels, giving a total of 715 people who require alcohol brief advice and/or referral to a specialist alcohol service.

For the remaining analysis, dependent and harmful/hazardous categories have been combined due to low numbers once split across variables including teams, age, ethnicity, and IMD.

Alcohol by team

Figure 13 Recorded alcohol status by team, Southampton Division Adult Mental Health open caseload



Source: Tableau, 30.4.21

Within the different community mental health teams in Southampton Division the highest prevalence of drinking at dependent, harmful or hazardous drinking is in people under the care of AMHT (13%);

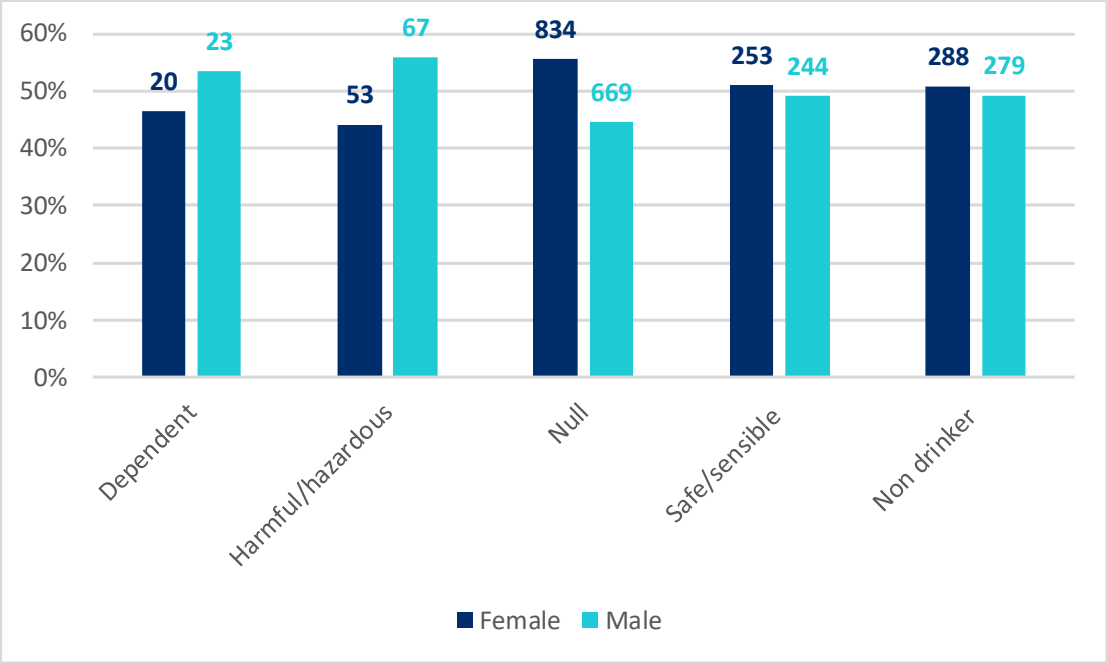
Data, Intelligence & Insight Team
Southampton City Council, Municipal Block – West,
Civic Centre, Southampton, SO14 7LT

E-mail: strategic.analysis@southampton.gov.uk
Website: https://data.southampton.gov.uk/

this is with only 29% of people having an alcohol status recorded. The prevalence in CMHT is much lower at 6%, but again with the majority of people not having an alcohol status recorded – 57%. Recording of alcohol status is more common in AOT and EIP; only 29% and 24% respectfully don't. Prevalence in AOT is 8%, but in EIP only 2%; this could be a reflection of the younger age group they care for (see alcohol and age later in the section).

Alcohol and gender

Figure 14 Recorded alcohol status by gender, Southampton Division Adult Mental Health open caseload



Source: Tableau, 30.4.21

Of everyone drinking alcohol at dependent or harmful/hazardous levels, more men than women are recorded as doing so (53% and 56% vs 47% and 44%). However, a greater percentage of those without their alcohol status recorded are women (55% vs 45%); some of those women may be drinking at these higher levels. The percentages of safe/sensible and non-drinkers who are female or male are broadly the same (51% vs 49%). The data suggests that only 22% of women are drinking alcohol at some level, and 26% of men.

Gender differences in alcohol consumption within the general population are observed via two different sources – the Opinions and Lifestyle Survey[75] and the HSE[65] - but paint a different picture to the one described above in terms of the percentages at which both men and women were drinking:

- 23% women and 17% men did not drink[75] (vs 20% and 22% in this caseload)
- 83% of men and 78% of women had drunk alcohol in last year[65]
- 63% of men and 53% of women had drunk alcohol in the last week[75]
- 62% women and 53% men drank at lower risk levels[75] (vs 17% and 19%)
- 12% women and 25% men drank at increasing risk levels[75] (vs 4% and 5%)
- 3% women and 5% men drank at higher risk levels[75] (vs 1% and 2%).

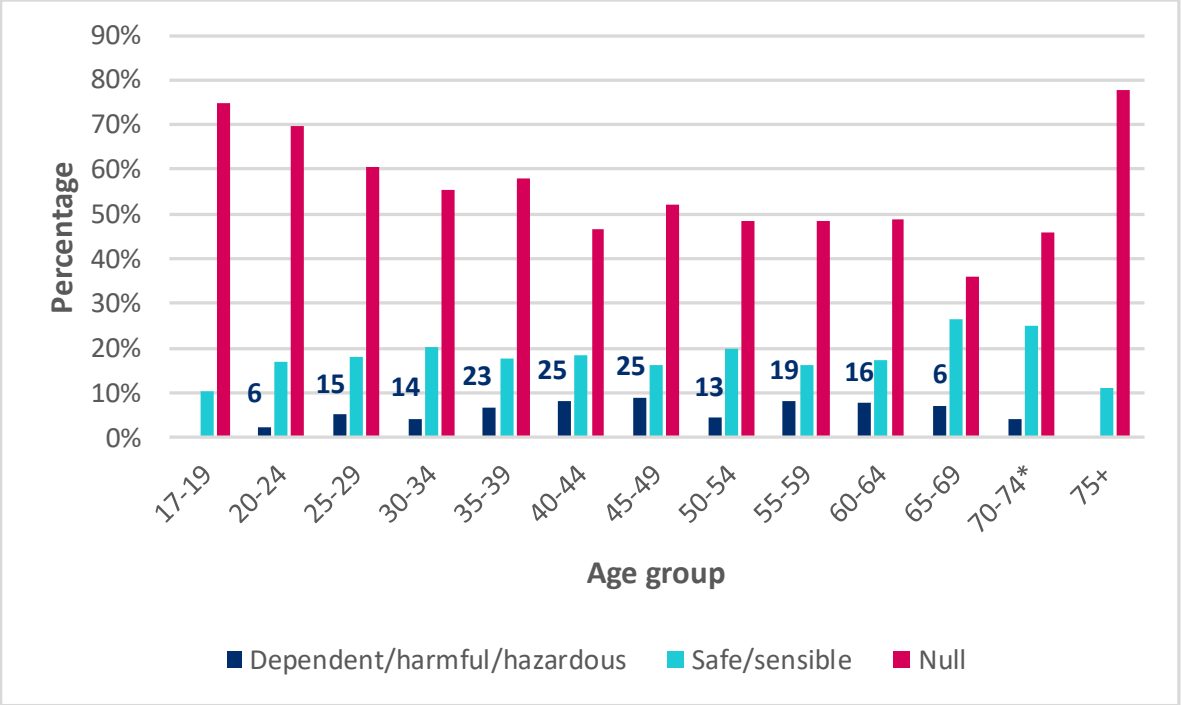
Data, Intelligence & Insight Team
Southampton City Council, Municipal Block – West,
Civic Centre, Southampton, SO14 7LT

E-mail: strategic.analysis@southampton.gov.uk
Website: https://data.southampton.gov.uk/

The differences between this general population data and the Southern Health data demonstrates the impact of the large proportion with no alcohol status recorded.

Alcohol and age

Figure 15 Recorded alcohol status by age, Southampton Division Adult Mental Health open caseload



*values <5 removed to preserve anonymity
Source: Tableau, 30.4.21

There was a rise in the prevalence of drinking alcohol at dependent or harmful/hazardous levels as age increased in adult mental health services; the highest prevalence was in the 45- 49-year-old age group. 74% of all those drinking at dependent levels were aged between just 40 and 59, whereas 70% of all the people drinking at harmful/hazardous levels were distributed across a wider age range and started younger – 25 to 49. Fewer people had an alcohol status recorded within the age groups at either end of the distribution, although there are smaller numbers in these groups.

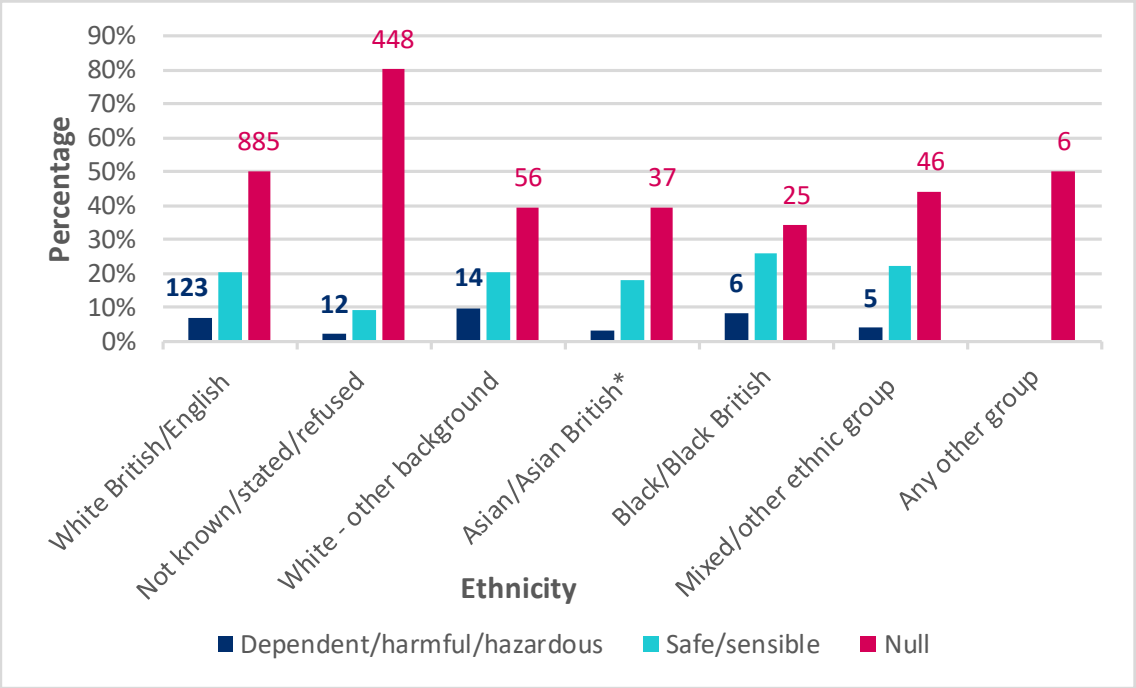
National data for the general population reflects this picture, with any level of drinking increasing with age and in particular drinking at increasing risk:

- Drinking in the last year increased with age – 74% at ages 16 – 24 rising to 85% for 55 – 74-year-olds[65].
- This difference was even more marked for drinking at least once per week; 30% for the younger age group and 58% for those older[65].
- Prevalence for people drinking in the last week peaked aged 45 - 64 (65%[75]) and then decreased; for people drinking over 14 units it peaked aged 55 – 64

Less is known about alcohol use by age for people accessing secondary mental health care. Weekly alcohol consumption amongst 20 – 30-year-olds accessing mental health care in Australia was found to be 45%, and daily use for men and women 15% and 8% respectively[72].

Alcohol and ethnicity

Figure 16 Recorded alcohol status by ethnicity, Southampton Division Adult Mental Health open caseload



*values <5 removed to preserve anonymity

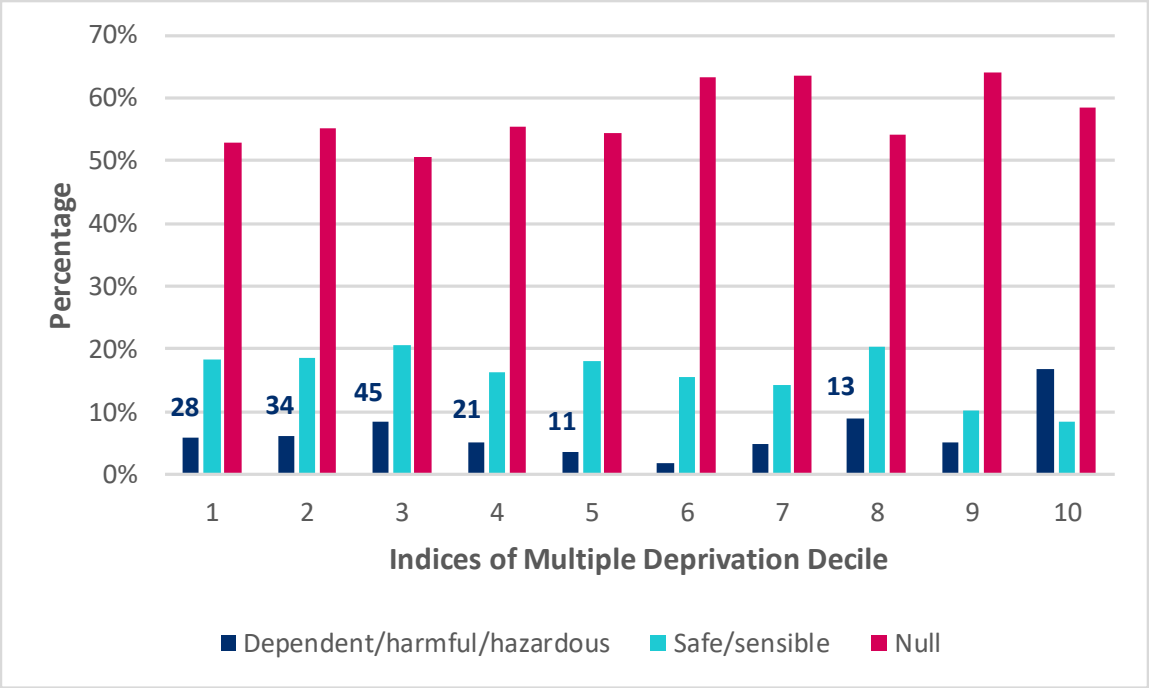
Source: Tableau, 30.4.21

The highest prevalence of drinking at dependent or harmful/hazardous levels was for people of White other ethnicity (10%), followed by those recorded as Black/Black British (8%), and White British (7%). White British, the largest ethnicity within the service, also had the highest percentage of alcohol status not being recorded (50%); it is reasonable to expect prevalence would rise in this group (as in all groups) should more people have a recorded alcohol status. 85% of all those drinking at dependent and harmful/hazardous levels were of White ethnicity; only 8% were from an ethnicity other than White.

This reflects what is known from the Adult Psychiatric Morbidity Survey[61] about drinking at dependent and harmful/hazardous levels amongst different ethnic groups. The highest prevalence was for people who were White British (22.6%), followed by White Other (14.8%) with much lower prevalence for people from Asian (3.7%), Black (7.1%), and Mixed/Other (9.9%). This is for people with common mental health conditions rather than only those accessing secondary care.

Alcohol and IMD

Figure 17 Recorded alcohol status by Indices of Multiple Deprivation, Southampton Division Adult Mental Health open caseload



Deciles 6,7,9,10 – values <5 removed to preserve anonymity
Source: Tableau, 30.4.21

Due to the small number of people in adult mental health services recorded as drinking at dependent and harmful/hazardous levels, as well as the small numbers in some deciles, the descriptive analysis of alcohol and deprivation must be viewed with caution. The highest prevalence of dependent and harmful/hazardous drinking was in decile 10, least deprived, (17%) but with less than 15 people recorded within this category in total.

72% of people recorded as drinking at dependent and harmful/hazardous levels and 63% at harmful/hazardous levels lived in areas in deciles 1 – 3; these areas are in the 30% most deprived neighbourhoods nationally. This is with more than 50% for whom no alcohol status was recorded – 830 people. It is impossible to predict what effect a higher percentage of people having their alcohol status recorded would have on the prevalence of dependent/harmful/hazardous levels in each decile.

Alcohol status is slightly more likely to be recorded for people living in more deprived areas compared with those living in less deprived areas.
Data from the HSE for the general population did demonstrate higher levels of drinking at dependent and harmful/hazardous levels in the least deprived areas[66]:

- There was a greater percentage of non-drinkers in the most deprived (29%) areas vs the least (10%)
- 18% of people in the most deprived areas drank more than 14 units per week, vs 27% in the least deprived

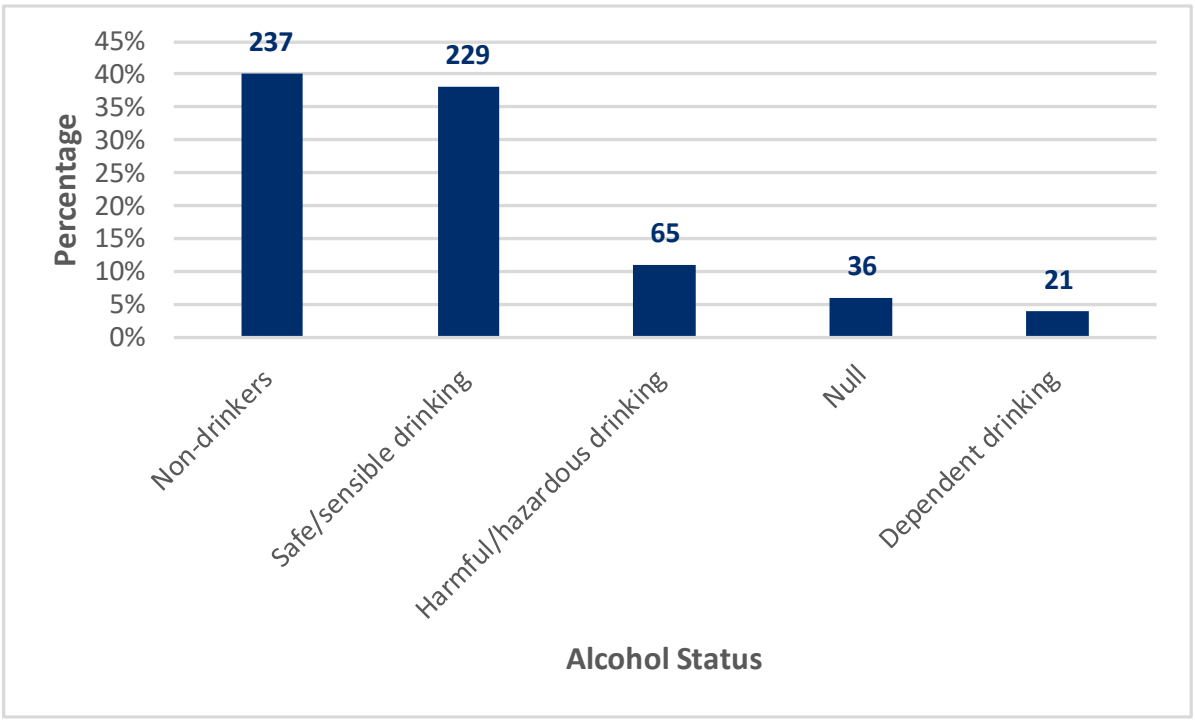
- There were also some gender differences within the data on drinking at increasing and higher risk levels; 27% of men in the most deprived areas drank at these levels vs 36% in the least deprived, and for women it was 10% vs 17%. The proportion of people drinking at increasing risk accounts for this difference – those drinking at higher risk was similar in the most and least deprived areas.

It is widely acknowledged that people of lower socioeconomic status can experience greater harm from similar or even lower levels of alcohol consumption in comparison to people of higher socioeconomic status – the alcohol harm paradox. The mechanism for this is not entirely understood, but is thought to involve patterns of drinking (as opposed to overall volume)[78], intersectionality with other determinants of ill health such as smoking, obesity and lack of physical activity[79] which are more prevalent in more deprived areas, and also differences in access to health services[7]. Whether or not and how people with severe mental illness are affected by the alcohol harm paradox is undocumented.

Smoking and alcohol

People who smoke and drink alcohol at harmful levels have an increased risk of experiencing physical ill-health as a result, particularly respiratory conditions and some cancers[11], in comparison to those who smoke or drink. The following two charts present the alcohol status of people recorded as smokers, and the smoking status of people recorded as drinking at dependent/harmful/hazardous levels. Once again, this is within the context of the majority of people having neither status recorded; the true prevalence of smoking and drinking combined is not known.

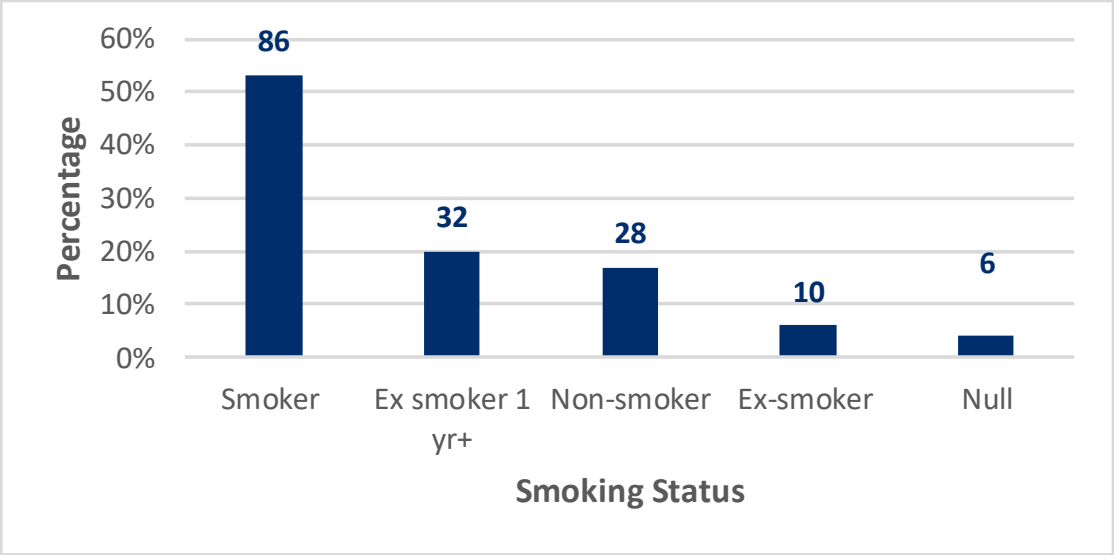
Figure 18 Current Smokers' recorded alcohol status, Southampton Division Adult Mental Health open caseload



Source: Tableau, 30.4.21

The majority of people who smoke were non-drinkers or drinking at safe/sensible levels (78%), 15% were drinking at dependent or harmful/hazardous levels. This is a higher level of drinking than was found in the total caseload. Only 6% of smokers didn't have their alcohol status recorded.

Figure 19 Dependent and harmful/hazardous drinkers' recorded smoking status, Southampton Division Adult Mental Health open caseload



Source: Tableau, 30.4.21

The majority of people who were drinking at dependent or harmful/hazardous levels were or had been smokers at some time - 53% current smokers and 37% ex-smokers. Only 6 (4%) didn't have their smoking status recorded. People who were both smoking and drinking at dependent or harmful/hazardous levels:

- Were 53% male
- Were fairly evenly distributed across the age groups up to the age of 60 after which very few were drinking at those levels; 29% were concentrated in the age group 40-49
- 71% White British/English, 82% from a White Background
- 66% lived in the 30% most deprived areas.

The relationship between tobacco dependency and alcohol consumption is thought to involve both cross reinforcement and cross tolerance; one enhances the reward experienced from the other and vice versa, and nicotine decreases the sedative effect of alcohol, encouraging further consumption[80].

Nulls

Of all those who's smoking status wasn't recorded (1456) 1431 also didn't have their alcohol status recorded – 52% of the whole caseload had neither recorded. Of this group, 55% were female, and 30% also had no ethnicity recorded (78% of those with unknown ethnicity).

Treatment

A limitation of this health needs assessment is the lack of data and information about the treatment available to people who are accessing community mental health services, for tobacco dependency and

increasing or higher risk drinking. Southern Health data regarding treatment offered and whether it was accepted and delivered or declined, is likely to be recorded in the progress notes on Rio and therefore not accessible in Tableau – this would need to be audited. Physical health checks and recording smoking and alcohol status alone do not improve the physical health of people with severe mental illness. Effective treatment for tobacco and alcohol consumption is required to achieve this, and it is not as it is so often described, prevention, but treatment[82].

Smoking

There are a number of elements to treatment for tobacco dependency; NRT, behavioural support, stop smoking medications such as varenicline and e-cigarettes. It is well known that anyone making a quit attempt has more chance of success with a combination of NRT, and/or a stop smoking medication, and behavioural support. It has been shown that the same interventions work for people with SMI as do for smokers more generally, and without worsening their mental health[83]. People with SMI are thought to experience greater tobacco dependence possibly as a result of higher daily average consumption of cigarettes, smoking each cigarette more intensely, and other contextual factors[11]. As a result, they require combination NRT (fast and slow acting) of adequate dosage and for a sufficient length of time – potentially longer than someone without mental illness[11].

Whilst nicotine replacement therapy is offered to anyone who is admitted to a mental health inpatient setting, there is currently no provision in the community. NRT is mainly procured via the NHS supply chain, with few prescriptions, and only for inpatients (although this has recently changed to prescriptions). Whilst their greatest concern is experiencing cravings, and most commonly cited barrier to quitting[84], people with SMI can be more likely to quit without any support at all[85]. Brief advice delivered to young adults with SMI in the USA improved perceptions of stop smoking treatment but did not increase their uptake and led to unsupported quit attempts[85]. This demonstrates the complexity of tackling tobacco dependency and that one intervention alone will not reduce smoking prevalence in this population. The unintended consequences of actions to improve quit rates must be considered; unsupported quit attempts are likely to be unsuccessful and could perpetuate the belief held by some that they won't be able to quit.

A pragmatic, randomised controlled study (SCIMITAR trial) with heavy smokers in primary and community secondary care services has demonstrated that enhanced support designed for people with SMI and including behavioural support from a mental health smoking cessation practitioner, pharmacological aids, extended pre-quit sessions, cut down to quit, and home visits can reduce tobacco dependency in this population[86]. The proportion of participants who remained quit at 6 months was significantly higher for the intervention group compared to the usual care group – 14% vs 6%, however this difference wasn't sustained at 12 months[86]. Other studies have also demonstrated improvements in nicotine dependence but not beyond 4 – 6 months, signalling a need for longer term support[87,88]. Specific behaviour change techniques that have been shown to lengthen abstinence are pharmacological support, goal-setting and social support[89]. The in-house model of tobacco dependency treatment, where support can be ongoing as part of someone's overall mental health support rather than accessed via an external service and time bound, would address these findings.

Data, Intelligence & Insight Team
Southampton City Council, Municipal Block – West,
Civic Centre, Southampton, SO14 7LT
E-mail: strategic.analysis@southampton.gov.uk
Website: https://data.southampton.gov.uk/

A prospective cohort study found that people with mental ill health were less likely to be prescribed stop smoking medications such as varenicline than they were NRT, compared with people without mental illness[90]. If they were prescribed it, they were more likely to quit smoking than with NRT. The study also demonstrated that they experienced the same or slightly better mental health outcomes when compared with those prescribed NRT[90].

E-cigarettes are part of the Southern Health smoke free policy; appendix 3 explicitly states support for their use in hospital. It is unclear how much they are promoted in the community and whether people are assisted to access them. In their seminal report on mental health and smoking, the Royal College of Physicians endorsed the use of e-cigarettes, suggesting that such a harm reduction approach may lead to a quit attempt in the future[11]. There is evidence to suggest that e-cigarettes are as safe and effective as NRT for people with mental health conditions, and in fact are more acceptable and result in greater reduction in smoking[91]. They may serve to redress the inequalities that remain in smoking prevalence and the harms experienced despite population wide tobacco control strategies[92]. This is likely to require more than being an 'e-cigarette friendly service' – increasing awareness of organisational policy, working with stop smoking services to increase access and actively promoting their use[93] are all necessary.

Alcohol

Different approaches to treatment for alcohol use are required depending on the level at which alcohol is being consumed. People identified as drinking at dependent or in some cases harmful levels may require referral to specialist alcohol services; people with co-occurring mental health and substance use conditions would be treated according to the relevant policy. It is outside the scope of this health needs assessment to look in detail at the extent to which the policy is applied, the types of treatment delivered, and the outcomes achieved.

Routine data is available detailing the number of people in treatment for alcohol use in Southampton, and the percentage successfully completing treatment[93]. The number of people in treatment for this health needs assessment has been provided by the local alcohol specialist service and is more up to date than is available publicly (see CGL data section). The percentage of people in Southampton who successfully completed treatment for alcohol use, in 2019, was nearly 39% - this is the highest it's been since 2014[93].

Very little is documented about delivery of alcohol brief advice in mental health services, it is known to be effective in reducing alcohol consumption in a primary care population if universally applied. However, it isn't universally delivered and known barriers to its implementation are practitioners feeling they don't have enough time or training and that they feel awkward when asking about alcohol consumption[7]. Facilitators for having conversations about alcohol include training, evidence of the impact it has, and access to resources including the expertise held in specialist services[7]. Similar themes were identified more broadly about smoking and alcohol by stakeholders consulted for this health needs assessment. Mental health staff recognised that increasing use of alcohol could signify a deterioration in someone's mental health, and the potential benefit therefore from asking people

Data, Intelligence & Insight Team
Southampton City Council, Municipal Block – West,
Civic Centre, Southampton, SO14 7LT
E-mail: strategic.analysis@southampton.gov.uk
Website: https://data.southampton.gov.uk/

about their alcohol use more routinely. The more regular contact that is had with people accessing mental health services in comparison to primary care provides a slightly different context within which to apply alcohol identification and brief advice.

As with treatment for dependent and harmful drinking, any interventions offered and delivered for increasing risk drinking are likely to be recorded in the progress notes section of Rio and would need to be audited to review this aspect of care.

Smoking and Alcohol

Whilst there are associations between use of tobacco and alcohol, the same has not been widely demonstrated between people's intentions or their attempts to quit smoking and reduce alcohol consumption[94]. A time series analysis of general population trends in England, did show a reduction in smoking prevalence was followed by a reduction in prevalence of higher risk drinking two months later[94]. More broadly, an intervention aimed at improving the provision of preventive care in community healthcare services in Australia demonstrated how difficult it is to improve practice or patient outcomes. A multifaceted intervention including training, support and leadership only resulted in an improvement in assessment of risk (including for smoking and alcohol) but not for delivery of brief advice (although there was some improvement for delivery of alcohol brief advice)[88].

6.4.2 Pharmacy data

267 people were seen via the pharmacy stop smoking service in 2020/21(the first full year) – the service was impacted by the Covid-19 pandemic; of the 10 pharmacies two paused their delivery of the service and the others had to adjust to remote and online support rather than face to face. As has been discussed elsewhere, the pandemic also effected people's intentions to quit or keep smoking, in different ways, as well as how they made any quit attempts. As far as is known, none of those seen disclosed having SMI (this would attract a higher payment); this is a consideration for any future evaluation of the service, particularly if part of a tobacco dependency treatment pathway includes strengthening links between secondary care and community resources.

6.4.3 CGL data

A study investigating the prevalence of alcohol dependency in England estimated the number and rate of adults with alcohol dependency potentially in need of treatment (with an AUDIT score of 20+ and a proportion of those scoring 16-19) in each local authority, based on the APMS[95]. Southampton was estimated to have 5,355 people in need of treatment for alcohol dependency in 2018/19, a rate of 2.65 per 100 adults age 18 or over. This was a large increase on the previous 7-year trend (from 3,360 in 2010). The study also found that people needing treatment were more likely to be of a younger age, male, white and living in areas of greatest deprivation.

The following data describing people who had accessed the alcohol service was available for a three-year period, 2018 – 2021:

Table 5 Demographics of people being seen by the alcohol service in Southampton, 2018 - 2021

	2018/19	2019/20	2020/21
Total	424	369	293
Male	60%	59%	58%
Age group with highest proportion seen	45-54-year olds (33%)	45-54-year olds (30%)	35-44-year olds (30%)
Ethnicity: White/Other/Irish	92%	91%	90%
Smoking status not recorded	43%	82%	95%

Source: CGL

In 2018/19, when recording of smoking status was higher, 36% were current smokers and 6% ex-smokers. This is slightly lower than national alcohol and drug treatment statistics for 2017/18 (42% were smoking at the start of treatment)[96]. In 2019/20, the National Drug Treatment Monitoring system data reports smoking prevalence for Southampton as 62%[97].

As well as seeing less people, the impact of Covid-19 may explain the reduction in recording of smoking status. There was also a downward shift in the age groups predominantly being seen, with a higher proportion of 25 – 34-year-olds accessing the service (16% vs 10-12% in previous years) and a lower percentage of those age 65+ (6% vs 10-11% in previous years).

The number of individuals open to treatment for alcohol support and in receipt of treatment from mental health services:

- Rose from 43% in 2018/19 to 73% in 2019/20 and 2020/21
- 8-10% already engaged with MH team
- 8-10% had a need identified but were not receiving treatment
- 27% were receiving treatment from their GP in 2018/19 rising to 49% and 53% in the years following.

National data collected from people in alcohol treatment in 2017/18 described 47% identifying a mental health need (higher than people being treated for opiate dependency), and of all those accessing drug and alcohol services 74% were receiving treatment; 48% from their GP and 22% from a community mental health service[96]. In a cross-sectional survey of four UK centres, 85% of people using the alcohol service reported psychiatric disorder in the past year[13].

Data, Intelligence & Insight Team
Southampton City Council, Municipal Block – West,
Civic Centre, Southampton, SO14 7LT

E-mail: strategic.analysis@southampton.gov.uk
Website: https://data.southampton.gov.uk/

7. Stakeholders

People who use Southern Health community mental health services have not contributed to this health needs assessment.

The data collected from stakeholders supports what has been published about culture and attitudes towards smoking in mental health services, and relationships between mental health and alcohol services.

There is a resistance to change amongst staff regarding discussing smoking and alcohol use and a perception of resistance amongst service users to stop or reduce tobacco and alcohol consumption.

Staff report that most of the people they support smoke and drink alcohol, to manage boredom and as a coping mechanism, which they empathise with and accept.

Health deterioration amongst people with mental ill-health is seen as inevitable; they are perceived to have a lack of awareness about their physical health.

Physical and mental health are regarded separately, perpetuated by having separate 'physical health' clinics. Conversations about smoking and alcohol use are most likely to occur at these clinics but are unlikely to be followed up.

Both mental health and alcohol services consider there to be a 'right time' to discuss smoking, which would not be until further into the person's care.

Smoking and alcohol use are more likely to be discussed when they are believed to have an impact on a person's diagnosis or medication rather than solely as contributing factors to their mental ill-health.

Alcohol and mental health services do not share expertise and do not perceive or understand each other well. Any joint working that occurs is viewed as practitioner dependent leaving some people with no support for their alcohol use.

Mental health and alcohol service staff would like better links with one another, to share expertise through training and champions within their teams – as well as see more of one another. They would like to work in parallel with people who have both mental health and substance use needs, rather than sequentially.

Mental health staff are keen to undertake tobacco dependency treatment training – one team had already arranged for all staff to have brief advice training and identified a few members of the team for NCSCT certified practitioner training.

A range of stakeholder views were sought for this health needs assessment, from within Southern Health as well as their partner organisations – this includes other services that work with the same people either concurrently or at different times, and stakeholders within commissioning organisations.

Within Southern Health's Southampton Division, the leadership team, all three CMHTs (Central, West and East), EIP team, AMHT and OPMH teams were consulted on their views and experiences of meeting service users smoking and alcohol needs (including psychiatrists, social workers, mental health nurses, psychologists and support workers). This involved one to one discussion as well as group meetings; an online survey (see appendices) was made available for staff who hadn't had the opportunity to express their views during a meeting, but with only one response. Support services that operate across the whole of Southern Health were also included; Occupational Health, facilitators for Making Every Contact Count, pharmacy, procurement, and Patient and Public Engagement and Patient Experience.

Partners were consulted via one-to-one discussion from the voluntary sector - No Limits and CGL - the Alcohol Care Team at University Hospital Southampton, commissioners of mental health services at Southampton Clinical Commissioning Group and of drugs, alcohol and tobacco dependency services at Southampton City Council.

We also hoped to gain the views and experiences of people who use Southern Health services, but this wasn't achieved. Avenues explored included a paper and online survey (see appendices) to be disseminated by voluntary sector organisations, front line mental health teams within Southern Health and also via Southern Health's leads for Patient and Public Engagement and Patient Experience. Due to Covid-19 restrictions in person consultation was not possible. The survey received four responses – in order to preserve anonymity these results will not be presented here. There are published accounts of service user consultations regarding smoking and to a lesser extent alcohol which will be summarised throughout as well as at the end of this section.

Notes taken during conversations with all stakeholders have been reviewed for themes and subthemes and are presented here. Individuals are not identified but where it is helpful to know the views of staff within a specific service, to evidence recommendations, this is represented as such. During discussions with all stakeholders, there was much more of a focus on smoking which could be for a number of reasons;

- it's wider recognition as a public health issue and the contribution it makes to ill health and premature death
- the differing societal norms associated with smoking and alcohol use
- very simply the limited time with each team to capture their views.

7.1 Culture within services and its impact on addressing smoking and alcohol use

7.1.1 Resistance

Some mental health staff acknowledged a resistance to change within the service, with certain customs and practices ingrained. This included resistance from some care coordinators, who have

large caseloads, to take on what is perceived as 'physical health' work, particularly as historically it has not been part of their remit. They perceived service users as reluctant to change, and when they pushed back on issues such as smoking staff would empathise – in the face of this staff described adopting a mindset where smoking and tobacco addiction wasn't taken seriously. The exception to this was the impact smoking had on medication doses, as with clozapine (a type of anti-psychotic medication). Similarly, smoking and alcohol might be discussed when medication is changed.

Staff reported taking for granted that service users smoke, and acknowledged they were accepting of a certain amount of health deterioration. This culture of acceptance of smoking has been widely documented[11]. They found it difficult to imagine what behaviours or activities service users would replace smoking with.

In 2020 ASH and the Mental Health & Smoking Partnership published findings from a survey of 427 mental health nurses and psychiatrists to assess training needs and focus groups to understand barriers and views on discussing smoking with patients. They found

- an enduring culture that smoking is inevitable for people with severe mental illness and, a belief that they don't want to or can't quit, and the only option is to contain it when absolutely necessary.
- staff could identify smoking as a risk factor for poor physical health but believed that quitting was detrimental to patients' mental health and that it wasn't their role to address it – they also didn't perceive the purpose of smoke free policies to be to reduce harm and improve health[98].

A few Southern Health staff involved with inpatient care spoke about the introduction of the latest smoke free policy in 2019, and the lack of understanding of the rationale behind it, but that now, a few years on, no smoking on and in trust premises was recognised as the norm – perhaps evidence that culture can be changed.

7.1.2 Smoking

Staff reported that most service users smoke, and few would want to give up. In the drug and alcohol services they reported 100% of service users said 'no thanks' when asked about stopping smoking at initial assessment. They felt service users would be more likely to consider it in the later stages of recovery (after initially compensating for a reduction in the pleasure response when not drinking by smoking more) and therefore it would be asked again in 3-6 months.

Some mental health staff described smoking as a well-known issue, making it easier to talk about – one team spoke about experiences of service users dying prematurely, and that perhaps this was a consequence of long-term smoking and conditions such as COPD. Staff perceived smoking to be part of service users' lifestyle, using it as a crutch or coping mechanism, because service users are isolated or bored, for comfort and as one of their luxuries, all of which would affect their motivation to quit. These reasons for smoking are supported by findings from a survey with service users published in 2020[99]; managing their stress and emotions, boredom and being part of a social network. Those working with young people also described smoking as a bonding activity, as something to do with their

hands when anxious, and having little regard for the longer-term consequences (even when witnessing relatives experience them).

Voluntary sector partners voiced life being hard for people with mental ill health and smoking being the norm, making quitting smoking a hard sell, and particularly difficult when they are already trying to give up other substances. This was echoed by mental health staff, who described service users telling them it was their choice to smoke; some staff perceived people would only consider quitting if they couldn't afford to smoke. However, surveys with smokers with psychiatric illness have reported health concerns to be the most common reason for making a quit attempt[85]. In the Health and Wellbeing Alliance survey[99], service users described lacking the confidence to quit, based on past attempts that hadn't worked, and fear of a worsening of their mental health. They believed their mental ill-health affected their ability to quit but not their desire to quit, in order to improve their physical health and reduce their chances of dying prematurely, as well as because of the expense of smoking. An American study into the quit experiences of smokers with psychiatric illness demonstrated stress to be the most common reason for smoking relapse[85].

A minority of staff expressed the view that smoking lifts people's mood, with nicotine countering anxiety, and that vaping being offered as an acceptable alternative wasn't helpful due to the risks associated with nicotine addiction. The idea that smoking is a form of self-medication and that quitting can exacerbate negative symptoms are not supported by research, but can be explained by symptoms of nicotine withdrawal being very similar to experiences of mental ill health (and may be strong as a result of smoking more cigarettes and each one more intensely); it is therefore important to ensure people with mental ill health access NRT for longer and at higher doses than people without mental health conditions[11]. Misunderstandings around e-cigarettes can be addressed using up to date publications such as the South East E-Cigarette Position Statement[100], and indeed the Southern Health Smoke Free Policy.

Vaping was described as a potential facilitator for change by some, with lower uptake of NRT, and use of dedicated services if encouraged including pharmacies but less likely GPs. Young people were thought to be more motivated by how they are perceived by others, and changes to their physical appearance.

Very few staff spoke about smoking themselves; those that did thought it discounted them from speaking to service users about quitting – other staff members felt quite the opposite was true, that they would be more empathetic. There is evidence to suggest staff who smoke are less likely to discuss smoking[98].

7.1.3 Alcohol

Mental health service staff reported that many or most of the people in their care drink alcohol, and often 'to excess'. They felt few people knew or understood the 14 units per week recommended limit, that it was in fact very easy to exceed this, and most had no idea how many units they drank – 'they just drank'. Staff also suggested service users wouldn't be honest about how much they drank, and that they can only report what they are told – other stakeholders agreed that national routine data

Data, Intelligence & Insight Team
Southampton City Council, Municipal Block – West,
Civic Centre, Southampton, SO14 7LT
E-mail: strategic.analysis@southampton.gov.uk
Website: https://data.southampton.gov.uk/

doesn't reflect what is known via research about prevalence of alcohol use in mental health services, which could indicate underreporting, or a lack of access to services.

Staff believed mental health service users drank to block out previous trauma, as a coping mechanism for their mental ill health, to self-medicate, due to a lack of anything else to do (including a lack of services) and family influences. Whilst some staff reported being more motivated to look at alcohol use (in comparison to smoking), and found it easier to talk about, partly as they believed service users were willing to cut down, others felt most would only stop drinking when they got too old to consume the same volume or they died. This could be a reflection of the different treatment approaches to tobacco and alcohol addictions; one is thought of as having a threshold under which it can be used at lower risk (although not 'no risk' which may not be commonly understood) whereas for the other there is no 'safe limit'. In OPMH, alcohol was discussed at the initial assessment but then only again if it was 'needed' rather than routinely.

The impact of Covid-19 was mentioned by some but with no consensus; that it had both reduced and increased consumption of alcohol.

7.1.4 1st things 1st

It was clear from Southern Health staff their primary focus would always be mental health, and similarly for CGL and No Limits staff it was alcohol. Smoking would be a focus for neither, the reason for which was verbalised by mental health staff as 'it does not impact their mental health' and 'too overwhelming for the service user'(whereas for drug and alcohol service staff it was a combination of not giving up two substances at once, and life being too difficult for people to consider quitting). Staff spoke about there being a 'right time' to address smoking, and frequently cited that the initial assessment, when in crisis or being admitted was not it. Some staff voiced a desire to do more 'prevention' but felt they were always managing 'high risk behaviours and situations'.

In a survey of staff and people being treated for substance use in seven London addiction services, 79% of clients who smoked expressed a desire to quit smoking, 46% wanted advice on stopping but only 15% had been offered it; only 29% of staff thought it should be addressed early in the treatment journey, compared with 48% of people receiving treatment[102]. There is evidence to suggest that making a simultaneous quit and alcohol reduction attempt improves outcomes; a recently published study demonstrated that heavier smoking on admission to an alcohol service resulted in increased alcohol use six months post treatment[103].

This principle of 'first things first' was highlighted in the Royal College of Physicians report into smoking and mental health in 2013[11] but is not supported by evidence regarding the benefits to mental health of stopping smoking nor service users' own reports of being motivated to quit. An association between long term alcohol dependence and smoking has been found which may be helped by concurrent treatment for nicotine addiction[104], and supported by physiological evidence of an interaction between the reinforcing effects of alcohol and nicotine, enhancing motivation to consume the other, and in particular that nicotine reduces the sedating effect of alcohol encouraging further consumption[80]. A Cochrane review of cessation interventions provided during substance use

Data, Intelligence & Insight Team
Southampton City Council, Municipal Block – West,
Civic Centre, Southampton, SO14 7LT
E-mail: strategic.analysis@southampton.gov.uk
Website: https://data.southampton.gov.uk/

treatment and whether they help tobacco users to quit concluded there was enough evidence of sufficient quality to recommend interventions, particularly pharmacotherapy ones, to help people to quit, with no evidence that it affected recovery from alcohol or drug use[105].

Within the mental health service, alcohol use was considered to impact on mental health and therefore was more likely to be addressed than smoking – but only if it was impeding the mental health problem. The drugs and alcohol service spoke about their attempts to challenge the view that alcohol dependence was not mental ill-health.

Service users have reported a lack of support for quitting, which was rarely raised by mental health professionals, who would tell them to focus on their mental health. They perceived they would be quitting on their own, which would take willpower, and this affected their own belief about success. Service users report wanting a personalised approach, with access to the full range of support and pharmacotherapy options[99].

7.2 Separate 'physical health provision'

All three Southampton CMHTs as well as AMHT have separate clinics where service users are offered the requisite checks for their 'physical health'. There is also a Health and Wellbeing Clinic hosted by the Central team for all Southampton Southern Health service users taking clozapine. Staff spoke about these clinics being for screening of physical health issues, some ongoing monitoring (as service users tend to attend repeatedly, albeit at different frequencies) but not for health promotion, following up or interventions to address issues such as smoking and alcohol use. There was a view that as a result of these clinics, conversations about physical health issues aren't discussed at other times by care coordinators, with particular problems for those without a care coordinator (service users seen solely by a medic and followed up in clinic). There was also concern that signposting to GPs probably didn't result in an appropriate intervention. Service users appeared to be prioritised for the physical health clinics based on which medication they take which may leave some with high need for intervention unsupported. A systematic review and meta-analysis of preventive care provision in mental health services found that assessment for smoking was high (78%), but was not for other issues such as alcohol, and care for modifiable chronic disease risk behaviours was suboptimal and variable[106]. A recent local cross-sectional study into physical health checks undertaken in primary care for people with severe mental illness found that receiving no health checks in the previous 12 months was associated with greater deprivation, being male, underweight and having an SMI for 5+ years[107].

'Improving physical health in mental health services' is a workstream being given priority across Southern Health currently; asking about smoking and alcohol is part of a 'physical health check' and therefore somewhat dependent on this function and giving it relevance to this health needs assessment. It would be interesting to further explore whether the distinction between 'physical' and 'mental' health is helpful (whilst an understandable one when planning and delivering services) or rather takes the onus away from the majority of staff, and reduces the opportunities for conversations and interventions. It also perpetuates the view that smoking is a physical health condition –

information about the impact of smoking on mental health and effect of quitting being similar to that of an anti-depressant medication is widely available[108]. Equally, the link between alcohol use and mental ill-health is well understood, albeit complex, and drinking at harmful levels has implications for both physical and mental wellbeing[109]. The separation of physical and mental health and the prioritisation of mental health makes the provision of physical health clinics vulnerable in times of increased pressure; during the first wave of the pandemic staff reported that physical health clinics were stopped.

7.3 Collaboration

7.3.1 Separate services and expertise

Several different stakeholders expressed concern that mental health and addiction services are within separate organisations. Whilst mental health and drugs and alcohol services both see service users with co-occurring mental health and addiction conditions, neither are experts in both; there hasn't been a consultant psychiatry trainee in addiction locally for at least 5 years. Whilst, for example, a CMHT may have some staff with drugs and alcohol knowledge and experience within the team, it was acknowledged that this really only benefits that practitioner's own caseload of people; other practitioners in the team felt they had only basic knowledge and would refer their service users straight to the drugs and alcohol service without offering any intervention either before or during that referral period.

It was highlighted that the drugs and alcohol service is open access, whereas secondary health care services generally require referral and assessment, meeting a set of criteria at each step to be accepted into the service. This disparity in how services operate, that are seeing a proportion of the same service users, can cause friction and confusion and historically has often meant that the alcohol use is dealt with first. Both CGL and No Limits felt that a significant proportion of their service users have mental health issues likely to meet the criteria for a CMHT. Neither felt equipped to help service users with severe and enduring mental ill health.

7.3.2 Services perceptions of each other

Services spoke about how they perceive one another. The mental health teams reported not being sure if service users would meet CGL's criteria, that they have to want to change and show motivation and commitment (which some commented was too high an expectation) before they can be referred, that it is a limited resource for which people must be prioritised and spaces within the service not wasted, with long waiting lists (which they said service users reflected in descriptions of long waits and not hearing from them) and a policy of 'first strike and you're out'. This concept of CGL as a limited service left some teams feeling like they were 'picking up the slack' and delivering everything for service users who were open to them. They also thought CGL used to have a mental health specialist and would benefit from one.

This contrasted with how CGL described themselves; whilst they recognised that they were a relatively new service having formed from an amalgamation of previous services just before the pandemic, they described three levels of service for people using alcohol with increasing intensity, using a proactive

approach that helped people work towards being motivated to change, and that people could stay in the service as long as they needed to, and come and go, if they were engaging. They do have a psychologist who is working with case workers particularly on trauma informed practice, but that their mental health offer is similar to that of primary care, and they cannot manage service users alone who have enduring and complex mental health issues.

CGL made similar observations about the mental health service, not being sure of their criteria, not seeing them once they have been referred to CGL, and that they suffer with a high turnover of staff (which the mental health staff also said about CGL).

From both services there was some consideration given to why they experience each other in the way they do, and what might be fuelling their perceptions. They felt changes to services didn't help, that they lacked knowledge of each other's services, referral process, expertise, ways of working and what needs they can manage. There was also recognition that both services were likely to be feeling overwhelmed.

7.3.3 How services work together

PHE guidance on commissioning and providing services for people with co-occurring conditions[110] suggests that it is the mental health service that takes the lead in any joint working. However, mental health staff described working quite separately to CGL, and once referred they may discharge particularly if they viewed alcohol use as the 'main issue'. Some staff reported that if a service user did not meet the threshold for CGL, they would not receive any intervention regarding their alcohol use. Similarly, CGL described difficulty in working with CMHTs, who they felt would want to discharge someone who had been referred to CGL, and sometimes didn't accept them back into the service even when they were abstinent. They described never being sure if they would agree to joint working or not and felt that it was very difficult for them to help someone with their alcohol issues if their mental ill health wasn't also being addressed.

Other staff spoke about working jointly, having good links with CGL and No Limits and going to them for advice, but that this depended on the practitioner. One practitioner spoke about needing to find a service user a rehab bed, and working with the alcohol service to do this, which they found invaluable. There is a dual diagnosis meeting every two to three months attended by AMHT, CMHTs, CGL, No Limits and the Increasing Access to Psychological Therapy service, which all agreed was positive. However, there was also frustration about this meeting, that actions weren't taken forward between meetings and communication wasn't filtered down to the wider teams. It was felt that communication could be improved as well as greater oversight of strategic and operational meetings and workstreams.

In findings published from a joint survey of alcohol and mental health services, the Institute of Alcohol Studies reported:

- 7% of alcohol workers thought alcohol was adequately considered in mental health services compared with 45% of mental health staff

- 32% of mental health workers thought alcohol services adequately considered mental health compared with 66% of alcohol staff
- Over 65% of alcohol workers thought mental health issues were adequately considered in alcohol services, vs just over 30% of mental health staff
- More than two thirds of all respondents thought joint working and the delivery of the 'no wrong door' policy was poor or very poor
- To some degree, more than 95% of all respondents wanted more collaborative working, and increased awareness and training on each other's specialties[109].

Mental health teams also spoke about how they interacted with the wider health care system, for example GPs. It was common to write to GPs to highlight health issues picked up in physical health clinics, but a recognition that the follow up was then left to them, with no ongoing monitoring, or knowledge as to whether an intervention had been offered or accepted. There was recognition that having to contact the GP was an extra step for service users and could be a barrier (and specifically for NRT). Efforts by individual practitioners were again pivotal, for building relationships with GPs and following up on interventions. Some specifically said they find it uncomfortable to challenge smoking and alcohol as they don't know where to signpost people; most teams didn't know the latest developments in stop smoking support in Southampton, nor where to signpost people who were drinking at higher risk levels but weren't dependent. The importance of the wider system was acknowledged; one team spoke about advocates that would engage people using the night-time economy, to increase awareness of alcohol harms, and felt the loss of these workers impacted their work.

7.3.4 Ideal way of working

Front line staff shared views about what would help different services work together more effectively, including more collaboration, building links, educating each other, having champions within the team to link in with other services on their behalf, knowing each other by face as well as name, or even to be co-located.

When asked what joint working would look like the answer was; from the point of referral, writing and reviewing the care plan together (to be physically in the same meeting), discussing issues and collaborating, focused on the individual; put simply, each service doing what it does at the same time, enabling the service user to work on their alcohol use and improve their mental health simultaneously, with one benefitting the other. There was also a suggestion that using a clear and evidenced dual diagnosis pathway as well as objective measures such as AUDIT and GAD-7 Generalised Anxiety and Depression assessment) would help to avoid professional differences.

7.4 Resources

7.4.1 Knowledge and Skills

Southern Health staff reported feeling deskilled and lacking knowledge particularly with regards offering support for smoking, without training or experience for doing so. (Conversely, drug and alcohol services described their workforces as confident to have conversations about smoking). Some felt that training wasn't available, all were keen to take up offers of training and indeed some teams

already had via the new Southampton Smoke Free Solutions Team. Staff would like this training to be with a facilitator rather than e-learning and formalised on the Learning and Development system to book a convenient time and access refresher training regularly. Some staff made the connection with Making Every Contact Count; there is a trust-wide ambition spearheaded by the Executive Lead for MECC, the Director of Nursing, for all frontline staff to be MECC trained. Results from an ASH survey with mental health staff in 2016[101] suggested staff who had been trained

- Were twice as likely to discuss training
- Were less likely to think quitting would negatively impact a patient's recovery
- but 45% had received no training.

Very little had changed in their follow up survey in 2019[98] - training provision was identified as inadequate, with low levels of knowledge and skills particularly regarding medication, e-cigarettes and referral. Interestingly, they found where staff said they carried out very brief advice regularly the answers given portrayed that they didn't fully understand how to deliver it. In a systematic review which investigated how to increase the effectiveness of interventions to improve preventive care provision more broadly in mental health settings, educational meetings were identified as important, as well as redefining roles and responsibilities within the team, having local processes and procedures and a structure for authority and accountability[106].

Whilst some Southern Health staff gave examples of service users they had not known how to help, others recognised that they could use transferable skills such as those used in motivational interviewing (MI), skills they use every day with service users in respect of their mental health, to address smoking and alcohol issues. This was mentioned by mental health staff in the context of alcohol as well as smoking, for example using it when a service user isn't ready to engage with an alcohol service, and also by partners as something they would expect a mental health service to offer.

Where staff didn't explicitly mention techniques such as MI, they did offer up examples of applying their mental health skills as part of their approach to smoking and alcohol use; via conversations about emotional wellbeing and coping strategies for distress, building rapport over time, mentioning smoking and alcohol casually and slowly at first, building to more in-depth conversations and moving them on in the behaviour change process. A recent study demonstrated that a range of behaviour change techniques are required to support people with SMI to reduce their cardiovascular risk, for example, which need to be individualised to match the drivers of behaviour[111].

7.4.2 In-house model

Most mental health teams were keen to have tobacco dependency expertise within the team, with for example health care support workers taking a lead on this, and where this didn't already exist there was recognition of a need for it. The potential for care coordinators to be pivotal in this work was voiced, with their existing relationships and rapport, but that a lack of time would impede this as addressing addictions requires more contacts with service users. Partners also believed it should be part of core care. This is encouraging; there is evidence to suggest that service users want support and encouragement to quit smoking, and from the mental health service rather than mainstream smoking cessation services, but that staff didn't have the confidence to offer it – the findings of this

health needs assessment do not corroborate this[112]. Pharmacological and psychosocial interventions begun in the inpatient setting and continued for four months in the community have shown improved cessation rates at six months, but not in the longer term[88]; an inhouse model would allow staff to offer support continuously, and whenever the need arises. More broadly, interventions to improve the physical health of people with SMI have been demonstrated to be more successful if staff have the confidence to engage people with mental health conditions and are able to reduce the stigma associated with mental ill health[111].

Other suggestions that would make use of existing resources within Southern Health included a support group at the Recovery College and expanding the programme of peer support to include service users and staff with lived experience of tobacco addiction.

7.5 IT/Data

Whilst issues regarding IT and data collection were raised in conversations with Southern Health staff about addressing smoking and alcohol use with service users, it wasn't represented as a primary concern. IT was described as a barrier to providing this care, for the following reasons:

- Difficulties with using RiO
- Misrepresentation in Tableau of the work undertaken

Staff across all teams spoke about recording smoking and alcohol status on RiO on the core assessment form for physical health, although there was some deviation from this, when this information was recorded in the progress notes instead. This form was reported by some to be difficult to complete, not nuanced enough to allow for individualised care, and confusing to find or use the correct form – there was a perception of too many forms on RiO, being unaware of all the different forms and only using what is familiar. Some suggested this information would be better recorded in the demographics section. Whilst some teams reported to only ask smoking and alcohol status during the initial assessment, it is unclear how often, on average, this information would be updated. Those working in the physical health clinics felt the core assessment form was likely only completed during one of their clinics.

There was frustration with how the information on Rio pulled through to Tableau and therefore reflected in performance reporting – not only was this dependent on the core assessment form being filled in (rather than information recorded in the progress notes) but unless all the checks were completed the whole assessment would be deemed incomplete, with no ability to evidence conversations had or differentiate between refusals and 'not asked'. Tableau will also include people only just open to teams in the denominator, without allowing for the time it might take to have these conversations. Staff reported feeling demoralised by how Tableau represented the care they were giving to service users; it also doesn't join up with the gradual approach described by staff to move service users to being ready to discuss smoking and alcohol use.

Staff seemed accepting of Rio's limitations and used to finding ways to work around it – for example most teams record their physical health checks on excel spreadsheets, which they believe can be

updated and service users tracked more easily on. This has implications for performance reporting, if Rio is not also being updated.

7.6 People who use community mental health services

Only a few people spoke about what resources people who use services might need to access offers of support and treatment, and experience successful outcomes – written leaflets, social media and free NRT, and for longer than is usual, were all mentioned, as well as needing to raise the profile of the importance of their physical health.

In the absence of local evidence, consultations with people who use mental health services have been undertaken by national organisations, specifically about smoking. From their 2016 survey[101], ASH reported that 43% smokers with a mental health condition said no one had asked them about smoking in the last year, two thirds with inpatient experience said no support was offered to help them abstain or quit. Importantly, 80% of respondents who were current smokers had attempted to quit and 46% said they wanted to quit. A few years later 11 experts by experience offered their insights about smoke free policy implementation via a focus group with key themes including:

- implementation needed to be more person-centred, with service user involvement – there was a perception that trusts went smoke free because they had to, rather than to encourage service users to improve their health
- There is a need for greater provision of support, both pharmacotherapy (nicotine withdrawal and cravings were not managed effectively) and behavioural (this was felt to be a tick box exercise and that giving someone a card shouldn't count as support) and including in the community, particularly after discharge – they wanted to discuss smoking cessation with mental health staff but would also value peer support
- Better communication, highlighting the rationale behind smoke free trusts, using positive language, raising awareness of the impact of smoking on mental and physical health, and interactions with medication as well as applying the policy consistently (seeing some people smoking undermined other's efforts)[113].

The desire to receive stop smoking support from mental health professionals is supported by a meta-synthesis of 15 studies undertaken by the Cochrane tobacco group[112].

The National Collaborating Centre for Mental Health was commissioned by NICE to undertake four evidence reviews to inform the development of NICE guidance NG58 - Coexisting severe mental illness and substance misuse: community health and social care services. One of these focused on the views and experiences of people who use mental health and social care community services for people and also use substances, their families or carers, providers and commissioners[114]. Out of a total of 35 studies included, a number were UK based, and described service users' experiences of care for co-occurring conditions as fragmented, under-resourced and stigmatised. They described this impacting their ability to form trusting relationships, which was an important facilitator for a more positive experience, and better engagement.

This gives some insight into the expressed need and care experience of people who are dependent on alcohol. No evidence was found that describes in detail the views of people who use mental health

Data, Intelligence & Insight Team
Southampton City Council, Municipal Block – West,
Civic Centre, Southampton, SO14 7LT
E-mail: strategic.analysis@southampton.gov.uk
Website: https://data.southampton.gov.uk/

services in relation to alcohol use, how their needs are being met by mental health services, and in particular for those who are drinking at levels lower than this. Evidence exploring this, as well as views and experiences of being offered and delivered very brief and brief advice for alcohol use within mental health services (rather than the intervention being outside of the service) would be beneficial to service development.

8. Conclusions

A health needs assessment from the perspective of a population accessing one healthcare service is relatively unique. It has facilitated a greater focus and deeper understanding of the views and experiences of frontline staff. It did not come without challenges, the main two being incomplete data – for describing the need – and a lack of involvement from people who use the service. Despite its limitations, this health needs assessment makes an important contribution to understanding the needs of people in Southampton who access community mental health services and who smoke or drink alcohol. The data collected and presented was sufficient to identify the current unmet need and to make recommendations for addressing it, particularly as the themes are broadly supported by what has previously been written about smoking, alcohol use and mental health services. There are important next steps which now need to be taken.

8.1 Recommendations

8.1.1 Individualised and holistic care

Discussions about tobacco and alcohol use are part of a holistic rather than medical model of care, recognising their impact on the whole person, the resulting reduction in quality of life and the perpetuating cycle of further deterioration in physical and mental health.

How and when people are asked about their use of tobacco and alcohol and offered treatment is influenced by what the person using the service requires, rather than how the service operates. These conversations should not be confined to physical health clinics, they must happen at any contact and include an intervention, however brief.

Consider a proportionate universalism approach to supporting people with tobacco and alcohol use – this health needs assessment has highlighted that men, younger age groups and people living in more deprived areas smoke and drink alcohol more, and according to a local study are less likely to have had recent physical health checks. There will also be people whose health is already deteriorating because of their use of tobacco and alcohol. Use may differ according to mental health diagnosis, which may warrant further investigation.

The culture of inevitability around smoking, alcohol use and declining physical health for people with mental illness is challenged and replaced with individualised and holistic care. Parity of esteem relates not just to physical and mental health care, but to all care offered to and received by people with mental illness in comparison to those without.

Not all people using tobacco and alcohol do so for the same reasons. People should be asked this question, helped to identify what is and isn't beneficial about this use, and crucially what would motivate them to reduce or stop.

Everyone using community mental health services is given appropriate opportunities to be meaningfully involved in the development of services to better address tobacco and alcohol use. For

a variety of reasons including cultural barriers, some may need more support to do this than others, therefore the current mechanisms for engagement should be reviewed.

8.1.2 Leadership

The required culture change begins with leadership; senior leaders within Southern Health need to be vocal and visible regarding the importance of tobacco and alcohol use by people with mental ill-health, and unrelenting. Named Executive and Clinical Leads for tobacco and alcohol are required.

Having a Smoke Free policy and being a Smoke Free organisation are good first steps and necessary, but they are not sufficient. The policy must be comprehensive (meeting all the NICE guidance requirements), widely communicated and implemented with formal mechanisms for monitoring.

A whole-organisation focus will help staff to consistently record smoking and alcohol status, as well as interventions offered – data on prevalence of tobacco and alcohol use is communicated back to teams, as well as in time the outcomes of those conversations, to demonstrate their value.

A communications strategy to address the perception of inevitability about use of tobacco and alcohol as well as poor physical health, for staff, people with severe mental illness and their carers which carefully considers what messages, and modes of delivery, are likely to be acceptable and effective.

Southern Health signs up to Equally Well UK, an initiative seeking to promote and support collaborative action to improve physical health among people with a mental illness, through a charter and organisational pledge.

Senior leaders lead by example by prioritising and visibly working with partners to address the complex needs of people who require tobacco and alcohol addiction as well as mental health services.

The governance for reporting on and improving the care offered to people who use tobacco and alcohol is clear and robust, with mechanisms for communicating information up and down the organisation. Ambitions around tobacco, alcohol and physical health need to be clearly stated in all organisational plans and priorities.

An action plan to implement these recommendations is agreed and overseen by the Southampton Division Leadership Team.

The impact of the Covid-19 pandemic on tobacco and alcohol use by people with mental illness, which is expected to have increased, is included in any organisational recovery plans. Community mental health teams are likely to require support to address this increase in need, as well as making relationships across the system even more vital.

8.1.3 Training

The reduction in life and healthy life expectancy as well as quality of life for people with mental illness, in comparison to those without, needs to be brought to life in training.

Training content includes the interdependency of smoking, alcohol use and mental health; smoking and alcohol use have an impact on a person's mental health, mental ill-health increases the likelihood of using tobacco and alcohol and it follows that reducing one will likely reduce consumption of the other, as well as improve mental health. Sharing this training with alcohol services would further support this.

The willingness of staff to be trained in brief advice techniques and tobacco dependency behavioural support is capitalised upon and a strong and sustainable relationship built with stop smoking organisations. Any training offer needs to be continuous rather than one-off or adhoc, with oversight of compliance.

Brief advice training is delivered to address both smoking and alcohol use, and consideration given to how this aligns with Southern Health's Making Every Contact Count Strategy; partners such as Health Education Wessex are engaged to support this and advise on other workforce considerations.

Staff are empowered to use their existing skills, applied every day to address people's mental health needs, to help people replace smoking and alcohol with strategies that don't harm their long-term health.

Resources within Southern Health, such as the quality improvement programme, can release time to address tobacco and alcohol use alongside mental health priorities.

8.1.4 Tobacco dependence treatment pathway

The NHS Long Term Plan has provided an opportunity to develop and implement a model and pathway for tobacco dependence treatment – this must be taken full advantage of.

Undertaking the PHE self-assessment tool for mental health trusts will enable full oversight of the existing gaps in tobacco dependency treatment and inform an action plan for developing the model and pathway. A quality improvement approach to addressing the gaps may be beneficial.

Both research and local staff engagement favour an in-house model for tobacco dependency treatment. This supports seamless care and reduces opportunities for people to return to smoking. All staff can be trained to deliver brief advice and some to offer extended interventions.

The same person or team are responsible for the assessment of tobacco and alcohol use and interventions to reduce or stop their consumption. This will ensure the 'so what' is followed up; recording alone will not improve health outcomes.

Data, Intelligence & Insight Team
Southampton City Council, Municipal Block – West,
Civic Centre, Southampton, SO14 7LT
E-mail: strategic.analysis@southampton.gov.uk
Website: https://data.southampton.gov.uk/

The pathway flows between inpatient and community services, capitalising on opportunities to maintain abstinence. The pathway should reach out to partners such as the alcohol service to embed consistency wherever someone receives care, as well as to stop smoking organisations who can support. The contribution other services such as the Community Wellbeing Team make to the physical health care of people with mental illness should be investigated and incorporated.

The concept of a right time to discuss tobacco and alcohol use is challenged by this pathway; opportunities can be taken at different times in a person's care, using different approaches according to what's appropriate at that moment. As a minimum, smoking and alcohol use should be discussed at initial assessment, during care plan reviews, at discharge, as well as woven throughout care.

Support for using NRT, stop smoking medications and e-cigarettes is addressed by the pathway, including sufficient NRT to minimise cravings and reducing misconceptions and barriers to access.

If changes are required to the recording of smoking (and alcohol) status and related interventions, this is undertaken alongside the development of the pathway or to support improvements in care, rather than as a focus for improvement in themselves. Changes to Rio alone will not meet the needs of people who use community mental health services.

An equality impact assessment will help to safeguard against any inequality in access, experience and outcomes already experienced by those with mental illness being worsened by the new pathway. There is an NHS Advancing mental health inequalities strategy and supporting programme to drive forward the actions required to reduce the likelihood that people from certain communities will have worse outcomes than others. How this fits in locally should also be considered.

8.1.5 Co-occurring conditions

Collaborative working between alcohol and mental health services is robust and sustainable, rather than reliant on individuals. People with needs related to alcohol and mental health should benefit from services sharing their expertise and working in tandem not sequentially. This is clearly stated in Southern Health's 'dual diagnosis' policy and yet stakeholders report it doesn't happen.

Collaborative working will not become the norm without significant effort from all parties; historical and cultural differences will need to be aired and new relationships developed at all levels within all relevant organisations.

How these relationships are strengthened is explored with all staff and may benefit from a quality improvement approach.

Renewed effort into the Southampton-wide co-occurring conditions strategic group can provide a platform for this work and drive forward a commitment to make care better for people with these complex needs.

Alcohol use at dependent levels is not the only focus; a greater proportion of people in mental health services are using alcohol at levels of increasing risk. They must also be offered support to reduce their alcohol consumption and its related harms. As suggested for tobacco dependency, very brief advice, MECC and existing mental health skills can be utilised by staff to address these needs. The Southampton-wide co-occurring conditions group may want to include within its remit the full spectrum of alcohol use by people accessing mental health services to oversee this.

Further work to better understand the role alcohol plays for people experiencing a mental health crisis is required, including a more focused look at Southern Health data and engaging staff and people open to AMHT or who have spent time in an inpatient setting. Stronger links between AMHT and CGL in particular should be a focus to address this.

Using alcohol at dependent or harmful levels and tobacco at any level, as well as other substance use, are addictions; they need to be considered in the round clinically and strategically.

8.2 Next Steps

This health needs assessment will be disseminated to all those who contributed to it within Southern Health as well as their external partners. It will be circulated to specific groups within Southern Health; the Southampton Division Quality and Performance Group, the organisation-wide Improving Physical Health in Mental Health Settings Group, the Tobacco Dependency Treatment Steering Group, and these three groups will also have a summary presented to them. It will be made publicly available on the Southampton Data Observatory.

The action plan which results from the full (rather than the executive summary version) recommendations will be devised, agreed and monitored by the Southampton Division Quality and Performance Group, with updates to the Physical Health and Tobacco Dependency Groups, the Integrated Care System (ICS) Tobacco Dependency Steering Group and the Southampton Co-occurring Conditions Strategic Group.

9. Appendices

9.1 Extra Info as Prompts for CMHTs

1. How often are service users asked about smoking and alcohol use and how is this recorded?
   a. Info on referral?
   b. Along the care pathway?
   c. Just in annual check?
   d. By whom?
   e. Is the info shared with partners?
   f. Are you able to offer help/interventions?

2. What are your experiences of asking about smoking and alcohol use – how do you feel about it and how do you think service users feel about it?
   a. Has anyone ever wanted to quit/cut down?!
   b. Examples of good outcomes?
   c. Barriers?

3. Do you have links with CGL and No Limits at a team or individual level? How often do you work with them?
4. Would anything make it easier to discuss? If so, what?
   a. Training
   b. Info on services
   c. How can service users better understands benefits overall and to MH of cutting down/quitting
   d. What would you change?

9.2 Mental Health Service support for people who smoke and drink alcohol – service user views and experiences

Thank you for taking part in this survey. Southern Health NHS Foundation Trust is reviewing how it supports people who smoke and/or drink alcohol, when they are seen in community mental health services.

We will use the information your share with us to improve care for people who have a mental health issue and who smoke and/or drink alcohol.

You do not need to give your name and your answers will be treated confidentially.

If you have any concerns about these questions or about the issues they raise, please contact your care coordinator or support worker, or you can email Rebecca Perrin at rebecca.perrin2@nhs.net.

1. Do you smoke
   Yes ☐ No ☐

2. If no, have you ever smoked?
   Yes ☐ No ☐

3. Do you drink alcohol?

Yes ☐ No ☐

4. If no, have you ever drunk alcohol?
   Yes ☐ No ☐

5. Are you, or have you ever been, open to any of the following services? Tick all that apply to you.

   Mental health service ☐

   Drugs and Alcohol service ☐

   Stop Smoking service ☐

   Alcoholics Anonymous ☐

   Other ☐

   If other, which service?

   ☐

6. If you have been open to an alcohol and mental health service, were you seen

   At the same time ☐

   By the mental health service first ☐

   By the alcohol service first ☐

   If you would like, please provide further information

   ☐

Data, Intelligence & Insight Team
Southampton City Council, Municipal Block – West,
Civic Centre, Southampton, SO14 7LT

E-mail: strategic.analysis@southampton.gov.uk
Website: https://data.southampton.gov.uk/

7. If you were seen by the alcohol service first, when were you seen by the mental health service?

Once I had stopped drinking ☐

Once I had been through detox ☐

Once I had reduced the amount I was drinking ☐

Other ☐

If other, please say when you were seen by the mental health service?

8. Can you remember being asked by the mental health service about your alcohol use? Tick all that apply to you.

The first time I saw them ☐

Every time I saw them ☐

Occasionally ☐

Never ☐

9. Were you happy with the number of times alcohol was discussed?

Yes ☐ No ☐

If you would like, please provide further information

10. What help were you offered by the mental health service for your alcohol use? Tick all that apply to you.

Information about the benefits of reducing my alcohol use for my mental health ☐

Information about how to reduce or stop drinking alcohol ☐

Information about other services that offer support for alcohol use ☐

Referral to an alcohol service ☐

No help ☐

Other ☐

If other, what help was this?

11. Did you feel supported by the mental health service about your alcohol use?

Yes ☐ No ☐

12. Is there any other feedback you would like to give the mental health service about how they support people who drink alcohol?

13. Can you remember being asked by the mental health service whether you smoke? Tick all that apply to you.

The first time I saw them ☐
Every time I saw them ☐
Occasionally ☐
Never ☐

14. Were you happy with the number of times smoking was discussed?
    Yes ☐ No ☐

If you would like, please provide further information

15. What help were you offered by the mental health service for smoking? Please tick all that apply.

Information about the benefits of cutting down or stopping smoking for my mental health ☐
Information about how to reduce or stop smoking ☐
Information about other services that offer support for smoking ☐
Referral to a stop smoking service ☐
No help ☐
Other ☐
If other, what help was this?

16. Did you feel supported by the mental health service about your smoking?
    Yes ☐ No ☐

17. Is there any other feedback you would like to give the mental health service about how they support people who smoke?

Thank you for your time. If you would like any more information about reducing or stopping smoking or drinking alcohol, please speak to your care coordinator or support worker. There are also the following phone numbers or websites that you might find helpful:
https://www.nhs.uk/live-well/quit-smoking/nhs-stop-smoking-services-help-you-quit/ (or search for NHS Stop Smoking)
Smokefree National Helpline on 0300 123 1044

https://www.southampton.gov.uk/health-social-care/health/stopping-smoking/ (or search for Southampton Stop Smoking)
https://www.changegrowlive.org/ (or search alcohol service Southampton) – if you are over 25 – or call 02382 002764
https://nolimitshelp.org.uk/ (or search No Limits Southampton) – if you are aged 25 or under – or call 02380 224 224

9.3 Survey Monkey version

Mental Health Service support for people who smoke and drink alcohol – Southern Health NHS Foundation Trust service user views and experiences

Thank you for taking part in this survey, hopefully it will only take 5-10 minutes. Southern Health NHS Foundation Trust is reviewing how it supports people who smoke and/or drink alcohol, when they are seen in community mental health services.
We will use the information your share with us to improve care for people who have a mental health issue and who smoke and/or drink alcohol.
You do not need to give your name and your answers will be treated confidentially.
If you have any concerns about these questions or about the issues they raise, please contact your care coordinator or support worker, or you can email Rebecca Perrin at rebecca.perrin2@nhs.net.
There are also the following phone numbers or websites that you might find helpful:
https://www.nhs.uk/live-well/quit-smoking/nhs-stop-smoking-services-help-you-quit/ (or search for NHS Stop Smoking)
Smokefree National Helpline on 0300 123 1044
https://www.southampton.gov.uk/health-social-care/health/stopping-smoking/ (or search for Southampton Stop Smoking)
https://www.changegrowlive.org/ (or search alcohol service Southampton) – if you are over 25 – or call 02382 002764
https://nolimitshelp.org.uk/ (or search No Limits Southampton) – if you are aged 25 or under – or call 02380 224 224

1. Please tick all that apply - I.....
currently smoke
used to smoke
have never smoked
drink alcohol
used to drink alcohol
have never drunk alcohol

2. Are you, or have you ever been, open to any of the following services? Tick all that apply to you.
Mental Health Service
Drugs and Alcohol Service
Stop Smoking Service

Alcoholics Anonymous
Other (please specify)
None of the above

3. If you have been open to an alcohol and mental health service, were you seen
At the same time
By the mental health service first - once I had stopped drinking
By the mental health service first - once I had been through detox
By the mental health service first - once I had reduced my drinking
By the alcohol service first
Not applicable
Other - please provide further information if you would like

4. Can you remember being asked by the mental health service about your alcohol use? Tick all that apply to you.
The first time I saw them
Every time I saw them
Occasionally
Never

5. Were you happy with the number of times alcohol was discussed?
Yes
No
If you would like, please provide further information

6. What help were you offered by the mental health service for your alcohol use? Tick all that apply to you.
Information about the benefits of reducing my alcohol use for my mental health
Information about how to reduce or stop drinking alcohol
Information about other services that offer support for alcohol use
Referral to an alcohol service
No help
Not applicable
Other (please say what help you received)

7. Can you remember being asked by the mental health service whether you smoke? Tick all that apply to you.
The first time I saw them
Every time I saw them
Occasionally
Never

8. Were you happy with the number of times smoking was discussed?
Yes
No
Not applicable
If you would like, please provide further information

9. What help were you offered by the mental health service for smoking? Please tick all that apply
Information about the benefits of cutting down or stopping smoking for my mental health
Information about how to reduce or stop smoking
Information about other services that offer support for smoking
Referral to a stop smoking service
No help
Not applicable
If other, what help was this?

10. Did you feel supported by the mental health service about your smoking and alcohol use?
Yes
No
Not applicable
Other (please provide feedback for the service if you can)

9.4 Southern Health NHS Foundation Trust Mental Health Service support for people who smoke and drink alcohol – staff views and experiences

Thank you for taking part in this survey. Southern Health NHS Foundation Trust is reviewing how it supports people who smoke and/or drink alcohol, when they are seen in community mental health services.
We will use the information your share with us to improve care for people who have a mental health issue and who smoke and/or drink alcohol.
You do not need to give your name and your answers will be treated confidentially.
If you have any concerns about these questions or about the issues they raise, please email Rebecca Perrin at rebecca.perrin2@nhs.net.
You may find the following phone numbers or websites helpful:
https://www.nhs.uk/live-well/quit-smoking/nhs-stop-smoking-services-help-you-quit/ (or search for NHS Stop Smoking)
Smokefree National Helpline on 0300 123 1044
https://www.southampton.gov.uk/health-social-care/health/stopping-smoking/ (or search for Southampton Stop Smoking)
https://www.changegrowlive.org/ (or search alcohol service Southampton) – if you are over 25 – or call 02382 002764

https://nolimitshelp.org.uk/ (or search No Limits Southampton) – if you are aged 25 or under – or call 02380 224 224

1. When and how often do you ask service users about smoking and alcohol use?
2. How do you record this conversation?
3. How do you ask about smoking and alcohol - how do you start the conversation and what do you include in it?
4. What help are you able to offer someone who smokes or drinks alcohol above the recommended limits? When would you offer this help?
5. How do you feel about discussing smoking and alcohol use with service users?
6. How do you think people feel when they are asked about smoking and alcohol use - what reactions do you see, and what outcomes from those conversations?
7. How much contact do you have with the Drugs and Alcohol Services and when/why? What does that contact involve (i.e. signposting to, referrals, information sharing, joint working)?
8. If smoking and alcohol use were to be talked about and recorded more often, what would make this easier?

10. References

1. Chang CK, Hayes RD, Perera G, Broadbent MTM, Fernandes AC, et al. Life Expectancy at Birth for People with Serious Mental Illness and Other Major Disorders from a Secondary Mental Health Care Case Register in London. PLoS ONE 2011; 6(5): e19590
2. Hayes RD, Chang CK, Fernandes A, Broadbent M, Lee W, Hotopf M, Stewart R. Associations between substance use disorder sub-groups, life expectancy and all-cause mortality in a large British specialist mental healthcare service. Drug Alcohol Depend. 2011; 1;118(1):56-61
3. NHS England. NHS RightCare Toolkit: Physical ill-health and CVD prevention in people with severe mental illness. 2019. https://www.england.nhs.uk/rightcare/wp-content/uploads/sites/40/2019/03/nhs-rightcare-toolkit-cvd-prevention.pdf
4. John A, McGregor J, Jones I, Lee SC, Walters JTR, Owen MJ, O'Donovan M, DelPozo-Banos M, Berridge D, Lloyd K. Premature mortality among people with severe mental illness — New evidence from linked primary care data, Schizophrenia Research 2018; Volume 199, Pages 154-162, ISSN 0920-9964, https://doi.org/10.1016/j.schres.2018.04.009.
5. Public Health England. Severe mental illness (SMI) and physical health inequalities: briefing. 2018 https://www.gov.uk/government/publications/severe-mental-illness-smi-physical-health-inequalities/severe-mental-illness-and-physical-health-inequalities-briefing
6. Public Health England. Health Profile for England 2019. https://www.gov.uk/government/publications/health-profile-for-england-2019
7. Public Health England. The Public Health Burden of Alcohol and the Effectiveness and Cost-Effectiveness of Alcohol Control Policies: An evidence review. 2016 https://www.gov.uk/government/publications/the-public-health-burden-of-alcohol-evidence-review
8. Osborn DP, Levy G, Nazareth I, Petersen I, Islam A, King MB. Relative risk of cardiovascular and cancer mortality in people with severe mental illness from the United Kingdom's General Practice Research Database. Arch Gen Psychiatry 2007; 64: 242–9
9. Das-Munshi J and others. 'Type 2 diabetes mellitus in people with severe mental illness: inequalities by ethnicity and age. Cross-sectional analysis of 588 408 records from the UK' Diabetic Medicine 2017: volume 34, issue 7, pages 916 to 924
10. Public Health England. Co-occurring substance misuse and mental health issues. https://fingertips.phe.org.uk/profile-group/mental-health/profile/drugsandmentalhealth/data#page/0/gid/1938132790/pat/6/par/E12000008/ati/102/are/E06000036/cid/4/tbm/1/page-options/car-do-0 [accessed 15/9/21]
11. Royal College of Physicians. Smoking and Mental Health. 2013 https://www.rcplondon.ac.uk/projects/outputs/smoking-and-mental-health
12. Public Health England. Health Matters: Smoking and mental health. 2020 https://publichealthmatters.blog.gov.uk/2020/02/26/health-matters-smoking-and-mental-health/
13. Weaver T, Madden P, Charles V, Stimson G, Renton A, Tyrer P, Barnes T, Bench C, Middleton H, Wright N, Paterson S, Shanahan W, Seivewright N and Ford C. Comorbidity of substance misuse and mental illness in community mental health and substance misuse services. Cambridge University Press: 02 January 2018.
14. Public Health England. Alcohol and drug treatment for adults: statistics summary 2017 to 2018 - GOV.UK (www.gov.uk) 2018.

15. Hart CL, Davey Smith G, Gruer L. et al. The combined effect of smoking tobacco and drinking alcohol on cause-specific mortality: a 30 year cohort study. BMC Public Health 2010; 10, 789. https://doi.org/10.1186/1471-2458-10-789
16. World Health Organisation. 2021. https://www.euro.who.int/en/health-topics/disease-prevention/tobacco/news/news/2021/2/world-cancer-day-know-the-facts-tobacco-and-alcohol-both-cause-cancer
17. The Kings Fund. 2021. https://www.kingsfund.org.uk/publications/communities-and-health
18. Steinbach R and Kwiatkowska R. Concepts of Need and Social Justice. 2009 & 2016 https://www.healthknowledge.org.uk/public-health-textbook/medical-sociology-policy-economics/4c-equality-equity-policy/concepts-need-sjustice [accessed 19/8/21]
19. https://data.southampton.gov.uk/population/pop-structure/ [accessed 23/8/21]
20. Davies SC Annual Report of the Chief Medical Officer 2013, Public Mental Health Priorities: Investing in the Evidence. 2014. London: Department of Health https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/413196/CMO_web_doc.pdf
21. Public Health England. Severe Mental Illness. https://fingertips.phe.org.uk/profile-group/mental-health/profile/severe-mental-illness/data#page/4/gid/1938132719/pat/46/par/E39000041/ati/165/are/E38000167/iid/90581/age/1/sex/4/cat/-1/ctp/-1/cid/4/tbm/1 [accessed 15/9/21]
22. https://data.southampton.gov.uk/health/life-expectancy-mortality/life-expectancy/ [accessed 23/8/21]
23. Public Health England. Health matters: reducing health inequalities in mental illness. 2018. https://www.gov.uk/government/publications/health-matters-reducing-health-inequalities-in-mental-illness/health-matters-reducing-health-inequalities-in-mental-illness
24. Public Health England. Local Alcohol Profiles for England - Data - PHE [accessed 20/8/21]
25. ASH "ready reckoner" The Local Costs of Tobacco. : 2019 edition v7.1 https://ash.org.uk/ash-ready-reckoner/ [accessed 24/8/21]
26. Public Health England. The range and magnitude of alcohol's harm to others. A report delivered to the Five Nations Health Improvement Network A rapid review of cross-sectional surveys. 2019. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/806935/Alcohols_harms_to_others-1.pdf
27. ASH. Supporting smokers to quit can help tackle surge in poor mental health. 2020 https://ash.org.uk/media-and-news/press-releases-media-and-news/supporting-smokers-to-quit-can-help-tackle-surge-in-poor-mental-health/
28. Niedzwiedz CL, Green MJ, Benzeval M, et al. Mental health and health behaviours before and during the initial phase of the COVID-19 lockdown: longitudinal analyses of the UK Household Longitudinal Study. J Epidemiol Community Health 2021;75:224-231.
29. Jackson SE, Garnett C, Shahab L, Oldham M, Brown J. Association of the Covid-19 lockdown with smoking, drinking, and attempts to quit in England: an analysis of 2019-2020 data medRxiv 2020.05.25.20112656; doi: https://doi.org/10.1101/2020.05.25.20112656
30. Jacob L, Smith L, Armstrong NC, Yakkundi A, Barnett Y, Butler L, McDermott DT, Koyanagi A, Shin JI, Meyer J, Firth J, Remes O, L´opez-S´anchez GF, Tully MA. Alcohol use and mental health during COVID-19 lockdown: A cross-sectional study in a sample of UK adults Drug and Alcohol Dependence. 2021; 219, 108488

31. Institute of Alcohol Studies. Alcohol Consumption During The Covid-19 Pandemic in the UK. 2nd IAS Briefing. 2020. https://www.ias.org.uk/wp-content/uploads/2020/10/sb29102020.pdf
32. Jackson SE, Beard E, Angus C, Field M, Brown J. Moderators of changes in smoking, drinking, and quitting behaviour associated with the first Covid-19 lockdown in England. 2021 https://www.medrxiv.org/content/10.1101/2021.02.15.21251766v1
33. Department of Health. Dual Diagnosis Good Practice Guide 2002
34. Department of Health. No Health without Mental Health 2011
35. HM Government. Alcohol Strategy 2012. Home Office.
36. NHS England.The Mental Health Five Year Forward View 2016
37. Department of Health and Social Care. Tobacco Control Plan 2017
38. Public Health England. Better Care for people with co-occurring mental health and alcohol/drug use conditions, a guide for commissioners and service providers 2017
39. NHS England. Commissioning for Quality and Innovation 2017-2020. https://www.england.nhs.uk/nhs-standard-contract/cquin/
40. NHS England. The NHS Long Term Plan 2019
41. NHS England. Tobacco dependence treatment services delivery model v2.0. 2021
42. Royal College of Physicians. Hiding in plain sight: Treating tobacco dependency in the NHS. 2018
43. Department of Health and Social Care. Green Paper on Prevention 2019
44. NHS England. The Community Mental Health Framework for Adults and Older Adults 2019
45. National Institute for Health and Care Excellence. Psychosis and schizophrenia in adults: prevention and management CG178. Overview | Psychosis and schizophrenia in adults: prevention and management | Guidance | NICE
46. National Institute for Health and Care Excellence. Smoking: acute, maternity and mental health services PH48 Overview | Smoking: acute, maternity and mental health services | Guidance | NICE
47. Public Health England. CLeaR local tobacco control assessment 2017 https://www.gov.uk/government/publications/clear-local-tobacco-control-assessment
48. National Institute for Health and Care Excellence. Stop smoking interventions and services NG92 Overview | Stop smoking interventions and services | Guidance | NICE
49. National Institute for Health and Care Excellence. Tobacco: harm reduction approaches to smoking PH45 Overview | Smoking: harm reduction | Guidance | NICE
50. National Institute for Health and Care Excellence. Cardiovascular disease: identifying and supporting people most at risk of dying early PH15 Overview | Cardiovascular disease: identifying and supporting people most at risk of dying early | Guidance | NICE
51. National Institute for Health and Care Excellence. Coexisting severe mental illness (psychosis) and substance misuse: assessment and management in healthcare settings CG120 Overview | Coexisting severe mental illness (psychosis) and substance misuse: assessment and management in healthcare settings | Guidance | NICE
52. National Institute for Health and Care Excellence. Coexisting severe mental illness and substance misuse: community health and social care services NG58 Coexisting severe mental illness and substance misuse: community health and social care services (nice.org.uk)
53. National Institute for Health and Care Excellence. Alcohol use disorders: prevention PH24 Overview | Alcohol-use disorders: prevention | Guidance | NICE
54. Southampton City Council. Southampton tobacco control plan 2014 – 2016 https://www.southampton.gov.uk/moderngov/documents/s20699/Appendix%201.pdf

55. Southampton City Council. Southampton Health and Wellbeing Strategy 2017 – 2025 https://www.southampton.gov.uk/images/health-and-wellbeing-strategy_tcm63-391952.pdf
56. Southampton City Council. Southampton Alcohol Strategy https://www.southampton.gov.uk/images/alcohol-strategy_tcm63-391993.pdf
57. Southampton City Council. Southampton City Health and Care Strategy 2020 – 2025 https://www.southampton.gov.uk/images/southampton-city-5-year-health-care%20strategy_final_post-covid_tcm63-435823.pdf
58. Public Health England. Severe Mental Illness - PHE [accessed 19/8/21]
59. https://data.southampton.gov.uk/population/pop-structure/ [accessed 15/6/21]
60. NHS Digital Adult Psychiatric Morbidity Survey: Survey of Mental Health and Wellbeing, England, 2014. 2016. Adult Psychiatric Morbidity Survey: Survey of Mental Health and Wellbeing, England, 2014. - NHS Digital
61. NHS Digital. Use of NHS mental health, learning disability and autism services. 2021. https://www.ethnicity-facts-figures.service.gov.uk/health/mental-health/adults-using-nhs-funded-mental-health-and-learning-disability-services/latest [accessed 15/6/21]
62. Deprivation and poverty (southampton.gov.uk) [accessed 15/6/21]
63. Langley T. Mental health, smoking and poverty in the UK – report commissioned by Action on Smoking and Health and Public Health England. 2016. University of Nottingham and UK Centre for Tobacco & Alcohol Studies.
64. Public Health England. Local Tobacco Control Profiles - Data - PHE [accessed 21/6/21]
65. NHS Digital. Health Survey for England 2019. Adult health related behaviours (digital.nhs.uk)
66. NHS Digital. Health Survey for England, 2019: Data tables - NHS Digital
67. Public Health England. Local Tobacco Control Profiles - Data - PHE [accessed 17/9/21]
68. Locally obtained data
69. Ainscough TS, Mitchell A, Hewitt C, et al. Investigating changes in patients' smoking behaviour, tobacco dependence and motivation to stop smoking following a 'smoke-free' mental health inpatient stay: results from a longitudinal survey in England. Nicotine Tob Res. 2020:ntaa258 (in press).
70. Richardson S, McNeilla A, Brosea LS. Smoking and quitting behaviours by mental health conditions in Great Britain (1993–2014) Addictive Behaviors 2019; 90 14–19
71. Office for National Statistics. Smoking habits in the UK and its constituent countries 2019 - Office for National Statistics 2020.
72. Hermens DF, Scott EM, White D, et al. Frequent alcohol, nicotine or cannabis use is common in young persons presenting for mental healthcare: a crosssectional study. BMJ Open 2013;3:e002229.doi:10.1136/bmjopen-2012-002229
73. Office for National Statistics. Smoking inequalities in England, 2016 - Office for National Statistics (ons.gov.uk). 2018.
74. Public Health England. Public Health Matters Alcohol dependence and mental health. 2020 https://publichealthmatters.blog.gov.uk/2020/11/17/alcohol-dependence-and-mental-health/
75. Office for National Statistics. Adult drinking habits in England 2017- Office for National Statistics (ons.gov.uk). 2018
76. NHS Digital. HSE18-Adult-Health-Related-Behaviours-rep-v3.pdf (digital.nhs.uk) 2019.
77. NHS Digital. Health Survey for England 2018: Data tables - NHS Digital 2019.

78. Liverpool John Moores University. Understanding the alcohol harm paradox in order to focus the development of interventions Final report 2015 Centre for Public Health, Faculty of Education, Health & Community.
79. Bellis MA, Hughes K, Nicholls J, Sheron N, Gilmore I & Jones L. The alcohol harm paradox: using a national survey to explore how alcohol may disproportionately impact health in deprived individuals. BMC Public Health 2016; volume 16, Article number: 111
80. Adams A. Psychopharmacology of Tobacco and Alcohol Comorbidity: a Review of Current Evidence. Curr Addict Rep (2017) 4:25–34 DOI 10.1007/s40429-017-0129-z
81. Ilyas A, Chesney E, Patel R. Improving life expectancy in people with serious mental illness: should we place more emphasis on primary prevention?. Br J Psychiatry. 2017;211(4):194-197. doi:10.1192/bjp.bp.117.203240
82. Banham L, Gilbody S. Smoking cessation in severe mental illness: what works? Addiction. 2010 Jul;105(7):1176-89. doi: 10.1111/j.1360-0443.2010.02946.x. Epub 2010 May 11. PMID: 20491721.
83. Lum A, Skelton E, Wynne O, Bonevski B. A Systematic Review of Psychosocial Barriers and Facilitators to Smoking Cessation in People Living With Schizophrenia. Front Psychiatry. 2018 Nov 6;9:565. doi: 10.3389/fpsyt.2018.00565. PMID: 30459658; PMCID: PMC6232499.
84. Tulloch HE, Pipe AL, Clyde MJ, Reid RD, Els C, The Quit Experience and Concerns of Smokers With Psychiatric Illness, American Journal of Preventive Medicine 2016; Volume 50, Issue 6, Pages 709-718, ISSN 0749-3797, https://doi.org/10.1016/j.amepre.2015.11.006.
85. Brunette MF, Ferron JC, Aschbrenner KA, Pratt SI, Geiger P, Kosydar S. Attitudes about smoking cessation treatment, intention to quit, and cessation treatment utilization among young adult smokers with severe mental illnesses. Addict Behav. 2019 Feb;89:248-255. doi: 10.1016/j.addbeh.2018.09.028. Epub 2018 Sep 25. PMID: 30343187; PMCID: PMC6368265.
86. Gilbody S, Peckham E, Bailey D, et al. Smoking cessation for people with severe mental illness (SCIMITAR+): a pragmatic randomised controlled trial. Lancet Psychiatry. 2019;6(5):379–90.
87. Metse AP, Wiggers J, Wye P, et al. Efficacy of a universal smoking cessation intervention initiated in inpatient psychiatry and continued post-discharge: a randomised controlled trial. Aust N Z J Psychiatry. 2017;51(4):366–81.
88. Stockings et al Impact of a post-discharge smoking cessation intervention for smokers admitted to an inpatient psychiatric facility: a randomized controlled trial Nicotine Tob Res . 2014 Nov;16(11):1417-28. doi: 10.1093/ntr/ntu097. Epub 2014 Jun 17
89. Shoesmith E, Huddlestone L, Lorencatto F, Shahab L, Gilbody S, Ratschen E. Supporting smoking cessation and preventing relapse following a stay in a smoke-free setting: a meta-analysis and investigation of effective behaviour change techniques. Addiction. 2021 Feb 23. doi: 10.1111/add.15452. Epub ahead of print. PMID: 33620737.
90. Taylor GMJ, Itani T, Thomas KH, et al. Prescribing prevalence, effectiveness, and mental health safety of smoking cessation medicines in patients with mental disorders. Nicotine Tob Res. July 2020;22(1):48–57.
91. O'Brien B, Knight-West O, walker N, Parag V, Bullen C. E-cigarettes versus NRT for smoking reduction or cessation in people with mental illness: secondary analysis of data from the ASCEND trial. Tob Indue Dis 2015; 13: 5.
92. Thirlway F, Bauld L, McNeill A & Notley C. Tobacco smoking and vulnerable groups: Overcoming the barriers to harm reduction. Addictive Behaviors 2019; 90, pp. 134-135. https://doi.org/10.1016/j.addbeh.2018.10.016

93. Public Health England. Local Alcohol Profiles for England - PHE [accessed 17/9/21]
94. Beard E, West R, Michie S, & Brown J. Association between smoking and alcohol-related behaviours: a time-series analysis of population trends in England. Addiction 2017; 112(10), 1832–1841. https://doi.org/10.1111/add.13887
95. Pryce R, Buykx P, Gray L, Stone T, Drummond C, and Brennan A. Estimates of Alcohol Dependence in England based on APMS 2014, including Estimates of Children Living in a Household with an Adult with Alcohol Dependence Prevalence, Trends, and Amenability to Treatment. 2017. University of Sheffield and King's College, London
96. Public Health England. Alcohol and drug treatment for adults: statistics summary 2017 to 2018 - GOV.UK (www.gov.uk)
97. Public Health England. Local Tobacco Control Profiles - Data - PHE [accessed 17/9/21]
98. ASH and the Mental Health and Smoking Partnership. Executive Summary from Smokefree Skills: Training Needs of Mental Health Nurses and Psychiatrists. December 2020. https://ash.org.uk/wp-content/uploads/2020/12/ExecSummary_MHTraining_F.pdf
99. Voluntary, Community and Social Enterprise Health & Wellbeing Alliance - A time to quit. 2020
100. South East Tobacco Control Network. South East of England Position Statement on Electronic Cigarettes. 2021 https://www.stopforlifeoxon.org/media/1071/adph-south-east-newposition-statement-on-electronic-cigarettes-sps-v9.pdf
101. ASH. Smoking and Mental Health survey: An analysis of the views of people with a mental health condition and staff working in mental health services. 2016.
102. Cookson C, Strang J, Ratschen E, Sutherland G, Finch E, McNeill A. Smoking and its treatment in addiction services: Clients' and staff behaviour and attitudes. BMC Health Services Research. 2014;14:304.
103. Eastwood B, Clare T, Dockrell MJ, Locker J, Chowdary Q, Jahr S, Jones A, Robson D, Marsden J. Reciprocal influences of tobacco use on illicit opioid and alcohol use during the first six-months of specialist addiction treatment. Drug Alcohol Depend. 2021 Jan 1;218:108418. doi: 10.1016/j.drugalcdep.2020.108418. Epub 2020 Nov 23. PMID: 33262003.
104. Weinberger AH, Platt J, Jiang B, and Goodwin RD. Cigarette Smoking and Risk of Alcohol Use Relapse Among Adults in Recovery from Alcohol Use Disorders Alcohol Clin Exp Res, 2015; Vol 39, No 10: pp 1989–1996
105. Apollonio D, Philipps R, Bero L. Interventions for tobacco use cessation in people in treatment for or recovery from substance use disorders. Cochrane Database of Systematic Reviews 2016, Issue 11. Art. No.: CD010274. DOI: 10.1002/14651858.CD010274.pub2.
106. Fehilya C, Hodder R, Bartlema K, Wiggers J, Wolfenden L, Draya J, Baileya J, Wilczynskaa M, Stockings E, Clinton-McHarga T, Regana T, Bowman J. The effectiveness of interventions to increase preventive care provision for chronic disease risk behaviours in mental health settings: A systematic review and meta-analysis. Preventive Medicine Reports 19 (2020) 101108
107. Garwin N. Improving access to physical health checks for people with severe mental illness in primary care. A cross-sectional study in Hampshire and Isle of Wight. Submitted in partial fulfilment of the requirements for the Degree of Master of Science, MSc Public Health, April 2020, University of Southampton
108. Stopping smoking for your mental health - NHS (www.nhs.uk)
109. The Institute of Alcohol Studies. Alcohol and Mental Health: Policy and practice in England. 2018

110. Public Health England. Guidance on commissioning and providing services for people with co-occurring conditions 2017
111. Hassan S, Ross J, Marston L, Burton A, Osborn D, Walters K. Exploring how health behaviours are supported and changed in people with severe mental illness: a qualitative study of a cardiovascular risk reducing intervention in Primary Care in England. Br J Health Psychol. (2020) 25:428–51. doi: 10.1111/bjhp.12415
112. Malone V, Harrison R, Daker-White G. Mental health service user and staff perspectives on tobacco addiction and smoking cessation: A meta-synthesis of published qualitative studies. J Psychiatr Ment Health Nurs. 2018 May;25(4):270-282. doi: 10.1111/jpm.12458. Epub 2018 Apr 14. PMID: 29498459.
113. ASH Smokefree trusts: Making it work for service users 2019
114. Marcus E, Brown M, Stockton S Pilling S. Severe mental illness and substance misuse (dual diagnosis): community health and social care services. Draft Review 2: Service user, family and carer, provider and commissioner views and experiences of health and social care services for people with a severe mental illness who also misuse substances. A systematic review. National Collaborating Centre for Mental Health. Draft version 4.0, December 2015 evidence-review-2 (nice.org.uk)