with mental illness are disadvantaged in receiving intervention and support for their tobacco dependence, which is often overlooked or even tolerated. This statement from the European Psychiatric Association (EPA) systematically reviews the current evidence on tobacco dependence and withdrawal in patients with mental illness and their treatment. It provides seven recommendations for the core components of diagnostics and treatment in this patient group. These recommendations concern: (1) the recording process, (2) the timing of the intervention, (3) counselling specificities, (4) proposed treatments, (5) frequency of contact after stopping, (6) follow-up visits and (7) relapse prevention. They aim to help clinicians improve the care, health and well being of patients suffering from mental illness.

Disclosure of interest In the last three years, HJM received honoraria for lectures or for advisory activities by the following pharmaceutical companies: Lilly, Lundbeck, Servier, Schwabe and Bayer.

He was president or in the Executive Board of the following organisations: CINP, ECNP, WFSBP, EPA and chairman of the WPA-section on Pharmacopsychiatry.

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S079

Smoking cessation and soft signs of mental disorders

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Smoking is associated with major depression, schizophrenia, anxiety and compulsive disorders, personality disorders, or substance abuse disorders [1,2]. More than that, smokers often report higher levels of novelty seeking, anxiety or depressive symptoms without fulfilling full diagnostic criteria for a psychiatric disorder.

In a former study, Batra et al. [3] had shown that smokers reporting higher levels of novelty seeking/hyperactivity, depressivity, and nicotine dependence evince higher relapse rates after completion of a six-weeks behavioural treatment program than smokers reporting low scores on self-report psychological symptom measures.

Another study [4] showed that a modified smoking cessation program matched to at-risk smokers' needs with $n = 268$ adult smokers leads to higher long-term abstinence rates.

All at-risk smokers had been randomly assigned to receive either a standard or modified treatment. Best results were shown for smokers with mild depressive symptoms. The talk reports results of former and recent studies and focuses on the German treatment guidelines for tobacco related disorders.

These [5] recommend to assess tobacco use among patients with mental disorders and should be offered smoking cessation support under consideration of the acuteness and the particularities of the mental disorder using the same psychotherapeutic and pharmaceutical measures as for smokers without additional mental disorders.

Disclosure of interest Financial support by Pfizer, Parexel, SKB, Novartis for smoking cessation studies.

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S080

Smoking: A risk factor for suicide

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First demonstrated in 1976, the robust association between smoking and suicide mortality has been established and is dose-dependent, with an estimated increase in suicidal deaths risk of 24% for each increment of 10 cigarettes smoked per day. The statistical association has been shown to exist very soon after smoking initiation, during adolescence, and to withstand adjustments for confounding factors, such as demographics, socio-economic status, somatic and psychiatric comorbidity, and substance use. As the underlying mechanism of the greater suicide risk in smokers is not currently elucidated, we will briefly recapitulate the main hypotheses proposed to date: the toxic effects of nicotine, hypoxemia, monoamine oxidase activity inhibition, the high prevalence of psychiatric comorbidity and consequent suicide risk, and smoking-induced serious physical illness with pain and disability resulting in negative mood response. Smoking could also be an inadequate self-medication for psychological symptoms, themselves causing suicide, and finally the association could be due to a third underlying factor associated with both smoking and suicide.

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S081

Is it feasible and effective to help patients with severe mental disorders to quit smoking?

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Despite the proven association between smoking and high rates of medical morbidity and reduced life expectancy in people with severe mental disorders (SMD), their smoking rates do not decline as they do in the general population. We carried out a non-randomized, open-label, prospective, 9-month follow-up multicentre trial to investigate the clinical efficacy, safety and tolerability of a smoking cessation programme designed for the treatment of patients with SMD in the community under real-world clinical conditions. A total of 82 patients were enrolled. Short-term efficacy: The 12-week 7-day smoking cessation (self-reported cigarettes per day =0 and breath CO levels $\leq$9 ppm) prevalence was 49.3%, with no statistically significant differences between medications (transdermal nicotine patches 50.0% vs. varenicline 48.6%, chi-square =0.015, $P = 1.000$). Long-term efficacy: At weeks, 24 and 36, 41.3 and 37.3% of patients were abstinent, with no statistically significant differences between treatments. Safety and tolerability: No patients made suicide attempts or required hospitalization. There was no worsening of the scores on the psychometric scales. In both groups, patients significantly increased weight, without significant changes in vital signs or laboratory results, with the exception of significant decreases in ALP y LDL-cholesterol levels in the varenicline group. Patients under varenicline more frequently presented nausea/vomiting ($P < 0.0005$), patients under TNP experienced skin reactions more frequently ($P = 0.002$). Three patients under varenicline had elevated liver enzymes. In conclusion, we have demonstrated that in real-world clinical settings it is feasible and safe to help patients with stabilized severe mental disorders to quit smoking.

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