Report by MAXIE ASHTON -2010 Churchill Fellow

To investigate international approaches that effectively help people with mental illness to quit tobacco

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Signed                      Dated  

Maxine Ashton
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"With opportunity comes responsibility". Winston Churchill.
1. Introduction

This report documents the findings of a 2010 Churchill Fellowship to:

Investigate international approaches that effectively help people with mental illness to quit tobacco.

While the rates of tobacco smoking across the general community have reduced significantly, they are still high for people who live with mental illness, and in particular those with severe and disabling mental illness. As a result many have poor physical health, reduced life expectancy, financial difficulties and poor quality of life.

Effective treatment and support approaches to address this problem are still in the early stages of development, and this Fellowship provided a valuable opportunity to meet with colleagues in the USA and Canada.

I met with researchers, mental health and tobacco control workers, peer workers, Quitline counsellors, people with mental illness and others in San Diego, San Francisco, San Rafael, Denver, Hamilton, Toronto, New York, New Brunswick, Seattle and Portland.

I would like to thank the following:

- The Winston Churchill Trust who provided the opportunity, the financial assistance and support.
- All of the people I visited in the United States and Canada, who arranged opportunities and spent time answering questions and providing information. All gave time generously and shared their experience and wisdom.
- Professor Cherrie Galletly and Dr Eli Rafalowics who as my referees were encouraging and their words of support were very important.
- My colleagues in the Tobacco and Mental Illness Project, South Australia, who have always recognised the importance of this work and have tried very hard to make a real difference.
- The participants within the Tobacco Free groups who have asked for help and who constantly inspire and challenge us to improve services.
- My family and friends who continually support and encourage me.
- The Tobacco Control Unit, Drug and Alcohol Services of South Australia who funded the Tobacco and Mental Illness Project, SA.

This report is drawn from my notes and impressions. It does not aim to report in detail all of the work being undertaken by those I met with. It includes some suggested opportunities for services in Australia in addressing the very serious health effects of smoking by people with mental illness.
2. **Executive Summary**

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**Project Description:** This study tour aimed to investigate international approaches that effectively help people with mental illness to quit tobacco.

People with mental illness are now a significant (over 38%) and increasing percentage of the smokers in the Australian community and they smoke over 40% of the cigarettes. As a result many suffer poor physical health, poverty, increased disability and reduced life expectancy.

Programs to assist people with mental illness are still in the early stages in Australia, while in United States and Canada there is a network of services and practitioners with many years of experience. This Fellowship provided a valuable opportunity to meet with them and learn from their experience.

**Highlights:**
There were many highlights, but the most important was the opportunity to meet with people who share a passion and commitment for helping people with mental illness to tackle their tobacco use.

It was wonderful to meet with phone counselling services who were implementing proactive approaches to help the many smokers with mental illness who call them.

To observe smoking cessation work within inpatient units and community mental health settings and to be a part of the training and involvement of peer workers. It was inspiring to talk with researchers who are developing, implementing and reporting about approaches that really work in helping smokers with mental illness.

**Opportunities for Australia**
A number of key themes emerged that can be applied within Australia:

- Addressing tobacco needs to be a part of routine mental health care.
- Helping smokers with mental illness should be a significant component within tobacco control services, with appropriate funding and proactive approaches.
- Tobacco control and mental health services need to work together to address this shared problem.
- People with mental illness are a diverse group with different needs and abilities and they need a comprehensive range of responses.
- Services need to evaluate the effectiveness of approaches, in particular approaches for those living with severe and disabling mental illness.
- Training programs need to be provided for psychiatrists, mental health providers and tobacco control workers about helping people with mental illness.

**Implementation:**
The experience gained through this Fellowship will be incorporated into the work of the Tobacco and Mental Illness Project in South Australia. The Project will utilise the experience in the ongoing development and implementation of services. It will share ideas and assist in the development of effective models. It will provide training and disseminated information through conference presentations, journal articles, written materials, newsletters and the media.

Two books, ‘Now I can smell the orange blossom’ and ‘Tobacco Free, -a guide to supporting people with mental illness to tackle tobacco’, will be distributed widely.
3. Programme, people and places

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<tr>
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| University of California, San Diego |  |
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<td>Jefferson Centre for Mental health</td>
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4. Tobacco Control in the United States of America

Tobacco Control programmes are developed and implemented by Government and Non Government services at federal, state and local levels across the US.

The Office of Smoking and Health (OSH) is the lead federal agency for tobacco prevention and control in the United States of America and developed the guide, ‘Best Practices for Comprehensive Tobacco Control Programmes -2007’. This Guide aims to support the development of tobacco control approaches and ultimately eliminate the burden of tobacco use.

There are also a number of national organisations which are involved in tobacco control, including the American Legacy Foundation, Americans for Non-smokers’ Rights, the Robert Wood Johnson Foundation, Tobacco Free Kids, the American Cancer Society, American Heart Association, American Lung Association and the Tobacco Control Legal Consortium. These groups provide a strong network of services and are involved in different activities to reduce tobacco use.

The National Network of Tobacco Cessation Quitlines provides callers with a single, toll-free number (1-800-QUIT NOW) that then links them to their state’s telephone-based cessation services.

The Master’s Settlement Agreement
The Masters Settlement Agreement was signed in 1998, and was the largest civil litigation settlement in US history. The Agreement required tobacco companies to make yearly payments to compensate the States for taxpayers’ money spent on tobacco related diseases. In addition the Agreement placed significant restrictions on tobacco advertising and created the American Legacy Foundation, which is a non-profit organisation dedicated to reducing the harm caused by tobacco use.

Graphic health warnings
In June 2011, the US congress passed a law to permit the use of graphic health warnings on cigarettes packages.

4.1 Tobacco use in the United States

Tobacco use is the single most preventable cause of death and disease in the US:
- an estimated 45 million American adults currently smoke tobacco.
- 438,000 deaths are caused by smoking each year.
- for every person who dies, another 20 suffer with tobacco related illness.
- nicotine addiction costs the US $96 billion in direct medical expenses and another $97 billion in lost productivity each year.

‘Best Practices for Comprehensive Tobacco Control Programmes -2007’

4.2 Tobacco use and mental illness in the United States

People with mental illness smoke at rates almost twice that of the general population and nearly half of all cigarettes sold in the United States (44 percent) are consumed by people with mental illness.

The report by American Legacy, “A hidden epidemic: Tobacco Use and Mental Illness” calls attention to the high prevalence of tobacco use and nicotine dependence among people with mental illness.
The National Association of State Mental Health Program Directors, in “Morbidity and Mortality People with Serious Mental illness”, 2006, reported that, “People with a serious mental illness are now dying 25 years earlier than the rest of the population and this is due in a large part to risk factors such as smoking, obesity, substance abuse and inadequate access to medical care.”

There has been growing awareness of the very high rate of tobacco use by people with mental illness over the past few years and as a result a number of very important initiatives have developed within the United States to build knowledge, provide training, advocate for the development of services and initiate and provide effective programs.

References:

5.1 San Diego

California Smoker’s Helpline

The California Smokers’ Helpline is a free state-wide quit smoking service operated by the University of California, San Diego. The Helpline offers self-help materials, referral to local programs, and one-on-one, telephone counselling to quit smoking.

The population of California is over 36 million and the California Smokers’ Helpline receives between 3,000 and 5,000 calls per month. Quitlines across the United States, receive over 400,000 calls per year.

I met with Gary Tedeschi, Kirsten Hansen, Sharon Cummins and Shu-Hong Zhu, and each talked about their specific area of work and I gave a presentation about the Tobacco and Mental Illness Project, South Australia.

Historically, the Quitlines in California and in the United States generally, have provided people with mental illness with a very limited service but over the last few years there has been growing awareness that people with mental illness are now a large percentage of the smokers who need help and that they need to develop effective approaches for this group of smokers.

One study undertaken by the California Smoker’s Helpline found nearly 50% (48.9%) of all callers said they had a mental illness.

Given the large number of callers and time constraints, Quitline services are needing to manage the demands and there is an ongoing debate in the United States, as there is in Australia, about the need for Quit services to either provide a public health approach across the population or an approach that addresses the more specific needs of some groups of smokers.
Studies have shown that Quitlines are effective in increasing the quit rates of those who call, but few studies have been undertaken to determine the effectiveness for people with mental illness and in-particular those with severe and disabling mental illness.

The North American Quitline Consortium has recommended that all callers be asked a set of questions about basic demographic, smoking status and physical health issues. However asking about mental health status is still optional and most Quitline services do not currently ask about mental illness.

The reasons against asking about mental health status:
- the initial interview currently takes about 5-7 minutes and to add further questions may discourage the caller.
- there should be a reason for asking, that is of benefit to the caller.
- it may offend the person, due to the stigma associated with mental illness and seem irrelevant and/or intrusive to callers who do not understand the relationship between smoking and mental illness.

The reasons for asking about mental health status:
- the service can be tailored to their needs, eg. longer and more frequent calls, proactive follow up.
- specific information about mental health related factors can be provided, such as coping with stress, anxiety, medication, mood and relevant services.
- mental health is as relevant as heart problems, diabetes, asthma etc.
- if all health matters are asked about together, and their relevance explained, it is less likely to offend the caller.
- with the caller’s permission, information can be sent to service providers, eg. psychiatrist, mental health providers to extend the support the caller receives.
- to monitor the effectiveness of the Quitline service for people with mental illness and in particular those with severe and disabling mental illness, it is necessary to collect information about mental health status, and to some extent, the severity of illness and the degree of disability.

Some Quitlines in the US have developed protocols specifically for callers who report having a mental illness. Some have increased the number of calls a person may receive, some have suggested shorter calls but more frequent, or over a longer period of time. Some people with mental illness have more difficulty concentrating, problem solving, have financial difficulties or other issues that affect their quit attempt and so the counselling approach is adjusted to meet the needs of the caller.

Some services have provided specific training for Quitline staff and so they are more confident and have a better understanding of the issues involved for callers who have a mental illness. Some services have employed staff with mental health training, for example, the Arizona Quitline has employed 2 mental health workers and a pharmacist to improve services for smokers with mental health issues and other smokers who are taking medications.

Some Quitlines have identified some populations eg. pregnant smokers, young people, indigenous people, people with mental illness; and ensured resources are provided and specific programs developed and evaluated. Alternatively, some Quitlines have worked in partnership with specialised services, and together have provided smoking cessation services for select groups.

Concern has been expressed about diverting Quitline resources from the general population to meet the higher, more complex needs of specific groups especially people with mental illness, and the impact this may have on overall community quit
rates. There is ongoing debate within tobacco services about Quitline services providing a lesser service to a larger number of people or offering a more intensive service to a smaller number of people, i.e. heavier smokers, smokers with lower socio-economic status and those with complex health needs. Quitline services can reach across the community and provide a service to smokers with varying degrees of need, tailoring the intensity of the intervention to the individual.

**Opportunities for services in Australia**

- Promote increased awareness of the serious health effects of smoking for people with mental illness.
- Clarify the roles and responsibilities of tobacco control and mental health services in relation to this group of smokers.
- Identify specific and ongoing funding within tobacco control and mental health services to develop specific programs to effectively help people with mental illness, in particular severe and disabling mental illness, to quit smoking.
- Quitlines to develop specific approaches for people with mental illness, and to monitor and report on access and effectiveness.
- Provide information for the caller’s doctor and mental health service either by providing information to the caller to give to their health worker or by sending information directly, if the caller has given permission.
- Provide the caller, their doctor and mental health workers with information about mental illness and addressing tobacco.
- Quitlines to consult with mental health providers and agree upon appropriate questions to ask callers about their health, including mental health and disability.
- Provide training for Quitline staff about the specific needs of smokers with mental illness, and have readily available resources to assist staff when they are working with people with mental illness.
- Recruit staff with mental health training as Quitline counsellors, to work alongside other Quitline counsellors.
- Employ people with personal experience of mental illness who have quit tobacco, as peer workers, to work with Quitline counsellors. Support the peer workers to use their lived experience to help others.
- Develop media campaigns that specifically target smokers with mental illness and include graphic warnings on cigarette packets about the impact of tobacco use on stress, depression and mental illness.

**Reference:**
5.2 San Francisco

University of California

The University of California, San Francisco is undertaking a number of different research projects in the area of smoking cessation.

Dr Judith (Jodi) Prochaska, Associate Professor and clinical psychologist

Most research in this area is being led by Dr Judith (Jodi) Prochaska who is a clinical psychologist with a particular interest in helping people with mental illness to address tobacco. Jodi’s father, James Prochaska was one of the researchers involved in the development of the Stages of Change Model which has been very important in addiction work and has been the most influential model underpinning the work of the Tobacco and Mental Illness Project in South Australia.

Jodi has reviewed papers from tobacco companies and found records of their deliberate targeting of people with mental illness. She found evidence that the tobacco industry had funded research supporting the idea that people with schizophrenia were less susceptible to the harms of tobacco and that they needed tobacco as a form of self-medication. The industry had also provided cigarettes to mental health services and lobbied to block Smoke Free policies.

Inpatient Unit work:
I met with the research assistants and went to the inpatient unit to observe the recruiting of patients into the smoking cessation study. The study involved a randomized controlled trial of tobacco treatment for smokers hospitalized in an acute psychiatric unit. All smokers who smoked 5 or more cigarettes per day were asked if they would like to be involved. Those willing to be involved were randomly selected into 3 groups:

**Group One:** received brief cessation advice, a quit smoking guide and NRT during their hospital admission.

**Group Two:** received the same as Group 1 plus, counselling which was repeated at 3, 6 months, they also received 12 weeks NRT following hospital.

**Group Three:** received the same as Group 2 plus an additional 12 weeks NRT and 10 sessions of cognitive-behaviourally oriented cessation counselling.

The counsellors used a computer based cessation approach, which is based on the transtheoretical model, and developed by researchers at ProChange Inc.

The initial assessment involved a series of written questionnaires including information about smoking and quitting history, drug and alcohol use, Basis 24, health risk assessment, SF12, demographics, social standing self assessment, internalised stigma, acculturation and ethnic identity.

Each person was followed up very thoroughly for evaluation; using phone, email, postal, facebook, contacting places where participant spends time, through friends, family, clinicians, through jails, coroner and medical centres. For each assessment, participants were paid $10.00 for travel and $10.00 for attending and participating.

Overall the results are finding that with evidence based treatments, people with mental illness are quitting tobacco at rates comparable to the general population and there is a need to bring these treatments into settings that will reach smokers with severe mental illness.
Hospital policies:
Although many hospitals have implemented smoke free policies in the United States there has been very little detailed evaluation of the impact on hospital admission rates or willingness to go into hospital voluntarily, client satisfaction, staff observation and the maintenance cessation rates following discharge. Often people are observed smoking in ‘hidden’ areas on the hospital grounds.

Opportunities for services in Australia

- Add to the evidence by undertaking further systematic research projects to evaluate effective smoking cessation approaches for people with mental illness.

- Make tobacco cessation support a routine part of inpatient care, by ensuring:
  - all clients are asked about tobacco use,
  - encouraged to quit,
  - offered smoking cessation medications,
  - provided with information,
  - offered referral to the Quitline and group programs
  - smoking status and support is included in the discharge summary
  - follow up cessation programs are provided in community settings

- Document smoking status and support provided in electronic medical records.

- Evaluate the impact of Smoke Free policies on hospital admission rates or willingness to go into hospital voluntarily, client satisfaction, client time spent on and off the ward, ‘hidden’ smoking and the cessation rates following discharge.

- Investigate computerized smoking cessation counselling approaches.

Dr. Sharon Hall, Director of San Francisco Treatment Research Centre
She had undertaken research in the area of smoking cessation and depression. The results did not indicate there is an increase in relapse of depression following cessation.

Professor Hai-Yen Sung, Institute of Health and Aging
She is evaluating the economic impact of tobacco taxation and other tobacco policies on people with mental illness. The increase in taxes for cigarettes is a popular tobacco control approach in both the US and Australia, and has been shown to be effective in reducing the overall rates of tobacco use across the community. The impact on people with mental illness and other disadvantaged groups has not been thoroughly investigated and anecdotally has resulted in limited change to smoking rates and an increase in poverty, social disadvantage and isolation. Hai-Yen felt the reduced prevalence of smoking in California; (13%) compared to 20% across the US, was primarily due to high taxes on tobacco and the reinvesting of taxes back into cessation programs, research, media, school programs etc.

Dr Sebastien Fromont, Psychiatrist, Director acute psychiatric unit in San Francisco General Hospital.
Sebastien has been interested in helping people with mental illness address tobacco for a long time and has collaborated with Jodi Prochaska on the Psychiatry Rx for Change curriculum. It is a training curriculum about addressing tobacco that was evaluated, demonstrated efficacy, and is now being disseminated globally on http://rxforchange.ucsf.edu website. It has over 1800 registrants to date and over 7700 file downloads.
The training program was developed for psychiatrists, and has been extended to include other disciplines such as pharmacists, cardiologists, mental health workers and peer counsellors. It can be accessed free of charge. He has also developed a 4 hour component on tobacco within the psychiatry training.

The Joint Commission (TJC), formerly the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), is the organization that accredits health care organizations and programs in the US. The Joint Commission has recognized that cigarette smoking is the leading preventable cause of death in America and has developed accredited hospital performance measures that address assessment and treatment of tobacco use and dependence for all hospitalized patients.

Sebastien felt there is a lack of ongoing care about tobacco use from case managers and psychiatrists and that addressing tobacco needs to be a part of routine mental health care, and should include the additional support of smoking cessation group programs.

Dr Dorie Apollonio, Assistant Adjunct Professor in Clinical Pharmacy
Dorie is involved in investigating the development of policies and the reason why some policies are adopted across States and others are not. She is investigating strategies that have influenced policy makers and resulted in policy change. Dorie had also been involved in analyzing tobacco industry documents and journal articles and found the industry had marketed cigarettes to homeless and the seriously mentally ill.

Dr Norval Hickman, post doctorate fellow (phone conference)
Norval has been involved in the clinical tobacco cessation trials in inpatient units, and he has a particular interest in cultural and psychosocial factors that are associated with quitting smoking. He has worked in the public county hospital, which is generally for people from lower SES backgrounds and who do not have insurance cover. He said 66% of patients earn less than $10,000 per year. He implemented a randomly controlled trial within the inpatient unit, in which one group received basic care which involved, a Quit book, written materials for African Americans and gay/lesbian smokers, and on the dangers of menthol. The other group received the same plus 10 weeks of NRT, and counselling.

80% of African-Americans smoke menthol cigarettes, compared to only 20% of white Americans, and it has been found that menthol use is associated with higher rates of ill health. African Americans also tend to have higher cotinine levels and smoke more deeply. A higher proportion also live in poverty and have a poor diet.

Opportunities for services in Australia

- Develop and implement a training component on tobacco cessation within the psychiatrist’s training program and include it in other mental health training.

- Investigate using the Psychiatry Rx for Change, computer module for training psychiatrists, mental health workers, pharmacists, peer counsellors and others.

- Investigate the economic impact of tobacco taxation and other tobacco policies on people with mental illness within Australia.

- Develop accredited health performance measures that address assessment and treatment of tobacco use for all patients in health services. Ensure these performance measures are included in the standards that are used to accredit hospital and health services within Australia.
Smoking Cessation Leadership Centre

I met with Reason Reyes, Margaret Meriwether, Christine Cheng, Jennifer Matekuare and the Deputy Director, Catherine Saucedo. The Director, Dr Steve Schroeder was away at the time I was in San Francisco.

The Smoking Cessation Leadership Center (SCLC) is a national program office of the Robert Wood Johnson Foundation which aims to increase smoking cessation rates and increase the number of health professionals who help smokers quit. The Center creates partnerships to develop and implement action plans around smoking cessation. Partnerships include dental hygienists, mental health services, nurses, pharmacists, emergency physicians, hospitals, labour unions, family physicians, the Veterans Health Administration, and other groups.

The SCLC started in 2003, with the aim of increasing clinician’s involvement in smoking cessation support by building capacity across services, providing broad access to cessation support tools and forming sustainable partnerships. One strategy of the SCLC has been to offer small grants to ‘champions’ in the field to build capacity within their services. One way they maintain these partnerships is to provide free technical assistance through webinars, email, toll-free line, toolkits etc. SCLC also offers communication and networking opportunities for all their partners through the formation of “100 pioneers for smoking cessation” listserv.

Another strategy for SCLC has been to market the telephone Quitline to clinicians through the production and dissemination of the Blue Wallet Card. The card is similar in size and feel to a credit card and offers motivational messages that encourage a smoker to call the Quitline. There are over 4.5 million now in circulation.

The SCLC has refined the smoking cessation message for clinicians to include the Quitline shortcut, “Ask, Advise, Refer” and has marketed the tobacco control training curriculum, Rx for Change for health workers.

In 2007, SCLC began working with the federal Substance Abuse and Mental Health Services Administration (SAMHSA) and others in this field to put smoking cessation on the front burner for people with mental illness and/or substance use disorders.

Opportunities for services in Australia

- Offer small grants for ‘pioneers’ within mental health services to implement initiatives that promote smoking cessation eg. for materials, posters, art projects training, seminars, signage, specific smoking cessation programmes etc.

- Maintain contact with ‘pioneers’ within mental health to encourage the development of ongoing tobacco cessation initiatives.

- Make use of webinars and other electronic training and networking tools.
5.3 San Rafael

Bay Area Community Resources

The Bay Area Community Resources Services provides a range of drug and alcohol services in the bay area, just north of San Francisco.

The staff from the Smoking Cessation Leadership Centre and I met with Beth Lilliard, Project Director who had organised an afternoon seminar about helping people with mental illness address tobacco. Beth had contacted the Tobacco and Mental Illness Project a couple of years earlier to request permission to use the written resources that had been developed by the Project and we had kept in contact by email.

The first session of the afternoon involved 5 people with mental illness, Karen, Steve, Bless, Pat and Lynda presenting about their experiences of quitting tobacco, what worked and how they did it. The group made a list of approaches that are needed to help more people with mental illness to quit tobacco.

I visited the Enterprise Resource Centre, a drop in centre, run primarily by consumers. It was a busy centre with lots of people and a range of different activities, including 2 smoking cessation groups.

The second session of the afternoon was a meeting with approximately 20 local mental health providers, including the director and chief psychiatrist and managers. Approximately 8 mental health providers from inpatient, clinical services and community housing, presented about their services and the activities, both large and small, they have undertaken to address tobacco.

It was very evident that Beth Lilliard had developed very positive relationships with mental health service providers and had encouraged them to address tobacco. She had organised the meeting as an opportunity to show case the work happening in the local region, learn from one another and to meet an Australian who is also involved in this work.

I watched the DVD Smoke Alarm, which was made by staff and consumers at Clubhouse of Suffolk, Suffolk County, New York, in 2006. It included people with mental illness speaking about tobacco addiction and their experience of quitting.

Opportunities for services in Australia

- Facilitate the development of supportive networks between mental health services and acknowledge the important work mental health providers are doing to help people with mental illness to address tobacco.

- Make a DVD, that is similar to the “Smoke Alarm” DVD with an Australian perspective, involving the people who have contributed their stories to the book, “Now I can smell the orange blossom".
5.4 Denver

**Behavioural Health and Wellness Program, University of Colorado**

The Behavioural Health and Wellness Program provides a range of services to support communities and health organisations through research, evaluation, education, clinical care and policy change. They have an overall philosophy of wellness, and so it has always been broader than just tobacco. The program is based on the recovery model, developed by Courtney Harding and includes economic wellbeing, weight, fitness, spirituality and tobacco.

The team is currently facilitating 10-15 projects, including clinical trials, policy work, education, training, evaluation and supervision of PhD students.

I had met Chad Morris, Director at the World Tobacco Conference in India in 2009, where we had both presented at a session on tobacco and mental illness.

**2Succeed, Mental Health Centre of Denver, Colorado**

I visited 2Succeed, a rehabilitation centre with a high degree of consumer involvement in the running of the centre. It provides an education component offering computer training, cooking, gym, art, library, music etc and an employment component which provides individual employment counselling and work placement.

As a Rehabilitation & Recovery Center, 2Succeed assists individuals as they strive to attain their social, wellness, educational, vocational and recreational goals in the community. The chief focus is helping individuals with career decisions. 2Succeed is a strengths-based program, which means it focuses on an individual’s strengths rather than pathology.

200-400 people use the centre each day, there are 12 staff in education and 17 staff in employment, plus approx. 10-15 peer workers.

Karen, from the Behavioural Health and Wellness Program was running the last day of the Peer-to-Peer Tobacco Recovery Training. 10 peer workers were involved and eager to learn about helping others to address tobacco. The course is run over 2 days. The goal of the training is to train peers to use motivational interviewing, raise awareness about tobacco, become positive social net workers for health, and to run 6 session smoking cessation groups.

The Peer-to-Peer Tobacco Recovery Training has been run in 7 states of the US and 350 peer workers have been trained. It is a train the trainer model and those trained are able to train others with the help of video modules and a national peer listserv.
The peers who undertake the course complete a pre and post written questionnaire about their learning within the course and then are followed up immediately after the course to assess any consultation needed to implement their site program.

At every session of tobacco cessation support, participants complete an attendance sheet where they record, smoking status, NRT, other medications, and other cessation interventions. Participants are also asked to volunteer to be involved in a national evaluation and if they agree they complete consent forms (approved by ethics), a phone baseline, 6 and 12 months evaluations, and they are paid $10-15.

Peer workers can join a monthly conference link up with Karen for ongoing support.

**Dr Laura Martin, Assistant Professor, Psychiatrist.**
Laura had worked with Lawrence Adler who undertook research on schizophrenia and nicotine and reported that nicotine can assist people with schizophrenia and their relatives to screen out background noise and concentrate better. Researchers in Colorado are currently looking into the development of a new medication DMXBA which comes from a marine worm, and effects the alpha 7 receptors which may offer the beneficial effects of nicotine without the build up of tolerance.

Laura felt mental health providers need to be encouraged and skilled to address tobacco use. At times workers tend to focus on the immediate, brief, beneficial effects of nicotine which are mainly related to relief of nicotine withdrawal and overlook the longer term problems caused by tobacco.

**Denver, Veterans Hospital**
I met with Dr Jeff Smith, Administrative Director inpatient mental health services and three peer workers, Donna, Jo and Terry and discussed the range of peer worker programs currently running within the inpatient unit.

**Rainbow Centre.**
The Rainbow Centre is a drop-in centre which is completely peer-run. The centre offers a range of recreation and health oriented activities and lunch is provided. Two peer workers are employed within the Rainbow Centre with wellness activities being their primary role. I joined in a group run by Roosevelt, who is one of the peer workers. He runs groups about fitness, walking, nutrition and laughing yoga.

**Jefferson Centre for Mental Health**
The Jefferson Centre for Mental Health, is a community mental health centre which is very similar to the community clinics in Adelaide, however the Jefferson centre has a team of approximately 7 drivers who pick people up for appointments, groups, deliver medications etc.

I met with Vladimir Perez and Jim O’Connell, two peer specialists, who have been working in the centre for many years and have both run tobacco cessation groups and provided individual support. Vlad also runs a bike adoption type program, linking repaired bikes with people who need a bike.

**Opportunities for services in Australia**

- Train peer workers in tobacco cessation work, and provide follow up support.

- Develop an advanced course for peer workers who have completed the general peer worker training.
• Provide a comprehensive training program (ie 6 half day sessions) for mental health workers in tobacco cessation work, and then provide follow up support.

• Utilise phone conferencing for support of peer workers and mental health workers who are involved in tobacco cessation work.

• Produce a DVD which involves experienced peer workers and project workers presenting each of the Tobacco Free course sessions and so peer workers and mental health workers can use the DVD within group programs.

5.5 Hamilton, Canada

Hamilton Program for Schizophrenia

The Hamilton Program for Schizophrenia is a multidisciplinary mental health case management team that works with people who have schizophrenia or schizoaffective disorders. They mainly do one to one case management work but provide some groups including the Smokebusters group program.

I met with Carling Provost and gave a presentation to the team about the Tobacco and Mental Illness Project, South Australia.

Carling Provost has been running the Smokebusters program, which was originally developed with input from Dr. Joel Goldberg, Assoc. Professor, Dept. of Psychiatry.

The program runs for 15 weeks, and where possible they employ peer counsellors to co run the groups. The group has good support from the clinical team with referrals, individual support and medication monitoring by medical staff.

Carling meets with each person at the beginning of the program, and then again at least once during the first 6 weeks to do individual planning. Every week participants set individual goals. Participants get NRT fully subsidized while in group and then half subsidized at the end if they continue to come and see Carling individually. Participants record the number of cigarettes they smoke on a card which fits into a cigarette packet. The group gets together again after 3 months for a review.

References:

5.6 Toronto

Centre for Addiction and Mental Health, CAMH

The Centre for Addiction and Mental Health (CAMH) is Canada's largest mental health and addiction teaching hospital, as well as one of the world's leading research centres in the area of addiction and mental health.

The service has 3 components, Education, Clinic and Research.

The clinic provides tobacco cessation services; counsellors include social workers, Occupational Therapists, Pharmacist, Psychiatrist and Medical staff.

The clinic is available to smokers who want to quit tobacco. It is linked to the hospital and the university and many clients are referred by the hospital, however clients can walk in without a referral. The clinic sees approximately 1200 individuals each year.

Those who register for tobacco cessation support are asked to attend a workshop, called a Getting Ready workshop, it is a 2 hour introduction to tobacco cessation. At the workshop, participants complete a Nicotine Dependence Assessment. The Getting Ready workshop, has been useful as an introduction and has increased the % of people who do attend the initial assessment with a counsellor.

Clients are offered medication, counselling or both, and most access both. If a client is receiving medications from the clinic they have to see the doctor and if taking a medication that is affected by smoking cessation, they meet with the pharmacist, and the medications are monitored and adjusted accordingly.

The CAMH formularies hold Champix, Zyban and all NRTs and those who attend the clinic can access a combination of medications. Approximately 50% of the clients are prescribed higher dose NRT and they can access it for 12 months. Doctors have prescribed up to 4 patches for a person per week.

If the client does not have financial problems the medications cost the same as they do if being accessed from a chemist, however if the person is assessed to have financial difficulties then medications are subsidised and cost $5.00 per week.

Most clients of the clinic are physically unwell as a result of their smoking and many also have mental health and social problems.

The clinic assists the client to work toward their own goal, for example, work toward reducing, reducing then cessation or cessation.

The clinic also provides a group program which runs Monday-Friday and clients can come as long as they feel they need to. There is also an alumni group, for people who want to continue to attend to get support or to support others.

Clients are followed up every 3 months, and an incentive a $5.00 Tim Horton (Canadian coffee chain) card is sent out after the evaluation is completed.

Hospital Smoke Free policies:
In Canada most hospitals introduced Smoke Free policies indoors several years ago (psychiatric units in 2005-06). Most health services are now Smoke Free outdoors as well or they have designated outdoor smoking areas. CAMH have provided designated areas, mainly because of concerns expressed by local residents and businesses about smoking on the footpaths.
Health Worker training:
Clinical guidelines for smoking cessation are available on line, CAN ADAPTT

CAMH run training programs for health professionals across Canada, and over 2,400 health professionals have completed training. The program involves a 3 day core course and then additional 2 day specialties including mental health, pregnancy, aboriginal, chronic disease and healthy lifestyle. The training is CME accredited. The Training Enhancement in Applied Cessation Counselling and Health (TEACH) Project is geared toward training health care professionals who provide counselling services to people who use tobacco. The program is designed to enhance the knowledge and skills in the delivery of intensive cessation interventions. Webinars are held regularly to provide online training.

The CAMH team have developed a tool kit especially for tobacco cessation work with indigenous Canadians, “It’s Time: Indigenous tools and strategies on Tobacco Interventions, Medicines and Education.” The tool kit is designed to facilitate knowledge transfer and increase capacity in health and social services for indigenous peoples in Canada. The tool-kit is beautifully presented and brings together TEACH and other materials which have been adapted to reflect indigenous ways of learning, knowing, healing and recovery.

Opportunities for services in Australia

- Incorporate tobacco cessation work, both individual and group programs within the integrated mental health clinics, making it a routine part of mental health care, with the appropriate back up and support of the medical and clinical teams.

- Provide shop front clinics for smokers who want to quit with close links with hospital and mental health clinics. Provide group and individual programs.

- Investigate the effectiveness of higher dose NRT for people with mental illness who are heavy smokers and have difficulties coping with symptoms of nicotine withdrawal.

- Investigate the effectiveness of titrated NRT for people with mental illness.

- In community settings, evaluate the impact of cessation on serum levels of clozapine and other psychiatric medications and make clinical recommendations.

- Include comprehensive information about helping people with mental illness to address their tobacco use within QuitSkills training programs, and provide an additional intensive module for those who work in mental health and tobacco control services about the specific needs of people with mental illness.

- Make use of webinars and other technology to provide training, especially for those who work in rural and remote areas.

- Investigate the approach taken in the development and implementation of “It’s Time: Indigenous tools and strategies on Tobacco Interventions, Medicines and Education.” The kit for indigenous Canadians and consider the relevance and potential use in the work being developed and implemented to address the high rates of tobacco use for indigenous Australians.
5.7 New York

Veteran Affairs, New York, Harbor Healthcare System

Dr. Scott Sherman, Associate Professor, Department of Medicine, is the primary care physician and principle researcher and he has been focusing on how services can reach people efficiently and help hospitals increase smoking cessation. He is involved in investigating how health systems can change to be more effective in the delivery and quality of preventive care and he has been focusing on different organizational approaches to smoking cessation and tobacco control.

A number of different research projects have been developed to investigate effective and efficient smoking cessation approaches.

One of the studies described involved on-call counsellors. As soon as a clinician spoke to a patient who said they wanted to quit, a counsellor was called and met with the patient within 10 minutes to provide detailed smoking cessation counselling. After the initial contact, the counsellor followed up the patient for 2 months, calling them at 2, 4, 6, and 8 weeks and providing further counselling and medication.

Other studies involved trials at multiple sites using NRT, Varenicline, counselling and proactive calls.

A current study, TeleQuitMH, investigates the cessation rates for people with mental illness who receive phone counselling and medication. The study compares the impact of counselling received from a Quitline counsellor to the counselling received from a VA trained mental health counsellor. Both groups receive at least one 10-15 phone counselling calls. Patients randomized to the VA arm can receive between 1-3 planning calls and 6 follow-up calls. Follow-up calls are scheduled at specific dates proven to be most effective in helping prevent relapse. Patients receive a call on their quit date, quit date plus 1 day, 3 days, 7, 14 and 21 days and then again at one month after their quit date. VA mental health phone counsellors are specifically trained in Motivational Interviewing (MI) and offer a more problem solving approach, link with the mental health system and consult with the mental health providers.

The mental health providers are able to refer patients to this study electronically, and then the patient can receive the proactive phone counselling. The mental health sites have included inpatient and out patient units, medical centres and community based centres.

Generally the study is indicating that people with mental illness are interested in smoking cessation but the mental health providers are slow to discuss this with their clients and refer to the service. The study has received 600 referrals in 18 months, and they were hoping for 5000.

To increase the interest of mental health providers the team has conducted service presentations, sent emails and monthly newsletters. Mental health providers have received feedback about their referrals and those who have referred the most, have been highlighted. These interventions have not been really successful although there are some ‘champion’ mental health workers who are clearly concerned about their clients tobacco use, discuss it with them, promote TeleQuitMH and refer clients to the service.
Population approaches in New York
In New York City, the current mayor, Mayor Bloomberg has been very proactive about tackling tobacco use. Cigarettes are more expensive in New York (they cost about the same as they do in Australia) and more public places are smoke free.

Opportunities for services in Australia

- Develop practice guidelines for mental health services and implement system-wide approaches ie. provide supportive smoke free environments, identify all smokers, assess smoking status regularly, provide brief advice, counselling, provide information and refer to tobacco cessation services.

- Monitor implementation and performance across the service and feedback to management and staff.

- Promote tobacco cessation as a routine part of mental health services, ensure addressing tobacco is included in mental health assessment tools and care plans.

- Provide ongoing training programs for mental health providers and Quitline counsellors about smoking cessation and people with mental illness.

Reference:
Sherman, S. E. A framework for tobacco control: lessons learnt from Veterans Health Administration, BMJ 2008; 336:1016-1019
Fountain House was the first Clubhouse to be formed and it is the largest. It provides a range of opportunities for people with severe and persistent mental illness to participate in activities which focus on their strengths and abilities, not their illness.

I was shown around the centre by David who works within the reception unit. There are several work units including reception, horticulture, employment, research, clerical, wellness, fundraising and education. Fountain House also provides housing and support.

The centre is open every day and prepares meals for over 450 people who attend the centre each day. In addition there are 2 evening sessions with meals and activities for people who have moved on to employment and cannot attend during the day. Currently there are outdoor designated smoking areas provided which are away from group sitting areas and other activities. Support is provided for those members who want to quit or reduce their tobacco use.

5.8 New Brunswick, New Jersey

UMDNJ- Robert Wood Johnson Medical Centre

Dr. Jill Williams, psychiatrist has been involved in addressing tobacco use by people with mental illness for many years and has been responsible for the development of the CHOICES program. (Consumers Helping Others Improve Their Condition by Ending Smoking).

The CHOICES program employs people with mental illness who are non smokers. They are called Consumer Tobacco Advocates (CTAs) and they are employed to reach out to their peers and educate about tobacco use and cessation. They travel state-wide and present to groups of consumers in mental health clinics, day programs, inpatient units and residential settings. The presentation includes information about the risks involved in smoking, the benefits of quitting tobacco, support and medications available and the health consequences of second hand smoke.

Participants are invited to have their carbon monoxide reading taken and they are provided information about smoking cessation clinics that are near to where they live.

The team also produces a CHOICES newsletter.
Health worker training:
The team also provides two day training, *Treating Tobacco dependence in Mental Health Settings*, twice a year.
The training includes topics such as:
- How to assess and treat tobacco dependence
- The neurobiology of tobacco use and mental illness
- Pharmacotherapy and interactions with psychiatric medications
- Integrating tobacco control into existing evaluation and treatment plans.

Opportunities for services in Australia

- Employ peer workers and involve them in making presentations on a regular basis to their peers about tobacco use within all mental health clinics, day programs, inpatient units and residential settings across the State.
- Provide funding for a Tobacco and Mental Illness Team with involvement of a psychiatrist, researchers, smoking cessation workers and peer workers to develop further the research and clinical expertise, and to provide more comprehensive training programs for mental health workers in tobacco cessation work.
- Produce a Tobacco Free newsletter for mental health sites and participants within the Tobacco Free programs.

5.9 Seattle

Alere Wellbeing

I met with Ken Wassum, Associate Director, Clinical Development & Support, Tobacco. He has been treating tobacco users for over 18 years and currently provides clinical oversight of the phone counselling services for smoking cessation for 27 States; over half of the US.

In 2010 nearly 350,000 people contacted the Quitline, including callers from health services and employers, and asked for help.

State callers can receive either one call or proactive multiple calls. Callers who are ready to quit may also access free medication, if they live in a State which offers a medication benefit.

Ken is involved in the Behavioural Health Advisory Forum which has been exploring the role of tobacco Quitlines in treating tobacco use and dependence. He recognised there are some who are passionate about the needs of particular groups and strongly advocate for specific services. The evidence suggests that smokers with mental illnesses do want to quit and that they utilize the state tobacco Quitlines. A small pilot conducted in 2009 showed that slightly over 30% of callers reported depression and indicated they felt it may make quitting difficult. However, he felt the evidence does not suggest that most smokers with less severe mental illnesses need specialized services to succeed in quitting. However, as with all callers treatment should be tailored to the needs of the individual to assure that the caller understands how to follow up on treatment recommendations. Callers with mental illness should be encouraged to inform their mental health care provider of their intention to quit, especially if they are taking psychoactive medication.
He emphasized that Quitlines need to treat each person with empathy and respect, recognizing their individual and cultural strengths and challenges and to tailor treatment accordingly.

Ken feels it is essential that Quitline counsellors receive training about mental illness and how to tailor communication and structure treatment to suit the caller’s needs. Protocols within Quit services may need to be adjusted slightly ie to allow extra calls, and to be more proactive with some clients, especially those with cognitive challenges.

The North American Quitline Consortium was formed to facilitate communication between Quitlines across US and Canada. This group aimed to collect consistent data and evaluate service use and outcomes. The Behavioral Health Advisory Forum identified optional questions about mental health status that may be asked at the initial point of contact. The tobacco dependence treatment services at Alere do ask about chronic illnesses such as heart disease, diabetes, cancer, asthma, and COPD.

Alere has developed a range of printed materials including information on spit tobacco, smoking and pregnancy, adolescents, Native American materials, gay/lesbian information and materials about smoking and chronic health problems such as heart disease, lung problems and asthma. Alere has also produced quit guides in Spanish and Creole. There is no written information specifically for people with mental illness.

5.10 Portland

Oregon Health & Science University, Smoking Cessation Centre

I met with Wendy Bjornson who is the Director of the Oregon Health & Science University Smoking Cessation Centre

Her role is to coordinate the tobacco cessation policy and treatment program in the hospital and to manage a number of clinical trials including trials on bupropion and varenicline. She also directs the National Smoking Cessation Leaders Collaboration.

The hospital went smoke free in 2007 and the team which consists of Wendy and 3 others provide smoking cessation counselling to clients in the hospital.

The team receives an electronic referral from a physician; they then look at the patient’s electronic records to find out about the patient’s health needs and go to the ward setting to meet with the patient. They provide smoking cessation advice and counselling and NRT, if the person is not already receiving it. Usually they only meet with the patient once unless the person requires more than one visit.

The team gets approximately 5-8 referrals per day. Although most referrals come from the cardiac, medical and respiratory units, approximately 70% of the patients have some form of mental health issue.

The general approach with each patient is:
- determine the patient’s stage of readiness to change,
- ask about level of discomfort due to nicotine withdrawal
- provide NRT if the patient is not already receiving it, or increase the dose if necessary.
-discuss smoking cessation
-make the discussion specific to the patient’s health issue and treatment plan.
-follow up 2 weeks after discharge for evaluation and ongoing counselling.

If the person is in hospital for a reason related to tobacco use, or continued tobacco use is likely to affect their recovery, this is made clear, and the person is encouraged to see cessation as a component of their treatment plan. The team have found that during a hospital admission is a useful time to discuss tobacco, raise awareness, promote options and reinforce cessation as an important part of recovery.

**Nicotine Replacement Therapy (NRT)**
The team have found patches and lozenges to be the most useful in the hospital setting. NRT gum is messy within a hospital and NRT inhalers and the nasal sprays are more difficult to use.

They have found that although their smoking cessation service is available for patients who are within the psychiatric unit, they receive very few referrals from the unit. The psychiatric unit uses a lot of the NRT that is used within the hospital.

The team felt one of the difficulties involved in addressing the high rate of tobacco use amongst people with mental illness, is the ‘fractured funding’. They felt that tobacco work with people with mental illness needs to be undertaken within mental health services but funding is located within tobacco control services. There needs to be a transfer of funding from tobacco control to mental health services to address the needs of people with mental illness.

**Tobacco Control Integration Project (TCIP) and the Tobacco Prevention and Education Program (TPEP)**

The Tobacco Control Integration Project (TCIP) and the Tobacco Prevention and Education Program (TPEP) work together to provide tobacco control approaches primarily for people with fewer resources and who are most in need of support.

I met with Cinzia Romoli and Cathryn Cushing, and they have been involved in:
- changing policies to reduce exposure to second-hand smoke,
- changing procedures to ensure all disadvantaged and high need clients have access to cessation resources,
- bringing targeted messages to where clients are sure to see them

They formed advisory groups which have included residential facility managers, people with mental illness, peer workers, mental health workers and other stakeholders. These groups met regularly, participate in training and are involved in planning, policy development and implementation of smoking cessation support.
6. Conclusion

This Churchill Fellowship has been a very valuable opportunity to meet with key people who are involved in helping smokers with mental illness to quit or reduce their tobacco use. It has enabled me to gain knowledge about a range of different approaches and has prompted many ideas of opportunities for Australian services.

It has also been affirming to learn that the work we have done in South Australia has been important, and has been recognised internationally as offering an effective tobacco cessation approach for people with mental illness, in particular those living with severe and disabling mental illness.

It is well known that people with mental illness are now a significant percentage of the smokers in the US, Canada, and in Australia and they are an even larger percentage of the smokers who smoke heavily, have fewer resources and are likely to have more difficulties stopping smoking.

People with mental illness are a diverse group of people with widely varying abilities, cultural backgrounds, life circumstances and needs. They receive services through a network of different public, private; Government and Non Government, health and social support services. Most people with mental illness spend very little time in hospital or within mental health services. Addressing tobacco use by people living with mental illness requires a coordinated and comprehensive range of responses. No one approach is likely to reach all those living with mental illness or meet the diverse range of needs.

In the United States and Canada I met with people who are developing different approaches, including through phone counselling, inpatient units, hospital standards, cessation clinics, community mental health settings, training models, written and electronic resources, group programs and grant initiatives.

The research is demonstrating that many people living with mental illness want help to address tobacco and if provided with evidence based treatments they can and they do quit tobacco.

It is also clear that without quality treatments, smokers with mental illness, in particular those with severe and disabling mental illness will continue to be a growing proportion of the smoking population and as a result have poor physical health, reduced life expectancy, financial difficulties and poor quality of life.

In Australia there are some excellent services which are helping people with mental illness to tackle tobacco; however there are still significant gaps.

Mental health and tobacco control services have a shared responsibility for addressing the health and well being of smokers with mental illness and there is a need to clarify roles and responsibilities in relation to this group.

These significant gaps in services provide an exciting opportunity for mental health and tobacco control services to work together and there is also a clear indication that if they do develop an effective range of services, they will significantly improve the health and wellbeing of people with mental illness, and reduce the harm caused by tobacco use across the community.

“With opportunity comes responsibility”. Winston Churchill