



SAINSBURY CENTRE
for MENTAL HEALTH
removing barriers achieving change



Smoking & Mental Health: *Quit Now* Project

March 2010

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Mary Tidyman, mental health promotion specialist, analysed the data and wrote the first draft of this report.

March 2010

Background to the project

QUIT Now, the Smoking and Mental Health Project, was funded by Cancer Research UK from January 2007 until July 2008. The project was managed by QUIT, the UK's leading charity aiming to help smokers quit. The Sainsbury Centre for Mental Health provided expertise on mental health and smoking issues, as well as service user involvement during the project's development stage.

Strategic objectives included provision of:

- Stop smoking support for smokers with mental health problems comprising:
 - Specialist telephone helpline stop smoking counselling support for smokers who wished to stop and/or to reduce then stop;
 - Web-based and paper resources providing motivational support to make a quit attempt or to reduce consumption and then move on to a quit attempt;
- Health Care Professional Training to provide the necessary skills to engage with and provide stop smoking brief interventions and offer appropriate behavioural support.

Smoking and mental health

About a sixth of the total UK population are current smokers. 10 million adults – just over one in five men and women – number amongst the country's remaining smokers (ASH, 2010). Cigarette smoking is now concentrated in the most deprived groups, which include those with mental health problems (Fryers *et al.*, 2003).

People with depression are more likely to smoke and have difficulty when they try to stop (Doll *et al.*, 2004). Smoking rates among people with schizophrenia are significantly higher than those in the general population, with estimates ranging between almost six in ten to almost nine in ten (Sacco *et al.*, 2005).

Studies of psychiatric patients in hospitals have shown that up to seven in ten smoke, and around half are heavy smokers (Coulthard *et al.*, 2002; Foster *et al.*, 1996; Kelly & McCreadie, 1999; Meltzer *et al.*, 1996; Jochelson & Majrowski, 2006). It is not clear what impact the 2008 smoking legislation has had on prevalence in this group; research has demonstrated that breaches are widespread (Ratschen *et al.*, 2008).

High levels of smoking amongst populations with mental health conditions puts them at particular risk of increased morbidity and mortality from heart and respiratory disease (McCreadie, 2003; Joukamaa *et al.*, 2001; Hennekens *et al.*, 2005). A UK study found that heart disease is 1.6 times more common in people with schizophrenia and bipolar disorder than in the general population (Disability Rights Commission, 2006). A Canadian study found that deaths from ischaemic heart disease in people with mental illness are more than twice that of the general population (Kisely *et al.*, 2005). Another study found the prevalence of respiratory disease in a random sample of

psychiatric patients was 23 per cent and that they were more likely to have chronic bronchitis (15.9 per cent versus 6.1 per cent) and emphysema (7.9 per cent versus 1.5 per cent) than the general population (Himmelhoch *et al.*, 2004).

Chronic smoking is also associated with and may intensify some mental disorders. Epidemiological studies suggest chronic smoking is associated with agoraphobia, generalised anxiety disorder and panic disorder (McNeill, 2001). Smokers have higher rates of and experience more severe depression, are more likely to think about suicide, and have higher suicide rates (Wilhelm *et al.*, 2004). Heavy smoking is also associated with more severe psychotic and schizophrenic illness, poorer outcomes and more frequent hospital admissions (Corvin *et al.*, 2001, Aguilar *et al.*, 2005).

Despite a high prevalence of smoking, many mental health patients would like to quit (Meltzer *et al.*, 1996; McCreadie, 2003; Doherty, 2006). However, many studies show that quit rates for people with a mental illness are very low. This may be because smoking is part of the culture of psychiatric institutions, but also because staff and patients believe nicotine helps patients to cope with the symptoms of their illness or with the side effects of medication (Lawn, 2004; Lawn & Pols, 2003; Lawn & Pols, 2005). People with mental illness also may find it hard to get access to smoking cessation services, and are not directed there by medical professionals (McNeill, 2001; El-Guebaly *et al.*, 2002; Dickens *et al.*, 2005; Prochaska *et al.*, 2004).

The Quit Now Project

The project aimed to provide smokers with mental health problems, who wanted to reduce or stop, bespoke assistance that could be accessed via a free telephone helpline.

Specialist telephone stop smoking counselling service

The project built on the existing *Quitline*[®] model of stop smoking support that comprised-

- Intensive and proactive stop smoking expertise and immediate frontline counselling;
- Staff with skills to undertake rapid needs assessment, offer accurate and active listening, accessible and friendly advice, and with in-depth understanding of human behaviour;
- Cognitive Behavioural Therapy (CBT) and motivational interviewing.
- Referral to community based NHS smoking cessation support.

A telephone stop smoking counselling service, tailor-made to the smoker and their individual needs, was provided to facilitate smokers with mental health problems accessing appropriate and specialist support.

The telephone line was a free service operating twelve hours per day, seven days a week during fixed hours. The project allowed for six telephone counselling sessions including the initial call, all diarised to suit the smoker's convenience.

Any health professional working with a smoker with mental health problems was able to make a referral to the *Quit Now* project. They could also assist smokers to self refer, using a referral form developed by the project (See **Appendix A**, p.17).

The sample of smokers participating in the project were also able to take advantage of the wide range of stop smoking services and support provided by QUIT or NHS stop smoking services.

Dedicated web-based support and email counselling

In addition to telephone support, dedicated web-based support and email counselling was made accessible to ensure that smokers who preferred web-based interventions could access the support of their choice. This service was available from mid December 2007.

Links to local services

Smokers involved with the project were linked and signposted to local services to ensure their attempt to quit, or reduce then stop, could be successfully managed within complex and interdependent health problems.

Free motivational resource

The Quit Guide to Stopping Smoking and Mental Health, a free motivational resource that complemented the available telephone counselling, was also available to smokers in the project (QUIT, 2007). The resource included information and advice on dealing with cravings, daily tips, a

diary for smokers to measure their own progress, and useful telephone numbers and details of local services.

The tone, content and design of the resource were developed in collaboration with mental health service users who smoked. Three focus groups, with nineteen participants, were held in London, Birmingham and Warwick. An independent mental health service user researcher facilitated the focus groups.

Training programme for health care professionals

The *QUIT Now* project provided free training to health care professionals working with smokers with mental health problems living in the community, e.g.:-

- Smoking cessation counsellors
- Primary care practitioners
- Mental health specialists such as registered mental health nurses or community psychiatric nurses.

The specialist training had the following goals:-

- skills and knowledge to offer a stop smoking brief intervention at Level 1;
- confidence to refer smokers to the *Quit Now* project i.e. the telephone, web-based and motivational resources provided
- knowledge of local NHS stop smoking services and referral methods;
- capability to become peer group leaders.

Full or half day training covered the following areas:

- Project outline
- Why do we smoke?
- Quit quiz
- Prevalence of smoking & mental health
- Active listening + role play
- NICE recommendations
- Brief intervention + role play
- Referral process + role play
- Review & Evaluation

From May 2007 the planned training sessions began, each accommodating up to twenty delegates. The majority of participants were either smoking cessation advisors or mental health workers and a total of 260 health professionals received training.

Collaborative approach

QUIT also worked in partnership with the Tobacco Control Collaboration Centre (TCCC) and both agencies combined their health care professionals' training to widen its reach and impact. QUIT

contributed to nine regional workshops and three different national conferences during 2007 and 2008.

The QUIT/ TCCC Support Pack for Smoke Free Mental Health Services included the QUIT *Guide to Stopping Smoking and Mental Health: So you want a smoke free life*. It also contained various leaflets and posters designed for display within mental health units, and these featured the QUIT helpline number. Consequently a small increase was noted in numbers of smokers with mental health conditions accessing the Quitline.

Follow-up to the training

The Project Co-ordinator provided regular on-going support to the trainees once they had completed the course. The intention was to support and facilitate their referring clients to the project. Consequently a small increase in smokers with mental health conditions accessing the *Quitline*[®] was noted.

At 3 and 6 months following the training, the co-ordinator carried out telephone interviews to assess the extent to which newly acquired skills were being used and to identify any outcomes. Trainees' feedback was also used to inform amendments to the training programme.

From January 2008, the QUIT website contained a new **smoking and mental health** page. It included detailed content for smokers who wanted to stop, and for health care professionals who needed additional skills to support their clients.

QUIT Now project: process and outcomes

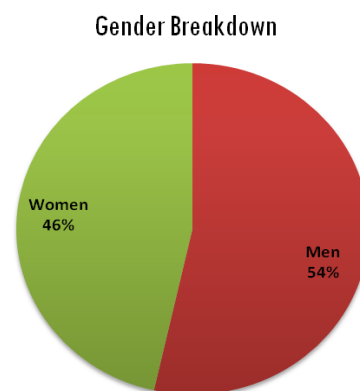
There were a number of complementary drivers for the *QUIT Now* project. Smoking prevalence among people with mental health problems has remained high, alongside seemingly few reliably effective interventions to aid reduction or cessation. Another key variable was the smoking legislation scheduled for July 2008.

There was always a sense that smokers with mental health problems would need specialist support in the run up to implementation of smoke free legislation. The model of a tailor-made support plan, provided for the smoker, followed with them and sent to them for their records, was intended to augment any existing available support. The added value of the project was the follow-up support at one, three, six and twelve months.

Data analysis revealed however that the number of smokers seeking telephone counselling support was lower than had been anticipated. Over the life of the project 68 people accessed the *QUIT Now* telephone counselling service. QUIT estimated that this number represented approximately 40% of all callers who might have been eligible to access the support.

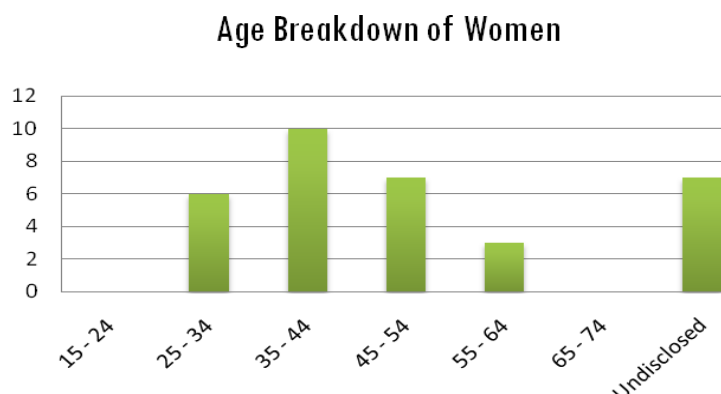
Gender

Of the 68 people accessing the *QUIT Now* telephone counselling service, there were 33 women and 35 men.

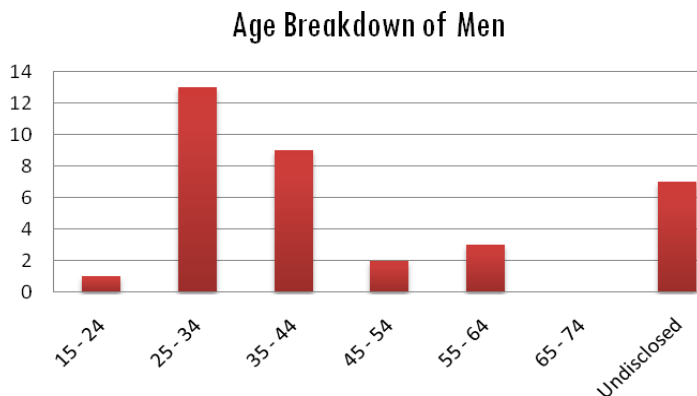


Age

Age distribution among female callers was fairly evenly spread i.e. 35 – 44 years (10 women), 45 – 54 years (7 women) and 25 – 34 (6 women). There were no women under 25 years or over 64 years old. Ten women did not have their age recorded.

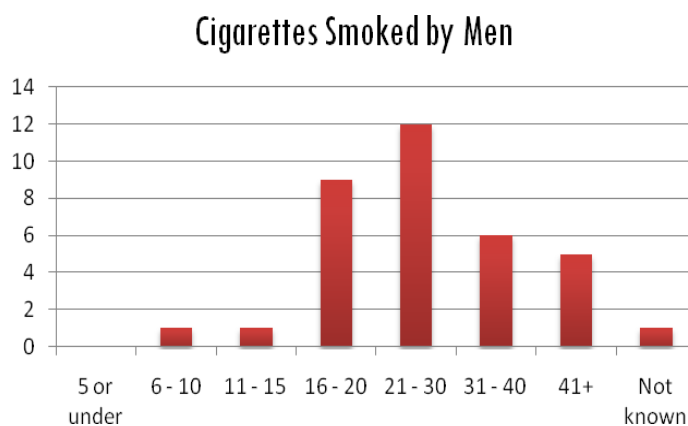


Age distribution among male callers was more skewed towards younger ages i.e. 25 – 34 years (14 men), 35 -44 years (8 men) 55 -64 years (3 men). One man was aged between 15 – 24 years. Nine men did not have their age recorded.

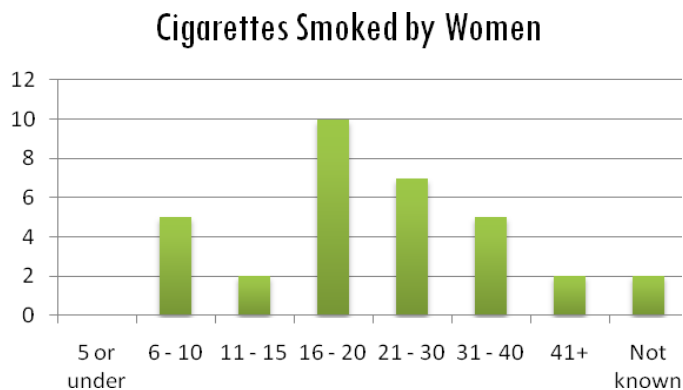


Number of cigarettes smoked

The majority of male callers smoked between 21 – 30 cigarettes per day.



The majority of female callers smoked between 16 – 20 cigarettes per day.

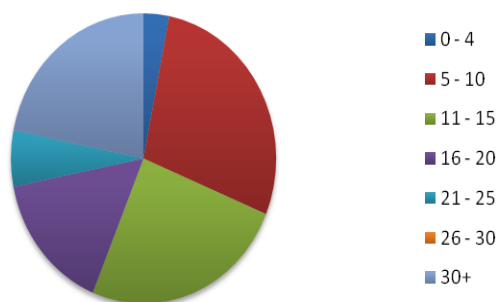


More male callers smoked at the rate of 41+ cigarettes per day (14.2%); and more female callers smoked fewer than 10 cigarettes per day (15.1%).

Number of years smoking

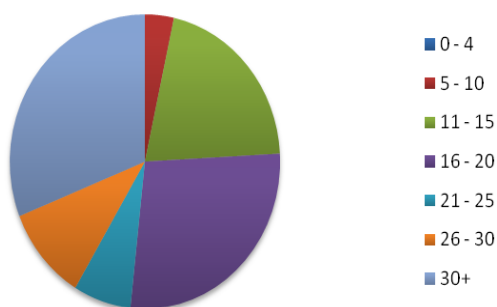
A larger proportion of male (28.5%) than female (3%) callers had smoked for 10 years or less.

Number of Years, Men Smoking



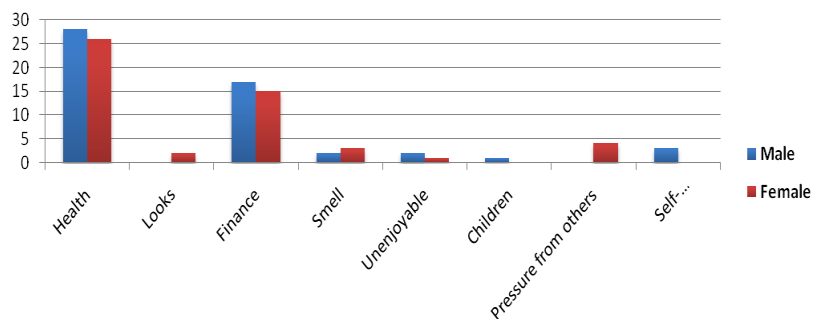
A larger proportion of female (39.3%) than male (22.8%) callers had smoked for more than 21 years.

Number of Years, Women Smoking



Reasons for quitting: 80.8% of all participants (77.1% men and 84.8% women) cited health as the reason for wanting to quit. For 45% the second most common reason was finance (48.5 % men and 42.4% women).

Reasons for Quitting

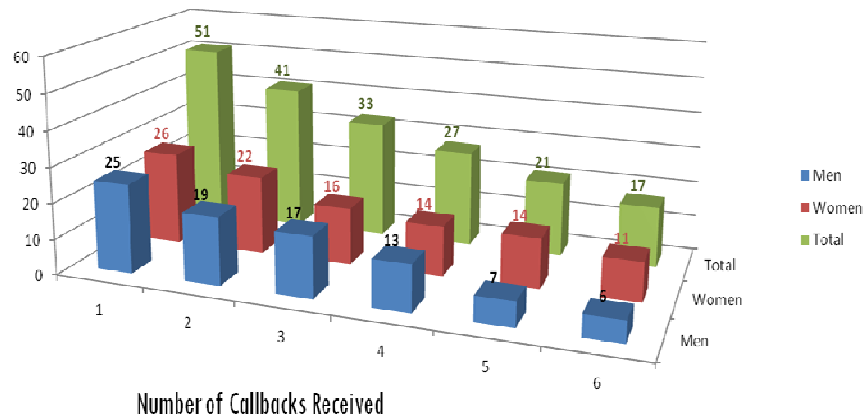


Women mentioned *pressure from others* and *looks* as two additional reasons for wanting to quit. Men mentioned *children* and *self control*. Both men and women mentioned *smell* and *lack of enjoyment* as further reasons.

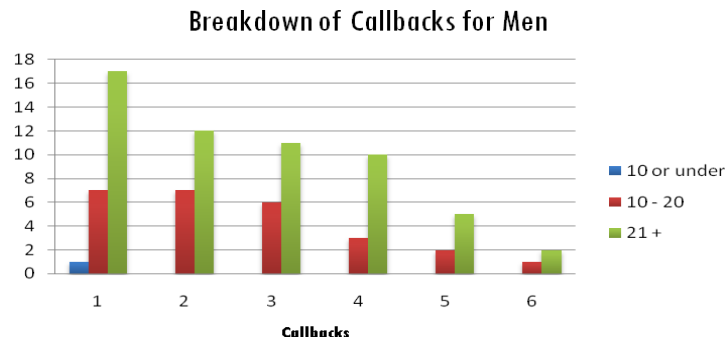
Call backs to the counselling service

Following the initial telephone counselling session, a further 6 sessions were offered to participants to help support them to quit. These telephone sessions were arranged to take place at agreed and convenient times.

75% of participants (n = 25 men; 26 women) accessed the first follow up telephone counselling session. For each subsequent call back session a smaller number of participants took part, dropping to 25% of participants (n = 6 men; 11 women) accessing all six follow up sessions.

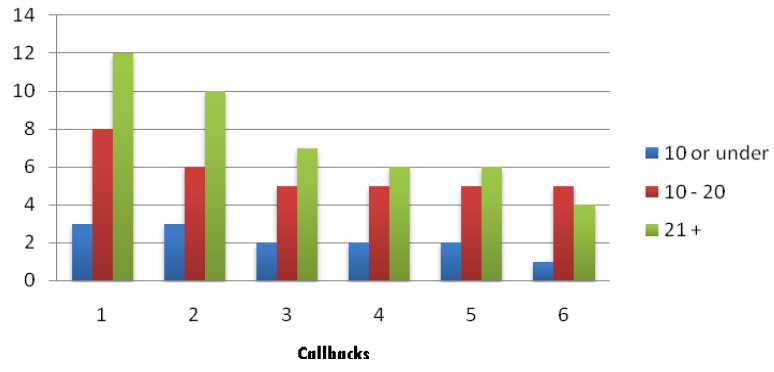


There was a correlation between amount smoked and follow-up sessions. Men smoking more than 20 cigarettes per day were more likely to access follow-up counselling sessions.



A similar association was marked amongst female callers. Women smoking at the top end for their group were more likely to access all six follow-up counselling sessions, whereas those smoking less did not.

Breakdown of Callbacks for Women



Discussion

The *QUIT Now* project was an innovative pilot programme to test out the use of dedicated telephone counselling support for callers with mental health conditions who wanted to reduce or quit smoking. Evidence shows that these groups would like to address their smoking habit but there are limited effective means to do so.

The project achieved some key successes with partner agencies, amongst health professionals and with the smokers themselves. For example the working partnership between Quit and the Tobacco Control Collaboration Centre (TCCC) increased the reach and impact of the project, which had input into a total of nine regional workshops.

260 male and female health professionals - smoking cessation advisors, mental health professionals and other practitioners – were trained to offer specialist tailor-made support to people with mental health problems wishing to quit smoking. These professionals were able to offer active listening, a brief intervention in smoking cessation, and referral to the *QUIT Now* project specialist telephone counselling service, web-based and motivational resource and/or to local NHS stop smoking services. They were also enabled to become peer group leaders, giving the project additional sustainability.

The project recruited 68 people with mental health problems, who wished to reduce or quit smoking, to access the specialist telephone counselling service. However these numbers fell far short of the capacity available to help smokers with mental health problems. A possible explanatory factor is that these groups of smokers may take longer to engage with a stop smoking service of this kind.

The project was more successful at recruiting men than women in the 25 – 34 years old age group (n = 14 men; 6 women). However in the 45 – 54 year old age group, more women than men were recruited (n = 7 women; 2 men). Given the small sample size, these figures are not statistically significant. But they raise issues of the gender and age appropriateness of different referral techniques and their efficacy.

Health was the dominant reason all callers gave - both men and women - for wanting to quit. The next most important reason was the impact of spending on smoking and individual finances; this is hardly surprising given that many people from these groups are on low or restricted income.

Many callers cited both health and finances as motivations to quit. These responses mirror those of the general population and demonstrate that people with mental health conditions share the same concerns and drive to quit as any smoker. This intelligence can be utilised in future work to encourage people with mental health problems to quit.

The project offered up to 6 telephone counselling sessions following the initial call, but those taking advantage of the service diminished markedly after the first session. Three in four participants accessed the first follow up session, but only one in four made use of all six sessions. And another one in four participants did not access any of the follow up counselling sessions.

These results do not lend themselves to clear interpretation. They may indicate that callers did not find the initial session useful. Perhaps these clients did not remember or prioritise the arranged call back session date and time. Even if they were keen to use the follow-up sessions, they may have been unable to keep the subsequent appointments because of other issues in their lives. These possible obstacles will be addressed by introducing a txt message reminder for clients who have mobile phones and evaluated in future projects. And of course callers may have been accessing other forms of support located more locally to them, on advice from the QUIT counsellor who might have judged that community support was preferable.

Recommendations

Smoking prevalence is significantly higher among people with mental health problems than among the general population. Consequently they have high levels of nicotine dependency and greater risk of smoking-related morbidity. Their elevated incidence chronic morbidity and excess mortality is associated with their levels of smoking.

Health professionals working with people with mental health problems, as well as smoking cessation specialists, need to have an array of effective stop smoking services for these vulnerable groups of smokers. Crucial issues that should inform the continued development of such services include the following:-

- Smokers with mental health conditions may take longer to engage with stop smoking services, and may need repeated opportunities to do so, with regular follow up.
- Smokers with mental health conditions may benefit from multiple stop smoking support and quitting options, including face-to-face and telephone counselling support, brief interventions, web-based support, and email counselling.
- Tailor-made stop smoking resources for people with mental health problems are particularly welcomed by this group. They can provide motivation and encouragement that successfully quitting is possible; and can answer specific questions for those concerned about the effect of quitting on their prescribed medication.

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Appendix A

QUIT Now – Smoking & Mental Health Project

SELF REFERRAL FORM

I _____ (insert name) wish to access the QUIT Now project.

Address

Postcode

Contact Telephone No

(a QUIT Counsellor will contact you by the number provided above)

Smoking History

How much do you smoke per day?							
1-5 <input type="checkbox"/>	6-10 <input type="checkbox"/>	11-15 <input type="checkbox"/>	16-20 <input type="checkbox"/>	21-30 <input type="checkbox"/>	31-40 <input type="checkbox"/>	41+ <input type="checkbox"/>	Not known <input type="checkbox"/>
How soon after waking do you have your first cigarette? _							
How long have you smoked for?							
How much do you want to quit smoking?				Have you tried to quit before?			
Very much <input type="checkbox"/> Not very much <input type="checkbox"/> In between <input type="checkbox"/>				Yes <input type="checkbox"/> No <input type="checkbox"/>			
If you have quit before? (longest time)				If yes, how many times?			
1-6 days <input type="checkbox"/>		1-2 weeks <input type="checkbox"/>		1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6+ <input type="checkbox"/>			
2-3 weeks <input type="checkbox"/>		3-4 weeks <input type="checkbox"/>					
1-2 months <input type="checkbox"/>		2-3 months <input type="checkbox"/>					
3-4 months <input type="checkbox"/>		4-5 months <input type="checkbox"/>					
5-6 months <input type="checkbox"/>		6-12 months <input type="checkbox"/>					
1 year + <input type="checkbox"/>		Undisclosed <input type="checkbox"/>					
What methods did you use?							
Counselling <input type="checkbox"/>							
Cold turkey <input type="checkbox"/>							
Cutting down <input type="checkbox"/>							
NRT <input type="checkbox"/> (state type) _____							
Other <input type="checkbox"/> (please detail): _____							

Medical History

Please can you provide QUIT with a brief overview of your medical history

--

To be completed by Health Professional

Name	
Address	
Contact No	

I _____ (insert name) confirm that I have provided _____ (insert name) with a stop smoking brief intervention and that they wish stop smoking support from QUIT/The QUIT Now project.

Date _____

Please fax this form to QUIT on 020 7251 1661

A QUIT counsellor will be in touch with the smoker within 24 hours, if there is a preferred call back time please state here _____

Additional methods of contacting QUIT:

Quitline: 0800 00 22 00

Email: stopsmoking@quit.org.uk

www.quit.org.uk