Organization: NAMI Minnesota
Request ID: 16872475
Program Title: Reducing Smoking Among People with Mental Illnesses

1. **Overall Goal & Objectives**

The overall goal of this project is to reduce the rate of tobacco use among individuals living with mental illnesses. This goal aligns with the aim of the grant to support projects that focus on improving the competence of healthcare professionals and the performance of healthcare systems so that all smokers can be helped to quit.

Our primary objectives are to 1) Increase awareness and engagement among mental health providers on the importance of smoking cessation; 2) Increase awareness of the benefits and cessation tools among people living with mental illnesses and their families, 3) Institute smoking cessation supports such as facilitating weekly wellness and smoking cessation groups; and 4) track cessation attempts, reductions and cessation longer than three months.

2. **Technical Approach**

This project aims to reduce the rate of tobacco use among individuals living with mental illnesses. This goal aligns with NAMI Minnesota's mission to improve the lives of people affected by mental illnesses. Quitting smoking will reduce the risk of early morbidity, increase quality of life and is congruent with SAMHSA's eight dimensions of wellness involving a person's social, physical, emotional, spiritual, occupational, intellectual, environmental and financial spheres. This also aligns with the focus of the RFP, as it addresses a special population that is disproportionately burdened by smoking and the negative health effects that result from it.

Current Assessment of Need in Target Area

In 1977, tobacco companies began a marketing plan to target psychiatric hospitals, individuals that were less educated, had lower income, and those from minority populations. Free cigarettes were distributed to homeless shelters, state institutions and homeless service organizations. Smoking cessation among individuals is a complicated issue that involves biological predisposition, social and psychosocial considerations and stigmatizing beliefs around smoking among individuals with mental illnesses.

Individuals with mental illnesses are disproportionately affected by tobacco use and are not receiving adequate information and cessation services. Individuals with mental illnesses and substance abuse disorders are nicotine dependent at rates that are two to three times higher than the general population.

The statistics are alarming. According to a report released by the Centers for Disease Control and Prevention (CDC) in collaboration with the Substance Abuse and Mental Health Services Administration (SAMHSA), 39 percent of adults with a mental illness are cigarette smokers, compared with only 19 percent of adults who do not have a mental illness. In addition, adults with mental illnesses who do smoke are heavy smokers. Over 200,000 of the 443,000 annual deaths from smoking in the U.S. occur among people with mental illnesses and/or substance

use disorders. The prevalence of smoking by diagnosis is as follows: major depression 36-80%; bipolar disorder 51-70%; schizophrenia 62-90%; anxiety disorders 32-60%; post-traumatic stress disorder 45-60%; attention deficit/hyperactivity disorder 38-42%; alcohol abuse 34-93%; other drug abuse 49-98%. Because individuals with mental illness have a higher rate of tobacco use, they are at greater risk to smoking-related illnesses and higher morbidity.

According to a needs assessment report prepared for the State Tobacco Education and Prevention Partnership (STEPP), Colorado Department of Public Health and Environment, individuals with mental illnesses want to quit smoking and want information on cessation services and resources. Individuals with mental illnesses deserve accurate information regarding tobacco use and options for quitting. There are real and perceived barriers to providing smoking cessation options in mental health and substance abuse settings. Many clinicians do not view tobacco cessation as a part of their scope of practice, feel tobacco cessation could be detrimental to the treatment plan, believe that tobacco use is not a treatment priority, and think that tobacco cessation strategies would be too time consuming. Lastly, many of the traditional smoking cessation programs are not as effective for persons with a serious mental illness.

Like any addiction, intervention and cessation are extremely difficult. For individuals with mental illnesses the complexity is even greater and requires intensive education and outreach. Many factors play into this complex issue. Researchers believe that individuals with mental illnesses have unique neurobiological features that may increase their tendency to use nicotine, making it more difficult to quit and more likely to experience complicated withdrawal symptoms. Individuals with serious mental illnesses have less access to general medical services and are less likely to seek out other community resources. Smoking is often associated with social activities and promoted among peers.

On the other hand, individuals with severe mental illnesses tend to be more isolated and bored and will smoke more. For people with serious mental illnesses using public programs in Minnesota, 85% are unemployed.

Tobacco use also may temporarily relieve feelings of tension and anxiety and is often used to cope with stress, a prevalent symptom among individuals with mental illnesses. Finally, providers often inadvertently perpetuate the stigma and think that individuals with mental illnesses are unable to quit and that symptom management takes precedence over promoting preventive health measures. At this time, we do not have exact numbers since we do not provide direct treatment and services and will be partnering with community mental health providers.

NAMI Minnesota received a yearlong grant from the Medica Foundation in 2013/2014 to address the disproportionate rate of tobacco use among individuals living with mental illnesses and increase mental health providers' awareness of tobacco use as a problem. Tobacco use has historically been seen as a "lesser of evils" for people with mental illnesses, and was even used as a bribe or reward for complying with treatment. We found that for a number of reasons,

smoking cessation is still seen as a job for primary care providers, despite the fact that people with mental illnesses have lower rates of accessing primary care. Mental health providers do not have the education or resources to help their clients quit and face competing demands with treating mental illnesses and other substance use. Mental health providers, however, are most likely to have frequent interactions with individuals who live with mental illnesses and smoke. They have also built a relationship and a level of trust, which is helpful when addressing a sensitive issue.

NAMI developed an hour-long curriculum that addressed tobacco use statistics, assessment tools and planning for interventions, cessation treatment options, and relapse prevention strategies. The workshop outlined the reasons behind why the rate of smoking is so high among individuals with mental illnesses, how smoking can affect mental illnesses, and how providers can work with their clients on quitting smoking. It goes through the "5 A's", the best-practice method for providers to talk to their clients about tobacco use and assist them in quitting. We also emphasized the importance of organizational change, putting the "5 A's" into practice, and communication strategies for making these changes.

These workshops were delivered to over 300 mental health providers throughout Minnesota. NAMI also worked with mental health facilities on making organizational change that supports tobacco reduction utilizing the Colorado smoking cessation model. NAMI also included cessation information in all of NAMI's support groups and classes. Educational materials were distributed to organizations around the state and articles about the importance of addressing tobacco use in a mental health setting were placed in newsletters of the Minnesota Hospital Association, Minnesota Association of Community Mental Health Programs, and Minnesota Psychological Association.

This proposed project would build on NAMI's previous efforts to increase education and awareness. Rather than just educating providers, it would turn its focus on educating the individuals who are affected by smoking and interested in quitting. It would also provide the support and tools that are needed for those with mental illnesses to remain quit.

Despite receiving initial hesitance from many mental health providers, the workshops were very well received. NAMI created evaluation forms for providers to complete after each workshop. Based on these, 90% of respondents said that their knowledge of smoking cessation strategies for individuals with mental illnesses increased, 91% would feel comfortable discussing assessment tools and planning for interventions with clients, 90% agreed that their knowledge about specific types of mental illnesses in relation to smoking has increased, 89% feel more familiar with different cessation treatment options, 91% had a better understanding of relapse prevention strategies. This directly shows the impact that even a simple workshop had on mental health providers. They are now better prepared and more likely to address tobacco use with their clients. This is a crucial component to improving health outcomes and length of life for individuals living with mental illnesses.

When talking to mental health providers about the importance of organizational commitment to change we found that many providers have not felt ready to make immediate changes but they felt it was something that was needed within the next few years. Although there was initial hesitance, providers recognized that organizational changes and adjusting policies are effective ways of impacting tobacco use among individuals living with mental illnesses. Because of the resistance from providers on making larger changes, we focused on emphasizing smaller, more immediate changes that can be made. Asking every client about their tobacco use is a simple thing that can be implemented in electronic health records, intake forms, or other forms that are regularly used. This small intervention opens a discussion among providers and clients about a person's tobacco use, why it would be beneficial to quit, and some available resources for doing so.

NAMI Minnesota has also learned this past year about barriers that people face in accessing cessation services and what can be done to reduce those barriers. People may face barriers to accessing other cessation services like counseling and quit lines. For people with lower incomes or disabilities, having access to reliable transportation, a telephone, and internet can be difficult. A lack of education about the effects of smoking or not knowing how to quit also inhibits people from making quit attempts. More cessation services tailored to fit the needs of individuals with mental illnesses are needed to improve accessibility and reduce the rate of smoking.

This proposed project would build on NAMI's previous efforts to increase education and awareness. It would go beyond educating providers and add a focus on educating the individuals who are affected by smoking and interested in quitting. It would also provide the support and tools that are needed for those with mental illnesses to quit.

Project Design and Methods

The project will target mental health professionals and providers, and individuals who live with mental illnesses and smoke. As stated above, tobacco use often goes unaddressed in mental health settings despite the fact that those with mental illnesses have drastically higher rates of tobacco use and resulting health effects. By educating and collaborating with mental health providers and making weekly meetings available to these individuals, people with mental illnesses will be encouraged and able to make successful quit attempts.

The key activities of the project will be to:

- Work with mental health providers around the state to "buy in" to the importance of smoking cessation. This includes making a commitment from the top leadership, educating staff and clients, and making available smoking cessation tools.
- Provide the smoking cessation curriculum 100 times to 300 people who work in mental health treatment and support settings.

- Provide a workshop based on Learning About Healthy Living, Tobacco and You, including the benefits of smoking cessation and how to prepare to quit, 20 times to 200 people who live with a mental illness.
- Facilitate two weekly groups in the metropolitan area at clubhouses and drop-in centers that provide information, support, and resources to individuals with mental illnesses who are interested in quitting smoking. At the weekly group, people will fill out a "change plan" that identifies the most important reasons for wanting to quit, steps they plan to take, how people can help them and some things that could interfere with the plan.
- Gather information from participating individuals on their history of tobacco use, quit attempts, resources used, and successes to determine which methods are more effective.
- Share information and materials through newsletters and online.
- Include smoking cessation information in all of NAMI's current educational workshops, support groups, on the website and through social media.

These activities address the need to continue to raise awareness and engage mental health providers as to why smoking cessation is important and why they must be involved. It also addresses the issue that the subject of smoking cessation has not been broached with people with mental illnesses. NAMI wants to provide them with this information along with the tools and support needed. This includes educating family members on how to be supportive of smoking reduction and cessation.

Evaluation Design

There has not been much research on the reasons why people with mental illnesses decide to attempt to quit smoking or the methods that are most effective. The best way to learn how to help people with mental illnesses quit is to work directly with them and learn from them.

NAMI will have participating individuals complete initial surveys to measure baseline. We will ask when they started smoking, how much they smoke, if they have made previous quit attempts and why they are interested in learning about smoking cessation. Surveys will be conducted at each support group to measure progress including any reduction in smoking, any cessation medications or counseling that are being used any health or mental health benefits being experiences. Interviews will be conducted with those that quit to learn more about what was helpful and effective and what they would tell others in terms of the benefits of quitting.

This information will allow NAMI to analyze what leads to people with mental illnesses in becoming interested in quitting and what strategies are helpful. This will lead to evaluating the efficacy of the project and compare it against baseline quit rates. The findings will be included in statewide publications and online and will be shared with mental health providers so that it can be replicated across the state.

In addition, NAMI will continue to work with participating providers to measure the number of times that smoking cessation was raised to clients. We believe that the issue must be raised,

despite the difficulties a person may be experiencing at the time. Providers will be given "bookmarks" about smoking cessation. NAMI will record how many have been distributed each month.

3. Detailed Workplan and Deliverables Schedule

Goals/Objectives	Activities/Deliverables	Timeline
Increase awareness and engagement among mental health providers on the importance of smoking cessation	Identify mental health providers around the state to "buy in" to the importance of smoking cessation.	May – November
	Identify mental health providers willing to make a commitment from the top leadership to smoking cessation.	May – November
	Provide the smoking cessation curriculum 100 times to 300 people who work in mental health treatment and support settings.	May – April
	Provide bookmarks to be distributed to clients each time they are asked about smoking. Conduct monthly counts re: distribution.	June - April
Increase awareness of the benefits and cessation tools among people living with mental illnesses and their families,	Develop a workshop based on Learning About Healthy Living, Tobacco and You, including the benefits of smoking cessation and how to prepare to quit.	May – July
	Have at least 5 mental health providers agree to allow the workshop to be presented to their clients.	June-September
	Provide the workshop 20 times to 200 people who live with a mental illness.	August – April
	Share information and materials in each quarterly newsletter, once a month in the enewsletter and online through social media twice a month	May – April
	Include smoking cessation information in all of NAMI's current educational workshops, support groups, on the website.	June - September

Institute smoking cessation supports such as facilitating weekly wellness and smoking cessation groups	Identify and obtain commitment from at least five mental health providers to hold smoking cessation support groups. Facilitate two weekly groups in the metropolitan area at clubhouses and drop-in centers that provide information, support, and resources to individuals with mental illnesses who are interested in quitting smoking. Create and institute a “change plan” that identifies the most important reasons for wanting to quit, steps they plan to take, how people can help them and some things that could interfere with the plan.	July – August September – April September - April
Track cessation attempts, reductions and cessation longer than three months.	Gather information from participating individuals on their history of tobacco use, quit attempts, resources used, and successes to determine which methods are more effective. Write articles with findings and publish in mental health professional newsletters and present at mental health provider conferences	August – April August - April