What Do Persons with Mental Illnesses Need to Quit Smoking?
Mental Health Consumer and Provider Perspectives

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Objectives: Forty-one percent (41%) of persons in the U.S. who reported having recent mental illnesses also smoke cigarettes. Tobacco use among this population is associated with up to 25 less years of life and excess medical comorbidity compared to the general population. While research demonstrates that tobacco interventions can be effective for persons with mental illnesses, they are not commonly utilized in clinical practice. The current study explored how to adapt evidence-based tobacco cessation interventions to meet the unique physiological, psychological, and social challenges facing persons with mental illnesses. Methods: Ten focus groups were conducted utilizing a semi-structured discussion; 5 for adult mental health consumers (n = 62) and 5 with mental health clinicians and administrators (n = 22). Content analysis was used to organize themes into categories. Results: Five thematic categories were found: (1) Barriers to treatment, (2) Resources and infrastructure, (3) Negative influences on smoking behavior, (4) Knowledge deficits, and (5) Treatment needs. Conclusions: These findings are instructive in developing appropriate tobacco cessation services for this population. Specifically, these data have been incorporated into a mental health provider toolkit for smoking cessation and have informed the development of a tobacco cessation intervention study.

Keywords: person centered planning, mental health, addiction, quality of life

While the prevalence of tobacco use in the U.S. general population is declining, this is not the case for persons with mental illnesses. This group represents approximately 7% of the U.S. population but consumes over 30% of cigarettes and comprises 44% of the entire U.S. tobacco market (Grant, Hasin, Chou, Stinson, & Dawson, 2004; Lasser et al., 2000). Nationally, tobacco use prevalence among persons with mental illnesses is over 40% (Lasser et al., 2000), twice that of the general population. Smoking rates vary greatly by psychiatric diagnosis (Beratis, Katrivanou, & Gourzis, 2001; Hughes, Hatsuakami, Mitchell, & Dahlgren, 1986; Morris, Giese, Turnbull, Dickinson, & Johnson-Nagel, 2006), e.g. persons with schizophrenia smoke at rates over 60% compared to approximately 50% of those with schizoaffective or bipolar disorder, and smoking is associated with higher rates of alcohol and drug use (Morris et al., 2006). If persons with mental illnesses have multiple
psychiatric diagnoses, their tobacco use is further increased (Lasser et al., 2000).

Persons with mental illnesses die up to 25 years earlier and suffer increased medical comorbidity when compared to the general population (Brown, Inskip, & Barracough, 2000; Colton & Manderscheid, 2006; Dixon, Postrado, Delahanty, Fischer, & Lehman, 1999; Joukamaa et al., 2001; Osby, Correia, Brandt, Ekborn, & Sparén, 2000). These persons have greater risk of metabolic syndrome, a group of risk factors for cardiovascular disease, which is associated with the high prevalence of second-generation antipsychotic medication use (American Diabetic Association, 2004; McEvoy et al., 2005; Newcomer, 2007). In addition to a high risk for metabolic syndrome, smokers with mental illnesses have more psychiatric symptoms, increased hospitalizations, and require higher dosages of medications (Dalack & Glassman, 1992; Desai, Seabolt, & Jann, 2001; Goff, Henderson, & Amico, 1992; Williams & Ziedonis, 2004; Ziedonis, Kosten, Glazer, & Frances, 1994). Smoking may be the most modifiable risk factor for decreasing the excess mortality and morbidity persons with mental illnesses face (National Association of State Mental Health Program Directors, 2006; U.S. Department of Health and Human Services, 2004).

Neurobiological, psychological, social, and societal variables are all associated with the high tobacco use prevalence among persons with mental illnesses. Some mental illnesses have associated neurobiological features that may increase nicotine use and make it more difficult to quit. Geneticists have found a link to the chromosome 15q14 region located at the alpha 7-nicotinic receptor subunit gene for persons with schizophrenia with nicotine dependence (Freedman et al., 2001). Nicotine transiently improves the sensory processing system in schizophrenia and may offer temporary relief from some negative symptoms (Ziedonis, Williams, & Smelson, 2003).

Smoking also increases the metabolism rate of many psychotropic medications (e.g., olanzapine, clozapine) used to treat mental illnesses such as schizophrenia, thus reducing both medication effectiveness and side effects (Desai et al., 2001; Forchuk et al., 2002). Therefore, persons with mental illnesses may, in part, smoke to reduce medication side effects (e.g., akithea). At the same time, psychiatric institutions have historically promoted the use of smoking to control psychiatric symptoms (NASMHPD, 2006), and the tobacco industry has supported research suggesting that persons with schizophrenia benefited from smoking and were less susceptible to the health effects of smoking (Prochaska, Hall, & Bero, 2007).

Current treatment options for tobacco cessation in general populations are not tailored for the unique characteristics of persons with mental illnesses. Treatment intervention studies have found that quit rates for persons with mental illnesses are lower than for general populations but still substantial. Individuals with a history of major depression have quit rates as high as 38% (Lasser et al., 2000), while for schizophrenia quit rates may be between 10–30% (Addington, el-Guebaly, Campbell, Hodgins, & Addington, 1998; Baker et al., 2006). A large community-based study of cessation for persons with non-acute psychotic disorders utilized a motivational interviewing/cognitive behavioral therapy intervention and found that a significantly higher proportion of smokers who completed all treatment sessions were abstinent at each of the follow-up points (point-prevalence rates: 30% at 3 months, 18.6% at 6 months, 18.6% at 12 months) (Baker et al., 2006).

Although these earlier studies are encouraging, persons with mental illnesses continue to face significant barriers to accessing effective cessation treatment. Evidence-based tobacco cessation interventions are typically developed at research and academic centers and are only slowly adopted in clinical practice (Berwick, 2003). The 2003 President’s New Freedom Commission on Mental Health noted that stigma, system fragmentation and economic barriers make diffusion of evidence-based practices for patients with serious mental illnesses especially challenging (Hogan, 2003). Few mental health providers currently ask patients about smoking or advise them to quit (Himmelhoch & Daumit, 2003). This is a critical issue because mental health patients often do not receive consistent medical care nor have a designated primary care physician, and may have difficulty accessing services in public community health clinics. Instead, they typically consider their mental health provider their principal health care resource (Giese, Morris, & Olincy, 2000).

Persons with mental illnesses clearly bear a disproportionate share of the burden related to tobacco use. New community-based strategies are required to address the unique smoking cessation needs of these individuals. A previously conducted needs assessment identified the potential for intervention through the Colorado public mental health system (Giese et al., 2000). Although attention to tobacco cessation is currently quite limited in the public mental health system, the findings of this assessment suggested both a widespread interest in tobacco cessation strategies and a great need for additional research and dissemination in this area.
for education and resources regarding evidence-based prevention and treatment options. Community mental health centers’ ability to treat and monitor symptoms through pharmacotherapy and psychosocial interventions makes these settings a logical place to address mental health patients’ high prevalence of tobacco use.

There is a clear gap between science and service in providing smoking cessation services to persons with mental illnesses. The objective of this study was to qualitatively understand the factors that impede and support tobacco cessation efforts from the perspectives of both community mental health patients and providers. The findings will be utilized to adapt evidence-based tobacco cessation interventions to meet the unique physiological, psychological, and social challenges facing persons with mental illnesses.

Methods

Participant Recruitment and Data Collection

We conducted ten focus groups consisting of adult (18 years and older) persons with psychiatric disorders, mental health clinicians, and community mental health administrators. The focus groups included participants representing both urban and rural regions in Colorado’s public mental health system. There were five groups with mental health consumers and five groups with mental health clinicians and administrators. Participants were recruited via community flyers, internet, and direct communication. They had to be cognitively able to participate in the discussion and be able to provide consent. Sixty-two (62) mental health consumers participated, including 21 tobacco users with prior quit attempts, 11 tobacco users with no quit attempts, 9 former tobacco users, and 2 lifetime non-smokers. The mental health clinician and administrator cohort included 3 case managers, 2 health educators, 4 psychiatrists, 2 psychologists, 2 registered nurses, 4 mental health workers, and 2 community mental health administrators.

We utilized focus group methodology to meet the study’s aim, as this semi-structured interview method captures the multi-dimensional nature and complexity of tobacco cessation issues, including consumer interactions with peers, health care providers, and the public mental health system (Krueger, 1988). Focus group questions were developed based on literature review and a previous qualitative study (Giese et al., 2000; Levinson, Borrayo, Espinoza, Flores, & Perez-Stable, 2006). Participants were asked to review prototypes of a provider tobacco cessation toolkit for persons with mental illnesses and patient smoking cessation handouts. The toolkit included evidence-based guidelines for smoking cessation (American Psychiatric Association, 2006) and a review of empirical research regarding smoking cessation interventions for this population. Smoking cessation materials for consumers included tips and resources for quitting smoking (e.g., quitline referral form, information about health and financial costs of tobacco use). Some of the consumer information was based on existing U.S. Department of Health and Human Services (DHHS) materials for smoking cessation (http://www.surgeongeneral.gov/tobacco/quit s.pdf) and from the Quitline’s smoking cessation materials. Both provider and consumer focus groups were asked structured interview questions regarding the toolkit and materials and about smoking cessation (see Table 1). Focus groups were digitally recorded for later transcription, and each participant received $15 for the hour-long group.

Analysis

We entered Microsoft Office Word 2003 files of focus groups transcribed verbatim into NVivo 7 qualitative data analysis software. We used an editing process of analysis which encourages interpretation of the data using a team approach. Through an iterative process, we did a thematic audit to track code usage across transcripts.

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**Table 1—Tobacco Cessation Focus Group Questions**

**Patient Questions:**

1. What information and resources do you or others need to stop smoking?
2. What suggestions do you have for improving these current materials? (e.g., prototype patient specific materials)
3. How can mental health providers be of most help in assisting persons with mental illnesses to quit smoking?
4. What has prevented you or others from quitting in the past and what has worked?

**Provider Questions:**

1. Would this toolkit be helpful to you?
2. How can we improve upon the current prototype materials?
3. What barriers do you (or might you) encounter in trying to provide tobacco cessation services to your patients?
4. What prevents persons with mental illnesses from quitting and what has worked?
and examine consistency in application of codes by different coders.

Several strategies were utilized to reduce coder bias. Each of four team members initially read and coded the first consumer and provider focus groups, highlighting themes that might not fit a priori coding. Examples or quotes for coding themes were also identified. The coding interpretations and schema were amended based on group consensus of the initial results. The remaining transcripts were divided among three coders. The fourth coder became the study auditor. This auditor was responsible for scanning all coding for potential inconsistencies and need for clarification. These transcript sections were then brought to the overall group for further clarification and final coding decisions. Regular consensus meetings were used to create the codebook of themes and definitions.

Results

Five thematic categories emerged from the focus groups: (1) Barriers to treatment, (2) Resources and infrastructure needed to implement tobacco cessation efforts, (3) Negative influences on smoking behavior, (4) Knowledge deficits among both providers and consumers, and (5) Treatment needs. Information about the thematic categories including number of references and transcript coverage for each category is displayed in Table 2.

1. Barriers to Treatment. Consumers and providers identified barriers to treatment that fell into two subcategories—lack of resources and negative expectations among providers and patients. Although both consumers and providers described a paucity of tobacco cessation resources within the public mental health system, providers identified this theme at a rate threefold to that of consumers. Providers cited a lack of clinical resources such as smoking cessation groups and financial resources (both patient and system) to pay for the treatment. The state of Colorado presently does not reimburse for specific tobacco cessation interventions or the development of tobacco-focused programs within mental health clinics. Given competing clinical demands and difficulty being reimbursed, mental health providers generally did not view tobacco as a high-priority issue for their practices.

Consumers reported frequently observing tobacco use among treatment staff, with one person noting “they (mental health providers) have to not smoke or they’re not a good example for me. If they smoke, they’ve got nothing to tell me.” Consumer comments were common regarding the negative impact providers’ tobacco use had on their own motivation to quit. Providers were also often frustrated by their colleagues’ overt tobacco use. As one provider summarized, “I’m busy talking to my folks about better health maintenance overall, including smoking cessation and weight loss and exercise, and they’re out there smoking with their case manager.” Moreover, in some settings, such as psychiatric hospitals, consumers earned smoking privileges as a behavioral reward. Consumers expressed a preference for both inpatient and outpatient mental health treatment settings to provide tobacco cessation interventions and support resources rather than the direct or indirect promotion of tobacco use.

Providers and consumers both voiced negative expectations regarding the ability of persons with mental illnesses to quit smoking, but providers made these comments more frequently. Providers expressed the belief that tobacco cessation for persons with mental illnesses is unlikely to occur and not worth the effort, largely due to person’s lack of motivation. Some consumers concurred with providers that quitting tobacco use was unfeasible for persons with mental illnesses. As one provider put it, “the problem is that there isn’t actually evidence that it (cessation strategies) works.”

2. Implementation. Implementation refers to necessary factors and resources which support tobacco cessation at mental health hospitals, clinics, or agencies. Sub-themes under implementation are community resources, organizational or clinic infrastructure and resources, provider education, and positive expectations and interest. Community resources and policies for tobacco control, such as state-wide smoking bans, were primarily viewed by providers as means to advance tobacco cessation.

Providers identified tobacco cessation for persons with mental illnesses as a promising or emerging evidence-based practice and strongly supported integrating tobacco cessation services in mental health settings as a clinical priority. Systematic identification and assessment of smokers was a preferred method of advancing this priority (e.g., chart tracking mechanisms, management information systems and electronic medical records). Providers also identified the need for strategic partnerships to fully implement smoking cessation services, such as partnerships to secure nicotine replacement therapies for inpatients and smoking cessation groups for outpatients. Case managers, nurses, and psychiatrists were identified as the most likely mental health providers to champion tobacco cessation efforts.

Provider education was identified as a crucial component by both consumers and providers, including evidence-based pharmacotherapies and behavioral interventions. Providers identified the need for on-site training sessions
### Table 2—Focus Group Themes for Persons with Mental Illnesses

<table>
<thead>
<tr>
<th>Emergent Theme</th>
<th>Number of Words</th>
<th>Average Percentage References</th>
<th>Total Coverage</th>
<th>Number of References</th>
</tr>
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<td></td>
<td>Patient</td>
<td>Provider</td>
<td>Patient</td>
<td>Provider</td>
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<tr>
<td><strong>1. Barriers to Treatment</strong></td>
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<tr>
<td>Lack of Resources</td>
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<td>Community Barriers</td>
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<tr>
<td>Negative Expectations</td>
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<td></td>
<td></td>
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<tr>
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<tr>
<td>Patient</td>
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<td>4</td>
<td>1.20</td>
<td>0.78</td>
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<tr>
<td><strong>2. Implementation</strong></td>
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<td></td>
<td></td>
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<tr>
<td>Community Resources Organizational/ Clinic</td>
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<tr>
<td>Infrastructure and Resources</td>
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<td></td>
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<tr>
<td>Existing Resources within Clinic System</td>
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<tr>
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<td>2.77</td>
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<tr>
<td>Patient Positive Expectation/ Interest</td>
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<td><strong>3. Knowledge Deficits</strong></td>
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<tr>
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<td><strong>4. Negative Influences on Smoking Behavior</strong></td>
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<td>Social-Family</td>
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<td>7</td>
<td>1.09</td>
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<tr>
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<tr>
<td>Boredom</td>
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<tr>
<td><strong>5. Treatment Needs</strong></td>
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<td>17</td>
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<td></td>
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<td>Nicotine Replacement</td>
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<td>Psychotropic Medications</td>
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<tr>
<td>Behavioral Strategies-Counseling</td>
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<td></td>
</tr>
<tr>
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<tr>
<td>Group</td>
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<td>0.96</td>
<td>1.60</td>
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<td><strong>TOTAL</strong></td>
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<td>182</td>
<td>6.42</td>
<td>0.16</td>
</tr>
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</table>

Total Coverage includes Patient and Provider references combined.

Total Number of References includes both Patient and Provider references.

References are based on the number of times each theme was mentioned in the focus group discussions.
and user-friendly, manualized tools. Content identified as important by providers included the existing evidence base and clinical guidance as how to best approach mental health patients. Consumers and providers also reported the importance of education about the harmful effects of tobacco use versus the potential benefit of symptom control.

A positive expectation of mental health consumers’ ability to quit smoking was identified as a crucial prerequisite for successful smoking cessation efforts by both consumers and providers. Smoking cessation was seen as “…something that you just keep coming back to. You talk about it every single time you see the consumer.” At the individual level, consumer and provider focus group participants noted that consumers need to maintain a positive attitude while making a cessation attempt as a negative outlook will assuredly lead to failure. At the clinical systems level, providers recommended that treatment sites with a clear interest in tobacco cessation become first adopters as a means of building an early record of success, rather than trying to mandate universal participation.

3. Knowledge Deficits. Lack of knowledge and misinformation was widespread among consumer and provider participants regarding tobacco use, health risks, motivations for use, and cessation strategies. Consumers identified symptom relief from tobacco, but generally knew little of its health consequences. As one participant poignantly stated, “I more or less became a smoker because I was told it would help me with my illness. I was taught more about it helping my illness than I was about cancer and stuff like that.”

Providers had little accurate knowledge of evidence-based tobacco cessation treatments, treatment outcomes, consumers’ desire or motivation to quit, or local tobacco control resources. Several providers commented that “they (mental health consumers) don’t care how much they spend on cigarettes. Their cigarettes are so important to them, it doesn’t matter.”

4. Negative Influences. Focus group participants identified specific factors that negatively influence smoking behavior. Providers and consumers both reported that greater acuity of psychiatric symptoms was associated with increased tobacco use. Smoking was used to control symptoms and enhance attention. General stress was also an ongoing issue, and consumers and providers reported that tobacco use temporarily relieved feelings of tension and anxiety.

Boredom was common among consumers in both hospital and community settings. As one focus group participant told us, “give me something to occupy my time. There is nothing to do...except smoke, sleep, and shower.” Consumers maintained that they smoked in the absence of other meaningful daily activities.

When social activities were available, these also often reinforced smoking. Consumers commented on how difficult it was to consider quitting when those around them smoked. Both consumers and providers viewed smoking as a social event, and a way of connecting with family, peers, and mental health staff. Peer settings such as clubhouses and drop-in centers were particularly prone to condone smoking. A common perspective was captured by a provider who commented “if they (mental health consumers) stop and their friends are all smoking, who do they hang out with?”

5. Treatment Needs. Focus group participants identified a number of treatment modalities, such as counseling and nicotine replacement, to assist persons with mental illnesses to quit smoking. Consumer-focused strategies include individualized tactics that might help during quit attempts. Consumers reported the need for consumer-focused strategies at a rate of 49 to 1 compared to providers, the most significant discrepancy among consumers and providers across all the emergent focus group themes.

Other identified treatment needs included individual or group behavioral counseling, with more consumers than providers making comments such as, “I think support groups would be helpful. The more people that are trying to quit you can feed off each others’ need to quit, or motivation to quit.”

Structured patient education was another common theme for both providers and consumers. Pharmacotherapy was stressed by both consumers and providers, but consumers focused on nicotine replacement therapy and psychotropic medications, while providers were much more apt to focus solely on psychotropic medications. Providers and consumers stated the need for peer support at similar rates. One consumer shared that “…maybe a peer advocate, maybe somebody that’s smoked and quit smoking and they have ideas of how they dealt with stress at that time and how they deal with it now.” Peer support, also known as consumer-driven services or self-help, was defined as the involvement of one or more persons with a history of mental illnesses and/or substance abuse, in the support of others with similar illnesses (Davidson, Chinman, Sells, & Rowe, 2006).
Conclusions

These qualitative findings complement a prior study (Levinson et al., 2006) by further expanding the understanding of mental health consumers’ and providers’ perspectives on tobacco cessation. The primary findings suggest that persons with mental illnesses often desire to quit smoking, struggle to find assistance, and encounter barriers to effective tobacco cessation services within the public mental health system. Insufficient resources are exacerbated by lack of knowledge and the negative expectations of both patients and providers.

Focus group results also lend support to past findings that certain provider factors may be especially relevant impediments to implementing tobacco cessation initiatives (Burling, Ramsey, Seidner, & Kondo, 1997; Fogg & Borody, 2001). Our findings reflect that most mental health providers receive little or no training on smoking cessation, that common misperceptions persist, and that tobacco use is still encouraged in mental health settings. One important misconception is many providers’ belief that tobacco cessation is unrealistic for persons with mental illnesses, leading to low interest. This suggests a strong need to disseminate the growing evidence base to providers regarding the effectiveness of cessation strategies, as well as information about health disparities associated with smoking for this population.

It appears that tobacco use is reinforced by multiple-patient, programmatic and systemic factors, including historical and cultural aspects of the mental health system, competing demands on mental health providers’ time, and lack of reimbursement by third party payers. Focus group participants’ perspectives are consistent with past findings that smoking is a coping strategy for anxiety (Gurpegui et al., 2007; Van Dongen, Kriz, Fox, & Haque, 1999) and boredom (Smith, 1996; Van Dongen et al., 1999). Many of these individuals have impaired functioning, and limiting social and vocational opportunities. Smoking breaks up monotony and is a means of connecting to others (Goldberg, Moll, & Washington, 1996; Strasser, 2001).

While previous studies have found that mental health providers smoke at rates higher than health providers working in other fields (Mester, Toren, Ben-Moshe, & Weizman, 1993; Tagliacozzo & Vaughn, 1982; Trinkoff & Storr, 1998; Wagner, 1985), and may be less willing to address tobacco addiction with patients (Gorin, 2001), our findings reflect the qualitative impact this may have on persons with mental illnesses. This suggests that successful tobacco interventions may require a dual process addressing the smoking cessation needs of mental health staff concurrently with the patient population.

Mental health consumers are open to evidence-based approaches for tobacco cessation, including combined medication and psychosocial interventions (Drake et al., 2001; Ziedonis et al., 2005), and findings suggest that interventions need to address patients’ misconceptions regarding tobacco use and common fears about quitting (e.g., weight gain, withdrawal symptoms). Peer-to-peer services, or the delivery of services to mental health consumers by mental health consumers need to be included as treatment modalities in comprehensive tobacco cessation programs as patients prefer such strategies. In the general population, peer-to-peer models have been shown to be effective (Lancaster & Stead, 2005), but there has been little exploration of applying this model to the behavioral healthcare sector.

This study may have limited generalizability to other populations or settings. We used a convenience sample, and we did not use probability or stratified sampling procedures. Age, race, and other demographic characteristics were not recorded because individual-level data and subgroup comparisons were not part of our study. Notwithstanding these limitations, thematic findings have been utilized to inform the development of a mental health toolkit for mental health providers available at http://smokingcessationleadership.ucsf.edu/Downloads/MH/Toolkit/Quit_MHToolkit.pdf as well as an ongoing community cessation study (Morris, Waxmonska, Giese, Graves, & Turnbull, 2007). The toolkit provides an overview of prevalence statistics and biopsychosocial risk factors, best practice guidelines for implementing smoking cessation for persons with mental illnesses, cessation resources, and a literature review of smoking cessation interventions for this population. This qualitative exploration suggests that ongoing study is needed to determine the most effective tobacco cessation strategies for persons with mental illnesses.

References


