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ASH Scotland Tobacco and Inequalities Case Study Report
**Kirkcaldy and Levenmouth Smoking
and Mental Health Programme**

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The full version of the Tobacco & Inequalities final report, and case study reports, are available on the ASH Scotland website
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A list of projects and individual final reports produced by the projects are also available on the ASH Scotland website.

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1. INTRODUCTION

1.1. The Tobacco and Inequalities Project

The ASH Scotland Tobacco and Inequalities Initiative (T&I) is a national community development programme which focuses on capacity building and sustainability, raising awareness of inequalities with regards to smoking and health and identifying and disseminating good practice. The projects funded by the T&I small grants scheme are categorised into three priority groups: black and minority ethnic groups (BME), older adults and mental health.

The T&I Small Grants fund was evaluated by a team of researchers from the University of Glasgow. The research uses an approach known as theory-based evaluation, which involves developing a 'Theory of Change' (ToC) for individual projects, tracking their progress and the outcomes achieved (Judge and Bauld, 2001). In addition, 3 case study projects were selected as part of the research and evaluated in greater detail to offer an insight into how the small grants funding has been utilised at project level.

The report describes the Kirkcaldy and Levenmouth CHP Smoking and Mental Health Programme, which received funding from Wave One and two of the T&I small grants fund targeting tobacco and mental health and well-being.

This report is divided into five main sections. Section one summarises evidence regarding the relationship between mental health and smoking and introduces the Kirkcaldy and Levenmouth programme. Section two describes the research methods used for the case study. Section three describes the outcomes of the programme, while section four discusses the factors that shaped those outcomes. Section five concludes the report.

1.2. Mental health and smoking

Smoking is more prevalent among people with mental health problems than in the general population. This relationship is apparent among people with mental health problems living in the community as well as those living in mental health settings.

The ONS Psychiatric Morbidity Surveys provide data on the relationship between smoking and mental health in Scotland. The 1993 survey found that people with all categories of mental health problems had higher levels of smoking (Meltzer *et al*, 1995). However, much higher rates of smoking were observed among those living in mental health institutions (Meltzer *et al*, 1996) with nearly three quarters reporting smoking. The survey was repeated in 2000. It found that rates of heavy smoking increased with the number of disorders suffered and the severity of the illness.

Other smaller scale surveys have been carried out in Scotland. The most recent ones, carried out by McCreadie on behalf of the Scottish Schizophrenia Lifestyle Group, were among people living in the community with a diagnosis of schizophrenia. Their findings are similar to the psychiatric morbidity study with elevated levels of smoking being observed: 65% being current smokers in one study (McCreadie 2002) and 70% smokers in another study (McCreadie 2003) with 54% of those who smoked being heavy smokers.

In addition to higher smoking rates amongst people with mental health problems, the burden of smoking related diseases amongst this group is significant. For example, one study found that rates of cardiovascular and respiratory diseases were twice as high among people with a diagnosis of schizophrenia as among controls (Brown, Inskip and Barraclough, 2000) and Hennekens *et al* (2005) found that two-thirds die of coronary heart disease compared with half in the general population. A more recent study from Finland which had a 17 year follow up found that people with schizophrenia had an almost 10 fold greater risk of death from respiratory disease compared with the general population (Joukamaa *et al*, 2001). People with mental health problems already experience high levels of social exclusion and health inequality and these are exacerbated by smoking.

1.3. Smoking cessation and mental health

Survey data indicate that around a half of smokers with mental health problems wish to stop smoking (Jochelson and Majrowski, 2006). Research suggests that they can and do successfully quit, particularly when provided with appropriate treatment. For example, Hall and colleagues (2006) have shown that smoking cessation treatments used with the general population of smokers can be used successfully with those having a diagnosis of depression. A number of small trials have also been carried out with smokers having a diagnosis of schizophrenia using treatments such as nicotine replacement therapies (NRT), bupropion and individual or group behavioural support (Addington *et al*, 1998; George *et al*, 2000; Evins *et al*, 2005; George *et al*, 2002; Weiner *et al*, 2001, Baker *et al*, 2006).

SANE Australia has produced a SmokeFree Kit for smoking cessation for people with a diagnosis of schizophrenia (<http://www.sane.org/>), which includes a 10 week group smoking reduction and cessation manual plus handouts and materials. A preliminary evaluation of this kit indicated that its effectiveness was enhanced by participation of the smoker's doctor. SANE Australia has therefore developed clinical practice guidelines for general practitioners to accompany the kit (Strasser, *et al*, 2002). The guidelines primarily recommend the use of NRT and suggest that bupropion should only be used with care and caution in people with a diagnosis of schizophrenia. Other studies have however shown that bupropion can be used with modest success rates with this group (for example, Evins *et al*, 2005).

Research suggests that smoking cessation programmes for people with mental health problems may be more successful when they also work with the client to prevent a deterioration in mental health during treatment. For instance, clients with depressive illness who experience an increase in their depressive symptoms during the quit attempt are more likely to return to smoking (Burgess *et al*, 2002).

In the UK, NHS stop smoking services, developed from 1999 onwards, have been successful in supporting large numbers of the general population to quit but less effective in reaching subgroups with particular needs, such as people with mental health problems. What is apparent is that these clients may need a slightly different approach, and a cessation programme tailored to their needs, if they are to be successful in quitting (McNally, 2006). The Kirkcaldy and Levenmouth programme was one of the earliest specialist programmes set up in the UK for people with mental health problems living in the community, and remains one of very few examples of this type of work in Scotland.

1.4. The Kirkcaldy and Levenmouth CHP Smoking and Mental Health Programme

The Kirkcaldy & Levenmouth Community Health Partnership (CHP) is one of three CHPs in Fife covering a population of approximately 97,000 people (Eardley and O'Neill, 2005; 2006).

The aim of the Kirkcaldy and Levenmouth CHP Smoking and Mental Health Programme is to promote smoking cessation and provide a tailored cessation support to adults with mental health problems in Kirkcaldy and Levenmouth in partnership with local mental health groups.

The Wave One application laid out the following six key objectives for the programme, to be met over a two year period:

1. to increase awareness of smoking cessation issues for people that have mental health needs amongst staff working in the identified groups
2. support staff to access training and develop skills to discuss smoking cessation with clients
3. develop and implement an appropriate model of smoking cessation support that will incorporate evidence based practice and be responsive to the needs of the individual
4. support mental health groups to develop smoke free policies in partnership with the health promotions department
5. promote partnership working between local mental health services, general practice and the smoking cessation service to raise the awareness of smoking cessation within this priority group
6. develop a resource pack to provide staff with information on smoking cessation

The fourth objective was removed due to the introduction of smoke-free public places in Scotland following the implementation of the Smoking, Health and Social Care (Scotland) Act 2006. Wave Two funding extended the Smoking and Mental Health Programme until the end of March 2007 and essentially the same objectives (with the exception of objective four) were pursued.

The Kirkcaldy and Levenmouth smoking cessation service applied for £28,000 funding over two years to develop the programme. It received £15,000 in Wave One and £11,500 in Wave Two for the financial years 2005/06 and 2006/07 respectively. In addition, the CHP committed an extra £5,000 to the programme in 2005/06. The principal expenditure of the project was the salary costs of a specialist mental health smoking cessation worker, at £18,500 on a part-time basis over 18 months. Further costs included staff training, promotional materials, equipment and internal evaluation.

The principal outputs and outcomes that the programme intended to produce over the two year funding period were a resource pack, training of staff, awareness-raising of smoking cessation issues and the delivery of smoking cessation support to people with mental health problems. In Wave One this support was delivered at Contact Point community day centres in Kirkcaldy and Buckhaven and in Wave Two this was extended to cover Dunnikier Day Hospital.

2. METHODS

2.1 External Evaluation

The initial research for this case study involved the development of a 'Theory of Change' (ToC) framework for the Kirkcaldy and Levenmouth programme. This was jointly developed by the researcher and CHP team, laying out the overall intended aims of the project and taking into account key activities and outcomes that had to be achieved throughout the course of the programme.

The ToC framework was produced shortly after the Wave One project had commenced, in September 2005, with the smoking and mental health programme coordinator, specialist smoking cessation worker and specialist mental health smoking cessation worker. In this instance, the ToC framework had been produced by the project team prior to the initial meeting with the researcher, with the researcher then going over the framework with them in person, making refinements as required. The ToC framework was then redrafted and emailed back to the project team to check.

A follow up interview was carried out with the Smoking Cessation Coordinator and smoking cessation worker to review the ToC framework at the end of the Wave One project in July 2006. This was used to assess what had been achieved and identify factors that affected the project's progress or forced a change of direction. The initial and follow-up ToC framework can be found in Appendix 1. A further ToC framework was developed by the researcher at the outset of the Wave Two funding period (also in July 2006) with a review of this ToC in May 2007 to capture the actual activities and outcomes of the project. The Wave Two ToC framework can be found in Appendix 2.

Throughout the course of the Wave One and two funding periods a representative of the research team attended the programme steering group meetings to maintain contact with the team and to obtain regular updates on progress. Two members of the researcher team also carried out in-depth, semi structured interviews with nine key members of the project steering group in February and March 2007. These interviewees are listed in Table 1.

Table 1: Case Study Interviewees

Tobacco Issues Coordinator
Training Facilitator
Specialist Mental Health Smoking Cessation Worker
Charge Nurse Smoking Cessation Service
Senior Nurse, Mental Health Directorate
Manager, Contact Point
Senior Health Promotion Officer, Mental Health
Clinical Effectiveness Coordinator
Clinical Nurse Specialist – Long-term Conditions

The interviews covered both funding waves and explored the smoking cessation programme, the resource pack, training sessions, key lessons of the project and the challenges of delivering smoking cessation to clients with mental health needs. The topic guide used in interviews can be found in Appendix 3.

2.2 Internal Evaluation

In addition to the external evaluation, the Wave One element of the programme had been internally evaluated in late 2006 by the Kirkcaldy and Levenmouth CHP Clinical Governance Team. This focused on the outcomes of the pilot smoking cessation programme delivered at Contact Point Kirkcaldy.

The internal evaluation included an analysis of client data, interviews with service users and end of programme questionnaires. In addition, mood swing charts completed by service users at the beginning and end of each weekly sessions provided softer data on how service users were engaging with the sessions. Attendance records from the 10 programme sessions and drop-in sessions were used to examine drop out rates. A focus group was held at the end of the programme to allow all service users the opportunity to identify what had worked well and what had not worked so well. This was facilitated by the two Clinical Effectiveness Facilitators. Lastly sessional reflection diaries kept throughout by the smoking cessation worker and co-facilitator were used to gather further qualitative data on the programme.

Interviewees reported that the internal evaluation provided a valuable source of quantitative and qualitative data on the running of the pilot smoking cessation programme. The external evaluation team did not want to duplicate this work, and for this and ethical reasons no direct contact between the evaluation team and service clients was made. However, client monitoring data gathered from both Wave One and two was used by the research team to inform the external evaluation.

3. RESULTS

3.1 Origins of the Smoking and Mental Health Programme

In 2003 an internal evaluation of the NHS smoking cessation services in Kirkcaldy and Levenmouth was carried out, analysing data from 1,637 clients (Eardley and O'Neill, 2005). A key finding of the evaluation was that the service, whilst effective overall, did not appear to be reaching more vulnerable groups within the area, including people with mental health problems.

Subsequently, the smoking cessation service made contact with mental health service providers to try and raise awareness. This included presentations at the Contact Point Community Centres for in Kirkcaldy and Buckhaven in late 2004 and early 2005. Contact Point is a voluntary organisation that provides services for clients with mental health needs. The presentations covered the health effects of smoking, the benefits of quitting and information about how people could access NHS smoking cessation services.

The staff at the Contact Point community day centre in Kirkcaldy were enthusiastic about becoming involved in providing access to smoking cessation for their clients. As a result, they worked with the smoking cessation service to provide access to the seven-week cessation programme normally offered in the community. Fourteen individuals took part in this initial stop smoking group. At the end of the eight-week programme, one person had stopped smoking and two reported that they had reduced their cigarette consumption.

Following the delivery of this initial group intervention, smoking cessation staff and Contact Point Managers felt there was potential to offer more cessation support, but tailored more specifically to the needs of people with mental health problems. It was felt that the client group may need more intensive support and so it was necessary to design something slightly different. In order to inform the development of any future work, the smoking cessation coordinator conducted an informal search of relevant literature, including available toolkits (such as the SANE Australia resource pack) to obtain ideas about how a new specialist service might be delivered. This review informed the development of a bid to the ASH Scotland Tobacco and Inequalities initiative. This was successful, and £15,000 of ASH Scotland funding was initially obtained as part of Wave One of T&I, supplemented with an additional £5,000 provided by Kirkcaldy and Levenmouth CHP.

The Kirkcaldy and Levenmouth Tobacco and Inequalities steering group was established in March 2005 to define the aims and objectives of the smoking and mental health programme, agree the best path to achieving those goals, establish an appropriate monitoring and evaluation framework and provide support to the specialist mental health smoking cessation worker who was to be appointed with the

funding. The worker's direct line management and day-to-day operational management and overall project management was provided by the charge nurse for the smoking cessation service when the smoking cessation coordinator changed posts in February 2006 (Connor and Morrison, 2006). However, the smoking cessation coordinator, now the Clinical Nurse Specialist – Long-term Conditions, remained the project lead and retained responsibility for the overall management of the project.

The Kirkcaldy T&I steering group decided that the first step of the project would be to carry out an internal review of the smoking cessation work that had been conducted at Contact Point in 2005, as well as to consult with both Contact Point staff and service users to develop the new pilot group smoking cessation programme earmarked to commence in January 2006.

3.2 Outcomes of the Pilot Review

The service user feedback from the 2005 work was positive. Clients reported that they particularly valued the group format of the intervention, the peer support and the encouragement from the smoking cessation worker (Eardley and O'Neill, 2005).

The staff consulted advocated the greater use of one-to-one support, the integration of the smoking cessation programme with a buddy system and developing contacts with other mental health services. It was also suggested that Contact Point staff should receive training in smoking cessation, at the level of brief advice.

The early 2005 work and subsequent consultation conducted as part of the review of this work laid the groundwork for the ASH Scotland funding application. For example, the consultation found that staff felt that seven weeks was too short for the intervention and it should have a longer duration. In addition, sessions should be longer than one hour. There was also a feeling that additional drop-in sessions during and post programme should be part of service delivery to this client group. The consultation also underlined the benefits of developing a smoking cessation resource pack, which would outline effective interventions, structure and a consistent approach for people with mental health problems (Eardley and O'Neill, 2005).

The 2005 consultation put forward the following recommendations that would shape the subsequent smoking cessation programme funded by ASH Scotland (Eardley and O'Neill, 2005):

- staff should be trained and have access to ongoing support to the practical issues raised by the Smoking, Health and Social Care (Scotland) Act 2006 and potential subsequent increase in clients interested in quitting smoking
- staff should be involved at all stages of service delivery, including knowledge of client status
- a ten-week, one hour programme with additional support should be specifically developed for clients with mental health needs
- the programme would focus on cessation; whilst recognising that the individual goals of clients may be aimed at reduction, and displacement activities would be identified for participants recruited to the smoking cessation programme
- the programme should be carried out in a suitable and safe environment

- networking with other relevant mental health organisations should be pursued, in order to build links and raise awareness of smoking issues amongst people with mental health needs in the area

3.3 Staffing

Funding from Wave One of the T&I initiative was received in May 2005 and following an initial period of planning by the steering group, the specialist mental health smoking cessation worker was recruited in August that year. Her work was to focus primarily on developing and delivering the smoking cessation programme and promoting awareness of smoking cessation issues to mental health staff, service users and other relevant organisations and individuals.

In late 2005 the specialist mental health smoking cessation worker visited the Contact Point centres to explain what the cessation programme would entail. As one interviewee described:

“[The specialist mental health smoking cessation worker] did a lot of groundwork, going in there and really getting to know the centre, getting to know the people... you could see that whenever we went in with her, and I think that could be down to her personal qualities. I actually do think a lot of [her] personal qualities as a coordinator and as a facilitator. I think she’s been really key to this project.”

3.4 Training

Training in smoking cessation interventions was an important component of the programme and a number of sessions were held in both Wave One and two. Two initial training events were carried out in January and March 2006 in Kirkcaldy and were attended by Contact Point staff as well as other staff working with patients with mental health needs in Fife.

The training was developed and delivered by a team consisting of the Clinical Nurse Specialist – Long-term Conditions, the Fife Tobacco Issues Coordinator, the Education and Tobacco Services Manager from West Lothian (now based at ASH Scotland) and the specialist mental health smoking cessation worker, with administrative support provided by the Kirkcaldy and Levenmouth cessation service (Connor and Morrison, 2006). The training events were designed to provide an evidence-based introduction to smoking and mental health, and consisted of presentations and interactive sessions.

Training events were promoted through psychiatric wards in the area, the Smokeless Project newsletter, ASH Scotland Bulletin, mail shots to the heads of local NHS services and senior nurses, an email to the NHS Fife intranet and the organisations and staff listed on their T&I database.

Four training events were delivered in total over the course of the smoking and mental health programme. Three of the training events focussed on brief intervention and were attended by fifty-five people, drawn from both NHS Fife and the voluntary and community sector. The fourth session was delivered in May 2007 - this focussed

on intensive behavioural support and was attended by thirteen people.

Participants evaluated the training sessions positively and the future intention is to roll out this training provision through the Fife Health Improvement Training Programme.

3.5 Awareness Raising

In addition to training sessions, the programme included a number of awareness-raising activities. Some of this activity was intended to publicise the programme, while other elements had the broader aim of informing the public and relevant organisations about issues surrounding smoking and mental health and tobacco-related harm in general.

Three newsletters were produced over the course of the project and circulated widely. The newsletters contained updates on the project's progress and future plans, with input from service users. The project team also proactively pursued coverage of the project in the local press, including an article in the Fife Free Press and Fife Life - the latter a quarterly newsletter produced by NHS Fife and Fife Council and delivered to every household in Fife. Also, an article on the project was placed in the STCA¹ Bulletin and staff gave presentations on the project to the Dundee University and West Lothian Drug and Alcohol Service.

Links were established with a wide range of mental health staff and services within NHS Fife and other agencies. A database was constructed, with details of over two hundred and fifty individuals and groups that were interested in the ASH Scotland funded project specifically and tobacco and mental health issues in general. All groups and individuals in the database received copies of the project newsletter.

The programme also made links with cessation services developing similar initiatives in Tayside, West Lothian, Glasgow and Wales.

In addition, Kirkcaldy and Levenmouth smoking cessation service took part in a health event held in March 2007 in Fife. This was aimed at promoting a holistic approach to health and wellbeing, including raising awareness of smoking cessation services.

The health event was delivered in partnership with other key service providers including Contact Point, NHS Fife Mental Health Services, Fife Adam Smith College, Fife Police, ASH Scotland and other local voluntary sector mental health groups and organisations.

The health event included presentations on the ASH Scotland funded project and wider work relating to mental health, stands providing information on a range of health-related issues such as alcohol, smoking cessation and key local services, workshops on a variety of issues such as healthy eating, smoking cessation, Tai Chi and Indian head massage, and nurses also offered individual cardiac health checks and men's health checks and advice.

¹ Scottish Tobacco Control Alliance, managed by ASH Scotland.

Ninety-three people attended the health event, drawn principally from the Fife area. Feedback back from attendees on the day was very positive and staff involved commented on the opportunity it had afforded for networking.

3.6 Smoke-free Policy

The delivery of the smoking cessation programme at Contact Point in Kirkcaldy in early 2005 overlapped with the phasing in of a smoking reduction policy at Contact Point.

The joint policy group in Contact Point took the decision, in partnership with service users, to introduce this reduction policy in preparation for Scottish smoke-free legislation which would come into effect in March 2006. Although the legislation included an exemption for inpatient psychiatric services, community-based services such as Contact Point would need to comply with the new law (Bauld *et al*, 2007). Service users agreed that providing an environment where people would smoke less was a good idea in order to help them prepare for smoke-free legislation. It involved gradually reducing the time permitted for indoor smoking, with reductions made every six weeks. By the end of this phasing in period smoking was no longer allowed indoors. It is still permitted in the garden adjacent to the day centre in Kirkcaldy and outside on the street as well, in line with the provisions of Scotland's smoke free legislation.

Enthusiasm for the bedding-in period of smoke free was not universal amongst clients who attended the day centres. Twelve clients submitted official complaints to Contact Point. On the one hand the smoke-free policy, brought in at the centre as a response to the forthcoming change in legislation, may have adversely affected the number of people who used the centre. On the other hand, it may have encouraged smokers amongst the centre users to consider quitting or at least reducing smoking. As one interviewee described:

“They [Contact Point staff] were really, really worried about their clientele not coming along to the centre because of the smoking ban, they were really worried about that.”

However, none of the twelve people who submitted official complaints regarding the smoking reduction policy stopped attending the centre.

It was noted by both the smoking cessation facilitators that there was a positive cessation/reduction culture amongst Contact Point staff due principally to the smoking reduction policy. This facilitated the introduction of the smoking cessation programme.

3.7 The Wave One Smoking Cessation Programme

The Wave One smoking cessation programme was publicised through open days at Contact Point in Kirkcaldy and Buckhaven, flyers and health awareness events. The CHP had a list of people who had been identified as wishing to give up smoking or at least cutting down and this had been further refined through the interviews carried out at the start of the pilot programme. The Wave One smoking cessation

programme was intended to be run as a pilot project at Contact Point community day centres in Kirkcaldy and Buckhaven. It involved a cessation intervention that had been modified from the Maudsley model² to better meet the needs of mental health clients. The programme was based principally on group-based cessation support and was run over a ten week period between February and April 2006. The group was facilitated by the specialist mental health smoking cessation worker, supported by a co-facilitator from Contact Point.

Table 2 briefly outlines the content of the ten weeks of behavioural support. This support was complemented by access to nicotine replacement therapy (NRT) for the smokers taking part. In addition to the ten week group programme, service users could also access one-to-one support - during and after the programme - and drop-in sessions began in week three and ran until the end of the programme. As one interviewee explained:

“Some people really benefited from still seeing the support worker so they could keep their smoking down... knowing someone is caring keeps them on track, thinking that other people believe in them. People in centres don’t have time, they do already so many other things so someone coming from outside keeps them [the service users] motivated.”

Importance was attached to getting staff at the point of delivery engaged with the project in order to back up the programme on a day-to-day basis. The co-facilitator provided support to service users throughout the rest of the week and it was emphasised by interviewees that Contact Point staff had provided excellent support to the pilot programme, particularly as the project had limited financial resources. This underlines the added value of partnership working when delivering small grants projects.

Table 2: The Kirkcaldy smoking and mental health cessation intervention

Session	Content
Pre-Assessment	Obtaining personal information and consent – individual interview
Session 1	Introductions facilitator/participants; why we smoke and reasons for quitting
Session 2	Preparing to stop
Session 3	Planning to stop; preparing for quit day
Session 4	Stopping smoking; withdrawal symptoms
Session 5	Coping with stress; relaxation
Session 6	Lapses; relapses
Session 7	Difficult situations; assertiveness
Session 8	Weight management
Session 9	Smoke free lifestyle
Session 10	Future plans and support

Source: Connor and Morrison, 2006, p7

As described in the Wave One ToC, the initial smoking cessation programme intended to include four groups of six to eight people in two pilot sites. However, the number of service users accessing the programme was lower than expected. In the

² The Maudsley Model or Specialist Intensive Group Support is a withdrawal oriented, evidence based approach that is run over a seven week period. Most cessation services in the UK use some form of this model, either through group support or modified to provide one-to-one sessions.

end, only one formal group was delivered during Wave One, at the Contact Point community day centre in Kirkcaldy. In total sixteen clients attended the sessions over the course of the ten weeks. Ten of those sixteen service users (sixty-two per cent) attended five or more sessions in the pilot programme (Eardley and O'Neill, 2006, p7).

Basic monitoring (as required for the ISD minimum dataset for Scotland) was carried out during the ten week intervention. Monitoring results show that ten out of twelve respondents had a nicotine dependency score ranging from six to ten points which is a high level of dependence. On average, two respondents smoked ten or less cigarettes per day, four smoked between eleven and twenty cigarettes per day, one smoked between twenty-one and thirty cigarettes per day and five smoked more than thirty cigarettes per day. Five out of twelve respondents had tried to quit smoking at least two or three times and four had never tried to stop previously (Eardley and O'Neill, 2006).

In addition to monitoring data, the internal evaluation interviews carried out with each interested client indicated that client's main reasons for smoking were as a source of stress relief, a coping mechanism and to alleviate boredom. The clients' reasons for wanting to quit or reduce smoking typically included concern for their health, whilst some mentioned the imminent ban as a motivator (Eardley and O'Neill, 2006).

As noted earlier, drop-in sessions were established at week three of the programme. The attendance at drop-in sessions also varied throughout the course of the programme, tailing off towards the end – in total eight of the sixteen individual participants attended the drop-in sessions (Eardley and O'Neill, 2006, p7).

The service users who finished the ten week programme were asked to fill in a post programme questionnaire, with the help of the facilitators. Seven out of the nine respondents had set a target to stop smoking by the end of the programme and one managed to achieved this target. A further two of the nine respondents had set a target to reduce their smoking by end of the programme, with one person achieving this target. These two respondents significantly cut their smoking from fifty to between twenty-five and thirty per day and twenty to ten per day respectively (Eardley and O'Neill, 2006).

The feedback gathered during the internal evaluation focus groups indicated that the participants' experience of the pilot programme was, "on the whole very positive" (Eardley and O'Neill, 2006, Appendix E1). Eleven out of thirteen service users used group support as a smoking cessation intervention (Eardley and O'Neill, 2006, p7).

Whilst run with lower numbers than anticipated, and only one client achieving cessation by the end of the group sessions, the Wave One smoking cessation programme was reviewed positively by both staff and clients. Moreover, the Kirkcaldy and Levenmouth Tobacco and Inequalities steering group viewed the pilot as a positive learning experience, which was intended to inform subsequent smoking cessation support for clients with mental health problems.

The delivery of the Wave One smoking cessation programme, and its internal evaluation, helped inform the development of the smoking cessation and mental health programme during its next phase.

In November 2005 Kirkcaldy and Levenmouth CHP applied for Wave Two funding from the Tobacco and Inequalities initiative, which proved successful. The aims and objectives of the Wave Two project were fundamentally the same as Wave One, extending the project lifespan for until March 2007. This would entail running more cessation groups and one to one support, in particular in an additional (day hospital) setting. Wave Two programme work also intended to continue to deliver training to local mental health staff, running awareness raising events and developing the resource pack.

3.7 The Wave Two Smoking Cessation Programme

Following the initial intervention in Contact Point Kirkcaldy, the programme steering group decided to explore the feasibility of offering smoking treatment in a hospital setting, initially in a day hospital.

Links had already been established with staff at Dunnikier Day Hospital, based at Whyteman's Brae psychiatric hospital in Kirkcaldy, and this was identified as an additional setting for the Wave Two cessation programme.

It was initially intended that the Wave Two cessation programme would follow the structure of the Wave One intervention, utilising group sessions and one-to-one support depending on the needs of clients. Six people were identified to receive smoking cessation support based at Dunnikier Day Hospital. Three people came to the first session although two people then dropped out and smoking cessation support was delivered to just one person through one-to-one sessions. All the participants came into the hospital from the community on an out-patient basis, rather than coming from the acute wards.

In addition to initial attempts to deliver a group-based intervention at Dunnikier, staff continued to offer one-to-one sessions to Contact Point clients and to individuals in the community. In total 10 clients were seen on a one-to-one basis during the Wave Two funding period. Some of these sessions were delivered during joint visits by Community Psychiatric Nurses (CPNs) and the specialist mental health smoking cessation worker. Amongst the Contact Point clients, at least three individuals treated during Wave Two had initially attended the Wave One pilot group sessions. The specialist mental health smoking cessation worker was also active in providing brief advice and information to inpatients to try and encourage them to reduce their cigarette consumption.

Interviewees provided some comments on why it may have been more difficult to engage clients at Dunnikier than in the community setting at Contact Point. One of the primary reasons given was that, although the day hospital is smoke-free, other parts of the psychiatric hospital in which it is based are not:

"The [2006 Health] Act did not quite include mental health establishments... it was probably felt a step too far to start on acute wards, rehab wards or day hospitals. So a community setting, you could access people with mental health problems but not have to tackle the establishment, not have to deal with that issue."

Compared with the Wave One programme, the Wave Two cessation programme had

fewer initial numbers and higher drop off rates, which effectively precluded the use of group sessions. However, interviewees did point out that they thought the presence of the Wave Two programme had positively impacted upon the smoking culture within the hospital. Overall, however, the cessation element of the Wave Two work appears not to have met the initial objectives as set out prospectively in the ToC. There are a number of reasons for this, which we explore further in the discussion section of this report.

Examining client throughput and outcomes across both waves of ASH Scotland funding, involving the group interventions and one to one support, shows that:

- 32 clients used the smoking cessation mental health programme
- 6 clients were CO validated as quitters at four weeks
- 3 clients were CO validated as quitters at 3 months
- 1 client remained abstinent (also CO validated) at 12 months

3.8 The Resource Pack

In addition to training staff and delivering a tailored cessation intervention for people with mental health problems, the Kirkcaldy and Levenmouth programme also included the development of a resource pack. It was intended that this could be used within Fife and disseminated nationally to provide helpful information to those wishing to support people with mental health problems to stop smoking. The initial application to ASH Scotland laid out a two-year plan and it was always intended that the final resource pack would be ready by the end of the Wave Two funding period.

A small working group, drawn from the steering group, was established to support the development of the resource pack. The working group members gathered information for different parts of the pack and progress was monitored on a monthly basis.

The resource pack drew on the growing literature on smoking and mental health and included material developed by services in Scotland (ie in Lothian) and elsewhere (such as by SANE Australia). The results of the internal evaluation were also used to garner the reflections of staff involved in the delivery of the pilot smoking cessation programme in Kirkcaldy and also the clients who had accessed the service.

The aim was to produce a grounded, concise and flexible guide that would inform the development and delivery of smoking cessation interventions for clients with mental health needs. As such, the pack includes: best practice guidance on behavioural support for smoking cessation; information about appropriate pharmacotherapies and the interaction between these therapies and some medication prescribed to people with mental health problems; a toolkit of useful resources and materials; information on the key health and social issues that relate to smoking cessation and reduction; a list of relevant local contacts and information sources; and a monitoring and evaluation framework (Connor and Morrison, 2006).

A Fife-wide resource pack for smoking cessation for the general population has been developed concurrently with the mental health resource pack. Both the 'mainstream' and mental health resource packs have informed each other.

The initial ToC framework anticipated that the resource pack would be ready for consultation and proof reading by August 2006. The completion of the resource pack

was subject to some delay. A first draft was completed and circulated for comment in February 2007.

The resource pack was subsequently peer reviewed by members of the steering group and ASH Scotland, amendments were made and a further peer review was conducted in April 2007. A final draft of the resource pack has been completed and discussions are ongoing with graphic designers over the most effective means of presenting the content developed.

The resource pack will be disseminated throughout Fife, although budgetary constraints mean that it may not be possible to circulate hard copies of the pack more widely. However, Kirkcaldy and Levenmouth smoking cessation service have discussed with ASH Scotland the possibility of making the resource pack available on the ASH Scotland website.

4. DISCUSSION

This section reviews out the principal outcomes and key lessons from the Kirkcaldy Smoking and Mental Health Programme.

As originally intended, the main outcomes of the programme were the development of tailored smoking cessation interventions for people with mental health problems in Kirkcaldy, the delivery of training and awareness raising activities and the development of a smoking and mental health resource pack. While the programme achieved most of its original aims as set out in the ToC, it was less successful than was originally anticipated in terms of client recruitment and cessation.

4.1 Outcomes of the Wave One Smoking Cessation Programme

In the original ToC framework (see Appendix 1) it was hoped that a total of four smoking cessation groups involving twenty-four to thirty clients would be delivered in the first year (Wave One) of the programme (Connor and Morrison, 2006). Difficulties in recruiting clients for the Buckhaven pilot site meant that the programme was, in practice, delivered solely at the Contact Point community day centre in Kirkcaldy. The time required for preparation resulted in just one formal group being established during the Wave One period. This meant that fewer smokers received treatment than was originally intended.

However, the two Contact Point centres are only six miles apart and several interviewees pointed out that many of the centres' users attended both facilities. Interviewees reported that the client base at Contact Point was relatively modest and so expecting to recruit four groups within one year may have been too ambitious.

Interviewees described the delivery of the single Contact Point group and associated work as a success. They emphasised that this had been facilitated by the specialist mental health smoking cessation worker building up a positive relationship with service users. In addition, the fact that Contact Point had independently chosen to implement a smoking reduction policy to prepare for smoke-free legislation meant that the organisation and its staff were particularly receptive to an intervention that would potentially help reduce smoking levels. As one interviewee said:

“It was good timing... a good time to try and run something... because I don't think from the service users' point of view that a lot of people were going to stop just because of the legislation.”

Interviewees suggested that the media coverage and the widespread public acceptance of smoke-free legislation may also have positively impacted upon the attitudes of both staff and service users towards the goals of the programme.

Interviewees also reported that limiting the intervention to one initial group may in fact have had benefits:

“I think that took up all of [the specialist worker's] time and more of it than I think probably expected because I think initially we were talking about more sites. That would have been detrimental, I think... Looking back, if she had had to have spread herself, I think it would not have worked as well.”

Interviewees also commented on the limited client numbers available for treatment:

“It is probably quite a limited client group that go [to Contact Point]. It is probably the same faces. Probably only so many of them want to try and stop smoking at a time.”

Thus, running a second group within the same year may simply have attracted clients from the first group who had unsuccessfully tried to quit and wished to repeat the programme.

The attendance of the Wave One group sessions fluctuated throughout the ten weeks and this had been anticipated due to the nature of the client group. However, this variation in attendance was not seen by facilitators to adversely affect the running of the group, as a core body of people regularly came along,

“At the end of the day, we had quite a good group in Kirkcaldy. We had sixteen names or something like that, I don't know exactly anymore but quite a few names and we had eleven on a regular basis.”

Feedback from the facilitators suggested that the optimum size of groups was six to eight people and increasing the size of sessions beyond that produced diminishing returns. That said, the group dynamic over the course of the pilot programme was felt to be “tolerant” and “lively” by service users (Eardley and O'Neill, 2006, Appendix E1) and the continuity afforded by dedicated facilitators was important for establishing and developing a pattern of trust.

Despite the achievement of managing to deliver a programme of 10 week cessation support and maintain a good level of client participation, only one smoker had successfully stopped by the end of the 10 week programme. A further two reported that they had significantly reduced their cigarette consumption. Similar interventions delivered to people without mental health problems would expect between one-third and half to remain abstinent by week ten, so in comparison this is a disappointing outcome. The published evidence around smoking cessation and mental health also reports better outcomes for structured programmes than the Kirkcaldy pilot achieved (Hall *et al*, 2006; Addington *et al*, 1998; Baker *et al*, 2006).

Interviewees defended this less than optimum outcome by arguing that the impact of the smoking cessation programme could not be ascertained solely by looking at quit rates. They pointed to the fact that people with mental health problems generally have lower cessation rates than the general population (Burgess *et al*, 2002) and referred to the internal evaluation of the pilot, which had looked at 'softer' outcomes and found a more positive picture. The internal evaluation had included some exploration of service users' perceived identities, moods and self-esteem as well as an end of programme questionnaire which found that all clients agreed or strongly agreed that they had found the group sessions helpful in deciding and attempting to stop smoking, helpful in maintaining both motivation and confidence levels (as well as withdrawal symptoms) to stop smoking and that the programme provided the support they needed (Eardley and O'Neill, 2006).

The internal evaluation had also found that clients expressed positive feelings towards the Scottish smoke-free legislation at the end of the programme and felt confident they could attempt to cut down or stop smoking in future (Eardley and O'Neill, 2006, Appendix F21).

All the steering group members interviewed as part of the external evaluation stressed that they felt the pilot smoking cessation programme had been a positive venture, not least for providing an invaluable learning curve that would feed into the production of the resource pack and promoting awareness of the ill effects of smoking amongst the Contact Point staff and service users:

"...this pilot project's given people informed choices, and that again is something that I think is on the whole has been very limited to people in mental health services...Health professionals have not been talking to groups of people around, about their physical health, about diet and nutrition, about levels of physical activity, about smoking rates, about... you know, they might talk to them about drug and alcohol misuse, but that is... quite often as far as it's gone."

The smoking cessation programme was designed prior to delivery but allowed for a degree of flexibility. The actual programme design and composition of sessions changed little from the design stage, with the exception being the extension of sessions from an hour to an hour and a half in length. This was due to the larger than expected size of groups, around eight on average, which then required more time for the facilitators to allocate individual time with service users.

The facilitators felt that it would be prudent to introduce more interactive activities into future programme sessions to retain the attention of the service users (Eardley and O'Neill, 2006, Appendix G3). The development of new approaches was also identified as being important for a smoking cessation programme for clients with mental health needs, not least because service users would be likely to re-attend subsequent programmes.

Thus, minor modifications were made to the session plans on an ad hoc basis:

"...the session plan had to be changed because I think on the day, I think most of them, challenges came up that you just weren't expecting."

As McNally (2006) has argued, it is necessary to tailor smoking cessation support to the specific needs of clients with mental health problems. The Smoking and Mental Health Programme utilised a modified Maudsley model, run over 10 weeks with sessions each lasting an hour and a half. In addition, drop-in sessions were run from week three and one-to-one sessions were available for clients that required further support.

The impact of the venue on the pilot programme was also considered in the internal evaluation. It was recommended that a separate designated area be allocated for group sessions to ensure privacy and also to allow for the room to be prepared in advance (Eardley and O'Neill, 2006). The pilot programme group sessions had originally been held in the café area of the Kirkcaldy Contact Point community day centre, but this impacted upon confidentiality of the service users and there were too many distractions for the participants. Thus, the group sessions were moved to the quiet room. In this setting it was easier to establish a positive group dynamic based on trust and also retaining confidentiality of clients.

4.2 Outcomes of the Wave Two Smoking Cessation Programme

The second year of the Kirkcaldy programme involved the continued delivery of some one to one support to a small number (10) of Contact Point and other clients in the community as well as ongoing awareness-raising and training work, plus the completion of the programme resource pack.

In addition, the programme intended to expand to deliver group-based support in Dunnikier Day Hospital. This element of the work did not progress as planned for a variety of reasons, including an extended period of absence (November 2006 until February 2007) by the specialist mental health smoking cessation worker. The Contact Point pilot programme had approximately three months lead-in time to identify people who were interested in stopping or cutting down, and to carry out individual interviews with them. The Wave Two group, by comparison, had little preparation time:

"I think that's what's gone wrong with the Dunnikier one. They didn't have enough time to prepare or to be involved with it and also we didn't do the individual interviewing, we just went by the numbers we were given... and on the first day we thought we would have nine people and there were only three there. I think the preparation, lead-in time is very important... Other staff just didn't have time to do it."

The Wave One project had benefited from the enthusiasm and support of Contact Point staff and an identified demand amongst service users. The preparation work carried out prior the Wave One smoking cessation programme commenced allowed the programme to hit the ground running. However, the lack of lead-in time on the Wave Two smoking cessation intervention created a contrasting experience:

"I think that... we lacked to build up the relationship in the day hospital... 'cos the clients need to be comfortable with you and get to know you, and... and staff as well."

The capacity of the Smoking and Mental Health Programme was obviously limited in terms of time, funding and staff resources. The Wave Two part of the project was funded by ASH Scotland for £11,500 over a six month period. The Dunnikier group was overseen by the charge nurse from the smoking cessation service and delivered by two smoking cessation workers. This stretching of existing resources, when combined with the specialist worker's absence, further impacted upon the Wave Two smoking cessation work:

"[The specialist mental health smoking cessation worker] dealt with that work quite in isolation on her own, and those skills and things weren't really getting passed on, so when she went off sick, the two girls that went to Dunnikier to run the group and that were unsure and felt a bit, you know, uncomfortable with it, because they didn't have clarity regarding the patient group and they weren't comfortable with doing the programme exactly."

One of the key lessons to emerge from the Dunnikier Day Hospital work was the need for knowledge transfer and retention within the Smoking and Mental Health Programme, particularly with regards to clients with mental health needs. However, the commitment of the Kirkcaldy Levenmouth CHP smoking cessation service staff enabled the Wave Two intervention to continue.

Another contrast with the Kirkcaldy pilot programme was the difference in the smoking cultures at the different settings. Contact Point had embraced the smoking reduction policy that had been phased in the year preceding the smoking ban whilst Dunnikier Day Hospital was described as having a more entrenched smoking culture, particularly within psychiatric services,

"That was maybe... the Contact Point staff were not allowed to smoke even before the ban. In hospitals a lot of psychiatric staff smoke and it's maybe harder to get them on board. Maybe the legislation would have changed that. It's very much the relationship with staff [that makes projects work]."

The Dunnikier group was hampered by a relative lack of lead-in time and low demand but it did provide a valuable learning curve in terms of identifying the importance of partnership support, setting and preparation time when delivering smoking cessation support.

In addition to developing and delivering smoking treatment for people with mental health problems during Wave One and two, the Kirkcaldy programme also involved training and awareness raising activities and the development of a resource pack. All of these activities were successfully delivered, more or less as envisaged in the original ToC. In many ways these activities were probably just as valuable as the actual delivery of treatment, as they all contributed to the future sustainability of tailored smoking cessation and tobacco control work with mental health clients in Fife.

Four training events for mental health professionals were carried out during Wave One and two, with sixty-eight people trained overall. The training sessions all received very positive feedback from participants. A number of successful awareness-raising activities took place as we outlined earlier in this report.

The resource pack has the potential to provide a lasting source of information for both mental health staff and smoking cessation workers within Fife. There is also the possibility of the resource pack being placed on the ASH Scotland website making the work of the project accessible to health professionals from further afield.

4.3 Key Lessons

A principal lesson that can be drawn from the contrasting experiences of the Wave One and two smoking intervention element of the Kirkcaldy and Levenmouth programme is the importance of preparation. The steering group had been set up four months prior to the appointment of the specialist mental health smoking cessation worker and this time was utilised to develop a viable project plan which interviewees felt had contributed to the relative success of the group-based intervention at Contact Point.

It is particularly resource intensive to deliver smoking cessation support to clients with mental health needs. This requires greater time than working with some other groups of service users through longer sessions, more one-to-one support and longer-term support.

The smoking cessation programme was shown to have wider benefits for clients beyond cessation and reduction rates, with reported increases in clients' self-esteem, confidence and social support.

Mental health problems are not homogenous and so whilst the cessation programme was tailored to run over ten weeks, with hour and half long sessions and more displacement activities, there is no "one size fits all" approach. For example, group sessions may not be suited to clients with severe mental health problems such as schizophrenia. This emphasises that one-to-one sessions, whilst time consuming to run as a complimentary service, are paramount for helping clients with mental health problems to significantly reduce or quit smoking.

The smoking cessation intervention at Contact Point community day centre in Kirkcaldy benefited not just from four months of lead-in time but prior cessation work delivered at that location. The smoking cessation programme at Dunnikier day hospital lacked that preparation time.

There were also contrasting attitudes towards smoking cessation across the Wave One and two smoking cessation programmes. The prevalence of an entrenched smoking culture in psychiatric hospital, and the problems posed by their exemption from smoke-free legislation, has been a consistent issue across the other mental health projects examined as part of the overall T&I evaluation.

The preparation time for the Wave Two project had been substantially compressed by capacity issues; as the specialist mental health smoking cessation worker had been instrumental in building trust with clients and staff on the Wave One smoking cessation programme:

"[The specialist mental health smoking cessation worker] did a lot, she did a lot of one-to-one with people who were able to phone her, you know? She was accessible to them, it seemed, even outwith I think... I think it kind of extended out when she should have been accessible."

The nurses who ran the Dunnikier smoking cessation programme lacked this dedicated time to provide additional support to the smoking cessation sessions and also lacked the experience of dealing with clients with mental health problems, accentuating not just issues of capacity but knowledge transfer and retention as well. However, the overall Smoking and Mental Health Programme was kept on track primarily due to the effective management support mechanisms in place. The role of an experienced and active local smoking cessation coordinator in developing and maintaining the programme and keeping it on track was key. Enthusiasm, support and the commitment of the project team, partner organisations and steering group were all paramount in the running of the project, particularly with the bounded capacity of available staff time and the limited budget available.

4.4 Future Plans for the Smoking and Mental Health Programme

In December 2006 the project secured an additional year's funding from NHS Fife to continue after the Tobacco and Inequalities Project funding ended in March 2007. The intention was to roll out the Smoking and Mental Health Programme to the rest of Fife and also expand smoking cessation activities within Kirkcaldy and Levenmouth, such as offering more domiciliary visits and one to one support. This would effectively mainstream the programme within Fife until March 2008 and possibly beyond. In addition, the work of the Smoking and Mental Health Programme has fed into the framework for smoke-free mental health services in Fife.

The continuation of the Smoking and Mental Programme reflects not only the positive outcomes achieved but also the forward planning of the steering group:

"...the steering group had discussed early enough the importance of looking at sustainability. We started last summer looking at sustainability... we had enough evidence as we had been evaluating the programme from the start so we could prove there was a need to deliver this kind of programme"
(Participant 3).

Provisional plans have also been made to roll out the training provision through the Fife Health Improvement Training Programme. The CHP has also had initial discussions with other smoking cessation services and mental health services in Fife to ascertain the best means of sharing knowledge and rolling out the tailored smoking cessation programme.

5. CONCLUSION

The Kirkcaldy and Levenmouth CHP Smoking and Mental Health Programme received £26,500 from ASH Scotland over a two year period to deliver smoking cessation support to clients with mental health needs, train staff, promote awareness and develop a smoking cessation resource pack. The funding was used primarily to cover the salary costs of the key staff member and the specialist mental health smoking cessation worker.

The Smoking and Mental Health Programme achieved important outcomes on a small budget. The project met all the original objectives set out in the ToC, with the exception of significantly lower than expected client numbers.

The Wave One smoking cessation programme ran with one group in one site rather than four groups over two sites. During Wave Two, some one-to-one support was delivered in the community plus efforts were made to establish group treatment in Dunnikier Day Hospital, but this had limited success.

In total, thirty-two clients were treated. Six people were validated as quitters at four weeks, three people at three months and one person at twelve months. These low quit rates were balanced to some extent by positive outcomes reported by clients via an internal evaluation, including smoking reduction and increased confidence and self-esteem as a result of the programme, as well as a reported intention to try and quit in the future.

The programme encountered some challenges along the way, including staff absence, but managed to overcome these through strong management, the support of a committed steering group and input from other cessation staff and CPNs. Wider activities associated with the programme – including training more than 68 staff, awareness raising (through meetings, presentations, newsletters, articles and a health event) and the development of a resource pack, all developed more or less as planned.

Unlike many of the other projects funded through the small grants component of the ASH Scotland Tobacco and Inequalities initiative, the Kirkcaldy programme has been mainstreamed through core (NHS Fife) funding. This means that tailored smoking cessation support will be available to people with mental health problems in Kirkcaldy and other parts of the Fife for the foreseeable future. This is important because such specialist support is not widely available in other parts of Scotland. Learning from the Kirkcaldy programme will inform developments in other parts of the country, particularly when the exemption from smoke-free legislation currently provided to psychiatric hospitals is lifted, as it is likely to be in the near future.

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Appendix 1: Wave One Theory of Change

Long-term Outcomes: Reduce the prevalence of tobacco smoking amongst people that access local community-based mental health services in Kirkcaldy and Levenmouth

Resources	Activities	Short-term outcomes	Intermediate outcome	Penultimate outcomes
<ul style="list-style-type: none"> • SMHSCW • Key workers Contact Point • Protected time • Service users • Venue • Refreshments • NHS Support staff • Co monitors • Leaflets • Display materials HP • Flipcharts • Stationery • Funds for rewards etc • Evaluation tools • Smoking Cessation Team 	<ul style="list-style-type: none"> • Map/critique what resources and evidence are currently available • Meet with service users to identify their needs and expectations • Meet with staff to discuss their views • Reach agreement on the objectives of the programme and link this into an appropriate health promotion model/framework • Decide on method of delivery i.e. group, one-to-one or both. Clarify if support will be offered out with the programme i.e. via key worker/ telephone/drop in session • Reach agreement on operational aspects of the delivery i.e. time, venue, length of programme, number of participants, co-facilitation, intensity and frequency of support offered. • Develop a draft of the proposed programme and seek agreement from staff, service users and steering group to pilot it. • Identify any incentives that may be used within this programme • Recruit clients to participate in the programme <p>Evaluate this first programme, identify changes required and refine programme as necessary</p>	<p>Programme tools and resources identified (Nov 05) Yes.</p> <p>List of references for model created (Jan 06) Yes.</p> <p>Focus groups with service users and staff set up to decide objectives and delivery of program (Dec 05) Yes.</p> <p>ISD Database set up for Evaluation purposes (Jan 06) Yes.</p> <p>Agreement reached on draft pilot program (Jan 06) Yes.</p>	<p>Matrix of Evaluation Criteria completed (June 06) Yes.</p> <p>Statement of objectives and protocol of programme drafted by (Feb 06) Yes.</p> <p>6/8 clients recruited in each site (Jan 06)</p> <p>First Pilot program delivered and evaluated (Jan-April 06) Yes.</p> <p>Subsequent Pilot programs in delivered twice in each site (April - Aug 06) This was not delivered twice in each site as Contact Point felt it was too much too soon.</p>	<p>Programme of smoking cessation support developed and delivered (Sep 06) The project ran in one pilot site, instead of two, with 15 clients instead of 6 – 8 from two sites.</p> <p>The 10 week programme was felt to be fine, with few if any required modifications.</p>

Long-term Outcomes: Reduce the prevalence of tobacco smoking amongst people that access local community-based mental health services in Kirkcaldy and Levenmouth

Resources	Activities	Short-term outcomes	Intermediate outcomes	Penultimate outcomes
<ul style="list-style-type: none"> • Existing Resource Pack • Suggested materials from other projects • Internet downloads • NHS support staff • SMHSCW • Smoking Cessation Team • Specialist SC staff in Fife • ASH Scotland • Protected time • Stationery 	<ol style="list-style-type: none"> 1. Identify what information staff would like to be included in a pack to support them to deliver the programme based on best available evidence for practice 2. Identify current resources that can be used/adapted to form the basis of this pack 3. Agree format and contents page for the pack 4. Develop a work plan for creating the pack 5. Develop first draft of the pack 6. Consult with local services and specialist staff to ensure that all information is current and accurate (liaise with Fife wide Resource Group) 7. Pilot pack to support delivery of the programme 8. Refine in accordance with changes made to the programme or recommendations from consultation 9. Develop final draft of pack 10. Distribute for consultation and proof reading 11. Make final changes and print pack. 	<p>Compile materials for first draft (Sep 05 – Jan 06) Yes</p> <p>Consultation regarding content completed (Feb 06) Yes</p> <p>The short-life Working Group set up to produce the first draft (Jan 06)</p> <p>None of the staff had prior, specialist mental health training. Thus, a key task of the Working Group was to collate information relating to mental health and smoking.</p>	<p>Pack ready for consultation/ proof reading (Aug 06)</p> <p>This was re-scheduled to be complete by the end of January 2007. A workbook was developed for service users and piloted in the first programme.</p>	<p>Resource pack to support the delivery of the smoking cessation programme (Sep 06)</p> <p>This is still in the drafting process and will be completed by the end of January 2007</p>

Long-term Outcomes: Reduce the prevalence of tobacco smoking amongst people that access local community-based mental health services in Kirkcaldy and Levenmouth

Resources	Activities	Short-term outcomes	Intermediate outcomes	Penultimate outcomes
<ul style="list-style-type: none"> • Key workers/ service users Contact Point • SMHSCW • Smoking Cessation Team • Posters/ publicity materials • NHS support staff 	<ul style="list-style-type: none"> • Meet with staff and service users to actively involve them in project development/ implementation • Find out about forthcoming local mental health forums and seek permission to attend// display information • With permission from service users/staff run articles/updates in local media/newsletters • Build relationship with staff and service users at pilot site (Dec 05) • Opportunistic informal contact achieved by actively working in the pilot sites 	<p>Focus groups/open discussion groups held with staff and service users (Nov 05) <i>Yes, the results were included in the internal evaluation</i></p> <p>Promote the Pilot Project and smoking cessation issues locally in relevant places (Nov 05) <i>Yes</i></p>	<p>Summary of findings from focus groups completed (Jan 06) <i>Yes</i></p> <p>Poster displays in pilot centres and at local mental health events (05/06) <i>Yes</i></p> <p>Articles and updates placed in local media (05/06) <i>An article was printed in the Fife Free Press</i></p>	<p>Awareness of cessation issues for people that have mental health needs increased amongst staff and service users (Sep 06) <i>The mailing list for the project newsletter has 250 contacts.</i></p> <p><i>Cessation issues were also communicated through poster displays at local health events and forums</i></p>

Long-term Outcomes: Reduce the prevalence of tobacco smoking amongst people that access local community-based mental health services in Kirkcaldy and Levenmouth

Resources	Activities	Short-term outcomes	Intermediate outcomes	Penultimate outcomes
<ul style="list-style-type: none"> • Venue • Stationery • Trainers • Evaluation tool • Delegate packs • Laptop • Projector • Flip charts • Admin support • Publicity materials 	<ul style="list-style-type: none"> • Meet with Fife smoking cessation co-ordinator and external trainer to plan training • Reach agreement on operational aspects of the delivery i.e. time, venue, number of participants, content and delivery • Develop accurate costing plan • Book venue • Develop and circulate “flyer” to advertise the event (8 weeks before event) • Write to delegates to confirm attendance • Develop evaluation tools for event • Deliver event 1 • Refine and plan for event 2 as per points 1-7 • Deliver event 2 • Liaise with Fife smoking cessation co-ordinator regarding increasing access by mental health staff to existing local smoking cessation training programmes 	<p>Session aims and objectives. Identified (Nov 05) Yes</p> <p>Short life working group to set up support the development delivery and evaluation of training sessions (Nov 05) Yes</p> <p>Evaluation tools for event completed (Dec 05) Yes</p>	<p>Session 1 delivered and evaluated (March 06) Yes</p> <p>Session 2 delivered and evaluated (Aug 06) Yes</p> <p>Smoking cessation and mental health integrated into local training programme (Sep 06) This has since been pushed forward as the third objective of the Wave Two project</p>	<p>Staff will have been trained and developed skills to discuss smoking cessation issues (Sep 06) Approximately 42 staff have been trained; 26 in Session One and 16 in Session Two.</p> <p>This was carried out by an external practitioner (Brian Pringle) to train people at brief intervention level</p> <p>No charge was applied to staff for the training.</p>

Resources	Activities	Short-term outcomes	Intermediate outcomes	Penultimate outcomes
	<ul style="list-style-type: none"> • Liaise with Fife smoking cessation co-ordinator regarding incorporating smoking cessation and mental health into a local training programme (PATH) • Liaise with Fife SC Coordinator to promote access to NHS Fife training (Nov 05) 			

Long-term Outcomes: Reduce the prevalence of tobacco smoking amongst people that access local community-based mental health services in Kirkcaldy and Levenmouth

Resources	Activities	Short-term outcomes	Intermediate outcomes	Penultimate outcomes
<ul style="list-style-type: none"> • Time • Email • Display boards • Posters • Leaflets 	<p>Find out about forthcoming local mental health forums and seek permission to attend/display information</p> <p>Meet with representatives and staff from wider mental health organisations as opportunities arise throughout the duration of the project.</p> <p>Publicise the project and outcomes</p> <p>Explore opportunities for wider partnership working</p> <p>Create links with relevant voluntary sector services, local authority services and mental health services that work with this client group</p>	<p>Promotion of the project and smoking cessation issues (05/06) Yes</p> <p>Communication network set up across Fife with Voluntary sector, local authority services, Mental Health and Smoking Cessation Services (Sep 05 – Aug 06)</p> <ul style="list-style-type: none"> • Focus on good practice sharing • Cessation & mental health issues <p>Yes, the onus has been on sharing good practice and lessons learnt from piloting the smoking cessation service</p>	<p>Further promotion of the project and smoking cessation issues (05/06) Yes, this is being continued in Wave Two</p>	<p>Build on existing partnerships and create new links to raise the profile of smoking cessation (Aug 06) Links have either been established or developed further between mental health services and VOs</p>

Long-term Outcomes: Reduce the prevalence of tobacco smoking amongst people that access local community-based mental health services in Kirkcaldy and Levenmouth

Resources	Activities	Short-term outcomes	Intermediate outcomes	Penultimate outcomes
<p>Time</p> <p>Links with TIG and HP</p>	<p>Facilitate links between the pilot sites and the TIG protection subgroup.</p> <p>Facilitate links between the pilot sites and the Fife smoking cessation co-ordinator</p> <p>Explore attitudes and perceptions amongst staff and service users relating to smoke free policies/smoke free areas</p> <p>Discuss the social, environmental and economic factors that affect service users health and help groups identify if other services need to be involved</p>	<p>Chairperson of the Protection Subgroup of TIG informed about this project. (Nov 05)</p> <p>Fife SC Coordinator informed about this project. (Sep 05)</p> <p>The pilot sites advised about the staff / services that are available to support development of smoke free policies.</p> <p>Policy on the agenda of Pilot site Committees developed (Feb 06)</p>	<p>Ongoing links between pilot sites TIG and HP promoted (Aug 06)</p> <p>Policy agreements by Pilot site committees in line with legislation (June 06)</p>	<p>Support mental health groups to develop smoke free policies (Aug 06)</p> <p><i>This was not necessary due to the implementation of the new legislation</i></p>

Appendix 2: Wave Two Theory of Change

Long-term Outcomes: Reduce smoking prevalence of client group that access community-based mental health services in Kirkcaldy and Levenmouth

Resources	Activities	Short-term outcomes	Intermediate outcomes	Penultimate outcomes
<p>£11,500 from ASH Scotland</p> <ul style="list-style-type: none"> Smoking Cessation Worker - £8,800 On-going costs e.g. travel, resources, publicity - £1,000 Delivery of training - £1,200 Evaluation/outcomes - £500 <p>£5,000 from CHP</p> <ul style="list-style-type: none"> Clerical support Co-ordination & line management through existing management structure Patient education resources, e.g. leaflets & visual displays Monitoring equipment Clinical supervision In-house training 	<p>Extend Wave One services into Wave Two period.</p> <p>Implement changes from Wave One evaluation.</p>	<p>Clients recruited (Aug/Sep 06)</p> <p>Sites for delivering smoking cessation service will be identified (Aug/Sep 06)</p> <p>Resources will be in place (Aug-Sep 06)</p> <p>Changes suggested from evaluation will be implemented and smoking cessation service will be refined (Sep/Nov 06)</p> <p>Training needs for contact staff will have been identified (Aug/Sep 06)</p> <p>Service users continued involvement in smoking cessation service</p> <p>Monitoring data inputted into ISD database (Ongoing)</p>	<p>Group programme delivered, with 6 – 10 clients in one site in Kirkcaldy (Jan/Feb 07)</p> <p>One to one clinic established and operating</p> <ul style="list-style-type: none"> 3 clients a week, with 10 – 15 overall Ad hoc domiciliary visits (Oct 06) <p>Group programme set up in new setting in Dunnikier Day Hospital (Nov 06)</p> <p>Evaluation report delivered to ASH Scotland</p> <p>Wave Two: 1 month quit rates</p> <p>Wave1: 3 month quit rates (Mar 07)</p>	<p>Deliver well-established smoking cessation support that will incorporate evidence-based practice and be responsive to needs of individual clients (Mar 07)</p>

Long-term Outcomes: Develop a resource pack to support the delivery of the Kirkcaldy and Levenmouth smoking cessation programme

Resources	Activities	Short-term outcomes	Intermediate outcomes	Penultimate outcomes
<p>£11,500 from ASH Scotland</p> <ul style="list-style-type: none"> Smoking Cessation Worker - £8,800 On-going costs e.g. travel, resources, publicity - £1,000 Delivery of training - £1,200 Evaluation/outcomes - £500 <p>£5,000 from CHP</p> <ul style="list-style-type: none"> Clerical support Co-ordination & line management through existing management structure Patient education resources, e.g. leaflets & visual displays Monitoring equipment Clinical supervision In-house training 	<p>Peer review from Ash Scotland</p> <p>Graphics design</p> <p>Production of resource pack</p> <p>Identify key people to consult on areas of specialist expertise</p> <p>Disseminate resource pack</p>	<p>Discuss dissemination strategy with ASH Scotland (Aug/Sep 06)</p> <p>Identify potential funding streams for wider production and dissemination of resource pack (Aug/Sep 06)</p>	<p>Wider consultation on content of resource pack with mental health services in Fife will have been carried out (Oct 06)</p> <p>ASH Scotland will have peer reviewed resource pack (Nov 06)</p> <p>Resource pack will have been refined after consultation and final draft will be ready for production (Jan 07)</p> <p>Resource pack produced and ready for dissemination to relevant health professionals in Fife and possibly wider (after discussion with ASH Scotland & reliant on funding) (Mar 07)</p>	<p>Resource pack refined by process of peer review with ASH Scotland to provide a user-friendly, practical guide for use by wide range of staff (Mar 07)</p>

Long-term Outcomes: Increase awareness of smoking cessation and people with mental health difficulties amongst staff and service users in Kirkcaldy and Levenmouth

Resources	Activities	Short-term outcomes	Intermediate outcomes	Penultimate outcomes
<p>£11,500 from ASH Scotland</p> <ul style="list-style-type: none"> • Smoking Cessation Worker - £8,800 • On-going costs e.g. travel, resources, publicity - £1,000 • Delivery of training - £1,200 • Evaluation/outcomes - £500 <p>£5,000 from CHP</p> <ul style="list-style-type: none"> • Clerical support • Co-ordination & line management through existing management structure • Patient education resources, e.g. leaflets & visual displays • Monitoring equipment • Clinical supervision • In-house training 	<p>Update CHP about project.</p> <p>Disseminate results of Wave One evaluation report.</p>	<p>Wave One evaluation report produced and distributed (Sep 06)</p> <p>Presentation to Fife T.I.G. (Sep 06)</p> <p>Offer one-one support training to smaller health organisations (Oct 06)</p>	<p>Open day</p> <p>Ongoing engagement with relevant local agencies, VO's etc</p> <p>Articles in local media (Ongoing)</p> <p>Article for Ash Bulletin produced (Jan/Fe 07)</p>	<p>Increase awareness of smoking cessation issues for people that have mental health amongst staff and service users by actively working within the pilot sites (Mar 07)</p> <p>Build on existing partnerships and create new links with relevant organisations to raise the profile of smoking cessation amongst the client group.</p>

Long-term Outcomes: Support staff to access training and develop understanding of smoking cessation support for client group in Kirkcaldy and Levenmouth

Resources	Activities	Short-term outcomes	Intermediate outcomes	Penultimate outcomes
<p>£11,500 from ASH Scotland</p> <ul style="list-style-type: none"> • Smoking Cessation Worker - £8,800 • On-going costs e.g. travel, resources, publicity - £1,000 • Delivery of training - £1,200 • Evaluation/outcomes - £500 <p>£5,000 from CHP</p> <ul style="list-style-type: none"> • Clerical support • Co-ordination & line management through existing management structure • Patient education resources, e.g. leaflets & visual displays • Monitoring equipment • Clinical supervision • In-house training 	<p>Identify mental health services staff for training</p> <p>Identify venues for training</p> <p>Design third day of training.</p> <p>Deliver training programme.</p>	<p>Venues for training identified (Sep 06)</p> <p>Staff from mental health services with Kirkcaldy and Levenmouth to be trained identified and enrolled on course (Sep 06)</p>	<p>Staff trained in brief intervention, at least one day (Jan 07)</p> <p>Specialist third day of training designed (Nov 06)</p> <p>Specialist third day of training evaluated (Jan/Feb 07)</p> <p>'Health Day' delivered, passing out holistic advice on healthy living aimed at mental health services (Jan/Feb 07)</p>	<p>One advanced training day delivered and previous training has been expanded upon (Mar 07)</p>

Appendix 3: Interview Schedule

Kirkcaldy and Levenmouth CHP Topic Guide

1. Personal

- 1.1 What is your job role and responsibilities?
- 1.2 How long they have been in your job?
- 1.3 What is your professional background?

2. Organisation

- 2.1 How is your organisation structured?
- 2.2 Do you have a line manager you report back to or staff you manage?
- 2.3 How many staff does your organisation employ in the administrative area?

3. Project Rationale

- 3.1 Where did the idea for the project originate?
- 3.2 Had a significant demand for a smoking cessation service in Kirkcaldy and Buckhaven been identified before the project?

4. Process

- 4.1 Do you think the project has changed direction since the initial proposal?
- 4.2 Has the project achieved the objectives set out at the beginning?
- 4.3 Have there been any barriers to the project succeeding?
- 4.4 Were there any issues that you were aware of regarding funding?

Training

Have you received smoking cessation training?

- 4.5a If so, what kind: brief intervention or Maudsley?
- 4.5b What this part of the ASH funded project or prior to the project?
- 4.6 How did you find the training provided?
- 4.7 How relevant did you find the training with regards to your client group?

Smoking cessation programme

- 4.8 How do you feel the smoking cessation programme ran?
- 4.9 Were you happy with the number of clients who accessed the programme?
- 4.10 Do you feel the programme was sufficiently promoted beforehand?
- 4.11 Do you think the project increased awareness of the ill effects of smoking within the administrative areas?

- 4.12 Do you feel that clients engaged with the cessation programme well?
- 4.13 What did they particularly like about the programme?
- 4.14 Do you feel it is particularly problematic delivering a cessation programme to clients with mental health issues?
- 4.15 Is it more effective to utilise group sessions, domiciliary visits, one-to-one sessions or is this best assessed according to the clients' individual needs?
- 4.16 Were there significant levels of drop-offs from the groups?
- 4.17 How many people reduced their smoking consumption significantly or quit?
- 4.18 Have there been any repeat referrals/ self-admissions to the Wave Two programme?
- 4.19 Do you feel the 10-week model is effective or not?

- 4.20 What key lessons have you learned from the cessation programme?
- 4.21 What could be done to improve the cessation programme?

Resource Pack

- 4.22 Were you involved in the working group set up to develop the resource pack?
- 4.22a How often did the working group meet?
- 4.22b Did you carry out tasks individually or in groups, e.g. brainstorming sessions?
- 4.22c Do you feel the working group worked well?
- 4.23 Do you feel the resource pack is a valuable resource for delivering smoking cessation to clients with mental health issues?

5. Context

- 5.1 Were there any organisational issues that affected the running of the project?

Networking/partnership

- 5.2 Was networking and partnership working effective or not?
- 5.3 Were there any local issues that affected the running of the project?
- 5.3a The programme was initially to be provided with four groups in two pilot sites (24 –30 clients), but only one group ran in one site; why was this?
- 5.3b Do you think that the number of service users was affected by running in one site rather than two?
- 5.4 What do you think the future of the project will be after the ASH Scotland funding period ends?
- 5.4a Will the cessation programme be absorbed into the mainstream service or will trained staff continue to deliver cessation support to the client group?