Engaging Consumers, Community, and Health Care to Support Smoking Cessation among People Living with Mental Illness

Delivered in partnership by the Canadian Mental Health Association, Kings County Branch & the Nova Scotia Health Authority, Mental Health and Addictions

Final Report
March 2018
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Acknowledgements

The project management team is grateful for the significant contributions of the project delivery team who were key to the successful creation and delivery of this program. Your passion for this work made it possible.

We would also like to thank our advisory committee who helped to shape the direction of the project, and to connect participants to the project. Thank you for your time, and the thought and care you put into shaping this project.

Thank you to the management of the Nova Scotia Health Authority’s department of Mental Health and Addictions. This project would not have been possible without your support.

We would also like to thank the staff of the Canadian Mental Health Association, Kings County Branch, for their support and contribution to the creation and delivery of this program.

We are thankful to the members of the Central Kings Community Health Board, who endorsed this project to the Chronic Disease Innovation Fund. Your support for this work made the project possible. Thank you.

We would also like to extend a heart-felt note of thanks and appreciation to the story-sharing team. Thank you for sharing your experiences and perspectives with us, and for your commitment to creating meaningful community change.

Lastly, we would like to thank everyone who contributed to the success of this project, be it through talking about the project in the community, participating in the project in some way or supporting a spouse, friend or partner involved in the project.

Project Description

The Engaging Consumers, Community, and Health Care to Support Smoking Cessation among People Living with Mental Illness project was delivered through a partnership between the Canadian Mental Health Association, Kings County Branch (CMHA-Kings), and the Nova Scotia Health Authority (NSHA), Mental Health and Addictions Services (MHA). The program was funded through the NSHA-administered Chronic Disease Innovation Fund, and made possible through the support of community partners.

The cessation programming delivered through this project followed the syllabus of the Mental Health Addictions Services Public Health Program (MAPP), created in Colchester, Nova Scotia. The MAPP program “is intended to guide health professionals in implementing tobacco cessation treatment to clients living with mental illness, using best practice solutions to address the unique needs of this population”\(^1\). This program was built on the established MAPP syllabus. In addition to the existing sessions described in the MAPP Manual, the NSHA/CMHA-Kings program included a corresponding and complementary peer support program which ran weekly, in tandem with the clinical treatment sessions. Academic literature

\(^1\) MAPP (2013). MAPP Program Manual. CEHHA, Truro, Nova Scotia, Canada [McMullin, Krista; Morse, Neil; and Skinner, Nancy (PCHA)]
supports the use of peer support programming to help people living with a chronic mental illness to quit or reduce their tobacco use, and to live a meaningful life through the process of mental health recovery.

The closed (registration required) clinical part of the program followed the MAPP syllabus, and provided participants with nicotine replacement quit aids, as prescribed by a doctor or pharmacist. Participants were provided a minimum of one full course of pharmacological support, with additional support as needed, and as funds allowed. The open (no registration required) peer support part of the program expanded on the topics in the MAPP syllabus, and provided participants with a place and time to socialize in a place free from tobacco use, support one another’s goals and check-in with program facilitators, in-between clinical treatment sessions. Peer support sessions provided participants with an expanded social support system and an additional form of cessation support, thereby increasing the likelihood of cessation success.

In addition to providing cessation supports, this project focused on reducing the stigmatization of tobacco use by people living with a chronic mental illness (PLWCI) in our communities.

**Project Goals & Objectives**

The goals and objectives of this project were identified from the outset, but also evolved over the duration and delivery of the project programming. The following goals and objectives reflect the final evolution of the initial goals and objectives outlined in the original Chronic Disease Innovation grant proposal.

**Goals:**
- Provide accessible and safe and culturally appropriate tobacco cessation programming for PLWCI
- Address stigma against PLWCI who use tobacco within our communities
- Re-orient cultural beliefs and attitudes regarding PLWCI and tobacco use, both within the health system and in the wider community
- Address health disparities in tobacco control for PLWCI
- Build health system, organizational, professional, peer and social supports to sustainably address tobacco addiction in PLWCI beyond the project
- Build capacity for implementation across the Western Zone

**Objectives:**
- Work with NSHA-MHA to provide community based nicotine addiction cessation/reduction with necessary supports
- Work with Primary Health Care (PHC) to engage primary care supports, including physicians, and nurse practitioners
- Establish a replicable best practice peer support model
- Seek advice, support and engagement of persons with lived experience of mental illness and smoking for program development and delivery
- Begin a community-based conversation about the connection between tobacco use and mental

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illness through community presentations

- Deliver first-voice stories to community and government groups, with the goal of reducing stigma toward people who live with a chronic mental illness and use tobacco
- Work with partners to establish effective environmental and community supports
- Develop community level tobacco addiction expertise
- Begin project implementation in Kentville; then seek to create readiness and support in other areas in Western Zone.

Project Activities

Clinical Treatment
The clinical treatment element of the smoking cessation program ran for 14 weeks, and followed the curriculum outlined in the Centre for Addiction and Mental Health (CAMH) endorsed MAPP Smoking Cessation Program. The program was delivered on Tuesdays, and ran for 2 sessions (a total of 28 weeks) and supported a total of 9 different participants living with a chronic mental illness to reduce or quit their tobacco use.

The clinical treatment element of this program met several of the project objectives, as outlined below:

Objective:
Work with NSHA-MHA to provide community based nicotine addiction cessation/reduction with necessary supports

Activities:
Clinical treatment was coordinated by project staff and delivered weekly by two NSHA-MHA employees, a community mental health nurse and community outreach worker. Participants were provided with the necessary supports, including transportation subsidies, healthy snacks and regular check-ins about mental health symptoms and potential side effects from nicotine replacement treatments prescribed to program participants.

Objective:
Work with partners to establish effective environmental and community supports

Activities:
The clinical treatment element of the program was, in itself, a new community support for participants. Clinical treatment was delivered by two NSHA-MHA staff members, who worked in partnership with project staff to provide and coordinate supports for program participants. These supports included: transportation subsidies, dependent support, regular healthy meals, answering questions about NRT, and monitoring participants for possible side effects of cessation as related to their mental health medications.

Staff who delivered clinical treatment also met with NSHA Psychiatry twice over the course of the program, to share program learnings, academic research related to tobacco use and mental illness, and best-practice cessation approaches for this population.

Supports created by this program were wide reaching, and involved cooperation from both partner agencies; in order to create a circle of support which met the individual needs of each participant.
Peer Support

The peer support element of the smoking cessation program began as a pilot program in the summer of 2017. The pilot program ran once weekly for six weeks before the beginning of the first official program session. The purpose of the pilot program was to begin offering support as soon as possible, and to raise awareness about the upcoming program sessions. Over the course of the pilot program nine different people participated, with four people attending regularly.

Sessions one and two of peer support ran for 11 weeks, and followed the curriculum outlined in the CAMH endorsed MAPP Smoking Cessation Program, with several new activities and measures added. Sessions were co-facilitated by project staff, CMHA-Kings staff with peer support experience and a NSHA-MHA community support worker with peer support experience. Peer support sessions took place at the end of the week, following clinical sessions which took place at the beginning of the week. The program ran for two sessions (a total of 22 weeks) and supported a total of 21 different participants living with a chronic mental illness to reduce or quit their tobacco use (see appendix 1 for full attendance information).

The peer support element of this program met several of the project objectives, as outlined below:

**Objective:**

Establish a replicable best practice peer support model

**Activities:**

The peer support session plan followed the themes outlined in the best-practice MAPP curriculum. Each week participants revisited the theme discussed in the clinical session, with the addition of an interactive activity. This format allowed participants time to reflect on a topic during the week, and to bring questions or other thoughts on that topic to peer support at the week’s end.

The session plan was revised and improved after the completion of session one. All materials (including activities and measurement materials) and the session schedule are available for any future peer support programs.

**Objective:**

Work with partners to establish effective environmental and community supports

**Activities:**

The peer support element of the program was, in itself, a new community support for participants. Peer support provided participants with a weekly social space, and with a healthy meal. Participants were also provided with transportation subsidies, and given access to dependent supports, in order to facilitate their participation in the program. The peer support element of this program was unique in that each session had a theme, but ultimately participants were given the opportunity to shape each session. The peer support element of this program effectively supported participants through the provision of life skills, and the creation of a safe space where peers could come together to discuss their shared experiences living with a mental illness and reducing their tobacco use.

**Anti-Stigma Work**

**Objective:**

Deliver first-voice stories to community and government groups, with the goal of reducing stigma toward
people who live with a chronic mental illness and use tobacco

Activities:

In collaboration with three first-voice speakers, the project’s anti-stigma working group created a first-voice story sharing presentation, which was delivered to nine different organizations, including community groups, local government and NSHA committees/teams. The presentation consisted of three first-voice stories about the realities of living with a mental illness and attempting to quit smoking, followed by a group discussion facilitated by the program coordinator.

Objective:

Begin a community-based conversation about the connection between tobacco use and mental illness through community presentations

Activities:

The first-voice story sharing program included a facilitated discussion and time for questions from the audience. The purpose of this portion of the presentation was to draw the audience into the discussion. When we presented to NSHA staff the purpose was to have the audience reflect on the stories presented, and consider how they may change their approach to working with people who live with a mental illness and use tobacco in order to provide more effective support. When we presented to community groups the purpose was to have the audience reflect on the stories presented, to consider how we as a community stigmatize people who live with a mental illness and use tobacco, the damage that stigma may cause and how we as members of this community can address tobacco use in our communities without further contributing to the stigmatization of PLWCM who use tobacco.

Promotion and Relationship Building

Objective

Work with Primary Health Care (PHC) to engage primary care supports, including physicians, and nurse practitioners

Activities

Over the course of the project, in-person presentations were made by members of the project delivery team to four practitioner groups (nurse practitioners, G.P.’s, psychologists and a collaborative care clinic). Additionally, program information rack cards, as well as program RX pads were distributed to over 60 practitioners by NSHA-PHC.

Objective

Seek advice, support and engagement of persons with lived experience of mental illness and smoking for program development and delivery

Activities

From the outset, we sought the input of people with lived experience to inform the creation and implementation of this project. Initially, during the implementation of the program, we had two first-voice members on the Project Advisory Committee. One of these people participated in session one of the program. After the completion of session one a third first-voice member (a
participant from session one) was invited to sit on the Project Advisory Committee in order to provide input into the delivery of session two.

We also conducted evaluation activities throughout both sessions, asking participants for feedback on project delivery and activities in order to adjust project delivery as the sessions progressed.

The three participants in the story sharing project were asked for input on the project’s direction, potential presentation opportunities and discussion questions, and debriefed with the project coordinator after each story sharing session.

Training and Capacity Building

Objective

Develop community level tobacco addiction expertise

Activities

Over the course of the project six staff (1 from CMHA-Kings, 5 from the NSHA) completed Training Enhancement in Applied Cessation Counselling and Health (TEACH) Tobacco Cessation Training through the university of Toronto and CAMH. The TEACH training increases the capacity of both CMHA-Kings and NSHA-MHA to support people living with a mental illness to successfully reduce or cease their tobacco use.

During the project CMHA-Kings staff attended a training session with a staff member from NSHA-MHA, where they learned best practice approaches to supporting their clients to quit or reduce their tobacco use.

Project Outcomes

Clinical Treatment

Over the course of the two clinical treatment sessions, nine people participated in the clinical treatment program. At the beginning of each session participants measured their CO₂ levels, did a round table check-in and then followed the curriculum described in the MAPP manual.

Each of the nine participants was successful in either significantly reducing (8 participants) or quitting (1 participant) their tobacco use. Two of the participants indicated a readiness to quit entirely, at the end of their respective sessions, and hoped to do so soon after the session’s end. All participants were given information about NSHA-MHA cessation groups at the end of each session, as an alternative cessation program they may attend if they are interested in further supports after the conclusion of this program.

Participant’s CO₂ reading as well as their weekly tobacco reduction progress was recorded by NSHA-MHA staff at each session. A summary of the participants’ outcome data can be found in Appendix 1.

Peer Support

Over the course of the three peer support sessions, 21 different people participated in the peer support program. Of these 21 people, five were repeat participants who participated in more than one session. The 11 week program followed a session schedule with topics that mirrored the topics being covered in
the clinical sessions, but did not repeat the information delivered in the clinical sessions. These complementary session schedules allowed for those participants participating in the clinical sessions to reflect on the discussion from that group and bring questions and further thoughts to the peer support session later in the week, as well as to contribute their learnings to the group discussion in the peer support sessions.

Participants were asked for feedback on the peer support sessions throughout session one and session two. Feedback to both sessions was overwhelmingly positive. Participants reported feeling accepted and understood in the peer support sessions. Participants also indicated that they felt comfortable talking freely within the group because they knew that everyone there would understand their experience, because everyone in the room lived with a mental illness. Participants enjoyed the informal nature of the peer support sessions, and the support they got from the facilitators and the other participants for their decision to quit their tobacco use. Overall, participants indicated (through formalized feedback forms as well as during group conversations during the sessions) that the group had been very valuable to them and had contributed to their progress in reducing their tobacco use.

A summary of participant’s feedback on the peer support sessions can be found in Appendix 2.

**System Reorientation/Staff Training**

The six staff from CMHA-Kings and NSHA-MHA who completed the TEACH tobacco cessation training through the University of Toronto and CAMH now have the training required to effectively support their clients who live with a mental illness to successfully reduce or cease their tobacco use.

The TEACH training also provides these six staff members with evidence based information to share with their colleagues at both agencies. The TEACH training addresses smoking myths (ex. smoking is a personal failing) and provides students with evidence based practical approaches towards cessation. The sharing of best-practice, evidence based information will hopefully contribute to reorienting the health system towards an up-to-date evidence based approach to supporting clients towards their cessation goals.

The stories shared by the three participants in the story sharing program help to support the evidence based information in the TEACH training. The lived experiences of the three story sharers put a human face to the statistics and research described in TEACH. The infusion of the information provided through the TEACH training, combined with the voices of the story sharers will contribute to reorienting the health system’s approach to supporting people living with a mental illness to quit or reduce their smoking.

CMHA-Kings staff have changed intake procedures for new CMHA-Kings clients. New clients are now asked if they use tobacco, and if they do, if they are interested in accessing supports to quit or reduce their use. This new procedure is based on the best practice Three A’s of Smoking Cessation.

**Key Learnings**

Over the course of project development and delivery, the project delivery team have identified a few key learnings, which should be considered if this program is to be duplicated elsewhere, or expanded within the Western Zone of the NSHA.

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4 Smoking Cessation Advice: Healthcare Professional Training. The Use of the 5 & 3 A’s Protocol
http://smokingcessationtraining.com/contents/use-S-3-protocol-smoking-cessation/
Participant Identification and Selection
For the duration of this program (two sessions) all recruitment materials listed the contact details for one employee at the NSHA-MHA. One employee was solely responsible for receiving communication from people interested in the program, and screening potential participants into either the CMHA-Kings program or the more general community cessation groups delivered by NSHA-MHA.

Asking one person to be responsible for this process is not conducive with a community/health systems partnership model. Moving forward the management team recommends that participants be identified and selected by a Community/Clinical Administration Committee made up of staff from NSHA, as well as staff from CMHA-Kings and potentially a member of the advisory committee.

Although this change would require significant preparation and cooperation between the two partnering agencies, the creation of a participant selection committee would strengthen the relationship between the two agencies, and ensure that both groups had a more active role in the delivery of the program.

Definitions
Mental illness can be difficult to define. This program was designed to meet the needs of participants living with a chronic mental illness, however, the program delivery team did not agree on a definition of chronic mental illness.

Going forward the management committee recommends the Community/Clinical Administration Committee establish an agreed upon definition of chronic mental illness, in order to clearly delineate who qualifies for the participation in the program.

Partnership Maintenance
Inter-agency partnerships allow for both parties to achieve things they would not otherwise have the resources to achieve. However, inter-agency partnerships also require maintenance and upkeep in order to remain active and successful.

The two agencies involved in the partnership that produced this project work with similar populations, but have distinctly different structures. It is also important to note that NSHA-MHA is a government funded agency, while CMHA-Kings is a community not for profit organization. The NSHA is a much larger organization, with considerable resources, which facilitated the success of this program (established billing through local pharmacies, financial resources, staff time, cessation expertise etc.) while CMHA-Kings is a smaller agency with limited resources and staff time to contribute to this project and partnership. Both agencies played a key role in the success of the project, however the partnership may have been smoother in nature had the pre-existing hierarchy between the two organizations (size, relative power and resource availability) been specifically named and addressed from the outset of the project.

The following are suggested approaches to partnership building and maintenance:

1. **Create shared definitions from the project’s outset.**
   When this project began there was an assumption made that both partner organizations shared the same definition of mental illness, as well as who the “ideal participant” would be for the program. Over the course of the project we realized that each organization had slightly differing definitions of these two key foundational elements of the project. Going forward we recommend that the key decision makers (the staff delivering the project) sit down with the management team and other staff members who may be less directly involved (from both agencies) at the very beginning of the project and create a set of shared definitions to act as the foundation of the program going forward. This exercise is important for several reasons: it ensures that key
decision makers are involved in creating the foundation of the program, and that these key stakeholders have “bought in” to the direction of the project. This approach also supports the project goal of systems reorientation, by combining community health definitions and systems’ definitions (i.e. definition of chronic mental illness) and creating shared norms for the project which draws from each agency’s experiences within the context of their work environment, and the differences in approach to practice taken by each partner when working with clients.

2. **Engage in on-going team building exercises throughout the project.**

This project was delivered by CMHA-Kings. However, the majority of the CMHA-Kings staff are not directly engaged in the delivery of this program, and may therefore feel removed from it. In order to build and maintain project ownership we recommend that team building exercises, involving staff from both agencies, be organized by the management group each fiscal quarter. These exercises would create the opportunity for staff less directly involved to learn about the project, and give feedback and/or input into project delivery or design. These sessions would also help to build relationships and trust between staff from partnering agencies, and ownership of the project.

**Program Differentiation**

This unique program was created in order to meet the needs of people living with a chronic mental illness who want to quit or reduce their tobacco use. It is different from the community programs already offered by the NSHA in several key ways: the inclusion of the peer-support element, the on-going consideration of, and focus on, mental illness and the shared lived experiences of the participants.

A key learning from the first two sessions is the importance of differentiating this program from the existing NSHA community programs, in order to ensure that we reach the target audience. This could involve further program presentations to health professionals (GPs, psychiatry, nurse practitioners etc.) and more targeted advertising which specifically states that this program is intended to meet the needs of people living with a chronic mental illness.

**Limited Staff Resources**

Considerable staff time was allocated to the creation and delivery of this program, by staff from CMHA-Kings and NSHA-MHA. The amount of time required to create and run the program, on top of existing duties, was not sustainable for some of the staff members involved. Going forward, the management team recommends the creation of a part-time staff position for a qualified peer support worker, to deliver the peer support sessions and reduce the time demands placed on NSHA and CMHA-Kings staff members.

**Long Term Process of Change**

The process of change within systems takes time. Within the limited time afforded by the funding timeline for this project the project delivery team began the process of working with relevant parts of the NSHA (including psychiatry and NSHA-PHC) to reorient treatment and practice. However, the process of initiating this process (i.e. accessing the time of busy staff and practitioners) took longer than anticipated. Significantly more time is required in order to create meaningful systems change.

**Learnings Recommendations**

Based on the key learnings outlined above, the management team recommends implementation of the following, if this program is to be delivered in the future:

- *The creation of a Community/Clinical Administration Committee made up of staff from NSHA, as well as staff from CMHA-Kings and potentially a member of the advisory committee.*
- *Participants be identified and selected by the Community/Clinical Administration Committee*
• Create shared definitions from the project’s outset.
• Engage in on-going team building exercises throughout the project.
• The creation of a part-time staff position for a qualified peer support worker, to deliver the peer support sessions and reduce the time demands placed on NSHA and CMHA-Kings staff members.
• Identify and engage change agents within an organization who will continue to work within the organization beyond the end of the funding period, and can continue the work of systems change after the project ends.

What Comes Next

Although this program has come to an end, the important work of this program will not stop.

Within the NSHA

Staff from NSHA-MHA who worked to create and deliver this program will continue to use their TEACH training when working with clients within Mental Health and Addictions. NSHA staff will also continue to share their learnings from the TEACH training and through the delivery of this project with their colleagues at the NSHA, in order to reorient health system approaches to cessation and to increase the capacity of the NSHA to best support people living with a chronic mental illness to quit or reduce their tobacco use.

NSHA staff will also continue to engage with NSHA management, psychiatry, the inpatient team, community support workers and NSHA-PHC to provide cessation training opportunities and support for practitioners and staff, based on the TEACH training and learnings gained through the delivery of this program.

Within CMHA-Kings

Staff from CMHA-Kings who worked to create and deliver this program will incorporate their TEACH training into existing peer support programs delivered at CMHA-Kings. As a result of training delivered through this program, staff at CMHA-Kings also changed their intake procedure, and now each new client is given the opportunity to find out about supports to help them quit or reduce their tobacco use. Although this program is no longer available as a support, clients will be directed to the community cessation groups delivered by NSHA-MHA, and will be made aware of peer support programs available through CMHA-Kings, where facilitators will be capable of supporting them in their quit or reduction attempt.

Conclusion

The Engaging Consumers, Community, and Health Care to Support Smoking Cessation among People Living with Mental Illness project delivered a unique set of specialized supports through a combination of clinical treatment and peer support programming. Many of the program’s participants valued the program, citing appreciation for the regularity of the meetings, the topics discussed and the unique social space created when a group of often marginalized people with similar lived experiences come together in mutual support of one another.
The partnership between CMHA-Kings and NSHA-MHA allowed for the two agencies to create and deliver a program that neither agency could have delivered on its own, while the distinctly different but complementary approaches of the two agencies created a dynamic experience, well received by program participants.

Over the course of the project the project management team identified a list of key learnings, which should be carefully considered if this program is to be replicated or expanded in the future. Although the program has come to an end, the important work started by CMHA-Kings and NSHA-MHA staff will be carried on in both agencies. This ongoing work will continue to contribute to reducing systems-level and community-level stigmatization and to improving the effectiveness of cessation supports offered to people who live with a chronic mental illness and use tobacco.
Appendix 1: Quantitative Data Summaries

Overall Attendance

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<th>Session</th>
<th># of Participants</th>
<th># Who Continued</th>
<th># Unique Participants</th>
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<td>9</td>
<td>9</td>
<td>9</td>
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<tr>
<td>Fall</td>
<td>10</td>
<td>1</td>
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<tr>
<td>Winter</td>
<td>7</td>
<td>4</td>
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<tr>
<td>TOTAL PROGRAM PARTICIPANTS</td>
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Pilot Program

General Data Summary

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<th>Duration</th>
<th># Participants</th>
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<td>Peer Support Pilot</td>
<td>6 sessions</td>
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Session 1

General Data Summary

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<th>Group Type</th>
<th>Duration</th>
<th># Participants</th>
<th>NRT Prescribed</th>
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<tr>
<td>Clinical</td>
<td>14 sessions</td>
<td>5</td>
<td>Champix (x2), Nicotine gum, Nicotine patch</td>
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<tr>
<td>Peer Support</td>
<td>11 sessions</td>
<td>10</td>
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Summarized Reduction Results (Clinical)

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<th>Participant #</th>
<th>Tobacco Use September 2017</th>
<th>Tobacco Use December 2017</th>
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<tbody>
<tr>
<td>1</td>
<td>25-40 cigarettes/day</td>
<td>Reduced, but did not complete the program</td>
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<tr>
<td>2</td>
<td>12-15 cigarettes/day</td>
<td>1 cigarette/week</td>
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<tr>
<td>3</td>
<td>1 pack/ day</td>
<td>10 or fewer cigarettes/day</td>
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<td>4</td>
<td>1/2 pack/day</td>
<td>1 cigarette/day</td>
</tr>
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<td>5</td>
<td>+/- 1 pack/day</td>
<td>Cigarette free</td>
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Peer Support Attendance

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<tr>
<th>Date</th>
<th>Attendance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sep 29</td>
<td>6 participants</td>
</tr>
<tr>
<td>Oct 6</td>
<td>4 participants</td>
</tr>
<tr>
<td>Oct 13</td>
<td>5 participants</td>
</tr>
<tr>
<td>Oct 20</td>
<td>4 participants</td>
</tr>
<tr>
<td>Oct 27</td>
<td>5 participants</td>
</tr>
<tr>
<td>Nov 3</td>
<td>8 participants</td>
</tr>
<tr>
<td>Nov 10</td>
<td>4 participants</td>
</tr>
<tr>
<td>Nov 24</td>
<td>6 participants</td>
</tr>
<tr>
<td>Date</td>
<td>Attendance</td>
</tr>
<tr>
<td>----------</td>
<td>------------</td>
</tr>
<tr>
<td>Dec 1</td>
<td>3 participants</td>
</tr>
<tr>
<td>Dec 8</td>
<td>2 participants</td>
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</table>

**Session 2**

**General Data Summary**

<table>
<thead>
<tr>
<th>Group Type</th>
<th>Duration</th>
<th># Participants</th>
<th>NRT Prescribed</th>
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</thead>
<tbody>
<tr>
<td>Clinical</td>
<td>14 sessions planned (No session March Break &amp; 3 cancelled due to weather)</td>
<td>4</td>
<td>Champix (x2), Nicotine gum/lozenges</td>
</tr>
<tr>
<td>Peer Support</td>
<td>11 sessions planned (No session March Break &amp; 2 cancelled due to weather)</td>
<td>7</td>
<td>N/A</td>
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</table>

**Summarized Reduction Results (Clinical)**

<table>
<thead>
<tr>
<th>Participant #</th>
<th>Tobacco Use Upon Entry to Program</th>
<th>Tobacco Use March 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>25+ cigarettes/day</td>
<td>Only a few cigarettes/day</td>
</tr>
<tr>
<td>2</td>
<td>10 cigarettes/day</td>
<td>Use varies (as low as 1 cig/day) Still plans to quit soon</td>
</tr>
<tr>
<td>3</td>
<td>1 pack cigarettes/ day</td>
<td>5-10 cigarettes/day</td>
</tr>
<tr>
<td>4</td>
<td>1 pack cigarettes/ day</td>
<td>A few puffs/day Ready to quit</td>
</tr>
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</table>

**Peer Support Attendance**

<table>
<thead>
<tr>
<th>Date</th>
<th>Attendance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan 26</td>
<td>6 participants</td>
</tr>
<tr>
<td>Feb 2</td>
<td>4 participants</td>
</tr>
<tr>
<td>Feb 9</td>
<td>3 participants</td>
</tr>
<tr>
<td>Feb 16</td>
<td>6 participants</td>
</tr>
<tr>
<td>Feb 23</td>
<td>3 participants</td>
</tr>
<tr>
<td>Mar 2</td>
<td>3 participants</td>
</tr>
<tr>
<td>Mar 9</td>
<td>4 participants</td>
</tr>
<tr>
<td>Mar 29</td>
<td>3 participants</td>
</tr>
</tbody>
</table>
Appendix 2: Qualitative Data Summaries

Smiley Evaluation Summary

Overview

Participants were asked to fill out an evaluation form at the end of several clinical and peer support sessions over the 2 program sessions. The evaluation requested participants to indicate how they felt about the session by selecting a happy, neutral or sad face. This format was chosen in order to make the evaluation process accessible for all participants, regardless of their level of literacy. Participants were also asked to describe, in a few words, what they felt was done well, and what could be done better.

- 79 evaluations completed
- Completed periodically by participants at both clinical and peer support sessions
- Results: 76 Happy Faces, 7 Neutral Faces, 0 Sad Faces
  (participants checked as many faces as applied)

Done Well/Do Better

Overall: Feedback was almost entirely positive.

Done Well

The most common response in the “done well” session was “everything”.
There were several specific activities, elements of program delivery and specific program sessions which participants identified as particularly well done:

- Organization
- Cooperation within the group
- Everyone being given space to speak
- Open sharing and discussion
- Detailed information and discussion
- Sharing progress and successes
- Support
- Conversation
- Preparation
- A chance “to vent”
- Insight on why individual participants smoke
- Lunch/food
- Fun!
• Specific sessions and activities
  o Learning to say “no”
  o Coping with withdrawal
  o Guided/Deep breathing exercise
  o Coping with stress
  o Hobbies to replace smoking
  o Setting quit date
  o Triggers and cravings
  o Mindfulness exercise
  o Chair yoga

Do Better

The most common response in the “do better” section of the evaluation was that everything was done well.

In addition, there were three specific suggestions made for improvement:

• Peer support to continue running after clinical is finished
• An on-going program
• Longer (than 1 hour) clinical sessions
• Better attendance/larger group

What is Special about Peer Support?

At the end of the first MAPP session, participants were asked how they felt about the Friday Peer Support Sessions. The following is a summary of their feedback:

• It’s comfortable
• It’s informal
• The people are like family
• People are easy to get along with
• No one looks down on anyone
• I get support for my decision to quit
• I like the atmosphere
• All people [at peer support] are good people
• We see something in each other’s stories that helps us (both the teller and the listener)
• Everyone is going through the same things
• Can open up and get things off our chests
• Can share our experience, strength and hope with each other
Participant Advisor Feedback

After completion of the first session, 2 participants joined the project advisory group. During their first meeting they were asked to reflect on their experiences in the program. These are their responses:

**What was helpful about this group? What was different than past groups you have participated in?**

- “It takes time to learn about myself and why I smoke. Coming to peer support gives me that time. Each cigarette had a different trigger, it wasn’t just when I was down. I smoked when I was happy too. A better understanding my triggers makes it more possible for me to reduce my smoking. This program is [not just the opportunity to quit, it is] also an opportunity to learn about ourselves.”
- “If I hadn’t done this program I would lay money on it that I would still be smoking.”
- In the past allowed cigarettes to control me, now I control them.
- Coping skills taught in the group were helpful. In the moment I forget to breathe. It’s a good reminder that I can sit and take deep breaths and the craving will pass. It’s good to know there are ways to cope that don’t cost money.
- Meeting with the group helps to keep me smoke free. It’s also good to support other people.
- For a lot of people, if they didn’t have this group they might smoke more.
- Going forward: if this project ends I will go back to open group. But in this group I am more willing to talk because we all have mental health. It feels more like a community. I am less likely to talk in the open groups. I feel much more comfortable knowing that other people in the group live with mental illness too. They will understand why I smoke more than people in the other open groups.
- We can relate to one another more.
- Listening to other people and hearing what they have been doing and works for them has been helpful.
- Cigarettes were attached to so many emotions for me, so figuring out the triggers (happy, sad- both made me want a smoke) has been important for me. It’s not just a quick fix. A cigarette means a different thing depending on the mood a person is in.
- The atmosphere of these groups is warmer and inviting, more so than the open community groups.
- I was ready to quit, because I was afraid for my health. I heard about the group through my support worker and psychiatrist who encouraged me to go.
- A key part is praising each other for our accomplishments and the positive changes we are seeing. Really focus on the positives.
• I was not being consistent with the NRT (why did not want to do second clinical session). For me I find the support and accountability more helpful.
• The atmosphere is so non-judgmental. I feel more judged by other participants in open groups.
• I am enjoying it even more the second time around (peer support)
• It was nice to have food there. When I started I wasn’t buying groceries. Now that I have cut back on cigarettes I buy better food, but at the start food was important.

How would you make it better? What would you change?
• It’s a very good group. There is very little change I would make if I were in charge. I would like to see more participants. That’s the only change I would make.
<table>
<thead>
<tr>
<th>Program Start</th>
<th>Program Completion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stress: money, physical health, mental health</td>
<td>Stress: money, mental health</td>
</tr>
<tr>
<td>Quit/Group: never participated in cessation group before, only 1 previous quit attempt</td>
<td>Change: - physical health</td>
</tr>
<tr>
<td>Tobacco: used 8-9 cigarettes/day</td>
<td>Quit/Group: 1 new attempt, this group met needs (never been in group before)</td>
</tr>
<tr>
<td>Why: manage stress, control food craving, take mind off, take a break, habit, avoid withdrawal</td>
<td>Change: successful quit attempt</td>
</tr>
<tr>
<td>Stress: money, work, physical health, mental health</td>
<td>Tobacco: have not used in last month/I do not use tobacco</td>
</tr>
<tr>
<td>Quit/Group: participated in group before. Quit 3 times (successfully) made many, many other attempts. Past groups have met needs. Tobacco: 2-10 cigarettes/day</td>
<td>Change: from 8-9 cigarettes/day to no tobacco use over several months</td>
</tr>
<tr>
<td>Why: manage stress, control food, socialize, habit, take a break</td>
<td>Why: none of the above apply</td>
</tr>
<tr>
<td>Stress: money, work, relationships, physical health, mental health</td>
<td>Change: - manage stress, control food craving, take mind off, take a break, habit, avoid withdrawal</td>
</tr>
<tr>
<td>Quit/Group: never done group before, never attempted to quit Tobacco: used in past month. 25 cigarettes/day</td>
<td>stress, control food craving, take mind off, take a break, habit, avoid withdrawal</td>
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<tr>
<td>Why: manage stress, take mind off bad things, socialize, habit, take a break</td>
<td>Stress: money, work</td>
</tr>
<tr>
<td>Stress: money, work, relationships, mental health</td>
<td>Change: - physical/mental health</td>
</tr>
<tr>
<td>Quit/Group: tried a quit group before. Met needs but when it was over went back to smoking Tobacco: used in past month. 10 cigarettes/day Why: manage stress, habit, take a break</td>
<td>Quit/Group: has made a quit attempt in this group</td>
</tr>
<tr>
<td>Stress: money, work</td>
<td>Change: has now made a quit attempt</td>
</tr>
<tr>
<td>Quit/Group: tried a quit group before. Met needs but when it was over went back to smoking Tobacco: used in past month. 10 cigarettes/day Why: manage stress, habit, take a break</td>
<td>Tobacco: has used in past month, 10 cigarettes/day</td>
</tr>
<tr>
<td>Tobacco: used in past month. 10 cigarettes/day</td>
<td>Change: from 25 to 10 cigarettes/day</td>
</tr>
<tr>
<td>Why: manage stress, habit, take a break</td>
<td>Why: manage stress, socialize, habit, take a break, avoid withdrawal symptoms, when agitated by something Change: - take mind off bad things + when agitated</td>
</tr>
<tr>
<td>Stress: money, work, relationships, mental health</td>
<td>Stress: money, work</td>
</tr>
<tr>
<td>Quit/Group: tried a quit group before. Met needs but when it was over went back to smoking Tobacco: used in past month. 10 cigarettes/day Why: manage stress, habit, take a break</td>
<td>No change</td>
</tr>
<tr>
<td>Tobacco: used in past month. 10 cigarettes/day</td>
<td>Quit/Group: tried a quit group before. Met needs but when it was over went back to smoking Change: one more quit attempt made</td>
</tr>
<tr>
<td>Why: manage stress, habit, take a break</td>
<td>Tobacco: used in past month. 10 cigarettes/day</td>
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<tr>
<td>Stress: money, physical health, mental health</td>
<td>Change: from 10 to 2-3 cigarettes/day</td>
</tr>
<tr>
<td>Quit/Group: tried a quit group before. Met needs but when it was over went back to smoking Tobacco: used in past month. 10 cigarettes/day Why: manage stress, habit, take a break</td>
<td>Why: manage stress, habit, take a break</td>
</tr>
<tr>
<td>Tobacco: used in past month. 10 cigarettes/day</td>
<td>Change: - to take a break</td>
</tr>
</tbody>
</table>
Appendix 3: Project Teams

**Project Management Team**
- Brenda Main, Executive Director, CMHA-Kings
- Sarah Hergett, Mental Health Promotion Coordinator, NSHA
- Gwennyth Dwyn, Health Promotion Team Lead MHA, NSHA

**Project Delivery Team**
- Kris Garby-Legge, Community Outreach Worker, NSHA
- Jennifer Breen, Community Mental Health Nurse, NSHA
- Candy O’Brien, Project HOPE, CMHA-Kings
- Pam Callan, Community Outreach Worker, NSHA
- Emma Van Rooyen, Program Coordinator, CMHA-Kings

**Project Advisory Committee**
- Brenda Main, Executive Director, CMHA-Kings
- Sarah Hergett, Mental Health Promotion Coordinator, NSHA
- Gwennyth Dwyn, Health Promotion Team Lead MHA, NSHA
- Kris Garby-Legge, Community Outreach Worker, NSHA
- Jennifer Breen, Mental Health Nurse, NSHA
- Pam Callan, Community Support Worker, NSHA
- Jennifer Kelday, Health Services Lead, Primary Health Care, NSHA
- Emma Van Rooyen, Program Coordinator, CMHA-Kings
- Shannon Westerby, Director, The Evangeline Recreation Society
- Shelley Linders, Co-Chair The Evangeline Recreation Society
- Penni Burrell, Volunteer, Eastern Kings Community Health Board
- Darryl Brown, Kentville Police
- Jennifer Young, Volunteer, Open Arms
- John Murphy, Citizen Member

**Anti-Stigma Team**
- Sarah Hergett, Mental Health Promotion Coordinator, NSHA
- Emma Van Rooyen, Program Coordinator, CMHA-Kings
- Penni Burrell, Volunteer, Eastern Kings Community Health Board

**Evaluation Team**
- Sarah Hergett, Mental Health Promotion Coordinator, NSHA
- Emma Van Rooyen, Program Coordinator, CMHA-Kings

**First-Voice Story Share Team**
- Emma Van Rooyen, Program Coordinator, CMHA-Kings
- Tony Legere, Story Writer/Presenter
- Claire LeFort, Story Writer/Presenter
- Anonymous Contributor
- Natalie McIssac, Drama Teacher, Horton High School
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<tr>
<th>Source: Project Management Institute (PMI)</th>
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<td><strong>Program Logic Model</strong></td>
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<tr>
<td><strong>Logic Model:</strong> Engaging Consumers, Community, and Health Care to Support Smoking Cessation Among People Living with Mental Illness</td>
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<td><strong>Inputs (Resources)</strong></td>
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<td>1. Health and Wellness Resources</td>
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<td>2. Community Engagement</td>
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<td>3. Health Care Services</td>
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<tr>
<td>4. Economic Support</td>
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<tr>
<td><strong>Outputs</strong></td>
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</tr>
<tr>
<td>1. Increased Engagement in Health and Wellness</td>
<td></td>
</tr>
<tr>
<td>2. Improved Community Engagement</td>
<td></td>
</tr>
<tr>
<td>3. Access to Health Care Services</td>
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<td>4. Economic Well-Being</td>
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<td><strong>Program Impact</strong></td>
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<td>1. Engaging Consumers</td>
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<td>2. Community Engagement</td>
<td></td>
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<td>3. Health Care Services</td>
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<td>4. Economic Support</td>
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<tr>
<td><strong>Program Logic Model</strong></td>
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<td><strong>Inputs:</strong></td>
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<tr>
<td>1. Health and Wellness Resources</td>
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<td>2. Community Engagement</td>
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<td>3. Health Care Services</td>
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<td>4. Economic Support</td>
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<td><strong>Outputs:</strong></td>
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</tr>
<tr>
<td>1. Increased Engagement in Health and Wellness</td>
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<tr>
<td>2. Improved Community Engagement</td>
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</tr>
<tr>
<td>3. Access to Health Care Services</td>
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<tr>
<td>4. Economic Well-Being</td>
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Appendix 5: Glossary of Acronyms

CAMH- Centre for Addiction and Mental Health
CMHA-Kings- Canadian Mental Health Association, Kings County Branch
MHA- Mental Health and Addictions
NSHA- Nova Scotia Health Authority
PLWCMI- People Living with a Chronic Mental Illness
PHC- Primary Health Care
TEACH- Training Enhancement in Applied Cessation Counselling and Health
Appendix 6: Program Infographics

CMHA-KINGS & NSHA SMOKING CESSION PROGRAM

Highlights from
CLINICAL TREATMENT
September 2017 - April 2018

SESSION ONE

Five registered participants
14 sessions over 12 weeks
Quit aids used: Champix, Nicotine gum, Nicotine patch

SESSION ONE

4 participants significantly reduced their smoking
1 participant quit smoking completely
4/5 completed the program & 3/5 continued on in Session 2

SESSION TWO

Four registered participants
14 sessions over 12 weeks
Quit aids used: Champix & Nicotine gum

SESSION TWO

4 participants significantly reduced their smoking
4 participants significantly reduced CO2 levels
4 participants completed the program

CANADIAN MENTAL HEALTH ASSOCIATION - KINGS
(902) 679 7464
WWW.KINGSNS.CMHA.CA

nova scotia health authority
WHAT PARTICIPANTS SAID

About their experiences with Peer Support in the smoking cessation program delivered by CMHA-Kings and NSHA

EMPOWERMENT

* In the past I allowed cigarettes to control me, now I control them. *
* This program gives us an opportunity to learn about ourselves. *

SOCIAL CONNECTION

* The atmosphere is non-judgmental. *
* Everyone is going through the same things. *

MUTUAL SUPPORT

* A key part is praising each other for our accomplishments and the positive changes we are seeing. *
* I get support for my decision to quit. *

WHY IT IS SPECIAL

* We can relate to one another... because we all have mental health. *
* It’s not just a quick fix. *
* No one looks down on anyone. *

SUCCESSES

* If I hadn’t done this program I would lay money on it that I would still be smoking. *

CANADIAN MENTAL HEALTH ASSOCIATION - KINGS
(902) 679 7464
WWW.KINGSNS.CMHA.CA
CMHA - Kings and NSHA Mental Health and Addictions

Smoking Cessation for People Living with Chronic Mental Illness

PROGRAM HIGHLIGHTS

A MEANINGFUL EXPERIENCE FOR PARTICIPANTS
This program provided participants with best-practice practical tools and social-emotional supports to facilitate the reduction and/or cessation of their tobacco use. Both clinical treatment and peer support sessions focused on creating meaningful experiences for participants through regular check-ins, the creation and delivery of engaging activities and the facilitation of inclusive group discussions.

SUCCESSFUL REDUCTION AND CESSATION
This program took a harm reduction approach, in which each reduction in tobacco use was celebrated as a success, and used as motivation to reach the participant’s next goal on the path to cessation. When participants reduced their tobacco use they also reduced the associated health risks. Each participant’s progress was celebrated, whether they were at the beginning of their quit journey, or were working to maintain total tobacco cessation.

THE OPPORTUNITY TO GIVE SOMETHING BACK
One of the most important parts of this project was the opportunity participants had to support one another through their quit/reduction journey. Several participants returned to the peer support program after the end of the first session in order to sustain their progress, as well as for the opportunity to give back by supporting other participants through their journey.

REDUCTION OF STIGMA
Within our communities there exists significant stigma toward people who live with a mental illness and use tobacco. This project contributed to a shift in attitudes toward this population through sharing first voice stories and facilitating follow up discussions with community groups, local government and health systems teams at the NSHA.

COMMUNITY PARTNERSHIPS & ENGAGEMENT
This program was delivered through a partnership between CMHA Kings and NSHA Mental Health and Addictions, with advisory support from a variety of other community organizations throughout the development and delivery of the program.