



OXLEAS NHS FOUNDATION TRUST RESEARCH PROPOSAL

Title of the Proposal

Does using Motivational Interviewing (MI) in a group setting for people with severe mental illness (SMI) have a positive impact on smoking cessation uptake?

To what extent does MI used in a group setting impact on smoking cessation for people with severe mental illness?

Hypothesis

Motivational Interviewing in a group setting improves the uptake of smoking cessation services for people with severe mental illness.

The Objectives

- To provide a three session group for people with SMI utilizing MI skills to work specifically on issues of ambivalence and lack of motivation in stopping smoking.
- To develop a group intervention using Motivational Interviewing that facilitates access to local smoking cessation services, and which can be provided as core intervention which is integrated with local smoking cessation resources within the primary care setting.
- To improve uptake of Nicotine Replacement Therapy (NRT) in the local community through attendance at smoking cessation related clinics, drop-ins and structured groups in the local community.

Background to the study

MI is a counselling approach with fundamental principles and methodologies that have been applied and tested in various health care settings with research findings demonstrating efficacy.

MI is now established as evidence based practice in many areas of health care provision from primary care to substance misuse and can be used to support any area of behaviour or lifestyle change or dilemmas faced by individuals.

The method differs from more “coercive” or externally driven methods for motivating change as it does not impose change but rather supports change as coming from within the individual which can be influenced by their environment and own values.

It is grounded in a respectful stance with a focus on building rapport in the initial stages of engagement. It is a collaborative person centred approach based on partnership, honours autonomy rather than expert - recipient roles. It holds many parallels with the Recovery ethos and the recovery star.

The Adult Mental Health Directorate aims to integrate Motivational Interviewing approach within all services and evaluate the programme which, if positive results are found, could be replicated within other Oxleas services where staff deal with health behaviour change.

Rationale

There is evidence to show that people living with SMI have a much higher prevalence of tobacco smoking than the rest of the population. People affected by mental ill health area also responsible for 42% of the tobacco consumption in England, with 31% of all tobacco consumption accounted for by those with common mental disorder (McManus et al 2010).

Such high levels of smoking increase the amount of smoking-related harm that people with mental disorders suffer. It is responsible for the largest proportion of the excess mortality of people with mental disorder (Brown et al 2010). Those with schizophrenia and bipolar affective disorder die many years earlier than the general population. A recent UK study highlighted that men living with schizophrenia in the community have 20 years’ reduced life expectancy, while women have 16 years’ reduced life expectancy. The death rate from respiratory disease among people with schizophrenia, for example, is three times higher than the average (Saha et al 2007). Smoking tobacco is significantly associated with increased prevalence of all mental disorders (McManus et al 2010), with smokers 50% more likely to suffer from a mental disorder than non-smokers (Cuijpers et al 2007), and more likely to commit suicide (Malone et al 2003). It

is therefore crucial that people with mental disorders have appropriate access to stop smoking support and be encouraged to stop.

A recent systematic review found that smoking cessation treatments that work in the general population work for those with severe mental illness and appear approximately as effective. The same review found that treating tobacco dependence in patients with stable psychiatric conditions does not worsen their mental state (Banham and Gilbody 2010). Combining pharmacotherapy with other support such as counselling can increase abstinence rates in those with mental health problems to rates similar to those of the general population (Campion et al 2008; Foulds et al 2006). However, up to now, people with mental health disorder have been less likely to receive smoking cessation interventions in primary care (Phelam et al 2001).

The evidence for MI on promoting healthy behaviour continues to grow. A meta-analysis (Hettema & Hendricks 2010) found that overall MI has efficacy for ceasing smoking and is particularly effective where motivation is low. Steinberg et al (2004) carried out a study looking at the efficacy of MI for motivating smokers with schizophrenia. They found that a one-session MI intervention was more effective than other interventions in motivating this group to access smoking cessation services and suggest that the logical next step is to explore whether it is appropriate as part of a more intensive treatment programme for this client group.

Lai et al (2010) performed a meta-analysis using a fixed-effect Mantel-Haenszel model, the objective was to determine the effects of motivational interviewing in promoting smoking cessation for the Cochrane systematic review database. The results identified 14 studies published from 1997- 2008, involving over 10,000 smokers in which trials were conducted in one to four sessions, and the duration of each session ranged from 15 to 45 minutes. Meta-analysis of Motivational Interviewing versus brief advice or usual care yielded a modest but significant increase in quitting. Subgroup analyses suggested that MI was effective when delivered by primary care physicians and by counsellors, and when it was conducted in longer sessions (more than 20 minutes per session). Multiple session treatments may be slightly more effective than single session.

Motivational interviewing is designed to engage ambivalent or resistant clients in the process of health behaviour change, and it has been widely used in different clinical conditions such as substance abuse, dietary adherence and smoking cessation. Motivational interviewing has also been proposed as a method for improving modifiable coronary heart disease risk factors of patient. Thompson et al's meta-analysis suggests that MI can help nurses to reduce and improve the modifiable coronary heart disease risk factors.

Since increased levels of smoking are responsible for the largest proportion of health inequality in this group, supporting people with mental disorders to stop smoking has an

even larger impact on health outcomes, thereby directly reducing health inequalities. However, health inequality experienced by people with mental disorder will widen if investment in smoking cessation services for this group is not greater than for the general population. Making access to smoking cessation services easier for those with disability due to mental disorder will also comply with the Equality Act (2010).

In people with schizophrenia, there is little evidence to show any worsening of symptoms following stopping smoking (Campion et al 2008). Stopping smoking can result in significant reductions in the dosages of some medications, which can reduce the long-term consequences such medication can have. Evidence suggests that there is a link between the amounts smoked and the number of depressive and anxiety symptoms (Farrell et al 2001). When stopped, these symptoms are seen to reduce (Campion et al 2008), and can be accompanied by a sense of achievement.

Although half of all smokers with a mental disorder want help to quit smoking (Siru et al 2009) they are less likely to receive smoking cessation interventions in primary care than the general population.

Research Design

- Staff qualified in Motivational Interviewing will develop a group protocol to cover three sessions of 90 minutes
- Group participants will be identified adults with a diagnosis of severe mental illness under enhanced or standard care with an open referral to Recovery Teams located in London Borough of Greenwich.
- Group participants will be invited to attend and will be identified a suitable people based on MDT discussion.
- An initial telephone call to group participants using an 'AIMS' procedure (adapted from McNally & Ratschen 2010) will be adopted to ensure that we **A**sk individuals about mental health problems. **I**nforn other relevant professionals of an anticipated attempt to quit smoking. **M**edication advise service user of potential effects of quitting smoking and also confirm that **S**upport will be tailored to suit personal need.
- The group will be facilitated at a location not recognised as part of mental health services.
- Staff will facilitate the group using a highly responsive approach to the nature and content of the group.

- The four processes of MI -engaging, focusing, evoking and planning will be used within the group context to elicit any positive changes amongst the group members.
- The underlying spirit of MI will be the backbone of the group, recognising that people are the expert on themselves with their own strengths, motivations and resources.
- The group will encourage partnership working and support each member to make their own decisions about possible change.
- The recipients of the group will be identified as suitable by the Community Mental Health Team and approached to ascertain if they are interested in taking part.
- As part of the group programme, the recipients will be introduced to local smoking cessation services, this is so all current and any new NICE-recommended products are made known to group participants. (Current experimental statistics from stop smoking services indicate that Varenicline was the most successful smoking cessation aid between April 2009 and March 2010. Of those who used Varenicline 60% successfully quit, compared with 50% who received bupropion only and 47% who received NRT)
- Follow-up by telephone will be made 4-6 weeks after completion of group and Patient Reported Outcome Measure (PROM) will be used .The most likely tool (awaiting license purchase) will be the Patient Activation Measure (PAM).

Timeline

Key project dates are outlined below. Dates are best-guess estimates and are subject to change.

Description	Start Date	End Date	Duration
Manual audit of smoking screening assessments to identify cohort	June 2014	July 2014	6 weeks
Develop course content	June 2014	August 2014	8 weeks
Data collection	October 2014	November 2014	6 weeks
Research Group	November 2014	December 2014	6 weeks
Report writing	January 2015	March 2015	8 weeks

Qualifications

Oxleas NHS Foundation Trust is continually proven to be a leader for high quality, innovative care with values of collaboration, and striving for learning and trying to be the best, through the values of the organisation.

References

Brown S, Kim M, Mitchell C et al. (2010) 'Twenty-five year mortality of a community cohort with schizophrenia.' *British Journal of Psychiatry*. 196:116–21 145 Ibid.

Cuijpers P, Smit F, ten Have M and de Graaf R (2007) 'Smoking is associated with first-ever incidence of mental disorders: prospective population-based study.' *Addiction* 102(8):1303

Hettema J.E & Hendricks P.S (2010) Motivational interviewing for smoking cessation: a meta-analytic review. *Journal of Consulting and Clinical Psychology* 78(6):868-84

Malone KM, Waternaux C, Haas GL et al. (2003) 'Cigarette smoking, suicidal behaviour, and serotonin function in major psychiatric disorders.' *American Journal of Psychiatry* 160(4):773–9150

Lai DTC, Cahill K, Qin Y, Tang J-L. (2010) Motivational interviewing for smoking cessation. *Cochrane Database of Systematic Reviews* 2010, Issue 1. Art. No.: CD006936. DOI: 10.1002/14651858.CD006936.pub2

McManus S, Meltzer H and Campion J (2010) *Cigarette Smoking and Mental Health in England: Data from the Adult Psychiatric Morbidity Survey 2007*. National Centre for Social Research. www.natcen.ac.uk/study/cigarette-smoking--mental-health

Saha S, Chant D and McGrath JA (2007) 'Systematic review of mortality in schizophrenia: is the differential mortality gap worsening over time?' *Archives of General Psychiatry* 64:1123–31;

Steinberg ML, Ziedonis M, Krejci JA & Brandon TH (2004) Motivational Interviewing with Personalised Feedback: A Brief Intervention for Motivating Smokers with Schizophrenia to See Treatment for Tobacco Dependence *Journal of Consulting and Clinical Psychology* 2004, vol. 72, No. 4, 723-728

Banham L and Gilbody S (2010) 'Smoking cessation in severe mental illness: what works?' *Addiction* 105(7):1176–89

Brown S, Kim M, Mitchell C et al. (2010) 'Twenty-five year mortality of a community cohort with schizophrenia.' *British Journal of Psychiatry*.196:116–21 145 Ibid.

Campion J, Checinski K and Nurse J (2008) 'Review of smoking cessation treatments for people with mental illness.' *Advances in Psychiatric Treatment* 14:208–16

Cuijpers P, Smit F, ten Have M and de Graaf R (2007) 'Smoking is associated with first-ever incidence of mental disorders: prospective population-based study.' *Addiction* 102(8):1303

Heatherton TF, Kozlowski LT, Frecker RC and Fagerström KO (1991) 'The Fagerström Test for Nicotine Dependence: A revision of the Fagerström Tolerance Questionnaire.' *British Journal of Addiction* 86(9):1119–27

McManus S, Meltzer H and Campion J (2010) Cigarette Smoking and Mental Health in England: Data from the Adult Psychiatric Morbidity Survey 2007. National Centre for Social Research. www.natcen.ac.uk/study/cigarette-smoking--mental-health

Phelan M, Stradins L and Morrison S (2001) 'Physical health of people with severe mental illness.' *British Medical Journal* 322:443–4

Siru R, Hulse GK and Tait RJ (2009) 'Assessing motivation to quit smoking in people with mental illness: a review.' *Addiction* 104(5):719–33

Foulds JGK, Steinberg MB, Richardson D et al.. (2006) 'Factors associated with quitting smoking at a tobacco dependence treatment clinic.' *American Journal of Health Behavior* 30:400–12

Farrell M, Howes S, Bebbington P et al. (2001) 'Nicotine, alcohol and psychiatric morbidity: Results of a national household survey.' *British Journal of Psychiatry* 179:432–7