The Frontline Reports column features short descriptions of novel approaches to mental health problems or creative applications of established concepts in different settings. Material submitted for the column should be 350 to 750 words long, with a maximum of three authors (one is preferred), and no references, tables, or figures. Send material to Francine Cournos, M.D., at the New York State Psychiatric Institute (fc15@columbia.edu) or Stephen M. Goldfinger, M.D., at SUNY Downstate Medical Center (steve007ny@aol.com).

Using Peer Counselors to Address Tobacco Use: the CHOICES Program

Although tobacco dependence is a proven major health issue, changes within the mental health system to increase treatment options have been slow to develop. Outreach to professionals has had limited success, as indicated by the continued low rates of diagnosis of nicotine dependence and treatment planning despite ten-year-old recommendations for psychiatrists to treat tobacco use among their patients. An alternative model for system change is to directly target smokers who have mental illness in order to increase the demand for tobacco cessation services among consumers. Here we describe the unique consumer-driven perspective of the CHOICES program for addressing tobacco use.

CHOICES stands for "consumers helping others improve their condition by ending smoking" and is a name that symbolizes empowerment and personal choice in recovery. CHOICES employs mental health peer counselors to deliver the vital message to smokers with mental illness that addressing tobacco use is important to their health and to motivate them to seek treatment. Advantages of using peer counselors include reduced language and cultural barriers, increased trust and lowered defenses, and low cost. Peer counselors often are rated highly by other consumers, and there is an added benefit in the modeling that comes from seeing peers do well.

Mental health peer counselors called "consumer tobacco advocates" serve as tobacco-focused consultants to consumers or agencies to assist with linkages to treatment, referrals, advocacy, support, and the provision of educational materials. Advocates must be nonsmokers or former smokers, and most work for the program part-time. The goal of the consumer tobacco advocate is not to provide direct tobacco treatment but to visit mental health centers, self-help centers, and health fairs to communicate with and educate consumers about their smoking. They also provide resources about places in New Jersey where smokers with mental illness can receive tobacco dependence treatment.

The consumer tobacco advocates for CHOICES participate in 30 hours of intensive training in order to learn how to discuss tobacco issues with peers and to organize activities such as health fairs and "smoke-out" cessation days. In addition they are instructed on how to perform a 20-minute peer-to-peer feedback intervention that was developed from the work of Marc Steinberg, Ph.D. This method is simple and straightforward and relies on the use of brief, personalized feedback about the impact of expired carbon monoxide from tobacco use and about the money spent on tobacco. Each CHOICES team member is provided with a small, handheld carbon monoxide meter, which is used in the feedback intervention. Each consumer tobacco advocate also receives ongoing supervision and feedback from the leadership team of two part-time mental health professionals.

The CHOICES program mails a free quarterly newsletter to consumers. Consumers are encouraged to submit articles and art to the newsletter, which also incorporates information on tobacco education and treatment options. Consumers need not to have quit smoking to write for the newsletter and often choose to write about their struggles with tobacco or other aspects of their recovery story. The CHOICES Web site (www.nj choices.org) was created as an additional tool to link consumers to available resources.

A program evaluation study that is under way tracks the activities and impact of the program. Since its inception two years ago, CHOICES has made more than 133 on-site visits to community sites, fostering interaction with more than 3,660 consumers who smoke. More than 530 smokers have received the individualized peer-to-peer feedback session, which includes a carbon monoxide reading. Feedback is positive from smokers, who report that consumer tobacco advocates are extremely knowledgeable about tobacco and interested in helping them to address their smoking. Seventy percent of those surveyed said it was a lot easier to talk to an advocate about their smoking than to their psychiatrist or mental health professional.

Successful partnerships have contributed to the rapid growth and success of CHOICES. The program is supported by grants from the American Legacy Foundation, the New Jersey State Division of Mental Health Services, and the Cancer Institute of New Jersey. The Mental Health Association in New Jersey, a consumer-driven mental health advocacy organization, has been an especially effective partner, linking CHOICES to an audience of consumers and sharing a commitment to addressing tobacco through policy and other work (www.mhanj.org/tobaccopolicypapernov2004.pdf).

The CHOICES program continues to accomplish its goal of using peer counselors to address tobacco use among mental health consumers by increasing awareness through targeted education, linking consumers to treatment services, and advocacy. Future goals are to continue to expand the program and develop satellite CHOICES organizations in other states.

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A Fast, Implementable Psychoeducation Program for Schizophrenia

Although psychoeducational programs for patients with schizophrenia and their families can significantly reduce relapse rates, few patients are offered a psychoeducational program in routine clinical treatment. Implementation difficulties and lack of experience, training, and time are considered as the primary reasons for this situation. Therefore, we assessed whether a structured, manual-supported psychoeducational program for schizophrenia is suitable for broad implementation in routine clinical treatment and whether its results are comparable with those in experimental settings, namely the Munich Psychosis Information Project Study, which was previously conducted in our department.

We developed a psychoeducational program for patients with schizophrenia and their family members in cooperation with consumers, family members, and health care professionals from other institutions. The development of the Alliance Psychoeducation Program, supported by Pfizer, comprises 12 modules that cover symptoms and causes of schizophrenia, effects and side effects of medication, warning signs, contingency plan, psychosocial treatment, tasks of family members, alcohol and drugs, and partnership and sexuality. Manuals, workbooks, and flip charts are available for each module, and videotapes are available for several.

Multiprofessional teams in 154 hospitals were trained in a one-day workshop on the Alliance Program. Twenty-three hospitals evaluated their psychoeducational groups from April 2004 to April 2006. The information that follows pertains to these 23 sites. We assessed the implementability of the program and its impact on knowledge of schizophrenia and medication adherence.

Separate groups for patients and family members were held by two moderators, once or twice per week, with each session lasting 60–90 minutes. Some of the moderators had experience in conducting psychoeducation; however, most did not. Before (baseline) and after (endpoint) participation in the program, patients and family members completed a knowledge-of-illness questionnaire about schizophrenia (maximum score of 70 points) and a feedback questionnaire at endpoint. Patients also completed the Medication Adherence Rating Scale (MARS, maximum score of 10 points). Professionals completed a feedback questionnaire after having conducted at least one psychoeducational group.

Data sets of 407 patients (62% male, 38% female) and 92 family members (74% female, 26% male) were evaluated. The mean age of patients was 32±10 years, mean duration of illness was six years; 83% were inpatients, 5% outpatients, and 12% patients in a daycare clinic. The mean age of family members was 51±12 years (66% parents, 14% partners, 8% siblings, 5% daughters and sons, and 7% other). On average, patients participated in 7.5 sessions and family members in six sessions.

Among patients, scores on the knowledge questionnaire significantly increased from 43.8 to 52.0 ($N=370$, $p<.001$) and on the MARS from 6.9 to 7.8 ($N=211$, $p<.001$). Among family members, knowledge of illness increased significantly, from 47.0 to 55.4 ($N=92$, $p<.001$) (paired t tests). Overall satisfaction of participants with the program and the moderators was high.

A total of 129 professionals (36% physicians, 30% psychologists, 18% nursing staff, 14% social worker, and 2% others) completed the feedback questionnaire. The handling of the material was considered convenient by 95% of respondents; 84% needed preparation time (33±36 minutes). Also, 88% of respondents regarded the effort to conduct the program as moderate, 8% substantial, 1% immoderate, and 3% negligible. All professionals considered the program to be very useful (53%) or useful (47%); 93% would use the program in the future, and 7% would use it with modifications.

These results showed that professionals trained in the program efficiently conducted groups, as indicated by the significant increase in participants' knowledge about schizophrenia and improvement in medication adherence. Participants considered the professional moderators to be helpful or very helpful. Most professionals found the effort to conduct the program to be moderate and indicated that they would use the program, which suggests compatibility with their other work.

The program successfully addressed two main reasons for not conducting psychoeducation: lack of training and lack of time. The program appeared to be easy to conduct even for "psychoeducation newcomers," perhaps because it provides comprehensive working material and is highly structured.

Increase in knowledge and medication adherence was comparable with that observed in the randomized, controlled Psychosis Information Project Study. In the seven-year follow-up of that study, patients in the psychoeducation group had been hospitalized for 75 days, compared with 225 days in the routine treatment group. Because the short-term results of the two studies are comparable, the long-term effects might be comparable as well.

This study was limited because of unavailability of long-term data and participation of few trained hospitals (15%). However, these findings support the feasibility of the successful implementation of the Alliance Psychoeducation Program in routine clinical treatment after only a one-day training workshop.

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