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 to Stephen M. Goldfinger, M.D., at SUNY Downstate Medical Center (steve007ny@aol.com).

ACT Tailored for Ethnocultural Communities of Metropolitan Toronto

Persons with mental illnesses who are from ethnic minority groups are underserved in multicultural Canada and the United States. Ethnic minorities with serious mental illness have above-average rates of homelessness, emergency visits, hospitalizations, and legal involvement, resulting in high risks of morbidity and relapse. Matching clients with mental health service providers in language and cultural backgrounds is effective in improving care for ethnic minority groups.

Toronto is one of the most culturally diverse cities in the world: 37% (1.7 million) of its population, versus 17% in Canada, is from a minority group. In 1999 the Ontario Ministry of Health funded Toronto's Mount Sinai Hospital Assertive Community Treatment (ACT) team—developed in partnership with Hong Fook Mental Health Association, a community agency—to provide intensive, community-based services tailored to ethnic minority persons with serious mental illness.

The ACT team was set up in the heart of Chinatown. It has high fidelity to the ACT model. Its innovations are in the operational aspects of the team. Of the 90 clients, 45% are Chinese (80% Cantonese speaking; 20% Mandarin), 21% Tamil, 16% Vietnamese, 7% Korean or Japanese, and 6% Afro-Caribbean, and 5% are from other minority groups. Seventy-two percent of the clients live in boarding homes or supported housing, 16% live with family, and 12% live independently. Ninety-four percent have schizophrenia or schizoaffective disorder; 6% have bipolar affective disorder. English is not the first language for 82% of the clients, 32% are unable to communicate in English, and 35% have no family members in Canada. Eighty percent of the clients are first-generation immigrants from Asian countries. Of this group 58% are unfamiliar and uncomfortable with mainstream culture or with negotiating activities of daily living, such as getting telephone services, obtaining financial assistance, or finding housing. Informed by these facts, team members are selected to match the clients' language and cultural backgrounds: ten of the 11 staff members speak one of the main target group languages—Chinese, Tamil, Vietnamese, or Korean. Sixty-seven percent of the clients are matched with workers in both language and ethnicity and communicate in languages other than English.

In addition to the classic ACT services in pharmacotherapy and psychosocial rehabilitation, the ACT team also tailors services to meet the specific cultural needs of the clients. There are restaurant outings for Chinese noodles and groups for practicing yoga, baking, exercising, and singing karaoke. There is an annual music festival as well as seasonal and New Year's celebrations, including Chinese, Vietnamese, and Tamil festivals.

The clients' wide range of views concerning the nature of mental illness (overseen by ancestral gods and astrology) and treatment approaches are assessed by the explanatory model pioneered by cultural psychiatrist Arthur Kleinman. The responses to model questions yield rich information about the clients' perceptions, expectations, insight, past experiences, and personal healing practices, which in turn inform the team's treatment plans. The team also systematically inquires about cultural identity and culturally relevant issues, such as level of community stigma about mental illness, role of family, social status changes after immigration, and subjective experience of discrimination, social defeat, psychosomatic expression of illness and suffering, and exposure to war and trauma.

In outcome studies, the team compared clinical records of clients one year before ACT team admission and one year after and found a statistically significant 83% reduction in total hospital days (from 7,095 to 1,221 days) and a 68% reduction in the number of patients hospitalized more than 30 days (from 44 to 14) (*Psychiatric Services* 56:1053–1055, 2005). The Brief Psychiatric Rating Scale showed moderate but significant improvement in psychopathology. Satisfaction surveys of clients and families found that 91% of clients (N=61) were satisfied or very satisfied and that 100% of families (N=33) were satisfied or very satisfied with the services. With the McFarlane model of family psychoeducation translated into the primary languages of the clients, we found significant positive results in families' knowledge of mental illness, empathy for their ill family member, and lowered rejection of the clients.

The Mount Sinai ACT team appears to be the only ACT team in the field of community psychiatry that specifically serves ethnocultural populations. In 2006 the team won recognition from the American Psychiatric Foundation and the Ontario Hospital Association for advancing minority mental health.

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Stage-Tailored Tobacco Cessation Treatment in Inpatient Psychiatry

Individuals with mental illness and co-occurring addictive disorders account for 44% of the cigarettes sold in the United States (*JAMA* 284:2606–2610, 2000). Smokers with mental illness face serious tobacco-related consequences, including increased morbidity and mortality, isolation, stigma, and financial hardship. Tobacco use also increases the metabolism of some antipsychotic and antidepressant medications, with the potential for subtherapeutic treatment and higher rates of rehospitalization.

Nearly half of U.S. state psychiatric hospitals now ban tobacco use on their premises. The American Psychiatric Association identifies psychiatric hospitalizations as an ideal opportunity to treat tobacco dependence. Yet little research has examined tobacco cessation treatments in inpatient psychiatry. If tobacco dependence is left unaddressed, most psychiatric patients return to smoking immediately after discharge (*American Journal of Addictions* 15:15–22, 2006). Multicomponent interventions are needed that address the motivational, behavioral, and physiological aspects of nicotine dependence for smokers with co-occurring psychiatric disorders.

We briefly describe an innovative tobacco treatment intervention initiated during psychiatric hospitalization. The intervention combines a computer-delivered expert system intervention and manual based on the transtheoretical model, an individual counseling session, and nicotine replacement therapy (NRT). The model identifies five stages of change: precontemplation (no immediate intention to stop smoking), contemplation (intending to quit in the next six months), preparation (considering quitting in the next month with a quit attempt in the past year), action (quit smoking for less than six months), and maintenance (smoke-free for at least six months).

The 20-minute computer intervention generates individualized feedback at a sixth-grade reading level to guide participants through the stages of quitting smoking and to direct them to relevant sections of the manual. In a 30-minute session with the participant, study counselors review the printed feedback and manual, identify and support goals concerning tobacco use, and discuss proper use of NRT.

Nine hospitalized psychiatric patients representing a range of psychiatric, demographic, and tobacco-use characteristics intensively evaluated the intervention components. Despite having fairly limited computer experience, all agreed or strongly agreed that the program was easy to understand and gave sound advice, and all recommended the computer program to others. Most participants required assistance with program navigation, suggesting the need for more user-friendly capabilities, such as a touch screen and audio. All participants read part of the manual, and most read beyond their stage-of-change chapter. Participants rated the manual highly for its organization and helpful strategies, describing it as "realistic" and "easy to understand . . . good for any person to read." Participants also rated the counseling session highly, citing the openness of the dialogue, the focus on their needs and interests, and the lack of pressure to quit: "She didn't push any points . . . she just presented the material. She was open, nonjudgmental. . . . She let me come to my own conclusions that I want to quit." Most participants used NRT, identified several benefits, and expressed interest in continuing NRT after hospitalization. Side effects also were noted. Of concern, most participants stated that clinical staff did not instruct them in proper use of NRT.

This small and intensive evaluation suggests that the intervention provides a viable and acceptable strategy for initiating tobacco treatment in the inpatient psychiatric setting. In a randomized clinical trial, we are evaluating efficacy of the intervention relative to usual care. With a 79% recruitment rate, we enrolled 224 participants. After the brief hospital stay, intervention participants received ten weeks of NRT and two additional computer contacts, and their outpatient providers were informed of their cessation goals. Follow-up continues for 18 months.

Psychiatric hospitals are making important strides in banning tobacco use. Bans, however, are only part of a much larger strategy needed to overcome the high rates of tobacco use in populations with mental illness. If cessation services are not offered, patients may misperceive smoking bans as punitive and themselves as unworthy of receiving intervention on this deadly addiction. When smoking was allowed on psychiatric units, an average of 15 minutes was spent per nursing shift managing patients' cigarette use. Ideally, a portion of the time saved with a no-smoking policy could be shifted to delivery of cessation services. The findings present an innovative, acceptable, multicomponent intervention for initiating tobacco treatment in inpatient psychiatry.

Acknowledgments and disclosures

This program is funded by grants K23-DA-018691, K05-DA016752, and P50-DA09253 from the National Institute on Drug Abuse. The computerized tobacco cessation program and manual were developed by Pro-Change Behavior Systems, Inc.

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