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Peer Supports for Tobacco Cessation for Adults with Serious Mental Illness: A Review of the Literature

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Abstract

Objective—A relatively new approach to addressing tobacco use in mental health settings is the involvement of consumers or peers, defined as other individuals with mental health conditions, as service providers. This review examines the literature describing peer delivered supports for tobacco cessation for adults with serious mental illness.

Methods—The authors conducted a review of online databases to identify reports of tobacco cessation interventions in which peers play a key role in the provision of services to help other adults with serious mental illness to reduce or quit using tobacco.

Results—Our review yielded reports of four tobacco cessation interventions for persons with serious mental illness that include peer providers. The roles of peers in these interventions include that of co-leaders of an educational smoking cessation group, individual counselors as part of a multi-faceted tobacco treatment program, and as outreach tobacco cessation advocates.

Conclusions—The roles of peers in these interventions are promising; however, more detail about the selection and experience of the peer providers, as well as the services they deliver in tobacco cessation interventions, would be helpful. In addition, rigorous research is needed to evaluate the impact of peer providers on reducing tobacco use in this population.

Keywords

mental health; serious mental illness; tobacco cessation; smoking cessation; peer supports; psychosocial rehabilitation

Tobacco use represents a major health problem among persons with serious mental illness (Brown, Barraclough, & Inskip, 2000; Curkendall, Glasser, Rose Stang, & Jones, 2004; Joukamaa et al., 2001). More than three times as many persons with serious mental illness smoke cigarettes than adults in the US general population (Lasser et al., 2000; Centers for Disease Control and Prevention [CDC], 2008). In addition, persons with serious mental illness are more likely to be heavy smokers and to have longer histories of smoking

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compared with smokers in the general population (Tidey, Rohsenow, Kaplan, & Swift, 2005). The reasons for excess cigarette smoking among persons with serious mental illness are not known with certainty but may include smoking to cope with boredom or stress (Lucksted, Dixon, & Sembl, 2000; Snyder, McDevitt, & Painter, 2008; Solway, 2011) or to manage psychiatric symptoms (Ziedonis, Williams, & Smelson, 2003). Compared with persons in the general population, persons with serious mental illness are also at greater risk of tobacco-related medical illnesses (Brown et al., 2000), health problems, and premature death (Kelly et al., 2011; Parks, Svendsen, Singer, & Foti, 2006).

To compound the adverse effects of tobacco use in this population, individuals with serious mental illness have less access to tobacco cessation treatment services compared with the general population (Williams, Zimmerman et al., 2011). Tobacco use is typically not prioritized or addressed routinely in mental health treatment for persons with serious mental illness (American Legacy Foundation, 2011; Schroeder & Morris, 2010; Solway, 2009; Ziedonis & Williams, 2003; Ziedonis et al., 2008). Historically smoking was viewed as an acceptable practice within many mental health treatment settings as an individual right of persons with serious mental illness. The use of cigarettes in this population was reinforced by the provision of cigarettes and other items promoting tobacco use by major companies at a reduced cost or at no charge (Apollonio & Malone, 2005; Ziedonis et al., 2008). In a survey examining psychiatric services, less than ten percent of psychiatric clients who had a tobacco addiction received treatment (Montoya, Herbeck, Sviki, & Pincus, 2005). Two additional studies found that approximately one third of psychiatrists ask their clients about tobacco use (Price, Ambrosetti, Sidani, & Price, 2007) or recommend that their clients quit smoking (Prochaska et al., 2011).

Despite the lack of routine screening for tobacco use or access to tobacco treatment, tobacco cessation studies have shown beneficial outcomes for adults with serious mental illness. The outcome of targeted interventions indicates that smoking quit rates in this population are lower than in the general population (Lasser et al., 2000; Ziedonis et al., 2008) but, importantly, individuals with mental illness can quit using tobacco successfully and many indicate that they want to do so (Baker et al., 2006; Currie et al., 2008; Dickerson et al., 2011; el-Guebaly, Cathcart, Currie, Brown, & Gloster, 2002; Evins et al., 2005; George et al., 2002; Morris, Giese, Turnbull, Dickinson, & Johnson-Nagel, 2006; Morris et al., 2011).

Consequently, tobacco cessation efforts for this population are beginning to receive increased attention in mental health services. Identified strategies for tobacco cessation for adults with serious mental illness include traditional approaches, and follow recommended guidelines such as providing education, FDA approved medications, social support, and psychosocial interventions (American Psychiatric Association [APA], 2006; Fiore, Jaén, & Baker, 2008; Kreyenbuhl, Buchanan, Dickerson, & Dixon, 2010).

In the general population, peer support and other social support interventions have been developed to address a wide variety of medical conditions and health problems including smoking cessation (Malchodi et al., 2003; May & West, 2000; Myers, MacPherson, Jones, & Aarons, 2007; Webel, Okonsky, Trompeta, & Holzemer, 2010). Among persons with serious mental illness, several surveys of mental health consumers indicate that receiving support from consumers or peers who have quit smoking would be useful strategies (Dickerson et al., 2011; Goldberg, 2010; Lucksted et al., 2000; Morris, Waxmonsky, May, & Giese, 2009; Schroeder & Morris, 2010) or that peer supports are essential (Williams, Zimmermann et al., 2011).

Over the last two decades, mental health consumers have become more engaged in providing services, offering support and companionship, and promoting recovery for their

peers (Davidson, Chinman, Sells, & Rowe, 2006; Morris et al., 2009; Solomon, 2004). Peer supports and services may include self-help groups (Katz & Bender, 1976), case management (Davidson, et al., 2006), linkages to reduce involvement in the criminal justice system (Davidson & Rowe, 2008), and wellness planning (Cook et al., 2010).

Although peer involvement is increasingly becoming an integral component of mental health services and is consistent with the recovery model of care (New Freedom Commission on Mental Health, 2003), the inclusion of peer providers in tobacco cessation in the mental health community is relatively new and has not been widely developed or disseminated. In mental health services more generally, peers may be able to provide valuable support and experiential knowledge based on their own wellness and recovery, to deliver cost-effective services, and to act as role models (Goldberg 2010; Solomon, 2004; Solway, 2009; Williams, Zimmermann et al., 2011). In addressing tobacco use, it has been suggested that peers can advocate for reducing tobacco use and implementing culture change in mental health settings (Solway, 2009). It has also been noted that peer counselors for smoking cessation may be seen as less threatening and share a common language and culture with other peers (Williams, Dwyer et al., 2011).

However, the role of consumers or peers in addressing tobacco use among individuals with mental illness has not been established. Few randomized trials of tobacco cessation interventions have been conducted with persons with serious mental illness in general (Prochaska et al., 2011) and interventions utilizing peer supports to address tobacco use are an even more recent development. This article reviews the literature to date that describes peer supports in order to help adults with serious mental illness reduce or quit using tobacco.

METHODS

The authors conducted searches of literature published between January 1990 and December 2011, inclusive, using electronic databases including MEDLINE, OVID and EBSCO. The OVID search included all OVID journals full-text, all EBM reviews, Ovid MEDLINE, and PsycInfo databases. The EBSCO search included Alt Health watch, CINAHL, Nursing and Allied Health Collection, and Psychology and Behavioral Sciences Collection databases. Literature prior to 1990 was not searched because tobacco cessation services were not offered in mental health settings until recently.

Keywords including “mental health”, “mental illness”, “tobacco cessation”, “smoking cessation”, and “peer support” were used to identify English language articles about peer providers in tobacco cessation interventions for adults with serious mental illness. The initial search yielded 75 articles which were imported into Reference Manager Software and which were reviewed for content relevant to peer delivered supports for tobacco cessation for adults with serious mental illness. Articles that mentioned peers but did not describe in any detail the tobacco cessation intervention in which peers were involved were excluded. We also excluded articles that did not define peers as adults with mental health conditions. Applying these criteria narrowed the total number of articles reviewed to seven (Ashton, Miller, Bowden, & Bertossa, 2010; Lee et al., 2011; O'Shaughnessy, Cain, & Fredericks, 2008; Williams, Cain, Fredericks, & O'Shaughnessy, 2006; Williams, 2007; Williams, Dwyer et al., 2011; Williams, Zimmermann et al., 2011).

RESULTS

The seven articles yielded by our search describe four smoking cessation interventions that include peer providers. The primary roles of these peer providers are as co-leaders of an educational group, as providers of additional support to persons in a Clubhouse with a multi-

faceted smoking cessation program, and as outreach workers, delivering presentations about smoking at mental health programs and brief tobacco feedback sessions to individuals at these programs. The four interventions described in the literature have all been developed and implemented within the last five years. These interventions have not been widely disseminated or subjected to rigorous research methods such as quasi-experimental or experimental studies, but the articles provide useful information regarding the provision of peer supports for tobacco cessation for adults with serious mental illness.

One intervention is a multi-faceted smoking cessation program at a psychosocial rehabilitation Clubhouse program for persons with serious mental illness in the New York area that was funded through a two-year grant from the Department of Health (Williams et al., 2006; O'Shaughnessy et al., 2008). Clubhouses are recovery-oriented community centers that provide a variety of supports and services including employment, education, housing, advocacy, social supports, outreach, health promotion interventions, and recreational opportunities (McKay, Yates, & Johnsen, 2007). Clubhouse participants, typically adults with serious mental illness, are referred to as members, work side-by-side with program staff, and are involved in all aspects of clubhouse operations including decision-making and leadership efforts (Fountain House, 1999; McKay et al., 2012).

The smoking cessation intervention at this Clubhouse included an eight-week wellness curriculum focused on tobacco use, nutrition, and exercise. Persons who graduated from the wellness curriculum were able to join smoking cessation classes, which were offered twice a week for eight-week cycles. Clubhouse staff received training and led the tobacco cessation groups. Within the first year, the Clubhouse hired two peer leaders to support staff efforts. The peer leaders had both been tobacco free for at least six months. They provided additional support for members who had recently quit smoking through daily phone calls and support groups. The Clubhouse held health fairs focused on the risks of tobacco use, provided access to tobacco cessation medications, and made environmental changes to promote non-smoking. The two articles describing this effort are primarily descriptive and include details about program implementation. The authors indicate that they were able to influence culture change with regard to tobacco use and that members were supportive of these new interventions but they do not provide information regarding satisfaction among participants. The authors also did not provide data regarding the number of individuals who participated in the interventions, the number of individuals who reduced tobacco use or quit smoking, or how the peer providers contributed to the effectiveness of the program.

Another intervention involving peers to support smoking cessation is described by Ashton, Miller, Bowden, & Bertossa (2010). The "South Australian Tobacco and Mental Illness Project" was funded by the Australian government tobacco control and the South Australia Cancer Council. Ashton and colleagues describe program implementation and report quit rates assessed at the end of the study intervention and at 12 month follow-up. The intervention was a group smoking cessation or reduction program that was open to persons who wanted to reduce or quit using tobacco and who received services at community mental health centers in a large urban area in Australia. The smoking cessation group was facilitated by mental health workers and peer workers; the latter were persons with a mental illness and a personal experience of quitting tobacco. The content of the group included material from standard tobacco cessation interventions that was tailored for individuals with mental illness who may have problems with cognitive functioning. Groups were offered weekly for 10 weeks and were two hours in duration. The groups covered topics including managing mental health, boredom and stress, and building confidence and coping strategies. Course leaders used carbon monoxide meters to measure tobacco use and provided individual telephone counseling; eight weeks of nicotine replacement therapy was provided to anyone requesting it.

A total of 226 smokers registered interest in the program. Participants smoked approximately 30 cigarettes per day at baseline. Ashton and colleagues followed participants for 12 months and used self-reported smoking status to determine changes in tobacco use. At the 12-month follow-up, approximately 81% of the registered participants had attended at least one educational session. Among participants who attended at least one session, there was a significant decrease in tobacco consumption with almost a third quitting tobacco for at least thirty days. Almost half (47%) of registered participants attended 10 or more sessions and approximately 20% of this group reported being abstinent at the 12-month follow-up. Participants who attended more sessions were more successful at the 12-month follow-up. In their feedback, participants highlighted the peer leader as especially helpful as a role model. The participants noted that the peer worker enabled them to feel more confident since the peer leader was living proof that having a mental illness was not a barrier to quitting tobacco. The participants also appreciated the suggestions that the peer providers offered from the peers' own experiences.

A third smoking cessation intervention in which peer providers have been included is the "Breathe Easy, Live Well" program offered at nine Clubhouse settings in North Carolina (Lee et al., 2011). The program was developed and funded by the North Carolina Health and Wellness Trust Fund and the North Carolina Southern Regional Area Health Education Center. The program is based on a modified version of the "Learning about Healthy Living" curriculum developed at the University of Medicine and Dentistry of New Jersey (Williams et al., 2009; Williams, Zimmermann et al., 2011).

Learning About Healthy Living is comprised of two educational groups for tobacco cessation that are led by a clinician. Group I is an educational and motivational-based intervention useful for all smokers with serious mental illness that promotes wellness and interest in quitting tobacco. Group I participants learn about risks associated with tobacco use, benefits of and ways to quit using tobacco, and healthy behaviors. Learning About Healthy Living Group I occurs over twenty weeks and addresses topics such as the dangers associated with smoking; why people with serious mental illness smoke; the cost of smoking; what's in cigarette smoke and second hand smoke; how medications are affected by smoking; why cigarettes are addictive; quitting smoking; managing stress; physical activity; and healthy foods.

The Learning About Healthy Living Group II, "Quitting Smoking," is for highly motivated smokers with serious mental illness who want to set a quit date and try to quit smoking. Group II emphasizes action-based techniques for quitting that improve success and reduce the risk of relapse. Group II encourages the use of FDA approved medications for tobacco cessation with group support and individual collaboration with the primary care physician or psychiatrist. Activities within Learning About Healthy Living Group II include the tobacco quit plan, preparing to quit, identifying supports, triggers for tobacco use, dealing with setbacks, and celebrating success. In this modified version of the traditional Learning About Healthy Living program implemented by the North Carolina Clubhouses, group facilitators were Clubhouse staff members and peer consumers rather than clinicians and they participated in a two-day training prior to leading the groups. The criteria for peer leaders are not described in the report and the authors do not provide information regarding the number of peers who participated in the two-day training. In another departure from the traditional Learning About Healthy Living model, Clubhouse staff expanded on the content in Learning About Healthy Living to include more information about wellness and to make the activities more interactive. Eight Clubhouses successfully implemented the modified Learning About Healthy Living program and 271 members participated. The research team conducted interviews with Clubhouse staff ($n=12$) and Clubhouse members ($n=157$) upon

completion of the program to examine curriculum implementation, satisfaction with the activities, perceived barriers, and reported changes in tobacco use.

Twenty-five percent of members participated in 12 or more educational sessions and over 70 percent of members surveyed described the modified Learning About Healthy Living program as helping them become healthier. Almost three quarters (71%) of members who had used tobacco within the prior week indicated that they reduced or quit using tobacco because of the curriculum. Eighty two percent of members ($n=72$) reported having greater awareness of the harmful effects of second hand smoke and 69% of tobacco users ($n=71$) indicated they were more likely to talk with their medical providers about quitting because of the Learning About Healthy Living program.

Four Clubhouses implemented tobacco use policies and 62% of tobacco users ($n=73$) indicated that members were interested in new tobacco-free areas at the program. Seventy percent of tobacco users ($n=68$) reported that having tobacco free policies would make quitting easier, and 84% of tobacco users ($n=70$) indicated that they would continue to participate in the Clubhouse even if the Clubhouse did not allow tobacco use in the building or on the grounds.

This article does not report specific details about the peer leaders' implementation of the curriculum. The evaluation did not include a pre-test survey of participating members, and members who did not complete the program were not included in the post-program survey. Interviews with Clubhouse staff upon completion of the modified Learning About Healthy Living curriculum highlighted the importance of social supports for quitting tobacco and the existence of barriers, particularly with regard to accessing FDA-approved medications for tobacco cessation. The findings indicate that the curriculum was well received and that organizational changes were implemented because of the activities promoting tobacco cessation.

The final intervention we identified in the literature, "Consumers Helping Others Improve their Condition by Ending Smoking" or "CHOICES," is a multi-faceted peer-based educational intervention that utilizes peers as outreach workers and as advocates for smoking reduction. In contrast to the other interventions included in this review, this program uses peer providers exclusively and their roles are well described in the literature. Consumers Helping Others Improve their Condition by Ending Smoking is funded by grants from several sources including the New Jersey State Division of Mental Health Services, the Cancer Institute of New Jersey, and the American Legacy Foundation. The program involves trained peer leaders encouraging other individuals with serious mental illness to make healthy lifestyle changes and reduce their tobacco use. Peer leaders deliver education about smoking at local mental health programs, disseminate information about smoking to persons at these programs, and help other consumers to access tobacco treatment (Williams, 2007). These consumer leaders also provide brief individual counseling sessions to interested persons at the mental health programs, giving motivational feedback about expired carbon monoxide from tobacco use and about the cost of tobacco products. In addition, the Consumers Helping Others Improve their Condition by Ending Smoking leaders organize activities such as health fairs and "smoke-out" cessation days at mental health programs. These peer leaders are all mental health consumers with a minimum of one-year being tobacco free. They must also have a vehicle and a valid driver's license. All receive a 30-hour intensive training on being an advocate and working with peers, strategies for presenting tobacco health information, and facts about tobacco dependence, along with a detailed manual, to provide them with the knowledge and the skills for the job. Consumers Helping Others Improve their Condition by Ending Smoking peer leaders (also called

Consumer Tobacco Advocates) are employed part time and they receive a fixed monthly stipend for their services.

Evaluation of this program indicates that Consumers Helping Others Improve their Condition by Ending Smoking peer leaders connected with over 10,000 smokers diagnosed with serious mental illness in the period between approximately 2005 and 2010 (Williams, Dwyer et al., 2011; Williams, Zimmermann et al., 2011). Williams, Dwyer and colleagues (2011) followed a sample of 102 outpatient smokers with serious mental illness who received the Consumers Helping Others Improve their Condition by Ending Smoking peer intervention. Participants smoked an average of 19 cigarettes per day, had a mean of three quit attempts, and smoked for an average of twenty-five years. The average age when participants first began smoking was 15 years.

Williams, Dwyer and colleagues (2011) conducted interviews with participants by telephone at one-month and six-month follow-ups after the Consumers Helping Others Improve Their Condition by Ending Smoking peer intervention. At the one-month follow-up ($n=86$), participants had a significant reduction in the average number of cigarettes smoked per day going from an average of 19 to 13 cigarettes per day. Twenty-nine percent ($n=25$) of participants made a quit attempt in the month following the Consumers Helping Others Improve their Condition by Ending Smoking intervention and 47% of participants made reductions in tobacco use. Over half (55%) of the participants indicated they were thinking about making a quit attempt within the next six months.

Participants also provided positive feedback about the Consumers Helping Others Improve Their Condition by Ending Smoking consumer tobacco advocates regardless of whether they made quit attempts. The majority of participants (83%) felt the consumer advocates were interested in their smoking; 71% said it was easier to talk about smoking with a consumer advocate than it would be to discuss it with their psychiatrist.

The fifty nine percent of the 60 participants who completed the six-month follow-up interview provided findings that were similar to those at the one-month follow-up. Forty-seven percent ($n=28$) of the participants in the six-month follow-up made a quit attempt in the six months following the Consumers Helping Others Improve their Condition by Ending Smoking peer session. Forty-two percent of the participants in the six-month follow-up indicated they were thinking about making a quit attempt within the next six months. The authors do not provide data regarding the number of peers that were trained as Consumer Tobacco Advocates or the number of peers that are currently serving as peer leaders.

DISCUSSION

Overall, this review revealed several interventions that include peer providers for tobacco cessation for persons with serious mental illness that have been described in the literature. The interventions identified in our review were supported by funds from health services departments within state or national governments or grant funding from private foundations. However, the number of such interventions is small, they have not been implemented in a broad range of mental health programs, the roles of the peers are typically not described in detail, and the interventions have been subject to only limited evaluation. None of the interventions that we identified in our review have been subjected to more rigorous evaluation methods including quasi-experimental or experimental designs that would allow the intervention to meet minimum qualifications for inclusion on evidence-based practice registries such as the Substance Abuse and Mental Health Services Administration's National Registry of Evidence Based Practices and Programs. Nor have the interventions been scrutinized by research studies funded by major granting organizations within the

United States Federal Government such as the National Institute of Mental Health or the National Institute on Drug Abuse.

Future publications would benefit from the inclusion of more details about peer-delivered components of smoking cessation programs for persons with serious mental illness. For example, it would be helpful to have more information regarding the criteria for becoming a peer provider for tobacco cessation, the strategies for engaging peers as tobacco cessation providers, and the number of individuals that have become or currently serve as peer providers in each intervention. Also useful would be historical and demographic information about the peer providers, the types of training and/or ongoing support provided to these individuals, attrition rates of peer providers in tobacco cessation programs, and data about their experience in this peer provider role. It also needs to be determined how peer providers contribute to the overall effectiveness and cost-effectiveness of these tobacco cessation interventions, as the interventions described, with the exception of the Consumers Helping Others Improve Their Condition by Ending Smoking program, involved a combination of peer and other providers.

It is of note that a number of peer-based approaches to smoking cessation that have been described at professional meetings or in electronic communications were not identified in our review (Table 2). For example, while we found articles describing tobacco quit lines in our initial search (Ferron et al., 2011; Morris et al; 2009), we did not find any articles that described a quit line staffed by peer counselors or other types of peer-driven tobacco cessation interventions for adults diagnosed with serious mental illness. In addition, our review did not yield published articles describing the impact of some emerging peer-based tobacco cessation interventions such as the Australia SANE model; the Peer-to-Peer Tobacco Program at the University of Colorado Denver; The University of California, San Francisco's Rx for Change online peer training Tobacco Free for Recovery Program; or the Promoting Healthy Lifestyles in ICCD Clubhouses approach (Australia SANE, 2009; Behavioral Health and Wellness Program, University of Colorado Denver, 2011; American Legacy Foundation, 2011; Schroeder & Morris, 2010). It may be that these interventions are so new that there has not been ample time to implement them, evaluate their impact, and publish findings in the professional literature.

Nevertheless, results from the articles that we were able to locate in this review suggest that peer co-leaders for tobacco cessation educational groups, peer individual counselors, and peer tobacco advocates are promising roles for peer providers and may contribute to reductions in tobacco use. Ongoing peer support may also have the potential to help persons with serious mental illness who have successfully quit using tobacco remain abstinent. Clearly more resources need to be directed towards tobacco cessation services for this population. Given the lack of widespread health promotion interventions in mental health settings and the extent of co-morbid health problems and tobacco related illnesses among adults with serious mental illness, we recommend that funding be directed towards this issue so that mental health programs can routinely address tobacco use and researchers can begin to evaluate their impact. Using peer supports to address tobacco use may be beneficial and is consistent with a recovery oriented approach. For example, addressing health and recovery efforts supported by peers are key elements in the United States Substance Abuse and Mental Health Service Administration's Recovery Support Strategic Initiative. However, interventions that attempt to improve health and address tobacco use among adults with serious mental illness have yet to receive funding to match the need for services in this area. Organizations that support recovery for adults with serious mental illness should consider advocating for funding for peer led tobacco cessation services. Additional studies, especially ones that include rigorous research methods, are necessary to provide a better understanding

of the role of peer providers in tobacco cessation services and their impact on reducing tobacco use and improving physical health in this population.

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Table 1**Peer Supports for Tobacco Cessation Interventions for Persons with Serious Mental Illness Identified in Our Review**

Intervention Description	Role of Peers	Citation(s)	Internet Link (where available)
An eight-week wellness curriculum focused on tobacco use, nutrition, and exercise at a New York Clubhouse Program. Health fairs, access to tobacco cessation medications, and environmental changes to promote non-smoking	Two peer providers made daily phone calls and led support groups.	Williams, Cain, Fredericks, & O'Shaughnessy (2006) O'Shaughnessy, Cain, & Fredericks (2008)	
Ten week smoking cessation groups in Australia. Individual telephone counseling; eight weeks of Nicotine Replacement Therapy for those requesting it.	Facilitators of smoking cessation groups.	Ashton, Miller, Bowden, & Bertossa (2010)	
Consumers Helping Others Improve Their Condition by Ending Smoking (CHOICES) involves trained peer outreach workers who disseminate information about smoking at mental health programs to encourage individuals with serious mental illness to make healthy lifestyle changes and reduce their tobacco use.	Peer leaders help consumers access tobacco treatment and provide brief counseling sessions and motivational feedback. Peer leaders organize health fairs and "smoke-out" cessation days at mental health programs.	Williams (2007) Williams, Dwyer et al. (2011) Williams, Zimmermann et al. (2011)	http://www.njchoices.org/
Learning About Healthy Living (modified)* educational groups for tobacco cessation. Group I is a motivational-based intervention for smokers with serious mental illness that promotes wellness and interest in quitting tobacco. Learning About Healthy Living Group II is for highly motivated smokers with serious mental illness who want to set a quit date and try to quit smoking.	Group facilitators or co-facilitators of the educational groups in the modified version of Learning About Healthy Living.	Williams et al. (2009) Williams, Zimmermann et al. (2011)	http://www.tobaccoprogram.org/healthyliving.htm
"Breathe Easy, Live Well" program offered at nine Clubhouse settings in North Carolina (Modified Learning about Healthy Living)	Group facilitators or co-facilitators of the educational groups in the modified version of Learning	Lee et al. (2011)	http://www.ncebpcenter.org/index.php?option=com_content&view=article&id=88&Itemid=68

Intervention Description	Role of Peers	Citation(s)	Internet Link (where available)
	About Healthy Living		

* Groups are typically led by a clinician

Table 2**Additional Resources for Tobacco Cessation Supports Involving Peers^{*}**

Intervention Description	Citation(s)	Internet Link(s)
The Peer-to-Peer Tobacco Dependence Recovery Program at the University of Colorado, Denver trains existing peer specialists to integrate tobacco cessation and wellness services to support and train other individuals with serious mental illness. Peers receive a two day training and ongoing technical assistance through a national listserv, conference calls, and web-based educational information. Peers create services, lead support groups, provide motivational interviewing, and give information and linkages to existing supports like 12-step groups or quit lines.	Behavioral Health and Wellness Program, University of Colorado Denver (2011) Schroeder, & Morris (2010)	http://www.bhwellness.org/initiatives/peer-to-peer/
The Tobacco Free for Recovery Program is a three hour online training tailored for peer providers in mental health settings that was designed by staff at the University of California San Francisco and faculty at Rx for Change. The training covers information about the different types of tobacco products, why they are addictive, FDA approved medications for tobacco cessation and strategies to help people quit using tobacco. This training presentation can be downloaded as a PDF.	Rx for Change (2011)	http://smokingcessationleadership.ucsf.edu/Downloads/oct_14_2009_webinar_slides.pdf
The Promoting Healthy Lifestyles in International Center for Clubhouse Development (ICCD) Clubhouses approach incorporates aspects of the Addressing Tobacco through Organizational Change (ATTOC); Learning About Healthy Living, and Consumers Helping Others Improve their Condition by Ending Smoking models. A clubhouse established weekly healthy living meetings and developed resources with input from clubhouse members (peers) including a 'Promoting Healthy	McKay, Ziedonis, & Williams (2011) American Legacy Foundation (2011)	http://umassmed.edu/uploadedFiles/cmhsr/Publications/RyCUtobaccoCessClubhouses.pdf http://www.legacyforhealth.org/PDF/A_Hidden_Epidemic.pdf

Intervention Description	Citation(s)	Internet Link(s)
Lifestyles Clubhouse Toolkit'. Peers were involved with all aspects of the interventions including co-leading educational meetings, as members of the leadership team to create organizational change with regard to tobacco use, activities on tobacco free days, and co-authorship of the clubhouse toolkit. These efforts resulted in the clubhouse establishing a tobacco free campus.		
SANE Australia produces publications and multimedia resources on mental illness and tobacco cessation including: The SANE Smoke Free Kit was developed with input from people living with a mental illness and mental health service providers. The kit is designed to be used by mental health or substance use service providers to help people with mental illness quit smoking. This is an eight session interactive educational program that includes aspects of motivational interviewing and cognitive behavioural therapy. The Smoke Free Kit includes the SANE Guide to a Smoke Free Life, which is designed for people with a mental illness. These materials are available for purchase on the SANE website.	Australia SANE (2009)	<i>SANE SmokeFree Kit</i> <i>SANE Guide to a Smokefree Life</i>

* Peer supports for tobacco cessation that did not have published findings at the time of our review and which describe the role of peers