

Mobilizing Clinicians' Motivation to Intervene with their Clients who use Tobacco

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*Living Well: Strategies for Tobacco Free Recovery
Santa Monica, CA*

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Clarifying Expectations

- What brought you to this session?
- What are you looking for?
- What are your experiences thus far in trying to help people to stop smoking?
- How many of you are from fully tobacco free facilities?
- How many of you offer intensive tobacco dependence interventions in your facility?



Objectives

- To discuss evidence-based pharmacological & counseling strategies for those who are tobacco dependent
- To describe an intensive tobacco dependence intervention program for those with psychiatric disorders
- To describe the APNA/SCLC performance partnership model



Where are we?

- We have made progress *BUT*:

TOBACCO DEPENDENCE REMAINS THE LARGEST PREVENTABLE CAUSE OF DEATH & DISABILITY WORLDWIDE

- Smoking is concentrated in subpopulations of those with mental illnesses and/or substance use disorders



Prevalence rates by diagnostic category across studies (Morris et al., 2009)

- Major depression • 36-80 %
- Bipolar disorder • 51-70 %
- Schizophrenia • 62-90 %
- Anxiety disorders • 32-60 %
- PTSD • 45-60 %
- ADHD • 38-42 %
- Alcohol abuse • 34-93 %
- Other drug abuse • 49- 98 %



Factors linked with high smoking rates

See *Counseling Points*, Vol.1, Number 1, 2010

- Genetic predisposition
- Nicotine effects
- Boredom
- Smoking part of culture
- Used as a reward in some psychiatric settings
- May negate some antipsychotic agents' side effects
- Increased sensitivity to nicotine withdrawal
- Lack of social support
- High unemployment rates & poverty
- Relatively low education levels



Genetic vs. Environmental Influences on Smoking

Increasing evidence that there are inherited vulnerabilities to nicotine addiction and differences in abilities to quit

May allow tailored treatments

- focusing on dopamine and noradrenergic systems in the brain
- suggests long-term treatment may be needed

(Benowitz, 2008)



The nature of nicotine addiction

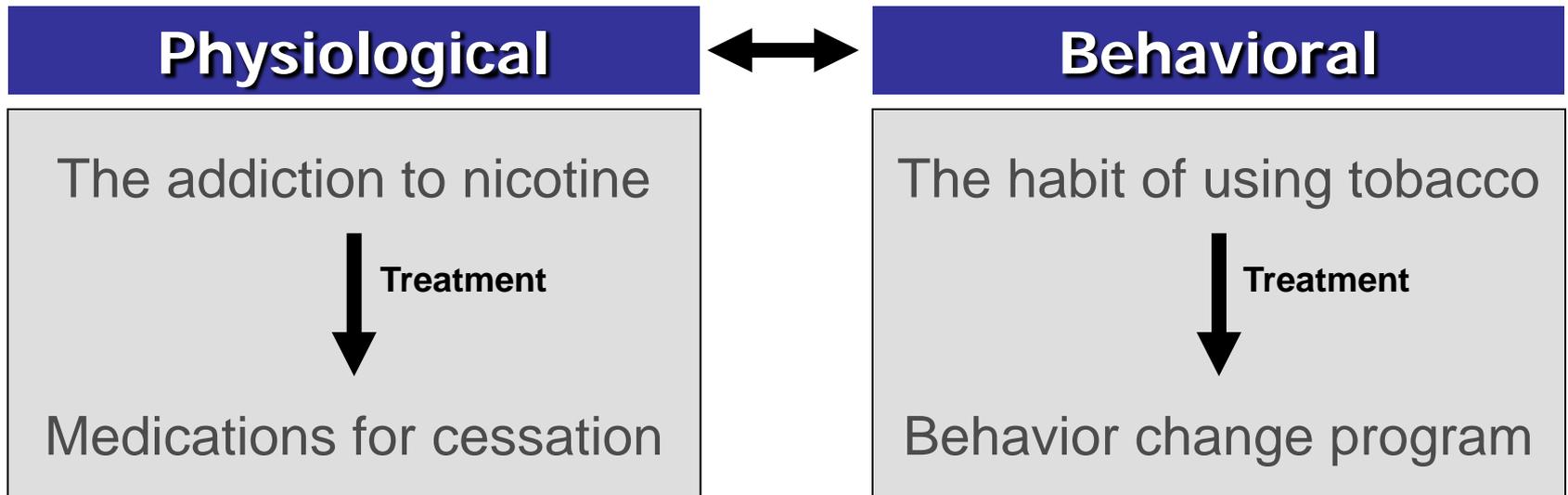
Of all the substances of abuse, nicotine has the highest probability of causing dependency when one has tried it at least once; nicotine may be the most addicting substance known.

(Stahl, 2008)



Tobacco Dependence Treatment

Tobacco Dependence



Treatment should address the physiological *and* the behavioral aspects of dependence.

Fiore et al. 2008; rxforchange/ucsf



Treating Tobacco Use And Dependence

CLINICAL PRACTICE GUIDELINE
2008 UPDATE

U.S. Department of
Health and Human Services
Public Health Service

2008 Guideline: 5/7/08



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PHS Guideline for Treating Tobacco Use & Dependence

- Highly significant health threat
- Disinclination among clinicians to intervene consistently
- Presence of effective interventions



Fiore et al., 2008



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Types of Interventions

(Fiore et al., 2008)

- **Briefer**

- 3-10 minutes
- Targets smokers who are willing, unwilling, and those who recently quit

- **More intensive**

- Total clinician-client time > 30 minutes with at least 4 sessions
- Tend to be coordinated by tobacco dependence specialists
- May use multiple clinician types & formats



Recommended Clinical Approaches

- ▶ The “5 A’s including STAR” for patients willing to make a quit attempt
- ▶ The “5 R’s” for patients unwilling to make a quit attempt at this time
- ▶ Relapse prevention for patients who have recently quit
- ▶ Intensive interventions should be provided when possible
- ▶ Health care administrators, insurers, and purchasers should institutionalize guideline findings

(Fiore et al., 2008)



The “5 A’s”

For Patients Willing to Quit

(Fiore et al., 2008)

- **ASK** about tobacco use
 - ▶ **ADVISE** to quit in clear, strong, personalized message
 - ▶ **ASSESS** willingness to make a quit attempt
 - ▶ **ASSIST** in quit attempt
 - ▶ Develop quit plan
 - ▶ Recommend medication unless contraindicated
 - ▶ **STAR: Set date; Tell others; Anticipate challenges; Remove tobacco products**
 - ▶ **ARRANGE** for follow-up



The “5 R’s”

For Patients Unwilling to Quit

(Fiore et al., 2008)

- ▶ **RELEVANCE** of quitting: Tailor advice & discussion
- ▶ **RISKS** of continued smoking: Ask person to identify negative consequences
- ▶ **REWARDS** of quitting: Ask person to identify potential benefits
- ▶ **ROADBLOCKS** to quitting: Identify barriers & problem--solve
- ▶ **REPEAT**: Reinforce motivational message at every visit



Components of Intensive Counseling

- ***Pharmacotherapy***
 - **Problem solving & skills training**
 - educate about withdrawal /toxicity
 - teach coping strategies
 - **Ongoing interpersonal support**
 - be positive, encouraging, & compassionate
 - **Mobilizing support from others**
 - Quitline at 1-800-QUIT-NOW
 - Family/friends education
- (Fiore et al., 2008)



Pharmacotherapy Interventions

All patients attempting to quit smoking should be encouraged to use effective pharmacotherapy except under special circumstances

Fiore et al., 2008



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Nicotine Pharmacodynamics

Central nervous system

- Pleasure
- Arousal, enhanced vigilance
- Improved task performance
- Anxiety relief

Other

- Appetite suppression
- Increased metabolic rate
- Skeletal muscle relaxation

Cardiovascular system

- ↑ Heart rate
- ↑ Cardiac output
- ↑ Blood pressure
- Coronary vasoconstriction
- Cutaneous vasoconstriction

(Benowitz 1992, 1997, 2008)



NRT: Products

Polacrilex gum

- Nicorette (OTC)
- Generic nicotine gum (OTC)

Lozenge

- Commit (OTC)
- Generic nicotine lozenge (OTC)

Transdermal patch

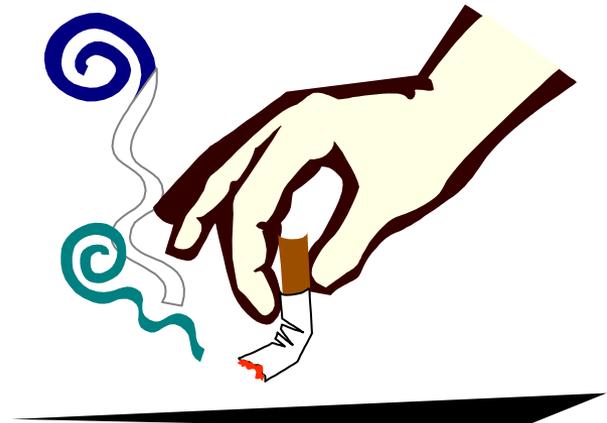
- Nicoderm CQ (OTC)
- Generic nicotine patches (OTC, Rx)

Nasal spray

- Nicotrol NS (Rx)

Inhaler

- Nicotrol (Rx)



Fiore et al., 2008



Tobacco is Carcinogenic

Nicotine, Although Addictive, is Not Carcinogenic

- Tobacco smoke contains greater than 60 carcinogenic agents and approximately 200 known toxins
- Smoking cigarettes with lower yields of tar has not been proven to decrease associated risks
- Nicotine is not carcinogenic
- Nicotine is the substance in cigarettes that causes addiction

Carcinogenic/Toxic Chemicals in Tobacco Smoke

Ammonia

Arsenic

Cadmium

Carbon monoxide

Formaldehyde

Hydrogen cyanide

Toluene

How Nicotine Replacement Therapies (NRT) Work

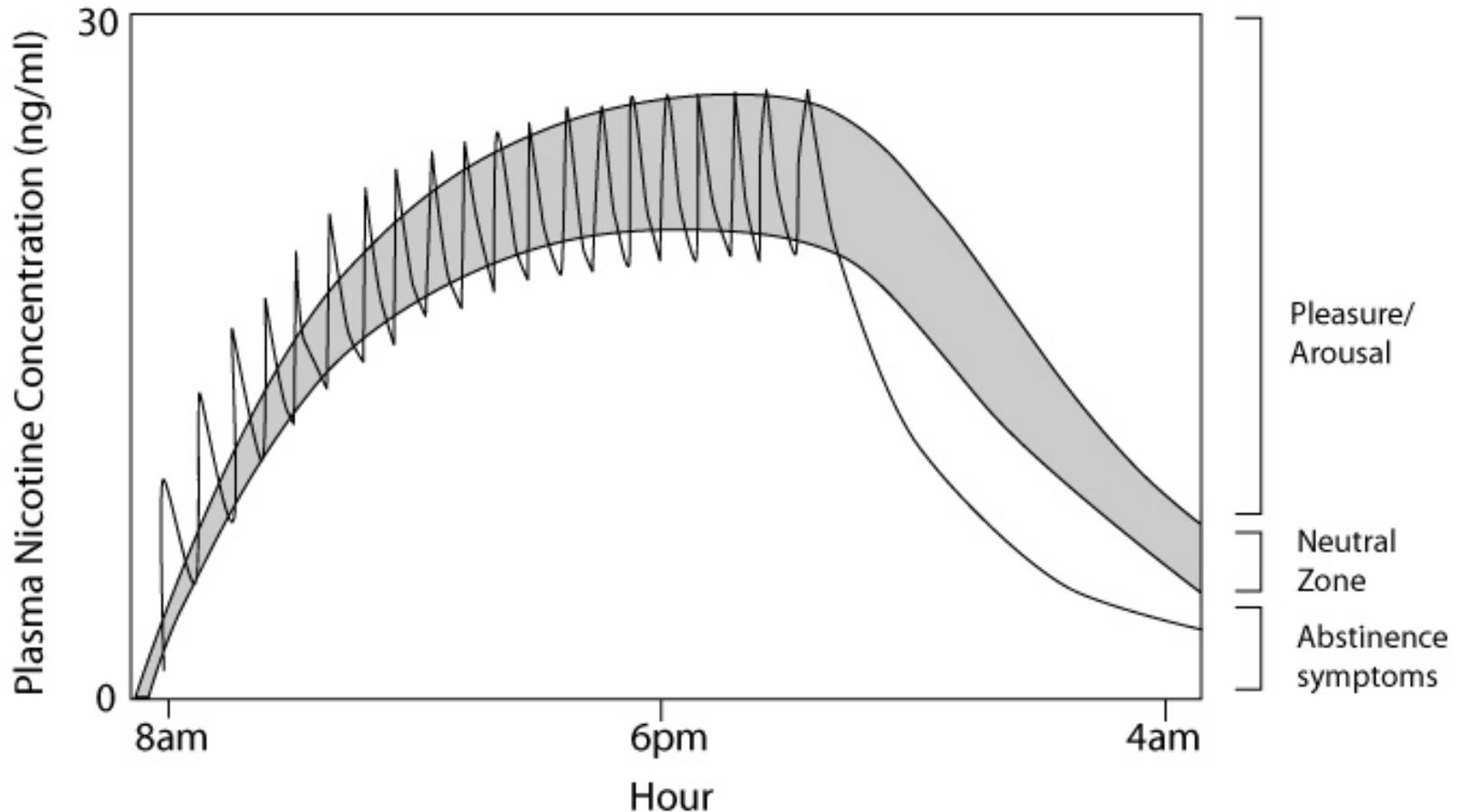
- Smoking stimulates $\alpha 4\beta 2$ receptors
- Receptors become desensitized within minutes (~one cigarette)
- Receptors re-sensitize after 45 minutes
➔ WITHDRAWAL symptoms
- NRT alleviates re-sensitization of nicotinic $\alpha 4\beta 2$ receptors responsible for withdrawal
- 20 cig/pack

Stahl, 2008



Nicotine Addiction Cycle

(Benowitz, 1992)



A Patient-Centered Approach to NRT Dosing

- **Estimate amount of nicotine patient is getting from smoking**
 - **Generally 1-1.5 mg. of nicotine/cigarette**
- **Cover with comparable NRT (often helpful to use a continuous + intermittent form of NRT) mindful that NRT is more slowly absorbed than nicotine from cigarettes; higher peak levels of nicotine result in higher subjective effects of nicotine; often need higher doses of NRT to achieve same effects**
- **Review signs/symptoms of potential side effects including information that combination NRT is not FDA approved/discuss risks & benefits**

Benowitz & Dempsey, 2004; Williams, G.C. et al., 2006



A Patient-Centered Approach to NRT Dosing

- **Teach patient signs/symptoms of nicotine withdrawal & nicotine toxicity**
- **On a scale of 0-3 (0=none; 1=mild; 2= moderate; 3= severe)**
 - ***Signs of withdrawal:***
 - Anxiety
 - Irritability
 - Difficulty concentrating
 - Cravings for cigarettes
 - ***Signs of toxicity***
 - Nausea
 - Sweating
 - Palpitations

Williams, G.C., et al., 2006



Nicotine Patch

- **Advantages:**

Easy to use, private, one per day, helps with early morning cravings

- **Disadvantages:**

Skin reactions, not orally gratifying, vivid dreams, insomnia

- **Dosage:** 4 weeks - 21mg/24hrs.

then 2 weeks - 14mg/24hrs.

then 2 weeks - 7mg/24 hrs.

- **Costs:**

\$4.25/day

Fiore et al., 2008



Nicotine Gum

- **Advantages:**

Orally gratifying, useful to offset cravings

- **Disadvantages:**

Poor taste, mouth soreness, dyspepsia, hiccups

- **Dosage:** Maximum dose: 24 pieces/day

patient smokes < 25 cigs/day: 2mg

patient smokes > 25 cigs/day: 4mg

**must use correctly: chew & park*

- **Costs:**

\$6.25/day (about 10 pieces)

Fiore et al, 2008



Nicotine Inhaler

- **Advantages:**
 - Mimics smoking, keeps hands & mouth busy**
- **Disadvantages:**
 - Mouth & throat irritation, coughing, rhinitis,**
 - Less effective below 40° F**
- **Dosage:** 6 – 16 cartridges/day
 - One cartridge lasts 20 min. continuous puffing**
 - Good for 24 hours if not used completely**
- **Costs:** \$6.00 -16.00/day

Fiore et al., 2008



Nicotine Nasal Spray

- **Advantages:**

Higher nicotine levels, fast relief for heavy smokers, rapid delivery of nicotine

- **Disadvantages:**

Nasal irritation, sneezing, coughing, runny nose

- **Dosage:** 1 – 2 doses/hour (in each nostril)

minimum dose: 8 doses/day

maximum dose: 40 doses/day

- **Costs:** \$5.00 -15.00/day

Fiore et al., 2008



Nicotine Lozenge

- **Advantages:**

 - Keeps mouth busy, easy to use in social situations

- **Disadvantages:**

 - Mouth/throat irritation, heartburn, indigestion, hiccups & nausea

- **Dosage:** minimum dose: 9 lozenges/day

 - 2mg: smokes 1st cigarette after 30 min. of waking

 - 4mg: smokes 1st cigarette within 30min.of waking

- **Costs:**

 - \$4.50/day

Fiore et al., 2008



Additional NRT Guidelines

- **Combining the nicotine patch & *ad libitum* NRT (nicotine gum/nicotine nasal spray) is more efficacious than a single form of NRT**
- **FDA has not approved combination NRT strategy**
- **Certain groups of smokers may benefit from extended use of NRT**
 - **Continued use of medication is clearly preferable to a return to smoking with respect to health consequences**
- **Risks/benefits analysis and patient preferences should inform pharmacotherapy choices**

Fiore et al., 2008



NRT: Precautions

- **Patients with underlying cardiovascular disease; package inserts recommend caution:**
 - Recent myocardial infarction (within past 2 weeks)
 - Serious arrhythmias
 - Serious or worsening angina
 - *There is no evidence of increased cardiovascular risk with NRT*
- **Other precautions**
 - Active temporomandibular joint disease (gum only)
 - Pregnancy/Lactation

Fiore et al., 2008



Common Beliefs about NRT

- Medications to stop smoking are too expensive
- One addiction may be traded for another
- Worry about the risks & safety of NRT
- Only 16% of those who smoke feel NRT helps people quit

(Bansal et al., Nicotine & Tobacco Research, 2004)



Bupropion SR

- **Advantages:**
Antidepressant, less weight gain,
FDA approved for maintenance therapy (6mos)
- **Disadvantages:**
May disrupt sleep, possible headaches, &
dry mouth, seizure risk
- **Dosage:** Begin 1-2 weeks prior to quit date
150mg q am for 3 days
Increase to 150mg b.i.d. (at least 8 hours apart)
- **Costs:** \$3.25/day

Fiore et al., 2008



Varenicline

Partial agonist selective for the nicotine acetylcholine receptor

- **Advantages:**

- Dual mechanism of action: agonist and antagonist effects

- **Disadvantages:**

Nausea, insomnia, vivid dreams, headaches; use with caution in patients with renal dysfunction

- **Dosage:** Begin 1 week prior to quit date to minimize nausea/insomnia
 - Days 1 – 3: 0.5 mg qd
 - Days 4 – 7: 0.5 mg bid
 - Days 8 – 28: 1 mg bid

An additional 12 wks recommended for those who quit
Adjust dose for renal insufficiency 0.5 mg/d for GFR < 30

*Should be taken after eating and with full glass of water

- **Costs:** \$3.30/day

Fiore et al., 2008



Varenicline: Public Health Advisory

- **FDA WARNINGS and PRECAUTIONS (February 2008)**
 - Serious neuropsychiatric symptoms
 - Changes in behavior
 - Agitation
 - Depressed mood
 - Suicidal ideation
 - Attempted and completed suicide
 - **Developed during Chantix therapy and during withdrawal of Chantix therapy**
 - **May cause recurrence or exacerbation of psychiatric illness**

Fiore et al., 2008



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Combination Pharmacotherapy

- Bupropion SR + NRT can be safely combined; considered a first line medication combination
- NRT should **NOT** be combined with Varenicline
- The safety of combining Bupropion & Varenicline has **NOT** been established

Fiore et al., 2008



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When people stop smoking

- May be at risk for medication toxicity
- The tar in smoke enhances P450 enzyme system
 - Increased 1A2 isoenzyme activity
- Smoking can increase metabolism of meds (decreased serum levels)
- Those who smoke tend to be on higher medication doses

Stahl, 2008



Drugs potentially affected by smoking

- Watch for signs of toxicity
 - Caffeine
 - Theophylline
 - Fluvoxamine
 - Olanzapine
 - Clozapine

Not a problem with NRT!

Fiore et al., 2008



Preventing Relapse

(Fiore et al., 2008)

- ▶ Relapse prevention interventions should be provided with every smoker who has recently quit
- ▶ Crucial to address relapse the first 3 months after quitting (6 months in SMI population)
- ▶ Strategies to use with recent quitters:
 - Encourage continued abstinence
 - Invite discussion of benefits, success milestones, problems encountered or anticipated
 - Use or refer to an intensive intervention as appropriate



Electronic cigarettes*

*e-Cigarettes

(*BMJ* 2010; 340:c311; FDA, 2010)

- Widespread & increasingly popular
- Potential safety concerns:
 - Toxic chemicals
 - Labeling inaccuracies
- September 9, 2010: FDA cited 5 electronic cigarette distributors: violations of the Federal Food, Drug, & Cosmetic Act (FDCA) including unsubstantiated claims & poor manufacturing practices



Any exposure = HARM

“There is no level of cigarette smoking or exposure to cigarette smoke that does not make the cells in your lungs sick; don’t think that smoking one or two cigarettes a week means you are home free.”

Dr. Ronald Crystal

Weill Cornell Medical Center, NY, NY

(Strulovici-Barel et al., 2010, *Am Journal of Respiratory & Critical Care Medicine*)



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Medications are often necessary but not sufficient:

People do best with properly dosed pharmacotherapy AND intensive tobacco dependence counseling

Fiore et al., 2008



Components of Intensive Counseling

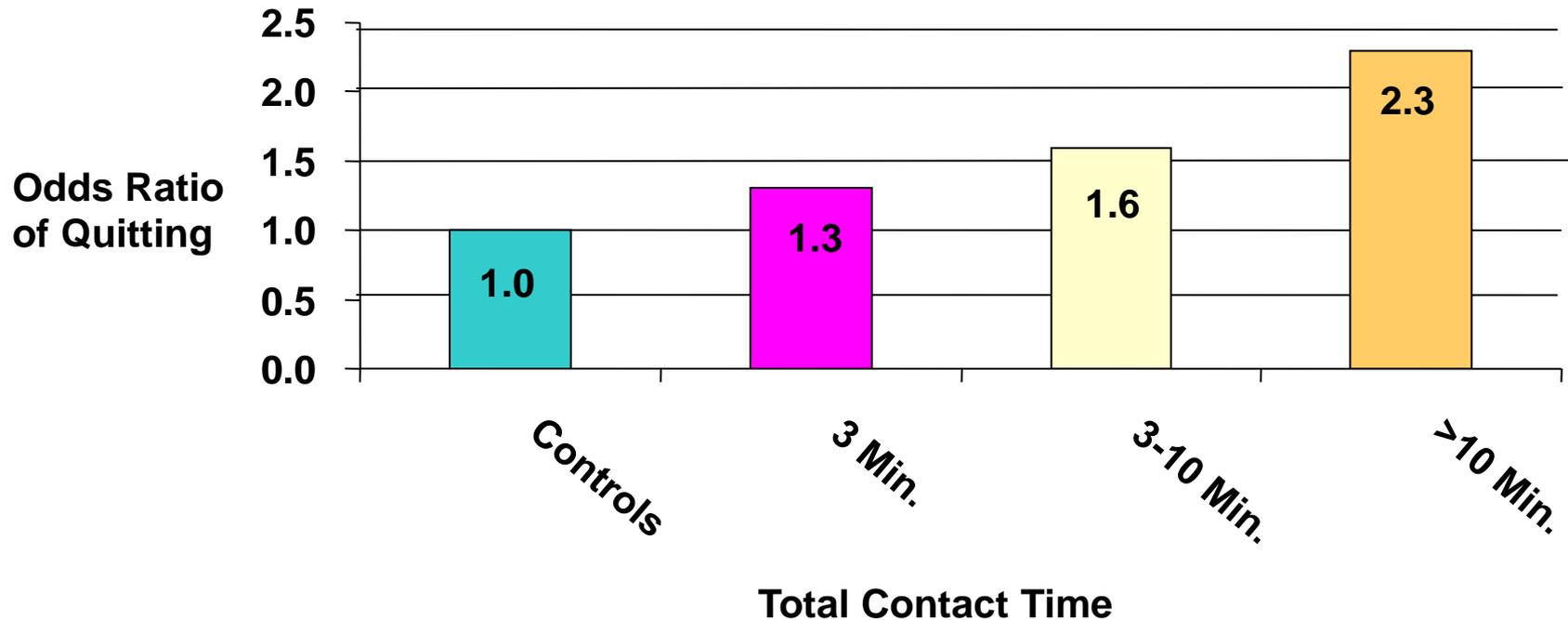
- **Pharmacotherapy**
- ***Problem solving & skills training***
 - educate about withdrawal /toxicity
 - teach coping strategies
- ***Ongoing interpersonal support***
 - be positive, encouraging, & compassionate
- ***Mobilizing support from others***
 - NYS Quitline at 1-866-NY-QUITS/1-866-697-8487
 - Family/friends education (Fiore et al., 2008)



Quitting Increases with Counseling

Strong dose-response relation between counseling intensity & cessation success

(Fiore et al., 2008)



Practical Counseling:

Skills building/problem solving and mobilizing social support

- Developing Quit Plans
 - Problem-solving
 - Skills building
 - Identifying sources of social support
 - Intratreatment (treatment team)
 - Extratreatment (family/friends; not included in 2008 PHS Guidelines)

Fiore et al., 2008



Process of Counseling

- Studies have shown that the way in which you counsel your clients makes a difference in how successful they are in changing health behaviors
- The ***PROCESS*** of counseling is as important as the ***CONTENT*** of the intervention

Williams et al., 2006



Smoker's Health Study

(Geoffrey Williams, MD, PhD, PI; funded by NIMH/NCI)

- Randomized Controlled Trial
- N = 1006 adults who smoked
 - Relatively disadvantaged (poor/undereducated)
 - More than half not initially ready to stop smoking
- Intervention
 - Integration of PHS guidelines/SDT
 - Targeted smoking and LDL cholesterol
- Sample excluded people with psychosis/bipolar disorder

Williams et al., 2006



Self-determination theory

(Deci & Ryan, 1985)

- Human beings intrinsically motivated toward health

Three psychological needs:

- Autonomy
- Competence
- Relatedness



Self-determination theory

(Deci & Ryan, 1985)

- Autonomous motivation:
 - Sense of volition
 - Self-initiation
 - Personal endorsement of behavior
- Controlled motivation:
 - Pressured by interpersonal or intrapsychic force



Self-determination theory

(Deci & Ryan, 1985)

Autonomy supportive care environments:

- Understand patient's perspective
- Acknowledge feelings
- Offer choices
- Provide relevant healthcare information



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Self-determination theory

(Deci & Ryan, 1985)



Autonomy supportive environments
enhance autonomous motivation



Self-determination theory

(Deci & Ryan, 1985)

- Controlling care environments:
 - Pressure patients to act in certain way
 - Threaten with information



Self-determination theory

(Deci & Ryan, 1985)



Controlling environments inhibit autonomous motivation



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Smoker's Health Study

(Geoffrey Williams, MD, PhD, PI; funded by NIMH/NCI)

- The clinical endpoint of the intervention was to guide the client to making a clear choice about whether he wanted to change or not (***support client's autonomy need***)
- If the client wanted to stop smoking or change diet then the clinician provided competence training on how to reach that goal (***support client's competence & relatedness needs***)



Smoker's Health Study

(Williams et al., 2006)

- **Results:**

- Those who received the autonomy supportive intervention (process), which also was based on the PHS guidelines for treating tobacco use and dependence (content) had significantly higher quit rates at 6 & 18 months than those in the comparison condition (who were encouraged to work with their primary care providers and community agencies)



Mobilizing Motivation:

Autonomy Support/Motivational Interviewing

- **Stay mindful of importance of psychological need satisfaction:**
 - Autonomy
 - Competence
 - Relatedness
- **Counselor-client relationship is a partnership (not expert/recipient)**
- **Elicit and acknowledge the client's perspective**
 - Listen well and reflect

Miller & Rollnick, 2002;
Williams et al., 2006



Mobilizing Motivation:

Autonomy Support/Motivational Interviewing

- **Advise client about the importance of stopping smoking to health in a clear but non-controlling manner**
 - Do not use information as a weapon/threatening manner
- **Provide health risks/benefits information; pharmacotherapy & quit plan options when invited/client signals readiness**
 - Ask permission
 - Check in with clients about how they are hearing the information
 - Provide rationale for suggestions you offer
- **Avoid willfulness and maintain neutrality**
- **Support client initiatives for change**

Miller & Rollnick, 2002;
Williams et al., 2006



FIVE KEYS FOR QUITTING

YOUR QUIT PLAN



1. GET READY.

- ▶ Set a quit date and stick to it—not even a single puff!
- ▶ Think about past quit attempts. What worked and what did not?



2. GET SUPPORT AND ENCOURAGEMENT.

- ▶ Tell your family, friends, and coworkers you are quitting.
- ▶ Talk to your doctor or other health care provider.
- ▶ Get group or individual counseling.
- ▶ For free help, call 1-800-QUIT NOW (784-8669) to be connected to the quitline in your State.



3. LEARN NEW SKILLS AND BEHAVIORS.

- ▶ When you first try to quit, change your routine.
- ▶ Reduce stress.
- ▶ Distract yourself from urges to smoke.
- ▶ Plan something enjoyable to do every day.
- ▶ Drink a lot of water and other fluids.
- ▶ Replace smoking with low-calorie food such as carrots.



4. GET MEDICATION AND USE IT CORRECTLY.

- ▶ Talk with your health care provider about which medication will work best for you:
- ▶ Bupropion SR—available by prescription.
- ▶ Nicotine gum—available over the counter.
- ▶ Nicotine inhaler—available by prescription.
- ▶ Nicotine nasal spray—available by prescription.
- ▶ Nicotine patch—available over the counter.
- ▶ Nicotine lozenge—available over the counter.
- ▶ Varenicline—available by prescription.



5. BE PREPARED FOR RELAPSE OR DIFFICULT SITUATIONS.

- ▶ Avoid alcohol.
- ▶ Be careful around other smokers.
- ▶ Improve your mood in ways other than smoking.
- ▶ Eat a healthy diet, and stay active.

1. YOUR QUIT DATE:

2. WHO CAN HELP YOU:

3. SKILLS AND BEHAVIORS YOU CAN USE:

4. YOUR MEDICATION PLAN:

Medications: _____

Instructions: _____

5. HOW WILL YOU PREPARE?

Quitting smoking is hard. Be prepared for challenges, especially in the first few weeks.

Followup plan: _____

Other information: _____

Referral: _____

Clinician

Date

USDHHS. (2010). At: <http://www.ahrq.gov/clinic/tobacco/tearsheet.pdf>.



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URSON Tobacco Dependence Intervention Program

Purpose: To deliver and evaluate an intensive multifaceted tobacco dependence intervention program designed to meet the special needs of those with SMI

Funded by NYS Tobacco Control Program, 2006-2009



Intensive Intervention

- Intensity increased in comparison to standard intensive interventions via:
 - Greater clinician time
 - More treatment sessions
 - More treatment formats
 - Multiple types
 - Longer-term pharmacotherapy intervention
 - NRT/Bupropion SR/Varenicline
 - Harm reduction strategies
 - Extended and repeated problem-solving/skills building
 - Enhanced intratreatment social support
 - Enhanced extratreatment social support

(Fiore et al., *Clinical Practice Guideline for Treating Tobacco Use & Dependence*, 2000)



Key intervention components

- Nurse practitioner in psychiatry coordinating program/direct care provider experienced RN
- Distinct from but connected to extant MH treatment program
- Ongoing exposure to multiple treatment components
 - Individual
 - Group
 - Milieu
 - Peer advocate
 - Family/significant other psychoeducation



Resource for Treatment Staff

- Offered individual or group intervention for staff who smoke
- Confidential
- Delivered at work site or off site at URSON (staff preference)



Assessment Measures

- Follow-up assessments
 - 3, 6, 12 months
 - Number of cigarettes smoked daily
 - 7 day point prevalence (PP; CO verified)
- Nurse encounter forms (tracking nurse activities)
- Qualitative interviews (initial slides)



Nurse Activities

- **Contact time:**
 - **< 10 minutes: 59%**
 - **10-20 minutes: 20%**
 - **> 30 minutes: 21%**
- **Most frequent form of contact: unscheduled, walk-in visits**
- **Point of contact:**
 - **Clients: 68%**
 - **Treatment team members: 22%**
 - **Group home staff, peers, family/friends: 8%**



Nurse Activities

- **Competence building (42%)**
 - Educating; problem solving/skills building, medications, withdrawal/toxicity symptoms; providing resources
- **Autonomy support (32%)**
 - Listening; rapport building
- **Mobilizing social support (10%)**
 - Advocating on behalf of the client; mobilizing social support; reaching out to potential clients
- **Team collaboration (7%)**
 - Consultation, referral, charting
- **Intervening re: general mental health issues (5%)**



Sample

- **Gender**
 - 45 women
 - 54 men
- **Race**
 - 62% majority
 - 38% minority
- **Age**
 - Median = 44 years
- **Relationship status**
 - 32 % partnered
- **Education**
 - 35% < high school
 - 37% high school education
 - 28% > high school education
- **Income**
 - 95 < \$20,000
 - 3 \$20,000-\$40,000

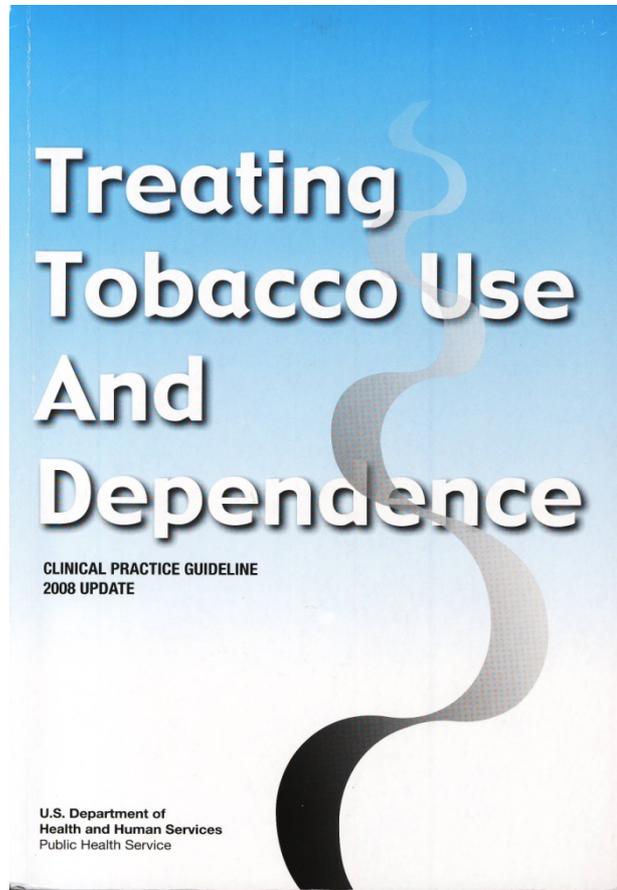


Smoking History

- **Average cigarettes smoked daily: 21**
- **Average years smoked: 24**
- **Average Fagerstrom score: 5.7 (moderately high)**
- **72 permitted to smoke on residence property**
- **70 wanted to quit within next 30 days**



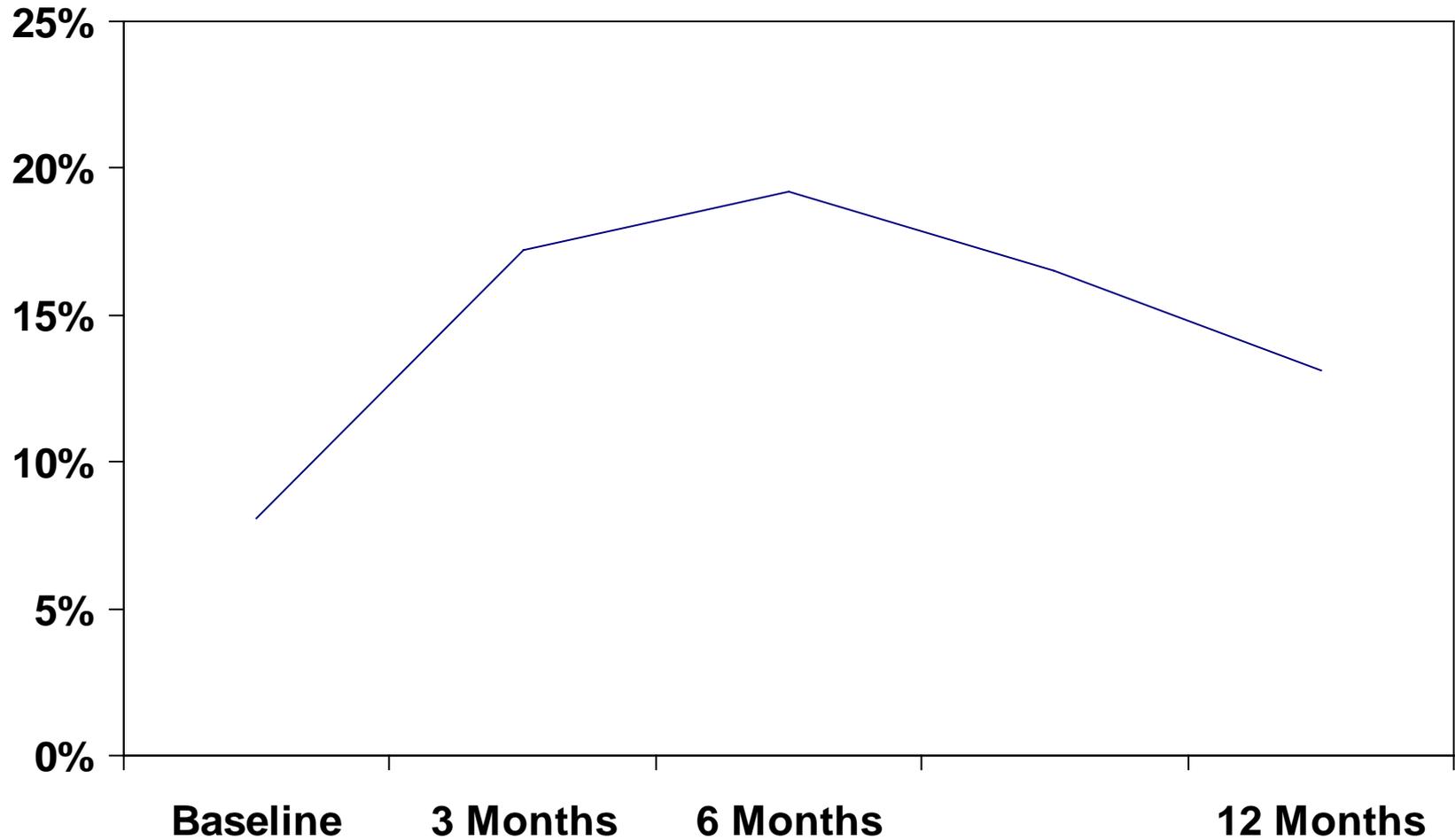
Cessation medications



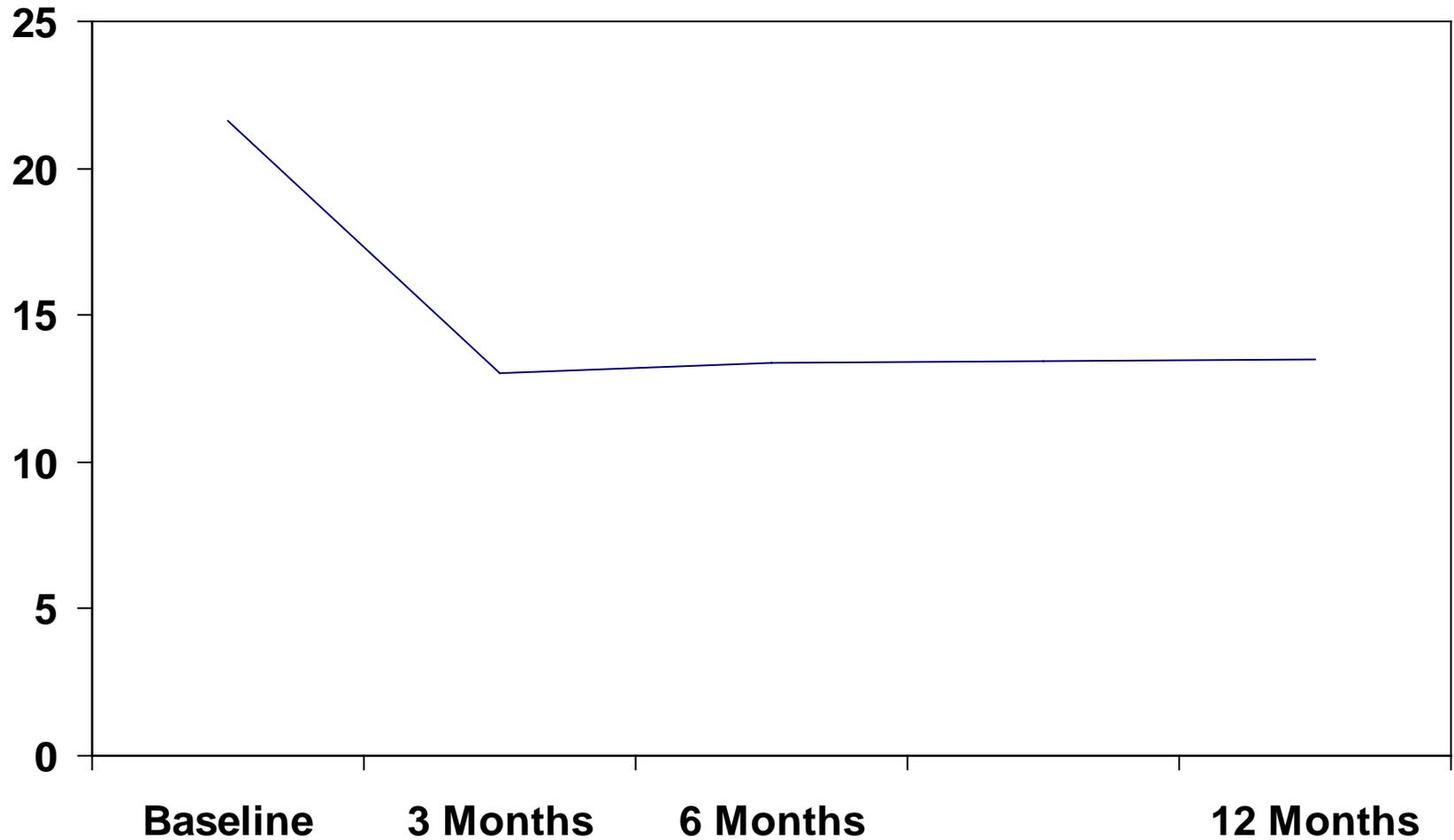
Patch	74%
Gum	86%
NS	16%
Inhaler	31%
Lozenge	12%
Zyban	40%
Chantix	24%



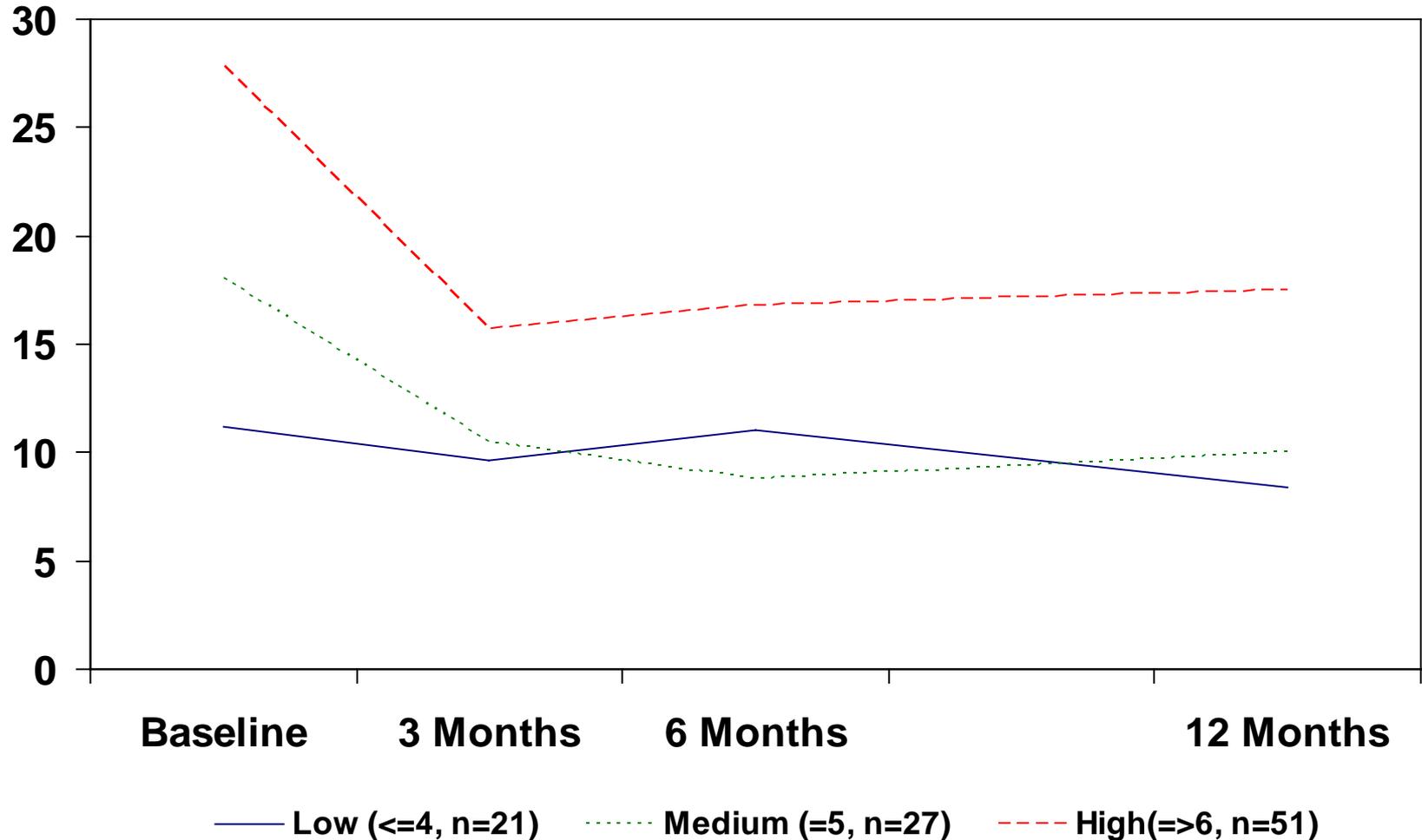
7-Day Point Prevalence Over Time



Cigarettes Smoked per Day



Cigarettes Smoked per Day by Dependence (Fagerstrom Score)



Tobacco Dependence Bundle

- **Smoke free facility with environmental cues to action**
- **At least 2 identified site champions, preferably from different disciplines**
- **All staff trained and competent in providing brief interventions**
- **Intensive interventions easily accessible/tailored for the mentally ill**
- **Access to sufficient supplies of pharmacotherapy (e.g. NRT)**
- **Intervention to assist staff who are tobacco dependent**



Our Experience in Building the Bundle

- **High demand (clinical program delivered to 276 clients, 99 of whom participated in evaluation)**
- **Space negotiations**
- **Staffing problems**
- **Sabotage**
- **Medication access**
- **Ask-Advise-Refer more likely with intensive program in place**



The Program Was Effective

- Despite roadblocks
- Went into a primed setting (partially built bundle)
 - Smoke free with environmental cues
 - Site champions
 - Some staff trained in brief interventions
 - Chart reminders



The Grant Has Ended; So Too Has The Program

The facility is back to its partially bundled status

Lack of interest in or motivation to continue to provide an intensive program

- **“If it doesn’t generate revenue, it doesn’t warrant space”**
- **“Medical morbidities from tobacco dependence are not charged to our cost center”**
- **The current emphasis on prevention and managing multiple chronic conditions is likely to help us provide more treatment for those who use tobacco and have psychiatric illnesses**





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American Psychiatric Nurses Association



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- **Fall 2007: Smoking Cessation Leadership Center (SCLC) contacted APNA to explore partnership**
- **APNA Board of Directors convened Tobacco Dependence Task Force**
- **National call inviting participation**
- **APNA members surveyed**
- **February 2008: Smoking Cessation Performance Partnership Summit, Leesburg, VA**





TASK FORCE CHARGE:

Develop a nationwide strategic plan designed to strengthen the scope and effectiveness of psychiatric nurses' interventions with their clients who smoke



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Performance Partnership Model:

- *Where are we now?*
- *Where do we want to be?*
- *How do we get there?*
- *How will we know we are getting there?*





PERFORMANCE PARTNERSHIP MODEL:

Where are we now?



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APNA Tobacco Dependence Survey

- Design: Cross sectional analysis of 29-item online survey
- Sample: APNA members accessible by email in early 2008
- Measures: Anonymous, Survey Monkey
 - 10-15 minute completion time
 - 2 email reminders

(Sharp, Blaakman et al., 2009)



APNA Tobacco Dependence Survey

- Analyses:
 - Descriptive statistics
 - T-tests (continuous); Chi-square (nominal), Kendall's tau (ordinal) to compare nurses referring to cessation resources vs. non-referrers & nurses involved with intensive interventions vs. those not involved

(Sharp, Blaakman et al., 2009)



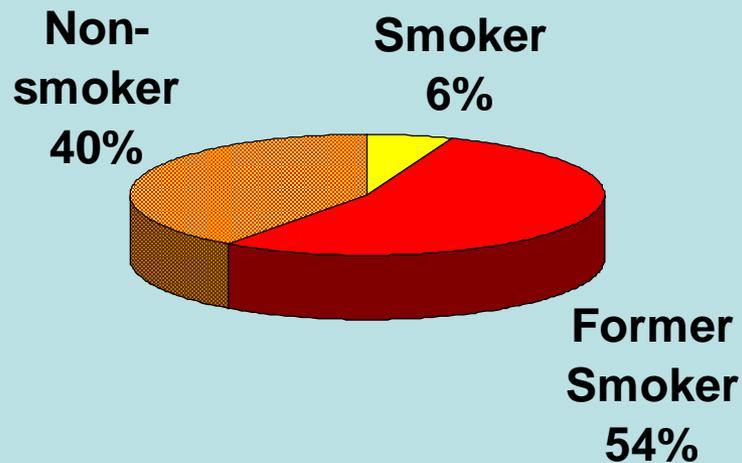
Survey Results

- 4000 surveys emailed; 1365 responded
 - **31.6% response rate**
- 45% > 20 yrs PMH RN; 17.2% < 5 yrs
- 35% BSN; 54.5% MS; 9.6% PhD/DNP
- 23% Staff RN; 32.4% APN; 17.3% Faculty
- 42.8% Inpatient; 33% Outpatient; 17.3% Faculty

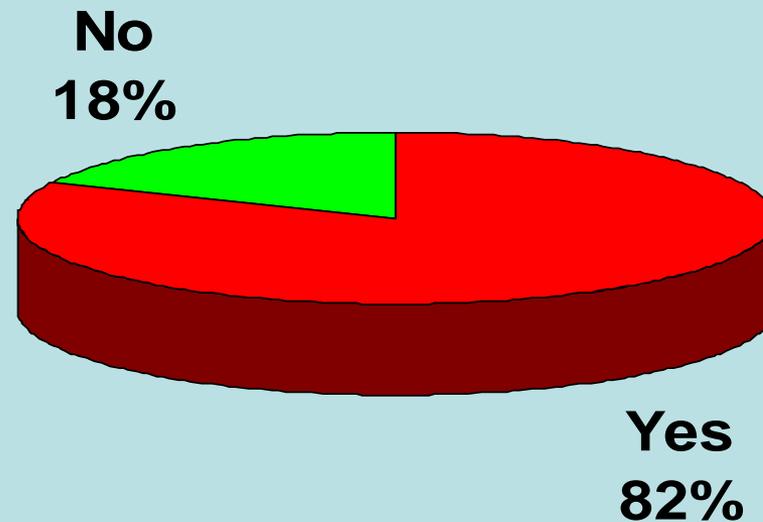
(Sharp, Blaakman et al., 2009)



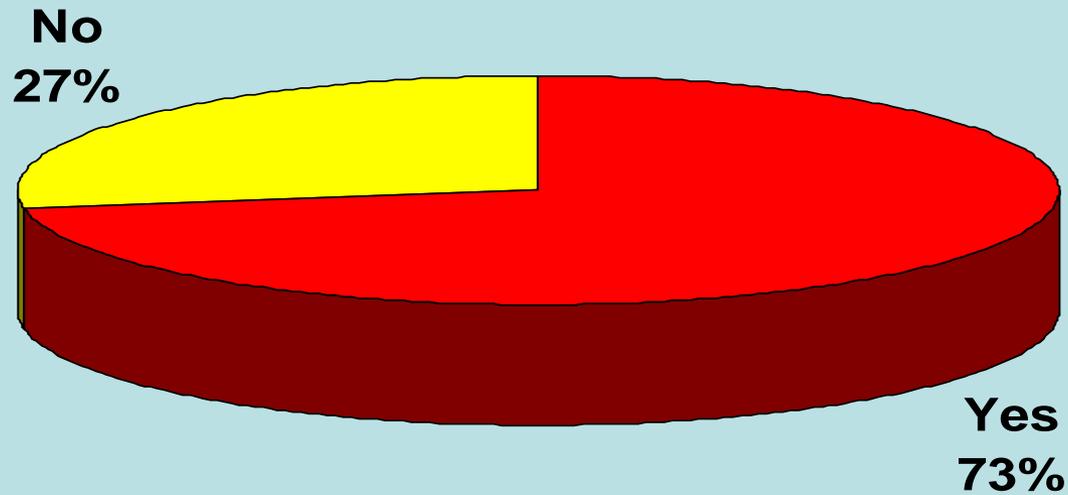
Nurses' Smoking Status



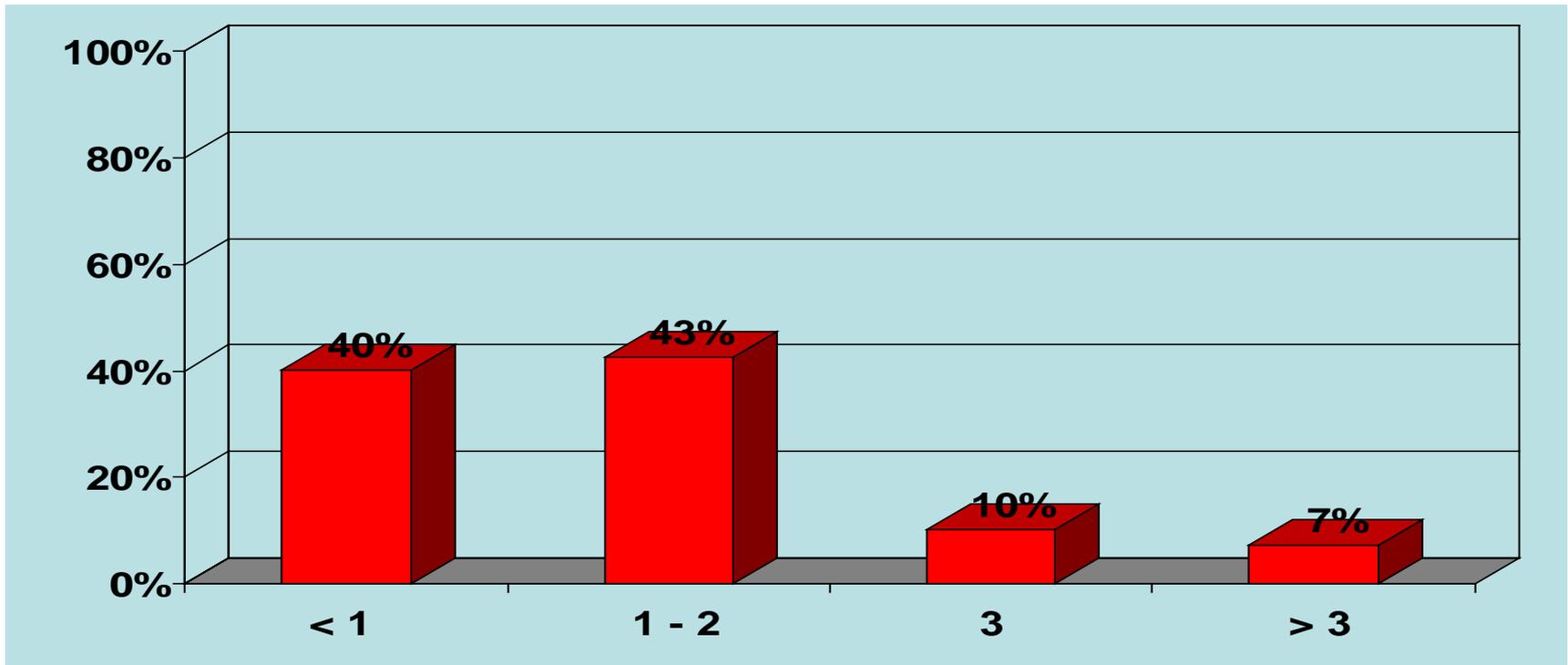
Smoke-Free Workplace



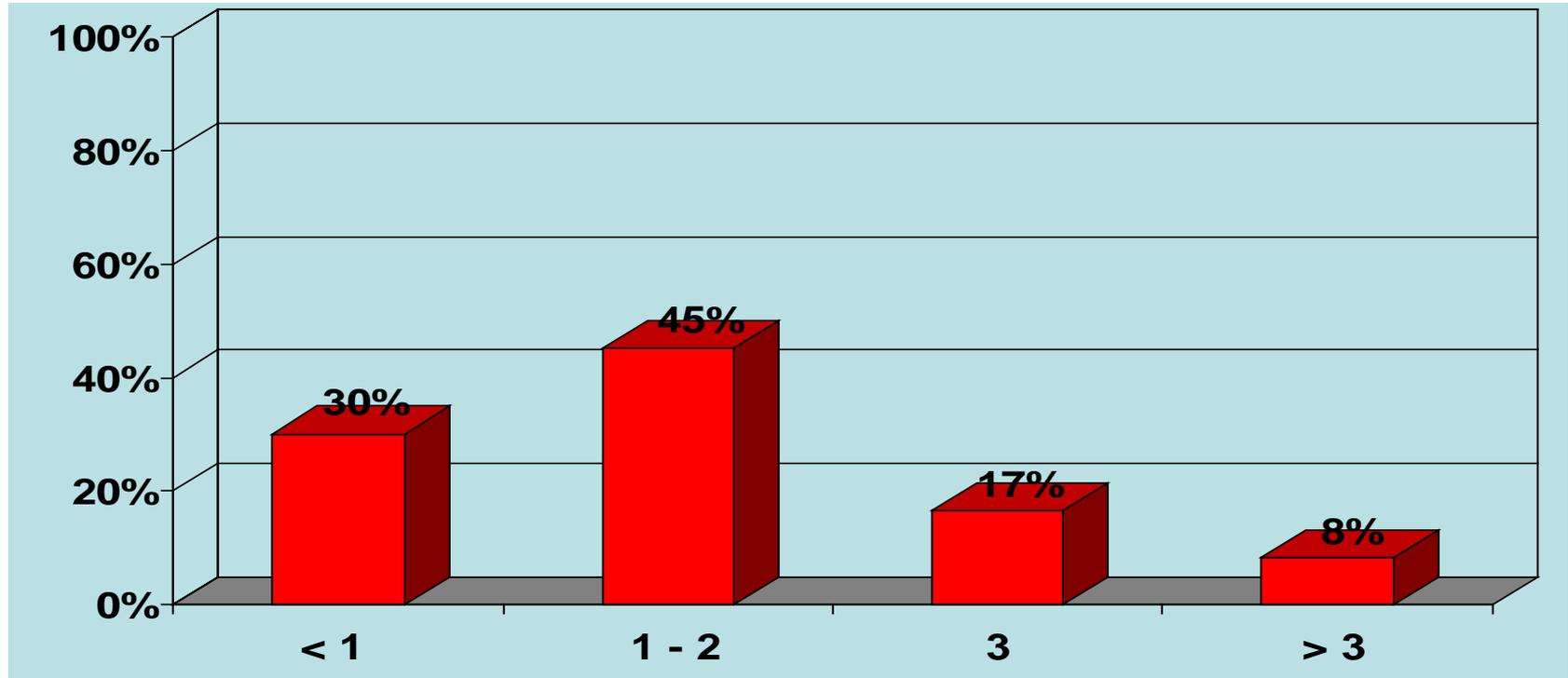
Necessary Part of Recovery from MI or Addictive Disorders?



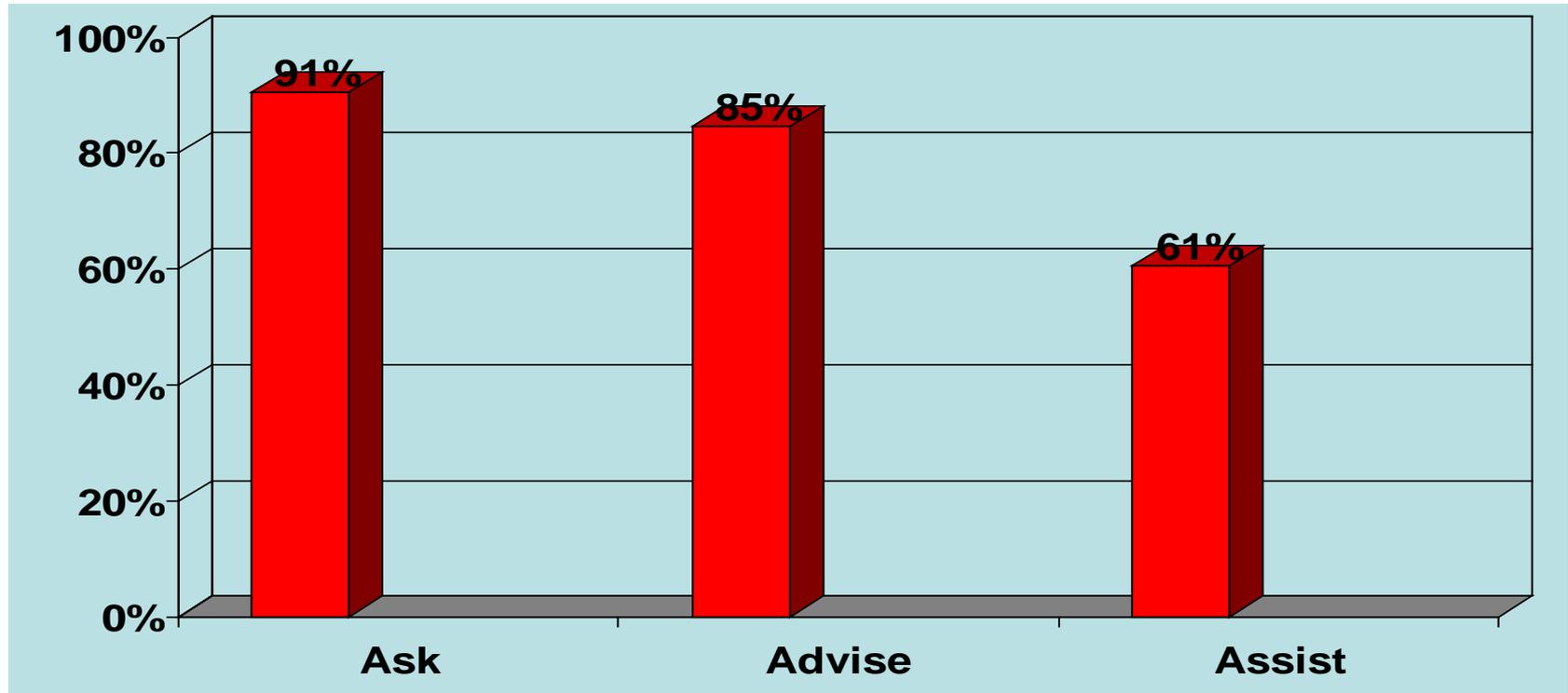
Hours Spent on Tobacco Dependence: Undergraduate Curricula



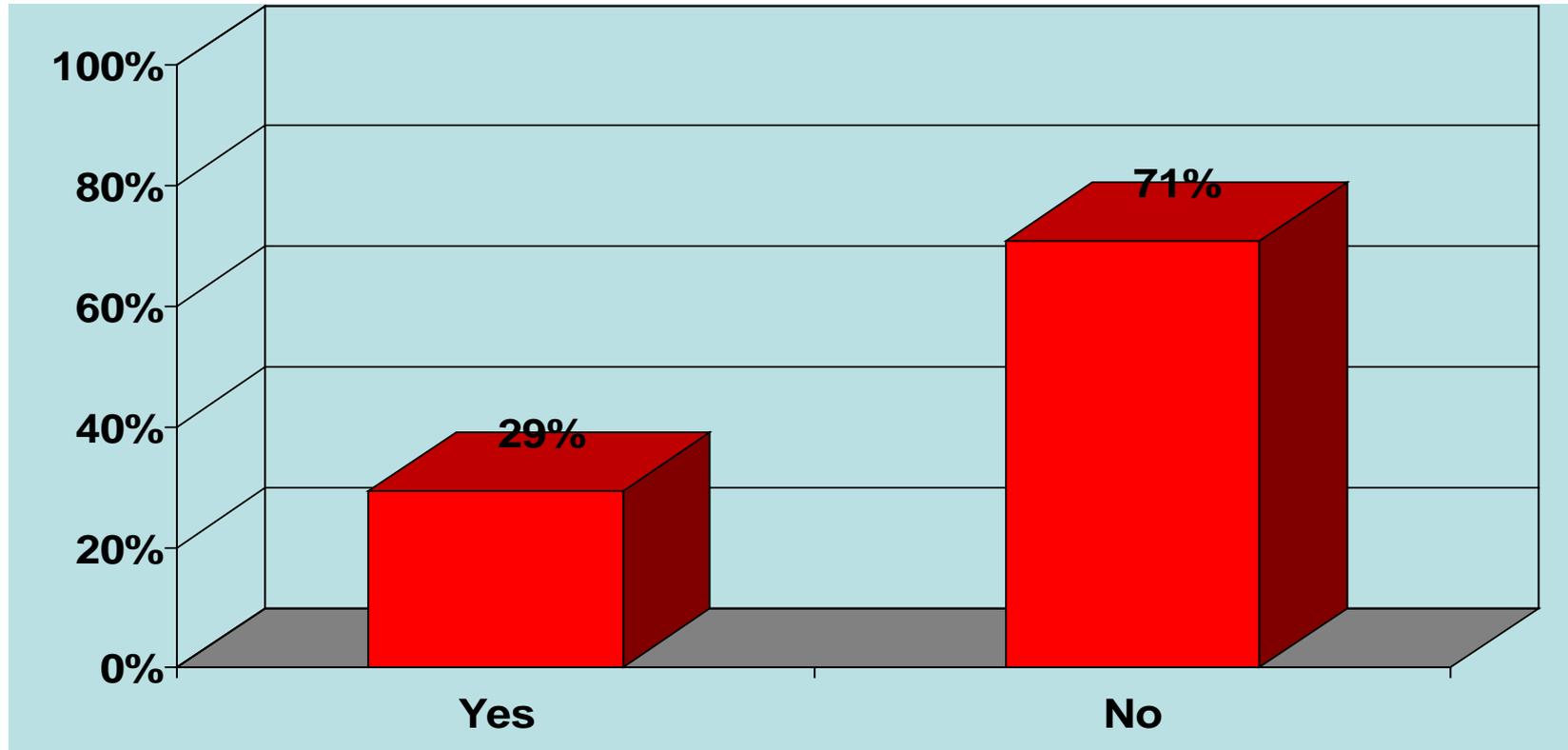
Hours Spent on Tobacco Dependence: Graduate Curricula



Brief Interventions by Nurses



Intensive Interventions by Nurses



Findings/Implications

- Nurses reported relatively high knowledge (meds, counseling, resources) but lacked confidence in ability to help & in clients' abilities to reduce/quit smoking
- Nurses asked & advised but did not consistently refer or provide intensive interventions
- Nurses less likely to intervene if not confident

(Sharp, Blaakman et al., 2009)



Findings/Implications

- Tobacco dependence education including strategies to enhance motivation needed to enhance nurses' efficacy/confidence
- Respondents more likely interested in topic but ¼ did not rate it as a work priority
- ***Per NASMHPD (Mauer, 2008): Cardiac deaths outnumber suicides among those with mental illness but smoking assessment/intervention less likely to be routine***

(Sharp, Blaakman et al., 2009)



Findings/Implications

- Increasing value of tobacco dependence interventions is vital to support wellness/recovery & denormalization efforts
- Workplace values impact nurses
- ***We must work collaboratively to strengthen our intervention skills and public voices to advocate for smoking cessation among ourselves & those entrusted to our care***

(Sharp, Blaakman et al., 2009)





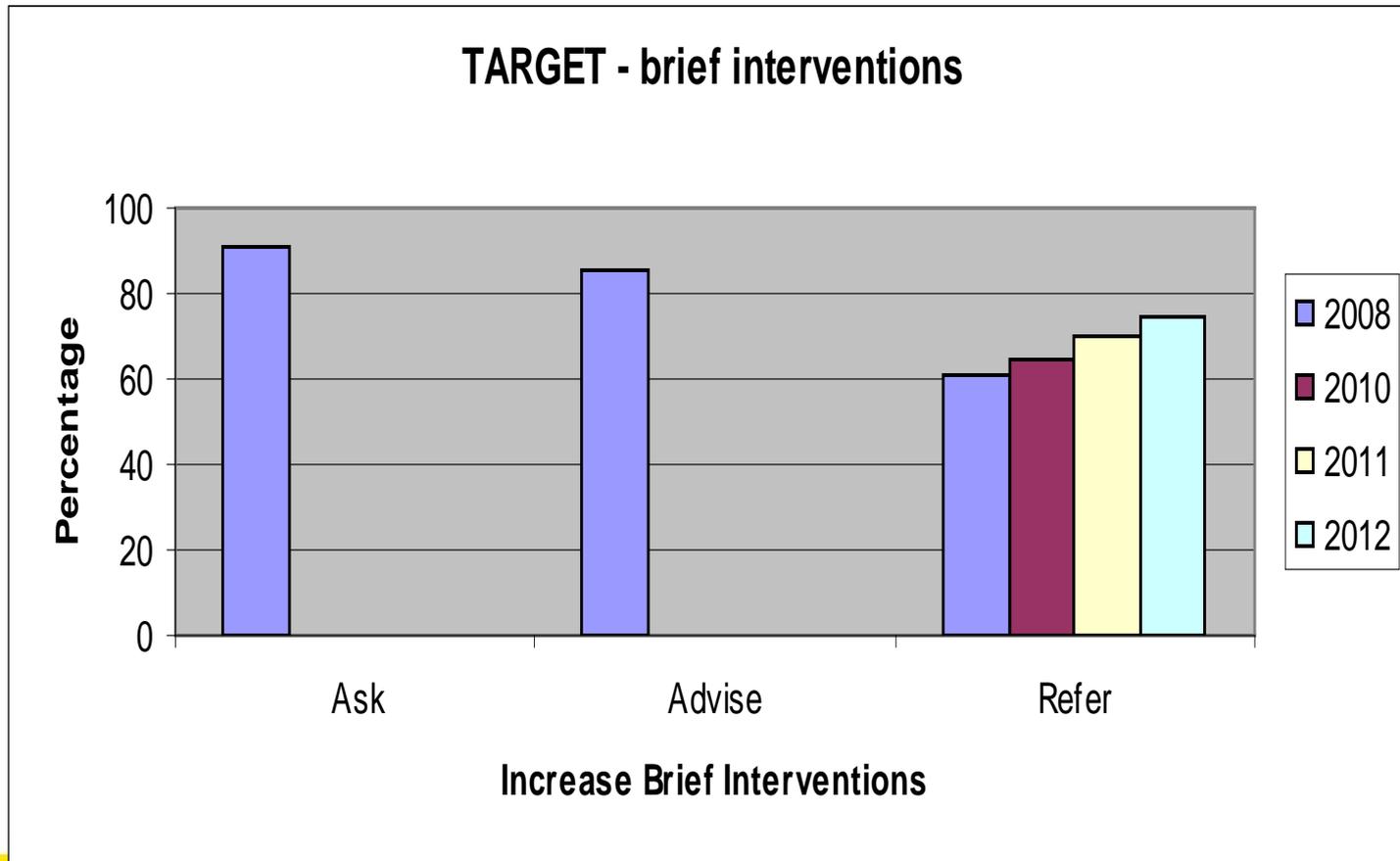
PERFORMANCE PARTNERSHIP MODEL:

Where do we want to be?

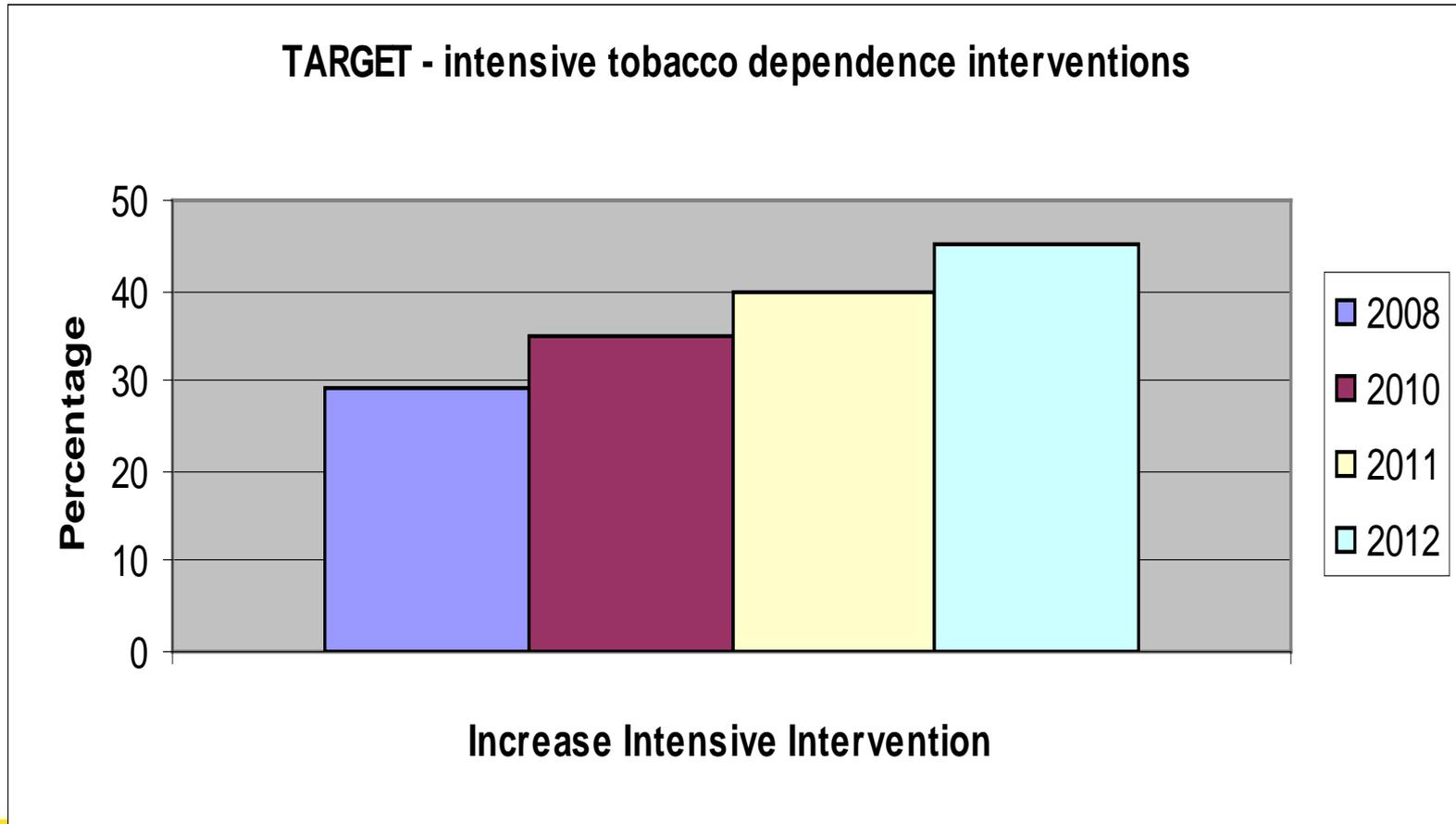


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Strategic Plan Goal #1: Increase RNs who Refer



Strategic Plan Goal #2: Increase RNs who provide higher intensity interventions





PERFORMANCE PARTNERSHIP MODEL:

How do we get there?



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Strategic Plan Strategy Focus:

**Partnership-building locally,
regionally, nationally**



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Specific initiatives:

- Networking & collaboration:
 - Local & regional APNA members
 - OMH, OASAS, SAMHSA policy makers
 - SCLC partners
 - <http://smokingcessationleadership.ucsf.edu>
 - 2 national webinars
 - C. Everett Koop conference; Steve's editorial
 - Tobacco Free Nurses



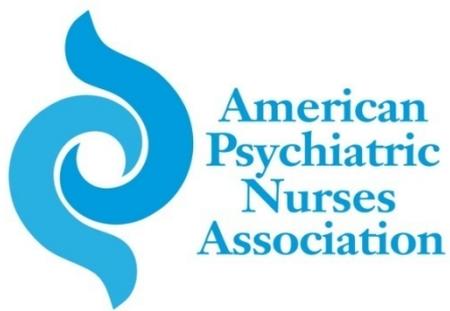


Strategic Plan Strategy Focus:

Plan dissemination



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Specific initiatives:

- Smoking Cessation Position Statement
- Task force report, *APNA Newsletter*, May 2008
- *SCLC Partner Meeting*, May, 2008
- Poster presentation with SCLC partners: *National Council on Tobacco or Health*, June 2009
- Tobacco dependence survey results: June/July 2009, *JAPNA*





APNA Position Statement:

Psychiatric Nurses as Champions for Smoking Cessation
(Naegle, Baird, & Stein, 2009)

The time to act is now!

**Failure to act on tobacco
dependence equals harm.**



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Strategic Plan Strategy Focus:

Education & awareness/media



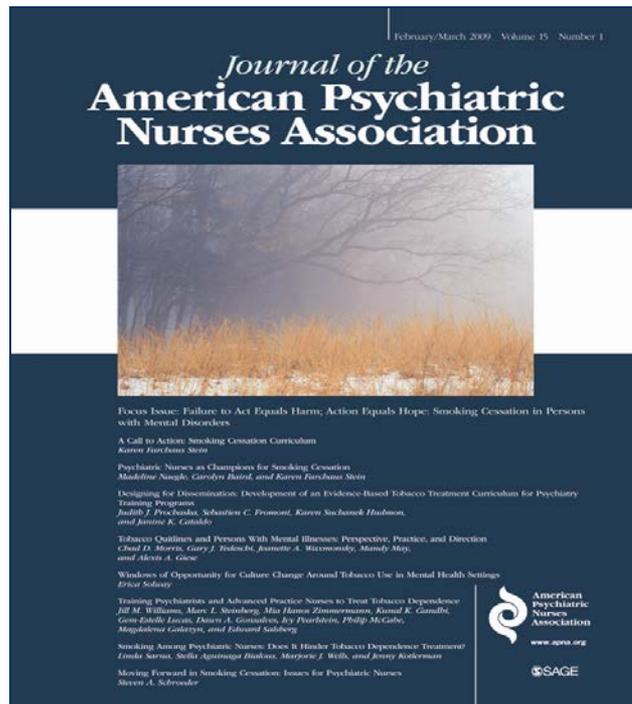
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Specific initiatives:

- Tobacco Dependence Information Center: APNA website, <http://www.apna.org>
- JAPNA February/March 2009 issue dedicated to tobacco dependence
- Presentations: APNA Annual Conference, 2008 & 2009
Clinical Psychopharmacology Institute, 2008, 2009, 2010
- Interactive panel discussions: APNA Annual Conference, 2008, 2009, 2010, 2011
- 3 part *Counseling Points* series: 2010





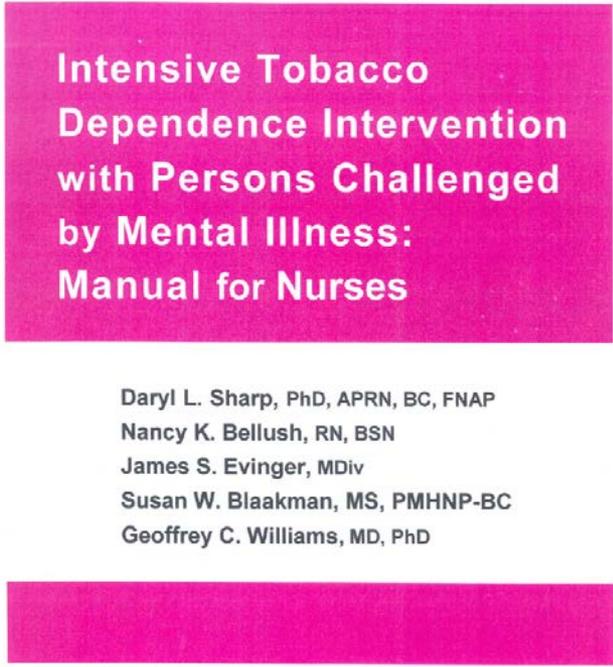
JAPNA
February/March 2009
issue fully dedicated
to tobacco
dependence!



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APNA Tobacco Dependence Information Center

- <http://www.apna.org/i4a/pages/index.cfm?pageid=3643>
- For questions and/or more information, see APNA Council Chairpersons, Daryl Sharp and Susan Blaakman



The image shows the cover of a manual. The title is in white text on a pink background. Below the title, the authors' names and credentials are listed. At the bottom, there are logos for the University of Rochester School of Nursing and the Tobacco Dependence Intervention Program.

Intensive Tobacco Dependence Intervention with Persons Challenged by Mental Illness: Manual for Nurses

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University of Rochester
School of Nursing
Tobacco Dependence
Intervention Program

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Strategic Plan Strategy Focus:

Communication/support



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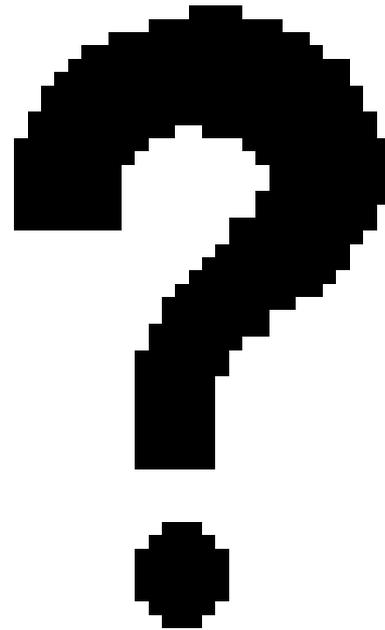


Specific initiatives:

- Council members-SCLC partners conference call strategy meetings
- Advise APNA Board of Directors re: initiatives as needed, e.g. endorsement of the *Clinical Practice Guideline for Treating Tobacco Dependence: 2008 Update; proposed Joint Commission tobacco use & dependence performance measures; developed APNA's position on USDHHS *Managing Multiple Chronic Conditions (2010)**



Questions/Thoughts



Acknowledgements

Smoking Cessation Leadership Center:
<http://smokingcessationleadership.ucsf.edu/>

Substance Abuse & Mental Health Services Administration:
<http://www.samhsa.gov/>

American Psychiatric Nurses Association:
<http://www.apna.org/>



And thank you, too, for your attention!



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