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

Daryl L. Sharp, PhD, APRN, BC, FNAP
Nancy K. Bellush, RN, BSN
James S. Evinger, MDiv
Susan W. Blaakman, MS, PMHNP-BC
Geoffrey C. Williams, MD, PhD

University of Rochester
School of Nursing
Tobacco Dependence
Intervention Program

SCHOOL OF NURSING
UNIVERSITY of ROCHESTER MEDICAL CENTER

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

Daryl L. Sharp, PhD, APRN, BC, FNAP
Nancy K. Bellush, RN, BSN
James S. Evinger, MDiv
Susan W. Blaakman, MS, PMHNP-BC
Geoffrey C. Williams, MD, PhD

University of Rochester School of Nursing
Tobacco Dependence Intervention Program

※

Rochester, New York

Intensive Tobacco Dependence Intervention with Persons Challenged by Mental Illness: Manual for Nurses was prepared by the University of Rochester School of Nursing Tobacco Dependence Intervention Program.

The manual is a component of an approved program evaluation, University of Rochester Research Subjects Review Board, RSRB #015780, and New York State Department of Health Institutional Review Board, #06-083.

Principal Investigator: Daryl L. Sharp, PhD, APRN-BC, FNAP
Associate Professor of Clinical Nursing
University of Rochester School of Nursing
601 Elmwood Ave., Box SON
Rochester, New York 14642
Office: (585) 275-6465
Daryl_Sharp@urmc.rochester

The program evaluation was funded by:

Promising Tobacco Control Interventions
Contract #C021009 (04/01/06-03/31/09)
Bureau of Tobacco Use Prevention & Control
New York State Department of Health
ESP Corning Tower Bldg.
Albany, New York 12237

March, 2009

ACKNOWLEDGEMENTS

The clients and staff of Strong Ties
University of Rochester Medical Center
Rochester, New York

Smoking Cessation Leadership Center
University of California at San Francisco
San Francisco, California

Contents

Failure to Act on Tobacco Dependence = HARM

Action = HOPE

The time to Act is NOW!

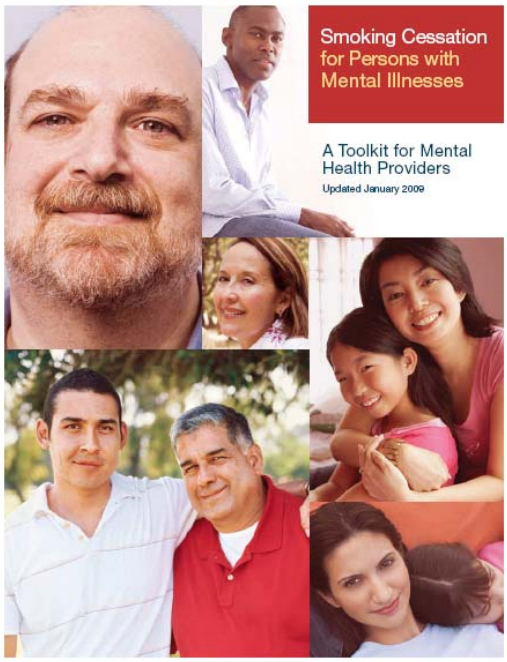
American Psychiatric Nurses Association

Tobacco Dependence Position Statement

October 14, 2008

1 Introduction to Intensive Tobacco Dependence Intervention & SPMI

This is a tobacco dependence intervention manual written by nurses for nurses. It complements the 2009 update of *Smoking Cessation for Persons with Mental Illnesses: A Toolkit for Mental Health Providers* (Morris, Waxmonsky, May, Giese, & Martin, 2009) in which the epidemiology, special challenges, and specific evidence-based interventions needed to help those with mental illnesses to stop smoking are well described.



Nurses have a long history of promoting health in the patients entrusted to our care. Equipped with a rich education grounded in biopsychosocial and spiritual approaches to care delivery, including a focus on helping patients improve health and prevent illness, nurses are especially well positioned to address tobacco dependence with their patients who smoke.

Responding to a quiet epidemic

Tobacco dependence is a multifaceted illness with neurobiological, psychological, social, economic, and cultural underpinnings. Among people who are mentally ill and/or those with substance use disorders (in addition to tobacco dependence), smoking is a quiet epidemic (Schroeder, 2007).

- *75% of those with either addictions or mental illness smoke, compared to 21% in the general population.*
- *Americans with mental illness represent approx. 44% of the tobacco market.*

Grant, et al. (2004).

Smoking prevalence among people with mental illnesses

- *Major Depression: 50-60%*
- *Anxiety Disorder: 45-60%*
- *Bipolar Disorder: 55-70%*
- *Schizophrenia*: 65-85%*
- *ADHD: 40%*

**20% of those with schizophrenia started smoking at college age, and many began smoking in mental health settings, receiving cigarettes for 'good behavior.'*

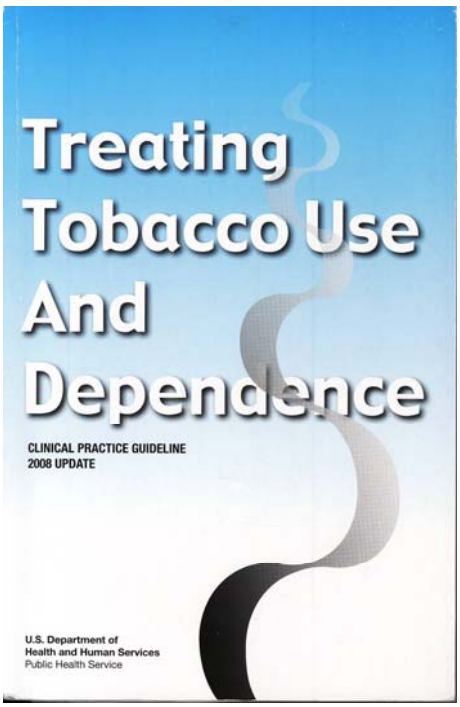
National Association of State Mental Health Program Directors. (2007), p. A-1.

Sadly, health care clinicians, including nurses, have been slow to intervene. Given that tobacco dependence is the #1 cause of morbidity and mortality in the United States, we simply *must* and *can* do more to help our patients to stop smoking (Fiore, et al., 2008).

"All smokers with psychiatric disorders, including substance use disorders, should be offered tobacco dependence treatment, and clinicians must overcome their reluctance to treat this population."

Clinical Practice Guideline, 2008 Update, p. 154.

This manual utilizes the central, evidence-based treatment recommendations from *Clinical Practice Guideline for Treating Tobacco Use and Dependence* (2000; 2008), the gold standard for tobacco dependence treatment.



In addition, this manual describes the treatment approach of a small group of nurses in Rochester, New York, who implemented an intensive tobacco dependence program at a university-based outpatient facility serving persons with serious and persistent mental illness (SPMI). The program was funded through the New York State Department of Health Bureau of Tobacco Use Prevention & Control from April 1, 2006, through March 31, 2009.

A nurse-managed and intensive intervention

The intensive, nurse-managed tobacco dependence intervention described subsequently is informed by the basic tenets of self-determination theory, which is a general theory of motivation, and existential advocacy, Sally Gadow's moral framework for nursing.

The content of the intervention corresponds to the *Clinical Practice Guideline* and *Toolkit*, i.e., properly dosed pharmacotherapy; building quit plans via problem-solving and skills building, and mobilizing social support.

What is unique about this intervention is the process that guides its delivery. Self-determination theory (Deci & Ryan, 1985) and the nursing framework of existential advocacy (Gadow, 1980) each support a person-centered approach to caregiving in which patients and nurses fully partner with one another to help patients meet their health goals.

This manual describes how our team, along with other members of the larger interdisciplinary treatment team at the outpatient clinic, worked collaboratively

with patients to help them reduce and/or stop smoking in a manner that honored their personhood and respected their recovery goals. A detailed description of the theoretical underpinnings of the intervention approach is described in a paper referenced in Appendix E (Minicucci Sharp, Schmitt, Dombeck, & Williams, 2003).

Concurrent to the clinical intervention delivered by the nurses, a program evaluation was conducted to measure the results of this project. Treatment outcomes (# of cigarettes smoked daily and carbon monoxide verified point prevalence) were clinically and statistically significant across 12 months (manuscript in preparation).

2 Guide to Counseling Approaches: Theoretical Background

A. Self-determination theory and tobacco dependence interventions

Self-determination theory (SDT) is a general theory of motivation that rests on two basic assumptions:

1) people are intrinsically motivated toward health; and,
2) people have three primary psychological needs:

- *autonomy*, which entails experiencing one's actions as emanating from the self;
- *competence*, which is similar to self-efficacy; and,
- *relatedness*, which encompasses relating to and caring for others, as well as feeling related to or cared for by others in authentic ways (Deci & Ryan 1985).

When our needs for *autonomy*, *competence*, and *relatedness* are more satisfied, we engage in a behavior because it is personally important to us and is something we truly want to do for ourselves.

Autonomy, *competence* & smoking cessation

Behavior is *autonomous* to the extent that people experience a sense of volition, self-initiation, and personal endorsement of the behavior. In contrast, behavior is *controlled* to the extent that people feel pressured to behave by some interpersonal or intrapsychic force, such as shame or guilt (Deci & Ryan 1985).

In health care, when practitioners are *autonomy supportive*, clients are more likely to become *autonomously motivated* and perceive themselves as *competent* to engage in smoking cessation, i.e., able to quit. *Autonomy support* refers to practitioners' eliciting and acknowledging clients' perspectives, supporting their initiatives, offering choices about treatment options, and providing relevant information, while minimizing pressure and control (Williams et. al., 2006).

In contrast, *controlling* health care environments are those in which clients are pressured through threats about the negative health consequences of continued smoking, or through providers who try to induce clients' shame or guilt.

When clinicians are guided by SDT, the goal is to foster client internalization of *autonomous* and *competence* motivations – regardless of the client's stage of change.

Practitioner role in enhancing cessation smoking outcomes

We know that the practitioner's relationship with the client can make a clinical difference in smoking cessation. In addition to clinicians providing evidence-based pharmacotherapy and cognitive-behaviorally oriented

counseling to enhance cessation, smoking outcomes can be improved when clinicians function in *autonomy supportive* ways with clients who smoke.

In a randomized clinical trial with 1,000+ people who smoked, an *autonomy supportive* intensive tobacco dependence intervention, based on an integration of the basic tenets of SDT and the *Clinical Practice Guideline for Treating Tobacco Use and Dependence* (2000), resulted in greater cessation outcomes at 6 months, regardless of participants' initial intention to stop smoking, i.e., stage of change.

Williams, et al., 2006.

B. Gadow's moral framework for nursing and tobacco dependence interventions

According to nurse philosopher, Sally Gadow, *existential advocacy* is the philosophical foundation and ideal of nursing. Her perspective provides nurses with a vision of how nursing ought to be, both in relation to the experience of patients, but also in relation to the experience of nurses.

"…existential advocacy [is] the essence of nursing… the nurse's participation with the patient determine[es] the unique meaning which the experience of health, illness, suffering, or dying is to have for that individual."

Gadow, 1980, p. 81.

The basic tenets of *existential advocacy* can be synthesized with SDT to inform the way nurses deliver tobacco dependence interventions through the vehicle of the ideal nurse/patient relationship.

Nurse/patient relationship & *existential advocacy*

Gadow describes *existential advocacy* as a way of thinking about our moral obligation to patients. She challenges nurses not only to understand the perspectives and feelings of our patients, but also to strive to understand our own experiences in caregiving. By doing so, she argues, we bring more of our *authentic* selves to our interactions with our patients, which she argues is central to optimal, moral care delivery.

With respect to tobacco dependence interventions, the more nurses can bring their knowledge (of evidence-based interventions), interest, and unrushed presence (full attention) to their work with patients who are trying to stop smoking, along with the interpersonal sensitivity and respect for their patients' desires, feelings, and thoughts (autonomy support), the more they are likely to help their patients meet their health goals (Minicucci Sharp et al. 2003).

C. Motivational Interviewing from an SDT & existential advocacy perspective

Motivational interviewing (MI) is a person-centered approach that has guided considerable health behavior change research. It rests on the underlying premise that motivation is elicited from within a person (not

imposed on him or her), and that a person's readiness to change is a product of a dynamic interaction (Blaakman, 2009; unpublished manuscript; Miller & Rollnick, 2002).

For the most part, MI has not been aligned closely with any particular theoretical framework. Conceptually, though, MI shares many similarities with both SDT and Gadow's moral framework for nursing. This is very relevant for our clinical intervention.

The importance of using SDT and *existential advocacy* to understand the potential theoretical underpinnings of MI is that when clinicians stay mindful of the theory and Gadow's framework, they can offset the risk of using MI simply as a toolkit of techniques that may or may not be effective over time.

Technique AND relationship

The effectiveness of MI techniques in promoting behavior change is maximized when clinicians who use MI are grounded in an authentic, interpersonal partnership with their clients, and understand the central importance of psychological need satisfaction. Such clinicians also understand their clients' need for freedom from pressure and control (in the external environment and/or within the person's psyche) as they promote sustained behavior change (Markland, Ryan, Tobin, & Rollnick, 2005).

If care is delivered in this way, it is more likely that patients will feel authentically supported in their attempts to reduce and/or stop smoking. This may have important implications for their continuing cessation efforts.

Considering that tobacco dependence is a chronic, relapsing illness, it is important that patients feel hopeful about being able to try reducing their consumption and/or quitting again should any single effort fail. They are more likely to do so when they experience their caregivers as true partners – rather than hired workers with clever techniques – in their battle against smoking.

Stopping smoking is quite challenging, even when the full self of the nurse is working with the full self of the patient. We simply cannot afford to rely on superficial interpersonal working relationships with our patients if we are going to be effective in helping them to stop using one of the most addictive substances known to humans.

There are clear similarities between SDT, existential advocacy, and the basic underpinnings of motivational interviewing (MI). All assume that humans have an innate propensity for personal growth toward cohesion and integration. This integrative tendency is enhanced, or thwarted, through the social environment, and, in particular, supports or barriers for *autonomy*, *competence*, and/or *relatedness*. From all three perspectives, *autonomy support* is integral. From Gadow's perspective, the authentic self of the nurse also is essential to optimal caregiving.

Interpersonal strategies for practitioners

We know from evidence that interpersonal support improves the likelihood that patients will successfully meet their health goals regarding

smoking (Minicucci Sharp et al. 2003; Williams et al. 2002).

The following interpersonal strategies derive from a synthesis of the basic tenets of SDT, existential advocacy, and MI. They reflect an *autonomy supportive* approach to working with patients who smoke, while also using Gadow's moral framework for nursing. They are designed to support patients' *autonomous* and *competence* motivations within a caring, supportive nurse/patient partnership.

- Recognize that the clinician/client relationship is a partnership (versus an expert/recipient model).
- Stay mindful of the need to support the client's psychological needs for autonomy, competence, and relatedness (i.e., client-centered).
- Elicit and acknowledge the client's perspective.
- Listen well and use reflective skills.
- Strive to understand and reflect both sides of the person's ambivalence as it arises.
- Advise about the importance of stopping smoking to health in a clear, but non-controlling, manner.
- Do not use information as a weapon.
- When invited or as the client signals readiness, provide information about: pharmacotherapy, health risks and benefits, and quit plan options.
- Provide rationale for the suggestions you offer.
- Check in with clients to hear how they are hearing the information.
- Whenever possible, offer clients options, e.g., "You could use gum *or* lozenge."
- Stay mindful of how very difficult it often is to stop smoking; use this knowledge to maintain a compassionate perspective.
- Bring your full presence to your encounters with your patients.
- Cultivate a self-reflective approach to caregiving.
- If you are losing your own motivation to deliver tobacco dependence intervention, seek consultation with a colleague so that you can once again utilize the energy of your *self* to work creatively and collaboratively with your patients.

3 Intensive Tobacco Dependence Intervention: Clinical Guidelines

Our clinical guidelines supplement *Smoking Cessation for Persons with Mental Illnesses: A Toolkit for Mental Health Providers, (Updated version, January 2009)*, a manual developed by the University of Colorado Denver, Department of Psychiatry, Behavioral Health and Wellness Program.

We applied these evidence-based guidelines for behavioral and cessation medication interventions and tested them in a three-year program evaluation with persons who were seriously and persistently mentally ill (SPMI). These guidelines will assist nurse clinicians who work with mentally ill persons toward their smoking cessation and/or harm reduction.

The clinical role of the nurse in tobacco cessation/reduction

Consistent with SDT, MI, and Gadow's framework, the nurse strives to facilitate the client's autonomous motivation so change arises from within, rather than being imposed from without. The nurse's role is to encourage the client that he can make a successful change in smoking behavior, and, consequently decrease the health risks associated with smoking.

Within a safe and supportive atmosphere, the nurse should not provide solutions or analysis. Such behavior may be well-intended, but it undermines the client's motivation and sense of competence for change. And the nurse should never argue with or attempt to coerce the client to change her smoking behavior.

Instead, the role of the nurse is to offer accurate empathy (identification with the client through reflective listening, not by sharing mutual experiences), non-possessive warmth, and genuineness. Emphasis is placed on the client's ability to make a personal choice and responsibility to decide her own potential for changing behavior based on autonomous value.

In this way, the nurse applies self-determination theory to promote the patient's sense of self-efficacy. The purpose of developing self-efficacy is to increase the client's perception of his capability to cope with obstacles and succeed in change. Clearly, the nurse's own expectations about the client's ability to make change can have a powerful impact on the outcome.

Tobacco use is the single largest cause of premature death in the United States. Tobacco dependence is a chronic disease, associated with periods of abstinence, and often entails recurring relapse. Although clients challenged with SPMI have the highest incidence of smoking, many truly do want to quit and have proven that they can quit smoking, as much as any smoking population.

In the contemporary treatment of mentally-ill clients, focus has shifted to a mode of whole health and recovery. Ignoring tobacco dependence is no longer acceptable, and is not consistent with current health promotion programs

and the task of reducing tobacco-related deaths in all populations.

The most important thing nurses can do to decrease morbidity and mortality attributable to smoking is to incorporate the assessment of tobacco use into everyday clinical practices. In keeping with Gadow's moral framework of existential advocacy, nurses often have the unique ability to spend more time with the client than any other practitioner, and therefore form an interpersonal partnership to help clients reach their health goals.

Nurses, working along with members of the interdisciplinary treatment team, have the ability to guide the team in a person-centered approach to care-giving. They can collaboratively help clients reduce and or stop smoking in a manner that honors them as individuals, and is respectful of their personal recovery and health goals.

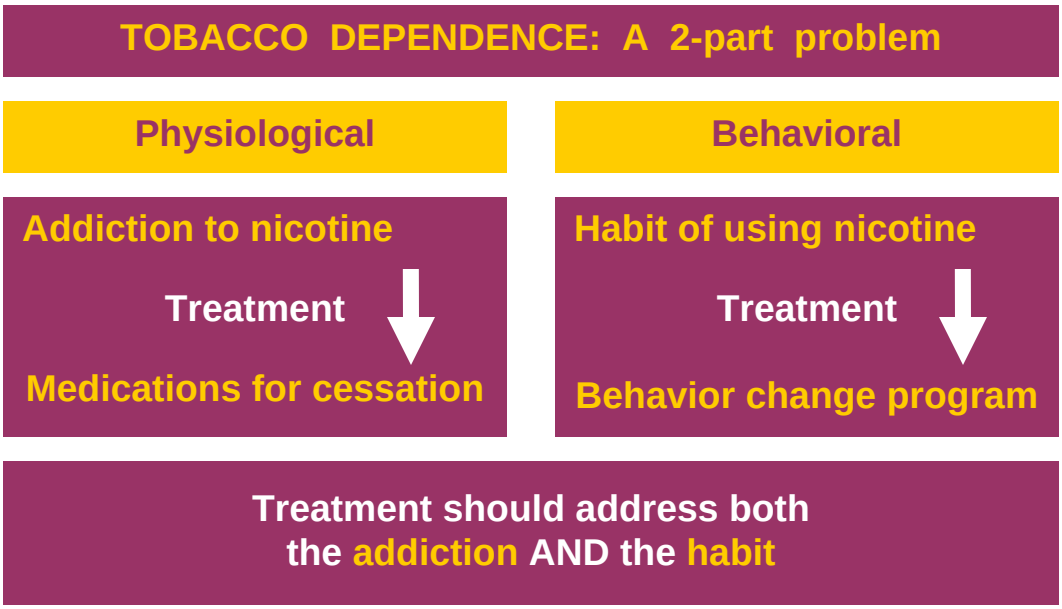
Persons with serious mental illness and tobacco cessation

Mentally ill clients may differ from other populations in the way they use tobacco because they often smoke their cigarettes close to the butt where nicotine levels are highest (Lyon, 1999), and inhale frequently, rapidly, and deeply (Olincy, Young, & Freedman, 1997).

The neurobiological etiologies of psychiatric disorders predispose our clients to high susceptibility for nicotine dependence. The basic structure of the intervention does not change based on the client's diagnosis or the severity of their psychiatric symptoms. There is, however, a dose-response with respect to cessation rates. Compared to the general population, our clients often need higher dose tobacco dependence interventions in order to successfully reduce or stop smoking.

Treatment involving one-on-one counseling and group and/or telephone counseling is consistently effective. As nurse contact time and support increase relative to the person's symptom severity, the likelihood of reduction or cessation increases. It is essential for the person to feel she is always welcome to return for follow up, regardless of whether she has succeeded in reaching her goal.

Our intervention follows the Public Health Service Guideline and its integrated approach. This consists of *integrated medication* (first-line pharmacotherapy) and *psychosocial treatments* (problem solving and skills training, and ongoing interpersonal support) which are adapted specifically for people with SPMI.



Adapted from: *Tobacco Free for Recovery: Assisting Mental Health Consumers with Tobacco Cessations: Training*. Rx for Change, San Francisco, CA.

A. Getting started

It is important to recognize that these guidelines are flexible and fluent. It is also necessary in a client-centered approach that the client knows and feels that he is in control of the decisions being made around his care regarding smoking cessation. This supports personal choice and autonomous value.

Typically with the general population, intensive tobacco treatment consists of at least 4-8 sessions within 6 months. However, for people who have SPMI, intensive interventions – easily accessible sessions on a more frequent basis (often exceeding 4-8 contacts) and longer-term pharmacotherapy, as needed – are usually more helpful, and should be utilized whenever possible.

All sessions are conducted in a client-centered, non-controlling atmosphere in which the nurse reflects the client's perceptions and experiences without labeling, lecturing, or correction.

B. Session 1

Allow 60 minutes to conduct Session 1 (subsequent sessions are shorter). The goals are to:

1) Establish trust and build rapport while gathering information;
2) Gather health history (medical, surgical, psychiatric, ob-gyn, medications);
3) Gather tobacco history (may include addiction severity, prior quit attempts, duration and use of pharmacotherapy);

4) Understand reasons the person smokes; and,

5) Develop a Quit Plan, as appropriate.

The effective introductory session is conducted with open-ended questions in conversation form to get to know the individual, and initiate problem solving.

Session 1 questions

These are examples of questions used to gather information. Not all are used at once They are best used, as the nurse feels appropriate, within the context of the conversation.

- "How are you today?"
- "What brings you here, today?"
- "How are you feeling?"
- "What kinds of things do you like to do?"
- "What are your thoughts about your smoking?"
- "How many cigarettes are you smoking per day?"
- "Has it always been this amount?"
- "Can you remember when you began smoking?"
- "What was it like?"
- "What changed?"
- "Have you ever quit?"
- "What was it like for you?"
- "Did you use any medication?"
- "How did it feel?"
- "What is the hardest part of quitting?"
- "What was the easiest part of quitting?
- "What are some goals you have for yourself – not necessarily related to smoking?"
- "What are some health goals you may have?"
- "How does smoking fit in with these goals?"
- "How does smoking not fit with these goals?"
- "Are you aware of any health risks involved with smoking?"

Session 1 process

1) Every few minutes, reflect back to the person to ensure there is a true understanding of what she said and how she is feeling. Examples of reflective statements include:

- "My understanding is you started smoking when you were 16, and liked it right away – that it made you feel cool."
- "It sounds like you started smoking at ½ pack per day and increased your level of smoking to where you are today – around 1½ packs per day, is that right?"
- "I heard you say you tried to quit 5 years ago and used the nicotine patch, and you were able to quit for 3 weeks. Then it sounds like stress contributed to your relapse. Can you tell me more about that?" *Alternative:* "Can you think of another way you could deal with it so you would be less likely to smoke again?"

2) Ask if the person has any questions.

3) If there are educational materials to share, ask first if the person would like to hear about them:

- "Would you like to hear about some of the health risks associated with smoking?"
- "Would you like to hear about the medications available to help manage withdrawal which some feel when they quit smoking?"

4) The information-gathering will be helpful when developing the person's

individualized Quit Plan – it will be specific to his life experiences.

Assessing readiness to quit

The responses to Session 1 questions provide information for an assessment of the person's readiness to quit smoking. The three general categories for assessing a person's readiness to quit are:

- Ready to quit in the next 30 days;
- Ready to quit in the next 6 months;
- Not thinking of quitting at all.

Although this intensive intervention relies on the establishment of autonomy support for all clients, regardless of their stage of change, assessing a person's readiness to quit can help the nurse better understand the client's experience. Assessment can also help discern the quality of a client's motivation and sense of competence with respect to changing smoking behavior.

It is important to remember that this autonomy supportive tobacco dependence intervention can be effective even when clients do not initially wish to reduce and/or stop smoking.

The following are suggested responses for specific circumstances, and are not intended as rigid guidelines.

The person who is not ready at all

If the patient is pursuing the path of *not ready to quit at all*, it is imperative that the nurse express understanding and empathy. Reflective listening and feedback let the person know that she is welcome at any time to discuss her smoking behavior.

People are unwilling to quit due to a variety of reasons, e.g., misinformation, concern about what to expect when quitting, or demoralization because of previous unsuccessful quit attempts. At this point, it may be helpful to negotiate a follow-up date – "Just to check in with you." – without placing any pressure or judgment on her decision or goals. (This offers autonomy support).

The greatest chance the nurse has to aid the client who does not want to stop smoking at the present, but is open to consider quitting at some point in the future, is to ***not*** pressure her while letting her know you are always willing to help if she ever decides differently.

The person who is ready to quit in 6 months

If the client is ready to quit in the next 6 months, it is important to reflect this with him to ensure that he feels his point of view is understood by the nurse, and that he feels he is not being pressured.

- "My understanding is you are thinking about quitting in month X, is that right?"

Begin by seeking to understand his reasons for waiting, or his ambivalence around quitting. Ambivalence is sometimes considered the nucleus of the problem, i.e., the barrier to making a quit attempt. This intervention is best done with considerable patience, tolerance, and respect for his potential ambiguity. Ways to explore ambivalence include:

- "So, it is my understanding that you want to quit smoking, but would like to wait until X, is that right?"
- "It seems like that will be a better time for you, because …"
- "Can you help me understand what will be different for you then that will help you to feel more confident in your

quitting efforts?" *Alternative:* "What is it about now that is in the way of you thinking about quitting?"

- "Would you be willing to do an experimental quit for 14 hours and see what it feels like? You may use intermittent Nicotine Replacement Therapy (NRT), like gum, lozenge, inhaler, or nasal spray, if you would like."

  [This is especially helpful if the person has never made a quit attempt. If coached in the correct use and proper dosing of NRT, the client may experience significant relief from withdrawal symptoms, which is often a central barrier to quitting smoking. Symptom relief can instill hope, which is frequently a key ingredient in successful behavior change.]

This discussion helps the client to sort through her ambivalence and assume responsibility (autonomy support) for her decision regarding a change in her smoking behavior.

Ambivalence and a decisional balance exercise

It often helps to use a decisional balance exercise with a person who is ambivalent (Janis & Mann, 1977). This tool is best implemented in visual format – written by the client and simply facilitated by the nurse. A decisional balance exercise includes dialogue around the client's perceptions of:

pros of smoking
"What kinds of things do you like about smoking?"

pros of quitting
"What kinds of things do you dislike about smoking?"

cons of quitting
"What kinds of things would you consider to be negative, or not so good, about quitting smoking?"

cons of smoking
"What kinds of things would you consider to be negative, or not so good, about smoking?"

This exercise can elicit useful information for discussion purposes. It helps the nurse understand the client's perceptions. It helps the client see more clearly, and take responsibility for, his thoughts and actions related to his smoking behavior (autonomy support).

After discussing his thoughts and feelings about his smoking behavior, including the decisional balance discussion, negotiate a plan to connect again to assess his readiness to quit, e.g., in the next month, or once a month.

The person who is ready to quit within 30 days

For the person who is ready to quit within the next 30 days, and there is still time in the first session, and the client is amenable, it is a great time to begin developing a Quit Plan.

If there is not enough time, or the nurse senses the client lacks energy to move in this direction, it can be done in Session 2. Close the discussion:

- "It has been a pleasure meeting with you, today. Our session is coming to an end, and I want to be clear about where you are with your smoking. It is my understanding you would like to quit smoking in the next 30 days, and are considering a quit date of X. Is it okay if we continue this in our next session? "

Developing the Quit Plan ~ Introduction

If the nurse and patient decided to wait until Session 2 to develop the Quit Plan, begin by summarizing and reviewing Session 1.

If the nurse and patient decided to develop the Quit Plan in Session 1, begin the process of problem solving, skills building, and identifying social support, the Quit Plan building blocks. Check with her and make sure it is acceptable with her to proceed:

- "It is often helpful for folks like you who are planning on quitting smoking to develop a Quit Plan."
- "Other people have found that by planning strategies and eliciting support, it helps them get ready and feel prepared to quit. Would you like me to show you what the Quit Plan looks like and help you with it?"

Developing the Quit Plan ~ 1. Get Ready

Use a copy of the Quit Plan (Appendix A for form). By encouraging the person to choose a quit date, the Quit Plan is structured around a specific timeline, and keeps him focused on his goal.

- "Have you thought about a quit date?"

Help him negotiate his quit date, perhaps around a quiet weekend, and/or a time when he has support, and/or on a meaningful date (e.g., an anniversary or birthday). Find out if he made a previous quit attempt, and whether it helped to choose a specific date.

Developing the Quit Plan within 2 weeks of a specific quit date is recommended. If a quit date is too far in the future, the person may never get to it. Remember that setting a quit date within 2 weeks is a suggestion, not a mandate.

People sometimes experience setting specific quit dates as too pressuring, and prefer instead to "simply begin by not smoking one day, and see how it goes." The autonomy supportive nurse supports the client's choice and helps him build his plan, honoring and guided by his preferences.

Developing the Quit Plan ~ 2. Support & Encouragement

Social support is a very important part of the smoking cessation process. The nurse's goal is to assist the person to identify strategies to build social support networks before quitting smoking.

Help her identify those who would be most supportive, and the ways in which they can help her, whether through problem-solving, or moral or emotional support. Identify who in her support network will help with specific tasks, such as housework or childcare, gathering information and resources about quitting and staying abstinent, and/or talking with others who have been through the process.

Her social support can include: family, friends, peer specialists, therapists, case managers, or anyone from her treatment team. Clients with mental illness may feel increased support and relatedness from peer-run services which provide a sense of mutual benefit (peer to client/client to peer). This often gives a sense of empowerment and self-efficacy, thus increasing motivation to make a positive change in behavior.

- "Is there anyone that you would find helpful with supporting you in your efforts to quit? Any family members, friends, or peers?"
- "How can they help you?"
- "What kinds of things would you like them to do for you?"

Some persons who are trying to quit like someone just to be available to talk with them. Some want a support person who talks with them every day about how much they are smoking.

- "What sounds supportive to you?"

At this point, she may benefit from a role play with the nurse that helps her identify ways to ask for support from her chosen person(s).

- "Mom, I need you to tell me I'm doing a good job every day when I don't smoke. And if I do smoke, I want you to help me problem-solve about how I might prevent myself from smoking in that situation, okay? Can you do that for me?"

Developing the Quit Plan ~ 3. Learn New Skills & Behaviors

This part of the Quit Plan is a process of developing coping skills, and identifying and practicing coping or problem-solving behaviors. It helps to discuss the person's pattern of smoking throughout the day, i.e., which cigarettes are most important/least important to him.

It can be very helpful for the client to track his pattern of smoking. This allows him to get an idea of how much he smokes, why he smokes, and how he feels when smoking, e.g., smoking due to craving or stress, or "just because I feel like having one."

Because smoking is usually integrated into all parts of a patient's daily activities, it is often beneficial for him to change his routine. The nurse can facilitate his considering parts of his schedule he may be able to change. Help him identify smoking triggers and explore how he can deal with them.

- "Can you tell me about your pattern of smoking?"
- "Where could you make changes?"
- "Is there something else you could do at that time?"
- "What kinds of things can you do to distract yourself?"
  (E.g., Delay, Drink water, Do something else, Deep breath, Discuss with a friend)
- "What kinds of things do you enjoy doing as an alternative to smoking?"
- "Are there self-statements you can use to remind yourself of your goals?"
  (E.g., "I want to be healthy for me and my family.")

Developing the Quit Plan ~ 4. Get Medication & Use It Correctly

The medication portion of the Quit Plan is described in Chapter 4.

Developing the Quit Plan ~ 5. Be Prepared for Relapse or Difficult Situations

Help the individual to plan ahead, if possible, by reflecting on situations that may cause her stress, and often lead to her smoking. Discuss how she can avoid these situations or prepare for them in advance.

For example, if social situations are stressful for her, preparation could include: taking a buddy with her to the

event, or talking to the buddy in advance; stepping outside during the event; practicing stress relief; and, using intermittent Nicotine Replacement Therapy (Chapter 4).

Help her to consider how, at the least, she can reduce the stress, or avoid or minimize her triggers for smoking, e.g., drinking coffee, talking on the phone.

- ""What types of things cause stress for you?"
- "Is there anything you can do differently to avoid these situations/people, or at least reduce your exposure to them?"
- "Are there certain activities that trigger your smoking?"
- "Can you think of ways you may avoid, or minimize, them?"

If stress is an apparent barrier to her success, assist her to identify activities that would help relieve stress, based on the discussion from the previous example questions, and using her personal experiences.

Examples of stress relievers include activities such as: reading, listening to music, dancing, walking, spending time with a particular person or pet, gardening, drinking water, deep breathing, and chewing gum, among others. Remember to listen intently to what she is suggesting, elicit and acknowledge her perspective, and provide rationale with any suggestions that are offered.

At the end of this Quit Plan development session, review verbally your understanding of the patient's thoughts, feelings, and goals, and negotiate follow-up sessions. Reflect their words and understand their position, and support their decision.

Developing the Quit Plan ~ Use of a CO Monitor

During Quit Plan session, the nurse may introduce use of a carbon monoxide (CO) monitor, a tool for assessing expired carbon monoxide. This is helpful with clients who prefer a more concrete method to monitor their smoking reduction or cessation efforts.

The person's' recent smoking is measured by asking him to breathe into a non-invasive breath monitor. The instrument measures expired CO in parts per million (ppm CO), and blood carboxyhemoglobin in percentages (%COHb). Smokers typically have levels that exceed 8 ppm (the number on the monitor will read 8 or above) or 1.6 % COHb (Dixon et al., 2007, p. 103).

For many individuals, seeing the actual reading of how tobacco use is affecting their health can be a powerful motivator, especially when used in comparison at each subsequent session. (It may be necessary to explain the significance of the numeric reading each time.) In the client-centered approach, it is important to ask him how he feels about the reading from the CO monitor. Conclude by arranging for a follow-up session.

C. Session 2: Keeping It Going

In this follow-up session, ask the person her thoughts about Session 1, the Quit Plan development. Ask whether she has any questions since you met last.

If she had prepared for relapse or difficult situations, find out what she experienced, what she tried, and how it worked. This session may be used to develop her Quit Plan in more detail.

- "Did you have a chance to try the experiment we discussed?"
- "How is your Quit Plan working out?"
- "What are your thoughts about it?"

Encourage him in the quit attempt, and develop relapse prevention strategies, i.e., reducing stress or stressful situations, adhering to the medication regimen, continuing to use what works in the Quit Plan, minimizing glamorization of smoking (the perception of "how great smoking is/was"), planning ahead, and staying focused.

Reflect for her what you remember was occurring in her life at the last session, while continuing to communicate caring and concern for her. Typical Session 2 questions include:

- ""It's my understanding, you were involved in X. How's that going for you?"
- "Has anything come up for you since our last session that you would like to discuss?"
- "How would you like to use our time together?"
- "Have there been any changes in your circumstances?"
- "Do you have any questions about our last session?"

Use open-ended questions designed to initiate problem-solving, encourage any successes, and encourage his commitment to maintain abstinence.

Advise him about the importance of quitting smoking to his health in a clear, but non-threatening manner, while taking care to support his psychological needs for autonomy, competence, and relatedness.

- "Although it sounds like it is difficult for you, you are working on one of your goals toward improving your health. Quitting smoking is the number one thing you can do to improve your health – how does that feel for you?"
- "It sounds like you are proud of yourself for your success thus far."
- "Even after you slipped, you got right back on the wagon, and continued your original plan, and it sounds like you have been doing well!"

Help her assess the efficacy of any medications she may have chosen.

- "What are your thoughts about the medication you chose?"
- "What did you like about it? What didn't you like about it?"

Open-ended questions are useful in the context of discussion, and are not useful as a battery of questions.

Assessing nicotine withdrawal

Assess person's level of nicotine withdrawal by using the Nicotine Withdrawal vs. Nicotine Toxicity Worksheet (Appendix B).

- "On a scale of 0 – 3, 0 being None, 1 being Mild, 2 being Moderate, and 3 being Severe, how would you rate your level of Anxiety? Irritability? Difficulty concentrating? Cravings for cigarettes?"

Recommend medication adjustments or additions at this time. If you are not prescribing the cessation medications

yourself, collaborate closely with the prescribing health care professional. If the client would like to perform a CO monitor reading, proceed and use a follow-up discussion.

- "Your reading last week was X. This week it is X. What are your thoughts about that?"
- "What are your thoughts about your smoking at this time?"

Always arrange for follow-up at each subsequent session. It is very important to establish a specific date for follow-up communication, either through an office visit or a telephone consult.

D. Subsequent Sessions: Keeping It Going

If a client relapses, express empathy, encourage quitting again, and find out what prompted her relapse:

- "Can you recall how or when you slipped?"
- "How could you change the situation to prevent relapse from happening again?"

Review with him withdrawal symptoms, side effects of any medication, and proper use of medication. Continue to refine the Quit Plan in more detail, and encourage him to talk about the quitting process.

- "What works, what isn't working?"
- "How do you feel?"

Relapse prevention strategies

Develop relapse prevention strategies:

- reducing stress or stressful situations;
- adhering to a medication regimen;
- continuing to use what works in the Quit Plan;
- preventing glamorization of smoking;
- planning ahead; and,
- staying focused.

Like previously, use open-ended questions designed to initiate problem-solving. Encourage any successes, and encourage commitment to maintaining abstinence.

- "What kinds of positive changes have you noticed since you quit smoking?"
- "What kinds of negative changes have you noticed since you quit smoking?"
- "Are there things you miss about smoking?"
- "Are there things you don't miss about smoking, or are there things you are glad to be free of since you quit smoking?"

Repeat the CO measure at the individual's' request. Continue to reflect what she is saying. Work to understand her thoughts and feelings while offering choices whenever possible. Review each session by using reflective listening. Arrange for follow-up.

Telephone follow-up

One-to-one interventions can be performed by telephone, or in a group setting, whichever the person prefers. Without non-verbal feedback, phone interviews present a greater challenge for the nurse. These require the nurse to listen with a very skilled ear, and to increase the use of reflective listening to ensure proper understanding of the person's verbal cues.

Group follow-up

Some persons prefer group counseling because it provides an additional element of social support. Other benefits of group counseling include: modeling by group members, i.e, seeing others' ability to succeed; learning through others how to cope effectively with nicotine withdrawal; learning the proper use and efficacy of NRT as well as other cessation medications; and, gaining additional support from one's peers.

Peer modeling and interpersonal connections with nonsmokers may be valued by group members because it offers the potential for supportive nonsmoking relationships. It also increases the likelihood of a person working toward, and maintaining, abstinence from smoking.

A group format can be both cost- and time-effective for any SPMI treatment center. Groups generally are most effective when an open format is used. This allows clients to enter at all stages of readiness or change.

The nurse's role, in a client-centered group approach is to facilitate problem-solving and support for group members. Discussion topics are based on issues and concerns raised with the group. The nurse asks open-ended questions and elicits responses from group members.

E. Harm reduction strategies

By *harm reduction,* we refer to a reduction in the number of cigarettes smoked per day. This is not to be confused with switching to a lower level nicotine or tar cigarette.

Although it is well known that ***there is no safe amount of cigarette smoking***, harm reduction for people with serious mental illness can be useful both as a stepping stone toward total cessation by decreasing nicotine dependency, and by increasing the client's self efficacy, an important component in establishing abstinence from smoking. Further, harm reduction is often recognized as a goal for some clients, rather than complete abstinence.

As more and more people with mental illnesses actively work on reducing and/or stopping smoking, tobacco use is becoming denormalized in this population. This is very important because denormalization of tobacco use has been a powerful and effective public health strategy for decreasing smoking prevalence in the general population (Solway, 2009).

Typically, there are two ways to help a client to reduce harm:

1) **Hierarchical Reduction**
   This strategy eliminates those cigarettes the person finds easiest to give up (Appendix C).

2) **Increased Inter-Cigarette Interval**
   This strategy increases the time interval between cigarettes, and thus reduces the number of cigarettes consumed (Appendix D).

Either strategy is accomplished within the same outline as the Quit Plan. The goal becomes harm reduction, rather than complete smoking cessation. Use of pharmacotherapy in conjunction with

a harm reduction strategy is a way to increase the client's efficacy for stopping smoking.

In a nurse-managed intervention program at a university-based outpatient treatment facility, clients (N=99) reported on a 10-point scale: 0 = "I am not motivated to stop smoking." 10 = "I am highly motivated to stop smoking."

Mean score was 9.

Clients participating in the program reported that nurses delivering tobacco dependence interventions were highly motivated and autonomy supportive in working with them. Clients significantly reduced the number of cigarettes they smoked daily at 3, 6, and 12 months; a significant number stopped smoking at 3 and 6 months after beginning the program (Sharp, Cole, Evinger, & Bellush, 2009).

University of Rochester School of Nursing Tobacco Dependence Intervention Program, 2006-2009.

4 Intensive Tobacco Dependence Intervention: Pharmacotherapy Guidelines

Seven 1st-Line, FDA-approved, pharmacotherapy options are available to help our clients stop smoking. Five are categorized as Nicotine Replacement Therapy (NRT) medications: nicotine gum, nicotine lozenge, nicotine patch, nicotine inhaler, and nicotine nasal spray. Two are categorized as Non-Nicotine Replacement Therapy medications: buproprion SR and varenicline.

These medications are discussed in detail in the 2008 update of the *Clinical Practice Guideline* of the United States Public Health Service. Another very helpful pharmacotherapy guideline is Bader, McDonald, & Selby (2009) which provides an algorithm for tailoring pharmacotherapy for smoking cessation.

A. Getting started

It is generally helpful to ask if clients are interested in hearing about the available medications. Explore their prior experiences with cessation medications: What was helpful? Likes? Dislikes?

It is important to ask specific questions, such as how much NRT they were using. It is quite common for people to have used insufficient amounts of NRT and then erroneously concluded that NRT is not efficacious. Therefore, be sure you know specifically how they used the medications prescribed for them. Ask about their uses/experiences with any over-the-counter NRT medications.

If the client wishes to hear more about the available medications, briefly highlight the options, and follow her lead as to what sounds best. You can also make suggestions, but be sure not to get invested in her following your suggestions. (This puts you at risk for being controlling, which is likely to undermine her autonomous motivation and efficacy for stopping smoking.)

B. NRT and avoiding withdrawal symptoms

For highly tobacco-dependent clients, and many of those with SPMI are, longer term, combination pharmacotherapy is likely to be needed. With respect to NRT, this typically involves using a *continuous* form of nicotine replacement, i.e., the patch, along with an *intermittent* form of nicotine replacement, e.g., gum, lozenge, inhaler, and/or nasal spray.

A person-centered approach to prescribing NRT considers the client-provider relationship a partnership. As partners in getting the medications right, we find it quite helpful to teach clients the signs and symptoms of nicotine withdrawal and toxicity (Appendix B).

We let clients know that if they are experiencing cravings, anxiety, irritability, and/or difficulty concentrating – the 4 most common symptoms, they

are withdrawing from nicotine. If they experience withdrawal symptoms, they know they need to increase their nicotine replacement, e.g., increase the patch dosage or use gum at higher doses and/or at more frequent intervals.

Alternatively, if they experience nausea, and sweating and/or palpitations – the 3 most common symptoms, they are nicotine toxic. If they experience signs of nicotine toxicity, they need to cut back on their nicotine replacement, e.g., fewer doses of the inhaler or nasal spray, or a decrease of patch dosage.

It is important to help clients understand that we are confident they are experts about themselves. Only they know their experiences of the nicotine withdrawal process. Our responsibility as clinicians is to understand the clients' past experiences, estimate the amount of nicotine clients receive from their cigarettes (generally 1-1.5 mg. per cigarette), and approximate the nicotine replacement they require to avoid withdrawal symptoms while not becoming nicotine toxic.

The aim is essentially to provide NRT equivalent to the amount of nicotine clients absorb daily from their cigarettes. This will help them avoid the discomfort of withdrawal symptoms, which so often leads clients to relapse. Our goal is to help our clients find their own therapeutic window by teaching them the signs of withdrawal and toxicity

Increased NRT dosage

Remember that nicotine from NRT is more slowly absorbed than nicotine from cigarettes, and that higher arterial peak levels of nicotine (the highest levels being those achieved from smoking) result in higher subjective effects of nicotine, i.e., pleasure, anxiety relief, and greater ability to concentrate.

Clients, especially those who are highly tobacco-dependent, often need relatively high doses of NRT to achieve adequate relief from withdrawal symptoms. Using combination NRT often helps clients achieve sufficiently high blood levels. For example, a person who smokes 1 pack of cigarettes daily is absorbing approximately 20-30 mg. of nicotine. Although a 21 mg. patch might seem to appropriately approximate this daily amount, he is not likely to absorb all 21 mg. of nicotine from the patch.

In addition, because the nicotine is released from the patch quite slowly, he will probably need the supplement of an intermittent form of NRT that is released more quickly, e.g., nasal spray, gum, inhaler, or lozenge, in order to adequately manage his withdrawal symptoms.

Clinicians should remember that nicotine absorption rates from NRT are in decreasing order as follows: nasal spray, gum, inhaler, lozenge, and patch. The optimal choice of intermittent NRT is made based on patient preferences and past experiences (Bader et al., 2009; Benowitz & Dempsey, 2004; Fiore et al., 2008; Williams et al., 2006).

Educating our clients

As with all medications, nurses should review with clients the potential side effects of each of the nicotine replacement medications. This includes the fact that *combination* NRT is not

currently approved by the Food & Drug Administration (FDA). A full discussion of the risks and benefits of each medication with the client is the responsibility of the prescribing advanced practice nurse (APN). When you as a registered nurse (RN) are working with a client to develop a comprehensive Quit Plan, you should collaborate closely with APN colleagues regarding the proper choice and dose of medication to aid cessation.

RNs also should teach clients the appropriate use of these medications, including possible side effects, as well as signs and symptoms of nicotine withdrawal and toxicity. Clients should be assessed for signs and symptoms of withdrawal and toxicity at each visit so that medications can be adjusted accordingly. This assessment also can serve as an objective measure to document clients' experiences with NRT in the clinical record.

NRT is only one line of pharmacotherapy options available to clients. The Non-NRT 1st-Line medications include Bupropion SR, which can be taken concurrently with NRT, and Varenicline, which is not indicated for concurrent use with NRT. The references cited at the beginning of this chapter are helpful in providing more information regarding all 1st-Line pharmacotherapy options to aid cessation.

Finally, clients need to know also that the hydrocarbons in the tar of smoke can induce the metabolism of some psychotropic (and other) medications. Thus, when clients stop smoking, they may experience rising levels of certain medications that are metabolized through the cytochrome P450 system. This may require dosage adjustments of such medications. For more information of listing of medications potentially affected, see Stahl, 2008, as well as the references cited at the beginning of this chapter.

Medications are not magic !

Cessation plans that only focus on pharmacology are not as likely to be as effective as those that include autonomy supportive tobacco dependence counseling by a nurse who is fully and authentically present to her client who smokes.

APPENDIX A	Quit Plan

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?

1. YOUR QUIT DATE:

_____

_____

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, individual, or telephone counseling.

2. WHO CAN HELP YOU:

_____

_____

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.

3. SKILLS AND BEHAVIORS YOU CAN USE:

_____

_____

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.
- Nictone patch—available over-the-counter.

4. YOUR MEDICATION PLAN:

Medications: _____

Instructions: _____

_____

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.

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

U.S. Department of Health and Human Services.
Retrieved November 04, 2008, from:
http:iml.dartmouth.edu/education/cme/Smoking/Linkpage/resources/tearsheet.pdf

APPENDIX B	Nicotine Withdrawal vs. Nicotine Toxicity Worksheet

Client: _____ **Date:** ____ / ____ / ____

Nicotine Withdrawal

On a scale of 0 to 3 (0 = None, 1 = Mild, 2 = Moderate, 3 = Severe), indicate the degree to which you have the following symptoms:

	None	Mild	Moderate	Severe
Anxiety	0	1	2	3
Irritability	0	1	2	3
Difficulty concentrating	0	1	2	3
Cravings for cigarettes	0	1	2	3

Nicotine Toxicity

Since you began taking NRT, or the NRT dose was changed, indicate the degree to which you are experiencing the following symptoms:

	None	Mild	Moderate	Severe
Nausea	0	1	2	3
Sweating	0	1	2	3
Palpitations	0	1	2	3

ACTION TAKEN:

APPENDIX C	Eliminating Your Easiest Cigarettes: *Hierarchical Reduction Strategy*

Based on: Shapiro, D., Schwartz, G. E., Tursky, B., & Shnidman, S. R. (1971). Smoking on cue: A behavioral approach to smoking reduction. *Journal of Health and Social Behavior, 12*, 108-113.

During the 1st week (7 full days) of treatment: Continue to smoke as you typically would. Use this form to record the following:

1) Time of day you wake up.
2) Time of day you smoke each cigarette.
3) Rate each cigarette on how difficult it would be to give up.
   Use a scale of 1-10, where 1 is "Not at all Difficult" and 10 is "Extremely Difficult."
4) The time of day you go to sleep.
5) Calculate the average number of cigarettes you smoked per day (CPD) over the seven days by adding the number of cigarettes you smoked each day. Then divide the total number by 7 (the number of days you recorded).

1st reduction week (Week 2): Eliminate the easiest 25% of your cigarettes from Week 1 according to how you rated them. Record your CPD goal for Week 2 on the next page.

2nd reduction week (Week 3): Eliminate the easiest 50% of remaining cigarettes from Week 2 according to how you rated them. Record your CPD goal for Week 3 on the next page.

Example of a Hierarchical Reduction Plan

Week 1 – CPD (Daily Diary)	**Week 2 – CPD** (25% reduction)	**Week 3 – CPD** (50% reduction)
If 40 CPD	= 30 CPD	= 15 CPD
If 30 CPD	= 22 CPD	= 11 CPD
If 20 CPD	= 15 CPD	= 7-8 CPD
If 10 CPD	= 07 CPD	= 3-4 CPD

My Hierarchical Reduction Plan

	Week 1 – CPD (Daily Diary)	**Week 2 – CPD** (25% CPD reduction)	**Week 3 – CPD** (50% CPD reduction)
Day 1	____ CPD	CPD goal = ____	CPD goal = ____
Day 2	____ CPD		
Day 3	____ CPD		
Day 4	____ CPD		
Day 5	____ CPD		
Day 6	____ CPD		
Day 7	____ CPD		

____ total cigarettes

____ CPD average

1st Week (7 full days) of Treatment: <u>Day 1</u> Date: _____

<u>Directions</u>: Continue to smoke as you typically would. Time you awaken: _____

Time you smoke each cigarette today: Time you went to bed at night: _____

_____ (___)	_____ (___)	_____ (___)	_____ (___)
_____ (___)	_____ (___)	_____ (___)	_____ (___)
_____ (___)	_____ (___)	_____ (___)	_____ (___)
_____ (___)	_____ (___)	_____ (___)	_____ (___)
_____ (___)	_____ (___)	_____ (___)	_____ (___)
_____ (___)	_____ (___)	_____ (___)	_____ (___)
_____ (___)	_____ (___)	_____ (___)	_____ (___)
_____ (___)	_____ (___)	_____ (___)	_____ (___)

In the parentheses above, rate each cigarette as to how difficult it be would be to give it up.
Use a scale of 1 - 10, where 1 is "Not at all Difficult" and 10 is "Extremely Difficult."

How many cigarettes did you smoke today? _____ (Record in Week 1, Day 1)

1st Week (7 full days) of Treatment: <u>Day 2</u> Date: _____

<u>Directions</u>: Continue to smoke as you typically would. Time you awaken: _____

Time you smoke each cigarette today: Time you went to bed at night: _____

_____ (___)	_____ (___)	_____ (___)	_____ (___)
_____ (___)	_____ (___)	_____ (___)	_____ (___)
_____ (___)	_____ (___)	_____ (___)	_____ (___)
_____ (___)	_____ (___)	_____ (___)	_____ (___)
_____ (___)	_____ (___)	_____ (___)	_____ (___)
_____ (___)	_____ (___)	_____ (___)	_____ (___)
_____ (___)	_____ (___)	_____ (___)	_____ (___)
_____ (___)	_____ (___)	_____ (___)	_____ (___)

In the parentheses above, rate each cigarette as to how difficult it be would be to give it up.
Use a scale of 1 - 10, where 1 is "Not at all Difficult" and 10 is "Extremely Difficult."

How many cigarettes did you smoke today? _____ (Record in Week 1, Day 2)

1st Week (7 full days) of Treatment: <u>Day 3</u> Date: _____

<u>Directions</u>: Continue to smoke as you typically would. Time you awaken: _____

Time you smoke each cigarette today: Time you went to bed at night: _____

_____ (___)	_____ (___)	_____ (___)	_____ (___)
_____ (___)	_____ (___)	_____ (___)	_____ (___)
_____ (___)	_____ (___)	_____ (___)	_____ (___)
_____ (___)	_____ (___)	_____ (___)	_____ (___)
_____ (___)	_____ (___)	_____ (___)	_____ (___)
_____ (___)	_____ (___)	_____ (___)	_____ (___)
_____ (___)	_____ (___)	_____ (___)	_____ (___)
_____ (___)	_____ (___)	_____ (___)	_____ (___)

In the parentheses above, rate each cigarette as to how difficult it be would be to give it up.
Use a scale of 1 - 10, where 1 is "Not at all Difficult" and 10 is "Extremely Difficult."

How many cigarettes did you smoke today? _____ (Record in Week 1, Day 3)

1st Week (7 full days) of Treatment: <u>Day 4</u> Date: _____

<u>Directions</u>: Continue to smoke as you typically would. Time you awaken: _____

Time you smoke each cigarette today: Time you went to bed at night: _____

_____ (___)	_____ (___)	_____ (___)	_____ (___)
_____ (___)	_____ (___)	_____ (___)	_____ (___)
_____ (___)	_____ (___)	_____ (___)	_____ (___)
_____ (___)	_____ (___)	_____ (___)	_____ (___)
_____ (___)	_____ (___)	_____ (___)	_____ (___)
_____ (___)	_____ (___)	_____ (___)	_____ (___)
_____ (___)	_____ (___)	_____ (___)	_____ (___)
_____ (___)	_____ (___)	_____ (___)	_____ (___)

In the parentheses above, rate each cigarette as to how difficult it be would be to give it up.
Use a scale of 1 - 10, where 1 is "Not at all Difficult" and 10 is "Extremely Difficult."

How many cigarettes did you smoke today? _____ (Record in Week 1, Day 4)

1st Week (7 full days) of Treatment: <u>Day 5</u> Date: _____

<u>Directions</u>: Continue to smoke as you typically would. Time you awaken: _____

Time you smoke each cigarette today: Time you went to bed at night: _____

_____ (___)	_____ (___)	_____ (___)	_____ (___)
_____ (___)	_____ (___)	_____ (___)	_____ (___)
_____ (___)	_____ (___)	_____ (___)	_____ (___)
_____ (___)	_____ (___)	_____ (___)	_____ (___)
_____ (___)	_____ (___)	_____ (___)	_____ (___)
_____ (___)	_____ (___)	_____ (___)	_____ (___)
_____ (___)	_____ (___)	_____ (___)	_____ (___)
_____ (___)	_____ (___)	_____ (___)	_____ (___)

In the parentheses above, rate each cigarette as to how difficult it be would be to give it up.
Use a scale of 1 - 10, where 1 is "Not at all Difficult" and 10 is "Extremely Difficult."

How many cigarettes did you smoke today? _____ (Record in Week 1, Day 5)

1st Week (7 full days) of Treatment: Day 6

Date: _____

Directions: Continue to smoke as you typically would.

Time you awaken: _____

Time you smoke each cigarette today:

Time you went to bed at night: _____

_____ (___)	_____ (___)	_____ (___)	_____ (___)
_____ (___)	_____ (___)	_____ (___)	_____ (___)
_____ (___)	_____ (___)	_____ (___)	_____ (___)
_____ (___)	_____ (___)	_____ (___)	_____ (___)
_____ (___)	_____ (___)	_____ (___)	_____ (___)
_____ (___)	_____ (___)	_____ (___)	_____ (___)
_____ (___)	_____ (___)	_____ (___)	_____ (___)
_____ (___)	_____ (___)	_____ (___)	_____ (___)

In the parentheses above, rate each cigarette as to how difficult it be would be to give it up.
Use a scale of 1 - 10, where 1 is "Not at all Difficult" and 10 is "Extremely Difficult."

How many cigarettes did you smoke today? _____ (Record in Week 1, Day 6)

1st Week (7 full days) of Treatment: Day 7

Date: _____

Directions: Continue to smoke as you typically would.

Time you awaken: _____

Time you smoke each cigarette today:

Time you went to bed at night: _____

_____ (___)	_____ (___)	_____ (___)	_____ (___)
_____ (___)	_____ (___)	_____ (___)	_____ (___)
_____ (___)	_____ (___)	_____ (___)	_____ (___)
_____ (___)	_____ (___)	_____ (___)	_____ (___)
_____ (___)	_____ (___)	_____ (___)	_____ (___)
_____ (___)	_____ (___)	_____ (___)	_____ (___)
_____ (___)	_____ (___)	_____ (___)	_____ (___)
_____ (___)	_____ (___)	_____ (___)	_____ (___)

In the parentheses above, rate each cigarette as to how difficult it be would be to give it up.
Use a scale of 1 - 10, where 1 is "Not at all Difficult" and 10 is "Extremely Difficult."

How many cigarettes did you smoke today? _____ (Record in Week 1, Day 7)

Record in *My Hierarchical Reduction Plan*

Divide your total cigarettes for 7 days by 7 _____ = CPD average, Week 1 (Cigarettes per day)

Divide your CPD average, Week 1, by 4 _____ = Number of cigarettes to eliminate in Week 2

Divide your CPD goal for Week 2 by 2 _____ = Number of cigarettes to eliminate in Week 3

APPENDIX D	Spacing Your Cigarettes: *Increased Cigarette Interval Strategy*

Based on: Cincripini, P. M., Lapitsky, L., Seay, S., Wallfisch, A., Kitchens, K., & Van Vunakis, H. (1995). The effects of smoking schedules on cessation outcome: Can we improve on common methods of gradual and abrupt nicotine withdrawal? *Journal of Consulting and Clinical Psychology, 63*, 388-399.

During the 1st week (7 full days) of treatment: Continue to smoke as you typically would. Use the pages of this form to record the following:

1) Time of day you wake up.
2) Time of day you smoke each cigarette.
3) The time of day you go to sleep.
4) Calculate the average number of minutes you are awake per day.
5) Calculate the average number of cigarettes you smoke per day (CPD) over the seven days by adding the number of cigarettes you smoked each day. Then divide the total number by 7 (the number of days you recorded).
6) Divide the average number of minutes you are awake per day by the average number of CPD. This gives you an approximate number of minutes between each cigarette smoked. This number is called your Inter-Cigarette Interval (ICI).

1st increase interval week (Week 2): Increase the time between cigarettes by 25% over Week 1. Record your ICI goal for Week 2 in the table on the next page.

2nd increase interval week (Week 3): Increase the time between cigarettes by 50% over Week 2. Record your ICI goal for Week 3 in the table on the next page.

Example of an Increased Cigarette Interval Plan

Week 1 * Average ICI (Daily Diary)	**Week 2 *** (25% increase ICI)	**Week 3 *** (50% increase ICI)
If ICI = 24 minutes, CPD = 40	If ICI = 30 minutes, CPD = 32	If ICI = 45 minutes, CPD = 21
If ICI = 32 minutes, CPD = 30	If ICI = 40 minutes, CPD = 24	If ICI = 60 minutes, CPD = 16
If ICI = 48 minutes, CPD = 20	If ICI = 60 minutes, CPD = 16	If ICI = 90 minutes, CPD = 11
If ICI = 96 minutes, CPD = 10	If ICI = 120 minutes, CPD = 8	If ICI = 190 minutes, CPD = 5

****** Based on 16 hours of awake time (960 minutes).*

My Increased Cigarette Interval Plan

	Week 1 * ICI (Daily Diary)	**Week 2 *** (25% ICI increase)	**Week 3 *** (50% ICI increase)
Day 1	Minutes awake ____ CPD ____ Minutes awake = ICI ____ CPD	ICI goal = ____ min.	ICI goal = ____ min.
Day 2	Minutes awake ____ CPD ____ Minutes awake = ICI ____ CPD		
Day 3	Minutes awake ____ CPD ____ Minutes awake = ICI ____ CPD		
Day 4	Minutes awake ____ CPD ____ Minutes awake = ICI ____ CPD		
Day 5	Minutes awake ____ CPD ____ Minutes awake = ICI ____ CPD		
Day 6	Minutes awake ____ CPD ____ Minutes awake = ICI ____ CPD		
Day 7	Minutes awake ____ CPD ____ Minutes awake = ICI ____ CPD		

****** Based on 16 hours of awake time (960 minutes)***

____ total minutes awake

____ total cigarettes smoked

____ CPD average

____ ICI average

1st Week (7 full days) of Treatment: Day 1 Date: _____

Directions: Continue to smoke as you typically would. Time you awaken: _____

Time you smoke each cigarette today: Time you went to bed at night: _____

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

For how many minutes were you awake today? _____ (Record in Week 1, Day 1)

How many cigarettes did you smoke today? _____ (Record in Week 1, Day 1) This is the CPD.

Divide the number of minutes you were awake by the number of cigarettes you smoked today (CPD). This will give you the approximate number of minutes between each cigarette. This is your ICI.

$$\frac{\text{Minutes awake}}{\text{Number of cigarettes}} = \text{ICI (Minutes between cigarettes) (Record in Week 1, Day 1)}$$

1st Week (7 full days) of Treatment: Day 2 Date: _____

Directions: Continue to smoke as you typically would. Time you awaken: _____

Time you smoke each cigarette today: Time you went to bed at night: _____

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

For how many minutes were you awake today? _____ (Record in Week 1, Day 2)

How many cigarettes did you smoke today? _____ (Record in Week 1, Day 2) This is the CPD.

Divide the number of minutes you were awake by the number of cigarettes you smoked today (CPD). This will give you the approximate number of minutes between each cigarette. This is your ICI.

$$\frac{\text{Minutes awake}}{\text{Number of cigarettes}} = \text{ICI (Minutes between cigarettes) (Record in Week 1, Day 2)}$$

1st Week (7 full days) of Treatment: Day 3 Date: _____

Directions: Continue to smoke as you typically would. Time you awaken: _____

Time you smoke each cigarette today: Time you went to bed at night: _____

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

For how many minutes were you awake today? _____ (Record in Week 1, Day 3)

How many cigarettes did you smoke today? _____ (Record in Week 1, Day 3) This is the CPD.

Divide the number of minutes you were awake by the number of cigarettes you smoked today (CPD). This will give you the approximate number of minutes between each cigarette. This is your ICI.

$$\frac{\text{Minutes awake}}{\text{Number of cigarettes}} = \text{ICI (Minutes between cigarettes) (Record in Week 1, Day 3)}$$

1st Week (7 full days) of Treatment: Day 4 Date: _____

Directions: Continue to smoke as you typically would. Time you awaken: _____

Time you smoke each cigarette today: Time you went to bed at night: _____

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

For how many minutes were you awake today? _____ (Record in Week 1, Day 4)

How many cigarettes did you smoke today? _____ (Record in Week 1, Day 4) This is the CPD.

Divide the number of minutes you were awake by the number of cigarettes you smoked today (CPD). This will give you the approximate number of minutes between each cigarette. This is your ICI.

$$\frac{\text{Minutes awake}}{\text{Number of cigarettes}} = \text{ICI (Minutes between cigarettes) (Record in Week 1, Day 4)}$$

1st Week (7 full days) of Treatment: Day 5 Date: _____

Directions: Continue to smoke as you typically would. Time you awaken: _____

Time you smoke each cigarette today: Time you went to bed at night: _____

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

For how many minutes were you awake today? _____ (Record in Week 1, Day 5)

How many cigarettes did you smoke today? _____ (Record in Week 1, Day 5) This is the CPD.

Divide the number of minutes you were awake by the number of cigarettes you smoked today (CPD). This will give you the approximate number of minutes between each cigarette. This is your ICI.

$$\frac{\text{Minutes awake}}{\text{Number of cigarettes}} = \text{ICI (Minutes between cigarettes) (Record in Week 1, Day 5)}$$

1st Week (7 full days) of Treatment: Day 6 Date: _____

Directions: Continue to smoke as you typically would. Time you awaken: _____

Time you smoke each cigarette today: Time you went to bed at night: _____

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

For how many minutes were you awake today? _____ (Record in Week 1, Day 6)

How many cigarettes did you smoke today? _____ (Record in Week 1, Day 6) This is the CPD.

Divide the number of minutes you were awake by the number of cigarettes you smoked today (CPD). This will give you the approximate number of minutes between each cigarette. This is your ICI.

$$\frac{\text{Minutes awake}}{\text{Number of cigarettes}} = \text{ICI (Minutes between cigarettes) (Record in Week 1, Day 6}$$

1st Week (7 full days) of Treatment: Day 7 Date: _____

Directions: Continue to smoke as you typically would. Time you awaken: _____

Time you smoke each cigarette today: Time you went to bed at night: _____

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

For how many minutes were you awake today? _____ (Record in Week 1, Day 7) This is the CPD.

Divide the number of minutes you were awake by the number of cigarettes you smoked today (CPD). This will give you the approximate number of minutes between each cigarette. This is your ICI.

$$\frac{\text{Minutes awake}}{\text{Number of cigarettes}} = \text{ICI (Minutes between cigarettes) (Record in Week 1, Day 7)}$$

Record in *My Increased Intra-Cigarette Interval Plan*

Find the total of minutes you were awake in Week 1 by adding the number for each day _____
Record this number below the Week 1 column.

Find the total of cigarettes you smoked in Week 1 by adding the CPD number for each day _____
Record this number below the Week 1 column.
Divide this number by 7 _____
This is your CPD average for Week 1. Record this number below the Week 1 column.

Divide the total minutes awake number by the total cigarettes smoked number _____
Record this number below the Week 1 column. This is the ICI average for the week.

Divide your ICI average number for Week 1 by 4 _____
Add this number to your ICI average for Week 1 _____
This is your ICI increase goal for Week 2. Record this number in the heading for Week 2.

Divide your ICI goal for Week 2 by 2 _____
Add this number to your ICI goal for Week 2 _____
This is your ICI increase goal for Week 3. Record this number in the heading for Week 3.

APPENDIX E	References

Bader, P., McDonald, P., & Selby, P. (2009). An algorithm for tailoring pharmacotherapy for smoking cessation: Results from a Delphi panel of international experts. *Tobacco Control, 18*, 34-42.

Benowitz, N. L., & Dempsey, D. A. (2004). Pharmacotherapy for smoking cessation during pregnancy. *Nicotine & Tobacco Research, 6*(S2), S189-S202.

Blaakman, S. W. (2009). Self-determination theory and caregiver smoking bans for asthmatic children. University of Rochester. Unpublished doctoral dissertation.

Deci, E. L., & Ryan, R. M. (1985). *Intrinsic motivation and self-determination in human behavior*. New York, NY: Plenum Press.

Dixon, L., Medoff, D. R., Wohlheiter, K., DiClemente, C., Goldberg, R., Kreyenbuhl, J., et al. (2007). Correlates of severity of smoking among persons with severe mental illness. *The American Journal on Addictions, 16*, 101-110.

Fiore, M. C., Jaén, C. R., Baker, T. B., Bailey, W. C., Benowitz, N. L., Curry, S. J., et al. (2008). *Treating tobacco use and dependence: 2008 update. Clinical practice guideline.* Rockville, MD: U. S. Department of Health and Human Services. Retrieved May 22, 2008, from the U.S. Surgeon General's World Wide Web site: http://www.surgeongeneral.gov/tobacco/treating_tobacco_use08.pdf

Gadow, S. (1980). Existential advocacy: Philosophical foundations of nursing. In S. F. Spicker, & S. Gadow (Eds.), *Nursing: images and ideals, opening dialogue with the humanities* (pp. 79-101). New York: Springer.

Grant, B. F., Hasin, D. S., Chou, S. P., Stinsom, F. S., & Dawson, D. A. (2004). Nicotine dependence and psychiatric disorders in the United States. *Archives of General Psychiatry, 61*, 1107-115.

Janis, I. L., & Mann, L. (1977). *Decision making: A psychological analysis of conflict, choice, and commitment.* New York: The Free Press.

Lyon, E. R. (1999). A review of the effects of nicotine on schizophrenia and antipsychotic medications. *Psychiatric Services, 50*, 1346-1350.

Markland, D., Ryan, R. A., Tobin, V. J., & Rollnick, S. (2005). Motivational interviewing and self-determination theory. *Journal of Social and Clinical Psychology, 24,* 811-831.

Miller, W. R., & Rollnick, S. (2002). *Motivational interviewing: Preparing people for change, 2nd ed.* New York: Guilford Press.

Minicucci Sharp, D., Schmitt, M. H., Dombeck, M. T., & Williams, G. C. (2003). Actualizing Gadow's moral

framework for nursing through research. *Nursing Philosophy, 4*, 92-103.

Morris, C., Waxmonsky, J., Giese, A., Graves, M., & Turnbull, J. (2009, January). *Smoking cessation for persons with mental illnesses: A toolkit for mental health providers*. Denver, CO: State Tobacco Education and Prevention Partnership. Retrieved March 9, 2009, from http://smokingcessationleadership.ucsf.edu/Downloads/catalogue/MHtoolkitJan_2009.pdf

National Association of State Mental Health Program Directors. (2007). *Tobacco-free living in psychiatric settings: A best-practices toolkit promoting wellness and recovery*. Alexandria, VA: Author. Retrieved October 24, 2007, from http://www.nasmhpd.org/general_files/publications/NASMHPD.toolkitfinalupdated90707.pdf

Olincy, A., Young, D. A., & Freedman, R. (1997). Increased levels of the nicotine metabolite continue in schizophrenic smokers compared to other smokers. *Biological Psychiatry, 42*, 1-5.

Schroeder, S.A. (2007, November 18). A hidden epidemic. *Washington Post*. Retrieved March 9, 2009, from http://www.washingtonpost.com/wp-dyn/content/article/2007/11/16/AR2007111601618.html

Sharp, D. L, Cole, R. E., Evinger, J. S., & Bellush, N. (2009, March). *URSON Tobacco Dependence Intervention Program: Outcomes and implications.* Invited presentation at a meeting of Office of Mental Health, Office of Alcoholism & Substance Abuse Services, and Bureau of Tobacco Use Prevention & Control, New York State Department of Health, Albany, NY.

Solway, E. (2009). Windows of opportunity for culture change around tobacco use in mental health settings. Journal of the *American Psychiatric Nurses Association, 15,* 41-49.

Stahl, S. M. (2008). *Stahl's essential psychopharmacology: Neuroscientific basis and practical applications* (3rd ed.), NY: Cambridge University Press.

Williams, G. C., McGregor, H. A., Sharp, D., Levesque, C., Kouides, R. W., Ryan, R. M., et al. (2006). Testing a self-determination theory intervention for motivating tobacco cessation: Supporting autonomy and competence in a clinical trial. *Health Psychology, 25*, 91-101.

APPENDIX F	Resources

Agency for Healthcare Research and Quality
U.S. Department of Health and Human Services
http://www.ahrq.gov/path/tobacco.htm

Treating Tobacco Use and Dependence: 2008 Update

Treating Tobacco Use and Dependence: 2008 Update, sponsored by the Public Health Service, includes new, effective clinical treatments for tobacco dependence that have become available since the 2000 Guideline was published. This update will make an important contribution to the quality of care in the United States and to the health of the American people.

American Psychiatry Association
http://www.psych.org/MainMenu/PsychiatricPractice/AddictionPsychiatry/ClinicalPracticeGuidelinesandOther.aspx

PRACTICE GUIDELINE + RESOURCES for:

Treatment of Patients With Substance Use Disorders, Second Edition

American Psychiatric Nurses Association

http://www.apna.org/i4a/pages/index.cfm?pageid=3751

Centers for Disease Control and Prevention: Office on Smoking and Health, National Center for Chronic Disease Prevention and Health Promotion
U.S. Department of Health and Human Services
http://www.cdc.gov/tobacco/

Mayo Clinic Nicotine Dependence Center
http://www.mayoclinic.org/ndc-rst/

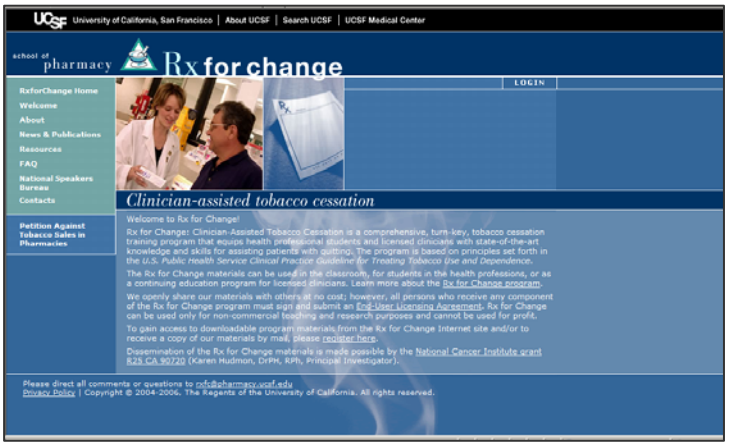
New York State Tobacco Control Program
http://www.nysmokefree.com/newweb/pageview.aspx?p=55

New York State Tobacco Control Program

NY State Medicaid Smoking Cessation Coverage Highlights

A Collaborative Conference Call is coordinated by the New York State Tobacco Control Program on a monthly basis. The call focuses on key smoking-related topics and features guest speakers.

Rx for Change
http://rxforchange.ucsf.edu/



[Note: In 2009, **Rx for Change** intends to release *Psychiatry Rx for Change*, a curriculum specific to psychiatry.]

Smoking Cessation Leadership Center
http://smokingcessationledership.ucsf.edu/

Society for Research on Nicotine and Tobacco
http:www.srnt.org/

Tobacco Free Nurses
http:www.tobaccofreenurses.org/

University of Medicine & Dentistry of New Jersey Tobacco Dependence Program
http://www.tobaccoprogram.org/index.htm

University of Wisconsin Center for Tobacco Research and Intervention
http://www.ctri.wisc.edu/About.CTRI/About.CTRI

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

University of Rochester School of Nursing
Tobacco Dependence Intervention Program

※

Rochester, New York