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Initiating Nicotine Cessation in a Community Mental Health Center

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Abstract

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MSN, Arkansas State University, 2001

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Abstract

Individuals suffering from mental illness are often adversely affected by tobacco use. Historically, clinicians are reluctant and inadequately prepared to recognize and treat comorbid nicotine addiction in the chronic mentally ill (CMI) client. As evidenced by a review of the literature, healthcare providers are missing opportunities for nicotine cessation treatment. There is a lack of educational preparation amongst clinicians to treat nicotine addition and a concern that treatment of nicotine addiction can negatively impact existing psychiatric disorders. The purpose of this project was to create an educational plan for nicotine cessation for CMI clients at a community health center. The conceptual framework to guide this project is premised on Lewin's Change Theory and the Logic Model. Nine clinicians, specializing in mental health, reviewed the developing education program at three distinct times and responded to a 12-item author-developed questionnaire to determine their understanding of nicotine cessation and their willingness to initiate the nicotine cessation program. A review of the questionnaire responses indicates the clinicians agreed nicotine abuse is a problem for the CMI client, they had not received adequate training on nicotine cessation, and they would be comfortable incorporating the nicotine cessation education program in their practice. The findings were presented to key organization stakeholders at the community mental health center. Social change will result with implementation of the education program empowering clinicians, in this mental health center, to gain the knowledge to effectively diagnose and intervene when clients present with comorbid nicotine addiction and mental health conditions.

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Dedication

I would like to dedicate my DNP Project to the memory of my mother, Julia Hamilton. My mother was my greatest inspiration in encouraging me to never give up and reach for the stars.

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I would like to thank my children, Jessica and Justin Buckley; my colleagues, Stephanie Cowan, Shirley Perry-Jackson, Carla Williams, and Faye Stewart; and my classmate, Patricia McAfee for supporting and encouraging me in my quest to obtain my DNP degree. I would also like to thank my preceptor, Dr. Deborah Lewis, and the faculty at Walden University for your time and dedication throughout my DNP project.

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Section 1: Nature of the Project

Introduction

Nicotine abuse and dependence are significantly higher in the chronically mental ill (CMI) than in the general population (Williams, Steineberg, Zimmerman, Gandhi, Lucas, Gonslaves… &McCabe, 2009). In a recent nicotine study, providers asked less than 4% of the mental health participants about their nicotine use (Prochaska, Hall, Delucchi, & Hall, 2013). Historically, clinicians in both inpatient and outpatient mental health services have displayed a reluctance to diagnose and treat comorbid nicotine and psychiatric disorders (referred to as cooccurring or coexisting disorders) (Williams et al., 2009). Many clinicians may ask patients about their smoking status; however, only a small percentage of these clinicians recommend cessation techniques or pharmacological options (Williams et al., 2009).

There are many reasons clinicians do not recommend nicotine cessation. One of these reasons is the view of mental patients not wanting to quit and for the mental health patient, smoking is a choice that should not be terminated (Williams et al., 2009). Another reason is the lack of provider training to address the smoking and treatment options in mental health care settings (Williams et al., 2009). Studies show a high rate of tobacco addiction in people who suffer from mental illnesses (Williams et al., 2009). Unfortunately, content related to nicotine addiction treatment is not a requirement in psychiatry residency programs and is usually not a priority for the clinician in the community mental health center (Williams et al., 2009).

Background of the Problem

The rationale for nicotine use and abuse by the CMI is a complex mix of genetic, environment, and neurobiological factors. Some studies suggest there are certain genetic factors that predispose individuals to nicotine use (Durazzo. Meyerhoff, & Dixon, 2010). Environmental factors, including stress and poverty, are contributors to nicotine use and abuse in the CMI (Durazzo, Meyerhoff, & Dixon, 2010). Psychiatrists believe patients affected by depression, bipolar disorders, and schizophrenic illnesses abuse nicotine (Durazzo, Meyerhoff, & Dixon, 2010). This abuse relieves the symptoms of their disorders through sensitizing the reward centers once nicotine reaches the brain (Durazzo, Meyerhoff, & Dixon, 2010).

In 2009, the Tobacco Disparities Initiatives of the State Tobacco Education and Prevention Partnership reported approximately 48% of individuals affected by depression abuse nicotine (Williams et al., 2009). Sixty-five percent affected by bipolar disorder misuse nicotine (Williams et al., 2009). Eighty percent suffering from schizophrenic illnesses are abusers of nicotine (Williams et al., 2009). In general, the life expectancy of the CMI patient who abuses nicotine is about 25 years less than the overall population (Williams et al., 2009).

A decrease in life expectancy is not only an issue for the CMI patient who abuses nicotine. Nicotine abuse causes more deaths than suicide and homicide together as well as a broad range of health consequences (Prochaska, Hall, & Bero, 2008). Clients suffer from high levels of medical comorbidity, disability, and premature death (Prochaska, Hall, & Bero, 2008). Even though there is increasing literature on the success of

psychosocial treatments, standard treatment of the mentally ill with this dual diagnosis is low (Prochaska, Hall, & Bero, 2008). In America, approximately 250,000 CMI individuals suffer from complications of nicotine addiction/abuse annually (Prochaska, Hall, & Bero, 2008). Without adequate nicotine cessation strategies, the CMI will continue to succumb at twice the rate of the general population (Collins, Tranter, & Irvine, 2012). It is important for clinicians in a community mental health center make the effort to reduce nicotine use in the CMI.

Ongoing nicotine use prevention and reduction efforts have created opportunities and imperatives for change in clinical practice. First, there is a renewed interest by physicians and advanced psychiatric nurse practitioners (APNP) to help reduce related morbidity and mortality in mental health patients (Baker, Breslau, Covey, & Shiffman, 2012). Second, the Diagnostic and Statistical Manual of Psychiatric Disorders Fifth (DSM-5) Edition recently expanded diagnosis criteria for nicotine-related disorders that will be reimbursable by insurance companies (Baker et al., 2012). The reimbursement will provide a financial incentive for mental health clinicians to diagnose effectively and treat co-occurring mental health and nicotine-related illness (Baker et al., 2012). The American Psychiatric Nurses Association (APNA), in partnership with International Nurses Society on Addiction (IntNSA), and International Society for Psychiatric Nursing (ISPN), developed and published competencies (National Organization of Nurse Practitioner Faculties, 2003). These skills encouraged the APN to be a more effective clinician in the treatment and diagnosis of nicotine use disorders.

Many psychiatric nurses may assume CMI nicotine abusers do not want to quit smoking because of the reward effect of nicotine (Crocq, 2003). These rewards include helping the smoker concentrate, reason, and perform (Crocq, 2003). Smokers report that smoking helps them to improve their mood in stressful situations (Crocq, 2003). However, the Centers for Disease Control and Prevention (CDC) (2011) reports many as 70% of smokers, including individuals suffering from comorbid nicotine and mental health disorders, express a desire to quit. Psychiatric nurses trained in nicotine cessation are in a position to deliver effective smoking cessation services to their clients by using evidence-based treatments and recommendations. The APNA encourages psychiatric nurses to initiate nicotine cessation within their various workplace settings (Psychiatric Nurses as Champions, 2008). The settings include inpatient institutions, private doctors' practices, and outpatient treatment centers (Psychiatric Nurses as Champions, 2008). They are also encouraged to make positive changes in attitudinal, institutional, and organizational obstacles that impede CMI patient's access to nicotine cessation services (Psychiatric Nurses as Champions, 2008).

Problem Statement

The CMI patient population has a higher incidence of smoking than the general population (Hirshbein, 2010). They are the primary consumers of tobacco products (Hirshbein, 2010). CMI clients have been described as the tobacco industry's most loyal and eager customers (Hirshbein, 2010). Mental health providers should encourage behaviors that result in better health choices. The use of tobacco is possibly the most changeable risk factor to a healthy lifestyle (Bradshaw & Pedley, 2012). Smoking

cessation is an essential component and should be a priority issue for mental health providers (Bradshaw & Pedley, 2012). In 2003, the World Health Organization (WHO) presented document called Policy Recommendations for Smoking Cessation and Treatment of Tobacco Dependence.

Purpose Statement

The purpose of this project is to make recommendations for an education plan to introduce a nicotine cessation program to clinicians at a community mental health facility. The objectives of this educational project are based on findings from the literature regarding clinician's lack of knowledge, skills, and confidence in assessing smoking cessation. As a part of the process, the first step according to Melnyk and Fineout-Overholt (2005) is to identify the clinical question: What educational intervention would be effective in meeting the established objectives? The clinical focus is to assist clinicians in developing their knowledge, skills, confidence to improve interactions with patients in order to provide smoking cessation counseling.

Project Objectives

The objects for this project are as follows:

To examine national standards of smoking cessation programs that will be beneficial to the CMI patient in the community mental health center.

To develop criteria for implementation of nicotine cessation program in the community mental health center.

To produce recommendations for clinicians at a community mental health center on methods needed to implement a nicotine cessation program

Guiding Questions

I used the following questions to guide my research when developing this study:

What are the national standards for nicotine cessation programs?

What is the basis of educational competencies in a nicotine cessation program?

What is the provider's perception regarding the interest level in the patient to quit nicotine use?

What is the practicality of the project in terms of the resources needed for providers to initiate nicotine cessation as a part of a patient's ongoing plan of care?

Evidence-Based Significance of the Project

Community mental health centers provide clinicians with an opportunity to engage patients regarding their health. They offer a unique opportunity to affect patients' health through assessing, discussing, and developing a plan of care regarding their smoking status. Researchers found that 80% of community mental health clinics' patients who smoke desire to quit. However, because smoking cessation is not a priority in these centers, they do not have the tools to assist them (Himelhoch & Daimut 2003). Because of the clinician's lack of knowledge regarding smoking cessation, patients do not receive the necessary smoking cessation support.

This project will enable clinicians in mental health centers to gain the knowledge needed to understand the greater role in the diagnosis, treatment, and intervention of comorbid nicotine use disorders in their population. Filling this knowledge gap should awaken prescribers to become advocates for nicotine cessation in the CMI. It will provide

avenues to update protocols when identified and provide interventions for patients who suffer from nicotine disorders.

Implications for Social Change

CMI patients consume approximately half of all tobacco (Ronis, 2006). Their chronic mental illnesses produce higher rates of tobacco dependence than the general population (Ronis, 2006). Therefore, they have a higher rate of medical comorbidity, disability, and premature death (Ronis, 2006). Psychiatrists and APNPs have an opportunity to be at the forefront of research efforts to thoroughly examine and document the causes of this phenomenon. Providing information that will implement programs and interventions to help this population contend with the high rates of nicotine disorders can be very instrumental in changing the negative dynamics of nicotine disorders in the CMI.

Nicotine disorders cause a multitude of diseases. These diseases usually lead to a disability and/or death and include conditions such as cardiovascular, pulmonary, cancer, and diabetes (Fineberg, 2013). There are many positive impacts when the smoker decides to quit. Positive impacts include breathing better, improved nutrition, having more stamina, and a decrease of the effects that smoking has on one's health (Fineberg, 2013). Other benefits include saving money, becoming a sharper thinker, and having more endurance (Fineberg, 2013). Quitting smoking also means better health at a lower cost and higher workforce productivity (Fineberg, 2013). These changes make positive impacts on the lives of the ex-smokers, their families, and the community.

Assumptions

An assumption underlying this project is that the CMI do not have a working knowledge of the relationship between nicotine, chronic illness, and death. Even when the CMI are diagnosed with serious physical illnesses that could be attributed to smoking, they refuse to blame cigarettes (Hirshbein, 2010). Healthcare providers are in a good position to educate this population about smoking and chronic health problems that may influence them to make better health options. Another assumption is the CMI do not want to quit smoking because of the rewards derived from abusing nicotine. Some current literature refutes this conjecture and suggests that the CMI would be interested in nicotine cessation interventions (Reilly, Murphy, & Alderton, 2006). The third assumption involves the notion that psychiatric healthcare providers have little interest in advocating nicotine cessation in their clients. Based on the literature this has proven not to be the case (Johnson, Moffat, & Malchy, 2010).

Summary

Clinicians in both outpatient and inpatient mental health services have been reluctant to diagnose and treat comorbid nicotine and psychiatric disorders (Williams et al., 2009). However, nicotine abuse is significantly higher in the CMI population (Williams et al., 2009). Nicotine prevention measures have created opportunities for change in clinical practice. The purpose of this project is to provide information to clinicians at a community mental health center in Memphis, Tennessee regarding smoking cessation for the CMI population. A review of literature and different methodologies was conducted to gather information to support the need for smoking

cessation. Once the information was gathered, an educational plan was recommended to community mental health center clinicians.

Section 2: Review of Literature and Theoretical and Conceptual Framework

Introduction

The educational preparation for psychiatrists and the advanced practice nurse (APN) has not included nicotine cessation for the CMI population in their day-to-day practice (Williams et al., 2009). As a result, they have been reluctant to initiate programs for nicotine cessation (Williams et al., 2009). The literature review for this educational plan will examine the psychiatrist's and the APN's role in nicotine cessation in community mental health centers. The first literature review relating to psychiatrists entailed a search of databases including PubMed, CINAHL, Cochrane Database of Systematic Reviews, and MEDLINE. Relevant search terms included *psychiatrists, training, diagnosis, treatment, nicotine,* and *assessment*. A thorough literature review highlighted psychiatrists' attitudes regarding nicotine cessation and the use of different nicotine assessment tools used to assess, diagnose, and treat nicotine use disorders. Full-text articles between the years 1999 – 2013 recovered from scholarly, peer-reviewed journals made available through the Walden University Library were reviewed.

The second section of this literature review addresses the readiness of APNs in mental health to address nicotine use disorders. This thorough analysis was developed using electronic databases from Walden University library. The analysis extracted data related to the APN in diagnosis and management of nicotine disorders. The databases include PubMed, CINAHL, Cochrane Database of Systematic Reviews, and MEDLINE. Related search terms included *advanced practice nurses, diagnosis, and treatment* and

nicotine use disorders. Full-text studies extracted from scholarly journals are included in the review ranging from the years 2001 to 2013.

Evidence in the literature supports psychiatric patients' abuse nicotine more than other patients who use healthcare services; psychiatric patients are more adversely affected by the negative health consequences of nicotine use disorders. The Association of American Medical Colleges (AAMC) (2007) found that psychiatrists reported more than half of their clients abused nicotine. This abuse is more than any other medical specialty including internal medicine, obstetrics and gynecology, and family practice. Himelhoch and Daimut (2003) stated that out of 1,610 persons attending office visits to psychiatrists only 12% reported receiving counseling for nicotine abuse from their clinician. Psychiatrists appear to display great reluctance to broach the topic of nicotine use disorders in their clients and stated they feel unprepared by their medical education to effectively diagnose and treat these disorders.

Specific Literature Psychiatrists

Williams, Zimmerman, Steinberg, Ghandi, and Delnevo (2011) recognized that psychiatrists are often remiss in approaching their clients with advice and counseling on nicotine use disorders and offered several reasons. According to the study results, psychiatrists often display a professional tendency to undervalue nicotine addiction as a problem in their clients (Williams et al., 2011). Undervaluing nicotine addiction as a problem could relate to the fact therapists do not ask their clients about nicotine behaviors and may be unaware of the breadth of the problem (Williams et al., 2011). Another reason therapists appear to be hesitant to broach nicotine use with their clients involves

the assumption that nicotine has a sedative effect and helps the CMI stay tranquil, which results in fewer exacerbations of their disorders (Williams et al., 2011). Psychiatrists and physicians seem to feel that without nicotine their clients will become stressed and relapse into a psychotic episode or become more anxious and depressed (Williams et al., 2011). Some also fear without nicotine some CMI clients will turn to street drugs to relieve their mental discomfort, which may further complicate the course of their disorders (Williams et al., 2011). These issues make it appear as though psychiatrists somehow view abusing nicotine as the lesser of two evils (Williams et al., 2011). It is also proposed psychiatrists seem to exhibit a lack of hope these clients want to and can quit abusing nicotine (William et al., 2011).

Research evidence has contested the theory that psychiatrists lack a sure hope for their clients' success in nicotine cessation (Addington, el-Buebaly, Campbell, Hodgins, and Addington, 1998). Addington et al. (1998) completed a research project involving 50 subjects affected with schizophrenic illness and had a desire to quit abusing nicotine. Six weeks into the project, 42% of the schizophrenic subjects achieved nicotine free status (Addington, 1998). Three months into the study, 16% remained nicotine free and at 6 months 12% of the study group stayed nicotine-free (Addington, 1998). These statistics were shown to be equivalent to quit rates in none CMI populations (Addington, 1998). Most importantly, during the intervention there were no reports of worsening the participant's positive and negative symptoms of schizophrenia (Addington, 1998). These results indicate mentally ill clients are willing and can successfully quit nicotine.

Studies suggest mental health clinicians tend to focus on their client's mental health diagnosis and mostly ignore other comorbid and chronic disorders (Bradshaw and Pedley, 2012). According to Bradshaw and Pedley (2012), clinicians believe these disorders are to be addressed and treated by other medical specialists. This belief is often attributed to the assumption that psychiatrists lack a working knowledge of an evidence-based care of nicotine disorders, owing to a lack of focus in this area in their medical education programs (Bradshaw and Pedley, 2012). Hudson and Mannino (2010) propose treating nicotine use disorders as a chronic illness given the relationship between these disorders and cardiovascular disease, diabetes, and chronic respiratory disease.

There is clear evidence a practice change is warranted in psychiatry in the treatment of comorbid nicotine disorders (Kleinfelder, Price, Drake, Jordan, & Price, 2013). However, 80% of psychiatrists report they feel poorly prepared by their medical education to treat these disorders (Kleinfelder, et al., , 2013). In a study evaluating all medical specialties familiarity with nicotine cessation practices, cardiologists exhibited a greater familiarity with nicotine treatment services and were more likely to refer their patients for these services (Foulds, Gandhi, Steinberg, Richardson, Williams, Rhoads, 2006). Psychiatrists scored the lowest among the specialties to know about nicotine cessation services and were noted to be the last to refer clients for these services (Foulds et al., 2006). Psychiatrists are missing key opportunities to help their clients deal with comorbid nicotine use disorders. These lost opportunities are due to inadequate preparation from their medical education and insufficient knowledge of the guidelines used to for nicotine use disorders in the CMI (Foulds et al., 2006).

Several research groups have investigated measures to increase psychiatrists' effectiveness in diagnosing and treating nicotine use disorders. Caplan, Stout, and Blumenthal (2011) suggest training physicians to increase office-based assessment and treatment of nicotine use disorders. The five A's guidelines for smoking cessation were developed by the Public Health Services Clinical Practice Guidelines (2009). They promote:

Asking the client about their nicotine use with each clinic visit.

Advising clients about the negative health consequences of nicotine abuse

Assisting the client who wants to quit abusing nicotine

Assessing clients' progress with each clinic visit

Arranging for follow-up help such as quit lines or support groups

In the past, psychiatry has made a poor show of responding to these guidelines (Cabana, Rand, Powe, Wu, Wilson, Abbound, & Ribom,1999), suggest physicians, including psychiatrists, have difficulty complying with smoking cessation guidelines recommended by the Public Health Service for several reasons (Cabana et al., 1999). The author states physician resistance to nicotine cessation guidelines often stems from their lack of awareness of the guidelines (Cabana et al., 1999). Eighty-four percent of medical clinicians responding to this study admitted to an ignorance of the practice procedures related to nicotine cessation (Cabana et al., 1999). Eighty-nine percent of the respondents claimed unfamiliarity with nicotine cessation guidelines as their reason for not following them (Cabana et al., 1999). Ninety-one percent of the study participants indicated they simply were not in agreement with specific guidelines and, as a result, were hesitant to

initiate them into their practice (Cabana et al., 1999). The physicians displayed a small belief they would be able to be effective in nicotine cessation treatments. Ninety percent of the respondents cited a low expectancy for good outcomes and did not believe their efforts to help nicotine abusers change or modify their behaviors would make a difference (Cabana et al., 1999). Finally, 66% of the physicians responding to this study reported no motivation to become involved in nicotine cessation practices, which may prove to be the most difficult barrier to overcome related to nicotine cessation intervention (Cabana et al., 1999). While the Cabana et al. (1999) study was not specific to psychiatry, it does offer insight into why some physicians are not prepared to respond to the need for increased efforts to control nicotine abuse in CMI populations.

Specific Literature - APN

Studies indicate a majority of APNs did not receive any extensive training related to nicotine cessation in their undergraduate or postgraduate educations. A national survey of psychiatric nursing faculty in 2006 found only 51% reported the assessment and treatment of nicotine was a part of their curriculums (Prochaska, Fronmont, Hudmon, & Cataldo, 2009). Most of those reporting observed the average duration of the instruction on nicotine abuse and treatment was 2 hours or less (Prochaska, Fronmont, Hudmon, & Cataldo, 2009). Kehoe (2008) conducted a qualitative study assessing the views and practices of APNs related to nicotine control. This study found fewer than 15% of nurse practitioners provides nicotine use prevention, and most of the study's participants displayed a poor knowledge of national clinical guidelines related to nicotine use disorders (Kehoe, 2008). The Kehoe tated APNs unfortunate acquaintance with federal

guidelines related to nicotine use disorders might be a reflection of the wide gaps in nursing programs addressing nicotine use disorders. One study showed mental health clinicians are willing to explore nicotine cessation with their client populations if they receive proper training techniques of nicotine cessation (Himelhoch, Riddle, & Goldman, 2013).

One of the most important roles of the APN is as an educator (Porter, 2013). Studies indicate clients in most medical specialties are more receptive to consultation with an APN because APNs spend more quality time with them during their visits (Porter 2013). These studies also report finding APNs knowledgeable as general medical practitioners (Seale, Anderson, & Kennersley, 2005). Therefore, APNs may also be squandering prime time that could be used to address nicotine use disorders in their clients (Porter, 2013).

Several impediments in APNs assuming leadership roles in nicotine cessation in their clients are identified (AHRQ, 2008). The Agency for Health Care Research and Quality (AHRQ) (2008) suggests APNs do not incorporate nicotine cessation as a part of clinical care for their clients who smoke or use nicotine products. The AHRQ (2008) suggest APNs lack knowledge of the guidelines for smoking cessation developed by the Public Health Services and are not well versed in the use of the five A's to quitting nicotine abuse. McEwen and West (2001) suggested APNs may not be fully aware of their ability to treat and diagnose nicotine use disorders and have reduced comfort in prescribing nicotine replacement therapy. There remain a few states that have withheld

prescriptive authority from APNs for any medications including those for nicotine replacement McEwen & West, 2001).

Williams et al. (2009) state because of the number of patients they serve with comorbid nicotine disorders, APNs already possess the skills necessary to implement nicotine cessation strategies in the CMI. The authors promote APNs "owning" (p. 3) the problem of comorbid nicotine disorders and using their learned skills of assessment, motivational techniques, and counseling (Williams et al., 2009). "Owning" will assist in bringing nicotine addicted populations under control (Williams et al., 2009).

There is a paucity of research in this area. However, help for psychiatrists and APNs that treat the CMI may be present in the future (Ratschen, Britton, and McNeill, 2011). Research in this area is increasing, and the different factions of the medical and scientific communities weigh in on different strategies to enhance knowledge and practice of psychiatric clinicians in treating comorbid nicotine disorders (Ratschen, Britton, and McNeill, 2011). Ratschen, Britton, and McNeill (2011) suggest nicotine abuse "should be acknowledged as a vital sign in mental health as in all other aspects of healthcare provision" (p. 7).

Studts, Flynn, Dill, Ridner, Worth, and Sorrell (2010) found that 80% of APNs reported being comfortable discussing nicotine cessation with their clients in mental health. Ninety percent of the APNs in this study reported uneasiness with providing specific forms of assistance including devising cessation plans and recommending the different types of nicotine replacement therapies (Studts, 2010). This discomfort indicates

more training is needed for APNs in this area so they can develop the necessary skill sets required to treat nicotine use disorders.

The challenge with APN treatment of nicotine use disorders needs to be addressed if APNs are to become better at treating these disorders in their clients. Williams et al. (2009) state interventions at training medical professionals, including advanced nurse practitioners is an important first step towards improving the disbursement of nicotine disorder treatment in mental health clients. Heath, Kelley, Andrews, Crowell, Corelli, & Hudmon (2007) concluded APN training should begin at the lowest level of nursing education to the highest level. A system of "training the trainer" (p. 286) can disseminate training and research across a broader spectrum of nicotine cessation interventions across all medical specialties (Heath et al., 2007).

Theoretical Framework

For this project, the theoretical framework is based on theories related to change. One theory is Everett Rogers' Diffusion of Innovations (DOI) theory (Sahin, 2006). There are four components to Rogers' theory including the concepts of innovation, communication channels, time, and social systems (Sahin, 2006). The premise of this theory suggests innovation or new ideas and technology, are diffused by way of specific channels of communication (Sahin, 2006). Rogers' model has been used across a broad range of disciplines including public health (Sahin, 2006). Rogers describes innovation as an "idea, practice or project perceived as new" (Sahin, 2006, p. 1) within particular social systems. The idea of a nicotine cessation screening tool may not be an innovation for healthcare providers at the community health care center. However, the tool being

developed to support the goals of this project was new to them. Change can be a painful process for healthcare providers so it was important to solicit their input while reviewing with them all the advantages and disadvantages of the proposed tool.

Another theory used to strengthen the foundation of this project is Kurt Lewins' Change Theory . It is a useful complement to Rogers' model. The change theory consists of three distinct stages including 1) unfreezing 2) new behaviors and 3) refreezing. Unfreezing provides people with a process that facilitates letting go of old or nonproductive patterns of behavior (Suc, Prokoscha, & Ganslandt, 2009). The second stage is described as one of growth towards new levels of behavior and knowledge. The third stage of Lewins' theory is called refreezing, which incorporates applying new and learned knowledge and practices consistently into medical or nursing practice, so they become standard operating procedures (Suc, Prokoscha, & Ganslandt, 2009). Using Lewins' theory to effect change in the healthcare providers in community mental health centers may accomplish:

Helping providers break free of the old habits of ignoring nicotine use disorders in their client population;

Assisting providers in achieving improved levels of patient care; and

Encouraging providers to screen, diagnose and treat nicotine use in their populations until it becomes routine practice.

The Cognitive Behavior Theory (CBT) is a tool used to identify what triggers nicotine use and abuse in the CMI. This theory is a psychotherapy used to help people with many different types of psychological problems (Ratschen, Britton, & McNeill,

2011). It is based on changing maladaptive thinking patterns and the negative behaviors associated with the patterns (Ratschen, Britton, & McNeill, 2011). It can be used as a promising psychological invention for people who want to quit smoking and maintain cessation. The CBT will address the following to help clinicians devise a plan for the smoking CMI:

Individualized strategies to help patients cope with stressful environments and situations

Change thinking patterns to help patients cope with mood changes associated with nicotine withdrawal

Identify social or environmental to assist the patient in determining which situations make the patient desire nicotine

Provide educational information during the quitting process

(Ratschen, Britton, & McNeill, 2011)

Summary

The literature review supported psychiatrists and the APN were not adequately trained in the assessment and treatment of nicotine abuse in the CMI client. Everett Rogers DOI and Kurt Lewin's Change theories were reviewed as means to address the changes needed for these clinicians to provide assistance when addressing nicotine cessation for the CMI client. CBT was introduced as a tool to assist in changing the thinking of the CMI client who abuses nicotine. This information was useful when evaluating designs and methods needed for this educational plan.

Section 3: Methodology

Project Design/Methods

This project made recommendations for an education plan that introduced a nicotine cessation program to clinicians at a community mental health facility. The principles of the Knowles Educational Theory were chosen as a secondary framework for the project. Knowles' theory applies to adult learners (Knowles, 1975). His theory suggests that these students desire to gain knowledge to live more effective lives and that learning experiences are organized around competency-development categories (Knowles, 1975). This learning theory based on competency suggests that as people grow and develop they develop the need to help others benefit from their learning experience (Knowles, 1975). According to Knowles, individuals take the initiative in diagnosing their learning needs, setting goals, and identifying resources for learning and evaluating outcomes. Knowles' theory is centered on competencies; it is an excellent fit for this project (Knowles, 1975). It will enable clinicians to implement a nicotine cessation program effectively and will prove beneficial through each phase of the project.

The project began with a review of the national standards for nicotine cessation programs. The second phase developed recommendations for educational competencies for the program. The last stage was a recommendation to the community mental health center on an education plan. This educational plan will result in a nicotine cessation program implemented for the CMI.

Phase One

The project began with a review of the national standards of nicotine cessation programs. According to the American Lung Association (ALA) website (2014), the approach to nicotine cessation treatment includes standard interventions of tobacco cessation counseling (TCC) and nicotine replacement therapy. TCC is a standard of care recommended as part of nicotine cessation (ALA, 2014). Clinicians' role in educating their patients about the harmful consequences of tobacco use has been proven to be influential in motivating patients to stop smoking Hudmon, Hemberger, Corelli, Kroon, & Prokhorov, 2002). Counseling includes assisting patients with planning a quit day, identifying barriers and the prevention of relapse. Individual and group counseling are effective parts of nicotine cessation. However, active telephone therapy is also useful. Using self-help materials is an alternate option for participants who do not want to participate in counseling. However, research has proven it is not as effective as TCC. According to the ALA, TTC increases smoking cessation success rates 6-12% (Hudmon et al.,, 2002). The 5 A's is a nationally used smoking cessation plan that includes a brief counseling intervention of five15 minute sessions used by clinicians that have proved to double the smoking cessation rates in patients (Clinician's Guide, 2014).

The 5 A's process is for patients who present a desire to quit smoking within a 30day time frame. The process is built around the 5 A's: asking, advising, assessing, assisting, and arranging. These techniques are provided by the United States Public Health Service Clinical Practice Guideline: Treating Tobacco Use and Dependence. The 5 A's was created to keep steps simple when introducing patients to a smoking cessation

program and provide onsite clinicians with a strategy for smoking cessation for smokers who want to quit Caplan, Stout, and Blumenthal, 2011).

Nicotine replacement therapy (NRT) is a national standard in smoking cessation. NRT is the dispensation of nicotine into the body by means other than tobacco and is used to reduce nicotine cravings in smokers (Johnson, 2011). It enables them to have an easier transition when overcoming the nicotine addiction (Johnson, 2011). According to the National Center for Biotechnology Information (NCBI) (2012), the use of nicotine replacement therapy increases the chances of a smoker quitting up to 50-70%. The United States Food and Drug Administration approved the patch, gum, nasal spray, inhalers, and lozenges for nicotine replacement therapy (Johnson, 2011). Using nicotine replacement therapy and getting the support of a counselor doubles the chance for a smoker to quit (Johnson, 2011).

Phase Two

Developing recommendations for educational competencies was the next phase of the project. Competencies are defined in this project as the set of abilities, skills, knowledge, and attitudes required to conduct the tasks and functions needed for a successful smoking cessation plan. The three levels are (a) Core, (b) Generalist, and (c) Specialty. The Core Level competencies are ones the health care workers should possess. Health care workers include clinicians, community health workers, registered health professionals, and therapists (Sims & Sims, 2005). The Generalist level capabilities are for individuals providing cessation services as one of the several roles they perform, dependent of their time available and skill, in a supervised environment (Sims & Sims,

2005) . The third level is the Specialist Level and includes competencies for individuals providing smoking cessation services as their primary role (Sims & Sims, 2005).

Phase Three

For the purpose of this project, core competencies were defined. The first competency included professional development. Health care workers should be confident when inquiring about nicotine use, giving advice, and arranging for cessation support. Clinicians in the community mental health center may not have knowledge of the smoking cessation field and should be offered adequate training in the guidelines for a successful smoking cessation program. The second competency considered for this project was communications. Effective communication skills are vital to effective cessation programs as communication is necessary when discussing the impact of continued nicotine use. Constant communication with the patient and on the patient's level of understanding provides the clinician with information needed to identify sources to assist the patient in quitting.

Phase Four

In the final phase of the project, the scholar-practitioner presented recommendations to the community mental health center on the necessary steps needed to implement a smoking cessation program. In order to complete this process, I developed a document outlining national standards and competencies. It provided information on the measures used on a national basis to include the 5 A's and 5 R's as a model cessation program. Competencies were explained and included as a part of the recommendation.

Methodology

The methodology guiding this project was based on Quigley's logic model (Lando, Williams, Sturgis, & Williams, 2006). Business managers use these skills in planning and executing the changes in the industry (Lando et al., 2006). The components of the logic model that would be applicable to this project included identifying the problem, goal setting, outputs, and outcomes. Based on the literature review and needs assessment, the facility can benefit from a nicotine cessation program. Clinicians at the community mental health center do not practice the guidelines for nicotine cessation set forth by the Public Health Service.

Goals were set based on a needs assessment and a perceived gap in knowledge contributing to the ineffective treatment of nicotine use disorders in community mental health centers. Outputs and outcomes will center on an evaluation of the healthcare improved competencies in using a nicotine cessation tool to assist them in screening, diagnosing and treating nicotine use disorders. The key variables of the project include the health providers and the tool that was developed to help implement the program.

The community mental health center's two psychiatrists and seven APNPs are the only healthcare providers authorized to diagnosis and treat comorbid nicotine use disorders embedded in their practice framework. At the center, APNs, physicians, and other leaders function at the system level already. They have collaborative relationships and practices. These tenets/elements effect and sustain change.

Project Evaluation Plan

The projected was conducted in four phases. During the first phase, the medical director, vice president of out-patient clinics, and two nurse practitioners were identified as key stakeholders. They were presented with the national standards for nicotine cessation programs during a weekly staff meeting. After reviewing the standards, they were presented with a list of "yes/no" questions (Appendix A) to determine their understanding of nicotine cessation.

Phase 2 included describing educational competences beneficial for a successful nicotine cessation program. Stakeholders were asked to review the competences and respond to a short list of questions (Appendix B) to validate that these were the educational competences needed for the program.

In Phase 3, providers' interest and resources needed for implementation were identified. Providers' interest was established by the willingness of the stakeholders to participate in the ongoing formative evaluation of this project. Stakeholders reviewed literature and current practices to identify resources needed for a successful program. A review of available resources needed for implementation of this project was developed and reviewed with stakeholders. Since stakeholders represent clinicians, clinician leadership, and administrative leadership, they should be able to identify gaps in needed resources and the potential for the community mental health center to fill those gaps. The list of needed resources (Appendix C) was presented to each member of the stakeholder group. They were asked to respond with "yes/no" answers indicating their willingness to provide needed resources.

The final phase of the project presented recommendations to the community mental health center on the necessary steps needed to implement a smoking cessation program. In order to complete this process, a document outlining national standards and competencies was developed. It provided information on the measures used on a national basis to include the "5 A's" and "5 R's" as a model cessation program. Competencies will also be explained and included as a part of the recommendation.

Summary

The lack of programs for nicotine cessation at community mental health facilities results in the CMI not receiving help to quit smoking. This DNP project examined national standards of nicotine cessation and measures that would help clinicians identify clients who could benefit from a nicotine cessation program. Information was identified that would help clinicians develop their knowledge, skills, confidence, and interactions with clients in order to provide nicotine cessation counseling. The plan's objective was to introduce clinicians to smoking cessation techniques that will encourage CMI clients with nicotine addiction to quit smoking. IRB approval (09-15-0356723) was obtained from Walden University before the project was initiated. Questionnaires were distributed to clinicians at the community mental health clinic. The information gathered was used for discussions and implementations. The next section will describe the community mental health clinic, as well as, provide information from questionnaires, findings, discussions, and implications.

Section 4: Findings, Discussions, and Implications

Findings

The community mental health clinic located in Memphis, Tennessee has provided treatment for patients for over 20 years. However, it does not offer a nicotine cessation program for its clients. Outpatient mental health facilities have historically displayed reluctance in diagnosing and treating comorbid nicotine in clients diagnosed with psychiatric disorders (Williams et al., 2009). The intention of this project was to introduce a smoking cessation plan to providers in the community mental health center located in Memphis, Tennessee that will encourage CMI clients with nicotine addiction to quit smoking.

Providers completed a list of yes/no questions (Appendix A) to determine their understanding of nicotine cessation, reviewed competences, and responded to a short list of questions (Appendix B) to validate that they were educational competences needed for the program. Providers also answered a list of yes/no questions (Appendix C) to indicate their willingness to provide resources needed for a smoking cessation plan. Table 1 represents responses from Appendix A, Table 2 represents responses from Appendix B, and Table 3 represents responses from Appendix C. Providers were provided with a document outlining the measures used on a national basis that included “5 A’s” and “5 R’s” as a model cessation program.

Table 1
Stakeholder Group Questionnaire 1

Question	Yes	No
Would you agree that nicotine abuse is a problem in the mental health population?	4	0
Did you receive adequate training on nicotine cessation in your nursing or medical education?	0	4
Would you be comfortable using a nicotine cessation tool in your practice?	4	0
Do you feel utilizing the national standards of nicotine cession will benefit clients in this community mental health center?	4	0
Are you willing to incorporate these standards in your day-to-day practice?	4	0

Table 2
Stakeholder Group Questionnaire 2

Question	Yes	No
Did the information increase your understanding of nicotine cessation?	4	0
Did the information boost your confidence in discussing nicotine cessation with your client?	4	0
Are you comfortable in advising and recommending nicotine cessation to your client?	4	0

Table 3
Stakeholder Group Questionnaire 3

Question	Yes	No
Are you willing to provide resources needed for ongoing training?	2	0
Are you willing to provide resources for educational material needed for a smoking cessation program?	2	0
Are you willing to provide resources for first-line pharmacotherapy?	2	0
Are you willing to provide therapeutic counseling for the CMI client interested in quitting?	4	0

Discussion of Findings in the Context of Literature

A review of scholarly literature indicates a practice change is necessary in the treatment of comorbid nicotine disorders in mentally ill clients. Evidence in this literature supports the fact that psychiatric clients' abuse nicotine more than other clients who use healthcare services. Kleinfelder et al. (2013) report 80% of psychiatrists did not feel they were adequately educated to treat nicotine disorders. Psychiatrists are missing key opportunities to help their clients deal with comorbid nicotine use disorders. These lost opportunities are due to inadequate preparation from their medical education and insufficient knowledge of the guidelines used for nicotine use disorders in the CMI.

A review of the 2009 Public Health Services Clinical Practice Guidelines endorse the 5 A's as a guideline for smoking cessation. The 5 A's is a nationally used smoking cessation plan that includes a brief counseling intervention of 15 minutes used by clinicians and has proved to double the smoking cessation rates in patients(ALA.org). This process includes *asking*, *advising*, *assisting*, *assessing,* and *arranging* clients regarding their nicotine abuse. Once tobacco using clients are identified, these individuals should be asked about their smoking habits. Providers may also use this opportunity to advise clients about the negative health consequences of nicotine abuse. If the client desires to quit smoking, the provider is then able to provide assistance. The client's progress was assessed on each clinical visit. The provider was able to arrange follow-up support through groups and/or quit lines. This technique is a part of the recommendation to the providers.

Another component of the recommendation includes the 5 R's of quitting. This process entails addressing the relevance, risks, rewards, roadblocks and repetition of the individual identified as wanting to quit. In general, the provider must communicate the relevance of smoking cessation for the person, i.e. why would this change be beneficial to the individual who wants to stop smoking. This would be immediately followed with a discussion of the risks on the individual if they continue smoking. Real life experiences, including family histories and risks to the client's well-being, are most effective. Next, the providerwould identify rewards to the client's life and the impact on social change when they successfully stop smoking. These could include benefits that will lower the risk of smoking diseases such as cancer, heart disease, stroke, high blood pressure and lung disease. Not only will stopping smoking have positive effects on health but there are financial rewards as well. These include a savings of over $2,000 a year if a client smokes one pack of cigarettes a day which can add up to $10,000 over a 5 year period (www.quitterscircle.com). Other more personal rewards include a delay in facial aging and a reduction in the staining of teeth. Nonsmokers have better sex because the blood flow in the body improves sensitivity. Stopping smoking also improves fertility and decreases the chances of miscarriage. When individuals stop smoking their chances of living a longer life is increased. At the same time, the provider must identify potential roadblocks that could make the client's journey to smoking cessation more difficult (nhs.uk). The provider would want to explain at this time that the path to recovery is bumpy and may include repetitive attempts to stop smoking and many relapses in

treatment. The results were only specific to the sample studied in this inquiry and are not generalizable to any other sample.

Implications

Ronis (2006) reported that CMI clients produce higher rates of tobacco dependence than the general population. As a result, they have higher rates of medical comorbidity, disability, and premature death. Quitting smoking offers the CMI client mental health benefits. Many CMI clients believe smoking is a benefit. They smoke to regulate mood swings, anxiety, and believe smoking has psychological benefits. Research, on the other hand, indicates that quitting smoking results in a significant decrease in mood swings, anxiety, psychological quality of life, and depression (Taylor et al., 2014).

Research indicates nicotine cessation provides interventions to decrease this population's high rates of nicotine disorders. There are increased rates for diseases such as cardiovascular, pulmonary, cancer, and diabetes. However, if these clients are successful in quitting, they will experience better breathing, improved nutrition, more stamina and a decrease in the effects smoking has on one's health. Other benefits include saving money, becoming a sharper thinker, and having more endurance. Quitting smoking also means better health at a lower cost with resulting higher workforce productivity (Fineberg, 2013). These changes make positive impacts on the lives of the ex-smokers, their families, the community and society as a whole.

"Smoking cessation increases both quantity and quality of life expectancy" (Hurley & Matthews, 2007, p. 548). Literature indicates CMI clients have similar benefits

if they are successful in quitting as nonCMI clients. They exhibit improvements in self-esteem, physical appearance, and in their health (Fillia, Baker, Gurvich, Richmond, & Kulkarni, 2014). Many clients have concerns regarding weight gain once they have quit smoking. Smoking cessation decreases the dangers of cardiovascular disease (CVD). If the client's experiences weight gain, those dangers may lessen the risk of CVD. However, evidence suggests the CVD benefits outweigh the dangers of weight gain (*Does Weight Gain After Quitting Smoking* 2013). Other health issues such as stroke, lung cancer, and chronic obstructive pulmonary disease (COPD) put the smoker at a high risk of fatality. However, when smokers quit smoking, these risks decline over time (Hurley & Matthews, 2007).

Policies that control tobacco use have had important influences on reducing tobacco use and impacting social change (Hurley and Matthews, 2007). Nicotine cessation programs have improved these rates within the context of these policies (Hurley & Matthews, 2007). Policies such as the Family Smoking Prevention, Tobacco Control Act, and the Affordable Care Act were designed to regulate tobacco products and provide nicotine cessation programs to individuals desiring to quit smoking (Hurley & Matthews, 2007). Many policy-makers have questioned the cost-effectiveness of tobacco control (Hurley & Matthews, 2007). Analyses believe investing in public policy can reduce smoking rates (Hurley & Matthews, 2007).

Hurley and Matthews (2007) found public policy on smoking had a significant impact in reducing smoking rates. They predicted that a 5% reduction in smoking rates would reduce spending on drugs for cardiovascular disease from smoking by $4.5 billion

over a 40-year period (Hurley & Matthews, 2007). The Quit Benefits Model (QBM) is a model used to assess consequences in terms of health care costs and quitting smoking and to evaluate the cost-effectiveness of nicotine cessation program (Hurley & Matthews, 2007). The QBM predicts quitting smoking can provide a savings of more than $400,000 in health care costs (Hurley & Matthews, 2007).

Project Strengths and Limitations

Mental health clinicians are in a good position to educate the CMI population on smoking and chronic health problems associated with nicotine abuse. They are able to offer a unique opportunity that will affect the clients' health through assessing, discussing, and developing a plan of care regarding their smoking status. This has the potential to influence the CMI to make better healthcare options. However, because smoking cessation is not a priority in these centers, clinicians do not have the tools to assist them (Himelhoch & Daimut 2003). The clinician's lack of knowledge in regards to smoking cessation results in clients not receiving the necessary help to quit smoking.

Historically, clinicians in both inpatient and outpatient mental health services have displayed a reluctance to diagnose and treat comorbid nicotine and psychiatric disorders (Williams et al., 2009). Many clinicians may ask patients about their smoking status; however, only a small percentage of these clinicians recommend cessation techniques or pharmacological options (Williams et.al, 2009). Offering nicotine cessation to CMI clients has the potential of encouraging providers to become advocates for nicotine cessation in the CMI (Williams et al., 2011). Nicotine cessation programs will provide avenues to update protocols when identified and provide interventions for

patients who suffer from nicotine disorders (William et al., 2011). A medical director, vice president of out-patient clinics, and two nurse practitioners at a mental health clinic in Memphis, Tennessee were identified as key stakeholders to participate in this project. As a result of this small sample size, there are significant limitations associated with the project.

Recommendations for Remediation of Limitations in Future Work

One of the major contributors to premature mortality among persons with mental illness is nicotine abuse (Santhosh, Meriwether, Saucedo, Rees, Cheng, Clark, &…Schhrodeder, 2011). Until recently, the Substance Abuse and Mental Health Services Administration (SAMHSA) did not include smoking cessation as a part of its mission; nor did medical or nursing schools include it as a part of mental health education (Santhosh et al., 2014). This omission reflected a lack of awareness to address the problem in clients with mental disorders (Santhosh et al., 2014). These omissions lead to significant problems in the behavioral health community along with a lack of motivation to address the issue (Santhosh et al., 2014). In 2008, it was recommended that collaboration between SAMHSA and mental health educators be formed to raise awareness, encourage quit attempts and make progress in tobacco cessation (Santhosh et al., 2014). This academic cross-agency collaboration has proven to be instrumental in improving cessation with CMI clients (Santhosh et al., 2014). Collaborations such as this were instrumental in improving smoking cessation for the mental health client (Santhosh et al., 2014).

Analysis of Self

As a scholar-practitioner I am able to use my knowledge and desire to continuously learn while I engage in my profession as a nurse practitioner. By using data, research, study, and findings of the best practices, thoughts, and beliefs, I am able to make effective decisions regarding the care of my clients. Making effective decisions requires me to form visions through intense self-reflections. Self-reflections provide the opportunity to refine and frame my beliefs on scholarly research and provide effective leadership in my profession. Social relationships are also a part of effective leadership. Reflection in social relationships is necessary for group accomplishments. It provides avenues for collaborative reflection and group accomplishments (Leithwood & Riehl, 2005).

As a project developer, I am able to utilize my research, writing, and self-reflection skills to identify the purpose, goal and method needed for successful project completion. I am also able to inspire and encourage others to be team players for successful project completion. Utilizing effective communication skills is another benefit of self-reflection. Effective communication skills are instrumental in promoting thought in others and promoting growth and development of new leaders.

This project has significant implications for my professional development. It prepares me to be a leader in recommending plans that I feel necessary to assist the CMI client. I am better able to locate material of research that supports theory, procedures, and policies that benefit providers in our quest to provide the best services possible for our clients.

Summary and Conclusions

The lack of programs for nicotine cessation at community mental health facilities results in many CMI clients not receiving help to quit smoking. Literature supports smoking cessation for the CMI client is beneficial and suggests that mental health providers provide this service. Recommending a plan to providers at the community mental health center in Memphis, Tennessee will provide providers an opportunity to increase their knowledge base in smoking cessation, as well as provide the necessary information to initiate a smoking cessation program for the CMI client.

Section 5: Scholarly Product

Initiating Nicotine Cessation in a Community Mental Health Center

By

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Introduction

Ensuring information is distributed once evidence-based guidelines are developed is important when initiating a new nicotine cessation program. It provides clinicians with up-to-date-information regarding nicotine cessation to help the CMI client. I plan to submit the manuscript below to the *Journal of American Psychiatric Nurses Association*.

Objective: To examine national standards of smoking cessation programs that will be beneficial to the CMI patient in the community mental health center; to develop criteria for implementation of nicotine cessation program in the community mental health center; and to produce recommendations for clinicians at a community mental health center on methods needed to implement a nicotine cessation program

Background: This project's purpose was to develop an evidence-based educational plan for clinicians at a community mental health center located in Memphis, Tennessee.

Method: A stakeholder group was used to determine their understanding of nicotine cessation and their willingness to implement a nicotine cessation program in their daily practice.

Participants: The medical director, vice president of out-patient clinics, and two nurse practitioners were identified as key stakeholders.

Conclusions: The stakeholders received information to prepare them to incorporate a nicotine cessation program at the community mental health center.

INTRODUCTION

Nicotine abuse and dependence are significantly higher in the chronic mental ill (CMI) than in the general population. Historically, clinicians in both inpatient and outpatient mental health services have displayed a reluctance to diagnose and treat comorbid nicotine and psychiatric disorders. Many clinicians may ask patients about their smoking status; however, only a small percentage of these clinicians recommend cessation techniques or pharmacological options. Studies show a high rate of tobacco addiction with people who suffer from mental illnesses. Unfortunately, nicotine addiction treatment is not a requirement in psychiatry residency programs and is usually not a priority for the clinician in the community mental health center.

BACKGROUND AND OBJECTIVES

The rationale for nicotine use and abuse in the CMI is a complex mix of genetic, environment, and neurobiological factors. In 2009, the Tobacco Disparities Initiatives of the State Tobacco Education and Prevention Partnership reported approximately 48% of individuals affected by depression abuse nicotine. Sixty-five percent affected by bipolar disorder misuse nicotine. Eighty percent suffering from schizophrenic illnesses are abusers of nicotine. Clients suffer from high levels of medical co-morbidity, disability, and premature death. Even though there is increasing literature on the success of psychosocial treatments, standard treatment of the mentally ill and dual diagnosis is slow. Without adequate nicotine cessation strategies, the CMI will continue to succumb at twice the rate of the general population. Therefore, it is important for clinicians in a community mental health center make the effort to reduce nicotine use in the CMI.

Many psychiatric nurses may assume CMI nicotine abusers do not want to quit smoking because of the reward effect of nicotine. These rewards include helping the smoker concentrate, reason, and perform. However, the Centers for Disease Control report as many as 70% of smokers, including individuals suffering from comorbid nicotine and mental health disorders, express a desire to quit. Psychiatric nurses trained in nicotine cessation are in a perfect position to deliver effective smoking cessation services to their clients by using evidence-based treatments and recommendations. The APNA encourages them to initiate nicotine cessation within their various workplace settings. They are also encouraged to make positive changes in attitudinal, institutional and organizational obstacles that impede CMI patient’s access to nicotine cessation services.

The objectives of this article include examining national standards and developing criteria for implementation of a nicotine cessation program in a community mental health center.

GUIDELINE EVALUATION

PROJECT METHOD

Based on the literature review and project outcomes, the facility can benefit from a nicotine cessation program. Clinicians at the community mental health center do not practice the guidelines for nicotine cessation set forth by the Public Health Service. Outputs and outcomes were centered on an evaluation of the healthcare improved competencies in using a nicotine cessation tool to assist them in screening, diagnosing and treating nicotine use disorders.

METHOD: STAKEHOLDER GROUP

The stakeholders consisted of a medical director, vice president of out-patient clinics and two nurse practitioners. They completed a list of "yes/no" questions to determine their understanding of nicotine cessation. The group reviewed competences and responded to a short list of questions to validate that they were educational competences needed for the program. A questionnaire to indicate their willingness to provide resources needed for a smoking cessation program was completed.

DATA ANALYSIS

The findings from the questionnaires indicated the stakeholder group was in agreement that nicotine abuse is a problem in the community mental health center located in Memphis, Tennessee. The group found the information presented to them on national standards of nicotine cessation would be beneficial to the CMI client at the center. It was also found that the group had not received adequate training on nicotine cessation during their educational studies. However, from the information they received, the group agreed they would be comfortable incorporating nicotine cessation in their day-to-day practice.

CONCLUSION

The lack of programs for nicotine cessation at community mental health facilities results in many CMI clients not receiving help to quit smoking. Literature supports smoking cessation for the CMI client is beneficial and suggests that mental health providers provide this service. Recommending a plan to providers at the community mental health center in Memphis, Tennessee provided clinicians an opportunity to increase their knowledge base in smoking cessation, as well as provide the necessary information to initiate a smoking cessation program for the CMI client.

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Appendix A: Questions for Phase 1

Would you agree that nicotine abuse is a problem in the mental health population?

Yes _____ No _____

Did you receive adequate training on nicotine cessation in your nursing or medical education?

Yes _____ No _____

Would you be comfortable using a nicotine cessation tool in your practice?

Yes _____ No _____

Do you feel utilizing the nationals standards of nicotine cession will benefit clients in this community mental health center?

Yes _____ No _____

Are you willing to incorporate these standards in your day-to-day practice?

Yes _____ No _____

Appendix B: Questions for Phase 2

Did the information increase your understanding of nicotine cessation?

Yes _____ No _____

Did the information boost your confidence in discussing nicotine cessation with your client?

Yes _____ No _____

Are you comfortable in advising and recommending nicotine cessation to your client?

Yes _____ No _____

Appendix C: Questions for Phase 3

Are you willing to provide resources needed for ongoing training?

Yes _____ No _____

Are you willing to provide resources for educational material needed for a smoking cessation program?

Yes _____ No _____

Are you willing to provide resources for first-line pharmacotherapy?

Yes _____ No _____

Are you willing to provide therapeutic counseling for the CMI client interested in quitting?

Yes _____ No _____