continued from page 8

free. “We were very aware of the patient situation. We had a gradual decline in tobacco use. There was less access to tobacco. The store stopped selling tobacco to non-tobacco users and there were increasing limits placed on the amount of tobacco that patients who did use tobacco could purchase. We wanted to force patients to use up their ‘stores’ of tobacco. There were also decreased numbers of smoke breaks per day. While patients still went outside for fresh air, fewer and fewer of these breaks permitted smoking.”

During this phasing out of tobacco use, medical and psychiatric staff encouraged patients to quit smoking. The nicotine patch and nicotine nasal spray were medications that were offered to assist with withdrawal. “Each patient had a complete treatment plan review. Patients who used tobacco were identified and tobacco dependence was incorporated into their overall treatment. Even if patients refused medication(s), the option was left open should they change their minds.” The facility chose to offer these medications over others because of the circumstances of the setting. The gum was not an option because it could be used to plug up locks in the facility and the inhaler was deemed inappropriate because the points [in the inhaler] used to puncture the nicotine cartridges could pose a danger. It was believed that the patch and nasal spray were relatively simple to use and could be effectively monitored.

“Interestingly, there wasn’t a great demand for use of the medications.” This was attributed to the “weaning off” of nicotine that occurred as availability of tobacco and opportunities to use tobacco were decreased.

There has been some positive feedback since going tobacco-free. Patients with COPD who normally would not have pursued quitting seem to appreciate the benefits. For some other patients, the feedback has been neutral and other patients report the intent to smoke when they are released.

Mr. Kane recently took a group of occupational therapy students out to one of the courtyards. These concrete areas were once the place where patients got their six smoke breaks per day. Patients who chose not to be exposed to smoke would need to stay inside during these supposed “fresh air” breaks, as they had no other option to get away from the smoke. Today, all patients have the opportunity for true fresh air breaks, six times a day. “It’s hard to believe we were once a smoking facility. It’s not part of the culture at Ann Klein Forensic Center anymore.”

From Research to Practice: Smoking and Mental Health Programs

by Philip T. McCabe CSW, CAS

University Behavioral Health Care MICA Club, Cherry Hill NJ, is showing measurable success with tobacco dependence treatment. Glenn Roth, UBHC, Habilitation Counselor, took quitting smoking seriously. After his own personal success with quitting tobacco, he became more motivated to help the consumers of the UBHC MICA CLUB with their tobacco dependence. He advocated for himself to attend the 8-day Tobacco Dependence Treatment Specialist Training offered by the UMDNJ School of Public Health, Tobacco Dependence Program. Glenn received the same intensive training that is required for NJ Quitcenter staff. He also requested a consultation with the Mental Heath Consultant who originally met Glenn during the training. Glenn was enthusiastic and dedicated to addressing this challenging addiction with consumers at the MICA Club. On April 16th, a two hour in-service training was offered to 16 staff members. “The Challenge of Addressing Tobacco with Mental Health Clients” is part of the clinical training provided by the Tobacco Dependence Program. The training included topics such as: nicotine as an addiction, the harm caused by tobacco use, morbidity and mortality, consumer manipulation by Big Tobacco, nicotine and the brain, and specialized information on mental heath consumers and tobacco dependence. An overview on treatment recommendations, Motivational Enhancement Techniques and the use of nicotine replacement therapies was also included. Staff at the MICA Club were encouraged to discuss their concerns and beliefs about tobacco as well.

Contemplation/ Preparation

After some adjustments within the MICA program, a weekly Tobacco Dependence Treatment Group was developed and offered to the consumers. There are forty-nine consumers who attend the MICA Club. Forty-four of the consumers were using tobacco products, two had never smoked, and three had stopped using tobacco on their own. The group met weekly to receive psychosocial education about tobacco and to develop a quit plan. The average attendance for this group was thirty individuals. This number is exceptional considering that most of the MICA Club's other scheduled groups (for issues other than tobacco) have an average attendance of fifteen.

Action

The group made their first group quit attempt on September 16, 2002. Twenty-four members were enrolled. Under the medical supervision of Dr. Robert Hudrick, UMDNJ Family Practice, each client was reviewed for NRT. Based on individual assessments, six consumers received NRT nasal spray and patch, fourteen received inhaler and patch, three received patch only, and one received no NRT. Additionally, two members were prescribed Zyban two weeks prior to the quit date.

Maintenance/Relapse Prevention

After the first week, 5 members decided they no longer wanted to try to quit and returned the NRT. For others in the group, their average 2 packs a day consumption was reduced to 1 pack per day. Five clients continued to remain abstinent following the first week. By week 7, thirteen members were still involved in their quit attempts. Four continued to remain abstinent, while the other nine remaining members had reduced their consumption to between 4 -30 cigarettes per *week*.

A follow up training was provided to the staff on clinical interventions for working with low motivated clients. This clinical intervention includes the monitoring of clients' carbon monoxide levels, a method that Quitcenters have reported to have an impact on clients. Carbon monoxide monitoring has been shown to exhibit increased motivation and self-efficacy in quitting for many clients.

Effective intervention for these consumers includes utilization of best practices from the American Psychiatric Association and The Public Health Service guidelines. The MICA Club clients report that the use of NRT along with group support and staff involvement has also been helpful. In addition, the modeling of a staff member's successful quitting combined with the staff's commitment to treating tobacco dependence, have together served as powerful contributors to the success of this innovative and supportive program.