

Challenges & Strategies on Becoming Tobacco-Free

In the Residential Licensure Standards adopted on November 15, 1999 by the New Jersey Department of Health and Senior Services, tobacco was given parity with alcohol and other drugs of abuse. The licensure standards provide for comprehensive alcohol, tobacco, and other drug treatment for patients through screening, assessment, diagnosis, education, treatment planning, and continuing care. In addition, the provisions mandate that "the use of tobacco products and spit tobacco on the grounds of free standing treatment facilities shall be phased out by November 15, 2001" (8:42A-3.11(a)). As this date fast approaches, we would like to share with you some of the challenges faced and strategies developed by various facilities as they addressed the provisions relating to tobacco.

The programs that have successfully met the challenge of the new licensure standards have all stressed the importance of the administration's commitment to a tobacco-free environment and to integrating tobacco treatment into all aspects of the program. This commitment is the foundation for implementing change and establishing a tobacco-free policy.

Successful programs have also established a committee dedicated specifically to addressing tobacco policy and developing a comprehensive plan of action, including an implementation timeline. This strategy minimizes the conflicts that inevitably occur when issues are addressed by one or two individuals. Typically, a staff member who is in a policy-making capacity chairs the committee. Other committee members represent different departments as well as administration. A flexible timeline outlines the steps for implementing the plan of action, provides a way to monitor progress and ensures that goals are met in a timely fashion. Programs report that instituting changes in small steps eases the adjustment for both staff and clients. Allocating sufficient time to plan and implement the policy is essential.

Programs note the importance of addressing staff concerns and ambivalence regarding a tobacco-free policy. Without the support of staff, efforts are undermined and changes are difficult to implement. Programs that have become

tobacco-free report that they provided training to all staff on the rationale for treating tobacco in the chemical dependence setting.

Another important issue for programs to address is smoking staff members. It is especially important for programs to acknowledge the challenge a tobacco-free policy presents for staff who smoke and to provide support for those who wish to quit. Some offer voluntary "For Smokers Only" workshops facilitated by the Tobacco Dependence Program for staff wishing to address their tobacco use. Facilities are encouraged to check their healthcare plans to see if coverage for nicotine dependence treatment is includ-



ed and to advocate for its coverage when healthcare plans are chosen. It is imperative, however, that programs clearly state their expectations about compliance with the new policy as well as the consequences for violations. A number of programs note that smoking staff report cutting down tobacco use substantially or quitting entirely.

Clinical staff often express concern about their lack of knowledge regarding tobacco dependence treatment and question its efficacy with a client not interested in quitting smoking. These concerns are addressed through clinical training, which builds on staff's existing skills in treating other substances of abuse. The National Institute on Drug Abuse's Principles of Drug Addiction Treatment (1999) state that treatment does not have to be voluntary to be effective and reinforces the experience clinicians have in addressing clients' use

of substances other than the one that may have brought them into treatment. Most programs adopt a stage-based model of treatment (Prochaska and DiClemente) using interventions based on a client's level or motivation to address tobacco use.

With regard to consequences for tobacco policy violations, approaches tend to vary by client and program. For example, in residential programs where clients work during the day, on-campus violations may be differentiated from off-campus violations. In general, however, violation of the tobacco policy is seen as a clinical issue requiring clinical interventions. Consequences range from creating contracts to revocation of privileges or demotion to a lower phase of treatment. Some programs have adopted a policy where repeated violations of the tobacco policy are evaluated as part of overall program compliance. When tobacco violations are seen as a demonstration that the client is not serious about treatment, tobacco use may be the way they are acting out.

Programs have handled the period of final transition to tobacco-free status in a variety of ways. Some programs feel that special recognition would be counterproductive if the message is that tobacco is no different than other drugs. Other programs have held ceremonies the night before, with clients and staff acknowledging the loss while welcoming in their new tobacco-free status. One halfway house made the transition on a Friday and held a relapse prevention workshop for all residents that day. The residents also stayed home that weekend and participated in fun-filled, resident-planned activities.

The issue of nicotine replacement therapy (NRT) also varies among programs. Some offer the nicotine patch, which has the least behavioral reinforcement associated with it. Other programs are opposed to use of any medication because of religious or philosophical conflicts. However, many programs would like to offer NRT to ease the process of physical withdrawal, understanding that NRT doubles quit rates and is the humane way to deal with clients in withdrawal. While lack of funding for

continued on next page