

New Residential Licensure Standards Establish Parity for Tobacco

On November 15, 1999, the substance abuse treatment field witnessed the adoption of New Jersey Department of Health and Senior Services' Residential Substance Abuse Treatment Facilities: Licensure Standards. The new rule applies to all residential health care facilities which provide substance abuse treatment including, but not limited to, halfway houses, extended care facilities, therapeutic communities, short term residential treatment programs, and other non-hospital based (medical) detoxification programs. All aspects of providing treatment for chemical dependency in a residential setting are included, thus establishing a level of care that will insure quality programming for the provision of these services.

Of particular significance are the provisions that give tobacco parity with alcohol and other drugs of abuse. This paradigm shift is the culmination of years of work by the NJ Department of Health and Senior Services, Division of Addiction Services, and provides for comprehensive alcohol, tobacco, and other drug treatment for patients through screening, assessment, diagnosis, education, treatment planning, and continuing care. Specifically, the new mandate integrates tobacco in the definition of chemical dependency, personnel and volunteer requirements, information dissemination, patient assessment and treatment planning, patient education, family counseling, and discharge planning. In addition, tobacco-free buildings and vehicles and, within two years, tobacco-free grounds establish clear standards in support of this new understanding.

Definitions

Beginning with the definitions section of the standards, tobacco is included in the list of substances which, when used chronically and habitually, constitute "chemical dependency." In addition, the understanding of "substance abuse" includes substance related disorders as defined in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV), which lists three nicotine specific disorders in this category. Inclusion of tobacco and nicotine in these definitions reflects a genuine understanding of the need for treatment parity for tobacco dependence.

Community Education

The standards require that, in the facility's policies and procedures manual, provisions are made for "making information about alcohol, tobacco and other drug use and abuse available to the public." The paradigm shift for the treatment community is, again, the inclusion of tobacco as a drug of dependence on par with alcohol and other drugs. As in the not too distant past, the addictions field taught the general public about the disease of alcoholism, the opportunity now exists to teach others about the often forgotten or minimized addiction to tobacco.

Assessment

New Jersey residential programs will now be including the patient's tobacco use history as an integral part of the bio-psychosocial assessment. This has important implications for the clinician as well as the client. For the clinician performing the assessment, there will be a growing awareness of tobacco use as part of the client's chemical use history. For the client, asking about tobacco use history - age of onset, first brand used, current brand, period of heaviest use, quit attempts or attempts to cut down, health or other consequences of use, etc. - teaches that tobacco is indeed relevant to present dependency issues. Similar to the way in which a client who presents with a DWI is asked about other drug use, or a heroin addict is asked about alcohol use, asking about tobacco use helps the client understand the role that all chemicals play in his or her life. Clients recognize that 'it must be important if I'm being asked about it.' By including a tobacco use history in the bio-psychosocial assessment, the importance of tobacco as a substance causing dependence, as well as its place in the client's chemical use history, is legitimized.

Treatment Planning

As stated in the standards, each problem identified in the assessment becomes part of the patient treatment plan. In addition to a standard set of approaches to treating problems, tobacco dependence treatment will also include defining the client's stage of readiness for change, listing the client's personal goals, setting measurable objectives and time frames for accomplishing goals, and exploring methods for achieving both short-term and long-term goals. The use of adjunctive medications (nicotine replacement and/or Zyban) will also be a consideration in the treatment plan. Unresolved tobacco issues will be included on the client's discharge plan.

Patient Education

The new standards also include a mandate for didactic sessions each week with respect to at least drug, alcohol, and tobacco education, AIDS education and health education. Programs can respond to this provision in one of two ways. One option would be to simply add a tobacco lecture or video to the patient schedule. On the other hand, programs may choose to rethink their overall educational program and more fully integrate tobacco dependence information in essentially every activity. For example, when explaining how addicts use chemicals to modify and control feelings, the staff member might use 'alcohol, cocaine, nicotine and heroin' as examples. When describing the consequences of chemical use, a staff member might describe liver disease from alcohol, seizures from cocaine, and emphysema from smoking. Workbook activities and written assignments can also include tobacco use as a focus.

Family Education

There is continued opportunity to further integrate tobacco into the treatment milieu by providing education to family members as well. This is implied in the standards which require the provision of family counseling to "patient's family members who exhibit co-dependent behavior." With appropriate information, family members are in a better position to support and encourage recovery from tobacco dependence for the patient, and perhaps to examine their own experience with tobacco. This educational opportunity may encourage those who use tobacco to seek assistance in quitting, and those who do not use tobacco to be validated and supported in setting healthy and appropriate limits regarding exposure to environmental tobacco smoke.

Self-Help Groups

In addition, the standards require that facilities provide patients and their family members information regarding the desirability of participating in self-help and support groups, including making literature and representatives of such groups available to patients and their families and enabling patients and their families to attend some meetings of support groups. This is another opportunity to fully integrate tobacco dependence treatment into

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the milieu. Patients and family members can be encouraged to attend Nicotine Anonymous meetings and speakers from Nicotine Anonymous can be invited to speak at the treatment facility. Nicotine Anonymous literature can be integrated with material that is made available from other 12-step groups.

Facilities and Grounds

The treatment of tobacco typically raises concerns regarding the inconsistencies of tobacco use on the grounds while patients are attempting to deal with their own dependence, and the use of tobacco by staff and volunteers. The standards address these concerns directly. The smoking of tobacco products and the use of spit tobacco is prohibited within all buildings, and the use of tobacco products and spit tobacco on the grounds of free standing treatment facilities will be phased out by November 15, 2001. This regulation demonstrates a genuine understanding of the need for treatment programs to eliminate tobacco use along with all alcohol and other drug use in buildings and on grounds in order to facilitate a truly drug-free environment. It demonstrates an understanding of the difficulty patients have quitting tobacco while still being exposed to triggers and cues of active tobacco use in the environment. The two-year time frame acknowledges the complexity of making this policy change and allows programs time to prepare patients, staff members, and the broader treatment community (family members, visitors, alumni, referral sources, etc.) for this change.

Staff Issues

The standards also address the conflict of tobacco use by staff in the personnel requirements. First, there is a requirement that facilities "establish written policies and procedures addressing the period of time during which former substance abusers (alcohol, nicotine and/or drugs) shall be continuously substance free before being employed in the facility." This is consistent with policies that many facilities already have regarding the employment of staff who are in recovery from alcohol and other drugs.


The second standard addressing personnel requires that "staff shall not use alcohol, tobacco or illegal drugs during working hours or when representing the treatment facility." This rule is also consistent with many programs' existing policies regarding the use of alcohol or non-prescription drugs by staff during work hours. It validates the need for staff to model drug-free living. The spirit of the regulation is that staff not be identifiable as tobacco users. Just as it is a professional standard that a staff member's alcohol use not become an issue in the workplace, the use of tobacco by staff should not create a conflict in the treatment setting. When a staff member's use of the very substances for which patients are being treated enters into the clinical picture, it undermines the work being done with patients as well as the integrity and credibility of the clinician. Patients focus on tobacco use by staff as a means of deflecting from their own tobacco issues, much as they would deny or minimize their own use of alcohol if staff returned from breaks or lunch, or came into work smelling of alcohol. The standards address tobacco use by all staff, not just clinical staff or those staff

members who have direct contact with clients. The ruling aims to create a therapeutic environment where tobacco and nicotine dependence is treated on par with alcohol and other drugs of abuse.

Volunteers

Other role models for clients are the volunteers who work in the treatment setting. The standard's subchapter on volunteer services requires that programs develop policies and procedures for volunteer recruitment addressing "the minimum period of time during which those persons who had a prior history of substance abuse (alcohol and/or drugs, nicotine) shall be continuously substance free before being accepted as volunteers." This creates a standard of practice in the recruitment of volunteers which is consistent with recognizing tobacco as a drug of dependency.

While it is clear that the standards require a major shift in perspective regarding tobacco, the time has come for the substance abuse field to accept the challenge of helping individuals recover from all life-threatening addictions. Tobacco use is currently responsible for more deaths among recovering alcoholics and drug addicts than the addictions that brought them to treatment in the first place. The licensure standards support our making sure that this will not be the case in the future.

An outline of the tobacco-related provisions in the standards can be obtained by contacting the Addressing Tobacco Project at (732) 846-4338. 

Addressing Tobacco Project

Steps for Becoming a Tobacco-Free Treatment Facility

1. Acknowledge the profound challenges tobacco creates for the addictions treatment community.
2. Establish a leadership group or committee and secure the commitment of the organization.
3. Develop a tobacco-free policy.
4. Establish a policy implementation timeline with measurable goals and objectives.
5. Conduct staff training.
6. Provide treatment for nicotine-dependent staff.
7. Assess and diagnose nicotine dependence in patients and use this in treatment planning.
8. Incorporate tobacco & nicotine into patient education curriculum.
9. Establish on-going communication with 12-step recovery groups, professional colleagues and referral sources about policy changes.
10. Require that no staff member be identifiable as a tobacco user.
11. Establish tobacco-free facility and grounds.
12. Implement comprehensive nicotine dependence treatment throughout the program.