

New Jersey Addiction Treatment Programs: A Model for Success

by Martha Dwyer, MA, CADC

New Jersey has been at the forefront in addressing tobacco in the treatment of other addictions since 1991. This is reflective of a larger paradigm shift within the addictions treatment community that began in the late 1980s and early 1990s with the convergence of two advances in the understanding of addiction and of tobacco. The first advance was the conceptualization of addiction as a biopsychosocial disease that is not drug specific. The second advance was the recognition by the Surgeon General in 1988 that tobacco is addicting, that nicotine is the substance in tobacco that causes addiction and that the processes of tobacco addiction are similar to that of other drugs. These two forces together prompted a paradigm shift to the importance of integrating tobacco into addictions treatment. This shift was fueled by subsequent research indicating that addressing tobacco concurrently with other drugs of dependence does not hinder, and may well support, a person's recovery. It logically followed that state-of-the-art comprehensive treatment should include all drugs, including tobacco. In its 2001 Position Statement, NAADAC, The Association for Addiction Professionals, voiced its support of "the development of policies and programs that promote the prevention and treatment of nicotine dependence on a par with alcoholism and drug dependence."

In 1993, the Addictions Professionals Certification Board of New Jersey added the requirement of 6 hours of nicotine education as part of initial certification. In 1999 the Division of Addictions Services (DAS) of New Jersey's Department of Health and Human Services adopted Residential Substance Abuse Treatment Facilities Standards for Licensure. The tobacco provisions of these standards give tobacco parity with other drugs of abuse by including tobacco in the list of substances that, when used chronically and habitually, constitute "chemical dependency." They provide for comprehensive alcohol, tobacco and other drug treatment through screening, assessment, education, treatment planning, family counseling and discharge planning. In addition, the Standards for Licensure require written policies about tobacco use by staff and volunteers and specify that by November 15, 2001 all buildings, vehicles and grounds were to be tobacco-free.

New Jersey chemical dependency programs now take a multimodal and multidisciplinary approach to treatment based on the biopsychosocial model of addiction and tailor treatment to the individual needs of each client. DAS supports addressing the physiological component of tobacco dependence through the provision of nicotine replacement therapy (NRT), in the form of the patch and gum, to clients in residential programs. Over the past year approximately 1300 clients have availed themselves of this NRT either to ease the discomfort of withdrawal or from a sincere desire to quit their tobacco use. They report that being able to offer NRT to clients is an important adjunct to treatment. This message was echoed by a former client of a residential program who shared her experience, strength and hope at our annual conference in October. She feels that having to address her tobacco use in treatment facilitated and strengthened her recovery, and that NRT helped her through the process. She remains free from tobacco and other drugs today.

The Tobacco Dependence Program has trained more than 850 staff and administration at 40 addiction treatment programs on the integration of tobacco into policies, procedures and treatment. New Jersey clinicians are incorporating tobacco into their clinical work. Many indicate that they are better able to address the affective component of addiction when clients are no longer using tobacco to self-medicate painful feelings.

Society in general has experienced a cultural shift towards tobacco use being less acceptable. However, families and friends of addicts have remained more tolerant. Some use tobacco themselves and addressing tobacco would force them to confront their own dependence. An issue that arises is that family members generally see tobacco as separate, and less important than the drug that brought their loved one into treatment. They are simply relieved if the client just stops using the identified drug and consider it a small price to pay if a client continues to use tobacco. Yet, they may not realize that their loved one may in fact be at greater risk of dying from a tobacco-caused illness than due to the drug or alcohol problem that initially brought them to treatment. Although educating

continued on page 10



The Steps for Treatment Organizations Becoming Tobacco-Free

1. Acknowledge the profound challenges tobacco creates for the 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 ongoing communication with 12-step recovery groups, professional colleagues, and referral sources about policy changes.
10. Require that no staff be identifiable as a tobacco user.
11. Establish tobacco-free facility and grounds.
12. Implement comprehensive nicotine dependence treatment throughout the program.

the family about tobacco dependence and its role in addiction remains a challenge for clinicians, there is evidence that progress is being made. For example, a former client of a particular program had been doing well for a number of years, but then relapsed to alcohol and other drugs, and struggled with the ensuing shame and sense of hopelessness. In contacting the program, the family reported they recognized that their son had been in trouble when he had resumed smoking and begun to isolate himself from others. Clearly, this family understood smoking as a red flag for relapse to other drug use.

Twelve Step work is frequently used to address the spiritual component of addiction. Attendance and participation in 12 Step Programs, AA and/or NA, meetings are included in treatment plans. Many New Jersey treatment programs are taking their clients to Nicotine Anonymous meetings, establishing Nicotine Anonymous meetings on site, and/or are integrating tobacco into groups on spirituality. At least one program in New Jersey awards specific medallions for clean time from tobacco. Clinicians are helping to raise client awareness of how tobacco has ruled and controlled their lives, thus hindering spiritual growth in recovery.

New Jersey programs reporting the greatest success in addressing tobacco are the ones that have fully integrated tobacco treatment into the milieu. The culture becomes self-reinforcing and provides the opportunity for clients to experience the benefits of a tobacco-free life. A violation of the tobacco policy becomes an opportunity to provide education on tobacco dependence and addiction in general. For example, asking a client how sneaking out to smoke a cigarette is any different than sneaking any other drug forces the client to look at the issues of dishonesty, the feeling of being terminally unique (i.e., “the rules apply to everyone but me”), and compulsion to use, all of which are universal to any addiction. The “treatment culture” is defined not only by the clients, but also by the staff, and it is important to note that many programs have reported a significant decline in staff use of tobacco.

It is exciting to witness a paradigm shift that will work to save lives - the integration of tobacco into addictions treatment. Let us acknowledge the great progress that has been made in New Jersey, and use it as a source of strength and confidence to continue the challenges ahead.