An addiction treatment campus goes tobacco-free: Lessons learned

January 30, 2014 by Brian Coon

"Did we really treat the patient's *disease*, or did we merely treat an *alcohol addiction*?"

How would you answer that question if we had a graduate of an addiction treatment program who was in recovery from alcoholism for many years, perhaps even decades, and yet was dying of emphysema because he/she continued to smoke cigarettes? This is a tough question that calls the bluff of our intent as addiction treatment providers.

Our facility, Pavillon in North Carolina, has made previous attempts over a number of years to intervene in the problem of nicotine addiction. In essence, our organization itself has gone through stages of change in addressing this problem.

A few years ago we implemented optional weekly groups that focused on nicotine use for those interested in quitting. Attendance was low. A lecture for all patients was added in order to provide accurate and up-to-date information concerning tobacco and the problems associated with nicotine addiction. This helped raise awareness, but achieved little else in terms of real results.

A year later, an additional effort was made in functionally addressing nicotine addiction in all of our clinical programming. We added or included nicotine use in our entire assessment, treatment and multidisciplinary team approach. This meant that medical, psychology, nursing, spiritual care and counseling staff all applied their efforts for each patient on an individualized basis, as we do with other addictions. We had a variety of positive results over the course of many months. And yet, we still allowed smoking on our campus in designated areas and times. Results remained below what we had hoped.

The historical view from addiction treatment providers has been purposefully to avoid the topic of nicotine[1]. Generally, this avoidance was based on the idea that abstinence, treatment and early recovery are hard enough to endure, so abstaining from nicotine as well would make things even harder and would promote relapse to alcohol or other drug use. This was accepted as a fact and became the conventional wisdom held by many in the treatment field for decades.

At Pavillon, we knew it was time for real change. We decided it was time to change to a tobacco-free campus, given research showing that recovery rates are enhanced by the cessation of nicotine use[2]. We knew it was best to establish our campus as tobacco-free, as this would be the best way systematically to support recovery from nicotine addiction. We are choosing to treat the person's core disease—not just focusing on one addiction while allowing another addiction to go overlooked or unchallenged.

Getting started

Yet in spite of our identity as an addiction treatment organization, for our change effort to succeed we had to:

- Obtain “buy-in” from existing staff;
- Establish willingness among the organizational leadership and continue to rely on their direction;
- Begin an ongoing task force made up of key managers and staff from all facets of the organization (admissions, clinical, facilities, administration, medical, etc.); and
- Establish policies and procedures for staff and patients to follow.

Further, we had to have the organization’s Board of Directors agree with and support the concept of this change while it was still impossible for them to know the actual impact the change would have on the number of admissions to our facility.

To prepare for the initiation of the tobacco-free campus, we modified our written program materials and our procedures concerning visitation. In spite of that preparation, we have had to respond to some family members and visitors attempting to bring tobacco on campus, individual patients and groups of patients attempting to hide smoking materials on campus, and the emergent identification of tobacco use itself during treatment in spite of our policy. This is no surprise in an addiction treatment setting. These situations have provided opportunities for us to intervene, teach and provide care to both patients and family members about abstinence, recovery, and relapse prevention dynamics.

We are now making sure to apply our treatment efforts in a way that supports our patients’ total recovery. We now require cessation from tobacco use in the same way that we require it regarding other drugs and alcohol.

Resources are plentiful for those interested in implementing what works and avoiding what doesn't in going tobacco-free[3].

Treatment strategies

Our nicotine replacement therapies include a patch and adding lozenges or gum if necessary. Typically, the medication taper is completed within two weeks of admission to our residential program, and this is intentional: We generally prefer a shorter medical withdrawal protocol and a longer time in abstinence during the residential stay. For some patients, a prescription medication also might be required, but we have found this to be quite rare.

Beyond nicotine replacement therapies, we also know the value of the recovery fellowship, the 12 Steps, and proper clinical and medical help in treatment. From a counseling standpoint, we use a range of methods. Foundationally, we encourage each person to include the subject of nicotine in their Step work.

We find that the 12 Steps apply well to nicotine addiction, but we also find that most patients need additional support, and counselors must add this intentionally. Fortunately, the techniques we know in addiction treatment for craving management, positive self-soothing, self-care skills, identification and management of triggers, and obtaining family support work well in supporting a decision to be nicotine-free.

Going further, recovery supports are vital, including those found in the fellowship. Why? It is a total life of recovery that we support—a plan of mere nicotine abstinence might constitute little more than an attempt to control one's nicotine addiction.

Overcoming organizational barriers

In this example of organizational change, lack of know-how is not the barrier to implementation. Rather, many addiction treatment programs are reluctant to implement a tobacco-free campus policy and truly treat the entire disease of those patients who use nicotine for reasons such as fear of fewer admissions; worries about increased frustration among patients, their families and referral sources; and lack of emotional buy-in from current staff within various disciplines.

To help obtain buy-in from staff we used a variety of strategies. At the core of the issue, our organizational leadership, starting at the executive and board levels, made the emotional decision to change. This was a decision not merely at the intellectual level. For us it was a movement in the direction of increased congruence with our mission and purpose.

For the multidisciplinary treatment teams, before the change was adopted we amplified the incongruence of not changing by regularly discussing our provision of addiction treatment services while allowing an addiction to be practiced on our campus. Staff ultimately supported the organizational change at the belief level as a result. This was bolstered as we at the same time provided formal in-service education for staff concerning the benefits of stopping smoking during treatment, clinical and medical supports, and data from national practice guidelines evidencing a nicotine-free approach as a best practice.

We took an additional step for staff and added access to medication support from nicotine cessation medications as an employee benefit for those employing choosing to stop their own nicotine use.

One main source of support has been family members of prospective patients. Desiring total health and wellness (and total recovery), family members have demonstrated time and time again a conceptual and practical willingness to support this effort.

We often are asked, "How has it gone? Are people accepting a tobacco-free model of treatment?" The answer is simple. We have learned that identified patients, family members and program staff alike naturally understand and give their overall support to a program focused on total recovery.

Pavillon officially became a tobacco-free campus on Feb. 4, 2013. Our admissions have not decreased as a result.

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