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Addressing Tobacco Use Through Organizational Change: A Case Study of an Addiction Treatment Organization†

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Abstract

Compared to the general population, persons entering addiction treatment are three to four times more likely to be tobacco dependent and even addiction treatment staff members are two to three times more likely to be tobacco dependent. In these settings, tobacco use continues to be the norm; however addiction treatment programs are increasingly aware of the need to assess for and treat tobacco dependence. The problem is a cultural issue that is so ingrained that assumptions about tobacco use and dependence in addiction treatment are rarely questioned. Denial, minimization, and rationalization are common barriers to recovery from other addictions; now is the time to recognize how tobacco use and dependence must be similarly approached. This article describes the Addressing Tobacco through Organizational Change (ATTOC) model which has successfully helped many addiction treatment programs to more effectively address tobacco use. The article will review the six core strategies used to implement the ATTOC intervention, the 12-Step approach guiding the model, and describe a case study where the intervention was implemented in one clinic setting. Other treatment programs may use the experience and lessons learned from using the ATTOC organizational change model to better address tobacco use in the context of drug abuse treatment.

Keywords

drug abuse treatment; nicotine dependence; organizational change; smoking; tobacco

Tobacco dependence is the leading cause of death among individuals in recovery and yet most addiction treatment programs don't include it in their treatment planning or treatment interventions (American Psychiatric Association 2006). This is not because addiction treatment specialists don't treat multiple addictions concurrently, aren't wellness oriented, or don't change to address new clinical problems. Tobacco use has been accepted in the culture of addiction treatment programs over the past seventy-five years—clients smoke, staff members smoke, and they often smoke together. The founders of Alcoholics Anonymous, Bill W. and Dr. Bob, were both smokers and died of tobacco-caused diseases (emphysema and cancer, respectively) before the health consequences and addictive nature of tobacco use were fully recognized. Myths and misperceptions persist about why tobacco use should be tolerated in addiction treatment programs. Cigarettes have been accepted and even promoted as part of the norm in the recovery community. The smoking break is sometimes viewed as a reward. But the tipping point may be approaching in drug abuse treatment settings so that, as has happened in the general population, it is no longer acceptable to use tobacco products within addiction treatment programs.

There are barriers within addiction treatment programs that contribute to the limited focus on tobacco use and addiction. These include staff and patient attitudes about tobacco use, limited staff training, fears about the negative impact that would result from limiting tobacco use, belief that quitting tobacco is a major life change versus another addiction, resistance from staff and patient smokers, and limited financial resources to support tobacco dependence treatment (Ziedonis et al. 2006; Williams et al. 2005; Asher et al. 2003; Hurt et al. 1995; Bobo & Davis 1993). With regard to adolescents, little is known about the longitudinal course of nicotine dependence following interventions designed to affect smoking, particularly among high-risk samples (Strong et al. 2007). Another barrier to cultural change has been the reality that addiction treatment staff in community-based programs are about two to three times more likely to be tobacco dependent (Bernstein & Stoduto 1999) compared with the general population (Richter, Choi & Alford 2005; Lasser et al. 2000). Smoking prevalence among community-based drug abuse treatment staff (40% to 60%) is much higher than the 5% prevalence observed among other healthcare providers such as physicians, dentists, and dental hygienists (American Psychiatric Association 2006; Goldstein et al. 1998). From our experience, staff members who smoke are less likely to try to help a patient quit smoking, sometimes due to guilt and shame about their own smoking, and they may smoke with patients in the name of "better therapeutic alliance." However, staff members who make the quit attempt may also become the most supportive of others who are trying to quit.

Incorporating tobacco dependence treatment into addiction treatment settings must change the current culture and address training needs. Specific approaches to organizational change have been developed (Simpson 2002; Rosenheck 2001; DeSmet 1998; Backer 1995; Backer, David & Saucy 1995), and factors supporting organizational change have been identified. Factors influencing the adoption of new approaches in addiction treatment settings include providing staff with the new information, providing evidence that the intervention will make a difference, having support to make the changes, and the staff/organization level of readiness for change (Backer 1995, 1991; Backer, David & Saucy 1995; Rogers 1995).

Organizational change models have been developed and adapted specifically to address tobacco in addiction treatment settings (Bowman & Walsh 2003; Sharp et al. 2003; Stuyt, Order-Connors & Ziedonis 2003; Ziedonis & Williams 2003; Campbell, Krumenacker & Stark

1998; Rustin 1998; Bobo, Anderson & Bowman 1997; Hoffman et al. 1997; Campbell et al. 1995; Hoffman & Slade 1993). Research has shown that minimal interventions (such as the traditional "half-day skills-building workshop") are not powerful enough to change nicotine-related counseling practices of outpatient staff, and there is a need for more intensive and multidimensional interventions to affect attitudes and increase skills and knowledge (Bobo, Anderson & Bowman 1997). Tobacco use should be addressed in both adult and adolescent addiction treatment programs. Nicotine dependence usually begins in adolescence, and addressing tobacco in adolescent addiction treatment should include both treatment and prevention efforts. Hymowitz and colleagues (2001) instituted organizational change in a pediatrics residency program that led to increased youth tobacco interventions; these approaches may also be helpful in adolescent addiction treatment programs.

This article describes a specific organizational change intervention, Addressing Tobacco Through Organizational Change (ATTOC), in terms of its history and development, core implementation components, and the 12-Step approach guiding the model. In addition, it includes a description of one addiction treatment program that implemented the ATTOC intervention.

HISTORY AND DEVELOPMENT OF THE ATTOC MODEL

There have been reports from several different groups describing organizational change interventions that include some combination of staff training, providing staff with nicotine dependence treatment, providing nicotine dependence treatment for clients, changing program structure and clinical chart templates, and implementing local program policy changes. For example, Sharp and colleagues (2003) reported on three programs that successfully incorporated nicotine dependence treatment into clinical practice. All of the programs followed an organizational change model, and all instituted nicotine dependence treatment and a "zero-tolerance" tobacco-free policy. Sharp contrasts this finding with those of Rustin (1998) who reported that programs not following an organizational change model failed in attempts to integrate nicotine dependence treatment. Campbell and colleagues (1995) implemented a demonstration organizational change effort in a multisite treatment center which included staff education, training to conduct nicotine dependence treatment groups, voluntary nicotine dependence treatment for staff, and nicotine dependence treatment for clients. In this study, efforts to treat nicotine dependence were most successful in the site that agreed to integrated program features, such as incorporating smoking cessation into individual treatment plans and incorporating cessation groups into the treatment schedule.

The ATTOC intervention model has been developed, modified, and implemented in many addiction and mental health treatment programs. Hoffman and Slade (1993) first identified steps necessary for addressing tobacco use in addiction treatment settings, and these were developed into a manual titled *Drug Free is Nicotine Free*, which helped addiction treatment programs better address tobacco use and included a focus on developing smoke-free grounds (Hoffman et al. 1997; Slade & Hoffman 1992). Dr. Slade was a great mentor for Dr. Ziedonis when they teamed up in 1998 at the Robert Wood Johnson Medical School. Their team further implemented and developed the model in both addiction and mental health treatment settings. The approach was further described in other articles (Williams et al. 2005; Ziedonis, Williams & Smelson 2003), but basically stays focused on staff development, basic and advanced training, offering staff members and clients assistance to quit smoking, developing a change plan for the organization, helping the leadership team to organize for the changes that they want to achieve, considering organizational structure and process changes, and also policy development. The model developed from the premise that staff training was not enough and that these treatment settings had a culture where it was normal not to address tobacco.

The current version of this organizational change intervention is the Addressing Tobacco Through Organizational Change (ATTOC) model. This approach emphasizes and recommends a tobacco dependence treatment model that includes multiple interventions for different states of motivation on the clinical level (Ziedonis et al. 2006; Ziedonis & Trudeau 1997) and offers a menu of options for organizational change goals on the organizational level. Part of the intervention includes assessing the agency's motivation to change; the agency then determines its major goals. For example, some organizations just want the intervention to focus on increasing staff knowledge and skills through training. Other agencies might want to also include treating staff nicotine dependence and want the setting to be smoke-free for staff only. Other agencies want sweeping changes that include smoke-free grounds for all, including staff and patients.

The ATTOC model described in this article is currently being implemented and evaluated in a National Institute of Drug Abuse (NIDA) study, using a multiple baseline design with each of three residential addiction treatment programs. The six month ATTOC intervention is designed to support organizational change, including developing a leadership team, goals, change plan, communication effort, staff training, treatment for staff and patients, and policies on tobacco use restrictions. These clinical, program, and system level interventions (Ziedonis et al. 2006) include a focus on both the process of change and the content specific to tobacco use and dependence.

This article includes a more detailed description of the ATTOC intervention at one clinical agency, Willamette Family Treatment Services (WFTS), which decided to have smoke-free grounds for staff but allow only adult patients (not adolescents) to smoke in designated places. In a "motivation-based" treatment model the approach varies based on the motivational level of the patient, including having different strategies for lower and higher motivated patients. All patients who are tobacco dependent are screened, assessed, and offered some type of nicotine dependence treatment.

The ATTOC intervention is driven by six core implementation strategies that define the implementation process, and by 12 steps in the organizational change process. The use of a 12-Step organizational change model, in addition to laying out a clear approach to addressing tobacco within an organization, can also defuse staff resistance through its familiarity in the addiction treatment and recovery community. The sections below describe the six core implementation strategies and the guiding 12 steps of the ATTOC model.

SIX CORE STRATEGIES USED TO IMPLEMENT THE ATTOC MODEL

The ATTOC intervention is delivered through a combination of phone consultations and on-site consultations and trainings. The six core strategies include: (1) preparation activities for the start of the intervention, (2) on-site consultation, (3) formation of the agency's Addressing Tobacco Leadership Group, (4) formation of work groups to address the specific areas of the ATTOC 12-Step approach, (5) development of tobacco treatment specialists at the agency, and (6) phone consultations to provide ongoing technical assistance.

Preparation for the ATTOC Intervention

Prior to the six month intervention, there is a one month planning period in which the site champion(s) anticipate the intervention and begin to work with the intervention team. The champion(s) are the leader(s) of the event and serve a vital role for facilitating the organizational change plan. Having leaders with authority in the agency is important, as is a passion for the issues of addressing tobacco, wellness, and recovery. A first step is planning for the development of the leadership team and anticipating the intervention team's on-site consultation. The membership of the Addressing Tobacco Leadership Committee (or whatever

local name might be selected) reflects a broad stakeholder involvement. During the preparation period, the leadership committee reviews the existing policies and the manner in which the clinical chart reflects documentation for tobacco use, dependence, and treatment. Other preparation work includes planning for the on-site staff training (such as arranging for Continuing Medical Education units and logistics for staff attendance) and selection of the three on-site staff members to attend the off-site advanced training. Carbon monoxide (CO) meters are purchased for the agency to provide routine screening and assessment for tobacco use and exposure. The CO meter is also a great teaching tool to help patients to see the personal advantages of tobacco dependence treatment (Steinberg et al. 2004).

On-Site Three Day Consultation

During the first month, the ATTOC intervention team does an on-site consultation which includes four primary activities: providing organizational change consultation to the leadership committee, meeting the agency's leadership and staff, training staff, and doing an on-site assessment of the organization's capabilities to address tobacco use. The intervention team meets with the leadership committee to review current policies and practices, consider past efforts at organizational change, acknowledge the challenges tobacco creates for the agency, and begin development of the change plan.

During the three day on-site consultation there is a one-day tobacco training for all staff. The on-site training, entitled "Integrating Tobacco Dependence Treatment into Your Professional Practice," trains staff to: (1) communicate the importance of addressing nicotine in their clinic, (2) identify nicotine resources, treatment, and training options, (3) incorporate tobacco screening, assessment treatment planning, and treatment of nicotine dependence into practice, and (4) inform clients of evidence-based nicotine dependence treatments, including psychosocial and pharmacological treatments. Medical staff members (nurses and physicians) are provided with intensive training on prescribing FDA-approved medications for nicotine dependence treatment.

Addressing Tobacco Leadership Committee

Throughout the ATTOC intervention, the champions and the leadership committee meet at least monthly to provide clinical, training, human resources, and policy leadership. The leadership committee maintains a written change plan and monitors and supports its implementation over time. Communication from the leadership committee is critical for staff, patients, families, and other community agencies.

Formation of Tobacco Work Groups

The leadership committee is encouraged to develop work groups to implement the goals developed from the 12 steps of the ATTOC model. The agency has flexibility in how to organize these tasks, but typical workgroups are concerned with assessment/documentation, staff training, communication, staff recovery, medication management, policy development, and program development. Ultimately the goal is to have these tasks become integrated into existing agency committees and structure.

Training Tobacco Treatment Specialists

Staff members across various disciplines may have received little training in nicotine dependence, but they do have the necessary tools to adapt existing knowledge and skills. The ATTOC intervention includes the further development of two or three staff members to increase their ability and identity as the organization's tobacco treatment specialists. These individuals receive an extensive three-day off-site training focused on motivation-based treatment approaches including motivational enhancement therapy, specific lesson plans for

use in group treatment or for individual treatment with lower motivated clients, cognitive behavioral therapy for smoking cessation with adaptations for substance abusers, cultural competence, and case discussions/role plays.

Weekly Phone Check-ins

The ATTOC intervention includes weekly phone check-ins conducted by the intervention team with the program champion(s) and the leadership committee. These calls provide additional technical assistance on the 12 step change process, and support the agency in maintaining the gains achieved through the intervention.

Nicotine Dependence Treatment Medications

As it was applied in the NIDA study, the ATTOC intervention provided $ 11,000 to each agency to purchase nicotine dependence treatment medications. The agency had flexibility to choose from among the seven FDA-approved medications (five types of nicotine replacement therapy (NRT), varenicline, and bupropion). Providing medication in the NIDA study supported the goals of increasing access to treatment for staff and patients, and facilitating training on medication treatment.

THE ATTOC 12 STEP APPROACH

Table 1 outlines the 12 steps of the ATTOC model that are used to guide the intervention. A manual was developed that describes these 12 key issues, and includes a description of the motivation-based orientation to organizational change.

Step One: Acknowledge the Challenge

The intervention consultant helps the champion(s) and the agency to develop a sense of urgency in addressing the issue of tobacco use and dependence, including creating a vision and addressing the common barriers for addiction treatment programs.

Step Two: Establish a Leadership Committee

The champion(s) cannot facilitate cultural change without the help of others at the agency. The leadership committee needs to represents all staff at the organization (i.e., administration, medical, nursing, counselor and social work staffs, union members, housekeeping, security and grounds staff, etc.) and have members who are leaders within the agency and are able to make decisions with financial support.

Step Three: Create a Written Change Plan and Implementation Timeline

What are the short, medium, and long-term goals and plans? Who will be affected? When will goals be achieved? In this step the leadership committee establishes a timeline with measurable goals and objectives. This intervention process includes planning, collecting data to measure change, evaluating outcomes, and making further improvements (Ziedonis & Williams 2003).

Step Four: Start with Easier System Changes

Many clinicians and program directors initially get overwhelmed when they consider addressing tobacco use, so there is a need for early victories in the effort. Breaking the task into smaller steps can also help. Commonly perceived "easier things to do" are listed in the Table 2.

Step Five: Conduct Staff Training

All staff should be trained to screen, assess, and develop treatment plans for tobacco dependence. Staff training includes a motivation-based treatment approach with specific interventions for lower and higher motivated patients, including both psychosocial and pharmacologic treatment options. This training includes increasing knowledge of local resources, regional and national web-based interventions and educational sites, and community support groups (e.g., Nicotine Anonymous).

Step Six: Provide Treatment Assistance for Interested Nicotine-Dependent Staff

Staff who smoke are often resistant to organizational change to better address tobacco use among patients. Some of this is their own ambivalence about their tobacco use, but there is also concern that they will be forced to be tobacco-free while at work. Staff members deserve the same sensitivity and compassion provided to the clients on this issue, including education and access to medication, psychosocial treatment, and social support. Sensitivity to staff's nicotine dependence is important in training—especially the counter-transference issues that arise, and the staff's resistance to intervening with their patients on smoking. Such resistance is often due to their own guilt or shame about smoking, or a sense of hypocrisy in helping others to quit smoking while they continue.

Step Seven: Document Assessment and Treatment Planning for Nicotine Dependence

Changing intake/assessment, treatment and discharge planning forms to include tobacco items will prompt staff to assess tobacco use comprehensively. Modifications can be made to these tools to include nicotine, to have questions that are more detailed (e.g., progression of use, CO meter score, history of prior quit attempts, motivational level, support system), and to assess its relationship to alcohol and other drugs and its impact on functioning. All tobacco-dependent clients should have this problem listed on their treatment plan.

Step Eight: Incorporate Tobacco Issues into Patient Education Curriculum

Information for all smokers and tobacco users should include the health consequences of tobacco, interactions between medications and tobacco, what medications and other treatments are available for nicotine dependence treatment, fact sheets on common patient concerns, strategies to address cravings, information personalizing risks, and nicotine dependence measurement tools. Educational information on how tobacco impacts the family and what the family can do is also important.

Step Nine: Provide Medications for Nicotine Dependence Treatment and Required Abstinence Periods

Medication usage in treating nicotine dependence parallels its use for other addictions in treating acute withdrawal (detoxification), protracted withdrawal, and even maintenance as harm reduction. Primary medications are NRT (patch, gum, spray, inhaler, lozenge), bupropion, and varenicline. Utilizing these treatments to help manage required abstinence periods and as part of nicotine dependence treatment is routine. Some agencies cannot afford to integrate these medications into their agency and must rely on behavioral interventions.

Step Ten: Integrate Tobacco Dependence Treatment Groups into the Program and Include the Development of Onsite Nicotine Anonymous Meetings

The ATTOC model encourages the use of evidence-based tobacco dependence treatments that integrate medications and psychosocial interventions (motivation based treatments, education, relapse prevention, and support). Staff are trained in core psychosocial treatments (cognitive behavioral therapy and motivational enhancement therapy) for the "quitters" group treatment,

which is for smokers ready to quit and emphasizes techniques for quitting. It is recommended that staff provide the quitters group treatment for 10 weeks. For lower motivated patients, the staff are trained in motivational enhancement therapy and also delivering a more educational model that allows for interaction with the clients. The approach has more of a "wellness" orientation and describes the importance of addressing tobacco at some time in the individual's recovery process. A useful resource for these two types of groups is the *Learning about Healthy Living* manuals (Williams et al. 2005). These manuals were designed for individuals with serious mental illness and are adapted in the NIDA study for the substance abuse treatment population. The manual is readily available via the internet site: http://ubhc.umdnj.edu/nav/LearningAboutHealthyLiv-ing.pdf. The group treatment approach for lower motivated clients includes information regarding the risks associated with smoking, what is in cigarettes, the benefits of quitting and ways to quit smoking, and healthy lifestyle behaviors that can assist them in quitting smoking. Education and other motivational interventions can help less-motivated patients to incrementally increase their commitment to quit.

For individuals with other addictions that utilize the 12-Step approach of Alcoholics Anonymous, Nicotine Anonymous (Nic-A) and "working a program" for addressing tobacco dependence can be familiar and helpful. In most communities in the United States there are few Nic-A meetings whose members meet on a regular basis, so some individuals benefit from just reading the Nic-A materials and sharing these concepts with their sponsor or therapist. Addiction treatment programs are a good place to have Nic-A meetings, and one goal for programs in the ATTOC model is to develop Nic-A meetings at their site.

Step Eleven: Communicate with 12-Step Groups, Colleagues, and Referral Sources about System Changes

Communication is needed, throughout the intervention, with staff, patients, families, local Alcoholics Anonymous and other support groups, colleagues, insurance companies, and referral sources. Often agencies are concerned about negative fall-out that may accompany an aggressive change in smoking policies. For example, providers may worry that making their program smoke free, including smoke-free grounds, may result in a loss of business.

Step Twelve: Develop Policies Addressing Tobacco Use

Addiction treatment programs routinely use policy manuals for clinical and nonclinical issues, and this is one way to assess prior tobacco dependence policies. Tobacco policies often include rules about the boundaries on specific behaviors and consequences for violation, including if smoking and use of other forms of tobacco are allowed and at what locations if allowed. Policies need to include how to manage violations, and should apply to both staff and patients. In some cases, programs will require that staff members not be identifiable in any way as tobacco users, in order to prevent the sight or smell of tobacco from triggering the relapse of clients, staff, or visitors. Some system changes may necessitate modifying standard intake forms to better assess tobacco use, include tobacco on the treatment plan, and require discharge planning on tobacco dependence. Signage such as pro-wellness posters and no-smoking signs reminding people of these new policies can be helpful. In some cases the treatment program will want to have tobacco-free grounds for staff and/or patients, recognizing that environmental tobacco smoke is a substantial health risk (US DHHS 2006).

WILLAMETTE FAMILY TREATMENT SERVICES (WFTS) CASE STUDY

This article now offers the perspective of an addiction treatment program that participated in the NIDA ATTOC study (October 2006 to March 2007). WFTS is the largest substance abuse treatment agency in Lane County, Oregon, with an operating budget of over $4 million per

year, and includes both adolescent and adult treatment programs. The three core facilities within the WFTS adult treatment program are Women's Rehabilitation, Men's Rehabilitation and Detoxification. The Women's Treatment Facility offers a full spectrum of care including outpatient, residential and aftercare services, and annually serves 400 women in outpatient and 200 women in residential services. The residential (35 beds) and outpatient programs serve both women and teens, including those who are pregnant and parenting. A licensed Child Development Center provides care for infants and children while their mothers are in treatment. The Men's Treatment Facility provides the same continuum of care, serving nearly 200 clients in residential and 160 in outpatient treatment. The Buckley Detoxification Center, serving over 500 men and women annually, offers short sobering stays (less than 10 days) for those in need of acute withdrawal management.

For over 10 years, WFTS policy as stated in the Employee Handbook prohibited tobacco use on site at any program facility. However, this policy had largely been ignored. All the WFTS facilities had designated smoking areas for clients and staff, and supervisors overlooked frequent staff smoking breaks and the use of break areas as social meeting places. Although most WFTS programs ignored written smoking policies, two programs (the Adolescent Program and the Child Development Center) maintained strict policies against tobacco use. The Adolescent Program prohibited tobacco use by all clients. Staff members were prohibited from smoking during the workday, and staff members who were addicted to tobacco were encouraged to quit. New staff hires were informed of this policy and were generally not tobacco users.

Prior to beginning the ATTOC intervention, there was consensus determined by the WFTS top administrative staff that WFTS needed to do more about addressing tobacco. The period before the intervention began induced anxiety in staff members, as it was unclear whether WFTS would have tobacco-free grounds as the goal of the intervention. Staff who smoked were fearful that they would have to quit smoking, or that their "right to smoke" would be curtailed. Many nonsmokers expected a complete ban on tobacco, including tobacco-free grounds. Before the intervention there were two smoking areas at the Women's Program facility, at opposite ends of the building. The clients smoked in a large covered shelter located just off the facility grounds, while the staff members smoked in a covered outdoor spot in the maintenance area. Both spots had seating conducive to socializing. Staff members with heavy tobacco addictions often used their area hourly, with little restriction by supervisors (some of whom also smoked). The ATTOC intervention helped many staff quit smoking; however, some relapsed while others remained abstinent. Initially the tobacco awareness efforts of nonsmoking staff were met with resistance by smoking staff and clients. In the men's residential setting (20 beds), residents arrive from jails, prisons, and other treatment centers, and nearly all clients are tobacco users, either smokers or chewers. Before the intervention, staff and clients shared a smoking area at this facility, and there were few restrictions on shared tobacco use, with staff smoking with clients during individual counseling sessions, and staff chewing of tobacco common. At that time clients would pool their money, augment it with recreation funds earned through fundraising events, and buy bulk tobacco for rolling or inexpensive cigarettes. When new clients entered treatment, they were provided with tobacco and invited into the pool. These practices were ended in the course of the ATTOC intervention.

Two WFTS opinion leaders worked in partnership to lead the ATTOC intervention, the Adolescent Program Director and the Women's Treatment Director. Because this leadership team included both a smoker and a nonsmoker, both of whom were committed to the organizational change process, WFTS was able to reach all clinical staff and most other staff to present the goals of the project. These two champions represented the agency as a whole, and had years of experience and a grassroots connection to both clients and staff. Other staff

provided leadership support, notably by developing Nicotine Anonymous meetings on site, and publicizing local Nicotine Anonymous meetings to staff.

Shortly before the start of the intervention, a Tobacco Leadership Committee was developed with representation from every clinical program as well as support and maintenance staff. A mission statement regarding tobacco use and nicotine cessation was developed, presented to the board of directors, and endorsed by the president of the board and the executive director. The statement outlined that, in addition to health concerns related to the use of tobacco by employees, tobacco-related organizational costs (lost productivity, absenteeism, health care costs, and insurance) were $178,500 per year. The Leadership Committee met monthly, and subgroups were formed to mirror key steps in the ATTOC model (e.g., supervision and training, program implementation, policies and procedures, assessment and documentation, patient education, patient medications/NRT, Nicotine Anonymous Meetings, treatment and recovery resources for staff).

In the course of the ATTOC intervention, Leadership Committee members estimated that 150 patients and staff benefited from NRT and other nicotine dependence medications provided by the study. Having NRT available during the NIDA-funded ATTOC intervention was important in expanding nicotine dependence treatment on-site, since not having access to NRT or other medications for nicotine dependence is a barrier. WFTS staff commented that clients were often receptive to smoking-related interventions. Clinical staff benefited from the general staff training offered during the on-site consultation in October 2006. The key tobacco treatment specialists were identified and received advanced training off-site about one month later.

After several months of collaborative effort, a new agency tobacco policy was finalized by the Leadership Committee and proposed to staff on January 1, 2007. At this time the staff smoking area at the Women's Facility was closed, and smoking staff were asked to smoke off site. After some additional changes, the final WFTS Tobacco Policy was implemented on February 1, 2007. A short staff satisfaction survey taken soon after the policy was implemented showed a generally positive response to the tobacco policy. At the time of this writing, one year after the ATTOC intervention was initiated, there continues to be maintenance of the progress, including the desire to be a tobacco-free agency, with strong incentive for staff to quit smoking, and a focus on cessation efforts for all clients.

The new agency policy required staff to use tobacco products off-site and restricts break times to one ten-minute morning and afternoon break, along with a lunch break. This restriction curtailed excessive use of work time for smoking breaks. Many employees have found it inconvenient to go off grounds to smoke and have chosen to either quit smoking or to use NRT during the workday. Several people have reported that they couldn't have quit smoking without the NRT, as well as the emotional and behavioral support offered as a result of the intervention.

Staff members found it was helpful to have both a quitters group treatment approach and a lower motivated group treatment approach. Continued trainings for clinical staff were provided through in-service trainings and by distributing the ATTOC binders and manuals again. Tobacco education videos and tobacco cessation posters were placed throughout the agency's three facilities. One limitation was that nicotine-related training and education was offered only to counselors and supervisors; other staff, and particularly support staff, may have benefited from the education and should have had the opportunity to participate. Another potential limitation of the study is that all clients at the agency aren't evaluated — only a sampling of the clients. The NIDA-funded study will assess whether WFTS clients were more likely to receive nicotine dependence services (e.g., assessment, counseling, referral) after the intervention was completed; however, those data are not available at this writing. In addition, as the focus of the study was on organizational change and not on client-level change, the NIDA

study will not directly measure whether clients are more likely to quit smoking after the intervention. Whether changes in organizational practices to better address smoking among clients may affect client smoking behavior (e.g., quit attempts, quit rates), and how much change in client smoking behavior may occur, are questions for future research.

A key issue for the success of the intervention was effective communication, and the Leadership Committee took the lead in this. Nicotine Anonymous meetings and the incorporation of CO meters in smoking cessation groups were well received by the clients and motivated several clients to attempt smoking cessation. A tobacco cessation support group was offered to staff as well. Although the staff support group was small and only met weekly for a few months, those who attended said they found it to be helpful. Members of the WFTS Tobacco Leadership Committee report that, through education and encouragement, a gradual shift in the WFTS tobacco culture has occurred. As an example, some residential clients complain that they are "having trouble finding someone to smoke with."

CONCLUSION

Tobacco use and dependence is the leading cause of morbidity and mortality to clients in addiction treatment programs. The ATTOC model can be helpful to addiction treatment programs making the organizational change effort toward controlling and eliminating tobacco use. Today it continues to be normal to smoke in most addiction treatment programs; however, the tipping point is near and broad cultural change is likely to occur in coming years. Addressing tobacco use requires clinical, program, and system level change. The 12 steps of the ATTOC model provide a prescriptive approach to helping organizations change so that they can support clients in their recovery from tobacco addiction as well as other addictions. The ATTOC model provides a general structure and guidance for organizational change, but programs must adapt it to the unique features of their treatment population, including culture, co-occurring disorders, and other factors that are unique to their needs and social context.

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TABLE 1

The Addressing Tobacco Through Organizational Change 12 Step Approach

1	Acknowledge the challenge of addressing tobacco use.
2	Establish a leadership group; secure the commitment of the organization to addressing tobacco use.
3	Create a change plan and implementation timeline with measurable goals and objectives.
4	Start with easy system changes that can be implemented.
5	Conduct staff training and ongoing supervision.
6	Provide treatment and recovery assistance for interested staff who are nicotine dependent.
7	Require better assessments and documentation in charts of nicotine use, dependence, and prior tobacco dependence treatments, including previous quit attempts.
8	Incorporate tobacco dependence treatment materials into patient education curriculum, including information about the new tobacco dependence group treatment and NRT.
9	Provide NRT medications for nicotine dependence treatment.
10	Integrate tobacco dependence treatment groups into the program.
11	Develop onsite Nicotine Anonymous meetings. Establish communication with 12-Step recovery groups, professional colleagues, and referral sources about system changes.
12	Develop written policies addressing tobacco use.

TABLE 2

Easy Policy Changes to Better Address Tobacco Use

- Use the phrase "alcohol, tobacco, and other drugs" when discussing substance use disorders and include tobacco dependence in co-occurring disorders.

- Modify existing assessment forms to include tobacco use and motivation to change.

- Identify smokers in the clinical chart.

- Make sure tobacco dependence is on the problem list.

- Provide educational materials about tobacco dependence and treatment.

- Re-label "smoke breaks" to just "breaks."

- Ban sales of cigarettes.

- Do not allow staff to smoke with patients.

- Limit hours and places for smoking.

- Obtain tool kit files from the Internet (www.aptna.org/APTNA_Prov_Toolkits.html)

- Provide educational materials about tobacco dependence and treatment.

- If not requiring smoke-free grounds, create less visible places where smoking is permitted.

- Smoking staff should not give the appearance of smoking (i.e. smelling of smoke).