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Understanding the Drug Treatment Community's Ambivalence Toward Tobacco Use and Treatment

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Abstract

Background—Most clients in drug treatment smoke cigarettes, but few facilities provide treatment for tobacco dependence. We identify subjective experiences and social processes that may influence facility adoption of tobacco treatment policies and practices.

Methods—Cross-sectional, semi-structured interviews were conducted with staff, directors and clients of 8 drug treatment facilities in the Midwestern U.S. We assembled a purposive sample stratified by ownership, methadone provision, and treatment service provision. We conducted in-person interviews with clinic directors and 54 staff and clients and employed a mixed-method analytic approach.

Results—Facility policies and philosophy related to tobacco differed from those regarding alcohol and other drugs. Participants suggested facilities may not treat tobacco dependence because it does not create legal and social problems that force clients into treatment. Tobacco dependence treatment falls outside of a core function of drug treatment, which is to help clients fix legal problems caused by their drug use. Moreover, proactively treating clients for tobacco dependence creates strong ambivalence among staff and directors. On the one hand, staff smoking would violate core principles of drug treatment (i.e., the importance of staff abstinence from drugs of abuse); on the other, staff who smoke feel their personal rights and jobs are threatened. This situation creates strong incentives for staff to resist adoption of tobacco dependence treatment. Unlike other studies, the fear of jeopardizing clients' abstinence from other drugs did not emerge as a downside for treating tobacco dependence.

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AUTHORS' CONTRIBUTIONS

Kim Richter conceived of the study, and participated in its design and coordination and drafted the manuscript. Jamie Hunt and Paula Cupertino assisted in the study design and coordination and in drafting the manuscript. Susan Garrett assisted in the study design and coordination and in manuscript development and Peter Friedmann assisted in the conception of the study design. Charles Cohlmia and Wei Hou assisted in editing the manuscript. All authors contributed to drafts of the manuscript and have read and approved the final manuscript.

Conclusions—International and national trends will probably increase the pressure to treat tobacco dependence during drug treatment. However, the U.S. context of drug treatment, as a patchwork, under-funded industry with high employee turnover, may undermine true adoption. At present, many facility staff resolve their ambivalence by reporting they "offer" treatment, but actually providing none. To facilitate dissemination of service provision, it may be useful to identify incentives for U.S. facilities that are closely aligned with the criminal justice system, help facilities define policies and treatment roles for staff who smoke, and better define the role of facilities in preventing morbidity and mortality.

Keywords

Smoking Cessation; Tobacco Treatment; Substance Abuse Treatment; Health Services Research; Drug Policy

BACKGROUND

Most clients in substance abuse treatment smoke cigarettes (Best et al., 1998; Hughes, 1993; Kalman, 1998; Poirier et al., 2002; Richter & Ahluwalia, 2000) and people in recovery may have high rates of tobacco-related illnesses and mortality (Hser, Anglin, & Powers, 1993; Hurt et al., 1996; McCarthy, Zhou, Hser, & Collins, 2002; Richter, McCool, Okuyemi, Mayo, & Ahluwalia, 2002). Clients are interested in quitting smoking (Clemmey, Brooner, Chutuape, Kidorf, & Stitzer, 1997; Frosch, Shoptaw, Jarvik, Rawson, & Ling, 1998; Meyer, Lin, & Brown, 1996; Nahvi, Richter, Li, Modali, & Arnsten, 2006; Orleans & Hutchinson, 1993; Richter, Gibson, Ahluwalia, & Schmelzle, 2001; Sees & Clark, 1993) and are able to quit without jeopardizing abstinence from their other drugs of abuse (Burling, Burling, & Latini, 2001; Clemmey, et al., 1997; DiFranza & Guerrera, 1990; Hughes, Novy, Hatsukami, Jensen, & Callas, 2003; Joseph, Lexau, Willenbring, Nugent, & Nelson, 2004; Kalman et al., 2001; Nahvi, et al., 2006; Reid et al., 2008; Richter, Ahluwalia, Mosier, Nazir, & Ahluwalia, 2002; Richter, et al., 2001; Shoptaw et al., 2002; Stein et al., 2006; Tsoh, Chi, Mertens, & Weisner, 2011). Some substance abuse treatment programs are beginning to provide tobacco dependence treatment but many still fail to do so (Currie, Nesbitt, Wood, & Lawson, 2003; Friedmann, Jiang, & Richter, 2008; Richter, Choi, McCool, Harris, & Ahluwalia, 2004; Walsh, Bowman, Tzelepis, & Lecathelinais, 2005).

Given that cigarette smoking is widely acknowledged as addictive and harmful, even by staff of substance abuse treatment facilities (Hahn, Warnick, & Plemmons, 1999), it is worth asking why substance abuse treatment providers still feel it is acceptable to *not* treat tobacco dependence. The few studies that have addressed this issue focus mainly on global support for treating tobacco dependence, the pros and cons of providing treatment, the potential impact of staff smoking on treatment provision, and smoke-free policies that might support or undermine treating tobacco dependence (Fuller et al., 2007; Richter, et al., 2004; Walsh, et al., 2005).

Two large-scale, representative surveys found that staff members are supportive of treating tobacco dependence. In a survey of 213 managers and 204 other staff representing 60% (n=260) of all Australian drug and alcohol treatment agencies, most respondents (82%) believed that clients should receive advice/counseling to quit smoking (Walsh, et al., 2005). A survey of U.S. methadone programs also found that most clinic directors (76%) believed that methadone clinics should provide tobacco treatment and/or refer patients for tobacco treatment (91%) (Richter, et al., 2004). Among 3,786 staff within the National Drug Abuse Treatment Clinical Trials Network, Fuller (2007) assessed staff agreement with whether tobacco dependence treatment should be integrated into drug treatment. Support was lukewarm with a mean of 3.54 on a scale of 1 (strongly disagree) to 5 (strongly agree)—

reflecting the ongoing ambivalence in the field toward treating tobacco dependence (Fuller, et al., 2007).

Yet facilities that report they offer group or individual counseling for smoking cessation are in the minority: 41% of U.S. facilities and only 10% of Canadian facilities (Currie, et al., 2003; Friedmann, et al., 2008). In Australia, tobacco dependence treatment appears to be more prevalent as it is estimated that 26% of all clients that smoke are treated for tobacco dependence (Walsh, et al., 2005).

Drug treatment staff and directors consistently report several barriers, including lack of staff training in treating tobacco dependence, the perception that clients are not interested in quitting, fear of jeopardizing clients' progress with other drugs, belief that smoking may help with the stress and withdrawal of quitting other drugs, and belief that treating illicit drug/alcohol dependence is more important than treating tobacco dependence (Hahn, et al., 1999; McCool, Richter, & Choi, 2005; Walsh, et al., 2005). These same barriers exist, however, for other drugs of dependence such as concomitant marijuana, benzodiazepine, or prescription drug abuse. And yet facilities commonly address poly-drug dependence and encourage clients to quit multiple drugs at the same time—with the exception of tobacco use. Interestingly, lack of reimbursement is often included in lists of barriers to providing tobacco treatment, but is rarely selected by staff or directors as a top problem (McCool, et al., 2005).

Staff smoking is another barrier that may account for low rates of treatment provision. Many drug treatment professionals in recovery from drugs or alcohol are current or former smokers (Walsh, et al., 2005). Studies of staff attitudes and practices found that staff who smoke are less likely to report they address smoking among their clients (Bobo & Davis, 1993) and more likely to feel that tobacco use hinders recovery from other drug use (Gill & Bennett, 2000).

Hence, staff's personal experiences with smoking and quitting, their thoughts about how smoking is similar to or different from other drug abuse, and their feelings regarding the fundamental purpose of drug treatment may all be important determinants for whether a program provides tobacco dependence treatment. Most facilities are not required to do so—in the U.S., only two states, New York and New Jersey, require drug treatment facilities to address tobacco dependence. Even when a program is mandated to provide treatment, staff and director attitudes will very likely influence implementation. Informal, employee-generated norms strongly influence behaviors within organizations, even when they conflict with formal policy or guidelines (Ferrante, 2006). Staff perspectives are especially important in facilities where the decision to treat a client's smoking, and the types of treatments clients receive, are left up to individual staff members—as is the norm in Australia (Walsh, et al., 2005).

There may be other staff attitudes about tobacco and tobacco treatment—not yet articulated by researchers, policy makers, or even clinic directors—that influence whether or not staff will support or implement tobacco treatment. Prior studies that have examined staff perspectives on tobacco treatment have done so using closed-ended questions, developed by researchers, sometimes in collaboration with clinic directors. The problem with closed-ended questions is "you get what you ask for" (Thomas, Greenfield, & Carter, 1997). It is not possible to identify whether there are fundamental issues related to tobacco treatment that one simply failed to ask about.

The purpose of this study was to explore, in an open-ended manner, staff, director, and client perspectives on the pros and cons of providing tobacco treatment, how tobacco is similar to or different from other drugs, similarities and differences in their facilities treatment

philosophy toward tobacco versus other drugs, and how staff smoking affects tobacco treatment. We sought to uncover some of the core thoughts and feelings that underlie the current low rates of tobacco treatment in drug treatment. Qualitative approaches are especially well suited for collecting data on insider knowledge about these values and the context in which they occur (Zickmunnd, Bokhour, & A, March 3, 2010).

This study was part of a larger project to develop and validate a brief measure of tobacco treatment services in drug treatment (R21 DA020489, P.I., Richter). The goal of the present study was to identify core thoughts and feelings regarding providing tobacco dependence treatment in drug treatment. These ideas were then used to developed closed-ended questions on these items as part of a comprehensive survey of tobacco treatment attitudes and practices in drug treatment. The survey is currently being administered to a representative sample of U.S. drug treatment facilities to identify the impact on the provision and quality of services. However, the findings of the present study are also very relevant to providers considering providing tobacco dependence treatment in their substance abuse facilities as well as policymakers interested in understanding and increasing the adoption of tobacco treatment in substance abuse facilities.

METHODS

Facility sample and participants

We conducted the study among substance abuse facilities in a metropolitan area in the Midwestern United States. We aimed to recruit a purposive sample of 6–12 facilities that differed according to several variables that correlate to treatment provision – specifically profit versus non-profit and methadone versus non-methadone (Friedmann, et al., 2008; Richter, et al., 2004). We also sought to observe facilities that provided either high or low levels of tobacco dependence treatment services. To select facilities, we assembled a large target pool of eligible facilities, stratified by profit/nonprofit, methadone/non-methadone, and tobacco service status. We invited and interviewed participants from sequential facilities until we had completed data collection from at least one facility within each strata and/or until saturation was reached – the point at which respondents no longer expressed new opinions or information (Glasser & Strauss, 1967).

To identify our initial study population of facilities, we used the Substance Abuse and Mental Health Services Administration (SAMHSA) Substance Abuse Facility Treatment Locator (www.findtreatment.samhsa.gov). We sent letters to 51 local metropolitan area facilities serving outpatient adults. The letters described the study, invited clinic directors to return a self-addressed letter indicating interest in participating, and notified directors that we would call shortly to invite them by phone and screen for eligibility. Eligibility criteria included: 1) facilities serve predominantly adults, and 2) provide outpatient treatment. Two of the 51 facilities immediately returned letters indicating they refused to participate. Staff then recruited 8 initial sites for participation by phone. To do so, they contacted a total of 12 facilities. Of the 12 facilities screened for eligibility, two were ineligible, two refused and 8 were eligible and agreed to participate in the study. After eight site visits, study staff agreed that participant responses to interview questions were becoming repetitive and recruitment was closed because saturation was reached.

Procedures

The design was a cross-sectional survey of facilities conducted to the point of theoretical saturation. We used a multi-method approach to data collection that included quantitative surveys and qualitative interviews.

Over a 3-month period in 2008, research staff visited each study clinic. We worked with the clinic staff liaison to schedule the date and time of the visit, recruit staff and clients, and schedule interviews. Data collection lasted 1½ –2 days depending on the number of interviews conducted; interviews lasted approximately 40 minutes. Staff and clients were recruited based on a convenience sample for the scheduled days interviews were to take place. Subjects provided verbal consent before the interview began. Participants received a $25 gift card to reimburse them for their time. The study liaison was reimbursed $100 and each facility was reimbursed $500 to compensate for staff time spent in data collection.

Measures

Brief quantitative surveys collected demographic information and smoking status from all participants. Qualitative measures consisted of open-ended questions beginning with a "grand tour" question that asked all participants to describe how their clinic currently provides tobacco treatment. Subsequent questions explored staff and clients' thoughts and feelings about tobacco, tobacco treatment and other issues. Preceding open-ended questions on staff smoking, one question asked respondents to rate the facility's stance toward staff smoking on premises (discourage, remain neutral, encourage). The entire interview guide is available on request. Interviewers were trained to 1) ask questions from the interview guide, 2) ask respondents to clarify or amplify their responses when necessary, and 3) ask respondents to expand on new perspectives that had not been heard in previous interviews.

Analysis

We conducted purposive sampling, as described above, to collect a broad array of perspectives from a variety of providers. Interviews were audio taped, transcribed, and coded using Ethnograph VI by three investigators. We noted and discussed themes as they emerged during data collection in order to identify the point at which we had achieved data saturation. We employed elements of grounded theory and content analysis to inductively generate a list of core thoughts and feelings regarding providing tobacco treatment in drug treatment (Borgatti, 1998).

We used a grounded theory approach in constructing our sampling frame and developing our coding scheme inductively from interviews (Borgatti, 1998). We developed our coding scheme as we collected data; multiple investigators (KR, JH, SG) open-coded interviews to identify key words, themes, meanings of phrases, and descriptions of behavior as they emerged in interviews. A broader team reviewed initial analyses and drafted a common set of codes based on these categories. These codes were applied to several more transcripts, in which new themes were also identified, and the code list was refined and applied to more transcripts. We compared responses from interview to interview within each site and across sites in order to identify similar codes and collapse them into more general categories—these categories are represented by the major topic headings of the results section. We also used comparisons to identify differing perspectives on issues. We refined the code list, definitions, and examples of codes in several iterations and then applied the finalized codes to all interviews. Throughout the process, investigators maintained notes and memos regarding relationships between themes (such as the relationship of staff smoking to the organizations' philosophy toward treating tobacco dependence) which are reported in the results and explored at greater length in the discussion.

We opted to generate a list of issues that participants felt were barriers to implementing tobacco treatment in drug treatment, rather than generate a comprehensive theoretical model for why or how these issues occur, as is the goal of grounded theory. Hence we employed approaches from content analysis to quantify the number of times themes were mentioned in order to identify how widely held thoughts and feelings were among our participants

(Weber, 1990). Also, we assessed the extent to which we made valid inferences from our interviews by calculating inter-rater reliability agreement across 9 codes that addressed key implementation issues. We calculated reliability on codes that corresponded to major questions in our interviews in order to ensure we would have sufficient data to code. We selected these codes a priori, and only calculated reliability for the selected codes in order to avoid the possibility of selectively reporting reliability for stronger codes. Percentage agreement across all codes was 87%, with a substantial kappa score of 0.66 (ranging from 57% to 74% across codes) (Argesti, 1990; Sierra & Cardenas, 2007). Quantitative data were analyzed using SPSS.

RESULTS

Data collection consisted of 62 in-depth interviews among 8 clinic directors, 25 staff (2–4 per clinic) and 29 clients (4–5 per clinic). We first describe features of our sample, including facilities, directors and staff, and clients. We then describe the findings of qualitative interviews.

Sample characteristics

Facility characteristics are shown in Table 1. Three facilities had fewer than 10 staff members, two ranged between 10 and 25 staff and two ranged between 60–75 staff members. The majority was non-methadone (6), not affiliated with a hospital (7), and provided low-treatment of tobacco (5). Slightly less than half were for-profit. None of the facilities allowed smoking inside the facility. Three facilities were located on smoke-free campuses, four facilities permitted smoking in designated areas and one facility did not have a smoke-free campus policy but the director reported staff is required to go off-site to smoke.

Among directors and staff, over 2/3 were female (69%) and white (69%), and most were non-Hispanic (91%). Most had had a bachelor's degree (42%) or completed some form of graduate school (46%). Many played multiple roles in the facility, including counseling, administrative, and medical. Almost 1/3 of directors and staff self-identified as a smoker. Only 2 (25%) directors reported that any staff completed training in treating tobacco dependence. Over half of directors (63%) reported their facility has treated tobacco for 1–5 years and 37% reported their facility has been treating tobacco for 10–25 years.

Participating clients were predominantly male (55%), white (69%), and non-Hispanic (96%). Most were younger than 45 years (69%) and were between 18 and 35 when first entering treatment (76%). The majority of clients were current smokers (90%).

Coding of Themes

Table 2 lists the final codes, brief definitions, and the number of participant comments within each code. When describing the data in our results, we indicate the number of comments that were coded in each category by (N=); the number of comments made by directors and staff grouped together and are denoted by D/S; comments by clients are denoted by C.

Opinions and attitudes on tobacco treatment

In order to introduce the topic to interviewees, we asked about the "pros" and "cons" of treating tobacco use in drug treatment.

Reasons for treating tobacco (N= 54)—Many participants (20 D/S, 12 C) cited health as a reason for treating tobacco, *"The pros are saving my health and my lungs and I do have*

a history of emphysema and my whole…my dad's whole side of the family has emphysema, so I do really want to quit (Client).” The next reason most cited was that it would be financially beneficial for clients to treat tobacco common (3 D/S, 6 C).

Interestingly, when discussing health as a reason for quitting smoking, some participants attributed the cause of clients' respiratory problems to *other* drugs of abuse, not tobacco use —the reason offered for quitting smoking is to prevent further injury.

> “I think that, um, it certainly health benefits with lung, breathing…a lot of our clients have done damage to their lungs because of the drugs that they've used and continuing to smoke adds to that.” Director

> “We have so many clients who are long term cocaine use, they come in with emphysema. They come in with other like health lung type of problems, so it would be beneficial to their health.” Staff

Reasons to not treat tobacco (N=48)—Many (19 D/S, 8 C) cited that a con to treating tobacco in drug treatment programs is that it is =too much' to treat all drugs at one time:

> “Well I think, you know, they already feel that they are having to change their entire life. And sometimes the cigarette smoking does kind of calm them down.” Staff

> “I've been in a program. But I believe it should be one thing at a time. I don't think the body can handle too many withdrawals there.” Client

Some directors and staff members (9) and only 1 client cited that clients do not want to quit. Others expressed that smoking helps keep clients calm and experience less anxiety (8 D/S, 4C), *“But the reality is most of our adult smokers could care less. I mean they're not interested in quitting smoking (Director).”*

When asked how they felt about treating clients' tobacco dependence, some (11 D/S, 3 C) were supportive of tobacco treatment, *“I as a non-smoker think it's important just because if we're addressing one substance we need to address all of them. Cigarettes kill more than every other drug combined, so I'm seeing it as a necessity (Staff).”* A few directors and staff (6) expressly stated they did not support providing tobacco treatment. Some staff (4) thought that tobacco treatment was appropriate if it is what the client wanted and some (3) wanted more tobacco treatment services to offer clients.

How is tobacco like or unlike other drugs?

Tobacco is like other drugs (N=56)—Many (19 D/S, 16 C) thought cigarettes are just as addictive as drugs and alcohol.

> “Well it's the exact same addiction process as far as, you know, brain chemistry. I mean it is an addiction, there's no doubt that…and it's an addiction that destroys your body, just like, you know, alcohol abuse or other illicit drug abuse. Just because it's legal doesn't mean it's less damaging.” Director

> “Well, you plan your day and schedule your day around breaks maybe to smoke where if you were a drinker you would plan your day and schedule your day around when you were going to drink, how are you going to drink, how much you are going to drink. People do the same with cigarettes or tobacco products.” Staff

Some thought tobacco was similar to other drugs because both are unhealthy (10 D/S, 3 C) and mood altering (7 D/S, 10 C).

> "Anything you put in your body that's going to change your body, mind, emotion or soul or all of the above or none of the above, it doesn't matter, if anything's going to change your way of thinking or your way of feeling, like if you're going to feel calmed down when you smoke a cigarette, that's a drug." Client

Tobacco is unlike other drugs (N=56)—A major difference noted by participants was that tobacco is legal (N=38); people do not get in trouble with the law or with drug treatment staff for smoking cigarettes. Few directors and staff (4) specifically stated that their job was primarily to keep clients compliant with the law and/or deal with their legal problems.

> "Pretty much our outcome studies would be--have you reviolated any conditions of your probation parole and have you relapsed. Pretty much cause that's…my big part of my job is to help keep you out of trouble." Director

> "So I don't really treat them for tobacco, we would focus more on the substance abuse and targeting that and getting there, you know, their legal cases taken care of. So that kind of takes a back…we touch on it but they always say it's not causing any trouble, that's not my problem." Staff

Respondents noted other differences between tobacco and other drugs. Several respondents said that tobacco is more socially acceptable than other drugs (12 D/S, 6 C). Some thought drugs are more detrimental to health compared to tobacco (6 D/S, 4 C), *"And also the harder drugs tear down your body a whole lot quicker…. they cause more complications in your life (Director)."* Some clients and staff felt that tobacco was not mind/mood altering as compared to alcohol and illegal drugs (9 S, 9 C), *"Well I think that cigarette nicotine is a drug. How it's different is I don't think it alters the mind as much and I don't think that it directly affects your decision making (Client)."*

Use of tobacco and other drugs is interconnected (N=23)—Some (5 D/S, 7 C) said that smoking is tied into other behaviors, *"Sometimes addictions go hand in hand with other things. You know, you do one thing, you smoke when you do it (Staff)."* Some (3 D/S, 2 C) felt that smoking is a trigger for other drugs. Some staff (4) and clients (2) thought that smoking increases when clients try to quit using drugs or alcohol:

> "Most people that are not…no longer on drugs they become heavier smokers, kind of substitutes for the drugs, you know." Client

> "I picked them up again when I got sober, just something to do." Client

Philosophy toward tobacco treatment (N=48)—Some (8 D/S, 6 C) noted that, unlike alcohol and drug use, tobacco use is accepted by treatment staff.

> "A client can come in and continue to use…smoke cigarettes, but if they are using alcohol or drugs they would be…especially on our premises, they would be discharged from treatment services. We treat a relapse to alcohol or drugs much differently than what we treat somebody who said they were going to stop smoking and took up smoking again." Director

> "Why yes. They let you smoke. You know, let you smoke, but drugs and alcohol are not allowed. You get in trouble for using drugs and alcohol, but you can smoke as many cigarettes as you can get down." Client

Another difference reported was that smoking was not a focus or a high priority in drug treatment (6 S, 6 C). Some (4) reported they had no formal policy around treating tobacco as there was for drug treatment. One director felt the philosophy was that they were not *required* to treat tobacco. Conversely, others (5 D/S, 3 C) felt their philosophy for treating

tobacco was no different from their philosophy of drug treatment, *"It's the same. It's just like the 12 step, we can use that as an example, in the AA…….You're just treating two different addictions (Client)."*

Policies regarding tobacco use

Several interview questions focused on tobacco use policy and its impact on treating tobacco use. Half of the directors reported having a written policy, protocol or guidelines regarding discussion about tobacco use and a procedure or protocol for clinicians to provide smoking cessation counseling or education.

Tobacco use policies are different from drug use policies (N=18)—Some (11 D/S, 4 C) said that tobacco use is treated differently, such as, staff would not get fired for smoking during work hours but would get fired for using drugs or alcohol during work hours, staff members have an obligation to report to the clinic director if they relapse on drugs or alcohol but do not have that obligation for tobacco use.

> "Alcohol and drug use is absolutely forbidden. In fact, if alcohol or drug use occurs on the job then you are immediately put on administrative leave with possible termination. Tobacco use, again, we encourage people to quit but we don't require it." Director

> "And that is they do not want you to use illegal street drugs, they do not want you to use alcohol and I don't think they care about nicotine so much." Client

Staff smoking

Several interview questions focused on staff smoking and how, if at all, it might affect treating clients' tobacco use.

Program policies related to staff smoking (N=37)—Several directors and staff (10) reported that the program provides tobacco treatment to staff or reimbursed staff for cessation medications, *"She'd be more than happy to reimburse us. We have to pay for it out of our pocket initially but after, you know, a month, she would be more than happy to reimburse us for it. It's highly encouraged to stop (Staff)."* Some (19 D/S, 7 C) expressed that staff are allowed to smoke on breaks. A few (2 D/S, 1 C) said there were no restrictions on where staff can smoke.

Attitudes and practices related to staff smoking at work (N=52)—All directors reported that they either remained neutral (5) or discouraged (3) smoking during work hours. Some staff (9) said that the program accommodates but does not encourage smoking during work. Other staff members reported they either remained neutral (8) or discouraged smoking during work hours (5). Clients had a somewhat different perspective on program practices related to staff smoking; some (5) felt the program accommodated staff smoking, six reported the program remained neutral, and others (6) reported that the program either discourages or forbids (7) smoking during work hours. When asked to explain their response, several explained their facility remained neutral toward staff smoking in that they permitted smoking on the grounds, even though a similar stance toward alcohol use might be considered accommodating or condoning drug use.

> "We usually stay neutral. When someone takes a break and they smoke on their break, such as myself, no one's ever challenged me on it." Director

> "I have to leave the property in order to smoke. So I'd say it's discouraged." Staff

> "They discourage but they don't really go out of their way to enforce their non-smoking ban." Client

Effects of staff smoking on client tobacco treatment (N=51)—Several (16 D/S, 18 C) thought that tobacco treatment would be hindered if staff that smoke were involved in tobacco treatment—smoking staff would provide a poor example, make clients want to smoke, undermine the importance of quitting smoking, or be hypocritical.

> "I think it affects it tremendously. I think it affects how seriously staff take having clients or urging to clients to quit. I think it affects clients even thinking that it's a serious problem because they see the people that they look up to, their counselors, smoking." Director

> "It bothers me…it bothers me that they're, you know, contributing to unhealthy behavior or exhibiting that in front of the clients when we're trying to teach these clients healthy behavior and lifestyles" Staff

> "It would make me want to smoke it because I've smoked pot since I was 14, I'm 32 years old. That's a long time. And to walk in there knowing that I am not doing that anymore, to smell it would make me want to smoke it. Just like cigarettes, smelling it, you know and seeing it would make me want to smoke it." Client

> "I feel like if they was treating our tobacco dependency and we were here for that type of treatment then I don't feel like they should be allowed to smoke a cigarette around us, you know. Because that's just like drinking a drink." Client

Some clients (7) thought that it didn't make a difference; either because they didn't want to quit, smoking together helps staff relate better to clients, people have a right to smoke, or because it was possible for staff to treat smoking while continuing to smoke.

> "It doesn't affect me at all. Because I choose to smoke, I enjoy smoking. So whether or not a staff member is standing next to me smoking a cigarette, doesn't bother me. And actually, to be quite honest, I enjoy it a little more because it puts them down to…it somewhat puts them down to my level. And we've talked over smoking a cigarette a lot about the reason why we're here; the treatments." Client

> "It might not help seeing her smoke, but I have to…have to deal with it so I feel… that's how I feel. You know, it's my…my demon, not theirs. People have the right to do what they want to do." Client

> "I don't think that it, I don't think that it does have any significant problem I mean you know it would staff addressing it because just because a staff member may smoke don't mean they can't help you stop." Client

CONCLUSION

Drug treatment facilities may not treat tobacco dependence because it does not create the kinds of legal and social problems that force clients into treatment. Much of the ambivalence about treating tobacco stems from the fact that many staff smoke. Unlike other studies, the fear of jeopardizing clients' abstinence from other drugs did not emerge as a downside for treating tobacco dependence. This finding may indicate that treatment providers are now familiar with the research that suggests that trying to quit smoking does not adversely affect other substance use outcomes (Bobo & Davis, 1993; Burling, et al., 2001; Reid, et al., 2008; Shoptaw, et al., 2002; Stein, et al., 2006).

Tobacco treatment is problematic for drug treatment because it falls outside of a core function of drug treatment in the United States, which is to help clients comply with, the

law. Virtually all agreed tobacco is addictive and harmful in the long term. However, although tobacco use is fatal, it is legal. In 2002, the criminal justice system accounted for 36% of referrals to the U.S. substance abuse treatment system (Drug and Alcohol Services Information System, 2002). Tobacco treatment will not help clients satisfy legal requirements that will lead to child custody, keys to their car, or freedom from incarceration. For many staff in our interviews, tobacco is not a focus of treatment because clients do not get into “trouble” for tobacco use: they are not mandated into treatment for smoking tobacco, and they will not get discharged from treatment for continuing to smoke.

Moreover, tobacco treatment is not what clients or other important audiences pay for. Most drug treatment is paid for by public government dollars or out of pocket, not through health insurance (D'Aunno, 2006; Drug and Alcohol Services Information System, 2002). A significant “market” for drug treatment services is the Driving While Under Influence or Driving While Intoxicated (DUI) population, which often pays for treatment out of pocket and constitutes 10% of criminal justice referrals (Arfken & Kubiak, 2007). Facilities serving DUI offenders are mostly (69%) private-for-profit enterprises (Office of Applied Studies, 2004). As such, financial considerations may exert greater influence on their care than that of public providers. For example, Nahra et al., found that private for-profit units were less likely to admit clients and more likely to shorten treatment duration for clients unable to pay (Nahra, Alexander, & Pollack, 2009). Hence the goals and practices of tobacco treatment among DUI providers deserve special attention.

Even where drug treatment is publicly funded, facilities may rightly consider tobacco treatment a misuse of public funds, in the absence of a state mandate. Health insurance-funded drug treatment programs have a stronger incentive to include tobacco treatment, because of tobacco’s deleterious effects on physical health. Indeed, drug treatment facilities with nonprofit status, hospital affiliation, and the greatest priority given to physical health are most likely to provide tobacco treatment services (Friedmann, et al., 2008; Richter, et al., 2004; Walsh, et al., 2005). Facilities with other sources of funding and less health-oriented missions are less likely to do so (Friedmann, et al., 2008; Richter, et al., 2004). There is little incentive to do so because stakeholders—clients, payers, the legal system—are not demanding it.

Staff smoking feeds the ambivalence. Most staff and clients reported the policies and philosophy for tobacco treatment differ from those guiding drug treatment. In order to treat tobacco dependence, facilities would have to re-examine their policies on smoking by staff and directors. Staff and clients in some facilities felt that staff smoking *at a facility that offers tobacco treatment* violates core principles of drug treatment. Several of the facilities in our sample offered little to no tobacco treatment, and so smoking staff in these facilities did not undermine the facility’s mission. If anything, staff felt their smoking made them more approachable or credible to clients—helped them be better counselors. Hence, if a facility doesn’t have a formal tobacco treatment program, staff smoking is acceptable.

Opinions depended on the context. It appeared that clients and staff who did not want to quit thought staff smoking was good—it provided an opportunity to bond. However, most seemed to feel staff smoking would undermine tobacco treatment if a program decided to provide it. This situation creates strong incentives for smoking staff and directors to resist adoption and implementation of tobacco treatment. As long as the facility does not include tobacco treatment in its mission, staff members do not have to address their tobacco addiction and directors do not have to create or enforce policies related to tobacco-addicted staff.

Across studies, many staff report lack of client interest as a barrier to addressing tobacco (Hahn, et al., 1999; Walsh, et al., 2005), but many clients report that they are interested in quitting and would like the option of receiving tobacco treatment (Doll, Peto, Boreham, & Sutherland, 2004; Hser, et al., 1993; Hughes & Kalman, 2006; Hurt, et al., 1996; McCarthy, et al., 2002; Nahvi, et al., 2006; Peto et al., 2000; Richter, McCool, et al., 2002; Velicer et al., 1995). At this ambiguous juncture in the field, it may be convenient for some staff to report that clients do not want tobacco treatment because they themselves do not want to provide it. In 1999, New Jersey required all residential addiction treatment programs to treat patients for tobacco dependence. Our results echo the evaluation of the New Jersey initiative, which found that the greatest resistance to implementing the policy come from staff rather than patients (Foulds et al., 2006).

Interestingly, numerous staff attributed clients' preexisting respiratory illnesses to illicit drugs, not tobacco. This reaction was surprising because cigarette smoking is the single largest risk factor for chronic obstructive pulmonary disease (Viegi, Scognamiglio, Baldacci, Pistelli, & Carrozzi, 2001), much more so than crack and marijuana (Tashkin, 2001). Alcohol abuse alone does not cause acute lung injury though it does increase risk for infection and acute respiratory distress syndrome (Guidot & Hart, 2005). Damage due to concurrent drug and tobacco use is often indistinguishable (Karkoulias et al., 2008) but can be additive (Fligiel et al., 1997). Future research should identify the extent to which clients in drug treatment have respiratory problems, the degree to which respiratory problems are attributable to tobacco or other drug use, and whether quitting smoking helps ameliorate these problems.

Strengths of the study included a well defined sample representing a broad array of treatment approaches; obtaining the perspectives of clients, staff, and patients; having multiple research team members involved in developing and applying the code scheme; and good reliability for core codes. These data are limited in that they rely on self-reports from a non-random sample of directors, staff and clients at substance abuse treatment facilities in one Midwestern city. Only 8 facilities were included, which undoubtedly limits the generalizability to all drug treatment facilities. The sample included 8 of 12 contacted facilities, 2 of which were ineligible; hence the response rate could be considered 2/3 of all contacted facilities or 3/4 of all eligible facilities. This introduces response bias, as non-responding sites could be significantly different from responders. Sites that agreed to participate could have been more supportive of tobacco dependence practices and policies than non-participating sites. The study may be difficult to replicate as qualitative data is very much a result of the skills of interviewers; although study staff employed the same question guide, the ability to identify and explore novel participant reports (the entire focus of our interviews) may differ from one research team to the next. However, the purpose of this research was to identify thoughts and feelings about treating tobacco from the perspectives of directors, staff and clients. Future research, such as epidemiological studies and clinical trials, can and should examine the extent to which these perspectives are prevalent and/or predictive of implementation outcomes. Unless there are reasons that these attitudes might not be present in other regions of the country or world (for example, in places where criminal justice has no linkages with substance abuse treatment) these observations remain valid candidates for hypothesis-driven research.

International and national trends will probably increase the pressure to address tobacco dependence during drug treatment. Clean indoor air laws and moves to ban hiring of smokers in health care and other industries may create more demand for cessation assistance. Article 14 of the Framework Convention on Tobacco Control requires countries to create treatment guidelines and promote cessation (World Health Organization, 2003). At the same time, the Patient Protection and Affordable Care Act (U.S. Government, 2010),

will expand public and private coverage of cessation services without cost-sharing for patients. Also, new, regulated, tobacco product formulations and other potential reduced exposure products may emerge as significantly less harmful alternatives to cigarette smoking. The availability of these alternatives may help patients and staff in terms of motivation and harm reduction. More may be willing to address their smoking because they won't have to stop using tobacco altogether. Switching to products with an evidence base of safety could improve their health immediately and reduce their future risks for tobacco-related harm.

However, there is a danger that facilities may continue to resolve their ambivalence toward providing tobacco treatment by reporting they "offer" treatment, but actually providing close to none. In order to take advantage of these new "sticks" and "carrots" related to tobacco treatment, it may be useful to identify incentives for facilities that are closely aligned with the criminal justice system, help facilities define policies and treatment roles for staff who smoke, and evaluate interventions that do so using hypothesis-driven research designs.

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Table 1

Characteristics of Drug Treatment Facilities

No. of Staff	No. of Clients	Methadone	Profit Status	Self-reported Treatment Level	In/Outdoor Smoking Policy
6	70	No	For Profit	High[a]	Smoke-Free Campus
22	80	No	Non-Profit	High[a]	Outside Only
2	120	No	For Profit	Low/No[b]	Off-site Only
6	112	No	For Profit	Low/No[b]	Smoke-Free Campus
60	32	No	Non-Profit	Low/No[b]	Outside Only
75	270	No	Non-Profit	Low/No[b]	Outside Only
13	220	Yes	Non-Profit	Low/No[b]	Outside Only
11	340	Yes	Non-Profit	Low/No[b]	Smoke-Free Campus

[a]High intensity tobacco treatment is defined as individual/group counseling and/or pharmacotherapy

[b]Low intensity/No tobacco treatment is defined as brief advice, educational materials, or no formal services

Table 2

Codes definitions and the number of participants that provided comments within each code.

Brief Definition of Codes	N
Pros for treating or quitting tobacco dependence[a]	54
Cons for treating or quitting tobacco dependence[a]	48
Smoking goes with or replaces other addictions/behaviors	23
Tobacco is like other drugs, health issues[a]	56
Tobacco is unlike other drugs, health issues[a]	56
Program philosophy toward cigarettes vs. alcohol/other drugs	48
Tobacco is legal	40
Staff smoking policies/enforcement	47
Staff smoking affects tobacco treatment[a]	51
Program support of staff smoking	54
Program policies for tobacco vs. alcohol/other drugs	18
Indoor/outdoor policy and practices re staff/client smoking	33

[a]Code was used to score inter-rater reliability