Original Investigation

# A Qualitative Examination of the Positive and Negative Consequences Associated With Going Tobacco-Free in Substance Abuse Treatment: The NY State Experience

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Received October 3, 2011; accepted January 28, 2012

## Abstract

**Introduction:** In 2008, the New York State (NYS) Office of Alcoholism and Substance Abuse Services (OASAS) required all state-funded or state-certified addiction treatment programs to be 100% tobacco-free. The regulation prohibits the use or possession of all tobacco products by patients, employees, volunteers, and visitors. This includes exterior grounds and vehicles owned, leased, or operated by the facility. Addiction treatment centers are also required to screen patients for tobacco use and incorporate tobacco cessation into treatment programming. This study examined the perceived effectiveness of this regulation from the perspective of counselors and clinical supervisors.

**Methods:** Qualitative data were collected from 261 counselors and 80 clinical supervisors working in 50 free-standing substance abuse treatment programs throughout NYS. Questions asked about the perceived positive and negative consequences of the OASAS regulation approximately 1 year after its implementation.

**Results:** The findings indicate mixed reactions to the regulation. A wide range of positive and negative consequences were identified, which were generally consistent across counselor and clinical supervisor reports. The most commonly reported positive outcomes were positive behavior change (e.g., less smoking, increased intentions to quit) and increased awareness about smoking (e.g., dangers, available assistance to quit). The most commonly reported negative consequences were reinforcing addict behaviors among patients (e.g., lying, "dealing" cigarettes) and enforcement problems (e.g., difficulty enforcing, policing for compliance).

**Conclusion:** Findings have implications for the implementation of tobacco-free regulations in substance abuse treatment programs.

## Introduction

On July 24, 2008, New York State (NYS) became the first in the nation to require all 1,419 state-funded or state-certified addiction treatment programs to be 100% tobacco-free (New York Office of Alcoholism and Substance Abuse Services [OASAS], n.d.a). Far beyond other smoking bans which limit their scope to indoor smoking, this new, strict, and comprehensive regulation put forth by the NYS OASAS prohibits the use or possession of all tobacco products by patients, employees, volunteers, and visitors. This includes exterior grounds and vehicles owned, leased, or operated by the facility. Addiction treatment centers are also now required to screen patients for tobacco use and incorporate tobacco cessation into treatment programming.

### Why Care About Tobacco Use in Substance Abuse Treatment?

Tobacco use is responsible for more deaths than alcohol and all other drugs combined (U.S. Department of Health and Human Services, 2006). Tobacco use is particularly prevalent among individuals seeking drug treatment. Approximately 70%–95% of individuals seeking treatment for drug use smoke (Burling & Ziff, 1988; Fiore, Bailey, & Cohen, 2000; Kozlowski, Skinner, Kent, & Pope, 1986; McCarthy, Zhou, Hser, & Collins, 2002). These individuals are also more likely to have negative health consequences due to the combined effects of smoking and substance use (Battjes, 1988).

### Tobacco Policies in Substance Abuse Treatment

Many substance abuse treatment centers ban indoor smoking in compliance with state or local ordinances, yet only around 10%–20% have policies that completely prohibit smoking (Knudsen, Roman, & Johnson, 2009; Richter, Choi, & Alford,

doi:10.1093/ntr/nts027
Advance Access published on March 13, 2012

2005). In fact, treatment centers often permit smoking in designated outdoor areas (Fuller et al., 2007; Richter et al., 2005), allowing both employees and patients to maintain their smoking behavior (Borland, Cappiello, & Owen, 1997; Brigham, Gross, Stitzer, & Felch, 1994). A notable exception is Washington State which has highly restrictive state legislated tobacco use laws, banning smoking in virtually all public places and 25 feet from entrances, exits, windows that are open, and ventilation intakes (American Lung Association, 2011). In terms of offering smoking cessation services alongside the treatment of a patient's other addictions, a 2007 study found that 69% of 342 treatment units surveyed offered no treatment for nicotine dependence (Fuller et al., 2007). A study of 223 Canadian addiction treatment programs found that while 54% of the programs surveyed provided patients some help in quitting smoking, only 10% offered formal smoking cessation treatment (Currie, Nesbitt, Wood, & Lawson, 2003).

The State of New Jersey was the leader in efforts to formally integrate smoking cessation into substance abuse treatment. Starting in 1999, New Jersey required residential treatment centers to assess and treat tobacco dependence as well as maintain smoke-free facilities and campuses (Williams et al., 2005). An evaluation of 30 residential treatment programs in the state found that 1 year after implementation, all program directors reported that their centers provided some sort of tobacco dependence treatment and 50% had tobacco-free grounds. In addition, very few (4.5%) patients who smoked were identified as leaving treatment early, quelling concerns that the policy would negatively affect patient census. Moreover, 44% of the smokers seeking treatment thought that the tobacco-free policy helped them address their tobacco use (Williams et al., 2005).

Like the New Jersey initiative, the NYS OASAS regulation represents a major paradigm shift. However, the NYS OASAS regulation is more comprehensive and stringent since it applies to all OASAS-certified and/or -funded substance abuse treatment programs, not just residential programs. The regulation forbids all indoor and outdoor smoking, removing the use of designated outdoor smoking areas. In addition, no tobacco products can be brought into the treatment center in pockets, purses, briefcases, etc., and these tobacco possession rules apply to patients, staff, and visitors. It requires patient screening for tobacco dependence and the incorporation of tobacco dependence treatment into treatment planning, although OASAS-licensed programs are not allowed to admit patients for the sole purpose of treating tobacco dependence. Finally, on-site compliance inspections document policy adherence. This is different from the New Jersey initiative, where enforcement occurs through encouragement only (Williams et al., 2005).

The current study explores counselors' and clinical supervisors' perceptions of the regulation by content analyzing responses to open-ended questions asking about the positive and negative effects of the regulation approximately 1 year after its official passage. Focusing on the perspective of clinical staff is important for several reasons. First, without the cooperation of clinical staff, it is unlikely that the change will be implemented or sustained (Amiot, Terry, Jimmieson, & Callan, 2006; Jimmieson, Terry, & Callan, 2004; Lehman, Greener, & Simpson, 2002). Second, staff resistance represents the greatest barrier to the effective implementation of a tobacco-free policy (Foulds et al., 2006). Third, clinical staff is in the best position to report on how this state-wide policy change influences those who work in addiction treatment as well as the patients that are served in treatment centers. Finally, the only report examining the success of the OASAS regulation from the perspective of staff used program administrator reports and was an internal document prepared by OASAS (Tesiny, Robinson, & Nottingham, 2010). An independent assessment of the perceived consequences is important, particularly since program administrator reports of regulatory compliance and implementation often diverge considerably from that reported by staff (Eby, 2010).

## The Potential Consequences of Going Tobacco-Free

The goal of creating tobacco-free workplaces for employees and fostering tobacco independence in patients may yield positive effects over time. This may include higher rates of recovery from other substances (Bobo, Walker, Lando, & McIlvain, 1995), more pleasant work environment (e.g., cleaner air), reduced smoking among staff (Williams et al., 2005), and more comfortable entry into smoke-free 12 Step Groups. However, there may also be negative consequences. The regulation may challenge some clinicians' beliefs about how to best treat substance using patients (Fuller et al., 2007) and goes against the smoking culture that exists in many drug treatment settings (McIlvain & Bobo, 2005; Reilly, Murphy, & Alderton, 2006; Sees & Clark, 1993). It also reaches into the personal lives of staff by forbidding them from having a personal supply of tobacco while at work, which may be viewed as an invasion of privacy by some staff.

# Methods

## Participants

Participants are 261 substance abuse treatment counselors and 80 clinical supervisors working in a 50 freestanding substance abuse treatment centers, affiliated with 16 treatment organizations throughout NYS. Due to the large population census and corresponding high concentration of treatment centers in the greater New York City area, 26 of the treatment centers reside in the five boroughs of New York City. The remaining 24 centers are in other geographic regions of NYS (e.g., Buffalo, Niagara Falls, Mount Kisco). Based on a survey completed by program administrators, the majority of the participating treatment organizations are nonprofit (81%) and accredited by entities such as JCAHO, CARF, or COA (entire organization, 60%; methadone-only, 13%). About three-quarters (73%) are freestanding entities that are not on a hospital campus. Treatment organizations offer a wide range of services (e.g., inpatient detoxification, residential, aftercare, adult inpatient psychiatric, outpatient detoxification, day treatment, outpatient nonmethadone, outpatient methadone). Both adult and adolescent service providers are included in the sample. The most frequently reported substances used among patients seeking treatment are alcohol (39%), marijuana (29%), cocaine (27%), and heroin (27%). In terms of characteristics of the specific treatment programs, 38% offer inpatient and 60% offer outpatient or day treatment services (three programs offer both). Eighty-five percent offer treatment for adults and 45% offer treatment for adolescents (18 programs offer treatment for both adults and adolescents).

Counselors report an average organizational tenure of 4.77 years (*SD* = 5.52 years). Sixty percent of counselors are licensed substance abuse professionals, 50% hold a master's degree or higher, and 44% are personally in recovery. Counselors are 60% Caucasian, 61% female, and, on average, 44 years of age (*SD* = 13.15 years). They work an average of 39 hr per week (*SD* = 8.05 hr) at the clinical site being studied and earn an average of $37,415 a year (*SD* = $11,850).

Clinical supervisors report an average organizational tenure of 8.82 years (*SD* = 7.50 years). On average, clinical supervisors are 48 years old (*SD* = 11.71 years), supervise around six counselors (*SD* = 3.80 counselors), work 43 hr a week (*SD* = 7.91 hr) at the clinical site under study, and earn $58,524 (*SD* = $16,870) per year. Over 77% of clinical supervisors are licensed substance abuse professionals, and 52% are personally in recovery. Moreover, 58% of clinical supervisors are female, 70% are Caucasian, and 62.5% hold a master's degree or higher.

Regarding smoking behavior, 19% of counselors and 24% of clinical supervisors are current smokers. This is slightly higher than the percentage of adult smokers in NYS (18%; U.S. News and World Report, 2010) and in the U.S (21%; Centers for Disease Control, 2011). Counselors reported that, on average, 69% of clients smoke, and clinical supervisors reported that, on average, 65% of clients smoke.

## Procedure

The treatment facilities were not randomly selected. The research was funded by a grant from the National Institute on Drug Abuse (NIDA) in response to a program announcement focusing on health services research on practice improvement utilizing community treatment programs (CTPs) within NIDA's Clinical Trials Network (CTN). At the time of initial data collection, the CTN had two New York "nodes"—these are partnerships between a research center and a number of CTPs. One CTN node was based in New York City and the other on Long Island. Together, they comprised 10 eligible CTPs. Seven CTPs agreed to participate. Because we were not able to meet our data requirements with clinicians from these two CTN nodes, recruitment was extended outside of the CTN, with the aim of assuring that we obtained a broad cross-section of treatment programs that were representative of the population of treatment programs in existence in NYS. We reviewed available data from the 2006 SAMHSA facility locator and NSSATS database and determined that our sample of participating programs was similar to the aggregate characteristics of all NYS treatment programs in terms of having a primary focus on substance abuse, offering detoxification services, offering methadone maintenance, having hospital inpatient services, offering short-term residential services, offering long-term residential services, operating as a halfway house, offering services for adolescents, and serving criminal justice clients (a full report of this information is available upon request from the first author).

The regulation went into effect on July 28, 2008. Data were collected 10–12 months after the passage of the regulation, between May and July of 2009. There were 34 specific regulatory components (e.g., signs posted at entrance of center informing all persons that tobacco is prohibited, clients prohibited from bringing tobacco products and paraphernalia into facility, employees prohibited from bringing tobacco products and paraphernalia into facility, written tobacco-free policy established for visitors) and on average, treatment organizations had implemented 21.00 (*SD* = 7.12) of these components at the time of data collection. None of the treatment organizations were in full compliance with the regulation, although there was considerable variability in compliance across treatment organizations (range of scores on compliance measure was 11–32).

Researchers traveled to CTPs to administer paper-and-pencil surveys to research participants. The survey contained questions about clinician work and career attitudes, the work context (e.g., caseload, job autonomy), clinical supervision (e.g., frequency of interaction with clinical supervisor, support from supervisor), health and well-being (e.g., physical complaints, psychological well-being), and the OASAS regulation. A trained research assistant proctored survey administration. Counselors and clinical supervisors completed surveys in separate group sessions. All counselors and clinical supervisors employed at the treatment centers were eligible to participate but participation was voluntary. All materials and procedures were reviewed and approved by the first author's university. The response rate was 69% for counselors and 79% for clinical supervisors.

The survey items are two open-ended questions, which ask participants, "What positive things (if any) have occurred as a result of the regulation?" and "What negative things (if any) have occurred as a result of the regulation?" The following lead-in was included on the survey: "On July 24, 2008, the NYS OASAS passed a regulation requiring all treatment programs certified or funded by the to be 100% tobacco-free. We are interested in your reaction to this regulation. Please think about how things have changed, for better or for worse, since the passage of the OASAS regulation." All comments were typed verbatim, organized into the categories of positive and negative consequences, and recorded separately for counselors and clinical supervisors.

## Content Analysis

The purpose of the content analysis was to categorize responses to these two open-ended survey items, separately for counselors and clinical supervisors. Two of the authors have extensive experience conducting content analysis. One of these two authors trained a third author in content analysis procedures over a 2-week period, following Weber's (1990) and Krippendorff's (1980) guidelines on conducting content analysis. The training consisted of practice coding text segments, reading primary texts, and discussion. Each open-ended comment was independently coded by two of the study authors. We used grounded theory (Glaser & Strauss, 1967) as our content analysis strategy. This is an inductive approach whereby the coders did not go into the coding process with any a priori categorization scheme. Rather, the content codes emerged from recurring themes in the data.

### Coding Taxonomy

The two coders independently reviewed the positive and negative comments provided by counselors and clinical supervisors and separately generated possible categories to capture the meaning reflected in similar groups of comments. After each researcher generated a list of possible categories, they shared their lists. Similarities among the independently generated categories were noted, and after several iterations, consensus was reached on

the final taxonomy. Next, the first author, who was not involved in the coding process or the development of the initial taxonomy, reviewed the taxonomy with the coders to clarify theme definitions and make slight modifications to ensure that the coding taxonomy was as parsimonious as possible. With the taxonomy in place, the researchers clustered categories into higher-level themes and meta-themes (see Allen, Poteet, & Burroughs, 1997).

### Coding Process

The next step was the classification of the positive and negative consequences. Each response was reviewed independently by two coders and classified into one of the categories in the coding taxonomy. If disagreement occurred, coders discussed the rationale for their classification and a decision was made regarding the appropriate categorization. Interrater agreement was assessed. The initial overall hit rate (percent agreement) was 70%, with agreement reaching 100% after discussion. Percent agreement is the most commonly utilized method of assessing rater reliability in content analytic studies (Hughes & Garrett, 1990), and levels around .70 are considered reliable (Neuendorf, 2002). The unit of analysis was defined as a meaningful thought, which could include a word, phrase, sentence, or set of sentences (Miles & Huberman, 1994). Using this process, if a respondent mentioned more than one unique consequence, each thought was coded separately. If the same issue was discussed repeatedly by the same respondent, it was coded only once.

## Results

A total of 350 distinct positive consequences (268 from counselors and 82 from clinical supervisors) and 300 distinct negative consequences (207 from counselors and 93 from clinical supervisors) were identified. Of all the survey respondents, 81% of clinical supervisors and 72% of counselors offered at least one comment regarding the OASAS regulation. The average number of positive comments made by counselors was 1.20 ($SD = 0.49$) and the average number of negative comments was also 1.20 ($SD = 0.64$). Clinical supervisors mentioned an average of 1.21 ($SD = 0.58$) positive consequences and 1.53 ($SD = 0.79$) negative consequences.

The final coding taxonomy consists of broad categories or meta-themes as well as more specific themes. This provides a fine-grained analysis of the perceived consequences of the OASAS regulation. Separate meta-themes and themes were identified for positive consequences and negative consequences. The meta-themes and subthemes for perceived positive consequences, along with representative comments, are shown in Tables 1 and 2 for counselors and clinical supervisors, respectively. Tables 3 and 4 lists the meta-themes and themes and provides sample comments for counselors and clinical supervisors, respectively.

## Perceived Positive Consequence: Counselors

As shown in Table 1, the most positive consequence of the OASAS regulation noted by counselors is perceived positive behavior change (46.6%). This includes less smoking by patients and staff, improvements in patient and staff physical health, greater intentions to quit smoking among patients and staff, and other positive behavior change. The next most frequently reported positive consequence is increased smoking awareness (22.0%). This meta-theme contains the themes of greater awareness of the dangers of smoking, availability of assistance to quit smoking, and general awareness. Improvement in the physical work environment is mentioned in 15.7% of the positive comments by counselors. This includes better air quality, less smoking on outdoor grounds, cleaner indoor facility, and other general comments about improved environment. The meta-theme of treatment improvement was also mentioned in 15.7% of the comments. This includes greater resources and support for addressing patient smoking in treatment, patients more proactively seeking smoking cessation in treatment, and other.

## Perceived Positive Consequences: Clinical Supervisors

Similar to counselors, and as shown in Table 2, clinical supervisors most frequently cited positive behavior change as a positive consequence of the OASAS regulation (52.4%). This includes less smoking by patients and staff, greater intentions to quit smoking among patients and staff, and improvements in patient and staff physical health. The second most frequently reported positive consequence by clinical supervisors is increased smoking awareness (20.7%). This meta-theme primarily reflects the theme of greater awareness of the dangers of smoking and general awareness. The third most commonly cited positive outcome, improvement in the physical work environment, was mentioned in 18.3% of the comments by clinical supervisors. This includes better air quality, less smoking on outdoor grounds, cleaner indoor facility, and other general comments about improved environment. The meta-theme of treatment improvement was mentioned in 8.5% of clinical supervisors' comments. This includes better strategies by which to address patient smoking in treatment, patients more proactively seeking smoking cessation in treatment, and other general treatment improvements.

## Perceived Negative Consequences: Counselors

Table 3 illustrates the perceived negative consequences associated with the OASAS regulation, along with sample comments for each theme. The most frequently cited negative consequence of the OASAS regulation mentioned by counselors was addict behaviors (34.3%). This meta-theme captured increases in sneakiness such as breaking rules and other furtive behaviors, smoking in unauthorized areas of the facility, and the development of an underground economy as patients mimic "street behaviors" of selling and dealing cigarettes. Enforcement problems were the second most commonly reported negative consequence by counselors (17.9%). This meta-theme contains the themes of difficulty enforcing or properly penalizing violations, time lost due to policing and monitoring smoking, and other. The third most commonly cited negative consequence was compromising treatment goals (14.5%). This included the theme of interfering with drug treatment by, for instance, creating a barrier between counselor and patient or placing even more pressure on patients as they attempt to battle addiction, increasing patients' resistance to the treatment process, and other. The fourth most common meta-theme that surfaced among counselors' negative comments focused

**Table 1. Perceived Positive Consequences of Office of Alcoholism and Substance Abuse Services Regulation: Counselors**

| Category | *N* | % | *n* | % | Sample comment |
|---|---|---|---|---|---|
| Positive behavior change | 125 | 46.6 | | | |
| Less smoking behavior | | | 80 | 29.9 | "I quit smoking" |
| | | | | | "Several patients have stopped smoking, a few are trying" |
| Improvement in physical health | | | 23 | 8.6 | "Clients will establish a more health conscious, and live a healthier lifestyle" |
| | | | | | "Staff and clients are living healthier" |
| Intent to quit smoking | | | 20 | 7.5 | "More clients interested in quitting" |
| | | | | | "Clients and staff are acknowledging their need to stop smoking" |
| Other | | | 2 | 0.7 | "Less loitering around center" |
| Increased smoking awareness | 59 | 22.0 | | | |
| Dangers of smoking | | | 40 | 14.9 | "People are more aware of the negative effect of tobacco use" |
| | | | | | "Clients can now connect tobacco use to other drug use" |
| | | | | | "Clients are beginning to acknowledge nicotine as an addiction" |
| Assistance to quit | | | 13 | 4.9 | "Clients are able to obtain [information], education and support" |
| | | | | | "…free programs and assistance to stop smoking" |
| General awareness | | | 6 | 2.2 | "Some slight improvements in awareness" |
| Improvement in physical work environment | 42 | 15.7 | | | |
| Better air quality | | | 21 | 7.8 | "The air is fresh inside the facility" |
| | | | | | "I don't have to deal with the smell of smoke as I once did" |
| Less smoke on outdoor grounds | | | 7 | 2.6 | "Less tobacco and second hand smoke near the facility" |
| Other | | | 10 | 3.7 | "Tobacco free environment" |
| Cleaner indoor facility | | | 4 | 1.5 | "Less litter from cigarette butts" |
| Treatment improvement | 42 | 15.7 | | | |
| Addressing client smoking in treatment | | | 30 | 11.2 | "Additional training on tobacco recovery and availability of tobacco cessation medication, tools, etc…" |
| | | | | | "Cessation program/availability to clients and staff" |
| Patients seeking smoking cessation | | | 9 | 3.4 | "More clients are asking for patches and gum so they can quit" |
| Other | | | 3 | 1.1 | "Less distraction" |

*Note.* Total $N = 268$. Percentages may not equal 100% due to rounding.

on negative attitudes (14.0%). This theme included both negative emotional reactions such as irritability and increasing stigmatization of smokers. Reduction in patient census was the next most frequently mentioned meta-theme (10.1%) This included increases in both patients voluntarily leaving treatment prematurely or against medical advice and involuntary discharges for smoking as well as fewer individuals even seeking treatment. Next, counselors cited negative patient behavior as a repercussion of the OASAS regulation (5.3%). This meta-theme primarily focused on acting out but also included other general behavior problems. A final meta-theme of "miscellaneous" (3.9%) comprised comments that were provided in response to the question about negative outcomes of the OASAS regulation but could not be classified into any of the existing meta-themes or themes (e.g., "Increased fire risk for all").

## Perceived Negative Consequences: Clinical Supervisors

Finally, Table 4 provides data from clinical supervisors on the perceived negative consequences, along with representative comments. The negative outcome most commonly mentioned by clinical supervisors was addict behaviors (34.4%). This meta-theme captured increases in sneakiness, unauthorized smoking, and the development of an underground economy. Enforcement problems were the second most commonly reported negative consequence by clinical supervisors (17.2%). This meta-theme contains the themes of difficulty enforcing and time lost due to policing. The third most commonly cited negative consequence was a reduction in patient census (14.0%). This included fewer patients seeking treatment, patients voluntarily leaving treatment prematurely, and involuntary discharges for smoking. The fourth most commonly cited negative consequence among clinical supervisors was increased negative attitudes (11.8%). This theme included both negative emotional reactions and stigmatization of smokers. The next most common meta-theme that surfaced among clinical supervisors' negative comments focused on compromising treatment goals (9.7%). This included the themes of interfering with drug treatment and also increasing patients' resistance to treatment. Clinical supervisors also cited negative patient behavior (8.6%) such as acting out as a repercussion of the OASAS regulation. A final meta-theme of "miscellaneous" (4.3%) comprised comments that were provided in response to the question about negative outcomes of the OASAS regulation but could not be classified into any of the existing meta-themes or themes.

**Table 2. Perceived Positive Consequences of Office of Alcoholism and Substance Abuse Services Regulation: Clinical Supervisors**

| Category | *N* | % | *n* | % | Sample comment |
|---|---|---|---|---|---|
| Positive behavior change | 43 | 52.4 | | | |
| Less smoking behavior | | | 33 | 40.2 | "Some coworkers have stopped smoking"<br>"Some clients have quit or decreased tobacco use" |
| Intent to quit smoking | | | 6 | 7.3 | "More people deciding to quit"<br>"Encouraged clients and staff, alike, to consider stopping tobacco usage" |
| Improvements in physical health | | | 4 | 4.9 | "Residents are paying more attention to their health and increasing their knowledge in healthy living/lifestyle" |
| Increased smoking awareness | 17 | 20.7 | | | |
| Dangers of smoking | | | 13 | 15.9 | "Many more clients and staff are more aware of the consequences associated with smoking, healthwise"<br>"Higher awareness of the dangers of nicotine use and second hand smoke" |
| General awareness | | | 4 | 4.9 | "Awareness raised" |
| Improvement in physical work environment | 15 | 18.3 | | | |
| Better air quality | | | 7 | 8.5 | "There is less second hand smoke exposure"<br>"Not smelling smoke as much" |
| Less smoke on outdoor grounds | | | 5 | 6.1 | "Grounds are cleaner and pleasant with no smoking" |
| Cleaner indoor facility | | | 2 | 2.4 | "Work environment and building are cleaner" |
| Other | | | 1 | 1.2 | "Workplace is more inviting" |
| Treatment improvement | 7 | 8.5 | | | |
| Addressing patient smoking in treatment | | | 4 | 4.9 | "It has started more of a discussion with consumers about quitting whereas it wasn't addressed as much before" |
| Patients seeking smoking cessation | | | 2 | 2.4 | "Clients are more focused on treatment groups and not on getting outside to smoke" |
| Other | | | 1 | 1.2 | "Fewer clients have relapsed" |

*Note.* Total $N = 82$. Percentages may not equal 100% due to rounding.

# Discussion

The purpose of the present study was to examine counselors' and clinical supervisors' perceptions of the positive and negative consequences of the NYS OASAS regulation approximately 1 year after its formal passage. Several conclusions can be reached from the findings. First, clinician reactions are mixed about the regulation. Second, a wide range of positive and negative consequences are identified; however, positive behavior change dominates the positive outcomes, and addict behaviors is the most frequently noted negative outcome. Third, considerable consistency exists between counselors and clinical supervisors, both in terms of the content and relative rank ordering of positive and negative consequences.

## Perceived Positive and Negative Consequences of the OASAS Regulation

Arguably the driving force behind implementing the OASAS regulation is to save lives by fostering tobacco independence (New York OASAS, n.d.a.). Our findings are promising because the most frequently reported positive consequence is positive behavior change related to smoking among both patients and staff. Moreover, approximately one quarter of the other positive comments from both groups center on improved awareness of the health dangers of smoking and increased awareness of the availability of assistance to quit. This is important as educational efforts and clinical encouragement increases motivation to quit smoking, decreases smoking behavior, and facilitates the decision to quit smoking (Fiore et al., 2000; Stack, Goalder, Calhoun, Bradshaw, & Samples, 2009). Although the findings represent perceptions and do not examine actual behavior change, they are generally consistent with the internal tobacco regulation impact report produced by OASAS. Specifically, patients who complete treatment are more likely to have quit smoking at discharge (39.4%) than those who do not complete drug treatment (18.1%), based on patient admission and discharge forms and monthly service delivery reports (Tesiny et al., 2010). Williams et al.'s (2005) report on the New Jersey tobacco provisions finds that at discharge, 44% of smokers felt that the tobacco-free policy helped them address their tobacco use. Likewise, Williams et al. note that about one third of the program directors surveyed report that a major benefit of the tobacco provisions is that it prompted staff to either smoke less or quit entirely.

Notwithstanding these perceived positive consequences, around one third of the perceived negative consequences found in the present study deal with addict behaviors, primarily among patients, but also occasionally mentioned in terms of staff. This includes rule breaking, lying about nicotine use, unauthorized smoking, and the creation of a "black market" for cigarettes. These findings suggest a potentially serious downside of going tobacco-free. Specifically, many models of effective substance

**Table 3. Perceived Negative Consequences of Office of Alcoholism and Substance Abuse Services Regulation: Counselors**

| Category | *N* | % | *n* | % | Sample comment |
|---|---|---|---|---|---|
| Addict behaviors | 71 | 34.3 | | | |
| Sneakiness | | | 48 | 23.2 | "More people smoking on the 'downlow,' more smoking inside the facility" "Clients develop sneaky behaviors to enable them to continue to use nicotine" |
| Unauthorized smoking | | | 12 | 5.8 | "Smoking in the bathrooms" |
| Underground economy | | | 11 | 5.3 | "Selling and dealing cigarettes" |
| Enforcement problems | 37 | 17.9 | | | |
| Difficulty enforcing/penalizing | | | 20 | 9.7 | "Staff cannot penalize people correctly for breaking policy" "[W]e are not always able to prevent their smoking on the property" |
| Policing/time lost | | | 16 | 7.7 | "Monitoring smoking takes up the time and energy of staff" |
| Other | | | 1 | 0.5 | "More regulation to comply with" |
| Compromises treatment goals | 30 | 14.5 | | | |
| Interferes with drug treatment | | | 19 | 9.2 | "Creates a barrier to clinical connection" "Staff's focus shifted from drug use to nicotine use" |
| Resistance to treatment | | | 10 | 4.8 | "It gives clients another reason to argue against treatment for addictions they may be willing to address" |
| Other | | | 1 | 0.5 | "Clients no longer come early to fellowship before program" |
| Negative attitudes | 29 | 14.0 | | | |
| Negative emotional reactions | | | 23 | 11.1 | "Clients are more irritable" |
| Stigmatization of smokers | | | 6 | 2.9 | "Cigarette smokers are more and more stigmatized and ostracized" |
| Reduction in patient census | 21 | 10.1 | | | |
| Voluntarily leaving treatment | | | 9 | 4.3 | "Some clients are not ready to stop and leave treatment because of it" |
| Involuntary discharge | | | 8 | 3.9 | "More people get kicked out of rehab due to smoking" |
| Fewer patients seeking treatment | | | 4 | 1.9 | "People are not coming into treatment because of this regulation" |
| Negative patient behavior | 11 | 5.3 | | | |
| Acting out | | | 10 | 4.8 | "You see a lot of clients act out at times if they can't smoke when they want to" |
| Other | | | 1 | 0.5 | "Behavior problems increase" |
| Miscellaneous | 8 | 3.9 | | | "Increased fire risk for all" |

*Note.* Total $N = 207$. Percentages may not equal 100% due to rounding.

use disorder treatment encourage pro-social lifestyle changes, personal responsibility, and coping strategies that are different from those that sustain a criminal lifestyle (Simpson, 2008; Walters, 1994). If going tobacco-free perpetuates addict behaviors, it may be more difficult to encourage alternative pro-social behaviors while individuals are seeking treatment. Interestingly, neither the Williams et al. (2005) evaluation of the New Jersey initiative nor the internal OASAS evaluation report (Tesiny et al., 2010) reports negative consequences such as these. One reason for this may be because neither report includes survey data from frontline clinical staff, who are arguably in the best position to observe the negative consequences identified in the current study (e.g., addict behavior, compromising treatment goals, negative patient behavior). Another reason may be that the Williams et al. and Tesiny et al. reports relied extensively on archival data (e.g., Alcohol and Drug Abuse Data System, NRT utilization database, monthly service delivery reports), so there may not have been an opportunity for providers to provide their opinions about the negative outcomes of the OASAS regulations.

The findings are mixed in terms of counselors' and clinical supervisors' beliefs about whether or not going tobacco-free influences treatment. Counselor comments are just as likely to focus on how the tobacco-free regulation enhanced substance abuse treatment as they are to note on how it compromised treatment. In terms of clinical supervisor comments, about twice as many comments mention compromising treatment outcomes compared with enhancing treatment outcomes. Some of the comments also indicate that both groups are concerned that the tobacco-free policy has a negative effect on patient census. This stands in contrast to OASAS internal report, which notes no noticeable effects on admissions or treatment completion (Tesiny et al., 2010). Moreover, negative attitudes and behaviors are also perceived consequences of the OASAS regulation. Negative attitudes include enhanced irritability and stigmatization of tobacco users, whereas negative behaviors include aggression and other forms of acting out, presumably due to frustration over not being able to smoke. Some of these reactions are likely to be due to the physiological and psychological withdrawal reactions that smokers experience when they

**Table 4 .Perceived Negative Consequences of Office of Alcoholism and Substance Abuse Services Regulation: Clinical Supervisors**

| Category | *N* | % | *n* | % | Sample comment |
|---|---|---|---|---|---|
| Addict behaviors | 32 | 34.4 | | | |
| Sneakiness | | | 19 | 20.4 | "Client and staff have been forced to engage in sneaky behaviors" "Encourages clients to lie which is absolutely not a good thing in terms of their recovery on life in general" |
| Unauthorized smoking | | | 9 | 9.7 | "More smoking indoors" "The clients will now go to unauthorized areas" |
| Underground economy | | | 4 | 4.3 | "The regulation has created an underground economy around tobacco use" |
| Enforcement problems | 16 | 17.2 | | | |
| Difficulty enforcing/penalizing | | | 10 | 10.8 | "Not enough staff to monitor violations" "Uneven enforcement" |
| Policing/time lost | | | 6 | 6.5 | "Employees spend quite a bit of time policing the grounds" |
| Reduces patient census | 13 | 14.0 | | | |
| Fewer patients seeking treatment | | | 6 | 6.5 | "Some clients won't come into treatments inpatient because they can't smoke" |
| Voluntarily leaving treatment | | | 4 | 4.3 | "Many patients have been unable to tolerate a smoke free environment and have left AMA [Against Medical Advice]" |
| Involuntary discharge | | | 3 | 3.2 | "Clients were being discharged for smoking when they still need treatment" |
| Negative attitudes | 11 | 11.8 | | | |
| Negative emotional reactions | | | 8 | 8.6 | "Staff and client morale has decreased" |
| Stigmatization of smokers | | | 3 | 3.2 | "Shame-more-shame" |
| Compromises treatment goals | 9 | 9.7 | | | |
| Interferes with drug treatment | | | 6 | 6.5 | "Client success rates have declined significantly" |
| Resistance to treatment | | | 3 | 3.2 | "We have more resistance in the program" |
| Negative patient behavior | 8 | 8.6 | | | |
| Acting out | | | 8 | 8.6 | "Dealing with 'acting out' behaviors" |
| Miscellaneous | 4 | 4.3 | | | "Fires have started" |

*Note.* Total $N = 93$. Percentages may not equal 100% due to rounding.

attempt to quit smoking (West, 2001). Notwithstanding these outcomes, it is important to note the relatively small percentage of the comments in these categories.

Finally, both groups reported that the OASAS regulation improved the physical work environment in terms of improving air quality, reducing litter, and improving the overall aesthetics of the treatment center. The work environment provides important cues to both staff and patients about the goals of an organization and the professionalism of the staff (Carnevale, 1992). Moreover, pleasant working conditions are associated with more positive work attitudes among staff (Carlopio, 1996; Carnevale, 1992). This suggests that tobacco-free settings may have indirect positive effects on attitudes toward the center and treatment environment.

## Implications for Practice

Our findings suggest several implications for practice. Because the most frequently reported positive consequences were positive behavior change and increased awareness of smoking, when implementing a tobacco-free policy, there may be a window of opportunity to increase awareness of the dangers of smoking and facilitate efforts to quit among both patients and staff. This is underscored by the finding that some patients entering drug treatment express willingness to quit smoking (e.g., Joseph, Lexau, Willenbring, Nugent, & Nelson, 2004). We recommend that treatment organizations offer staff training on evidence-based practices to treat smoking and distribute educational material on the negative effects of smoking alongside organization-wide smoke-free initiatives. Another suggestion is to offer incentives to staff to quit smoking, such as a lottery system, cash incentive, or team competition, perhaps in conjunction with a workplace support group (Jason, Jayaraj, Blitz, Michaels, & Klett, 1990; Koffman, Lee, Hopp, & Emont, 1998). Contingency management systems can also be used with patients to facilitate smoking cessation (for a review see Donatelle et al., 2004).

Other practical implications involve strategies to combat some of the negative consequences of going smoke-free. An increase in addict behaviors was the most commonly mentioned negative outcome of the OASAS regulation, indicating that clinicians need to be aware that lying, stealing, and smuggling cigarettes may accompany efforts to go smoke-free. Clinicians need to work with patients to understand that these behaviors are counterproductive and can interfere with the treatment process. This is consistent with several models of substance use disorder treatment (Simpson, 2008; Walters, 1994) and as such, can be easily adopted to address addict behaviors related to unauthorized smoking. An important element in reducing addict behaviors is swift and consistent enforcement of policy violations related to smoking. However, difficulty with enforcement

was a frequently reported problem in the present study. This is consistent with the large body of research on difficulty implementing and sustaining large-scale organizational change initiatives (Fixsen, Naoom, Blasé, Friedman, & Wallace, 1995; Lehman et al., 2002). Drawing from this literature, difficulty with enforcement may stem from inadequate preparation, lack of involvement in the planning for change, lack of communication about the change, and lack of buy-in regarding the importance of the change (Fixsen et al., 1995; Lehman et al., 2002; Wanberg & Banas, 2000). It is incumbent on management to involve clinicians in all phases of the change process vis-à-vis advisory groups, planning committees, regular communication, and messaging that the regulatory change is both necessary and important.

### Limitations and Directions for Future Research

Our findings should be interpreted in light of several study limitations. First, the participants were all employed in a single state, and while there are numerous facilities and programs represented, all of the treatment centers experienced the implementation of the same regulation. Thus, the perceived positive and negative consequences that surfaced may not occur in treatment organizations in other states. However, it is likely that NYS will serve as a model for other states that are considering tobacco-free regulation.

Another limitation is that we did not survey every treatment organization or freestanding center in NYS. As such, it is not clear if the findings generalize to all NYS treatment organizations affected by the regulation. However, this concern is tempered with the finding (discussed in the method section) that the treatment organizations in the current study were similar in several key ways to the population of NYS treatment organizations. We also did not survey medical staff working in these treatment centers who may have a different view of the importance of this problem and be integral in the treatment of tobacco dependence (e.g., prescribing pharmacotherapy).

Finally, our study focused on staff beliefs about the consequences of the OASAS regulation. As perceptions, these may not reflect actual positive and negative consequences of the OASAS regulation. Nonetheless, it is important to consider staff perceptions since their beliefs and attitudes about the policy change likely influence the extent to which the provisions are implemented on a day-to-day basis and the sustainability of any changes that are made to comply with the regulation. A particularly important area for future research is examining how different implementation strategies influence the adoption and implementation of tobacco cessation efforts.

In closing, this study emphasizes the importance of focusing on the perspectives of substance abuse treatment counselors and clinical supervisors when considering the integration of tobacco regulations into treatment center policies. As these individuals are "in the trenches," they have a unique opportunity to closely observe both benefits and costs associated with such a policy change. It is clear that there are both positive and negative consequences of integrating tobacco regulations into substance abuse treatment programming. By highlighting the perceived negative and positive outcomes of the OASAS tobacco regulation in NYS, our findings provide useful insight into what centers may experience should they implement similar regulations. Equipped with this knowledge, treatment centers may more effectively plan for change and proactively identify potential barriers and solutions to overcome them.

## Funding

This research was funded by a grant from the National Institutes of Health (R01 DA019460) awarded to LTE. The opinions expressed are those of the author and not the granting agency.

## Declaration of Interests

*There are no conflicts of interest. None of the authors have financial or personal relationships with the funding agency.*

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