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## Counselor and Clinical Supervisor Perceptions of OASAS Tobacco-Free Regulation Implementation Extensiveness, Perceived Accountability, and Use of Resources

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### Abstract

New York State required substance use disorder (SUD) treatment programs to be 100% tobacco-free in 2008. The current study examined counselor (N = 364) and clinical supervisor (N = 98) perceptions of how extensively the tobacco-free regulation was implemented in their treatment programs, perceived accountability for implementing the regulation, and use of OASAS-provided resources to aid implementation one year after the regulation went into effect. Results showed that compared to counselors, supervisors perceive greater implementation extensiveness and report using more resources, yet they perceive lower accountability. In addition, whereas perceived accountability is significantly and positively associated with implementation extensiveness perceptions for counselors, the relationship is negative for supervisors. The association between use of resources and implementation extensiveness perceptions is significant and positive for both counselors and supervisors. We conclude that implementation experiences differ between counselors and clinical supervisors, suggesting the importance of tailoring interventions to promote tobacco-free policies in SUD treatment programs.

### Keywords

implementation; tobacco cessation; smoking treatment; substance abuse treatment workforce; substance use disorder treatment

### Introduction

Tobacco use is a public health concern and of particular relevance to substance use disorder (SUD) treatment programs. Smoking rates are approximately 70% for patients seeking treatment for SUDs (Rothrauff & Eby 2010; Fiore et al. 2008; Williams & Ziedonis 2004) and between 20% (Eby & Laschober 2013; Knudsen, Studts & Studts 2012; Rothrauff & Eby 2011, 2010) and 40% for SUD clinicians (Fuller et al. 2007)). Moreover, compared to other adults, individuals with SUDs are heavier tobacco users, have more difficulties quitting tobacco use, and are more likely to die from tobacco-related diseases (Richter et al. 2002; Hays et al. 1999; Breslau et al. 1996; Hurt et al. 1996)).

## NYS OASAS Tobacco-Free Regulation and Implementation Research

In an effort to decrease tobacco-related addictions, diseases, and mortality, create healthier work environments for patients, employees, and visitors, and provide tobacco cessation services to patients who smoke, New York State (NYS) became the first state to require all Office of Alcoholism and Substance Abuse Services (OASAS) certified and/or funded OASAS SUD treatment programs to be 100% tobacco-free in 2008 (NYS OASAS n.d.). This study investigates counselor and clinical supervisors' perceived implementation extensiveness of the tobacco-free regulation, perceived accountability, and use of OASAS-provided resources for implementing the regulation.

Tobacco cessation treatment implementation is slow in SUD treatment programs (Knudsen et al. 2012; Knudsen & Studts 2011; Rothrauff & Eby 2010; Friedmann, Jiang & Richter 2008; Fuller et al. 2007; Richter et al. 2004)). Major implementation barriers include clinicians' beliefs that patients are not interested in tobacco cessation (Campbell et al. 1995)), that smoking is a lesser evil compared to other SUDs (Campbell et al. 1995)), and that tobacco cessation compromises the successful treatment of other SUDs (McIlvain & Bobo 2005; Bobo & Husten 2000; Campbell et al. 1995)). Other barriers involve clinicians' smoking status (Richter et al. 2012; Gill & Bennett 2000)), lack of tobacco cessation training (Ziedonis et al. 2006)), and the thinking that tobacco use does not create legal and social issues (Richter et al. 2012)).

On July 24, 2008, NYS required all 1,419 OASAS certified and/or funded OASAS SUD treatment programs to go 100% tobacco-free (NYS OASAS n.d.). The tobacco-free regulation applies to patients, employees, and visitors and forbids anyone from bringing or using tobacco in indoor facilities, outdoor grounds, and vehicles owned, operated, or leased by the SUD treatment organization. Moreover, tobacco cessation treatment has to be offered to patients who are interested in quitting smoking (NY OASAS n.d.). The strict requirements went well beyond other tobacco prevention measures in SUD treatment organizations at the time, such as bans on indoor smoking to comply with state or local decrees (e.g., National Association of State Alcohol and Drug Abuse Directors [NASADAD] 2010). Thus, NYS provided a naturalistic setting and rich opportunities for implementation research.

Specific to the OASAS tobacco-free regulation implementation, three published studies showed a significant implementation increase between pre- and post-regulation. Brown and colleagues (2012) found that administrators working in SUD treatment programs affected by the OASAS regulation reported increased implementation of tobacco cessation services, tobacco pharmacotherapy, and tobacco screening between pre- and post-regulation, and complete compliance with a tobacco-free campus policy post-regulation. The authors concluded that implementation of tobacco-free regulations can be achieved without negatively affecting patient admission to treatment.

A second study using longitudinal data also found an increase in clinicians' implementation of tobacco cessation-related intake procedures and guideline recommended counseling for treating tobacco dependence one year after the regulation went into effect, compared to 4 months pre-regulation (Eby & Laschober 2013). The authors suggested that the OASAS regulation reached programs with various characteristics and promoted the implementation of the tobacco-free regulation. Finally, Guydish et al. (2012) found a decrease in patient smoking based on patient data and, based on staff data, that the implementation of the tobacco-free regulation in terms of staff attitudes, practices, and knowledge related to tobacco use was dependent on the treatment setting (e.g., outpatient, residential, methadone).

## Implementation Perceptions, Clinician Accountability Perceptions, and Clinician Use of Resources

We explore two factors that may be related to clinicians' perceived implementation extensiveness of the OASAS tobacco-free regulation: perceived accountability for implementing the tobacco-free regulation and use of OASAS-provided resources to promote implementation of the tobacco-free regulation. Accountability refers to employees' sense of responsibility to implement an innovation to avoid facing individual and organizational sanctions for non-compliance (e.g., Schlenker et al. 1994; Tetlock 1992)) and is positively related to job performance (e.g., Davis, Mero & Goodman 2007; Lerner & Tetlock 1999)). In the current study, job performance is conceptualized as how extensively the tobacco-free regulation is implemented because it represents a mandated change in program operations. Further, employees who utilize resources that support the implementation of innovations have increased self-efficacy and control, which in turn predicts more positive attitudes and behaviors toward organizational change (Wanberg & Banas 2000; Judge et al. 1999)).

The present study adds to the limited tobacco cessation implementation literature in SUD treatment programs and extends previous research by comparing counselor and clinical supervisor (1) perceptions of the implementation extensiveness of the OASAS tobacco-free regulation, (2) perceptions of accountability, and (3) use of OASAS-provided resources to implement the tobacco-free regulation. In addition, we examine the association between counselor and clinical supervisor perceptions of implementation extensiveness and (4) perceptions of accountability and (5) use of OASAS-provided resources. Differences in counselor and clinical supervisor perceptions of implementation extensiveness, perceptions of accountability, and use of OASAS-provided resources are expected based on their differential job descriptions, roles, and responsibilities (e.g., Laschober, Eby & Sauer 2013; Lindbloom, Ten Eyck & Gallon 2005; Powell & Brodsky 2004)).

## METHODS

### Study Design and Sample

As part of the Managing Effective Relationships in Treatment Services (MERITS II) project, data for the current study were collected in 2009, approximately 10–12 months after the OASAS tobacco-free regulation went into effect. The purpose of MERITS II was to longitudinally examine the effects of the OASAS tobacco-free regulation on employees in SUD treatment programs in NYS. The study was funded by the National Institute on Drug Abuse (NIDA) in response to a program announcement for health services research on practice improvement utilizing community treatment programs within NIDA's Clinical Trials Network (CTN). All procedures were approved by the Institutional Review Board at [author anonymity].

At the time of data collection, the CTN had two NY "nodes", which are partnerships between a research center and a number of Clinical Trials Providers (CTPs). The two nodes comprised 10 CTPs that were located in NY City and Long Island. We contacted each CTP leader, explained the purpose of our study, and invited them to participate. Seven of the 10 CTPs agreed to participate. The clinician sample size requirements were not obtained with these 7 CTPs to achieve adequate power and recruitment was extended to non-CTN-affiliated SUD treatment programs in NYS. The sampling frame for the non-CTN-affiliated programs came from a list of NYS treatment programs that had previously participated in another project.

In order for CTN- and non-CTN-affiliated SUD treatment organizations to be eligible for participation, they had to be located in NYS, affected by the OASAS tobacco-free regulation, offer SUD counseling services, and be located in the community. Thus,

organizations that were prison-based programs, Veteran's Health Administration programs, and driving-under-the-influence schools were excluded. None of the treatment organizations initially recruited were ineligible based on these criteria. This resulted in a final sample of 16 organizations (7 were CTN-affiliated) with 51 unique programs (23 were CTN-affiliated; range of 1–8 programs per organization) in NYS in 2009. Trained research assistants traveled to each program to administer paper-and-pencil surveys to SUD clinicians. An administrator in each organization also provided organization-level data. Treatment organizations were compensated for their participation and received an additional incentive for each completed counselor and clinical supervisor survey to offset the staff time required to collect the data during normal business hours.

Because our sample was not randomly selected, we used the 2006 Substance Abuse and Mental Health Services Association (SAMHSA) facility locator and National Survey of Substance Abuse Treatment Services (N-SSATS) database to examine the representativeness of our sample. Organizations in our study were similar to the aggregate characteristics of all NYS SUD treatment programs in terms of having a primary focus on SUDs and providing detoxification services, methadone maintenance, hospital inpatient services, short-term and long-term residential services, services for adolescents, functioning as a halfway house, and treating criminal justice patients (a full report is available upon request).

Administrator-provided organization-level data showed that almost half of the organizations offered outpatient-only services (43.75%), 18.75% offered inpatient-only care, and 37.50% offered a mixture of inpatient and outpatient care. The majority of organizations operated as not-for-profit (81.3%), were free-standing units that were not located on a hospital-campus (75%), and were accredited (60.0%). In addition, only 13.33% of organizations were based on a 12-step model whereas 86.67% noted an eclectic approach to treatment. Organizations employed an average of 10.25 ( $SD = 12.83$ ) clinical supervisors and 43.50 ( $SD = 55.33$ ) counselors. The administrator response rate was 100%.

For clinicians to be eligible to complete a survey, counselors had to have direct contact with patients in a therapeutic relationship such as individual counseling, group counseling, or a combination of individual and group counseling; clinical supervisors had to be in a supervisory position with at least one counselor. The response rate was 69% for counselors and 78% for clinical supervisors. The sample for this study included 364 counselors and 98 clinical supervisors (see Table 1 for counselor and clinical supervisor characteristics).

## Measures

*Perceived implementation extensiveness of the OASAS tobacco-free regulation* was measured with 17 items (see Appendix A). We developed the type and number of items as well as the response options based on the 9 regulatory elements outlined in the Tobacco-Free Services Title 14 NYCRR Part 856 issued by OASAS for treatment programs to comply with the regulation (NYS OASAS n.d.). Several of the regulatory elements referred to more than one stakeholder by OASAS [e.g., Section 856.5 (a)(2) “prohibits staff, family members, and visitors from bringing tobacco products and paraphernalia to the service”; Section 856.5 (a)(3) “requires all patients, staff, volunteers, and visitors be informed on the tobacco-free policy...”]. For these regulatory elements we created separate items because, for example, the regulation may be implemented for staff but perhaps not for visitors. The measure included 6 items specific to *patient policies and strategies*, three items referred to *visitor policies and strategies*, and eight items concerned *employee policies and strategies*. Response options were 0 = *no* and 1 = *yes*. The overall scale was developed by summing the number of *yes* responses to represent an index of implementation extensiveness (i.e., number of regulatory elements implemented).

*Accountability for implementing the OASAS tobacco-free regulation* included 4 items developed for the present study based on a review of the management literature on perceived accountability (e.g., Davis et al. 2007; Mero, Guidice & Brownlee 2007; Lerner & Tetlock 1999)). Items include, “If I don’t follow the OASAS regulations, then nothing much will happen to me” (reverse scored). “No one is really monitoring whether or not my treatment center is in compliance with the OASAS regulations” (reverse scored). “Management is not really concerned about whether or not we are following the OASAS regulations” (reverse scored). “Compliance with the OASAS regulation is carefully monitored at my treatment center”. The scale was developed by creating the mean across the 4 items ( $\alpha = .79$  for counselors and  $.75$  for clinical supervisors) with higher scores indicating greater accountability. Response options ranged from 1 = *strongly disagree* to 5 = *strongly agree*.

*Utilization of OASAS-provided resources* to support the implementation of the OASAS tobacco-free regulation included eight items (i.e., used...OASAS website, OASAS on-line tobacco training, OASAS Learning Thursdays for tobacco, OASAS mentor, tobacco recovery exchange website, technical assistance and training from Rockefeller College and University of Albany, NYS tobacco cessation centers, NYS tobacco community partnerships). The items and response options were selected directly from the information posted on the OASAS website (NYS OASAS n.d.). Response options were 0 = *no* and 1 = *yes*. The scale was developed by summing the number of *yes* responses.

*Control variables.* Personal smoking status (0 = *non-smoker*, 1 = *current smoker*) was added as a control variable to all analyses because previous research has shown a relationship between clinician tobacco use and tobacco cessation service delivery (Guydish et al. 2007; Ziedonis et al. 2006)). Further, clinician certification/license as SUD professional, education, race, age, hours worked per week, and annual income, were added as control variables because they showed significant differences in characteristics between counselors and clinical supervisors (see Table 1).

## Data Analysis

Significant differences in demographic characteristics between counselors and clinical supervisors were determined using chi-square analyses for categorical variables and general linear models for continuous variables due to unequal group sizes. Prior to addressing the research questions, we calculated intraclass correlation coefficients (ICCs) to determine whether mixed-method statistical models needed to be used over more traditional models (e.g., ANOVA, OLS regression) to account for the nested structure of our data (i.e., counselors and clinical supervisors are nested within treatment programs and treatment programs are nested within organizations). We followed generally accepted guidelines that ICCs greater than 10% indicate a fair amount of clustering and require the use of mixed-method models to avoid misleading inferences (Kreft & de Leeuw 1998).

Program nesting explained 17.48% of the variance for implementation extensiveness perceptions, 1.05% for perceived accountability, and 5.49% for use of OASAS-provided resources. Organization nesting explained 19.67% of the variance for implementation extensiveness perceptions, 0% for perceived accountability, and 5.80% for use of OASAS-provided resources. As a result, the three research questions pertaining to implementation extensiveness perceptions (i.e., differences in counselor and clinical supervisor perceptions of implementation extensiveness, and whether perceived accountability and use of OASAS-provided resources are significantly related with implementation extensiveness perceptions) were explored using mixed-method models to account for nesting of clinicians within programs and within organizations. The latter two analyses (whether perceived accountability and use of OASAS-provided resources are significantly related with implementation extensiveness perceptions) were conducted separately for counselors and

clinical supervisors. The two research questions on differences in counselor and clinical supervisor perceptions of accountability and use of OASAS-provided resources were answered using general linear models, which are ANOVA-based frameworks that account for unequal sample sizes by computing least-square (weighted) means. All analyses were conducted using SAS 9.3.

## Results

As shown in Table 2, clinical supervisors perceived greater implementation extensiveness of the OASAS tobacco-free regulation and reported greater use of OASAS-provided resources than did counselors. Counselors perceived higher clinician accountability compared to clinical supervisors. Regarding the control variables, clinicians who identified themselves as Caucasian perceived less implementation extensiveness and used fewer resources; certified/licensed SUD clinicians used more resources. No other statistically significant relationships were found. Table 3 shows that for counselors, there was a positive association between perceived implementation extensiveness and both perceived accountability and use of OASAS-provided resources. For clinical supervisors, there was a negative relationship between perceived implementation extensiveness and perceived accountability but a positive association with use of OASAS-provided resources. None of the control variables were significantly related to implementation extensiveness perceptions for counselors or clinical supervisors.

## Discussion

Before discussing the findings pertaining to our research questions, it is worth noting the generally low perceptions of implementation extensiveness of the tobacco-free regulation and low use of OASAS-provided resources among counselors and clinical supervisors (see Table 2). The low implementation perceptions are consistent with findings that implementation of EBPs in SUD treatment is a slow process that in many cases does not fully materialize (e.g., Eby & Laschober 2013; Knudsen et al. 2012; Rothrauff & Eby 2011; Knudsen & Studts 2010). The low utilization of OASAS-provided resources may suggest that clinicians are not aware of the available resources, do not have adequate time to access and utilize the resources, or do not find available resources relevant to greater implementation of the tobacco-free regulation.

Regarding our research questions, we find that clinical supervisors perceive higher implementation extensiveness of the tobacco-free regulation than do counselors. This may be explained by differences in the type of work they each perform (e.g., Laschober et al. 2013; Powell & Brodsky 2004). Because clinical supervisors mentor counselors in the use of EBPs (Powell & Brodsky 2004), they need to be knowledgeable about all aspects of the tobacco-free regulation and what has been done by the program to meet the tobacco-free regulation (e.g., Brass 2004; Seibert et al. 2001), increasing their implementation perceptions.

We further find that counselors perceive greater accountability for implementing the tobacco-free regulation than do clinical supervisors. Counselors are in a subordinate position relative to the clinical supervisor and may fear greater reprimands or disciplinary write-ups if the regulation is not implemented as required (e.g., Schlenker et al. 1994; Tetlock 1992). Counselors are also expected to implement the regulation under their clinical supervisor's guidance. This may heighten counselors' sense of accountability relative to clinical supervisors.

Counselors and clinical supervisors also report significant differences in the utilization of resources provided by OASAS to help implement the tobacco-free regulation. Clinical supervisors' duties include educating, training, and mentoring counselors to help them develop professional competencies (Laschober et al. 2013; Powell & Brodsky 2004). Thus, supervisors may seek more information about the regulation to pass on information to counselors and help them enforce the regulation with counselors.

Finally, we find clinician differences in the relationships between implementation extensiveness perceptions and both accountability perceptions and the use of OASAS-provided resources. The finding that use of OASAS-provided resources is positively associated with implementation extensiveness perceptions for both clinical supervisors and counselors suggests that they are equally benefitting from using the resources. However, considering the generally low use of the resources, future studies should attempt to identify barriers to resource utilization to develop better strategies for promoting implementation of tobacco-cessation services.

Bearing in mind that accountability has been found to be positively associated with job performance (Davis et al. 2007; Mero et al. 2007; Lerner & Tetlock 1999), it is not surprising that counselors' perceived accountability is positively related to their perceptions of implementation extensiveness. It may be that counselors develop a sense of accountability based on the extent to which the clinical supervisor stresses the importance of complying with the regulation and the negative sanctions for non-compliance (e.g., Schlenker et al. 1994).

However, we are surprised by the negative association between implementation extensiveness perceptions and accountability perceptions for clinical supervisors. Clinical supervisors may develop a sense of accountability based not on the sanctions for non-compliance, but rather whether or not policies are actually followed by others. When policies are being followed more uniformly by staff, clinical supervisors may be less concerned about accountability because the likelihood of negative sanctions is reduced.

### **Implications for SUD Treatment Programs and Clinicians**

To better align clinician perceptions of the implementation extensiveness of the tobacco-free regulation, treatment programs and clinical supervisors may need to better inform counselors of the changes that the program is undergoing, the type of changes that have to be made, and how these changes are being implemented. This will help reduce resistance to change and increase implementation behaviors (e.g., Eby, George & Brown 2013; Rafferty & Griffin 2006; Jimmieson, Terry & Callan 2004). Differences in clinician accountability perceptions may be lessened by clearly communicating implementation expectations, to whom counselors and clinical supervisors are accountable, and consequences for inconsistent implementation behavior. Clinician differences in the use of OASAS-provided resources may be reduced by targeting the different stakeholders of interest. Programs should evaluate whether both clinical supervisors and counselors have equal access (e.g., time, space) to utilize the OASAS-provided resources.

### **Limitations and Conclusion**

Treatment programs in our study are limited to NYS because it was the only state in 2008 that required all OASAS certified and/or funded SUD treatment programs to be 100% tobacco-free. Consequently, NYS provided a naturalistic setting for examining the implementation of such strict tobacco cessation regulations. Treatment programs interested in implementing similar policies may encounter different challenges, clinicians with greater or lesser perceptions of their programs' implementation of mandated changes, differences in

accountability perceptions should clinicians not implement requirements as mandated, and in their use of resources and support intended to promote the implementation of tobacco cessation efforts.

Clinicians may have overstated their perceptions of the implementation extensiveness of the tobacco-free regulation, perceptions of accountability, and use of resources to report compliance with the mandatory regulation. However, their overall low reports suggest that socially desirable responding is unlikely in this sample. Moreover, not all of the clinicians who were invited to participate chose to complete a survey, which may pose another source of response bias.

Our survey was designed to assess clinicians' perceptions of implementation extensiveness of the tobacco-free regulation, perceptions of accountability, and use of OASAS-provided resources. We recognize that clinicians' perceptions may differ from their actual behaviors. Future research using observational designs and organizational records would offer a complimentary perspective to the current study and provide a more complete understanding on the implementation of the OASAS tobacco-free regulation in NYS.

In conclusion, this study adds to the sparse literature on implementation research in SUD treatment and provides a better understanding of implementation extensiveness of the OASAS tobacco-free regulation and factors associated with implementation experiences by examining perceptions of both counselors and clinical supervisors. Findings indicate that counselors and clinical supervisors differ in their perceptions of implementation extensiveness, perceived clinician accountability, and clinician use of OASAS-provided resources to implement the OASAS tobacco-free regulation. Findings suggest that it is important to utilize different strategies to affect implementation experiences of counselors and clinical supervisors.

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## Appendix A: Perceived Implementation Extensiveness of the OASAS Tobacco-Free Regulation\*

For patients:

1. \_\_\_ Written policy established for patients that bans tobacco products in the facilities, grounds, and vehicles owned, leased, or operated by the center
2. \_\_\_ Patients prohibited from bringing tobacco products and paraphernalia into facility
3. \_\_\_ Information disseminated on tobacco-free regulation for patients (e.g., pamphlets)
4. \_\_\_ Treatment modalities established for patients who smoke (e.g., nicotine replacement, counseling)

5. \_\_\_ Tobacco and nicotine prevention and education programs available for patients
6. \_\_\_ Written policy on how patient policy violations will be handled

For visitors:

7. \_\_\_ Written policy established for visitors that bans tobacco products in the facilities, grounds, and vehicles owned, leased, or operated by the center
8. \_\_\_ Visitors prohibited from bringing tobacco products and paraphernalia into facility
9. \_\_\_ Information disseminated on tobacco-free regulation for visitors (e.g., pamphlets)

For employees:

10. \_\_\_ Written policy established for employees that bans tobacco products in the facilities, grounds, and vehicles owned, leased, or operated by the center
11. \_\_\_ Employees prohibited from bringing tobacco products and paraphernalia into facility
12. \_\_\_ Information disseminated on the tobacco-free regulation for employees (e.g., e-mail, discussion at staff meeting)
13. \_\_\_ Staff prohibited from indoor smoking during work hours
14. \_\_\_ Staff prohibited from outdoor smoking during work hours
15. \_\_\_ Clinicians trained on how to treat nicotine dependence in patients
16. \_\_\_ Tobacco and nicotine prevention and education programs available for employees
17. \_\_\_ Written policy on how employee policy violations will be handled

\*Items come directly from the nine components of the OASAS tobacco-free regulation, Title 14 NYCRR Part 856 (<http://www.oasas.state.ny.us/tobacco/providers/reg856.cfm>). Some of the original 9 regulatory components jointly referred to “patients, visitors and employees.” In developing the measure, separate items were created for each because the regulation might be implemented for patients but not visitors or employees.

**Table 1**

## Counselor and Clinical Supervisor Characteristics

Variable	Counselor	Supervisor	$X^2 / F$	<i>p</i>
SUD Certified/licensed [F, (%)]	221 (61.90)	73 (77.66)	8.14	.004
Female [F, (%)]	219 (60.33)	56 (58.33)	.13	.723
Master's degree or higher [F, (%)]	183 (51.40)	67 (69.07)	9.62	.002
Caucasian [F, (%)]	204 (56.04)	68 (69.39)	5.68	.017
In recovery [F, (%)]	151 (42.66)	45 (47.37)	.68	.411
Married or cohabiting [F, (%)]	164 (46.07)	53 (54.64)	2.24	.134
Current smoker [F, (%)]	74 (20.39)	20 (21.05)	.02	.886
Tenure in current position/yrs [M, (SD)]	5.85 (7.24)	7.44 (7.63)	3.54	.061
Age/years [M, (SD)]	44.55 (12.96)	48.22 (11.48)	6.21	.013
Hours worked per week [M, (SD)]	38.22 (8.26)	42.02 (8.05)	16.23	<.0001
Income/\$1,000 [M, (SD)]	37.847 (12.159)	59.119 (17.582)	168.15	<.0001

Table 2

Differences in the Perception of OASAS Tobacco-Free Implementation Extensiveness, Perceived Accountability, and Use of OASAS-Provided Resources between Counselors and Clinical Supervisors

Variable	Counselor		Supervisor		F	P
	LSM <sup>a</sup>	SE	LSM <sup>a</sup>	SE		
Implementation Extensiveness (0–17) <sup>b,c</sup>	9.27	.55	11.97	.77	16.80	<.0001
Accountability (1–5) <sup>b,d</sup>	3.70	.05	2.25	.10	143.20	<.0001
Use of Resources (0– 8) <sup>b,d</sup>	1.38	.10	2.03	.23	6.05	.014

Note.

<sup>a</sup>LSM = Least square means.

<sup>b</sup>Controlling for clinician smoking status, certification/licensure, education, race, age, hours worked per week, and annual income.

<sup>c</sup>Results of mixed-methods models for nested data.

<sup>d</sup>Results of general linear models.

**Table 3**

Relationship between Perceptions of OASAS Tobacco-Free Regulation Implementation Extensiveness and Perceived Accountability and Use of OASAS-Provided Resources<sup>a</sup>

	Counselor			Supervisor		
	B	SE	t	B	SE	t
Accountability (1-5) <sup>b</sup>	1.26	.31	4.03	-1.73	.39	-4.47
Use of Resources (0-8) <sup>b</sup>	.30	.15	2.03	.81	.17	4.84
-2 Res Log Likelihood	1735.7			403.9		

*Note.*

<sup>a</sup> Results of mixed-methods models for nested data. Implementation extensiveness measured on a 0-17 scale with higher values indicating greater extensiveness.

<sup>b</sup> Controlling for clinician smoking status, certification/licensure, education, race, age, hours worked per week, and annual income.